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REPORTING THE COSTS AND BENEFITS OF THE 3Rs

By Maureen Nelson, Matthew Haaf and Megan Lansden

Congress enacted the Affordable Care Act[1] (ACA) with the simultaneous goals of decreasing the number of individuals without health insurance coverage, increasing the quality of health insurance coverage, and reducing the costs of coverage for individuals and the government. As part of the effort to achieve these goals, beginning in 2014 the ACA requires that each issuer that offers a qualified health plan (QHP) on the marketplace "Exchange,"[2] individual health insurance coverage sold outside of the Exchange, or small group market coverage must provide insurance that meets certain minimum standards of coverage without adjusting rates for pre-existing conditions or the gender of the insured.

In order to encourage issuers to offer health insurance coverage on the Exchange and on the individual and small group markets, while ameliorating the potential impact on any particular health insurance issuer of providing coverage without pricing for pre-existing conditions or the gender of the insured, the ACA includes three risk-sharing programs. These programs, which began in 2014, are the Transitional Reinsurance program,[3] the Risk Corridor program[4] and the Risk Adjustment program[5] (collectively referred to as the "3Rs"). The Risk Adjustment program operates to spread the risks of adverse selection among the health insurance issuers operating within a particular state, and the Transitional Reinsurance and Risk Corridor programs operate to improve risk on a national level. The Transitional Reinsurance and Risk Corridor programs are temporary programs effective for 2014-16; the Risk Adjustment program is permanent.

The financial and tax reporting of each health insurance issuer is affected by the implementation of these risk-sharing programs because each health insurance issuer is required to pay for the programs' costs, and some issuers are or will be eligible for benefits under them. To fund the costs of the 3Rs, assessments are levied on health insurance issuers (and, in the case of the Transitional Reinsurance program, on sponsors of self-insured group health plans).[6] These assessments in turn pay for distributions to eligible health insurance issuers, program administrative expenses and contributions to the U.S. Treasury.

For statutory reporting, guidance as to the characterization and recognition of the assessments and potential distributions under the different programs is found in National Association of Insurance Commissioners (NAIC) Statement of Statutory Accounting Principles (SSAP) No. 107, *Accounting for the Risk-Sharing Provisions of the Affordable Care Act.* To date, the Internal Revenue Service (IRS) has provided limited published guidance on the tax implications of these risk-sharing programs.[7]

TRANSITIONAL REINSURANCE PROGRAM

The Transitional Reinsurance program is intended to provide temporary relief to health insurance issuers from some of the claim costs incurred for coverage provided to individuals with significant health care needs ("high-risk individuals") under certain non-grandfathered health insurance products.[8] It operates by creating one or more "applicable reinsurance entities" that will collect amounts assessed on issuers of individual and group health plans and on sponsors of self-insured group health plans[9] (collectively, "covered entities") and will make program distributions.[10] The Transitional Reinsurance program is designed to fund a reinsurance pool,[11] pay the administrative expenses of the applicable reinsurance entities[12] and make a contribution to the U.S. Treasury.[13] Under the Transitional Reinsurance program, a health insurance issuer is only eligible for distributions from an applicable reinsurance entity for costs associated with its issuance of individual insured health products that are subject to the 2014 ACA market reforms. For costs associated with other insured health products, including coverage sold under individual grandfathered plans, group health plans and self-insured health products, program distributions are not available.

Each covered entity is required to submit a report to HHS that provides its annual enrollment count by November 15 of the coverage (i.e., benefit) year. The amounts assessed are based on the number of individuals insured by the covered entity, whether pursuant to an individual plan, a group plan or a self-insured plan. For the 2014 coverage year, the reinsurance assessment was $5.25 per enrollee per month or $63 for the entire coverage year; at least $52.50 per enrollee must have been

paid no later than Jan. 15, 2015, and the remaining $10.50 per enrollee must be paid no later than November 15, 2015.[14] HHS will tell each covered entity how much of its total assessment HHS is allocating to the U.S. Treasury contribution from the program.

The applicable reinsurance entities will make reinsurance program distributions to reimburse issuers of eligible individual insured health products for a portion (coinsurance rate) of the total cost of benefits provided for a coverage year that is in excess of a specified minimum total cost (attachment point) up to a maximum total benefit cost (cap). For the 2014 coverage year, the coinsurance rate is 80 percent, the attachment point is $45,000 and the cap is $250,000.[15] An eligible covered entity may submit claims for reimbursement to the applicable reinsurance entity through April 30 of the year following the benefit year. HHS will distribute reinsurance program funds among issuers nationally based on submitted claims. Issuers will be notified of pending reinsurance distributions by June 30 of the year following the benefit year.

Statutory Accounting Treatment

For coverage provided to enrollees in an individual non-grandfathered plan that is eligible for reinsurance program distributions, SSAP No. 107 requires reinsurance program assessments to be divided into two parts. One part funds the reinsurance pool and pays the administrative expenses of the applicable reinsurance entity operating the reinsurance pool, and the other part funds the amount payable to the U.S. Treasury. The portion of the reinsurance program assessment that funds the reinsurance pool and pays its administrative expenses is accounted for as ceded reinsurance premium in accordance with SSAP No. 61R, *Life, Deposit-Type and Accident and Health Reinsurance,* and recorded as a reduction to premium income for the coverage period. Similarly, amounts received by a covered entity for reinsurance program distributions are reported as ceded claim benefit recoveries with distributions receivable from the reinsurance program reported in the same manner as traditional reinsurance recoveries, as described in SSAP No. 61R. The portion of the reinsurance program assessment that funds the amount payable to the U.S. Treasury is to be accounted for as an expense for "taxes, licenses and fees" that must be recorded when the liability for this payment attaches and the amount can be reasonably estimated (i.e., when the coverage is issued), consistent with SSAP No. 35R, *Guaranty Fund and Other Assessments.*

For coverage provided to enrollees in all other plans that are not eligible for reinsurance program distributions, SSAP No. 107 requires reinsurance program assessments (including both the portion going to the applicable reinsurance entity and the portion going to the U.S. Treasury) to be treated as assessments payable by the reporting entity and charged to "taxes, licenses and fees" when the coverage is issued, consistent with SSAP No. 35R. Reinsurance program assessments made on behalf of a self-insured plan administered by the reporting entity are passed through to the self-insured plan and are not reported as revenues or expenses by the reporting entity, consistent with SSAP No. 47, *Uninsured Plans.*

Federal Income Tax Treatment

We anticipate that many issuers will reflect the payments and recoveries accounted for as adjustments to premiums in taxable income in the year they are recorded on the Annual Statement for statutory reporting.[16] One potential question is whether the portion of the assessments treated as "taxes, licenses and fees" for statutory accounting purposes is deductible as an expense incurred within the meaning of IRC §832(b)(6) in the year it must be recorded as an expense for statutory accounting purposes or when "economic performance" under IRC §461(h) has occurred and therefore the "all events" test has been satisfied. If a health insurance issuer is required to satisfy the economic performance test before it may deduct the portion of the reinsurance program assessment reported on its Annual Statement under the category of "taxes, licenses and fees," then the next question is whether this liability is the type of liability for which the recurring item exception is permitted.

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If economic performance is required, the liability to pay the assessments imposed under the Transitional Reinsurance program would be a "payment liability" under Treas. Reg. §1.461-4(g). One type of payment liability eligible for the recurring item exception is described under Treas. Reg. §1.461-4(g)(6), which is captioned "Taxes" but which addresses both taxes and "licensing fees." Treas. Reg. §1.461-4(g)(6)(ii) describes licensing fees as follows: "If the liability of a taxpayer is to pay a licensing or permit fee required by a governmental authority, economic performance occurs as the fee is paid to the governmental authority, or as payment is made to any other person at the direction of the governmental authority." Under the ACA, all covered entities issuing insurance in the individual and small group markets must pay the transitional reinsurance assessment (or face significant penalties) and it must be paid to a governmental authority (either to the U.S. Treasury or to the applicable reinsurance entity operated by either HHS or a state). This argues for concluding that these amounts qualify as licensing fees and would be eligible for the recurring item exception for a health insurance issuer that has elected the recurring item exception for this type of tax item, which would enable an electing health insurance issuer to deduct this expense in the year the liability is incurred.

RISK CORRIDOR PROGRAM

The Risk Corridor program applies to QHPs offered on the Exchange and to policies or plans substantially similar to QHPs offered on the individual and small group markets outside of the Exchanges.[17] The program provides limitations on health insurance issuers' losses and gains for QHPs by creating a mechanism for risk sharing for allowable costs between the federal government and the QHP issuers, thus providing QHPs additional protection against initial pricing risk. For each QHP sold by a health insurance issuer, the health insurance issuer must calculate its "allowable costs"[18] (i.e., medical claim payments plus quality improvement costs) and compare those to a "target amount"[19] (i.e., premiums collected reduced by "allowable administrative costs").[20] The allowable costs for a QHP are then compared to the target amount and if the QHP has exceeded the target amount by 103 percent or more, the issuer of the QHP is entitled to a distribution from HHS under the Risk Corridor program.[21] If the allowable costs for a QHP are less than 97 percent of the target amount, the issuer is required to remit an assessment to HHS under the Risk Corridor program.[22] Issuers are required to report their target amounts and allowable costs for each QHP to HHS by July 31 of the year following the benefit year. After receiving this information, and after the adjustments related to the Transitional Reinsurance and Risk Adjustment programs have been determined, HHS will calculate the risk corridor assessments and distributions and issue invoices to QHP issuers for assessments due.

Arguably, the ACA as enacted could have required HHS to make total risk corridor distributions to QHP issuers for a coverage year in excess of the total risk corridor assessments collected from QHP issuers for that coverage year, although HHS expected assessments collected to be sufficient to cover distributions under the program. The so-called "CRomnibus" legislation,[23] passed by Congress just before the end of 2014, includes a provision requiring HHS to limit total risk corridor distributions to eligible health insurance issuers to total risk corridor assessments received by HHS.

In guidance issued as a "Q&A," HHS advised that if assessments collected for 2014 were insufficient to cover distributions, distributions would be reduced on a pro rata basis and assessments collected for 2015 would first be used to pay, in a proportional manner, the remaining amounts owed to QHP issuers for 2014. The same procedures will be used for making risk corridor distributions for 2015. In the Q&A, HHS indicated that if it appears that assessments for all three years under the existing rules will be insufficient to make all risk corridor distributions owed to QHP issuers, it would provide additional guidance for calculating risk corridor assessments owed by QHP issuers for 2016.

Statutory Accounting Treatment

Under SSAP No. 107, assessments and distributions under the Risk Corridor program are treated like premium adjustments for retrospectively rated contracts under SSAP No. 66, Retrospectively Rated Contracts. As such, they increase or decrease premium revenue over the contractual period of coverage based on experience to date and are recognized to the extent that such increases or decreases are reasonably estimable. Receivables under the Risk Corridor program are considered receivables from a federal government program. Accordingly, amounts outstanding over 90 days will not cause the receivable to be treated as a nonadmitted asset based solely on aging. SSAP No. 107 requires, however, that an issuer evaluate the collectability of any risk corridor receivable and charge any uncollectible amounts to income in the period it is determined that such amounts will not be collected, in accordance with SSAP No. 5R, Liabilities, Contingencies and Impairments of Assets.

Federal Income Tax Treatment

We anticipate that many issuers will reflect the assessments and distributions accounted for as adjustments to premiums in taxable income in the year they are recorded on the Annual Statement for statutory reporting. This suggests that an issuer unable to estimate its distribution for the 2014 benefit year and waiting until the earlier of notice or receipt of a distribution to record it on its Annual Statement may wait until the earlier of notice or receipt of a distribution to include it in taxable income.

RISK ADJUSTMENT PROGRAM

As explained in SSAP No. 107, the purpose of the Risk Adjustment program is "to transfer funds from lower risk plans to higher risk plans within similar plans in the same state in order to adjust premiums for adverse selection among carriers caused by membership shifts due to guarantee issue and community rating mandates." The accounting elements of the Risk Adjustment program, which must be considered separately, include the user fee and the risk adjustment assessment or distribution.

The user fee supports the administration of the Risk Adjustment program and is imposed on all issuers of health plans (except certain exempt and grandfathered plans) in the individual and small group markets within a particular state, whether sold on or outside of the Exchange (each, a "reporting entity"). It is paid to the administrator of the program (in most instances, HHS), is charged monthly on the basis of premiums written and is collected in July following the close of the benefit year when risk adjustment assessments are collected.[24]

The risk adjustment assessment is imposed on a reporting entity if the actuarial risk score of the enrollees in the reporting entity's health plans for the coverage year is determined to be less than the average risk score of other reporting entities within that market and state after certain adjustments are taken into account. The actuarial risk score of a reporting entity is determined by the program administrator under a complex methodology set forth in HHS regulations that takes into account various factors affecting a reporting entity's costs of providing its promised coverage for the year, including each insured's demographics and diagnoses. Risk adjustment assessments are made by June 30 of the year following the benefit year and must be paid within 30 days of notification of the assessment (i.e., by July 30).

A reporting entity will be eligible for a risk adjustment distribution if its actuarial risk score for the coverage year is determined to be greater than the average risk score of other reporting entities within that market and state. Because the source of funds for risk adjustment distributions is risk adjustment assessments, distributions will be made only after assessments are paid in July.

Statutory Accounting Treatment

SSAP No. 107 requires that risk adjustment assessments and distributions be treated as adjustments (decreases or increases) to premium revenue. A reporting entity will record such adjustments in the period in which the changes in risk scores of its enrollees result in reasonably estimable decreases or increases. An adjustment that is estimated for the portion of the policy period that has expired is reported as an immediate adjustment to premium revenue. The user fee is recorded as an expense for "taxes, licenses and fees" when the premium subject to the user fee is written, consistent with SSAP No. 35R.

Federal Income Tax Treatment

Similar to the transitional reinsurance assessments and distributions, we expect that many issuers will reflect the assessments and distributions accounted for as adjustments to premiums in taxable income in the year they are recorded on the Annual Statement for statutory reporting. An issuer should consider whether the user fee treated as "taxes, licenses and fees" for statutory accounting purposes may be deducted as an expense incurred under IRC §832(b)(6) in the year it must be recorded as an expense for statutory accounting purposes or may only be deducted when the "economic performance" test under IRC §461(h) is satisfied. If economic performance is required, the issuer should also consider whether the "recurring item exception" under IRC §461(h)(3) is available.

Health insurance issuers' facts and circumstances differ based on product line, use of estimates, Annual Statement presentation, previous accounting methods, etc. Accordingly, tax professionals will need to work closely with financial accounting professionals to determine the appropriate tax treatment of the required assessments and potential receivables under the 3Rs when determining proper tax reporting for 2014.◂

Note: *The views expressed herein are those of the authors and do not necessarily reflect the views of Ernst & Young LLP.*

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Maureen Nelson is an executive director in the Business Tax Advisory practice with Ernst & Young LLP and may be reached at *maureen.nelson@ey.com.*

Matthew Haaf is a partner in the Business Tax Advisory practice with Ernst & Young LLP and may be reached at *matthew.haaf@ey.com.*

Megan Lansden is a senior manager in the Global Compliance and Reporting practice with Ernst & Young LLP and may be reached at *megan.lansden@ey.com.*

END NOTES

[1] The Affordable Care Act refers to the Patient Protection and Affordable Care Act (enacted March 23, 2010, Pub. L. No. 111-148) (ACA), as amended by the Health Care and Education Reconciliation Act of 2010 (enacted March 30, 2010, Pub. L. No. 111-152), codified as amended in various sections of Title 26 (the Internal Revenue Code) and Title 42 (Public Health and Welfare) of the U.S. Code.

[2] The ACA establishes the Exchange as a marketplace where individuals may shop for and purchase QHP coverage. The Exchange operates in each state and may be established and administered by the state, or established and administered on behalf of the state by the Department of Health and Human Services (HHS).

[3] See section 1341 of the ACA.

[4] See section 1342 of the ACA.

[5] See section 1343 of the ACA.

[6] The required payments to the programs are described as "contributions" in the program literature, but are referred to as "assessments" or "payables" in this article to be consistent with the terminology used in SSAP No. 107. Amounts redistributed by the programs back to reporting entities are described as "payments" in the program literature, but are referred to as "distributions" or "receivables" in this article and in SSAP No. 107.

[7] The IRS has posted a FAQ on its website regarding the Transitional Reinsurance program, which indicates that "[h]ealth insurance issuers will be able to treat contributions under the Reinsurance Program as ordinary and necessary expenses paid or incurred in carrying on a trade or business … or as a reduction to taxable income as provided under Subchapter L." See http://www.irs.gov/uac/Newsroom/ACA-Section-1341-Transitional-Reinsurance-Program-FAQs.

[8] Section 1251 of the ACA provides that certain group health plans and health insurance coverage existing on March 23, 2010 (the date of enactment) that continue to satisfy requirements set forth in regulations issued by the Departments of Treasury, Labor and HHS are considered "grandfathered" health plans and are not subject to certain ACA requirements.

[9] On Jan. 26, 2015, the state of Ohio filed suit against the United States, specifically HHS, challenging the constitutionality of the imposition of the transitional reinsurance assessment against state and local governments that provide employees with health insurance through self-insured group health plans. See *State of Ohio et al v. U.S.,* et al, docketed at 15-cv-0321 (S.D. OH).

[10] HHS has the authority to administer the Transitional Reinsurance program fee. Although HHS' authority to impose penalties on covered entities for failure to pay the fee is not entirely clear, section 1321(c) of the ACA (via a cross-reference to section 2736(b) of the Public Health Service Act) can be read to provide HHS with penalty authority with respect to the establishment of the Transitional Reinsurance program. Penalties under section 2736(b) of the Public Health Service Act are up to $100 per day per affected individual.

[11] The assessed amounts will provide a reinsurance pool of $10 billion for the 2014 coverage year, $6 billion for the 2015 coverage year and $4 billion for the 2016 coverage year.

[12] The administrative expense is estimated to be $20.3 million for the 2014 coverage year. HHS is organizing and operating the reinsurance entities for all states but one.

[13] The contribution to the U.S. Treasury will be $2 billion for both 2014 and 2015, and $1 billion for 2016.

[14] For the 2015 coverage year, the reinsurance assessment will be $44 per enrollee, of which $33 per enrollee must be paid by Jan. 15, 2016, with the balance due no later than Nov. 15, 2016. For the 2016 coverage year, the reinsurance assessment is set at $27 per enrollee, with $21.60 per enrollee due no later than Jan. 15, 2017, and the remaining $5.40 per enrollee due no later than Nov. 15, 2017.

[15] For the 2015 coverage year, the coinsurance rate is 50%, the attachment point remains at $45,000 and the cap remains at $250,000. For the 2016 coverage year, HHS has proposed a coinsurance rate of 50 percent, an attachment point of $90,000 and a cap of $250,000.

[16] See, for example, Treas. Reg. §1.832-4(a)(4)(i) and Revenue Ruling 77-453.

[17] For purposes of this discussion of the Risk Corridor program, QHPs means policies and plans offered on the Exchange and policies and plans offered on the individual or small group market that are substantially similar to the QHPs.

[18] For a QHP, "allowable costs" is composed of the sum of incurred claims of the QHP issuer, adjusted to include qualifying expenditures by the QHP for activities that improve health care quality, expenditures for health information technology, and meaningful use requirements and other required adjustments.

[19] The "target amount" is equal to the total premiums earned with respect to a QHP, including any premium tax credit under any governmental program, reduced by the allowable administrative costs of the plan.

[20] For a QHP, "allowable administrative costs" consist of the sum of (1) administrative costs of the QHP, other than taxes and regulatory fees, plus (2) profits earned by the QHP, but as limited to the sum of 20 percent and the adjustment percentage of after-tax premiums earned with respect to the QHP (including any premium tax credit under any governmental program), plus (3) taxes and regulatory fees. The adjustment percentage for the 2014 coverage year is zero; for the 2015 coverage year it is 2 percent.

[21] If the QHP's allowable costs for a coverage year are more than 103 percent but not more than 108 percent of the target amount, the QHP issuer is entitled to receive an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount. If the QHP's allowable costs are more than 108 percent of the target amount, the QHP issuer is entitled to receive an amount equal to the sum of 2.5 percent of the target amount, plus 80 percent of the allowable costs in excess of 108 percent of the target amount.

[22] If the QHP's allowable costs for a coverage year are less than 97 percent but not less than 92 percent of the target amount, the QHP issuer is required to pay HHS an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs. If the QHP's allowable costs are less than 92 percent of the target amount, the QHP issuer is required to pay HHS an amount equal to the sum of 2.5 percent of the target amount, plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

[23] The official title of the CRomnibus legislation is the "Consolidated and Further Continuing Appropriations Act, 2015," H.R. 83.

[24] For the 2014 and 2015 coverage years, the rate is $.08 per insured per month.