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Chairperson's Corner

by Leigh M. Wachenheim

Earlier this year, the Health Section Council posted a Request for Proposals (RFP) to the Society Web site. The RFP was a call for research projects that would result in information, data, or tools useful to practicing health actuaries. We received many fine proposals for worthwhile projects and wished we had the resources to accept them all.

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Financial Reporting for Healthcare Plans: An Outline of Best Practices

by James P. Galasso, reviewed by Anthony Wittman

Overview

This paper was written with the following objectives in mind:

1. To communicate some of the trials and tribulations we "more seasoned" actuaries have experienced in our seemingly never-ending struggle with financial reporting for healthcare organizations to those a little fresher behind the ears. The paper limits discussion to managed care and other short-term medical care policies and avoids the more complex issues related to: long term disability policies, long term care policies, or other health

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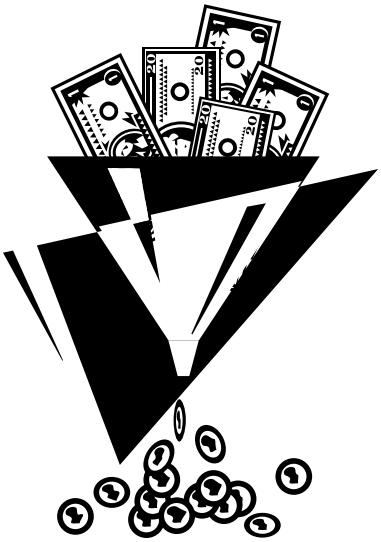

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product offerings with long-tail actuarial liabilities.

2. To introduce some potentially controversial subjects in the hopes that they may create an ongoing constructive dialogue.

3. To focus attention on healthcare industry data and financial reporting issues with the hope that actuaries will act as catalysts for company-specific and industry-wide improvements.

4. To provide various specific bench marks against which a company may measure their own financial reporting capabilities and target specific areas for improvement.

> ***"If a company is experiencing a downward trend line in financial performance, a greater potential for continued adversity exists for that company than for a company with lower immediate earnings, but with a positive financial trend line."***

5. To identify the type of reporting necessary to create a clear link between financial reporting and company performance (i.e. profitability, growth, and financial reporting integrity).

I. Overall Objectives of a Financial Reporting Process:

While there may be other equally important questions, I have distilled the ultimate objectives of a financial reporting process down to the ability to answer three key questions:

(i) "Where is the Company making or losing money?"

(ii) "Are things getting better or worse?"

(iii) "Is the Company financially viable?"

Where is the Company making or losing money?

In order for a company to make more money or to stop losing money, it must know where it is currently making money and where it is currently losing money. This is not a very controversial statement. What may be controversial, however, is the belief that most companies do not have a clear understanding, and in sufficient actionable detail, to properly respond to this question. The phrase "actionable detail" in the preceding statement suggests that it is not enough to have a report showing gains or losses; rather, reports need to support specific action steps that can be taken to improve a company's financial position.

Are things getting better or worse?

This is perhaps the single most important financial question that needs answering. More important than where a company is making or losing money is the recent financial trend line, again at an actionable level of detail. Putting potential seasonality aside, one should take little comfort in knowing that a company made $10.0 million last quarter for a particular product if that same product made $20.0 million in the prior quarter, and $40.0 million in the quarter before that. Management's job (and a company's viability) is to make the next quarter better than the prior quarter — not to rest comfortably on a single earnings number. If a company is experiencing a downward trend line in financial performance, a greater potential for continued adversity exists for that company than for a company with lower immediate earnings but with a positive financial trend line.

Is the Company financially viable?

The distinction between financial solvency and financial viability is critical and closely related to the distinction between the first two questions presented above. A company's balance sheet may appear quite adequate and pristine. The company may, in fact, be quite "solvent". The balance sheet, however, is a point-in-time snapshot of a company's condition. It provides little to no indication as to current and emerging trends impacting a company's financial condition. Is the company's cost structure so out of line that it can no longer profitably compete in the marketplace? Is the company's financial trend line such that what appears to be adequate capital, is not adequate at all? Are the company's product lines out of date and subject to replacement by fierce competition? Is there recently passed or impending legislation (or litigation) that threatens the company's solvency? These questions help differentiate the solvency of a company from its longer-term viability.

II. Defining Market Segments:

The first step to review an existing or establish a new financial reporting system generally involves defining the market segments a company would like to monitor and manage. As you may soon appreciate, virtually all of the items presented in this paper are deceptively simple and straightforward. What could be easier than identifying the core market segments that comprise a company? Many companies, however, experience significant difficulties in agreeing on market segment definitions — especially the larger, more complex companies. In

fact, many companies have multiple and conflicting definitions. Market segments are typically categorized by a combination of one or more of the following:

(i) Legal Entity (e.g., ABC-HMO, DEF-HMO, and XYZ Life & Health Insurance Company)

(ii) Product type (e.g., HMO, POS, and PPO)

(iii) Group Size (e.g., Groups with 2-25 employees, Groups with 26 to 100 employees, Groups with 101 to 500 employees, Groups with more than 500 employees)

(iv) Individual Products (e.g., HMO offerings, PPO offerings, Medicare Supplement, Conversion policies)

(v) Geographic Area (e.g., North, South, East, West)

(vi) Provider Network (e.g., Hospital A Network, Hospital B Network, Physician Group A, Physician Group B)

(vii) Government Programs (e.g., Medicare Risk, Medicaid Risk, CHAMPUS)

All of the above categories are fairly common with the possible exception of "Provider Network" defined market segments. Whether or not a company considers a provider network a market segment, provider risk arrangements may very well require that financial reports be prepared by provider network and shared with the participating providers.

Market segment categories must satisfy a company's multiple constituencies. For example, specific individuals may have bottom-line accountability for specific markets. Individuals may have product-specific accountabilities, others may be accountable for groups of a certain size, and yet other individuals may have provider-network-bottom-line or relationship accountabilities. Aside from a company's desire to define and manage its markets in a specified way, all companies must also comply with numerous laws, regulations, and accounting requirements. This creates other constituents such as accountants, lawyers, actuaries, and compliance officers who must also participate in the market segment definition process.

Finally, defining market segments, more often than not, is a dynamic process. Most companies change market segment definitions with a regularity that is quite frustrating to those responsible for financial reporting and compliance. Whether such change is attributable to acquisitions, divestitures, group size definitions, geographic definitions, or some other combination of events, a company's financial reporting and information system processes must be flexible enough to accommodate major and often frequent changes.

III. Preparing a Market Segment Monitoring Report:

Once the market segments have been defined, the next step involves putting in place the financial reports that help a company answer the three key questions noted in Section I. Best Practices suggest that these reports be part of the monthly closing ritual of the finance department. Not only must a company prepare basic monthly income statement and balance sheet information, but a month-by-month report by defined Market Segment should be prepared ***that reconciles to corporate totals*** and includes at least the following key components:

(1) Members

(2) Earned Premium

(3) Other Income

(4) Total Revenue

(5) Paid Fee for Service Claims

(6) Unpaid Claim Liability Estimates

(7) Capitation Payments

(8) Provider or Other Contractual Risk Sharing Settlements

(9) Other Paid Medical Costs

(10) Other Medical Cost Liabilities

(11) Net cost of reinsurance

(12) Total Medical Costs

(13) Administrative Expenses

(14) Commissions

(15) Premium Taxes

(16) Miscellaneous Expenses

(17) Total Expenses

(18) Pre-tax Operating Gains (Losses) = (4) – (12) – (17)

Note the emphasis on capturing a significant amount of financial statement detail with respect to medical costs. Given the complexity of managed care arrangements and claim payment details, this is the area that generally provides the greatest frustration to company actuaries, company accountants, and external auditors. Item (5) [Paid Fee for Service Claims] is, by this paper's definition, *exactly equal* to the paid claims in the claim lag reports provided to the actuary for Unpaid Claim Liability (UCL) estimation (most often erroneously referred to as IBNR — Incurred But Not Reported claims). To the extent claim payments are made that are not captured by the claim lag reports, such payments are included in item (9) [Other Paid Medical Costs]. Item (6) [Unpaid Claim Liability Estimates] captures the estimates derived from the paid claims in item (5). Item (10) [Other Medical Cost Liabilities] captures the estimates derived from the paid medical costs in item (9).

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Items (7) thru (10) are often collectively referred to as the "non-lagged" medical costs since they represent the medical costs that are never captured by the claim lag reports that the actuary traditionally relies on for the UCL estimates. Non-lagged medical costs may include such items as capitation payments, provider risk sharing payments and corresponding liability estimates, and prescription drug claims paid by a Pharmacy Benefit Manager (PBM).

The difficulty of estimating provider risk sharing liabilities, potential liabilities related to capitation payments, and other liabilities related to third parties for which access to detailed financial records is limited or unavailable is a significant issue deserving of special attention. The topic, however, is too complex for this discussion and deserving of a separate paper.

IV. Recasting a Market Segment Monitoring Report:

Once a set of Market Segment monitoring reports have been developed that reconcile to a company's reported financial results, the actuary should update historical actuarial liability estimates based on the most current available information. These updated estimates should be more accurate than the original reported estimates and will often differ materially from the company's reported numbers. Accordingly, to obtain a more accurate analysis of the company's (or a Market Segment within the company) financial performance and financial trend line, the actuary should prepare a "Recast" market segment monitoring report by replacing reported estimates with the updated (or, "Recast") estimates. This should provide a more accurate picture as to the financial health and financial trends currently being experienced by the company.

V. Identification and Quantification of All Potential Actuarial Liabilities:

In addition to UCL and possible provider liabilities, the actuary must also review the potential need for recognizing other liabilities in a company's financial statements. Such liabilities might include (but are not limited to):

i Loss Adjustment Expenses (LAE) – This is an estimate of the administrative expenses required to pay the claims represented by the UCL estimate. Some companies make the assumption that the relative conservatism of their UCL estimate along with the investment earnings on the assets backing this liability is sufficient to cover the LAE. The actuary should be comfortable that this implicit approach to covering potential LAE costs is appropriate.

ii Extension of Benefits (EOB) – This is an estimate of the liabilities that may exist upon the termination of individual employee certificates covered by an employer contract. Such liabilities are generally related to disabled or hospitalized employees at time of individual certificate termination. Specialized procedures that are beyond the scope of this paper may be needed to properly estimate potential EOB liabilities. Such procedures should start with a review of actual contract forms to determine the existence and relative magnitude of any potential liability. EOB reserves are fairly common among health insurance companies but are quite rare within the HMO industry. Nevertheless, the actuary should review an HMO's contracts and provider agreements to determine if an EOB liability may exist.

iii Premium Deficiency Reserves (PDR) – This is a liability that originated in Generally Accepted Accounting Principles (GAAP) accounting, gradually became prevalent in Statutory Accounting (STAT) as various States mandated its recognition, and has now been standardized in STAT accounting due to the National Association of Insurance Commissioners' (NAIC) adoption of codification standards effective January 1, 2001. The liability is effectively an estimate of losses attributable to contractual agreements currently in place that will occur after the current financial reporting period.

Many actuaries have expressed concerns over the application of PDR reserve requirements since they have the effect of significantly distorting a company's income statement by accelerating future losses. The effect is to understate earnings in the financial reporting period for which the PDR is recorded and to overstate earnings in the financial reporting period when the PDR is released.

When PDRs are recorded in a company's reported financial statements, they should be removed when attempting to analyze a company's actual financial trend line.

VI. Reconciliation of Claim Payments (Actuarial Reserves, Other Medical Costs, and Total Incurred Medical Costs):

All medical costs must find a home in a defined category (e.g., one of the seven items identified as (5) through (11) in Section III) so that the entire market segment report reconciles and is internally consistent with all other financial reports. The actuary must understand the Total Medical Costs presented in these market segment reports — both the paid claims used in developing the UCLLiability estimates and the remaining medical costs.

Without such a complete understanding, it is difficult to impossible for the actuary to state with any degree of certainty that the actuarial estimates included in a financial report are consistent with the data making up the financial reports that he may be certifying. In addition, if total medical costs are not understood, the accuracy of a company's financial reports may be called into question.

Please note that the preceding statements of concern are irrespective of whether the actuary accurately estimated the UCL based on the data provided for the actuarial analysis. If a reconciliation from (1) the claim lag reports to (2) the actuarial estimates to (3) the Total Medical Costs is not made, any retrospective look at the ultimate "accuracy" of the actuarial estimates is an interesting but largely irrelevant exercise.

VII. Medical Management Reports:

This is probably the area that offers the greatest potential for unlimited analysis with limited actionable results. While it is essential for a managed care company to understand the details of its medical costs, the complexity of interpreting results increases exponentially as additional reporting procedures evolve with time. A healthy industry movement that is beginning to emerge is the conversion from a focus on the ever-expanding list of medical procedures to the monitoring of individuals with specified diseases and treatment patterns. This holds out the ultimate promise made by managed care — that it will help control costs while identifying the most effective medical procedures for specified conditions. If managed care can withstand the current onslaught of criticism from providers, the public, legislators, and litigators, it may be offered the opportunity to significantly improve the practice of medical care. If we appropriately apply our analytical capabilities, this offers the actuarial profession an opportunity to assist the companies with whom we work and the healthcare industry itself. How we might apply our unique skills in this area is a potential topic for another paper.

VIII. Expense Control, Allocation and Recovery:

Administrative expenses is another key area that requires significant attention if a company is to remain financially viable. There are three major areas for consideration with respect to a company's administrative expenses:

i Expense Control – this refers to a company's ability to maintain administrative expenses at a level below that of its major competitors. The actuary may not drive the expense control process itself (i.e. the budgeting process), but certain reports can have a very definite influence. For example, the actuary must ensure that the company understands the impact expense control has on the pricing of each of the company's product offerings.

ii Expense Allocation – aside from the potential need for company downsizing initiatives, the greatest area for potential conflict within an organization with respect to expenses is the allocation of company expenses to each of the defined market segments and subsets of those market segments. In fact the conflict is so great that many, if not most, companies simply ignore this essential financial measurement. Allocation, by definition, is subjective and many would argue arbitrary. Accordingly, companies that do attempt to appropriately allocate expenses to defined Market Segments can be assured that every recipient of those allocations will consume considerable corporate time explaining why their particular allocation is inappropriate. Quite often all involved individuals will have their credibility and/or motives called into question. The purpose of this paper is not to discuss various expense allocation methodologies. Suffice it to say that pricing and financial monitoring of gains and losses by market segment is impossible without the implementation of an acceptable expense allocation methodology. The actuary should play a key role in developing this methodology.

iii Expense Coverage – this is perhaps the actuary's primary responsibility with respect to administrative expenses. Expense coverage is the degree to which the expense component of a company's premium (along with any other administrative fees charged by the company) is sufficient to cover the company's total administrative expenses. Any difference is often referred to as the "expense gap." The expense gap can be either positive (aggregate expense charges and administrative fees exceed total company expenses) or negative (aggregate expense charges and administrative fees fall short of total company expenses). The actuary must ensure that company management understands the direction and absolute value of any expense gap. Even if a company does not formally allocate total expenses to defined market segments, the actuary should develop reports capable of monitoring the premium component related to expense charges for each such market segment. This enables the actuary to determine the aggregate expense gap that can then be communicated to company management.

IX. Company Plans, Financial Projections, and Budgets:

All companies generally have business and financial plans that are prepared for at least a one-year time horizon. Ideally the financial plan will be prepared in a format consistent with that described in Section III with respect to monitoring defined market segments. While it is not necessary for a financial plan to have all of the components identified in Section III, the basic components that make up a company's balance sheet and income statement should be specified (e.g., members, premium, medical costs, administrative expenses, and risk-based capital ratios). Various assumptions applied to these basic elements can generally be made to complete a financial plan (e.g., interest earnings on the unpaid claim liability to obtain most of what may make up "other income," premium tax rates to obtain projected premium

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taxes, commission rates to obtain projected commission payments).

Member projections should reflect market conditions and company plans and expectations. Premium projections must reflect the actual months and the expected amounts by which premium rates will change (e.g., renewal dates and corresponding loss ratios for group customers).

Medical cost projections, as defined by a company's medical cost trend expectations, are generally the most volatile and significant risk factor in the business plan. Many of the other business plan variables are highly dependent upon the actuary's detailed analysis of medical cost trends. Required premiums and, consequently, membership assumptions are directly related to the assumed medical cost trends. Given this variability and dependency, financial projection models are often prepared on a dynamic (versus static) basis in an effort to evaluate plan sensitivities to various medical cost trend levels.

Administrative expenses, also indirectly dependent upon medical trends (due to the influence on membership and related service levels), are generally derived from an approved corporate budget.

The whole projection process generally requires the use of a fairly sophisticated model capable of developing multiple scenarios that reflect various assumptions. This provides the actuary and management with a tool to evaluate the impact various assumptions have on a company's projected financial performance.

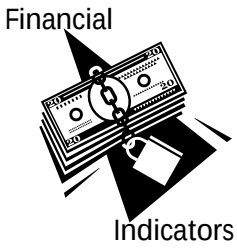
The capital position (sometimes referred to as surplus, contingency reserves, or equity) of healthcare companies has received increased scrutiny since the NAIC promulgated Risk-Based Capital (RBC) standards for regulators. The Risk-Based Capital ratio is a measure obtained by dividing a company's "Total Adjusted Capital" by what is called the "Authorized Control Level" (ACL). The ACL is a number that represents the bare minimum amount a company should have as capital given the risk characteristics of that company. In states where the NAIC's RBC Model Bill has become law, if a company's capital falls below the ACL, a regulator may seize control of that company (in fact, the regulator is required to seize control at a specified level of capital deficiency). Accordingly, this has become an extremely important indicator within the healthcare industry.

The administrative expense budget should be prepared in fairly excruciating detail in order to address the three key areas noted in Section VII (i.e. expense control, expense allocations, and a projection for expense coverage).

Finally, a financial plan should not be a once-a-year exercise. Rather, the actuary should continuously (i.e. monthly) evaluate how close actual company results by defined market segment match the financial plan numbers. Management can then take actions to correct or exploit significant deviations.

X. Financial Indicators and Measurements:

While there is no one best set of company financial measurements, a company should define consistent measures and communicate these measures to its various stakeholders (e.g., its Board of Directors, employees, investors, providers, rating agencies, major customers). Basic indicators of financial performance are often expressed in ratio form as a percent of premium and include: the medical loss ratio, the administrative expense ratio, and operating gains/losses.



For managed care companies, "per member per month" (PMPM) indicators for premiums, medical costs, and administrative expenses are always included as performance measurements. Annual trends in these PMPMs are additional indicators worthy of attention.

A vast array of medical management performance measurements that are generally expressed in terms of "unit cost" and "utilization per 1,000 members per year" are also typical of a managed care company's array of key indicators.

Consistent with the previously noted emphasis on Risk-Based Capital, capital adequacy and return on capital are becoming standard measurements of financial performance. Best practices suggest that such equity measurements be applied to each of a company's defined set of market segments. This necessitates the ability to allocate a company's total Risk-Based Capital to its defined market segments, consistent with the risk characteristics of those segments.

Financial reporting involves a large number of fairly complex topics that, as noted in the introduction, can often frustrate the most experienced healthcare actuary. Hopefully, this paper has some value for individuals at various experience levels — whether the value is just the sharing of common frustrations or the actual transfer of knowledge.

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