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Health Insurer Financial Reporting Post-ACA: What Is the Current Thinking?

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Our pricing actuary colleagues recently completed their second round of rate filings for individual and small group policies subject to the full implementation of the Affordable Care Act (ACA). In 2014 valuation actuaries will have their turn. Valuation actuaries have had to deal with medical loss ratio (MLR) accruals for the past couple of years, but in 2014 several other aspects of the ACA are driving the need for valuation actuaries to consider establishing additional payables or receivables during 2014 or at year-end.

In June 2013, the American Academy of Actuaries Health Practice Financial Reporting Committee issued a white paper called "Financial Reporting Implications Under the Affordable Care Act." This paper discussed the impact of the 3Rs (risk adjustment, reinsurance and risk corridors) on insurers' financial statements. As each of these programs includes a retrospective settlement process, financial statements may need to include estimates of amounts payable or receivable. Even in the case where an actuary concludes that the amounts related to any of these programs are not material, how the actuary arrived at that conclusion will need to be documented.

The health insurance providers (HIP) fee and cost-sharing reductions (CSRs) and their potential impacts on insurer financial statements were also discussed in the white paper.

The Society of Actuaries Health Section Council and Financial Reporting Section Council jointly developed a survey to gauge how actuaries are progressing with respect to these new potential assets or liabilities. The survey was sent to the members of the Health Section and the Financial Reporting Section. Fifty responses were received. The majority (over 80 percent) of respondents indicated that they worked for a health insurance company or a health subsidiary of a diversified parent. Almost half (48 percent) of the respondents indicated that their company covered over 1 million lives.

RISK ADJUSTMENT—INDIVIDUAL

The risk adjustment program is designed to financially protect issuers that enroll a higher-risk (less-healthy) population than the statewide average. Under this program, money is transferred from issuers with low-risk enrollees to issuers with higher-risk enrollees in order to equalize the differences in cost related to differences in risk. The transfer payments in the program take place at the state level and apply to ACA-compliant plans in the individual markets, inside and outside of exchanges.

Fifty-seven percent of respondents plan to accrue for risk adjustment settlement amounts during the calendar year. Of those who plan to accrue during the year, 41 percent plan to spread the estimate evenly throughout the year while 64 percent said they would not try to account for seasonality throughout the year.

When asked how they plan to develop estimates for the settlement amounts several respondents indicated they would be using statewide risk adjustment studies, some of which are being performed by consulting firms. Others indicated they would be doing some modeling of their own or using original pricing estimates.

The majority (55 percent) indicated "other," when asked if they anticipated setting up a receivable or payable amount at year-end for individual risk adjustment. This is likely a byproduct of the lack of information available with respect to the market average risk score at the time the survey was sent out; however, 29 percent anticipate setting up a receivable.

Respondents were then asked to rate their ability to develop the estimate from a low of "I have no idea/early stage discussion" to "We have a well-thought-out, detailed implementation plan." No one rated themselves as having no idea, while 36 percent answered "N/A." Not surprisingly, only 3 percent said they have a well-thought-out plan. The remaining 61 percent of respondents were spread fairly evenly among the other available response levels.

We then asked respondents if the states in which they do business intend to gather data during the year to help with the estimation of market average risk scores and which states were planning to do so. Only 22 percent (eight respondents) indicated

that states were planning to provide information. California, Massachusetts, New York (although this is really for pricing purposes), Utah and Florida were the states mentioned.

RISK ADJUSTMENT—SMALL GROUP

Similar to the individual risk adjustment program, the small group risk adjustment program is designed to financially protect issuers that enroll a higher-risk (less-healthy) population than the statewide average. Under this program, money is transferred from issuers with low-risk enrollees to issuers with higher-risk enrollees in order to equalize the differences in cost related to differences in risk. The transfer payments in the program take place at the state level and apply to ACA-compliant plans in the small group markets, inside and outside of exchanges.

Forty-seven percent of respondents plan to accrue for risk adjustment settlement amounts during the calendar year. Of those who plan to accrue during the year, 47 percent plan to spread the estimate evenly throughout the year while 82 percent said they would not try to account for seasonality throughout the year.

Similar to the responses for individual risk adjustment, several respondents indicated they would be using statewide risk adjustment studies, some of which are being performed by consulting firms. Others indicated they would be doing some modeling of their own.

The majority (56 percent) indicated "other," when asked if they anticipated setting up a receivable or payable amount at year-end for small group risk adjustment. Twenty-six percent anticipate setting up a receivable, while 18 percent anticipate setting up a payable. The high level of uncertainty is not surprising considering the lack of information available with respect to the market average risk score at the time the survey was sent out.

Respondents were then asked to rate their ability to develop the estimate from a low of "I have no idea/early stage discussion" to "We have a well-thought-out, detailed implementation plan." As for individual, no one rated themselves as having no idea while 37 percent answered "N/A." Five percent said they have a well-thought-out plan. The remaining 58 percent of respondents were spread fairly evenly among the other available response levels, leaning a little more toward the uncertain end of the scale.

TRANSITIONAL REINSURANCE

The transitional reinsurance program is a temporary program that will only be in operation for 2014 to 2016. Individual, small group, large group and self-funded or third-party-administered (TPA) plans will all be required to pay into the reinsurance program; however, only ACA-compliant individual plans (on and off the exchange) will receive reinsurance payments.

The reinsurance contributions, collected from insured customers, will be based on premium paid in 2014. Many customers renew throughout the year; therefore, some of their annual premium would be paid in 2013 and some would be paid in 2014. Respondents were asked if they included an amount for the transitional reinsurance contribution in their 2013 premium rates that carried over into 2014, and 64 percent indicated that they did.

When asked if they plan to accrue for reinsurance settlement amounts during the year, 77 percent indicated that they would make an accrual. Of those who plan to accrue throughout the year, 34 percent plan to spread the accrual out evenly throughout the

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year and 41 percent plan to account for seasonality in their accrual.

When asked if they will apply a valuation allowance against the full reinsurance estimate to account for the possibility that there may not be enough money in the program to fund the entire liability, 45 percent indicated they would not, 34 percent indicated they would, and 21 percent responded "other." Some respondents elaborated. The decision may depend on market information or what is developing in the company's own experience, and some plan to discuss this option with their outside auditors.

Promulgation of standards or safe harbors would be helpful, as would wide dissemination of data on emerging experience, risk scores, reinsurance claims, etc.

Respondents were also asked if their accrual would be offset by an estimate of an amount for claims to be denied. A large majority (82 percent) said they would not include an offset for claims to be denied.

When asked to explain how they will handle unpaid claim reserves for large claims at the end of the calendar year, some respondents indicated that they will run a separate lag analysis for large claims or that standard large claim reserving methods will be used. Some plan to look at specific claims where possible. One respondent noted that we have until March 31, 2015 to pay claims run-out for services with discharge dates in 2014, and they plan to work to reduce open claims as much as possible. One indicated they will likely use a seriatim calculation applying truncated completion factors. Finally, one respondent said they will estimate the reinsurance receivable using accumulated claims as of year-end and an estimation of completion for them, and then compare that to an estimated percentage of total claims that are expected to be reimbursed.

RISK CORRIDOR

The risk corridor program is a temporary program that will only be in operation for 2014 through 2016 and applies only to Qualified Health Plans (QHPs) for individual and small group business. Large group, grandfathered, extended policies, and self-funded or TPA plans will not participate in the risk corridor program. The goal of risk corridors is to temporarily dampen gains and losses, due to mispricing of plans by having insurers pay to or receive funding from the federal government. The program compares "allowable costs" (claims costs) with target amounts that are determined from premiums less allowable administrative (non-medical) costs.

Survey respondents were asked if they plan to accrue for risk corridor settlement amounts during the calendar year. Forty-eight percent said they would not and 52 percent said they would. Of those who said they would, 59 percent said they would spread the estimate evenly throughout the year.

Methodologies to be used include:

- Forecast results relative to target amount.
- According to federal formula.
- Based on claims and estimates for reserves, reinsurance, risk adjustment and CSR.
- Sensitivity analysis shows stability in loss position that government will reimburse X percent of losses. This will be used until closer to year-end, when all components can be estimated for a detailed calculation. The X percent factor will also be changed when year-to-date (YTD) financial results change enough to warrant it.

When asked to rate their ability to develop appropriate estimates, 17 percent said they have no idea or are in early stage discussions and, at the other extreme, only 5 percent feel they have a detailed implementation plan in place. Twenty-two percent did not give a rating. The rest tended to rate themselves toward the lower end of the capability range.

Fifty-three percent of respondents indicated they will have individual off-exchange products that qualify for risk corridor provisions. When asked how many such plans they will have, responses ranged from "small number" to 48, and included the following comments:

- "All of our plans are QHPs."
- "Almost all of our plans are substantially similar on- and off-exchange."
- "Where we offer plans on-exchange, we offer those same plans off-exchange."

Of those who are offering individual off-exchange products that qualify for risk corridor provisions only 35 percent indicated they were required to do so.

Thirty-three percent of respondents indicated they will have small group off-exchange products that qualify for risk corridor provisions. Fifty-eight percent of those offering such products indicated that they are required to do so.

HIP FEE

This fee is imposed on certain insurers providing health insurance coverage, including commercial coverage as well as Medicare Advantage, Medicare Part D and Medicaid. The fee applies beginning in 2014, but only if the covered insurers' aggregate net premiums written in the preceding calendar year exceed $25 million. Self-insured groups, government entities, some non-profit organizations and voluntary employee beneficiary associations (VEBAs) are not subject to this fee.

Two-thirds of respondents indicated that they included an estimate of the HIP fee in their 2013 rates that carry over into 2014. Comments that respondents shared include:

- "All health insurer fees were billed beginning 1/1/14, regardless of renewal date."
- "Our rate filings reflected this."
- "Since it is based on 2013 premiums it should be called a 2013 tax rather than a 2014 tax ... this has created lots of accounting and rating issues."

CSR PAYMENTS

For individual members whose income is below 250 percent of the federal poverty level (FPL), there exist variants of silver products available through the exchanges for which the federal government will subsidize a portion of the member cost-sharing amounts. The government will pay insurers an estimated monthly amount to cover this portion. There exist two different methods for estimating the amount, as defined in the Federal Register.

Under the "standard methodology," QHP issuers calculate the cost sharing for each claim twice—once using the cost-sharing structure that would have been in place if the individual were not eligible for CSR, and again using the reduced cost-sharing structure in the applicable plan variation for which the individual is eligible.

Under the "simplified methodology," QHP issuers calculate the value of the CSRs provided by using a formula based on certain summary cost-sharing parameters of the standard plan, applied to the total allowed costs for each policy. Note that these survey questions were asked before the final rules were issued, which materially altered the "simplified method" for some issuers, so responses may be different now that the methodology is more clearly defined.

When the survey was done the percentage of respondents who planned to use the standard methodology and the percentage that planned to use the simplified methodology were split about 50/50.

Sixty-four percent of respondents plan to collect advance payment credits. When asked how they plan to set up a payable for potential overpayments, several indicated they had not made a determination yet or did not believe there would be an overpayment. One respondent shared this formula: deferred liability account = advanced payment less estimated CSR. Another indicated that they will compare a vendor's estimate from re-pricing to payments monthly.

Finally, we asked for any additional feedback respondents wanted to share and received the following comments:

- Promulgation of standards or safe harbors would be helpful, as would wide dissemination of data on emerging experience, risk scores, reinsurance claims, etc.
- Answers to many of the questions may be different if my view is to answer for 2014 financials vs. say 2015 financials. 2015 will have more clarity.

I want to thank all the actuaries who took the time to fill out this survey. There are still a lot of unanswered questions and no clear guidance on many of the issues addressed in this survey. Hopefully, by sharing your current thinking, we will come closer to consistent methodology for many of these items.