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Health Insurer Balance Sheets 10 Years After ACA

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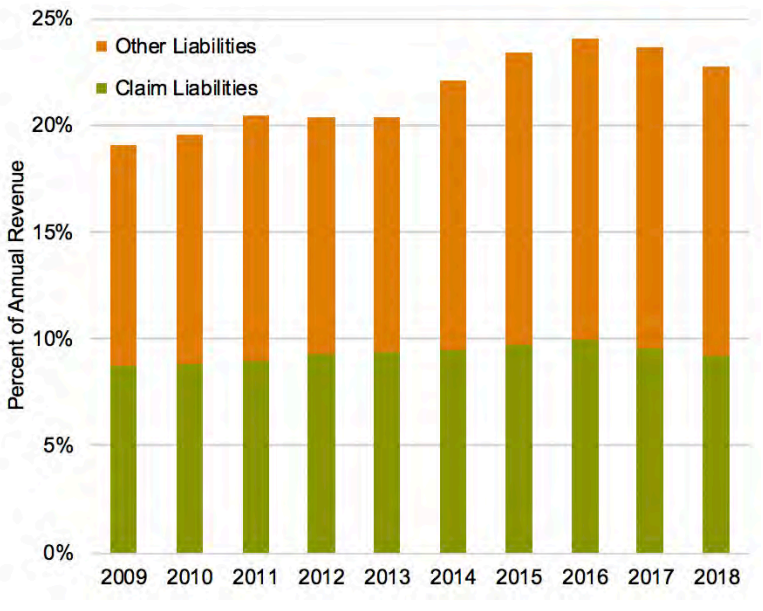
Health insurance company assets and liabilities have evolved since the Patient Protection and Affordable Care Act (ACA) was signed into law in March 2010. The ACA fundamentally rearranged how commercial health insurance is funded by integrating federal premium subsidies and pass-throughs together with a marketplace interwoven with transfer payments among stakeholders.[1] The impacts of these programs can be seen in specific accounting items on the balance sheets of health insurance companies over the past 10 years. Their emergence follows three primary trends: (1) balance sheet items tend to be larger and take longer to settle, (2) there are more interactions among items and (3) the final settlement amounts are more uncertain.

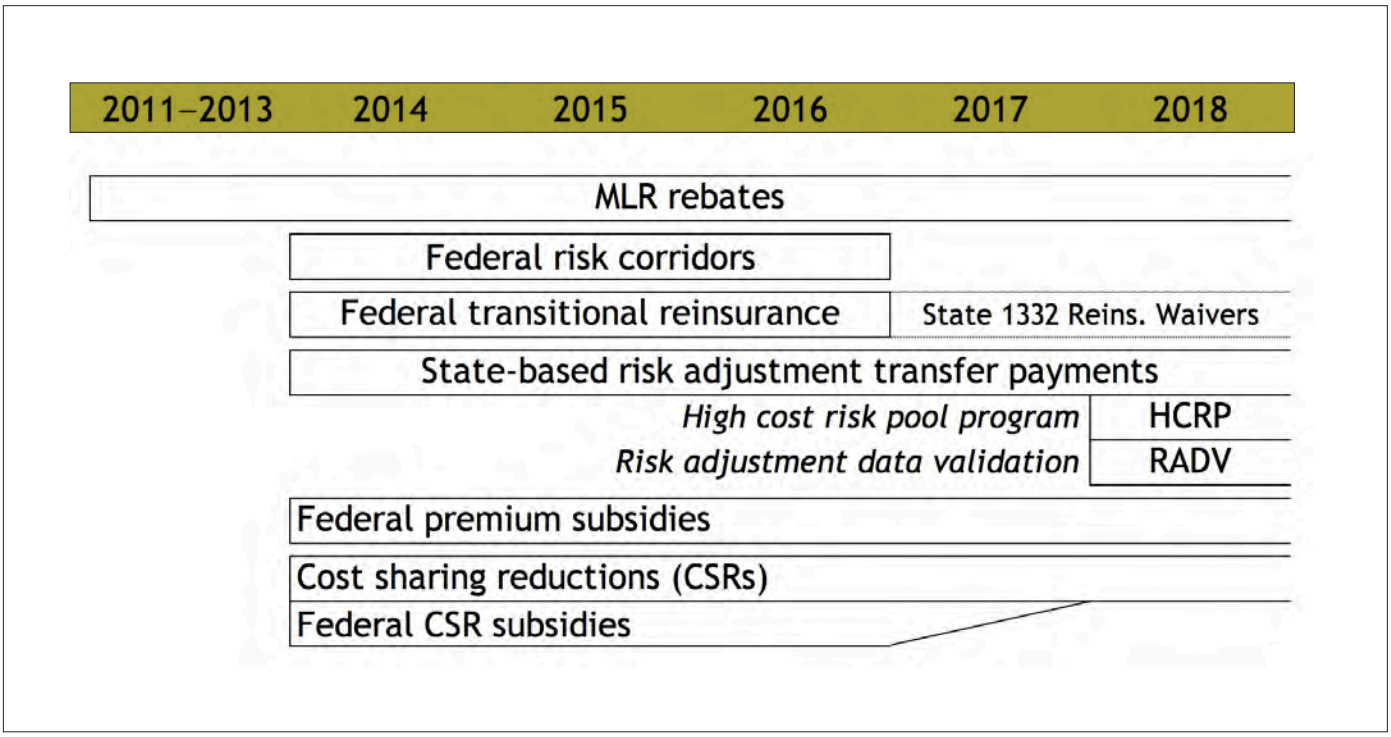
Insurance companies usually have multiple lines of business, including commercial health insurance, Medicare Advantage, Medicaid managed care, dental, vision, long-term care and administrative services only (ASO) contracts. Moreover, within commercial health insurance, not all lines of business are the individual and small group marketplace products traditionally associated with the major ACA reforms. Large group and other employer-sponsored health plans, including those for federal employee health benefits, comprise a major portion of risk revenue. Individual health insurance represents about 20 percent of commercial health insurance premiums. Consequently, the ACA's impact on a company's balance sheets depends on its mix of business. Looking at a representative basket of insurers primarily focused on commercial health insurance, the fingerprints of the ACA can be seen in a direct expansion of year-end liabilities, beginning with the major marketplace and risk mitigation reforms of 2014 (see Figure 1).

Figure 1
Liabilities as a Percentage of Annual Revenue: Selected Commercial Health Insurance Issuers



Based on analysis of data provided by S&P Global Market Intelligence

Figure 2
Key Assets and Liabilities Introduced by the ACA to Commercial Insurers



In Figure 1, as well as Figures 3–6, the sample of insurers is composed of state-level statutory entities filing 2018 health annual statements (i.e., "Orange Blanks") and for whom at least 75 percent of revenue comes from comprehensive major medical insurance policies other than federal employee health benefit plans. As a result, the sample insurers do not have substantial Medicare, Medicaid and other lines of business, and the annual statements, therefore, primarily reflect commercial health insurance. Although the numerical relationships in the figures differ in other samples, the directional relationships hold up over time under a variety of sampling approaches, including selecting insurers based on their 2009 business mix or using an 80 percent threshold instead. The amounts shown here and in the other figures reflect statutory accounting at year-end. For example, the health insurance providers fee (i.e., "the ACA tax") represents about 1 percent to 2 percent of revenue but is accounted for as an assignment of year-end surplus rather than a year-end liability, due to accounting rules.

The largest single liability of a typical health insurance company is the unpaid claims liability, representing claims for health care expenses that have already occurred but either have not yet been received by or have not yet been processed and paid by the insurer. Most important, it represents mostly short-term liabilities that settle within two to three months, is diversified across independent policies and health care providers and is straightforward to estimate. The other liabilities category can be of a very different nature: longer duration, nondiversified, sometimes exhibiting greater variability and often more difficult to estimate. This is the category that has grown the most under the ACA (see Figure 2 for a timeline).

RISK ADJUSTMENT GROWS THE BALANCE SHEET

Complementing the implementation of community rating and guaranteed issue for individual and small group markets starting in 2014, the risk adjustment program calculates market-neutral transfer payments among insurers within the same state and market. By comparing estimated morbidity differences among insurers to allowable differences in premium rates,[2] the annual transfer payments are intended to approximately equalize for morbidity profile differences among insurers that may attract very different enrollee mixes during the benefit year. The transfer payments can be a significant portion of aggregate risk revenue for a particular insurer's business in a state market; an insurer that attracted the healthier and lower-cost members will have to pay a significant portion of collected premiums into the risk pool, and those amounts are owed to insurers that attracted sicker and higher-cost members. The federal government administers the program, reporting transfer payment amounts at the end of June following the benefit year, with settlements occurring throughout the summer (for payables) and autumn (for receivables).[3]

Insurers submit encounter data, which is used to calculate the demographic and diagnosis-based transfer payments for each risk pool. The rate of diagnosis capture in particular (e.g., overcoding and undercoding) can vary significantly across insurers. Insurers attempting to forecast their transfer payments must make material assumptions about how their enrollee profiles will compare to the market average. Not only is this difficult to project before the benefit year's open enrollment period culminates, but it is also difficult to estimate for year-end financial reporting, owing to the veil of confidentiality shielding the health care encounters of individuals enrolled with other insurers. The transfer payments are therefore heavily influenced by information not readily available to each insurer, are affected by the coding practices of competitors, are subject to prolonged settlement lag and may not be fully collectible if another insurer becomes insolvent while owing a transfer payment to the pool.

Beginning with the 2018 benefit year, a risk adjustment data validation (RADV) program was implemented in order to identify insurers that are diagnosis coding outliers in either direction and to make corrective adjustments to their transfer payments, offset by adjustments in the opposite direction to all other insurers, in order to regain market neutrality.[4] Although this program is intended to reduce variations in transfer payments due to insurer coding practices alone, it introduces new complications. First, insurers do not know whether they are outliers until a few months after the benefit period ends,[5] and the indirect, offsetting impact of outliers on *other* insurers in the market—positive or negative—is not publicly known until the summer after the benefit year.[6] Second, the settlement of RADV's incremental adjustments to the transfer payments occurs nearly three years (and in certain cases nearly four years) after the benefit year ends, further extending the risk transfer settlement lag.

The absolute value of risk transfer payments among insurers has averaged about 4.5 percent to 5.5 percent of premium. This significantly extends the timing of risk revenue, turning what used to be underwritten and paid-up premiums into payables and receivables with potentially lengthy settlement periods. This has the effect of growing insurer balance sheets. For example, an insurer with a large payable is expected to accumulate surplus cash by the end of the year from premiums that are higher than immediately necessary, while setting up an offsetting liability for its future risk adjustment payable.

An enduring legacy of the ACA is a more complex and interrelated mix of assets and liabilities.

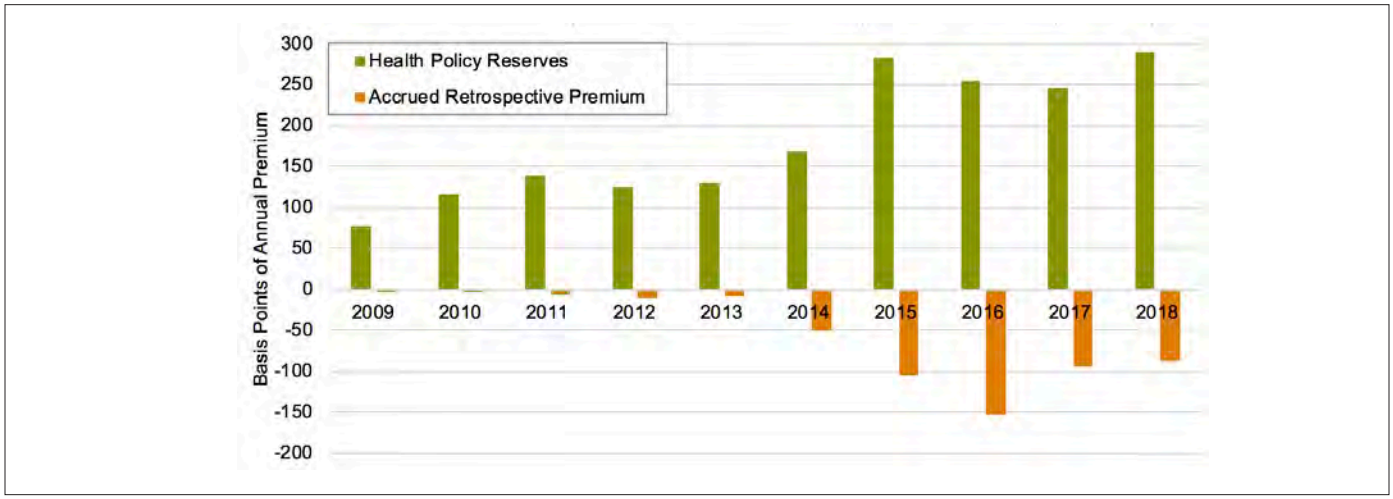
MLR REBATES, RISK CORRIDORS AND PREMIUM DEFICIENCY RESERVES

The minimum medical loss ratio (MLR) requirement was the first major program to create new insurer liabilities (see Figure 2 for a timeline). A rebate is owed to policyholders if an insurer's MLR, after adjusting for taxes, fees and a credit for health care quality improvement expenses, is below 80 percent.[7] All combined, $1.1 billion in rebates was paid for the 2011 benefit year, though this dropped to around $0.3 billion to $0.5 billion per year following significant administrative cost-saving initiatives by insurers. Poor financial results, particularly in the individual market following the major market reforms of 2014, kept loss ratios high and rebates low until pricing caught up to, and in some cases surpassed, experience in the 2017–2018 period. Average rebates paid to individual policyholders increased from 0.2 percent of premium for 2017 to 1.0 percent for 2018.

The risk corridor program lasted from 2014 to 2016 and was initially designed to transfer unexpectedly high gains or losses, after risk adjustment and MLR rebates, between insurers and the federal government. Accrued MLR rebate liabilities and risk corridor payments are accounted for as health policy reserves on the balance sheet. When these amounts are receivables, risk corridors are accounted for on the asset side as accrued retrospective premium. All of these amounts interact with each other, including risk adjustment and unpaid claims liabilities. These interactions are very important to recognize and understand during year-end actuarial valuations.[8] As an example of the interactions, an insurer may have high-cost claimants with unreported claims incurred prior to year-end. These claims are included in the unpaid claims liability estimate, but also impact the estimated reinsurance recovery. Unreported claims may include previously unreported diagnoses, impacting an insurer's risk scores and risk adjustment transfer payment. Unpaid claims and risk adjustment must be estimated before calculating any risk corridor payables or receivables. All of these estimated items are included in the MLR rebate formula.

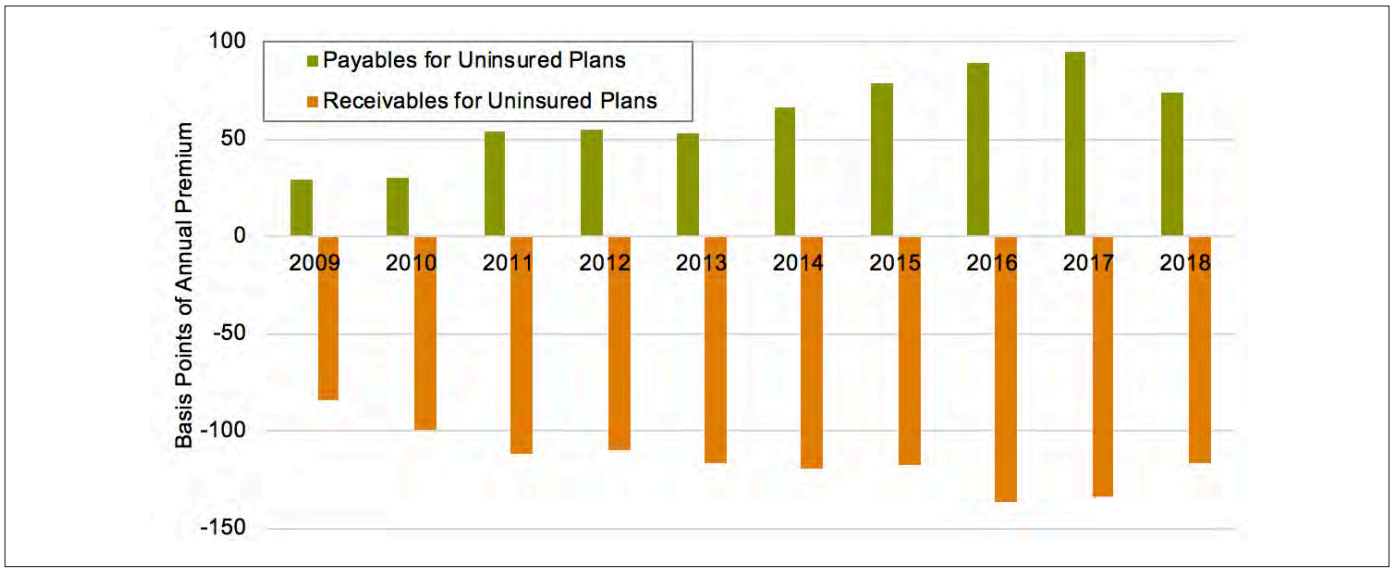
Premium deficiency reserves (PDRs)—set-asides for anticipated future losses—are also accounted for as health policy reserves. Times of great market volatility, as has occurred frequently in the individual market since 2014, can expand these and other health policy reserves: When premiums are overestimated, they may lead to MLR rebates, and when premiums are deficient, they may lead to risk corridor receivables and PDRs (see Figure 3).[9]

Figure 3
Health Policy Reserves and Accrued Retrospective Premium: Basis Points of Annual Premium



Based on analysis of data provided by S&P Global Market Intelligence

Figure 4
Payables and Receivables for Uninsured Plans: Basis Points of Annual Premium



Based on analysis of data provided by S&P Global Market Intelligence

PASS-THROUGHS

In addition to underwriting insurance policies, many health insurance companies will also administer claims where the liability is actually the responsibility of another organization. The most common example of this arrangement is an ASO contract, in which a government entity or self-insured employer provides monthly funding and relies on the insurance company to administer claims in a timely manner. Although the final amount of the liability is reconciled and settled over time, the balance of payments can shift between a payable and receivable throughout the year. These amounts are accounted for as payables and receivables for uninsured plans, to distinguish them from accruals under an insurer's primary insurance business. Although the insurance company ultimately has no insurance risk, it is exposed to the credit risk that the plan sponsor defaults on its promise to fund the full amount.

These pass-through amounts expanded under the ACA beginning in 2014 (see Figure 4), when the federal government sponsored cost-sharing reductions (CSRs) for low-income participants in the individual market, fully subsidizing insurers for the enhanced benefits through a monthly advance payment and a final settlement the following year. CSRs complemented the federal premium subsidies for low-income individuals.[10]

In October 2017 the federal government ceased the monthly advance payments,[11] collected from insurers that had an account payable at 2017 year-end, and did not pay insurers that had an account receivable at year-end.[12] Notwithstanding the cessation of federal CSR subsidies, the ACA requirement for insurers to provide CSRs to eligible individuals remained. Insurers subsequently took on the insurance risk for the program and increased premiums over time to account for the funding shortfall.[13]

CASH IS KING

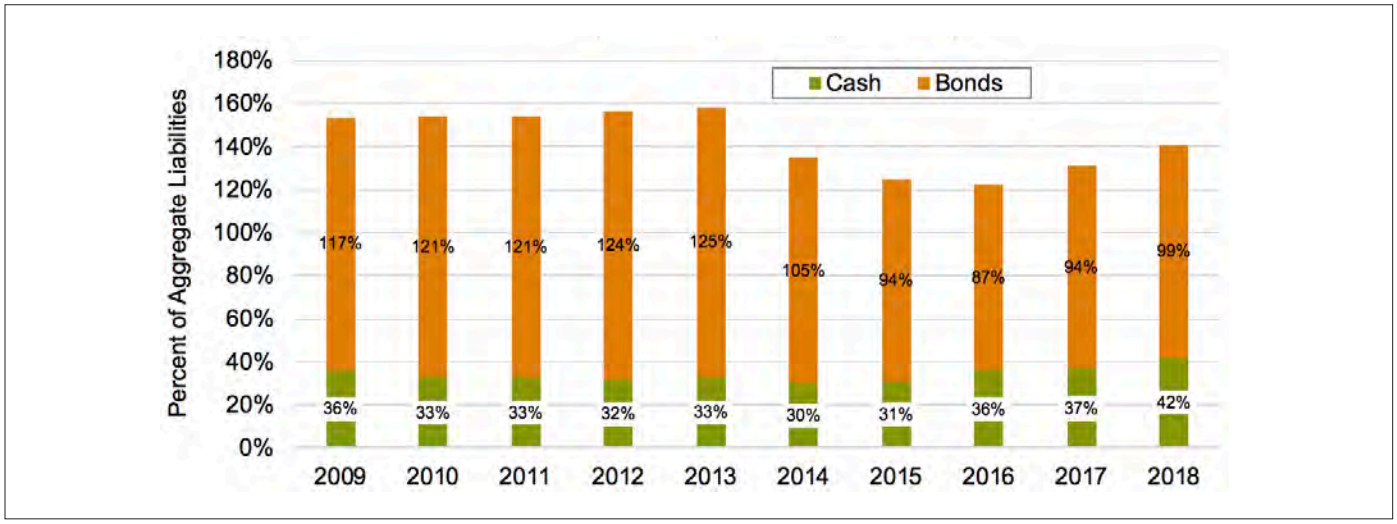
A hallmark of health insurance before the ACA was that insurance companies received monthly premiums up front and then paid claims throughout the benefit year, typically with a short settlement period for unpaid claims liabilities. Private reinsurance contracts helped manage both the underwriting risk and cash flow strain of the largest claims by providing prompt reimbursement in exchange for predictable reinsurance premiums. Under that business model, health insurance contracts, if adequately priced, were cash flow positive, with receivables having a shorter duration than liabilities.

The ACA changed the timing and uncertainty of receivables and complicated cash flows:

- Insurers on the receiving end of risk adjustment transfer payments have an illiquid claim on risk revenue, which may not be fully received until at least 10 months after the year ends. Moreover, the estimation of transfer payments is dependent on enrollment and diagnosis data from competing insurance companies, which cannot be known until late June following the end of the benefit year.[14]
- Starting in 2018, amounts under RADV are not reported until the summer following the benefit year and not settled until three years after the benefit year. The majority of insurers affected by RADV are impacted indirectly by the outlier status of a relative few insurers, which is not public information until five months after the benefit year ends.
- Insurers suffering large insurance losses during the 2014–2016 period held risk corridor receivables that were delayed until risk corridor payables could be collected. The risk corridor program was operated in a budget-neutral manner because the federal government did not appropriate funds for the program, which meant that collectability was dependent on good financial performance of unrelated insurers across the nation.[15] Good financial performances were few and far between, and to date, the collection rate has averaged well below 10 percent.
- When the federal transitional reinsurance program was operated from 2014 to 2016, the receipts were not settled until the autumn after the benefit year, which is generally longer than private reinsurers take to reimburse shock claims. Additionally, the attachment point was considerably lower than most private reinsurance contracts. Both factors caused the reinsurance receivables at year-end to balloon during the 2014–2016 period. Since the program ended, an increasing number of states have used the ACA's waiver flexibility to reintroduce state-specific reinsurance programs,[16] so reinsurance receivables could begin to increase again in many markets.
- The CSR program expanded accounts receivable under uninsured plans and also led to collectability problems starting in the autumn of 2017.
- Beginning in 2014, the ACA expanded the grace period for members to pay premiums up to three months for individuals receiving premium subsidies, which increased the size and settlement duration of premium receivables.[17]

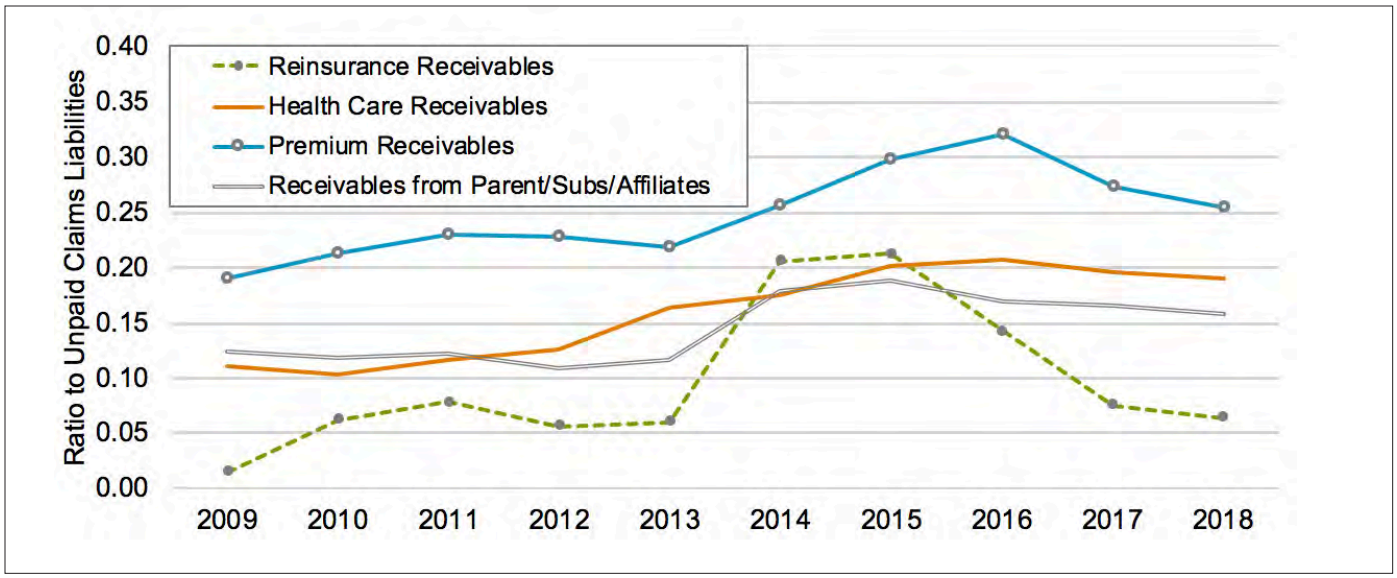
Successful insurers adapted to the changing characteristics of their receivables. The balance sheets of health insurance companies are closely regulated by risk-based capital (RBC) requirements, and most companies maintain conservative balance sheets in order to mitigate the risk of liquidity challenges. As demonstrated in Figure 5, commercial health insurers maintained, on average, financial assets of sufficient liquidity and size to meet their estimated liabilities. Nevertheless, beginning in 2014, the combination of a difficult rate-setting environment and a shift of revenue from short-term cash flows to longer-term receivables dampened insurers' ability to cover liabilities with their most liquid assets, as can be seen through a lower ratio of highly liquid assets to aggregate liabilities.

Figure 5
Cash and Bonds, as a Percentage of Aggregate Liabilities



Cash and bonds are divided by aggregate liabilities, after removing liabilities for amounts owed to parent, subsidiaries or affiliates and amounts owed under uninsured plans.
Based on analysis of data provided by S&P Global Market Intelligence

Figure 6
Ratio of Selected Receivables to Unpaid Claims Liabilities



For the illustrative group of commercial health insurers, the combined value of the selected receivables grew from 44 percent of unpaid claims liabilities in 2009 to 66 percent in 2018.
Based on analysis of data provided by S&P Global Market Intelligence

During this period, insurers had relatively fewer liquid assets available to match to their liabilities, and some had to match an increasing portion of liabilities with longer-duration, less liquid assets. Evidence of the changing characteristics of selected receivables can be seen in Figure 6, with reinsurance receivables spiking during the 2014–2016 period and premium receivables ramping up beginning in 2014.[18] To the extent that these assets have longer settlement durations than unpaid claims liabilities, insurers have to rely more on their shorter-term, liquid assets, such as cash and short-term Treasury bills, to meet short-term liabilities. Using cash and short-duration assets to cover claims liabilities can decrease the amount of liquid assets available on an insurer's balance sheet and increase average duration of assets, which can negatively impact insurer cash flows and RBC ratios.

Other industry trends over the past several years (not directly due to the ACA) have also contributed to the growth in receivables and corresponding cash flow challenges for insurers:

- Pharmacy rebates have been steadily increasing as a percentage of total health care expenditures, as have overall prescription drug costs.[19] However, rebates tend to take three to six months to settle and are therefore not immediately available to support cash flows. Payments to health care providers for medical services (e.g., office visits or hospital admissions) do not have a rebate mechanism built into them, yet pharmacy expenses do. Consequently, as pharmacy expenses have grown faster than medical expenses over time, so too have pharmacy rebates, and they are a contributing factor to the gradual increase of health care receivables on insurer balance sheets.[20]
- Another trend in recent years is increasing market consolidation (both consolidation of insurers and mergers of insurance companies and health care providers, such as hospital systems and medical groups). Related parties may provide administrative or health care services for each other, and related health care providers may take on a portion of insurance risk as well. To the extent that affiliated health care providers assume some downside risk from the insurance company, then receivables under those risk contracts can increase in times of poor financial performance of health care providers.

ON BALANCE

Payables and receivables have grown on balance sheets under the ACA, as have the uncertainty and settlement duration of many assets and liabilities. Successful health insurers in the commercial market have grown more sophisticated in their cash flow management and accounting methodologies as a result of the ACA. Credit risk and other counterparty risk have grown in importance alongside claims volatility risk. These impacts have continued to evolve in the years since the ACA was implemented, with some program dynamics phasing out (e.g., risk corridors, transitional reinsurance) and other new dynamics being introduced (e.g., RADV, high-cost risk pool, 1332 waivers). An enduring legacy of the ACA is a more complex and interrelated mix of assets and liabilities, with longer run-out and settlement periods, greater credit and counterparty risk and greater variation in underwriting outcomes. These evolving dynamics warrant the continued attention of actuaries and accounting professionals alike to ensure they are accurately represented in premiums and financial statements. ■

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The authors are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial analyses herein.

In preparing this article, they relied upon health annual statements, reports and regulations promulgated by the Department of Health and Human Services (HHS), and articles as referenced. In particular, the health annual statements are issuer-populated, and they may not complete, accurate or consistent. The authors performed high-level reviews of the results and compared them to alternate sources, where possible. To the extent the underlying data is not accurate, the conclusions in the article may change.

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ENDNOTES

1 Examples include risk adjustment transfer and risk corridor payments among insurers, rebates from insurers to policyholders under minimum medical loss ratios and implicit cross-subsidization between individuals via community rating.

2 For example, insurers in most states may rate for differences in enrollee age, using prescribed rating factors that vary by no more than a 3:1 ratio among adults.

3 States may elect to operate their own risk adjustment programs in place of the federal program, but no states currently exercise this option.

4 Additional background can be found in Karcher, J., J. Petroske, and C. Gleed. A Breakdown of ACA Risk Adjustment Validation. *Milliman*, October 24, 2019, *https://www.milliman.com/en/insight/a-breakdown-of-aca-risk-adjustment-validation* (accessed May 6, 2020).

5 The audit is based on diagnosis coding from the prior benefit year (e.g., 2017 diagnosis coding during the 2018 benefit year).

6 Centers for Medicare and Medicaid Services. 2017 Benefit Year HHS Risk Adjustment Data Validation Results. *CMS*, May 31, 2019, *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/2017-Benefit-Year-HHS-Risk-Adjustment-Data-Validation-Results.pdf* (accessed April 1, 2020).

7 The calculation is done at the level of state and market (individual, small group, large group), with a higher minimum threshold of 85 percent for large group.

8 The RADV adjustments further complicate interactions across benefit periods. For example, RADV impacts to benefit year 2018 risk adjustment are supposed to be settled in 2021, and those cash flows are required to be treated as if they were incurred in 2021 for the purpose of 2021 MLR calculations.

9 The COVID-19 pandemic of 2020 is unfolding while premium rates are being developed and filed for the 2021 benefit year, adding to uncertainty.

10 Kaiser Family Foundation. Explaining Health Care Reform: Questions About Health Insurance Subsidies. *Kaiser Family Foundation*, January 16, 2020, *https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/* (accessed April 1, 2020).

11 Congress had not appropriated a budget for the CSR program, and the administration's view was that it did not have the authority to continue paying the advance payments.

12 Insurers have initiated litigation to collect more than $2 billion in unpaid CSR settlements, with mixed success. See Keith, K. Insurers Ask for More Than $2 Billion in Unpaid CSRs. *Health Affairs Blog*, March 6, 2019, *https://www.healthaffairs.org/do/10.1377/hblog20190306.139866/full/* (accessed March 30, 2020); and Keith, K. More Insurers Win Lawsuits Seeking Cost-Sharing Reduction Payments. *Health Affairs Blog,* February 17, 2019, *https://www.healthaffairs.org/do/10.1377/hblog20190217.755658/full/* (accessed March 30, 2020).

13 Kaiser Family Foundation. The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments. *Kaiser Family Foundation,* April 28, 2017, *https://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/* (accessed April 1, 2020).

14 Centers for Medicare and Medicaid Services. Summary Report on Permanent Risk Adjustment Transfers for the 2018 Benefit Year. *CMS*, June 28, 2019, *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Report-Risk-Adjustment-2018.pdf* (accessed April 1, 2020).

15 Centers for Medicare and Medicaid Services. Risk Corridors Payment Proration Rate for 2014. *CMS*, October 1, 2015, *https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf* (accessed April 1, 2020). Receivables for 2014 were reduced by around 87 percent, and receivables for 2015 and 2016 were not reimbursed at all. All told, at least $12 billion in risk corridor receipts remained unpaid. On April 27, 2020, the Supreme Court ruled in favor of health plans with outstanding risk corridor receivables. See *Maine Community Health Options v. United States*, *590 U.S.* __ (2020), *https://www.supremecourt.gov/opinions/19pdf/18-1023_m64o.pdf* (accessed April 30, 2020).

16 Kaiser Family Foundation. Tracking Section 1332 State Innovation Waivers. *Kaiser Family Foundation*, January 7, 2020, *https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/* (accessed April 1, 2020).

17 Health Reform: Beyond the Basics. Key Facts: Premium Payments and Grace Periods. *Health Reform: Beyond the Basics,* June 9, 2016, *https://www.healthreformbeyondthebasics.org/key-facts-premium-payments-and-grace-periods/* (accessed April 1, 2020).

18 The reversal of the premiums due trend in 2017 and 2018 is partly caused by tightening premium grace period exceptions, a shift in enrollment mix and better streamlined marketplace functions. The 2018 Market Stabilization Rule is an example of a regulatory reform contributing to this trend. See Centers for Medicare and Medicaid Services. CMS Issues Final Rule to Increase Choices and Encourage Stability in Health Insurance Market for 2018 [press release]. *CMS*, April 13, 2017, *https://www.cms.gov/newsroom/press-releases/cms-issues-final-rule-increase-choices-and-encourage-stability-health-insurance-market-2018* (accessed April 1, 2020).

19 Rebates are paid by pharmaceutical manufacturers to insurance companies based on prescription drug purchases made on behalf of policyholders, and the overall premium is set at a lower level in anticipation of receiving these rebates. For a primer on pharmacy rebates and health care financing, see Alston, M., G. Dieguez, and S. Tomicki. A Primer on Prescription Drug Rebates: Insights Into Why Rebates Are a Target for Reducing Prices. *Milliman*, May 21, 2018, *http://www.milliman.com/insight/2018/A-primer-on-prescription-drug-rebates-Insights-into-why-rebates-are-a-target-for-reducing-prices/* (accessed March 30, 2020).

20 Another type of health care receivable is advance payments to health care providers, against which future claim payments are deducted. This practice can help providers manage their cash flows, and there is some evidence that it may be used more frequently during the COVID-19–related business disruptions.