Discussion of the Academy White Paper on the Financial Reporting Implication of the Affordable Care Act

Actuaries Club of the Southwest

November 8, 2013

Background

- In June 2013, the Health Practice Financial Reporting Council of the American Academy of Actuaries' (AAA) issued a white paper on the Financial Reporting Implications Under the Affordable Care Act
- This presentation is a discussion on the American Academy of Actuaries' white paper and does not represent the actual view of the speaker or their employer.
- All information provided is of a general nature and is not intended to address the circumstances of any particular individual or entity. Although we endeavor to provided accurate and timely information, there can be no guarantee that such information is accurate in the future. No one should act upon such information without appropriate professional advice after a thorough examination of the particular situation

Agenda

- 3Rs - Premium Stabilization Programs
- Taxes & Fees
- Advanced Payments: Subsidies and Cost-Sharing
- Changes to Actuarial Liabilities

*Per slide 1, this presentation is based on the AAA White Paper, Financial Reporting Implications Under the Affordable Care Act.

Background

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- **The ACA market reforms may create uncertainty for health issuers beyond current changes**
  - Customer behavior
  - Additional volatility due to increased need for actuarial estimates in financial reporting
- **The white paper is based on final and proposed ACA related regulations issued through March 2013 and Generally Accepted Accounting Principles (GAAP) and statutory accounting guidance adopted as of that date (March 2013)**

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Possible Financial Reporting Effects Due to Provisions

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

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3Rs - Premium Stabilization Programs

Premium Stabilization Programs

- **Risk Adjustment**
- **Reinsurance Benefits**
- **Risk Corridors**

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Risk Adjustment (1 of 3)

- **Designed to replace traditional risk management techniques**
- **Closed system for each risk adjustment cell**
- **States can operate their own**
- **Risk-adjustment settlements depend on the relative measured risk of the issuer's enrollees compared to all enrollees in the market**

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Risk Adjustment (2 of 3)

- **Risk-adjustment mechanism is similar to Medicare Advantage (MA), however, differences exist including:**
  - MA risk adjustment is based on a retrospective model
  - MA risk adjustment is performed as a single national program
  - MA plans expect a high level of stability in membership
  - Federal government administers a majority of the MA program population

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Risk Adjustment (3 of 3)

- **The risk-adjustment mechanism may lead to increased uncertainty in:**
  - Issuer's risk score
  - Issuers' risk scores
  - Issuers' membership exposure
  - Granularity of the calculation for each risk adjustment cell
  - Data validation reviews

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Reinsurance Benefits (1 of 3)

- **Available from 2014 to 2016 or when funding expires**
- **Denial based on preexisting conditions is no longer allowed in individual market**
- **Proportion of chronic conditions expected to rise**
- **Intended to reduce premiums in the individual market due to pent up demand of the uninsured and unknowns**

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Reinsurance Benefits (2 of 3)

- **Reinsurance program may increase uncertainty in the financial statements**
  - Accrual for reinsurance on unpaid claims
    - Before issuers accrued for reinsurance receivables on specifically identified claims only
    - Now issuers may estimate reinsurance recovery on unpaid claims with no specific information
  - Magnitude of reinsurance recovery accrual
    - An issuer will be recording an accrual at Dec. 31 for the full year's reinsurance recovery
    - The accrual will complicate any year-over-year comparability of financial statements

Reinsurance Benefits (3 of 3)

- Valuation allowance
  - Potential for reinsurance benefits to be reduced due to availability of funds
  - Funding sufficiency will make determining the amount of expected reinsurance recoveries to accrue at year-end difficult
- Potential for denied reinsurance claims

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Risk Corridors (1 of 1)

- **Designed to provide some aggregate protection against variability for issuers in the individual and small-group markets from 2014 through 2016**
- **Qualified health plans only**
- **Risk-corridor calculation is to be performed at the plan level**
- **Risk-corridor calculation is to be performed after considering risk-adjustments and reinsurance programs**
- **Calculations may require some additional allocations**
- **Any accrual calculation is relatively complex needing to integrate with other items**
- **Calculation is not symmetrical—one cell can not offset another cell**

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Taxes and Fees

Health Insurance Providers Fee (1 of 3)

- **Beginning in 2014, new excise tax call the Health Insurer Provider (HIP) fee**
- **HIP fee will be assessed on an annual basis starting on Sept. 30, 2014**
- **Companies not subject to federal income tax only count one-half of its premiums in the HIP fee calculation**
- **Industry pricing practice regarding the HIP fee is varied**

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Health Insurance Providers Fee (2 of 3)

- **HIP fee raises a number of issues:**
  - Expense risk
    - Misestimate the HIP fee amount
  - Revenue/expense mismatch
    - Issuer may not be able to defer the recognition of revenue from 2013 to 2014
    - Could create an upward bias in 2013 and could create a downward bias in 2014 on year over year earning growth

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Health Insurance Providers Fee (3 of 3)

- Different tax code provisions
  - HIP fee is a non-deductible excise tax
  - Tax status may lead to differences in the impact of the HIP fee on the issuer's financial statement
- Customer rebate implications due to revenue/expense mismatch
  - Federal taxes and fees are adjustments to the denominator of the ACA's MLR metric
  - If incremental premiums for a year exceed the recognized tax expense, the net effect would be to increase the denominator, decrease the MLR, and potentially increase rebates to customers

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Reinsurance Contribution (1 of 4)

- **Contribution assessed on an annual basis for calendar years 2014 - 2016**
- **Contributing entity will submit membership data for first nine months of the calendar year to federal regulators in November**
- **Funding is based on assessments charged to health insurance issuers in the individual and group markets and sponsors of self-funded plans**
- **Reinsurance contributions should be incorporating it into the pricing of those products whose enrollees are subject to the assessment**

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Reinsurance Contribution (2 of 4)

- **HIP fee differs from reinsurance contribution in 3 ways. The reinsurance contribution has:**
  - More direct relationship with a particular enrollee
  - Greater transparency
  - Tax deductible

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Reinsurance Contribution (3 of 4)

- **Financial reporting implications**
  - Expense estimation risk
    - Reinsurance contribution is fixed in advance therefore the total amount of funding generated may end up different
    - Estimation risk exposure will be limited to the fourth quarter financial statements with respect to amounts recognized in the previous three quarters
  - Implications of revenue/expense mismatch on expense
    - Similar to HIP fee issue
  - Implications of revenue/expense mismatch on Customer rebates
    - Similar to HIP fee issue
    - Issuer's payment of reinsurance contributions is a negative adjustment to the denominator of the MLR formula

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Reinsurance Contribution (4 of 4)

- Cash Flow Timing
  - Issuers will receive the annual reinsurance contribution invoice in mid-Dec. and will have 30 days to pay the bill
  - Issuer's cash flow could be impacted materially by whether the issuer chooses to pay the reinsurance contributions bill in Dec. or in Jan.
- Self-funded business
  - Self-funded plan sponsors are liable for reinsurance contributions

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Other New Fees (1 of 1)

- **Patient Centered Outcomes Research Institute (PCORI) fee**
  - Small per-member federal tax ($1 PMPY for year 1) that applies to plan years ending between Oct. 1, 2012, and Sept. 30, 2019
- **Risk adjustment user fee**
  - Small per-member fee ($0.96 PMPY for 2014) that will apply to issuers of plans to which the ACA risk-adjustment program applies
- **Federally-facilitated exchange (FFE) user fee**
  - Fee is set at 3.5% of premiums for 2014 for issuers on a federally-facilitated exchange

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Advanced Payments: Subsidies and Cost Sharing

Premium Subsidies (1 of 1)

- **Premium subsidies are paid directly to health issuers, in the form of tax credits, for those members with income of 100% to 400% of the federal poverty level**
- **Timing of the subsidy payments may create a need to set up a receivable for credits due to members or a liability for payments received on lapsed members**

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Cost-Sharing Reduction Payments (1 of 1)

- **Households with income of 250% of FPL or less are eligible for cost-sharing reduction (CSR) silver plan versions that have reduced cost-sharing amounts on essential health benefits**
- **The government pays the insurer the difference in the CSR silver plan and the standard silver plan on a monthly basis. The insurer may need to set up an asset or liability for the monthly payments until the annual true up.**

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Changes to Actuarial Liabilities

Claim Liabilities (1 of 2)

- **Using historical payment patterns to calculate unpaid liabilities will be difficult in 2014 as the population will be changing:**
  - New insureds
  - High risk insureds
  - Uncertainty around morbidity
  - Changes in plan design

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Claim Liabilities (2 of 2)

- **Provider risk sharing also will have an impact on claims reserves due to gain sharing**
- **Things to what for:**
  - Claim inventory changes
  - ICD-10 coming in October 2014

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Contract Reserves (1 of 1)

- **Some issuers have held contract reserves based on underwriting and renewal pricing that used a portion of past premiums was designed to prefund future claims**
- **No medical underwriting is allowed for new 2014 population**
- **For pre-2014 individual policies, assumptions for contract reserves currently being held will change**
  - For GAAP, due to the lock-in principle, issuers may not be able to update their contract reserve assumptions to reflect the change in expected lapse rates
  - For SAP, some issuers are already changing future lapse assumptions
  - For the MLR rebate calculation, change in contract reserves will impact customer rebates

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Due and Unpaid Premium Asset (1 of 1)

- **A 90-day premium grace period, instead of a 30-day grace period is allowed for members receiving premium subsidies**

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Premium Deficiency Reserves (1 of 1)

- **One possible change for PDR calculations is the level of granularity at which the issuer's business is grouped**
- **Another issue is the estimation of future premiums and rate increases going into the PDR calculation as these assumptions are more uncertain**

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Thank you

Presentation by

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