Actuaries' Club of the Southwest (ACSW)

Spring Meeting

Health Insurer Financial Reporting Post-ACA

Presented by:

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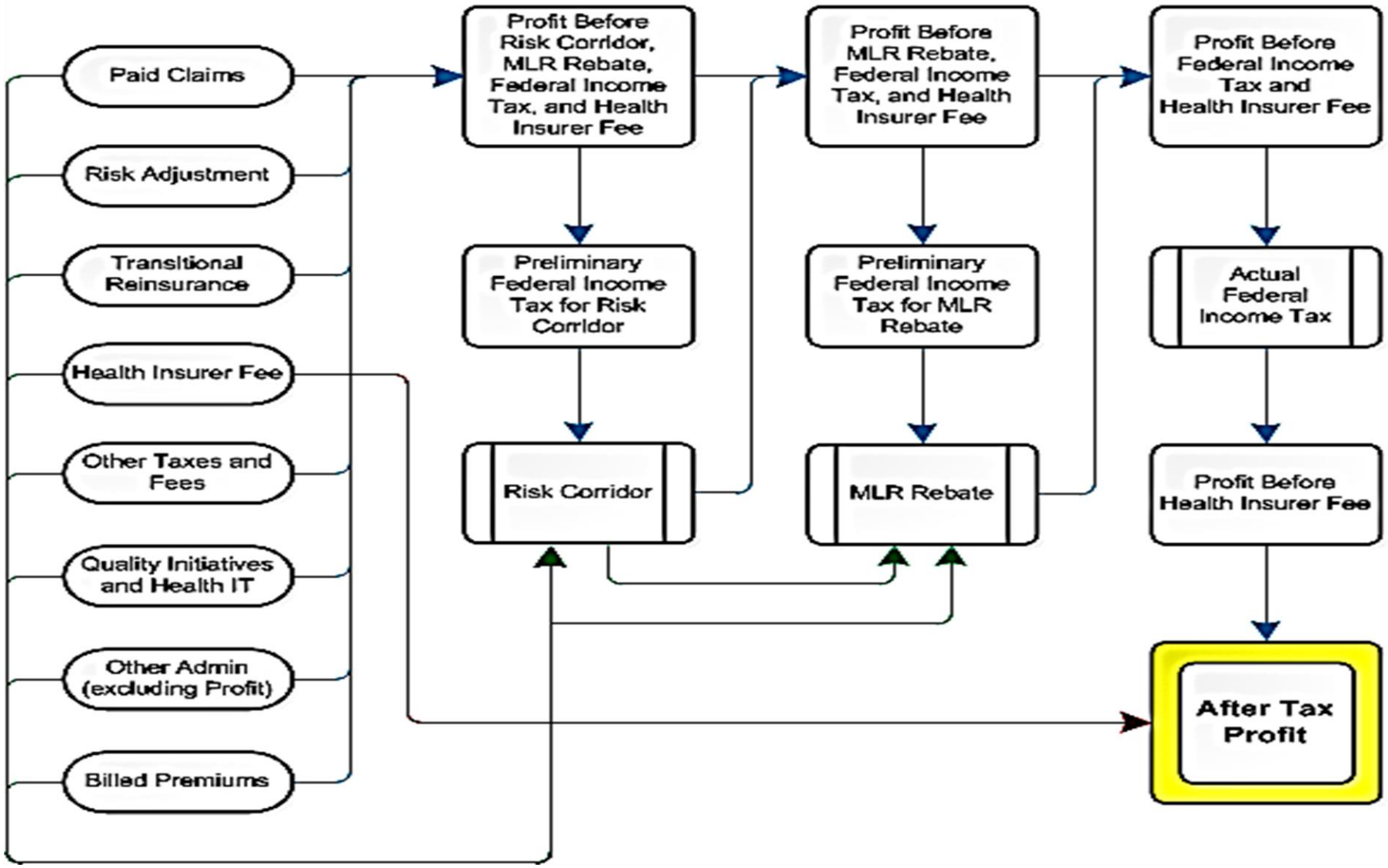
Consulting Actuary

We Will Discuss…

- Basic and advanced concepts related to the major financial items created by the ACA
- This includes estimation methods, accounting handling, and optimization techniques for each
- As well as global issues like the SAO, handling restatements, and interactions

Any questions? Don’t be shy!

Interactions of Cash Flows Under the Affordable Care Act



Reinsurance 101

- Individual, Small Group, Large Group, and most self-funded markets pay fixed PMPM contribution
- Individual market receives a percentage of claims between an attachment point and a cap
- Can receive a pro rata share if the program is over or under funded
- Reported on page 2 line 16.1 (Amounts Recoverable from Reinsurers) and page 3 line 1 (Claims Unpaid) of annual statement

Reinsurance Complications

- Estimate using CPDs or Completion Factors
- Difficult to know funding in advance & impact can be counter-intuitive
- Cash flow strain since large and long delay
- Accounting handling of contributions is complicated

Risk Adjustment 101

- Plans with healthier members pay into the pool and vice versa
- HHS built 15 risk scoring models to define morbidity
- Transfer payments based on state average premium and the issuers risk score normalized for plan, age, and geography
- Affects all non-grandfathered non-transitional individual and small group plans
- Treated as revenue whether payment or receipt, but annual statement line not prescribed

Risk Adjustment Complications

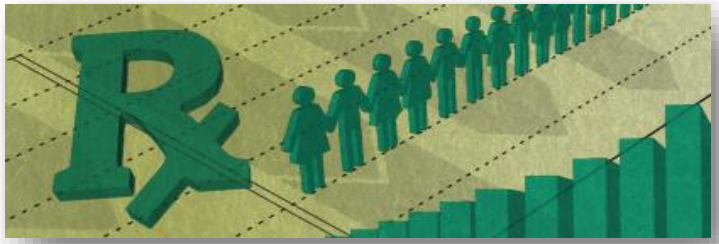
- Traditional risks can go away or are turned on their head
- Estimate using demographic analyses, selection analyses, comparison to benchmarks, or simulation studies
- Potentially large margins needed
- Commercial market for 1st time must consider coding, provider education & chart review

“You don’t have to run faster than the bear to get away. You just have to run faster than the guy next to you.”

The **key component** in determining whether a carrier will **receive** or **make** a transfer payment is:

- How your calculated risk score (after normalizing across all carriers) **compares** to the product of the actuarial value and allowable rating factors (after normalizing across all carriers)

So How Can We Do Better?



Front End

- Perform health risk assessment
- Ensure members see a provider annually
- Require clinical tests to identify common conditions
- Educate doctors on best coding practices
- Capture encounter / claim data accurately & completely
- Use Rx history from Pharmacy / PBM databases for newly insured

Back End

- Use a medical & Rx data to identify missed opportunities
- Identify conditions with low prevalence compared to benchmarks
- Educate providers not adhering to best practices
- Perform chart review and home visits

Risk Adjustment Estimates are Optimistic

- Milliman compiled data from 2014 annual statements
- Issuers expect receipts **$400 million** more than payments (representing 25% of expected receipts)
- 49 parent companies report receipts, 40 report payments, 26 report $0 but appear eligible

Risk Corridors 101

- Intended to reimburse a % of deviations in earnings from expected
- Originally parameters identical from 2014-2016 except since altered
- Affects issuers offering QHPs
- Compare “Allowed Costs” (i.e., claims, admin, etc.) to a “Target Amount”
- Structured similarly to MLR (except there is upside potential, does not include non-ACA plans, and no credibility adjustment)
- Accounted for as Accrued Retrospective Premium or Aggregate Health Policy Reserves depending on direction

Risk Corridor Funding Uncertain

- Last year changed to be revenue neutral
- CMS insists these will be funded over 3-year lifetime
- Studies by Citi, S&P, and Milliman indicate likely underfunded
- Milliman study indicates 5% funded (i.e., a $900 million shortfall)

Risk Corridor Other Complications

- Admissibility is debatable given funding issues
- Need, direction, and method for margin is debatable
- Expense allocation important
- Can maximize benefit by using full 20% of premium in expenses
- Changed calculation so non-QHP experience is allocated to QHPs

MLR Rebates 101

- One sided mechanism that results in rebates if loss ratio is below 80% or 85%
- Have existed since 2011 but rules changing in 2014 so 3 years of experience will be used and incorporate 3Rs
- Effects all fully insured lines of business indefinitely
- Accounted for as Aggregate Health Policy Reserve, not all issuers have included in SAO

MLR Rebate Complications

- Need to control, track, & characterize administrative expenses
- Unlike previous items MLR even in principle increases risk

Cost Sharing Reduction Subsidies 101

- Complicated subsidization program requiring alternate Silvers and Indian variation plans
- Members <250% of FPL can opt for a richer plan with fed paying plans the difference
- At YE issuers can accrue for difference between earned & received
- Multiple methods to value the subsidy

CSR Subsidies Complications

- The simplified method isn't!
- Nobody will have necessary data
- The resulting "simplified-simplified" method would short the industry 8-13% of Silver plan premium
- Moving to the standard method is a big lift

Global Issues

- More restatements than in the past, and come in 2 flavors
- Interactions between FIT, RC, and MLR
- Health Insurance Provider Fee not tax deductible
- Qualified opinions more common

What is an ORSA?

- Assessment of risks, business plan, and capital
- Nature of the assessment is largely defined by the company
- Examines all material risks
- Focus on solvency within a 1 to 3-year time frame
- Appropriate to nature, scale, & complexity of business
- Applies to companies reporting > $500 million or groups reporting > $1 billion in annual premium in states having passed the law

More ORSA Information…

- Official Goals:
  - Foster an effective level of ERM at all insurers
  - Provide group-level perspective on risk & capital
- Not necessarily about creating or introducing new processes
- Not a “cookbook” exercise: Company staff defines what their company’s ORSA looks like
- Not just a regulatory exercise
  - There is a “use test”: Companies may be called upon to demonstrate how they are using their processes and controls described in the ORSA report to manage their risks

What Does The Law Require?

- Conduct an ORSA at least annually
- Compile ORSA Summary Report
  - 3 sections
  - Signed by Chief Risk Officer or other executive
  - Contents of report must comply with NAIC ORSA Guidance Manual
- ORSA Summary Report must be filed with Commissioner of Insurance in State of Domicile
  - Commissioner may request additional details
  - Report is strictly confidential and not subject to FOIA
  - If group is domiciled in more than one state, Commissioners in states will coordinate