

Issue Paper No. 148

Affordable Care Act Section 9010 Assessment

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SUMMARY OF ISSUE

1. This issue paper establishes statutory accounting principles for the fee payable under Section 9010 of the federal Affordable Care Act (ACA) by reporting entities. This issue paper provides historical documentation of the substantive revisions to *SSAP No. 35—Guaranty Fund and Other Assessments – Revised* (SSAP No. 35R) in Appendix A. The changes reflected in Appendix A were adopted in SSAP No. 35R in December 2013 and were subsequently moved in 2014 to a separate statement, *SSAP No. 106—Affordable Care Act Section 9010 Assessment*. Also at that time, additional disclosures related to the risk-sharing provisions of the Affordable Care Act were incorporated. These changes are shown in Appendix B. In addition, this issue paper provides documentation of the extended discussion related to the Section 9010 ACA assessment including the two major viewpoints on the topic. Paragraphs 2 through 8 of this issue paper provide the proposed new guidance to SSAP No. 35R, and paragraph 9 shows the tracked changes to the existing 2013 disclosure as well as expanding the 2014 disclosure. Paragraphs 10 through 21 detail the discussions, paragraphs 22 through 33 provided comments on the Statement of Concepts, and the remaining paragraphs contain relevant literature.

SUMMARY CONCLUSION

Affordable Care Act Section 9010 Assessment

2. *ASU 2011-06: Other Expenses – Fees Paid to the Federal Government by Health Insurers* (ASU 2011-06) provides specific guidance related to the assessment in Section 9010 of the Affordable Care Act. ASU 2011-06 is a consensus of the Financial Accounting Standards Board (FASB) Emerging Issues Task Force. This issue paper proposes to adopt ASU 2011-06 with the following modifications: 1) to require full expense recognition on January 1 of the fee year and 2) to require the reclassification from unassigned surplus to special surplus in the data year for the estimated amount payable in the upcoming year, and 3) other modifications for statutory accounting terminology as reflected in this issue paper.

3. The Affordable Care Act (ACA) imposes an assessment on entities that issue health insurance for each calendar year beginning on or after January 1, 2014. Pursuant to Section 9010 of the ACA, a reporting entity's portion of the assessment is paid no later than September 30 of the applicable calendar year (the fee year) beginning in 2014 and is not tax deductible. The amount of the assessment for the reporting entity is based on the ratio of the amount of an entity's subject net health premiums written for any U.S. health risk during the preceding calendar year (data year) to the aggregate amount of subject net health premiums written by all subject U.S. health insurance providers during the preceding calendar year. The ACA includes some significant exclusions regarding which entities are required to pay the assessment. This guidance applies to all entities that are subject to the fee. The guidance in this section (paragraphs 3-9) applies to the unique facts and circumstances in the ACA; accordingly, an entity should

apply judgment when evaluating the facts and circumstances of other assessment arrangements before analogizing to the guidance for Section 9010 of the ACA.

4. Throughout this discussion of the Section 9010 assessment of the ACA, the following terms apply:

- a. The term “data year” means the calendar year immediately before the fee year. For example, 2014 is the data year for fee year 2015.
- b. The “term fee” year means the calendar year in which the assessment must be paid to the U.S. Treasury.

5. A reporting entity’s portion of the annual assessment becomes payable to the U.S. Treasury once the reporting entity provides health insurance (in the fee year) for any subject U.S. health risk for each calendar year beginning on or after January 1, 2014.

6. The liability related to the Section 9010 ACA assessment shall be estimated and recorded in full once the entity provides qualifying health insurance (typically January 1) in the applicable calendar year in which the assessment is paid (fee year) with a corresponding entry to expense. The Section 9010 ACA assessment shall be recognized in full on January 1 of the fee year, in the operating expense category of Taxes, Licenses and Fees.

7. Liability recognition of the Section 9010 fee is not required in the data year. In the data year, the reporting entity is required to reclassify from unassigned surplus to special surplus an amount equal to its estimated subsequent fee year assessment. This segregation in special surplus is accrued monthly throughout the data year. The reclassification from unassigned surplus to special surplus does not reduce total surplus. On January 1 of the fee year, the prior year segregation in special surplus is reversed and the full current fee year assessment liability shall be accrued.

8. The Section 9010 ACA annual assessment does not represent a cost related to the acquisition of policies that is consistent with the definition of acquisition costs in *SSAP No. 71—Policy Acquisition Costs and Commissions*.

Disclosures

9. A disclosure for year-end 2013 was adopted in SSAP No. 35R early in the discussion on the Section 9010 fee. The disclosure was subsequently extended to include years on and after 2014. In addition, for 2014 and thereafter, the disclosure was also expanded to include information on the amounts reflected in special surplus in the data year as detailed below:

23. For the Section 9010 ACA assessment:

- a. For the annual reporting period ending December 31, 2013 and thereafter, a reporting entity subject to the assessment under Section 9010 of the Affordable Care Act, shall provide a disclosure of the assessment payable in the upcoming year consistent with the guidance provided under *SSAP No. 9—Subsequent Events* for a Type II subsequent event. The disclosure shall provide information regarding the nature of the assessment and an estimate of its financial impact, including the impact on its risk based capital position as if it had occurred on the balance sheet date. In accordance with SSAP No. 9, paragraph 9, the reporting entity shall also consider whether there is a need to present pro forma financial statements regarding the impact of the assessment, based on its judgment of the materiality of the assessment.
- b. Additionally for annual reporting periods ending on or after December 31, 2014, the disclosure in paragraph 23.a. is expanded to include information on the amounts reflected

in special surplus in the data year. The disclosure shall provide information regarding the nature of the assessment and the Total Adjusted Capital and Authorized Control Level (in dollars) before and after adjustment (as reported in its estimate of special surplus applicable to the 9010 fee) to reflect the fee as of the annual reporting date as if it had been reported on the balance sheet date. The disclosure shall also provide a statement as to whether an RBC action level would have been triggered had the fee been reported as of the balance sheet date.

DISCUSSION

10. This topic was discussed at the Statutory Accounting Principles (E) Working Group with input from the Financial Condition (E) Committee. In addition, the Health Insurance and Managed Care (B) Committee and the Accounting Practices and Procedures (E) Task Force were invited to participate in a number of the discussions via conference call. The Working Group reviewed Section 9010 of the ACA and the generally accepted accounting principles (GAAP) guidance in ASU 2011-06 (excerpted in the relevant literature section of this issue paper).

Timing of Liability Recognition

11. During this review, the Working Group had a series of discussions regarding the timing of the recognition of the liability. Section 9010 of the ACA allocates the assessment based on the ratio of prior year premium to total subject premium. Section 9010 further notes, “the term ‘covered entity’ means any entity which provides health insurance for any United States health risk during the calendar year in which the fee under this section is due.” Different parties participating in the discussions put varying degrees of emphasis on the ACA phrase “provides insurance.”

12. ASU 2011-06 specifies that the liability for the fee should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable, with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable.

13. The discussions coalesced into two primary views regarding the timing of the recognition of the liability for the Section 9010 ACA fee. These views are summarized below as the data year view and as the fee year view. Data year and fee year terms are defined in the summary conclusion section of this issue paper. Although both views had some impact on the ultimate decisions, the fee year view is the primary view reflected in the summary conclusion.

Data Year Recognition View

14. The group that advocated liability recognition at December 31 of the data year had the following primary points:

- a. This group was in support of the generally accepted accounting principles (GAAP) dissenter opinion detailed in ASU 2011-06, which advocated data year liability recognition. This dissenter opinion was based on the view that an entity subject to the fee incurs a constructive liability throughout the year as related revenues are recognized. Following that view, the constructive liability then becomes a legal liability the first day revenues are recognized in the subsequent year; a relatively inconsequential event for a going concern. Therefore, absent a decision (before the start of the next calendar year) to cease doing business, an entity should record a liability in the same year related revenues are recognized.
- b. This group noted the objectives of GAAP reporting differ from the objectives of statutory accounting principles (SAP) reporting. GAAP is designed to meet the varying needs of the different users of financial statements, while SAP is designed to address the concerns

- of regulators, who are the primary users of statutory financial statements. The differences in objectives between GAAP and SAP are especially pronounced in the FASB Emerging Issues Task Force opinion detailed in ASU 2011-06. The summary of ASU 2011-06 states that the objective is to address questions about how health insurers should recognize and classify in their income statements fees mandated by the ACA. It is clear from this language that FASB's focus was on the impact of the ACA fee on the income statement with limited focus on when the ACA fee liability should be recognized.
- c. This group advocated that the fee, at a minimum, represents a loss contingency in the data year.
 - d. As a practical matter, insurers legally commit to provide insurance for the subsequent year (fee year) before the end of the year (data year). This view places emphasis on the fact that the reporting entity has "committed to provide insurance" in the year the fee is paid on or before December 31 of the data year. This group contended that "committing to provide insurance" is the same as the "provides insurance" liability threshold in the ACA.
 - e. Advocates of this view noted that the obligation to recognize a liability in *SSAP No. 5—Liabilities, Contingencies and Impairments of Assets – Revised* (SSAP No. 5R) had been met because it factors in the ACA law, contract law and the federal Health Insurance Portability and Accountability Act (HIPAA). Some of the federal laws, in particular, require 3 to 6 months' notice if a policy will not be renewed or will be cancelled.
 - f. A significant percentage of policies are non-calendar year policies. Policies have level-term payments and, as such, billings in the data year include anticipated costs for the fee year amount. Members of industry confirmed that amounts were being collected in the data year for non-calendar year policies. Advocates of this view noted that if there is not a corresponding accrual in the data year, then data year income and assets are overstated. Correspondingly, there would be a permanent increase (overstatement) in capital in the year-end financial statements.
 - g. Supporters of this view noted that it is also consistent with the existing liability recognition principles in SSAP No. 35R regarding guaranty fund assessments which are recognized on the date of insolvency, instead of on the date of assessment. In addition, it is consistent with the existing guidance for premium-based assessments in SSAP No. 35R, which notes that the event that obligates the entity is generally writing the premiums or becoming obligated to write or renew (such as multiple-year, noncancelable policies) the premiums on which the assessments are expected to be based.
 - h. Supporters of this view noted that failure to recognize the liability for the fee in the data year's financial statements hampers the regulators' ability to utilize critical solvency tools that are dependent on an accurate assessment of an insurer's total surplus. Solvency monitoring tools such as risk-based capital (RBC), Insurance Regulatory Information System (IRIS) ratios, Financial Analysis Solvency Tools (FAST) including scores, holding company approval thresholds, standards for companies deemed to be in hazardous financial condition, investment law limitations, and extraordinary dividend approval thresholds will be rendered ineffective due to the failure to record the liability for the fee.
 - i. Supporters of this view noted that it is consistent with statutory Statement of Concepts **conservatism** principle.
 - j. In the event of liquidation, the ACA fee may have higher priority for payment than certain recorded liabilities.

Fee Year Recognition View

15. The group that advocates liability recognition on January 1 of the fee year had the following primary points:

- a. This group was in support of the GAAP majority (adopted) FASB Emerging Issues Task Force opinion detailed in ASU 2011-06, which requires liability recognition in the year the fee is paid. This group advocated for statutory accounting principles (SAP) and GAAP to be consistent regarding accrual of the Section 9010 ACA fee.
- b. This group contended that the criteria of an incurred liability in SSAP No. 5R and SSAP No. 35R have not been met in the data year. This group contends that the insurer must actually “provide coverage in the fee year” before the liability is incurred. They view the obligating event as providing coverage on or after January 1 of the fee year.
- c. As a practical matter, insurers legally commit to provide insurance for the subsequent year (fee year) before the end of the year (data year). Supporters of this view contended that legally committing to provide insurance in the fee year was not enough to trigger the liability.
- d. In response to the issue of contract law cancellation requirements of the federal Health Insurance Portability and Accountability Act (HIPAA) that require, in some cases, 3 to 6 months’ notice by an insurer if a policy is not going to be renewed, or is planned to be cancelled; this group noted that it is possible for policyholders to cancel without notice.
- e. A significant percentage of policies are non-calendar year policies. Policies have level-term payments and, as such, billings in the data year include anticipated costs for the fee year amount. Members of industry confirmed that amounts were being collected in the data year for non-calendar year policies. They expressed concerns regarding Medical Loss Ratio (MLR) treatment of these amounts and recommended as a possible compromise, to include in the unearned premium liability, the amount collected in the data year. This liability was not included in the proposed guidance because it was determined this treatment would not be consistent with unearned premium guidance currently within statutory accounting, as well as some MLR guidance issued by the U.S. Department of Health and Human Services which prohibited deduction of fee amounts in the data year for the MLR calculation.
- f. Although the assessment is based on prior year premium, supporters of this view argued that it should be viewed as an annual operating expense consistent with the ASU 2011-06 as opposed to the existing liability recognition for premium based assessment guidance in SSAP No. 35R.

Timing of Expense Recognition and Surplus Impact

16. The Working Group discussed the timing of the surplus reduction and expense recognition and exposed multiple documents for discussion including various proposals for phasing in liability recognition in the data year. The phase-in proposals were an attempt to ease the concerns raised by industry regarding rate-shock and the inability of some insurers to raise rates for the next couple of years due to various issues. The August 2013 and November 2013 Working Group exposures reflect a modified GAAP approach with fee year recognition modified for full surplus recognition on January 1 of the fee year.

17. The Working Group discussed various options for the timing of expense recognition including expensing 1) in the data year; 2) in full January 1 of the fee year; 3) over nine months in the fee year; 4)

over 12 calendar months of the fee year and 5) over 12 months from October 1 of the data year through payment on September 30 of the fee year.

18. ASU 2011-06 recognizes the expense over the calendar year or another method if it is more accurate. Industry representatives advocated for a similar expense recognition approach with modifications using a nonadmitted deferred expense asset. Industry advocated an approach, which recognized the full impact in surplus on January 1, and then establishes a nonadmitted deferred expense asset. The deferred expense asset is then amortized to expense over the calendar year similar to GAAP expense recognition timing.

19. Deferring expenses over 12 months of the fee year was determined to be inconsistent with explicit language in the Statement of Concepts Recognition guidance which notes that:

Accounting treatments, which tend to defer expense recognition, do not generally represent acceptable SAP treatment.

In addition, some members of the Working Group noted that the nonadmitted deferred cost asset does not meet the definition of an asset. The Working Group's exposure adopts GAAP with modification to require full expense recognition on January 1 of the fee year. and 2) to require the reclassification from unassigned surplus to special surplus in the data year for the estimated amount payable.

Special Surplus Segregation

20. It was noted that the year-end financial statements are used in many of the regulatory financial solvency tools, such as risk-based capital (RBC), dividend limitations noted in the Insurance Holding Company System Regulatory Act (Model 440), various financial analysis and regulatory tools. Therefore, omitting this material liability from year-end recognition in the data year would hamper year-end analysis of insurers and require state regulators to perform additional manual reviews. Partially to address these concerns, disclosures regarding the estimated fee year amount and the impact on RBC were adopted. However, Working Group members noted that the regulatory ability to act on disclosures is weaker than the regulatory ability to act on liability recognition.

21. An industry compromise was developed to require the estimated amount payable for the fee year to be reflected as a reclassification of surplus from unassigned surplus to special surplus in the data year. This reclassification does not decrease total surplus. While this does provide transparency to the financial statements and somewhat limits the source of dividend payments, it does not fully limit the amount of dividends which may be paid. The primary determinant of whether a dividend is extraordinary is ten percent of total surplus. If a dividend is not extraordinary, a company may pay it without prior approval. The Working Group noted that an insurer would get an artificial increase in the ordinary/extraordinary dividend data year threshold equal to ten percent of the amount payable for the fee year. This accrual in special surplus is subsequently reversed on January 1 of the fee year when the fee year payable is recognized.

Statutory Statement of Concepts

22. The Working Group discussion directed that an analysis of the proposed guidance with the statutory statement of concepts be prepared for inclusion in this Issue Paper.

Conservatism

23. The Preamble, paragraph 30 calls for accounting to be reasonably conservative. Section 9010 of the Affordable Care Act (ACA) indicates the amount of the fee is allocated based on prior year health premium (data year) if the reporting entity is a provider of health insurance coverage as of January 1 of the year the fee is paid (fee year). The unusual wording in the ACA creates questions regarding when the

liability is triggered. *ASU 2011-06 – Fees Paid to the Federal Government by Health Insurers* (ASU 2011-06) determined that the liability is incurred on January 1 of the year the fee is paid. ASU 2011-06 also explicitly scoped the liability as separate from insurance-related assessments and notes that the fee does not meet the GAAP definition of a policy acquisition cost. The definition of a liability incorporated by statutory accounting in *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets –Revised* (SSAP No. 5R) is based on the GAAP definition of a liability. Therefore, SAP and GAAP should have similar conclusions regarding the incurral of a liability.

24. The fee year view currently exposed by the Working Group and the position adopted by the Emerging Issues Task Force in ASU 2011-06 indicates that a liability has not been incurred until provision of insurance coverage in the fee year. If the obligating event for the liability is viewed as January 1 of the fee year, then it is conservative to recognize the liability in full as soon as it is incurred on January 1 of the fee year.

25. The fee year view is not considered as conservative as the data year view with regard to recognition of the ACA fee liability, but it is consistent with the GAAP guidance in ASU 2011-06 that was adopted.

Consistency

26. Paragraph 31 of the Preamble highlights the importance of meaningful and comparable financial information. Statutory accounting requires expensing of acquisition costs and establishing loss reserves at policy inception. Other administrative costs of policies are recognized as a liability when incurred. Policy pricing includes some elements, such as administrative overhead, which are not recognized as liabilities until they are incurred.

27. Preamble, paragraph 31 also calls for “consistency in the development and application of statutory accounting principles.” This proposal preserves that consistency without imposing a different standard for recognition of the future fee payments.

Recognition

28. The Preamble, paragraph 34 states that liabilities require recognition as they are incurred. Under this proposal, GAAP and SAP define liability recognition consistently. Given the dual trigger in the law of writing premium in the data year and providing insurance in the fee year, recognition in the fee year is consistent with the FASB Emerging Issues Task Force conclusion in ASU 2011-06. Therefore, defining the liability triggering event as providing insurance in the fee year is consistent with U.S. GAAP.

29. The Fee can be invoiced any time during the fee year, but must be paid no later than September 30. GAAP guidance in ASU 2011-06 amortizes the Fee through December of the fee year. Statutory accounting recognizes expenses as incurred, as they are no longer available to pay policyholders. This is consistent with the statement of concepts regarding recognition and conservatism. However, ASU 2011-06 varies from statutory conservatism, by deferring recognition of the liability expense over the course of the fee calendar year. Deferring expenses is explicitly in conflict with the following quote in the Recognition concept in paragraph 35 of the Preamble, “Accounting treatments which tend to defer expense recognition do not generally represent acceptable SAP treatment.” A deferred expense asset is also inconsistent with the definition of an asset as it does not represent a future benefit and no expenses have been prepaid. The current exposure by the Working Group is to expense in full on January 1 of the fee year.

30. The Working Group noted that provision of coverage to a single policyholder in the fee year triggers the obligation of the full liability based on all subject policies in the preceding year. Policyholder acceptance on January 1 of the fee year of a calendar year policy is further evidence of a liability existing in the data year.

31. The proposal requires that reporting entities establish in special surplus funds an amount equal to the anticipated Fee payable in the next year. This segregation in special surplus in the data year is to provide transparency on the face of the financial statements regarding the subsequent year's fee payable. This provides regulators additional information for year-end regulatory decisions and financial analysis. In addition, there are annual disclosures, including a disclosure that reflects RBC as if the liability was accrued in the data year.

Conclusion

32. The proposal generally defers recognition of the Fee liability until the fee year consistent with GAAP. It also provides transparency with the segregation in special surplus.

Data Year Recognition (Dissenting Opinion) Statutory Statement of Concepts

33. The group that advocated liability recognition at December 31 of the data year conducted its own analysis that reflects how the proposed guidance aligns with the statutory accounting principles Statement of Concepts:

Conservatism

34. The Working Group is concerned regarding the material amount of the Fee that will be recognized as a liability on January 1 of the fee year without substantive commercial action of the insurer. It was further concerned that not recognizing the liability in the data year was inconsistent with the concept of conservatism.

35. The most fundamental question that the Working Group addresses in the proposed guidance is the timing of the liability for the ACA fee. Should the liability be accrued at year-end of the data year or accrued on January 1 of each fee year? The general concept of conservatism states that if there is uncertainty about incurring a loss, one should tend toward recording such loss. Although there may be disagreement with respect to the appropriate timing for recognition of this liability, recording the liability at year-end is the most conservative approach. Since the primary responsibility of statutory accounting is to regulate for financial solvency, the use of conservatism by the SAPWG in developing accounting principles for statutory reporting purposes is critical and cannot be ignored.

36. The proposed guidance clearly violates the concept of conservatism when focusing on the fundamental question: when should the liability for the ACA fees be established.

Consistency

37. Current statutory accounting in SSAP No. 35R requires that entities subject to premium-based administrative type assessments recognize a liability for such assessment when the entity writes the premium or becomes obligated to write the premium. However, the proposed guidance ignores this approach and creates a special exception for health insurance entities subject to the ACA fee. This special treatment is inconsistent with the existing liability recognition principles in SSAP No. 35R.

38. One of the three essential characteristics of a liability is that the duty or responsibility obligates a particular entity, leaving it little or no discretion to avoid the future sacrifice. Some advocates of the proposed guidance have argued that an entity can avoid tax obligations by not providing any health insurance coverage during the fee year by choosing to go or be out of business each December 31; and, therefore, the health insurers should not have to record a liability for the ACA fee. However, the same health insurers that make this contention are also reporting significant amounts of deferred tax assets that are dependent on the existence of sufficient taxable income of the appropriate character in the carryforward period. These contradictory outlooks on future operations and earnings are inconsistent.

39. The proposed guidance violates the concept of consistency and the regulators' need for meaningful, comparable financial information to determine an insurer's financial condition.

Recognition

40. The fee meets the definition of a liability when the premium subject to the assessment has been written or the reporting entity is obligated to write the premium. In order to meet Health Insurance Portability and Accountability Act (HIPAA) requirements or to comply with contractual commitments, insurers are legally obligated to provide insurance in the subsequent year when entering into contracts during the previous year that have policy periods that extend into that same subsequent year. When a reporting entity has committed, or has a legal obligation, to provide insurance in the year the assessment is payable, it has met the secondary trigger in the ACA and a liability should be required to be accrued in that year's financial statements.

41. Advocates of the proposed guidance have argued that while a health insurer may be contractually bound to provide coverage in the payment year, the policyholder has no reciprocal obligation to accept such coverage. However, *SSAP No. 9—Subsequent Events* (SSAP No. 9) would address this particular situation. SSAP No. 9 requires an entity to recognize in the financial statements the effects of all material Type I subsequent events that provide additional evidence about conditions that existed at the date of the balance sheet. The health insurer's contractual obligation to provide coverage in the payment year is the condition that existed at the date of the balance sheet date. The policyholders' actions on January 1 provide the additional evidence about those same conditions. If all of the policyholders of the health insurer do not accept coverage, there is no need to establish an ACA fee liability. However, if any single policyholder does accept coverage, that acceptance provides the additional evidence about conditions that existed at the date of the balance sheet (the contractual obligation), and an ACA fee liability needs to be recognized in the financial statements.

42. The revised SSAP No. 35R violates the concept of recognition and the principal focus of solvency measurement: the determination of financial condition through analysis of the balance sheet.

Data Year (Dissenting Opinion) Conclusion

43. The proposed guidance clearly violates the fundamental concepts on which statutory financial accounting and reporting standards are based.

RELEVANT LITERATURE

Generally Accepted Accounting Principles

44. *Accounting Standards Update 2011-06 Other Expenses (Topic 720) Fees Paid to the Federal Government by Health Insurers* (ASU 2011-06) was issued in July 2011. The amendments in this update specify that the liability for the fee should be estimated and recorded in full once the entity provides qualifying health insurance in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. Additionally, this Update indicates that the fee would not meet the definition of an acquisition cost. Excerpts from ASU 2011-06 are as follows:

Scope and Scope Exceptions

405-30-15-3 The guidance in this Subtopic does not apply to the following transactions and activities:

- a. Amounts payable or paid as a result of reinsurance contracts or arrangements that are in substance reinsurance, including assumed reinsurance activities and certain **involuntary pools** that are covered by Topic 944.
- b. Assessments of depository institutions related to bank insurance and similar funds.
- c. The annual fee imposed on health insurers by the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (the Acts). The accounting for the Acts' fee is addressed in Subtopic 720-50.

Other Expenses—Fees Paid to the Federal Government by Pharmaceutical Manufacturers and Health Insurers

Overview and Background

720-50-05-1 This Subtopic provides guidance on the annual ~~fee~~fees paid by pharmaceutical manufacturers and health insurers to the U.S. Treasury in accordance with the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (the Acts).

720-50-05-2 The Acts impose ~~an annual fee~~fees on the pharmaceutical manufacturing industry for each calendar year beginning on or after January 1, 2011, and on the health insurance industry for each calendar year beginning on or after ~~January 1, 2014~~January 1, 2014. An entity's portion of the annual fee is payable no later than September 30 of the applicable calendar year and is not tax deductible. ~~The annual fee ranges from \$2.5 billion to \$4.1 billion in total, a portion of which will be allocated to individual entities on the basis of the amount of their branded prescription drug sales for the preceding year as a percentage of the industry's branded prescription drug sales for the same period. An entity's portion of the annual fee becomes payable to the U.S. Treasury once a pharmaceutical manufacturing entity has a gross receipt from branded prescription drug sales to any specified government program or in accordance with coverage under any government program for each calendar year beginning on or after January 1, 2011.~~ **[Content amended and moved to paragraph 720-50-05-3]**

720-50-05-3 For the pharmaceutical manufacturing industry, ~~the~~The annual fee ranges from \$2.5 billion to \$4.1 billion in total, a portion of which will be allocated to individual entities pharmaceutical manufacturers on the basis of the amount of their branded prescription drug sales for the preceding year as a percentage of the industry's branded prescription drug sales for the same period. ~~AA~~ A pharmaceutical manufacturing entity's portion of the annual fee becomes payable to the U.S. Treasury once the a pharmaceutical manufacturing entity has a gross receipt from branded prescription drug sales to any specified government program or in accordance with coverage under any government program for each calendar year beginning on or after January 1, 2011. **[Content amended as shown and moved from paragraph 720-50-05-2]**

720-50-05-4 For the health insurance industry, the annual fee will be allocated to individual health insurers based on the ratio of the amount of an entity's net premiums written during the preceding calendar year to the amount of health insurance for any U.S. health risk that is written during the preceding calendar year. A health insurance entity's portion of the annual fee becomes payable to the U.S. Treasury once the entity provides health insurance for any U.S. health risk for each calendar year beginning on or after January 1, 2014.

Scope and Scope Exceptions

720-50-15-1 The guidance in this Subtopic applies to all pharmaceutical manufacturers and health insurers that are subject to the annual fee imposed by the Acts described in paragraphs 720-50-05-1 ~~and 720-50-05-2~~through 05-4. The guidance in this Subtopic is based on the unique facts and circumstances of the fee to be paid by pharmaceutical manufacturers and health insurers in accordance with the Acts; accordingly, an entity should

apply judgment when evaluating the facts and circumstances of other fee arrangements before analogizing to the guidance in this Subtopic.

Recognition

720-50-25-1 The liability related to the annual fee described in ~~paragraph~~ paragraphs 720-50-05-1 through 05-4 shall be estimated and recorded in full upon the first qualifying sale for pharmaceutical manufacturers or once the entity provides qualifying health insurance for health insurers in the applicable calendar year in which the fee is payable with a corresponding deferred cost that is amortized to expense using a straight-line method of allocation unless another method better allocates the fee over the calendar year that it is payable. The annual fee imposed on health insurers does not represent a cost related to the acquisition of policies that is consistent with the definition of an acquisition cost in Subtopic 944-30.

Other Presentation Matters

720-50-45-1 The annual fee described in ~~paragraph~~ paragraphs 720-50-05-1 through 05-4 shall be presented as an operating expense.

Transition Related to Accounting Standards Update No. 2011-06, Other Expenses (Topic 720): Fees Paid to the Federal Government by Health Insurers

720-50-65-2 The following represents the transition and effective date information related to Accounting Standards Update No. 2011-06, *Other Expenses (Topic 720): Fees Paid to the Federal Government by Health Insurers*:

- a. The pending content that links to this paragraph shall be effective for calendar years beginning after December 31, 2013.
- b. The pending content that links to this paragraph does not require an entity to reevaluate its existing policies related to similar fees assessed by governmental authorities.

45. The amendments in ASU 2011-06 were adopted by the affirmative vote of six members of the Financial Accounting Standards Board. The Statutory Accounting Principles (E) Working Group also noted and discussed the dissenting opinion.

Mr. Schroeder objects to the issuance of the amendments in this Update. Mr. Schroeder agrees with recognition of the liability for the fee, but disagrees with the timing of its recognition and the related deferred cost being amortized over the calendar year the fee is payable. Mr. Schroeder believes that the fee generally meets the essential characteristics of a liability, as outlined in paragraphs 35 through 40 of FASB Concepts Statement No. 6, *Elements of Financial Statements*, in the year used to calculate the fee and should be accrued over the course of that year. This is based on the view that an entity subject to the fee incurs a constructive liability throughout the year as related revenues are recognized. Following that view, the constructive liability then becomes a legal liability the first day revenues are recognized in the subsequent year; a relatively inconsequential event for a going concern. Mr. Schroeder believes that absent a decision (before the start of the next calendar year) to cease doing business, an entity should record a liability in the same year related revenues are recognized.

46. Excerpts of the federal Affordable Care Act, Section 9010, are as follows:

SEC. 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS.

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the annual payment date of each

calendar year beginning after 2013 a fee in an amount determined under subsection (b). *[Amended by section 10905(f)(1) and section 1406(a)(1) of HCERA.]*

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term “annual payment date” means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—*[Replaced by section 10905(b).]*

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to the applicable amount as—

(A) the covered entity’s net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, bears to

(B) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year.

(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1)—*[As revised by section 1406(a)(2) of HCERA.]*

(A) IN GENERAL.—The net premiums written with respect to health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

<i>With respect to a covered entity’s net premiums written during the calendar year that are:</i>	<i>The percentage of net premiums written that are taken into account is:</i>
Not more than \$25,000,000	0 percent
More than \$25,000,000 but not more than \$50,000,000.	50 percent
More than \$50,000,000.....	100 percent

(B) PARTIAL EXCLUSION FOR CERTAIN EXEMPT ACTIVITIES.—
After the application of subparagraph (A), only 50 percent of the remaining net premiums written with respect to health insurance for any United States health risk that are attributable to the activities (other than activities of an unrelated trade or business as defined in section 513 of the Internal Revenue Code of 1986) of any covered entity qualifying under paragraph (3), (4), (26), or (29) of section 501(c) of such Code and exempt from tax under section 501(a) of such Code shall be taken into account.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity’s fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity’s net premiums written with respect to any United States health risk on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—*[As revised by section 1406(a)(3) of HCERA.]*

(1) IN GENERAL.—For purposes of this section, the term “covered entity” means any entity which provides health insurance for any United States health risk during the calendar year in which the fee under this section is due.

(2) EXCLUSION.—Such term does not include—

(A) any employer to the extent that such employer self-insures its employees' health risks,

(B) any governmental entity, *[As revised by section 10905(f)(2).]*

(C) any entity— *[Subparagraphs (C) through (E) revised by section 10905(c) and subsequently rewritten in entirety, including striking subparagraph (E), by section 1406(a)(3) of HCERA.]*

(i) which is incorporated as a nonprofit corporation under a State law,

(ii) no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in section 501(h) of the Internal Revenue Code of 1986), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office, and

(iii) more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act, and

(D) any entity which is described in section 501(c)(9) of such Code and which is established by an entity (other than by an employer or employers) for purposes of providing health care benefits.

(3) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414 of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)). *[Note: sentence at end should have been inserted at end of this subparagraph.]*

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof. If any entity described in *[executed to reflect probable intent of amendment made by section 1406(a)(3)(C)]* subparagraph (C) or (D) of paragraph (2) is treated as a covered entity by reason of the application of the preceding sentence, the net premiums written with respect to health insurance for any United States health risk of such entity shall not be taken into account for purposes of this section. *[Previous sentence added by section 10905(f)(3) “at the end” of this paragraph; likely placement should have been at end of subparagraph (A).]*

(4) JOINT AND SEVERAL LIABILITY.—*[As added by section 1406(a)(3)(D) of HCERA.]* If more than one person is liable for payment of the fee under subsection (a) with respect to a single covered entity by reason of the application of paragraph (3), all such persons shall be jointly and severally liable for payment of such fee.

(d) UNITED STATES HEALTH RISK.—For purposes of this section, the term “United States health risk” means the health risk of any individual who is—

- (1) a United States citizen,
- (2) a resident of the United States (within the meaning of section 7701(b)(1)(A) of the Internal Revenue Code of 1986), or
- (3) located in the United States, with respect to the period such individual is so located.

(e) APPLICABLE AMOUNT.—*[Replaced by section 10905(b) and subsequently revised by section 1306(a)(4) of HCERA.]* For purposes of subsection (b)(1)—

(1) YEARS BEFORE 2019.—In the case of calendar years beginning before 2019, the applicable amount shall be determined in accordance with the following table:

Calendar year Applicable amount	
2014	\$8,000,000,000
2015	\$11,300,000,000
2016	\$11,300,000,000
2017	\$13,900,000,000
2018	\$14,300,000,000.

(2) YEARS AFTER 2018.—In the case of any calendar year beginning after 2018, the applicable amount shall be the applicable amount for the preceding calendar year increased by the rate of premium growth (within the meaning of section 36B(b)(3)(A)(ii) of the Internal Revenue Code of 1986) for such preceding calendar year.

(f) TAX TREATMENT OF FEES.—The fees imposed by this section—

- (1) for purposes of subtitle F of the Internal Revenue Code of 1986, shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and
- (2) for purposes of section 275 of such Code shall be considered to be a tax described in section 275(a)(6).

(g) REPORTING REQUIREMENT.—

(1) IN GENERAL.—Not later than the date determined by the Secretary following the end of any calendar year, each covered entity shall report to the Secretary, in such manner as the Secretary prescribes, the covered entity’s net premiums written with respect to health insurance for any United States health risk for such calendar year. *[As revised by section 10904(f)(4).]*

(2) PENALTY FOR FAILURE TO REPORT.—

(A) IN GENERAL.—In the case of any failure to make a report containing the information required by paragraph (1) on the date prescribed therefor (determined with regard to any extension of time for filing), unless it is shown that such failure is due to reasonable cause, there shall be paid by the covered entity failing to file such report, an amount equal to—

- (i) \$10,000, plus
- (ii) the lesser of—
 - (I) an amount equal to \$1,000, multiplied by the number of days during which such failure continues, or
 - (II) the amount of the fee imposed by this section for which such report was required.

(B) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A)—

(i) shall be treated as a penalty for purposes of subtitle F of the Internal Revenue Code of 1986,

(ii) shall be paid on notice and demand by the Secretary and in the same manner as tax under such Code, and

(iii) with respect to which only civil actions for refund under procedures of such subtitle F shall apply.

(3) ACCURACY-RELATED PENALTY.—*[As added by section 1406(a)(5) of HCERA.]*

(A) IN GENERAL.—In the case of any understatement of a covered entity's net premiums written with respect to health insurance for any United States health risk for any calendar year, there shall be paid by the covered entity making such understatement, an amount equal to the excess of—

(i) the amount of the covered entity's fee under this section for the calendar year the Secretary determines should have been paid in the absence of any such understatement, over

(ii) the amount of such fee the Secretary determined based on such understatement.

(B) UNDERSTATEMENT.—For purposes of this paragraph, an understatement of a covered entity's net premiums written with respect to health insurance for any United States health risk for any calendar year is the difference between the amount of such net premiums written as reported on the return filed by the covered entity under paragraph (1) and the amount of such net premiums written that should have been reported on such return.

(C) TREATMENT OF PENALTY.—The penalty imposed under subparagraph (A) shall be subject to the provisions of subtitle F of the Internal Revenue Code of 1986 that apply to assessable penalties imposed under chapter 68 of such Code.

(4) TREATMENT OF INFORMATION.—*[As added by section 1406(a)(5) of HCERA.]* Section 6103 of the Internal Revenue Code of 1986 shall not apply to any information reported under this subsection.

(h) ADDITIONAL DEFINITIONS.—For purposes of this section—

(1) SECRETARY.—The term “Secretary” means the Secretary of the Treasury or the Secretary's delegate.

(2) UNITED STATES.—The term “United States” means the several States, the District of Columbia, the Commonwealth of Puerto Rico, and the possessions of the United States.

(3) HEALTH INSURANCE.—*[Replaced by section 10905(d).]*

The term “health insurance” shall not include—

(A) any insurance coverage described in paragraph (1)(A) or (3) of section 9832(c) of the Internal Revenue Code of 1986,

(B) any insurance for long-term care, or

(C) any medicare supplemental health insurance (as defined in section 1882(g)(1) of the Social Security Act).

(i) GUIDANCE.—The Secretary shall publish guidance necessary to carry out the purposes of this section and shall prescribe such regulations as are necessary or appropriate to prevent avoidance of the purposes of this section, including inappropriate actions taken to qualify as an exempt entity under subsection (c)(2). [*As revised by section 10905(e).*]

(j) EFFECTIVE DATE.—[*Replaced by section 1406(a)(6) of HCERA; previous amendment by section 19095(f)(5)(A) was unexecutable.*] This section shall apply to calendar years beginning after December 31, 2013.

Effective Date and Transition

47. Upon adoption of this issue paper, the NAIC will release a Statement of Statutory Accounting Principles (SSAP) for comment. The SSAP will contain the adopted Summary Conclusion of this issue paper. Users of the *Accounting Practices and Procedures Manual* should note that issue papers are not represented in the Statutory Hierarchy (see Section IV of the Preamble) and, therefore, the conclusions reached in this issue paper should not be applied until the corresponding SSAP has been adopted by the Plenary of the NAIC. It is expected that the SSAP will contain an effective date of years beginning on or after January 1, 2014.

Appendix A – Tracked Changes to SSAP No. 35R

Note – The changes reflected in this Appendix illustrate the revisions to SSAP No. 35R adopted in December 2013. This guidance was subsequently moved in 2014 into *SSAP No. 106—Affordable Care Act Section 9010 Assessment* as illustrated in Appendix B.

Statement of Statutory Accounting Principles No. 35 – Revised

Guaranty Fund and Other Assessments

SCOPE OF STATEMENT

1. This statement establishes statutory accounting principles for guaranty fund and other assessments.
2. Guaranty fund assessments represent a funding mechanism employed by states to provide funds to cover policyholder obligations of insolvent reporting entities. Most states have enacted legislation establishing guaranty funds for both life and health insurance and for property and casualty insurance to provide for covered claims or to meet other insurance obligations of insolvent reporting entities in the state.
3. This statement addresses other assessments including but not limited to workers' compensation second injury funds and for funds that pay operating costs of an insurance department, a state guaranty fund, and/or the workers' compensation board. This statement also addresses health related assessments including but not limited to state health insurance high-risk pools, health insurance small group and individual reinsurance pools, state health demographic or risk adjustment assessments.

SUMMARY CONCLUSION

4. This statement adopts with modification guidance from *Accounting Standard Codification 405-30, Insurance-Related Assessments* (ASC 405-30) as reflected within this SSAP. Consistent with ASC 405-30-25-1, entities subject to assessments shall recognize liabilities for insurance-related assessments when all of the following conditions are met (paragraph ~~4315~~ provides guidance on applying the recognition criteria):
 - a. An assessment has been imposed or information available prior to issuance of the statutory financial statements indicates that it is probable that an assessment will be imposed.
 - b. The event obligating an entity to pay an imposed or probable assessment has occurred on or before the date of the financial statements.
 - c. The amount of the assessment can be reasonably estimated.

Guaranty fund and other assessments shall be charged to expense (Taxes, Licenses and Fees) and a liability shall be accrued when the above criteria are met except for certain health related assessments which shall be reported as a part of claims. Health related assessments that are reported as a part of claims instead of taxes, licenses and fees are those assessments that are designed for the purpose of spreading the risk of severe claims or adverse enrollment selection among all participating entities, and where the funds collected via the assessment are re-distributed back to the participating entities based upon the cost of specific claims, enrollment demographics, or other criteria affecting health care expenses. This standard does not permit liabilities for guaranty funds or other assessments to be discounted.

5. ASU 2011-06: Other Expenses – Fees Paid to the Federal Government by Health Insurers (ASU 2011-06) is adopted with modifications reflected in this statement. ASU 2011-06 provides specific guidance related to the assessment in Section 9010 of the Affordable Care Act and the statutory accounting guidance is included in paragraphs 16-21.

5-6. For refunded guaranty or other fund assessments and assessments used to fund state operating expenses, reporting entities shall credit the refund or charge the assessment to expense when notification of the refund or assessment is made.

6-7. For premium-based guaranty fund assessments, except those that are prefunded, paragraph 4.a. is met when the insolvency has occurred. For purposes of applying this guidance, the insolvency shall be considered to have occurred when a reporting entity meets a state's (ordinarily the state of domicile of the insolvent reporting entity) statutory definition of an insolvent reporting entity. In most states, the reporting entity must be declared to be financially insolvent by a court of competent jurisdiction. In some states, there must also be a final order of liquidation. Prefunded guaranty-fund assessments and premium-based administrative type assessment are presumed probable when the premiums on which the assessments are expected to be based are written. Loss-based administrative-type and second injury fund assessments are presumed probable when the losses on which the assessments are expected to be based are incurred.

7-8. Paragraph 4.b. requires that the event obligating an entity to pay an imposed or probable assessment has occurred on or before the date of the financial statements. Based on the fundamental differences in how assessment mechanisms operate, the event that makes an assessment probable (for example, an insolvency) may not be the event that obligates an entity. The following defines the event that obligates an entity to pay an assessment:

- a. For premium-based assessments, the event that obligates the entity is generally writing the premiums or becoming obligated to write or renew (such as multiple-year, noncancelable policies) the premiums on which the assessments are expected to be based. Some states, through law or regulatory practice, provide that an insurance entity cannot avoid paying a particular assessment even if that insurance entity reduces its premium writing in the future. In such circumstances, the event that obligates the entity is a formal determination of insolvency or similar triggering event. For example, in certain states, an insurance entity may remain liable for assessments even though the insurance entity discontinues the writing of premiums. In this circumstance, the underlying cause of the liability is not the writing of the premium, but the insolvency. Regulatory practice would be determined based on the stated intentions or prior history of the insurance regulators.
- b. For loss-based assessments, the event that obligates an entity is an entity's incurring the losses on which the assessments are expected to be based.

8-9. Paragraph 4.c. requires that the amounts can be reasonably estimated. For retrospective-premium-based guaranty fund assessments, a reporting entity's estimate of the liability shall reflect an estimate of its share of the ultimate loss expected from the insolvency. The reporting entity shall also estimate any applicable premium tax credits and policy surcharges. An entity need not be able to compute the exact amounts of the assessments or be formally notified of such assessments by a guaranty fund to make a reasonable estimate of its liability. Entities subject to assessments may have to make assumptions about future events, such as when the fund making the assessment will incur costs and pay claims to determine the amounts and the timing of assessments. The best available information about market share or premiums by state and premiums by line of business generally should be used to estimate the amount of future assessments. Estimates of loss-based assessments should be consistent with estimates of the underlying incurred losses and should be developed based upon enacted laws or regulations and expected assessment rates. Premium tax credits or policy surcharges may only be considered in the estimate if it is probable they will be realized. Because of the uncertainties surrounding some insurance-related

assessments, the range of assessment liability may have to be re-evaluated regularly during the assessment process. Changes in the amount of the liability (or asset) as information becomes available over time and revisions to estimates in the amount or timing of the payments shall be recorded in taxes, licenses and fees.

9-10. In accordance with SSAP No. 5R, when the reasonable estimate of the loss is a range, the amount in the range that is considered the best estimate shall be accrued. When, in management's opinion, no amount within management's estimate of the range is a better estimate than any other amount, however, the midpoint (mean) of management's estimate in the range shall be accrued. For purposes of this statement, it is assumed that management can quantify the high end of the range. If management determines that the high end of the range cannot be quantified, then a range does not exist, and management's best estimate shall be accrued.

Reporting Assets for Premium Tax Offsets and Policy Surcharges

10-11. The liability for accrued assessments shall be established gross of any probable and estimable recoveries from premium tax credits and premium surcharges. When it is probable that a paid or accrued assessment will result in an amount that is recoverable from premium tax offsets or policy surcharges, an asset shall be recognized for that recovery in an amount that is determined based on current laws, projections of future premium collections or policy surcharges from in-force policies, and as permitted in accordance with paragraphs ~~1011.a.~~, ~~1011.b.~~ and ~~1011.c.~~ Any recognized asset from premium tax credits or policy surcharges shall be re-evaluated regularly to ensure recoverability. Upon expiration, tax credits no longer meet the definition of an asset and shall be written off.

- a. For assessments paid before premium tax credits are realized or policy surcharges are collected, an asset results, which represents a receivable for premium tax credits that will be taken and policy surcharges which will be collected in the future. These receivables, to the extent it is probable they will be realized, meet the definition of assets, as specified in *SSAP No. 4—Assets and Nonadmitted Assets* and are admitted assets to the extent they conform to the requirements of this statement. The asset shall be established and reported independent from the liability (not reported net).
- b. Assets recognized from accrued liability assessments shall be determined in accordance with the type of guaranty fund assessment as detailed in the following subparagraphs. Assets recognized from accrued liability assessments meet the definition of an asset under SSAP No. 4, and are admitted assets to the extent they conform to the requirements of this statement.
 - i. For retrospective-premium-based and loss-based assessments, to the extent that it is probable that accrued liability assessments will result in a recoverable amount in a future period from business currently in-force considering appropriate persistency rates for long-duration contracts, an asset shall be recognized at the time the liability is recorded. (In-force policies do not include expected renewals of short-term contracts.
 - ii. For prospective-premium-based assessments, the recognition of assets from accrued liability assessments is limited to the amount of premium an entity has written or is obligated to write and to the amounts recoverable over the life of the in-force policies. This SSAP requires reporting entities to recognize prospective-based-premium assessments as the premium is written or obligated to be written by the reporting entity. Accordingly, the expected premium tax offset or policy surcharge asset related to the accrual of prospective-premium-based assessments shall be based on and limited to the amount recoverable as a result of premiums the insurer has written or is obligated to write.

- c. An asset shall not be established for paid or accrued assessments that are recoverable through future premium rate structures.

~~11-12.~~ An evaluation of assets recognized under paragraph ~~10-11~~ shall be made in accordance with *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets* (SSAP No. 5R) to determine if there is any impairment. If, in accordance with SSAP No. 5R, it is probable that the asset is no longer realizable, the asset shall be written off to the extent it is not realizable and charged to income in the period the determination is made. Considering expected future premiums other than on in-force policies in evaluating recoverability of premium tax offsets or policy surcharges is not permitted.

Acting as an Agent for Collection and Remittance of Fees and Assessments

~~12-13.~~ In certain circumstances, a reporting entity acts as an agent for certain state or federal agencies in the collection and remittance of fees or assessments. In these circumstances, the liability for the fees and assessments rests with the policyholder rather than with the reporting entity. The reporting entity's obligation is to collect and subsequently remit the fee or assessment. When both the following conditions are met, an assessment shall not be reported in the statement of operations of a reporting entity:

- a. The assessment is reflected as a separately identifiable item on the billing to the policyholder; and
- b. Remittance of the assessment by the reporting entity to the state or federal agency is contingent upon collection from the insured.

~~13-14.~~ The impact to the statement of operations depends on the nature of the charge:

- a. For charges which are the ultimate responsibility of the policyholder, follow existing guidance in paragraph ~~12-13~~, and pass these charges and recoveries through the balance sheet with no impact to the statement of operations.
- b. For charges which are the ultimate responsibility of the reporting entity and may be recovered all or in part, apply gross or net reporting in the statement of operations as appropriate based on the nature of the charge and recovery. For example, charges which are considered in rate development or for which the recovery is classified as premium should be reported gross, charges for which recovery is considered a reduction of the expense should be reported net.
- c. For collection or administrative fees, report such fees as revenue in the statement of operations as "Finance and Service Charges Not Included in Premiums" or "Aggregate Write-Ins for Miscellaneous Income".

Applying the Recognition Criteria

~~14-15.~~ Application of the recognition criteria in paragraph 4:

- a. *Retrospective-premium-based guaranty-fund assessments* - An assessment is probable of being imposed when a formal determination of insolvency occurs¹. At that time, the premium that obligates the entity for the assessment liability has already been written. Accordingly, an entity that has the ability to reasonably estimate the amount of the

¹ As detailed within paragraph ~~6-7~~ for premium-based guaranty-fund assessments, an insolvency shall be considered to have occurred when a reporting entity meets a state's (ordinarily the state of domicile of the insolvent reporting entity) statutory definition of an insolvent reporting entity. In most states, the reporting entity must be declared to be financially insolvent by a court of competent jurisdiction. In some states, there must also be a final order of liquidation.

assessment shall recognize a liability for the entire amount of future assessments related to a particular insolvency when a formal determination of insolvency is rendered.

- b. *Prospective-premium-based guaranty-fund assessments* - The event that obligates the entity for the assessment liability generally is the writing of, or becoming obligated to write or renew, the premiums on which the expected future assessments are to be based (for example, multiple-year contracts under which an insurance entity has no discretion to avoid writing future premiums). Therefore, the event that obligates the entity generally will not have occurred at the time of the insolvency. Law or regulatory practice affects the event that obligates the entity in either of the following ways:
 - i. In states that, through law or regulatory practice, provide that an entity cannot avoid paying a particular assessment in the future (even if the entity reduces premium writings in the future), the event that obligates the entity is a formal determination of insolvency or a similar event. An entity that has the ability to reasonably estimate the amount of the assessment shall recognize a liability for the entire amount of future assessments that cannot be avoided related to a particular insolvency when a formal determination of insolvency occurs.
 - ii. In states without such a law or regulatory practice, the event that obligates the entity is the writing of, or becoming obligated to write, the premiums on which the expected future assessments are to be based. An entity that has the ability to reasonably estimate the amount of the assessments shall recognize a liability when the related premiums are written or when the entity becomes obligated to write the premiums.
- c. *Prefunded-premium-based guaranty-fund assessments* - A liability for an assessment arises when premiums are written. Accordingly, an entity that has the ability to reasonably estimate the amount of the assessment shall recognize a liability as the related premiums are written.
- d. *Other premium-based assessments* - Other premium-based assessments shall be accounted for in the same manner as prefunded premium-based guaranty-fund assessments.
- e. *Loss-based assessments* - An assessment is probable of being asserted when the loss occurs. The obligating event of the assessment also has occurred when the loss occurs. Accordingly, an entity that has the ability to reasonably estimate the amount of the assessment shall recognize a liability as the related loss is incurred.
- f. *Administrative-type assessments* - As this assessment is typically an annual amount per entity assessed to fund operations of the guaranty association, regardless of the existence of an insolvency, such assessments are generally expensed in the period assessed.

Affordable Care Act Section 9010 Assessment

16. The Affordable Care Act (ACA) imposes an assessment on entities that issue health insurance for each calendar year beginning on or after January 1, 2014. Pursuant to Section 9010 of the ACA, a reporting entity's portion of the assessment is paid no later than September 30 of the applicable calendar year (the fee year) beginning in 2014 and is not tax deductible. The amount of the assessment for the reporting entity is based on the ratio of the amount of an entity's subject net health premiums written for any U.S. health risk during the preceding calendar year (data year) to the aggregate amount of subject net health premiums written by all subject U.S. health insurance providers during the preceding calendar year. The ACA includes some significant exclusions regarding which entities are required to pay the assessment. This guidance applies to all entities that are subject to the fee. The guidance in this Section

(paragraphs 16-21) applies to the unique facts and circumstances in the ACA; accordingly, an entity should apply judgment when evaluating the facts and circumstances of other assessments arrangements before analogizing to the guidance for Section 9010 of the ACA.

17. Throughout this discussion of the Section 9010 assessment of the ACA, the following terms apply:

- a. The term "data year" means the calendar year immediately before the fee year. Thus, For example, 2014 is the data year for fee year 2015.
- b. The term "fee year" means the calendar year in which the assessment must be paid to the U.S. Treasury.

18. A reporting entity's portion of the annual assessment becomes payable to the U.S. Treasury once the reporting entity provides health insurance (in the fee year) for any subject U.S. health risk for each calendar year beginning on or after January 1, 2014.

19. The liability related to the Section 9010 ACA assessment shall be estimated and recorded in full once the entity provides qualifying health insurance (typically January 1) in the applicable calendar year in which the assessment is paid (fee year) with a corresponding entry to expense. The Section 9010 ACA assessment shall be recognized in full on January 1 of the fee year, in the operating expense category of Taxes, Licenses and Fees.

20. Liability recognition of the Section 9010 fee is not required in the data year. In the data year, the reporting entity is required to reclassify from unassigned surplus to special surplus an amount equal to its estimated subsequent fee year assessment. This segregation in special surplus is accrued monthly throughout the data year. The reclassification from unassigned surplus to special surplus does not reduce total surplus. On January 1 of the fee year, the prior year segregation in special surplus is reversed and the full current fee year assessment liability shall be accrued.

21. The Section 9010 ACA annual assessment does not represent a cost related to the acquisition of policies that is consistent with the definition of acquisition costs in SSAP No. 71—Policy Acquisition Costs and Commissions.

Disclosures

15-22. For guaranty fund and other non-Section 9010 ACA assessments, a reporting entity shall disclose the following:

- a. Describe the nature of any assessments that could have a material financial effect, by type of assessment, and state the estimate of the liability, identifying whether the corresponding liability has been recognized under paragraph 4, a liability has not been recognized as the obligating event has not yet occurred, or that an estimate cannot be made.
- b. For assessments with liabilities recognized under paragraph 4, disclose the amount of the recognized liabilities, any related asset for premium tax credits or policy surcharges, the periods over which the assessments are expected to be paid, and the period over which the recorded premium tax offsets or policy surcharges are expected to be realized.
- c. Disclose assets recognized from paid and accrued premium tax offsets or policy surcharges, and include a reconciliation of assets recognized within the previous year's Annual Statement to the assets recognized in the current year's Annual Statement. The reconciliation shall reflect, in aggregate, each component of the increase and decrease in paid and accrued premium tax offsets and policy surcharges, including the amount charged off.

- d. Disclosures shall be made in accordance with paragraph 25 of SSAP No. 5R when there is at least a reasonable possibility that the impairment of an asset from premium tax offsets or policy surcharges may have been incurred.

~~16-23.~~ For the Section 9010 ACA assessment:

- a. For the annual reporting period ending December 31, 2013 and thereafter, a reporting entity subject to the assessment under Section 9010 of the Affordable Care Act, shall provide a disclosure of the assessment payable in the upcoming year consistent with the guidance provided under *SSAP No. 9—Subsequent Events* for a Type II subsequent event. The disclosure shall provide information regarding the nature of the assessment and an estimate of its financial impact, including the impact on its risk based capital position as if it had occurred on the balance sheet date. In accordance with SSAP No. 9, paragraph 9, the reporting entity shall also consider whether there is a need to present pro forma financial statements regarding the impact of the assessment, based on its judgment of the materiality of the assessment.
- b. Additionally, for annual reporting periods ending on or after December 31, 2014, the disclosure in paragraph 23.a is expanded to include information on the amounts reflected in special surplus in the data year. The disclosure shall provide information regarding the nature of the assessment and the Total Adjusted Capital and Authorized Control Level (in dollars) before and after adjustment (as reported in its estimate of special surplus applicable to the 9010 fee) to reflect the fee as of the annual reporting date as if it had been reported on the balance sheet date. The disclosure shall also provide a statement as to whether an RBC action level would have been triggered had the fee been reported as of the balance sheet date.

~~17-24.~~ Refer to the preamble for further discussion regarding disclosure requirements.

Relevant Literature

~~18-25.~~ This statement adopts GAAP guidance for recording guaranty fund and other assessments, which is contained in *Accounting Standards Codification 405-30, Insurance Related Assessments* (ASC 405-30) to the extent reflected in this SSAP. Statutory accounting modifications from ASC 405-30 are as follows:

- a. The option to discount accrued liabilities (and reflect the time value of money in anticipated recoverables) is rejected for statutory accounting. Liabilities for guaranty funds or other assessments shall not be discounted.
- b. The use of a valuation allowance for premium tax offsets and policy surcharges no longer probable for realization has been rejected for statutory accounting. Evaluation of assets shall be made in accordance with SSAP No. 5R, and if it is probable that the asset is no longer realizable, the asset shall be written off and charged to income in the period the determination is made.
- c. Guidance within ASC 405-30 pertaining to noninsurance entities has been rejected as not applicable for statutory accounting.

~~26.~~ The guidance in paragraph ~~13-14~~ adopted *Emerging Issues Task Force No. 06-3: How Taxes Collected from Customers and Remitted to Governmental Authorities Should Be Presented in the Income Statement (That is, Gross versus Net Presentation)* and was effective September 2007.

~~19-27.~~ *ASU 2011-06: Other Expenses – Fees Paid to the Federal Government by Health Insurers* is adopted with modifications: 1) to require full expense recognition on January 1 of the fee year and 2) to

require the reclassification from unassigned surplus to special surplus in the data year for the estimated amount payable, and 3) other modifications for statutory accounting terminology as reflected in paragraphs 16-21.

Effective Date and Transition

~~20-28.~~ This statement is effective for years beginning January 1, 2001. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with *SSAP No. 3—Accounting Changes and Corrections of Errors*. Substantive revisions to paragraphs 4, ~~67~~, 78, 89, ~~1011~~, ~~1112~~, ~~1315~~ and ~~1422~~ are initially effective for the reporting period beginning January 1, 2011. The result of applying this revised Statement shall be considered a change in accounting principle in accordance with SSAP No. 3. Pursuant to SSAP No. 3, the cumulative effect of changes in accounting principles shall be reported as an adjustment to unassigned funds (surplus) in the period of the change in accounting principle. The cumulative effect recognized through surplus from initial application of this Statement shall reflect the removal of liabilities established under SSAP No. 35, and the re-establishment of liabilities required under SSAP No. 35R. If there is no change in the liabilities recognized (for example, retrospective-premium based assessments), no cumulative effect adjustment shall occur. With regards to assets, the entity shall complete an assessment of the SSAP No. 35 asset reported as of the transition date. If it is determined that the reported asset exceeds what is allowed under SSAP No. 35R, then the excess asset shall be written-off, through unassigned funds, so the ultimate asset reflected corresponds with what is permitted under SSAP No. 35R. Although it is possible that the excess asset will be reinstated once the liability assessment is recognized (prospective-premium based assessments), it is inappropriate to continue to reflect an asset for assessments that are not reflected within the financial statements. The guidance in paragraph ~~13-14~~ adopted *Emerging Issues Task Force No. 06-3: How Taxes Collected from Customers and Remitted to Governmental Authorities Should Be Presented in the Income Statement (That is, Gross versus Net Presentation)* and was effective September 2007. The Section 9010 ACA fee has specific guidance (adopted December 2013), detailed in paragraphs 16-21, that is initially effective for annual reporting periods beginning January 1, 2014.

RELEVANT ISSUE PAPERS

- *Issue Paper No. 35—Accounting for Guaranty Fund and Other Assessments*
- *Issue Paper No. 143—Prospective-Based Guaranty Fund Assessments*

EXHIBIT A – PRIMARY METHODS OF GUARANTY FUND ASSESSMENTS

- a. *Retrospective-premium-based assessments* - Guaranty funds covering benefit payments of insolvent life, annuity, and health insurance entities typically assess entities based on premiums written or received in one or more years before the year of insolvency. Assessments in any year are generally limited to an established percentage of an entity's average premiums for the three years preceding the insolvency. Assessments for a given insolvency may take place over several years.
- b. *Prospective-premium-based assessments* - Guaranty funds covering claims of insolvent property and casualty insurance entities typically assess entities based on premiums written in one or more years after the insolvency. Assessments in any year are generally limited to an established percentage of an entity's premiums written or received for the year preceding the assessment. Assessments for a given insolvency may take place over several years.
- c. *Prefunded-premium-based assessments* - This kind of assessment is intended to prefund the costs of future insolvencies. Assessments are imposed before any particular insolvency and are based on the current level of written premiums. Rates to be applied to future premiums are adjusted as necessary.
- d. *Administrative-type assessments* - These assessments are typically a flat (annual) amount per entity to fund operations of the guaranty association, regardless of the existence of an insolvency.
- e. *Other premium-based assessments* - Entities are subject to a variety of other insurance-related assessments. Many states and a number of local governmental units have established other funds supported by assessments. The most prevalent uses for such assessments are (a) to fund operating expenses of state insurance regulatory bodies (for example, the state insurance department or workers' compensation board) and (b) to fund second-injury funds.
 - i. *Premium-based* - The assessing organization imposes the assessment based on the entity's written premiums. The base year of premiums is generally either the current year or the year preceding the assessment.
 - ii. *Loss-based* - The assessing organization imposes the assessment based on the entity's incurred losses or paid losses in relation to that amount for all entities subject to that assessment in the particular jurisdiction.

Appendix B – Illustration of SSAP No. 106: ACA Assessments

Note – The changes reflected in this Appendix illustrate the substantive placement revisions to SSAP No. 35R adopted in December 2013 (reflected in Appendix A), which were subsequently moved in 2014 into *SSAP No. 106—Affordable Care Act Section 9010 Assessments*. Also at that time, additional disclosures related to the Section 9010 fee of the Affordable Care Act were incorporated. The changes to the disclosures are reflected as tracked revisions in this issue paper.

Statement of Statutory Accounting Principles No. 106**Affordable Care Act Assessments****SCOPE OF STATEMENT**

1. This statement establishes statutory accounting principles for the Affordable Care Act Section 9010 assessment and disclosures related to the risk sharing provisions of the Affordable Care Act.

SUMMARY CONCLUSION

2. This statement adopts *ASU 2011-06: Other Expenses – Fees Paid to the Federal Government by Health Insurers* (ASU 2011-06) with modifications identified in paragraph 11. ASU 2011-06 provides specific guidance related to the assessment in Section 9010 of the Affordable Care Act.

Affordable Care Act Section 9010 Assessment

3. The Affordable Care Act (ACA) imposes an assessment on entities that issue health insurance for each calendar year beginning on or after January 1, 2014. Pursuant to Section 9010 of the ACA, a reporting entity's portion of the assessment is paid no later than September 30 of the applicable calendar year (the fee year) beginning in 2014 and is not tax deductible. The amount of the assessment for the reporting entity is based on the ratio of the amount of an entity's subject net health premiums written for any U.S. health risk during the preceding calendar year (data year) to the aggregate amount of subject net health premiums written by all subject U.S. health insurance providers during the preceding calendar year. The ACA includes some significant exclusions regarding which entities are required to pay the assessment. The guidance in this statement applies to all reporting entities that are subject to the fee. The guidance in this statement applies to the unique facts and circumstances in the ACA; accordingly, an entity should apply judgment when evaluating the facts and circumstances of other assessments arrangements before analogizing the guidance for Section 9010 of the ACA.

4. Throughout this discussion of the Section 9010 assessment of the ACA, the following terms apply:

- a. The term "data year" means the calendar year immediately before the fee year. For example, 2014 is the data year for fee year 2015.
- b. The term "fee year" means the calendar year in which the assessment must be paid to the U.S. Treasury.

5. A reporting entity's portion of the annual assessment becomes payable to the U.S. Treasury once the reporting entity provides health insurance (in the fee year) for any subject U.S. health risk for each calendar year beginning on or after January 1, 2014.

6. The liability related to the Section 9010 ACA assessment shall be estimated and recorded in full once the entity provides qualifying health insurance (typically January 1) in the applicable calendar year in which the assessment is paid (fee year) with a corresponding entry to expense. The Section 9010 ACA

assessment shall be recognized in full on January 1 of the fee year, in the operating expense category of Taxes, Licenses and Fees.

7. Liability recognition of the Section 9010 fee is not required in the data year. In the data year, the reporting entity is required to reclassify from unassigned surplus to special surplus an amount equal to its estimated subsequent fee year assessment. This segregation in special surplus is accrued monthly throughout the data year. The reclassification from unassigned surplus to special surplus does not reduce total surplus. On January 1 of the fee year, the prior year segregation in special surplus is reversed and the full current fee year assessment liability shall be accrued.

8. The Section 9010 ACA annual assessment does not represent a cost related to the acquisition of policies that is consistent with the definition of acquisition costs in *SSAP No. 71—Policy Acquisition Costs and Commissions*.

Disclosures

9. For the Section 9010 ACA assessment:

a. For the annual reporting period ending December 31, 2013, and thereafter, a reporting entity subject to the assessment under section 9010 of the Affordable Care Act, shall provide a disclosure of the assessment payable in the upcoming year consistent with the guidance provided under *SSAP No. 9—Subsequent Events* for a Type II subsequent event. The disclosure shall provide information regarding the nature of the assessment and an estimate of its financial impact, including the impact on its risk-based capital position as if it had occurred on the balance sheet date. In accordance with *SSAP No. 9*, paragraph 9, the reporting entity shall also consider whether there is a need to present pro forma financial statements regarding the impact of the assessment, based on its judgment of the materiality of the assessment.

b. Additionally, for annual reporting periods ending on or after December 31, 2014, the disclosure in paragraph 9.a. is expanded to include information on the amounts reflected in special surplus in the data year.

i. The reporting entity shall disclose the amount of premium written for the current year that is the basis for the determination of the section 9010 fee assessment to be paid in the subsequent year (net assessable premium). Prior year amounts shall also be included for comparative purposes;

i-ii. Reporting entities shall provide information regarding the nature of the assessment, the estimated amount of the assessment payable in the upcoming year (current and prior year) and the amount of assessment paid (current and prior year), and ;

ii-iii. The disclosure shall also provide the Total Adjusted Capital and Authorized Control Level (in dollars) before and after adjustment (as reported in its estimate of special surplus applicable to the 9010 fee) to reflect the fee as of the annual reporting date as if it had been reported on the balance sheet date. The disclosure shall also provide a statement as to whether an RBC action level would have been triggered had the fee been reported as of the balance sheet date.

10. Refer to the preamble for further discussion regarding disclosure requirements.

Relevant Literature

11. ASU 2011-06: *Other Expenses – Fees Paid to the Federal Government by Health Insurers* is adopted with the following modifications: 1) to require full expense recognition on January 1 of the fee year, 2) to require the reclassification from unassigned surplus to special surplus in the data year for the estimated amount payable, and 3) other modifications for statutory accounting terminology as reflected in this statement.

Effective Date and Transition

12. This statement is effective for years beginning January 1, 2014. A change resulting from the adoption of this statement shall be accounted for as a change in accounting principle in accordance with SSAP No. 3—*Accounting Changes and Corrections of Errors*. The Section 9010 ACA fee specific guidance in paragraphs 2-8 and paragraph 9.b. was adopted December 2013 with a January 1, 2014, effective date. This guidance was originally reflected in SSAP No. 35—*Guaranty Fund and Other Assessments – Revised* (SSAP No. 35R). The disclosure language in paragraph 9a was also moved from SSAP No. 35R, but was originally effective December 31, 2013. The guidance from SSAP No. 35R was moved into this statement in month/year. This movement was a placement change and did not result revisions to the accounting guidance previously included in SSAP No. 35R.

REFERENCES**Relevant Issue Papers**

- *Issue Paper No. 148—Affordable Care Act Section 9010 Assessment*