

# Statutory Issue Paper No. 150

## Accounting for the Risk-Sharing Provisions of the Affordable Care Act

### STATUS

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**Original SSAP and Current Authoritative Guidance: SSAP No. 107**

### Type of Issue:

**Common Area**

### SUMMARY OF ISSUE

1. The Affordable Care Act (ACA) imposes fees and premium stabilization provisions on health insurance issuers offering commercial health insurance. This issue paper recommends accounting for three programs known as risk adjustment, reinsurance and risk corridors that take effect in 2014. Risk adjustment is a permanent risk-spreading program (ACA Section 1343). The temporary transitional reinsurance program (ACA Section 1341) and temporary risk corridors program (ACA Section 1342) are for years 2014 through 2016.

2. Specific terms included in Appendix A are unique to these programs and should not be applied to other aspects of statutory accounting. The required payments to the programs by reporting entities are described as “contributions” in the program literature but are referred to in this guidance as assessments for clarity. Amounts redistributed by the programs back to reporting entities are termed “payments” by the programs. These “payments” are recoverables/receivables for the reporting entity and are termed program distributions or receivables (to the reporting entity) in this guidance. The reporting of payable or receivable amounts in this guidance is from the perspective of the reporting entity. The statement based on this issue paper will nullify *INT 13-04: Accounting for the Risk-Sharing Provisions of the Affordable Care Act*.

### SUMMARY CONCLUSION

3. This issue paper establishes statutory accounting principles for the risk-sharing provisions of the ACA. The manner in which these provisions are applied in the determination of the medical loss ratios (MLR) and rebates may be different from these as the MLR calculations are based on the ACA Section 2718(b).

### Risk Adjustment Program – Description and Overview

4. The risk adjustment program based on Section 1343 of the ACA is effective beginning in the 2014 benefit year and continues as a permanent program.

5. The risk adjustment program includes health plans (except certain exempt and grandfathered plans) in the individual or small group markets both on and off the exchange. All covered risk adjustment plans are required to participate in the risk adjustment program.

6. The purpose of the risk adjustment program is to transfer funds from lower risk plans to higher risk plans within similar plans in the same state in order to adjust premiums for adverse selection among carriers caused by membership shifts due to guarantee issue and community rating mandates. States may set up their own risk adjustment programs, or they may permit Health and Human Services (HHS) to develop and manage the program in the state. In addition to the risk adjustment amount, HHS determines the user fee. In states operating their own risk adjustment program, the state will determine the fee.

7. Risk adjustment assessments and distributions will be computed based on the reporting entity's risk score versus the overall market risk score after applying adjustments. Risk adjustment assessments will be made if the plan average actuarial risk of all of their enrollees in a market and state is lower than the plan average risk of all enrollees in fully insured plans in that market and state risk pool. Risk adjustment distributions will be made to health plan issuers whose plans have an average actuarial risk that is greater than the plan average actuarial risk scores in that market and state risk pool. The reinsurance program is not considered in the computation.

8. HHS will collect a user fee to support the administration of the HHS-operated risk adjustment program. This fee applies to issuers of risk adjustment covered plans in states in which HHS is operating the risk adjustment program. For example, HHS projects that the per capita risk adjustment user fee for 2014 is approximately \$1 per enrollee per year. Similar terms will apply for the user fees of state operated programs.

9. All risk adjustment distributions made to issuers are completely funded through the amounts assessed to other issuers within the same market in the same state to ensure equality between program distributions and assessments. Consequently, risk adjustment assessments will be invoiced prior to processing program distributions to issuers. Once applicable risk adjustment assessments by issuers are received by HHS or the state, funds will be redistributed to the higher risk plans. Each issuer that offers a risk adjustment covered plan will be notified of risk adjustment distributions or assessments by June 30 of the year following the benefit year to align with the program distributions and assessment processing. Risk adjustment assessments owed by an issuer to HHS or the state are required to be remitted within 30 days of notification of the assessment. Once applicable assessments are received by HHS or the state, funds will be redistributed to the higher risk plans.

### **Risk Adjustment Program – Accounting Treatment**

10. The accounting elements of the ACA permanent risk adjustment program, which are considered separately, include the user fee and the risk adjustment assessments and distributions.

11. The user fee is paid to HHS in states where the risk adjustment program is being operated by HHS and to the state program if operated by the state. Risk adjustment user fees shall be treated as government assessments. These fees are treated the same as other non-income-based governmental taxes and fees in that they are recognized as an expense and liability when the premium subject to the assessment is written.

12. Premium adjustments pursuant to the risk adjustment program will be based upon the risk scores (health status) of enrollees, participating in risk adjustment covered plans rather than the actual loss experience of the insured. This program bears some similarities to the Medicare Advantage risk adjustment program<sup>1</sup> under which the plan receives additional funding (or pays additional amounts) based on adjustments to risk scores of enrollees (see *INT 05-05: Accounting for Revenues Under Medicare Part D Coverage*).

13. The risk adjustment payables and receivables shall be accounted for as premium adjustments subject to redetermination as specified in this issue paper.

- a. Risk adjustment payables meet the definition of liabilities as set forth in *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets* (SSAP No. 5R). Risk adjustment receivables meet the definition of an asset and are admissible to the extent that they meet all of the criteria in this issue paper.

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<sup>1</sup> The ACA program also has significant differences from the Medicare Advantage risk adjustment program, which is retrospective, administered as a single national program, with most enrollees administered by the federal government. By contrast, the ACA risk adjustment is not retrospective, and is administered by each entity by state and by plan.

- b. Risk adjustment payables and receivables shall be estimated based on experience to date. The method used to estimate the payables and receivables shall be reasonable and consistent between reporting periods. Reporting entities shall be aware of the significant uncertainties involved in preparing estimates and be both diligent and conservative in their estimations. In exercising the judgment required to prepare reasonable estimates for the financial reporting of risk adjustment program payables and receivables, the statutory accounting concept of conservatism shall be followed. In addition, reporting entities are required to have sufficient data to determine a reasonable estimate. Ensuring sufficient data requires that the reporting entity's estimate is based on demonstrated knowledge of the marketplace and annual information which includes patient encounter and diagnosis code data to determine the differences in the actuarial risk profile of the reporting entity's insureds versus the market participants in the particular market and state risk pool. Sufficient data shall incorporate patient default scores, if applicable, under the terms of the risk adjustment program. In addition, the estimates shall be consistent with other financial statement assertions and the pricing scenarios used by the reporting entity.
- c. Premium revenue adjustments for the risk adjustment program are estimated for the portion of the policy period that has expired and shall be reported as an immediate adjustment to premium. Accrued risk adjustment receivables shall be recorded as a write-in for other-than-invested assets, with a corresponding entry to premiums; accrued risk adjustment payables shall be recorded as a liability with a corresponding entry to premiums. Reporting entities shall record additions or reductions to revenue resulting from the risk adjustment program in the period in which the changes in risk scores of enrollees result in reasonably estimable additions or reductions. The risk adjustment program receivables shall be reported gross of payables.
- d. The risk adjustment receivables are administered through a federal governmental program. Once amounts are collected by the governmental entity, there is an obligation to distribute the funds. Amounts over 90 days due shall not cause the receivable to be treated as a nonadmitted asset based solely on aging.
- e. Provided that the risk adjustment receivables due the reporting entity are determined in a manner that is consistent with the requirements of this issue paper, the receivables are admitted assets until determination of impairment or payment denial is received from the governmental entity or government-sponsored entity administering the program. Upon notification that payments to be paid to the reporting entity will be less than the recorded receivables, any amount in excess of the confirmed amount shall be written off and charged to income, except for amounts that are under appeal. Any receivable for risk adjustment amounts under appeal shall be reflected as a nonadmitted asset.
- f. Evaluation of the collectibility of all amounts receivable from the risk adjustment program shall be made for each reporting period. If, in accordance with SSAP No. 5R, it is probable that the risk adjustment receivables are uncollectible, any uncollectible receivable shall be written off and charged to income in the period the determination is made. If it is reasonably possible that a portion of the balance determined in accordance with this paragraph is not anticipated to be collected and is therefore not written off, the disclosure requirements outlined in SSAP No. 5R shall be followed.

### **Transitional Reinsurance Program – Description and Overview**

14. The transitional reinsurance program based on Section 1341 of the ACA is effective for plan years 2014 through 2016. Reinsurance assessments will be collected and distributions will be issued during the three-year term.

15. All issuers of major medical commercial products and third party administrators (TPAs) on behalf of uninsured group health plans are required to contribute funding at the national contribution rate to HHS. States establishing reinsurance programs may collect additional funding. Non-grandfathered individual plans are eligible to receive benefit program distributions via an excess-of-loss reinsurance system. Grandfathered plans are ineligible. Group plans are required to contribute funding, but are not eligible to receive reinsurance program distributions.

16. In general, this transitional reinsurance program provides funding to issuers in the individual market that incur high claims costs for enrollees. The program requires assessments from all issuers and TPAs on behalf of group health plans based on a per member annual fee established by HHS. The reinsurance assessment will fund reinsurance program distributions plus disbursements to the U.S. Treasury, in addition to covering administrative expenses of the program.

17. Consequently, the term “reinsurance” does not represent actual reinsurance between licensed insurers as defined by *SSAP No. 61—Revised—Life, Deposit-Type and Accident and Health Reinsurance* (SSAP No. 61R). This program is similar to an involuntary pool in *SSAP No. 63—Underwriting Pools and Associations Including Intercompany Pools* (SSAP No. 63) for the individual insured health products subject to the 2014 ACA market reforms. For the group plans, which are required to contribute funding but are not eligible to receive program distributions, the program is an assessment payable by the reporting entity and not a pool.

18. The national transitional reinsurance program assessment rate for all issuers and TPAs will be established by HHS and will be designed to collect more than \$12 billion in 2014 to cover the required \$10 billion for the reinsurance program, the \$2 billion contribution to the U.S. Treasury, and additional amounts to cover the administrative costs of the federal government entity and applicable reinsurance entities. States electing to operate their own reinsurance program have the option to increase the reinsurance assessment rate to provide additional funding for the reinsurance program or to fund the administrative expenses of the applicable reinsurance entity. Assessments for the reinsurance program must fund the reinsurance program of \$10 billion in 2014, \$6 billion in 2015 and \$4 billion in 2016, plus disbursements to the U.S. Treasury of \$2 billion, \$2 billion and \$1 billion for years 2014 through 2016, in addition to covering administrative expenses of the applicable reinsurance entity or HHS.

19. Reinsurance program distributions will be processed either by the applicable reinsurance entity or by HHS and will be made to issuers of non-grandfathered individual market plans for high claim costs of enrollees. Distributions from the applicable reinsurance entity to insurers providing individual coverage will be calculated as a coinsurance rate multiplied by the eligible claims submitted for an individual enrollee’s covered benefits between an attachment point and the reinsurance cap for each benefit year. The coinsurance rate, attachment point and reinsurance cap are initially determined by HHS, but may be modified by the state, if the state chooses to establish its own reinsurance program.

20. Each state is eligible to establish a reinsurance program, regardless of whether the state establishes a Marketplace Exchange. If a state establishes a reinsurance program, the state must enter into a contract with an applicable reinsurance entity or entities or establish a reinsurance entity to carry out the program. If a state does not elect to establish its own reinsurance program, HHS will administer the reinsurance program on behalf of that state. HHS establishes the annual administrative portion for the fee. (For example, the 2014 fee will be \$0.11 per-member per-year resulting in \$20.3 million of administrative expense funding).

21. Reinsurance assessments to fund the program are made on an annual basis with billing beginning December 15, 2014. An insurer may submit claims for reimbursement when an enrollee of the reinsurance-eligible plan has met the applicable criteria as determined by either the state or HHS. Claims may be submitted through April 30 of the year following the benefit year. HHS will distribute reinsurance program funds among issuers nationally based on submitted claims. Issuers will be notified of pending reinsurance distributions by June 30 following the benefit year. If the requests for distributions exceed the

actual assessments collected, HHS will reduce reinsurance distributions on a pro-rata basis. If the requests for distributions are less than actual assessments collected, HHS will increase reinsurance distributions on a pro-rata basis.

### **Transitional Reinsurance Program – Accounting Treatment**

22. Due to the diverse elements of the transitional reinsurance program, which includes characteristics of traditional reinsurance, involuntary pools and governmental assessments, a hybrid accounting approach is required. The accounting treatment for the transitional reinsurance program outlined below is discussed in terms of the payables and receivables and the impact to the health insurance products subject to the program.

23. The following are the broad groupings of the health insurance products subject to the transitional reinsurance program:

- a. Individual insured health products subject to the 2014 ACA market reforms. This excludes grandfathered and non-grandfathered 2013 products (referred to as subject individual insured products);
- b. Other insured health products. This encompasses products which are not subject to the ACA market reforms including individual grandfathered and non-grandfathered (referred to as other insured health products);
- c. Self-insured health products.

24. The guidance in this section will provide treatment for each of the assessments payable and program distribution receivable elements of the program listed below for the health insurance products listed in paragraph 23.

- a. Assessments for reinsurance
- b. Administrative costs assessments
- c. Additional U.S. Treasury assessment
- d. Reinsurance distributions

#### **Subject Individual Insured Health Products**

##### **Subject Individual Insured Issuers - Assessments Payable for Reinsurance**

25. Transitional reinsurance assessments attributable to enrollees in individual plans are treated as ceded reinsurance premium. This applies both to assessments made at the national assessment rate and to any state-elected additional assessments that will fund reinsurance program distributions. Ceded premiums would be reported as a reinsurance cession and follow reinsurance accounting in accordance with SSAP No. 61R, paragraph 17 and paragraphs 25-26:

#### **Transfer of Risk**

17. Reinsurance agreements must transfer risk from the ceding entity to the reinsurer in order to receive the reinsurance accounting treatment discussed in this statement. If the terms of the agreement violate the risk transfer criteria contained herein, (i.e., limits or diminishes the transfer of risk by the ceding entity to the reinsurer), the agreement shall follow the guidance for Deposit Accounting. In addition, any contractual feature that delays timely reimbursement violates the conditions of reinsurance accounting.

## Reinsurance Premiums

25. For all reinsurance arrangements, the assuming entity must report premiums under the terms of the reinsurance contract as income and establish any asset or liability consistent with the methods and assumptions used to establish its policy reserves and guidance contained in SSAP No. 51—*Life Contracts*, SSAP No. 54—*Individual and Group Accident and Health Contracts*, and SSAP No. 59—*Credit Life and Accident and Health Insurance Contracts*. The ceding entity shall reduce premium income by the amounts paid or payable to the reinsurers. The ceding entity shall reduce its deferred and uncollected premiums reported as an asset by the corresponding proportionate amount of any deferred and uncollected premium attributable to those insurance policies reinsured. When the ceding entity has collected the premium but has not remitted the proportionate share to the reinsurer, the ceding entity shall establish a liability for the amount due the reinsurer. The assuming entity shall record an asset for premiums receivable from the ceding entity.

26. If the assuming entity receives reinsurance premium prior to the due date, consistent with SSAP No. 51, paragraph 7, and SSAP No. 54, paragraph 6, advance premiums are reported as a liability for the reinsurer in the statutory financial statement and not considered income until due. Such amounts are not included in premium or the unearned premium reserve (if applicable) until the due date. If the ceding entity pays reinsurance premium prior to the due date, the amount of the prepaid item shall be reflected as a write-in admitted asset and it should not be recognized in the income statement until due. Such amounts are not included in ceded premiums or ceded unearned premium but should be subject to impairment analysis.

26. For the individual coverage issuers, this is an involuntary pool and under the terms of the transitional reinsurance program, the transfer of risk and timely reimbursement requirements of SSAP No. 61R are deemed to be met.

27. With regard to individual coverage issuers, the transitional reinsurance program is more similar to traditional reinsurance than it is to an assessment, because program assessments are made to and program distributions are received from the government or government-sponsored entity. Accordingly, the program is accounted for as reinsurance for individual insured products subject to the transitional reinsurance program.

28. The provisions of SSAP No. 63, paragraph 3, define involuntary pools as follows:

3. Involuntary pools represent a mechanism employed by states to provide insurance coverage to those with higher than average probability of loss who otherwise would be excluded from obtaining coverage. Reporting entities are generally required to participate in the underwriting results, including premiums, losses, expenses, and other operations of involuntary pools, based on their proportionate share of similar business written in the state. Involuntary plans are also referred to as residual market plans, involuntary risk pools, and mandatory pools.

29. The transitional reinsurance program differs from an involuntary pool as just described, in that there is not a proportionate sharing of the entire results of a pool. However, the purpose is very similar: to address the additional costs associated with high-risk individuals. Furthermore, HHS has noted, "*the Affordable Care Act ... requires that states eliminate or modify high-risk pools to the extent necessary to carry out the reinsurance program,*" which likewise highlights the similar purposes of the two mechanisms. Therefore, SSAP No. 63, paragraph 8, provides additional relevant guidance:

8. Underwriting results relating to voluntary and involuntary pools shall be accounted for on a gross basis whereby the participant's portion of premiums, losses, expenses, and other operations of the pools are recorded separately in the financial statements rather than netted against each other. Premiums and losses shall be recorded as direct, assumed, and/or ceded as applicable. If the reporting entity is a direct writer of the business, premiums shall be recorded as directly written and accounted for in the same manner as other business which is directly written

by the entity. To the extent that premium is ceded to a pool, premiums and losses shall be recorded in the same manner as any other reinsurance arrangement. A reporting entity who is a member of a pool shall record its participation in the pool as assumed business as in any other reinsurance arrangement.

As the transitional reinsurance program is a mechanism for sharing the additional costs associated with high-risk individuals, it is accounted for as traditional reinsurance.

#### Subject Individual Insured Issuers - Reinsurance Administrative Expense Assessments

30. The assessment payable by the reporting entity for administrative expenses attributable to individual coverage is reflected as ceded premium. This applies both to assessments made at the national assessment rate and to any state-required assessments that will provide additional funding for administrative expenses.

31. Normally reinsurance premiums are set at a level intended to cover anticipated claim costs and include an administrative charge component. Therefore, as a matter of consistency, it is appropriate to include the administrative charge component for the transitional reinsurance program in ceded premium for individual insured products.

#### Subject Individual Insured Issuers - U.S. Treasury Assessment

32. Because this portion of the assessment is earmarked for the U.S. Treasury and not for the reimbursement of claims or to cover the operating costs of the reinsurance program, it is a federal assessment not based on income. This portion of the assessment is not treated as ceded premium, but as an assessment under SSAP No. 35R and is reflected in the same expense category as taxes, licenses and fees. This is also consistent with annual statement expense reporting categories.

#### Subject Individual Insured Issuers - Reinsurance Program Distributions

33. Program distributions received from the ACA transitional reinsurance program for individual insurance is reflected as ceded claim benefit recoveries. This applies both to distributions received pursuant to the uniform federal reinsurance parameters and to any state distribution received.

34. In keeping with the rationale for reinsurance assessments above, distributions receivable from the transitional reinsurance program for individual insurance products is reflected the same as traditional reinsurance recoveries. SSAP No. 61R, paragraph 27, states:

27. Policy benefit payments paid or payable by the reinsurer shall be reported in the summary of operations and reduces the ceding entity's reported benefit payments. The reinsurer shall establish a liability for its share of any unpaid claim payments and the ceding entity shall reduce any policy and contract claim liability with respect to the reinsured policies or establish a receivable for the amount due from the reinsurer for claims paid.

35. Therefore, recoveries received are reported in the summary of operations and will reduce the ceding entity's reported benefits paid.

36. HHS and all applicable reinsurance entities shall be reported consistent with providers to an involuntary pool and will be treated as authorized reinsurers for the purposes of financial reporting for subject individual health products.

37. All receivables from the transitional reinsurance program are subject to the 90-day nonadmission rule beginning from when program receivables are due to be disbursed by the government or a government-sponsored entity. That is, the 90-day rule begins when governmental receivables are due, not from the date of initial accrual. The announced governmental or government-sponsored entity distribution date shall be the contractual due date similar to Appendix A-791, paragraph 2h, which requires that

payments due from the reinsurer are made in cash within ninety (90) days of the settlement date. The receivable is also subject to impairment analysis.

#### Other Insured Health Products

##### Other Insured Health Products – Assessments Payable for Reinsurance

38. Transitional reinsurance program reinsurance assessments made for enrollees in fully insured plans other than individual plans are treated as an assessment payable by the reporting entity and charged to taxes, licenses and fees. This applies both to assessments made at the national assessment rate and to any state assessments that will fund reinsurance program distributions. In this case, for fully insured non-individual plans, the entity cannot, under the terms of the program, be deemed to be “participating,” as funds for claim recoveries will not be re-distributed back to the issuer for the coverage that is being assessed. Therefore, issuers of other insured health products that are not for individuals are paying an involuntary fee but are not participating in an involuntary pool.

39. The treatment of the transitional reinsurance program reinsurance assessments for non-individual fully insured plans differs from the treatment for individual plans. Since the non-individual plans are not eligible for reimbursement, they are not participating in a reinsurance arrangement, and thus, the assessments are not treated as ceded premium. As an involuntary assessment, the transitional reinsurance program reinsurance assessments, consistent with SSAP No. 35R are treated as an assessment payable by the reporting entity and charged to taxes, licenses and fees expense. The expense is accrued in proportion to the other insured health enrollees base that will be used to determine the assessments payable as the premium subject to the assessment is written.

##### Other Insured Health Products - Reinsurance Administrative Expense Assessments

40. The reinsurance program administrative costs for other insured health products are an assessment payable by the reporting entity. This applies both to assessments made at the national assessment rate and to any state assessment that will fund administrative expenses and is reflected in the same expense category as taxes, licenses and fees.

##### Other Insured Health Products - U.S. Treasury Assessment

41. The additional U.S. Treasury assessment for other insured health products is a federal assessment payable by the reporting entity which is not based on income and is reflected in the same expense category as taxes, licenses and fees.

##### Other Insured Health Products - Reinsurance Program Distributions (not applicable)

42. Reinsurance recoveries will not occur for insured health products other than individual. Other insured health products will pay the transitional reinsurance program assessments payable but not receive program distributions for claims.

#### Self-Insured Health Products

##### Self-Insured Health Products - Assessments Payable for Reinsurance

43. Assessments made on behalf of self-insured plans which are administered by the reporting entity are uninsured plans and are excluded from the reporting entity’s statement of operations, with respect to both monies received from the plans and assessments disbursed by the reporting entity. Any resulting liabilities or receivables shall be reported as liabilities and receivables held in connection with uninsured plans. This treatment is consistent with *SSAP No. 47—Uninsured Plans* (SSAP No. 47), paragraphs 5 and 8-11.

44. The self-insured plan, not the reporting entity, is legally liable for assessments for the transitional reinsurance program. The funds are a bona fide pass-through by the reporting entity, which is merely providing a service for the self-insured (uninsured) plan. Therefore, the reporting entity will not report revenues or expenses for the assessments for the transitional reinsurance program.

45. The reporting entity may have received funds from the self-insured plans in advance of making disbursements. In that event, a liability is established for funds held in connection with self-insured plans.

46. The reporting entity, depending on its arrangement with the (uninsured) plan, may make a disbursement before receiving full funding from the plan. In that event, an asset is established for amounts receivable in connection with uninsured plans. The asset would be subject to the rules for admissibility and impairment as prescribed in SSAP No. 47, paragraphs 9-10.

#### Self-Insured Health Products - Reinsurance Administrative Expense Assessments Payable and U.S. Treasury Assessment

47. A reporting entity providing a service for a self-insured plan that is uninsured shall apply the pass-through treatment for the transitional reinsurance program's administrative cost assessments and additional U.S. Treasury contribution amounts. The uninsured plan, not the reporting entity, is legally liable. Therefore, the reporting entity will not report revenues or expenses with respect to the transitional reinsurance program's administrative cost assessments and additional U.S. Treasury contribution amounts.

#### Self-Insured Health Products - Reinsurance Payments (not applicable)

48. Reinsurance recoveries will not occur for self-insured health products, as these products will pay fees but not receive claims reimbursements.

### **Risk Corridors – Description and Overview**

49. The risk corridors program based on Section 1342 of the ACA is effective for benefit years beginning in 2014 through 2016. The risk corridors program applies to Qualified Health Plans (QHPs) in the individual and small group markets whether sold on or outside of an exchange.

50. The purpose of the risk corridors program is to provide limitations on issuer losses and gains for QHPs through additional protection against initial pricing risk. The program creates a mechanism for sharing the risk for allowable costs between the federal government and the QHP issuers. The program is applied at the QHP level, not the issuer or market segment level. Although the risk-corridor program provides protection against extreme bounds of experience, there is a substantial corridor in which all variance in experience directly affects the financial return of the reporting entity.

51. To determine whether an issuer pays into (contributes), or receives distributions from, the risk corridors program, HHS will compare Allowable Costs<sup>2</sup> and the Target Amount<sup>3</sup> based on a formula that compares allowable costs. Below is an example (before transition requirements) for a QHP.

- a. When a QHP's Allowable Costs for any benefit year are more than 103% but not more than 108% of the Target Amount, HHS will pay the QHP issuer an amount equal to 50% of the Allowable Costs in excess of 103% of the target amount.

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<sup>2</sup> With respect to a QHP, Allowable Costs is an amount equal to the sum of incurred claims of the QHP issuer, adjusted to include qualifying expenditures by the QHP for activities that improve health care quality, expenditures for health information technology and meaningful use requirements and other required adjustments.

<sup>3</sup> With respect to a QHP, the Target Amount is an amount equal to the total premiums earned with respect to a QHP, including any premium tax credit under any governmental program, reduced by the allowable administrative costs of the plan.

- b. When a QHP's Allowable Costs for any benefit year are more than 108% of the Target Amount, HHS will pay the QHP issuer an amount equal to 2.5% of the Target Amount plus 80% of the Allowable Costs in excess of 108% of the target Amount.
- c. If a QHP's Allowable Costs for any benefit year are less than 97% but not less than 92% of the Target Amount, the QHP issuer must remit assessments payable to HHS in an amount equal to 50% of the difference between 97% of the Target Amount and the Allowable Costs.
- d. When a QHP's Allowable Costs for any benefit year are less than 92% of the Target Amount, the QHP issuer must remit assessments payable to HHS in an amount equal to the sum of 2.5% of the Target Amount plus 80% of the difference between 92% of the Target Amount and the Allowable Costs.

52. The risk corridors program creates a mechanism for sharing risk for allowable costs between the federal government and QHP issuers. The ACA establishes the risk corridors program as a federal program; consequently, HHS will operate the risk corridors program under federal rules without state variations. The risk corridors program is intended to protect against inaccurate rate setting in the early years of the exchanges by limiting the extent of issuer losses and gains. In the event that risk corridors programs collections are not sufficient to cover all the required distributions, the ACA requires the use of other sources of federal funding for the required distributions, subject to the availability of appropriations.

53. The final risk corridors settlement calculation will be communicated by HHS after the end of the benefit year and after premium and loss adjustments related to the reinsurance and risk adjustment programs have been determined.

### **Risk Corridors – Accounting Treatment**

54. This program is similar to the risk corridors program established for the Medicare Part D prescription drug coverage<sup>4</sup>. However, due to the asymmetrical nature of the risk-corridor calculation, an overstatement of expense in one cell, which is theoretically offset by the understatement of expense in another cell, does not necessarily result in zero financial impact.

55. Payables and receivables pursuant to the temporary risk corridors program shall be accounted for as specified in this issue paper.

56. Risk corridor assessments meet the definition of liabilities as set forth in SSAP No. 5R. Risk corridor receivables due to the reporting entity meet the definition of an asset and are admissible to the extent that they meet all of the criteria in this issue paper.

- a. Assumptions used in estimating retrospective premium adjustments shall be consistent with the assumptions made in recording other assets and liabilities necessary to reflect the underwriting results of the reporting entity such as claim and loss reserves (including IBNR) and contingent commissions. Contingent commissions and other related expenses shall be adjusted in the same period the additional or return retrospective premiums are recorded.
- b. The additions or reductions to premium revenue resulting from the risk corridors program are recognized over the contractual period of coverage, to the extent that such additions or reductions are reasonably estimable. Reporting entities shall be aware of the

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<sup>4</sup> The ACA risk corridors program also has significant differences between the Medicare risk corridors program. The ACA risk corridors program is performed at a significantly more granular plan specific level with a pro-rata allocation of the issuer's overall claim costs for the plan's state/ market cell.

significant uncertainties involved in preparing estimates and be both diligent and conservative in their estimations. Risk corridors payables and receivables shall be estimated based on experience to date. The method used to estimate the payables and receivables shall be reasonable and consistent between reporting periods. In exercising the judgment required to prepare reasonable estimates for the financial reporting of risk corridors program payables and receivables, the statutory accounting concept of conservatism shall be followed. In addition, reporting entities are required to have sufficient information to determine a reasonable estimate. Part of ensuring sufficient information requires that the reporting entity's estimate is based on demonstrated knowledge of the impacts of the other risk-sharing programs on the risk corridors program and the terms of the risk corridors program. In addition, the estimates shall be consistent with other financial statement assertions and the pricing scenarios used by the reporting entity.

- c. The risk corridors receivables are from a federal governmental program. Amounts over 90 days due shall not cause the receivable to be treated as a nonadmitted asset based solely on aging.
- d. Provided that the risk corridors receivables due the reporting entity are determined in a manner that is consistent with the requirements of this issue paper, the receivables are admitted assets until determination of impairment or payment denial is received from the governmental entity or government-sponsored entity administering the program. Upon notification that payments to be paid to the reporting entity will be less than the recorded receivables, any amount in excess of the confirmed amount shall be written off and charged to income, except for amounts that are under appeal. Any receivable for risk adjustment amounts under appeal shall be reflected as a nonadmitted asset.
- e. Evaluation of the collectibility of all amounts receivable from the risk corridors program shall be made for each reporting period. If, in accordance with SSAP No. 5R, it is probable that the risk corridors receivables are uncollectible, any uncollectible receivable shall be written off and charged to income in the period the determination is made. If it is reasonably possible, that a portion of the balance determined in accordance with this paragraph is not anticipated to be collected and is therefore not written off, the disclosure requirements outlined in SSAP No. 5R shall be followed.
- f. Reporting shall be consistent with *SSAP No. 66—Retrospectively Rated Contracts* (SSAP No. 66), paragraph 9 guidance on reporting for retrospective premium.

9. Retrospective premium adjustments are estimated for the portion of the policy period that has expired and shall be considered an immediate adjustment to premium. Additional retrospective premiums and return retrospective premiums shall be recorded as follows:

- a. Property and Casualty Reporting Entities:
  - i. Accrued additional retrospective premiums shall be recorded as a receivable with a corresponding entry made either to written premiums or as an adjustment to earned premiums. Premiums not recorded through written premium when accrued shall be recorded through written premium when billed.
  - ii. Accrued return retrospective premiums shall be recorded as part of the change in unearned premium (detailed in the underwriting and investment exhibit) liability with a corresponding entry made either to written premiums or as an adjustment to earned premiums. Premiums not recorded through written premium

when accrued shall be recorded through written premium when billed.

- iii. Ceded retrospective premium balances payable shall be recorded as liabilities, consistent with SSAP No. 62R. Ceded retrospective premiums recoverable shall be recorded as an asset. Consistent with SSAP No. 64—*Offsetting and Netting of Assets and Liabilities* (SSAP No. 64), ceded retrospective premium balances payable may be deducted from ceded retrospective premiums recoverable when a legal right of setoff exists.
- b. Life and Accident and Health Reporting Entities:
    - i. Accrued additional retrospective premiums shall be recorded as an asset, accrued retrospective premiums with a corresponding entry to premiums;
    - ii. Accrued return retrospective premiums shall be recorded as a liability, provision for experience rating refunds, with a corresponding entry to premiums.
  - c. Managed Care/Accident and Health Reporting Entities
    - i. Accrued additional retrospective premiums shall be recorded as an asset, accrued retrospective premiums with a corresponding entry to premiums;
    - ii. Accrued return retrospective premiums shall be recorded as a liability, as part of Accident and Health Reserves (reserve for rate credits or experience rating refunds), with a corresponding entry to premiums.

## Disclosures

57. The financial statements shall disclose on an annual and quarterly basis beginning in the first quarter of 2014, the assets, liabilities and revenue elements by program regarding the risk-sharing provisions of the Affordable Care Act for the reporting periods which are impacted by the programs including the listing in sections a-c below. Reporting entities shall also indicate if they wrote any accident and health insurance premium, which is subject to the Affordable Care Act risk-sharing provisions. In the event that the balances are zero, the reporting entity should provide context to explain the reasons for the zero balances, including insufficient data to make an estimate, no balances or premium was excluded from the program, etc. Asset balances shall reflect admitted asset balances. The disclosure shall include the following:

- a. ACA Permanent Risk Adjustment Program
  - i. Premium adjustments receivable due to ACA Risk Adjustment
  - ii. Risk adjustment user fees payable for ACA Risk Adjustment
  - iii. Premium adjustments payable due to ACA Risk Adjustment
  - iv. Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment
  - v. Reported in expenses as ACA risk adjustment user fees (incurred/paid)

- b. ACA Transitional Reinsurance Program
  - i. Amounts recoverable for claims paid due to ACA Reinsurance
  - ii. Amounts recoverable for claims unpaid due to ACA Reinsurance (contra-liability)
  - iii. Amounts receivable relating to uninsured plans for contributions for ACA Reinsurance
  - iv. Liabilities for contributions payable due to ACA Reinsurance - not reported as ceded premium
  - v. Ceded reinsurance premiums payable due to ACA Reinsurance
  - vi. Liability for amounts held under uninsured plans contributions for ACA Reinsurance
  - vii. Ceded reinsurance premiums due to ACA Reinsurance
  - viii. Reinsurance recoveries (income statement) due to ACA Reinsurance payments or expected payments
  - ix. ACA Reinsurance Contributions – not reported as ceded premium
- c. ACA Temporary Risk Corridors Program
  - i. Accrued retrospective premium due from ACA Risk Corridors
  - ii. Reserve for rate credits or policy experience rating refunds due to ACA Risk Corridors
  - iii. Effect of ACA Risk Corridors on net premium income (paid/received)
  - iv. Effect of ACA Risk Corridors on change in reserves for rate credits

58. In addition, beginning in annual 2014 and both quarterly and annual thereafter, a roll forward of prior year ACA risk-sharing provisions specified asset and liability balances shall be disclosed in the annual statutory Notes to Financial Statements, as illustrated in Appendix B. Note for the roll forward illustration, assets shall be reflected gross of any nonadmission. The reasons for adjustments to prior year balances (i.e. federal audits, revised participant counts, information which impacted risk score projections, etc.) shall also be disclosed. For year-end 2014, all columns and rows are expected to be zero since 2014 is the first year that a receivable or liability will be recorded.

### **Effective Date and Transition**

59. 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 ending on or after December 15, 2014.

**DISCUSSION**

60. The Emerging Accounting Issues (E) Working Group adopted *INT 13-04: Accounting for the Risk-Sharing Provisions of the Affordable Care Act* in April 2014, and made a simultaneous referral to the Statutory Accounting Principles (E) Working Group to consider accounting guidance for the ACA risk-sharing provisions, including potential nonadmittance for receivables for the risk adjustment and risk corridors receivables in excess of payables, in an issue paper and SSAP as soon as possible.

61. The overall parameters of the risk adjustment program create uncertainties in the estimation process and ultimately in the reporting entities' financial statements, particularly in 2014.

- a. The reporting entity/issuer does not have all of the data that is relevant to calculating its risk score because the reporting of risk score data will lag. For example, it is unlikely that encounter data will be complete for October, November and December. This fact will likely cause the issuer to employ one of two courses of action:
  - i. The reporting entity might seek to perform a complex estimation on the incurred but unpaid claims in order to attempt to translate the information to increases in enrollees' risk scores as of year-end, or
  - ii. The reporting entity might conclude that it is unable to reliably estimate the risk score attributable to incurred but unpaid claims and derive its risk adjustment score estimate from claims already paid. In that case, the issuer will expect to see favorable development in its risk adjustment estimate in successive calendar years as the estimate is adjusted to reflect the improved accuracy in risk scores from claims paid after year-end.
- b. The reporting entity/issuer's ultimate assessment payable or receivable for a risk adjustment cell is based on the relative relationships between its aggregate risk score and the risk scores of all issuers participating in the risk adjustment cell. Although some states will ask issuers to propose data prior to the close of the benefit year, changes by one issuer of information or classification can significantly impact the risk adjustment estimates for all issuers. The American Academy of Actuaries has noted that this uncertainty will be greater in 2014 than in subsequent periods because after 2014, carriers will have an understanding of what the aggregate risk score is for each risk adjustment cell from prior year's data<sup>5</sup>.
- c. The ACA will increase existing uncertainty at year-end regarding exposure to the number of insureds since the ACA requires that reporting entity/ issuers extend a grace period from the typical historical practice of 30 days to 90 days for insureds receiving a premium subsidy via the exchanges.

62. The risk corridors program has elements of federal responsibility and industry representatives requested that this be treated as a federal governmental obligation and not subject to the 90-day rule similarly to a government uninsured or insured plan similar to the treatment in *SSAP No. 47—Uninsured Plans* and *SSAP No. 84—Certain Health Care Receivables and Receivables Under Government Insured Plans*. This was subsequently extended to the risk adjustment program after the Working Group heard comments on the first exposure draft.

63. For a number of reasons, the Working Group directed redrafting of the nonadmission of receivables in excess of payables for the risk adjustment and risk corridors programs to allow admission of the receivables subject to specified criteria. The Working Group noted that the Capital Adequacy (E)

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<sup>5</sup> Financial Reporting Implications Under the Affordable Care Act, developed by the Health Practice Financial Reporting Committee of the American Academy of Actuaries.

Task Force has adopted a health RBC sensitivity test related to the Section 9010 ACA fee and that this issue paper will incorporate the balance and roll-forward disclosures which were originally placed in SSAP No. 35R by a separate agenda item. Premium deficiency reserve guidance in SSAP No. 54 continues to apply to the health products and must be considered in the development of the actuarial opinion. In addition, it was noted that the transitional reinsurance program and the risk adjustment program have mitigating effects to the possible errors in the risk corridors program.

64. The replacement language stressed conservatism in the preparation of estimates, having sufficient data to base estimates on and having knowledge of the marketplace. In addition, impairment evaluations were stressed and nonadmission of amounts after notification of denial even if appeals are pending was added. While SSAP No. 54 provides guidance on contracts subject to redetermination, and SSAP No. 66 provides guidance on retrospectively rated contracts, this issue paper provided more explicit guidance which shall be followed to fit the facts and circumstances of the risk adjustment and risk corridors programs.

## RELEVANT LITERATURE

### Statutory Accounting

65. Statutory accounting provides guidance in various statements that are relevant to the accounting for risk-sharing provisions.

66. Excerpts of SSAP No. 6 on Determination of Due Date

#### Determination of Due Date

7. The due date for all premium balances addressed by this statement is determined as follows:

The due date for all premium balances addressed by this statement is determined as follows:

- a. Original and deposit premiums—governed by the effective date of the underlying insurance contract and not the agent/reporting entity contractual relationship;
- b. Endorsement premiums—governed by the effective date of the insurance policy endorsement;
- c. Installment premiums—governed by the contractual due date of the installment from the insured;
- d. Audit premiums and retrospective premiums—governed by insurance policy or insurance contract provisions. If the due date for receivables relating to these policies is not addressed by insurance policy provisions or insurance contract provisions, any uncollected audit premium (either accrued or billed) is nonadmitted.

8. The provisions of paragraph 7 shall be applied to all balances due except those arising from force placed insurance obtained by a lender for collateral protection, certain policies, known as Trustee Sales Guarantees (TSGs), issued by title insurance companies to lenders on defaulted real estate loans and crop/hail policies. For forced placed insurance policies, the due date for purposes of applying paragraph 9 shall be the date of billing. For TSGs, the due date for purposes of applying paragraph 9 shall be the expiration of the grace period given to the defaulted debtor, which is provided by statute. Crop/hail premiums are considered installment premiums in accordance with paragraph 7 and accordingly, the due date for purposes of applying paragraph 9 shall be governed by the contractual due date of the installment.

67. SSAP No. 54 provides the following regarding contracts subject to redetermination:

#### Contracts Subject to Redetermination

27. This statement also applies to other contracts which are subject to redetermination such as Federal (and State) Groups - subject to rate adjustments through audits by the Office of Personnel Management (OPM). Reporting entities are required to give Federal Groups the lowest rates that are being charged to similar groups.

28. Amounts due from insureds or subscribers and amounts due to insureds or subscribers under contracts subject to redetermination meet the definitions of assets and liabilities as set forth in *SSAP No. 4—Assets and Nonadmitted Assets* and SSAP No. 5R, respectively.

29. Contract redeterminations shall be estimated based on the experience to date. The method used to estimate the liability shall be reasonable based on the reporting entity's procedures, and consistent among reporting periods. An examination of contract requirements in relation to the rates being charged and the current status of applicable audits (e.g., OPM, Centers for Medicare and Medicaid Services (or such other name that this entity shall be known as) and other Federal, state or government department) is a common method used to estimate such contract redeterminations.

30. Premium adjustments for contracts subject to redetermination are estimated for the portion of the policy period that has expired and shall be considered an immediate adjustment to premium. Accrued premium adjustments shall be recorded as a write-in for other-than-invested assets, with a corresponding entry to premiums; accrued return premium adjustments shall be recorded as a liability with a corresponding entry to premiums.

31. If, in accordance with SSAP No. 5R, it is probable that the additional premium adjustment is uncollectible, any uncollectible premium shall be written off against operations in the period the determination is made and the disclosure requirements outlined in SSAP No. 5R shall be made.

32. Premium adjustments for contracts subject to redetermination shall be determined and billed or refunded in accordance with the policy provisions or contract provisions. If such premiums are not billed in accordance with the policy provisions or contract provisions, or the policy provisions or contract provisions do not address the due date of such premiums, the accrual shall be nonadmitted. This is consistent with the guidance for audit premiums established in SSAP No. 6.

68. SSAP No. 61R, paragraph 27, provides the following regarding treatment of the transitional reinsurance program for individual insurance products and is reflected the same as traditional reinsurance recoveries:

Policy benefit payments paid or payable by the reinsurer shall be reported in the summary of operations and reduces the ceding entity's reported benefit payments. The reinsurer shall establish a liability for its share of any unpaid claim payments and the ceding entity shall reduce any policy and contract claim liability with respect to the reinsured policies or establish a receivable for the amount due from the reinsurer for claims paid.

69. The provisions of SSAP No. 63, paragraph 3, defines involuntary pools and paragraph 8 provides additional relevant guidance:

3. Involuntary pools represent a mechanism employed by states to provide insurance coverage to those with higher than average probability of loss who otherwise would be excluded from obtaining coverage. Reporting entities are generally required to participate in the underwriting results, including premiums, losses, expenses, and other operations of involuntary pools, based on their proportionate share of similar business written in the state. Involuntary plans are also referred to as residual market plans, involuntary risk pools, and mandatory pools.

8. Underwriting results relating to voluntary and involuntary pools shall be accounted for on a gross basis whereby the participant's portion of premiums, losses, expenses, and other operations of the pools are recorded separately in the financial statements rather than netted against each other. Premiums and losses shall be recorded as direct, assumed, and/or ceded as applicable. If the reporting entity is a direct writer of the business, premiums shall be recorded as directly written and accounted for in the same manner as other business which is directly written by the entity. To the extent that premium is ceded to a pool, premiums and losses shall be recorded in the same manner as any other reinsurance arrangement. A reporting entity who is a member of a pool shall record its participation in the pool as assumed business as in any other reinsurance arrangement.
70. SSAP No. 66, provides the following regarding retrospectively rated contracts:
3. *A retrospectively rated contract is one which has the final policy premium calculated based on the loss experience of the insured during the term of the policy (including loss development after the term of the policy) and the stipulated formula set forth in the policy or a formula required by law. The periodic adjustments may involve either the payment of return premium to the insured or payment of an additional premium by the insured, or both, depending on experience. Retrospective rating features are common in certain property and casualty contracts, group life, and group accident and health contracts. Some contracts have retrospective features required by law. Contracts with retrospective rating features are referred to as loss sensitive contracts.*
8. Assumptions used in estimating retrospective premium adjustments shall be consistent with the assumptions made in recording other assets and liabilities necessary to reflect the underwriting results of the reporting entity such as claim and loss reserves (including IBNR) and contingent commissions. Contingent commissions and other related expenses shall be adjusted in the same period the additional or return retrospective premiums are recorded.
9. Retrospective premium adjustments are estimated for the portion of the policy period that has expired and shall be considered an immediate adjustment to premium. Additional retrospective premiums and return retrospective premiums shall be recorded as follows:
- a. Property and Casualty Reporting Entities:
- i. Accrued additional retrospective premiums shall be recorded as a receivable with a corresponding entry made either to written premiums or as an adjustment to earned premiums. Premiums not recorded through written premium when accrued shall be recorded through written premium when billed.
- ii. Accrued return retrospective premiums shall be recorded as part of the change in unearned premium (detailed in the underwriting and investment exhibit) liability with a corresponding entry made either to written premiums or as an adjustment to earned premiums. Premiums not recorded through written premium when accrued shall be recorded through written premium when billed.
- iii. Ceded retrospective premium balances payable shall be recorded as liabilities, consistent with SSAP No. 62R. Ceded retrospective premiums recoverable shall be recorded as an asset. Consistent with SSAP No. 64—*Offsetting and Netting of Assets and Liabilities* (SSAP No. 64), ceded retrospective premium balances payable may be deducted from ceded retrospective premiums recoverable when a legal right of setoff exists.

- b. Life and Accident and Health Reporting Entities:
- i. Accrued additional retrospective premiums shall be recorded as an asset, accrued retrospective premiums with a corresponding entry to premiums;
  - ii. Accrued return retrospective premiums shall be recorded as a liability, provision for experience rating refunds, with a corresponding entry to premiums.
- c. Managed Care/Accident and Health Reporting Entities
- i. Accrued additional retrospective premiums shall be recorded as an asset, accrued retrospective premiums with a corresponding entry to premiums;
  - ii. Accrued return retrospective premiums shall be recorded as a liability, as part of Accident and Health Reserves (reserve for rate credits or experience rating refunds), with a corresponding entry to premiums. Retrospective premium adjustments are estimated for the portion of the policy period that has expired and shall be considered an immediate adjustment to premium.

11. Once accrued retrospective premium is billed, the due date is governed by SSAP No. 6—*Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers*. Life and accident and health reporting entities shall nonadmit any accrued retrospective premium that is more than 90 days due. If a reporting entity has issued more than one policy to the same insured, retrospective balances shall be netted in accordance with SSAP No. 64.

12. If, in accordance with SSAP No. 5R, it is probable that the additional retrospective premium is uncollectible, any uncollectible additional retrospective premium shall be written off against operations in the period the determination is made. If it is reasonably possible a portion of the balance in excess of the nonadmitted portion determined in accordance with paragraph 109 is not anticipated to be collected, the disclosure requirements outlined in SSAP No. 5R shall be made.

### Generally Accepted Accounting Principles

71. GAAP did not issue additional guidance to address the risk-sharing provisions of the ACA.

### REFERENCES

#### Other

- *SSAP No. 5R—Liabilities, Contingencies and Impairments of Assets* (SSAP No. 5R)
- *SSAP No. 35—Revised—Guaranty Fund and Other Assessments* (SSAP No. 35R)
- *SSAP No. 47—Uninsured Plans* (SSAP No. 47)
- *SSAP No. 54—Individual and Group Accident and Health Contracts* (SSAP No. 54)
- *SSAP No. 61—Revised—Life, Deposit-Type and Accident and Health Reinsurance* (SSAP No. 61)
- *SSAP No. 63—Underwriting Pools and Associations Including Intercompany Pools* (SSAP No. 63)
- *SSAP No. 66—Retrospectively Rated Contracts* (SSAP No. 66)
- *SSAP No. 84—Certain Health Care Receivables and Receivables Under Government Insured Plans* (SSAP No. 84)

**APPENDIX A: GLOSSARY**

The terms included in this appendix are specific to the risk-sharing provisions of the ACA; accordingly, they are not intended to be applied to other topics.

**Affordable Care Act (ACA)** – The Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA), is a United States federal statute signed into law on March 23, 2010.

**Applicable Reinsurance Entity** – A tax-exempt not-for-profit organization, the duties of which shall be to carry out the transitional reinsurance program by coordinating the funding and operation of the risk-spreading mechanisms designed to stabilize the individual markets during the implementation of health reform.

**Cell** – The risk corridor calculation is done at the QHP (Qualified Health Plan) level – the cell is state, market (individual or small group), QHP.

**Assessment** – Required payments into the applicable reinsurance entity by all issuers of major medical commercial products and third-party administrators to fund the transitional reinsurance program.

**Exchange** – Health insurance marketplaces, also called Health Exchanges, are organizations set up to facilitate the purchase of health insurance in every state of the United States in accordance with the Patient Protection and Affordable Care Act. The exchanges are regulated, online marketplaces, administered by either federal or state government, where individuals, families and small businesses can purchase qualified health insurance plans starting October 1, 2013, with coverage beginning January 1, 2014. Exchanges will also determine who qualifies for subsidies and make subsidy payments to insurers on behalf of individuals receiving them. They will also accept applications for other health coverage programs such as Medicaid and Children’s Health Insurance Program (CHIP).

**Exempt Plans** – Certain health plans that are determined not to be a risk adjustment covered plan in the applicable federally certified risk adjustment methodology (45 C.F.R. § 153.20), grandfathered health plans, group health insurance coverage benefits that are not an integral part of a group health plan, are limited scope, or supplemental benefits (45 C.F.R. § 146.145(c)), and individual health insurance coverage excepted benefits (45 C.F.R. § 148.220).

**Grandfathered Plans** – A group health plan that was created or an individual health insurance policy that was purchased on or before March 23, 2010. Grandfathered plans are exempted from many changes required under the ACA. Plans or policies may lose their “grandfathered” status if they make certain significant changes that reduce benefits or increase costs to consumers. New employees and new family members may be added to grandfathered group plans after March 23, 2010.

**Health & Human Services (HHS)** – The Department of Health and Human Services (HHS) is the United States government’s principal agency that oversees CMS, which administers programs for protecting the health of all Americans and providing essential human services.

**Market Segment** – Subset of consumers with its own set of demographic and other assumptions such as individual, state/federal, small group, group, Medicaid or Medicare.

**Program Distribution** – Amounts payable to or redistributed by the applicable reinsurance entity or the HHS to issuers of non-grandfathered individual market plans that incur high claims costs for enrollees and are eligible to receive benefit payments (recoveries).

**Qualified Health Plan (QHP)** – Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance Marketplace, provides essential health benefits and follows

established limits on cost-sharing (such as deductibles, copayments, and out-of-pocket maximum amounts).

**Risk Score** – Individual risk score means a relative measure of predicted health care costs for a particular enrollee that is the result of a risk adjustment model. Claims-based risk-assessment models use data, typically from a 12-month period, to identify underlying conditions and assign a risk score for each individual based on an algorithm.

**APPENDIX B: ACA Risk-Sharing Provisions Roll-Forward Illustration**

Receivables are reflected gross of any nonadmission for this illustration.

	Accrued During the Prior Year on Business Written Before December 31 of the Prior Year		Received or Paid as of the Current Year on Business Written Before December 31 of the Prior Year		Differences		Adjustments			Unsettled Balances as of the Reporting Date	
					Prior Year Accrued Less Payments (Col 1 - 3)	Prior Year Accrued Less Payments (Col 2 - 4)	To Prior Year Balances	To Prior Year Balances		Cumulative Balance from Prior Years (Col 1 - 3 + 7)	Cumulative Balance from Prior Years (Col 2 - 4 + 8)
	1	2	3	4	5	6	7	8	9	10	11
	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Receivable	(Payable)	Ref	Receivable	(Payable)
<b>a. Permanent ACA Risk Adjustment Program</b>											
1. Premium adjustments receivable	4,000,000		3,000,000		1,000,000		-800,000		A	200,000	0
2. Premium adjustments (payable)		8,000,000		9,000,000		-1,000,000		1,000,000	B		0
<b>3. Subtotal ACA Permanent Risk Adjustment Program</b>	<b>4,000,000</b>	<b>8,000,000</b>	<b>3,000,000</b>	<b>9,000,000</b>	<b>1,000,000</b>	<b>-1,000,000</b>	<b>-800,000</b>	<b>1,000,000</b>		<b>200,000</b>	<b>0</b>
<b>b. Transitional ACA Reinsurance Program</b>											
1. Amounts recoverable for claims paid	22,000,000		15,000,000		7,000,000		-7,000,000		C	0	
2. Amounts recoverable for claims unpaid (contra liability)	8,000,000		9,000,000		-1,000,000		990,000		D	-10,000	
3. Amounts receivable relating to uninsured plans	3,000,000		2,800,000		200,000		-100,000		E	100,000	
4. Liabilities for contributions payable due to ACA Reinsurance – not reported as ceded premium		90,000		75,000		15,000		-14,000	G		1,000
5. Ceded reinsurance premiums payable		100		200		-100		100	I		0
6. Liability for amounts held under uninsured plans		125,000		15,000		110,000		90,000	J		200,000
<b>7. Subtotal ACA Transitional Reinsurance Program</b>	<b>33,000,000</b>	<b>215,100</b>	<b>26,800,000</b>	<b>90,200</b>	<b>6,200,000</b>	<b>124,900</b>	<b>-6,110,000</b>	<b>76,100</b>		<b>90,000</b>	<b>201,000</b>
<b>c. Temporary ACA Risk Corridors Program</b>											
1. Accrued retrospective premium	12,000,000		14,000,000		-2,000,000		1,750,000		K	-250,000	
2. Reserve for rate credits or policy experience rating refunds		150,000		250,000		-100,000		100,000	L		0
<b>3. Subtotal ACA Risk Corridors Program</b>	<b>12,000,000</b>	<b>150,000</b>	<b>14,000,000</b>	<b>250,000</b>	<b>-2,000,000</b>	<b>-100,000</b>	<b>1,750,000</b>	<b>100,000</b>	<b>M</b>	<b>-250,000</b>	<b>0</b>
<b>d. Total for ACA Risk-Sharing Provisions</b>	<b>49,000,000</b>	<b>8,365,100</b>	<b>43,800,000</b>	<b>9,340,200</b>	<b>5,200,000</b>	<b>-975,100</b>	<b>-5,160,000</b>	<b>1,176,100</b>		<b>40,000</b>	<b>201,000</b>

## Explanation of Adjustments

- Adjusted due to federal audit
- Adjusted because of revised participant count
- Adjusted due to poor experience of other participants in the reinsurance pool.
- Revised risk score information in the state of substantially impacted risk scores