INT 13-04 Discussion

RISK ADJUSTMENT PROGRAM

Risk Adjustment Program - Description

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. All risk adjustment covered plans are required to participate in the risk adjustment program. 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.

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.

Risk Adjustment Program - Contributions

7. An issuer that offers risk adjustment covered plan, that has a net balance of risk adjustment contributions payable will be notified, and contribution to the state or HHS on behalf of the state will be required by June 30 of the calendar year following the benefit year. Contributions will be computed based on the reporting entity's risk score versus the overall market risk score after applying adjustments. The reinsurance program is not considered in the computation.

Risk Adjustment Program - Payments (Recoveries)

8. Each state or HHS on behalf of the state shall assess reporting entities 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. Payments 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.

Risk Adjustment Program - Administration

9. 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. HHS will invoice risk adjustment program contributions and payments. Similar terms will apply for the user fees of state operated programs.

Risk Adjustment Program -Timing of Contributions and Payments (recoveries)

10. All payments made to issuers (recoveries) must be completely funded through the contributions assessed to other issuers within the same market in the same state to ensure equality between payments and contributions. Consequently, contributions will be invoiced prior to processing issuer payments. Once applicable contributions are received by HHS or the state, funds will be redistributed to the higher risk plans. Each issuer will be notified of risk adjustment

Transitional Reinsurance Program – Payments (Recoveries)

22. Reinsurance payments 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. Payments 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.

Transitional Reinsurance Program – Administration

23. 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).

Transitional Reinsurance Program - Timing of Contributions and Payments (Recoveries)

24. Contributions 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 payments among issuers nationally based on submitted claims. Issuers will be notified of pending reinsurance payment (recovery) amounts by June 30 following the benefit year. If the requests for payments exceed actual contribution amounts, HHS will reduce reinsurers' payments (recoveries) on a pro-rata basis. If the request for payments is less than actual contributions, HHS will increase reinsurers' payments (recoveries) on a pro-rata basis.

Accounting for the Transitional Reinsurance Program

25. Due to the diverse elements of the tran

27. The guidance in this section will provide treatment for each of the contribution and payment elements of the program listed below for the health insurance products listed in paragraph 26.

a. Contributions for reinsurance

b. Program administrative costs contributions

c. Additional U.S. Treasury contribution

d. Reinsurance payments (recoveries)

Transitional Reinsurance Program - Individual Insured Health Products Subject to the 2014 ACA Market Reforms

Individual Insured Issuers - Contributions for Reinsurance

28.

> 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.

This gives further support to the concept that the transitional reinsurance program, as a mechanism for sharing the additional costs associated with high-risk individuals, is accounted for as traditional reinsurance.

Individual Insured Issuers -Reinsurance Program Administrative Expense Contributions

33. The portion of the reinsurance program administrative expense contributions attributable to individual coverage is reflected as ceded premium. This applies both to contributions made at the national contribution rate and to any 98 90t5(on)5(rs)6(as0.0/TT2 u(ind51 -1.15/(red ative Td[ional0oins

Transitional Reinsurance Program - Self-insured Health Products Reinsurance Program

Self-insured Health Products Reinsurance Program - Contributions for Reinsurance

45. Contributions made on behalf of self-insured plans which are administered by the reporting entity are uninsured plans are excluded from the reporting entity's statement of operations, with respect to both monies received from the plans and contribution payments 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.

46. The self-insured plan, not the reporting entity, is legally liable for contributions 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 contributions for the transitional reinsurance program.

47. 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.

48. 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 pre98(e)]0.68313 Tc 0.0-hat-(005 Tw 1A plan) whic Tw Cost.191 0 Td[0 Td[

Risk Corridors Program - Contributions and Payments (Recoveries)

53. To determine whether an issuer pays into (contributes), or receives payments (recoveries) from, the risk corridors program, HHS will compare Allowable Costs[2] and the Target Amount[3] 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.
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 contributions 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 contributions 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.

Risk Corridors Program - Administration

54. 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 with no state variation. 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.

Risk Corridors Program - Timing of Contributions and Payments

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

Risk Corridors Program - Accounting Treatment

56. This program is substantively similar to the risk corridors program established for the Medicare Part D prescription drug coverage[4]. Pursuant to INT 05-05 paragraph 4.b., the Part D Risk Corridor Payment adjustment is acc

57. Receipts and payments pursuant to the temporary risk corridors program shall be treated as premium adjustments for retrospectively rated contracts under SSAP No. 66. The ultimate premium with respect to a QHP will be determined by the QHP's claims experience, therefore retrospective rating accounting is appropriate for premium adjustments resulting from this program. SSAP No. 66, paragraph 3 states:

> *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.*

58. 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 should be aware of the significant uncertainties involved in preparing estimates and be both diligent and conservative in their estimations.

SSAP No. 66, paragraph 8 states:

> 8. 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.

59. All receivables from the temporary risk corridors program should be considered admitted assets, inasmuch as they are a receivable from a government or a government-sponsored entity, the funding of which is mandated by law. This is comparable to the situation addressed by SSAP No. 84, paragraph 23. The receivable is also subject to impairment analysis.

INT 13-04 Status

60. The Working Group reached a consensus to adopt the accounting treatment and references noted in the discussion section above for risk adjustment, transitional reinsurance and risk corridors risk-sharing provisions of the ACA. The Working Group also made a referral to the Statutory Accounting Principles Working Group to request the development of specific accounting guidance for the ACA risk-sharing provisions, including potential nonadmittance, in an issue paper and statement of statutory accounting principle as soon as possible.

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.