

**Interpretation of the Emerging Accounting Issues Working Group****INT 13-04: Accounting for the Risk-Sharing Provisions of the Affordable Care Act****ISSUE NULLIFIED BY SSAP NO. 107****INT 13-04 Dates Discussed**

December 15, 2013, February 12, 2014, March 29, 2014

**INT 13-04 References**

*SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers (SSAP No. 6)*

*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*

**INT 13-04 Issue**

1. The Affordable Care Act (ACA) imposes fees and premium stabilization provisions on health insurance issuers offering commercial health insurance. This interpretation 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 (Section 1343). The temporary transitional reinsurance program (Section 1341) and temporary risk corridors program (Section 1342) are for years 2014 through 2016.

2. Specific terms included in the attached appendix in this interpretation are unique to these programs and should not be applied to other aspects of statutory accounting. The required payments to the program by reporting entities are described as contributions. Amounts redistributed by the program back to reporting entities are termed payments. These “payments” would be viewed as recoveries in most instances.

3. The accounting issues are how to account for the various components of the risk-sharing provisions of the ACA and which of the existing statements of statutory accounting principles are to be applied for the various risk-sharing provisions of the ACA. The manner in which these provisions are applied in the determination of the Medical Loss Ratios and rebates may be different from these as the calculations are based on the ACA Section 2718(b).

**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

payments owed to, or contributions owed by, the issuer by June 30 of the year following the benefit year to align with the payments (recoveries) and contribution processing. Contributions owed by an issuer to HHS or the state must be remitted within 30 days of notification of the risk adjustment contribution amount. Once applicable contributions are received by HHS or the state, funds will be redistributed to the higher risk plans.

#### Risk Adjustment Program - Accounting Treatment

11. There are two accounting elements of the ACA permanent risk adjustment program that must be considered separately: the risk adjustment contributions and payments (recoveries), and the user fee contribution. 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.

12. Premium adjustments pursuant to the risk adjustment program shall be accounted for as premium subject to redetermination in accordance with the guidance in *SSAP No. 54—Individual and Group Accident and Health Contracts* (SSAP No. 54). These premium adjustments 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 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). In contrast, this program does not meet the definition of a retrospectively rated contract as defined in *SSAP No. 66—Retrospectively Rated Contracts* (SSAP No. 66), in which the final policy premium is calculated based on the loss experience of the insured during the term of the policy (including loss development after the term of the policy).

13. Risk adjustment user fees shall be treated as government assessments and accounted for under *SSAP No. 35—Revised—Guaranty Fund and Other Assessments* (SSAP No. 35R). These fees are treated the same as other non-income-based governmental taxes and fees.

14. The event that will entitle or obligate a risk adjustment covered plan to additions or reductions to revenue under the risk adjustment program is the provision of services by the risk adjustment covered plan to its enrollees. This will occur throughout the period of coverage.

15. Program participants 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 such additions or reductions, 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.

16. All receivables from the permanent risk adjustment program are subject to the 90-day nonadmission rule beginning from when payment is due to be disbursed by the government or a government-sponsored entity. That is, the 90-day rule begins when governmental disbursement is due, not from the date of initial accrual. The announced dispersal date shall be considered the contractual due date similar to *SSAP No. 6—Uncollected Premium Balances, Bills Receivable for Premiums, and Amounts Due From Agents and Brokers* (SSAP No. 6) treatment of installment premium. The receivable is also subject to impairment analysis.

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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.

## TRANSITIONAL REINSURANCE PROGRAM

### Transitional Reinsurance Program - Description

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

18. 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 payments (recoveries) 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 payments (recoveries).

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

20. 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)*.

### Transitional Reinsurance Program - Contributions

21. The national transitional reinsurance program contribution 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 in reinsurance payments, 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 contribution rate to provide additional funding for reinsurance payments or to fund the administrative expenses of the applicable reinsurance entity. Contributions for the reinsurance program must fund reinsurance payments 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 in these years, in addition to covering administrative expenses of the applicable reinsurance entity or HHS.

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

26. 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
- b. All other insured health products. This includes individual grandfathered and non-grandfathered products not subject to the ACA market reforms
- c. Self-insured health products

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. Transitional reinsurance contributions attributable to enrollees in individual plans are treated as ceded reinsurance premium. This applies both to contributions made at the national contribution rate and to any state-elected additional contributions that will fund reinsurance payments. Ceded premiums would be reported as a contra-revenue under reinsurance accounting in accordance with *SSAP No. 61-Revised-Life, Deposit-Type and Accident and Health Reinsurance*, paragraph 17 and paragraphs 25-26.

29. For the individual coverage issuers, this is an involuntary pool and under the terms of the ACA transitional reinsurance program, the transfer of risk and timely reimbursement requirements of SSAP No. 61R are satisfied.

30. With regard to individual coverage issuers, the ACA transitional reinsurance program is more similar to traditional reinsurance than it is to an assessment, because contributions are made to and payments are received from the reinsuring entity. Accordingly, the ACA program is accounted for as traditional reinsurance.

31. The provisions of *SSAP No. 63-Underwriting Pools and Associations, Including Intercompany Pools*, paragraph 3 defines 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.

32. 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.

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 state-elected additional contributions that will fund administrative expenses.

34. 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.

*Individual Insured Issuers -Reinsurance Program Additional U.S. Treasury Contribution*

35. Because this portion of the contribution 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, which, is not based on income. This portion of the contribution 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.

*Individual Insured Issuers -Reinsurance Program Reinsurance Payments (Recoveries)*

36. Payments received from the ACA transitional reinsurance program for individual insurance is reflected as ceded claim benefit recoveries. This applies both to payments received pursuant to the uniform federal reinsurance parameters and to any state-elected additional payments.

37. In keeping with the rationale for reinsurance contributions above, payments received (recoveries) from the transitional reinsurance program for individual insurance products is reflected the same as traditional reinsurance recoveries. SSAP No. 61R, paragraph 27 of states:

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.

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

38. HHS and all applicable reinsurance entities are providers to an involuntary pool will be considered authorized reinsurers for the purposes of financial reporting for individual health products.

39. All receivables from the transitional reinsurance program are subject to the 90-day nonadmission rule beginning from when payment is due to be disbursed by the government or a government-sponsored entity. That is, the 90-day rule begins when governmental disbursement is due, not from the date of initial accrual. The announced dispersal date shall be considered the contractual due date similar to SSAP No. 6 treatment of installment premium. The receivable is also subject to impairment analysis.

#### Transitional Reinsurance Program - All Other Insured Health Products

##### *All Other Insured Health Products -Contributions for Reinsurance*

40. Transitional reinsurance program reinsurance contributions made for enrollees in fully insured plans other than individual plans are treated as an assessment and charged to taxes, licenses and fees. This applies both to contributions made at the national contribution rate and to any state determined additional contributions that will fund reinsurance payments. 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.

41. The treatment of the transitional reinsurance program reinsurance contributions 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 contributions are not treated as ceded premium. As an involuntary assessment, the transitional reinsurance program reinsurance contributions, consistent with SSAP No. 35R are treated as an assessment 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 for assessing the contributions.

##### *All Other Insured Health Products Reinsurance Program - Administrative Costs Contributions*

42. The reinsurance program administrative costs contributions for all other insured health products is an assessment. This applies both to contributions made at the national contribution rate and to any state-elected additional contributions that will fund administrative expenses.

##### *All Other Insured Health Products Reinsurance Program - Additional U.S. Treasury Contribution*

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

##### *All Other Insured Health Products Reinsurance Program -Reinsurance Payments (not applicable)*

44. Reinsurance recoveries will not occur for insured health products other than individual. Other insured Health products will pay the transitional reinsurance program contributions but not receive payments (Recoveries) of claims.

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 prescribed in SSAP No. 47, paragraphs 9-10.

Self-insured Health Products Reinsurance Program - Program Administrative Cost Contributions and Additional U.S. Treasury Contribution

49. 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 contributions 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 contributions and additional U.S. Treasury contribution amounts.

*Self-insured Health Products Reinsurance Program -Reinsurance Payments (not applicable)*

50. Reinsurance recoveries will not occur for Self-insured Health Products, as these products will pay fees but not receive claims reimbursements.

**RISK CORRIDORS***Risk Corridors Program - Description*

51. 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.

52. 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.

*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<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.
- 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<sup>4</sup>. Pursuant to INT 05-05 paragraph 4.b., the Part D Risk Corridor Payment adjustment is accounted for in accordance with SSAP No. 66.

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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.

<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.

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.

## Appendix 1-Glossary

The terms included in the attached 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.

**Contribution** – 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 call 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.

**Payment** – Amounts issued 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.