Statutory Accounting Principles (E) Working Group

**Maintenance Agenda Submission Form**

**Form A**

## **Issue: State ACA Reinsurance Programs**

**Check (applicable entity):**

 P/C Life Health

Modification of Existing SSAP [x]  [x]  [x]

New Issue or SSAP [ ]  [ ]  [ ]

Interpretation [ ]  [ ]  [ ]

Description of Issue:

*SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act* provides guidance regarding the three Affordable Care Act (ACA) risk sharing programs known as risk adjustment, the transitional reinsurance program and risk corridors. All three programs were to assist with rate stabilization in the individual market. Risk adjustment was originally the only permanent program and the other two were temporary. Although the 2014-2016 transitional reinsurance program has ended, several states have received approval from the Department of Health and Human Services (HHS) to run similar state ACA reinsurance programs under what are known as Section 1332 waivers.

This agenda item is to provide accounting and reporting guidance regarding State ACA reinsurance programs being run under Section 1332 waivers. Note that states can seek Section 1332 waivers to address a variety of issues such as:

* Individual and employer mandates;
* Essential health benefits (EHBs);
* Limits on cost sharing for covered benefits;
* Metal tiers of coverage;
* Standards for health insurance marketplaces, including requirements to establish a website, a call center, and a navigator program; and
* Premium tax credits and cost-sharing reductions.

To date, most of the states that have sought 1332 waivers did so to implement state ACA reinsurance programs which have the goal of using the reinsurance programs to lower individual health insurance premium in the jurisdiction. As these programs seek to operate to cover higher individual health claims in a manner similar to the transitional reinsurance program, the initial recommendation is to provide guidance that such state programs should follow the guidance in SSAP No. 107 to the extent the state program has similar terms.

The original transitional reinsurance program and the subsequent state ACA reinsurance programs are not reinsurance in the true sense. They typically rely on group products to help fund the program, but do not typically allow the group products to receive reinsurance distributions. Therefore the group products help fund the program but are not true participants. Because of this, a hybrid approach was incorporated into the SSAP No. 107 accounting guidance. A similar hybrid approach is recommended for state ACA reinsurance programs. At a high level this approach divides products into 3 broad categories. This includes:

1. Subject individual products (typically individual plans) that may pay an insurance contribution and are eligible to receive reinsurance distributions. These programs report like an involuntary reinsurance pool as is described in *SSAP No. 63—Underwriting Pools*.
2. Other insured health products (typically group plans) that are not eligible for reinsurance distributions under the terms of the state ACA reinsurance program. These products treat the amounts as assessments reported in taxes, licenses and fees similar to treatment under *SSAP No. 35R—Guaranty Funds and Other Assessments*.
3. Self-insured plans where the reporting entity is acting as an administrator, and will exclude the payments made on behalf of the self-insured plan from the reporting entity’s operations, consistent with the guidance in *SSAP No. 47—Uninsured Plans*.

Existing Authoritative Literature:

### *SSAP No. 35R—Guaranty Funds and Other Assessments* provides guidance on assessments*.*

### *SSAP No. 63—Underwriting Pools* provides guidance regarding involuntary pools.

### *SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act* provides the following: Transitional Reinsurance Program – Description and Overview

1. 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.
2. 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.
3. 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.
4. Consequently, the term “reinsurance” does not represent actual reinsurance between licensed insurers as defined by *SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance*. This program is similar to an involuntary pool in *SSAP No. 63—Underwriting Pools* 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.
5. 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.
6. 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.
7. 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 portionfor the fee. (For example, the 2014 fee will be $0.11 per-member per-year resulting in $20.3 million of administrative expense funding).
8. 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**

1. 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.
2. The following are the broad groupings of the health insurance products subject to the transitional reinsurance program:
3. 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);
4. 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);
5. Self-insured health products.
6. 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 26.
7. Assessments for reinsurance
8. Administrative costs assessments
9. Additional U.S. Treasury assessment
10. Reinsurance distributions

**Subject Individual Insured Health Products**

Subject Individual Insured Issuers - Assessments Payable for Reinsurance

1. 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 25-27:
2. 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.
3. 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.
4. The provisions of SSAP No. 63, paragraph 3, define involuntary pools.
5. The transitional reinsurance program differs from an involuntary pool, 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. 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

1. 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.
2. 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

1. 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

1. 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.
2. 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 as described in SSAP No. 61R, paragraph 27.
3. Therefore, recoveries received are reported in the summary of operations and will reduce the ceding entity’s reported benefits paid.
4. 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.
5. 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 2.h., 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

1. 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.
2. 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

1. 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

1. 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)

1. 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

1. 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,* paragraphs 5 and 8-11.
2. 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.
3. 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.
4. 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

1. 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)

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

Activity to Date (issues previously addressed by the Working Group, Emerging Accounting Issues (E) Working Group, SEC, FASB, other State Departments of Insurance or other NAIC groups): None.

**Information or issues (included in *Description of Issue*) not previously contemplated by the Working Group:**

The following website provides a useful overview and map of existing state Section 1332 waivers.

<https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/>

**Convergence with International Financial Reporting Standards (IFRS):** None

Staff Recommendation:

NAIC Staff recommends that the Working Group move this item to the active listing, categorized as nonsubstantive and expose revisions to SSAP No. 107 as illustrated below. These revisions would include State ACA reinsurance programs which are using Section 1332 waivers in the scope of *SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act*. The intent of the proposed accounting revisions is to continue to follow the SSAP No. 107 hybrid accounting approach for the state ACA programs as they operate in a similar manner.

In general, state ACA reinsurance programs provide funding to issuers in the individual market that incur high claims costs for enrollees. The programs often require assessments from issuers typically on behalf of group health plans. At a high level this hybrid accounting approach divides products into 3 broad categories. This includes:

1. Subject individual products (typically individual plans) that may pay a reinsurance funding contribution and are eligible to receive reinsurance distributions shall report similar to an involuntary reinsurance pool as described in *SSAP No. 63—Underwriting Pools*.
2. Other insured Health products (typically group plans) that are not eligible for reinsurance distributions under the terms of the state ACA reinsurance program shall treat the amounts as assessments reported in taxes, licenses and fees similar to treatment under *SSAP No. 35R—Guaranty Funds and Other Assessments*.
3. Self-insured plans where the reporting entity is acting as an administrator, and will exclude the payments made on behalf of the self-insured plan from the reporting entity’s operations, shall report consistent with the guidance in *SSAP No. 47—Uninsured Plans*.

Staff Review Completed by:

Robin Marcotte

**NAIC Staff**

**SCOPE OF STATEMENT**

* 1. The Affordable Care Act (ACA) imposes fees and premium stabilization provisions on health insurance issuers offering commercial health insurance. This statement provides 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. Subsequent to the end of the transitional reinsurance program, several states received waivers to have state specific ACA reinsurance programs, which operate similarly to the transitional reinsurance program. These programs are addressed in this statement.

**State ACA Reinsurance Programs – Overview**

1. After the 2014-2016 transitional reinsurance program ended, several states received approval from the HHS to run similar state ACA reinsurance programs under what are known as Section 1332 waivers. While Section 1332 waivers can be sought on a variety of topics, state ACA reinsurance programs are the most common. These state ACA reinsurance programs have similar goals of lowering individual health insurance premium in the jurisdiction.
2. The terms of these programs will have jurisdiction-specific variations. For example, the percentage of claims covered and the cap on claims covered varies by jurisdiction and sometimes by year. The initial flow of funding and covered policies may also have differences from the original transitional reinsurance program. However, several of the state ACA programs also include excess of loss coverage for individual claims in excess of a specified amount. One example would be reimbursing 80% of claims in excess of $50,000 up to a cap of $250,000 in the individual market in a state.
3. In general, state ACA reinsurance programs provide funding to issuers in the individual market that incur high claims costs for enrollees. The programs often require assessments from issuers and TPAs typically on behalf of group health plans based on a per member annual fee established by the state specific ACA reinsurance program.
4. Consequently, the term “reinsurance” does not represent actual reinsurance between licensed insurers as defined by *SSAP No. 61R—Life, Deposit-Type and Accident and Health Reinsurance*. These programs are similar to an involuntary pool in *SSAP No. 63—Underwriting Pools* for the individual insured health products subject to the State ACA reinsurance program. 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 reinsurance pool.

**State ACA Reinsurance Programs – Accounting Treatment**

1. The state ACA reinsurance programs shall follow the same principles of accounting and reporting as the transitional reinsurance program to the extent that the state ACA reinsurance program has similar features. The state ACA reinsurance program components including the treatment of reinsurance assessments, administrative costs assessments, and the reinsurance distributions, shall follow similar accounting and reporting principles as the transitional reinsurance program.
2. Due to the diverse elements of the State ACA reinsurance programs, which include characteristics of traditional reinsurance, involuntary pools and governmental assessments, a hybrid accounting approach is required for the state ACA reinsurance programs. The accounting treatment for the state ACA reinsurance programs is discussed in terms of the payables and receivables and the impact to the health insurance products which are subject to the program.
3. The broad groupings for health insurance products used for the original transitional programs discussed in paragraph 26 will continue to apply to the state ACA reinsurance programs with jurisdiction specific modifications regarding the scope of health products subject to the market reforms. At a high level this approach divides products into 3 broad categories which are detailed in the accounting guidance below more specifically. This includes:
4. Subject individual products (typically individual plans) that may pay a reinsurance funding contribution and are eligible to receive reinsurance distributions. These programs shall report similar to an involuntary reinsurance pool as described in *SSAP No. 63—Underwriting Pools*.
5. Other insured Health products (typically group plans) that are not eligible for reinsurance distributions under the terms of the state ACA reinsurance program. These products shall treat the amounts as assessments reported in taxes, licenses and fees similar to treatment under *SSAP No. 35R—Guaranty Funds and Other Assessments*.
6. Self-insured plans where the reporting entity is acting as an administrator, and will exclude the payments made on behalf of the self-insured plan from the reporting entity’s operations, shall report consistent with the guidance in *SSAP No. 47—Uninsured Plans*.

State ACA - Subject Individual Insured Health Products

1. For subject individual insured products which are subject to reinsurance assessments and also eligible for reinsurance distributions according to the program’s terms, should follow the same guidance as provided in paragraphs 28-40 to the extent the state program incorporates similar terms. For example, if the state ACA reinsurance program does not incorporate an assessment to the U.S. treasury, paragraph 35 would not apply.
2. For subject individual insured products, the accounting is similar to an involuntary reinsurance pool. The subject individual insured products will report both the state ACA reinsurance funding and State ACA reinsurance administrative assessments as premium ceded. Program distributions received from the state ACA reinsurance program for individual insurance is reflected as ceded claim benefit recoveries.

State ACA - Other Insured Health Products

1. Fully insured health products which are required to contribute to funding state ACA reinsurance programs, but are not eligible to receive reinsurance program distributions under the terms of the program, shall report the contributed reinsurance and administrative expense funding as assessments which is charged to taxes, licenses and fees expense. For these products, the accounting shall be consistent with paragraphs 41-45 to the extent the state ACA reinsurance program incorporates similar terms.

State ACA – Self-Insured Health Products

1. If a reporting entity is an administrator for a self-insured health plan, the accounting for the state ACA reinsurance program amounts for the self-insured plan administrator is similar to the accounting in SSAP No. 47. The administrator of such plans shall follow the accounting described in paragraphs 46-51 to the extent the state program incorporates similar terms. The self-insured plan, not the administrator reporting entity, is legally liable for assessments for the state ACA 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.

**Disclosures**

72. 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 paragraphs 60.a. through 60.c. 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:

1. ACA Permanent Risk Adjustment Program

Premium adjustments receivable due to ACA Risk Adjustment (including high-cost risk pool payments)

Risk adjustment user fees payable for ACA Risk Adjustment

Premium adjustments payable due to ACA Risk Adjustment (including high-cost risk pool ceded premium)

Reported as revenue in premium for accident and health contracts (written/collected) due to ACA Risk Adjustment

Reported in expenses as ACA risk adjustment user fees (incurred/paid)

1. State ACA Reinsurance Program

Amounts recoverable for claims paid due to state ACA Reinsurance Programs

Amounts recoverable for claims unpaid due to state ACA Reinsurance (contra-liability)

Amounts receivable relating to uninsured plans for contributions for state ACA Reinsurance

Liabilities for contributions payable due to state ACA Reinsurance - not reported as ceded premium

Ceded reinsurance premiums payable due to state ACA Reinsurance

Liability for amounts held under uninsured plans contributions for state ACA Reinsurance

Ceded reinsurance premiums due to state ACA Reinsurance

Reinsurance recoveries (income statement) due to state ACA Reinsurance payments or expected payments

State ACA Reinsurance Contributions – not reported as ceded premium

1. ACA Temporary Risk Corridors Program

Accrued retrospective premium due from ACA Risk Corridors

Reserve for rate credits or policy experience rating refunds due to ACA Risk Corridors

Effect of ACA Risk Corridors on net premium income (paid/received)

Effect of ACA Risk Corridors on change in reserves for rate credits

**Status:**

On March 15, 2021, the Statutory Accounting Principles (E) Working Group moved this agenda item to the active listing, categorized as nonsubstantive, and exposed revisions to *SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act*, as illustrated above. The revisions include State ACA reinsurance programs which are using Section 1332 waivers in scope of SSAP No. 107 and will provide guidance to follow the hybrid accounting approach for the state ACA programs as they operate in a similar manner.

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