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Current Issues in Health Financial Reporting

Chicago Actuarial Association – March 13, 2007

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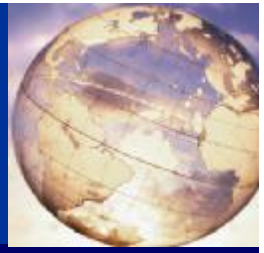
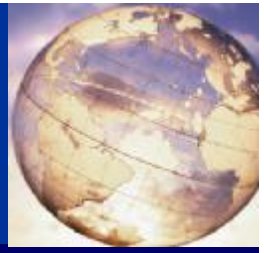
Overview



- Bifurcation of Insurance Contracts
- DAC, SOP 05-1, and TPA 6300.32
- Principles-Based Reserves
- IASB Insurance Contracts Phase II

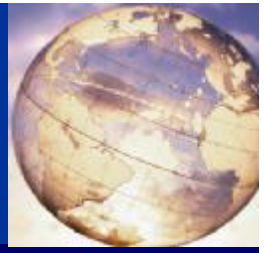
Caveat: *This session is intended to shed light on current and emerging financial reporting issues of interest to health actuaries. It is not intended to provide accounting advice.*

Bifurcation of Insurance Contracts



- In 2005, FASB initiated Insurance Risk Transfer project in response to concerns over “finite risk reinsurance” contracts
- Existing risk transfer guidance (FAS 113) is a “pass-fail paradigm”
- A determination needs to be made as to whether the contract does, or does not, “transfer significant insurance risk”
  - If it does, insurance accounting should be used by both parties
  - If it does not, deposit accounting should be used (premium received is not considered revenue)
  - “Insurance risk” involves both “underwriting risk” and “timing risk”

Bifurcation of Insurance Contracts

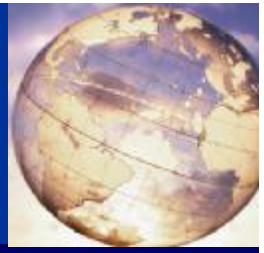


- By late 2005, FASB expressed interest in an alternate paradigm: bifurcation of a contract into insurance and deposit pieces
- May 2006: FASB Invitation To Comment (ITC), "Bifurcation of Insurance and Reinsurance Contracts for Financial Reporting"

  http://www.fasb.org/draft/ITC_Bifurcation_Insurance.pdf

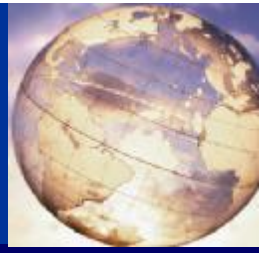
  - The ITC was "intended to be a neutral discussion document whose sole purpose is to gather information to help the FASB in its discussion"
- August 2006: Comments to FASB received from insurance industry, Academy, other stakeholders

Bifurcation of Insurance Contracts



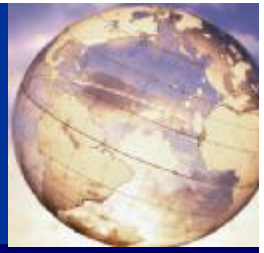
- An example of bifurcation in current financial reporting: Medicare Part D
- Carrier contract with CMS involves multiple cash inflows having differing financial reporting treatments
  - Beneficiary premiums, direct subsidies, premium subsidies – INSURANCE ACCOUNTING
  - Reinsurance subsidies, low-income cost sharing subsidies – DEPOSIT ACCOUNTING
- As a result, carrier only recognizes revenue corresponding to the cash flows for which it bears risk

Bifurcation of Insurance Contracts



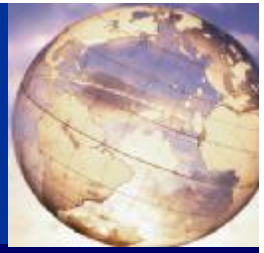
- Another example: ASO medical with stop loss
- Carrier contract with employer group involves multiple cash inflows having differing financial reporting treatments
  - Monthly premiums for stop loss coverage – INSURANCE ACCOUNTING
  - Funds received from employer to cover medical claims – DEPOSIT ACCOUNTING
  - Monthly fees for administrative services are recognized as revenue for GAAP, as contra-expense for SAP
- Once again, carrier doesn't recognize revenue for cash flows where it doesn't bear insurance risk

Bifurcation of Insurance Contracts



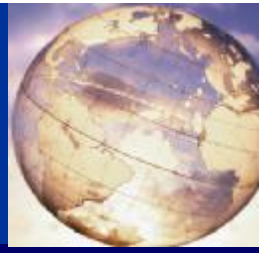
- Both of these examples have a clear separation of the contract into risk versus non-risk pieces
- The FASB ITC proposed an accounting model where a wider array of contracts would be bifurcated risk versus non-risk pieces
- Example cited in ITC: Group medical insurance
- Viewpoint expressed in ITC is that some portion of group premiums represent a “dollar-trading component” for which there is not truly a transfer of risk

Bifurcation of Insurance Contracts



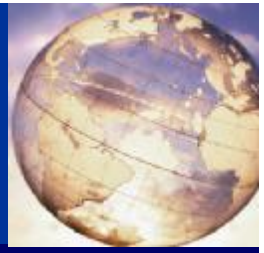
- "Bifurcation would separate the dollar-trading component of the contract and account for it as a deposit for funding expected claim payments."
- "The remainder of the premium would be allocated to insurance for claims exceeding the expected claims and the administrative contract."
- Implementing this concept would appear to require specification of probability levels and models of the probability distribution of claim amounts around their expected value

Bifurcation of Insurance Contracts



- In the ITC, an individual health insurance policy is presumed to not require bifurcation, as contrasted with a group policy
- However, the cession of a portfolio of individual health contracts to a reinsurer may require bifurcation
- As such, bifurcation could lead to reporting differences between the direct piece and the reinsurance ceded piece, even for a straight quota share treaty

Bifurcation of Insurance Contracts

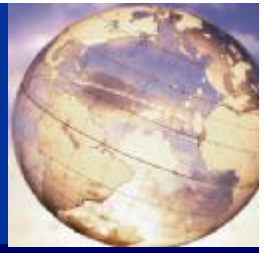


- Academy's Health Practice Council submitted comment letter to FASB – see

  http://www.actuary.org/pdf/finreport/bifur_aug06.pdf

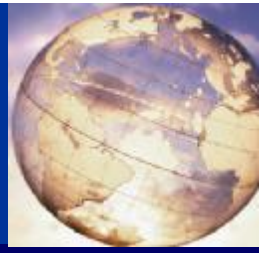
- Letter raises a number of practical difficulties with bifurcation of group medical contracts, e.g.:
  - Sensitivity of revenue recognition to actuarial models that aren't calibrated to market transactions
  - Potential need to estimate unpaid claim liabilities on a contract-by-contract basis to comply with bifurcation

Bifurcation of Insurance Contracts



- FASB summary of comment letters available at
  http://www.fasb.org/project/cl_analysis_prt.pdf
- "Overall, the bifurcation of insurance and reinsurance contracts did not receive support from respondents."
- December 2006: FASB decides not to proceed with the general bifurcation framework outlined in the ITC
- Current FASB focus is on drafting editorial changes to existing risk transfer guidance in FAS 113
- Possible IASB interest in this issue as part of Phase II?

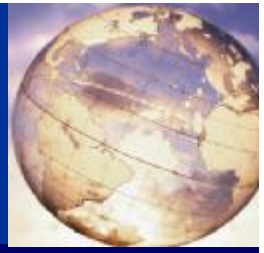
DAC, SOP 05-1 and TPA 6300.32



- GAAP guidance from FAS 60 (applicable to “insurance enterprises”):

  “Acquisition costs are those costs that vary with and are primarily related to the acquisition of new and renewal insurance contracts. … Acquisition costs shall be capitalized and charged to expense in proportion to premium revenue recognized. … Unamortized acquisition costs shall be classified as an asset.”
- This asset is called the DAC (deferred acquisition cost) asset, or DPAC (deferred policy acquisition cost) asset
- No DAC asset in SAP

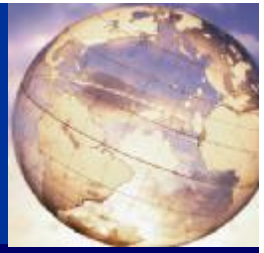
DAC, SOP 05-1 and TPA 6300.32



- GAAP guidance from AICPA Health Care Organizations Audit Guide (applicable to "HMOs and similar prepaid health service plans"):

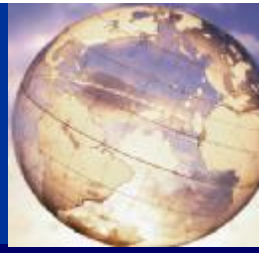
  "Many prepaid health care providers incur costs that vary with, and are primarily related to, the marketing of subscriber contracts and member enrollment. These costs [are] sometimes referred to as acquisition costs … Although there is theoretical support for deferring certain acquisition costs, acquisition costs of providers of prepaid health care services—other than costs of advertising—should be expensed as incurred."

DAC, SOP 05-1 and TPA 6300.32



- DAC considerations vary by product:
  - Group medical, stop loss
  - Medicare Advantage
  - Group life, group LTD
  - Individual medical, Medicare Supplement
- Variance in industry practice (influenced by company history and culture? By materiality considerations?)
- Short duration versus long duration contracts
- “Inter-year” DAC versus “intra-year” DAC

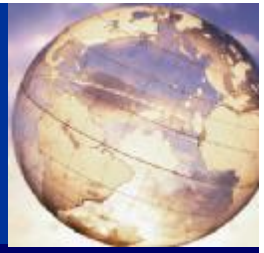
DAC, SOP 05-1 and TPA 6300.32



Individual medical DAC example: Deferring 10% of first year premiums over 10 years; assuming 10% annual rate increases, 5% discount rate, lapses as shown (all at beginning of year)

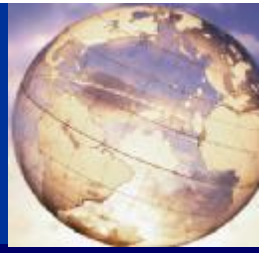
	PMPY	Deferable					DAC	DAC
Year	Premium	Expenses	Lapse	Members	Premium	PVFP	Asset	Factor
1	2,000	200		1.0000	2,000	5,703	205	0.1025
2	2,200		40%	0.6000	1,320	4,635	167	0.1262
3	2,420		30%	0.4200	1,016	3,825	137	0.1353
4	2,662		20%	0.3360	894	3,100	111	0.1246
5	2,928		20%	0.2688	787	2,449	88	0.1118
6	3,221		20%	0.2150	693	1,861	67	0.0966
7	3,543		20%	0.1720	610	1,330	48	0.0784
8	3,897		20%	0.1376	536	847	30	0.0567
9	4,287		20%	0.1101	472	405	15	0.0309
10	4,716		20%	0.0881	415	0	0	0.0000

DAC, SOP 05-1 and TPA 6300.32



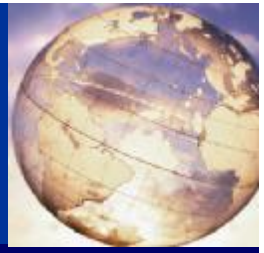
- September 2005: AICPA issues Statement of Position (SOP) 05-1, “Accounting by Insurance Enterprises for Deferred Acquisition Costs in Connection with Modifications or Exchanges of Insurance Contracts”
- Result of 5 years of deliberations, very complex! (e.g., E&Y’s interpretive summary is 86 pages long)
- Effective for most companies in 2007
- General concept: Some types of modifications to existing insurance contracts will require the insurer to write off the unamortized DAC asset balance

DAC, SOP 05-1 and TPA 6300.32



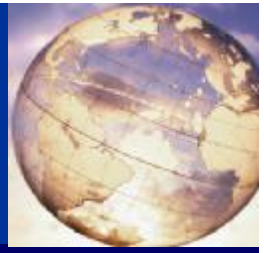
- SOP 05-1 definition: "An internal replacement is a modification in product benefits, features, rights or coverages that occurs by the legal extinguishment of one contract and the issuance of another contract (a contract exchange), or by amendment, endorsement, or rider to a contract, or by the election of a benefit, feature, right, or coverage within a contract."
- Distinction between "substantially changed" and "substantially unchanged" internal replacements – the former require writing off DAC, the latter are a continuation of the original contract (DAC persists)

DAC, SOP 05-1 and TPA 6300.32



- Six criteria need to be met in order for an internal replacement to be considered “substantially unchanged”
- Main criteria of interest is that “the insured event, risk, or period of coverage of the contract has not changed, as noted by no significant changes in the kind and degree of mortality risk, morbidity risk, or other insurance risk”
- Reunderwriting the contract is considered as an indication that there is a significant change in the insurance risk (else why would insurer incur costs of reunderwriting?)

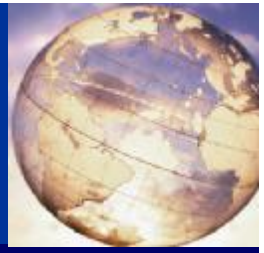
DAC, SOP 05-1 and TPA 6300.32



- As companies conducted SOP 05-1 implementation planning in 2006, many questions arose
- February 2007: AICPA issues several Technical Practice Aids (TPA) regarding SOP 05-1:

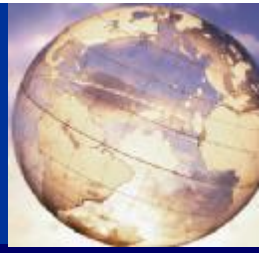
  http://www.aicpa.org/download/acctstd/SOP_05-1_TPAs.pdf
- One of these Technical Practice Aids is of particular interest from a health standpoint – Section 6300.32, "Premium Changes to FAS 60 Long Duration Contracts in Applying SOP 05-1"

DAC, SOP 05-1 and TPA 6300.32



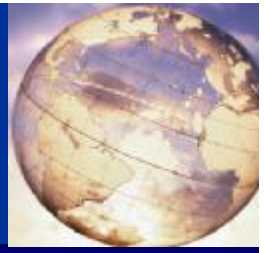
- TPA Section 6300.32 poses the following question: Are changes in premiums to FAS 60 long-duration insurance contracts for which the insurer has the right to make changes in premium rates considered modifications under SOP 05-1?
- Short answer: "It depends."
- "Changes to a contract that involve the adjustment of rates or benefits based on a judgmental review of actual experience of the contract holder or the renegotiation of rates or benefits with that contract holder, even if no reunderwriting has occurred, generally would be considered a modification."
- On the other hand….

DAC, SOP 05-1 and TPA 6300.32



- TPA 6300.32 presents four criteria that, if met, would generally indicate that a premium change does not constitute a modification:
  - Contractual right to adjust premium rates
  - Premium rate change for a given contract holder is the same change applicable to the entire class of contract holders
  - Premium rate changes do not involve consideration of the specific experience of the contract holder
  - No other changes in benefits or coverages occur
- These criteria are articulated in the context of a group long-duration contract; are they equally applicable to an individual long-duration contract?

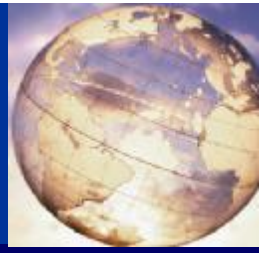
DAC, SOP 05-1 and TPA 6300.32



SOP 05-1 implementation steps might include:

- Create inventory of products, benefits, rights & coverages
- Identify common contract exchanges, classify as substantially changed versus substantially unchanged
- Identify common contract modifications and determine which should be classified as substantially changed
- Review administration and accounting systems to see if changes need to be made
- Review existing DAC processes, controls and models

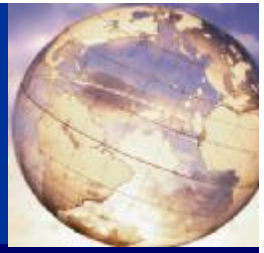
Principles-Based Reserves



- Principles-based approach (PBA) to reserving and capital is currently a major initiative at the NAIC's Life/Health Actuarial Task Force, with substantial technical support from the Academy's Life Practice Council
- For further details, see:
  - Academy's PBA website:

    http://www.actuary.org/risk.asp
  - "Principles-Based Approach to Reserving and Capital" session in next timeslot
- Primary focus is on life & annuity products

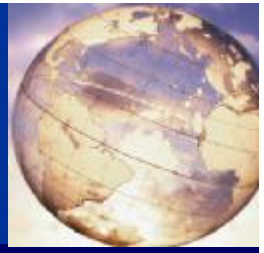
Principles-Based Reserves



5 principles underlying the principles-based approach:

1. PBA captures all of the identifiable, quantifiable, and material financial risks, benefits, and guarantees associated with the contracts
2. PBA uses risk analysis and risk management techniques to quantify the risks
3. PBA incorporates assumptions and methods that are consistent with, but not necessarily identical to, those utilized within the company's overall risk assessment process

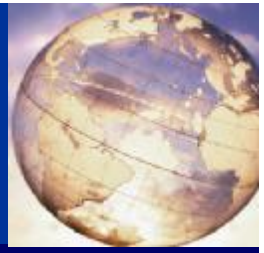
Principles-Based Reserves



5 principles underlying the principles-based approach:

4. PBA permits the use of company experience, based on the availability of relevant company experience and its degree of credibility, to establish assumptions for risks over which the company has some degree of control or influence
5. PBA provides for the use of assumptions, set on a prudent best estimate basis, that contain an appropriate level of conservatism when viewed in the aggregate and that, together with the methods utilized, recognizes the solvency objective of statutory reporting

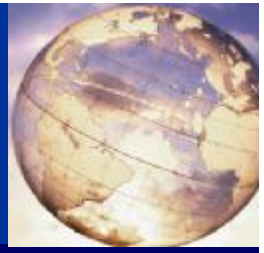
Principles-Based Reserves



Two main reasons for health actuaries to monitor PBA:

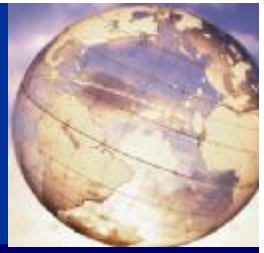
- Regulatory framework considerations – as changes are made to the NAIC Standard Valuation Law, there could be impacts (intended or unintended) on A&H products for carriers subject to SVL (e.g., Blue blank companies)
- Long-Term Care – NAIC has expressed interest in principles-based reserves for LTC, with potential later expansion to other A&H products (e.g., IDI)
  - Academy has a State LTC Principles-Based Work Group, currently identifying issues and developing models – work somewhat slower than on life/annuity side but progressing

IASB Insurance Contracts Phase II



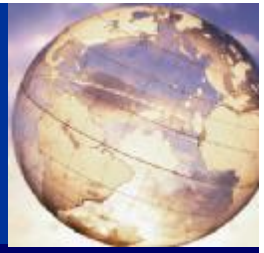
- IASB (International Accounting Standards Board) is the body that promulgates IFRS (International Financial Reporting Standards) accounting literature
  - IFRS used for EU public company reporting as of 2005
- IASB had adopted so-called “Phase I” guidance on insurance contracts (IFRS 4), as a stop-gap measure
- IASB currently in middle of “Phase II” project to replace existing guidance, working with an Insurance Working Group (CFOs of major international insurers)

IASB Insurance Contracts Phase II



- IASB to issue a Discussion Paper in March 2007 containing its tentative decisions
- FASB has not been actively participating in the Phase II discussions
- However, FASB has agreed that it will issue an Invitation To Comment on the IASB Discussion Paper
- Depending on feedback received, FASB may work jointly with IASB to bring to fruition a single standard on insurance contracts for both IFRS and US GAAP

IASB Insurance Contracts Phase II



Current estimate of IASB Phase II timetable:

- Discussion Paper to be released in March 2007
- After that, at least 18 months to issue an Exposure Draft (i.e., late 2008 at earliest)
- After that, at least 12 months to issue a Final Statement (i.e., late 2009 at earliest)
- Implementation = 2010?

http://www.iasb.org/Current+Projects/IASB+Projects/Insurance+Contracts/Insurance+Contracts.htm

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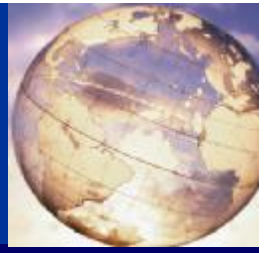

- Ultimately, this project could impact US SAP
- NAIC is working as part of IAIS (International Association of Insurance Supervisors) to provide input to IASB
- "The IAIS believes that it is most desirable that the methodologies for calculating items in general purpose financial reports can be used for, or are substantially consistent with, the methodologies used for regulatory reporting purposes, with as few changes as possible to satisfy regulatory reporting requirements"
- Some similarities and differences between NAIC's current Principles-Based Reserves project and IASB Phase II project

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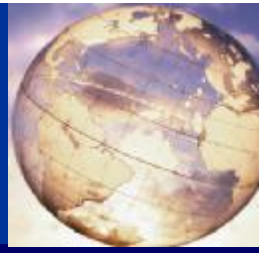
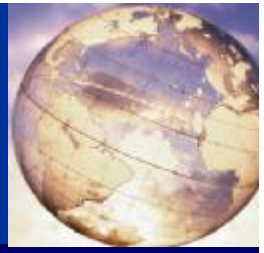


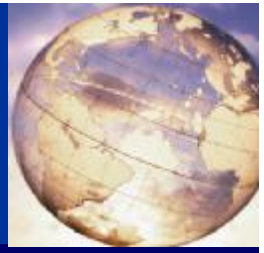
- Three building blocks for insurance liabilities, referred to collectively as the “current exit value” approach:
  1. Current unbiased probability-weighted estimates of future cash flows
  2. Current market discount rates that adjust the estimated future cash flows for the time value of money
  3. An explicit and unbiased estimate of the margin that market participants require for bearing risk (a risk margin) and for providing other services, if any (a service margin)
- Current exit value = “the amount the insurer would have to pay now if it transferred all its remaining rights and obligations to a third party”

IASB Insurance Contracts Phase II



- Remaining slides explore one potential implication of "current exit value" approach: recognition of intra-year seasonality in financial reporting for medical products via use of a Pre-Claim Liability (PCL)
- Theoretical inconsistency in current practice (stop loss; high-deductible medical; Medicare Part D and Medicare Supplement)
- Caveat: This is intended as an illustrative demonstration of a potential issue, prior to any exposure of guidance – simply trying to provoke thought and interest

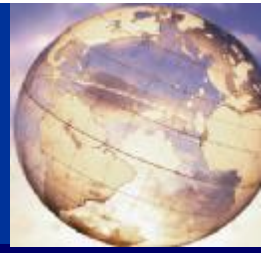
PCL Example

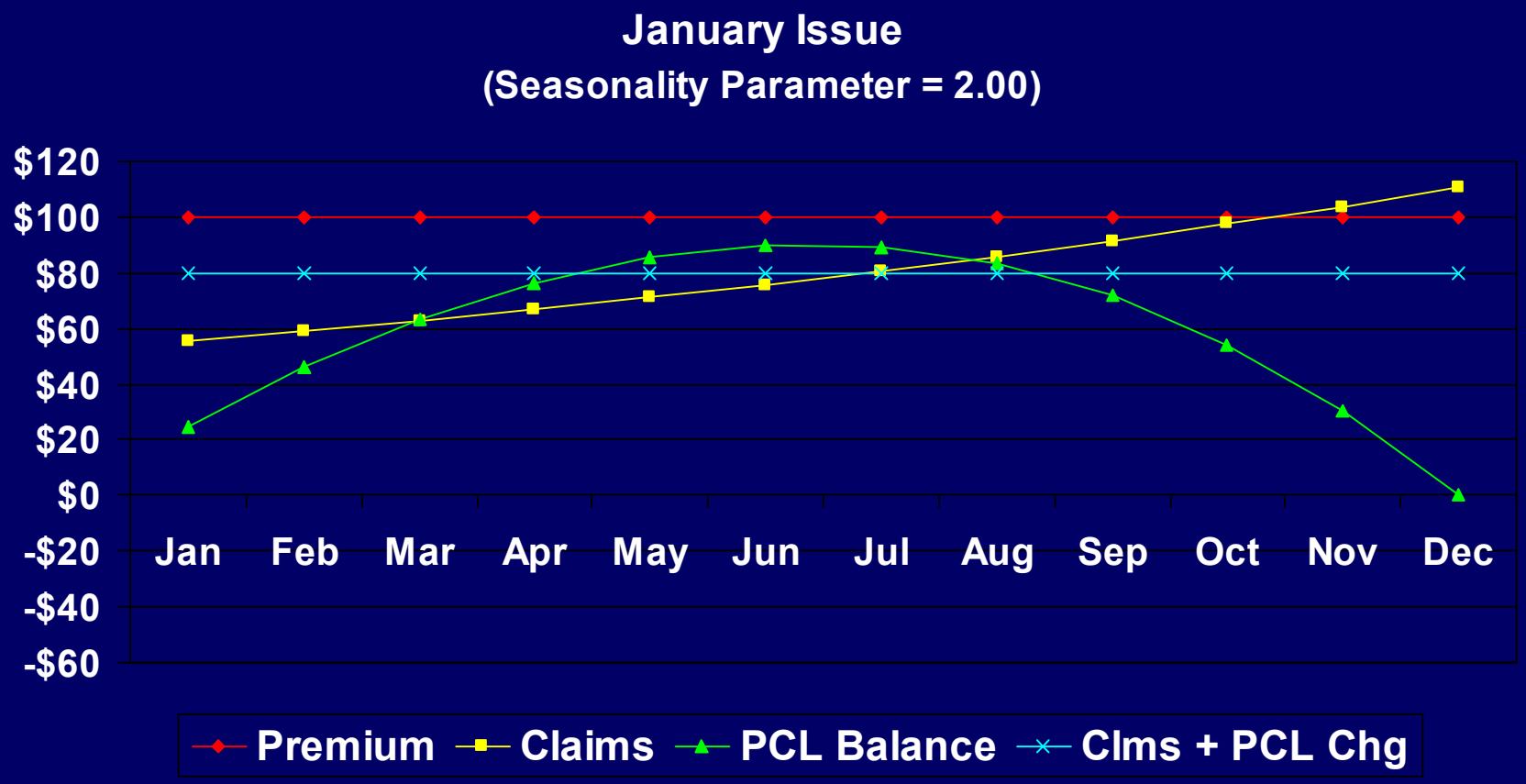


Situation:

- 12-month medical policy with calendar year seasonality in claims costs (e.g., deductibles and other cost-sharing feature are based on calendar year, not policy year)
- Claim costs independent of policy issue month
- Product priced to achieve 80% loss ratio, rate increases on policy anniversary
- Seasonality parameter = ratio of December claim costs to January claim costs; assume monthly claim cost growth is constant throughout calendar year
- 10% annual medical claims inflation, in January

PCL Example





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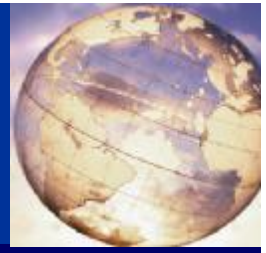

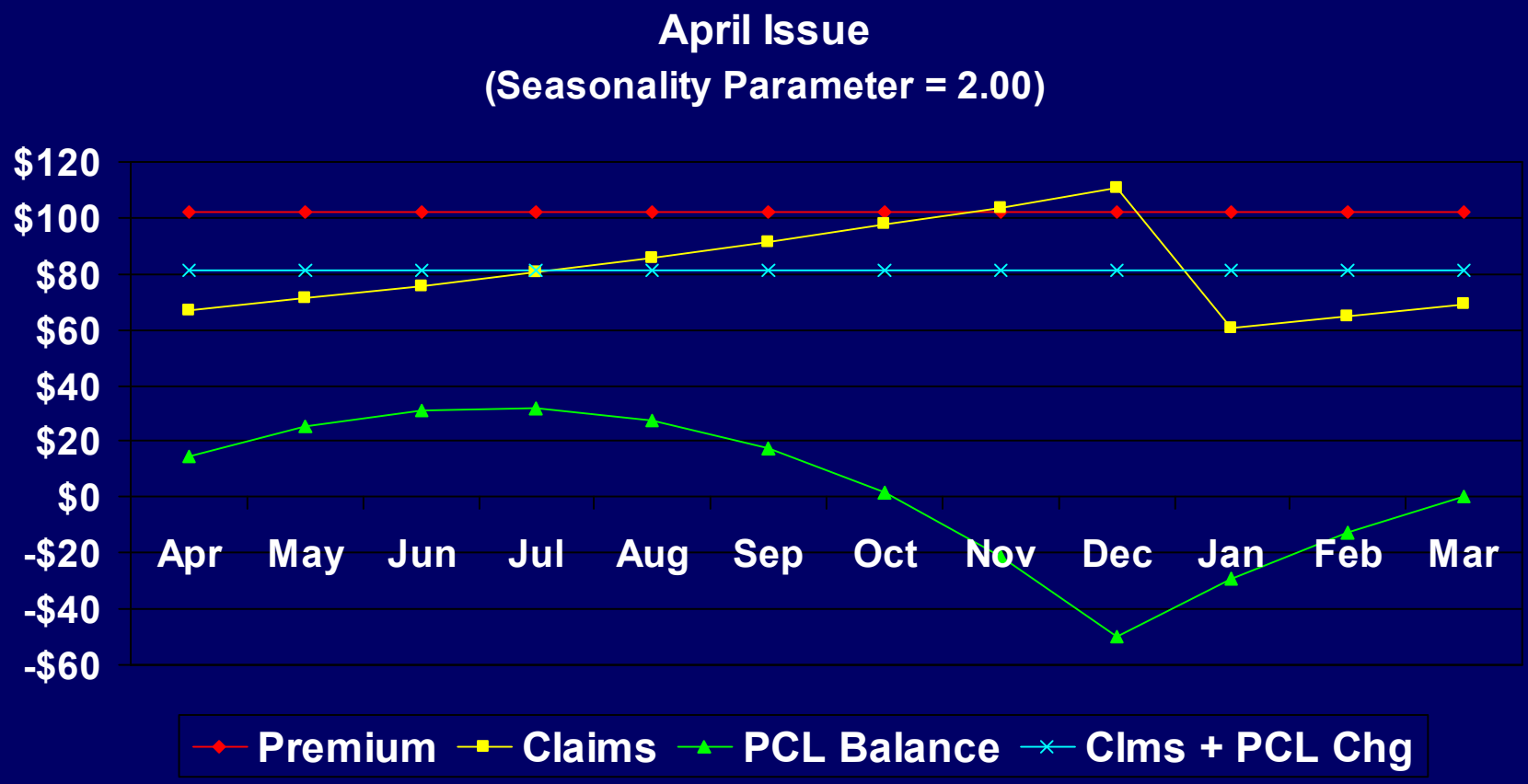

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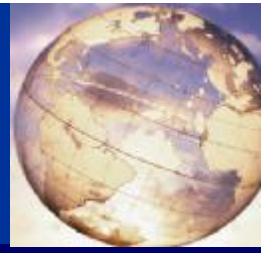

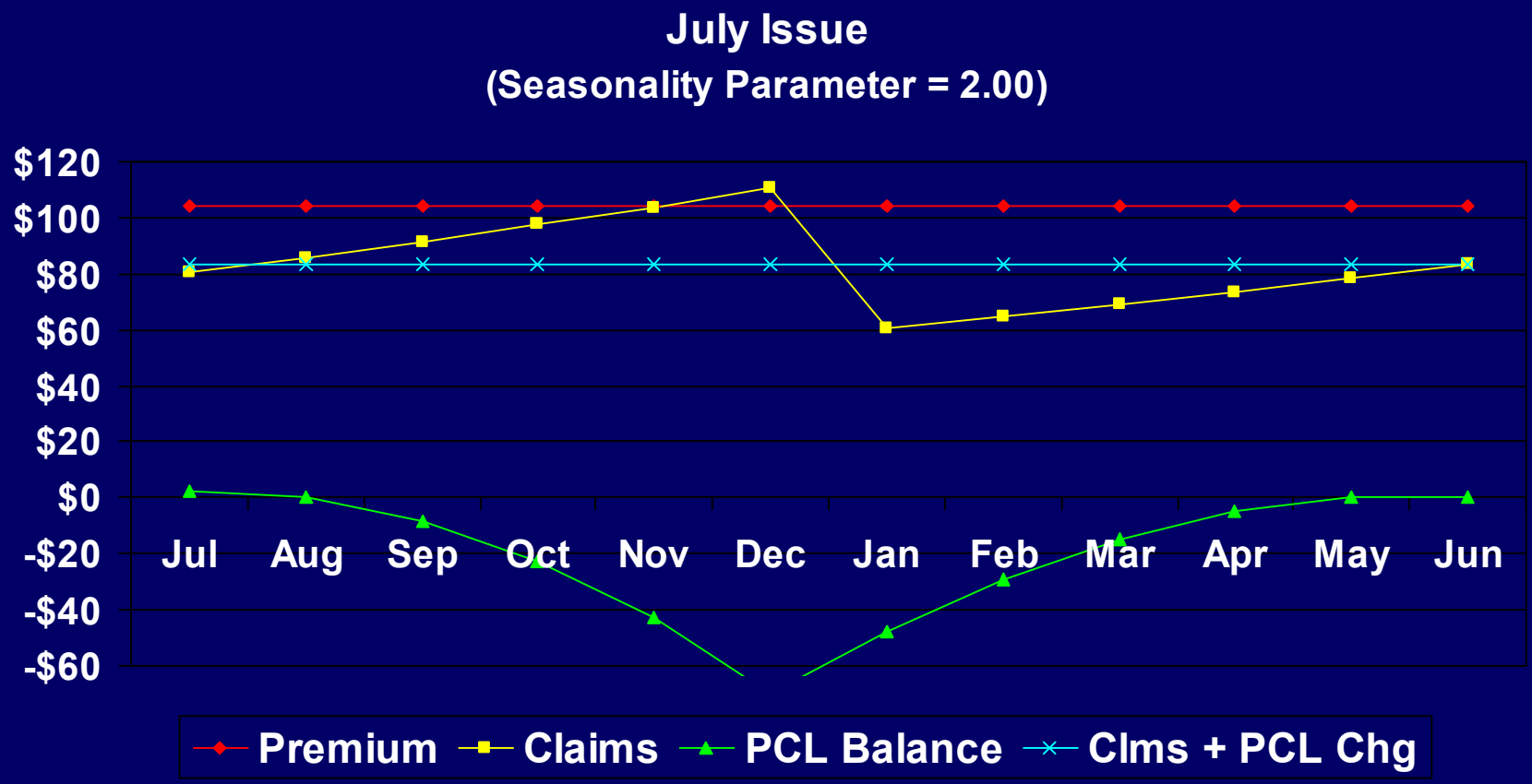

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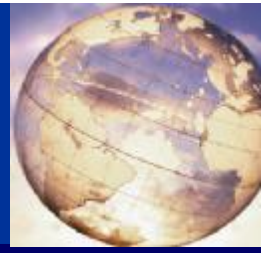

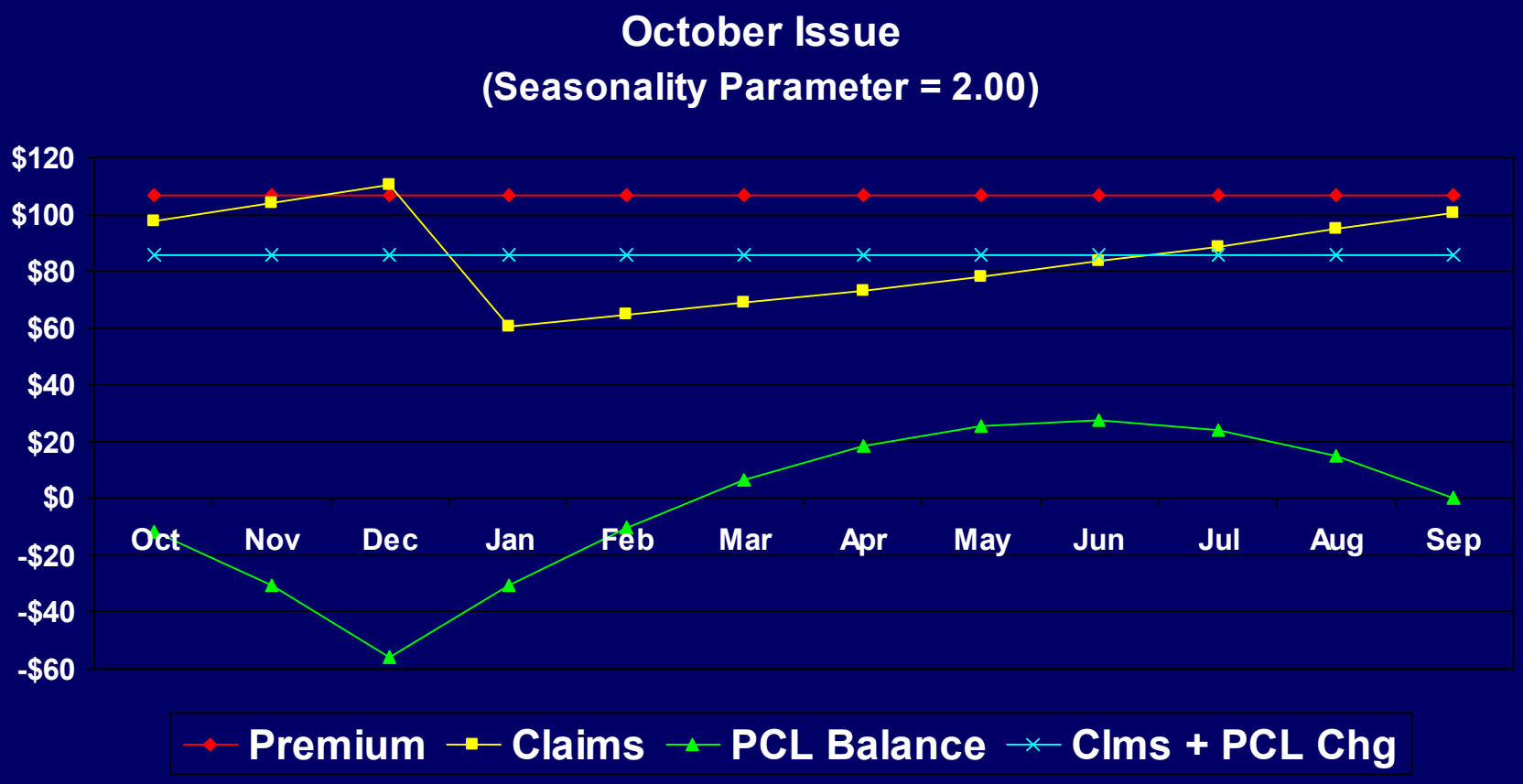

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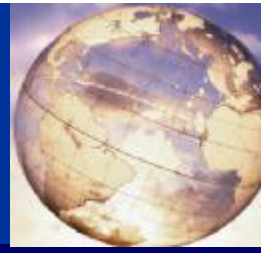

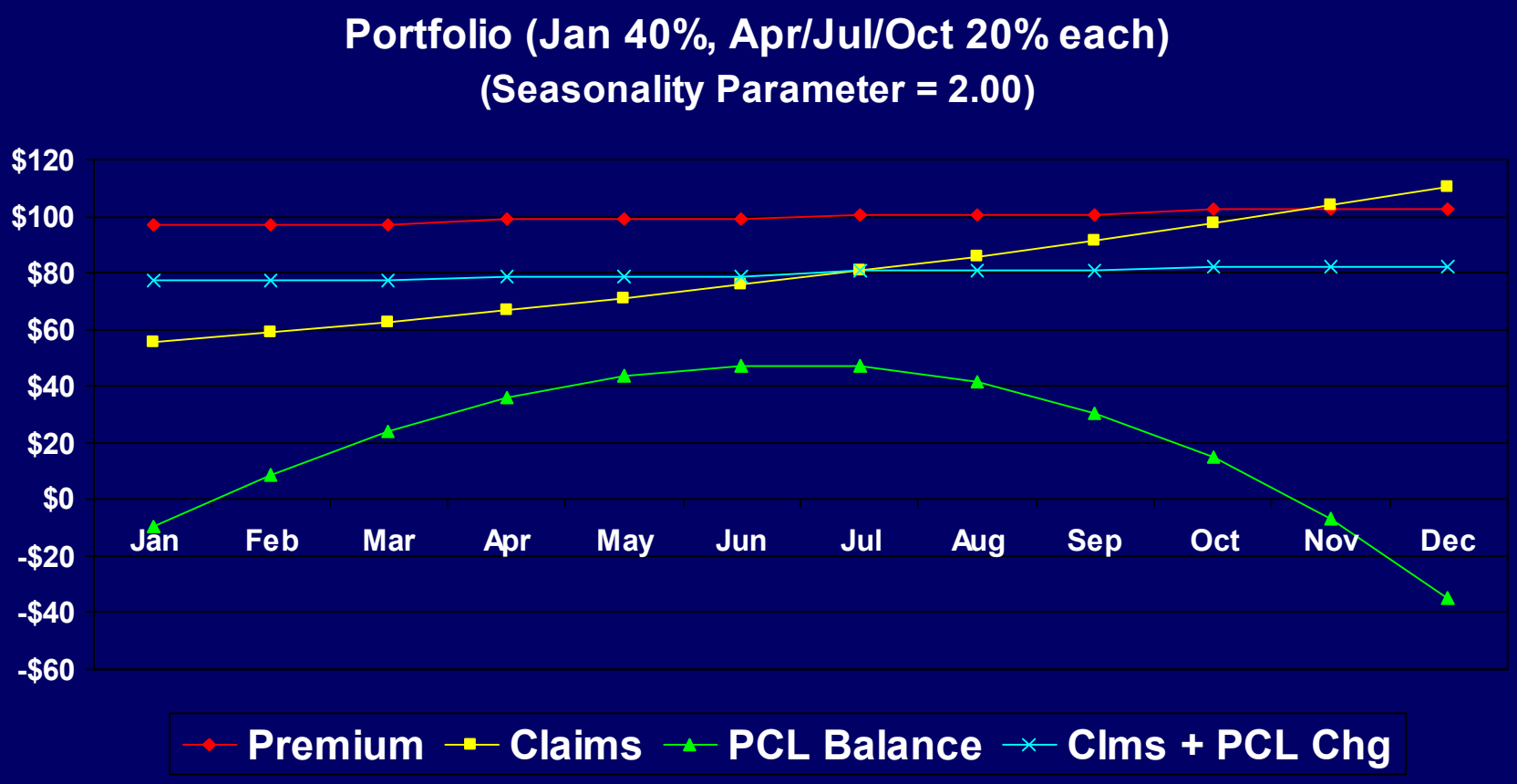

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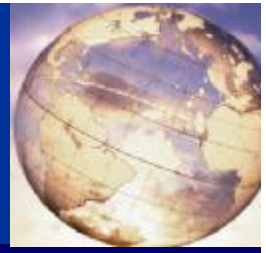

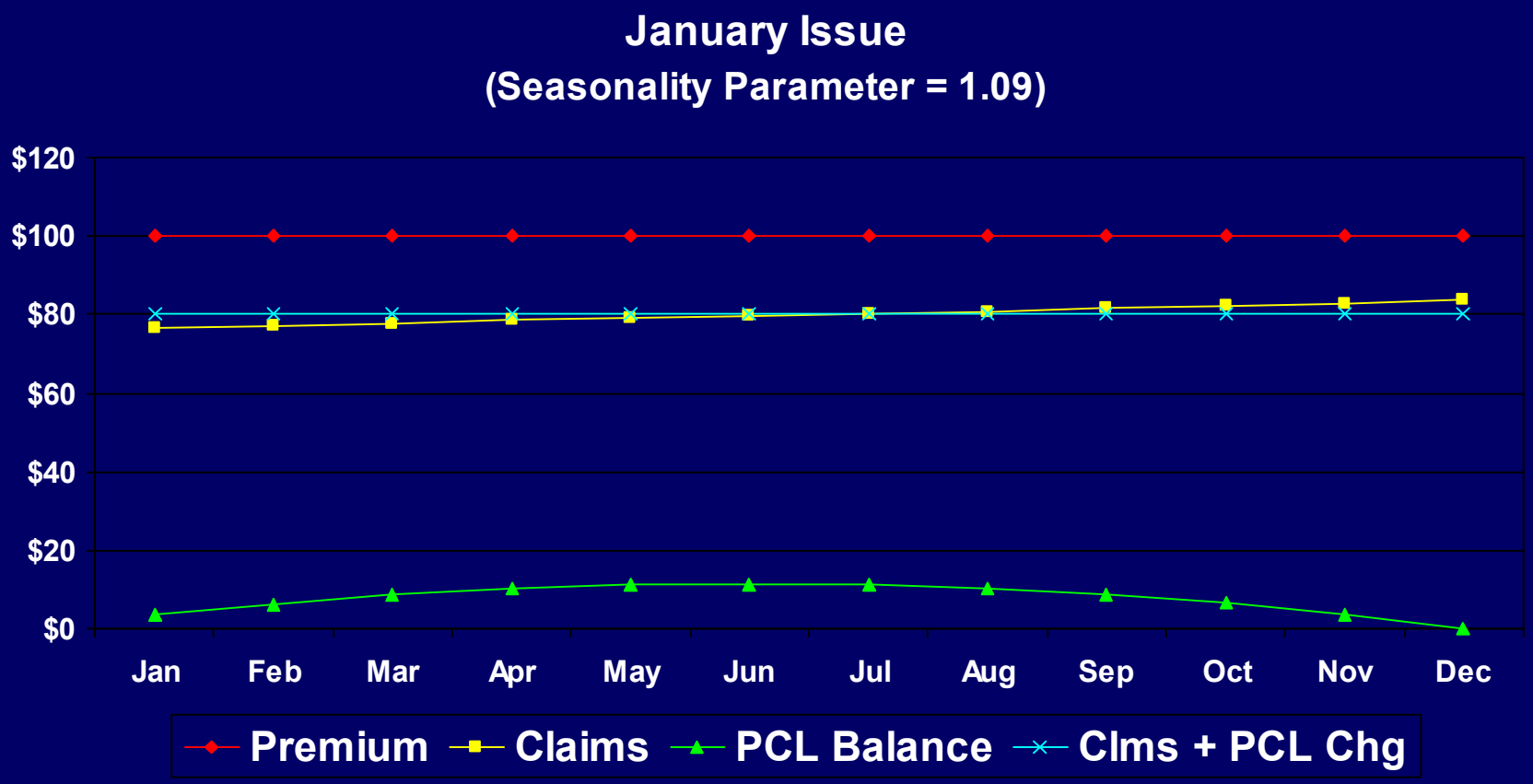

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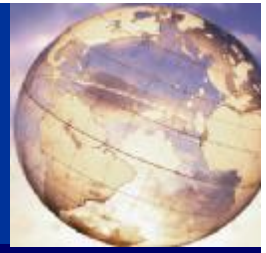

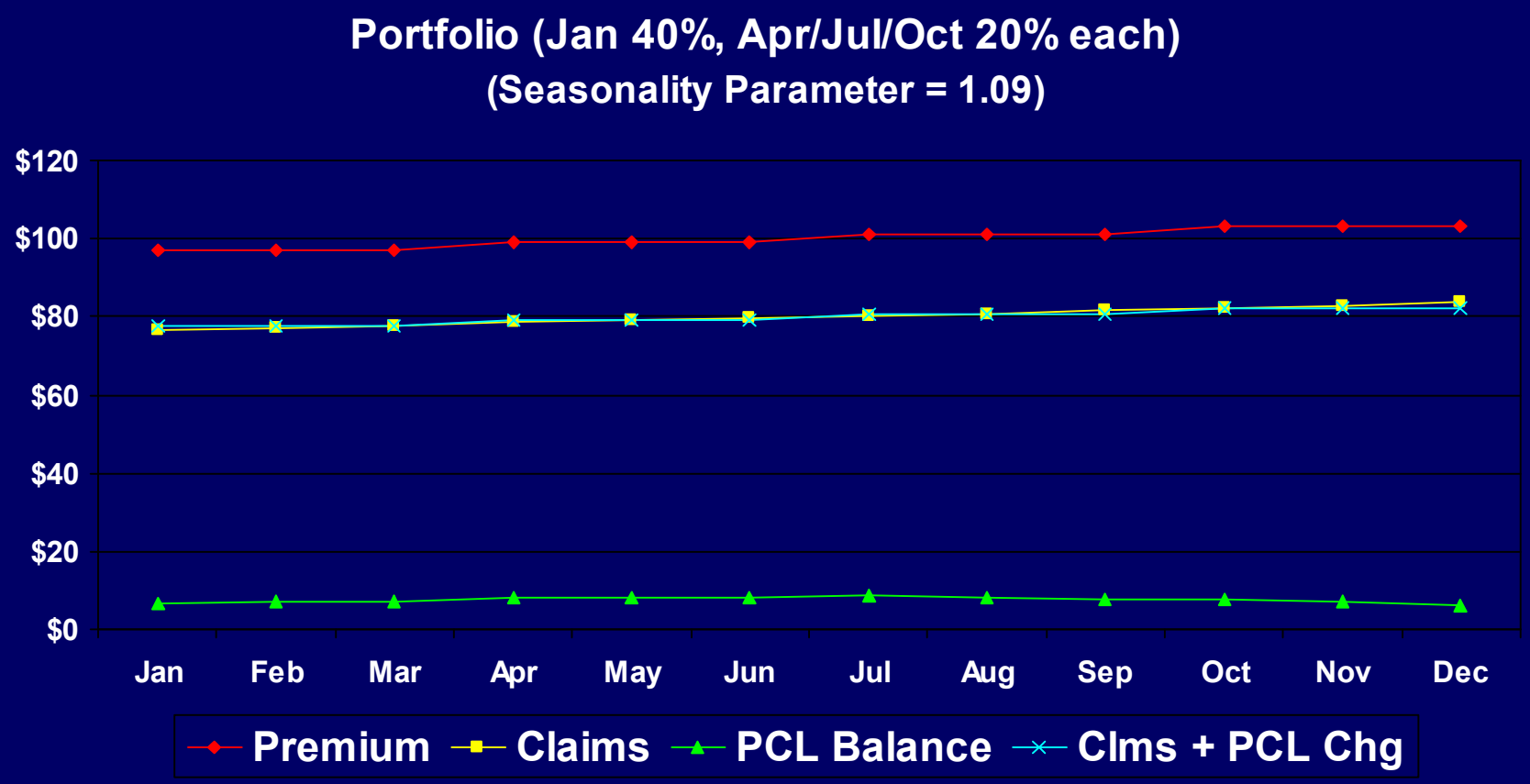

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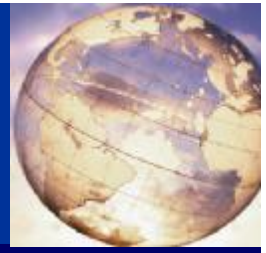

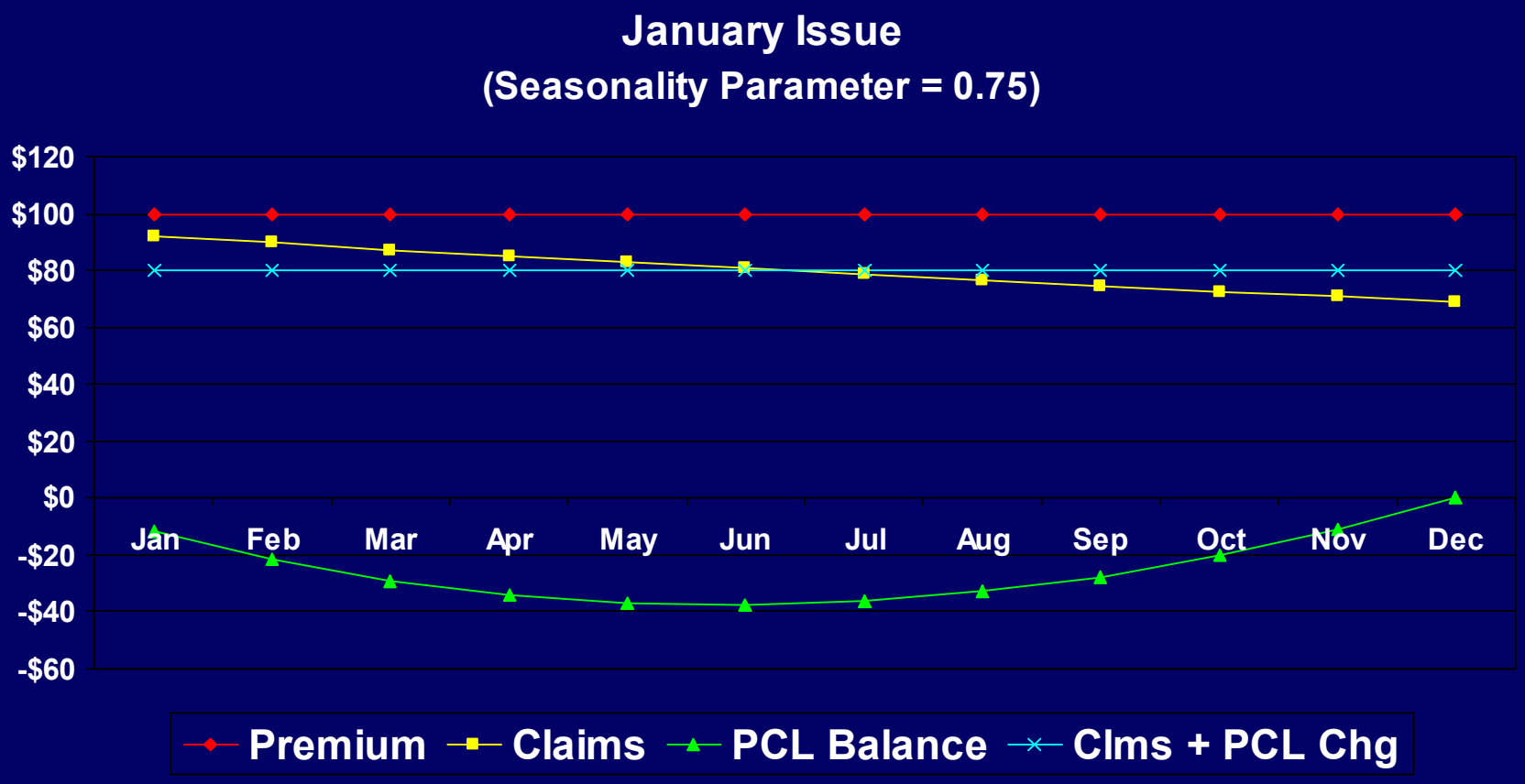

PCL Example