Medicare Advantage financial reporting: What accruals need to be considered?

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The Medicare Advantage (MA) line of business has been a means for carriers to diversify their products and for new carriers to enter the health insurance marketplace. Entering the MA line of business can be very exciting. Once the dust has settled from the application, bid work, and approval process, the open enrollment period soon begins. New members start to enroll, and a carrier must quickly consider and evaluate the need for many different accruals that must be calculated and held as liabilities and assets in the financials.

The need for accruals can begin as early as the year in which the MA bid is filed, depending on the projected gain/loss position that the carrier is expecting in the first few years. Therefore, it is necessary for the financial and actuarial teams to begin work on determining how such accruals will be calculated and the proper amounts that will need to be held. Additional accruals may also be necessary in future years, depending on the operations of the MA carrier.

MA ACCRUALS: WHAT, WHEN, AND HOW TO BEGIN?

Bid submission year (Year 0)

For many carriers, a loss in the first three to five years is typical because of high start-up costs, low risk scores, and membership levels that will not yet support the administrative costs. When a carrier anticipates that future years will result in losses for a line of business, it is prudent to consider whether a premium deficiency reserve should be accrued and if it should be done as early as the end of the first month of open enrollment. This is based on the National Association of Insurance Commissioners (NAIC) Statement of Statutory Accounting Principle (SSAP) 54, which specifies, when there is an expected loss, that accruals for premium deficiency reserves should be established, even if the contract year has not started.

In order to establish a premium deficiency reserve, the filed MA bid and any multiyear projections can be used as a starting point; however, there are adjustments that will need to be considered. The amount of losses will need to be adjusted to reflect the actual enrollment versus the projected enrollment that was filed at the time of the bid. Further, because the bid revenue does not reflect the impact of sequestration, the revenue will need to be adjusted to account for this impact. Any other new information developed or obtained since the bids, such as updated administrative costs and/or final provider/pharmacy contracting efforts, should also be reflected.

Contract year (Year 1)

Accruals not unique to MA business

MA is a health insurance product that offers consumers coverage of both medical and prescription drug benefits. As is the case with any medical and prescription drug product, certain liabilities and assets accrue as the product is purchased and utilized by members.

Typical liabilities and assets that will need to be calculated include:

- Unpaid claims liability for medical and prescription drugs
- Claims/loss adjustment expense liability
- Due and unpaid premium asset
- Unearned and/or advance premium liability
- Rx rebate receivable asset

Techniques used to estimate the above accruals are similar to those used for other lines of business that contain medical and prescription drug coverage.

Starting with calendar year 2014, the Centers for Medicare and Medicaid Services (CMS) requires a medical loss ratio rebate calculation for the MA line of business. Although the calculation is similar to that used for commercial lines of business, there are differences between the MA and commercial calculations, including the fact that any rebates are payable to CMS rather than to the members. If the calculation results in an estimated rebate to CMS, then a liability will need to be established prior to the rebate being paid to CMS.

Accruals unique to MA business

MA prescription drug coverage is referred to as Medicare Part D coverage. There are a few MA accruals that are created because of the unique benefit and program features of Part D. The estimation of these accruals can be determined from monthly membership reports (MMRs) and claims reports in the form of Prescription Drug Event (PDE) files that are provided by CMS. The required accruals are as follows:

- **Federal reinsurance:** In 2016, once members reach $4,850 in true out-of-pocket (TrOOP) expenses, CMS pays 80% of the costs. A monthly prospective amount is paid by CMS based on the filed bids; however, CMS will ultimately pay the actual amounts for these claims. However, until the reconciliation between the actual and bid amount occurs (in late summer following the contract year), a liability or receivable must be established in the financials.

- **Low-income cost-sharing subsidy (LICS):** Low-income members have some or all of the member cost sharing paid for by CMS, based on their income/asset level (including prescriptions filled in the coverage gap). A monthly prospective amount is paid by CMS, based on the filed bids. Any difference between the prospective payment and actual claims paid on behalf of these members is reconciled in full with CMS. That is, CMS ultimately pays for the reduced cost sharing for these members in full. However, until the reconciliation between the actual and bid amount occurs, a liability or receivable must be established in the financials.
- **Coverage Gap Discount Program (CGDP):** Members receive a 50% discount off brand name drugs in the coverage gap. A prospective amount is transferred to plans by CMS, based on the filed bids. Any difference between the prospective payment and actual claims paid on behalf of these members is reconciled in full with pharmaceutical manufacturers. Similar to how CMS pays the LICS and federal reinsurance, the pharmaceutical manufacturers ultimately pay the actual amount for these claims. However, until the reconciliation between the actual and bid amount occurs, a liability or receivable must be established in the financials.
- **Loss sharing (Risk Corridor Program):** CMS shares in the Part D risk with carriers. The 2016 risk corridors are shown in the table in Figure 1.

FIGURE 1: CMS PART D RISK CORRIDORS

	CY2016	
Actual Compared to Target	Part D	CMS
< 90%	20%	80%
90% to 95%	50%	50%
95% to 105%	100%	0%
105% to 110%	50%	50%
> 110%	20%	80%

Target = Risk-adjusted basic Part D claim costs in the bids

Depending on whether the above estimated Part D accruals are liabilities or assets, the amounts should be reported in the annual statement, as listed below:

For reinsurance, LICS, and CGDP liabilities/receivables:

- Liabilities should be listed on page 3, under Liability for amounts held under uninsured plans.
- Receivables should be listed on page 2 under Amounts receivable relating to uninsured plans.

For risk sharing:

- Liabilities should be included on the Underwriting and Investment Exhibit, Part 2D under Reserve for rate credits or experience rating refunds, which rolls up onto page 3 under Aggregate health policy reserves.
- Receivables should be listed on page 2 under Accrued retrospective premiums.

Note that the above references pertain to the Orange Blank Annual Statement. Similar placement would be used for carriers filing a Blue Blank Annual Statement.

After contract year (Year 2+)

Beginning in the second contract year, MA carriers may begin to realize the benefits of any efforts they have made toward risk score coding improvement. Carriers may consider holding an accrual to estimate additional revenue that is projected to be earned because of late diagnosis submissions that are part of the MA risk adjustment mechanism.

Even prior to the second contract year, there may also be some additional claims run-out that can positively impact the risk scores of members that are new to a MA carrier. This is due to normal claims diagnosis reporting for a member rather than from the carrier's own risk score coding efforts. If a carrier determines that it should hold an accrual for this, then it would do so in Year 1.

Summary

Entering a new line of business can be both exciting and challenging for the company. The actuarial and finance teams must consider new financial items and accruals specific to the MA program. For many of these accruals, the estimation process can be complex, requiring the processing of data according to CMS specifications, projections for the impact of incomplete data, and the incorporation of formulas specific to the MA program. In addition, because the impact of each item will not be known until at least several months after the end of a contract year, it is important for carriers to review and update the accruals as additional information becomes available. Consideration should be made as to any data that will be needed, the appropriate methods that should be used for the estimates, and the timing of when the accruals should be established. With careful planning, the financial reporting challenges of the new line of business can be minimized.

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