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Navigating the Decisions of Self-Insurance Financial Reporting

A primer for MPL carriers looking to new markets and for self-insurers

With the growth of self-insured entities, and as medical professional liability (MPL) carriers look to expand with new products and services, such as consulting services, Physician Insurer will offer some timely guidance for working in these new markets. Here, we present some expert advice for avoiding the major pitfalls in accounting for self-insured entities.

The speed of change in healthcare has amplified to an unprecedented rate. With healthcare reform, increased merger and acquisition activity, expanding regulatory compliance requirements, and continued downward pressure on reimbursement and margins, healthcare management is faced with difficult challenges and decisions on a daily basis. In addition to these and other issues, hospital and physician group practice management may also be concerned about increases in MPL insurance costs with the next renewal cycle.

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Self-insurance, in the form of a large retention program or a captive, has historically been used to help control total insurance expense. However, when you're focused on addressing day-to-day operating challenges, it may be difficult to stay up-to-date on the requirements for financial reporting of self-insurance, and the decisions about it you need to make. This article provides background, insight, and guidance into some of the core issues that come up frequently, in regard to financial reporting for MPL self-insurance programs.

What are the common program decisions in financial reporting?

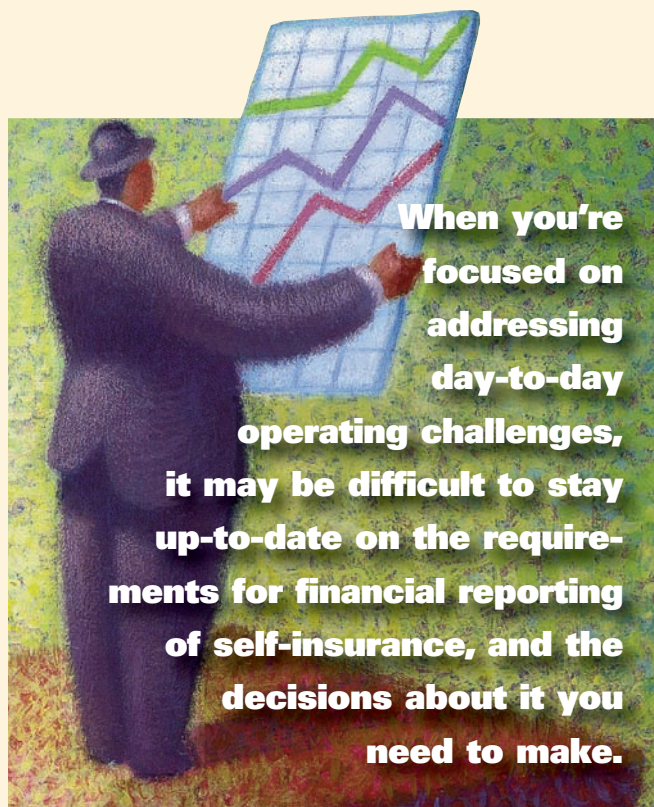
Many self-insured programs in the United States comply with the guidance and standards for accounting and financial reporting for MPL established by certain sections of the Financial Accounting Standards Board (FASB) Accounting Standards Codification (ASC). Programs with captives should ensure compliance with the guidance and standards that are generally accepted in the domicile of the captive.

Non-governmental healthcare entities should follow the guidance contained in ASC Section 954-450, Contingencies, while governmental healthcare entities should also consider the requirements of Governmental Accounting Standards Board Statement No. 10, *Accounting and Financial Reporting for Risk Financing and Related Insurance Issues*, as amended. In accordance with ASC Section 954-450, healthcare entities should accrue for the best estimates of the ultimate costs of MPL claims, including the amounts needed to litigate or settle such claims, when the related incidents occur, as of the reporting date, if the related loss is probable and reasonably estimable.

ASC 450-20-50 requires disclosure of the MPL contingencies that are reasonably possible to anticipate, but not accrued because they do not meet the recognition criteria of ASC 450-20-25-2, or because the exposure to loss exceeds the amounts accrued. The following text summarizes the current noteworthy topics.

Discounting. The American Institute of Certified Public Accountants (AICPA) Audit and Accounting Guide *Health Care Entities* (Audit Guide) permits, but does not require, discounting of MPL reserves. In order to discount an MPL liability: (a) the amount of the liability must be fixed or reliably determinable; (b) the amount and timing of cash payments for the liability, based on the healthcare entity's specific experience, must be fixed or reliably determinable; and (c) the expected insurance recoveries, if any, must also be discounted.

In addition, ASC 954-450-50 requires disclosure of the carrying amount of discounted accrued MPL claims and the interest rate(s) used to discount the claims. There is some diversity in the approaches used to select discount rates. Common among these are: (a) the return on investments used to pay the claims



expected to be realized over the period during which the claims are expected to mature; (b) a risk-free rate; and (c) the rate paid by highly rated corporate bonds with maturities matching to the average length of an MPL award payment. The selected discount rate(s) may need to be adjusted for the impact of expected changes in future economic conditions.

Percentile. While many companies outside the healthcare industry do not record liabilities with a contingency margin, it is not uncommon for healthcare entities to evaluate MPL liabilities at a percentile, such as the 75th percentile. ASC 954-450-25 indicates that the liability recorded is independent of funding considerations, which may include the adjustments needed to bring a funding requirement to a selected confidence level.

The definition of "best estimate" is not specifically provided in ASC 954-450-30, but it indicates that the entity should use all relevant information, including the entity's own historical experience, as well as the experience of the industry as a whole. The actuarial central estimate is often considered as the "best estimate," and does not explicitly include a contingency margin.

Gross vs. net presentation. In August 2010, FASB issued Accounting Standards Update (ASU) 2010-24, *Healthcare Entities (Topic 954): Presentation of Insurance Claims and Related Insurance Recoveries*. Effective for financial statements with fiscal years, and interim periods within those years, beginning after December 15, 2010, ASU 2010-24 requires that healthcare entities report MPL and similar liabilities on a gross basis, reporting separately any receivable related to anticipated insur-

ance recoveries.

While early adoption was permitted for this standard, many healthcare entities have only recently reflected the change in their financial statements. ASU 2010-24 reduces the diversity in practice related to healthcare entities' reporting of MPL claim liabilities and related anticipated insurance recoveries, and does a better job in reflecting the exposure of the healthcare entity to credit risk from the insurer: the healthcare entity generally remains primarily liable for payment of claims until the insurer makes payments. For most entities that have adopted ASU 2010-24, there has been no net impact on financial statements.

In October 2012, the AICPA issued four Technical Practice Aids (TPAs) that provide clarifying guidance for ASU 2010-24. These TPAs:

- Clarify that the guidance in ASU 2010-24 would apply to other contingent liabilities that are similar to those of MPL, such as workers' compensation and directors and officers claims
- Clarify that the adoption of ASU 2010-24 would not affect an entity's accounting policy for legal costs for contingencies other than MPL
- Address the presentation of insurance recoveries in instances when the insurer pays the claims directly
- Address accounting for insurance recoveries under retrospectively rated policies.

Accrual. Its managers determine whether a company will provide for self-insured losses, and, if so, how much, but adequate reserves must be recorded as of a specific financial reporting

date. The interpretation and application of an "accrual" varies in practice, according to the judgment of the healthcare entity's managers. A common application is the contribution amount (or expense provision) for the next fiscal or policy year of exposures. The new occurrence-year contribution (expense provision) minus total payments for the program during the year provides a quick estimate of the change in liability during the fiscal year. You can also think of an accrual as the change in unpaid claim liability estimates during the fiscal year. Similarly, you can also add the payments made during the year to the change in unpaid claim liability as a total expense. While the interpretations may vary by application, the core elements remain similar.

Other considerations. You may want to get some guidance from an actuary or auditor for booking a liability within a range and then determining the acceptable range, the impact of large losses in unpaid claim liability estimates, reconciling data, the degree of credibility you have in your loss development, and emerging trends. The managers of captives can also help in working through some of the particular requirements of a specific domicile, and even with on-site meetings.

How can you best ensure that the program is compliant?

The following practices will help in keeping on the right course toward full compliance in financial reporting.

- **Update the key parties whenever you make changes.**

Table 1 The Information You Need

Question	From Actuary	From Auditor
1	Have there been any significant changes in the guidelines for setting and reviewing unpaid case reserves during the most recent years?	Based on the ultimate resolution of claims, have your estimated case reserves historically been accurate?
2	Have there been any noticeable shifts in the reporting of large losses?	What processes do you use to ensure that loss data provided to the actuary is complete and accurate?
3	Have any significant changes occurred in the types and volume of services provided in recent years?	To what extent does the valuation of the liability rely on entity-specific versus industry experience? Is the entity-specific experience sufficiently credible?
4	Has there been any change in the structure of the program since the last evaluation (e.g., new entities or providers added to the program, changes in self-insured retentions)?	Are any of the entity's insurers experiencing financial difficulties that would indicate insurance recoveries receivable may not be fully collectible? If so, have appropriate allowances for uncollectibility been recorded against the receivable?
5	Has the discount rate or any financial reporting requirement changed since the last evaluation?	If liabilities are discounted, what is your rationale/support for the discount rate selected?

Frequent conversations are beneficial. At minimum, you should have annual conversations with the actuary and auditor. If changes occur, in either the program or your loss experience, it is important that all parties understand all of the program changes that have been enacted by management, as soon as possible. Table 1 shows some common questions.


■ **Create a checklist of requirements.** The best way to stay “on top” of the requirements may be to use a single source that lists all of the requirements and indicates when each is due. In addition, it may make sense to determine who will complete each task and to have a strategy in place for efficiently completing the task.

■ **Seek timely advice.** Guidelines are best interpreted by experienced professionals who have the skills needed to understand the current practices and communicate any change from the past. Auditors and actuaries make every effort to update management on a timely basis of any changes that would affect the financial reporting of the entity’s liability, but you can help out by proactively asking for advice for any changes you find out about.

■ **Request more frequent evaluations.** When a program experiences adverse or favorable loss activity or undergoes mul-

iple changes during a fiscal year, you can always ask for an interim actuarial study. You’ll need to determine your comfort level with the program’s current amount of activity, with the goal of reducing year-end “surprises.” Additional analysis may also be helpful during an audit.

■ **Obtain an outside opinion.** If you don’t have sufficient confidence in the current direction of the program, you can request a second opinion, from an outside actuary. This additional guidance will provide an unbiased, independent estimate or interpretation, and may provide confirmation of the program—or at least stimulate a productive discussion for understanding the underlying reasons for the differences.

There should be a plan in place for handling any changes in financial reporting during the year, whether due to changes in loss experience or updated accounting guidance. The benefits of a strong working relationship between a company’s managers, actuary, and auditor should not be underestimated. All three must work together effectively, and understand each other clearly, to add value and insight, and best meet the financial-reporting needs of the healthcare entity. 

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