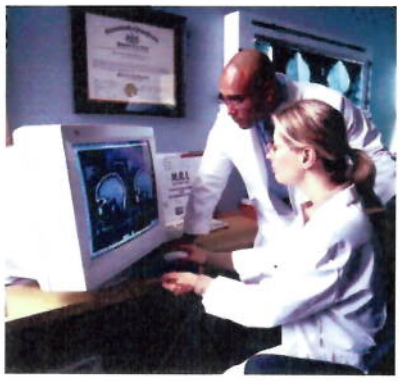
EXHIBIT 16



Recommended Surplus Range for CFMI: Approach and Considerations for Determining the Appropriate Range of Surplus in 2011

Prepared for CFMI

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June 24, 2011

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Executive Summary

The Lewin Group (Lewin) has been retained by CareFirst, Inc. (CareFirst) / CareFirst of Maryland, Inc. (CFMI) to calculate an assessment of an "appropriate" range of surplus (measured in terms of Risk Based Capital) that CFMI executives and leadership could consider in managing the company. Lewin performed similar analysis in 2009 for GHMSI, including 40% of CareFirst BlueChoice ("CFBC") and again in May 2011 including 50% of CFBC. The purpose of this report is to identify a surplus range, and to discuss the risks, unique market considerations, and other factors that Lewin has taken into account to calculate a recommended RBC range.

The Patient Protection and Affordable Care Act (ACA) has introduced pricing and regulatory restrictions and significant requirements and market changes to the operation of health insurance entities. The enactment of ACA changes the historical market dynamics upon which working surplus levels have been managed and regulated.

- Contribution to surplus has traditionally been created from retained earnings generated by a relatively narrow range of underwriting outcomes applied against a relatively stable mix of product segment offerings. Emerging markets over the next several years will require a new understanding of the potential mix among product segments and related opportunities for contribution to surplus.
- Changes in market/product mix will create discontinuities between historical experience and projections of anticipated cost. This greatly increases the risk of pricing errors and the resulting "down cycle" loss periods for which working surplus has traditionally been held.
- Changes in regulation and regulatory oversight, as well as new competitive market dynamics, will make the filing and implementation of corrective pricing actions less certain and less timely.
- The traditional cyclical process by which carriers recover from "down cycle" pricing errors through "up cycle" recovery has been altered. The Minimum Loss Ratio limitations and refunds effectively "clip" the upside potential for the carriers to apply favorable results to rebuild surplus levels. A good portion of the historical "up-cycle" contribution to surplus could be diverted to rebates.

We believe the passage of ACA will necessarily increase factors to be considered in setting working surplus needs. Since our GHMSI 2009 assessment we have essentially created another layer of simulation analysis. We have overlaid our working surplus models with microeconomic simulation of the financial impact of ACA-induced changes in both the dollar volume and potential risks associated with these newly shaped emerging markets.

Our analysis includes development of working surplus ranges based on current company financial information and interviews with company staff, as well as an assessment of the expected effects of ACA. As a broad categorization of our work, it is clear that health insurance markets will become much more complex and more uncertain. By definition, this uncertainty correlates with higher risks and therefore greater surplus needs. Retrospectively-based factor formulas such as RBC will need to be expanded to consider the impact of a redefined

marketplace when it comes to determining the need for working surplus – and potentially even for basic solvency measures.

Our Approach

The NAIC developed the concept of RBC to assist with the monitoring of insurers in order to be forewarned of potential insolvency. By designating a minimum solvency level known as the authorized control level (ACL), the NAIC created a standardized approach to insurance company monitoring. The development of the RBC and ACL gives regulators objective tools to monitor minimum amounts of capital needed to maintain financial viability; however, the RBC and ACL thresholds were not developed as tools for determining adequate or excess capital to be held by an insurer. Appropriate surplus must be held by an insurer to withstand the risks faced and to provide for capital needs that are above that which can be paid for with current earnings. The passage of ACA creates additional pressures on the pricing and administration of health insurance as well as shifts in the mix of business for which risk is being undertaken. Implementation of these changes will occur incrementally over the next several years and adds uncertainty to our financial models. This report describes the amount of capital or 'working surplus' needed to maintain and thrive as an insurance company.

We developed our range of working surplus by using a projection model which estimates surplus requirements specific to CFMI operations. The projection model uses the same broad categorization of risk as employed in RBC development, resulting in a range of risk outcomes.

The four categories of risk considered follow the RBC formula:

1. Underwriting Risk,
2. Asset Risk,
3. Cost of Capital and Credit Risk, and
4. Operational and Business Risk.

In addition to the risk categories listed above, surplus must also cover costs that maintain the insurer's business vitality:

1. Planned Capital Expenditures,
2. Anticipated Business Plan Changes,
3. Direct Subsidization of the Health Care Marketplace, and
4. Social Mission Philosophy and Obligation.

In addition to our working surplus modeling, we must now address the impact of ACA on both the dynamics and volumes of business insured by CFMI:

- We must consider significant potential shifts in the risk profiles and volumes of blocks of business being insured by CFMI. Members will move between products as Exchanges and increased subsidized Medicaid availability options are implemented. Every product segment may now represent a different risk profile and a different potential contribution to surplus from historical precedent.

- New underwriting and rating regulations will be developed in conjunction with ACA. These will alter both the nature of the resulting morbidity and the rating mechanisms by which surplus needs might be ultimately serviced.

In order to address these significant changes, we have employed a proprietary simulation model which reflects individual member reactions to subsidies, penalties, and regulations as they choose among a new landscape of product offerings. This is a simulation exercise which develops ranges of mix in volume and morbidity profiles for newly structured blocks of business. Some of this exercise can become almost circular – if the Exchange can capture a broad mix of risk, it becomes more attractive to even better risks. On the other hand, if this option becomes more anti-selective by individual and employer choices, the Exchange becomes less viable. Given the complexity, and current lack of clearly defined regulations, our simulation tends to be more scenario-focused and less stochastic.

We have employed our simulations to develop mix scenarios which might drive CFMI product risk mix and contribution to surplus opportunity – essentially a future-state product mix. These products are then subject to the same modeling of RBC metrics as we see in our surplus simulation modeling – but are now scaled by the volume of business and different risk profiles such market components exhibit.

Our modeling took these considerations into account and modeled them in the specific context of CFMI's business and potential business profile after ACA. Our previous surplus modeling considered historically similar Blue plans to verify the range of surplus fluctuations; however, with the changes in the marketplace due to the passage of ACA we felt that a historical comparison would not be useful.

Prospective Surplus Modeling and Model Results

The projection of CFMI experience was accomplished by estimating the underwriting losses and gains using Monte-Carlo simulation techniques. We also took into account the impact of trends, incurred claims, regulatory factors, investment income, expenses and changes in membership. Specific ACA-related factors include the disbursement of rebates based on medical loss ratio, limitations on rate increases, member movement, and exchange-related expenses. The model uses experience from previous years to determine future premiums charged to customers that results in cyclical experience, which is similar to what occurs naturally in the health insurance market, known as the underwriting cycle.

In order to fulfill its corporate mission, CFMI must be stable and strong financially. Adequate surplus is needed to enable a company like CFMI to ensure that the promises and commitments made can continue to be met. The results of our Monte-Carlo simulations were compared with two important RBC thresholds: 200% of ACL which results in a loss of the Blue Cross Blue Shield Association (BCBSA) trademark, and 375% of ACL, which results in early warning monitoring.

As noted in our modeling conclusions, the 375% RBC target is a critical benchmark. Having long operated under the BCBSA trademark, any concerns which erode subscriber and provider confidence in retaining that affiliation will seriously undermine the ongoing operations of the company. That erosion of confidence would make it all the more difficult for an insurer that falls below the 375% threshold to improve surplus levels and avoid further deterioration. As for the 200% threshold, it is the level at which a BlueCross and BlueShield Plan loses the use of the trademark. Moreover, an RBC-ACL level below 200% would bring into question the solvency of CFMI. The loss of trademark due to inadequate financial strength would likely be a catastrophic event: If the trademark were lost the remaining organization, and more importantly its Maryland subscribers, would lose the breadth and strength of the Blues' system. Product recognition, favorable reimbursement rates out-of-area, and current levels of service would be forfeited. Certain other financial opportunities would also be lost as a result, such as the ability to offer benefits to certain large national accounts and the access fees for offering CFMI's network to other BCBS Plans. Furthermore, removal of the trademark due to financial weakness would open the door to the entry of a replacement BCBS Plan, presumably one domiciled outside of Maryland.

Previous testimony on behalf of CareFirst (in Maryland and Washington DC) has discussed the importance of these thresholds for both GHMSI and CFMI. Specifically, the Invotex report, prepared on behalf of the MIA in 2009, has emphasized the importance of avoiding these crucial thresholds.

Our analysis gave us the recommended range of surplus, which is noted below.

CFMI's Working Surplus Range	Low	High
% of RBC Level	1,050%	1,600%

Conclusion

Results are based on our market simulation of product mix and subsequent surplus modeling. We conclude that an appropriate range of working surplus for CFMI to hold is 1,050% - 1,600% of the ACL. Our modeling indicates that CFMI is not currently holding an appropriate amount of working surplus.

Purpose of Our Analysis

Lewin has been asked to prepare a model of the "appropriate" range of RBC that CFMI executives and leadership could consider in managing the company. The purpose of this report is to identify a recommended surplus range based on the current and near-term prospective

health care environment, and to discuss the risks, unique market considerations and other factors that Lewin has taken into account to calculate the recommended RBC range.

Our analysis includes developing projected surplus ranges based on current company financial information and interviews with company staff.

Minimum Surplus Requirements Versus a Working Surplus Range

History and Limitations of the RBC Calculation

In the early 1990's, the National Association of Insurance Commissioners (NAIC) led the development of RBC standards to develop a formula-based measure reflecting the risks assumed by a Life and Annuity carrier. The result was the RBC Model Act. Health care insurers were not subject to many of the interest and investment matching risks of the Life and Annuity carriers. However, regulators were concerned about an increasing number of insolvencies among smaller health maintenance organizations (HMOs) and other health carriers. Additionally, regulators came to recognize that the nature of a carrier's contracts for the reimbursement of health care services, products offered, and general business operations introduced a fairly wide range of risks.

Recognizing the limitations of the original RBC Model Act when applied to health insurers, the NAIC developed the Health RBC Model Act in the late 1990's. The Health-based RBC calculations offer a standardized approach to developing a minimum solvency indicator, known as the authorized control level (ACL). This is a valuable metric because it is derived from, and included in, the NAIC annual statements. It provides regulators a consistent benchmark across a variety of carriers to take action based on risks as identified by a common formula. However, it is important to recognize that the formula was developed as an indicator of minimum acceptable surplus levels. In both its development and application, the RBC benchmark was developed and tested to provide regulators with an indication that an insurer's financial condition requires immediate monitoring and possible intervention.

Unfortunately, the fact that a recently computed RBC value is documented for each carrier offers a "common denominator" for comparison among carriers. Just as "months in reserve" or percent of revenue had been used to rank companies by relative levels of surplus, RBC-multiples have been used to develop broad rankings of financial strength. However, use of the RBC value for any measure other than as a regulatory minimum surplus is inappropriate:

- The RBC formula computes a static measure of currently required minimum surplus in the context of solvency requirements at a single point in time. It measures nothing with regard to issues of long-term solvency in connection with future cash flows or vitality and other surplus requirements connected with long-term management of the plan.
- The RBC triggers were modeled only in terms of the ability to suggest that a carrier might not remain solvent should surplus fall below a trigger level.
- The development of the RBC formula included no consideration of a specific multiple of RBC as representing either "optimal" or "excessive" surplus.
- RBC values were designed to be computed from a finite set of entries available in NAIC reporting formats. The exact allocation of some of the reported elements and applicable factors can vary from entity to entity based on business mix and possibly allocation and reporting judgments on the part of those doing the reporting.
- Both in creating a common formula, and selecting the appropriate RBC factors for the formula, compromises were made which allow the formula to provide an adequate

determination of potential insolvency. However, these compromises were at the expense of a generalization that may not reflect specific surplus issues for a given carrier.

As we move forward under ACA, challenges arise in the use of the RBC formula for assessment of working surplus requirements, and potentially even solvency applications. The formula is based on application of a series of multiplicative factors created from extensive modeling of historical variability in industry outcomes for certain risk elements. ACA will substantially alter these historical patterns from those on which RBC factor analysis was based. While the risk categorizations are still valid, mechanisms which drove potential variability will undoubtedly change. Eventually, formula factors catch up with emerging experience, but historically-based formulas will necessarily be challenged by increased uncertainty during a period of change.

This in no way detracts from the RBC measure as a valuable architecture for identifying problem situations which may require intervention from regulators. It merely suggests that while RBC measures may remain appropriate for identifying carriers with solvency problems, other metrics are more valuable for developing optimal working surplus targets. In particular, the precision of RBC factors as a predictor will be challenged in the face of ACA changes, and additional scenario modeling and potential conservatism is likely warranted.

Development of a Working Surplus Range

Given the limitations of the RBC in establishing an appropriate amount of surplus, we have employed an approach that is aimed at identifying a working surplus range. A working surplus range is defined as the surplus a specific insurer needs to maintain operations, and ranges are unique to an individual insurer and the market in which the insurer operates. Working surplus ranges can be developed by using a projection model which estimates surplus requirements specific to a plan's operations. The projection model uses the same broad categorization of risk as employed in RBC development, yet the end result is a quantification of the probabilities of a range of risk outcomes instead of a single factor to estimate the minimally acceptable surplus levels of the RBC formula.

Patient Protection and Affordable Care Act (ACA) Considerations

The passage of ACA will have many effects on the calculation of RBC, since ACA is transforming the historical business model for health insurance. There is still a good deal of uncertainty as to how regulations to implement the goals of ACA will ultimately be written, interpreted and enforced. Issues will certainly be resolved over the next few years, but a great deal of uncertainty exists in the current timeframe. Delays, modifications, and even wholesale changes, are very likely to occur. We can anticipate changes in products and operations stemming from the introduction of insurance Exchanges and Medicaid expansion. We have modeled and can extrapolate a variety of potential changes in behavior of consumers and providers as changing regulations and coverages affect these stakeholders. There is no clear single reliable projection as to these outcomes. However, it is possible to articulate a logical range of potential results. In terms of risk management and surplus needs, this range of outcomes, by their very definition, increases the uncertainty facing health insurers, and will restrict the insurer's ability to recover from adverse events.

Our model considers the following effects:

- **Medical Loss Ratio (MLR) limits:** If an insurer's MLR is below a certain threshold, the insurer is required to pay a rebate to its customers. This results in an asymmetrical risk profile for health insurers in that they have to pay rebates when there are financial gains but their ability to recoup losses is restricted. At the same time there is an increased cost of compliance with paying rebates, since ACA puts the onus on the insurer with heavy fines if the rebates are not administered correctly and in a timely manner. Therefore the MLR requirements in ACA increase administrative burden while intensifying pressure to constrain administrative expenses and premium rates.

- **More stringent rate review framework**: At the same time that there is an increased cost of compliance with many ACA requirements, there is a lessened ability to increase premiums to cover this cost due to rate increase approval processes and restrictions. Rate increases will be more constrained than they were previously, and we have reflected this in our model.

- **Increased trend risk:** Reform changes create entirely new mixes of morbidity and products for payers. This could diminish the reliability of historical trends as a basis for rate projections and further increase the odds of unfavorable material trend misses and resultant negative impacts on surplus.

- **Guaranteed issue and restriction on rating** in the individual market could result in gradual adverse selection of the individual pool over time. Guaranteed issue will increase costs if the individual mandate is not sufficient to effectively offset adverse selection. Restrictions on rating will cross-subsidize more expensive populations and further discourage healthy risks from purchasing products which they perceive to be overpriced.

- **Risk Adjustment** will attempt to offset adverse selection between carriers, however the methodology is not finalized at this time and therefore the result is increased uncertainty in the industry.

Risk Categories

In developing a working surplus range, we will follow the general risk categories used in the RBC formula[1]:

1. **Underwriting Risk.** This is the largest risk component creating surplus demands for health care insuring entities. Historical results, confirmed by an understanding of the general health care business model, show that surplus must be available to absorb potential multi-year adverse underwriting results

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1 The broad major categories of risk are addressed in the RBC formula and are therefore implicitly included to that extent in the historical comparisons of surplus held by other carriers. Underwriting and Asset risk can be modeled in a relatively straightforward set of scenarios. Operational and Business risks are more difficult to quantify, as they tend to represent low probability events, but with high impact. Part of the reason for establishing a working surplus range is to assure that some surplus might still be available under more common scenarios to cover these events.

- Surplus is required for maintaining solvency in the face of anticipated long-term fluctuations in underwriting results for health care operations.
- It is modeled in such a way as to reflect the unique underwriting characteristics and mix of business for the CFMI products being offered.
- Surplus requirements must also address non-routine catastrophic risks such as epidemics or natural disasters. Many of these non-routine risks can be categorized as "low probability / high impact" events.

2. **Asset Risk.** While the issue of matching assets to liabilities is not as significant as for life or property and casualty carriers, health care insurers face specific risks associated with their investments portfolio. Since health care insurer margins are relatively thin, investment income on accumulated surplus can be relatively significant.
   - Working surplus must be available to handle the risk of short-term liquidity requirements in the face of adverse cash flow.
   - Risk quantification must consider the impact of interest changes on investment contribution to surplus and on the value assigned to the assets which form the basis for surplus determination.
3. **Cost of Capital and Credit Risk**
   - Surplus requirements must consider the impact of solvency and cash flow issues stemming from contracts with health care providers, self-funded employers, and other vendors.
   - Surplus may have to absorb changes in the demand for capital expenditures and the cost of funding such initiatives.
4. **Operational and Business Risk.** Even "risk-free" products such as administrative services only include risks which surplus may be required to fund. Additionally, there are risks associated with the general business operations which may create adverse outcomes and resulting surplus drain.
   - Litigation costs,
   - Regulatory and Tax changes, including possible health care reform,
   - Dramatic changes in membership distribution between products,
   - Expense recovery as impacted by business and portfolio changes, and
   - Business recovery costs associated with natural disasters.

Determination of working surplus levels can be achieved by modeling these risks using the specific risk parameters of CFMI. The goal is to develop the probability of aggregate negative outcomes, and then, to establish sufficient surplus to weather these outcomes.

Vitality Considerations

In addition to the above risk-based outcomes associated with solvency objectives, a working surplus range must include an allocation of surplus required to maintain the vitality of an insurer's operations. These are not necessarily current liabilities, and may be somewhat flexible in terms of timing and scope. However, they characterize known future allocations of surplus

required to maintain a specific insurer's role in health care insurance and delivery. These vitality-related considerations include:

1. **Planned Capital Expenditures**
   - Capital must be allocated to specific known or anticipated business initiatives which require a long-term horizon for completion and funding.
   - These items are usually distinct from potential risk-based expenditures in that they tend to have very high probabilities of execution.
   - These expenditures are typically multiple year commitments and are usually too costly to be directly included as operating expenses in rate development for any single year. Most not-for-profit plans finance such large-scale expenditures from surplus and investment returns on surplus.
2. **Anticipated Business Plan Changes**
   - There can be significant long-term costs associated with product development required to react to market changes (e.g., operational changes to support consumer-driven health care).
   - In addition to administrative cost, competitive pressures can impact product morbidity levels.
3. **Direct Subsidization of the Health Care Marketplace.** Plans with dominant market share in regulated markets are often constrained in their ability to fully charge for their cost of services. This can take the form of either regulatory constraints or an inability of employers and individuals to accept sizeable increases. In such cases, there may be a known subsidy in terms of a difference between known costs and rates charged. This scenario is particularly true for certain types of BCBS plans, such as CFMI, which have large market shares within their respective markets.
4. **Social Mission Philosophy and Obligation.** BCBS and other non-profit plans tend to be more deeply involved in the overall social and economic aspects of their markets than plans with geographically diverse markets and relatively modest market share. These social mission obligations can go well beyond the more narrow concerns of a for-profit or geographically diverse health care insurer and in order to meet these obligations in the future, must be considered in analysis of working surplus targets.

Surplus Considerations for CFMI

Prior to modeling CFMI's target surplus level, we needed to first assess the risks and capital demands, discussed above, within the context of CFMI. CFMI, like all insurers, faces certain constraints and issues specific to its operations. Identification and quantification of these risks and capital demands are the determining factors in establishing appropriate working surplus targets.

Access to Capital

If CFMI is to remain competitive with their large commercial competitors, it must address technology and market initiatives with its own response.

One recent example was the needed large-scale update to computer systems used for CFMI administration of its insurance products. Recent market demands include improvements in technology to service new trends such as consumer driven health care products. Along with the rest of the health care industry, CFMI faces the need for additional investment to allow it to offer members medical homes, communications improvements, data to feed consumer reporting related to quality and access, and the internal analysis to keep track of the emerging operational and cost data.

Since CFMI lacks publicly-traded access to equity markets, funding for these initiatives places a demand on accumulated surplus and future gains from underwriting and investment. Even with the exception of "up-cycle years", market constraints limit the margin in rates available in any given year and thereby limit funding for these capital investments – even over a multi-year period. Therefore, working surplus targets must include the need for such capital investments as a means of spreading the cost over longer periods.

CFMI and GHMSI also operate under an intercompany agreement which is intended to facilitate the movement of funds between entities subject to regulatory approval. However, while such transfer mechanism is theoretically available, there is substantial uncertainty as to whether this transfer would be allowed given the separate regulatory bodies involved.

Economic Concentration Issues

Due to its geographical market limitations, CFMI faces more concentrated economic risks than its geographically diverse competitors. Since the timing and depth of problems in a local economy can vary from region to region, geographically diverse carriers have some ability to shift marketing emphasis to weather a local downturn.

The ability of CFMI to raise rates or sell new business can be significantly undermined by a downturn in the local economy. Such downturns are doubly damaging, since they are typically associated with poorer investment returns. The contraction of the economy reduces the number of new employees being added to accounts and can often cause insured businesses to fail or drop their coverage. These lapses can increase overall claims cost morbidity as young healthy members are terminated, exactly at the worst possible time to increase rates.

Regulatory and Legislative Issues

Maryland law requires CFMI to pay premium taxes equal to two percent of premiums or, in lieu thereof, provide community benefits equal to such amount. CFMI generally meets or exceeds the Maryland requirement through financial support of community benefits programs rather than direct payment of premium taxes.

Business Risks

All insurers face certain business risks in terms of changes in contractual relationships and risks being insured. In addition to the general potential business risks, several specific situations can be identified which might require a call on surplus while CFMI adjusts to a change in these risk arrangements.

Federal Employees are covered under a unique arrangement.

CFMI is a participant in a consortium of BCBS plans contracting with the federal government to offer benefit options to federal employees. The current CFMI program involves rate stabilization reserves with sufficient backing to render this a relatively low risk business. However, it consequently offers lower margins and therefore means that CFMI cannot generate needed surplus on half of its revenue. This program represents about 50% of CFMI's annual revenue and would clearly be a major shift in risk if contractual changes were made. When comparing results against other plans for either surplus levels or the ability to quickly generate needed contribution to surplus, the Federal program impact needs to be factored into the assessment of CFMI.

Several situations regarding this program represent more unique risks, but are nonetheless issues which must be considered in CFMI strategic and surplus planning:

- Events triggering a loss cycle for CFMI will typically impact other carriers, and usually most of the BCBS plans providing coverage for FEP. In cases of significant plan losses due to trend pricing misses, the ability of the collective risk stabilization reserve to spread losses across plans will be jeopardized and CFMI may actually have to fund losses from surplus.
- The FEP program is often quoted as a baseline for reform initiatives. Any changes to the program – whether as an expansion by extension to new members or some other restructuring – represent a potential change in RBC status for CFMI. We did not consider these specifically, but most scenarios would represent a demand for higher surplus without any mechanism for funding such demand in the short term.
- CareFirst provides services for the administration of the entire FEP program for the coverage consortium. CFMI and its sister companies enjoy a favorable administrative expense arrangement through this plan by spreading general expense overhead as well as certain systems technology costs. The administrative arrangement may be revoked by the Blue Cross Blue Shield Association (BCBSA) if CareFirst should lose the BCBS trademark or fail in certain other service standards. These again represent issues that must be addressed in setting working surplus targets because they represent singular, but still potential, high-end surplus drawdown scenarios.

Investments and Pension Obligations

CFMI's surplus serves to meet the company's RBC requirements. The investment of these funds provides an important additional source of revenue for the organization, returns on invested assets. CFMI's investment portfolios are a key contributor to its surplus stability and cash flow; however, in economic downturns it can further exacerbate the organization's losses. Investment decisions are implemented by Management as directed by the Board's approved Investment Policy which is also used for other CareFirst entities.

CFMI maintains an extremely conservative asset allocation, predominantly holding investment grade bonds.

CFMI continues to be exposed to potential downturns in equity markets and further downgrades within fixed income securities that could result in material realized losses through Other Than Temporary Impairment (OTTI). Lower bond and dividend yields could reduce projected investment income that has traditionally been used to offset premium rate increases in its various products. Furthermore, market declines could lead to additional funding requirements of the pension plan.

Surplus Ranges in the Context of Prospective Modeling

To prospectively model CFMI's working surplus range for CFMI management, we employed an actuarial model which uses the same broad categorizations of risk as employed in RBC development. However, the end result is a range of surplus outcomes rather than a specific minimum threshold.

In this case, we began with the pro-forma projections CFMI employs to develop budgets. The model focuses on a multi-year projection based on a number of input variables typically used by actuaries and underwriters to model most likely financial outcomes. In many cases, unforeseen events or trends emerge which vary from these projections. Depending on the triggering event, these variances can range from minor to quite extreme.

Model Characteristics

One of the most significant surplus requirements is related to underwriting risk. This demand on surplus can be approximated by the amounts required to absorb accumulated underwriting losses during a multi-year loss cycle. These loss cycles are actually cause and effect outcomes of the dynamics of pricing reaction to a triggering event. Therefore, our stochastic model is designed to develop a probability-weighted set of outcomes resulting from such triggering events based on the mechanics by which CFMI must rate its business.

Our model develops an estimate of income statement underwriting gains and losses, since this is the major component of CFMI's contribution to surplus. Some of the variables and operational elements employed in our model include:

1. **Impact of Trend Estimates**. Differences from projected estimates of anticipated cost trends are the substantial contributor to the development of future losses or gains. As described above, the combination of the length of time to recognize an error and to implement changes tends to create a multi-year impact.
2. **Incurred Claims Estimates**. Since incurred claims estimates are based on projections from historical data, differences between projected unpaid claims liabilities and the ultimate payments made against those claims are commonplace. Such misstatements of the liability do not create an absolute loss in the context of a multi-year cycle. The understatement or overstatement in a given year is a timing issue which distorts earnings by year, but does not misstate them across several years. However, the estimates also form the basis for an understanding of incurred claims levels used in pricing decisions. Therefore, an error in unpaid claims estimates will directly impact the projection of subsequent costs used for pricing. The need to complete claims is therefore a very common cause for a delay in recognizing changes in emerging cost trends and resultant pricing mismatches.
3. **Unique Morbidity Events**. CFMI faces the potential of significant increased morbidity due to influenza or other large-scale disease outbreaks. Such episodes offer low probability, but high-cost, impacts that one would not typically load into projected costs used in pricing. These are also difficult to model, since it is difficult to assign a probability of occurrence or dollar impact. One aspect of choosing a confidence level for

targeted working surplus is to make certain that appropriate consideration is given to the very real impact of such low-probability / high cost events.

4. **Regulatory and Marketplace Limits**. The ability to charge targeted rates can come into play when projected cost increases exceed the ability to effectively recover these costs. It has already been announced that regulators will be expected to create additional review of "excessive" rate increases exceeding 10%. This suggests a pre-disposition against what might well be reasonable increases based on experience. Additionally, churn in the market/product mix will likely require adjustments to historical experience. Such adjustments make rate development less transparent and more subject to review.

5. **Investment Income.** We used current surplus levels as our starting base and increased or decreased surplus by any investment income produced by the asset mix underlying the organization's Corporate Investment Portfolio at its anticipated rates of return for each year. To the extent that our model simulates an underwriting loss in any given year, investment income (if greater than the underwriting loss) is reduced to offset the loss. If the underwriting loss exceeds the investment income, surplus is reduced to offset the excess loss. As such, returns on investment assets are based on the net assets in any given year. Since we do not believe the current economic recession will persist materially into our projection period and asset earnings yields are slowly returning to their long-term historical averages, we did not attempt to make investment return a stochastic variable in our model. Instead, we have assumed CareFirst's Corporate Investment Portfolio average rate of return will be based on a CareFirst dollar-weighted average of each asset classes' historical average rates of return. In light of this assumption, we did not attempt to project write-ups, write-downs or Adjusted Funding Target Attainment Percentage (AFTAP) pension adjustments resulting from unfavorable rate of return scenarios; however, in actuality those events may still occur. We did test and incorporate dynamic return scenarios in developing our estimate of working surplus levels.

6. **Expenses.** We used current expense loads as reflected in pricing as well as projected capital expenditures which have recently been reduced as a result of the completion of an IT systems updating project. We did not reflect income tax as an expense since our focus was on underwriting losses and their impact on accumulated surplus.

7. **Membership.** Based on discussions with CFMI management and Lewin's microsimulation of the health care marketplace, we have accounted for expected shifts and additional uptake in health insurance due to ACA. Our modeling includes the effects of subsidies to lower-income individuals and mandated coverage requirements on the underlying population of the CFMI service areas. Underlying populations are estimated using various census data, with migration from traditional coverage to newer, subsidized coverage plans for those who qualify, such as plans offered through the health care exchanges. We also consider the current trend from more traditional plan designs into higher deductible consumer directed health plans. The RBC calculation is to some degree scalable and is expressed as a percentage of current volume values. This makes the growth in membership a less critical assumption.

Most significant in setting working surplus ranges are potential underwriting losses. In general, this risk is categorized by a mismatch between the claims costs incurred by insured

members and the plan's ability to charge a rate sufficient to cover this risk. Clearly, if the carrier can achieve matching of rates to expense then there is no drain on surplus. In fact, most health care rates are established with a goal of achieving margin as contribution to accumulated surplus. The exact matching of projected claims costs to those realized, however, is seldom precise. Most of the rate a plan charges its members is used to pay for medical and drug claims. CFMI employs as much analysis and insight as available to estimate future claims costs. However, actual claims costs will almost always show some degree of variation from those expected. The causes are common to all insurers:

- Unanticipated changes in the cost of services as billed by providers;
- Increasing variability in cost per service – driven by new treatments and technologies; and
- Variation in the frequency in which members seek these services.

However, results can vary greatly due to the extent to which each of these factors and their multiplicative impact has been shown to change over time. Quite often, the cause for the variation is simply not something which CFMI could foresee early enough to factor into projected rates.

Cyclicality

Historical underwriting results for most health insurers have been somewhat cyclical, characterized by several years of gains and then several years of losses. For many years, collective underwriting results across the health insurance industry showed such a steady three-year "underwriting cycle" that they were treated as if automatic. This actually confuses cause and effect – ignoring the fact that a commonality of pricing methodology and marketing actions in response to changes in risk and cost actually created this cycle.

One of the fundamental tests of surplus adequacy is therefore the ability to weather the period of financial down-turn periods until such time as gains can be accrued to maintain financial solvency. Unforeseen events that create a mismatch between pricing and claims costs are additionally somewhat cyclical themselves. The overall business economy impacts the revenue providers feel they must generate and the perceived ability of employers and members to pay increased rates for coverage. Such changes in economic cycles are typically multi-year events. Similarly, new technology, drugs, and treatments tend to roll out gradually often raising the cost to a new plateau rather than having a quick impact. Claims cost changes tend to have a multi-year impact rather than a one-year variance.

The actual processes of analysis and implementation in health care insurance pricing in reaction to the above changes in cost actually explains the second major contributor to this historical cyclicality.

1. **Historical Data and Analysis Lag**
    a. The insurer's primary basis for projecting future costs for a block of business is their own emerging experienced PMPM cost trends. This can be adjusted for anticipated changes in cost and utilization based on benefits and contract negotiations with providers. Such adjustments, however, are judgmental and must include potential

changes in morbidity due to aging and/or lapses, as well as the members' response to the anticipated changes.

b. To make emerging PMPM experience trends as current as possible, the analysis must include an estimate of unpaid claims (IBNR). This recognizes the delay between the incurral of a claim and the date it is actually processed and paid. Unless this estimate is included, the recognition of emerging trends based on fully incurred claims is delayed by an additional 3-6 months. However, the addition of IBNR is again judgmental, and actually somewhat circular. The most recent months in most IBNR estimates rely on PMPM trend estimates, which are the near-term goal of the trend-setting exercise.

c. Identifying a shift in emerging fully incurred PMPM costs can be difficult. PMPM claims costs often exhibit seasonal patterns, random fluctuations, and shifts in the underlying morbidity of the membership exposure. All of these can obscure the true cost pattern developing. In general, pricing trends are established by attempting to understand the emerging patterns and determining if they can be projected to future periods.

2. Recognition and Movement to Action

a. Given the above uncertainties, insurers may often detect a potential shift in cost but may not be ready to act immediately. Future rate increases are somewhat limited (or at least made more difficult) by new regulations in ACA, and will not typically be taken by the insurer until they are fairly certain there are not statistical problems or temporary spikes.

b. Even if relatively confident of an emerging trend, new rates are only as achievable as the insurer's ability to convince regulators and clients of the correctness of the estimate. An insurer might feel it is necessary to raise rates, but if no other carriers are raising rates or if the employers do not perceive the change as valid, most insurers have been forced to modify or defer the increase. This is one reason why such downturns in results impact the entire health care sector.

c. Significant changes in rates may not be possible. If the claims cost change is dramatic, the resulting increases in rates may be larger than the employers can handle on short notice. Very large rate increases can actually be counter-productive. If the increase is large enough, many clients will seek other insurance carriers in hopes of cheaper or more manageable increases, especially with the insurance exchanges to be operating in 2014. Among smaller employers and individuals, the choice may be to drop coverage altogether, or seeking less costly coverage on the Exchange. Besides lowering the overall revenue, many times the members lost are actually the healthy insureds – as they can go without coverage although they would have to pay a penalty under the mandate requirements.

3. Implementation of New Rating Assumptions

a. Rates are most commonly increased on a contract effective date for each client under a 12-month rate guarantee. Full implementation of new rate levels therefore requires waiting until all the clients have come to their renewal date. With the need for notification of new rates, and sometimes regulatory approval, it can commonly take

18-24 months to complete the process going from the determination of new rates to complete implementation for an entire block of business.

b. Given that the events causing increases in claims costs are typically multi-year phenomenon, the above cycle of analysis-recognition-implementation may actually be underway for the currently anticipated cost level while a new, higher cost level is still emerging.

Surplus is required to weather the losses created by the above processes. The sequence of pricing error, recognition of an event, action taken, approval, and implementation creates a sizeable delay between the occurrence of an event or shift in cost and full implementation of rate changes in response. As a result, precedent has shown health care insurance losses experienced in a given year are most often followed by even deeper losses in the second year as rates are being adjusted. If the events triggering the losses are fully appreciated, and not compounded by another unanticipated cost increase, some reduction of losses begins in the third year as rate increases take hold.

While not guaranteed, it is clear that underwriting cycles do not "just happen", but are caused by the collective pricing actions of the marketplace in response to unforeseen events. Most importantly to our exercise in establishing appropriate working surplus targets is the recognition that these multi-year earnings troughs constitute one of the primary drains on an insurer's accumulated surplus level.

Far from eliminating the causes of cyclicality, ACA actually creates incentives and mechanisms that are likely to deepen and lengthen loss cycles. The above mechanisms are actually deepened and lengthened:

- New subsidies and penalties, expansions of Medicaid, and the introduction of Exchanges will alter the future insurance pool compared to the historical mix of insured members and morbidity. This makes traditional historical cost analysis a much less reliable predictor of future costs and therefore greatly increases the potential for an error in estimating emerging experience for pricing.
- The entire process of determining liabilities, detecting trends, and determining causality is challenged by changes in the underlying risks and historical run rates.
- Once established as an emerging trend, the historical nature of trend projection and rate justification will be more complex with carriers having difficulty generating unequivocally convincing analysis to convince regulators of the need for an increase.
- New players and new programs will expand the marketplace, but also create potential for a less efficient market. The ability to implement increases for emerging costs may well be dampened while the rest of the market achieves the same understanding.
- The opportunity to apply "up-cycle" gains as contribution to surplus will be limited by the MLR/Rebate aspects of ACA.

Modeling Trend Assumptions

It is important to note that the "trend miss" which triggers such loss cycles is really a function of the differential between the current pricing trends and the potential trend outcomes. We have therefore modeled our scenarios on current CFMI pricing and anticipated trends. In reviewing current CFMI trends, however, we have noted certain local market conditions:

- Trends used in this exercise are "net trends" and cover all services. This means they are impacted by changes in member cost sharing – also referred to as "benefit buy-downs". This temporarily reduces the unit cost component in the plan trend by shifting some of that cost to the insured.
- A number of the trends used in this modeling exercise appear low compared to expected market averages because of what we believe had been significant benefit buy down. This has modeling implications because such increased cost sharing cannot continue over extended periods and will eventually result in a resumption of expected trend levels when underlying trends reassert themselves.
- Other products exhibit somewhat higher trends due to "trend leveraging" or "deductible leveraging". As the average benefit content of such products reflects greater member cost sharing, the base cost against which overall medical trend is applied declines. Additionally, the numbers of members satisfying a given higher deductible level increases and more members reach maximum out of pocket limits. In these plans, it is common to therefore see plan-specific trends which exceed the secular average trends.
- CFMI provided trend data including medical, dental, and vision components. We have made the general assumption that the mix of these various business components will not change.
- Net trends were simulated assuming a "random walk" with a mean-reversion process. A random walk is a mathematical formalization of a trajectory that consists of taking successive random steps, also known as Brownian motion. The random walk is used in simulating net trends based on the assumption that trend rate changes are independent of one another. Mean reversion can be thought of as a modification of the random walk, where trend rate changes are not completely independent of one another but are related. Mean reversion assumes that the net trend rate will continue to return to an average value over time, despite fluctuations above and below the average value. We assumed the average net trend rate value over time, and its associated volatility, are consistent with the historical average annual trend rate produced by the private component of the national health expenditure amounts. In addition, we assumed a speed of reversion factor (i.e., the speed in which the simulated net trend rate returns to the average net trend rate value) that is consistent with the historical values simulated from the national health expenditure annual trend rates.

Modeling Underwriting Outcomes

Our model produces underwriting gains and losses over a typical underwriting loss cycle based on stochastic modeling of potential outcomes associated with various percentile levels. We chose to focus on outcomes at the 90th and 95th percentile level.

Since underwriting risk is a dominant factor in both RBC and working surplus targets, we examined the outcome of our model against historical results. Below we discuss our retrospective analysis which analyzes surplus needs of other Blue plans since 1992.

One would assume that a prospective actuarial model, having properly reflected CFMI business dynamics, would produce outcomes that are explainable in terms of historical results. Model

results which are consistent with prior industry experience tend to validate the general reasonability of the modeling exercise. The model produces outcomes which reflect a loss cycle of approximately 13% of revenue at the 90th percentile of all outcomes, and 18% of revenue at the 95th percentile, which is similar to the historically observed results of other Blue plans' experience.

The specific historical loss cycles experienced by CFMI since 1980 include one cycle that is more severe than we have recommended in our working surplus target range, which occurred in 1986 and was approximately 25%[2]. Therefore, the working range will not cover every conceivable threat to CFMI's solvency, which is why it is imperative to be able to react to a fall in surplus and to try to maintain surplus toward the middle of the working range. The model variables and mechanics were designed independently of CFMI's historical cycle data, and we believe that this model provides a less biased range than relying on historical loss cycles.

Credit and Asset Risk

Investment decisions are implemented by Management as directed by the CareFirst and Affiliates Board's approved Investment Policy, which is also used for other CareFirst entities. CareFirst's Corporate Investment Portfolio contains a significant investment in fixed income vehicles (e.g., investment grade bonds) and the balance in equities, convertibles, and cash-or-cash equivalents. While not subject to the risk of "matching" against benefit obligations as in life insurance products, CFMI surplus levels will be impacted by a change in asset rates of return based on the market values of the invested assets. We have considered the potential impact of interest rate changes on assets and surplus generation when setting our targeted working surplus.

For purposes of this analysis, we have not included specific credit or cost of capital impacts as a modeling issue. However, we have included their potential impact as a factor when choosing an appropriate level of confidence in our targeted working surplus.

Business Risk

Some catastrophic and related business risks are reflected in the medical expense projections discussed above. Other risks, such as litigation and business changes can again be considered to be low probability / high cost incidents. As such, they are best reflected by using conservatism when finalizing targets in terms of confidence ranges.

Capital Expenditure and Planned Business Changes

We have not included any specific planned business or capital expenditures directly in our model. While not fully known at this point in time, the nature of ACA and other anticipated regulatory and business model changes will force CFMI to call upon accumulated surplus to react to changing business environments.

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[2] Milliman, "CareFirst, Inc. CareFirst of Maryland, Inc. Need for Statutory Surplus and Development of Optimal Surplus Target Range," December 10, 2008 p. 35.

- As an example, all Payers can anticipate near-term expenditures related to required adoption of the ICD10 claims payment standards. This change requires not only systems changes, but impacts pricing analysis, provider contracting, and care management functions.
- ACA will undoubtedly change the nature of how insurance products are both sold and serviced as plans attempt to achieve the targeted goals of broader coverage and more efficient administration.

It is still early for CFMI to estimate these costs. There will undoubtedly be other situations as a response to changing markets and regulations evolve. We therefore did not attempt to develop specific scenarios. However, such changes cannot be priced into ongoing premium rates. This is particularly true now that administrative costs are restricted by minimum loss ratio constraints. Therefore, these must be funded from accumulated surplus. We would therefore advocate conservatism in surplus targets to recognize the need for surplus to fund these contingencies.

CareFirst Community Giving

We included provision for the required "in lieu of" community giving in Maryland, which is in lieu of a two percent premium tax.

Model Results

We established a working surplus range for CFMI's management to consider based on the above stochastic model, the results of historical observations of CFMI results, and a broad general reasonability comparison against other carriers. This range reflects the requirements for underwriting losses from our stochastic model, the probability of other risk-related surplus requirements, and the need for surplus as a funding vehicle for vitality and other market-demand expenditures.

RBC targets traditionally focus on a minimum surplus known as the ACL. Since we are attempting to develop "working surplus", our focus is a minimal level which:

- Prevents CFMI from dropping below 375% of ACL as required for normal operations under the BCBSA trademark agreement 90% of the time;
- Prevents CFMI from dropping below 200% of ACL as required for normal operations by most state insurance regulators following NAIC guidelines and retention of BCBSA trademark 95% of the time;
- Provides a reasonably high degree of likelihood that CFMI can sustain anticipated underwriting losses;
- Provides for business, asset, and other risks in addition to the potential drain of underwriting losses; and
- Offers some residual surplus to fund capital expenditures, required new business ventures, and overall CFMI mission statement obligations.

As discussed above, the stochastic modeling exercises allow us to develop a range that provides both a "low" to "high" level of certainty that surplus will be adequate. These depend upon the

items to be included as surplus concerns and the probability of outcomes in the surplus model. Observations of most health care insurers suggest that surplus levels can be quite volatile.

In general, we believe that below the 90th-percentile level is too low to be adequately certain that potential events over a long-term period will not create problems with working surplus levels – or even solvency surplus levels. Conversely, the dollar requirements increase dramatically as one seeks to become more and more certain that all contingencies have been covered. It is likely to be theoretically impossible to have sufficient surplus to be 100% certain that events will not cause the level to be below a chosen target range.

We have therefore chosen to establish a recommended range which approximates something between a 90% and 95% likelihood of surplus adequacy based on our models and on other surplus requirements. A higher level helps offset the risk of the low probability / high risk events, which are very difficult to reflect in stochastic modeling. This level is also consistent with our observations of CFMI historical results and the level of surplus being held by other BCBS plans. We believe that these levels of confidence are prudent since the loss of solvency would be a devastating event for the community served by CFMI. It would seem questionable to have a 10% likelihood of the failure of a plan with the associated wholesale dislocations in service to members, disruptions in provider reimbursement, and loss of continuity of courses of treatment. We note that the NAIC reports that 94% of insurers required no statutory action in 2009[3], therefore we believe that our confidence intervals of 90% and 95% are not overly cautious.

As one would suspect from the above development discussion, we believe this is a management decision which is clearly not quantifiable in absolute terms. The choice of a working surplus range should be based on management's comfort level with the uncertainties of the current business environment and with the knowledge of likely non-risk-related demands on surplus for capital investment and other expenditures.

We have quantified these outcomes using several of the metrics we have seen applied at CFMI and elsewhere. All of our observations are in terms of statutory financial reporting, *see* Md. Code Ann., Ins. §§ 4-301 to -314, since this provides the best common metric between carriers and in terms of ongoing monitoring.

CFMI's Working Surplus Range	Low	High
% of RBC Level	1,050%	1,600%

Overall, this CFMI working surplus range appears to offer a reasonable level of certainty of surplus sufficiency while addressing capital needs and other uses of surplus.

[3] NAIC Staff, "Health Industry RBC Results for 2009," 2010 National Association of Insurance Commissioners.

Conclusion

Analysis of working surplus in the current market environment must accommodate ACA changes and the greater inherent variability they create in financial outcomes and working surplus needs. Our analysis employed microeconomic simulation modeling which accounts for variability in likely market/product mix outcomes. The model then examines the statistical variability of pricing mechanisms against these outcomes in terms of our historical surplus modeling considerations. Based on our modeling, we created a projection of CFMI's specific business conditions as best as can be determined on a prospective basis. We conclude that an appropriate range of working surplus for CFMI to hold is 1,050% – 1,600% of the ACL.

The working surplus range of 1,050% – 1,600% of ACL represents the appropriate way of looking at CFMI's long-term surplus needs. These needs clearly exceed the minimum surplus levels defined by RBC calculations. In fact, the process of setting such a range differs sufficiently from RBC calculations that working surplus ranges cannot be developed simply by using a multiplier of the RBC level. However, for the sake of comparison, we have adopted the common practice of expressing an independently developed working surplus range as a percentage of the RBC level.

Our process has attempted to reflect business factors which are common to the industry and those which are unique to CFMI. The objective of this range is to provide confidence that CFMI can remain above the 375% of RBC target set by BCBSA for unencumbered operations as a holder of the BCBS trademark with reasonable (90%) certainty, and remain above the 200% of RBC set by regulators with more (95%) certainty.

We are, however, concerned that merely modeling a range of working surplus requirements does not fully explore the issues faced by CFMI. As articulated in our report, the changes introduced by ACA and other market dynamics take us to a different place in terms of understanding working surplus needs. While we have applied our historical RBC modeling tools, we have done so in a context which applies the analysis to multiple scenarios for the future state in which CFMI may operate. We believe we have provided a reasonably analytical basis of determining working surplus needs for those future states.

EXHIBIT 17

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I. Executive Summary

Background

In March 2010, the U.S. Congress passed the Patient Protection and Affordable Care Act (ACA), a sweeping piece of legislation designed to overhaul the country's health care system and extend health insurance to millions of uninsured Americans. The law includes numerous provisions that aim to accomplish this goal. One way in which the ACA increases access to commercial health insurance coverage is by restricting insurers from denying coverage, excluding individuals with pre-existing conditions, and varying premiums based on an individual's health status. To minimize the adverse selection that could result from certain provisions, the ACA includes other provisions, such as premium and cost-sharing subsidies administered via a Health Benefits Exchange (HBE) and an individual tax penalty for those who do not purchase sufficiently valuable health insurance coverage. These provisions aim to increase overall participation in health insurance plans. The ACA includes additional provisions to expand health coverage to U.S. residents, such as the option for states to expand Medicaid to nearly all adults below 138 percent of FPL, a requirement for all large employers to offer health insurance to full-time employees or face a penalty, and a tax credit to small employers to offset the cost of insurance and thus incentivize them to offer coverage. [1]

Our baseline estimates indicate that of the 52.4 million individuals who would have been expected to otherwise lack health insurance coverage in the absence of the ACA, 32.4 million will obtain coverage, assuming all ACA provisions were fully implemented and presented in 2014, and assuming all states expand Medicaid.[2] This includes 10.4 million individuals who gain coverage through the individual exchange, 0.4 million individuals who gain private non-group coverage, 2.2 million individuals who gain coverage in a Small Business Health Options Program (SHOP) Exchange, 5.4 million individuals who gain other employer coverage, and 14.0 million individuals who gain coverage through Medicaid expansion, if all states participate, which may not occur. Given that all states will not participate in the Medicaid expansion, state-level estimates comparing number of uninsured under expansion versus no expansion are presented in ***Figure S-1*** and ***Figure S-2***.

Project Scope

The SOA's research objective is to provide guidance to state exchange officials and administrators, federal officials and administrators, and actuaries assisting states and health plans. The goal of the project is to estimate the morbidity and/or cost for newly insured individuals in the individual market (and to some degree, the small group exchange) relative to the morbidity and/or cost for the current commercially insured population. This analysis will primarily focus on the individual, non-group market. In order to plan for the impact that these currently uninsured individuals will have on the health insurance markets, it is important to understand their costs relative to the costs for people already enrolled, for whom many health insurers have experience and data.

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[1] The ACA provides the option for states to expand Medicaid to 133% of FPL and includes a provision to disregard 5% income of a family's income for eligibility determination, which effectively increases eligibility to 138% of FPL.
[2] The 32.4 million estimate is an overestimate, as many states have indicated that they will not participate in Medicaid expansion.

The key research questions explored in this analysis include:

- What is the anticipated enrollment for the currently uninsured under the ACA?
- For the newly insured, what is their relative morbidity and what could reasonably be expected for relative costs, compared to the currently insured?
- What will be the general impact of the newly insured on the overall post-reform health care industry and insurance market, in terms of supply and demand for health care services and insurance carriers?
- How will health care costs for the newly insured differ by state?
- What will be the relative health status and cost for individuals who remain uninsured and how will this vary by state?
- If states expand Medicaid under the ACA, what is the impact on Medicaid costs and enrollment?

Note that the ACA's affect on *premium* is not modeled in this research; rather, *long-term relative claims cost* is modeled. Many aspects of the ACA will affect premiums, including changing benefit designs, new taxes and assessments, federal risk mitigation programs, minimum loss ratio rules, rate review rules, and premium subsidies.

Research Model Used

Our research estimates are made using The Lewin Group Health Benefits Simulation Model (HBSM). The HBSM is a micro-simulation model of the U.S. health care system. HBSM is a fully integrated platform for simulating policies ranging from narrowly defined insurance market regulations to Medicaid coverage expansions and broad-based reforms involving multiple programs such as the ACA. It was developed in 1989 to simulate the wave of reform proposals that culminated in the health reform proposal introduced by President Clinton in 1993. The model was used by the U.S. Bipartisan Commission on Comprehensive Health Care (the Pepper Commission) in 1990 and has been in almost constant use since then by The Lewin Group at the state and national levels. The Lewin Group has been using this model since 2010 to assist clients with ACA planning, strategies and actions. The SOA retained Optum, who chose to use the HBSM model and engage The Lewin Group to conduct this research study. Optum is the parent company of The Lewin Group. Randy Haught and John Ahrens, authors of this report, are employees of Optum. However, the authors' analyses and interpretations are based upon their own professional expertise and are offered within the scope of work they were asked to perform by the SOA. Their findings or conclusions do not necessarily represent a position of Optum or Lewin.

The HBSM is explained in greater detail within the Technical Notes and in Appendix A and B. The reader is encouraged to read and understand the model and assumptions prior to using the model results for analysis.

The HBSM model outputs are based on expected cost results in 2014, but assuming full implementation of the 2016 penalties (when full penalties apply) and also assuming that ultimate enrollment in the various programs and the Exchanges is completed right away. Reality will likely result in a lag in enrollment shifts, such that not all people who are modeled

to ultimately take coverage will do so in immediately in 2014, as presented in this research. Observations from prior Medicaid expansions show that it may take three to four years to reach an ultimate enrollment state. In addition, this research does not reflect that newly insured individuals may have a pent-up demand for services due to previously unmet health care needs, and further does not reflect that the earliest new enrollees may differ from the average risk group that will ultimately enroll. Therefore, each user of this report will need to make their own assumptions for each state with respect to how the initial years' (2014 and 2015) enrollment and distribution of risks may occur, as well as the appropriateness of the model for 2016 and subsequent years. In order to assist the practitioner in modifying the results, Excel worksheets are provided for each state to facilitate the process.

Key Findings

Key findings are summarized in ***Figure S-1*** and ***Figure S-2*** by state. Due to the changing status of participation in the Medicaid expansion for individual states, ***Figure S-1*** shows the percent uninsured, non-group enrollment, and non-group costs pre- and post- ACA for each state assuming that all states expand Medicaid, resulting in many of the uninsured enrolling in Medicaid. ***Figure S-***2 shows these same results for each state, but assumes that none of the states expand Medicaid. The reader can select the appropriate table based on the state's current Medicaid participation status. The three findings summarized below assume Medicaid expansion in all states. Although the costs shown in the tables are at projected 2014 levels, the actual enrollment and percentage increases in costs reflect an "ultimate" or "steady-state" environment, which we assume corresponds to about 2016 or 2017 (after three years of exchanges). Therefore, mitigating strategies being considered in 2013 for 2014 and 2015 (for example, some states are considering transitioning state high risk pools gradually) are not reflected in this model. The research models the long-term likely scenario when high risk pools have been fully transitioned into the market.

Finding 1: After three years of exchanges and insurer restrictions, the percentage of uninsured nationally will decrease from 16.6 percent to between 6.8 and 6.6 percent, compared to pre-ACA projections.

In the first section of ***Figure S-1***, estimates are shown for the percentage of all individuals uninsured in absence of the ACA and compared to two estimates of the percentage of all individuals uninsured in under the ACA, assuming full implementation and presented in 2014 dollars and population counts. Note that the counts are annual equivalents so that an individual who is uninsured for three months would count as 0.25 uninsured. This approach can result in differences with other counts of the uninsured which might be based on a snap shot on a given date, or count someone who is uninsured at any time in a year.

One of the key findings of our analysis is that the impact of the ACA on reducing the number of uninsured will vary substantially across states. Some of the factors that may explain these differences include: proportion of population that is uninsured prior to the ACA; portion of the uninsured below 400 percent of FPL, which is based in part on current Medicaid eligibility levels in the state; and average non-group costs.

To provide a range of results, the percentage of uninsured are simulated under two models: a price "elasticity" model and a "utility" function model. The elasticity model simulates the

decision to take coverage based upon the change in the net cost of coverage to the individual under reform, a decision which varies by demographic characteristics of the individual. The utility function models an amount that someone is willing to pay to be protected against the risk of going without insurance; they choose coverage if the cost is less than that figure.

Finding 2: Under the ACA, the individual non-group market will grow 115 percent, from 11.9 million to 25.6 million lives; 80 percent of that enrollment will be in the Exchanges.

The middle section of ***Figure S-1*** provides estimates for the number of non-group individuals covered pre-ACA compared to the number of those expected to be covered post-ACA; this is shown under the elasticity model. The percentage of non-group individuals in the Exchanges is shown as well. We model that 80 percent of non-group coverage will be through the Exchanges, since subsidies will only be available for coverage purchased through the Exchanges. Our model assumes that people purchasing non-group coverage who are eligible for subsidies will purchase through the Exchanges. Much of the increase in coverage is a result of the premium and benefit subsidies for lower income individuals, many of who will select the "silver" benefit tier since that is the tier for which benefit subsidies are tied.

Finding 3: The non-group cost per member per month will increase 32 percent under ACA, compared to pre-ACA projections.

In the last section of ***Figure S-1***, the average non-group allowed per member per month cost, excluding those in high risk pools (state-run pools that existed pre-ACA and federally funded state pools under ACA), is shown in absence of the ACA; these costs reflect the "underwritten" risk in most states.[3] The percentage increase between pre- and post-ACA estimates is shown as well. The post-ACA figures include the impact of a) high risk pool members, b) employers dropping group coverage, and c) increased morbidity from selection by those currently uninsured who now purchase coverage. The results of this analysis indicate that there will be significant variation across states in the impact of the ACA on average cost in the non-group market. These estimates come from ***Figure 5*** of the state-specific tables. Since the populations before and after ACA may be significantly different, ***Figure 6A*** shows the increase by age bracket. States that show a decrease in average costs under the ACA are primarily those that currently use community rating in the non-group market. The reduction in average costs for these states reflects the younger and healthier individuals that will enroll due to the reduced cost from the premium subsidies.

Our analysis also indicates that while high risk pools generally have few enrollees, the cost per individual is very high. Movement of the high risk pool individuals into the non-group Exchange will generally create a significant increase in cost. However, it can be reasonably argued that proportionately more uninsured individuals will have similar risks in states that had relatively small high risk pools. The reader is encouraged to further examine this issue.

[3] Our analysis assumes that both the State and Federal High Risk Pools will be rolled into the exchanges at some point in time. However, individual states may decide not to transition its state high risk pool enrollees in 2014 and phase this transition in over time. Reader should refer to their individual state's plan. For example, Maryland is planning to transition high risk pool enrollees into the exchange over time.

Figure S-1. Summary of "Ultimate" Findings- Assuming All States Expand Medicaid

State	% Uninsured Pre-ACA	% Uninsured Post-ACA Elasticity	% Uninsured Post-ACA Utility	Size of Non-Group Pre-ACA	Size of Non-Group Post-ACA	% of Non-Group in Exchange	Average Non-Group PMPM Pre-ACA	Average Non-Group PMPM Post-ACA	% Change in Non-Group PMPM
Alabama	14.7%	4.9%	4.2%	117,257	295,633	86.8%	$263	$422	60.3%
Alaska	20.6%	8.5%	8.3%	22,702	62,501	83.8%	$436	$520	19.2%
Arizona	21.1%	12.0%	12.1%	250,488	570,681	81.5%	$290	$355	22.2%
Arkansas	18.1%	6.0%	4.9%	112,882	233,527	82.7%	$238	$335	40.9%
California	18.2%	8.4%	8.1%	1,789,865	3,163,015	72.4%	$260	$420	61.6%
Colorado	18.0%	7.9%	7.5%	293,851	502,554	75.7%	$262	$365	39.1%
Connecticut	12.7%	6.0%	6.0%	126,997	255,216	76.7%	$399	$514	28.8%
Delaware	9.5%	4.9%	4.9%	25,902	56,946	80.8%	$380	$491	29.3%
District of Columbia	12.3%	5.7%	5.5%	25,343	41,271	76.4%	$348	$528	51.9%
Florida	19.6%	8.3%	8.0%	843,935	1,684,727	79.4%	$313	$396	26.5%
Georgia	18.2%	6.9%	6.6%	349,454	762,955	81.6%	$310	$396	27.6%
Hawaii	8.0%	3.8%	3.9%	26,584	73,534	83.8%	$374	$456	21.9%
Idaho	16.6%	5.8%	6.1%	98,954	186,187	77.3%	$211	$343	62.2%
Illinois	13.1%	5.9%	5.6%	471,343	978,648	80.1%	$304	$459	50.8%
Indiana	14.3%	5.2%	4.8%	178,442	463,393	88.0%	$272	$455	67.6%
Iowa	13.2%	4.8%	5.0%	147,357	267,001	77.1%	$350	$384	9.7%
Kansas	16.6%	6.6%	6.3%	151,303	254,839	81.3%	$306	$364	18.9%
Kentucky	16.7%	5.6%	5.3%	143,620	346,334	84.3%	$297	$398	34.1%
Louisiana	15.7%	4.9%	4.6%	166,093	335,015	78.5%	$346	$444	28.6%
Maine	13.9%	5.4%	6.0%	43,870	121,784	84.3%	$468	$487	4.1%
Maryland	13.1%	6.0%	5.8%	184,809	386,491	78.4%	$284	$473	66.6%
Massachusetts	8.5%	4.9%	5.6%	178,053	362,583	75.7%	$519	$453	-12.8%
Michigan	12.2%	4.5%	4.4%	307,935	699,656	86.1%	$321	$404	25.8%
Minnesota	13.2%	4.9%	5.5%	247,752	524,708	82.1%	$356	$424	18.9%
Mississippi	18.2%	5.3%	4.7%	103,368	214,209	86.8%	$291	$417	43.2%
Missouri	17.4%	5.7%	5.2%	226,603	491,027	83.1%	$238	$378	58.8%
Montana	20.6%	7.7%	7.2%	64,363	116,419	84.3%	$331	$397	20.1%
Nebraska	14.3%	5.5%	5.5%	97,872	170,822	81.7%	$342	$448	30.8%
Nevada	20.4%	8.2%	8.6%	99,860	260,813	79.2%	$278	$359	29.2%
New Hampshire	12.2%	4.6%	5.4%	50,189	112,728	78.4%	$339	$464	36.8%
New Jersey	16.9%	7.4%	8.4%	272,731	724,548	76.5%	$481	$474	-1.4%
New Mexico	22.9%	8.8%	8.9%	42,890	173,704	89.6%	$291	$392	34.9%
New York	12.8%	6.0%	6.9%	450,240	1,615,925	84.3%	$619	$533	-13.9%
North Carolina	18.2%	6.6%	6.4%	402,677	855,147	81.7%	$361	$409	13.5%
North Dakota	14.1%	5.9%	6.2%	51,468	74,774	80.6%	$326	$353	8.4%
Ohio	13.3%	5.0%	3.6%	414,914	805,282	80.9%	$223	$403	80.9%
Oklahoma	16.9%	6.3%	5.6%	134,305	290,180	84.1%	$275	$355	29.3%
Oregon	21.0%	7.2%	8.1%	169,412	435,206	82.7%	$335	$383	14.3%
Pennsylvania	11.2%	4.5%	4.0%	488,341	863,565	80.5%	$356	$455	28.0%
Rhode Island	14.9%	6.6%	7.1%	42,842	91,031	79.4%	$587	$548	-6.6%
South Carolina	17.3%	5.9%	5.5%	161,496	367,909	87.9%	$309	$423	36.8%
South Dakota	14.3%	5.3%	5.3%	52,775	85,094	79.9%	$318	$410	29.0%
Tennessee	15.0%	5.7%	4.9%	281,421	532,091	81.7%	$260	$380	46.4%
Texas	27.1%	10.5%	10.2%	888,205	2,448,638	83.4%	$249	$333	33.8%
Utah	15.5%	6.4%	6.3%	163,811	300,123	75.9%	$245	$314	28.4%
Vermont	13.6%	6.7%	7.3%	15,376	56,986	87.8%	$587	$514	-12.5%
Virginia	15.1%	6.4%	6.1%	328,880	628,457	79.6%	$306	$393	28.4%
Washington	15.6%	6.2%	6.6%	344,620	665,284	74.2%	$314	$357	13.7%
West Virginia	15.6%	4.6%	4.0%	33,191	113,534	89.5%	$347	$469	35.3%
Wisconsin	10.4%	4.8%	4.5%	215,407	442,020	85.1%	$258	$464	80.0%
Wyoming	16.4%	6.0%	6.2%	29,076	54,265	82.6%	$434	$571	31.6%
National	**16.6%**	**6.8%**	**6.7%**	**11,931,125**	**25,618,984**	**80.4%**	**$314**	**$413**	**31.5%**

Assumes all ACA provisions are implemented by 2014, even provisions effective later. Results are similar to what would be expected by 2017, but presented in 2014 dollars and counts. Average non-group PMPM includes total expected claims costs for members but excludes other important items that are needed to model premium, including admin, taxes, and subsidies. States with large high risk pools may consider transitioning these enrollees into the exchange over a longer time frame in order to mitigate cost increases.

Figure S-2. Summary of "Ultimate" Findings- Assuming No States Expand Medicaid

State	% Uninsured Pre-ACA	% Uninsured Post-ACA	Size of Non-Group Pre-ACA	Size of Non-Group Post-ACA	% of Non-Group in Exchange	Average Non-Group PMPM Pre-ACA	Average Non-Group PMPM Post-ACA	% Change in Non-Group PMPM
Alabama	14.7%	8.4%	117,257	378,573	89.5%	$263	$416	58.2%
Alaska	20.6%	11.4%	22,702	74,109	86.3%	$436	$497	13.9%
Arizona	21.1%	12.4%	250,488	577,725	81.8%	$290	$367	26.3%
Arkansas	18.1%	10.0%	112,882	295,130	86.2%	$238	$334	40.4%
California	18.2%	11.3%	1,789,865	3,653,808	76.3%	$260	$403	55.2%
Colorado	18.0%	10.6%	293,851	595,460	79.4%	$262	$354	34.8%
Connecticut	12.7%	8.0%	126,997	285,552	79.0%	$399	$491	23.0%
Delaware	9.5%	4.9%	25,902	63,450	82.7%	$380	$484	27.4%
District of Columbia	12.3%	8.6%	25,343	46,803	78.7%	$348	$497	43.1%
Florida	19.6%	11.4%	843,935	2,002,920	83.0%	$313	$382	22.1%
Georgia	18.2%	10.7%	349,454	934,891	85.1%	$310	$383	23.2%
Hawaii	8.0%	4.9%	26,584	83,153	85.5%	$374	$421	12.6%
Idaho	16.6%	8.3%	98,954	224,042	81.1%	$211	$342	61.8%
Illinois	13.1%	8.2%	471,343	1,102,590	82.1%	$304	$447	46.9%
Indiana	14.3%	8.0%	178,442	560,081	89.9%	$272	$452	66.4%
Iowa	13.2%	7.0%	147,357	319,447	80.6%	$350	$369	5.5%
Kansas	16.6%	9.4%	151,303	309,683	84.6%	$306	$353	15.5%
Kentucky	16.7%	9.1%	143,620	431,290	87.5%	$297	$393	32.2%
Louisiana	15.7%	8.7%	166,093	418,914	82.4%	$346	$459	32.7%
Maine	13.9%	7.3%	43,870	137,524	86.0%	$468	$490	4.7%
Maryland	13.1%	8.1%	184,809	440,563	80.9%	$284	$459	61.4%
Massachusetts	8.5%	5.0%	178,053	373,953	76.4%	$519	$478	-8.0%
Michigan	12.2%	6.5%	307,935	854,242	88.4%	$321	$399	24.3%
Minnesota	13.2%	6.9%	247,752	613,391	84.4%	$356	$413	16.1%
Mississippi	18.2%	10.4%	103,368	278,048	89.7%	$291	$419	43.9%
Missouri	17.4%	9.5%	226,603	613,937	86.2%	$238	$370	55.8%
Montana	20.6%	11.0%	64,363	143,119	87.1%	$331	$389	17.8%
Nebraska	14.3%	7.5%	97,872	205,753	84.8%	$342	$430	25.5%
Nevada	20.4%	11.3%	99,860	303,175	82.9%	$278	$346	24.5%
New Hampshire	12.2%	6.2%	50,189	131,811	81.5%	$339	$471	38.8%
New Jersey	16.9%	10.0%	272,731	776,556	78.8%	$481	$492	2.2%
New Mexico	22.9%	12.1%	42,890	214,044	91.9%	$291	$373	28.2%
New York	12.8%	6.2%	450,240	1,708,252	85.2%	$619	$556	-10.1%
North Carolina	18.2%	10.2%	402,677	1,043,777	85.1%	$361	$392	8.7%
North Dakota	14.1%	7.5%	51,468	88,358	83.4%	$326	$353	8.3%
Ohio	13.3%	7.8%	414,914	1,000,301	84.1%	$223	$406	82.1%
Oklahoma	16.9%	9.1%	134,305	358,001	87.0%	$275	$358	30.3%
Oregon	21.0%	11.0%	169,412	522,363	86.1%	$335	$378	12.8%
Pennsylvania	11.2%	6.5%	488,341	1,054,988	83.8%	$356	$443	24.5%
Rhode Island	14.9%	9.0%	42,842	102,090	81.4%	$587	$549	-6.4%
South Carolina	17.3%	9.4%	161,496	455,872	90.0%	$309	$433	39.9%
South Dakota	14.3%	7.5%	52,775	101,767	83.1%	$318	$434	36.6%
Tennessee	15.0%	8.6%	281,421	654,610	85.0%	$260	$372	43.4%
Texas	27.1%	14.9%	888,205	2,975,371	86.9%	$249	$316	26.9%
Utah	15.5%	8.3%	163,811	348,665	79.2%	$245	$302	23.4%
Vermont	13.6%	6.9%	15,376	58,693	88.2%	$587	$546	-7.1%
Virginia	15.1%	8.8%	328,880	738,858	82.7%	$306	$380	24.1%
Washington	15.6%	8.4%	344,620	775,837	78.0%	$314	$351	11.9%
West Virginia	15.6%	8.4%	33,191	145,591	91.6%	$347	$468	35.1%
Wisconsin	10.4%	6.4%	215,407	506,471	86.8%	$258	$463	79.6%
Wyoming	16.4%	8.6%	29,076	66,105	85.6%	$434	$577	32.9%
National	**16.6%**	**9.5%**	**11,931,125**	**30,149,705**	**83.4%**	**$314**	**$405**	**28.9%**

Assumes all ACA provisions are implemented by 2014, even provisions effective later. Results are similar to what would be expected by 2017, but presented in 2014 dollars and counts. Average non-group PMPM includes total expected claims costs for members but excludes other important items that are needed to model premium, including admin, taxes, and subsidies. States with large high risk pools may consider transitioning these enrollees into the exchange over a longer time frame in order to mitigate cost increases.

EXHIBIT 18

A PUBLIC POLICY WHITE PAPER

Financial Reporting Implications Under the Affordable Care Act

June 2013

American Academy of Actuaries
Health Practice Financial Reporting Committee

American Academy of Actuaries

Financial Reporting Implications Under the Affordable Care Act

June 2013

Developed by the

Health Practice Financial Reporting Committee
of the American Academy of Actuaries

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Financial Reporting Implications Under the Affordable Care Act

Executive Summary

As 2014 approaches, the market reforms introduced by the Affordable Care Act (ACA) may create uncertainty for health insurance issuers above and beyond the changes that have occurred in the first three years after enactment. Much of this uncertainty surrounds the risk that customer behavior in the reformed market may deviate from the projections made by each issuer in its pricing and strategic decisions.

Another element has received comparatively less attention—the extent that an issuer's future financial statements may be subject to additional volatility due to the ACA because of an increased need for actuarial estimates in financial reporting. The purpose of this white paper is to address that topic, as well as new ways in which the ACA may affect financial statement comparability both among issuers and over time.[1]

This white paper provides considerations related to final, as well as proposed, ACA-related regulations issued through March 2013.[2] Any modifications made after that date to these regulations could impact some of the observations and conclusions made in this document. Further, this paper reflects the Health Practice Financial Reporting Committee's understanding of Generally Accepted Accounting Principles (GAAP) and statutory accounting guidance adopted through March 2013. Any new accounting guidance adopted also could affect observations and conclusions in this paper.

This white paper is divided into four sections, each of which discusses a category of ACA provisions that may affect health insurance issuers' financial reporting.

Section I is devoted to the impact of the ACA's premium stabilization programs, which are referred to as the 3Rs—risk adjustment, temporary reinsurance, and temporary risk corridors. These programs primarily affect the commercial individual and small-group markets starting in 2014. Since each of these programs includes a retrospective settlement process, the issuer's annual financial statements will need to include estimates of amounts payable or receivable. In some cases, the magnitude of these estimates may be large relative to the issuer's expected net income for the affected lines of business.

Section II focuses on the impact of new taxes and fees established by the ACA, with an emphasis on the Health Insurance Providers Fee (HIP fee) and the per-capita reinsurance contributions used to procure funding for the transitional reinsurance program. The introduction of these new fees, coupled with issuers' decisions on how to reflect them in pricing may alter certain financial statement metrics (e.g., medical benefit ratios (MBR)) materially. Other complicating factors

[1] This paper does not address implications for employee benefit financial reporting.

[2] In particular, this white paper was developed based on the HHS final rule, Standards Related to Reinsurance, Risk Adjustment and Risk Corridors (March 2012), as amended by the HHS final Notice of Benefit and Payment Parameters for 2014 (March 2013); the HHS final rule, Health Insurance Market Rules (February 2013); the HHS interim final rule, Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 (March 2013); and the Treasury notice of proposed rulemaking, Health Insurance Providers Fee (March 2013).

surrounding the HIP fee include its treatment as a non-deductible expense for income tax purposes and an issuer's challenge in estimating its own expense liability prior to receiving the annual assessment. Both this fee and the reinsurance contribution can lead to a revenue/expense mismatch in light of the interplay between accounting treatments and pricing actions.

Section III briefly examines issues relating to new ACA programs for which the government makes advance payments to issuers that may require subsequent adjustment: premium subsidies and cost-sharing reductions. These programs may result in significant new assets or liabilities for Dec. 31, 2014, which limits year-over-year comparability of financial statements.

Lastly, Section IV examines ways in which the 2014 market reforms may affect the existing categories of actuarial estimates found on an issuer's balance sheet, including unpaid claim liabilities, contract reserves, due and unpaid premium assets, and premium deficiency reserves.

The combination of these provisions has a number of potentially significant effects on the financial statements of health insurance issuers. These effects include:

- *Increased level of uncertainty in financial statements.* Increased uncertainty will be driven by the need to estimate the impact of risk-adjustment provisions, benefits from the transitional reinsurance program, and the seasonal pattern of incurred claims in light of significant plan design changes. The risk-corridor receivable or payable also may provide unique estimation challenges. In addition, longer lead time in the rating and rate review process may result in increased consideration of premium deficiency reserves.

- *Issues with year-to-year comparability of the balance sheet.* A number of large new assets or liabilities will create difficulties in doing year-to-year comparisons of balance sheets. Some of these assets and liabilities include transitional reinsurance program receivables, risk-adjustment receivables or payables and transitional reinsurance program assessment payables.

- *Issues with year-to-year comparability of the income statement.* The accounting treatment for certain provisions may result in year-to-year mismatches between revenue and expense, which will lead to year-to-year comparability issues in the income statements. These provisions include the HIP fee and the transitional reinsurance program contributions. In addition, the treatment of existing contract reserves for individual medical business may result in significant volatility in the income statement depending on how they are released.

- *Issues with issuer-to-issuer comparability.* The increased level of estimates (discussed above) and a few provisions for which the issuer has flexibility with regard to accounting policy or timing of payment may lead to issues regarding company-to-company comparability. The significant areas for flexibility in accounting policy or timing of payment include: treatment of reinsurance receivable on unpaid claims; whether risk-adjustment receivable/payable is estimable; timing of adding fees and transitional reinsurance assessments into premiums; and timing of payment of transitional reinsurance assessments. In addition, the impact of the HIP fee on customer premiums will vary significantly depending on the tax status of the issuer.

The cumulative effect of all of these items is that users of health insurance issuer financial statements will have to be diligent in the next few years to ensure that conclusions drawn reflect the underlying performance of the business and not just intermediate changes in treatment as a result of ACA implementation.

Section I – Premium Stabilization Programs

One of the most significant new drivers of accounting uncertainty attributable to the ACA is its premium stabilization programs, which are referred to as the 3Rs—risk adjustment, reinsurance benefits, and risk corridors. These programs primarily affect the commercial individual and small-group markets starting in 2014.[3] As such, the impact on a specific company will be somewhat dependent on its concentration in those markets.

Each of the premium stabilization programs is designed to provide protection to the health insurance issuer by mitigating adverse financial outcomes; however, these programs could have a negative effect as well. Moreover, each program includes a retrospective settlement process. As such, the issuer's annual financial statements will need to include estimates of amounts payable or receivable under these programs. As discussed below, these estimates may be uncertain in magnitude and direction, and may be large in relation to the forecasted annual net income for the affected lines of business.

A. Risk Adjustment

The risk-adjustment program is designed to allow a health insurance issuer to price and offer individual and small-group products without consideration of the underlying relative health status of the individuals purchasing these products. This concept is particularly important for the post-reform individual market since issuers can no longer employ traditional risk-management techniques, such as medical underwriting. Instead issuers must offer coverage at market rates to any applicant without regard to that applicant's health status. A high-level description of the new risk-adjustment mechanism is that the relative health status risk of each issuer's pool of insured enrollees in a given market space will be measured, and those issuers whose pools of insured enrollees have lower-than-average risk scores will transfer funds to those issuers whose pools have greater-than-average risk scores.

Risk adjustment is a closed system at the following levels: state, market (i.e., individual versus small group unless the state has formally merged the two), and risk pool (e.g., metal plans versus catastrophic plans). That is, within each state/market/risk pool combination, the total inflows to the system by definition will be equal to the total outflows from the system. For ease of understanding, hereafter we will refer to a state/market/risk pool combination as being a "risk-adjustment cell." As such, a given issuer's risk-adjustment payable or receivable for a given risk-adjustment cell will be dependent not just on the risk scores of their insured enrollees, but also on the risk scores of all other issuers with enrollees in that risk-adjustment cell. The regulations call for carriers to be notified of risk-adjustment settlements by June 30 of the year following the applicable benefit year (e.g., June 30, 2015, for the 2014 coverage year).

[3] Somewhat similar premium stabilization programs have existed for the Medicare Advantage and Medicare Part D lines of business since 2006.

States have the right to operate their own risk-adjustment program, but if they choose not to, the federal government will manage the risk-adjustment program for those states. As of Feb. 25, 2013, the only state known to be operating its own risk-adjustment program in 2014 was Massachusetts. For the federal program, the regulations indicate risk adjustment will be performed with concurrent data applied retrospectively, using demographic and diagnosis information in a benefit year to predict total plan liability for that benefit year. The regulations also indicate that a distributed-data environment will be employed, in which each issuer maintains its own data in a standardized format and allows the organization managing the risk-adjustment program to install software performing risk-score calculations for the issuer's data.

The magnitude and direction of the risk-adjustment settlement is dependent on the relative measured risk of the issuer's enrollees compared to all enrollees in the market (and implicitly dependent on the completeness and accuracy of the captured diagnosis data). The magnitude measured as a percentage of premium would be expected to be less for an issuer that had significant market share than for issuers with limited market share. But for either issuer, the settlement could be material in relationship to the expected profit margin for the line of business.

As a simplified example,[4] consider a risk-adjustment cell with only two issuers—Issuer A with 90 percent market share and Issuer B with 10 percent market share. Further, the two issuers charge identical premiums for the same cohort of enrollees, and Issuer A has an aggregate raw risk score of 1.0 while Issuer B has an aggregate raw risk score of 1.25.[5] In this example, Issuer A would be transferring 2.4 percent of its premium revenue to Issuer B as follows:

Aggregate risk score for cell = 0.9 * 1.0 + 0.1 * 1.25 = 1.025
Normalized relative risk score for Issuer A = 1.0 / 1.025 = 0.976
Transfer from Issuer A, as a percent of premium = 1.0 – 0.976 = 2.4 percent

This transfer would represent almost 22 percent of Issuer B's collected premium as follows:

Normalized relative risk score for Issuer B = 1.25 / 1.025 = 1.219
Transfer to Issuer B, as a percent of premium = 1.219 – 1.0 = 21.9 percent

Failure of either issuer to appropriately reflect risk adjustment in their financial statements could significantly change a user's view of financial performance.

Many have drawn parallels between the proposed ACA individual and small-group risk-adjustment mechanism and the risk-adjustment mechanism that has been in place for Medicare Advantage for a number of years. However, there are a number of significant differences between the two programs, including:

- Medicare Advantage risk adjustment is based on a retrospective model, in which demographic and diagnosis information from the prior calendar year is used to develop risk scores for the current calendar year. The retrospective model allows for most of the

[4] In actuality, factors such as metal level (platinum vs. gold vs. silver vs. bronze) and demographics (infant vs. child vs. adult) will impact the calculation of risk-adjustment transfers within a particular risk-adjustment cell.

[5] A difference of this magnitude in aggregate risk scores between carriers may be unlikely, but it is possible. For example, Issuer B could be a small Health Maintenance Organization (HMO) owned by a teaching hospital, while Issuer A could be a large company with a broad network and that historically performed significant underwriting.

input for the risk-adjustment mechanism to be known prior to the close of the calendar year, a characteristic not shared by a concurrent risk-adjustment model. Even so, there have been instances in which material modifications to the Medicare Advantage risk-adjustment payments have occurred in the year following the close of the benefit year, resulting in financial statement entries in a given calendar year that pertain to previous benefit years. The retrospective model also allows for interim risk-adjustment payments within the benefit year, while a concurrent model likely will have no payment transfers occur until final settlement.

- Medicare Advantage risk adjustment is performed as a single national program, instead of multiple programs based on state/market/risk pool combinations. Consequently, the complexity involved in estimating Medicare Advantage risk-adjustment amounts is somewhat less than it would be if the program operated on a more granular level.

- With many Medicare Advantage plans, the issuer expects to have a relatively high level of stability in membership from year to year; the primary reasons for membership changes are initial attainment of age 65 and death. In the commercial individual and small-group markets, by contrast, there is a greater likelihood of membership migration between markets (including the large-group and Medicaid markets) and/or between states. Instability in membership limits the ability to estimate risk-adjustment amounts accurately.

- For the Medicare Advantage program, the vast majority of enrollees are administered by the federal government. Their risk scores can be calculated precisely and payments based on prior diagnosis information, subsequently adjusted on a predetermined schedule using updated diagnosis information. As such, an issuer can assume that any payment adjustments subsequent to the benefit year will be based on the difference between final diagnosis information and what the issuer was paid based on the preliminary risk score calculation. This has allowed issuers to develop relatively accurate estimates of the ultimate risk-adjustment settlement.

Similarly, there are some parallels between the proposed ACA risk-adjustment mechanism and the risk-adjustment programs that some states adopted for Medicaid previously. Medicaid risk-adjustment programs typically are designed to be budget neutral to the state, and each issuer's risk score needs to be normalized relative to those of other issuers. However, typically the Medicaid risk scores are calculated using concurrent data applied, not retrospectively to adjust the current year's capitation rates, but prospectively to adjust the following year's capitation rates.

The ACA risk-adjustment mechanism has several elements that may lead to increased uncertainty in an issuer's reported financial statements, particularly with respect to 2014 financial reporting. These include:

- *Uncertainty as to the issuer's risk score*. With the risk-adjustment mechanism being based on concurrent analysis, as of year-end, the issuer does not possess all of the data that ultimately will be relevant to calculating its own risk score. Encounter reporting as of year-end will be substantially incomplete, as much will be unknown in terms of October, November, and December encounters. As such, the issuer's estimate at year-end of its

aggregate risk score systematically will be understated if it were to rely solely on the encounter data in its possession as of year-end.[6]

To rectify this, the issuer might seek to estimate, as of year-end, the extent to which its enrollees' incurred but not paid (IBNP) claims in time will translate to increases in the enrollees' risk scores. This is a substantially more complicated exercise than simply estimating the issuer's unpaid claim liabilities. To estimate aggregate unpaid claim liabilities, one only needs to work with total claim dollars for a given population, which may span multiple risk-adjustment cells. To estimate the impact of IBNP claims on the aggregate risk score, however, one would need to project specific distributions by diagnosis and severity of conditions at the risk-adjustment cell level. In short, new methodologies would need to be developed for this task. In any situation in which new methodologies are employed, substantial uncertainty exists around the validity of the arising estimates, until the models can be tested and calibrated.

Alternatively, the issuer might conclude that it cannot reliably estimate the risk score improvement attributable to IBNP claims, and instead base its year-end risk-adjustment estimate solely on the risk scores derived from claims already paid. In that case, the issuer systematically would expect to see favorable development in its risk-adjustment estimate in the successive calendar year, as the estimate is trued up to reflect the improvement in risk scores arising from claims paid after year-end. This would lead to positive net income in 2015 financial statements, but the direction and magnitude of the effect on net income for later years is less certain.

- *Uncertainty as to other issuers' risk scores*. This is perhaps the largest uncertainty. Even if an issuer had perfect knowledge of its own aggregate risk score for a particular risk-adjustment cell, the ultimate payment it makes or receives for that cell is dependent not on its absolute aggregate risk score, but on the relative relationship between its aggregate risk score and those of all issuers participating in that risk-adjustment cell. As such, in estimating its year-end risk-adjustment liability or asset, the issuer will need to take a position as to what it thinks the aggregate risk score is across the entire risk-adjustment cell. In some states, issuers may be asked by state regulators to provide data prior to the close of the benefit year that can be analyzed for the purpose of understanding each issuer's relationship to the aggregate risk of the market, or they may voluntarily contract with a third party to provide data for the same purpose. However, even with such an information sharing effort, changes by one issuer in information reported or how information is classified can impact significantly the risk-adjustment estimates for all issuers. Alternatively, some issuers are considering using population data by condition incidence to supplement their understanding of their relative risk profiles.

  This uncertainty will be greater in 2014 than in subsequent periods because after 2014, carriers will have an understanding of what the aggregate risk score is for each risk-adjustment cell based on the prior year's reported data. Since enrollees will become eligible for risk adjustment at different times throughout 2014 based on their policy

[6] Note that, as a matter of definition, additional encounter data can only increase an enrollee's risk score, never decrease it.

renewal dates, the estimation process for 2015 also may be complex, albeit not as complex as 2014.

- *Uncertainty as to member exposure*. There has always been some uncertainty at year-end around the issuer's membership, due to premium grace period provisions that customers may exercise after year-end that keeps their coverage inforce. However, the ACA could increase the uncertainty around estimating the issuer's member exposure, since it requires that issuers extend the grace period from 30 days (per typical historical practice) to 90 days for any member receiving a premium subsidy via the exchanges. As such, it becomes less clear at year-end which of the issuer's members have remained through the entire year. In turn, this can affect estimates relating to risk adjustment.

- *Granularity of the calculation*. The commercial risk-adjustment mechanism, as contrasted with the existing Medicare Advantage risk-adjustment mechanism, is not a single national calculation but rather a series of separate calculations for each risk-adjustment cell. Even an issuer operating in only one state likely will have at least three risk-adjustment cells to evaluate, namely individual catastrophic, other individual, and small group (as well as multiple metal-level models included within a cell's calculation). A larger holding company with multi-state operations and/or multiple legal entities will have significantly more cells to track. This level of granularity will complicate the modeling required to perform effective estimates of commercial risk-adjustment balances.

- *Implications of data reviews*. Although the data supporting the risk scores is maintained by each issuer, the regulations call for a data validation review that could lead to payment adjustments. The current regulations are proposing that no payment adjustments be made in 2014 or 2015. However, given the closed-pool nature of the risk-adjustment mechanism, it is unlikely issuers would agree to allow risk transfers based on data that was demonstrated subsequently to be erroneous to occur without adjustment. As such, there will be some level of increased uncertainty around potential adjustments in 2014 and 2015, and significant uncertainty in subsequent periods as a result of data validation reviews.

The regulations specify no interaction between the risk-adjustment mechanism and the reinsurance mechanism (discussed in Section I.B below). The risk-adjustment mechanism will be settled prior to the risk corridors and the calculation of any minimum loss ratio liability. As such, these other programs will not contribute to the uncertainty related to the risk-adjustment program.

B. Reinsurance Benefits

Starting in 2014, issuers offering products in the individual market can no longer deny coverage based on preexisting conditions. As a result, in 2014 the individual risk pool is expected to include a greater proportion of people with chronic conditions, resulting in increased incidence of large claims. The transitional reinsurance mechanism is designed to protect issuers in the individual market from this expected increase in large claims. The reinsurance protection is funded by assessments from the commercial health insurance market and from sponsors of self-funded health benefit plans (discussed further in Section II.B below). This funding is scheduled

to decrease systematically from 2014 through 2016 and be eliminated in 2017. Reinsurance benefits could be paid out of the funding through 2018 to the extent the funds collected through 2016 are not exhausted by 2016.

The reinsurance benefits are scheduled to be settled by June 30 of the year following the applicable benefit year. The regulations stipulate that the 2014 reinsurance benefits will be 80 percent of claims between $60,000 and $250,000 for a given individual, with no reinsurance benefit available for claims greater than $250,000.[7] HHS estimates the reinsurance benefits to result in individual premium reductions of 10 percent to 15 percent in 2014. The total dollars available for reinsurance benefits are targeted to be $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016.

There are a number of aspects of the reinsurance program that can increase uncertainty and/or impair comparability in the 2014 financial statements for an issuer. These include:

- *Accrual for reinsurance on unpaid claims*. With respect to excess-of-loss reinsurance, many issuers historically have accrued for reinsurance receivables on specifically identified claims only. However, the magnitude of the expected ACA reinsurance benefit in relationship to premium will motivate issuers to consider estimating the potential reinsurance recovery on unpaid claims for which no specific information is available, if permitted under the relevant accounting basis. This is somewhat complicated by differing payment patterns for large claims due to differences in claim submission processes and claim payment processes. As such, an accurate estimation of the reinsurance recovery on unpaid claims will not be as simple as applying a fixed percentage of overall unpaid claims. Many issuers have already needed to confront a similar estimation issue with respect to the Medicare Part D reinsurance program, and some of the techniques developed in that context may be transportable to this new context. To the extent issuers that historically have accrued reinsurance receivables only on identified claims do not change their accounting policies, the level of the reinsurance recoverable on unpaid claims will be of a magnitude that may make company-to-company comparability more difficult.

- *Magnitude of the reinsurance recovery accrual*. Since the regulations do not require interim settlements, an issuer will be recording an accrual at Dec. 31 for the full year's reinsurance recovery. For GAAP accounting, this probably will be a new receivable that potentially may be greater than the reported net income for the individual line of business. Under statutory accounting, reinsurance receivables relating to unpaid claims typically are recorded as an offset to unpaid claim liabilities, with only those reinsurance receivables relating to previously paid claims recorded as a separate asset. If the same accounting principles are applied to the new ACA reinsurance program, then a carrier's overall unpaid claim liabilities for the individual line of business, as reported on statutory financial statements, could be reduced noticeably. Under either accounting convention, the accrual will complicate any year-over-year comparability of financial statements for an issuer with significant participation in the individual market.

[7] One reason for this is so that the transitional reinsurance program does not "crowd out" the existing private reinsurance market, which typically involves attachment points of $250,000 or higher. However, the absence of protection for claims above $250,000 implies that the transitional reinsurance program will be less effective in mitigating financial statement volatility.

- *Potential valuation allowance on reinsurance recoverable*. Since reinsurance benefits are limited to available funds in the reinsurance pool, there is potential for reinsurance benefits to be reduced due to availability of funds. The reinsurance parameters (i.e., the 80 percent coinsurance, the $60,000 attachment point, and the $250,000 coverage limit) were set by HHS based on its modeling of not only expected individual market large claims, but also expected lives subject to the fixed per capita reinsurance contribution. If HHS has over-estimated the number of lives that will pay the reinsurance contribution, and/or under-estimated the number of individual market large claims, then the amounts collected to fund the 2014 reinsurance program may prove to be insufficient to pay out benefits in full. As such, each issuer will need to consider whether the reinsurance program will have sufficient funding to fully pay out reinsurance benefits according to the published parameters. To the extent that an issuer believes there is a risk that payment in full will not be made, then the issuer may wish to reduce its reinsurance recoverable by a valuation allowance, reflecting its assessment of the risk that the recoverable computed according to the published program parameters will not be paid in full. There likely will be a wide variety of models at Dec. 31, 2014 regarding assumptions around any reductions in reinsurance recoveries. This will complicate the company-to-company comparability across issuers with significant participation in the individual market.

- *Potential for denied reinsurance claims*. The review process for reinsurance claims may lead to some denial of filed claims. Since this review process will not occur until after the year-end financial statements are filed, the issuer either will have to estimate a probability of claim denial or accept the possibility that future income could be impacted adversely by any claim denial. Since there is no prior history for the ACA-specific reinsurance program, any estimates of the probability of a claim denial likely will vary significantly by issuers. Some issuers may conclude that they are unable to make such an estimate.

C. Risk Corridor

The risk-corridor program was designed to provide some aggregate protection against variability for issuers in the individual and small-group markets during the period 2014 through 2016. In many cases, the risk corridor will lessen much of the potential volatility and uncertainty in ultimate earnings that may be driven by the other two premium stabilization programs discussed above. The risk-corridor program pertains only to "qualified health plans" which includes products offered via the exchanges but also could include some off-exchange products.

The risk-corridor calculation is to be performed at a plan-specific level, which is far more granular than the level used to define risk-adjustment cells. The risk-corridor mechanism calls for payments from the issuer to HHS if actual experience is more than 3 percent below a target, and payments from HHS to the issuer if actual experience is more than 3 percent above the target. The amount of the payment is 50 percent of the amount between +/-3 percent of the target and +/-8 percent of the target and 80 percent of the amount that is +/-8 percent of the target. The risk corridor is to be settled by July 31 of the year following the applicable benefit year.

The risk-corridor calculation is to be performed after considering any amounts transferred to or from the issuer as a result of the risk-adjustment or reinsurance programs. Although the risk-corridor mechanism provides protection against extreme bounds of experience, there is a

substantial corridor in which all variance in experience directly affects the financial return to the company. In estimating the risk-corridor receivable or liability, it will be important that the company fully consider the expected impact of the risk-adjustment and reinsurance mechanisms. Failure to have a consistent and comprehensive model may result in large differences between projected settlements and actual settlements.

The estimation of the risk-corridor liability will be a relatively complex calculation at a finer level of granularity than the level at which most other reporting is made. However, the complexity of the risk-corridor calculation has been mitigated somewhat under an interim final rule promulgated in March 2013, which states that the claims costs used in a particular plan's risk-corridor calculation should not be specific to that plan, but instead should represent a pro rata allocation of the issuer's overall claim costs for the plan's state/market cell.

Due to the asymmetrical nature of the risk-corridor calculation, an overstatement of expense in one cell offset by an understatement of expense in another cell does not necessarily result in zero financial impact; for example, if the overstatement is in the 80 percent corridor while the understatement is in the 0 percent corridor, the financial impact would be 80 percent of the differential. In light of the use of allocated state/market results in risk-corridor calculations rather than plan-specific results, however, the likelihood that an issuer would have some plans in the 0 percent corridor and others in the 80 percent corridor becomes significantly diminished.

Section II – New Taxes and Fees

The ACA creates a number of new taxes and fees that will be levied in the future on health insurance issuers (and sometimes on sponsors of self-funded benefit plans). Two of these new expenses, in particular, may be material to issuers' financial statements in the near future—the new non-deductible excise tax assessed to issuers under ACA Section 9010 and the contributions made by issuers (and also self-funded benefit plan sponsors) to fund the reinsurance benefits discussed in Section I.B above.

A. Health Insurance Providers Fee

Under the ACA, starting in 2014, any company that writes certain types of health insurance on U.S. risks will be subject to a new excise tax, which is referred to in proposed regulations as the HIP fee.

The HIP fee will be assessed on an annual basis, with the first payment due by Sept. 30, 2014. Companies active in the health insurance market will receive a bill from the federal government based on market share as measured using the previous year's amount of premiums in eligible lines of business. However, there are a few adjustments to premiums in the HIP fee calculation, and the most notable is that a company not subject to federal income tax only counts one-half of its premiums in the calculation. Under the proposed regulations, eligible lines of business appear to include insured major medical, dental/vision, Medicare Advantage, Medicare Part D, and Medicaid. It excludes stop-loss, self-funded products, Medicare Supplement, disability, long-term care, specified disease, and accident products. The statute specifies the total amounts to be collected from the industry in each year, starting with $8.0 billion for 2014, increasing to $11.3 billion for both 2015 and 2016, and then increasing again beyond 2016. Federal regulators will use premium reporting from the prior year to issue a set of bills to companies that sum exactly to

the statutory level of fees to be collected from the industry. In this regard, the HIP fee assessment mechanism has strong similarities to mechanisms that exist today in some states (e.g., Texas, Illinois) for the assessment of fees to fund state high-risk pools—an aggregate dollar amount established by regulators is apportioned to issuers in proportion to prior year premium market share.

In situations in which premium market share information for 2013 is used to determine the amount of an assessment that an issuer will be required to pay in 2014, normal practice under both GAAP (see AICPA SOP 97-3) and statutory accounting is for the issuer to accrue its estimate of the assessment due in 2014 as a liability in its year-end 2013 financial statements. However, in the case of the HIP fee, a different treatment has been adopted for both GAAP and statutory accounting. Under the GAAP treatment (see FASB ASU 2011-06), the issuer would recognize the liability for the first time on Jan. 1, 2014, at which point it would recognize its estimate of the full year's expected liability and simultaneously recognize an offsetting intangible asset. Over the course of 2014, the asset established at the beginning of the year would be amortized away, leading (assuming the accuracy of the original liability estimate) to ratable recognition in GAAP expense throughout 2014 of the HIP fee payable in 2014. In 2012, the NAIC adopted a statutory accounting treatment for 2013 that, if extended into 2014, would produce largely the same results as GAAP, with the added nuance that the intangible asset would be non-admitted. This implies that the issuer's statutory surplus in its first quarter 2014 statutory financial statements would be reduced by the issuer's estimate of the full year's HIP fee. However, as of this writing, the 2014 statutory accounting treatment remains under discussion. A proposal recently exposed for public comment by the NAIC would involve recognition of five years' worth of HIP fee payments (2014-2018) as expense over the course of four years' statutory financial statements (2014-2017), creating significant GAAP-Statutory Accounting Principles (SAP) differences in 2014-2016 followed by smaller GAAP-SAP differences in 2017 and beyond.

A discussion of how the HIP fee may influence premium pricing is necessary to understand the financial reporting implications.

The evolving industry practice has been to include the HIP fee in pricing for products sold or renewed in February 2013 and later, with the amount included being level over the 12-month contract period and reflective of the proportion of the policy period that intersects 2014. Under this approach, the amount to be included in monthly premiums for a 12-month contract issued in June 2013 would be five-twelfths of the amount to be included in monthly premiums for a 12-month contract issued in January 2014, since only five-twelfths of the coverage under the June 2013 contract lies within 2014. Some states allow this approach; others prefer an approach in which the HIP fee should not be included in premiums until 2014. Another potential approach is to dispense with level premiums over the 12-month policy period, and instead charge one premium for the portion of the policy year in 2013 and a higher premium, inclusive of a provision for the HIP fee, for the portion in 2014. However, there may be regulatory hurdles to such an approach. Further, it also could raise accounting issues: should revenue recognition be levelized over the policy year even if premiums will be charged in a non-level fashion?

With this as background, the existence of the HIP fee raises a number of issues regarding issuers' financial statements and metrics used by financial analysts:

- *Expense estimation risk*. Issuers' interim financial statements, particularly in 2014, could materially misestimate the HIP fee amount. By the time March 31, 2014, financial statements are prepared, an issuer will know its own 2013 premiums and may be able to derive some reasonable estimate of industry wide 2013 premiums (e.g., by subscribing to data sources that compile issuers' year-end statutory financial statements) in order to develop its estimate of what portion it will need to bear of the total $8 billion fee. This industry level estimation is made more challenging by 1) the need to identify those companies that are allowed to discount the amount of premium included in the calculation, and 2) that existing public financial statements may not delineate between premiums subject to the HIP fee and those premiums not subject to the fee. As such, with no prior year calculation to serve as a guide, there will be some uncertainty in even the most sophisticated issuer's estimate. That uncertainty could manifest itself during, for example, the third quarter 2014 via a need to recognize more, or less, year-to-date HIP fee expense after the HIP fee bills have been issued and the actual full year exposure is known. As opposed to many of the other issues discussed in this paper, however, the HIP fee does not raise concerns about inter-year estimation risk, only intra-year estimation risk.

- *Earnings emergence implications of revenue/expense mismatch*. To the extent that the issuer does collect premiums in 2013 that are intended to prefund the HIP fee owed in 2014, the evolving accounting consensus appears to be that the issuer has no ability to defer the recognition of revenue from 2013 to 2014. To the extent that the associated expense is not being recognized until 2014, a mismatch exists so that many issuers will report material amounts of positive incremental net income in 2013 attributable to its HIP fee recoupment strategy. Potentially, that positive incremental net income in 2013 could be offset by negative incremental net income in 2014, to the extent that what the issuer collects in 2014 premiums related to the HIP fee is less than the associated 2014 outflows. As such, with respect to year-over-year earnings growth, the HIP fee creates an upward bias in 2013 and (depending on the precise details of the issuer's pricing strategy) could create a downward bias in 2014.

- *Comparability across issuers subject to different tax code provisions*. As noted above, the HIP fee is a non-deductible excise tax, and companies exempt from federal income tax receive preferential status in the calculation of the HIP fee owed. These differences related to tax status lead to differences in the impact of the HIP fee on the issuer's financial statement and metrics derived from there.

  To demonstrate this, below is a simple, hypothetical example involving three issuers: one exempt from federal income tax, a second that pays federal income taxes at the alternative minimum corporate rate of 20 percent (e.g., a Blue Cross Blue Shield organization benefiting from the special deduction found in Section 833(b) of the Internal Revenue Code), and a third that pays federal income taxes at the normal corporate rate of 35 percent. In the example, we presume that in absence of the HIP fee, each of the three issuers would have written $10,000 of premium priced to achieve an after-tax profit margin of 4.0 percent. We then assume that each dollar of premiums included in the market share calculation generates one-and-a-half cents of HIP fee liability for the issuer, and that each issuer will raise premiums as necessary to maintain the same amount of

expected after-tax profits after the introduction of the HIP fee as it would have had before the fee's introduction.

		Issuer's Income Tax Rate		
		0%	20%	35%
Premiums before HIP Fee recoupment		10,000	10,000	10,000
Premiums for HIP Fee recoupment		75	188	231
Total premiums		10,075	10,188	10,231
Claims		8,350	8,250	8,250
Expenses excluding HIP Fee		1,250	1,250	1,135
Health Insurance Providers Fee		75	150	150
Operating Income		400	538	696
Taxable Income		*NA*	*688*	*846*
Federal Income Tax		NA	138	296
Net Income		400	400	400
MBR before HIP Fee recoupment		83.5%	82.5%	82.5%
MBR after HIP Fee recoupment		82.9%	81.0%	80.6%
Effective Tax Rate		NA	25.6%	42.5%

Key observations from this example include the following:

- The required increment to premiums, expressed as a percentage of what the premiums otherwise would have been, varies from 0.75 percent for the tax-exempt issuer to 2.31 percent for the issuer taxed at 35 percent. These differences reflect two issues: first, the tax-exempt issuer's lower level of HIP fee per dollar of premium written, by statute, and second, the taxable issuers' need to gross up the HIP fee by the applicable income tax rate for the issuer to remain whole on an after-tax basis, due to the HIP fee having been defined as a non-deductible excise tax.

- The recoupment of the HIP fee in premiums leads to a decrease in the pure ratio of claims to premiums, which we refer to as the MBR.[8] Moreover, the magnitude of that decrease is more significant the higher the issuer's income tax rate.

- The ratio of income taxes to operating income, which in the table is referred to as the effective tax rate, materially exceeds the statutory tax rate. This is attributed to the fact that the issuer now has a non-deductible expense, namely the HIP fee, that is significant in relation to operating income.

- *Customer rebate implications of revenue/expense mismatch*. The example above did not consider the rebates owed by issuers to their customers under the ACA in situations in which a federally defined medical loss ratio (MLR) exceeds a given threshold.

[8] We use the term MBR to distinguish this metric from the medical loss ratio (MLR) defined in federal regulation for purpose of calculating customer rebates, which we discuss below.

Federal taxes and fees are adjustments to the denominator of the ACA's MLR metric. Therefore, if the incremental premiums collected by an issuer in a given year are equal to the incremental HIP fee expense and associated incremental federal income taxes recognized by that issuer in that year's federal MLR reporting, then there is no net impact on the MLR or on the denominator and, hence, no net impact on rebates. However, if incremental premiums for a year exceed that year's incremental recognized tax expense, which is likely to occur in 2013, then the net effect is to increase the denominator, decrease the MLR, and potentially increase rebates to customers. Conversely, if incremental premiums for a year are less than the year's incremental recognized tax expense, which could occur for some issuers in 2014, then the net effect is to decrease the denominator, increase the MLR, and potentially decrease rebates to customers. As a result, the impact of customer rebates could lessen the swing in earnings from 2013 to 2014 as discussed earlier.

As discussed above, it is possible that statutory accounting may evolve in such a way that the amount of the HIP fee expense recognized in the statutory income statement in a given year differs materially from the amount of fee expense paid in that year. The implications that this might have on federal MLR reporting are unclear.

B. Reinsurance Contribution

As discussed in Section I.B, the ACA creates a transitional program providing reinsurance benefits to issuers operating in the individual market. These benefits will be funded by assessments charged to health insurance issuers operating in the group or individual markets and to sponsors of self-funded health plans. This payment was named the "reinsurance contribution" in federal regulation, although the terms "reinsurance fee" and "reinsurance assessment" also have been used. As contrasted with the HIP fee discussed above, regulations implementing the reinsurance contributions have already been finalized.

The reinsurance contribution will be assessed on an annual basis for calendar years 2014 through 2016 only. Federal regulators will announce the national reinsurance contribution rate, expressed in per-member-per-month (PMPM) terms, in advance of the applicable calendar year. For 2014, it was proposed in November 2012 and confirmed in March 2013 that the national reinsurance contribution rate would be $5.25 PMPM. In addition to the national reinsurance contribution rate, states have the ability to charge their own supplemental contribution rate to insured residents of that state to fund additional reinsurance benefits for the individual market in that state beyond the benefits funded by the national reinsurance contributions. The authors are not aware of any state that, for 2014, will exercise the option to charge a supplemental reinsurance contribution.

The regulations state that each contributing entity (meaning a health insurance issuer or self-funded plan sponsor) will submit membership data spanning only the first nine months of the calendar year to federal regulators in November. Most observers think that the entity's reinsurance contribution liability for the calendar year will be determined by taking the submitted membership data, annualizing it (e.g., multiplying the member months for the first nine months of the year by a factor of twelve-ninths), and multiplying by the announced PMPM contribution rate. Via this process, bills will be sent to entities in December, and the sum of those

bills generally will be unequal to the statutory funding target for aggregate reinsurance contributions ($12 billion in 2014, $8 billion in 2015, and $5 billion in 2016). This reflects the reality that actual industry-wide enrollment will not match the industry-wide enrollment assumption used previously to set the PMPM contribution rate. A different interpretation could be that the regulators will use the enrollment data submitted in November to retroactively change the contribution rate for that year, thus producing a set of bills in December that exactly matches the statutory funding target.[9]

As discussed above with the HIP fee, health insurance issuers are expected to attempt to recoup the reinsurance contribution by incorporating it into the pricing of those products whose enrollees are subject to the assessment. The magnitude of the issuer's 2014 reinsurance liability will be based on its membership over the period January 2014 through September 2014. This will be the same for future years (in particular, note that membership figures from the fourth quarter are never used). As such, the issues surrounding the inclusion of the reinsurance contribution in pricing for products sold or renewed in February 2013 and later are similar to issues discussed above involving the HIP fee.

There are three key differences, however, between the reinsurance contribution and the HIP fee. First, there is in some sense a more exact and direct relationship between the reinsurance contribution and a particular enrollee than between the HIP fee and that enrollee. Earlier, we analogized the HIP fee to existing state high-risk pool assessments. Continuing that analogy, the reinsurance contribution can be viewed as being conceptually similar to existing state premium taxes, albeit calculated on a per capita rather than percent-of-premium basis. This difference could influence the attitudes of issuers and regulators, with respect to recoupment strategies and associated messaging. Second, there is far greater transparency available with respect to the magnitude of the reinsurance contribution. As already noted, regulators have stated that the 2014 rate will be $5.25 PMPM. Third, the reinsurance contribution is tax-deductible, so considerations related to the issuer's tax status are not relevant in this context, as contrasted with the HIP fee situation described above.

With this as background, the existence of the reinsurance contribution raises some of the same issues discussed above for the HIP fee, as well as some issues, regarding issuers' financial statements and metrics used by financial analysts:

- *Expense estimation risk*. As discussed above, the most common interpretation of the final regulation is that each year's national reinsurance contribution rate is fixed in advance, and the total amount of funding generated by that rate may end up differing from the statutory funding target. As such, then from an issuer standpoint, expense estimation risk relating to the reinsurance contribution is unlikely to be significant. However, if the final regulation is modified to allow an alternative interpretation, namely that regulators will reset the national contribution rate in December after the enrollment reports come in, then issuers will be exposed to estimation risk in their fourth quarter financial statements with respect to amounts recognized in the previous three quarters.

[9] See comments submitted in Dec. 2012 by the ERISA Industry Committee, available at http://www.eric.org/uploads/doc/health/ERIC%20Comment%20Letter%20on%20Transition%20Reinsurance%20Fee.pdf

- *Earnings emergence implications of revenue/expense mismatch*. Assume for the moment that the national reinsurance contribution rate is $5.25 PMPM for 2014 and $3.50 PMPM for 2015. Assume also that the issuer remains committed to level premiums across the policy year, and recoups in those level premiums the following amounts for the reinsurance contribution: $5.25 PMPM for customers whose policy year starts in January 2014; $3.50 PMPM for customers whose policy year starts in January 2015; steadily declining amounts between $5.25 PMPM and $3.50 PMPM for customers whose policy year starts between February 2014 and December 2014; and steadily increasing amounts between zero and $5.25 PMPM for customers whose policy year starts between February 2013 and December 2013. The total amount collected by the issuer should equal its aggregate reinsurance contribution expense (excluding, for simplicity, issues such as lapses and incremental premium taxes). If looking at 2014 in isolation, however, the issuer is paying out $5.25 PMPM for every member, but collecting less than $5.25 PMPM for every member except those whose policy year started in January 2014. Therefore, this issuer can be expected to have negative 2014 earnings associated with the reinsurance contribution, offset by positive earnings in 2013 and in years beyond 2014. As such, the earnings emergence timing issues associated with the reinsurance contribution are similar to those discussed above for the HIP fee.

- *Comparability across issuers subject to different tax code provisions*. This issue is not relevant to the reinsurance contribution, unlike the HIP fee. For all issuers, however, note that efforts to recoup the reinsurance contribution via premiums will cause a decrease in the MBR, similar to what was shown above in the numerical example for the HIP fee.

- *Customer rebate implications of revenue/expense mismatch*. This issue is largely the same for the reinsurance contribution as it is for the HIP fee. Under the final regulations, similar to the HIP fee, the issuer's payment of reinsurance contributions is a negative adjustment to the denominator (this was a change from the proposed regulations, in which the issuer's payment of reinsurance contributions would have been a positive adjustment to the MLR numerator, rather than a negative adjustment to the MLR denominator[10]).

- *Cash flow timing*. Under the regulations, issuers will receive the annual reinsurance contribution in mid-December and will have 30 days to pay the bill. This proposed timing gives the issuer discretion over whether the cash payment of the reinsurance contribution will occur in the same year as the expense is recognized in the issuer's income statement or in the subsequent year. As such, the relationship between an issuer's cash flow from operations and its operating earnings for the calendar year could be impacted materially by whether the issuer chooses to pay the reinsurance contribution bill in December or in January.

- *Administration of self-funded business*. Self-funded plan sponsors also are liable for reinsurance contributions. To the extent that those plan sponsors employ health insurance

[10] The Academy's Medical Loss Ratio Subgroup submitted a comment letter to HHS, advocating for the change that was ultimately adopted, wherein reinsurance contributions would be treated as regulatory fees subtracted from the MLR denominator. See http://www.actuary.org/files/Acad_comments_MLR_123112.pdf.

issuers as benefit administrators, a sponsor may ask an issuer to get involved in the process of remitting the sponsor's reinsurance contribution to regulators. However, in this situation, an issuer would not recognize any income statement items related to serving as a payment conduit for its self-funded customers. If a self-funded customer wished to prefund its reinsurance contribution liability by making monthly estimated payments to the issuer, rather than waiting to pay the annual bill in one lump sum, then the issuer's balance sheet could be grossed up (i.e., an asset for funds held on deposit with an equal and offsetting liability).

C. *Other New Fees*

In addition to the HIP fee and the reinsurance contributions, there are other new ACA-related taxes and fees that will apply to health insurance issuers in the near future. Each of these fees are mentioned below for completeness, although in general they do not generate as many significant issues from a financial reporting perspective as the two items previously discussed at length.

- The *Patient Centered Outcomes Research Institute (PCORI) fee* is a per-member federal tax that applies to plan years ending between Oct. 1, 2012, and Sept. 30, 2019. The magnitude of the PCORI fee is very small—$1 PMPY for the first plan year, and $2 PMPY for the second, with successive increases commensurate with inflation.

- The *risk adjustment user fee* is a per-member fee that will apply to issuers of plans to which the ACA risk-adjustment program applies. It is intended to fund the administrative costs of the risk-adjustment program. The magnitude of this is also small—for 2014, the fee has been set at $0.96 PMPY.

- The *federally facilitated exchange (FFE) user fee* will apply to issuers of plans offered through a federally facilitated exchange. Similar fees may apply to issuers of plans offered through state-operated exchanges. For 2014, the FFE user fee has been set at 3.5 percent of premium, which may make it the largest in magnitude of the various ACA-related taxes and fees. A recently proposed regulation on preventive services created conditions under which an issuer may be entitled to credits against its FFE user fees.[11]

  Recent regulations have clarified that, from a pricing standpoint, the FFE user fee needs to be pooled across the issuer's exchange and off-exchange business, even though the expense itself is incurred only with respect to exchange premiums. As such, while an issuer faces little estimation risk with respect to the FFE user fee expense itself (apart from the issue noted above regarding potential credits), an issuer may be exposed to estimation risk as it prices for the FFE user fee expense as it makes an assumption regarding , the mix of business on and off-exchange.

[11] These credits relate to situations in which the issuer (or an affiliate) administers benefits for a self-funded plan sponsor that qualifies for a religious exemption to the usual ACA requirement that contraceptive benefits be covered. In that situation, under the proposed regulations the contraceptive benefits for that sponsor's enrollees are to be covered under special insurance policies, for which the issuer cannot collect any premium but receives FFE user fee credits corresponding to the claims incurred under these policies. For further discussion of the potential MLR implications of this situation, see the Academy's MLR Regulation Work Group's comment letter to HHS, at: http://www.actuary.org/files/Academy_letter_on_MLR_and_preventive_coverage_032813.pdf.

Section III – Advanced Payments

The ACA creates new programs under which health insurance issuers will receive from regulatory agencies advance payments that may require subsequent true-ups. Although similar situations exist today, their prevalence will increase dramatically under the ACA. Some financial reporting considerations related to these new forms of advanced payments are discussed below.

A. Premium Subsidies

The ACA creates premium subsidies in the form of tax credits, paid in advance of tax filing and paid directly to health insurance issuers whose members have income of 100 percent to 400 percent of the federal poverty level (FPL). Conceptually, this resembles the Health Coverage Tax Credit (HCTC) created under the Trade Act of 2002. However, the scope and magnitude of the ACA's new premium subsidies far exceeds that of the existing HCTC premium subsidies.

Some of the premium subsidy payments made to issuers likely will be on behalf of members who are no longer enrolled with the issuer, due to having lapsed coverage without notifying the issuer or the exchange. The availability of a 90-day grace period for these members will make it more difficult to determine if a member continues to be in force. The issuer will need to make an estimate of the portion of advanced payment tax credits it has received from the exchange for members who may no longer be in force, and establish a liability for the amount that will need to be refunded to the government.

Alternatively, depending on the timeliness with which the exchange and the government pay the issuer for the advance payment tax credits applicable to its members, a receivable for these outstanding receipts may need to be set up.

B. Cost-Sharing Reduction Payments

The ACA requires that issuers make available cost-sharing reduction (CSR) silver plan versions that have reduced cost-sharing amounts on essential health benefits for enrollees who have household income of 250 percent of FPL or less. These plans result in lower out-of-pocket costs for the eligible enrollee. The issuer is reimbursed by the federal government for the difference in cost-sharing amounts between these CSR plans and the standard silver plan. This is done via monthly estimated payments from the federal government to the issuer, with a true-up to occur each year.

If the government paid too much in estimated payments to the issuer, the issuer will need to reimburse the government for the overpayment, and vice versa. This potential mismatch between the advanced CSR payments and the annual true-up will require the issuer to set up an asset or liability to account for these differences. For known claims, this can be an exact calculation; however, the issuer may need to consider how to handle incurred but unpaid claims.

The subsidization of cost sharing under the ACA has strong similarities to the Medicare Part D low-income cost-sharing (LICS) subsidy program. Under NAIC interpretation 05-05 for statutory accounting, a health insurance issuer does not recognize any income statement items relating to the Part D LICS program. Our understanding of industry practice is that issuers

typically follow the same practice in their GAAP accounting. Similar logic may apply to the ACA's CSR program.

Section IV – Existing Actuarial Liabilities

Earlier sections of this white paper have focused on items that will be new to a health insurance issuer's financial statements as a result of the ACA's 2014 market reforms. In the remainder of this paper, we discuss the impact that these same market reforms are expected to have on the issuer's existing types of actuarial liabilities.

A. Claim Liabilities

Typically, health insurance issuers calculate unpaid claim liabilities by analyzing historical payment patterns for a block of business using completion factors, coupled for the most recent months with a PMPM or loss ratio approach taking into account trend, seasonality, large claims, inventory, and other operational factors. With changes from the ACA, however, this approach may be more challenging.

There will be considerable uncertainty around the morbidity level of issuers' insured members in 2014. An issuer's risk pool in a market will change with the introduction of health benefit exchanges, as a significant portion of the individual and/or small-group market likely will come from the previously uninsured population and/or from those previously enrolled in high-risk pools. For issuers active in multiple markets, shifts in membership can be expected across markets—individual, small group, large group, Medicare Advantage, and Medicaid. In light of this, issuers will need to use marketplace modeling to project the PMPM for recent months in 2014. They will not be able to rely on pre-2014 experience trended forward due to the substantial change in mix. Morbidity after Jan. 1, 2014, will be different from historical morbidity due to the change in mix of members who also may use coverage differently than past members.

Plan designs also will be changing significantly in 2014. Monitoring the mix of plans has always been a consideration in determining the claim liability, and this will become more important in 2014. The average benefit level for blocks of individual business likely will be higher in 2014 than in the past due to minimum actuarial value and essential health benefit requirements. The opposite could occur for blocks of group business, with silver plans becoming the de facto benchmark. Issuers will need to evaluate whether to combine on-exchange and off-exchange plans. They also will need to evaluate whether to combine exchange plans across metal levels, for reserving purposes, to the extent that completion factors and seasonality are expected to be materially different. Issuers will need to take into account benefit design changes and the impact that new low-income cost-sharing subsidies will have on seasonality patterns.

Increased provider risk sharing also will have an impact on claims reserves. Issuers will have to decide if they will calculate reserves separately for Accountable Care Organizations (ACOs) or combine them with commercial business. If they are combined, the PMPM membership base becomes an issue. With risk-sharing, issuers will have to determine provider incentive liabilities for amounts owed to providers under gain sharing. If claims are higher than targets, issuers will need to determine if they are going to set up a receivable from the providers or cut off claim payments. Provider solvency becomes an issue and will need to be part of the calculation.

Consideration will need to be given to margin/provision for adverse deviation (PAD) amounts since these liabilities are not like medical claims.

In periods during which an issuer's risk pool changes significantly (e.g., first quarter 2014), claim liability estimates are based more on pricing assumptions and judgment rather than definitive data on morbidity of new entrants. As such, it is expected that there will be greater potential for intra-year prior period reserve development (adverse and/or favorable) in periods immediately subsequent to large changes in risk pool (e.g., second quarter 2014). As the nature of risk pool stabilizes, the potential for reserve development should diminish to historically normal levels. Note that the impact of prior period reserve development on financial statements may be muted by partially offsetting entries to risk corridor and MLR rebate amounts.

Payment patterns also are likely to be impacted by claims operations. Health issuers will need to monitor claims inventories. This will be exacerbated by the implementation of ICD-10, currently slated for October 2014. This transition is expected to lead to greater volumes of pended claims and a lengthening of lag times due to coding errors and questions. This will further add to the volatility in 2014 and will prolong the transition to a new steady state in claims lag patterns.

B. Contract Reserves

Some issuers have held contract reserves (i.e., policy reserves, benefit reserves, or active life reserves) in the individual market to reflect the extent to which a portion of past premiums was designed to prefund future claims. In a few cases, this prefunding was a consequence of an issue age, rather than attained age, premium structure. More commonly, however, this prefunding went hand-in-hand with medical underwriting and renewal pricing practices, in which the issuer expected that policyholders in early policy durations would have lower medical benefit ratios than policyholders in later policy durations. This type of reserve appears to be far less relevant with respect to new policies written in 2014 and later, since medical underwriting will no longer be allowed. However, some issuers may consider holding a small contract reserve under the theory that claims will be higher in the second year for new entrants to the individual market, as those individuals become familiar with provider networks and higher-deductible plans.

For pre-2014 individual policies, issues arise about how to handle contract reserves currently being held. For GAAP, to the extent that the lock-in principle is applied, it may not be possible for issuers to update their contract reserve assumptions to reflect the fact the future expected lapse rates now differ greatly from original assumptions (e.g., as individuals move from closed blocks to new exchange products).[12] In that case, we would expect to see large changes in reserve balances and Deferred Acquisition Costs (DAC) balances when the excess lapses actually occur. With respect to significant lapses expected to occur on Jan. 1, 2014, the issuer may have an option whether to recognize those lapses in the Dec. 31, 2013, reserve calculation. For SAP, the lock-in principle generally is believed to not apply. Therefore, some issuers already may have been making changes to their future lapse assumptions in their 2011 and 2012 reserve calculations, reducing the potential for a large impact on reserves when the excess lapses materialize.

[12] Situations may exist in practice in which the issuer is not applying the lock-in principle to the GAAP contract reserves (e.g., when the SAP reserves are being continuously unlocked and the issuer wants to avoid having GAAP-SAP differences in the reserves), but the deviation from GAAP is not judged to be material to the financial statements.

Since the change in contract reserves is one piece of the MLR rebate calculation, the release of contract reserves will have an impact on the magnitude of customer rebates. However, there is some uncertainty as to whether the future release of contract reserves that accrued prior to the inception of rebate requirements in 2011 should be allowed to impact future years' MLR calculations. Similarly, some ambiguity may exist over how a change in policy reserves arising from a change in methodology or from the unlocking of previous assumptions should be handled within the MLR calculation.

C. Due and Unpaid Premium Asset

As mentioned in Sections I.A and III.A, under the ACA, exchange members receiving premium subsidies will have a 90-day premium grace period, rather than the 30-day grace period used today. This will introduce a need for issuers to rethink their existing approach for estimating the due and unpaid premium asset.

D. Premium Deficiency Reserves

An issuer records a premium deficiency reserve (PDR) when it projects that future premiums for a block of business will be insufficient to cover, over some timeframe, future claims plus future expenses that are attributable directly to the block of business, or represent overhead allocated to the block that cannot be covered by profits from other blocks of business. In essence, a PDR leads to an acceleration of some expected future losses into the present.

Some of the issues discussed earlier in this paper can affect an issuer's PDR calculations. For example, if an issuer has over-estimated its risk adjustment receivable, then it also may have over-estimated future risk-adjusted premium revenues. As such, it may have under-estimated future period losses and the currently required PDR.

One of the main inputs into a PDR calculation involves the timing and magnitude of future rate increases. ASOP 42 implies that the rate increase assumptions used in a PDR calculation should take into account the issuer's expectations, in light of market conditions and regulatory restrictions. As such, a PDR model that assumes rates will increase by 15 percent in six months' time is appropriate only to the extent not only that management proposes such an increase, but also that the increase will not encounter any regulatory impediments. As such, with enhanced levels of rate review under the ACA, considering the likelihood of regulatory approval becomes even more important when evaluating appropriate rate increase assumptions for PDR calculation purposes. Viewed differently, the likelihood that the issuer's PDR estimate will, with hindsight, prove to have been "wrong" is now heightened by the additional uncertainty, attributable to the enhanced rate review process, regarding whether the magnitude and timing of actual future rate increases will match the assumptions made in the PDR model.

Another principal consideration in PDR calculations is the level of granularity at which the issuer's business is grouped into blocks for PDR testing purposes. Practice varies among issuers in this regard, as different issuers take different interpretations of the "marketed, measured and serviced" language found in the accounting literature. Conceivably, changes in the health insurance marketplace beginning in 2014 could lead to changes in how issuers define their

blocks of business for PDR testing purposes. Exchange products and off-exchange products may, or may not, be considered to constitute different blocks of business for PDR purposes.

As discussed above, users of issuers financial statements need to be aware of the many changes in 2014. They will need to take these into account as they look at trends and comparability from period-to-period and between issuers.