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Statement of Position 87-1

Accounting for Asserted and Unasserted Medical Malpractice Claims of Health Care Providers and Related Issues

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NOTE

This statement of position applies to all health care providers and provides guidance concerning medical malpractice insurance financial-reporting issues.

Statements of position of the Accounting Standards Division present the conclusions of at least a majority of the Accounting Standards Executive Committee, which is the senior technical body of the Institute authorized to speak for the Institute in areas of financial accounting and reporting. Statements of position do not establish standards enforceable under rule 203 of the AICPA Code of Professional Ethics. However, Statement on Auditing Standards (SAS) No. 5, *The Meaning of "Present Fairly in Conformity With Generally Accepted Accounting Principles" in the Independent Auditor's Report*, as amended by SAS No. 43, *Omnibus Statement on Auditing Standards*, identifies AICPA statements of position as another source of established accounting principles that the auditor should consider. Accordingly, members should be prepared to justify departures from the recommendations in this statement of position.

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Introduction

1. Health care providers have traditionally purchased occurrence-basis insurance to protect themselves against losses from malpractice claims. Such losses include the costs of claims investigation and settlement resulting from allegedly improper professional health care services provided to patients. The cost of such insurance is fixed at the beginning of the policy term, and the premium has been charged to expense pro rata over the term of the policy.

2. The changing social and economic environment has both increased the cost and limited the availability of occurrence-basis medical malpractice insurance. Insurance companies have substantially raised premiums or restricted the degree of risk they were willing to assume. As a result, some health care providers have dropped their insurance coverage; others have kept their coverage but modified it to retain more of their malpractice risk by accepting higher deductibles, by purchasing retrospectively rated policies, by forming captive insurance companies, or by joining with others to form multiprovider captive insurance companies. Still other providers have purchased claims-made policies, which cover only claims reported to the insurance carrier during the policy term. Today, few health care providers have full insurance protection against losses from medical malpractice claims, and careful evaluation of ongoing insurance protection is required whenever one of the above modifications is made.

3. Many health care providers established trust funds as a means of funding the cost of uninsured (also referred to as self-insured) malpractice claims and related expenses. Others simply pay such costs out of general funds when they are incurred.

4. Accounting for asserted and unasserted medical malpractice claims has become diverse. The diversity is compounded by the use

of captive insurance companies, retrospectively rated policies, claims-made insurance programs, and trust funds because accounting pronouncements offer no specific guidance in those areas. Neither the AICPA's 1972 *Hospital Audit Guide* nor the AICPA's 1978 Statement of Position (SOP), *Clarification of Accounting, Auditing and Reporting Practices Relating to Hospital Malpractice Loss Contingencies*, provides specific guidance on those accounting issues. Accordingly, this statement has been prepared (*a*) as a basis for reducing the existing diversity of practice and (*b*) as a guide on accounting for uninsured asserted and unasserted medical malpractice claims and related issues.

Definitions

5. The following are definitions of terms used in this statement.

Asserted claim. A claim made against a health care provider by or on behalf of a patient alleging improper professional service.

Claims-made policy. A policy that covers only malpractice claims covered by the policy reported to the insurance carrier during the policy term.

Discounting. Measuring the cost of malpractice claims at the present value of the estimated future payments.

Health care provider. A person or other entity or group of entities under common control that delivers health care services, including, but not limited to, hospitals, nursing homes, and practices of physicians, dentists, or other health care specialists.

Multiprovider captive. An insurance company owned by two or more health care providers that underwrites malpractice insurance for its owners.

Occurrence-basis policy. A policy that covers claims resulting from incidents that occur during the policy terms, regardless of when the claims are reported to the insurance carrier.

Reported incident. An occurrence identified by a health care provider, usually under some form of claim-management-reporting system, as one in which improper professional service may be alleged, thereby resulting in a malpractice claim.

Retrospectively rated policy. An insurance policy with a premium that is adjustable based on the experience of the insured health care provider or group of health care providers during the policy term.

Self-insurance. Risk of loss assumed by a health care provider. No external insurance coverage.

Tail coverage. Insurance designed to cover malpractice claims incurred before, but reported after, cancellation or expiration of a claims-made policy.

Trust fund. A fund established by a health care provider to pay malpractice claims and related expenses as they arise. (In the case of a government, the trust fund often is established as an "internal service fund.")

Ultimate cost. Total claim payments, including costs associated with litigating or settling claims.

Unasserted claim. A medical malpractice claim that has not been, but may in the future be, asserted by or on behalf of a patient related to a reported or unreported incident.

Unreported incident. An occurrence in which improper professional service may have been administered by the health care provider that may result in a malpractice claim. The occurrence, however, has not yet been identified by the health care provider under a formal or informal claims-reporting system.

Wholly owned captive. An insurance company subsidiary of a health care provider that provides malpractice insurance primarily to its parent.

Scope

6. This statement applies to all health care providers and their wholly owned and multiprovider-owned captive insurance companies.

Relevant Accounting Pronouncements

7. Three accounting pronouncements provide guidance on accounting for medical malpractice claims: FASB Statement No. 5, *Accounting for Contingencies,* FASB Interpretation No. 14, *Reasonable Estimation of the Amount of a Loss,* and the 1978 AICPA Statement of Position, *Clarification of Accounting, Auditing, and Reporting Practices Relating to Malpractice Loss Contingencies.* The following discussion cites relevant passages from those pronouncements.

Accounting for Uninsured Asserted and Unasserted Malpractice Claims

8. An issue in accounting for uninsured asserted and unasserted malpractice claims is whether a health care provider should accrue for the ultimate cost of uninsured asserted and unasserted malpractice claims when incidents occur. Other accounting issues include how such losses should be accrued and how those accrued losses should be classified in the financial statements.

Discussion

9. Many health care providers that do not obtain insurance for their malpractice risks establish risk management systems to reduce their exposure to malpractice claims. Risk management systems are designed (*a*) to reduce the likelihood of incidents that may result in malpractice claims, (*b*) to identify such incidents that have occurred and to correct the underlying causes, (*c*) to minimize the amount of payments made on reported claims, and (*d*) to provide for the availability of financial resources to settle claims.

10. For accounting purposes, the two major categories of malpractice loss contingencies are asserted and unasserted claims. *Asserted claims* are claims made against a health care provider by or on behalf of a patient alleging improper professional service. *Unasserted claims* (that is, incurred but not reported claims) are claims that have not been asserted by or on behalf of a patient and may relate to either—

a. *Reported incidents*, which are occurrences that have been identified by the health care provider, usually under some form of claims management reporting system, as incidents in which improper care may be alleged, thereby resulting in malpractice claims, or—

b. *Unreported incidents*, which are occurrences that have not yet been identified by the health care provider under a formal or informal claims-reporting system as incidents in which improper professional service may be alleged, and can result in malpractice claims.

11. The 1978 SOP provides limited guidance on accounting for uninsured malpractice claims. That SOP requires estimated losses resulting from malpractice claims to be accounted for in accordance with FASB Statement No. 5 and FASB Interpretation No. 14.

Accordingly, an expense should be accrued if an incident has occurred that will probably result in an uninsured loss and if the amount can be reasonably estimated. In making the estimate, prior claim experience should be considered, including an analysis of the frequency of past claims. The SOP indicates that a qualified actuary may be helpful in deriving an estimate of claims incurred but not reported and also in quantifying the uncertainties inherent in such estimates.

12. FASB Interpretation No. 14 states that if it is probable a loss has been incurred but that only a range of loss can be reasonably estimated, the loss should still be accrued. However, in such circumstances, the most likely amount in the range should be accrued. If no amount is more likely than any other amount, the minimum amount should be accrued, and the amount of any potential additional loss should be disclosed in the notes to the financial statements.

Present Practices

13. Some health care providers accrue estimated losses from malpractice claims based on information developed from their risk management systems. Losses from asserted claims are based on the best estimate of the cost of settling or litigating the claims, including the expense of settlement and litigation (ultimate cost). Many of those estimates are made by claims managers or attorneys.

14. Losses from unasserted claims arising from reported incidents are estimated and accrued either individually or in groups. Individual accrual is based on an analysis of each incident; group accrual is based on the historical relationship between unasserted claims arising from reported incidents and eventual loss.

15. Some health care providers also estimate and accrue losses from unreported incidents. Those estimates are generally based on the provider's experience of the relationship between unreported incidents and eventual losses or on industry experience. Losses from reported and unreported incidents are often estimated with the help of actuaries.

16. Other health care providers accrue amounts for estimated losses from malpractice claims based on actuarially determined payments to a trust fund or captive insurance company. Many of those payments represent the present value of expected future payments for malpractice claims less amounts previously funded and

amounts to be funded in future years. Those amounts generally result in leveling the reported expense of malpractice claims over a period of years and are not usually based on incidents occurring in the current year.

Views on the Issues

17. Some believe that the ultimate costs of malpractice claims should be accrued when the incidents that cause them occurred, if it can be determined that it is probable that losses have been incurred and if the amounts can be reasonably estimated. However, they maintain that the ability to make reasonable estimates varies for asserted and unasserted claims. They believe that accrual of estimated losses from asserted claims and the related settlement and litigation expenses should be based on the best estimate of the costs of settling or litigating the claims.

18. These individuals also believe that estimated losses from reported incidents should be accrued if sufficient information is available from the health care provider's own experience to determine—either individually or on a group basis—that it is probable that losses have been incurred and that they can be reasonably estimated. In addition, they maintain that estimated losses from unreported incidents should also be accrued if the health care provider has sufficient statistics on its paid claims that resulted from unreported incidents to provide a basis on which to estimate the amount of such losses. However, if a health care provider does *not* have sufficient historical experience on which to estimate losses from reported or unreported incidents, they believe the cost of such claims should not be accrued. The existing contingency should be disclosed in the notes to the financial statements.

19. Others maintain that the actuarially determined payment to a trust fund or captive insurance company should be accrued as an expense in the health care provider's financial statements because the amount was determined by an actuary, who is a specialist in the field. They believe that Statement on Auditing Standards No. 11, *Using the Work of a Specialist*, supports their position. SAS No. 11 states in paragraph 9 that "if the auditor determines that the specialist's findings support the related representations in the financial statements, he may reasonably conclude that he has obtained sufficient evidential matter." Those who support accruing actuarially

determined payments contend that accountants do not have the level of expertise to challenge an actuary's recommendations.

20. Others believe that actuarially determined payments frequently include amounts that do not meet the criteria for accrual under FASB Statement No. 5 for the following reasons:

a. Actuarially determined payments generally result in leveling the cost of malpractice claims over a period of years. For example, if it is probable that a $1 million loss will occur some time in the next five years, $200,000 may be funded in each of the next five years. For accounting purposes, $1 million should be accrued in the year the incident occurred if the amount of loss can be reasonably estimated at that time.

b. Many actuarially determined payments are computed at the request of the health care provider at the beginning of a year or earlier, and, therefore, the health care provider's claim experience for that year is not considered.

c. The actuarial computations may be based on industry experience rather than on the health care provider's claim experience. If the health care provider's claim experience differs materially from the experience of others, the actuarial determinations would not conform with FASB Statement No. 5.

d. Actuarially determined payments may contain provisions for adverse deviation that do not conform with FASB Statement No. 5, which requires an accounting accrual based on reasonable estimates of incurred losses.

Conclusions

21. The ultimate costs of malpractice claims, which include costs associated with litigating or settling claims, should be accrued when the incidents occur that give rise to the claims, if it can be determined that it is probable that liabilities have been incurred and if the amounts of the losses can be reasonably estimated.

22. *Estimating the Amount of Loss.* If it is probable that a loss has been incurred and the information available indicates the loss is within a range of amounts, the most likely amount of loss in the range should be accrued. If no amount in the range is more likely than any other, the minimum amount in the range should be accrued, and the

potential additional loss should be disclosed if there is at least a reasonable possibility of loss in excess of the amount accrued. (See FASB Interpretation No. 14.) If the range of loss cannot be reasonably estimated, no loss should be accrued.

23. Estimated losses should be reviewed and changed if necessary at each reporting date; the amounts of the changes would be recognized currently as additional expense or reductions of expense.

24. *Asserted Claims and Unasserted Claims Arising From Reported Incidents.* Estimated losses from asserted claims should be accrued either individually or on a group basis, based on the best estimates of the ultimate costs of the claims. Estimated losses from unasserted claims arising from reported incidents should be accrued individually or on a group basis, using the relationship of past reported incidents to eventual claim payments. All relevant information, including industry experience, should be used in estimating the expected amount of asserted claims and unasserted claims arising from reported incidents.

25. *Unreported Incidents.* A health care provider should accrue estimated losses from unreported incidents based on its best estimate of the ultimate costs. Those estimates should be based on all available evidence that is relevant to estimating unreported incidents that have occurred as well as the *amount of loss* related to those estimated incidents. Such evidence may include industry experience, the provider's own historical experience, and the provider's existing asserted claims and reported incidents. The accrual should be limited to an estimate of the losses that will result from unreported incidents that are probable of having occurred before the end of the reporting period.

26. In estimating the extent to which unreported incidents are probable of having occurred, some health care providers may develop a range of possible estimates of the number of unreported incidents, including zero. However, the greater the volume of a health care provider's operations, the greater the likelihood that the provider's minimum estimate of the number of probable unreported incidents will be greater than zero.

27. *Use of Industry Experience.* In estimating losses from malpractice claims, a health care provider should use data on industry experience only to the extent that such data is relevant to developing an estimate specific to the entity. The relevance of industry data depends principally on the comparability of the health care provider with the entities whose experiences are used in developing that data. Various factors, such as the nature of operations, size, and geographic location, should be considered in assessing comparability. Further, industry data that is not current may not be relevant. How the health care provider plans to use the data affects which factors are more important in a given circumstance, as indicated in the following examples:

a. In estimating the amount of loss, the nature of the incident would typically be critical in using industry data.

b. In estimating the extent to which unreported incidents have occurred, the comparability of a provider's business activity and risk management system to that of the other providers included in the industry data would be critical in determining whether and how industry experience can be used. (Not being able to make such comparisons of the risk management systems would indicate that industry data should not be used in estimating the extent of a provider's probable unreported incidents.)

28. Accrued unpaid claims and expenses that are expected to be paid during the normal operating cycle (generally within one year of the date of the financial statements) should be classified as current liabilities; all other accrued unpaid claims and expenses should be classified as noncurrent liabilities.

29. *Disclosure.* A health care provider should disclose its program of medical malpractice insurance coverages and the basis for any related loss accruals. If the health care provider cannot estimate losses relating to a particular category of malpractice claims (for example, asserted claims, reported incidents, or unreported incidents) in accordance with paragraphs 22 through 27, the potential losses related to that category of claims should not be accrued. However, the contingency should be disclosed in the notes to the financial statements, as required by FASB Statement No. 5.

Disclosure of Discounting Accrued Unpaid Malpractice Claims

30. An issue in accounting for medical malpractice claims is what should be disclosed by health care providers that discount accrued unpaid medical malpractice claims.

Discussion

31. The relevant accounting pronouncements are not specific about whether unpaid malpractice claims should be recorded at the estimated ultimate cost of settlement or at the present value of anticipated future cash payments. Because of the substantial delay between the date an incident occurs and the date the claim is paid, the difference between recording the amount of accrued asserted and unasserted claims at their estimated ultimate cost of settlement and at their present value is significant.

Conclusions

32. A task force of the Accounting Standards Division is considering the accounting implications of certain discounting applications, including discounting insurance claims. Until the discounting issue is resolved, health care providers that discount accrued malpractice claims should disclose in the notes to their financial statements the carrying amount of accrued malpractice claims that are discounted in the financial statements and the interest rate(s) used to discount those claims (see FASB Statement No. 60, *Accounting and Reporting by Insurance Enterprises*, paragraph 60(d)).

Accounting for Claims-Made Policies and Tail Coverage

33. An issue in accounting for a claims-made policy is whether a health care provider should accrue for the ultimate costs of malpractice claims and incidents not reported to the insurance carrier during the term of the policy. Other issues include (*a*) how that accrual should be made and (*b*) whether buying tail coverage satisfies the requirement to provide for the costs of malpractice claims and incidents not reported to the insurance carrier.

Discussion

34. Many health care providers now buy claims-made malpractice insurance. A claims-made policy differs from an occurrence-

basis policy in that it covers only claims reported to the insurance carrier during the policy term. If a claims-made policy is not continually renewed or if tail coverage is not obtained when the policy is discontinued, a health care provider is uninsured for malpractice claims reported to the insurance carrier after the termination of the policy, regardless of when the incidents occurred.

35. An accounting issue to be addressed is whether a health care provider with a claims-made policy should accrue a liability for estimated losses relating to unasserted claims and incidents not reported to the insurance carrier, although they may be covered by future claims-made policies.

36. A health care provider may terminate a claims-made policy and buy tail coverage. If so, another accounting issue to be addressed is whether the cost of tail coverage should be charged to expense when the decision is made to terminate the claims-made policy or whether the cost should be deferred and amortized to expense over the period that claims are expected to be reported.

Present Practices

37. Few health care providers now accrue for estimated losses from unasserted claims and incidents not reported to the insurance carrier that are expected to be covered under future claims-made policies.

38. Most health care providers charge the cost of tail coverage to expense in the periods in which they obtain the coverage.

Views on the Issues

39. Some believe that a claims-made policy represents a transfer of risk within the policy limits to the insurance carrier and that it is unnecessary to accrue for estimated losses from unasserted claims and unreported incidents to be covered under future claims-made policies. They maintain that such accrual would be necessary only if the health care provider decided not to renew a claims-made policy or the insurance carrier indicated it would not renew the policy and tail coverage was not going to be or could not be obtained.

40. Others believe that a claims-made policy does not transfer risk to the insurance carrier for unasserted claims and incidents not

reported to the insurance carrier; they maintain that the health care provider should accrue for such claims. The accrual should be reversed when the claims are subsequently reported and covered by a claims-made or tail coverage policy.

41. Some believe the premium for tail coverage should be charged to expense when the coverage is obtained because the premium relates to past occurrences.

42. Others believe recognition in expense of the cost of tail coverage should be deferred. They maintain that it should be charged to expense over the estimated period in which the claims will be reported because the tail coverage is a continuation of the claims-made policy.

Conclusions

43. A claims-made policy represents a transfer of risk within the policy limits to the insurance carrier for asserted claims and incidents reported to the insurance carrier; however, this policy does not represent a transfer of risk for claims and incidents not reported to the insurance carrier. Consequently, a health care provider that is insured under a claims-made policy should account for the estimated cost of those claims and incidents not reported to the insurance carrier in accordance with paragraphs 22 through 27. This should be done unless the health care provider has bought tail coverage and included the cost of the premium as expense in the financial statements for that period.

Accounting for Retrospectively Rated Premiums

44. The issues to be addressed in accounting for retrospectively rated premium policies are (*a*) how health care providers should account for premiums and (*b*) what disclosures of estimated losses should be made under such policies if the ultimate premiums are based primarily on each health care provider's loss experience or on the experience of a group of health care providers.

Discussion

45. The premium for a nonretrospectively rated policy is fixed for the period of the contract and is usually charged to expense pro rata over the contract period. However, for a retrospectively rated

policy, an estimated or deposit premium is generally paid to the insurance company at the inception of the contract period. The deposit premium usually consists of a minimum premium, representing the insurance company's expenses and profits, plus an amount for estimated claims experience. During the term of the policy, the deposit premium is adjusted, subject to any minimum and maximum premium limitations of the contract, based on the experience of the health care provider.

46. Some retrospectively rated policies are primarily based on the experience of the individual health care provider and some are primarily based on the experience of a group of health care providers. Other policies may be based on some combination of both individual and group experience.

Present Practices

47. Some health care providers account for minimum premiums paid to insurance companies on retrospectively rated policies as expense over the period of coverage and recognize estimated losses in excess of the minimum premium from asserted and unasserted claims as additional insurance expense for the period.

48. Others amortize premiums on retrospectively rated policies over the period of coverage and recognize adjustments resulting from favorable or unfavorable claim experience in the financial statements when the insurance company reports them.

Views on the Issues

49. A retrospectively rated policy may provide that the insurer will not return the minimum premium regardless of the degree of favorable experience and, if experience is unfavorable, that the insured will only be required to pay a maximum amount. Some believe an estimate of the total premium ultimately to be paid should be charged to expense over the term of the contract.

50. Those who support that view maintain that health care providers retain risk of loss up to the maximum premium under those contracts. Estimated losses from asserted and unasserted claims should be accrued as indicated in paragraphs 22 through 27 up to that maximum amount.

51. Others believe that minimum premiums on retrospectively rated policies should be amortized pro rata over the period of coverage. Retrospective premium adjustments should be recorded as adjustments of insurance expense when the insured is notified of such adjustments. Those who support this view maintain that the premium is the best estimate of losses from asserted and unasserted claims and, therefore, should be the insurance expense for the period.

Conclusions

52. A health care provider with a retrospectively rated medical malpractice insurance policy whose ultimate premium is based primarily on the health care provider's loss experience should account for the minimum premium as expense over the period of coverage under the policy and accrue estimated losses from asserted and unasserted claims in excess of the minimum premium as indicated in paragraphs 22 through 27. However, such estimated losses should not be accrued in excess of a stipulated maximum premium. If the health care provider cannot estimate losses from asserted or unasserted malpractice claims as indicated in paragraphs 22 through 27, the health care provider should disclose the existing contingency in the notes to the financial statements (see paragraph 29).

53. A health care provider insured under a retrospectively rated policy with premiums based primarily on the experience of a group of health care providers should amortize the initial premium to expense pro rata over the policy term. The provider should also accrue additional premiums or refunds on the basis of the group's experience to date, which should include provision for the ultimate cost of asserted and unasserted claims before the financial statement date, whether reported or unreported. The health care provider should disclose (*a*) that it is insured under a retrospectively rated policy and (*b*) that premiums are accrued based on the ultimate cost of the experience to date of a group of providers. If the health care provider cannot estimate losses from asserted or unasserted malpractice claims as indicated in paragraphs 22 through 27, it should disclose the existing contingency in the notes to the financial statements (see paragraph 29).

Accounting for Medical Malpractice Claims Insured With Captive Insurance Companies

54. In accounting for medical malpractice claims insured with wholly owned and multiprovider owned captive insurance companies, an accounting issue to be considered is how health care providers should account for estimated losses from asserted and unasserted claims.

Discussion

55. Some health care providers have formed wholly owned subsidiaries to insure the parent entity and possibly other health care providers. Those entities are captive insurance companies for which FASB Statement No. 60 specifies the accounting.

56. Other health care providers have formed multiprovider captive insurance companies to insure their medical malpractice claims. Those entities are also captive insurance companies for which FASB Statement No. 60 specifies the accounting. A multiprovider captive insurance company is commonly formed by a group of health care providers that are related geographically, that are affiliated or under common control, such as by members of a religious community, or that have similar malpractice claims experience. A multiprovider captive insurance company may be formed to (*a*) spread the risk of malpractice claims among a number of similar institutions, (*b*) obtain excess coverage at a lower cost, or (*c*) provide for advance funding of the cost of malpractice claims within the provisions of reimbursement regulations. The captive may retain the entire risk assumed from its insureds or it may obtain excess coverage from a commercial insurance company.

57. Premiums on some policies issued by multiprovider captives are fixed for the period of the contract. However, premiums on many policies issued by such insurers are retrospectively rated. Such premiums may be based on the experience of the individual health care provider or on the experience of the group. The arrangements between providers and their captive may be complex; a careful analysis is generally required to determine the extent of coverage that in fact is provided by the captive. If, for instance, the insurance contract requires a premium essentially equal to claims incurred by the provider plus a fee for expenses and profit, the captive is, in effect, only a claims-paying agent.

Present Practices

58. Financial statements of health care providers generally do not disclose the method of accounting for captive insurance companies.

Views on the Issues

59. Some believe that a health care provider that is insured by its wholly owned captive is, in substance, uninsured. They believe, therefore, that the same considerations apply in accounting for estimated losses from uninsured asserted and unasserted malpractice claims of the parent as described in paragraphs 21 through 29. FASB Statement No. 5, paragraph 27, states that "uninsured risks may arise in a number of ways, including . . . insurance through a subsidiary or investee to the extent not reinsured with an independent insurer." A footnote to that paragraph states that "the effects of transactions between a parent or investor and a subsidiary or investee insurance company shall be eliminated from an enterprise's financial statements."

60. Similarly, some believe that policies issued by multiprovider captives in which the premiums are based on the experience of the individual health care providers are, in substance, not insurance. Thus, the premiums should be accounted for as expense over the periods of coverage; estimated losses from asserted and unasserted claims should be accrued and reported as indicated in paragraphs 21 through 29. However, if the premiums are based on the experience of the group, they should be amortized to expense pro rata over the terms of the policies.

61. Others believe that for retrospectively rated policies issued by multiprovider captives, with the premiums based only on the health care provider's individual experience, the initial premiums should be amortized to expense pro rata over the terms of the policies. Premium adjustments should be recorded only when the health care providers are notified by the multiprovider captives.

Conclusions

62. The financial statements of a health care provider insuring medical malpractice claims through a wholly owned captive insurance subsidiary must include provision for estimated losses from asserted and unasserted claims as indicated in paragraphs 21 through

29. That may be done directly in the financial statements of the health care provider or in consolidation of the financial statements of the wholly owned captive.

63. A health care provider insured by a multiprovider captive insurance company for medical malpractice claims under a retrospectively rated insurance policy whose ultimate premium is primarily based on the health care provider's experience up to a maximum premium, if any, should account for such insurance as indicated in paragraph 52.

64. A health care provider insured by a multiprovider captive insurance company for medical malpractice claims under a retrospectively rated policy based primarily on the experience of a group of health care providers should account for such insurance as indicated in paragraph 53. However, the health care provider should consider whether the economic substance of the multiprovider captive is sufficient to relieve the health care provider from further liability. The health care provider should disclose (*a*) that it is insured under a retrospectively rated policy of a multiprovider captive and (*b*) that premiums are accrued based on the captive's experience to date.

65. A health care provider that is insured by a multiprovider captive should disclose in its financial statements that it is insured by a multiprovider captive, and it should disclose its ownership percentage in the captive as well as the method of accounting for its investment in and the operations of the captive. In addition, if the health care provider cannot make the necessary estimates of losses from asserted or unasserted claims as indicated in paragraphs 22 through 27, the health care provider should disclose the existing contingency in the notes to the financial statements (see paragraph 29).

Accounting for Trust Funds

66. Another issue is how a health care provider should account for a trust fund established to make resources available to settle malpractice claims.

Discussion

67. One of the objectives of a risk management system is to make sure that sufficient resources are available to settle malpractice claims as they come due. Some health care providers establish trust funds in an attempt to make sure that financial resources are available to pay claims. In most circumstances, a trustee controls the trust fund assets and the trust agreement provides that the assets can be used only to investigate, litigate, and settle malpractice claims and to pay administrative expenses of the trust fund.

68. Diverse practices have developed for reporting medical malpractice trust funds and their revenues and administrative expenses in the financial statements of the health care provider.

Present Practices

69. Some health care providers treat a payment to a trust fund as a transfer of funds from one case account to another. Others exclude the trust fund from their financial statements and charge the payment to an expense account. They recognize a liability for unpaid claims only to the extent that claims exceed the amount in the trust fund. Revenues, generally interest income, and administrative expenses of the trust fund are recorded in the financial statements of the health care provider only if the trust fund is included in the statements.

Views on the Issues

70. Some believe that a trust fund, whether legally revocable or irrevocable, should be included in the health care provider's financial statements because establishing a trust fund does not relieve the health care provider of the financial responsibility for malpractice claims. A health care provider cannot limit its legal obligation for malpractice claims to the amount in the trust fund; a malpractice claimant can look to all the assets of the health care provider as well as to the trust fund to satisfy a malpractice claim. A medical malpractice trust fund cannot be compared to a pension fund because, under certain circumstances, a company's pension obligations can be limited to the amount in the pension fund.

71. Others maintain that a medical malpractice trust fund is comparable to a pension fund and should not be reported in the health care provider's financial statements. They believe that because

future malpractice claims will be paid from the trust fund, establishing a fund provides a transfer of risk and that only malpractice claims exceeding the amount in the trust fund should be reported in the health care provider's financial statements. They also maintain that there is no significant distinction for accounting purposes between assets held in revocable and irrevocable trusts because the assets of the trust are used solely to discharge obligations for unpaid claims.

72. Some believe that a trust fund included in the financial statements of the health care provider should be classified as a current asset, and others maintain that it should be classified as a noncurrent asset. Still others believe that classification should depend on the classification of estimated unpaid malpractice claims.

Conclusions

73. A trust fund, whether legally revocable or irrevocable, should be included in the financial statements of the health care provider. A portion of the fund equal to the amount of assets expected to be liquidated to pay malpractice claims classified as current liabilities should be classified as a current asset; the balance of the fund, if any, should be classified as a noncurrent asset. In the financial statements of the health care provider, revenues of the trust fund should be included with other operating revenues; the administrative expenses of the trust fund should be included with other administrative expenses. In some circumstances the foregoing may not be possible: for example, if a common trust fund exists for a group of health care providers; if the health care provider is part of a common municipality trust fund; and if legal, regulatory, or indenture restrictions prevent the inclusion of a trust fund in a health care provider's financial statements. In those circumstances, the provisions of paragraphs 74 and 75 still apply.

74. Estimated losses from asserted and unasserted claims should be accrued and reported as indicated in paragraphs 21 through 29 and should not be based on payments to the trust fund.

75. A health care provider's financial statements should disclose the existence of the trust fund, and, if the trust is irrevocable, that should also be disclosed.

Effective Date and Transition

76. This statement is effective for fiscal years beginning after June 30, 1987, with earlier application encouraged. Accounting changes adopted to conform to the provisions of this statement should be applied retroactively. In the year this statement is first applied, the financial statements should disclose the nature of any restatement and its effect on income before extraordinary items, net income, and related amounts per share for each year restated.

77. If retroactive restatement of all years presented is not practicable, the financial statements presented should be restated for as many consecutive years as practicable. The cumulative effect of applying the statement should be included in determining net income of the earliest year restated, which is not necessarily the earliest year presented. If it is not practicable to restate any prior year, the cumulative effect should be included in net income in the year in which the statement is first applied, in conformity with paragraph 20 of APB Opinion 20, *Accounting Changes*. For that year, what should be disclosed is the following: the effect on income before extraordinary items, net income, and related per share amounts of applying this statement in a year in which the cumulative effect is included in determining that year's net income.

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