University of Mississippi

eGrove

Issues Papers | American Institute of Certified Public Accountants (AICPA) Historical Collection

1982

Accounting for medical malpractice loss contingencies (asserted and unasserted claims) and related issues of health care providers; Issues paper (1982 August 13)

American Institute of Certified Public Accountants. Medical Malpractice Self-Insurance Task Force

Follow this and additional works at: https://egrove.olemiss.edu/aicpa_iss

Part of the Accounting Commons, and the Taxation Commons

Recommended Citation

American Institute of Certified Public Accountants. Medical Malpractice Self-Insurance Task Force, "Accounting for medical malpractice loss contingencies (asserted and unasserted claims) and related issues of health care providers; Issues paper (1982 August 13)" (1982). *Issues Papers*. 20.
https://egrove.olemiss.edu/aicpa_iss/20

This Book is brought to you for free and open access by the American Institute of Certified Public Accountants (AICPA) Historical Collection at eGrove. It has been accepted for inclusion in Issues Papers by an authorized administrator of eGrove. For more information, please contact egrove@olemiss.edu.

Issues Paper

ACCOUNTING FOR MEDICAL MALPRACTICE LOSS CONTINGENCIES (ASSERTED AND UNASSERTED CLAIMS) AND RELATED ISSUES OF HEALTH CARE PROVIDERS

August 13, 1982

Prepared by
The Medical Malpractice Self-Insurance Task Force
American Institute of Certified Public Accountants

815179

AICPA

American Institute of Certified Public Accountants
1211 Avenue of the Americas, New York, New York 10036 (212) 575-6200

File Ref. No. 3166

August 18, 1982

J.T. Ball
Financial Accounting
Standards Board
High Ridge Park
Stamford, CT 06905

Dear J.T.:

Enclosed for consideration by the Financial Accounting Standards Board is an issues paper, "Accounting for Medical Malpratice Loss Contingencies (Asserted and Unasserted Claims) and Related Issues of Health Care Providers." The Medical Malpractice Self-Insurance Task Force prepared the issues paper for review by the AICPA Insurance Companies Committee and Health Care Matters Subcommittee. The Accounting Standards Executive Committee reviewed and approved the paper.

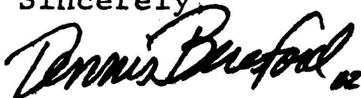
The paper addresses issues on

- accrual of uninsured asserted and unasserted malpractice claims,
- discounting accrued malpractice claims,
- claims-made insurance policies and the cost of tail coverage,
- retrospectively rated insurance policies,
- wholly owned captive insurance companies,
- multi-provider captive insurance companies,
- financial presentation of trust funds.

It contains advisory conclusions on these issues as approved by AcSEC.

Representatives of the accounting standards division will be pleased to discuss the issues paper with you or other representatives of the Board at your convenience.

Sincerely,



Dennis R. Beresford
Chairman
Accounting Standards Executive
Committee

DRB:ngr

Issues Paper

ACCOUNTING FOR MEDICAL MALPRACTICE LOSS CONTINGENCIES (ASSERTED AND UNASSERTED CLAIMS) AND RELATED ISSUES OF HEALTH CARE PROVIDERS

August 13, 1982

TABLE OF CONTENTS

	Page
Introduction	1
Definitions	2
Scope	4
Relevant Accounting Literature	4
Issue No. 1 Accounting for Uninsured Asserted and Unasserted Malpractice Claims	5
Statement of Issue	5
Discussion	5
Present Practices	7
Views on the Issue	8
Advisory Conclusions	11
Issue No. 2 Discounting Accrued Unpaid Malpractice Claims	16
Statement of the Issue	16
Discussion	16
Present Practices	17
Views on the Issue	18
Advisory Conclusion	21
Issue No. 3 Accounting for Claims-Made Policies and the Cost of Tail Coverage	21
Statement of the Issues	21
Discussion	22
Present Practices	23
Views on the Issues	23
Advisory Conclusions	24

TABLE OF CONTENTS

	Page
Issue No. 4 Accounting for Retrospectively Rated Premiums	26
Statement of the Issue	26
Discussion	26
Present Practices	28
Views on the Issue	28
Advisory Conclusions	30
Issue No. 5 Accounting for Wholly-Owned Captive Insurance Companies	31
Statement of the Issues	31
Discussion	31
Present Practices	32
Views on the Issues	32
Advisory Conclusions	35
Issue No. 6 Accounting for Multi-Provider Captives	36
Statement of the Issue	36
Discussion	36
Present Practices	37
Views on the Issues	37
Advisory Conclusions	38
Issue No. 7 Accounting for Trust Funds	40
Statement of the Issues	40
Discussion	40
Present Practices	41
Views on the Issues	41
Advisory Conclusions	43

INTRODUCTION

1. Health care providers have traditionally purchased occurrence basis insurance to protect themselves against losses from malpractice claims, including certain expenses of investigating and settling claims, resulting from injuries to patients due to alleged improper professional health care services. The cost of the insurance was fixed at the beginning of the policy term and the premium was charged to expense on a pro rata basis over the term of the policy.

2. The changing social and economic environment of the 1970s increased the cost and limited the availability of occurrence basis medical malpractice insurance. Insurance companies substantially increased premiums or limited the degree of risk they were willing to assume. As a result, some health care providers dropped their insurance coverage Others retained more of their malpractice risk by accepting higher deductibles, purchasing retrospectively rated policies, forming captive insurance companies, or joining with others to form multi-provider captive insurance companies. Others purchased claims-made policies, which only covered claims reported to the insurance carrier during the policy term. Today, very few health care providers have total insurance protection against losses from medical malpractice claims.

3. Some health care providers have established trust funds as means of funding the cost of uninsured (also referred to as "self insured") malpractice claims and related expenses Others simply pay these costs out of general funds as they arise.

4. Diverse practices in accounting for medical malpractice loss contingencies (asserted and unasserted claims), captive insurance companies, retrospectively rated premiums, claims-made insurance, and trust funds have developed because there is no guidance in the accounting literature in these areas. Neither the 1972 AICPA Hospital Audit Guide (Guide) nor the 1978 AICPA Statement of Position, Clarification of Accounting, Auditing and Reporting Practices Relating to Hospital Malpractice Loss Contingencies (SOP) provides adequate guidance on the accounting issues addressed in this paper. Accordingly, this issues paper has been prepared as a basis for eliminating the existing diversity of practice and establishing generally accepted accounting principles in accounting for uninsured medical malpractice loss contingencies (asserted and unasserted claims), retrospectively rated policies, and related items.

DEFINITIONS

5. The following definitions are used in this issues paper.

Asserted claim - a claim asserted against a health care provider by or on behalf of a patient alleging improper professional service

Claims-made policy - a policy that only covers malpractice claims reported to the insurance carrier during the policy term, regardless of the date of the incident giving rise to the claim.

Discounting - recording malpractice claims at the present value of the estimated future payments.

Medical malpractice loss contingency - an asserted or unasserted claim.

Multi-provider captive - an insurance company owned by two or more health care providers that provides malpractice insurance to its owners.

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

Reported incident - an occurrence identified by a health care provider as one in which improper care may be alleged resulting in a malpractice claim.

Retrospectively rated premium - a premium that is adjustable based on actual experience of a health care provider or group of health care providers during the policy term.

Self-insurance - no insurance coverage (risk assumed by a health care provider).

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.

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

Unasserted claim - a reported or unreported incident that has not been asserted by or on behalf of a patient that may give rise to a malpractice claim.

Unreported incident - an occurrence that has not yet been identified by the health care provider as an incident that could result in a malpractice claim; it is also called IBNR (incurred but not reported).

Wholly owned captive - an insurance company owned by a health care provider that provides malpractice insurance primarily to its parent.

SCOPE

6. This issues paper applies to all health care providers and their wholly owned and multi-provider owned captive insurance companies.

RELEVANT ACCOUNTING LITERATURE

7. The three sources in accounting literature that provide guidance on accounting for medical malpractice claims are FASB Statement No. 5, Accounting for Contingencies, FASB Interpretation No. 14, Reasonable Estimation of the Amount of a Loss, and the 1978 Statement of Position Clarification of Accounting, Auditing, and Reporting Practices Relating to Malpractice Loss Contingencies. When appropriate, the following discussion cites relevant passages from current standards.

ISSUE NO. 1

ACCOUNTING FOR UNINSURED ASSERTED AND UNASSERTED MALPRACTICE CLAIMS

Statement of the Issue

8. Should estimated costs of settling insured ("self insured") and unasserted malpractice claims be accrued on the basis of a health care provider's claim experience or industry experience?

Discussion

9. Health care providers that do not insure malpractice risks generally establish a risk management system to reduce their exposure to malpractice claims. Risk management systems are designed to (a) reduce the likelihood of incidents that may result in malpractice claims, (b) identify such incidents and correct the underlying causes, (c) minimize the amount of loss on reported claims and (d) assure that financial resources are available to settle claims.

10. For accounting purposes, the two major categories of malpractice loss contingencies are asserted and unasserted claims.

a. Asserted claims are claims asserted against a health care provider by or on behalf of a patient alleging improper professional service.

b. Unasserted claims are claims that have not been asserted by or on behalf of a patient. Unasserted claims may relate to reported incidents or unreported incidents.

i. Reported incidents are those occurrences that have been identified by the health care provider as incidents in which improper care may be alleged resulting in malpractice claims.

ii. Unreported incidents are those occurrences that have not yet been identified by the health care provider as incidents that could result in malpractice claims (that is, incurred but not reported claims).

11. The 1978 SOP provides limited guidance on accounting for uninsured malpractice claims. It requires that estimated losses resulting from malpractice claims should 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 the amount can be reasonably estimated. In making the estimate, it is appropriate to consider prior claim experience, 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 in quantifying the uncertainties inherent in such estimates.

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

Present Practices

13. Some health care providers are accruing estimated losses from malpractice claims based on information developed from their risk management system. 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"). The estimates are generally made by a claims manager or attorney.

14. Losses from unasserted claims arising from reported incidents are estimated and accrued either individually or on a group basis. Individual accrual is based on an analysis of individual incidents; group accrual is based on the historical relationship between unasserted claims arising from reported incidents and eventual losses.

15. Some health care providers also estimate and accrue losses from unreported incidents. These estimates are generally based on 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 an actuary.

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. These annual payments often represent the present value of expected future payments for malpractice claims less amounts previously funded and amounts to be funded in future years. These amounts may be designed to level the cost of malpractice claims over a period of years and are rarely specifically based on incidents occurring in the current year.

Views on the Issue

17. Some believe that the ultimate cost of malpractice claims should be accrued as the incidents that give rise to them are incurred, if a determination can be made that it is probable that loss has taken place and the amount can be reasonably estimated. However, they believe that the ability to make reasonable estimates varies for asserted and unasserted claims. They believe that estimated losses from asserted claims and related settlement and litigation expenses should be accrued based on the best estimate of the cost of settling or litigating the claims.

18. They 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 a loss has been incurred and that it can be reasonably estimated. In addition, they believe that estimated losses from unreported incidents should also be accrued if the health care provider has sufficient historical experience (statistics on its paid claims that resulted from unreported incidents) 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 do not believe an accrual should be made for the cost of such claims, but the existing contingency should be disclosed in the notes to the financial statements.

19. Others believe that the actuarially determined payment to a trust fund or captive insurance company should be accrued as the financial statement expense because the amount was determined by an actuary, who is a specialist in the field. They believe that Statement on Auditing Standards (SAS) 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 the actuarially determined payment contend that accountants do not have the level of expertise to challenge an actuary's recommendations.

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

a. A funding program is usually designed to level the cost of malpractice claims over a period of years. For example, if it is probable that a $1 million loss will occur sometime in the next five years, the funding philosophy may be to fund $200,000 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 reasonable estimated at that time.

b. The actuarially determined payment is usually computed at the request of the health care provider at the beginning of the year or before, and, therefore, no consideration is given to the health care provider's claim experience for that year.

c. The actuarial computations are usually 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 be in accordance with FASB Statement No. 5.

d. Actuarially determined payments may contain substantial explicit provisions for adverse deviations that are not in accordance with FASB Statement No. 5, which requires an accounting accrual based on reasonable estimates of incurred losses.

* * * * *

Advisory Conclusions

21. The ultimate cost of malpractice claims should be accrued as the incidents that give rise to the claims are incurred, if a determination can be made that it is probable that a loss has been incurred and the amount of the loss can be reasonably estimated.

Asserted Claims and Unasserted Claims
Arising From Reported Incidents

22. Estimated losses from asserted claims should be accrued either individually or on a group basis, based on the best estimate of the ultimate cost of the claims. It is appropriate to use industry experience in estimating the expected amount of those claims. However, if the amount of losses cannot be reasonably estimated, no accrual should be made. 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. It is appropriate to use industry experience in estimating the expected amount of those claims. However, if the amount of losses cannot be reasonably estimated, no accrual should be made.

Unreported Incidents --
Providers with Sufficient Claim Experience

23. A health care provider that has sufficient historical claim experience should accrue estimated losses from unreported incidents based on the historical relationship of unreported incidents to eventual claim payments. However, if the amount of losses cannot be reasonably estimated, no accrual should be made.

Unreported Incidents --
Providers Without Sufficient Claim Experience

24. A health care provider that has been in existence a relatively long time but that does not have sufficient historical experience (that is, statistically significant experience) on which to estimate losses from unreported incidents should use industry experience in estimating such losses only if:

a. The industry experience used is based on the experience of similar institutions, is reasonably consistent with the available data of the health care provider, and gives appropriate consideration to existing asserted claims and reported incidents of the health care provider; and

b. There is a reasonably acceptable confidence level (statistical probability) that the estimate will approximate actual experience and such estimate does not represent an amount equivalent to a premium ("premium equivalent") or such other amount designed to provide long-term funding.

Over a period of time, increasing weight should be given to the health care provider's own claim experience. A health care provider may obtain the assistance of a specialist in using industry experience to estimate losses from unreported incidents.

25. If a health care provider cannot meet the requirements of paragraph 24, it should not use industry experience and, accordingly, should not accrue losses from unreported incidents.

Unreported Incidents - New Providers

26. A health care provider that has been in existence a short time cannot determine if its claim experience will be reasonably consistent with industry experience; and, therefore, industry experience should not be used in estimating losses from unreported incidents. Accordingly, such losses should not be accrued.

Estimation of Losses

27. If it is probable that a claim has been incurred and the information available indicates that the estimated amount of 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, Reasonable Estimation of the Amount of a Loss.)

28. Changes in estimates resulting from the continuous review of estimated losses should be recognized when the estimates are changed.

29. Unpaid claims and espenses 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 unpaid claims and expenses should be classified as noncurrent liabilities.

Disclosure

30. If the health care provider cannot estimate losses relating to a particular category of malpractice claims (i.e., asserted claims, reported incidents, or unreported incidents) in accordance with paragraphs 22-27 potential losses related to that category of claims should not be accrued. However, as required by FASB Statement No. 5, the existing contingency should be disclosed in the notes to the financial statements.

* * * * *

ISSUE NO. 2

DISCOUNTING ACCRUED UNPAID MALPRACTICE CLAIMS

Statement of the Issue

31. Should accrued unpaid malpractice claims be discounted for the time value of money?

Discussion

32. The relevant accounting literature provides no guidance on 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 time lag that generally exists between the date the claim is incurred and the date the claim is paid, the difference between valuing unpaid claims (accrued asserted and unasserted claims) at the estimated ultimate cost of settlement and a discounted amount is significant.

33. The number and amount of malpractice claims have increased substantially in recent years, and obtaining meaningful historical experience on the general characteristics of the time lag between the incurred date and payment date is difficult. However, an article in Best's Review[1] indicated that only 2% of the dollar amount of malpractice claims incurred in 1975 were paid in that year, 4% in 1976, 10% in 1977, and 12% in 1978. Therefore,

---

1 Robert L. Westin, "The Economics of the Medical Malpractice Insurance Business," Best's Review (Property/Casualty Insurance Ed.) 80, no. 19 (February 1980): 16-18

by the end of 1978, only 28% of the dollar amount of 1975 claims had been paid. If the remaining claims (72% of the dollar amount) were paid evenly over the next five years, the discounted amount at the end of 1975 assuming a 10% discount rate would be only 66% of the estimated full cost of settlement.

34. It is rare that unpaid malpractice claims can be precisely estimated as a great number of factors have to be taken into consideration. Some health care providers do not have a sufficient number of claims to base their estimates on statistical projections of their experience. Even if statistical projections are used, there may be large differences between estimated claims and actual payments.

Present Practices

35. It is difficult to determine the extent to which health care providers are presently considering the time value of money in accruing the estimated costs of settling asserted and unasserted claims as financial statements generally do not disclose the basis on which the accruals are made. Estimates determined by actuaries are more likely to reflect the time value of money than those determined by others.

Views on the Issue

36. Some believe that the cost of settling malpractice claims should be accrued based on estimated ultimate cost of settlement, without consideration of the time value of money. They believe that discounting should not be applied to liabilities that are primarily estimates, particularly medical malpractice claims, because of the potential significant variability. They believe that discounting estimated amounts over estimated payment periods is too imprecise to maintain the credibility of financial statements.

37. They also believe that discounting should not be used because such estimates are not contractual obligations to pay money at fixed or determinable dates. Those who support this view believe that there is an inherent inability to determine the payment pattern on specific claims. They believe that by not discounting an element of conservatism is added to the estimate.

38. Others believe that the cost of settling malpractice claims should be accrued at the present value of anticipated future cash payments. They believe that discounting long term liabilities produces financial statements that are more in accord with the economic reality. They also believe it would be inconsistent to recognize the effects of anticipated future price changes, but not recognizing the effects of the time value of money.

39. They believe that discounting accrued unpaid claims is consistent with the generally accepted accounting principle of matching related revenues and expenses. The present value of incurred claims would be matched against current revenues and the interest added to the claim liability in future years would be matched against the investment income earned in those years. They believe that even if the health care provider does not have any investment income, the interest added to the claim liability should be considered a cost of that period.

40. Those who support discounting also believe that malpractice expense will be more consistent between health care providers that do and do not insure since malpractice insurance premiums reflect the time value of money.

41. Although supporters of discounting recognize the imprecision in establishing claim liabilities, they do not believe that such imprecision should be a determining factor in deciding whether to discount. They believe that if an individual or group of claims is accruable, the ability to make a reasonable estimate of when the claims will be paid is also likely. An estimate of the timing of claim payments is necessary to anticipate future price changes in establishing the claim liability The likelihood of inaccurately estimating the payment pattern is no greater than the likelihood of inaccurately estimating the amount of payment. They believe that in most

situations, it is easier to estimate the timing of payments than it is to estimate the ultimate cost of a claim. They point out that FASB Statement No. 5 does not explicitly or implicitly indicate whether estimates of long term loss contingencies that meet the criteria for accrual should or should not be based on the present value of anticipated future payments. They cite pension expense as an example of a long term estimated liability that is presently discounted.

42. Those who support discounting believe that the interest rate used should be the anticipated yield to be earned on investments made in the year the claims are accrued. If no investments were made that year, and the health care provider does not have any other investments, the interest rate should be consistent with the rate at which the health care provider would have to borrow funds.

43. Others believe that the accrual for unpaid malpractice claims should neither reflect the effects of anticipated future price changes nor the effects of the time value of money. In their view, the increase in the claim liability caused by price changes is a period cost that should be matched against investment earnings of that period.

* * * * *

Advisory Conclusions

44. The AICPA Insurance Companies Committee has been working for several years on an issues paper on discounting property and liability claims. Pending completion of that project this issues paper does not take a separate position on the issue of discounting. Accordingly, 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 presented at present value in the financial statements and the range of interest rates used to discount those claims (see FASB Statement No. 60, paragraph 60(d)).

* * * * *

ISSUE NO. 3

ACCOUNTING FOR CLAIMS-MADE POLICIES AND THE COST OF TAIL COVERAGE

Statement of the Issues

45. Should a health care provider insured by a claimsmade policy accrue for unasserted claims and claims relating to incidents not reported to the insurance carrier? When should the cost of tail coverage be charged to expense?

Discussion

46. Many health care providers now buy claims-made malpractice insurance. A claims-made policy differs from an occurrence basis policy in that it only covers 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 would be uninsured for malpractice claims that are reported after the termination of the policy, regardless of when the incidents occurred.

47. Because the possibility always exists that a health care provider will be unable to renew a claims-made policy, a question arises as to whether an estimate of losses relating to unasserted claims and incidents not reported to the insurance carrier should be accrued even though they may be covered by a future claims-made policy.

48. A health care provider may terminate a claims-made policy and buy tail coverage. In those circumstances a question arises as to 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 expected period that claims will be reported.

Present Practices

49. Very few, if any, health care providers now accrue for estimated losses from unasserted claims and incidents not reported to the insurance carrier that will probably be covered under future claims-made policies.

50. Most health care providers charge the cost of tail coverage to expense when they decide to terminate the claims-made policy.

Views on the Issues

51. Some believe that a claims-made policy represents a transfer of risk to the insurance carrier and that accruing for estimated losses from unasserted claims and incidents not reported to the insurance carrier that will probably be covered under future claims-made policies is unnecessary. They believe that such accrual would only be necessary if the health care provider decided to discontinue a claims-made policy or the insurance carrier indicated that it would not renew the policy and tail coverage was not going to be (or could not be) bought.

52. 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 and that the health care provider should accrue for these claims. The accrual should be reversed when the claims are subsequently reported and covered by a claims-made policy.

53. Some believe that the premium for tail coverage should be charged to expense when the health care provider terminates a claims-made policy because the premium relates to past occurences.

54. Others believe that the premium should be deferred and charged to expense over the estimated period that the claims will be reported because the tail coverage is a continuation of the claims-made policy.

* * * * *

Advisory Conclusions

55. A claims-made policy represents a transfer of risk to the insurance carrier for asserted claims and incidents reported to the insurance carrier, but does not represent a transfer of risk for claims and incidents not reported to the insurance carrier. A health care provider that is insured under a claims-made policy should accrue the cost of providing tail coverage at the end of the current accounting period. The health care provider may, as an alternative, accrue the estimated cost of claims and incidents not reported to the insurance carrier if that amount is less than the cost of tail coverage and the health care provider has sufficient historical claim experience to estimate the cost as described in the advisory conclusions to issue 1.

(This advisory conclusion was approved by 9 members of AcSEC and the Insurance Companies Committee.)

* * * * *

(Two members of AcSEC, the Health Care Matters Subcommittee, and the Medical Malpractice Self-Insurance Task Force recommended the following advisory conclusions.)

55A. A claims-made policy represents a transfer of risk to the insurance carrier, and estimated losses from unasserted claims and incidents not reported to the insurance carrier should not be accrued unless evidence suggests that the claims-made policy will not be renewed and tail coverage will not be bought.

56. If a health care provider discontinues its claims-made coverage and does not purchase tail coverage, it should accrue the estimated loss from unasserted claims and incidents not reported to the insurance carrier as indicated in the advisory conclusions of issue 1.

57. The cost of tail coverage should be charged to expense when the health care provider decides to terminate its claims-made policy or when the claims-made policy expires, whichever occurs first.

58. A health care provider should disclose in its financial statements that it is insured by a claims-made policy and any termination of such policy.

* * * * *

ISSUE NO. 4

ACCOUNTING FOR RETROSPECTIVELY RATED PREMIUMS

Statement of the Issue

59. How should health care providers account for premiums on restrospectively rated insurance policies?

Discussion

60. Premiums paid to an insurance company are not necessarily evidence that there has been a transfer of risk. To the extent risk has not been transferred, such premiums should not be accounted for as insurance expense. Paragraphs 44-45 of FASB Statement No. 5 discuss payments to insurance companies that may not involve transfer of risk. Paragraph 44 states:

> To the extent that an insurance contract or reinsurance contract does not, despite its form, provide for indemnification of the insured or the ceding company by the insurer or reinsurer against loss or liability, the premium paid less the amount of the premium to be retained by the insurer or reinsurer shall be accounted for as a deposit by the insured or the ceding company. Those contracts may be structured in various ways, but if, regardless of their form, their substance is that all or part of the premium paid by the insured or the ceding company is a deposit, it shall be accounted for as such.

61. In a nonretrospective policy, the premium is fixed for the period of the contract and is usually charged to expense pro rata over the contract period. However, for retrospectively rated policies, 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 the minimum and maximum premium limitations of the contract, if any, based on the experience of the health care provider.

62. 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. Some policies may be based partly on the individual's experience and partly on a group's experience.

63. The question is whether a retrospectively rated policy is in substance a transfer of risk or a financing arrangement. Normally, a retrospectively rated policy only transfers risk for losses in excess of the maximum premium. If actual losses are less than the maximum premium, the risk is not transferred since the ultimate premium will be essentially equal to the actual losses and the administrative expense charge. When an insurance

policy, despite its form, does not provide for indemnification of the insured by the insurer against loss or liability, the premium paid less the amount of the premium to be retained by the insurer or reinsurer is accounted for as a deposit by the insured.

Present Practices

64. Some health care providers account for premiums paid to insurance companies on retrospectively rated policies as deposits and recognize estimated losses from asserted and unasserted claims as insurance expense for the period.

65. 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 such adjustments to them.

Views on the Issues

66. Some believe that only a policy that provides a transfer of risk is an insurance contract. For example, if a retrospectively rated policy provides that the insurer will not return a

stipulated portion of the premium regardless of the degree of favorable experience and that the insured will only be required to pay a reasonably specified maximum amount if experience is poor, a sharing of risk may exist. The accounting should follow the substance of the contract; an estimate of the total premium ultimately to be paid should be amortized over the term of the contract.

67. Those who support that view believe contracts that do not provide a transfer of risk are not insurance contracts, and, for those contracts, estimated losses from asserted and unasserted claims should be accrued as indicated in the advisory conclusions of issue 1.

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

* * * * *

Advisory Conclusions

69. A retrospectively rated insurance policy whose ultimate premium is primarily based on the health care provider's experience does not transfer risk for losses less than the maximum premium, if any. The health care provider should account for any premium payment in excess of the minimum premium as a deposit and accrue estimated losses from asserted and unasserted claims as indicated in the advisory conclusions of issue 1. Estimated losses should not be accrued in excess of any stipulated maximum premium. If the health care provider cannot estimate losses from asserted or unasserted malpractice claims as indicated in the advisory conclusions to issue 1, the health care provider should disclose the existing contingency in the notes to the financial statements (see paragraph 30).

70. The minimum premium should be amortized pro rata over the policy term.

71. A retrospectively rated policy with premiums based on the experience of a group of health care providers transfers risk. The initial premiums should be amortized to expense pro rata over the policy term and additional premiums or refunds should be accrued based on the group's experience to date.

* * * * *

ISSUE NO. 5

ACCOUNTING FOR WHOLLY-OWNED CAPTIVE INSURANCE COMPANIES

Statement of the Issues

72. How should wholly owned captive insurance companies account for estimated losses from asserted and unasserted malpractice claims of its parent? How should parents of wholly owned captives account for investments in those subsidiaries?

Discussion

73. Some health care providers have formed wholly owned subsidiaries, called captive insurance companies, to insure the parent entity and possibly other health care providers. A health care provider that is insured by its wholly owned captive is, in substance, uninsured, and the same considerations apply in accounting for estimated losses from uninsured asserted and unasserted malpractice claims of the parent. FASB Statement No. 60 specifies the accounting by an insurance enterprise when it insures entities other than its parent.

74. A question arises as to whether the parent should consolidate the financial statements of the captive or report its investment on the equity method of accounting. Differences between the two methods relate to classification and the amount of detail reported in financial statements and generally do not affect net income or stockholders' equity.

75. Health care providers traditionally present classified balance sheets, whereas, because of the nature of their operations, insurance companies traditionally do not. However, if the financial statements of a captive are consolidated with the financial statements of the health care provider, its accounts would have to be classified into current and noncurrent assets and liabilities.

Present Practices

76. Determining whether health care providers now consolidate the financial statements of wholly owned captives or report their investments on the equity method of accounting is difficult because their financial statements generally do not disclose the basis of accounting.

Views on the Issues

77. Some believe that the financial statements of a wholly owned captive should be consolidated with the financial statements of the parent. They believe that since the captive is in substance a vehicle for self insurance, its operations are an extension of its parent's.

78. Those who hold that view cite existing accounting literature to support their position. They believe that Accounting Research Bulletin No. 51, Consolidated Financial Statements, indicates that the usual condition for consolidation is a controlling financial interest, that is, ownership of a majority voting interest. Based on their interpretation of that bulletin, they believe that health care providers should consolidate their wholly owned captives.

79. They also believe that the balance sheet of a captive insurance subsidiary can be classified to conform to the classification of the parent's balance sheet. They believe that liabilities estimated to be paid during the normal operating cycle of the parent (usually within a year of the date of the financial statements) should be classified as current liabilities and the captive's cash and a portion of its other assets that are reasonably expected to be realized in cash or sold or consumed during the normal operating cycle should be classified as current assets (see ARB 43, chapter 3A). All other assets and liabilities should be classified as noncurrent.

80. Some believe that wholly owned captives should be accounted for by the equity method of accounting. They believe that the operations of the captive insurance subsidiary are so different from those of the health care provider that consolidated financial statements would be less meaningful and may confuse readers. They believe that the equity method of accounting provides the most meaningful presentation. They support their position with ARB No. 51, paragraph 3, which states:

> In deciding upon consolidation policy, the aim should be to make the financial presentation which is most meaningful in the circumstances. The reader should be given information which is suitable to his needs, but he should not be burdened with unnecessary detail. Thus, even though a group of companies is heterogeneous in character, it may be better to make a full consolidation than to present a large number of separate statements. On the other hand, separate statements or combined statements would be preferable for a subsidiary or group of subsidiaries if the presentation of financial information concerning the particular activities of such subsidiaries would be more informative to shareholders and creditors of the parent company than would the inclusion of such subsidiaries in consolidation. For example, separate statements may be required for a subsidiary which is a bank or an insurance company and may be preferable for a finance company where the parent and the other subsidiaries are engaged in manufacturing operations.

81. Others believe that the equity method of accounting should be used only if the captive is not a domestic company since a precedent exists for excluding foreign subsidiaries from consolidation.

82. Still others believe that the equity method of accounting should be used because consolidation requires classification of the captive's balance sheet. They contend that any attempt to classify the balance sheet of an insurance company requires arbitrary classification which would be viewed by readers of financial statements as more precise than is warranted. Classifying certain estimated losses as current liabilities provides information to the courts or plaintiffs that may adversely affect the health care provider during the process of determining an award or settlement.

*   *   *   *   *

Advisory Conclusions

83. Wholly owned captive insurance subsidiaries should accrue estimated losses from asserted and unasserted claims of its parent as indicated in the advisory conclusions of issue 1.

84. Health care providers should consolidate the accounts of wholly owned captives. In the consolidated financial statements, health care providers should classify as current liabilities the estimated amount of unpaid malpractice claims expected to be paid during the parent's normal operating cycle (generally within one year of the date of the financial statements) and should classify as current assets cash and other assets that are reasonably expected to be realized in cash or sold or consumed during the normal operating cycle. The remaining assets and liabilities should be classified as noncurrent.

85. If the health care provider cannot estimate losses from asserted or unasserted malpractice claims as indicated in the advisory conclusions to issue 1, the health care provider should disclose the existing contingency in the notes to the financial statements (see paragraph 30).

* * * * *

ISSUE NO. 6

ACCOUNTING FOR MULTI-PROVIDER CAPTIVES

Statement of the Issues

86. How should health care providers that are members of a multi-provider captive insurance company account for retrospectively rated policies issued by the multi-provider captive? How should health care providers account for their investments in multi-provider captive insurance companies?

Discussion

87. A multi-provider captive insurance company is commonly formed by a group of health care providers related geographically, through common control or affiliation (for example, operated by members of a religious community) or a group with similar malpractice claim experience. The captive insurance company may be formed with the intention of (a) spreading the risk of malpractice claims among a number of similar institutions, (b) obtaining excess coverage at a lower cost than is available to individual health care providers, or (c) providing 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.

88. Premiums on some policies issued by multi-provider captives are fixed for the period of the contract. However, premiums on many policies issued by such insurers are retrospectively rated. The retrospectively rated premiums may be based on the experience of the individual health care provider or on the experience of the group. The arrangements between a multi-provider captive and health care providers may be complex and careful analysis is generally required to determine if their insurance contracts transfer risk. If the insurance contract requires a premium essentially equal to claims incurred by the provider plus a fee for expenses and profit, the policy does not provide a transfer of risk.

Present Practices

89. Financial statements of health care providers generally do not disclose the method of accounting for premiums paid to multi-provider captives.

Views on the Issues

90. Some believe that whether retrospectively rated policies issued by multi-provider captives transfer risk depends on whether the premium is based on the experience of the individual health care provider or on the experience of the group. If the premium is based on the experience of the individual health care provider, risk is not transferred; if the premium is

based on the experience of the group, risk is transferred. If risk is transferred, the premium should be amortized to expense pro rata over the term of the policy. If risk is not transferred, the premium should be accounted for as a deposit and estimated losses from asserted and unasserted claims should be accrued and reported as indicated in the advisory conclusions of issue 1.

91. Others believe that policies issued by multi-provider captives transfer risk even if the policies are retrospectively rated and the premium is based on the health care provider's individual experience. They believe that the initial premium should be amortized to expense pro rata over the term of the policy and that premium adjustments should be recorded when the health care provider is notified by the multi-provider captive.

* * * * *

Advisory Conclusions

92. A retrospectively rated insurance policy issued by a multi-provider captive insurance company where the ultimate premium is primarily based on the health care provider's experience does not transfer risk for losses less than the maximum premium, if any. The health care provider should account for any premium payment in excess of the minimum premium as a deposit and accrue estimated losses from asserted and unasserted claims as indicated in the advisory conclusions of issue 1. Estimated losses should not be accrued in excess of any stipulated maximum premium.

93. The minimum premium should be amortized pro rata over the policy term.

94. A retrospectively rated policy based on the experience of a group of health care providers transfers risk. The health care provider should amortize the premiums paid on such a policy to expense pro rata over the policy term and accrue additional premiums or refunds based on the multi-provider captive's experience to date.

95. A health care provider that owns over 50% of the outstanding voting shares of a multi-provider captive should consolidate the financial statements of the captive. A health care provider that owns 50% or less of the outstanding voting shares of the captive should account for its investment in accordance with APB Opinion 18, The Equity Method of Accounting for Investments in Common Stock, and FASB Interpretation No. 35, Criteria for Applying the Equity Method of Accounting for Investments in Common Stock.

96. A health care provider that is insured by a multi-provider captive should disclose in its financial statements that it is insured by a multi-provider captive, its ownership percentage in the captive, and the method of accounting for its investment in and the operations of the captive. Also, if the health care provider cannot make the necessary estimates of losses from asserted or unasserted malpractice claims as indicated in the advisory conclusions to issue 1, the health care provider should disclose the existing contingency in the notes to the financial statements (see paragraph 30).

* * * * *

ISSUE NO. 7

ACCOUNTING FOR TRUST FUNDS

Statement of the Issues

97. Should a trust fund be included in the financial statements of a health care provider and, if so, to what extent should it report the trust fund as a current asset? How should a health care provider account for the revenues and expenses of a trust fund included in its financial statements?

Discussion

98. One of the objectives of a risk management system is to make sure that sufficient resources are available to settle malpractice claims as they become due. Some health care providers that are not insured establish trust funds as an attempt to make sure that financial resources are available to pay for claims. They may also establish trust funds because they are permitted to recognize the contribution to a fund as an expense for Medicare reimbursement purposes. In most circumstances, a trustee controls the trust fund assets and the trust agreement provides that the assets can only be used to investigate, litigate, and settle malpractice claims and to pay administrative expenses of the trust fund.

99. With the increasing use of medical malpractice trust funds, diverse practices have developed for reporting trust funds and trust fund revenues and administrative expenses in the financial statements of the health care provider.

Present Practices

100. Some health care providers treat a payment to a trust fund as a transfer of funds from one cash 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. Administrative expenses and interest income 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

101. 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 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.

102. Others believe 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 that exceed the amount in the trust fund should be reported in the health care provider's financial statements. They also believe 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.

103. 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 believe that it should be classified as a noncurrent asset. Still others believe the classification should depend on the classification of estimated unpaid malpractice claims.

* * * * *

Advisory Conclusions

104. 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. The revenues of the trust fund should be included in the financial statements of the health care provider with other operating income and the administrative expenses of the trust fund with other administrative expenses.

105. Estimated losses from asserted and unasserted claims should be accrued and reported as indicated in the advisory conclusions of issue 1, and should not be based on payments to the trust fund.

106. A health care provider with a trust fund should disclose in its financial statements the existence of the trust fund. If the trust is irrevocable, that fact should also be disclosed.

* * * * *