1983

Accounting for asserted and unasserted medical malpractice claims of health care providers and related issues; Statement of position 87-1;

American Institute of Certified Public Accountants. Accounting Standards Division

EXPOSURE DRAFT

ACCOUNTING FOR ASSERTED AND UNASSERTED MEDICAL MALPRACTICE CLAIMS OF HEALTH CARE PROVIDERS AND RELATED ISSUES

PROPOSED

STATEMENT OF POSITION

JULY 22, 1983

PREPARED BY THE MEDICAL MALPRACTICE SELF-INSURANCE TASK FORCE
ACCOUNTING STANDARDS DIVISION
AMERICAN INSTITUTE OF CERTIFIED PUBLIC ACCOUNTANTS
FOR COMMENTS FROM PERSONS INTERESTED IN ACCOUNTING AND REPORTING

COMMENTS SHOULD BE RECEIVED BY OCTOBER 21, 1983,
AND ADDRESSED TO AUDITING STANDARDS DIVISION, FILE 3166,
AICPA, 1211 AVENUE OF THE AMERICAS, NEW YORK, N.Y. 10036

M815220

SUMMARY

This proposed statement of position provides guidance on applying generally accepted accounting principles in accounting for uninsured asserted and unasserted medical malpractice claims, captive insurance companies, retrospectively rated premiums, claims-made insurance policies, and trust funds of health care providers. The statement supplements the AICPA Hospital Audit Guide. Briefly, the statement recommends that--

- In general, the accrual of the estimated cost of uninsured asserted and unasserted medical malpractice claims should be based primarily on the health care provider's own experience. Only if certain specified conditions are met should a provider without sufficient claim experience use industry data to accrue estimated unasserted claims related to unreported incidents. If a provider cannot estimate a particular category of claims, the claims should not be accrued, but the contingency should be disclosed as required by FASB Statement No. 5.

- A health care provider insured under a claims-made policy should accrue the cost of providing tail coverage at the end of the current period.

- A retrospectively rated insurance policy whose ultimate premium is primarily based on the health care provider's experience does not transfer risk. The provider should account for any premium in excess of the minimum premium as a deposit and should accrue estimated losses from asserted and unasserted claims up to any maximum premium. A retrospectively rated policy whose premiums are primarily based on the experience of a group of providers does transfer risk. The initial premium 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.

- A wholly owned captive insurance subsidiary should accrue estimated claims of its parent based primarily on the parent's own experience. A provider that is insured by a multiprovider captive should disclose certain information regarding its ownership of the captive.

- A trust fund established to pay malpractice claims, whether revocable or irrevocable, should be included in the financial statements of a health care provider.

AICPA

American Institute of Certified Public Accountants
1211 Avenue of the Americas, New York, NY 10036-8775 (212) 575-6200

July 22, 1983

Accompanying this letter is an exposure draft of a proposed statement of position, Accounting for Asserted and Unasserted Medical Malpractice Claims of Health Care Providers and Related Issues. A summary of the proposed SOP also is included.

Comments or suggestions on any aspect of this exposure draft will be appreciated. The consideration of responses will be helped if comments refer to the specific paragraph numbers and include reasons for any suggestions or comments.

Comments on this exposure draft should be sent to--

Auditing Standards Division
File 3166
AICPA
1211 Avenue of the Americas
New York, NY 10036

Comments should be sent in time to be received by October 21, 1983.

Written comments on the exposure draft will become part of the public record of the AICPA and will be available for public inspection at the office of the AICPA after November 21, 1983, for one year.

Sincerely,

Roger Cason

Roger Cason
Chairman
Accounting Standards Executive Committee

Loren Kramer

Loren B. Kramer
Chairman
Medical Malpractice Self-Insurance Task Force

Proposed Statement of Position

ACCOUNTING FOR ASSERTED AND UNASSERTED MEDICAL MALPRACTICE CLAIMS OF HEALTH CARE PROVIDERS AND RELATED ISSUES

INTRODUCTION

1. Health care providers have traditionally purchased occurrence-basis insurance to protect themselves against losses from malpractice claims, including certain expenses of claims investigation and settlement, resulting from injuries to patients due to alleged improper professional health care services. The cost of that 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 multiprovider captive insurance companies. Still others purchased claims-made policies, which cover only 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 have developed in accounting for asserted and unasserted medical malpractice claims, captive insurance companies, retrospectively rated premiums, claims-made insurance, and trust funds because accounting pronouncements offer no specific guidance in these areas. Neither the AICPA Hospital Audit Guide (1972) nor the AICPA Statement of

Position Clarification of Accounting, Auditing and Reporting Practices Relating to Hospital Malpractice Loss Contingencies (1978) provides adequate guidance on the accounting issues addressed in this statement. Accordingly, this statement has been prepared as a basis for reducing the existing diversity of practice and providing guidance on accounting for uninsured asserted and unasserted medical malpractice claims and related issues.

Definitions

5. The following definitions are used in this statement.

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

Multiprovider 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 medical malpractice claim that may be asserted by or on behalf of a patient as a result of a reported or unreported incident.

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

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 and their wholly owned and multiprovider-owned captive insurance companies.

Relevant Accounting Pronouncements

7. The three sources in accounting pronouncements 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 AICPA 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.

ACCOUNTING FOR UNINSURED ASSERTED AND UNASSERTED MALPRACTICE CLAIMS

Discussion

8. Health care providers that do not obtain insurance for their malpractice risks generally establish a risk management system 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 and correct the underlying causes, (c) to minimize the amount of loss on reported claims, and (d) to assure that financial resources are available to settle claims.

9. For accounting purposes, the two major categories of malpractice loss contingencies are asserted and unasserted claims. Asserted claims are claims asserted against a health care provider by or on behalf of a patient alleging improper professional service. Unasserted 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 as incidents in which improper care may be alleged, resulting in malpractice claims.

b. Unreported incidents, which are 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).

10. The 1978 SOP provides limited guidance on accounting for uninsured malpractice claims. That SOP 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 that will probably result in an uninsured loss has occurred and if 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.

11. FASB Interpretation No. 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. 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 in the notes to the financial statements.

Present Practices

12. Some health care providers are accruing 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). The estimates are generally made by a claims manager or an attorney.

13. Losses from unasserted claims arising from reported incidents are estimated and accrued on either an individual or a group basis. 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 losses.

14. 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 an actuary.

15. 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. Those 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

16. Some believe that the ultimate cost of malpractice claims should be accrued as the incidents that give rise to them occur if it can be determined that it is probable that a loss has taken place and if 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 the accrual of estimated losses from asserted claims and related settlement and litigation expenses should be based on the best estimate of the cost of settling or litigating the claims.

17. 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 losses have been incurred and they 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 believe an accrual should not be made for the cost of such claims, but the existing contingency should be disclosed in the notes to the financial statements.

18. 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 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.

19. 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. 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 some time in the next five years, the 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 reasonably estimated at that time.

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

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 deviation that are not in accordance with FASB Statement No. 5, which requires an accounting accrual based on reasonable estimates of incurred losses.

Conclusions

20. The ultimate cost of malpractice claims should be accrued as the incidents that give rise to the claims occur if it can be determined that it is probable that a loss has been incurred and if the amount of the loss can be reasonably estimated.

21. 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. It is appropriate to use industry experience in estimating the expected amount of those claims. However, if the amount of losses or the range 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 or range of losses cannot be reasonably estimated, no accrual should be made.

22. Unreported incidents -- Providers with sufficient claim experience. 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 or range of losses cannot be reasonably estimated, no accrual should be made.

23. Unreported incidents -- Providers without sufficient claim experience. 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 the provider's own actual experience and the estimate does not represent an amount equivalent to a premium (premium equivalent) or another 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.

24. If a health care provider is without sufficient claim experience and cannot meet the requirements of paragraph 23, it should not use industry experience and, accordingly, should not accrue losses from unreported incidents.

25. Unreported incidents -- New providers. 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, estimated losses based on industry experience should not be accrued.

26. Estimation of losses. If it is probable that a claim has been incurred and if 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.)

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

28. 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 unpaid claims and expenses should be classified as noncurrent liabilities.

29. Disclosure. 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 21 through 26, 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.

DISCOUNTING ACCRUED UNPAID MALPRACTICE CLAIMS

Discussion

30. The relevant accounting pronouncements do not specify 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 recording unpaid claims (accrued asserted and unasserted claims) at the estimated ultimate cost of settlement and a discounted amount is significant.

31. 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 indicated that only 2 percent of the dollar amount of malpractice claims incurred in 1975 were paid in that year, 4 percent in 1976, 10 percent in 1977, and 12 percent in 1978.[1] Therefore, by the end of 1978, only 28 percent of the dollar amount of 1975 claims had been paid. If the remaining claims (72 percent of the dollar amount) were paid evenly over the next five years, the discounted amount at the end of 1975, assuming a 10-percent discount rate, would be only 66 percent of the estimated full cost of settlement.

32. Because a great number of factors have to be taken into consideration, it is rare that unpaid malpractice claims can be precisely estimated. 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.

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1. Robert L. Westin, "The Economics of the Medical Malpractice Insurance Business," Best's Review (Property/Casualty Insurance Edition) 80 (February 1980): 16-18.

Present Practices

33. 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 because 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 are those determined by others.

Views on the Issue

34. Some believe that the accrual of the cost of settling malpractice claims should be 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 their potentially significant variability. They believe that discounting estimated amounts is too imprecise to maintain the credibility of financial statements.

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

36. 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 economic reality. They also believe it would be inconsistent to recognize the effects of anticipated future price changes but not recognize the effects of the time value of money.

37. 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.

38. 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.

39. Although supporters of discounting recognize the imprecision in establishing claim liabilities, they do not believe it should be a determining factor in deciding whether to discount. They believe that if an individual claim 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.

40. Some 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.

41. 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.

Conclusions

42. The AICPA is considering the issue of discounting. Pending completion of that project, this statement does not take a separate position on the issue of discounting accrued medical malpractice claims. 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)).

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

Discussion

43. 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 to the insurance carrier after the termination of the policy regardless of when the incidents occurred.

44. Because the possibility always exists that a health care provider will be unable to renew a claims-made policy, a question arises about 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.

45. A health care provider may terminate a claims-made policy and buy tail coverage. In those circumstances a question arises about 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

46. 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.

47. 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

48. Some believe that a claims-made policy represents a transfer of risk to the insurance carrier and that it is unnecessary to accrue for estimated losses from unasserted claims and unreported incidents that will probably be covered under future claims-made policies. 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.

49. 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.

50. 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 occurrences.

51. 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.

Conclusions

52. 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 if the health care provider has sufficient historical claim experience, as described in paragraphs 20 through 29, to estimate the cost.

ACCOUNTING FOR RETROSPECTIVELY RATED PREMIUMS

Discussion

53. 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 and 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.

54. 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 any minimum and maximum premium limitations of the contract, based on the experience of the health care provider.

55. 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.

56. 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. According to FASB Statement No. 5, 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 should be accounted for as a deposit by the insured.

Present Practices

57. 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.

58. 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

59. 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, if experience is unfavorable, that the insured will only be required to pay a reasonably specified maximum amount, a sharing of risk may exist. They believe that 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.

60. 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 paragraphs 20 through 29.

61. 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.

Conclusions

62. 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 paragraphs 20 through 29. 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 paragraphs 20 through 29, the health care provider should disclose the existing contingency in the notes to the financial statements (see paragraph 29).

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

64. A retrospectively rated policy with premiums based primarily 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 on the basis of the group's experience to date.

ACCOUNTING FOR MEDICAL MALPRACTICE CLAIMS INSURED WITH CAPTIVE INSURANCE COMPANIES

Discussion

65. Some health care providers have formed wholly owned subsidiaries, called captive insurance companies, to insure the parent entity and possibly other health care providers.

66. Other health care providers have together formed multiprovider captive insurance companies to insure their medical malpractice claims. 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 claim 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.

67. 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. 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 providers and their captive may be complex; 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

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

Views on the Issues

69. Some believe that a health care provider that is insured by its wholly owned captive has not transferred its risk and 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 20 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."

70. Some believe that the determination of whether or not retrospectively rated policies issued by multiprovider 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 paragraphs 20 through 29.

71. Others believe that policies issued by multiprovider 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 multiprovider captive.

Conclusions

72. A wholly owned captive insurance subsidiary should accrue estimated losses from asserted and unasserted claims of its parent as indicated in paragraphs 20 through 29. FASB Statement No. 60 specifies the accounting by an insurance enterprise for the insuring of entities other than its parent.

73. A retrospectively rated insurance policy issued by a multiprovider captive insurance company 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 premium payments in excess of the minimum premium as a deposit and accrue estimated losses from asserted and unasserted claims as indicated in paragraphs 20 through 29. Estimated losses should not be accrued in excess of stipulated maximum premiums. The minimum premium should be amortized pro rata over the policy term.

74. A retrospectively rated policy based primarily 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 multiprovider captive's experience to date.

75. 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 and 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 20 through 29, the health care provider should disclose the existing contingency in the notes to the financial statements (see paragraph 29).

ACCOUNTING FOR TRUST FUNDS

Discussion

76. 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 in an attempt to make sure that financial resources are available to pay claims. They may also establish trust funds because they are permitted to recognize contributions 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.

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

Present Practices

78. 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

79. 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.

80. 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.

81. 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 that classification should depend on the classification of estimated unpaid malpractice claims.

Conclusions

82. 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 income, and the administrative expenses of the trust fund should be included with other administrative expenses.

83. Estimated losses from asserted and unasserted claims should be accrued and reported as indicated in paragraphs 20 through 29 and should not be based on payments to the trust fund.

84. 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

85. This statement is effective for fiscal years beginning after December 15, 1983, with earlier application encouraged. Accounting changes adopted to conform to the provisions of this statement should be applied retroactively. In the year that 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 per share amounts for each year restated.

86. If retroactive restatement of all years presented is not practicable, the financial statements presented should be restated for as many consecutive years as practicable, and the cumulative effect of applying the statement should be included in determining net income of the earliest year restated (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. (See paragraph 20 of APB Opinion No. 20, Accounting Changes.) 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 should be disclosed for that year.