



Understanding and evaluating deal considerations in the risk management and health insurance sectors

An update for private equity investors

This issue explores certain operational, financial, and tax issues that private equity investors should consider when making investments in health plans or risk based entities (Health Insurers).

Operational, financial and tax deal considerations

Estimate for claims incurred but not paid (IBNP)—The largest, and quite often the riskiest, component of a Health Insurer's balance sheet is its IBNP liability, which represents the estimate of unpaid and unreported claims for which a Health Insurer bears the insurance payment risk. IBNP liabilities should be developed

using actuarially sound methodologies, taking into account: claim payment patterns, claim denials, claim disputes, cost trends and inflation, seasonality, and membership data. An explicit provision for adverse development of claims and an estimate for unpaid loss adjustment expense are typically embedded within this liability. IBNP liabilities are highly reliant on management estimation,

and actual claims experience is likely to vary from IBNP estimates recorded by management. As a result, a retrospective analysis of IBNP liabilities, utilizing the most recent claim information, will typically result in adjustments to normalize historical earnings and potentially change expectations relating to forecast assumptions. The failure to properly assess IBNP liabilities 1) puts an

investor at risk for potentially not ascribing an appropriate valuation to the business and 2) may require an investor to have future injections of cash post transaction. For federal income tax purposes, insurance companies are generally allowed to deduct the majority of their IBNP reserves; however, there is a risk the IRS will challenge the deductibility of an explicit provision for adverse development of claims. Buyers should understand the insurer's historical tax treatment of IBNP reserves and the potential cash tax impact should the IRS successfully challenge the deductibility of any portion of the insurers IBNP reserves.

Statutory requirements—Certain regulatory restrictions have been established to improve the solvency of Health Insurers and in turn, protect the members that they serve. The maintenance of minimum capital and surplus levels is a common requirement measured by metrics such as risk-based capital and tangible net equity. The rules, and the level of scrutiny, vary by state and the risk profile of the Health Insurer. Regulators also impose differing levels of dividend restrictions limiting the amount of capital that can be extracted from the business. Investors should include proper protections within the transaction documents requiring Health Insurers to meet the designated minimum surplus requirement.

Impact of the Patient Protection and Affordable Care Act (PPACA)—The implementation of PPACA has materially impacted the way Health Insurers operate, including but not limited to the introduction of Health Exchanges, the expansion of Medicaid, the inability to deny coverage for preexisting conditions, the inability to place limitations on lifetime medical expenses, and the requirement to cover certain benefits. In addition to these operational changes, investors should consider certain elements of PPACA that create complexities from a financial reporting perspective and could meaningfully impact a Health Insurer's earnings, including:

- **Impact of the "3-R's"**—The PPACA has introduced transitional reinsurance and risk corridor programs from 2014 through 2016, and a permanent risk adjustment program, to help alleviate adverse selection on the Health Exchanges and stabilize premiums in the individual and small group markets. The determination of the amount due to/from these programs will not be known by the Health Insurer until the year following the program year. It is important to understand how a company is estimating and recording the due to/from amounts as this can have a direct impact to earnings.

- **Minimum medical loss ratios (MLR)**—Minimum MLR levels were implemented in 2011 as a method of requiring Health Insurers offering commercial products to spend a minimum level of premium revenue on clinical services and activities to improve health care quality for their members. For products offered to individual and small group markets, the minimum MLR level is 80% and for products offered to large markets the minimum MLR level is 85%. Health Insurers offering Medicare Advantage products were subject to a minimum MLR level of 85% beginning in 2014. Health Insurers that fail to meet the minimum MLR requirements are required to provide rebates to their members. The definitions of MLR and market groups are based on adopted guidance, which should be considered prior to assessing a Health Insurer's potential exposure.

- **Health insurer fee**—Beginning in 2014, certain U.S. health insurance issuers are required to pay an annual fee based on the proportional share of their premiums relative to the market as a whole. The aggregate annual fee increases from \$8.0 billion to \$14.3 billion from 2014 through 2018, and it will be indexed to the rate of premium growth thereafter. The fee is permanent and will fund subsidies for low-income beneficiaries that purchase coverage through the Health Exchange. Health Insurers ideally would have strategies

in place to pass the burden of this new assessment through to members and/or providers to the extent permissible. Any portion of the assessment that is ultimately absorbed by the Health Insurer has a direct impact on the Health Insurer's earnings. At a minimum, plans that wrote health insurance in 2013 should be accruing for the cost of this fee effective January 1, 2014. The annual fee is non-deductible for federal income tax purposes and is expected to increase a Health Insurer's overall effective tax rate which should be considered for cash tax modeling purposes. An investor should further note that the health insurer fee is generally considered an operating expense and a deduction to EBITDA. As such, the fee should be evaluated for valuation and modeling purposes.

- **Compensation deduction limitation**—Pursuant to Internal Revenue Code Section 162(m)(6), tax deductions for compensation paid to certain individuals in exchange for services provided to a covered health insurance provider ("CHIP") are limited to \$500 thousand per year. This limitation applies to any individual compensated for providing services to a CHIP, including employees and independent contractors, regardless of title or position within a CHIP. Further, this limitation applies to both public and non-public companies and there are generally no exceptions for deferred compensation or performance-based compensation. This limitation is expected to increase overall effective tax rate which should be considered for cash tax modeling purposes. Buyers should be aware that this limitation may also apply to compensation paid by other entities under common control with the CHIP (generally defined as 80% or more equity ownership based on vote or value).

- **PCORI Fee**—The PPACA imposes a fee on certain insurers to fund the Patient-Centered Outcome Research Institute (PCORI). The amount of the PCORI fee is equal to the average number of

lives covered during the policy year or plan year multiplied by the applicable dollar amount for the year. For policy and plan years ending after September 30, 2013, and before October 1, 2014, the applicable dollar amount is \$2. For subsequent years, through 2019, this amount will be adjusted for inflation as required under provisions of the Internal Revenue Code. An investor should consider the impact of this fee on a company's operating expenses

Narrow networks and shared risk—

Health Insurers have increased a focus on the development of narrow provider networks and increased risk-sharing arrangements with these providers as a means to manage care. These risk sharing arrangements may include settlement provisions that could impact a Health Insurer's historical quality of earnings. Investors may also consider the potential off-balance sheet risk associated with these risk sharing arrangements, as providers may not be adequately capitalized in order to take on the level of insurance risk that is being transferred, and the Health Insurer may be ultimately liable for these balances.

Governmental plans—Health insurers offering Medicaid Managed Care, Medicare Advantage, and Part D plans are awarded contracts through a bidding process, which serves as the basis for the premiums earned and benefits offered by the Health Insurers. There are several factors that can impact the premium earned by the Health Insurer, including the type of benefits offered, the "risk" of the Health Insurer's member, and quality measures. Certain provisions associated with these governmental plans are subject to a settlement process, for which management must estimate the amounts due to/from CMS and the State. The accounting for these settlements is

subject to significant levels of estimation and could result in a material impact to a Health Insurer's earnings.

Improper tax classification—Insurance companies are required to file as C corporations for federal income tax purposes. For such purposes, an insurance company is generally defined as a company whose primary and predominant activity is the business of issuing insurance contracts. To the extent an insurance company has historically filed as a pass-through entity (e.g., a partnership or S Corporation), there could be significant historical tax exposures for unpaid corporate level income taxes.

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