THE NEWSLETTER FROM THE BDO HEALTHCARE PRACTICE

BDO KNOWS HEALTHCARE

CONTENTS

THE REVENUE CYCLE PIPELINE: THE CONTINUED STRESS AND CHALLENGE FOR HEALTHCARE LEADERS 1

INCENTIVE PAYMENTS FOR MEANINGFUL USE OF ELECTRONIC HEALTH RECORDS (EHR) 3

CONGRESSIONAL OVERSIGHT HEARINGS ON TAX EXEMPT ORGANIZATIONS 5

AN AUDIT PERSPECTIVE: UNDERSTANDING THOSE SELF-INSURED RISKS 7

Material discussed is meant to provide general information and should not be acted upon without first obtaining professional advice appropriately tailored to your individual circumstances.

To ensure compliance with Treasury Department regulations, we wish to inform you that any tax advice that may be contained in this communication (including any attachments) is not intended or written to be used, and cannot be used, for the purpose of (i) avoiding tax-related penalties under the Internal Revenue Code or applicable state or local tax or (ii) promoting, marketing or recommending to another party any tax-related matters addressed herein.

© 2012 BDO USA, LLP.
All rights reserved. www.bdo.com

THE REVENUE CYCLE PIPELINE: THE CONTINUED STRESS AND CHALLENGE FOR HEALTHCARE LEADERS

By Claudia Birkenshaw Garabelli, MSA
Director of Revenue Cycle Services, The Rybar Group, Inc.

Many providers still struggle with working through backlogs of aged and denied claims, which slows cash flow and causes increased Accounts Receivable (AR) days. Sadly, many unpaid accounts average greater than 180 days from the date of service. Healthcare providers need meaningful metrics to address issues within the revenue cycle pipeline. These are a few things the leadership must do in order to create a positive revenue cycle:

- Communicate with the staff in all arenas of the revenue cycle and solicit their input. Their first-line understanding of the issues is often essential to resolve issues.
- Implement a process to track and trend denials. Are admissions from one or two physicians causing 60 percent of the inpatient rejections? Are four to six common lab tests causing 35 percent of the re-work by outpatient billers? What is the financial impact, direct bottom-line savings you would see if you identified/educated those physicians, their staff, front-line team, and the billing team? Quantify some of the intangibles, such as poor customer service and upset patients when they receive a bill for a service they felt was payable. What is the dollar impact of the rejections? Consider the amount of employee time it takes to review and respond to a denial; it may be

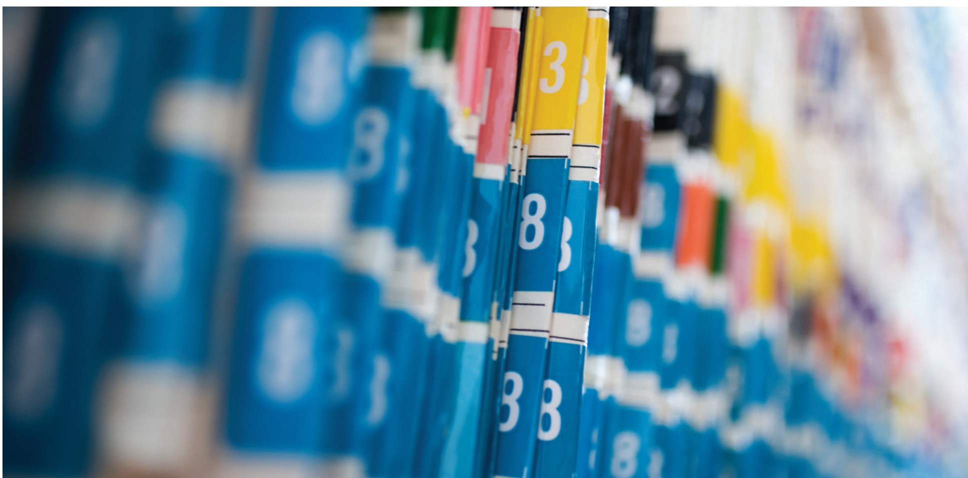
Read more on next page

▶CONTINUED FROM PAGE 1

THE REVENUE CYCLE PIPELINE

$35 to $200 for each claim. How many rejections do you receive every week?

- Through data mining, education and workflow changes, it is typically easy for most hospitals to prevent 75 rejections each week. With the estimated denial full-time employee (FTE) cost of $35 to $200, this can be an extrapolated savings of $136,500 to $260,000 for the year. This FTE savings can be redirected towards collecting self-pay accounts, following up on secondary claims, or reviewing other preventable denials and implementing a work plan/process to mitigate no/slow payments.
- Failure to document and track denied/rejected/partially paid/underpaid claims will ultimately result in failure, poor performance, and an ever-spiraling web of inefficiencies.
  - Some providers still struggle how to track denials with their current system, or they have poor processes, or have failed to hold key personnel accountable so that everyone shares the same vision of revenue cycle excellence.
  - Suggestions include:
    - Appoint an ANSI expert (or hire someone to educate/implement a process that works with your system/organization) to codify ANSI and manual payor nonpayments into a process for your organization.
      - Data mine and group those codes into general categories for follow-up. Examples include medical necessity errors (preventable), CCI errors (preventable), unpaid deductible or copay (preventable), and segregate by payor, type of service (such as observation, emergency room, radiology, laboratory, inpatient OB-GYN, NICU, etc.), provider, outpatient CPT codes, diagnosis codes and other categories that are relevant.
  - Analyze the data to determine the top two to five preventable issues, develop a team and create a work flow/process to address the issues.
  - Communicate issues, document, publicize and chat about the issue/program. Discuss when a new process fails and celebrate all successes. Get the teams involved, recognize staff, reward and celebrate milestones.
  - Follow up and track unpaid claims 30-35 days after a claim has been filed. Where are the problems? What is the productivity of each staff member? What needs to be addressed to resolve issues?
  - Follow up on denied, rejected or partially paid claims within five to seven working days of date received.
  - Ensure that point-of-service collection is being tracked and monitored by site (such as the emergency room, laboratory or hospital inpatient) and employee. Metrics should include opportunity (how much could have been collected) versus actual collections; track the opportunity (the gap) and implement processes to maximize and reward high performers.
  - Self-pay (patient balances) continues to grow due to reduced healthcare coverage and the overall economy countrywide. What processes are you implementing to work with your community, your payors, your staff and physicians to support and help this trend? Many options are viable.
  - The front end of the revenue cycle has never been more key than it is today. It starts when a physician calls the hospital to make an appointment or when a patient walks through your door. What are your financial clearance policies? How are staff educated? What scripting is in place to ensure that our team is interacting in a professional and caring manner to the core of our business? Our customers?
- Develop a preliminary plan.
- After you complete your diagnostic review, create a workplan to address various opportunities within your revenue cycle pipeline.
- Given your volume of unpaid claims, you may need two to four weeks to assess and then develop a plan to resolve the current backlog as well as identify the top 10 reasons why claims are not paid within 14-30 days.
- Generate passion within your hospital by spreading the word, identifying issues (in a non-blaming but transparent manner) and implementing a team approach to accelerate resolution of outstanding claims and issues.



Within the revenue cycle, it has never been more critical to track denials, create meaningful metrics, hold management, physicians and staff accountable, and to be transparent, keeping-up with changing rules/regulations, and providing education to the staff. It is through these activities that healthcare leaders will be able to address the issues of the revenue cycle pipeline and to create a positive environment, both financially and operationally.

To learn more about revenue cycle or reimbursement services, please contact The Rybar Group, Inc., a healthcare financial consulting firm and an independent member of the BDO Seidman Alliance.

INCENTIVE PAYMENTS FOR MEANINGFUL USE OF ELECTRONIC HEALTH RECORDS (EHRs)

By Karen Fitzsimmons, CPA, BDO partner

▶OVERVIEW

As part of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments were established under the Medicare and Medicaid programs for eligible professionals, eligible hospitals and critical access hospitals (CAHs) as they adopt, implement, upgrade or demonstrate "meaningful use" of certified electronic health record (EHR) technology. The primary goal of these incentive payments is to provide a financial incentive for the "meaningful use" of certified EHR technology to achieve health and efficiency goals. ARRA specifies three main components in demonstrating that "meaningful use" has been achieved:

- Use of certified EHR technology in a meaningful manner, such as e-prescribing or recording patient demographics and vital signs
- Use of certified EHR technology for electronic exchange of health information to improve quality of healthcare
- Use of certified EHR technology to submit clinical quality and other measures

Basically, providers need to show they are using certified EHR technology in ways that can be measured significantly in quality and in quantity. Under both the Medicare and Medicaid programs, the criteria to receive incentive payments is generally the same. However, there is a difference in the way the incentive payments are calculated and earned under each program.

▶CHALLENGES

The ability to implement an EHR system that meets the federal meaningful use criteria under ARRA is dependent upon the following key factors:

- Understanding the meaningful use requirements
- proper planning
- A dedicated project team
- Redesign efforts to capture clinical quality measures
- Training
- Effective data integrity controls
- Effective IT change management
- Coordination with vendors to achieve meaningful use compliance

We recommend, as clients embark on an initiative to move to an EHR system, that management first perform a readiness assessment to help define where they are from a current state of readiness. This assessment will allow management the ability to develop the appropriate plan for implementation.

▶ACCOUNTING TREATMENT

So, you are on your way to implementing an EHR system. There has been much debate about the appropriate accounting and reporting for these incentive payments under the Medicare and Medicaid programs.

▶ Read more on next page

▶CONTINUED FROM PAGE 3

ELECTRONIC HEALTH RECORDS

First, the good news is that EHR incentive payments are not included on the Schedule of Federal Awards for a provider and, therefore, not subject to audit under OMB Circular A-133. In practice, providers receiving these incentive payments have accounted for them by either using a "*gain contingency model*" or an "*IAS 20 grant accounting model.*" The staff at the Securities and Exchange Commission (SEC) has indicated that registrants should apply a gain contingency model and strongly recommended consultation with the SEC staff if a registrant chooses to use anything other than a gain contingency model. The following discussion is meant to be an aid for providers in determining the appropriate accounting treatment given their specific circumstance.

▶GAIN CONTINGENCY MODEL

The guidance under ASC 450 relates to accounting for uncertain cash inflows. Under ASC 450, incentive payments for meaningful use of EHR would not be recognized until all contingencies had been satisfied to allow nonrefundable receipt of an incentive payment. Therefore, the contingency model would not permit income recognition until the provider has complied with the meaningful use criteria for the entire EHR reporting period (90 consecutive days in the first payment year and 365 consecutive days for each of the second through fourth payment years). It is not appropriate under ASC 450 to consider the probability of compliance with the requirements when considering when to recognize income relating to the incentive program. The good news under this model is that the actual submission of the cost report and subsequent desk review or audit by CMS would not be viewed as a contingency that must be met before income recognition.

▶IAS 20 GRANT ACCOUNTING MODEL

Guidance is limited under U.S. GAAP on accounting for government grants received of this nature. International Accounting Standards 20, *Accounting for Government Grants and Disclosures of Government Assistance* (IAS 20), deals directly with situations where a government grants monies in return for compliance with specified conditions or activities of the provider. While IAS 20 is not authoritative under U.S. GAAP, many providers have elected to use this guidance for accounting for EHR incentive payments. IAS 20 defines two types of grants: grants related to assets, and grants related to income. Since the main condition related to this grant is related to compliance with an activity and not the purchase of an asset, an EHR incentive payment would be considered a grant related to income. Under IAS 20, a provider does not recognize income until the organization is reasonably assured that it will comply with the compliance conditions and the grant will be received. Given that the federal government has little credit risk, the receipt of the incentive payment is reasonably assured. Therefore, more simply stated, the provider could begin ratably recognizing income related to the incentive payment over the compliance period once management was able to determine with reasonable assurance that it would be able to comply with the conditions of the grant. "*Reasonable assurance*" is a judgment call. In evaluating whether reasonable assurance has been met, management should consider the following factors:

- Is the provider in the beginning of implementing a new EHR system or has the provider been operating EHR technology for years?
- At what stage is the hospital in meeting the meaningful use criteria?
- How long has the provider been able to achieve the meaningful use criteria?
- How reliable are the internal controls around IT at the provider?

▶REPORTING

These incentive payments represent other income and, if material, must be presented as a separate line item in the income statement or in the footnotes to the financial statements. SEC registrants would present other income as "non-operating income". Nonprofit healthcare entities have a great degree of latitude when determining what to include within the performance indicator. A provider must determine whether it considers these incentive payments to relate to ongoing and central activities and thus record them as other revenue related to income from operations, or that these incentive payments are not related to ongoing and central activities and thus should be presented as a non-operating activity within the performance indicator. Disclosures in the footnotes to the financial statements should include:

- Nature of the transaction (including description of the incentive program and how the incentive payments are determined/calculated)
- Method for accounting for the incentive payments (income recognition policy)
- If material and not separately disclosed on the statement of operations, the amount of gain contingency or grant income recognized as income and the amount deferred, if applicable. In addition, there should be a disclosure stating the fact that this amount is subject to audit by CMS and the amount is subject to change.
- Remaining contingencies relating to recognized government grants

▶ADDITIONAL RESOURCES

The Healthcare Financial Management Association published an "issue analysis" dated December 2011. entitled "Medicare Incentive Payments For Meaningful Use of Electronic Health Records: Accounting and Reporting Developments". This white paper has illustrative examples on how to recognize income under both accounting models described above. This white paper can be accessed through www.hfma.org. In addition, providers can go to www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms for detailed information from the Centers for Medicare & Medicaid Services on the EHR Incentive Program. CMS has developed a "Frequently Asked Questions (FAQs)" document which is a great resource to find more information about a specific topic. The FAQ is located at the same web address.

For more information, contact Karen Fitzsimmons, Assurance partner, Healthcare practice, at kfitzsimmons@bdo.com.

CONGRESSIONAL OVERSIGHT HEARINGS ON TAX-EXEMPT ORGANIZATIONS

By Laura Kalick, JD, LLM in Taxation, BDO director

NONPROFIT ORGANIZATIONS PLAY A KEY ROLE IN OUR ECONOMY. BESIDES PROVIDING ESSENTIAL SERVICES, IT IS ESTIMATED THAT NONPROFIT ORGANIZATIONS EMPLOY ONE IN 10 PERSONS IN THE NATION AND, AS OF 2008, CHARITABLE ORGANIZATIONS HAD $2.5 TRILLION IN ASSETS.

On May 16, 2012, the U.S. House of Representatives Ways and Means IRS Oversight Subcommittee held a hearing on tax-exempt organizations.[1] The Committee is chaired by Rep. Charles W. Boustany Jr., M.D (R-La.). The focus of the hearing was on current issues related to tax-exempt organizations, including the IRS compliance initiative related to universities, new requirements for tax-exempt hospitals, good governance standards and Form 990.

In addition, the hearing agenda included the history of recent legislative changes to the tax code dealing with tax-exempt organizations and what prompted those changes

The hearing was the first in a series by the subcommittee on the tax-exempt sector and IRS oversight of tax-exempt activities. The individuals who testified at the hearing were from the private sector and it is likely that the next hearing will involve IRS representatives.

One of the concerns of Congress is tax revenue and the ever growing number of nonprofit organizations and, in particular, IRC 501(c)(3) organizations. The Treasury loses money with 501(c)(3) organizations in three ways: the charitable contribution deduction; non-taxation of the income on tax-exempt bonds; and the exclusion from tax of income related to the tax-exempt purpose of an organization.

One theme that ran through the hearing was that there are no bright-line tests when it comes to what is considered charitable and that the category can be very broad. Whether an activity is considered substantially related to the exempt status of an organization is based on a facts and circumstances test. Therefore, even if the low audit rate of exempt organizations were increased, there would not necessarily be an increase in revenue as a result of increased audit activity, nor would there be a decrease in the number of organizations that qualify for 501(c)(3) status. One individual who testified[2] suggested an alternative to trying to restrict section 501(c)(3): Instead, IRC Section 170, the section that allows charitable contributions to 501(c)(3) organizations, should be more restrictive.

If the 501(c)(3) category was too broad to really oversee organizations, the question was posed whether Congress was on the right track to impose additional positive requirements on certain organizations such as those imposed upon tax-exempt hospitals with IRC 501(r) requirements. However, even with the new positive requirements geared to distinguish tax-exempt hospitals from their for-profit counterparts, the consequence for non-compliance, i.e., revocation of exemption, still appears to make enforcement difficult. Even though the new law imposes a $50,000 penalty for not complying with the Community Health Needs Assessment requirement, the penalty is in addition to and not in lieu of revocation of exemption. Revocation of exemption would be disastrous to a tax-exempt hospital and the community it serves, resulting in bonds losing tax-exempt status, charitable deductions not being available, income being taxable, and possibly,

▶ Read more on next page

[1] Written testimony from the hearing is available at: http://waysandmeans.house.gov/Calendar/EventSingle.aspx?EventID=294783
[2] Roger Colinvaux, associate professor of law, Columbus School of Law, The Catholic University of America, Legislation Counsel, Joint Committee on Taxation, 2001-2008.

▶CONTINUED FROM PAGE 5

CONGRESSIONAL OVERSIGHT HEARINGS

losing property tax exemptions. The atomic bomb approach of revocation was the reason that Congress enacted intermediate sanctions (IRC 4958), and there are also tax penalties for organizations involved in tax shelters. The dilemma is apparent in that the government has still not been able to issue regulations, even in proposed form.

Michael J. Regier, senior vice president of Legal and Corporate Affairs, VHA Inc., provided testimony and answered questions about the hospital industry. Regier described how the IRS had not yet issued regulations on the very important IRC 501(r), but rather had come out with additions to Form 990, Schedule H that were subsequently made optional. He also pointed out that the IRS had issued Notice 2011-52, which imposes what he considered to be excessive documentation requirements on reporting of community health needs assessments (CHNAs). In addition, he pointed out what he considered a discrepancy in the notice regarding the implementation strategy and the statute and noted that the industry still needs authority on critical definitions such as what constitutes an "extraordinary collection measure" and what constitute "reasonable efforts" to determine whether an individual is eligible for financial assistance.

Several witnesses also expressed concerns about the amount of information required on Form 990 and the burden it imposes on exempt organizations with no apparent tax benefit to the government. Of note was a new requirement imposed by the IRS to report income, expenses and balance sheet items related to partnership investments based on Schedule K-1 information. In response to an outcry from the nonprofit community regarding this requirement, the IRS made the requirement optional for the 2011 Form 990. One speaker's written testimony indicated that the IRS should eliminate the proposed requirement.[3]

A topic of conversation both at the hearing and at recent exempt organization tax conferences was whether all the questions the IRS asks about governance on Form

990 have validity. Recently, the IRS released the results of its audit checklist to show if there is a correlation between an organization that has certain governance practices and whether the organization is tax compliant.[4] Interestingly, the results were that there was a statistical correlation between tax compliance and organizations that had written mission statements, those that always use comparability data when making compensation decisions, those with procedures in place for the proper use of charitable assets and those where the Form 990 was reviewed by the entire board of directors. But there was no statistical correlation with tax compliance and those organizations that had conflict of interest policies; organizations that never or only occasionally use comparability data to set compensation; and voting board members having a family or outside business relationship with other board members, officers or key employees.

▶CONCLUSION

The Ways and Means Subcommittee on Oversight hearing in May was the first in a series on the tax-exempt sector. It is likely the next hearing will include the IRS to understand its perspective. In addition to the hearing and the comments of those who testified, many other stakeholders are sending in written comments that the staff reviews.[5] Stay tuned for future updates.

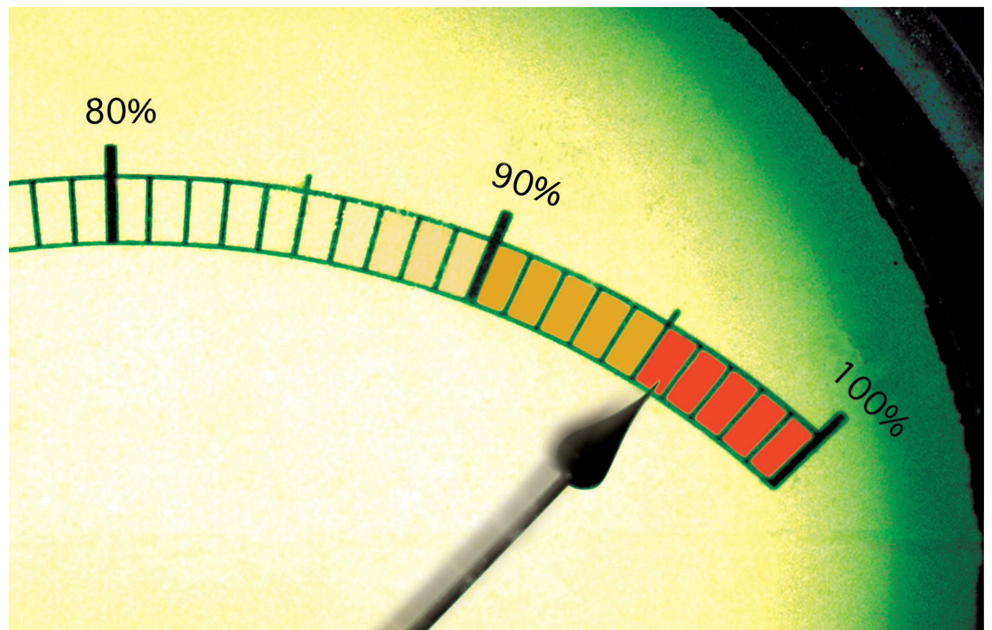
For more information, contact Laura Kalick, national director, Nonprofit Tax Consulting, at lkalick@bdo.com.

[3] See written testimony of Joanne M. Destafano, Vice President for Finance and Chief Financial Officer, Cornell University, on behalf of NACUBO.
[4] See prepared remarks of Lois Lerner, Director, IRS Exempt Organizations to a Georgetown University Conference, April 19, 2012
[5] See this link if you would like to send in written comments: http://waysandmeans.house.gov/committeesubmissions/

AN AUDIT PERSPECTIVE: UNDERSTANDING THOSE SELF-INSURED RISKS

By Corwin Zass, principal & consulting actuary, Actuarial Risk Management

The healthcare marketplace is changing rapidly. Financial executives within the healthcare industry continue to grapple on a monthly basis with the balance between revenue and costs. Unfortunately, it seems like many insurable risks are examined annually at the renewal period. The annual frustration and time-consuming effort of evaluating risk exposure and respective risk mitigation techniques serves to create a new argument to monitor more frequently new risk exposures or those existing risks with year-over-year double-digit exposure increases.



BACKGROUND

Self-Funding is an alternative risk transfer strategy used by tens of thousands of employers inside and outside the healthcare industry to finance their various risk programs (such as group medical cover for employees, workers' compensation exposure, professional liability exposure, etc.) Self-Funding has become an increasingly attractive option for many employers due to the rising costs (i.e., premiums charged) associated with health care, medical malpractice, and workers' compensation commercial insurance. In some situations, employers effectively create their own insurance company (i.e., captives) or risk retention groups.

The most common self-insured exposures for healthcare organizations tend to be split between employer-driven versus employee-driven. Those employer-related exposures relate to professional and medical malpractice liability, workers' compensation, general liability and property, while employee based exposures typically are medical and other supplemental life and/or health benefits. The retained risk generates a financial exposure to the entity and generally requires the recognition of a liability on the entity's balance sheet.

An organization's risk management program deals with risk mitigation, risk avoidance and risk financing, with some programs more elaborate than others. A larger or more complicated risk management program does not necessarily equate to a better program. Just as in the audit of financial statements, many of the same issues arise in the evaluation of self-funded programs. Specifically, the accuracy of the data used in the development and measurement of the exposure is one of the most important considerations.

Before turning to these aforementioned topics, we offer some observations as a result of auditing hundreds of self-insured program studies.

AN AUDITING ACTUARY'S POINT OF VIEW

More times than not, healthcare providers annually engage a third party to develop an analysis (report) for those risks that are not fully insured with a commercial insurance company. Those risks which are part of a provider's self-insured program typically range from medical professional, hospital professional and hospital general liability. While not mandated, these reports are typically developed by an actuarial firm although some providers rely on the third-party claims administrator (with no actuarial oversight) to develop "lag studies." The reports will (and do) vary, sometimes significantly, with respect to detail and methods employed in the analysis. Furthermore, the report details will differ by type of risk under analysis, the size of exposure(s), the adequacy of the claims detail supporting the study, the entity producing the report, and even down to the engaged professional signing the study.

The objective of these reports is to provide a range of plausible loss estimates that a provider can use to choose its point estimate, which that is recorded on the financial statements. Furthermore, these loss estimates must be adequate (not egregious) to cover all loss costs while sustaining minimal variation from the time of initially establishing the reserves until the time that all claims are fully paid and closed by the company.

More robust reports will provide quarterly or even monthly exposure levels and forecasts of losses. This article expands upon our generic observations from our review of hundreds of actuarial reports produced from the large

Read more on next page

▶CONTINUED FROM PAGE 7

UNDERSTANDING THOSE SELF-INSURED RISKS

national actuarial firms down to the "single-shingle" one-person firm.

▶ACTUARIAL REPORT

The uniqueness of healthcare entities is easily identifiable by those that review actuarial reports from a cross selection of comparable or peer entities within the healthcare spectrum. No two hospital groups will have the same loss experience, insurance coverage and limits, and exposures. These differences, while sometimes appearing minute, will result in varying methods ranging from loss estimates to the amount of insurance recovery receivables to be recorded with the financial impact sometimes being material.

Aside from the details found within the reports, our experience shows that many healthcare providers are simply relying on the work of the study authors. We have witnessed the frustrations encountered by providers in their discussions with actuarial professionals. From archaic acronyms to voluminous report details to large amounts of caveats, many providers simply do not have the time or expertise to determine if the risks are being managed efficiently or even properly. At times, although not surprising to us, our reviews of these reports show situations where the narratives are jargon filled, some with various layers of ambiguous wording or even the cases in which the verbiage is inconsistent within sections of the report.

Other observations include:

- Many of the providers do not have a separate document that:
  a. adequately support the rationale for any adjustments made to the actuarial estimates
  b. details how the reported loss estimate was computed. As an example, the provider uses the undiscounted value from the actuarial computations plus explicitly defined adjustments. The purpose is to create a consistent approach from period to period. We emphasize the need for maintaining a consistent position with respect to reported loss estimates position relative to the actuarial estimates.
  c. discuss the effects of reinsurance collectibles and whether the actuarial report includes these risk transfer effects.
- We further observe that few providers have a formal document describing the steps or processes used in computing and reporting these liabilities in the financial statements.
- We recognize that about half of the reports we review do not provide clear reasoning how the provider and/or the provider's actuaries established any subjective assumptions.
- Many providers rely on their third-party claims administrator to simply provide claims register listings directly to the actuarial consultant with no independent validation that the claims reconcile to the financial statements. This is important since most if not all actuarial studies have a caveat regarding the accuracy of the data used in the study.

As can be expected, actuarial studies vary in the level of explicit explanations that discusses any changes from the prior period made to methodologies or changes made in the provider's own risk programs. We have seen various situations where the actuarial advisor was not informed of a change in the underlying program under study which invalidated the estimates produced by the actuary.

We are beginning to see some healthcare providers engaging an advisor (or second set of eyes) to regularly help the CFO interpret and use the relevant data from an annual actuarial report to supplement his/her other spreadsheets and tools used to manage the provider's financial conditions.

▶SELF-FUNDED LOSS RESERVING

Here we delve into the minutiae of the self-funded loss reserving process. As actuaries, we recognize that loss estimates can be material to the balance sheet and variability in estimates may have a significant impact on income. Depending on the type of risk, a relatively small change in a reserve estimate can have a leveraged impact on reported income. Combined with the significant expenses associated with self-funding, companies are well advised to have a transparent self-funding loss reserving process.

Loss reserving, defined here, is the estimation of unpaid losses and loss expenses. As previously mentioned above, a robust loss reserving process goes beyond the financial reporting process and encompasses the holistic nature of risk management to ensure C-level executives have the best information available to make informed decisions about risk mitigation and financing.

Actuarial Risk Management has identified the following "best practices" regarding a loss reserving process:

- Management must be involved
- Internal staff must understand the risk management processes and rationale for such processes
- Data must be reliable, accurate and easily accessible
- The approach must include complete, supportable, and consistent documentation, including methodology, assumptions, reporting and disclosures

▶TERMINOLOGY OF LOSS RESERVING

Before proceeding, it is worth defining several concepts to remove any possibility of ambiguity.

Generally the claim reserve is categorized into two distinct categories:

- Unpaid claims for which the event has occurred, and which are already known and reported
- Unpaid claims for which the event has occurred, but which have not yet been reported

In other words, reserves are liabilities established on a company's balance sheet as of a specific accounting date and are estimates of the unpaid portion of what the company ultimately expects to pay out on claims. They are estimates of future payments for insured events (claims) that occurred prior to the

▶Read more on next page

▶CONTINUED FROM PAGE 8

UNDERSTANDING THOSE SELF-INSURED RISKS

accounting date, whether or not those claims have been reported to the company.

In general, financial statements report data on a calendar-year basis. However, payments and reserve changes may be made on accidents that occurred in prior years, thus not giving an accurate picture of the business that is currently insured. Therefore, it is important to understand the difference between calendar-year and accident-year losses.

Calendar Period Losses consist of payments and reserve changes that are recorded on the company's financial records during the period in question, without regard to the period in which the accident occurred. Calendar period results do not change after the end of the period, even as new claim information develops.

Accident Period Losses consist of payments and reserves that are assigned to the period in which the accident occurred. Accident period results will change over time as the estimates of losses change due to payments and reserve changes for all accidents that occurred during that period. Projection of ultimate losses by accident period is an important part of the reserve analysis.

Paid Development Patterns

Incurred losses consist of payments and reserve changes, so it is important to understand paid development patterns. The longer a claim is expected to stay open (not settled), the more difficult it is to establish an accurate reserve at the time the accident is reported. As an example, since injury claims tend to take longer to settle than property claims, reserve estimates for injury claims are more sensitive to the uncertainties mentioned above, such as changes in mix of business, inflation, and legal, regulatory and judicial issues. As more information is obtained about claims, the reserves are (supposed to be) revised accordingly. However, the ultimate amount continues to be unknown until the claims are settled and paid.

Reserve Development

Ultimate paid losses and loss adjustment expenses may deviate, perhaps substantially, from point-in-time estimates of reserves contained in a company's financial statements. A company's actual claim payments may exceed or may be less than its loss reserves causing a company to incur losses in subsequent calendars years that are higher or lower than anticipated.

Changes in the estimated ultimate cost of claims are referred to as development. There are several ways for reserve development to occur. They are:

- Claims settle for more or less than the established reserves for those claims
- Adjuster-set reserve estimates on open (reported) claims change
- Average reserves set by the actuaries for open (reported) claims change
- Unreported claims emerge (reported after the accounting date) at a rate greater or less than anticipated. This can be due to either or both of the following:
  - i. The actual number (frequency) of "late reported" claims differs from the estimate
  - ii. The average amount (severity) of these claims differs from the estimate
- Actuaries' estimates of future emergence patterns on unreported claims change
- Salvage and subrogation recoveries are greater or less than anticipated

Reserve development influences reported earnings. Current-year reported earnings would be understated when either or both of the following happen (and the relative impact of each):

- There is unfavorable development of prior accident years during the current year
- Reserves for accidents in the current year are overestimated (conservative)

On the other hand, current-year reported earnings would be overstated when the opposite of these items is true

Although it is not necessary to grasp the mathematical complexities involved in the loss modeling process, there are certain elements affecting the accuracy of loss estimates that management must understand. While actuaries practice actuarial science, we hope the reader recognizes that there is a component of art in the analysis. Our role as auditing actuaries is to both aid the audit team's navigation of the nuances of these actuarial reports, while also providing advisory services to those organizations that want to improve (with respect to utilizing existing studies) in other ways that enhance their understanding and management of the organizations' financial position.

Guest Contributors: Chuck Emma, managing principal & consulting actuary, EVP Advisors, Brad St. Pierre, consulting actuary, EVP Advisors

To learn more about interpreting your actuary's study or how ARM can assist you gain more from your actuary's analysis, please contact Actuarial Risk Management, a full service actuarial firm and an independent member of the BDO Seidman Alliance.

BDO HEALTHCARE INDUSTRY PRACTICE

BDO's national team of professionals offers the hands-on experience and technical skill to address the distinctive business needs of our healthcare clients. We supplement our technical approach by analyzing and advising our clients on the many elements of running a successful healthcare organization.

The BDO Healthcare practice provides services in the following areas:

- Acute Care
- Ancillary Service Providers
- Health Maintenance Organizations (HMOs)
- Home Care and Hospice
- Hospitals
- Integrated Delivery Systems
- International Health Research Organizations
- Long Term Care
- Physician Practices
- Preferred Provider Organizations (PPOs)
- Senior Housing, including CCRCs

CONTACT:

CHRIS ORELLA
Partner – Healthcare, National Leader
New York, N.Y.
212-885-8310 / corella@bdo.com

KAREN FITZSIMMONS
Partner – Healthcare
Bethesda, Md.
301-634-4969 / kfitzsimmons@bdo.com

ALFREDO CEPERO
Partner – Healthcare
Miami, Fla.
305-420-8006 / acepero@bdo.com

PHIL FORRET
Partner – Healthcare
Dallas, Texas
214-665-0769 / pforret@bdo.com

MIKE MUSICK
Partner – Healthcare
Nashville, Tenn.
615-493-5610 / mmusick@bdo.com

STEVEN SHILL
Partner – Healthcare, National Leader
Orange County, Calif.
714-668-7370 / sshill@bdo.com

ABOUT BDO

BDO is the brand name for BDO USA, LLP, a U.S. professional services firm providing assurance, tax, financial advisory and consulting services to a wide range of publicly traded and privately held companies. For more than 100 years, BDO has provided quality service through the active involvement of experienced and committed professionals. The firm serves clients through more than 40 offices and more than 400 independent alliance firm locations nationwide. As an independent Member Firm of BDO International Limited, BDO serves multinational clients through a global network of 1,118 offices in 135 countries.

BDO USA, LLP, a Delaware limited liability partnership, is the U.S. member of BDO International Limited, a UK company limited by guarantee, and forms part of the international BDO network of independent member firms. BDO is the brand name for the BDO network and for each of the BDO Member Firms. For more information, please visit: www.bdo.com.

© 2012 BDO USA, LLP. All rights reserved. www.bdo.com