





December 23, 2009

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Gentlemen:

Re: Insurance Contracts – Joint Project of the IASB and FASB

We appreciate the opportunity to share with the International Accounting Standards Board (the "IASB") and the Financial Accounting Standards Board (the "FASB") (collectively, the "Boards") our views and concerns related to the Boards' ongoing discussions of its joint project on Insurance Contracts. We are the five leading managed care companies in the United States: Aetna Inc., CIGNA Corporation, Humana Inc., UnitedHealth Group Inc. and WellPoint, Inc. As a group, we provide health insurance products and related services to more than 100 million individuals. Our customers include employer groups, individuals, college students, part-time and hourly workers, governmental units, government-sponsored plans, labor groups and expatriates. We also provide other insurance products, such as long-term care, dental, term life, disability and supplemental health insurance coverage and services. Collectively we reported annual premiums of approximately \$200 billion in 2008 (equivalent to 1.4% of the GDP of the United States).

We are in the process of scheduling meetings with project representatives from both the IASB and FASB. This letter sets forth our collective views on a number of important matters currently being addressed by the Boards, and is intended to provide a framework for our discussion at these meetings.

Background to the Managed Care Industry

As managed health care companies, we function as intermediaries between the suppliers of medical care (e.g., physicians, hospitals, pharmaceutical companies, etc.) and users of medical care (consumers). The core of our business is delivering access to cost effective, quality medical care to consumers that enroll in our medical benefit plans.

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Our active engagement in the delivery of our service offerings creates a substantially different value proposition and business model than that of traditional indemnity insurance. Indemnity insurance is generally a passive industry that focuses on payment of claims subsequent to covered events that occurred during a policy period. Indemnity insurance companies have little or no infrastructure to manage the cost and outcome of a covered event as it occurs. Accordingly, we believe the accounting policies of managed care companies would exhibit key differences from those used to report traditional indemnity insurance lines such as property/casualty insurance.

As our industry term "managed care" suggests, the care management services we deliver to our subscribers are integrated into our service offerings. These include providing access to a network of providers of medical services and pharmaceuticals at discounted rates; provision of data and information to help consumers determine which physician to see, which hospital to use, what treatments to obtain, and/or how to best manage a chronic medical condition. We also provide administrative support functions such as claims processing and the customized analysis of medical trends for larger customers.

The majority of our health benefit product customers purchase a bundle of integrated services. Some also purchase insurance coverage while others self-fund their own insurance protection. Furthermore, the provision of insurance coverage varies substantially by market segment between individual, employer and government (Medicaid and Medicare) customers.

We believe this context is important to any discussion of the accounting model for our industry.

Our Observations on the Boards' Joint Project

We have been monitoring the Boards' deliberations on the joint project on Insurance Contracts closely and we would appreciate the opportunity to share our perspective on certain aspects of the project prior to the April 2010 publication of an exposure draft. We also would like to offer our assistance as leading carriers of health insurance products to the Boards as your deliberations continue. In this letter, we would like to address four primary areas that the Boards have recently addressed (summarized here and detailed below):

- Contract Boundary We are concerned that the Boards' discussions defining the boundary of an
 insurance contract may not take into consideration the spectrum of medical insurance products sold
 in the United States. For example, most contracts can be cancelled by the policyholder with limited
 notice and certain policy holders possess a guaranteed insurability right. Failing to consider the
 unique nature of the products sold in our industry could inaccurately reflect the economics of our
 business.
- 2. Unearned Premium Approach We agree with the tentative decision of the IASB to require the use of an unearned premium reserve ("UEPR") to establish the pre-claim liability for short duration non-life insurance contracts as a practical expedient, after considering our thoughts related to contract boundaries. Given our views on contract boundaries, we believe that the amount of UEPR established at inception of the insurance contract will lead to a significant gross-up on the balance sheet. The unwinding of the UEPR, presumably through revenue, will need to be considered under this approach and we would encourage the Boards to develop a principles-based approach based upon the release of risk rather than prescriptive revenue recognition criteria.

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- 3. Onerous Contracts & Grouping of Contracts We are concerned that the Boards may require insurers to apply an onerous contract test to individual contracts in a loss position. We believe such a requirement would be inconsistent with the nature of the insurance business model and would unduly penalize the industry by requiring companies to accelerate losses that are inevitable on certain contracts within a pool of like contracts, while not requiring companies to measure those losses with expected gains from the majority of like contracts that are expected to be profitable. We would recommend the test for onerous contracts to be similar to the current U.S. GAAP approach for the determination of premium deficiency reserves.
- 4. Unbundling We are concerned that as insurers, we would be required to unbundle our insurance contracts between insurance and service components, as these components are interdependent. We believe such a requirement does not reflect the nature of the customer consideration we receive from the sale of our insurance contracts, and further such a requirement is impractical and will not provide additional benefit to the users of financial statements.

A more detailed discussion of these topics is provided below.

Contract Boundary

One of the central issues of the joint project on Insurance Contracts is to determine under what circumstances potential future premiums are to be considered in the calculation of the pre-claims liability. It is our understanding that the Boards have asked their staff to develop specific proposals to address this fundamental issue by considering whether an insurer has the right to cancel the contract or change the pricing or other terms to identify the boundary between an existing and future contract. Said differently, the issue is whether the existing contract should be viewed for accounting purposes as monthly coverage, a policy year or extending beyond the end of the current policy period.

A diversity of situations exists within the U.S managed care market with respect to defining the boundaries of a contract. In a letter to the IASB submitted by America's Health Insurance Plans ("AHIP") (an association that represents the companies signing this letter) dated May 8, 2009 (included as Attachment A to this letter), several fact patterns were described that exist in our business that could influence the definition of contract boundary. We recommend the following broad principles when deliberating this matter further:

If the premiums charged in the current policy year are explicitly intended to pre-fund claims incurred in periods after the current policy year, then it is appropriate for the pre-claims liability to take into account cash flows for periods after the current policy year.

Conversely, if the premiums charged in the current policy year are not explicitly intended to pre-fund claims incurred in periods after the current policy year, then it is not necessary, for the pre-claims liability to take into account cash flows for periods after the current year.

Typically, we bill our customers monthly. Because most of our customers can cancel their contracts with one month's notice, which frequently occurs with individual and small group (e.g., coverage for less than 50 lives) contracts, it is difficult to accurately predict the future premiums that will be collected over a policy year (which is typically one-year). Similarly, for larger groups, the amount of billing varies based on the number of covered lives. Although we may agree to a certain monthly rate with the sponsoring company, the volume of covered lives often changes and some of these changes could be

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material. Changes in covered lives occur when the sponsoring company changes its workforce by acquisition or lay-offs, employee turnover and other fact patterns. Therefore, predicting future premiums beyond one month is inherently subjective and could result in volatility in the pre-claims liability. The determination of contract boundaries is fundamentally important to the measurement of UEPR at the inception of, and during, the insurance contract policy period.

We would welcome the opportunity to assist in the Board's understanding of our health insurance products.

Unearned Premium Approach to Establishing a Pre-claim Liability

As described above, U.S. managed care entities typically bill premiums on a monthly basis. This premium is intended to cover projected health insurance claims incurred in that billed month. If a customer fails to remit payment for its premiums, in most cases, the insurer would be entitled to cancel coverage and would not be liable for claims incurred after the cancellation. Because of this dynamic, we do not bill, and customers generally do not remit payment to us, in advance for more than one month. At any given date, the amount of unearned premiums reflected is generally small. We note this as a distinguishing fact between our model of insurance and that of other lines of insurance, for example, the property and casualty insurance model.

If the final standard is developed requiring us to consider the contract period to be the policy year because we offer our customers a rate guarantee for this period (despite our views noted above), it is likely that the pre-claims liability will need to include an estimate of premiums billable over the contract period, which is normally one—year. For this reason, we concur with the IASB's tentative decision to require the use of an unearned premium approach as a practical expedient to estimating the pre-claims liability currently being considered by the Boards, and we would encourage the FASB to converge with the IASB on this point. Because the premium may not be sufficient to cover the obligation (either at inception of the contract, or during the policy period), we agree that a liability adequacy test (i.e., the so-called onerous contract test) would adequately reflect potential losses that would develop (although we would appreciate consideration of our views of contract grouping, identified below).

We view this approach as a simplification of the building blocks approach for the pre-claims liability currently being considered. However, we are concerned with our ability to accurately estimate the full contract-period premiums for reasons described in the section above. We also question the conceptual aspect of recording the offsetting asset, presumably as premiums receivable, because a managed care entity does not have a contractual right to those future premiums.

This approach will result in a material gross-up of the balance sheet, with one-years' worth of premium reflected as an unearned premium reserve with an offsetting unbilled premiums receivable. The balance of premiums receivable will decrease as customers are billed and remit payment over the course of the year. Additional guidance will need to be considered for the income statement recognition of the UEPR. We would like to offer our support to participate in this aspect of your project, or the joint project on Revenue Recognition.

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Onerous Contracts & Grouping of Contracts

The Boards have incorporated the notion of an "onerous contract test" into its developing projects on revenue recognition and insurance contracts. Specifically, relative to the joint project on Insurance Contracts, the Boards have tentatively decided that if the measurement of a performance obligation at any balance sheet date of a contract exceeds the amount of premium paid, the contract is "onerous" and any loss should be immediately recognized through income. We understand that the Boards are deliberating the appropriate unit of account for the onerous test, including whether it should be applied to individual contracts in a loss position. It is our view that, while such a model may be appropriate for certain revenue-generating contractual arrangements, contract-by-contract application is not appropriate for insurance contracts.

There are several factors that distinguish insurance contracts from other revenue-generating contracts and insurance companies from other global enterprises:

- 1. Insurance contracts are highly regulated. In the United States, in many cases, insurers, and especially health insurers, are *required* to provide coverage to clients at rates that are subject to regulatory constraints (as is the case with small group or individual health insurance rating regulations). As a result, the existence of individual onerous contracts is unavoidable. This fact pattern may not exist in other industries.
- 2. An insurer's business model differs significantly from that of other industries. An insurer's business model is rooted in risk and the statistical phenomenon "law of large numbers." The underlying premise is that if a large number of similar persons are exposed to the same risk, a predictable number of losses will occur during a given time. An insurer underwrites and prices business based on this rule (considering the demographics and other relevant factors relative to a prospective client), and views and manages their collection of contracts using this theory. When considering the mix of an insurer's portfolio (which could span thousands of contracts with specific clients consisting of groups or individuals), at any given point a number of contracts could be identified as being onerous (the clients' expected future claim costs exceed premium that the insurer is able to charge under regulatory restrictions). However, in general, an insurer's portfolio as a whole will not be onerous; by pooling experience across the portfolio, an insurer is able to generate sufficient profits from the majority of its clients that exceed the losses generated by a minority of unavoidable onerous contracts. This pooling is intrinsic to the nature of insurance, the actuarial determination of insurance liabilities, and intrinsic to the rate regulation that jurisdictions in the United States have adopted in the small employer health market to expand the availability of affordable coverage.

We disagree with an accounting model that would effectively require an insurer to accelerate the recognition of expected future losses associated with a portion of its insurance contracts that are expected to be onerous, without being able to measure those losses with expected future gains associated with the remainder of like insurance contracts. This would result in financial statements that reflect the economics of the business model underlying the entity.

For purposes of determining whether insurance business is premium deficient, current U.S. GAAP requires contracts to be aggregated consistent with an insurer's "manner of acquiring, servicing and measuring the profitability of its insurance contracts." We believe that requiring companies to set the unit of account by aggregating contracts in this manner for the onerous contract test is the *most* relevant model to apply to insurance contracts.

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Unbundling

The IASB staff has recommended that a) an insurer should unbundle an insurance contract if its components are not interdependent; and b) the exposure draft should not state whether unbundling is prohibited or permitted in other cases. We further understand that requiring a contract to be unbundled into insurance and service components may also require separate accounting standards to be applied to each component of that single contract. We disagree with this unbundling approach. In our view, insurance and service components of a single contract are not separable, and requiring the accounting model to attempt to do so adds undue complexity to the production and presentation of financial statements without providing a perceivable benefit to the users of those financial statements.

First, the suggestion to measure and present components of an integrated contract separately is inconsistent with a health insurer's business model. Two common forms of contracts sold by health insurance entities are fully-insured contracts and administrative services only ("ASO") contracts. In both situations, the policyholder receives value from negotiated, discounted charges for medical services; disease management; claims adjudication; subrogation with third parties; and other products or services. One might argue that, given the presence of the ASO market, a fully-insured contract has separable, not interdependent components. However, separating a fully-insured contract into service and insurance components is inappropriate for several reasons:

- the insurance and service elements are priced as integrated components of health insurance contracts.
- the insurance component cannot be purchased in absence of the service component, and
- the service component of the contract itself is often subject to variability due to the performance of a related insured risk (i.e. some medical provider contracting agreements are subject to experience results; some drug expense reimbursement agreements may pay rebates or volume discounts, etc.).

As a result, we do not believe it is meaningful or practical to separate insurance and service components of an integrated contract that are priced and delivered together over a policy period. An insurer's obligation to administer the contract is parcel with the obligation to cover the related risk. When management gauges the profitability and performance of its business it does not distinguish theoretical elements (insurance and service components) of an insurance contract. Such metrics are neither required by nor provided to management, insurance industry regulators, investors or any other stakeholders. Similarly, from a client perspective these elements are not independently priced, negotiated or provided to clients. When dealing with a standard insurance contract, both management's view and the client's view of the contract is as one integrated arrangement. We believe accounting and reporting requirements should reflect the business model in this respect.

Second, it is our view that any attempt to quantify these components of the contract would be arbitrary at best, and would create the perception that carriers can quantify these elements with a degree of precision that is not feasible. We believe such a requirement would produce significant implementation and audit challenges, would likely result in inconsistent reporting across insurers, and would be an unreliable basis for users of the financial statements to assess financial performance.

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Thank you for your attention to our concerns. We hope that these perspectives are of value to the deliberation processes and we hope to have the opportunity to discuss these matters with you in greater detail in the near term. If we can provide further information or clarification of our comments, please call any of the signatories listed below.

Sincerely,

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cc. Randi Reichel, AHIP

Enclosure: Attachment A - AHIP Letter dated May 8, 2009