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Hans van der Veen International Accounting Standards Board 30 Cannon Street London, EC4M 6XH United Kingdom Via email: hvanderveen@iasb.org

Re: Insurance Contracts Project – Perspectives from US Health Insurance Industry

Dear Mr. van der Veen:

We write today on behalf of America's Health Insurance Plans ("AHIP"), an association representing nearly 1,300 US-based companies providing health, long-term care, dental, disability and supplemental coverage to more than 200 million Americans. We appreciate this opportunity to provide input to the International Accounting Standards Board ("IASB") relative to certain issues relating to the IASB's ongoing Insurance Contracts project.

In reading through the April 2009 Staff Papers on the Insurance Contracts project, we identified four key issues currently under discussion where we felt that the perspectives offered by the US health insurance industry would be useful to the IASB and might differ from the perspectives offered by other constituents who have historically been more active in providing input to the IASB on this project. As you know, the US health insurance industry is a very large sector, with annual premiums measuring in the hundreds of billions of US\$, but whose products do not always cleanly fit into the "life" versus "non-life" bifurcation that has driven much of the dialogue around the Insurance Contracts project. Consequently, we believe it is important for AHIP to proactively offer comments to the IASB in areas where US health insurance contracts present novel examples or challenges.

The four issues that we address in this letter are as follows:

- 1. The question posed in paragraph 33a of April 2009 Staff Paper 5D ("Paper 5D"), namely does the insurer of a group health plan have a single contract with the employer or separate contracts with each employee.
- 2. Defining the boundaries of the contract for purposes of determining which cash flows are included in the measurement of the liability, as discussed in Paper 5D.
- 3. The level of aggregation at which an onerous contract test should be applied
- 4. The potential use of candidate 5, unearned premium reserve, as a proxy for the pre-claims liability for "short-duration non-life" contracts

1st Issue – Nature of Contracts for Group Health Plans

Paragraph 33a of Paper 5D poses the following question related to group health plans: Does the insurer have a single contract with the employer or a separate contract with each employee?

There are a variety of reasons why AHIP believes that, in general, the appropriate answer to this question from an accounting standpoint is that the insurer has a single contract with the employer:

- Generally speaking, the insurer decides whether or not to underwrite a group health plan on an "all or nothing" basis. The insurer's ability to decline to cover a particular employee, or to modify the terms of the coverage offered to a particular employee, is frequently prohibited by insurance regulation. The intent of the group health plan, after all, is to pool different risks (i.e., different employees) together and regard them as being a cohesive unit for purposes of negotiating terms of coverage with the insurer.
- An individual employee's ability to keep the health insurance coverage in force with the insurer is typically dependent on some combination of factors outside the individual's direct control, such as the employer's willingness to keep offering health benefits to employees, and/or the employer's willingness to keep coverage in force with that insurer, and/or the employer's willingness to continue employing the individual. As such, the individual employee typically will have significant constraints on the ability to maintain coverage at one's own discretion, relative to what would occur with a true individual insurance contract.
- In most cases, the insurer establishes a composite premium rate for the group health plan on a peremployee-per-month (PEPM) basis, based on an annual snapshot of the demographic characteristics of the group's members. That composite premium rate applies equally to all employees and remains in effect throughout a 12-month period. As such, when a new employee joins the group health plan in mid-year, that employee's marginal contribution to the premium received by the insurer is based not on the specific demographic characteristics of the new employee, but instead on the composite PEPM rate, which reflects aggregate demographic characteristics of the group's employees at the point in time when the composite rate for that 12-month period was set. Hence, the premium received by the insurer for a newly added employee may differ materially from the premium the insurer would charge based on the employee's own demographic characteristics.

In short, the migration of employees into or out of a group health plan does not really lead to re-underwriting or re-pricing of individual risks, in the sense discussed in Paper 5D. Instead, pricing and underwriting is typically performed with the group rather than the employee as the relevant unit, and consequently it is the group as opposed to the employee that should be viewed for accounting purposes as the entity with whom the insurer has a contractual relationship.

Similar considerations exist with certain types of health insurance contracts where an insurer contracts with a US governmental agency to provide health benefits on a voluntary basis to a prescribed population of individuals, e.g., Medicare risk, Medicare prescription drug, or Medicaid risk contracts. In many important respects, these contracts resemble a group health plan:

- Pricing and benefit design is typically established on an annual basis via negotiation between the
 insurer and the sponsoring governmental agency. Once the agency has authorized the terms of the
 arrangement for the coming year, the insurer markets the coverage to eligible individuals but does
 not perform any underwriting of applicants.
- Commonly, most (or even all) of the premium received by the insurer is funded directly by the sponsoring agency rather than by the individual covered by the insurance.

• Should the sponsoring agency decide not to renew its contract with the insurer, an individual currently covered by that insurer has no independent ability to maintain its current coverage with that insurer.

Due to these characteristics, AHIP believes that under these types of government programs the insurer should be viewed as having a single contract with the sponsoring agency, rather than having individual contracts with each enrollee.

2nd Issue – Boundaries of the Contract for Health Insurance

In a typical US health insurance contract, premiums are paid by the policyholder to the insurer on a monthly basis, and the premium rates remain in effect for a 12-month period, which we will refer to hereafter as the "current policy year". One of the central issues in the Insurance Contracts project, viewed in this context, is determining under what circumstances potential future premiums from periods after the current policy year are to be considered in the calculation of the pre-claims liability; in short, determining whether or not the existing contract should be viewed for accounting purposes as extending beyond the end of the current policy year.¹

In order to help illustrate the issues that arise in applying to US health insurance contracts some of the concepts that have been articulated surrounding the contract boundaries issue, we focus our attention herein on three sample fact patterns that are intended to be broadly representative of common situations in the US health insurance industry. We refer to these three examples as: Unregulated Group; Individual; and Regulated Group. These three fact patterns are not intended to be exhaustive, but we believe they do paint a reasonable picture of the most common practices that exist today in the US health insurance market.

Unregulated Group

This example is intended to be representative of health insurance products sold to employers that are large enough to be exempt from US state insurance regulations that pertain to "small employers". Typically, this would represent products sold to employers with more than 50 employees.

We define the Unregulated Group example as having the following characteristics:

- At the end of the current policy year, the insurer is under no obligation to offer to renew the health insurance contract.
- If the insurer does elect to offer a renewal, the insurer faces no regulatory constraints as to what premium it is allowed to charge the group.
- The insurer's determination of the renewal premium is typically based in part or in whole on the specific claims experience of the group.
- Once the insurer offers a renewal premium, there will frequently be negotiation between the
 employer and the insurer, resulting in a different premium rate than what the insurer originally
 proposed.

¹ In many cases, the insurer is contractually obligated to keep premiums at their current level until the end of the current policy year. In other cases, the insurer may have a contractual right to change premiums at any time during the current policy year, but the insurer's normal business practice is to keep premiums fixed for a 12-month period, and deviating from that practice, although legal, would be extremely rare and could have negative consequences to the insurer's reputation and future marketing prospects. One might argue that if the insurer has the contractual ability to change the premium at any time, then the boundary of the contract could be construed to be the end of the current month. However, if an insurer has an established pattern of not making premium adjustments prior to the end of the current policy year even in situations where the insurer has the contractual right to do so, then we believe that for accounting purposes it is appropriate to view the contract as extending at least through the end of the current policy year, and perhaps beyond for reasons discussed later in this section of the letter.

This Unregulated Group example is relatively clear, in that the boundary of the contract should not be viewed as extending beyond the current policy year. The employer has no form of guaranteed insurability right, since the insurer can freely decline to renew the policy and can freely re-underwrite at renewal. If the contract is "renewed" for another year, that renewal is the product of a true bilateral negotiation, and thus may be appropriately viewed for accounting purposes as a new contract rather than a continuation of an existing contract.

Nevertheless, there are some minor variations of the Unregulated Group fact pattern that are less clear:

- Premium guarantee. In some cases, the insurer may voluntarily offer the employer a premium rate that is valid for a period longer than 12 months, e.g., a 24-month premium guarantee. It is very important to remember that claim costs under US health insurance policies are frequently subject to material inflation.² As such, if an insurer guarantees a premium rate for a 24-month period, it is almost certainly the case that some portion of the premiums received in the first 12 months is intended to pre-fund the payment of claims in the second 12 months. Consequently, it would seem appropriate for the insurer to accumulate a pre-claims liability during the first 12 months and release it over the second 12 months. If the applicable accounting guidance were interpreted to prevent the insurer from setting up such a pre-claims liability, then the insurer's expected gains from this contract would be front-loaded into the first 12 months, rather than spread more evenly over the full 24 months.
- Premium increase cap guarantee. More common than the above example is the situation where an insurer offers a premium rate that is valid for only 12 months, together with a guarantee that the insurer will offer to renew the contract at the end of those 12 months and at a premium rate that will be no more than X% greater than the current premium rate. In other words, the insurer offers the employer a guarantee capping the premium increase applicable at the next negotiation period. Here, the guarantee may or may not have any material value at the time it is made, and the value of that guarantee may evolve throughout the current policy year. For example, if the employer's claims experience deteriorates, or if medical inflation exceeds the insurer's original expectation, a guarantee that was perceived by the insurer to have materially no value when originally made could end up being very valuable to the employer. It may be appropriate accounting for the insurer to establish a pre-claims liability corresponding to the estimated value of the premium increase cap guarantee, even though it is not certain that the employer will exercise the guarantee by accepting the offered renewal.

Individual

This example is intended to be representative of health insurance products sold directly to individuals, rather than sold to employers.

We define the Individual example as having the following characteristics:

- When an individual applies for coverage, the insurer is not obligated to offer a policy to that individual, but instead subjects the individual to underwriting. Once the individual has "passed underwriting" and the insurer makes the initial decision to offer insurance to that individual, the insurer no longer has the right to unilaterally cancel the policy.
- While the policyholder possesses a right to maintain coverage for a very long time period, possibly decades, the claim costs under that coverage are subject to a type of inflation that is very difficult to predict over long periods of time. Consequently, premium rates are not guaranteed, but instead are subject to change every 12 months.

² For a variety of reasons that we need not go into here, the rate of inflation for claim costs under US health insurance policies has historically been, and may well continue to be, materially in excess of general inflation.

- The annual premium increase that an insurer offers to an individual is based not on that individual's own claims experience, nor on an updated assessment of that individual's risk characteristics, but rather on the aggregate experience of some cohort of the insurer's individual health insurance business (e.g., all policies originally issued in a particular year). Furthermore, the premium increase is typically subject to some form of regulatory oversight.
- In addition, the premium increase offered to an individual may or may not, depending on the insurer's own practice, take into account the following factors:
 - O Age. Typically, expected claims costs increase with the policyholder's age. Most policies are written on an "attained-age rated" basis, meaning that the premium rate applicable in any given year reflects the individual's age in that year. This implies that premium increases may include a component for the change in expected claim costs due to the aging of the individual. However, some policies are instead written on an "issue-age rated" basis, meaning that the premium rate applicable in any given year reflects the individual's age in the year when the individual first obtained the policy. This implies that the initial premium rates are higher than they would be for an attained-age rated policy, since the insurer is precluded from including in later years' premium increases a component for the change in expected claim costs due to aging.
 - Duration. Expected claim costs for individual health policies have been observed to vary based on policy duration (the number of years the policy has been in force). All else being equal, a population of individual policyholders whose policies were issued this year will have more favorable claims experience than a population of individual policyholders whose policies were issued five years ago. This phenomenon reflects the fact that underwriting occurs only once, before policy issuance. Some portion of the individuals whose policies were issued five years ago have subsequently contracted chronic medical conditions that would make it impossible for them to pass underwriting today; these individuals will naturally have higher expected claim costs than recently-underwritten individuals.

Some insurers include in their annual premium increases a component reflecting the expected increase in claim costs due to the change in the individual's policy duration (e.g., from year one to year two), in addition to components reflecting medical inflation and/or the change in age. This practice is colloquially known as "durational rating". Other insurers do not durationally rate. For these insurers, the premiums collected from first-year policyholders are greater than what the insurer estimates is required to cover claims incurred in that year, plus expenses and desired profit. Instead, some portion of the premiums collected in the first policy duration is intended to fund claims incurred in later policy durations, for those policyholders who persist. This pre-funding is necessary in light of the insurer's decision to not include a component for change in duration in the annual premium increase calculation.

• Once the insurer has offered a premium increase to an individual, the individual has no ability to negotiate with the insurer regarding the increase. However, in an effort to ameliorate the level of premium increase, the individual may be allowed to modify the benefits of the policy in a way that reduces the policy's cost (e.g., increasing the annual deductible), without having to go through underwriting. This type of benefit change is generally viewed as a continuation of the original policy, due to the fact that no additional underwriting is involved.

Alternatively, the individual may be able to receive a lower premium rate by submitting a new application and passing underwriting. This, by contrast, is generally viewed as a replacement of the existing contract with a new contract, since underwriting is involved.

In the Individual example, the policyholder possesses a guaranteed insurability right. That right may be somewhat weaker than it is in the case of a whole life policy, wherein future premium rates are fully guaranteed. Nevertheless, the guaranteed insurability right may have value, not only when evaluated at the level of an individual policyholder, but more importantly when evaluated at the level of the insurer's entire book of individual health insurance business. Failure to recognize the value of the insurer's aggregate obligation to its policyholders could lead to financial statements that do not accurately portray the economics of the insurer's business.

For instance, consider the following cases:

- 1. Suppose that the insurer's Individual policies are issue-age rated. Taken as a whole, the insurer's Individual policyholders possess a valuable right, namely the right to pay future premiums based on the age at which they entered into the contract, rather than future premiums based on their current age (as they would need to pay if they re-entered the insurance market today). It is appropriate for the insurer to record a pre-claims liability in connection with the value of that obligation. If the insurer's Individual contracts were deemed for accounting purposes to end when the current policy year ends, then the insurer would not recognize a pre-claims liability for this purpose, and consequently the insurer's income and net worth could become distorted.
- 2. Suppose that the insurer does not employ durational rating with its Individual policies. Taken as a whole, the insurer's Individual policyholders again possess a valuable right, namely the right to pay future premiums that do not reflect the worsening in expected claims experience caused by the passage of time since underwriting occurred. Failure to allow the insurer to recognize a pre-claims liability for the value of this obligation could again, as in the previous case, lead to distortions in the insurer's income and net worth.
- 3. Finally, suppose that the insurer offers attained-age rated Individual policies and applies durational rating. In this case, taken as a whole, the premium rates established by the insurer for the current policy year are intended to be self-sufficient. Unlike in the previous two cases, there is no explicit cross-subsidization between policy years to reflect either age or duration. Consequently, in this case, when viewed at the level of the insurer's entire book of Individual business it may make no difference whether or not the Individual contracts are deemed for accounting purposes to end when the current policy year ends.³

Regulated Group

This example is intended to be representative of health insurance products sold to employers that fall under the scope of US state "small employer" rating regulations. Typically, this would represent products sold to employers with 50 or fewer employees.

We define the Regulated Group example as having the following characteristics:

- As long as certain eligibility conditions are met, the insurer must offer a health insurance contract to a group, and must offer to renew that contract.
- Premium rates offered to a group are allowed to reflect the demographic characteristics (e.g., age and/or gender) of the individuals within that group. After that, the insurer's ability to adjust the group's premium rates to reflect the claims experience of the group and/or the risk characteristics (as opposed to demographic characteristics) of individuals within that group is limited by state

³ However, an exception to this would occur if there were regulatory restrictions preventing the insurer from obtaining the level of future rate increases that the entire block of business requires, i.e., if the entire block of business had effectively become onerous due to regulatory rating restrictions. In such a case, an accounting determination that the contract ends when the current policy year ends would allow the insurer to avoid recognizing a liability emanating from its inability to receive the level of future rate increases that it needs for its entire Individual block to avoid future losses.

- regulation. A typical regulatory formulation is that the premiums charged to two demographically identical groups cannot vary by more than a certain percentage, e.g., 25%.
- As such, the premium increase offered to a group can be viewed as having a component that reflects
 the expected increase in claim costs across the insurer's aggregate book of Regulated Group business,
 plus a group-specific component. However, in light of the regulatory restrictions discussed above,
 the resulting premium for any one group may not be commensurate with the insurer's expectations
 as to that group's future claim costs.
- Once the insurer has offered a premium increase to a group, unlike in the Unregulated Group case here the group typically has no ability to negotiate with the insurer regarding the increase. However, as in the Individual case, in an effort to ameliorate the level of premium increase the group may be allowed to modify the benefits of the policy in a way that reduces the policy's cost (e.g., increasing the annual deductible).

This Regulated Group example is distinct from either the Unregulated Group example or the Individual example, and it resembles the situation of the Australian health insurance industry, which was alluded to in paragraph 33b of Paper 5D. Technically, the group has a guaranteed insurability right, since the insurer is obligated to renew the contract and cannot in all circumstances do so at rates reflecting the group's own expected claims, in light of regulatory restrictions. However, viewed across the insurer's book of Regulated Group business, the value of the insurer's aggregate guaranteed insurability obligation may be zero, unlike in the two cases discussed previously for Individual policies. This is because the insurer establishes premium rates for its Regulated Group policies by looking at the aggregate experience of its entire book of business. with the rates charged to some groups implicitly subsidizing the rates for those other groups that merit premium rates higher than what regulation will permit, and with no form of intentional cross-subsidization across policy years. Moreover, from the policyholder's perspective, the real value of the group's guaranteed insurability right may be minimal, since by regulation the group has a portability right that typically does not exist in the Individual market; that is, the group could obtain coverage from another insurer at premium rates that are protected by regulation and hence may not be too different from the current insurer's rates. As such, although on some level the insurer has a multi-year obligation to its Regulated Group customers, it may make sense in most circumstances to account for these contracts as if they were single-year obligations, as has generally been the historical practice.

Conclusion

We hope that these examples have successfully illustrated the diversity of situations that exist within the US health insurance market relative to the issue of defining the boundaries of the contract.

The main conclusion we draw from these examples is this: 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, or else the financial statements will not accurately reflect the economics of the insurer's business. 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, absent considerations regarding onerous contracts (but see our 3rd Issue below), for the pre-claims liability to take into account cash flows for periods after the current policy year. Put more succinctly: The accounting should follow the insurer's pricing structure. AHIP believes that the Exposure Draft emanating from the Insurance Contracts project should be consistent with these principles.

3rd Issue – Level of Aggregation for Onerous Contracts

Paragraph 11b of Paper 5D states that "it also seems uncontroversial to include in the measurement of the liability recurring premiums from contracts that have become onerous as part of the contract." Actually, we do have some concerns about this statement, in the context of highly regulated insurance markets.

We return to our example above of the Regulated Group US health insurance market. An insurer's portfolio of Regulated Group business may consist of hundreds or thousands of specific groups, each of which has a guaranteed right to coverage at rates subject to regulatory constraints. At any given point in time, the insurer could point to a number of groups in that portfolio and identify those groups as being onerous, in that the group's expected future claim costs exceed the premiums that the insurer is able under regulatory restrictions to charge that group. However, the insurer's Regulated Group portfolio as a whole will in general not be onerous; by pooling experience across the portfolio, the insurer is able to generate profits off of the majority of its groups that exceed the losses generated by the minority of unavoidable onerous contracts. This type of pooling is intrinsic to the very nature of insurance, and intrinsic to the method of rate regulation that US jurisdictions have adopted in the small employer health market as a means of expanding availability of affordable coverage.

What concerns us is the potential for an accounting model under which the insurer would be obligated to hold liabilities to effectively accelerate the recognition of expected future losses associated with the minority of its Regulated Group customers that are known to be onerous, without being able to employ as an offset expected future gains associated with the majority of its Regulated Group customers that are expected to be profitable. The potential that the accounting model could drift towards this conclusion is underscored by progress in the joint IASB/FASB Revenue Recognition project, which seems to be assuming that an onerous contract test should be applied at the level of each individual contract.

Similar concerns exist with our example above of the Individual US health insurance market. Clearly in any block of Individual policies, there will be a number of specific policyholders whose contracts have become onerous, in that the insurer is obligated to continue offering coverage at premiums reflecting aggregate experience of a population even though the expected claims costs for certain of those policyholders exceed the associated premiums. However, once again the insurer's Individual portfolio as a whole need not be onerous.

In an insurance market in which prices are regulated and access is guaranteed, onerous contracts are inevitable. However, what should be relevant to the users of an insurer's financial statement is whether or not the insurer can reasonably expect, via its pricing strategy (as impacted by appropriate regulatory constraints), to offset future losses from those onerous contracts with future gains from other similar contracts. This principle underscores the current guidance in US GAAP regarding recognition of premium deficiency reserves, in which similar contracts are grouped. When it comes to liability recognition for onerous insurance contracts, moving away from an appropriate aggregation paradigm and towards the potential of a contract-by-contract test would, in our view, be a dramatic step backward in the utility and quality of financial reporting for insurance contracts.

4th Issue Unearned Premium as a Proxy for Short-Duration Contracts

We understand that a number of parties representing the property/casualty insurance industry have advocated the point of view that, for a non-life insurance contract that is deemed for accounting purposes to end when the current policy year ends ("short-duration contracts"), the unearned premium reserve may be an appropriate proxy for the Discussion Paper's concept of a pre-claims liability. We also understand that the IASB will shortly turn its attention to this issue and consider whether short-duration non-life contracts should be allowed, or even forced, to record an unearned premium reserve in lieu of a pre-claims liability that is based on the Discussion Paper's three building blocks. Our current view is that this proposal, as we understand it, would be inappropriate for short-duration US health insurance contracts. As such, we wanted to provide the IASB with insights on the differences, as we see them, between the unearned premium reserve concept and the pre-claims liability concept as applied to US health insurance contracts.

As noted earlier, under a typical US health insurance contract, a monthly premium rate is established for a 12-month period, and premiums are due on a monthly basis. For group health insurance contracts in particular, it is extremely common for the monthly premium payment to be due on the ½ day of the month. For such a contract, under the accounting practices currently ubiquitous in the US health industry, the health insurer's unearned premium reserve ("UEPR") at the end of any month will be zero: The premium due on the ½ day of that month is earned in full by the end of month, leaving no UEPR. However, the expected claims over the 12-month contract period may vary significantly by month. This may occur for a number of reasons, including but not limited to the benefit design of the insurance product (e.g., the impact of deductibles and other cost-sharing features), and the impact of medical cost inflation.

So, under current financial reporting, the health insurer's reported revenue for a contract is level by month, even though the insurer expects in advance that its claim costs for that contract will vary by month. This mismatch between revenue and claims can cause confusion among users, particularly with respect to understanding the relationship between year-to-date results and expected full-year results.

As an example, suppose that the insurer issues three types of policies⁵ on January 1, having expected claim costs by month as shown in Table 1:

Table 1
Expected Claims by Month

Expected Claims by Month				
	A	В	C	
Jan	95	70	125	
Feb	96	80	105	
Mar	97	85	110	
Apr	98	90	106	
May	99	95	102	
Jun	100	100	99	
Jul	100	102	97	
Aug	101	105	94	
Sep	102	109	92	
Oct	103	114	90	
Nov	104	120	90	
Dec	105	130	90	
Total	1200	1200	1200	
1 Otal	1200	1200	1200	

Suppose further that the insurer's expected administrative expenses for each policy type are 20 per month, and that the insurer charges 125 per month in premium for each policy type. As such, for each policy type, over the course of the year the insurer collects 1500 in premium, incurs 1200 in claims and 240 in expenses, and hence makes a profit of 60, or 4% of premium.

However, the progression of the insurer's expected year-to-date cumulative profit under current financial reporting would vary dramatically across the three policy types, as shown in Table 2:

⁴ To the extent that a health insurer today reports a UEPR on its financial statement, that UEPR is typically coming from group and/or individual contracts that are due on a monthly basis but on a day other than the 1st of the month, and/or from individual contracts that are due on an other-than-monthly basis, e.g., quarterly. There are some health insurers today that have no policies of these types and hence report zero UEPR.

⁵ Policy A is intended to resemble a low-deductible health policy; Policy B is intended to resemble a high-deductible health policy; and Policy C is intended to resemble a Medicare Supplement policy. For simplicity, this example ignores expected variances by calendar month beyond those attributable to benefit design or medical inflation, e.g., variances in the utilization of healthcare services by calendar month.

Table 2
Expected YTD Gain by Month

	A	В	С
Jan	10	35	-20
Feb	19	60	-20
Mar	27	80	-25
Apr	34	95	-26
May	40	105	-23
Jun	45	110	-17
Jul	50	113	-9
Aug	54	113	2
Sep	57	109	15
Oct	59	100	30
Nov	60	85	45
Dec	60	60	60

This result occurs due to the combination of two factors. First, the insurer earns each month's premium entirely within that month and thus holds zero UEPR at any month-end, as noted above. Second, current US GAAP is widely interpreted as prohibiting the insurer from recording a policy benefit reserve for a short-duration contract to reflect variations within the 12-month policy period in expected claims costs. Consequently, revenue is recognized ratably over the year even though claims are not, with no actuarial reserve to bring things into balance.

By contrast, the accounting model introduced in the IASB's Discussion Paper would allow a health insurer to record a pre-claims liability that reflects expected future cash flows, even for a short-duration policy. This would be a welcome change from current US GAAP, in that it would provide the potential for health insurers to report on a basis that largely tempers the month-to-month seasonality seen under current reporting. This would produce income statements that better reflect of the economics of the insurer's business, which is to provide insurance coverage priced on an annual basis rather than on a monthly basis. Note that in order for that potential to be fully realized, it would seem to be necessary for the Exposure Draft to permit recognition of a "negative pre-claims liability" for contracts such as Policy C above, where the nature of the coverage is such that expected claims are frontloaded into the policy year.

In conclusion, we believe there are many examples of short-duration US health insurance contracts for which under current reporting the unearned premium reserve is zero, but for which the theoretical pre-claims liability based on the three building blocks could be materially non-zero (and either positive or negative). As such, we feel that the unearned premium reserve concept, as we understand it, would not be a suitable proxy for the pre-claims liability for short-duration US health contracts.

Thank you for your attention. We hope that these perspectives have been of value to the IASB. Please do not hesitate to reach out if we can be of further assistance. You may reach the undersigned at reichel01@comcast.net or by telephone at (301) 774-2268.

Sincerely yours,

Randi Reichel Consultant, America's Health Insurance Plans

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