



August 24, 2006

LETTER OF COMMENT NO. 26



**BlueCross BlueShield
Association**

An Association of Independent
Blue Cross and Blue Shield Plans

Technical Director
Financial Accounting Standards Board
401 Merritt 7
P.O. Box 5116
Norwalk, CT 06856

Via electronic mail

Re: File Reference No. 1325-100

Dear Technical Director:

On behalf of the Blue Cross Blue Shield Association, whose 38 independent members provide health insurance benefits to nearly 95 million Americans, we welcome this opportunity to provide comments on the Financial Accounting Standards Board (FASB) Invitation to Comment (ITC), Bifurcation of Insurance and Reinsurance Contracts for Financial Reporting.

The ITC proposes to include group accident & health insurance policies with finite risk contracts in the definition of limited insurance risk contracts. As a result, the accounting for health insurance for both the insurer and purchaser would be to bifurcate a standard fully-insured policy into a deposit contract and a reduced insurance policy. The inclusion of fully-insured group health insurance policies with finite risk contracts is based on the premise that these contracts are not truly insurance because they have expected claims that are greater than zero. We strongly disagree with this premise and believe that these contracts do transfer significant risk.

Please note that we did not comment on all the issues outlined in the ITC. Because we disagree with the premise, we feel that the resulting technicalities of bifurcation are irrelevant.

Comments on Health Insurance Scenarios

Paragraph 19 of the ITC outlines three scenarios for an employer to purchase group health coverage for its employees as the following:

- Scenario (a): Self-funded coverage whereby the employer assumes full risk of health claims and must pay administrative fees separately;
- Scenario (b): Partial self-funded with aggregate stop loss coverage whereby employer assumes some claims risk and the administrative costs, but buys insurance coverage for risk of excessive claims; and
- Scenario (c): Fully-insured product whereby the employer pays a set rate per employee for all claims risk and administrative costs.

The ITC implies that scenarios (b) and (c) are really equivalent, but are accounted for differently. We do not believe they are equivalent nor do we believe employers purchase group health insurance to enhance or distort their financial statements. Paragraph 20 states that scenarios (b) and (c) could be structured to provide the company equivalent insurance protection. While they might be structured to appear to have the same *expected* insurance protection, they will always have different costs, especially for groups of 1 (self-employed) to 500 employees. If these scenarios were truly equivalent, the market would demand that the costs be equivalent as well.

For example, consider a group of 20 employees under scenario (b). While the expected claims cost might be equivalent to scenario (c), the act of splitting the claims risk between the employer and the insurer distorts the claims distribution function. With a small group, the law of large numbers, which is critical to the concept of insurance, will not apply. For the stop loss insurance segment, the likelihood that the actual claims will fall in a pre-determined range is so low that the premium would have to be quite high relative to the expected claims (known as the risk margin) in order for an insurer to assume that risk. However, if an insurer were to assume all the risk as in scenario (c), the risk margin would be lower because the total claims are more predictable than the excessive claims. The insurer will also pool the experience of this group with many others to increase the predictability. The total cost to the employer under scenario (b) (self-funded claims, administrative expenses, and stop loss premiums) has a high probability of being higher than the fully-insured premiums under scenario (c).

Current Health Insurance Marketplace

All three scenarios currently co-exist in the marketplace further demonstrating that they are not equivalent. They offer various levels of risks, services, and costs that meet the particular needs of buyers of insurance and their levels of risk aversion.

Self-funded, or self-insured, health insurance is only practical for groups with enough employees to allow for generally predictable claims costs, i.e. their own claims experience is credible enough as a basis for future expected claims costs. For fully credible experience, the minimum number of employees needed is about 500 to 1,000. However, the claims experience for a group with about 200 employees is considered reasonably credible. In a self-funded scenario, the employer assumes full risk for all claims, including catastrophic claims, and should expect both monthly and yearly fluctuations from the expected claims costs. The employer must also arrange for and pay costs associated with claims adjudication services, provider network access, and case management services. This is often obtained from a third-party administrator, which in many cases is not an insurance carrier.

Partial self-funded with aggregate stop loss insurance, or a minimum premium plan, is practical for groups with fewer employees than for self-funded, but still enough to allow for fairly predictable claims costs. The minimum number of employees needed is about 150 to 250. The employer assumes the risk for claims up to 120% - 130% of the expected claims costs and the insurer assumes the risk above that level. The employer should expect both monthly and yearly fluctuations. The employer must also arrange for claims adjudication services, provider network access, and case management services, but may be able to purchase these from the stop loss carrier.

Fully-insured health insurance is often the practical choice for groups with less than 200 employees as it provides benefits with no risk-limiting features, i.e. the insurer assumes all the risk. The total cost to the employer is known at the beginning of the policy year eliminating the risks and fluctuations. These policies also must meet state-mandated benefits and may have state-regulated rates. The insurer also provides claims adjudication services, provider network access, and case management services as part of the pre-determined premiums.

Larger employers may choose to fully insure their employees' health benefits as well. Advantages for larger groups are pre-set rates based on the credibility of the groups' claims experience and ease of administration including setting actuarial reserves. In addition, fully-insured products offer employers access to national provider networks, case managers, and disease management programs as risk mitigators for fraud, catastrophic claims, and excessive claims.

Practicality of Bifurcation

There is a practical aspect to applying bifurcation to a purchaser of a fully-insured group health insurance policy. Because rates are generally fixed for the contract year, there will be no amount receivable or payable to the insurer at the end of the contract period. Rates will remain fixed under a bifurcation scenario, therefore, any variation in expected claims and administrative expenses from actual must be fully offset by the amount recoverable/payable to the insurer. In fact, because such contracts may generally be cancelled at any time, there would be no month-to-month effect either. Any accounting for incurred but not reported claims would be offset by an insurance recoverable, net of which must be zero. The effort required for such accounting versus the reporting enhancements obtained would seem to fail any cost-benefit consideration that might be applied, especially for smaller companies.

In addition, because the benefit promised to employees is an insured benefit to the certificate holders, the employer does not have the liability for the claims incurred, nor does it have any right to the insurance recovery receivable. By paying the premium to provide the insured benefit promised, the employer has no further obligation. Any reflection otherwise in its financial statements would be misleading.

Specifically addressing Issue No. 5, we believe the last characteristic, "the contract is not likely to result in any claims," is not a valid requirement. The nature of particular insurance coverages may result in it being more likely than not that some claims will be paid. We do not believe that this changes the fundamental underlying substance that risk has been transferred from insured to insurer. In the case of a partially self-funded (minimum premium) plan with an aggregate stop loss insurance component, it may be more likely than not (greater than a 50% likelihood) there will be at least one claim over the one year contract term. Is this policy then to be further bifurcated?

Conclusion

We understand the FASB's concern regarding the use of limited risk contracts, or finite risk contracts, on financial statements. However, we believe that fully-insured group health insurance does transfer significant risk and the underlying claims component is inseparable under the contract. We do not believe that bifurcation improves the understandability or the decision usefulness of the financial statements, therefore we see no benefits to such a change, but costs would increase significantly.

We believe that fully-insured group health insurance is not purchased by employers to enhance or distort financial statements. In our view, group health insurance is purchased by employers as a cost-effective way to provide one of the most, if not the most, treasured of employee benefits thus enabling the employer to attract and retain quality employees in a competitive market.

Thank you for your consideration. If you have any questions or comments, I may be reached at 312.297.6093 or shari.westerfield@bcbsa.com.

Sincerely yours,



Shari Westerfield, FSA, MAAA
Actuary, Financial Regulatory Services