Technical Director – File Reference No. EITF100D
Financial Accounting Standards Board
401 Merritt 7
P.O. Box 5116
Norwalk, CT 06856-5116

Via email: director@fasb.org

Re: File Reference No. EITF100D

Dear Sir or Madam:

WellPoint, Inc. (“WellPoint”) is the largest health benefits company in terms of medical membership in the United States, serving over 33 million members as of June 30, 2010 and with total revenues of $65.0 billion for the year ended December 31, 2009. We appreciate the opportunity to comment on the Financial Accounting Standards Board (the “Board”) Proposed Accounting Standards Update, *Fees paid to the Federal Government by pharmaceutical manufacturers* (the “Proposed ASU”).

Summary

We commend the Board on its effort to clarify accounting for new fees and assessments originating from the provisions of the Patient Protection and Affordable Care Act (“PPACA”) and the Health Care and Education Reconciliation Act (“HCERA” and, together, the “Acts”). We generally concur with the Board’s conclusions in this Proposed ASU with respect to the recognition of these assessments. However, we do not fully understand the Board’s basis for limiting the scope of the Proposed ASU to apply only to pharmaceutical manufacturers. As discussed more fully below, many of the provisions of the fees assessed to pharmaceutical manufacturers are identical to the provisions of the fees assessed against health insurers. Without broadening the scope of the Proposed ASU, different accounting could occur for almost identical fees between two different industries. Accordingly, we request that the scope be broadened to also encompass fees assessed to health insurers.

In addition, the Proposed ASU states that pharmaceutical manufacturers should recognize the fee “…over the calendar year the fee is payable using a straight-line method of allocation.” Besides specifying the appropriate allocation method, we believe the Board’s intention with this statement was to also clarify that the fee should be recognized in the calendar year it is due (i.e., 2011 for pharmaceutical manufacturers) rather than in
the year the sales occur (i.e., 2010 for pharmaceutical manufacturers) that are used to measure the liability. We agree with this timing of recognition; however, when the Board expands the scope of the Proposed ASU to also include health insurers (per the request of WellPoint and other insurers in our industry), we suggest the Board add language to more clearly specify this timing for recognition in light of the somewhat conflicting guidance in FASB Accounting Standards Codification Subtopic 405-30, Insurance-Related Assessments (“ASC 405-30”), which is related to guaranty fund and other similar assessments.

We are providing the below comments and responses to your questions in the Proposed ASU for your consideration:

Comments

Question 1: Do you agree that the scope of this proposed Update should be limited to the fees to be paid by pharmaceutical manufacturers or should it also include other fees required by the Acts that have similar characteristics as the pharmaceutical fees (for example, fees to be paid by health insurers)?

The Acts provided for various types of fees to be assessed to fund a portion of the costs associated with these new laws. Both the fees for pharmaceutical manufacturers and the fees for health insurers have similar provisions in terms of calculating the amount and determining the entities subject to the fees (see Appendix A for a comparison of the fees assessed to pharmaceutical manufacturers and health insurers). Accordingly, both groups have similar questions around the timing of recognition and reporting of the fees. The Board stated in the Basis for Conclusion section in paragraph BC2 that the guidance should not be analogized to other government-fee-based arrangements. While we agree that this guidance may not be appropriate for all other government assessments, we believe that the assessments under the Acts to pharmaceutical manufacturers and health insurers are similar enough to warrant extending the scope to health insurers. If the scope were not expanded to include health insurers, we believe it would be confusing to an investor looking at the financial statements of a pharmaceutical manufacturer and a health insurer to see different timing and methodology of recognizing the same type of assessment.

Question 2: The amendments in this proposed Update require that upon recognition of the liability, the fee should be recognized over the calendar year the fee is payable using a straight-line method of allocation unless another method better allocates the fee over the calendar year the fee is payable. Do you agree with this conclusion? If not, how do you think the fee should be recognized and why?

We would like to address this question by discussing both the timing of recognition and the method of allocation of the cost over the period in which it is recognized.
Timing of recognition

The provisions that require the fee for health insurers were first contained in section 9010 of the PPACA and required the payment of the fee in 2010 (later revised to 2014) based on a covered entity’s net written premiums and third-party administrative services fees (together “health revenues”) in the preceding year (i.e., 2009, which was later revised to 2013). This assessment was then amended in the HCERA bill to revise the definition of a covered entity as “…any entity which provides health insurance for any United States health risk during the calendar year in which the fee under this section is due.” We understand that this amendment was included in the HCERA based on initial concerns that the original definition of a covered entity could have been interpreted under the existing accounting rules to require accrual of the liability in the period the health revenues are recognized on which the calculation of the fee is based (i.e., in 2013 under the amended rules). However, it was the intent of members of the U.S. Congress for this assessment to be incurred in the year it is due and payable because it is a funding mechanism for the other provisions of the Acts. Nevertheless, we contend that the revised language does not fully address the accounting rules specific to health insurance and two opposing views might result from existing accounting guidance:

View A – The fee is a charge for doing business in 2014 and should be incurred in that year:

The fee was meant to be a charge for participating in the U.S. health insurance market in 2014 and the reference to 2013 health revenues was merely a methodology for determining the proper fee amount. Accordingly, a health insurer is not obligated to pay any fee in 2014 unless they have at least $1 of health revenues in 2014. Nevertheless, the amount of the fee would be determined by reference to their 2013 health revenues. This view is supported by the intent of the lawmakers drafting the provisions of the Acts that this fee was a charge for doing business in 2014. Furthermore, it corresponds with the definition of a liability contained in paragraphs 35 and 36 of Concepts Statement 6 (“CON 6”). Specifically, paragraph 36 (c) states that a liability has several essential characteristics, including that the transaction or other event obligating the entity has already happened.

In this analysis, proponents of View A would argue that no liability has been incurred until and unless an entity recognizes health revenues in 2014 as that would be the transaction that obligates the entity under paragraph 36 (c).

View B – An entity obligates itself in 2013 for writing certain health business in 2014 and the fee is incurred in 2013:

Health insurance business is highly regulated by the individual states and the laws in each state are very complex. However, the majority of the states provide for guaranteed renewability provisions for health insurance coverage for individuals, whereby a health insurer is precluded from withdrawing coverage for individuals after their annual health insurance coverage expires. In other words, the decision to continue coverage fully rests
with the insured and the insurer is merely able to adjust the premiums, generally subject to review or approval by the state regulator and only within certain parameters. Should the insurer determine that it no longer wants to participate in individual health insurance coverage in a certain state, it can completely withdraw from the market and certain transition rules apply. Similar guaranteed renewability provisions do not exist for large employer sponsored health insurance as this business is underwritten annually and the insurer is able to withdraw coverage completely for a particular employer group. As a result, depending on the type of coverage, a health insurer may or may not obligate itself when writing business in 2013 to renew this coverage in 2014.

Furthermore, proponents of View B would reference ASC 405-30 related to guaranty fund and other assessments, which states that “… premium-based administrative-type assessments are presumed probable when the premiums on which the assessments are expected to be based are written” and that “… for premium-based assessments, the event that obligates the entity is generally writing the premium or becoming obligated to write or renew the premiums on which the assessments are expected to be based.” For individual coverage, these provisions would generally be met in 2013, while for large group coverage, the provisions would be met in 2014. Opponents of View B would argue that, although rare, an entity would still be allowed to fully withdraw from writing individual health insurance coverage in a particular market and, as a result, the obligating event is the decision not to withdraw and continuing to offer individual coverage in 2014, which would result in recognition of the fee in 2014.

Timing of recognition – Conclusion

We believe the proper timing of recognition is best described by View A above. This conclusion is based on the premise that we believe the intention of Congress was for this fee to be a charge in 2014 to fund the other provisions of the Acts and that the reference to the prior year health revenues was merely a mechanism to allocate the fee among the various health insurers. This view is further supported by the belief that certain health insurers will potentially exit from certain markets at the end of 2013 as the cost of doing business in 2014 is too high if the assessable fee exceeds their profits. In such situations, it would not make sense to accrue a liability during 2013 as guaranteed renewable business is written, only to reverse it then at the end of 2013 when the decision is made to exit certain markets. We believe such accounting would be confusing to users of the financial statements.

We note that the Board appears to have come to the same conclusion as it states in Question 2 above that “upon recognition of the liability, the fee should be recognized over the calendar year the fee is payable...” which refers to 2014 for health insurers. However, we believe sufficient ambiguity currently exists in the accounting guidance as demonstrated by the differing views above to warrant the Board providing greater clarity on this issue when it finalizes the Proposed ASU.
Method of allocation

As discussed above, we believe that this fee is intended as a charge for doing business in 2014 to fund the other provisions of the Acts. As a result, an entity receives the same benefit (i.e., the right to participate in the U.S. health insurance market) each quarterly period in 2014. Accordingly, we concur with the proposal to recognize the fee evenly over the year using a straight-line method of allocation. We believe that this methodology is consistent with the existing guidance in FASB ASC section 270-10-45, which provides the applicable rules for allocation of costs for interim reporting periods.

Question 3: The amendments in this proposed Update require the fee to be classified as an operating expense in the income statements of [health insurers]. Do you agree with that conclusion? If not, how do you think the fee should be classified and why?

Health insurers are already subject to a number of similar fees and assessments from the various states. Such costs are currently classified as administrative type operating expenses rather than as a reduction of revenues. Accordingly, we agree that this classification is most appropriate for the health insurer assessments. However, as the fees assessed to other industries are similar but their facts and circumstances may be different, we believe that other presentation alternatives would be appropriate also with proper disclosure of the entity’s policy decision.

Question 4: Do you agree that no additional disclosures are necessary upon adoption or after the adoption of the amendments in this proposed Update? If not, please describe what disclosures should be required and why.

We agree that no additional disclosures are necessary.

Conclusion

We agree with the methodology of allocation, classification and disclosure provisions of the Proposed ASU. However, we believe that the scope of the final guidance should be expanded to also apply to health insurers as their assessed fees are similar to the fees assessed to the pharmaceutical manufacturers. In addition, once the Board includes health insurers in the scope of the final guidance, we believe it should also address the timing of recognition of the cost given that conflicting guidance currently exists. We believe that the costs should be recognized ratably over the year in which the fees are payable as different timing of recognition could be confusing for readers of the financial statements.

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We appreciate the opportunity to provide comments on the Proposed ASU and hope the Board will consider our comments. Should you have any questions or wish to discuss this letter with us, please feel free to contact me directly at 317/488-6684.

Very truly yours,

WellPoint, Inc.

[Signature]

Martin L. Miller
Senior Vice President, Controller,
Chief Accounting Officer and
Chief Risk Officer

Copy to: Angela F. Braly
Chair of the Board, President and
Chief Executive Officer

Wayne S. DeVeydt
Executive Vice President and
Chief Financial Officer
Appendix A

The following table presents a summary of certain key provisions of the fees assessed against pharmaceutical manufacturers and health insurers:

<table>
<thead>
<tr>
<th>Purpose of the fee</th>
<th>Pharmaceutical Manufacturer Fee</th>
<th>Health Insurer Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>To fund other provisions of the Acts</td>
<td>To fund other provisions of the Acts</td>
<td></td>
</tr>
<tr>
<td>Scope</td>
<td>Pharmaceutical manufacturers who sell branded prescription drugs to any government program specified in the bill</td>
<td>Health insurers who provide health insurance or administrative services for any United States health risk</td>
</tr>
<tr>
<td>Exclusions</td>
<td>Certain entities are excluded if their sales fall below a minimum threshold</td>
<td>Certain entities are excluded if their net written premiums or administrative services fees fall below a minimum threshold</td>
</tr>
<tr>
<td>Calculation basis</td>
<td>Liability only exists if entity sells branded prescription drugs to any government program in the year that the fee is payable (starting in 2011)</td>
<td>Liability only exists if entity provides health insurance in the year that the fee is payable (starting in 2014)</td>
</tr>
<tr>
<td>Calculation of liability</td>
<td>Ratio of entity’s eligible sales in prior year to total sales of all covered entities in prior year multiplied by a specified annual fee amount</td>
<td>Ratio of entity’s eligible health business in prior year to total health business of all covered entities in prior year multiplied by a specified annual fee amount</td>
</tr>
<tr>
<td>Payment date</td>
<td>Date specified by Secretary of the Treasury but no later than September 30 (starting in 2011)</td>
<td>Date specified by Secretary of the Treasury but no later than September 30 (starting in 2014)</td>
</tr>
<tr>
<td>Tax status of the fee</td>
<td>Not tax deductible</td>
<td>Not tax deductible</td>
</tr>
</tbody>
</table>