24 August 2006

Technical Director – File Reference No. 1325-100
Financial Accounting Standards Board
401 Merritt 7
P.O. Box 5116
Norwalk, CT 06856-5116

Re: File Reference No 1325-100
Invitation to Comment: Bifurcation of Insurance and Reinsurance Contracts for Financial Reporting

Dear Sir or Madam:

America’s Health Insurance Plans (“AHIP”) appreciates the opportunity to comment on Financial Accounting Series No. 1325-100, Invitation to Comment on Bifurcation of Insurance and Reinsurance Contracts for Financial Reporting (the Invitation). AHIP is the national trade association representing the private sector health insurance industry. AHIP’s nearly 1,300 member companies provide health, long-term care, dental, disability, and supplemental coverage to more than 200 million Americans.

Our overall comments on the concepts stated in the Invitation and our responses to the specific issues identified by the Invitation follow.

**Overall Comments**

While acknowledging recent high-profile financial statement restatements that were allegedly the result of misapplication of insurance and/or reinsurance accounting, we do not believe wholesale changes are warranted. Bifurcating insurance and reinsurance contracts, as discussed in the Invitation, would represent such a fundamental change to current accounting. Rather, we believe the FASB should focus its efforts on providing practical guidance for determining the appropriate degree of risk transfer that must be present for insurance accounting treatment.

With regard to purchasers and insurers of health insurance, implementation of a bifurcation approach would require significant changes to the current accounting systems. Furthermore, a change to the extent indicated by the Invitation would require new administrative processes for both insurers and the companies that sponsor insurance for their employees through group health contracts. These changes would likely be costly and burdensome, and do not necessarily address the problems identified recently with
accounting for "finite risk contracts". They may, however, add needlessly to the cost of health insurance.

The Invitation makes several statements distinguishing between individual insurance contracts and group insurance contracts that we believe are flawed. A majority of non-senior citizens receive their health coverage through employers that sponsor group health insurance contracts. The amount and timing of medical expenditures clearly are not known, or even predictable with measurable certainty, in advance. The primary purpose of group health insurance contracts is to transfer this uncertainty from the employees (or their benefit plan) to the insurer. Yet the bifurcation approach is based on the untenable assumption that these contracts represent something other than, or in addition to, insurance.

We believe the FASB should refocus its approach to identify contracts with deposit characteristics that are based on explicit or implicit guarantees in the contract and not the expected amount of insurance claim payments. We describe such deposit characteristics below in our responses to the specific issues (particularly Issue 6).

Overall, we do not support the bifurcation approach described by the Invitation. However, we applaud the FASB's approach to solicit input from all constituents before undertaking substantial changes in this field of accounting. Many of AHIP's members would like to offer assistance to the FASB and its staff as it continues to learn the dynamics of this complex field to develop solutions that will enhance the understandability and comparability of financial statements.

**Responses to Specific Issues**

**Issue 1:** Does the IFRS 4 definition of insurance contract identify insurance contracts and sufficiently distinguish those contracts from other financial contracts? Does the GAAP definition of insurance risk identify and separate that risk from other risks such as financial risk? Do the descriptions of finite insurance and reinsurance contracts, including the risk-limiting features, identify those contracts? How could the definitions and descriptions be improved?

**Response:**
The proposed definition of insurance contract fails to recognize that many contracts involve more than two parties. For example, in the group health insurance context, the key parties are the insurer, the employer or other plan sponsor (who has specific legal rights and obligations), and the employee/certificateholders (who are entitled to receive benefits under the policy). We also note that the phrase "compensate the policyholder" is incorrect in the group health context, as insurance payments are rarely made to the policyholder. Similarly, the phrase "adversely affects the policyholder" is incorrect, inasmuch as there are many group insurance situations where the "policyholder" – that is, the employer or other plan sponsor – is not adversely affected but the employee/certificateholder is.
We recommend a two part definition of insurance contract as follows:

An insurance contract is a legally enforceable agreement whereby one party, the insurer, assumes insurance risk. The party who contracts with the insurer may be referred to as the contractholder. The contract may also provide for third-party beneficiaries.

"Insurance risk" incorporates the following elements.

The risk arises from the occurrence of an event involving uncertainty that is not purely financial in nature, although typically the event will have financial consequences. Such events are dependent on contingencies such as mortality, morbidity, or risk of damage to property. Contingencies of a purely financial nature (such as changes in market interest rates or in the value of financial instruments) do not give rise to insurance risk. The uncertain event may affect the contractholder, or it may affect another party (a third-party beneficiary) in whose interest the contractholder is acting.

The insurer incurs a financial obligation upon the occurrence of the insured event, and that financial obligation is uncertain with respect to either its amount or the timing of its settlement. Uncertainty with respect to the amount of the obligation is dependent upon the financial severity of the insured event (i.e., the financial loss incurred by the contractholder or a third-party beneficiary). Uncertainty with respect to the timing of the settlement of the obligation is dependent upon the time at which the insurer is informed of the occurrence of the event and is able to determine the amount of the obligation. Neither the amount of the obligation nor the timing of settlement is wholly at the discretion of the insurer.

If the risk to the contractholder was assumed by it through its issuance of one or more insurance contracts, then the contract that transfers that risk is a reinsurance contract. The party that assumes the risk through the reinsurance contract is referred to as a reinsurer.

With regard to the contract terms and features listed in paragraph 36(b) as common elements of "finite risk" insurance/reinsurance, it should be noted that the same or similar features can be part of a "genuine" insurance arrangement. The key criterion is not the existence of a particular contract provision, but rather the likely effect of the provision on the financial results of the insurance or reinsurance. See our response to Issue 6, below.

**Issue 2:** Can the Statement 113 risk transfer guidance for reinsurance contracts be applied by corporate policyholders and insurers for determining whether an insurance contract transfers significant insurance risk? If not, how can the Statement 113 guidance be modified or clarified to apply to insurance contracts?
Response:
The principles that underlie the guidance in Statement 113 are sufficient principles for both insurance and reinsurance, if they are applied appropriately. The guidance cited in paragraph 37(a) of the Invitation requires “a significant variation in both the amount and timing of payments.” However, we believe the interpretation of Statement 113 given in paragraph 35 of this Invitation is more appropriate: “insurance risk requires a greater than remote possibility of a significant variation in either the amount or the timing of payments by the reinsurer.” Therefore, as already discussed in our response to Issue 1, the possibility of a significant variation in either the amount or the timing should be sufficient to indicate a true risk transfer.

The guidance cited in paragraph 37(b) of the Invitation requires the reasonable possibility of a significant loss by the reinsurer. One issue here is the interpretation of “reasonably possible.” We note, for example, that group disability insurance written on a one-year term basis clearly transfers risk; however, depending on the size and demographic composition of the underlying group, and the type of work in which they are engaged, the probability of a claim during the one-year term may be very small. The appropriate criterion is whether the possibility of a claim payment is reasonable in comparison to the probability of the event being insured. Another issue is the interpretation of “significant loss.” We note that a poorly priced contract may almost ensure a loss by the insurer or reinsurer, but it does not by virtue of that fact become any more effective at transferring risk than a contract that is priced to be profitable under ordinary circumstances. Again, the appropriate comparison is between the losses that arise under the event purportedly insured/reinsured, and the potential payments to be made by the insurer/reinsurer.

The above interpretations are consistent with the highly important concept stated in paragraph 37(c) of the Invitation: valid reinsurance exists if substantially all of the insurance risk of the ceded business is transferred to the reinsurer. If the insured event itself has only a remote possibility of occurring, there likewise will be only a remote possibility that the reinsurer (or insurer, for direct business) will make a payment under the contract; but if substantially all of the risk associated with the insured event is transferred, then the contract is legitimately insurance/reinsurance.

The recent focus for determining the transfer of significant insurance risk under reinsurance contracts appears to have been on the use, and alleged misuse, of a bright-line rule of thumb. This “bright line test” is inconsistent with the use of a principle-based approach to financial regulation. A principle-based approach seeks to identify deposit characteristics that do not transfer uncertainty and require separate accounting treatment only in those situations. See our response to Issue 6.

Issue 3: Does classifying an entire contract as insurance or bifurcating that contract into insurance and deposit components provide more understandable and decision-useful information? Which qualitative characteristics most influence your decision? Which approach more faithfully represents the economic substance of the contract? Why?
Health insurance contracts should not be bifurcated. The economic substance for the individuals covered must be recognized as insurance, inasmuch as there is no benefit other than the payment of claims in the vast majority of health insurance contracts. (Some contracts have “return of premium” riders that provide non-claim benefits under specified circumstances, but even then, the amounts and timing of the payments are uncertain at the time the contract is issued.) The manner in which the employer/policyholder participates in the transfer of risk from its employees and their dependents to the insurer should not vary the basis for financial reporting for the insurer. There is no “deposit” that the employer/policyholder is guaranteed to have returned. There may be experience-rating features, but those are currently addressed in FASB or EITF literature.

Therefore, bifurcation would not provide useful information. Instead, it would create complexity, require companies to develop artificial separations that are unlikely to be a valid representation of the economics of the transactions, would be less reliable, less understandable, and not comparable between companies. As a result, bifurcation might often produce misleading results.

**Issue 4:** The flowchart suggests a sequence for analyzing contracts that integrates current insurance accounting guidance with a hypothetical bifurcation analysis. Do you believe that the sequencing and integration are appropriate? What changes would you propose?

**Response:**
The above comments make clear that AHIP and its members see no value in any bifurcation of group health insurance contracts.

**Issue 5:** Do you agree with the characteristics identified for contracts that do or do not unequivocally transfer significant insurance risks? If not, why not? Should other characteristics be added? Are examples in Appendix B representative of the discussion in paragraphs 57-59?

**Response:**
The characteristics identified are not representative of health insurance contracts that transfer significant insurance risk. Nor are the examples in Appendix B consistent with those characteristics.

Paragraph 59 attempts to distinguish between individual insurance contracts and group insurance contracts on the grounds that “a portion of the premium for group and similar contracts compensates the insurer for the likely payment of expected claim losses.” That is equally true of individual insurance: by definition, the premium must compensate the insurer for expected claim losses. Also, even when the insured event has a low probability of occurrence, the expected losses (in the statistical sense of “expected,” which is the only meaningful sense in this financial context) will be greater than zero. Therefore, this attempted distinction is erroneous, and seems to reflect a serious
misunderstanding of the pricing of insurance products. Accordingly, it is inappropriate to
exclude group contracts from the contracts unequivocally transferring risk, as would be
required by subparagraphs (a) through (c) of paragraph 58.

The criteria stated in subparagraphs (d) through (f) are also inappropriate. Subparagraph
58(d) refers to “standard market terms,” but the meaning of that is unclear. For some
categories of unequivocal insurance, a wide array of options is available, differing from
company to company and within each company’s product portfolio. This is especially
true when, as in today’s environment, new products are being developed and the market
for these products is still immature. It is not clear what bearing the presence or absence
of “standard market terms” has on whether risk is being transferred, since many financial
contracts that are unequivocally non-insurance are subject to standard market terms.
Subparagraph 58(f) then requires that “the contract is not likely to result in any claims.”
This has the paradoxical effect of favoring a contract designed to make no payments at all
over one that is virtually certain to pay claims of uncertain amount and timing. Clearly
the latter contract transfers risk, and the former does not, yet subparagraph 58(f) would
reverse the logical treatment of the contracts.

Subparagraph 58(e) is more defensible but still too broad. The concern should not be
whether the contract has any risk-limiting features at all, but rather whether it has features
that essentially do not involve any risk. See our response to Issue 6.

As one example of some of the problems described above, we note that many seniors
recently purchased insurance policies that cover a portion of their out-patient prescription
drugs (Medicare Part D coverage). The government-imposed rules will generally
penalize individuals who delay the purchase of a Part D policy beyond a specific time.
Therefore, the “single personal insurance contract” may have been purchased not only to
cover a single risk, but also – perhaps primarily – to ensure a favorable price in the
future. In addition, those Medicare beneficiaries with existing prescription drug needs
can be certain that the contract will result in claims. Despite these facts, it is difficult to
argue that Medicare Part D contracts do not clearly transfer risk.

Also, while some of the Medicare Part D contracts may have deductibles and coverage
limits that are based on “standard market terms” (namely, the requirements specified in
federal law), the majority of actual coverage is provided through contracts where the
benefits, deductibles and coverage limits have been varied by the insurer subject to
government approval. Yet Appendix B would exempt this under the first “box” in the
table, which is inconsistent with paragraph 58(d).

In addition, for some larger employers, insurers may provide for experience rating
adjustments that adjust the profit or loss on the contract based on the claim loss
experience of the contract. If these contracts also provide that the policyholder may
terminate its contract without paying additional premiums for negative claim loss
experience, then the insurer has no loss limitations and such provisions should not be the
basis for excluding these contracts from insurance accounting.
**Issue 6:** Do you think that the characteristics described in paragraph 58 for unequivocal insurance contracts are an improvement over the exemption from cash flow testing in paragraph 11 of Statement 113?

**Response:**
No. The proposed characteristics are not a reliable basis for separating insurance and deposit-types of risks. Deposit characteristics exist when an arrangement explicitly or effectively substantially guarantees (not merely "makes likely") one of the following two outcomes:

1. The contractholder will reimburse the contract issuer to the extent that covered losses exceed the issuer’s premium less certain defined expenses. Thus, the issuer is indemnified against any net loss, so no risk is transferred.

2. The issuer will pay benefits whose amount and timing are both effectively fixed by the contract. Such arrangements do not incorporate the uncertainty required for insurance risk.

**Issue 7:** Do you prefer Approach A or Approach B for identifying contracts subject to bifurcation? Why? Do you believe another approach would be superior? If so, how would you describe that approach? Would your preferred approach be operational? Would it make financial statements more decision useful?

**Response:**
We suggest that an approach based on the identification of deposit characteristics as outlined in our response to Issue 6 is more accurate and appropriate than either Approach A or Approach B. However, if only these two options are available, then minor changes to Approach A focusing on deposit characteristics rather than the “required characteristics” would be better than either of the two approaches as presented.

**Issue 8:** Should the criteria for bifurcation be different for insurance contracts and reinsurance contracts? Why? If yes, what differences would you suggest?

**Response:**
We do not see a need for different criteria. Both types of contracts transfer and pool risk; their major distinction is the nature of the parties entering into the agreement, not the nature of the agreement itself.

**Issue 9:** Which of the methods identified in this Invitation to Comment for bifurcating insurance and reinsurance contracts do you believe has the most conceptual merit? Please explain. Please describe any additional bifurcation methods that you believe should be considered. Would corporate policyholders encounter unique implementation problems in applying any of the methods discussed in this Invitation to Comment?

**Response:**
None of the methods proposed could be effectively implemented in a consistent manner across all corporations acting as group health insurance policyholders. If, however, the focus is shifted to accurately identifying deposit characteristics as suggested above, the particular aspects of a contract with significant deposit characteristics are likely to be best understood through a cash flow analysis (akin to the present requirement).

**Issue 10:** Would data availability limit the development of any of the bifurcation methods discussed in this Invitation to Comment? To what extent are the methods that would form the basis for these methods used to underwrite and price products? Would data availability (or lack thereof) affect only certain insurance forms, products, or lines of business? If so, which ones and why?

**Response:**
The statement in paragraph 59 that “a portion of the premium for group and similar contracts compensates the insurer for the likely payment of expected claim losses” is not consistent with methods used to underwrite or price products. As noted, most group contracts are pooled by insurers to establish risk classes. Actual losses to some groups will be above their premiums while other groups will have losses substantially below the average per life for all groups in the pool. There is no “likely payment” that could be used for any of the bifurcation methods if applied to all group health products.

**Issue 11:** In view of the IASB’s project on insurance contracts, should the FASB be considering bifurcation of insurance contracts based on transfer of insurance risk?

**Response:**
No. Any further work on this subject should focus on identification of deposit characteristics rather than doing further analysis along the lines described in the *Invitation*.

* * * *

The responses above are directly related to the issues that have been presented for comment. We have not provided comments on other aspects of the *Invitation*. Should FASB decide to pursue the concept of bifurcation of health insurance contracts, we will provide further comments. However, we strongly urge that FASB focus on identifying the specific characteristics of deposit-type contracts in order to address the problem this project is intended to solve.

Thank you.

Sincerely,

William C. Weller
Consultant to AHIP