



AMERICAN ACADEMY of ACTUARIES

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Technical Director – File Reference No. 1325-100
Financial Accounting Standards Board
401 Merritt 7
PO Box 5116
Norwalk, Connecticut 06856-5116
Via email to: director@fasb.org, File Reference No. 1325-100



LETTER OF COMMENT NO. 49B

RE: Invitation to Comment, “Bifurcation of Insurance and Reinsurance Contracts for Financial Reporting”

Dear Sir or Madam:

The Health Practice Financial Reporting Committee of the American Academy of Actuaries¹ (Academy) is pleased to provide comments to the Financial Accounting Standards Board (FASB) regarding its recent Invitation to Comment (ITC), “Bifurcation of Insurance and Reinsurance Contracts for Financial Reporting.”

Please note that these comments focus solely on areas relating to accident & health insurance. Our counterparts within the Academy will be providing FASB separate comments on issues arising within other insurance lines. Furthermore, our comments target only those specific issues delineated within the ITC to which we feel our professional expertise is relevant.

Observations on Paragraphs 19-21

In paragraphs 19 through 21, the ITC considers the example of a non-insurance company providing a health plan for its employees and discusses the potential consequences of applying bifurcation to this situation. We wanted to provide some observations relating to this example.

In the example, three scenarios are considered. For purposes of clarity, and using terminology typical to the health insurance industry, we will refer to scenario (a) as being an ASO

¹ The American Academy of Actuaries is a national organization formed in 1965 to bring together, in a single entity, actuaries of all specializations within the United States. A major purpose of the Academy is to act as a public information organization for the profession. Academy committees, task forces and work groups regularly prepare testimony and provide information to Congress and senior federal policy-makers, comment on proposed federal and state regulations, and work closely with the National Association of Insurance Commissioners and state officials on issues related to insurance, pensions and other forms of risk financing. The Academy establishes qualification standards for the actuarial profession in the United States and supports two independent boards. The Actuarial Standards Board promulgates standards of practice for the profession, and the Actuarial Board for Counseling and Discipline helps to ensure high standards of professional conduct are met. The Academy also supports the Joint Committee for the Code of Professional Conduct, which develops standards of conduct for the U.S. actuarial profession.

(administrative services only) product, scenario (b) as being an ASO plus ASL (aggregate stop loss) product, and scenario (c) as being a fully insured product.

Typically, an ASL product design involves a parameter, known as the “aggregate corridor.” This parameter represents the level above which the insurance company bears responsibility for claims, expressed as a percentage of the expected level of underlying benefit payments.

The description of scenario (b) in paragraph 19 refers to a company buying insurance for “the claims exceeding *the* expected level of payments” (emphasis added), which would correspond to an aggregate corridor of 100 percent. However, in paragraph 20 it is suggested that scenario (b) could be structured in such a way as to provide the company with insurance protection that is “equivalent” to a fully insured product. We presume that when you say “equivalent,” you are implying that the probability the company will receive no reimbursements from the insurer under the ASL product is virtually zero. Of course, in order for this to occur, the selected aggregate corridor would need to be significantly lower than 100 percent. Thus, it might be clearer in future discussions if you were to articulate scenario (b) as involving insurance for the claims exceeding *some* expected level of payments, thereby emphasizing the fact that scenario (b) really represents a spectrum of possible options (varying with the chosen aggregate corridor) rather than a single option.

In our experience, ASL products with aggregate corridors at or below 100 percent are very rare in the current marketplace. Most product designs of this general type are currently structured with higher aggregate corridors, such as 125 percent. Although ASO plus ASL contracts having a dollar-trading component (i.e., products with aggregate corridors below 100 percent) may exist, they appear to be extremely uncommon. Moreover, the aggregate corridors in these products would rarely be set at levels so low that virtually all of the fluctuation risk in the company’s benefit payment levels has been transferred to the insurer.

Consequently, the specific issue articulated in paragraph 21 — namely that, in the absence of bifurcation, different accounting approaches are employed for two economically equivalent contracts — appears to us to be a theoretical concern rather than a practical concern, as few if any companies are providing health benefits to employees using an ASO plus ASL contract that is structured to be economically equivalent to a fully insured contract. This observation may be relevant in assessing whether there is a real need for bifurcation, at least with respect to group medical insurance contracts.

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?*

We are concerned that the IFRS 4 definition of insurance contract, excerpted in paragraph 34 of the ITC, could be interpreted as excluding certain types of insurance products, such as group

medical insurance, that are common in the United States but uncommon in other jurisdictions. The IFRS 4 definition refers to an insurance contract as one that “agrees to compensate the policyholder if a specified uncertain future event... adversely affects the policyholder.” With a group medical insurance contract, the policyholder is typically an employer-sponsored benefit plan; the uncertain future events covered by the contract are events that have adverse impacts not on the policyholder per se, but on the holders of certificates under the policy (i.e., eligible employees of the company sponsoring the benefit plan) or on certificate holders’ dependents; and the compensation paid under the insurance contract is typically paid not to the policyholder, or even to the certificate holders, but rather directly to health care providers from whom the certificate holders and their dependents have obtained medical services. (In some cases, the health care providers may be employees of the insurer or one of its affiliates, and hence the compensation paid to the providers is indirect, in the form of salaries, rather than being directly tied to the services provided under the insurance contract.) We believe that the definition of insurance contract under U.S. GAAP needs to be broad enough to not automatically exclude this very common type of insurance from eligibility for insurance accounting treatment.

We are also concerned about the potential implications of the commentary in paragraph 14 of the ITC regarding the current U.S. GAAP definition of insurance risk. The ITC states that “insurance risk requires both underwriting risk and timing risk” and, in its discussion of timing risk, indicates that “contracts with claims that are reported and paid quickly would not be exposed to this type of timing risk.” As health insurers continue to strive for administrative efficiencies, the elapsed time between when a health care service is provided to an insured person and when the insurer reimburses the provider of that service under the relevant contractual terms has been diminishing. With some types of health care services, most notably the fulfillment of pharmaceutical prescriptions, this time lag may even be nonexistent, thanks to point-of-service auto-adjudication of the claim. We believe that a contract should not cease to represent “insurance risk” simply because technological improvements have reduced or eliminated the time lag between the occurrence of the insured event and the processing of reimbursement under the contract, and we are concerned that the above-quoted passage from paragraph 14 could lead one to such a conclusion.

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?*

Our main concern with the potential application of Statement 113 risk transfer guidance to insurance contracts would be the criterion that (quoting from paragraph 37(a) of the ITC with appropriate modification) “the probability of a significant variation in both the amount and timing of payments by the insurer must be reasonably possible.” As noted in paragraph 39, a common rule of thumb that has evolved in response to this “reasonably possible” standard is the 10/10 rule, which considers whether the contract “has at least a 10 percent chance of resulting in at least a 10 percent loss.” Many group health insurance contracts having no risk-limiting features would be unlikely to pass the 10/10 rule, due to limited volatility in potential loss

experience under the contract. Nonetheless, such contracts may represent insurance risk from the standpoint of the insurer, in the sense that the risk of loss from a block of such contracts is non-negligible and risk capital needs to be allocated to support those potential losses.

Issue 3: Does classifying an entire contract as insurance or bifurcating that contract into insurance and deposit contracts provide more understandable and decision-useful information? Which qualitative characteristics most influence your decision? Which approach most faithfully represents the economic substance of the contract?

With respect to accident & health insurance contracts with no risk-limiting features (referred to above as “fully insured” contracts), we are concerned that bifurcating the contract into a dollar-trading component versus insurance and administration components would significantly detract from the ability of financial statement users to make meaningful comparisons among financial statements, both across insurers and across time periods.

Under a bifurcation approach, the revenue recognized by the insurer for a fully insured contract would be determined by reference to an actuarial model of the variability inherent in the claim costs under the contract. As discussed below in our comments to Issue 10, such models are not currently in widespread use among health actuaries. Consequently, bifurcation would involve using a mark-to-model approach for revenue in a situation where currently there are no generally accepted models and no relevant history of actuarial practice to guide the selection and calibration of such models. We believe this would naturally lead to an environment in which two companies would, given the same facts and circumstances, be likely to recognize different amounts of revenue for the same contract, due to professional differences of opinion in selecting and calibrating a model in order to comply with the bifurcation guidance. This would hamper the comparability of revenue recognition across health insurance companies. Similarly, there would likely be asymmetry between the insurance contract expense recognized by the insured company in its financial reporting and the revenue recognized by the insurer, due to differences in the models employed by the insurer and the insured. We would also note that, for both the insurer and the insured, additional costs would be incurred not only in developing the information necessary to bifurcate the insurance premiums into insurance and deposit components, but also in having that split audited.

The bifurcation approach would also cloud the financial statement user’s ability to interpret the meaning of period-to-period changes in an insurer’s revenue. In the current accounting approach, year-to-year revenue growth can be viewed as the compound effect of two factors: growth in underlying volume of business; and changes in premium rates (including the impact of shifts in the mix of products). A bifurcation approach would add a third factor, namely changes in the calibration of the actuarial model used to calculate revenue. For example, if the insurer were to conclude that the business it underwrites is now more volatile than it was previously, then under the expected payout bifurcation approach discussed in the ITC, the proportion of premium recognized as revenue would increase. This change in actuarial assumptions, however, would not necessarily be transparent to users of the financial statement. Such changes might be frequent even when made entirely in good faith, but there is also a danger that a bifurcated

accounting approach would permit companies to achieve revenue growth expectations simply by tweaking assumptions in actuarial models in ways that may not affect market prices.

In light of these issues, our sense is that moving to a bifurcation model for health insurance would only exacerbate the need for widespread use of non-GAAP metrics. This is already an issue for health insurers, due to the use of deposit accounting for ASO contracts. From an administrative perspective, the tasks a health insurer performs for its ASO customers are substantially similar to the tasks it performs for its fully insured customers. However, since different amounts of revenue are recognized for the two classes of customers, commonly used analytical ratios (e.g., claims expense to revenue, administrative expense to revenue) are highly dependent on the insurer's mix of business between ASO and fully insured contracts. In order to overcome this limitation, many insurers have reported a non-GAAP metric known as "premium equivalents," which adds benefit payments made under ASO contracts to revenue. Ratios of benefit payments (both insured and ASO) to premium equivalents and of administrative expenses to premium equivalents are far less dependent on mix-of-business considerations, and therefore are of greater use to financial statement users in comparing the administrative efficiency of different insurers that have different mixes of business. Under a bifurcation approach, the need for premium equivalents as a commonly accepted (albeit non-GAAP) quasi-revenue metric would increase, due to the introduction of differences among insurers in revenue recognition for fully insured contracts.

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?*

We have no comment on this issue.

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

Under the framework proposed in paragraph 58 of the ITC, an accident & health contract would be considered to unequivocally transfer insurance risk only if "the contract is not likely to result in any claims." On the other hand, Appendix B indicates that all individual accident & health insurance contracts, and no group accident & health contracts, would be unequivocally considered to be insurance contracts. We have several comments.

First, we are somewhat perplexed by the intended meaning of the phrase "not likely" in paragraph 58(f) (as quoted above) and the related use of such phrases as "expected claim losses" (e.g., in paragraph 59). In our view, the generally accepted meaning of the phrase "expected claim losses" would refer to the mean of the distribution of claim amounts. However, this does not appear to be the meaning attached to the phrase within the ITC. For instance, paragraph 59

mentions that “portfolios of contracts that qualify individually as unequivocal insurance contracts would have expected losses.” The obvious implication is that the underlying individual contracts within the portfolio do *not* have “expected losses.” However, *any* insurance contract has “expected losses” in the sense that the mathematical expectation (or mean) of the loss distribution is non-zero. Our impression from reading the ITC is that when the ITC indicates a contract “has expected losses,” the intended meaning is that the probability that losses under the contract will be equal to zero in some specified timeframe is “not likely.” This usage is confusing and we would encourage FASB to be clearer in the future.

For purposes of this comment letter, we have interpreted the phrase “the contract is not likely to result in any claims” as meaning “the probability of a claim under the contract within the next 12 months (that being the most typical duration for an accident & health contract) is less than 50 percent”; an equivalent phrasing of our interpretation would be that “the median of the distribution of claim amounts under the contract within the next 12 months is zero.”

Second, a wide variety of accident & health contracts are offered to individuals, and although some contract types clearly would meet the “not likely” standard as we have interpreted it above, others clearly would not. Medicare Supplement and Medicare Advantage products are designed so that almost every policyholder expects to receive some insurance benefits in any given policy year. The same can be said for many individual medical insurance products, particularly those having low deductible levels and cost-sharing features such as fixed-dollar co-pays for office visits or prescription drugs.

On the other hand, with other individual products such as disability income, long-term care, and critical illness, there is a high probability that no claims will be filed for a typical policy in a given timeframe. Making the situation more complex, with products such as the High Deductible Health Plans associated with health savings accounts as enacted under the Medicare Modernization Act, there may be a low probability of claims relating to the main coverage (e.g., high deductible medical insurance), but a high probability of claims relating to ancillary coverages (e.g., a product design where each policyholder is entitled to reimbursement for a physical every year without needing to first satisfy the deductible). Such products arguably meet the spirit, but not the letter, of the “not likely” standard.

By the same token, there would be some group accident & health contracts that would meet the “not likely” standard as we have interpreted it, and therefore should, under the paragraph 58 framework, be viewed as unequivocally transferring insurance risk. For example, in some regulatory jurisdictions, an insurer may have a regulatory obligation to offer a group medical policy form to a group consisting of a single person (a so-called “group of 1”). One can readily imagine a situation, therefore, where two identical individuals have obtained essentially identical medical insurance policies from the same insurer, but where one policy is considered to be an individual contract and the other policy is considered to be a group contract. Under Appendix B of the ITC, one of these policies would be exempted from bifurcation while the other would not. Consequently, the insurer’s accounting for economically equivalent policies would be determined by a regulatory definition that is not materially related to the insurer’s risk under the contracts.

Third, it is not clear whether FASB's intent would be for reporting entities to apply this "not likely" standard at the policy form level or at the contract level. For example, suppose that an insurer has issued a policy form of individual medical contracts having a \$5,000 annual deductible. The insurer believes, based on the product design and the insurer's historical experience, that a typical policyholder is not likely to receive any insurance benefits in a given policy year. On the other hand, the insurer could conclude, based on the historical experience of individual policyholders, that there are specific policyholders who are likely to receive substantial insurance benefits in the coming policy year. The question is: Are all policies issued under the policy form automatically exempt from bifurcation analysis, or does the exemption need to be evaluated on a policy-by-policy basis in light of each policyholder's own situation? We believe the former approach would be preferable, and that the latter approach would not only be very complicated for insurers to administer but also exacerbate the concerns expressed earlier regarding the introduction of judgment into revenue recognition for insurance companies.

In summary, our position is that the characteristic in paragraph 58(f) is not clearly stated or properly phrased. One can easily argue that any accident & health insurance contract is expected to result in a claim each and every year, though the expected amount of that claim may be very small per contract for certain types of policies. The savings from the contracts with no claims, when aggregated together, fund the claims on the policies with the very large claims. This is the essence of insurance.

Issue 6: *Do you think 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 (summarized in paragraph 37(c) of this Invitation to Comment)?*

We believe that if an insurance contract employs deductibles, coverage limits, etc., that are broadly consistent with those seen in the marketplace (i.e., "standard market terms" as in paragraph 58(d)), and if the contract transfers "substantially all of the insurance risk relating" to the coverage prescribed by those standard market terms (using the language of paragraph 37(c)), then it is appropriate to apply insurance accounting to the entire contract, as is currently the practice. Depending on the bifurcation methodology selected, application of the paragraph 58 characteristics may, or may not, preserve this desired objective. It is therefore difficult for us to evaluate the paragraph 58 characteristics in isolation without specification of other aspects of the proposed bifurcation approach.

Issue 7: *Do you prefer Approach A or Approach B for identifying contracts subject to bifurcation? Why? Do you believe that 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?*

We have no comment on this issue.

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

Perhaps the most common form of reinsurance employed in the health insurance industry is the type referred to in paragraph 69 as unrestricted quota share reinsurance, where the assuming carrier takes on a proportionate share (possibly 100 percent) of the direct carrier's premiums and claims for a defined set of contracts. The discussion in paragraph 69 suggests a bifurcation model in which the accounting for the quota share reinsurance cession would not necessarily follow the accounting for the original insurance contracts. In particular, even if the underlying contracts are exempt from bifurcation analysis (e.g., individual contracts meeting the "not likely" standard described above), under this model the reinsurance cession would potentially be subject to bifurcation.

We are concerned that creating a distinction between the accounting treatment for an insurance policy and the accounting treatment for the reinsurance of that policy to another insurer would be needlessly confusing to users of financial statements. As an illustrative example, consider the extreme case of 100 percent quota share insurance, which is a common practice in the individual health industry. (For instance, it has frequently been used by carriers who had previously underwritten a block of individual disability income policies and cannot cancel the block for regulatory reasons but no longer want to bear the risks and rewards of the block.) Under the current accounting approach, the insurer recognizes zero revenue and zero claims expense for a 100 percent ceded block. This approach is consistent with the economic impact on the carrier of period-to-period fluctuations in the experience of the block of business (absent any issues relating to the potential failure of the reinsurer). Under a bifurcation approach in which the accounting treatment for the reinsurance contract did not automatically follow the accounting treatment for the insurance contract, however, the insurer would recognize a non-zero amount of revenue (since deposit accounting treatment would apply to some portion of the ceded premium) and a non-zero amount of claims expense. This implies that period-to-period fluctuations in the experience of the ceded block would now affect the revenue recognized by the ceding insurer, as well as various analytical metrics, such as the insurer's loss ratio. This does not appear to us to be a representationally faithful portrayal of the ceding insurer's business.

Additionally, adopting this type of approach to reinsurance accounting could create new asymmetries between the revenue recognized by the assuming reinsurer and the reduction in revenue recognized by the ceding insurer, due to differences in the actuarial models employed by the two companies. This result would be ironic given that one of the drivers of the FASB project that led to this ITC, as we understand it, was heightened concern over asymmetric revenue recognition for certain reinsurance contracts.

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?*

We believe that, at least with respect to one key aspect, the proportional method described in paragraphs 74 and 75 has more conceptual merit than the other methods discussed in the ITC. The concept of relative risk transfer, under which insurance accounting would be used for the entire contract in any situation where the insured has not retained any risk, is intuitively very appealing. Having said that, it is unclear to us how to practically apply the proportional method in situations where the insurer has not assumed all of the insured's risk. As noted in paragraph 70, additional work would be needed to determine if and how this concept could be made operational.

In particular, there appears to be some ambiguity about how the proportional bifurcation method would be applied in the context of contracts involving medical benefits.

Paragraph 74 talks about computing the ratio of the risk that a policyholder bears before consideration of the contract compared to the portion of the risk retained by the policyholder after applying the terms of the contract, while paragraph 75 talks about whether or not the insurer has the same insurance risk as the insured would have had without the contract. These two concepts, however, are not always as directly related as one might think; in some circumstances, a contractual relationship between two parties can mitigate risk without transferring it.

First, consider the proportional bifurcation method from the viewpoint of a company that has entered into an ASO contract with an insurer covering health care employee benefits. Contrary to the statement made in paragraph 19(a) of the ITC, the company is not simply purchasing an administrative service from the insurer; the company is also obtaining access to the insurer's contracts with health care providers, which are more favorable than the contractual terms the company itself would be able to negotiate with providers. Therefore, the existence of the ASO contract has materially changed the nature of the risk retained by the company for health care employee benefits. The company's access to the insurer's provider discounts has drastically reduced its own underwriting risk, even though no underwriting risk has actually been transferred to the insurer. Consequently, the risk-retained ratio (as defined in paragraph 74) for the company's ASO contract would be unequal to 100 percent. Would this imply that the company should recognize some portion of its expenses under the ASO contract as being insurance expense?

Now consider an insurer that has issued a fully insured contract to a company for health care employee benefits. The company has retained zero insurance risk for these benefits. However, the insurance risk borne by the insurer is less than the insurance risk the company would have borne in the absence of any contractual relationship because of the discounted fee arrangements the insurer has negotiated with health care providers. Technically speaking, therefore, the insurer has not assumed all of the underwriting risk the company had prior to the inception of the contract. Would this imply that, under the proportional bifurcation method, the insurer should not apply insurance accounting to the entire contract?

Turning to the expected payout method of bifurcation, we foresee a number of practical difficulties with implementation. Earlier, we discussed the possibility that similarly situated

insurers would recognize different amounts of revenue for the same contract, due to differences in the models and assumptions used to bifurcate the contract. Another key operational difficulty with this approach would involve the actuarial estimation of the insurer's liability for unpaid claims.

Under current practice, an insurer typically calculates claim liability estimates for group medical contracts at the block-of-business level, not at the group level. Here a block of business may consist of hundreds, or possibly thousands, of group contracts having broadly similar characteristics. From the standpoint of external financial reporting, there is no need to apportion the claim liability estimate for the block on a group-by-group basis. Some insurers may employ some method of crude apportionment in order to understand each group's financial performance on an incurred rather than cash basis. Other insurers may not bother doing this, due in part to the fact that the claim liabilities have a short tail.

Under an expected payout bifurcation method, a probability level would have been specified (as noted in paragraph 23) and, for each group, deposit accounting would be used for the portion of that group's premium corresponding to what we will call the "threshold claims amount," meaning the point at which the probability that actual claims will exceed the threshold claims amount is equal to the specified probability level. In theory, the threshold claims amount, expressed as a percentage of premium, would vary for each group, due to group-specific characteristics (e.g., demographics, contract terms, volatility of historical experience, etc.). Consequently, the insurer would need to develop for each group and incurred month an estimate of the group's ultimate incurred claims for that month, in order to determine how much claims expense should be recognized above the threshold amount, since that is the only part to which insurance accounting would apply. This would seem to require that the insurer develop group-by-group unpaid claim liability estimates for external financial reporting purposes, which would be a significant departure from current actuarial practice and would be both more complex administratively and potentially less accurate.

Finally, at first glance we are having conceptual difficulty understanding how the cash flow yield method might be applied to accident & health contracts.

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 models 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?*

In order to apply the expected payout bifurcation method, the insurer would need to develop an actuarial model of the distribution of losses under that contract, since the insurer would need to identify what we have previously called the "threshold claims amount" for the contract.

In our experience, such models do not currently enjoy widespread use in the health insurance industry. As a general rule, the pricing of accident & health insurance contracts is based on a

point estimate of expected future experience, rather than through consideration of a statistical distribution of possible future outcomes. Some insurers may take the variability of future experience into account in establishing profit margin targets and/or in modifying past experience in order to select a point estimate of expected future experience. This, however, is typically done in an ad hoc way rather than by reference to a statistical loss distribution. We noted earlier that there are some health insurance products, such as aggregate stop loss, where the benefit design is based on a multiple of expected claims. In principle, pricing an ASL product would involve a loss distribution model; in practice, ASL pricing is typically performed along much cruder lines. (For most insurers, ASL is a relatively immaterial line of business that is not necessarily intended to be financially self-supporting, making the accuracy of the pricing methodology less crucial.)

Consequently, as noted earlier in our comments to Issue 3, the application of the expected payout bifurcation method to accident & health insurance contracts would create a situation where important financial statement items — most notably revenue — are determined by reference to a class of actuarial models that have not historically enjoyed widespread use and are not calibrated to observed market prices (i.e., premiums).

Some of these comments remain pertinent under the proportional method with respect to contracts having risk-limiting features, such as retrospective premium adjustments.

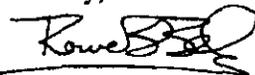
Issue 11: *In view of the IASB's project on insurance contracts, should the FASB be considering bifurcation of insurance contracts based on transfer of insurance risk?*

We have no comment on this issue.

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The Academy's Health Practice Financial Reporting Committee values the opportunity to provide input to FASB on this topic. It is vital that we continue to contribute and we appreciate the chance to be an active participant in this process. If there are any questions regarding these comments, I invite you to contact Tina Getachew at (202) 223-8196 or getachew@actuary.org.

Sincerely,



Rowen B. Bell
Chair, Health Practice Financial Reporting Committee
American Academy of Actuaries