



November 30, 2010

Ms. Leslie F. Seidman, Acting Chairman  
Financial Accounting Standards Board  
401 Merritt 7  
P.O. Box 5116  
Norwalk, Connecticut 06856-5116  
United States of America  
Via email: [director@fasb.org](mailto:director@fasb.org)

Sir David Tweedie, Chairman  
International Accounting Standards Board  
30 Cannon Street  
London, EC4M 6XH  
United Kingdom  
Via electronic submission: [www.ifrs.org](http://www.ifrs.org)

Ms. Leslie F. Seidman and Sir David Tweedie:

**Re: FASB File Reference No. 1870-100, Discussion Paper - *Preliminary Views on Insurance Contracts*, and IASB Exposure Draft - *Insurance Contracts***

We appreciate the opportunity to share with the Financial Accounting Standards Board (the "FASB") and the International Accounting Standards Board (the "IASB") (collectively, the "Boards") our views on their joint efforts to revise the accounting model for insurance contracts both within the United States and internationally. We are the five leading managed care companies in the United States: Aetna Inc., CIGNA Corporation, Humana Inc., UnitedHealth Group Inc. and WellPoint, Inc. As a group, we provide health insurance products and related services to more than 100 million medical members. Our customers include employer groups, individuals, college students, part-time and hourly workers, governmental units, government-sponsored plans, labor groups and expatriates. We also provide other insurance products, such as long-term care, dental, term life, short-term and long-term disability, and supplemental health insurance coverage and services. Collectively we reported annual premiums and fees of approximately \$225 billion in 2009 (equivalent to 1.6 percent of the gross domestic product of the United States). While we primarily report under generally accepted accounting principles in the United States ("U.S. GAAP") today, we also take a significant interest in the ongoing development of International Financial Reporting Standards ("IFRS") given that the United States Securities and Exchange Commission ("SEC") is currently considering whether IFRS should be incorporated into the United States financial reporting system, and each of our companies have operations in markets outside of the United States.

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In December 2009, we submitted a letter to the Boards expressing our views on several important issues then under discussion: specifically, contract boundaries, the premium allocation method (then referred to as the unearned premium approach), onerous contracts and the grouping of contracts, and unbundling. In January 2010, representatives from our organizations met with FASB and IASB staff members to further discuss these matters and we appreciated the Boards' interest in obtaining input from the managed care industry on this important project. We have continued to follow closely the Boards' deliberations and herein provide our formal response to the FASB's Discussion Paper, *Preliminary Views on Insurance Contracts* (the "DP" or "FASB proposals") and the IASB's Exposure Draft, *Insurance Contracts* (the "ED" or "IASB proposals") (collectively "the proposals").

Our comments are focused on the key issues that we believe most significantly impact the managed care industry, our investors and other users of our financial statements. As investors in approximately \$80 billion of primarily investment grade public and private debt securities and commercial mortgage loans, our organizations are both preparers and users of financial information. Our comments therefore represent the joint perspectives of our accountants/financial statement preparers and investment professionals/financial statement users. To the extent possible, we have also reflected the views of certain analysts and investors that use our financial statements.

### **Background to the Managed Care Industry**

Managed care companies function as intermediaries between the suppliers of medical care (e.g., physicians, hospitals, pharmaceutical companies, etc.) and users of medical care (consumers). The core of our business is delivering access to cost effective, quality medical care to consumers enrolled in our medical benefit plans.

Our active engagement in the delivery of these service offerings creates a substantially different value proposition and business model than that of traditional indemnity insurance. Indemnity insurance is generally a passive industry that focuses on the payment of claims subsequent to insured events that occur during a policy period. Indemnity insurance companies have little or no infrastructure to manage the cost and outcome of an insured event as it occurs. Accordingly, we believe the accounting policies of managed care companies would exhibit key differences from those used to report traditional indemnity insurance lines such as property/casualty insurance.

As our industry term "managed care" suggests, the care management services we deliver to our subscribers are integrated into our service offerings. In addition to offering licensed insurance products, managed care organizations also contract with employers, unions and other groups sponsoring self-insured plans on an administrative services only basis to administer claims and perform other plan-related services. The insurer collects administrative service fees in exchange for providing these self-insured plans with access to the insurer's provider networks and for providing other services and programs, including claims administration, quality management, utilization management, and cost containment. Managed care organizations may also sell specialty products such as health advocacy, 24-hour help lines, 24/7 call centers, case management, disease management, and behavioral health care management services (through their provider networks); or provide any combination of these services. Each customer can select from a broad array of services

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that are combined and priced to achieve a reasonable aggregated profit margin and to leverage cost synergies across similar contracts. Customer contracts are typically priced on an integrated basis reflecting the specific combination of services being purchased as well as each customer's unique risk profile.

Furthermore, the provision of insurance coverage varies substantially by market segment between individual, employer and government (Medicaid and Medicare) customers.

We believe this context is important to any discussion of the accounting model for our industry.

### **General Approach and Objectives**

We understand that the FASB and IASB have been working towards a targeted completion date of June 2011 for issuance of a final standard(s). Given the fundamental nature of the changes proposed, we urge the Boards to fully explore alternative suggestions proposed by interested parties during the comment process and other outreach efforts, and not sacrifice due process in order to meet what we believe is an unrealistic timetable. The accounting model for the insurance industry is too important to affect such a fundamental change without the strong support of both financial statement users and preparers. We strongly believe the Boards should prioritize quality over timeliness in this particular area of accounting and financial reporting convergence. Furthermore, given the FASB has not yet issued an exposure draft, we presume it is unlikely that both Boards will be in a position to issue a joint standard (or perhaps even different standards) within this stated timeframe. The Boards have reached different conclusions on several important issues including the fundamentally important topic of margins (i.e., composite versus an explicit risk adjustment) and the FASB has yet to express a formal position on either the use of a simplified approach for short duration contracts or transition methodologies. We are concerned that the Boards may ultimately issue two separate standards without reaching common consensus on these and other important issues. Because of the ongoing uncertainty as to whether the United States will in due course adopt IFRS, this could result initially in the adoption of the FASB model for U.S. preparers, only to be replaced shortly thereafter by the IASB model under an IFRS reporting regime. This scenario could impose a significant additional burden on preparers and create unnecessary confusion and complexity for users. Accordingly, we urge the Boards to reach a common position on *all* issues prior to issuing a single converged accounting standard.

We also strongly believe that any changes to accounting for insurance contracts must reflect the insurance business model and therefore the economic substance of pooled insurance risk. As discussed throughout this letter, we are concerned that many important aspects of the Boards' proposals do not in fact achieve this objective and will result in accounting outcomes that do not faithfully depict the manner in which an insurer prices, assumes and manages insurance risk. Furthermore, the proposed accounting framework for insurance contracts should not be developed in isolation and must consider the related accounting model for financial instruments. Our comments below describe this relationship and we recommend the Boards' conclusions address this interdependency, particularly with respect to discount rates.

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**Perception that Users of our Financial Statements Desire a New Accounting Model for Insurance Contracts, and that the Boards' Proposals Satisfy this Perceived Need for Change**

As publicly-traded companies in the United States, we meet frequently with professional industry analysts and the broader investor community to discuss the results of our businesses, provide earnings guidance and give direction on our future strategy. Our financial statements clearly play an important role in this dialogue and the users of our financial statements have articulated that, from an investor's perspective, financial statements should meet the following requirements:

- Provide information to identify and measure growth potential;
- Provide key metrics, such as benefit loss ratios to demonstrate cost trend and premiums to demonstrate volume and pricing trends; and
- Provide a measure of operating income and profitability based on the interaction of revenues and expenses.

We believe that the application of the current short duration accounting model used for our managed care indemnity products collectively meets these needs and best provides our financial statement users with the necessary useful information to make informed investment decisions. Much of this information would be lost or relegated to supplemental footnote disclosure if the proposed long duration model was applied as the basis for recognition and measurement. Importantly, our financial statement users have not expressed a desire for any fundamental changes to the short duration accounting model applied under existing U.S. GAAP.

The current U.S. GAAP guidance for insurance accounting has been in existence for almost three decades with periodic updates and amendments, partially to address the changing insurance environment. This guidance results in an accounting model for insurance contracts that has provided, and continues to provide, relevant and decision-useful information that is well understood by users of our financial statements. Accordingly, we do not believe that current U.S. GAAP for insurance requires a comprehensive overhaul. Many of the minor improvements that would be required could be achieved through enhancements in disclosure practices. However, we understand that no universal standards exist for insurance contracts under IFRS and we acknowledge the need for such guidance internationally. Nevertheless, we believe that a practical expedient for short duration insurance contracts should be available under both U.S. GAAP and IFRS to distinguish the accounting for short duration contracts from long duration products that have substantially different economic characteristics.

Although our comments clearly express the view that health insurance contracts should be measured and presented using a short duration accounting model, we have also provided a broader response that addresses the key concerns our industry would have if we were required to apply a full building block approach to our products.

**We Support a Simplified Approach for Insurance Contracts that are Short Duration**

The spectrum of insurance risk varies tremendously across different products and between different sectors of the insurance industry. Accordingly, a single unified model for insurance accounting

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would not be appropriate because it would force fundamentally dissimilar insurance products to be accounted on the same basis (e.g., health insurance, which generally has minimal long-term investment risk, and variable life insurance, which has significant long-term investment risk). We therefore fully support the IASB's proposal to permit a practical expedient for short duration contracts. As described in detail below, we have concerns (and related recommendations) regarding both the proposed definition of short duration contracts and the application of the proposed premium allocation method. However, we believe the principle of a separate practical expedient is fully justified for managed care insurance contracts because this concept most faithfully represents the commercial substance of the underlying risks being insured and the provision of related benefits.

Furthermore, this concept is consistent with a two-model approach under current U.S. GAAP<sup>1</sup> which explicitly recognizes that:

- Short duration contracts are intended to cover claims costs resulting from insured events that occur during a fixed period of short duration;
- An insurer has the ability to cancel the contract or re-price the premium at the beginning of each contract period (which is generally twelve months or less) to cover future insured events (notwithstanding our concerns regarding the interpretation of contract boundaries, described below); and
- Therefore, premiums from short duration contracts should be earned over the coverage period.

We believe that the premium charged to a policyholder is a reasonable proxy for the pre-claim liability because the likelihood of a managed care insurer identifying information after the inception of a coverage period that would materially affect the amount of the expected insurance obligation (and therefore earnings) is typically remote. For example, managed care companies use completion factors to project the ultimate expected insurance liability for a portfolio of insurance contracts. These factors measure the time it takes to process claims based on reported claims data. As an industry, these completion factors typically do not exceed fifty days, and most claims are reported to and paid by the insurer within a short period of occurrence. This is demonstrated by the fact that while it may take several years for the very last claim in a portfolio to be fully extinguished, greater than ninety percent of health insurance claims are fully settled within three months of incurral.

### **Summary of Recommendations and Concerns**

We support the Boards' proposed objective of measuring all cash inflows and outflows required to fulfill an insurance contract in a manner that reflects the principle of pooled insurance risk. In general, we support the use of a building block approach to achieve this objective for long duration contracts, distinguishing between estimated future cash flows and expected future profit based on initial pricing assumptions. However, as noted above, we believe the use of a practical expedient for short duration contracts most appropriately reflects the economic substance of our health insurance contracts.

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<sup>1</sup> FASB Accounting Standards Codification ("ASC") Topic 944-20-05-13

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We agree with the principle that an insurer should not recognize a gain at the inception of an insurance contract because the insurer has not yet performed under that contract. We also agree that a loss at inception should be recognized if the present value of fulfillment cash outflows exceeds the expected present value of future cash inflows, measured at the portfolio level.

However, we disagree with many of the specific principles or prescribed techniques proposed by the Boards to achieve these objectives. The following items summarize the areas where we agree with the FASB and/or IASB proposals, as well as our objections and proposed alternative approaches for those areas where we disagree with the proposals. Our rationale for these general recommendations is set out in detail in the remainder of this letter. In addition, our responses to specific questions raised by the Boards are included in the attached Appendix which combines the FASB and IASB questions by common theme. All references apply equally to both the FASB and IASB proposals unless otherwise indicated.

#### Proposals that fundamentally impact managed care insurers

- **Contract boundaries** – We agree that a contract boundary should be determined at the point at which an insurer is no longer required to provide coverage or no longer has the ability to re-price the contract to fully reflect risk. However, this occurs within the context of the underlying regulatory framework governing the insurance industry, and for managed care companies in particular, we expect the impact of healthcare reform in the United States over the next several years will further constrain an insurer's ability to underwrite and fully price for risk. Therefore, the ability to re-price for risk should be determined within the bounds of these limitations and not be constrained by them. Furthermore, the assessment of risk should be made at a portfolio level, not at the individual contract level, because this more faithfully represents the concept of pooled insurance risk and the regulatory framework that governs the insurance industry.
- **Unbundling and the interaction with revenue recognition proposals** – We agree with the principle that any components of an insurance contract that are not closely related to the insurance coverage should be excluded from the measurement of fulfillment cash flows. With respect to the managed care industry, we are particularly concerned that the concept of closely related could also be interpreted to require the bundling (i.e., not just unbundling) of non-insurance services with insurance contracts because managed care products are packaged and delivered on an integrated basis. We do not believe this outcome would appropriately reflect the distinct elements of the health care value proposition we deliver to our customers. Accordingly, we support the proposed principles-based approach requiring insurers to consider the facts and circumstances of each particular agreement and use judgment to determine whether or not components are closely related to the insurance coverage for the purpose of unbundling.
- **Premium allocation method** – We support the objective of providing a simplified measurement model for short duration insurance contracts. We generally believe the proposal of establishing an unearned premium reserve as a proxy for the pre-claim liability is a reasonable approach for health insurance contracts that are characterized by predictable premiums collected over a short coverage period, and a predictable and short term pay-out pattern relative to other insurance products such as life insurance. However, we do not agree with a definition of a short duration contract that is based primarily on the assumption that a

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coverage period of greater than one-year is necessarily a long duration contract and should therefore be measured using a full building block approach. Instead, we recommend that the definition of a short duration contract should be principles-based, reflecting the manner in which a portfolio of products is priced and managed, as well as the expected pattern and timing of fulfillment cash flows. This definition would also be an improvement relative to existing U.S. GAAP which does not currently provide a robust principles-based definition of short duration contracts.

#### Other important proposals for comment

- **Probability-weighted cash flows** – We do not believe that the use of probability-weighted cash flows is superior or more reliable than the concept of an actuarially-determined mean of the cash flows. Indeed, the use of probability-weighted estimates implies a false degree of precision potentially masking the fact that these estimates are inherently still based on actuarial judgment in determining both the number of possible outcomes and the probabilities assigned to each outcome. Under current standard actuarial methods for health insurance liabilities, actuaries inherently consider multiple inputs in developing an actuarial mean estimate. Attempting to prescribe a formulaic approach for this assessment (by requiring a defined set of probabilistic scenarios) adds complexity and cost without achieving any commensurate increase in the precision of the estimate relative to actuarial techniques currently applied in practice. Even if only a limited number of cash flow scenario analyses were performed (rather than full stochastic modeling, for example), this would significantly increase the amount of work a preparer would have to perform without producing any tangible improvements to measuring expected future cash flows. We believe any benefit of using a weighted-average approach is significantly outweighed by the incremental cost. Furthermore, we do not believe that the outcomes relative to approaches currently used in practice would yield a materially different result.
- **FASB composite margin versus IASB dual-margin approach** – We understand the perceived merit of separating risk from deferred profit by establishing a separate risk adjustment and residual margin, but believe this implies a false sense of precision because of the necessarily hypothetical objective of a risk adjustment. Although a dual-margin approach explicitly quantifies the risk associated with fulfillment cash flows, insurers would likely establish very different risk adjustments (and therefore different residual margins) for similar portfolios of risk. Because of the different earnings patterns proposed for each margin this creates the potential for inappropriate accounting arbitrage to manage future earnings results. We believe that any attempt to identify an explicit risk adjustment would not faithfully represent the manner in which the actuarial profession in practice determines insurance liabilities using accepted standard actuarial methods.
- **Observations specifically related to the proposed IASB dual-margin** - We do not believe the current definition of a risk adjustment is clear because it combines the concepts of entity specific assumptions and exit value measurements. Instead, we believe a risk adjustment should be defined as the present value of the amount of consideration an insurer would require to assume the risk of potential adverse variability in the development of future cash flows for a portfolio of insurance contracts. Additionally, we do not agree that a preparer should be limited

to the use of only three prescribed techniques when calculating the risk adjustment. An insurer should instead be able to apply the actuarially accepted technique that best depicts the variability in the amount and timing of cash flows, reflecting claim distributions and tail risk. Finally, we believe that under a dual-margin approach, adverse changes in the risk adjustment should first deplete any remaining residual margin before being recognized in earnings.

- **Discount rate** – We agree with the theoretical premise of discounting future cash flows necessary to fulfill an insurance contract. In practice, however, we do not believe the impact of discounting would be material for most health insurance contracts and, therefore, the need to constantly assess materiality would be unnecessarily burdensome for managed care companies. In practice, other than in periods of severely high interest rates, it would be self evident that the effect of discounting is immaterial. As a result, we expect that managed care companies would not in fact even track the potential impact of discounting for health insurance contracts. With respect to long duration products, we disagree in principle with the proposal to use a discount rate based on the risk-free yield curve adjusted for liquidity. This does not reflect the insurance business model whereby premiums collected from a policyholder are invested in assets used to support future incurred claims. Instead, we recommend the use of a discount rate that is based on the expected investment return on assets that will be used to settle future insurance obligations. We believe this approach more appropriately reflects the economic reality of our business model. Finally, we do not believe that non-performance risk should be included in the discount rate because an entity's own-credit risk does not affect the amount an insurer is obligated to pay a policyholder upon the occurrence of an insured event.
- **Acquisition costs** – We agree with the Boards' general principle that acquisition costs should be included as a relevant component of the initial measurement of fulfillment cash flows. This is consistent with the manner in which an insurer prices insurance risk to recover not only expected future claim payments but also the costs of acquiring insurance business. However, we disagree with the Boards' restrictive definition that only *incremental acquisition costs* at the *contract level* would be included in this measurement. This is inconsistent with the principle of measuring insurance cash flows at a portfolio level used elsewhere in the proposals. Furthermore, because insurance premiums are priced to recover all costs associated with acquiring or renewing insurance contracts, we believe that both incremental costs (i.e., specifically identifiable and associated with a successful sale) and a reasonable and systematic allocation of non-incremental acquisition costs<sup>2</sup> should be included in the measurement of fulfillment cash flows.
- **Level of aggregation** - We agree with the Boards' principles-based description of a portfolio and believe this approach provides necessary and reasonable flexibility to allow insurers to aggregate contracts in a manner that best reflects the characteristics of each preparer's portfolios of insurance risk. However, the definition is so broad it could result in significant inconsistencies in the identification of portfolios between preparers and we have, therefore, recommended a modified description (based on the existing U.S. GAAP requirements for aggregating risk when assessing potential premium deficiency) that we believe more clearly

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<sup>2</sup> For example, the direct salary paid to a sales agent implicitly acknowledges that less than 100 per cent of the agent's sales efforts will be successful, yet that total salary cost must be incurred to generate even a single successful sale.

achieves the Boards' objectives. Furthermore, we believe that *all* fulfillment cash flows should be measured at the portfolio level, including incremental acquisition costs.

- **Recognition** – We disagree with the principle of recognizing an insurance contract prior to the effective date of coverage. An insurance contract should not be recognized in earnings at the point at which an insurer has committed to terms with the insured (even if that restricts the ability to fully re-price to reflect risk) because the insurer is not exposed to the risk of claim incidence during the pre-coverage period. Identifying and tracking the date an insurer is deemed to be “on-risk” will also pose significant administrative challenges for which the perceived benefit will be outweighed by the actual costs to modify information systems and business processes. Furthermore, open enrollment (whereby prospective members of the policyholder select their coverage and benefits) occurs after an insurer is bound by the terms of a contract but before the effective coverage date. As a result, estimating an insurance liability during the pre-coverage period is not practical. Accordingly, we believe that an insurance contract should be recognized in earnings only from the effective date of coverage.
- **Financial statement presentation** – We disagree with the proposed margin approach for presenting the earnings or losses from insurance contracts in the income statement. Rather, information regarding insurance margins should instead be included in the notes to the financial statements. The margin approach results in a net presentation of the income statement by eliminating premiums and claim expense information from the primary financial statements. Volume-based metrics are integral to the way managed care insurers measure and assess financial performance, and are widely accepted as decision-useful data by our investors, analysts and other users of our financial statements. As previously discussed, we believe the concept of a simplified accounting model for short duration contracts better represents the commercial substance of our health care products, and are therefore supportive of the Boards' acknowledgement that a premium and claim-based presentation approach is best suited for such contracts.
- **Transition methods** - We disagree with the IASB's proposals to record, at the portfolio level, any measurement difference between the new basis of accounting (i.e., the expected cash flow building block and a risk adjustment) and the existing GAAP net insurance liability as an adjustment to retained earnings at the transition date. This approach results in the immediate recognition in equity of unrealized profits embedded in the in-force book of business even though the insurer has not yet performed under the unexpired portion of the coverage period, or satisfied all expected obligations during the claim run-out period. Furthermore, this outcome distorts future earnings patterns relative to pricing assumptions, is inconsistent with the accounting treatment for new business, and prevents an insurer from ever recognizing these expected profits in earnings in future periods. Instead we recommend a transition approach that establishes (at the portfolio level) a transition margin for any positive difference at the transition date that should be amortized into earnings based on the pattern of expected future cash outflows. Negative transition differences arising on a portfolio should be adjusted in retained earnings immediately at transition.
- **Scope implications** – We agree with the scope exceptions specified in the proposals but are concerned that the current definition of fixed-fee service contracts could imply that capitation

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arrangements between managed care insurers and health care providers are considered to be insurance contracts. The primary purpose of a capitation agreement is to contract for the provision of medical care services and not to transfer significant insurance risk. Accordingly, we recommend that the definition of fixed-fee service contracts be modified to ensure capitation agreements are excluded from the scope of the insurance contracts standard(s).

- **Scope of employer provided insurance** – We believe that the FASB’s observation that employer-provided insurance may be outside the scope of the insurance contracts standard(s) was intended to apply from the perspective of the sponsoring employer. However, to avoid any ambiguity, the Boards should clarify that risk-based health care indemnity insurance contracts are clearly within the scope of any insurance contract standard(s) from the perspective of the issuing insurer. From the perspective of a sponsoring employer, we believe that employer-provided insurance should not be included in the scope of the proposals as it represents compensation for employee services rendered rather than insurance.

## **1. Proposals that Fundamentally Impact the Managed Care Industry - Detailed Comments**

### **Contract Boundaries (IASB Question 9 / FASB Question 23)**

#### **Constraints imposed by the regulatory environment and health care reform in the United States**

Insurance companies operate in a highly regulated environment. Managed care companies in the United States are subject to oversight by State Insurance Departments that have the ability to restrict rates charged by insurers for certain risk-based products. State regulators review current levels of capital and liquidity as well as historical levels of profits to determine the level of premiums that should be allowed in the future and can therefore directly affect the underwriting profitability of insurance contracts issued in subject jurisdictions. Although regulatory practices vary by state and by product line, the existence of this regulatory framework clearly imposes a constraint on an insurer's practical ability or right to reassess risk and therefore charge a premium that fully reflects risk at the policyholder level (although market and regulatory dynamics at the portfolio level are not as restricted, as described below). This implies that health insurance contracts, typically priced for a twelve-month coverage period, could be deemed to extend for multiple consecutive coverage periods in the form of one single contract for accounting purposes under the Boards’ proposals. We do not believe the Boards’ intent was to establish an accounting principle that necessarily extends a contract’s boundary beyond the contractual terms simply because of the existence of a regulated environment, nor do we believe this approach would faithfully depict the economic substance of the way a managed care insurer prices and manages insurance risk at the portfolio level.

Contract boundaries are also of particular concern to managed care companies because of the statutory requirement to guarantee insurability and the related rate restrictions imposed by recently enacted health care reform legislation in the United States. In 2010, the United States Congress passed into law sweeping health-care reforms (*The Patient Protection and Affordable Care Act of 2010*, or the “Act”) that will significantly impact an insurer’s ability to underwrite and price

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insurance risk. Beginning on September 23, 2010, an insurer cannot terminate coverage for groups or individuals unless that group or individual performs an act or practice that constitutes fraud, or makes an intentional misrepresentation of material fact as prohibited by the terms of the plan. The Act also contains provisions related to guaranteed insurability and guaranteed renewability that come into effect on January 1, 2014. These provisions prohibit insurers from declining insurance coverage to an applicant and from cancelling coverage for any individual or group based on a pre-existing medical condition. An insurer will also be required to renew the policy regardless of changes to the health of the insured. Furthermore, the Act introduces an annual rate review by the states for the individual and group markets which will require justification for “unreasonable” premium increases and may result in constraints on an insurer’s ability to adjust rates to fully reflect risk for certain classes of policyholders.

As an industry, we are still in the process of evaluating the impact of health care reform legislation on our business models and products in the United States. However, at this time, we recommend the final standard(s) clarify that regulatory oversight itself is not considered a restriction that negates an insurer’s ability to re-price to fully reflect risk. Instead, the standard(s) should state that an insurer’s assessment of the ability to re-price to fully reflect risk must be made within the bounds of existing regulatory constraints; i.e., does an insurer have the ability to re-underwrite *within* these parameters?

*Insurers are not required to provide insurance coverage at the portfolio level*

Today, and even with the advent of the Act in the future, an insurer is not required to provide insurance coverage at the portfolio level. If competitive pricing or the effect of market regulation results in an unprofitable portfolio of insurance contracts, a managed care insurer may freely choose to exit a particular market at the end of the current coverage period (generally no more than twelve months). For example, with respect to the federal government’s Medicare program, insurers exit certain markets or products by not renewing their bids with the Centers for Medicare & Medicaid Services (“CMS”) if premium rates are set too low to support margins, key network providers are lost, or other competitors make it difficult to compete on benefits. Although the process is slightly different for other types of health insurance business, the same premise exists. Managed care companies are therefore not locked into long duration contracts and are able to define the contract boundary as the end of the current coverage period.

*Pricing of risk at the portfolio level versus the contract level*

Our business model is based on the assumption and management of insurance risk at a portfolio level. Virtually all decisions to participate in a given market or segment are made at this level rather than at the individual contract level, including: product and contract design, marketing, risk evaluation (except for very large customers), product management and performance evaluation, information systems design, and service administration. We are therefore concerned that the proposed definition of a contract boundary focuses on whether an insurer has the right or practical ability to reassess the risk of a particular policyholder rather than a portfolio of similar risks.

The proposed definition of a portfolio presumes that the appropriate unit of account is an individual insurance contract, which in turn implies that insurance contracts are priced and managed on an

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individual contract basis. However, insurance is predicated on the pooling of similar risks. Pooling enables an insurer to normalize the effect of variability in individual contract behavior by taking a more aggregated approach to pricing and the measurement of expected future cash flows. Similarly, State Insurance Departments also take this aggregated approach when determining rate regulations for different jurisdictions. Even with respect to individual products, premiums are typically determined based on community ratings where the price charged to an insured is derived from a rating that pools together expected risks for a common demographic group in a particular geographic location. Specifically with respect to Medicare, an insurer contracts directly with CMS and receives fixed payments per member based on these community rating assessments. Therefore, an insurer does not have the ability to price at the individual contract level but, when contracting with CMS and other groups subject to community rating, prices *do* reflect risk based on the expected behavior of the insureds that collectively comprise the community group.

Some indemnity products may also be offered with rate guarantees on the amount an insurer can charge in a subsequent coverage period if the insured decides to renew. These guarantees are typically offered for one or two additional coverage years. However, both the insurer and the insured usually have the ability to decline renewal and, therefore, these rate guarantees are not a binding feature that should be considered to extend the term of an in-force insurance contract beyond the contractual period of coverage, irrespective of expected persistency.

Proposed definition of a contract boundary

To address these practical realities of the health insurance industry in the United States, we recommend that the definition of a contract boundary should be modified as follows:

“The boundary of an insurance contract would be the point at which an insurer either:

- a. Is no longer required to provide coverage at a contract or portfolio level, as appropriate; or
- b. Has the right or the practical ability to reassess ~~the risk of the~~ at a portfolio level ~~policyholder~~ and, as a result, can set a price that fully reflects that portfolio level risk, within the bounds of any regulatory restrictions that may impose limitations on the premium rates charged.”

Under the IASB proposals, the determination of contract boundaries clearly impacts whether a preparer should apply the premium allocation method for short duration contracts or the full building block model for long duration contracts. The IASB has defined a short duration contract as one that has a coverage period of approximately twelve months or less and that does not contain any significant embedded options or other derivatives. Based on the factors described above, we are concerned that insurance contracts that are typically priced for a twelve-month coverage period could be deemed to have an effective coverage period of greater than twelve months and therefore be subject to the provisions of the full building block approach rather than the premium allocation method. This outcome would fail to represent the economic substance of most health insurance contracts which have a short coverage period and short claim pay-out tail (i.e., greater than ninety percent of claims are fully settled within three months of incurral and nearly all are fully settled within one year of the expiration of coverage), and should not therefore follow the same accounting model that will be applied (for example) to life insurers.

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**Unbundling and the Interaction with Revenue Recognition Proposals (IASB Question 12 / FASB Question 6)**

*Principle of unbundling*

If a component of an insurance contract is not closely related to the insurance coverage specified in the contract, an insurer would be required to account for that component as if it were a separate contract (i.e., unbundle) in accordance with applicable alternative accounting guidance. The Boards have provided three examples where cash flows may not be closely related to the insurance coverage – including “contractual terms relating to goods and services that are not closely related to the insurance coverage but have been combined in a contract with that coverage for reasons that have no commercial substance<sup>3</sup>.”

We support the proposal that components of a contractual arrangement between an insurer and the policyholder that are not closely related to the insurance coverage should be unbundled. We understand the Boards have debated this topic extensively and struggled to reach a common consensus on how to assess the interdependency of different contractual features with an insurance contract. This difficulty is understandable as we do not believe that it is possible to apply a rigid definition of “closely related” to the wide variety of insurance and insurance related product offerings across, and even within, different sectors of the insurance industry. Therefore, we are supportive of the proposed principles-based (and anti-abuse) definition that implicitly requires insurers to consider the relevant facts and circumstances of each agreement and use judgment to determine whether or not components are closely related to the insurance coverage for the purpose of unbundling.

*Interaction between the insurance contracts proposals and revenue recognition proposals*

The Boards previously considered whether insurance contracts should be included in the scope of their converged proposals for accounting for revenue recognition and concluded that revenue recognition guidance might provide decision-useful information for some insurance contracts but not for all. Therefore, the Boards addressed accounting for insurance contracts in a separate project.

Although insurance contracts are excluded from the scope of the Boards’ proposed accounting for revenue recognition<sup>4</sup>, the interaction of the proposed revenue recognition and insurance contracts models is unclear. As described above, managed care companies provide integrated packages of both insurance coverage and non-insurance services to their customers. We are concerned that that the concept of unbundling works in both directions and may actually imply the need to bundle non-insurance services with insurance coverage. For example, consider the common situation where a managed care company provides administrative claims adjudication services to a self-insured customer (generally large group customers) that may also purchase stop loss insurance from the managed care company to limit their risk above a certain threshold. For purposes of this example, assume that these arrangements are covered in two separate contracts but that they are executed concurrently. Arguably, these two contracts are “closely related” as they cover the same population

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<sup>3</sup> IASB ED paragraph 8(c) (equivalent to FASB DP paragraph 40(c)).

<sup>4</sup> FASB Proposed Accounting Standards Update, *Revenue Recognition (Topic 605): Revenue from Contracts with Customers*, and IASB Exposure Draft, *Revenue from Contracts with Customers*.

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of claims from the insureds. However, we believe it would be inappropriate to bundle these two distinct services and consider the cash flows of the administrative contract in the evaluation of the stop loss insurance contract.

Under the principle of “closely related”, non-insurance services provided to a customer that also purchases insurance coverage could be considered to be closely related to the insurance coverage and therefore require bundling with the insurance fulfillment cash flows under a single insurance accounting model (even if they are in the form of two separate contracts). This possibility could lead to two very different interpretations of the proposals:

1. The revenue (i.e., premium) attributable to insurance services is carved-out from the total transaction price charged under a customer relationship, even if the managed care company is providing an integrated package of health care services to that customer. Accordingly, the contractual premium included in the insurance contract would be subject to the insurance accounting model and the non-insurance transaction price would be subject to the revenue recognition model.
2. Alternatively, in determining which cash flows should be measured as insurance fulfillment cash flows, a preparer should consider whether the cash flows associated with non-insurance services sold to the same customer are closely related to the cash flows of the insurance coverage being provided. Although in the form of two separate contracts, economically both sets of cash flows may need to be considered together. This could result in a conclusion that the non-insurance cash flows should be bundled with the insurance risk and therefore all cash flows subjected to insurance accounting.

We do not believe the second outcome would be appropriate because it would neither reflect our business model or the diversity of the distinctive elements of health care management that we provide to our customers. Nor do we believe it was the Boards’ intention to create such ambiguity. We recommend that the final standard(s) clarify that appropriate judgment should be used to determine when separate components sold to a single customer are closely related and, for accounting purposes, should be grouped together.

#### **Premium Allocation Method (IASB Question 8 / FASB Questions 18-22)**

We support the IASB’s proposal to apply a simplified measurement approach for short duration insurance contracts where the cost of applying some aspects of the proposed full building block accounting model might exceed the benefits. We also agree that, when applicable, a simplified measurement approach should be required rather than permitted because we believe that financial statement users would prefer this comparability. We are, however, concerned with several aspects of the IASB’s proposals related to both the definition and measurement of short duration contracts.

#### **Definition of short duration contracts**

As described above, we believe a simplified approach is best suited to insurance contracts that have predictable pay-out patterns (i.e., relative to long duration contracts, or to other short duration

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contracts where the variability in the timing and amount of cash flows may be significant). The majority of health insurance contracts issued by managed care companies do have predictable pay-out patterns and the vast majority of insurance risk has been extinguished within a few months of the end of the coverage period. We therefore believe that the premium allocation method should apply to most health insurance contracts.

We also agree that the existence of embedded options or other derivatives in a short duration contract that significantly affect the variability of cash flows (after unbundling) would suggest that unearned premium is not a reasonable proxy for the pre-claim liability. However, we are concerned that the proposed definition of a short duration contract is based on a coverage period of “approximately one year or less”. For example, it would not make sense for an insurance contract with an eighteen-month coverage period to be accounted for under a significantly different model than a twelve-month insurance contract that insures a very similar risk. Furthermore, as noted previously, the determination of a twelve-month coverage period is potentially problematic for managed care insurers due to the related issue of contract boundaries.

Instead, we recommend the Boards adopt a principles-based definition of “short duration” that considers the qualitative characteristics of an insurance contract, such as an insurer’s ability to cancel coverage, re-price in a subsequent period, and the pattern of claims incurred during the coverage period (i.e., premium dollars collected early in the coverage period are expected to begin funding claims incurred early in the coverage period, even though ultimate settlement may extend into the post-coverage run-out period).

Accordingly, we recommend that the definition of a short duration contract be revised as follows:

~~“insurance contracts that meet both of the following conditions~~ insurance contracts that provide protection for a fixed period of short duration. In making this determination, each of the following criteria are indicative of a short duration contract:

- ~~a. The coverage period of the insurance contract is approximately one year or less —~~
- a. The insurer has the ability to either cancel the contract or to re-price the premium at the beginning of each contract period (typically annually), at the portfolio level; and/or
- b. The occurrence of insured events are not disproportionately concentrated in the latter portion of the coverage period (even if losses do not immediately attach under the contract); and
- c. The contract does not contain embedded options or other derivatives that significantly affect the variability of cash flows, after unbundling any embedded derivatives.”

#### Measurement of a risk adjustment

Under a dual-margin approach, an insurer would be required to establish an explicit risk adjustment in addition to the expected present value of probability-weighted fulfillment cash flows for the post-claim liability. We agree this adjustment would be necessary under the IASB’s proposed model

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because (1) the probability-weighted cash flows represent an unbiased estimate that is not risk adjusted, and (2) these cash flows are not calibrated to expected premium at inception of the contract via the recognition of a margin (instead, unearned premium is recorded as a proxy for the pre-claim liability). We therefore have the same concerns regarding the measurement of a risk adjustment under the premium allocation method as we do under the full building block model for long duration insurance contracts. Furthermore, the concerns raised in our subsequent comments regarding the use of probability-weighted cash flows also apply (refer to pages 17-18).

The FASB proposal does not address how the premium allocation method is applied to a post claim period liability (i.e., with or without recognition of a composite margin). The post-claim period liability would need to reflect some measurement of risk in addition to the unbiased estimate of future probability-weighted fulfillment cash flows. However, because the proposed composite approach does not recognize the need for an explicit risk adjustment, it is unclear in practice how risk would be reflected in the post-claim liability in the FASB proposal.

We believe these issues would be mitigated, as described above, if the post-claim liability were instead established using an actuarial mean estimate that implicitly reflected risk in the measurement of future expected cash flows.

#### *Pattern for recognizing the pre-claim liability in earnings*

We agree with the proposals to recognize the pre-claim obligation in earnings over the coverage period (and not over a combination of the coverage period and claim run-out period). This will result in an accounting outcome that fully earns premiums, and fully recovers acquisition costs, by the end of the coverage period. The only liability remaining at the end of the coverage period would be the estimated future claims liability which, in accordance with actuarial standards of practice, is expected to be adequate to cover claim experience during the run-out period under moderately adverse conditions.

#### *Discounting*

Our comments addressing the principle of discounting and the characteristics of the discount rate apply equally to the premium allocation method (refer to pages 22-24).

#### *Treatment of acquisition costs*

We support the IASB's proposed approach of deferring acquisition costs at the inception of an insurance contract, consistent with an insurer's objective to fully recover acquisition costs in pricing an insurance portfolio. Our comments regarding the measurement of incremental acquisition costs at the portfolio level (rather than the contract level), and the inclusion of certain non-incremental acquisition costs, apply equally to the premium allocation method (refer to pages 24-25).

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*An onerous “contract” test should be performed at a portfolio level*

We agree that a test is necessary to ensure that the unrecognized future contractual premiums are adequate relative to expected claims obligations. We also agree this test should be performed on a portfolio level rather than an individual contract level.

The proposals do not describe the circumstances or the manner in which this test would be applied. However, this concept is well understood by insurers and is a component of the current short duration accounting model under U.S. GAAP. We recommend that an insurer be required to perform an onerous portfolio test if qualitative factors indicate that the subject premium (plus expected investment income if determined to be significant by an insurer) may not be adequate to cover expected future claim liabilities and related expenses.

**2. Other Important Proposals for Comment – Detailed Comments**

*Probability-weighted Cash Flows (IASB Question 2 / FASB Question 7)*

*Principle of probability-weighted cash flows versus an actuarial mean estimate approach*

The Boards’ proposals explicitly reject the concept of developing an actuarial “best-estimate”<sup>5</sup>. Instead, the use of probability-weighted estimates suggests that the proposals will require an insurer to develop multiple scenarios that reflect a “full range of possible outcomes”, with each scenario specifying the amount and timing of the cash flows, and the estimated probability of that outcome. The discounted weighted-average of these outcomes creates an expected present value estimate of future cash flows used to establish the first building block under both the FASB and IASB models. The language contained in the IASB ED is confusing at best<sup>6</sup>, although, if read in context implies that an insurer does not have to perform exhaustive stochastic simulations of probability-weighted cash flows if a more simplified range of possible scenarios provides an answer within a tolerable range of precision<sup>7</sup>.

We do not believe that the use of explicitly defined scenarios and probability-weighted cash flows to derive an estimate of the expected cash flows of an insurance contract is necessarily superior to, or more reliable than, standard actuarial methods used by managed care companies today. These standard actuarial methods incorporate numerous inputs, including historical payment patterns, health care trends, seasonality, health service utilization levels, large claims, provider costs, benefit structures, and policyholder risk profiles and behavior; each of which has a range of possible outcomes. An actuary considers the results of these inputs to determine the expected value of the company’s liabilities. Based on human nature and the inherent tendency to develop a prudent and

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<sup>5</sup> IASB ED paragraph B38.

<sup>6</sup> IASB ED Paragraph B39 states: “When considering all possible scenarios, the objective is not necessarily to identify every possible scenario but rather to incorporate all relevant information and not simply ignore data or information that is difficult to obtain.”

<sup>7</sup> However, periodic stochastic modeling may be necessary to demonstrate that consideration of a smaller range of scenarios does in fact produce a tolerable level of precision.

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conservative estimate, a certain amount of risk is implicitly factored into this approach and the resulting liability estimate. In addition, because conditions in the future may differ from observed historical patterns, actuarial judgment is a critical component of developing actuarially sound liability estimates. Therefore, existing actuarial standards in the health insurance industry recognize the potential for variability of the ultimate outcomes by requiring the estimated future claims liability to be adequate under moderately adverse conditions.

While today's standard actuarial methods inherently consider multiple outcomes of each input, the application of such a rigid weighting or averaging approach (as indicated by a literal reading of the probability-weighted cash flow method currently described in the proposals) would significantly increase the measurement cost of estimating expected future cash flows arguably without providing for a more accurate estimate. The need to perform even a limited number of probability-weighted scenario analyses for each portfolio of insurance contracts would be an extremely labor intensive exercise that would require significant time and resources to implement and maintain without deriving any significant benefit. We assert that current estimation processes satisfy the intent of the Boards' proposals - that is, they result in a reliable estimate of the expected value of the relevant insurance obligations, although they do not meet a literal application of a prescribed set of scenarios and corresponding probabilities.

Accordingly, we recommend that the final standard should not mandate the use of a particular method. Nevertheless, we believe that an estimate of expected cash flows should consider a reasonable range of potential outcomes, and the cash flows associated with those outcomes, without explicitly requiring a specific set of defined scenarios with probabilities assigned to each. The manner in which an actuary applies this principle should be based on accepted actuarial standards and practices.

*Benefit versus cost considerations of modeling multiple scenarios*

We also note that if an insurer were to model "all possible scenarios" (even if this were theoretically possible), this could have an impact on the de-recognition of insurance contracts by extending the estimates of incurred but not reported claims to reflect extreme tail risk – even though the probabilities assigned to such outcomes for a managed care company would be extremely small. Insurers could therefore be left with small residual liabilities on each portfolio for a period that extends far beyond the typical claim run-out period even though no significant risk of incurring additional claim payments remains.

*FASB Composite Margin versus IASB Dual-margin Approach (IASB Question 4 / FASB Question 15)*

*Relative merits of the differing approaches*

The IASB's proposal requires an insurer to establish an explicit risk adjustment for each portfolio of insurance contracts, and a residual margin that calibrates the present value of expected future cash flows and the risk adjustment to expected premiums at inception of the contract ("the dual-margin approach"). The FASB's proposal does not require recognition of an explicit risk

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adjustment and instead treat the difference between the present value of future fulfillment cash inflows and outflows as a single composite margin.

While we understand the perceived merit of separately measuring an explicit risk adjustment (representing variability in the amount and timing of future cash flows) from a residual margin (expected deferred profit), we believe an explicit risk adjustment can create a false sense of precision in the measurement of fulfillment cash flows. Even if companies were to apply the same techniques to similar risk portfolios, it is likely they would generate significantly different measurement outcomes based on the proposed definition of a risk adjustment. Also, as discussed in the previous section of this letter addressing “probability-weighted cash flows, health insurance actuaries currently determine required reserve levels using a two-step approach. The first step involves determining an actuarial estimate by evaluating numerous factors, all of which may include some level of recognition of risk inherent in the estimation process. The resulting actuarial estimate would likely vary when performed by two or more actuaries with the same data set. The second step then explicitly adds an additional risk margin by including a provision to ensure that the estimated future claim liability is expected to be adequate under moderately adverse conditions. As a result, while the ultimate reserves established under this methodology might be reasonably similar between different actuaries, the components may be dissimilar. Under the dual-margin approach, this widely-accepted methodology would result in the disclosure of different risk margins between the two or more actuaries in this hypothetical scenario. We do not believe that this results in a decision-useful outcome for the users of our financial statements.

Accordingly, at best, the distinction between a risk adjustment and a residual margin is highly subjective. Furthermore, because the risk adjustment and residual margin are recognized in earnings using two different patterns, we are concerned this may encourage accounting arbitrage in the measurement of these two distinct margins to artificially achieve desired earnings results.

We believe the objective of a risk adjustment is adequately addressed by existing actuarial practice in the United States for health insurance contracts. The actuarial mean estimate of an insurance liability (described in detail above) considers multiple inputs and scenarios that reflect expected uncertainty and judgments regarding the emergence of future claim experience. Furthermore, these estimates are supplemented by a provision to ensure that the estimated future claim liability is expected to be adequate under moderately adverse conditions (and the IASB implicitly acknowledges the need for such an adjustment<sup>8</sup>). An explicit risk adjustment would attempt to unnecessarily extract and combine these different attributes of actuarial judgment into a single measurement amount.

Although the concept of a risk adjustment is therefore embedded in the measurement of insurance liabilities under many existing actuarial estimate approaches commonly used in the health insurance industry, we do not believe any attempt to separate an explicit risk component from other elements of an actuarial estimate (based on the requirements of an accounting standard rather than actuarial standards) would be meaningful and could in some cases even be misleading.

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<sup>8</sup> IASB paragraph BC146 states “if significant changes in estimates are made during the coverage period of a short duration contract, those changes are more likely to be unfavorable (that is, leading to losses) than favorable (that is, leading to gains).”

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Instead, we believe it is important to articulate to financial statement users that insurance liabilities have been determined using currently accepted actuarial methods, consistently applied from period to period. Indeed, existing case law in the United States typically supports the principle that specific methods for measuring insurance liabilities should not be imposed on the actuarial profession, and instead an actuary should be permitted to follow accepted actuarial methods and principles. As described above, current standard actuarial methods do not establish explicit risk adjustments in a prescriptive uniform manner, and to create such a measurement attribute for financial reporting purposes would therefore be an arbitrary exercise that misrepresents the manner in which insurance liabilities are determined in practice by the actuarial profession.

Furthermore, under the proposed disclosure requirements, users will be able to analyze historical loss development tables to develop their own judgments and expectations regarding the amount of risk assumed by an insurer. Although future losses may develop differently from historical patterns, the use of historical data and trends is fundamentally consistent with the manner in which actuaries determine insurance liabilities.

Accordingly, we recommend an approach that reflects the fact that some level of risk is implicitly recognized and remeasured in the actuarial mean estimate of future fulfillment cash flows. Therefore, in a calibration model, any difference between the estimated fulfillment cash outflows and inflows would represent a residual margin (distinct from cash flows deemed to be at risk from actuarial estimates) which should be recognized in earnings over the coverage period.

*Interest should not be accreted on either a composite margin or risk adjustment for short duration contracts*

We agree that interest should not be accreted on either a composite margin or a residual margin for short duration contracts. Because both margins represent an estimate of future deferred profit at inception relative to initial pricing assumptions, we do not believe this amount should change due to variability in the discount rate used to measure the underlying fulfillment cash flows over a short period. Neither a composite or residual margin generates cash flows, and therefore accreting interest on a non-cash item creates misleading and irrelevant volatility in earnings. Alternatively, for long duration contracts, these margins should accrete interest since they are determined based on a present value of future cash flows - otherwise true profits over time would be understated.

*Observations Specifically Related to the Proposed IASB Risk Adjustment (IASB Question 5 / FASB Questions 8-10)*

If the Boards ultimately decide to adopt an approach that requires an explicit risk adjustment (which we do not support), we have several concerns related to both the definition and calculation of the risk adjustment.

*The proposed definition of a risk adjustment does not clearly articulate the IASB's objective*

A risk adjustment is currently defined on a principles basis as "the maximum amount that the insurer rationally would pay to be relieved of the risk that the ultimate fulfillment cash flows

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exceed those expected". This definition is difficult to understand and, instead of following a fulfillment approach, appears to mix the concept of entity specific assumptions with the concept of an exit value measurement (which the IASB appropriately rejected after deliberation of their 2007 Discussion Paper). When an insurer establishes a premium rate for a particular portfolio of insurance risk it does so based on an entry level assessment of risk, not an exit value approach. An exit value measurement is hypothetical because it is dependent on another market participant's assessment of risk, not the insurer's. For example, the price at which a reinsurer would assume risk from a direct insurer is dependent on that reinsurer's risk appetite and ability to manage assumed risk on a portfolio basis, irrespective of the direct insurer's assessment of risk. However, an entry level approach *is* consistent with the concept of fulfilling relevant insurance cash flows

Furthermore, it is not clear how any of the techniques specified by the IASB for calculating a risk adjustment relate to the proposed definitional principle of a risk adjustment.

If the objective of an explicit risk adjustment is in substance to reflect the variability of fulfillment cash flows (and therefore to indicate the amount of expected future profits potentially at risk from adverse development due to that variability), we recommend instead that the risk adjustment be defined similar to a provision for adverse deviation. This would also be consistent with the current definitional objective of measuring the risk that ultimate fulfillment cash flows *exceed* those expected.

Accordingly, we recommend that the definition of a risk adjustment should be replaced as follows:

~~"The maximum amount that an insurer would rationally pay to be relieved of the risk that the ultimate fulfillment cash flows exceed those expected."~~

The present value of the amount of consideration an insurer would require to assume the risk of potential adverse variability in the development of future cash flows for a portfolio of insurance contracts".

*Insurers should not be limited to only three possible techniques for measuring a risk adjustment*

We do not believe it is appropriate to limit a preparer to only three prescriptive techniques (i.e., confidence interval, continuous tail expectation ("CTE") or economic cost of capital). This seems contradictory to the Boards' objective of establishing a principles-based definition. It also blurs the line between accounting rules and actuarial professional standards; accounting rules should not prescribe the methods a qualified actuarial professional should be permitted to use in measuring the risk associated with an insurance contract. We recommend that the final standard(s) explicitly permit a preparer's actuarial professionals to select a technique for determining the risk adjustment that best reflects the characteristics of the portfolio of insurance contracts being measured, in accordance with accepted actuarial techniques permitted in that jurisdiction. Although this outcome might hinder comparability between different companies it is preferable to measuring portfolios using a "three sizes fits all" approach. The reasons for selecting alternative techniques would also be explained under the proposed disclosure requirements addressing measurement inputs and assumptions.

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The proposals do not contain any guidance on the level of precision required when applying a confidence level technique. While we believe it is appropriate *not* to prescribe an expected level of precision in an accounting standard, this omission highlights the fundamental weakness in proposing a confidence level technique because it is a statistical measure that is not directly linked to the cost of fulfilling the insurance cash flows.

Furthermore, each of the prescribed techniques will generate different outcomes as economic circumstances change. For example, a cost of capital approach is directly linked to pricing, whereas a confidence level approach will remain unaffected by changes in pricing trends.

*Adverse changes in the risk adjustment should first deplete any remaining residual margin before being recognized in earnings*

If the Boards were to select a dual-margin approach (which we do not support), we do not agree with the proposals to reflect changes in these margins in earnings independently of each other. For example, consider a portfolio of insurance contracts that is being remeasured at period-end. The residual margin represents expected deferred profit under the contract and is therefore always accretive to earnings and amortized using a fixed pattern. At the same time, the insurer may determine that the portfolio of insurance risk is developing adversely relative to initial pricing assumptions and decide to increase the amount of the risk adjustment. This increase in the risk adjustment would be reflected as an expense in current period earnings. It seems counter-intuitive to recognize income from one margin and expense from the other in the same financial reporting period. Instead, we recommend that any remeasurement that increases the amount of the risk adjustment should first be offset against any remaining residual margin. Only if the residual margin is fully depleted should an increase in the risk adjustment be recorded immediately in earnings. Because the residual margin is fully amortized by the end of the coverage period, any increase in the risk adjustment during the run-out claim period would still be reflected in earnings. This recommended alternative approach properly reflects the fact that no further premiums are due and the insurer's earnings are directly at risk from any further adverse claim experience.

*Amortization of the residual margin*

We agree with the proposal to release a residual margin over the coverage period in a systematic manner based on the passage of time, unless the pattern of claims and benefits makes another pattern more appropriate. In a dual-margin approach, the risk of variability of future cash flows is addressed by the creation of an explicit risk adjustment and, therefore, it would not be necessary to extend the release of the residual margin into the post-coverage run-out period.

*Discount Rate (IASB Question 3 / FASB Question 12)*

*Principle of discounting*

We support the principle of discounting the fulfillment cash flows of an insurance contract, to the extent the effect of discounting is material. However, in practice, we would not expect the effect of discounting to be material for the majority of insurance products issued by managed care

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companies. Premiums are collected on a monthly basis, claim liabilities do not have a significant incurred but not reported component (compared to many other insurance products), and claim obligations are materially fully settled within one year of the expiration of coverage. For these reasons, managed care companies would not apply discounting to the vast majority of short duration contracts, and would not even establish systems or processes to demonstrate that the effect of discounting is self evidently immaterial (other than in periods of severely high interest rates). Accounting standards are intended only to apply to material items and preparers do not systematically track why items are *not* included in their financial statements due to immateriality.

Accordingly, we would also not expect a liquidity adjustment to be significant relative to the risk-free yield curve used to measure the fulfillment cash flows. Therefore, while we support the theory of discounting, we would not in practice expect to apply discounting to the majority of our insurance contracts. Furthermore, the cost of monitoring the potential magnitude of discounting (in order to demonstrate whether or not the effect of discounting was material) would impose an additional administrative burden for managed care companies.

#### Characteristics of the discount rate

Although we support the principle of discounting (if material), we do not agree with the proposal to discount fulfillment cash flows using a risk free rate plus an adjustment for liquidity. We believe the discount rate for insurance liabilities should reflect the actual invested assets supporting those liabilities, for the following reasons:

- In pricing insurance risk, an insurer may consider a discount rate that contemplates the expected investment return, quality of invested assets, and the nature of the insurance liabilities assumed. If the fulfillment cash flows are discounted using a risk free yield curve adjusted for liquidity this will create an accounting mismatch in earnings relative to the rate of return earned on the assets invested to support the expected future pay-out of claim liabilities. This mismatch exists under both the FASB's proposal<sup>9</sup> for accounting for financial instruments and IFRS 9, *Financial Instruments*. However, the mismatch will likely be greater under the FASB model which establishes fair value measurement through earnings as the default basis for measuring financial instruments. Recognizing a mismatch in earnings does not faithfully represent the insurance business model of investing premium collected during the coverage period to support pay-out of future losses, cover maintenance costs and to earn a profit margin on the portfolio. This mismatch would also create volatility and a period-over-period distortion in earnings that does not reflect the insurance risk being measured.
- Using a risk free-rate or a rate adjusted for liquidity that is inconsistent with the expected rates of return on the assets that will be invested and were assumed in pricing could force companies to report losses in certain periods on contracts that are ultimately expected to generate profits. Conceptually this is counter-intuitive and would make growing companies appear less profitable, while making companies with declining market share appear more

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<sup>9</sup> FASB Exposure Draft, *Accounting for Financial Instruments and Revisions to the Accounting for Derivative Instruments and Hedging Activities*.

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profitable. The pattern of earnings under this scenario would therefore be misleading to financial statement users.

- Another party would assume a liability from an insurer only if it received either the appropriate level of cash such that it would be invested in assets that yielded a return at least as great as that used in the liability valuation, or the actual assets currently backing the liabilities if deemed adequate. This would be true under any basis of accounting and therefore demonstrates the dependency between asset and liability matching that is integral to an insurer's business model.
- The proposals do not provide any guidance on how an insurer would be required to determine a liquidity adjustment and there does not appear to be any consensus or accepted practice amongst the actuarial profession on how to consistently measure a liquidity adjustment. Too much subjectivity will be involved in determining the liquidity adjustment and practices will vary widely from company to company – even for similar insurance risks.

We recommend that the discount rate applied to fulfillment cash flows should be determined by a company's actuarial professionals based on the characteristics of the assets supporting the expected insurance liabilities. This principle is widely accepted and understood by our financial statement users and best depicts the economic reality of the insurance business model.

#### *Non-performance risk*

We do not believe that an adjustment for non-performance should be applied to the risk-free yield curve. Although this would help to partially mitigate the accounting mismatch created between the measurement of invested assets (which reflects credit spreads) and insurance fulfillment cash flows (which do not), an insurer's own credit risk does not directly affect the amount an insurer is obligated to pay a policyholder upon the occurrence of an insured event. Insurance companies are subject to strict regulatory capital requirements and, in the United States, are required to pay into various state administered guaranty funds designed to protect policyholders in the event of an insurer's insolvency. These alternative mechanisms therefore exist to mitigate the risk of insurer non-performance and largely negate the need for any explicit measurement of non-performance risk in valuation of fulfillment cash flows. Furthermore, in keeping with the general principles set out by the Boards, any adjustment for non-performance risk would presumably need to reflect the characteristic of the portfolio being measured, rather than the credit risk of the insurer itself. The determination of non-performance risk for a particular portfolio would therefore be highly subjective and speculative.

#### *Acquisition Costs (IASB Question 7 / FASB Questions 13-14)*

We agree that incremental acquisition costs should be included in the initial measurement of an insurance contract's fulfillment cash flows. This treatment will appropriately reduce the FASB composite margin (or the IASB residual margin) and reflect the manner in which an insurer prices business to fully recover acquisition costs through future premiums.

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However, we do not agree that all other acquisition costs (i.e., non-incremental acquisition costs) should be recognized as an expense. The Boards' proposals specify that estimated cash flows include all cash flows incremental at the portfolio level and that cash outflows include direct costs and systematic allocations of costs that relate directly to the insurance contract or contract activities. The limitation for incremental acquisition costs to be identified at the level of an individual contract is inconsistent with:

- The general principle of accounting for relevant fulfillment cash flows at the portfolio level; and
- The actual business model of insurance entities to aggregate risk into portfolios for pricing, servicing and assessing performance.

As indicated by the IASB, insurance entities will acquire or renew contracts using a variety of sales structures depending on the various products and markets being accessed. Managed care companies have traditionally used internal sales forces and external brokers to acquire business in the United States because of the employer-centric health care market, while many international markets are increasingly accessed using telemarketing and direct marketing sales channels for various products. The costs incurred in each of these sales structures are considered in pricing health care and other insurance contracts, relate directly to contract activities, and can be systematically allocated at the portfolio level.

For example, an internal sales force may be paid incentive compensation that is incremental at the policy level or at the portfolio level. In either case, the costs should be included in estimated cash outflows by specific identification or by a systematic allocation. Such a systematic allocation could be based on time spent on successful efforts. Sales or telemarketing salaries and benefits are contract activities that can also be systematically allocated to estimated cash outflows on a similar basis. These costs should be treated consistently with similar internal costs of processing claim payments or policy administration and maintenance that must be included in estimating cash outflows under the proposals<sup>10</sup>.

In addition, the FASB has established guidance in U.S. GAAP for the costs of direct response advertising in the FASB's ASC Topic 340-20, *Capitalized Advertising Costs*, and recently the FASB's Emerging Issues Task Force has clarified guidance about accounting for the costs of acquiring and renewing insurance contracts to indicate that such costs should not be charged to expense as incurred<sup>11</sup>. We believe that direct response advertising costs can be directly related to the acquisition or renewal of insurance contracts and should not be expensed under the proposals. The guidance of ASC Topic 340-20 provides for the capitalization of direct response advertising costs if they can be shown to have elicited sales to customers who are documented as having responded to specific advertising and such advertising results in probable future benefits. This guidance recognizes that an entity conducts such marketing with the expectation of future economic benefits and, that if such benefits are demonstrated with persuasive verifiable evidence, the related costs should be capitalized. Because such advertising costs can be shown to result in future insurance margins sufficient to recover the costs, they should not be expensed as incurred.

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<sup>10</sup> IASB ED paragraphs B61(c) and (g).

<sup>11</sup> FASB ASU 2010-26, *Financial Services - Insurance (Topic 944): Accounting for Costs Associated with Acquiring or Renewing Insurance Contracts*.

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**Level of Aggregation (IASB Questions 5-6)**

**A principles-based approach provides insurers with reasonable and necessary flexibility to determine portfolios of insurance contracts**

Under the FASB proposals, individual insurance contracts are aggregated into portfolios for the purpose of measuring the composite margin. These portfolios are sub-divided into groups of insurance contracts with a similar date of inception and coverage period (referred to as cohorts). Under the IASB proposals, individual insurance contracts are aggregated into portfolios for the purpose of measuring the risk adjustment and the residual margin (and the residual margin is subdivided into cohorts). The Boards share a common definition of “portfolio”; namely a group of contracts that are subject to similar risks and managed together as a single pool. The IASB acknowledges in their Basis for Conclusions “that this description of a portfolio is not fully rigorous, but it believes that a more rigorous definition is not attainable and that this description will provide information that is relevant to users and faithfully represents the extent of risk, at a reasonable cost.”

We agree with a principles-based definition of a portfolio that allows an insurer to define a portfolio in a manner that most faithfully depicts the aggregation of broadly homogenous risks. In practice, insurers assess and price for risk based on a number of different criteria including product features, demographic characteristics and geographic location – each of which may have a meaningful impact on the pooling of risk and are likely to be specific to the particular risks assumed by each insurer. However, because the Boards’ proposed definition is so broad, we are concerned it could lead to abusive interpretation because at the extremes it may encourage the aggregation of risks that are in fact sufficiently different that they should be measured in separate portfolios. This issue could be mitigated if insurers were permitted to explicitly recognize diversification benefit between portfolios<sup>12</sup>. However, we acknowledge this determination is subjective and could therefore create additional discrepancies in the measurement of insurance liabilities between preparers.

As an alternative, we recommend that the definition of a portfolio should be modified in a manner consistent with the existing U.S. GAAP requirements that an insurer must follow in assessing whether or not a premium deficiency exists<sup>13</sup>. Although subjectivity also exists in this definition, we believe it more clearly articulates the Boards’ objectives, is widely understood by financial statement preparers and users, and permits a practical degree of flexibility. Furthermore, this definition closely aligns with the explicit requirement to perform an onerous contracts test under the IASB’s premium allocation method.

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<sup>12</sup> Under the proposals, diversification benefit can only be achieved within individual portfolios (IASB ED paragraph 36, FASB DP paragraph 66).

<sup>13</sup> FASB ASC Topic 944-60-25-25-3 states “insurance contracts shall be grouped consistent with the enterprise's manner of acquiring, servicing, and measuring the profitability of its insurance contracts to determine if a premium deficiency exists”.

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Proposed definition of a portfolio

Accordingly, we recommend that the definition of a portfolio of insurance contracts should be modified as follows:

“Insurance contracts that are subject to broadly similar risks and managed together as a single pool, consistent with the **insurer’s enterprise’s** manner of acquiring, servicing, and measuring the profitability of its insurance contracts”.

The fundamental objective of a fulfillment model for insurance contracts is to consider all incremental cash inflows and cash outflows arising from that portfolio<sup>14</sup>. As previously noted, however, the definition of incremental acquisition costs to be included in the measurement of fulfillment cash flows is determined at the individual contract level. We believe that fulfillment cash flows should be measured on a consistent basis throughout the proposed insurance model (i.e., at the portfolio level) and do not believe that any individual fulfillment cash flows should be measured at a more granular level that necessarily ignores the insurer's business model of managing those cash flows on a pooled basis. We therefore recommend that all fulfillment cash flows should be measured at the portfolio level.

Recognition

Insurance contracts should not be recognized in earnings before the effective coverage date because the insurer is not yet exposed to possible claim incidence during the pre-coverage period

We understand that the Boards’ proposals are intended to recognize and remeasure insurance risk in the pre-coverage period for insurance contracts that may be exposed to significant volatility or catastrophe risk during this pre-coverage period (for example, a property insurer exposed to imminent hurricane losses based on a developing storm that will impact policyholders for which coverage has been accepted but has not yet incepted). The managed care industry is not typically characterized by catastrophe risk. While our claim occurrence varies by product, demographic group and geographic location, such risks are generally stable at their respective portfolio levels relative to initial pricing assumptions.

As previously described, we believe that health care insurance contracts should be accounted for as short duration contracts using the premium allocation method. The Boards’ proposals do not explicitly address the accounting for a short duration contract during the pre-coverage period, but we presume that an insurer would not typically be required to record a pre-claim liability during the pre-coverage period<sup>15</sup>. However, in principle, we disagree with proposals to initially recognize an insurance contract in an insurer’s earnings prior to the commencement of the coverage period under any proposed accounting approach (unless the portfolio is onerous). This proposal will have a

<sup>14</sup> FASB DP paragraph 57 and IASB ED paragraph 23.

<sup>15</sup> i.e., the insurer has a pre-claims obligation (used to assess premium adequacy) but does not have a pre-claim liability until cash has actually been received from the policyholder.

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significant impact on managed care companies because of the long enrollment period associated with many health insurance products. Insurance contracts that are typically priced for a twelve-month period would be recognized several months before the effective commencement date of that coverage. Although an insurer is bound by a stand-ready obligation to provide coverage at some point in time before coverage actually begins, the insurer is not performing under that contract during the pre-coverage period – i.e., claims cannot be incurred under the insurance contract. Indeed, the possibility of recognizing earnings in the pre-coverage period would be akin to the concept of recognizing a day-one gain at contract inception, which the Boards have appropriately rejected. In addition, an insured is typically able to cancel an insurance contract prior to the commencement of coverage and having to unwind the accounting results for a contract that has not yet inception simply adds unnecessary complexity for financial statement preparers and unnecessary confusion for financial statement users.

Consider, for example, an insurance contract with a twelve-month coverage period and an effective coverage date of January 1, 20X1 that is initially recognized in the accounting records when the insurer has finalized terms with an insured on November 30, 20X0. Assuming the insurer has a December 31 year-end, remeasurement of the insurance contract during the month of December 20X0 will generate income or expense in the 20X0 financial statements for a contract that does not in fact provide coverage until the subsequent fiscal year. This outcome misrepresents the substance of the insurance coverage being provided by effectively requiring an insurer to re-underwrite during the pre-coverage period and to reflect any differences from initial pricing assumptions in earnings, even though by definition no claims data is yet available to support this assessment. Any profits recognized during the pre-coverage period would be available for distribution from retained earnings even though the insurer has not yet performed any services to the insured under the contracts.

Furthermore, if managed care contracts did not qualify for the simplified premium allocation method, it would be extremely difficult to apply the Boards' proposed recognition approach. The open enrollment period may span several months before the effective coverage date. During this time, prospective members evaluate whether or not to accept coverage and, in many instances, the insurer will not have an accurate estimate of the number of insureds until coverage has begun. The insurer, in some cases, has the ability to adjust the price of the contract depending on the volume of members that have actually accepted coverage (using pre-determined pricing corridors). Therefore, (1) no obvious point exists to determine the timing of initial recognition during the pre-coverage period because enrollment is a fluid process, and (2) the price charged for providing insurance coverage is neither fixed nor readily determinable until enrollment data has been substantially finalized.

The proposals also present further significant operational challenges. Policy administration systems are designed to record the effective date of coverage, but typically do not record the date on which an insurer is contractually obliged to provide insurance coverage and does not have the ability to re-price to fully reflect risk. Modifying systems and processes to capture this data would be an expensive and time consuming exercise in order to achieve an outcome that we believe is conceptually flawed and that does not provide additional benefit to financial statement users, particularly in the managed care industry where, during the pre-coverage period, insurers are not typically subject to significant volatility in the nature of the risks insured.

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We therefore recommend that the fulfillment cash flows of an insurance contract should initially be recognized in earnings from the effective date of coverage, and not before, consistent with current practice under U.S. GAAP. Accordingly, it would be appropriate to defer acquisition costs incurred in advance of the coverage period and amortize these in earnings over the coverage period.

**Financial Statement Presentation (IASB Question 13 / FASB Questions 28-30)**

Under the full building block model proposed for long duration insurance contracts that do not qualify for the simplified premium allocation method (in the IASB proposal), an insurer's income statement will present the earning of insurance margins (under either a composite margin or dual-margin approach), the effect of discounting fulfillment cash flows, claim experience, and changes in future risk estimates. The emphasis on insurance margins is fundamentally different to the volume-based metrics of earned premium and incurred claims that currently underpin investors and other users' analysis of our business. Insurance premiums are instead essentially treated as deposits received from the insured, resulting in a net presentation of the income statement for both revenue and expense.

While this approach may have merit for spread-based insurance products, we do not believe it provides more decision-useful information compared to the existing U.S. GAAP presentation for traditional indemnity products with a short period premium collection period and a short pay-out tail. We believe that a gross premiums and claims expense based presentation best represents the substance of health insurance contracts. Subject to our concerns regarding contract boundaries, we expect that the majority of health insurance products would be treated as short duration contracts and therefore subject to the simplified premium allocation method which retains a presentation based on premiums and claims expenses. However, if health insurance contracts were determined to be long duration products, we would object to their presentation using a margin approach because this would result in the performance of such contracts being presented on the same basis as much longer duration insurance products such as those containing life contingent risk. Clearly these products are structured, priced and managed in a fundamentally different manner to health care products.

From a practical perspective, we are also concerned that a presentation approach based on the earning of various insurance margins will be confusing to financial statement users and will not be widely understood. To the extent that investors and other financial statement users do perceive value in reviewing margin information, we believe this data should be included as supplemental footnote disclosure rather than contained in the primary financial statements.

**Transition Methods (IASB Question 17)**

The proposed IASB approach requires an insurer to measure each portfolio of in-force business at the transition date using the probability-weighted cash flow building block and a risk adjustment. Any difference between this amount and the net amount of that insurance liability measured in accordance with current GAAP would be recognized as an adjustment to retained earnings at the transition date. We disagree with this proposed transition approach for the following reasons.

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*Immediate recognition of expected future profits does not reflect an insurer's ongoing exposure to risk for in-force portfolios*

Although a risk adjustment is established at transition to reflect variability in the timing and amount of future cash flows on the in-force business, a residual margin is not established. Accordingly, some portion of the unrealized profits embedded in in-force portfolios at the transition date would be fully recognized in retained earnings<sup>16</sup>. Assuming that the risk adjustment for managed care companies is small (because cash flows are typically more predictable than many other types of insurance contracts, and the run-out period is shorter), a majority of these embedded profits would be recognized immediately - even though an insurer has not yet fully performed under the insurance contract.

This outcome not only potentially overstates the profitability of in-force portfolios at the transition date but also distorts the future earnings pattern of in-force business relative to new business written (for which a residual margin is established). Furthermore, by recognizing all transition differences in retained earnings, an insurer is prevented from recognizing expected future profits in subsequent periods as coverage is provided and claims are run-out.

We recommend that any positive difference calculated at transition for a portfolio of insurance contracts (i.e., the present value of future expected cash inflows exceeds the present value of future expected cash outflows) should be recognized as a transition margin. This margin should be amortized into income using a pattern that most faithfully depicts the timing of expected future cash flows over a combination of any remaining coverage period and the claim run-out period.

We understand that the Boards previously rejected a similar approach proposed by their Staff. However, that proposal would have required a negative transition difference to be recognized in retained earnings only if the aggregate difference for the whole entity were negative (i.e., positive differences would offset any negative differences across portfolios). The Board appropriately rejected the concept of netting positive and negative differences between different portfolios. However, we propose that the measurement of a positive transition margin or negative adjustment to retained earnings should occur on a portfolio-by-portfolio basis. We believe this would satisfy the Boards' concerns regarding netting and result in a margin for in-force business that is more consistent with the approach required for new business.

*Practical constraints of full retrospective adoption*

From a practical perspective, full retrospective adoption of either the IASB or the FASB proposals will pose tremendous systems, process, and resource challenges for insurers. The data required to calculate retrospective measurements will not be available in many cases because it differs so significantly from current data requirements. For example, probability-weighted cash flow scenarios would need to be modeled, liquidity adjustments developed, and (under the IASB model) explicit risk adjustments calculated. This is not only an extremely time consuming effort, but is rendered somewhat ineffective because an insurer clearly has the benefit of hindsight and it would

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<sup>16</sup> Although the FASB has not explicitly addressed the subject of transition in their DP, the FASB tentatively agreed at the joint Board meeting on June 1, 2010 that a risk adjustment should be measured for in-force business at the transition date, even under a composite margin approach.

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be difficult in practice to avoid reflecting this knowledge in retrospective measurement assumptions.

The IASB's proposed transition method does not explicitly address how transition would be accomplished for portfolios of short duration contracts that would be measured in accordance with the premium allocation method. Our comments apply equally to portfolios of insurance contracts accounted for using either the full building block approach or the premium allocation method.

### **Scope Implications for Capitation Agreements (IASB Question 11 / FASB Question 3)**

#### **Use of capitation arrangements in the managed care industry**

Managed care companies typically compensate providers of medical care services (physicians, hospitals, and others) on either a capitated or fee-for-service basis. Insurers often enter into capitation arrangements with providers as a way of incentivizing them to provide cost effective treatments to insureds. In a capitation agreement, a provider agrees to assume the cost of care for a specific group of patients insured by the managed care company. The insurer pays a set amount to the provider on a per member per month basis, which does not increase or decrease with the actual amount of health care provided to a patient. This differs from fee-for-service arrangements where the amount paid to a provider varies in accordance with the level of health care provided.

#### **The primary purpose of capitation agreements is the provision of medical care services**

Although the proposals contain a scope exemption for fixed-fee service contracts, we are concerned that the Boards' definition of insurance contracts could be interpreted as being applicable to capitation agreements, resulting in those agreements being accounted for by managed care companies as reinsurance. Specifically, although the amount paid on a per member per month basis is fixed, the total payment varies based on the number of members covered each month. Therefore, it is not clear if these contracts are determined to be "fixed-fee" under the proposals. Additionally, paragraph 28(e) of the FASB DP<sup>17</sup> states "an insurer would apply the proposed guidance to insurance contracts in which the insurer provides goods or services to the policyholder to compensate the policyholder for insured events." Because the definition of an "insurer" is expanded in the proposals relative to the current U.S. GAAP to include more than insurance entities, we are concerned that a health care provider that contracts with an insurer under a capitation arrangement could be determined to be an insurer providing services to a policyholder to compensate them for insured events. We do not believe this potential outcome would be appropriate or reflective of the economic substance of capitation arrangements for the following reasons:

- The primary purpose of capitation (and fee-for-service) agreements is the provision of medical care services. Therefore, the substance of a capitation agreement is consistent with the scope exception in the proposals related to fixed-fee service contracts and it would be inconsistent to account for them as insurance contracts. As a further example, capitation agreements are differentiated from a contract between a policyholder and either a health insurer that owns a clinic or employs physicians, or a property and casualty insurer that

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<sup>17</sup> Equivalent to Paragraph 4(e) of the IASB ED.

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owns an automotive body shop. Although in both instances a portion of the services related to an insurance claim may be performed by the insurer, the primary purpose of the contract between the insured and the insurer is to provide insurance coverage as opposed to perform a service.

- Although capitation arrangements expose health care providers to risk related to uncertain events, the cash flows exchanged between the insurer and the physician during the contract period do not vary in accordance with the actual incidence of claims or the provision of health care treatments, and these contracts are not accounted for as insurance or reinsurance contracts under current U.S. GAAP because they generally do not meet the definition of significant insurance risk. We do not believe the Boards' definition of insurance contracts and the transfer of insurance risk are intended to be different in substance from this existing approach.

Accordingly, we recommend that the scope exception included in the final standard(s) should be clarified to either (1) explicitly state that capitation agreements are not within the scope of the accounting model for insurance contracts or (2) explain that fees that are fixed per unit but vary based on the number of units subject to the uncertain event (for example, members in a capitation agreement) are not determined to be variable for the purposes of applying this scope exception.

#### **Scope of Employer-Provided Insurance (FASB Question 4)**

##### **Health insurance contracts containing significant insurance risk clearly meet the definition of an insurance contract from an insurer's perspective**

The proposals contain a scope exception for employers' assets and liabilities under employee benefit plans and retirement benefit obligations reported by defined benefit retirement plans. The FASB observes that under IFRS that exclusion would include, among other items, health insurance provided by an employer and specifically asks whether or not employer-provided insurance should be considered an insurance contract. We interpret this question as being posed from the perspective of a sponsoring employer, *not* from the perspective of an insurer issuing insurance contracts. Clearly we believe that contracts that transfer significant insurance risk from sponsoring employers or individuals to a managed care company for the compensation of health care costs should be included in the scope of the Boards' final standard(s) for insurance contracts.

From the perspective of a sponsoring employer, we believe that employer-provided insurance should not be included in the scope of the proposals as it represents compensation for employee services rendered rather than insurance.

The FASB should clarify this potential ambiguity in their final standard to explicitly state that health insurance contracts fall within its scope, but do not require sponsoring employers or equivalent organization to account for their obligations under such arrangements as insurance contracts.

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Thank you for your attention to our concerns. We hope that these perspectives are of value to your deliberation processes and provide a detailed illustration of the unique accounting issues associated with the managed care industry, which are often separate and distinct from either the life or property and casualty insurance industries that have thus far have been the most common examples cited by the Boards during their public deliberations on this important project. We also believe our views appropriately articulate and support the application of a practical expedient for health insurance contracts, recognizing the short duration and related characteristics of their fulfillment cash flows.

We look forward to discussing these matters with you in greater detail at the Insurance Roundtable in Norwalk, Connecticut on December 20, 2010. If we can provide further information or clarification of our comments in the meantime, please call any of the signatories listed below.

Sincerely,



Rajan Parmeswar  
Aetna Inc.  
Vice President, Controller and Chief Accounting Officer  
(860) 273-7231



Mary T. Hoeltzel  
CIGNA Corporation  
Vice President and Chief Accounting Officer  
(215) 761-1170



Steven E. McCulley  
Humana Inc.  
Vice President, Controller and Principal Accounting Officer  
(502) 580-3921

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Eric S. Rangen  
UnitedHealth Group Inc.  
Senior Vice President, Chief Accounting Officer  
(952) 936-5778



Martin L. Miller  
WellPoint, Inc.  
Senior Vice President, Controller, Chief Accounting Officer and Chief Risk Officer  
(317) 488-6684

**Appendix**  
**Supplementary Responses to Specific Questions in the IASB ED and FASB DP**  
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This Appendix supplements the detailed comments included in our preceding letter by addressing certain specific questions asked by the Boards. Responses to the IASB ED are provided first, followed by relevant supplemental questions extracted from the FASB DP. Where responses to IASB questions are provided, we have cross-referenced the corresponding questions from the FASB DP.

**Measurement Model**

**IASB Question 1 / (FASB Question 20) – Relevance of information for users (paragraphs BC13 – BC50):**

*Do you think that the proposed measurement model will produce relevant information that will help users of an insurer's financial statements to make economic decisions? Why or why not? If not, what changes do you recommend and why?*

We are generally supportive of the Boards' proposed objective of measuring all cash inflows and outflows required to fulfill an insurance contract in a manner that reflects the principle of pooled insurance risk. However, as described in our detailed comments and throughout this Appendix, we disagree with many of the specific principles or prescribed techniques proposed by the Boards to achieve these objectives and have proposed alternative approaches accordingly.

**IASB Question 2 / (FASB Questions 7 and 11) – Fulfilment cash flows (paragraphs 17(a), 22–25, B37–B66 and BC51):**

*a) Do you agree that the measurement of an insurance contract should include the expected present value of the future cash outflows less future cash inflows that will arise as the insurer fulfils the insurance contract? Why or why not? If not, what do you recommend and why?*

We agree that the measurement of an insurance contract should include the present value of all relevant cash inflows and outflows necessary for an insurer to fulfill its obligation. However, as described in our detailed comments on pages 17-18, we believe that a mean estimate approach to measuring cash flows using standard actuarial methods is preferable to an expected value methodology which we believe implies a false degree of precision.

*(b) Is the draft application guidance in Appendix B on estimates of future cash flows at the right level of detail? Do you have any comments on the guidance?*

We believe the application guidance with respect to estimates of future cash flows is sufficiently clear.

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**IASB Question 3 / (FASB Question 12) – Discount rate (paragraphs 30–34 and BC88–BC104):**

*(a) Do you agree that the discount rate used by the insurer for non-participating contracts should reflect the characteristics of the insurance contract liability and not those of the assets backing that liability? Why or why not?*

We do not believe that a discount rate used to measure fulfillment cash flows should reflect the characteristics of the insurance liability. This fundamentally misrepresents the insurance business model. As described in our detailed comments on pages 22-24, the discount rate should instead be based on the expected return on assets invested by an insurer to support the pay-out of future expected losses.

*(b) Do you agree with the proposal to consider the effect of liquidity, and with the guidance on liquidity (see paragraphs 30(a), 31 and 34)? Why or why not?*

We do not support the use of a liquidity adjustment. Furthermore, even if such an approach were required, the Boards would need to issue illustrative guidance on how an insurer would be expected to measure a liquidity adjustment because we do not believe this concept is widely understood in the context of an insurance contract liability.

*(c) Some have expressed concerns that the proposed discount rate may misrepresent the economic substance of some long-duration insurance contracts. Are those concerns valid? Why or why not? If they are valid, what approach do you suggest and why? For example, should the Board reconsider its conclusion that the present value of the fulfillment cash flows should not reflect the risk of non-performance by the insurer?*

We share these concerns. A discount rate based on the risk-free yield curve will be lower than the rate expected to be earned on the invested assets supporting the insurance obligations. Accordingly, the fulfillment cash flow calibration at inception is more likely to generate an initial loss because pricing assumptions used to determine an appropriate premium will be based off those asset rates. In addition, we do not believe that the discount rate should include any adjustment for non-performance risk because this does not affect the amount of an insurer's obligation to a policyholder upon the occurrence of an insured event. We do not believe the proposed approach for determining the discount rate will produce financial results that reflect the economic substance of our business model.

**IASB Question 4 / (FASB Question 15) – Risk adjustment versus composite margin (paragraphs BC105–BC115):**

*Do you support using a risk adjustment and a residual margin (as the IASB proposes), or do you prefer a single composite margin (as the FASB favours)? Please explain the reason(s) for your view.*

For the reasons explained in our detailed comments on pages 18-20, we believe that risk is inherently reflected in the assumptions used to develop an actuarial mean estimate of future claim obligations that is expected to be adequate under moderately adverse conditions. Therefore, in a calibration

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model, any difference between the estimated fulfillment cash outflows and fulfillment cash inflows would represent a residual margin that should be recognized in earnings over the coverage period.

**IASB Question 5 / (FASB Questions 8-10) – Risk adjustment (paragraphs 35-37, B67-B103 and BC105–BC123):**

*(a) Do you agree that the risk adjustment should depict the maximum amount the insurer would rationally pay to be relieved of the risk that the ultimate fulfilment cash flows exceed those expected? Why or why not? If not, what alternatives do you suggest and why?*

We do not agree with this definition because we believe it mixes the concepts of entity specific assumptions and exit value measurements. Instead, we have proposed that a risk adjustment be defined as the present value of the amount of premium an insurer would require to assume the risk of potential adverse variability in the development of future cash flows for a portfolio of insurance contracts.

*(b) Paragraph B73 limits the choice of techniques for estimating risk adjustments to the confidence level, conditional tail expectation (CTE) and cost of capital techniques. Do you agree that these three techniques should be allowed, and no others? Why or why not? If not, what do you suggest and why?*

As described in our detailed comments on pages 20-22, we do not believe it is appropriate to limit the range of available techniques for measuring a risk adjustment under the IASB model because this does not permit an insurer to select a method that best reflects the specific characteristics of insurance risks assumed. A “three sizes fits all” approach is clearly too restrictive and could result in measurement outcomes for portfolios of insurance contracts that do not represent the unique risk profiles associated with each insurer’s business strategy and underwriting decisions.

*(c) Do you agree that if either the CTE or the cost of capital method is used, the insurer should disclose the confidence level to which the risk adjustment corresponds (see paragraph 90(b)(i))? Why or why not?*

We do not agree with this proposal because it is not clear how a confidence level relates to the IASB’s definition of the risk adjustment. This is a statistical attribute that does not bear any relationship to the amount of the risk adjustment that an insurer would be required to record in order to ensure in aggregate that expected fulfillment cash inflows are adequate to satisfy expected claim obligations relative to initial pricing expectations.

*(d) Do you agree that an insurer should measure the risk adjustment at a portfolio level of aggregation (ie a group of contracts that are subject to similar risks and managed together as a pool)? Why or why not? If not, what alternative do you recommend and why?*

Although we disagree in principle with the measurement of an explicit risk adjustment, if such an approach were required by the Boards, we do agree that a risk adjustment should be determined at the portfolio level because this best reflects the manner in which an insurer prices and manages insurance risk.

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*(e) Is the application guidance in Appendix B on risk adjustments at the right level of detail? Do you have any comments on the guidance?*

If an explicit risk adjustment were required, we do not believe the application guidance is sufficient and should be supplemented with practical examples of how to link the objective of a risk adjustment to possible calculation techniques.

**IASB Question 6 / (FASB Questions 16-17) – Residual/composite margin (paragraphs 17(b), 19–21, 50–53 and BC124–BC133):**

*(a) Do you agree that an insurer should not recognise any gain at initial recognition of an insurance contract (such a gain arises when the expected present value of the future cash outflows plus the risk adjustment is less than the expected present value of the future cash inflows)? Why or why not?*

We agree that an insurer should not recognize any gain at initial recognition of an insurance contract because the insurer has not yet performed under the contract.

*(b) Do you agree that the residual margin should not be less than zero, so that a loss at initial recognition of an insurance contract would be recognised immediately in profit or loss (such a loss arises when the expected present value of the future cash outflows plus the risk adjustment is more than the expected present value of future cash inflows)? Why or why not?*

We agree that if the present value of fulfillment cash outflows exceeds the present value of fulfillment cash inflows an insurer should recognize an immediate loss at inception. This assessment should be made at the portfolio level, not the individual contract level, because this level of aggregation faithfully represents the pooling of insurance risk which is fundamental to the insurance business model.

*(c) Do you agree that an insurer should estimate the residual or composite margin at a level that aggregates insurance contracts into a portfolio of insurance contracts and, within a portfolio, by similar date of inception of the contract and by similar coverage period? Why or why not? If not, what do you recommend and why?*

We believe this a necessary consequence of the proposed calibration in order to calculate a residual margin or composite margin at inception of an insurance contract. From a practical perspective, we recommend that the concept “similar inception date” be sufficiently flexible so that an insurer is not forced to capture margin data at too granular a level – for example policies written each day or each week. This extreme level of disaggregation would impose a significant administrative burden on insurers and typically would not provide any additional benefit to financial statement users. The majority of health insurance contracts issued by managed care companies incept coverage on January 1 annually and for a twelve-month coverage period (although certain contracts such as Medicare and Medicaid products incept coverage throughout the year). Therefore, in practice, the concept of cohort may be less challenging for the managed care industry relative to other insurers writing products that have wider dispersion of effective coverage dates throughout the year.

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*(d) Do you agree with the proposed method(s) of releasing the residual margin? Why or why not? If not, what do you suggest and why (see paragraphs 50 and BC125–BC129)?*

We agree with the proposed method of recognizing the residual margin in earnings in a systematic manner over the coverage period.

*(e) Do you agree with the proposed method(s) of releasing the composite margin, if the Board were to adopt the approach that includes such a margin (see the Appendix to the Basis for Conclusions)? Why or why not?*

If a composite margin approach were required, we recommend it should be recognized over only the coverage period. Otherwise, premium is essentially deferred into the post-coverage period and we believe that earnings in the post-coverage period should only be affected by the actual emergence of claims relative to actuarial expectations.

*(f) Do you agree that interest should be accreted on the residual margin (see paragraphs 51 and BC131–BC133)? Why or why not? Would you reach the same conclusion for the composite margin? Why or why not?*

For short duration contracts, we do not agree that interest should be accreted on either a residual or composite margin. Because both the residual margin and composite margins represent an estimate of future deferred profit (estimated at inception relative to pricing assumptions) we do not believe this amount should change due to variability in the discount rate used to measure the underlying fulfillment cash flows. Alternatively, for long duration contracts, these margins should accrete interest since they are determined based on a present value of future cash flows (and the time value of money is material to long duration contracts). Otherwise, true profits over time would be understated.

**IASB Question 7 / (FASB Questions 13-14) – Acquisition costs (paragraphs 24, 39 and BC135–BC140):**

*(a) Do you agree that incremental acquisition costs for contracts issued should be included in the initial measurement of the insurance contract as contract cash outflows and that all other acquisition costs should be recognised as expenses when incurred? Why or why not? If not, what do you recommend and why?*

We believe that both incremental acquisition costs and certain non-incremental acquisition costs allocated on a systematic basis should be included in the measurement of the fulfillment cash flows. This would reflect the substance of an insurer's pricing assumptions that establish a premium amount expected to fully recover acquisition costs.

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**Measurement – Short Duration Contracts**

**IASB Question 8 / (FASB Questions 18-22) – Premium allocation method:**

*(a) Should the Board (i) require, (ii) permit but not require, or (iii) not introduce a modified measurement approach for the pre-claims liabilities of some short-duration insurance contracts? Why or why not?*

We strongly support the objective of requiring a simplified measurement and presentation approach for short duration contracts. We believe the use of a premium allocation method provides a better representation of the economic substance of health insurance contracts issued by managed care companies relative to the full building block model which is theoretically better suited to long duration contracts. However, as described in our detailed comments on page 15 we do not believe the definition of a short duration contract should be based on the premise of a coverage period of approximately one year or less and, accordingly, we have proposed an alternative definition based on the qualitative characteristics on an insurance contract's cash flows and contractual provisions. We have also highlighted additional practical concerns regarding the application of the premium allocation method.

*(b) Do you agree with the proposed criteria for requiring that approach and with how to apply that approach? Why or why not? If not, what do you suggest and why?*

We agree that if an insurance contract meets the definition of “short duration” (which we believe requires modification) then the premium allocation method should be required rather than permitted. To permit the use of two fundamentally different accounting models and presentation approaches for insurance contracts that may have essentially the same risk profile but slightly different coverage periods does not contribute to comparability in financial reporting across different companies. We believe the users of our financial statements would prefer the required application of a premium allocation method to achieve consistency.

**IASB Question 9 / (FASB Question 23) – Contract boundary principle:**

*Do you agree with the proposed boundary principle and do you think insurers would be able to apply it consistently in practice? Why or why not? If not, what would you recommend and why?*

We disagree with the proposed definition of a contract boundary because it may artificially extend the accounting for an insurance contract beyond the contractual coverage period (irrespective of anticipated persistency) due to the existence of pricing limitations imposed by regulatory authorities. This concern is heightened by the potential impact of health care reform in the United States. Among other suggestions, we recommend performing the evaluation of a contract boundary at the portfolio level rather than the individual policyholder level.

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**Participating Features**

**IASB Question 10 / (FASB Question 5) – Participating features:**

*(a) Do you agree that the measurement of insurance contracts should include participating benefits on an expected present value basis? Why or why not? If not, what do you recommend and why?*

We agree that the relevant fulfillment cash flows included in the measurement of an insurance contract should also reflect participating benefits because the premium included in the calibration measurement would presumably reflect the expected outcome of these participating features. Participating cash flows should be measured on the same basis as other fulfillment cash flows. As described in our detailed comments on pages 17-18, we also believe that a mean estimate approach using actuarial standards is preferable to an expected value methodology when measuring a fulfillment cash flow.

*(b) Should financial instruments with discretionary participation features be within the scope of the IFRS on insurance contracts, or within the scope of the IASB's financial instruments standards? Why?*

We have not responded to this question which we believe not to be materially applicable to the operations of the managed care insurance industry.

*(c) Do you agree with the proposed definition of a discretionary participation feature, including the proposed new condition that the investment contracts must participate with insurance contracts in the same pool of assets, company, fund or other entity? Why or why not? If not, what do you recommend and why?*

We have not responded to this question which we believe not to be materially applicable to the operations of the managed care insurance industry.

*(d) Paragraphs 64 and 65 modify some measurement proposals to make them suitable for financial instruments with discretionary participation features. Do you agree with those modifications? Why or why not? If not, what would you propose and why? Are any other modifications needed for these contracts?*

We have not responded to this question which we believe not to be materially applicable to the operations of the managed care insurance industry.

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**Definition and Scope**

***IASB Question 11 / (FASB Questions 1 – 4) – Definition and scope:***

*(a) Do you agree with the definition of an insurance contract and related guidance, including the two changes summarised in paragraph BC191? If not, why not?*

We agree with the proposed definition of an insurance contract and do not believe that the changes summarized in IASB ED paragraph BC191 have any substantive impact on health insurance contracts issued by managed care insurers relative to existing U.S. GAAP.

*(b) Do you agree with the scope exclusions in paragraph 4? Why or why not? If not, what do you propose and why?*

As described in our detailed comments on pages 31-32, we are concerned that capitation arrangements between managed care insurers and health care providers may be considered to be insurance contracts. The primary purpose of a capitation agreement is to contract for the provision of medical care services. Accordingly, we recommend that the scope exemptions included in the final standard(s) be appropriately modified to ensure that capitation arrangements are excluded from the definition of an insurance contract.

*(c) Do you agree that the contracts currently defined in IFRSs as financial guarantee contracts should be brought within the scope of the IFRS on insurance contracts? Why or why not?*

We have not responded to this question which we believe not to be materially applicable to the operations of the managed care insurance industry.

**Unbundling**

**IASB Question 12 / (FASB Question 6) – Unbundling:**

*Do you think it is appropriate to unbundle some components of an insurance contract? Do you agree with the proposed criteria for when this is required? Why or why not? If not, what alternative do you recommend and why?*

We believe that components of an insurance contract should be unbundled if they are not closely related to the insurance coverage. As described in our detailed comments on pages 13-14, we are supportive of the proposed principles-based definition that implicitly requires insurers to consider the relevant facts and circumstances of each agreement and use judgment to determine whether or not components are closely related to the insurance coverage for the purpose of unbundling.

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**Financial Statement Presentation and Disclosures**

**IASB Question 13 (FASB Questions 28-30):**

*(a) Will the proposed summarised margin presentation be useful to users of financial statements? Why or why not? If not, what would you recommend and why?*

As described in our detailed comments on page 29, we do not believe the proposed summarized margin presentation provides better decision-useful information in the primary financial statements compared to existing volume-based metrics based on premiums earned and claim expenses incurred.

*(b) Do you agree that an insurer should present all income and expense arising from insurance contracts in profit or loss? Why or why not? If not, what do you recommend and why?*

We agree that all income and expenses arising from the fulfillment of an insurance contract should be included in earnings.

**IASB Question 14 (FASB Questions 31) – Disclosures:**

*(a) Do you agree with the proposed disclosure principle? Why or why not? If not, what would you recommend, and why?*

We agree with the disclosure principles set forth by the Boards.

*(b) Do you think the proposed disclosure requirements will meet the proposed objective? Why or why not?*

We believe the proposals are so extensive as to potentially obscure important information due to the volume of disclosures required to be presented in financial statement footnotes. Our financial statement users want information that enables them to measure growth and cost trends derived from volume-based measures of revenues and expenses.

*(c) Are there any disclosures that have not been proposed that would be useful (or some proposed that are not)? If so, please describe those disclosures and explain why they would or would not be useful.*

We do not believe there are any significant omissions in the proposed disclosures and expect that insurers would provide supplemental additional disclosure in due course should such information be deemed meaningful to their financial statement users.

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**Unit-linked Contracts**

**IASB Question 15 – Unit-linked contracts:**

*Do you agree with the proposals on unit-linked contracts? Why or why not? If not what do you recommend and why?*

We have not responded to this question which we believe not to be materially applicable to the operations of the managed care insurance industry.

**Reinsurance**

**IASB Question 16/ (FASB Questions 26-27) – Reinsurance:**

*(a) Do you support an expected loss model for reinsurance assets? Why or why not? If not, what do you recommend and why?*

*(b) Do you have any other comments on the reinsurance proposals?*

We have not responded to these questions which we believe not to be materially applicable to the operations of the managed care insurance industry.

**Transition and Effective Date**

**IASB Question 17 – Transition and effective date:**

*(a) Do you agree with the proposed transition requirements? Why or why not? If not, what would you recommend and why?*

We disagree with an approach that requires any difference between the measurement of a portfolio based on the expected future cash flow building block and risk adjustment, and the current measurement of the net liability under existing GAAP, to be recognized as an adjustment to retained earnings. As described in our detailed comments on pages 29-31, this approach prematurely recognizes expected future profits in equity even though the insurer may still have a significant obligation to perform under those insurance contracts. This in turn distorts the future earnings pattern of the in-force business compared to the new business an insurer will also write. Instead, we recommend an approach that permits a transition margin to be established for the total amount of expected future profits. This transition margin should be released to earnings in a manner that best reflects the insurer's release from risk throughout the remainder of the coverage and run-out periods.

*(b) If the Board were to adopt the composite margin approach favoured by the FASB, would you agree with the FASB's tentative decision on transition (see the appendix to the Basis for Conclusions)?*

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We disagree that a composite margin should be recognized in earnings over both the coverage and claims periods. Instead, we recommend that a composite margin be recognized over the coverage period only, consistent with the proposed treatment of a residual margin (i.e., we do not believe that any portion of the premiums collected for short duration contracts should in essence be deferred into the claim run-out period).

*(c) Is it necessary for the effective date of the IFRS on insurance contracts to be aligned with that of IFRS 9? Why or why not?*

We do not believe it is appropriate to develop and implement an accounting standard for insurance contracts without regard to the Boards' ongoing development of a revised model for accounting for financial instruments. Such an approach would ignore the fundamental relationship between the fulfillment cash flows of an insurance contract and the invested assets supporting those cash flows. Therefore, we believe that any changes to the accounting models for insurance contracts and financial instruments should occur on a simultaneous basis. However, from a practical perspective, this would also impose a significant burden on insurers and users in preparing for such fundamental change on both the liability and asset side of the balance sheet at the same time.

*(d) Please provide an estimate of how long insurers would require to adopt the proposed requirements.*

We do not have a clear expectation of this timeframe. However, given the significant challenges in obtaining or constructing underlying data, developing the necessary system infrastructure and human capital, and establishing alternative measurement models, we would anticipate a transition period that provides a minimum of two to three years before the earliest period for which disclosures will be required (which for U.S. public companies means a total of five years of historical data for certain disclosures required by the SEC).

**Other**

**IASB Question 18 – Other comments:**

*Do you have any other comments on the proposals in the exposure draft?*

We do not have any additional comments at this time. Please refer to our detailed letter for extensive discussion of our perspectives and recommendations on the areas of the Boards' proposals that we believe most significantly affect managed care companies.

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**IASB Question 19 – Benefits and costs:**

*Do you agree with the Board’s assessment of the benefits and costs of the proposed accounting for insurance contracts? Why or why not? If feasible, please estimate the benefits and costs associated with the proposals.*

As described in our detailed comments on pages 14-17, we support a two-model approach that distinguishes between short duration and long duration insurance contracts. We also believe that the economic substance of health insurance contracts issued by managed care companies is most faithfully represented by the short duration model (subject to our specific recommendations on the IASB’s proposed premium allocation method). The benefits of this approach are likely to outweigh the costs, which we believe would essentially be a refinement of the existing short-duration model currently required under U.S. GAAP. However, for the reasons we have articulated, if health insurance contracts were required to be accounted for as long duration contracts using the full building block approach, we strongly believe that the costs would far outweigh any perceived benefits to our financial statement users.

**Additional Question for Respondents**

**FASB Question 4 – Scope of employer-provided insurance:** *Should benefits that an employer provides to its employees that otherwise meet the definition of an insurance contract be within the scope of the proposed guidance? Why or why not?*

As described in our detailed comments on page 32, we believe the Board’s intention is to ask this question from the perspective of a sponsoring employer and not a managed care company that issues health insurance contracts. In order to avoid ambiguity on this point, we recommend that the FASB clarify in a final standard that health insurance contracts clearly do fall within the scope of the accounting model for insurance contracts from the issuer’s perspective. From the perspective of a sponsoring employer, we believe that employer-provided insurance should not be included in the scope of the proposals as it represents compensation for employee services rendered rather than insurance.

**FASB Question 23 – Health care reform:** *What are the implications of the recent U.S. healthcare reform to the application of the proposed contract boundary principle, including whether health insurance contracts written under the new reforms would meet the conditions in the proposed guidance to be accounted for under the modified approach?*

As an industry, we are still in the process of evaluating the impact of health care reform in the United States. As described in our detailed comments on pages 10-12, the effect of these complex reforms must be considered in determining whether or not there is any impact on the definition of contract boundaries under the Boards’ proposals. However, we do not believe *The Patient Protection and Affordable Care Act of 2010* in principle should artificially extend for accounting purposes the duration of health insurance contracts beyond the period for which an insurer has priced for risk and is obligated to provide coverage.

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**FASB Question 32 – IASB vs. FASB Approach, New Guidance vs. Enhancement of Existing GAAP:**

*After considering your views on the specific issues contained in this Discussion Paper and the IASB's Exposure Draft, what do you think would represent the most appropriate improvement to U.S. GAAP? a.) Pursue an approach based on the IASB's Exposure Draft? b.) Pursue an approach based on the IASB's Exposure Draft with some changes? Please explain those changes. c.) Pursue an approach based on the Board's preliminary views in this Discussion Paper? d.) Pursue an approach based on the Board's preliminary views in this Discussion Paper with some changes? Please explain those changes. e.) Make targeted changes to address specific concerns about current U.S. GAAP (for example, items included in paragraph 7)? Please describe those changes.*

We do not believe that a comprehensive modification of the current insurance accounting guidance under U.S. GAAP is required. However, should the FASB move forward with this project, we strongly support the use of a short duration accounting model for health insurance contracts. Notwithstanding the specific recommendations we have regarding the proposed definition of a short duration contract, and the application of the proposed premium allocation method, we believe this approach most closely reflects option e.).

We have also expressed our views on the accounting model for long duration contracts (even though we do not believe this model is appropriate for health insurance contracts). With respect to long duration contracts, we support the principle of a measurement model based on fulfillment cash flows that is calibrated to expected premium. Although we have expressed significant concerns and recommendations regarding the Boards' proposals, our approach for long duration contracts is most closely aligned with option b.).

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