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**Re: File Reference No. 2013-290, Proposed Accounting Standards Update, *Insurance Contracts (Topic 834)*, and IASB Exposure Draft – *Insurance Contracts***

Ms. Susan M. Cospers and Mr. Hans Hoogervorst:

We are the five leading publicly-traded managed care companies in the United States: Aetna Inc., Cigna Corporation, Humana Inc., UnitedHealth Group Incorporated, and WellPoint Inc. (together, we, our or us). As a group, we provide health insurance products and related services to more than 120 million medical members. Our customers include employer groups, individuals, seniors, college students, part-time and hourly workers, governmental units, government-sponsored plans, labor groups, and expatriates. We also provide other insurance products, such as dental, vision, term life, short-term and long-term disability, and supplemental health insurance coverage as well as a variety of health care-related services that do not involve insurance products. Collectively we reported annual revenues of approximately \$276 billion in 2012 (equivalent to 1.7 percent of the 2012 gross domestic product of the United States). Please see the Appendix to this letter for further background on the managed care industry in which we participate.

We appreciate the opportunity to provide our comments in response to the Financial Accounting Standards Board's (FASB) and the International Accounting Standards Board's (IASB, and collectively with the FASB the Boards) joint efforts to revise the accounting standards for insurance contracts (Proposed Update) both within the United States and internationally.

**Executive Summary**

Consistent with our comments provided to both Boards on November 30, 2010, we continue to support convergence efforts and this joint project specifically; however, we believe the wholesale changes and voluminous disclosures required by these current proposals fall short of the primary objective to enhance the decision usefulness of the information about an entity's insurance contracts in its financial statements. Based on the testing we conducted, our initial concern that the Proposed Update fails cost benefit analysis as there is minimal, if any, improvement in transparency, at a significant cost outlay and at the risk of undermining the financial stability of our businesses, was validated.

The Proposed Update would add significant unnecessary costs to preparers and complexity to our financial statements. Consider the following as examples:

- Requiring probabilistic scenarios to measure the liability for incurred claims adds complexity and cost without achieving a commensurate increase in the precision of the estimate compared with actuarial techniques currently applied in practice.
- Health care insurance contracts are often: (1) cancellable by the insured during the duration of the contract (contract boundary), and (2) produce varying premiums based on the number of eligible plan members or consumers served throughout the typical contract boundary. Expected future premiums that are within the typical contract boundary can vary significantly and result in unnecessary judgments and unreliable estimates in our financial statements while at the same time inappropriately inflating receivables based on contractual terms. This impact could be exacerbated under a rigid contract boundary definition that would extend the boundaries of certain contracts beyond their contract terms.
- Applying the concept of estimated returnable amounts to determine revenue recognition could reduce revenues significantly under the Proposed Update, requiring data gathering and system changes that would impose a significant cost burden on our companies. Additionally, any related significant changes in estimates would increase volatility and add complexity to understanding our results of operations.

We continue to recommend that no significant changes to U.S. Generally Accepted Accounting Principles (U.S. GAAP) are required for short-duration contracts. The current U.S. GAAP guidance has been in existence for almost three decades with periodic updates and amendments, partially to address the changing insurance environment, primarily related to long-duration contracts and perceived abuses in accounting for reinsurance. We believe the current reporting from the short-duration model meets investor needs and provides financial statement users with the necessary useful information to make informed investment decisions. Users have not expressed a desire for any fundamental changes to that model and it seems to be well understood by said users. We believe the Board's goal for improvement can be accomplished with targeted and specific changes to the current U.S. measurement models for insurance. For optimal effectiveness and efficiencies, such changes should be addressed in a converged manner.

### **Improvement Opportunities**

The improvements that may be desired could be achieved through evolutionary enhancements, consistent with the historical incremental approach of issuing limited enhancements in select areas of current guidance and disclosure practices. While we acknowledge that no universal standards exist for insurance contracts under International Financial Reporting Standards (IFRS) we believe that applying U.S. GAAP for insurance contracts, particularly for short-duration contracts, has and would continue to provide relevant and reliable financial reporting of results and positions to users; and therefore revolutionary changes to either of the short- or long-duration contract models is unnecessary and will not prove to cost effectively advance the usability of our financial reporting. Although we do not support the wholesale change that these proposals would produce, we recognize that evolutionary improvements, particularly for long-duration contracts, are generally considered desirable by some users of financial statements for issuers of such contracts and we do support limited improvements such as:

- Redefining the scope of existing guidance from insurance entities to address insurance contracts;
- Incorporating time value of money concepts for the short-duration model when appropriate;
- Simplifying the mixed attribute model by aligning the effects of interest rates in other comprehensive income when appropriate; and

- Requiring consistent application of updated assumptions for various market elements of nontraditional long-duration contracts.

In the event that the Boards cannot come to convergence – we recommend that the FASB undertake to improve their existing guidance for insurance activities with the limited changes noted above.

### Alternatives

If the Boards persist in their revolutionary changes to accounting for insurance contracts, we strongly recommend that they converge and address the following:

1. **Revenue recognition and presentation** – We believe the proposed approach to measure total revenues within the contract boundary on day one, without further adjustment will inflate financial statements through the use of judgmental estimates that will overshadow other, more useful performance information. We therefore strongly recommend that premiums receivable be limited to uncollected premiums due under contractual terms with adjustments to initial estimates reflected in revenues when determinable.
2. **Estimated returnable amounts and loss sensitive features** – The distinction between these two elements is unclear and we recommend a definition for estimated returnable amounts similar to the current account balance concept, and improvements for the presentation and measurement of loss sensitive features.
3. **Premium allocation method** – We applaud a simplified measurement model for short-duration insurance contracts, but do not believe that the proposed Premium Allocation Approach (PAA) is cost effective. We strongly recommend that targeted changes to the current short-duration model (limited to addressing discounting) would be the most effective approach.
4. **Probability-weighted cash flows** – We do not believe that the use of unbiased, probability-weighted cash flows is superior or more reliable than the use of an actuarially-determined estimate of cash flows considering moderately adverse conditions. 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.
5. **Portfolio definition** – We support a principles-based definition of a portfolio that allows insurers to aggregate contracts in a manner that best reflects their management of insurance risk – but have determined in our limited testing that the proposed definition will produce significantly greater numbers of portfolios for certain products that is inconsistent with the manner in which we manage our businesses (acquiring, servicing and measuring profitability).
6. **Contract boundaries** – We support that a contract boundary occurs when an insurer is no longer required to provide coverage or no longer has the ability to re-price the portfolio to adequately reflect risk.
7. **Unbundling** – We agree that distinct performance obligations to provide goods or services should be separated from insurance contracts and suggest additional interpretive guidance to ensure consistent, appropriate application of this unbundling principle.
8. **Scope implications** – The current definition of fixed-fee service contracts could imply that capitation arrangements between managed care insurers and health care providers are insurance contracts. These agreements contract to provide medical care services, not to transfer insurance risk. Accordingly, we recommend that this definition be modified to ensure proper exclusion of capitation agreements from the scope of the Proposed Update.

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## Comments on Proposed Accounting Standards Update – Insurance Contracts (Topic 834)

### *Scope*

We agree with the Boards' transaction-based, rather than entity-based, approach to defining the scope of the Proposed Update and support the idea that all contracts that transfer significant insurance risk should be accounted for in accordance with this Proposed Update. This approach achieves consistency with other guidance in the Codification, accounting for contracts that contain similar economic characteristics in a similar manner. We also support using a specific, detailed list of scope exceptions that will help to ensure predictable application of the guidance.

### *Fixed-Fee Service Contracts*

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 to incent them to provide quality, cost effective treatment to insured members. In a capitation agreement, a provider agrees to assume the cost of care for a specific group of patients insured by the managed care insurer. The insurer pays a set per-member-per-month amount that does not increase or decrease with the quantity of health care provided. This differs from fee-for-service arrangements under which the amount paid to a provider varies in accordance with the quantity and type of health care services provided.

Additionally, in certain markets, the health care industry has moved towards horizontal and vertical integration, with provider groups organizing to provide services amongst a multiple set of provider groups and with managed care insurers operating certain medical facilities and providing some of the health care services in order to recognize the potential efficiencies of enhanced capabilities to manage health care.

We applaud the Proposed Update's exception for fixed-fee service contracts that have as their primary purpose the provision of services and the related example in 834-10-55-31 through 55-37 dealing with capitation and other fixed-fee medical arrangements. This principle allows for the substance of these contracts to be appropriately reflected as service arrangements, not insurance. However, without additional clarity we are concerned that this scope exception could produce unintended results for certain arrangements involving capitation and owned medical facilities. For example, the guidance in the Proposed Update could result in certain agreements being misrepresented by managed care insurers as reinsurance and by medical providers as insurance contracts while in other cases, vertically-integrated managed care insurers may account for insurance products under other accounting standards. It is our understanding that users of health care providers' financial statements do not consider capitation service contracts to be insurance contracts, just as users of health care insurers' financial statements do not consider these capitation service contracts as reinsurance contracts. There are fundamental differences between these capitation arrangements and reinsurance - a reinsurance arrangement provides compensation in cash, whereas a capitation agreement provides a service to the direct insurer's enrollees, consistent with the health care provider's business model.

The following fact patterns could prove difficult to properly classify under the Proposed Update's scope exception:

- ***Certain "risk-scored" capitation arrangements*** – In certain Medicare capitation arrangements, the fixed, per-member-per-month fee paid to a provider considers risk using individual Medicare members' risk scores. Typically the insurer underwrites the insurance contract, Medicare pays insurers risk-adjusted premiums, and insurers then pay capitated providers a negotiated percentage of those risk-adjusted premiums (the service provider does not consider the Medicare

members' risk in pricing the capitation contract). This process might seem to fail the condition in paragraph 15-5(f)(1) because the contract pricing is based on an assessment of risk associated with individual consumers. However, the use of a more "precise" pricing method when data is available (such as is the case for Medicare risk scores), does not necessarily result in a contract that is substantively different and, thus, should not be accounted for differently than one with a less "precise" individual pricing method (that still involves consideration of the risk characteristics of a pool of individuals). Under both pricing scenarios, the contracts have the primary purpose of providing services. Additionally, the language in paragraph 55-33, while acknowledging the risk-based nature of the arrangement, suggests that because "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," the arrangement may fall outside the scope of the Proposed Update. As currently proposed, it is unclear how the actual wording of the exception in 15-5(f) could impact this analysis and conclusion.

- **Global capitation arrangements**– Another type of arrangement occurs when an insurer contracts with a provider group to provide services covering some or all aspects of medical care, including primary care, hospitalization, specialist care, and ancillary services in exchange for fixed, per-member-per-month fees (global capitation). The health care provider accepting this global capitation may not have the capabilities to perform all of the services contracted. For example, the physician group would directly provide primary care services and sub-contract with other providers to provide the remaining contracted services – such as a group of hospitals to provide inpatient services, or labs for various testing, etc. However, we are concerned that without clarifying language in the implementation guidance the scope exception, as currently proposed, could be interpreted differently depending on the intent of the phrase "primary purpose." This could lead to significant changes from current practice and diversity in application for similar contracts.
- **Vertically-integrated entities** – As mentioned above, it is becoming more common for managed care insurers to own and operate both regulated health plans and certain care delivery businesses. The Proposed Update could lead to insurers with vertically-integrated models to conclude that the ultimate form of compensation is the provision of services. However, economically the primary purpose of the contract between the insurance company and its consumer is insurance and not the provision of services. This could lead to comparability issues across insurers depending simply on their level of vertical integration and will result in less meaningful and more complex financial statements. Also, determining what level of vertical integration is needed to differentiate between insurance and services would be difficult to apply in practice.

We strongly agree with the Proposed Update's exclusion of certain fixed-fee service contracts, and therefore recommend that the provision be modified to ensure consistent application. One suggested approach to address the concerns above is to modify the scope exception so that it can only be applied to entities that are not regulated as insurers. While this approach would introduce an element of entity-based scoping, we believe it aligns with the Boards' broader purpose for creating these scope exceptions and creates consistent treatment for similar fixed-fee service contracts.

If the Boards do not modify the exception to limit its application to those entities that are not regulated as insurers, we would then suggest the following items are addressed: (1) the business model criteria (because as illustrated above, the business model and the primary purpose of the contract is a critical factor in achieving representative accounting), and (2) the second criteria outlined within paragraph 15-5(f) regarding providing a service rather than a cash payment. As illustrated in the first example, the first criterion related to risk-based pricing can result in significantly different accounting for very similar contracts. To avoid this misrepresentation, this criterion should be clarified as follows: The price of the

contract is not based on **the service provider's risk assessment for an individual** unless that assessment is limited to the customer's credit risk.

#### *Interaction with FASB ASC 954*

In the managed care industry, professional judgment is required to apply either ASC 944, *Financial Services - Insurance* or ASC 954, *Health Care Entities* for entities that have a mix of traditional HMO and insurance entities. Because both ASC 944 and ASC 954 use an entity-based approach for scoping, it is usually possible to determine whether one or the other is most applicable. However, if the Proposed Update moves from an entity-based scope to a focus on the substance of individual transactions, there may be redundancy or confusion regarding the applicability of ASC 954 and the proposed ASC 834. The FASB should clarify how it expects ASC 954 to interact with the Proposed Update and potentially provide illustrative examples. We recommend that the FASB amend ASC 954 to exclude contracts within the scope of proposed ASC 834.

#### *Employer-Provided Insurance*

The Proposed Update contains a scope exception for "employer-provided insurance" under 834-10-15-5(c). We interpret this exception to apply from the perspective of a purchasing or sponsoring employer, and not from the perspective of an issuer of such an insurance contract. We clearly believe that contracts that transfer significant insurance risk from purchasing or sponsoring employers or individuals to a managed care insurer for the compensation of health care costs should be included in the scope of the proposed standard. We also believe that employer-provided insurance is compensation for employee services that is guided by the Codification (ASCs 710, 712, 715 and 718). This potential ambiguity should be clarified in the final standard by modifying the exception as follows:

- c. ~~Employers provided~~ contracting to provide insurance to their employees.

#### ***Recognition (Unbundling)***

We support the proposal that noninsurance components of contracts to provide goods or services that are not closely related to the insurance coverage should be separated and accounted for under other applicable guidance in the Codification, such as embedded derivatives, distinct investment components, and certain performance obligations.

We also understand that the Boards extensively deliberated this topic and potentially experienced difficulty in assessing the interdependency of different contractual features within an insurance contract. This difficulty is understandable as we do not believe it is possible to apply a rigid accounting framework to the wide variety of insurance and insurance-related product offerings across, and even within, different sectors of the insurance industry. Therefore, we support a principles-based approach that requires insurers to consider the relevant facts and circumstances and use judgment to determine whether or not components are closely related to the insurance coverage.

We are pleased with the illustrative examples specific to the managed care industry in 834-10-55-45 (Examples 2 through 4), and believe that such examples will be critical in promoting consistent application of the judgmental separation criteria. Our understanding has been that the Boards do not intend for the proposed unbundling guidance to create significant differences from current practice when services are highly interrelated with the insurance contract. This understanding is based on: (1) the conclusions reached in Examples 2 through 4 that are consistent with current health insurance industry practice, and (2) language in BC90 stating that the FASB does not intend for the unbundling principle to

require an exhaustive search for noninsurance components but rather to promote comparability. If administrative services were required to be unbundled from many health insurance contracts, we believe the added complexity and costs of separating cash flows, creating and understanding new metrics and educating management, auditors, and users would outweigh any perceived benefits (e.g., accepted industry ratios like benefit cost ratios would no longer be valid and new unfamiliar metrics would be needed) and could lead to significant changes in current industry practice to the detriment of users of our financial statements.

However, we believe that the guidance in 834-10-25-4 through 834-10-25-7, combined with the illustrative examples in 834-10-55-45, should be clarified to ensure consistent application. The following paragraphs illustrate our concerns and suggest clarifying changes.

In both Example 2(a) related to self-insurance or an administrative services only (ASO) contract and in Example 2(b) related to stop-loss coverage, the claims processing services are determined to be distinct performance obligations. Considering that similar claims processing services exist in a typical “fully-insured” health insurance contract (as in Example 3), a reader could conclude – especially in light of the judgment involved in applying the definition of a performance obligation – that the claims processing services for a fully-insured contract would also be distinct and should be unbundled. However, significant differences exist between a fully-insured health contract and an ASO contract that indicate that the conclusions and the analysis in Examples 2 and 3 are correct. For the fully insured product offering, the administrative services are not sold separately and the insured has no practical ability to obtain those services separate from the insurance component. Therefore, these services are best categorized as activities of the insurer as without those activities the insurer could not reasonably fulfill its insurance obligation.

To assist in applying the unbundling principle, we recommend the implementation guidance in Example 3 (paragraph 834-10-55-45) include the following: “The conclusion that the administrative services are activities of the insurer is further supported by the facts that: (1) the policy holder has no practical ability to purchase the administrative services separately from this insurance product, and (2) the services are interrelated to the insurance component. These facts are not overcome if similar administrative services are sold separately for different products under different facts and circumstances as in the case of Example 2(a) and 2(b) because this analysis should be performed using the relevant facts and circumstances.”

Although we understand the Board is considering modifying the separation principles in the 2011 Revenue Recognition Exposure Draft, we agree that performance obligations are not distinct if they are highly interrelated with other components and when the contract has been significantly customized to incorporate the various components (whether through pricing, delivery, or in some other manner). We believe that this principle should be retained and the same principle should apply to insurance contracts as well to most appropriately reflect the substance and economics of the underlying arrangements and would also assist in addressing the potential uncertainties related to examples 2(a), (b) and 3 described above.

Additionally, the current proposed definition of a performance obligation in the Glossary, when considered in conjunction with 834-10-25-4 through 25-7, appears somewhat circular, is difficult to apply, and is open to interpretation that could lead to more unbundled health contracts. The Glossary definition uses the term “distinct” to define a performance obligation, but the framework in 25-4 through 25-7 requires that a contract feature must be **both**: (1) a performance obligation, and (2) distinct to be unbundled, implying that a feature could be a performance obligation without being distinct. We suggest that the glossary definition of ‘performance obligation’ be revised to remove the circular application of the term “distinct.”

## ***Measurement Approaches***

We continue to believe a simplified approach is best suited for both short-duration contracts and those contracts with longer-term claims run-out for which the variability in the timing and amount of cash flows may be more than insignificant. The vast majority of health insurance contracts issued by managed care companies have predictable payout patterns and virtually all insurance risk has been extinguished within a few months of the end of the coverage period.

We commend the Boards for addressing the concerns voiced by our industry in proposing simplified models to be used for insurance contract assets and liabilities. We believe that the PAA (including our recommendations included in this letter) should appropriately apply to most health insurance contracts given the proposed criteria and 834-10-25-18. We support the outcome that most of our contracts will be accounted for under a simplified model that appropriately reflects the economic substance of our products and that they should not be subject to the complexities and cost of applying the Building Block Approach (BBA).

Nevertheless, we have some concerns with the “one year or less” bright-line characteristic proposed in 834-10-25-18(a). Existing authoritative guidance is more principles-based and has generally resulted in appropriate classification of insurance contracts between short- and long-duration. Accordingly, the principles based approach should be retained that will allow contracts written by insurance companies that are clearly of short-duration to continue to apply the simplified PAA reporting model. In the absence of principles-based guidance we run the risk of health insurers applying different accounting models to insurance contracts with similar characteristics with the exception of the coverage period.

We suggest that the FASB consider revising 834-10-25-18(a) as follows:

- a. The coverage period of the insurance contract (determined in accordance with the boundary of the contract in paragraphs 834-10-25-14 through 25-15) is one year or less. The insurance contract provides coverage for a fixed period of short-duration and enables the insurer to cancel the contract or to adjust the provisions of the contract at the end of any contract period, such as adjusting the amount of premiums charged or coverage provided. A coverage period of one year or less will typically meet this characteristic.

## ***Portfolio and Contract Boundary***

### *Definition of a Portfolio*

Under current authoritative guidance, a portfolio of insurance contracts is determined in a manner consistent “with the insurer’s manner of acquiring, servicing and measuring the profitability of its insurance contracts.” Although this judgmental definition may create some perceived diversity in its application, the use of the portfolio concept is currently limited to identifying and measuring premium deficiency reserves (PDR). We believe that PDR is most meaningfully presented in a manner consistent with an entity’s management of its business, so that some level of diversity is appropriate given that various entities may have very different strategies for collectively managing their insurance risks. We understand that the Boards are concerned that losses for certain contracts or groups of contracts will be offset by profitable contracts and not recognized timely. However, the economic reality of insurance is the pooling of risk such that loss contracts should be offset by profitable contracts and the alternative of creating a multitude of groups of similar contracts to identify and recognize losses earlier in a 12-month period, producing higher profits for the remaining groups of contracts will demand significant detailed data, estimates, systems, human resources, controls and audit processes that appear unwarranted. We do

not believe that unwarranted offsetting has been an abuse historically and recommend that the proposed definition be modified to mirror that used in the Codification.

Furthermore, we believe the proposed definition could result in significantly lower levels of portfolio identification for certain types of products. For example, the discrepancy in the issue age of two policyholders can make those respective contracts that are issued at the same time and similar in design and structure to be bifurcated into two separate portfolios simply because the contracts are determined to have different durations.

If the Boards continue to require refinement of the current definition, a more appropriate definition is as follows:

A group of insurance contracts with similar risks that are priced adequately for the risk undertaken and managed together as a single pool.

### *Contract Boundary*

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 rating level are not as restricted, as described below).

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 the recently enacted comprehensive health reforms of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (Health Care Reform) in the United States. Health Care Reform impacts an insurer's ability to underwrite and price insurance risk. The reforms also introduce regulations 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 preexisting medical condition. An insurer will also be required to renew the policy regardless of changes to the health of the insured. These provisions require that we cannot refuse to sell a group any product that we are currently approved to sell in the market. However, we can terminate an entire product line. If an entire product line is terminated, the impacted policyholders can simply buy a different product offered in that market. The only way to avoid selling any product to the impacted policyholders is to withdraw from the market completely. Furthermore, the legislation introduces an annual rate review by the states for the individual and group markets that 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. Rates requested for approval must be actuarially sound for the current rating period and do not take into account risks related to future period contract renewals.

Assessing risks at the rating level, rather than by contract, more faithfully represents the concept of pooled insurance risk and the regulatory framework that governs the insurance industry, and in that regard we agree with the decision to provide some flexibility via the (a) and (b) criteria in 834-10-25-14. However, 834-10-25-14(b)(1) requires that an entity must have the right or ability to reassess the risk of the portfolio by setting a price that "fully reflects the risk of that portfolio." This appears to ignore the

reality that an insurance contract “can only exist within the context of its legal and regulatory environment,” as acknowledged in BC88. The implication is that health insurance contracts, typically priced for a twelve-month coverage period, could be extended for multiple consecutive coverage periods in the form of one single contract for accounting purposes under the Proposed Update. We do not agree with an accounting principle that extends a contract’s boundary beyond the contractual terms due to the regulatory environment in which we operate, nor do we believe this approach would faithfully depict the economic substance of managed care pricing and management of insurance risk. The regulatory review and approval of rates “sets” the market rates for these contracts. As noted above, if the rate approvals are not adequate, health insurers are generally not required to participate in these markets.

To the extent that there are regulatory requirements limiting policy renewal or re-pricing (that exist for virtually all insurance contracts), the contract boundary definition should be clarified to focus on the economic substance of contracts operating within these externally-defined regulatory boundaries. We suggest modifying the contract boundary definition as follows:

**834-10-25-14** The contract boundary is the point at which the entity no longer has a substantive obligation to provide the policyholder with coverage, which occurs when either of the following takes place:

- a. For an individual contract, the entity is no longer required to provide coverage or has the right or the practical ability to reassess the risk of the particular individual policyholder and, as a result, can set a price or level of benefits that reflects that risk.
- b. For a portfolio of contracts, if both of the following criteria are satisfied:
  1. The entity has the right or the practical ability to reassess the risk of the group of contracts and, as a result, can set a price or level of benefits that ~~fully~~ reflects their risk. Reflecting their risk means that the insurer is reasonably compensated for the risks assumed, not that a certain level of profit is achieved; and
  2. The pricing of the **insurance contract premiums** for coverage up to the date that the risks of the portfolio are reassessed does not take into account risks relating to future periods.

**834-10-25-15** An entity shall determine the boundary of an insurance contract considering all substantive rights held by the policyholder, whether arising from contract, law, or regulation. Where applicable laws or regulations limit the ability of an insurer to cancel or non-renew a contract, but allow the insurer to re-price at the time of renewal based upon approved premium rates, the renewal date should be considered the contract boundary as long as the approved rates are based on an assessment of the risk at the contract or group rating level. An entity shall reassess its determination of the boundary of an insurance contract at each reporting period to the extent that there are changes in contractual features.

Additionally, because most health insurance contracts would use the PAA by virtue of 834-10-25-18(b) a contract boundary definition resulting in a multi-year view of these contracts has the potential to create extraordinarily complex and misleading accounting results. If a typical health insurance contract would be viewed as a long-term, multi-year arrangement because of the rigid contract boundary definition, an accounting model that is intended for short-duration contracts would be applied for a longer, multi-year contract. Recording multiple years’ worth of unreliably estimated premiums receivable and a corresponding multi-year liability for remaining coverage at contract inception would lead to a PAA balance sheet presentation that would be overwhelming in size, very misleading and unrepresentative of economic reality.

### ***Fulfillment Cash Flows***

We do not believe that the process for estimating the liability for incurred claims under the PAA and the insurance contract liability under the BBA should be presented based on an unbiased estimate given that significant judgment is required and multiple scenarios are currently considered in the overall actuarial models and processes. 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 scenarios and inputs in developing an actuarial mean estimate. We believe that attempting to prescribe a formulaic approach for this assessment (by requiring a 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.

The insurance liability under both the PAA and BBA is inherently judgmental and should be determined based on moderately adverse conditions in order to reflect the presence of risk in the contract during both the coverage and claim settlement period where actual claims may develop differently from expected claims. We believe this risk would be adequately covered through the recognition of a liability that is actuarially sound under moderately adverse conditions consistent with U.S. actuarial standards of practice that are in place today.

We believe that the proposed change in how the insurance liabilities are calculated would require significant costs to be incurred in order to revise actuarial techniques, models and controls as well as educating the preparers and users of our financial statements. We believe that users of our financial statements understand the inherent judgments in our reserve calculations. In addition, in order to address the concern that an adjustment for risk might introduce a manageable bias into the measurement of the liability, we support the IASB's proposal to disclose judgments, methodologies, and inputs used to determine the related confidence level. We believe that these disclosures can be presented within an entity's disclosure of critical accounting estimates and would allow users of its financial statements to compare the quality of the actuarially determined liabilities. In addition, we currently provide users with a roll-forward of our actuarial reserves that distinguishes claims incurred from claims paid as well as how the claim reserves have developed (commonly known in the industry as "favorable or unfavorable prior-period development"). We believe this disclosure is transparent and helpful for users to understand the sufficiency of actuarially determined liabilities each reporting period.

Ultimately, we believe the current approach is adequate, transparent, and well understood by users of our financial statements. We believe that the combination of an insurance liability that is based on an entity's confidence level along with disclosure of the judgments used to calculate the insurance liability provides transparent information to all users. Therefore, we believe that the costs of calculating the reserve using an unbiased approach would significantly outweigh the perceived benefits.

The Proposed Update's definition of a liability for incurred claims under the PAA and the definition of margin under the BBA utilize the phrase 'fulfillment cash flows', whose definition includes claims handling costs and policy maintenance costs. As such, it appears that the Proposed Update's fulfillment cash flows concept in essence commingles items that typically today are calculated and presented separately. If this was in fact the Boards' intent, this will likely add some complexity, relative to current

practice, with respect to the reconciliation of opening and closing balances of the liability for incurred claims and margin, in our view, with no perceived benefits.

However, if the model under the Proposed Update is retained, we believe the margin should be recognized over the contract and settlement period to reflect the risk extending through the settlement period.

### ***Discount Rates and Discounting***

We commend the Boards for addressing concerns of the managed care industry regarding volatility in net income resulting from reassessing the discount rate at each reporting period. We acknowledge that allowing changes in the discount rate to be recorded in other comprehensive income (OCI) will reduce volatility in net income; however, we have a number of operational concerns with this requirement. We believe that updating the discount rate at each reporting period while continuing to track the discount rate at inception would place a significant burden on the actuarial process. Furthermore, the correlation of OCI related to the insurance liabilities and the investment portfolio is highly contingent on the outcome of the financial instrument projects, given the potential to be required to record more investments at amortized cost or fair value with changes in net income or other comprehensive income. Therefore, we recommend that:

- The requirement to record the effects of changes in the discount rate in OCI be elective, depending on management's investment portfolio decisions and resulting classifications; and
- If the financial instruments project is implemented prior to this Proposed Update that this Proposed Update allow for reconsideration of management's classifications of financial instruments supporting portfolios of insurance contracts.

Furthermore, we disagree with the two proposed alternatives for determining the discount rate to be utilized in the measurement of the insurance contract liability. Based on an analysis of our long-duration contracts that we maintain today, utilizing the discount rate that is prescribed in the proposal could have significant unintended consequences by creating accounting losses at the inception of these contracts even though they are economically profitable. These potential losses are driven primarily by the fact that the insurer is compensated for the uncertainty inherent in the projected future cash outflows in fulfilling the contract and earns a profit margin on the contract. Taking these into account requires a spread above and beyond the discount rates prescribed by the proposal. The FASB acknowledged this potential pitfall in BC148.

Alternatively, consistent with BC 157, we believe the discount rate used in the pricing of contracts (pricing rate) most accurately reflects the characteristics of the liability and is more reflective of our business economics. However, older books will require a practical expedient as asset and pricing data is not always available. Additionally, in BC157, the FASB contends that the pricing rate is not observable and there would be complexities in determining current rates each reporting period, however, we believe that this rate is no more or less observable and/or complex than the two alternatives prescribed in the Proposed Update.

### ***Insurance Contract Revenue***

Because health care insurance contracts are often: (1) cancellable by the insured during the contract boundary, and (2) variable based on the number of consumers served throughout the year, actual revenue can vary significantly from estimated revenue at the beginning of the contract period. The proposed

guidance is not clear on how an insurer should recognize changes in recorded premium receivables and estimated revenue as better information becomes available during the contract boundary. We do not believe that such changes are appropriately reflected as modifications as they are provisions of the original contract versus a change in the terms of the contract. Rather, when additional information is obtained that indicates a new estimate is required, the liability for remaining coverage and the premium receivable amount should be adjusted at that time to reflect the new best estimate. If the proposed model is retained, implementation guidance should be added to provide clarity on this point.

#### *Pattern of Revenue Recognition*

The proposed pattern of revenue recognition will add unnecessary complexity and estimation into our financial statements, leading to diversity in practice, changes in key performance metrics, and will require substantial involvement from actuarial experts that places an unnecessary cost burden on preparers.

As stated in the Proposed Update, the pattern of revenue recognition under the PAA must be based on “the passage of time or on the expected timing of incurred claims and benefits if that pattern differs significantly from the passage of time.” The FASB acknowledges in BC336 that some diversity in practice may exist under the proposed pattern of revenue recognition model. We have the same concern and agree with this conclusion. Under the PAA, we suggest retention of the existing U.S. GAAP principle to recognize revenue over the coverage period in proportion to the amount of insurance protection provided to avoid comparability issues that will result in quarter-to-quarter variability with no meaningful benefit to the users of our financial statements.

While we believe the existing model for short-duration contracts appropriately addresses revenue recognition, reserves for incurred but not reported claims and the risk of loss development, if the Boards pursue the PAA model approach, then we strongly recommend the following improvement to margin recognition.

Because the risk of variability of claim payments under certain PAA products extends well beyond the contract’s coverage period, we believe that the PAA margin should be recognized over the coverage and settlement periods as services are provided and consistent with the BBA approach. For some products the economics are such that risk is substantially diminished within the coverage period, however, with products such as group long-term disability uncertainty remains well beyond the coverage period. Such products are measured based on the premium allocation approach under the proposed guidance primarily because of their one-year coverage, however such products typically experience upwards of 5-7 years of claim run off. Limiting the margin recognition to the coverage period while the risk of changing cash flows continues throughout an extended settlement period demands an extended recognition period for the PAA margin. Otherwise, claims development will produce variability in future disability income and future cash flows will be less predictable and less transparent to the users of long-term disability insurers.

Therefore, we recommend that margin be recognized as the entity is released from risk – evidenced by a reduction in the variability of cash outflows and that 834-10-35-27 be modified to: “An entity shall reduce measurement of the liability for remaining coverage in proportion to the value of coverage that the insurer has provided and as the variability of cash outflows are reduced.”

#### *Estimated Returnable Amounts and Loss Sensitive Features*

The interaction between estimated returnable amounts and loss sensitive features is unclear. As currently proposed, we believe that certain features in our health insurance contracts could meet the definition of either estimated returnable amounts or loss sensitive features and as a result would inappropriately be

treated as estimated returnable amounts, significantly misrepresenting these features. Additionally, further guidance is required regarding the recognition and presentation of loss sensitive features.

Within typical health insurance contracts there are a number of features that result in adjustments to the ultimate amount of premium we retain. For example, Health Care Reform requires:

- Rebates to be paid if our medical loss ratios (MLRs), or at a high level medical costs divided by premiums, are below certain percentages in our individual, and small and large group commercial businesses and, starting in 2014, in Medicare Advantage business;
- Risk adjustments in Medicare programs and for our individual and small group businesses with premiums adjusted by the accumulation of individual risk scores; and
- Risk corridors that share risk based on claim experience within certain thresholds in Medicare Part D contracts, as well as, temporarily starting in 2014, to individual and small group businesses, and other types of gain-sharing provisions.

In addition, experience-rated risk-sharing provisions, whereby ultimate premium is adjusted/determined based on **claim** experience, are typical in large group products. For these contracts, experience-rating does not mean that the insurer is guaranteed a margin or the policyholder is guaranteed a fixed return rather that there is risk sharing within the insurance contract between the insurer and the policyholder.

Estimated returnable amounts are defined in the Proposed Update as: “amounts a contract requires an entity to pay to policyholders regardless of whether an insured event occurs.” These amounts would be excluded from premium revenue and from benefit expenses. If some of these features are determined to be estimated returnable amounts, separating premiums based on the maximum payable or refundable amount will result in a material change in revenue and expenses recognized. We believe that excluding a vast majority of premium (and claims) components of such contracts will render volume and scale metrics unusable and will result in materially different and potentially misleading obligations to perform insurance services. In our view, the principle objective of sound financial reporting is to ensure accounting outcomes depict the manner in which an insurer prices, assumes and manages insurance risk – excluding this volume (potentially 80% of current premiums for certain portfolios) will not satisfy that reporting objective. We believe that where the law limits our profits, such circumstances should be excluded from the definition of estimated returnable amounts. We also believe that the proposed definition is unclear such that significantly varying interpretations are possible. The MLR rebates required under current Health Care Reform mentioned previously provide a relevant illustration of this concept:

- The definition could be reasonably interpreted to *apply* to these MLR rebates that are paid to each individual beneficiary **because the calculated rebate amounts depend on the occurrence of insured events.**
- However, another interpretation could conclude that the definition *does not apply* **because an individual beneficiary could theoretically incur high levels of claims yet still receive a rebate** (the rebate amounts are calculated at a pool level and the pool losses could be relatively lower).

To address these concerns and to clarify the interaction between estimated returnable amounts and loss sensitive features we recommend the scope of the estimated returnable amount guidance be clarified to exclude loss-sensitive features, features intended to adjust premium to better reflect the risk of an insured population, premium adjustments that are mandated by regulation and are directly related to the insurance coverage provided, and incorporate a “pool” exception to clarify that the definition of estimated returnable amounts is intended to cover features at a contract level, not at the pool level.

Additional guidance is required regarding the recognition and presentation of loss sensitive features. The proposal contains only one sentence in 834-10-35-36 discussing the treatment of loss-sensitive features – a surprising lack of guidance for a requirement that could have significant impacts on revenue recognized by health insurers based on the examples provided above. It is very common for health insurance contracts to contain provisions that allow for some level of premium adjustments based on actual claims experience. Experience-rated contracts, retrospective rating provisions, risk corridors, and other types of gain-sharing provisions might all seem to meet the definition of loss-sensitive features. The effect of reclassifying all potential adjustments relating to these features from premium revenue to claims expense would be an artificial gross up of value metrics obtained from financial statements that do not reflect the economic reality that insurers, customers, and regulators all have with respect to these features as contractual price adjustments, not medical costs paid to health care providers for claims. Key ratios and metrics used by our investor community would no longer be meaningful in relation to current reporting and contracts with similar economic substance but different pricing mechanisms could result in inconsistent application.

We believe that the existing recognition guidance in U.S. GAAP ASC 944-605-25-25-2 for experience rated contracts should be retained and incorporated into the loss sensitive feature guidance. That guidance states: “If the ultimate premium is reasonably estimable, the estimated ultimate premium shall be recognized as revenue over the period of the contract. The estimated ultimate premium shall be revised to reflect current experience.” Related to presentation, the Proposal should be adjusted to include guidance to allow for proper classification of loss sensitive features based on whether or not those features result in an adjustment to the ultimate amount of premium retained by the insurer or an adjustment to the amount of losses incurred by the insurer. If the features result in an adjustment in the premiums paid, those features should be classified as revenue adjustments.

### ***Insurance Contracts Acquired in a Business Combination***

We believe that entities should not be required to record a loss on insurance-related contracts at the acquisition date for any excess of the amounts recorded under the Proposed Update exceeding their fair values. Instead, insurers should continue to use current business combination guidance in ASC 805 and increase or decrease goodwill for the differences between the fair value and measurement of the net insurance related assets determined in accordance with the guidance in this proposal.

Under current authoritative guidance, assets and liabilities acquired in a business combination are recorded at fair value, with intangible assets, such as customer relationships, recorded separately from goodwill. The amount of purchase price in excess of the fair value of the net assets recorded is recognized as goodwill, not as a loss on the income statement. In rare circumstances, if the fair value of the net assets recorded exceeds the purchase price, the excess is recorded as a bargain purchase gain in net income. This bargain purchase gain is only recorded after a thorough reassessment of all elements of the accounting for the acquisition. We believe that the current business combination accounting model most appropriately and consistently recognizes the value of a business acquired.

Recognition of the total value of a business acquired is an important concept within the current business combination guidance. In determining the amount of consideration an entity might deliver for an acquisition target, many factors are considered, including those related to entity specific operating results as well as items associated with a particular industry. Within the insurance industry, factors might include enrollment, market share, or ability to price products based on this market share. When an acquisition is completed, the fair values of the acquired assets and liabilities assumed are determined using many estimates that are based on management judgment. All of these estimates, including amounts recorded for goodwill, equate to the total consideration delivered. The validity of assumptions made about the fair

values of the acquired assets and liabilities assumed at the acquisition date will be determined over time and any differences will be recorded to net income. We believe it is appropriate to record total value, including net goodwill, at the time of the acquisition. Not doing so might inflate the overall goodwill associated with an acquisition if a loss related to insurance contracts is recorded at the acquisition date.

We also believe that the proposal should allow practical expedients for entities that either dispose of a business through sale or reinsurance of the business after the transition date but prior to the effective date.

*Business disposals by sale prior to the effective date of a new insurance standard:*

- For businesses disposed of after the transition date but before the effective date, we see no benefit to users of restating prior period information using the proposal's measurement models. (Businesses disposed of before the transition date would naturally be disregarded in the adoption.) For businesses reported as discontinued operations, we do not believe that the application of the Proposed Update to discontinued operations prior to the effective date of a new standard provides useful information, as the discontinued operations of a prior period are not relevant in assessing the ongoing operations of an entity.
- We also believe that the costs of restating prior period information will outweigh any perceived benefits. The entity that sells the business (the "reporting entity") will most likely not have the personnel or records of the sold business necessary to meet the retrospective restatement requirements of the proposal. For the reporting entity, determining fulfillment cash flows and the appropriate discounting will be cost prohibitive and impracticable because the reporting entity will likely not own the intellectual property and systems necessary to perform the retrospective measurements. This problem will exist for the reporting entity even if it has access to the books and records of the acquirer because the current state of books and records may not allow for the data necessary to perform the retrospective measurements of the proposal. However, the larger issue is that the business experts, including actuaries familiar with the sold business, who have the expertise to perform the proposal's measurements, will likely no longer be employed or controlled by the reporting entity.
- We also believe that it will be cost prohibitive and impractical for the reporting entity to depend on the acquirer to provide information necessary for the reporting entity to restate prior period information and the gain or loss on the disposition. In order to retrospectively restate prior periods for its own financial statements as well as provide prior period restated information to the reporting entity, an acquirer would have to perform two different measurements. The proposal requires the acquirer to use assumptions as of the acquisition date in accordance with the acquiring entity's accounting policies; however, for the reporting entity the assumptions would need to reflect fulfillment cash flows and discount rates that would have been established at the inception of the insurance contracts. We believe full resources will be utilized by all entities that are implementing a new insurance standard, and do not believe that an acquirer will have the resources to also re-measure businesses acquired for prior periods using the reporting entity's assumptions and accounting policies.
- We recommend that any business sold prior to the effective date be allowed a practical expedient to be exempt from retrospective restatement.

*Business disposals by reinsurance prior to the effective date of a new insurance standard:*

For businesses effectively disposed of through reinsurance after the transition date but before the effective date, we believe the proposal should allow a practical expedient for a ceding company to measure its direct and ceded insurance based on the acquirer's/reinsurer's accounting policies and measurements as of the effective date of the ceded reinsurance, and for the ceding insurer's direct and ceded accounts to be

exempted from the retroactive transition application rules for periods prior to the effective date of the ceded reinsurance, especially in situations in which the assuming reinsurer accounted for the assumed business as a business acquisition or portfolio transfer. Our rationale for this is as follows:

- In many disposals effected as reinsurance transactions, it is customary for the assuming reinsurer to administer the business for the ceding entity, including the financial administration pertaining to the ceding entity's GAAP and statutory reporting requirements. Under the proposal, the assuming entity's measurement basis for the assumed business may differ from the ceding entity's direct and ceded amounts under either the BBA or PAA, as the proposal requires that the acquiring entity use assumptions as of the acquisition date in accordance with the acquiring entity's accounting policies.
- The proposal requires the acquiring entity to accrete interest based on the discount rates at the date of acquisition or portfolio transfer and set the initial margin also as of the acquisition date.
- For reinsurance transactions after the transition date but prior to the effective date, we believe it will be impractical and cost-prohibitive to require an assuming reinsurer to retrospectively measure the reinsured business under two different measurement models (one model for reporting its acquired, or assumed business, and another model for meeting its obligation to provide direct and ceded amounts for the ceding entity) for prior periods. We do not believe that an acquirer will have the resources to re-measure businesses acquired for the prior periods required to be reported by the reporting entity while it is attempting to implement a new insurance standard for its own acquired, or assumed, business.
- We believe it will also be impractical to require a ceding company to apply the building blocks or premium allocation measurement model to a business it has sold through reinsurance and no longer has the intellectual property, personnel, data or underlying systems necessary to effect such retrospective restatement.

### *Presentation*

#### *Balance Sheet Gross-Up*

For contracts meeting the PAA model, the proposal's "liability for remaining coverage" concept differs materially from existing practices for unearned premium reserves. Generally, for short-duration U.S. health insurance products, premiums are considered due monthly with their rates generally fixed for 12 months. Our predominant accounting practice has been to record a receivable asset for premiums not yet paid for full or partial coverage months prior to the financial statement date, and an unearned premium reserve reflecting premiums received that pertain to full or partial coverage months subsequent to the financial statement date. We believe this properly reflects the typical contractual terms for health insurance arrangements.

However, under the guidance in paragraph 834-10-25-14, the contract boundary would generally extend until the end of the 12-month policy period, that being the point when the insurer has the ability to adjust pricing for or cancel the contract. As such, the insurer would record a liability equal to the expected premiums to be collected across the entire 12 months, and would record a corresponding asset for premiums receivable.

The balance sheets of U.S. health insurers would be materially grossed up under the Proposed Update compared with current practice, diluting the significance of all other balance sheet line items, with large premium receivables relating to the expected premiums that are not yet contractually due and correspondingly large liabilities for remaining coverage. This treatment is at odds with the Boards'

proposed revenue recognition guidance whereby recognizing a contractual asset or liability depends on the relationship between the entity's performance and the customer's payment. We believe the existing U.S. GAAP approach of recording premium receivables to the extent coverage is provided before payment and unearned premium to the extent cash is received in advance of insurance coverage is the most appropriate presentation for these amounts and more accurately reflects contractual terms, including cancellation provisions (customers generally can cancel contracts with short notice periods).

*Significant number of line items on the face of the statements*

Under the Proposed Update, the following items are required to be presented in the statement of financial position:

- insurance contract asset (BBA);
- insurance contract asset (PAA);
- reinsurance contract asset (BBA);
- reinsurance contract asset (PAA);
- insurance contract liability (BBA);
- margin (BBA), liability for remaining coverage (PAA); and
- liability for incurred claims (PAA).

Given our comments above regarding the gross-up of the statement of financial position, if the proposal is revised to require application of existing U.S. GAAP as it relates to premiums receivable and unearned premiums, the insurance contract asset (PAA) and liability for remaining coverage (PAA) would no longer apply and would be replaced with premiums receivable for amounts earned and not yet paid and unearned premiums. We believe the remaining proposed items required to be presented on the face of the statement of financial position are appropriate given the varying settlement dates associated with PAA and BBA contracts.

Under the Proposed Update, insurers are required to separately present the following line items in the statement of comprehensive income:

- insurance contract revenue (separated between PAA and BBA);
- incurred claims and benefits (separated between PAA and BBA);
- acquisition cost amortization (or immediate expensing under a voluntary election); and
- the gross underwriting margin.

We believe this volume of items required in the statement of comprehensive income will not provide additional meaningful information to users. Rather, we believe that grouping these items into fewer line items consistent with current practice and providing similar information in footnote disclosures would clearly present performance and result in less complexity on the face of the statement while continuing to provide relevant information to users. We suggest the following line items on the statement of comprehensive income, to the extent material:

- insurance contract revenue (combined BBA and PAA);
- ceded reinsurance consideration (combined BBA and PAA);
- claims/benefits incurred (combined BBA and PAA)\*;
- reinsurance recoverable for claims/benefits incurred; and
- amortization of qualifying acquisition costs.

*\*Includes adjustments for changes in estimates of future benefits/claims and reversals of those changes.*

We believe the current disclosure requirements pertaining to segments that require disaggregated revenue by product, geography, etc. provides more relevant, transparent, and useful information to financial statement users than disaggregation based on the BBA and PAA approaches. Otherwise, we believe a more appropriate presentation of these items would be in the footnote disclosures thereby minimizing the volume of line items and complexity on the face of the statements.

#### *Presentation of the insurance contract liability under the BBA*

Under the BBA, the insurance contract liability should be bifurcated in order to provide users of financial statements with useful information regarding the balance of the pre-claims liability as well as the incurred claims liability.

As presented in the Proposed Update, under the BBA, a single insurance liability would be recorded that would include both the expected fulfillment cash flow for pre-claims liabilities as well as the liability for incurred claims. We believe that these two liabilities are separate and distinct, not only in the way that they are calculated and the assumptions that drive that amount but in the level of uncertainty and risk associated with each. Given that, we believe that the insurance contract liability under the BBA should be recorded consistently with current practice, whereas a separate liability is recorded for the pre-claims liability (i.e., future policyholder benefits) as well as the estimate of incurred claims.

We believe the pre-claims liability and incurred claims liability should be separately presented on the balance sheet in order to provide users of our financial statements with additional transparency. Under the Proposed Update, users of the financial statements would have a difficult time understanding and reconciling the beginning and ending balances of the insurance liability as the inputs in the reconciliation are drastically different for each of the components of the liability. For example, when premium is collected the pre-claims liability would increase; however, once a claim is incurred the pre-claims liability would be reduced while the incurred claims liability would subsequently increase. Given these changes in the composition of the liability, we believe users would better understand the reconciliations of beginning and ending balances if these two liabilities were separately presented. From an operational perspective, we believe these liabilities would already need to be tracked and analyzed separately and then combined into a single insurance liability on the balance sheet.

Presenting the insurance liabilities separately allows users of financial statements to understand the economics of the different liabilities. The liability for incurred claims would be consistent with that of the PAA while the pre-claims liability would represent premiums collected that will be used in future periods as well as any changes in estimated fulfillment cash flows.

We believe this approach is more transparent for users of our financial statements and presents information clearly on the balance sheet.

#### *Disclosure*

##### *Significant and uncertain detail required in disclosures*

The Proposed Update includes disclosures that discuss the impact of new business, cash flows, changes in assumptions, de-recognition of contracts, and the time value of money. Some of the required information is forward looking and would be most appropriately included in the Management's Discussion and Analysis (MD&A) section covered by the safe harbor provisions for forward-looking statements contained in the Private Securities Litigation Reform Act of 1995. As such, we believe this information would be more appropriately presented in the MD&A section. Examples include the requirement to

disclose the nature and extent of risks arising from insurance contracts (834-10-50-1(c)), explanations of reconciliation amounts including the reasons for the changes in the current period of prior estimates of the expected cash flows (834-10-50-10(a)) and the primary drivers behind the amount disclosed (834-10-50-10(c)). Further, we believe a portion of the sections on ‘Inputs, Judgments, and Assumptions’ and ‘Risks’ that encompass paragraphs 834-10-50-23 through 834-10-50-35, are most appropriately presented in MD&A, to the extent the required disclosures are forward looking. We strongly recommend that such forward-looking data be presented within the MD&A to afford safe harbor protections and avoid unnecessary potential litigation costs arising from likely changes in these estimates as time passes.

### ***Effective Date and Transition***

The coupling of disruption arising from implementing Health Care Reform legislation continuing over the next several years with possible revolutionary changes in reported financial information from implementing multiple significant new accounting standards covering insurance contracts, revenue recognition and financial instruments, could produce significant and unintended consequences in the manner of recognizing and presenting the majority of our businesses’ results. This will require unprecedented amounts of resources for data, process, internal control, and information system changes. The adoption of this legislation and the potential changes to U.S. GAAP are large undertakings and will require significant time and effort from our accountants, actuaries, management, our Boards of Directors, and auditors to make certain that these changes are appropriately examined and tested to validate that we are gathering, analyzing, and presenting our financial information appropriately and clearly. Furthermore, the magnitude of the proposed changes would warrant significant investor education.

We urge the Boards to ensure that the new standards are operational and are focused on producing financial reporting that truly represents the information that investors and other users need to make decisions.

Based upon the significance of the changes we anticipate with the Boards’ current project plans, we again stress the importance of creating accounting standards that are as converged as possible. The Insurance Contracts and Financial Instruments projects still contain key fundamental differences, and we urge the FASB and the IASB to work together diligently to eliminate these differences and improve the measuring and reporting models. We feel that fully-converged and high-quality decisions on all projects must take priority over meeting arbitrary deadlines.

We recommend that the Boards deliberate the effective date and transition of the major convergence standards holistically, rather than individually, taking into consideration the impact and interdependence of these standards to preparers, particularly for issuers of insurance contracts. In consideration of the concerns expressed by our investor communities that disruption and iterative change in the reporting models be minimized, we support a “big bang approach” and encourage the Boards to provide a minimum of six and a half years following the release of final fully-converged standards for implementation. This date will allow 18 months for interpreting the new accounting guidance, educating internal and audit staff, and developing the necessary system infrastructure and human capital; then five years to obtain and construct underlying data, run parallel systems, and educate our corporate governance functions and external constituents about the effects of the changes. We believe the need for parallel systems and the time to deliver could be significantly decreased depending on the pervasiveness of changes adopted. If the Boards converged by adopting limited changes to the current U.S. GAAP models for insurance, these timelines could be relatively shortened and investments in infrastructure and human capital minimized.

We believe that one ultimate date for implementation will result in less confusion for both the domestic and international investor and preparer communities, helping to make the adoption process and recovery from the associated market confusion swift and efficient.

Additionally, preparers will gain efficiencies with one-time system updates and upgrades to comply with the new standards as well as a one-time restatement of historical financial statements.

Once a timeline for implementation has been established, we agree with the FASB that retrospective adoption is the most appropriate transition for these accounting standards. Retrospective adoption provides the user comparative information for all years on the same basis of accounting, therefore increasing comparability and transparency. Therefore, we also recommend that early adoption be prohibited.

\* \* \*

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.

If we can provide further information or clarification of our comments in the meantime, please call any of the signatories listed below.

Sincerely,



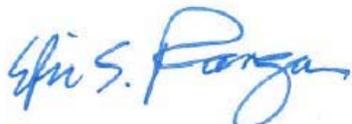
Rajan Parmeswar  
Aetna Inc.  
Vice President, Controller and Chief Accounting Officer  
(860) 273-7231



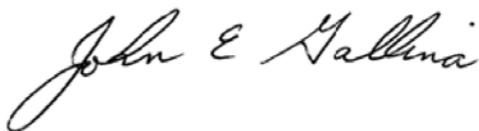
Mary T. Hoeltzel  
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## APPENDIX

### BACKGROUND – 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 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, along with the discussion of government health care reform legislation below, is important to any discussion of the accounting model for our industry.

#### *Health Care Reform*

In March of 2010, the comprehensive health reforms of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (Health Care Reform), were signed into law in the United States. This legislation is intended to expand access to coverage and modify aspects of the commercial insurance market, as well as Medicaid and Medicare programs, Children’s Health Insurance Program (CHIP) and other aspects of the U.S. health care system. Certain provisions of Health Care Reform have already taken effect and other provisions become effective at various dates over the coming years. The U.S. Department of Labor (DOL), U.S. Department of Health and Human Services (HHS) and the U.S. Treasury Department have issued or proposed regulations on a number of aspects of Health Care Reform, but final rules and guidance on other key aspects of the legislation remain pending.

One significant component of Health Care Reform is the establishment of a federal premium rate review process, which generally applies to proposed rate increases equal to or exceeding 10%. The regulations further require commercial health plans to provide to the states and HHS extensive information supporting any rate increases subject to the new federal rate review process. The regulations clarify that HHS review will not supersede existing state review and approval processes, but plans deemed to have a history of “unreasonable” rate increases may be prohibited from participating in the state-based exchanges that are scheduled to become active under Health Care Reform in 2014. Under current regulations, the HHS rate review process would apply only to health plans in the individual and small group markets.

In another significant change, under Health Care Reform all individual and group health plans must offer coverage on a guaranteed issue and guaranteed renewal basis during annual open enrollment and special enrollment periods and cannot apply pre-existing condition exclusions or health status rating adjustments. These plans must also provide certain essential health benefits, with member cost-sharing limitations and no annual limits on essential benefits coverage.

Overall, Health Care Reform and the related federal and state regulations will fundamentally impact how we do business and could restrict revenue and enrollment growth in certain products and market segments, restrict premium growth rates for certain products and market segments, increase our medical and administrative costs, expose us to an increased risk of liability (including increasing our liability in federal and state courts for coverage determinations and contract interpretation) or put us at risk for loss of business.