



# AMERICAN ACADEMY *of* ACTUARIES

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August 24, 2006

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



LETTER OF COMMENT NO. 49

Dear Sir/Madam:

We are submitting this comment letter concerning your Invitation to Comment (ITC) regarding “Bifurcation of Insurance and Reinsurance Contracts for Financial Reporting” on behalf of the Financial Reporting Committee of the American Academy of Actuaries<sup>1</sup>.

Since this ITC could have different effects on different types of contracts and businesses, we asked Academy committees representing the property/ casualty, health, and life insurance practice areas to prepare separate responses. The responses are attached.

The Academy stands ready and willing to provide further technical input to you as you continue deliberation of the concepts contained in this ITC. Should you desire any clarification or expansion of these comments, please contact Tina Getachew at [getachew@actuary.org](mailto:getachew@actuary.org) or at (202) 223-8196.

Sincerely,

Henry Siegel  
Chair, Financial Reporting Committee  
American Academy of Actuaries

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



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

Dear Sir or Madame:

The Financial Accounting Standards Board (FASB) published an *Invitation to Comment on the Bifurcation of Insurance and Reinsurance Contracts for Financial Reporting* (ITC), dated May 26, 2006. The purpose of this letter is for the Committee on Property and Liability Financial Reporting (COPLFR) of the American Academy of Actuaries<sup>1</sup> (Academy) to provide comments to the FASB on the ITC as it relates to property/casualty (P&C) insurance and reinsurance.

### **Background**

As stated in the “Conceptual Framework” section of the ITC, the principal issue in the ITC is whether bifurcation of insurance and/or reinsurance contracts would improve the understandability and decision usefulness of financial statement information. As stated in the ITC, bifurcation would divide some or all of these contracts into the following components for financial reporting purposes:

- a. Components that transfer significant insurance risk and are accounted for as insurance
- b. Financing components that are accounted for as deposits.

The Conceptual Framework Section of the ITC lists the following criteria the FASB would consider in deciding whether bifurcation would improve the decision usefulness of financial statements:

- Understandability – enabling users to perceive the significance of information in financial statements

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- Relevance – helping users to form predictions about the outcomes of past, present, and future events or to confirm or correct prior expectations
- Reliability – verifiability and representational faithfulness
- Constraints – balancing costs versus benefits

In addressing the concepts in the ITC, COPLFR has accepted the criteria outlined above as guidelines by which to evaluate the proposal. Our letter is focused primarily on the actuarial and market aspects of the proposals in the ITC, rather than the accounting, tax, or regulatory aspects. As such, our comments address some, but not all, of the specific questions posed throughout the ITC. We also have separated our comments for insurance contracts versus reinsurance contracts, because we believe that, for the most part, the substance of the arrangements between policyholders and insurance companies differs significantly from arrangements between insurance and reinsurance entities. Finally, this letter addresses only P&C insurance and reinsurance arrangements; other Academy letters have been provided to address this topic from the life and healthcare perspectives.

Throughout this letter, we refer to “problematic” insurance and reinsurance contracts, which we define as contracts that have each of the following characteristics:

- The primary intent and/or motivation of the purchasing or ceding entity is to obtain a financial reporting result, as opposed to the primary motivation of purchasing a traditional contract, which would be to obtain a risk transfer and/or servicing benefit;
- The form of the contract is a nontraditional or manuscript form, in which most of the individual contract terms are not generally available to a market, but rather are negotiated on a case-by-case basis;
- The contract is “finite,” meaning that the contract contains an element of risk transfer, but the purchasing or ceding entity retains more of the risk in the insured or reinsured layer than would typically be the case under traditional contracts; and
- The financial reporting result over most or all scenarios is significantly disproportionate to the economics and amount of risk actually transferred.

## **Conclusions and Recommendations**

We understand and strongly support the FASB’s desire to address problematic contracts, and as such we believe that the FASB should limit its focus in this assignment to such contracts instead of considering a much broader focus that results in a comprehensive restructuring of the fundamental insurance accounting model. We believe that such restructuring could have considerable unintended consequences, and we recommend that the FASB consider the potential impact of the unintended consequences before deciding whether to implement such extensive changes.

We believe there are other important considerations that impact the FASB’s decision, as follows:

- Many of the problems that have been encountered result from the undisclosed effects of finite reinsurance agreements on ceding companies’ financial statements. The National Association of Insurance Commissioners (NAIC) has just approved extensive new reinsurance disclosure requirements that took effect at year-end 2005. Further, the NAIC has implemented a CEO and CFO attestation requirement regarding the documentation of risk transfer and economic purpose for

reinsurance contracts in which risk transfer is not reasonably self-evident. We believe that these new disclosures and documentation requirements will have a major impact on the existence of problematic reinsurance contracts.

- COPLFR is currently engaged in a project to assist the NAIC's P&C Reinsurance Study Group by addressing technical questions regarding risk transfer analysis and screening. The results of the project will be available in the fall of 2006. We believe the results of this project could be useful to the FASB in evaluating what changes, if any, should be made to address risk transfer issues. COPLFR is available to assist the FASB in evaluating proposals and testing alternative approaches on real-life reinsurance contracts.
- The International Accounting Standards Board (IASB) is addressing the entire insurance accounting model and, as we understand it, the FASB intends to work with the IASB towards a single, optimal accounting system for insurance and reinsurance products. In order to avoid potentially significant divergence between international accounting and Generally Accepted Accounting Principles (GAAP) accounting for reinsurance contracts, which would likely create substantial inefficiency and confusion, we recommend that the FASB evaluate the insurance accounting model concurrently with the IASB.
- On a similar note, the current insurance accounting guidance under U.S. Statutory Accounting Practices (SAP) is very similar to U.S. GAAP. Significant changes to the U.S. GAAP accounting model would result in substantial divergence between U.S. SAP and U.S. GAAP, which we believe would create inefficiencies and confusion and therefore should be avoided.

### **Summary of Comments**

Our overall comments regarding the ITC are as follows:

- The ITC expanded the FASB's scope from an initial focus on addressing the financial reporting for finite insurance and reinsurance contracts to a comprehensive evaluation of the accounting model for traditional insurance and reinsurance arrangements, which includes potentially bifurcating traditional insurance and reinsurance arrangements.

We strongly disagree with this expansion of scope because we believe that bifurcation of corporate insurance contracts, as well as non-problematic reinsurance contracts, would result in less useful information for the user of the financial statements of insurance companies and policyholders. We believe that bifurcation would also result in less comparability of financial statements among insurance companies and significant market disruption and cost to both policyholders and insurance companies, with little or no apparent benefit.

- With the possible exception of a narrow category of contracts that clearly bundle an insurance arrangement with a deposit arrangement, bifurcation of problematic contracts may not result in more decision-useful information. To deal with problematic contracts, we suggest requiring deposit accounting in its entirety, more comprehensive disclosure, and/or other approaches. The NAIC recently expanded its disclosure requirements for certain reinsurance contracts, and we suggest that the FASB consider some type of similar requirements.
- We strongly believe that the FASB should separate insurance from reinsurance when considering risk transfer and bifurcation, in large part because insurance agreements often contain a

significant servicing component in addition to risk transfer.

We believe that bifurcation should not be considered for primary insurance because of the significant servicing element generally inherent in such contracts; the severe limitations regarding data, expertise, and the resulting cost to the policyholder; and the minimal, if any, identifiable financial reporting benefit.

These particular limitations are less prevalent with reinsurance, because there is generally a smaller servicing component, and the buyer and seller of a reinsurance contract are presumed to have some of the requisite expertise to comprehend the risks inherent in the transaction.

- If *Statement of Financial Accounting Standards, No. 113: Accounting and Reporting for Reinsurance of Short-Duration and Long-Duration Contracts* (FAS 113) and/or related guidance were modified so as not to require cashflow testing for contracts in which risk transfer and/or insurance servicing is/are deemed to be reasonably self-evident, we believe FAS 113 could be applied to primary insurance.

If the FASB intends to continue pursuing bifurcation despite the theoretical and pragmatic issues we have summarized above (and describe in greater detail in the following sections), we then offer the following comments on the flowchart and methods in the ITC:

- With regard to the flowchart and Approaches A and B, as defined in paragraphs 61 through 69, we believe that bifurcation should be considered only for problematic reinsurance contracts. Therefore, we do not believe Approach B should be adopted. Furthermore, we believe that the description in Approach A would require significant refining to be specific enough to achieve consistency among practitioners in the identification of problematic contracts. A possible improvement to this description would be to limit it to those contracts that are bundled, i.e., where the financing and insurance elements are clear and unambiguous.
- With regard to the methodology, we believe the most appropriate way to bifurcate a contract is to disassemble it in the manner in which it was originally assembled. There is no single bifurcation method that we know of that can separate the deposit and risk transfer components of a given contract such that the accounting and the economics would be aligned. Because no one method would work better than another for every contract structure, the accuracy of a bifurcation method would depend on how well the method and assumptions used to bifurcate the contract relate to the actual pricing and structuring of the transaction.

Therefore, we do not endorse any particular method or approach in all circumstances. We suggest that the efficacy of any method for a given purpose only be assessed after testing it on a wide variety of real-world insurance and reinsurance contracts.

The remainder of this letter provides more in-depth discussion of the points we have summarized in this section.

### **Expansion of Scope**

The history of this bifurcation project is summarized in the notes published on the FASB website from an April 6, 2005 FASB meeting, as follows:

*“Recently, a number of issues have arisen concerning the determination of whether an insurance or reinsurance contract transfers significant insurance (reinsurance) risk. The determination of significant risk transfer is necessary to determine whether the contract is accounted for as an insurance or reinsurance arrangement or whether it is accounted for as a financing arrangement (similar to a loan)... This project’s objective is to define an insurance contract and provide further assistance in identifying those contracts that transfer significant insurance risk. In addition, the project will explore the notion of bifurcation of insurance contracts into risk transfer and financing segments for purposes of establishing the appropriate accounting for those contract segments.”*

It is our understanding that the original issue being addressed was the occurrence of problematic contracts in which there may be sufficient risk transfer to meet the requirements for insurance or reinsurance accounting, but the economic substance of the transaction does not appear to match the accounting. The “Recent Reporting Issues” section of the ITC refers to press reports of alleged abuses of accounting for certain insurance and reinsurance contracts, specifically finite risk insurance and reinsurance. However, the ITC also extends well beyond problematic contracts and asks whether financial statements would be improved if many or most insurance and reinsurance contracts were bifurcated.

It appears that the original focus of the Risk Transfer Project was to address abusive contracts, i.e., to fix something that was perceived to be broken. However, the current scope of the ITC is a comprehensive revisiting of the insurance accounting model, such that fixing the broken element is now a small by-product of a much larger concept.

We disagree with the expansion of the original scope of the FASB’s Risk Transfer Project to include bifurcation of traditional insurance and reinsurance contracts because we believe that:

- The current insurance accounting model is not so flawed that it needs a comprehensive change of this nature and magnitude.
- Bifurcation of most insurance and reinsurance contracts is likely to result in less, rather than more, decision-useful information regarding traditional contracts.
- A comprehensive change in the current U.S. GAAP model for insurance to one that differs dramatically from statutory accounting in the United States is likely to cause significant market cost, confusion, and dislocation, in return for little or no apparent benefit.
- The focus of the Risk Transfer Project should remain on the identification and financial reporting of problematic or abusive contracts.

### **Decision Usefulness of Bifurcation**

*Problematic Contracts.* There are limited instances in which a problematic insurance or reinsurance contract essentially consists of two or more bundled coverages or layers, at least one of which transfers significant risk and at least one of which does not. By “bundled,” we mean that the contract explicitly provides separate cash flows, such as individual premium and loss calculations, for the two coverages or layers. In these instances, the contracts have essentially been structured in a bifurcated fashion, so that the cash flows for each component are explicit in the contract. The decision criteria regarding verifiability, representational faithfulness, and relevance of bifurcated accounting may typically be

satisfied in these instances. The benefit in these circumstances may justify the cost, which is likely to be fairly low, since little analysis is likely to be needed.

However, for other problematic contracts, we believe that bifurcation would not be the preferred approach and should be considered only as a last resort. Our reasoning, summarized using the decision criteria outlined in the ITC, is as follows:

- Verifiability – For many of these contracts, estimating the component parts of financing and risk transfer for bifurcation purposes would typically require significant judgment regarding both the method to be used and the underlying assumptions, and therefore it is likely that there would not be a high degree of consensus among independent measurers as to the outcome.
- Representational faithfulness – Unless the contract were bifurcated using the same assumptions and methods as those employed in the pricing and structuring of the original contract, a bifurcated contract would typically not represent the economics of the transaction.
- Understandability – If the bifurcated contract does not represent the economics of a transaction, the resulting accounting would not enable users to accurately perceive its significance.
- Relevance – Given the issues regarding verifiability and representational faithfulness, we do not believe that bifurcation is likely to help users of financial statements to form better predictions or to confirm or correct prior expectations.
- Costs versus benefits – The amount of additional work required to bifurcate problematic contracts is unlikely to yield a commensurate benefit with respect to better financial statements. We expect that one significant benefit of bifurcation would be to reduce the incidence of problematic contracts, but this result could be achieved in a more direct and cost-effective fashion.

As an alternative to bifurcating a problematic insurance or reinsurance contract, we suggest (a) requiring the ceding or purchasing company either to deposit account the contract in its entirety, or (b) requiring disclosure of the financial reporting effects so that they are not hidden in the financial statements. If the reporting entity does not wish to accept either of these alternatives, its option would be to restructure the contract to increase the risk transfer component and/or reduce the financing element so the resulting risk transfer and financial reporting are better aligned.

We believe that this approach to addressing problematic contracts will preserve the representational faithfulness of financial statements and result in more relevant information, while removing the concern of verifiability as described above.

Further, we believe that identifying problematic contracts will require better guidance on screening and analysis of risk transfer than has previously been available. By screening, we mean that cashflow analysis to assess risk transfer would not be required for groups of contracts that meet certain characteristics. COPLFR has been working with the NAIC on these issues, including guidance on situations in which risk transfer for P&C reinsurance is “reasonably considered to be self-evident,” and the FASB may wish to consider the materials developed as a result of these efforts in developing future guidance.

*Non-Problematic Contracts.* We believe that for the vast majority of insurance and reinsurance contracts, which are traditional contracts entered into primarily for risk transfer and/or servicing purposes, bifurcation is not desirable. Moreover, for finite contracts that are not determined to be abusive or problematic, we do not believe bifurcation is desirable.

Our opinion is based on the following:

- Representational faithfulness – The concept underlying bifurcation implies that risk transfer and financing are the only two items to consider in dividing up the premium paid for an insurance or reinsurance contract. However, particularly for insurance contracts, there are other important considerations that impact premiums, such as the claims handling, loss prevention and other services provided by the insuring entity, the market availability for the product, and the relative risk appetites of the buyer and seller.

In particular for insurance arrangements, we believe that bifurcating contracts without considering the servicing element oversimplifies the market dynamics, such that the resulting accounting elements would not accurately correspond to the economic elements they purport to represent.

- Verifiability - In most cases, the various considerations that impact the premium paid for an insurance or reinsurance contract are not reasonably separable between risk transfer, servicing, financing and other elements. The amount of subjective judgment needed and the inherent data constraints, especially with respect to primary insurance, will lead to a significant variety of estimates among reporting entities.
- Relevance – Given our comments regarding representational faithfulness and verifiability, we believe that bifurcation would generally result in confusing and non-standardized information in financial statements.

For example, if the bifurcation method is focused on “dollar trading,” an insurance company writing a large number of very small contracts might not bifurcate any of its contracts, if the probability of one or more claims is low for any given contract. However, another company, writing the same group of risks via a small number of large contracts, might bifurcate each of the contracts, because for any one contract the probability of one or more claims is higher. Thus, two entities having the same economics would report different premiums, unpaid losses and loss expenses, and amounts recoverable from reinsurance.

Therefore we believe that the relevance of this information to users is likely to be significantly reduced from the information available under current accounting practices.

- Cost/Benefit Constraints – We believe that the cost of implementing a bifurcation proposal that encompasses traditional insurance and reinsurance contracts is likely to significantly outweigh the benefits, if any, and could be particularly onerous to midsize and small insurance companies and policyholders.

Furthermore, in the vast majority of cases, we do not believe that policyholders’ financial statements would be impacted in a material manner by bifurcation. For such companies, insurance expense is typically a relatively minor component of total expenses, and in most cases the financial reporting of insurance premiums and self-insured insurance would be very similar.



Therefore, given that we believe the resulting information is likely to reduce the relevance of financial statements, we do not believe the cost justifies any expected benefit.

These issues are discussed further in this comment letter in the sections on “Implementation Issues” and “Bifurcation Methods.”

Stock analysts, regulators, rating agencies, and many other financial statement users generally have a strong understanding of the current GAAP accounting model for traditional insurance and reinsurance. The current model for such contracts results in reasonably comparable financial statements among companies. The introduction of bifurcation of such contracts to financial reporting would introduce a very significant cost, i.e., the expense incurred to develop and maintain the estimates and the risk of market and financial reporting disruption. Therefore, we believe there should be a very high threshold – a clearly and widely accepted understanding – that bifurcation of traditional contracts would significantly improve the decision-usefulness of financial statements to justify the cost. Given our concerns that bifurcation would actually decrease decision-usefulness, we do not believe that such a threshold has been met.

### **Implementation Issues for Primary Insurance vs. Reinsurance**

*Bifurcating Primary Insurance Contracts.* Based on our collective experiences in the P&C insurance market, we believe that nearly all primary insurance contracts are purchased for the purpose of risk transfer and the associated services provided by the insurer – most notably insurance expertise, claims handling, and the satisfaction of regulatory requirements. This statement is generally true even though there are many insurance contracts with elements of financing, “dollar trading” or experience rating. It is our experience that the circumstances under which an insurance contract is purchased primarily to achieve a financial reporting result are very rare.

The process suggested in the ITC of evaluating primary insurance contracts for risk transfer and bifurcation would require insurance buyers to obtain actuarial expertise, either by developing it internally or by engaging consultants. The following discussion is intended to provide a simplified explanation of the steps that would be required for a policyholder to implement bifurcation of an insurance contract.

To estimate expected losses for the policy period, which is generally the first step for risk transfer cashflow tests and the bifurcation methods suggested in the ITC, a buyer of insurance would typically need to go through the following process:

- Capture historical loss and loss adjustment expense data with, at a minimum, the following information – line of business, accident date, report date, payments, outstanding losses, all stated net and gross of deductible/retention.
- Reconcile the loss data to be sure it is materially accurate.
- Develop the historical losses to ultimate, using loss development factors that reflect the claims settlement patterns for the historical periods.

- Adjust the historical losses for changes in insurance limits and deductibles, irregular policy periods, exposures (new divisions, new types of hazards, etc.), and trends (wages, benefit levels, inflation, etc.).
- Project the historical losses to the upcoming policy period, considering future changes in trends, exposures, policy limits, and deductibles.

This will need to be repeated for each separate line of business (workers' compensation, general liability, automobile liability, property, directors and officers insurance, etc.) and layer for which the company purchases insurance.

There are several significant implementation issues with respect to this process:

- Capturing sufficient historical loss data for the estimation process would be a significant challenge for most insurance buyers. Companies may have some records for the claims they have retained, but they are much less likely to maintain records for the claims they have insured. Further, such companies might not have access to the amounts their insurers have paid or reserved for their past losses.
- The steps we described above are not exhaustive; rather, they are the minimum that would be required. For most companies, their own actual loss experience will not be fully credible, and, as such, it would be necessary to supplement their data with data from industry sources or that of similar companies. This type of information is typically available to insurance companies, who aggregate the data from many companies, but not to their policyholders. Further, the use of industry data introduces significant subjectivity to a company's internal analysis. In the case of startup companies or new operations within an existing company, for which there is no historical internal experience, the analysis would need to be based entirely on data from outside sources.
- This analysis should be performed by an actuary or another professional with strong knowledge of actuarial concepts. In general, the smaller the company, with potentially less credible data, the more difficult the analysis will become.
- In general, risk transfer cashflow tests and bifurcation methods will also require the estimation of some type of probabilistic loss distribution, and this requires a much more sophisticated level of actuarial expertise.
- While it is true that some non-insurance entities are skilled in quantifying their insurance liabilities, these buyers often elect to self-insure the portion of the risk for which management is comfortable. They rely on the commercial insurance market to evaluate and accept their risks above that level.
- The resulting estimate of expected loss for a given policyholder is not likely to be comparable to the estimate used by the insurance company in deriving the policy premiums, because most commercial insurance policies would be class-rated, not individually-rated. Class-rating depends on categorization to achieve homogeneity and statistical credibility, so that the expected loss for the class is the relevant loss statistic.
- Finally, even if the losses to an insured company were equal to the average losses of its class, the expense and profit/risk load components of the premium charged by the insurance company are

not comparable to those of the policyholder if it had retained the risks. An insurance company benefits from economies of scale by aggregating and diversifying its risks, and these economies are in some measure passed along through premiums.

In addition to the practical issues summarized above, we believe that the bifurcation of primary insurance contracts is not likely to yield more decision-useful information, for several reasons:

- The bifurcation of an insurance contract into deposit and risk transfer components does not consider the element of servicing, which is often a significant part of the price and motivation for purchasing insurance. For example, a retrospectively rated workers' compensation policy reflects self-funded layers and excess insurance layers. However, in both layers, the policyholder is acquiring claims handling, loss prevention, and mitigation services.
- Most corporate insurance contracts contain some level of expected loss, and in such contracts there are likely to be some recoveries each year. We do not believe that the expectation of some recoveries implies that the contract was purchased primarily for a reason other than the traditional insurance purposes of servicing and/or risk transfer. In fact, a primary purpose of insurance for corporations is to trade a premium whose amount is certain to obtain indemnification of losses for which the ultimate amount and timing of payments is highly variable.
- The relatively low statistical credibility of information for a given insurance buyer, and the amount of subjective judgment inherent in the bifurcation process, are likely to result in expected loss estimates that are not reliable in most instances.
- In many instances, we expect that bifurcation of primary insurance contracts may not have a material impact on the reporting company's financial statements.
- We expect that this process would be costly and confusing for most buyers of primary insurance. The incremental costs involved would include costs of management information systems, data entry, accounting reconciliations, actuarial studies, audit fees and management time to address these functions, and such incremental costs would likely be significant. For most of these buyers, it is not cost-effective to become experts in risk analysis, and as a result they outsource this function for their purchase of insurance. We believe that the low incidence of problematic primary insurance contracts does not justify the cost of implementing such a change.

Further, for most policyholders, insurance expense would typically be a relatively minor component of total operating expenses, and, therefore, the financial reporting effect of bifurcating insurance contracts in most cases would likely be even less significant.

*Applying FAS 113 to Primary Insurance.* The ITC asked whether the FAS 113 risk transfer standard should be applied to primary insurance. If the standard is interpreted to require cashflow testing for each contract, our objections to cashflow testing in the context of bifurcation apply. However, if FAS 113 and/or related guidance were modified to include screening by type of contract, and a carve-out was included in which cashflow testing is not required for contracts in which either risk transfer and/or an insurance servicing component are deemed to be reasonably self-evident, we believe the risk transfer requirements in FAS 113 could be applied to primary insurance. The concepts of screening contracts and defining "reasonably self-evident" are currently used by the NAIC in its CEO and CFO attestations for

reinsurance contracts, and we believe that the NAIC is in the process of developing further guidance on this topic for statutory reinsurance accounting.

*Reinsurance.* The data and expertise issues present in the context of primary insurance as described in the section above are typically less of a problem in the context of reinsurance, due to the relative sophistication of the buyer and seller. Most P&C insurance companies maintain the data described above, at least in enough detail to perform an analysis of loss reserves gross and net of reinsurance. P&C insurance companies have more expertise on the exposures and expected losses underlying their reinsured business than most corporations have for their insured exposures, although a bifurcation analysis may require more specialized actuarial expertise than many P&C insurance companies possess. Moreover, a risk transfer assessment is already required for reinsurance contracts under FAS 113. Finally, it is our impression, based on our experiences and publicly reported events, that the P&C reinsurance market has a higher incidence of problematic contracts than does the primary insurance market.

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If the FASB intends to continue pursuing bifurcation despite the theoretical and pragmatic issues raised above, we have additional comments on the flowchart and methods presented in the ITC. The remainder of this letter summarizes our comments with respect to these areas.

### **Flowchart**

Pages 14 through 20 of the ITC contain a flowchart depicting the proposed risk transfer and bifurcation testing process, as well as definitions of the terms used in the chart and discussion of possibilities of its implementation. Our comments on this section of the ITC are as follows:

- The test of unequivocal risk transfer as described in the ITC hinges primarily on the number of risks insured and not by the overriding substance, and as such it would not include many traditional corporate contracts that are now widely accepted as unequivocally being insurance contracts. Under the definition in the ITC, a contract does not unequivocally transfer risk if it insures more than one risk (one automobile, one professional, one building, etc.). The test is very limited, and only a small percentage of commercial insurance or reinsurance contracts will meet it.

Furthermore, the accounting for two single-risk contracts would be different than the accounting for one combined contract that applies identical terms and insures the same two risks, even though the economics of the two situations are the same. In this case, we do not believe that it is appropriate to bifurcate in one situation and not in the other. Taken in a macro context, i.e., the aggregate of portfolios of contracts, this distinction would lead to arbitrary differences and a lack of comparability of financial statements across the spectrum of insurance companies.

We believe that the ITC test of unequivocal risk transfer has a similar purpose as the NAIC's concept of "reasonably self-evident." However, the focus of the ITC test is very different than the focus COPLFR will suggest in our work with the NAIC regarding risk transfer analysis and screening. As previously stated, this work is not yet complete but is anticipated to be available in the fall of 2006.

- The flowchart would extend application of the FAS 113 risk transfer test to include primary insurance contracts. As previously stated, we do not believe primary insurance contracts should be subject to FAS 113, unless cash flow testing is not required for contracts in which risk transfer and/or insurance servicing are deemed to be reasonably self-evident.
- Approach A, the first of two alternative bifurcation screens, is described in various places within the ITC as targeting “finite risk contracts only,” “contracts that include a significant financing component,” and “problematic contracts including those that resulted in allegations of abusive accounting.” These are three overlapping but different categories to target.

The second part of the description in Approach A includes any contract with significant adjustable premiums or commissions. This is such a broad screen that it will capture a very large proportion of traditional insurance contracts, such as retrospectively rated workers’ compensation contracts, which are entered into primarily for purposes of risk transfer and claims and loss control servicing. It is not clear to us from our reading of the ITC whether the first and second parts of Approach A are intended to be “and” or “or” conditions.

- Approach B would result in the bifurcation of essentially all insurance and reinsurance contracts that meet risk transfer testing and are not single-risk contracts. Therefore, all traditional insurance and reinsurance contracts, other than single-risk contracts, would be bifurcated.

Importantly, this would result in the bifurcation of unlimited quota-share contracts, so that a reinsurer who assumes 100% of premiums and losses on a portfolio of individual risk insurance contracts would not account for the portfolio in the same way as the ceding insurer would if it retained the portfolio. We believe that this is an inconsistent accounting result and would lead to less comparability among insurance company financial statements.

If bifurcation is to be considered, we believe it should only be considered for problematic contracts. We believe that the description in Approach A would require significant refining to be specific enough for there to be consistency among practitioners in the identification of problematic contracts. One possible improvement to this description would be to limit it to those contracts that are bundled, i.e., where the financing and insurance elements are clearly and unambiguously separable and the amounts determinable.

As we described above, we believe that Approach B expands the scope of the bifurcation concept to traditional and other non-problematic contracts and should not be considered.

### **Bifurcation Methods**

Presuming bifurcation is to be considered only for problematic contracts, the methodology for bifurcating such contracts should depend on the nature, structure, and economic substance of the contract and the resulting manner in which the accounting under FAS 113 differs from the economics.

From our experience, the departure of accounting from economic substance for most problematic reinsurance contracts generally falls into three categories:

- A contract whereby a ceding company spreads the effect of an adverse event or poor aggregate results that occur in one period over a multiple-year period.

- A prospective contract structured in a manner that effectively allows a ceding company to discount loss reserves once the claims have been incurred, while transferring only a minor portion of the risk associated with those reserves.
- A contract, such as a finite quota share, whereby a ceding company reduces its net premium to surplus ratio by ceding premium, but it retains most of the risk associated with the ceded premium.

A typical problematic contract may be structured to achieve one of these objectives but may still be able to meet the risk transfer requirements under FAS 113 because such requirements focus on the potential downside to the reinsurer's results. Contract structures are often unique; a contract can initially be either a proportional or non-proportional contract and may contain one or a number of the features often associated with finite risk agreements – loss caps, experience accounts, etc.

If bifurcation is used to better align the accounting with the economics for such contracts, the approach should (1) produce an accounting effect that accurately portrays the economics of the insurance/reinsurance portion of the transaction, and (2) remove the improper accounting benefit. In doing so, the bifurcation method would need to estimate what risk has actually been transferred, what premium was paid for it, and how that premium relates to the whole transaction. We believe that the appropriate method to bifurcate a contract is to disassemble it in the way that it was originally assembled. Therefore, no one method will work better than another method in all situations, and the accuracy of a method will depend on how well the method and underlying assumptions relate to the actual pricing and structuring of the transaction.

Our additional comments regarding the methods suggested in the ITC are as follows:

- The expected payout method focuses on “dollar trading,” defined in the ITC as the “minimum amount of expected claim payments” or “any amount of claim payments that is highly probable of occurring.” The presumption underlying an expected payout method is that the deposit component of a contract's premium is equal to the present value of the minimum expected payments, and the remainder of the premium is equal to the price paid for risk transfer.

This presumption does not consider the cost of the servicing function, which is typically significant for primary insurance contracts. With respect to reinsurance, although there is much less of a servicing function, the presumption may result in an accounting based on arbitrary distinctions between what is risk transfer and what is financing.

For example, an unlimited 100% quota-share contract on a predictable portfolio of business would have most of its cash flows accounted for as a deposit under the expected payout method if the portfolio is reinsured. However, had the insurance company retained the portfolio, the business would be accounted for as insurance in its entirety.

- The proportional method focuses on relative risk transfer, so that if the assuming entity has the same risk as the policyholder or insurance company would have had without insurance, then the contract is accounted for in its entirety as insurance. Under this method, the concept of dollar trading is not directly captured, so that even a significant expected payout each year would not necessarily result in the identification of a significant deposit accounting component.

For example, under the proportional method, an unlimited 100% quota-share contract on a

predictable portfolio of business, as described above, would have all of its cash flows accounted for as reinsurance.

The proportional method may be useful to identify significant risk limitations in certain contracts. However, the application of a proportional method to bifurcate a finite risk contract will not necessarily result in deposit and risk transfer components such that the accounting and the economics are aligned.

- We do not understand the cash flow yield method sufficiently to comment on it.

In summary, the methods mentioned in the ITC may be able to achieve various purposes, but we do not believe any one of them is sufficient to address the goals outlined in the ITC for bifurcation for all types of contracts. There is no single bifurcation method that we know of that can separate the deposit and risk transfer components within any given contract, such that the accounting and the economics would be aligned. We would suggest that the efficacy of any method for a given purpose only be assessed after testing it on a wide variety of real-world insurance and reinsurance contracts.

\* \* \* \* \*

We hope that the comments in this letter are useful to the FASB. We would be pleased to meet with you and discuss this issue in greater depth.

Sincerely,



Nancy Watkins, Chair  
Committee on Property and Liability Financial Reporting



## AMERICAN ACADEMY *of* ACTUARIES

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August 24, 2006

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

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

Dear Sir or Madam:

The Health Practice Financial Reporting Committee of the American Academy of Actuaries<sup>1</sup> (Academy) is pleased to provide comments to the Financial Accounting Standards Board (FASB) regarding its recent Invitation to Comment (ITC), “Bifurcation of Insurance and Reinsurance Contracts for Financial Reporting.”

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

### **Observations on Paragraphs 19-21**

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

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

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



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

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

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

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

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

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

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

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

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

**Issue 2:** *Can the Statement 113 risk transfer guidance for reinsurance contracts be applied by corporate policyholders and insurers for determining whether an insurance contract transfers significant insurance risk? If not, how can the Statement 113 guidance be modified or clarified to apply to insurance contracts?*

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

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

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

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

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

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

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

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

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

We have no comment on this issue.

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

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

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

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

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

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

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

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

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

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

**Issue 6:** *Do you think the characteristics described in paragraph 58 for unequivocal insurance contracts are an improvement over the exemption from cash flow testing in paragraph 11 of Statement 113 (summarized in paragraph 37(c) of this Invitation to Comment)?*

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

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

We have no comment on this issue.

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

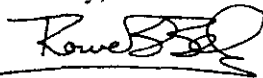
**Issue 11:** *In view of the IASB's project on insurance contracts, should the FASB be considering bifurcation of insurance contracts based on transfer of insurance risk?*

We have no comment on this issue.

\* \* \* \* \*

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

Sincerely,



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



## AMERICAN ACADEMY of ACTUARIES

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August 24, 2006

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

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

Dear Sir/Madam:

On behalf of the American Academy of Actuaries’<sup>1</sup> Life Financial Reporting Committee, I’d like to thank you for this opportunity to comment on the publication titled “Bifurcation of Insurance and Reinsurance Contracts for Financial Reporting”.

The Committee does not believe bifurcation would improve financial reporting. We believe the issues this FASB statement seeks to address can be done so more effectively through enhanced disclosure requirements. The Committee believes that the proposal will be ineffective because it will introduce unnecessary subjectivity into financial statements, which will cause confusion among the users and reduce comparability between or among entities.

The vast majority of life insurance contracts are sold through retail markets to private individuals who do not file financial statements with the Securities and Exchange Commission (SEC). Financial Accounting Statement (FAS) 60, FAS 97, and FAS 120 were written to address these individual contracts. These reporting standards accurately convey the financial consequences of the inherent risks to financial statement users. The current reporting framework does an excellent job of distinguishing between insurance-type contracts and deposit-type contracts. Since the current framework also minimizes subjective opinions in categorizing revenue, the resulting financial statements make corporate comparisons reliable. The current framework also has the advantage of being widely understood and very familiar to readers of financial statements.

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

Where the current reporting framework may be interpreted by some as falling short is in addressing the contracts that cover insurance risks that are individually negotiated between large corporate entities. For most individually negotiated contracts written by the insurance industry, the current framework does an excellent job of conveying the important financial consequences of risk to the users of the financial statements. The potential shortfall occurs among a tiny fraction of individually negotiated contracts when a deposit-type liability is mischaracterized as insurance. This is unquestionably a problem in the current framework, but it is one of communicating quality of risk, not quantity. We believe an enhanced disclosure requirement will more effectively communicate the needed information to users of financial statements.

If in the unlikely event it is determined that the potential benefits of implementing a bifurcation solution outweigh the considerable costs of changing the entire insurance reporting framework and retraining the analyst community in the new rules, the Committee would strongly urge the FASB to limit the scope of any standard to contracts negotiated between large corporate entities. The current framework produces results that are useful, relevant, reliable, and comparable for the vast majority of contracts written by insurance enterprises.

Finally, the Committee will briefly comment on the specific issues contained in the proposal:

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

The Committee believes that the IFRS 4 definition of insurance is sufficient and that indemnification need not be specifically referenced.

**Issue 2:** *Can the Statement 113 risk transfer guidance for reinsurance contracts be applied by corporate policyholders and insurers for determining whether an insurance contract transfers significant insurance risk? If not, how can the Statement 113 guidance be modified or clarified to apply to insurance contracts?*

The Committee doubts that corporate policyholders possess the expertise needed to apply subjective characterizations of risk consistently. Further, we doubt they possess the ability to bifurcate premiums into risk and deposit components. The 10/10 rule is the insurance industry consensus of “reasonable” that emerged in the absence of guidance on the meaning of “reasonable.” Absent further guidance from FASB as to the meaning of “reasonable,” it is very likely that the 10/10 rule will continue to be *de facto* guidance, whether it is applied to insurance contracts or not.

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

The Committee believes the current framework of characterizing contracts as 100 percent deposit or 100 percent insurance serves financial statement users well in their efforts to understand the risks a company writes and compare similar companies. We are concerned the subjectivity in the implementation of a

bifurcation proposal will cause unnecessary confusion and diminish comparability among like companies. Historically, contracts have either been characterized as insurance contracts or non-insurance contracts. This approach faithfully represents the economic substance of the contract. To acknowledge the fact that some contracts transfer more risk than others does not diminish this.

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

The Committee believes the hierarchy is unnecessary for the vast majority of all insurance contracts. We are intentionally not answering the question because we do not want to be seen as giving an endorsement to the hierarchy. (Our reasons are given above).

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

The Committee believes the characteristics are overly restrictive. For instance, we believe that participating whole life products sold by mutual insurance enterprises unequivocally transfer significant insurance risk. So do indeterminate premium term insurance products. However, criteria "e" in paragraph 58 reaches a different conclusion.

**Issue 6:** *Do you think the characteristics described in paragraph 58 for unequivocal insurance contracts are an improvement over the exemption from cash flow testing in paragraph 11 of Statement 113 (summarized in paragraph 37(c) of this Invitation to Comment)?*

The Committee does not believe the criteria are an improvement over FAS 113 because they are overly restrictive.

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

The Committee believes bifurcation is unnecessary for the vast majority of contracts written by insurance enterprises. We would favor whichever approach narrows the scope as much as possible.

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

The Committee believes the criteria for insurance and reinsurance should be the same. If a bifurcation standard is implemented, we believe it should apply only to individually negotiated contracts between large corporate entities. This would encompass 100 percent of all reinsurance treaties and a number of insurance contracts for which the quality of the risks transferred should be described in the financial statement disclosures.

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

We hesitate to endorse any method, but some of our members have said they found the cash flow yield method least objectionable. This, however, was not a unanimous sentiment.

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

We are unprepared to comment on the effects of data availability on any particular proposed method.

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

The Committee has stated it does not believe bifurcation will improve financial reporting. If the FASB ultimately decides that it believes bifurcation is needed, the Committee would encourage FASB to try to influence the IASB to incorporate bifurcation in its Phase II proposal.

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Again, we thank you for this opportunity to comment on this proposal. Even though we do not believe the suggested proposal will improve reporting overall, we value the exchange of ideas this has generated and believe that this alone is a positive development. We are available to answer any questions you may have regarding our comments. If there are any questions regarding these comments, please contact Tina Getachew at [getachew@actuary.org](mailto:getachew@actuary.org) or at (202) 223-8196.

Sincerely,



Darin Zimmerman  
Chair, Life Financial Reporting Committee  
American Academy of Actuaries