IFRS in Focus

Third Transition Resource Group meeting discussing the implementation of IFRS 17 *Insurance Contracts*

Contents

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www.iasplus.com

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This *IFRS in Focus* summarises the meeting of the IFRS 17 Transition Resource Group (TRG) which took place on 26–27 September 2018.

Introduction

The TRG is a discussion forum established by the International Accounting Standards Board (IASB) to support the implementation of IFRS 17 *Insurance Contracts*. The purpose of the TRG is

- To invite discussion and analysis of potential stakeholder issues arising from the implementation of the new insurance Standard
- To provide a public forum for stakeholders to learn about the new insurance accounting requirements
- To help the IASB determine whether additional action is needed, such as providing clarification or issuing other guidance

During the meeting the TRG members share their views on the issues discussed, followed by a meeting summary issued by the IASB. Reflecting on the issues raised, the IASB will decide whether any action is required.

This was the third meeting where submissions to the group were discussed. The next meeting is scheduled for 4 December 2018. However, the IASB staff have announced that the date may be revised and it may be rescheduled to early 2019 to accommodate a longer period for submissions to be made.

See the IASB website for more information about the TRG, including agenda papers further describing the topics below.

Topic 1—Insurance risk consequent to an incurred claim

Background

The topic considers a situation in which an incurred claim under an insurance contract creates insurance risk for the entity that would not exist if no claim were made. The IASB staff paper referred to such insurance risk as consequential insurance risk.

The liability for incurred claims and the liability for remaining coverage is defined as part of Appendix A of IFRS 17.

The IASB staff paper put forward two interpretations as to how the insurance risk that relates to an entity's obligation consequent to an incurred claim can be treated:

(a) As a liability for incurred claims

(b) As a liability for remaining coverage

Both the liability for incurred claims and the liability for remaining coverage are defined as part of Appendix A of IFRS 17.

The choice of treatment has an impact on the determination of the coverage period, changes in fulfilment cash flows and allocation of the contractual service margin (CSM).

Two different examples are considered in the agenda paper: fire insurance over a house and disability insurance. Depending on which interpretation was applied it could lead in some cases to different accounting outcomes. In some scenarios, the difference between the two approaches may not be significant. However, the staff paper considered it a matter of judgement in determining whether the obligation consequent to an incurred claim is a liability for incurred claim or a liability for remaining coverage. Factors such as the complexity of the two approaches could influence that judgement.

(a) Approach 1—Consequential insurance coverage being part of the liability for incurred claims

In case of a disability insurance, the liability for incurred claim is an entity's obligation to pay a policyholder upon becoming disabled. The liability for remaining coverage is viewed as the entity's obligation to pay valid claims relating to accidents/illnesses causing disability that have not yet occurred. In the case of fire insurance, the liability for incurred claims is the entity's obligation to indemnify the policyholder for the damage caused by the fire and the liability for remaining coverage is the entity's obligation to pay future fire claims relating to events that have not yet occurred.

(b) Approach 2—Consequential insurance coverage being part of the liability for remaining coverage

In case of a disability insurance, the liability for incurred claim is the entity's obligation to settle a claim already made by a policyholder for the current period of disability. Whereas, the liability for remaining coverage is the entity's obligation to pay claims for future periods of disability, both for policyholders that are disabled and for policyholders yet to become disabled. In case of fire insurance, the liability for incurred claims is the entity's obligation to pay for a policyholder's claims for the cost of rebuilding the house. The liability for remaining coverage is the entity's obligation to pay claims relating to fire events that have not yet occurred and to discover the ultimate cost of the damage caused by qualifying fire events. This treatment would be consistent with the treatment of an insurance contract protecting the policyholder against adverse claims development and with the treatment applicable to contracts acquired in the period after a fire event (see IFRS 17:B5 and B93).

In the IASB staff's view, the approach applied by an entity is a judgement under IFRS 17 to formulate its accounting policy as defined in IAS 8 *Accounting Policies, Changes in Accounting Estimates and Errors*. An entity should apply the same approach consistently for all similar transactions, i.e. to all groups of contracts for the same product type or all groups of contracts with similar insurance service provided by the entity. Whatever approach is adopted, IFRS 17 requires disclosure of significant judgements made in applying the Standard.

See TRG Agenda Paper 1 for additional details.

Discussion

A majority of TRG members agreed with the staff view that both approaches are in line with the words in IFRS 17 and supported the view that an implicit accounting policy choice exists in those cases. Applying IAS 8, the accounting policy is selected based on the facts and circumstances: this would not be a free choice. An entity selects the accounting policy that provides the most useful information to the users of its financial statements.

Some TRG members did not agree with the staff view and expressed concerns about the risk of significant diversity in practice if the summary published by the IASB staff will state an accounting policy choice for the cases described in the agenda paper. In particular, a few TRG members disagreed with there being a choice in the fact pattern where the entity has merely to discover the ultimate cost of a fire after the fire occurs. In the view of these TRG members, the occurrence of a fire is an incurred claim, since at initial recognition of the contract the fire has not yet occurred. Furthermore, one TRG member argued that the reference in the IASB staff analysis to the discovery of the ultimate cost of the claim as the insurance risk described in IFRS 17:B5 was inappropriate in both fact patterns, as it referred to events occurring before the contract's initial recognition. One TRG member suggested to provide more narrow fact patterns to illustrate that in some cases only one approach could be reasonably selected as the entity's accounting policy. Another TRG member disagreed with the staff view that the fact of whether the consequential insurance would be sold as a stand-alone product in the relevant jurisdiction played a significant role in selecting an accounting policy.

A significant part of the discussion focused on how to achieve a consistent application of the selected accounting policy. Many TRG members emphasised the fact that the accounting policy should be applied consistently for the same product in a particular jurisdiction. While some TRG members believed that the correct application of IAS 8 would always lead to the same accounting treatment for similar products even for different entities, others believed that consistent application between entities could not be guaranteed as different entities could give different importance to particular facts and circumstances. The TRG members agreed that within the same entity, IAS 8 requires the same accounting treatment for the same facts and circumstances. It was also mentioned that the approach currently applied in IFRS 4 *Insurance Contracts* for certain jurisdictions might change with the initial application of IFRS 17.

Topic 2—Determining discount rates using a top-down approach

Background

IFRS 17:B81 states that an entity may derive the appropriate discount rates for insurance contracts by adjusting a yield curve that reflects the current market rates of return implicit in a fair value measurement of a reference portfolio of assets (a top-down approach). An entity shall adjust that yield curve to eliminate any factors that are not relevant to the insurance contracts, but is not required to adjust the yield curve for differences in liquidity characteristics of the insurance contracts and the reference portfolio.

For entities applying IFRS 17:B81, using assets held as a reference portfolio, and ignoring the differences between liquidity characteristics of the assets and insurance contracts, the question is whether changes in the asset mix would adjust the yield curve for changes in the liquidity premium or not. There are two alternative views:

(a) View A—Changes in the entity's assets used as a reference portfolio should not affect the discount rates used to measure the insurance contracts. The characteristics of the cash flows of the insurance contracts do not vary following changes in the mix of the entity's assets.

(b) View B—Changes in the entity's assets used as a reference portfolio may impact the discount rates used to measure insurance contracts.

IFRS does not define 'a reference of portfolio of assets'. Consequently, a portfolio of assets that an entity holds can be used as a reference portfolio. IFRS 17:36 requires that discount rates reflect among other factors, the liquidity characteristics of insurance contracts and the entity should eliminate any differences in liquidity. However, in applying the 'top-down' approach, the entity is permitted not to eliminate the differences between the liquidity characteristics of assets in the reference portfolio and the group of insurance contracts. This is one of the reasons for 'bottom-up' and 'top-down' approaches giving different results in determining discount rates. The IASB staff view is that fluctuations affecting the yield of the reference of portfolio of assets could produce changes in the discount rate after the required 'top-down' adjustments have been calculated.

See TRG Agenda Paper 2 for additional details.

Discussion
TRG members noted that it is necessary to use an appropriate reference portfolio of assets to determine the discount rate. They also noted that the liquidity characteristics of the insurance contracts should be reflected in the discount rate after the 'top-down' adjustments are calculated. The TRG members agreed that the use of a simplification in a 'top-down approach' of allowing an entity not to eliminate a liquidity premium difference when there is a change in the composition of a reference portfolio of assets would result in a change to the insurance contracts' discount rate. Consequently, a small change in a discount rate might have a significant impact (for example in a long-term contract). Hence, appropriate disclosures should be made with respect to that.

Topic 3—Commissions and reinstatement premiums in reinsurance contracts issued

Background
The staff paper focuses on accounting for certain cash flows between a reinsurer and a cedant. These are commissions paid by a reinsurer to a cedant, including those contingent on claims, and reinstatement premiums charged by a reinsurer to a cedant when the cedant desires to continue coverage. The reinstatement premiums can be mandatory or voluntary and are charged following the occurrence of an insured event. The paper poses three questions:

(a) How to account for commissions due to the cedant (including those that are not contingent on claims and also those that are contingent on claims) and whether they are considered as part of the premium or claims

(b) Whether for reinsurers, the commissions paid to the cedant meet the definition of insurance acquisition cash flows or an investment component

(c) How to account for reinstatement premiums charged to the cedant following the occurrence of an insured event, depending on whether such reinstatement premiums are mandatory or voluntary

The submitter asks whether for a reinsurer, these amounts exchanged with the cedant can be recognised either within claims, as an insurance service expense, or as an insurance revenue. IFRS 17 does not provide specific guidance on these cash flows for the reinsurer, but provides guidance for the cedant. The presentation should be based on the economic effects of the exchange.

Based on the fact pattern provided in the example in this agenda paper, the IASB staff are of the view that the amounts exchanged between the cedant and the reinsurer that are not contingent on claims should be considered as part of the premium and be recognised as part of insurance revenue. Commissions paid to the cedant after the premium is received may meet the definition of an investment component.

Where commission payments are contingent on claims, the staff's view is that those amounts are part of claims and need to be included in the insurance service expense.

The reinstatement premium is an amount charged to the cedant when a claim is incurred in order for the cedant to continue receiving coverage. Staff analysis distinguishes mandatory and voluntary reinstatement premiums. The mandatory reinstatement premium amount is pre-determined and does not allow non-payment or termination of the contract. The reinsurer should recognise such amounts as part of insurance service expense when incurred. The voluntary reinstatement premium is contingent on the occurrence of the insured event and is an amount charged to the cedant on predetermined terms. However, the cedant can decide whether to pay and continue coverage or to terminate the contract. Hence, such premiums are not contingent on claims and the economic effect is equivalent to the effect of charging a higher premium to extend the contract coverage for an additional period. In the example provided in the agenda paper, the reinsurer has no right to exit the contract or reprice the contract, and this means that the expected cash flows related to the reinstatement premium are within the boundary of the initial reinsurance contract.

See TRG Agenda Paper 3 for additional details.

Discussion

The TRG members agreed with the staff analysis in the paper of treating such premiums and commissions based on their economic effects rather than their formal contractual definition in a contract. This would achieve symmetry between the treatment of such premiums and commissions by both cedants and reinsurers. Many observed that this may lead to a simplification of reinsurance contracts design. However, there are practical implications from implementing this approach, such as for example, the need for monitoring the type of each commission/reinstatement premium. Reflecting certain premiums and commissions as adjustments to claims will affect certain metrics (e.g. loss ratios, etc.). It was also noted that the same analysis would apply to direct insurance contracts issued, provided there are such payments/receipts to/from the policyholder. There was also a discussion that produced further clarification of the definition of an investment component. An investment component is the amount that must be paid back to the policyholder in all cases—i.e. not just in the event of no claims, but also on cancellation. There was a further staff clarification that an investment component arises when a cash flow is first paid to an insurer and then becomes due to be paid back to the policyholder in all circumstances, rather than net-settled.

Topic 4—Premium experience adjustments related to current or past service

This topic considered how to account for differences between expected premiums and actual premiums (premium experience adjustment) which relate to current or past service. Should those differences adjust the CSM or should they be recognised in the statement of profit or loss immediately as part of insurance revenue or insurance service expenses? Experience adjustments are defined in Appendix A of IFRS 17.

Three examples are considered in the agenda paper to analyse whether the premium experience adjustments relate to current or past service and each of those examples is analysed under the general measurement model and the premium allocation approach (PAA).

IFRS 17:B96(a) and 97(c) state that experience adjustments arising from premiums received in the period that relate to future service adjust the CSM. Consequently, those that do not relate to future service do not adjust the CSM. Accordingly, the IASB staff view is that experience adjustments that relate to current or past service are recognised immediately in the statement of profit or loss. Per IFRS 17:B120 and B123 these are recognised as part of insurance revenue, because total revenue is the total amount of premiums paid to the entity.

An example in which a premium experience adjustment relates to future service is when the actual premium received in the current period for coverage in the future period differs from the expected premium because lapses differ from those expected.

One of the submissions asks whether the principles of accounting for premium experience adjustments related to the current or past service cost are applied in a similar way to the general measurement model and the PAA. The staff considered two opposing views. The first is that PAA is a simplification of the general measurement model, and the treatment of premium experience adjustments relating to current or past service should be consistently applied. The second is that because IFRS 17 does not provide a specific requirement on how to account for premium experience adjustments for the PAA, an entity can select an appropriate approach and follow it consistently.

The IASB staff observed that the accounting mechanics for recognising insurance revenue applying the PAA are different to the accounting mechanics for recognising insurance revenue applying the general model even if they produce similar results.

The IASB staff's view was as follows:

(a) Experience variances from events like retrospective premium adjustments will be reported in profit or loss because they do not refer to future coverage periods

(b) Experience variances from lapse behaviours would adjust the CSM (see IFRS 17:B96(a)) or adjust the liability for remaining coverage under the PAA

See TRG Agenda Paper 4 for additional details.

Discussion

The TRG members agreed with the staff analysis that premium experience adjustments that relate to current or past service are recognised immediately in profit or loss, although in some fact patterns it might be difficult to judge whether premium experience adjustments relate to past or future service. Insurers need to consider the premium experience adjustments when preparing the reconciliation disclosures around insurance revenue and beyond the analysis in the paper, the CSM needs to be allocated to current and future periods.

Some TRG members struggled with the presentation of revenue resulting from premium experience adjustments. The note disclosure requirement in IFRS 17:106 is very precise as to how revenue should be disaggregated, however there is no line item for premium experience adjustments for current or past coverage. One TRG member suggested to add such a line item to IFRS 17:106 as part of the amendments that are proposed to IFRS 17 in the *Annual Improvements* cycle. This was supported by several TRG members. Adding the line item to IFRS 17:106 would bring clarity as to how to account for the premium experience adjustments and how to present them. This would facilitate consistent application amongst insurers. Without this addition, the premium experience adjustments would have to be allocated to the existing line items in IFRS 17:106 and that could be perceived as unnecessarily onerous by many insurers.

Topic 5—Cash flows outside the contract boundary at initial recognition

Background

At the February 2018 TRG meeting, it was noted that if a reinsurer has the right to terminate the coverage at any time with a three month notice period, the contract boundary would exclude cash flows related to premiums outside of that three month period. At the May 2018 TRG meeting, it was observed that an entity should focus on substantive rights and obligations arising from that option to determine whether the cash flows related to the option are within or outside the contract boundary.

The question submitted at this meeting relates to both insurance contracts issued and reinsurance contracts held and considers circumstances in which paragraphs IFRS 17:35 and B64 are applied.

The contract boundary requirements in IFRS 17 distinguish whether future premiums, and the resulting benefits and claims, arise from either an existing insurance contract or future insurance contracts. For future insurance contracts, no expected premiums or claims are recognised as assets or liabilities, as applying IFRS 17:35, those are outside the boundary of the existing insurance contract.

Per IFRS 17:B64, an entity reassesses the boundary of an insurance contract to include the effects of changes in circumstances on the entity's substantive rights and obligations. An example of contract boundary reassessment may occur when in one reporting period, repricing restrictions have no commercial substance, but in the next reporting period, they do. Consequently, a reassessment may result in cash flows that were outside the contract boundary at the previous reporting date being either within or outside the contract boundary at a subsequent reporting date.

The staff observe that the requirements in IFRS 17:35 and B64 are different and address different circumstances.

The agenda paper example presented cash flows related to future periods to be outside the original contract boundary applying IFRS 17:34. The example shows that later the policyholder pays more premiums either because of an option to renew the contract being exercised or an option to terminate the contract not being exercised. Since the likelihood of the exercise of the renewal/termination options was not assessed in determining the contract boundary on initial recognition, the exercising of those options is not considered a reassessment of the contract boundary of the existing contract. The additional cash flows relate to the rights and obligations of the future contract and they will be recognised as a new contract.

The requirements in IFRS 17:34 and 35 may or may not be consistent with the legal form of an insurance contract, depending on the circumstances. For example, looking at a yearly renewable contract with a boundary of one year, the renewed contract may be a separate contract in legal form. On the other hand, the extension of a long-term contract (with or without repricing) is considered a new contract while the legal form is still a single contract.

The IASB staff concluded that the reassessment of the contract boundary in IFRS 17:B64 must not include the assessment of whether or not the option to reprice has been exercised or not. Any event occurring beyond that point would be a new contract under IFRS 17 even if they come from a single legal contract.

The reassessment required in IFRS 17:B64 is solely focused on changes surrounding the practical ability to fully reprice.

See TRG Agenda Paper 5 for additional details.

Discussion
The majority of the TRG members agreed with the IASB staff analysis in the paper, as it applied to the examples in the paper. The members welcomed the analysis as helpful to clarify the possible conflict between IFRS 17:35 and IFRS 17:B64. For reinsurance contracts held, the recognition criteria in IFRS 17:62 mean that the new contract is not recognised until the coverage of that contract begins. Accordingly, for a 90-day cancellable reinsurance contract held, the new 90-day contract is recognised after the expiry of the coverage of the first 90-day contract. There was a general agreement with the staff analysis on the examples in the paper relating to a renewal/termination option of the contract. However, there were differing views, similar to the May 2018 TRG meeting, on the fact pattern when an additional rider (previously considered outside the contract boundary) was exercised. For some TRG members, the main concern in applying the staff analysis was to treat as a new contract an exercise of a rider that was always in the original terms of the existing contract, but was initially thought not to convey substantive rights and obligations, thus considered outside the original contract boundary.

Further, some of the members felt the paper does not consider some of the wider implications of contract modifications and would result in an accounting treatment that is inconsistent between modifying a contract by adding a renewal option (this would be treated as an extension of the existing contract) and the exercise of an existing renewal option (treated as a new contract).

Topic 6—Recovery of insurance acquisition cash flows

Background
This paper considers the possible relationship between inflows and insurance acquisition cash flows. The question is if there is an implicit recoverability of acquisition expenses from the inflows expected from the group of contracts then how should changes in assumptions and experience variances from acquisition costs be accounted for.

Insurance acquisition cash flows are reflected in the CSM or loss component for a group of insurance contracts on initial recognition. They are treated in the same way as any other cash flows incurred in fulfilling insurance contracts. An entity does not have to identify whether it will recover insurance acquisition cash flows at each reporting date. IFRS 17:BC180 explains that the measurement model captures any lack of recoverability automatically by remeasuring the fulfillment cash flows. The staff observed that changes in insurance acquisition cash flows should not impact the overall revenue recognised from the group of insurance contracts as they do not affect the total premiums. However, any changes in the expected future cash flows related to insurance acquisition cash flows would adjust the CSM. Experience adjustments would be accounted for similarly to changes in the expected future cash flows related to insurance acquisition cash flows.

The IASB staff concluded that:

- any reduction in CSM or increase of loss component because premiums are lower than outflows will impact insurance revenue
- changes in the expectations of acquisition cash flows adjusts the CSM and are reflected in insurance revenue and expenses according to IFRS 17:B125
- experience adjustments related to acquisition cash flows affect insurance revenue based on IFRS 17:B123 and insurance expenses according to IFRS 17:B125

See TRG Agenda Paper 6 for additional details.

Discussion
TRG members agreed with the staff analysis and found the examples helpful. It was highlighted that it may be difficult to know whether insurance acquisition cash flows relate to future or current and past coverage. If acquisition cash flows relate to future coverage, they adjust CSM, as per IFRS 17:B96(a). This would be similar to the analysis in Agenda Paper 4. After the unlocking adjustment, the CSM needs to be allocated to current and future periods. This would result in some associated acquisition costs relating to future coverage being allocated to current and future periods. It was clarified that the reference to IFRS 17:B56(h) meant that when looking at trail commissions, the portion of the commission that relates to the costs of selling and starting a group of insurance contracts is an acquisition cash flow, regardless of when it is paid.

Topic 7—Premium waivers

Background
The staff observed that the definition of insurance risk in IFRS 17 has not changed from IFRS 4 and it is not expected that the practice of determining whether a risk is an insurance risk would change. A waiver of premiums is caused by the occurrence of an uncertain future event. For example, when the policyholder becomes disabled for a period of six consecutive months which causes a loss of income. To the extent of the premiums payable, that risk is transferred to the entity which has to provide benefits under the contract for the primary coverage without receiving any premiums.

The staff observe that the risk of these events occurring exists before the contract is issued. The risk is not created by the contract, and it does not increase the potential adverse effects associated with it. Further, the occurrence of events that trigger a waiver of premiums are contractual preconditions without which the entity can deny the premium waiver. Consequently, the IASB staff concluded that the waiver of premiums if a specified event occurs creates insurance risk. It follows that the inclusion of such a waiver in an investment contract makes the investment contract an insurance contract. Inclusion of such a waiver in a contract that would be an insurance contract without the waiver may affect the quantity of benefits provided by the contract and the coverage period, both of which would affect the recognition of CSM.

See TRG Agenda Paper 7 for additional details.

Discussion
TRG members agreed with the staff analysis in the paper. It was further clarified that a premium waiver means no recognition of revenue/premium for that period, and it does not allow grossed up presentation by imputing premium and then recognising its waiver as a claim.

While there is no substantial change to the definition of insurance contract under IFRS 4, the application under IFRS 4 was different because of different unbundling rules (and lack of prescription on measurement) to the resulting application of the same principle under IFRS 17. Some TRG members observed that there seems to be a link to items on scope in Agenda Paper 11, specifically, those associated with Submission S33 on equity release mortgages and credit cards.

Topic 8—Group insurance policies

Background
This paper presents an analysis of contractual boundary for group insurance policies. Two fact patterns are considered in this paper. In both fact patterns, an entity provides insurance coverage under a group insurance policy: in one scenario the contract provides coverage to members of an association, and in a second scenario to customers of a bank. In the two scenarios, both the entity and the association/bank each have a unilateral right to terminate the group insurance policy at any time with a notice period of 90 days which, in turn, terminates the insurance coverage for all association members and borrowers. The entity cannot terminate coverage for specific certificate holders. Certificate holders have an expectation that the coverage would not be terminated early and would run the full contractual term. The members/customers are not related. The insurance coverage is optional for each individual, and it is priced for each certificate holder as if it were a separate insurance contract. The premiums are step-rated (increase with age) and the entity cannot reprice premiums. The benefits are paid directly to each certificate holder or their beneficiaries

Additionally, for customers of the bank the insurance coverage is linked to the remaining outstanding balance of any loan or mortgage issued to them by the bank (e.g. the contract duration is limited to the earlier of the certificate holder repaying the balance or reaching a specified age).

In both examples the entity cannot compel the certificate holders to pay premiums.

The question is whether the cash flows related to periods after the notice period are within the boundary of an insurance contract. To answer this question, the analysis considers three questions:

1. Who is the policyholder?

2. How many contracts have been issued?

3. What is the contract boundary of those contracts?

The legal form of the group insurance policy is a single contract between the entity and an association or bank. However, the legal form might not reflect the substance of contractual rights and obligations. In considering identity of the policyholder, the IASB staff observed that it is the certificate holder, because they are the party with a right to compensation due to being adversely affected by the insured event. This is the case regardless of whether the compensation is received by them directly or indirectly.

In considering the number of insurance contracts, consistent with the previous TRG discussion, the staff observed that separating components of a single contract involves significant judgement and careful consideration of all facts and circumstances. In the fact pattern presented, the staff concluded that the following three factors indicate that there is an insurance contract with each certificate holder:

1. Insurance coverage is priced and sold separately

2. Other than being members of the association, the individuals are not related to one another

3. Purchasing the insurance coverage is an option for each individual

The staff also concluded that the right of the entity to terminate the contracts does not in itself make this arrangement a single contract.

In addition, the entity should assess the boundary of each insurance contract it has with the certificate holder. The certificate holder's expectation that the policy will not be terminated earlier than the end of the contract term is not relevant to the assessment of the contract boundary. For the example in the paper, the entity's substantive obligation ends after 90 days and the cash flows within the contract boundary are those related to the obligation to provide service over the 90-day period.

See TRG Agenda Paper 8 for additional details.

Discussion

All the TRG members felt that this was a helpful paper and agreed with the analysis for the specific fact patterns provided. However, they also reiterated the fact that careful consideration of the specific facts and circumstances should be given when considering other arrangements. TRG members noted that the three step process used in the analysis (identity of policyholder, number of contracts and contract boundary) is relevant for all such fact patterns in performing the analysis. The three criteria used to determine the number of contracts (coverages priced and sold separately, coverages being optional and certificate holders not being related) are useful considerations, however they are just indicative and not determinative. This paper is also a timely reminder from an operational perspective for insurers to analyse their group insurance policies.

Topic 9—Industry pools managed by an association

Background

This paper considered the level for determining the risk adjustment for non-financial risk for insurance contracts that are within the industry pool managed by an association. The paper acknowledges previous discussion at the May 2018 meeting on the determination of the risk adjustment for non-financial risk for contract issued within a consolidated group.

In the fact pattern presented, all entities issuing automobile insurance contracts in a specific jurisdiction are required by law to be a member of an association. The purpose of association is to ensure that coverage is provided to all policyholders that would not otherwise get coverage in the market. The association manages two types of industry pools:

Pool 1—in which some members are appointed to issue contracts on behalf of all of the members

Pool 2—to which members can choose to transfer some insurance contracts they have issued

The members of the pool are jointly and severally liable for the results of the pool. The results of the pool are allocated to each member based on a formula, generally based on market share. For Pool 1 the member entities have no discretion not to take part in the pool, whereas for Pool 2 the entities are free to decide whether they want to transfer contracts to the pool or not.

The question is whether the risk adjustment for non-financial risk should be determined at either the association level or individual member entity level. Additionally, the paper considers whether the risk adjustment for non-financial risk could be measured differently in the financial statements of the members, when compared with the financial statements of the association.

The paper analyses the issue by considering the following questions:

1. In accounting for a share in the pool, who is the issuer: the individual member writing the contracts; the collective of all member entities; or each member for their share?

2. If an individual member entity writes the contract and then subsequently transfers the contract to the industry pool, does the transfer constitute reinsurance or extinguishment of the original contract?

3. On which level should the risk adjustment for non-financial risk should be determined?

The IASB staff observed that if the individual member entity that writes the contract is the issuer, the entity should assess whether the arrangement under which an insurance contract is issued by more than one entity would be considered a joint arrangement in the scope of IFRS 11 *Joint Arrangements*. The staff observed that even though an insurance contract issued by members together may not meet the definition of joint control as required by IFRS 11:7, putting it outside the scope of that Standard, in developing its accounting policy under IAS 8, the guidance in IFRS 11 may still be relevant. In considering the principles of the *Conceptual Framework* to reflect the entity's substantive rights and obligations, the entity may develop an approach that is similar to current practice of accounting for their share in the pool as a direct written insurance business. If the contracts are issued by the individual member entity that writes the contracts then revenue is recognised by that member entity applying IFRS 17, and that member entity determines the risk adjustment for non-financial risk. This may be the case where an individual member entity is identified as the issuer and subsequently transfers their risk to the pool. In the fact pattern provided, the staff concluded that this is the case for Pool 2, where member entities choose to transfer policies to the pool. If the contracts are issued by more than one entity, the staff view is that the risk adjustment is determined by all member entities together. In the fact pattern provided, the staff concluded that for Pool 1 the contracts are issued together by all the member entities in the pool and therefore the risk adjustment for non-financial risk is also determined from the perspective of all members together. Practically, the association may determine the risk adjustment for non-financial risk for all members. This would mean that each member entity accounts for its respective share in the results of the industry pool.

The IASB staff concluded for the second question that, for one group of insurance contracts there is only one risk adjustment for non-financial risk, however, the staff note that the TRG members have previously interpreted the requirements in IFRS 17 differently in this aspect.

See TRG Agenda Paper 9 for additional details.

Discussion
TRG members agreed with the staff analysis. There was a broad agreement with the second step of needing to consider the scope of IFRS 11 and other factors relevant to the particular scenarios. One TRG member noted the need to consider principal and agency considerations in determining who is issuing the contract. Other TRG members pointed out the fact that in this specific scenario the liability of each member in each pool was joint and several, whereas in some other fact patterns, such as coinsurance and Lloyds syndicates, the liability is joint, but not several. Furthermore, in the fact pattern presented in the paper, the pricing was determined by the association, and so when directly underwriting the contracts the individual members were, in effect, doing it jointly. In other scenarios, the lead underwriter may have discretion over the amount of discount it can offer to a policyholder on their share of the business that is different from the price set for the share of the other pool members.

In considering the risk adjustment for non-financial risk reflecting the compensation the entity would require for bearing the non-financial risk there was an acknowledgement of different views expressed previously (May 2018 TRG meeting, Agenda Paper 2). When reflecting the diversification benefits, the entity considers the diversification benefits arising from writing the contracts in the pool, as opposed to writing them as an individual entity. These would flow into the determination of the risk adjustment, together with the other diversification benefits specific to each member entity. That is to say that the risk adjustment for non-financial risk is different depending on whether the contracts are written collectively or by each member entity separately. However, for such collectively written contracts, the individual entity's risk adjustment for non-financial risk may not be an entity's share of the risk adjustment determined collectively by the association, it would also reflect the diversification benefits available to each of the member entities (for example, diversification arising from other lines of business).

Topic 10—Annual cohorts for contracts that share in the return on a specified pool of underlying items

Background
IFRS 17:B67 identifies insurance contracts that affect the cash flows to policyholders of other contracts by requiring the policyholder to share with policyholders of other contracts the returns on the same specified pool of underlying items, and requiring either:

(a) the policyholder to bear a reduction in their share of returns on the underlying items because of payments to policyholders of other contracts that share in that pool

(b) the policyholder of other contracts to bear a reduction in their share of returns on the underlying items because of payments to the policyholder

The question considers an annual group of contracts that share a return in the specific pool of underlying items, with some of the return passed from one group of policyholders to another. The submission asks in what circumstances measuring the CSM at a higher level than an annual cohort level, such as a portfolio level would achieve the same accounting outcome as measuring the CSM at an annual cohort level. There are three views expressed in the submission:

(a) View A—An entity is only able to consider the CSM at a level of a single combined risk-sharing portfolio when 100% of the returns on the specified pool are allocated back to the policyholders of the portfolio

(b) View B—An entity is only able to consider the CSM at a level of a single combined risk-sharing portfolio when a specified percentage of the returns of the specified pool is allocated back to the policyholders of the portfolio

(c) View C—An entity is only able to consider the CSM at a level of a single combined risk-sharing portfolio when a significant portion of the returns on the specified pool are allocated back to the policyholders of the portfolio

The IASB staff concluded that on contracts with policyholders that share in 100% of the returns, an entity measuring the CSM at a higher level than the annual cohort level, such as the portfolio level, would achieve the same accounting outcome as measuring the CSM at an annual cohort level. Further, for contracts with policyholders that do not fully share risks, the IASB staff concluded that the CSM of a group of contracts may differ from a CSM measured at a higher level, such as the portfolio level.

The agenda paper provided two examples. In Example 1, the policyholders participate in 100% of the returns on a specified pool of underlying items which are the insurance contracts issued to the policyholders.

In Example 2, ten groups share in the net return of the pool 90/10. The premiums of each group are CU1,000. Group 1 has a claim of 4,000. The paper provides the following analysis of the fact pattern:

	A **Group 1** **CU**	**B** **Each of groups 2–10** **CU**	**C = B × 9** **Total of groups 2–10** **CU**	**D = A + C** **Total of 10 groups** **CU**
Premium	1,000	1,000	9,000	10,000
Claim	(4,000)	0	0	(4,000)
	(3,000)	1,000	9,000	6,000
90% profit share	(540)	(540)	(4,860)	(5,400)
Subsidy	3,240	(360)	(3,240)	–
CSM	(300)	100	900	600

See TRG Agenda Paper 10 for additional details.

Discussion

Most TRG members agreed with the analyses on the examples in the agenda paper given the fact patterns, however many found the fact patterns to be unrealistic and therefore not as helpful. Some TRG members were concerned that Example 2 could send the wrong message to practice.

One TRG member highlighted that contracts with policyholders that do not fully share risks could cause the entity to be affected by the expected cash flows of each contract issued. It was therefore important to note that there are scenarios in which it does not affect the entity and hence, measuring the CSM at a higher level than an annual cohort level would achieve the same accounting outcome as measuring the CSM at an annual cohort level. The IASB staff confirmed that view.

One TRG member pointed out that full risk sharing does not necessarily mean that 100% of the returns on the pool go to the policyholders. There are scenarios in which the entity has a share, however that share is unaffected by the cash flows of the pool due to mutualisation and the policyholders would still fully share the risks. In that case the CSM would be greater than zero. The first example chosen by the staff seems extreme in that regard and unrealistic, as it applies only to some mutual entities. Several TRG members echoed this concern. The impression could arise that Example 1 is the only scenario in which it would be permitted to measure the CSM on a higher than annual cohort level.

Example 2 assumed that cash flows can be easily attributed to each group. Some TRG members commented that this is not the case in reality. Often cash flows can only be determined on an entity or subsidiary level and subsequently they are allocated to the groups on a systematic basis. It would not be appropriate if preparers concluded that the allocation has to follow Example 2. These TRG members noted that in practice, there can be

different ways of allocating cash flows. This concern was shared by another TRG member who suggested adding an explicit statement in the published summary to that effect. With regard to the limitations of examples, another TRG member stated that there are cases when the cash flows could not be allocated precisely as the sharing took place at a higher level. An observing IASB member acknowledged the concerns and highlighted that examples were only simplifications to illustrate the accounting treatment, and were illustrating the application of IFRS 17:B68, rather than commenting on the application of IFRS 17:B70.

One TRG member said with regard to Example 2 that the full guarantee should be included and not only 90% of the guarantee. This is based on IFRS 17:B69 where the full amount of 100 was taken into account. The guaranteed amount in B69 is an absolute guaranteed amount without subsequent sharing of the returns on the pool, while in the fact pattern in the submission, the entities do share the returns on the pool after paying the guaranteed amount. These different fact patterns would lead to different accounting responses.

One TRG member suggested that for Example 2, IFRS 17:B70 suggested to take the entire return on the pool (6,000) and allocate that return to each group on a systematic and rational basis (i.e. 10% per group = 600). The staff disagreed with that view as IFRS 17:B70 only applies when the entity has no option but to use a higher level of aggregation than the groups to identify the change in the underlying items and the resulting change in the cash flows in each group. In the fact pattern provided, however, it is known which cash flows arise in which group and therefore the entity does not need to use a higher level. IFRS 17:B70 is therefore not applicable.

One TRG member commended the staff on the paper and said that the paper addressed the question posed in the submission effectively and illustrated well using the submitter's examples whether it was permitted to measure the CSM at a higher level than the annual cohort level. The staff emphasised that when deciding on which level the CSM is measured, an entity would have to assess in advance whether the outcomes would always be the same and not only in one particular case.

An observer struggled with presenting a CSM of 900 in Example 2 when the entity knows already that future profits will only be 600. The staff justified that by saying that the loss component of 300 would be recognised as well, so the net figure was indeed 600. However, one TRG member was concerned about justifying a loss component to investors when it actually is only a reduction of profit.

One TRG member asked the staff why the measurement for Groups 2–10 was –360 in Example 2 and not –400 as the claims in Group 1 were 4,000 and every group carries 10% of those claims. The staff responded that a measurement of –400 would not be in line with IFRS 17:B68 as the share of the pool's return on profit would also have to be taken into account.

One observing IASB member highlighted that IFRS 17:BC138 was not a relief but simply stated the obvious fact that if another method leads to the same result as annual cohorts, it would be permitted. The IASB Vice-Chair confirmed that this should be read as a requirement to use annual cohorts, unless the entity can demonstrate that another method leads to the same outcome. This should be communicated to the market. A TRG member agreed with that but said that this needs more judgement than is indicated in the agenda paper.

The IASB staff summarised that the TRG agreed that determining CSM at a higher level than annual cohorts is only permitted if at the outset it is expected that it would always result in the same answer as determining it at the group level (regardless of how expectations or experience develop). The staff also noted that the TRG is concerned with the examples in the paper being unrealistic and too extreme. In particular, Example 2 assumes that IFRS 17:B70 cannot be applied while in practice, in most cases IFRS 17:B70 would be applied to determine the cash flows before IFRS 17:B68 is applied to account for the impact of mutualisation.

Topic 11—Reporting on other questions submitted

This paper summarised other questions submitted to the TRG and summarises the discussion, if any, that accompanied them during the meeting. Not all of the issues summarised below prompted comments from the TRG members.

See TRG Agenda Paper 11 for additional details.

Questions that can be answered by applying the words in IFRS 17

- Scope: Loan to buy a non-financial asset—the submission describes a specific fact pattern where a loan is repaid via low instalments over the period of the loan and a final higher payment at maturity. At maturity, the customer can choose to return the non-financial asset instead of making the final 'balloon' payment. The item is not a lease and the entity granting a loan is not a manufacturer, dealer or retailer and therefore the residual value guarantee scope exclusions do not apply. The IASB staff responded by quoting factors to consider whether the contract is an insurance or a derivative in IFRS 4:IG 2 Example 1.15 and IFRS 9:IG A2. While the Guidance on Implementing IFRS 4 is not carried forward to IFRS 17, the IASB staff confirmed that the guidance is the same as in IFRS 4.

- Scope: Loan with repayment waiver on death—the IASB staff responded that this is a cash death benefit, and is similar to Example 1.24 within paragraph IG2 of the Guidance on Implementing IFRS 4. Accordingly, the entity needs to assess the significance of insurance risk. If significant the contract is an insurance contract.

- Scope: Credit cards providing its holder with coverage for a supplier failure—the IASB staff responded that this risk is referred to in IFRS 17:B26 (f). Accordingly, the entity needs to assess the significance of insurance risk. If significant, the contract is an insurance contract.

- Scope: Minimum EBITDA guarantee from hotel management service contracts—the IASB staff responded that this is likely to be exempted from the scope of IFRS 17, because of the guarantee provided by the retailer/dealer or manufacturer exemption.

- Scope: Separating components from an insurance contract—the IASB staff acknowledged that the unbundling criteria in IFRS 17 are different so that investment components that do not meet the 'distinct' criteria are not unbundled. This means that an entity would be forced to account for contracts with a relatively small insurance component as insurance contracts in their entirety.

  Discussion:
  TRG members agreed with the staff analysis but highlighted the concerns about the scope implications for entities that currently do not consider that they have issued insurance contracts, such as credit card companies and banks. They either unbundle investment components and consider the insurance element immaterial, or do not apply IFRS 4. The TRG Chair noted that there is no significant change in the definition of an insurance contract between IFRS 4 and IFRS 17, and incorrect application of IFRS 4 is not the subject of the TRG discussion. The IASB Vice-Chair confirmed that they are aware that this is a big issue for the entities issuing such contracts. However, the staff noted that IFRS 17 is able to cope with investment components, unlike IFRS 4.

- Measurement: Interim financial statements—the IASB staff confirmed that only interim financial statements that meet the definition in IAS 34 *Interim Financial Reporting* would trigger the application of IFRS 17:B137. Other forms of internal or external reporting would not. The IASB staff acknowledges that this could create differences between subsidiary and consolidated financial statements.

  Discussion:
  A number of TRG members noted that this would create a significant operational difficulty for many group entities and would result in having to keep two sets of records for groups and subsidiaries for the same contracts. TRG staff noted that IFRS 17:B137 was added as a relief at the request of the industry. A few TRG members expressed a hope that the introduced operational complexity could be addressed in the annual improvements.

- Measurement: Actual crediting rate is different from expected and IFRS 17:B96(c)—the IASB staff concluded that IFRS 17:B96(c) only applies to experience variances associated with actual payments.

- Presentation: "Separate accounts" presentation for assets and liabilities—the IASB staff noted that IAS 1 *Presentation of Financial Statements* and IFRS 17 mandate certain line items in the statement of financial position. Sub-line items can be developed from that minimum presentation.

- Measurement: Effect of a right to cancel a free additional coverage at any time embedded in a paid for insurance contract covering a different risk—the IASB staff concluded that the cash flows from the free coverage are outside the contract boundary of the main contract and the accounting for that free coverage would begin when a claim is incurred given that the policyholder never pays a premium for it.

- Measurement: Applicability of the non-discounting exception to contracts under the general model—the IASB staff confirmed that, subject to materiality considerations, this exception is not available beyond contracts accounted for under the PAA.

- Measurement: Contract boundary of cedant and reinsurer when rights are different—the IASB staff concluded that the boundary is the same even if the reinsurer has the right to reprice with 90 days' notice that is not matched by an equivalent cancellation right by the cedant (see Paper 3 for a different fact pattern).

  Discussion:
  The TRG members asked the staff whether the analysis points to the boundary always being the same for reinsurer and cedant. The staff confirmed that the principle in determining the contract boundary is the same. While there is no rule saying that the boundary for reinsurer and cedant is always the same, in this example it is the same. This is because the same right to compel the policyholder to pay premiums for the twelve months duration of the contract that creates an obligation for the cedant creates a substantive right for the reinsurer, resulting in the twelve months contract boundary for both. The IASB staff also confirmed that the words in IFRS 17:34 mean that the entity must always choose the longest boundary from the compulsion of premium payment and the analysis of the practical ability to reprice fully the insurance risk.

- Measurement: Contract boundary and investment component—the IASB staff indicated the matter is clear and that contract boundary can extend beyond the coverage period.

Questions that do not meet the submission criteria

- Measurement: Significant possibility of becoming onerous—the IASB staff rejected the comment that this should be amended to be "significant probability" because of an alleged grammatical error.

- Measurement: Designation of reinsurance contracts as hedging instruments for the variable fee approach (VFA)—the IASB staff noted that IFRS 17 is intended to limit this hedge accounting to derivatives.

  Discussion:
  One TRG member noted that this is significant issue that they wish was added to the list of *Annual Improvements.*

- Measurement: Different levels of diversification benefits allowed in the calculation of the risk adjustment between consolidated and subsidiary financial statements—the IASB staff appeared to confirm that the differences in views noted in the May 2018 TRG meeting were presented to the IASB in June and no further action is planned.

Questions that are considered through a process other than a TRG discussion

- Mutual insurance companies—the IASB staff noted that a booklet with education material had been published in July 2018.

Discussion:
Several TRG members expressed a desire to participate in a group discussion to give input on the development of these materials. The staff confirmed that if they received any questions that were not directly answered by the Standard, these would be presented to the TRG.

- Coverage units for indirect participating contracts—This is the issue debated at the May 2018 TRG and June 2018 IASB meetings. The IASB staff explained that the debate in the TRG meetings held in February and May 2018 have led to a proposed amendment of IFRS 17 that the IASB tentatively approved in June. The amendment will explain the treatment of investment-related services from an insurance contract. The IASB staff noted that Examples 13 and 16 of the May 2018 TRG Agenda Paper 5 are relevant to understand their decision on the submission.

Discussion:
One TRG member observed that when a contract has multiple coverages in multiple currencies the determination of coverage units is very complex. The TRG members expressed a view that the issue of coverage period and recognition of investment services is still unresolved for contracts that do not meet the direct participating contracts definition. The staff confirmed that this issue is to be addressed by the IASB, and it is not for the TRG discussion. However, the staff asked to provide fact patterns of contracts that fall just either side of the dividing line of the direct participating contract definition and the issue created by recognising CSM over the relevant coverage period.

Effective date

IFRS 17 is effective for reporting periods beginning on or after 1 January 2021 with early adoption permitted. It is applied retrospectively unless impracticable, in which case modified retrospective approach or the fair value approach is applied.

Next steps

The next TRG meeting will take place on 4 December 2018. The deadline for submissions of issues and comments is 26 October 2018, with earlier submissions encouraged.

Further information

If you have any questions about the IFRS 17 TRG, please speak to your usual Deloitte contact or get in touch with a contact identified in this *IFRS in Focus*.

Key contacts

Global IFRS Leader
Veronica Poole
ifrsglobalofficeuk@deloitte.co.uk

Global IFRS Insurance Leader
Francesco Nagari
fnagari@deloitte.co.uk

IFRS centres of excellence

Americas		
Canada	Karen Higgins	ifrsca@deloitte.ca
LATCO	Miguel Millan	mxifrscoe@deloittemx.com
United States	Robert Uhl	iasplus-us@deloitte.com
Asia-Pacific		
Australia	Anna Crawford	ifrs@deloitte.com.au
China	Stephen Taylor	ifrs@deloitte.com.cn
Japan	Shinya Iwasaki	ifrs@tohmatsu.co.jp
Singapore	James Xu	ifrs-sg@deloitte.com
Europe-Africa		
Belgium	Thomas Carlier	ifrs-belgium@deloitte.com
Denmark	Jan Peter Larsen	ifrs@deloitte.dk
France	Laurence Rivat	ifrs@deloitte.fr
Germany	Jens Berger	ifrs@deloitte.de
Italy	Massimiliano Semprini	ifrs-it@deloitte.it
Luxembourg	Eddy Termaten	ifrs@deloitte.lu
Netherlands	Ralph Ter Hoeven	ifrs@deloitte.nl
Russia	Maria Proshina	ifrs@deloitte.ru
South Africa	Nita Ranchod	ifrs@deloitte.co.za
Spain	Cleber Custodio	ifrs@deloitte.es
United Kingdom	Elizabeth Chrispin	deloitteifrs@deloitte.co.uk

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