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Need to know

Transition resource groups discusses implementation of IFRS 17 Insurance Contracts

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February 2018

This Need to Know summarises the meeting of the IFRS 17 Transition Resource Group (TRG) which took place on 6 February 2018 in London.

Introduction

The TRG is a discussion forum established by 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 implementation of IFRS 17;
- To provide a public forum for stakeholders to learn about the new requirements from IFRS 17; and
- To help the IASB determine whether additional action is needed to support the implementation of IFRS 17, 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. The issues discussed arise from submissions that stakeholders have sent to the IASB for discussion.

This was the first meeting where submissions to the TRG were discussed. The next meeting is scheduled for 2 May 2018.

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

Topic 1 – Separation of insurance components of a single insurance contract

Background

IFRS 17 requires an entity to separate from insurance contracts certain non-insurance components. These are derivatives meeting separation criteria, distinct investment components and distinct performance obligations to transfer goods and non-insurance services. What is left of the host insurance contract is accounted for under IFRS 17 and forms the lowest level of the unit of account in IFRS 17. There are no further paragraphs requiring or permitting separating insurance components of an insurance contract. Insurance contracts are then aggregated into portfolios based on similarity of risks and being managed together and further subdivided into annual groups, based on profitability. The subsequent profit recognition is determined at the level of an annual group of insurance contracts, making the initial aggregation important.

However, insurance contracts often cover more than one type of insurance risk, for example, protecting policyholder against damage to car and home. Accordingly, a question arises whether an entity is permitted or required to split components of insurance contract and include them in different groups based on the similarity of the underlying insurance risk exposures.

Additionally, most of the requirements for insurance contracts apply equally to reinsurance contracts held. One reinsurance contract held may be covering underlying contracts included in different groups. The underlying insurance contracts issued may be accounted under different IFRS 17 measurement models, such as the general model and variable fee approach. The TRG submission asks whether it is possible or required to split components of a reinsurance contract and account for them as separate reinsurance contracts held to better align with the underlying reinsured contracts and to reduce potential complexity and cost of implementation.

See TRG Agenda paper 1 for additional details

Summary

The staff highlighted the fact that the host insurance contract, after unbundling of distinct non-insurance components, is the lowest unit of account in IFRS 17. As such, a single legal contract would generally be considered as one unit of account after unbundling is completed. Many TRG members agreed with this, but highlighted the fact that there may be circumstances where the legal form of one contract does not reflect the underlying substance. In general, it is assumed that the contract is written in a way that reflects its business purpose and underlying substance. However, a TRG member presented one example that may indicate that separation is required to represent the substance of the transaction. The example was of many coverages that an entity typically sells on a standalone basis being combined 'for customer convenience' into one legal contract, but on same terms and price as they would be done on each standalone contracts. In this example there will not be any interdependencies between the insurance coverages offered and no discounts granted to the combined contract only.

While different fact patterns would need to be analysed for their individual merit, it was noted that the following would need to be considered in deciding whether there might be justification in overriding the presumption of the contract being the lowest unit of account in IFRS 17.

- Presence or not of cash flows interdependencies between insurance components within a single contract;
- Different components can be lapsed separately, with components lapsing together in all cases indicating it is one indivisible contract;
- Different components being also sold by the entity separately as standalone contracts, with coverages only sold as part of a combined contract indicating it is one contract;
- Different components being managed separately as a pool of risks, with components managed together indicating one contract; and
- The substance of the combined contract being the same as the sum of several separate contracts, e.g. combined only for convenience, thus indicating that these are several contracts in substance.

There was a general agreement that separation of insurance components within a legal contract is not an accounting policy choice. This means that separation is required only when, upon analysis of the contract, the accounting for the contract as legally defined obscures the economic substance of the transaction and only the separate accounting for the different insurance components under IFRS 17 would faithfully represent the economic substance in the financial statements.

Topic 2 – Boundary of contracts with annual repricing mechanism

Background

The ability of the entity to fully reflect the risks of a particular policyholder in the price charged or level of benefits provided sets a contractual boundary. When the entity is not able to re-assess the risks of individual policyholders, it may reprice the contracts at a portfolio level. For the contractual boundary to be set at that point, the repricing must meet the criterial of paragraph 34(b).

Certain insurance contracts have annual repricing mechanisms allowing the policyholder a guaranteed yearly renewal of the policy at the price determined at a portfolio, rather than at the individual policyholder level. Initially the contract reflects the risk of the particular policyholder. These are usually life and health related risks. Subsequently, provided the policyholder pays the premium, the insurer is not able to deny coverage and cannot reflect in the price their individual policyholder's risk. Premiums are typically set to increase with policyholder age and a premium table detailing the different premiums payable at each age is communicated to policyholders in advance. The table is the same for all policyholders, except for specific adjustments relating to health conditions disclosed to the insurer at the time of the initial taking out of the policy. The premiums in the table are determined based on the cash flows projection over the expected potential lifetime of the contract (including expectations about renewals, mortality, morbidity, etc.). The entity is able to reprice the contract annually at a portfolio level setting a new premium table.

Another example is an insurance contract similar to the one described above, but with a unit-linked investment component determined based on the fair value of the underlying items. Policyholder premiums are accumulated in an account, from which every year the insurer deducts fees for the insurance coverage provided and the asset management service rendered for managing the items held in the unit-linked fund. The entity is able to reprice the premiums charged annually, based on the revised fee table applied at a portfolio level. The investment component is automatically repriced through the unit-linking feature.

Given the above two contract examples, the question arises whether or not the annual repricing mechanisms described meet conditions of paragraph 34(b), resulting in contracts with a one year boundary (i.e. until the next repricing date) thus being eligible for the premium allocation approach. In particular, whether the projection of cash flows beyond one year in establishing the original and the updated premium tables means that each repricing takes into account risks relating to periods after the next reassessment date, thus breaching the condition (ii) of paragraph 34(b).

See TRG Agenda paper 2 for additional details.

Summary

A number of TRG members highlighted the fact that there is a substantial benefit given to the existing policyholders when they can renew cover at the annual table rates without having to disclose the developments of their personal medical conditions. There was also a comment that the smooth progression of rates included in the premium table for different ages the entity is considering risks beyond one year. However, the staff highlighted that the analysis in the TRG paper depends on the fact pattern provided, as understood by the staff. This may differ by entity and jurisdiction. The basis for viewing the contract as annual rests on the understanding that on the renewal date the entity is able to reprice the portfolio and to reflect the experience obtained from the group of contracts previously issued. Several TRG members indicated that in many cases the premium table is re-issued with new rates for the whole community of policyholders and the uniformity of pricing applies to both new and existing policyholders. The staff reflected that this is an important point and the results of their analysis may have been different in that case. However, provided the portfolio repricing reflects the emergence of risk from the groups that are eligible for automatic renewal, the contracts would still have a short boundary. In general, it was observed, there is difficulty with extracting a principle from specific examples. For example, a change of fact pattern where the insurer has a contractual limitation on setting premium levels could lead to a long contract boundary. For example, on the participating contract example, staff's view would be different if the management fee percentage was for a fixed amount or capped. As a result, a unit-linked contract requires further analysis and submission of more and different fact patterns.

However, the staff clarified that in considering the application pf paragraph 34(b) of IFRS 17 an entity should consider, exclusively, policyholders risks, rather than any risks factored into the pricing of the contract, with policyholder risk referring only to insurance and financial risks that the policyholder can transfer to the insurer but excluding lapses or expenses risk which are created by the contract. These the policyholder-behaviour related risks are excluded for direct insurance contracts because they do not transfer risk from the policyholder to the issuer of the contract. It is different for reinsurance contracts, where such risks can be transferred.

Topic 3 – Boundary of reinsurance contracts held

Background

IFRS 17 paragraph 33 states that all future cash flows within the boundary of each contract in a group of insurance contracts shall be included in the measurement of that group, with paragraph 34 setting out the boundary when contractual rights and obligations end. The topic is on the practical application of the criteria in paragraph 34 to reinsurance contracts held, focusing on three reinsurance specific factors:

(a) The ability of reinsurer to exercise rights and have obligations similar to those described by paragraph 34 of IFRS 17;

(b) The reinsurer's right to terminate coverage; and

(c) The rights and obligations of the holder of the reinsurance contract (sometimes called the cedant).

Paragraph 34 of IFRS 17 states that insurer's substantive obligation to provide services ends when –

(a) The entity has the practical ability to reassess the risks of the particular policy holder and, as a result, can set a price or level of benefits that fully reflect those risks; or

(b) Both the following criteria are satisfied:

i. the entity has the practical ability to reassess the risks of the portfolio of insurance contracts that contains the contract and, as a result, can set a price or level of benefits that fully reflects the risk of that portfolio; and

ii. the pricing of the premium for coverage up to the date when the risks are reassessed does not take into account the risks that relate to the periods after the reassessment date.

It was noted that the wording in paragraph 34 does not directly apply to reinsurance contracts held. Under these contracts the cedant does not have the ability to compel premium payment or obligation to provide services. The cash flows within the boundary of the reinsurance contract held arise from the substantive rights and obligations of the cedant. The substantive right is to receive services from the reinsurer. The substantive obligation is to pay amounts to the reinsurer. Therefore the substantive right of the reinsurer to terminate the coverage would result in an entity not having the substantive rights to receive service beyond that point. Also the reinsurer's practical ability to reassess the risk based on the claims experience of the reinsured contracts and to set premium or level of benefits to fully reflect the reassessed risk means that the cedant's substantive right to receive service from the reinsurer ends at that point. One implication of this is that the boundary of a reinsurance contract held could include cash flows from underlying contracts covered by the reinsurance contract that are expected to be issued in the future (until the reinsurer would be able to fully reassess and reprice the risks of those future underlying contracts).

See TRG Agenda paper 3 for additional details.

Summary

The TRG members agreed with the staff observation that the boundary of a reinsurance contract held could include cash flows from underlying contracts covered by the reinsurance contract that are expected to be issued in the future. The contract is the lowest unit of account in IFRS 17 and consequently all the principles of IFRS 17 should be applied to each single contract, including reinsurance contracts held. It was further clarified that while there is a special concession for proportional reinsurance contracts in paragraph 62 of IFRS 17, it applies only as far as the initial recognition is concerned and measurement follows the general principle applicable to all contracts under IFRS 17. In reading paragraph 63 of IFRS 17, the measurement of fulfilment cash flows reflects consistency of assumptions with underlying insurance contracts issued, but only to the extent that those underlying contracts exist. That means that a group of reinsurance contracts held should be measured based on cash flows expectations of the group of reinsurance contracts itself for those cash flows that do not depend on underlying reinsured insurance contracts already issued. For reinsurance contract held, the inclusion of fulfilment cash flows from expected future underlying reinsured insurance contracts affects the CSM, but does not necessarily result in an entity having an asset or a liability when the group of reinsurance contract held is initially measured. However, the unlocking of the CSM in the group of reinsurance contracts held and the different discount rate used for calculating the unlocking adjustments compared to the discount rate utilised to measure the changes in future cash flows will create an asset or a liability in subsequent measurement of the group of reinsurance contracts held.

In discussion it was further clarified that the IASB's intention in providing an exemption for proportional reinsurance contracts in paragraph 62 was only for a relatively short time window between the beginning of the coverage period of the reinsurance contract held and the initial recognition date which would be based on any (first) underlying direct insurance contract issued.

Most of TRG members agreed with staff view, but noted significant operational consequences.

Topic 4 – Insurance acquisition cash flows paid on an initially written contract

Background

Insurance acquisition cash flows are cash flows arising from costs of selling, underwriting and starting a group of insurance contracts that are directly attributable the portfolio of insurance contracts to which the group belongs. They are considered in the measurement of the liability for remaining coverage of the groups of insurance contracts and affect its profitability. Acquisition costs can include commissions paid unconditionally for each initially written contract and are determined to compensate the insurance intermediary for having secured a policyholder who is expected to renew the contract in future periods. The renewals are new contracts outside the original contract boundary. There is a question as to whether these commissions can be allocated only to the initial group or also to the groups where the renewed contracts will be included.

There are several potential views:

View A: The acquisition cash flows incurred should be allocated to the groups of contracts in existence at that time, i.e. to the groups to which the initially written contracts belong. The future groups to which renewed contracts will belong are not considered in the allocation of these commissions. If in the same annual period there are contracts renewed and contracts initially written, they are treated as separate groups. The resulting allocation of the entire commission amount as an acquisition cost for the groups of initially written contracts may lead to those groups being onerous. This view is based on having to reflect in cash flow estimates all available information, resulting in acquisition cash flows incurred being within the contract boundary of initially written contracts. Additionally, applying paragraph 35, there is no possibility to recognise an asset or a liability relating to future premiums or claims outside the contractual boundary.

View B: These commissions relate to groups of contracts initially recognised and those groups to which renewed contracts are expected to belong in the future. Therefore an asset is recognised for part of the commission that would be allocated to future groups. If in the same annual period there are contracts renewed and contracts initially written, they are treated as separate groups. This view is based on analogy to paragraphs 95 and 99 of IFRS 15 Revenue from Contracts with Customers. IFRS 15 allows asset recognition for acquisition costs outside the scope of other standards that relate to anticipated contracts that an entity can specifically identify (e.g. renewals of existing contracts). This view is less likely to result in groups being onerous due to acquisition cash flows.

View C: This view is similar to view A, except for the interpretation of the level of aggregation requirements in IFRS 17: if in the same annual period there are contracts renewed and contracts initially written, they are treated as one group. As a result, part of the commission incurred on writing initial contracts is allocated to contracts renewed in the same annual period. This is based on interpreting paragraph B65(e) as requiring the allocation of acquisition cash flows directly attributable to a portfolio which comprises contracts managed together and subject to similar risks. Both new and renewed contracts are managed together and are subject to similar risks so are in the same portfolio. As they are issued within the same annual period, they form one annual group.

See TRG Agenda paper 4 for additional details.

Summary

On the fact pattern presented in the paper, with commission paid for each individually acquired contract being non-refundable, the staff view is that such costs are directly attributable only to the group of newly written contracts that is utilised to calculate the commission. The staff acknowledged that different fact patterns could result in different analysis.

There were several clarifications made in line with the example presented in agenda paper number 4. The first clarification is that IFRS 17 refers in paragraph 27 to 'contracts issued' in order to distinguish them from 'contracts held' and this does not imply that these contracts have already have been issued by the time the acquisition cash flows have been incurred. This means that acquisition expenses that are directly attributable to the portfolio but not to individual contracts can be allocated to future groups of that portfolio. Another clarification was around the distinction between costs directly and indirectly attributable to contracts. An example of costs directly attributable to the portfolio, but not to individual contracts are the costs of a call centre set up solely to sell insurance contracts that will constitute a portfolio. Such costs could potentially be allocated to future new or renewed contracts, depending on facts and circumstances. The discussion clarified that in the example presented in the paper the acquisition costs were directly attributable only to the group of newly issued contracts. This was because they were calculated and paid based on each individual new contract and were not refundable. Some TRG members noted that the absence of clawback in this example is realistic because there is market practice for the sale of certain insurance contracts where commissions are determined in line with this example.

Some other questions were considered. For example, if both new and renewed contracts are issued at the same time, are accounted under the premium allocation approach and entity choses to expense acquisition cash flows as they are incurred, can these contracts be in the same annual group? The staff suggested that this needs further consideration.

Overall, many TRG members agreed with the staff view on the fact pattern presented in the paper, but felt that it does not portray the economic substance, where the initial contracts end up being onerous and subsequent renewals more profitable rather than reporting all these groups of contracts with a similar profitability, all other things being equal.

Topic 5 – Determining quantity of benefits for identifying coverage units

Background

For a group of insurance contracts, the determination of coverage units affects the amount of CSM recognised in profit or loss in each period to reflect the services provided in that period. For each group, an entity first determines the quantity of the coverage units. At the end of the reporting period, it allocates the CSM equally to coverage units provided in the period and those expected to be provided in the future. The amount of CSM allocated to coverage units provided in the period is recognised in profit or loss.

Determination of the quantity of coverage units in the group is linked to the quantity of benefits the policyholders will receive from the contracts in the group. Paragraph B119(a) states that "the number of coverage units in a group is the quantity of coverage provided by the contracts of the group, determined by considering for each contract the quantity of benefits provided under a contract and its expected coverage duration".

In determining the quantity of benefits there are different factors that could be considered. The agenda paper uses four examples to illustrate the effect of including or excluding those factors for insurance contracts without investment components. These are: credit life insurance, reinsurance adverse development, five year warranty and life-contingent pay out annuity contracts. Questions relating to insurance contracts with investment components will be discussed at a later meeting. The different factors relevant to determining the quantity of benefits arising from insurance coverage analysis are as follows:

(a) Variability across periods in the duration of the coverage period by the contracts in the group; and

(b) Likelihood of an insured event occurring:

   i. To the extent that likelihood affects the expected duration of a contact (e.g. expectation of deaths, lapses and cancellations); and

   ii. To the extent that likelihood affects the amount expected to be claimed in a period.

Pattern of profit recognition reflects the service provided over the whole of the coverage period, and not just when a claim is incurred. Expectation of deaths, lapses and cancellations should be included in the determination of coverage units because paragraph B119 requires the coverage to be based on the expected duration of the contracts in the group. In other words, the expected events that would lead to the end of the coverage period are considered to measure the time over which an insurer will calculate how many coverage units there are for a group of insurance contracts. Further, coverage units were introduced to achieve an appropriate allocation of the contractual service margin of a group that contains contracts of different sizes. One view, proposed by the staff, is that the principle implicit in the words of IFRS 17 is that different levels of cover across periods should be included in the determination of the quantity of benefits. Contracts that offer larger benefits to a policyholder would have a larger number of coverage units.

Under that view the determination of coverage units of a group should:

(a) Reflect the likelihood of an insured event occurring to the extent they affect the expected duration of contracts in the group, applying paragraph B119(a)

(b) In principle, reflect variability across periods in the level of cover provided by the contracts in the group, with the level of cover (i.e. the benefits) being the contractual maximum level of cover in each period, not the level of cover reflecting expected events; but

(c) Not reflect the likelihood of an insured events occurring to the extent they affect the amount expected to be claimed in a period.

In considering variability in the level of cover, an entity would need to consider current and future periods and would not consider the level of cover provided in the past. The analysis would be more complex where different contracts in the group have different patterns of cover level variability over time, further complicated by interaction with investment components. As mentioned, examples of contracts with investment components would be discussed at a later meeting.

See TRG Agenda paper 5 for additional details.

Summary
There was some initial discussion of the agenda paper. However, given that the discussion of contracts with investment components will be discussed in May, it was decided to defer all discussion of coverage units till later date to ensure consistency in the TRG outcomes. Overall, it was agreed that it is difficult to extrapolate ideas of how to determine coverage units based on a few examples when there are so many different practices around the world. In particular there was concern with using maximum level of cover and the concept of possible 'valid claim' could merit further exploration. In the meantime the staff encourage submission of further comments on the examples in the paper.

Most of TRG Members agreed with this approach.

Topic 6 – Insurance acquisition cash flows when using fair value transition

Background
On transition, when full retrospective application of IFRS 17 is impracticable, entities are able to apply the fair value or the modified retrospective approaches. There is a question about the treatment of acquisition cash flows that occurred prior to the transition date. IFRS 17 requires an allocation of acquisition cash outflows to each group and this allocation will reduce the group's CSM. Insurance revenue and insurance service expense recognised in a period include equal and opposite amounts related to insurance acquisition cash flows, resulting in no impact on the recognised insurance service result.

Given that under both the modified and the fully retrospective approaches, the acquisition cash flows incurred before transition date impact the amount of CSM then determined and subsequent revenue and expense recognition, the question is whether the same treatment of these cash flows is required under the fair value approach.

The fair value approach states that the CSM or loss component at the transition date is determined as the difference between the fair value of the group of insurance contracts and the fulfilment cash flows measured at that date. As the difference between two forward looking measures, the CSM excludes past pre-transition date acquisition cash flows.

Regarding the presentation of insurance revenue and insurance service expense two views are presented:

View 1: Transitional application of the fair value approach implies that it is impracticable to determine the insurance acquisition cash flows that occurred prior to the transition date. Therefore, it is not necessary to identity and recognise these amounts.

View 2: It is necessary to estimate insurance acquisition cash flows related to existing contracts and to recognise the corresponding revenue and expense even if applying the fair value approach to determine the CSM at transition date. Given this would be burdensome and largely impracticable, an amendment or clarification is sought, if this is indeed required.

Further support for view 1 is the implicit principle in IFRS 17 that the total amount of acquisition cash flows recognised in insurance revenue and expense over the coverage duration of the group is the same as the amount of those cash flows first recognised in the group's CSM. Given that under the fair value approach such pre-transition date acquisition cash flows are required to be excluded from the CSM, they should not be included in presentation of insurance revenue and expenses. This provides the entity with a 'fresh start' approach to transition as intended by the Board

See TRG Agenda paper 6 for additional details.

Summary
All the TRG members agreed with the staff view presented in agenda paper number 6 that application of the fair value approach on transition reflects only the expectation of future and not past cash flows, including past insurance acquisition cash flows.

Topic 7 – Reporting on other questions submitted

Background

This paper summarises 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.

The staff will consider publishing educational materials on these topics in the future to further support implementation.

i. S04 – how insurance revenue and insurance service expense should be presented for insurance contracts acquired in conjunction with a business combination or similar acquisition in their settlement period? More specifically, whether revenue would reflect the entire expected claims or not.

   Response – Acquiring contracts in their settlement period is equivalent to entering into a contract that provides coverage for the uncertainty of adverse development of claims. The subsequent treatment for the liability for remaining coverage is set out in paragraph 41 of IFRS 17. Accordingly, revenue would reflect the entire expected claims amounts after disaggregation of any investment component.

   Summary of the TRG discussion:
   During the meeting some TRG members raised a concern that the insured risk is 'transformed' by the business combination, and contracts with expired coverage for the initial issuer have a new 'adverse development' coverage period when recognised in the financial statements of the acquirer. This may appear counter-intuitive and leads to the acquirer recognising different insurance service revenue on these contracts. However, the reflection by staff was that for the acquirer these contracts are new, and therefore it is not true that the requirement results in reporting insurance revenue for the second time. An additional concern was flagged around the application of these principles to transactions under common control, which were not considered here, but may merit further consideration.

ii. S09 – how to allocate the contractual service margin to coverage units provided in the current period and expected to be provided in the future applying paragraph B119(b) of IFRS 17?

   Response – Paragraph B119(b) of IFRS 17 states that the contractual service margin at the end of the period is allocated equally to each coverage unit provided in the current period and expected to be provided in the future. Therefore, the allocation is performed at the end of the period, identifying coverage units that were actually provided in the current period and coverage units that are expected at this date to be provided in the future.

   Summary of the TRG discussion:
   This submission was not discussed, but the issue was briefly touched upon in the agenda paper 5 on the discussion of coverage units (postponed till next meeting), in relation to interpretation of paragraph 73(c) of IFRS 17. It was confirmed that 73(c) requires the calculations in B119 to take into account the derecognition of contracts in the period and that the coverage units attached to the derecognised contracts will be reported as insurance revenue in the period when the derecognition has occurred.

iii. S17 – Paragraph 63 of IFRS 17 requires the use of assumptions for the measurement of the estimates of the present value of the future cash flows for a group of reinsurance contracts held that are consistent with those used to measure the underlying insurance contracts. Does this imply the use of an identical discount rates is required?

   Response – 'Consistent' in paragraph 63 of IFRS 17 does not necessarily mean 'identical'. The extent of the dependency between the cash flows of the reinsurance contract held and the underlying contracts should be evaluated in applying paragraph 63 of IFRS 17.

   Summary of the TRG discussion:
   This paper was not discussed at the meeting.

iv. S20 – On transition, applying the modified retrospective approach, there is a requirement to aggregate contracts in annual groups, provided the entity has reasonable and supportable information for that [IFRS 17:C8, C10]. The question is whether the wording in paragraph BC392 of the Basis for Conclusions on IFRS 17 and example 17 in the Illustrative Examples on IFRS 17 might suggest otherwise.

Response – The IFRS 17 requirement in paragraphs C8 and C10 is consistent with the explanation in paragraph BC392 that the Board acknowledges that it may not always be practicable for entities to group contracts not issued more than one year apart retrospectively.

Summary of the TRG discussion:
During discussion it was clarified that on transition, for modified retrospective approach paragraph C10 of IFRS 17 requires annual groups if such information is available, but the standard does not require annual groups if an entity applies the fair value approach, applying paragraph C23. An insurer that uses the fair value approach for restatement would only be able to create annual groups if and only if they have reliable information to do so. This clarification indicates that the fair value approach to restate CSM would usually be done without annual groups and only under the conditions set out in C23 annual groups of contracts that have been restated using their fair value can be created in an insurer's accounting system.

v. S23 – What is meant by "premiums, if any received" in paragraphs 55(a)(i) and 55(b)(i) of IFRS 17 with respect to the measurement of the liability for remaining coverage applying the premium allocation approach. It is noted that there could be three interpretations. The first based on a literal reading of the standard refers to premiums actually received. The other interpretations are broader and include premiums due and premiums expected.

   Response – "Premiums, if any received" as included in paragraphs 55(a)(i) and 55(b)(i) of IFRS 17 means premiums actually received in cash at the reporting date. It does not include premiums due or premiums expected. There is also a separate question that relates to this and it will be assessed for a future TRG discussion.

   Summary of the TRG discussion:
   Some TRG members noted that this issue is linked to the need to track actual group cash flows for balance sheet presentation of groups that are assets and liabilities, as raised in submission S03 (see below). They expressed a concern about the usefulness of such information and the resulting operational burden, citing the fact that preparers' systems are not integrated enough to reflect actual group cash flows paid or received. However, no further consensus emerged.

vi. S26 – Whether contracts with the return based on an amortised cost measurement of the underlying items would fail the definition of direct participating contract.

   Response – Contracts that provide a return that is based on an amortised cost measurement of the underlying items would not automatically fail the definition of insurance contract with direct participation features. Applying paragraph B107 of IFRS 17, entities expectations would be assessed over the duration of the contracts, and therefore returns based on amortised cost measurement might equal returns based on fair value of the underlying items over that duration.

   Summary of the TRG discussion:
   Some TRG members asked for an additional clarification, whether in the fact pattern provided an entity has to prove that over the long term policyholders are expected to benefit from changes in fair value. Staff view was that it is a judgement that depends on facts and circumstances.

There were also a few additional questions that did not meet the submission criteria (must be related to, or arise from IFRS 17, may result in possible diversity in practice and are expected to be pervasive):

i. S03 – whether the requirement in paragraph 78 of IFRS 17 to present separately in the statement of financial position groups of insurance contracts issued that are assets and group of insurance contracts that are liabilities is appropriate or whether presentation at a portfolio level would be more appropriate considering groups share similar risks and are managed together.

   Response – The submission acknowledges the requirements of IFRS 17, which are consistent with the Conceptual Framework on offsetting. Offsetting classifies dissimilar items together and therefore is generally not appropriate.

   Summary of the TRG discussion:
   This paper was not discussed at the meeting.

ii. S10 – According to the consequential amendments to IFRS 3 Business Combinations, classification of contracts acquired in a business combination is based on the terms and conditions at the transition date. This could lead to different contract classifications for an acquirer and an acquiree, resulting in onerous system implications and various consolidation complexities.

Response – Contacts might be classified differently in the financial statements of the acquiree and the acquirer as a result of applying the requirements in IFRS 3. It is noted that this accounting is consistent with business combination accounting generally.

Summary of the TRG discussion:
This paper was not discussed at the meeting.

iii. S24 – For insurance contracts without direct participating features, different discount rates are used for measurement initially [IFRS 17: B72(a)] and subsequently [IFRS 17: B72(b)]. This might result in diversity between insurance revenue recognised for insurance contracts without direct participating features but that have some asset dependant cash flows and for direct participating contracts.

Response – The requirement of paragraph B72(b) of IFRS 17 for insurance contracts without direct participating features is clear.

Summary of the TRG discussion:
The staff provided a clarification that the basis for the drafting of the standard was to simplify accounting for preparers and is expressed in paragraph BC273 of IFRS 17. Some TRG members questioned whether this requirement simplifies the implementation of IFRS 17. Other TRG members agreed with the intention set out in BC273.

iv. S25 – Paragraph B96 of IFRS 17 requires the carrying amount of the contractual service margin to be adjusted for a difference in the investment component as a result of the acceleration or delay of repayment. Why is this appropriate, given that it leads to the contractual service margin being adjusted for changes solely due to timing of payments. This appears to conflict with the principle underpinning insurance revenue set out in paragraph B120 of IFRS 17.

Response – Paragraph BC235 of the Basis for Conclusions on IFRS 17 explains the Boards reasons for this requirement.

Summary of the TRG discussion:
This paper was not discussed at the meeting.

And there were also questions that are being considered through other than TRG process.

i. S06 – What is the relevant date for assessing the classification of contracts acquired in previous business combinations as insurance contracts when an entity transitions to IFRS 17 retrospectively. There is an inconsistency in the requirements of the Standard and the intention of the Board set out in Agenda paper 2C of the February 17 Board meeting.

Response – Paragraph B93 of IFRS 17 states that contracts acquired are treated as if the entity had entered into the contracts on the date of the transaction. IFRS 3 (as amended) requires that classification of contracts acquired be based on the terms and conditions on the transaction date. On transition, applying IFRS 17 retrospectively, these requirements would be applied retrospectively too. Agenda paper 2C of the February 2017 Board meeting states in relation to the classification of contracts acquired in a business combination that "the staff note that this consequential amendment to IFRS 3 applies to business combinations that occur when or after IFRS 17 is effective". This question will be considered as part of the annual improvement process.

ii. S16 – What discount rate is used to adjust the contractual service margin of reinsurance contracts held applying paragraph 66(c) of IFRS 17?

Response – paragraph B72(c) of IFRS 17 is applicable to contracts without direct participating features, both insurance contracts issued and reinsurance contracts held, and requires the use of the discount rate determined on initial recognition. This will be addressed through an editorial correction to refer in paragraph 66(c) to paragraph B72(c).

See TRG Agenda paper 7 for additional details.

Next Steps

The Next TRG meeting will take place on the 2 May 2018. The deadline for submissions of issues is 21 March 2018, with earlier submissions encouraged.

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