IFRS

STAFF PAPER

**February 2018**

| **Project** | **Transition Resource Group for IFRS 17 *Insurance Contracts*** | | |
|---|---|---|---|
| Paper topic | Boundary of contracts with annual repricing mechanisms | | |
| CONTACT(S) | Roberta Ravelli | rravelli@ifrs.org | +44 (0) 20 7246 6935 |
| | Hagit Keren | hkeren@ifrs.org | +44 (0) 20 7246 6919 |



## Introduction

1. We have received a submission about how to determine the contract boundary of insurance contracts with annual repricing mechanisms. In particular, the submission asks whether those contracts would have a contract boundary of one year (ie the first annual repricing date) or longer than one year, depending on which type of risks are relevant in applying paragraph 34(b) of IFRS 17 *Insurance Contracts*.

2. The objective of this paper is to provide background and an accounting analysis to support discussion at the Transition Resource Group for IFRS 17 (TRG).

## Structure of the paper

3. This paper includes the following:

   (a) background information;

   (b) implementation question; and

   (c) review of accounting requirements.

4. There is an appendix to this paper:

   (a) Appendix A—Fact patterns provided in the submission.

## Background information

5. Paragraph 33 of IFRS 17 states:

> An entity shall include in the measurement of a group of insurance contracts all the future cash flows within the boundary of each contract in the group.

6. Paragraph 35 of IFRS 17 states:

> An entity shall not recognise as a liability or as an asset any amounts relating to expected premiums or expected claims outside the boundary of the insurance contract. Such amounts relate to future insurance contracts.

7. Paragraph 34 of IFRS 17 states:

> Cash flows are within the boundary of an insurance contract if they arise from substantive rights and obligations that exist during the reporting period in which the entity can compel the policyholder to pay the premiums or in which the entity has a substantive obligation to provide the policyholder with services (see paragraphs B61–B71). A substantive obligation to provide services ends when:

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

(b) both of 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 premiums for coverage up to the date when the risks are reassessed does not take into account the risks that relate to periods after the reassessment date.

8. Paragraph 53 of IFRS 17 states:

> An entity may simplify the measurement of a group of insurance contracts using the premium allocation approach set out in paragraphs 55–59 if, and only if, at the inception of the group:
>
> (a) […]; or
>
> (b) the coverage period of each contract in the group (including coverage arising from all premiums within the contract boundary determined at that date applying paragraph 34) is one year or less.

## Implementation question

9. The submission asks whether insurance contracts with annual repricing mechanisms would have a contract boundary of one year or longer than one year—ie whether the cash flows used to measure those contracts would be only those related to premiums up to their annual re-pricing date because the cash flows related to premiums after that date would relate to future contracts.

10. The submission notes that if those contracts are considered to have a contract boundary of one year or less, the optional simplified approach in IFRS 17—the premium allocation approach—may be applied to measure those contracts.

11. The submission describes the features of two insurance contracts. These are included in Appendix A to this paper.

12. The first contract is referred to as a 'step-rated insurance contract' and contains the following main features:

    (a) the contract covers life and health risks, such as trauma, disability and medical expenses and does not include any investment component.

    (b) the policyholder is underwritten via medical tests carried out at the time the policyholder buys the insurance contract.

    (c) the contract is guaranteed to be renewable every year with no further underwriting of the individual policyholder—ie the contract may be kept in-force at the sole option of the policyholder, provided the policyholder continues to pay the premiums every year.

    (d) premiums are typically:

        (i) step-rated—ie determined for each age, using a step-rated premium table, except for specific adjustments for some health conditions of the policyholder when he/she buys the contract or loyalty discounts when applicable. Therefore, the premium for a new 40 year old policyholder would be the same as the premium for an existing 40 year old policyholder, assuming that they are both in standard health when they buy the contracts and there are no loyalty discounts in place.

        (ii) increased each year based on the step-rated premium table such that each policyholder knows in advance that his/her

premium will change in line with his/her increase in age—ie the contract does not charge level premiums[1].

(e) the step-rated premium table is determined based on cash flow projections carried out over the potential future lifetime of a contract. The projected cash flows include premiums, claims and expenses, and, often, projected capital requirements. The underlying assumptions to derive these cash flows include assumptions about mortality/morbidity, lapses and expenses.

(f) the entity can reprice the contract annually at a portfolio level, rather than at an individual policyholder level. The re-pricing comprises creating new step-rated premium tables.

13. The second contract has a pure unit-linked investment component combined with an insurance component with characteristics similar to those of the first contract described above, including an annual repricing of the insurance fees at a portfolio level using step-rated fee tables. This second contract is referred to as a 'participating contract' and contains the following additional features:

(a) the contract has an investment component that is unit linked. The unit-linked component is always priced based on the fair value of the underlying items.

(b) premiums are accumulated in a policyholder account from which the entity deducts annually the fees for the insurance coverage provided (insurance fees) and the asset management of the assets held in a unit-linked fund (asset management fees).

[1] The staff note that an example of a simple level premium contract would be a 10-year life insurance contract where the policyholder pays CU100 per year, even though the actual cost for the entity might be CU70 in Year 1 and CU120 in Year 10. As mortality risk increases with age, the level premium charged in an earlier year of the contract includes some of the mortality cost for future years.

(c) the entity can reprice the contracts annually by reassessing the step-rated fee tables at a portfolio level. The investment component is automatically repriced via the unit-linking feature.

14. The submission notes that the features of the two contracts do not meet the requirements in paragraph 34(a) of IFRS 17—ie the entity:

(a) has no practical ability to reassess the risks of the particular policyholder (no medical tests on the policyholder are carried out after the inception of the contract); and

(b) cannot set a price or level of benefits that fully reflects those risks.

15. The submission notes that there are mixed views on the determination of the contract boundary for the two contracts with respect to the requirements in paragraph 34(b) of IFRS 17. Some believe that the contract boundary is longer than one year and others that the contract boundary is one year, depending on which type of risks are relevant in applying paragraphs 34(b)(i) and 34(b)(ii).

16. The submission therefore provides three alternative views:

(a) View 1—The contract boundary is longer than one year (ie the first annual repricing date) for both contracts because premiums and insurance fees are determined using cash flow projections carried out over the potential expected lifetime of a contract (ie applying paragraph 34(b)(ii) pricing does take into account risks that relate to periods after the re-assessment date).

(b) View 2—The contract boundary is one year for both contracts because the pricing mechanisms applied do not mean that the premium for a particular age of the policyholder is covering the claim risk for future ages of the policyholders (ie applying paragraph 34(b)(ii) pricing does not take into account policyholders' risks that relate to periods after the re-assessment date).

(c) View 3—The contract boundary is:

(i) one year for the 'step-rated insurance contract' for the reasons noted under View 2 above; and

(ii) longer than one year for the 'participating contract' because the entity draws the insurance fees from the investment component; therefore, the pricing of the 'participating contract' considers risks beyond the next re-assessment date.

## Review of accounting requirements

17. As noted in the submission, both contracts have repricing mechanisms at the portfolio level to reflect changes in the risks of the portfolio as a whole, rather than changes in the risks of a particular policyholder. Consequently, we discuss below only the criteria of paragraph 34(b) of IFRS 17 and, in particular, which risks are relevant in applying that paragraph.

18. The staff believe that paragraph 34(b) of IFRS 17 should be read in the context of the policyholder risks in the portfolio because:

(a) the original proposal of the Board (2010 Exposure Draft *Insurance Contracts*) only included the requirements in paragraph 34(a) of IFRS 17. The Board subsequently added in the 2013 Exposure Draft *Insurance Contracts* the requirements in paragraph 34(b) of IFRS 17 to capture contracts for which an entity is prevented from re-pricing using an individual policyholder's risk assessment, but may nonetheless be able to reprice the portfolio to which the contract belongs. As noted in paragraph BC163 of the Basis for Conclusions on IFRS 17, the Board was persuaded by the views expressed by stakeholders that applying only the requirements in paragraph 34(a) of IFRS 17 would result in some cash flows for which the entity does not have a substantive obligation being included within the boundary of some contracts. Consequently, the staff believe that the requirements in paragraph 34(b) should be read as an extension of the risk reassessment from individual

to portfolio level, without extending policyholder risks to all types of risks and considerations applied by an entity when pricing a contract.

(b) to meet paragraph 34(b), paragraph 34(b)(ii) requires the pricing of the premiums for coverage up to the date when the risks are reassessed not to take into account the risks that relate to periods after the reassessment date. If the pricing does take these into account then the entity is effectively considered to have an obligation to provide services even if it can reassess the risks at a portfolio level and has the practical ability to reprice contracts to reflect the reassessed risks. This is the case because the policyholder has an incentive to continue with or renew the contract because he/she has already paid amounts effectively relating to future services. Applying an interpretation of risks being all risks (for example, lapse risk) and not only policyholder risks (for example, mortality risk) would mean that most contracts with repricing mechanism will be long-term contracts because entities often price contracts considering the expected retention of policyholders for future contracts, even when the contract does not provide the policyholder with any renewal option. This approach would result in paragraph 34(b) being highly unlikely to be applied.

19. The staff believe that, consistent with the requirements in paragraph 34(a), when the Board added the requirements in paragraph 34(b) of IFRS 17, the Board had in mind the policyholder risks in the portfolio, rather than any wider risks to which the entity might be exposed or consider when pricing contracts.

20. Paragraph BC162(a) of the Basis for Conclusions on IFRS 17 explains that an entity may price a contract so that the premiums charged in early periods subsidise the premiums charged in later periods, even if the contract states that each premium relates to an equivalent period of coverage. This would be the case if the contract charges level premiums and the risks covered by the contract increase with time. The entity would therefore be bound to an insurance contract if, after

the first period of coverage, the policyholder has obtained something of value such as the ability to continue coverage at a level price despite increasing risk. The staff believe that paragraph BC162(a) of the Basis for Conclusions on IFRS 17 describes the logic behind paragraphs 34(a) and 34(b) of IFRS 17 with reference to the reassessment of policyholder risks.

21. Based on the features of the contracts described in the submission, the entity issuing a 'step-rated insurance contract' or a 'participating contract' can reset the premiums or the insurance fees of those contracts annually to reflect reassessed risks at a portfolio level. In particular, the entity set premiums using step-rated tables reflecting the risks that result from the actual age of a policyholder for the year of coverage, rather than level premiums over the expected lifetime of the contracts.

22. The submission notes that:

    (a) for the 'step-rated insurance contract' the premium for a new 40 year old policyholder would be the same as the premium for an existing 40 year old policyholder, assuming that they are both in standard health when they buy the contracts and there are no loyalty discounts in place (see paragraph 12(d)(i) above); and

    (b) similar pricing mechanisms apply to the 'participating contract'.

23. The staff believe that the underlying principle of the determination of the contract boundary is that a contract renewal with the same premium that would be available to a new policyholder should be treated as a new contract because the existing contract does not confer on the existing policyholder any further substantive rights.

24. Accordingly, the staff conclude that, for the 'step-rated insurance contract', the cash flows resulting from renewal terms should not be included with the boundary of the existing insurance contract.

25. Similar considerations apply to the ‘participating contract’. As noted in paragraph 21 above, the entity can reassess the policyholders’ risks and can set insurance fees that fully reflect the risk of the portfolio. Consequently, after the re-pricing date, the entity is no longer bound by the contract. As noted in the submission, the fact that the entity automatically reprices the investment component via the unit-linking feature is neutral in establishing if the requirements in paragraph 34(b) of IFRS 17 are met. Therefore, any cash flows arising beyond the re-pricing date relate to a future insurance contract, not to the existing insurance contract. This paper does not consider other potential fact patterns for which the pricing of the investment component could be different.

## TRG Discussion

**Question to TRG members**

What are your views on the implementation question presented above?

## Appendix A—Fact patterns provided in the submission

A.1 We report below the fact patterns provided in the submission.

Products that are yearly renewable “stepped” premium life cover products, and not simple "level” premium policies, hereinafter (“step-rated insurance”).

Step-rated insurance products usually contain the following features:

1. Cover is risk only, with no savings or profit-share component;
2. Cover types include: Life, Trauma, Total Permanent Disablement, Disability Income (and Medical Expenses);
3. The policyholder is underwritten via medical tests carried out at the time they take out the policy;
4. The policy on the original terms is guaranteed to be renewable at each policy anniversary with no further underwriting of the individual policyholder, i.e. policies may be kept in-force at the policyholders sole option, provided they continue to pay their premiums every year;
5. Certain jurisdictions may have regulations which require the contractual benefits to be fixed at policy issue (and cannot be reduced over the whole term of the contract, while benefits enhancements are allowed); and
6. There is a maximum entry age which is lower than the policy expiry age, therefore after a certain age a new policyholder cannot obtain this step-rated insurance. However policyholders who already have policies can renew their policies after this age, subject to the policy expiry age, if any.

The pricing generally applied to these products is as follows:

1. Step-rated insurance premiums are commonly based on age and rating factor based premium rate tables and the level of insurance cover (sometimes with further adjustments – for example pre-determined loyalty discounts);

2. The rating factors usually relate to gender, smoker status and, for some benefit types, occupation;

3. Premiums for individual policyholders at inception may be loaded or adjusted based on health/activity assessments (medical underwriting of the individual policyholder). These loadings may be temporary or permanent;

4. The policyholder's premiums are increased each year based on the pre-determined step-rated premium table such that each policyholder knows in advance that his premium will change in line with their increase in age (i.e. they move along the step-rated premium table) ), hence are 'stepped';

5. Base premium rate tables are determined using actuarial cash flow projections and company profit-related or value-related pricing criteria. Premium rates are generally calculated with competitive position and a smooth progression of rates (with age) in mind;

6. The base premium rates for step-rated insurance policies are typically determined for each age group using cash flow projections carried out over the potential future lifetime of a policy. The projected cash flows include premiums, claims, expenses and commissions, and commonly also projected capital requirements. The underlying assumptions to derive these cash flows include mortality/morbidity assumptions, lapse assumptions, and expense assumptions;

7. In determining the premium rates, different insurers may use different metrics/criteria for profitability/value including different "hurdle" rates of return. Consistent with the cash flows, these metrics will typically relate to the profitability or value assessed over the expected lifetime of a policyholder rather than the profitability/value over a single year;

8. The pricing process is typically iterative as the premium rates at older ages affect the expected lifetime profit/value of policies sold at younger ages, due to the progression through a premium rate table as a policyholder ages;

9. The premium for a new 40 year old policyholder would be the same as the pricing for an existing 40 year old policyholder, assuming that they are both in standard health and there are no loyalty discounts in place;

10. Although premiums for new and pre-existing policyholders of the same age are the same, acquisition costs (commission to advisers) are incurred for new policyholders and are not incurred for existing policyholders. The acquisition costs are subject to a two year clawback period;

11. The impact of selection and anti-selection effects which means there is fundamental and substantial funding of insurance risk across contract/portfolio years (and the future risk profile of inforce and new business is not the same even though this year's premiums may be the same);

12. The insurer can generally reprice at any time (contract terms allow repricing) but this is done at a portfolio level (again this is a contractual feature), not an individual policyholder level because the policyholder is not re-underwritten individually. Based on current practice, this repricing would effectively comprise creating a new base premium rate table, or new adjustment factors. The reprice would be effective from the policyholder's next policy anniversary;

13. In practice the frequency of repricing will differ from insurer to insurer. Currently some insurers reprice annually, others may reprice every few years or as required linked to observed experience and/or competitive pressures.

<u>Participating (unit-linked) contract with an accidental death benefit and a medical rider</u>

Step-rated pricing structures can be found also in regular premium insurance contract where there is a pure unit-linked investment component combined with a rider that transfers significant insurance risk for accidental death and medical

expenses. The unit-linked component is always priced based on the fair value of the underlying items. In addition this product usually contain the following features:

1. The contract is a regular premium contract with premiums paid monthly/ quarterly/ annually according to a plan selected by the policyholder. The plan determines the level of insurance protection (accidental death usually expressed as a percentage of the policyholder account described in point 4 below or as a lump sum and medical expenses based on specific terms and conditions) that the policyholder desires for himself and family;
2. Fees for the insurance riders at the point of purchase are differentiated based on different Sum Insured bands for both the accidental death benefit and the medical rider;
3. No individual policyholder's medical underwriting or health declaration is required unless the policyholder wishes to buy insurance protection that exceeds a specified Sum Insured amount;
4. The regular premium payment from the policyholder is accumulated in a policyholder account from which the insurer deduct annually the fees for paying the insurance coverage provided and the asset management of the assets held in the unit-linked fund;
5. The fees are structured such that the policyholders will get a periodic charge (i.e. monthly, quarterly or annually) for insurance based on the age when they buy the policy and then they would move inside the step-rated table of charges that alters the charges as each policyholder gets older, the table may be changed annually at portfolio level;
6. The step-rated fee tables are reassessed only at a portfolio level. The insurer has the practical ability to reassess them annually;

7. The pricing practices for the insurance charges are similar to those described in the step-rated insurance contract described above. For that reason they are not repeated here;

8. If the policyholder exercises the surrender option embedded in the policy the insurer would pay back the value of the account equivalent to the premiums paid to date, plus the revaluation derived from the changes in the unit prices of the unit-linked fund less the fees deducted up to the surrender date;

9. If the policyholder stops paying a premium beyond a grace period of 60 days beyond when the premium is due the contract treats that scenario as a request to surrender the contract and the payment described in point 8 above is made to the policyholder.