IFRS 17: Insurance Contracts

Key issues for health insurers

MJW Topix

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The International Accounting Standards Board released the long awaited update for insurance contracts in May this year. IFRS 17 will replace IFRS 4 from 2021, although early adoption is permitted. The NZ External Reporting Board accepted the standard for for-profit entities in August. An equivalent standard for public benefit entities is yet to be released.

The key issues we see for health insurers are:

- Deferred acquisition costs
- Onerous contracts
- Contract boundary

This newsletter starts by looking at the high level differences in approach between IFRS 4 and IFRS 17. We then go on to discuss the key issues noted above, although we acknowledge that there are many more issues that insurers will need to traverse over the next few years.

Similar newsletters looking at issues for life and general insurers are also available.

New names for unearned premium and outstanding claims

In its simplest form, what we currently know under IFRS 4 as the *unearned premium liability* and the *outstanding claims liability* will be relabelled as the *liability for remaining coverage* and *liability for incurred claims* respectively. However, there are some subtle differences, particularly around the risk margins.

Building Block vs. Premium Allocation

IFRS 17 is framed around what is referred to as the Building Block Approach. The BBA is very much in the style of the Margin on Services type approach which is used by life insurers.

However, IFRS 17 allows for a simplification in certain circumstances – the Premium Allocation Approach. The PAA works much more like the approach general and health insurers currently take under IFRS 4.

The criteria for using the PAA are:

- The coverage period is one year or less, or
- The PAA is expected to produce a materially similar result to the BBA.

Deferred acquisition costs

IFRS 4 allows an insurer to amortise the costs that are incurred in acquiring a policy i.e. to set up a DAC asset. This approach will remain under IFRS 17. However, exactly what can be amortised and over what period is up for change.

For insurers that pay significant upfront commissions to brokers – mostly life insurers but also health insurers – a typical practice under IFRS 4 is to amortise the costs over a number of years. To recognise the entire commission in the first year would make for a substantial new business strain when that commission exceeds the entire first year premium.

This is where IFRS 17 will potentially pose some problems. The new standard requires acquisition costs to be recognised as the contracts to which the costs are allocated are recognised. The implication here is that if the contracts are classified as being annual then those heavy commissions will (probably) need to be recognised in the first year. Given the considerable implications for broker focused life and health insurers, there are still some issues here which need to be ironed out.

A related issue is which costs will be allowed to be amortised. Under IFRS 4 some insurers choose to include both direct acquisition costs (e.g. commissions) and a portion of indirect costs (e.g. overheads) in their DAC asset. Under IFRS 17 the insurer will only be allowed to include costs which are *directly attributable* to the portfolio of contracts to which the policy relates. In the case of health insurance, where the market is dominated by not-for-profits and margins are thin, most insurers currently err on the conservative side when accounting for DAC. That is, most health insurers choose to defer less than the maximum possible allowance for acquisition costs and thereby reduce the likelihood that they will have to write down DAC.

Onerous contracts

Whether using the BBA or PAA, IFRS 17 requires reporting of insurance contracts to be divided at a minimum into:

- Contracts that are onerous from inception
- Contracts which have a significant possibility of becoming onerous
- Everything else.

The nature of insurance is that there is almost always the possibility that the insurer makes a loss on a contract. However, the definition of an onerous

contract is that the expected outflows exceed the expected inflows.

Under IFRS 4 an insurer must test the adequacy of their unearned premium reserve. Where expected outflows (claims – including a margin, expenses and the unwinding of deferred acquisition costs) exceed the pro-rata holding of premium income, an additional reserve must be held. For almost all health insurers this test is applied at the NZ entity level, even if segments of business within a portfolio might individually be inadequately reserved.

Under IFRS 17 onerous contracts must be reported separately and losses recognised immediately. This may mean, for example, that new business with high first year commissions needs to be declared and recognised separately. Whilst this won't be an issue for health insurers that don't have a strong broker focus, it does have implications for the market in which they operate.

The onerous contracts test may have implications where health insurers (deliberately or not) have cross subsidisation within their portfolios. For example if an insurer applies community rating principles over a certain age then policies for older individuals may need to be separately declared and reserved for.

Contract boundary

For most health insurance policies the contract boundary is straightforward: the insurer's obligation ends on the renewal date of the policy. When guaranteed renewability is a feature, however, then things may get slightly more complicated.

IFRS 17 notes that an insurer must consider whether it is *required by contract to renew or otherwise continue the contract* and what this means for when the insurer's obligation ends. For guaranteed renewal policies the insured has the option to renew on original terms without being re-underwritten.

An insurer's **Obligation** ends when it has the practical ability to reprice the particular policy or to reprice the portfolio, so long as the pricing for coverage up to the reassessment date does not take into account risks that relate to periods after the reassessment date. In most cases a guaranteed renewability feature of a health insurance policy is unlikely to affect the definition of the contract boundary, although it will depend on the specifics of the guaranteed renewability wording.

At a practical level, even where there is guaranteed renewability, an insurer generally has the option of ring-fencing a portfolio of guaranteed renewable policies and pricing them according to their own experience. The ultimate outcome is usually a pool of deteriorating risks (as healthy policyholders are re-underwritten into new products) with increasing prices which eventually become unaffordable. At a practical level the practice of ring fencing relieves an insurer of the burden associated with guaranteed renewable policies (and is also likely to relieve the insurer of the accounting complications under IFRS 17). Unfortunately ring fencing tends to negate many of the benefits of a guaranteed renewability. It will be telling to see how auditors respond to this when interpreting the contract boundary for guaranteed renewable policies.

Further reading

The full standard is available here.

In this brief newsletter we've picked out three key issues for health insurers – but there's a lot more to the standard than that. If you wish to discuss what any of this might mean for your business then please contact any of the authors below.

For further information please contact:

Craig Lough 09 300 7151	*Jeremy Holmes 09 300 7318*	*David Chamberlain 04 830 0117*
craig.lough@mjw.co.nz	*jeremy.holmes@mjw.co.nz*	*david.chamberlain@mjw.co.nz*