

Measurement of coverage units under IFRS 17:B119 and the use of the non-distinct investment component vs. the expected service expenses as a basis to determine the benefits provided by an investment-return service or by an investment-related service (Deloitte)

Background

The accounting for the amount of CSM in a group of contracts that is recognised as insurance revenue in a given period is based on the allocation process set out in IFRS 17:B119 where IFRS 17 mandates the allocation of CSM at the end of the period using the coverage units approach. The text in IFRS 17:B119(a) gives an indication of the logical connection the IASB intended between coverage units and contractual benefits because it states that "the number of coverage units in a group is the quantity of insurance contract services provided by the contracts in the group, determined by considering for each contract the quantity of the benefits provided under a contract and its expected coverage period."

IFRS 17:B119 also states that the coverage units are used to recognise in a period the amount of CSM that reflects, together with the other components of insurance revenue specified in IFRS 17:B121, "the insurance contract services provided under the group of insurance contracts in that period (see paragraphs 44(e), 45(e) and 66(e))."

The definition of insurance contract services is included in IFRS 17 Appendix A (emphasis added for subsequent analysis):

The following services that an entity provides to a policyholder of an insurance contract:

- (a) coverage for an insured event (insurance coverage);*
- (b) for insurance contracts without direct participation features, **the generation of an investment return** for the policyholder, if applicable (investment-return service); and*
- (c) for insurance contracts with direct participation features, **the management of underlying items** on behalf of the policyholder (investment-related service).*

Question

Can an insurer use

- the non-distinct investment components (NDIC, sometimes referred to as "account balances") or
- the expected service expenses that the insurer would include in the fulfilment cash flows of the group of contracts, adjusted to remove the effect of the probability of insured events occurring, if any

as a basis to determine the quantity of benefits provided by an investment-return service (whenever the NDIC is present) or by an investment-related service in a group of contracts?

Views

View 1 – The NDIC represents the benefit provided by an investment-return service or by an investment-related service. The expected service expenses do not.

The use of non-distinct investment components (NDIC, sometimes referred to as "account balance") as a basis to determine the benefits provided by an investment-return service or by an investment-related service is acceptable under IFRS 17 because **the NDIC represents the benefit from these services** provided under the group of insurance contracts in each period. The determination of the quantity of benefits for an investment-return service or an investment-related service **cannot be a function of the expected service expenses that the insurer would include in the fulfilment cash flows** of the group of contracts after removing the effect of the probability-weighting associated with insurance risk only.

Supporters of this view argue that the benefits expected to be received by the policyholder cannot be represented by the costs that the insurer expects to incur in providing those benefits. A comment to that extent had been made during the discussion on coverage units at the TRG meeting in May 2018 and it is included in AP05 for that meeting.

On the other hand the NDIC represents the amount of premium received that the insurer would invest to generate the promised return to the policyholder. This fact would appear to be true for both the investment-related service and the investment-return service. The NDIC combined with the return that the service would have generated produces contractual cash flows that match the benefits (in full or as a portion of) the policyholder is entitled to receive under the different contractual events. This fact provides a strong analogy with the insurance coverage benefits that are measured by reference to the relevant contractual cash flows due when the insured events occur, once the probability weighting of the insured event occurring is reversed.

For the investment-related service the NDIC is almost invariably associated with the underlying items that the insurer acquires through the investment of the premium received from the policyholder. Supporters of this view note that the IASB Staff commented in the AP05 discussed at the TRG meeting in May 2018 that "if the contract falls within the scope of the VFA: the expected coverage duration and quantity of benefits should be determined reflecting the benefits to the policyholder of both the insurance services and the investment-related services. One method of doing this would be by using the sum payable on death, ie including the investment-linked account balance." Given this comment was prior to the amendment to IFRS 17 it is reasonable to infer that the same would apply when the two services are identified separately and the insurer can decompose the amounts to use the NDIC to compute the coverage units for the investment-related service.

For the investment-return service this is true when the NDIC is present in the contract. There may be contracts with an investment-return service and no NDIC for which the insurer would need to consider a different benefit. During the same TRG meeting in May 2018 the IASB Staff also commented in the same paper AP05 that to calculate the coverage units for the insurance coverage when the contract is not within the scope of the VFA, the insurer should exclude the NDIC from the coverage unit calculation of the insurance coverage service. Supporters of this view argue that, in light of the subsequent amendments to IFRS 17 and the definition of an investment-return service, the logic that applies for contracts within the scope of the VFA can be

extended legitimately to the other contracts with an investment-return service. Through this analogy, the use of the NDIC, when present, for coverage unit calculations is acceptable in principle.

View 2 – The expected service expenses represent the benefit provided by an investment-return service or by an investment-related service. The NDIC does not, albeit it may act as a proxy for the benefit provided.

The use of non-distinct investment components (NDIC, sometimes referred to as "account balances") as a basis to determine the benefits provided by an investment-return service or by an investment-related service **is acceptable under IFRS 17 only if the NDIC is a reasonable proxy for the benefit from these services** provided under the group of insurance contracts in each period. The determination of the quantity of **benefits for an investment-return service or an investment-related service is a function of the expected service expenses that the insurer would include in the fulfilment cash flows** of the group of contracts after removing the effect of the probability-weighting associated with insurance risk only.

Supporters of this view note that the point on the benefits expected to be received by the policyholder not being represented by the costs the entity expects to incur in providing those benefits was made at a TRG meeting in May 2018 that pre-dated the amendments to IFRS 17 which resulted in the investment-related and investment-return services being added. These services were prohibited from consideration in the calculation of the coverage units except for a concession the IASB Staff made for contracts within the VFA where they had noted "the expected coverage duration and quantity of benefits should be determined reflecting the benefits to the policyholder of both the insurance services and the investment-related services". Supporters of this view also note that the IASB Staff in the same paper considered the death benefit as the amount to quantify coverage units rather than the NDIC.

Supporters of this view argue that these comments from the IASB Staff have to be taken in the context of the amended IFRS 17 requirements published in 2020 and the two new services introduced in IFRS 17 together with a requirement of considering them for coverage unit calculations. In light of the amendments to IFRS 17, supporters of this view argue that the benefits a policyholder receives from the delivery of these services are fairly represented by an insurance revenue amount that includes the expected expenses that an insurer would incur to render them plus the allocation of CSM that would be derived from the same basis once adjusted by removing any probability-weighting associated with insurance risk, if any. This is the same adjustment for the part of insurance revenue that relates to benefits representing insurance coverage services.

They also note that the use of incurred costs, once adjusted for the effect of insurance probabilities, is equivalent to the approach taken to calculate the benefit for insurance coverage benefit that are settled in-kind rather than through a cash settlement of the incurred claim.

Supporters of this view note that their arguments align with the overall insurance revenue amount representing the transfer of promised services inclusive of the expected expenses for the investment-related or the investment-return services and the allocation of the CSM based on the expected expenses once adjusted by removing any probability-weighting associated with insurance risk, if any. They also note that the NDIC does not feature in the insurance revenue

because it represents the financing element of the contract and the benefits referred to in B119 are associated with the relevant services and revenue not the financing part of an insurance contract. While the NDIC may be a valid proxy when in line with the benefit as depicted by the service expenses expected to be incurred to render the service, there are scenarios where the NDIC does not align with the benefit pattern e.g. when there are significant positive or negative results accrued on the NDIC.

The acceptance of expected service expense for the calculation of coverage units for the investment-return service has also the advantage of being applicable to all cases of contracts with investment-return service, even when the NDIC is absent.

View 3 – Both the NDIC and the expected service expenses represent the benefit provided by an investment-return service or by an investment-related service and it is an accounting judgement of the insurer to determine which amount to use for calculating the number of coverage units in a group of contracts having considered the specific facts and circumstances.

Technical references (emphasis added)

- IFRS 17:B119 An amount of the contractual service margin for a group of insurance contracts is recognised in profit or loss in each period to reflect the insurance contract services provided under the group of insurance contracts in that period (see paragraphs 44(e), 45(e) and 66(e)). The amount is determined by:
- (a) identifying the coverage units in the group. The number of coverage units in a group is the quantity of insurance contract services provided by the contracts in the group, determined by considering for each contract the quantity of the benefits provided under a contract and its expected coverage period.
 - (b) allocating the contractual service margin at the end of the period (before recognising any amounts in profit or loss to reflect the insurance contract services provided in the period) equally to each coverage unit provided in the current period and expected to be provided in the future.
 - (c) recognising in profit or loss the amount allocated to coverage units provided in the period.
- IFRS 17:BC280 The Board considered whether the allocation of the contractual service margin based on coverage units would result in profit being recognised too early for insurance contracts with fees determined based on the returns on underlying items. For such contracts, IFRS 17 requires the contractual service margin to be determined based on the total expected fee over the duration of the contracts, including expectations of an increase in the fee because of an increase in underlying items arising from investment returns and additional policyholder contributions over time. The Board rejected the view that the allocation based on coverage units results in premature profit recognition. The Board noted that the investment component of such contracts is accounted for as part of the insurance contract only when the cash flows from the investment component and from insurance and other services are highly interrelated and hence cannot be accounted for as distinct components. In such circumstances, the entity provides multiple services in return for an expected fee based on the expected duration of contracts, and the Board concluded the entity should recognise that fee over the coverage period as the insurance services are provided, not when the returns on the underlying items occur.

TRG Agenda Paper 05, May 2018 meeting

<https://www.ifrs.org/content/dam/ifrs/meetings/2018/may/trg-for-ifrs-17/ap05-quantity-of-benefits-for-identifying-coverage-units.pdf>

STAFF PAPER

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Project	Transition Resource Group for IFRS 17 <i>Insurance Contracts</i>		
Paper topic	Determining the quantity of benefits for identifying coverage units		
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Introduction

1. At its February 2018 meeting, the Transition Resource Group for IFRS 17 *Insurance Contracts* (TRG) considered a submission about how to determine the quantity of benefits in an insurance contract when determining the coverage units for a group of contracts. The coverage units establish the amount of the contractual service margin recognised in profit or loss in the period.
2. At the February 2018 meeting, the TRG considered only the questions raised in the submission relating to insurance contracts without investment components.
This paper:
 - (a) continues the discussion on insurance contracts without investment components; and
 - (b) discusses insurance contracts with investment components.
3. The objective of the paper is to provide background and an accounting analysis to support discussion at the TRG.

Structure of the paper

4. This paper includes the following:
 - (a) background information;
 - (b) implementation question; and
 - (c) review of accounting requirements.

5. There are three appendices to this paper:
 - (a) Appendix A—Extract: summary of the TRG meeting held on 6 February 2018 relating to Agenda Paper 5;
 - (b) Appendix B—Examples of insurance contracts without investment components; and
 - (c) Appendix C—Examples of insurance contracts with investment components.

Background information

6. IFRS 17 requires an entity to recognise the contractual service margin of a group of insurance contracts over the coverage period of the group. The relevant paragraphs of IFRS 17 are shown below.
 - (a) paragraphs 44(e) (and 45(e)) of IFRS 17:

[The contractual service margin is adjusted for] the amount recognised as insurance revenue because of the transfer of services in the period, determined by the allocation of the contractual service margin remaining at the end of the reporting period (before any allocation) over the current and remaining coverage period applying paragraph B119.
 - (b) the definition of coverage period in Appendix A of IFRS 17:

The period during which the entity provides coverage for insured events. This period includes the coverage that relates to all premiums within the boundary of the insurance contract.

- (c) the definition of an insured event in Appendix A of IFRS 17:

An uncertain future event covered by an insurance contract that creates insurance risk.

- (d) paragraph B119 of IFRS 17:

An amount of the contractual service margin for a group of insurance contracts is recognised in profit or loss in each period to reflect the services provided under the group of insurance contracts in that period (see paragraphs 44(e), 45(e) and 66(e)). The amount is determined by:

- (a) identifying the coverage units in the group. The number of coverage units in a group is the quantity of coverage provided by the contracts in the group, determined by considering for each contract the quantity of the benefits provided under a contract and its expected coverage duration.
- (b) allocating the contractual service margin at the end of the period (before recognising any amounts in profit or loss to reflect the services provided in the period) equally to each coverage unit provided in the current period and expected to be provided in the future.
- (c) recognising in profit or loss the amount allocated to coverage units provided in the period.

7. Appendix A of this paper sets out the summary of the discussion of this topic at the February 2018 meeting of the TRG.

Implementation question

8. The submission asks what is the definition of ‘quantity of benefits’ in paragraph B119(a) of IFRS 17. The submission identifies different factors that could be included in the determination of coverage units and uses examples to illustrate the effect of including or excluding those factors.
9. At the February 2018 meeting, TRG members discussed the analysis of the submission in Agenda Paper 5 from that meeting and observed that:
 - (a) coverage units reflect the likelihood of insured events occurring only to the extent that they affect the expected duration of contracts in the group; and
 - (b) coverage units do not reflect the likelihood of insurance events occurring to the extent that they affect the amount expected to be claimed in the period.
10. TRG members also discussed the extent to which the determination of coverage units should reflect variability across periods in the level of cover provided by contracts in the group, based on the narrow scope fact patterns presented. However, they observed that a view could not be reached before they also considered a wider scope including insurance contracts with investment components.
11. This paper:
 - (a) develops further the factors to be considered in the determination of coverage units for insurance contracts without investment components;
 - (b) addresses the determination of coverage units for contracts with investment components; and
 - (c) considers the balance to be struck between high-level principles and specific guidance, given the wide variety of insurance products that need to be considered.

12. At the February 2018 meeting of the TRG, to assist in the preparation of this paper, the staff asked TRG members for their comments on the examples from the submission included in Agenda Paper 5 from that meeting. The staff also asked TRG members for their reflections on the determination of coverage units for insurance contracts with investment components.
13. Having considered the responses from TRG members, the staff have developed the analysis set out below. In Appendices B and C to this paper, the staff have selected examples from those given by TRG members to illustrate key points.

Review of accounting requirements

14. This section is structured as follows:
 - (a) points relevant to insurance contracts with and without investment components;
 - (b) an analysis of the accounting requirements for insurance contracts without investment components; and
 - (c) an analysis of the accounting requirements for insurance contracts with investment components.

Points relevant to insurance contracts with and without investment components

15. Paragraphs 16–20 of this paper set out a number of aspects of IFRS 17 that are relevant to insurance contracts with and without investment components.
16. First, the recognition of the contractual service margin in profit or loss is not the only component of profit recognised in the insurance service result. The release of the risk adjustment for non-financial risk and some experience adjustments also create profit. The relative size of the contractual service margin and risk adjustment will vary across contracts.

17. Second, the period in which an entity bears insurance risk is not necessarily the same as the insurance coverage period. This is clear from the following discussion of recognition in paragraphs BC140–BC142 of the Basis for Conclusions on IFRS 17:

BC140 The Board considered whether an entity should recognise the obligations and associated benefits arising from a group of insurance contracts from the time at which it accepts risk. Doing so would be consistent with the aspects of IFRS 17 that focus on measuring the obligations accepted by the entity. However, such an approach would differ from that required for revenue contracts within the scope of IFRS 15, which focuses on measuring performance. Under IFRS 15, an entity recognises no rights or obligations until one party has performed under the contract. That model would be consistent with the aspects of IFRS 17 that focus on measuring performance.

BC141 Further, some stakeholders were concerned that a requirement to recognise the group of insurance contracts from the time the entity accepts risk would mean that the entity would need to track and account for the group even before the coverage period begins. Those expressing that view stated that accounting for the group of insurance contracts before the coverage period begins would require system changes whose high costs outweigh the benefits of doing so, particularly because the amount recognised before the coverage period begins might be immaterial, or even nil. In the view of these respondents, even if amounts recognised before the coverage period begins are insignificant, requiring an entity to account for groups of insurance contracts in the pre-coverage period would impose on the entity the requirement to track groups to demonstrate that the amounts are insignificant.

BC142 The Board was sympathetic to those concerns. Accordingly, the Board adopted an approach that combines aspects of both approaches set out in paragraph BC140 by requiring that an entity recognise a group of insurance contracts from the earliest of:

- (a) the beginning of the coverage period of the group of contracts;
- (b) the date on which the first payment from a policyholder in the group becomes due; or
- (c) for a group of onerous contracts, when the group becomes onerous.

18. Third, paragraph B119(a) of IFRS 17 requires coverage units to be determined for a group of insurance contracts, by considering for each contract the quantity of benefits provided under the contract and its expected coverage duration. The examples in the submission and many of the examples sent in by TRG members focus on individual contracts, or groups of contracts, providing a single type of benefit. The examples therefore illustrate how coverage units might reflect the quantity of benefits provided by the group over the duration of the coverage of the group. However, if contracts in a group provide different types of benefits (for example, insurance cover with a maximum limit compared to insurance cover with no maximum limit), the assessment of the quantity of benefits in the group requires a method of comparing those different benefits as well as how the benefits change over the coverage duration of a group. Such a comparison will require the application of judgement by the entity. This is illustrated in example 11 in Appendix B to this paper and examples 14-16 in Appendix C to this paper.
19. Fourth, expectations of lapses of contracts are included in the determination of coverage units because they affect the expected duration of the coverage.
20. Fifth, the staff observe in paragraph 30 of this paper that the objective in IFRS 17 for the allocation of the contractual service margin is to reflect the services provided in the period. The staff think the determination of coverage units to achieve this objective is not an accounting policy choice but involves judgement and estimates to best reflect the provision of service. That judgement and estimates should be determined systematically and rationally. The disclosure

requirements of paragraph 125 of IAS 1 *Presentation of Financial Statements* apply. Paragraph 125 of IAS 1 states:

An entity shall disclose information about the assumptions it makes about the future, and other major sources of estimation uncertainty at the end of the reporting period, that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year. In respect of those assets and liabilities, the notes shall include details of:

- (a) their nature, and
- (b) their carrying amount as at the end of the reporting period.

Insurance contracts without investment components

21. At the February 2018 meeting of the TRG, TRG members concurred with the views in Agenda Paper 5 from that meeting that:
- (a) coverage units reflect the likelihood of insured events occurring only to the extent that they affect the expected coverage duration of contracts in the group; and
 - (b) coverage units do not reflect the likelihood of insurance events occurring to the extent that they affect the amount expected to be claimed in the period.
22. In paragraph 12 of Agenda Paper 5 from the February 2018 meeting of the TRG, the staff observed:
- (a) coverage units were introduced to achieve an appropriate allocation of the contractual service margin of a group that contains contracts of different sizes. So if, for example, a group contains some contracts that offer a death benefit of CU10m and some that offer a death benefit of CU1m, the Board wanted to recognise an appropriate amount of the contractual service margin if the CU10m contracts have a different coverage duration from the CU1m contracts. The staff think reflecting

different levels of cover across periods (for example, a death benefit that fell from CU10m to CU1m over the duration of the contract) would be consistent with the principle of reflecting different levels of cover across contracts.

- (b) paragraph B119 of IFRS 17 requires coverage units to be reassessed at the end of each reporting period based on the coverage provided in the period and to be provided in the future. The implied objective is to achieve an allocation of the contractual service margin over time that reflects the insurance service provided by the entity in each period.

23. The staff therefore suggested in paragraph 13 of Agenda Paper 5 from the February 2018 meeting of the TRG 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.
24. In the comments received from TRG members, many specifically agreed that the determination of coverage units should reflect different levels of cover provided by contracts in different periods. No TRG members expressed opposition to that view.
25. However, many TRG members expressed concern about the staff view expressed in the paragraph 15 of Agenda Paper 5 from the February 2018 meeting of the TRG that the benefit provided under a contract is the entity standing ready to meet the contractual maximum cover.
26. Some TRG members observed that in some cases the contractual maximum cover gave a good depiction of the benefits provided under a contract, but many TRG members gave examples where they thought that the contractual maximum cover would not faithfully represent the quantity of benefits provided by:
 - (a) a contract in different periods; and
 - (b) different contracts in a group.

27. TRG members thought the contractual maximum cover would not always represent faithfully different quantity of benefits because:
- (a) the contractual maximum cover sometimes does not depict a benefit that has relevant commercial substance; and
 - (b) some insurance contracts do not specify a contractual maximum cover, making this approach difficult to apply when comparing contracts that do specify a maximum contractual cover with those that do not.
28. TRG members instead identified different methods of identifying the benefits provided under a contract. These are illustrated in Appendix B to this paper.
29. The staff have considered the comments from TRG members. The staff observe the wide variety of types of insurance cover and different ways in which they are combined. The staff also acknowledge the calls from TRG members for a principle-based approach—it is not possible to set detailed requirements that will apply appropriately to the wide variety of products.
30. The staff observe:
- (a) paragraph B119 of IFRS 17 requires that ‘An amount of the contractual service margin for a group of insurance contracts is recognised in profit or loss in each period to reflect the services provided under the group of insurance contracts in that period’.
 - (b) because the objective is to reflect the insurance service provided in each period, different levels of service across periods should be reflected.
 - (c) paragraph B119(a) of IFRS 17 requires an entity to determine the services provided by the group considering for each contract the quantity of benefits provided under a contract and its expected coverage duration.
 - (d) determining the quantity of benefits provided under a contract requires an entity to consider the benefits expected to be received by the

policyholder, not the costs of providing those benefits expected to be incurred by the entity.

- (e) a policyholder benefits from the entity standing ready to meet valid claims, not just from making a claim if an insured event occurs. The quantity of benefits provided therefore depends on the amounts that can be claimed by the policyholder. The entity is standing ready to meet those claims. The amount that a policyholder can claim affects the benefit of being able to make a claim. The probability of a policyholder making a claim does not affect the benefit of it being able to make a claim.
- (f) IFRS 17 does not specify a particular method or methods to determine the quantity of benefits. Therefore, different methods can be used to determine the quantity of benefits as long as they achieve the objective of reflecting the insurance service provided in each period. Judgement needs to be applied to determine the method that best reflects the insurance service provided. Possible methods include the use of:
 - (i) the maximum contractual cover in each period; and
 - (ii) the amount the entity expects the policyholder to be able to validly claim in each period if an insured event occurs.
- (g) The following methods would not meet the objective:
 - (i) for an insurance contract without an investment component, methods in which the quantity of benefits is affected by the performance of any of the entity's assets. The quantity of benefits provided under an insurance contract without an investment component depends solely on the insurance service provided (see paragraphs 31–43 of this paper for a discussion of insurance contracts with investment components).
 - (ii) methods that result in no allocation of the contractual service margin to periods in which the entity is standing ready to meet valid claims.

- (iii) methods based on premiums, unless they can be demonstrated to be reasonable proxies for the services provided by the entity in each period. For example, premiums will not be a reasonable proxy when comparing service across periods if they are receivable in different periods to those in which services are provided, or reflect different probabilities of claims in different periods rather than different levels of service of standing ready to meet claims. Additionally, premiums will not be a reasonable proxy when comparing contracts in a group if the premiums reflect different levels of profitability in contracts or different probabilities of claims rather than different levels of the service of standing ready to meet claims. The level of profitability in a contract does not affect the services provided by the contract.
- (iv) methods based on expected cash flows, unless they can be demonstrated to be reasonable proxies for the services provided by the entity in each period. For example, expected cash flows will not be a reasonable proxy if they reflect different probabilities of claims rather than different levels of the service of standing ready to meet claims.

Insurance contracts with investment components

- 31. The key question for insurance contracts with investment components is whether the coverage period and coverage units should be determined by reference to insurance coverage only, or by reference to insurance coverage and some aspect of the investment component.
- 32. The staff, by email on 7 March 2018, asked TRG members for their views on the recognition of the contractual service margin in profit or loss for insurance contracts with investment components in accordance with IFRS 17. Many, but not all TRG members, indicated that aspects of the investment component should be reflected in the determination of coverage units.
- 33. The staff think that the analysis of the IFRS 17 requirements on this question differs for insurance contracts with direct participation features (variable fee

approach (VFA) contracts) and insurance contracts without direct participation features (general model contracts).

Variable fee approach contracts

34. IFRS 17 identifies VFA contracts as contracts that provide both insurance services and investment-related services. Paragraph BC241 of the Basis for Conclusions on IFRS 17 contrasts these contracts with those to which the general model applies as follows:

The Board decided that these differences [in the adjustments made to the contractual service margin applying the VFA and general model] are necessary to give a faithful representation of the different nature of the fee in these contracts. As explained in paragraphs BC228–BC231 [reproduced in paragraph 41 of this paper], the Board concluded that for many insurance contracts it is appropriate to depict the gains and losses on any investment portfolio related to the contracts in the same way as gains and losses on an investment portfolio unrelated to insurance contracts. However, the Board also considered a contrasting view that, for some contracts, the returns to the entity from a pool of underlying items should be viewed as the compensation that the entity charges the policyholder for service provided by the insurance contract, rather than as a share of returns from an unrelated investment. Under this contrasting view, changes in the estimate of the entity’s share of returns are regarded as a change in the entity’s compensation for the contract. Such changes in the entity’s compensation should be recognised over the periods in which the entity provides the service promised in the contract, in the same way that changes in the estimates of the costs of providing the contract are recognised.

35. Paragraph BC280 of the Basis for Conclusions on IFRS 17 also confirms the Board’s view that VFA contracts provide investment-related services:

The Board considered whether the allocation of the contractual service margin based on coverage units would result in profit being recognised

too early for insurance contracts with fees determined based on the returns on underlying items. For such contracts, IFRS 17 requires the contractual service margin to be determined based on the total expected fee over the duration of the contracts, including expectations of an increase in the fee because of an increase in underlying items arising from investment returns and additional policyholder contributions over time. The Board rejected the view that the allocation based on coverage units results in premature profit recognition. The Board noted that the investment component of such contracts is accounted for as part of the insurance contract only when the cash flows from the investment component and from insurance and other services are highly interrelated and hence cannot be accounted for as distinct components. In such circumstances, the entity provides multiple services in return for an expected fee based on the expected duration of contracts, and the Board concluded the entity should recognise that fee over the coverage period as the insurance services are provided, not when the returns on the underlying items occur.

36. In responding to the staff request for views, some TRG members commented that they interpret paragraph BC280 of the Basis for Conclusions on IFRS 17 as saying coverage for VFA contracts includes investment-related services, and coverage units should reflect the pattern of those services, not when returns on underlying items occur. Others questioned what the coverage period in the last sentence of paragraph BC280 of the Basis for Conclusions on IFRS 17 refers to.
37. The staff think a consequence of VFA contracts providing both insurance services and investment-related services is that:
- (a) the references to services in paragraphs 45 and B119 of IFRS 17 relate to insurance and investment-related services;
 - (b) the reference to quantity of benefits in paragraph B119(a) of IFRS 17 relates to insurance and investment-related benefits; and

(c) the reference to expected coverage duration in paragraph B119(a) of IFRS 17 relates to duration of insurance and investment-related services.

38. The staff acknowledge that the definition of coverage period as the period during which the entity provides coverage for insured events is a barrier to interpreting the references in this way. The staff also acknowledge the last sentence of paragraph BC280 of the Basis for Conclusions on IFRS 17 may be unclear. The staff plan to recommend to the Board that it proposes a narrow amendment to IFRS 17 to modify the definition of coverage period for VFA contracts to clarify that it includes the period in which investment-related services are provided.
39. Including investment-related services in the determination of coverage units means an entity must assess how both investment-related services and insurance services are provided. This requires an assessment of the pattern of service provision reflecting both types of services. The staff think this assessment will be a matter of judgement.
40. The consequences of this approach for VFA contracts are illustrated in Appendix C to this paper.

General model contracts

41. In contrast to the VFA, the staff observe the general model in IFRS 17 does not treat contracts as providing investment-related services. The Basis for Conclusions on IFRS 17 states:

BC228 For insurance contracts without direct participation features, the Board concluded that changes in the effects of the time value of money and financial risk do not affect the amount of unearned profit. This is the case even if the payments to policyholders vary with returns on underlying items through a participation mechanism, for the reasons set out in paragraphs BC229–BC231. Accordingly, the entity does not adjust the contractual service margin to reflect the effects of changes in these assumptions.

BC229 For insurance contracts without direct participation features, the underwriting result is regarded as the difference between the amount of premiums the entity charges (less any investment component) and the payments the entity makes because of the occurrence of the insured event. The insurance finance result reflects the interest arising on the group of insurance contracts because of the passage of time and the effect of changes in assumptions relating to financial risk. The statement(s) of financial performance also reflect gains and losses from the investments in which the premiums are invested. Such gains and losses would be recognised in profit or loss according to other applicable IFRS Standards.

BC230 Thus, for insurance contracts without direct participation features, the entity's profit from financing activities arises from the difference between:

- (a) the gains (or losses) from the investments; and
- (b) the change in the insurance contract liability depicted by the insurance finance income or expenses including the gains (or losses) the entity passes to the policyholder through any indirect participation mechanism.

BC231 This approach to determining profit from financing activities reflects the separate accounting for the investment portfolio and the group of insurance contracts, regardless of any participation mechanism in the insurance contracts, consistent with the following:

- (a) the entity controls the cash flows of the investments, even when the entity is required to act in a fiduciary capacity for the policyholder.
- (b) in most cases, an entity would be unlikely to have a legally enforceable right to set off the insurance contract liability with the investment portfolio, even if the investment portfolio were to be invested in assets that exactly match the entity's obligation, because the entity retains the obligation to pay the policyholders the amounts that are determined on the basis of the investments in the portfolio, irrespective of the entity's investment strategy.

42. These paragraphs, together with paragraph BC241 of the Basis for Conclusions for IFRS 17 (reproduced in paragraph 34 of this paper), demonstrate that IFRS 17 uses the scope of the VFA to identify insurance contracts that provide investment-related services as well as insurance services. For contracts outside the scope of the VFA, there is not a sufficient link between the amounts promised to policyholders and the returns on assets for the entity to receive a fee from the policyholder for investment-related services. Instead, the assets arising from the premiums received are the entity's assets that it manages on its own behalf. The amounts promised to policyholders other than insurance benefits (ie the investment components) are not related to service, but are instead a form of financial instrument. The difference between the investment income from the entity's assets and insurance finance expenses is presented as a finance result.
43. Hence, for general model contracts, coverage units and the coverage period (duration of coverage) are determined by reference to insurance services only. The consequences of this approach are illustrated in Appendix C to this paper.

TRG Discussion

Question to TRG members

What are your views on the implementation question presented above?

Appendix A—Extract: summary of the TRG for IFRS 17 meeting held on 6 February 2018

Determining the quantity of benefits for identifying coverage units (Agenda Paper 5)

- A.1 Coverage units establish the amount of the contractual service margin to be recognised in profit or loss for services provided in a period. Agenda Paper 5 addresses a submission received about how to determine the coverage units of a group of insurance contracts with no investment component. Insurance contracts with investment components will be discussed at a later meeting.
- A.2 TRG members discussed the analysis in Agenda Paper 5 and observed that:
- (a) coverage units reflect the likelihood of insured events occurring only to the extent that they affect the expected duration of contracts in the group; and
 - (b) coverage units do not reflect the likelihood of insurance events occurring to the extent that they affect the amount expected to be claimed in the period.
- A.3 TRG members discussed the extent to which the determination of coverage units should reflect variability across periods in the level of cover provided by contracts in the group based on the narrow scope fact patterns presented. However, they observed that a view could not be reached before they also considered a wider scope including insurance contracts with investment components. Accordingly, the staff will bring a paper to a later TRG meeting that will address the determination of coverage units for contracts with investment components and will also develop further:
- (a) the use of the maximum level of cover and the expected level of cover in periods. For example, the TRG considered a contract that provides cover for fire damage up to CU50m per year on a five-year construction project. The value of the property covered is expected to increase over

the five years. The maximum level of cover is the contract CU50m limit. The expected level of cover is the increasing value on which the entity is exposed to insurance risk.

- (b) the balance to be struck between high-level principles and specific guidance, given the wide variety of insurance products that need to be considered.

A.4 TRG members agreed to send in their comments on the examples in Agenda Paper 5 by the end of February to help the development of the next paper.

Appendix B—Examples of insurance contracts without investment components

Example	Type of contract	Paragraphs
1	Credit life loan insurance	B.2–B.5
2	Credit life product with variable amount of cover	B.6–B.9
3	Mortgage loss cover	B.10–B.13
4	Product warranty	B.14–B.17
5	Extended product warranty	B.18–B.20
6	Health cover	B.21–B.24
7	Proportional reinsurance issued	B.25–B.28
8	Reinsurance adverse development of claims with claim limit	B.29–B.32
9	Reinsurance adverse development of claims without claim limit	B.33–B.36
10	Transaction liability	B.37–B.39
11	Combination of different types of cover	B.40–B.43
12	Life contingent annuity	B.44–B.46
13	Forward purchase of fixed rate annuity	B.47–B.49

B.1 As set out in paragraph 20 of this paper, the staff think the determination of coverage units is not an accounting policy choice but involves judgements and estimates on how best to reflect the provision of services. In the following examples, the staff comment on whether suggested methods of determining the quantity of benefits and the coverage duration might be valid ways of reflecting the provision of services. Which method gives the best reflection of the provision of service is a matter of judgment that depends on facts and circumstances.

Example 1—Credit life loan insurance

- B.2 Example: a life insurance policy pays a death benefit equal to the principal and interest outstanding on a loan at the time of death. The balance of the loan will decline because of contractually scheduled payments and cannot be increased.
- B.3 Method suggested for determining the expected coverage duration: the expected coverage duration should reflect expected deaths and lapses.
- B.4 Methods suggested for determining the quantity of benefits:
- (a) constant cover, being cover of a death benefit; and
 - (b) cover for the contractual balance outstanding.
- B.5 Staff comments:
- (a) the staff agree that the expected coverage duration should reflect expected deaths and lapses.
 - (b) for determining the quantity of benefits, the staff think method B.4(b) is valid because it is both the maximum contractual cover and the amount the entity expects the policyholder to be able to make a valid claim for if the insured event occurs. The staff do not think method B.4(a) is valid because it does not reflect different levels of cover provided across periods.

Example 2—Credit life product with variable amount of cover

- B.6 Example: credit life products where the amount payable on an insured event varies (for example, claims might relate to an outstanding credit card balance). In these cases the sum assured will vary over time, rather than simply reducing. In addition, the sum assured may be limited based on the lender's credit limits.
- B.7 No comments were made about the expected coverage duration.
- B.8 Methods suggested for determining the quantity of benefits:
- (a) constant cover of contractual maximum amount of the credit limit; and

- (b) cover based on expected credit card balances.

B.9 Staff comments:

- (a) the staff think the expected coverage duration is the period during which cover is provided, adjusted for any expectations of lapses.
- (b) for determining the quantity of benefits, the staff think either method suggested could be valid. Method B.8(a) is the maximum contractual cover and method B.8(b) is the amount the entity expects the policyholder to be able to make a valid claim for if the insured event occurs.

Example 3—Mortgage loss cover

B.10 Example: a contract provides cover for five years for default losses on a mortgage, after recovering the value of the property on which the mortgage is secured. The balance of the mortgage will decline because of contractually scheduled payments and cannot be increased.

B.11 No comments were made about the expected coverage duration.

B.12 Methods suggested for determining the quantity of benefits:

- (a) contractual balance of mortgage; and
- (b) the amount for which the policyholder has the ability to make a valid claim, ie the contractual balance of the mortgage, less the expected value of the property.

B.13 Staff comments:

- (a) the staff think the expected coverage duration is the five years during which cover is provided, adjusted for any expectations of lapses.
- (b) for determining the quantity of benefits, the staff think either method suggested could be valid. Method B.12(a) is the maximum contractual cover and method B.12(b) is the amount the entity expects the

policyholder to be able to make a valid claim for if the insured event occurs.

Example 4—Product warranty

- B.14 Example: a five-year warranty coverage contract provides for replacement of a purchased item if it fails to work properly within five years of the date of purchase.¹ Claims are typically skewed toward the end of the coverage period as the purchased item ages.
- B.15 No comments were made on the expected coverage duration.
- B.16 Methods suggested for determining the quantity of benefits:
- (a) the cover provided is constant until a claim is made; and
 - (b) the coverage units should include expectations about the cost of replacing the item, for example, inflation.
- B.17 Staff comments:
- (a) the staff think that the expected coverage duration is the five years the cover is provided, adjusted for any expected lapses.
 - (b) for determining the quantity of benefits, the staff think method B.16(a) is valid if the price of the product is expected to remain constant. The staff think method B.16(b) is valid if the price of the product increases. The benefit to the policyholder is not having to buy a replacement product.

¹ The contract is not a warranty provided by a manufacturer, dealer or retailer in connection with the sale of its goods to a customer and so is within the scope of IFRS 17.

Example 5—Extended product warranty

- B.18 Example: extended warranty policies cover the policyholders after the manufacturer's original warranty has expired. The policies provide new for old cover in the event of a major defect to the covered asset.
- B.19 Comments on the expected coverage period: the expected coverage duration does not start until the manufacturer's original warranty has expired.
- B.20 Staff comments: the staff agree the expected coverage duration does not start until the manufacturer's original warranty has expired. The policyholder cannot make a valid claim to the entity until then.

Example 6—Health cover

- B.21 Example: a contract provides health cover for 10 years for specified types of medical costs up to CU1m over the life of the contract, with the expected amount and expected number of claims increasing with age.
- B.22 No comments were made about the expected coverage duration.
- B.23 Methods suggested for determining the quantity of benefits:
- (a) compare the contractual maximum amount that could have been claimed in the period with the remaining contractual maximum amount that can be claimed as a constant amount for each future coverage period. So, if a claim of CU100,000 were made in the first year, at the end of the year the entity would compare CU1m coverage provided in the year with coverage of CU900,000 for the following nine years, resulting in an allocation of 1/9.1 of the contractual service margin for the first year.
 - (b) compare the maximum amount that could be claimed in the period with the expected maximum amounts that could be claimed in each of the future coverage periods, reflecting the expected reduction in cover because of claims made. The staff acknowledge that this approach

involves looking at the probabilities of claims in different periods to determine the expected maximum amounts in future periods. However, in this case, the probability of claims in one period affects the amount of cover for future periods, so does affect the level of service provided in those periods. So if a claim of CU100,000 were expected in each year, at the end of the year the entity would compare CU1m coverage provided in the year with coverage of CU4.5m (900k + 800k + ...) over the following nine years, resulting in an allocation of 1/5.5 of the contractual service margin for the first year.

- (c) compare the amount expected to be claimed in the period with the amounts expected to be claimed in future periods.

B.24 Staff comments:

- (a) the staff think the expected coverage duration is the 10 years during which cover is provided, adjusted for any expectations of the limit being reached during the ten years and lapses.
- (b) for determining the quantity of benefits, the staff think that either method B.23(a) or B.23(b) could be valid. The staff do not think method B.23(c) is a valid method because if no claims are expected in a period, there would be no contractual service margin recognised, contrary to the principles discussed in paragraph 30 of this paper. In addition, it appears that applying method B.23(c) the amount representing the contractual cover remaining is not reduced as claims are made.

Example 7—Proportional reinsurance issued

B.25 Example: a reinsurance contract issued provides proportional cover for underlying contracts issued during the contract period. The reinsurance contract issued is for a period of one year. Underlying contracts are written uniformly throughout the

year and are annual policies that are reasonably homogenous and provide relatively even cover over their one-year coverage periods.

- B.26 Methods suggested for determining the expected coverage duration: the insurer has a substantive obligation to provide services under the contract for a period of two years as the risks attaching over a single policy year will cover two-years of exposure to risk. The expected coverage duration of the reinsurance contract issued is therefore two years.
- B.27 Method suggested for determining the quantity of benefits: the amount for which the policyholder has the ability to make a valid claim—ie the pattern of coverage—should reflect the expected pattern of underwriting of the underlying contracts because the level of service provided depends on the number of underlying contracts in-force—the more contracts in force, the higher the level of service.
- B.28 Staff comments:
- (a) the staff agree that the expected duration is two years, adjusted for any expectations of lapse; and
 - (b) for determining the quantity of benefits, the staff think that method B.27 is valid.

Example 8—Reinsurance adverse development of claims with claim limit

- B.29 Example: a reinsurance adverse development cover contract will pay claims in excess of a stated aggregate amount on a group of underlying property and casualty contracts where the claim event has already been incurred. There is a total aggregate limit to the amount payable under the contract. Because there is uncertainty in the ultimate amount and timing of the final settlements of the underlying claims, the insured event is the determination of the ultimate cost of settling those claims.
- B.30 Methods suggested for determining the expected coverage duration: if the contract has an upper limit that is expected to be reached, the expected coverage duration

would be the period from inception of the contract to the time at which the limit of cover is expected to be reached, adjusted for expected lapses, if any.

B.31 Methods suggested for determining the quantity of benefits:

- (a) compare the contractual maximum amount that could have been claimed in the period with the remaining contractual maximum amount that can be claimed as a constant amount for each future coverage period;
- (b) straight line over the life of the contract which would end at the date of the last expected settlement payment; and
- (c) compare the expected amount of underlying claims covered in the period with the expected amount of underlying claims remaining to be covered in future periods.

B.32 Staff comments:

- (a) the staff agree that the expected coverage duration would be the period from inception of the contract to the time at which the limit of cover is expected to be reached, adjusted for expected lapses.
- (b) for determining the quantity of benefits, the staff think that methods B.31(a) and B.31(c) could be valid methods. The staff do not think that method B.31(b) is valid because it does not reflect different levels of cover provided across periods.

Example 9—Reinsurance adverse development of claims without claim limit

B.33 Example: a reinsurance adverse development cover contract will pay claims in excess of a stated aggregate amount on a group of underlying property and casualty contracts where the claim event has already been incurred. There is no total aggregate limit to the amount payable under the contract. Because there is uncertainty in the ultimate amount and timing of the final settlements of the

underlying claims, the insured event is the determination of the ultimate cost of settling those claims.

B.34 Coverage period comments:

- (a) in the case of an unlimited cover, the expected coverage duration would be the period to when it is expected there will be no other cash payments—ie the end of the expected claims settlement period.
- (b) some contracts for adverse claims development have no limit on the period in which claims can be made. For example, asbestos claims were still being made in 2017 under 1950s commercial liability policies in the US. Other examples will arise when an entity acquires claims in their settlement period in a business combination. In such situations there is no ‘date of the last expected settlement payment’. There is no clear date when potential claims are no longer possible. The time period for complete runoff of such liabilities is not reliably estimable for the purposes of the accounting proposed in Agenda Paper 5 from the February 2018 meeting of the TRG. Where a range of possible outcomes can be produced, possible guidance choices for the time period for contractual service margin amortisation would be basing it on the low estimate, basing it on the high estimate, or basing it on the midpoint of the low and high. There can also be situations where ranges do not exist. In any event, the lack of guidance is likely to result in significant diversity in practice.

B.35 Methods suggested for determining the quantity of benefits:

- (a) equal benefits in each coverage period, which would end at the date of the last expected settlement payment;
- (b) compare the number of underlying claims covered in the period with the number of underlying claims remaining to be covered in future periods; and

- (c) compare the expected amount of underlying claims covered in the period with the expected amount of underlying claims remaining to be covered in future periods

B.36 Staff comments:

- (a) the staff think the expected coverage duration would be the period to when the financial effect of the claims become certain. This may be before the claims are paid if certainty has been achieved prior to the actual payment. The staff observe that an entity will need to estimate the expected duration of the period in which claims will be made and payments will be made to estimate the fulfilment cash flows.
- (b) for determining the quantity of benefits, the staff think methods B.35(a) and B.35(c) could be valid. The staff think method B.35(a) could be valid in this example, while the same method was not valid in the previous example (method B.31(b) in the previous example). This is because unlike the first example, the amount of contractual cover remaining is not reduced as claims are made. The staff observe that equal benefits in each coverage period for each contract (method B.35(a)) will not necessarily result in a straight-line allocation of the contractual service margin of a group because different numbers of contracts will provide cover in different periods. Method B.35(b) could be valid if the underlying claims were expected to be of similar size.

Example 10—Transaction liability

B.37 Example: a transaction liability policy will pay claims for financial losses arising as a result of breaches of representations and warranties made in a specified and executed acquisition transaction. The policy period (contract term) is for 10 years from the policy start date. The insurer will pay claims for financial losses reported during the 10-year policy period up to the maximum sum insured.

B.38 Comments on the expected coverage duration:

- (a) the insured event is the representations and warranties made in the final executed transaction agreement which is dated the transaction closing date. Therefore, the coverage period (expected coverage duration) is one day, which is the transaction closing date. The policy period has been included in the contract to limit the reporting period for claims so it is not an indefinite period. This limits the timescale for loss reporting in the same way that the maximum sum insured limits the quantum of loss. Given the insured event arises from representations and warranties the concept of an ‘insurable interest’ is difficult to apply without needing to assess the expected frequency and severity of the loss, ie incidence of risk. However, a valid claim is only permitted in relation to the executed representations and warranties and therefore limited to a one-day period.
- (b) the insured event is the discovery of breaches of representations and warranties. Coverage starts at the moment the contract is signed and lasts for 10 years.

B.39 Staff comments: the staff think view B.38(b) is valid. The staff do not agree with the interpretation of the insured event in view B.38(a). The insured event is not that the policyholder will knowingly make false representations. The insured event is the future event that indicates that the representations made in good faith were in fact misrepresentations and resulted in financial losses. This is consistent with paragraph B18(i) of IFRS 4 *Insurance Contracts* which states:

title insurance (ie insurance against the discovery of defects in title to land that were not apparent when the insurance contract was written). In this case, the insured event is the discovery of a defect in the title, not the defect itself.

Example 11—Combination of different types of cover

B.40 Example: combinations of different benefits. Assume there are five different contracts (A-E) in a single group of insurance contracts. Each contract has a

different combination of four coverages (accidental death, cancer diagnosis, surgery and inpatient treatment²). Also, each contract has a different coverage period. Coverages have a high level of interdependency in the same insurance contract; if a coverage of an insurance contract in the group of insurance contracts lapses, other coverages of the same insurance contract lapse simultaneously.

Presented in the table below is the summary of the contracts.

Contract	Coverage				Coverage period
	Accidental death	Cancer diagnosis	Surgery	Inpatient treatment	
A	Cover of 2000	Cover of 1000	Cover of 500	Cover of 50	2 years
B	N/A	Cover of 1000	Cover of 500	N/A	5 years
C	N/A	N/A	Cover of 500	Cover of 50	2 years
D	N/A	N/A	Cover of 500	Cover of 50	5 years
E	Cover of 2000	N/A	N/A	N/A	10 years

The entity charges the same annual premiums for each type of cover, and the total annual premium for a contract is the sum of the premiums for each type of cover included in the contract.

B.41 No comments were made on the expected coverage duration.

B.42 Methods suggested for determining the quantity of benefits:

- (a) the quantity of benefits is the same for each contract.
- (b) the quantity of benefits for each contract is the maximum level of cover given by any of the benefits, ignoring the amounts of cover for the other benefits. So if, for example, the highest level of cover for contract A

² The example provided by the TRG member included an investment component. The discussion of a combination of insurance service and an investment component is discussed as example 14 in Appendix C to this paper.

was 2,000 for accidental death and for contract B was 1,000 for cancer diagnosis, the coverage units would be determined by reference to those amounts.

- (c) the quantity of benefits for each contract is the sum of all the levels of cover provided. So, based on the cover set out in the table, the coverage units for contract A for each year would be 3,550 and for contract B 1,500.
- (d) the annual premiums can be used to determine the coverage units because they reflect the amount of insurance service provided.

B.43 Staff comments:

- (a) the staff think the expected coverage duration is the period in which cover is provided, adjusted for expectations of lapses.
- (b) for determining the quantity of benefits, the staff think that method B.42(c) is valid. The staff think that method B.42(a) is not valid because it does not reflect the different amounts of cover provided by each contract. The staff think that method B.42(b) is also not valid for the same reason. The staff think that whether method B.42(d) is valid depends on the factors set out in paragraph 30(g)(iii) of this paper.

Example 12—Life contingent annuity

B.44 Example: a life contingent pay out annuity pays a fixed monthly amount of CU10 each period until the annuitant dies.

B.45 Combined comments on the expected coverage duration and the quantity of benefits:

- (a) there is a constant level of benefits provided over the life of the annuitant. The contractual service margin would be amortised straight line over the remaining expected life of the annuitant. That is the quantity of benefit is 10 per year, and the coverage duration is the

length of time until there is zero probability of making a payment to the policyholder (40 years).

- (b) the contract is a series of individual promises to pay a fixed amount at a future point in in time if the annuitant is alive at that point in time. The cumulative coverage units in the first period are the total expected dates a payment will be made. The second period cumulative coverage units would be one less coverage unit as a coverage unit expired with the reaching of the first promise to pay at a point in time. That is the quantity of benefit and coverage duration are determined together by multiplying the face amount by the probability of making payment in each year (not the probability weighted cash flow).
- (c) the coverage units are determined by the quantity of benefits and the expected duration. The quantity of benefits is a constant benefit of 10 per year. The expected duration is the probability-weighted average duration of the contract.

B.46 Staff comments:

- (a) the staff think the expected coverage duration is the probability-weighted average expected duration of the contract. The expected coverage duration is reassessed each period (same as view B.45(c)).
- (b) the staff think the quantity of benefits is the fixed monthly amount of CU10 (same as view B.45(c)).
- (c) the staff do not agree with view B.45(a) because it does not reflect the expected duration of the contract. The staff do not agree with view B.45(b) because it requires an entity to split a contract into multiple individual contracts. It also does not seem to require reassessment of the expected coverage duration.

Example 13—Forward purchase of fixed rate annuity

- B.47 Example: forward contract to buy an annuity in the future at a fixed rate. The premium is payable when the annuity is bought. If the policyholder dies, or cancels the contract, before the date the annuity can be purchased, the policyholder receives no benefit.
- B.48 Comments on the coverage period:
- (a) the entity bears insurance risk from the date the forward contract is issued. Hence, the coverage period starts at that date.
 - (b) the entity bears insurance risk from the date the forward contract is issued, but the coverage period does not start until the date the annuity starts. The insured event is that the policyholder lives long enough to receive payments under the annuity.
- B.49 Staff comments: The staff think view B.48(b) is valid. The staff do not think an insured event can happen in the period before the annuity starts.

Appendix C—Examples of insurance contracts with investment components

Example	Type of contract	Paragraphs
14	Insurance services and investment component with different durations	C.2–C.5
15	Endowment policy	C.6–C.9
16	Benefit of higher of investment component and multiple of salary	C.10–C.12

C.1 As set out in paragraph 20 of this paper, the staff think the determination of coverage units is not an accounting policy choice but involves judgement and estimates on how best to reflect the provision of service. In the following examples, the staff comment on whether suggested methods of determining the quantity of benefits and the coverage duration might be valid ways of reflecting the provision of service. Which method gives the best reflection of the provision of service is a matter of judgment that depends on facts and circumstances.

Example 14—Insurance services and investment component with different durations

C.2 Example: an investment contract matures in year 10 and pays the customer the account value at maturity. The contract also includes a death benefit that varies depending on which year in the 10 year period the death occurs. Specifically, if the customer dies during the 1–5 year period, the customer’s beneficiary would receive a death benefit that is the higher of 110 per cent of the premium paid or the accumulated account value (assume the death benefit for years 1–5 results in significant insurance risk). However, if the customer dies in years 6 to 10 the customer’s beneficiary only gets the account value. There is no surrender penalty. Does the insurer only have to consider years 1 to 5 for determining the coverage units to determine the amortisation of the contractual service margin? Or does the

insurer need to consider all 10 years for determining coverage units and amortisation of the contractual service margin?

C.3 Comments on the expected coverage duration:

- (a) View A—Years 1 to 5 are the only years in the 10 year period that could expose the insurer to paying an amount higher than the account value due to an insured event. Therefore, the portion of the contractual service margin allocated to the insurance risk portion of the contract is recognized over those five years. The portion of the contractual service margin allocated to the investment management portion will be recognised over the 10 years following the guidance in paragraph 71(c) of IFRS 17.
- (b) View B—Paying a death benefit equal to the account value is a benefit payment despite the fact that the insurer is not exposed to a risk of insurance loss. The entire contractual service margin is recognised over 10 years.
- (c) View C—Coverage units are defined as insurance units. The insurance coverage is in force in only the first five years. The contractual service margin should be amortised over the first five years. However, the contractual service margin is developed at inception and, as illustrated in Example 6 (IE 56–80) and Example 15 (IE 152–172) in the Illustrative Examples on IFRS 17, contains the present value of the expected spread in establishing crediting rates to the account balance if it is an indirect par policy. Recognising the entire contractual service margin in the first five years would also result in recognising the entire expected spread of the 10-year life over the first five years.

C.4 Comments on quantity of benefits: a practical approach for assessing the quantity of benefits for investment-related services is to use the amount of the investment component in the period, because this reflects the quantity of assets being managed for the policyholder under the contract.

C.5 Staff comments:

- (a) if the contract falls within the scope of the VFA:

- (i) the contract provides insurance and investment-related services. The coverage period for total services is 10 years.
- (ii) the coverage units should be determined reflecting the benefits to the policyholder of the insurance services and the investment-related services. Determining the amount and pattern of the insurance and investment-related services is a matter of judgement. Methods that rely solely on the amount of the investment component or solely on the death benefit would not be a faithful representation of the provision of services.
- (b) if the contract does not fall within the scope of the VFA, the contract provides only insurance services for the purpose of applying IFRS 17. The coverage period for those services is the first five years. In years 6–10, the policyholder can make no valid insurance claim and receives no insurance services from the entity.

Example 15—Endowment policy

C.6 Example: the entity has issued conventional participating insurance with the following features:

- (a) the policyholder pays a regular level premium to the insurance entity.
- (b) in return, the policyholder receives:
 - (i) insurance coverage, payable upon death of the life insured, of a specified sum insured; and
 - (ii) a share of the investment returns from an underlying pool of assets to which the policy refers.
- (c) the investment returns are allocated to the policyholder through bonuses that are added to the policy’s sum insured.
- (d) the insurance entity may allocate ‘reversionary bonuses’ (ie an annual incremental addition to the sum insured) or ‘terminal bonuses’ (ie an

amount in addition to the sum insured and reversionary bonuses that is payable to the policyholder upon maturity or death).

- (e) there are three ways in which the policy can terminate. The policyholder could:
 - (i) die. In this case the sum insured including all reversionary bonuses accumulated at the time of death and the terminal bonus would be payable.
 - (ii) survive and reach the maturity date of the policy. In this case the maturity value consisting of the sum insured, all reversionary bonuses accumulated at maturity and the terminal bonus would be payable.
 - (iii) voluntarily surrender their policy before the maturity date. In this case, a surrender value would be payable to the policyholder. The surrender value is generally based on a set schedule such that the surrender value is low in the early years of the policy and increases with policy duration. At maturity, the surrender value equals the maturity value.

A key point of these contracts is that the insurance component of the policy dominates at early durations and the investment component dominates at later durations as the policyholder accumulates investment returns.

- C.7 No comments were made about the expected coverage duration (there is insurance risk until maturity of the contract because the surrender value is always lower than the amount payable on death).
- C.8 The following methods were suggested for determining the quantity of benefits:
 - (a) coverage units are determined by reference to the amount payable on death, which reflects the quantity of benefits for both insurance and investment services provided by the entity; and
 - (b) coverage units are determined by reference to the difference between the amount payable on death and the surrender value, which reflects the

quantity of benefits only for the insurance services provided by the entity.

C.9 Staff comments:

- (a) for both VFA and general model contracts, the staff think the expected coverage duration is the expected duration of the contract, including expectations of surrender.
- (b) for the quantity of benefits, the staff think the analysis differs for VFA and general model contracts:
 - (i) if the contract falls within the scope of the VFA, the coverage units should be determined reflecting the benefits to the policyholder of the insurance services and the investment-related services. One method of doing this would be by using the amount payable on death (ie including the surrender value). (Same as method in C.8(a)).
 - (ii) if the contract does not fall within the scope of the VFA, the contract provides only insurance services for the purpose of applying IFRS 17. In principle, the coverage units should be determined by the insurance benefit only, ie excluding the surrender value. (Same as method C.8(b)). However, IFRS 17 does not require entities to separately identify investment components before a claim is incurred, because of the difficulties in doing so.³ Therefore, the staff think that determining the quantity of benefits by excluding the surrender value is a possible approach if an entity has reasonable and supportable information to do so. If the entity does not have such reasonable and supportable information, it will need to use its judgement to determine the quantity of benefits.

Example 16—Benefit of higher of investment component and multiple of salary

C.10 Example: the entity issues a contract comprising:

- (a) an investment linked account; and

³ See paragraphs BC10 and BC12 of the Basis for Conclusions on IFRS 17.

- (b) an insurance rider which insures payment of five times salary upon death or account balance if greater.

The entity prices for a 10 per cent profit margin in investment services and a 15 per cent return on insurance services. The investment component cannot be separated in applying paragraph 11(b) of IFRS 17 as it is not distinct.

There are three ways in which the contract can terminate:

- (a) the insured could die. In this case the higher of five times salary and the investment linked account balance are paid at the time.
- (b) the insured could reach retirement age. In this case the investment linked account balance would be paid and the contract including any insurance component would cease.
- (c) the policyholder could move to another employer and transfer the investment linked balance to another superannuation scheme, which also ceases the insurance cover provided the entity.

A key point of these contracts is that the insurance component of the policy dominates at early durations and the investment component dominates at later durations as the policyholder accumulates investment returns.

C.11 Combined comments on the expected coverage duration and the quantity of benefits:

- (a) coverage units should be based on the benefit payable on death—ie the higher of five times salary and the investment-linked account balance, which reflects the quantity of benefits for both insurance and investment services provided by the entity.
- (b) coverage units should be based on the difference between the benefit payable on death and the investment-linked account balance, which reflects only the quantity of benefits for only the insurance services provided by the entity. This difference is nil once the investment-linked

account balance exceeds five times salary, so the expected coverage duration would end at that point.

C.12 Staff comments:

- (a) if the contract falls within the scope of the VFA: the expected coverage duration and quantity of benefits should be determined reflecting the benefits to the policyholder of both the insurance services and the investment-related services. One method of doing this would be by using the sum payable on death, ie including the investment-linked account balance.
- (b) if the contract does not fall within the scope of the VFA: the contract provides only insurance services for the purpose of applying IFRS 17. If the investment-linked account is not guaranteed, one way of determining the insurance benefit would be to consider the maximum contractual amount of cover—ie five times salary. If the investment-linked account is guaranteed, or if the insurance benefit is determined by considering the expected amount of a valid claim rather than the maximum contractual amount, in principle, the coverage units should exclude the investment-linked account. However, IFRS 17 does not require entities to identify separately investment components before a claim is incurred, because of the difficulties in doing so⁴. The staff think determining the quantity of benefits by excluding the investment-linked account is a possible approach if an entity has reasonable and supportable information to do so. If the entity does not have such reasonable and supportable information, it will need to use its judgement to determine the quantity of benefits.

⁴ See paragraphs BC10 and BC12 of the Basis for Conclusions on IFRS 17.