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IFRS 17: Considerations for health insurers

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Introduction

International Financial Reporting Standard (IFRS) 17 Insurance Contracts was issued by the International Accounting Standards Board (IASB) on 18 May 2017 and had an initial effective date of annual periods beginning on or after 1 January 2021. However, IASB in its November 2018 meeting voted to propose a one-year deferral of the effective date for the new insurance contracts standard to 2022. It has also decided to propose extending to 2022 the temporary exemption for insurers to apply the financial instruments standard, IFRS 9, so that both IFRS 9 and IFRS 17 can be applied at the same time. It is intended to provide updated information about the obligations, risks and performance of insurance contracts, to increase transparency in financial information reported by insurance companies to help boost market confidence and to introduce consistent accounting for all insurance contracts based on a current measurement model. It also requires a company to recognise profits as it delivers insurance services (rather than when it receives premiums) and to provide information about insurance contract profits the company expects to recognise in the future.

However, a closer look at IFRS 17 highlights some complexities that come with increased transparency and consistency in reporting. This article focuses on some of the complexities and considerations for short-term health insurers.

Considerations

Like most general insurers, short-term health insurers may consider the Premium Allocation Approach (PAA) over the Building Block Approach (BBA) as most of the health contracts have a coverage period of 12 months or less. However, there are a few things to consider before deciding on the model for measuring liabilities. Some of these considerations include:

1. **Ability to fully reflect the risks when repricing the contracts:** Paragraph 34(b) for IFRS 17 insurance contracts relates to the assessment of contract boundaries for pricing of a portfolio of insurance contracts. The new standard allows the contract boundaries for contracts with coverage periods of 12 months to be limited to one year, provided the insurer has the ability to reassess the risks of the portfolio and can reprice to fully reflect the risk of that portfolio. However, there are some practical concerns that may restrict the insurer's ability to reprice fully to reflect the risk underlying the portfolio. They include:
   - Selective lapsing: Selective lapsing is a phenomenon where the relatively healthier risks have a greater tendency to lapse their policies than the poorer risks, leaving the insurer with a larger group of poorer risks. If large premium increases are required to fully reflect the risks on repricing the portfolio, this is likely to result in selective lapses causing the actual claims experience to be worse than expected. The risk will, however, depend on the specifics of each market, such as mandatory versus voluntary cover, commercial constraints, size of the market and the growth potential.
   - Treating customers fairly: Treating customers fairly principles in some markets require insurers to treat new and existing business consistently. This restricts companies from charging different premiums to new business and existing business with similar demographic risk profiles but vastly different claims experience due to differences in policy durations. This is because the claims costs increase with increasing duration in force (time since initial underwriting) and this trend persists over longer durations.
2. **Guaranteed renewability clause:** As per the new standard, the contract boundary should reflect the entity's substantive rights and obligations that exist during the reporting period in which the insurer has the substantive obligation to provide the services under the insurance contract. In some countries, the clause of guaranteed renewability may result in substantive obligations for the insurer and therefore introduce additional complexity when defining the contract boundaries for health insurance contracts. Policyholders are usually underwritten at the proposal stage for risk assessment to ensure that the premium charged reflects the risk profile of the customer. Substandard risks within a portfolio have the right to renew policies and continue coverage. This right together with no availability of cover with other insurers is likely to have implications on the contract boundary assessment for such segments of risks. However, the impact is limited in cases where insurers have the ability to not renew certain portfolios or segments of the risks, or can fully reprice or change benefit terms and conditions at annual renewal, as in some countries.

3. **Long-term view of risks:** Health insurance policies in many countries are considered short-term contracts and the pricing structure may only account for risks up to the reassessment date. It might, however, be worth taking a long-term view of the risks when setting the pricing structure as there are likely to be implicit cross-subsidies over coverage periods and between cohorts of different durations.
4. **Level of aggregation:**
   - IFRS 17 requires companies to identify a portfolio of insurance contracts. A portfolio comprises a group of contracts subject to similar risks and managed together. Applying the definition of a portfolio in practice may require some judgement. It is likely that contracts under different product lines will represent different portfolios, but a product line may have multiple portfolios if needed to create homogeneous risk groupings. The insurers also need to consider the consistency of portfolio definitions that apply across all frameworks, including Solvency II, for meaningful comparisons.
   - The new standard requires the contracts in each portfolio to be divided into groups, considering differences in the expected profitability of contracts. The grouping requirements, however, include an exemption for economic differences that arise because of regulatory restrictions. In all other cases, insurers are required to separately report:
     - A group of contracts that are onerous at initial recognition. The losses from these contracts need to be realised immediately. The onerousness will, however, depend on:
       - The definition of contract boundary.
       - The estimated cash flows recognised within it.
       - Any change in circumstances that may cause the cash flows that were once outside the contract boundary to fall inside the boundary.
       - Allocation of internal expenses.
       - Allocation of provider volume discounts between retail and group contracts.
     - Examples include any onerous multiyear group contracts issued by the company, contracts with large initial commissions and group contracts written with substantial up-front discounts.
     - A group of contracts that at initial recognition have no significant possibility of becoming onerous subsequently. The term 'significant possibility' is open to interpretation.
     - A group of the remaining contracts in the portfolio. Individual/retail contracts are likely to become onerous at higher durations, but exemptions granted for regulatory restrictions, where insurers cannot discriminate in pricing between new and existing business, may exempt the insurers from having to recognise these cohorts separately as onerous.
   - However, one of the amendments proposed by IASB at its December 2018 meeting is to raise the level of aggregation to portfolio level for presentational purposes:
     - Any multiyear contracts issued by the company would need to be reported separately to meet the requirement of separating contracts issued more than one year apart.
     - Inability to realise profits from future renewals outside the IFRS 17 contract boundary will result in the recognition of losses at inception, even when the insurer expects to recover all costs from future renewals. This is likely to impact the cohort groupings to show any onerous contracts separately. Examples here would include contracts with large initial commissions deferred over an expected policy duration and contracts written with substantial up-front discounts.
   - In terms of reporting, IFRS 17 limits the ability to cross-subsidise between contracts and duration to offset profits from some contracts against the expected losses from others. Changes in the level of aggregation may change the pattern of profit recognition over time. The new standard is likely to have significant impact on existing data collection and systems, which would need to be updated to meet the reporting requirements under the new standard.
   - **Reinsurance:** IFRS 17 treats reinsurance contracts held and underlying insurance contracts separately. This would result in differences arising between the value of the reinsurance recoverable and the ceded insurance liability, impacting the contract boundaries considered for the reinsurance contracts. That is not the case under Solvency II, where reinsurance and underlying contracts are generally treated on a consistent basis.
   - **Investment component:** An investment component is the amount an insurance contract requires the entity to repay to a policyholder even if an insured event does not occur. IFRS 17 requires an entity to separate distinct investment components from the host insurance contract. The considerations for health insurers in this case relate to the treatment of a no claims bonus (NCB) and retrospective profit shares on group policies:
     - **NCB:** For policies where the NCB guarantees the policyholder a refund of the premium, it could be considered as an investment component. However, as the NCB is a feature exercised at the renewal stage, it may not be considered as an investment component if the cash flows resulting from the NCB are assumed to be outside of the contract boundary.

  - **Retrospective profit sharing:** Group policies that allow for retrospective profit sharing may need to be reconsidered to see whether the profit share component qualifies as investment component under the new accounting standard. It may need to be allowed for separately from the host insurance contract.
- It may further be argued that the NCB and retrospective profit sharing are non-distinct, as termination of the insurance contract would result in the termination of such components.
- **Deferred acquisition costs (DAC):** Many companies that currently defer and amortise the acquisition costs present DAC as assets, separately from insurance contract liabilities. However, when applying IFRS 17, the amount of these acquisition costs will be included in the measurement of liabilities. If the acquisition costs are currently expensed as incurred, it will decrease the insurance contract liabilities.
- **Recognition and presentation of financial performance:** The new standard requires the insurers to disaggregate the amounts into insurance revenue, insurance service expense, finance income or expenses separately impacting the representation of the financial performance of the company. In addition, income and expenses from reinsurance contracts need to be presented separately from the income and expenses of the insurance contracts. This requirement is intended to result in timely recognition of profits and losses and hence provide a view on sustainability and future profitability of the insurer.

Final thoughts

While the new standard aims to bring increased transparency in the financial reporting by insurers, the complexities related to some aspects of it need to be carefully considered for short-term health insurers when estimating the financial, operational and business impact within the organisation's governance frameworks. Health business in some countries is treated as long-term business, while in other countries it is treated as short-term, annually renewable general insurance business from a regulatory perspective. However, there are some unique features of health business which merit careful consideration under IFRS 17 and it is unlikely there will be one unified interpretation across different countries of issues around guaranteed renewability, medical underwriting and selection periods and allocation of expenses and economic benefit of provider discounts across different types of contracts in an insurers' portfolio.

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