Insurance alert

FASB meeting on March 11, 2015

Since a variety of viewpoints are discussed at FASB meetings, and it is often difficult to characterize the FASB's tentative conclusions, these summaries may differ in some respects from the actions published in the FASB's Tentative Board Decisions. In addition, tentative conclusions may be changed or modified at future FASB meetings. Decisions of the FASB become final only after completion of a formal ballot to issue a final standard.

FASB completes its deliberations on disclosures for short-duration insurance contracts

Highlights

At the March 11 meeting, the Board focused on four key areas emanating from the fatal flaw review process: location of the 10 year development tables, use of claim counts and IBNR in those tables and the effective date.

The Board voted unanimously to require 10 years of claims development to be presented together and average annual payouts to be presented, characterizing each of the first 9 years as supplementary information. The notes to the financial statements only need to reflect these disclosures for the current reporting period and need not be comparative.

The Board replaced the claim count disclosure requirements previously included in the proposal with a disclosure objective of providing information about claim frequency, potentially both qualitatively and quantitatively, unless impractical to do so.

The Board had originally decided to require disclosure of the "pure" IBNR that is included in each accident year's total incurred claims in the 10 year development table. However, at the March meeting, the Board voted instead to require disclosure of the sum of "pure" IBNR plus expected development on reported claims. A description of the methodologies for determining the disclosed amounts would also be required.

For public business entities, the Board unanimously supported delaying the effective date by one year (i.e., year end 2016), with early adoption permissible. There would be a one-year delay for non-public entities. It is expected the final standard will be issued by June 2015.

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Details

This was the FASB's first meeting since August 2014 on short-duration insurance contract disclosures.

The staff noted that the following areas highlighted by the fatal flaw review process would require additional consideration by the Board prior to finalizing the standard.

Required supplementary information

To address potential auditor independence concerns with presenting 10 years of claims data in the claim development tables and the associated average annual payout percentages, the staff proposed including this data as required supplementary information. However, the years included in the supplemental schedules relating to the current reporting period would also need to be included in the notes to the financial statements. The Board had originally proposed in 2014 that all 10 years should be included in the notes to the financial statements. However during outreach, regulators as well as independent auditors noted that potential independence issues may arise due to this requirement.

There was limited support for maintaining the 10 year disclosures in the notes to the financial statements as previously proposed. However many Board members wanted to ensure that the wording of the standard would not result in separation of the 10 years of disclosure between the current reporting period included in the notes, and the prior 9 years in the supplemental schedules. Several stressed the importance to users of presenting all 10 years of disclosure together. The Board discussed that this could be accomplished by inclusion of all 10 years in the supplemental schedule.

This ultimately led the Board to vote unanimously to require the inclusion of claim development data and related information for the current reporting period in the notes to the financial statements, and to require that the 10 year table and related information be presented as required supplementary information. During the discussion, several Board members noted that while there was thus no requirement to present the 10 year information in the notes to the financial statements, in certain instances, an insurer might opt to do so voluntarily rather than to present it as supplementary information outside the audited financial statements.

The Board noted that the FASB's responsibility is to prescribe what is to be included in the notes to the financial statements and required supplementary information, but it is up to the regulators to determine what procedures, if any, would be required to be performed by auditors for the supplementary information. It was mentioned that it was the FASB's understanding, based on comments from the PCAOB and AICPA, that the auditor would not be expressing an opinion on the supplementary information, and thus that auditor independence would not be deemed to be impaired.

Claim counts

The staff cited several concerns from constituents with disclosing cumulative claim counts in the 10 year development tables. These concerns centered on diversity in practice in defining and computing claim counts, accessibility to relevant information, such as for assumed reinsurance, the applicability to non-proportional and aggregated coverages, and the potential for misapplication of the data by users.

The staff proposed to either eliminate claim counts from the disclosure, or require insurance entities to provide information about claim frequency, where practical. That information would include quantitative information about claim frequency (for example, claim counts) as well as a description of the entity's methodologies for determining claim frequency. No specific claim count methodology would be prescribed, and no frequency information would be required in situations in which it would be impracticable to do so.

The staff noted that differences exist in terms of how claim frequency could be measured, for example counting a claim occurrence as one claim versus multiple claims if there were multiple claimants, or including versus excluding claims occurring below the deductible level. When asked the difference between "claim count" and "claim frequency," the staff noted that in all cases, "claim frequency" would ultimately involve inclusion of some sort of raw claim count data. The staff provided an example of workers' compensation claim frequency being measured as the number of claims per $100 of payroll.

During the discussion, the staff highlighted that claim counts are not required for certain lines of business in Schedule P of the Annual Statement, such as for reinsurance, residual market pools and specialty lines. The staff also highlighted constituent comments that claim counts are most relevant for homogenous groups of claims, such as with auto coverage.

The chair noted that in his view, the disclosure should reflect how an insurer looks at claim information to derive its insurance obligation. The Board voted 6 – 1 in favor of accepting the staff's proposal to disclose information about claim frequency, along with a qualitative description of methodologies for determining claim frequency information, unless impractical. To the extent quantitative claim counts are included, the qualitative discussion will allow users to determine if the claim count is by incident or claimant or otherwise.

IBNR

The staff noted that the originally proposed disclosure of IBNR only includes incurred but not reported claims, exclusive of development on reported claims. They received feedback from many insurance entities that this "pure" IBNR would require a separate estimate, as many insurance entities develop an ultimate estimate of reserves, and derive IBNR for statutory reporting purposes by reducing the amount by paid claims and case reserves. In addition, Schedule P of the Annual Statement includes development on known claims together with "pure" IBNR. The staff proposed to either eliminate IBNR from the 10 year development table or expand the IBNR definition in the disclosure to include expected development on reported claims.

There was a fair amount of discussion among the Board members of what would be the most meaningful to users. Several suggested that the disclosure would be most meaningful if "pure" IBNR was presented separately from development on reported claims. Others noted that differences in case reserving practices further complicate the disclosure, noting that although a case reserve indicates a claim is known, it may not reflect the ultimate loss expectation of that claim.

Several Board members acknowledged that while "pure" IBNR may be useful and can be calculated, it may be costly for insurance entities. It may also be different from what users may expect to see based on their review of Annual Statements.

Rather than eliminating IBNR as a required disclosure, the Board voted between retaining "pure" IBNR, or expanding the definition of IBNR in the disclosure to be the sum of "pure" IBNR plus expected development on reported claims. The Board voted in favor of the latter by a 5 - 2 margin. The disclosure would be required for each accident year presented in the claims development table, along with an explanation of the methodologies used for determining the amounts disclosed.

Effective date

The staff proposed delaying the required effective date of the disclosures for public insurance entities by one year to annual reporting periods beginning after December 15, 2015 (i.e. 2016 year end), and all interim periods thereafter. There would be a one-year delay for non-public entities. Early adoption would be permitted. The staff noted this would allow preparers time to make updates to their reporting processes to capture the relevant disclosure information.

The Board highlighted during the last meeting in August 2014, the expectation was for the proposal to be finalized by year end 2014. Given that the project has not progressed based on this timeline, delaying the effective date by one year appeared reasonable to the Board. The Board voted unanimously to accept the staff's recommendation.

Next steps

With these decisions concluded upon, the Board directed the staff to complete drafting of the proposed standard to be presented to the Board for a final vote by written ballot. The disclosures will not be exposed for public comment. It is expected the final standard will be issued by June 2015.

Appendix

Background on FASB project on disclosures about short-duration insurance contracts

Through August 2014, the FASB tentatively decided on the following disclosures for short-duration insurance contracts. The level of disaggregation for such disclosures, where disaggregation is required, would be such that useful information is not obscured by either the inclusion of a large amount of insignificant detail or the aggregation of items that have different characteristics.

Disclosure requirements include:

- Disaggregated incurred and paid claims development tables that need not exceed the most recent 10 years in which claims were first reported, on a net basis after reinsurance (annual)
- Disaggregated net outstanding claims for years prior to those presented in table (annual)
- Average annual percentage payout of claims based on information in the paid claims development table (annual); not required for health insurance contracts
- Reconciliation of claims development tables to balance sheet claim liabilities, with separate disclosure of ceded reinsurance (annual)
- Disaggregated information about the number of reported claims (annual*) [changed at March 11 meeting]*
- The incurred but not reported (IBNR) claim liabilities included within the incurred claim development tables (annual) *[changed at March 11 meeting]*
- If a reporting entity discounts the liability for unpaid claims and claim adjustment expenses, the effects of discounting on the financial statements, including the aggregate amount of discount deducted from the claim liability, the amount of interest recognized during the period, and the line item(s) in which interest accretion is classified.
- Interim as well as year-end disclosure (which is already required by 944-40-50-3) of the claim liability roll forward and related qualitative information
- Qualitative information about liability estimates in annual financial statements (and interim, as needed) about material changes in judgments made in calculating the claim liability, including reasons for the change and effects on the financial statements.

The Board also tentatively decided to require additional interim and annual disclosures for health insurers given that they have shorter claim settlement periods. Interim and annual disclosures would include IBNR and disaggregated rollforwards of claim liabilities.

Contact us:

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