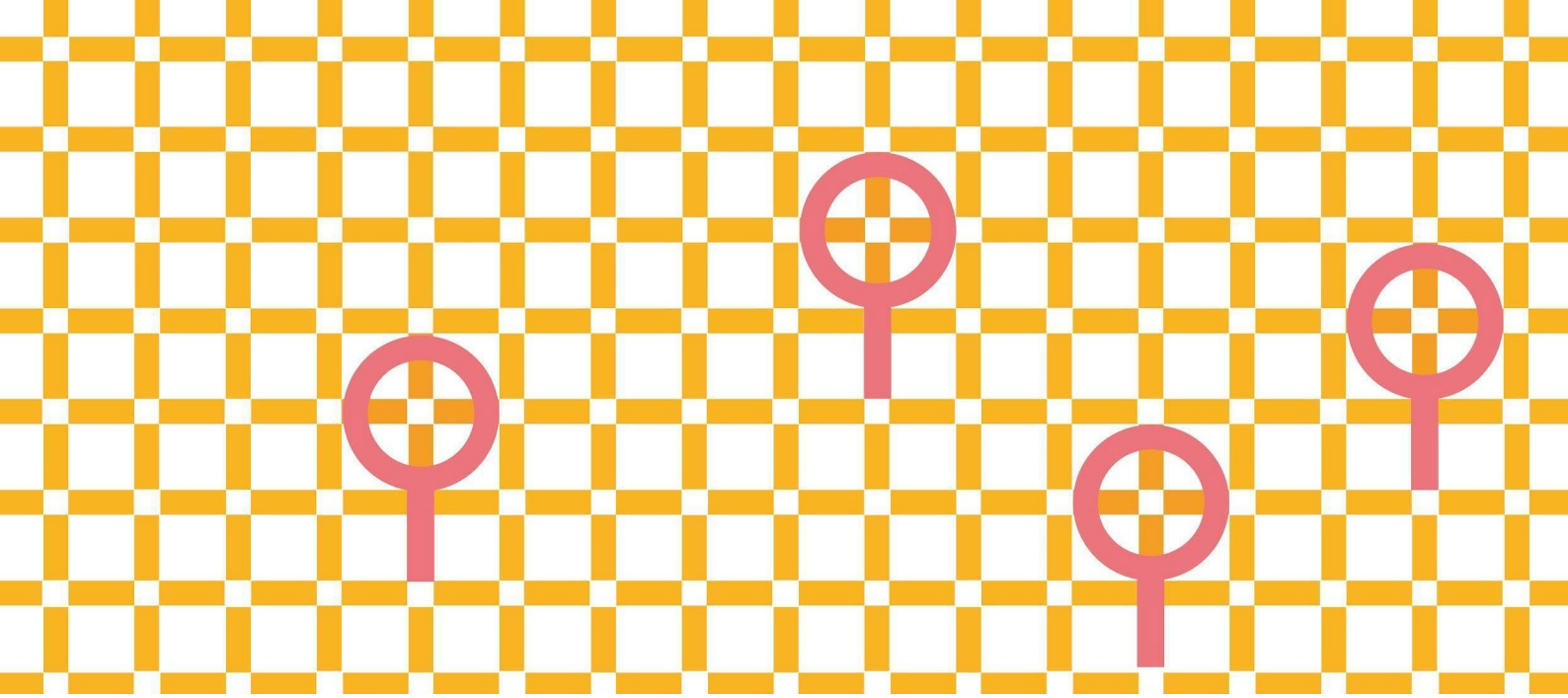

# In the Spotlight

## Determining CSM allocation using coverage units

Release Date: 14 December 2020

### Frequently asked questions on IFRS 17

**At a glance**

IFRS 17, 'Insurance Contracts', introduces the concept of 'coverage units' for determining how an insurer allocates to different reporting periods the expected profit for providing insurance contract services (that is, the contractual service margin).

Different insurance contracts are likely to provide different insurance contract services, with different relative weightings of the benefits provided by each service. The pattern of delivery of each of those services might also differ. There is little specific guidance in IFRS 17 on how to determine coverage units where more than one service is provided in a contract or group of contracts. An insurer will need to apply judgement in determining the allocation of coverage units, and those judgements might have a significant effect on system requirements and reported results.

This publication summarises the guidance relating to coverage units, along with related frequently asked questions ('FAQs').

### 1. Introduction

IFRS 17, 'Insurance Contracts', includes in the measurement of insurance contracts a contractual service margin ('CSM'), representing the expected profit for providing insurance contract services. That expected profit is recognised in profit or loss as the entity provides insurance contract services. Insurance contract services are defined as comprising insurance coverage, investment-return service and investment-related service.

Different insurance contracts provide different types of insurance contract services to different degrees and at different times during the contract term. For example, some contracts provide a constant level of service over the life of the contract (such as a fixed amount of death benefit over a fixed term), while other contracts provide a different level of cover in different periods (for example, a declining amount of death benefit over the contract term). Some contracts lapse when an insured event occurs (for example, a death benefit), while others continue for the contractual term unless cancelled (for example, coverage for car accidents). Under some contracts, the likelihood of a claim varies across periods. Each service in an insurance contract that provides more than one service can also provide a different amount of benefit, and the pattern of delivery of each of those services might also differ.

IFRS 17 introduces the notion of 'coverage units' as a proxy for the amount of benefits provided, in order to establish the amount of the CSM to be recognised in profit or loss for insurance contract services provided in a period. Coverage units were introduced to achieve an appropriate allocation of the CSM of a group that contains contracts of different sizes and duration, and contracts that provide different levels of cover across periods. Coverage units allow an entity to recognise an appropriate allocation of the CSM to each reporting period that reflects the different types of benefit provided in that period.

**Example**

A group contains some contracts that offer a death benefit of CU10m and some that offer a death benefit of CU1m. All other things being equal, allocating ten times as many coverage units to the contracts with a death benefit of CU10m would ensure that the entity recognised an appropriate amount of the CSM in each period if the CU10m contracts have a different duration from the CU1m contracts.

Although the recognition of the CSM in profit or loss is a fundamental aspect of the depiction of the performance of a group of insurance contracts, there are few requirements in IFRS 17 on how to determine coverage units. As a result, a number of key interpretative questions have arisen. This publication summarises the requirements relating to the determination of coverage units and considers some of those questions based on IFRS 17 as amended in June 2020.

## What's inside this Spotlight?



We hope that you find the publication useful in addressing some of your questions.

*The determination of coverage units necessitates the use of judgement. The methods and examples described in this publication provide one way of meeting the requirements. They do not illustrate all of the ways to determine coverage units; nor do they answer all of the questions that might arise in practice.*

## 2. Overview of requirements

The CSM at the end of each reporting period represents the profit in the group of insurance contracts that has not yet been recognised in profit or loss because it relates to the future insurance contract services that will be provided under the contracts in the group.

Paragraphs 44(e) (for insurance contracts without direct participation features) and 45(e) (for insurance contracts with direct participation features) of IFRS 17 require the CSM to be adjusted for *"the amount recognised as insurance revenue because of the transfer of insurance contract 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"*.

Thus, IFRS 17 requires an entity to recognise the CSM of a group of insurance contracts over the coverage period of the group. The coverage period is the period during which the entity provides insurance contract services.

IFRS 17 is not prescriptive about many aspects of recognising the CSM in profit or loss. Paragraph B119 of IFRS 17 requires an amount of the CSM for a group of insurance contracts to be recognised in profit or loss in each period to reflect the insurance contract services provided under the group of insurance contracts in that period. That 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 CSM at the end of the period (before recognising any amounts in profit or loss to reflect the benefits provided in the period) equally to each coverage unit provided in the current period and expected to be provided in the future; and
(c) recognising in profit or loss the amount allocated to coverage units provided in the period.

| FAQs on determining coverage units | |
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| 2.1 Does an entity have an accounting policy choice over how to determine coverage units for a group of contracts? | The determination of coverage units is not an accounting policy choice, but it involves estimation uncertainty and is likely to require the application of significant judgement to best achieve the principle of reflecting the benefits provided in each period. Those judgements and estimates should be applied systematically and rationally.<br><br>In addition, an entity must disclose information about the judgements and estimates that it makes, as described in section 5 below. |
| 2.2 At what level should coverage units be determined? | Paragraph B119 of IFRS 17 requires an entity, for the purpose of recognising CSM in profit or loss, to identify the coverage units at the level of a group of contracts. |
| 2.3 Can the time value of money (discounting) be taken into account in determining the allocation of the CSM to reporting periods using coverage units? | Yes. Whether discounting is taken into account in determining the allocation of CSM is a matter of judgement for an entity. However, the judgement would be expected to be applied consistently.<br><br>Paragraph BC 282 of the Basis for Conclusions on IFRS 17 states that: *"IFRS 17 requires the contractual service margin remaining at the end of the reporting period to be allocated equally to the coverage units provided in the period and the expected remaining coverage units. IFRS 17 does not specify whether an entity should consider the time* |

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| | *value of money in determining that equal allocation and consequently does not specify whether that equal allocation should reflect the timing of the expected provision of the coverage units. The Board concluded that should be a matter of judgement by an entity".*<br><br>The IASB Illustrative Example for IFRS 17 IE 17(e) illustrates how the time value of money could be considered when the CSM is allocated, and notes that: *"The entity could achieve the objective of the recognition of the contractual service margin on the basis of the coverage units using a different pattern. For example, the entity could allocate equally in each period the contractual service margin including the total interest expected to be accreted over the coverage period".* |

**Example – Determining the release pattern of the contractual service margin**

*This example illustrates one of the possible interpretations of the requirements related to treatment of coverage units. Other interpretations of the requirements might also be acceptable.*

The CSM at the end of the reporting period, after all adjustments other than the release of the CSM to revenue, is CU1,000. At the end of the period, there are two contracts in force in a group, and neither contract contains an investment component. Presented below is the information about benefits and remaining coverage periods for those contracts:

| | Maximum amount payable to the policyholder if insured event occurs | Number of coverage periods including reporting period (expected duration) |
|---|---|---|
| Contract 1 | CU100,000 | 3 |
| Contract 2 | CU150,000 | 2 |

The number of coverage units and the allocation of the CSM between current period and future periods could be calculated as follows:

| | Current period | Future period 1 | Future period 2 | Total |
|---|---|---|---|---|
| Contract 1 | CU100,000 | CU100,000 | CU100,000 | CU300,000 |
| Contract 2 | CU150,000 | CU150,000 | - | CU300,000 |
| Total | CU250,000 | CU350,000 | | CU600,000 |
| | 42% | 58% | | 100% |
| Allocation of CSM | CU420 | CU580 | | CU1,000 |

## 3. What are insurance contract services?

Insurance contract services are the only services that an entity considers when determining coverage units and hence the recognition of the CSM in profit or loss. They are defined in IFRS 17 as *"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)."*

IFRS 17 applies to investment contracts with discretionary participation features as well as to insurance contracts. Such contracts do not provide insurance coverage, but they do provide investment services. IFRS 17 has specific requirements for the allocation of CSM for such contracts, requiring the entity to recognise the CSM over the duration of the group of contracts in a systematic way that reflects the transfer of investment services under the contract.

Each type of insurance contract service is discussed further below.

### 3.1 Insurance coverage

All insurance contracts provide insurance coverage. Insurance coverage is the service that an entity provides by standing ready to pay valid insurance claims that arise within the period covered by an insurance contract. Because a policyholder benefits from the entity standing ready to meet valid insurance claims, and not just from making a claim if an insured event occurs, the amount of insurance coverage provided, and thus the quantity of benefits, relates to the amounts that could be claimed by the policyholder in each period if there were a valid claim. In other words, an insurer provides insurance coverage over the whole of the coverage period, and not just when the insurer incurs a claim. This means that an entity should recognise CSM relating to the insurance coverage in each period that the coverage is provided. Judgement needs to be applied to determine the method that best reflects the insurance benefit provided, because 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, provided that they achieve the objective of reflecting the insurance benefits provided in each period.

For insurance coverage, a reasonable proxy for the benefits provided under the group of insurance contracts in each period for insurance coverage might be based on the maximum contractual cover in each period or on the amount that the entity expects the policyholder to be able to validly claim in each period if an insured event occurs.

| FAQ on coverage units for insurance coverage | |
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| 3.1.1 Can methods that reflect the performance of assets that an entity holds to back insurance contracts be considered in determining benefit for insurance coverage where the amounts paid under the contracts do not depend on the returns on the assets? | No. The quantity of benefits relating to insurance coverage cannot be affected by the performance of any of the entity's assets. The quantity of benefits provided under insurance coverage depends solely on the insurance benefits provided. |

The period in which an entity provides insurance coverage is not necessarily the same as the period in which the entity bears insurance risk. For example, consider a contract in which a policyholder pays premiums during an accumulation phase. At a date in the future, the policyholder will be entitled to convert the amount accumulated and the associated investment returns into an annuity at a guaranteed annuity conversion rate. The policyholder might not be able to make a valid insurance claim under the contract until the annuity payments become payable. However, the entity bears insurance risk throughout the whole period that the

contract exists (that is, during the accumulation phase and the annuity phase). The service of insurance coverage is provided only in the period that the policyholder is able to make a valid claim (that is, during the annuity phase).

### 3.2 Investment-related service

Investment-related service is defined as *"the management of underlying items on behalf of the policyholder"*. An investment-related service can be provided only by a contract that meets the definition of an insurance contract with direct participation features. Therefore, an investment-related service is provided only for contracts that are substantially investment-related service contracts.

Applying paragraph B119A of IFRS 17, for the purpose of determining the amount of CSM to be allocated to profit or loss in the period, the period of investment-related service should be regarded as ending at or before the date when all amounts due to current policyholders relating to those services have been paid, without considering payments to future policyholders included in the fulfilment cash flows applying paragraph B68[1] of IFRS 17. This means that the period of investment-related service could end before the entity has paid all of the cash flows relating to the contract.

| FAQ on determining the pattern of investment-related services | |
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| 3.2.1 What methods could be considered reasonable proxies for determining the investment-related services provided under a group of insurance contracts? | For investment-related services, the following methods could be considered reasonable proxies for the services provided under a group of insurance contracts in each period that investment-related services are provided:<br><br>● Using the amount of assets under management. A practical approach for assessing the quantity of benefits for investment-related services is to use the quantity of assets being managed for the policyholder under the contract.<br>● Using the expected investment return to be earned in each period on assets being managed by the insurer.<br><br>Where a contract provides substantive financial guarantees, the amount of service varies depending on the likelihood that the guarantee would be called on (which depends on facts such as current market interest rates, minimum guarantee return of the products, historical actual pay-out rates, and other facts and circumstances). It is unlikely that the provision of investment-related service in a contract with substantive financial guarantees would be provided on a straight-line basis. |

[1] Paragraph B68 states that the fulfilment cash flows of each group reflect the extent to which the contracts in the group cause the entity to be affected by the expected cash flows, whether to policyholders in that group or to policyholders in another group.

### 3.3 Investment-return service

Investment-return service is defined as *"the generation of an investment return for the policyholder"*. An investment-return service can only exist in insurance contracts that do not have direct participation features.

An investment-return service provides a policyholder with the right to benefit from an investment return, which is generated by the entity's investment activity. That right provides the policyholder with access to an investment return that would not otherwise be available to the policyholder because of the amounts invested, liquidity, complexity and expertise.

Paragraph B119B of IFRS 17 specifies the following conditions that must be met if an entity is to conclude that an investment-return service is provided by a contract:

- An investment component exists, or the policyholder has a right to withdraw an amount. In IFRS 17, a right to withdraw an amount from the entity includes a policyholder's right to a surrender value or premium refund on cancellation of a policy and a policyholder's right to transfer an amount to another insurance provider.
- The entity expects the investment component or amount that the policyholder has a right to withdraw to include an investment return (an investment return could be below zero, for example, in a negative interest rate environment).
- The entity expects to perform investment activity to generate that investment return.

However, those conditions are not determinative. In other words, an investment-return service might not be provided by a contract, even if those conditions are met. The criteria in paragraph B119B set out the minimum requirements for an investment-return service to be present, but they still require an entity to exercise judgement in determining whether the contract provides such service, considering individual facts and circumstances.

For an investment-return service to exist, the policyholder needs to benefit from an investment return, which is generated by the entity's investment activity. Therefore, an investment-return service exists only where there is an investment component or a right for the policyholder to withdraw an amount from the entity. An investment-return service does not exist where an entity provides only custodial services relating to an investment component, or a contract provides the policyholder with a right to a refund of premiums paid in advance for future service, if that refund is not enhanced by an investment return.

As for the investment-related service in section 3.2, paragraph B119A of IFRS 17 specifies that the period of investment-related service should be regarded as ending at or before the date when all amounts due to current policyholders relating to those services have been paid for the purpose of determining the allocation of the CSM.

| FAQs on investment-return service | |
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| 3.3.1 Can an investment-return service be provided in a contract that does not contain an investment component? | Yes. An investment-return service could be provided in some insurance contracts that do not include an investment component, if those contracts require the entity to repay amounts to the policyholder in specified circumstances and those payments give the policyholder the right to benefit from investment returns if those payments are made. |
| 3.3.2 What methods could be considered reasonable proxies for determining the investment-return services provided under a group of insurance contracts? | For investment-return services, the following methods could be considered reasonable proxies for the services provided under a group of insurance contracts in each period that investment services are provided:<br><br>● Using the amount of assets under management or that an entity has a right to withdraw, where such amounts reflect the level of investment-return service. Such amounts could include a transfer value or surrender value.<br>● Using the expected investment return to be earned in each period.<br>● Using the stand ready obligation to provide access to investments and access to investment opportunities not otherwise available. Although the activity related to that service might vary over time, the service could in some cases be considered to be provided evenly over time.<br><br>Where a contract provides substantive financial guarantees, the amount of service varies depending on the likelihood that the guarantee would be called on (which depends on facts such as current market interest rates, minimum guarantee return of the products, historical actual pay-out rates, and other facts and circumstances). It is unlikely that the provision of investment-return service in a contract with substantive financial guarantees would be provided on a straight-line basis. |

## 4. How are coverage units identified?

Paragraph B119(a) of IFRS 17 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.

### 4.1 Coverage units and the quantity of benefits

IFRS 17 does not specify a particular method or methods to determine the quantity of benefits provided under a contract. Different methods could achieve the objective of reflecting the benefits provided in each period, depending on facts and circumstances. However, the quantity of benefits, and hence the number of coverage units allocated to the services relating to those benefits, should reflect:

- The benefits expected to be received by the policyholder, not the costs that the entity expects to incur in providing those benefits.
- The expected duration of the contracts, because this is the time over which the benefits are expected to be provided. This means that expectations of lapses of contracts, which affect the expected duration of benefits, are included in the determination of coverage units.
- The extent to which the contracts in the group contractually provide different levels of benefits across periods. This is consistent with the objective of coverage units, which is to reflect the insurance benefits provided in each period. Thus, different levels of benefits across periods should be reflected in the determination of coverage units.

The quantity of benefits provided by a contract, and hence the number of coverage units allocated to the services relating to those benefits, reflects the probability of events occurring in different ways:

- The probability of insured events occurring affects the quantity of benefits only to the extent that the probability affects the expected duration of coverage for contracts in the group. For example, consider a 25-year term life contract. The probability of death during the term affects the expected duration of coverage for the contracts and hence the quantity of insurance coverage that is provided by the contract.
- Different probabilities of different types of insured event occurring might affect the weighting applied in determining coverage units arising from service relating to different types of insured event, because they affect the extent to which the entity stands ready to meet valid claims for the different types of insured event. For example, consider a contract that provides coverage against two types of insured event: one event is likely to arise 1 in 100 times, and the other event is likely to arise 1 in 10 million times. The weighting applicable to determining the service arising from the entity standing ready to meet valid claims is greater for the 1-in-100 event compared to the 1-in-10 million event.
- To the extent that the probability of an insured event occurring affects the amount expected to be claimed in each period, that probability does not affect the pattern of allocation of coverage units recognised in those periods. This is because different probabilities of an insured event occurring in different periods do not affect the benefit provided in those periods of the entity standing ready to meet valid claims for that insured event. For example, consider a contract in which an entity stands ready to pay valid claims if an insured event happens within five years. The coverage provided by the entity is the same throughout the five years. It is not affected by the probability of when, within the five years, the claim is likely to occur.

| FAQs on determining quantity of benefits and coverage units | |
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| 4.1.1 Can coverage units be based on expected claims (or other expected cash flows)? | No, coverage units cannot be based on expected claims or other expected cash flows, unless expected claims can be demonstrated to be a reasonable proxy for the service provided under the group of insurance contracts for each period. The likelihood of insurance events occurring in a period should not dictate the quantity of benefits provided, given that an entity is standing ready to provide coverage, regardless of the claims expected to be incurred in a period.<br><br>Paragraph 35(h)(v) of the meeting summary for the May 2018 TRG meeting notes that methods based on expected cash flows might achieve the objective of the standard in some circumstances, but they would not do so if they result in no allocation of the CSM to periods in which the entity is standing ready to meet valid claims. |
| 4.1.2 Is the pattern of expected cash flows or the release of the risk adjustment for non-financial risk relevant in determining coverage units for insurance coverage? | No. Paragraph BC 279 of the Basis for Conclusions on IFRS 17 explains that the pattern of expected cash flows and the release of the risk adjustment for non-financial risk are not relevant factors in determining the provision of coverage, which is provided over the whole of the coverage period, and not just when the entity incurs a claim. They are already included in the measurement of the fulfilment cash flows and do not need to be considered in the allocation of the CSM.<br><br>Since the risk and expected cash flows should not be considered, the pattern of the CSM release for life insurance contracts based on mortality tables is not acceptable. |
| 4.1.3 Are methods based on premiums permitted in determining coverage units for insurance coverage? | No, unless those methods are reasonable proxies for the service provided by the entity in each period. Premiums will not be reasonable proxies, when comparing services across periods, if they are receivable in different periods to those in which insurance services are provided, or reflect different probabilities of claims for the same type of insured event in different periods rather than different levels of service of standing ready to meet claims. Additionally, premiums will not be reasonable proxies, when comparing contracts in a group, if the premiums reflect different levels of profitability in contracts. The level of profitability in a contract does not affect the services provided by the contract. |
| 4.1.4 Could methods based on cash flows be considered reasonable proxies for the benefits provided under the group of insurance contracts in each period? | No, unless those methods are reasonable proxies for the service provided by the entity in each period.<br><br>Methods that result in no allocation of the CSM to periods in which the entity is standing ready to meet valid claims do not meet the objective. |

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| 4.1.5 What are possible methods for determining the quantity of benefits related to insurance coverage? | Possible methods for determining the quantity of benefits provided under an insurance contract could, if they are reasonable proxies for insurance coverage provided in each period, include but are not limited to the use of:<br>● a straight-line allocation over the passage of time, but reflecting the number of contracts in a group;<br>● a method based on the maximum contractual cover in each period; and<br>● the amount that the entity expects the policyholder to be able to validly claim in each period if an insured event occurs. |
| 4.1.6 Should different levels of cover provided by a contract in different periods be reflected in determining coverage units? | Yes. Agenda paper 5 for the February 2018 TRG meeting explains that 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, and 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. |

Examples of coverage units for some life insurance contracts that could meet the requirements in IFRS 17 are set out in the Appendix.

**4.2 Allocating coverage units where there is more than one type of benefit**

Contracts in a group might provide different types of benefit. For example, a contract might provide insurance cover with a maximum limit together with insurance cover with no maximum limit, insurance coverage together with an investment-return service or insurance coverage with investment-related service. The amount of investment-return or investment-related service might also differ in different phases of a contract. For such contracts, the service provided for each type of insurance contract service will need to be weighted, to allow allocation of the CSM in a meaningful way.

IFRS 17 provides little specific guidance in this area, and it does not prescribe a single method for reflecting the insurance contract services provided under the group of insurance contracts in each period. Thus the allocation of the weighting of insurance contract services provided by each of the different insurance contract services in a group will require the application of judgement by the entity.

When determining the most appropriate weighting of insurance contract services where there is more than one insurance contract service being provided, the insurer should ensure that the method used results in:

- the identification of coverage units, and hence recognition of CSM for each period in which the policyholder benefits; thus, if an insurer provides insurance coverage in all periods, any method should result in the identification for each period of coverage units related to insurance coverage;
- no identification of coverage units or recognition of CSM related to a benefit that is not provided in a period; and
- no remaining coverage units relating to a benefit when the insurer has provided all of the related benefits.

Possible methods for weighting insurance contract services that an insurer might consider, if appropriate to the specific features of their groups of insurance contracts, include but are not limited to:

- using the amount of expected outflows (for example, claims and investment returns expected at inception) over the term of the insurance contract. This method ensures that the inclusion of a high monetary value, low likelihood benefit does not dominate the release of CSM, and reflects the extent to which an entity standing ready to meet valid claims for the different types of insured event reflects different amounts of service;

- using the stand-alone selling price for the individual services where available. This approach might be appropriate where such prices reflect the value of the services to policyholders; and
- for any given risk, using a combination of the amount of time for which the coverage is provided and the maximum amount available for policyholders to claim. This reflects that more service is provided when a given benefit is provided for a longer period, and that more service is provided when higher amounts are available for policyholders to claim.

These methods might not reflect the service provided by different benefits in all cases. In considering these or other methods, the insurer needs to apply judgement to determine whether the method for weighting insurance contract services reflects the services provided by the contract.

| **FAQs on determining coverage units where there is more than one type of benefit** | |
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| 4.2.1 How should coverage units be defined for contracts in a group with different types of benefit? | Paragraph 18 of agenda paper 5 of the May 2018 TRG meeting states that, where contracts provide different benefits, an entity will require a method to compare the different benefits attributable to each component in the contract. This will require the application of judgement by the entity. As one example, paragraph B42(c) of agenda paper 5 of the May 2018 TRG meeting suggests allocating the quantity of benefits for each contract within the group based on the sum of all of the levels of cover provided within the different contracts. For example, if contract A within a group provides for CU2,000 accidental death cover, CU1,000 cancer diagnosis, CU500 surgery, and CU50 of in-patient treatment, the coverage units for contract A would be CU3,550. If contract B provides only CU1,000 cancer diagnosis and CU500 surgery, the coverage units for contract B would be CU1,500. However, in certain instances, merely adding up the coverages of the individual components might not meet the objective of allocating CSM based on benefits provided, and therefore it might not be appropriate.<br><br>In the case of contracts that combine insurance coverage with investment-related or investment-return services, judgement is also required to define coverage units relating to the benefits arising from the two different types of benefit. |
| 4.2.2 Can an entity divide a group of contracts into 'subgroups' and allocate the CSM between the coverage units assigned to each subgroup? | No, unless determining CSM based on the initial fulfilment cash flows at a subgroup level and aggregating to a group results in:<br><br>● the allocation of the CSM equally to each coverage unit in the group; it should be noted that this will only be the case if the CSMs determined for each benefit provided by the group are proportionate to the quantity of coverage provided by that group; and<br>● a change in estimate that adjusts the CSM of the group is applied equally to each coverage unit in the group.<br><br>Paragraph B119(b) of IFRS 17 requires the CSM for a group of contracts to be divided equally between coverage units. |

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| 4.2.3 How should the quantity of benefits and expected coverage duration be established in situations where an incurred claim results in insurance risk that would not exist if no claim were made (for example, insurance coverage for disability that provides an annuity for the period in which the policyholder is disabled, or insurance coverage for fire damage that provides compensation for the uncertain cost of restoring or rebuilding a house after a fire)? | The definition of coverage units for these types of product is dependent on the definition of an insured event. This was discussed in agenda paper 1 of the September 2018 TRG meeting, with the following views for the example of the disability product (the illustration for the fire coverage product is shown in the TRG paper):<br><br>● *View A* – the insured event is the uncertain event that a policyholder becomes disabled because of the occurrence of an accident/illness. The coverage period is the period in which a policyholder can make a valid claim for becoming disabled due to an accident/illness.<br>● *View B* – the insured events are the uncertain event of the policyholder becoming disabled following an accident/illness in the period specified in the contract, and the uncertain event of the policyholder remaining disabled and eligible to claim. The coverage period is the period in which a policyholder might be eligible to make a claim for being disabled.<br><br>The meeting summary for that meeting noted that the TRG observed that the definitions of IFRS 17 allow an entity to use judgement when determining whether the obligation to pay an annuity after a disability event and the obligation to pay the costs of rebuilding a house after a fire event are part of a liability for remaining coverage or a liability for incurred claims. Thus, it is a matter of judgement for an entity to develop an accounting policy that reflects the insurance service provided by the entity to the policyholder under the contract in accordance with IFRS 17. The paper for the TRG meeting notes that this judgement will be influenced by:<br><br>● the complexity of the approach; and<br>● comparability with other products in the market.<br><br>In accordance with IAS 8, an entity is required to apply accounting policies consistently for similar transactions, other events and conditions. For example, the same approach should be applied to contracts of the same product type or with a similar insurance benefit. An entity might adopt different policies for, say, disability products and fire insurance products. However, different accounting policies could not be applied to the same products offered in different geographies. |

**PwC Observation:**

IFRS 17 provides little specific guidance for allocating the weighting of insurance contract services provided by each of the different insurance contract services in a group. Thus, the allocation will require the application of judgement by the entity. One way to allocate insurance contract services could be to determine an amount for the units of each service separately, based on the sum assured, and to weight those units of service according to the quantity of benefits provided, determined based on expected present value of future cash outflows. However, other methods are also possible.

**Example – weighting service where there is more than one type of benefit**

Consider a group of contracts that provides insurance coverage and investment-return service. The CSM for the group of contracts is CU750. The entity has determined that the insurance coverage is provided over five years and generates 1,000 units of insurance coverage service each period (that is, 5,000 units of insurance coverage service in total), while the investment-return services generate 125 units of investment-return service each period over 10 years (that is, 1,250 units of investment-return service in total). The entity also determines that the expected present value of future cash outflows over the whole contract term from the insurance coverage service and investment-return service is CU2,000 and CU1,000, respectively.

One method for weighting the units of service, and recognising CSM in profit or loss, could be as follows.

*At inception*

In order to combine the units of service determined for each insurance contract service in a meaningful way, the units of service need to be weighted to ensure that each coverage unit provides an equivalent amount of service. The insurer applied judgement and determined that the expected present value of future cash outflows represents an appropriate way of deriving the weighting in this example.

Each unit of service of insurance coverage is expected to result in CU0.4 of expected future cash outflows (being CU2,000 / 5,000 units of insurance coverage service), while each unit of investment-return service is expected to result in CU0.8 of expected future outflows (being CU1,000 / 1,250). Accordingly, the insurer concludes that each unit of investment-return services needs to be multiplied by a factor of 2 to also give CU0.4 (CU1,000 / (1,250 × 2)) of expected future cash outflows, consistent with each unit of insurance coverage service.

The coverage units and CSM at initial recognition have the following pattern:

| Benefit | Years 1–5 | Years 6–10 | Total |
|---|---|---|---|
| Insurance coverage | 1,000 | - | 5,000 |
| Investment-return service (unadjusted) | 125 | 125 | 1,250 |
| Weighting factor | 2 | 2 | |
| Investment-return service (weighted) | 250 | 250 | 2,500 |
| Total coverage units | 1,250 | 250 | 7,500 |

Since the CSM is CU750, this means that the application of paragraph B119(b) of IFRS 17 results in each coverage unit being allocated a CSM of CU0.1.

*Year 1*

There are no changes in assumptions. The amount of CSM recognised in profit or loss in year 1 is as follows:

| Benefit | Opening coverage units | Coverage units provided in period | CSM recognised in period (CU0.1 per coverage unit) | Coverage units remaining to be provided |
|---|---|---|---|---|
| Insurance coverage | 5,000 | 1,000 | CU100 | 4,000 |
| Investment-return service | 2,500 | 250 | CU25 | 2,250 |
| Total | 7,500 | 1,250 | CU125 | 6,250 |

The closing balance of the CSM at the end of year 1 is CU625.

*Year 2*

Assume that, at the beginning of the second year, there is a change in estimate of cash outflows that reduces the CSM to CU500. There is no change in expected coverage units in any period. The CSM associated with each of the 6,250 remaining coverage units is therefore CU0.08[2]. Note that this is true regardless of whether the change in estimate of cash outflows can be attributed to only one of the benefits (for example, the change in estimate relates only to claims arising from insurance coverage).

The amount of CSM recognised in profit or loss in year 2 is as follows:

| Benefit | Opening coverage units | Coverage units provided in period | CSM recognised in period (CU0.8 per coverage unit) | Coverage units remaining to be provided |
|---|---|---|---|---|
| Insurance coverage | 4,000 | 1,000 | 80 | 3,000 |
| Investment-return service | 2,250 | 250 | 20 | 2,000 |
| Total | 6,250 | 1,250 | 100 | 5,000 |

The closing balance of the CSM at the end of year 2 is CU400.

## FAQ on weighting different services for determining coverage units

4.2.4 An insurer issues insurance contracts that contain multiple services (for example, both insurance services and investment-return services)

The different services need to be combined in order to apply paragraph B119 of IFRS 17. The insurer therefore determines relative weightings applicable for each type of service at initial recognition of the group of insurance contracts.

When an annual cohort is 'closed' (that is, no new contracts are added to the group), does the insurer need to update the relative weightings between the services in subsequent periods?

No. The purpose of weighting is to convert the services into comparable coverage units that can then be combined in a meaningful way. The weighting aims to identify the relative level of benefits provided for each type of service provided by the group of contracts.

The services to be provided to the group of policyholders are defined and specified in the contractual terms at inception. Unless there is a modification to the contractual terms of the group of contracts, there is no need to update the weighting applied to different types of services.

Nevertheless, IFRS 17 does not preclude an insurer from updating the weightings to reflect a change in expectations if they wish to do so. The method of estimation chosen should be applied consistently.

[2] CU500 / 6,250 = CU0.08.

## 5. Disclosure

As described in sections 3 and 4, the determination of the coverage units recognised in profit or loss is highly dependent on the entity's judgements and assumptions. Disclosures about those judgements is therefore particularly important to help users of financial statements understand the effect of those judgements and assumptions.

IFRS 17 requires extensive disclosure about insurance contracts, including qualitative and quantitative information about the amounts recognised in the financial statements for contracts within the scope of IFRS 17 and the significant judgements, and changes in those judgements, made when applying IFRS 17.

Those disclosures include disclosures about the methods used to measure insurance contracts and the processes for estimating the inputs to those methods, and changes in those methods and processes. In particular:

- Paragraph 109 requires an entity to disclose information about when the entity expects to recognise, in profit or loss, the CSM remaining at the end of a reporting period, quantitatively, in appropriate time bands.
- Paragraph 117(c)(v) specifically requires an entity to disclose the approach used to determine the relative weight of the benefits provided for insurance coverage and investment-return service (for insurance contracts without direct participation features) or insurance coverage and investment-related service (for insurance contracts with direct participation features).

In addition, the disclosure requirements of paragraph 125 of IAS 1 apply to assumptions that the entity makes about the future (which would include the future pattern of recognition of CSM), as follows:

*"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."*


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## Appendix – Examples of coverage units for life insurance contracts

*Examples of coverage units for different products that could meet the requirements in IFRS 17 are set out below, but they are not the only permissible approaches.*

| # | Contract | Benefits that the policyholder receives | Permissible approach to determining coverage units | Rationale |
|---|---|---|---|---|
| 1 | Level term assurance | Payment of a sum assured on death within a defined term. Sum assured is level throughout term. No surrender value payable. | Projected total sum assured in-force | This reflects the benefit that a policyholder can claim (rather than expectation of claim amounts), and the difference in size of different contracts within the group; and the expected coverage duration appropriately allows for expected decrements (lapses/deaths). |
| 2 | Decreasing term assurance | Payment of a sum assured on death within a defined term. Sum assured decreases over policy term. | Projected total sum assured in-force | In addition to the above, this recognises the expected change in level of coverage provided over time. |
| 3 | Immediate annuity (level) | Fixed annual payment for as long as the policyholder stays alive. Benefit is level throughout. | Projected annual annuity in-force | Similar to the projected sum assured in-force for the above products, the projected annuity in-force reflects the benefit that a policyholder can claim in each period and the expected coverage duration. |
| 4 | Immediate annuity (indexed) | Fixed annual payment for as long as the policyholder stays alive. Benefit increases – either at a fixed rate or according to an index (such as inflation). | Projected annual annuity in-force | Similar to the projected sum assured in-force for the above products, this recognises the expected change in level of coverage provided over time from benefit increases. |
| 5 | Joint life immediate annuity | Fixed annual payment for as long as the policyholder stays alive. On death, an immediate annuity with a reduced benefit (such as 50%) is paid to the spouse until their death. | Projected annual annuity in-force | In line with Examples 1 to 4, this reflects the duration over which coverage is provided, while recognising the expected change in level of coverage provided over time (that is, the continuation of a reduced benefit on death of the first life). |

| # | Contract | Benefits that the policyholder receives | Permissible approach to determining coverage units | Rationale |
|---|---|---|---|---|
| 6 | Deferred annuity with spouse benefit | After an initial accumulation phase / deferral period, fixed annual payment for as long as the policyholder stays alive. On death (during the accumulation / deferral period or payment phase), an immediate annuity with a reduced benefit (such as 50%) is paid to the spouse until death.<br><br>In this example, there is no investment component or right to withdraw during the accumulation / deferral phase. | During accumulation phase / deferral period:<br><br>● Projected policy count, weighted by spouse annuity (assume that all policies provide the same level of coverage)<br><br>Following accumulation phase / deferral period:<br><br>● Projected policy count, weighted by first life annuity | This is an example of a product where benefits change over the coverage duration of a policy, and so judgement is required to compare the different benefits and determine coverage units. There is no single answer for the appropriate weighting between these different benefits, but we would expect entities to provide justification for the judgement taken. The following is the rationale for the option presented here.<br><br>During deferral period/accumulation phase:<br><br>The entity is standing by, ready to pay the annual spouse annuity, in the following situations:<br>● where the first life and spouse are both in-force (that is, both are still alive) at the start of the period – a claim will arise if the first life dies during the period; and<br>● where the first life is not in-force at the start of the period (or not expected to be, where this relates to future periods), but the spouse is (that is, the spouse annuity has already begun).<br><br>Coverage units should reflect the expected number of policies in the above scenarios (that is, all policies where the spouse is expected to be alive). If the proportion of scenarios where the spouse is not alive can be shown to be immaterial, the projected policy count, weighted by the spouse annuity amount, could serve as a reasonable proxy.<br><br>Expected claims might not act as a reasonable proxy during the deferral period / accumulation phase, because they do not reflect all policies for which the entity is standing by, ready to pay a spouse annuity (that is, if the first life dies in the period).<br><br>Following the deferral period / accumulation phase:<br><br>The benefit consists of:<br>● the first life annuity payment – to all those first lives in-force (or expected to be); and<br>● the spouse annuity payment – to all those where the first life is not in-force (or expected to be), but the spouse is alive.<br><br>Following the accumulation phase / deferral period, coverage units are in line with the joint life annuity example (Example 5) above. |

| # | Contract | Benefits that the policyholder receives | Permissible approach to determining coverage units | Rationale |
|---|---|---|---|---|
| 7 | Longevity swap | Payment of actual claims on a portfolio of immediate annuities ('floating leg'), in exchange for 'fixed leg' of premiums received (often from a pension scheme in a 'buy-in' arrangement). | Projected annual annuity in-force | There is no difference in the quantity of benefits and coverage period between a group of immediate annuities (see Example 3) and a single contract that covers the same group (this example), nor between an immediate annuity with just one 'leg' (see Example 3) and a longevity swap with two 'legs'. |
| 8 | Income protection | Regular fixed payments to policyholders when sick and unable to work. Payments continue until the policyholder recovers and returns to work (beyond the term of the original policy, if necessary). | *View A*:<br><br>Quantity of benefit = Present Value of regular payments on claim inception<br>Coverage period = expected term of policy (allowing for lapses)<br><br>*View B*:<br><br>Quantity of benefit = fixed regular payment amount payable in each period<br><br>Coverage period = probability-weighted duration of claim payments | This is dependent on the definition of the insured event and incurred claim.<br><br>*View A*: The insured event is the policyholder *becoming* sick, so the coverage period is limited to the term of the policy.<br><br>*View B*: The insured event is the policyholder *continuing to be* sick. The coverage period is the probability-weighted duration of the expected claims (in line with Examples 3 to 5 above). |
| 9 | Conventional endowment (under the variable fee approach ('VFA')) | Regular and terminal bonuses added to initial sum assured (in line with underlying investment returns) and paid out on death or maturity. Surrender value paid out on policyholder surrender. | Projected total sum assured in-force (including expected bonuses) | As in example 15 in agenda paper 5 of the May 2018 TRG meeting:<br><br>*"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 (i.e. including the surrender value)."* |
| 10 | Unit-linked investment contract (say, an investment contract with discretionary participation features under the VFA) | Policyholders receive returns relative to a given index or underlying assets[1]. | Unit fund (funds under management / account balances) | For investment contracts with discretionary participation features, *"the entity shall recognise the contractual service margin over the duration of the group of contracts in a systematic way that reflects the transfer of investment services under the contract"*. [IFRS 17 para 71(c)].<br><br>The investment services relate to management of 100% of the unit fund. |

| # | Contract | Benefits that the policyholder receives | Permissible approach to determining coverage units | Rationale |
|---|---|---|---|---|
| 11 | Unit-linked savings product with death benefit for initial period (under the VFA) | Payment of a sum assured on death (such as 110% of the unit fund) within a defined period (for example, first five years of a 10-year policy). | Higher of death benefit and unit fund (that is, 110% of unit fund in the first five years, and unit fund balance thereafter) | Coverage should reflect both insurance and investment-related service during the initial period, and investment-related service provided following the initial period. Where benefits change over the coverage duration of a policy, judgement is required to compare the different benefits and to determine coverage units (per para 18 of agenda paper 5 of the May 2018 TRG meeting). There is no single answer for the appropriate weighting between these different benefits, but we would expect entities to provide justification for the judgement taken. |

[1] This might be within the scope of IFRS 17 for certain hybrid contracts where a policyholder can invest in participating (unitised with-profit) or unit-linked funds.

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190130-132255-EP-OS