IFRS in Focus

Second Transition Resource Group meeting discussing the implementation of IFRS 17 *Insurance Contracts*

Contents

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This *IFRS in Focus* summarises the meeting of the IFRS 17 Transition Resource Group (TRG) which took place on 2 May 2018.

Introduction

The TRG is a discussion forum established by the International Accounting Standards Board (IASB) to support the implementation of IFRS 17 *Insurance Contracts*. The purpose of the TRG is:

- To invite discussion and analysis of potential stakeholder issues arising from the implementation of the insurance Standard.
- To provide a public forum for stakeholders to learn about the new insurance accounting requirements.
- To help the IASB determine whether additional action is needed, such as providing clarification or issuing other guidance.

During the meeting, the TRG members share their views on the issues discussed, followed by a meeting summary issued by the IASB. Reflecting on the issues raised, the IASB will decide whether any action is required.

This was the second meeting where submissions to the group were discussed. The next meeting is scheduled for 26 September 2018.

See the IASB website for more information about the TRG, including agenda papers further describing the topics below.

Topic 1 – Combination of insurance contracts

Background

This paper considers in which circumstances it is appropriate to combine separate legal contracts and account for them as one insurance contract. The discussion continues from the issue raised at the February meeting which considered what circumstances would lead to separation of one legal contract into several insurance contracts for the purposes of applying IFRS 17. The principle is to report the substance of transactions. Accordingly, the decision to override the legal form of a separate contract and to combine several contracts into one insurance contract is not an accounting policy choice, but a matter of judgement. IFRS 17:9 states that a set or a series of insurance contracts with the same or a related counterparty may achieve, or be designed to achieve, an overall commercial effect. In order to report the substance of such contracts, it may be necessary to treat the set or series of contracts as a whole. While the Standard provides one example when it is appropriate to combine contracts, there could be other examples.

The TRG submission identifies the following factors that could indicate that a set or series of insurance contracts are in substance a single contract, noting that different views could be reached, depending on which factor is considered determinative:

a. The contracts are priced as a single risk.
b. The lapse of one contract changes the rights and obligations of the other contract(s).
c. Measuring the contracts separately would result in one/some of the contract(s) being onerous, whereas the combination measured as a whole is profitable.

In their analysis, the IASB staff observe that entering contracts at the same time is not in itself sufficient to conclude that they should be combined, and the decision involves significant judgement based on facts and circumstances.

The IASB staff considered the presence of a discount in itself to not be a decisive factor. Even if the entity offers a discount only when the contracts are issued together, the overall commercial effect of such contracts considered in combination may not be different to looking at them separately.

On the other hand, while no single factor is determinative in applying the judgement, the inability to measure one component without considering the other is an important consideration. This may be the case when there is interdependency of risks and cash flows and the contracts lapse together. When contracts lapse together it is a strong indication that they were designed to achieve an overall commercial effect and should be combined.

In considering interdependency, the staff is of the view that interdependency between risks exists where, for example, one risk offsets or reduces the other, as in the example of mortality and longevity risks. Such interdependency could be indicative that the contracts are designed to achieve an overall commercial effect.

Another indication of separate contracts designed to achieving an overall commercial effect is where contractual rights and obligations are different when considered individually and together, with an extreme scenario being a complete cancellation of rights and obligations, as in the example in IFRS 17.9.

See TRG agenda paper 1 for additional details.

Summary

The TRG members agreed with the principle that the accounting should reflect the substance of the contracts and the need to apply judgement to particular facts and circumstances. The majority of the TRG members expected consistency in considering questions of separation and combination of insurance contracts. Many welcomed the clarification around discount, by itself, not being a decisive factor. There was a general agreement that no single factor is considered to be determinative. Contracts designed to lapse together should not automatically carry a greater weight than other factors, but instead be considered in the context of particular facts and circumstances.

Some of the TRG members expressed concern that while the examples in the submission paper and IFRS 17:9 refer to contracts issued simultaneously, this is not analysed as one of the requirements for combining them. There may need to be a separate question submitted that considers whether, in the absence of explicit reference to contracts issued at the same time or in contemplation of each other, the application of the guidance on combining contracts could lead to divergent accounting treatments.

Topic 2 – Risk adjustment for non-financial risk in a group of entities

Background

This paper looks at the level of aggregation for determining the risk adjustment for non-financial risk:

a. In the individual financial statements of entities that are part of a consolidated group (i.e. parent and subsidiary entities that issue insurance contracts).
b. In the consolidated financial statements of the group of entities.

The entity does not charge the policyholder an explicit separate amount for bearing non-financial risk. Rather this is implicit within the overall actual amount charged by the entity.

IFRS 17.B88 states that the risk adjustment for non-financial risk reflects the amount of compensation that the entity would require for bearing the non-financial risk. This amount reflects the entity-specific perspective on the degree of diversification benefits available to it and its degree of risk aversion.

The submission asks whether it is possible to have different amounts of risk adjustment determined in the individual financial statements of the entity issuing insurance contracts that is part of the group and the consolidated financial statements. In other words, whether it is possible to consider diversification benefits available only at the group level, resulting in a lower amount of risk adjustment, either in the individual entity or in the consolidated financial statements.

The IASB staff view is that there is only one amount of risk adjustment that exists in both individual and consolidated financial statements in relation to the same insurance contracts issued. This amount reflects the single decision made by the entity that is party to the contract (i.e. the issuer of the insurance contract). In the staff's view, the decision is made at an individual entity level. Applying IFRS 17:B88, an entity shall only reflect a diversification benefit in the risk adjustment for non-financial risk to the extent that the diversification benefit has been included when determining the compensation the entity would require for bearing non-financial risk. Therefore, the degree of risk diversification that occurs at a level above the entity is required to be considered in the determination of the risk adjustment for non-financial risk if, and only if, it is considered when determining the compensation the entity would require for bearing the non-financial risk related to insurance contracts it issued. Otherwise, it must not be considered–neither in individual nor in consolidated financial statements.

See TRG Agenda paper 2 for additional details.

Summary

The majority of the TRG members welcomed the clarification that the entity issuing insurance contracts can take into account diversification benefits available only at the group level if that is what it considers in determining the compensation it requires for bearing non-financial risk.

The TRG members agreed that the determination of a risk adjustment is not an accounting policy choice, but reflects the actual compensation the entity requires for bearing uncertainty. In considering compensation the views were split on whether the amount the entity would 'charge' in IFRS 17:B87 refers to pricing or to the issuer's cost, and accordingly, whether the risk adjustment relates to the single decision made by the issuer of the contract at its inception. Many TRG members viewed the risk adjustment for non-financial risk as an element of cost for bearing uncertainty, referring to IFRS 17:B91. In particular, they highlighted that the risk adjustment changes over time and, for contracts accounted under the premium allocation approach (PAA), it is not determined until claims occur, at which point any pricing decisions are irrelevant. In estimating the risk adjustment, it was agreed that the focus is on the 'compensation' the entity requires. This may not always be evidenced by the premiums charged, and may be evidenced by the capital required to be carried.

However, the TRG members were split on the level at which the risk adjustment for non-financial risk is determined in the consolidated financial statements. Many preferred a more flexible approach and were uncomfortable with the staff view that for the same group of insurance contracts the risk adjustment is always the same, regardless of the level of consolidation for financial reporting purposes. References were made to the Australian market where the risk adjustment is already reported and varies at different reporting levels. In particular, the TRG members read differently the reference to the 'entity' in the definition, with some taking it to mean 'reporting entity' and others – 'an issuing entity party to the contract'. If the risk adjustment is determined from the perspective of the reporting entity, then in many cases the amounts determined at different levels of consolidation would be different. Even the application of the same confidence level to different probability distributions of the same risk at individual and consolidated levels may give rise to different risk adjustment amounts.

Topic 3 – Cash flows within the contract boundary

Background

IFRS 17:B64 provides guidance on IFRS 17:34 and requires that, when assessing whether at a renewal date an entity has the practical ability to set a price that fully reflects the risks in the contract or portfolio, the entity shall consider all the risks that it would consider when underwriting equivalent contracts on the renewal date for the remaining coverage. Two questions have been asked following the previous TRG meeting.

Sources of constraints on an entity's practical ability to reprice the risks

The first question is which constraints or limitations, other than those arising from the terms of an insurance contract, would be relevant in assessing the entity's practical ability to reassess and reprice the risks/level of benefits for a particular policy holder (or the portfolio of insurance contracts that contains the contract). Examples considered are regulatory, commercial pressures and reputational risks, among others. With regards to market competitiveness being a constraint there are two potential views:

- View A – commercial considerations may not be relevant when considering the requirements in IFRS 17:34, since competitive market pressure is likely to apply equally to new and existing contracts.

- View B – commercial considerations might be relevant when considering the requirements in IFRS 17:34, since market pressure may prevent the entity from fully repricing existing riskier-than-average contracts, compared to equivalent new contracts with the same risks.

The IASB staff view is that constraints are irrelevant to the contract boundary assessment if they equally apply to new and existing policyholders in the same market (IFRS 17:B64).

Legal and regulatory constraints need to be considered because they affect the entity's substantive rights and obligations, unless they relate to terms that have no commercial substance (IFRS 17:2, B61).

In analysing pricing constraints, the entity needs to consider whether it is also prevented from changing the level of benefits, either for a contract or a portfolio as a whole.

IFRS 17 uses the term 'practical ability' and does not specify the sources of pricing constraints, not limiting them to contractual, legal and regulatory constraints. Market competitiveness and commercial considerations are factors typically considered in pricing and repricing decisions. However, as already mentioned, constraints applicable equally to new and existing contracts are ignored and a distinction is made between a constraint that limits an entity's practical ability to reassess and reprice the risks from an entity's choice or pricing decision that may not limit it.

Options to add future coverage

The second question is how to determine the contract boundary of insurance contracts that include an option to add insurance coverage at a future date, where the entity is obligated to provide additional coverage if the policy holder exercises the option. The submitted fact pattern distinguishes between additional coverage options with the premium agreed at inception of the base contract (without the ability to change) and options with premium not agreed until such options are exercised.

There are two potential views submitted:

- View A – the additional coverage option is a feature of the insurance contract with the resulting cash flows included in the contract boundary at initial recognition. The measurement of the group of insurance contracts reflects the entity's estimate of policyholder behaviour.

- View B – the entity's practical ability to set the premiums for additional coverage reflecting policyholder's risks at the time the option is taken means that the option is outside the contract boundary of the original contract until it is exercised. When the policyholder exercises the option the entity would either (i) change the estimate of the fulfilment cash flows of the original contract (effectively reassessing the boundary of the original contract) or (ii) treat the entire contract (original and new addition) as a new contract.

The IASB staff view is that from the date of initial recognition, the original contract includes the additional coverage option, unless it is required to be separated in order to reflect the economic substance of transactions (see discussion of contract separation at the February TRG meeting). The cash flows from the option are within the contractual boundary of the original contract up to the point that the entity is able to fully reprice the whole contract (IFRS 17:34). Where the additional premium from the option is guaranteed by the entity without the ability to reprice, the Standard is clear that all the cash flows are within the contractual boundary of the original contract. (This would reflect View A above). For an additional coverage option with the premium determined only on its exercise, all the subsequent cash flows relating to both the base contract and the option are outside the original contract's boundary (resulting in a new contract), if at that point the entity is able to reprice the whole contract to fully reflect policyholder risks. If the entity cannot reprice the whole contract, then the cash flows from the option would be within the boundary of the original contract. The exercise of an optional right present in the terms of the original contract is not a modification, whereas changes of the original contract that include new options to add additional coverage are and should follow the guidance in IFRS 17:72-73.

See TRG Agenda paper 3 for additional details.

Summary
The TRG members agreed with the staff view that constraints on the entity's practical ability to reprice can only exist, if they apply solely to existing contracts. Analysing commercial considerations requires the exercise of judgement in determining which of them result in a constraint.

As regards the question on whether to separate the additional coverage option, the focus should be on the entity's present substantive obligation, with its end indicating the contractual boundary. The future ability to reprice the whole contract, including the option, is not the only indication of there being no substantive obligation. In the submission paper the option for future coverage is assumed to result in the present substantive rights and obligations for the issuer. Some TRG members are of the view that the future coverage option is outside the contract boundary and does not contain a present substantive obligation for the issuer if there is no practical constraint (including from commercial considerations) on its future premium, even if the issuer cannot reprice the whole contract.

Topic 4 – Boundary of reinsurance contracts held with repricing mechanisms

Background
The measurement of a group of insurance contracts includes all the cash flows within the contractual boundary that arise from the entity's substantive contractual rights and obligations (IFRS 17:33-34).

For reinsurance contracts held, as discussed at the February TRG meeting, the contractual boundary ends when both of the following criteria are met:

- The entity no longer has the substantive right to receive services from the reinsurer.
- The entity no longer has the substantive obligation to pay amounts to the reinsurer.

The submission asks how the boundary of a reinsurance contract held should be determined when the reinsurer has the right to reprice the remaining coverage prospectively, but the entity is compelled to continue paying premiums if the reinsurer chooses not to exercise its repricing right. If the reinsurer does reprice, the entity has the right to terminate the remaining coverage. Such features often allow the reinsurer to reprice the contract at three months' notice. For the reinsurer, the contractual boundary would end at that three months repricing point (as was discussed at the February TRG meeting).

For the holder of the reinsurance contract the submission presents two views:

- View A – the entity has a substantive obligation to pay premiums to the reinsurer for the full duration of the underlying contracts. Therefore, the contract boundary would reflect the full duration of the underlying contracts. The projected future cash flows of the reinsurance contract held could (if considered to be best estimate) reflect assumptions including future premium adjustments and recapture decisions.

- View B–the contract boundary should end at the first point at which the reinsurer has the right to increase premium rates, as the holder of the contract has no substantive right to receive service beyond such date.

The IASB staff supported View A because in determining the contractual boundary an entity needs to consider both the end of its substantive right and substantive obligation. The reinsurer's right to terminate coverage, being outside the entity's control, is ignored, and the entity has an unavoidable obligation to pay premiums continuing for the entire contractual term. The entity reflects its expectations about the amount and timing of future cash flows, including the probability of the reinsurer repricing the contract in the fulfilment of cash flows.

See TRG Agenda paper 4 for additional details.

Summary
All TRG members agreed with the staff view. Although the submission considered a limited scope example, it illustrates the principle that in determining the contract boundary the entity is required to consider both sides: no longer having substantive rights and no longer having substantive obligations.

Topic 5 – Determining the quantity of benefits for identifying coverage units

Background
The estimation of total coverage units and their allocation to each part of the coverage period is necessary to depict the transfer of insurance service. This determines the release of the contractual service margin (CSM) during the period and affects the recognition of insurance revenue. For a group of insurance contracts, the total number of coverage units depends on each contract's quantity of benefits provided and expected duration of coverage. (IFRS 17:B119)

This paper continues from the discussion started at the February TRG meeting about the quantity of benefits provided by insurance contracts. There are 14 examples, analysed by the IASB staff, illustrating the application of the principles to both contracts with and without investment components (Appendix B and C of the paper).

Following on from the February meeting, the paper includes the following observations of the TRG members:

- Coverage units reflect the likelihood of insured events occurring only to the extent it affects contracts' expected duration; and

- Coverage units do not reflect the probability of insured events occurring to the extent it affects expected claim amounts.

Further observations of the IASB staff:

- The release of CSM is not the only driver of insurance service result, as it depends also on the release of risk adjustment for non-financial risk and on the experience adjustments.

- The period during which an entity bears insurance risk does not necessarily correspond with the coverage period and the provision of insurance service. For example, the contract's initial recognition starts at the earlier of the beginning of the coverage period, receipt of payment or a contract becoming onerous.

- When different contracts in the group provide different types of benefits, there is a need for a method of comparing them, as well as, determining how the benefits change over the term of the coverage period. Such comparison would require the exercise of judgement. This is illustrated by Examples 11 in Appendix B and 14-16 in Appendix C of the paper (discussed below).

- The expectations of lapses are considered in determining coverage units because they affect expected duration of coverage.

- The estimation of coverage units is not an accounting policy choice but involves judgement in determining the provision of service in a systematic and rational way.

Insurance contracts without investment components

The implicit principle in IFRS 17:B119 is that the determination of quantity of benefits should reflect different levels of cover across periods. The benefit to a policyholder is the entity standing ready to meet a valid claim. The change in the levels of cover could be expressed by considering maximum cover in each period. However, some contracts do not specify maximum cover. In addition, sometimes a policyholder cannot make a valid claim up to the contract's maximum cover amount in some of the periods, making it less relevant to the determination of coverage units.

Principles in measuring the quantity of benefits provided (paragraph 30 of the agenda paper)

An amount of CSM has to be recognised in each period when insurance coverage services are provided by contracts in the group. Furthermore, the benefit is provided even when the entity stands ready but does not expect a claim to occur. The quantity of benefits depends on the amount that the policyholder can validly claim in each period, rather than on the probability of the claim occurring.

In the IASB staff view, possible methods of estimating quantity of benefits include maximum amount of cover available in each period or the amount the entity expects policyholder to be able to validly claim during each period (if an insured event occurs).

The following methods would not meet the objective:

- For insurance contracts without investment components, methods based on the performance of entity's assets;
- Methods resulting in no allocation of CSM to periods when the entity is standing ready to meet a valid claim;
- Methods based on premiums, unless they can be demonstrated to be a reasonable proxy for services provided by the entity in each period. For such methods to be considered appropriate when comparing services across periods:
  - The timing of premium payments must correspond with the provision of insurance service.
  - The different levels of premiums must reflect different levels of service of standing ready to meet claims rather than different probabilities of claims occurring in each period.

For such methods to be considered appropriate when comparing contracts in a group:

  - The different levels of premiums must reflect different levels of service of standing ready to meet claims rather than different levels of profitability among contracts.

- Methods based on expected cash flows, unless they can be demonstrated to be a reasonable proxy for services provided by the entity in each period. Such methods would not meet the objective if they reflect different probabilities of claims occurring rather than different levels of stand-ready service to meet a valid claim.

Insurance contracts with investment components

For insurance contracts with investment components the main consideration is whether any coverage units should be allocated to the provision of investment service.

The IASB staff view is that for direct participating contracts, known as variable fee approach contracts (VFA contracts), insurance contracts provide both insurance and investment service. Accordingly, for these contracts the recognition of CSM should reflect the provision of both services. For such contracts both the coverage period and the quantity of benefits include the provision of insurance and investment services.

Accordingly, when a VFA insurance contract provides minimum death benefits only for the first five out of ten policy years, the coverage period is considered to be ten years and the quantity of benefits, while a matter of judgement, should consider both the death benefit and investment components. (Example 14, Appendix C of the paper).

Whereas, for insurance contracts with investment components that are not VFA contracts, the service provided to the policyholder does not include investment service. This has impact on both the coverage period and the quantity of benefits provided. In the above example of a non-VFA life insurance contract provides minimum death benefits only for the first five out of ten policy years, the coverage period is only five years. (Example 14, Appendix C of the paper)

For non-VFA contracts, The IASB staff view is that the quantity of benefits provided, in theory, should exclude the investment components. This would be a possible approach, if the entity has reasonable and supportable information to do so. However, because the entity does not have to estimate investment components until claims occur, methods of estimating quantity of benefits would require judgement. (Examples 15-16, Appendix C of the paper).

See TRG Agenda paper 5 for additional details.

Summary

The principles the IASB staff developed, reproduced above, were considered useful in identifying the quantity of benefits provided by the variety of contracts. However, it was noted that the analysis of examples is very facts-specific and there is a risk in extrapolating from them the application of the principles to similar, but slightly different scenarios. The methods identified by the IASB staff are not the only methods of determining the quantity of benefits. Other methods may also be in line with the principles and meet the objective. However the method of estimation of the quantity of benefits provided by the contract is not a choice, and different methods may be appropriate to different facts and circumstances.

The IASB staff acknowledged that while the likelihood of a claim does not affect the policyholder's ability to make the claim, sometimes, the probability of a claim affecting the claim amount is an approximation of service, for example, when comparing benefits provided by different types of coverages within the same contract, or by different contracts within a group.

The estimation of coverage units should reflect the passage of time, but for many contracts the quantity of benefits varies over time, as well as there being variability across the contracts in the group. Therefore, while in some simple fact patterns, straight line would be an approximation of the quantity of benefits provided over time, for many other scenarios it would not be. Some TRG members considered this to be an extension of one overall principle that quantity of benefits depends on the amount that entity expects policyholder can validly claim in each period.

Instead of an outright rejection of methods based on the performance of the entity's assets or those methods that may result in no allocation of CSM in periods where the entity is standing ready to meet a valid claim, the IASB staff may consider when such methods might be appropriate. For example, one TRG member observed that it may be correct to have a method resulting in no allocation of the CSM in some periods, during which policyholder cannot make a valid claim. Another member observed that asset dependency in benefits may be present in a contract without an investment component, if the insured claim amount is linked to asset returns.

For VFA contracts, there was a general support for referring the matter to the IASB Board to consider including provision of investment services in the definition of coverage period and coverage units.

However, there was no TRG agreement with the IASB staff view that insurance contracts with investment components accounted for under the general model (also known as indirect participating contracts) provide no investment services.

TRG members highlighted that for such contracts up to 90% of the CSM on initial recognition reflects income from investment services. In their view, the recognition of this CSM over the coverage period determined by provision of insurance services alone misrepresents the entity's performance, especially when considering that on a probability-weighted basis, such contracts may have a relatively small amount of insurance risk, but still be in the scope of IFRS 17.

The TRG members highlighted that for indirect participating contracts, the reference in IFRS 17:B98 to an entity's discretion in allocating asset returns is considered to be relating to the provision of service, being investment service.

Furthermore, many TRG members were concerned with the different treatment of VFA and non-VFA indirect participating contracts, when economically they may be similar. Their differences are already reflected in a separate model of CSM unlocking for VFA contracts. The IASB staff view draws further distinction, resulting in two models of CSM release, for VFA and non-VFA contracts respectively, when this is not mentioned in IFRS 17:B119.

The IASB staff will present this issue to the IASB Board.

Topic 6 – Implementation challenges outreach report

Background

This paper looks at the implementation concerns associated with the following three topics, the accounting aspects of which were discussed at the February TRG meeting:

- Presentation of groups of insurance contracts in the statement of financial position and the need to present separately groups of contracts that are assets and groups of contracts that are liabilities.
- The need to track premiums received for a group of insurance contracts in order to record the liability for remaining coverage on application of the PAA.
- Subsequent treatment of insurance contracts acquired in their settlement period.

Level of aggregation for presentation in the statement of financial position (including the contracts measured using the PAA)

In the statement of financial position, entities are required to present separately the carrying amount of groups of insurance contracts issued that are assets and those that are liabilities (IFRS 17:78). This requirement applies equally to all insurance contracts, including those measured using the PAA. Further, for disclosure, the group overall balance would need to be disaggregated into the liability for remaining coverage and the liability for incurred claims. This would require tracking actual cash movements at the group of insurance contracts level, including the identification of premiums received and claims incurred and may present a significant implementation challenge for some entities requiring change to their information systems.

It is noted that the challenge of identifying claims incurred at the group of insurance contract level maybe more relevant to non-life contracts, which tend to have long settlement periods.

Challenges in identifying premiums received

The challenge of tracking premiums received may be less relevant to life contracts with investment components where the coverage does not typically begin until the premium is received. For other contracts, whether tracking premiums received for the purpose of measuring the liability for remaining coverage under the PAA or for the purpose of presentation in the statement of financial position, the implementation challenges are similar.

In response, the IASB staff proposes to issue additional supporting material, but point out that IFRS 17 specifies the amounts to be reported and not the methodology of determining them. IFRS 17.24 allows estimates of fulfilment cash flows to be measured at a level higher than group or portfolio, provided they can be allocated to the group incorporating all reasonable and supportable information available to the entity without undue cost and effort.

Under existing practice, entities present gross amounts of premiums due to be received (sometimes on an accrual, rather than invoiced basis) and an amount of unearned premiums and regard these as important performance metrics that under IFRS 17 may either be lost or become alternative performance measures. The IASB staff suggestion is to provide information about exposures to financial and insurance risks arising from insurance contracts, as part of disclosures required by IFRS 17:121-132.

Treatment of contracts acquired during the settlement period
For contracts acquired in their settlement period, the insured event is the determination of the ultimate cost of the claim, and accordingly, the coverage period extends until the ultimate cost of claim is determined. Therefore, the settlement period for the issuer becomes the coverage period for the acquirer, and the liability for incurred claims of the issuer becomes the liability for remaining coverage of the acquirer. (IFRS 17:B5)

The implementation concerns arise from having to treat insurance contracts issued directly and those acquired differently, notably:

- Acquirer potentially having to apply the general model to acquired contracts, when had they been the issuer they may have applied the PAA.

- Acquirer having to recognise revenue for the acquired contracts in their settlement period, when they would not do so for similar contracts issued directly.

In particular, some entities have been expecting to apply the PAA to all their contracts and have not considered the requirements of the general model. In addition, it was discussed at the February TRG meeting that the same contracts are treated differently in the consolidated financial statements and the financial statements of the entity that has issued the contracts when the issuing entity is acquired by the group. The IASB staff suggestion is for entities to address some of the concerns through additional disclosures.

See TRG Agenda paper 6 for additional details.

Summary
The TRG members agreed that the outreach report accurately reflects the nature of the implementation challenges, but wished to emphasise their scale. In the view of the TRG members educational materials would not be enough to address their concerns. The issue of aggregating cash flows at a group level in order to determine whether it is a net asset or a net liability is one of the top three concerns for insurance entities. The cost involved in obtaining this information, does not, in the view of many TRG members, justify the benefit. Further, the issue may be relevant for reinsurers and for Lloyds syndicate entities, where the challenge of identifying these cash flows at a group level may be greater.

With regards to contracts acquired in their settlement period, contracts with a coverage period of greater than one year may still meet the criteria for the application of the PAA. For performance presentation, while accepting the need to record changes in initial expectations in the insurance service result, many TRG members questioned the validity of recording revenue for such contracts.

Topic 7 – Reporting on other questions submitted

Background
This paper summarises other 11 questions submitted to the TRG and summarises the discussion, if any, that accompanied them during the meeting. Not all of the issues summarised below prompted comments from the TRG members.

See TRG Agenda paper 7 for additional details.

The staff may consider publishing educational materials on these topics in the future to further support the implementation of IFRS 17.

Effective date

IFRS 17 is effective for reporting periods beginning on or after 1 January 2021 with early adoption permitted. It is applied retrospectively unless impracticable, in which case modified retrospective approach or the fair value approach is applied.

Next steps

The next TRG meeting will take place on 26 September 2018. The deadline for submissions of issues and comments is 20 July 2018, with earlier submissions allowing for earlier publication of agenda papers.

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