Question 1 – Relevant information for users (paragraphs BC13–BC50)	
Do you think that the proposed measurement model will produce relevant information that will help users of an insurer's financial statements to make economic decisions? Why or why not? If not, what changes do you recommend and why?	We believe that the proposed measurement model, with appropriate modifications, including those indicated herein, will provide useful information to the users of insurers' financial statements. We also believe that a single high quality international financial reporting standard will prove valuable to all stakeholders in this information.
Question 2 – Fulfilment cash flows (paragraphs 17(a) 22–25 B37–B66 and BC51)	Probability-weighted The application of the phrase 'probability-weighted' has been interpreted in several ways - in the extreme, requiring stochastic modeling for the timing and amount of all cash flows in an insurance contract, to the use of whatever is currently used to assess cash flows. While we agree with the concept underlying the derivation of expected values (mean), further explanation of the phrase may be warranted, that is, paragraph B39 might be expanded upon somewhat to clarify this concept, that is that it is expected to be expected value (mean) and capture any asymmetries in timing or amount (such as contractual options and guarantees). Expenses: In the Toronto discussion, a large majority of the members supported inclusion of the incremental acquisition costs relating to the portfolio, not to the contract. (a) A small minority supported inclusion of all acquisition costs. (b) The members' preference was evenly divided whether the general overheads should be excluded or not. The main reason for different preference on each issue seems to be as follows. In (a), including acquisition costs has effect only on initial measurement. It results in a decrease in the residual margin and also the total insurance contract liabilities. So the members seem to make more importance of prudence as required when we determine the insurance liabilities. The minority also seems

		to agree on that prudent standpoint, but they show a little more concern about the presented lower profitability of the new business that may be misleading to the users. In contrast, including general expenses does increase the future fulfillment cash flows. Although residual margin decreases similarly as in (a), the total insurance liability remains the same. So prudence is not as important. Furthermore, under the transition rules, since there is no residual margin to cover general expenses, there is concern about a misleading presentation as otherwise the residual margin would become larger. It seems there are no strong points for excluding general overheads other than that the IASB takes a strong position for excluding overheads because it is the usual accounting convention in most other measurements.
(a)	Do you agree that the measurement of an insurance contract should include the expected present value of the future cash outflows less future cash inflows that will arise as the insurer fulfils the insurance contract? Why or why not? If not, what do you recommend and why?	We agree. That is the basis of pricing and assessment of the rights and obligations of an insurance contract.
(b)	Is the draft application guidance in Appendix B on estimates of future cash flows at the right level of detail? Do you have any comments on the guidance?	Draft IAA position The ED is not clear enough why and how we should limit the inclusion of the fulfillment cash flows to incremental expenses. In order to avoid deterioration of the presented results and deviation from the insurers' perspective for fulfillment of the obligation, all relevant cash flows that the insurer believes necessary to fulfill the insurance contracts should be included. From this perspective, we suggest that the IASB would be principle based on this topic as well and delete the example of excluding general overheads as stated in B62(f), B63 in the application guidance. We agree part of the guidance in B63 that states an insurer shall allocate costs that cover more than one portfolio to individual portfolios and clarifies

		that those costs still be incremental at the portfolio level. We see it is difficult to draw a clear line between these incremental costs at the portfolio level and some indirect costs or overheads of the same business line. So in practice, all expenses other than abnormal or temporally costs would be included. Support for the position Importance and difficulty of distinction between fulfillment cash flows and margins: Users of the financial statements, at least insurers, insurance regulators and policyholders, expect the insurance liability can cover all the expected costs for fulfillment of insurance obligation. From this perspective, especially for portfolio under transition rules, where insurance liability has no residual margin, this will cause a very misleading presentation. Furthermore at subsequent measurement, release pattern of residual margin may not match with emergence pattern of such costs. In order to avoid these misleading presentation, distinction between fulfillment cash flows and residual margin as appropriate as possible. But it is very difficult to draw this line. So in practice, all but abnormal expenses would be included. For example, if we think of contracting out all maintenance and claims handling activities to fulfill the insurance contracts, the fee must include charge to cover indirect costs and general overheads. Other reasons why all expenses except for abnormal amounts should be included: Insurance contracts are priced in a way that include appropriate allowance for overheads and some costs not directly related to the contracts. It is also the basis on which portfolio transfers, mergers and acquisitions are assessed. Because cash inflows (premium) used for measurement include such

		allowance for expected costs, if expenses are limited only to strict incremental costs, the difference will be residual margin and cause misleading presentation.
Question 3 – Discount rate (paragraphs 30–34 and BC88–BC104)		(see 10a for further discussion relating to participating contracts)
(a)	Do you agree that the discount rate used by the insurer for non-participating contracts should reflect the characteristics of the insurance contract liability and not those of the assets backing that liability? Why or why not?	There is a body of opinion that agrees that there should not be a linking of the two and contends that if there are two entities with exactly the same liabilities then the same value should be placed upon those liabilities rather than the value being based upon the assets backing those liabilities. A smaller number contends the opposite basing their argument around the risk associated with the different investment strategies. It has also been suggested that if a contract's benefits reflect the return on the assets, the discount rate should be based on the return on the assets whether the contract is technically participating or non-participating. It is proposed that we should respond by stating that we agree with the principle set out in question 3(a) – i.e. that it is appropriate that the discount rate used to determine the value of the liabilities should reflect the characteristics of the liabilities not that of the assets backing those liabilities. Notwithstanding the fact that the exposure draft has moved on from the concept of "Current Exit Value" used in the DP, it is based around the principles of "fair value" / "market value". Whilst there is not a large market in individual insurance contracts when there is a trade of a block of contracts the value placed on the liabilities is more likely than not to reflect the nature of the liabilities regardless of the assets that are currently backing the assets. Thus on that basis it is appropriate to seek to place a value at each reporting date on the liabilities based on their characteristics at that time.
(b)	Do you agree with the proposal to consider the effect of liquidity, and with the guidance on liquidity (see paragraphs 30(a), 31 and 34)? Why or why not?	Whether or not we agree that the discount rate should be "risk free plus an allowance for illiquidity based on the characteristics of the liability", there appears to be amore of a consensus that we do not support that approach.

		The arguments against the Board's approach are both from a theoretical and a practical perspective. There is a view held by a number of members of the committee that the proposal in this ED is inconsistent with the approach adopted in other IAS / IFRS. From a practical perspective there is little guidance as to how to determine the illiquidity premium and seemingly little desire by the IASB to provide such guidance. Unless there is authoritative guidance there runs the risk that it will make comparison between preparers difficult. The IASB has indicated that it hopes that the standard (a) Faithfully represents the economics of the insurance contract (b) Provides information that helps investors make decisions (c) Is consistent with existing / evolving IFRS accounting framework There are very strong arguments that, especially for long term (primarily life insurance) contracts, the proposed approach does not reflect the economic reality of the business and / or will not provide meaningful information for users of the statements. This is primarily because of the volatility that will almost certainly be seen in the value placed on liabilities if the proposed discount rate is used in extreme market conditions such as at the end of 2008 which might be somewhat different from movements in the assets of the insurer. Life insurance, in particular, is a long term business and managed as such. If financial statements are liable to showing extreme movements year on year confidence in those statements could well fall. It is proposed that we respond to question 3(b) by stating that, for the reasons set out above, that we do not support the proposal for the discount rate to be determined as "risk free plus illiquidity". If that is our view then we need to offer alternative approaches that fit the conceptual framework. This could include

		(i) Amortised cost for assets (as per IFRS9) plus discount rate for liabilities based on the Internal Rate of Return at outset; each year building block 1 is reviewed as per the ED but the discount rate for building block 2 stays as per initial IRR (ii) Discount rate reflects the characteristics of liabilities in terms of duration, currency, taxation etc (but not liquidity) with addition to risk free reflecting the risk characteristics of the asset portfolio used to back liabilities [NB this could be counter to our answer to 3(a) and needs to be developed] (iii) Other?
(c)	Some have expressed concerns that the proposed discount rate may misrepresent the economic substance of some long-duration insurance contracts. Are those concerns valid? Why or why not? If they are valid, what approach do you suggest and why? For example, should the Board reconsider its conclusion that the present value of the fulfilment cash flows should not reflect the risk of non-performance by the insurer?	We believe the concerns expressed are valid for the reasons set out above – ie they do not reflect the way the business is run and the aim in many instances to invest in assets which have cash flows similar – if not exactly the same – as those of the liabilities. Nevertheless, we do not support the use of own credit rating, in that, as the controversy around it indicates, it has significant issues relating to its decision-usefulness.
Question 4 – Risk adjustment versus composite margin (paragraphs BC105–BC115)		
Do you support using a risk adjustment and a residual margin (as the IASB proposes), or do you prefer a single composite margin (as the FASB favours)? Please explain the reason(s) for your view.		[note - further discussion needed on this response] We do not agree that there should be a residual margin. We believe there is no justification for a requirement that there be no gain at issue for the following reasons: i. A residual margin does not represent a current estimate of the liability. ii. Some insurance contracts are priced to be extremely profitable (e.g. creditor insurance, where 60% or more of the premium is profit) such that while there is a scenario with commercial substance where a particular insurance contract would result in a loss for the

		enterprise, there is no plausible scenario where the portfolio would sustain a loss for all the insurance contracts in the portfolio. iii. [Should we add a discussion about how the use of a residual margin is or is not consistent with the conceptual framework?] We also disagree with the use of a composite margin. i. This construct, assumes that the pattern in which the enterprise is released from risk and the pattern in which the profit in the premium should be released the same manner. ii. If the IASB decides to retain the use a risk adjustment and a residual margin, we agree that these should be separate rather than use a composite margin for the following reasons: a) We believe a risk adjustment should be incorporated into the measurement of insurance contracts as this provides useful information b) We believe the residual margin and the composite margin are both an artificial construct which does not provide useful information. c) Therefore we believe a composite margin provides less useful information than separating the risk adjustment and disclosing a separate residual margin. We believe users will remove the residual margin from their considerations when analyzing the financial statements because of its artificial nature.
Question 5 – Risk adjustment (paragraphs 35, 37, B67, B103 and BC105–BC123)		
(a)	Do you agree that the risk adjustment should depict the maximum amount the insurer would rationally pay to be relieved of the risk that the ultimate fulfilment cash flows exceed those expected? Why or why not? If not, what alternatives do you suggest and why?	We agree with the ED that the measurement should incorporate a risk adjustment. It is a universal practice in all countries to incorporate a risk adjustment in the measurement of insurance contract liabilities. Some jurisdictions use an approach that separately identifies the explicit risk adjustment (e.g. Canada) while others uses an implicit approach (e.g. USA). Including a risk adjustment is consistent with professional actuarial standards

		and generally accepted actuarial practices. A risk adjustment will provide useful information to users of the financial statements as they will be able to compare the difference in risk adjustment between companies that have portfolios of similar insurance contracts. We agree that the risk adjustment should be separately calculated from the cash flows and discounting for the time value of money. As noted above, some jurisdictions require a separate measurement of the risk adjustment. We support this practice and the ED's requirement for the following reasons: i. Implicit methods make it difficult for a user of the financial statements to compare the relative riskiness of different enterprises engagement is issuing insurance contracts and vice versa. ii. Explicit methods require actuaries to determine all the risks of the portfolio of insurance contracts and to make an appropriate adjustment. We do not agree that the risk adjustment should be the maximum the insurer would rationally pay to be relieved of the risk. We take this position for the following reasons: i. There is no experience studies, academic papers, professional actuarial standards or generally accepted actuarial practice to date on how to determine what the 'maximum' would be. ii. The use of this approach is subject to significant judgement by management and, consequently, will reduce the comparability of the financial statements of different enterprises. iii. This characterization of the risk adjustment is consistent with an exit value perspective which is inconsistent with a fulfillment value perspective.

		iv. From a fulfillment value perspective, we believe the risk adjustment should reflect management's judgement of the level of prudence that should be reflected in the measurement of insurance contracts to account for uncertainty. We also note that the risk of uncertainty relates to the timing of cash flows as well as the amount, and therefore, the phrase "the ultimate fulfilment cash flows exceed those expected" should be "the ultimate fulfilment cash flows differ from those expected". An alternative would be "the present value of fulfilment cash flows will exceed that expected". We believe that the wording in paragraphs 17(a) and 22 contrasts with the wording in paragraph 35. Although it could be interpreted that paragraph 35 further refines the more general description in the earlier paragraphs, we believe it would be useful to have more consistent language (in particular, with respect to the objective considering reflection of only the adverse tail or the entire distribution of uncertainty.
(b)	Paragraph B73 limits the choice of techniques for estimating risk adjustments to the confidence level, conditional tail expectation (CTE) and cost of capital techniques. Do you agree that these three techniques should be allowed, and no others? Why or why not? If not, what do you suggest and why?	We do not agree that the techniques for estimating the risk adjustment should be limited to the three describe in the ED for the following reasons: i. CTE has limited applicability. It is best used for portfolios with fat tails. ii. Limiting the techniques to three is inconsistent with the principals based ethos of IFRS. iii. Other techniques may be more appropriate in certain circumstances. iv. New techniques will be developed in the future which would be more appropriate in certain circumstances. v. Actuarial standards of practice and generally accepted actuarial practice can assist in limiting the techniques used by companies to those that are appropriate in the circumstances. However, companies should be required to disclose the techniques used.

		See also our comments under 5(d).
(c)	Do you agree that if either the CTE or the cost of capital method is used, the insurer should disclose the confidence level to which the risk adjustment corresponds (see paragraph 90(b)(i))? Why or why not?	We do not agree that companies that use CTE or CoC to measure the risk adjustment should be required to disclose the equivalent CI level for the following reasons: i. This would create additional analytical work for those companies using CTE or CoC. ii. There is no experience, practice or academic literature on how to measure CTE or CoC results on a CI basis. iii. Management may be forced to use weak processes and to make significant judgements to determine the CI level.
(d)	Do you agree that an insurer should measure the risk adjustment at a portfolio level of aggregation (ie a group of contracts that are subject to similar risks and managed together as a pool)? Why or why not? If not, what alternative do you recommend and why?	We believe that the risk adjustment should not be determined at a portfolio level for all risks combined. Rather it should be determined at the "risk" level for the portfolio of insurance contracts. That is, the risk adjustment is best determined for each risk (mortality, morbidity, lapse, etc.) separately (possibly with an adjustment for co-relation between risks when sufficient experience is available). We take this position for the following reasons: i. Companies, regulations and industry bodies have significant experience and expertise measuring and monitoring experience at the risk level. Some work has been done in a limited number of jurisdictions on the co-relations between these risks under normal and some stressed market conditions, however this work is rudimental at present. ii. In transactions when portfolios of insurance contracts are transferred / acquired, the methodologies and assumptions used to measure the portfolio uses this level of risk adjustment. Other factors, some unrelated to the riskiness of the portfolio, impact the purchase price of these transactions. iii. In determining the 'maximum the insurer would rationally pay to be relieved of the risk', companies will use the risk level as the basis for determining the risk adjustment as all their experience, systems, models and expectations are formed,

		analyzed and monitored at this level. iv. Conversely, there is no information, data or experience in determining risk adjustments at a portfolio level aside from using a risk level approach. v. For example, there is no experience, professional literature or academic research on what the probability distribution of the total risks of an insurance portfolio would look like or how it would be measured. Since there are multiple risks in an insurance contract portfolio, the probability distribution for the risk adjustment would be some sort of multi-dimensional "probability surface". It is impossible to understand how to interpret this "surface" or to determine what a confidence interval is from such a surface, even by highly trained mathematicians or statisticians. We believe this information, if presented in financial statements, would have no meaning or use to a normal user. vi. A similar argument as v. above applies to the determination of a CTE model at the portfolio level.
(e)	Is the application guidance in Appendix B on risk adjustments at the right level of detail? Do you have any comments on the guidance?	We find some of the guidance in B67-103 unhelpful as part of application guidance. Below we have specific comments. B72 The risk adjustment is to be determined at the portfolio level (36), however the points in B72(a), B72(b) and B72(c) suggest there are a number of risk adjustments. We presume this is meant at the "risk" level (mortality, lapse, etc.) since this is the only level at which frequency, severity, duration, etc. can be and are currently measured. We refer you to our response to Question 5(d). B75-79 These paragraphs are based on the premise that a probability distribution for a portfolio of insurance contracts can be determined (see also our comments under question 5(d) above). As noted, there is no such thing as a probability distribution for the risk adjustment at a portfolio level which incorporates all risks; it is at best a probability surface. It is not possible to extract a confidence interval from such a mathematical construct that would have any meaning and therefore would be useful to users of the financial statements.

(e)	Is the application guidance in Appendix B on risk adjustments at the right level of detail? Do you have any comments on the guidance?	We find some of the guidance in B67-103 unhelpful as part of application guidance. Below we have specific comments. B72 The risk adjustment is to be determined at the portfolio level (36), however the points in B72(a), B72(b) and B72(c) suggest there are a number of risk adjustments. We presume this is meant at the "risk" level (mortality, lapse, etc.) since this is the only level at which frequency, severity, duration, etc. can be and are currently measured. We refer you to our response to Question 5(d). B75-79 These paragraphs are based on the premise that a probability distribution for a portfolio of insurance contracts can be determined (see also our comments under question 5(d) above). As noted, there is no such thing as a probability distribution for the risk adjustment at a portfolio level which incorporates all risks; it is at best a probability surface. It is not possible to extract a confidence interval from such a mathematical construct that would have any meaning and therefore would be useful to users of the financial statements. Consequently, we disagree in particular with B76, which states that the CI would be "relatively easy to calculate."
Question 6 – Residual/composite margin (paragraphs 17(b), 19–21, 50–53 and BC124–BC133)		
(a)	Do you agree that an insurer should not recognise any gain at initial recognition of an insurance contract (such a gain arises when the expected present value of the future cash outflows plus the risk adjustment is less than the expected present value of the future cash inflows)? Why or why not?	[see comments under Q4 above]
(b)	Do you agree that the residual margin should not be less than zero, so that a loss at initial recognition of an insurance contract would be recognised immediately in	If there is a residual margin, it should not be permitted to be negative. [it could be argued that, since the residual margin is measured at a portfolio, that it not be allowed to be negative at that level]

(e)	Do you agree with the proposed method(s) of releasing the composite margin, if the Board were to adopt the approach that includes such a margin (see the Appendix to the Basis for Conclusions)? Why or why not?	Although we note that the formula given in the Appendix for the Composite margin runoff is incorrect (see the FASB Discussion Paper), we have not formed an opinion on this yet. We do believe that, due to lack of definition of the treatment of a composite margin in the premium allocation model, that this is a serious concern. We do not believe that the claims liability should only consist of the present value of expected cash flows.
(f)	Do you agree that interest should be accreted on the residual margin (see paragraphs 51 and BC131–BC133)? Why or why not? Would you reach the same conclusion for the composite margin? Why or why not?	Yes, although this could mean that the amount of these margins held might increase over time.
Question 7 – Acquisition costs (paragraphs 24, 39 and BC135–BC140)		
(a)	Do you agree that incremental acquisition costs for contracts issued should be included in the initial measurement of the insurance contract as contract cash outflows and that all other acquisition costs should be recognised as expenses when incurred? Why or why not? If not, what do you recommend and why?	Draft IAA position Limiting only to incremental acquisition costs at the contract level will cause both conceptual and practical problems. We believe broader inclusion is appropriate, at least direct costs and systematic allocations of costs that relate to the portfolio initiation activities should be included. These costs are incremental acquisition costs relating to the portfolio, not to the individual contract. So we believe the example B61(f) in the application guidance should be altered as "the incremental costs of selling, underwriting and initiating insurance contracts and expenses related to the initiation of those portfolio". Support for the position Examples of problems about limiting acquisition costs incremental at the contract level:

		Most of career agents' compensation has the characteristics of the incremental acquisition costs. However, it is difficult to pull out the incremental costs at the contract level from the salaries of career agents because the determination method of salary is complicated and is not directly linked to each contract. At one extreme, offering insurance through the internet, with all clerical, assessment and underwriting functions handled by salaried staff, will generate very low recognition of acquisition costs and high losses at issue. At the other extreme of current practice, a model whereby acquisition is on a commission basis will generate higher costs and much lower losses at issue. Placing all staff on a piecework basis could further reduce these losses. A franchise model, where all activities are contracted out, with a fee charged to cover head office overheads, could eliminate losses at issue altogether. There are costs incurred in connection with applications that an insurer determined not to accept, for instance, due to the medical selection. Although these costs may not be allocated to the incremental acquisition costs at the contract level, they are the costs of activities to acquire new business portfolio. And in practice, it might be difficult to identify them from others. These examples show that the notion "incremental at the level of individual contract" is not conceptually robust or practically easy, and the notion "incremental costs relating to the portfolio" is relatively robust and easy.
Short-duration contracts (paragraphs 54–60 and BC145–BC148)		
Question 8 – Premium allocation approach		
(a)	Should the Board (i) require, (ii) permit but not require, or (iii) not introduce a modified measurement approach	The Board should permit, but not require, the modified measurement approach for pre-claims liabilities. Since the modified measurement approach is simply

	for the pre-claims liabilities of some short-duration insurance contracts? Why or why not?	an approximation of the result that is generated under the building block model and presumably should generate approximately the equivalent result, a company should not be precluded from using the standard approach. This would allow companies, such as those with predominately longer duration coverages but some shorter duration contracts, to retain a single measurement approach and a single presentation in the performance statement without a loss of consistency in measurement.
(b)	Do you agree with the proposed criteria for requiring that approach and with how to apply that approach? Why or why not? If not, what do you suggest and why?	**Criteria** With regard to the proposed criteria for requiring the modified approach, we understand that the proposed criteria of a coverage period of approximately one-year is intended to be interpreted in a strict manner, that is, contracts that might otherwise be considered short duration would not be eligible for the modified approach. For such contracts, the result is a more complicated building block model coupled with a different presentation (i.e., gross premium and gross loss statistics are not included in the income statement for contracts that are not subject to the modified approach). Instead of having a strict threshold of approximately one-year, the guidance should be principles based and state that it would typically apply to single year policies but might be applicable for policies of more than one year for products that have a predominately service function of risk protection. This would allow the simplified approach to be used for those multiple year agreements where the economic substance is essentially the same as those of single year or shorter agreements. **Application** With regard to application of the simplified model, while we believe the approach introduced in the exposure draft is, in concept, reasonably consistent to the earned premium approach that is common practice in many jurisdictions, there are additional features added likely to have the measurement be consistent with the building block approach. However, there are elements of the approach that deviate from common practice today, adding layers of complication to the approach but arguably without a corresponding benefit. These layers of complication include:

		• Consideration of interest in premium instalments to be received in determining the pre-claim obligation, described in paragraph 57(a). Currently, the collection of the premium is not tied to the accounting for the premium for short duration contracts. If these two had to be tied together, as under paragraph 57a, then the date the premium was received would have to be tracked and used in the premium recognition. This is not a trivial exercise, as it would require significant changes to existing systems. It would impact instalment billings, audit billings, and endorsement billings. This would result in significant complication of the current process, while producing a trivial difference in the vast majority of cases. • The accretion of interest, described in paragraph 59. Accreting interest adds complexity to the measurement and presentation of the pre-claim liabilities. Since the modified model only applies to short duration contracts, and as such would not expected to be of significant size or released over many periods, accreting interest on unearned premiums would likely have a minimal impact in the vast majority of cases. • The onerous contract test, described in paragraph 60. While we agree with the concept of onerous contract, the approach described requires that the calculation be performed at a cohort level within a portfolio, where the cohort is described as contracts with a similar date of inception. It is not clear as to how similar date of inception would be interpreted. If interpreted as quarterly or monthly, this would result in a much more granular evaluation of premium adequacy than is done today, and would require significant effort while the results of which would play out in a short time frame. Since these are by definition short duration contracts, there is rarely information that comes available in the pre-claim period that would provide significantly different views as regards the expected economics of the business, particularly across a broader spectrum of business. As a result, we would recommend that the application of the modified approach be performed in a manner that is more consistent with the earned premium approach that is common practice today, is easy to apply and understand, and produces decision useful information. As such, we would recommend the

		following: • Amend paragraph 57(a) to exclude the word "present", and then include "adjusted for the time value of money, if significant" before the word "less at the end of the sentence. Further, amend the end of paragraph 59 to include the phrase, "if the impact from discounting produces an earning pattern that differs significantly from the application of paragraph 58." The intent of both these changes would limit the consideration of the time value of money under the short duration approach to those very limited circumstances in which the impact of such accretion is significant, similar to the principle introduced in paragraph 58 for seasonality of losses. This amendment would enable companies to maintain a simplified measurement and presentation model in the vast majority of cases. • Amend paragraph 60 to require that the onerous contract test be performed at the level in which management manages its business, which might be at a portfolio level or in some cases at a more aggregated level.
Cash flows that arise from future premiums (paragraphs 26–29 and BC53–BC66)		
Question 9 – Contract boundary principle		The applicable contract boundary rule included in the ED is: "The boundary of an insurance contract distinguishes the future cash flows that relate to the existing insurance contract from those that relate to future insurance contracts. The boundary of an insurance contract is the point at which an insurer either: (1) is no longer required to provide coverage, or (2) has the right or the practical ability to reassess the risk of the particular policyholder and, as a result, can set a price that fully reflects that risk. In assessing whether it can set a price that fully reflects the risk, an insurer shall ignore restrictions that have no commercial substance (ie no discernible effect on the economics of the contract)." Several issues relate to the application of this boundary.

	1. There is the question of who/what is the particular policyholder. In a group insurance contract, it might be interpreted to be the group itself or the individual insured. 2. For the start of a contract, there is not a clear point to use other than the initial effective date of the contract, unless the contract is determined to be onerous prior to the effective date. As such, we would suggest changing paragraph 14 to "An insurer shall become a party to an insurance contract on the original effective date of the contract except in the case of an onerous contract or if there is not a clear original effective date of the contract... If the contract is onerous or if there is not a clear original effective date of the contract, the insurer shall become a party to an insurance contract on the earlier of the following two dates: . . ." 3. Whether group (or individual term) conversions are considered part of the boundary of the contract and exempts them from the short-duration alternative under paragraph 54(b). However, the use of the word "significantly" in paragraph 54(b) likely addresses this concern--a conversion option would not be expected to significantly modify cash flows. 4. There is a question of whether or how a rate regulatory regime should be considered to affect the practical ability of the insurer to set a price that fully reflects the risk. In some regulatory environments, barriers are in place to limit an insurer's ability to withdraw from the market place and insurance rates are controlled by the regulators such that insurance companies cannot always charge the full price for the risk. Under the proposed boundary definition, both of these issues would result in certain non-life contracts having to be valued through renewal periods. It would be useful if the Board clarified its intent concerning the considerations of the boundary conditions when regulatory constraints exist. There is a gray area for contract boundaries in such situations, for example, for health insurance in the US. In order to provide appropriate comments, we need to consider pre and post 2014 health reforms in the US, separately for contracts to individuals and to small groups.

	For pre-reform individual contracts, the insurer typically cannot cancel the contract without withdrawing from the market (usually a state) and any rate increases must be applied to all policies regardless of risk. This could result in a lifetime contract boundary (at least until age 65, when public health care programs take effect), which appears to be appropriate. Post-reform individual contracts have one slight difference in that the insurer is not allowed to underwrite or exclude conditions for any risk, whether they are a current insured or not. As such, although the insurer does not have the right to cancel the contract, that right provides no benefit to the insured, in that another insurer has to accept the risk without preconditions, so the insured can obtain the market rate from other insurers without insurability consideration. In this case, it seems that this should be considered to be a limited boundary contract (generally through the period that the premium rate is set in practice (most frequently one year). This is in spite of the fact that although the individual's rate cannot be affected by health condition, the rate can change due to a change in family status. An alternative view regarding post-reform individual contracts is if the insurer cannot set a price that fully reflects the risk, the contract boundary should be long. For pre-reform small group insurance in the US (often less than 10 or 25 lives), in most states, the carrier cannot cancel a contract except by market withdrawal, but they can adjust the premium rates for a given group within some specified bounds. It is unclear as to whether those limited bounds would negate the right to set a price that fully reflects the risk referenced in 27(b) and the determination of whether the boundary is one year or lifetime is unclear. For post-reform, the carrier will no longer have the freedom to change rates for a group within the range and the business should be treated the same as individual. Again, although the carrier does not have the right to cancel or rate based on the group's risk, they must offer that same product to both existing and new customers at the same rate, so there is no value to this right from either the customer's or the insurer's viewpoint. The Basis for Conclusions discussion indicates that while the cash flows should contemplate regulatory action when determining premium rate increase assumptions, the threat of regulatory restrictions on renewal rating actions is not alone sufficient to extend the contract boundary. Therefore, these may not be

	large issues. A potential resolution of these issues is to add a paragraph after paragraph 27 that states "If the requirement to continue to provide insurance coverage has no economic value to the insured, then this does not extend the boundary of the contract." This would address the situation where the policy is required to be renewed, but, due to guarantee issue requirements, the right of renewal has no value--an individual with no relationship with the insurer would have the same right to acquire coverage at the same rates. This would effectively define the post 2014 individual and small group health markets as short duration in spite of the requirement of renewability. An alternative view regarding the post-reform group contracts is if the insurer does not have the right to reassess the particular policyholder and the measurement is based on the going-concern principle, market withdrawal is not an option. Therefore, according to BC57, the post-reform contracts should have the boundary of lifetime.
Do you agree with the proposed boundary principle and do you think insurers would be able to apply it consistently in practice? Why or why not? If not, what would you recommend and why?	
Participating features (paragraphs 23, 62–66, BC67–BC75 and BC198–BC203)	**Discussion at Toronto meeting** To clarify our understanding of participation features, we provide a possible definition, which is intended to refer to the characteristics of such features of accounting relevance: **Definition of a Participation Feature (PF):** An enforceable obligation of the insurer (issuer) established by a current contract to forward a specific part of the surplus remaining after performing all or specific other obligations under that contract (normally together with that of other contracts) as additional benefit to current or future contracts. Purpose of PFs is to reduce the risk to be born by the insurer mainly in case of long-term guarantees by charging in a first step premium, which are overstated in comparison with the guaranteed benefits, and adjust subsequently the pricing

	by returning resulting surplus to policyholders (two-step or retroactive pricing). The retroactive pricing refers to the entity-specific surplus, not to market factors. We therefore believe that it is essential that accounting emphasizes that risk reducing capacity of PFs. To achieve that it is necessary that the measurement of the PF reflects consistently and simultaneously the surplus from the business as reported under IFRS. There is further a wide variety of similar features, specifically retroactive premium adjustment clauses. Those forward entity-specific losses (often in addition to PFs) to policyholders by a right of the insurer to increase retroactively premiums. Further there are collective prospective premium adjustment clauses, intended to avoid future losses by adjusting premiums to observed entity-specific trends. Those features cause similar measurement issues as in case of PFs. The measurement of PFs and similar features is, considering the variety of such features world-wide, best guided by general principles. It should be noted that in some jurisdictions specific forms of PF are referred to as "discretionary features", since the fulfilment of the obligation, i.e. the ultimate distribution to policyholders, is at the discretion of the insurer. However, there is a current obligation and those amounts do never contribute to the benefit of the insurer, i.e. are excluded permanently from profit. "Discretion" is here merely a technical issue, who gets when which amounts than an accounting issue, distinguishing between equity and liability. The amounts resulting from the PF are clearly a liability to a third party, but the recipient is at the discretion of the insurer. 2. We recommend a differentiation of such features from discretionary benefits, which could be defined as follows: **Definition of Discretionary Benefits (DB):** Additional benefits provided under an insurance contract whose value is at the discretion of the insurer without

		constraints of commercial substance. The main accounting issue of Discretionary Benefits (DBs) is whether they are to be recognized, while this is out of question for PFs. If recognized, the measurement of DBs depends on their intended trigger, i.e. whether they are paid to forward some of the excess premiums (i.e. surplus) or whether they are intended to achieve a certain minimum return to policyholders (even if that might cause a severe reduction of insurer's profit). In the first case, DBs would be measured similar to PFs, in the second case similar to guaranteed benefits, considering in both cases in determining the risk margin that the amounts are at the discretion of the insurer.
Question 10 – Participating features		
(a)	Do you agree that the measurement of insurance contracts should include participating benefits on an expected present value basis? Why or why not? If not, what do you recommend and why?	We understand the reference to "expected present value basis" as referring to an overall consistent measurement of the contract in compliance with the principles set out in paragraphs 17, 23, 30, 35 and 47. We agree with this principle-based approach. *Contract Boundary Issues* We understand paragraphs 32 and B61 (j) that current obligations under PFs, i.e. resulting from current contracts, to be fulfilled to current or future contracts, and expected payments under DBs intended to be triggered by surplus from current contracts, to both current or future contracts, are to be considered in measurement. However, contract boundaries apply as well here. Considering the purpose of PFs (and some DBs) to refund premiums, it is sufficient guidance to require consideration of cash flows "resulting" from premiums within the contract boundary. However, issues arise with the contract boundary if the obligations under a PF are not fulfilled by an immediate payment to a third party but might be fulfilled by increasing performance obligations under current or future contracts, which are potentially profitable for the insurer. In that case, the cash flows originally

		triggered by the PF are in the far distant future arising in performing the additional performance obligation. Here, the obligation under the PF is not paid out but transformed to another obligation. The question is whether the profits under such additional performance obligations should be anticipated in determining the current obligation under the PF, i.e. reducing the obligation under the PF to amounts actually paid in future. We believe that at least subsequently resulting cash flows from allocations to future contracts are beyond the contract boundary of current contracts. The gains from allocations would be recognized (and considered in the residual margin), when such future contracts are initially recognized. Consequently, the related current obligation under the PF cannot be measured on a cash flow basis but needs to be considered as nominal amount, e.g. by requiring that any allocation to future contracts is assumed to be paid in cash directly. In case of allocations to current contracts, which belong often to different sub-portfolios as described in paragraph 20 for purposes of initially measuring the residual margin. If the allocation to particular contracts is subject to insurer's discretion, we do not believe that it is adequate to anticipate the gains incurring subsequently to the allocation and consider it in the residual margin of particular contracts. We believe that those gains should be considered when the allocation actually incurs and should than result in an initial recognition similar as in case of a change of the contract. We recommend therefore adding two sentences to paragraph 26: If the net obligation under a particular current contract is expected to be increased in future not as a result of a premium payment under that particular contract but at the discretion of the insurer in fulfilling a present obligation to other contracts or a collective of contracts (which might include the particular contract), the resulting cash flows from that increase of the net obligation are beyond the contract boundary. It is in that case assumed that the present obligation is fulfilled by a direct payment under the particular contract at the time of expected increasing

		of the net obligation. *Internal Comment: That means that expected discretionary allocations (bonuses/dividends) under a PF are assumed to be paid in cash. Bonuses/dividends as actually made use of, is initially recognized at actual allocation. I.e., the residual margin is established at that time to eliminate any gain from making use of the bonus/dividend in form of additional coverage etc. In those cases, where policyholders have a direct right to get allocated certain amounts of surplus in a given manner, future gains from those allocations are anticipated at outset and considered in the residual margin at that time.* *Cash Flow Issues* In compliance with paragraph B61 (j) to consider the part of surplus to be forwarded under a PF to current and future contracts, the main issue is to identify the current obligation under a PF or DBs intended to be triggered by surplus. The amount of the obligation is triggered by the past surplus and future occurrence of surplus, as defined in the PF (typically based on measurement under statutory accounting principles, the measurement basis of the PF is subsequently referred to as "participation measurement basis"). The three building blocks of the premiums and guaranteed benefits include already some assumptions about future occurrence of surplus and the IFRS report might to some extent already anticipate future surplus not yet considered in the participation measurement basis or might defer some of the surplus already considered in participation measurement basis. For example, the participation measurement basis might consider already future premiums which are beyond the contract boundary under IFRS. It might anticipate as well future overhead cost which is not anticipated by IFRS. Therefore, the "realistic" expectations for future payments under the PF, i.e. those based on the participation measurement basis, are inconsistent with the amounts recognized under IFRS. Consequently, a clarification in paragraph B 61 (j) would be suitable that "expected" means in case of cash flows which forward entity-specific surplus to contracts, those expected in the scenarios reflecting the surplus as considered at the reporting

		date under IFRS: > … in the performance of a portfolio of insurance contracts or pool of assets, as far as the respective performance is already considered at the measurement date in the measurement according to this IFRS or other IFRS. *Discount Rate Issues* We understand that as well for PFs paragraph 30 applies and that paragraph 32 does not provide an exemption from that. Paragraph 32 simply states that PFs are to be considered (replicating portfolios will be rarely if ever be suitable, since PFs typically require only to forward a certain share of performance to policyholders and refer to the entity-specific surplus, which cannot be matched in markets) in measurement, where ever that might be seen as adequate in complying with the principles, not necessarily but possibly in deviation from paragraph 31. If the IASB does not agree with that interpretation, we recommend a change in the wording. That principle-based guidance permits to decide which of the following approaches reflect best the characteristics of the particular PF a) to reflect cash flows under the PF based assuming a risk-free matching of the guarantees combined with a consequently risk-free discount rate or b) to reflect cash flows under the PF on a realistic basis of investment returns combined with a discount rate reflecting those characteristics. However, we recommend clarifying the wording of paragraph 30 in that regard that not the characteristics of the insurance contract liability in its entirety are relevant, but the characteristics of the cash flows to be discounted considering that there is as well a risk adjustment: > The relevant characteristics of the insurance contract liability are those, which are present in the cash flows according to paragraph 22 (a) to be

		discounted, considering the risk adjustment according to paragraph 22 (c). Otherwise double counting could occur, since characteristics of the liability are considered in both, discount rate and risk margin. Paragraph 33 excludes only double counting of cash flows and discount rate. *Contract Boundary in Case of Discretionary Benefits* In case of discretionary benefits, i.e. benefits where the insurer is not subject to a contractual obligation to provide a specific benefit, and specifically contracts do not prescribe that a specific share of surplus has to be forwarded, BC70 emphasizes that the general guidance for the contract boundary applies as well to such benefits. Premiums within the contract boundary are recognized and "cash flows … resulting from those premiums". Hence, only discretionary benefits resulting from premiums within contract boundaries are generally included in measurement. Since discretionary benefits do, by definition, not have a direct linkage to any premium, the reference to "resulting" needs to be understood economically: If discretionary benefits have the economic function of 1. premiums reimbursement (retroactive pricing on a voluntary basis, a kind of ex gratia rebate), 2. an adequate return on premiums (voluntary interest payment) or 3. to motivate to pay premiums or to enhance persistency within contract boundaries, we understand them to "result" from those premiums and consequently a requirement to be recognized. If the IASB does not consider the interpretation before as adequate, it should consider rephrasing the wording for recognition and measurement to better reflect its intentions.
(b)	Should financial instruments with discretionary participation features be within the scope of the IFRS on insurance contracts, or within the scope of the IASB's	Our response should be read in connection with our response to question 10 (c), where we recommend that instead of discretionary participation feature the

	financial instruments standards? Why?	above definition of a PF should be used. We welcome that the IASB decided to include within the scope of the draft IFRS 4, any investment contract which shares in the same surplus as contracts already under it. We believe that a common PF, especially if it is a collective feature, causes a need of consistent measurement. However, we believe that PFs should be in any case cause that the entire contract is subject to the guidance of the insurance standard, by expanding its scope to a standard for contracts including significant insurance risk or PFs. That would cover as well all service contracts containing PFs, currently ignored by the ED. As alternative, the guidance for PFs in the insurance standard would need to be copied to the measurement guidance for financial instruments and for service contracts. It is clear that investment contracts with PFs, which establish a collective obligation together with insurance contracts, cannot be measured separately since the resulting obligation under the PF cannot be split. We do not believe that their might be actually misuse of that guidance. It is legally impossible to establish such a collective obligation other than within one single legal entity. That means, only legal entities which are insurance companies can have collective obligations from PF in investment contracts which are common with those of insurance contracts. Hence, including such investment contracts within the scope of the insurance standard will not affect non-insurance companies. However, we believe that it is justified to extend the scope of the insurance standard should be extended to cover both, insurance contracts and contracts with PF, based on 1. the fact that PFs can only be measured on a fulfilment basis since they refer specifically to the particular, i.e. entity-specific surplus, and 2. the fact that they are found nearly exclusively in insurance companies (considering the precise definition above).

		Only insurers developed – for reasons resulting from insurance-specific issues – the concept of PFs in the pure form complying with the definition above. There might be rare cases where other institutions provide similar features, but those are typically not fully in line with the definition. The issues do not only arise in case of investment contracts with PFs but as well in case of any service contract with a PF.
(c)	Do you agree with the proposed definition of a discretionary participation feature, including the proposed new condition that the investment contracts must participate with insurance contracts in the same pool of assets, company, fund or other entity? Why or why not? If not, what do you recommend and why?	We do not agree with the proposed definition of a Discretionary Participation Feature. We believe that the definition mixes up unnecessarily two separate characteristics which have significant different accounting relevance and does not comply with the substance over form principle. Further, we do not agree that the definition refers to the need that just one contract needs to be included in the same participation source. Further, we believe that the feature should cover any linkage to surplus, e.g. as well retrospective premium adjustments, which do not include guaranteed benefits to which additional benefits are provided but provides a minimum premium. We recommend that the final IFRS refer to any contract with a participation feature as defined in our response to question 10 (b). As already outlined in our comment to ED5 in 2003, we do not believe that the definition of a DPF, as already provided at that time, is suitable. The definition requires that the feature need to include both, discretion and a linkage to surplus. 1) The definition does not require that each of both features have commercial substance. I.e. a feature with irrelevant discretion is covered as well as a feature with irrelevant linkage to surplus, while a feature entirely without discretion or a feature entirely without linkage to surplus is not covered. That is a violation of substance over form. That caused in practice the need to search for any extent of discretion or for any, even just formal, linkage to surplus. 2) It is not the combination of both features which causes the relevant issues. Any discretionary benefit, disregarded whether "linked" to surplus or not, causes the issue of recognition, less of measurement. The ED solved that issue by defining contract boundaries allowing the decision whether

		discretionary benefits are to be considered or not. Any linkage to surplus (PF as defined above), whether containing some discretion or not, causes measurement issues, but not recognition issues. The artificial combination of both issues in one feature caused that the discussions of the boards were confused. At the very end, the general principles of the ED help to solve the recognition issues for all discretionary benefits, disregarded whether there is any linkage to surplus or not, and help to measure all PFs, without any need to care specifically for any inherent discretion regarding the choice of the measurement approach (although discretion of course affects the amount of risk adjustment). 3) The ED restricts the application of the definition of a DPF purely to the classification of investment contracts, i.e. for checking whether such are subject to the scope of the insurance standard or not. Hence, the question arises (in addition to the fact that we believe that as well service contracts with PF should be covered by the insurance standard), whether the definition of the DPF properly identifies all contracts which should be subject to the insurance standard. We believe that the feature requiring applicability of the insurance standard is the PF, i.e. the linkage to surplus. Whether there is discretion or not, does not matter at all. Specifically an investment contract or service contract with a PF without any discretion should be subject to the insurance standard, at least when the feature covers commonly as well insurance contracts. On the other hand, an investment contract or service contract with discretionary benefits, which are linked in a just formal or irrelevant manner to surplus, need not to be subject to the insurance standard. Any other IFRS would work as well. According to our interpretation of the ED, as well the insurance standard would not anticipate those benefits since they are beyond the contract boundaries, i.e. not resulting from premiums within the contract boundaries. Except that the definition of the DPF requires that at least one insurance contract is also subject to the PF. If the IASB does not consider our recommendation to include any contract with a PF in the scope of the insurance standard, we would expect at least a definition which copes with substance over form. If the insurance contract within the same participation pool does not have discernible effects to the pool, it should not be considered. Otherwise, misuse would be easily possible. E.g. any insurer could easily include one specifically

		designed insurance contract to a participation pool. That could apply even if the insurance contract is issued by another entity within the consolidated group. The definition of a PF should not require a guaranteed benefit to which the participation benefits are in addition. As well retrospective premium adjustment clauses, requiring a retrospective additional contribution (which is clearly not an additional benefit to a guarantee but actually the absence of a guarantee) should be treated as PF.
(d)	Paragraphs 64 and 65 modify some measurement proposals to make them suitable for financial instruments with discretionary participation features. Do you agree with those modifications? Why or why not? If not, what would you propose and why? Are any other modifications needed for these contracts?	We agree in principle that references to coverage or coverage period are replaced by references to the PF. However, we believe that in some cases the reference to coverage should be replaced in any case by a reference to services provided. Specifically the residual margin should be released as well in case of contracts with PFs based on services provided, not the PF. The residual margin is deferred profit of the insurer after PF and therefore has nothing to do with the PF itself.
Definition and scope (paragraphs 2–7, B2–B33 and BC188–BC209)		
Question 11 – Definition and scope		
(a)	Do you agree with the definition of an insurance contract and related guidance, including the two changes summarised in paragraph BC191? If not, why not?	Definition of an insurance contract a. We agree with the definition, with some suggested improvements to the guidance as discussed below. We agree with the changes summarized in BC 191. The term compensation is clearer than indemnification. The emphasis of the timing of the risk is economically significant and hence appropriate. b. Regarding the requirement in B25, that there must be a scenario of commercial substance where cash outflows exceed premiums, both on a present value basis, we are not fully convinced that this appropriate generally. B25 is derived from a similar rule in US-GAAP (BC191 (c)). We saw it in Phase I as an improvement to refer to significant insurance risk without any need for such a loss test. We believe that the requirement

		of pre-existing risk, now in B12, would eliminate any danger of misuse, since a contract, where the premium is higher than the maximum possible benefit would not normally mean the transfer of a pre-existing risk but such a contract creates a new risk. However, insurance transfers adverse deviations for a price, while the insurer pools a large number of similar risks to reduce the deviation risk effectively. As a result, it may occur that, on the level of the portfolio, there is virtually no longer any risk of loss, just a significant deviation risk from the expected profit. It might be possible that the insurer earns less than actually required to provide adequate return for the entrepreneurial activities provided, considering overhead, non-incremental acquisition cost and a service margin and to compensate for capital provided. If an insurer intends to transfer that deviation risk, to reduce its volatility, mainly to reduce capital requirements, to another insurer by means of taking reinsurance, the accepting entity bears the same risk as the direct insurer, who measures the risk anyway on a portfolio level. US-GAAP provides in case of a full transfer of a risk existing at the direct insurer at original terms that as well the transferring contract is a reinsurance contract, without the need to proof that a loss is possible. In such a situation, deviation risk is a pre-existing risk for the direct insurer, although no loss is possible, and therefore under Phase I the transfer was seen as reinsurance contract. We believe this to be appropriate and therefore would recommend omitting B25, since B12 is already sufficient. Otherwise, B25 should be amended to exclude contracts transferring the original risk of insurance contracts from the loss test. c. Reference to a contract The ED refers to contracts without providing a definition of that term. To some extent it requires bundling of (legal) contracts (paragraph B28), to some extent unbundling of a single (legal) contract (paragraphs 8-10). Bundling and unbundling should be based more on the concept of "substance over form", rather than establishing rules based on legal

		contracts provisions and interpretations. Under the concept of "substance over form", the contract to be considered should be the relevant economic relationship rather than the legal contract. We recommend a reference to the guidance in ED/2010/6, Revenue from Contracts with Customers, paragraphs 8-24. The IAA believes there should be no requirement to artificially split insurance contracts that contain many bundled, and interrelated, features. The IFRS for insurance should refer to the whole insurance contract in the sense of the ED/2010/6. The requirement to measure those financial components of the contract for which replicating portfolios exist, makes unbundling redundant. See to our response to unbundling in that regard. Referring to that principle eliminates the bracket insert in B28. We are not aware that this requirement, other than significant burden in realization, had any practical relevance. d. Insured interest The current requirement regarding insured interest in Appendix B should be reduced or even eliminated. While the IAA recognizes the allure of differentiating gambling from insurance, the necessity to apply a test of insured interest may unduly complicate the application of the ED. Any suggestion that the requirement of the last sentence in B14 could be interpreted as requiring the preparer to demonstrate that, before a benefit is paid, it has to explicitly prove that the insured event had an adverse effect on the beneficiary should be eliminated. This would be onerous on any insurer. In practice, that requirement already present in IFRS 4 was entirely ignored in case of life insurance. According to our knowledge, no life insurance contract world-wide contains a requirement to prove on request

		insured interest as pre-condition for payment of a benefit. Nevertheless, everywhere, ignoring B14, life insurance was assumed to be in scope of IFRS4. We recommend to extent the paragraph in that regard, that such a requirement is not needed in the contract, if the insured interest is invaluable for ethical reasons and therefore a need to prove its presence would be seen as inappropriate. Further, considering the kind of the insured event, insured interest generally would be assumed to be present, referring to the example of insurance on the life or the health of a human being: … if it is not satisfied that the event caused an adverse effect. Further, the contract does not need to include such a precondition, if the kind of insured risks, specifically if referring to the life or health of human beings, styling and purpose of the contract indicates generally the presence of insured interest but any requirement of a proof would be seen as inappropriate. e. Financial Risk and Financial Variables The Board should consider distinguishing between market and non-market driven variables rather than between financial and non-financial variables in the guidance about the definition of insurance contracts. Otherwise, an appropriate definition of the term "financial risk" is recommended. Subsequently, in the ED, reference is only made between market and non-market variables, but requiring in addition that those are directly observed in markets. Changes of variables are triggered by events. Events could be distinguished between those, which reflect changes of views of other, mainly market participants, of unchanged items and those which reflect actual changes in the characteristic of items, i.e. real events. The first could be referred to as market driven variables, the latter as non-market driven risk. A storm index and a bankruptcy index are not market driven variables. An inflation index is, since derived from market variables, a market driven variable. It appears

		important to distinguish market and non-market driven variables considering the very specific trigger of the first one. Clearly as well non-market driven variables could be distinguished further, e.g. physical variables, variables resulting from business activities, or variables affecting one party adversely (causing insurance risk if transferred) etc. The lacking differentiation resulting from the term of a "financial variable" becomes best clear in case of credit insurance. If the adverse consequences of a bankruptcy of an entity are transferred, it is insurance risk, if the adverse consequences of change in the credit rating (a third party view, not a real event) are transferred, it is not insurance risk. However, as well an actual bankruptcy could be understood to be a "financial variable" since it is a purely financial event, not a physical one, but it is clearly not a market driven variable.
(b)	Do you agree with the scope exclusions in paragraph 4? Why or why not? If not, what do you propose and why?	a. We agree with the scope exclusions in paragraph 4 because we believe that the topics are better addressed in specific guidance. We nonetheless do not see any reason for significantly different measurement principles. We believe that warranties should have the same measurement principle as insurance. We also believe that if insurance liabilities are measured with building blocks that include an adjustment for risk, then pension liabilities should be measured as well with an adjustment for risk. b. Presentation Guidance regarding assets covering unit linked obligations, unbundled unit linked obligations and any fulfilment cost other than directly paid in cash to policyholders We believe that paragraph 3 requires clarification. It does not consider that the ED includes guidance for presentation regarding items not within the scope of the ED. That applies to assets subject to IFRS 9 covering unit linked obligations according to ED.71 (a) and 78 (b). That applies to unit linked liabilities, which are, if unbundled according to ED.8 (a), subject to IFRS 9, according to ED 71 (b) and 78 (a) (if the ED actually intends to expand that guidance as well to such unbundled obligations). That applies to any acquisition, administration or settlement cost (including benefits in

		kind), which are not reported according to the presentation guidance for revenues and expenses usually applied for such cost, but net of released estimated cash flows from the insurance contract liability. That should be clarified here. c. Inclusion of Financial Guarantees We agree with the inclusion of financial guarantees in the scope of the standard. The insurance standard is the best fit as the contracts transfer risk related to a third party. We believe the markets would have been better served if these contracts had been subject in the past to measurement and disclosure requirements of insurance contracts. d. Inclusion of fixed fee service contracts We see no reason to exclude from scope fixed fee service contracts that would qualify as insurance contracts, such as roadside assistance. Just because legally standalone roadside assistance is not regulated as insurance, does not mean that it is appropriate to consider them as insurance for this purpose. We note that for this example, such service is also included in many insurance contracts.
(c)	Do you agree that the contracts currently defined in IFRSs as financial guarantee contracts should be brought within the scope of the IFRS on insurance contracts? Why or why not?	We see no reason that a financial guarantee contract qualifies under the definition of an insurance contract, that it should not be included in the scope of this project.
Unbundling (paragraphs 8–12 and BC210–BC225)		**Discussion at Toronto meeting** There was confusion about the meaning of "closely related" and how it related to terms previously used by the Board in its discussions, namely interrelated or interdependent. The term should be defined in the paragraph on unbundling and not left to the paragraph in embedded derivatives.

	There is not a way to draw line between the financial element and insurance in a single contract. There shouldn't be an abrupt break in treatment along the spectrum of contracts. On the other hand if the break point is not when to unbundle, then it is when the contract meets definition of an insurance contract Measurement of financial elements in insurance contracts is not significantly different from standalone financial instruments, so accounting will be comparable. Unbundling is practically difficult. Background reasons for desire of the IASB for unbundling • for embedded derivatives so entities can't avoid fair value measurement by making it insurance and • for minimum deposit floor Perception is that the intent is that any insurance contract with an explicit account value should be unbundled If unbundled, negative reserves must be allowed to have the same effect as no cash value floor. Suggestion that the guidance in paragraph 8c is all that is needed "contractual terms relating to goods and services that are not closely related to the insurance coverage but have been combined in a contract with that coverage for reasons that have no commercial substance " Also could use guidance from paragraph 15 of revenue recognition regarding no discernable impact on price charged for the contract. "… an entity shall segment a single contract and account for it as two or more contracts if the price for some good or services in the contract is independent of the price of other goods and services in the contract. Goods or services are priced independently

	of other goods or services in the same contract only if both of the following conditions are met: a) the entity, or another entity, regularly sells identical or similar goods or services separately; and b) the customer does not receive a significant discount for buying some goods or services together with other goods or services in the contract.
Question 12 – Unbundling	
Do you think it is appropriate to unbundle some components of an insurance contract? Do you agree with the proposed criteria for when this is required? Why or why not? If not, what alternative do you recommend and why?	We think it is appropriate to unbundle some components of an insurance contract but we do not agree with the proposed criterion. We believe that it is appropriate to unbundle derivatives embedded in insurance contracts that are not themselves insurance features. In other words we would retain the criteria in IFRS 4 for separating embedded derivatives. We believe that it is appropriate to separate service components of insurance contracts when the insurance is provided as an ancillary benefit to the service, for example, when stop loss insurance is provided to accompany an administrative services contract related to employer-provided health or welfare benefits. The criterion "closely related" lacks the clarity to be practically implemented. The example in paragraph 8(a) describes a contract type (apparently variable or unit-linked) for which unbundling is typically difficult and, in our view, not appropriate. We are concerned that the intent of the Board is to require unbundling when the separation would be artificial. The wording in paragraph 9 regarding cross-subsidies asks insurers to assume away the inter-dependence in order to make components appear to be not closely related when in fact they are. We suggest that the criterion for unbundling for insurance contracts be along the lines in paragraph 15 of the IASB's exposure draft *Revenue from Contracts with Customers*. The criterion is that entities segment single contracts and

	account for certain goods and services as separate contracts when their price is independent of the price for other goods and services. This criterion could be made applicable to insurance contracts. We also recommend that the Board retain paragraph 8(c) of the ED, which refers to goods and services that have been combined for reasons that lack commercial substance, in order to prevent abuse. Vote of meeting attendees on proposals to suggest 1 Closely related w/o example 4 2 Follow 8c w/o ref to closely related 11 3 Use rev rec Para. 15 4 4 We suggest therefore that criteria for unbundling be based the apparent transparency of the movement in the deposit component to the policyholder and the ability to analyze the deposit component based on explicit elements of the contract. 1 Vote on unbundling or separating - embedded derivatives all - account value products 3 - service components 8c all In view of the sentiment to recommend that contracts not be unbundled unless the financial component lacked commercial substance, the method for unbundling was not discussed. BC215 purpose to consistency across industry and user insight into workings of hybrid contracts
Presentation (paragraphs 69–78 and BC150–BC183)	
Question 13 – Presentation	**<u>Discussion at Toronto meeting</u>** The main topic was presentation and a discussion of whether the presentation

		should be an expanded margin or a summarized margin. Views varied with some saying an expanded margin was needed to present the quantum of claims and expenses not found in the summarized margin approach. Some were satisfied that this information was provided in the notes to the financial statements. A vote showed stronger support of expanded margin, but the count indicates that a number of attendees were indifferent. <u>Vote count</u> Expanded 7 Summarized 5 In other matters, the group agreed that fees and expenses for linked contracts should not be netted and that the language in paragraph 78(a) should be clarified if this is not the intent. Similarly the language in paragraph 69 should be revised so that it does not seem to require that the liability for each portfolio must be presented separately.
(a)	Will the proposed summarised margin presentation be useful to users of financial statements? Why or why not? If not, what would you recommend and why?	We believe the summarized margin approach will be useful but we believe the presentation would be more useful if additional amounts reflecting the quantum of the items that result in the experience adjustment for long duration contracts. The ED proposes this information be presented for short duration contracts and it is presented in profit or loss for most accounting regimes currently. The amounts that give rise to the experience adjustment are the expected claims and expenses (including expected incremental acquisition costs) and the actual claims and expenses (including actual incremental acquisition costs). We are aware that the disclosure of the movement in the liability will reflect the expected amounts in the reconciliation of the beginning liability to the ending liability and that the actual payments will be disclosed as well. We nonetheless believe that the experience gain or loss presented in profit or loss is placed in

(a)	Will the proposed summarised margin presentation be useful to users of financial statements? Why or why not? If not, what would you recommend and why?	We believe the summarized margin approach will be useful but we believe the presentation would be more useful if additional amounts reflecting the quantum of the items that result in the experience adjustment for long duration contracts. The ED proposes this information be presented for short duration contracts and it is presented in profit or loss for most accounting regimes currently. The amounts that give rise to the experience adjustment are the expected claims and expenses (including expected incremental acquisition costs) and the actual claims and expenses (including actual incremental acquisition costs). We are aware that the disclosure of the movement in the liability will reflect the expected amounts in the reconciliation of the beginning liability to the ending liability and that the actual payments will be disclosed as well. We nonetheless believe that the experience gain or loss presented in profit or loss is placed in perspective if actual and expected claims and expenses are presented as well.
(b)	Do agree that an insurer should present all income and expense arising from insurance contracts in profit or loss? Why or why not? If not, what do you recommend and why?	Yes we agree. We do not see a need to present any items of income or expense in other comprehensive income. Our position is premised on the understanding that the movement in investments supporting liabilities will be presented in profit or loss. If some part of the movement in investments is presented in other comprehensive income, we would recommend that the Board consider presenting the corresponding part of the movement in insurance liabilities in other comprehensive income as well.
Disclosures (paragraphs 79–97, BC242 and BC243)		**Discussion at Toronto meeting** There was agreement on the disclosure principle
Question 14 – Disclosures		
(a)	Do you agree with the proposed disclosure principle? Why or why not? If not, what would you recommend, and why?	We agree with the principle. We believe that the principles are consistent with the principles and practices already in place as a result of IFRS 7 and IFRS 4, which have proven to be useful and to be adequate.
(b)	Do you think the proposed disclosure requirements will meet the proposed objective? Why or why not?	In general, yes. We note that in our response to question 5(c) we have expressed our position to 90(b)(ii) that if the insurer uses TVaR or CoC method

Question 15 – Unit-linked contracts		
Do you agree with the proposals on unit-linked contracts? Why or why not? If not what do you recommend and why?		We agree.
Reinsurance (paragraphs 43–46 and BC230–BC241)		
Question 16 – Reinsurance		
(a)	Do you support an expected loss model for reinsurance assets? Why or why not? If not, what do you recommend and why?	Yes, we favour an expected loss model for reinsurance assets.
(b)	Do you have any other comments on the reinsurance proposals?	We agree with the statement in the basis for conclusions, paragraphs BC233, that "a cedant should measure its reinsurance assets on the same basis as its underlying direct insurance liability." There is further discussion of this concept in paragraph BC234. However, these concepts did not appear to be carried to the exposure draft in several instances, as described below. There are elements as to the application of ceded reinsurance that would create challenges as currently stated, in particular as it regards property/casualty insurance, including: • Measurement issues, such as: o Ceded reinsurance and the modified approach - - it is not clear whether the modified approach for short duration contracts (par. 54-60) would be applicable for ceded reinsurance o Many property/casualty reinsurance contracts are entered into on a risks attaching basis; in this regard, it is not clear if a 12 month risks attaching contract covering one year policies, but having an aggregate coverage period spanning 2 years, would be accounted for under the modified approach. o Measurement and linkage with the direct contracts - for risks attaching ceded reinsurance contracts, the ceding company

		would need to project cash flows, estimate building blocks and set their margin based on expected cash flows at contract inception. However, the direct policies have not yet been written, and as such the ceding company would be accounting for the policies before they are written on a direct basis. o Measurement objective of the explicit risk adjustment - it is not clear as to whether the measurement objective for the explicit risk adjustment on ceded reinsurance contracts is based on the fulfilment cash flows on the ceded reinsurance contract, or the expected reduction in the risk adjustment for the direct business based on the existence of ceded reinsurance. • Presentation and disclosure - both the summarized margin and the traditional presentations of the performance statement are to be prepared on a gross of reinsurance basis, with the net impact of reinsurance reflected in a single line. However, for many property/casualty companies, having the results both gross and net as to reinsurance would provide a more meaningful insight into the financial results of the company. *Ceded Reinsurance and Measurement Issues* The ED's discussion of ceded reinsurance is in paragraphs 43 through 46. In addition, there are additional paragraphs in the ED that discuss disclosure of amounts related to ceded reinsurance. Paragraph 43 directs to the preparer to measure a ceded contract based on the fulfilment value cash flow approach (i.e., the "building block" approach described in paragraph 22, with guidance on the detailed in paragraphs 23 through 39, and further explained in Appendix B, paragraphs B34 through B103). The same paragraph directs the preparer to include a residual margin in measuring the ceded liabilities, to the extent that such margin is positive. Paragraph 44 then directs to the preparer to estimate ceded contract cash flows "in the same manner as the corresponding part of the present value of the fulfilment cash flows for the underlying contract …". In other words,

		follow the same building block approach as used for the direct insurance contracts. However, paragraphs 54-60 directs the preparer to use a modified approach for short duration contracts, that is, the building block approach is replaced with an unearned premium approach for short duration pre-claims liabilities. While we would expect that the guidance in paragraphs 54-60 applies to both direct and ceded short duration contracts, we note following: • Paragraphs 54-60 do not address ceded reinsurance. • The example provided in the Appendix that provides an example as to how ceded reinsurance would be applied, as provided in paragraph B36, uses the standard building block approach, not the modified approach, and further it does not address short duration contracts. • In the Basis for Conclusions paragraph BC233, it says that "a cedant should measure its reinsurance assets on the same basis as it underlying direct liability", but (1) this section of the document is not an official part of the standards, and (2) the subsequent wording in BC234 assumes that the building block approach is used, with no reference to the short duration "premium allocation" method. In addition, many ceded reinsurance contracts cover policies attaching during a 12 month period, not the underlying covered exposure during a 12 month period. As such, these ceded contracts have a 24 month coverage period, and as such, the ceded contract might not be viewed as "short duration" under the ED since the period of risk coverage is longer than 12 months. If such ceded reinsurance contract would not be accounted for under the modified approach, the same issues regarding mismatch of direct and ceded amounts as described above would exist in this scenario. The following illustration provides more insight on this matter. Assume a ceded reinsurance contract covers claims over $100,000 for insurance contracts that become effective from January 1, 2012 to December 31, 2012. Direct insurance policy A is sold with an effective date of January 1,

		2012 and a 12 month term. Direct insurance policy B is sold with an effective date of December 31, 2012 and a 12 month term. Both policies A and B are covered by the ceded contract, hence the coverage period for the ceded contract is from January 1, 2012 to December 31, 2013 – a period of 24 months. The language in paragraphs 54-60 would apply the "premium allocation" method for determining the pre-claims liability of the direct policies. However, given the coverage period of the ceded contract would span 24 months, the ceded reinsurance contract would be determined using the building block approach. As a result, the direct and ceded accounting would not be consistent, resulting in less useful financial statements, especially when compared to the existing accounting paradigm for such business. Similar examples can be made for other reinsurance contracts, such as certain catastrophe contracts, that are longer than 12 months but insure direct policies that are 12 months are less. In addition, for risks attaching contracts, under either the modified approach or the building block approach, as written the ceding company would need to estimate and account for cash flows for policies that may not have yet even been written or accounted for on a direct basis. It is not clear that this result is intended or even desirable. Further, it is not clear as to the measurement objective for the explicit risk adjustment on ceded reinsurance contracts. For consistency in measuring direct and ceded amounts, we would expect that the measurement objective of the risk adjustment for ceded reinsurance contracts would be based on the amount that the presence of such reinsurance reduces the risk adjustment that was calculated on a direct basis. Given the importance of ceded reinsurance to the financial results of a company, presentation and comparability would be improved by recognizing and estimating ceded amounts in a manner that matches the approach used for the direct business to which it applies. Accordingly, we would recommend that the same model (e.g., the standard model or the modified approach) and consistent measurement objective be used to

		measure and present amounts ceded to reinsurance as that used for the direct amounts to which the cessions relate. This would make clear that it would be appropriate to calculate the risk adjustment on amounts ceded to reinsurance based on the difference between the risk adjustment determined on a gross of reinsurance basis less a net of reinsurance basis. If the measurement, presentation and disclosure for amounts direct and ceded to reinsurance are not consistent, the result would not be useful for users of the financial statements. *Ceded Reinsurance and Presentation* For many property/casualty companies, reinsurance is a fundamental part of the business model. In addition, most property casualty contracts would be covered under the modified approach for short duration policies. Either in the presentation statement or in the notes to the financial statements, such presentation would include premiums and losses, gross as to reinsurance. The impact of amounts ceded to reinsurance would appear to be condensed in a single line. Reinsurance is a fundamental to the financial performance of many insurance companies. While the evaluation of property/casualty insurance companies does consider information gross of reinsurance, key income statement statistics such as earned premiums and incurred losses are often evaluated on a net of reinsurance basis. In most jurisdictions, earned premiums and incurred losses are presented in the income statement on a net of reinsurance basis. Insurance companies often use reinsurance to manage reduce their risk as a key part of their business model, and as such statistics measured net of such statistics have significant value. In this regard, would recommend the following: • In paragraph 75, clarify that items (a) (i) premium revenue, and (a) (ii) losses incurred, are meant to be presented and/or disclosed, gross as to reinsurance and ceded as to reinsurance and net of reinsurance • In paragraph 90 (b) (i), clarify that the disclosure on risk adjustment should be prepared on a gross as to reinsurance and net of

(b)	Do you have any other comments on the reinsurance proposals?	We agree with the statement in the basis for conclusions, paragraphs BC233, that "a cedant should measure its reinsurance assets on the same basis as its underlying direct insurance liability." There is further discussion of this concept in paragraph BC234. However, these concepts did not appear to be carried to the exposure draft in several instances, as described below. There are elements as to the application of ceded reinsurance that would create challenges as currently stated, in particular as it regards property/casualty insurance, including: • Measurement issues, such as: o Ceded reinsurance and the modified approach - - it is not clear whether the modified approach for short duration contracts (par. 54-60) would be applicable for ceded reinsurance o Many property/casualty reinsurance contracts are entered into on a risks attaching basis; in this regard, it is not clear if a 12 month risks attaching contract covering one year policies, but having an aggregate coverage period spanning 2 years, would be accounted for under the modified approach. o Measurement and linkage with the direct contracts - for risks attaching ceded reinsurance contracts, the ceding company would need to project cash flows, estimate building blocks and set their margin based on expected cash flows at contract inception. However, the direct policies have not yet been written, and as such the ceding company would be accounting for the policies before they are written on a direct basis. o Measurement objective of the explicit risk adjustment - it is not clear as to whether the measurement objective for the explicit risk adjustment on ceded reinsurance contracts is based on the fulfilment cash flows on the ceded reinsurance contract, or the expected reduction in the risk adjustment for the direct business based on the existence of ceded reinsurance. • Presentation and disclosure - both the summarized margin and the

Question 19 – Benefits and costs	
Do you agree with the Board's assessment of the benefits and costs of the proposed accounting for insurance contracts? Why or why not? If feasible, please estimate the benefits and costs associated with the proposals.	No comment at this time.
Other Issues	
Treatment of policy loans	
Recognition date	If earlier than the initiation of the coverage period, most insurers do not currently capture this date. Although we recognize the need of reflection of onerous contracts when initially obligated, we are concerned with the cost and measurement issues associated with the use of the definition of this date.