Draft Educational Note

Application of IFRS 17 Insurance Contracts to Public Personal Injury Compensation Plans

Committee on Workers' Compensation

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The actuary should be familiar with educational notes. They do not constitute standards of practice and are, therefore, not binding. They are, however, intended to illustrate the application of the Standards of Practice, so there should be no conflict between them. The actuary should note however that a practice that the educational notes describe for a situation is not necessarily the only accepted practice for that situation and is not necessarily accepted actuarial practice for a different situation. Responsibility for the manner of application of standards of practice in specific circumstances remains that of the members. As standards of practice evolve, an educational note may not reference the most current version of the Standards of Practice; and as such, the actuary should cross-reference with current Standards. To assist the actuary, the CIA website contains an up-to-date reference document of impending changes to update educational notes.

MEMORANDUM

To: Members in the PPICP area

From: Steven W. Easson, Chair
Actuarial Guidance Council

Wai (Ryan) Tse, Co-Chair
Michael Williams, Co-Chair
Committee on Workers' Compensation

Date: November 13, 2020

Subject: **Draft Educational Note: Application of IFRS 17 Insurance Contracts for Public Personal Injury Compensation Plans**

The Committee on Workers Compensation (CWC) has prepared this draft educational note to provide guidance to all Public Personal Injury Compensation Plans (PPICP) practitioners in implementing IFRS 17 Insurance Contracts (IFRS 17) for PPICPs in Canada.

This draft educational note refers to the subjects covered by IFRS 17 with specific application to PPICP insurance contracts issued in Canada. Other educational notes on IFRS reporting may also be relevant to PPICP practitioners. For example, additional information can be found in the draft educational note *Application of IFRS 17 Insurance Contracts*.

The draft educational note is structured into seven (7) sections plus one (1) appendix in addition to an introduction and a background. The introduction covers guiding principles and some formatting rules. The background documents for PPICP practitioners and other users relevant variations among PPICP entities which may influence the implementation of IFRS 17 standards. The first three sections consider (1) insurance contracts, (2) identification, aggregation and recognition, and (3) measurement approaches. Section four (4) introduces contract boundary, a complex concept for actuaries in the PPICP area which is reflected in separate guidance for short contract boundary (Section five (5)) or long contract boundary (section six (6)). Section seven (7) ends with the role of the actuary. The appendix provides a glossary of terms.

The draft educational note *Compliance with IFRS 17 Applicable Guidance* provides guidance to actuaries when assessing compliance with IFRS 17. It is applicable to all educational notes pertaining to IFRS 17 and members are encouraged to review it prior to reading any educational note related to IFRS 17.

The determination of the contract boundary is critical to the measurement and presentation of insurance contracts under IFRS 17. As this draft educational note covers such a vital IFRS 17 issue, the CWC and the Actuarial Guidance Council (AGC) wish to emphasize the substantial amount of ongoing professional judgment that is necessary in the determination as well as implementation of contract boundary for a PPICP entity. There were rigorous debates, with supporting arguments, amongst many committees within the CIA on whether a PPICP insurance contract has a short contract boundary or long contract boundary. Actuaries, accountants and auditors from the PPICP area have together and separately considered (i) providing guidance only for short contract boundary; (ii) providing guidance only for long contract boundary; (iii) providing guidance on both short contract boundary and long contract boundary and allowing the entity with its auditor to determine based on "facts and circumstances" whether its insurance contract has a short contract boundary or a long contract boundary. The practice is also aware that the Accounting Standards Board of Australia has mandated short contract boundary for entities that issue workers compensation insurance contracts. On balance, the CWC and the AGC have preliminarily concluded the best approach is approach (iii) which allows for short contract boundary or long contract boundary as warranted by "facts and circumstances" for each PPICP entity.

The CWC recognizes that:

i) There are potential variations in accounting interpretations and resulting financial reporting.

ii) Management together with the external auditor will be making determinations (accounting in nature) with respect to IFRS 17 that will be used by actuaries in measuring liabilities.

iii) The valuation of liabilities for financial reporting purposes (IFRS 17) could be different than the valuation of benefits liabilities for funding purposes.

The CWC and AGC are committed to closely monitoring the continued appropriateness of this draft educational note so that it can be updated in a timely manner.

The creation of this cover letter and draft educational note has followed the AGC's Protocol for the Adoption of Educational Notes. In accordance with the Institute's *Policy on Due Process for the Approval of Guidance Material other than Standards of Practice and Research Documents*, this draft educational note has been prepared by the CWC and has received approval for distribution by the AGC on November 10, 2020.

The actuary should be familiar with relevant educational notes. They do not constitute standards of practice and are, therefore, not binding. They are, however, intended to illustrate the application of the Standards of Practice, so there should be no conflict among them. The actuary should note however that a practice that an educational note describes for a situation is not necessarily the only accepted practice for that situation and is not necessarily accepted actuarial practice for a different situation. Responsibility for the manner of application of standards of practice in specific circumstances remains that of the members. As standards of practice evolve, an educational note may not reference the most current version of the

Standards of Practice; and as such, the actuary should cross-reference with current Standards. To assist the actuary, the CIA website contains an up-to-date reference document of impending changes to update educational notes.

The CWC would like to acknowledge the following individuals for their contribution to the development of this draft education note: Ligia Acevedo, Julie Bélanger, Crispina Caballero, Peter Douglas, Conrad Ferguson, Matthew Garnier, Carol-Anne Garon, Rob Hinrichs, Candice Lam, Lalina Lévesque, Marie-Hélène Malenfant, Mario Marchand, Ke Min, Marie-Eve Morency, Cynthia Potts, Mark Simpson, Lesley Thomson, Wai Tse, Jeffery Turnbull, Stanley Warawa, Michael Williams, Yun Xu, and Ray Ying.

Questions or comments regarding this draft educational note may be directed to the co-chairs of the CWC (Ryan Tse at ryan.tse@worksafebc.com and Michael Williams at mwilliam@wcb.mb.ca).

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Introduction

IFRS 17 establishes principles for the recognition, measurement, presentation, and disclosure of insurance contracts. The purpose of this educational note is to provide practical guidance on Canadian-specific issues relating to implementing IFRS 17 for PPICP insurance contracts in Canada. References to specific paragraphs of IFRS 17 are denoted by IFRS 17.XX, where XX represents the paragraph number.

In writing this educational note, the CWC followed these guiding principles:

- Consider Canadian-specific perspectives rather than simply repeating international actuarial guidance.
- Develop application guidance that is consistent with IFRS 17 and applicable Canadian actuarial standards of practice and educational notes without unnecessarily narrowing the choices available in IFRS 17.
- Consider practical implications associated with the implementation of potential approaches and methods; in particular, ensure that due consideration is given to options that do not require undue cost and effort to implement.

Background

1. Public Personal Injury Compensation Plans

Paragraph 1120.54 of the CIA *Standards of Practice* states:

> Public personal injury compensation plan means a public plan
>
> - Whose primary purpose is to provide benefits and compensation for personal injuries;
> - Whose mandate may include health and safety objectives and other objectives ancillary to the provision of benefits and compensation for personal injuries; and
> - That has no other substantive commitments.
>
> The benefits and compensation provided under such public plans are defined by statute. In addition, such public plans have monopoly powers, require compulsory coverage except for those groups excepted by legislation or regulation and have the authority to set assessment rates or premiums.

PPICP contracts are specific to each board (the entity as defined under IFRS 17). The characteristics of the contracts are defined in the relevant legislation (Act or Acts) and regulations. Furthermore, each Act is administered by an independent board. Each board in its administration of the Act and related policies and practices may have board-specific variations in the terms of contracts, which could affect financial reporting requirements under IFRS 17. As a result, there could be different conclusions across boards about key determinations under IFRS 17 that affect the financial measurements required from actuaries. For example, while each board may have a funding policy, the implementation details would differ across jurisdictions. For instance, the target period of recovery of deficits would vary (e.g., five years

versus 20 years). Further, if the funding policy is defined only in policy and not in legislation, then it can be suspended or modified by the board. If instead, it is defined in legislation, then any modification will require action from the governing legislative body.

The financial statements and other financial reporting constitute an essential source of information to the stakeholders of these boards, the employers (policy-holders as defined under IFRS 17), the employees (insured population), the provincial/territorial government, and the general public. There are no investors per se, but the stakeholders are users who need to understand economic results. Since these boards are not subject to financial supervision by a regulatory authority the financial statements are the only source of externally audited financial information that readers can rely on to understand the financial operations and results at a given measurement date. For the users, transparency of financial results is more important than comparability of the financial results.

The purpose of the IFRS 17 valuation is no longer the same as the funding valuation. There needs to be a separate funding valuation for purposes of setting assessment rates.

Further, some public systems offering coverage in other areas (i.e., Société de l'assurance automobile du Québec (SAAQ)) were set up to operate on a basis similar to workers compensation boards (WCBs). Such systems may provide similar benefits and may operate under the same or similar principles. Where the context applies, mention of WCBs would also include such systems.

2. Meredith principles

The Meredith principles established in 1913 by Sir William Meredith underlie the workers compensation systems in Canada. These principles are important to understand the context of WCBs and may be relevant to some of the determinations required under IFRS 17.

Sir Meredith had reviewed the private tort liability system that was providing injured workers in Ontario with compensation for injuries (and illnesses) suffered in the workplace. Key findings included deficiencies in coverage of injured workers and lack of benefit security for injured workers and their families. He recommended the implementation of an independent body (WCB) to provide coverage and administer benefits for injured workers. The recommended principles were no fault insurance, security of benefits, collective liability, independent administration (WCB) and exclusive jurisdiction. In time, every jurisdiction in Canada adopted systems guided by the Meredith principles.

The development of workers compensation systems in Canada involved a historical compromise whereby workers gave up their right to sue their employer in the event of a work-related injury or illness in exchange for employers accepting full responsibility for funding a multi-party, no-fault system of workers compensation operated by an independent board at arm's length from the government. The systems have evolved to respond to changing socio-economic circumstances and court decisions under private tort liability, but the Meredith principles are still adhered to today.

3. The unique features of WCBs

WCBs have many financial and operational characteristics embedded in their foundational principles and historical operations that make them unique in the context of IFRS 17. Some of the key differentiators with private insurers are discussed below to provide more context to this educational note.

a. Operating environment:

- WCBs have a monopoly on providing workers compensation coverage to employers who meet the coverage requirements of the Acts and are obligated to provide coverage to all qualified employers.
- Workers compensation legislation mandates employers to register with the board upon commencing operations in the jurisdiction and to pay the assessed premiums. The legislation empowers the WCB to enforce payment of premiums (often referred to as assessments), including provision of security to cover payment, withholding of clearances, suspending operations, liens on property, or seizure of debtor assets. However, the WCB has a statutory obligation to provide employer coverage and pay benefits, irrespective of insurable risk, default on premiums, or insolvency. Neither employers nor the board can opt out of coverage at any time (no contract renewal is contemplated by the Acts). There could be jurisdictional variations.
- There are no solvency requirements, nor has there ever been a closure. These systems have demonstrated a strong resilience to the economic volatility and an ability to adapt to a changing socio-economic environment. Even if there has never been a closure, huge deficit positions in some period have not been uncommon and as a result, additional material assessments have been levied for a few years and major benefit cuts have been imposed.
- Legislation (and associated regulations), policies and practices are reviewed and updated from time to time and are not a constant. However, in assessing the nature of the contract, IFRS requires the assumption that the current environment continues unless and until a change is substantively enacted.
- The nature of the workers compensation insurance system forces a correction when the system becomes too expensive for the employers or becomes too lean for the employees. A few if not most of the boards have been at a low funded level (<70%) which has required specific intervention to get to fully funded.

b. Coverage:

- The coverage is provided on a continuing basis. When an employer meets the requirements of the board, registration is required, and premiums are paid. Qualified employers remain covered until they cease to operate their business and no longer have any paid staff.
- Workers cannot seek coverage on their own.

- Workers have to be employed by a covered employer in order to be eligible for benefits.

c. Premium rates:

- Acts often stipulate that WCBs shall set rates annually to cover the cost of new claims expected to occur along with administrative expenses. The Act also often stipulates that WCBs shall increase premiums and recover past deficits over a reasonable period. Adjustments are often implemented in premiums (surcharge or discount) to recover past deficits or amortize funds in excess of the level deemed by each WCB to be required for financial sustainability. The amortization periods vary by jurisdiction.
- Premium rate setting, in advance of the year in question, is currently managed on an annual cycle. Claims tracking, experience, assumptions, and cash flow estimates supporting the valuation of liabilities are reviewed and updated at least as often as annually.
- Employers are individually accountable as their rate depends on the industry they belong to and for some employers, their own cost experience. The other side of individual accountability is collective liability. The balance between collective liability and individual accountability can vary. Generally, collective liability is a more significant element of coverage provided by WCBs than private insurers.
- All boards operate a diversified portfolio of assets, developed to balance risk and return and with the expectation that the premiums and investment returns will fund the cost of benefits defined under the Act, at rates that are deemed fair and affordable, over time.
- Operationally, there are employers which pay premiums on an annual basis based on estimated payroll and there is an adjustment for the actual payroll at the end of the year. There are employers which pay premiums on a monthly basis. The timing and proportion of premiums paid in advance vary by the employer. The total premium charged for the year include new claim costs for the coverage year and, if applicable, the amount of rebate or surcharge under the funding policy.

d. Insurance risk:

- In most cases, individual employers transfer significant insurance risks to WCBs.
- Covered employers are collectively liable for the costs of claims from employers that have gone out of business and for those which did not pay their premiums.

e. Benefits:

- Entitlement to benefits is triggered by a work-related incident (injury or illness). The worker is entitled to all benefits covered by the Act, sometimes for life, to the age set by the Act or as benefits for dependants. These benefits are typically paid regardless of the premium paying status of their employers.

f. Funding:

- In most cases, the WCB has a funding policy in place which is approved by the board. Some have a history of adjusting rates below and above the rate required for new claim costs.
- There are accepted intergenerational transfers as new employers are treated the same as renewing employers. The funding policies strive to maintain intergenerational equity by ensuring orderly funding and reducing the incidences where employers are burdened with costs of prior years.
- Some Acts mandate full funding but policy provides guidance on implementation. Policies are usually reviewed regularly and can be suspended or changed by the board.
- Some boards have experienced low funding levels (<70%) in the past. In these cases, additional assessments were charged in order to recover the deficit. These additional assessments sometimes took five to 10 years or more to recover the deficit. In some cases, the boards also had to resort to benefit changes (sometimes affecting claims in payment) in order to recover the deficit. Sometimes the investment returns greater than expected provided some relief to the large deficits.

g. Claims are closed when survivor benefits terminate:

- Workers are entitled to the benefits that were in existence at the time of the recurrence or worsening of the injury condition. Re-opening of a particular claim because of a recurrence or worsening of the injury might trigger additional benefit payment many years after the injury or many years after the previous payment.
- Legislative changes, including extent of work-related covered conditions and types of benefits, sometimes apply to all injured workers regardless of when the initial work injury occurred.

4. Variations by WCBs

There are some relevant variations by WCBs that could affect the implementation of IFRS 17. The legal form of the contracts and their administration vary by board. This includes the legislation along with the related regulations, policies and practices. Examples of variations (each item discussed in the highlighted chapter) include the following:

a. Extent of employers' coverage: The coverage may exclude or exempt major industries (i.e., finance industry), occupations (i.e., professional athletes) and employer types (those with less than three employees). Chapter1.

b. Self-insured employers: The prevalence and size of self-insured employers, the administration in terms of security provisions (collateral) required by the plan, and the party who is ultimately liable in the case of default of payment of the required sums by the employers. Chapter 1.

c. Other coverage: The proportion of employers obtaining other coverage such as personal, voluntary, etc. Chapter 1.

d. Other services: The extent of additional services that are the responsibility of the board (e.g., prevention services, occupational health and safety services, funding of worker/employer advisor) as well as the terms governing such services and their administration. Chapter 1.

e. Regulatory governance: The party (parties) ultimately responsible for regulating the activities of the board (e.g., minister of labour, auditor general). Chapter 7.

f. Funding policies: The existence and terms of a formal funding policy, the funding target, funding basis and any legislative funding requirements. Chapters 4, 5, and 6.

g. Rate setting: The model and process used to set assessment or premium rates, and any administrative or legislative constraints that impact the ability to fully adjust rates as required from year to year. Chapters 4, 5, and 6.

In summary, WCBs:

- operate on a going-concern basis;
- have a monopoly on insurance coverage for the population defined in their governing legislation where the employers are required to pay premiums as determined by the boards and cannot opt out of coverage;
- issue contracts where the terms are defined by legislation;
- are obliged to provide benefits to claimants for as long as required and services to employers for as long as they are operating, except in the case of some self- insured employers; and
- usually establish premiums annually and require premium adjustments to support the financial sustainability of the system, guided by a funding policy adopted by the board. The funding policy typically defines the basis for the financial measurement that will be used to estimate the required rate adjustments, if any.

Owing to the unique characteristics of PPICPs in general, and of the unique features in each board's governing legislation and resulting administration, there may be variations in financial reporting from board to board. In addition, there will be an evaluation of various management (accounting in nature) determinations with respect to IFRS 17 standards and accordingly provision of appropriate disclosures with respect to any inconsistencies between the financial reporting basis and the funding operations of the boards. This educational note is intended to provide guidance in light of these potential variations in accounting interpretations and resulting financial reporting.

Chapter 1 – Insurance contracts for WCB

1.1 Types of policy-holders of WCB insurance contracts

WCBs provide coverage to three types of employers:

1. Premium paying employers, including some who may opt for coverage on a voluntary basis.
2. Self-insured employers.
3. Employers under the Government Employee's Compensation Act (GECA).

As mentioned in the background, there is a small proportion of employers with personal or voluntary coverage which are usually grouped with premium paying employers.

1.2 Insurance contracts under IFRS 17

As defined in Appendix A of IFRS 17, an insurance contract is an agreement between the entity and a policy-holder whereby the entity accepts significant insurance risk from the policy-holder. IFRS 17.2 indicates that contracts can be written, oral, or implied by an entity's customary business practices. Further, contractual terms include all terms in a contract (explicit or implied), and implied terms in a contract include those imposed by law or regulation.

To understand whether the contracts issued by a WCB for each type of employer meet the definition of insurance contracts and thus are in scope of IFRS 17, one will look at the legal form of the coverage, the relevant Act or Acts (Act) supplemented by regulations and policies, and customary business practices.

Premium paying employers (assessed)

IFRS 17 would apply if there is significant transfer of insurance risk in the agreement between a policy-holder and the WCB. Such transfer of insurance risk would usually exist for premium paying employers because of the potential economic impact on an individual employer that a severe injury claim could impose in the absence of PPICP coverage. Correspondingly, it could be inferred that a WCB accepts significant insurance risk in exchange for the premiums that each assessed employer pays.

While the terms "insurance contract" and "policy-holder" are generally not found in the governing workers compensation legislations, it can be inferred that the two parties under the contract for purposes of IFRS 17 reporting are the WCB and each premium paying employer, respectively. In this case, the issuer of the contract is the board, which is required under statute to administer the workers compensation system, and the policy-holder is the individual assessed employer, who is required to register under the Act and cannot opt out of coverage.

Self-insured employers (self-insured)

If the legal form of the contract defines employers as falling under the definition of self-insured as used for financial reporting, then the board needs to evaluate whether such contracts meet the definition of insurance contracts under IFRS 17. Self-insured employers typically fund the cost of workplace insured events on a pay-as-you-go basis. Other than small amounts on

deposit, they make payments to the board to cover the cash payments on claims, the accumulation of annuity accounts where applicable and a share of the administration expenses. In effect, all incoming and outgoing cash flows are exactly matched, usually on monthly basis.

Whether these contracts transfer significant insurance risk or not depends on the terms of the contract and related legislation. To the extent that these contracts are determined to be within the scope of IFRS 17, the measurement of insurance contract liabilities would follow similar considerations as for premium paying employers. If the contracts are not within the scope of IFRS 17, they would be covered by IFRS 15.

Employers under the government employee's compensation act (GECA)

The contract for an employer under GECA is always for administration services only as the covered employer is bound under GECA for insurance coverage, while the board provides claims adjudication, accounting, and other administrative services. By statute, the boards clearly do not accept any insurance risk in relation to workers and employers under GECA. Accordingly, financial reporting is not covered under IFRS 17 but rather IFRS 15.

Chapter 2 – Identification, aggregation, and recognition of insurance contracts

2.1 Identification of insurance contract portfolios

IFRS 17.14 states that*, "*An entity shall identify portfolios of insurance contracts. A portfolio comprises contracts subject to similar risks and managed together. Contracts within a product line would be expected to have similar risks and hence would be expected to be in the same portfolio if they are managed together*."*

The legislation governing workers compensation coverage in each jurisdiction establishes the benefits available to covered workers who sustain a work-related injury or illness. The Acts separate insurance contracts into insurance contracts for two types of employer categories as described in Chapter 1, and these would normally define two insurance contract portfolios for each board – one for premium paying employers and another for self-insured employers (where applicable).

Portfolios of contracts are divided into groups of contracts as described below. "Group" is the level of aggregation at which insurance contract liabilities are measured under IFRS 17.

2.2 Grouping of insurance contracts by profitability

IFRS 17.16 states that, "An entity shall divide a portfolio of insurance contracts issued into a minimum of:

a) a group of contracts that are onerous at initial recognition, if any;

b) a group of contracts that at initial recognition have no significant possibility of becoming onerous subsequently, if any; and

c) a group of the remaining contracts in the portfolio, if any."

For the reasons stated above, these concepts present challenges in direct application to the WCB. Entities are, by definition under their governing legislations, "not-for-profit". Therefore,

the determination of whether a contract is onerous or not is dependent on the various accounting interpretations made for each specific board. In particular, the determination of whether the contract boundary is short (to the next renewal period, usually one year) or long (including all future renewals, indefinite length) is an essential first step (see Chapter 4), as this determines whether future premiums (assessments) are taken into account in the measurement of liabilities.

If the contract boundary is determined to be short, each new issue and each renewal is considered to be a separate contract. Grouping of contracts by profitability will be required, because, although "not for profit" over the long run, any particular year's contracts (whether newly issued or a renewal) can be profitable or onerous. If the premium allocation approach (PAA) is applied, the assessment of whether contracts are onerous and what group they fall into is based on relevant facts and circumstances (IFRS 17.57).

However, if the contract boundary is determined to be long, grouping of contracts by profitability will be unnecessary, because over the long run (including future assessments), there can be no profit or loss in the portfolio of contracts. There will be only one group per portfolio, and the measurement of insurance contract liabilities for the group would be performed in aggregate for all contracts (including all future renewals) in the group.

2.3 Grouping of insurance contracts by annual cohorts

IFRS 17.22 states that, "An entity shall not include contracts issued more than one year apart in the same group."

The application of this requirement depends on whether the contract boundary is short or long.

If the contract boundary is short, each year of coverage for each employer is a separate contract for IFRS 17 reporting purposes. Because coverage years usually line up with calendar years, grouping by annual cohorts will be straightforward, with all new and renewal coverages for the same calendar year in the same group.

Note that IFRS 17 requires grouping by annual cohorts based on the date of issue rather than the coverage period, where the date of issue is the date the terms of the contract are determined and both parties are obligated to enter into the contract. For boards, the terms of the contract are determined when the next coverage year's assessment rate is set, which is normally before the coverage period begins. However, because it is uncertain which employers will enter into the contract before the coverage period begins, in practice, for short contract boundary insurance contracts, it is reasonable to set the issue date as the same date the coverage period begins, and each annual cohort will line up with the coverage year.

If the contract boundary is long, grouping by annual cohorts will be unnecessary, because over the long run (including future assessments), there can be no profit or loss in the portfolio of contracts. As above, there will be only one group per portfolio, and the measurement of insurance contract liabilities for the group would be performed in aggregate for the contracts (including all future renewals) in the group. As individual contracts (employers) are issued/terminated, they are added/removed from the single group.

2.4 Initial recognition

Under paragraph IFRS 17.25, initial recognition for a group of contracts is the earliest of:

a) the beginning of the coverage period;

b) the date when the first payment from the policyholder in the group becomes due; and

c) for a group of onerous contracts, when the group becomes onerous.

As noted above (2.3), if the contract boundary is short, in practice the date of issue is the same as the date the coverage period begins. Therefore, initial recognition will always be the beginning of the coverage period for each new and each renewing contract, whether the contract is onerous or not.

If the contract boundary is long, initial recognition will always be at the beginning of the initial coverage period (renewals are not new contracts).

Chapter 3 – Measurement approach

The default approach to valuation is the general measurement approach (GMA, (IFRS 17.30–52)). In some specified circumstances, deviation from this approach is permitted or required. The circumstances are defined in IFRS 17.29 and would, in the case of the WCB, depend on whether the boundary of the insurance contracts is determined to be short or long (see Chapter 4).

Regardless of the measurement approach, the total carrying amount of the liability is reported in two pieces – the liability for remaining coverage (LRC) and the liability for incurred claims (LIC). The LIC is the liability for claims incurred on or before the measurement date. The LRC is the liability for claims that will be incurred from the measurement date to the end of the coverage period (renewal).

If the contract boundary is short (the coverage period is one year), under IFRS 17.53(b)[1], the board would be eligible to apply the PAA (IFRS 17.55 to 59), which simplifies the LRC compared to the GMA. The remainder of this draft educational note will assume that entities would apply the PAA whenever the contract boundary is short.

If the contract boundary is long, the board would, in theory, determine whether the contract meets the definition of an insurance contract with direct participation features (IFRS 17.B101). If so, the variable fee approach (VFA) (IFRS 17.71) applies; if not, the GMA applies. However, the only difference between the GMA and the VFA lies in the measurement of the contractual service margin (CSM). In the case of PPICP's with a long contract boundary, there would never be any CSM (because there can be no profit or loss), and therefore the application of GMA versus VFA is moot.

The components of the LRC and LIC for short and long contract boundaries are discussed in Chapters 5 and 6 below.

[1] If the coverage period is longer than one year, eligibility for PAA would require demonstrating that PAA is a reasonable approximation to the GMA (IFRS 17.53(a)). See the CIA Draft Educational Note *Assessing Eligibility for the Premium Allocation Approach Under IFRS 17 for Property & Casualty and Life & Health Insurance Contracts*.

Chapter 4 – Contract boundary

The determination of the contract boundary is critical to the valuation of insurance contracts under IFRS 17. For the WCBs, the contract boundary influences identification and grouping of insurance contracts, the approach used to measure the LRC and LIC, the cash flows included in measurement (importantly, whether future assessments are taken into account), the discount rates and other important features.

The contract boundary will typically be determined by management in consultation with the external auditor based on interpretations and presumptions regarding the nature of the insurance contracts for each board. Such determination will typically take into account several factors including the Act, the regulations, the policies, and the business practices of the board. IFRS 17 provides guidance on the determination of a boundary of an insurance contract in IFRS 17.34 and IFRS 17. B61, and in the Basis for Conclusions paragraphs IFRS 17.BC159–IFRS 17.BC164.

The determination involves consideration of the features of the respective statutes governing the business, including the ability to adjust premiums and to compel employers to pay premiums, the application of the Act, the specific features of the board including the different portfolios of insurance contracts (premium paying, self-insured, voluntary coverage).

Boards generally set premium rates annually and report on a calendar year basis. The unconstrained right to set premium rates that result in no profit or loss over the long run and the fact that employers are compelled to accept premium rates set by the board suggest a long contract boundary. However, arguments might be made that although the boards have the authority to adjust premiums in the future to recover prior year losses, there may well be a practical limit on how much the premium payers may be willing to absorb at some unknown future date. Also, based on the history of such occurrences, benefits to injured workers may be reduced, theoretically leading to an end of the previous contract. Such circumstances combined with the unique features of each Act and supporting regulations and policies may lead a board to determine that the contract boundary is short.

Consequently, it is conceivable that, owing to the specifics of each board, there will be contracts with a short (to the next renewal, usually one year) or long (including future renewals, indefinite length) contract boundary or both. For example, a particular board may have a short boundary for premium paying employers and a long boundary for self-insured employers.

The measurement of liabilities will be in a manner consistent with the determination of the insurance contract boundary that is consistent with the board's accounting policy.

The next two chapters describe the measurement of liabilities for a short and long contract boundary respectively.

Chapter 5 – Measurement considerations for short contract boundary (PAA)

As noted earlier, groups with short contract boundary will generally be eligible to use the PAA. This chapter describes the application of the PAA.

When the contract boundary is short, neither the LRC nor the LIC include any cash flows related to premiums or benefit adjustments in future coverage periods (renewals), as those cash flows would be outside the boundary of the contract. As noted earlier, each renewal is effectively a new separate contract. If premiums are paid when due, the LRC will be nil at the end of the coverage period (i.e., immediately before renewal).

5.1 Liability for remaining coverage (LRC)

Under the PAA, the LRC is equal to unearned premium[2] unless facts and circumstances indicate that the group is onerous (IFRS 17.18), in which case the LRC will be supplemented by an amount (the loss component) that would bring it to the level it would be under the GMA.

To determine whether a group is onerous, it is useful to gain an understanding of the meaning of onerous contracts under IFRS 17. An onerous contract is defined in IFRS 17.47 as:

> "An insurance contract is onerous at the date of initial recognition if the fulfilment cash flows allocated to the contract, any previously recognised acquisition cash flows and any cash flows arising from the contract at the date of initial recognition in total are a net outflow."

For onerous contracts, no CSM is established and a loss component is calculated at the time of initial recognition.

Under the PAA, the entity assumes contracts are not onerous unless facts and circumstances indicate otherwise (IFRS 17.18).

Basically, a contract is onerous or becomes onerous if it is expected to generate losses, inclusive of, if any, a risk adjustment for non-financial risk (RA) over its coverage period. It would be useful to review IFRS 17.47–52 to gain a better understanding of onerous contracts in the context of IFRS 17.

A relevant fact and circumstance in determining whether contracts are onerous at initial recognition is the relationship between the expected return built into a board's pricing model (which was set before initial recognition) and the discount rate applied to LICs under IFRS 17, which will be set as claims are incurred. If claims incurred over the coverage period have a long settlement period and will be discounted at a lower rate than provided for when premiums were set, the contract could be onerous.

For onerous groups, the LRC would be set to approximate the fulfilment cash flows (i.e., present value of future cash flows plus, if any, RA) under GMA. For non-onerous groups, the LRC is the unearned premium, where premium is the total charged for the year, including new claims costs for the coverage year and, if part of the contract, the amount of rebate/charge in the year that was included in the price of coverage when applying the funding policy.

Therefore, LRC could be determined for each contract, as follows:

a. Adjust the premium rate by excluding any margins and any reductions or charges related

[2] Less acquisition expenses, if any, and adjusted for premiums paid in advance and premiums due and unpaid. For simplicity, these adjustments are ignored for the rest of this draft educational note.

to a funding surplus or deficit. Apply this adjustment only if the exclusion amounts related to funding are not part of the current year contract.

b. Compare this adjusted premium to the present value of the benefit payments and administration costs applicable to the risk of the employer using the current IFRS 17 discount rate for LIC (see Section 5.2.2 below).

c. If the adjusted premium is higher, the contract is not onerous and the LRC is the unearned adjusted premium.

d. If the adjusted premium is lower (premium deficiency), the contract is onerous and the LRC is the premium deficiency used for the employer in the rate setting process (which is the loss component) plus the unearned adjusted premium.

Amounts paid/received in respect of past contract years (i.e., the adjustment in step a. if the amounts are not part of the current year contract) would be recognized in revenue when received and would not affect the LRC for the current contract year.

Whether onerous or not, under PAA there is no explicit RA nor CSM in the LRC. For boards doing interim financial reporting, the assessment of whether each group remains or has become onerous and the resulting LRC will be based on the facts and circumstances at the reporting date.

5.2 Liability for incurred claims (LIC)

The measurement of the LIC under the PAA is the same as under the GMA – essentially the present value of future cash flows plus, if any, RA, except that IFRS 17.59(b) allows the board to ignore discounting of the future cash flows if the claim settlement period is less than one year. Also, there is a small difference in presentation if the other comprehensive income (OCI) option is elected, viz., the portion of the change in LIC that goes to profit and loss (P&L) (vs. OCI) uses the discount rate in effect on the date the claim is incurred rather than the discount rate in effect at the initial recognition date of the group.

Changes in LIC from period to period flow through profit and loss as there is no CSM. Changes related to non-financial risk (e.g., changes in estimated claim termination rates) are presented in insurance service expenses, while changes related to financial risk (e.g., change in discount rates) are presented in insurance finance income or expense (or OCI if the OCI option is elected).

5.2.1 Estimates of future cash flows

LIC cash flows include all future outflows (benefit payments and expenses) associated with all claims incurred (and not fully discharged) and workplace exposures prior to the reporting date, whether reported or not.

Estimates of future cash flows are discussed in IFRS 17.33–35, IFRS 17.B36–B71, and IFRS 17.BC146–BC184. In particular, IFRS 17.B37 states that, "the objective of estimating future cash flows is to determine the expected value, or probability-weighted mean, of the full range of possible outcomes, considering all reasonable and supportable information available at the reporting date without undue cost or effort."

IFRS 17 Estimates of Future Cash Flows for Life and Health Insurance Contracts covers accounting concepts and actuarial approaches for applying IFRS 17 estimates of future cash flows to life and health insurance contracts. Many of the accounting concepts and actuarial approaches also apply to IFRS 17 accounting for PPICP insurance contracts.

In particular, the estimates of future cash flows that relate to incurred claims (benefit payments and expenses) can be determined using the concepts described in the above educational note. As discussed in that note, IFRS 17 does not bring about material change from the pre-IFRS 17 (i.e., IFRS 4) approach of projecting best estimate (unbiased) cash flows and considering a range of outcomes, which would achieve the measurement objective of IFRS 17. Considerations when setting assumptions used to project future cash flows are historical claims experience, recoveries, relapses, mortality, mortality improvements, changing benefit levels, rehabilitation, and the potential impact on future benefit payments of factors such as changing economic conditions, employment levels, the claimant's occupation and industry, and seasonal variations.

Most, if not all, boards have benefit cash flows that are increased annually to an outside index, as is the case for wage loss benefits, or the impact of inflation affecting the cost of delivery of certain services (e.g., hospital visits or stays, doctors, prescribed drugs).

Under IFRS 17, if assumed future inflation rates are linked to external indexes or to future interest rates, inflation is considered an assumption related to financial risk, in which case the impact of changes in inflation assumptions are reported as insurance finance income or expense (or OCI if the OCI option is elected). However, if assumed future inflation rates are not linked to other financial variables (i.e., if a flat 2% rate is used), then inflation is considered an assumption related to non-financial risk, in which case the impact of changes in inflation assumptions is reported as insurance service expense.

5.2.2 Discount rates

The discount rates to apply to estimates of future cash flows would follow IFRS 17 and the guidance in *IFRS 17 Discount Rates for Life and Health Insurance Contracts*; *IFRS 17 Discount Rates for Life and Health Insurance Contracts – Excel Tool*; *IFRS 17 Discount Rates and Cash Flow Considerations for Property and Casualty Insurance Contracts*; *IFRS 17 Discount Rates and Cash Flow Considerations for Property and Casualty Insurance Contracts – Excel file: Examples (basic)* that are applicable to other insurance contracts. In general, LIC cash flows would be highly illiquid, unless the claimant or employer has the right to commute the benefit, in which case the cash flows would be relatively liquid.

It would often be the case that such discount rates would be different than those used for funding purposes, and therefore would be a source of required disclosure under the CIA *Standards of Practice*: Section 2800.

5.2.3 Risk adjustment (RA)

The RA for non-financial risk is defined in Appendix A of IFRS 17 as:

> *"*The compensation an entity requires for bearing the uncertainty about the amount and timing of the cash flows that arises from non-financial risk as the entity fulfils insurance contracts.*"*

IFRS 17 Risk Adjustment for Non-Financial Risk for Life and Health Insurance Contracts; *IFRS 17 Risk Adjustment for Non-Financial Risk for Property and Casualty Insurance Contracts* would provide guidance on RAs that are applicable to other insurance contracts. Further explanations are contained in paragraphs IFRS 17.37 and IFRS 17.B86 to IFRS 17.B92. The RA has a similar, though not identical, purpose as margin for adverse deviations currently used by some PPICP actuaries. Both cover uncertainty, but the focus of the RA is on the board's view of the compensation required to bear the uncertainty in the estimates of cash flows.

Since benefit payment cash flows can theoretically be better or worse than the unbiased best estimate cash flows, the determination of the RA requires consideration of both possibilities and the degree to which the board is risk averse.

Note that when the contract boundary is short, the ability to recover deficits through future premiums is not part of the current contract, and therefore the RA on the LIC is not automatically nil (as it would be with a long contract boundary – see Chapter 6). To establish the RA, the compensation the board requires for the uncertainty in estimates of future cash flows needs to be identified through understanding of the board's risk tolerance, pricing and funding policies. The ability to recover deficits through pricing of future contracts may or may not be a relevant factor determining the compensation the board requires. If it is, then the RA could be nil even if the contract boundary is short.

Note that IFRS 17 requires separate disclosure of the RA on the LIC, and therefore there is need to exercise care to avoid including provision for risk implicitly in the estimates of future cash flows and to disclose the rationale and basis for the RA.

Chapter 6 – Measurement considerations for long contract boundary

When the contract boundary is long, the coverage period is open-ended for each employer, beginning when the employer registers for coverage for the first time and extending for as long as the employer is in business in a covered industry in that jurisdiction. Future cash flows within the contract boundary include future benefit payments related to claims incurred and claims expected to be incurred, administrative expenses, and, of particular importance, all cash flows related to future premiums including future premium (or benefit) adjustments.

However, boards are managed on a not-for-profit basis in aggregate, and this is key to the measurement of total liabilities under IFRS 17. Deficits/surpluses arising from any source, (e.g., a particular contract (employer) or industry, claims incidence rates, claim payment amounts, investment returns) are recovered/distributed via premium assessments (or changes in benefit levels) such that over the long run, there is no profit or loss.

In other words, a board's contracts with a long contract boundary are "Contracts with cash flows that affect or are affected by cash flows to policyholders of other contracts*"* (see IFRS 17.B67–B71). In the case of boards, the sharing of risk and cash flows is complete – covering all

contracts (existing and future employers) and all risks (financial and non-financial), even those related to claims already incurred.

Therefore, to measure IFRS 17 liabilities, there is no need to project explicit cash flows for any contract. Rather, it is known that total insurance contract liabilities will equal the value of the assets currently supporting the liabilities. Another way to look at this is to recognize that in aggregate, the current assets plus future premiums (adjusted as and when needed) will be exactly enough to cover all future cash outflows with no surplus or deficit remaining. The present value of future outflows minus future inflows equals the current assets.

Furthermore, because there is no uncertainty or profit in aggregate, the RA and CSM are nil. As noted earlier, because CSM is nil, the question of whether the GMA or VFA applies is moot.

6.1 LRC vs. LIC

IFRS 17 requires separate presentation and disclosure (including roll-forward) of LRC and LIC. One unusual aspect of boards with long contract boundaries is that actual versus expected experience associated with incurred claims is offset in premium adjustments. This is not contemplated in any IFRS 17 material, so there is no explicit guidance on how to separate LRC from LIC when only the total is known.

In effect, separating LRC from LIC requires an attribution of future premium adjustments between LRC and LIC, which requires judgment. Since there is no single correct approach, the approach used, and the rationale would be disclosed.

One possible approach would be to calculate LIC as estimates of future cash flows (as in Section 5.2.1) discounted at rates consistent with the assets supporting liabilities (per IFRS 17.B74(b)(i)) with no RA (recognizing future premium adjustments). Another (often similar) approach would be to calculate LIC as it would be in the valuation of benefit liabilities for funding purposes.

Under these approaches, the LRC would be calculated as the total liability (equal to the value of assets) minus the LIC. The value of LRC (i.e., whether positive or negative) would provide an indication of the funding status of the plan (i.e., whether future premium adjustments are likely to be positive or negative) and therefore such approaches might be chosen to complement the funding valuation.

Another possible approach would be to report the entire liability as LRC, taking the view that the insurance risk consequent to an incurred claim is part of LRC rather than LIC[3].

Whatever approach is chosen would be applied consistently and the rationale disclosed to enable users to understand the effects of the approach applied.

Chapter 7 – Role of the actuary

In performing a valuation for financial reporting under IFRS 17, the actuary has two important roles. The first is to confirm in the Statement of Opinion that the valuation was performed in accordance with IFRS 17. This includes consideration of any items (such as the contract boundary) that may have been determined by others. The actuary would refer to CIA *Standards*

[3] See Agenda Paper 01 of the September 2018 TRG meeting.

of Practice Paragraph 2210.05 and Subsection 1510, for guidance on the actuary's use of another person's work. In other words, the actuary would have to be satisfied that the determinations leading to groupings, contract boundary and other items that may be more accounting than actuarial in nature are in accordance with the requirements of IFRS 17. A confirmation to that effect from the Comptroller or external auditor of the board might be sufficient.

The second role is to ensure that appropriate disclosures are made in circumstances where the liabilities reported in the financial statements of the boards are not consistent with the liabilities used in the determination of premium rates or the valuation for funding purposes.

The actuary would look to the CIA *Standards of Practice*, Section 2800 Public Personal Injury Compensation Plans for standard reporting language and any additional disclosures, and for guidance on the valuation for funding purposes.

Appendix: Glossary of terms

Term	Definition
PPICP	*Standards of Practice*, Paragraph 1120.54 Public Personal Injury Compensation Plan means a public plan ▪ Whose primary purpose is to provide benefits and compensation for personal injuries; ▪ Whose mandate may include health and safety objectives and other objectives ancillary to the provision of benefits and compensation for personal injuries; and ▪ That has no other substantive commitments. The benefits and compensation provided under such public plans are defined by statute. In addition, such public plans have monopoly powers, require compulsory coverage except for those groups excepted by legislation or regulation, and have the authority to set assessment rates or premiums. [*régime public d'assurance pour préjudices corporels*] For the EN, PPICP includes WC and SAAQ, unless specifically excluded. Benefits and compensation are largely the same for WCB and SAAQ Board.
WCB	Workers Compensation Board. Corporate body with authority to administer workers compensation insurance in each jurisdiction.
WCA	Workers Compensation Act. Legislation defining workers compensation insurance in the jurisdiction. Workers compensation insurance is a PPICP.
SAAQ Board	Corporate body with the authority to administer SAAQ insurance, a PPICP.
SAAQ Act	Legislation defining SAAQ insurance, another public plan that meets the definition of a PPICP.
Assessed contract	▪ Insurance contracts to assessed employers ▪ Premium-paying employer insurance contract ▪ Insurance contracts to SAAQ policy-holders

Term	Definition
Self-insured contract	▪ administrative services only contract with significant insurance risk transfer would be classified as insurance contract, IFRS 17 ▪ administrative services only contract with no significant insurance risk transfer would be classified as service contract, IFRS 15 ▪ Insurance contract to employers ▪ Service contract to employers
GECA contracts	Contracts under Government Employee's Compensation Act Note variance of term used by jurisdiction, i.e., contracts for federal employee workers compensation. Workers compensation insurance contract administered by a federal board.
CSM	▪ Contractual service margin It is measured at initial recognition for a group of contracts as the excess (if any) of the expected present value of cash inflows over cash outflows, within the boundary of the contract (including acquisition costs), after adjustment for non-financial risk. Therefore, at initial recognition, the CSM considers all contractual cash flows (future and past) within the contract boundary.
Onerous contract	If there is an excess of outflows over inflows at inception, the contract is onerous, no CSM is established and a loss component is calculated at the time of initial recognition.
Surplus distributions and special levies	In some jurisdictions, excess investment income or funding surplus is returned to employers as discretionary distributions, or used to subsidize premiums, as a tool of funding policy to manage funding level. Conversely, funding deficits are eliminated through special levies or premium assessments over a specified period.