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AKTUARVEREINIGUNG e.V.

Ergebnisbericht des Ausschusses Rechnungslegung und Regulierung
(Report on findings of the Accounting and Regulation Committee)

IFRS 17 für die Krankenversicherung in Deutschland (IFRS 17 for German health insurance)

Köln, 14. Juni 2022

Präambel

Die Arbeitsgruppe *IFRS* des Ausschusses Rechnungslegung und Regulierung der Deutschen Aktuarvereinigung e. V. (DAV) hat den vorliegenden Ergebnisbericht erstellt.[1]

Zusammenfassung

Der Ergebnisbericht behandelt Fragestellungen zur Auslegung und Anwendung des Rechnungslegungsstandards IFRS 17 auf deutsche Krankenversicherungsverträge und betrifft Aktuare, die mit der Aufstellung und Prüfung von Bilanzen nach IFRS betraut sind.

Der Anwendungsbereich umfasst die Verträge, die unter den internationalen Rechnungslegungsstandard IFRS 17 *Insurance Contracts* fallen. Die Anwendung von IFRS 17 ist für nach IFRS berichtende Konzerne verpflichtend. Da hiervon vor allem internationale kapitalmarktorientierte Unternehmen betroffen sind, wurde der vorliegende Ergebnisbericht in englischer Sprache verfasst.

Der Ergebnisbericht ist an die Mitglieder und Gremien der DAV zur Information über den Stand der Diskussion und die erzielten Erkenntnisse gerichtet und stellt keine berufsständisch legitimierte Position der DAV dar.[2]

Verabschiedung

Dieser Ergebnisbericht ist durch den Ausschuss Rechnungslegung und Regulierung am 14. Juni 2022 verabschiedet worden.

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[1] Der Ausschuss dankt der Unterarbeitsgruppe *Kranken* der Arbeitsgruppe *IFRS* ausdrücklich für die geleistete Arbeit, namentlich Dr. Christine Barop, Stefan Bause, Kerstin Block, Walter Claßen, Dr. Jan Esser, Dr. Anselm Fleischmann, Gerd Radtke, Jörg Reichenberger, David Richter, Sabine Schadschneider und Dr. Claudio Schmidt-Wegenast.

[2] Die sachgemäße Anwendung des Ergebnisberichts erfordert aktuarielle Fachkenntnisse. Dieser Ergebnisbericht stellt deshalb keinen Ersatz für entsprechende professionelle aktuarielle Dienstleistungen dar. Aktuarielle Entscheidungen mit Auswirkungen auf persönliche Vorsorge und Absicherung, Kapitalanlage oder geschäftliche Aktivitäten sollten ausschließlich auf Basis der Beurteilung durch eine(n) qualifizierte(n) Aktuar DAV/Aktuarin DAV getroffen werden.

Preamble

The Working Group *IFRS* of the Accounting and Regulation Committee of the German Association of Actuaries (Deutsche Aktuarvereinigung (DAV) e. V.) has issued the following report on findings to the topic IFRS 17 for German health insurance.[3]

Issue

This report deals with the interpretation and application of IFRS17 on German health insurance contracts and concerns actuaries that prepare or audit IFRS financial statements.

This report addresses contracts that are subject to the international reporting standard IFRS 17 *Insurance Contracts*. The application of IFRS 17 is compulsory for group reporting under IFRS. This report is written in English because it particularly addresses international and capital market-oriented companies.

The report is addressed to actuaries and is focused on providing an overview of the current state of discussions and the insights gained in the sub-working group. It is not a professionally position of the DAV and is meant to support actuaries in actuarial teams.

Adoption

The report on findings was adopted by the DAV's Accounting and Regulation Committee on 14 June 2022.

[3] The Committee would like to explicitly thank the sub-working group *Kranken* of the working group *IFRS* for their work, by name Dr. Christine Barop, Stefan Bause, Kerstin Block, Walter Claßen, Dr. Jan Esser, Dr. Anselm Fleischmann, Gerd Radtke, Jörg Reichenberger, David Richter, Sabine Schadschneider and Dr. Claudio Schmidt-Wegenast.

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Preliminary remark

Generally, the interpretation of the standard from an acturarial point of view is subject to continuous development as implementation projects proceed. For this reason some topics are under ongoing discussion. Therefore, DAV's work on the standard will continue going forward by amplifying elements of particular interest for German health insurance.

1. Legal form and economic substance of German health insurance contracts

The term "contract" is defined in IFRS 17.2 as an agreement between two or more parties that creates enforceable rights and obligations.

Health insurance contracts can contain more than one insured person; each person can have more than one tariff. Persons can enter the contract at different times and different tariffs can have different inception dates.

Moreover, different tariffs can have different contractual conditions (AVBs) and premium adjustments are carried out per tariff rather than per coverage.

Hence, the single tariffs within health insurance coverage typically form separate contracts and may be measured accordingly.

On the other hand, following IFRS 17.9, an aggregate view would be possible if an aggregate view is necessary in order to report the substance of those contracts.

The same considerations apply to group coverage. For example, if the conditions form a mere organisational framework for individual contracts then the contracts can be treated as individual contracts. In any case, a faithful presentation of the economic substance of group coverage should be achieved.

More information about the general principles concerning the contract definition can be found in the DAV paper "Portfoliobildung unter IFRS 17".

The following general statements are of special relevance in the context "tariff view":

According to the Transition Resource Group (TRG, February 2018), there is a presumption that a single legal contract is the smallest unit of account, but it may be appropriate to override this presumption in order to reflect the substance of the contractual rights and obligations. An example given by the TRG where it may be appropriate to override the presumption is "*when more than one type of insurance cover is included in one legal contract solely for the administrative convenience of the policyholder and the price is simply the aggregate of the standalone prices for the different insurance covers provided.*"

Hence, if insurance contracts contain several separable insurance components and the conditions stated by the TRG are fulfilled, e.g. if a disaggregation leads to more useful information about the economic substance of the contract, then the disaggregation into insurance components (which then would be subject to IFRS 17) might be prescribed (whereas separating non-insurance components from insurance contracts is either required or prohibited).

2. Scope

As the definition for insurance contracts remains largely unchanged compared to IFRS 4[4], and no changes affecting the classification of typical German health insurance contracts could be identified, all typical health insurance contracts that were subject to IFRS 4 are also subject to IFRS 17.

According to IFRS 17 Appendix A, an insurance contract is "a contract under which one party (the issuer) accepts significant insurance risk from another party (the policyholder) by agreeing to compensate the policyholder if a specified uncertain future event (the insured event) adversely affects the policyholder."

This has to be checked based on the entity's individual contracts.

In typical health insurance contracts, the entity accepts significant insurance risk (change in the policyholder's health status) from the policyholder who gets compensation if the insured event (change in the policyholder's health status) occurs, which adversely affects the policyholder. This also holds for the typical options for later health insurance coverage (e.g. "Anwartschaften") and any typical forms of pre-payment of premiums (e.g. "Beitragsentlastung im Alter" or "gesetzlicher Zuschlag").

IFRS 17.8 provides the possibility to apply IFRS 15 to certain insurance contracts that primarily provide service for a fixed fee, if the conditions outlined in IFRS 17.8 are met. The choice can be made contract by contract but is irrevocable once made.

Most German health insurance contracts protect insured persons against health risks on a life-long (long-term) basis against contractually agreed premiums. As part of the contractual arrangement for these tariffs, the entity may (and regularly does) adjust the premiums according to the change in expected benefits. This procedure is commonly referred to as premium adjustment clause. Note that level premiums may both increase and decrease by this procedure, depending on the development of those indicators that are contractually defined to specify the adjustments to the change in expected benefits and premiums.

In addition to long-term insurance where three typical categories can be observed, there is also short-term insurance. We distinguish the following categories of health insurance contracts and their typical features:

Category 1 (substitutive health insurance):

- substitutive[5]
- long-term
- with ageing reserves[6]

[4] e.g. other than in IFRS 4, the significance of insurance risks has to be checked on a present value basis, see IFRS 17.B19-21

[5] Some products can be part of either a comprehensive or a supplementary health insurance.

[6] A contract in this category can have a non-zero aging reserve, but does not necessarily have one at every point in time.

- with premium adjustment clause
- with profit sharing according to KVAV

Category 2 (supplementary health insurance, with ageing reserve and profit sharing)

- not substitutive[7]
- long-term
- with ageing reserves[8]
- with premium adjustment clause
- with profit sharing according to KVAV

Category 3 (supplementary health insurance, without ageing reserves and without profit sharing)

- not substitutive
- long-term
- without ageing reserves
- with premium adjustment clause
- without profit sharing according to KVAV

Category 4 (supplementary health insurance, short-term)

- not substitutive
- short-term
- without ageing reserves
- without premium adjustment clause
- without profit sharing according to KVAV

[7] Some products can be part of either a comprehensive or a supplementary health insurance.

[8] A contract in this category can have a non-zero aging reserve, but does not necessarily have one at every point in time.

3. Separating non-insurance components from an insurance contract

According to IFRS 17.11-12, the following components shall be separated from an insurance contract and measured according to the applicable IFRSs:

- derivatives embedded in the contract if not closely related (IFRS 9)
- investment components if distinct (IFRS 9)
- promise to transfer goods or non-insurance services if distinct (IFRS 15)

Non-insurance components that do not fulfil the criteria for separation have to be measured together with the host contract (IFRS 17.BC114).

"Distinct" is defined in IFRS 17.B31-35 as not highly interrelated (i.e. the components can be measured separately or the policyholder can benefit from one component even if the other is not present) and the component could theoretically be sold as a separate product in the same market or jurisdiction.

The remaining paragraphs of IFRS 17 apply to the host contract after separation of these components (IFRS 17.13).

3.1. Embedded Derivatives

Embedded derivatives that are themselves contracts within the scope of IFRS 17 are excluded from the scope of IFRS 9 (IFRS 9.2.1(c)), hence such embedded derivatives should not be separated. There are no embedded derivatives to be separated in known typical products.

For any non-typical products or features, it should be analysed if

a) the criteria for an embedded derivative are fulfilled (see IFRS 9) and
b) the embedded derivative is not closely related to the host contract and
c) the embedded derivative is not in the scope of IFRS 17

If all three criteria are fulfilled then the embedded derivative has to be separated.

3.2. Investment Components

Investment components are defined as *the amounts that an insurance contract requires the entity to repay a policyholder in all circumstances regardless of whether an insured event occurs* (IFRS 17, Appendix A).

The contract does not contain investment components if there is one scenario where the policyholder does not receive any payment out of the contract.

Hence, guaranteed premium refund in German health insurance is not an investment component, if e.g.

- the guaranteed payment will only be made if the contract is still in-force, or

- It may be the case that a payment is made in the case of death, but not in the case of lapse or
- the payment is not made in all circumstances (see IFRS 17.BC34).

Likewise, no investment component is contained in "Beitragsentlastung im Alter", "gesetzlicher Zuschlag" or "Übertragungswert" (transfer value) since no payment is made in the case of death.

If a payment is made in every scenario, then the criteria for an investment component are fulfilled and the investment component has to be separated if distinct (see above).

Non-distinct investment components are not separated, but excluded from certain items in the presentation (see IFRS 17.83, 85).

3.3. Promise to transfer goods or non-insurance services (IFRS 17.B33-35)

According to IFRS 17.B35 *a good or non-insurance service that is promised to the policyholder is not distinct if:*

a) *the cash flows and risks associated with the good or service are highly interrelated with the cash flows and risks associated with the insurance components in the contract; and*

b) *the entity provides a significant service in integrating the good or non-insurance service with the insurance components.*

Therefore, typical assistance tariffs sold as riders do not have to be measured separately, since they are highly interrelated with the risk of the main tariff. However, promises to transfer goods or non-insurance services in health insurance contracts have to be checked on contract clause basis.

4. Contract boundary

4.1. General Issues

General guidance on contract boundaries can be found in the DAV paper "Portfolibildung unter IFRS 17".

The contract boundary marks the point where the contract's substantive obligations cease to exist. Under certain circumstances, coverage period and contract boundary might differ.

According to IFRS 17.34, the contract boundary of a contract ends when the entity can set a price or level of benefits that fully reflects the risks[9]

- of the particular policyholder
- or of a set of insurance contracts that contains the contract and the pricing of the premiums for coverage up to the date when the risks are reassessed does not take into account the risks that relate to future periods.

4.2. Special issues for German health insurance

4.2.1. Categories 1, 2 and 3: Contracts with premium adjustment clause

For these contracts, health insurers waive their cancellation right upon conclusion of the contract and the contracts do not have specified an end date.

4.2.1.1. IFRS17.34 a)

When reassessing the risks in the course of the premium adjustment process, a German health insurer does not have the right to set a price or level of benefits that fully reflect the risks of the particular policyholder, since that would include a new risk assessment of the individual policyholder. Thus, IFRS17.34 a) is not satisfied.

4.2.1.2. IFRS17.34 b) i)

However, an insurer can set a new price or level of benefits via the premium adjustment clause and is legally obliged to reassess the risks of the portfolio annually.

[9] TRG Agenda Paper 03 (May 2018) clarifies that *risks* in this context means *risks transferred from the policyholder to the entity*. It also states that the entity has to be able to set a price that fully reflects the risks for the entire contract, not only for certain components. If this is not the case, the criteria of IFRS 17.34 are not fulfilled and the reassessment does not mark a contract boundary. Further, the TRG views constraints in pricing that equally affect new and existing contracts as no restriction of the entity's practical ability to reprice existing contracts. On the other hand, according to the TRG, a practical ability to reassess the risks does not mark a contract boundary if the entity lacks a right for adequate repricing. The TRG also points out that pricing constraints are not limited to legal or regulatory constraints.

This reassessment usually results in a premium adjustment for some products, while the premiums of others stay the same. The premium adjustments for different products may also be carried out at different points in time (usually for processual or technical reasons).

Nevertheless all products with such a clause have to be reassessed and neither the level nor the difference in timing of this reassessment limits the practical ability postulated in IFRS17.34. b) i).

If the reassessment does not result in an adjustment, it may be assumed that the premium (or the level of benefits) is still adequate if the contractual premium adjustment clause does not impose material restrictions on the entity's ability to reprice the contracts. This has to be checked individually, where the entity's and the tariffs' specific conditions, as well as security margins might be taken into account.

If no material restrictions on the entity's ability to reassess the risks, set a new price or to conduct a premium adjustment are present, the new premium (or level of benefits) might be seen as fully reflecting the risk of the portfolio.[10]

Remarks:

1. In IFRS17.34 b) i) the standard only requires the (expected) existence of such a practical ability. Whether or not the entity actually sets a new price is irrelevant.
2. The condition in IFRS17.34 b) i) should be assessed on the portfolio level. However, it may still be fulfilled even if a minor part of the contracts in the portfolio cannot be reassessed.
3. The inability to conduct a new individual risk assessment at the reassessment date does not violate IFRS17.34 b) i).[11]

4.2.1.3. IFRS17.34 b) ii)

The remaining question is whether the premiums for coverage up to the date when the risks are reassessed do take into account the risks that relate to future periods. Depending on the category of the contract and the entity's interpretation of the sentence above, the answers could be different.

4.2.1.3.1. Categories 1 and 2

Premiums calculated for products with ageing reserves always contain provisions for future risks. Even if an individual contract of these categories does not have an aging reserve, its cash flows contribute to the participation mechanism and result

[10] In May 2018 the TRG stated that „a constraint that equally applies to new contracts and existing contracts would not limit an entity's practical ability to reprice existing contracts to reflect their reassessed risks." and „a constraint that limits an entity's practical ability to price or reprice contracts differs from choices that an entity makes (pricing decisions), which may not limit the entity's practical ability to reprice existing contracts in the way envisaged by paragraph B64 of IFRS 17."

[11] See TRG Meeting February 2018, Agenda Paper 2 Fact Pattern A.1

in an obligation to grant future premium reductions to this or contracts of other policyholders in periods after the premium adjustment. Therefore, the premium adjustment clause does not mark the contract boundary for these contracts.

4.2.1.3.2. Category 3

Whether or not IFRS17.34 b) ii) is satisfied ultimately comes down to the entity's pricing methods of the individual products.

Deliberations

The following aspects may be relevant for the deliberations on IFRS17.34 b) ii):

IFRS 17.BC162 (a) states: "*an entity may price a contract so that the premiums charged in early periods subsidise the premiums charged in later periods, even if the contract states that each premium relates to an equivalent period of coverage. This would be the case if the contract charges level premiums and the risks covered by the contract increase with time. The Board concluded that the premiums charged in later periods would be within the boundary of the contract because, after the first period of coverage, the policyholder has obtained something of value, namely the ability to continue coverage at a level price despite increasing risk.*"

This could apply to contracts in category 3, since although they usually do not carry aging reserves, the risks covered by the contract may increase with time, while usually the premiums do not.

In addition, the point in time of the premium adjustment is uncertain. This could mean that the premiums consider the risks over the whole coverage period.

Another indicator is whether "the policyholder has obtained something of value". For contracts in categories 1 and 2, this can usually be quantified by the corresponding aging reserve, but such an ability to continue coverage at a level price despite increasing risks does not necessarily require aging reserves.

It this case the entity should consider, whether this results in an obligation to the policyholder and if this obligation has a significant economic value. An entity could further consider whether or not such an obligation is present in other GAAPs as well.

If this would result in no obligation of economic value, the policyholder would not have "obtained something of value".

For the question, whether the policyholder has obtained a substantial right or "something of value", the following deliberations might be helpful:

IFRS17.B64 specifies the "practical ability" described in IFRS17.34 b) i) by comparing the new and existing business:

„An entity has that practical ability in the absence of constraints that prevent the entity from setting the same price it would for a new contract with the same characteristics as the existing contract issued on that date […]"

In February 2018 the TRG extended this idea to the contract boundary in general:

"The staff believe that the underlying principle of the determination of the contract boundary is that a contract renewal with the same premium that would be available to a new policyholder should be treated as a new contract because the existing contract does not confer on the existing policyholder any further substantive rights."

In the context of this discussion „renewal" refers to the continuation of the contract: *„The policy on the original terms is guaranteed to be renewable at each policy anniversary with no further underwriting of the individual policyholder, i.e. policies may be kept in-force at the policyholders sole option, provided they continue to pay their premiums every year"*

And "*same premium*" is further specified as: *„for the 'step-rated insurance contract' the premium for a new 40 year old policyholder would be the same as the premium for an existing 40 year old policyholder, assuming that they are both in standard health when they buy the contracts and there are no loyalty discounts in place"*

The "substantive rights" of the policyholder are assessed by comparing the existing policyholder to a fictional new policyholder with the same sate of health. If both would be charged with the same premium, the existing policyholder does not have any advantage over the fictional new one. For some tariffs, it might not be sufficient to only compare premium rates at current age, but also further premium steps or contractual refunds other than loyalty discounts. The specific method used to calculate the premiums is irrelevant.

Conclusion

Depending on the deliberations pointed out above and the entity's interpretation, the UAG identified the following possibilities for these contracts:

If the premium adjustment clause does not constitute a contract boundary, the contract boundary is reached at the contractually agreed end of the coverage period.

If the premium adjustment clause does constitute a contract boundary, then the determination of the actual point in time when the contract boundary is reached depends on the individual design of the tariff and the entity's interpretation of "practical ability to reassess the risks".

For example, the contract boundary might be reached

a) when the entity could be or is expected to be able to adjust the premiums, regardless of the fact whether the entity actually expects to adjust the premiums at that point in time or
b) when the next premium adjustment could be or could expected to be carried out in a way equivalent to new business or
c) when the AF could be or is expected to be calculated, or
d) when the new premiums could be or are expected to be charged to the policyholder.

As the interpretation strongly depends on tariff- and entity-specific factors, no general statement or recommendation can be given here.

If the entity's considerations lead to the conclusion that the contract boundary is reached at the contractually agreed end of a long-term coverage period, then the contract is directly participating via the premium adjustment clause.

If, on the other hand, the (possibility of a) premium adjustment marks the contract boundary, premium adjustment cannot be viewed as a form of participation.

The PAA can be applied, if the resulting contract boundary is one year or less, or if it can be shown that the outcome of the PAA is an appropriate approximation for the general measurement model (or VFA if applicable).

4.2.2. Category 4: Contracts without premium adjustment clause

Contracts in category 4 have an agreed upon coverage period and no premium adjustment clause. They often include a renewal option, but the insurer as well as the policyholder have a cancellation right. Therefore, their contract boundary is the agreed coverage period.

4.2.3. Tariff change

The right to change tariff without risk assessment does not mark the contract boundary for German health insurance contracts. If the new tariff contains additional features for which an individual risk assessment is carried out, then the additional feature might be seen as outside the contract boundary (see below).

4.2.4. Including new features without risk assessment

Contractual options to add new features to the contract without carrying out a new risk assessment are within the contract boundary (see also TGR Agenda Paper 03 (May 2018), paragraph 39.

4.2.5. Including new features with risk assessment

According to TRG Agenda Paper 03 (May 2018), an option to add insurance coverage is a contractual feature that is not measured separately from the original contract unless the additional cover can be viewed as a separate contract. If the additional cover cannot be viewed as a separate contract and the entity has not the practical ability to reprice the whole contract when the cover is added, then the exercise of the option does not mark a contract boundary (see TRG Agenda Paper 03 (May 2018), paragraph 42).

Hence, an entity might adopt the view that the feature itself is within the contract boundary at initial recognition and measure it accordingly.

It might also be possible to argue that the feature is outside the contract boundary at initial recognition and treat the addition of cover as a contract modification.

An entity might need to develop an appropriate accounting policy that takes the specific characteristics of the features into account.

An example for such a feature would be the reduction of payment limits ("Selbstbehalt").

4.2.6. Right to include children in health insurance

The contractual right to insure an insured person's newly born or adopted child without risk assessment ("Kindernachversicherung") is an example where a price cannot be set to fully reflect the new risk.

If, following the considerations of the TRG (February 2018), see chapter 1, the entity views separate persons in the same health insurance frame as separate contracts, then the children's contracts would have to be seen as separate contracts. The "Kindernachversicherung" might then e.g. be treated in analogy to a legal requirement to provide coverage ("Kontrahierungszwang"), i.e. children's contracts are not anticipated in the cash flow projection.

If, on the other hand, this right is seen as a contractual option in the adults' contracts, then a separate view of the children's contracts might lead to contradictions and the children's tariffs might have to be anticipated and considered in the projection as a part of the corresponding adults' contracts.

The interpretation of "Kindernachversicherung" strongly depends on the individual entity and has hence to be analysed individually. Thus, no general statement or recommendation apart from establishing a consistent accounting policy can be given here.

4.2.7. Children becoming adults

Whether the adult's contracts are viewed as new contracts or as a continuation of the children's contracts has to be analysed taking the entity's specific contract features as well as materiality aspects into account. Hence, no general statement can be made here.

5. Level of aggregation

The level of aggregation describes the grouping of insurance contracts for measurement purposes. The general principles of the level of aggregation are outlined and discussed in the DAV paper "Portfoliobildung unter IFRS 17".

According to IFRS 17.BC126, the board's objective behind the criteria for grouping is to achieve a balance between loss of information and useful information, rather than ending up with a very large number of groups and thus in an operational burden, which would contradict the objective (see also IFRS 17.BC 123-127).

To build groups of insurance contracts (GIC), the total pool of the entity's insurance contracts should be subdivided as follows:

- portfolios of contracts, i.e. contracts that have similar risks and are managed together
- within the same portfolio: different profitability types, i.e. contracts that are onerous at inception, contracts that have no significant probability to become onerous and all other contracts
- within different profitability types: cohorts of contracts with an issue date not more than one year apart (on the other hand, IFRS 17.BC138 indicates that annual cohorts might not be necessary if the same accounting outcome is achieved without annual cohorts, see discussion in subchapter 5.3 Annual cohorts).

Moreover, although not explicitly addressed in IFRS 17.14-24, it may be assumed that contracts subject to different measurement models (BBA, VFA or PAA) cannot be in the same GIC.

Further distinctions within the subsets, e.g. finer profitability-levels based on information from the entity's internal reporting are permitted but not required (see IFRS 17.21).

When allocating contracts to portfolios and GICs, contractual rights and options have to be taken into account. Materiality aspects might be considered here as well as the fact that the border between certain options (e.g. conversion options) and contract modifications might be fuzzy in some cases (see chapter 9 Contract modifications).

According to IFRS 17.24, contracts are assigned to a GIC at initial recognition and stay in that very GIC until derecognition. In particular, there is no reassessment of profitability or risks until the contract is derecognized.

According to IFRS 17.18, contracts that are accounted for under the Premium Allocation Approach (PAA), are assumed to be not onerous, "*unless facts and circumstances indicate otherwise*".

The GIC does not necessarily affect the cash flow calculations; cross-influence between these groups has to be considered in the cash flows (see chapter 10 Estimates of future cash flows). Furthermore, the aggregation used for determining

the cash flows can differ from the aggregation used for the GIC as long as the cash flows can be allocated to the GIC in an appropriate way (see IFRS 17.24).

5.1. Portfolio of insurance contracts

According to IFRS 17.14, a portfolio of insurance contracts "*comprises contracts subject to similar risks and managed together*".

That means that the whole (sub-)pool of insurance contracts, that the entity identifies as subject to similar risks may well be seen as one portfolio if managed together. Further distinction is not prohibited by IFRS 17.

Possible interpretations of "managed together" and "similar risks" for German health insurance are discussed in the following subchapters.

A discussion on a more general level can be found in the DAV paper "Portfoliobildung unter IFRS 17".

5.1.1. Managed together

IFRS 17 provides no further guidance on how to interpret "managed together". Of course, the analysis of this criterion strongly depends on the entity's internal management practice. Therefore, only some hints and indications how one might identify contracts considered as managed together can be given here which are not intended as a directive, let alone a complete list of possible criteria and interpretations.

For example, for German health Insurance it may be worth considering the level of…

- (new business) reporting
- pricing
- (local GAAP) policyholder profit participation schemes
- reinsurance
- asset management
- underwriting rules
- different treatment of inforce business
  organisational setup and reporting lines (e.g. different board members for retail and corporate)
- Premium adjustments and (local GAAP) policyholder profit participation (PHPP) (limitation of premium adjustment, premium refund)
- AUZ-method (method for determining the technical interest rate AUZ)
- right to change tariffs ("Tarifwechsel")

For example, an analysis for German health Insurance based on

> the entity's internal management practice and
>
> the board's objective to obtain useful information without creating too large numbers of GICs, might take the following considerations into account (note that these are only examples, do not form a complete list and the entity's individual view might yield different criteria and different interpretations):

Criterion	Analysis
Reporting	The entity's requirements for reporting might be a strong indication towards the management focus. For example, if the overall result is in focus and can be seen as managed on a global basis for a pool of contracts, then the complete pool of contracts might be rather seen as managed together under this criterion.
Pricing, premium adjustments, policyholder profit participation, AUZ-method, right to change tariffs, individual policyholder profit participation, premium reduction	Although pricing is one of the central issues in health insurance, it might be seen as dependent on profit-participation and hence seen as interrelated with asset management and result management rather than seen on a stand-alone basis. • Contractual rights allowing the policyholder to change cover within a pool of tariffs during the lifetime of a contract give a strong indication that these tariffs belong to the same portfolio. • AUZ, surplus interest (see § 150 VAG) and (local GAAP) policyholder profit participation (see § 151 VAG) influence individual premiums. • Individual contracts influence each other via (local GAAP) policyholder profit participation. Furthermore, a differentiation that would result in a very large number of portfolios and thus in an operational burden would contradict the board's objective to achieve a balance between loss of information and useful information (IFRS 17.BC123-127). Therefore, cross-influences between policyholders, tariffs and management need to be taken into account when determining the portfolios. For example, if there are cross-influences between all tariffs in a certain (sub-)pool of contracts, the whole (sub-)pool might be seen as managed together under this criterion.
Reinsurance	Has to be checked for the individual entity.
Asset Management	AUZ-method as well as the entity's internal asset management strategy might be seen as strong indications whether a pool of insurance contracts is managed together. For example, if "global" asset management is carried out for a pool of contracts, then these contracts might be seen as managed together.
Underwriting rules	Has to be checked for the individual entity.
Different treatment of inforce business	Has to be checked for the individual entity.

5.1.2. Similar Risks

The definition of "similar risks" is rather wide (product lines, see IFRS 17.14).

In order to identify contracts subject to similar risks, several criteria can be applied, for example (see IFRS 17.BC124 (a)) where „*type of insurance risk*" and similar response "*in amount and timing to changes in key assumptions*" are discussed:

- Insured risk
- Financial risk (influence of investment assumptions)

The following table provides some examples what considerations might be taken into account when analysing the criterion "similar risks" for German health insurance contracts, and provides some possible interpretations but – as for the *managed together*-criterion – the analysis has to be carried out on the entity's individual situation which might also result in different interpretations.

Criterion	Analysis
Insured risk	Given that German legislation requires health insurance to be pursued as a distinct line of business, it is reasonable to assume, that an entity's health insurance contracts are all exposed to similar risks, relating to the health status of insured persons. There may be differences in the degree of similarity between risks originating from the different scope of health insurance contracts, e.g. • daily lump sum for treatments in hospital • full cost cover for defined health benefits (inpatient, outpatient) • partial cover (with annual limits and/or deductibles) for defined health benefits • income compensation • long-term care benefits depending on frailty conditions • substitutive cover • non-substitutive cover • additional cover for statutory insurance If an entity considers such differences in the degree of similarity of risks to be material, it may as well assemble portfolios of insurance contracts accordingly. The risks arising from category 1 and 2 could be considered similar, since the product features are very close. Some products can even be part of contracts in both categories. If an entity deduces that the premium adjustment clause does not constitute a contract boundary, the risks arising from category 3 could be considered similar to those arising

	from categories 1 and 2, although they only partially share the participation mechanisms. If an entity deduces that the premium adjustment clause does constitute a contract boundary, the risks arising from category 3 could be considered similar to those arising from category 4. Though medical cost inflation is different from general inflation, they are usually positively correlated. The same is true for wage inflation and general inflation. On the other hand, changes in a policyholder's salary will, on an expected value basis, result in a corresponding change in the insured amounts of fixed daily benefits products. An entity might come to the conclusion, that these correlations are significant and consequently conclude that the risks arising from covering medical expenses are similar to those arising from fixed daily benefits. As pointed out above, as all insured risks in German health insurance relate to the health status, they might as well be seen as similar for all of an entity's health insurance contracts and hence all of an entity's health insurance contracts may as well be seen as subject to "similar insured risks".
Financial risk	Although financial assumptions might have significant influence on the cash flows (e.g. for tariffs with actuarial reserves), financial risk might not be seen as a predominant criterion for "similar risk" in German health insurance if the entity's internal view does not indicate otherwise. Since the technical interest rate is not guaranteed and is adjusted via the AUZ-method, the financial risk for all tariffs with actuarial reserve might be seen as similar. Given their (life-)long duration, (all of) an entity's health insurance contracts may generally be more exposed to long-term financial effects such as inflation than short term fluctuations in the financial market. Hence, the whole pool of health insurance contracts may be seen as subject to "similar risk" under this criterion, depending on the entity's internal considerations.
Derivation of actuarial assumptions (1st or 2nd order)	Due to premium adjustment, this criterion is considered barely relevant for German health insurance tariffs. As mentioned above, a finer grouping is not prohibited by the standard. A differentiation that would result in a very large number of portfolios and thus in an operational burden would contradict

	the board's objective to achieve a balance between loss of information and useful information (IFRS 17.BC123-127)

Possible portfolios in German health insurance could hence e.g. be (depending on the entity's assessment):

- all health insurance contracts that are managed together or
- Private Pflegeversicherung, PflegeBahr and all other health insurance tariffs that are managed together or
- further distinction between different types of health insurance tariffs, e.g. Krankentagegeld, Krankenhaustagegeld, allgemeine Gesundheitsleistungen, etc.

5.2. Profitability types

According to IFRS 17.16, a portfolio of insurance contracts should at least be subdivided into the three subsets (where two of them might be empty):

- "contracts that are onerous at initial recognition",
- "contracts that at initial recognition have no significant possibility of becoming onerous subsequently" and
- "the remaining contracts in the portfolio".

Further subdivision into finer profitability-levels based on information from the entity's internal reporting is permitted but not required (see IFRS 17.21).

According to IFRS 17.47 and 17, the assessment whether contracts are onerous or have no significant possibility of becoming onerous can be carried out for a whole set of contracts if there is *reasonable and supportable information* that the contracts are in the same group. The premium adjustment clause can be seen as such *reasonable and supportable information*.

As the cash flow calculations are used for determining the profitability types, cross-effects between different types of products are taken into account when determining the probability of becoming onerous (IFRS 17.B67-B69).

IFRS 17.20 provides an exception if the only reason for contracts/tariffs within the same portfolio to fall into different groups are constraints imposed by law or regulation on taking certain characteristics of different policyholders into account when setting the price or benefit levels. In this case, these contracts/tariffs may be included in the same group.

If the respective portfolio would not be separated without those constraints imposed by law or regulation, then the portfolio need not be separated on these grounds.

Examples for such regulatory constraints may be effects resulting from contractual or regulatory imposed rights like

- Kontrahierungszwang (the entity is required to provide coverage)
- Kappung (upper limits for premiums)
- Notlagentarif (substitute tariff in case the original tariff is resting because the policyholder did fail to pay due premiums)
- Regulatory imposed unisex pricing
- policyholder right to change tariffs ("Tarifwechselrecht")

Considering that the information disclosed for a group of health insurance contracts enables inference about the health-status of an individual person (e.g. arising from claims or health-related add-on charges to premiums) when groups of health insurance contracts contain only a few insured persons, it may be required that groups of health insurance contracts are sufficiently large, given that information about personal health is under special protection by (European) data protection regulation.

The majority of contracts issued in German private health insurance belong to category 1 and 2. Premiums for these contracts have to be calculated with prudent calculation assumptions and an added safety margin according to German law and regulation (§2 KVAV, §7 KVAV, §8 KVAV). Additionally, these contracts contain a premium adjustment clause (§203(2) VVG). Each year, a German private health insurance company is obliged to review the calculation assumptions for mortality and health payments for actual adverse developments and eventually adjust the premiums according to strict specifications by German law and regulation (§155 VAG, §15-17 KVAV). If a premium adjustment is performed, all calculation assumptions have to be reassessed considering the prudent calculation principle (the reassessed calculation assumptions particularly include the actuarial interest rate).

Due to medical inflation it is reasonable to assume that expected actual health payments will exceed calculated health payments over time which will lead to consistent and regular premium adjustments and consequently to constant prudent premium calculations. In fact, premium adjustment frequencies between one and four years have been observed in the German health insurance market in the past years for most tariffs.[12]

Unexpected adverse developments of calculation assumptions which are not reflected by mortality or health payments and therefore do not lead to premium adjustments are not anticipated to exceed the safety margins of the calculation permanently until the next premium adjustment takes place.

Due to these existing mechanisms and securities, it is reasonable to assume that German private health insurance contracts in category 1 and 2 should be grouped as contracts that at initial recognition have no significant possibility of becoming onerous subsequently.

[12] Refer to „Fachgrundsatz der Deutschen Aktuarvereinigung: Der aktuarielle Unternehmenszins in der privaten Krankenversicherung", 9 October 2019, page 50

For health insurance contracts in category 3 no legal equivalent requirements for prudent calculation exist by German law and regulation. Nevertheless, many German private health insurance companies use the same prudent calculation principles described above. Most long-term contracts include a premium adjustment clause in the general policy conditions and also a premium adjustment clause from German law (§203(2) VVG) applies. This can be taken into account when determining the profitability types, but the assessment has to be based on the individual design of the tariffs, hence no general statement can be made here.

5.3. Annual cohorts

According to IFRS 17.22 contracts should be grouped into annual cohorts (i.e. contracts issued no more than one year apart) at initial recognition. Note: both the initial issue date of a contract as well as a significant modification of a contract constitute an issue date (see also chapter 9 Contract modifications).

Also, a finer grouping (e.g. quarterly) might be possible, although this is not required by the standard.

According to the Basis of Conclusions (IFRS 17.BC136- BC138), the annual cohorts were introduced as a practicable and simplified method to achieve the standard's objectives to provide useful information about the profitability trends (especially about groups of contracts becoming onerous) and to ensure that the CSM does not persist beyond the duration of the group (BC136). According to BC137, a test for similar profitability (which was considered burdensome) would otherwise be necessary.

IFRS 17.BC138 indicates that annual cohorts might not be necessary if the same accounting outcome is achieved without annual cohorts.

There is a great variety of cross-effects, interactions and mutualisation between German health Insurance contracts (see 10.3 Contracts with cash flows that effect or are affected by cash flows to policyholders of other contracts ("Mutualisation")) which are independent of the issue date and might have to be considered in the cash flow calculations on a higher level of aggregation and which then would have to be allocated to the annual cohorts in a on a "systematic and rational basis" (see B70).

Premium adjustments are carried out per "Beobachtungseinheit" (observation unit) irrespective of the issue dates of the single contracts and might level out the individual profitabilities in the observation unit. In this case, this might be seen as an indicator for continuous similar profitability within the profitability classes. The contractual right to change tariff has a similar effect. This might create similar results when calculating with or without annual cohorts.

Hence annual cohorts might not be necessary in German health Insurance if a calculation without annual cohorts does not create systematic misstatements of the profitability and the CSM (or the loss component) is released in an appropriate way that faithfully represents the service provided.

There might be differences in the structure of profitability or service within the portfolios of contracts, which might for example be due to different age-, tariff- or gender-structures. If the coverage units (which are to be determined in accordance with IFRS 17.B119) also reflect such structural differences appropriately, these differences are not expected to yield different accounting outcome with or without annual cohorts.

This view is also supported by the IDW.[13]

In addition the European Institutions approved in 2021 the carve-out option, aiming at eliminating the annual cohorts requirement in case of participating business with mutualization features. As discussed above this clearly applies for German health insurance contracts.

[13] see IDW Life, 05.2019, S. 378f.: VFA: Anwendungsfragen in Bezug auf IFRS 17 „Insurance Contracts"'.

6. Recognition

IFRS 17.25 defines the first recognition of a group of insurance contract as the earlier of

- the beginning of the coverage period and
- due-date of first payments from policyholders of that group.

However, for a group of onerous contracts recognition has to take place immediately when the information about onerousness is available.

There is a further important topic to be mentioned regarding recognition: For insurance acquisition cash flows (e.g. in general: acquisition costs already paid-out) relating to a group of contract which has not been recognized, the entity has to account for a separate asset / liability (typically: asset, e.g. for commissions paid) according to IFRS 17.27. Such an asset / liability will be derecognized immediately when the corresponding group of contract is recognized (and therefore, also the acquisition cash flows are recognized within the fulfilment cash flows of that group of contract). An example may be commissions paid during December for contracts with coverage period starting at 1st January and premium due-date also on 1st January.

7. Measurement Models

Insurance contracts (after separation of components according to IFRS 17.11-12) are measured according to the general measurement model (BBA) outlined in IFRS 17.32 and IFRS 17.40 or in certain cases according to an alternative model:

- For contracts with direct participation features, the variable fee approach (VFA, IFRS 17.B101-B118) has to be applied.
- The use of the premium allocation approach (PAA, IFRS 17.53) is an option if certain criteria are fulfilled. (see 8.2 Applicability of the Premium Allocation Approach)

The classification to one of these measurement models is carried out at initial recognition (or significant modification), taking into account the total duration of the contract until the contract boundary is reached. Except in case of a specified modification, there is no re- classification of an insurance contract at subsequent measurement.

It deserves to be mentioned that reinsurance contracts do not qualify for the VFA.

The insurance liability (IL) is split into a liability for remaining coverage (LRC) and a liability for incurred claims (LIC).

The general measurement model and the VFA are based on the following building blocks (IFRS 17.32):

a) Estimates of future cash flows

b) Adjustment for the time value of money and for financial risk (discounting)

c) Risk adjustment for non-financial risk (risk margin)

d) the contractual service margin (CSM)

The building blocks a)-c) form the fulfilment cash flows. As mentioned above the insurance liability is split into LRC and LIC:

- The LRC is calculated using building blocks a)-d) for cash flows related to future coverage.

  The LIC is calculated using building block a)-c) for cash flows related to past insured events – without d) since the CSM is only established during the coverage period. More details concerning the LIC are included in chapter 15 Liability for Incurred Claims.

For a group of onerous contracts, the CSM is zero and the LRC carries a loss component.

Insurance contracts with direct participation features are defined in IFRS 17.B101 and Appendix A as *insurance contracts for which, at inception:*

a) the contractual terms specify that the policyholder participates in a share of a clearly identified pool of underlying items (see IFRS 17.B105–B106);

b) *the entity expects to pay to the policyholder an amount equal to a substantial share of the fair value returns on the underlying items (see IFRS 17.B107); and*

c) *the entity expects a substantial proportion of any change in the amounts to be paid to the policyholder to vary with the change in fair value of the underlying items (see IFRS 17.B107).*

The fundamental concept behind contracts with direct participation features is a match between assets and liabilities, resulting in the entity's share in the fair value returns on the underlying items having the character of a fee.

The IASB's considerations regarding the VFA are outlined in IFRS 17.BC238-246.

The variable fee approach addresses contracts where "*the returns to the entity from a pool of underlying items should be viewed as the compensation that the entity charges the policyholder for service provided by the insurance contract, rather than as a share of returns from an unrelated investment."* (IFRS 17.BC241).

Hence the entity's activities can rather be seen as managing the underlying item on behalf of the policyholder as a part of the contractual services and charging a variable fee for that service where the fee is "*expressed as a share of the fair value of the underlying items*" (IFRS 17.BC243). The underlying item can be any item, even the contracts, see e.g. TRG 10 (September 2018), paragraph 15: "(…) *when a specified pool of underlying items consists of the insurance contracts that share in the return of that pool* (…)"

As a consequence, changes in those returns to the entity have to be seen as changes in the entity's compensation for providing service and hence should adjust the contractual service margin (IFRS 17.BC241).

These considerations are reflected in the definition of direct participation given in IFRS 17.B101.

The term "underlying items" is defined in IFRS 17.Appendix A as "*items that determine some of the amounts payable to a policyholder*". Thus, underlying items are not restricted to a portfolio of assets. Other examples of possible underlying items are the net asset of the entity or a specified subset of the net assets (IFRS 17.B106) or a subset of insurance contracts (TRG 10 (September 2018)).

IFRS 17.B101 a) refers to the requirement of contractual or legal regulations and a clearly defined link to the pool of underlying items. IFRS 17.B105 specify that the link to the underlying items needs to be enforceable, but that the share of the participation in underlying items can be subject to the entity's discretion.

IFRS 17.B101 b) is fulfilled if a substantial share of the fair value return on the underlying items is paid to the policyholders – and not to the shareholder. The payment can be to any of the policyholders or to future policyholders. "Payment"

can also comprise future set-off that might either affect cash inflows or cash outflows. Note that the return can also be negative, yielding negative participation of the policyholders.

IFRS 17.B101 c) is fulfilled if the variability of the change in the amounts to be paid to the policyholders is substantially dependent on the variability of the change in the fair value of the pool of underlying items.

IFRS 17.B107 and B108 state, that the condition "substantial proportion" should be assessed on a present value probability-weighted average basis.

IFRS 17.B101 b) and c) explicitly state "the entity *expects*" and "*substantial*", hence the assessment of the given criteria relies on the individual judgement of the entity.

8. Measurement models for German health insurance

German health insurance offers a range of diverse contract types with each providing different covers, durations and participation features.

Depending on these characteristics, an entity's reasoning may well result in any of the measurement models specified in IFRS 17 being appropriate for a specific group of insurance contracts.

8.1. Applicability of the VFA

The assessment whether a contract is subject to the VFA has to be made

- at inception,
- over the duration of the GIC and
- on a "*present value probability-weighted average basis*" (IFRS 17.B107),

i.e. the total period and the estimates average outcome matters, not a singled out scenario or reporting period.

German health insurance typically includes different participation features, especially

- participation in the investment returns on assets and in the total gross surplus of the contracts (contracts of categories 1 and 2, "contracts with profit sharing according to KVAV"),
- participation via the premium adjustment clause (contracts of categories 1, 2 and 3),

Concerning the profit sharing IFRS 17.B101 (b) and (c) use the term "pay to the policyholder". According to IFRS 17.B65 theses payments can be "on behalf" of the policyholder, hence payments of profits resulting from one policyholder to another policyholder are "payments to the policyholder" according to IFRS 17.B101 (b) and (c) as far as these payments are not allocated to the entity. KVAV requires the entity to allocate at least 80% of gross profits to the policyholders.

Moreover, the term "pay" is not restricted to a cash payment to the policyholders. It also includes any financial items that are used in favor of the policyholders, especially the entitlement to higher benefits or the reduction of the price without a change in benefits. The latter case describes the typical use of profit for the reduction of premiums increases in health insurance.

IFRS 17.B101 (b) and (c) refers to the variation of the cash flows with the underlying item. This variation can be positive or negative; there is no restriction in IFRS 17.B101 (b) and (c) to the sign of the variation.

Premium adjustments in German health insurance consider future changes in claims. The difference between expected claims and actual claims during the current period is not adjusted by the premium adjustment, but the policyholder participates in the future changes.

Therefore, the level of claims and costs of a "Beobachtungseinheit", interpreted as in Appendix A, could be considered as part of the pool of the underlying items[14] for the contracts of that observation unit.

Premium adjustments due to the premium adjustment clause are a result of (and result in) variations of the underlying item. Thus, a pricing that transmits the profit or loss of the business to the policyholders by an adjustment of premiums represents a direct participation.

However, if the premium adjustment clause is the only form of participation and constitutes a contract boundary, the VFA is not applicable.

In insurance contracts with profit sharing, the policyholder participates in the differences in claims of the current period via profit sharing, thus the policyholder participates in the total change in underlying item.

As IFRS 17.B101 does not require that the policyholder participates in the total change in underlying items, insurance contracts with premium adjustment clause but without profit sharing might meet the conditions of IFRS 17.B101 (contracts with direct participation features). It has to be checked for these contracts:

- if they comply with the conditions of IFRS 17.B101 (b) and (c) and
- if the premium adjustment clause does not represent a contract boundary.

A reasoning for VFA applicability for contracts where the premium adjustment clause is the only form of participation and does not constitute a contract boundary is provided in Appendix A of this paper (in German, since the relevant contractual features are very specific and rather unique).

8.2. Applicability of the Premium Allocation Approach

Concerning the Premium Allocation Approach, we refer to the report on findings of the Accounting and Regulation Committee to the topic "IFRS 17 for non-life insurers" prepared by "DAV Unterarbeitsgruppe IFRS 17 Sach".

[14] In one interpretation of the standard only assets in which the policyholder participates in should be considered as part of the underlying item. In view of IFRS17 B106, which explicitly allows "any item" to be considered, this seems to be a unnecessary restriction. Regardless of this, when VFA applies, then especially the fair value perspective is relevant, which gives the link between the abstract definition and a concrete figure to be reported following IFRS17.111. Here no material difference to the asset-oriented definition of the underlying item is to be expected (see chapter 8.3/8.4 for details on the fair value perspective).

8.3. Categories 1 and 2 – Contracts with profit sharing according to KVAV

For long-term contracts with profit sharing according to KVAV (Categories 1 and 2), applicability of the VFA can be assumed (see 8.1 Applicability of the VFA).

These contracts are long-term contracts, usually with an excepted term of many decades. Based on a present value perspective, the systematic changes resulting in premium adjustments are predominant compared to the random effects of the current period for these long-term contracts. Thus, the conditions of IFRS 17.B101 (b) are met. IFRS 17.B101 (c) refers to the change in amounts in different scenarios. In case of long-term contracts with profit sharing, the policyholder participates in the change in amounts either by premium adjustments or by profit sharing.

The premium adjustment clause for category 1 and 2 contracts does not represent a contract boundary (see 4.2.1 Categories 1, 2 and 3: Contracts with premium adjustment clause).

The underlying item according to IFRS 17.B101 (a) of contracts with profit sharing according to KVAV is defined as the whole participating insurance business including the assets (note that different definitions of the underlying item are possible): Because of various complex interactions between not only the entity's pool of health insurance contracts but also between the pool of contracts and the assets the entity holds in order to fulfil its obligations, the entity's whole participation business including all its assets and costs can be seen as underlying item, managed by the entity which receives the remaining surplus after policyholder participation as compensation.

The definition of the underlying item given in the DAV paper on Life Insurance might (with appropriate alterations) be transferrable to German health Insurance. For example, an underlying item, which includes both direct participation features and allows for all relevant services provided under a health insurance contract might be the sum of:

- recent gross surplus less granted direct bonus
- future gross surpluses
- recent RfB (excluding the allocation of the recent period)
- future benefits less future premiums including future contractual adjustments e.g. due to inflation or claims index (note: double counting due to profit sharing has to be avoided)
- all other receivables and payables arising under the contract between the insurer and the policy holder
- shareholder's equity (HGB-Eigenkapital)

Applying a "fair value" perspective, the definition of the underlying item includes all assets available to cover all liabilities under the insurance contracts, as far as these liabilities are part of the respective participation mechanism. As in German

health insurance policyholders participate in the investment returns on shareholders' fund, the assets allocated to shareholders' funds are included in the fair value of underlying items.

Please note that the fair value of the underlying item can be equal to zero, e.g. if there are no assets backing the contract, as it might be the case at inception (even for category 1 and 2).

8.4. Category 3 – Contracts with premium adjustment clause, without profit sharing

For long-term health insurance contracts in category 3 (with premium adjustment clause , without contractually agreed profit sharing) the premium adjustment clause may represent a contract boundary, cf. chapter 4 Contract boundary. If the premium adjustment clause represents a contract boundary, there is no participation of the policyholders within the contract boundary.

In case the premium adjustment clause does not represent a contract boundary, category 3 contracts qualify for VFA application , see above and Appendix A.

The general approach for the determination of the underlying item following the DAV paper for life insurance (see above) can (with appropriate alterations and excluding items that are not applicable) generally be adopted for category 3 business qualifying for VFA eligibility.

8.5. Category 4 – short-term health insurance

For short term health insurance (Category 4) in many common cases PAA applicability should be given, though this has to be carefully checked against IFRS 17 requirements, compare the DAV paper "IFRS 17 for non-life insurers".

9. Contract modifications

9.1. General issues

IFRS 17.72 defines contract modifications and the conditions under which a contract modification is specified, i.e. when such a modification triggers derecognition of the original contract and recognition of the modified contract as a new contract.

Exercising contractual rights is explicitly not a contract modification (IFRS 17.72).

If the contract modification is not specified, the changes are treated as changes in the fulfilment cash flows and reflected according to IFRS 17.40-52 (see IFRS 17.73).

A contract modification is specified if the modified terms would have caused differences in the applicability of IFRS 17, the separation of components, the contract boundary (only if substantially different) or the GIC (see chapter 5 Level of aggregation) at initial measurement. Modifications that affect the applicability of the measurement model of the original contract are also specified (see IFRS 17.72 (a)-(c)).

Changes in regulation or in entity-specific rights might meet the definition of a contract modification or a specified contract modification. This has to be assessed individually for each change in regulation or in an entity-specific right.

The border between certain options and contract modifications might be fuzzy in some cases. It might then be necessary to establish an appropriate accounting policy for those cases.

For further information and general guidance see DAV paper "Portfoliobildung unter IFRS 17".

9.2. Special issues for German health insurance

The contractual changing and premium adjustment rights without new risk assessment in German health insurance are no contract modifications in the sense of IFRS 17, since they are existing contractual options which are present in the original agreement with the policyholder.

Options to exercise contractual rights are reflected in the cash flows and are considered when forming the GIC (if material).

Examples for such contract changes that are no contract modifications are:

- Change of tariff without new risk assessment
- Premium adjustments
- Executing dynamic options without new risk assessment (according to contractual rights)
- (Partial) de- and reactivating of coverage

Change of tariff with risk assessment like the reduction of payment limits (with risk assessment for the reduction) in German health insurance might be seen as a contract modification. If this modification is not seen as specified, the reduction is treated as change in the fulfilment cash flows and reflected according to IFRS 17.40-52 (see IFRS 17.73).

10. Estimates of future cash flows

In IFRS 17.33 the overall principles for estimates of future cash flows are established as part of the fulfilment cash flow definition, IFRS 17.B36-B71 provides further guidance. This applies both at issue of the contract and at subsequent measurements for all groups of insurance contracts not measured under the premium allocation approach.

According to Appendix A of IFRS 17 the "fulfilment cash flow" is defined as

"An explicit, unbiased and probability-weighted estimate (i.e. expected value) of the present value of the future cash outflows minus the present value of the future cash inflows that will arise as the entity fulfils insurance contracts, including a risk adjustment for non-financial risk."

Therefore, future cash flows can be regarded as all cash flows resulting from the fulfilment of the contractual obligations of all underlying groups of insurance contracts. Discounting and risk adjustment will be discussed in the following two separate chapters.

10.1. Requirements

IFRS 17.33 states the key requirements of the measurement of estimates of future cash flows within the boundary of each contract:

a) Include in an unbiased way all reasonable and supportable information and calculate a probability weighted mean of the full range of possible outcomes (IFRS 17.B37-B41)

b) Reflect the perspective of the entity and be consistent with observable market prices (IFRS 17.B42-B53)

c) Be current, including available assumptions of the future (IFRS 17.B54-B60)

d) Be explicit in terms of the risk adjustment for non-financial and financial risks (IFRS 17.B46 & B90)

Only cash flows within the contract boundary are considered.

Cash flows attributable to fulfillment of the portfolio of insurance contracts are considered and allocated in an appropriate way if necessary.

IFRS 17.24 states that recognition and measurement requirements need to be fulfilled at a group level of contracts where the fulfilment cash flows might be estimated at a higher level of aggregation, provided the entity is able to allocate the estimated fulfilment cash flows adequately to each group. IFRS 17.BC117 states that IFRS 17 allows an entity to estimate the fulfilment cash flows at whatever level of aggregation is most appropriate from a practical perspective.

IFRS 17.B37 requires the calculation of an expected value or a probability-weighted mean of the full range of possible outcomes.

Further, it is not required to look at all possible scenarios, but to include in an unbiased manner all available and reliable information that can be identified without undue cost or effort. Stochastic modelling is therefore not explicitly required, but is considered to be adequate under certain circumstances, e.g. if "cash flows may be driven by complex underlying factors and may respond in a non-linear fashion to change in economic conditions". This has to be analysed based on the entity-specific situation.

10.2. Types of cash flows

Paragraph B65 provides examples of cash flows that are typically included within the boundary of the contract. These include cash flows the entity has discretion over the amount or timing. They include but are not limited to:

- Premiums including safety margin ("Sicherheitszuschlag") as well as premium adjustments
- Payments to or on behalf of the policyholders including claims that have been reported but not yet paid, incurred claims that have not yet been reported and future claims on unexpired risks
- Payments due to future discretionary and mandatory profit sharing, depending on return of the "underlying item" or based on regulatory requirements
- Directly attributable acquisition costs, claim handling costs including those for payments in kind
- Policy administration and maintenance costs as well as an allocation of (directly attributable) fixed and variable overheads
- Potential cash inflows from recoveries
- Costs for performing certain investment activities on behalf of the policyholder or for providing investment-related service to policyholders (see IFRS 17.B65 (ka))
- Any other cost chargeable to the policyholder under the terms of the contract

Besides those stated examples of cash flows, further health specific cash flows need to be considered as well, e.g. all payments to or from one of the several pooling agreements within the German health market and incoming or outgoing transfer values ("Übertragungswerte").

IFRS 17.B66 states examples of cash flows that should not be included. These are mainly cash flows that will be recognized and measured separately, e.g. investment returns, reinsurance held, cash flows outside the contract boundary, income tax payments or cash flows from components separated from insurance contracts.

Regulatory changes often require changes to existing products or drive new product developments. Due to the policyholder right to change from one tariff into a

comparable other tariff, those product development costs might not be assigned to new business only.

IFRS 17.B66(d) states that some product development costs shall not be included when estimating the future cash flows if they cannot be directly attributed to the respective portfolio of insurance contracts. Hence, it has to be analysed whether (especially for German health insurance business in category 1 and 2) product development costs might be seen as directly attributable to a certain degree[15] to a portfolio of insurance contracts and therefore be treated in analogy to overhead costs in the sense of IFRS 17.B65(l). However, the interpretation strongly depends on tariff- and entity-specific factors and has to be carried out individually.

IFRS 17.B65 requires the recognition of premium adjustments and payments due to future profit sharing within the cash flow projection. Therefore, a statutory HGB projection is as well required.

Health insurance cash flows are influenced by a number of factors, either depending on general assumptions and trends or on product or entity specific circumstances, e.g.

- economic conditions including interest rates and general inflation
- specific health related inflation and general development of claim payments
- mortality and lapse rates
- regulatory requirements including different pool agreements

Both, insurer and policyholder, have several options to react on certain developments which need to be considered in the estimation of future cash flows as well, for example premium adjustments (including limitation and profit sharing), tariff change and surrender.

IFRS 17.B59 requires considering the impact of inflation. This should be consistent with underlying economic assumptions, see IFRS 17.B51. For a health insurance contracts, special influence on the development of claim payments might be considered.

According to IFRS 17.B60, expectations regarding future changes in regulation shall not be considered "until the change in legislation is substantively enacted".

[15]Due to the policyholder right to change from one tariff into a comparable other tariff, the respective product development costs might not be seen entirely to be related to future contracts and they might therefore be not entirely in the scope of IFRS 17.B66(d).

10.3. Contracts with cash flows that effect or are affected by cash flows to policyholders of other contracts ("Mutualisation")

Cash flows of contracts effecting or being affected by cash flows of other contracts ("mutualisation") are described in paragraph B67:

- sharing the returns on the same pool of underlying items and
- the share of the own group is reduced or increased due to payments to or from other groups of contracts.

There are various examples of wide-reaching mutualisation effects between German health Insurance contracts, e.g.

- the premium adjustment clause
- policyholder participation via the RfB According to German legislation separate RfB pools have to be set up for health insurance, PPV, GEPV and voluntarily for P&C type insurance. Those RfB funds shared between all contracts belonging to the respective pool and are mainly used to finance limitations of peak premium increases or premium refunds. The amount a group of contracts receives from those funds does not depend on the amount it had contributed.
- required premium loadings in some tariffs to finance premium cappings in other tariffs. These include financing mechanisms over certain tariffs within one company and a pooling over the whole health market as for the PPV.

All these mutualisation effects are very unlikely to have a significant impact on whether groups of contracts are expected to be onerous or not.

Especially, but not only in the case of small groups of contracts, inadequate consideration of mutualisation effects might lead to misleading information.

IFRS17.B68 describes the underlying economics of the business. In practice, an application of approximations according IFRS17.B70 ("systematic and rational" allocation) might be necessary for German health insurance contracts in order to meet the objective of IFRS17.B68.

Some possible approaches are lined out in the DAV paper on life insurance which might be transferrable to German health insurance (with appropriate alterations where necessary). Whether, to what extend and with which necessary alterations these approaches are transferrable strongly depends on the individual entity and has hence to be checked individually. Thus, no guidance or recommendation can be given here.

In addition, it might be analysed whether too small groups could be avoided while still fulfilling the requirements of IFRS 17.

10.4. Insurance Acquisition cash flows

Insurance acquisition cash flows (IACF) are defined as "*Cash flows arising from the costs of selling, underwriting and starting a group of insurance contracts (issued or expected to be issued) that are directly attributable to the portfolio of insurance contracts to which the group belongs. Such cash flows include cash flows that are not directly attributable to individual contracts or groups of insurance contracts within the portfolio.*"

- *According to IFRS17.28A "An entity shall allocate insurance acquisition cash flows to groups of insurance contracts using a systematic and rational method". This is detailed in IFRS17.B35A, which states that* IACF that are directly attributable to a group of insurance contracts shall be allocated between the group and "*groups that will include insurance contracts that are expected to arise from renewals of the insurance contracts in that group*" (future groups) and IACF that are directly attributable to a portfolio of insurance contracts (but not a single group) shall be allocated between the groups in the portfolio.

According to IFRS17.B35B, the allocation method is revised in each reporting period for each group as long as the group is still open for new contracts.

For IACF allocated to future groups an impairment test has to be carried out (IFRS17.B35D).

According to B125, "*An entity shall determine insurance revenue related to insurance acquisition cash flows by allocating the portion of the premiums that relate to recovering those cash flows to each reporting period in a systematic way on the basis of the passage of time. An entity shall recognise the same amount as insurance service expenses.*"

The allocation and recovering mechanism for IACF strongly depends on the contractual structure and the individual circumstances in the entity and has therefore to be determined individually and no guidance or recommendation can be given here.

11. Discount Rates

Concerning discount rates we refer to the report on findings of the Accounting and Regulation Committee on the topic "Discount curve in IFRS 17" prepared by "DAV Unterarbeitsgruppe Zinsen unter IFRS 17".

Special issues concerning health insurance:

- If the medical inflation used for the projection of future cash flows is derived from other inflation assumptions, the entity should analyze, whether these inflation assumptions are consistent with the assumptions about discount rates
- The parameters used in the projection of the AUZ (method for determining the technical interest rate AUZ) should be consistent with discount rates.

12. Risk Adjustment

Concerning the risk adjustment, we refer to the report on findings of the Accounting and Regulation Committee on the topic "Risikomarge unter IFRS 17" prepared by "DAV Unterarbeitsgruppe Risikomarge unter IFRS 17".

13. CSM Unlocking and CSM Release for VFA

For contracts subject to the VFA the CSM is adjusted according to IFRS 17.45.

IFRS 17.45 (a)-(d) describe adjustments according to changes within the group of contracts and the underlying item during the reporting period (experience adjustments, unlocking), IFRS 17.45 (e) describes the amount of the CSM that is realised as profit for the current reporting period (release).

According to IFRS 17.45, it is not necessary to report these adjustments separately.

13.1. CSM Unlocking

Following IFRS 17.45 (a)-(d), the CSM of a group of contracts is unlocked with respect to

- the effect of new contracts added to the group of contracts
- the change in the amount of the entity's share of the fair value of the underlying item and the change in fulfilment cash flows relating to future service, both except for risk mitigation mechanisms according to IFRS 17.B115 and changes due to establishing or adjusting loss components
- effects of currency exchange differences arising on the CSM

Further guidance on these amounts is given in IFRS 17.B110-B118.

Fulfilment cash flows that do not vary based on the returns of underlying items (IFRS 17.B113) and effects of currency exchange differences are not expected to be material in standard German health Insurance contracts.

If the underlying item is shared between different groups of contracts, the change in the entity's share of the fair value of the underlying item has to be allocated to the groups.

Further approaches are described in the DAV paper on IFRS 17 for German Life Insurance, which might be transferable for German health Insurance (with appropriate alterations where necessary).

As allocation methods strongly depend on specific characteristics of the entities, no further guidance or recommendation can be given here.

13.2. CSM Release

IFRS 17.45 (e) describes the basic idea to calculate the CSM release at the end of the period: The CSM is adjusted by the amount recognised as insurance revenue because of the transfer of services in the period, determined by the allocation of the contractual service margin remaining at the end of the reporting period (before any allocation) over the current and remaining coverage period applying paragraph B119.

The amount of the contractual service margin for a group of insurance contracts recognised in profit or loss is determined by:

a) identifying the coverage units in the group. The number of coverage units in a group is the quantity of coverage provided by the contracts in the group, determined by considering for each contract the quantity of the benefits provided under a contract and its expected coverage duration."

b) allocating the contractual service margin at the end of the period (before recognising any amounts in profit or loss to reflect the services provided in the period) equally to each coverage unit provided in the current period and expected to be provided in the future.

c) recognising in profit or loss the amount allocated to coverage units provided in the period.

IFRS 17 gives no precise definition of coverage units apart from "quantity of coverage provided by the contracts in the group" (see B119 a)). Discussions within TRG acknowledge that insurance contracts offer different services, e.g. insurance and investment service. The amendments proposed for IFRS 17 allow for these services.

The proposed amendments also include the definition of insurance contract services for contracts with direct participation features as "*coverage for an insured event (insurance coverage)*" and "*the management of the underlying items on behalf of the policyholder*" (see IFRS 17.App. A). The term *„investment-related services*" is used for the management of the underlying items on behalf of the policyholder, even if the underlying item is not an "investment" in the classical sense (but, for example, a set of contracts).

Some approaches are discussed in the DAV paper on IFRS 17 for German Life Insurance, which might be transferable for German Health Insurance (with appropriate alterations where necessary). Whether, to what extend and with which necessary alterations these approaches are transferrable strongly depends on the individual entity and has hence to be checked individually. Thus, no guidance or recommendation can be given here.

There are certain special issues to be considered for German health insurance, e.g. there might be no fixed upper limits for the benefits and no sum at risk available. This might impose some restrictions on possible approaches and judgement might be needed which approach is most appropriate in order to fulfil the requirements of IFRS 17.

Further possible coverage units might be for example (weighted combinations of)

- (expected) claims
- Costs
- (positive) reserves
- number of policies
- investment service

This is not intended to be a complete list and no further guidance on the appropriateness can be given here. This issue will be discussed in a follow-up of this paper, as well as the consequences that might be drawn from the discussion on possible coverage units in TRG Agenda Paper 05 (Mai 2018).

Appropriate weighting of the coverage units might be necessary.

The coverage units might also be important in the context of annual cohorts, see chapter 5.3 Annual cohorts.

The DAV paper on IFRS 17 for German Life Insurance also addresses the issue of "overreturns" due to differences between real world and risk neutral assumptions for asset returns in the reporting period, which might yield systematic delays in profit recognition. The paper discusses possible ways to approach this, which might be transferrable to German health insurance if this issue arises. As possible solutions strongly depend on the entity's individual situation, no further recommendations or guidance can be given here.

14. Loss component

This chapter describes the loss component (LC) of the liability for remaining coverage (LRC) for contracts measured under the variable fee approach (VFA).

According to IFRS 17.49 a LC of the LRC shall be established for any onerous group of insurance contracts (GIC). The LC is required to determine

a) losses and reversals of losses on onerous GICs in P/L

b) to what extent expected cash flows from the LRC are released to insurance revenue or insurance service expenses

As a matter of principle: When a GIC is onerous, its CSM is zero. The LRC reported in the balance sheet is in this case identical to the fulfilment cash flows for remaining coverage. The LC is not explicitly accounted[16] in the balance sheet.

14.1. Subsequent Measurement

The subsequent measurement of the LC consists of the following components:

- **Adjustments to the Carrying Amount of the Loss Component**:
  When a GIC is onerous at the beginning of the period, the carrying amount of the LC is adjusted for further favourable and unfavourable changes arising from amounts according to IFRS 17.45(a)-(c).

- **Systematic Decrease of the Loss Component:**
  At the end of the period, after the adjustments outlined above are applied to the LC, the LC needs to be decreased, so that the LC is zero by the end of the coverage period of a group of contracts (see IFRS 17.52).
  This decrease of the LC shall be based on a systematic release pattern (see IFRS 17.50(a)). The systematic release pattern has to be determined by the entity.
  A suitable release pattern could be derived from coverage units, in the same way as the CSM is released to revenue (see IFRS 17.45(e)). The usage of other patterns could also be possible (see IFRS 17.BC287).

[16] The loss component of the liability for remaining coverage (LRC) is implicitly accounted because it is part of the LRC.

15. Liability for Incurred Claims

For subsequent measurement a liability of incurred claims (LIC) has to be calculated based on IFRS 17.40:

The carrying amount of a group of insurance contracts at the end of each reporting period shall be the sum of:

(a) the liability for remaining coverage comprising:

> *(i) the fulfilment cash flows related to future service allocated to the group at that date, measured applying paragraphs 33–37 and B36–B92;*
>
> *(ii) the contractual service margin of the group at that date, measured applying paragraphs 43–46; and*

(b) the liability for incurred claims, comprising the fulfilment cash flows related to past service allocated to the group at that date, measured applying paragraphs 33–37 and B36–B92.

German health insurance is short-tail business and claims to be considered for the LIC will generally have been incurred within the last 3 years, with the majority incurred in the previous year. This means that there should not be any significant discounting effects. The approach used under German GAAP to calculate the "Schadenrückstellung" could be applied to determine the estimates of future cash flows of the LIC.

Future cash flows form profit sharing already allocated might belong to the LIC, when the entity no longer provides investment related services based on those cash flows.

16. Transition

Concerning the transition we refer to the report on findings of the Accounting and Regulation Committee to the topic "IFRS 17: Übergangsbilanzierung (Transition)" prepared by "DAV Unterarbeitsgruppe Transition".

Abbreviations

BBA	Building block approach
CSM	Contractual service margin
DAV	Deutsche Aktuar Vereinigung
GAAP	Generally accepted accounting principles
GIC	Group of insurance contracts
IFRS	International Financial Accounting Standards
IL	Insurance liability
KVAV	Krankenversicherungsaufsichtsverordnung
LIC	Liability for incurred claims
LRC	Liability for remaining coverage
PAA	Premium allocation approach
PIC	Portfolio of insurance contracts
PHPP	Policyholder profit participation
UAG	Unterarbeitsgruppe – working sub-group
TRG	Transition Resource Group
VFA	Variable fee approach

Appendix A: VFA for Category 3 contracts where the premium adjustment clause does not constitute a contract boundary

Versicherungsnehmer-Beteiligung am Leistungs- und Kostenbedarf eines Teilkollektivs (Beitragsanpassungsklausel)

Beschreibung der Beteiligung

Die Beitragsanpassungsklausel kann beispielsweise direkt im Vertrag oder gesetzlich in §203 VVG verankert sein. Über die Beitragsanpassungsklausel werden die Versicherungsnehmer an den positiven und negativen Entwicklungen hinsichtlich Leistungs- und Kostenniveaus des jeweiligen Teil-Kollektivs beteiligt, dem der Vertrag angehört. Dieses Leistungs- und Kostenniveau des jeweiligen Teil-Kollektivs kann auch als Index verstanden werden, in den der Versicherungsnehmer investiert und an dessen Entwicklung die Versicherungsnehmer-Beteiligung gekoppelt ist.

Die Beitragsanpassungen führen dazu, dass Returns aus den in das Teil-Kollektiv (bzw. in den Index) investierten Beiträgen im Sinne einer realisierten Rendite mit der Entwicklung des Kosten- und Leistungsniveaus desselben Teil-Kollektivs (in der Erwartung) übereinstimmen.

Bei einem Verzicht auf das ordentliche Kündigungsrecht ist zudem vertraglich sichergestellt, dass der Vertrag auch bei veränderter Entwicklung hinsichtlich Leistungs- und Kostenniveaus des jeweiligen Teil-Kollektivs fortgeführt wird, wodurch diese Form der Beteiligung bei langfristigen Verträgen ein wesentlicher, integraler Vertragsbestandteil wird.

Dies grenzt diese Verträge z.B. auch von Verträgen ab, bei denen Prämien von (individuellen oder kollektiven) Schadenverläufen abhängig sind, aber entsprechendes Kündigungsrecht seitens des Versicherungsunternehmens besteht.

Bei isolierter Betrachtung ist nach *IDW Life, 05.2019, S. 378f.: VFA: Anwendungsfragen in Bezug auf IFRS 17 „Insurance Contracts"* folgendes zu berücksichtigen: *„Nur wenn die Vertragsgrenze nicht durch eine Beitragsanpassungsmöglichkeit bewirkt werden sollte, könnte aufgrund einer Prüfung der Kriterien der VFA anwendbar sein. Grundsätzlich ist IFRS 17.B101 (a) durch eine BAK erfüllt. Die quantitativen Kriterien in IFRS 17.B101 (b) und (c) können ggf. bei einer bestehenden Dominanz des Änderungs- und Irrtumsrisikos gegenüber dem Zufallsrisiko bei erwarteten langen Laufzeiten nachgewiesen werden."*

In weiterer Folge werden Verträge betrachtet, wo durch die Beitragsanpassungsklausel keine Vertragsgrenze ausgelöst wird.

Bei langfristigen Krankenversicherungsverträgen mit Beitragsanpassungsklausel stellt die Beitragsanpassung die Realisierung des Änderungsrisikos gegenüber den ursprünglichen Kalkulationsannahmen dar. Die Rechnungsgrundlagen werden regelmäßig systematisch geprüft, somit ist über die Totalperiode gesehen eine Dominanz zufälliger Schwankungen der Zahlungsströme ausgeschlossen, die

Schwankungen in den Zahlungsströmen werden vielmehr maßgeblich durch die und mit den Beitragsveränderungen bestimmt. So bewirkt beispielsweise die medizinische Inflation einerseits höhere Zahlungen an die Versicherungsnehmer, andererseits aber auch höhere Beiträge.

In der ganzheitlichen Betrachtung über die Gesamtlaufzeit entspricht dabei der Barwert des Zahlbeitrags ohne den Anteil des Versicherungsunternehmens an der Marge in etwa dem Barwert der Leistungs- und Kostenaufwendungen.

Nur die entsprechenden Margenanteile des Versicherungsunternehmens verbleiben beim Versicherungsunternehmen.

Das Versicherungsunternehmen erhält seinen Anteil an den Margen als Ausgleich für die Service-Erbringung für den Versicherungsnehmer. Hierzu gehört neben dem Leistungsversprechen auch das Management des (Teil-) Kollektivs inklusive Durchführung von Beitragsanpassungen.

Nach Aussage des IDW kann auch eine Tarifierung, die den Erfolg oder Misserfolg des Geschäfts an die Versicherungsnehmer über die Beiträge weitergibt, den Vertrag als direkt beteiligt qualifizieren, wenn hierdurch auch die quantitativen Kriterien von IFRS 17.B101 (b) und (c) erfüllt sind.

Prüfung der Kriterien einer direkten Beteiligung (IFRS 17.B101)

B101(a)

Die Versicherungsnehmer mit Verträgen mit Beitragsanpassungsklausel sind am Leistungs- und Kostenniveau des jeweiligen Teil-Kollektivs beteiligt, dem der Vertrag angehört.

Somit ist eine Versicherungsnehmer-Beteiligung an einem pool of underlying items gegeben.

Der Pool of underlying items – hier das Leistungs- und Kostenniveau des jeweiligen Teil-Kollektivs – ist klar definiert und durch vertragliche bzw. gesetzliche Regelungen spezifiziert.

Da es sich um vertragliche bzw. gesetzliche Regelungen handelt, ist die Beteiligung bindend (IFRS 17.B105).

Ein weiteres Argument im Kontext von B105 kann die Überwachung der ordnungsgemäßen Durchführung der Beitragsanpassung von einem unabhängigen Treuhänder sein.

Durch den Verzicht auf das ordentliche Kündigungsrecht bei verändertem Leistungs- und Kostenniveau des jeweiligen Teil-Kollektivs ist diese Form der Beteiligung bei langfristigen Verträgen wesentlicher, integraler Vertragsbestandteil.

Ein vorhandenes Tarifwechselrecht in Tarife mit Beitragsanpassungsklausel beeinflusst die Erfüllbarkeit der Kriterien von B101(a) nicht.

Somit können hier die Kriterien von B101(a) als erfüllt angesehen werden.

- Fazit: B101(a) ist erfüllt.

B101(b)

Über die Beitragsanpassungsklausel werden die Versicherungsnehmer an den positiven und negativen Entwicklungen hinsichtlich Leistungs- und Kostenniveau des jeweiligen Teil-Kollektivs beteiligt, dem der Vertrag angehört.

Einem Return gemessen in relativen Größen (z.B. Prozent bzw. auslösender Faktor) entspricht die Veränderung des (Pool of) Underlying Items, also die Veränderung des Leistungs- und Kostenniveaus des genannten Teil-Kollektivs. Die über die Vertragslaufzeit durch Investment von (nicht angepassten) Beiträgen in diesen Pool in Geldbeträgen (unter Berücksichtigung der Anpassungen) realisierten Renditen – gemessen zum Fair Value – entsprechen dem Fair value return on underlying items im Sinne des B101(b)[17].

Dabei führt gerade der Mechanismus der Beitragsanpassung - bis auf in der Regel geringfügige Abweichungen wegen z.B. verzögerter Beitragsanpassung in Folge von noch nicht angesprungenen auslösenden Faktoren oder Zinseffekten - dazu, dass der Fair Value Return im Erwartungswert in substanziellem Ausmaß an die Versicherungsnehmer fließt, da das Kosten- und Leistungsniveau des Teilkollektivs mit dem erwarteten Kosten- und Leistungsbedarf eines Vertrages übereinstimmt (Erwartungstreue des besten Schätzwerts)

- Fazit: B101(b) ist erfüllt.

B101(c)

Zu Vertragsbeginn (d.h. at initial recognition) entspricht der Fair Value of Underlying items den aus den Beiträgen (einschließlich erwarteter Beitragsanpassungen) getätigten Investments in das Leistungs- und Kostenniveau (einschließlich Margen/Fee des Unternehmens) sowie allfälliger Zuführungen/Entnahmen (Additions-/Withdrawals) von Eigenkapital des Unternehmens (sofern aufgrund der spezifischen Vertragsgestaltung eine Beteiligung an Eigenkapitalbestandteilen vorgesehen ist).

Der Fair Value von Kosten und Leistungen (als Payments to the Policyholder) des Vertrages bilden das Gegenstück, das in B101(c) zu betrachten ist.

Sowohl für das Underlying Item wie auch für die Kosten und Leistungen ergibt sich – bei der Betrachtung unterschiedlicher Szenarien – jeweils als Change in Fair Value die Differenz zwischen betrachtetem Szenario und Ausgangsszenario (das auch als mittleres Szenario bezeichnet wird).

[17] Wenn ein Index als Underlying item verstanden wird, dann entspricht dem Return die Veränderung des Index: Fair Value Return = „realisierte Rendite" aus dem Investment in den Index. Es kann sein, dass sich der Index um 7% ändert, jedoch ist die realisierte Rendite (wegen auslösendem Faktor) 0%. In diesem Sinne kann das Underlying Item als Derivat auf einen medizinischen Index angesehen werden.

Szenarien beinhalten unterschiedliche Pfade von Marktvariablen (d.h. Variablen deren Change ein Financial Risk bedeutet, z.B. Zinsen, Inflation) und nicht-Marktvariablen. Für jede Betrachtung eines Szenarios gegenüber dem Ausgangsszenario) werden auf der einen Seite der Change in Fair Value des Underlying Items (d.h. Prämien und Beteiligung, d.h. angepasste Prämien) mit dem Change in Fair Value der Kosten- und Leistungen verglichen. B101(c) ist bei substanzieller Kovarianz (damit auch bei substanzieller Korrelation) erfüllt.

Da der Fair Value of Underlying Items im Gleichklang mit dem Fair Value der Zahlungen an den Versicherungsnehmer (über die Totalperiode) schwanken, ist B101(c) erfüllt.

Außerdem kann erwartet werden, dass das Kosten- und Leistungsniveau eines Teil-kollektivs (d.h. das Underlying Item) in hohem Maß mit der Inflation korreliert ist und kein materielles Anlagerisiko aufgrund der geringen Vererbung bei Tarifen nAdS vorhanden ist. In diesem Fall kann von perfekter Korrelation, d.h. Komonotonie in allen Szenarien ausgegangen werden.

- Fazit: B101(c) ist erfüllt.

Fazit

Die Versicherungsnehmer-Beteiligung am Leistungs- und Kostenniveau des jeweiligen Teil-Kollektivs für die Verträge mit Beitragsanpassungsklausel erfüllt die Kriterien von IFRS 17.B101 und ist somit eine Form der direct participation, sofern die Beitragsanpassungsklausel keine Vertragsgrenze bewirkt.

Die Beitragsanpassungen stellen insbesondere auch eine Form einer realisierten Rendite bzw. einer realisierten Wertänderung dar, da hier die günstigen oder ungünstigen Effekte der Schaden- und Kostenentwicklung an die Versicherungsnehmer weitergegeben werden.

Der Versicherungsnehmer investiert dabei in das Leistungs- und Kostenniveau des jeweiligen Teil-Kollektivs.

Dem Versicherungsunternehmen fließen bei rechnungsmäßigem Verlauf lediglich die einkalkulierten Margen aus dieser Form der Beteiligung als variable fee zu.

Anhang: Übersicht

Standard bzw. Begrifflichkeit	**Definition**	**Bemerkung**
pool of underlying items	Leistungs- und Kostenniveau des jeweiligen Teil-Kollektivs	Die Versicherungsnehmer werden an den positiven und negativen Entwick-

		lungen hinsichtlich Leistungs- und Kostenniveau des jeweiligen Teil-Kollektivs beteiligt
fair value of the underlying items	Totalperiode: Beiträge einschließlich Anpassungen (siehe Argumentation zu B101b) (plus allfällige Zuführungen/Entnahmen von Eigenkapital) Ende aktuelle Periode: Marktwert der Kapitalanlagen die in das Kosten- und Leistungsniveau investiert sind. Eine passende Bezeichnung hierfür wäre Depot an investierten Anteilen in das Underlying Item eines Vertrags.	Preis für den Gegenwert (d.h. inklusive Margen, „at cost") für das Leistungs- und Kostenniveau des jeweiligen Teil-Kollektivs im Ausmaß des Vertrags
Fair value returns on underlying items	Fair Value (Barwert) aller zukünftigen Returns (Niveauänderungen), die aus der Veranlagung in das Kosten- und Leistungsniveau gemessen in Geldbeträgen als erzielte Rendite gemessen werden. (siehe B101b und c)	Der auslösende Faktor ergibt sich aus dem Leistungs- und Kostenbedarf des jeweiligen Teil-Kollektivs. Über die Beitragsanpassungsklausel werden die Versicherungsnehmer an den positiven und negativen Entwicklungen hinsichtlich des Leistungs- und Kostenniveaus des jeweiligen Teil-Kollektivs beteiligt
change in the fair value of the underlying items	Bei B101(c) über die Totalperiode at initial recognition – als Differenz der o.a. Größen im Fair Value gemessen zwischen Szenarien. Ende Aktuelle Periode: Veränderung Marktwert der (in das UI investierten)	

	Kapitalanlagen, sofern nicht durch Zuführungen/Entnahmen (Additions/Withdrawals) herbeigeführt	
entity's share of the fair value of the underlying items	VU Anteil an den Beiträgen einschließlich im UI eingebrachtes Eigenkapital (s.o.), also Fair Value der Margen	
entity's share of the change in the fair value of the underlying items	VU-Anteil an den Veränderungen der o.a. Größe, also VU-Anteil an der Veränderung der Margen	
fulfilment cash flows that do not vary based on the returns on underlying items	Variante 1: Leistungen und Kosten eines Vertrages die vom Leistungs- und Kostenniveau abweichen	Variante 1: Beitrage finanzieren nur das Leistungs- und Kostenniveau. Darüber hinausgehende und darunterliegende Abweichungen gehen zu Gunsten/zu Lasten des Entitys
	Variante 2: Alle Leistungen und Kosten sind "vary based on the returns on underlying items"	Variante 2: Alle Leistungen werden aus den Beiträgen (at Cost) finanziert Obwohl der tatsächliche Jahresschaden Abweichungen gegenüber dem erwarteten Mittelwert aufweist, besteht eine grundsätzliche Abhängigkeit (basedness) vom erwarteten Niveau.
B101 Insurance contracts with direct participation features are insurance contracts that are **substantially investment-related service contracts** under which an **entity promises an investment return**		VN investiert in das Leistungs- und Kostenniveau des jeweiligen Teil-Kollektivs. Dies garantiert, dass Leistungen (und Kosten) zu einem beliebig ändernden Niveau beglichen werden, wobei dem Unternehmen nur eine

based on underlying items. Hence, they are defined as insurance contracts for which: (a) the **contractual terms specify** that the **policyholder** **participates in a** **share of a clearly** **identified pool of** **underlying items** (see paragraphs B105–B106); (b) the entity **expects to pay to the policyholder an amount equal to a substantial share of the fair value returns on the underlying items** (see paragraph B107); and (c) the entity expects a **substantial proportion of any change in the amounts to be paid to the**	Anpassungsklausel vertraglich bzw. gesetzlich festgelegt Pool of underlying items = Leistungs- und Kostenniveau des jeweiligen Teil-Kollektivs Beteiligung am Leistungs- und Kostenniveau des jeweiligen Teil-Kollektivs über Beitragsanpassungsklausel klar definiert. Eine Beteiligung in Form von Beitragsanpassung führt dazu, dass der Fair Value Return on underlying items dem sich ändernden Kosten- und Leistungsniveau des Teilkollektivs bzw. des erwarteten kosten- und Leistungsniveau des Vertrages entspricht. Fair value return on underlying items Die Zahlungen an die VN variieren in der Totalperiode im Gleichklang mit der Veränderung des Beitrags (insbesondere aufgrund der Beitragsanpassung).	Marge (variable Fee) verbleibt. Das Risiko einer Änderung des Kosten- und Leistungsniveaus wird durch vertragliche Regelung zwischen Versicherungsnehmer und Unternehmen geteilt. in Form des auslösenden Faktors, durch den sich die Beiträge in Abhängigkeit von den positiven und negativen Entwicklungen hinsichtlich Leistungs- und Kostenniveau des jeweiligen Teil-Kollektivs verändern. "Pay" umfasst auch negative Zahlungen und Zahlungen, die nicht als unmittelbare Barzahlungen erfolgen, „Pay the policyholder" ist im Sinne von „to or on behalf of" zu verstehen.

policyholder to vary with the change in fair value of the underlying items (see paragraph B107).		
B104 The conditions in paragraph B101 ensure that insurance contracts with direct participation features are contracts under which **the entity's obligation to the policyholder** is the net of: (a) **the obligation to pay the policyholder an amount equal to the fair value of the underlying items**; and (b) a **variable fee** (see paragraphs B110–B118) that the entity will deduct from (a) in exchange for the future service provided by the insurance contract, comprising: (i) **the entity's share of the fair value of the underlying items**; less (ii) **fulfilment cash flows that do not vary based on the returns on underlying items**.	VU_obligation_to_VN = fv_underlying – variable fee VU_obligation = Beitrag - (VU-Anteil an den Margen - 0) Variable fee = VU-Anteil an den Margen	In der ganzheitlichen Betrachtung über die Gesamtlaufzeit entspricht der Barwert des Zahlbeitrags ohne VU-Anteil an der Marge in etwa dem Barwert der Leistungs- und Kostenaufwendungen. Für langfristige Verträge nach Art Schaden ergibt sich: VU_obligation_to_VN = Beitrag – VU-Anteil an den Margen = Leistungen inkl. Kosten. Nur die entsprechenden VU-Margenanteile verbleiben beim VU. Das VU erhält seinen Anteil an den Margen als Ausgleich für die Service-Erbringung für den VN. Hierzu gehört neben dem Leistungsversprechen auch das Management des (Teil-) Kollektivs inklusive Durchführung von Beitragsanpassungen.
B111 Changes in the obligation to pay the policyholder an amount equal to the fair value of the underlying items (paragraph B104(a)) do not relate to future service	Ohne Auswirkung	Die Veränderungen zum Ende der aktuellen Periode betreffen höchstens Veränderungen im Marktwert der investierten Kapitalanlagen.

and do not adjust the contractual service margin.		
B112 Changes in the amount of the entity's share of the fair value of the underlying items (paragraph B104(b)(i)) relate to future service and adjust the contractual service margin, applying paragraph 45(b).	Veränderungen im VU-Anteil an den Margen gehen durch die CSM	