INSURANCE COUNCIL OF AUSTRALIA

AASB Transition Resource Group for AASB 17 *Insurance Contracts*

Submission form for potential implementation question

In addition to the form, attachments (such as memos) may be included with the submission.

Any public discussion of issues submitted will be without the identification of the submitter's name. Although the submission forms will remain private, please do not include any confidential information in your submission.

Email a PDF of the completed (including any attachments) form to standard@aasb.gov.au.

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Do you wish to present to the TRG?	Yes

Potential implementation question

What is the coverage period for compulsory third party (CTP) insurance contracts in Australia?

Paragraph of IFRS 17 *Insurance Contracts*

IFRS 17 paragraphs B65; 2; 14; 20; 32; 33; 34; 35; 53.

Analysis of the question

The analysis of the question should include a detailed description of the different ways the new Standard may be applied, resulting in possible diversity in practice.

Contract Boundary and CTP Insurance

July 2018

1. Purpose and conclusions

Purpose

1.1 This paper analyses the current features of Australian compulsory third party (CTP) insurance markets, regulations and contract terms to identify an industry position and help ensure consistent application of the contract boundary requirements of AASB 17 *Insurance Contracts* to CTP contracts.

1.2 This paper considers the main CTP markets open to private sector insurers as of May 2018; that is, NSW, South Australia and Queensland.

1.3 Contract boundaries are significant because they determine the coverage period. When the coverage period is a year or less, contracts can automatically be accounted for using the premium allocation approach (PAA) under AASB 17. The PAA is simpler and less costly to implement than the general model under IFRS 17. To be eligible to apply the PAA to contracts with coverage

periods longer than a year, an insurer needs to establish that the PAA liability for remaining coverage (LfRC) will not be materially different from the general model LfRC.

1.4 All CTP contracts are currently regarded as having contract boundaries of a year or less for the purposes of AASB 1023 *General Insurance Contracts*.

Conclusions based on experience to-date

1.5 Based on the research conducted for this paper, CTP contracts will have a contract boundary of one year for the purposes of IFRS 17. Temporary exceptions may arise if and when jurisdictions transition from government-operated schemes to schemes involving private sector insurers. For example, the South Australian transition (which will be completed by the IFRS 17 mandatory application date) may result in contract boundaries of up to 15 months.

1.6 As jurisdictions reform and adjust their CTP schemes, there can be either:

(a) one-off adjustments, such as: (i) the 'clawback' associated with Queensland's *National Injury Insurance Scheme* serious injuries reforms; and (ii) adjustments associated with NSW's SIRA serious injuries reforms; and

(b) ongoing adjustments, such as obligations associated with Nominal Defendant claims in NSW and South Australia.

1.7 The adjustments associated with reform experience to-date would be cash flows within the one-year coverage period specified in each CTP contract [IFRS 17.B65]. These adjustments do not cause premiums for the one-year coverage period to take into account risks that relate to periods after that period [in the context of IFRS 17.34(b)(ii)]. This is because of the following.

(a) Premium refunds have been accompanied by relief from related substantive obligations that exist during the reporting period in which the entity can compel the policyholder to pay the premiums. Whether the refund is to policyholders for reduced risk in absolute terms or to another party that has assumed risk previously held by the insurer is not relevant.

(c) The quantum of the adjustments is actuarially determined, albeit externally and still reflecting community-pricing factors, to reflect a reduction in risk on active policies facing insurers.

Comments on potential future changes

1.8 It is not possible to predict the way in which CTP schemes might develop in future and affect contracts boundaries. However, experience to-date suggests the following.

(a) Governments that privatise CTP markets have an interest in fostering a commercially successful environment.

(b) Initiatives to increase the efficiency, effectiveness and perceived 'fairness' of CTP schemes have incorporated reasonable adjustments in premiums that have not resulted in premiums that take into account risks outside the contractual one-year contract boundary.

(c) Despite the extent of regulatory constraints on insurers, the only recent case (in South Australia) that may extend the CTP contract boundary beyond a year relate to a three-year transition arrangement with locked-in inflationary rate increases, but no other changes. In this situation, although the market is intended and expected to be profitable in each of the three years, there is no capacity for an insurer to re-price for changes in risks or benefits during that term.

2. IFRS 17 contract boundary

2.1 The contract boundary is essentially the time from when coverage commences to the time when the insurer has the practical ability to reassess risks and/or benefits at the contract or portfolio level. IFRS 17.34 says (emphasis added):

> 34 Cash flows are within the boundary of an insurance contract if they arise from substantive rights and obligations that exist during the reporting period in which the **entity can compel the policyholder to pay the premiums or in which the entity has a substantive obligation to provide the policyholder with services** (see paragraphs B61–B71). A substantive obligation to provide services ends when:

(a) the entity has the **practical ability to reassess the risks of the particular policyholder** and, as a result, can set a price or level of benefits that fully reflects those risks; or

(b) both of the following criteria are satisfied:

(i) the entity has the **practical ability to reassess the risks of the portfolio** of insurance contracts that contains the contract and, as a result, can set a price or level of benefits that fully reflects the risk of that portfolio; and

(ii) 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 periods after the reassessment date**.

2.2 The key criterion in applying IFRS 17.34 is that the insurer has the practical ability to reassess risks and/or benefits. It does not matter:

(a) if an insurer chooses not to exercise this practical ability; or

(b) why an insurer might choose to not exercise this practical ability – for example, even though there might be strong commercial incentives not to exercise its ability (such as substantial capital investment), these incentives do not change the fact that the insurer has the practical ability; or

(c) that the insurer's only avenue for exercising its practical ability might be to exit the market.

2.3 IFRS 17.53 in relation to applying the PAA says (emphasis added):

53 **An entity may simplify the measurement of a group of insurance contracts using the premium allocation approach** set out in paragraphs 55–59 if, and only if, at the inception of the group:

(a) the entity reasonably expects that such simplification would produce a measurement of the liability for remaining coverage for the group that would not differ materially from the one that would be produced applying the requirements in paragraphs 32–52; or

(b) **the coverage period of each contract in the group** (including coverage arising from all premiums within the contract boundary determined at that date applying paragraph 34) **is one year or less**.

2.4 IFRS 17.53 is applied at the group level; however, IFRS 17.20 permits an insurer to not disaggregate a portfolio into different groups when law or regulation specifically constrains the entity's practical ability to set a different price or level of benefits for policyholders with different characteristics. Based on IFRS 17.20, it is expected that insurers will account for portfolios of CTP contracts in each jurisdiction. Therefore IFRS 17.53 is expected to be applied at the CTP portfolio level in each jurisdiction.[1]

2.5 IFRS 17.53(b) refers to 'each contract in the group' implying that, in theory, only one contract with a coverage period in excess of a year is sufficient to prevent an insurer applying it in relation to a whole group or portfolio. However, materiality is expected to apply.

3. CTP general market context in NSW and Queensland

3.1 CTP insurance covers people injured or killed when a vehicle is involved in an accident. There are three parties to CTP insurance:

(a) the owner(s) or driver(s) of the 'at fault' vehicle(s);

(b) the CTP insurer of the vehicle(s); and

(c) the injured person(s).

3.2 CTP insurance is compulsory in all states and territories and a vehicle cannot be registered without it. There is a separate market in each state or territory, but cover applies throughout Australia, wherever the state or territory in which the vehicle is registered.

1 Probably across all states based on IFRS 17.14 which defines 'portfolio of insurance contracts' as insurance contracts subject to similar risks and managed together.

State/Territory	CTP Insurers (May 2018)
NSW	QBE, Allianz, CIC Allianz, AAMI and GIO (Suncorp), NRMA (IAG)
Queensland	QBE, Allianz, RACQ, Suncorp
Victoria	Transport Accident Commission (state government)
South Australia	QBE, Allianz, AAMI (Suncorp), SGIC (IAG)
Western Australia	Insurance Commission of Western Australia (state government)
Tasmania	Motor Accidents Insurance Board (state government)
ACT	AAMI (Suncorp), GIO (Suncorp), APIA (Suncorp), NRMA (IAG)
Northern Territory	TIO (Allianz)

3.3 CTP insurers are obligated to provide CTP insurance to those who request it and pay the premium. In Queensland and South Australia, the insurer has no oversight over the policy underwriting as this activity is performed during the vehicle registration and the registration fee includes CTP insurance; the state government subsequently remits premiums to insurers. In NSW, the insurance contract is executed with the insurer, prior to registration, and the policy incepts on registration.

NSW – general market environment

3.4 CTP providers submit premium rate proposals to the regulator at least once a year and demonstrate the overall expected level of profitability, given assumptions on claims and expenses. Insurers can submit tactical rate reviews more often than annually to the State Insurance Regulatory Authority (SIRA).[2]

3.5 Premium rates to customers are based on parameters such as:

- Class of vehicle, e.g., cars, motorcycles, light goods carrying vehicles, taxis
- Age of vehicle and driver
- Driver's safety record (based on demerit points)
- Geographic zone where garaged, e.g. Sydney Metro, Newcastle/Central Coast, Country
- Whether use is private (no input tax credit) or for business (with input tax credit)
- Period of registration – for example, 6 or 12-month contractual coverage periods.
- Number of at fault claims
- Period of comprehensive insurance

3.6 In general, insurers are able to freely set premiums[3] within the bonus-malus bands advised by SIRA for each class and relativities between classes, subject to being able to justify to SIRA that their premiums reflect expected claims and permitted expense assumptions to generate a reasonable but not excessive (or insufficient) profit at an annual portfolio level. SIRA issues 'no-objection' (or 'objection') notices, rather than approvals (or disapprovals).

3.7 Pricing proposals do not consider claim costs beyond the next annual repricing cycle. Paragraph 1.49 of the NSW Motor Accident Guidelines (MAG) requires that total estimated claim costs underlying an insurers' proposals to "reflect the expected outcomes of the Act"; that is, claim costs that would emerge on policies to be written under the annual pricing review being submitted based on risks in the insurer's existing portfolio.

3.8 If risks change mid-term, for example, a young driver is added, pricing is updated at the next renewal.

Queensland – existing market environment

3.9 The Motor Accident Insurance Commission (MAIC) oversees the scheme and sets upper and low limits for premium rates. Insurers determine premium rates every quarter within these limits

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[2] In NSW, the 2017 legislation introduced a perpetual licence fee of $5,000.

[3] Including loyalty discounts, varied rates between new business and renewals, or fleet rates. Fleet rates may be differentiated on an underwritten basis and credit terms rather than up-front premiums. Additionally, commissions may be offered to dealers and brokers.

(generally at or near the ceilings) based on class of vehicle (for example, cars and station wagons are class 1. MAIC then specify loadings based on:

- whether use is private (no input tax credit) or for business (with input tax credit); and
- period of registration – 12 or 6 months (plus 3 months for trucks) coverage.

However, pricing does not differentiate by age of vehicle or age of driver.

3.10 Queensland vehicle owners may nominate to change CTP insurer at any time while a vehicle is registered, which comes into effect from the date of the next registration renewal.

3.11 No commissions are permitted; however, incentives based on factors, such as geographical location, may be provided to policyholders using, for example, fuel cards or charitable donation.

3.12 If risks change mid-term, for example, a change of use to rally driving, extra premiums can be charged.

IFRS 17 contract boundary based on general NSW and Queensland market environments

3.13 This paper takes the view that, while the regulation of CTP premiums involves a level of community pricing / cross-subsidisation within the portfolio, the contract boundary does not extend beyond a year for the following reasons.

(a) Policyholders must pay premiums at or prior to registration / policy inception), either directly to the insurer or to the motor registry (if obtaining CTP cover is part of the registration process, in which case the state government must forward premiums to the insurer). Fleets may be offered credit terms, but the insurer still has a right to receive a premium from policy inception.

(b) Under current arrangements in NSW and Queensland, contractual policy periods are one year or less and insurers have the practical ability, at least annually, to reassess the risks of their portfolio and, as a result, set prices that reflect those risks.

(i) At a portfolio level, CTP regulatory regimes allow premiums to adequately reflect updated risks and enable insurers to be reasonably profitable in each year of cover.

(ii) Community-based pricing restrictions focus mainly on limiting risk differentiation (cross-subsidisation of pockets of the market and ensuring CTP insurers cannot refuse particular customer classes through prohibitive pricing).

(iii) Ultimately, even though licenced insurers are obligated to provide CTP insurance to those who request it, they are free (without a fixed notice period in NSW or Queensland) to withdraw from the CTP market if they were to consider it unprofitable.

4. CTP market transition in South Australia

4.1 A three-year transition to private sector insurer involvement in the market is underway, having started on 1 July 2016 under the *Compulsory Third Party Insurance Regulation Act 2016* (*CTPIR* Act).

4.2 Although the privatisation transition period will be completed prior to the mandatory application date for IFRS 17, as three more states could in the future be privatised, the features of the South Australian transition scheme may have implications once IFRS 17 is applicable.

- One insurer is allocated for 3 years as part of vehicle registration. Changing insurer is not encouraged but is possible if a policyholder has serious and legitimate concerns.
- Rates are set for Class 1 policies for Years 1, 2 and 3, with inflationary increases of approximately 3% p.a., and relativities between different classes locked for three years.
- All four licenced insurers provide the same CTP contracts at the same prices.
- Rates reflect only vehicle type and region (metro / non-metro), with no distinction by driver age or vehicle age. Cover periods are for 3 or 12 months only.
- Insurers can give notice on 1 April to exit the market by the following 1 July

4.3 The way in which insurers are locked-in to particular levels and relativities of CTP premiums during the three-year transition period may cause the contract boundary to extend beyond a year. During transition:

(a) policies are allocated to insurers based on pre-agreed market shares;

(b) rates and cover are consistent across all insurers;

(c) there is no ability to re-price or amend benefits for any changes in risk, apart from a fixed inflationary increase.

4.4 Based solely on these three factors, during the transition period, South Australian CTP contracts would probably be three-year contracts. However, the ability to exit the market with a notice period would, in most cases, reduce the coverage period to 12 months or less; depending on the insurer's reporting date, the notice period and exit date. Modelling would be required to establish whether the contacts with coverage that would extend beyond a year (and up to 15 months) would be material relative to the whole portfolio.

4.5 Given the long-tail nature of the business and up-front investment by approved insurers in privatisation fees,[4] people and systems, exiting the market may not be commercially practicable. In addition, in privatising its CTP market, the South Australian government has a clear interest in ensuring the scheme's success, such that premiums are sufficient to ensure that insurers are profitable (generating a return on their initial investment / capital). However, as noted above, this does not preclude an insurer from having a practical **ability** to exit the market.

4.6 Discussions have commenced on pricing after 1 July 2019 and the regulator seems to be looking to continue a strong community pricing approach, although this is still at a very early stage. Accordingly, the frequency and scope of re-pricing is still to be established.

IFRS 17 contract boundary based on South Australian transition

4.7 Insurers participating in this market in transition have their practical abilities to reassess risks and/or benefits constrained over three years. Although an insurer could exercise its practical ability to reassess risks and/or benefits by giving notice to exit the market, it could remain on risk for up to 15 months at the rates set in the transition arrangements. Accordingly, some percentage of an insurer's business could be regarded as having a contract boundary in excess of a year and, therefore, an insurer may be ineligible to use the PAA based on IFRS 17.34(b). The PAA may still be available based on IFRS 17.34(a).

Fees paid to participate in CTP market

4.8 Insurers tendered for a guaranteed market share for the first 3 years of the new arrangements, in return for a fixed and non-refundable fee. Additionally, unexpired premium risk was transferred to approved insurers in accordance with their market share, and payments equivalent to unearned premium were made accordingly; run off of the existing claims portfolio is managed by MAC. The Lifetime Support Scheme was not part of the transaction.

4.9 The accounting for the non-refundable fees seems uncontroversial – fees would be capitalised as an intangible asset under IAS 38 *Intangible Assets* to be amortised over the periods expected to benefit from holding a licence.

5. Other factors and developments in CTP markets

NSW – reforms

5.1 The Risk Equalisation Mechanism (REM) is a component of the NSW Government's plans to reform its CTP market. Approved premium rates include significant cross-subsidisation across different risk classes and insurers have some scope to target certain parts of the market. SIRA considers an insurer's portfolio may become unbalanced *vis-a-vis* risk assumed and premium received, and may require correction. REM adjustment rates are reviewed by SIRA at least annually.

[4] Four insurers have paid for licences for varying shares – QBE 35%, Allianz 15%, AAMI (Suncorp) 30%, and SGIC (IAG) 20%.

5.2 REM adjustments (plus or minus to premiums) are set by SIRA in advance, and vary according to vehicle class and age, driver age, postcode zone and sub-zone, and policy duration. REM adjustments will be paid to / received from the pool by each insurer, quarterly in arrears, such that each REM pool is self-funding (balancing to $0 across the pool within a fiscal year). Adjustments are applied at policy level, and net amounts due to/from other insurers via an ICA clearing house. There is no impact on policyholders.

5.3 Risk equalisation premium adjustments would be treated as premium adjustments [AASB 17.B65(a)] and do not cause the contract boundary to extend beyond a year for the following reasons.

(a) The right to receive / obligation to pay quantifiable adjustments is established at policy inception.

(b) The level of adjustments per class are set in advance but reviewed at least annually.

(c) These are adjustments designed to improve the insurers' abilities to set prices that reflect the risk of their CTP portfolios.

Regulated claims

5.4 The NSW, Queensland and SA CTP schemes are largely common law fault-based, which means the injured person must prove another driver was at fault in a motor vehicle accident. If an owner/driver was partly at fault in causing their own injuries, compensation will generally be less than if the driver was fully at fault. The following points are relevant.

(a) In NSW, all parties can receive compensation for loss of income and treatment and care up to 6 months for "Minor Injuries[5]", , regardless of fault, and certain children's benefits are also paid regardless of fault.

(b) In Queensland, while the insurer pays compensation according to the type and extent of injury, you may get less if you were partly at fault.

(c) In South Australia, an excess applies to all drivers/owners who are found to be more than 25% at fault, but the excess is only payable once the claims cost exceeds the excess amount.

5.5 In respect of serious long-term injuries, an insurer's liability is limited, and lifetime care and support is provided by state government agencies, funded on an ongoing basis by additional levies on policyholder premiums or vehicle registration, at no cost to insurers.

5.6 These regulated claims do not affect the contract boundary as they relate to the liability for incurred claims rather than the liability for remaining coverage.

Premium refunds from regulated scheme reform

5.7 There have been two recent examples of mandatory premium refunds required by regulators following state government initiatives to reform CTP markets.

5.8 In NSW, new regulations governing CTP claims took effect from 1 December 2017. To reflect the anticipated significantly lower cost of claims, SIRA required insurers to refund policyholders a portion of unearned premiums (approximately 25%) on all policies on risk at 30 November 2017. (The scheme changes also necessitated insurers to submit new, lower pricing for policies issued after 1 December 2017).

5.9 In Queensland, changes to the funding of treatment and care for serious injuries from July 2016 (refer below) reduced the risk to insurers. To initially fund the scheme, insurers were required to pay the scheme manager, the *National Injury Insurance Scheme Queensland,* a one-off 'clawback' from unearned premiums through to September 2017.

5.10 The premium refunds would be treated as premium adjustments [AASB 17.B65(a)] and do not cause the contract boundary to extend beyond a year because they are designed to be commensurate with the anticipated reductions in claims.

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5 As defined in the Motor Accidents Injuries Act 2017 (NSW)

Claims sharing

5.11 CTP claims are 'shared' with another CTP insurer when there is joint responsibility for an accident, and the various parties have different CTP insurers (or will claim on the Nominal Defendant – refer below). One insurer takes the lead in managing and paying the claim and recovers from the other insurer(s) an agreed percentage. Sharing is adopted in NSW, Queensland and South Australia, and involves both receipts and payments for each insurer.

5.12 After a claim subject to sharing is fully paid and officially closed, it will be submitted for settlement to an industry clearing house at the end of each quarter; that is, a claim closed in July would not be submitted to the clearing house for settlement until after 30 September. Settlement generally follows within the quarter, when amounts have been checked by the other insurers. However, in certain cases, delays and disputes between insurers can arise, and be settled by negotiation or ultimately by reference to a dispute panel.

5.13 Claims sharing does not affect the contract boundary as they relate to the liability for incurred claims rather than the liability for remaining coverage.

Nominal Defendant claims

5.14 The 'Nominal Defendant' is a statutory body in each state, used in relation to claims when people are injured by a vehicle that was uninsured or unidentified (for example, hit and run), meaning the injured person wouldn't usually be able to make a claim against the owner/driver's CTP insurer. In this case, claims may be made against the Nominal Defendant. Regimes can vary:

(a) In NSW and SA, all insurers are required to manage and pay claims for the Nominal Defendant; claims are randomly allocated by the regulator to the licenced insurers, who then manage the claims as normal. As the financial impacts are not known when the allocation is made, once claims are paid they are rebalanced between insurers on a quarterly basis based on market share of premiums (a rolling 4 quarter average). In NSW, a specific allowance to cover such claims is included in the premium submissions to SIRA.

(b) In Queensland, the Nominal Defendant is managed by the state government, and funded by a levy within the CTP insurance premium. There is no charge to insurers.

5.15 There is no documented insurance contract between the public-sector Nominal Defendant entity in each state and the insurers – the share of its claims cost paid by insurers in NSW and SA is created by statute, i.e. as a condition of each insurer's licence to operate.[6] AASB 17.2 says:

> 2. An entity shall consider its substantive rights and obligations, whether they arise from a contract, law or regulation, when applying IFRS 17. …

5.16 This is consistent with more specific public guidance for public sector entities in the AASB Discussion Paper *Australian-Specific Insurance Issues – Regulatory Disclosures and Public-Sector Entities*[7] ("AASBDP-Nov17"), which highlights the following indicators that an insurance contract is created between the Nominal Defendants and the insurers:

(a) Significant insurance risk is transferred – insurance cover is provided to members of the public injured in motor vehicle accidents where the at-fault driver has no CTP cover or cannot be identified.

(b) Insurers exercise a choice to operate in the market, and therefore whether to commit to paying its share of Nominal Defendant claims.

(c) The arrangement is reciprocal – in effect, the Nominal Defendants in effect reinsure 100% of their risk to the licenced insurers.

5.17 It must be determined whether such "contracts" should be classified with issued CTP contracts (and subject to the same contract boundaries) or treated separately. Factors to consider include:

(a) The 'contract is not 'issued' by an insurer in the conventional sense and there is no premium attached to it. However, premium pricing proposals make allowance for the cost of Nominal Defendant claims – premium for the contract could be derived and isolated from other premiums.

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6 There is also no documented insurance contract between the Nominal Defendant and the injured party making a claim, but one likely exists under AASB DP-Nov17.

7 Issued for comment in November 2017; refer Appendix 1 for extracts.

(b) The regulator recognises that the cost of such claims must be covered with a reasonable profit margin – there is no reason to expect that a group of the Nominal Defendant contracts would be more or less likely to be onerous at inception than other CTP contract groups.

(c) The amount an insurer pays is based upon its market share of premiums when the claim was incurred. As this is a rolling four-quarter average, the risk and benefits for that accident date would have been updated less than 12 months previously.

(d) Materiality – at an industry level, the cost of Nominal Defendant claims in NSW is approximately 2.5% to 3.5% of total claims. South Australian data is yet to be sufficiently developed but is unlikely to be significantly different.

5.18 Accordingly, this paper takes the view that Nominal Defendant contracts would be included within the same CTP portfolios / groups as conventional policies issued to policyholders.

Regulatory excess profit or loss adjustments

5.19 The NSW Government has undertaken various measures to further reform the NSW CTP market. SIRA has views on the expected outcome of its measures to reduce the cost and duration of claims and will approve premiums on a basis that should deliver a reasonable level of profitability for insurers. However, the success of the claims reforms will not be fully evident from some years given the long-tail nature of CTP insurance.

5.20 For a transitional period of at least three accident years beginning 1 December 2017, SIRA may regulate realised profits and adjust "premiums to avoid transitional excess profits and ... losses" (TEPL). TEPL is profit that is in excess of, or falls short of, a 'reasonable level of profit', to the extent it is attributable to the underestimation or overestimation of the reduction in the cost of claims to result from the reforms to claim benefits. A reasonable level of profit for the overall industry is between 3% and 10% of industry gross earned premium, around an 8% benchmark.[8] TEPL adjustments will operate on an accident year as follows.

(a) If the industry has excess profit (above 10%), all insurers in excess of 8% are charged based on their share of the excess profit relative to 8% until the industry is normalised back to 10%.

(b) If the industry has insufficient profit (under 3%), all insurers below 8% benefit based on their share of the excess loss relative to 8% until the industry is normalised back to 3%.

5.21 Increased individual insurer profitability (up to 3%) may be permitted by way of an 'Innovation Bonus', to reward insurers for improving scheme effectiveness and/or efficiency for the claimant, the insurer or society.

5.22 Retrospective adjustments to CTP premiums would be regarded as premium adjustments and/or additional cash flows that result from these premiums [IFRS 17.B65(a)] and do not cause the contract boundary to extend beyond a year.

(a) The intent of TEPL adjustments is to constrain insurer profitability within a regulatory 'reasonable' band once the actual outcome of the claims scheme reforms is known. Theoretically, premiums after TEPL adjustments will be materially consistent with what the insurer included in its pricing submissions, which take place at least annually.

(b) Even though there will likely be no cash flows for at least two years after policy inception, they arise from rights / obligations that exist during one-year coverage periods. Insurers will have little or no practical ability to vary TEPL adjustments once advised, other than to 'correct' any actuarial issues, and subsequent withdrawal from the market would have no impact on the calculations for an accident year. The fact that cash flows will not be to/from the policyholder is not relevant [IFRS 17.B65(a)].

(c) Although NSW TEPL adjustments will be based on accident year not underwriting year, this can affect their measurement, but they do not affect the coverage of one year.

5.23 TEPL adjustments would be put to insurers as special Motor Accident Fund (MAF) levies; but are not expected until 2019 or 2020 at the earliest, when claims will have developed sufficiently.

[8] Report of the Independent Review of Insurer Profit within the NSW Compulsory Third Party Scheme (October 2015)

5.24 Although TEPL only operates in NSW, a committee appointed by MAIC reviewed the Queensland CTP scheme in 2016, with a focus on scheme affordability and efficiency in light of insurers' reported profits considerably in excess of the 8% quoted to the regulator, and premium rates consistently rising in excess of inflation. Various recommendations to improve the scheme were made, but not for a profit clawback mechanism (such as TEPL) at this stage, given the numerous legislative and practical issues that would need to be addressed; the scope or timing of other actions remains unclear.

Appendix 1 – Technical Guidance

AASB 17 *Insurance Contracts*

AASB17.32 requires that on initial recognition, an entity shall measure a group of insurance contracts at the total of the fulfilment cash flows (i.e. estimates of all the future cash flows within the boundary of each contract in the group [AASB17.33]) and the contractual service margin.

AASB17.34 states that "Cash flows are within the boundary of an insurance contract if they arise from substantive rights and obligations that exist during the reporting period in which the entity can compel the policyholder to pay the premiums or in which the entity has a substantive obligation to provide the policyholder with services. A substantive obligation to provide services ends when:

(a) the entity has the practical ability to reassess the risks of the particular policyholder and, as a result, can set a price or level of benefits that fully reflects those risks; or

(b) both of the following criteria are satisfied:

(i) the entity has the practical ability to reassess the risks of the portfolio of insurance contracts that contains the contract and, as a result, can set a price or level of benefits that fully reflects the risk of that portfolio; and

(ii) 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 periods after the reassessment date".

AASB17.B65 notes that cash flows within the boundary of an insurance contract are those that relate directly to the fulfilment of the contract, including cash flows for which the entity has discretion over the amount or timing. Examples include:

- Premiums (including premium adjustments and instalment premiums) from a policyholder and any additional cash flows that result from those premiums.
- Payments to (or on behalf of) a policyholder, including claims reported but unpaid, claims incurred but not reported and all future claims for which the entity has a substantive obligation.
- An allocation of acquisition cash flows attributable to the portfolio to which the contract belongs.
- Policy administration and maintenance costs, and recurring commissions that are expected to be paid if a particular policyholder continues to pay the premiums within the contract boundary.
- Transaction-based taxes (such as premium taxes and goods and services taxes) and levies (such as fire service levies and guarantee fund assessments) that arise directly from existing insurance contracts, or that can be attributed to them on a reasonable and consistent basis.
- Potential cash inflows from recoveries (such as salvage and subrogation) on future claims covered by existing insurance contracts and, to the extent that they do not qualify for recognition as separate assets, potential cash inflows from recoveries on past claims.
- Any other costs specifically chargeable to the policyholder under the terms of the contract.

Thus, as a general rule, cash flows are within the boundary of an insurance contract if they relate directly to the fulfilment of the contract, i.e. they arise from rights and obligations that exist during the period in which the entity can compel the policyholder to pay the premiums or in which the entity has a substantive obligation to provide the policyholder with services. The cash flows need not be solely between the insurer and the policyholder.

Public Sector Entity Guidance

The AASB Discussion Paper *Australian-Specific Insurance Issues – Regulatory Disclosures and Public-Sector Entities,* issued for comment in November 2017 ("AASBDP-Nov17"), considers a number of issues arising from AASB 17 for regulated insurance-like environments in the public sector, including CTP. Given the regulated nature of CTP, and the involvement of public sector bodies in the market (such as for Nominal Defendant claims), such guidance is of relevance.

AASBDP-Nov17 highlights that the scope of AASB17 depends on the definition of an insurance contract - "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." (A reinsurance contract is defined as "An insurance contract issued by one entity (the reinsurer) to compensate another entity for claims arising from one or more insurance contracts issued by that other entity (underlying contracts))".

AASB17.2 states "A contract is an agreement between two or more parties that creates enforceable rights and obligations". AASBDP-Nov17.E9 notes that enforceable rights and obligations may also arise by statute alone, with no contractual relationship (as there is no element of 'voluntariness' or 'reciprocity'), such as certain motor vehicle accident schemes funded by levies. For AASB17 to apply to these sort of schemes, an arrangement that transfers significant insurance risk must also be "insurance-like". Necessary (but not sufficient) criteria for "insurance-like" are [AASBDP-Nov17.E13]:

- The arrangement must have commercial (i.e. economic) substance, giving rise to substantive rights and obligations that will expect to impact on risk, timing or amount of the entity's future cash flows;
- The key criterion of the arrangements, particularly beneficial rights, cannot be altered without a specific change in legislation or relevant governing measures and cannot be retrospectively amended; and
- If the insured event occurs, the arrangement provides the beneficiaries with enforceable rights.

Additional criteria include [AASBDP-Nov17.E14]:

- The legislation or other governing measures provide for funding by premiums or levies paid by the potential beneficiaries, those whose activities create or exacerbate the risks, or contributions by the government or other public-sector entities.
- The financial performance and financial position of the scheme is assessed on a regular basis, and, where necessary, action is taken to address any underfunding of the scheme.
- Similar transactions or arrangements with similar characteristics and level of insurance risk are entered into by for-profit entities and accounted for as insurance contracts.
- Assets and liabilities arising from the arrangements are held in a separate fund, or otherwise specifically identified as used solely to provide benefits to beneficiaries.

To determine the contract boundary, for insurance-like arrangements where premiums are charged, public sector entities should apply AASB17.34-35. For insurance-like arrangements that are not funded by way of premiums, the following approach should apply [AASBDP-Nov17.E21]:

(a) where the funding of an arrangement cannot be changed without the need to amend legislation, the contract boundary is presumed to be more than 12 months;

(b) where the legislation establishing an arrangement requires a process, usually performed annually, by which the arrangement's activities are assessed and funding may be changed, the contract boundary is presumed to be one year or less; and

(c) if the funding of the arrangement may be changed at any time, i.e. without an annual review, the contract boundary is presumed to be one year or less.

The examples to AASBDP-Nov17 also confirm that CTP insurance provided by private sector insurers with regulated premiums is covered by AASB17 [AASBDP-Nov17.IE8-9] and has a 1-year coverage period:

"Despite the obligation being created under legislation, the existence of choice for the driver (and by extension, the driver's intention to engage with a particular entity) is likely, in the absence of other relevant circumstances, to mean that a contract is formed between the driver and the private sector insurance company".

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Appendix 2 - Summary for NSW, Queensland and South Australia

NSW

Current Characteristics

Cover provided to all-comers, prior to registration.

Regulated, community-priced premiums, repriced at least annually.

Regulated premium refunds due to regulated post-inception change in risk.

Regulated adjustments to rebalance premium vs risk between insurers, to reduce impacts of community pricing.

Claims scope is regulated and includes sharing (inwards and outwards).

Nominal Defendant claims cost based on market share but no underlying insurance contract. The relationship with the Nominal Defendant is an in-substance contract separate from contracts with vehicle owners.

Imposed, retrospective premium adjustments to maintain underwriting P&L within certain regulated boundaries.

Contract Boundary Based on Underlying Contracts?

Yes – all the NSW market features reflect rights and obligations that arise during the 12-month policy period.

Queensland

Current Characteristics

Cover provided as part of registration – insurer not involved in policy inception.

Regulated, community-priced premiums, repriced at least annually.

Regulated premium refunds due to regulated post-inception change in risk.

Claims scope is regulated, and includes sharing (inwards and outwards).

Contract Boundary Based on Underlying Contracts?

Yes – all the Queensland market features reflect rights and obligations that arise during the 12-month policy period.

South Australia

Current Characteristics

Cover provided as part of registration – insurer not involved in policy inception.

3-year privatisation transitional period featuring:

- Privatisation fees paid by insurer for licence and to guarantee market share;
- Fixed, imposed community-priced premiums;
- A 3-15 month period of insurer being bound but not incurred, due to timing restrictions to exit the market.

Claims scope is regulated and includes sharing (inwards and outwards).

Nominal Defendant claims cost based on market share but no underlying insurance contract. The relationship with the Nominal Defendant is an in-substance contract separate from contracts with vehicle owners.

Will move to regulated, community-priced premiums, repriced at least annually prior to AAB17 implementation.

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Contract Boundary Based on Underlying Contracts?

The 3-year transitionary period expires on 30 June 2019.

Assuming the regulator moves to a regulated model consistent with other privatised markets (i.e. regulated but not fixed premiums, subject to at least annual repricing by insurers, greater flexibility to exit the market), after this date all the SA market features reflect rights and obligations that arise during the 12-month policy period.

From a conceptual standpoint, during such a transitionary period:

- It is in the interests of the state government for the newly licenced insurers to be profitable (within reason);
- Inflationary rate increases of 3% are locked in by the regulator; and
- A community pricing approach requires a portfolio level view of risks (and profitability) rather than individual risk classes.

However, in terms of the AASB 17.34 criteria:

- The insurer does not have the practical ability to reprice risks of the policyholder or change the level of benefits so the price fully reflects the risks; nor
- The insurer does not have the practical ability to reprice the contract or portfolio of contracts so that the price fully reflects the reassessed risk of that portfolio.

Hence, in such circumstances, the end of the contract boundary must be the end of the transitionary period.

Additionally, the privatisation fee is unable to be attributed to specific contracts and should be accounted for as an intangible asset.