EXPOSURE DRAFT: A WHITE PAPER

Challenges and Issues Implementing the FASB Short-Duration Contract Disclosures

February 2016

Developed by
the Short-Duration Contracts Work Group
of the Financial Reporting Committee
of the Risk Management and Financial Reporting Council
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This white paper was prepared by the Short-Duration Contracts Work Group of the Financial Reporting Committee within the Risk Management and Financial Reporting Council of the American Academy of Actuaries. This white paper provides an overview with some of the challenges and issues associated with implementing the Financial Accounting Standards Board's (FASB) Accounting Standards Update (ASU) 2015-09, *Financial Services—Insurance (Topic 944) Disclosures about Short-Duration Contracts*.

This white paper is intended for use as a reference tool only and is not a substitute for any legal or accounting analysis or interpretation of the regulations or statutes. This white paper is not a promulgation of the Actuarial Standards Board (ASB), is not an actuarial standard of practice, is not binding upon any actuary, and is not a definitive statement as to what constitutes appropriate practice or generally accepted practice in the area under discussion. In addition it is not a practice note. Events occurring subsequent to this publication of the white paper, including future regulatory or legislative activity, may make the challenges or issues described in this overview irrelevant or obsolete.

We welcome comments and questions. Please send comments to Nikhail Nigam, the Academy's policy analyst for risk management and financial reporting, at nigam@actuary.org.

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I. Introduction

The accounting for short-duration contracts under U.S. Generally Accepted Accounting Principles (U.S. GAAP) has remained relatively unchanged since Financial Accounting Standard (FAS) 60, *Accounting and Reporting by Insurance Enterprises*, was initially published in 1982 and effective for year-ends beginning after Dec. 15, 1982. From 2007 through 2013 the Financial Accounting Standards Board (FASB) explored, through a joint project with the International Accounting Standards Board (IASB), changing the accounting for insurance contracts, including short-duration contracts, to provide users of financial statements with more decision useful information. The two boards were unable to reach agreement on a consistent accounting model or models for insurance contacts. However, the FASB published an exposure draft in June 2013 that would have required, among other things, short-duration contracts to be recorded at a value adjusted for the time value of money.

Most respondents to the FASB proposals in the exposure draft were supportive of keeping the model that has been in place since FAS 60, indicating this longstanding approach to measuring short-duration contract liabilities was reasonable. Analysts, in particular, indicated they would not find the proposal an improvement over current U.S. GAAP. However, financial statement users indicated they would benefit from additional disclosures to increase transparency around the estimates of unpaid claim liabilities. Based on this feedback, the FASB decided not to change the measurement approach for short-duration contracts but instead make changes to disclosure requirements.

The FASB did not issue an exposure draft for its proposals for additional disclosures for short-duration contacts. Instead, after a limited fatal flaw review, the FASB issued ASU 2015-09. This ASU is effective for public companies for annual reporting periods starting after Dec. 15, 2015, and for other companies after Dec. 15, 2016.

The key disclosures required under the ASU are:

- Quarterly reserve roll-forwards;
- Annual paid loss and allocated loss adjustment expense (ALAE), and ultimate incurred loss and ALAE development triangles by accident year, for up to 10 accident years, net of reinsurance and reconciled to the carried reserves in the current reporting period;
- Current reported claims frequency by accident year including descriptions of methodologies used to determine the claim frequency;
- Current loss and loss adjustment expense (LAE) incurred but not reported (IBNR) by accident year, net of reinsurance, including descriptions of methodologies used to determine the IBNR estimates;
- Explanations of significant changes in methods and assumptions used to calculate reserves and derive reported claim frequency and IBNR; and
- Average annual percentage payout of incurred claims by age of accident year.

The disclosures are required to be disaggregated or aggregated in a manner such that *"useful information is not obscured by either the inclusion of a large amount of insignificant detail or the aggregation of items that have significantly different characteristics."*[1] ASU 2015-09 also requires that no information be presented that aggregates or combines data from different financial reporting segments.

Due to concerns raised by accounting firms related to any future changes in an insurer's auditor and the inability to state reliance on another auditors work, ASU 2015-09 considers the information disclosed for reporting periods prior to the current period to be supplementary information. While this means the information is "unaudited," because it is still required under U.S. GAAP, it will be subject to certain limited procedures by the external auditor as described in the Public Company Accounting Oversight Board's (PCAOB) auditing standard AU 558, *Required Supplementary Information*[2].

AU 558 indicates that required supplemental information is regarded by standard-setters as essential to financial reporting. The limited procedures required of the auditor include inquires of management on how the information was prepared, and comparing the supplemental information for consistency with those inquiries of management and other knowledge obtained through the audit. While an adverse finding may not change an auditor's opinion, the auditor is required to add an explanatory paragraph to the audit report if any of the following situations apply:

- The required supplementary information has been omitted by the preparer;
- The information has been prepared or presented in a way that departs materially from the guidelines;
- The auditor was unable to complete the limited procedures; or.
- There are unresolved doubts as to whether the supplementary information conforms with the required guidelines.

This white paper was drafted prior to the effective date of the ASU. As such, we have yet to observe the application of the ASU in practice. This white paper is intended to outline the new disclosures under ASU 2015-09, and highlight areas where decisions will need to be made by the preparers of these disclosures. An actuary may wish to consult with accounting professionals concerning the appropriate information required for the disclosures and any materiality level impacting the level of detail of the disclosure.

For public companies, the Securities and Exchange Commission (SEC) has defined a non-GAAP measure as:

> *"numerical measure of a registrant's historical or future financial performance, financial position or cash flows that:*
>
> - *excludes amounts, or is subject to adjustments that have the effect of excluding amounts, that are included in the most directly comparable measure calculated and*

[1] ASU 2015-09, paragraph 944-40-50-4H
[2] http://pcaobus.org/Standards/Auditing/Pages/AU558.aspx

presented in accordance with GAAP in the statement of income, balance sheet or statement of cash flows (or equivalent statements) of the issuer; or

- *includes amounts, or is subject to adjustments that have the effect of including amounts, that are excluded from the most directly comparable measure so calculated and presented."*[3]

When producing historical information, any adjustments to the information could be interpreted as producing a non-GAAP measure, where upon the most directly comparable unadjusted GAAP equivalent also would be required to be disclosed.

II. Primary Source Materials

This white paper is intended to outline FASB's short-duration contract disclosure requirements and explain some of the challenges and issues in their implementation. Primary source materials referenced in this overview include:

A. Accounting Standards Update (ASU) 2015-09, *Financial Services—Insurance (Topic 944) Disclosures about Short-Duration Contracts*, FASB, May 2015
B. SEC Industry Guides—Guide 6: "Disclosures Concerning Unpaid Claims and Claim Adjustment Expenses of Property Casualty Insurance Underwriters"[4]
C. PCAOB Interim Audit Standard AU 558, *Required Supplementary Information*[5]

This overview discusses considerations and issues the work group believes to be relevant to the preparation of the disclosures. This overview is also intended to encourage discussion on the issues set forth below, providing a framework to foster dialogue among the actuaries and other stakeholders, such as management, auditors, and investors involved in the process.

III. Challenges and Issues with Implementing the Disclosures

A. Quarterly Reserve Roll-Forwards

ASU 2015-09 requires interim period roll-forwards in addition to the annual roll-forward required under preexisting U.S. GAAP.

Under pre-existing U.S. GAAP, a roll-forward of the liability for unpaid claims (including all claim adjustment expenses) is required when reporting on an annual basis (e.g., the year-end financial statements). The current requirement affects both short- and long-duration insurance policies and is presented in a tabular format as follows:

- Beginning unpaid claim liability balance, gross of reinsurance, amounts ceded to reinsurance and then the net of reinsurance amounts;

[3] https://www.sec.gov/rules/final/33-8176.htm
[4] https://www.sec.gov/about/forms/industryguides.pdf
[5] http://pcaobus.org/Standards/Auditing/Pages/AU558.aspx

- Incurred claims in the period, net of reinsurance, with current accident year and changes to prior accident year liabilities shown separately;
- Paid claims in the period, net of reinsurance, also having current year and prior year shown separately; and
- Ending unpaid claim liability, net of reinsurance, amounts ceded to reinsurance and then gross of reinsurance.

Pre-existing U.S. GAAP also requires an explanation for incurred claims affecting prior periods and the impact, if applicable, of retrospective rating provisions (e.g., return premiums on such amounts).

ASU 2015-09 requires that a roll-forward similar to the annual one be included in interim reporting periods (e.g., quarterly financial statements). According to the ASU, the key changes from the annual table are:

- The roll-forward will have a year-to-date presentation, with the beginning balance being the prior year-end unpaid claim liability and the paid and incurred amounts being the year-to-date amounts.
- For health insurance claims only, the new guidance further requires that such roll-forwards be presented in a disaggregated manner; with the guidance for disaggregation the same as that used for the triangle disclosures (see later discussion).

B. Annual Development Triangles

The following discussion is from the Property & Casualty (P&C) perspective. Health issues for this topic will be discussed in Section H.

ASU 2015-09 includes a new loss development triangle disclosure. These required FASB triangles are different from the National Association of Insurance Commissioners (NAIC) triangles in Schedule P and the triangle required by the SEC (in the SEC's industry-specific guidance to P&C companies, known as Guide 6). It is unknown at the time of writing whether the SEC would amend Guide 6 based on the ASU 2015-09.

The following is a list of some of the basic requirements. A summary table of how these basic requirements compare to the current NAIC and SEC requirements is also included.

Basic requirements for the annual development triangles

The following bullets address the basic requirements in terms of when information is required, what is required, and information on LAE, IBNR, lines, and audited data:

- Year-end GAAP financial statements, starting with year-end 2016, for publicly held companies. Privately held companies have an additional year before this is required (i.e., year-end 2017).

- Cumulative incurred and paid accident year triangles, net of reinsurance, for 10 accident years (current and nine prior),[6] similar to Schedule P, Parts 2 and 3. (Incurred here is "ultimate incurred," which includes case plus Bulk & IBNR, as in Schedule P, Part 2.)

  There is no "all prior" line in these triangles. Instead, for all prior accident years, the total outstanding liabilities are shown at the bottom of the incurred and paid triangles. Those "all prior" liabilities, when added to the difference between the latest incurred and paid for the accident years shown, typically would equal the total net outstanding liabilities for the business shown in the triangle. Otherwise, any remaining liabilities would be reported in the required reconciliation exhibit.

- The NAIC triangles include loss plus Defense & Cost Containment expenses; i.e., they do not include Adjusting & Other (A&O) expenses. However, the triangles required under the ASU are for loss and ALAE. Unallocated Loss Adjustment Expenses (ULAE) are not included in the FASB triangles.

- There is no required IBNR triangle (i.e., nothing similar to Schedule P, Part 4). Instead the ASU requires disclosure of the Bulk/IBNR component of the latest incurred valuation by accident year/line.

- There is a requirement to show disaggregated data, but the extent of the disaggregation is left to each individual company to determine. There is no requirement to show the total loss and ALAE for all lines combined and no requirement to include all loss and ALAE data for a disaggregated segment in the same triangle. To the extent that some data is not included in any triangle, it is accounted for in a reconciliation of the outstanding liabilities shown in the triangles to total outstanding liabilities as of the balance sheet date (see Exhibits section).

- The latest diagonal (i.e., latest calendar year) of the triangle is to be audited. This may include the beginning outstanding, paid during the year, and ending outstanding information shown in the triangles. The earlier time periods in the triangle are considered "supplementary information" by the FASB, hence subject to only limited auditor procedures outlined in AU558.

[6] The requirement is "for the number of years for which claims incurred typically remain outstanding, but need not exceed 10 years including the most recent reporting period." Many U.S. companies have 10 years of information for domestic business readily available to fulfill current Schedule P reporting requirements.

Item	NAIC – Sched. P	SEC – Guide 6	FASB – ASU 2015-09
Stated purpose of the disclosure	Part 2 (incurred losses) – overview to test the adequacy of reserves Part 3 (paid losses) – "cash flow projections, discounting calculations, and actuarial projections" (*2014 Ann. Statement Instructions*, p. 280).	Not stated in Guide 6 but generally understood intent *is to understand the reliability of management's estimates.*	"allow users to understand the amount, timing, and uncertainty of cash flows arising from contracts issued by insurance entities." (paragraph 944-40-55-9A)
Ultimate incurred triangles	Yes	Yes	Yes
Paid triangles	Yes	Yes	Yes
IBNR triangles	Yes	No	No—Only the latest IBNR values at the "as of" date are required
Includes LAE?	Only Defense & Cost Containment	Includes all LAE	Only ALAE (not defined)
Discount	Undiscounted	Practice varies	Undiscounted
Valuation dates	10	11	10 (less if shorter tail)
Consolidated?	By legal entity, and combined for U.S. entities only	Consolidated, including non-U.S. business.	Consolidated, including non-U.S. business (see "lines" section for possible exception)
Accident years	10 accident years and an "all prior" line	No accident year split—runoff of reserve as of the prior 10 calendar year-ends.	10 accident years, no "all prior" line ("all prior" reserves are a balancing item)
Lines of business	22 lines, plus total Some of the lines are 2-year lines	Total consolidated only	Disaggregated, as determined by company. Could be by entity in some cases. (See detailed discussion.)
Coverage	All lines fit somewhere, but only applies to U.S.-domiciled insurers	All lines included, all insurance entities (U.S. and others).	Not required for "insignificant categories." Categories not in triangles are a balancing item in the reconciliation.

Audited	Latest diagonal in total (i.e., Part 1 summary, excluding Bulk/IBNR, claim counts, and prior calendar year paids).	Not audited (MD&A)	Current period information (i.e., latest diagonal)
Acquisitions/ Divestitures	Restate history to reflect current status (with regard to acquisitions, divestitures, repooling).	Runoff prior reserves based on original company structure at prior calendar year-ends.	No guidance as to how to reflect acquisitions, divestitures.
Foreign Exchange (FX) effects	FX changes will distort triangles. Can be disclosed in Schedule P interrogatory.	FX changes will distort triangles. Can be discussed in required explanation of "unusual circumstances … which might distort the data" (Guide 6)	Company choice as to how to reflect FX.

Significant implementation considerations

Significant implementation considerations associated with this required disclosure are:

- Level of disaggregation;
- Mergers, acquisitions, divestitures; and
- Foreign exchange (FX)

Level of disaggregation

The ASU provides a principle on how the loss triangles should be disaggregated (i.e., segregated in some manner, rather than single set of triangles for the grand total). In limited circumstances a company may conclude only one triangle is needed (e.g., a mono-line single-state writer). The ASU provides guidance in several areas for such disaggregation, including:

> 944-40-50-4H "An insurance entity shall aggregate or disaggregate the [triangle disclosures] so that useful information is not obscured by either the inclusion of a large amount of insignificant detail or the aggregation of items that have significantly different characteristics. …
>
> An Insurance entity need not provide disclosures about claims development for insignificant categories; however, balances for insignificant categories shall be included in the reconciliation required." [See discussion below about reconciliation exhibits]

The ASU suggests basing the disaggregation on how loss reserves are presented for other purposes, such as earnings releases, annual reports, statutory filings, and investor presentations. It also suggests looking at how business is disaggregated internally by company senior management in evaluating performance.

Examples of possible disaggregation categories include:

- Type of coverage (e.g., major product lines)
- Geography
- "Reportable segment"[7] (only applicable to public entities).
- Market or type of customer
- Claim duration

The ASU also includes a meaningful restriction on such disaggregations—"an insurance entity should not aggregate amounts from different reportable segments."

Discussion

For most public companies, the existing segmentation for U.S. GAAP reporting may not match the Schedule P line of business splits. For example, a company with segments of personal and commercial lines may write property (Schedule P line I—Special Property) in both segments. As a result, the company may not be able to use the Schedule P line of business detail as is for its U.S. GAAP reporting. But it is possible that the portion of a Schedule P line written under one segment is not material to either the total for the segment or the total for the Schedule P line. This may result in that portion of the Schedule P line being labeled "insignificant" and not reported in any triangle, which could lead to inclusion of that business solely as a reconciliation adjustment. (See Reconciliation discussion below.)

One consideration is whether public entities want to use the major product line splits by reporting segment already included in their GAAP financials. An additional consideration in the level of disaggregation may be the level used in prior voluntary disclosures. For example, some international companies already issue global loss development triangles at a certain disaggregated level.

The decision on how to disaggregate and when to label a category as "insignificant" also may be influenced by the mergers/acquisitions/divestitures and the FX issues discussed below.

Mergers/acquisitions/divestitures

The ASU does not provide definitive guidance on how to handle these situations. The only mention of the topic is in the nonbinding Basis for Conclusions section, where it states:

> BC32. "[T]he Board decided that the [loss development triangles and other items] should be communicated in a manner that allows users to understand the amount, timing, and uncertainty of cash flows arising from its contracts in light of relevant circumstances (such as, but not limited to, business combinations and the effect of foreign currency exchange rate changes)."

[7] GAAP reporting rules require that financial reports for public entities disclose more than just grand totals for the consolidated entity; the reporting rules also require a breakdown of key financials by major operating unit, or "reportable segment." How these segments are defined will vary by entity. They could vary by geography (such as North America, Europe, etc.), by market (e.g., commercial, personal, specialty), product line (e.g., auto, homeowners) or various combinations. The reporting segments for a particular entity should already exist.

Current NAIC Schedule P instructions require that the triangle history be restated for this activity, such that the triangle data reflect the current structure of the entity, not the past situation/structure. In contrast, the current SEC triangle (required by Guide 6) requires the runoff of an entity's past reserves as the entity existed at that time the losses were incurred, even if the current runoff of that past reserve is commingled with acquired business such that separating out the acquired from the pre-existing runoff is difficult.

Discussion
One consideration is whether companies are able to choose between the NAIC approach, the SEC approach, some combination of the two, or a totally different approach in producing their triangles that are impacted by mergers/acquisitions/divestitures. The ASU states that the purpose of these triangles is to allow "users to understand the amount, timing and uncertainty of cash flows arising from the liabilities."

The following tables discuss several possible approaches for acquisitions and divestitures, outlining advantages and disadvantages for each approach, starting first with approaches for acquired business.

Acquisitions	
Restate the entire history as if the acquired company had always been part of the group (i.e., the NAIC approach) *Note: This is only an issue in cases in which the disaggregated triangle would include both pre-existing and acquired business disaggregated segment.*	
Advantages	**Disadvantages**
• Relative to several alternatives, all accident years shown are on a consistent basis (i.e., they all show the combined business after the acquisition). In contrast, under the SEC approach the runoff of accident years starting prior to acquisition are not on the same basis as those starting after the acquisition, as the acquired business is only included from the point of acquisition onward. • Where the acquired operations were integrated or commingled into the existing operations (and not run as a separate operation), it may not be possible to split out the runoff into acquired and pre-existing pieces.	• The restated history in the triangle would not match disclosures from before the acquisition, potentially causing confusion to a reader comparing the current disclosures to prior ones, and data reliability concerns. • The necessary historical data for this approach may not exist for the acquired company/business. • May create a non-GAAP measure.

Include the data from the acquired operations only for accident years starting after the date of acquisition (i.e., the SEC approach)	
Advantages	**Disadvantages**
• No need to restate any history shown in previous disclosures. • Only requires data for the acquired business going forward.	• The accident years that started prior to the acquisition would not be directly comparable to those from after the acquisition, and may not be informative relative to the future "amount, timing, and uncertainty of cash flows arising from the liabilities" (i.e., the stated objective of the FASB triangles in the ASU).[8] • If the business is commingled, it may not be possible to reliably report the runoff of accident years prior to the acquisition.[9] • Complicates the required reconciliation exhibits, as they now would include runoff of accident years prior to the year of acquisition. This could cause confusion to the users of the information and lead to other disclosure issues if the reconciliation amounts are material to the overall totals.
Maintain the acquired business in a separate triangle	
Advantages	**Disadvantages**
• No need to restate any history shown in previous disclosures. • May be able to minimize issues with the availability of historical data. (May be able to start only with relatively recent accident years, if prior accident year data is unavailable.)	• Not feasible for acquired business that is commingled with pre-existing business. • If a company makes many acquisitions, could result in a large number of triangles to be displayed and maintained.

[8] ASU 2015-09, paragraph 944-40-50-4H

[9] Reasons for this difficulty could be due to the lack of IBNR estimates established at the pre-existing legacy group level, the inability to split residual market or other pool participations into the prior legacy groupings, and a possible change in claim settlement practices given the current portfolio of exposures. (An example of the latter situation is where a carrier may have had only primary exposure on a disputed claim, but now also has umbrella and excess exposure due to the acquisition. This material change in the exposure may lead to a different settlement strategy.)

Label the acquired business as "insignificant"	
Advantages	**Disadvantages**
• No need to restate any history shown in previous disclosures.	• Only possible for those acquired businesses that are "insignificant" relative to the total claim activity. • May not always be possible for a company that makes many acquisitions, as this approach would eventually lead to the sum of all "insignificant" items being significant. • Not feasible for acquired business that is commingled with pre-existing business.

Divestitures

Note: The following discussion assumes that the divested business was not previously isolated in its own triangle(s).

Restate the entire history as if the divested operations were never part of the group (i.e., the NAIC approach)	
Advantages	**Disadvantages**
• Makes old accident years consistent with newer accident years that began after the divestiture.	• Requires removing the divested operations from the history, which may not be possible (e.g., separate IBNR reserves may not have been maintained for the business that has now been divested).

Record a paid loss equal to the reserve at the time of the divestiture for each accident year	
Advantages	**Disadvantages**
• Historical incurred data does not change for the divested business. • Simple and easy to accomplish from an actuarial perspective.	• Creates a paid history that does not reflect actual paid amounts. • May be viewed as counter to the objective of helping users understand the "amount, timing and uncertainty of cash flows arising from the liabilities"[10] (i.e., the stated objective of the triangles) if actual payments are not reflected in the triangles.

[10] ASU 2015-09, paragraph 944-40-50-4H

Effect of Foreign Exchange (FX) rate changes[11]

The only mention in the ASU of how to deal with the effect of FX rate changes in preparing the disclosures is in the same paragraph quoted above under the Mergers/Acquisitions/Divestitures section.

Discussion

As it relates to currencies, there are generally three types of companies—those that transact business in a single currency (in which case the effective of foreign exchange rates is a nonissue); those that transact business in dozens of currencies; and those that may do so in no more than a handful of currencies.

To the extent that liabilities for unpaid claims denominated in one currency are supported by assets in that same currency, the only exposure of the company's balance sheet to FX rates may be the net surplus or equity by currency (and not the total liabilities or assets by currency).

The following table highlights several approaches that could be taken in dealing with FX rate changes in the new disclosures, outlining advantages and disadvantages for the approach in question.

Foreign Exchange (FX) Effects	
Each year, convert the entire triangle of non-U.S. dollar activity to U.S. dollars using the latest year-end exchange rates	
Advantages	**Disadvantages**
• Where only a single currency is involved, the paid loss development is an accurate depiction of the underlying loss and ALAE development • Each accident year is consistent with the other accident years, with no development due to FX movements.	• All data for all accident years shown must be retained at the original currency level to allow for conversion using the latest FX rate. • The history of the triangle changes each year by a single scalar for a single currency, but the development factors would change where multiple currencies are involved. • Requires adding reconciliation entries for calendar year paid loss items, as these payments generally would have been converted to U.S. dollars at the average transaction date (i.e., generally midyear), while paid losses in the triangle would be converted to U.S. dollars at year-end FX rates.

[11] Generally, where the financial statements are in U.S. dollars but some transactions are in other currencies, paid transactions are converted to U.S. dollars using the FX rate at the time of the transaction (or average transaction date for bulk totals), and balance sheet values are converted using the FX spot rate at the time of the balance sheet "as of" date.

	• Ignores the uncertainty in the liabilities from FX changes that the business had experienced in the past and may be relevant to the user of the financial statements. • Restating the history in U.S. dollars could create a non-GAAP measure.
Separately report triangles in their original currency, not translated to U.S. dollars; the translation to U.S. dollars would be treated as a reconciliation item	
Advantages	**Disadvantages**
• Simple to disclose these triangles if the data triangles are historically retained in their original currency. • No restatement of history required. • Would eliminate any development from FX changes in the paid development history. At the same time, would indicate where FX exposure exists.	• Requires maintaining the history in the original currency. • May not be feasible if multiple currencies exist for the company, as there would be too many triangles. • May be viewed as overstating the FX exposure if the FX exposure is defined as the net of assets and liabilities in a given currency, not the level of either of these in isolation.
Lock in the FX rates for each accident year at the rates that existed at the end of that accident year (i.e., original FASB proposal)	
Advantages	**Disadvantages**
• The paid development for each accident year is unaffected by FX rate changes. • No restatement of history required.	• To the extent that a triangle includes activity in multiple currencies, the accident years will not be directly comparable to each other because FX movements between currencies, and between the transaction currency and U.S. dollars, may appear as if it were a business mix change. • All paid data for the current calendar year must be maintained in the original currency to allow the conversion at the year-end FX rate (as opposed to the payment date FX rate reflected in the income statement). • The reconciliation exhibit would be complicated, as the calendar year payments and ending reserve shown in the triangle reflect different FX rates than the balance sheet and income statement.

Report the same paid and outstanding values as reported in the income statement and balance sheet (paid values are converted to U.S. dollars based on the payment date FX rate; outstanding values are converted based on the balance sheet FX rate)	
Advantages	**Disadvantages**
• No additional reconciliation required. • No change to the historical data.	• Paid development in the triangle will include the impact of FX rate movements, rather than just underlying loss development patterns, comingling the volatility in historical cash flows from FX changes versus the natural variation in the outcomes due to the underlying insurance process.
Each year for each accident year, record a "Foreign Exchange Paid Loss" adjustment to reflect the impact of FX rate movement on the otherwise reported incurred losses	
Advantages	**Disadvantages**
• The incurred loss development is an accurate depiction of the underlying development for each accident year. • No change to the historical data. • Requires only the disclosure of a straightforward reconciliation adjustment	• Paid development includes development from FX changes. • The "paid" data reported in the history does not fully represent past cash flows due to the impact of these adjustments. • Prior year-end loss reserves must be maintained in the original currency in order to calculate these adjustments. • The relative volumes of each accident year change each period due to FX movements, making any growth measurements from one accident year to another unreliable.

In cases in which the operations in non-U.S. currencies are small enough, it might even be possible to place that activity into the "insignificant" category, avoiding FX issues entirely in the triangle disclosures.[12]

Other Issues

Other issues for this disclosure are the (a) reconciliation exhibits, (b) significance of Notes versus MD&A disclosures, (c) underwriting year, (d) change in definition of reporting segment and the impact on disaggregate disclosures, and (e) timing issues with the triangle requirements.

[12] See the end of paragraph 944-40-50-4H: "An insurance entity need not provide disclosures about claims development for insignificant categories; however, balances for insignificant categories shall be included in the reconciliation required by paragraph 944-40-50-4C."

Reconciliation Exhibits
The ASU requires that the loss reserves in the triangles be reconciled to the recorded balance sheet reserves. This reconciliation reflects the fact that the all prior reserves for the latest as of date related to a given triangle are already reported with that triangle. Reconciliation items could include:

- Insignificant lines
- Discount
- ULAE reserves
- Ceded reinsurance reserves
- FX adjustments
- Lines other than short duration (i.e., in which the insurer also has long-duration reserves or lines otherwise not included in the scope of the ASU)
- Other

Of the above items, only the ceded reinsurance reserves are required to be reported by disaggregated level, using the same segmentation as in the triangles. The total after these reconciliation items should be equal to the reported gross loss and loss expense reserves.

Notes versus MD&A disclosures
Much of the written disclosures being required by the ASU are already required by the SEC in Guide 6. The SEC requirements, however, generally are reported in what is known as the MD&A section, which is not required to be audited. The ASU requirements are part of the notes to the financial statement that are required to be audited.

This requirement for disclosures to be audited necessitates more than just additional time for preparation and documentation—it also adds the involvement of an third party to the preparation of these disclosures (i.e., the external auditor). The external auditor will likely require a certain amount of time to complete the audit work. Despite the additional time needed to prepare and audit, the due dates for SEC filings are not being extended because of this new requirement. As a result, the requirement to audit these disclosures may add time pressure to the GAAP reporting process for publicly traded insurers.

Underwriting year
The required disclosure is by accident year. There is no mention in the ASU of other groupings such as underwriting year or policy year. Companies that only capture their data on these other bases will have to decide how to address the requirement for accident year data. Some companies may treat their smaller groupings without accident year detail as "insignificant"; others may do some approximate conversion of these other bases to accident year, capture accident year detail, or disaggregate the data with non-accident year history so as to prevent distortions from any conversion issues.

Assuming an insurer's losses are subject to the full 10-year history requirement, they are allowed to phase in the requirement by disclosing only five years the first year and adding another year each successive annual report (until the 10-year requirement is met). This allowance may give some entities more time to meet the full requirement.

The need to audit the most recent calendar year of activity also may impact how this issue is handled.

Change in definition of reporting segment and the impact on disaggregate disclosures
Any chosen disaggregation for these triangles needs to avoid combining data from different reporting segments, per the ASU.[13] A problem can arise when a company changes the definition of its reporting segments from those definitions used in the past.[14] The disaggregation chosen for past disclosures may result in combining data from different reporting segments under the new definition of reporting segment. As such, the change in reporting segment definitions may require a restatement of triangle histories to avoid combining data under different reporting segments, and could lead to a change in the lines/disaggregation chosen for disclosure.

Given the potential for having to restate triangle histories or change the level or lines to be disaggregated, one consideration is whether to maintain the triangle history at a more granular level than that used in the disaggregated ASU disclosure. With that approach, a change in reporting segments might only result in changing the remapping of the more granular lines to the more aggregated lines being disclosed. Alternatively, the change in reporting segment definition could necessitate reconstructing past historical triangles, if that past data were even available.

Timing issues
Currently, the NAIC requires Schedule P data to be reported annually by March 1. A similar deadline exists for the largest SEC filers, with the smallest SEC filers given until the following month for the filing of their 10-K reports (that include the SEC loss triangle). Because of the need to disaggregate the data combined with the new audit requirements of those new disclosures, the new ASU will make these unchanged deadlines seem tighter.

Currently, the SEC triangle is not disaggregated, and not audited. If a company writes solely U.S. business that is already reported in Schedule P, there may be fewer timing challenges. Public companies, however, may have the added complication of disaggregating reporting segments. They may not have this capability currently, at least not in the timeframe provided and including an audit requirement. In addition, what limited audit procedures that are performed on Schedule P as part of the statutory audits aren't required to be performed by the March filing date, but must be done by the date of the audit report due on June 1.

The more significant issues relate to those companies with non-U.S. business (i.e., insurance business not included in any Schedule P report). The U.S. statutory reporting requirements are currently viewed as world-leading.[15] Data from other countries may or may not be readily available and audited (or auditable) in the time permitted. One consideration is whether some of

[13] End of paragraph 944-40-55-9C.
[14] Changes in the definition of reporting segment can occur due to mergers/acquisitions/divestitures, changes in the senior management team, changes in business strategy, or other reasons.
[15] The 2010 FSAP report included the statement "NAIC data collection and analysis capabilities are world-leading" (page 14 of the 2010 FSAP report on the U.S. relative to the IAIS Insurance Core Principles, issued May 2010, and available at https://www.treasury.gov/resource-center/international/standards-codes/Documents/FSAP_DAR_Insurance_Final_5%2011%2010.pdf).

these issues may be addressed by including items in the "insignificant" category,[16] which may not be possible for the larger items.

Another consideration are situations in which, due to the need to close the books on a timely basis at year-end, estimates are recorded rather than actuals. For example, this may include recording an estimate of the paid losses between the data cut-off date and the financial reporting date. Given that estimates are rarely 100 percent accurate, decisions will need to be made as to how to handle the difference between these estimates and the actual values that are subsequently known when reporting the history. One approach might be to restate prior values to reflect the actuals in place of the originally reported estimates. Another approach might be to reflect any actual vs. estimate difference in later periods (when the actual values became known).

C. Claim Counts

The FASB's new guidance requires the reporting entity to disclose cumulative claim "frequency"[17] information in its disclosures for statements issued for annual periods. According to ASU 2015-09, such information would be provided in a tabular format for the same accident years and disaggregations as the claim development triangles, but would include only current information and not the entire triangle. There are several key discussion points around the requirement:

- The phrase "cumulative claim frequency information" was not explicitly defined by the FASB, and as such it gives preparers flexibility to consider the level of disclosure that provides the most useful information given the paid and incurred loss triangles disclosed. The FASB recognizes that companies have different approaches to defining claim frequency (e.g., per claim, per claimant, etc.). In practice, multiple definitions of "claim" may exist within the same company. The FASB requires the preparer to describe the methodology used to develop such cumulative claim frequency information.

- The cumulative claim frequency information is not required if it is impracticable for the user to provide such information, with "impracticable" meaning that such information is unable to be provided after reasonable efforts. This would be common in certain assumed reinsurance agreements for which such data may not be tracked or maintained. Accordingly, even if it is difficult to obtain or is not considered meaningful, the guidance does require that such frequency information be disclosed. If it is impracticable to provide such information, ASU 2015-09 requires the reason to be explained in the disclosures.

- This information is meant to include actual reported claim frequency and not include unreported claims. The objective of the requirement is to allow the reader to impute average severity of reported claims.[18] The different bases in the claim counts versus the

[16] See the last sentence of 944-40-50-4H.
[17] The ASU uses the term "claim frequency," although its use in the ASU seems to be synonymous with the term "claim count." In actuarial literature, the term "claim frequency" typically refers to claim counts relative to some measure of exposure, but the ASU makes no mention of an exposure basis in the mention of "claim frequency."
[18] ASU 2015-09, paragraph BC24.

disclosed loss amounts (e.g., when the amounts are net but the counts are only direct), however, makes this objective difficult without further calculations to exclude IBNR from the ultimate incurred amounts in the numerator. Even then, the resulting column of average case incurred values per reported claims may not add value to the user of the financial statements without additional background information and the construction of a triangle of historical average case incurred values.

It is reasonable to expect that users of the financial statements will consider the claim frequency as a measure of exposure. In addition, users may compare such information among insurance sector participants who are writing similar business. The users of financial statements may not realize without additional disclosure by the preparer some of the complications that may arise in preparing such information and the value therein of the claim frequency disclosure. Some of those complications may include:

- *Partially available information.* In certain cases, it may be common for an insurance company to have mostly direct business, with some assumed reinsurance business (e.g., personal auto or workers' compensation) in which there are requirements for carriers to assume from residual markets. In such cases, the claim frequency information may not be available for the assumed portion, but the assumed paid and incurred loss amounts would have been included in the loss development table. As a result, the preparer may disclose that the claim counts do not include residual market business. Alternatively, the preparer may exclude residual market losses from the paid and incurred triangles, treating them as insignificant.

- *Claims below attachment points.* Companies that provide insurance above per claim or aggregate deductibles typically would have records of claims that have not reached the deductible, but may in the future once these develop or aggregate with other claims into the company's layer of coverage. Companies often have different definitions of claim counts with regard to uninsured layers of coverage, and may disclose such information because it could provide helpful information to the user.

- *Direct claim counts on 100 percent ceded business.* Counts for this business may be included in the company's claim count data (such as from some residual market carriers or fronted business), but there would be zero dollars from this business in the reported triangles.

- *Changes in ceded reinsurance terms over time*. Given that incurred and paid losses are presented on a net of ceded reinsurance basis, there exists a potential mismatch between the presentation of losses and claim frequency because there is no common approach for stating claim counts net of reinsurance. One consideration is whether, to the extent there have been changes in reinsurance terms (e.g., attachment points, quota share percentages, etc.), the user of the statements may benefit from having information regarding changing ceded reinsurance terms disclosed.

- *The existence of multiple lines, coverages, and covered perils underlying the triangle of dollar amounts*. Each line/coverage/peril may have its own implicit severity distribution

or characteristics. Even if the exposures among the various lines/coverages/perils are consistent over time, random variation will result in the mix of claim counts by line/coverage/peril varying from one period to the next.

- *Changes in mix of business, policy terms, and similar changes to the portfolio over time*. Similar to the ceded reinsurance example above, companies often have changes to their portfolio of business that affect the comparison of losses to cumulative claim frequency. Again, a consideration is whether, to the extent such changes impact the comparison of losses to claim frequency, it may be helpful for the preparer to disclose such changes.

With regard to each of the above, it may be difficult to prepare disclosures that allow for the cumulative claim frequency information to be used in a decision useful manner. This is particularly the case based on the number of coverages included in the disaggregations, the more changes there have been over time, and the different definitions of claim count a company may have for its various operations. In general, the greater the complexity of the company, the more difficult the company may find it to prepare decision useful disclosures on claim frequency at the required level of disaggregation. One consideration is whether it is useful for the preparer to explain the limitations of this information in its disclosures.

D. IBNR and IBNR Methodology

Currently, there is no explicit requirement for the separate reporting of Bulk/IBNR (including "IBNER") under U.S. GAAP (although the SEC has required disclosure of IBNR for some companies via private comment letters).

The absence of U.S. GAAP guidance regarding IBNR disclosure will change when this new ASU becomes effective. The new guidance requires that for annual reporting, "the total of incurred but not reported liabilities plus expected development on reported claims included in the liability for unpaid claims and claim adjustment expenses" be reported separately for each accident year. Such information would be provided in a tabular format for the same accident years and disaggregations as the claim development triangles. Only the value as of the latest year-end would be reported, however, and not the entire triangle of Bulk/IBNR values. (Bulk/IBNR disclosure also would not be required for lines/categories deemed "insignificant.") Essentially, this is pure IBNR plus IBNER (incurred but not enough reported, or Bulk) for each accident year for losses plus ALAE combined. Neither the separate presentation of IBNR, IBNER, ALAE, nor loss is explicitly required.

An accompanying description of the (reserving) methodologies employed to derive the Bulk/IBNR estimates is required. For P&C business, it is common practice to estimate an ultimate incurred loss and LAE, then subtract case basis incurred to obtain Bulk/IBNR reserves. It is unclear whether describing this practice will be sufficient to address the new FASB requirement, or whether additional disclosure would be needed of how the ultimate incurred was

estimated. The new guidance requires changes in the methodologies employed to be noted.[19] No specific guidance or requirement is offered regarding the level of detail contemplated.

E. Payment Patterns

The ASU 2015-09 requires that a company disclose, as supplementary information, "the historical average annual percentage payout of incurred claims by age, net of reinsurance." The requirement is for all the development periods shown in the loss development triangles, but it is not clear from the document whether the level of disaggregation required by the FASB is the same as the loss development triangles.

The examples in ASU 2015-09 use an all-year average percent payout being calculated for each development period. An alternative consideration could be to use a volume-weighted approach. The ASU requirement is historical only, so one consideration may be whether forward-looking assumptions would be appropriate in calculating the payout pattern. Excluding certain years entirely from the calculation, even if the actuary would regard them as anomalous, could create a non-GAAP measure.[20] Another consideration is whether it might be useful to give additional weight to recent accident years at each development period rather than older accident years through some weighting mechanism, while still including all years. Such an approach may better reflect future expected experience, but the disclosure itself is for the "historical" percentages. One consideration for the preparer when electing his or her approach is whether the objective is being met with a weighted mechanism.

The FASB indicated in BC25 that if a company believes this information to be "confusing or misleading to financial statement users," the company is not precluded from providing additional information to allow the user to interpret the information. As such, it is possible that additional qualitative and quantitative disclosures could be used to explain large catastrophes in certain years or changes in claim settlement practices that have sped up or slowed down claims payments.

Regardless, the ASU included an example of how the requirement might be met. Note that payment patterns following this example could result in percentages that add up to less than 100 percent (due to tails beyond 10 years or data anomalies), or payment patterns that add up to more than 100 percent (due to data anomalies).

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[19] Per paragraph 944-40-55-4F.b.

[20] It may be possible to show the historical average for all years excluding those considered anomalous, accompanied with disclosure of the historical average for those considered anomalous (perhaps due to a weather-related catastrophe occurring in those years) as long as all accident years shown in the triangles are included somewhere. This still may require additional efforts, however, to convince an auditor that this is a GAAP measure. Note that the ASU stated objective for this disclosure is "information … that allows users to understand the amount, timing and uncertainty of cash flows arising from the liabilities" aggregating or disaggregating "so that useful information is not obscured by either the inclusion of a large amount of insignificant detail or the aggregation of items that have significantly different characteristics," such as high-cat years being aggregated with low-cat years.

F. Discounting Tables

If an insurance entity presents its liabilities for unpaid claims and claim adjustment expenses at present value in its financial statements, the following information is required to be disclosed on an annual basis.[21]

a) For each period presented in the statement of financial position, the carrying amount of liabilities for unpaid claims and claim adjustment expenses relating to the short-duration contracts that are presented at present value.
b) The range of interest rates used to discount the liabilities disclosed in (a).
c) The aggregate amount of discount related to the time value of money deducted to derive the liabilities disclosed in (a).
d) For each period presented in the statement of income, the amount of interest accretion recognized.
e) The line items(s) in the statement of income in which the interest accretion is classified.

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Amount

The ASU requires the company to disclose the amount of discount, as well as the amount of unpaid claims and claims adjustment expense for the contracts that are discounted. There are no examples provided in the ASU on how this information should be presented. One consideration is whether company could present this information in table or narrative form, as well as what segmentation, if any, should be provided.

Accretion

The following are six potential sources of changes in discount for prior accident years that would affect interest accretion.

- Change in the amount of undiscounted reserve due to paid losses
- Change from prior year development
- Change in the payout pattern used in the discount calculation
- Change in the interest rate or rates used in the calculation
- Acquisitions or dispositions of discounted business
- Changes in foreign exchange rates

All six items may be included in the accretion disclosure, although whether they should be shown separately or combined is not defined in the new guidance. As such, presentation is left to the discretion of the preparer.

Interest Rates

There are various possible ways to disclose the interest rate (item (b) above) in discounting. One consideration is how many rates are used. If only one rate is used, a simple paragraph may be sufficient, while a table may be needed if a range of rates from a yield curve is used, or if different rates are used for different segments.

[21] Paragraph 944-40-50-5.

Another consideration is whether an explanation as to why the specified interest rate or rates were used also may be included to provide the user of the financial statements with an understanding of the reason for selecting these particular rates.

G. Changes in Methods and Assumptions

The ASU includes the following:

> "944-40-50-4I For annual reporting periods, an insurance entity shall disclose information about significant changes in methodologies and assumptions used in calculating the liability for unpaid claims and claim adjustment expenses, including reasons for the change and the effects on the financial statements for the most recent reporting period presented."

The current SEC Guide 6 requires that the following items be discussed for public P&C filers:

> "(3) Significant reserving assumptions and recent changes therein"

The following is from the NAIC instructions for P&C loss reserve opinions. (Note that it relates to changes with regard to reviewing reserves, not setting reserves):

> "If there has been any significant change in the actuarial assumptions and/or methods from those previously employed, that change should be described in a RELEVANT COMMENT paragraph. If the actuary is unable to review the work of a prior Appointed Actuary, then the actuary should disclose this."

Discussion

In general, current U.S. statutory accounting does not address changes in methods for calculating reserves. Instead, statutory accounting standards address calculating a reasonable reserve, concerned only with changes in previously booked estimates and changes in reserve review methodologies. If the method changed but the net result is no change in the indicated ultimate loss amounts, then no statutory disclosures are triggered.

The ASU requirement is similar to, but an expansion of, the current SEC requirement. The expansion is the explicit requirement to disclose the reasons for the change and the effects on the income statement.

In practice, it may be difficult to be definitive in the wording that meets this new FASB disclosure, despite the proposed expansion of the SEC disclosure. This is due to the loss reserve setting process for many P&C lines used by many insurers. One approach insurers might use to set the initial reserve for a P&C line is a loss ratio approach. Under that approach, company management selects a projected future business loss ratio based on past loss experience for recent accident years, developed to ultimate, trended, and divided by on-level earned premium (with possible adjustment for anticipated future underwriting, premium, and similar changes). The resulting selected loss ratio times current period earned premium equals current period incurred losses. Incurred losses plus the beginning reserves less current period paid losses equal ending

reserves. A possible description (consistent with the above) is that the company used multiple methods and scenarios to determine the possible loss ratio, then selected the resulting loss ratio indication that seemed most consistent with the particular facts and circumstances. Described in these generic terms, changes to the method described might turn out to be very rare.

A similar situation also may exist even in cases in which a loss ratio reserving approach is not used. For example, if a company describes its reserve-setting process as the use of multiple methods and scenarios to determine various estimates of ultimate losses, it may then select a single point estimate that is believed to be most consistent with the particular facts and circumstances. This is also a generic description, such that changes to this method might be rare.

Another approach may involve a more mechanical approach to reserve setting. For such situations, one consideration may be the degree of granularity of the disclosure, at least for those insurers with many reserving lines. This is at least partially due to the fact that this requirement in the ASU is not included in the sections that require disaggregation. As such, materiality evaluations for this disclosure may be on total reserves, not disaggregated reserves.

Note that the discussion above does not address changes in methodology or assumptions that led to changes in prior period estimates. That is addressed elsewhere in the ASU, the SEC Guide 6, and the Statutory Annual Statement Note 25 (as of year-end 2014). In particular, previous FASB guidance already required disclosure of the reasons for a change in prior estimates (in paragraph 944-40-50-3d), with the new ASU retaining the prior wording.

H. Special Considerations for Health

As noted earlier, the new ASU applies to all short-duration insurance contracts, including many accident & health insurance contracts and even some life insurance contracts (e.g., group term life). Readers whose primary interest lies in health (or life) contracts are encouraged to read this white paper in its entirety; however, we also wanted to provide a separate section that includes material aimed specifically at a health/life audience rather than a P&C audience.

Applicability

The new disclosure requirements apply only to contracts that are classified under GAAP as short-duration rather than long-duration. However, in some circumstances the distinction between whether the product is classified as short-duration versus long-duration may be unclear. Representative examples include the following:

- With coverages like group long-term disability and group life, some issuers have classified the contract as long-duration while others have classified it as short-duration. The difference in practice largely relates to whether the issuer is seeking to amortize deferred acquisition costs over a period of time longer than one year. The valuation methodologies for actuarial liabilities under existing GAAP for these coverages are likely the same regardless of whether the contract has been classified as long- or short-duration.
- Some issuers have blocks of Medicare Supplement policies in which some policy forms are issue-age-rated and carry reserves for future policy benefits; other policy forms are attained-age-rated and do not carry such reserves. In these situations, the issue-age-rated

contracts have been classified as long-duration, while the attained-age-rated contracts likely have been classified as short-duration. However, from a claim reserving standpoint, the same methodologies and assumptions may be applied to both sets of contracts.

What these examples highlight is that, for many health issuers, the existing annual reserve roll-forward may amalgamate balances from short-duration and long-duration contracts. For example, an issuer who has both attained-age-rated and issue-age-rated Medicare Supplement policies may be including the claim reserves for both sets of contracts in its existing reserve roll-forward.

In that context, the fact that the new expanded disclosures apply just to short-duration contracts may raise concerns about which contracts to scope into those disclosures. One consideration is whether, based on issuers' reserving practices, the inclusion of certain long-duration contracts within the scope of the expanded disclosures would provide greater value to users of their financial statements than if those contracts were scoped out of the disclosures.

Aggregation

ASC 944-40-50-4A creates a new requirement, specific to health insurance claims, that the quarterly reserve roll-forward discussed in Section III.A above be aggregated or disaggregated in such a manner "so that useful information is not obscured by either the inclusion of a large amount of insignificant detail or the aggregation of items that have significantly different characteristics."

ASC 944-40-55-9C implies that, at a minimum, the reporting entity needs to disaggregate the reserve roll-forward at the reportable segment level. So, for example, if a health insurance reporting entity had a commercial segment that included its individual and group medical business and a government segment that included its Medicare and Medicaid business, then at a minimum under the ASU the reporting entity would need to have a commercial roll-forward and a government roll-forward. Disaggregation by reportable segment is a minimum requirement for public companies, though, and not necessarily a safe harbor. So, continuing the example, if the commercial segment also included group long-term disability business, one consideration for the reporting entity would be whether the disability business ought to be presented in a separate roll-forward, to the extent that long-term disability (LTD) claim reserves have "significantly different characteristics" than medical claim reserves.

ASC 944-40-55-9B provides further criteria that the reporting entity ought to consider in selecting the level of aggregation for the reserve roll-forward, including but not limited to the types of disclosures already being made within statutory filings. For health insurers, the reference to statutory filings has two types of implications. First, the business included within a particular reportable segment for any given health insurance reporting entity may be spread among many different statutory entities. Second, for entities filing the NAIC Health Blank, the Underwriting and Investment Exhibit Part 2C provides reserve development information for several different defined lines of business: hospital & medical, Medicare Supplement, dental only, vision only, Federal Employees Health Benefits Program, Medicare, Medicaid, and other health (including LTD, long-term care, and stop loss). In setting the aggregation level for the reserve roll-forward and related disclosures, a consideration for the reporting entity may be

whether the existence of these various statutory disclosures, together with materiality considerations for the consolidated entity.

(See also the discussion below under "Claim Frequency.")

Accident Year Versus Policy Year

As discussed above in Section III.B (*Underwriting Year)*, the claims development table is required to be shown on an accident-year basis. For most health coverages this is a common approach to present the data. However, for stop loss coverage, a policy-year presentation might be a consideration, given how the insurer calculates the reserves. Refer to the discussion in Section III.B about possible considerations a company may make in a situation where accident-year claims development is not currently being monitored.

Claim Frequency

ASC 944-40-50-9D creates a new requirement for reporting entities to disclose "cumulative claim frequency information," as discussed above in Section III.C (*Claim Counts*), as part of the annual reserve development disclosure. For certain contracts, such as group disability or group term life waiver of premium claims, this information may be meaningful and relatively straightforward to calculate. For other health contracts such as medical insurance, for which claim reserves typically are set not on a seriatim basis but by considering homogenous cells of business, this information may be both less meaningful and less straightforward to assemble.

Note that the aggregation criteria discussed above apply not only to the reserve roll-forwards, but also to the reserve development tables, including the presentation of claims frequency information. As such, the "significantly different characteristics" principle behind disaggregation might suggest that differences between types of contracts in claims frequency characteristics may need to be taken into account in determining the appropriate aggregation level.

IBNR Disclosure

The ASU creates a new disclosure regarding the "the total of incurred-but-not-reported liabilities plus expected development on reported claims included in the liability for unpaid claims and claim adjustment expenses," which was discussed from a property/casualty perspective in Section III.D (*IBNR and IBNR Methodology*) above. Note that for health insurance claims, ASC 944-40-50-9E requires this disclosure on a quarterly rather than just annual basis. From a health perspective, the issues involved are different from medical-type coverages versus other coverages, so we discuss each category separately below.

Medical-Type Coverages

Typical claim reserving methodologies for medical insurance and similar coverages (e.g., dental, vision) are oriented around determining the IBNP (incurred-but-not-paid) liability in total. The IBNP liability is often referred to as the IBNR; however, health actuaries may consider the IBNP to have the following three components:[22]

[22] For instance, see page 8 of the report "Comparison of Incurred But Not Reported (IBNR) Methods" published in 2009 by the Society of Actuaries, at http://www.soa.org/files/research/projects/research-ibnr-report-2009.pdf. (The title of the report belies the abuse of language by which the IBNP is referred to as being "IBNR".)

- the IBNR, for claims not yet reported;
- the in-course-of-settlement (ICOS) for claims reported to the insurer but not yet adjudicated;
- the Due & Unpaid (D&U), for claims reported and adjudicated but where payment has not yet been made.

The term IBNER is not commonly used among health actuaries.

Similarly, the concept articulated in the ASU as "expected development on reported claims" is not a familiar one among health actuaries. In practice, health actuaries might include that amount in the IBNR, because it's part of neither the ICOS nor the D&U.

Therefore, it appears that for medical claims and similar coverages, this new disclosure might have the reporting entity disclose the portion of the overall IBNP reserves that is neither ICOS nor D&U. This disclosure requirement may create some challenges to the extent that the reporting entity may not today be explicitly calculating the ICOS or D&U as part of its process for estimating the overall IBNP. There are limited circumstances today (e.g., Exhibit 8 of the NAIC Life/A&H Blank) in which an insurer may need to decompose its total IBNP into D&U vs. ICOS vs. IBNR, but that decomposition is usually unaudited and is often done using approximations and historical studies rather than precise data.[23]

Other Health/Life Coverages

For other types of health and life insurance subject to this disclosure, claim reserves are more frequently calculated on a true seriatim basis, with explicit calculation of a true IBNR component. The concept of "expected development on reported claims" remains unfamiliar in this context, however. (For instance, with death claims under group term life, the magnitude of the ultimate claim payment is not subject to change based on new information.) As such, for these coverages, one consideration is whether this disclosure would incorporate just the explicitly calculated IBNR component of the total claim reserves.

Payment Patterns

The new disclosure (in ASC 944-40-50-9G) regarding the history of claims duration by age, as discussed in Section III.E (*Payment Patterns)* above, specifically excludes "health insurance claims" from its scope. The definition of "health insurance claims" includes the phrase "claims related to the cost of medical treatments." As such, it seems unlikely that either death claims or waiver of premium claims under short-duration group term life policies could qualify for this exclusion. Another consideration is whether claims under group disability policies qualify for this exclusion.

Discounting

The ASU expands on the existing disclosure requirement in ASC 944-40-50-5 regarding claim liabilities for which discounting is applied, such as long-term disability claim reserves or group

[23] Also, in recent years many health insurers have been allowed to migrate from the NAIC Life/A&H Blank to the NAIC Health Blank, and the Health Blank doesn't have the Exhibit 8 requirement to decompose the IBNP into D&U vs. ICOS vs. IBNR.

term life waiver of premium reserves. Please see the discussion in Section III.F (*Discounting Tables*) above.

Changes in Methods and Assumptions
As discussed in section III.G (*Changes in Methods and Assumptions)* above, the ASU creates a new disclosure regarding the reasons for and effect of "significant changes in methodologies and assumptions used in calculating the liability for unpaid claims." Many of the considerations discussed in that section for P&C practice are similar to health practice, at least as it pertains to shorter-tailed lines (e.g., medical insurance).

This new disclosure is more likely to come into practice on the health/life side with respect to coverages for which tabular reserves are held (e.g., long-term disability and group term life waiver of premium). With these coverages, a reporting entity may on occasion perform a study to develop new best-estimate assumptions for recovery rates, mortality rates, interest rates, and other major variables impacting the reserves, and then apply the new best-estimate assumptions across its entire portfolio of reserves. Under the ASU, the reporting entity would need to consider if this type of reserve basis change would be a significant change in methods or assumptions and have to be disclosed.

IV. Conclusion

This white paper has outlined the key requirements of ASU 2015-09. It also has demonstrated several areas in which the updated accounting standards require clarity or result in the need for decisions to be made by preparers on implementation.

The work group that wrote this paper plan will monitor emerging practice and continue to have conversations with other bodies with a vested interest in the implementation of these additional disclosures. This document is not intended to be a practice note; however, the work group hopes that feedback received on and uncertainty addressed by this white paper might eventually result in a formal practice note.

Glossary

Accretion—The growth in a discounted reserve as the discount unwinds over time.

Bulk and IBNR reserve—A term used for incurred but not reported reserves to incorporate all aspects of IBNR, including: 1) reserves for unreported claims, 2) development on reported claims, 3) reported claims that have not yet been fully entered into the claims system and a case reserve set, and 4) reserves for the reopening of closed claims.

Management Discussion & Analysis (MD&A)—A disclosure section of a company's annual report in which management discusses the financial condition and results of operations of the company.

Schedule P—A schedule required to be filed by U.S.-domiciled statutory insurance entities that includes various schedules with loss, ALAE, ULAE, and claim count information in the aggregate and by line of business.

Exhibits

The following Exhibits have been reproduced from the Accounting Standards Update 2015-09: *Financial Services—Insurance (Topic 944): Disclosures about Short-Duration Contracts* with the permission of the Financial Accounting Standards Board (FASB).

Homeowners' Insurance
in thousands

	Incurred Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance										As of December 31, 20Y6	
	For the Years Ended December 31,											
Accident Year	20X7	20X8	20X9	20Y0	20Y1	20Y2	20Y3	20Y4	20Y5	20Y6	Total of Incurred-but-Not-Reported Liabilities Plus Expected Development on Reported Claims	Cumulative Number of Reported Claims
20X7	$10,000	$ 9,900	$ 9,700	$ 9,800	$ 9,750	$ 9,750	$ 9,600	$ 9,650	$ 9,575	$ 9,550	$ 5	39
20X8		10,950	11,000	10,500	10,750	10,850	10,600	10,250	10,150	10,250	30	37
20X9			12,000	11,750	11,500	10,900	10,900	10,850	10,750	10,500	90	38
20Y0				12,250	12,500	12,550	12,400	12,200	12,150	12,000	300	36
20Y1					12,300	12,500	12,650	12,750	12,800	12,850	900	35
20Y2						12,800	12,900	12,750	12,700	12,700	1,100	34
20Y3							13,000	13,250	13,100	13,150	1,500	31
20Y4								13,150	13,250	13,300	2,100	29
20Y5									13,500	13,250	3,100	26
20Y6										13,750	5,000	22
									Total	$ 121,300		

Homeowners' Insurance
in thousands

	Cumulative Paid Claims and Allocated Claim Adjustment Expenses, Net of Reinsurance									
	For the Years Ended December 31,									
Accident Year	20X7	20X8	20X9	20Y0	20Y1	20Y2	20Y3	20Y4	20Y5	20Y6
20X7	$ 3,000	$ 5,000	$ 5,500	$ 6,000	$ 6,800	$ 7,500	$ 8,500	$ 9,000	$ 9,050	$ 9,075
20X8		3,500	5,750	6,500	7,500	7,750	8,250	8,500	9,000	9,500
20X9			3,750	6,000	6,500	7,500	7,900	8,250	8,950	9,700
20Y0				3,750	6,250	7,250	7,750	8,900	9,700	9,950
20Y1					4,250	5,500	6,750	8,000	8,950	9,250
20Y2						4,125	5,250	7,000	8,000	9,000
20Y3							4,500	5,750	7,250	7,750
20Y4								4,600	6,000	6,950
20Y5									4,750	6,125
20Y6										4,850
									Total	$ 82,150
									All outstanding liabilities before 20X7, net of reinsurance	1,400
									Liabilities for claims and claim adjustment expenses, net of reinsurance	$ 40,550

Reconciliation of the Disclosure of Incurred and Paid Claims Development to the Liability for Unpaid Claims and Claim Adjustment Expenses

The reconciliation of the net incurred and paid claims development tables to the liability for claims and claim adjustment expenses in the consolidated statement of financial position is as follows.

[For ease of readability, the calculation is not underlined as new text.]

	December 31, 20Y6
Net outstanding liabilities	
Homeowners' insurance	$ 40,550
Other short-duration insurance lines	1,976
Liabilities for unpaid claims and claim adjustment expenses, net of reinsurance	42,526
Reinsurance recoverable on unpaid claims	
Homeowners' insurance	13,880
Other insurance lines	283
Total reinsurance recoverable on unpaid claims	14,163
Insurance lines other than short-duration	3,315
Unallocated claims adjustment expenses	2,420
Other	10
	5,745
Total gross liability for unpaid claims and claim adjustment expense	$ 62,434

> > Example 2: Information about Historical Claims Duration

944-40-55-9F An illustrative Example of the supplementary information that an insurance entity would disclose to meet the requirements in paragraph 944-40-50- 4G is as follows.

Note X: Liability for Unpaid Claims and Claim Adjustment Expenses

The following is supplementary information about average historical claims duration as of December 31, 20Y6.

[For ease of readability, the illustration is not underlined as new text.]

Average Annual Percentage Payout of Incurred Claims by Age, Net of Reinsurance

Years	1	2	3	4	5	6	7	8	9	10
Homeowners' insurance	33.8%	14.9%	8.5%	7.2%	6.6%	4.9%	5.4%	5.7%	2.7%	0.3%

944-40-55-9G For this illustrative Example, the approach selected by the insurance entity to compute historical claims duration using the information about claims development included in paragraph 944-40-55-9F is as follows. These calculations are for illustrative purposes only and would not be included in the disclosure.

[For ease of readability, the illustration is not underlined as new text.]

	Percentage of Claims Paid in Year 1			Percentage of Claims Paid in Year 2			
Accident Year	Claims Paid in Year 1 (A)	Most Recently Re-estimated Incurred Claims (B)	Percentage of Claims Paid in Year 1 (A) / (B) = (C)	Accident Year	Total Claims Paid End of Year 2 (D)	Claims Paid in Year 2 (D) – (A) = (E)	Percentage of Claims Paid in Year 2 (E) / (B)
20X7	$ 3,000	$ 9,550	31.4%	20X7	$ 5,000	$ 2,000	20.9%
20X8	3,500	10,250	34.1%	20X8	5,750	2,250	22.0%
20X9	3,750	10,500	35.7%	20X9	6,000	2,250	21.4%
20Y0	3,750	12,000	31.3%	20Y0	6,250	2,500	20.8%
20Y1	4,250	12,850	33.1%	20Y1	5,500	1,250	9.7%
20Y2	4,125	12,700	32.5%	20Y2	5,250	1,125	8.9%
20Y3	4,500	13,150	34.2%	20Y3	5,750	1,250	9.5%
20Y4	4,600	13,300	34.6%	20Y4	6,000	1,400	10.5%
20Y5	4,750	13,250	35.8%	20Y5	6,125	1,375	10.4%
20Y6	4,850	13,750	35.3%				
		Average	33.8%			Average	14.9%

	Percentage of Claims Paid in Year 3			Percentage of Claims Paid in Year 4			
Accident Year	Total Claims Paid End of Year 3 (F)	Claims Paid in Year 3 (F) – (D) = (G)	Percentage of Claims Paid in Year 3 (G) / (B)	Accident Year	Total Claims Paid End of Year 4 (H)	Claims Paid in Year 4 (H) – (F) = (I)	Percentage of Claims Paid in Year 4 (I) / (B)
20X7	$ 5,500	$ 500	5.2%	20X7	$ 6,000	$ 500	5.2%
20X8	6,500	750	7.3%	20X8	7,500	1,000	9.8%
20X9	6,500	500	4.8%	20X9	7,500	1,000	9.5%
20Y0	7,250	1,000	8.3%	20Y0	7,750	500	4.2%
20Y1	6,750	1,250	9.7%	20Y1	8,000	1,250	9.7%
20Y2	7,000	1,750	13.8%	20Y2	8,000	1,000	7.9%
20Y3	7,250	1,500	11.4%	20Y3	7,750	500	3.8%
20Y4	6,950	950	7.1%				
		Average	8.5%			Average	7.2%

Percentage of Claims Paid in Year 5

Accident Year	Total Claims Paid End of Year 5 (J)	Claims Paid in Year 5 (J) – (H) = (K)	Percentage of Claims Paid in Year 5 (K) / (B)
20X7	$ 6,800	$ 800	8.4%
20X8	7,750	250	2.4%
20X9	7,900	400	3.8%
20Y0	8,900	1,150	9.6%
20Y1	8,950	950	7.4%
20Y2	9,000	1,000	7.9%
		Average	6.6%

Percentage of Claims Paid in Year 6

Accident Year	Total Claims Paid End of Year 6 (L)	Claims Paid in Year 6 (L) – (J) = (M)	Percentage of Claims Paid in Year 6 (M) / (B)
20X7	$ 7,500	$ 700	7.3%
20X8	8,250	500	4.9%
20X9	8,250	350	3.3%
20Y0	9,700	800	6.7%
20Y1	9,250	300	2.3%
		Average	4.9%

Percentage of Claims Paid in Year 7

Accident Year	Total Claims Paid End of Year 7 (N)	Claims Paid in Year 7 (N) – (L) = (O)	Percentage of Claims Paid in Year 7 (O) / (B)
20X7	$ 8,500	$ 1,000	10.5%
20X8	8,500	250	2.4%
20X9	8,950	700	6.7%
20Y0	9,950	250	2.1%
		Average	5.4%

Percentage of Claims Paid in Year 8

Accident Year	Total Claims Paid End of Year 8 (P)	Claims Paid in Year 8 (P) – (N) = (Q)	Percentage of Claims Paid in Year 8 (Q) / (B)
20X7	$ 9,000	$ 500	5.2%
20X8	9,000	500	4.9%
20X9	9,700	750	7.1%
		Average	5.7%

Percentage of Claims Paid in Year 9

Accident Year	Total Claims Paid End of Year 9 (R)	Claims Paid in Year 9 (R) – (P) = (S)	Percentage of Claims Paid in Year 9 (S) / (B)
20X7	$ 9,050	$ 50	0.5%
20X8	9,500	500	4.9%
		Average	2.7%

Percentage of Claims Paid in Year 10

Accident Year	Total Claims Paid End of Year 10 (T)	Claims Paid in Year 10 (T) – (R) = (U)	Percentage of Claims Paid in Year 10 (U) / (B)
20X7	$ 9,075	$ 25	0.3%
		Average	0.3%