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Technical Line

FASB — final guidance

Insurers will have to make additional disclosures about short-duration contracts

In this issue:

Overview 1
Disclosure requirements 2
Disaggregation of certain disclosures 2
Incurred and paid claims development and related disclosures 4
Incurred but not reported claims and claims frequency 10
Claims duration 12
Significant changes in methodologies and assumptions 12
Information about amounts reported at present value 14
Claims and claim adjustment expenses rollforward 14
Supplementary information and audit considerations .. 15
Effective date 16
Appendix: Summary of new disclosures 17

What you need to know

- The FASB has issued final guidance that requires insurers to make additional disclosures about their liability for unpaid claims and claim adjustment expenses for short-duration contracts.
- Insurers will need to collect more information than they do today to make these disclosures, and they may need to adjust their processes, systems and controls to do so.
- This publication reflects the SEC staff's views on the presentation of acquisitions, disposals and foreign currency exchange translation adjustments in the incurred and paid claims development tables required by the guidance. All insurers, not just SEC registrants, should consider those views.
- The guidance was effective for annual periods beginning after 15 December 2015, and interim periods within annual periods beginning after 15 December 2016, for public business entities and a year later for all other entities.

Overview

The disclosures required by the Financial Accounting Standards Board (FASB or Board) relating to short-duration insurance contract liabilities are designed to help users of insurers' financial statements assess the nature, amount, timing and uncertainty of future cash flows related to these liabilities and the effect of those cash flows.

The disclosures are also meant to provide more insight into how an insurer estimates claim costs and improve the comparability of insurers' financial statements by requiring consistent disclosures.

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The FASB issued the guidance in Accounting Standards Update (ASU) 2015-09[1] after deciding to end its joint insurance project with the International Accounting Standards Board and instead make targeted improvements to US GAAP. The Board subsequently issued ASU 2018-12[2] to address the recognition, measurement and disclosures for long-duration insurance contracts. Refer to our Technical Line, ***A closer look at how insurers will have to change their accounting and disclosures for long-duration contracts***, for more information.

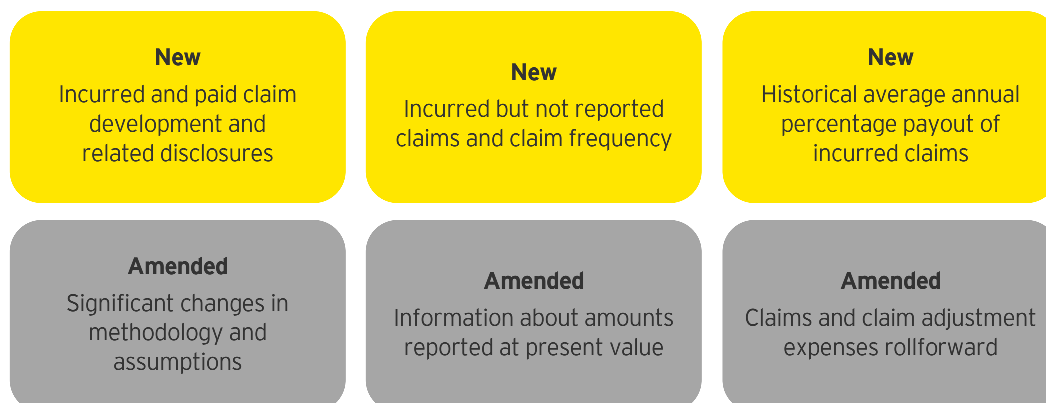
This publication updates the Technical Line we issued in 2015 to reflect the Securities and Exchange Commission (SEC) staff's responses to questions about the presentation of acquisitions, disposals and foreign currency exchange translation adjustments in the incurred and paid claims development tables required by the guidance. It also discusses implementation considerations and provides examples of the disclosure requirements.

Disclosure requirements

The guidance does not change how insurers classify their contracts as short duration[3] or long duration but does require new disclosures about short-duration insurance contracts.

Property and liability insurance contracts and certain health insurance contracts are typically considered short duration. Some contracts written by life insurers, such as one-year term life, group long-term disability and group long-term care contracts, are also considered short duration and are subject to the new disclosure requirements.

The final guidance amends the disclosure requirements and adds new ones (collectively, new disclosures) related to short-duration contracts as follows:



Some of the disclosures are considered supplementary information, which may be presented within the footnotes to the financial statements or in separate schedules outside of the financial statements.

Disaggregation of certain disclosures

In the Background Information and Basis for Conclusions in the ASU, the Board observed that useful disaggregation of information depends on the characteristics of the contracts that an insurer writes and on various entity-specific factors. The liability for unpaid claims and claim adjustment expenses (CAE) is an aggregated amount arising from many insurance policies with different characteristics that affect the amount and timing of cash flows. The Board noted that it is important for users of the financial statements to understand the effects of those differences on the liability for unpaid claims and CAE.

The guidance requires insurers to disaggregate certain disclosures that are identified in the appendix to this publication. Because insurance contracts have different characteristics, the guidance does not prescribe how the disclosures should be disaggregated, but rather, specifies a principle for providing disaggregated information. As a result, insurers will need to consider aggregating or disaggregating information so that useful information is not obscured by either the inclusion of a large amount of insignificant detail or the aggregation of items with significantly different characteristics. While the standard does not specify how the information should be disaggregated, the implementation guidance provides the following examples of categories an insurer might use:

- Type of coverage (e.g., major product line)
- Geography (e.g., country or region)
- Reportable segment as defined in Accounting Standards Codification (ASC) 280, *Segment Reporting*
- Market or type of customer (e.g., personal or commercial lines of business)
- Claims duration (e.g., claims that have short settlement periods or claims that have long settlement periods)

The Board acknowledged that an insurer may need to use more than one type of category (e.g., type of coverage and geography) to disaggregate its insurance liabilities. The implementation guidance indicates that the most appropriate disaggregation for a particular entity depends on its facts and circumstances. However, an insurer should consider how information about its liability for unpaid claims and CAE has been disaggregated for other purposes when determining which categories are the most relevant and useful. Some examples include the following:

- Disclosures presented outside the financial statements (e.g., statutory filings, investor presentations, earnings releases, annual reports)
- Information reviewed regularly by the chief operating decision maker
- Other information used by the insurer or users of its financial statements to evaluate its financial performance

The implementation guidance clarified that the aggregation of the disclosures on liabilities for unpaid claims and CAE should at a minimum be consistent with segment-related disclosures. That is, if an insurer provides segment-related disclosures in its audited financial statements under ASC 280, *Segment Reporting*, the disaggregated categories should not include amounts of the liabilities for unpaid claims and CAE from different reportable segments.

For example, if an insurer determines that the most relevant and useful categories for presenting its unpaid claims and CAE disclosures are based on geography but presents its segment-related disclosures based on type of coverage, the insurer would disaggregate its disclosures by geography within the types of coverage.

Insignificant categories

The guidance does not require an insurer to provide disclosures about the liabilities for unpaid claims and CAE for insignificant categories. Such insignificant categories (if any) would be included in the reconciliation disclosure.

The guidance does not prescribe how to determine insignificant categories. When making this determination, insurers may consider both quantitative and qualitative factors. For the quantitative metric, for example, they may consider analogizing to ASC 280, which requires an entity to report a segment separately if its revenues, profit/loss or assets are 10% or more of

the combined revenues, profit/loss or assets. In addition, ASC 280 requires that at least 75% of total consolidated revenues be included in separately reported segments. A segment that does not meet the quantitative thresholds may be presented as a separate segment if the information can be useful to users of the financial statements.

When analogizing to ASC 280, an insurer may consider whether any disaggregated category that is 10% or more of its liability for unpaid claims and CAE should be disclosed separately, and whether at least 75% of its liability for unpaid claims and CAE is included in the separate disclosures.

When assessing qualitative factors, insurers may consider whether the liabilities with more significant variability are significant (i.e., not an insignificant category). In doing so, insurers should consider the absolute value of changes in the incurred amounts to the prior-year claims recorded in the income statement. For example, $1 million of favorable development and $2 million of unfavorable development would be considered $3 million of development.

If an insurer's ASC 280 segment disclosures change, it will have to assess the effect on the new disclosures for short-duration contracts and potentially make changes to them. Similarly, insurers will need to continually assess their business to determine whether they will need to change the disaggregation of unpaid claims and CAE in future periods.

Insurers could consider both qualitative and quantitative factors when assessing whether categories are insignificant.

How we see it

- Management will need to determine the appropriate level of disaggregation of the liabilities for unpaid claims and CAE, but an entity cannot include amounts from different reportable segments in the same category. When making this determination, management should consider the various disclosures and whether the level at which the information is being disclosed is meaningful based on the characteristics of the liability.
- Management will need to determine which groupings within the categories of liabilities are insignificant and should consider whether that would change from one year to the next.
- Insurers will need to consider whether their current systems and processes can accumulate and track the data in each disaggregated category for each disclosure requirement and whether that can occur timely.

Incurred and paid claims development and related disclosures

Claims development tables

For the annual reporting period, insurers must present in separate tables incurred and paid claims by accident year (i.e., the year in which a covered event, as defined by the contract, occurs) for the most recent reporting period for each of the disaggregated categories. These are referred to as the claims development tables. In the Basis for Conclusions, the Board noted that users of financial statements have said that disclosures of incurred and paid claims development tables would increase transparency relating to the liability for unpaid claims and CAE by facilitating analysis of initial liability estimates and subsequent adjustments to those estimates.

The claims development tables should be presented net of risk mitigation through reinsurance and should include allocated CAE. These tables require insurers to present data back to the earliest period when uncertainty arose, but the data presented need not exceed 10 years.

This could result in insurers presenting data for three years or less in the claims development tables for certain health claims, where the uncertainty is resolved relatively quickly. For certain claims, such as those from certain product liability coverage, the period of uncertainty prior to claim resolution could be 15 years or longer. In these situations, insurers may elect to disclose 15 years (or more) of data to increase transparency even though the disclosure need not exceed 10 years of data.

The total net outstanding claims and CAE for accident years that are not separately presented in the claims development tables should be added to the most recent reporting period presented, so that users of the financial statements can determine the liabilities for unpaid claims and CAE, net of reinsurance, for each disaggregated category. That is, the total incurred claims from the incurred claims table, minus the total paid claims from the cumulative paid claims table, plus the outstanding liabilities (which include case reserves and incurred but not reported (IBNR) liabilities) for periods not reported in the tables will represent the total liabilities for unpaid claims and CAE, net of reinsurance.

There may be certain lines of business where the liability for unpaid claims and CAE is significant to the overall liability for unpaid claims and CAE and/or where there may be significant variability in the liability for unpaid claims and CAE, but the liability relates to accident years prior to the last 10 years. For example, many asbestos and environmental (A&E) claims relate to years before the 1990s, so including the last 10 or even 20 years of claims development tables would not provide meaningful information to the users of the financial statements because the majority of the liability would be for accident years not separately presented. In these situations, insurers may consider excluding the A&E claim liability from the claims development table disclosures but including them separately in the reconciliation disclosure (see the *Reconciliation* section below) and in the other disclosures required by the ASU if doing so would not duplicate other required information.

Illustration 1 — Claims development tables

Insurer A has multiple lines of business; however, one of them (workers' compensation) accounts for the vast majority of its overall business. Therefore, Insurer A presents the incurred and paid claims and allocated CAE development, net of reinsurance, only for workers' compensation:

In thousands

Accident year	Incurred claims and allocated claim adjustment expenses, net of reinsurance For the years ended December 31,									
	20X5	20X6	20X7	20X8	20X9	20Y0	20Y1	20Y2	20Y3	20Y4
20X5	$ 25,292	$ 24,107	$ 22,971	$ 22,421	$ 22,223	$ 22,143	$ 25,208	$ 25,064	$ 25,016	$ 25,109
20X6		27,693	26,312	25,743	25,335	25,177	27,534	27,369	27,328	27,437
20X7			27,288	26,801	26,536	26,545	28,713	28,590	28,498	28,551
20X8				26,265	26,620	26,962	28,982	28,941	28,953	29,030
20X9					24,367	24,592	26,172	26,319	26,202	26,331
20Y0						24,099	26,512	26,757	26,699	26,871
20Y1							27,072	27,346	27,515	27,729
20Y2								28,126	27,552	27,618
20Y3									28,248	27,982
20Y4										29,073
									Total	**$ 275,732**

In thousands

Accident year	Cumulative paid claims and allocated claim adjustment expenses, net of reinsurance For the years ended December 31,									
	20X5	20X6	20X7	20X8	20X9	20Y0	20Y1	20Y2	20Y3	20Y4
20X5	$ 4,689	$ 9,773	$ 12,720	$ 14,593	$ 15,741	$ 16,623	$ 19,397	$ 19,905	$ 20,459	$ 20,969
20X6		5,025	10,661	14,185	16,122	17,473	20,173	20,886	21,687	22,294
20X7			5,183	11,378	14,802	16,982	19,971	21,080	22,054	22,870
20X8				5,364	11,555	15,215	18,699	20,334	21,573	22,596
20X9					4,902	10,634	14,749	16,934	18,524	19,791
20Y0						5,093	11,571	15,259	17,553	19,290
20Y1							5,525	11,831	15,568	18,054
20Y2								5,332	11,563	15,212
20Y3									5,173	11,447
20Y4										5,242
									Total	**$ 177,764**
									All outstanding liabilities for unpaid claims and CAE prior to 20X5, net of reinsurance	42,894
									Total outstanding liabilities for unpaid claims and CAE, net of reinsurance	**$ 140,862**

If the table above is included as a schedule separate from the financial statements, the insurer will include the current-year information in the notes to the financial statements:

Accident Year	Claims and allocated claim adjustment expenses, net of reinsurance For the year ended December 31, 20Y5		
		Incurred	Cumulative paid
20X5		$ 25,109	$ 20,969
20X6		27,437	22,294
20X7		28,551	22,870
20X8		29,030	22,596
20X9		26,331	19,791
20Y0		26,871	19,290
20Y1		27,729	18,054
20Y2		27,618	15,212
20Y3		27,982	11,447
20Y4		29,073	5,242
	Total	$ 275,732	$ 177,764
All outstanding liabilities for unpaid claims and CAE prior to 20X5, net of reinsurance			42,894
Total outstanding liabilities **for unpaid claims and CAE**, net of reinsurance			$ 140,862

Some of the information insurers will have to disclose under the new guidance is similar to information they already provide.

Comparison of new requirements with existing regulatory requirements

The information insurers must disclose in the claims development tables under the guidance is similar to the information they already provide in US regulatory filings.

In their annual statement filings with state insurance departments in the US, insurers provide incurred and paid claims development tables in Schedule P, *Analysis of Losses and Loss Expenses* (Schedule P). However, there are several differences between the information required in the new disclosures and what insurers provide in Schedule P, including the following:

- The new disclosures are based on the consolidated financial statements that may include multiple legal entities, such as international subsidiaries; insurers provide data in Schedule P only for the US legal entity or entities included in the Annual Statement.
- The ASU requires information to be presented in disaggregated categories based on what is considered important to the readers of the financial statements; the information insurers provide in Schedule P must be disaggregated into approximately 20 predetermined lines of business.

The SEC Securities Act Industry Guide No. 6, *Disclosures concerning unpaid claims and claim adjustment expenses of property-casualty insurance underwriters* (Guide 6), requires reserve development disclosures in management's discussion and analysis disclosures. Differences between the requirements in the ASU and those in Guide 6 include the following:

- The ASU requires insurers to disclose information on an accident-year basis; under Guide 6, they present the information on a "runoff" of balance sheet reserves (rather than accident or policy-year basis).
- Insurers must present information in disaggregated categories under the ASU; they present it on a consolidated basis under Guide 6.
- The ASU requires insurers to disclose information on all short-duration contracts, including certain health insurance contracts and certain contracts issued by life insurers; under Guide 6, they disclose information on property casualty insurance liabilities.

- The required disclosures under the ASU include consolidated subsidiaries; Guide 6 disclosures may include consolidated subsidiaries, unconsolidated subsidiaries and 50% or less owned equity-basis investees, if certain materiality thresholds are reached.

Many life insurers with small amounts of short-duration contracts have not previously provided the Guide 6 claims development tables due to the materiality thresholds in the SEC guidance, which do not apply to the audited financial statements.

While insurers already may be accumulating and reporting the types of information required under the ASU in Schedule P or Guide 6, they will need to consider the differences in the requirements to modify their processes or systems to develop the new disclosures.

The SEC's Division of Corporate Finance recently updated its Financial Reporting Manual (Question 11310.1) to state that a registrant that includes the new disclosures required by ASU 2015-09 in its financial statements does not have to separately provide the 10-year claims development table required by Guide 6 but may choose to do so.

Discounting

The guidance doesn't address the presentation of the discounting adjustment that is necessary to reconcile the tables back to the liability for unpaid claims and CAE on the balance sheet, because the claims development tables are presented on an undiscounted basis. When considering the most useful presentation, insurers with discounted liabilities (such as those relating to workers' compensation) may consider showing an adjustment at the bottom of the claims development tables to account for the effect of discounting or include an adjustment in the reconciliation.

All entities should consider the SEC staff's views, because the staff said its responses are consistent with the objectives of the guidance.

Treatment of acquisitions, disposals and foreign currency translation

ASU 2015-09 does not prescribe how insurers should disclose claim development information related to acquisitions, disposals or foreign currency translation adjustments. However, the Basis for Conclusions says insurers should consider the information that is most useful to the users of the financial statements. The Board also said the information should be communicated in a manner that allows users to understand the amount, timing and uncertainty of cash flows arising from the insurer's contracts in light of relevant circumstances.

Due to the lack of guidance on these items, the American Institute of Certified Public Accountants (AICPA) Insurance Expert Panel (IEP) discussed alternative presentations for each item with the SEC staff.

The SEC staff's responses should be considered by all insurers, not just registrants, because the staff said its views are based on the following disclosure objectives and requirements in the standard:[4]

- The claims development information should reflect the liabilities that exist as of the most recent balance sheet date and not those that existed at earlier dates.
- Information should be disaggregated and presented in a manner that allows users to understand the amount, timing and uncertainty of cash flows and does not distort trends or obscure useful information.
- Incurred and paid claims activity should be presented separately in the claims development tables.
- Information should be presented by accident year, meaning the year in which a covered event occurs.

The SEC staff said registrants that believe their facts and circumstances support the use of a presentation that differs from those described below should discuss their views with the SEC staff.

Acquisitions

The SEC staff said that retrospectively presenting an acquired insurer's historical incurred and paid accident-year claim information in the claims development table would best achieve the objectives of the ASU. Using a retrospective approach would present all relevant historical information related to the liability for all periods presented at the current balance sheet date. In accordance with the disaggregation principle, the SEC staff said an insurer could present the information for an acquired business either in separate tables or combined with the claims development information of the insurer's existing business.

The SEC staff said that separately presenting the acquired insurer's historical information by accident year as of the acquisition date (i.e., using a prospective approach) could meet the disclosure objectives. However, the SEC staff said that combining the acquired insurer's incurred and paid claim information with the insurer's incurred and paid claim information on existing business as of the acquisition date (i.e., prospectively) would not meet the objectives of the ASU. The SEC staff also noted that depicting the year of acquisition as the accident year for the acquired liabilities would not be consistent with the definition of accident year in the ASU.

Disposals

The SEC staff said that retrospectively excluding incurred and paid claims information for a disposed business from the claims development table for all periods presented would best achieve the objectives of the ASU. Not adjusting historical claim information (i.e., not removing the disposed business for all periods presented) and instead presenting a reduction in the incurred table or increasing the amount in the claims paid table in the period of disposal would be inconsistent with the objectives of ASU 2015-09.

Foreign currency translation

The SEC staff said that recasting all periods presented in the claims development tables to reflect the foreign exchange rate at the current-year balance sheet date would be consistent with the objectives of the guidance. This presentation would use the same exchange rate for all periods presented, meaning the trends in development would not be affected by changes in foreign currency translation amounts. In addition, there would be no need for an adjustment to reconcile to the amounts reported in the current balance sheet.

Not using the same exchange rate for all accident years could distort trends and would be inconsistent with the objectives of the ASU, the SEC staff said.

The SEC staff also said that presenting separate claims development tables for each functional currency (i.e., not translating the tables into the reporting currency) would meet the objectives of the ASU. If this approach is used, the insurer would need to disclose the effect of the foreign currency translation adjustment (i.e., reconcile the total outstanding liability in the functional currency to the total outstanding liability in the reporting currency, for each disaggregated category).

Treatment of reinsurance

The information in the claims development table can significantly change if an insurer assumes or cedes a significant block of business. The ASU indicates the claims development tables should include reinsurance assumed and should exclude reinsurance ceded. However, the ASU does not prescribe how an insurer would incorporate information relating to agreements to assume or cede insurance in its claims development tables. Complexities arise when insurers assume or cede insurance on a retrospective basis or commute reinsurance agreements. Insurers will need to apply judgment to determine whether presenting these agreements prospectively or retrospectively would provide the most useful information to the financial statement users.

Reconciliation

The guidance requires insurers to reconcile the claims development tables to the aggregate carrying amount of the liability for claims and CAE for the most recent reporting period presented in the statement of financial position. The reconciliation should include unpaid claims and CAE, net of reinsurance, from each of the disaggregated categories and a sum of the insignificant categories, plus reinsurance recoverables, if any, for each of the disaggregated categories and for the insignificant categories in total.

Insurers currently disclose reinsurance recoverables on a consolidated basis and do not break them down by product, geography or other category. In the Basis for Conclusions, the Board noted that disaggregating the reinsurance recoverables in the same manner as the claims development tables will make an insurer's reinsurance strategies and changes in those strategies more transparent.

Some reinsurance contracts provide coverage on an aggregate basis for multiple products that may be included in different disaggregated categories in these new disclosures. In these situations, the characteristics of the reinsurance arrangement may not be comparable to the underlying characteristics of the direct contracts that are being reinsured. Many times, insurers enter into these types of reinsurance contracts to mitigate the risk at the entity level rather than the product level. Disaggregating the reinsurance recoverables for such arrangements that are determined based on the aggregate of losses from different products could be challenging.

Most insurers also will need to include in the reconciliation unallocated CAE and discounting adjustments, as applicable. Insurers that present separate claims development tables for each functional currency will need to include the foreign currency exchange translation adjustments in the reconciliation.

Illustration 2 — Reconciliation of the claims development information to the consolidated statement of financial position

Insurer A includes the following disclosure, reconciling the workers' compensation claims development tables to the liability for claims and CAE in the consolidated statement of financial position. This disclosure is included in the notes to the financial statements:

	December 31, 20Y4
	(In thousands)
Net outstanding liabilities for unpaid claims and CAE	
Workers' compensation	$ 140,862
Other insurance lines	12,678
Liabilities for unpaid claims and allocated CAE, net of reinsurance	153,540
Reinsurance recoverable on unpaid claims	
Workers' compensation	$ 41,790
Other insurance lines	11,410
Total reinsurance recoverable on unpaid claims	53,200
Unallocated claims adjustment expenses	7,440
Insurance lines other than short duration	704
Impact of discounting	(3,356)
Total gross liability for unpaid claims and CAE	$ 211,528

How we see it

- Many insurers will need to change their processes and systems to develop the disclosures.
- Most of the data needed for the claims and CAE development tables should come from actuarial analyses, which may not always reconcile to management's estimate of the liability for unpaid claims and CAE on the balance sheet. Many insurers will need to consider how best to reflect in the development tables any difference between the recorded reserves and the actuarial analyses.
- Insurers with only a few functional currencies and disaggregated categories may choose to present separate claims development tables for each functional currency, but insurers with multiple functional currencies and/or disaggregated categories may reject this approach because it would require too many disclosures.

Incurred but not reported claims and claims frequency

For each accident year presented in the claims development tables, insurers will be required to disclose in the notes to the financial statements for the most recent reporting period the following information:

- Cumulative claims frequency information
- IBNR liabilities

In the Basis for Conclusions, the Board noted that users of financial statements have said that additional disclosure about claims frequency and severity would increase the transparency of an insurer's estimation practices and claims experience.

Claims frequency can be determined in a number of ways. In auto insurance, an insurer can calculate the number of claims by counting auto accidents or the number of claimants from auto accidents and/or by counting claims for a type of coverage, such as physical damage and bodily injury. While the guidance does not specify how insurers should determine the claims frequency or that the methodology needs to be consistent across the insurer's aggregation categories, it requires insurers to disclose their methodologies for determining the claims frequency.

For certain businesses, such as some types of excess of loss assumed reinsurance or residual market pools, an insurer may not have claims frequency information. The guidance states that an insurer doesn't have to disclose claims frequency information if it is impracticable for the insurer to obtain the information. ASC 250-10-45-9a indicates that applying a requirement is impracticable when "after making every reasonable effort to do so, the entity is unable to apply the requirement." If this is the case, the insurer should disclose that fact and explain why the disclosure is impracticable.

Insurers also need to disclose the IBNR from the cumulative incurred claim amounts by accident year. The guidance clarifies that IBNR should include both expectations about incidents not yet reported and expected development on reported claims, which is consistent with the US statutory description. The guidance requires insurers to disclose their methodologies for determining such amounts and any significant changes to those methodologies.

In its deliberations, the Board focused on severity of reported claims as an important metric. The Board noted in the Basis for Conclusions that the IBNR information can be subtracted from the cumulative incurred claim amounts by accident year to calculate the liability for reported claims. Dividing this balance by the claims frequency will allow users of the financial statements to determine the severity of reported claims. However, users will have to consider the methodology used by insurers to determine claims frequency and how relevant a severity measure is for certain types of insurance products.

There may be instances in which an insurer may have claims frequency information for only a portion of the disaggregated liability. For example, if an insurer is disaggregating by product type, it will often have claims frequency information for its directly written business but not for business assumed on an excess of loss basis. In this situation, the insurer may consider disclosing the amount of the incurred liability for reported claims (after deducting the IBNR) for the business for which claims frequency is available with the claims frequency information to allow users to calculate the severity on that portion of the business.

There may be other instances when an insurer uses multiple claims frequency methodologies within a disaggregated category. In this situation, the insurer may consider disclosing the amount of the incurred liability for reported claims (after deducting the IBNR) and the claims frequency separately for each claims frequency metric used.

For health insurance claims, the IBNR liability disclosure is required to be provided on an interim basis. In the Basis for Conclusions, the Board indicated that because health insurance claims are paid out quickly, it is important for insurers to disclose the IBNR portion of the liability of unpaid claims and CAE on a quarterly basis in order to make information about the development of claims more transparent.

The ASU does not indicate whether the IBNR claims and claims frequency tables should be reflected gross or net of ceded reinsurance. Because these disclosures are based on the claims development tables that are on a net of reinsurance basis, it would be reasonable to report the IBNR claims net of reinsurance as well.

Illustration 3 — Incurred but not reported claims and claims frequency

Insurer A includes the disclosure below about IBNR liabilities and claims frequency. In addition, to show the relationship of the IBNR liabilities and the claims frequency for each accident year presented, Insurer A has included the cumulative incurred claims and CAE from the most recent reporting year from the claims development tables:

	As of December 31, 20Y4		
Accident year	Incurred claims and allocated claim adjustment expenses, net of reinsurance *(In thousands)*	Total of incurred but not reported liabilities plus expected development on reported claims *(In thousands)*	Cumulative number of reported claims
20X5	$ 25,109	$ 1,970	4,140
20X6	27,437	2,596	4,063
20X7	28,551	2,893	3,846
20X8	29,030	3,463	3,519
20X9	26,331	3,622	3,033
20Y0	26,871	4,196	3,063
20Y1	27,729	5,490	3,049
20Y2	27,618	7,311	2,956
20Y3	27,982	10,030	2,856
20Y4	29,073	16,191	2,580

How we see it

- Although insurers may not currently track claims frequency information for certain lines of business, it may be difficult for them to meet the impracticability threshold, and they will need to start tracking this information to provide the disclosures.
- Insurers should consider whether there are measures of frequency, other than claim counts, that may better depict the objective of claims frequency information. However, using a measure other than claim counts may not achieve the Board's objective of allowing users to calculate the average severity of reported claims.

- Insurers have different reserving methodologies, and the guidance gives them latitude in how they determine claims frequency information. As a result, the claims frequency and severity information of different insurers may not be comparable. Users of the financial statements will likely be looking for trends and anomalies in the accident years presented, so insurers may decide to explain these differences.
- The guidance requires IBNR to be calculated by accident year for each of the disaggregated categories. This could be a change for insurers and could require an allocation of the prior-year IBNR amounts included in the cumulative current-year liability estimates on transition.

Claims duration

For the accident years disclosed in the claims development tables, insurers are required to disclose the historical average annual percentage payout of incurred claims categorized by age, net of reinsurance, as of the most recent reporting period. This disclosure is not required for health insurance claims because most of them have short settlement periods. In the Basis for Conclusions, the Board noted that disclosures about the actual timing of claims payments will provide users of financial statements with information that can be used in independent discounting analyses and to gain insight into an insurer's claim settlement practices.

The claims duration disclosure reflects the timing of claim payments that have already been made and not necessarily the expected timing of future payments.

The implementation guidance provides an example of how an insurer could calculate the historical claims duration using the incurred and paid claims data in the claims development tables. In the example, the average percentage of the claims paid in each development year is calculated for the number of years presented in the claims development tables. The calculation uses the amount of claims paid in each development year compared with the estimated incurred claims as of the most recent period presented. Insurers can use other methods to calculate the historical claims duration.

Because this calculation may include up to 10 or more years of data, changes in the insurer's claims department practices on closing claims may not be fully reflected, and an anomaly in claim payments in one of the years may skew results. While the guidance does not require insurers to explain the claims duration, insurers are not precluded from providing a qualitative explanation of the results.

Because certain lines of business have periods of uncertainty that may last longer than the 10 years required to be disclosed, certain claims duration disclosures will reflect less than the full 100% in the years disclosed. An example of this could be workers' compensation or other contracts with long payout periods.

Illustration 4 — Claims duration disclosure

Insurer A provides the following disclosure of the average annual percentage payout of incurred claims by age, net of reinsurance, for the workers' compensation line of business as supplementary information as of 31 December 20Y4:

	Average annual percentage payout of incurred claims by age, net of reinsurance									
	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Workers' compensation	18.7%	21.9%	13.2%	8.6%	6.3%	5.3%	5.1%	2.6%	2.2%	2.0%

Significant changes in methodologies and assumptions

Choosing an actuarial method and making assumptions used in estimating the liability for unpaid claims and CAE require significant judgment. Changes in those methods and assumptions used could materially affect the financial statements. As a result, the Board decided to require insurers to disclose information about any changes in methods and

assumptions in the most recent reporting period reported, including the reasons for the changes and their effect on the financial statements, when those changes are significant. This will help users distinguish the changes in the estimate of the liability between "pure" claims development and the effect of changes in the methodologies and assumptions.

These disclosure requirements enhance the requirements in the general guidance in US GAAP on disclosing the reasons for changes in significant accounting estimates and their effects. The Board observed that there is diversity in practice in disclosing the reasons for the change in estimates and said that the additional requirement should significantly improve the consistency of the disclosures.

Insurers use various methods to calculate the liability for unpaid claims and CAE. When multiple approaches are used, an estimate is selected based on weighting given to each approach, which may differ by accident year. Sometimes certain methods, such as the Bornhuetter-Ferguson methods, may be used in the earlier years of development (i.e., in the calendar year of the accident year and a few development years after that year). In later years, increased weight may be given to other methods, such as the loss development methods. Insurers should consider disclosing when they change the weightings given to a specific method or when a specific method is used in the life cycle of a claim, if the effects of those changes on the liability for unpaid claims and CAE are significant.

Insurers may perform the same valuation method on both paid loss and case incurred loss data. A significant change in method can occur, for example, when an insurer has a change in claims handling and the relative strength of case reserves is believed to have increased during the most recent year. In this scenario, the case incurred development method would likely overstate the unpaid claims liability. Therefore, the actuary may introduce a new adjusted case incurred method and/or give more weight to another method, such as the paid development method. If changing the method to and/or giving more weight to the paid method results in a significant change to the liability versus using the old methods and weighting, the insurer should consider disclosing this change and its effect.

Insurers also will be required to disclose significant changes in assumptions. There are several critical assumptions that could drive material changes to the liability for unpaid claims and CAE, including (1) loss development factors selected from the company's historical data, (2) the tail factor for development of the available historical data, (3) the initial expected ultimate loss used in the Bornhuetter-Ferguson methods and (4) ultimate frequency and ultimate severities in frequency- and severity-based methods. An example of a significant change in assumptions could be a change in the tail factors.

How we see it

- Insurers should coordinate closely with their actuaries to determine whether changes in methods or assumptions have a significant effect on the amounts reported for the liability for unpaid claims and CAE.
- While the guidance does not require insurers to disclose the effect of changes in methods and assumptions on the disaggregated categories, insurers may want to consider doing so if that information would be more useful to the users of the financial statements, rather than just disclosing the aggregate effect on the financial statements.
- While the guidance requires insurers to disclose changes in methods and assumptions only in their annual financial statements, insurers may consider making interim disclosures about changes in methods or assumptions made during the year that have a significant effect on the interim financial statements.

Information about amounts reported at present value

Current guidance requires insurers to disclose the carrying amount of the liabilities for unpaid claims and CAE that are presented at present value and the range of interest rates used to discount the liabilities. Under the new guidance, insurers will have to disclose additional information about those liabilities, including:

- The aggregate amount of discount related to the present value of the carrying amount of the liabilities
- The amount of interest accretion recognized in the statement of operations and the line item(s) within that statement in which the interest accretion is classified

Such disclosures must include information for each reporting period presented for each of the categories of disaggregated liabilities for unpaid claims and CAE.

An insurer may only discount a portion of a total disaggregated liability, in which case, it may consider disclosing the total liability for this disaggregated unit and the portion of the liability that is discounted. For example, an insurer may disaggregate the liabilities by geography but only discount the workers' compensation product within the geographies. In this situation, the insurer may consider disclosing the amount of reserves recorded for workers' compensation within each of the geographies, which could help users of the financial statements better understand how discounting affects the liabilities for unpaid claims and CAE.

Illustration 5 — Liabilities for unpaid claims and CAE that are reported at present value

Insurer A includes the following disclosures for the portion of the workers' compensation line of business that is reported at present value:

Liabilities for unpaid claims and claim adjustment expenses reported at present value

	Carrying amount of liabilities for unpaid claims and claim adjustment expenses		Discount rate		Aggregate amount of discount		Interest accretion	
	As of December 31,		As of December 31,		As of December 31,		For the year ended December 31,	
	20Y4	20Y3	20Y4	20Y3	20Y4	20Y3	20Y4	20Y3
	(In thousands)				*(In thousands)*		*(In thousands)*	
Workers' compensation	$40,470	$ 39,237	3%	3%	$ 3,356	$ 3,313	$ 1,105	$ 1,053

Claims and claim adjustment expenses rollforward

Insurers will be required to disclose the rollforward of the liability for unpaid claims and CAE for each reporting period presented in interim financial statements. For this disclosure, CAE would include both the allocated loss adjustment expenses and unallocated loss adjustment expenses. This rollforward, which currently must be disclosed only in the annual financial statements or in complete sets of interim financial statements, is required for all unpaid claims and CAE, including those incurred for long-duration contracts.

Today, insurers are required to disclose the rollforward for all contracts under ASC 944, including long-duration contracts. However, the liability for unpaid claims and CAE (that is, the ultimate cost of the insured events that have occurred on or before the balance sheet date) for long-duration contracts is often immaterial to the total policyholder benefit liability recorded in the financial statements, which is based on the present value of future benefits to be paid. As such, the rollforward typically is not disclosed for long-duration contracts.

This rollforward should be disclosed in the aggregate for all unpaid claims and CAE, except for health insurance claims, which are required to be disclosed on a disaggregated basis consistent with the disaggregation of the claims development tables. The rollforward disclosure should continue to include the following information:

- The balance at the beginning and end of each reporting period presented and the related amount of reinsurance recoverable
- Year-to-date incurred claims and CAE with separate disclosure of the provision for insured events of the most recent reporting period and of increases or decreases in the provision for insured events of prior reporting periods
- Year-to-date payments of claims and CAE with separate disclosure of payments of claims and claim adjustment expenses attributable to insured events of the most recent and prior reporting periods
- The reasons for the change in incurred claims and CAE recognized in the income statement stemming from insured events of prior reporting periods and any resulting additional premiums or return premiums that have been accrued

Supplementary information and audit considerations

Management of a registrant must assess controls over the current-year information in the claims development table as part of its ICFR assessment.

The guidance describes the periods presented in the incurred and paid claims development tables preceding the most recent reporting period and the average annual percentage payout disclosures as supplementary information. In the Basis for Conclusions, the FASB acknowledged that requiring up to 10 years of information could have implications for auditor independence and could add significant cost and complexity when there is a change in auditor or an acquisition of an insurer that was previously audited by a different firm.

Because the FASB requires these disclosures to be presented as supplementary information to the financial statements, they are considered required supplementary information (RSI) under the auditing standards of the Public Company Accounting Oversight Board (PCAOB) and the AICPA. While the FASB does not prescribe the location of the RSI, many insurers have included this information in the footnotes to the financial statements. However, it would also be acceptable to present this information in supplementary schedules to the financial statements (i.e., outside the financial statements).

While auditors are required to perform only limited procedures on RSI, they could be engaged to audit the RSI. When the auditor performs limited procedures, it should be clear that the RSI is not audited. For example, the RSI should be labeled unaudited. It is important to note that the most recent reporting period of the claims development table is not classified as RSI. This information is required to be presented in the footnotes to the audited financial statements and is subject to audit procedures.

The SEC does not require management to assess the internal control over financial reporting (ICFR) for RSI. However, management of a registrant must include controls over the current-year information in the claims development table in its ICFR assessment since it is not considered RSI.

The AICPA clarified[5] that RSI is not part of the basic financial statements, and the auditor's opinion on the basic financial statements does not cover RSI. Because of the characteristics of RSI and the limited nature of the procedures, the auditor is not required, for purposes of complying with AICPA auditing standards, to be independent of the audit client for years presented in the RSI that were not audited by that auditor. However, if the auditor is engaged by the insurer to audit the information included in the RSI, the auditor must be independent for all periods presented.

For engagements performed under PCAOB auditing standards, auditors do not need to be independent of the audit client for years presented in the RSI that were not audited by that auditor if it is not covered by the auditor's opinion, since only limited procedures are performed.

Effective date

The guidance was effective for public business entities for fiscal years beginning after 15 December 2015, and for interim periods within fiscal years beginning a year later. For all other entities, the guidance was effective for annual periods beginning after 15 December 2016, and, if applicable, interim periods beginning after 15 December 2017.

Endnotes:

[1] ASU 2015-09, *Disclosures about Short-Duration Contracts*.

[2] ASU 2018-12, *Targeted Improvements to the Accounting for Long-Duration Contracts*.

[3] For a contract to be classified as short duration, it must meet the criteria in ASC 944 that the insurance be provided for "a fixed period of short duration" and that the insurer have the ability to cancel or adjust the terms of the contract at the end of any contract period.

[4] See the IEP's minutes for meetings on 1 November 2016 and 17 November 2016 on the AICPA website at https://www.aicpa.org/resources/download/insurance-expert-panel-meeting-minutes-2011-2017.

[5] The AICPA released a Technical Questions and Answers document on Section 9180, *Required Supplementary Information*, in August 2015.

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Appendix: Summary of new disclosures

	Annual or interim and annual disclosure	Supplementary information	Most recent reporting period or comparative disclosure	Disaggregation applied
Incurred and paid claims development	Annual	Yes, except for the most recent reporting period	Most recent reporting period	Yes
Reconciliation	Annual	No	Most recent reporting period	Yes
Cumulative claims frequency information	Annual	No	Most recent reporting period	Yes
Total of incurred but not reported (IBNR) liabilities	Annual for all short-duration contracts; interim and annual for health insurance claims	No	Most recent reporting period	Yes
Average annual percentage payout of incurred claims	Annual	Yes	Most recent reporting period	Yes
Significant changes in methodologies and assumptions	Annual	No	Most recent reporting period	No
Information about amounts reported at present value	Annual	No	Comparative	Yes
Claims and claim adjustment expenses rollforward	Interim and annual	No	Comparative	No, except for health insurance claims, which are disaggregated