STAFF PAPER

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FASB | IASB Meeting

Project	**Insurance Contracts**		
Paper topic	Scope: Fixed Fee Contracts		
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Purposes of this paper

1. During the March 1st joint meeting, the boards discussed the scope of a standard on insurance contracts, including the proposal in the IASB's Exposure Draft, *Insurance Contracts (ED)* and the FASB's Discussion Paper, *Preliminary Views on Insurance Contracts (DP)*, to exclude from the standard some fixed-fee contracts that have as their primary purpose the provision of services.
2. At that meeting, the boards tentatively decided to exclude from the scope of the standard some fixed-fee contracts that have as their primary purpose the provision of services. The boards asked the staff to provide additional analysis to identify which fixed-fee contracts, that meet the definition of insurance, should be excluded from the scope of the insurance contracts standard.
3. The purposes of this paper are to:

   (a) explain the rationale for a scope exclusion; and

   (b) determine criteria that a fixed-fee contract should possess to be excluded from the insurance contracts standard.

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Structure of this paper

4. The remainder of this paper is structured as follows:
   (a) Summary of staff recommendation
   (b) Background
      (i) Feedback received
      (ii) Previous analysis in Agenda Paper 2D/Memo No. 59D
   (c) Staff analysis
      (i) Rationale for a scope exclusion
      (ii) Discussion of fixed-fee service contracts
      (iii) Examining characteristics of fixed-fee contracts to determine criteria

Summary of staff recommendation

5. The staff recommend that the boards exclude fixed-fee contracts that provide service as their primary purpose if they exhibit all of the following characteristics:
   (a) contracts are not priced based on an assessment of the risk associated with an individual customer,
   (b) contracts typically compensate customers by providing a service, rather than by paying cash, and
   (c) the type of risk transferred relates mostly to the overutilization of services.

Background

6. At the March 15, 2011 joint meeting, the boards tentatively decided to define an insurance contract as "a contract under which one party accepts significant

insurance risk from another party by agreeing to compensate the policyholder if a specified uncertain future event adversely affects the policyholder."

7. In addition, the boards confirmed that:

> "A contract does not transfer significant insurance risk if there is no scenario that has commercial substance in which the insurer can suffer a loss, with loss defined as an excess of the present value of cash outflows over the present value of the premiums."

8. Under some contracts, a service provider agrees to compensate a customer by providing services following an uncertain event that adversely affects the customer, in exchange for a fixed fee. This fee may not be sufficient to cover the costs of services rendered. Therefore, these contracts meet the definition of an insurance contract, but the DP/ED proposed to exclude fixed-fee service contracts from the insurance contracts standard.
9. Paragraph B6 of the IASB ED explains:

> "Some insurance contracts require or permit payment to be made in kind in which case the insurer provides goods or services to the policyholder to settle its obligation to compensate the policyholder for insured events. An example is when the insurer replaces a stolen article directly, instead of reimbursing the policyholder for the amount of its loss. Another example is when an insurer uses its own hospitals and medical staff to provide medical services covered by the insurance contract."

Paragraph B7 continues:

> "For some fixed-fee service contracts the level of service depends on an uncertain event. Although such contracts meet the definition of an insurance contract if the uncertain event would cause significant additional payments by the insurer, they are outside the scope of this [draft] IFRS if the

primary purpose of the contract is the provision of services. Examples of such contracts are:

(a) a maintenance contract in which the service provider agrees to repair specified equipment after a malfunction.

(b) a contract for car breakdown services in which the provider agrees for a fixed annual fee, to provide roadside assistance or tow the car to a nearby garage."

10. Paragraphs BC208 and BC 209 of the IASB Basis for Conclusions clarifies why these contracts meet the definition of an insurance contract, and why the boards excluded these contracts from the scope of the insurance standard:

(a) "A fixed fee service contract is a contract in which the level of service depends on an uncertain event. Examples include roadside assistance programs and maintenance contracts in which the service provider agrees to repair specific equipment after a malfunction. Such contracts meet the definition of an insurance contract because:

(i) it is uncertain whether, or when, a repair or assistance is needed;

(ii) the owner is adversely affected by the occurrence;

(iii) the service provider compensates the owner if a repair or assistance is needed.

(b) The Board proposes to exclude fixed-fee service contracts from the scope of the proposed IFRS if their primary purpose is the provision of services. In the Board's view, the existing practice of accounting for such contracts as revenue contracts provides relevant information for the users of financial statement for the

entities that issue such contracts and changing the existing accounting for these contracts would impose costs and disruption for no significant benefit."

Feedback received

11. Most respondents supported the proposal to exclude some fixed-fee contracts that met the proposed definition of an insurance contract. Many of the respondents that agreed with the intention of the Boards in paragraphs BC208 and BC209 of the IASB ED expressed concern that it is difficult to determine whether the primary purpose of some fixed-fee contracts is the provision of service or insurance coverage. Respondents also expressed concern that, in some cases, there is little distinction between the benefits received under a fixed fee service contract and under an insurance contract.
12. Additionally, some respondents requested clarification on whether capitation arrangements qualified for the proposed scope exclusion. Under these arrangements, a health insurer pays a health care provider to perform specified medical services for the policyholders assigned to them by the insurer. The amount paid per policyholder is fixed regardless of the level of service provided. However, the total consideration usually fluctuates on a monthly basis depending on the group of policyholders assigned to that healthcare provider. Respondents proposed several alternatives to clarify the exclusion including:

    (a) narrowing the scope of the standard to require adoption only by insurance entities;

    (b) distinguishing between services and the provision of insurance coverage;

    (c) excluding contracts that are not managed as insurance according to the business model of the entity; and

    (d) drafting guidance that explicitly identifies whether different types of contracts meet the criteria in the proposed scope exclusion.

Previous analysis in Agenda Paper 2D/Memo 59D

13. In March, the boards discussed *Agenda Paper 2D/Memo No. 59D*. The staff explained the reasons to consider excluding some fixed-fee service contracts and proposed several alternatives to the guidance in the DP/ED. Relevant excerpts of that analysis are summarized in Appendix A.

Staff analysis

14. In order for the boards to determine appropriate criteria for excluding some fixed fee service contracts the staff believe it is important to explain the reasons for a scope exclusion and to review some common service contracts.

The rationale for a scope exclusion

15. Fixed fee service contracts are typically accounted for using the revenue recognition guidance in the various jurisdictions. Many respondents argue that the application of the insurance proposals introduces unnecessary complexity into the accounting for these contracts that would clearly impose an onerous burden on some entities.
16. The table below summarizes a staff assessment of the impact of applying either the premium allocation approach or the revenue recognition approach to fixed-fee service contracts. We have used the tentative board decisions related to the premium allocation approach in our comparison rather than the building blocks approach because we believe that most fixed-fee service contracts would qualify for the premium allocation approach.

Topic	Revenue Recognition	Insurance - Premium Allocation Approach	Comparability	Implementation Concerns
Measurement	The transaction price is the amount of consideration to which an entity expects to be entitled in exchange for transferring promised goods or services to a customer. An entity shall assume that the goods or services will be transferred to the customer as promised in accordance with the existing contract and the contract will not be cancelled, renewed, or modified. The variable portion of the consideration is measured at the probability-weighted or best estimate of the amount.	The measurement of the pre-claims obligation includes a current estimate of the expected (probability-weighted) present value of premiums received at initial recognition plus the expected present value of future premiums. The liability for incurred claims also measures amounts at the expected (probability-weighted) present value.	Differences between the amounts are unlikely to be material.	Assessing all relevant scenarios to determine the expected present value of future premiums and claim costs may require an entity to hire actuaries, unlike the revenue recognition proposal. Additionally, the insurance proposals will require entities to recognize the pre-claims obligation and present value of future premiums at initial recognition. The revenue recognition guidance does not require the recognition of a contract asset or liability until the entity performs under the contract or receives consideration for future performance. The cost guidance in the revenue recognition proposals refers to other applicable guidance and is less complex than the insurance proposals. Applying the insurance guidance imposes an additional burden on preparers.

Topic	Revenue Recognition	Insurance - Premium Allocation Approach	Comparability	Implementation Concerns
Satisfaction of performance obligation (revenue recognition)	The objective of measuring progress toward complete satisfaction of a performance obligation is to depict the transfer of control of goods or service to the customer. Appropriate methods of measuring progress include output and input methods.	The insurer should reduce the measurement of the pre-claims obligations over the coverage period on the basis of time but on the basis of the expected timing of incurred claims and benefits if that pattern differs significantly from the passage of time.	The objective of recognizing the pre-claims obligation over the coverage period is consistent with the objective of measuring progress toward complete satisfaction of a performance obligation. Differences are unlikely to be material.	Similar
Discount rate	The entity shall use a discount rate that would be reflected in a separate financing transaction between the entity and its customers at contract inception.	The objective of the discount rate is to adjust the future cash flows for the time value of money and to reflect the characteristics of the insurance contract liability that are not reflected elsewhere in the measurement of the liability. The rate should be a current rate that is updated at each reporting period.	See below	Determining a discount rate that reflects the characteristics of the contract is more complex than determining a discount rate based on market features.

Topic	Revenue Recognition	Insurance - Premium Allocation Approach	Comparability	Implementation Concerns
Discount when	Discount when the contract has a significant financing element. Do not account for the time value of money if the period between payment and performance is one year or less.	The discounting of insurance liabilities should not be required when the effect of discounting would be immaterial.	Slight differences between the measurement of the pre-claims obligation (insurance) and performance obligation (revenue) may exist when payments are made evenly throughout the year (instead of at contract inception). Differences are unlikely to be material.	Insurance proposals to date still require assessing the impact of time value of money on the pre-claims and post-claims liabilities. This could impose an additional burden on preparers.
Acquisition or Upfront Costs	An entity shall recognize as an asset the incremental costs of obtaining a contract with a customer if the entity expects to recover those costs. As a practical expedient, an entity is permitted to recognize the incremental costs of obtaining a contract as an expense when incurred if the amortization period of the asset that an entity otherwise would have recognized is one year or less.	The acquisition costs to be included in the initial measurement of a portfolio of insurance contracts should be all of the direct costs that the insurer will incur in acquiring the contract in the portfolio. The FASB tentatively decided that the acquisition costs will be limited to those related to successful acquisition efforts.	The models measure and present acquisition costs differently. Users that commonly view these contracts as service may experience confusion when the contracts are measured under the insurance proposals as they may not realize the pre-claims liability reflects the unamortized acquisition costs.	Requiring entities to apply the premium allocation approach to acquisition costs would create an additional burden on preparers

Topic	Revenue Recognition	Insurance - Premium Allocation Approach	Comparability	Implementation Concerns
Unbundling	If an entity proposes to transfer more than one good or service, the entity shall account for each promised good or service as a separate performance obligation only if it is distinct.	The unbundling guidance is intended to be consistent with the approach in the revenue recognition project, subject to consideration of whether the pattern of transfer criterion is needed in this context and to future decisions on allocation.	Differences are likely immaterial.	Similar
Onerous test	For a performance obligation that an entity expects at contract inception to satisfy over a period of time greater than one year an entity shall recognize a liability at the amount by which the lowest cost of settling the obligation exceeds the amount of the transaction price allocated to the remaining performance obligation.	An insurance contract liability is onerous if the present value of fulfillment cash flows relating to future insured claims exceeds the carrying amount of the pre-claims obligation.	When applied, results under the application of both onerous tests would be similar as they measure the difference between the carrying amount of the performance obligation and expected future fulfillment costs.	Revenue recognition does not require an onerous test for contracts with durations less than one year whereas insurance will require the assessment for all contracts. Additionally, under the IASB model, including a risk adjustment would complicate the test.

Topic	Revenue Recognition	Insurance - Premium Allocation Approach	Comparability	Implementation Concerns
Disclosures	Disclosure requirements are principles-based without contract-specific requirements	Disclosure requirements are specific to the type of insurance contract	Subject to future board deliberation, applying the insurance guidance may encompass relevant disclosures from the revenue recognition project. (For example, disaggregation of revenue) However, the insurance project would also require disclosures about the liability that are irrelevant as incurred claims are resolved much quicker than traditional insurance policies.	Preparation of some insurance disclosures would be onerous and may not produce any additional benefit.

17. The staff analysis in the previous table confirmed:

    (a) the results for fixed-fee contracts under both proposals are comparable, and,

    (b) the costs associated with applying the insurance guidance to these contracts impose an additional burden on preparers relative to the application of revenue recognition guidance.

18. The staff have assessed various contracts that provide service for a fixed fee, and identified the features of those contracts that distinguished them from traditional insurance contracts. The following section discusses the results of this analysis.

Discussion of fixed fee service contracts

19. The staff considered contracts that agree to provide an uncertain level of service in exchange for a fixed amount of consideration, but do not transfer insurance risk. For example, a mobile phone service provider offers various plans to customers. Some plans will offer a maximum amount of service (i.e. minutes) per month and for an additional fee, provide additional services (i.e. additional minutes, text messaging, etc.). The service provider may also offer unlimited plans. In both circumstances, the service provider accepts some level of uncertainty with regard to the final costs required to fulfill the obligation. However, these contracts do not provide service based on the occurrence of an adverse event from the customer's perspective. Therefore, these contracts do not transfer insurance risk.
20. Other fixed-fee contracts provide service following an adverse event experienced by the customer. These contracts include roadside assistance contracts, and other fixed-fee contracts, which provide a combination of regularly scheduled service and services following an adverse event. Similar to the mobile phone contract, these contracts expose the service provider to uncertain fulfillment costs related to the level of services provided. However, in both of these examples, the existence of an adverse event that triggers additional service causes these contracts to meet

the definition of an insurance contract. Many respondents expressed concern that the primary purpose of these contracts was not to transfer insurance risk and, therefore, the application of insurance contracts guidance was unnecessary. The staff explored the terms of the following agreements as examples of such contracts, including:

(a) Capitation and other fixed-fee medical service arrangements;

(b) Maintenance and repair contracts; and

(c) Roadside assistance programs.

Capitation and other fixed-fee medical service arrangements

21. Heath insurers enter into three general types of fixed-fee arrangements with policyholders related to the provision of medical services:

(a) capitation agreements;

(b) fee-for-service arrangements; and

(c) bundled or episode-based arrangements.

22. Health insurers often enter into capitation arrangements with healthcare providers (hospitals, individual medical practices, etc.) to contract for the provision of medical service to their plan members (patients). In exchange for a fixed amount of consideration per patient, the healthcare provider agrees to provide medical services to the assigned patients for a specified coverage period.
23. Under a capitation arrangement, a healthcare provider accepts a portion of the insurance risk. The healthcare provider agrees to service patients that require an uncertain level of medical care (an adverse event) in exchange for a fixed amount of consideration per patient. When the contract transfers significant insurance risk, a capitation arrangement meets the definition of an insurance contract.
24. However, both insurers and healthcare providers view these plans as prepaid arrangements for medical services. Requiring these entities to account for capitation arrangements as (re)insurance may not be appropriate or useful. One comment letter respondent explained:

> "The primary purpose of capitation (and fee-for-service) agreements is the provision of medical care services. Therefore, the substance of a capitation agreement is consistent with the scope exception in the proposals related to fixed-fee service contracts and it would be inconsistent to account for them as insurance contracts. As a further example, capitation agreements are differentiated from a contract between a policyholder and either a health insurer that owns a clinic or employs physicians, or a property and casualty insurer that owns an automotive body shop. Although in both instances a portion of the services related to an insurance claim may be performed by the insurer, the primary purpose of the contract between the insured and the insurer is to provide insurance coverage as opposed to perform a service.
>
> Although capitation arrangements expose health care providers to risk related to uncertain events, the cash flows exchanged between the insurer and the physician during the contract period do not vary in accordance with the actual incidence of claims or the provision of health care treatments, and these contracts are not accounted for as insurance or reinsurance contracts under current U.S. GAAP because they generally do not meet the definition of significant insurance risk. We do not believe the Boards' definition of insurance contracts and the transfer of insurance risk are intended to be different in substance from this existing approach."

25. Healthcare providers also enter into fee-for-service arrangements with health insurers. Under these arrangements the provider agrees to provide services related to an individual service event (i.e. yearly exam, diagnostic test, etc.) according to a fee schedule. Unlike capitation arrangements, it is unlikely that these contracts expose the provider to significant insurance risk, as the provider incurs relatively predictable costs related to an individual service event and would not accept a fee

that did not at least provide reimbursement for this amount and some profit margin.

26. Similarly, some health insurers arrange for bundled or episode-based payments. These contracts contain terms that blend the "lump sum" per patient feature of capitation arrangements with the event-based schedule of a fee-for-service arrangement.

27. The staff also note that entities contract for healthcare services on a capitated basis to reduce the moral hazard inherent in fee-for-service agreements. Under a fee-for-service arrangement, the healthcare provider is more likely to perform unnecessary procedures to increase profitability. A capitation arrangement is intended to incentivize the healthcare provider to make cost-effective treatment decisions, often focused on preventative care. Therefore, the transfer of significant insurance risk is a consequence of the economics related to the primary purpose of the contract, the provision of medical services.

28. The staff compared traditional health insurance policies to the capitation arrangements discussed above. The following table highlights this analysis:

	Capitation arrangement	Traditional health insurance
Pricing	Contracts priced at a fixed amount per person regardless of individual risk characteristics (although prices are adjusted slightly to reflect age and gender differences)	Contracts priced depending on regulatory environment and type of plan. Some plans assess individual riskiness more than others.
Form of Compensation	Form of compensation is routinely service and rarely cash	Form of compensation varies depending on insurer, type of plan, procedure performed, etc.
Amount of Compensation	Amount of compensation following an individual adverse event is relatively predictable because the health care provider only agrees to specific procedures (i.e. primary care)	Amount of compensation following an individual adverse event varies significantly. A health insurer is exposed to a broader range of health outcomes than a capitation arrangement for specific procedures

29. Unlike some traditional insurance policies, many arrangements between health care providers and health insurers are not priced based on an assessment of the risks associated with an individual customer. For individual health insurance

policies, a physical examination and medical history review is often required and health insurers base pricing decisions on such evaluations. In contrast, capitation agreements are priced at a fixed amount per person regardless of individual risk characteristics. However, these amounts are sometimes adjusted for the age or gender of a patient.

30. In this example, the nature of the risk transferred distinguishes the two types of contracts more clearly than the pricing. A health insurer accepts and pools the health risks of policyholders. Conversely, a health care provider who enters into a capitation agreement agrees to a limited amount of compensation following adverse events because it only agrees to provide specified procedures (i.e. primary care). The health care provider is primarily exposed to the risk of a higher than expected frequency of adverse events.

Equipment maintenance contracts

31. Entities often agree to provide routine maintenance services for a fixed amount of consideration. These contracts are found in a wide array of industries, including office equipment, home appliances, and heavy machinery.
32. The staff reviewed various fixed-fee maintenance and repair contracts. For example, the staff evaluated an annual oil burner maintenance contract that included (a) regularly scheduled maintenance, and (b) 24 hours per day, 7 days per week technician assistance related to an equipment malfunction. In the event of equipment malfunction, the contracts provide a limited range of services. The contracts do not provide assurance that the equipment will be restored to full working condition under all circumstances, but the service provider may offer to repair the equipment for an additional fee.
33. The nature of the insurance risk transferred in the oil burner example is very similar to the capitation arrangements discussed in the previous section. Agreeing to provide emergency assistance to all plan customers creates the possibility that a particular customer will require enough visits during the coverage period to result in a loss on the contract (i.e. that a specific customer will over utilize the service). However, the primary purpose of these contracts is not to insure against the risk of

multiple service technician visits. Similar to the capitation arrangements discussed above, contract economics unrelated to the transfer of insurance risk increase the incentive to enter into contracts on a fixed fee basis relative to a fee-for-service arrangement. The annual service plan, because of routine inspections, decreases the risk of malfunction, and, when malfunction does occur, plan membership increases the likelihood that a service provider will receive additional business to service the malfunction.

34. The staff compared the maintenance and repair contract to traditional boiler insurance. A boiler insurance policy covers significantly more risks than the oil burner maintenance agreement. Similarly, a boiler insurance policy is not issued until the equipment is inspected to allow the insurer to quote a premium based on the assessed riskiness of an individual machine. The staff observed the following features that distinguish the two types of contracts:

	Boiler Breakdown Insurance	Maintenance and Repair Service
Pricing	Requires additional information to underwrite policy and provide a quote	Offers a limited range of plans at fixed prices regardless of specific model covered under the contract
Type of Compensation	Provides cash after a deductible is exceeded relating to an insured event	Provides some level of technician service following an equipment malfunction
Amount of Compensation	Compensation for insured events includes direct property damage and extra expenses of operating business	Compensation for insured event is limited to waiver of service technician fee and in some cases a limited amount of parts

35. The table above illustrates the differences between contracts intended to transfer significant insurance risk and contracts that only transfer significant insurance risk as a consequence of providing an uncertain level of services for a fixed fee. The staff also note that fixed-fee contracts do not indemnify customers against insured events in all circumstances unlike traditional insurance contracts, which are often underwritten for the express purpose of compensating a policyholder for their losses (up to a policy limit).

Roadside assistance programs

36. Roadside assistance providers agree to deploy technicians when a customer experiences an adverse event that affects the drivability of their vehicle. Roadside protection plans are often offered to all customers for the same price, although the staff observed some service providers distinguishing between older and high-mileage vehicles. Like in the case of the contracts reviewed above, the staff concluded that roadside assistance programs transfer insurance risk as a consequence of accepting a fixed-fee to provide an uncertain level of services following adverse events. Again, the primary risk of incurring a loss on an individual contract originates from the possibility that an individual customer experiences an excessive number of events requiring compensation.

Summary of contracts reviewed

37. The staff observed that the contracts reviewed had several features in common that distinguished them from traditional insurance contracts, including differences in the entities' determination of product pricing, the form of compensation the policyholder receives following an adverse event, and the nature of the risk the entity assumes as a result of the contract. In the following section, the staff examine how these characteristics can be included in criteria to exclude some fixed-fee service contracts from the insurance contracts standard.

Examining characteristics of fixed-fee contracts to determine criteria

38. Considering the characteristics of the contracts discussed above, the staff analysed various criteria suggested during outreach and board meetings, grouped into three categories:

    (a) *Provision of in-kind compensation* - whether the entity primarily provides in-kind compensation or cash as compensation for adverse events

    (b) *Business model* - whether the contract is managed in a manner consistent with the transfer of significant insurance risk

(c) *Risk of overutilization (frequency risk)* - whether the transferred insurance risk is primarily related to the frequency of adverse events, also referred to as the risk of overutilization

Payment of in-kind compensation

39. The provision of service as compensation following adverse events was present in all fixed-fee contracts identified by the staff. However, as the DP/ED recognized, a traditional insurance contract may also permit or require the payment of in-kind compensation. An insurer may own an auto mechanic subsidiary and provide auto services to customers as compensation. Alternatively, an insurer may replace stolen goods in-kind. For this reason, the staff believe that the payment of in-kind compensation following an adverse event does not effectively delineate between these two types of contracts on a standalone basis. However, the staff explored the payment of in-kind compensation in these contracts to possibly develop this criterion in conjunction with other criteria.
40. The staff believe that customers entering into the fixed-fee contracts discussed place a greater emphasis on receiving in-kind compensation than on the transfer of insurance risk. If a customer enters into a contract for the purpose of transferring insurance risk, a substantial amount of the insuring entity's obligation relates to the reduction of uncertainty for the customer. The customer receives assurance that the economic impact of an uncertain cash flow stream has been transferred to another entity. In contrast, a customer requiring roadside assistance or equipment maintenance places greater emphasis on receiving in-kind compensation (in the form of a tow or other service, as opposed to receiving cash for the amount of a tow) than the transfer of risk associated with requiring roadside assistance. Customers entering into roadside assistance contracts are typically not indifferent to the form of compensation; they prefer service.

Business model

41. Many respondents suggested criteria based on the business models of entities that write service contracts.

42. The staff agree that contracts primarily written to provide service create value for stakeholders (customers and shareholders) in a different manner than traditional insurance contracts. However, as discussed in previous papers, an exclusion based on the business model of an entity contradicts the contract-based scope of the tentative insurance proposals. However, some characteristics of the contract issuers' business model may provide a criterion that delineates insurance contracts from fixed-fee service contracts, specifically pricing.
43. The pricing (underwriting) of insurance risk is essential to writing traditional insurance contracts. Quantifying the risk associated with an individual contract requires significant expertise and resources.
44. Issuers of fixed-fee contracts certainly must contemplate the risk of providing an uncertain level of service related to adverse events, but they do not rely on an assessment of the risk of an individual contract to determine pricing for products.
45. In the fixed-fee contracts reviewed, the staff observed that the entity required little information to price an individual contract. Some roadside assistance programs do not distinguish the risk of individual contracts at all. One roadside provider separated cars into one of two risk classifications based on mileage or age. These contracts do not consider other indicators that increase the likelihood of adverse events, including, for example, geography, average annual mileage of vehicles, or specific historical customer behaviour.
46. Additionally, service providers do not re-price individual contracts as they collect more information about a specific customer. The fixed-amount paid for a patient covered under a capitation arrangement will not reflect that patient's individual or contract level claim experience in previous periods.
47. In a perfectly competitive insurance market, an insurer would charge a premium based on the expected losses of an individual risk and the amount of profit that the insurer requires to persuade it to accept that risk. However, an entity would offer to accept insurance risk from all customers for the same price if one or both of the following were true:

    (a) the entity is insuring a homogenous pool of risks, or

(b) the benefits of underwriting a contract to set a premium that fully reflects customer risk do not outweigh the costs related to collecting and analyzing the information to make that risk assessment.

48. The staff believe that for many fixed-fee contracts a combination of both factors result in an entity offering identical prices to all customers. This does not mean service providers do not evaluate the expected losses for a group of contracts when setting prices, but they do not thoroughly evaluate the risk profile related to an individual contract. Most likely, variability of expected losses across contracts may be so small that underwriting each contract would be more costly than offering a single amount that creates insignificant cross-subsidies.
49. The staff also noted some traditional insurers do not determine premiums based on evaluation of an individual policyholder's risk profile. For example, in some jurisdictions, regulation prohibits considering an individual's health risk when determining the premium charged for health insurance.
50. Based on the previous analysis, the staff believe that the degree to which an entity evaluates the risk of an individual contract to ultimately set a price for accepting insurance risk (or providing a service) is a plausible criteria. The staff believe this criterion is more intuitive than referring to the business model of an entity and will be commonly understood in practice.

Utilization (frequency) risk

51. The primary source of significant insurance risk transferred in the fixed-fee contracts discussed above relates to the frequency of adverse events. Said differently, loss scenarios occur when the provision of service is required more frequently than expected for an individual contract. For this analysis, the staff identified the sources of insurance risk as follows:

(a) severity risk,

(b) frequency risk, and

(c) timing risk.

52. It is helpful to consider these risks in the context of individual adverse events. The risk profile related to individual adverse events depends on the terms of the contract. For many long-duration contracts, timing risk is often the most significant risk related to an individual event. For this analysis, the staff assumed that timing risk is immaterial. Absent significant timing risk, when comparing fixed-fee contracts to insurance contracts, a clear distinction arises with regard to the relative importance of severity and frequency risks related to individual adverse events.
53. An issuer of a roadside assistance contract is not exposed to significant severity risk related to providing service following a single event because contracts are structured in a manner that limits severity risk. For example, towing longer distances is precluded. The primary risk lies in the level of service to be provided in the aggregate, i.e. providing the service to one or more customers an unexpected amount of times during the coverage period.
54. The staff considered when a service provider would hypothetically accept severity risk related to an individual event. If a roadside assistance provider accepted severity risk, it would need to tow a vehicle further[1]. Similarly, a healthcare provider would need to assume greater financial responsibility for the treatment of a group of capitated patients. An oil burner maintenance arrangement would need to provide a level of coverage comparable to the boiler insurance policy discussed above.
55. The staff recognize traditional insurance contracts also expose insurers to significant frequency risk. However, on a relative basis, the significant risk transferred in fixed-fee contracts is more attributable to frequency risk than traditional insurance contracts. For example, frequency risk is the most significant source of risk in a portfolio of automobile physical damage policies. However, the potential variability in claim costs associated with an individual event under an automobile policy is much greater than under the fixed-fee contracts evaluated.

[1] The staff observed some roadside assistance programs that expose an entity to severity risk related to an individual adverse event. For example, some contracts transport customers to their final destination when they experience breakdown events. The staff noted some entities referred to these arrangements as "insurance".

56. In the case of fixed-fee service contracts, the staff note that the period of time between the adverse event and the provision of service is typically short and the expected cash outflows related to the event are typically known (or within a known range) at the time the event occurs. In contrast, in the case of traditional insurance contracts, the period of time between the adverse event and indemnifying the policyholder could be much longer and the cash outflows are typically more variable. The staff also note fixed-fee service contracts typically do not give rise to claims that are incurred but not reported (IBNR). However, the staff do not believe these differences are sufficient to distinguish between the two types of contracts for purposes of developing criteria.
57. The most significant risk in the service contracts reviewed by the staff in this paper is the risk of overutilization of services, or the frequency risk associated with providing service following adverse events.
58. Finally, the staff believe that the concept of overutilization risk is more commonly understood than the concept of significant frequency risk. The staff observed that in many fixed-fee contracts, utilization management is an important part of the entity's business model and believe that including the term in a list of criteria is appropriate.

Staff Recommendation

59. The staff recommend that the boards exclude fixed-fee contracts that provide service as their primary purpose if they exhibit all of the following characteristics:

    (a) contracts are not priced based on an assessment of the risk associated with an individual customer,

    (b) contracts typically compensate customers by providing a service, rather than by paying cash, and

    (c) the type of risk transferred relates mostly to the overutilization of services.

60. The staff considered whether these criteria should be indicators or required. Characterising these criteria as indicators would allow for more use of judgment

when determining whether a contract is a fixed fee service contract. However, the staff think that these criteria should be requirements. Some traditional insurance contracts may meet one or more of these criteria. For example, annuity contracts are not priced on the risk profile of the individual customer. Also, health insurers in some jurisdictions are precluded from determining premiums based on a policyholders' health exam by regulations. However, these contracts do not meet all the criteria. If these criteria are asserted as indicators of whether or not a contract should be excluded, users may find application of the scope exclusion confusing or may consider the exclusion an option. In addition, the staff believe that contracts that don't meet all the criteria should apply the insurance guidance because this may indicate that the primary purpose of the contract is to accept risk.

Question #1 for the board

Do the boards agree with the staff recommendation that that the boards exclude fixed-fee contracts that provide service as their primary purpose if they exhibit all of the following characteristics:

(a) contracts are not priced based on an assessment of the risk associated with an individual customer,

(b) contracts typically compensate customers by providing a service, rather than by paying cash, and

(c) the type of risk transferred relates mostly to the overutilization of services?

Appendix A – Previous Analysis in Agenda Paper 2D/Memo 59D

A1. Fixed-fee service contracts meet the definition of an insurance contract when the insurance risk transferred by the contract is significant. Examples include:

(a) A maintenance contract in which the service provider agrees to provide a basic level of service to maintain specified equipment and additionally to repair the equipment in the event of a malfunction.

(b) Roadside assistance contracts, in which a provider agrees to provide roadside assistance, sometimes including the costs of any related parts and labour, in exchange for a fixed fee.

(c) Capitation agreements in which a healthcare provider agrees to provide, in exchange for a fixed fee, a variable amount of defined medical services for a specified group of patients. For example, a healthcare provider might agree to provide all ambulance transfer services for a specified period.

A2. In addition, most fixed-fee service contracts would likely be eligible for the premium allocation approach if they were included in the scope of the insurance contracts standard. This would mean that the accounting for such contracts would be similar, regardless of whether such contracts were to be accounted for in accordance with the standard for insurance contracts or for revenue recognition (assuming the final standard retains an approach reasonably consistent with the revenue recognition standard).

A3. In the staff's view, excluding some fixed-fee service contracts from the scope of the insurance contracts standard had the following disadvantages:

(a) It is an exception to the principle that the proposed standard applies to all contracts that meet the definition of insurance contracts.

(b) It is difficult to draw the line between fixed-fee service contracts and insurance contracts, and between different types of fixed-fee service contracts.

(c) It results in lack of comparability because different accounting models would apply to similar types of contracts.

A4. However, the costs for non-insurance companies to implement the insurance contracts standard could be significant when the results are expected to be similar, if not the same, and therefore there would be minimal to no benefit. Therefore the staff believe some fixed fee service arrangements should be excluded when specified criteria are met that consider the cost/benefits and the disadvantages noted above.

A5. In *Agenda Paper 2D/Memo No. 59D* the staff identified the following approaches to improve the scope exclusion:

(a) *Confirming the approach in the ED/DP*:

(i) Confirm the proposed scope exclusion in the DP/ED, including possible clarification that the assessment of whether the primary purpose is the provision of services is performed at the contract level.

(ii) The disadvantage of this approach is that some have criticised the clarity of the proposed scope exclusion, in particular the reference to the 'primary purpose' of the contract. However, most did not disagree. Although subjective, this approach would be based on a relatively clear principle: that contracts intended to provide service are service contracts and those intended to provide insurance are insurance contracts.

(b) *Scope exclusion based on entity's business model*:

(i) Provide a scope exclusion based on whether an entity's business model leads it to perceive itself as a provider of non-insurance services or as a provider of insurance. Using this approach, entities that are primarily providers of insurance and that have applied insurance accounting in the past would continue to be in the scope of the insurance contracts standard. Entities that are primarily providers of underlying services rather than providers of insurance, and

who have accounted for such contracts as services in accordance with relevant revenue recognition standards would have their contracts excluded from the scope of the insurance contracts standard.

(ii) This approach has the advantage of being relatively clear because it is fairly easy to determine the primary purpose at an entity level. Furthermore, the approach would probably be workable. However, the disadvantage of this approach is that it undermines the principle that the insurance contracts standard should deal with the accounting for insurance contracts, and not for the entities that issue those contracts (Assumption 6(f) as discussed in the February 2011 *Agenda Paper 31/ Memo No. 56A: Project Assumptions*). In addition, this approach may result in using insurance accounting for service contracts that are issued by insurance entities but are not considered insurance under current standards. For example, health insurers routinely provide third-party administration services related to claims processing for entities that choose to self-insure employee health coverage.

(c) *Scope exclusion based on uncertain event*:

(i) Eliminate the reference to the 'primary purpose' of the contract and distinguish only between a contract that provides service to the policyholder only in the event of an uncertain event, and a contract that provides both (i) a basic level of service in all cases and (ii) the possibility of extra services in the case of an adverse uncertain event. For example:

(a) in the maintenance contract described in paragraph A1(a), the provider would expect to provide some services, even without malfunction. However, if the equipment malfunctioned, the provider would incur additional costs. Such contracts would be excluded from the scope of the insurance contracts standard.

(b) in the roadside assistance contract described in paragraph A1(b), the provider would provide service only in the event of a breakdown. Such contracts would be included in the scope of the insurance contracts.

(c) in a contract which combines a car maintenance programme with roadside assistance, the provider would always expect to provide services and would incur additional costs in the event of a breakdown. This would therefore be treated in the same way as the maintenance contract and be excluded from the scope of the insurance contracts standard.

A6. This approach has the advantage that it does not rely on a subjective estimate of what a contract's 'primary purpose' is. It is consistent with the definition of an insurance contract in that it depends on the occurrence or non-occurrence of an uncertain event. However, any provision of service would result in the contract being treated as a fixed fee service contract and thus outside the scope of the insurance contracts standard. In addition, this approach would prevent entities that provide both included and excluded services, perhaps to the same customers, from using a common accounting and reporting model for both.