



ACTUARIAL BUSINESS SOLUTIONS

TFRS 17 Practice and Interpretation for Thai Non-Life Insurance Volume 1

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Introduction

TFRS 17 is a financial reporting standard written as Principle-based, meaning it provides broad principles on how standards should be formulated, allowing each company to interpret them differently.

For example, if we say, "be a good person," under Principle-based standards, it will broadly describe what being a good person entails without specifying exact steps to follow. This differs from the past Rule-based criteria, where specific rules (e.g., brush your teeth twice a day, cross the street at the crosswalk, vote in elections, listen to your parents) would define being good. Following all 10 specified rules would make one good; failing to adhere to these rules would not.

In the Principle-based world, expertise is crucial for both regulators and users to discuss and interpret compliance with the standards. In accounting language, "complying with standards" is termed as "Comply," allowing companies to interpret and comply with the standards in various ways.

In the context of TFRS 17, it has been developed to encompass both life insurance and non-life insurance businesses. Those familiar with both sectors understand well that they operate differently in terms of data collection, customer demographics, insurance product characteristics, sales mindset, and regulatory frameworks. This distinction is evident in Thailand, where there are separate laws governing life insurance under the Life Insurance Act and non-life insurance under the Non-Life Insurance Act.

Some might wonder why TFRS 17 doesn't specifically tailor its guidelines separately for each type of insurance business, given the differences between non-life insurance and life insurance sectors.

In this regard, those drafting the TFRS 17 standard do not distinguish between life insurance and non-life insurance businesses (nor do they consider whether a company is licensed as a life insurance or non-life insurance company). Instead, they focus on the nature of the contracts such as either Long Duration Contracts or Short Duration Contracts.

To illustrate simply, a Short Duration Contract insurance policy provides coverage on an annual basis with premiums that can be adjusted, while a Long Duration Contract involves coverage over a longer period exceeding one year.

As seen, life insurance companies can sell Short Duration Contracts such as health insurance policies, while non-life insurance companies can simultaneously sell Long Duration Contracts like cancer insurance policies.

It is evident that typically, life insurance companies predominantly sell Long Duration Contracts with a small portion selling Short Duration Contracts. Conversely, non-life insurance companies mainly sell Short Duration Contracts with a small (or non-existent) portion selling Long Duration Contracts.

Furthermore, for those who have read TFRS 17 extensively, it may seem that TFRS 17 is primarily designed to encompass Long Duration Contracts while providing simpler guidelines for Short Duration Contracts. TFRS 17 considers Short Duration Contracts as a subset of Long Duration Contracts.

Therefore, even though both insurance sectors utilize the same TFRS 17 framework, businesses can interpret TFRS 17 to suit their specific context. By tailoring the interpretation to the context of the non-life insurance sector (which predominantly sells Short Duration Contracts with a small portion involved in Long Duration Contracts), compliance with TFRS 17 becomes effective, addresses issues directly, simplifies compliance, and minimizes undue cost burdens on businesses.

In interpreting TFRS 17, each business can develop Guidance Notes that are tailored to their specific operations. These Guidance Notes serve as benchmarks or initial guidelines rather than operational manuals. They allow businesses to adapt TFRS 17 principles according to their unique contexts, reflecting the principle-based nature rather than a rigid Rule-based approach.

For example, in a neighboring country like Malaysia, there is an Industry Guidance Note for the non-life insurance sector, spanning approximately 88 pages. This document serves as an interpretation of the over 600-page TFRS 17 standards, adapting it to the broader context of the non-life insurance industry.

Industry Guidance Notes serve as a collective outline of recommended practices for businesses, capturing the general consensus on how operations should be conducted. However, they do not cover every possible scenario, leaving room for companies to interpret and apply the standards in their own unique ways.

Therefore, it's not surprising that each company (especially multinational firms) has its own set of practices, known as a Positioning Paper. This additional document allows them to align with their specific

databases, customer segments, product groups, profit management methods, and even future business plans. Even small companies can adapt the Industry Guidance Note into their own Accounting Positioning Paper and Actuarial Methodology Paper.

The industry practices for the insurance sector cover various aspects such as interpreting the framework to define what falls under TFRS 17 standards, grouping contracts, defining coverage periods, categorizing insurance types, defining profit or loss annually, specifying risk definitions and variables for calculations, and determining financial statement disclosures including necessary footnotes.

If categorized for interpretation purposes, these can be explained as follows:

Introduction and Framework

1. Separation of Insurance Contracts
2. Combination of Contracts
3. Contract Boundary
4. Level of Aggregation

Technical Actuarial Group

5. Choice of Measurement Model
6. Contractual Service Margin and Coverage Unit, including Onerous Contract
7. Discount Rate
8. Risk Adjustment

Technical Accounting Group

9. Attributable Insurance Expense
10. Transition Approach

Technical Reinsurance Group

11. Reinsurance Treatment

Display group

12. Presentation Chart of Account and Disclosure

13. Accounting Policy Choices

In this first volume of the TFRS 17 Practice and Interpretation for Thai Non-Life Insurance, will cover only Introduction and Framework by outlining the 4 key topics.

Topic 1: Separation of Insurance Contract

It is common practice for each financial reporting standard to delineate the scope of insurance contracts, defining what falls within and outside its purview. In TFRS 17, the standard specifies its own boundaries, detailing which components are subject to consideration under TFRS 17. For instance, it addresses the insurance component, the Non-Distinct Investment Component (NDIC), etc.

This chapter aims to categorize and analyze various types of insurance contracts, identifying elements that may not align with TFRS 17. Such additional components often arise from life insurance policies incorporating investment features or other bundled services alongside life coverage.

Thus, the focus here is on extracting and distinguishing the pure insurance component. This aspect is less problematic for non-life insurance businesses since it aligns more directly with their core offerings (in contrast, it was initially written to encompass life insurance to a greater extent).

Topic 1 : Separation of Insurance Contract

An insurance contract may contain one or more components of which these components would need to be separated and account for them under the relevant IFRS.

1. Insurance component
2. Embedded derivatives
3. Investment components
4. Promises to transfer goods or non-insurance services

After unbundling those non-insurance components, the remaining component left from the contract would be the insurance component, which would be accounted for under IFRS 17.

Separation of Insurance Contract divides its content into four parts:

1. Insurance Component

The Insurance Component refers to elements of the insurance contract that focus on providing coverage. In simpler terms, it involves the sum insured designated to pay out when specified events occur as outlined in the policy document.

2. Embedded Derivatives

The Embedded Derivative component is less relevant to traditional non-life insurance as it involves derivative instruments created within insurance contracts that include investment elements. Examples include:

- Callable Bond (where the debtor can repay the principal at any time and cease interest payments immediately.)
- Interest Rate Swap (financial instruments requiring financial engineering knowledge, exchanging floating interest rates for fixed rates or vice versa.)
- Currency Swap (financial instruments exchanging one currency's interest rate for another.)

When applying the concept of Embedded Derivatives to insurance business, there are certain types of insurance products that may potentially involve them, such as:

- Guaranteed Minimum Benefits (GMXB) in life insurance, including various guarantees associated with investment-linked products like Unit Linked or Universal Life policies.
- Insurance policies where premiums collected are invested in one currency while the sum insured are denominated in a different currency. This scenario involves assets and liabilities in different currencies, akin to guaranteeing liabilities in a foreign currency different from the asset side.

These examples illustrate how Embedded Derivatives can be relevant within certain types of insurance contracts, particularly those with integrated investment components and currency exposure.

In this first topic, Embedded Derivatives are not significantly relevant to the context of non-life insurance but are more relevant to life insurance business. They are rarely seen in life insurance policies in Thailand as well. Therefore, if readers find Embedded Derivatives confusing or unclear, they can safely skip this section without affecting their understanding of non-life insurance business directly.

3. Investment Component

One area that many people tend to find confusing is the distinction of the Investment Component. This part is relevant to insurance business because insurers typically invest premiums to generate returns to meet future claim obligations, which is prominently observed in life insurance operations.

The Investment Component can be classified into two types:

- 3.1. **Distinct Investment Component:** This refers to investments that are clearly separated and visible, such as in Unit Linked insurance products where there is a Unit Account or Account Value that shows the investment's current worth and can be used to assess withdrawals. This aspect is typically not relevant to non-life insurance, except in cases where non-life insurance products are structured as Unit Linked policies (though this is rare).
- 3.2. **Non-distinct Investment Component:** This involves investments embedded within insurance contracts that is non-distinct (unable to measure one component without considering the other). These often include types where funds are returned to customers, such as Return of Premium (ROP) policies or Experience Refunds, which are considered part of the Non-distinct Investment Component (NDIC). This component resembles deposits where funds are held and later returned.

The key point is that the Distinct Investment Component will not fall under TFRS 17 but will be treated as financial instruments under TFRS 9 for financial reporting purposes. On the other hand, the Non-distinct Investment Component remains subject to TFRS 17.

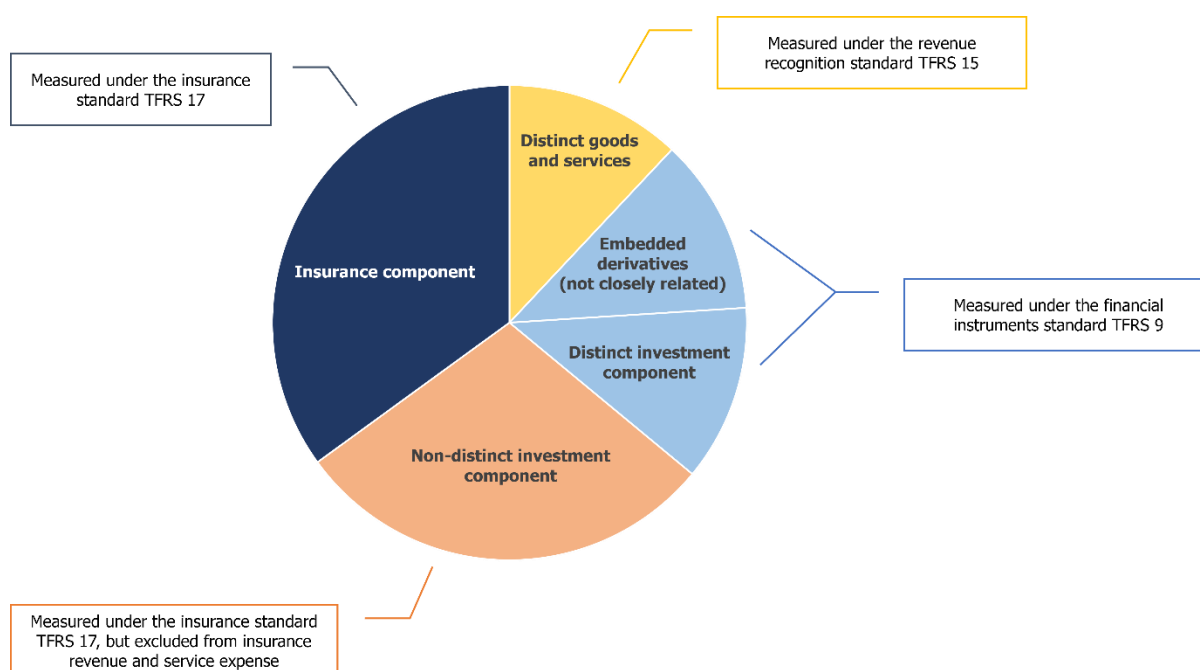
In interpreting this for the ease of insurance business operations, we can equate No Claim Bonus (NCB) to a straightforward insurance premium discount. These adjustments can simplify complexities without needing to categorize them as Non-distinct Investment Components.

Regarding life insurance (potentially also applicable to non-life insurance in the future), it involves types like Equity Index Linked or Gold Index Linked policies where the policy specifies payouts based on the performance of invested stocks or gold, respectively.

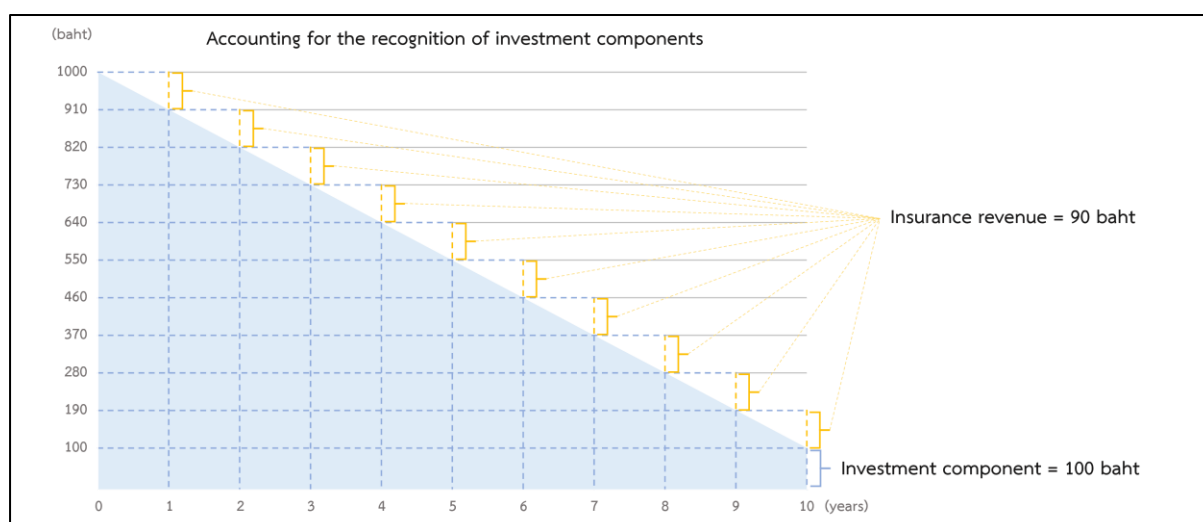
4. Promises to Transfer Goods or Non-Insurance Services

The final part of the first topic is Distinct Goods and Services (Promises to Transfer Goods or Non-Insurance Services), which falls under TFRS 15 and pertains to revenue recognition. This section typically involves supplementary services that accompany insurance premiums, such as additional medical services that are charged separately. However, such elements are rarely seen in the non-life insurance business, as additional charges for supplementary services are not commonly levied.

In summary, this first section outlines the standard's requirement to define the scope of the Insurance Contract. Apart from insurance components, there is a component that still relates to TFRS 17 which is Non-distinct Investment Components, however when presenting in financial position this item does not appear on the top line (Insurance Revenue and Service Expense).

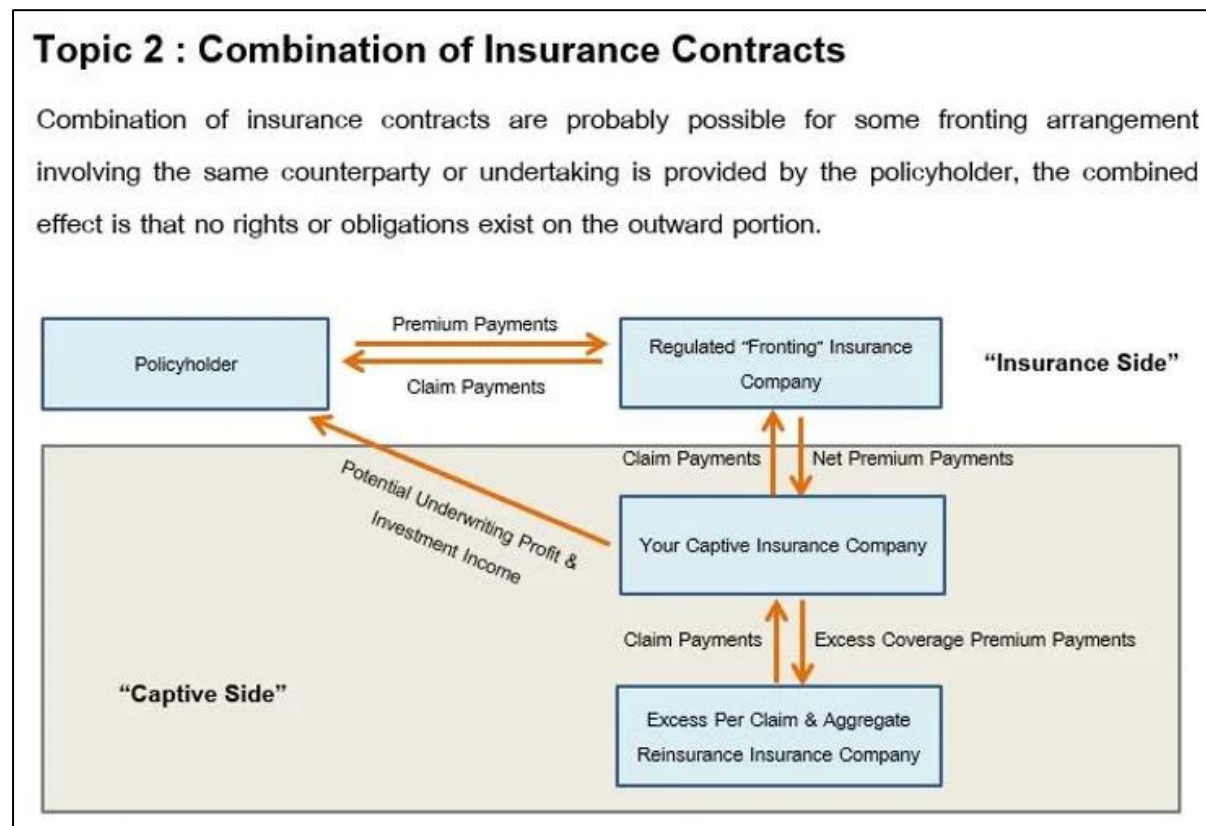


Let's consider an example of a Non-distinct Investment Component (NDIC) like Return of Premium (ROP) in life insurance. Suppose the insurance premium is 1,000 Baht paid upfront, and the contract duration is 10 years. At the end of the 10-year period, the Return of Premium is 100 Baht. In this example, the insurance company would recognize revenue annually, averaging 90 Baht per year (1,000 Baht minus 100 Baht return, divided by 10 years). Over the 10-year term, the total recognized revenue would amount to 900 Baht. This implies that the 100 Baht that is not recognized (Revenue recognized 900 Baht compared to the expected 1,000 Baht) will then be offset by the 100 Baht from return of premium.



Another important aspect of the Non-Distinct Investment Component (NDIC) to emphasize is that the 100 Baht from the Return of Premium (ROP), classified as NDIC, will not be recorded in the profit and loss statement. Instead, it will be fully reserved from the first day in the amount of 100 Baht. This reserve will remain until the ROP is actually paid to the beneficiary, at which point the reserve will be reduced to zero. It is important to note that from the start of reserving until the ROP is paid, this amount will not impact the profit and loss statement at all.

Topic 2: Combination of Contracts



Topic 2 is more critical to non-life insurance business than life insurance, with fronting business being slightly more emphasized. In this perspective, there are three stakeholders: a Policyholder Company (The company that buy insurance policies); a Fronting Company; and a Captive Insurance Company. These three companies can engage in a special form of transaction together that requires special attention and are brought for adjustment under TFRS 17.

This section focuses on addressing the issue of "shell game" transactions where the insurance company acts as a Fronting Company, receiving premiums and then passing them on, resulting in inflated sales figures.

This type of Fronting arrangement involves a Policyholder Company paying premiums to an insurance company acting as a Fronting Company. Subsequently, the Fronting Company passes on these premiums (potentially to another insurance company acting as the reinsurer).

Therefore, if an insurance company can engage in Fronting frequently, it can appear to inflate its sales figures significantly. For example, it might receive premiums amounting to 1,000 million baht but pass on 999 million baht as premiums to another entity.

For example, consider an insurance company operating under Thai law, which practices "Regulated Fronting." They receive insurance premiums totaling 100 million baht and subsequently transfer 99 million baht to another country in the form of Captive Insurance Premiums. Under the TFRS 17 accounting standard, only 1 million baht can be recorded as revenue for the company acting as the Fronting entity in Thailand. This restriction aims to prevent sales manipulation (known in financial terms as "Window Dressing").

This article emphasizes preventing Window Dressing, where sales figures appear artificially inflated beyond actual performance. This technique has been used by some international insurance companies to manipulate their insurance volume.

Specifically addressed by this second section, if the Policyholder company is the same counterparty or affiliated with the Captive insurance company, the standards mandate their Combination of insurance contracts. This means that revenue recognition must strictly adhere to net amounts only, prohibiting any form of sales puffery.

Furthermore, another instance where Combination is required is when the Policyholder company allows the Captive insurance company to undertake and act as underwriting company. This undertaking means the Policyholder company agrees that the Fronting company can pass through all liabilities and responsibilities to the Captive insurance company, effectively treating them as a single entity. In such cases as well, Combination is mandated under the standard.

In practice, only the underwriters at the Fronting company typically know whether transactions like these should be Combination or not. It can be difficult for others to discern, and if the Fronting company subtly manipulates endorsements or engages in deceptive practices, it might go undetected during audits. Hence, this section is highlighted as the second part to ensure that regulators and auditors can prevent sales manipulation.

In an exception, purchasing Excess of Loss (XOL) coverage does not necessarily require Combination because it is considered a routine operation under existing practices. Therefore, sales figures can be recorded without netting, reflecting actual volumes accurately.

In cases where the Policyholder company is the same as the Fronting company and the Captive insurance company, it often occurs that the Captive insurance company refunds money back to the Policyholder, resembling an experience refund. However, in practice, such refunds typically do not happen (due to tax

reasons involving double taxation), unless the Policyholder company incurs losses and requires capital injection from the Captive insurance company.

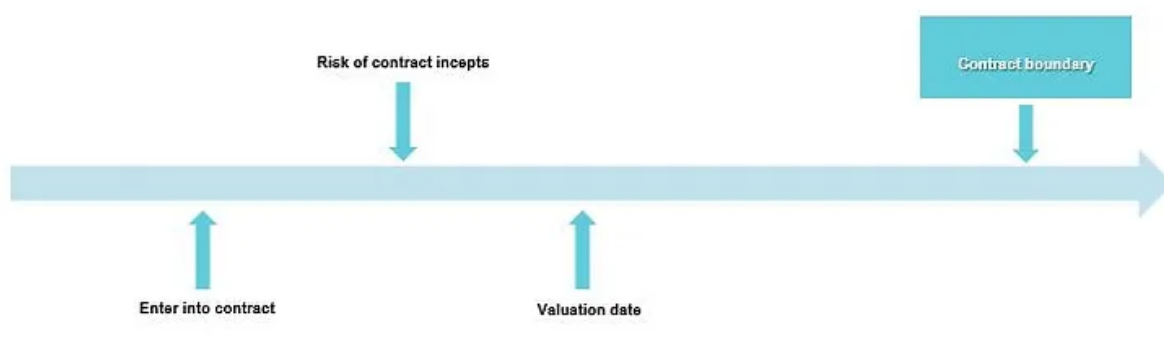
Another scenario involving Combination is when an insurance company undertakes a large project with sum insured exceeding its capacity (sometimes over tens of millions of baht). Unable to bear the risk alone, the company seeks co-insurance partners. This approach differs from traditional insurance in that the Policyholder company knows which companies are sharing the insurance coverage (unlike reinsurance, where the Policyholder company does not know who the insurer is). Consequently, the Policyholder company accounts for only the portion of the risk it assumes, rather than recording the entire sum of ten million (in the event that insurance company and the Policy company are the same party).

Topic 3: Contract boundary

This chapter will cover two key issues: one regarding **Coverage Period and Coverage Term**, and the other concerning **the recognition date for coverage or calculation**.

Topic 3 : Contract Boundary

Overall, the guidance notes consider various scopes of the contract boundary vis-a-vis current practices, we are aware of certain types of insurance, such as contractor all risk insurance and risk attaching reinsurance may be affected in its unearned premium reserve calculations and advance premium recognition.



1. The Coverage Period and Coverage Term

Coverage Term refers to the duration specified in the insurance contract, which can also be called the Legal Term. In contrast, Coverage Period refers to the duration defined under TFRS 17 standards, and it can also be referred to as the Accounting Term. The main emphasis is on interpreting the Coverage Period itself.

“In the insurance industry, it is possible to encounter a Coverage Period that exceeds the Coverage Term.”

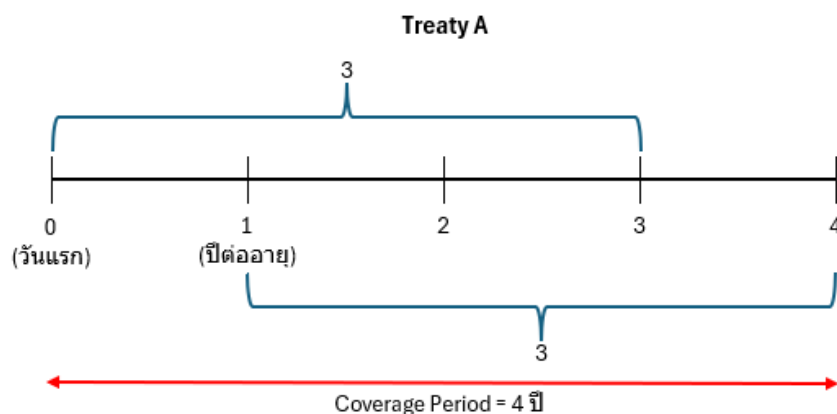
For example, in the Engineering sector, suppose the contract term is 3 years (indicating a Coverage Term of 3 years), but the Coverage Period could be 5 years. This is because there is an additional 2-year responsibility for extended warranty at the end, making the Coverage Period longer than the Coverage Term. Generally, most insurance contracts have a coverage period that is equal to the coverage term.

This Coverage Period determines the model used for calculation as follows:

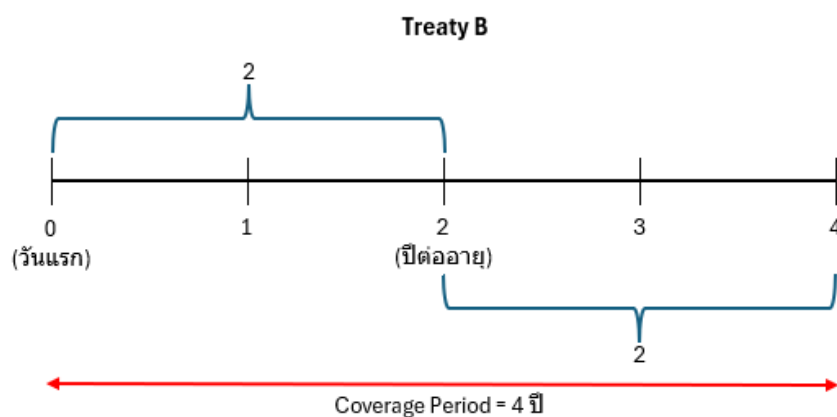
- If Coverage Period \leq 1 year, a simple calculation model can be applied (This is referred to as the PAA Method, which stands for Premium Allocation Approach).
- If Coverage Period $>$ 1 year, a PAA Eligibility Test must be conducted. If the test is passed, a simplified calculation model can be used. If the PAA Eligibility Test is not passed, then a general calculation model (GMM Approach, which stands for General Measurement Model) must be used, incorporating fulfillment cash flows (covered in subsequent sections), which aligns with the Coverage Period.

Another typical example is Single Premium insurance covering a 3-year period, where both the Coverage Term and Coverage Period are 3 years. In this scenario, the Coverage Period is greater than 1 year, but it may pass the PAA Eligibility Test and hence can use a simple calculation model (PAA Approach).

Another interesting point for insurance companies is the Coverage Period of risk attaching reinsurance (or facultative reinsurance). Typically, this Coverage Period is longer than that of the insurance policies received from the insurer, as these reinsurance contracts are structured as treaties rather than individual policies like those of non-life insurers. An example is provided in the image below,



- Treaty A is renewed annually, and the coverage period of the policy is 3 years. If we consider the length of the coverage period from the first day of coverage under the treaty until the end of the coverage period of the last policy issued before the treaty's renewal date, the coverage period of the treaty would be 4 years.



- Treaty B is renewed every 2 years, and the coverage period of the policy is 2 years. Thus, the coverage period of the treaty would also be 4 years, as shown in the image above.

In summary, reinsurance treaties do not operate on a policy-by-policy basis. They require allowance for run-off time, meaning if renewals occur annually, an additional year of run-off must be considered. Similarly, if renewals occur every 2 years, then 2 years of run-off time must be factored in. Therefore, reinsurers tend to lean towards using a general calculation model (GMM Approach) due to Coverage Periods exceeding 1 year.

2. The recognition date for coverage or calculation.

In this section, there are three key characters to understand. The first character is “Enter Into Contract.” The second character is “Risk of Contract Incepts”, and the final character is “Valuation Date”.

- Enter into Contract: The date premiums or funds are received.
- Risk of Contract Incepts: The date when coverage begins (if an incident occurs before this date, coverage does not apply).
- Valuation Date: The date used for assessment or evaluation.

Therefore, money received before the Risk of Contract Incepts (Enter Into Contract occurring before Risk of Contract Incepts) is referred to as Advance Premium. This concept was traditionally recognized as other liabilities before the adoption of TFRS 17, where it is now classified as insurance liabilities (differing from previous accounting items like Prepaid Premiums).

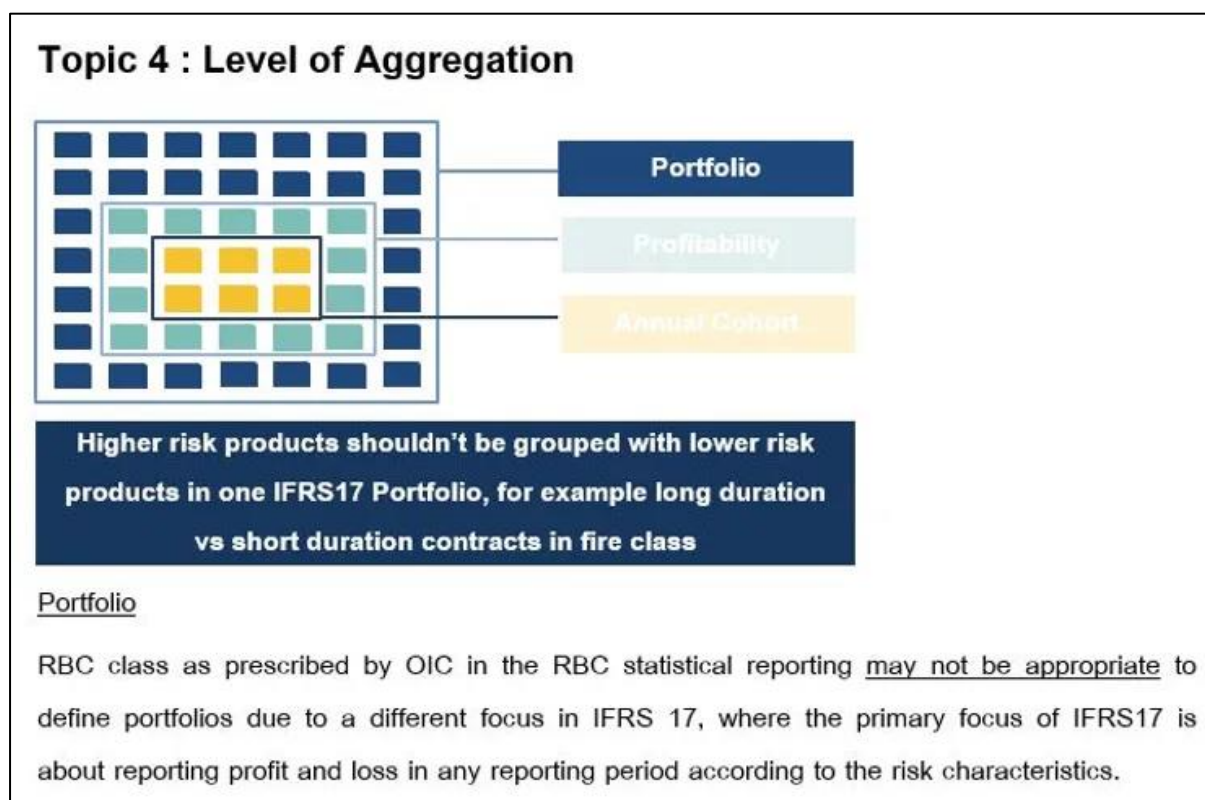
Additional examples and interpretations commonly observed are:

- If Enter into Contract coincides with Risk of Contract Incepts, it means coverage starts immediately upon premium payment.
- Valuation Date occurs after Risk of Contract Incepts, from which Unearned Premium Reserve (UPR) calculation begins.
- Policies paid after coverage begins (where Risk of Contract Incepts precedes Enter Into Contract) are akin to traditional principles, often referred to as Due Premiums.

In summary, this chapter discusses time periods and counting days as fundamental concepts. The critical aspect that will impact subsequent chapters is the interpretation of Coverage Period, influencing the choice of calculation models and financial reporting. This will be elaborated upon in relevant chapters specifically addressing these topics later on.

Topic 4: Level of Aggregation

In topic 4, the focus is on categorizing insurance types, specifically regarding the portfolio management under TFRS 17. The key requirement is that portfolios must be managed together and exhibit similar risk nature, such as short-term versus long-term durations, which should be distinctly separated.



Often, we observe that in other reporting frameworks, such as RBC in some countries, insurance types are grouped together based solely on "Manage Together" criteria without considering "Similar Risk Nature." This distinction highlights how TFRS 17 differs from RBC.

In practical terms, when categorizing insurance types under RBC versus TFRS 17, they should ideally align or at least TFRS 17, being a newer standard with extensive data requirements, should consider aligning its classification with RBC. This alignment would benefit database management and reduce undue operational burdens on the insurance sector.

A notable observation in the insurance industry is that classes such as Marine, Fire, and Engineering can span both short-term and long-term liabilities. However, under current RBC guidelines, these classes are categorized strictly under short-term liabilities. This simplifies calculations. TFRS 17 could similarly adopt

the principle of grouping classes according to RBC to streamline processes. For example, currently, insurance portfolios in the non-life insurance sector are grouped into 15 classes under RBC, and TFRS 17 could feasibly organize them into 15 portfolios following these classes.

Topic 4 : Level of Aggregation

TFRS 17 limits offsetting of cohorts and onerous contracts against profitable contracts

Cohort

The requirement could be translated in the following methods:

- Underwriting year (using policy effective date)
- Policy year (using premium due date or issue date)

Profitability

All assessments of profitability shall be identified and then measured at product level by cohort for general insurance.

The critical aspect is that each company must clearly explain whether each group Portfolio is managed together and possesses a similar risk nature or not.

In terms of financial reporting, for each Portfolio, we refer to it as the Unit of Account of Presentation. Ultimately, this resembles creating a mini financial statement consisting of Profit & Loss (P&L) and Balance Sheet for each Portfolio. However, we refrain from calling it a full Financial Statement. The complexity lies in that smaller companies may not have previously engaged in this type of reporting. To do so, they would need to establish income versus expenses and derive a bottom-line profit for each Portfolio.

Another detailed aspect of each Portfolio is what we call Cohort and Profitability, which can be analyzed together. We refer to this as the Unit of Account of Measurement.

The challenge lies in the past ability to assess how profitable a company would be based on its Portfolios, either collectively or individually. However, under TFRS 17, each insurance type must undergo testing before sale to determine whether the type to be sold will be profitable or not. If not profitable, it will be termed "Onerous" (as discussed later). This means TFRS 17 mandates detailed pricing and Profitability Tests for each type before sale. This is a significant issue that insurance companies in Thailand will need to seriously address, focusing more on Product Level (rather than just setting prices according to tariffs and selling them).

In TFRS 17, for grouping Cohorts, insurers have the option to consider either Underwriting Year or Policy Year. Typically, non-life insurers opt for Underwriting Year because they need to track transactions for Cohort grouping. Conversely, life insurance businesses often choose Policy Year for Cohort grouping.



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