Analysis of Arrangements Against Insurance-like Criteria: AASB 17 for Public Sector Entities

This paper analyses the characteristics of a number of illustrative example public sector arrangements against the criteria in paragraphs E13-E14 of the discussion paper (agenda paper 8.1).

Arrangement 1: Compulsory third party motor insurance provided by private sector insurers with regulated premiums

Fact pattern

This state requires motorists to acquire insurance that will pay for treatment and support services for people injured in transport accidents directly caused by the driving of a car, motorcycle, or other vehicle. Proof of insurance must be provided by motorists when they register their vehicles each year. The scheme operates on a 'no-fault' basis, which means that anyone injured in a transport accident within the state (or interstate if the vehicle is registered on the state) is eligible to receive support services, irrespective of who caused the crash.

Currently a small number of private sector insurers provide this type of insurance and their premiums are regulated so that each insurer charges a similar amount for policies of similar risks. The state does not have any obligation to fund shortfalls suffered by the private sector insurers.

Obligation created by statute versus contract

The need for insurance is prescribed under state legislation and the premiums are regulated. There is an element of voluntariness in that motorists can choose whether to drive and register their vehicles in the state (noting it is illegal to not register a vehicle or acquire the third-party insurance).

The nature of what motorists receive for purchasing third party insurance is not entirely clear at time of payment. Whilst owners of registered vehicles can research the basis of this insurance and what benefits it provides, this is not apparent at time of payment.

The existence of multiple insurers means that motorists can choose which private sector entity that they use. The price of insurance and benefits provided by the private sector insurers are similar but not identical.

Conclusion:

Despite the obligation being created under legislation, the existence of choice for the driver means that a contract is formed between the driver and the private sector insurance company, and the arrangement is contractual in nature.

Accordingly the arrangements are caught within AASB 17.

Arrangement 2: Compulsory third-party motor insurance provided by the ABC agency

Fact pattern

The ABC agency (ABC) pays for treatment and support services for people injured in transport accidents directly caused by the driving of a car, motorcycle, bus or train. ABC is funded by state motorists when they pay to register their vehicles each year, an amount payable to ABC being incorporated into the registration fee. The scheme operates on a 'no-fault' basis, which means that anyone injured in a transport accident within the state (or interstate if the vehicle is registered in the state) is eligible to receive support services, irrespective of who caused the crash.

ABC has not received any supplementary funding from the state.

Obligation created by statute versus contract

The following factors are relevant in determining whether ABC's obligations are contractual or statutory in nature.

The activities of ABC and the payment through the annual registration fee are prescribed under state legislation. There is an element of voluntariness in that motorists can choose whether to drive and register their vehicles in the state (noting it is illegal to not register a vehicle).

The nature of what motorists receive for paying the ABC charge is not entirely clear at time of payment. Whilst owners of registered vehicles can research the basis of the ABC arrangement and what benefits it provides, this is not fully apparent at time of payment. There is no ability to use any other entity to provide the services.

Conclusion

There is a lack of specific intention on behalf of both parties to enter a contract, a lack of market choice and accordingly voluntariness required to enter a contract. The arrangement's obligations are statutory in nature.

For the purpose of AASB 17:

- the insurance risk is the cost of rehabilitation and compensation for loss of earnings from those injured in motor vehicle accidents that would otherwise be the responsibility of the drivers,
- ABC is identified as the issuer as it is the entity that has accepted the insurance risk,
- policyholders are the drivers who have transferred insurance risk to the scheme
- premium is the registration charge.

To be within the scope of AASB 17, statutory arrangements are further assessed to determine if they are 'insurance like'.

Criteria (summary)	**Comments**
Mandatory Criteria	
a) The arrangement has commercial substance.	Criteria met – in the event of the insured event occurring, it is possible that ABC will incur a loss on a present value basis in respect of an individual vehicle.
b) The arrangement cannot be altered without a specific change in legislation and cannot be retrospectively amended.	Criteria met – the arrangement is established by state legislation and the benefits are specified in that legislation.
c) The arrangement provides the beneficiaries enforceable rights in the event that the insured	Criteria met – ABC provides an injured party with a right to have decisions reviewed.

event occurs.	
Funding	
d) The legislation or other measure governing the arrangement provides for the scheme to be funded by premiums, contributions by the government or other public sector entities, or levies paid by or on behalf of either the potential beneficiaries or those whose activities create or exacerbate the risks.	Criteria met – ABC requires the owner of each registered vehicle to pay a 'charge'. The operation of these vehicles is the usual cause of motor accidents and hence the creation of the insurance risk.
e) The entity reviews (and, where necessary, adjusts) revenue (which may be in the form of premium, contributions by the government or other public sector entities, or levies) and/or benefits provided on a periodic basis, with the aim that the arrangement is substantially self-funded.	Criteria partially met – ABC's financial position is reviewed periodically but the linkage to adjustment to premium where deficits are identified are opaque and subject to economic, political or other imperatives not to increase costs to motorists.
Management of claims	
f) The entity assesses its financial performance and financial position on a regular basis, uses actuarial assumptions, reports internally and/or externally on the financial performance of the scheme, and, where necessary, takes action to address any underfunding of the scheme.	Criteria met – ABC undertakes actuarial analysis to estimate claim liabilities and funding levels and has a capital management strategy to achieve its target funding level. ABC prepares annual general purpose financial reports.
Similar arrangements in the public sector	
g) Transactions or arrangements with similar characteristics are entered into by for-profit entities and accounted for as insurance contracts.	Criteria met – similar insurance is provided by private sector insurers in other states.
Separate assets and liabilities	
h) The assets and liabilities arising from the arrangements are held in a separate fund, or otherwise specifically identified as used solely to provide benefits to participants.	Criteria met – legislation requires ABC to establish a separate fund to hold monies collected and make payments in accordance with that legislation.
i) A separate entity has been established by the government.	Criteria met – legislation establishes ABC as a statutory corporation.

Conclusion

ABC generates insurance risk as a result of statute requirements and operates an 'insurance-like' arrangement included within the scope of AASB 17.

Arrangement 3: Life Care scheme operated by the DEF authority

Fact pattern

The DEF Authority (DEF) provides lifelong treatment, rehabilitation and care services to people catastrophically injured in a motor vehicle accident in the state, regardless of who was at fault. CTP insurance (provided by private sector entities) provides cover for third parties who suffer less serious injuries as a result of motor accidents.

DEF is funded by a levy paid by motorists when they purchase CTP insurance. The amount of the levy is determined by a different public sector entity to the entity that accepts insurance risk (DEF). DEF is not obligated to fund any shortfall incurred by the private sector entities for the CTP element.

Obligations created under statute versus contract

DEF is prescribed under state legislation. There is an element of voluntariness in that state residents can choose whether to own and register their vehicle but having decided to register a vehicle, they have no option other than to pay the DEF levy.

The nature of what motorists receive for paying DEF levies is somewhat unclear at time of payment (different private sector insurers may have different disclosure of what the scheme does).

Given the largely involuntary payment for DEF and limited disclosure of what it entails, it is not likely that a contract is formed and the arrangement is more likely to be statutory in nature.

Conclusion

The CTP element of the transaction is of a contractual nature as there is market choice and voluntariness of entry into the transaction.

However, with regard to the registration fee paid to DEF, there is a lack of specific intention on behalf of both parties to enter a contract, a lack of market choice and accordingly voluntariness required to enter a contract. The arrangement's obligations are statutory in nature.

For the purpose of AASB 17:

- the insurance risk is the cost of rehabilitation and compensation for loss of earnings from those injured in motor vehicle accidents that would otherwise be the responsibility of the drivers,
- DEF is identified as the issuer as it is the entity that has accepted the insurance risk,
- policyholders are the drivers who have transferred insurance risk to the scheme
- premium is the registration charge.

To be within the scope of AASB 17, statutory arrangements are further assessed to determine if they are 'insurance like'.

Nature of arrangement	
Criteria (summary)	**Comments**
Mandatory criteria	
a) The arrangement has commercial substance.	Criteria met – in the event of the insured event occurring, it is possible that DEF will incur a loss on a

	present value basis in respect of an individual vehicle.
b) The arrangement cannot be altered without a specific change in legislation and cannot be retrospectively amended.	Criteria met – the arrangement is established by state legislation and the benefits are specified in the legislation.
c) The arrangement provides the beneficiaries enforceable rights in the event that the insured event occurs.	Criteria met – the legislation provides an injured party with right to have decisions reviewed.
Funding	
d) The legislation or other measure governing the arrangement provides for the scheme to be funded by premiums, contributions by the government or other public sector entities, or levies paid by or on behalf of either the potential beneficiaries or those whose activities create or exacerbate the risks.	Criteria met – DEF requires CTP insurers to collect a levy from each CTP policyholder prior to issuing a CTP policy. The amount of the levy is determined by a separate public sector entity that regulates the DEF arrangement. The operation of vehicles is a usual cause of motor accidents and hence the source of the insurance risk.
e) The entity reviews (and, where necessary, adjusts) revenue (which may be in the form of premium, contributions by the government or other public sector entities, or levies) and/or benefits provided on a periodic basis, with the aim that the arrangement is substantially self-funded.	Criteria met – the legislation requires DEF to determine "the amount required to fully fund" its liabilities and the regulator determines the levy that will result in the collection of an amount that fully funds DEF.
Management of claims	
f) The entity assesses its financial performance and financial position on a regular basis, uses actuarial assumptions, reports internally and/or externally on the financial performance of the scheme, and, where necessary, takes action to address any underfunding of the scheme..	Criteria met – DEF undertakes actuarial analysis to estimate liabilities for participants' care and support services and has risk management policies to manage funding levels. DEF prepares annual general purpose financial reports.
Similar arrangements in the public sector	
g) Transactions or arrangements with similar characteristics are entered into by for-profit entities and accounted for as insurance contracts.	Criteria met – cover provided under DEF was previously provided by CTP insurance policies issued by private sector insurers in the state.
Separate assets and liabilities	
h) The assets and liabilities arising from the arrangements are held in a separate fund, or otherwise specifically identified as used solely to provide benefits to participants.	Criteria met – the legislation requires DEF to establish a separate fund to hold levies collected and make payments in accordance with it.
i) A separate entity has been established by the government.	Criteria met – the legislation establishes DEF as a statutory body.

Conclusion

DEF generates insurance risk as a result of statute requirements and operates an 'insurance-like' arrangement included within the scope of AASB 17.

Arrangement 4: Universal health care operated by federal department 'GHI'

Fact pattern

GHI provides universal health care that enables those eligible to access cost effective medical, optometry and hospital care and, in some circumstances, other allied health services at no cost.

Obligations created under statute versus contract

GHI operates under federal legislation. All taxpayers are charged a levy of a fixed percentage of taxable income.

The only voluntary aspect is the option to opt out of public health services and pay for additional private cover. Payment of taxes that fund the arrangement is not voluntary. There is no alternative market provider at the same premium level.

Conclusion:

There is no reciprocal intention to create legal relations that is voluntarily undertaken. Accordingly, a contract is not formed and the arrangement is statutory in nature.

For the purpose of AASB 17:

- the insurance risk is the cost of treating the illness of all those eligible under the registration,
- GHI is identified as the issuer as it is the entity that has accepted the insurance risk,
- policyholders are those eligible under the scheme who have transferred insurance risk to the scheme
- premium is the levy.

To be within the scope of AASB 17, statutory arrangements are further assessed to determine if they are 'insurance like'.

Nature of arrangement	
Criteria (summary)	**Comments**
Mandatory criteria	
a) The arrangement has commercial substance.	Criteria met – in the event of the insured event (sickness or injury) occurring, it is possible that GHI will incur a loss on a present value basis in respect of an individual.
b) The arrangement cannot be altered without a specific change in legislation and cannot be retrospectively amended.	Criteria met – Commonwealth legislation establishes eligibility to receive benefits in respect of medical expenses
c) The arrangement provides the beneficiaries enforceable rights in the event that the insured event occurs.	Criteria met – legislation provides an individual with the right to have decisions reviewed.
Funding	

d) The legislation or other measure governing the arrangement provides for the scheme to be funded by premiums, contributions by the government or other public sector entities, or levies paid by or on behalf of either the potential beneficiaries or those whose activities create or exacerbate the risks.	Criteria not met – GHI is funded by Government appropriation rather than by those that are the potential beneficiaries or those that create or exacerbate the risk. GHI will provide benefits in respect of pre-existing conditions which is less likely to meet definition of insurance risk.[1]
e) The entity reviews (and, where necessary, adjusts) revenue (which may be in the form of premium, contributions by the government or other public sector entities, or levies) and/or benefits provided on a periodic basis, with the aim that the arrangement is substantially self-funded.	Criteria not met – GHI funding not addressed in the Department's annual report and an assessment of liabilities is not performed. The funding is not provided by those that create or exacerbate the risk.
Management of claims	
f) The entity assesses its financial performance and financial position on a regular basis, uses actuarial assumptions, reports internally and/or externally on the financial performance of the scheme, and, where necessary, takes action to address any underfunding of the scheme..	Criteria not met – the Department prepares annual general purpose financial reports but GHI transactions are not separately identified. The obligations of the scheme are not valued using analysis of past and assumptions as to future experience (such as actuarial analysis), and not reported internally or externally.
Similar arrangements in the public sector	
g) Transactions or arrangements with similar characteristics are entered into by for-profit entities and accounted for as insurance contracts.	Criteria partially met – similar benefits are provided by for-profit entities that issue insurance contracts but not usually in respect of pre-existing conditions.
Separate assets and liabilties	
h) The assets and liabilities arising from the arrangements are held in a separate fund, or otherwise specifically identified as used solely to provide benefits to participants.	Criteria not met – GHI is delivered by the Department and the relevant assets and liabilities are not held in a separate fund.
i) A separate entity has been established by the government.	Criteria not met – GHI is delivered by the Department and the relevant assets and liabilities are not held in a separate fund.

Conclusion

GHI is not an 'insurance-like' arrangement. Despite the benefits provided under GHI meeting a number of the criteria, the substance of the arrangement is not similar to insurance and it is not managed on an insurance like basis with actuarial assessments of the costs of the cover being provided. In addition, GHI activities are mingled with the other activities of the department and the activities are not fully funded.

1 AASB17.B5 notes that some insurance contracts cover events that have already occurred but he financial effect of which is still uncertain, the determination of the ultimate cost being the insured event. In the case of Medicare, it is inappropriate to apply this guidance as the funding does not appear to take account of the expected ultimate cost.

Arrangement 5: Disability Services provided by JKL agency

Fact pattern

JKL provides funding and support for people with disabilities. Participation is available to people under 65 years of age with significant and permanent disability who meet residency requirements. Participants develop plans that meet their support needs and services, that are provided by third parties and paid for by JKL. There is a set amount payable to JKL per person that is eligible under the legislation, which is periodically altered. The premium payable to JKL does not depend on specific services being provided to the beneficiaries. The beneficiary identifies the services they require to be funded by the levy. JKL does not have a right to veto the decision as to services provided to the beneficiary.

Obligations created under statute versus contract

JKL operates under federal legislation and receives government funding from consolidated revenue.

The only voluntary aspect is the option to opt out of public health services and pay for additional private cover. Payment of taxes that fund the arrangement is not voluntary. There is no alternative market provider at the same premium level.

Conclusion:

There is no reciprocal intention to create legal relations that is voluntarily undertaken. Accordingly, a contract is not formed and the arrangement is statutory in nature.

For the purpose of AASB 17:

- the insurance risk is the cost of treating the illness of all those eligible under the legislation,
- JKL is identified as the issuer as it is the entity that has accepted the insurance risk,
- policyholders are those eligible under the scheme who have transferred insurance risk to the scheme
- premium is the levy.

To be within the scope of AASB 17, statutory arrangements are further assessed to determine if they are 'insurance like'.

Criteria (summary)	**Comments**
Mandatory criteria	
a) The arrangement has commercial substance.	Criteria may be met – The requirement for a person to have a disability in order to be a participant means the arrangement provides benefits in respect of past events rather than uncertain future events, however, when a disability arises from a future event, it is possible that JKL will incur a loss on a present value basis in respect of an individual.
b) The arrangement cannot be altered without a specific change in legislation and cannot be retrospectively amended.	Criteria met – legislation establishes eligibility to receive support in respect of disabilities.
c) The arrangement provides the beneficiaries enforceable rights in the event that the insured event occurs.	Criteria met – legislation provides an individual with the right to have decisions reviewed.

Funding	
d) The legislation or other measure governing the arrangement provides for the scheme to be funded by premiums, contributions by the government or other public sector entities, or levies paid by or on behalf of either the potential beneficiaries or those whose activities create or exacerbate the risks.	Criteria may be met –JKL is funded by a combination of cash and in-kind contributions agreed between Commonwealth, state and territory governments. Whilst there is little linkage with the potential beneficiaries or those who create or exacerbate the risks, actuarial assessments as to the funding of the scheme do occur. Inadequate funding of JKL's future needs to meet existing commitments does not prevent the scheme from being 'insurance-like'. The availability of support to those with pre-existing conditions may mean that insurance risk is not transferred in every case.
e) The entity reviews (and, where necessary, adjusts) revenue (which may be in the form of premium, contributions by the government or other public sector entities, or levies) and/or benefits provided on a periodic basis, with the aim that the arrangement is substantially self-funded.	Criteria met –the risks to funding are addressed in the annual report which notes the continued existence of the arrangement is dependent on Government policy and agreements with states and territories. Funding is provided to JKL on a cash needs basis rather than ensuring sufficient assets are held to meet all obligations to current scheme participants.
Management of claims	
f) The entity assesses its financial performance and financial position on a regular basis, uses actuarial assumptions, reports internally and/or externally on the financial performance of the scheme, and, where necessary, takes action to address any underfunding of the scheme.	Criteria met – JKL undertakes actuarial assessments of current and future expenditure to support those with disabilities as well as identifying and managing financial risks and issues relevant to the financial sustainability of JKL from the perspective of having sufficient financial resources to be able to make cash payments as debts fall due. General Purpose financial report prepared for the JKL.
Similar arrangements in the public sector	
g) Transactions or arrangements with similar characteristics are entered into by for-profit entities and accounted for as insurance contracts.	Criteria not met – coverage for people with pre-existing conditions is usually excluded from insurance contracts.
Separate assets and liabilities	
h) The assets and liabilities arising from the arrangements are held in a separate fund, or otherwise specifically identified as used solely to provide benefits to participants.	Criteria met – assets and liabilities are held by a dedicated entity.
i) A separate entity has been established by the government.	Criteria met – JKL is delivered by the JKL agency.

In addition, JKL assesses whether the service received by the beneficiaries are effectively outsourced services received by the government (payments are outsourced through the beneficiary), as the government would otherwise have had to pay for those services. As the services to be provided are determined by the beneficiary and not the government, the government is not receiving outsourced services.

Conclusion

JKL generates insurance risk as a result of statute requirements and operates an 'insurance-like' arrangement included within the scope of AASB 17, despite the benefits not being fully funded by the beneficiaries.

Arrangement 6: Workers Insurance delivered by the MNO agency

Fact pattern

The MNO agency accepts insurance risk from state employers by covering the costs associated with supporting an injured worker after a workplace injury or illness. Employers are obliged to obtain workers insurance under state legislation.

MNO outsources the distribution, some underwriting and claims management activities to private sector insurers who are paid a fee to deliver these services.

Obligation created by statute versus contract

MNO operates under state legislation.

Employers are required to purchase workers insurance.

An insurance policy is issued by MNO however employers are compelled to acquire this insurance and, despite the policies being distributed by private sector insurers, employers have no choice as to who underwrites the insurance.

Conclusion:

The lack of choice available to employers means it is unlikely that there is an insurance contract and the arrangement is statutory in nature.

For the purpose of AASB 17:

- the insurance risk is the employer costs[2] in the event an employee is injured,
- MNO is identified as the issuer as it is the entity that has accepted the insurance risk,
- policyholders are those employers eligible under the scheme who have transferred insurance risk to the scheme
- premium is the levy.

To be within the scope of AASB 17, statutory arrangements are further assessed to determine if they are 'insurance like'.

Criteria (summary)	Comments
Mandatory criteria	
a) The arrangement has commercial substance.	Criteria met – in the event of the insured event occurring, it is possible that MNO will incur a loss on a present value basis in respect of an individual

2 Such costs may include medical expenses, weekly and lump sum compensation payments.

	employer.
b) The arrangement cannot be altered without a specific change in legislation and cannot be retrospectively amended.	Criteria met – the arrangement is established by state legislation and the benefits are specified in it.
c) The arrangement provides the beneficiaries enforceable rights in the event that the insured event occurs.	Criteria met – legislation provides an injured worker with right to have decisions reviewed.
Funding	
d) The legislation or other measure governing the arrangement provides for the scheme to be funded by premiums, contributions by the government or other public sector entities, or levies paid by or on behalf of either the potential beneficiaries or those whose activities create or exacerbate the risks.	Criteria met – legislation requires each employer to pay a 'premium'. The employment of people exposes the employees to risk of injury in the workplace and hence the creation of the insurance risk.
e) The entity reviews (and, where necessary, adjusts) revenue (which may be in the form of premium, contributions by the government or other public sector entities, or levies) and/or benefits provided on a periodic basis, with the aim that the arrangement is substantially self-funded.	Criteria met – MNO undertakes regular actuarial assessments of its funding. Whilst premiums may not respond immediately to the need for change (due to commercial, economic or other factors) the intention is for the scheme to be appropriately funded.
Management of claims	
f) The entity assesses its financial performance and financial position on a regular basis, uses actuarial assumptions, reports internally and/or externally on the financial performance of the scheme, and, where necessary, takes action to address any underfunding of the scheme.	Criteria met – MNO undertakes actuarial assessment of claims liabilities as well as ability to influence claim outcomes and future premiums. MNO prepares annual general purpose financial reports.
Similar arrangements in the public sector	
g) Transactions or arrangements with similar characteristics are entered into by for-profit entities and accounted for as insurance contracts.	Criteria met – workers insurance is provided by private sector insurers in other states.
Separate assets and liabilities	
h) The assets and liabilities arising from the arrangements are held in a separate fund, or otherwise specifically identified as used solely to provide benefits to participants.	Criteria met – legislation requires MNO to establish a separate fund to hold premiums and make payments in accordance with it.
i) A separate entity has been established by the government.	Criteria met – legislation establishes MNO as a statutory corporation.

Conclusion

MNO generates insurance risk as a result of statute requirements and operates an 'insurance-like' arrangement included within the scope of AASB 17,