EITF ABSTRACTS

Issue No. 03-8

Title: Accounting for Claims-Made Insurance and Retroactive Insurance Contracts by the Insured Entity

Dates Discussed: March 13–14, 1986; May 1, 1986; July 24, 1986; May 19–20, 1999; May 15, 2003; July 31, 2003; November 12–13, 2003

References: FASB Statement No. 5, *Accounting for Contingencies*
FASB Statement No. 113, *Accounting and Reporting for Reinsurance of Short-Duration and Long-Duration Contracts*
FASB Interpretation No. 14, *Reasonable Estimation of the Amount of a Loss*
FASB Interpretation No. 39, *Offsetting of Amounts Related to Certain Contracts*
AICPA Statement of Position 96-1, *Environmental Remediation Liabilities*
AICPA Statement of Position 98-7, *Deposit Accounting: Accounting for Insurance and Reinsurance Contracts That Do Not Transfer Insurance Risk*
AICPA Audit and Accounting Guide, *Health Care Organizations*

ISSUE

1. The purpose of this Issue is to codify and reconcile the guidance contained in the following Issues, which address the accounting by the insured entity for claims-made insurance and retroactive insurance contracts:

- Issue No. 86-12, "Accounting by Insureds for Claims-Made Insurance Policies"
- Issue No. 03-3, "Applicability of Topic No. D-79 to Claims-Made Insurance Policies"
- Topic No. D-79, "Accounting for Retroactive Insurance Contracts Purchased by Entities Other Than Insurance Enterprises."

This Issue does not apply to reinsurance transactions.

2. Many entities use claims-made policies to satisfy their insurance needs for such coverage as product, directors and officers (D&O), and malpractice liabilities. However,

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in recent years entities have been purchasing coverage for a variety of other exposures using a claims-made format. Under a claims-made insurance policy, an entity is insured for any claims reported during the term of the policy, in many cases including those that occurred prior to the policy effective date, but after the specified retroactive date.

3. Generally, entities purchasing a claims-made policy will renew the policy each year. The amount of coverage purchased may change over time to meet current needs (for example, changing risk within the entity) or to respond to the overall environment (for example, the expected settlement costs of the same claim today may cost more than in prior years). When operations cease, the entity generally purchases tail coverage to insure itself against any previously unasserted claims. Presuming the entity can renew the claims-made policy each year and can obtain tail coverage when desired, such a strategy effectively converts the claims-made policy into an occurrence-based policy covering the entity for any claim made against it. Entities generally use claims-made coverage because it is the only form of insurance available for certain exposures, particularly exposures for which the occurrence dates may be difficult to determine or for which the occurrence may span a long period of time. Therefore, a claims-made policy mitigates potential coverage disputes because the occurrence date generally is not relevant to the determination of coverage. Also, there may be reduced insurance costs in the first several years of a claims-made policy as compared to an occurrence-based policy. Many entities that purchase claims-made insurance policies have no knowledge of unasserted outstanding claims or, because their liabilities have not met the recognition criteria contained in Statement 5 or in other applicable U.S. GAAP, have no recognized

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liability for claims, including incurred but not reported (IBNR)[1] claims. In other situations, however, entities that purchase claims-made insurance policies are aware of potential claims based on a specific incident(s) or historical experience. In those situations, unasserted claims can be either specifically excluded from or specifically included in the coverage.

4. The issues are:

Issue 1—How an insured entity, including an insurance entity purchasing insurance unrelated to its core insurance operations, (for example, manufacturing concerns, retailers, service entities, and financial institutions) should account for a purchased retroactive insurance policy and whether the transaction results in gain recognition (excluding reinsurance transactions). For example, a company records a liability of $100 million incurred as a result of a past event in accordance with Statement 5. The company then buys an insurance policy for $60 million to cover that liability.

Issue 2—Whether a claims-made insurance policy represents a purchased retroactive insurance contract subject to the consensus in Issue 1.

Issue 3(a)—Whether an insured entity should recognize a liability at the balance sheet date for IBNR claims.

Issue 3(b)—If the probable losses from IBNR claims and incidents cannot be reasonably estimated, whether a liability may be accrued based on the estimated cost of

[1]Paragraphs 8.05 through 8.12 of the health care organizations Guide provides further guidance on the

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purchasing "tail" coverage, which would insure the entity for events that occur during the claims-made policy period but are not reported to the insurance carrier in that period.

Issue 4(a)—In situations in which an entity's fiscal year and policy term coincide and the contract is prospective, the appropriate accounting for both (a) the IBNR liability in subsequent periods when the entity purchases another claims-made insurance policy that, in part, covers a portion of the losses included in the IBNR liability and (b) the premiums for that subsequent claims-made insurance policy.

Issue 4(b)—The accounting ramifications on the consensus reached in Issue 4(a) of having a prospective claims-made policy term that does not coincide with the enterprise's fiscal year.

Issue 5—Disclosures that should be made by companies insured under claims-made policies.

EITF DISCUSSION

Issue 1—How an insured entity, including an insurance entity purchasing insurance unrelated to its core insurance operations, (for example, manufacturing concerns, retailers, service entities, and financial institutions) should account for a purchased retroactive insurance policy and whether the transaction results in gain recognition (excluding reinsurance transactions). For example, a company records a liability of $100 million incurred as a result of a past event in accordance with Statement 5. The company then buys an insurance policy for $60 million to cover that liability.

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recognition of a liability for claims incurred but not reported.

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5. The scope of Issue 1 is limited to retroactive insurance contracts that (a) do not legally extinguish the entity's liability, (b) meet the indemnification against loss or liability conditions of Statement 5, (c) provide indemnification against loss or liability relating to liabilities that have been incurred as a result of a past event (for example, environmental remediation liabilities),[2] and (d) are not reinsurance transactions. The Task Force observed that paragraph 44 of Statement 5 requires that an enterprise determine whether insurance risk has been transferred through an insurance contract; entities may find the conditions in Statement 113 useful in assessing whether an insurance contract transfers risk.

6. Statement 113 specifies the accounting by insurance enterprises for reinsurance contracts. Reinsurance contracts that do not meet the conditions for reinsurance accounting under Statement 113 are to be accounted for as deposits.[3] The Task Force observed that Appendix C of Statement 113 defines retroactive reinsurance as follows:

> Reinsurance in which an assuming enterprise agrees to reimburse a ceding enterprise for liabilities incurred as a result of past insurable events covered under contracts subject to the reinsurance.

7. Notwithstanding that Statement 113 applies only to insurance enterprises, the Task Force reached a consensus that purchased retroactive insurance contracts that indemnify

[2]SOP 96-1 provides accounting guidance for environmental remediation liabilities within its scope. The SOP provides that the amount of an environmental remediation liability should be determined independently from any potential claim for recovery and that an asset relating to the recovery should be recognized only when realization of the claim for recovery is deemed probable. Fair value should be used to measure the amount of a potential recovery. The concept of fair value requires consideration of both transaction costs related to the receipt of the recovery and the time value of money. However, the time value of money should not be considered in the determination of the recorded amount of a potential recovery if (a) the liability is not discounted and (b) the timing of the recovery is dependent on the timing of the payment of the liability. The SOP does not address the accounting for the purchase of retroactive insurance contracts.

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the insured should be accounted for in a manner similar to the manner in which retroactive reinsurance contracts are accounted for under Statement 113. The guidance in paragraphs 22–25 of Statement 113 should be applied, as appropriate, based on the facts and circumstances of the particular transaction. That is, amounts paid for retroactive insurance should be expensed immediately. Simultaneously, a receivable should be established for the expected recoveries related to the underlying insured event. If the receivable established exceeds the amounts paid for the insurance, the resulting gain is deferred. If the amounts and timing of the insurance recoveries can be reasonably estimated, the deferred gain should be amortized using the interest method over the estimated period over which the entity expects to recover substantially all amounts due under the terms of the insurance contract. If the amounts and timing of the insurance recoveries cannot be reasonably estimated, then the proportion of actual recoveries to total estimated recoveries should be used to determine the amount of the amortization. Immediate gain recognition and liability derecognition are not appropriate because the liability has not been extinguished (the entity is not entirely relieved of its obligation). Additionally, the Task Force observed that the liability incurred as a result of a past insurable event and amounts receivable under the insurance contract do not meet the criteria for offsetting under Interpretation 39.

8. The Task Force observed that if the purchased insurance contract includes coverage for legal and other costs, the accounting for legal and other costs should be consistent between the asset and the liability. That is, if the entity's accounting policy is to accrue

[3]SOP 98-7 provides guidance on how to account for insurance and reinsurance contracts that do not transfer insurance risk.

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for those costs, then the insurance receivable also should reflect those costs if they are covered under the terms of the insurance policy. If an entity's accounting policy is not to accrue for those costs, then the insurance receivable should not reflect those costs on an accrual basis.

Issue 2—Whether a claims-made insurance policy represents a purchased retroactive insurance contract subject to the consensus in Issue 1.

9. The Task Force reached a consensus that a claims-made insurance policy contains a retroactive provision if it provides coverage for specific, known claims that were reportable[4] prior to the policy period. If a claims-made insurance policy contains a retroactive provision, the retroactive and prospective provisions of the policy should be accounted for separately, if practicable. If it is not practicable to separate the retroactive and prospective provisions, the claims-made insurance policy should be accounted for entirely as a retroactive contract in accordance with paragraphs 22–25 of Statement 113. A claims-made insurance policy that contains no retroactive provisions should be accounted for on a prospective basis as described in the consensuses reached in Issues 4(a) and 4(b).

10. The Task Force observed that paragraph 95 of Statement 113 states that "in claims-made insurance, the insured event is the reporting to the insurer, within the period

[4]The phrase *specific, known claims that were reportable* (by the insured entity to the insurance carrier) would encompass asserted claims, known unasserted claims, and any known previous event or circumstance that might result in a specific claim (whether asserted or unasserted), regardless of whether the insured has recognized a loss contingency for those claims. Such claims include those claims that were not reported by the insured to the insurance carrier, but would have been reportable to the carrier had a claims-made policy been in place in a prior period. A recognized liability for claims for losses related to events that the insured is not specifically aware of but expects to be reported to the insurance carrier (IBNR) (and, therefore, are not yet reportable), generally would not be determinative in concluding that the claims-made insurance policy contains a retroactive provision.

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specified by the policy, of a claim for a loss covered by the insurance contract." Accordingly, a prospective claims-made insurance policy only covers claims for losses reportable to the insurer during the policy term. A retroactive provision provides coverage for known claims, for which the underlying event had occurred and the incident would have been reportable prior to the effective date of the claims-made policy. The Task Force noted that a recognized liability for IBNR claims generally would not be determinative in concluding that a claims-made insurance policy either does or does not contain a retroactive provision.

11. In reaching its consensus, the Task Force also noted that all relevant facts and circumstances should be considered in evaluating whether a claims-made policy contains a retroactive provision. The Task Force provided the following indicators that a claims-made insurance policy does not contain a retroactive provision (that is, it is not providing coverage for previously reportable claims) and, therefore, should be accounted for on a prospective basis. No one indicator is determinative in this evaluation; the determination must be made upon the specific facts and circumstances:

a. The insured consistently purchases claims-made insurance policies as part of its risk management program for the specific type of risk being insured, and tail coverage for both prior periods and prior policies is readily available and not excessively priced as compared to tail coverage offered to similar companies, that do not contain retroactive provisions.
b. The claims-made insurance policy is responsive to unknown risks for a finite or limited period of time, as evidenced by the fact that (1) the type of risk being insured is inherently short-tailed, that is, the claims are incurred during the policy period and paid out in their entirety shortly after the end of the policy period, (2) the policy term is for a limited period of time (for example, one-year coverage), (3) claims-made coverage is the most readily available coverage for this type of insurance risk, and (4) the occurrence date of the

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type of risk covered by the policy is unclear (that is, the causal event that gives rise to an insured claim is difficult to determine).[5]

c. The claims-made insurance policy contains an unambiguous trigger indicating that a claim is covered by the policy. That contract trigger should not be subject to interpretation, negotiation, or manipulation. An example of an unambiguous "trigger" that indicates that a claim is covered by a claims-made insurance policy would include the following provisions:

i. The insured notifies the insurance carrier during the policy term that a claim has been asserted, or that an incident has occurred, and

ii. The insured must represent that it was not aware of any such incident when the claims-made policy was purchased.

d. The premium charged for the claims-made insurance policy is not significantly in excess of the premium that would be charged for a claims-made insurance policy that could be purchased by a similar entity with similar insurance risks and that has no knowledge of any circumstances or events that would result in any claims, excluding any anticipated amounts for a typical number of claims for which the insured is not aware to have specifically occurred, but that it expects would be reported (IBNR).

e. The insurer may base the premium for the claims-made insurance policy on estimates and predictions that are based on the past experience of the insured, but the premium is not based on settlement estimates of specific, known events that are expected to be recovered under the policy.

f. The premium charged for the policy in the current year is not significantly in excess of that charged in previous years, other than for increases in the amount or type of coverage. An anticipated increase in premiums that is expected to occur because the insured entity is advancing toward the "mature stage" of premiums for claims-made insurance would not be considered in making that determination.

g. The claims-made insurance policy is primarily intended to cover insurance risk and is not a financing arrangement. Claims-made insurance policies that are intended to cover insurance risk typically include features such as (a) an absence of adjustment features based on experience and (b) coverage of the ultimate loss from the claim, once made, regardless of period of settlement.

h. If the claims-made insurance policy has a specified retroactive date prior to the inception of the claims-made relationship with the insurer, the period from that specified retroactive date to the inception of the claims-made relationship with that insurer is either short or covered by other insurance policies.

12. The Task Force further observed that although the consensus in Issue 1 applies to situations in which the insured entity uses a claims-made insurance policy to finance

[5]Such a lack of identification creates difficulty in assessing risk for an entity considering whether to self-insure its insurance risk (for example, a manufacturing entity may be completely unaware of the potential

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known losses, (that is, when the insurance contract was purchased in order to provide insurance coverage for specific, known events that occurred or were reportable prior to the inception of the contract), the consensus in Issue 1 does not preclude prospective accounting for those claims-made insurance policies or portions of those policies that contain only prospective provisions.

13. The Task Force also observed that an insured entity may, for various reasons, contemporaneously enter into multiple claims-made insurance policy contracts. In those circumstances, an entity should consider whether those insurance contracts should be combined in order to determine the appropriate accounting treatment. The guidance contained in paragraph 8 of Statement 113 is helpful in those instances.

14. Examples to illustrate the application of this consensus are included in Exhibit 03-8A.

Issue 3(a)—Whether an insured entity should recognize a liability at the balance sheet date for IBNR claims.

15. The Task Force reached a consensus that Statement 5 requires insured entities (except for those in the scope of Statement 113), including those that use a claims-made approach for insuring certain risks, to recognize a liability for the probable losses from IBNR claims and incidents if both criteria in paragraph 8 of Statement 5 are met, that is, if the loss is both probable and reasonably estimable. The Task Force also observed that unless the conditions of Interpretation 39 are met, offsetting prepaid insurance and

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health hazards attributable to its core products and may want to protect itself in case a by-product of its production process becomes the next "asbestos").

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receivables for expected recoveries from insurers against a recognized IBNR liability or the liability incurred as a result of a past insurable event would not be appropriate.

Issue 3(b)—If the probable losses from IBNR claims and incidents cannot be reasonably estimated by an insured entity that uses a claims-made insurance approach to insure certain risks, whether that entity may measure the liability based on the estimated cost of purchasing "tail" coverage, which would insure the

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company for claims and incidents that occur during the claims-made policy period but are not reported to the insurance carrier in that period.

16. The Task Force reached a consensus that the estimated cost of purchasing tail coverage is not relevant in determining the loss to be accrued because Interpretation 39 prohibits netting the insurance receivable against the claim liability. However, the Task Force noted that, if the insured entity had the unilateral option to purchase tail coverage at a premium not to exceed a specified fixed maximum, then the insured entity could record a receivable for expected insurance recoveries (after considering deductibles and policy limits) for the portion of the IBNR liability that is insurable under the tail coverage. In that case, the entity would need to record as a cost the expected premium for the tail coverage. The Task Force also agreed that the purchase of tail coverage does not eliminate the need to determine if an additional liability should be accrued because of policy limits or other factors.

Issue 4(a)—In situations in which an entity's fiscal year and policy term coincide, the appropriate accounting for both (a) the insured liability (including IBNR) and the related insurance recoverable in subsequent periods when the entity purchases another prospective claims-made insurance policy that, in part, covers a portion of the losses included in the IBNR liability and (b) the premiums for that subsequent prospective claims-made insurance policy.

17. Regarding interim financial reporting, the Task Force reached a consensus that when the enterprise's fiscal year and policy year coincide, an appropriate method would be to recognize expense—through a combination of (a) accruing the IBNR liability, (b) accruing any expected increase in insurance recoverables, and (c) amortizing the insurance premium—on a pro rata basis over the year. In addition, the liability for any unusual claims or incidents, as well as any applicable insurance recoverable related thereto, would be recognized in the interim period in which they become known.

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18. For interim reporting, the approach treats usual recurring losses as integral to annual reporting, and, therefore, any expected changes in the IBNR liability and related insurance recoverables that are not related to specific events can be spread over the entire year. However, material unusual losses must be accounted for as discrete items and recognized as they occur. The approach discussed in Issue 4(a) assumes the recurring purchase of a claims-made insurance policy with a one-year term and the payment of premiums on the first day of each policy year.

19. Members of the Task Force observed that when the enterprise's fiscal year and policy term coincide, the year-end IBNR liability relates to the enterprise's obligation for claims and incidents that have been incurred prior to year-end but will be reportable after year-end. The approach for accounting by policyholders who purchase claims-made insurance policies that consist of prospective provisions is as follows:

a. The premium paid at the beginning of the fiscal year for the new claims-made insurance policy should be recognized as a prepaid expense.
b. At the beginning of the fiscal year, the enterprise should estimate its IBNR liability as of the end of the fiscal year. That estimate involves estimating the claims and incidents that will be incurred prior to year-end but will not be reportable until after year-end. Presumably the estimated year-end IBNR liability would approximate the beginning IBNR liability adjusted for relevant historical patterns unless the enterprise has identified new factors (such as a major change in products, manufacturing processes, or risk management systems) that warrant further adjustment of the ending IBNR liability.
c. The enterprise should compute an estimated annual expense as the sum of (1) the premium paid for the claims-made policy, (2) the difference between the beginning IBNR liability and the estimated year-end IBNR liability, and (3) the difference between the beginning insurance recoverable related to the IBNR liability and the estimated ending amount. That estimated annual expense should be recognized in interim periods based on the methodology that best reflects the manner in which the

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benefits of the insurance coverage are consumed and the IBNR liability is incurred.[6] In addition, liabilities for specific claims incurred during the year that are not included in the IBNR estimate should be recognized as expense in the interim period in which they are incurred.

d. The estimated year-end IBNR liability should be reviewed whenever interim financial statements are prepared. Routine adjustments to the estimated liability would be recognized ratably in each of the remaining interim periods. However, if events and circumstances in that interim period indicate that unusual claims and incidents have been incurred prior to the end of the interim period, the enterprise should recognize in that interim period any related significant adjustments of the estimated year-end IBNR liability.

e. For any insurance recoverable recognized, either related to the IBNR liability or to a specific incurred claim, the entity should evaluate those assets and adjust them, if necessary, based on changes in circumstances. Paragraphs 140 and 141 of SOP 96-1 provide further guidance on the recognition of a receivable for expected insurance recoveries.

f. Any unusual claims and incidents that have been incurred prior to the end of an interim period but will probably be reported prior to year-end should not affect net income if they will be covered (insured) under the existing claims-made insurance policy. However, both the asset (under the insurance claim) and the liability (for the incident) will be reflected on the balance sheet.

20. The Task Force observed that unless the conditions of Interpretation 39 are met, offsetting prepaid insurance and receivables for expected insurance recoveries against a recognized IBNR liability (or the claim liability incurred as a result of a reported event) would not be appropriate.

21. Examples to illustrate the application of this consensus are included in Exhibit 03-8B.

Issue 4(b)—The accounting ramifications on the consensus reached in Issue 4(a) of having a claims-made policy term that does not coincide with the enterprise's fiscal year.

[6]Insurance premiums are typically amortized over the policy period on a straight-line basis, since that matches the cost to the period benefited. In the case of a claims-made policy, however, some question whether a straight-line amortization would achieve that matching, as occurrences in the early part of the year are normally more likely to result in a claim by year-end (and thus are covered by the policy) than occurrences later in the year. Accordingly, some believe that an accelerated method of amortization achieves a better matching of costs to the interim period benefited. The method selected should be appropriate in light of the relevant facts and circumstances and consistently applied.

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22. The Task Force reached a consensus that when the enterprise's fiscal year and policy year do not coincide, the insurance premium component of the overall IBNR expense in interim periods could be based on the estimated premium for claims-made coverage that the enterprise expects to be able to acquire later in the fiscal year.

23. When the enterprise's fiscal year and policy term do not coincide, an enterprise should recognize three elements at year-end: (a) an IBNR liability related to the enterprise's obligation for claims and incidents that have been incurred prior to year-end but will be reportable after year-end, (b) an insurance recoverable for any outstanding claims that are reimbursable under the existing claims-made policy, and (c) an asset for prepaid insurance premiums related to the coverage for claims and incidents that will be incurred after year-end but reported prior to the expiration of the existing claims-made policy. The approach for accounting by policyholders who purchase claims-made insurance policies that have terms of duration that do not coincide with the enterprise's fiscal year is as follows:

a. At the beginning of the fiscal year the enterprise should make an estimate of its future premium cost of the new claims-made policy that is expected to be purchased during the fiscal year. The enterprise should also estimate the portion of that future premium cost that would relate to coverage for claims and incidents that will be incurred after the end of the fiscal year but reported prior to the expiration of that new claims-made policy; that portion represents the estimated prepaid asset at the end of the fiscal year. The estimate of the future premium cost involves estimating the effect of past claims and incidents that are expected to affect the premium level, as well as the effect of historical patterns and any new factors (such as a major change in products, manufacturing processes, or risk management systems) that are relevant.
b. At the beginning of the fiscal year the enterprise should make an estimate of its IBNR liability as of the end of the fiscal year. That estimate involves estimating the claims and incidents that will be incurred prior to year-end but will not be reportable

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until after the year-end. Presumably the estimated year-end IBNR liability would closely approximate the beginning IBNR liability adjusted for relevant historical patterns unless the enterprise has identified new factors (such as a major change in products, manufacturing processes, or risk management systems) that warrant further adjustment of the ending IBNR liability.

c. The enterprise should compute an estimated annual expense as the sum of (1) the balance of the premium cost for the claims-made policy expiring during the year, (2) the estimated future premium cost for the new claims-made policy, (3) the difference between the beginning IBNR liability and the estimated year-end IBNR liability, and (4) the difference between the beginning and estimated ending insurance receivable related to IBNR. That estimated annual expense should be recognized ratably in interim periods based on the methodology that best reflects the manner in which the benefits of the insurance premiums are consumed and the IBNR liability is incurred.[7] In addition, liabilities for specific claims incurred during the year that are not included in the IBNR estimate should be recognized as expense in the period in which they are incurred.

d. The estimated year-end IBNR liability should be reviewed whenever interim financial statements are prepared. Routine adjustments in the estimated liability (such as adjusting the estimated future premium cost to reflect actual) would be recognized ratably in each of the remaining interim periods. However, if events and circumstances in that interim period indicate that unusual claims and incidents have been incurred prior to the end of the interim period, the enterprise should recognize in that interim period any related significant adjustments of the estimated year-end IBNR liability.

e. For any insurance recoverable recognized, either related to the IBNR liability or to a specific incurred claim, the entity should evaluate those assets and adjust them, if necessary, based on changes in circumstances. Paragraphs 140 and 141 of SOP 96-1 provide further guidance on the recognition of a receivable for expected insurance recoveries.

f. Any unusual claims and incidents that have been incurred prior to the end of an interim period and that will probably be reported prior to expiration of the new claims-made insurance policy should not affect net income if they will be covered by insurance. However, both the asset (under the insurance claim) and the liability (for the incident) will be reflected on the balance sheet.

24. The Task Force observed that unless the conditions of Interpretation 39 are met, offsetting prepaid insurance and receivables for expected insurance recoveries against a recognized IBNR liability (or the claim liability incurred as a result of a reported event) would not be appropriate.

[7]Refer to footnote 6.

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25. Examples to illustrate the application of this consensus are included in Exhibit 03-8C.

Issue 5—Disclosures that should be made by companies insured under claims-made policies.

26. The Task Force discussed what disclosures would be appropriate when an enterprise changes from occurrence-based insurance to claims-made insurance or elects to significantly reduce or eliminate its insurance coverage. Members of the Task Force noted that paragraph 10 of Statement 5 requires disclosure if it is at least reasonably possible that a loss has been incurred. That paragraph also discusses disclosure with respect to unasserted claims.

27. In July 1987, the AICPA issued the Report of the Task Force on Disclosure of Insurance, *Disclosure Concerning Insurance Coverage*. That report encouraged publicly held entities and entities with public accountability, such as governments, to disclose circumstances in which they are exposed to certain uninsured risks of future material loss. The report indicates that each reporting entity should decide the matters to be disclosed, depending on its circumstances. The report does not recommend any specific disclosures that would be appropriate when an entity changes from occurrence-based insurance to claims-made insurance or elects to reduce significantly or eliminate its insurance coverage.

28. The Task Force Report issued in 1987 may no longer be retrievable. Therefore, the conclusions reached by AcSEC have been provided below.

> In its Statement No. 5, the FASB said that it did not discourage disclosure of uninsured risks in appropriate circumstances. AcSEC

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believes that, though operational criteria have not been developed for such disclosures as stated in Statement No. 5, they should be encouraged rather than simply not discouraged. Accordingly, AcSEC reached the following conclusions:

1. Publicly held entities and entities with public accountability, such as governments, are encouraged, but not required, to disclose circumstances in which
   a. They are exposed to risks of future material loss related to
      i. Torts,
      ii. Theft of, damage to, expropriation of, or destruction of assets,
      iii. Business interruption,
      iv. Errors or omissions,
      v. Injuries to employees, or
      vi. Acts of God, and
   b. Those risks have not been transferred to unrelated third parties through insurance.
2. Each reporting entity should decide the matters to be disclosed, depending on its circumstances. A standard form of disclosure is therefore not recommended. The following are some of the matters reporting entities might consider for disclosure:
   a. The actual and potential effects of losses from such risks on the entity's historical or planned operations, including exposure to losses from claims, curtailment of research and development or manufacturing, or contraction or cessation of other activities, such as discontinuance of a product line
   b. Comparison of current insurance coverage by major categories of risk to coverage in prior periods, without necessarily quantifying such coverage or change in coverage
   c. Recent claims experience
   d. A description of the reporting entity's risk management programs.
3. Disclosure of this kind is experimental. Its location in a financial report therefore depends on the judgment of those preparing the financial report.

Transition

29. The Task Force observed that the transition guidance for the above Issues is governed by the original consensuses on those Issues.

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STATUS

30. No further EITF discussion is planned.

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Exhibit 03-8A

EXAMPLES OF THE APPLICATION OF THE EITF CONSENSUS ON ISSUE 2 OF ISSUE 03-8

Example 1

Company ABC is a manufacturer that purchases D&O insurance under a claims-made insurance policy each year. Company ABC immediately reports any asserted claims or incidents that could result in an asserted claim to its insurance carrier. Company ABC currently has no knowledge of any unasserted claims against it. Further, Company ABC is unaware of any event that would result in any claims. Company ABC considers the use of a claims-made insurance policy to be the most efficient and least costly method available to manage its insurance risk related to suits against its directors and officers. Company ABC pays BrokerCo to handle its insurance needs. BrokerCo supplies Company ABC with binding quotes from several insurance carriers and a comparison to binding quotes for other similar companies. Company ABC believes that its premiums are comparable to those of other similar entities that have similar insurance risk profiles and no knowledge of any events or circumstances that might result in a claim. Company ABC has an option to purchase tail coverage, which would effectively convert its claims-made policies into occurrence-based policies at any time. On January 1, 20X3, Company ABC pays its annual premium of $5 million for its policy. The policy has a retroactive date to January 1, 20X0, which is the year that Company ABC first started using the claims-made insurance approach with its insurance carrier. Company ABC is unable to bifurcate its policy premium into its retroactive and prospective provisions.

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In June 20X3, there is a precipitous drop in the stock price of Company ABC, and a lawsuit is brought against the directors of Company ABC. Company ABC notifies its insurer about the asserted claim, and the insurer agrees that those claims are covered by its claims-made policy in effect for 20X3.

Evaluation: Company ABC determined in 20X0 that its claims-made insurance policy is a prospective contract that does not contain any retroactive provisions. Essentially, Company ABC was unaware of any known events or circumstances that might result in a claim and viewed the premiums paid for its D&O insurance as providing coverage against claims that might occur during the policy period. In making its determination that the claims-made insurance policy did not contain a retroactive provision, Company ABC also considered the following:

- Company ABC typically uses a claims-made policy to manage its insurance risk and plans to continue purchasing a claims-made insurance policy annually.
- Tail coverage is readily available.
- The premium charged for the claims-made policy is not significantly in excess of premiums charged to other similar entities with similar insurance profiles.
- The claims-made policy contains an unambiguous contract trigger to determine when claims are covered.
- Because Company ABC has no knowledge of any asserted claims or events that would result in a claim, the claims-made policy is primarily expected to cover insurance risk related to future claims.
-

Example 2

Same facts as Example 1, except that the precipitous drop in the stock price of Company ABC occurred in 19X9, prior to the inception of Company ABC's claims-made insurance program with its insurance carrier. During the negotiation of the contract premium, Company ABC discussed its concerns with its insurance carrier, and the two agreed that

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the retroactive date would include any claims related to the drop in the stock price. As a result, the premium was $50 million.

Evaluation: Company ABC determined in 20X0 that its claims-made insurance policy contains a retroactive provision. Company ABC knows that the $50 million premium charged represents the expected costs of settling any claims related to the drop in its stock price, an event that was fully known at the inception of the contract. Company ABC disclosed this fact to its insurer, and the two agreed that it might result in a claim and negotiated a premium based on that premise. In making its determination that its D&O policy contains a retroactive provision, Company ABC also considered the following:

- The claims-made policy was taken out in part in response to a known incident that was reported to the insurer.
- The premium charged by the insurer includes an estimate of the expected settlement costs for the unasserted claim.
- The premium charged primarily represents a financing of the unasserted claim.

Prior to accounting for the entire contract retroactively, Company ABC should, if practicable, bifurcate the contract into its retroactive and prospective provisions and account for each separately.

Example 3

On February 20, 20X2, Company XYZ determined that it needed to recognize a $100 million liability for environmental contamination as a result of an accident at one of its manufacturing plants. Company XYZ initially believed that it would manage the cleanup and any lawsuits arising from the accident through an internal self-insurance program.

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Subsequently, Company XYZ decided to purchase a claims-made insurance policy that would include all claims arising from the incident. Company XYZ decided that it should purchase the policy because (a) it would be more efficient to transfer the risk associated with the development and timing of claims to a third party and (b) representing that the risk associated with all claims had been transferred to a third party would reduce the risk profile of the Company to its shareholders and other potential investors. On April 1, 20X2, Company XYZ pays InsurerCo $60 million for a claims-made insurance policy. Company XYZ and InsurerCo expect the claims related to the incident to be settled over a 10-year period after the purchase of the policy.

Evaluation: Based on an evaluation of the indicators, Company XYZ determines that its claims-made insurance policy contains a retroactive provision. In making that determination, Company XYZ specifically considered the following:

- The claims-made policy was purchased specifically to cover known claims for which a liability had been recognized.
- The claims-made policy effectively represented a financing of the liability previously recognized by Company XYZ.
- The premium charged was primarily based on expected payouts for an event that had already occurred.

Example 4

HealthCo is a health care provider that purchases medical malpractice insurance in order to manage its insurance risks. HealthCo purchases a claims-made insurance policy each year from its insurance carrier. HealthCo would be able to purchase tail coverage from its insurance carrier if it chose to do so. Although HealthCo has no knowledge of any asserted or unasserted claims against it, HealthCo estimates and recognizes a liability for claims incurred but not reported of $25 million at December 31, 20X2, based on actuarial

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reviews of its historical claims reporting and payment patterns. HealthCo engages an insurance brokerage firm to ensure that its insurance premiums are consistent with those offered to similar companies with similar insurance risks. During 20X2, HealthCo paid out $95 million of malpractice claims that were fully covered by its insurance program. On January 1, 20X3, HealthCo pays its annual premium of $100 million for its claims-made policy. HealthCo expects that it will require a liability of $29 million on December 31, 20X3. The policy does not cover incidents occurring prior to the inception of the claims-made insurance program with that insurance carrier. In negotiating its policy with InsurerCo, HealthCo asserts to InsurerCo that it is unaware of any specific, current claims (asserted or unasserted) against it.

Evaluation: Based on an evaluation of the indicators, HealthCo determines that its claims-made insurance policy is a prospective contract that does not contain any retroactive provisions. In making that determination, HealthCo specifically considered the following:

- There are no known asserted or unasserted claims that are expected to be covered by the policy. The liability recognized for IBNR claims would not preclude HealthCo from concluding that its claims-made insurance policy is prospective as the Company represented that it did not know of any asserted claims.
- Tail coverage is readily available.
- The premium charged for the claims-made policy is not significantly in excess of premiums charged for similar policies with no retroactive dates.
- There is a clear and unambiguous contract coverage trigger.

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Exhibit 03-8B

EXAMPLES OF THE APPLICATION OF THE EITF CONSENSUS ON ISSUE 4(a) OF ISSUE 03-8

Example 1

Assumed facts:

- XYZ Company purchases claims-made policies every year for its insurable risk. The insurance arrangement meets the criteria for prospective treatment as described in Issue 03-8. The policy has a $500,000 per incident deductible and a $2 million per incident maximum with a policy limit of $15 million. When calculating the insurance recoverable related to IBNR incidents, XYZ assumes that approximately 50 percent of the gross claim value will be recovered because of the deductible. XYZ does not anticipate incurring any losses in excess of the policy's maximums.
- Accrued IBNR liability at 12/31/X0 $2 million
- Receivable for insurance recoverable at 12/31/X0 $1 million
- Estimated IBNR liability at 12/31/X1 $2.2 million
- Estimated receivable for insurance recoverable at 12/31/X1 $1.1 million
- Premium for claims-made policy for year ending 12/31/X1,
  - payable 1/1/X1 $1.6 million
- Value of claim for an incident reported during the second quarter[8] $750,000
-

Computations (in thousands):

Expected annual expense = annual premium + expected increase in IBNR liability − expected increase in insurance recoverable
= $1,600 + ($2,200 − $2,000) − ($1,100 − $1,000)
= $1,600 + $200 − $100
= $1,700

Expected quarterly expense = $1,700 ÷ 4 = $425

[8]The claim is covered by the insurance policy subject to a $500,000 deductible and was both paid to the claimant and recovered from the carrier during the third quarter.

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IBNR liability[9] (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Balance, beginning of quarter	$(2,000)	$(2,050)	$(2,100)	$(2,150)
Add: accrual[10]	(50)	(50)	(50)	(50)
Balance, end of quarter	$(2,050)	$(2,100)	$(2,150)	$(2,200)

Known claims liability (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Balance, beginning of quarter	$ —	$ —	$ (750)	$ —
Add: claims made	—	(750)	—	—
Less: claims paid	—	—	750	—
Balance, end of quarter	$ —	$ (750)	$ 0	$ —

Prepaid insurance (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Balance, beginning of quarter	$ —	$1,200	$ 800	$ 400
Add: premium payments made	1,600	—	—	—
Less: amortization[11]	(400)	(400)	(400)	(400)
Balance, end of quarter	$1,200	$ 800	$ 400	$ 0

[9]Interpretation 39 was issued in March 1992 and provides additional guidance on when the legal right to setoff exists and should be used to determine whether prepaid insurance (or insurance recoverable) and a recognized IBNR liability (or the claim liability incurred as a result of a reported event) may be offset. Such offsetting would not be appropriate unless the conditions of Interpretation 39 are met. For income statement purposes, however, the expenses related to claims reported and the income related to insurance recoverables may be offset.

[10]Straight-line accrual of the IBNR liability is assumed for purposes of simplicity but would only be appropriate if management expects that the underlying IBNR claims covered by the insurance arrangement would occur evenly throughout the year. Refer to paragraph 19(c).

[11]Straight-line amortization of the prepaid insurance premium is assumed for purposes of simplicity only. Refer to footnote 6.

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Insurance recoverable[12] (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Balance, beginning of quarter	$ 1,000	$ 1,025	$ 1,300	$ 1,075
Add: Expected recoveries	25	275	25	25
Less: Recoveries received	—	—	(250)	—
Balance, end of quarter	$ 1,025	$ 1,300	$ 1,075	$ 1,100

Quarterly expense (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Amortization of prepaid insurance	$ 400	$ 400	$ 400	$ 400
Accrual of IBNR liability	50	50	50	50
Accrued claims reported	—	750	—	—
Accrued insurance recoveries	(25)	(275)	(25)	(25)
Total expense	$ 425	$ 925	$ 425	$ 425

Example 2

Assume the same facts as in Example 1, except that (a) the enterprise revises its estimated year-end IBNR liability from $2.2 million to $2.6 million in the second quarter due to overall increases in settling claims, which is considered a routine adjustment by management, and (b) the enterprise determines that a reasonable matching of the additional cost to the periods benefited results in recognizing one-half of the adjustment in the second quarter and the remainder of the adjustment over the remaining interim periods on a pro rata basis.

IBNR liability (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Balance, beginning of quarter	$(2,000)	$(2,050)	$(2,300)	$(2,450)
Add: accrual	(50)	(250)	(150)	(150)
Balance, end of quarter	$(2,050)	$(2,300)	$(2,450)	$(2,600)

Known claims liability (in thousands):

Same as Example 1.

[12]Paragraphs 140 and 141 of SOP 96-1 provide further guidance on the recognition of a receivable for expected insurance recoveries.

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Prepaid insurance (in thousands):

Same as Example 1.

Insurance recoverable (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Balance, beginning of quarter	$ 1,000	$ 1,025	$ 1,400	$ 1,225
Add: Expected recoveries	25	375	75	75
Less: Recoveries received	—	—	(250)	—
Balance, end of quarter	$ 1,025	$ 1,400	$ 1,225	$ 1,300

Quarterly expense (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Amortization of prepaid insurance	$ 400	$ 400	$ 400	$ 400
Accrual of IBNR liability	50	250	150	150
Accrued claims reported	—	750	—	—
Accrued insurance recoveries	(25)	(375)	(75)	(75)
Total expense	$ 425	$ 1,025	$ 475	$ 475

Example 3

Assume the same facts as in Example 2, except that the enterprise discovers a defect in the manufacturing process in the third quarter and corrects it. The enterprise evaluates whether its IBNR liability warrants adjustment and concludes that an additional $2.1 million liability is needed for claims that are expected to be reported after year-end. The enterprise considers the discovery of the defect to be an unusual event and determines that a reasonable matching of the additional cost to the periods benefited results in the entire adjustment being recognized in the third quarter.

IBNR liability (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Balance, beginning of quarter	$(2,000)	$(2,050)	$(2,300)	$(4,550)
Add: accrual	(50)	(250)	(2,250)	(150)
Balance, end of quarter	$(2,050)	$(2,300)	$(4,550)	$(4,700)

Known claims liability (in thousands):

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Same as Example 1.

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Prepaid insurance (in thousands):

Same as Example 1.

Insurance recoverable (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Balance, beginning of quarter	$ 1,000	$ 1,025	$ 1,400	$ 2,275
Add: Expected recoveries	25	375	1,125	75
Less: Recoveries received	—	—	(250)	—
Balance, end of quarter	$ 1,025	$ 1,400	$ 2,275	$ 2,350

Quarterly expense (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Amortization of prepaid insurance	$ 400	$ 400	$ 400	$ 400
Accrual of IBNR liability	50	250	2,250	150
Accrued claims reported	—	750	—	—
Accrued insurance recoveries	(25)	(375)	(1,125)	(75)
Total expense	$ 425	$ 1,025	$ 1,525	$ 475

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Exhibit 03-8C

EXAMPLES OF THE APPLICATION OF THE EITF CONSENSUS ON ISSUE 4(b) OF ISSUE 03-8

Example 1

Assumed facts:

- XYZ Company purchases claims-made policies every year for its insurable risk. The insurance arrangement meets the criteria for prospective treatment as described in Issue 03-8. The policy has a $500,000 per incident deductible and a $2 million per incident maximum with a policy limit of $15 million. When calculating the insurance recoverable related to IBNR incidents, XYZ assumes that approximately 50 percent of the gross claim value will be recovered because of the deductible. XYZ does not anticipate incurring any losses in excess of the policy's maximums.
- The policy period runs from May 1 to April 30, and XYZ uses a December 31 year-end for financial reporting purposes.
- Accrued IBNR liability at 12/31/X0 $2 million
- Receivable for insurance recoverable at 12/31/X0 $1 million
- Estimated IBNR liability at 12/31/X1 $2.2 million
- Estimated receivable for insurance recoverable at 12/31/X1 $1.1 million
- Premium for one-year claims-made policy expiring 4/30/X1 $1.2 million
- Estimated premium for one-year claims-made policy commencing
  - 5/1/X1 $1.8 million
- Value of claim for an incident reported during the second quarter[13] $750,000
  -

Computations (in thousands):

Expected annual expense = premium costs + expected increase in IBNR liability − expected increase in insurance recoverable
= {[$1,200 × (4/12)] + [$1,800 × (8/12)]} + ($2,200 − $2,000) − ($1,100 − $1,000)
= ($400 + $1,200) + $200 − $100
= $1,700

[13]The claim is covered by the insurance policy subject to a $500,000 deductible and was both paid to the claimant and recovered from the carrier during the third quarter.

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Expected quarterly expense = $1,700 ÷ 4 = $425

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IBNR liability (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Balance, beginning of quarter	$(2,000)	$(2,050)	$(2,100)	$(2,150)
Add: accrual	(50)	(50)	(50)	(50)
Balance, end of quarter	$(2,050)	$(2,100)	$(2,150)	$(2,200)

Known claims liability (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Balance, beginning of quarter	$ —	$ —	$ (750)	$ —
Add: claims made	—	(750)	—	—
Less: claims paid	—	—	750	—
Balance, end of quarter	$ —	$ (750)	$ 0	$ —

Prepaid insurance (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Balance, beginning of quarter	$ 400	$ —	$ 1,400	$ 1,000
Add: premium payments made	—	1,800	—	—
Less: amortization	(400)	(400)	(400)	(400)
Balance, end of quarter	$ 0	$ 1,400	$ 1,000	$ 600

Insurance recoverable (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Balance, beginning of quarter	$ 1,000	$ 1,025	$ 1,300	$ 1,075
Add: Expected recoveries	25	275	25	25
Less: Recoveries received	—	—	(250)	—
Balance, end of quarter	$ 1,025	$ 1,300	$ 1,075	$ 1,100

Quarterly expense (in thousands):

	Qtr 1	Qtr 2	Qtr 3	Qtr 4
Amortization of prepaid insurance	$ 400	$ 400	$ 400	$ 400
Accrual of IBNR liability	50	50	50	50
Accrued claims reported	—	750	—	—
Accrued insurance recoveries	(25)	(275)	(25)	(25)
Total expense	$ 425	$ 925	$ 425	$ 425

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Suggested Index Entries for Issue No. 03-8, "Accounting for Claims-Made Insurance and Retroactive Insurance Contracts by the Insured Entity"

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