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# Introduction

Our Insurance Outlook publication is produced annually and offers thought leadership on topics that are relevant to African insurers. All articles are penned by Deloitte professionals that provide services to the insurance industry.

While the publication has a South African flavour the editorial team has also sourced articles from elsewhere in the continent. Readers will find a contribution from our Nigerian office on digital distribution trends as well as an article on risk-based capital developments in Africa.

Our publication this year is produced against the backdrop of an industry that, in the past two years, has proven its resilience in facing higher than normal levels of claims while investment markets have been skittish. The pace of digital distribution has picked up with insurers having to understand their clients now more than before. More granular information on clients' behaviours and their needs are required to sell to and service clients. The 2022-and-beyond business plans for insurers have now switched from merely recovering from the pandemic to building scale to combat a higher cost base. This growth needs be achieved while capital allocation remains frugal as the industry still recovers from the losses brought about by the pandemic. Regulators are increasingly showing interest in the reporting practices of insurers and on the sustainability of the business model, management teams and the governance structures.

It is therefore no surprise that our publication focuses on business, capital, governance and financial reporting priorities in the insurance industry. Other than those articles already mentioned you will find pieces that offer unique insights into:

- The financial reporting results of the largest five insurance groups in South Africa for the 12 months ended 31 December 2021;
- Accounting, taxation and auditing considerations of IFRS 17 as the implementation date of the accounting standard looms large;
- The Financial Action Task Force (FATF) and what it highlights for insurers.

We hope you enjoy reading our publication and look forward to your feedback.

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# 2021 financial results of listed insurers - SA (Including 2021 short-term insurance industry results)

With the 31 December reporting season for South Africa's large, listed insurance groups complete, we have an opportunity to take stock of the financial performance of the industry. At first glance it is easy to see an improvement in the financial results. For almost all metrics, whether earnings, headline earnings, underwriting margins, value of new business and embedded value, South African insurers reported improved results from the previous year. Shareholders should now be able to breathe easier looking forward to better dividend declarations and capital growth.

Presentations to investment analysts on last year's financial results were cautiously optimistic on both the industry's performance and what the future might hold. While life insurers underlined the adverse impact of excess deaths from the continuing COVID-19 pandemic (notably wave three), they were also able to show improved new business volumes, margins and asset-based fees. While experiencing headwinds to premium growth, short-term insurers were able to report improved underwriting margins that fit well within their target ranges.

The following will highlight key themes reported by the five largest listed insurance groups in South Africa. We refer to their International Financial Reporting Standards (IFRS) and embedded value (EV) results that collectively represent more than 80% of the local industry's premiums and assets. We analysed the results in aggregate to form an industry view, rather than comment on the results of the individual insurance groups.



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Three of the five largest insurance groups have 31 December year-ends, and two of the groups have 30 June year-ends. For the two groups that have 30 June year-ends we used their 2021 interim results and historic announcements to calculate pro forma results for a 12-month period ending 31 December 2021. Where the article refers to “total” or “aggregated” it is the sum of the five insurance groups.

The South African equities market recovered as corporate profits increased with the relaxation of lockdown restrictions. The JSE SWIX was up 17% at the end of the year, positively impacting the average asset base of insurers. Although most foreign assets of the insurers also yielded good returns these were somewhat offset by the relative strength of the Rand in 2021. Overall, the total assets increased by 12.1% (2020: 3.8%) which led to higher asset-based fees earned by insurers on policyholder funds and other asset-backed products.

Total liabilities increased by 12.9% which is also mostly a function of the higher asset base. Another notable contributor is the strengthening short-term COVID-19 provisions.

The aggregated equity for the insurance groups increased by R7.6 billion, or 3.1%. The increase equity following aggregated profit after tax of R23.9 billion (2020: loss: R4.7 billion) reported by the insurance groups less the ordinary dividends paid of R21.1 billion (2020: R12.7 billion). The 2021 dividend declarations follow on from the improved profitability and balancing rewarding shareholders while keeping longer-term capital management objectives in mind. An outlier in the 2021 dividend payments is Old Mutual which, in addition to its normal dividend payments, distributed a portion of its stake in Nedbank, returning R10.7 billion to shareholders. An aggregate return on equity calculation for the current year shows 9.7% recovering from the negative return reported in the previous year.

Consolidated results of the five large listed insurance groups in South Africa as at and for the 12 months ended 31 December 2021.

As at and for the 12 months ended 31 December 2021

Rand million	Old Mutual			Sanlam			MMH		
	2021	2020	% change	2021	2020 (Restated)	% change	2021	2020 (Restated)	% change
Total assets	1 053 854	940 682	12,0%	1 056 178	942 670	11,9%	590 611	520 716	13,3%
Total liabilities	-988 553	-871 359	13,4%	-973 282	-865 446	12,3%	-568 038	-497 368	14,1%
Equity	65 301	69 323	-5,8%	82 896	77 224	7,3%	22 573	23 348	-3,3%
Profit/(loss) before tax	13 427	-3 272	>100%	17 502	5 207	>100%	3 284	1 890	73,8%
Tax	-5 964	-2 076	>100%	-6 152	-3 805	61,7%	-2 942	-2 202	33,6%
Profit/(loss) after tax	7 463	-5 348	>100%	11 350	1 402	>100%	342	-312	>100%

As at and for the 12 months ended 31 December 2021

Rand million	Liberty			Discovery			Total		
	2021	2020	% change	2021	2020	% change	2021	2020	% change
Total assets	510 551	475 598	7,3%	274 390	227 280	20,7%	3 485 584	3 108 565	12,1%
Total liabilities	-482 858	-447 601	7,9%	-222 215	-182 145	22,0%	-3 234 946	-2 865 538	12,9%
Equity	27 693	27 997	-1,1%	52 175	45 135	15,6%	250 638	243 027	3,1%
Profit/(loss) before tax	2 197	-2 219	>100%	6 313	434	>100%	42 723	2 040	>100%
Tax	-2 070	-403	>100%	-1 663	-461	>100%	-18 791	-8 947	>100%
Profit/(loss) after tax	127	-2 622	>100%	4 650	-27	>100%	23 932	-6 907	>100%

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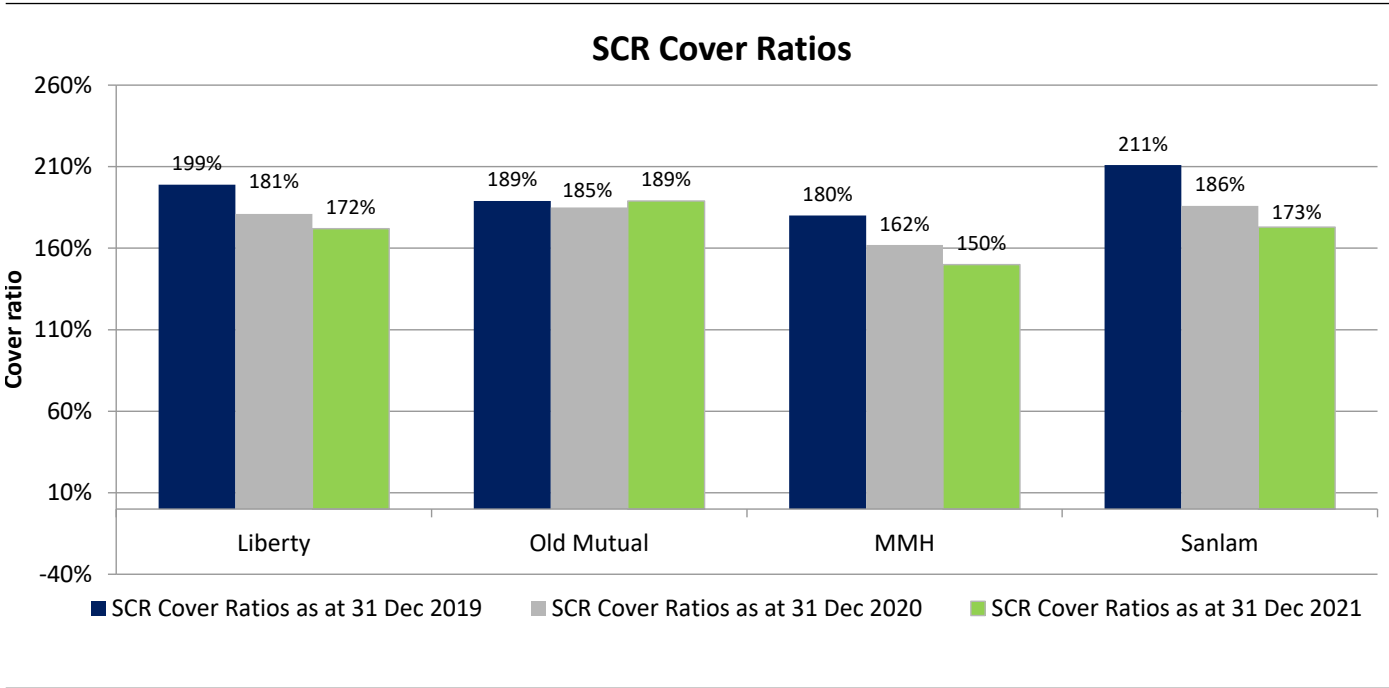
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Insurance groups continued reporting relatively healthy regulatory Solvency Capital Requirement (SCR) cover ratios, although a general trend of reducing SCR ratios were observed over the past three years.

On an aggregated basis the insurance groups reported profit before tax of R42.3 billion which is a substantial improvement on the R2.0 billion profit reported in 2020 (restated). The financial results include the impact of:

- Improved investment returns on shareholder assets coupled with an increase in asset-based fees on customer assets;
- Healthier new business volumes as adviser productivity improved with increased face-to-face sales coupled with digital strategies becoming more effective. Sanlam, for instance, reported a 14% increase in new business volumes;
- Levels of death claims greater than normal – the Association for Savings and Investment South Africa (ASISA) noted that South African life insurers reported a 53% surge in death claims for the six months between 1 April 2021 and 30 September 2021 when compared to the same period in 2019. The Rand value of these claims increased by 127%. This period covered the third wave of COVID-19 transmissions from early May 2021 to the middle of September 2021;
- Improved persistency for life insurance policies – The ASISA statistics show that 7.4 million risk policies lapsed last year compared to 10.4 million in 2020. While the actual lapse experience in the current year tracked favourably against expectations as policyholders opted to hold onto their insurance policies in uncertain times, insurers have continued to adopt a conservative approach in their assumptions at 31 December 2021 for future terminations;
- Improved short-term insurance underwriting results – most of the conventional short-term insurance subsidiaries in the insurance groups reported only single digit premium growth although their profits showed an upward trend. Despite some large risk events, including the July 2021 civil unrest in KwaZulu-Natal and Gauteng, these subsidiaries recorded healthy underwriting margins well within their target ranges.



For example, Santam reported an underwriting margin for its conventional insurance business of 8.0% (2020: 2.5%); and

- Legal certainty and settlement of Business Interruption (BI) claims – 2021 brought further legal certainty as it relates BI claims reported during the pandemic with court processes ruling on the length of the indemnity to be applied. At the same time short-term insurers continued to make progress in settling BI claims and were, therefore, able to use the data that became available from the settlement process to revisit estimates for BI claims that remain open. Not unexpectedly, the gross liabilities and related reinsurance assets for BI claims reported at 31 December 2021 are substantially lower than the year before.

In response to COVID-19, insurers have set up various short-term provisions to offset the financial impact of the pandemic. With the emergence of new variants throughout 2021 and low vaccine

uptake, South Africa continued to experience elevated excess deaths. According to ASISA, excess deaths experience for assured lives was about 200% higher than the general population. The concentration by geographic locations and sub-populations resulted in many insurers recalibrating their COVID-19 provisions throughout 2021. However, the latest data suggest that Omicron and its subvariants, although more transmissible, are less severe compared to previous variants. This may be a turning point in the pandemic and could translate into reductions in various COVID-19 provisions, but considerations about long-term impact of the pandemic will emerge as topical discussion point.

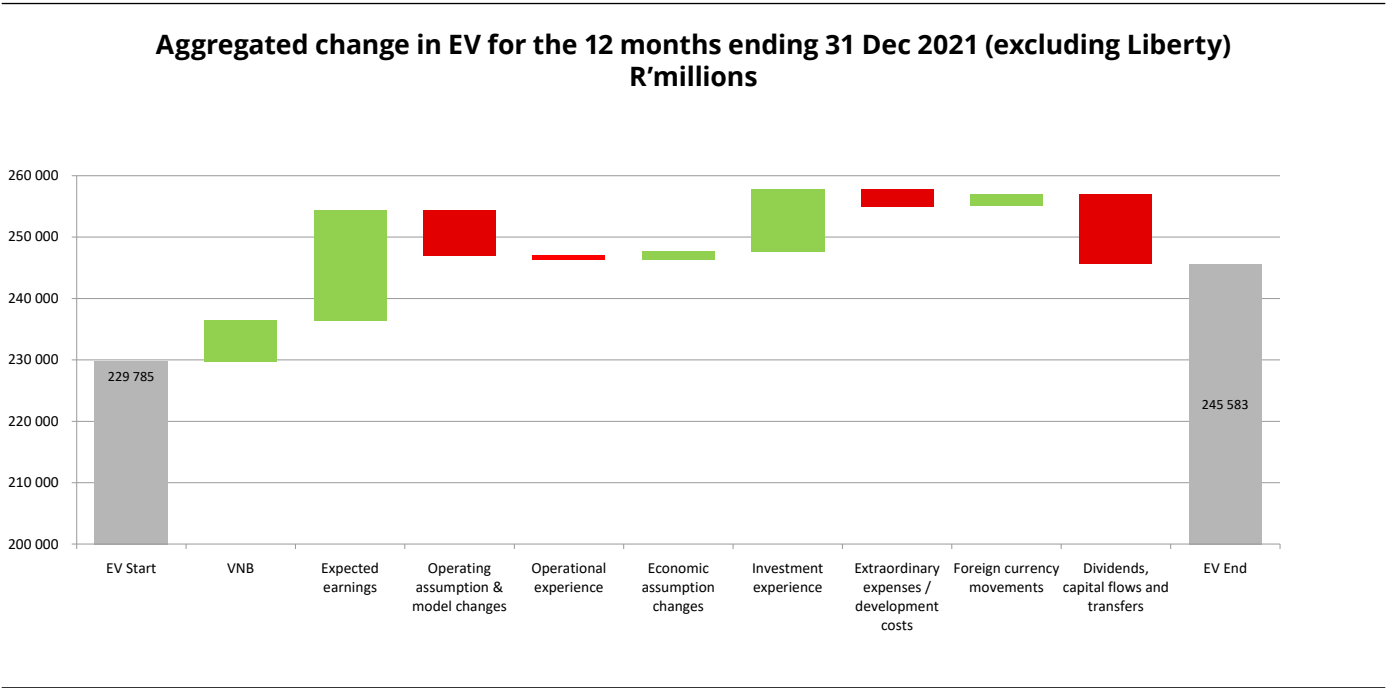
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The impact of these COVID-19 assumptions and provisions is also evident in the disclosed Embedded Value (EV) results. ‘Operating assumption and model changes’ resulted in a significant decrease in EV across insurance groups, mainly driven by the need to strengthen mortality bases and provide for increased future claims due to COVID-19 and other pandemics in the future.

The aggregated EV (excluding Liberty) increased from R229.8 billion to R245.6 billion, or 7.0%. Following Standard Bank’s buy-out of Liberty minority shareholders, Liberty has not published EV and VNB results as at 31 December 2021.

Insurance groups reported deteriorating ‘operating experience variances’ because of COVID-19 related claims in excess of COVID-19 provisions previously set up. This was partly offset by an improved persistency experience, significantly so for some insurance groups. Effective expense management also contributed to positive operating experience variances.

All insurance groups’ EVs increased, benefiting from positive investment experience as a result of the recovery in investment markets.



Excludes Liberty

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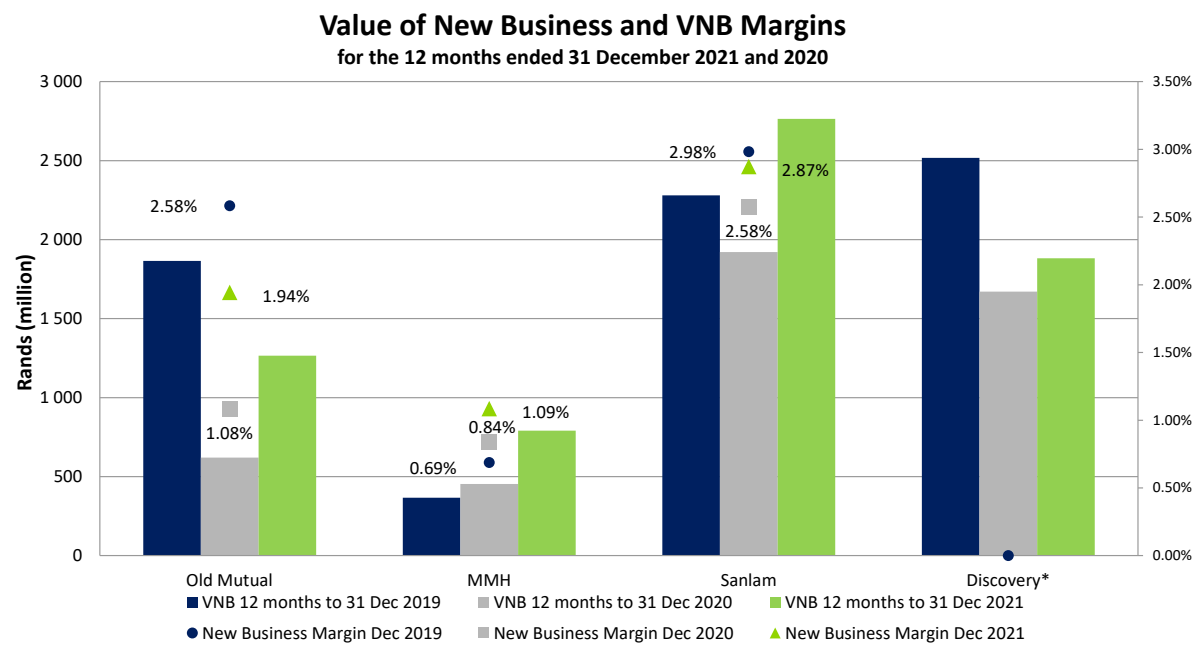
The EV results were further bolstered by a strong recovery in the Value of New Business (VNB) across the life insurance industry.

Despite a challenging economic and business environment, the new business volumes and VNB Margins recovered well and, in some instances, exceeded pre-COVID-19 levels. Although Liberty did not publish VNB results, the Standard Bank Annual Integrated Report as at 31 December 2021 stated that Liberty’s “New business margin and value of new business improved but remained below pre-pandemic levels.”

It was interesting to observe that the insurance groups’ mass market product offerings contributed significantly to the increase in new business in terms of increased volumes and higher profit margins. This contrasted with muted or strained new business growth for the more affluent market offering. The trend of increased sales of conventional annuity business as observed in the previous financial year continued for some insurance groups.

Sanlam, Old Mutual and MMH also reported pleasing new business growth in their portfolios pertaining to the rest of Africa.

If a label was to be placed on the 2021 financial year it would be that of a ‘recovery period’. The industry has mostly returned to performance levels similar to those of 2019. While at the start of 2022 the global economic outlook remains uncertain, and the possibility still exists of increased claims through a continuing pandemic and catastrophe-related events the industry deserves much credit for how it was able to restore its operational environments while at the same time applying sound capital management practices. Even though the waters are by no means calm it is clear to see that the industry has reset its course to profitability and growth.



Discovery group VNB margin not disclosed

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# Risk-based capital developments across Africa

Insurers across Africa are placing significant attention on the implementation of IFRS 17 and IFRS 9. At the same time, regulators in a number of African countries are upgrading their risk and capital regimes and introducing new or enhancing existing risk-based capital (RBC) regimes.

We have explored the application of RBC in several African countries using the following approach:

- We investigated the kind of RBC regimes that are being considered and the impact they could have on the insurance market.
- We also looked at the progress made by the various countries in adopting an RBC approach.
- We have interviewed a number of regulators and insurance practitioners in order to understand their reasoning for transitioning to an RBC regime.

## RBC in Africa

One of the primary roles of insurance regulators is to ensure that insurance companies are able to meet the promised benefits to their policyholders.

Most countries have announced that they are transitioning to an RBC regime. Kenya, Ghana and Nigeria have started by increasing the minimum capital requirements (MCR) for insurers. The MCR has been increased to ensure a smooth transition to an RBC regime. Weakly capitalised insurers are given time to recapitalise or to restructure their businesses. One regulator indicated that a criterion they are applying to implement an RBC regime is that capital is commensurate with the nature, size and complexity of the risks borne by the regulated entities.

African insurers employ a range and sometimes a mix of solvency and capital practices including:

- imposing minimum capital requirements;
- rules-based regime which does not consider variation between the approaches of different companies;
- rules-based regime with stress scenarios that require individual company calculations, but not necessarily calibrated to the market; and
- a principles-based regime, covering all known risks with market calibrations.

## West Africa: Nigeria and Ghana

**Ghana:** The National Insurance Commission (NIC) announced plans for an RBC regime in December 2014. The draft technical specifications were shared with the industry and feedback incorporated into the final documentation released by the NIC.



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The NIC revised the minimum capital requirements of all insurance entities in Ghana, effective from the 31st of December 2021. The minimum capital requirement for insurers in Ghana has increased from GHC15m to GHC50m. The minimum amount for reinsurers was raised from GHC40m to GHC125m.

**Nigeria:** The National Insurance Commission (NAICOM) announced in August 2018 that they are adopting an RBC measure. NAICOM issued a circular requesting all insurance companies to recapitalise, based on a 3-level tier-based minimum solvency capital which was in line with a Risk- Based Supervision (RBS). The circular was later withdrawn in November 2018.

In 2019, as part of a phased approach to RBC, Nigeria increased the minimum capital requirements for insurers. The minimum capital requirements have been increased from N2bn to N8bn for life insurers, from N3bn to N10bn for general insurers, and from N5bn to N18bn for composite insurers. Reinsurers have also seen an increase in their minimum capital requirement from N10bn to N20bn. Insurers were requested to hold at least 50% of these minimum capital requirements by the 31st of December 2020, after which all insurers were required to be fully compliant with the minimum capital requirements by no later than the 30th of September 2021. At the time of writing this paper, NAICOM has not yet enforced the second phase because of industry pushback via the courts.

East Africa: Kenya and Uganda

**Kenya:** The RBC implementation journey in Kenya started in 2011. The regulator embarked on an internal and industry-wide capacity building exercise and issued guidelines to support the implementation of an RBC regime. The regulator also updated its reporting systems to automate the collection of industry data to aid supervision. In 2017, RBC regulations were published, and insurers were given a transition period, with the adoption date set to July 2020. However, during the course of 2020, this was extended to December 2020 due to the COVID-19 pandemic. The requirements set minimum capital based on three measures:

- a minimum capital of KES 400m;
- a volume-based measure of 5% of best estimate liabilities (carried over from the previous regime); and
- an RBC measure based on stresses applied to assets and liabilities.

The regulator planned a gradual increase of capital requirements to 200% of the minimum under the different measures. This has paused this given the impact of the COVID-19 pandemic.

**Uganda:** The Ugandan RBC regime commenced in 2018. The regulator applied a structure similar to the Kenyan RBC regime and issued Capital Adequacy Regulations in 2020.

Southern Africa: South Africa, Zimbabwe and Zambia

**South Africa:** In July 2018, South Africa implemented Solvency and Asset Management (SAM), an RBC regime which shares many similarities with Solvency II of Europe.

**Zimbabwe:** The Insurance and Pension Commission (IPEC) first announced plans to transition to an RBC regime in 2015. In June 2021, the IPEC launched a new RBC regime commonly referred to as the Integrated Capital and Risk Programme (ZICARP). ZICARP has three pillars: Pillar 1 - quantitative requirements, Pillar 2 - qualitative requirements and Pillar 3 - disclosure requirements. It is very similar to SAM of South Africa.

The IPEC has held a number of industry workshops since 2018, conducted qualitative risk & capital management surveys and quantitative impact studies in 2019. In 2021, the IPEC released several circulars documenting the requirements for all three pillars of ZICARP. The IPEC has been conducting dry runs scheduled to end in December 2022.

**Zambia:** The process of transition to an RBC regime gained significant traction when the Parliament passed the Insurance Act in 2021. In addition to the provisions for the enhancement of consumer protection, the Act also allows for the creation of a new solvency/capital adequacy framework that will respond to the level of risks that insurers and reinsurers are allowed to take on as they provide cover.

The Pension and Insurance Industry Authority (PIA) has issued a draft RBC regulation which is very similar to the old SAP 104 approach that was used in South Africa before the introduction of the SAM regime.

North Africa: Morocco

**Morocco:** As part of the ongoing insurance sector reforms, the Moroccan lawmakers have set up a new independent regulatory authority for insurers, the Autorité de Contrôle des Assurances et de la Prévoyance Sociale (ACAPS) in 2016. The ACAPS is in the process of implementing an RBC regime similar to Solvency II of Europe but adapted to the Moroccan insurance market. A three-pillar structure has been adopted as a regulatory framework: Quantitative requirements (Pillar I), a qualitative pillar focusing on governance of the undertaking and supervisory activity (Pillar II) and a disclosure pillar focusing on supervisory reporting (Pillar III).

At the time of writing, the ACAPS had made the following progress:

- Pillar I: quantitative impact assessment exercises have been performed with insurance companies. However, finalised regulatory standards have not yet been issued. These stress tests have been performed to calibrate the final regulatory standards.
- Pillar II: Regulations have been issued with the end of December 2022 as the target date for the implementation by insurance companies.
- Pillar III: The ACAPS has not yet issued any updates relating to this pillar.

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General remarks

**Capital implications:** As regulators adopt RBC regimes, the required solvency capital may be higher than the stipulated minimum for some companies, depending on the risks they face. The increase in capital requirements may result in some companies failing to meet their solvency capital requirements which in turn may prompt an increase in merger and acquisition activities.

**Company standards:** In the absence of risk-based regulatory solvency measures, some insurance companies have adopted principles from SAM (and SAP104) and Solvency II from South Africa and Europe when calibrating their economic capital. This is mostly the case for large insurers and those that are in the same stable as South African and European insurers and need to report on SAM or Solvency II numbers to their parent company.

**Skills levels:** Some insurers and regulators have engaged external experts for assistance as they transition to RBC regimes. One regulator indicated that, as expected, insurance industry players do not currently have the technical expertise in-house and will require external assistance where applicable, although the regulator will be providing training to support the transitioning to RBC regime. Regulators are engaging with the insurance players to ensure that they achieve a smooth transition to RBC. One regulator indicated that they believe that “the ultimate benefits for industry as a whole will outweigh the initial costs of implementation”.

**COVID-19:** Most regulators and insurers also agree that there is a need to upgrade their solvency and capital regimes following the learnings from the COVID-19 pandemic. This will ensure that the sector is well prepared for future shocks.

Looking ahead


There are many benefits of a solid RBC regime for both regulators and insurance companies. On the one side RBC regime will assist the regulators in understanding the risks companies are facing and how to monitor these risks. On the other side RBC regimes will assist the insurance industry to understand economic capital underlying the insurance business and their solvency position. It will also help those companies that have already calibrated their economic capital models to compare with the standard formula (if available) from the regulator.

The learnings from South Africa and other African countries that have implemented a Solvency II-type RBC regime suggest that the insurance industry will need significant time to implement and to develop internal expertise. Different companies are likely to have different target operating models. Small to medium size companies are likely to focus on ensuring compliance with regulations, while larger companies will focus on the overall transformation of their risk and capital management functions, developing economic capital models and ensuring efficient utilisation of capital. Insurers will be able to leverage learnings gained during the implementation of IFRS 17.


Likewise, regulators can leverage the learnings from the IFRS 17 implementation when developing the RBC regime. There are similarities between RBC regime and IFRS 17 including data granularity (although IFRS 17 requires more data), and new features such as risk margin/risk adjustment, contract boundaries and the use of best estimate valuation assumptions without margins.

Given the potential lack of internal capabilities and experience, insurers and regulators will need support in areas such as RBC training, statutory actuarial support, quantitative and qualitative impact assessment and model development, model validation and general assistance in embedding the new regime.

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# New generation risk premium reviews. Have you considered all the factors?

Premium reviews are a product development mechanism used by insurers to reduce the initial cost of insurance. While they are effective at enabling greater access to the insurance market, premium reviews introduce their fair share of complexities and uncertainties.

Insurers need to perform financially significant premium reviews in a complex and competitive market with an attentive regulator. This requires them to have planned well and be deliberate about premium reviews. A well thought out premium review framework that has been embedded into the business is an ideal tool to capture the necessary planning and thought.

In this article we provide context to the premium review issues, introduce some of the thinking and complexities associated with premium reviews, as well as explore how a premium review framework can assist insurers to achieve an optimal outcome.

## Where did this all start?

For many years leading into the 2000s, universal life insurance products were the most common products to meet the combined life insurance and savings needs in the South African middle to upper income segment of the market. However, since these were phased out at the turn of the century, the insurance offering in this market segment has been pure risk policies without underlying investment component to the product.

To ensure that these policies are affordable when insurers are faced with long-term uncertainty, insurers have only guaranteed the premium rate for a limited period of time. Effectively, this product design feature allows the insurer to share some risk with the policyholder which results in a lower initial premium.

Contract wording is often open-ended regarding the treatment of premium reviews. This leaves the insurer with significant discretion in the implementation of premium reviews, resulting in uncertain policyholder outcomes. The Financial Services Conduct Authority (FSCA) has recently proposed changes to the Policyholder Protection Rules (PPRs) which includes amendments



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to the requirements for the carrying out of premium reviews for insurance contracts to ensure that policyholder rights are appropriately protected.

As the economic conditions in South Africa have developed, the need for life insurers to review premiums has become more pressing. In the recent past, the industry has seen several insurers carrying out premium reviews.

Philosophical framework

Life insurers find themselves needing to review premiums in a complex and competitive environment. Premium reviews raise many questions around which components of the premium can be reviewed and the extent to which they can be reviewed. A well-documented and clearly defined set of Principles and Practices for Premium Reviews (PPPR) will help to ensure that fair and efficient premium reviews are carried out in the future.

A valuable by-product of the PPPR is that it enables the insurer to capture the underlying philosophy of the product design, which could be lost when managing staff change, and where new staff members have different philosophical views. A useful consequence of having a clearly articulated philosophy is that policyholder expectations can be managed appropriately since there is a documented view of how the insurer intended to adjust the originally priced premiums.

While not necessarily explicitly determined in the pricing basis, or held in an administration system, the aggregate expected insurance premium can be broken down into the following components:

- a portion of the premium to cover risk benefits (current period and future periods);
- a portion to cover administration and sales expense;
- a portion to provide for a Cost of Risk Capital; and
- residual after-risk profit margin.

Where the incidence of costs and premiums are not aligned (e.g. in a level premium contract that covers a level sum assured whose expected risk benefit cost is expected to increase as the

policyholder ages), there will be an element of pre-funding that needs to be considered in the premium review.

The first three components of the premium can be reviewed for changes in the expected experience of the insurer. The reasons for which they can be changed may be constrained by the policy wording; however, policy wording is often open-ended. This leaves the insurer with discretion in determining which risks and financial impacts are passed on to policyholders. A view that can be considered is that only risks that are either not foreseeable or not within the control of the insurer should be passed on to policyholders. This would, for example, prohibit the insurer from passing on losses that arise due to factors in the control of the insurer. Expense management would be one such factor.

The fourth premium component, residual profit, is not typically constrained by policy wording; however, the PPRs prevent insurers from using premium reviews to increase profit margins. Profit margins are not defined in the PPRs leaving the complexity of defining this to the discretion of the insurer. The PPRs also prevent insurers from using premium reviews to recoup past losses. This is considered reasonable since the insurer would have taken, and charged for, all the risk during this period and benefitted from any profit arising.

To ensure a fair outcome for policyholders, an insurer needs to consider principles and implement practices that balance the regulatory requirements, competitive pressures, customer experience outcomes and the preservation of future profit for the insurer.

The considerations for principles would include:

- the granularity of the premium review: this requires the balancing of fair outcomes with practical complexity;
- symmetry of premium reviews: policyholders may expect that being exposed to downside risk entitles them to the benefits of a positive expected experience.



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Regulation and professional guidance

The FSCA has recently proposed changes to the PPRs. The changes proposed to the PPRs that affect premium reviews introduce a requirement for insurers to maintain a PPPR document and a requirement to notify the regulator where premium reviews are expected to be in excess of 20%. The FSCA has also recently communicated concern around the premium increases effected on funeral policies. These are both indications that the regulator's intention is to ensure that premium reviews are fair and that reviews carried out will be monitored.

In October 2021, the Actuarial Society of South Africa (ASSA) issued a version of an Advisory Practice Note (APN) on reviews of life insurance policies to its members for comment. This draft APN emphasises the need for actuaries to act responsibly and apply their minds to the discretion available to them. The APN encourages upfront consideration of the principles that will be applied at review stage and there is a strong focus on communication and policyholder expectation management.

Potential blind spots

Premium reviews give rise to many issues that are not immediately obvious. Determining and maintaining a record of an asset share for pure risk policies is one such issue.

Where policies have a premium pattern that pre-funds the cost of insurance later in the policy's life, the review should consider the value of the pre-funding that has accrued to the policyholder at the review date. This quantum of pre-funding is often referred to as the asset share of the policy. The basis used to determine the asset share would imply what is guaranteed to the policyholder during

the guarantee period. Asset shares are typically retrospectively calculated and consider actual experience. Basing an asset share for premium review purposes on actual experience would mean that the policyholder shares in the experience during the guarantee period and this may not be the intention of the insurer. It is also not typical for insurers to have tracked asset shares for pure risk policies and if this has not been done, pragmatic estimations would be needed.

Where to from here?

Clearly articulating the premium review intention in a contract, managing policyholder expectations through the policy lifetime, setting up systems to administer policies that will be reviewed and actually carrying out a premium review creates a complex and comprehensive actuarial control cycle. The issues faced during a premium review require actuaries and other professionals involved to exercise judgement and execute tasks professionally and ethically. Tasks of this magnitude stand the best chance of being executed successfully if there is adequate planning and forethought. A PPPR provides a valuable tool to enable the insurer to do this efficiently. Apart from the value added by practices and principles that will be embedded in the business, the process of developing the PPPR provides the insurer with a unique opportunity to assess the products that it is selling, their implications and the needs that they are meeting.

While it is important to have a PPPR to assist with planning and forethought, it is important to ensure that it is complete. This begs the question: Have you considered all the factors?

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# The FATF Report: what you need to know

The Financial Action Task Force (FATF) recently released its 2021 Mutual Evaluation Report for South Africa. The FATF's findings show clearly that South Africa needs to significantly improve its practices and processes with regard to countering money laundering and terrorist financing. FATF has also made it clear that it believes the large banks have established better practices and processes than the rest of the Accountable Institutions, and accordingly there is a need for the insurance sector to reassess and refresh their responses to financial crime. In light of this, it is perhaps not surprising that in 2021 the South African Reserve Bank fined more insurers than banks for financial crime compliance weaknesses.

While the FATF's report contains a wide range of findings and recommendations, we will look at four key focus areas highlighted by the FATF that require immediate improvement.

### Risk-based approach

According to the FATF most financial institutions show an acceptable understanding of their anti-money laundering (AML) and counter terrorist financing (CFT) obligations. However, beyond the large banks, most demonstrate a largely rule-based, compliance-focused approach. A focus on compliance, rather than a truly risk-based approach (RBA) is likely to result in too much emphasis being placed on the client, with insufficient attention paid to other risk factors such as products, sectors and geographies. The report also voices the concern that RBAs are not systematically updated, and so they are potentially under-assessing emerging risks. An RBA which is static and reactive, rather than dynamic and proactive, may lead to important risk triggers being missed.

Where the RBA is underdeveloped, so are the risk management plans and, as a consequence, also the mitigation measures implemented. In these cases, the approach usually results in missing the intent of identifying true high-risk areas and

implementing controls and mitigation measures that target these directly. The suggestion from the FATF report is that RBAs need to be refreshed periodically to ensure that they adequately and comprehensively reflect and address the organisation's AML and CFT inherent risks. The refreshed RBA should then result in amended risk management plans and more effective control of financial crime risks.

The products offered by insurers are often not considered to be of high risk to money laundering and terrorist financing due to the delays between the premium payments and the eventual claim which often reduces the benefit of integration in the money laundering process. Nevertheless, the products do still share several key features such as: reliance on intermediaries, policies that can be used as collateral for loans, high value products, numerous parties to the contract (the insured, the premium payer, the claimant), lack of frequency of client contacts and multiple hand-offs in the pay-out process.

Further, the process of insurance also has wide ranging impact, from insuring of illegal goods, the sales-driven nature and incentivisation of brokers and limited oversight and control over intermediaries and their processes from the perspective of financial crime.

### Beneficial ownership

There is a well-known challenge with identifying and verifying ultimate beneficial ownership (UBO) of juristic customers and obtaining evidence of this. This is primarily driven by the lack of publicly available information in this area, and hence organisations often simply rely on customer disclosures. The result, however, is generally weak UBO data and controls. This in turn increases the risk of companies and the misuse of trust structures. There have been some attempts to improve this assessment by assessing

fund flows and undertaking behavioural analytics, but weaknesses remain. The critical question is whether insurers, in the absence of acceptable UBO data, will refuse to onboard a customer? The policy of the organisation should be clear and formal, and both staff and most importantly, intermediary training should be aligned.

While Government is assessing its role in improving the public recording of entity ownership information, all insurers should consider improved mechanisms to collect UBO data and must train staff on these mechanisms, especially where complex structures are involved.

Identification of UBO is often problematic for insurers as these are often only parties to the contract once the actual payment of the claim is processed. In such cases, and provided insurers implement strong and effective controls, insurers could potentially delay the identification and verification of these parties, provided no payment is made until the UBO is identified and verified.

### Politically Exposed Persons

Given the experience of South Africa with state capture and corruption, the FATF highlighted the issue of Politically Exposed Persons (PEPs) as a key risk. It was specifically noted that there are weaknesses in the PEP identification processes, and these often emanated from the PEPs occurring at provincial and local, rather than national, level. Provincial and local PEPs are typically not covered on traditional lists contributing to this weakness.

Critically assessing the completeness of an insurer's PEPs checklists is an important risk mitigation measure. In this context, the legislated timeline needs to be disregarded and an adage of 'once a PEP, always a PEP' should be applied.

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Transaction monitoring

Transaction monitoring (TM) observations are mixed, and while many entities generate a good number of alerts, others are almost exclusively focused on monetary limits. A balance is required between generating adequate numbers of alerts and ensuring that they are based on effective scenarios. An overreliance on generic system-based scenarios will lead to weak alert data. The value in the process is intentionally assessing valid alerts, rather than simply going through the process.

From an insurance company’s perspective, this always remains a challenge as most TM solutions on the market have limited scenarios that are focused on insurance transactions, and rather focus on the typical transactional accounts for banks. However, there are a number of innovative solutions developed by fintechs that are becoming more robust and widely available to handle these issues. It is important that the selection of a solution is performed in line with the risk assessment and risk-based approach to ensure that there is alignment, and the risk is appropriately managed. We believe that monitoring of insurance contract transactions for financial crime could be considered and performed as part of the process when considering claims fraud. While claims fraud is a different set of risks to money laundering and terrorist financing, it is an area where insurers have a very good understanding, and it can be used as a strong foundation for managing financial crime risk more broadly.

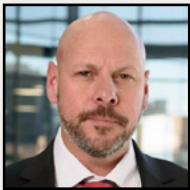
The FATF report findings highlight disappointing results for South Africa, as it introduces the real risk of a grey listing. While the

South African government understands that there are aspects it needs to correct, it will also require stronger cooperation between Accountable Institutions and law enforcement. Two things are clear from the report. The first is that the FATF have provided some clear indications of where the areas of weakness are, and second, there is no doubt that the Regulator will be far more active at monitoring Accountable institutions’ responses. The combination of these two is that the responsibility for reducing financial crime has increased for Accountable Institutions. Insurers will need to respond accordingly.

Ensuring the sustainability of the insurance sector

While the insurance sector might not be the most obvious one in the context of financial crimes, failure to strengthen preventative measures could undermine the sustainability of the sector. The FATF report provides a good starting point as it identifies key weaknesses of the current system and offers recommendation on how to strengthen it. Stronger cooperation and alignment between law enforcement and insurance companies will be necessary to tackle the risk of financial crimes. Further, the government will need to address certain weaknesses from a regulatory/ legislative perspective. This will likely increase the responsibility of Accountable Institutions to be more active in their response to financial crime risks.

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# The customer gold rush

Customer experience and satisfaction are critical components for insurance. In Africa, many insurers are still in the early adoption stage of digital transformation and have only recently started to focus on customer centricity. However, customers already demand greater digitisation and process automation, flexibility in product offerings and terms, and individualisation of risk profiling and pricing. The mismatch between offerings and engagement models of insurers and customer demand was amplified by the COVID-19 pandemic. This highlights the need for insurers to adapt their traditional business models to more customer-centric ones.

Customers expect fast and personalised service wherever and whenever they need it. To remain competitive, insurers need to offer the best, most seamless customer experiences possible at the right price. There are three 'action' avenues that insurers take in response to these customer requirements: (1) large-scale digital and customer transformation initiatives (2) partnerships or (3) merger and acquisition (M&A). A fourth 'inaction' avenue exists when insurers do not change or adapt. However, inaction would make it difficult for insurers to remain profitable in the medium to long term as the competitive landscape evolves and more attractive options emerge.

## Customer and digital transformation: gamification, big data and personalised risk profiling

Most African insurers have existing internal projects aiming at the improvement of client engagement journeys and portals or streamline internal processes through automation or robotics process automation. While these interventions are likely to improve the current customer journey for existing customers and may prevent margin leakage in the short term, insurers need to think bigger if they want to remain competitive in the long term. Seamless customer journeys and competitive prices were a competitive advantage five years ago – today they are table stakes.



On the other end of the spectrum, some insurers have made great advancements on their digital transformation journey and have thought about personalised customer service and pricing in more innovative ways. These leaders have embarked on targeted and thought-out projects to gamify and incentivise customers leveraging big data. The utilisation of big data enables insurers to offer more individualised products. The application of the Internet of Things (IoT) in the insurance industry, or 'connected insurance', allows insurers to collect and transmit additional personal data, which can be used to create personalised risk profiles. This is particularly relevant in the health and vehicle insurance categories in South Africa, pioneered by a leading health and lifestyle rewards programme.

Data collected from wearables, in the case of Vitality Health, and by telematic sensors, for Vitality Drive, creates a symbiotic relationship between the customer and the insurer. Vitality members can monitor their performance and are offered incentives to modify their behaviour and reduce their risk profiles. In turn, Discovery aims to reduce claims paid out. These connected insurance methods also act as early warning systems, to detect and prevent accidents and subsequent, and potentially expensive, insurance claims. In the case of Discovery Drive customers already have the option to receive a premium discount of up to 20%, calculated based on their personal driving behaviour profile, underpinned by the client's telematic data.

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Application of individualised risk-based pricing is likely to increase the spread of customers by risk segment. However, while many customers will benefit, for some customers insurance may become unaffordable.

While Big Data will inevitably become increasingly valuable to create truly revolutionary customer offerings, insurers will need to navigate the landscape carefully to ensure that customers continue to see the benefit associated with sharing private data, and at the same time feel that their data is safe, and regulations are complied with.

Partnerships: digitisation through application of InsurTech and Artificial Intelligence (AI)

Over the past decade, customer expectations shifted heavily towards increased digitisation, accessibility and flexibility. This is compounded by the growing focus on virtual customer engagement, expedited by the COVID-19 pandemic. Large insurers, which are unable to adapt quickly, have often partnered with smaller and more agile InsurTech companies to augment their value proposition. In addition, some new market entrants, unencumbered by legacy systems or processes, have become serious competitors to incumbent insurance companies.

Naked Insurance, launched in 2018, has fully automated the quoting and transacting processes via a mobile app which utilises AI-based algorithms. Customers have access from anywhere and can purchase insurance in under two minutes, with no agent intervention or paperwork. Insurers are also able to cut the cost of premiums due to automation-related savings. Utilising automation enables the company to offer competitive premiums. Furthermore, the company offers a ‘pay-as-you-go’ model. The flexibility of this model creates a shift from product- to customer-centric insurance offerings, as customers adjust or pause cover to suit their lifestyle, for example pausing vehicle cover while not travelling. These measures have allowed Naked Insurance to grow their customer base and will enable it to ultimately benefit from economies of scale.

Naked Insurance has already received financial backing from Naspers and Hollard, and several other players have implemented various forms of digital customer engagement platforms. Although existing giants in the industry may struggle to adapt quickly, customer-centric insurers will need to leverage InsurTech, or partner with InsurTech providers to embrace the level of digitisation and flexibility which today’s customers expect.

M&A activity: bolster or streamline the group value proposition

Many insurers recognise the limitations of old business models in meeting changing customer expectations in a profitable way. To overcome these limitations, they have turned to M&A initiatives or partnerships with other large companies in the sector, adjacent industries or FinTech/InsurTech or MedTech startups. Alternatively, companies have started to dispose of non-core service offerings to increase their focus. This created an exponential upswing in M&A activities across the sector over the past five years, with deal numbers more than doubling year-on-year. Specifically, in 2020, African M&A transactions in insurance increased by close to 170%, year on year.

Recently, Alexander Forbes sold their group life insurance business to Sanlam for R100 million. Sanlam has reaffirmed that this in line with their growth strategy to have a strong leading position in the life insurance sector in South Africa. In addition, this acquisition will enable Sanlam to diversify its risks across a larger pool. Alexander Forbes, in the meantime, is in the process of exiting insurance altogether to focus on their core advisory and administration businesses. Furthermore, Sanlam and Absa are consolidating their savings business in Southern Africa, to create a business with over R1 trillion in assets under management, administration and advice.

Similarly, many multinational insurers recognise the limitations of a one-size-fits-global business model in Africa. Hence, some of them have made significant investments into African businesses to remain competitive on the continent. In recent years, Prudential

Financial Inc. (through its separate account managed by Leapfrog), invested into Enterprise Group Limited (Ghana), Prudential plc invested in Zenith Bank (Nigeria), Old Mutual invested in Oceanic Life (Nigeria) and Swiss Re invested in Leadway Assurance (Nigeria).

These examples indicate that the industry is reorganising itself to adapt to customer requirements, but to also remain sustainable, profitable businesses that are focused on specific business lines, tailored for specific jurisdictions and associated customer behaviours.

Conclusion

To remain competitive, it is crucial for African insurers to evolve with the customers’ need for increased digitisation, accessibility, flexibility, and individualisation. While there are clear leaders in the industry, there is still time to invest in beyond-the-obvious customer initiatives and partnerships to enable all insurers to move from a product-push mentality to individualised customer offerings in a streamlined and deliberate fashion.

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# Adopting digital technologies to unlock the Nigerian insurance market

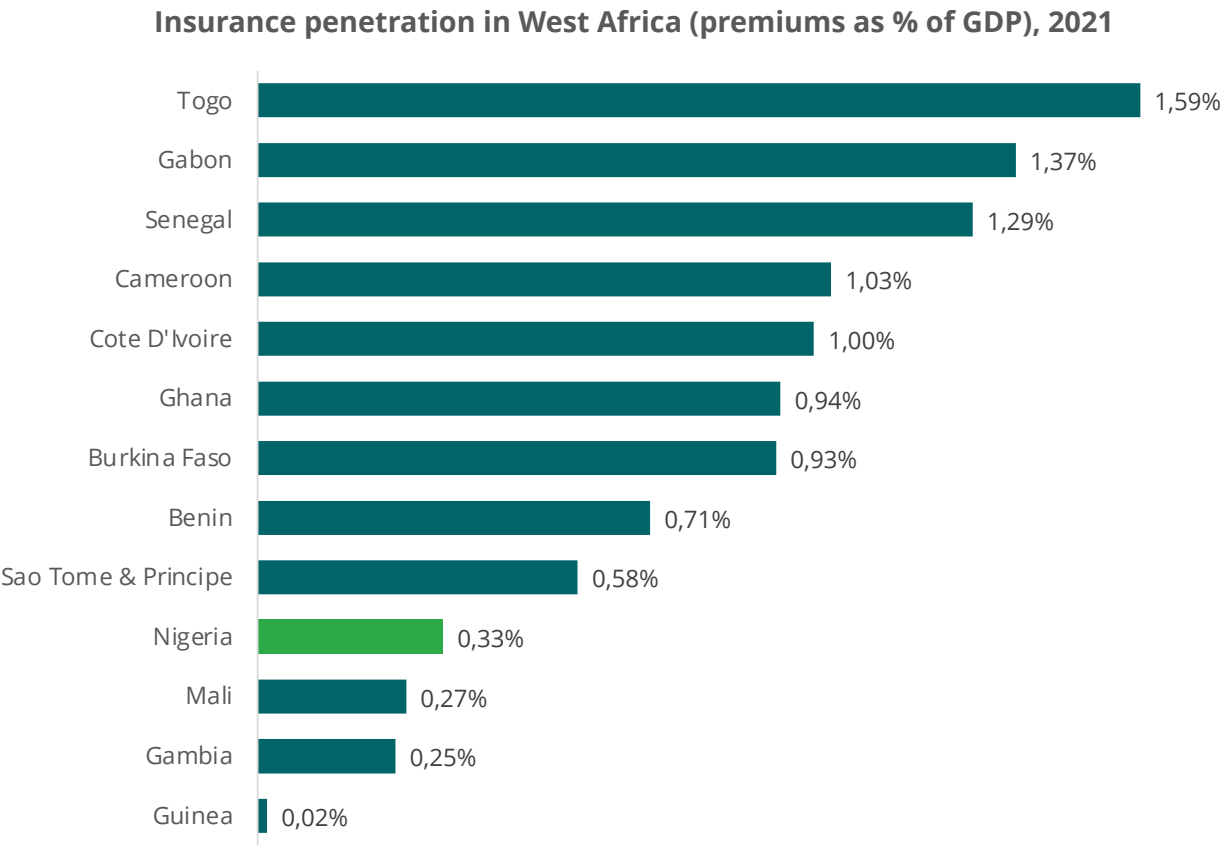
In Nigeria, Africa's most populous economy, insurance penetration remains considerably below 1%. This is one of the lowest penetration rates in West Africa and below the African and global averages of 2.6% and 7.4% respectively.

Poorly tailored products, cumbersome claims processes and unsuitable premium collection methods, coupled with limited awareness, negative public perception about insurance and low purchasing power are some of the factors constraining the growth of the insurance industry in Nigeria.

While Nigeria is the world's seventh most populous country and the 28th largest economy, it was only the 72<sup>nd</sup> largest insurance market with total industry premiums of US\$1.2bn in 2020. This gap between its economy's size and the industry's size, reflects a sizeable opportunity for growth.

Given this untapped potentially huge insurance market, a number of InsureTech start-ups and investors have turned their attention to Nigeria. In addition, local entrepreneurs, including at least 15 local InsureTech start-ups, increasingly focus on creating solutions for currently unserved and underserved markets.

Most of these InsureTech companies deploy a range of digital tools such as advanced Customer Relationship Management (CRM) systems, Artificial Intelligence (AI) powered virtual assistants, data analytics and geo-tagging to reach customers that were regarded as unviable by traditional insurance companies in the past. To compete with these new market entrants, key traditional insurance companies have started to turn to digital tools to develop products for underserved market segments.



Source: Fitch Solutions (2022)

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**Key digital technologies reshape the insurance sector in Nigeria**

AI and data analytics will assist with risk mitigation and fraud detection. The introduction of innovative Customer Relationship Management systems will improve customer experience and potentially attract new customers. Improved access to customer data due to the introduction of the Bank Verification Number (BVN) and the National Identification Number (NIN) has made the use of these CRM systems much more effective and powerful.

Further, leading insurance providers have started to improve customer experience by getting closer to their customer by using email, instant messaging platforms, mobile applications, and

Unstructured Supplementary Service Data (USSD). To use these technologies, customers do not need advanced smartphones or other mobile devices but can access them through feature phones and entry-level smartphones.

To overcome issues related to the claims and premium collection process, insurance companies have started to utilise mobile payment services or mobile airtime-based payment methods, which do not require traditional bank accounts. By doing so, insurance companies can service parts of the unbanked population, which used to be inaccessible for insurance companies that relied on bank accounts for claims and premium payments.

**The power of partnerships**

In recent years, traditional insurance companies have formed partnerships with InsureTech start-ups or mobile operators to expand their reach to previously underserved or unserved market segments. Partnerships with mobile operators allow insurance companies to deploy, for instance, airtime or mobile money as payment methods. While this technology has already been deployed in other African markets, the introduction of such solutions has been delayed in Nigeria due to certain regulatory restrictions. However, at least one leading insurance company is already collaborating with a mobile operator to enable mobile payments for health insurance. Discussions are currently underway between Nigerian payments service providers and telecommunications companies to extend access to health insurance via mobile phones.

A major insurance provider has partnered with a mobile operator and developed a product that combines life and hospital Insurance. The product leverages USSD technology and data analytics to provide the firm with access to millions of mobile subscribers. At the time of launch, this was the first free for customer life and hospital cash insurance policy offered via mobile phone technology in Nigeria. Within the first 12 months of the launch of the product, the product’s customer base grew by over 160% . Data analytics enables the insurance company to track and follow up with subscribers that failed to complete the registration process through the USSD menu.

In addition to partnerships between insurance companies and mobile operators, discussions are currently underway between Nigerian payment providers and mobile operators to extend access to health insurance via mobile phones. The aim is to allow Nigerians in rural areas to access services in local health centres by making insurance payments by phone, using a digital wallet and without a bank account.

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Digitisation front and back-end operations

The Nigerian insurance industry is evolving from an analogue to a digitally driven industry. Office processes are automated, manual registers and record keeping are being phased out, policy and clients’ information are spooled electronically, policy documents are generated and transmitted electronically, and the client onboarding process has been streamlined. However, despite the progress made so far, the industry still struggles with challenges, including inadequate access to public data which limits automation of insurance, substandard product knowledge, delayed adoption of technology, absence of innovative products tailored to meet clients’ needs, data related issues around premium payment, poorly implemented CRM to personalise and address customer needs.

C-suite focus areas and impact of digital transformation

The future of insurance is being driven by rapid changes in retail insurance, which have led to mindset shifts among insurance executives. There is now a stronger emphasis on having unified multi-channel platforms for selling all retail insurance products, on agile and flexible product delivery, on personalised services, digitised processes, and digital tools, as well as on cross-industry partnerships. This has helped and will continue to help insurance providers to be cost efficient and able to provide affordable products.

As Insuretech companies have started to offer health and income protection products at the fraction of the cost of that of incumbents and within a couple of minutes, incumbent players must appreciate the need for a different approach and need to consider delivering innovative solutions at more competitive prices.

While several insurance companies have started to embrace digital technologies and are creating products that are more suitable to the low-income mass market, the regulatory environment will also require an alignment to these recent developments. Fortunately, the National Insurance Commission (NAICOM) seems to have taken a step in this direction and released its Statement of Regulatory Priorities in 2017 which aims at the development of a framework for the balanced adoption of technology driven innovation in the industry. As of March 2022, the Commission stated that it will implement various initiatives focused on using technology to boost access to insurance. These include the unveiling of their sandbox, which will give room for innovative expansion of insurance reach and the web aggregators’ guidelines, which are expected to open access to insurance.

What’s next?

Being digital requires focusing on the customer and to understand the particular nuances of the local market. Forging partnerships and alliances, investing in skills and talent, and embracing a digital mindset will be critical to leveraging innovative technologies that can unlock the currently underserved and unserved insurance market in Nigeria.

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# Are you ready for an IFRS 17 external audit?

The adoption date of the new financial reporting standard for insurance contracts (IFRS 17) is drawing near. As insurers start entering the home stretch, we expect to see engagement with external audit ramp up significantly. Management teams need to take steps to ensure that documentation and evidence of implementation and transition activities, as well as new processes and controls to address new risks and changes to financial reporting, stand up to external audit scrutiny.

### The external audit process in a nutshell

In determining how insurers can prepare for an external audit under IFRS 17, it is important that those engaging with the auditors understand the context of the external audit approach. During the planning stage of an audit, the auditor performs a risk assessment of the entity, its environment and internal controls. By doing so, the auditor identifies risks that might result in material misstatement to the financial statements and assesses to what degree these risks will be significant or not. The higher the level of audit risk identified, the more audit effort is required to provide the appropriate level of assurance.

Based on the risk assessment, auditors will design and perform audit procedures to address these risks. These procedures could include substantive tests alone (test of detail, such as sample testing, and predictive analytical procedures) or a combined approach of substantive tests and controls testing, which include testing the design and implementation and operating effectiveness of the entity's system of internal control. Where the internal controls are weak, the emphasis of the audit will be on performing substantive tests which require significant additional effort and are more costly.

In certain instances, auditors will have to take a combined audit approach. Such circumstances arise when substantive procedures alone may not provide sufficient and appropriate audit evidence,<sup>1</sup>

e.g., environments where there are high volumes of data or transactions, complex calculations or where several systems with many handoffs and interfaces of data between the systems exist. Given these circumstances are expected to be prevalent in adopting IFRS 17, as well as the heightened risk of material risk of misstatement in an IFRS 17 set of financial statements, auditors will likely have to test the operating effectiveness of controls in addition to performing substantive testing<sup>2</sup>.

Given the role of internal audit in providing independent assurance that an organisation's internal controls are operating effectively, external audit may seek to rely on the work performed by internal audit in this regard.

External audit will further consider the work of other risk and compliance functions and their role in identifying and managing risks within the entity.

How management engages with these stakeholders and respond to risk in their IFRS 17 programmes will influence the approach adopted by external audit and the nature, extent, and timing of audit work to be done.

<sup>1</sup>ISA 330 The Auditor's Responses to Assessed Risks paragraph 8: "The auditor shall design and perform tests of controls to obtain sufficient appropriate audit evidence as to the operating effectiveness of relevant controls when:  
(a) The auditor's assessment of risks of material misstatement at the assertion level includes an expectation that the controls are operating effectively, or  
(b) Substantive procedures alone cannot provide sufficient appropriate audit evidence at the assertion level."  
<sup>2</sup>ISA 330 The Auditor's Responses to Assessed Risks paragraph 18: "Irrespective of the assessed risk of material misstatement, the auditor shall design and perform substantive procedures for each material class of transactions, account balance, and disclosure."

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Which areas are most likely to increase the risk of material misstatement under the application of IFRS 17?

- Actuarial models and the assumptions underpinning these models
- Data volume and granularity
- Information technology changes
- Interim transition solutions
- Complex and voluminous disclosures prepared within pressurised timelines

Actuarial models and the assumptions underpinning these models

In line with the International Standards on Auditing, accounting estimates derived from the data, assumption setting process and actuarial models are susceptible to an inherent lack of precision in their measurement<sup>3</sup>. Further considerations that increase audit risk include:

- **Judgment about the interpretation of the Standard:** IFRS 17 is a principles-based standard, and this results in key drivers of the balance sheet and revenue being open to interpretation and hence involve judgement which may be subject to management bias.
- **Judgement applied in determining assumptions:** Although insurers are experienced in having to apply judgement in determining subjective assumptions, the requirements of IFRS 17 takes the risk in these estimation processes to new levels.
- **Accuracy of complex models:** IFRS 17 requires models to be calibrated to the requirements of the standard and to solve for complex concepts such as non-distinct investment components, loss components and loss recovery components. This requires changes to existing models and may necessitate the development of new models that are able to produce accurate results.

Significant judgement and estimation uncertainty will be ubiquitous in determining the inputs, assumptions and techniques used to develop accounting estimates, increasing the risk of material misstatement.

Data volume and granularity

Complete and accurate data is the foundation for the production of relevant and reliable financial reporting and should not be underestimated. Many insurers have grappled with the demand

of IFRS 17 in this space. Not only has the volume and granularity of data requirements increased, but this data needs to be sourced, interpreted, grouped, and used based on the complex technical requirements set out by IFRS 17.

Key drivers impacting data requirements include the level of aggregation on insurance contracts, explicit measurement of the individual components of both insurance and reinsurance contracts held, more detailed disclosures, and the restatement of prior period results on transition. These factors, along with the requirement to source both historical and current data sets, possibly from areas outside current financial reporting systems or from outsourced providers, increase the risk of material misstatement of the financial results.

Information technology changes

For many insurers, IFRS 17 has required significant investments in systems. Even outside the changes to the modelling systems we have seen enhancements to data storage and processing capabilities, and significant changes to the financial ledger systems. Whether an insurer has taken the decision to purchase, enhance existing or develop new systems, it would have required a review of their technology landscape and resulted in system and operating model changes. Management needs to consider what impact their system implementation approach has had on the financial reporting process holistically and the degree to which additional risks have arisen because of this approach. Examples of factors that may increase the risk of material misstatement in financial reporting include:

- Increased organisation and transfer of data: this may result in lesser degrees of automation and more manual activities, which have increased susceptibility to human error.

<sup>3</sup>ISA 540 (Revised) Auditing Accounting Estimates and Related Disclosures. defines an accounting estimate as “a monetary amount for which the measurement, in accordance with the requirements of the applicable financial reporting framework, is subject to estimation uncertainty.” Estimation uncertainty is further defined as “Susceptibility to an inherent lack of precision in measurement.”

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- The use of service organisations: In implementing new technologies insurers may have taken the decision to use a service organisation e.g., for cloud-based solutions.
- Where insurers have elected this option, management and Boards cannot abdicate from their responsibilities for the oversight and governance of information generated for use in the preparation of IFRS 17 financial statements. Outsourcing will therefore introduce.

Interim transition solutions

While some insurers may perform transition calculations using their “business as usual” IFRS 17 systems and models, others may adopt more “tactical solutions” outside of their core architecture. The latter may result in increased levels of risk depending on how well governed these proxy models are. For example, in those entities that are running transition calculations in Excel spreadsheets, the risk of misstatement may increase due to the manual nature of the process, with data and calculations not likely to be maintained in a secured controlled environment.

Complex and voluminous disclosures prepared within pressurised timelines

Relevant and reliable disclosures are fundamental to communicating deeper insights about an entity’s financial position and financial performance. IFRS 17 requires an insurer to prepare more extensive qualitative and quantitative disclosures that provides users insight into highly subjective matters such as alternative measurement bases, assumptions, models, and sources of estimation uncertainty. Under IFRS 17, insurers will experience increased time and resource pressure on their financial reporting working day timetable and financial close processes. These factors increase the susceptibility of the financial statements to error.

Key questions that management need to address in assessing whether the disclosures are subject to increased risk of material misstatement include:

- Have accounting policies and significant areas of judgement and estimation uncertainty been adequately disclosed?
- Have the IFRS 17 note disclosures been correctly calculated, aggregated and presented in the financial statements in accordance with the IFRS 17 requirements?
- Is the information in the financial statements relevant, reliable, comparable, and understandable?
- Do the financial statements achieve fair presentation of the entity’s performance and financial position?

All these questions will be areas of focus for external audit, who need to provide assurance to the Board, investors and other key stakeholders that the financial reports fairly present the financial performance, cash flow and financial position of the entity.



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What can management do to prepare for an IFRS 17 external audit?

- Engage early with external audit to enable progressive and continuous assurance
- Apply an “if it’s not documented, it’s not done” rule
- Prioritise the enhancement, design, and implementation of manual and automated internal controls
- Bed down management’s view of materiality
- Optimise IFRS 17 implementation testing strategies

Engage early with external audit to enable progressive and continuous assurance

If you have not already started, now would be the time to engage with external audit. Akin with the challenges faced by management in adopting the standard, external audit will be required to redesign their external audit approach to provide assurance on the IFRS 17 results. This will require external auditors to develop an accelerated understanding of the key changes to, and impact of, IFRS 17 on the entity. To facilitate this understanding, management should encourage participation of external audit in internal forums such as IFRS 17 Steering Committees. In order for external audit to appropriately plan the nature, timing and extent of their audit procedures, management must provide the external auditors with a view of project milestones and timelines and schedule frequent check-ins to discuss project developments as they arise. This will not only facilitate a more streamlined audit process but provide management the benefit of obtaining progressive assurance, allowing sufficient time to resolve any differences in opinion and implement remediation plans where necessary.

Apply an “if it’s not documented, it’s not done” rule

In general, the starting point for external audit will be to review policy and methodology papers prepared by the entity. These papers are critical for the auditor to obtain an understanding of the key judgements, accounting policy choices, methodologies and interpretations taken by management and approved by those in charge of governance. External audit will use these papers to test management’s interpretation of the standard, and the practical application of their policies between reporting entities (in a group set of financial statements) and from reporting period to reporting period.

To ensure that there is sufficient and appropriate documentation, substantiating the entity’s decisions, management should approach the documentation in a way that someone without knowledge of the entity can logically follow and understand the

conclusions reached. Where appropriate, management should ensure that the discipline of documenting new policies and methodologies is embedded in their new business processes and that existing documentation is periodically reviewed and updated and that any changes are approved by the relevant governance structures.

Prioritise the enhancement, design, and implementation of manual and automated internal controls

Internal controls are not only imperative to the safeguarding of your organisation but, as previously discussed, directly impact the quality and efficiency of an external audit process. As with current practice, management need to ensure that any risks that arise from the implementation and application of IFRS 17 are appropriately identified and mitigated by internal controls.

The type of controls that need to be designed and implemented will vary based on an insurer’s specific circumstances; however, new controls implemented for IFRS 17 should link to the additional risks introduced by the new standard:

- Controls over the models** – such as appropriate access control, change management control, data quality checks, model validations and approvals. Controls over the models need to ensure that the methods, assumptions, and data used are appropriate, judgements made in selecting these are applied consistently and that the calculations are mathematically accurate. An advanced insurer will have a model risk policy, setting out the model governance, model change management control and model validation requirements expected of management. The insurer’s Chief Risk Officer and risk team, or sometimes Internal Audit, would then test and assess compliance with the model risk policy, assessing effectiveness of governance and control activities. Management should further consider the regulatory actuary’s role in ensuring the models are well controlled and governed.

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- **Controls over data** – appropriate data management and governance controls through the journey of data to ensure validity, accuracy and completeness including data quality checks, reconciliations, audit trail logs, data lineage and information security controls.
- **Information technology controls** – adequate general and application computer controls such as information access controls, IT change management controls, processing controls, software, and physical hardware controls, interface, and input controls. Given the changes brought about by IFRS 17 to the technology stack, it will be critical for insurers to harmonise controls across source, actuarial and finance reporting systems.
- **Manual controls** – particularly in addressing proxy transitional solutions, management will need to ensure inputs, calculations and all changes in manual processes are appropriately controlled through robust management review controls before amounts are approved. The adage of “if it is not documented, it is not done” is very pertinent in the auditor’s assessment of such management review controls.
- **Monitoring controls** – both entity-level and group-wide controls to ensure that all controls are operating as intended throughout the financial reporting period, including during the transition and determination of opening balances and restated comparative information, and any deviations are identified and rectified.

Management must ensure that end-to-end process and control documentation is updated to reflect changes resulting from transitioning to the new standard, including ‘business-as-usual’ ongoing controls and processes beyond transition.

Management should engage and collaborate with internal audit and other risk functions to perform both inflight development and post-implementation risk and control reviews. This will significantly aid management in assessing the appropriateness and readiness of the entity’s control environment and support increased reliance of the external auditors on the work performed by internal audit.

Bed down management’s view of materiality

Materiality works as a filter by ensuring that transactions that are sufficiently large and could influence the users of financial statements, are identified and managed. Insurers with a comprehensive log of all materiality judgements made during the implementation activities will allow management to assess the overall aggregate impact of these on the financial statements. This will further facilitate the required ongoing assessment that management will need to perform for each financial reporting period to ensure the materiality judgments remain appropriate and do not in the aggregate materially misstate the financial statements when taken as a whole.

Optimise IFRS 17 implementation testing strategies

In preparation for an external audit, management should seek to optimise the insurer’s testing strategies to ensure that people, processes, systems, and controls are well rehearsed in preparing IFRS 17 financial information. The benefits will be the limiting of processing and human errors and assist in identifying bottlenecks in the working day timetable. Any risks identified during testing should be included in the entity’s risk register, along with relevant risk mitigations, and addressed by designing and implementing relevant controls or by applying other appropriate measures.

Conclusion

Preparing for an audit of a standard as complex as IFRS 17 is no simple task. However, the upfront investment required to be audit-ready will have enduring benefits for management. Management’s awareness and ownership of key risk factors, combined with the adoption of robust strategies, to better prepare for the audit process will facilitate a more efficient and effective quality audit, reduce significant audit findings, contain audit fees, and enhance the confidence of the users of the financial statements.

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# Impact of IFRS 17 on the tax base of long-term insurers in South Africa

As insurers are well aware, the current financial reporting standard for insurance contracts (i.e. IFRS 4) will be replaced by a new reporting standard (i.e. IFRS 17) effective for reporting periods starting on or after 1 January 2023. The implementation of IFRS 17 will likely have a material impact on, among others, the carrying value and nature of policyholder liabilities in the financial statements and the profit profiles of insurers for reporting purposes. The policyholder liabilities recognised for IFRS purposes are currently taken into account in the determination of the taxable profits for long-term insurers. The transition to IFRS 17, therefore, potentially has significant corporate tax implications for insurers both at and after the transition date.

While the national legislature has acknowledged that changes to the current tax basis may be needed to mitigate the impact of the transition to IFRS 17, there is no clarity yet on what such changes may entail. Consequently, it will be important for insurers to anticipate the likely impact and to prepare accordingly.

Currently, the income tax regime for long-term insurers (the so-called 'five funds' tax regime) is based on the premise of insurance profits being taxed at the corporate tax rate, with such insurance profits determined based on the IFRS policyholder's liability values and certain adjustments required for tax purposes. The most significant of these adjustments relates to recognised negative actuarial liabilities being zeroised for tax, to the extent that they exceed positive liabilities in a tax fund. In addition to insurance profits, long-term insurers are also subject to tax on other income earned and are also liable for policyholder taxes in respect of net investment income earned in certain policyholder tax funds.

The transition to IFRS 17 is not expected to have a significant impact on other income and policyholder taxes incurred by

long-term insurers. The focus of the following will therefore lie on understanding the differences between the insurance profits of IFRS 4 and IFRS 17, and the impact this has on the existing tax basis.

## Reasons for significant accounting profit adjustments

As explained above, the tax value of insurance profits is directly linked to the IFRS value thereof and hence tax would be payable on any day one transitional IFRS profit adjustment (including any retained earnings impact), which could be significant. The impact on profits at transition to IFRS 17 could be positive or negative and depends on the extent to which profit recognition under IFRS 4 deviates from that under IFRS 17 retrospectively. In turn, this is dependent on the extent to which the value of IFRS 4 policyholder liabilities differ from the IFRS 17 carrying amount of the groups of insurance contracts.

The IFRS 4 and IFRS 17 liabilities may differ due to the following, although the below is not intended to be an exhaustive list:

- The extent to which the margins contained within the IFRS 4 liabilities result in a different margin for risk, compared to the risk adjustment under IFRS 17.
- The methodology, granularity and extent to which zeroisation was used under IFRS 4 to delay profit emergence and hence results in a different profit recognition pattern to that under IFRS 17. Under IFRS 17 the emergence of profit is driven by the Contractual Service Margin (CSM) which can be thought of as a mechanism to zeroise profits on day one of a contract.
- The transition approach used to determine the IFRS 17 transition balance sheet. The use of fair value, for example, will lead to a different opening CSM to that calculated under a fully retrospective approach.

- The choice of coverage units. Coverage units are a new concept brought about by IFRS 17, designed to release profit in line with service provided.
- The outcome of the IFRS 17 expense attribution exercise, through the impact on the Risk Adjustment and CSM components of policyholder liabilities.

For completeness, onerous contracts and the need to separate reinsurance contracts should not create significant differences beyond those described above.

There is therefore no single outcome that is expected for all long-term insurers in the industry. Results will differ depending on the current approach to reserving for policyholder liabilities under IFRS 4 (which allows for significant differences between insurers) and the extent to which this produces different results to IFRS 17, resulting in a different pattern of profit emergence.

## Key considerations

For a tax director or CFO of a long-term insurer, the following considerations should be top of mind when it comes to the tax impact of IFRS 17.

### Day one adjustment

As discussed above, a key consideration is the tax impact of any large day one IFRS adjustments. Anecdotally, it is anticipated that the transition to IFRS 17 will likely give rise to significant additional day one profits across the long-term insurance industry. Given how the current tax regime operates, these increased profits will result in increased tax payable on transition which may place certain insurers under severe liquidity strain. The extent of the impact will depend on a number of factors such as the quantum of the expected IFRS profit adjustment, the availability of accumulated

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deficits in specific tax funds to absorb the impact, and whether an insurer is in an overall net negative liability position in a tax fund which provides tax relief to the extent that such negative liabilities are disregarded for tax purposes in that specific tax year.

**Business as usual (BAU) impact**

Besides the day one impact on transition, the future profit profile of insurers could also change and the BAU impact that IFRS 17 has on the accounting profit over the remaining term of the affected policies will also impact the insurers’ tax profits in the medium- to long-term. It is recommended that insurers model the expected day one as well as BAU impact of transitioning to IFRS 17, as this may be used as a basis for lobbying the legislature for an appropriate phase-in period of the expected day one impact, or possibly for a different tax basis to apply under IFRS 17.

**Tax legislation uncertainty**

The National Treasury has proposed in the 2022 Budget Review that changes be made to relevant income tax provisions to mitigate the tax impact of IFRS 17 on the cash flow and profit profiles of insurers. However, there is no indication from the legislature as to what the nature of these changes may entail. The National Treasury has commenced interactions with industry bodies and other industry participants on the expected tax impact of IFRS 17, but such interactions are at a preliminary stage and there is no indication of what these interactions may produce.

Historically, where there has been a change in the valuation basis of liabilities for tax purposes, the legislature has acceded to providing a phase-in of the transition tax impact over a period of time. It is likely that this is something that will also be considered for the IFRS 17 transition. Another aspect presumably to be deliberated in the interaction with National Treasury would be the appropriateness of the current tax basis, but more specifically the treatment of zeroising negative liabilities.

**Systems changes and availability of information**

Given that IFRS 17 will fundamentally transform the disclosure of income, expenditure, assets and liabilities on the face of the statement of comprehensive income and the statement of financial

performance, insurers may encounter challenges in reconciling the data reflected in the financial statements and the data required to support the income tax return submission. Assuming no change to the current tax basis, insurers will still be required to allocate policies and the corresponding assets, liabilities, income and expenditure across the five tax funds. Policyholder taxes in the individual policyholder fund and company policyholder fund will still be required to be determined based on existing tax principles and will require insurers to support the actual legal nature of underlying investment income streams and expenses, as well as the proper allocation of these to each of the tax funds. As such, insurers will still need to maintain the existing granularity of data to support such submissions to the tax authority, irrespective of how these items will be recognised and disclosed for accounting purposes under IFRS 17.


In this regard, specific attention should also be paid to the allocation of the CSM across the five tax funds to meet the tax requirements in this regard.

**The way forward**


Given that IFRS 17 will be effective from 1 January 2023, any legislative changes impacting tax would need to be finalised prior to that date. Industry interactions with the National Treasury are expected to continue throughout this year and culminate in proposed changes to be enacted as part of the 2022 cycle of tax amendments. As noted, the legislature has not provided any indication as to what changes may be likely. However, we expect industry participants to lobby for the necessary tax amendments and expect consensus to be achieved at least on the introduction of a phase-in of the expected day one tax impact. This view is supported by the current experience in the United Kingdom where the HMRC, after consulting industry participants, has indicated its intention to spread the once-off transitional IFRS 17 profits and losses for tax purposes to mitigate the tax cash flow and regulatory impacts of the accountancy change and consequent volatility in tax receipts.

In this regard, we recommend that insurers ensure that adequate modelling of day one and BAU IFRS 17 profit and tax impacts are expedited and discussed with the legislature to achieve a suitable phase-in period. In addition, we recommend that insurers assess the system, model and data requirements that will be required to support income tax return submissions going forward and how these will interact with expected changes to accommodate IFRS 17.


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