Financial Reporting Insights

IMPACT OF REVENUE RECOGNITION GUIDANCE IN ASC 606 ON INSURANCE ENTITIES

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1. Introduction

In 2014, the Financial Accounting Standards Board (FASB) issued Accounting Standards Update (ASU) 2014-09, *Revenue from Contracts with Customers (Topic 606)* to provide a robust framework and comprehensive principles for addressing revenue recognition issues. Additionally, the guidance on accounting for certain costs related to a contract with a customer in the scope of Topic 606 was codified in ASC 340-40, *Other Assets and Deferred Costs – Contracts with Customers.*

Additionally, the American Institute of Certified Public Accountants (AICPA) has published a comprehensive nonauthoritative revenue recognition guide (the Revenue Recognition AAG) that provides helpful discussion and illustrative examples on how to apply the guidance. The guide includes discussion of various topics that an insurance entity may encounter in its application of the guidance in ASC 606.

For a comprehensive discussion of the revenue recognition model and other aspects of the guidance, refer to our guide to revenue recognition.

2. Scope

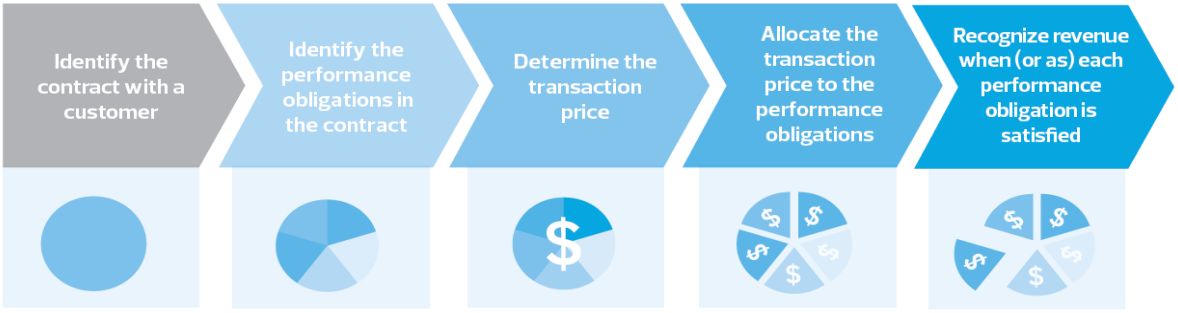
While ASC 606 replaced most existing industry-specific revenue recognition guidance, it did not replace the guidance applicable to insurance entities in ASC 944, *Financial Services—Insurance*. Accordingly, most insurance contracts entered by risk-bearing insurance entities are scoped out of ASC 606. This exclusion applies to all contracts within the scope of ASC 944, such as life and health insurance, property and liability insurance, title insurance, and mortgage guarantee insurance. However, as noted in paragraph BC14 of ASU 2016-20, *Technical Corrections and Improvements to Topic 606, Revenue from Contracts with Customers,* the scope exception does not apply to contracts of insurance entities with customers that are outside the scope of ASC 944. For example, a contract for administrative services (such as claims processing) without any insurance element would be accounted for under ASC 606.

Entities also should consider whether contracts are only partially within the scope of ASC 944. ASC 606-10-15-4 requires an insurance entity to bifurcate contracts into elements within the scope of ASC 944 and elements within the scope of ASC 606.

When considering costs to fulfill an insurance contract, costs that relate to activities within the scope of ASC 944, such as insurance risk mitigation or cost containment activities, continue to be accounted for in accordance with ASC 944. Refer to Chapter 9 for discussion of contract costs within the scope of ASC 606.

3. Core principle and key steps

To put the specific aspects of the revenue recognition guidance discussed in this white paper into proper context, it is important to know that the core principle included in the guidance (ASC 606-10-10-2) is to "recognize revenue to depict the transfer of promised goods or services to customers in an amount that reflects the consideration to which the entity expects to be entitled in exchange for those goods or services." In addition, the guidance sets out the following steps for an entity to follow when applying the core principle to its revenue-generating transactions:



4. Step 1: Identifying the contract with a customer

A contract is defined in ASC 606-10-25-2 as "an agreement between two or more parties that creates enforceable rights and obligations." To account for a contract in accordance with the guidance, the following five contract existence criteria must be met:

- Approvals have been obtained and a commitment to perform exists on the part of both parties
- Rights of both parties are identifiable
- Payment terms are identifiable
- Commercial substance exists
- Collection of substantially all of the amount to which the entity will be entitled in exchange for the goods or services that will be transferred to the customer is probable (i.e., likely to occur)

When all of the contract existence criteria are met, the remaining steps in the five-step revenue recognition model are applied to the contract. When all of the contract existence criteria are not met, revenue is deferred and the contract existence criteria continue to be evaluated to determine whether they are subsequently met. Absent meeting the contract existence criteria, revenue is only recognized under very limited circumstances, which could result in the initial deferral of revenue for what may be a significant period of time, even if nonrefundable cash has been received.

4.1 Combining contracts

When an insurance entity enters into multiple agreements with the same customer, the insurance entity should consider whether the contracts should be combined and accounted for as one contract for accounting purposes. If one or more of the following criteria are met, individual contracts with the same customer (or parties related to the customer) that are entered into at or near the same time are combined for accounting purposes:

- The contracts were negotiated as a package and share the same commercial objective
- The consideration to be paid under one contract is tied to the other contract's price or performance

- Some or all of the goods or services in one contract and some or all of the goods or services in the other contracts represent a single performance obligation (i.e., some or all of the goods or services in each contract are not distinct from each other)

Paragraphs 14.7.13 through 14.7.15 of the Revenue Recognition AAG should be considered following the insurance entity's determination of whether the contracts should be combined for accounting purposes.

4.2 Contract modifications

Changes or updates may be made to the contract during the life of the contract or relationship with the customer. Such changes should be assessed to determine if they are contract modifications that impact the accounting for the contract. The accounting model applied to a contract modification under ASC 606 depends on a number of factors, including the pricing of the modification, whether any new products or services added by the modification are distinct and whether any of the remaining goods or services are part of a single partially-satisfied performance obligation. Refer to Section 5.5 of our revenue recognition guide for further details on the accounting for contract modifications.

5. Step 2: Identifying performance obligations in the contract

After contract identification (Step 1), an insurance entity needs to identify the performance obligations in the contract (Step 2). Identifying the performance obligations in a contract establishes the units of account to which the transaction price should be allocated and for which revenue is recognized.

5.1 Identifying promises to transfer goods or services

The first step in identifying the performance obligations in the contract is to identify all promises to provide goods or services. An insurance entity should scrutinize its customer contracts and identify all the promises to transfer goods or services to the customer. Consideration also needs to be given to whether there are promises to transfer goods or services that arise out of the insurance entity's customary business practices instead of an explicit contract provision.

Not all activities performed by the insurance entity in connection with the contract transfer a good or service to the customer. For example, setup activities do not transfer a good or service to the customer. Instead, those activities are necessary for the insurance entity to fulfill the contract and do not themselves represent a good or service transferred to the customer. As a result, they cannot represent a performance obligation.

5.2 Separating promises to transfer goods or services into performance obligations

If there is more than one promise to transfer goods or services in a contract, consideration must be given to whether the promises to transfer goods or services should each be considered performance obligations and accounted for separately. The determining factor in this analysis is whether each promised good or service is distinct. A promised good or service is considered distinct if it is capable of being distinct and is distinct within the context of the contract. A promised good or service that is considered distinct is accounted for separately as a performance obligation unless the series exception applies. For additional information about the series exception, refer to Section 6.3 of our revenue recognition guide.

5.2.1 Capable of being distinct

If a customer can benefit from the promised good or service on its own or by combining it with other resources readily available to the customer, the good or service is capable of being distinct. A promised good or service is capable of being distinct when the insurance entity regularly sells that good or service separately or when the customer could generate an economic benefit from using, consuming, selling or otherwise holding the good or service for economic benefit either on its own or when combined with other readily available resources. For a resource to be readily available to the customer, it must be sold separately either by the insurance entity or another party, or it must be a good or service that the

customer already has obtained as a result of either a contract with the insurance entity (including the contract under evaluation) or another transaction or event.

5.2.2 Distinct within the context of the contract

To determine whether a promised good or service is distinct within the context of the contract, the insurance entity must ascertain which of the following best describes its promise within the context of the specific contract:

- *The promise in the contract is to transfer the promised good or service individually*. If this best describes the insurance entity's promise within the context of the specific contract, the promised good or service is distinct within the context of the contract.
- *The promise in the contract is to transfer a combined item or items to which the promised good or service is an input.* If this best describes the insurance entity's promise within the context of the specific contract, the promised good or service is not distinct within the context of the contract.

Indicators are provided to assist in determining whether a promised good or service is distinct within the context of the contract. Answering yes to any of the following questions is an indication that the promised good or service is not distinct within the context of the contract:

- Is the insurance entity providing a significant service of integrating the promised good or service with one or more of the other promised goods or services in the contract, with the result of that integration being one or more of the combined outputs contracted for by the customer?
- Does the promised good or service significantly modify or customize one or more of the other promised goods or services in the contract, or is the promised good or service significantly modified or customized by one or more of the other promised goods or services in the contract?
- Is the promised good or service highly interdependent or highly interrelated with one or more of the other promised goods or services in the contract, such that each of the promised goods or services is significantly affected by one or more of the other promised goods or services (i.e., can the insurance entity satisfy each of the promises in the contract independent of its efforts to satisfy the other promises)?

If a promised good or service is distinct, it is considered a performance obligation and accounted for separately. However, a series of distinct promised goods or services that are substantially the same should be considered a single performance obligation and accounted for as one unit of account if each of the goods or services has the same pattern of transfer to the customer because each of the goods or services is considered satisfied over time and the insurance entity uses the same method of measuring progress toward completion for each of the goods or services.

If a promised good or service is not distinct, it is combined with other promised goods or services until the group of promised goods or services is considered distinct, at which point that group is considered a performance obligation and accounted for separately. It is possible that all of the promised goods or services in the contract might have to be accounted for as a single performance obligation. This happens when none of the promised goods or services are considered distinct on their own or together with other promised goods or services in the contract.

6. Step 3: Determining the transaction price

6.1 General requirements for determining the transaction price

Transaction price is defined in ASC 606-10-32-2 as "the amount of consideration to which an entity expects to be entitled in exchange for transferring promised goods or services to a customer, excluding amounts collected on behalf of third parties (for example, some sales taxes)." An insurance entity may

elect an accounting policy under which it excludes from the transaction price taxes it collects from its customers that were assessed by a government authority on or contemporaneous with the insurance entity's revenue-generating transactions with its customers. Examples of taxes to which this accounting policy would apply if elected are sales taxes, use taxes, value-added taxes and excise taxes. Examples of taxes to which this accounting policy would not apply if elected are gross receipts taxes and taxes imposed during the inventory procurement process.

If an insurance entity elects this accounting policy, it must apply the policy to all sales and similar taxes. In other words, the insurance entity cannot choose to apply the policy to some sales and similar taxes and not apply the policy to other sales and similar taxes. In addition, if the insurance entity elects the accounting policy, the accounting policy disclosure requirements in ASC 235 apply.

If an insurance entity does not elect the accounting policy, it must determine whether it is a principal or an agent with respect to each sale or similar tax assessed on its revenue-generating transactions. If it is a principal, the tax is included in the transaction price. If it is an agent, the tax is not included in the transaction price. Making the determination as to whether the entity is a principal or an agent with respect to each sale or similar tax in every tax jurisdiction in which its revenue-generating transactions are subject to such taxes could be a very onerous exercise. It is for this reason that the FASB provided the alternative accounting policy.

6.2 Accounting for variable consideration

The transaction price should reflect the amount to which the insurance entity expects to be entitled in exchange for transferring promised goods or services to a customer, which may include variable consideration. Variability in the amount of consideration to which the insurance entity is entitled may be caused by explicit terms in the contract or it may be caused by an implicit price concession, discount, refund or credit the entity intends to offer the customer or that the customer has a valid expectation of receiving based on the insurance entity's customary business practices, published policies or specific statements.

There are certain scenarios in which an entity may not be required to estimate variable consideration:

- An entity provides a series of distinct good or services for which the variable payments relate specifically to the entity's efforts to transfer each distinct good or service within the series (see Section 8.3.2.1 5 of our revenue recognition guide)
- An entity is entitled to sales- or usage-based royalties and the only, or predominant, item to which the royalty relates is the license of IP (see Section 7.3.5 of our revenue recognition guide)
- An entity elects to apply the practical expedient that allows revenue to be recognized for the amount the entity has a right to invoice (see Section 9.3.1.1 of our revenue recognition guide)

Outside of these exceptions, an estimate of the variable consideration to which an insurance entity expects to be entitled should be included in the transaction price to the extent it is probable that its inclusion will not result in a significant reversal of cumulative revenue recognized when the uncertainty giving rise to the variability is resolved. This approach to determining the amount of variable consideration that an insurance entity should include in the transaction price suggests the following two steps should be performed:

1. Estimate the amount of variable consideration to which the insurance entity expects to be entitled using either the expected value method or the most likely amount method (the specific method used depends on which will better predict the amount of variable consideration in a particular set of facts and circumstances)
2. Constrain the estimated amount of variable consideration such that it is probable that the inclusion of the estimate in the transaction price will not result in a significant reversal of

cumulative revenue recognized for the contract when the uncertainty giving rise to the variability is resolved

While these appear to be two discrete steps, as discussed in Question 7Q.3.3.1 of our revenue recognition guide, an insurance entity's use of the expected value method to estimate the variable consideration to which it expects to be entitled may, depending on the facts and circumstances, reduce the probability of a revenue reversal such that the entity does not have to separately constrain its estimate of variable consideration.

The estimate of variable consideration must be reassessed each reporting period until the underlying uncertainty is resolved. Any changes in the estimate of variable consideration are treated the same as any other changes in the transaction price. The method used to initially estimate the variable consideration included in the transaction price should also be used when the estimate is reassessed each reporting period.

7. Step 4: Allocating the transaction price to the performance obligations

7.1 Overall allocation model

Step 4 of the five-step revenue recognition model in ASC 606 requires an insurance entity to allocate the transaction price (determined in Step 3) to each performance obligation in the contract (identified in Step 2).

The overall objective of the guidance on allocating the transaction price is to allocate an amount to each performance obligation (or distinct good or service in a single performance obligation resulting from the series exception [refer to Section 6.3 of our revenue recognition guide]) that represents the consideration to which the insurance entity expects to be entitled as a result of transferring control of the underlying goods or services to the customer.

If a contract has more than one performance obligation, the transaction price generally should be allocated to each performance obligation based on the standalone selling prices of each performance obligation in relation to the total of those standalone selling prices (i.e., on a relative standalone selling price basis). Exceptions are provided for certain situations involving discounts or variable consideration that can be shown to be related to one or more (but not all) performance obligations. Those exceptions are discussed in Section 7.3 of this whitepaper and Section 8.3.1 of our revenue recognition guide.

7.2 Standalone selling prices

The standalone selling price of a performance obligation is the amount the insurance entity charges (or would charge) when the distinct goods or services that make up the performance obligation (i.e., the underlying distinct goods or services) are sold on their own to a customer. Standalone selling prices are determined at contract inception and are not subsequently adjusted for changes in facts and circumstances.

The best evidence of the standalone selling price of the underlying goods or services is the observable price charged by the insurance entity for those goods or services when they are sold separately in similar circumstances to similar customers. Absent evidence of a directly observable standalone selling price, the insurance entity is required to estimate a standalone selling price. In making this estimate, the insurance entity should maximize observable inputs and consider all reasonably available and relevant information, including information specific to the insurance entity, the market, the customer and the customer class. In addition, an insurance entity should be consistent in how it applies an estimation method and the situations in which it applies an estimation method.

Whether the contract price or list price for a good or service represents the good's or service's standalone selling price depends on the facts and circumstances. There is no presumption that the contract price or list price for a good or service does or does not represent its standalone selling price.

If the contract price or list price for a good or service is different from the observable price charged by the insurance entity for that good or service when it is sold separately in similar circumstances to similar customers, the contract price or list price does not represent the good's or service's standalone selling price because the observable price (to the extent one exists) should be used as the standalone selling price.

When an observable standalone selling price does not exist, the contract price or list price for a good or service is one data point that should be considered by the insurance entity in addition to other data points (such as the standalone selling price for the good or service estimated using the adjusted market assessment approach or the expected cost plus a margin approach). Only after considering all reasonably available and relevant data points will an insurance entity know if the contract price or list price for a good or service represents the good's or service's standalone selling price. Question 8Q.2.3 in our revenue recognition guide discusses other data points that may be considered when an observable standalone selling price does not exist.

7.3 Allocating variable consideration

Variable consideration included in the transaction price should be allocated on a proportionate basis to each of the performance obligations in a contract, except when:

- The terms of the variable payment are specifically related to the entity's efforts to satisfy, or achieve a specific outcome from satisfying, a specific performance obligation or to transfer, or achieve a specific outcome from transferring, a distinct good or service in a single performance obligation resulting from application of the series exception
- Allocating the variable payment to the specific performance obligation, or distinct good or service in a single performance obligation resulting from the series exception, depicts the amount of consideration to which the entity expects to be entitled in exchange for transferring that good or service to the customer when considering all of the performance obligations and payment terms in the contract

When both criteria are met, the variable payment included in the transaction price that meets these criteria, and any change in the estimate of that payment, should be allocated in its entirety to the specific performance obligation or distinct good or service to which the variable payment relates.

8. Step 5: Recognizing revenue when (or as) each performance obligation is satisfied

Revenue is recognized when (or as) a performance obligation is satisfied, which is when control of the underlying good or service (i.e., an asset) is transferred to the customer. The amount of revenue recognized upon satisfaction of a performance obligation is the transaction price allocated to it.

To properly assess when revenue should be recognized, the insurance entity must perform at contract inception an evaluation focused on whether a performance obligation is satisfied over time or at a point in time.

If a performance obligation meets one or more of the following criteria, it is considered satisfied over time:

- *Customer simultaneously receives and consumes benefits as the entity performs.* A performance obligation is satisfied over time if the customer consumes the benefits of the entity's performance at the same time as the customer receives those benefits and the entity performs and creates those benefits.

- *Customer controls the asset as the entity creates or enhances the asset.* A performance obligation is satisfied over time if the customer controls the asset (which could be tangible or intangible) as it is created or enhanced by the entity's performance.
- *No alternative use and an enforceable right to payment for performance to date.* A performance obligation is satisfied over time if the asset created by the entity's performance does not have an alternative use to the entity upon its completion and the entity's right to payment for its performance to date is enforceable.

If a performance obligation does not meet any of these three criteria, then it is considered satisfied at a point in time and revenue is recognized at the point in time the customer obtains control over the underlying good or service.

9. Contract costs

9.1 Scope

ASC 340-40 addresses the circumstances under which certain costs that arise in conjunction with performing under contracts within the scope of ASC 606 should be capitalized. The two categories of costs addressed in ASC 340-40 include costs to fulfill a contract and costs to obtain a contract.

9.2 Costs to fulfill a contract

If there is other guidance in the ASC that applies to the costs incurred to fulfill a contract within the scope of ASC 606, that other guidance should be applied. Examples of other guidance on how to account for costs that may be involved in the fulfillment of a contract are listed in the following table:

ASC	Type of fulfillment cost
330	Inventory
340-10-25-1 to 25-4	Preproduction costs related to long-term supply contracts
350-40	Costs of internal-use software
360	Costs related to property, plant and equipment
720-35-25-1A	Certain advertising expenditures incurred after revenue is recognized (e.g., cooperative advertising)
946-720-25-3	Offering costs of advisors of both public and private funds
985-20	Costs of software to be sold, leased or marketed

Note 1: Prior to applying the guidance noted, it is important to understand the specific scope provisions of the guidance to ensure it is applicable to an entity and the specific cost being evaluated.

If the guidance in the table or other specific guidance is applicable to a fulfillment cost incurred by the entity, it must be applied. ASC 340-40 is only applicable to costs to fulfill a contract when there is no other applicable guidance. For example, if there are setup costs that do not fall within the scope of the preproduction cost guidance in ASC 340-10 or other guidance in the ASC, then such costs would be accounted for in accordance with ASC 340-40.

If certain criteria are met, fulfillment costs within the scope of ASC 340-40 must be capitalized. An insurance entity may not choose to expense such costs when the criteria are met.

When considering costs to fulfill an insurance contract, costs that relate to activities within the scope of ASC 944, such as insurance risk mitigation or cost containment activities, continue to be accounted for in

accordance with ASC 944. Paragraph 14.7.10 of the Revenue Recognition AAG notes that the following costs generally should be considered fulfillment activities (that either mitigate risks to the insurer or contain costs related to services to fulfill the insurer's obligation) and are not within the scope of ASC 606:

- Claims adjudication and processing
- Additional activities related to the fulfillment of health insurance contracts, including enrollment, provider network access, routine physicals and screenings, immunizations, preventative care, and wellness benefits
- Safety inspections
- Roadside assistance provided with an automobile insurance policy
- Cybersecurity activities
- A title search provided with a title insurance policy

9.3 Costs to obtain a contract

The incremental costs to obtain a specific contract within the scope of ASC 606 are those costs that would not have been incurred if the contract was not obtained, such as a sales commission. For a cost to be considered an incremental cost of obtaining a contract, the insurance entity must be obligated to make a payment only as a result of entering into the contract. The incremental costs to obtain a contract should be capitalized if the insurance entity expects to recover those costs (i.e., the net cash flows of the contract and expected renewals will cover the costs). However, an insurance entity may elect a practical expedient that allows it to expense the incremental costs to obtain a contract if the amortization period for those costs would otherwise be one year or less.

Costs to obtain a contract within the scope of ASC 606 that are not incremental are those costs related to obtaining the contract that would have been incurred even if the contract was not obtained (e.g., travel costs incurred to present a proposal to the customer). These costs should only be capitalized if they are explicitly chargeable to the customer regardless of whether the insurance entity enters into a contract with the customer. Otherwise, such costs are expensed as incurred. However, it's important to note that the guidance in FASB ASC 340-40 differs from the guidance in FASB ASC 944-30 regarding acquisition costs and contracts that are not subject to ASC 606 should continue to follow the guidance in ASC 944-30. The Revenue Recognition AAG further notes in paragraph 1.82:

> FASB ASC 944-30-25-1A requires the capitalization of acquisitions costs that are either incremental direct costs or costs directly related to the successful acquisition of new or renewal insurance contracts. Directly related costs include the portion of employees' compensation directly related to contract acquisition. This contrasts with FASB ASC 340-40-25-3, under which the portion of an employee's compensation (that is not an incremental cost of obtaining the contract such as a sales commission) directly related to contract acquisition is required to be expensed because those costs would have been incurred regardless of whether the contract was obtained.

9.4 Amortization and impairment of capitalized costs

ASC 340-40 provides guidance on amortizing costs capitalized in accordance with its provisions as well as testing those capitalized costs for impairment. This guidance is summarized and illustrated in Sections 13.3 and 13.4 in our revenue recognition guide.

10. Disclosure requirements

Many qualitative and quantitative disclosure requirements are included in ASC 606-10-50 and ASC 340-40-50. ASC 606-10-50-1 states the following as the overall disclosure objective of ASC 606 (which is also

the overall disclosure objective of ASC 340-40): “The objective of the disclosure requirements in this Topic is for an entity to disclose sufficient information to enable users of financial statements to understand the nature, amount, timing, and uncertainty of revenue and cash flows arising from contracts with customers.”

The disclosures required to achieve this objective focus on providing a variety of revenue-related information. Some of the information that must be disclosed is high-level, such as the amount of revenue recognized from customer contracts and the amount of any impairment (or credit) losses recognized on receivables or contract assets related to customer contracts. However, there is also a significant amount of detailed information that must be disclosed annually related to customer contracts, including information about:

- Disaggregated revenue
- Contract assets, contract liabilities and receivables
- Performance obligations
- Transaction price allocated to remaining performance obligations at the end of the reporting period (disclosures required for public entities and elective for nonpublic entities)
- Significant judgments about the timing of satisfying performance obligations
- Significant judgments about the transaction price and the amounts allocated to performance obligations
- Practical expedients (disclosures required for public entities and nonpublic entities, elective for nonpublic entities)
- Capitalized costs related to obtaining or fulfilling a customer contract (disclosures required for public entities and elective for nonpublic entities)

The nature and extent of the required disclosures in each of the preceding categories depends on whether the insurance entity is a public entity (more required disclosures) or nonpublic entity (fewer required disclosures). In addition, while more disclosures are required for annual periods, some disclosures also are required for interim periods. However, when an insurance entity applies ASC 606 and 340-40 in its interim financial statements for one or more interim periods before it applies ASC 606 and 340-40 in its annual financial statements, the insurance entity must provide all the required annual disclosures in those interim financial statements.

Detailed discussion and illustrations of the disclosure requirements for both public and nonpublic entities are included in Chapter 15 of revenue recognition guide.

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