
PRACTICE GUIDELINE 699.01

PRICING AND FINANCIAL PROJECTIONS FOR PRIVATE HEALTH INSURERS

September 2012

INDEX

1.	INTRODUCTION	3
1.1	Application	3
1.2	Classification	3
1.3	Background	3
1.4	Purpose	3
1.5	Previous versions	3
1.6	Legislation	3
2.	COMMENCEMENT DATE	4
3.	DEFINITIONS	4
4.	INDUSTRY AND BUSINESS CONTEXT	7
5.	DATA	8
6.	ASSUMPTIONS	8
7.	PRICING	9
7.1	Principles of providing advice on products	9
7.2	Assumptions about future experience	10
7.3	Finance	10
7.4	Premium rate suitability or sufficiency	11
7.5	Other policy terms and conditions	12
7.6	Commission	12
8.	FINANCIAL PROJECTIONS	12
8.1	Purpose	12
8.2	Approach	12
8.3	Assumptions	13
8.4	Consistency with business plan	15
8.5	Policyholders	16
8.6	Earned Premium Income	16
8.7	Incurred Claims	16
8.8	Risk Equalisation	17

8.9	Management expenses	18
8.10	Investment income and other income	18
8.11	Taxation	18
8.12	Dividends	19
8.13	Liability Adequacy Test (Unexpired Risk Liability for AASB 1023)	19
8.14	Health Related Business	19
8.15	Non-Health Insurance Business	19
8.16	Solvency and capital adequacy	19
8.17	Capital Adequacy Margin	19
8.18	Renewal Option Amount	20
8.19	Business funding reserve	21
8.20	Sensitivities, scenarios and reasonableness	21
9.	REPORTING AND RECORD-KEEPING	22
9.1	General reporting requirements	22
9.2	Premium rate change application	23

1. INTRODUCTION

1.1 Application

1.1.1 This Practice Guideline applies to Members preparing financial projections and providing advice on pricing products for Private Health Insurers.

1.1.2 This Practice Guideline also applies to Members performing a review of another Member's financial projection and advice on pricing products for Private Health Insurers. When reviewing another Member's projections, the reviewing Member should comment on or acknowledge the methods and assumptions which have been used by the original Member.

1.2 Classification

1.2.1 This Practice Guideline has been prepared in accordance with Council's Policy for Drafting and Developing Practice Guidelines. It must be applied in the context of the Code.

1.2.2 This Practice Guideline is not mandatory.

1.2.3 Nevertheless, if the Professional Services provided by a Member are covered to any extent by this Practice Guideline, a Member should consider explaining any Material departure from this Practice Guideline to the Principal, and document such explanation.

1.3 Background

This Practice Guideline was developed in response to the need to update Guidance Note 660 (Financial Projections for Health Insurers) issued in December 2002 to reflect necessary changes following the introduction of the Act and the Policy for Drafting and Developing Practice Guidelines referred to in clause 1.2.1.

1.4 Purpose

The purpose of this Practice Guideline is to assist Members in performing the work referred to in clause 1.1. This Practice Guideline reflects generally accepted practices and techniques in this regard.

1.5 Previous versions

This Practice Guideline replaces Guidance Note 660 (Financial Projections for Health Insurers) issued in December 2002. There were no other previous versions of Guidance Note 660.

1.6 Legislation

1.6.1 The legislation relevant to this Practice Guideline is the Act and the Rules.

- 1.6.2 Also relevant to this Practice Guideline are industry guidelines and circulars issued by PHIAC and the Department.
- 1.6.3 A reference to legislation or a legislative provision in this Practice Guideline includes any statutory modification, or substitution of that legislation or legislative provision and any subordinate legislation or rules issued under that legislation or legislative provision. Similarly, a reference to a Professional Standard, Practice Guideline or Guidance Note includes any modification or replacement of such.
- 1.6.4 If there is a difference between this Practice Guideline and the applicable legislation, the legislation takes precedence. In this context, legislation includes regulations, prudential standards, subordinate standards, rules issued by government authorities and standards issued by professional bodies which have the force of law.

2. COMMENCEMENT DATE

This Practice Guideline commences on 30 September 2012.

3. DEFINITIONS

- 3.1 In this Practice Guideline:

'AASB 1023' means the Australian Accounting Standards Board's accounting standard AASB 1023 (General Insurance Contracts).

'Act' means the Private Health Insurance Act 2007 (Cth).

'Average Benefit' is a measure of an amount of Incurred Claims divided by the number of Incurred Claims.

'Capital Adequacy Margin' is as defined in Schedule 3, paragraph 13 of the Rules.

'Capital Adequacy Requirement' is as defined in the PHIAC Standards.

'Central Estimate' (or 'best estimate') of liabilities means the expected value of the liabilities. In other words, if all the possible values of the liabilities are expressed as a statistical distribution, the Central Estimate is the mean of that distribution. This Practice Guideline uses the term 'Central Estimate', while PHIAC Standards use the term 'best estimate'. For the purposes of this Practice Guideline, they have the same meaning.

'Claims' means benefit liabilities to, or on behalf of, the claimant under a private health insurance contract.

'Claims Group' means a homogenous group defined by product, type of Claim or Claims run-off pattern.

'Claims Ratio' is the sum of Incurred Claims, Risk Equalisation payments and Risk Equalisation recoveries and any Health Insurance Levies, divided by Earned

Premium Income for the private health insurance business. (Gross margin is one minus the Claims Ratio).

'Code' means the Code of Professional Conduct of the Institute.

'Department' means the Department of Health and Ageing or, in the event of any change in Government departments or their responsibilities, the department carrying responsibility for the conduct of private health insurance under the Act.

'Drawing Rate' (or **'Claims Rate'**) is a measure of Incurred Claims per policy or per SEU, and can be expressed as the product of the Utilisation Rate and the Average Benefit.

'Earned Premium Income' is the amount of premium income that can be allocated to a particular time period. It takes into account movements in premiums in advance and premiums in arrears.

'Health Benefits Fund' is as defined in section 131-10 of the Act.

'Health Insurance Business' is as defined in section 115 of the Act.

'Health Insurance Levies' refers to both the health insurance levies payable under the Health Insurance Levies Act 1982 (NSW) and levies payable under the Ambulance Service Levy Act 1990 (ACT).

'Health Related Business' is as defined in section 131-15 of the Act.

'Incurred Claims' is a measure of Claims which includes an allowance for Outstanding Claims. This measure can include or exclude Risk Equalisation payments and recoveries.

'Liability Adequacy Test' is as defined in section 9 of AASB 1023.

'Lifetime Health Cover' is as defined in the scheme referred to in Part 2-3 of the Act.

'Loss Ratio' is the Claims Ratio plus the MER.

'Material' means important or essential in the opinion of the Member. For this purpose, 'Material' does not have the same meaning as in Australian accounting standards.

'Management Expense Ratio' or **'MER'** is the ratio of expenses (including commissions, but excluding Health Insurance Levies) to Earned Premium Income for the Health Insurance Business. [Note that PHIAC reports use an MER that includes Health Insurance Levies.]

'Notifiable Circumstance' is as defined in sub-section 1(3) of Schedule 2 of the Private Health Insurance (Insurer Obligations) 2009 Rules.

'Outstanding Claims' is as defined in clause 2 of Guidance Note 650 (Actuarial Reports and Advice on Outstanding Claims in Health Insurance). The Outstanding Claims at a valuation date are equal to the value of Claim payments to be made after the valuation date in respect of Claims which arose on or before the valuation date for which the Private Health Insurer is expected to be liable. It includes Claims that have been:

- (a) reported and have not yet been settled;
- (b) incurred but not yet reported, and

includes allowance for future adjustments of settled Claims.

'PHIAC' means the Private Health Insurance Administration Council (and its successors from time to time).

'PHIAC Standards' means Schedule 2 – Solvency Standard and Schedule 3 - Capital Adequacy Standard of the Private Health Insurance (Health Benefits Fund Administration) Rules 2007 and other relevant standards in force from time to time.

'Policyholder' means the owner(s) of a policy that provides health insurance cover for one or more persons.

'Private Health Insurer' has the same meaning given in Schedule 1 to the Act.

'Provision for Outstanding Claims' is as defined in clause 2 of Guidance Note 650 (Actuarial Reports and Advice on Outstanding Claims in Health Insurance). This means an amount set aside in the Private Health Insurer's accounts to provide for liabilities for Outstanding Claims. This may include, or be separate from, provisions for other benefit entitlements such as loyalty benefits. It must also include the estimated cost of administering and settling such Incurred Claims. For the avoidance of confusion, a distinction is drawn between the 'provision' (the amount set aside in the accounts) and the 'liability' (the unknown actual value of the Outstanding Claims).

'Rate Protection' is a product feature provided in the Private Health Insurance industry, whereby Policyholders are protected from the financial impact of rate increases for the period for which they are paid in advance at the time of the rate increase.

'Renewal Option Amount' is as defined in Schedule 3, paragraph 19 of the Private Health Insurance (Health Benefits Fund Administration) Rules 2007.

'Report' means a report prepared by a Member under this Practice Guideline.

'Risk Margin' (also referred to as a 'prudential margin') refers to the amount by which the provision for liabilities set aside in the Private Health Insurer's accounts is greater than the Central Estimate. The purpose of the Risk Margin is to increase the probability of adequacy.

'Risk Equalisation' means the arrangements described under Division 318 of the Act.

'Rules' means all rules supporting the Act, including the Private Health Insurance (Health Benefits Fund Administration) Rules 2007 as well as rules made by PHIAC or the relevant Commonwealth Minister having responsibility for the Act.

'Single Equivalent Unit' or **'SEU'** is as defined in paragraph 4 of the Private Health Insurance (Risk Equalisation Policy) Rules 2007. It is a standardised measure where hospital policies covering single persons, single parent families and two non-adult people, are given a weighting of one, and other policies (couples, 3 or more adults and families) are given a weighting of two.

'Solvency Requirement' is as defined in the PHIAC Standards.

'Unexpired Risk Liability' is the deficiency resulting from the Liability Adequacy Test.

'Utilisation Rate' is a measure of the number of Incurred Claims per Policyholder or per SEU.

- 3.2 A word that is derived from a defined word has a corresponding meaning.
- 3.3 Other capitalised terms used in this Practice Guideline have the same meaning as set out in the Code.

4. INDUSTRY AND BUSINESS CONTEXT

- 4.1 Members performing work for Private Health Insurers in Australia should be conscious of general features of the industry which are different from those commonly encountered in other insurance industries in Australia and other health insurance markets.
- 4.2 These features include:
- (a) mandatory community rating, modified by Lifetime Health Cover provisions;
 - (b) extensive cross subsidies;
 - (c) Risk Equalisation arrangements designed to support community rating of hospital treatment cover;
 - (d) important relationships with health service providers;
 - (e) the differences between the large taxed Private Health Insurers, the large non-taxed Private Health Insurers and the remaining (mostly) small non-taxed Private Health Insurers; and
 - (f) the extensive political influences in many aspects of the industry.

- 4.3 Private Health Insurers operate in an environment with typically large cash flows and small margins where Claims can be influenced by the behaviour of health care providers and the Policyholders. Claims experience can be variable and can change quickly.
- 4.4 The Member should be aware of, and familiar with, the relevant legislation and regulations governing the operation of a Private Health Insurer, especially the Act and relevant subordinate legislation made by PHIAC and the Department.
- 4.5 The Member should be familiar with the relevant aspects of the procedures for the administration of, and accounting for, the Private Health Insurer's Policyholders, revenue and benefits.
- 4.6 The Member should be conversant with the general characteristics of the Private Health Insurer's Policyholders and products as these characteristics may have a Material bearing on the estimation of future surplus and capital outcomes. This includes familiarity with the contractual terms and legislated benefits payable under the fund rules of the Private Health Insurer, as well as other attributes such as product structure, Policyholder movements, Utilisation Rates, seasonality of benefits, refunds, management expenses and the impact of Risk Equalisation.
- 4.7 The Member should also be familiar with the Private Health Insurer's assets, investment policy and risk management framework and policies.

5. DATA

- 5.1 In any projection it is important to ensure that the nature and the limitations of the data provided or derived are understood.
- 5.2 Checks should be performed to ensure that the data is Materially complete and accurate. This is likely to include discussions with management, as well as numerical analysis.
- 5.3 If the data includes projected values, such as estimated future number of Policyholders, it is important to ensure that their derivation is understood and Materially consistent with other elements of the projection.
- 5.4 The Member should take reasonable steps to verify the overall consistency and reasonableness of any data with the Private Health Insurer's financial and other records. Where the data are Materially inconsistent, unreasonable or not credible, then the Member should seek clarification or make suitable modifications based on judgment and disclose the quantifiable effect, and state any reliance or limitations as a result of data shortcomings in his or her Report.

6. ASSUMPTIONS

- 6.1 The Member may be involved in the determination of appropriate assumptions for use in the projection, or may be supplied with assumptions for this purpose by the Private Health Insurer.

- 6.2 If the assumptions are developed by the Member, experience analysis and/or an understanding of any trends in historical data should be undertaken to support the assumption setting or review process commensurate with the volume of data available and the purpose of the projections being undertaken.
- 6.3 The Member should conduct a review of the accuracy of past assumptions (such as an 'analysis of surplus'), and consider incorporating the results of this analysis when determining assumptions or consider commenting in his or her Report on the consistency of the assumptions based on this analysis.
- 6.4 If the assumptions are supplied by the management of the Private Health Insurer, the Member should discuss the assumptions and their derivation with the relevant personnel within the Private Health Insurer. If the assumptions supplied by management are Materially different to the assumptions the Member would make, the Member should understand and document these differences. For each Material assumption, the Member should provide the Private Health Insurer with the Member's view that either:
- (a) the assumptions are within a reasonable range of the Central Estimate for the purpose for which the forecast is being prepared; or
 - (b) the assumption is unreasonable; or
 - (c) no opinion regarding the reasonableness of the assumption has been reached.
- 6.5 There must be sufficient experience analysis, in the Member's opinion, to assess the appropriateness of the Material assumptions. If such experience analysis is not practical, the Member should comment in his or her Report accordingly.

7. PRICING

7.1 Principles of providing advice on products

- 7.1.1 As set out in sub-section 1(2) of Schedule 2 of the Private Health Insurance (Insurer Obligations) Rules 2009, the Private Health Insurer must notify the Appointed Actuary of Notifiable Circumstances. Sub-section 9 of Schedule 2 of those Rules states that the Private Health Insurer could request advice on a Notifiable Circumstance or upon notification. The Appointed Actuary must advise the Private Health Insurer whether he or she considers that actuarial advice on a Notifiable Circumstance is warranted. In particular reference to products, the Member should provide advice when he or she recognises the proposed changes may have a Material financial impact on the Private Health Insurer resulting from:
- (a) proposed changes to the premium rates charged under a product;
 - (b) proposed changes to the benefits provided under a product;
 - (c) development of a new product; or

- (d) major revision of an existing product,
of a Health Benefits Fund conducted by the Private Health Insurer.

7.1.2 The Member should comment in his or her Report on the impact:

- (a) of the proposals referred to in clause 7.1.1 above on the business already issued and on new business; and
- (b) on the Private Health Insurer and on the Health Benefits Fund.

7.2 Assumptions about future experience

7.2.1 The undertaking of new types of risk should not be prevented solely because no specific past experience exists or is available. In determining an opinion as to the likely future experience in such circumstances, the Member should take into account such statistics relating to similar events or conditions as can be obtained and are considered relevant. The Member should comment on any limitations set out in the Health Benefits Fund's rules on policies while experience for these new types of risk is being gained. Where appropriate, and quite apart from any general monitoring that the Member undertakes for pricing risks, the Member should specify close monitoring of the emerging experience relating to the new types of risk.

7.2.2 The various elements in the assumptions may have experienced variability in the past and confidence about the likely future experience will vary according to that and other considerations. The Member should consider the degree of uncertainty in each of the assumptions and the potential effects of experience being relatively adverse. The Member should consider the Private Health Insurer's capacity to finance the potential effects of adverse experience.

7.3 Finance

7.3.1 Benefits paid plus net Risk Equalisation transfers plus incurred expenses plus the required increase in reserves to be held in respect of the future liabilities and future capital targets may exceed premiums received in certain circumstances. Where this is the case, the Member should consider:

- (a) the amount and incidence of the estimated required finance;
- (b) the capacity of the Private Health Insurer to meet this requirement for finance and the source(s) of this finance;
- (c) commenting in his or her Report on assumptions for increases in the number of Policyholders and the consequences of Material differences between actual and expected number of Policyholders increases; and
- (d) providing management with sensitivities or alternative financial projections scenarios (particularly based on alternative Policyholder increase assumptions).

7.4 Premium rate suitability or sufficiency

- 7.4.1 The Member should test the suitability or sufficiency of premium rates by using projection methods with all reasonable contingencies.
- 7.4.2 The Member should test, not only on the Central Estimate view of future experience, but also on a range of plausible variations from that Central Estimate.
- 7.4.3 If the Member considers that it is not appropriate to test the suitability or sufficiency of premium rates, the Member should explain in his or her Report why it is not considered appropriate.
- 7.4.4 For each variation in the view of future experience, the Member will make a number of assumptions about items listed in clause 8.3 of this Practice Guideline.
- 7.4.5 In testing the suitability or sufficiency of the premium rate for individual products, the Member should consider commenting in his or her Report on:
- (a) the impact resulting from the competitiveness against similar products offered by other Private Health Insurers (having collaborated with, or sought advice from, the relevant personnel from the Private Health Insurer on what is an appropriate and similar product for this comparison);
 - (b) the impact of the Private Health Insurance rebate from the Policyholder's point of view;
 - (c) the impact on the other products offered by the Health Benefits Fund, including any inconsistencies in premium rate or benefit relativities as well as internal cross subsidies between other products offered;
 - (d) the impact on the other products offered by the Private Health Insurer; and
 - (e) meeting corporate pricing standards, as well as regulatory capital and internal capital targets.
- 7.4.6 The range of matters to be taken into account when considering suitability may vary with the particular circumstances. In each case, the Member should be in a position to justify any decision to limit the range of the scenarios tested.
- 7.4.7 In particular, apart from any general advice that the Member provides, if the premium rates for a product are considered unsuitable or insufficient, the Member should state in his or her Report why that opinion is held and indicate the potential or likely financial consequences of their adoption by the Private Health Insurer. The Member should indicate actions the Private Health Insurer could take to mitigate or minimise the potential associated risks.

7.5 Other policy terms and conditions

7.5.1 The Member advising a Private Health Insurer on the structure of a health insurance product should consider all terms and conditions, not just the suitability or sufficiency of the premium rates. The Member should give advice on the financial impact or risks of the proposed terms and conditions, and any other matter the Member considers relevant.

7.6 Commission

7.6.1 The Member should consider all expenses when advising on products.

7.6.2 The Member should provide advice on the financial risks that any commission terms and arrangements may impose (including the commission allowed for in the pricing of a product).

7.6.3 If commission has been deferred for the purposes of the Private Health Insurer's financial statements, the Member should consider the recoverability of commission in the case of early termination of policies. If appropriate, the risks associated with a high level of policy termination, and a subsequent failure to realise the assumed recoverability of commission, should be highlighted.

8. FINANCIAL PROJECTIONS

8.1 Purpose

8.1.1 The Member may prepare financial projections for various purposes, including:

- (a) supporting business planning;
- (b) budgeting for the Private Health Insurer;
- (c) as part of product development activities;
- (d) as part of a premium rate change application;
- (e) as part of the Renewal Option Amount calculation under the PHIAC Standard relating to capital adequacy; and/or
- (f) as part of the determination of the Unexpired Risk Liability to meet AASB 1023.

8.2 Approach

8.2.1 The Member should develop or use a model or approach that is consistent with the purpose of the projection.

8.2.2 The complexity of the model will depend on the purpose of the projection, size and nature of the Private Health Insurer, data available and the level of detailed results required. The Member should exercise judgment in determining

the level of granularity of the model and whether the model used is appropriate for the purpose and the data is sufficient and appropriate for the model.

8.2.3 When establishing the projection model, the Member should consider:

- (a) projecting monthly forecasts of Earned Premium Income, Incurred Benefits, Risk Equalisation payments and recoveries, Health Insurance Levies, management expenses, commission, investment income, movement in Unexpired Risk Liability, dividends and taxation;
- (b) projecting the monthly capital position of the Private Health Insurer, including net assets, solvency reserve and capital adequacy reserve; and
- (c) projecting each of the Health Benefits Funds explicitly and separately.

8.3 Assumptions

8.3.1 The projection will require a number of assumptions to be made in respect of future experience. The complexity of the assumptions required will depend on the individual circumstances of the Private Health Insurer, the Materiality of the assumption and the workings of the individual model.

8.3.2 Assumptions may be required in respect of:

- (a) **Policyholders:**
 - (i) the number of Policyholders projected including the number of joins, lapses, discontinuances, suspensions, deaths and transfers between products;
 - (ii) state mix of the Policyholders of the Private Health Insurer;
 - (iii) product mix of the Policyholders of the Private Health Insurer (hospital, general treatment, ambulance products);
 - (iv) demographic mix of the Policyholders of the Private Health Insurer;
 - (v) Policyholder category mix (singles, couples, families, single parents, extended single parents, extended families); and
 - (vi) premium payment method mix;
- (b) **premium income:**
 - (i) premium rate for each product, state and category;
 - (ii) future premium rate increase assumptions;
 - (iii) discounts given;
 - (iv) loadings for Health Insurance Levies;

- (v) Rate Protection (if any); and
- (vi) incidence and amounts of Lifetime Health Cover loadings;

(c) **benefits:**

- (i) level of, and change in, Utilisation Rate;
- (ii) level of, and change in, Average Benefits;
- (iii) level of, and change in, Drawing Rates;
- (iv) benefit seasonality;
- (v) inflation of health costs, especially any periodic indexation and increase in hospital contracted rates, prostheses and medical costs;
- (vi) mix of services provided, especially public/private hospital mix and same day/overnight mix;
- (vii) ageing of the Policyholders;
- (viii) changes in the demographic profile of the Policyholders (for example, single, couples, families);
- (ix) impact of changes in product mix;
- (x) impact of waiting periods or reduced benefit periods;
- (xi) any benefit or product changes to be introduced in the future; and
- (xii) level of, and changes in, the rates for the Health Insurance Levies;

(d) **Risk Equalisation:**

- (i) average deficit per hospital SEU for each state; and
- (ii) level of, and change in, benefits eligible for Risk Equalisation (gross deficit);

(e) **management expenses:**

- (i) operating management expenses;
- (ii) abnormal management expenses; and
- (iii) commissions;

- (f) **investment income:**
 - (i) asset mix of the Private Health Insurer;
 - (ii) assumed earning rates by asset class; and
 - (iii) income from Health Related Business or non-health insurance business;
- (g) **tax;**
- (h) **dividends;** and
- (i) **solvency and capital adequacy:**
 - (i) future capital expenditure – timing and amount;
 - (ii) inadmissible assets;
 - (iii) asset mix;
 - (iv) business funding reserves;
 - (v) capital adequacy margin; and
 - (vi) balance sheet items, including provisions for Outstanding Claims, premiums in advance, Unexpired Risk Liability and unclosed business premiums.

8.3.3 It is also important to note that a number of assumptions may be made implicitly, such as the proportion of business that is 'single persons' or the age profile of Policyholders. Where Material, the Member should document and review these assumptions for validity.

8.3.4 As projected financial results (and projected solvency and capital adequacy reserves) are dependent on many assumptions, it is important that the Member clearly specify the Material assumptions in any Report prepared to accompany projections. The Report should disclose the source of the assumptions and any relevant reliance and limitations in the use of the assumptions.

8.3.5 If the revised assumptions are Materially different from the previous set of assumptions, the Member should understand and document the reasons for the change.

8.4 Consistency with business plan

8.4.1 Projections will usually commence with the projection prepared for the Private Health Insurer's business plan or financial condition report or the most recent premium rate change application.

- 8.4.2 If this projection was prepared some time ago, or actual results have departed Materially from the business plan, the Member should consider preparing an updated projection.

8.5 Policyholders

- 8.5.1 If the Member is involved with the projection of the number of Policyholders, the Member should consider projecting the expected sales, joins, transfers, lapses, suspensions, deaths and discontinuance experience of the Private Health Insurer.
- 8.5.2 The Member should also allow for future movement in product mix over time, including any transfers between products as changes in Policyholder category (singles, families, etc).
- 8.5.3 The Member should consider past performance as well as industry trends and recent and planned marketing activities when the projection is formulated.

8.6 Earned Premium Income

In projecting Earned Premium Income, the Member should:

- (a) allow for future premium rate changes reflected in the current business plan, making allowance for the impact of any Rate Protection given to current Policyholders at the time of the proposed rate change;
- (b) recognise the current and expected extent to which discounts are provided and the current and expected extent to which loadings will be earned (for example, under Lifetime Health Cover provisions); and
- (c) allow for unearned loyalty premiums if applicable.

8.7 Incurred Claims

- 8.7.1 In projecting Incurred Claims, where it is Material the Member should allow for:
- (a) historical trends in Utilisation Rates, Average Benefits and Drawing Rates;
 - (b) phasing of Incurred Claims expenditure, including seasonality;
 - (c) likely indexation of hospital, medical and other benefits;
 - (d) any new benefit changes and proposed product design changes;
 - (e) impact of waiting periods and other membership duration effects;
 - (f) movements in the Unexpired Risk Liability (if any);
 - (g) any expected changes in product mix;
 - (h) other non-assessed benefits (such as chronic disease management plans or support benefits under a Policy); and

- (i) any relevant legislative changes.
- 8.7.2 In assessing the historical benefit trends, the Member should be cognisant of, or standardise for, historical impacts resulting from indexation of benefits, product design and benefit changes, waiting periods, changes in product mix, seasonality, the historical mis-estimation of Provisions for Outstanding Claims and any legislative changes.
- 8.7.3 There are various methods that can be used to project benefits. Usually this will involve a projection of Drawing Rates for product groups and/or Claims Groups. The Member should select the most appropriate method and level of detail for the particular circumstance.
- 8.7.4 If the Private Health Insurer has Policyholders resident in New South Wales or the Australian Capital Territory, the Member should also estimate the likely ambulance levy rate under the Health Insurance Levies that will apply over the projection period. The Member should give consideration to Policyholders who are exempt from the ambulance levy under the Health Insurance Levies.
- 8.7.5 Policyholders may transfer to a lower benefit coverage or lower cost product which may likely result in a reduction in Earned Premium Income without a corresponding reduction in Incurred Claims. The Member should consider the impact of Policyholders transferring between products where this is Material.

8.8 Risk Equalisation

- 8.8.1 The components which result in the net Risk Equalisation transfer (sometimes known as the calculated deficit and the gross deficit) should be projected explicitly and separately. Members should note that the transfers reported by PHIAC are on a 'paid basis' rather than on an 'incurred basis'.
- 8.8.2 When projecting the gross deficit, the Member should consider:
- (a) analysing the proportion of hospital benefits eligible for Risk Equalisation as observed in historical data and hospital Policyholders for both the Private Health Insurer and the industry at a state level, and any anticipated changes;
 - (b) allowing for high cost claims eligible for Risk Equalisation if Material;
 - (c) the impact of Policyholders ageing, as well as the factors listed in clause 8.7.1 of this Practice Guideline; and
 - (d) ensuring consistency of the projected gross deficit with the projected Incurred Claims.
- 8.8.3 The calculated deficit is the product of the number of SEUs and the state average deficit per SEU. When projecting the calculated deficit, the Member should consider separately projecting by state the number of SEUs and the state average deficit per SEU.

8.9 Management expenses

When projecting management expenses or assessing the projected management expenses set out in the Private Health Insurer's business plan, the Member should consider:

- (a) checking for consistency with past experience for:
 - (i) Management Expense Ratio expressed as a percentage of Earned Premium Income;
 - (ii) increases in management expenses from prior years; and
 - (iii) dollar expenses;
- (b) allowing for any future Material one-off expenses that are expected to be incurred;
- (c) checking for consistency of the projected management expenses against the Private Health Insurer's business plan;
- (d) projecting commissions separately; and
- (e) projecting write-downs in deferred acquisition costs or other intangible assets separately.

8.10 Investment income and other income

When projecting investment and other income or assessing the projected investment and other income set out in the Private Health Insurer's business plan, the Member should:

- (a) understand the current investment policy and asset mix of the Health Benefits Fund or Private Health Insurer and any likely changes to the investment policy and asset mix;
- (b) ensure that the assumed earning rates for each asset class are within a reasonable range when compared with historical performance as well as benchmark returns;
- (c) consider net income from Health Related Business and non-Health Related Business; and
- (d) ensure the appropriate investment income earning capital base is used both in quantum and for the calculation time period.

8.11 Taxation

- 8.11.1 Where the Private Health Insurer is subject to taxation, the Member should make appropriate allowance in the projections.

8.11.2 The Member should also consider the impact of taxation on the elements of the solvency and capital adequacy reserves, specific guidance on which is given in the PHIAC Standards.

8.12 Dividends

8.12.1 The Member should allow for dividends to be paid to a shareholder taking into account the Private Health Insurer's business plan or dividend policy.

8.12.2 The Member should ensure such allowance complies with the Private Health Insurer's constitution and does not breach PHIAC Standards.

8.13 Liability Adequacy Test (Unexpired Risk Liability for AASB 1023)

The Member should allow for the Liability Adequacy Test for each month of the forecast period in accordance with Guidance Note 650 (Actuarial Reports and Advice on Outstanding Claims in Health Insurance) and AASB 1023.

8.14 Health Related Business

Subject to Materiality, the Member should consider separately projecting the income and outgo for each Health Related Business.

8.15 Non-Health Insurance Business

Subject to Materiality, the Member should consider projecting the appropriate financial impact for each non-Health Insurance Business.

8.16 Solvency and capital adequacy

8.16.1 In preparing projections on the solvency and capital adequacy position of the Private Health Insurer, the Member's attention is drawn to the requirements set out in the PHIAC Standards.

8.16.2 The Member should understand the historical movement in the elements that constitute the solvency and capital adequacy reserve for the Private Health Insurer, especially the financial performance, asset mix, seasonality of provisions and strategic developments.

8.16.3 The Member should disclose the assumptions made, or estimates required, in forecasting the components of the solvency and capital adequacy reserves.

8.17 Capital Adequacy Margin

8.17.1 The Capital Adequacy Margin allows for the uncertainty associated with the estimation of liabilities and future projections in the capital adequacy context.

8.17.2 The PHIAC Standards require consideration of the size of the Private Health Insurer, and the stability of the number of Policyholders and Incurred Claims experience in the selection of the appropriate Capital Adequacy Margin. The component relating to the stability of the number of Policyholders and Incurred Claims experience is referred to as the discretionary margin.

- 8.17.3 Under sub-section 7(2)(c) of Schedule 2 of the Private Health Insurance (Insurer Obligations) 2009 Rules, one of the Appointed Actuary's duties is "the assessment of the reasonableness of any discretionary margin adopted by the insurer for the purpose of assessing the capital adequacy of a fund".
- 8.17.4 Whilst the margin is to be determined by the board of the Private Health Insurer after consideration of the qualitative factors specified, the Member may be involved in recommending an appropriate discretionary margin to the board of the Private Health Insurer. In this situation, the Member should use relevant historical information as to:
- (a) Policyholder numbers and movements; and
 - (b) all relevant Incurred Claims information.
- 8.17.5 Some guidance on the appropriate Capital Adequacy Margin is provided in the PHIAC Standards. However in determining an appropriate Capital Adequacy Margin including the discretionary margin, the Member should also consider other factors including:
- (a) historical and projected Policyholder numbers and movements;
 - (b) historical and projected Incurred Claims;
 - (c) the variability of historical Incurred Claims;
 - (d) any legislative or regulatory changes that may impact, or have impacted, on the Private Health Insurer; and
 - (e) any Material historical or projected changes in the operation or strategy of the Private Health Insurer.
- 8.17.6 The Member should obtain a copy of the relevant resolution of the board of the Private Health Insurer approving the Capital Adequacy Margin for use in the calculations. PHIAC requires that the board of the Private Health Insurer decide on the Capital Adequacy Margin at least once per year as part of the annual reporting process.

8.18 Renewal Option Amount

- 8.18.1 The Renewal Option Amount makes provision for the risks and potential costs in providing the right of renewal to Policyholders of the Private Health Insurer. The calculation of this reserve requires a best estimate projection over the following twelve months for Earned Premium Income, Incurred Claims, Risk Equalisation and management expenses with the addition of the Capital Adequacy Margin on all outlays except for management expenses where only half the Capital Adequacy Margin is required.
- 8.18.2 The purpose of the Renewal Option Amount is to minimise the risk of loss to existing Policyholders and to continue cover in an ongoing situation by

adequate provisions to pay the Incurred Claims and expenses of the Private Health Insurer for twelve months following the date of the calculation.

- 8.18.3 The Renewal Option Amount is usually a key driver of the capital adequacy reserve set out in the PHIAC Standards.
- 8.18.4 The PHIAC Standards set out detailed requirements of the projection which should be taken into account in the calculation of the Renewal Option Amount.
- 8.18.5 The Member should be aware that the Renewal Option Amount can be particularly sensitive to small changes in the assumptions used.
- 8.18.6 The Member should be aware that the cashflows for the Renewal Option Amount should exclude any movements in the Unexpired Risk Liability, and that the Renewal Option Amount appropriately allows for any offsetting Unexpired Risk Liability.
- 8.18.7 Since the Renewal Option Amount requires a twelve month projection, the Member should ensure that the model projects for a period of twelve months beyond the period for which the projected capital adequacy position is required.
- 8.18.8 The Member should be aware that, for each Health Benefits Fund, a Renewal Option Amount is required separately for the health insurance business and each Health Related Business.

8.19 Business funding reserve

- 8.19.1 The PHIAC Standards set out the detailed requirements of the calculation of the business funding reserve.
- 8.19.2 The business funding reserve is required in respect of any additional capital likely to be required to ensure that, if experience during the next three years is in accordance with the intended business plan of the Private Health Insurer, the Health Benefits Fund will be able to meet the solvency obligation calculated in accordance with the relevant solvency standard issued by PHIAC, over those three years. The business funding reserve is used to ensure that the capital adequacy reserve is at least equal to the solvency reserve.
- 8.19.3 The calculation of this reserve should take into account planned business growth and the impact of business development strategies and plans.
- 8.19.4 The Member should obtain such information from the Private Health Insurer's business plans and from discussions with the Private Health Insurer's management.

8.20 Sensitivities, scenarios and reasonableness

In addition to projecting the best estimate financial result and capital position of the Private Health Insurer, the Member should consider:

- (a) and comment in his or her Report on, the plausible range of potential profit and capital outcomes for the Private Health Insurer over the projection period;
- (b) highlighting any limitations or shortcomings of the projections;
- (c) providing the Private Health Insurer with a range of results to indicate the variability of projection results resulting from key inputs or assumptions (such as Policyholder increases, Drawing Rates, Drawing Rate inflation rates and premium rates) via sensitivity analysis of key assumptions and scenario analysis. This will provide insight into the main drivers of the business and the significance of the assumptions. It is likely that a number of assumptions will interact and the sensitivity testing should take this into account; and
- (d) performing reasonableness tests on the projection results including comparing projected results with:
 - (i) historical results;
 - (ii) previous projections; and
 - (iii) key inputs and assumptions.

9. REPORTING AND RECORD-KEEPING

9.1 General reporting requirements

- 9.1.1 Members' attention is drawn to clause 1.1.2 of Practice Guideline 199.01 (Prescribed Actuarial Advice Reporting).
- 9.1.2 The Member should prepare a Report that documents the assumptions and methods used in producing a financial projection or providing actuarial advice or a Professional Service. The level of detail contained in such a Report will vary depending on the purpose of the financial projection.
- 9.1.3 The Report should describe the steps taken by the Member to verify the accuracy of the data, any limitations on the extent or quality of the data and the extent to which the Member has relied upon the Private Health Insurer or the Private Health Insurer's auditor for checking.
- 9.1.4 The assumptions and methods should be stated clearly and their derivation explained. Any qualifications should also be clearly stated.
- 9.1.5 Where:
 - (a) legislation, accounting standards, PHIAC guidelines or other rulings require the Member to use specific assumptions or methods;

- (b) an interpretation of legislation, accounting standards, PHIAC guidelines or other rulings supplied by the Private Health Insurer or its advisers is being relied upon; or
- (c) the Private Health Insurer requires the Member to use specific assumptions or methods,

the Member should, in his or her Report:

- (d) clearly state the circumstances; and
- (e) express an opinion on the assumptions in accordance with clause 6.4 of this Practice Guideline.

9.1.6 The Member may be called upon to justify the work undertaken. The Member should therefore compile and retain documentation that shows that the Member has considered the matters set out in this Practice Guideline and any external requirements as appropriate.

9.2 Premium rate change application

9.2.1 Private Health Insurers are required to follow specific reporting requirements set out by the Department. One of the Department's reporting requirements is an opinion from the Appointed Actuary for the Private Health Insurer on:

- (a) the financial forecasts, including the assumptions; and
- (b) the appropriateness and sufficiency of the financial model.

9.2.2 The Member should provide actuarial advice on the premium rate change to the Private Health Insurer as set out in clause 7.1.1 of this Practice Guideline. The Member may choose to incorporate the opinion required by the Department as set out in clause 9.2.1 of this Practice Guideline, with this actuarial advice. The Member may choose to provide, to the Private Health Insurer, the opinion required by the Department as set out in clause 9.2.1 separately to the actuarial advice on the premium rate change.

9.2.3 The Member should seek a copy of the premium rate change application in its entirety from the Private Health Insurer to ensure that the opinion set out in clause 9.2.1 of this Practice Guideline, and actuarial advice given, is consistent with the premium rate change application.

END OF PRACTICE GUIDELINE 699.01