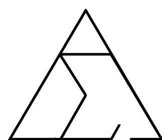

THE INSTITUTE OF ACTUARIES OF AUSTRALIA
A.C.N. 000 423 656

GUIDANCE NOTE 650
ACTUARIAL REPORTS AND ADVICE ON OUTSTANDING CLAIMS IN HEALTH INSURANCE

I. INTRODUCTION

APPLICATION

This Guidance Note applies to actuaries preparing estimates of the liabilities for outstanding claims of Registered Health Benefit Organisations and providing advice on the provisions to be set aside to meet those liabilities in the balance sheet and for tax purposes where relevant.

This Guidance Note does not apply to outstanding claims advice for life or general insurance organisations.

LEGISLATION

This Guidance Note applies particularly to advice which is expected to be used to fulfil requirements under the National Health Act, the Corporations Law and Accounting Standards, the Income Tax Assessment Act, and current Private Health Insurance Administration Council (PHIAC) circulars.

FIRST ISSUED

This Guidance Note was first issued in June 1999. It is the first professional requirement to be issued by the Institute in the area of health insurance.

2. DEFINITIONS

Claims refer to benefit payments to or on behalf of the claimant under a health insurance contract.

Refunds refer to amounts or expected amounts to be recovered by an organisation, usually from workers' compensation, compulsory third party (CTP), public liability insurers or for claims paid but subsequently reversed in respect of hospital, medical and other ancillary expenses.

Outstanding claims include claims that have been reported and have not yet been settled, claims which have been incurred but not yet reported (IBNR), and claims which have been administratively finalised and which may be reopened.

A **central estimate** is an estimate which is intended to contain no intentional over or under estimation. The nature of health insurance claims is such that the actual value of the liabilities is unknown and it is usually difficult to determine the central estimate with a reasonable degree of precision. For this reason the inherent uncertainty in the central estimate must also be considered.

Administrative expenses are the estimated expenses associated with the discharge of the claims liabilities in the central estimate.

The **Reinsurance pool** is a trust fund constituted under Section 73BC of the National Health Act. In simplified terms, each organisation is required to contribute to the pool or is paid from the pool to equalise their hospital claims exposure to members aged over 65 years of age and to members who have long lengths of hospital stay.

The **National Health Act** means the *National Health Act 1953* as subsequently amended and includes all subordinate legislation arising from the provisions of that Act.

A **provision for outstanding claims** is an amount set aside in the organisation's accounts, to provide for outstanding claims. In order to deal with uncertainty a distinction is drawn in this document between the 'provision' (the amount set aside in the accounts) and the 'central estimate'.

A **prudential margin** refers to the amount by which the provision set aside in the accounts is greater than the central estimate of outstanding claims (after expense allowance and resinsurance allowance) due to the inherent uncertainty in their determination.

PHIAC means the Private Health Insurance Administration Council.

The components of the Provision for Outstanding Claims are related as follows:

Provision for Outstanding Claims = Central Estimate + Administration Expense Allowance + Reinsurance Allowance + Prudential Margin

3. PROCEDURES

Often, an organisation will not know, until after the valuation date, exactly how much each claim is going to cost or when the benefits will be paid. It is, therefore, necessary to estimate the amount and timing of benefit payments, on the basis of the available information, particularly the past behaviour of similar claims.

The steps which an actuary should take when advising on liabilities in respect of outstanding claims are similar to those for other actuarial investigations.

1. Clarify the terms of reference and purpose of the report.
2. Collect the necessary data.
3. Analyse the experience.
4. Select a valuation model.
5. Select valuation assumptions.
6. Do the valuation calculations.
7. Reconcile the results with the previous investigation.
8. Analyse variability and sensitivity.
9. Reach conclusions.
10. Present a written report.

It may be necessary to go through part of the process several times to determine an appropriate central estimate and prudential margin, for example collecting and analysing additional data. Steps may be combined or taken out of sequence. It may be appropriate to repeat parts of the process with different models or assumptions.

The actuary may be called upon to justify the work undertaken. The actuary should therefore compile and retain documentation which shows that the work conforms to this Guidance Note and PHIAC requirements as appropriate.

Approximations are acceptable provided they do not materially affect the result. A difference is material if it is significant in the context of the purpose for which the advice is given. The actuary should choose a standard of materiality which should reasonably satisfy each anticipated user of the advice and the stated purpose of the report.

4. DATA

The actuary should be familiar with the relevant aspects of the procedures for the administration and accounting for the organisation's benefits and membership. The actuary should be conversant with the general characteristics of the organisation’s membership and products, which may

have a material bearing on the estimation of the central estimate. This may include familiarity with the contractual terms and legislated benefits payable under the rules of the organisation as well as other attributes, such as product structure, membership year, seasonality of benefits, refunds and the impact of the reinsurance pool.

The actuary also has a responsibility to be familiar with the general economic, legal and social trends in the community which may have a bearing on the central estimate.

The actuary should also be familiar with the organisation's assets and its investment policy.

It is the actuary's responsibility to ensure that the data utilised is appropriate, and sufficient for the valuation. The actuary should take reasonable steps to verify the overall consistency of the valuation data with the organisation's financial records.

5. CENTRAL ESTIMATE

ANALYSIS

The calculation of the central estimate will require the subdivision of the claims data into categories exhibiting similar characteristics. When determining appropriate subdivisions a balance must be found between homogeneity and statistical reliability, and should take into account the product and membership-category structure of the organisation.

The claims experience should at least be analysed with respect to the development over time of claims or cohorts of claims. Depending on the availability and reliability of the data, analysis should include some or all of:

- the rate of reporting claims
- the rate of settlement
- the development of benefit payments
- the impact of refunds
- other analyses relevant to the circumstances.

The experience would normally be analysed without distinguishing between reported and IBNR claims. Attention should be paid to trends in cash flow, especially regarding seasonality and other factors which may influence claims lodgement or processing trends.

The analysis should take into account any special features of or changes to the experience such as changes in benefit design, claims handling

procedures, and the mix of products and members. The analysis should investigate any trends in the development of the experience.

VALUATION MODEL

Selection of the most appropriate valuation model to estimate the central estimate is the responsibility of the actuary. The actuary may investigate more than one model before arriving at an estimate. The model or models should take into account the available data, the nature of the portfolio, and the results of the analysis of experience.

CLAIMS EXPERIENCE ASSUMPTIONS

Selection of the claims experience assumptions should have regard to the valuation model and the analysis of the experience. These assumptions should include trends in the claims experience and assumptions about refunds.

The actuary need not change assumptions from those of the prior valuation unless the effect of the change is material. The actuary should not spread the effect of any changes over more than one valuation. The effect of any change should be disclosed.

DISCOUNT RATE

The actuary may choose on the grounds of materiality not to make specific allowance for discounting. Discounting is not usually applied due to the short tailed nature of health insurance business.

The actuary should give due consideration to determining the discount rate to be used.

VALUATION RESULTS

The actuary has a responsibility to consider the reasonableness of the estimates produced by the valuation procedures employed and to quantify the effects of any changes in the valuation basis since the previous actuarial valuation. Explanation should be sought where possible for any major departures from past results.

UNCERTAINTY

Uncertainty in the estimation of the central estimate will arise from:

- appropriateness of the valuation approach and assumptions
- the quality and depth of the historical data available
- the fact that the model(s) chosen for analysis and projection will never exactly match the actual claim process

- the impact of past claim fluctuations and undetected data errors on the estimation of the parameters for the model(s)
- statistical fluctuations affecting the ultimate discharge of the liabilities for outstanding claims
- the extent to which the outstanding claims at the valuation date have been discharged by the estimation date
- The impact of environmental and systemic change on the incurring of claims and claims development.

It is part of the actuary's task to respond to uncertainty, both as a technical matter and in the presentation of results. Assessment of uncertainty will generally require the use of one or more of:

- statistical analysis;
- sensitivity analysis - making changes to the model assumptions and/or the models themselves;
- analysis of the outcomes of previous valuations;
- analysis of different scenarios; and
- judgment.

While the principal should be provided with a single central estimate, the actuary should also explain the practical consequences of the uncertainty relating to this estimate.

6. ADMINISTRATIVE EXPENSES

Appropriate allowance for future costs of administering claims and paying claims should be made having regard for the organisation's level of expenses, management structure and any other relevant factors. The complexity of the approach used to determine the allowance should be commensurate with the materiality of the amount of the allowance.

7. REINSURANCE

The actuary should calculate an appropriate allowance for reinsurance in recognition of the payment to or receipt from the reinsurance pool which will arise in respect of eligible claims which form part of the central estimate. This may be a difficult amount to estimate given its dependence on the central estimates and membership levels of other Registered Health Benefit Organisations. An estimate should be made using available information, including recent trends in membership and eligible reinsurance claims.

It needs to be recognised that an organisation's accounts are required to be prepared on an accrual basis by PHIAC, whereas the reinsurance pool operates on a claims paid basis. This leads to a timing mismatch between

the recognition of eligible reinsurance claims in the central estimate (and therefore the provision for outstanding claims) and settlement through the reinsurance pool.

On a going concern basis, each organisation has a future claim on the reinsurance pool in respect of the ultimate eligible reinsurance claim payments arising out of its central estimate, and also a liability for its share of the total reinsurance pool. The organisation should make allowance in its accounts for the expected operation of the reinsurance pool in respect of the estimated central estimate for claims incurred prior to balance date, by separately considering the two components of the net reinsurance amount described above. This may result in a net addition to the central estimate if expected payments to the reinsurance pool exceed expected claims reimbursed from the reinsurance pool.

8. PROVISION

Though the precise amount required to meet an organisation's liability for outstanding claims is subject to uncertainty, a specific amount must nonetheless be set aside as a provision in the accounts at the balance date. The directors of the entity, not the actuary, have the ultimate responsibility for the provision. To reflect the uncertainty of central estimates and the inherent variability of conditions affecting future claims, the organisation may wish to establish provisions in excess of the central estimate of outstanding claims so as to enhance the likelihood of the provision being sufficient to meet outstanding claims. The level of this excess provision, or prudential margin, is a matter to be determined by the directors of the organisation, and may take account of the level and purpose of statutory solvency requirements.

9. REPORTING

The actuary's report should specifically comprise identified component amounts for:

- the central estimate;
- a margin for administrative expense associated with those claims;
- a margin for reinsurance.

Any prudential margin established by the directors should be separately identified.

The actuary should prepare, date and sign a written report. The report should state:

- who has commissioned the report and, if different, the addressee(s) of the report
- the name of the actuary and the capacity in which the actuary is acting
- the purpose of the report or the terms of reference given
- the extent, if any, to which the report falls short of, or goes beyond, its stated purpose, including any qualifications judged appropriate by the actuary in arriving at the conclusions of the report
- the extent of compliance with this Guidance Note and the reasons for not complying fully with it
- any restrictions imposed on the actuary in preparing the report.

The report should deal with:

- the nature, accuracy and interpretation of the data
- the analysis of experience
- the valuation model and key assumptions
- any changes in the method and key assumptions since the last similar report
- comparisons of actual experience with that expected under the assumptions in the last similar report
- the results of the valuation
- uncertainty of the valuation result.

The attached checklist provides a guide to the matters the actuary would normally consider in preparing actuarial reports and giving advice on oustanding claims in health insurance, but it should not be considered comprehensive.

The report should describe the steps taken by the actuary to verify the accuracy of the data, any limitations on the extent or quality of the data and the extent to which the actuary has relied upon the organisation or the organisation's auditor for checking.

The assumptions and methods should be stated clearly and their derivation explained. Any qualifications should also be clearly stated. Where the legislation, accounting standards, PHIAC guidelines or other rulings require the actuary to use specific assumptions or methods, particularly if they are materially different from those the actuary would otherwise use under this Guidance Note, the actuary must clearly state the circumstances, discuss whether or not the assumptions and methods are reasonable and consistent with this Guidance Note, and discuss the implications of divergence from this Guidance Note.

Where the principal requires the actuary to use specific assumptions or methods, or the actuary is relying upon an interpretation of legislation, accounting standards, PHIAC guidelines or other rulings supplied by the

principal or its advisers, the actuary must clearly state the circumstances, discuss whether or not the assumptions and methods are reasonable and consistent with this Guidance Note, and discuss the implications of divergence from this Guidance Note.

Sufficient detail of the valuation results should be available in the report or separately to enable the organisation to comply with the disclosure requirements under the accounting standards, and complete PHIAC returns unless requested otherwise.

In some circumstances it may be necessary to prepare a short statement or certificate regarding the valuation. Considerable care is required to ensure that the statement contains the necessary relevant information and will not be misleading nor quoted out of context. The certificate should include a reference to the actuary's full report and the qualifications stated therein.

CHECKLIST

1. IDENTIFICATION
Purpose
Name of company
Date of Investigation
Name of Actuary
Relationship to company
Date of Report
Previous report - name of Actuary, date

2. GENERAL COMMENT ON NATURE OF BUSINESS
Membership
Products
Fund Rules - benefit provisions

3. DATA
Veracity
Consistency of valuation data with financial records
Analysis of Experience

4. CENTRAL ESTIMATE
Valuation model
Claims Experience Assumptions
Discount Rate
Changes from previous valuation
Reason for changes
Quantification of changes
Assessment of Uncertainty

5. ADMINISTRATIVE EXPENSES
Allowance made

6. REINSURANCE
Method
Allowance made

7. REPORTING
Components separately identified
Adherence to Statutory and Professional Standards
Circumstances, reasons and implications of departure from Standards

END OF GUIDANCE NOTE 650