THE INSTITUTE OF ACTUARIES OF AUSTRALIA
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GUIDANCE NOTE 670
FINANCIAL CONDITION REPORTS FOR HEALTH INSURERS

PURPOSE

1. The purpose of this Guidance Note is to provide guidance to actuaries preparing a financial condition report for a health insurer. The financial condition report will be prepared at the end of each financial year for submission to the Board of the health insurer with a copy being provided to the Private Health Insurance Administration Council (PHIAC).

EFFECTIVE DATE

2. This Guidance Note was first issued in July 2004.

APPOINTED ACTUARY

3. PHIAC requires that each health insurer have an Appointed Actuary. In requiring health insurers to have an Appointed Actuary, PHIAC's objective is to ensure that appropriate financial advice is available to support the Board and management of a health insurer. The Appointed Actuary is concerned with the continuing financial viability of the health insurer.

4. The statutory duties of an Appointed Actuary for a health insurer are to provide the Board of a health insurer with:
    - An actuarial opinion on financial forecasts included in a contribution rate change application;
    - An actuarial report in relation to any new product applications;
    - Actuarial assessment of the reasonableness of the discretionary margin selected for the purposes of the prudential standards;
    - Actuarial advice in relation to risk margins for technical liabilities;
    - An annual Financial Condition Report.

DEFINITIONS

5. **Gross Margin** means earned contributions less incurred benefits (net of reinsurance) and state levies.

6. **Health Insurer** means a Registered Health Benefits Organization (RHBO) registered under the National Health Act.

7. A **membership** is a policy that provides health insurance cover for one or more persons. A **contributor** is the person in whose name the membership is registered.

8. 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.

9. **Outstanding claims** at a valuation date is an estimate of 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 health insurer is expected to be liable. This will comprise claims that have been reported and have not yet been settled, claims which have been incurred but not yet reported (IBNR), and allowance for future adjustments of settled claims.

10. **PHIAC** means the Private Health Insurance Administration Council.

11. **PHIAC Standards** means *Health Benefits Organisations – Solvency Standard 2003, Health Benefits Organisations – Capital Adequacy Standard 2003 and Health Benefits Organisations – Interpretation Standard 2003* under sections 73BCB(1) and 73BCG(1) of *the National Health Act 1953*, or as amended.

12. The **Reinsurance pool** is the trust fund constituted under Section 73BC of the National Health Act. Health insurers operate under community rating constraints where contribution rates cannot differ by age, sex or health status. The Reinsurance pool attempts to equalise the differing risk profiles of each health insurer's hospital membership. The reinsurance pool operates at a state level.

13. **Single Equivalent Unit (SEU)** is a standardised membership measure where memberships covering one person are given a weighting of one, and memberships covering more than one person are given a weighting of two.

BUSINESS CONTEXT

14. Actuaries performing work for health insurers in Australia should be conscious of the features of the health insurance industry which differ from those commonly encountered in other insurance industries in Australia and other health insurance markets.

15. These features include mandatory community rating, no individual policy reserves, the state reinsurance pools, the largely mutual nature and lack of ready access to external capital of many health insurers, the importance of relationships with providers of health services and the extensive political influences in many aspects of the industry.

16. Actuarial advice to health insurers is given in an environment with typically large cash flows and small margins. Claims are short term in nature and may be influenced by many factors including the behaviour of health care providers. Claims experience can be volatile.

17. The Appointed Actuary should be aware of and familiar with the relevant legislation and regulation governing the operation of a health insurer, especially the National Health Act and relevant subordinate legislation, PHIAC standards and Department of Health and PHIAC circulars.

18. The Appointed Actuary should be familiar with the relevant aspects of the procedures for the administration of and accounting for the health insurer's membership, revenue and benefits (eg. treatment of members in arrears, timing of when new contribution rates apply, discounts given, application of benefit increases).

19. The Appointed Actuary should be conversant with the general characteristics of the health insurer's membership and products that may have a material bearing on the estimation of the liabilities. This includes familiarity with the contractual terms and legislated benefits payable under the rules of the health insurer as well as other attributes, such as product structure, membership movements, utilisation rates, seasonality of benefits, refunds, expenses and the impact of the state reinsurance pools.

20. The Appointed Actuary should be familiar with the health insurer's assets and investment policy.

21. The Appointed Actuary may be called upon to justify the work undertaken. The Appointed Actuary should therefore compile and retain documentation that shows that the work conforms to this Guidance Note and any external requirements as appropriate.

SCOPE

22. The purpose of the Financial Condition Report is to present to the Board of the health insurer the Appointed Actuary's assessment of the financial condition of the health insurer.

23. The Financial Condition Report is a formal documentation of the financial performance of the health insurer. It formally brings together an experience analysis of the health insurer, forms a

significant input to management decision making and Board communication, and provides an overview of the key financial issues and risks facing the health insurer.

24. The financial condition report should address:
    - The principal risks faced by the insurer in respect of solvency and profitability;
    - The recent and prospective performance of the health insurer as a whole;
    - The adequacy of the health insurer's contribution rates;
    - The current and prospective adequacy of the health insurer's capital (this may include any internal capital adequacy targets as well as the statutory requirements);
    - Any important financial implications of the insurer's business plan.

25. This assessment should address not only the financial condition of the health insurer as at the balance date, but should also consider how the financial condition of the health insurer has progressed since the previous report.

26. The Appointed Actuary should exercise judgement in the amount of detail included in the Financial Condition Report in respect of advice already given during the period under review. If the Appointed Actuary considers it inappropriate to include all the details of previous advice, then a summary of the main advice given throughout the period and the outcomes should be included in the Financial Condition Report. In examining and reporting on the financial condition of the health insurer the Appointed Actuary needs to consider issues of materiality.

27. The Financial Condition Report is a formal document which should be submitted to the Board prior to the signing of the annual financial statements. The Appointed Actuary should seek to discuss the report with the directors at a meeting of the Board or the Board Audit Committee.

28. The Appointed Actuary should be cognisant of the fact that a wide audience including the directors and senior management of the health insurer and PHIAC may read the Financial Condition Report. The Appointed Actuary should therefore ensure that the report is written in appropriate terms so that its readers, beyond those to whom it is actually addressed, will be able to understand its basic assumptions, conclusions and recommendations.

29. The financial condition of a health insurer may be affected by the state of and processes for managing matters including:

Membership

- the current and prospective membership profile and size
- the marketing plans and in particular the expected volumes and costs of membership recruitment
- the lapse experience, its selectivity and the health insurer's membership retention measures
- membership movements, including between products

Contributions

- the contribution rates and their immediate and prospective adequacy at a gross margin level
- competitive position
- level of any rate protection given
- discounts and premium waivers offered on both a permanent and temporary basis
- commission arrangements
- Lifetime Health Cover loadings

Benefits

- the adequacy of the provisions, and the existence of any longer term commitments
- the nature, terms and conditions of the health insurer's rules and product conditions including benefit structures, the method of benefit or service delivery, benefit adequacy, limits, co-payments, deductibles, exclusions, waiting periods and other benefit design features
- fees charged by providers, or agreed with providers
- contractual increases that may have been arranged with preferred providers
- impact of reinsurance on the cost of hospital benefits

Management Expenses

- level and trend of management expenses
- product allocation

Assets

- the liquidity of the assets of the health insurer
- the existing investments, investment policy and likely future investment experience
- the extent and value of the health insurer's fixed assets and their use
- the extent to which the health insurer owns assets that may be affected by changes in health insurance arrangements (for example private hospitals)

Other

- the diversification activities of the health insurer and the extent of any associated guarantees given by the health insurer.
- the support given or likely to be given to the health insurer by

any parent or associated body including both explicit and implicit guarantees.

- recent and prospective changes to health insurance legislation.

30. In any projections or calculations that are performed for inclusion in the Financial Condition Report where:
    - legislation, accounting standards, PHIAC guidelines or other rulings require the Appointed Actuary to use specific assumptions or methods,
    - an interpretation of legislation, accounting standards, PHIAC guidelines or other rulings supplied by the principal or its advisers is being relied upon, or
    - the health insurer requires the Appointed Actuary to use specific assumptions or methods,

    the Appointed Actuary must clearly state the circumstances, discuss whether or not the assumptions and methods are reasonable and consistent with this Guidance Note and Guidance Note 660, and discuss the implications of divergence from this Guidance Note or Guidance Note 660.

31. Where matters are omitted or limited in scope, or if the health insurer has not provided information that the Appointed Actuary considers necessary for the preparation of the Financial Condition Report, this must be highlighted.

32. The preparation of the Financial Condition Report should involve detailed consultation with management and discussions with the health insurer's auditors.

33. The appendix provides a checklist of matters that the Appointed Actuary would normally include in the Financial Condition Report.

DATA

34. The Appointed Actuary should ensure that the health insurer is aware that preparation of the Financial Condition Report requires the provision of appropriate and adequate data in a timely manner. In this regard the Appointed Actuary should specify to management, at an early stage, the data and information requirements. If the appropriate information is not provided, the Financial Condition Report should comment on any information that was requested but not provided and the likely consequent impact on the assessment of the financial condition of the health insurer.

35. In preparing a Financial Condition Report, the Appointed Actuary will usually be provided with various amounts of data. The Appointed Actuary should take reasonable steps to verify the overall consistency and reasonableness of any data provided with the health insurer's financial and statistical returns and with other data available to the Appointed Actuary. Where data is inconsistent, unreasonable

or not credible then the Appointed Actuary should seek to resolve the data issues with management of the health insurer. If the Appointed Actuary cannot resolve the data issues, this should be stated in the Financial Condition Report together with any consequent limitations of the report.

36. Checks should be performed to ensure the data is complete and accurate. Generally this would include discussions with management as well as numerical analysis. The Appointed Actuary should comment on the data checks and analysis performed to ensure the accuracy of the data for the purposes of the Financial Condition Report.

37. The Appointed Actuary should comment on any of the operations or systems that are likely to impact upon the adequacy of the data. Where necessary, the risks arising from any data inadequacy should be quantified.

RECENT EXPERIENCE

38. For the key items of experience, the Appointed Actuary should identify and comment upon any significant trends or significant deviations from expected experience. This may take the form of a profit analysis by source to quantify the financial impact of each item, including comparisons of actual experience with expected experience (for example, variation against the following may be investigated: budget, forecast, rate change submission, prior Financial Condition Report). Where possible, the reasons for significant variances should be identified. The report may also recommend actions or comment on management's progress in addressing any areas of adverse experience.

39. The report should contain sufficient experience analysis in respect of the key assumptions.

40. The Appointed Actuary should examine recent product development, product changes, pricing relativities and opportunities for movements between products. Any consequent financial impacts should be examined.

41. Where appropriate, margins should be analysed by product and relevant segment. The extent and implications of any cross-subsidies between products and/or groups of products should be identified. This analysis may exclude management expenses and investment income.

42. The Appointed Actuary should be aware of recent industry developments and membership trends.

INSURANCE LIABILITIES

43. The Financial Condition Report should comment on the appropriateness or otherwise of the method used to determine the outstanding claims liability at the reporting date. In determining the appropriateness or otherwise of the method adopted, consideration needs to be given to the requirements of IAAust Guidance Note 650 'Actuarial Reports and advice on Outstanding Claims in Health Insurance' and the requirements of PHIAC.

44. The adequacy of the outstanding claims provision in the recent past should be assessed against subsequent claims experience. The Appointed Actuary should comment on the past accuracy of historic outstanding claims provisions and any subsequent impact on the determination of the outstanding claims liability at the reporting date.

45. The Appointed Actuary should comment on any known change to claims submission and processing patterns, and actual and potential impacts on the level of outstanding claims provisions.

INVESTMENTS

46. The Appointed Actuary should provide some general comments on the appropriateness of, and any recent changes to, the health insurer's investment policy.

47. Where appropriate, the Appointed Actuary should report and comment on:
    - inadmissible assets
    - mix of assets by sector type
    - mix of assets by quality (level of security)
    - mix of assets by category and sub-category
    - asset concentrations – by investment type

48. The directors are responsible for the values to be placed on the assets in the health insurer's balance sheet. The Appointed Actuary should consider and comment on the methods by which those values have been obtained and their appropriateness for the purpose of the investigation. The Appointed Actuary should comment on any significant changes in the method of valuation of the assets.

49. Particular care needs to be taken when assessing the value of assets dependent on income from the health insurance business. In times of adversity for health insurers, the realizable value of a private hospital asset, for example, may fall substantially.

PROJECTIONS

50. The Appointed Actuary will need to perform or review projections of the financial position of the health insurer for at least three years from

the effective date of the Financial Condition Report in order to comment on the financial condition of the health insurer.

51. Projections will usually commence with the health insurer's business plan or most recent projection.

52. The Appointed Actuary should be satisfied as to the suitability of all material assumptions about expected future experience for the purposes of the projections used for the Financial Condition Report, and modifications should be made to the assumptions if necessary.

53. The Appointed Actuary should consider the degree of uncertainty in each of the assumptions and the potential effects of adverse experience, and conduct sensitivity testing on key assumptions.

54. IAAust Guidance Note 660 'Financial Projections for Health Insurers' sets out detailed requirements in relation to financial projections carried out for various purposes, including conducting a financial condition investigation.

SOLVENCY AND CAPITAL ADEQUACY

55. The Appointed Actuary should comment on the overall financial position of the health insurer at the reporting date, including:
    - Compliance with the solvency requirements
    - Compliance with the capital adequacy requirements
    - If required, the adequacy of any higher level of target capital established by the Board

56. The health insurer must meet the solvency and capital adequacy requirements at all times. The Appointed Actuary should therefore comment on the level of and reasons for any breaches of the Solvency or Capital Adequacy Standard during the past year and the subsequent actions that were taken by the health insurer, and any regulatory interventions and responses.

57. The Appointed Actuary should assess the likely future solvency and capital adequacy position and consider and comment on scenarios of adverse future experience from the best estimate assumptions. The Appointed Actuary should consider the likelihood of and the health insurer's capacity to endure such adverse experience.

58. Where a breach of the solvency or capital adequacy standards may result under reasonable adverse assumptions (or where such a breach has already occurred), the Appointed Actuary should comment on:
    - the reasons for the deficiency;
    - the proposed management actions to address the deficiency, and the likely effect of these actions.

59. In assessing the present and future solvency and capital adequacy position, a number of components will be based upon projected financial results, which are dependent on many assumptions. It is important to clearly disclose the assumptions and their source. Particular items of focus would be the provision for unexpired risk, renewal option reserve and business funding reserve.

CONTRIBUTION RATES

60. Consideration of the sufficiency of contribution rates will be an important part of the assessment of the current and future financial condition of the health insurer.

61. The Appointed Actuary should comment on the sufficiency of contribution rates in aggregate and the potential or likely financial consequences of the health insurer's past and future pricing strategies.

RISK MANAGEMENT

62. The Appointed Actuary should comment on the business risk exposures that could adversely affect the financial condition of the health insurer. The Appointed Actuary should make an assessment of the health insurer's response to the management of these identified risks, including any contingency plans.

RECOMMENDATIONS

63. The Appointed Actuary should consider whether the financial condition and risk management of the health insurer warrants any specific actions, and if so, the Appointed Actuary should make specific recommendations to the Board within the Financial Condition Report.

64. It is desirable that the Appointed Actuary should consult with management and the Board as appropriate in relation to any recommendations in the Financial Condition Report.

65. The Appointed Actuary should provide sufficient information to support any recommendations included in the Financial Condition Report. Any consequences of not adopting the recommendations should also be identified.

66. Where recommendations have been made in previous Financial Condition Reports, the Appointed Actuary should comment on management progress in addressing those recommendations.

APPENDIX

HEALTH INSURER FINANCIAL CONDITION REPORT CHECK LIST

1. Report Identification

1.1 Purpose of Report
1.2 Name of health insurer
1.3 Date of report and period of Investigation
1.4 Name of Appointed Actuary
1.5 Relationship to health insurer
1.6 Date of Report
1.7 Last or Previous Report (name of Appointed Actuary, date)

2. General Comment on Nature of Business

2.1 Corporate structure of health insurer (Company, Friendly Society, etc.)
2.2 Restricted or open (if restricted, nature of restriction)
2.3 For profit or not for profit (taxation status)
2.4 Diversification Activities
2.5 Business Plan

3. Fund Rules

3.1 Recent Changes
3.2 Summary of rules relating to membership, including transfers, suspensions, etc.
3.3 Summary of rules relating to contributions, including rate protection rules and discounts
3.4 Summary of rules relating to benefit payments, including waiting periods, benefit limits, equity/loyalty features, deductibles and co-payments

4. Product Range and Performance

4.1 Product Identification
4.2 Open or Closed to new contributors
4.3 Contribution Rates
4.4 Product Benefits
4.5 Product Combination Restrictions (ie. some products not available separately or only sold in combination)
4.6 Membership Trends by product
4.7 Margins by Product

5. Membership Performance

5.1 Analysis by state, age, sex, family/single, product, etc
5.2 Current membership profile and trends
5.3 Marketing Methods and Distribution Channels
5.4 Profiles of new entrants, withdrawals and lapses
5.5 Relevant Marketing activities and plans and expected projections
5.6 Comparison with past budgets and forecasts

6. Data

- 6.1 Data provided
- 6.2 Commentary on adequacy of data
- 6.3 Reconciliations performed
- 6.4 Data issues

7. Actual Financial Performance

- 7.1 Contributions
- 7.2 Benefits – by benefit type
- 7.3 Reinsurance Trust Fund
- 7.4 Expenses
- 7.5 Investment Income
- 7.6 Surplus

8. Comparison of Actual Financial Performance with Expected (budget, rate submission)

- 8.1 Contributions
- 8.2 Benefits – by benefit type
- 8.3 Reinsurance Trust Fund
- 8.4 Expenses
- 8.5 Investment Income

9. Technical Provisions

- 9.1 Provision for Outstanding Claims (including expense loading)
- 9.2 Provision for Reinsurance on Outstanding Claims
- 9.3 Provision for Contributions in Advance / Unexpired Risk
- 9.4 Provision for Loyalty Benefits
- 9.5 Prudential Margins
- 9.6 Adequacy of past Outstanding Claims provisions

10. Assets

- 10.1 Investment Policy
- 10.2 Summary by type and term
- 10.3 Investment returns
- 10.4 Contributions in Arrears

11. Solvency and Capital Adequacy

- 11.1 Past Trends
- 11.2 Components
- 11.3 Analysis of movements
- 11.4 Future trends and capital requirements
- 11.5 Future sources of capital

12. Forecasts

- 12.1 Forecasting model
- 12.2 Assumptions
- 12.3 Adequacy of contribution rates
- 12.4 Sensitivity analysis

13. Business Risks

13.1 Risk Management Strategy
13.2 Liability Risks
13.3 Asset Risks
13.4 Operations Risks

END OF GUIDANCE NOTE 670