PRACTICE GUIDELINE 699.02

VALUATION OF HEALTH INSURANCE LIABILITIES

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1 INTRODUCTION

1.1 Application

1.1.1 This Practice Guideline applies to Members preparing estimates of the health insurance liabilities of Insurers licensed under the Act. Health insurance liabilities include both the Outstanding Claims Liability and the Future Claims Liability.

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 significant departure from this Practice Guideline to the Principal, and document such explanation.

1.3 Background

1.3.1 This Practice Guideline was developed in response to the need to update Guidance Note 650 (Actuarial Reports and Advice on Outstanding Claims in Health Insurance) issued in June 1999 to reflect necessary changes following the introduction of 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 650 (Actuarial Reports and Advice on Outstanding Claims in Health Insurance) issued in June 1999. There were no other previous versions of Guidance Note 650.

1.6 Legislation

1.6.1 The legislation relevant to this Practice Guideline are the:

(a) Act and rules made by PHIAC under that Act; and

(b) Corporations Act 2001 (Cth).

1.6.2 Also relevant to this Practice Guideline are:

(a) AASB 1023;

(b) any other relevant accounting standards issued by any of the Accounting Bodies; and

(c) industry guidelines and circulars issued by PHIAC.

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 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 31 December 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).

'Accounting Bodies' means the Australian Society of Certified Practising Accountants, The Institute of Chartered Accountants in Australia and the National Institute of Accountants (and their successors from time to time).

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

'**Administrative Expenses**' means the management and administrative expenses incurred by the Insurer in relation to the discharge of the Outstanding Claims Liability and Future Claims Liability.

'**Central Estimate**' is intended to be an unbiased estimate of the mean (statistical expectation) of the Outstanding Claims Liability or Future Claims Liability.

'**Claims'** means benefit payments to, or on behalf of, the claimant under a health insurance policy.

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

'Future Claims Liability' or '**(FCL)'** means the value of Claims payments, related Risk Equalisation Trust Fund transfers and Administrative Expenses, made after the valuation date, for future Claims for which the Insurer is liable in respect of:

(a) premiums in advance on closed business on premium received but not earned as at the valuation date; and

(b) unclosed business which relates to future Claims incurred from premium revenue on policies that have not yet been processed, but for which the Insurer is liable at the valuation date; and

(c) constructive obligation which relates to the premium to be received before the next rate review date from the policyholder base as at the valuation date.

The FCL value is unknown at the date of the valuation. Such Claims events would have been neither incurred nor reported as at the valuation date.

'**Insurer**' has the same meaning given to 'private health insurer' in Schedule 1 to the Act.

'**Liability Adequacy Test**' means the test as defined in section 9 of AASB 1023 to assess the adequacy of the unearned premium liability to cover the Future Claims Liability.

'**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.

'**Outstanding Claims Liability**' or '**(OCL)**' at a valuation date is an estimate of the value of Claims payments, related Risk Equalisation Trust Fund transfers and Administrative Expenses to be made after the valuation date in respect of Claims which arose from a health service delivered on or before the valuation date for which the Insurer is expected to be liable. It also includes liabilities for other benefit entitlements such as loyalty benefits. The value is unknown at the valuation date.

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

'**Recoveries**' means those amounts or expected amounts to be recovered by an Insurer, usually from workers' compensation, compulsory third party (CTP), public liability insurers or for Claims paid but subsequently reversed.

'**Risk Equalisation Trust Fund**' means a trust fund constituted under Division 318 of the Act. Each Insurer is required to contribute to the trust fund and/or is paid from the trust fund to equalise their hospital Claims for older policyholders and for high cost Claims.

'**Risk Margin**' means any positive amount added to the Central Estimate in order to achieve a liability estimate for Claims appropriate for the purpose of the valuation.

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 PROCEDURES

4.1 An Insurer will not know, until after the valuation date, how many Claims have been incurred up to the valuation date, how much each Claim will cost or when it will be paid. Therefore, it is necessary to estimate the amount and timing of Claims, on the basis of the available information, particularly the past behaviour of similar Claims.

4.2 When advising on the health insurance liabilities of an Insurer, it is good professional practice for a Member to adopt similar steps as for other actuarial investigations, namely:

(a) clarify the terms of reference and purpose of the actuarial investigation;

(b) collect the necessary data;

(c) analyse the experience;

(d) select a valuation method;

(e) select valuation assumptions;

(f) perform the valuation calculations;

(g) reconcile the results with the previous investigation;

(h) analyse variability and sensitivity;

(i) reach conclusions; and

(j) present a written report/results in agreed form.

4.3 It may be necessary to go through part of the process several times to determine an appropriate Central Estimate and Risk Margin for the OCL and FCL (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.

4.4 The Member may be called upon to justify the work undertaken. As such, best professional practice is to compile and retain documentation which shows that the work conforms to this Practice Guideline and PHIAC requirements as appropriate.

4.5 Approximations are acceptable provided the effect on the result is not Material. Best professional practice is to choose a standard of Materiality which should reasonably satisfy each intended user of the Member's advice and the stated purpose of the report or advice.

5 DATA

5.1 In applying best professional practice, a Member would ensure that he or she was familiar with the:

(a) relevant aspects of the procedures for the administration and accounting for the Insurer's benefits and policyholders;

(b) general characteristics of the Insurer's policyholders and products, which may have a Material bearing on the estimation of the Central Estimate or the OCL and/or FCL. This may include familiarity with any current Claims processing issues, the contractual terms and legislated benefits payable under the rules of the Insurer as well as other attributes, such as product structure, policyholder

growth, policyholder demographics, seasonality of benefits, Recoveries and the impact of transfers to/from the Risk Equalisation Trust Fund;

(c) changes to benefit design that will be made before the expiry of unearned premium and/or the next premium rate increase date that should be considered for the FCL;

(d) projected premium income over the period until the next premium rate increase and the payment frequency of the current policyholder base; and

(e) general economic, legislative, political and social trends in the community which may have a bearing on the OCL or FCL.

5.2 It is the Member's responsibility to ensure that the data utilised is appropriate and sufficient for the valuation. In exercising that responsibility, best professional practice is to take reasonable steps to verify the overall consistency of the valuation data with the Insurer's financial records.

6 CENTRAL ESTIMATE

6.1 Analysis

6.1.1 The calculation of the OCL Central Estimate and FCL Central Estimate should require the sub-division of the Claims data into categories exhibiting similar characteristics. When determining appropriate sub-divisions, best professional practice is to find a balance between homogeneity and statistical reliability, and take into account the product and policyholder base of the Insurer.

6.1.2 Best professional practice, at a minimum, is to analyse the Claims experience with respect to the development over time of Claims or cohorts of Claims. Depending on the availability and reliability of the data, this analysis should include some or all of:

(a) Claim utilisation/frequency;

(b) average Claim size/benefit average;

(c) pattern (or seasonality) of Claim occurrence;

(d) development of reporting of Claims;

(e) development of Claim settlement or finalisation;

(f) development of benefit payments;

(g) the impact of Recoveries;

(h) the impact of Risk Equalisation Trust Fund transfers; and

(i) any other aspect of Claims experience that may be relevant to the valuation.

6.1.3 The Claims experience is commonly analysed without distinguishing between reported Claims and Claims which have been incurred but not reported. Relevant

trends in cash flow, especially regarding seasonality and other factors which may influence Claims reporting or processing trends, should be considered.

6.1.4 Best professional practice is for the analysis to:

(a) take into account any special features of, or changes to, the Claims experience such as changes in benefit design, Claims handling procedures, and the mix of products and policyholders; and

(b) investigate any trends in the development of the Claims experience.

6.2 Valuation approach

6.2.1 It is the Member's responsibility to select the most appropriate valuation approach to estimate the OCL and FCL Central Estimates. The Member may investigate more than one approach before arriving at an estimate. In making the selection, it is important to take into account the available data, the nature of the portfolio and the results of the analysis of Claims experience.

6.2.2 The FCL approach would usually involve either a full financial projection or applying a Claim or loss ratio to the future premium components of advance, unclosed and constructive obligation policy premiums. The Member should consider how best to adjust the Claim/loss ratio used so that it is consistent with the reasonably expected outcomes over the FCL period. The impact of policy lapses and premium refunds should also be considered.

6.3 Claims experience assumptions

6.3.1 Selection of the Claims experience assumptions in accordance with best professional practice has regard to the valuation method and the analysis of the Claims experience (including trends in such and assumptions about Recoveries).

6.3.2 It is unnecessary to change the prior valuation assumptions from those of the prior valuation unless the effect is Material. In this case, best professional practice is to disclose the effect of any such change and reflect the impact of Material changes in the current valuation rather than spreading it over several valuations.

6.4 Discount and inflation rate

6.4.1 The Member may choose, on the grounds of Materiality, not to make specific allowance for discounting or inflation.

6.4.2 Discounting is not usually applied to the OCL due to the short tailed nature of health insurance business.

6.4.3 Because of the longer payment period of the FCL, the Member should consider the use of both interest and inflation rates as these may be Material.

6.4.4 When discounting, the discount rate commonly used is the risk-free rate of interest underlying the Commonwealth Government Bond yield curve (that is, current observable, objective rates that are in essence risk-free).

6.4.5 Inflation rate assumptions should consider available consumer price indices, including medical cost inflation and wage inflation measures and the Insurer's own experience.

6.5 Valuation results

The Member should consider the reasonableness of the estimates produced by the valuation procedures employed and quantify the effects of any changes in the valuation basis since the previous actuarial valuation. In doing so, best professional practice is to seek an explanation where possible for any major departures from past results.

6.6 Uncertainty

6.6.1 Uncertainty in the estimation of the OCL and FCL Central Estimates will arise from Claims costs and processing variability, statistical fluctuations, operational aspects, mismatches between the model used and the actual process, amongst others. The Member should:

(a) consider the level and implications of the Claims cost estimation uncertainty and any potential future deviations they may cause; and

(b) describe and quantify the main sources of uncertainty in the valuation and communicate the consequences of that uncertainty.

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

(a) statistical analysis of the probability distribution of Claims cost outcomes;

(b) sensitivity analysis (making changes to the model assumptions and/or the models themselves);

(c) analysis of the outcomes of previous valuations;

(d) analysis of different scenarios; and

(e) judgment.

6.6.3 The Member should document the key risks and uncertainties identified during the valuation and provide the Principal with a single Central Estimate, along with an explanation of the practical consequences of the uncertainty relating to that Central Estimate.

7 ADMINISTRATIVE EXPENSES

7.1 Accounting, legislative and/or regulatory requirements prescribe the appropriate allowance for the future costs of policy, premium and Claims administration. The Member should have regard for the Insurer's level of expenses, management structure and any other relevant factors to determine this allowance. Appropriate professional practice is for the complexity of the approach used to determine the allowance to be commensurate with the Materiality of the amount of the allowance.

7.2 The OCL valuation includes allowance for Claims management costs.

7.3 For the FCL valuation, the relevant Administrative Expenses include:

(a) policy management and premium handling to allow for the cost of managing unexpired policies for which the Insurer is on risk; and

(b) Claims management costs for Claims establishment and runoff.

7.4 The Member could use either or both of the following to estimate future Administrative Expenses:

(a) the Insurer's historical management expense information that is reasonably allocated; and/or

(b) the Insurer's internal information that is available to notionally allocate expenses between policy, premium and Claims administration.

7.5 If such information is unavailable or is unreliable, best professional practice is to consider any available external benchmarks to assist in setting an appropriate assumption for the Administrative Expenses, and ensuring that the overall expense assumptions adopted for the Insurer are reasonable.

8 RISK EQUALISATION

8.1 Best professional practice is to calculate an appropriate allowance in recognition of the payment to, or receipt from, the Risk Equalisation Trust Fund 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 experience of other Insurers. As such, best professional practice is to arrive at an estimate using available information, including recent trends in policyholder numbers and eligible risk equalisation Claims.

8.2 It needs to be recognised that an Insurer's accounts are required to be prepared on an accrual basis (both by AASB 1023 and PHIAC), whereas the Risk Equalisation Trust Fund operates on a Claims paid basis. This leads to a timing mismatch between the recognition of eligible risk equalisation Claims in the OCL and FCL Central Estimates and settlement through the Risk Equalisation Trust Fund.

8.3 Each Insurer has a future claim on the Risk Equalisation Trust Fund in respect of the ultimate eligible risk equalisation Claim payments arising out of its Central Estimate, and also a liability for its share of the total Risk Equalisation Trust Fund. The Insurer should make allowance in its accounts for the expected operation of the Risk Equalisation Trust Fund in respect of the estimated Central Estimate for Claims incurred prior to balance date for the OCL and Claims incurred after the balance date that are included in the FCL.

8.4 The Member should determine the two components of the net Risk Equalisation Trust Fund transfer amount described above. This may result in a net addition to the Central Estimate of the OCL and/or FCL if expected payments to the Risk Equalisation Trust Fund exceed expected Claims reimbursed from the Risk Equalisation Trust Fund

or a reduction, if not. If appropriate, the net impact of these two components may be determined directly.

8.5 Risk Equalisation Trust Fund calculations are done separately by State. The Member should consider whether an Insurer's circumstances require separate risk equalisation allowances by State. Separation by State is not commonly done.

9 RISK MARGINS

9.1 Best professional practice is to consider:

(a) Risk Margins or, if the scope of the valuation does not include the estimation of Risk Margins, documenting this with the reasons; and

(b) the nature and extent of the Risk Margins estimation process which would be reasonable to cover potential future deviation from the Central Estimate.

9.2 For the estimation of Risk Margins, best professional practice is to provide a quantitative indication of the variability. This can be done using the approach described in clause 6.6.2 above.

9.3 If Risk Margins are required for separate sub-divisions of the Insurer, or for multiple benefit types, then the estimation process should be reasonable in aggregate and the Member should consider and document any diversification benefit allowed in the valuation.

9.4 The variability of the OCL and FCL is different. Unlike other types of insurance, the FCL variability in health insurance is usually lower than for the OCL. This means the FCL Risk Margin percentage is usually lower than for the OCL for the same probability of adequacy.

9.5 AASB 1023 requires that an Insurer include a Risk Margin in its balance sheet OCL provision. The Member would usually be involved in determining an appropriate Risk Margin based on Claims variability and the Insurer's stated objectives, including its required level of adequacy for the balance sheet and/or regulatory purposes.

10 VALUATION ESTIMATES

10.1 The Member should produce valuation results appropriate to the valuation date.

10.2 If, before releasing the valuation results, the Member becomes aware of events after the valuation date which (based on reasonable grounds) are expected to have a Material financial impact on the valuation results, then the Member should:

(a) disclose in his or her advice that such events have occurred and comment on the possible effect on the valuation results; and

(b) if time reasonably permits, consider allowing for such events in the Member's valuation, taking into account the nature of the event and other relevant matters, such as the regulations and/or accounting standards relevant to the Member's valuation.

10.3 As with any accounting provision, the exact amount required to satisfy the OCL and FCL is subject to uncertainty, however a specific amount is required as the provision in the Insurer's accounts at the balance date. The directors of the Insurer, not the Member, have the ultimate responsibility for the provision.

10.4 The Member should perform and document a comparison of the actual experience with that expected by the last similar valuation and also reconcile the insurance liabilities between these two valuations. The reconciliation should quantify the amount by which the previous Central Estimate has proven too great or too small for the Claim payments in the inter-valuation period and the residual insurance liability for the exposure at the last valuation.

11 LIABILITY ADEQUACY TEST

11.1 The Member should perform and present the results of the Liability Adequacy Test:

(a) at an appropriate level of sub-division of the portfolio/benefit types;

(b) on a premiums in advance basis including unclosed business; and

(c) on a constructive obligation basis to the date of the next anticipated premium rate increase.

Current industry practice is to perform this test at a whole of insurer level.

11.2 When presenting the results of the Liability Adequacy Test on a premiums in advance basis, the Member should present:

(a) the Insurer's unearned premium less any allowance for deferred acquisition costs as held in its balance sheet;

(b) the FCL on a premiums in advance basis including appropriate allowance for Administrative Expenses and Risk Margin;

(c) the Insurer's current unearned premium liability deficiency, if any; and

(d) if an unearned premium liability deficiency is identified, the level of deferred acquisition costs (as defined in AASB 1023) write down required and the size of the additional unexpired risk liability to be recognised.

11.3 When presenting the results of the Liability Adequacy Test on a constructive obligation basis, the Member should present:

(a) forecast premiums the Insurer expects to receive from the current policyholder base until at least the next anticipated premium rate increase;

(b) the FCL on a constructive obligation basis including appropriate allowance for Administrative Expenses and Risk Margin;

(c) the Insurer's forecast deficiency, if any; and

(d) if a forecast deficiency is identified, the size of the additional unearned premium liability to be recognised.

11.4 If deferred acquisition costs are amortised over a longer period than the premium paid to date, the allowance in clause 11.2 above should be only that portion which relates to the premiums in advance.

12 REPORTING

12.1 A formal report on the valuation performed by the Member may or may not be required by the Principal. The sections below provide guidance on content, documentation and considerations in any such report. The Member should maintain sufficient working documentation to satisfy the conditions below if a formal report is not required.

12.2 Members' attention is drawn to clause 1.1.2 of Practice Guideline 199.01 (Prescribed Actuarial Advice Reporting).

12.3 A report consistent with best professional practice would:

(a) detail the OCL and FCL estimates as at the valuation date;

(b) identify the OCL and FCL component amounts for:

(i) the Central Estimate, including an allowance for Risk Equalisation; and

(ii) an allowance for Administrative Expenses associated with those Claims;

(c) separately identify any Risk Margin established by the directors of the Insurer; and

(d) detail the results of the Liability Adequacy Test and the unearned premium liability deficiency, if any.

12.4 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 be neither misleading nor able to be quoted out of context. Best professional practice would be to include, in the certificate, a reference to the Member's full report and the qualifications stated therein.

END OF PRACTICE GUIDELINE 699.02