Actuaries Institute

PRACTICE GUIDELINE 699.00
DEFINITIONS

March 2018

INDEX

1.	INTRODUCTION	1
1.1	APPLICATION	1
1.2	About this Practice Guideline	1
1.3	Other relevant documents	2
2.	COMMENCEMENT DATE	2
3.	DEFINITIONS	2

1. INTRODUCTION

1.1 APPLICATION

1.1.1 This Practice Guideline defines key terms referred to in other Practice Guidelines applicable to Australian private health insurers.

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

1.2 About this Practice Guideline

1.2.1 This Practice Guideline:

(a) has been prepared in accordance with the Institute's Policy for Developing Documents to Guide and Regulate Professional Practice; and

(b) is to be applied in the context of the Code.

1.2.2 This Practice Guideline is not mandatory. Even so, if this Practice Guideline covers the Professional Services a Member provides, then the Member should consider explaining any significant departure from this Practice Guideline to the Principal, and document that explanation.

1.3 Other relevant documents

1.3.1 This Practice Guideline must be applied in the context of the relevant law, and relevant accounting and auditing standards.

1.3.2 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 or Practice Guideline includes any modification or replacement of that Professional Standard or Practice Guideline.

1.3.3 Apart from the Code or a Professional Standard, from legislation or from regulatory standards, no other document, advice or consultation can be taken to modify or interpret the requirements of this Practice Guideline.

2. COMMENCEMENT DATE

This Practice Guideline commences on 31 March 2018.

3. DEFINITIONS

3.1 In this Practice Guideline:

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

'**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 expenses incurred by the Insurer in relation to the discharge of the Outstanding Claims Liability and Future Claims Liability.

'**APRA**' means the Australian Prudential Regulation Authority (and its successors from time to time).

'**APRA Standards**' means in-force Private Health Insurance Prudential Standards issued by APRA under the Act.

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

'**Capital Adequacy Requirement**' is as defined in the APRA Standards.

'**Central Estimate**' (or 'best estimate') means the expected value or the statistical mean free from bias.

'**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.

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

'**Department**' means the Department of Health 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.

'Future Claims Liability' or '**(FCL)'** means the value of Claims payments, related Risk Equalisation Special Account 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/premium received but not earned as at the valuation date; and

(b) premiums in advance on 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 earned after the valuation date but 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.

'Gross Margin' is the result of 1 minus the Claims Ratio.

'**Health Benefits Fund'** is as defined in the Act.

'**Health Insurance Business'** is as defined in the Act.

'**Health Insurance Levies'** refers to the state government Ambulance levies payable under relevant legislation.

'**Health Related Business'** is as defined in the Act.

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

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

'**Liability Adequacy Test'** is as defined in AASB 1023.

'**Lifetime Health Cover**' is as defined in the scheme referred to in the Act.

'**Loss Ratio**' is the sum of Claims Ratio and 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 APRA reports use an MER that includes Health Insurance Levies.]

'Net Margin' is as the result of 1 minus the Loss Ratio.

'**Notifiable Circumstance**' is as defined in APRA HPS320.

'**Outstanding Claims**' is as defined in AASB 1023. 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 but have not yet been settled;

(b) incurred but not yet reported, and

(c) includes allowance for future adjustments of settled Claims.

'**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 the Act.

'**Provision for Outstanding Claims**' means an amount set aside in the Private Health Insurer's accounts to provide for liabilities for Outstanding Claims. This would normally include an allowance for Risk Equalisation and the Risk Margin. This may include, or be separate from, provisions for other benefit entitlements such as loyalty benefits. It typically also includes 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 premiums are paid in advance.

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

'**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 the Act.

'**Rules**' means all rules supporting the Act as well as rules made by APRA or the relevant Commonwealth Minister having responsibility for the Act.

'**Single Equivalent Unit**' or '**SEU**' is as defined in the Rules. 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 APRA 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.

END OF PRACTICE GUIDELINE 699.00