Actuaries Institute.

Exposure Draft of Professional Standard 600

Valuations of Health Insurance Claims

October 2023

Contents

1. Introduction

1.1 Application – specific situations

1.1.1. This Professional Standard applies to a number of situations that involve a Member undertaking a valuation of Health Insurance Claims for an Entity. This section sets out those situations where PS 600 applies.

1.1.2. Insurance Claims is defined as:

(a) claims for which an Entity is liable in respect of the Entity's Health Insurance Business; and/or

(b) claims for which an Entity is liable in respect of the Entity's Health Related Insurance Business; and/or

(c) liabilities incurred by an Entity which, if that Entity was a health insurer as defined in Division 3 of the PHI(PS) Act, would be classed as being Health Insurance Business or Health Related Insurance Business

1.1.3. The following table and subsequent paragraphs set out the situations where PS 600 applies.

Valuation purpose	**PS 600 application**
Required under the *PHI(PS) Act* including via APRA Prudential Standards.	Yes - see paragraph 1.1.4.
Required to prepare financial statements where accounting standard AASB 17 Insurance Contracts applies.	Yes – PS 600, together with consideration of PG 4, will apply. See paragraph 1.1.6.
Required to prepare financial statements where a different accounting standard applies.	Yes – see paragraph 1.1.7.
In a foreign jurisdiction without local actuarial standards, where the valuation is required by foreign regulators or governments.	Yes - see paragraph 1.1.5.
Other purposes.	No – see paragraph 1.1.8.

1.1.4. The PHI(PS) Act provides for APRA to issue prudential standards regulating the activities of, and imposing requirements on, registered private health insurers. APRA Prudential Standards mandate valuations of Health Insurance Claims for registered private health insurers. PS 600 applies to these valuations.

1.1.5. In countries other than Australia, valuations of Health Insurance Claims may be required. A Member undertaking a Health Insurance Claims valuation for an Entity in a jurisdiction other than Australia does not have to comply with this Professional Standard if the actuarial standards in that jurisdiction govern the valuation of Health Insurance Claims. If there are no local actuarial standards, or if they do not govern the valuation of Health Insurance Claims, then PS 600 applies to the valuation where the valuation is required by foreign regulators or governments.

1.1.6. A valuation of Health Insurance Claims may be required by an Entity to enable the Entity to prepare financial statements in accordance with accounting standard AASB 17. PS 600 applies to this type of valuation, as does the Institute's Practice Guideline 4 and accounting standard AASB 17.

1.1.7. A valuation of Health Insurance Claims may be required by an Entity to enable the Entity to prepare financial statements under an accounting standard other than AASB17. PS 600 applies to this type of valuation.

1.1.8. There may be other situations where an Entity requires a valuation of Health Insurance Claims, such as for internal management purposes. PS 600 does not apply to these valuations unless the Member and Client agree that it does apply. If the Member and Client have agreed that it does not apply, it may be prudent for the Member to consider to what extent the principles of PS 600 are applicable in their situation.

1.2 Application – generally

1.2.1. A Member who provides advice under this Professional Standard must exercise independent professional judgement and give impartial advice.

1.2.2. All work performed under this Professional Standard, whether by the Member providing advice or by a Member supporting the Member providing advice, is designated as an Applicable Service. As such, Members' attention is directed towards Practice Guideline 1 (General Actuarial Practice) which applies to Applicable Services. In the case of a Member supporting the Member providing advice, Practice Guideline 1 applies as relevant to their contribution to the Services.

1.2.3. An Appointed Actuary undertaking a valuation of Health Insurance Claims for a registered health insurer has legal obligations to report certain matters or information to APRA. These obligations are referred to as "whistleblowing". An Appointed Actuary and Members supporting the Appointed Actuary must understand the obligations that apply to them in their circumstances. This may require the Appointed Actuary and/or Members to seek legal or other professional

advice.

1.3 Previous Versions

1.3.1. This is the first Professional Standard issued for the Valuation of Health Insurance Liabilities.

1.3.2. This Professional Standard replaces Practice Guideline Valuations of Health Insurance Liabilities (PG 699.02), most recently issued in March 2018.

1.4 About this Professional Standard

1.4.1 This Professional Standard:

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

(b) must be applied in the context of the Code;

(c) must be applied by Members of the Institute when they perform work that the Professional Standard covers; and

(d) defines the Institute's requirements for work the Professional Standard covers.

1.4.2 If a Member believes that this Professional Standard is ambiguous or wishes to seek clarification of it, then they may consult the Institute's Professional Practice Committee for an interpretation.

1.4.3 A Member may in rare circumstances be unable to carry out their work in full compliance with this Professional Standard. If a Member finds that they cannot carry out their work in a way that fully complies with this Professional Standard then they must:

(a) decline to carry out the work;

(b) end their agreement to do so; or

(c) perform the work to the fullest extent possible under this Professional Standard; and qualify the work accordingly as set out in clause 1.4.4.

The approach adopted in such circumstances will require the exercise of the Member's professional judgement having regard to Materiality as appropriate.

1.4.4 In the scenario described in clause 1.4.3 (c), the resulting work product must be clearly qualified, with both the title of the report and the scope of the work set out in the report acknowledging the relevant limitations. All reasonable attempts must be made to comply with this Professional Standard to the fullest extent possible. A description of the areas where change would be needed to enable the creation of an unqualified work product must be disclosed along with a description of the reasons

for issuing qualified work.

1.4.5 If a Member does not comply with this Professional Standard then that may constitute Misconduct under the Institute's Disciplinary Scheme, although proper account will be taken of provisions of clauses 1.4.3 and 1.4.4.

1.4.6 This Professional Standard does not constitute legal advice. Any interpretation or commentary within this Professional Standard regarding specific legislative or regulatory requirements reflects the expectations of the Institute but does not guarantee compliance under applicable legislation or regulations. Accordingly, Members should seek clarification from the relevant regulator and/or seek legal advice in the event they are unsure or require specific guidance regarding their legal or regulatory obligations.

1.5 Other relevant documents

1.5.1. This Professional Standard must be applied in the context of the relevant law and relevant accounting standards.

1.5.2. A reference to legislation or a legislative provision in this Professional Standard 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 includes any modification or replacement of that Professional Standard.

1.5.3. Apart from the Code, from legislation or from regulatory standards, no other document, advice or consultation (including Practice Guidelines of the Institute) can be taken to modify or interpret the requirements of this Professional Standard.

1.5.4. If there is a conflict between this Professional Standard and any legislation, then 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 Professional Standard applies to relevant valuations conducted where the balance date is on or after 1 April 2024.

3. Definitions

3.1 In this Professional Standard:

'AASB Insurance Liabilities' is the insurance liabilities calculated to be compliant with AASB 17 for purposes of financial reporting.

'Act' means the Private Health Insurance Act 2007.

'Analysis Groups' is grouping of contracts and/or payment types for the purposes of analysis.

'Applicable Services' means Services that are designated in an Institute Professional Standard or Practice Guideline as being Applicable Services.

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

'**APRA Insurance Liabilities**' means the insurance liabilities calculated to be compliant with APRA HPS 340 for purposes of the capital calculations.

'Asset for Incurred Claims (AIC)' means the value at the valuation date of the insurance asset in respect of past service that exists for a Portfolio under AASB 17. The OCL calculated under AASB 17 requirements is one component of the AIC.

'Asset for Remaining Coverage (ARC)' means the value at the valuation date of the insurance asset in respect of future service that exists for a Portfolio under AASB 17.

'Carrying Amount of the LRC' means the component of the AASB 17 LRC/ARC that covers the amount held to reflect future cashflows excluding the deficit in the premium of the onerous GIC captured by the Loss Component.

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

'Claim Payments' means the amounts an Entity has paid, or is liable to pay in the future, in respect of its exposure to Health Insurance Claims, comprising payments made directly to claimants and Direct Expenses.

'Class of Business' means a grouping of Health Insurance Claims valued as a unit, which may be a regulator-defined class of business.

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

'Direct Expense' means allocated third party costs. These include payments on behalf of the Entity or claimants, for example medical and legal fees, where these are allocated to particular Health Insurance Claims. They may also include recoveries and risk equalisation payments.

'Disciplinary Scheme' means the document of that name prepared by the Institute setting out the rules and procedures governing professional discipline of a Member, as amended by Council from time to time.

'**Diversification Benefit'** means the amount by which an overall Entity Risk Margin is less than the sum of individually assessed Outstanding Claims Liability and Future Claims Liability Risk Margins by Class of Business, where diversification between them occurs.

'Entity' means one or more companies, corporations or other bodies with a liability to pay Health Insurance Claims.

'Financial Condition Report (FCR)' means a report prepared in accordance with the Institute's Professional Standard 102 (Financial Condition Report).

'Future Claims Liability (FCL)' (also known as 'Premium Liability (PL)') means the insurance liabilities in respect of future service calculated for the APRA Insurance Liabilities. The FCL is the value of Claim Payments and related Indirect Expenses, to be made after the valuation date, arising from future events for which the Entity is liable under insurance policies it has issued. Such events would not have been reported as at the valuation date.

'Gross Measurement Method (GMM)' means the default measurement method to calculate the AASB Insurance Liabilities.

'Group of Insurance Contracts (GIC)' means a grouping of insurance contracts within a portfolio for the calculation of the insurance liabilities under AASB 17. A GIC will include contracts within a portfolio with similar profitability characteristics and that were underwritten within 12 months of each other.

'Health Insurance Claims' is defined in Section 1.1.2

'Health Insurance Business' has the same meaning as under the Act.

'**Health Related Insurance Business'** is as defined in *APRA HPS 001 Definitions*.

'Indirect Expense' means the management and administrative expenses incurred by the Entity in relation to resolving the contractual liabilities arising from writing insurance contracts. The exact definition of which expenses are attributable to the insurance contracts varies depending on the purpose of the calculation of the insurance liabilities. Indirect Expenses exclude Direct Expenses and are not allocated to individual claims.

'**Insurance Liabilities**' means the liabilities that the Insurer holds to extinguish the legal obligations to policyholders under the terms of contracts issued. Insurance Liabilities can be calculated in different ways and with different coverage depending on the purpose and scope of the calculation. Examples include the APRA Insurance Liabilities and the AASB Insurance Liabilities.

'Insurance Risk Charge' means the amount determined in accordance with APRA's

Prudential Standard HPS 115 (Capital Adequacy: Insurance Risk Charge).

'Liability for Incurred Claims (LIC)' means the value at the valuation date of the insurance liability in respect of past service that exists for a Portfolio under AASB 17. The OCL calculated under AASB 17 requirements is one component of the LIC.

'Liability for Remaining Coverage (LRC)' means the value at the valuation date of the insurance liability in respect of future service that exists for a Portfolio under AASB 17.

'Loss Component' means the component of the AASB 17 LRC/ARC that covers the deficit in the premium of the onerous GIC.

'**Material'** means relevant to the Entity's circumstances and is either 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 Claim Liability (OCL)' means the value at the valuation date of Claim Payments and related Indirect Expenses to be made after the valuation date arising from events occurring on or before the valuation date. It may be calculated for the AASB Insurance Liabilities or APRA Insurance Liabilities, and the calculation basis may differ depending on the purpose.

'PHI(PS) Act' means the Private Health Insurance (Prudential Supervision) Act 2015.

'Portfolio' means a portfolio of insurance contracts which are subject to similar risks and managed together and have been assigned as a portfolio for the calculation of the AASB 17 insurance liabilities/assets associated with them.

'Premium Allocation Approach (PAA)' means an alternative measurement method in AASB 17 that can be used to calculate the AASB Insurance Liabilities under some circumstances. It is a simplified approach compared to the GMM.

'Regulator' means any agency, body or instrumentality established by an Australian Commonwealth, State or Territory government and includes APRA and the Australian Securities and Investments Commission or an overseas equivalent.

'Reinsurance Cost' means the cost to the Entity of purchasing insurance or reinsurance cover in respect of the Health Insurance Claims being valued.

'Reinsurance Recovery' means an amount recoverable, in respect of an Entity's Claim Payments, from insurance or reinsurance agreements.

'Report' means a report prepared by a Member under this Professional Standard as the context requires. This Report may be a liability valuation report, a summary of the insurance liability valuation in the FCR, or a 'Regulatory Report' (a report required by a Regulator to be prepared by an Entity).

'Risk Adjustment' means the compensation an entity requires for bearing the uncertainty about the amount and timing of the cash flows that arises from

non-financial risk as the entity fulfils insurance contracts as measured by AASB 17.

'Risk Equalisation' means the scheme for transfer of funds between insurers as set out in *Private Health Insurance (Risk Equalisation) Rules 2015* to support the principles of community rating and incorporating the calculation of the Age Based Pool (ABP) and the High Cost Claimants Pool (HCCP) outlined in the rules.

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

'To disclose' means to include information within a written communication, such as a Report where one is prepared.

'To record' means to include information within working papers or other documentation, but this information does not need to be included in written Reports or similar communication.

'Unclosed Premium' means the premium revenue from insurance policies that have not yet been processed, but for which the Entity is liable at the valuation date.

3.2. A word that is derived from a defined word has a corresponding meaning.

3.3. Other capitalised terms used in this Professional Standard have the same meaning as set out in the Code.

4. Materiality

4.1. The Member must take Materiality into account when performing work under this Professional Standard. In determining whether something is Material, the Member must consider the purpose of the work. Whether something is Material or not will always be a matter requiring the exercise of the Member's professional judgement.

4.2. If the Member has formed the opinion that a matter required to be considered under this Professional Standard is not Material, then:

(a) the Member must record that the matter is not Material and provide reasons for forming that opinion, but does not have to further consider that matter; and

(b) if the matter is not relevant to the Entity's circumstances, the matter may be omitted from any applicable Report; or

(c) if the matter is relevant to the Entity's circumstances, but is not Material because it is neither important nor essential in the Member's opinion, the Member must disclose in any applicable Report that the matter is not Material and provide reasons for such opinion.

5. Documentation

5.1 Requirement for a Report

5.1.1 Where a Member performs a valuation to which this Professional Standard applies and:

(a) those valuation results are intended to be used in, or as part of, the FCR or other Regulatory Report, or published financial statements; or

(b) those valuation results are intended to be used in connection with a change or transfer of ownership of liabilities for Health Insurance Claims; or

(c) the Member forms a view, as a matter of judgment (and subject to clause 4.3), that the circumstances surrounding or affecting that valuation warrant it,

then, subject to clause 5.1.2, the Member must provide a Report on the valuation which satisfies all the requirements laid down in clause 5.2.

5.1.2 If the Member is issuing a Financial Condition Report, and the Financial Condition Report satisfies all the requirements laid down in clause 5.2, then a separate Report is not required.

5.1.3 If clause 5.1.1 does not apply in relation to a valuation performed by a Member, then the Member is not required to comply with the documentation requirements set out in this Professional Standard (including clause 5.2), but must:

(a) comply with any relevant documentation and reporting requirements set out in the Code; and

(b) disclose such other things as to which the Member reasonably forms a view, as a matter of judgment, that circumstances surrounding or affecting the valuation warrant documentation.

5.2 Content of a Report

5.2.1 A Report must:

(a) comply with any relevant documentation and reporting requirements set out in the Code;

(b) include all relevant matters stipulated in this Professional Standard (and if applicable in APRA's Prudential Standards); and

(c) disclose such other things as to which the Member reasonably forms a view, as a matter of judgment, that circumstances surrounding or affecting the valuation warrant documentation.

5.2.2 A statement must be included that the Report has been prepared in accordance with this Professional Standard.

5.2.3 In this Professional Standard, where a Member is placed under an obligation "where reasonably practicable", and the Member forms the view that it is not reasonably practicable, the Member must disclose a summary of and record their reasons.

5.2.4 The level of detail to be provided in a Report will depend on the purpose of the valuation, the size and complexity of the portfolio being evaluated and considerations of Materiality. A Member must provide sufficient information in the Report that an informed reader of that report could draw a conclusion that the derivation of the results stated in the Report was reasonable.

5.2.5 Where APRA Insurance Liabilities have been estimated the Member must clearly disclose each of the following elements (if relevant) in the Report:

(a) the Central Estimate of the OCL;

(b) the Risk Equalisation component of the OCL;

(c) the Central Estimate of any FCL;

(d) Risk Margin; and the

(e) sum of relevant items.

5.2.6 Where the AASB Insurance Liabilities have been estimated the Member must clearly disclose each of the following elements (if relevant) in the Report:

(a) the Central Estimate of the OCL component of the LRC/ARC;

(b) the Central Estimate of non-OCL assets and/or liabilities components of the LRC/ARC;

(c) the Risk Adjustment component of the LRC/ARC;

(d) the carrying component of the LRC/ARC;

(e) the Loss Component of the LRC/ARC; and

(f) the sum of relevant items.

5.2.7 The Member must record the control process around the valuation results, including any high-level reasonableness tests undertaken during the valuation.

5.3 Working papers and other documentation

5.3.1 A Member must include in their documentation, all items required by this Standard to be recorded or disclosed. The items required by this Standard to be recorded or disclosed must contain sufficient detail and clarity that another actuary qualified in the same practice area could make an objective assessment of the reasonableness of the Member's work.

5.3.2 CPS 320 requires an Entity to take all reasonable steps to ensure that working papers and other documentation of an Appointed Actuary in relation to prudential requirements are retained for a period of seven years. An Appointed Actuary must assist an Entity by identifying their working papers and other documentation and retaining this information and/or providing it to the Entity. The Appointed Actuary must also make this information available to APRA when requested in writing.

6. Valuation requirements

6.1. In undertaking a valuation of Health Insurance Claims, a Member must consider and record each of the matters listed below:

(a) purpose of valuation and terms of reference;

(b) information and data;

(c) valuation methods;

(d) valuation assumptions;

(e) valuation estimates;

(f) uncertainty; and

(g) any other matter as to which the Member reasonably forms a view, as a matter of judgment, that circumstances surrounding or affecting the valuation warrant and is not detailed elsewhere in this Professional Standard.

6.2. The Member must also consider and record an assessment of the past adequacy of recent valuation estimates, including any implications for the current valuation estimate.

7. Information and data

7.1 Information requirements

7.1.1 The Member must request the Entity to provide:

(a) all relevant information required for the valuation, including data and other documents; and

(b) access to relevant staff and/or contractors of the Entity.

7.1.2 The Member must take reasonable steps to verify the consistency, completeness and accuracy of the information provided by the Entity (for example, by undertaking reconciliations against the Entity's financial statements, trial balances and/or other relevant records, if these are available).

7.1.3 The Member must consider:

(a) the administration of policies and claims;

(b) the characteristics of insurance policies, insurance risk management, hospital contracting and claim processes; and

(c) the relevant economic, regulatory and social environments and trends.

7.2 Information controls and limitations

7.2.1 The Member must consider and record together with any consequent limitations:

(a) data controls, including reconciliations undertaken or relied upon;

(b) discrepancies that cannot be resolved with the Entity;

(c) comments the Member has on the data used, data extraction, data summarising, quality checking and auditing at source;

(d) the completeness and accuracy of the data relied upon; and

(e) any consequent limitations arising from any reliance placed on others in accordance with clause 7.3 of this Professional Standard.

7.2.2 If:

(a) the Member is unable to obtain timely access to some or all of the required information from other persons (including the Entity); or

(b) such information as is provided is limited,

then the Member may omit, from the Report, analysis that depends on that information. However, the Member must disclose details in the Report regarding the circumstances as to why that analysis has been omitted and explain any consequent limitations.

7.3 Reliance on others

7.3.1 If, in performing work under this Professional Standard, a Member wishes to rely on someone else's work (including another Member's work), then the Member must:

(a) if possible, inform the other person that the Member is relying on their work; and

(b) assess the appropriateness of the other person's work for that purpose.

If, following the Member's assessment under clause 7.3.1(b), the Member determines that it is not appropriate to rely on the other person's work, the Member must do their own alternative or supplementary analysis and must disclose a summary of and record that analysis.

7.3.2 In any Report prepared under this Professional Standard, the Member must disclose:

(a) the information the Member has relied on that has been provided by another person; and

(b) the steps the Member took to determine whether it was appropriate to rely on the other person's work.

8. Valuation methods

8.1 Selection of valuation methods

8.1.1 The Member must determine the appropriate Analysis Groups to aggregate the data for calculation purposes. The groupings can be by Portfolio, Class of Business, GIC, claim type, payment or recovery type, or other grouping that increases the homogeneity of the data, consistency of the data and/or the power of the statistical analysis while balancing materiality and useability.

8.1.2 An Analysis Group may also be determined to align with the scope of the valuation and the relevant standards being followed for calculation purposes. Multiple types of groupings may be used simultaneously, such as grouping by claim type (hospital and medical) and payment type (claim cashflows and risk equalisation cashflows).

8.1.3 The valuation methods the Member uses to determine the Central Estimate of the Insurance Liabilities, applied separately by Analysis Group, must be methods that incorporate actuarial principles which, in the Member's judgment, are reasonable in the circumstances.

8.1.4 The valuation methods and the Analysis Groups selected will depend on:

(a) the purpose of the valuation;

(b) the available information;

(c) the nature and homogeneity of the data;

(d) the maturity of the business;

(e) the results of the analysis of the adequacy of recent valuation estimates;

(f) the Entity's environment;

(g) relevant industry practice;

(h) the particular circumstances of the Entity; and

(i) any other matters identified by the Member as being relevant.

8.1.5 The Member must disclose a summary of the reasons for the chosen valuation approach, including the key risks or limitations of the methods used. This summary must

include, where relevant, the reasons for any change to the valuation methods adopted since the most recent report or FCR.

8.2 Indirect Expense assumptions

8.2.1. Accounting, legislative and/or regulatory requirements prescribe whether an allowance needs to be made for Indirect Expenses. In that light, the Member must consider the terms of reference and the purpose of the valuation and disclose whether an allowance for relevant Indirect Expenses has been made.

8.2.2. The Member can use either or both of the following to estimate future Indirect Expenses:

(a) the Entity's historical Indirect Expense information that is reasonably allocated; and/or

(b) the Entity's internal information that is available to notionally allocate expenses.

If such information is unavailable or is unreliable, the Member must consider any available external benchmarks to assist in setting an appropriate assumption for the Indirect Expenses, and adopt reasonable overall expense assumptions for the Entity.

9. Valuation assumptions

9.1 Selection of assumptions

9.1.1. In setting the valuation assumptions to determine the Central Estimate of the Insurance Liabilities, the Member must:

(a) consider the relevant experience of the Entity or, if the relevant experience of the Entity is not sufficiently credible, then consider the available relevant industry statistics or other information;

(b) consider any special features of, or trends in, the claims experience; and

(c) consider the consistency of the valuation basis as a whole, including: consistency between the Central Estimate of the Insurance Liabilities in respect of past and future service allowing for changes in pricing, product design or similar issues, as well as consistency with the results of the analysis of the past adequacy of estimates undertaken in clause 8.1.4 (e).

9.1.2. The Member must record, by Analysis Group, the assumptions adopted with the rationale explained, including the extent to which the assumptions used are based on the historical experience of the Entity.

9.1.3. Accounting, legislative and/or regulatory requirements may prescribe whether Claim Payments are to be discounted. The Member must consider the purpose of the valuation and record whether the future Claim Payments are to be discounted. If they are, the Member must record the approach and rationale for the method adopted for determining the discount rates.

9.2 Indirect Expense assumptions

9.2.1. Accounting, legislative and/or regulatory requirements prescribe whether an allowance needs to be made for Indirect Expenses. In that light, the Member must consider the terms of reference and the purpose of the valuation and disclose whether an allowance for relevant Indirect Expenses has been made.

9.2.2. The Member can use either or both of the following to estimate future Indirect Expenses:

(c) the Entity's historical Indirect Expense information that is reasonably allocated; and/or

(d) the Entity's internal information that is available to notionally allocate expenses.

If such information is unavailable or is unreliable, the Member must consider any available external benchmarks to assist in setting an appropriate assumption for the Indirect Expenses, and adopt reasonable overall expense assumptions for the Entity.

9.2.3. For the OCL, the relevant Indirect Expenses include future ongoing claim management and administration expenses for all claims that have been incurred before the valuation date, whether or not they have been reported.

9.2.4. For any FCL, the relevant Indirect Expenses include:

(a) policy management and administration expenses to allow for the cost of managing unexpired policies for which the Entity is on risk; and

(b) claims management and administration expenses for claims establishment and run off.

9.2.5. For any AASB Insurance Liabilities calculation the relevant Indirect Expenses are stipulated in AASB 17.

9.3 Reinsurance Recovery and Reinsurance Cost assumptions

9.3.1. The Member must consider whether to make an allowance for any relevant future Reinsurance Recovery and disclose the results of that consideration.

9.4 Unclosed Premium assumptions

9.4.1. If any FCL is being estimated, then where relevant the Member must consider and disclose:

(a) unexpired contractual obligations arising from the Insurance Business with an inception date up to the valuation date, for which the Entity is liable as at the valuation date, particularly how long after the valuation date events may

occur for which the Entity is on risk; and

(b) the Entity's Unclosed Premiums and other commitments arising from its insurance policies, and make reasonable allowance.

9.5 AASB Insurance Liabilities for future service

9.5.1. If the AASB 17 insurance liabilities/assets for future service are being estimated, then where relevant the Member must consider and disclose:

(a) whether the entire LRC/ARC is being calculated or just a component of the calculation;

(b) whether the GMM or PAA was used to calculate the LRC/ARC;

(c) the exposure included in the calculation of the LRC/ARC, including the contract boundary;

(d) the GICs being analysed and the basis upon which the onerous GIC (if any) has been identified;

(e) if the PAA is applied, what options have been selected by the entity in respect of expensing of acquisition costs, discounting, recognition of insurance revenue, and whether there is a significant financing component; and

(f) the basis of the claim expense and indirect expense assumptions used.

9.6 Taxation assumptions

9.6.1. The Member must consider how the taxation environment, as well as government charges, levies and duties, impact the valuation assumptions. If necessary, the Member must make reasonable allowance for, and disclose, such impacts.

9.7 Margin and diversification benefit assumptions

9.7.1. Accounting, legislative and/or regulatory requirements may prescribe that an allowance needs to be made for a margin (either a Risk Margin or Risk Adjustment) to be included in the calculation of the Insurance Liabilities. The margin may be based on the variability of the assumptions or be prescriptive, depending on the basis and purpose of the margin.

9.7.2. The member must consider and disclose:

(a) the basis of the margin;

(b) the types of risks and/or variability the margin is meant to include; and

(c) to which cashflows the margin is being applied.

9.7.3. If the scope of the valuation includes the estimation of a margin that is based on the variability of the assumptions, then the Member must disclose a quantitative indication of the variability. The variability can be assessed by examining scenario analyses, sensitivity analyses and/or statistics such as the estimated standard deviation of any assumed probability distribution of claim cost outcomes and may be expressed in terms of the probability of adequacy.

9.7.4. If the scope of the valuation includes the estimation of a margin that is based on the variability of the assumptions and if margins are required for an Entity, or for multiple Analysis Groups, then the estimation process must be reasonable in aggregate and the Member must consider and disclose the justification for, and method of determining, any Diversification Benefit.

10. Valuation estimates

10.1.1. The results of the Insurance Liabilities valuation must be disclosed. Where reasonably practicable, the Member must separately disclose the results by relevant Analysis Group, any Risk Equalisation liability, any margin and any Diversification Benefit.

10.1.2. It must be clearly stipulated whether results are gross or net of reinsurance recoveries, and the gross and reinsurance positions must be disclosed separately.

10.1.3. If the Central Estimate of the Insurance Liabilities where calculated includes an allowance for Indirect Expenses (refer to clause 9.2) the allowance must be separately disclosed.

10.1.4. Where reasonably practicable, if the Central Estimate of the Insurance Liabilities explicitly allows for Government charges imposed, such as levies, duties and taxes, then they must be separately disclosed.

11. Uncertainty

11.1.1. The Member must consider the level and the implications of the uncertainty related to the assessment of possible future claims cost outcomes and any potential future deviations they may cause to the results obtained.

11.1.2. The Member must describe, qualitatively, the key risks and main sources of uncertainty in the valuation and disclose the consequences when preparing a Report.

11.1.3. To assist in quantitatively describing these sources of uncertainty, the Member must, if reasonably practical and as appropriate, use sensitivity analyses and/or scenario analyses and/or descriptive statistics (such as the estimated standard deviation of any assumed probability distribution of claim cost outcomes).

11.1.4. The assumptions used in these analyses must be selected to illustrate the impact on results when a reasonable variation to key assumptions is made. Where a report is prepared, the Member must state that the variations selected in the

sensitivity analyses do not indicate upper or lower bounds of all possible outcomes.

End of Professional Standard 600