EXPLANATORY MEMORANDUM TO PS 602 VALUATIONS OF HEALTH INSURANCE CLAIMS April 2024 (rebranded October 2024)

1. Background

This Explanatory Memorandum has been prepared to assist Members in understanding the proposed implementation of a new Professional Standard, PS 602 Valuations of Health Insurance Claims which is to apply when a Member is undertaking certain types of valuations of Health Insurance claims for an entity.

A series of recent developments has led the Institute to consider that both the profession, and entities and regulators that rely on actuarial valuations of health insurance liabilities to protect and safeguard the interests of policyholders, would benefit from the additional confidence and integrity provided to users by a Professional Standard. This approach would align with General and Life Insurance practice streams, where valuations of claims are covered by a Professional Standard.

This Professional Standard is intended to replace Practice Guideline PG 699.02 Valuations of Health Insurance Liabilities (March 2018).

The Exposure Draft was opened to Member consultation for the eight weeks to 30 November 2023, including an Insights session held virtually on 26 October 2023.

Given this was the first practice-specific Professional Standard applying to Members practising in health insurance, the Health Practice Committee (HPC) was particularly interested in ensuring the Standard was aligned with current practices and that any unintended consequences were identified prior to introduction. HPC requesting specific feedback on (but not limited to):

- the suitability of the proposed application of PS 602 in the context of new APRA Capital Standards and the requirements of AASB17;
- whether the application of PS 602 is consistent with the role, requirements and expectations of the Appointed Actuary, and Actuaries more generally within PHI; and
- appropriateness and proportionality of the proposed reporting and valuation requirements, and the value to users of valuations from the specific reporting requirements, including whether the requirements align with current practice and Member and stakeholder expectations.

The purpose of this memorandum is to briefly summarise the correspondence received via Member consultation and to explain how that was considered and addressed in the final Standard.

2. Commencement date

PS 602 applies to relevant valuations conducted where the balance date is on or after 1 April 2024.

3. Consultation feedback & response

Written feedback was received from five Members, in addition to that which was provided through Q&A or the chat feature of the virtual Insights session. In the presentation that follows we have grouped the feedback into broad themes.

Application of the standard in overseas jurisdictions

Some challenge was raised as to the suitability of the standard when working for insurers based in overseas jurisdictions, particularly noting the Australian flavour of the Standard and the relatively unique features of Australia's private health insurance market compared to medical insurance globally. A specific piece of feedback challenged whether a mandatory Professional Standard would offer value and potentially disincentivise the seeking of Australian actuarial input into valuations from the South Pacific.

As this is the first valuation Professional Standard applying in Health Insurance, and HPC was not aware of the scale or scope of Australian actuarial input into health insurance outside of Australia, it was considered reasonable to limit the mandatory scope of the Standard to Australian health insurers and encourage Members to consider the Standard in situations where no local actuarial standards are available. HPC will consider a separate piece of work to understand the scale and scope of Member practice outside Australia, and consider the implications for the broadening of PS 602 as required.

Absolute clarity as to when the Standard applies and further clarity on the distinction between when a report is required and when it is not

Consultation responses indicated concern around the specific application of the Standard as the ED stated that it would apply when 'preparing financial statements' and that this could be interpreted as applying for monthly reporting.

There were also questions raised as to when a report was required as the ED stated that a report was required where valuation results were part of a 'Regulatory Report or published financial statements' and there was not a universal understanding of these terms.

The final standard tightens the wording to limit the mandatory scope of PS602 to valuations required to meet APRA Prudential Standards (ordinarily insurers submit quarterly returns, with one additional annual return), and valuations that form part of financial reports submitted to ASIC (which will be annually for most health insurers, and six monthly for listed insurers).

The wording as to the specific valuations which require the preparation of a report has been reviewed to better clarify the intent – the reference to 'Regulatory Report' was removed to avoid confusion between APRA initiated reviews and routine prudential reporting, and 'published financial statements' was changed to 'financial reports submitted to ASIC'. This will mean for the vast majority of insurers, that a PS602 compliant Report will only be required once per year.

Each of these elements describes the minimum requirements and of course does not preclude the Member, the Client or the Regulator from requesting/conduction a PS602 compliant valuation and valuation report at other times. This is now specifically addressed in Section 5.1.

Clarification of who is the Client

Some feedback questioned who was the Client referred to in the ED, and asked whether there was scope for the Actuary to determine who the client was and therefore who any PS602 Report could be addressed to.

Client is a term defined in the Code of Conduct, and has been retained in PS 602 with the same meaning. No further clarification was considered necessary in light of existing references to the Code.

PS 602 does not mandate who specifically the Report should be addressed to, however, we would expect an insurer's Actuarial Advice Framework to offer clarity as to whether a PS602 report should be addressed to the Board.

Broadening and clarity of wording in situations where the Member is an employee of the Client

Observation was made that some aspects of the ED were written with the Member being at arms-length from the Client, a situation more consistent with a consultant working for an insurer, than for an internal actuarial team employed by an insurer.

The ED was heavily reliant on PS302 for its structure and the wording of common elements and it is accepted that this observation could fairly apply to PS 302. While some consideration was given to generalising the wording or making provision for internal actuarial teams (e.g. see Section 7.1.1) we have generally maintained the 'voice' to preserve consistency as far as it is possible and helpful to do so with PS302.

Various minor matters

The ED proposed the Professional Standard be numbered as PS600. This was noted as potentially being confused with a prior PS600, being the Professional Standard applied to Financial Condition Reporting for Health Insurers which was subsequently replaced by PS 102. We have suggested this standard be numbered PS 602 ensuring alignment with the 'equivalent' PS 302 in General Insurance.

A number of definitions set out in the Glossary were identified as not being used in the ED. These were identified and removed.

References to the Asset for Incurred Coverage and Asset for Remaining Coverage were withdrawn to assist document simplicity, on the understanding that it is possible for the Liability for Incurred Coverage and Liability for Remaining Coverage to have a negative balance in certain circumstances.

A small number of editing corrections were also provided (e.g. consistent capitalisation of defined terms) and accepted.

END OF EXPLANATORY MEMORANDUM