Actuaries Institute.

Practice Guideline 699.01 PRICING AND FINANCIAL PROJECTIONS FOR AUSTRALIAN PRIVATE HEALTH INSURERS
December 2025

Contents

Contents 1

INTRODUCTION 2

2. COMMENCEMENT DATE 3

3. DEFINITIONS 3

4. INDUSTRY AND BUSINESS CONTEXT 5

5. DATA 6

6. ASSUMPTIONS 7

7. PRICING 8

8. FINANCIAL PROJECTIONS 10

9. REPORTING AND RECORD-KEEPING 19

INTRODUCTION

1.1. Application and purpose

1.1.1. This Practice Guideline applies to Members preparing financial projections and providing advice on pricing products for Australian Private Health Insurers.

1.1.2. This Practice Guideline also applies to Members performing a review of another Member's financial projection and advice on pricing products for Private Health Insurers. When reviewing another Member's projections, the reviewing Member would typically comment on or acknowledge the methods and assumptions which have been used by the original Member.

1.1.3. The purpose of this Practice Guideline is to assist Members in performing the work referred to in clause 1.1.1. This Practice Guideline reflects generally accepted practices and techniques in this regard.

1.2. About this Practice Guideline

1.2.1. This Practice Guideline has been prepared in accordance with the Actuaries Institute's Policy for Developing Professional Practice Documents and 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 Services a Member provides, then the Member would typically consider explaining any significant departure from this Practice Guideline to the Client, 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 Institute's 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.

1.3.4. If there is a conflict between this Practice Guideline 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.

1.4. Governance

1.4.1. This Practice Guideline replaces PG 699.01 issued on March 2018. Key changes since the previous version include:

a. Updates to reflect the current APRA Standards.

b. Updates to reflect the current Australian Accounting Standards. Specifically, the replacement of AASB 1023 with AASB 17.

c. Minor amendments to wording to increase clarity and resilience against obsolescence.

2. COMMENCEMENT DATE

2.1. This Practice Guideline commences on 31 December 2025.

3. DEFINITIONS

3.1. Terms used in this Practice Guidance have the same meaning as set out in the Code of Conduct ('Code') or in PS 602 Valuations of Health Insurance Claims of the Actuaries Institute.

3.2. Additionally, in this Practice Guideline:

'AASB' means the Australian Accounting Standards Board.

'AASB X' means the AASB's accounting standard 'X'.

'Actuarial Advice Framework' or **'AAF'** is the Actuarial Advice Framework, as set out in APRA's CPS 320.

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

'AASB' means the Australian Accounting Standards Board.

'APRA Standards' means in-force Private Health Insurance Prudential Standards issued by APRA under the Act including HPS 001 Definitions.

'Attributable Expenses' is the expenses included in AASB 17 paragraphs B65(e), B65(f), B65(g), B65(h) and B65(l).

'Australian Accounting Standards' means the AASB's accounting standard AASB 17 (Insurance Contracts) and other relevant Australian Accounting Standards.

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

'Capital Base' is as defined in APRA's HPS 001.

'Capital Requirement' is the Prudential Capital Requirement defined in APRA's HPS 110.

'Claims Group' means a homogenous group split by product, type of Health Insurance Claim or Health Insurance Claims run-off pattern.

'Claims Handling Expenses' or **'CHE'** is as defined in APRA's HPS 001.

'Claims Ratio' is the sum of Incurred Claims, Risk Equalisation payments and Risk Equalisation payment Recoveries and any Health Insurance Levies, divided by Earned Premium Income for the private health insurance business.

'Client' is as defined in the Code.

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

'Contract Boundary' is the boundary within which cash flows are associated with insurance contracts as determined by AASB 17.

'Department' means the Department of Health, Disability and Ageing 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' 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. Drawing Rates may be in current dollars or in the nominal value at the time of payment. The Member must be clear on the definition used in communication to the Entity.

'Earned Premium Income' is the amount of premium income that can be allocated to a particular time period.

'Health Benefits Fund' 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.

'Hospital Product Tier' is as defined in the Private Health Insurance (Complying Product) Rules 2015.

'Incurred Claims' is a measure of Health Insurance Claims that includes an allowance for Outstanding Claim Liability. This measure may include or exclude Risk Equalisation payments and Recoveries.

'Initial Recognition' is when a contract is first recognised under AASB 17.

'Insurance Revenue' is the insurance revenue described in AASB 17 paragraph 83.

'Insurance Service Expense' is the insurance revenue described in AASB 17 paragraph 84.

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

'Management Expense Ratio' or **'MER'** is the ratio of total management expenses (referred to as 'other business expenses' in industry reporting) to Earned Premium Income for the Health Insurance Business. The exact expenses and levies included within the MER will vary depending on the purpose of the calculations.

'Member' is as defined in the Code.

'Net Margin' is as the result of 1 minus the sum of the Claims Ratio and the MER.

'Onerous' means that a product or products have an expected negative net outflow when all Attributable Expenses and a Risk Adjustment are allowed for.

'Onerous Contracts' are contracts that on Initial Recognition are not forecast to achieve a positive

net margin when the Risk Adjustment for non-financial risk and all Attributable Expenses are included. The rules for their identification and treatment are set out in AASB 17.

'Policyholder' means the owner(s) of a policy that provides health insurance cover for one or more persons.

'Practice Guideline' is as defined in the Policy for Developing Professional Practice Documents of the Actuaries Institute.

'Pricing Policy' means any policy set by the Private Health Insurer on the methodology, requirements or philosophy when setting premiums.

'Private Health Insurer' is as defined in the Act.

'Prudential Capital Requirement' or **'PCR'** is as defined in APRA's HPS 001.

'Product Group' means a homogenous group defined by a combination of product, scale, state and coverage type. Other factors may be used in some circumstances such as distribution channel and contract type.

'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.

'Remaining Coverage' means the amounts of coverage that has not been earned that the Private Health Insurer is exposed to. This will reflect the Private Health Insurer's accounting policy on the contract boundary of products sold, as defined by AASB 17.

'Service' is as defined by the Code.

'Single Equivalent Unit' or **'SEU'** is a standardised measure where hospital policies covering various types of policyholder family situations are given a standardised number of units. For example, a family with two adults and varying numbers of children will all have the same number of SEUs.

'Solvency Requirement' means any policy set by the Private Health Insurer on minimum requirements to maintain solvency.

'Utilisation Rate' is a measure of the number of Incurred Claims per Policyholder or per SEU.

3.3. Other capitalised terms have the same meaning as in the Act, the Australian Accounting Standards or the APRA Standards.

4. INDUSTRY AND BUSINESS CONTEXT

4.1. Members performing work for Private Health Insurers in Australia would typically be conscious of general features of the industry which are different from those commonly encountered in other insurance industries in Australia and other health insurance markets.

4.2. These features include:

a. Mandatory community rating, modified by Lifetime Health Cover provisions;

b. Restrictions on what can be offered in hospital and general treatment products, and rules on the clinical treatments that can be offered by Hospital Product Tier;

c. Extensive cross subsidies;

d. Risk Equalisation arrangements designed to support community rating of hospital treatment cover;

e. Important relationships with health service providers;

f. The differences between the large taxed Private Health Insurers, the large non-taxed Private Health Insurers and the remaining (mostly) small non-taxed Private Health Insurers; and

g. The extensive political influences in many aspects of the industry.

4.3. Private Health Insurers operate in an environment with typically large cash flows and small margins where Health Insurance Claims can be influenced by the behaviour of health care providers and the Policyholders. Health Insurance Claims experience can be variable and can change quickly.

4.4. The Member would typically be aware of, and familiar with the following:

a. The relevant legislation and regulations governing the operation of a Private Health Insurer, especially the Act and relevant subordinate legislation made by APRA, the Department and the AASB;

b. The relevant aspects of the procedures for the administration of, and accounting for, the Private Health Insurer's Policyholders, revenue and benefits;

c. The general characteristics of the Private Health Insurer's Policyholders and products as these characteristics may have a Material bearing on the estimation of future financial outcomes. This includes familiarity with the contractual terms and legislated benefits payable under the fund rules of the Private Health Insurer, as well as other attributes such as product structure, Policyholder movements across products and demographics, Utilisation Rates, healthcare cost inflation, seasonality of benefits, refunds, management expenses, Health Insurance Levies and the impact of Risk Equalisation;

d. The Private Health Insurer's position on Materiality; and

e. The Private Health Insurer's assets, investment policy, pricing philosophy, Internal Capital Adequacy Assessment Process and risk management framework and policies.

5. DATA

5.1. In any projection, it is important to ensure that the nature and the limitations of the data provided or derived are understood.

5.2. Checks would typically be performed to determine if the data is Materially complete and accurate. This is likely to include discussions with management, as well as numerical analysis.

5.3. If the data includes projected values, such as estimated future number of Policyholders, it is important to ensure that their derivation is understood and Materially consistent with other elements of the projection.

5.4. The Member would typically take reasonable steps to verify the overall consistency and reasonableness of any data with the Private Health Insurer's financial and other records.

5.5. Where the data are Materially inconsistent, unreasonable or not credible, then the Member would typically seek clarification or make suitable modifications based on judgment and disclose the quantifiable effect, and state the extent of any reliance, or limitations in findings as a result of data shortcomings in their Report.

6. ASSUMPTIONS

6.1. The Member may be involved in the determination of appropriate assumptions for use in the projection, or may be supplied with assumptions for this purpose by the Private Health Insurer.

6.2. If the assumptions are developed by the Member, experience analysis and/or examination of any trends in historical data would typically be undertaken to support the assumption setting or review process, commensurate with the volume of data available and the purpose of the projections being undertaken. Where this is not available or limited, then industry data may be used to supplement analysis.

6.3. The Member would typically conduct a review of the accuracy of past assumptions and consider incorporating the results of this analysis when determining assumptions, or consider commenting in their Report on the consistency of the assumptions based on this analysis.

6.4. If the assumptions are supplied by the management of the Private Health Insurer, the Member would typically discuss the assumptions and their derivation with the relevant personnel within the Private Health Insurer. If the assumptions supplied by management are Materially different to the assumptions the Member would make, the Member would typically analyse and document these differences. For each Material assumption, the Member would typically provide the Private Health Insurer with the Member's view that either:

a. The assumptions are within a reasonable range of the Central Estimate for the purpose for which the forecast is being prepared; or

b. The assumption is unreasonable; or

c. An opinion on the reasonableness of the assumption is not possible.

6.5. The Member would typically assess the appropriateness of the Material assumptions by performing experience analysis. If such experience analysis is not practical, the Member would typically comment in their Report accordingly.

7. PRICING

7.1. Principles of providing advice on products

7.1.1. Where the Member is be asked to provide advice on changes to products the Member would typically consider the Private Health Insurer's Actuarial Advice Framework and the reporting, materiality and advice required under that policy.

7.1.2. The Member would typically comment in their Report on the impact:

a. Of the proposals referred to in clause 7.1.1 on the business already issued and on new business; and

b. On the Private Health Insurer and on the Health Benefits Fund.

7.2. Assumptions about future experience

7.2.1. The undertaking of new types of risk should not be prevented solely because no specific past experience exists or is available. In determining an opinion as to the likely future experience in such circumstances, the Member would typically take into account such statistics relating to similar events or conditions as can be obtained and are considered relevant.

7.2.2. The Member would typically comment on any limitations set out in the Health Benefits Fund's rules on policies while experience of these new types of risk is being gained.

7.2.3. Where appropriate, and quite apart from any general monitoring that the Member undertakes for pricing risks, the Member would typically specify close monitoring of the emerging experience relating to the new types of risk.

7.2.4. The various elements in the assumptions may have experienced variability in the past and confidence about the likely future experience will vary according to that and other considerations. The Member would typically consider the degree of uncertainty in each of the assumptions and the potential effects of experience being relatively adverse. The Member would typically consider the Private Health Insurer's capacity to finance the potential effects of adverse experience.

7.3. Finance

7.3.1. Health Insurance Claims paid plus net Risk Equalisation transfers plus incurred expenses plus Health Insurance Levies plus the required increase in balance sheet reserves to be held in respect of the future insurance liabilities may exceed premiums received over a given period in certain circumstances. Where this is the case, the Member would typically consider:

a. The amount and incidence of the shortfall;

b. The capacity of the Private Health Insurer to meet this requirement for finance and the source(s) of this finance;

c. Commenting in their Report on assumptions about the number of future Policyholders and the consequences of Material differences between actual and expected numbers of Policyholders; and

d. Providing management with sensitivities or alternative financial projections scenarios (particularly based on alternative Policyholder increase assumptions).

7.4. Premium rate sufficiency

7.4.1. The Member would typically test the sufficiency of premium rates on both a retrospective and prospective basis in relation to the Private Health Insurer's Pricing Policy.

7.4.2. The Member would typically test, not only on the Central Estimate view of future experience, but also on a range of plausible variations from that Central Estimate.

7.4.3. If the Member considers that it is not appropriate to test the suitability or sufficiency of premium rates, the Member would typically explain in their Report why it is not considered appropriate.

7.4.4. For each variation in the view of future experience, the Member would typically make a number of assumptions about items listed in clause 8.3 of this Practice Guideline.

7.4.5. In testing the sufficiency of the premium rate for individual products, the Member would typically consider commenting in their Report on:

a. The impact of competition from similar products offered by other Private Health Insurers (having collaborated with, or sought advice from, the relevant personnel from the Private Health Insurer on what is an appropriate and similar product for this comparison);

b. The impact of potential regulatory changes on the profitability of the product;

c. The impact on or from the other products offered by the Health Benefits Fund, including any inconsistencies in premium rate or benefit relativities as well as internal cross subsidies between other products offered; and

d. The Private Health Insurer's Pricing Policy and target margins, as well as regulatory capital and internal capital targets.

7.4.6. The range of matters to be taken into account when considering suitability may vary with the particular circumstances. In each case, the Member would typically be in a position to justify any decision to limit the range of the scenarios tested.

7.4.7. In particular, apart from any general advice that the Member provides, if the premium rates for a product are considered unsuitable or insufficient, the Member would typically state in their Report why that opinion is held and indicate the potential or likely financial consequences of their adoption by the Private Health Insurer. The Member would typically indicate actions the Private Health Insurer could take to mitigate or minimise the potential associated risks.

7.5. Other policy terms and conditions

7.5.1. The Member advising a Private Health Insurer on the structure of a health insurance product would typically consider all terms and conditions, not just the suitability or sufficiency of the premium rates. The Member would typically give advice on the financial impact and risks of the proposed terms and conditions, and any other matter the Member considers relevant.

7.6. Commission

7.6.1. The Member would typically consider all expenses when advising on products.

7.6.2. The Member would typically provide advice on the financial risks that any commission terms and arrangements may impose (including the commission allowed for in the pricing of a product).

7.6.3. If commission has been deferred for the purposes of the Private Health Insurer's financial statements, the Member would typically consider the recoverability of commission in the case of early termination of policies. If appropriate, the risks associated with a high level of policy termination, and a subsequent failure to realise the assumed recoverability of commission, would typically be highlighted.

8. FINANCIAL PROJECTIONS

8.1. Purpose

8.1.1. The Member may prepare financial projections for various purposes, including:

a. Supporting business planning and budgeting;

b. As part of product development activities;

c. As part of a premium rate change application;

d. Determining regulatory or target capital;

e. As part of the determination of the Unexpired Risk Liability to meet Australian Accounting Standards.

8.2. Approach

8.2.1. The Member would typically develop or use a model or approach that is consistent with the purpose of the projection.

8.2.2. The complexity of the model will depend on the purpose of the projection, size and nature of the Private Health Insurer, data available and the level of detailed results required. The Member would typically exercise judgment in determining the level of granularity of the model and whether the model used is appropriate for the purpose and the data is sufficient and appropriate for the model.

8.2.3. When establishing the projection model, the Member would typically consider:

a. Projecting monthly forecasts of Earned Premium Income, Incurred Claims, Risk Equalisation payments and Recoveries, Health Insurance Levies, management expenses, commission, investment income, movement in the Loss Component, dividends and taxation;

b. Projecting the monthly capital position of the Private Health Insurer, including net assets, Capital Base, Prescribed Capital Requirement, and if required, the Private Health Insurer's Solvency Requirements; and

c. Projecting each of the Health Benefits Funds explicitly and separately.

8.3. Assumptions

8.3.1. The projection will require a number of assumptions to be made in respect of future experience. The complexity of the assumptions required will depend on the individual circumstances of the Private Health Insurer, the Materiality of the assumption and the workings of the individual model.

8.3.2. Assumptions may be required in respect of:

a. Policyholders:

i. The number of Policyholders projected including the number of joins, discontinuances, suspensions, deaths and transfers between products;

ii. State mix of the Policyholders of the Private Health Insurer;

iii. Product mix of the Policyholders of the Private Health Insurer (hospital, general treatment, ambulance products);

iv. Demographic mix of the Policyholders of the Private Health Insurer;

v. Policyholder category mix (for example: singles, couples, families, single parents, extended single parents, extended families); and

vi. Premium payment method mix;

b. Premium income:

   i. Premium rate for each product, state and category;

   ii. Timing of premium payments and the amount of premium received that is for future coverage captured by the FCL;

   iii. Future premium rate increase assumptions;

   iv. Discounts given;

   v. Loadings for Health Insurance Levies;

   vi. Rate Protection (if any);

   vii. Incidence and amounts of Lifetime Health Cover loadings; and

   viii. Level of, and change in, the Loss Component;

c. Health Insurance Claims:

   i. Level of, and change in, Utilisation Rate;

   ii. Level of, and change in, Average Benefits;

   iii. Level of, and change in, Drawing Rates;

   iv. Health Insurance Claims seasonality;

   v. Inflation of health costs, especially any periodic indexation and increase in hospital contracted rates, prostheses and medical costs;

   vi. Mix of services provided, especially public/private hospital mix and same day/overnight mix;

   vii. Age distribution of the Policyholders;

   viii. Changes in the demographic profile of the Policyholders (for example, single, couples, families);

   ix. Impact of changes in product mix;

   x. Impact of waiting periods, duration effects or reduced benefit periods;

   xi. Any benefit or product changes to be introduced in the future; and

   xii. Level of, and changes in, the rates for the Health Insurance Levies;

d. Risk Equalisation:

   i. Average deficit per hospital SEU for each state; and

   ii. Level of, and change in, benefits eligible for Risk Equalisation (gross deficit);

e. Contract grouping:

   i. Information may need to be collated by GICs;

f. Management expenses:

   i. Operating management expenses;

   ii. Abnormal management expenses; and

   iii. Commissions;

g. Investment income:

   i. Asset mix of the Private Health Insurer;

   ii. Assumed earning rates by asset class; and

   iii. Income or expense from Health-Related Business or non-health insurance business;

h. Tax;

i. Dividends;

j. Financial statements:

   i. Statement of financial position (balance sheet) items, including Liability for Incurred Claims, and Liability for Remaining Coverage;

   ii. Statement of Comprehensive Income (profit and loss) items, including Insurance Revenue and Insurance Service Expense;

k. Capital Adequacy:

   i. future capital expenditure – timing and amount;

   ii. Prescribed Capital Requirement;

   iii. Capital Base; and

   iv. Solvency Requirement (if required)

8.3.3. It is also important to note that a number of assumptions may be made implicitly, such as the proportion of business that is 'single persons', or the age profile of Policyholders. Where Material, the Member would typically document and review these assumptions for validity.

8.3.4. As projected financial results are dependent on many assumptions, it is important that the Member clearly specify the Material assumptions in any Report prepared to accompany projections. The Report would typically disclose the source of the assumptions and any relevant reliance and limitations in the use of the assumptions.

8.3.5. If the revised assumptions are Materially different from the previous set of assumptions, the Member would typically understand and document the reasons for the change.

8.3.6. Where the Member may only have access to relatively low volumes of data, the Member would typically consider whether it is reasonable to allow low volumes of data to artificially create volatility in adopted assumptions.

8.4. Consistency with business plan

8.4.1. Projections will typically commence with the projection prepared for the Private Health Insurer's business plan, financial condition report or the most recent premium rate change application.

8.4.2. If this projection was prepared some time ago, or actual results have departed Materially from the business plan, the Member would typically consider preparing an updated projection.

8.5. Policyholders

8.5.1. If the Member is involved with the projection of the number of Policyholders, the Member would typically consider projecting the expected sales, transfers, discontinuances, suspensions and deaths experience of the Private Health Insurer.

8.5.2. The Member would typically also allow for future movement in product mix over time, including any transfers between products as changes in Policyholder category (singles, families, etc).

8.5.3. The Member would typically consider past performance as well as industry trends and recent and planned marketing activities when the projection is formulated.

8.6. Earned Premium Income

8.6.1. In projecting Earned Premium Income, the Member would typically:

a. Allow for future premium rate changes reflected in the current business plan, making allowance for the impact of any Rate Protection given to current Policyholders at the time of the proposed rate change;

b. Recognise the current and expected extent to which discounts are provided and the current and expected extent to which loadings will be earned (for example, under Lifetime Health Cover provisions); and

c. Allow for the impact of loyalty or other bonuses on the earned premiums if applicable.

8.7. Loss Component

8.7.1. In projecting the Loss Component, the Member would typically:

a. Consider the Private Health Insurer's accounting policy and their approach to setting the Risk Adjustment, identifying the Contract Boundary, grouping of contracts, and estimating Attributable Expenses;

b. Consider the requirement to split analysis between GICs.

c. Consider the timing of premium payments across the year and to the Contract Boundary;

d. Consider the level of Attributable Expenses when assessing the Onerous Contracts and when calculating the Loss Component;

e. Consider the proportion of the policies that will be Onerous, or the previously defined Onerous GICs;

f. Consider the net outflow after allowance for incurred costs, Attributable Expenses and the Risk Adjustment for each set of Onerous Contracts;

8.8. Incurred Claims

8.8.1. In projecting Incurred Claims, where it is Material, the Member would typically allow for:

a. Historical trends in Utilisation Rates, Average Benefits and Drawing Rates;

b. Phasing of Incurred Claims expenditure, including seasonality;

c. Likely indexation of hospital, medical and other benefits;

d. Any new benefit changes and proposed product design changes;

e. Impact of waiting periods and other membership duration effects;

f. Movements in the Loss Component (if any);

g. Any expected changes in product mix;

h. Any expected changes in the demographic mix;

i. Other non-assessed benefits (such as chronic disease management plans or support benefits under a Policy); and

j. Any relevant legislative changes.

8.8.2. In assessing the historical benefit trends, the Member would typically be cognisant of, or standardise for, historical impacts resulting from indexation of benefits, product design and benefit changes, waiting periods, changes in product mix, seasonality, the historical mis-estimation of Outstanding Claim Liability and any legislative changes.

8.8.3. There are various methods that can be used to project benefits. Typically this will involve a projection of Drawing Rates for Product Groups and/or Claims Groups and/or GICs. The Member would typically select the most appropriate method and level of detail for the particular circumstance.

8.8.4. If the Private Health Insurer has Policyholders resident in New South Wales or the Australian Capital Territory, the Member would typically also estimate the likely ambulance levy rate under the Health Insurance Levies that will apply over the projection period. The Member would typically give consideration to Policyholders who are exempt from the ambulance levy under the Health Insurance Levies.

8.8.5. Policyholders may transfer to a lower benefit coverage or lower cost product which could reduce Earned Premium Income without a corresponding reduction in Incurred Claims. The Member would typically consider the impact of Policyholders transferring between products where this is Material.

8.9. Risk Equalisation

8.9.1. Members would typically project the components of the net Risk Equalisation transfer (known as the calculated deficit and the gross deficit) separately, although in certain situations an aggregate projection may be reasonable. Note that the transfers reported by APRA are on a ‘paid basis’ rather than on an ‘incurred basis’.

8.9.2. When projecting the gross deficit, the Member would typically consider:

a. Analysing the proportion of hospital benefits eligible for Risk Equalisation as observed in historical data and hospital Policyholders for both the Private Health Insurer and the industry at a state level, and any anticipated changes;

b. Allowing for high-cost claims eligible for Risk Equalisation if Material;

c. The impact of Policyholders ageing, as well as the factors listed in clause 7.8.1 of this Practice Guideline; and

d. ensuring consistency of the projected gross deficit with the projected Incurred Claims.

8.9.3. The calculated deficit is the product of the number of SEUs and the state average deficit per SEU. When projecting the calculated deficit, the Member would typically consider separately projecting by state the number of SEUs and the state average deficit per SEU.

8.9.4. The Member would typically consider the consistency of the forecast net Risk Equalisation transfer with historical experience and understand any inconsistencies.

8.10. Management expenses

8.10.1. When projecting management expenses or assessing the projected management expenses set out in the Private Health Insurer's business plan, the Member would typically consider:

a. checking for consistency with past experience for:

i. Management Expense Ratio expressed as a percentage of Earned Premium Income;

ii. increases in management expenses from prior years; and

iii. dollar expenses;

b. allowing for any future Material one off expenses that are expected to be incurred;

c. checking for consistency of the projected management expenses against the Private Health Insurer's business plan;

d. projecting commissions separately; and

e. projecting write downs in deferred acquisition costs or other intangible assets separately.

8.11. Investment income and other income

8.11.1. When projecting investment and other income or assessing the projected investment and other income set out in the Private Health Insurer's business plan, the Member would typically:

a. understand the current investment policy and asset mix of the Health Benefits Fund or Private Health Insurer and any likely changes to the investment policy and asset mix;

b. ensure that the assumed earning rates for each asset class are within a reasonable range when compared with historical performance as well as benchmark returns;

c. consider net income from Health-Related Business and non-Health Related Business; and

d. ensure the appropriate investment income earning capital base is used both in quantum and for the calculation time period.

8.12. Taxation

8.12.1. Where the Private Health Insurer is subject to taxation, the Member would typically make appropriate allowance in the projections.

8.12.2. The Member would typically also consider the impact of taxation on the elements of the Capital Adequacy Requirements, specific guidance on which is given in the APRA Standards.

8.13. Dividends

8.13.1. The Member would typically allow for dividends to be paid to a shareholder taking into account the Private Health Insurer's business plan and dividend policy.

8.13.2. The Member would typically ensure such allowance complies with the Private Health Insurer's constitution, Solvency Requirements and does not breach APRA Standards.

8.14. Health Related Business

8.14.1. Subject to Materiality, the Member would typically consider separately projecting the income and outgoings for each Health-Related Business.

8.15. Non-Health Insurance Business

8.15.1. Subject to Materiality, the Member would typically consider projecting the appropriate financial impact for each non-Health Insurance Business.

8.16. Capital Requirements

8.16.1. The Member's attention is drawn to the requirements set out in the APRA Standards.

8.16.2. The Member would typically understand the historical movement in the elements that constitute the Capital Requirements for the Private Health Insurer, especially the financial performance, asset mix, seasonality of provisions and strategic developments.

8.16.3. The Member would typically disclose the assumptions made, or estimates required, in forecasting the components of the Capital Requirements.

8.17. Solvency

8.17.1. The Member's attention is drawn to the requirements set out in the Private Health Insurer's Solvency Requirement (if any) and that the Solvency Requirement relates to liquidity and may not be a required element of a financial projection.

8.18. Sensitivities, scenarios and reasonableness

8.18.1. In addition to projecting the best estimate financial result and capital position of the Private Health Insurer, the Member would typically consider:

a. The plausible range of potential profit and capital outcomes for the Private Health Insurer over the projection period;

b. Highlighting any limitations or shortcomings of the projections;

c. Providing the Private Health Insurer with a range of results to indicate the variability of projection results resulting from key inputs or assumptions (such as Policyholder changes, Drawing Rates, Drawing Rate inflation rates and premium rates) via sensitivity analysis of key assumptions and scenario analysis. This will provide insight into the main drivers of the business and the significance of the assumptions. It is likely that a number of assumptions will interact and the sensitivity testing would typically take this into account;

d. Providing scenario analysis illustrating the key risks and uncertainties the member has identified and as identified in the Risk Management Framework and/or risk register;

e. Performing reasonableness tests on the projection results including comparing projected results with:

i. historical results;

ii. previous projections; and

iii. key inputs and assumptions.

9. REPORTING AND RECORD-KEEPING

9.1. General reporting requirements

9.1.1. Members' attention is drawn to clause 3.2 of Practice Guideline 1 (General Actuarial Practice).

9.1.2. The Member would typically prepare a Report that documents the assumptions and methods used in producing a financial projection or providing actuarial advice or Services. The level of detail contained in such a Report will vary depending on the purpose of the financial projection.

9.1.3. The Report would typically describe the steps taken by the Member to verify the accuracy of the data, any limitations on the extent or quality of the data and the extent to which the Member has relied upon the Private Health Insurer or the Private Health Insurer's auditor for checking.

9.1.4. The assumptions and methods would typically be stated clearly and their derivation explained. Any qualifications would typically also be clearly stated.

9.1.5. Where:

a. legislation, accounting standards, APRA guidelines or other rulings require the Member to use specific assumptions or methods;

b. an interpretation of legislation, accounting standards, APRA guidelines or other rulings supplied by the Private Health Insurer or its advisers is being relied upon; or

c. the Private Health Insurer requires the Member to use specific assumptions or methods,

9.1.6. the Member would typically, in their Report:

a. clearly state the circumstances; and

b. express an opinion on the assumptions in accordance with clause 6.4 of this Practice Guideline.

9.1.7. The Member may be called upon to justify the work undertaken. Therefore, the Member would typically compile and retain documentation that shows that the Member has considered the matters set out in this Practice Guideline and any external requirements as appropriate.

9.2. Premium rate change application

9.2.1. Private Health Insurers are required to follow specific reporting requirements set out by the Department.

9.2.2. The Member would typically seek a copy of the premium rate change application in its entirety from the Private Health Insurer to ensure that the actuarial advice given is consistent with the requirements of the premium rate change application.

End of Practice Guideline

Document control

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