d'finitive

January 2022

Private health insurance capital framework

APRA releases full proposals

APRA has now released a full suite of prudential and reporting standards, and is requesting responses by 31 March 2022. This d'finitive summarises the information from APRA, and what private health insurers need to do next.

In summary

What has happened?

The table below provides a brief summary of the APRA material, and notes where further information is included in this d'finitive:

Numbers	By 31 March 2022, a Quantitative Impact Study (QIS) is requested including: • An assessment of regulatory capital adequacy, using the draft prudential standards • Information on the impact of adopting AASB 17 • Complete regulatory returns showing the results as at 30 June 2021, on a best endeavours basis.
Policies and more	APRA also sets out new policy and practice requirements, including those relating to ICAAP, liability valuation, regulatory reporting and audit.
Many pages, few surprises	Most of the proposals were also included in APRA's May 2021 QIS or the December 2019 consultation paper. However, some elements have been refined in response to industry feedback.
Next steps for insurers	After estimating the financial impacts and reviewing the other requirements, insurers should plan out the work program required in readiness for July 2023. This may include re-evaluation of risk appetite, a review of capital targets, as well as, preparing for the first round of ICAAP reporting.

Impact

Working through the voluminous standards and reporting forms will be time consuming, especially for insurers with unusual or complex business features.

The calculation of asset risk is complex, however the requirements were signalled well in advance and many insurers have started work. Future investment strategy reviews will need to give greater weight to regulatory capital considerations, as well as practical issues regarding how those requirements are calculated.

Excluding asset risk, we do not expect the capital and AASB 17 calculations to be complex for most insurers. Many of the calculations will be familiar from the May 2021 QIS.

Once insurers have estimated their capital position under the new standards, they can develop firm plans for implementation in July 2023. In addition to determining any changes to capital or investment management, new policy requirements such as ICAAP will need to go into workplans.

New capital standards

The new standards are undoubtably more complex and prescriptive than the current standards, however some insurers will have less reading to do than others. For example, the standards bring across detailed General Insurance rules on the treatment of reinsurance, tax and unusual capital instruments, which are irrelevant for most health insurers.

The table on page 3 summarises the main content of each standard. The regulatory capital requirement is the sum of amounts required for insurance, asset and operational risks, less an aggregation benefit. Insurers must ensure they have high quality capital which exceeds this requirement.

We show the calculations to be undertaken by most insurers, however insurers will of course need to check the detail. For brevity we provide only limited detail or omit matters that apply to only a small number of insurers (for example, tax, reinsurance, international business, subsidiary companies, business conducted outside the health fund, and subordinated debt).

Standard	APRA requirement (in brief)	Notes and examples
Measurement of capital (HPS 112)	Include only high-quality capital when assessing capital adequacy. The standards include detailed rules intended to prevent "double counting". For example, an asset excluded under one component of the calculation does not have further adjustments applied under other components.	The most common adjustments will be to: • Increase the capital base, if the insurance liability risk margins are at a greater than 75% probability of sufficiency. • Exclude deferred tax assets net of deferred tax liabilities. • Exclude goodwill and intangibles. The treatment of investments in subsidiaries or joint ventures depends on the nature of that investment, including whether the subsidiary is prudentially regulated.
Asset risk (HPS 114)	Determine the fall in the capital base under seven prescribed tests, including: • Changes in real interest rates, expected inflation, credit spreads and exchange rates • Default risk, and specific stresses for property and equities Some stresses apply to both assets and liabilities, others apply to only assets. The information required for each asset includes asset type, term (where relevant), currency/hedging, and credit profile. Additional information is required for some assets such as derivatives. Where insurers invest in managed funds, the information is required on every underlying asset, otherwise the fund is treated as an unlisted equity exposure and subject to very high charges.	The asset risk charge depends on the specific assets held by an insurer. As a very rough guide, insurers holding 30% of investments in growth assets can expect the asset risk charge to be around 15% of total assets. Insurers holding only cash assets might expect the asset risk charge to be around 1% of total assets. Insurers should get in touch with their investment managers to ensure the required asset level detail is available (as at 30 June 2021 for QIS purposes). Finity has a detailed asset risk charge calculation template and support available for clients.
Asset concentration risk (HPS 117)	The standard sets limits on the exposure to a particular asset, counterparty, or group of related counterparties. The limit depends on the: • Asset: type and term • Counterparty: credit quality, and whether it is related and/or regulated • Other factors: such as whether the asset is guaranteed or collateralised. The capital requirement is the amount by which any asset exceeds the relevant limit.	Examples of the limits include: • Government counterparty with AA- or higher credit rating: No limit. • Assets with remaining term of less than 1 year, where the counterparty is an unrelated APRA-regulated entity: 100% of the capital base (or $22.5m if higher). • Exposures other than to government or APRA-regulated entities: 25% of the capital base.
Insurance risk (HPS 115)	The sum of an insurance liability risk charge (for balance sheet liabilities) and the future exposure risk charge. The requirements for health insurance business (HIB or Australian residents insurance) are set out below.	The requirements for health-related business (HRB or overseas student/worker insurance) are similar except: • Premium liability risk charge: Size adjustment reflects revenue rather than policy numbers. • Future exposure charge: No adverse event stress is applied. Both HIB and HRB components are subject to a minimum of nil, meaning insurers can no longer offset HRB profits against HIB losses under a stressed scenario.

Standard	APRA requirement (in brief)	Notes and examples
Insurance liability risk charge (part of HPS 115)	Sum of: • Outstanding claims charge: Multiply provision by a prescribed factor, which depends on insurer size. • Premium liabilities charge: Multiply provision by a prescribed factor, which depends on insurer size. A higher factor is applied if the number of SEUs insured has increased by more than 2.5% p.a. in any of the previous three years, unless the increase is due to merger. • Risk equalisation charge: 4% of unbilled calculated deficit. • Other liabilities charge: Increase liabilities such as for loyalty bonus or deferred claims to 99.5% probability of sufficiency . The capital charges are applied to outstanding claims and premium liabilities which are calculated in a similar way to the existing AASB1023 provisions, and are at a 75% probability of sufficiency.	The examples below assume the insurer has not experienced policy growth in the last three years. • For an insurer with 20,000 hospital treatment SEUs, multiply outstanding claims by 21% and premium liabilities by 11%. • For an insurer with 100,000 hospital treatment SEUs, multiply outstanding claims by 16% and premium liabilities by 9%. • For an insurer with 1 million hospital treatment SEUs, multiply outstanding claims by 11% and premium liabilities by 7%. If the number of hospital SEUs insured has increased by more than 2.5% p.a. in any of the last three years, the premium liability stress is increased. The calculation is based on the highest growth rate over the last three years. For example, if the highest growth rate of the period was: • 5%, the premium liabilities stress increases by 0.8% • 10%, the premium liabilities stress increases by 2.5% • 17.5% or more, the premium liabilities stress increases by the maximum additional loading of 4.95%.
Future exposure risk charge (part of HPS 115)	This is the forecast underwriting loss over the following year, after applying both an adverse event stress and a prescribed benefit stress. The adverse event stress assumes high lapse by younger policyholders across the industry. Specific assumptions include: • 25% of policyholders under 65 lapse immediately. • Forecast premiums and claims reduce, assuming those who lapse within each age cohort are typical of their age cohort (that is, the stress is applied equally across all products, states, scales, etc). • Forecast calculated deficit per SEU increases by 20%. • Forecast management expenses may reduce, where this would in practice be expected to occur. • After month 9, forecasts may be adjusted to allow for justifiable management actions, reducing losses to (at best) nil for the last quarter of the year. • The stress cannot be reduced to allow for investment income, profit from other activities, or tax. (A limited tax adjustment may be allowed under HPS 110). The prescribed benefit stress further increases the forecast benefits and management expenses by the same stress as applied to the premium liabilities (see above).	As intended by APRA, this represents a severe adverse event, and is similar to that insurers considered in the May QIS. The scenario is expected to result in very large losses for almost all insurers, although the quantum depends on a range of factors such as insurer size, forecast profitability and age mix.

Standard	APRA requirement (in brief)	Notes and examples
Operational risk (HPS 118)	For most insurers, this will equal 2% of premium revenue for the prior 12 months. An additional amount is added if revenue changed by more than 20% over the prior year.	Very few insurers have experienced annual revenue changes of more than 20%. However, the operational risk capital requirement of 2% of premium revenue for the prior 12 months increases to: • 2.4%, if the insurer experienced 50% revenue growth in the year. • 3.2%, if the insurer revenue was half the amount of the prior year.
Aggregation benefit (included in HPS 110)	Reduces capital requirements to allow for diversification between asset and insurance risks. Asset concentration and operational risk are not included in the aggregation benefit.	If an insurer decides to invest in growth assets, it will tend to have both a high asset risk charge and high aggregation benefit. For example, suppose the insurance risk charge is $10m. If the fund invests in growth assets and has an asset risk charge of $10m, the aggregation benefit is $4.5m. If the fund invests in defensive assets and has an asset risk charge of $1m, the aggregation benefit is $0.8m.

AASB17

The new standards and reporting forms set out the requirements for insurers in respect of AASB 17 for APRA reporting. The key takeaways are:

a In form HRS 300 APRA will require a full balance sheet, income statement and reconciliation of key assets and liabilities across the period on an AASB 17 basis. This should reconcile with insurers' financial accounts and the disclosures made for the annual report. AASB 17 will be in effect for all funds at the first APRA submission date (30 September 2023).

   i The number of entries for the balance sheet and income statements that are impacted by AASB 17 are relatively few. For example, for most PHIs, we expect five balance sheet numbers will change with other entries consistent with the current financial accounts.

   ii For most PHI Funds only one of the four worksheets for HRS 320.0 will be required to be filled out. Many of the cells in the remaining worksheets can be ignored.

b The AASB 17 net asset position will be the starting point for the determination of the capital base in HRS 112. Further steps in the calculation will require the unwinding of some AASB 17 elements; those where the AASB 17 element is (effectively) the net sum of several AASB 1023 assets and liabilities. An example is the DAC intangible asset, which under AASB17 will be split with some amounts recorded as the DAC asset and some included in the calculation of the LRC.

c The remainder of the capital calculations do not appear to be impacted by AASB 17.

As a result of the requirements of HRS 112, insurers will need to continue to be able to track some information on an AASB 1023 basis, even after AASB 17 takes effect.

In addition to the reporting requirements, the QIS also requires a small number of AASB 17 questions to be answered. These should be relatively simple for insurers who have started their AASB 17 preparation.

Although the list of AASB 17 requirements for the QIS is not extensive, a number of calculations will need to occur behind the scenes to complete the forms. For example, entry 18.2 in the balance sheet (HRS 300.0) is a single number; the liability for remaining coverage. However, calculation of the value to input will require more extensive effort. The calculations can be simplified for a best endeavours approach, but will still require some work and decision making.

New processes and policies

There are a number of requirements relating to processes and policies, which we summarise below:

ICAAP

ICAAP is an insurer's process to ensure capital adequacy and capital management processes are appropriate given its business plans and risk appetite. ICAAP introduces a requirement to prepare an annual ICAAP report for APRA, and undertake an independent triennial review. We will shortly release an article on the practicalities of ICAAP, sharing our experience in assisting general insurers.

Pricing philosophy

There are some changes to the requirement for a pricing philosophy, which is currently required to be included in the capital management policy. Specifically, insurers must set targets for major product groups, tolerances, and identify the parties responsible for monitoring adherence and approving remedial action. The insurer must provide the pricing philosophy to APRA within one month following approval.

Liability valuation (HPS 340)

In life and general insurance, liability valuation and documentation is a major part of the Appointed Actuary role. Because health insurance liabilities are generally paid shortly after they are incurred, it is appropriate that APRA has not fully aligned the valuation requirements with general insurance. However, there are some additional reporting requirements, for example, splitting non-reinsurance recoverables, and reporting to APRA on how experience has compared to prior liability estimates.

Premium liabilities must allow for existing policies, but need not consider "renewals". The concept of policy renewals in PHI is ambiguous, and if the intention is to align with current practice it would be helpful to state this in the standards.

HPS 340 states that valuation of liabilities is the responsibility of the insurer, however there are some actuarial requirements. In particular, the insurer must:

- Have regard to advice of the Appointed Actuary (AA) in determining central estimate assumptions.
- For risk margins, the AA must document any material changes in uncertainty which may drive changes in risk margin.
- Comprehensive actuarial analysis and modelling techniques should be employed.
- Approximate valuation methods can be used, but the onus for justification of the appropriateness of the valuation rests with the Board and AA.
- There are various AA requirements in the reinsurance attachment, which will be irrelevant to most PHIs.

While there remains no formal requirement for the AA to prepare an Actuarial Valuation Report, advice may be required each time an insurer estimates liabilities for capital calculations.

Other matters

- **Audit:** There are some minor changes to the audit standard HPS 310 relating to quarterly reporting (HPS 310).
- **Disclosures:** Health insurers must make various public disclosures regarding capital adequacy each year, including the prescribed capital amount. This level of disclosure is currently only made by listed insurers (HPS 110).
- **Approval for dividends / capital reductions:** Consistent with general insurance, insurers will require APRA's approval for any dividend exceeding post-tax profit. The requirement is drafted quite broadly, so insurers planning member givebacks would need APRA consent (HPS 110).

Some LAGIC lingo

While there's an entire prudential standard for definitions (HPS 001), here are a few terms that may be new to some readers:

Aggregation benefit: An allowance for diversification between asset and insurance risk. It is calculated using an APRA-prescribed formula, and reduces the prescribed capital amount.

ICAAP: Internal Capital Adequacy Assessment Process.

LAGIC: Life and general insurance capital requirements. The new requirements for PHI align closely with LAGIC in some areas, such as asset risk and measurement of the capital base. The insurance risk proposal is the least aligned with LAGIC as it is intended to be PHI industry specific.

Prescribed capital amount (PCA): The regulatory minimum capital requirement before any supervisory adjustment, determined by undertaking the calculations in prudential standards.

Prudential capital requirement (PCR): The prescribed capital requirement, plus any supervisory adjustment applied by APRA. Because supervisory adjustments are unusual, the prescribed and prudential capital requirements are generally the same.

QIS: Quantitative impact study, which involves estimating the financial impact of the proposals and submitting the result to APRA. A written response is also requested on AASB 17.

Tier 1 Capital (including Common Equity Tier 1, Additional Tier 1), Tier 2 capital: These are various categories of capital set out in the APRA standards.

- Common Equity Tier 1 (CET1) consists of the highest quality components on capital, such as retained earnings, paid up shares, accumulated income and reserves. Most health insurers only have CET1 capital (ie, not-for-profit capital would likely be CET1).
- Additional Tier 1 and Tier 2 include components of capital that, to varying degrees, fall short of CET1 but still contribute to the overall capital strength and capacity to absorb losses. For example, subordinated debt may be Tier 2 if certain conditions are met.

Some AASB 17 terms

LIC: Liability for Incurred Costs, which replaces outstanding claims. This will also include other receivables and payables specifically relating to resolving claims.

LRC: Liability for Remaining Coverage, which replaces Unearned Premium Liability. It will combine a number of asset and liabilities, being roughly the sum of the Unearned Premium Liability, the Unexpired Risk Liability, premium receivables and Medicare Rebate receivables.

Loss Component: the equivalent of the Unexpired Risk Liability.

OCT: Onerous contracts test, the equivalent of the Liability Adequacy Test (LAT).

Onerous Contracts: Unlike the LAT, the OCT is only performed on a subset of policies, those for which there are 'facts and circumstances' indicating that they are loss making on a conservative basis (the onerous contracts).

How can we help

Finity's Private Health team look forward to helping our clients with capital management, AASB 17, ICAAP and APRA-related matters. Please contact your usual Finity consultant – we are always pleased to answer your questions and discuss the best course of action for your organisation.

AUSTRALIA

Sydney
Level 7, 68 Harrington Street
The Rocks NSW 2000
+61 2 8252 3300

Melbourne
Level 3, 30 Collins Street
Melbourne VIC 3000
+61 3 8080 0900

Adelaide
Level 30, Westpac House
91 King William Street
Adelaide SA 5000
+61 8 8233 5817

NEW ZEALAND

Auckland
Level 5, 79 Queen Street
Auckland 1010
+64 9 306 7700

Contact the authors

Jamie Reid
jamie.reid@finity.com.au
Sydney | +61 2 8252 3309

Nicholas Stolk
nicholas.stolk@finity.com.au
Sydney | +61 2 8252 3415

Andrew Matthews
andrew.matthews@finity.com.au
Melbourne | +61 3 8080 0951