EXPLANATORY STATEMENT

Issued by the Authority of the Private Health Insurance Administration Council

Private Health Insurance Act 2007

Private Health Insurance (Health Benefits Fund Administration) Amendment Rule 2013 (No.1)

Authority for the Rules

Item 1 of the table in section 333-25 of the *Private Health Insurance Act* 2007 (the **Act**) provides that the Private Health Insurance Administration Council (the **Council**) may, by legislative instrument, make the *Private Health Insurance (Health Benefits Fund Administration) Rules 2007* (the **Rules**).

Sections 140-5(1) and 143-5(1) of the Act provide that the Rules may establish a solvency standard and capital adequacy standard respectively.

Solvency standard:

Section 140-5 of the Act provides that:

> "(1) The Private Health Insurance (Health Benefits Fund Administration) Rules may establish a solvency standard for the purposes of this Division.
>
> (2) The *solvency standard may be expressed:
>
> (a) to set different standards of solvency:
>
> (i) for *health benefits funds conducted by different private health insurers; or
>
> (ii) for different classes of health benefits funds; or
>
> (b) to apply to a health benefits fund only in circumstances specified in the standard."

Section 140-10 of the Act provides that:

"The purpose of the *solvency standard is to ensure, as far as practicable, that at any time the financial position of a *health benefits fund conducted by a private health insurer is such that the insurer will be able, out of the fund's *assets, to meet all liabilities that are referable to the fund as those liabilities become due."

Capital adequacy standard:

Section 143-5 of the Act provides that:

> "(1) The Private Health Insurance (Health Benefits Fund Administration) Rules may establish a capital adequacy standard for the purposes of this Division.
>
> (2) The *capital adequacy standard may be expressed:
>
> (a) to set different standards of capital adequacy:
>
> (i) for *health benefits funds conducted by different private health insurers; or
>
> (ii) for different classes of health benefits funds; or
>
> (b) to apply to a health benefits fund only in circumstances specified in the standard."

Section 143-10 of the Act provides that:

"The purpose of the *capital adequacy standard is to ensure, as far as practicable, that there are sufficient *assets in a *health benefits fund conducted by a private health insurer to provide adequate capital for the conduct of the fund:

(a) in accordance with this Act; and

(b) in the interests of the *policy holders of the fund."

The Rules and the *Private Health Insurance (Health Benefits Fund Administration) Amendment Rule (No. 1)* (**the Amendment Rules**) are legislative instruments for the purposes of the *Legislative Instruments Act 2003*. The Amendment Rules repeal the current solvency and capital adequacy standard and substitute new standards.

All legal and other requirements for making the Amendment Rules have been met.

Purpose of the Rules

The purpose of the Amendment Rule is to replace and update the solvency and capital adequacy standards, currently comprised in Schedules 2 and 3 of the Rules, respectively. The objectives of the Amendment Rule are, in the context of both today's industry, and that of the likely future to:

- ensure that the standards consistently and accurately reflect the risks faced by private health insurers;
- improve both private health insurers' engagement with those risks and the quality of information available to support the Council's regulation of the industry; and
- provide protection for policy holders against financial loss.

The revised standards will resolve a number of problems with the extant standards, including:

1. The changing and dynamic industry environment and a lack of engagement by some insurers with key industry and business risks. The current standards do not cover all risks faced by insurers, and are falling behind best practice regulatory (domestic and international) approaches.
2. A growing variation in the overall level of protection afforded to consumers. The use of fund size as a proxy for risk in several important risk areas is an imprecise reflection of risk severity and leads to differing overall levels of protection that is afforded to policy holders through the current capital requirements.
3. The current solvency standard lacks relevance, adds very little to the current capital adequacy standard and does not fully achieve its objective of ensuring that liabilities can be paid in a forward-looking sense.
4. The complexity of the concepts and the legislation does not adequately encourage insurer engagement with, and understanding of, the detailed components of the current standards, particularly at board level.
5. The current standards no longer reflect the Council's risk appetite in relation to prudential requirements.

An explanation of each of the Amendment Rules is set out in the **Attachment**.

Summary of impact of the Amendment Rule

These Rules were prepared under Office of Best Practice Regulation ID No 2012/14174.

The likely impact of the Amendment Rule is expected to be minimal given private health insurers' current compliance with the extant standards and the quantum and nature of health benefits fund assets.

The Amendment Rules (establishing a new solvency standard at Schedule 2 and a new capital adequacy standard at Schedule 3) impose obligations on Australian private health insurers. These obligations are necessary for ensuring that private health insurers have sufficient assets in terms of both quantum and liquidity to meet their liabilities. The new obligations also mean that private health insurers will have in place a comprehensive risk-based capital. The new standards require for:

- **capital adequacy standard:** that each health benefits fund has sufficient assets to ensure the continuing financial soundness taking into account business plans and the potential of adverse profitability outcomes and catastrophic losses in the asset portfolio.
- **solvency standard**: that each health benefits fund has sufficient assets of a sufficient quality to ensure that obligations to, and reasonable expectations of, policy holders and creditors can be met under adverse cash outflow circumstances.

Consultation

The proposed changes to the solvency and capital adequacy standards have been subject to extensive consultation with industry stakeholders. This included:

- initial consultations over the period from 2007 to the first half of 2012;
- a first round of consultation on a specific reform proposal over a three month period commencing in July 2012;
- a second round of consultations on a proposal developed as a result of feedback from the first round of consultations over a two month period commencing in June 2013; and
- a third and final round of industry notification advising of refinements to the proposed reform arising out of the second round of consultation in August 2013.

The Council considers that the release of two consultation papers and extensive consultation with industry stakeholders as detailed below means that the Council has fully complied with best practice regulation. In particular, the two consultation papers (in combination):

- included discussion of the problem, objectives and options – the minimum three elements of an options-stage RIS;
- included various options for reform including the option of no change;
- were released on the basis of an announced decision that the Council would regulate the capital and solvency position of the industry, but against the background of no announcement of a decision on the form of this regulation; and
- were certified for release by the Council.

Initial consultations

The Council is in constant contact with the private health insurance industry regarding its overall regulatory stance, and its approach to specific areas of concern. The origins of the current review date back to a review of the solvency and capital adequacy standards in 2007 and 2008 with the issue of two consultation papers. That review focused on making some changes to how the various elements of the current standards are calculated rather than on redesigning the standards, but no substantive changes were made as a result of this review. Since then, there has been periodic discussion with the industry including in the first half of 2012 about the design parameters of the current solvency and capital adequacy standards at a more fundamental level.

First consultation round

This led to the Council releasing a consultation paper on 2 July 2012 setting out problems with the current solvency and capital adequacy standards and proposed reforms to these standards. The objective of this consultation round was to determine whether there is a strong case to reform the standards, as well as to obtain feedback on an option overhaul the standards and on whether a more incremental change is preferred. Private health insurers were also provided the opportunity to complete a Quantitative Impact Study (QIS). The QIS enabled insurers to better understand the nature and extent of the proposed changes to capital and solvency requirements, and the practices applied to determine those requirements. It also provided insurers and the Council with qualitative and quantitative information on the impact of the proposed changes. The QISs were completed on the basis of the position of the health benefits fund as at 30 June 2012.

Submissions commenting on the proposed reforms, and QIS responses were sought from industry stakeholders by 1 October 2012, or three months after the release of the consultation paper. Of the 24 responses to this first round of consultation, most were broadly supportive of the proposed framework, although there was considerable discussion of the technical detail. The Council agreed with many of the comments and suggestions from industry, the most significant of which were:

- removing the growth component of the operational risk formula;
- increasing the level of sufficiency from 95% to 98%;
- allowing insurers three more months to implement the standards;
- broadening the definition of qualifying assets; and
- simplifying the calculations relating to concentration risk

Furthermore, the consultation resulted in further proposals to modify the solvency standard, which led to the proposal to replace the current solvency standard with a standard focused on the liquidity position of the health fund.

Second consultation round

On 3 June 2013, the Council released to the private health insurance industry a second consultation paper. This consultation paper set out a number of proposed changes arising out of the first round of consultations, and contained a draft of the subordinate legislation containing the proposed solvency and capital adequacy standards. The industry was also provided the opportunity to complete a second QIS based on the proposal set out in the

second discussion paper. Clarification on some items in the QIS was issued on 12 July 2013. Further, the Council met with all 34 private health insurers and a number of other stakeholders for one-on-one discussions during June and July 2013. Submissions from industry stockholders were sought by 31 July 2013.

A total of 27 submissions were received, with 21 from private health insurers and 6 from other industry stakeholders.

In response to comments received in the second round of consultation, a number of amendments were made. The industry was notified of these changes in the third round of consultation.

Third consultation round

Between August and September 2013, industry received a penultimate draft of the proposed Amendment Rules, notifying them of final changes reflecting issues raised in consultation round two.

Documents incorporated by reference

The following documents are incorporated in this Amendment Rule, by reference:

- Australian Accounting Standards (Australian Accounting Standards Board);
- *Private Health Insurance (Risk Equalisation Policy) Rules 2007*; and
- *Banking Act 1959 (Cth)*.

ATTACHMENT

DETAILS OF THE *PRIVATE HEALTH INSURANCE (HEALTH BENEFITS FUND ADMINISTRATION) AMENDMENT RULE 2013 (No. 1)*

1. Name of rule

Section 1 provides that the title of the Rule is the *Private Health Insurance (Health Benefits Fund Administration) Amendment Rule 2013 (No. 1).*

2. Commencement

Section 2 provides details in relation to the commencement of the provisions of the Amendment Rule. The section stipulates that the provision of the Amendment Rule specified in column 1 of the table commences in accordance with column 2 of the table. In effect the table results in the following commencement:

1. Sections 1 to 4 of the Amendment Rule and anything else not covered by the table commence the day after the rule is registered on the Federal Register of Legislative Instruments;
2. Schedule 1 of the Amendment Rule Items [1] to [19] commence on 31 March 2014;
3. Schedule 1 of the Amendment Rule Item [20] commences on 1 July 2014;
4. Schedule 1 of the Amendment Rule Item [21] commences on 31 March 2014
5. Schedule 1 of the Amendment Rule Item [22] commences on 1 July 2014.

The result of this is that all registered private health insurers will be required to comply with the capital adequacy standard from 31 March 2014, while the solvency standard and the capital management policy (an element of the capital adequacy standard) have to be complied with from 1 July 2014.

3. Authority

Section 3 provides that the *Rules and the Private Health Insurance (Health Benefits Fund Administration) Amendment Rule (No. 1)* is made under the *Private Health Insurance Act 2007*.

4. Schedule(s)

Section 4 provides *the Private Health Insurance (Health Benefits Fund Administration) Rules 2007* are amended or repealed as set out in the applicable items in the Schedule concerned, and any other item in a Schedule to this instrument has effect according to its terms.

SCHEDULE 1 – Amendments

Item [1] Rule 3, definition of *insurer*

The Amendment Rule will omit the original instrument's definition of "insurer", as this definition is redundant due to the "private health insurer" being a defined in the Rules as having the meaning set out in the Act. This change is further supported by the operation of section 13 of the *Legislative Instruments Act 2003*.

Item [2] Rule 3, Definitions

This set of insertions inserts new definitions and replaces existing definitions for the purposes of the revised solvency and capital adequacy standards comprised in Schedules 2 and 3 respectively.

approved loss absorbing subordinated debt

This provision defines approved loss absorbing subordinated debt as a security or other debt instrument, which has been approved by the Council under rule 3A of the Rules.

Australian Accounting Standards

This provision defines the "Australian Accounting Standards" as those issued by the Australian Accounting Standards Board (AASB). It is noted that the Australian Accounting Standards referenced in these rules are taken to be as they are at the date of commencement of these rules.

authorised deposit-taking institution

This provision defines "authorised deposit-taking institution" as a body corporate authorised under subsection 9(3) of the *Banking Act 1959* as defined at the commencement of these Amendment Rules.

billed risk equalisation trust fund liability

This provision defines the concept of "billed risk equalisation trust fund liability" as being:

- the amount of risk equalisation trust fund payments;
- on the "relevant day";
- for which an invoice from the Council has been received by the insurer; but
- that have not yet been paid by the insurer.

borrowings

This provision refers to Part 2, Rule 5 of the Rules.

capital adequacy maximum default loss amount

This provision refers to clause 13 of Schedule 3 for the definition of "capital adequacy maximum default loss amount".

capital adequacy standard

This provision defines the "capital adequacy standard" by referring the reader to Part 6 of the Rules, and to the whole of Schedule 3 of the Rules, as established under subsection 143-5 (1) of the Act.

capital adequacy supervisory adjustment amount

This provision defines the "capital adequacy supervisory adjustment amount" by referring the reader to clause 12 of Schedule 3 of the Rules.

cash

This provision defines "cash" as having the meaning given by the Australian Accounting Standards, which at commencement, is "cash on hand and demand deposits" (AASB 107.6).

cash management amount

This provision defines "cash management amount" by referring the reader to clause 5 of Schedule 2.

central estimate

This provision defines "central estimate" as a term applying to both the solvency and capital adequacy standards. "Central estimate" is defined as the average of the range of possible outcomes of any calculation required under either of the standards.

constructive obligation

This provision defines constructive obligation as having the meaning given in the liability adequacy test, at the time of commencement, in the AASB Standard 137.

financial interdependency

This provision defines "financial interdependency" in the context of a group of related counterparties. This provision explains this term as a situation in which the financial security of one counterparty in such a group may affect the financial security of another counterparty in the group.

future claims liability

This provision defines "future claims liability" of a health benefits fund as the amount calculated at a 75% probability of adequacy, based on the following calculation:

(a) the total of the following items:

  (i) future payments for claims owing under current private health insurance policies; and

  (ii) a private health insurer's additional risk margin; and

  (iii) the sum of:

    - related identifiable intangible assets; plus
    - related deferred policy holder acquisition costs.

(b) where all elements of (a) are defined in a manner consistent with the definitions contained in the liability adequacy test set out in the Australian Accounting Standard 1023, at commencement, except that that discounting is not applied and the constructive obligation component is not included.

At commencement, the AASB's Standard 1023 contains the following definition for "liability adequacy test":

> "an assessment of whether the carrying amount of an insurance liability needs to be increased (or the carrying amount of the related deferred acquisition costs or related intangible assets decreased) based on a review of future cash flows."

future claims liability amount

This provision defines "future claims liability amount" by referring the reader to clause 7 of Schedule 3 of the Rules, which provides a formula for its calculation.

group of related counterparties

This provision describes the phrase "group of related counterparties" as meaning two (2) or more counterparties which are "related parties", or are linked in either of two ways:

(a) financial interdependency (where parties are in a reciprocal, financially symbiotic or parasitic relationship); or

(b) any other connection or relationship which may subject each of the counterparties in the group to one specific risk.

health business revenue estimate

This provision defines the term "health business revenue estimate" as it's:

- "premium income estimate" plus a central estimate of the gross revenue (that is, total revenue received before any deductions or allowances) earned in relation to health related business for the 12 months after the "relevant day";
- less any premium paid to reinsurers in relation to health-related business.

liquidity management plan

This provision refers the reader to subclause 4 (3) of Schedule 2 to outline private health insurers' obligation in relation to a mandatory "liquidity management plan".

maximum default loss

This provision describes the concept of a private health insurer's health benefits fund's "maximum default loss" as the largest "uncompensated loss", of the health benefits fund arising from any loss, other than losses arising from assets held with an Australian Government counterparty or deposits held with an authorised deposit-taking institution, in relation to:

(a) of any asset or group of assets of the fund which are interdependent; and

(b) of any individual counterparty or group of related counterparties.

operational risk amount

This provision defines the term "operational risk amount" by referring the reader to clause 11 of Schedule 3, which contains a prescribed formula with which the amount is calculated.

other liabilities amount

This provision defines the term "other liabilities amount" by referring the reader to clause 9 of Schedule 3.

outstanding claims liability

This provision defines the term "outstanding claims liability" by providing the qualification that is has the meaning given by AASB Standard 1023, where the term is defined, at commencement as:

> "…the central estimate of the present value of the expected future payments for claims incurred with an additional risk margin to allow for the inherent uncertainty in the central estimate."

Secondly, the conditions attached to the Standard's definition of the term include:

(a) the risk margin applied must produce a 75% "probability of adequacy";

(b) discounting is not applied; and

(c) any outstanding claims liabilities from health related business are incorporated; and

(d) receipts from the risk equalisation trust fund are incorporated.

The goal of this definition is to ensure that the liability reflects the net impact on the fund of paying all claims to policy holders where the claims event has been incurred but the claim has not yet been settled. It should therefore include claims on health related business, as well as any offsetting receipts from the risk equalisation trust fund. The risk margin is specified so that the probability of adequacy is consistent with other elements of the standards, while discounting is not applied since it would be complex and have an immaterial impact.

outstanding claims liability amount

This provision refers the reader to clause 6 of Schedule 3 to define the term "outstanding claims liability amount", which is determined by way of a prescribed formula.

premium income estimate

This provision defines "premium income estimate" which is a term used in the stress test in clause 10 of Schedule 3, and as part of the calculation used to determine a private health insurer's health business revenue estimate.

This definition requires that a private health insurer's premium income estimate is the lesser of:

(a) the "central estimate" of the amount of revenue the private health insurer's health benefits fund will earn in the 12 months after the "relevant day"; and

(b) the amount the private health insurer calculates in accordance with the Council's published methodology.

Subclause (b) only applies where the Council is uncertain as to the status of the particular private health insurer's anticipated premium increase (that is, when a premium increase application is made but not yet determined).

previously approved subordinated debt

This term is defined as referring to a private health insurer's health benefits fund. It is described as being a debt of the kind previously approved by the Council as "subordinate debt" under Part 9 of Schedule 2 of the *Private Health Insurance (Health Benefits Fund Administration) Rules 2007* in force immediately prior to 31 March 2014.

probability of adequacy

This provision defines the phrase “probability of adequacy” as meaning the percentile level of financial safeguarding determined by the Council as being required to meet different requirements of either the solvency standard or capital adequacy standard.

prudent liabilities amount

This provision seeks to define the term “prudent liabilities amount” by referring the reader to clause 5 of Schedule 3 of the Rules, which describes the term as meaning the sum of a number of other prescribed amounts.

Item [3] Rule 3, Definitions

This set of definition insertions, aims to clarify the broader changes to the original instrument, and the reformed Schedules 2 and 3.

related party

This provision refers the reader to the relevant Australian Accounting Standards for the definition of “related party”. At commencement, AASB Accounting Standard 124 defines the term as follows:

> a party is related to an entity if:
>
> (a) directly, or indirectly through one or more intermediaries, the party:
>
> (i) controls, is controlled by, or is under common control with, the entity (this includes parents, subsidiaries and fellow subsidiaries);
>
> (ii) has an interest in the entity that gives it significant influence over the entity; or
>
> (iii) has joint control over the entity;
>
> (b) the party is an associate (as defined in AASB 128 Investments in Associates) of the entity;
>
> (c) the party is a joint venture in which the entity is a venturer (see AASB 131 Interests in Joint Ventures);
>
> (d) the party is a member of the key management personnel of the entity or its parent;
>
> (e) the party is a close member of the family of any individual referred to in (a) or (d);
>
> (f) the party is an entity that is controlled, jointly controlled or significantly influenced by, or for which significant voting power in such entity resides with, directly or indirectly, any individual referred to in (d) or (e); or
>
> (g) the party is a post-employment benefit plan for the benefit of employees of the entity, or of any entity that is a related party of the entity.

relevant day

This provision defines the term “relevant day” as meaning any day on which the Council may wish to test and prove a private health insurer’s compliance with either of the solvency or capital adequacy standards.

risk equalisation trust fund accrued liability amount

This provision defines the concept of “risk equalisation trust fund accrued liability amount” by referring the reader to clause 8 of Schedule 3.

Item [4] Rule 3, Definitions

This set of definition insertions, aims to clarify the broader changes to the original instrument, and the reformed Schedules 2 and 3.

single equivalent units (SEUs)

This provision refers the reader to Part 1, Rule 4 of the *Private Health Insurance (Risk Equalisation Policy) Rules 2007* for the definition of the term "single equivalent units".

size margin

This provision describes the meaning of the term "size margin" by reference to a mathematical calculation. A private health insurer's health benefits fund's "size margin" under the standard is the lesser of two options:

(a) as calculated by the following formula:

0.75 x (the health benefits fund's total number of single equivalent units, to the power of negative 0.16; and

(b) (b) 0.25.

solvency standard

This provision defines the "solvency standard" itself by referring the reader to Part 6 of the Rules, and to the whole of Schedule 2 of the Rules.

solvency supervisory adjustment amount

This provision refers the reader to subclause 6 (2) of Schedule 2 of the Rules, for a definition of the phrase "solvency supervisory adjustment amount".

stress test amount

This provision refers the reader to clause 10 of Schedule 3 of the Rules for explanation of the concept "stress test amount".

stressed cash inflow amount

This provision defines the term "stressed cash inflow amount" as the 2nd (second) percentile estimate of total cash flowing into a private health insurer's health benefits fund, for 30 days from the "relevant day".

stressed net cash outflow amount

This provision defines the term "stressed net cash outflow amount" as the 98th (ninety-eighth) percentile estimate of the net cash outflows for a 30 day period from the relevant day, where:

(a) net cash outflow means the cash outflows from the health benefits fund less cash inflows to the health benefits fund; and

(b) cash outflows are limited to cash payments required to meet all liabilities that are, or might become, referable to the health benefits fund; and

(c) cash inflows represent cash receipts arising from:

(i) premiums payable under policies of insurance that are referable to the fund; and

(ii) income from the investment of assets of the fund held on the relevant day including amounts receivable on maturity and excluding revenues from the sale

of assets, except where a binding agreement for the sale has been entered into prior to the relevant day; and

(iii) any other money due to be received by the insurer in connection with its conduct of the business of the fund.

stressed investment income estimate

This provision refers the reader to subclause 10 (3) of Schedule 3 of the Rules for the definition of the "stressed investment income estimate".

stressed net margin estimate

This provision refers the reader to subclause 10 (2) of Schedule 3 of the Rules for the definition of the "stressed net margin estimate".

stressed other income estimate

This provision refers the reader to subclause 10 (4) of Schedule 3 of the Rules for the definition of the "stressed other income estimate".

Item [5] Rule 3, Definitions

This set of definition insertions, aims to clarify the broader changes to the original instrument, and the reformed Schedules 2 and 3.

subordinated debt

This provision defines the term "subordinated debt" (defined above in "approved loss absorbing subordinate debt" as a type of "security or other debt instrument") as a private health insurer's total amount of any subordinated debt and loss absorbing subordinate debt previously approved by the Council.

unbilled calculated deficit means the central estimate of the sum of all the amounts calculated for each risk equalisation jurisdiction, and under the following conditions:

(a) in accordance with Part 2, Rule 11 (1) (e) of the *Private Health Insurance (Risk Equalisation Policy) Rules 2007*;

(b) over the period up to the relevant day;

(c) where the risk equalisation trust fund payments or receipts have accrued but have not yet been paid; and

(d) where an invoice, notice or receipt from the Council has not yet been received by the private health insurer, for that period.

unbilled gross deficit means the central estimate of the sum of the eligible benefits notionally allocated to the aged-based pool and the high cost claimants pool, calculated for each risk equalisation jurisdiction, and under the following conditions:

(a) in accordance with Part 2, Rule 11 (1) (a) of the *Private Health Insurance (Risk Equalisation Policy) Rules 2007*;

(b) over the period up to the relevant day;

(c) where the risk equalisation trust fund payments or receipts have accrued but have not yet been paid; and

(d) where an invoice, notice or receipt from the Council has not yet been received by the private health insurer, for that period.

uncompensated loss

This provision defines the term “uncompensated loss” as the likely net loss after insurance, derivative, recoveries and compensation.

unexpired risk liability

This provision defines the phrase “unexpired risk liability” as having the meaning given in the liability adequacy test in the relevant Australian Accounting Standards Board Standard 1023.

xth percentile

This provision defines the term “xth percentile” as the measurement with which the:

(a) net margin for the health insurance business; and

(b) investment income; and

(c) health related business income and all other income, less associated expenses;

must be measured at, in order to achieve a second (2nd) percentile profit margin, incorporating allowance for correlation between (a), (b) and (c).

Item [6] After rule 3 insert rule 3A

This item inserts a new rule 3A which dictates the steps an applicant private health insurer and the Council will go through in applying for approval of loss absorbing subordinate debt, and the characteristics the debt must have in order to be approved.

Firstly, the provision outlines in clause (1) that approved loss absorbing subordinated debt must be approved by the Council prior to the time of issue.

Subclause (2) stipulates that the Council must consider the requirements in subclause (3) and have regard to the quantum of the proposed issue and the timing for draw down, in making its decision on approval.

Subclause (3) then goes on to outline the terms and conditions which a debt instrument must include. In particular, approved loss absorbing subordinated debt must be created by a debt instrument or agreement which meets and continues to meet the following terms and conditions:

(a) it must comprise a mechanism which specifies the conditions and process for loss absorption, through diminution of value, conversion or other means, of the instrument or agreement on a going concern basis, such that prior to non-compliance with the capital adequacy standard the value of the debt would be reduced to the relevant extent, and if necessary exhausted; and

(b) it must have a minimum term of 10 years from the commencement of the loan; and

(c) there must be no circumstances where repayment may be accelerated or called at the lender’s or any third party’s option; and

(d) interest payments must not be payable where the payment of these would cause the fund to breach the capital adequacy standard; and

(e) interest payment obligations may be capitalised and interest may be charged on capitalised interest; and

(f) capital repayments must not be made where repayment would cause the fund to breach the capital adequacy standard; and

(g) delayed capital repayments may be subject to continuing interest charges, on the interest charge and repayment conditions specified in this paragraph.

Item [7] Subrule 8 (1)

This substitution aims to provide clarity around what is being referred to – that is, the "restructure of a health benefits fund conducted by a private health insurer" (defined in section 131-10 of the Act).

Item [8] Paragraphs 8 (1) (d) and (e)

This substitution is a simple re-wording of the provision as it appears in the original instrument, to clarify that solvency and capital adequacy directions apply to private health insurers, as opposed to being matters to which private health insurers are "subject". This amendment simultaneously corrects the reference from "insurer" to "private health insurer".

Item [9] Paragraph 9 (a)

This substitution aims to clarify the ownership and direction of the restructure proposal – that it is initiated and implemented within the health benefits fund conducted by a private health insurer.

Item [10] Subrule 10 (1)

This substitution aims to provide clarity around what is being referred to – that is, the "restructure of a health benefits fund conducted by a private health insurer (defined in section 131-10 of the Act).

Item [11] Subrule 10 (3)

This amendment is a simple re-wording, for the purpose of grammatical accuracy.

Item [12] Subrule 10 (4)

This amendment is a simple re-wording, for the purpose of grammatical accuracy.

Item [13] Subrule 11 (1)

This insertion is aimed at clarifying that the "transferring funds" referred to, belong to the "transferor private health insurer" (that is, the private health insurer transferring its health benefits fund or funds, as opposed to the private health insurer which is to receive the funds).

Item [14] Paragraph 12 (1) (g)

This insertion is aimed at clarifying that in a merger or acquisition, it is the statement of the "transferor private health insurer" (that is, the private health insurer being transferred), which must be submitted to the Council.

Item [15] Paragraph 13 (1) (d) and (e)

This substitution is a simple re-wording of the provision as it appears in the original instrument, to clarify that solvency and capital adequacy directions apply to private health insurers, as opposed to being matters to which private health insurers are "subject". This amendment simultaneously corrects the reference from "insurer" to "private health insurer".

Item [16] Subrule 13 A (4)

This substitution aims to clarify that the transferred health benefits fund and or funds referred to in subclause 11 (1) will, according to the operation of this provision, be transferred from the relevant private health insurer's health insurance business, as opposed to any other part of the private health insurer's operations.

Item [17] Subrule 15 (1)

This insertion is to clarify that it is the responsibility of the private health insurers who have made the application under section 146-5 of the Act, to provide a statement of the outcome of the application to its policy holders.

Item [18] Subrule17 (1)

The insertion of these extra words is aimed at clarifying that it is the private health insurer that is notified that a policy holder of a policy has an address which is not in the same risk equalisation jurisdiction as the address of one or more other policy holders of the same policy.

Item [19] Further amendments

This set of substitutions aims to substitute definition provisions, for the purposes of updating and clarifying the functioning of the revised solvency and capital adequacy standards, comprised in Schedules 2 and 3 respectively.

Item [20] Schedule 2

This direct substitution comprises the major revision of the Rules – being the replacement of the current solvency standard at Schedules 2.

SCHEDULE 2 – Solvency standard

(rule 18)

Part 1 – Preliminary

1 Purpose of the solvency standard

Subclause 1 (1) explains that Division 140 (specifically, section 140-1 of the Act) of the Act enables provision for establishing and requiring private health insurers to comply with standards of solvency in order to ensure that the health benefits funds conducted by private health insurers remain solvent – that is, being able to meet, out of its assets, all liabilities incurred, as those liabilities become due.

Subclause 1 (2) requires the private health insurer to demonstrate that it will be able to meet the obligations of its health benefits fund, allowing for adverse circumstances.

Subclause 1 (3) describes the new solvency standard's approach towards having sufficient liquidity to meet its cash demands and unanticipated losses, by describing this notion as a "central pillar of a private health insurer's financial strength".

Subclause 1 (4) reinforces the importance of compliance with the solvency standard as an indication of a private health insurer's health benefits fund's financial strength.

Subclause 1 (5) places the responsibility of ensuring the private health insurer's compliance with the solvency standard with the private health insurer's board.

Part 2 - Complying with the solvency standard

2 Application of Australian Accounting Standards

Subclause 2 (1) stipulates that the Australian Accounting Standards, administered by the Australian Accounting Standards Board (AASB), are to be relied on for the purposes of calculating any amount or value under the solvency standard, unless otherwise indicated.

3 Estimates, forecasts and calculations

Subclause 3 (1) explains that all estimates, forecasts and calculations referred to in the solvency standard are made having regard to two important conditions.

Subclause 3 (1) (a) explains that one of the conditions outlined in subclause 3 (1) is that all estimates, forecasts and calculations required under the solvency standard, are made having regard to any relevant statistics which are practically accessible, and "other relevant information".

Subclause 3 (1) (b) explains that one of the conditions outlined in subclause 3 (1) is that all estimates, forecasts and calculations required under the solvency standard, are neither deliberately or carelessly overstated, but rather are the best and central estimate, not being overly conservative. This condition reinforces the professional obligations of those interpreting and applying the standard, but also reminds them that it is important for all calculations required under the standard to be made reasonably, having regard to all relevant information.

4 Complying with the solvency standard

Subclause 4 (1) specifies that each and every health benefits funds conducted by a private health insurer is subject to, and must at all times comply with the solvency standard.

Subclause 4 (2) provides that private health insurers must make sure that at all times, the value of the cash in its health benefits fund is more than the sum of the total "cash management amount" (defined below), added to any "solvency supervisory adjustment amount" determined in accordance with clause 6 of Schedule 2 .

Subclause 4 (3) requires a private health insurer to have and comply with a liquidity management plan for all and each of the health benefits funds it conducts. The subclause stipulates that a private health insurer's liquidity management plan(s) must:

- be board-endorsed;
- be designed to enable the private health insurer's health benefits fund to continually comply with the solvency standard;
- set minimum liquidity requirements; and
- set minimum liquidity management action triggers.

Subclause 4 (4) outlines each of the factors a private health insurer's liquidity management plan must take into consideration, including:

(a) the extent to which the assets of the health benefits fund could be readily converted to cash under stressed market conditions; and

(b) the concentration of exposures to related counterparties for the assets which may be required to be converted to cash under stressed market conditions; and

(c) the seasonality and variability in cash flows; and

(d) the potential size of cash outflows under stressed business conditions; and

(e) the potential that the health benefits fund may have to draw down its cash to repay borrowings; and

(f) any other matter the board of the private health insurer considers relevant.

It is important to note that subclause 4 (4) is drafted in a way which means that each and all of the above considerations must be taken into account.

Subclause 4 (5) provides that the board of a private health insurer must review the liquidity management plan at least every two years and either:

(a) re-endorse the existing liquidity management plan; or

(b) endorse a new liquidity management plan.

Subclause 4(6) provides that private health insurer must provide a report to the Council, in the approved form, within 28 days of the end of each financial quarter, or as otherwise required by the Council, for the purposes of the Council assessing the compliance of the private health insurer with the solvency standard. This enables the Council to assess compliance with the solvency standard on a regular basis having regard to information provided by the private health insurer. Should the Council require it, on any grounds, a request may be made of the private health insurer for the information in the approved form,

that must be met by the private health insurer, for information out of the regular reporting cycle.

Subclause 4 (7) provides that a private health insurer must notify the Council immediately, in writing, if the private health insurer becomes aware that it does not comply with any aspect the solvency standard.

5 Cash management amount

Subclause 5 (1) of the standard defines the term “cash management amount”, by explaining that the amount is the greater of two options:

(a) the amount resulting from the “stressed net cash outflow amount” plus one (1) per cent of the “health business revenue estimate”; and

(b) one (1) per cent of the "health business revenue estimate”.

6 Solvency supervisory adjustment amount

Subclause 6 (1) provides that the supervisory adjustment amount is an amount, determined by the Council, on reasonable grounds which is not less than zero (0) and would not result in a negative amount, further the amount may be expressed as:

(a) an amount expressed in dollars; or

(b) a percentage figure; or

(c) a factor; or

(d) an amount, or a description of an amount, derived through another basis for calculating the solvency supervisory adjustment amount; or

(e) a methodology to be applied that will result in an amount.

Subclause 6 (2) seeks to aid the transparency of the application of the amount by providing a non-exhaustive list of examples for subclause 6 (1) of the types of grounds the Council may consider as being “reasonable”, for the determination of the adjustment amount, including:

(a) if the private health insurer’s health benefits fund’s “cash management amount” does not make adequate allowance for uncertainty; and/or

(b) if the private health insurer’s health benefits fund’s “cash” has not been classified as such, appropriately; and/or

(c) if the private health insurer conducting the health benefits fund does not have adequate data with which to assess the risks the fund faces; and/or

(d) the private health insurer has not adequately considered the contagion risks facing its health benefits fund in relation to a related party, for the purpose of its obligation under this Schedule.

It is important to note that the factors outlined in subclause 6 (2) do not limit the Council’s ability to consider other relevant grounds for the Council’s determination.

Subclause 6 (3) details the process the Council must follow in applying the adjustment amount, and explains that if the adjustment amount is applied, the Council must as soon as possible after making the determination to do so, notify the private health insurer in writing.

Paragraph 6 (3) (a) confirms that the first step in the process of applying an adjustment amount, is determining reasonable grounds, in accordance with subclause 6(2), and paragraph 6 (3) (b) outlines the second step as determining an amount to be applied.

Paragraph 6 (3) (c) details that the written notice provided to the private health insurer in question, must contain the amount, factor or figure to be applied and how this was arrived at by the Council, and paragraph 6 (4) (d) explains that the notice should provide the private health insurer in question, with an explanation of the reason for the Council's determination.

Paragraph 6 (3) (e) stipulates that the notice referred to in subclause 6 (3) must also include reference to the private health insurer's right to apply for review of the decision, as is later outlined in subclause 6 (4).

Subclause 6 (4) explains that any private health insurer which finds itself subject to an adjustment amount may apply to the Administrative Appeals Tribunal for review of the Council's decision to apply the adjustment amount, as it is empowered to do under subclause 6 (1).

Item [21] Schedule 3

This direct substitution comprises the major revision of the Rules – being the replacement of the current capital adequacy standard at Schedule 3.

SCHEDULE 3 – Capital adequacy standard

(rule 19)

Part 1 – Preliminary

1 Purpose of the capital adequacy standard

Subclause 1 (1) of this provision explains the purpose of this capital adequacy standard, in relation to the Act that is, to ensure that as far as possible, there are sufficient assets in a health benefits fund conducted by a private health insurer, to provide adequate capital for the fund to be conducted in accordance with its purpose, as stipulated in the Act.

This provision points out that a major purpose of the capital adequacy standard is to protect the interests of private health insurance policy holders.

Subclause 1 (2) explains that the capital adequacy standard requires the private health insurer to demonstrate that the assets of its health benefits fund will be able to meet the liabilities of the fund after a 12 month period, in the context of enabling the future business plans of the fund, and any difficult market conditions it may encounter.

Subclause 1 (3) stresses that a private health insurer's health benefits fund's compliance with the capital adequacy standard, is viewed by the Council as an indication of its future financial strength, on an ongoing basis.

Subclause 1 (4) places the onus of ensuring the compliance of a private health insurer's health benefits fund with the capital adequacy standard, firmly in the hands of the insurer's board.

Part 2 – Complying with the capital adequacy standard

2 Application of Australian Accounting Standards

Subclause 2 (1) qualifies that the Australian Accounting Standards, administered by the Australian Accounting Standards Board (**AASB**), are to be relied of for the purposes of calculating any amount or value under the capital adequacy standard unless otherwise indicated.

3 Estimates, forecasts and calculations

Subclause 3 (1) explains that all estimates, forecasts and calculations referred to in the capital adequacy standard are made having regard to two important conditions.

Subclause 3 (1) (a) explains that one of the conditions outlined in subclause 3 (1) is that all estimates, forecasts and calculations required under the capital adequacy standard, are

made having regard to any relevant statistics which are practically accessible, and any other relevant information.

Subclause 3 (1) (b) Subclause 3 (1) (a) explains that one of the conditions outlined in subclause 3 (1) is that all estimates, forecasts and calculations required under the capital adequacy standard, are not deliberately or carelessly overstated or understated. This condition reinforces the professional obligations of those interpreting and applying the standard, but also reminds them that it is important for all calculations required under the standard to be made reasonably, having regard to all relevant information.

4 Complying with the capital adequacy standard

Subclause 4 (1) states that a private health insurer must comply with the Schedule (comprising the capital adequacy standard) in relation to each and all of the health benefits funds it conducts.

Subclause 4 (2) explains the obligation private health insurers are under to ensure that, at any time, the value of their health benefits fund's assets is more than both the total amounts outlined in paragraphs 4 (2) (a) and 4 (2) (b).

This requirement is set in the context of paragraph 4 (2) (a) amounting to a total of the health benefits fund's:

(i) "prudent liabilities amount"; plus

(ii) "stress test amount"; plus

(iii) "operational risk amount"; plus

(iv) any "capital adequacy supervisory adjustment amount" determined in accordance with clause 12 of Schedule 3; less

(v) any subordinated debt.

This requirement is also set in the context of paragraph 4 (2) (b) amounting to a total of the health benefits fund's:

(i) "prudent liabilities amount"; plus

(ii) "capital adequacy maximum default loss amount"; plus

(iii) any "capital adequacy supervisory adjustment amount" determined in accordance with clause 12 of Schedule 3; less

(iv) any subordinated debt.

Subclause 4(3) provides that private health insurer must provide a report to the Council, in the approved form, within 28 days of the end of each financial quarter, or as otherwise required by the Council. This allows Council to regularly oversight and assess the compliance of the private health insurer with the solvency standard and capital adequacy standard. The Council may require a private health insurer to provide information, in the approved form, outside of the regular reporting cycle.

Subclause 4 (4) provides that a private health insurer must notify the Council immediately, in writing, if the private health insurer becomes aware that it does not comply with any aspect the capital adequacy standard.

5 Prudent liabilities amount

Subclause 5 (1) defines the term "prudent liabilities amount" as being the private health insurer's health benefits fund's total:

(a) "outstanding claims liability amount" ; plus

(b) "future claims liability amount" ; plus

(c) "risk equalisation trust fund accrued liability amount" ; plus

(d) "other liabilities amount" .

6 Outstanding claims liability amount

Subclause 6 (1) defines a private health insurer's health benefit fund's "outstanding claims liability amount" as being calculated in accordance with the following formula:

"outstanding claims liability" multiplied by the sum of positive "1" plus the health benefits fund's "size margin".

7 Future claims liability amount

Subclause 7 (1) defines a private health insurer's health benefits fund's "future claims liability amount" as being calculated in accordance with the following formula:

"future claims liability" multiplied by the sum of positive "1" plus the health benefits fund's "size margin".

8 Risk equalisation trust fund accrued liability amount

Subclause 8 (1) defines a private health insurer's health benefits fund's "risk equalisation trust fund accrued liability amount" as the larger of:

(a) 0.1 multiplied by the health benefits fund's "unbilled calculated deficit"; and

(b) (1.1 multiplied by the fund's "unbilled calculated deficit" minus its "unbilled gross deficit", plus its "billed risk equalisation trust fund liability".

9 Other liabilities amount

Subclause 9 (1) defines the private health insurer's health benefits fund's "other liabilities amount" as being is the sum of all other liabilities not included in clauses 5, 6, 7 and 8 of this Schedule, valued as follows:

(a) individually, at a 98% probability of adequacy, where the balance sheet value of the liability is not less than 2% of the total value of balance sheet liabilities; and

(b) collectively, at least a 98% probability of adequacy, where the balance sheet value of the liability is less than 2% of the total value of balance sheet liabilities.

10 Stress test amount

Subclause 10 (1) contains one of the key components of the capital adequacy standard – the "stress test". This subclause describes a private health insurer's health benefits fund's "stress test amount" as being the greater of zero dollars and an amount calculated using a set formula:

negative "N" minus "I" minus "O" plus "T"

Subclause 10 (1) then goes on to define each of the components of this formula as follows:

- "N" being the health benefits fund's "stressed net margin estimate" ;
- "I" being the health benefits fund's "stressed investment income estimate" on the "relevant day";
- "O" being the health benefits fund's "stressed other income estimate" on the "relevant day"; and
- "T" being the amount of tax attributable to the private health insurer's health benefits fund, in the event that – for the 12 months after the relevant day - it achieves its:

  (i) "stressed net margin estimate" ; and

  (ii) "stressed investment income estimate" ; and

  (iii) "stressed other income estimate" .

Subclause 10 (2) explains defines the term "stressed net margin estimate" ("N") as belonging to the private health insurer's health benefits fund, and as calculated in accordance with a set formula:

"P" multiplied by "NM%"

The subclause then goes on to qualify this explanation by defining the formula components as follows:

- "P" being the "premium income estimate" of the health benefits fund in question, on the "relevant day";
- "NM%" being the private health insurer's estimate of its health benefits fund's "xth percentile" net margin percentage for the health insurance business for 12 months after the relevant day calculated:
- using the same premium increases as those assumed in calculating the premium income estimate;
- excluding any expected changes in the unexpired risk liability or constructive obligation during that period.
- In calculating NM% the following must be taken into account:

  (a) historical variability in net margins; and

  (b) changes in the fund's policy holder growth rate; and

  (c) expansion into new complying health insurance product(s); and

  (d) expansion into new markets.

Subclause 10 (3) outlines the definition of a health benefits fund's "stressed investment income estimate" ("I") as being the private health insurer's estimate of the fund's "xth

percentile" of its investment income for the 12 months after the "relevant day", taking into account the following significant risks:

(a) market risk;

(b) credit risk; and

(c) the risk of incorrect asset valuation on the balance sheet.

Subclause 10 (4) defines "stressed other income estimate" ("O") as a private health insurer's health benefits fund's estimate of its health benefits fund's "xth percentile" of its:

- health related business; and
- all other income; less
- any expenses for the 12 months after the "relevant day".

11 Operational risk amount

Subclause 11 (1) defines the term "operational risk amount" as being the sum of 0.5 per cent of a private health insurer's health benefits fund's "health business revenue estimate" on the "relevant day"; plus the results of the following formula:

1 million dollars multiplied by (1.025 to the power of [the calendar year of the "relevant day" minus 2014]).

12 Capital adequacy supervisory adjustment amount

Subclause 12 (1) provides for the application of the "capital adequacy adjustment amount" which for health benefits fund, on the relevant day, is:

(a) an amount expressed in dollars; or

(b) a percentage figure; or

(c) a factor; or

(d) an amount, or a description of an amount, derived through another basis for calculating the capital adequacy supervisory adjustment amount;

which is not less than 0, and would not result in a negative amount, determined by the Council (including by the application of specified methodology), upon reasonable grounds.

Subclause 12 (3) seeks to aid the transparency of the application of the amount by providing a non-exhaustive list of examples for subclause 12 (1) of the types of grounds the Council may consider as being "reasonable", for the determination of the adjustment amount, including:

(a) there is a less than 98% probability that the health benefits fund will meet its prudent liabilities in 12 months' time; and/or

(b) the health benefits fund's stress test amount does not make adequate allowance for:

(i) growth in policy holders, including in new markets; and/or
(ii) changes to the fund's products, including the launch of new products; and/or
(iii) a lack of asset diversification; and/or
(iv) market risk; and/or

(iv) mismeasurement of asset values; and/or
(vi) credit risk; and/or

(c) the health benefits fund's prudent liabilities amount does not make adequate allowance for inherent uncertainty; and/or

(d) the health benefits fund's operational risk amount does not make adequate allowance for inherent uncertainty; and/or

(e) the health benefits fund's assets are not valued appropriately; and/or

(f) the private health insurer conducting the health benefits fund does not have adequate data to assess its risks; and/or

(g) the health benefits fund is exposed to contagion risks from a related entity, and the private health insurer conducting it has not properly considered these risks for the purpose of its obligations under this Schedule; and/or

(h) the health benefits fund's capital adequacy maximum default loss has not been appropriately calculated.

It is important to note that the factors outlined in subclause 12 (3) do not limit the Council's ability to consider other relevant grounds for the Council's determination.

Subclause 12 (4) provides that the Council may determine the same or a different amount for the adjustment amount for the purposes of the two arms of the capital adequacy requirement set out in paragraphs 4 (2) (a) and 4 (2) (b).

Subclause 12 (5) details the process the Council must follow in applying the adjustment amount, and explains that if the adjustment amount is applied, the Council must as soon as possible after making the determination to do so, notify the private health insurer in writing.

Paragraph 12 (5) (a) confirms that the first step in the process of applying an adjustment amount, is determining reasonable grounds, in accordance with subclause 12 (1), and paragraph 12 (5) (b) outlines the second step as determining an amount to be applied.

Paragraph 12 (5) (c) details that the written notice provided to the private health insurer in question, must contain the amount to be applied and how this was arrived at by the Council, and paragraph 12 (5) (d) explains that the notice should provide the private health insurer in question, with an explanation of the reasons for the Council's determination.

Paragraph 12 (4) (e) stipulates that the notice referred to in subclause 12 (4) must also include reference to the private health insurer's right to apply for review of the decision, as is later outlined in subclause 12 (6).

Subclause 12 (6) provides that any private health insurer which finds itself subject to an adjustment amount may apply to the Administrative Appeals Tribunal for review of the Council's decision to apply the adjustment amount, as it is empowered to do under subclause 12 (1).

13 Capital adequacy maximum default loss amount

Subclause 13 (1) defines the "capital adequacy maximum default loss amount" of a health benefits fund on the "relevant day" (explained above) as being a prudent estimate of the fund's maximum default loss.

Subclause 13 (2) describes the conditions a fund's "capital adequacy maximum default loss amount" must meet in order to be correctly calculated, including:

(a) that it must be:

(i) at least as large as the maximum default loss; and
(ii) less than the maximum default loss, plus 10 per cent of the value of the fund's assets, less its prudent liabilities.

14 Transitional provisions

Subclause 14 (1) explains that on commencement of Schedule 3 of the Rules (that is, the capital adequacy standard from 31 March 2014), a private health insurer that has any "previously approved subordinate debt" may treat it as having its full value for the purposes of the Schedule subject to subclause (2).

Subclause 14 (2) explains that by way of transitioning the arrangement of such insurers into the new capital adequacy standard, the value of "previously approved subordinate debt" will be linearly decreased each month over 48 months to zero.

Subclause 14 (2) sets the commencement date for this reduction in value as being the earlier of paragraphs 14 (2) (a) and 14 (2) (b), where paragraphs 14 (2) (a) is five (5) years from commencement, and paragraph 14 (2) (b) is four (4) years before the maturity date of the subordinated debt.

Item [22] Schedule 3 Part 3 – Capital management policy

Part 3 – Capital management policy

15 Capital management policy

Subclause 15 (1) provides that in order to comply with the capital adequacy standard, a private health insurer must have, and comply, with a capital management policy for each of the health benefits funds it conducts. The capital management policy must be board-endorsed and in writing.

Subclause 15 (2) stipulates the elements a private health insurer's capital management policy must contain, including:

(a) a capital management plan, which must contain:

(i) a description of the insurer's board's appetite for risk as that relates to its health benefits fund's capital needs, and also the way the board came to determine that appetite;
(ii) the fund's capital target, and – in relation to subclause 15 (5) – how these have been arrived at;
(iii) clearly articulated trigger points, at which the private health insurer's board will act in order to protect the capital reserves of the fund; and

(iv) the actions and timeframes for which, the private health insurer's board will take in returning the fund to its capital targets.

(b) a pricing philosophy, which must include:

(i) profitability targets; and
(ii) direct and explicit consideration of the capital implications of particular profitability levels; and
(iii) guidelines on the speed of correction of deviations from these profitability targets.

(c) investment rules, which must include:

(i) clear objectives; and
(ii) asset allocation limits; and
(iii) asset concentration limits; and
(iv) a consideration of capital strength.

(d) rules stipulating circumstances under which the capital management policy is to be reviewed, which must include changes in:

(i) policy holder growth rates; and
(ii) registration status; and
(iii) net margin; and
(iv) broader economic conditions.

Subclause 15 (3) stipulates that the private health insurer must provide the Council with a copy of its board endorsed, written, capital management policy as soon as practicable after it has been endorsed. This includes following reindorsement or endorsement after a change in the capital management policy.

Subclause 15 (4) requires the board of the private health insurer to review the capital management policy at least every two (2) years, and either:

(a) re-endorse the existing capital management policy; or

(b) endorse a new capital management policy.

Subclause 15 (5) of the Schedule explains that in meeting the requirements in subparagraphs 15 (2) (a) (ii) and 15 (2) (a) (iii), a private health insurer must use methods designed in alignment with the purpose of the capital management standard - to protect the health benefits fund from defined events over a defined period of time, at a specified level of probability, and in a manner which considers the fund's:

(a) access to internal and external capital; and

(b) the impact on premiums of holding more or less capital than the amount determined.

Statement of Compatibility with Human Rights

Prepared in accordance with Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011

Private Health Insurance (Health Benefits Fund Administration) Amendment Rule 2013 (No. 1)

This Legislative Instrument is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

Overview of the Legislative Instrument

The *Private Health Insurance (Health Benefits Fund Administration) Amendment Rule 2013 (No. 1)* comprises major amendments to the *Private Health Insurance (Health Benefits Fund Administration) Rules 2007* (the **Rules**). Simply, the amendments replace the extant prudential requirements, the solvency standard and the capital adequacy standard, for private health insurers with new standards.

The new standards, together, will ensure that private health insurers have sufficient capital in both total quantum (capital adequacy) and in terms of quality, being sufficiently liquid, (solvency) to meet the liabilities of the insurer. If insurers do not meet these requirements the Council will take action to ensure that policy holders are protected.

This ensures that Australian's with private health insurance can have a level of assurance that holding private health insurance will enable them to access and meet the costs associated with the provision of health care.

The amendments to the prudential standards address a range of issues in the extant standards, including:

1. The changing industry environment and a lack of engagement with key industry risks. Over time, the risks facing private health insurers have changed with the changing nature of the business conducted by them. The prescriptive nature of the current standards in dealing with these changes has become increasingly anachronistic and no longer sufficiently encourages insurer engagement with key risks as good business practice.
2. A growing variation in the overall level of protection afforded consumers. The use of fund size as a proxy for risk in several important risk areas is an imprecise reflection of risk severity and leads to differing overall levels of protection that is afforded to policyholders through capital requirements.
3. The current standards do not cover all risks faced by insurers, and are falling behind best practice regulatory (domestic and international) approaches.
4. The current solvency standard lacks relevance, adds very little to the current capital adequacy standard and does not fully achieve its objective of ensuring that liabilities can be paid in a forward-looking sense.

5. The complexity of the concepts and the legislation does not adequately encourage insurer engagement with, and understanding of, the detailed components of the current standards, particularly at board level.
6. The current standards no longer reflect the Council's risk appetite and views regarding efficiency.
7. The current standards allow subordinated debt to be treated as capital even though this may not be able to absorb losses while the insurer remains an ongoing concern.
8. Council does not receive sufficient risk-related information about key risks, and in particular the key risk of adverse future profitability.

Simply put, the new standards introduce a comprehensive risk-based capital regime aimed at ensuring the following:

- **capital adequacy standard:** that each health benefits fund has sufficient assets to ensure the continuing financial soundness taking into account business plans and the potential of adverse profitability outcomes and catastrophic losses in the asset portfolio.
- **solvency standard**: that each health benefits fund has sufficient assets of a sufficient quality to ensure that obligations to, and reasonable expectations of, policyholders and creditors can be met under adverse cash outflow circumstances.

Human rights implications

The solvency and capital adequacy standards place restrictions and requirements on private health insurance businesses. All of these businesses are, subject to the registration provisions of the *Private Health Insurance Act 2007* (Cth),[1] companies or constitutional corporations.[2] As human rights are inherent in human beings, as opposed to corporate entities, on its face, the instrument does not directly engage human rights, to the extent that its only direct interface is with corporate entities.

The proposed standards do, however; indirectly promote the human rights of private health insurance consumers. Paradoxically, assurance in relation to the prudential status of private health insurance promotes the use of the private health system and thus reduces the impact on the public system thereby allowing the public system to focus on servicing those in economic need or clinical need.

Right to health

The right to health appears in a number of treaties under the definition of 'human rights' in the Human Rights (Parliamentary Scrutiny) Act, most notably in Article 12 of the *International Covenant on Economic, Social and Cultural Rights* which protects "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".[3]

By placing particular restrictions and obligations on insurers to ensure that they act with prudence in conducting their operations, the Council aims to protect the private health insurance industry and its consumers from potential financial losses.

[1] S 126-10 *Private Health Insurance Act 2007* (Cth).
[2] As defined in the *Private Health Insurance Act 2007* (Cth).
[3] Article 12, International Covenant on Economic, Social and Cultural Rights, done at New York on 16 December 1966 ([1976] ATS 5).

In providing this consumer protection in a strong and stable industry, the solvency and capital adequacy standards will work to indirectly promote the right to health of private health insurance consumers. The standards will do this by ensuring that the systems through which consumers of private health insurance access the Australian health system are financially sound and efficient.

The Office of the United Nations High Commissioner for Human Rights explains that some key freedoms and entitlements comprised in the right to health are:

- the right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health;
- access to essential medicines;
- equal and timely access to basic health services;
- the provision of health-related education and information;
- participation of the population in health-related decision-making at the national and community levels; and
- all health services, goods and facilities must be available, accessible, acceptable and of good quality.[4]

The solvency and capital adequacy standards will promote these key aspects of the right to health by making sure private health insurers effectively manage the risks associated with their capital arrangements. In turn, this practice provides people who choose to access the health system with the assistance of a private health insurer, with financial protections.

Conclusion

The *Private Health Insurance (Health Benefits Fund Administration) Amendment Rule 2013 (No. 1)* is compatible with human rights because:

a) it does not directly engage human rights, as it applies substantively only to companies and constitutional corporations; and

b) where it indirectly engages with the human rights of consumers of private health insurance, it promotes these rights.

[4] Office of the United Nations High Commissioner for Human Rights and World Health Organisation, *The Right To Health – Fact Sheet No. 31*, http://www.ohchr.org/Documents/Publications/Factsheet31.pdf