9 July 2020

General Manager
Policy Development
Australian Prudential Regulation Authority
GPO Box 9836
Sydney NSW 2001

Dear Sir,

Private Health Insurance Capital Standards Review

The Actuaries Institute ("the Institute") welcomes the opportunity to comment on this Discussion Paper from APRA.

The Institute supports the overarching intent of the proposals in the Discussion Paper, as well as APRA's roadmap to strengthening the prudential regulation of the private health insurance industry. The attached submission responds in detail to the various issues and questions raised.

Please do not hesitate to contact us if we can be of further assistance.

Yours sincerely,

Chief Executive Officer

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Actuaries Institute Submission on PHI Capital Standards Review

1. Overview and recommendations

1.1 Introduction

The Actuaries Institute ("the Institute") has prepared this submission in response to a discussion paper released by APRA in December 2019 outlining its proposals for a new structure for the capital framework for private health insurers (insurers). This discussion paper is titled "Discussion paper: Private Health Insurance Capital Standards Review".

APRA's proposals are not defined to the degree needed to enable quantitative impacts to be measured. Therefore, our submission is focussed on the soundness of the rationale supporting specific proposals, suggestions for further consideration by APRA and any practical considerations that may strengthen the transition and implementation of the new framework.

As is evident from the date of this submission, our comments are provided at a time when the current COVID-19 pandemic and responses by all stakeholders, including private health insurers, are still evolving. This is obviously an exceptional event. Our comments necessarily reflect our views at this point in time and may continue to evolve.

1.2 Guiding Principles

Underpinning this submission are a set of guiding principles:

- The capital framework should be appropriately tailored to the nature of private health insurance (PHI) risk. Just as the LAGIC framework was specifically designed for Life and General Insurance, so should the capital framework for PHI be designed accordingly.
- Each insurer's regulatory capital should be based on an objective assessment of the risks inherent in the operations of that insurer.
- The capital framework should avoid unnecessary complexity and be as easy to implement as possible.
- The capital framework should be efficient in the sense that it avoids any potential double counting (and vice versa does not allow under counting).
- Impacts on individual insurers should be taken into account in determining timing and transition periods.

1.3 Unique Features of Private Health Insurance

Over the years, the Institute has shared its views with APRA on the unique features of PHI and the implications for prudential supervision. Although we can see that our views have broadly been considered by APRA, we summarise them here for completeness as they have continued to inform our thinking on APRA's latest proposed structure for the capital framework.

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- PHI insurance risk is different to that of Life and General Insurance. Specific characteristics of PHI that impact on insurance risk include:
    - community rated premiums are required (i.e. cannot risk rate premiums);
    - the role of government, particularly with regards to approving premiums;
    - the effect of risk equalisation;
    - the short time frame over which PHI claims are notified and paid; and
    - the fact that PHI contracts have no end dates, continue indefinitely and give insurers the ability to adjust policy terms and conditions with 60 days notice.
- Furthermore, within Hospital cover there are additional factors that significantly reduce the insurer's degree of control over claims costs including:
    - legislation enables each policyholder to either renew at their option or to switch to another insurer with full and immediate continuity of benefits;
    - claims are significantly influenced by policyholders' medical practitioners and admitting hospital; and
    - claims are affected by changes in practice in the public hospital system.
- PHI in Australia does not have any obvious exposures to catastrophic events. Whilst certain types of events (e.g. pandemics) potentially impact across the health system, the types of benefits typically funded by PHI (i.e. elective surgery) and the availability of the public health system mean that the impact for insurers from catastrophes that impact the broader health system are less obvious or even potentially minimal.
- PHI has historically been impacted by various government policies from time to time. Depending on the nature, scope and transition, any of these changes could lead to significant financial impacts on insurers. However, we note that the introduction of government policies would typically follow a period of consultation allowing insurers opportunity to prepare for major changes. Ultimately, our view is that it is not appropriate to anticipate and allow for the impact of unpublicised government policy in the context of regulatory capital.

1.4 Summary of Recommendations

In summary, the Institute recommends that APRA:

1. In potentially designing any requirements for non-Health Benefits Fund (HBF) business, to reflect the potential for contagion risk to impact the HBF and draws on any similarities that exist in other regulated entities such as Life Insurance.
2. Develops detail around its definition of "gone concern" in a PHI context and how it will reflect this concept in capital charges.
3. Considers making special allowances (by extending the transition timeframe) on request from funds which may struggle to make the transition to the new requirements within the timeframe.

4. Considers the responsibility for the insurer specific adjustment to rest with the insurer and their Appointed Actuary with appropriate "guard rails" developed by the Institute in the form of professional standards and guidance notes.
5. Identifies each risk within the major risk categories identified by APRA and articulates how each identified risk is intended to be addressed through the capital framework - whether it is through the prescribed factor component, adverse event, capital management and/or recovery planning.
6. Considers an adverse event that is industry wide in cause and scale, and one where no future premium increases are assumed.
7. Considers how charges for each risk are to be prescribed to ensure there is no double counting within the calculations.
8. Provides more explanation on why it proposes risk charges apply to a risk exposure period of twelve months and how it derived this length of exposure.
9. Ensures that its approach to capital does not create perverse incentives.
10. In deriving the aggregation benefit, it considers the underlying nature of PHI risks. In particular, we suggest APRA details the reasons for its proposed 0.2 correlation assumption.

2. Discussion of APRA's Technical Proposals

In this part of our submission, we discuss in detail our views and suggestions relating to APRA's proposals. For convenience, the discussion of each topic has been covered under the same section number as it appears in APRA's discussion paper.

2.1 Applying the LAGIC framework for PHI

The Institute agrees that the objectives of the LAGIC framework form an appropriate basis for prudential regulation from a capital perspective, and these objectives align well with the current capital standards.

The proposed structure for the prescribed capital amount (PCA) is sensible in that it captures all the main categories of risk to capital and uses a modular structure, which assists in understanding the relative contributions of these categories. It is reasonable for the prudential regulator to have the ability to apply supervisory adjustments in certain situations and, as this does not represent an increase in APRA's powers from the current capital standards, the Institute agrees with their inclusion in the PCA.

Clearly, although the framework is appropriate, the appropriateness of the standards will depend on the specific design of the components within the framework and their application in practice.

2.2 Scope of the capital standards

The Institute agrees that the scope of the capital standards should capture the contagion risk that arises from non-insurance business activities of the health insurer on the HBF. APRA should consider the consistency in its approach with its other regulated entities in this regard.

Ultimately, there may be practical challenges with developing charges that are overly complex given the diversity of activities undertaken by health insurers. APRA will need to be cognisant that its approach cannot be easily circumvented through a corporate restructure and should consider whether dealing with this risk through Internal Capital Adequacy Assessment Process (ICAAP) is more appropriate.

Reasonable to extend scope to non-insurance business activities

Given that one of the main purposes of the capital standards is to protect policyholders, it is reasonable for the scope of the standards to include business activities of the broader entity that controls the HBF to the extent that those activities may put the sustainability of the HBF at risk.

The current PHI Act gives APRA the power to apply capital standards at the insurer level and so we agree that the standards should be extended to apply to the insurer, as well as the HBF.

However, we believe it is important to note that all overseas health insurance business (i.e. overseas visitors cover and overseas student heath cover) is already sold from within the HBF. Therefore, such an extension to the insurer will apply risk charges to non-health insurance activities, which are potentially wide ranging. There are no policyholder entitlements arising from activities outside of the HBF – the risks that the extension should cover are purely those of contagion from the perspective of the HBF.

There may be a case for extending the scope of the PHI Act to give APRA powers relating to the broader group within which the insurer operates, but we agree with APRA that further evidence would be required to support such a case as it would involve changing legislation. This could include looking at available case studies both in and out of Australia of the impact of non-health insurance activities on the health insurance business. This might help crystallise the type and severity of risk and whether such powers will provide the desired risk mitigation.

We note that, at a high-level, there are at least three approaches available to APRA:

- Apply capital charges to insurer operations outside of the HBF; and/or
- Require contagion risks on the HBF from the insurer (and even the broader group) to be considered explicitly within the ICAAP – including within stresses, scenarios, and capital triggers and targets; and/or
- Place additional regulations around capital moving from the HBF to the insurer. This could include stressing expected capital injections and/or applying restrictions on the process for declaring dividends.

Each of these approaches is reasonable if designed appropriately, although we believe that they each have varying degrees of success at meeting our guiding principles. We discuss each of these three approaches in detail.

Additional capital charges on insurer operations outside of the HBF

As with all elements of the capital standard, APRA would need to ensure requirements for non-insurance business are commensurate with the risk arising from that business.

Designing appropriate capital charges to apply to non-insurance business will be challenging given the wide range of current and potential business types that could be included. This implies complexity.

If APRA were to consider this approach further, we believe the design of the capital charges should be designed so as to:

- ensure consistent application on a given business activity regardless of structural location, for example, some insurers post commissions on agency business outside the HBF while others conduct this business inside the HBF. The capital charge should be agnostic as to the location of this event;
- reflect the risk of contagion on the HBF (only), which should be net of any diversification benefits that may arise from operating different business types; and
- ensure it is still appropriate if the risks are already captured in the rest of the capital standards e.g. the other two approaches.

In designing any capital charge, APRA may find it instructive to draw on similarities that exist in other regulated entities, particularly where they relate to activities that are not regulated by APRA. For example:

- a life insurer's subsidiary investments attract a risk charge on their net assets – this would be unlikely to have a material impact on the industry, and may send an (additional) appropriate signal to insurers to consider their risk profile more holistically than a pure HBF focus; and
- reinsurance assets also attract asset charges, particularly some overseas placements, and so an asset charge could be similarly applied to the health insurer's activities outside the HBF.

The Life Insurance approach of considering non-insurance/statutory fund operations as a (net) asset and applying an asset risk charge would be an acceptable option. An alternative would be to use revenue or net profit after tax (NPAT), with its underlying volatility a potential proxy for risk.

To reiterate, such a charge would need to reflect contagion risks on the HBF only, and as noted above, we do not consider this option to be necessary if the rest of the capital standards are designed appropriately.

However, if APRA does decide to apply such a charge, then our view is that any prescribed factor(s) should reflect the risk and be based on industry information available (i.e. objective). We would expect that risk charge to be relatively small.

The industry information we have been able to identify shows:

- only one of the three largest for-profit insurers has any material non-HBF net assets – these are in the order of 10% of the insurer's net assets; and
- smaller insurers also tend to have immaterial non-HBF net assets – in a selection of five smaller insurers (those that we were able to access), only one had non-HBF net assets that were more than 3% of total insurer net assets.

These net assets relate to a variety of business types, including dental practices, commissions from selling agency business, in home care, and other preventative health practices.

Given the relatively small size of these operations, it is unlikely that (all else equal) a small charge on non-HBF operations would lead to insurers significantly reconsidering their strategies. Despite this we note that if an insurer could avoid additional charges by a corporate restructure to move operations from the insurer to a subsidiary of the broader group that is outside of the insurer, this would render the additional requirements obsolete, although noting this may also lead to a potential reduction to contagion risk. APRA should therefore consider if this aligns with its objectives for managing contagion risk.

Allowing for contagion risks explicitly in the ICAAP

In our view, ensuring the explicit consideration of contagion risks on the HBF from the insurer (and even the broader group) in the ICAAP would be an appropriate solution. This option would enable the standards to reflect the diversity of risk profiles and non-HBF activities of different insurers. However, we understand it would require supervisory follow-up and may impose a higher workload on the regulator, although one that could be adjusted to accommodate APRA's views on the attendant risk. This approach would allow the capital framework to reflect each individual insurer's risk and is potentially easier to implement for insurers.

Additional regulations on movement of capital out of the HBF

This option is also appropriate. It should target the ability of insurers to move capital out of the HBF to support other activities and/or to address the risk that activities outside of the HBF potentially create liabilities that are referrable to the HBF.

We suggest that APRA considers how restrictions on movement of capital could be designed in a similar way to that applying to life insurers. For example, life insurers face restrictions on the process for a statutory fund to declare dividends, which includes requiring Appointed Actuary advice and APRA approval where the intended dividend can only be funded through a reduction to their capital base. We do not anticipate that this requirement would have an adverse impact on insurer practices around dividend declarations.

Aside from dividends, APRA could also be given the powers to approve capital reductions such as share buybacks or the redemption, repurchase or repayment of any qualifying Common Equity Tier 1 Capital, Additional Tier 1 Capital and Tier 2 Capital instruments. APRA would base its decision on the insurer's forecast showing the projected capital position after the proposed capital reductions.

Although regulating the movement of capital out of the HBF improves the protection for policyholders, it may also have implications for the solvency of business activities conducted outside of the HBF but within the insurer. ARPA may also need to consider its tolerance for adverse events impacting the insurer, as opposed to just the HBF.

This option would be consistent with APRA's restrictions on other regulated entities. If the decisions are based on a clear set of rules, then this option is also potentially objective. However, where APRA applies subjectivity to its decision making, this potentially introduces complexity that is undesirable.

2.3 Level of sufficiency

The Institute supports a level of sufficiency that achieves consistency with APRA's other regulated entities. However, it is not possible to comment conclusively due to lack of detail around APRA's definition of "gone concern" in a PHI context.

99.5% and "gone concern"

APRA's proposal to target a 99.5% probability of sufficiency is reasonable given that:

- It is APRA's responsibility to determine the risk appetite and design standards that are consistent with its governing legislation; and
- the same probability of sufficiency applies to all insurance - Life, General and Private Health.

APRA's proposal that the probability of sufficiency requirement apply on a gone concern basis may have implications depending on how it intends to apply this. These are discussed elsewhere in our response. However, we believe that APRA should provide further guidance on what it means by "gone concern" basis.

Impact on insurers

The most obvious drawback of these changes is that, all else equal, they will result in higher minimum capital requirements. APRA states that it 'does not expect a material need to raise additional capital across the industry'. However, we note that the setting of target capital varies by insurer according to their appetite for breaching the regulatory minimum. Therefore, if an insurer's appetite for such a breach under the new regime is similar, this will increase the insurer's total capital accordingly. This could be material depending on the scale of the increase in the minimum capital requirements.

APRA also states that 'higher minimum capital requirements are not expected to impact premiums'. However, if additional capital is required to meet higher capital targets, then most of this would need to be funded from net profits on Health Insurance Business (HIB), which would require higher premiums (at least in the short term). This would be challenging to implement with the affordability issues currently facing the industry and we recommend that support for individual insurers' ability to transition be considered in determining timing and transition periods.

In times of an adverse event stress (a 1-in-200 year event) we note it will be important that the capital standards recognise, as soon as is reasonably possible, that such an event is occurring. One major implication should be allowing insurers' capital to temporarily breach the 99.5% probability of sufficiency, recognising that the buffers are operating as they should. It would be an excessively prudent system if insurers were required to maintain a 99.5% probability of sufficiency during a 1-in-200 year event stress.

From an insurer and policyholder perspective, it would be an excessively inefficient, inadequate and inaccessible system. The Institute recognises there will be practical difficulties in contemporaneously identifying with sufficient certainty how adverse an event is and notes this highlights the importance of open dialogue in such times between APRA and insurers.

2.4 Defining the capital base

Overall the Institute is supportive of the proposed changes to the composition of an insurer's capital base and minimum proportions of each capital tier. The Institute believes that the current timeframes for implementation will allow sufficient time for funds to transition to the new standards with minimum disruption or upheaval.

The Institute supports the proposal to allow mutuals an alternate method of accumulating sufficient CET1 capital and the proposed limits on how much MEIs can be counted towards CET1.

Consistency and Mutual Equity Interest

The changes proposed by APRA would align capital base restrictions and capital proportion requirements with those of general and life insurers, and would be consistent with the overall LAGIC principles that a significant proportion of the assets that the health fund uses to meet its Prudential Capital Requirement (PCR) should be unrestricted and freely available to meet policyholder obligations.

Allowing mutual funds to count MEIs towards the CET1 capital base may improve the resilience of smaller mutual health funds, and may provide additional capital with which to support growth activities that ultimately improve industry competition. The proposal to limit the proportion of an insurer's CET1 capital for MEIs to 25% is consistent with other industries and is an appropriately low level given the uncertainty around their underlying risk.

Impact on insurers

If there is a significant increase in regulatory capital requirements, some mutual funds may struggle to raise sufficient Tier 1 capital within the transitional period to remain PCR-compliant.

More stringent capital requirements will increase the cost of capital for health funds, which could potentially result in higher premiums under a LAGIC-style system if health funds attempt to retain current returns on capital.

Considerations

Some funds would be able to meet proposed restrictions with their current asset base, while some would need to raise additional CET1/Tier 1 capital, potentially creating a short-term disadvantage for insurers who have lean capital bases.

2.5 Valuing liabilities for capital purposes

The Institute agrees with the proposal that PHI capital standards be based on AASB 17 and the alignment of the commencement of the new PHI capital standards and implementation of AASB 17 for prudential purposes.

The Institute notes that the PHI draft prudential standards timeframe of Q3 2020 will precede AASB 17 prudential/reporting standards in Q4 2021. As such, liability valuation and other relevant aspects of the draft PHI capital standards may change after the consultation for AASB 17 draft standards. We strongly encourage that AASB 17 draft prudential standards include a proposed approach for the new PHI capital standards.

2.6 Prescribed capital and its components

This section has been split into five sub-sections dealing with each capital component of the PCA and the minimum prescribed capital:

- 2.6.1 Insurance risk and insurance concentration risk including a) prescribed factor component and b) prescribed adverse event stress
- 2.6.2 Asset risk and asset concentration risk
- 2.6.3 Operational risk
- 2.6.4 Aggregation benefit
- 2.6.5 Minimum prescribed capital

2.6.1 Insurance risk and insurance concentration risk

The Institute conceptually supports the proposed prescribed factor component. This approach is consistent with other industries and the Institute agrees that the approach would provide simplicity and comparability between insurers.

The Institute believes that the adverse event stress component which APRA proposes be part of the insurance risk charge also conceptually makes sense as it potentially captures events more severe than historical experience. We request that APRA provide further detail around the types of risks that it is trying to address through this component.

Ultimately, we believe that APRA needs to ensure that it is clear about how each risk is addressed through the capital framework - whether it is through the prescribed factor component, adverse event, capital management (ICAAP) and/or recovery planning. Achieving such clarity would help with providing greater definition around the adverse event stress and its approach towards aggregation benefits.

If it is not possible to make a clear distinction between the risks captured by the prescribed factor versus the adverse event, an allowance for aggregation benefits will be required. Alternatively, APRA may want to consider capturing the risk intended to be captured by the prescribed adverse event component in the design or calibration of the prescribed factor component. This approach provides simplicity and comparability between insurers.

Prescribed factor component

The Institute agrees with the proposal to have separate factors applying to risk exposure relating to liability for incurred claims and liability for remaining coverage. This approach is consistent with other industries and retains simplicity for calculation.

The Institute also supports the allowance for fund size and growth profile in the risk margins, to the extent they are supported by historical data. We note that under LAGIC for general insurance, there are no additional capital charges arising from insurer size, however growth profile is reflected through the operational risk amount. Other potential variabilities between insurers may be alternatively addressed through the insurer specific adjustment to the insurance risk charge rather than the risk margins.

With regards to the insurer specific adjustment, the Institute believes that this should be the responsibility of the insurer and the Appointed Actuary who we would expect to have the deepest understanding of the idiosyncratic risks that the insurer is exposed to. This could draw on stress testing a 1-in-200 year event as part of the ICAAP, for example. If these calculations were materially different to the prescribed factor and adverse event stress, then the adjustment could be applied to reflect the higher charge. The Institute would be willing to work with APRA to provide "guard rails" through the use of professional standards and guidance notes to support this responsibility resting with the insurer and the Appointed Actuary and not with APRA should APRA see merit in this approach.

For existing claims risk, the Institute notes that current reporting of the outstanding claims in the APRA HRF602 blends a number of different provisions, not all of which are subject to uncertainty. For example, it is common for insurers to hold a 'paid but not released' balance for approved claims which have not left the Fund's bank account on the valuation date. This provision is certain and insurers do not attach a risk margin to achieve (the current) 75% probability of sufficiency. However, the current guidance for APRA HFR602 is for these provisions to be reported as outstanding claims. The Institute recommends that APRA ensures its calibration of the risk factor will take this into account.

We also propose that the risk equalisation accrued liability on an insurer's balance sheet should be explicitly considered. The magnitude of risk equalisation charge should be consistent with the volatility inherent in the estimation of the risk equalisation accrued liability.

The Institute agrees with the proposed metrics for remaining coverage – expected premium revenue or estimate of claims liabilities over a fixed period, taking into account the revised approach under the upcoming AASB 17.

Prescribed adverse event stress

APRA should provide clarity on the types of risks that should be addressed and depending on the types of risks that APRA believes are not adequately captured through the prescribed factor, capital management or recovery plans, the Institute believes that having an adverse event stress component conceptually makes sense.

The Institute's stance, however, would require APRA to provide more detail on its overall approach to ensure that there is no double counting of risks.

We believe that a prescribed adverse event potentially makes sense if the following approach is being adopted:

- Treating the prescribed factor as dealing with risks that are idiosyncratic to the insurer. This would still leave industry wide events that could be dealt with through the prescribed adverse event stress.
- We define idiosyncratic risks to be those that an insurer is exposed to because of its specific business model and operations, leading to that risk varying uniquely by insurer. On the other hand, we define industry wide risks as those that the insurer has no control over, they are an outcome of events and decisions happening or being made by parties other than the insurer.

- Treating the differences between the prescribed factor and adverse event stress as reflecting differences in the practical ability for management to apply corrective action. This should tie in with APRA's definition of "gone concern".

To develop the prescribed adverse event in more detail, we offer APRA the following suggestions and observations:

- Consider what it means by a "gone concern" basis e.g. this could be a completely unmitigated scenario with no available actions over the risk exposure period. As an example, the Singapore stress testing regime for insurers requires scenario modelling with and without management actions for different exposure periods over a short (1 year) and medium term (5 year), with only a subset of management actions available in the short term. Applying this to the Australian PHI context could mean assuming no premium increases over the term of the adverse event.
- In addition to identifying the risks that are already captured by the prescribed factor, to further identify those risks that are also managed elsewhere. For example, the Commonwealth (and State) governments' plans on how to deal with a pandemic scenario. This potentially provides a boundary for where government responsibility starts and ends.
- APRA's proposed magnitude of the prescribed event stress (30%-50% change in memberships within 12 months), is a scenario that, on balance, we believe will be very unlikely to occur for large/medium sized insurers unless driven by government policy to drive PHI participation. This is informed by historical industry hospital insured persons data from 1970s. Since that time there have been significant lapse and growth events of the magnitude of 20-50% within a 1-year period, but only around times of significant changes in government policies (refer Figure 1 in the Institute's previous submission).
- Currently the prescribed adverse event is described as an absolute change in membership. However, some insurers may plan for significant changes to membership. Therefore, the risk for insurers in such a position is not the absolute level of growth but the actual growth being different to expected.
- The intention of the prescribed event for dealing with industry wide versus insurer specific risks would have flow on effects to risk equalisation. That is, an industry wide event may not impact on the relative contribution or receipt of risk equalisation for an individual insurer. However, a risk impacting the insurer but not the rest of the industry would potentially be mitigated by that insurer drawing on greater risk equalisation benefits from the rest of the industry.
- Whilst historically PHIs have made profits during pandemics (e.g. during SARS) we note that this could simply be deferring claims and hence losses. Therefore, there may be a pandemic style scenario that could be developed that creates stress for PHIs, although care would need to be taken when exploring the horizon. We note that in the current COVID-19 pandemic, insurers have deferred previously planned and approved premium increases and provided other forms of premium relief. Hospital claims are expected to have declined as well as most ancillary services claims due to social control measures. On the other hand, early signs are that claims for some other ancillary services, such as mental health, will increase even in the short term.

- When Lifetime Health Cover loading was introduced in 2000, some insurers subsequently experienced major losses due to mispricing from misunderstanding the impact of their waiting periods on first and second year claims and hence profits. This is another example of the potential deferral in the financial impact to the insurer sometime after the initial event.
- We note that a "gone concern" basis is one where membership growth is unlikely given that an insurer is closed to new business. Therefore, there is an inherent contradiction in requiring insurers to perform a growth driven adverse scenario whilst being in a state of "gone concern".
- It is challenging to identify a 1-in-200 year event given the limited historical data of PHI. The historical experience available (which is more than 200 insurer years of data) suggests that there are likely to be multiple factors contributing to an adverse outcome. The current COVID-19 pandemic stress has coincided with widespread economic stress from natural disasters (bushfires).
- APRA should consider individual insurer's stress testing and recovery plans in developing the prescribed adverse event stress.

In pursuing a prescribed adverse event, we believe there are some important considerations for APRA including:

- There may be implications for perverse incentives (e.g. if the membership impacts lead to a worse risk profile, this implies that the lapses were concentrated in the younger segment. Therefore, APRA should take care that it does not inadvertently discourage PHIs from seeking out younger members).
- The scenario and the parameters used for the adverse event stress have to be sufficiently prescriptive to ensure comparability between insurers.
- It is challenging to calibrate the stress event to achieve 99.5% probability of sufficiency.

Overall, whilst we conceptually support the need for a prescribed adverse event to capture risks not dealt with elsewhere in the capital framework, we believe that there are challenges for describing what such an event will look like.

Our suggestion is for APRA to consider an adverse event that is industry wide in cause and scale, one where no future premium increases are assumed, and a "gone concern" basis that limits other management actions as well.

2.6.2 Asset risk and asset concentration risk

The Institute agrees with adopting the LAGIC framework for asset risk and asset concentration risk. Notwithstanding our comments in section 2.2 on the approach for dealing with non-insurance business activities of the health insurer, in the main the PHI industry holds similar assets to those in the life and general insurance industry and hence the charges should align for consistency.

PHI Specific Assets

The main industry specific characteristic for which PHI needs differentiation is risk equalisation receivables/payables. An estimate of the risk equalisation provision for the latest quarter will be on the balance sheet as either an asset or liability. There needs to be recognition that this amount is an estimate and that there should be a charge that relates to this uncertainty. The focus of the capital charge should be on the accuracy of the estimate of the provision rather than the current LAGIC framework of liquidity, concentration and credit risks in the asset and asset concentration risk charges.

Recalibration of Asset Charges

The asset risk charge calibration was done a number of years ago when LAGIC was first introduced and has not been updated since. The Institute notes that the financial world has changed considerably since, the low cash rate in particular, and an update of the calibration factors or an analysis to show that it remains relevant would be a helpful addition to the industry discourse.

2.6.3 Operational risk

In line with the guiding principles, the Institute believes that a simple charge would be appropriate for operational risk. We recommend that any robust, and presumably more complex calculations, are balanced with the view that the charge is easy to implement. Any complex calculations will potentially have shortfalls and be subjective. In theory, operational risk losses are events that do not repeat in exactly the same manner. Hence, we believe it would be challenging to determine the dollar amount to hold for a future unknown event.

Linear vs non-linear

There are arguments both for and against each of a non-linear or linear charge.

Currently LAGIC is linear which is simple and easy to implement. The current PHI standards are non-linear with the $1 million charge having a relatively higher impact to smaller insurers.

Operational risk can happen to any insurer regardless of size. Therefore, we believe there is a base level of exposure for all insurers.

Beyond that, the number of employees, transactions performed, complexity of IT systems, robustness of risk controls and processes and so on will start to have an effect. In general, we believe these exposures increase with insurer size. Hence, it would not be unreasonable to adopt insurer size as a driver for operational risk exposure. We believe the linear LAGIC method can be adopted for simplicity and consistency.

Ultimately whichever method is adopted we agree that the relative proportion of the operational risk charge to the total PCA should be similar to the proportion in the current standards.

Scope of HBF

Conceptually we agree that operational risk should be applied for the whole licensed insurer however this has practical implications. While the nature of operational risk of insurance operations will have similarities across insurers, it will also vary according to the type of non-

insurance activity undertaken outside of the HBF. For example, the operational risk of running a dental centre is very different to the risk of selling white labelled travel insurance products.

Developing an appropriate exposure measure for those businesses and identifying a corresponding operational risk charge will require further analysis. This analysis would need to identify the root causes of operational risk in those businesses and even similar activities may present different operational risks depending on the insurer, due to its expertise in conducting that activity. In addition, referring to our earlier suggestions in section 2.2 care should be taken to ensure there is no overlap with asset risk charges on non-HBF activities, should that approach be adopted.

Alternatively, it may be worthwhile for APRA to consider this as a requirement for insurers to consider in the ICAAP, in other words the operational risk charge would only apply to the HBF. This would be in keeping with the principle of avoiding complexity and forming an approach that is easy to implement.

2.6.4 Aggregation benefit

We agree that insurance and asset risks are not perfectly correlated and therefore an aggregation benefit is appropriate. In determining an appropriate correlation factor for PHI, we recommend that APRA consider the underlying nature of PHI risks and to derive the factor from first principles, noting that this cannot be calibrated until the nature of the insurance risk charge is finalised. Based on our understanding of PHI versus other types of insurance, we would anticipate a correlation factor that is no higher than 0.2.

Consistent with LAGIC

The advantage of APRA's proposed formula is that it is:

- relatively simple, intuitive and transparent;
- identical to the current LAGIC formula for general and life insurers; and
- consistent with modelling approaches (square root formula combined with correlation matrix) adopted by international insurance regulatory frameworks (e.g. Solvency II, US RBC).

On this basis we see no reasons why the approach adopted should differ for PHI.

A suitable correlation factor for PHI

However, the challenge with APRA's proposed formula is setting an appropriate correlation factor that reflects the underlying risk profile of PHI.

We make the following observations for how the correlation factor is derived for other types of insurance and how that could apply to PHI:

- The correlation factor of 0.2 is the same as for all insurance business currently subject to LAGIC with the exception of lenders mortgage insurance (factor 0.5).
- The logic behind the correlation factor for lenders mortgage insurance being higher is that this type of insurance is more exposed to economic downturns. Specifically, during economic downturns, unemployment typically rises and the ability of borrowers to service their mortgages decreases leading to higher claims for this type of insurance.

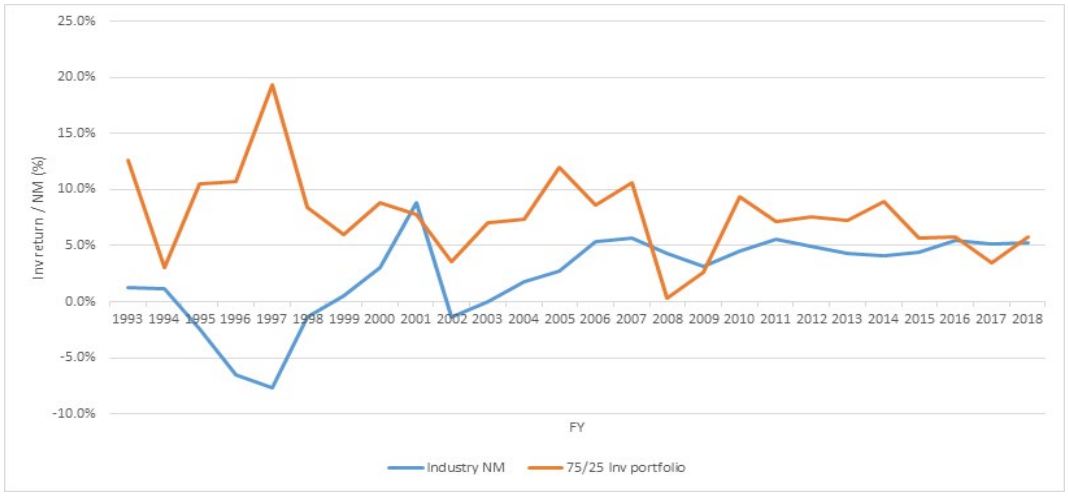
- For PHI, during economic downturns, the propensity for someone to go to hospital should be less affected as decisions to undergo treatment are mainly driven by their underlying physical wellbeing. To the extent that the treatment being sought is elective, the potential out-of-pocket costs could act as a deterrent for seeking that treatment. We note there may be some rationale for the level of mental wellbeing to suffer during an economic downturn but mental health claims, while significant, are still a relatively small component of overall industry claims. Therefore, our starting point is that the correlation factor should be lower than that for lenders mortgage insurance.
- Furthermore, for other types of insurance such as in life and workers compensation, economic downturns can often lead to policyholder decisions adversely affecting rates of return to work and recovery from a disablement. Therefore, we also believe that the correlation factor could be even lower than 0.2.

The Institute therefore sees no reason why the correlation factor should be higher for private health insurers than for other insurers and consideration be given to the factor potentially being lower than 0.2.

An analysis of correlation for PHI over the period 1993-2018 highlights how the correlation factor can change and underscores the challenge of understanding the correlation for PHI.

Graph 1 compares historic industry PHI net margin (as a proxy for insurance risk) with historic investment performance (as a proxy for asset risk). For simplicity it has been assumed that a typical PHI asset portfolio would comprise 75% Australian Bonds and 25% Australian Equities.

Graph 1: Illustration of Historical Industry Net Margins vs Investment Returns



Source: Net margins from APRA annual operations report; Investment returns from Vanguard 2018 Index Chart Report

Key features in the two dips during this period for Industry Net Margin are:

- 1995-1997: Industry faced reducing participation primarily from the young and price competition in Victoria in response to aggressive price reductions from Medibank Private
- In 2000-2002: The industry had rapid growth in participation (related to introduction of the combination of the Medicare Levy Surcharge (MLS) in July 1997, private health

insurance rebate in January 1999, and Lifetime Health Cover (LHC) in July 2000) and nil or low premium increases.

The analysis shows insurance and asset risks experienced:

- a correlation of -0.5 over the full period;
- a strong negative correlation of the order of -0.7 during 1993-1999; and
- a weak positive correlation of the order of 0.2 during 2000-2018.

While we recognise that this simple analysis does not cover a long period of data, it highlights how correlation can change.

We suggest APRA details the reasons for its proposed 0.2 correlation assumption.

2.6.5 Minimum prescribed capital

The Institute is not opposed to the proposed $5 million in minimum prescribed capital. While we note that some insurers may be impacted in the short term, we also note that this amount is consistent with general and life insurers and we do not expect it to have a material bearing on new market entrants.

Short term impact

We note that there may be some PHIs with limited options to raise capital and therefore may need a longer transition period than others to meet this requirement. This would place short term pressure on premiums and may even lead to the activation of recovery plans (e.g. reduced investment risk profile and/or a redirection of strategic plans).

Market Entry

While a number of insurers have commenced operations with a minimum capital requirement (MCR) of less than $5 million in recent years, it would be reasonable to expect that the MCR of a new insurer would grow to more than $5 million within 5 years, thus a minimum requirement of $5 million is not an unreasonable starting requirement. Under the current standards once an insurer has more than 3,000 policyholders we would ordinarily expect its MCR to exceed $5 million. It would be hard to imagine new market entrants entertaining growth plans that would limit them to this size.

Indexation

The indexation of the minimum amount is not likely to be a material consideration for some years. Theoretically it could be indexed to the headline/average premium increase to reflect a proxy for the general growth of insurance risk. Practically this could be rounded to the nearest $250,000 increment. Alternatively, the amount could be left unindexed and reviewed every five years.

A consistent approach should be adopted across all regulated industries, unless there is good reason not to.

2.7 Supervisory Adjustments

The Institute believes that is it sensible for APRA to have wide discretion to adjust regulatory minimum capital requirements as it sees appropriate and in line with its governing legislation and management of objectives.

We would expect the number of adjustments made to be relatively small. If a large number of adjustments need to be made, this may indicate that the capital standards require revision.

2.8 Capital management planning

In principle, the Institute believes it is sensible to adopt ICAAP for PHI, achieving consistency in the way capital is managed across life insurers, general insurers and ADIs.

Enhances PHI capital management

To the extent there are elements of the ICAAP that are enhancements compared with the existing practice around capital management, this will be beneficial for the PHI sector. This includes the requirement to perform stress testing and scenario analysis, although we note that many private health insurers are already performing these as part of developing their capital management and recovery plans.

We also support APRA's proposal to enhance the ICAAP by incorporating elements of existing PHI capital standards (namely, to establish a pricing philosophy and investment rules). These are good practices that should be kept for PHI and potentially considered for APRA's other regulated entities.

Non-insurance business activities

Elsewhere in our submission, we have discussed the considerations around APRA's proposed scope of the capital standards and to also consider whether certain risks are best dealt with via a risk charge or through the ICAAP. We believe that exploring how non-PHI business could be captured within the ICAAP would be worthwhile and would be in keeping with the principle of avoiding complexity.

Implementation

From an implementation perspective, we note that some insurers may find the ICAAP supporting documentation requirements onerous and would support insurers being allowed sufficient transition time. We also note that APRA has said it will be requiring a private health insurer to perform a "more comprehensive and transparent assessment of its risk profile". We support this conceptually and will look for greater detail from APRA at the next consultation on what this would or may look like.

2.9 HPS 100 Solvency Standard

In principle, we agree that the move to LAGIC for private health insurers will act as a baseline on the quality and liquidity of PHI assets.

Currently, CPS220 requires that the Head of a group must maintain a Board-approved liquidity management policy for the group to adequately and consistently identify, measure, monitor and manage its material liquidity risks. The policy must include a strategy that ensures the

group has sufficient liquidity to meet its obligations as they fall due, including in stressed conditions, and outline processes to identify existing and potential constraints on the transfer of funds within the group. The Head of a group must submit to APRA a copy of its group liquidity management policy as soon as practicable, and no more than 10 business days, after Board approval. The Institute supports this qualitative requirement and believes it should apply at insurer level rather than HBF level.

3. Discussion of APRA's Implementation Proposals

Ultimately the time required will depend on the complexity of the changes APRA proposes. For example, if APRA does not significantly increase regulatory capital requirements, or increase the complexity of capital management, implementation will generally be straight forward.

The necessity of aligning implementation with AASB 17 will also depend on the changes APRA ultimately proposes. If AASB 17 were further delayed, APRA could continue with the current implementation timetable, and update the relevant components of the capital calculations when required.