

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) Rules 2007

Authority for the Rules

The *Private Health Insurance (Health Benefits Fund Administration) Rules 2007* (the **Rules**) are made by the Private Health Insurance Administration Council (the **Council**) under item 1 of the table in section 333-25, for the purposes of Part 4-4 of the *Private Health Insurance Act 2007* (the **Act**).

Section 333-25 of the Act provides that the Council may make rules providing for:

- (a) matters required or permitted by the corresponding Chapter, Part or section of the Act to be provided; or
- (b) necessary or convenient to be provided in order to carry out or give effect to that Chapter, Part or section.

The Rules are a legislative instrument for the purposes of the *Legislative Instruments Act 2003*.

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

Purpose of the Rules

The purpose of these rules is to specify requirements for the administration and operation of health benefits funds, including requirements about the expenditure and application of fund assets, restructure of health benefits funds and merger and acquisition of health benefits funds. The rules specify risk equalisation jurisdictions for the purposes of the Act and establish solvency and capital adequacy standards for the conduct of health benefits funds.

The Rules largely replace processes and requirements that were in place under the regulatory regime created by the *National Health Act 1953* (the **National Health Act**).

If these Rules were not made, the new regulatory regime created by the Act would be ineffective. Various matters that were dealt with in the National Health Act or by conditions of registration imposed under that Act, are to be dealt with in rules made under the Act, under the new legislative framework. Further, various matters that previously were dealt with in Council determinations and circulars are now to be legislated in rules made under the Act.

The Rules:

- deal with matters relating to borrowings, mortgages and charges which a private health insurer is permitted to enter into for the purposes of its health benefits fund(s) (subsections 137-10 (3) and (4) of the Act);

- specify requirements relating to the restructure of the health benefits funds of an insurer, including what must be included in an application for approval, criteria for Council approval of the restructure proposal, the time when a restructure is taken to have effect and policy holder notification requirements (section 146-1 of the Act);
- specify requirements relating to the merger and acquisition of health benefits funds between insurers, including what must be included in an application for approval, criteria for Council approval of the transfer arrangements, the time when a transfer is taken to have effect, certification requirements and notification requirements (section 146-5 of the Act);
- specify the areas that are risk equalisation jurisdictions for the purposes of the Act (subsection 146-1 (6) of the Act);
- establish a solvency standard for the purposes of Division 140 of the Act (subsection 140-5 (1) of the Act);
- establish a capital adequacy standard for the purposes of Division 143 of the Act (subsection 143-5 (1) of the Act).

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

Summary of impact of the Rules

The Rules were prepared under RIS ID 8072.

The likely impact of the Rules is small as they largely replace processes and requirements that were in place under the National Health Act.

Consultation

A draft of the Rules was issued publicly on 7 February 2007. The draft solvency and capital adequacy standards were issued for comment separately on 12 January 2007. There were also public consultation forums on 19 February and 23 February 2007, where input on these rules was sought.

Comments received as a result of the consultation process were taken into account by the Council in finalising these rules.

ATTACHMENT

DETAILS OF THE *PRIVATE HEALTH INSURANCE (HEALTH BENEFITS FUND ADMINISTRATION) RULES 2007***PART 1 PRELIMINARY****1. Name of Rules**

Rule 1 provides that the title of the Rules is the *Private Health Insurance (Health Benefits Fund Administration) Rules 2007*.

2. Commencement

These Rules commence:

- (a) if the Rules are registered before the Act commences—at the same time as the Act commences; or
- (b) if the Rules are registered on or after the day on which the Act commences—on the date on which the Rules are registered,

whichever occurs first.

The Rules do not have retrospective application.

3. Definitions

Rule 3 defines terms used in the Rules.

PART 2 EXPENDITURE AND APPLICATION OF HEALTH BENEFITS FUNDS**4. Mortgages and charges**

Rule 4 specifies the purposes for which, and conditions on which, a private health insurer may enter into a mortgage and charge relating to assets of a health benefits fund. It is stated that a mortgage or charge must be for the sole purpose of the benefit of the business of the fund, or funds. This is subject to the conditions specified in subrules (2) and (3), which relate to the terms of the mortgages and charges, their impact on the insurer's ability to comply with solvency and capital adequacy requirements and the need for the transaction to be the subject of actuarial advice or to be consistent with a pre-existing statement or policy of the insurer that has been developed with regard to actuarial advice.

5. Borrowings

Rule 5 specifies the circumstances in which a private health insurer may borrow money for the purposes of the business of the health benefits fund. A borrowing can be by way of subordinated debt within the meaning of the Rules, by means of a bank overdraft, to cover settlement of certain transactions to acquire an asset for the fund and for other purposes subject to specified limits about the nature and extent of the borrowing.

PART 3 RESTRUCTURE

6. Restructure under section 146-1 of the Act

Rule 6 allows an insurer to apply to the Council for approval to restructure its health benefits funds and sets out the information to be included in the restructure proposal that is to be provided by the insurer to the Council for that purpose.

Subrule 6 (2) sets out the required content of the restructure proposal that the application must contain in order for the Council to consider whether or not to approve the restructure.

Subrule 6 (3) specifies how an insurer may meet requirements set out in subclause (2).

7. Requirements in relation to a restructure

Rule 7 sets out certain information to be provided by the insurer to the Council that is to accompany an application for approval of a restructure proposal.

Under subrule 7 (1), this includes:

- a business plan for the receiving fund covering the first 36 months of its operation from the restructure date. The business plan is to set out in detail various specified matters;
- a certification by an officer of the insurer that the Board or governing body of the insurer has considered the restructure proposal and is of the view that it meets the requirements of the Act, and any regulations and rules made under it (including these Rules);
- a report from the insurer's appointed actuary which confirms that the business plan is well-founded, confirms that the assets and liabilities to be transferred represent a reasonable estimate of the asset position of the transferring fund or funds immediately before the restructure and makes certain statements about the effect of the restructure on premiums, benefits and compliance with applicable standards;
- a copy of statements, if any, issued in accordance with subsections 93-20 (2) and 93-20 (4) of the Act, if such statements have been provided by the insurer to policy holders prior to the application. A summary of any submissions received from a policy holder of the relevant fund in relation to the restructure are also to be provided.

Subrule 7 (2) requires the insurer to procure, prior to the restructure date, any amendments to its constitution and rules required for the restructure proposal to take place.

Subrule 7 (3) requires the insurer to take, prior to the restructure date, all steps required by laws under any other law of the Commonwealth, a State or Territory for the restructure to take place.

8. Criteria for approving or refusing a restructure

Rule 8 sets out criteria to be used by the Council in making a decision about whether to approve or refuse an insurer's application to restructure its health benefits funds under section 146-1 of the Act.

The matters set out in rule 8 include criteria for determining whether the proposed distribution of assets and liabilities between receiving funds is not fairly distributed, which relates to the proposed distribution causing, or contributing to causing, the insurer to be in breach of the Act, regulations, Rules or solvency or capital adequacy directions.

A decision to refuse an application for a restructure is a reviewable decision under section 328-5 of the Act.

Section 146-1 of the Act sets out other grounds on which a restructure may be refused (including that the restructure may result in unfairness to policy holders of the affected fund).

9. How a restructure takes place

Rule 9 sets out how a restructure takes place, in relation to the policies, assets and liabilities of a fund subject to a restructure once the Council has granted approval of the restructure proposal and all actions necessary to enable the restructure to take place have been taken.

10. Notification to interested persons of the outcome of an application

Rule 10 specifies;

- notice to be given by insurers about the outcome of an application to restructure, any appeals of decisions to refuse such an application and any appeal outcomes; and
- timeframes within which an insurer must issue give the notice.

Under the rule, notice must be given to at least one adult insured or, for a policy covering no adults, the person who paid the premium, under each policy to be made referable to another fund.

PART 4 MERGER AND ACQUISITION OF HEALTH BENEFITS FUNDS

11. Merger and acquisition under section 146-5 of the Act

Under section 146-5 of the Act, a private health insurer may enter into an arrangement with one or more other private health insurers for the transfer of policies, assets and liabilities of a health benefit fund or funds are transferred to another insurer's or insurers' funds. However, the arrangement has no effect unless the insurers have applied jointly to the Council for approval of the arrangement, the Council approves the arrangement and the insurers have complied with any requirements in the Rules.

Rule 11 specifies the information that must be provided to the Council in an application for approval of the arrangement. The insurers must provide a written and signed record of the arrangement to the Council. The arrangement must contain all the information specified in subrule 11(3).

12. Requirements in relation to a merger or acquisition

Rule 12 specifies information that must be provided to the Council by the parties as the application to the Council for approval of the arrangement.

Under subrule 12 (1), this includes:

- a business plan for the receiving fund covering the first 36 months of its operation from the transfer date. The business plan is to set out in detail various specified matters;
- a certification by an officer of the insurer that the Board or governing body of the insurer has considered the arrangement and is of the view that it meets the requirements of the Act, and any regulations and rules made under it (including these Rules);
- a report from the insurer's appointed actuary which confirms that the business plan is well-founded, confirms that the assets and liabilities to be transferred represent a reasonable estimate of the asset position of the transferring fund or funds immediately before the transfer take place and makes certain statements about the effect of the restructure on premiums, benefits and compliance with applicable standards; and
- a copy of statements required to be made under subsections 93-20 (2) and 93-20 (4) of the Act, and copies of any submissions received from policy holders affected by the transfer.

Subrule 12 (2) requires the insurer to procure, prior to the transfer date, any amendments to its constitution or rules required for the restructure proposal to take place.

Subrule 12 (3) requires the insurer to take, prior to the transfer date, all steps required by law for the restructure to take place. The insurers must comply with laws such as those relating to the transfers of assets, contracts, transfer of bank accounts.

13. Criteria for approving or refusing a merger or acquisition

Rule 13 sets out criteria to be used by the Council in making a decision about whether to approve or refuse an application under section 146-5 of the Act.

The matters set out in rule 13 include criteria for determining whether the proposed distribution of assets and liabilities between receiving funds is not fairly distributed, which relates to the proposed distribution causing, or contributing to causing, a transferee insurer to be in breach of the Act, regulations, Rules or solvency or capital adequacy directions.

14. How a merger or acquisition takes effect

Rule 14 specifies how a merger or acquisition takes effect.

15. Notification to interested persons of outcome of section 146-5 application

Rule 15 specifies notification which insurers must give to interested persons of the outcome of an application.

PART 5 Risk equalisation jurisdictions

16. Areas that are risk equalisation jurisdictions

Rule 16 specifies the areas that are risk equalisation jurisdictions for the purpose of subsection 146-1 (6) of the Act.

17. Working out the policy group for a policy that has two or more policy holders whose addresses are not in the same risk equalisation jurisdiction

Rule 17 specifies the process by which an insurer can make a written determination to allocate to a single risk equalisation jurisdiction a policy that covers two or more policy holders whose addresses are not in the same risk equalisation jurisdiction.

Under subrule 17 (4) if an insurer does not make a determination in respect of a policy that covers two or more policy holders whose addresses are not in the same risk equalisation jurisdiction, or if it refuses to give the Council access to that determination in response to a written request, the policy is allocated to the risk equalisation jurisdiction applicable to the first person named in the policy records of the insurer.

PART 6 Solvency and capital adequacy standards

18. Solvency standard

Rule 18 establishes a solvency standard for the purposes of Division 140 of the Act.

The solvency standard is set out in Schedule 2 to the Rules (see below).

19. Capital adequacy standard

Rule 19 establishes a capital adequacy standard for the purposes of Division 143 of the Act.

The capital adequacy standard is set out in Schedule 3 to the Rules (see below).

SCHEDULE 1 RESTRUCTURES AND TRANSFERS

1. Trust

Clause 1 provides requirements for the trust arrangement referred to in subrule 11 (2).

2. Actions for transfer of assets and liabilities

Clause 2 sets out actions to be undertaken by an insurer to transfer assets and liabilities to another insurer in accordance with a scheme associated with the transfer of a health benefits fund.

SCHEDULE 2 SOLVENCY STANDARD

PART 1 INTRODUCTION

1. Purpose of solvency standard

Clause 1 states the provisions of the Act to which the solvency standard relates and the purpose of the standard.

Subclause 1 (2) provides that the solvency reserve to be calculated under the solvency standard is to be based on a run-off view of the fund in order to ensure that the insurer will be able to meet the liabilities of the fund in the event that the fund is terminated.

2. Application

Clause 2 provides that the solvency standard applies to each fund conducted by an insurer.

3. Interpretation

Subclause 3 (1) defines terms used in the standard.

Subclause 3 (2) requires the application of relevant accounting standards in the valuation of assets and liabilities under the standard.

Subclause 3 (3) provides that the management capital amount for each fund is \$1 million. This amount is used in the calculation of the solvency reserve in clause 6 of the standard.

4. Related parties

Clause 4 defines a related party for the purposes of the standard. This term is used in Part 7 of the Standard, which specifies the inadmissible assets amount for a fund.

PART 2 Solvency Reserve

5. Solvency Obligation

Clause 5 imposes on an insurer a solvency obligation in relation to each of its health benefits funds.

Subclause 5 (1) provides that an insurer must at all times keep its health benefits funds solvent by ensuring that the value of the capital of each fund equals or exceeds the solvency reserve for the fund calculated under this standard at the valuation date.

Subclause 5 (2) requires an insurer to disclose in its financial statements the solvency reserve for each of its funds.

6. Determination

Clause 6 imposes on an insurer a requirement to determine the solvency reserve for each fund.

Subclause 6 (1) requires an insurer to determine the solvency reserve for each of its funds in accordance with the standard.

Subclause 6 (2) specifies the elements of the calculation of the solvency reserve. The calculation of those amounts is detailed later in the standard, with the exception of the management capital amount, which is defined as \$1 million for each fund.

7. Treatment of negative amounts in calculations

Clause 7 provides that an amount or a component of an amount calculated under this standard which results in a negative value will be taken to be zero.

PART 3 PRINCIPLES

8. Asset exposure

Clause 8 requires an insurer to take account of certain asset and investment risks related to the insurer in applying the standard.

9. Integrity of asset risk calculations

Clause 9 requires an insurer to determine whether to increase amounts calculated under this standard to ensure solvency in light of risks associated with diversification, liquidity and credit risks.

10. Discounting of insurance liabilities

Clause 10 provides the basis on which discounting of future claims liabilities is permitted under the standard.

11. Adjustment for taxation

Subclause 11 (1) provides for adjustment of the solvency insurance liabilities amount to account for the impact of taxation.

Subclause 11 (2) provides for adjustment relating to tax benefits arising from increases in liabilities.

PART 4 MATERIALITY

12. Materiality standards

Clause 12 provides a materiality test to enable simplification of valuations that are to be undertaken in the determination of the amounts that comprise the solvency reserve under the standard.

Subclause 12 (1) provides that if an amount is material in accordance with the clause, strict compliance with the standard is required in its calculation for the purposes of determining the solvency reserve of the fund. Where an estimated amount is immaterial under this clause, a reasonable alternative valuation method can be adopted.

Subclauses 12 (2) and 12 (3) specify the method for determining whether amounts are material or immaterial for the purposes of the standard.

Subclause 12 (4) requires an insurer to consider at each reporting date whether detailed valuations are required to demonstrate the continued appropriateness of any alternative valuation methods that have been adopted.

PART 5 EXPENSE AMOUNT

13. Calculation of the expense amount

Clause 13 provides the formula to calculate the expense amount for the purposes of the determination of the solvency reserve. Non-claim expenses are expenses of the fund other than benefit payments.

PART 6 SOLVENCY INSURANCE LIABILITIES AMOUNT

This Part provides for the calculation of an amount, which forms part of the solvency reserve, to provide for the risks arising from assumptions in valuing the accrued liabilities of the fund.

14. Calculation of solvency insurance liabilities amount

Clause 14 provides for the calculation of the solvency insurance liabilities amount, being the sum of the components set out in clauses 15 and 16.

15. Calculation of solvency health insurance liabilities component

Clause 15 sets out the four components that when added together, form the solvency health insurance liabilities amount.

16. Calculation of solvency health-related insurance liabilities component

Clause 16 sets out the two components that when added together, form the solvency health-related insurance liabilities amount.

17. Outstanding claims liability

Clause 17 provides for the calculation of liabilities of a fund in respect of outstanding claims, which is part of the health insurance liabilities component and the health-related insurance liabilities component.

The outstanding claims liability is a central estimate of all outstanding claims liabilities at the valuation date. Historical data must be considered in calculating the outstanding claims liability.

There will be two different outstanding claims liability components calculated for each fund: one for health insurance business of the fund, and one for any health-related insurance business of the fund.

18. Risk equalisation outstanding claims liability

Clause 18 provides for the calculation of the risk equalisation outstanding claims liability, which is part of the risk equalisation outstanding claims component of the solvency health insurance liabilities component.

19. Unearned premium liability and unexpired risk liability

Clause 19 provides for the calculation of the unearned premium liability and unexpired risk liability, which is part of the health insurance liabilities component and the health-related insurance liabilities component.

PART 7 INADMISSIBLE ASSETS AMOUNT

20. Calculation of the inadmissible assets amount

Clause 20 provides for the calculation of the inadmissible assets amount, which is a part of the solvency reserve, to reflect certain asset risks to the fund.

Subclause 20 (1) provides that the inadmissible assets amount is the sum of components that reflect risks associated with:

- assets which have values that are dependent upon the continuation of the business;
- holdings in an associate and subsidiary entities; and
- asset concentration.

21. Assets used for the conduct of business component

Clause 21 provides for the calculation of a component that represents the amount by which the value of the assets of a fund would be reduced if it was in a run-off situation.

Subclause 21 (1) specifies that the component is the amount by which the stated value of the assets exceeds the value that the assets would have if the fund was in terminating management.

Subclause 21 (2) specifies requirements to be observed in the valuation of assets in the calculation of the component.

22. Holdings in associate and subsidiary entities component

Clause 22 provides for the calculation of a component that represents the value to a fund of its holdings in associate and subsidiary entities.

Subclause 22 (1) requires an insurer to determine the value of a fund's holdings in associate and subsidiary entities.

Subclauses 22 (2) to (4) specify requirements to be observed in the calculation of the component.

23. Asset concentration risks component

Clause 23 provides for the calculation of a component that represents the risks to the fund arising from asset or credit concentration risks.

Subclause 23 (1) specifies that the component is the sum of the amounts by which any asset of the fund of a kind listed in subclause (2) exceeds the amount specified in that subclause for that kind of asset. For any other kind of asset, the component is calculated as the amount by which any such asset exceeds 10 per cent of the value of the assets of the fund.

Subclause 23 (2) specifies, for the purposes of the calculation in subclause (1), the relevant amounts for various kinds of assets.

PART 8 RESILIENCE AMOUNT

24. Determination of resilience amount

Clause 24 provides for the calculation of an amount that represents the risk to the assets of a fund associated with the occurrence of shocks to the economic environment.

Subclause 24 (1) specifies the formula for the determination of the resilience amount for a fund.

Subclause 24 (2) prescribes the formulae to be applied to asset values to reflect the economic changes applicable to the assets of the fund that fall within the classes listed in the table.

Subclause 24 (3) defines the diversification factor (DF) which appears in the formulae in the table in subclause (2).

PART 9 SUBORDINATED DEBT AND ALTERNATIVE SOURCES OF CAPITAL

25. Overview

Subclause 25 (1) states the purpose of the Part, which is to specify the terms on which subordinated debt qualifies as subordinated debt within the meaning of the Part and to specify the amount of subordinated debt that may be counted for the purposes of the standard.

Subclause 25 (2) provides that the capital adequacy obligation may be satisfied from either shareholder or member capital or the use of alternative sources of capital support where the obligations to the debtor are subordinate to the other obligations of the fund.

Subclause 25 (3) specifies that it is only subordinated debt within the meaning of the Part that will qualify as an alternative source of capital for the purposes of the standard.

26. Subordinated debt

Clause 26 specifies requirements for debt to be subordinated debt within the meaning of the Part.

Subclause 26 (1) requires proposals to issue or borrow subordinated debt to be approved by the Council before the debt can be taken into account under the standard.

Subclauses 26 (2) to (4) specify further requirements for the approval of subordinated debts and for their continued application under the standard.

27. Amount of subordinated debt to be counted

Clause 27 provides the maximum amount of subordinated debt that may be counted for the purposes of the standard.

Subclause 27 (1) provides the maximum amount of subordinated debt that may be counted for the purposes of the standard.

Subclauses 27 (2) and (3) provide a transitional treatment for funds to count for the purposes of this standard subordinated debts that were approved under the previously applicable standards made under the National Health Act.

SCHEDULE 3 CAPITAL ADEQUACY STANDARD

PART 1 INTRODUCTION

1. Purpose of capital adequacy standard

Clause 1 of the standard states the provisions of the Act to which the capital adequacy standard relates and the purpose of the standard.

Subclause 1 (2) provides that the capital adequacy reserve to be calculated under the capital adequacy standard is to be an assessment of the financial strength of the fund as an ongoing operation, in particular its ability to remain solvent for at least the next three years.

2. Application

Clause 2 provides that the capital adequacy standard applies to each fund conducted by an insurer.

3. Interpretation

Subclause 3 (1) defines terms used in the standard.

Subclause 3 (2) requires the application of relevant accounting standards in the valuation of assets and liabilities under the standard.

4. Related parties

Clause 4 defines a *related party*. This term is used in Part 9 of the Standard, which specifies the inadmissible assets amount of a fund.

PART 2 CAPITAL ADEQUACY RESERVE

5. Capital adequacy obligation

Clause 5 imposes on an insurer a capital adequacy obligation in relation to each of its health benefits funds.

Subclause 5 (1) provides that an insurer must at all times maintain adequate capital within its health benefits funds by ensuring that the value of the capital of each fund equals or exceeds the capital adequacy reserve for the fund calculated under this standard at the valuation date.

Subclause 5 (2) requires an insurer to disclose its capital adequacy reserve to the Council.

6. Determination

Clause 6 imposes on an insurer a requirement to determine the capital adequacy reserve for each fund.

Subclause 6 (1) requires an insurer to determine the capital adequacy reserve for each of its funds in accordance with the standard.

Subclause 6 (2) specifies the elements of the calculation of the capital adequacy reserve, which in light of the terms of paragraph (b), will be a minimum of \$1.5 million for each fund.

7. Treatment of negative amounts in calculations

Clause 7 provides that an amount or a component of an amount calculated under this standard which results in a negative value will be taken to be zero.

PART 3 PRINCIPLES

8. Asset exposure

Clause 8 requires an insurer to take account of certain asset and investment risks related to the insurer in applying the standard.

9. Integrity of asset risk calculations

Clause 9 requires an insurer to determine whether to increase amounts calculated under this standard to ensure solvency in light of risks associated with diversification, liquidity and credit risks.

10. Discounting of insurance liabilities

Clause 10 provides the basis on which discounting of future claims liabilities is permitted under the standard.

11. Adjustment for taxation

Subclause 11 (1) provides for adjustment of the solvency insurance liabilities amount to account for the impact of taxation.

Subclause 11 (2) provides for adjustment relating to tax benefits arising from increases in liabilities.

PART 4 MATERIALITY

12. Materiality standards

Clause 12 provides a materiality test to enable simplification of valuations that are to be undertaken in the determination of the amounts that comprise the capital adequacy reserve under the standard.

Subclause 12 (1) provides that if an amount is material in accordance with the clause, strict compliance with the standard is required in its calculation for the purposes of determining the capital adequacy reserve of the fund. Where an estimated amount is immaterial under this clause, a reasonable alternative valuation method can be adopted.

Subclauses 12 (2) and 12 (3) specify the method for determining whether amounts are material or immaterial for the purposes of the standard.

Subclause 12 (4) requires an insurer to consider at each reporting date whether detailed valuations are required to demonstrate the continued appropriateness of any alternative valuation methods that have been adopted.

PART 5 CAPITAL ADEQUACY MARGIN

13. Determination of capital adequacy margin

Clause 13 provides the methodology for calculating the capital adequacy margin which is used in the calculation of the capital adequacy insurance liabilities amount and renewal option amount. The margin must be 12.5% or more. While there is no upper limit for the margin, a high value would be around 30%.

Subclause 13 (1) requires an insurer to determine the margin for risk to be used in certain calculations under this standard.

Subclause 13 (2) specifies the method for determining the margin. The margin is calculated by a progressive sum of the minimum capital adequacy margin value (12.5%), the fund size value calculated under subclause (3) and an additional qualitative margin determined in accordance with subclause (5)..

Subclause 13 (3) sets out the method for determining the fund size value, based on the number of hospital SEUs of the fund. A hospital SEU has the same meaning in this standard as in the *Private Health Insurance (Risk Equalisation Policy) Rules 2007*.

Subclause 13 (5) provides broad principles to be applied by the board or equivalent governing body of the insurer to determine the additional qualitative margin for the fund.

PART 6 CAPITAL ADEQUACY INSURANCE LIABILITIES AMOUNT

This Part provides for the calculation of an amount, which forms part of the capital adequacy reserve, to provide for the risks arising from assumptions in valuing the accrued liabilities of the fund.

14. Calculation of capital adequacy insurance liabilities amount

Clause 14 provides for the calculation of the capital adequacy insurance liabilities amount, being the sum of those components set out in clauses 15 and 16.

15. Calculation of capital adequacy health insurance liabilities component

Clause 15 details the three components that when added together, form the capital adequacy health insurance liabilities amount.

16. Calculation of capital adequacy health-related insurance liabilities component

Clause 16 details the calculation of the capital adequacy health-related insurance liabilities amount.

17. Outstanding claims liability

Clause 17 provides for the calculation of liabilities of a fund in respect of outstanding claims, which is part of the health insurance liabilities component and the health-related insurance liabilities component.

The outstanding claims liability is a central estimate of all outstanding claims liabilities at the valuation date. Historical data must be considered in calculating the outstanding claims liability.

There will be two different outstanding claims liability components calculated for each fund: one for health insurance business of the fund, and one for any health-related insurance business of the fund.

18. Risk equalisation outstanding claims liability

Clause 18 provides for the calculation of the risk equalisation outstanding claims liability, which is part of the risk equalisation outstanding claims component of the capital adequacy health insurance liabilities component.

PART 7 RENEWAL OPTION AMOUNT

19. Calculation of renewal option amount

Clause 19 provides for the calculation of an amount, which forms part of the capital adequacy reserve, to provide for the risks and potential costs associated with policy renewal and the consequences for available capital of the intended business plans of the insurer.

Subclause 19 (1) provides that the amount is to be calculated separately for the health insurance business and health-related business of the fund over a 12-month projection period from the valuation date.

Subclauses 19 (2) to (4) specify the method for calculating the renewal option amount.

20. Health insurance business and health-related insurance business projection

Subclause 20 (1) provides for the calculation of the projection for health insurance business and health-related insurance business based on the insurer's current business plan.

Subclause 20 (2) specifies the projection method to be applied in cases where the amounts in the business plan has not been determined on a best estimate basis.

Subclauses 20 (3) to 20 (5) set out the method for carrying out the business projection.

Subclause (5) specifies various amounts that are to be included in the business projection and the clauses in which the calculation of the amounts is detailed.

21. Earned premium income

Clause 21 sets out the method for the calculation of the projected premium income of a fund to be included in the insurance business projection. Premium income must be based either on the current business plan, or existing premium rates.

22. Benefit claims

Clause 22 sets out the method for the calculation of the projected benefits claims of a fund to be included in the insurance business projection. Projected gross benefits claims are determined by calculating the benefit ratio applicable to the membership of the fund over the effective premium rate for the projection period, with an allowance for options provided to members.

23. Risk equalisation levy and payments

Clause 23 sets out the method for the calculation of risk equalisation levy and payments to be included in the insurance business projection.

24. Administration and other expenses

Clause 24 sets out the method for the calculation of administration and other expenses to be included in the insurance business projection. Administration and other expenses must be calculated in accordance with subclause 24 (1), and then, pursuant to clause 19 multiplied by an amount 50% of the margin.

25. Investment earnings rate

Clause 25 provides the rate of investment earnings to be adopted in the calculation of the insurance business projection.

26. Other business projection

Clause 26 sets out the method for the calculation of a projection for health-related other business conducted by the insurer. The method of calculation is to be based on the same principles that apply to the calculation of the health insurance business and health-related insurance business projection.

PART 8 BUSINESS FUNDING AMOUNT

27. Determination of the business funding amount

Clause 27 provides for the calculation of an amount, which forms part of the capital adequacy reserve, to provide for planned business growth or other relevant business development strategies that are likely to absorb capital and impact on the ability of the fund to meet its solvency obligation over the next three years.

Subclause 27 (2) sets out the method for the calculation of the business funding amount, which includes an amount for new business capital calculated in accordance with subclause (3).

PART 9 INADMISSIBLE ASSETS AMOUNT

28. Calculation of the inadmissible assets amount

Clause 28 provides for the calculation of an amount that forms part of the capital adequacy reserve, to reflect certain asset risks to the fund.

Subclause 28 (1) provides that the inadmissible assets amount is the sum of components that reflect risks associated with:

- holdings in an associated and subsidiary entities; and
- asset concentration.

29. Holdings in associate and subsidiary entities

Clause 29 provides for the calculation of a component that represents the value to a fund of its holdings in associate and subsidiary entities.

Subclause 29 (1) requires an insurer to determine the value of a fund's holdings in associate and subsidiary entities.

Subclause 29 (2) specifies the treatment of minimum capital requirements that regulators may impose upon associate and subsidiary entities.

30. Asset concentration risks component

Clause 30 provides for the calculation of a component that represents the risks to the fund arising from asset or credit concentration risks.

Subclause 30 (1) specifies that the component is the sum of the amounts by which any asset of the fund of a kind listed in subclause (2) exceeds the amount specified in that subclause for that kind of asset. For any other kind of asset, the component is calculated as the amount by which any such asset exceeds 10 per cent of the value of the assets of the fund.

Subclause 30 (2) specifies, for the purposes of the calculation in subclause (1), the relevant amounts for various kinds of assets.

PART 10 RESILIENCE AMOUNT

31. Determination of resilience amount

Clause 31 provides for the calculation of an amount that forms part of the capital adequacy reserve that represents the risk to the assets of a fund associated with the occurrence of shocks to the economic environment.

Subclause 31 (1) specifies the formula for the determination of the resilience amount for a fund.

Subclause 31 (2) prescribes the formulae to be applied to asset values to reflect the economic changes applicable to the assets of the fund that fall within the classes listed in the table.

Subclause 31 (3) defines the diversification factor (DF) which appears in the formulae in the table in subclause (2).

PART 11 SUBORDINATED DEBT AND ALTERNATIVE SOURCES OF CAPITAL

32. Overview

Subclause 32 (1) states the purpose of the Part, which is to specify the terms on which subordinated debt qualifies as subordinated debt within the meaning of the Part and to specify the amount of subordinated debt that may be counted for the purposes of the standard.

Subclause 32 (2) provides that the capital adequacy obligation may be satisfied from either shareholder or member capital or the use of alternative sources of capital support where the obligations to the debtor are subordinate to the other obligations of the fund.

Subclause 32 specifies that it is only subordinated debt within the meaning of the Part that will qualify as an alternative source of capital for the purposes of the standard.

33. Subordinated debt

Clause 33 specifies requirements for debt to be subordinated debt within the meaning of the Part.

Subclause 33 (1) requires proposals to issue or borrow subordinated debt to be approved by the Council before the debt can be taken into account under the standard.

Subclauses 33 (2) to (4) specify further requirements for the approval of subordinated debts and for their continued application under the standard.

34. Amount of subordinated debt to be counted

Clause 34 details the maximum amount of subordinated debt that may be counted for the purposes of the standard.

Subclause 34 (1) provides the maximum amount of subordinated debt that may be counted for the purposes of the standard.

Subclauses 34 (2) and (3) provide a transitional treatment for funds to count for the purposes of this standard subordinated debts that were approved under the previously applicable standards made under the National Health Act.