Guidance notes for application of AASB 1023: *General Insurance Contracts to Registered Health Benefit Organisations.*

28TH OCTOBER 2005

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INTRODUCTION

From 2005, insurance contracts issued by organisations registered under the *National Health Act1953* as Registered Health Benefit Organisations (RHBOs), are required to be treated under Accounting Standard AASB 1023 *General Insurance Contracts* for the purposes of an entity's financial report required by the Corporations Act or for the purposes of a general purpose financial report.

This guidance has been issued to assist RHBOs in applying AASB 1023 when preparing general purpose financial reports. It does not address all aspects of AASB 1023 and it should not be seen as a substitute for the Standard in the areas it does address. This guidance does not address any implications for reporting to PHIAC under PHIAC's prudential standards.

AASB 1023 has been revised to incorporate the requirements of international accounting standard IFRS 4 *Insurance Contracts*. The previous version of the general insurance accounting standard, AASB 1023 *Financial Reporting of General Insurance Activities*, did not apply to medical benefits insurance. The revised version of AASB 1023 was issued in July 2004 and applies to annual reporting periods beginning on or after 1 January 2005. Any entity that issues an insurance contract is an insurer for the purposes of the Standard.

A key aspect of AASB 1023 is that it must be applied to all contracts that meet the definition of an insurance contract under the Standard. To meet the definition of an insurance contract a contract must transfer significant insurance risk. This test must be applied at the contract level. It is possible that there are certain products sold by RHBOs that will not meet the definition of an insurance contract. Where a contract does not meet the definition of an insurance contract it must be treated under AASB 139 *Financial Instruments: Recognition and Measurement*, to the extent that it gives rise to financial assets or financial liabilities, and under AASB 118 *Revenue*, to the extent that it represents a service contract. This guidance does not address such contracts.

This guidance addresses key steps an insurer will need to take in considering the accounting for insurance contracts:

1. is the contract an insurance contract or not? Whilst the test is applied at an individual contract level, the results of the test can be applied to groups of contracts that broadly have the same terms and conditions;
2. what is the period of the contract over which premiums are to be recognised? and
3. what is the expected pattern of the incidence of risk? Premiums must be recognised in accordance with this pattern.

The guidance also provides simple examples to clarify these steps and deals with specific issues such as periods of "free" cover.

Critical to AASB 1023 is the manner in which premiums are recognised in the income statement. AASB 1023 requires premiums and acquisition costs to be recognised, over the contract period, in accordance with the expected pattern of the incidence of risk under the related insurance contracts. Claims costs are recognised when incurred. When claims are incurred in line with expectations, underwriting profit is earned in accordance with the pattern of risk; this is the underlying objective of the requirements.

Other aspects of RHBOs financial reports must be treated under the other applicable accounting standards; for example, investments in term deposits are to be treated under AASB 139. However, for assets that back general insurance liabilities, whilst they are treated under the applicable accounting standard, AASB 1023 restricts the measurement choices available under those

standards. AASB 1023 requires all assets backing general insurance liabilities to be measured at fair value, where this is allowable under the applicable accounting standards.

The requirements of AASB 1023 apply to an RHBO's financial report where information from their application is material in accordance with AASB 1031 *Materiality*. Note that materiality under Australian Auditing Standards may be lower than materiality defined by Accounting Standards.

This document has been prepared by the Finance and Audit Committee of the AHIA with input and guidance from the AHIA, PHIAC, the AASB, Ernst & Young, KPMG and PricewaterhouseCoopers.

While this guidance represents the consensus view of the members of the panel at the time of issue, it should not be regarded as representative of the official views of the AHIA, PHIAC, the AASB or of any of the members in isolations, nor of their respective employers.
This guidance has been prepared based on AIFRSs on issue as at 24th August 2005.

INSURANCE CONTRACTS - SIGNIFICANT INSURANCE RISK

OVERVIEW

Insurance contracts are defined in AASB 1023 as:

A contract under which one party (the insurer) accepts ***significant insurance risk*** *from another party (the policyholder) by agreeing to compensate the policyholder if a specified uncertain future event (the insured event) adversely affects the policyholder.*

ASSESSMENT AND APPLICATION OF SIGNIFICANT INSURANCE RISK

The key consideration for RHBOs in assessing whether they have issued an insurance contract is whether "significant insurance risk" has been transferred.

Insurance risk is significant if an insured event could cause an insurer to pay significant additional benefits in any scenario excluding scenarios that lack commercial substance (refer to paragraph 22 in the Appendix to AASB 1023). Additional benefits refer to amounts that exceed those that would be payable if no insured event occurred. Assessment of risk should be at an individual contract level.

In applying these rules, RHBOs should perform at least the following steps:

1. List the different types of contracts the RHBO has in their portfolio. Contracts with different premium or benefit structures should be separately identified as different contract types. Internal management reporting structures, such as product tables, could be a useful guide or a starting point to this analysis, but should still be challenged.

2. For each contract type determine the potential cashflows that could occur for an individual contract in a scenario where a member claims the maximum benefits available under the contract's benefit structure. These cashflows should exclude reinsurance.

   For the purposes of this analysis it is not necessary to analyse each individual member's circumstances, only the benefit structure. Note that the scenario should have commercial substance; for example where certain types of benefits are mutually exclusive they should not both be included in the maximum benefits claimable.

3. For each contract type the RHBO should similarly determine the potential cashflows where a claim does not occur.

4. If the RHBO is able to demonstrate that there are commercial scenarios where significant additional cashflows occur in the event of a claim beyond those where no claim was made, then they are able to conclude that significant insurance risk has been transferred.

NO SIGNIFICANT INSURANCE RISK

If no significant insurance risk is transferred, AASB1023 will not apply and RHBO's should apply AASB 139 *Financial Instruments: Recognition and Measurement* to the contract to the extent that the contract gives rise to financial assets or financial liabilities. To the extent that the contract is a service contract it should be treated under AASB 118 *Revenue*. An example of a contract where no significant insurance risk transfers may be NSW Ambulance Levy plans where the RHBO claims cost is no greater than the premium paid by the policyholder.

SIGNIFICANT INSURANCE RISK DURING WAITING PERIODS

In determining the effect of 'Waiting Periods' in the assessment of significant insurance risk, an RHBO may consider the following:

a) during the waiting period, the level of insurable risk increases until full coverage is obtained;
b) the benefits in each contract where waiting periods are applicable and the timeframes attached to each;
c) that waiting periods are not applicable to accidents;
d) waiting periods in most cases are not applicable to customers transferring from RHBO's who have served waiting periods;
e) the likelihood of the RHBO reducing or waiving the waiting period;
f) the RHBO may limit the benefits payable, but still pay benefits, to the government minimum default level during the waiting period; and
g) pricing of products does not explicitly quantify the impact of waiting periods as the price reflects the aggregate experience across a product portfolio

Taking account of such factors, an RHBO would normally be expected to conclude that significant insurance risk is transferred during a waiting period and that the premium for an insurance contract could not be separately apportioned to a waiting period.

If however the RHBO is able to identify and quantify the financial impact of waiting periods for an insurance contract, the part of the premium received during the waiting period should be deferred and recognised in the period following the expiry of the waiting period in accordance with the expected pattern of the incidence of risk (as determined by the expected claiming pattern).

In considering the need to defer part of the premium in respect of the period following the expiry of the waiting period, the insurer would consider the requirements of AASB 1031 *Materiality*.

LOYALTY BONUSES AND PROGRAMS

A number of health funds provide benefits that can be described as loyalty bonuses or programs. Policyholders typically become entitled to these loyalty benefits simply based on their length of membership. These benefits can take a variety of forms, from additions to or extensions of existing benefit entitlements, or as completely separate policyholder benefits.

Examples include: hospital excess levels varying by length of membership, an annual 'bonus' that can be used for a wide range of services, benefit entitlements that accumulate over a number of years, and maximum benefits that increase with length of membership.

It can be difficult to distinguish between loyalty programs and normal benefit entitlements. The usual distinguishing features are: benefit entitlements that vary based on length of membership, coverage for a wide range of services, reimbursement of 'gaps' between fees charged and benefits paid, a high expected utilisation rate and accumulation of unused annual entitlements to future years.

If the RHBO is able to identify and quantify the financial impact of loyalty programs for an insurance contract, a part of the premium received prior to the commencement of the loyalty program may need to be deferred and recognised in the period of the loyalty program in accordance with the expected pattern of the incidence of risk (as determined by the expected claiming pattern).

The insurer would need to consider how much of the premium represents the current risk component and how much of the premium is in respect of the period during the loyalty program. The insurer would need to consider:

1. the likely claims during the current contract period; and
2. the likely additional claims that will be made in future periods as a result of the loyalty bonus or program. Past claims experience may indicate the impact loyalty programs and bonuses have on claims experience.

The deferred premium would be recognised in the balance sheet as an unearned premium liability.

In considering the need to defer part of the premium received in respect of the period of the loyalty program, the insurer would consider the requirements of AASB 1031 *Materiality*.

PREMIUM RECOGNITION

OVERVIEW

AASB 1023 section 4 stipulates the principles for premium revenue classification, recognition and measurement.

Premium revenue is recognised in the income statement from the attachment date over the period of the insurance contract in accordance with the pattern of the incidence of risk. For many insurance contracts issued by RHBO's this will be achieved by accounting for cash premiums received adjusted for contributions in advance and contributions in arrears.

Three key principles apply to the recognition of revenue. Revenue is recognised:

1. from the date on which the insurer accepts insurance risk ("attachment date");
2. over the period of the general insurance contract; and
3. in accordance with the pattern of the incidence of risk expected.

ATTACHMENT DATE

The attachment date is the date from which the insurer accepts insurance risk. An RHBO accepts insurance risk when they agree to cover the policyholder for claims incurred from that date based on the policyholder having paid, or being reasonably expected to pay, the premium owed for that product for that period of cover. For example, if a policyholder pays a month's premium for the period 1st January to 31st January, the attachment date is 1st January. Where waiting periods exist, and an RHBO has concluded that significant insurance risk is transferred during this time, then the attachment date is the commencement of the waiting period (this will usually be the date of joining).

It should be noted that the attachment date is not the same as the date of joining except when a policyholder first joins a fund and pays their first premium.

Periods of "free" cover by insurers, for example, one month free, still result in an attachment date as the insurer agrees to pay claims incurred from the start of the contract period. These arrangements are effectively discount mechanisms, as a policyholder, in most cases, is required to pay some premium up-front to obtain the discount. For example, usually the first month's premium is paid and the second month is the "free" period. RHBO's would spread the first month's premium over the two month period, given that this is the period of the contract. Similarly, where significant insurance risk has been transferred during a waiting period, RHBOs would spread a portion premium received over the waiting period.

TERM OF CONTRACT – ATTACHMENT DATE TO DATE PAID TO

A contract is an agreement enforceable by law. Unlike traditional general insurance contracts with specified contract periods (usually one year) insurance contracts issued by RHBO's do not have expressly defined contract periods.

Health insurance policyholders generally pay a premium for a chosen period of cover. This period can vary from a period of one week up to one year or more. Each premium payment advances the risk expiry date (or date paid to) for their insurance cover (risk expiry date is plus 2 months) At the expiry of this period, the policyholder has the right, but not the obligation, to extend the period of cover by the payment of a further premium.

Upon termination, a refund of any monies paid in advance by the member would be refunded. The right to terminate or lapse the contract rests solely with the policyholder. The health fund has no right to terminate cover provided that the policyholder pays the relevant premiums.

However it could be said that a policyholder could only enforce the contract or the RHBO will only agree to recognise the policyholder's rights to claim, where the premium has been paid or the RHBO has a reasonable expectation of receiving this premium.

RHBO's, in practice, acknowledge this right to claim, based on the premiums paid or payable, by using the risk expiry date or "date paid to" of the policyholder as the last date of the contract period. – (this is subject to a notice of termination being sent to a member which will be at least 2 months of a member being in arrears)

RHBO's are legally obliged to continue cover (but not pay benefits for the period in arrears) for 2 months if a policyholder's premiums are in arrears. However, for any claims to be payable, and hence risk assumed, a policyholder must bring their membership up to-date. In general therefore it is likely that RHBO's would only recognise premiums in arrears, up to 2 months since the last financial date paid to, being their likely risk expiry date.

It is essential to recognise the difficulties in identifying the term of a private health insurance contract for the purposes of ensuring compliance with the Standard. Accordingly, it is accepted that classifying this contract as outlined in these guidance notes is only for the purposes of effecting the Standard. These guidance notes will not have the effect of overriding applicable legislative or contractual obligations under which private health insurance funds operate.

The term of a private health insurance contract, or period of cover, for the purposes only of compliance with the Standardis therefore between the attachment date and this risk expiry "date paid to".

PATTERN OF INCIDENCE OF RISK

Revenue is recognised from the attachment date over the contract period in accordance with the pattern of incidence of risk. For many insurance contracts issued by RHBO's, the likely incidence of claims risk across a product table during such a period of cover is evenly spread, that is, is linear. Where this is the case, premium should be recognised evenly over the period of cover between the attachment date and the date paid to.

However, where the insurer considers that the pattern of risk for a certain product table grouping is not evenly spread throughout the period (e.g. as a result of a waiting period or loyalty program), an insurer should assess:

a) the amount of revenue that would be recognised in the reporting period, if the premium were recognised in accordance with the pattern of incidence of risk for that product;

b) the amount of revenue that would be recognised in the reporting period, assuming the risk is evenly spread; and

c) whether the difference between the amounts calculated in (a) and (b) is material.

Example 1: Consider an RHBO with a stable membership base and a low proportion of new memberships. A new product group is released to which waiting periods are applicable. At the reporting date, the waiting period exceeds the prepaid period for policyholders of the new product. The RHBO assesses the incidence of risk not to be linear for this product table grouping. However, as the difference in revenue for this product (linear method vs. incidence of risk method) is not material to the total revenue recognised for the period reported on, the RHBO may recognise revenue for this product table grouping as if the incidence of risk was linear.

Example 2: Consider the above scenario for a 'start up' or rapidly expanding insurer with low membership base and high proportion of new policyholders. Due to size of insurer and the total

revenue to be recognised for the reporting period, the difference in revenue recognised for the new product table grouping between the linear method vs. incidence of risk method, would be material and therefore the linear method would not be appropriate.

UNEARNED PREMIUM LIABILITY AND PREMIUM RECEIVABLE

Section 7 of AASB 1023 stipulates that premium revenue paid by policyholders that has not been recognised in the income statement is to be recognised in the balance sheet as unearned premium liability. This unearned premium is brought to account in future periods as it is earned.

The unearned premium liability as at reporting date will consist of two balances:
1. Actual cash premium receipts for periods in advance of reporting date; plus
2. Forecasted premiums receivable from policyholders at reporting date (Unclosed Business Premium)

For item 1, as RHBO's require premiums to be paid in advance, per National Health Act requirements, this amount will be a matter of fact based on physical cash receipts and something RHBO's will already be calculating.

For item 2, the Unclosed Business Premium, this amount could be calculated based on a review of the past payment experience of current policyholders (being those from who the RHBO has accepted insurable risk at reporting date). This calculation could be made as follows:

1. Split existing policyholder's by payment frequency – eg. fortnightly, monthly, annually
2. Calculate premium amount payable by the policyholder for the period of their payment frequency – eg. monthly paying policyholder would pay 1 months premium, annual payer would pay 12 months
3. Deduct from this any assumed non-collection rate for policyholder discontinuance
4. Deduct from the amount calculated, actual cash premium receipts paid in advance by the policyholder at reporting date (being Item 1 above)

Item 2, Unclosed Business Premium will generate the following journal entries:

Debit Premium Receivable (Unclosed Business Premium)
Credit Unearned Premium Liability (Unclosed Business Premium)

Premiums received or expected from policyholders and used in calculating revenue earned are based on those applicable or paid at the attachment date. For example, if a policyholder pays 2 months of premiums on 1 March for cover to 1 May, the premium rate is that applicable at 1 March, notwithstanding any rate increase on 1 April.

PREMIUM IN ARREARS

In general RHBO's require premiums to be paid in advance, per National Health Act requirements. However, policyholder may fall into arrears with premium payments.

An insurer will need to consider the probability of receiving the revenue before recognising premiums owed but not received in the balance sheet. This will involve the insurer considering the date from which are they have accepted insurance risk (ie. the attachment date), the contract period and previous experience with regard to policyholders falling into arrears and subsequently paying premiums owing.

RHBO's are legally obliged to continue cover for 63 days if a policyholder's premiums are in arrears. In general, for monthly contracts, it is likely that RHBO's would only recognise premiums in arrears, up to 2 months since the last financial date paid to.

PRIVATE HEALTH INSURANCE REBATE ON PREMIUM INCOME

PHI rebate amounts owed from the Health Insurance Commission for policyholders registered for the PHI rebate should be recognised in the income statement in the same pattern as the premium from the policyholder is recognised.

REVENUE RECOGNITION EXAMPLES

Example 1: Contributions neither in advance or arrears
Policyholder pays one month's premium for product cover for the period 1st December to 31st December. Revenue should be recognised in the December income statement for the period 1st December to 31st December.

Example 2: Contributions in advance - monthly
Policyholder pays one month's premium for product cover for the period 3rd December to 2nd January. Revenue should be recognised in the December income statement for the period 3rd December to 31st December. The remaining premium received is recognised in the balance sheet as an unearned premium liability.

Example 3: Contributions in advance – annual where claims evenly spread
Policyholder pays 12 month's premium for product cover for the period 1st January to 31st December. Revenue should be recognised in the income statement each month by evenly recognising 1/12th of the 12 month's premium. As at 30th June, revenue equal to 6 month's of premiums will be recognised in the income statement with the remaining 6 month's of premium received recognised in the balance sheet as an unearned premium liability.

Example 4: Contributions in advance – seasonal claims trend
An insurer receives a premium of $300 on 1 November for cover until 31 January. The insurer prepares financial reports to 31 December. The insurer has a seasonal pattern of claims over the Christmas holiday. From previous claims payments the insurer has determined that claims are expected to arise as follows: 40% in November, 35% in December and 25% in January. The 31 December financial report will recognise 75% of $300 as premium income and 25% of $300 as unearned premium liability.

Example 5: Contributions in arrears (Monthly contracts)
Policyholder misses due date for their monthly premium payment for period 25th December to 25th January and does not pay their monthly premium for 25th December to 25th January until 2nd January. For the income statement ended 31st December, the insurer considers that the policyholder is still insured from 25th December and therefore recognises the premium for the period 25th December to 31st December with a corresponding entry in the balance sheet to contributions in arrears. Assume that the monthly premium is $64 for the period 25 December to 25 January (i.e. $2 per day) and assume an even pattern of risk over the contract period. The double entries to reflect this transaction are as follows:

Dr	Contributions in arrears (Receivable) B/S	64
Cr	Unearned Premium Liability (UPL) B/S	64
Dr	UPL (B/S)	14
Cr	Income Statement – Earned Premium	14

Therefore, at 31 December 2005:

- The net impact on the income statement is to recognise premium revenue of $14.

- In the balance sheet, the net UPL is $50 and receivable is recognised for the full amount in arrears i.e. $64.

Example 6 – Contributions in arrears (Annual contracts)
Policyholder misses due date for their annual premium payment for the 12 month period from 1 December. The payment of $730 is less than sixty days in arrears. The policyholder has been a member of the fund for many years and has historically paid premiums annually in advance by the due date. In these circumstances, an RHBO would be more likely to recognise an accrual for 12 months premium revenue up to the balance sheet date. Assuming a 31 December balance sheet date and assume an even pattern of risk over the contract period, the following journal entries would be recognised to bring the 12 months premium revenue to account:

Dr	Contributions in arrears (Receivable) B/S	730
Cr	Unearned Premium Liability (UPL) B/S	730
Dr	UPL (B/S)	62
Cr	Income Statement – Earned Premium	62

(Using 365ths method, the earned portion is $730 ÷ 365days × 31 days)

Example 7 – Contributions in arrears (Annual contracts)
Policyholder misses due date for their annual premium payment for the 12 month period from 1 December. The payment of $730 is more than sixty days in arrears. The policyholder has been a member of the fund for many years and has historically paid premiums annually in advance. In that time, the policyholder has occasionally missed the due date for payment but has always paid within 60 days. In this case, RHBOs should assess whether it is appropriate to recognise any premium revenue (or recognise a receivable) at the balance sheet date. The amount of premium revenue recognised might be based on the funds' historical information about lapse rates where premium payments are in arrears.

Outstanding Claims Provisions

Overview

AASB 1023 section 5 stipulates the principles for recognition and measurement of the Outstanding Claims Liability.

An outstanding claims liability shall be measured at the reporting date as the sum of the:

- central estimate of the present value of claims incurred, plus
- a risk margin to allow for inherent uncertainty in the central estimate

Central estimate of claims incurred

A central estimate of claims incurred is the mean of all possible values of outstanding claims liabilities as at the reporting date.

Claims incurred, whether reported or unreported, should be included in the outstanding claims provision. As claims for RHBO's are generally settled within one year, no discounting of claims is likely to be required as the difference between the undiscounted value of claims payments and the present, value of claims payments is not likely to be material.

Risk Margin included in the Outstanding Claims Provisions

A risk margin is included in the outstanding claims liability to allow for inherent uncertainty in the calculation of the central estimate and Health Benefits Reinsurance Trust Fund ("HBRTF") balances.

The risk margin for a given level of probability of adequacy will be specific to each insurer, taking into account the variability of claims processing, the availability of claims data and the features of the claims being provided for at the reporting date.

AASB 1023 paragraph 5.1.11 states that: "Risk margins adopted for regulatory purposes may be appropriate risk margins for the purposes of this Standard, or they may be an appropriate starting point in determining such risk margins."

For RHBO's, a useful point of reference for determining a risk margin may be the guidance provided by PHIAC prudential standards. However, insurers should note that prudential standards are designed to achieve very high probability of adequacy levels and as such may go beyond a reasonable allowance for inherent uncertainty when preparing financial reports.

AASB 1023 permits insurers to apply a different probability of adequacy (POA) through adoption of the risk margin in determining the outstanding claims liability and in performing the liability adequacy test (see below). However, insurers should disclose both the risk margin and POA adopted when calculating the outstanding claim provision and in performing the liability adequacy test.

It is likely that RHBO's would seek actuarial guidance in relation to risk margins.

LIABILITY ADEQUACY TEST

OVERVIEW

AASB 1023 para 9.1 requires an RBHO to perform a liability adequacy test ("LAT") on its unearned premium liability to ensure that loss making business is identified and the loss measured and recognised.

The test is performed on the adequacy of the Unearned Premium Liability at the level of a portfolio of contracts that are subject to broadly similar risks and are managed together as a single portfolio. The Unearned Premium Liability is, as discussed earlier under Unearned Premium Liability and Subscriptions Receivable, the total of Actual cash premium receipts and Unclosed Business Premiums.

To determine the potential liability arising from policyholders' option to renew existing health insurance contracts, the liability adequacy test should be extended to assess the present value of the expected future cash flows relating to future claims arising from the rights and obligations under (a) current health insurance contracts and (b) health insurance contracts that are expected to be renewed for the period to the next expected pricing review or change in contractual benefits (this may be the annual pricing review).

ASSESSING THE ADEQUACY OF THE UNEARNED PREMIUM LIABILITY

An insurer needs to determine whether the Unearned Premium Liability is adequate to cover the expected cash flows from future claims arising from rights and obligations under:

1. current contracts and;
2. contracts expected to be renewed for the period to the next expected pricing review or change in contractual benefits
3. plus an additional risk margin.

The expected cash flows relating to future claims should include:

a) the policy benefits to be paid,
b) claims handling costs associated with the settlement of the claim such as legal, professional fees and administration costs, and
c) reinsurance cashflows to / from the HBRTF

An Insurer compares the expected cash flows from future claims (plus a risk margin) to the following amounts:

	Unearned Premium Liability
Less	any related Intangible Assets
Less	any related Deferred Acquisition Costs

Where the above amount is insufficient to meet the future cash flows, the entire deficit shall be brought to account in the insurers financial statements. Any related intangible assets and deferred acquisition costs are first written down and any additional liability required is then recognised as an Unexpired Risk Liability.

For example, RHBO has a forecasted Loss Ratio after reinsurance of 88%, claims handling of 2% of premiums, plus risk margin of say 5%, the total projected loss is 95% of premium value. As the total is less than 100%, there is no deficit. Conversely, if Loss Ratio after reinsurance was 98%, claims handling of 5% of premiums, plus risk margin of say 5%, the total projected loss is 108%, in which case the projected deficit of 8% should be brought to account.The following table illustrates the application of the Liability Adequacy Test:

LAT EXAMPLES

	PV (Exp Claims etc)	UPL Less IA Less DAC	Adequacy of UPL	Action / Entries required
Scenario 1	95	100	Sufficient	No further action required
Scenario 2	115	100	Deficient by 15	Recognise entire Deficiency in Income Statement and reduce related IA and DAC. DR Deficiency in UPL (I/S) 15 CR Intangible Asset (B/S) 5 CR DAC (B/S) 10
Scenario 3	140	100	Deficient by 40	Recognise entire Deficiency in Income Statement, reduce related IA, DAC and create an Unexpired Risk Liability on the Balance Sheet. DR Deficiency in UPL (I/S) 40 CR Intangible Asset (B/S) 5 CR DAC (B/S) 20 CR URL (B/S) 15

Key:
PV (Exp Claims etc) = Present value of expected future claims, associated expenses to settle claims and HBRTF payments / receipts amounts.
UPL = Unearned Premium Liability
IA = Intangible Asset
DAC = Deferred Acquisition Costs
URL = Unexpired Risk Liability

CLASS OF BUSINESS

AASB 1023 para 9.1 requires the liability adequacy test to be performed at the level of a portfolio of contracts that are subject to broadly similar risks and are managed together as a single portfolio.

Health insurers may have two portfolios of contracts - Hospital and Ancillary. An insurer may however determine further disaggregation of portfolios is more appropriate after considering their own circumstances.

TREATMENT OF THE HEALTH BENEFITS REINSURANCE TRUST FUND UNDER IFRS

OVERVIEW

The legal form of the Health Benefits Reinsurance Trust Fund (HBRTF) arrangement does not represent an insurance contract or a reinsurance contract in the “usual” sense as defined in AASB1023. There is certainly a legally binding requirement for RHBO’s to contribute to the HBRTF and an ability to receive payments from the HBRTF as appropriate. The government, via PHIAC, acts to administer this arrangement, however it is not at risk itself. Net payers into the HBRTF finance RHBO’s that are net receivers from the HBRTF. If a fund makes an error, within certain restrictions, it is the other funds who bear the subsequent cost, or receive the additional benefits.

As a result, payments should continue to be accounted for as a provision at the end of each quarter where appropriate under AASB 137 *Provisions, Contingent Liabilities and Contingent Assets*.

The HBRTF has two components, HBRTF Levies and HBRTF Recoveries. HBRTF Levies are contributions to the HBRTF based on the RHBO’s number of single equivalent units (SEU) times a prescribed fixed dollar rate per SEU. HBRTF Recoveries are RHBO withdrawals from the HBRTF based on their reinsurable claims.

DISCLOSURE OF HBRTF LEVIES (THE CALCULATED DEFICIT PER SEU)

HBRTF levy payments should continue to be accounted for as a provision at the end of each quarter where appropriate under AASB 137. The requirements to be met before a provision should be recognized have been summarized below:

Conditions for a Provision to Exist		Comments
1	An enterprise has a present obligation (legal or constructive) as a result of a past event	As the HBRTF levy obligation arises from the previous quarter’s claim activity this condition is met.
2	It is probable that an outflow of resources embodying economic benefits will be required to settle the obligation	This condition is met, as there is a predictable quarterly process in place for levy payments.
3	Reliable estimate can be made of the amount of the obligation In the majority of cases	Funds are able to make a reliable estimate, based on analysis of the past quarter’s claim experience and the history of past levy requirements.

Accordingly, a HBRTF levy provision and corresponding expense should be raised at the end of each period to reflect the expected subsequent settlement.

The HBRTF levy should be presented as a separate expense.

DISCLOSURE OF HBRTF RECOVERIES (THE GROSS DEFICIT)

HBRTF Recoveries are reimbursements to RHBO’s for reinsurable claims paid. These amounts are directly associated with claims incurred and as such are not revenue in the ordinary sense as they are not proceeds from the sale or provision of goods or services. Any recoveries that a fund receives from the HBRTF should also be accounted for under AABS 118, and should be shown as a separate line item. The recoveries should not be netted against the benefit payments (i.e. only net benefits shown).

HBRTF RECOVERIES EXPECTED IN RESPECT OF THE PROVISION FOR OUTSTANDING CLAIMS

The provision for outstanding claims provides for:

- amounts in relation to unpaid reported claims;
- claims incurred but not reported;
- claims incurred but not enough reported; and
- the expenses associated with the processing of these claims.

Many RHBO's currently also include in this Provision the expected payments to/ receipts from the HBRTF in relation to the outstanding claims liability. In some cases the entire provision is then usually discounted for the time value of money, as appropriate, which is consistent with the requirements of AASB 1023. Note that given the short tail nature of the outstanding claims, this discounting is generally not material.

The HBRTF component should not be netted off against the outstanding claims liability. No profit impact would be expected from separating the HBRTF component from the Outstanding Claims liability, and this treatment is also consistent with the current requirements of the PHIAC 2 Annual Report.

ASSET VALUATIONS FOR REGISTERED HEALTH BENEFIT ORGANISATIONS

<u>OVERVIEW</u>

Under AASB 1023, an Insurer must:

1) determine which assets back their insurance liabilities; and
2) measure these assets at fair value.

Those assets that an Insurer determines as not backing insurance liabilities, may be measured using any of the measurement choices available under other applicable accounting standards.

Whilst AASB 1023 does not prescribe how an Insurer should determine which assets back insurance liabilities, paragraph 17.3 does require the Insurer to disclose the process used to determine which assets back insurance liabilities.

Each RHBO will need to consider their own circumstances in determining which assets back their health insurance liabilities.

<u>MEASUREMENT CHOICES</u>

<table>
<tr><th>Asset type</th><th>Deemed to back insurance liabilities</th><th colspan="2">Valuation method</th><th>Accounting Standard Reference</th></tr>
<tr><td rowspan="6">Financial assets</td><td>Yes</td><td colspan="2">Fair value through income statement</td><td rowspan="6">AASB 139</td></tr>
<tr><td rowspan="5">No</td><td colspan="2">Following choices are available, dependent on purpose for which the asset is held:</td></tr>
<tr><td>a) Held for Trading</td><td>Fair value through income statement</td></tr>
<tr><td>b) Available for Sale</td><td>Fair value to Equity until realised and impairment test</td></tr>
<tr><td>c) Loans & receivables</td><td>Amortised cost to income statement and impairment test</td></tr>
<tr><td>d) Held to Maturity</td><td>Amortised cost to income statement and impairment test</td></tr>
<tr><td rowspan="2">Investment Property</td><td>Yes</td><td colspan="2">Fair value through income statement</td><td rowspan="2">AASB 140</td></tr>
<tr><td>No</td><td colspan="2">Fair value through income statement or cost model</td></tr>
</table>

Property, Plant & Equipment (including owner – occupied property)	Yes	Revaluation model: 1) increases booked directly to Equity unless it reverses a previous decrease that has been booked to income statement for the same asset, 2) decreases booked directly to income statement unless it is a reversal of a previous increase that has been booked to Equity.	AASB 116
	No	Revaluation model or Cost model	

ACCOUNTING FOR DEFERRED ACQUISITION COSTS

OVERVIEW

AASB 1023 section 8 states that the costs of acquiring an insurance contract may only be deferred and brought to account where it is probable that these costs will give rise to contribution revenue over subsequent periods.

DEFINITION OF ACQUISITION COSTS

Costs of acquiring an insurance contract may include:

- fees and/or commissions paid to agents or brokers;
- advertising and promotion and other selling costs;
- administrative costs of recording membership and policy details; and
- administration and transactional costs of collecting contributions.

MEASUREMENT

In line with asset recognition criteria, deferred acquisition costs may be capitalised only where:

1. it is probable that future economic benefits will eventuate, and
2. they possess a cost that can be reliably measured.

An RHBO must therefore first assess what the expected future economic benefits arising from the acquisition cost and the probability that these benefits will eventuate. The RHBO would need to perform a calculation quantifying these benefits and make an assessment of the probability that these benefits will arise in the future ordinary course of business. The benefits of many acquisition costs may already have eventuated in which case these would not be deferred but recognised when incurred.

Direct selling costs such as agent or broker commissions or fees paid on specific insurance contracts are usually readily measurable.

However, other indirect administrative or advertising costs, for example, may be difficult to measure reliably as it may be difficult to associate them with particular insurance contracts.

In order to measure amounts that shall be recognised as deferred acquisition costs in relation to indirect expenses, costs would need to be analysed and apportioned between activities that will probably give rise to future economic benefits and those that will not.

AMORTISATION

An understanding of the pattern of incidence of risk under an insurance contract is a prerequisite to the amortisation of deferred acquisition costs. This pattern will have been established to account for contribution revenue.

An assessment will need to be made of the period of likely future economic benefits yielded from each category of deferred acquisition costs. These costs will then be systematically expensed over the subsequent period(s) in accordance with the pattern of incidence of risk under the insurance contracts.

It will be necessary to separately identify the categories of expenses representing the deferred acquisition costs (for example, initial or trailing commissions, advertising, contribution collection costs etc) in the financial records. This will facilitate the assignment of appropriate amortisation policies for each category. As such the period of amortisation of DAC is not required to be limited to the period until the next "paid to" date in those circumstances where the acquisition cost is incurred in relation to a longer period of expected benefit. For example, it may be probable that direct advertising expenditure to acquire new policyholders and policies that is deferred will give rise to contribution revenue over a number of years. However, the costs that could be deferred relating to collection of contributions from policyholders may only give rise to future revenue for a relatively short period.

DISCLOSURES

ASSUMPTIONS

- These pro forma accounts focus primarily on the disclosure requirements of AASB 1023, and do not include disclosures that other Australian standards may require (eg cashflows). Accordingly only AASB 1023 is cross-referenced.
- A statement of changes in equity and a cash flow statement have not been included
- The company does not own any subsidiaries
- The company does not have any non-insurance contracts
- The company has not failed the liability adequacy test
- Claims are typically resolved within one year
- The company does not have any DAC or UPL balances.
- As with any pro-forma set of accounts, the disclosures (particularly qualitative disclosures) will need to be tailored for the circumstance of the individual health fund.

Income Statement
For the year ended 30 June 2006

	Notes	2006 $'000	2005 $'000	
Direct premium revenue		XX	XX	*1023.17.6.3(a)*
Net premium revenue		XX	XX	
Direct claims expense	2	(XX)	(XX)	*1023.17.6.3(d)*
Plus: HBRTF levies		(XX)	(XX)	*1023.17.6.3(f)*
Less: State levies		(X)	(X)	*1023.17.6.3(g)*
Less: HBRTF recoveries		X	X	*1023.17.6.3(c)*
Net claims incurred		(XX)	(XX)	
Acquisition costs		(X)	(X)	*1023.17.6.3(g)*
Other underwriting expenses		(X)	(X)	*1023.17.6.3(h)*
Underwriting Result		**XX**	**XX**	*1023.17.1(d)* *1023.17.1.1*
Investment income		X	X	
Other revenues		X	X	
Salaries and employee benefits expense		(X)	(X)	
Other expenses from ordinary activities		(X)	(X)	
Result of Operating Activities		**XX**	**XX**	
Finance costs		**(X)**	**(X)**	
Profit before income tax		**XX**	**XX**	
Income tax expense		(X)	(X)	
Profit attributable to members		**XX**	**XX**	

Balance Sheet
As at 30 June 2006

	Notes	2006 $'000	2005 $'000	
Assets				
Current Assets				
Cash and cash equivalents		XX	XX	
Trade and other receivables	4	XX	XX	*1023.17.6.2(b)* *1023.17.6.2(i)*
Investments		XX	XX	
Other financial assets	5	XX	XX	*1023.17.6.2(k)*
Total Current Assets		XX	XX	
Non-current Assets				
Other financial assets		XX	XX	
Property, plant & equipment		XX	XX	
Total Non-current Assets		XX	XX	
Total Assets		XX	XX	
Liabilities				
Current Liabilities				
Trade and other payables	6	XX	XX	*1023.17.6.2(h)*
Gross outstanding claims	3	XX	XX	*1023.17.6.2(a)*
Provisions		XX	XX	
Income tax payable		XX	XX	
Total Current Liabilities		XX	XX	
Non-current Liabilities				
Provisions		XX	XX	
Total Non-current Liabilities		XX	XX	
Total Liabilities		XX	XX	
Net Assets		XX	XX	
Equity				
Issued capital		XX	XX	
Retained earnings		XX	XX	
Other reserves		XX	XX	
Total Equity		XX	XX	

Notes to the Financial Statements
For the year ended 30 June 2006

Note 1 Summary of significant Accounting Policies

Product Classification

Insurance contracts:
Insurance contracts are defined as those containing significant insurance risk at the inception of the contract, or those where at the inception of the contract there is a scenario with commercial substance where the level of insurance risk may be significant over time. The significance of insurance risk is dependant on both the probability of an insurance event and the magnitude of its potential effect.

Once a contract has been classified as an insurance contract, it remains an insurance contract for the remainder of its lifetime, even if the insurance risk reduces significantly during this period.

The Company has determined that all current contracts with policyholders are insurance contracts.

Investments
As part of its investment strategy the Company actively manages its investment portfolio to ensure that investments mature in accordance with the expected pattern of future cash flows arising from health insurance liabilities.

Investments include assets backing insurance liabilities and owner-occupied properties.

All investments are initially recognised at cost, being the fair value of the consideration given and including acquisition charges associated with the investments.

Assets backing insurance liabilities
All investments held by the Company, with the exception of owner-occupied properties, have been determined to be assets backing insurance liabilities, and accordingly are designated as "at fair value through profit or loss". These are initially recorded at cost and subsequently re-measured at fair value. All related realised and unrealised gains or losses are included in investment income. Interest earned or dividends received are included in interest and dividend income respectively.

Owner occupied properties
Owner occupied land and buildings are held at cost less accumulated depreciation.

Depreciation is calculated on a straight-line basis over the estimated useful life of the building of 20 years.

Insurance contract liabilities

Health insurance outstanding claims liabilities
Health insurance outstanding claims liabilities are measured as the central estimate of the present value of expected future payments against claims incurred but not settled at the balance sheet date, whether reported or not, together with related claims handling costs and an additional risk margin to allow for the inherent uncertainty in the central estimate.

Claims handling costs include internal and external costs incurred in connection with the negotiation and settlement of claims. Internal costs include all direct expenses of the claims department and any part of the general administrative costs directly attributable to claims function.

The expected future payments are discounted to present value using a risk free rate.

Provision for unearned premium and unexpired risks
The proportion of written premiums, gross of commission payable to intermediaries, attributable to subsequent periods is deferred as unearned premium. The change in the provision for unearned premium is taken to the income statement in the order that revenue is recognised over the period of risk. Further provisions are made to cover claims under unexpired insurance contracts which may exceed the unearned premiums and the premiums due in respect of these contracts.

The adequacy of the unearned premium liability in respect of each class of business is assessed by considering current estimates of all expected future cash flows relating to future claims covered by current insurance contracts.

If the present value of the expected future cash flows relating to future claims plus the additional risk margin to reflect the inherent uncertainty in the central estimate exceeds the unearned premium liability less related intangible assets and related deferred acquisition costs then the unearned premium liability is deemed to be deficient.

The entire deficiency is recognised immediately in the income statement both gross and net of reinsurance. The deficiency is recognised first by writing down any related intangible assets and then related deferred acquisition costs, with any excess being recorded in the balance sheet as an unexpired risk liability.

Claims
Health insurance claims incurred include all claim losses occurring during the year, whether reported or not, including the related handling costs and any adjustments to claims outstanding from previous years.

Claims handling costs include internal and external costs incurred in connection with the negotiation and settlement of claims. Internal costs include all direct expenses of the claims department and any part of the general administrative costs directly attributable to claims function.

Revenue recognition

Premium revenue
Premium revenue is recognised in the income statement from the attachment date, as soon as there is a basis on which it can be reliably measured. Revenue is recognised in accordance with the pattern of the incidence of risk expected over the term of the contract.

The proportion of premium received or receivable not earned in the income statement at the reporting date is recognised in the balance sheet as an unearned premium liability.

Health Benefits Reinsurance Trust Fund levies/recoveries
Under the provisions of the National Health Act 1953, all health insurers must participate in the Health Benefits Reinsurance Trust Fund, which charges a levy to all health insurers and

shares a proportion of the hospital claims of all persons aged 65 years and over and those memberships with more than 35 days of hospitalisation in any one year to all health insurers.

The amounts payable to and receivable from the Reinsurance Trust Fund are determined by the Private Health Insurance Administration Council after the end of each quarter. Estimated provisions for amounts payable and income receivable are recognised on an accruals basis.

Acquisition costs

Acquisition costs incurred in obtaining health insurance contracts are deferred and recognised as assets where they can be reliably measured and where it is probable that they will give rise to premium revenue that will be recognised in the income statement in subsequent reporting periods.

Deferred acquisition costs (DAC) include commission paid to intermediaries and other direct costs incurred in relation to the acquisition or renewal of health insurance contracts. Acquisition costs are amortised in accordance with the expected pattern of the incidence of risk under the health insurance contracts to which they relate. This pattern of amortisation corresponds to the earning pattern of the corresponding premium revenue.

Notes to the Financial Statements (continued)
For the year ended 30 June 2006

Note 2 – Net claims incurred

1023.17.1(e)

	2006 Current year $'000	2006 Prior year $'000	2006 Total $'000	2005 Current year $'000	2005 Prior year $'000	2005 Total $'000
Gross claims incurred and related expenses						
Undiscounted						
Discounted						
HBRTF and other recoveries						
Undiscounted						
Discounted						
Net claims incurred and related expenses						
Undiscounted						
Discounted						

In the classes of business in which the Company operates, all material claims are resolved within one year.

Note 3 – Outstanding Claims provision

	Notes	2006 $'000	2005 $'000	
Outstanding claims – central estimate of the expected present value of future payments for claims incurred[1]		XXX	XXX	*1023.17.2(a)(i)*
Risk margin[2]		XX	XX	*1023.17.2(a)(ii)*
Claims handling costs		XX	XX	
Gross outstanding claims liability		**XXX**	**XXX**	*1023.6.2(a)*
Changes in the gross outstanding claims liabilities can be analysed as follows:				
At 1 July		XXX	XXX	*1023.17.6(e)*
Claims incurred during the year		(XX)	(XX)	
Claims paid during the year		XX	XX	
At 30 June		**XXX**	**XXX**	

[1] The expected future payments are discounted to present value using a risk free rate.

[2] The risk margin of X% (2005: X%) of the underlying liability has been estimated to equate to a probability of adequacy of approximately Y% (2005: Y%). *1023.17.2(b-d)*

The risk margin has been based on an analysis of the past experience of the company. This analysis examined the volatility of past payments that has not been explained by the model adopted to determine the central estimate. This past unexplained volatility has been assumed to be indicative of the future volatility.

Followed by either:
The outstanding claims estimate is derived based on x valuation classes, namely a,b and c. Diversification benefits within a valuation class are implicitly allowed for through the model adopted. The determination of the risk margin has allowed for diversification between valuation classes based on an analysis of past correlations in deviations from the adopted model. The allowance for diversification benefits has reduced the risk margin by x%.

Or:
The outstanding claims estimate is derived using all data combined in an aggregate model. As such diversification benefits have been implicitly allowed for in this process.

Assumptions

The following range of inflation and discount rates were used in the measurement of outstanding claims:

	2006 %	2005 %	
Discount rate	X.00	X.00	*1023.17.6.1(c)*

The Outstanding Claims provision has been estimated using a modified chain ladder method, based on historical experience and future expectations as to claims. The calculation was determined taking into account two months of actual post balance date claims.

Based on historic experience, approximately 80% of outstanding claims are received within two months of balance date, and accordingly only 20% of the outstanding claims provision requires an estimate. Accordingly, reasonable changes in assumptions would not have a material impact on the outstanding claims balance.

Note 4 – Trade and other receivables

	Notes	2006 $'000	2005 $'000	
Trade debtors		XX	XX	
Premiums in arrears		XX	XX	
HBRTF recoverable		XX	XX	
Trade and other receivables		**XXX**	**XXX**	
Changes in the HBRTF recoverable can be analysed as follows:				
At 1 July		XXX	XXX	*1023.17.6(e)*
Levy recoveries revenue recognised during the year		XX	XX	
Levy recoveries received during the year		(XX)	(XX)	
At 30 June		**XXX**	**XXX**	

Note 5 – Other financial assets

	Notes	2006 $'000	2005 $'000	
Deferred acquisition costs		XX	XX	
Other assets		XX	XX	
Other financial assets		**XXX**	**XXX**	
Changes in the deferred acquisition costs can be analysed as follows:				
At 1 July		XX	XX	*1023.17.6(e)*
Acquisition costs deferred during the year		X	X	
Acquisition charged to the income statement during the year		(X)	(X)	
At 30 June		**XX**	**XX**	

Note 6 – Trade and other payables

	Notes	2006 $'000	2005 $'000

Trade creditors	XX	XX
HBRTF Levy payable	XX	XX
Trade and other payables	**XXX**	**XXX**