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Australian Government
Australian Accounting Standards Board

Private Health Insurance Focus Group ("PHI FG")

AASB 17 TRG Meeting
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- A focus group of the AASB TRG
- The purpose and function is to provide a forum for communication and discussion of PHI specific topics or issues
- Preparers will drive problem statements for discussion, and where such problems may be deadlocked, the focus group can facilitate discussions with the AALC and AASB 17 TRG

Membership	Role
HCF, HBF, BUPA, Medibank, Teachers Health, NIB, GMHBA, Australian Unity, Finity Consulting	Preparers
Big 4 participants	Provides input
Anne Driver	Chair of the AASB TRG
Marion Smith	Co-ordinator

Issue/topic	Status
Contract boundary	Tabled in current AASB TRG Meeting
Level of Aggregation / Portfolios	Tabled in current AASB TRG Meeting
Onerous contracts	Tabled in current AASB TRG Meeting
Annual cohorts	Completed draft – final review and comment being performed
Risk equalisation scheme	Completed draft – final review and comment being performed
Premium reduction scheme	To be allocated
Loyalty schemes	To be allocated
PAA Eligibility	Allocated - to be drafted
Risk adjustment	Allocated - to be drafted
Acquisition costs	To be allocated

- Cadence of meetings: Fortnightly beginning 17th November 2020
- More information: Contact Marion Smith: marion.smith@ey.com.au

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Implementation Question
The ways in which PHI contracts in Australia are bought, sold and renewed, together with the specific regulatory context, means determination of the contract boundary in AASB 17 may be open to interpretation.

Relevant characteristics of Australian resident health insurance contracts	
Guaranteed renewal	Contracts do not stipulate an explicit term of coverage. Each payment of premium (with frequencies varying from weekly to annually) automatically renews the policy and extends coverage to the paid-to date.
Premium rate protection	Premiums paid in advance are locked in at current prices, despite premiums typically increasing on a uniform date (generally 1 April) each year. Prepaid premiums are not exposed to repricing until the next payment after the premium increase date.
Community rating	PHI in Australia is "community rated", meaning premiums are not based on an individual policyholder's risk. Health insurance must be equally accessible and cost the same for everyone regardless of health status, claims history, gender or age. Therefore, Para 34(a) has limited relevance to PHIs and a portfolio view referred to in Para 34(b) is relevant.
Government approved price increases	PHI premium increases must be approved by the Minister of Health. This is generally done through an annual industry-wide repricing cycle. Applications for out-of-cycle increases may be made but this is highly unusual. PHIs may make changes to benefits and product coverage, open, close and migrate policies without regulatory approval, provided reasonable notice of detrimental changes is given to policyholders (60 days is a guide).

Key interpretative position discussed	
View 1 – Contract boundary end point is first renewal date after the annual premium increase each year (generally 1 April)	• Implication is a contract boundary of up to one year. • Annual repricing cycle typically considered central to managing portfolio risk. • Whilst a PHI may effectively reassess risk through adjustments to product design and benefits this may not always be fully achieved in conjunction with a pricing change, given the regulator approval barrier that limits a PHI from freely repricing premiums more frequently than the accepted annual repricing.
View 2 – Contract boundary ends at the end of the period in which an insurer may change prices, migrate policies or change benefits with regulatory approval and/or notice to policyholders (PHI conduct of conduct specifies 60 days as the minimum notice for detrimental changes)	• Implication is a contract boundary of less than one year. • PHIs may create or close products, transfer policies to other products or vary coverage or benefits at any time without regulator approval but with appropriate notice to policyholders. • PHIs have the ability to apply for out-of-cycle repricing, though this is not widelyconsidered sustainable or practical to use as a regular re-pricing mechanism, with this option flagged by some insurers as a remediation strategy when facing financial stress • View 2 may be supportable for an insurer based on their specific facts and circumstances.

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- **Similar risks**: General consensus by preparers that risks in PHI products are health risks.
  - Products issued by PHI's (including hospital/ancillary or domestic/overseas) are expected to all be considered "health risks".
  - To be monitored for any emerging products.
- **Managed together:** How risks are managed together is specific to the circumstances of each insurer.
  - One approach for insurers to determine the level at which portfolios are managed would be to evaluate internal management reporting and management structures.
  - However, how risks are managed in practice may differ from and override a conclusion purely based on management reporting.
- **Profitability Groups:** PHIs may not need to allocate policies to groups of contracts that "at initial recognition have no significant possibility of becoming onerous subsequently", depending on their own "facts and circumstances".

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Overview of issues

- Australian PHIs are anticipating the use of the PAA method for the majority of their complying health insurance products. Under PAA the entity shall assume no contracts are onerous at initial recognition, unless “facts and circumstances” indicate otherwise.
- “Facts and circumstances” are not defined in AASB 17 and it becomes an area of judgement for each entity.
- AASB17.20 provides exemption from dividing a portfolio of insurance contract into profitability groups. Due to the special characteristics of law and regulations within Australian PHI in support of community rating and restriction in rate increase, Australian PHI may qualify for the exemption of paragraph 20.

Summary of discussions

• Identification of onerous contracts under PAA	• The identification of “facts and circumstances” of onerous contracts does not require entities to perform additional analysis. • Reporting within the entity such as internal senior management reporting, pricing submission, pricing philosophy, or Financial Condition Report (FCR) may highlight the existence of certain onerous products. An onerous group of contracts would then be recognised, unless such contracts are onerous only due to specific constraints from law or regulation.
• AASB 17.20 exemption application	• Due to the specific characteristics of laws and regulations within Australian PHI, in support of community rating, where PHI’s are not able to refuse cover, or differentiate pricing by age, health conditions and claims history, risk equalisation requirements as well as regulations that exist around rate increase, the exemption under paragraph 20 may be applied; however • The exemption under paragraph 20 is not applicable where there is known shortfalls in pricing due to the insurer's self-regulatory pricing, philosophy, or practices based on industry norms that are not underpinned by legal or regulatory requirements.
• Subsequent measurement	• Subsequently, an entity shall assess annually whether contracts that are not onerous at initial recognition have subsequently become onerous by assessing the likelihood of changes in applicable “facts and circumstances”. Where the basis has not changed (e.g. there has been no updated forecast) then there would be no new facts and circumstances. As per AASB 17.B65, the definition of fulfilment cash flows includes direct insurance acquisition costs, claims handling cost, and policy administration and maintenance costs, and those costs are likely to be different for individual products.

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AASB Transition Resource Group for AASB 17 *Insurance Contracts*

Implementation question discussed by the Private Health Insurers (PHI) focus group – Level of Aggregation & Profitability Groups

Submission date	22/03/2021
Name	Alane Fineman
Title	Coordinator of Level of Aggregation & Profitability Groups Paper
Organisation	PHI focus group (a working group of the AASB TRG)
Stakeholder group	Industry Group

Potential implementation question

The purpose of this paper is to summarise industry discussions of Australian Private Health Insurer's (PHI's) regarding their approach to AASB 17's definition of portfolios.

This paper determines that the health insurance book may form one portfolio where all policies cover similar health risks and are managed together. Products issued by PHI's were generally considered and expected to all be considered "health risks", noting that individual health insurers will need to perform their own assessments based on their specific set of 'facts and circumstances'. An entity may manage risks and products collectively resulting in one portfolio but any objective evidence of an internal management structure that differentiated products would be a rebuttable presumption that there is more than one portfolio and the entity would need to demonstrate that risks are collectively managed.

Domestic, overseas visitor cover (OVC) and overseas student health cover (OSHC) contracts, may be required to be identified as separate portfolios where they are separately managed, but considerations should be given to the materiality of these components and whether this warrants allocation into a separate portfolio.

Paragraph of IFRS 17 *Insurance Contracts*

IFRS 17.14-16, IFRS 17.78

Analysis of the question
The analysis of the question should include a detailed description of the different ways the new Standard may be applied, resulting in possible diversity in practice.

Refer to Appendix A for paper drafted and discussed by the PHI industry

Is the question pervasive?
Explain whether the question is expected to be relevant to a wide group of stakeholders.

The question is relevant for all PHIs and may also impact others in assessing the definition of "similar risks managed together".

Appendix A – Level of Aggregation & Profitability Groups considerations for Australian PHI

A.1 Background

AASB 17 requires at a minimum, segregation of contracts by:

- Portfolio: Similar risks and managed together; then by
- Profitability groups: whether onerous at inception, no significant possibility of becoming onerous and remaining contracts; with groups then separated across;
- Annual cohorts (AASB 17:14-24).

The classification of portfolios determines the level at which policyholder assets or liabilities are presented in the statement of financial position.

A.2 Accounting Analysis

<u>Accounting requirement</u>

AASB 17.14 requires insurers to "identify *portfolios of insurance contracts*. A portfolio comprises contracts subject to similar risks and are managed together. Contracts within a product line would be expected to have similar risks and hence would be expected to be in the same portfolio if they are managed together."

i) Similar risks

The standard infers that contracts in the same portfolio should have cashflows which respond similarly in amount and timing to changes in key assumptions, meaning that losses on insurance contracts for one type of insurance risk would not be offset by gains on insurance contracts with exposure to different insurance risks or in a different annual cohort of contracts issued.

Contracts within a product line would be expected to have similar risks and therefore be in the same portfolio if they are managed together. Note that the term 'product line' is not defined under AASB 17.

ii) Managed together

"Managed together" is not defined by AASB 17 and judgement is required to determine the appropriate application. In making the judgements of whether contracts are managed together, Actuaries Institute Information Note: AASB 17 Insurance Contracts suggests that an entity may consider factors such as how senior management manages financial performance internally. Management structure and reporting management information can be an indicator of how the PHI manages the business. This may provide factual evidence to support the assertion, however, where a management reporting structure is used for reporting and analysis but not for managing collective risk then consideration of the predominant management activity may be more relevant.

iii) Presentation

AASB 17.78 requires entities to aggregate portfolios of insurance contracts held at each reporting date across:

- Insurance contracts issued that are assets
- Insurance contracts issued that are liabilities

AASB17 17.95,96 requires an entity to aggregate or disaggregate information so that useful information is not obscured either by the inclusion of a large amount of insignificant detail or by the aggregation of items that have different characteristics. Examples of aggregation bases that might be appropriate for information disclosed about insurance contracts are:

- type of contract (for example, major product lines);
- geographical area (for example, country or region); or
- reportable segment, as defined in AASB 8 Operating Segments.

iv) Profitability groups

AASB 17.16 requires an entity to divide portfolios of insurance contracts issued into a minimum of:

- a group of contracts that are onerous at initial recognition, if any;

- a group of contracts that at initial recognition have no significant possibility of becoming onerous subsequently, if any; and
- a group of the remaining contracts in the portfolio, if any.

Applicability to PHI

i) Similar risks

As risks managed by PHIs are all health-related risks (i.e. an adverse event or negative health consequence due to a specific event, disease, or condition), it is expected a view of how risks are similar will be established across the industry.

Health related risks arise from hospital and ancillary policies:

- Hospital policies: The insurer is liable to pay the total claim cost of eligible treatments less excess/deductibles.
- Ancillary products: These include some members who are expected to claim more than the premium each year. However, it is not legally permitted to underwrite individuals based on their individual past claiming experience or individual risk characteristics. As such, there is a clear transfer of risk.

Hospital and ancillary products can be sold separately, sold together, or as combined products that cover both areas. The underlying risks often give rise to integrated or intertwined health related risks as a single medical condition or event can lead to claims for hospital treatment and ancillary treatment. For instance, knee surgery might require physiotherapy follow-up as would many other surgeries. This demonstrates that the same risk results in clams across a multitude of medical service and claim types.

Furthermore, all health insurance claims across both hospital and ancillary products have similar treatment times and are short tail in nature with an expected run-off of 3 months. They are also impacted by the same systemic events, such as the COVID-19 pandemic, medical inflation, and MBS pricing changes.

While OSHC policies have a longer contract boundary (average of 3-5 years), their insurance risks are sufficiently similar to Domestic and OVC policies given they have the same benefit coverage, claims have the same short-tailed nature, and are subject to the same systemic risks. The events that give rise to claims (ill-health, injuries, preventative care) are identical.

In general, based on the points above, it could be concluded that health insurance products reflect similar insurance risks noting that each insurer would need to make their own assessment based on their specific set of facts and circumstances,

ii) Managed together

Managed together is not defined by AASB 17 and judgement is required to determine the appropriate level. As the circumstances of each insurer vary, how an insurer assesses the level at which their policies are managed together is specific to each insurer.

A practical approach for insurers to determine the level at which portfolios are managed would be to evaluate internal management reporting and management structures.

Insurers should also consider whether management reporting is intended to manage risks or is used for other purposes, i.e. reporting on member numbers by state may be used to track expansions into new markets, and not for managing risks. Thus, while management reporting is central to any assessment of whether risks are managed together, there are potentially other considerations to take into account that may influence the overall conclusion.

Considerations which may restrict a PHI from managing domestic policies, i.e. by product, branding, channel or customer segment, include:

- Domestic products are subject to community rating whereby insurers are not able to risk assess individual policyholders and charge a different price due based on health status or claims history.
- There is cross-subsidising of risk across the PHI industry as funds with an older or higher risk membership base, who incur greater claims costs, are compensated by funds with a younger membership base through the risk equalisation process.
- There is a common annual premium increase cycle across the PHI industry where rate rises are approved by the Minister of Health. This process largely drives the profitability of policies for the following year relative to claims inflation factions which are also prevalent across the PHI industry.

Other factors which may indicate that an insurer's policies (Domestic, OVC and OSHC) are managed together include:

- While hospital and ancillary policies can be issued separately, they are typically held by the same policyholder.
- Capital adequacy is assessed across the fund as a whole and there is no distinct capital allocation across sub-portfolios of products.
- Pricing decisions are performed by a common actuarial team.
- Contracts with hospital providers to manage incurred claims apply to both domestic and overseas policies. Contracts are national.
- Management incentives are based on the performance of the Health Insurance business as a whole.

iii) Presentation

Under the Premium Allocation Approach (PAA), the portfolio level may impact whether a portfolio is in an asset or liability position. In line with AASB 17.78, those in an asset position are shown separately on the balance sheet. As PHI premiums are received in advance, it is expected that all insurance contracts will be in a net liability position as the aggregation of prepaid premiums and claims liabilities will outweigh premium receivables, Medicare rebates and risk equalisation recoveries.

PHIs may be able to present and disclose insurance contracts at a total level in the financial statements under certain circumstances, for example:

- OVC and OSHC contracts – these typically make up small percentage of the total portfolio and therefore further disaggregation may be unnecessary if immaterial to the users of financial statements under the requirements of AASB17.95. Materiality considerations will be specific to each company and should be discussed with their auditor.
- PHI policies are health insurance contracts. Presentation by type of contract may be an acceptable outcome under AASB17.96(a) as the major product line.
- Whether the information provided at a single portfolio level is sufficient to provide users of financial statements sufficient information to enable understanding of the financial results and position.

Each PHI may elect to disaggregate the presentation further to suit their specific reporting requirements, ie for segment reporting.

iv) Profitability groups

After portfolios have been determined, insurers applying the PAA review "facts and circumstances" to determine how a portfolio is allocated across profitability groups.

"Onerous" or "profitable" groups
Refer to the **Onerous Contacts Paper** for discussion of how PHIs approach the allocation of contracts to onerous or profitable groups under AASB 17.

Group of policies with "no significant possibility of becoming onerous subsequently"
It could be that facts and circumstances can support an assertion that policies have no significant possibility of becoming onerous subsequently as profitability can be adversely impacted by abnormal future claims experience and other market factors.

A.3 Summary of discussions

While all health insurance policies share similar risks, how risks are managed together is specific to the circumstances of each insurer. Therefore a “one size fits all” approach to assessing portfolios is not expected to be adopted for PHI.

Presentation of insurance contracts in the financial statements may be able to aggregate domestic, OVC and OSHC contracts, unless PHI’s require more granular disclosure, i.e. for segment reporting.

PHIs may not need to allocate policies to groups of contracts that “at initial recognition have no significant possibility of becoming onerous subsequently”, depending on their own “facts and circumstances”.

AASB Transition Resource Group for AASB 17 *Insurance Contracts*
Submission form for potential implementation question

Submission date	15/03/2021
Name	Cassandra Cope
Title	Participant in PHI Focus Group
Organisation	PHI Focus Group (a working group of the AASB TRG)
Stakeholder group	Industry Group

Potential implementation question

Can Australian Private Health Insurers apply Paragraph AASB 17.20 due to the Community Rating requirements that impact their insurance products?

The paper addresses the unique features of Complying Health Insurance Products (CHIP) as defined in the Private Health Insurance Act 2007 that are issued by Australian Private Health Insurers (PHIs) in the context of the AASB 17 Onerous Contracts requirements.

Paragraph of IFRS 17 *Insurance Contracts*

Various, including: AASB 17.18, 17.20 and 17.47-52

Analysis of the question
The analysis of the question should include a detailed description of the different ways the new Standard may be applied, resulting in possible diversity in practice.

Refer to Appendix 1 for detailed discussion paper in relation to applying the onerous contracts requirements to CHIP, issued by PHIs.

Is the question pervasive?
Explain whether the question is expected to be relevant to a wide group of stakeholders.

Yes. This is expected to impact the Australian PHI industry.

Appendix 1 - AASB 17 Onerous Contracts in Australian PHI

Background

In May 2017, the International Accounting Standards Board ("IASB") issued a comprehensive accounting standard for insurance contracts ("IFRS 17"). The overall objective of IFRS 17 is to provide a more useful, transparent and consistent accounting model for insurance contracts among entities issuing insurance contracts globally. The Australian equivalent ("AASB 17") was released in July 2017.

It replaces:

- AASB 4 Insurance Contracts
- AASB 1023 General Insurance Contracts
- AASB 1038 Life Insurance Contracts.

On 30 July 2020 the AASB issued amendment AASB 2020-5 Amendments to Australian Accounting Standards – Insurance Contracts, which includes a deferral of the effective date of AASB 17 by two years so that entities would be required to apply AASB 17 for annual periods beginning on or after 1 January 2023.

AASB 17 establishes principles for the recognition, measurement, presentation of disclosure of insurance contracts issued. It requires companies to measure insurance contracts at current value, estimated future payments to settle incurred claims on a discounted basis and the discount rate needs to reflect the characteristics of the insurance cash flows. Under the new standard, companies will provide information about different components of current and future profitability.

To increase the transparency of an entity's performance, AASB 17 introduces a comprehensive framework – recognition of onerous contracts.

Executive Summary

This is a discussion paper on "Onerous Contracts", which is one of the new frameworks introduced by AASB 17 Insurance Contracts. This paper studies this concept by reviewing:

- the definition and requirements in AASB 17 Insurance Contract and Private Health Insurance Act;
- the Community Rating requirements in the Australia Private Health Industry (PHI); and
- reviews the eligibility of applying the exemption for the onerous contract.

This discussion paper's main focus is to address the treatment of onerous contracts under AASB 17 on Complying Health Insurance Products (CHIP) as defined in the Private Health Insurance Act 2007. Other insurance products such as overseas student health cover, or overseas visitor health cover are not specifically addressed in this paper and will be covered in a separate discussion paper.

One of the characteristics of the Australian Private Health Insurance (PHI) is community-rating. This means for each type, level of insurance coverage and state, the insurer is only allowed one premium rate and is not able to risk-rate the insured based on age, medical conditions, claims history or other pre-existing factors. Under the Private Health Insurance Act 2007, PHI insurers are not permitted to refuse to underwrite anyone who seeks to be insured, and policyholders are guaranteed the right to renew cover.

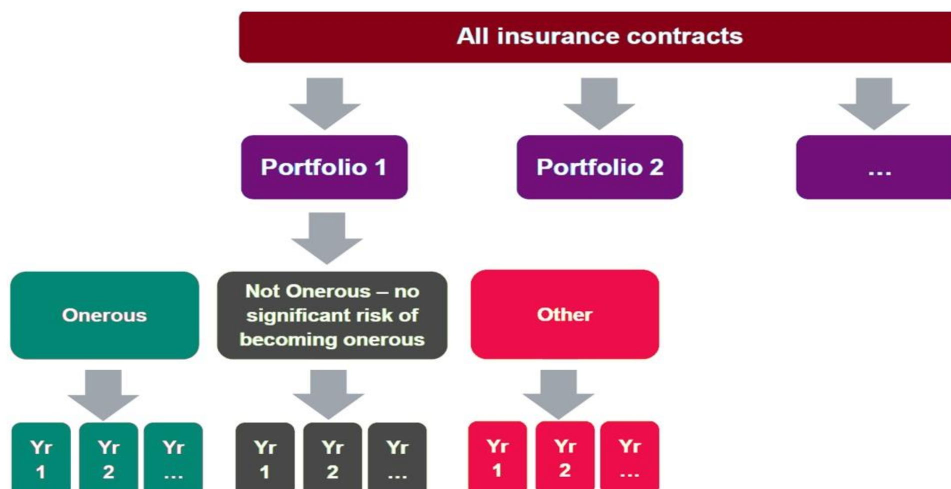
Why identification of onerous contracts is required

An entity shall identify portfolios of insurance contracts. A portfolio comprises contracts subject to similar risks and managed together. Contracts within a product line would be expected to have similar risks and hence would be expected to be in the same portfolio if they are managed together. Contracts in different product lines (for example single premium fixed annuities compared with regular term life assurance) would not be expected to have similar risks and hence would be expected to be in different portfolios. [AASB 17.14] *An entity shall divide a portfolio of insurance contracts issued into a minimum of:* *(a) a group of contracts that are onerous at initial recognition, if any;* *(b) a group of contracts that at initial recognition have no significant possibility of becoming onerous subsequently, if any; and* *(c) a group of the remaining contracts in the portfolio, if any. [AASB 17.16]* *An entity shall not include contracts issued more than one year apart in the same group. To achieve this the entity shall, if necessary, further divide the groups described in paragraphs 16–21. [AASB 17.22]*

The existence of onerous contracts impacts the level of aggregation of contracts and data and may affect insurers' ability to aggregate contracts for valuation purposes. If an insurer chooses to use different aggregation for valuation purposes, it will then need to perform an allocation back to the level of aggregation required under AASB 17.

The Standard requires insurers to aggregate insurance contracts:

1. By portfolios of contracts
   Defined as 'insurance contracts that are subject to similar risks and managed together'.
2. By expected resilience to becoming onerous as at initial recognition:
   - a group of contracts that are onerous (loss-making) at initial recognition
   - a group of contracts that at initial recognition are at no significant possibility of becoming onerous; and
   - a group of any remaining contracts in the portfolio level of aggregation
3. By annual cohort
   Contracts issued more than one year apart cannot be included in the same group.



These aggregation rules are expected to result in more granular groupings than current Australian practice, necessitating more complex modelling, valuation processes, data requirements and different profit profiles than is currently the case. More contracts may be recognised as 'onerous' at initial recognition because the requirement to identify and separate individual onerous contracts into a separate group means insurers will not be able to offset these loss-making contracts against profitable ones within the same portfolio. Cross-subsidies between different segments of business will become

more transparent and may directly impact SoCI and net assets with potentially wide-reaching implications for the design and pricing of affected insurance products.

Onerous Contract Definition

An insurance contract is onerous at the date of initial recognition if the fulfilment cash flows allocated to the contract, any previously recognised insurance acquisition cash flows and any cash flows arising from the contract at the date of initial recognition in total are a net outflow. Applying paragraph 16(a), an entity shall group such contracts separately from contracts that are not onerous. To the extent that paragraph 17 applies, an entity may identify the group of onerous contracts by measuring a set of contracts rather than individual contracts. An entity shall recognise a loss in profit or loss for the net outflow for the group of onerous contracts, resulting in the carrying amount of the liability for the group being equal to the fulfilment cash flows and the contractual service margin of the group being zero. [AASB 17.47]

An insurance contract is onerous at the date of initial recognition if the fulfilment cash flows allocated to the contract, any previously recognised insurance acquisition cash flows, and any cash flows arising from the contract at the date of initial recognition in total are a net outflow. In another words, **A group of contracts becomes onerous if its estimated cash outflows exceed its estimated cash inflows.**

Onerous contracts under General Model

If an entity has reasonable and supportable information to conclude that a set of contracts will all be in the same group applying paragraph 16, it may measure the set of contracts to determine if the contracts are onerous (see paragraph 47) and assess the set of contracts to determine if the contracts have no significant possibility of becoming onerous subsequently (see paragraph 19). If the entity does not have reasonable and supportable information to conclude that a set of contracts will all be in the same group, it shall determine the group to which contracts belong by considering individual contracts. [AASB 17.17]

Under General Model, entities can use “reasonable and supportable” information to conclude that a set of contracts belong to the same group (onerous / other) • e.g. business plans • e.g. pricing models/structures. In the absence of this, the expectation is the test is done on individual contract and assign to group on that basis.

If contracts are onerous, losses are recognised immediately in profit or loss. No contractual service margin is recognised on the balance sheet on initial recognition for gross policies. (AASB 17.47) On subsequent measurement, if a group of insurance contracts becomes onerous (or more onerous), that excess shall be recognised in profit or loss. Additionally, CSM cannot increase and no revenue can be recognised, until the onerous amount previously recognised has been reversed in profit or loss as part of service expenses. (AASB 17.48-49).

Onerous contracts under Premium Allocation Approach (PAA)

For contracts issued to which an entity applies the premium allocation approach (see paragraphs 53–59), the entity shall assume no contracts in the portfolio are onerous at initial recognition, unless facts and circumstances indicate otherwise. An entity shall assess whether contracts that are not onerous at initial recognition have no significant possibility of becoming onerous subsequently by assessing the likelihood of changes in applicable facts and circumstances. [AASB 17.18]

If facts and circumstances indicate that a group of contracts is onerous during the coverage period, an entity shall calculate the difference between:

(i) the carrying amount of the liability for remaining coverage (LRC), excluding the loss component determined under Premium Allocation Approach (PAA), and
(ii) the fulfilment cash flows that relate to remaining coverage.

The entity shall recognise this difference as a loss and increase the liability for remaining coverage.

For entities that qualify to use PAA, insurance contracts are assumed to not be onerous ***unless "facts and circumstances" indicate otherwise***. This may set a lower threshold of evidence for identifying contracts however we would be basing reviews on similar information.

Unprofitable contracts will now be recognised using the onerous contracts test, instead of the Liability Adequacy Test required under AASB 1023. It is expected that this test will be at a more granular level.

AASB 17 does not define facts and circumstances and therefore this is a key area of judgement.

Considerations for facts and circumstances (under the PAA)

Given PAA was developed as a simplified approach that was meant not to burden entities by creating high costs and operational complexity, insurers applying PPA may review 'facts and circumstances' using information which is readily available from the existing financial reporting and planning processes i.e. a high-level net margin (net of claims and expenses) assessment.

The following sets out the considerations for facts and circumstances for the identification of onerous contracts:

- As 'facts and circumstances' is not defined in the Standard, each individual PHI will need to consider their own circumstances when defining facts and circumstances. This will reflect the information available within the entity that indicate loss making products, and what is considered to be existing facts and circumstances. Sources of information could include documents such as the annual rate submission, internal management reporting at the senior level, Pricing Philosophy, and the Financial Conditions Report (FCR).
  Consideration will need to be given to what gross and net margin information is available at various levels, and that the default position is that all contracts are profitable. Reports with more granular information may only be available excluding expenses, a simple allocation of expenses may not be appropriate.
  An example of PHI entity judgement would be each individual entity deciding the weight they will put between historical performance and the forecast future performance.
- When utilising retrospective information to assess the profitability at initial recognition of contracts to be incepted (i.e. management reporting based on policies already written), each insurer should determine the hurdle level that a product must pass before being considered not onerous.
- An entity shall assess whether contracts that are not onerous at initial recognition have subsequently become onerous by assessing the likelihood of changes in applicable 'facts and circumstances'. Where the basis has not changed (e.g. there has been no updated forecast) then there would be no new facts and circumstances.

Note: As per AASB 17.B65, the definition of fulfilment cash flows includes directly attributable insurance acquisition costs, claims handling cost, and policy administration and maintenance costs, and those costs are likely to be different for individual products. When performing subsequent measurement, the test will only include on-going expenses.

Exemption from dividing a portfolio of insurance contracts into profitability groups

If, applying paragraphs 14–19, contracts within a portfolio would fall into different groups only because law or regulation specifically constrains the entity's practical ability to set a different price or level of benefits for policyholders with different characteristics, the entity may include those contracts in the same group. The entity shall not apply this paragraph by analogy to other items. [AASB 17.20]

AASB 17 gives exemption from dividing a portfolio of business into profitability groups for economic differences that arise as a result of regulation. For example, in some jurisdictions, local regulations may prohibit a company from charging different premiums to policyholders because of a specific characteristic (for example, gender, age, race or location of residence). These regulations **may prevent companies from pricing a contract to reflect the risk** of a particular policyholder based on that characteristic. The application of this exemption will require analysis of the precise nature of any

pricing constraints specific to each insurance industry. Pricing constraints relevant to Australian PHI are discussed further below.

Constraints on pricing due to law or regulation

- PHIs are not permitted to refuse to sell an existing product to anyone who seeks to be insured, and policyholders are guaranteed the right to renew cover. Exclusions apply where a PHI entity is only open to specific types of members, and for corporate products.
- The insurance must be in the form of a Complying Health Insurance Product (CHIP) under Private Health Insurance Act 2007.
- Due to community rating requirements within the Private Health Insurance Act 2007 for domestic policies and Private Health Insurance (Health Benefits Fund Policy) Rules 2015 for OSHC policies, for each type and level of insurance coverage, the insurer is only allowed one premium rate, as it is not allowed to risk-rate the insured based on age, medical conditions, claims history, or other pre-existing factors. This restricts the practical ability for PHIs to differentially price products to recover high expected future claims from some contracts. The community rated price applies equally to both new and renewing policyholders who have held private health insurance continuously with any PHIs since the age of 30.
- Medicare levy surcharge (MLS) is levied on Australian taxpayers by the ATO if they do not continuously hold insurance from the age of 30 and are earning above a certain threshold.
- 2% Lifetime Health Cover (LHC) loading is charged to policyholders on top of their premium for every year they did not hold insurance after the age of 30.
- Health insurers seeking to change their premium are required under legislation to obtain regulatory approval. Through this process the Minister for Health must approve the proposed changes, unless this “would be contrary to the public interest’, whereby the Minister can request changes to submitted rates.
- PHIs may request to change their prices with 6 weeks’ notice to the regulator. In practice the majority of insurers update their prices on 1 April each year, which is the industry norm.
- PHIs allow policyholders to pay premiums in advance. This is usually limited, with many PHI entities capping the prepayment period at 12-18 months. Policyholders who prepay are not subject to any premium increases until their next premium payment is due.
- The PHI Reform determined the minimum benefit requirements for each level of hospital cover. PHIs are able to include additional benefits, however cannot set benefit lower than the minimum level prescribed in the PHI Reform.
- Waiting periods may apply to new policyholders for certain benefits or with certain pre-existing conditions.
- PHIs may change their products with 60-day notice to the insured for detrimental changes. Detrimental changes can include level of benefits, waiting periods, product closure and increases in premium.
- All health insurers must participate in Risk Equalisation Special Account (RESA). The purpose of risk equalisation is to support the community rating principal. Insurers are not allowed to risk rate premiums; therefore, risk equalisation partially compensates insurers with a riskier demographic profile by re-distributing money from those insurers paying less than average benefits to those paying higher than average benefits. Age based pool (ABP) claims and high cost claimant pool (HCCP) claims in respect to hospital policies are shared among all PHIs in proportion to the number of Single Equivalent Units (SEUs) insured in each state. The Risk Equalisation Trust Fund is administered by APRA.

Note: For the purposes of this discussion paper it is assumed that RESA is accounted for under AASB 17 and not another accounting standard. Further, it is assumed that RESA is not accounted for as a reinsurance arrangement under AASB 17. A separate paper is being drafted on how the RESA cashflows will be treated under AASB 17.

Broadly, Australian PHIs are expecting to use the PAA method, and also expecting to have a low number of portfolios, some potentially even one portfolio. Once portfolio is determined, the entity needs to consider the facts and circumstances they have available which indicates that there are “onerous groups”.

Due to the specific characteristics of laws and regulations within Australian PHI in support of community rating, where PHIs are not able to refuse cover, or differentiate pricing by age, health

conditions and claims history, risk equalisation requirements as well as regulations that exist around rate increase, the exemption under paragraph 20 may be applied. However, it is not an all-out solution, but it will certainly reduce onerous contracts.

Exemption under paragraph 20 is not applicable where there is known shortfalls in pricing due to the insurer's self-regulatory pricing philosophy, or practices based on industry norms that are not underpinned by legal or regulatory requirements.

For complying health insurance products, the following sets out the considerations for the application of paragraph 20:

- PHIs can price by product, excess levels, membership scales, and state (PHI Act 2007, subsection 63-5(2)(A), 66-5 and 66-10), which may contain certain assumptions regarding the proportion of policyholder demographics within a product, however due to community rating principles, not able to differentiate pricing by age, claims history and health status, or refuse certain groups from being insured (PHI Act 2007 subsection 55-5(20), 66-1 and 66-5).
- The legislation does not allow PHIs to refuse cover for anyone who seeks to be insured (with the exception of PHI entities who are only open to specific types of members and corporate products).
- There is no regulation/legislation restriction on the relativities selected between different membership categories. Traditionally, the price for family contributors was fixed by *National Health Act* at twice the single rate. From 1 October 1996, membership categories have been extended to single, couple, family and single parent family. The requirement for the family contribution rate to be twice the single contribution rate was removed, with no specific requirements for the relativity of the scale splits. PHI entities were also given the flexibility not to offer all categories of membership for a given product.
- PHI Reform determined the minimum benefit requirements for each level of hospital cover. PHI entities are able to include additional benefits, however cannot be lower than the minimum level set.
- There are limited opportunities to increase rate, with industry norm increasing annual rate on 1 April, following approval from Minister for Health after rate increase submissions made in November. PHIs can apply to Minister for Health anytime during the year to increase rates, however, there is a limited window for this to occur, with compiling submission, seeking approval, communication to members and system changes. This is due to customer affordability concerns in the health insurance industry, resulting in reduced opportunities for higher rate increases. Hence, there may be limited opportunity to turn loss making into profit making within a short time period. As such, while technically PHIs can influence the gross margin through pricing by product, the legislation can still indirectly cause the products to become onerous.
- PHI entities can close products, change benefits and transfer members to new funds with sufficient notice.

Australian PHI's view

The general consensus among Australian PHIs is, by virtue of the specific laws and regulations to support community rating, risk equalisation requirements as well as price increase restrictions and inability to refuse cover, paragraph 20 of the Standard is relevant for the application of onerous contract exemption.

As Australian PHIs are anticipating the use of the PAA method for the majority of their complying health insurance products, and given such extensive legislative restrictions within PHI industry, it can be assumed that no complying health insurance contracts at initial recognition are onerous or have any significant possibility of becoming onerous, unless facts and circumstances for that particular PHI indicate otherwise.

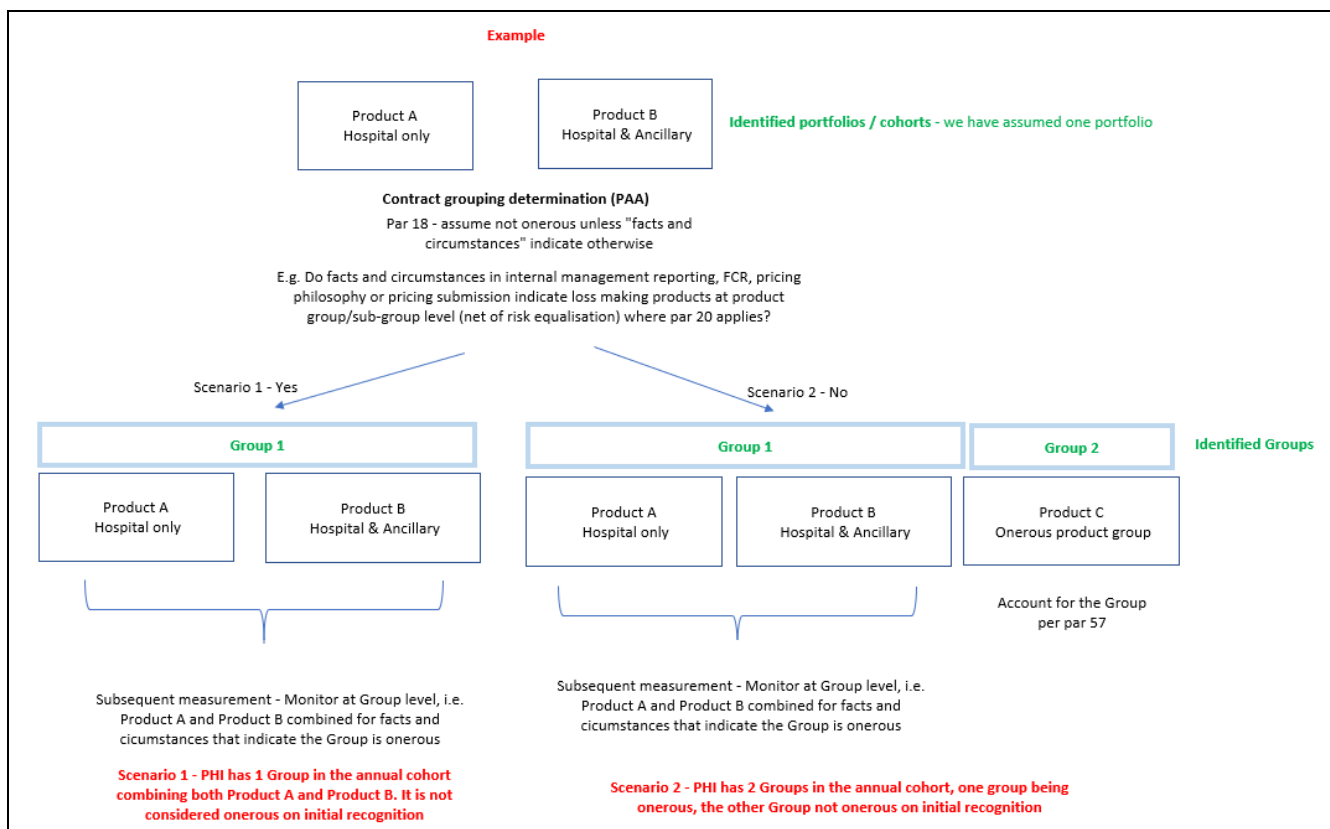
For an individual PHI, it may be the case that facts and circumstances cannot support an assertion that policies have no significant possibility of becoming onerous subsequently as profitability can be adversely impacted by abnormal future claims experience and other market factors.
Reporting within the entity such as internal management reporting, pricing philosophy, FCR, or the planning/pricing process may highlight the existence of certain onerous products. Considerations need to be taken into account:

- That the default position is that all products are profitable.
- Identification of onerous contracts should not be at a level in which pricing has been restricted by regulator (e.g. by age/claims history/health status).
- Different options are available to determine the appropriate margin test threshold for evidence of identification of onerous contracts (e.g. gross margin, loss ratios etc), and taking into account ongoing servicing expense, risk adjustment and allowance for net impact of risk equalisation.
- The appropriateness of equally allocating expense loadings.
- That PHI entities are not required to create new information or analysis, but use existing facts and circumstances.
- The fact that products are assessed on an annual basis as part of the repricing process to determine what the new premium rate would be. This assessment would clearly indicate whether there are facts and circumstances that would indicate onerous contract pricing exists.
- APRA reporting requirements where more granular data is required to be reported, e.g. geographical data, which may provide evidence of onerous contracts.
- Whether the risk equalisation payments should be considered as part of the fulfillment cash flows (i.e. assessment of the profitability/onerous contracts net of risk equalisation payment or receipt). Further analysis is being performed on this consideration in a separate paper.

Paragraph 20 exemption must not be applied for known and intended shortfalls in profitability of certain groups of contracts. If in the internal management reporting, pricing philosophy, FCR or during the planning/pricing process, the PHI identifies particular sub-groups as loss-making products, this would indicate “facts and circumstances” of the existence of an onerous group of contracts. An onerous group of contracts would be then recognised, unless such contracts are onerous only due to specific constraints from law or regulation.

PHI entities can identify onerous contracts and assess the applicability of paragraph 20 exemption as follows:
Step 1 – Identify portfolios of insurance contracts
Step 2 – Assess whether PAA measurement model can be applied to each groups of insurance contracts
Step 3 – Where PAA model is used, assume no groups of contracts are onerous at initial recognition, unless facts and circumstances indicate otherwise.
After the initial test for onerous groups, this should continue annually in the planning/pricing process, in line with the annual rate increase.
Step 4 – Assess whether paragraph 20 exemption can be applied to identified onerous contracts.
If paragraph 20 exemption is not applicable to those groups of contracts, recognise loss component.
Step 5 – AASB 17.21 permits, but does not require, further segmentation of by groups of different levels of profitability (i.e. multiple profitable or multiple onerous groups) at initial recognition.
Step 6 – Subsequent measurements:

- In line with AASB 17.24, entities shall establish the groups of contracts at initial recognition and shall not reassess the composition of the groups subsequently until they are derecognised.
- PHI should monitor remaining contracts at group level and only if a whole group becomes onerous, the entity will need to recognise a loss component.
- If an onerous product group subsequently becomes profitable, those loss components are to be reversed in profit and loss and offset against the losses on onerous contracts disclosed in the financial statements.



Conclusion

Australian PHIs can apply paragraph 20 exemption in identification of onerous contracts to complying health insurance products. However, if there are facts and circumstances specific to each PHI that indicates the existence of loss-making products, it will result in the recognition of onerous contracts.

Disclosure of the Onerous Contracts in Financial Statements

An entity shall disclose reconciliations from the opening to the closing balances separately for each of:
(a) the net liabilities (or assets) for the remaining coverage component, excluding any loss component.
(b) any loss component.
(c) the liabilities for incurred claims.
For insurance contracts to which the premium allocation approach described in paragraphs 53–59 or 69–70 has been applied, an entity shall disclose separate reconciliations for: (i) the estimates of the present value of the future cash flows; and (ii) the risk adjustment for non-financial risk. [AASB 17.100]

The losses on Onerous contract and reversal of those losses are displaced as part of the insurance service expenses. See the example below: (Ernst & Young – Selected illustrative disclosures for IFRS 17 Insurance Contracts (Premium allocation approach), IFRS 9 Financial Instruments and IFRS 7 Financial Instruments: Disclosures)

6. Insurance service expense

The breakdown of insurance service expenses by major product lines is presented below:

In €000		2023				
		Personal accident insurance	**Marine insurance**	**Property insurance**	**Liability reinsurance issued**	**Total**
Incurred claims and other expenses	a	1,109	2,207	4,317	1,090	8,723
Amortisation of insurance acquisition cash flows	a	33	285	–	109	427
Losses on onerous contracts and reversals of those losses		–	(3)	–	–	(3)
Changes to liabilities for incurred claims		(27)	16	(122)	(8)	(141)
Impairment of assets for insurance acquisition cash flows		–	19	–	–	19
Reversal of impairment of assets for insurance acquisition cash flows		–	–	–	–	–
Insurance acquisition cash flows recognised when incurred		–	–	396	–	396
Total		**1,115**	**2,524**	**4,591**	**1,191**	**9,421**

Notes to the Financial Statements

11.1. Roll-forward of net asset or liability for insurance contracts issued showing the liability for remaining coverage and the liability for incurred claims *(continued)*

11.1.2. Marine insurance

The roll-forward of the net asset or liability for insurance contracts issued, showing the liability for remaining coverage and the liability for incurred claims for marine insurance product line, is disclosed in the table below:

		2023						
		Liabilities for remaining coverage		**Liabilities for incurred claims**		**Assets for insurance acquisition cash flows**	**Total**	*IFRS 17.100(a)-(c)* *IFRS 17.105A, B*
In €000		**Excluding loss component**	**Loss component**	**Estimates of the present value of future cash flows**	**Risk adjustment**			
Insurance contract liabilities as at 01/01		2,071	17	2,099	49	(406)	3,830	*IFRS 17.99(b)*
Insurance contract assets as at 01/01		-	-	-	-	-	-	*IFRS 17.99(b)*
Net insurance contract (assets)/liabilities as at 01/01		**2,071**	**17**	**2,099**	**49**	**(406)**	**3,830**	
Insurance revenue		(3,012)	-	-	-	-	(3,012)	*IFRS 17.103(a)*
Insurance service expenses		285	(17)	2,216	21	19	2,524	
Incurred claims and other expenses		-	(14)	2,166	55	-	2,207	*IFRS 17.103(b)(i)*
Amortisation of insurance acquisition cash flows	**a**	285	-	-	-	-	285	*IFRS 17.103(b)(ii)*
Losses on onerous contracts and reversals of those losses		-	(3)	-	-	-	(3)	*IFRS 17.103(b)(iv)*
Changes to liabilities for incurred claims		-	-	50	(34)	-	16	*IFRS 17.103(b)(iii)*
Impairment of assets for insurance acquisition cash flows		-	-	-	-	19	19	*IFRS 17.105A, B*
Reversal of impairment of assets for insurance acquisition cash flows		-	-	-	-	-	-	*IFRS 17.105A, B*
Investment components		-	-	-	-	-	-	*IFRS 17.103(c)*
Insurance service result		**(2,727)**	**(17)**	**2,216**	**21**	**19**	**(488)**	
Insurance finance expenses	**b**	**16**	**-**	**62**	**-**	**-**	**78**	*IFRS 17.105(c)*
Effect of movements in exchange rates		**4**	**-**	**2**	**-**	**-**	**6**	*IFRS 17.105(d)*
Total changes in the statement of comprehensive income		**(2,707)**	**(17)**	**2,280**	**21**	**19**	**(404)**	
Cash flows								*IFRS 17.105(a)*
Premiums received	**c**	2,410	-	-	-	-	2,410	*IFRS 17.105(a)(i)*
Claims and other expenses paid		-	-	(1,599)	-	-	(1,599)	*IFRS 17.105(a)(iii)*
Insurance acquisition cash flows		(85)	-	-	-	(147)	(232)	*IFRS 17.105(a)(ii)* *IFRS 17.105A*
Total cash flows		**2,325**	**-**	**(1,599)**	**-**	**(147)**	**579**	
Allocation from assets for insurance acquisition cash flows to groups of insurance contracts		**(131)**	**-**	**-**	**-**	**131**	**-**	*IFRS 17.105A*
Other movements		**-**	**-**	**-**	**-**	**-**	**-**	*IFRS 17.105(d)*
Net insurance contract (assets)/liabilities as at 31/12		**1,558**	**-**	**2,780**	**70**	**(405)**	**4,005**	
Insurance contract liabilities as at 31/12		1,558	-	2,780	70	(403)	4,005	*IFRS 17.99(b)*
Insurance contract assets as at 31/12		-	-	-	-	-	-	*IFRS 17.99(b)*
Net insurance contract (assets)/liabilities as at 31/12		**1,558**	**-**	**2,780**	**70**	**(403)**	**4,005**	

ATT5C

AASB Transition Resource Group for AASB 17 *Insurance Contracts*

Implementation question discussed by the Private Health Insurers (PHI) focus group – contract boundary

Submission date	22/03/2021
Name	Jane Coleman
Title	Coordinator of contract boundary paper
Organisation	PHI focus group (a working group of the AASB TRG)
Stakeholder group	Industry Group

Potential implementation question

The purpose of this paper is to set out considerations for private health insurers (PHIs) in Australia when identifying the end of the contract boundary in AASB 17 Insurance Contracts (AASB 17).

The contract boundary is used to determine the start and end points of coverage in order to identify cash flows for inclusion in the measurement of an insurance contract under AASB 17. Cash flows are within the boundary of an insurance contract if they arise from substantive rights and obligations that exist during the reporting period in which the entity can compel the policyholder to pay the premiums or in which the entity has a substantive obligation to provide the policyholder with coverage or other services.

The ways in which PHI contracts in Australia are bought, sold and renewed, together with their specific regulatory context, means the contract boundary may be open to interpretation.

Paragraph of AASB 17 *Insurance Contracts*

AASB 17.34, AASB 17.B64

Analysis of the question

The analysis of the question should include a detailed description of the different ways the new Standard may be applied, resulting in possible diversity in practice.

Refer appendix A for paper drafted and discussed by the PHI industry

Is the question pervasive?

Explain whether the question is expected to be relevant to a wide group of stakeholders.

The question is relevant for all PHI’s and may also impact others in similarly regulated insurance industries in Australia.

Appendix A – Contract boundary considerations for Australian PHI

A.1. Implications of contract boundary

The contract boundary assessment has a number of implications in relation to other aspects of AASB 17, including:

- Premium Allocation Approach ("PAA") - Contract boundaries must be determined to assess eligibility to adopt the PAA or simplified approach. To automatically qualify for PAA, the coverage period for each contract (including coverage arising from all premiums within the contract boundary) is one year or less.
- Onerous contracts: The determination of a contract boundary will have an impact on the consideration of onerous contracts. This is because all future cash flows, within the boundary of the relevant group of insurance contracts, are included in the onerous contract provision calculation.

Eligibility for the PAA and approach to onerous contracts will be discussed in separate papers, in part, informed by the interpretation of the contract boundary.

A.2. Summary of possible approaches to contract boundary discussed by Australian PHI focus group

A number of views have been identified on where the contract boundary could be drawn for Australian PHI:

Views identified	Implication and Response
View 1 *– Contract boundary end point is first renewal date after the annual premium increase each year (typically 1 April).*	*Implication is a contract boundary of up to one year.* ***Supported by a number of PHIs – refer discussion points in section A.5.***
View 2 *– Contract boundary ends at the end of the period in which an insurer may change prices, migrate policies or changes benefit entitlements with regulatory approval and/or notice to policyholders (the PHI code of conduct specifies 60 days as the minimum notice for detrimental changes).*	*Implication is a contract boundary of less than one year.* ***Under consideration by a number of PHIs– refer discussion points in section A.5.***
View 3 *– Contract term is for a consistent period linked to cycle of premium payments. Maximum contract term of 12 months if this is the limit on periods that may be prepaid and not subject to repricing.*	*Policyholders may pay on cycles ranging from weekly, fortnightly, monthly, quarterly, annually. These payment elections can be modified at any time. Considering a contract term as short as a weekly payment cycle is not in the spirit of what AASB 17 intends. Para 34(b)(i) also contemplates actions in response to the risks of the portfolio of insurance contracts, and there is no practical ability to deal with such an array of contract terms for this purpose.* ***Not supported in industry focus group discussions***

Views identified	Implication and Response
View 4 *– Contracts are perpetual due to guaranteed renewability subject to ongoing payment of premiums.*	*Implication could be a contract boundary extending beyond 12 months. Ignores practical ability to alter pricing and/or benefits to reflect risk.* ***Not supported in industry focus group discussions***

A.3. Relevant extracts from AASB 17 Insurance Contracts

Para 34

Cash flows are within the boundary of an insurance contract if they arise from substantive rights and obligations that exist during the reporting period in which the entity can compel the policyholder to pay the premiums or in which the entity has a substantive obligation to provide the policyholder with services (see paragraphs B61–B71). A substantive obligation to provide services ends when:

(a) the entity has the practical ability to reassess the risks of the particular policyholder and, as a result, can set a price or level of benefits that fully reflects those risks; or

(b) both of the following criteria are satisfied:

  i. the entity has the practical ability to reassess the risks of the portfolio of insurance contracts that contains the contract and, as a result, can set a price or level of benefits that fully reflects the risk of that portfolio; and

  ii. the pricing of the premiums for coverage up to the date when the risks are reassessed does not take into account the risks that relate to periods after the reassessment date.

Application guidance, para B64

Paragraph 34 refers to an entity's practical ability to set a price at a future date (a renewal date) that fully reflects the risks in the contract from that date. An entity has that practical ability in the absence of constraints that prevent the entity from setting the same price it would for a new contract with the same characteristics as the existing contract issued on that date, or if it can amend the benefits to be consistent with the price it will charge. Similarly, an entity has that practical ability to set a price when it can reprice an existing contract so that the price reflects overall changes in the risks in a portfolio of insurance contracts, even if the price set for each individual policyholder does not reflect the change in risk for that specific policyholder. When assessing whether the entity has the practical ability to set a price that fully reflects the risks in the contract or portfolio, it shall consider all the risks that it would consider when underwriting equivalent contracts on the renewal date for the remaining coverage. In determining the estimates of future cash flows at the end of a reporting period, an entity shall reassess the boundary of an insurance contract to include the effect of changes in circumstances on the entity's substantive rights and obligations.

A.4. Relevant Context for PHI in Australia

Background and scope

PHIs in Australia are engaged in some or all of the following types of PHI contracts:

- Australian resident health insurance contract (or 'domestic insurance');
- Overseas students health cover (OSHC); and
- Overseas visitor cover (OVC).

This paper focuses on domestic insurance. Given the OSHC and OVC products often have set periods and/or there is no guaranteed renewal, it is expected they would be treated similarly to other, standard

insurance products (i.e. the contract boundary is either clearly set out within the terms of the contracts or is the point at which the insurer can fully reprice or cease cover).

Resident health insurance contract (or 'domestic insurance')

These are contracts issued under the *Private Health Insurance Act*, encompassing both hospital cover (for in-hospital treatment) and general treatment/ancillary or 'extras' cover (for ambulance, optometry, dental, physiotherapy and other ancillary services).

Unique characteristics of domestic insurance

Guaranteed renewal
All domestic insurance contracts are guaranteed-renewal contracts. That is, policyholders pay premiums upfront at the frequency they select (fortnightly, monthly, quarterly, half-yearly or annually). Each payment automatically renews the policy, provided that policyholders continue to make scheduled payments. If a policyholder has not paid the premium in the renewal period, PHIs have no right to compel the policyholder to pay a further premium. If the policyholder has not paid the premium for more than two months, the insurance contract will lapse and the policyholder will no longer be insured.

Rate protection
PHIs provide premium rate protection on prepaid policies. For example, if a policyholder pays a premium 12 months in advance and the rates are increased within this 12-month period, the policyholder will not be required to pay the increased rate.

Community rating
Health insurance in Australia is 'community rated', meaning premiums are not based on an individual policyholder's risk (i.e. likelihood of claims to be made by the individual policyholder). Instead, community rating stipulates that health insurance must be equally accessible and cost the same for everyone regardless of health status, claims history, gender or age. Therefore, Para 34(a) has limited relevance to PHIs in Australia due to the inability to price products or tailor benefits based on many of the risk characteristics of individuals. A portfolio view outlined in Para 34(b) should be taken.

Government approved rate increase
In Australia, health insurers seeking to increase their premiums are required under legislation to obtain regulatory approval. Applications for the premium increases can be made by a health insurer at any time; however, the practice of applying for an increase through the annual premium round process is the industry norm. Through this process the Minister of Health must approve the proposed changes, unless this 'would be contrary to the public interest', whereby the Minister can request changes to submitted rates. Premium changes arising from the annual premium round typically take effect from 1 April each year, although there are exceptions.

Based on historical precedent it would be highly unusual for the Minister of Health to engage with PHIs on premium rate applications outside of the annual industry cycle. Ministerial press releases reinforce the whole-of-industry, annual premium rate review cycle.

Product and benefit changes
PHIs may make change the benefits covered on their products, including the closure of products and transferral of policyholders to other products. Detrimental changes require reasonable notice to policyholders (typically 60 days as a guide).

A.5. Analysis of Views 1 and 2

	View 1 - Contract boundary end point is first renewal date after the annual premium increase	**View 2 – Contract boundary ends at the end of the period in which an insurer may change prices, migrate policies or change benefit entitlements with regulatory approval and/or notice to policyholders**
Assessment of practical ability to reassess risks		
Practical ability to reprice / reassess risks	Generally, subject to regulatory approval, a PHI typically updates prices on an annual basis with the majority of PHI repricing each 1 April. Some PHI Funds have historically (and currently) updated prices on 1 July. As the Department for Health needs to consider public interests to approve the changes to premiums, there is an extra barrier that prevents a PHI from repricing premiums more frequently. This potentially restricts the practical ability of the insurer to reprice. PHIs typically adopt a level of cross-subsidisation between products and consumer cohorts to manage portfolio level risks. The annual repricing cycle is typically considered central to managing portfolio risk.	A PHI entity has the ability to reassess the risks of the portfolio of insurance contracts and can set a price or the level of benefits that fully reflects the risk of that portfolio outside of the "annual" premium round process. Given the need to gain regulatory approval to increase prices, there are significant practical impediments to out-of-cycle repricing. Adjustments to product design and benefits are far more practical avenues for PHIs to address portfolio risks. PHIs do so frequently, and regulatory approval is not necessarily required. PHIs may act swiftly at any time throughout the year to modify products and/or benefits to address specific commercial risks. It is doubtful though that product and benefit changes alone, if not accompanied by repricing, could be effective in fully addressing the risk of the portfolio of insurance contracts. However, in addition, PHI Funds have the opportunity to close a product and transfer policyholders to a new product.
Other considerations of practical ability	The Minister for Health may refuse a rate increase and ask for PHI's to resubmit. This may mean that the risks are not fully repriced. However, there would be no advantage to refuse rates which allowed PHIs to cover risk as this would ultimately drive PHIs out of the market.	Using the notice period (e.g. 60 days' notice) as a contract boundary may not be practical as it does not consider the additional time for governance and operational considerations that would pre-date a decision to change benefits.
Other areas of consideration / implication		
Customary practice	Based on historical data, the likelihood of repricing more than once a year is remote. This is indicative of a customary business practice. From time to time PHIs defer or do not proceed with an approved annual premium increase, however, this does not alter the fact that a practical ability to reprice was available and therefore would not further extend the contract boundary. In these situations, the next repricing opportunity is typically	PHIs more frequently amend benefits outside of the annual repricing cycle than seek special premium adjustments as a means of managing risks – there are practical examples of these changes by a number of insurers each year. PHI Funds' may allow for changes in benefits, closure of products and the closure & transfer of policyholders as one of the actions to take if the Fund is distressed.

	considered to be the following annual repricing date (e.g.1 April). Although customary business practice is not to make out of cycle premium change requests of the Minister, PHI Funds' may allow for this as one of the actions to take if the fund is distressed.	
Ability to explain results	PHI Funds with differing reporting dates and an annual repricing contract boundary (e.g. 1 April) may, all else being equal, report a different loss component based on the timing of their reporting date. Using a fixed contract boundary during the year creates a cycle of profit and loss recognition across the year that reflects the changing size of the loss component, and not changes in the underlying performance of the fund. This cycle needs to be understood by users of the accounts when interpreting PHI Funds who report more frequently than annually.	The implication of view 2, if adopted by all PHIs is that the contract boundary could represent a rolling window (or say 30 or 60 days). One benefit this offers in the interpretation of financial reports is the avoidance of the "cliff" approach to the expired contract period that results from view 1.
Comparison to current approach	Aligns the contract boundary with the industry and fund practice of repricing. Has similarities to the customary approach adopted by PHIs to the current boundary for performing the liability adequacy test to determine any unexpired risk reserve for a constructive obligation under the existing AASB 1023 General Insurance Contracts.	

A.8. Summary of discussions

The decision around the contract boundary adopted needs to take into account the facts and circumstances relevant to each individual PHI Fund.

Broadly PHI Funds consider that as a jurisdiction there is acceptance of the annual renewal date (generally 1 April) as an acknowledged repricing date, at which PHI Funds can reprice for risk, and therefore it is considered reasonable to adopt this as an effective contract boundary despite the existence of guaranteed renewability of domestic products.

Whilst a PHI Fund may plan to change prices outside the industry cycle, the requirement for regulator approval creates a practical barrier that is unlikely to be passed except in extreme circumstances.

A PHI Fund may be able to effectively reassess risk through adjustments to product design and benefits at any time, with written notice. This cannot always fully achieve rebalancing of the risk due to restrictions on product coverage for each product tier. However, PHI Funds can cancel products and transfer policyholders to new products. This is permitted but may not be considered to be sustainable practice if used continually as a "mechanism" to effectively reassess and reprice for risk.

A contract boundary shorter than the annual repricing point may be supportable for an entity based on their specific facts and circumstances (e.g. where an entity chooses to adopt a pattern of amending terms and benefits, cancelling and opening products and more frequent price setting in conjunction with regulator approval). This may indicate the need to consider a shorter boundary than 12 months for some PHI Funds based on their facts and circumstances. Paragraph B64 sets out that a fund has the practical ability if an entity has the ability; there is no consideration of business practice given.

The approach adopted by the PHI needs to be supported by evidence of their own facts and circumstances and be consistent with their other policies and procedures.