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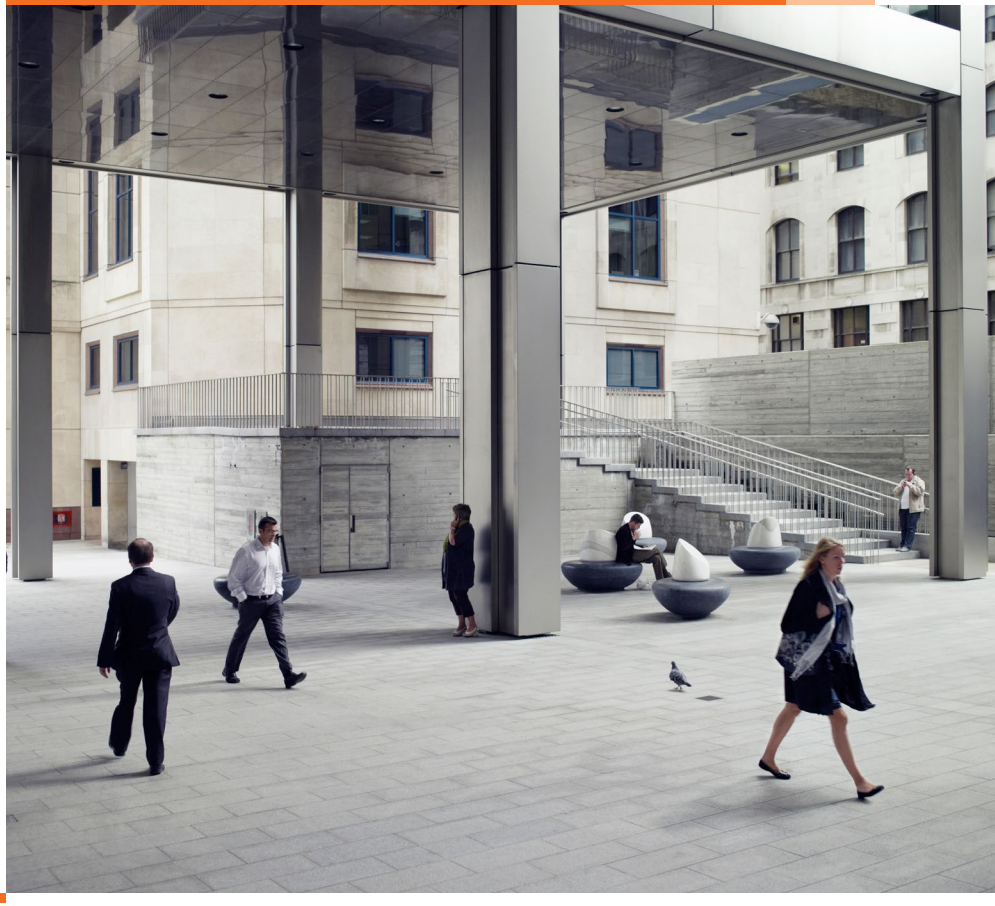
# *Insurance Facts and Figures* 2014



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**Insurance Facts & Figures 2014**

# *Insurance Facts and Figures 2014*

# Contents

# *Foreword*

## Scott Fergusson

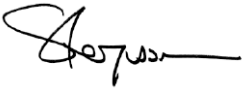
*Welcome to the 2014 edition of Insurance Facts & Figures. PwC is proud to be a significant service provider to the Australian and global insurance sector, and are pleased to share this updated summary of the key players in the Australian insurance marketplace, the regulatory and accounting requirements, and an overview of the tax regime for insurers.*

*In operating terms for years ending in 2013, general insurers overall have generated good results in the face of competitive headwinds and in the absence of major catastrophes. Life insurers have been doing it tough, both in the group life space, where insurers have been dealing with a ramp up in claim activity relative to expectation, and in the retail space where retention of policyholders on the books has continued to be a challenge. Private health insurers have maintained steady performance with the means testing of private health insurance appearing to have less of an impact than it might have. At the sametime, while the increasing profile of aggregators and the upcoming privatisation of Medibank Private are contributing to a changing landscape and dynamic in how private health insurers compete.*

*While 2014 has had less regulatory change than last year when the LAGIC capital standards were introduced, there has been considerable focus on preparing for the implementation of the CPS220 Risk Management standard from 1 January 2015. Risk culture – what is it and how do you promote and assess it – has been a hot topic this year.*

*We hope you find this publication useful and as always if you would like to discuss any aspects of it please contact me on scott.k.fergusson@au.pwc.com.*

*Best wishes*



*Insurance practice leader,*
*PwC Australia*

# 1 General Insurance

# *Introduction*
## Scott Hadfield

*The key themes of the Australian General Insurance market for 2013 were a relatively benign catastrophe year and a focus by many players on expense management. These in conjunction with reinsurance rate reductions and premium rate increases (albeit easing from the overall levels in recent years), have culminated in most insurers posting strong local results. There was transactional activity in the market with IAG's purchase of Wesfarmers' underwriting businesses which was announced late in 2013 and has subsequently passed all regulatory hurdles.*

*Elaborating on the key themes; the only Australian event that exceeded $100 million was Cyclone Oswald. This experience, which was very much in line with a benign global claims environment and the increased capital capacity of reinsurers, has led to downwards pressure on reinsurance rates. On the asset side of the balance sheet, insurers continue to face a market dominated by low investment yields which has been further compounded by the traditional risk adverse asset allocations. As a consequence, we have seen insurers start to explore alternative investment strategies in the pursuit more favourable returns.*

*With the threat from smaller players and new entrants (who are disrupting the market through price and elements of product innovation) remaining, larger less nimble insurers are investing in transformational projects to help enhance shareholder value. These key transformational projects are largely focused on simplification or streamlining key business processes to help deliver cost savings and/or an enhanced customer experience. The overall trend has seen this being achieved predominately through offshoring or outsourcing arrangements, but others have been focussed on increasing productivity.*

*From a regulatory perspective, the industry's capital coverage has increased primarily off the back of the trading performance in 2013. Looking forward, APRA has continued to focus on risk management and governance through the revision of CPS 220 and 510 which places greater requirements on how insurers manage and monitor risk. The updated prudential standards become effective from 1 January 2015.*

*In the accounting space, the IASB are still finalising the much anticipated Insurance Contracts accounting standard and are working towards its release in 2015 with it becoming effective three years later. However, key challenges remain in finalising the framework for life participating contracts and this on its own could delay the overall project yet further. As stated in previous years, I would encourage insurers to closely monitor the debate and since the accounting framework for general insurers is largely complete, developing a plan to respond to this change could prove to be a wise investment.*

**Scott Hadfield**
*Partner*

1.1

# *Statistics*
# Top 15 general insurers

| | | | Ranking Measure: | | | | | Performance: | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Net earned premium | | | | | Underwriting result | | Net investment result | | Result after income tax | |
| | Entity | Year end | Current $m | Current Rank | Prior $m | Prior Rank | % Change | Current $m | Prior $m | Current $m | Prior $m | Current $m | Prior $m |
| 1 | QBE Insurance Group | 12/13 | 16,033 | 1 | 15,201 | 1 | 5% | 355 | 436 | 834 | 1,170 | (254) | 751 |
| 2 | Insurance Australia Group | 06/13 | 8,318 | 2 | 7,346 | 2 | 13% | 1,158 | (69) | 641 | 1,015 | 882 | 265 |
| 3 | Suncorp | 06/13 | 7,298 | 3 | 6,804 | 3 | 7% | 626 | (207) | 621 | 921 | 883 | 493 |
| 4 | Allianz Australia | 12/13 | 3,067 | 4 | 2,773 | 4 | 11% | 228 | 60 | 155 | 358 | 317 | 358 |
| 5 | Wesfarmers | 06/13 | 1,469 | 5 | 1,250 | 5 | 18% | 160 | (71) | 71 | 75 | 144 | 4 |
| 6 | Zurich Australian Insurance Limited | 12/13 | 980 | 6 | 923 | 6 | 6% | 32 | 6 | 94 | 147 | 100 | 117 |
| 7 | Munich Reinsurance Australia | 12/13 | 808 | 7 | 775 | 7 | 4% | 180 | 128 | 87 | 135 | 69 | 211 |
| 8 | Commonwealth Insurance | 06/13 | 498 | 8 | 426 | 8 | 17% | 93 | 45 | 13 | 15 | 71 | 39 |
| 9 | Westpac Insurance | 09/13 | 437 | 9 | 401 | 9 | 9% | 120 | 64 | 33 | 53 | 110 | 84 |
| 10 | Genworth Financial Mortgage Insurance | 12/13 | 398 | 10 | 363 | 11 | 10% | 160 | 3 | 103 | 257 | 178 | 172 |
| 11 | Chubb Insurance | 12/13 | 350 | 11 | 335 | 12 | 4% | 27 | – | 29 | 90 | 39 | 62 |
| 12 | RAC Insurance | 06/13 | 296 | 12 | 270 | 13 | 10% | 73 | 42 | 13 | 13 | 30 | 6 |
| 13 | Swiss Re | 12/13 | 288 | 13 | 389 | 10 | -26% | 79 | 329 | 51 | 90 | 80 | 281 |
| 14 | Auto & General Insurance Company Limited | 06/13 | 261 | 14 | 221 | n/a | 18% | 47 | 32 | 7 | 7 | 14 | 9 |
| 15 | ACE Insurance | 12/13 | 239 | 15 | 236 | 14 | 1% | 15 | 20 | 9 | 46 | 13 | 44 |
| NR | Lloyd's* | 12/13 | 1,755 | NR | 1,652 | NR | 6% | n/a | n/a | n/a | n/a | n/a | n/a |

Source: Published annual financial statements or APRA annual returns, including segment reporting for organisations with significant non-general insurance activities.

Notes: World wide premium is included for those companies/groups based in Australia, while only premium under the control of the Australian operations are included for those with overseas parents.
Where a group has significant non-general insurance operations, only performance and position information relating to general insurance is disclosed (subject to availability). In some instances this involves estimating a notional tax charge for the result after tax. Outstanding claims are net of all reinsurance recoveries.
Where applicable, comparatives have been updated to be in line with updated comparatives in current year financial reports.
Financial information denominated in a foreign currency has been translated using the closing and average rate for the applicable financial year.

* Lloyd's Underwriters are authorised in Australia under special provisions contained in the Insurance Act 1973. Because of the unique structure of the Lloyd's market Lloyd's reports to APRA on a different basis from Australian general insurers. Lloyd's is required to maintain onshore assets in trust funds and as at 31 December 2013 its Australian assets comprised of $3,190m in trust funds and a statutory deposit of $2m.

# *Statistics*
## Top 15 general insurers (Continued)

| | | | Financial Position: | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Net outstanding claims | | Investments securities | | Net assets | | Total assets | |
| | Entity | Year end | Current $m | Prior $m | Current $m | Prior $m | Current $m | Prior $m | Current $m | Prior $m |
| 1 | QBE Insurance Group | 12/13 | 20,349 | 17,731 | 32,821 | 28,381 | 11,626 | 10,995 | 52,829 | 48,871 |
| 2 | Insurance Australia Group | 06/13 | 7,616 | 7,781 | 13,616 | 12,953 | 4,988 | 4,524 | 24,859 | 25,132 |
| 3 | Suncorp | 06/13 | 6,890 | 6,953 | 12,305 | 11,477 | 7,955 | 7,748 | 25,003 | 25,019 |
| 4 | Allianz Australia | 12/13 | 4,024 | 3,938 | 4,757 | 4,358 | 1,865 | 1,900 | 10,106 | 9,948 |
| 5 | Wesfarmers | 06/13 | 763 | 728 | 1,215 | 1,152 | 1,571 | 1,435 | 4,440 | 4,423 |
| 6 | Zurich Australian Insurance Limited | 12/13 | 1,249 | 1,191 | 2,003 | 1,899 | 713 | 702 | 4,416 | 4,555 |
| 7 | Munich Reinsurance Australia | 12/13 | 1,163 | 1,242 | 2,656 | 3,157 | 949 | 1,150 | 4,581 | 5,647 |
| 8 | Commonwealth Insurance | 06/13 | 94 | 122 | 337 | 284 | 218 | 157 | 762 | 658 |
| 9 | Westpac Insurance | 09/13 | 138 | 153 | 580 | 842 | 499 | 563 | 1,161 | 1,274 |
| 10 | Genworth Financial Mortgage Insurance | 12/13 | 240 | 301 | 3,554 | 3,524 | 2,177 | 2,129 | 3,980 | 3,888 |
| 11 | Chubb Insurance | 12/13 | 537 | 547 | 1,145 | 1,122 | 534 | 525 | 1,531 | 1,560 |
| 12 | RAC Insurance | 06/13 | 39 | 50 | 220 | 196 | 226 | 219 | 510 | 499 |
| 13 | Swiss Re | 12/13 | 695 | 773 | 1,405 | 1,711 | 814 | 973 | 2,960 | 3,602 |
| 14 | Auto & General Insurance Company Limited | 06/13 | 39 | 27 | - | - | 63 | 49 | 302 | 257 |
| 15 | ACE Insurance | 12/13 | 208 | 214 | 659 | 614 | 228 | 253 | 1,498 | 1,561 |
| NR | Lloyd's | 12/13 | 1,703 | 1,876 | 3,117 | 3,085 | n/a | n/a | 3,190 | 3,258 |

# *Statistics*
# Top 10 government insurers

| | | | Ranking Measure: | | | | | Performance: | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Net earned premium | | | | | Underwriting result | | Investment result | | Result after tax | |
| | Entity | Year end | Current $m | Current Rank | Prior $m | Prior Rank | % Change | Current $m | Prior $m | Current $m | Prior $m | Current $m | Prior $m |
| 1 | NSW WorkCover | 06/13 | 2,616 | 1 | 2,509 | 1 | 4% | 1,302 | 616 | 1,331 | 996 | 1,806 | 866 |
| 2 | Victorian WorkCover Authority (Work Safe Victoria) | 06/13 | 1,852 | 2 | 1,878 | 2 | -1% | 227 | (1,149) | 1,563 | 422 | 1,084 | (676) |
| 3 | WorkCover Queensland | 06/13 | 1,606 | 3 | 1,442 | 3 | 11% | 438 | 186 | 301 | 100 | 517 | 200 |
| 4 | Transport Accident Commission (Vic) | 06/13 | 1,455 | 4 | 1,383 | 4 | 5% | 183 | (1,786) | 1,195 | 311 | 973 | 1,024 |
| 5 | NSW Self Insurance Corporation | 06/13 | 1,239 | 5 | 1,197 | 5 | 4% | 167 | 179 | 1,223 | (77) | 676 | (205) |
| 6 | WorkCover Corporation (SA) | 06/13 | 667 | 6 | 639 | 6 | 4% | (180) | (466) | 249 | 92 | 23 | (437) |
| 7 | Motor Accident Commission (SA) (MAC) | 06/13 | 572 | 7 | 543 | 7 | 5% | 71 | (187) | 308 | 160 | 371 | (34) |
| 8 | Insurance Commission of WA | 06/13 | 459 | 8 | 440 | 8 | 4% | 83 | (258) | 450 | 41 | 312 | (122) |
| 9 | Comcare (Cwlth) * | 06/13 | 342 | 9 | 271 | 9 | 26% | (104) | (980) | 21 | 21 | (98) | (687) |
| 10 | Victorian Managed Insurance Authority (VMIA) | 06/13 | 231 | 10 | 195 | 10 | 18% | 18 | (383) | 226 | 63 | 244 | (320) |

Source: 2013 published annual accounts.

Notes: Outstanding claims are net of recoveries.

* Underwriting result has not been disclosed in the financial statements and has been recalculated as net earned premium less net claims incurred.

# *Statistics*
## Top 10 government insurers (Continued)

| | | | Financial Position: | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | Net outstanding claims | | Investment securities | | Net assets | | Total assets | |
| | Entity | Year end | Current $m | Prior $m | Current $m | Prior $m | Current $m | Prior $m | Current $m | Prior $m |
| 1 | NSW WorkCover | 06/13 | 13,557 | 14,134 | 13,689 | 12,784 | 308 | (1,497) | 15,397 | 14,565 |
| 2 | Victorian WorkCover Authority (Work Safe Victoria) | 06/13 | 10,187 | 10,290 | 11,136 | 9,833 | 1,579 | 688 | 12,210 | 11,387 |
| 3 | WorkCover Queensland | 06/13 | 2,534 | 2,681 | 3,288 | 2,652 | 1,054 | 541 | 3,851 | 3,412 |
| 4 | Transport Accident Commission (Vic) | 06/13 | 9,574 | 9,653 | 8,870 | 7,716 | (607) | (1,404) | 10,254 | 9,490 |
| 5 | NSW Self Insurance Corporation | 06/13 | 6,138 | 5,745 | 6,531 | 5,219 | 783 | 107 | 7,464 | 6,370 |
| 6 | WorkCover Corporation (SA) | 06/13 | 3,703 | 3,328 | 2,258 | 1,867 | (1,366) | (1,389) | 2,398 | 2,014 |
| 7 | Motor Accident Commission (SA) (MAC) | 06/13 | 2,314 | 2,282 | 3,152 | 2,807 | 768 | 397 | 3,310 | 2,954 |
| 8 | Insurance Commission of WA | 06/13 | 1,695 | 1,757 | 3,411 | 2,863 | 1,098 | 784 | 3,916 | 3,465 |
| 9 | Comcare (Cwlth) * | 06/13 | 3,998 | 3,801 | 290 | 239 | (929) | (830) | 3,180 | 3,140 |
| 10 | Victorian Managed Insurance Authority (VMIA) | 06/13 | 1,649 | 1,654 | 1,674 | 1,408 | (75) | (335) | 2,335 | 2,032 |

1.2

# Regulation and supervision

## The Australian Prudential Regulation Authority (APRA)

APRA is the single Commonwealth authority responsible for licensing and prudential regulation of all deposit-taking institutions, life and general insurance companies, superannuation funds and friendly societies. APRA is also empowered to appoint an administrator to provide investor or consumer protection in the event of financial difficulties experienced by life or general insurance companies.

APRA's powers to regulate and collect data from the general insurance industry stem principally from the following acts:

- Insurance Act 1973 (the Insurance Act);
- Financial Sector (Collection of Data) Act 2001;
- Financial Sector (Shareholdings) Act 1998;
- Insurance (Acquisitions and Takeovers) Act 1991; and
- Insurance Regulations 2002.

While licences to write most classes of insurance business are provided by APRA, state and territory governments issue licences to write certain compulsory classes of business, such as Workers compensation and Compulsory Third Party (CTP). The status of these lines of business varies between states.

As supervisor of general insurance companies, APRA administers the Insurance Act. APRA's stated objective in respect of general insurance is "to protect the interest of insurance policyholders, in particular, through the development of a well managed, competitive and financially sound general insurance industry".

APRA is responsible for the prudential regulation of insurers. APRA's aim is to apply similar principles across all prudential regulation and to ensure that similar financial risks are treated in a consistent manner whenever possible. It is not responsible for product disclosure standards, customer complaints or licensing of financial service providers (including authorised representatives and insurance brokers) as these responsibilities fall to the Australian Securities and Investments Commission (ASIC) under its Australian Financial Services Licence (AFSL) regime.

APRA co-operates with other regulators where responsibilities overlap. In particular, APRA works closely with ASIC and the Reserve Bank of Australia. It also liaises, when necessary, with the Federal Department of Treasury, the Australian Competition and Consumer Commission (ACCC) and the Australian Stock Exchange (ASX).

## *Probability and Impact Rating System*

APRA's primary objective is to minimise the probability of regulated institutions failing and to ensure a stable, efficient and competitive financial system. APRA uses its Probability and Impact Rating System (PAIRS) to classify regulated financial institutions in two key areas:

- The probability that the institution may be unable to honour its financial promises to beneficiaries – depositors, policyholders and superannuation fund members; and
- The impact on the Australian financial system should the institution fail.

As part of its role as a prudential regulator, APRA uses PAIRS to assess risk and to determine where to focus supervisory effort, determine the appropriate supervisory actions to take with each regulated entity, define each supervisor's obligation to report on regulated entities to APRA's executive committee, board, and, in some circumstances, to the relevant government minister, and to ensure regulated entities are aware of how APRA determines the nature and intensity of their supervisory relationships.

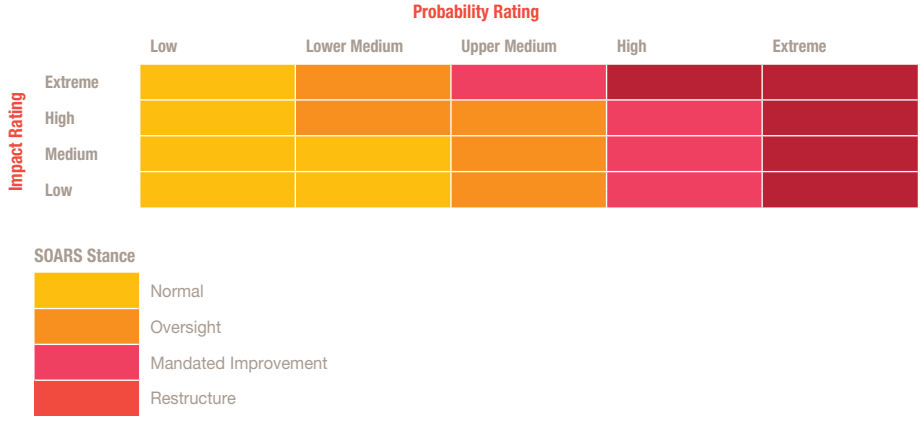
The PAIRS Supervisory Attention Index rises as the probability of failure and the potential impact of failure increase, ranging from 'Low' to 'Extreme'. These ratings are not publicly available, and are used only to identify potential issues and seek remediation before serious problems develop.

## *Supervisory Oversight and Response System*

Supervisory Oversight and Response System (SOARS) is used to determine how supervisory concerns based on PAIRS risk assessments should be acted upon. It is intended to ensure that supervisory interventions are targeted and timely. All APRA-regulated entities that are subject to PAIRS assessment are assigned a SOARS stance. Supervisory strategies vary according to an entity's supervision stance.

The supervision stance of a regulated entity is derived from the combination of the Probability Rating and Impact Rating of the PAIRS process, as illustrated in figure 1.1 below.

**Figure 1.1 – PAIRS and SOARS**



## *Regulatory framework*

The General Insurance Reform Act 2001 (amendment to the Insurance Act) created a three-tier regulatory system for general insurers:

- Tier 1 – The Insurance Act contains the high-level principles necessary for prudential regulation.
- Tier 2 – Prudential standards detail compliance requirements for companies authorised under the Insurance Act. This has been updated to include more high-level and principles-based requirements.
- Tier 3 – Guidance notes accompany each prudential standard, providing details of how APRA expects them to be interpreted in practice. This has been updated to provide non-binding guidance on prudential good practice and on how best to meet the requirements of the new standards.

## *Categories of general insurer*

The different categories of insurers referred to in the GI Prudential Standards are defined in GPS 001. Definitions as follows:

| *Category* | *Description* |
|---|---|
| A | • Insurers incorporated in Australia, excluding all insurers falling within any other categories below.<br>• Wholly owned subsidiaries of corporate groups that are not insurance groups fall into this category where they do not already fall into another category below.<br>• Category A insurers could be mutual companies or shareholder companies. |
| B | • Insurers incorporated in Australia and a subsidiary of a local or foreign insurance group.<br>• Category B insurers could be subsidiaries of mutual or shareholder companies.<br>• An insurance group captive is not a Category B insurer. |
| C | • A foreign general insurer operating as a foreign branch in Australia; could be a branch of a foreign mutual or shareholder company. |

| Category | Description |
|---|---|
| D | • Often referred to as 'association captives'; an insurer incorporated in Australia that:<br>– is owned by an industry or a professional association, or by the members of the industry or professional association or a combination of both; and<br>– only underwrites business risks of the members of the association or those who are eligible, under the articles of the association or constitution of the association, to become members of the association; but<br>– is not a medical indemnity insurer as defined under the *Medical Indemnity Act 2002*. |
| E | • Often referred to as 'sole parent captives'; an insurer incorporated in Australia that is a corporate captive or partnership captive. |

## *Licensing*

Private sector general insurance companies may conduct insurance business in Australia only if authorised under the Insurance Act. APRA can impose and vary licence conditions of an insurer under Section 13 and exempt an insurer from complying with all or part of the Insurance Act under Section 7.

In addition to requiring compliance with prudential standards, APRA may request additional information as it sees fit. The information expected to be provided includes:

- Details of the ownership structure, board and management (including resumes and the company's constitution);
- Applications for the proposed appointed auditor and actuary;
- A three-year business plan with financial and capital adequacy projections, including sensitivity analysis;
- Systems and controls documentation (risk management strategy, reinsurance management strategy, business continuity plan and details of accounting and reporting systems);
- Details of subsidiaries and associates and any proposed relationships;
- An auditor's certificate verifying the level of capital and capital ratios of the applicant;
- Written undertakings to comply with prudential standards at all times, consult and be guided by APRA on prudential matters and new business initiatives and provide relevant information required for the prudential supervision of the applicant; and
- For foreign-owned insurers, approval of foreign parent's home supervisor and details of the foreign parent's operations and an acknowledgement that APRA may discuss the conduct of the applicant with its head office and home supervisor.

In order to underwrite workers compensation or CTP insurance, additional approval from state and territory government regulators is required under the relevant state or territory legislation.

## *Restructure of operations*

The Insurance Act provides for the restructuring of insurance operations. Sections 17A to 17I of the Act allow for the assignment of insurance liabilities between insurers subject to the satisfaction of several steps, including approval of APRA, informing affected policyholders; and obtaining confirmation of the assignment from the Federal Court of Australia.

GPS 410 Transfer and Amalgamation of Insurance Business for General Insurers sets out more detailed information on the requirements for transferring insurance portfolios between registered insurers. In the event of revocation of an insurer's authorisation, APRA can stipulate the assignment of liabilities immediately prior to the revocation. It should be noted that APRA can revoke a licence only with the Federal Treasurer's approval, unless it is a request from an insurer with no remaining Australian insurance liabilities.

Section 116 addresses the issue of winding up an insurer and stipulates that assets in Australia can be applied only to settle liabilities in Australia (unless these are nil). For the purpose of this and the Section 28 solvency requirement, a reinsurance receivable from an overseas party is considered to be an asset in Australia if:

- the reinsurance contract is established under Australia Law;
- the reinsurance contract relates to Australian liabilities; and
- reinsurance payments are made in Australia.

The definition of liability in Australia is complex, but in general terms it is if the risk is in Australia or if the insurer has undertaken to satisfy the liability in Australia.

## *Prudential Standards*

APRA's supervision currently spans two levels:

- Level 1 – applicable to individual APRA-authorised general insurers on a stand-alone basis.
- Level 2 – applicable to consolidated general insurance groups incorporating all general insurers (both domestic and international) within the group. The group may be headed by an APRA authorised insurer or an APRA authorised non-operating holding company.

A framework for Level 3 supervision has been developed by APRA to cover the supervision of conglomerate groups which comprise more than one APRA regulated industry. There are currently eight applicable conglomerates that APRA has identified in the Australian market. The framework consists of four components: group governance, risk exposures, risk management and capital adequacy. APRA has deferred the implementation date until after the recommendations from the Federal Government's Financial Services Inquiry are made later in 2014.

The Prudential Standards that are currently in force for general insurers are listed below and outlined in the following sections.

| *Prudential standard* | *Explanation* |
|---|---|
| GPS 001 Definitions | See section 1.3 |
| GPS 110 Capital Adequacy | See section 1.3 |
| GPS 112 Capital Adequacy: Measurement of Capital | See section 1.3 |
| GPS 113 Capital Adequacy: Internal Model-based Method | See section 1.3 |
| GPS 114 Capital Adequacy: Asset Risk Charge | See section 1.3 |
| GPS 115 Capital Adequacy: Insurance Risk Charge | See section 1.3 |
| GPS 116 Capital Adequacy: Insurance Concentration Risk Charge | See section 1.3 |
| GPS 117 Capital Adequacy: Asset Concentration Risk Charge | See section 1.3 |
| GPS 118 Capital Adequacy: Operational Risk Charge | See section 1.3 |
| GPS 120 Assets in Australia | See section 1.3 |
| GPS/CPS 220 Risk Management | See section 1.4 |
| GPS 230 Reinsurance Management | See section 1.4 |
| GPS 310 Audit and Related Matters | See section 1.5 |
| GPS 320 Actuarial and Related Matters | See section 1.5 |
| GPS 410 Transfer and Amalgamation of Insurance Business for General Insurers | See section 1.4 |
| CPS 231 Outsourcing | See section 1.4 |
| CPS 232 Business Continuity Management | See section 1.4 |
| CPS 510 Governance | See section 1.5 |
| CPS 520 Fit and Proper | See section 1.5 |

# Australian Securities and Investments Commission (ASIC)

ASIC is the single Commonwealth regulator responsible for market integrity and consumer protection functions across the financial system. It is responsible for:

- Corporate regulation, securities and futures markets;
- Market integrity and consumer protection in connection with life and general insurance and superannuation products, including the licensing of financial service providers; and
- Consumer protection functions for the finance sector.

Most insurers require an Australian Financial Services License (AFSL), and as such, a dual licensing system exists with overlapping requirements under both ASIC and APRA.

## *Australian Financial Services Licence (AFSL)*

The Corporations Act requires all sellers of insurance products to retail clients, including registered insurers and brokers, to obtain an Australian Financial Services Licence (AFSL). Refer to Insurance Intermediaries chapter for details of the AFSL reporting requirements for Insurers and Brokers.

Insurers that are regulated by APRA are exempted from the financial obligations of an AFSL as their financial position is separately monitored by APRA.

## *Ownership restrictions*

The Financial Sector (Shareholdings) Act limits shareholdings to 15 per cent of an insurer, unless otherwise approved by the Federal Treasurer. The Insurance (Acquisitions and Takeovers) Act complements this legislation by requiring government approval for offers to buy more than 15 per cent of an insurer.

# 1.3 Capital adequacy

## Overview

Under Section 28 of the Insurance Act, authorised insurers are required to hold eligible assets in Australia that exceed liabilities in Australia, unless otherwise approved by APRA. Section 116A of the Insurance Act and GPS 120 Assets in Australia provide further details of excluded assets and liabilities.

The prudential standards aim to ensure the security of policyholder obligations of all insurers is established at an appropriate level by requiring that each insurer maintains at least a prudential capital requirement (PCR).

This section gives an overview of the various Prudential Standards for Capital Adequacy and Assets in Australia.

## Capital Adequacy (GPS 110)

APRA has adopted a three pillar approach to the capital adequacy framework:

| | |
|---|---|
| **Pillar I** | Quantitative requirements for the calculation of a Prudential Capital Requirement (PCR) and the recognition of an eligible capital base to meet this requirement. |
| **Pillar II** | Adequate system of governance including an effective risk management system and prospective risk identification through the Internal Capital Adequacy Assessment Process (ICAAP). |
| **Pillar III** | A set of reporting and disclosure requirements including private reporting to APRA (ICAAP Report), management and public reporting. |

The requirements to address these pillars are set out in Prudential Standards GPS 110-GPS 118. GPS 110 to GPS 118 form part of a comprehensive set of prudential standards that deal with the measurement of a general insurer's capital adequacy.

They are a culmination of APRA's Life and General Insurance Capital (LAGIC) review replacing previous prudential standards from 1 January 2013.

# GPS001 Definitions

This Prudential Standard defines key terms referred to in other prudential standards applicable to general insurers and Level 2 insurance groups. All prudential standards applicable to general insurers and Level 2 insurance groups must be read in conjunction with this Prudential Standard.

# GPS110 Capital Adequacy

GPS 110 Capital Adequacy aims to ensure that the regulated institution maintains adequate capital to act as buffer against the risk associated with their activities and sets out the overall framework adopted by APRA to assess the capital adequacy of a general insurer.

The key requirements of this Prudential Standard are that a general insurer or Level 2 insurance group must:

- have an Internal Capital Adequacy Assessment Process (ICAAP);
- maintain required levels of capital;
- determine its Prescribed Capital Requirement (PCR) having regard to a range of risk factors (discussed below) that may threaten its ability to meet policyholder obligations;
- comply with any supervisory adjustment to capital imposed by APRA;
- make certain public disclosures about the capital adequacy position of the general insurer or Level 2 insurance group;
- seek APRA's consent for certain planned capital reductions; and
- inform APRA of any significant adverse changes in its capital position.

## *Internal capital adequacy assessment process (ICAAP)*

A regulated institution must have in place an ICAAP that is adequately documented. The ICAAP documentation is made available to APRA on request and approved by the Board initially and when significant changes are made.

ICAAP must include at a minimum:

- adequate policies, procedures, systems, controls and personnel to identify, measure, monitor and manage the risks arising from the regulated institution's activities on a continuous basis, and the capital held against such risks;
- a strategy for ensuring adequate capital is maintained over time;
- actions and procedures for monitoring the regulated institution's compliance with its regulatory capital requirements and capital targets;
- stress testing and scenario analysis relating to potential risk exposures and available capital resources;
- processes for reporting on the ICAAP and its outcomes to the Board and senior management of the regulated institution;

- policies to address the capital impact of the material risks not covered by explicit regulatory capital requirements; and
- an 'ICAAP summary statement (discussed below).

## *ICAAP Summary Statement*

This is a high level document that describes and summarises the capital assessment and management process of the general insurer. At the least, it must include the aspects of the ICAAP listed above whilst also including:

- a statement of the objectives, the time horizon and the expected level of financial soundness associated with the capital targets of the ICAAP;
- a description of the key assumptions and methodologies used;
- triggers that identify the need to review the ICAAP arising from changes to the business operations, regulatory, economic and financial market conditions, group structure and other factors impacting the insurer's risk profile and capital resources;
- a summary of the policy for reviewing the ICAAP (who is responsible for the review, frequency and scope of the review) and mechanisms for reporting on the review and its outcomes to the Board and senior management; and
- a description of the basis of measurement of capital used in the ICAAP and an explanation of the differences where this basis differs from that used for regulatory capital.

An ICAAP review must be conducted at least every three years by an appropriately qualified person who is operationally independent of the conduct of capital management.

## *ICAAP report*

The regulated institution must provide a report on the implementation of its ICAAP annually to APRA no later than three months from the date on which the report has been prepared. The ICAAP report must include:

- detailed information on current and three-year projected capital levels;
- detailed information on the actual outcomes of applying the ICAAP over the period, relative to the planned outcomes in the previous ICAAP report;
- description of the material changes to the ICAAP since the previous ICAAP report;
- detail and outcomes of stress testing and scenario analysis used in undertaking the ICAAP;
- a breakdown of capital usage over the time horizon;
- an assessment of anticipated changes in risk profile or capital management processes;
- details of any review of the ICAAP since the previous ICAAP report, including any recommendations for change and how those recommendations have been, or are being addressed; and
- where relevant, references to supporting documentation and analysis.

The report submitted to APRA must be accompanied by a declaration approved by the Board and signed by the CEO stating whether or not capital management has been undertaken

in accordance with the ICAAP over the period, the regulated institution has assessed the capital targets contained in its ICAAP to be adequate given the size, business mix and complexity of its operations, and the information included in the ICAAP report is accurate in all material respects.

## *The ICAAP in practice*

The implementation of ICAAP has proven to be challenging for insurers on various levels, with some practical implementation considerations being:

- ensuring that ICAAP fits in with the both the risk management and capital management framework of the regulated entity and takes a whole of entity approach which is self-contained.
- ensuring the following is clearly described: material risks from business activities, risk appetite and tolerance, how capital is allocated against identified risks and how the risk management framework and the ICAAP are inter-related.
- ensuring the Summary Statement clearly defines board and management responsibilities in respect of the ICAAP and makes it clear how the board expects to receive feedback on the implementation and effectiveness of the ICAAP, including reporting responsibilities.
- scope & objectives for ICAAP should be clearly articulated, Summary Statement should be institution specific, forward looking and embedded.
- ensuring techniques and approach used for stress testing are adequate and sufficiently explained, including the outcomes.
- ensuring that the ICAAP is reviewed at least every three years by an appropriately qualified person who is operationally independent of the conduct of capital management.
- ensuring that the ICAAP defines specific capital targets that take into account the risk appetite and the outcomes of stress and scenario testing.

## *Prudential Capital Requirement*

The required level of capital for regulatory purposes is referred to as the Prudential Capital Requirement (PCR). The regulated institution's capital base must exceed its PCR at all times.

There are two methods for calculating the PCR:

- The Standard Method; and
- The Internal Model Based Method (using an internal model developed by the general insurer to reflect the circumstances of its business)

GPS 110 specifies that the PCR for Category A to C insurers must be greater than $5 million. In the case of Category D or Category E insurers the PCR cannot be less than $2 million.

## *The Standard Method*

The PCR is determined as:

*Insurance Risk Charge* **plus** *Insurance Concentration Risk Charge* **plus** *Asset Risk Charge* **plus** *Asset Concentration Risk Charge* **plus** *Operational Risk Charge* **less** *an Aggregation Benefit*

- Insurance risk charge – The risk that the value of net insurance liabilities is insufficient to cover net claims as they fall due (GPS 115 Capital Adequacy: Insurance Risk Charge)
- Insurance concentration risk charge – The net financial impact on the general insurer from the occurrence of events within a one year period (GPS 116 Capital Adequacy: Insurance Concentration Risk Charge)
- Asset risk charge – The risk of adverse movements in the value of the general insurer's on-balance sheet and off-balance sheet exposures (GPS 114 Capital Adequacy: Asset Risk Charge)
- Asset concentration risk charge – The risk resulting from concentrations in individual assets or large exposures to counterparties (GPS 117 Capital Adequacy: Asset Concentration Risk Charge)
- Operational risk charge – The risk of loss resulting from inadequate or failed processes, people and systems or from external events (GPS 118 Capital Adequacy: Operational Risk Charge)
- Aggregation benefit – This makes an allowance for diversification between asset risk and the sum of insurance risk and insurance concentration risk in the calculation of the PCR.

## *Supervisory Adjustment*

If APRA has prudential reasons for doing so, APRA may, in writing, determine a supervisory adjustment to be included in the PCR of the general insurer.

## *Internal Model Based Method (IMB)*

A regulated institution may use its own internal capital measurement model to calculate the prescribed capital amount. Use of the IMB Method is conditional on APRA's approval. GPS 113 Capital Adequacy: Internal Model Based Method sets out the criteria that the regulated institution must satisfy before they can use their own IMB Method.

## *Category C insurers*

By the nature of its Australian balance sheet, a Category C insurer will not typically have capital instruments of the type specified in GPS 112 Capital Adequacy: Measurement of Capital. Category C insurers are nevertheless required to meet a variant of the PCR. Specifically, Category C insurers are required to maintain assets in Australia (where the assets are the ones that are recognised under GPS 120 as assets in Australia) that exceed liabilities in Australia adjusted for any surplus or deficit of technical provisions as required by GPS 320 (adjusted net assets in Australia) by an amount that is greater than the PCR determined by this Prudential Standard.

### *Disclosure*

A regulated institution must publish, at least annually, the following items:

a) the amount of Common Equity Tier 1 Capital;

b) the aggregate amount of any regulatory adjustments applied in the calculation of Common Equity Tier 1 Capital;

c) the amount of Additional Tier 1 Capital;

d) the aggregate amount of any regulatory adjustments applied in the calculation of Additional Tier 1 Capital;

e) the amount of Tier 2 Capital;

f) the aggregate amount of any regulatory adjustments applied in the calculation of Tier 2 Capital;

g) the total capital base derived from the items (a) to (f);

h) the prescribed capital amount;

i) the components of the prescribed capital amount; and

j) the capital adequacy multiple (item (g) divided by item (h)).

## GPS 112 Capital Adequacy: Measurement of Capital

GPS 112 Capital Adequacy: Measurement of Capital sets out the essential characteristics that an instrument must have to qualify for inclusion in the capital base that is used to assess the capital adequacy of a general insurer or Level 2 insurance group.

The key requirements of this standard are that a general insurer or Level 2 Insurance Group must:

- comply with the minimum requirements regarding the size and composition of the capital base;
- include in the appropriate category of capital (i.e. Common Equity Tier 1 Capital, Additional Tier 1 Capital or Tier 2 Capital) only those capital instruments that meet the detailed criteria for that category;
- ensure all capital instruments are capable of bearing loss; and
- make certain regulatory adjustments to capital, mainly from Common Equity Tier 1 Capital, to determine the capital base.

## GPS 113 Capital Adequacy: Internal Model-based Method

GPS 113 Capital Adequacy: Internal Model-based method (IMM) sets out the requirements that a general insurer or Level 2 insurance group must meet to use an Internal Model-based Method for calculating the prescribed capital amount.

The key requirements to obtain and maintain approval for the use of an Internal Model-based method are that:

- the general insurer or Level 2 insurance group must have an Internal Capital Adequacy Assessment Process that demonstrates an advanced approach to risk management and capital management that includes an appropriate Economic Capital Model (ECM);
- governance arrangements for the development and use of the ECM are suitable;
- the ECM must be used by the general insurer or Level 2 insurance group for its own purposes or the purposes of the group, and be embedded in management, operations and decision making processes; and
- the ECM must be technically sufficient to produce a reliable estimate of the capital required by the general insurer or Level 2 insurance group.

There is no prescribed form or structure for a regulated institution's ECM. Each regulated institution has the flexibility to develop a model that is suited to its business. APRA will not provide approval for use of the IMB Method unless it is satisfied with the regulated institution's governance arrangements for the ECM and RCM (Regulatory Capital Model).

## GPS 114 Capital Adequacy: Asset Risk Charge

GPS 114 Capital Adequacy: Asset Risk Charge sets out the method for calculating the Asset Risk Charge. This charge is one of the components of the Standard Method for calculating the prescribed capital amount for general insurers and Level 2 insurance groups.

The Asset Risk Charge is the minimum amount of capital required to be held against asset risks. It relates to the risk of adverse movements in the value of a general insurer's or Level 2 insurance group's on-balance sheet and off-balance sheet exposures. Asset risk can be derived from a number of sources, including market risk and credit risk.

The asset risk charge is calculated as the 'aggregated risk charge component' less any 'tax benefits'. The risk charge components are calculated by determining the fall in the capital base of the regulated institution in seven stress tests. These stresses are applied either directly to asset values or by way of changes to economic variables that in turn affect the assets and liabilities:

1. real interest rates;
2. expected inflation;
3. currency;
4. equity;
5. property;
6. credit spreads; and
7. default.

In determining each risk charge component, a regulated institution must include the effective exposure of the regulated institution's assets and liabilities to each of the risks if the exposure is impacted by the stress test. Investment income receivables must be included with the asset that generated the income and then subject to the appropriate stress tests. Assets

whose value must be deducted from the capital base in GPS 112 and any part of assets in excess of the asset concentration limits specified in GPS 117 are not permitted to be stressed.

The stress tests must be applied to the fair value of each of the regulated institution's assets. The risk charge component for each asset is the value reported in the regulated institution's statutory accounts less the stressed value of the asset.

Adjustments are made for off-balance sheet exposures and assets subject to collateral and guarantees. Changes to the capital base arising from off-balance sheet exposures must be recognised in each of the asset risk stresses. Where the regulated institution holds certain types of collateral against an asset, or where the asset has been guaranteed, the impact of applying the asset risk stresses may be reduced.

## GPS 115 Capital Adequacy: Insurance Risk Charge

GPS 115 Capital Adequacy: Insurance Risk Charge sets out the method for calculating the Insurance Risk Charge. This charge is one of the components of the Standard Method for calculating the prescribed capital amount for general insurers and Level 2 insurance groups.

The Insurance Risk Charge is the minimum amount of capital required to be held against insurance risks. It relates to the risk that the value of the net insurance liabilities is greater than the value determined by the Appointed Actuary or Group Actuary in accordance with GPS 320 Actuarial and Related Matters.

Insurance risk comprises two components: outstanding claims risk and premium liability risk.

The outstanding claims risk is calculated by multiplying the net outstanding claims liabilities for that class (as determined in accordance with GPS 320) by the relevant Outstanding Claims Risk Factor (Attachment A of Prudential Standard GPS 115).

The premium liability risk is calculated by multiplying the sum of the net premiums liabilities (as determined in accordance with GPS 320) and material net written premiums by the relevant Premiums Liability Risk Capital Factor (Attachment A of Prudential Standard GPS 115).

Where underwriting of an inwards reinsurance contract spans multiple classes, the contract must be allocated by using an appropriate method:

- allocating the contract on a pro rata basis to each of the relevant categories; or
- allocating the contract to the category which represents the greatest exposure; or
- allocating the contract to the category representing the greatest premium income.

## GPS 116 Capital Adequacy: Insurance Concentration Risk Charge

GPS 116 Capital Adequacy: Insurance Concentration Risk Charge sets out the method for calculating the Insurance Concentration Risk Charge which is one of the components of the Standard Method for calculating the prescribed capital amount for general insurers and Level 2 insurance groups.

It is the minimum amount of capital required to be held against insurance concentration risks and is intended to represent the net financial impact on the regulated institution from either a single large event, or a series of smaller events, within a one year period.

The insurance concentration risk for an insurer is the greatest of the following amounts:

- the natural perils vertical requirement
- the natural perils horizontal requirement (applicable from 1 January 2014)
- the other accumulations vertical requirement
- the lenders mortgage insurer (LMI) concentration risk charge (where applicable).

The natural perils horizontal requirement (NP HR) (applicable from 1 January 2014) is the net financial impact on an insurer from the occurrence of a series of smaller but significant sized events. NP HR includes the cost of reinsurance reinstatements and an offset for catastrophic losses included in net premiums liability;

In calculating potential reinsurance recoverables in any component of the insurance concentration risk charge, an insurer may take into account potential reinsurance recoverables receivable from a reinsurance arrangement to which it is a party only if it satisfies certain criteria.

There are specific requirements for this calculation for lenders mortgage insurers (LMI), due to the nature of the risks which gives rise to insurance claims. Attachment A of GPS116 sets out the method of calculating LMI concentration risk charge.

## GPS 117 Capital Adequacy: Asset Concentration Risk Charge

GPS 117 Capital Adequacy: Asset Concentration Risk Charge sets out the method for calculating the Asset Concentration Risk Charge which is one of the components of the Standard Method for calculating the prescribed capital amount for general insurers and Level 2 insurance groups.

The Asset Concentration Risk Charge relates to the risk of a regulated institution's concentrations in exposures to a particular asset, counterparty or group of related counterparties resulting in adverse movements in the regulated institution's capital base.

Exposures include all on and off balance sheet exposures of the regulated institution. The portion of any exposure which is subject to the asset concentration risk charge must not be subject to the asset risk charge as defined in GPS 114 Capital Adequacy: Asset Risk Charge.

The asset concentration risk charge for each exposure is the amount by which the exposure exceeds the limits set out in Attachment A to the Prudential Standard. Separate treatment applies for reinsurance and non-reinsurance exposures.

There are differing treatments for collateral and guarantees. Where a regulated institution possesses eligible collateral against an asset, it may treat the underlying asset as an exposure to the eligible collateral item. This means that the asset is included in the limits with respect to the collateral, rather than the underlying counterparty. In the case of guarantees, the asset is included in the limits with respect to the guarantee, rather than the underlying counterparty.

# GPS 118 Capital Adequacy: Operational Risk Charge

GPS 118 Capital Adequacy: Operational Risk Charge sets out the method for calculating the Operational Risk Charge which is one of the components of the Standard Method for calculating the prescribed capital amount for general insurers and Level 2 insurance groups. The Operational Risk Charge is the minimum amount of capital a regulated institution must hold against the risk of loss resulting from inadequate or failed internal processes, people and systems or from external events.

It is calculated as the sum of:

- the Operational Risk Charge for inwards reinsurance business (ORCI); and
- the Operational Risk Charge for business that is not inwards reinsurance business (ORCNI).

All of the values in the calculation should correspond to the value in the regulated institution's statutory accounts.

The Operational Risk Charge for a Level 2 insurance group is calculated after consolidation of intra-group exposures.

# GPS 120 Assets in Australia

GPS 120 Assets in Australia sets out requirements applying to general insurers in relation to when assets are eligible to be counted as assets in Australia. Section 28 of the Insurance Act 1973 requires that all insurers are to maintain assets in Australia (excluding goodwill and other amounts excluded by GPS 120) of a value that equals or exceeds the total amount of the general insurer's liabilities in Australia.

GPS 110 Capital Adequacy also requires that a Category C insurer operating in Australia as a branch maintains assets in Australia that exceed its liabilities in Australia by an amount that is greater than its Prudential Capital Requirement.

# Investment policy

There are no absolute restrictions on investments that may be held by insurance companies except the trust account requirements of the Financial Services Reform (FSR) Act 2001. Under Section 1017E of the FSR Act, where monies received cannot be applied to the issue of a product within one business day of receipt (i.e. unmatched cash), the monies must be held in a trust account. In calculating the prescribed capital requirement of an insurer under GPS 110, the capital charge assigned to each asset type is given a different weighting, taking into account its nature and the credit rating of any counterparties. Significant individual exposures may require an additional capital charge. APRA also has the power under Section 49N to direct an insurer to record an asset at a specified value, subject to approval of the Federal Treasurer.

1.4

# Management of risk and reinsurance

## GPS 220 Risk Management

GPS 220 Risk Management aims to ensure that a general insurer has systems for identifying, assessing, mitigating and monitoring the risks that may affect its ability to meet its obligations to policyholders. These systems – together with the structures, processes, policies and roles supporting them – are referred to as a general insurer's risk management framework.

The prudential standard requires that a general insurer and a Level 2 insurance group must:

- include a documented Risk Management Strategy (RMS) in its risk management framework;
- have sound risk management policies and procedures and clearly defined managerial responsibilities and controls;
- submit its RMS to APRA when any material changes are made;
- have a dedicated risk management function (or role) responsible for assisting in the development and maintenance of the risk management framework;
- submit a three-year Business Plan to APRA and re-submit after each annual review or when any material changes are made;
- submit a Risk Management Declaration (RMD) to APRA on an annual basis; and
- submit a Financial Information Declaration (FID) to APRA on an annual basis.

### *Risk Management Framework*

The risk management framework of a regulated institution should consider, at a minimum, the following risks:

- asset risk, including asset and liability mismatch;
- asset concentration risk;
- credit risk;
- operational risk;
- insurance risk;
- insurance concentration risk; and
- risks arising from the business plan.

The regulated institution must ensure that its risk management framework is reviewed by operationally independent, appropriately trained and competent members of staff (including external consultants). The frequency and scope of this review will depend on the size, business mix, complexity of the insurer's operations and the extent of any change in the business mix or risk profile. The review must cover the RMS, the risk management role and the system of internal control.

## *Risk Management Strategy (RMS)*

The RMS is a high level, strategic document that sets out the elements of a regulated institution's risk management framework and includes the following:

- the risk governance relationship between the Board, Board committees and senior management;
- the insurer's risk appetite;
- description of the processes for identifying, assessing, mitigating, controlling, monitoring and reporting risk issues;
- the roles and responsibilities of the persons with managerial responsibility for the risk management framework;
- description of the process by which the risk management framework (including the RMS) is reviewed; and
- an overview of mechanisms for ensuring continued compliance with the with the Prudential Capital Requirement (PCR).

Where the regulated institution is part of an Australian or global corporate group or is a Category C insurer, the elements of the RMS differ.

The risk management framework and ICAAP (GPS 110) must be consistent with one another.

The Board must provide APRA with a Risk Management Declaration and a Financial Information Declaration on or before the day that the yearly statutory accounts are required to be submitted to APRA.

## *Update effective 1 January 2015*

APRA proposed that each APRA-regulated institution establish and maintain a risk management function headed by a designated CRO to support sound, risk-based decision-making in the institution. To heighten the importance and stature of a CRO within an institution, CPS 220 states that the CRO must:

- be independent from business lines, other revenue-generating responsibilities and the finance function;
- be explicitly excluded from also being the CEO, CFO, Appointed Actuary or the Head of Internal Audit; and
- have a direct reporting line to the CEO, and regular and unfettered access to the Board and Board Risk Committee.

APRA-regulated institutions must have adequate management information systems (MIS) for the purpose of measuring, assessing and reporting on all material risks. CPS 220 states that MIS must be able to produce regular, accurate and timely information on the institution's risk profile to support risk-based decision-making.

CPS 220 has identified key Board responsibilities to establish and maintain a sound risk management framework.

## GPS 230 Reinsurance Management

GPS 230 Reinsurance Management aims to ensure that a general insurer and a Level 2 insurance group, as part of its overall risk management framework, has a specific reinsurance management framework to manage the selection, implementation, monitoring, review, control and documentation of reinsurance arrangements. Where relevant, the reinsurance management framework must also deal with the retrocession arrangements of the regulated institution.

GPS 230 requires that a general insurer and a Level 2 insurance group must:

- have in its reinsurance management framework a documented Reinsurance Management Strategy (ReMS), sound reinsurance management policies and procedures and clearly defined managerial responsibilities and controls;
- submit its ReMS to APRA when any material changes are made;
- submit a Reinsurance Arrangements Statement (RAS) detailing its reinsurance arrangements to APRA at least annually; and
- make an annual reinsurance declaration (RD) based on the 'two-month rule' and 'six-month rule' specified in the standard and submit the declaration to APRA.

A regulated institution must ensure that its reinsurance management framework is reviewed by operationally independent, appropriately trained and competent members of staff. The frequency and scope of this review will depend on the size, business mix, complexity of the regulated insurer's operations and the extent of any change in the reinsurance program or risk appetite.

There must be consistency between the reinsurance management framework, the Business Plan and the Internal Capital Adequacy Assessment. There must also be a clear link between the risk management framework and ReMS.

## CPS 232 Business Continuity Management

CPS 232 Business Continuity Management requires each regulated institution and Level 2 group to implement a whole-of-business approach to business continuity management that is appropriate to the nature and scale of its operations. Business continuity management increases resilience to business disruption arising from internal and external events and may reduce the impact on the regulated institution's or group's business operations, reputation, profitability, depositors, policyholders and other stakeholders.

The key requirements of the prudential standards are that:

- a regulated institution must identify, assess and manage potential business continuity risks to ensure that it is able to meet its financial and service obligations to its depositors, policyholders and other creditors;
- the Board of the regulated institution must consider business continuity risks and controls as part of its overall risk management systems and approve a Business Continuity Management Policy;
- a regulated institution must develop and maintain a Business Continuity Plan that documents procedures and information which enable the regulated institution to manage business disruptions;
- a regulated institution must review the Business Continuity Plan annually and periodically arrange for its review by the internal audit function or an external expert; and
- a regulated institution must notify APRA in the event of certain disruptions.

BCM is a whole-of-business approach that includes policies, standards and procedures for ensuring that critical business operations can be maintained or recovered in a timely fashion, in the event of a disruption. Its purpose is to minimise the financial, legal, regulatory, reputational and other material consequences arising from a disruption.

## CPS 231 Outsourcing

CPS 231 Outsourcing aims to ensure that all outsourcing arrangements involving material business activities entered into by an APRA-regulated institution are subject to appropriate due diligence, approval and on-going monitoring.

The key requirements of the standard are that a regulated institution must:

- have a policy relating to outsourcing of material business activities;
- have sufficient monitoring processes in place to manage the outsourcing of material business activities;
- have a legally binding agreement in place for all material outsourcing arrangements with third parties, unless otherwise agreed by APRA;
- consult with APRA prior to entering agreements to outsource material business activities to service providers that conduct their activities outside Australia; and
- notify APRA after entering into agreements to outsource material business activities.

Where a regulated institution is the Head of a Level 2 group, this Prudential Standard requires that any outsourcing arrangements involving material business activities entered into by members of the group must be subject to appropriate due diligence, approval and on-going monitoring, and the provisions of this Prudential Standard must be are applied appropriately throughout the group.

### *Offshoring*

APRA should be consulted prior to entering into offshoring agreements involving material business activities. This prior consultation is intended to provide an opportunity for APRA to review the licensee's assessment of offshoring risks, and the processes and controls introduced to mitigate them.

If, in APRA's view, the offshoring agreement involves risks that the regulated institution is not managing appropriately, APRA may require the regulated institution to make other arrangements for the outsourced activity as soon as practicable.

## GPS 410 Transfer and Amalgamation of Insurance Business for General Insurers

GPS 410 Transfer and Amalgamation of Insurance Business for General Insurers aims to ensure that affected policyholders, and other interested members of the public, are informed and given accurate information about the transfer or amalgamation of an insurer's insurance business.

The key requirements of GPS 410 are as follows:

- Prior to making an application to the Court for a transfer or amalgamation of its insurance business, an insurer must:
  - provide a copy of the scheme and any relevant actuarial reports to APRA;
  - publish a notice of intention to make the application in the Government Gazette and relevant newspapers; and
  - send a summary of the scheme (approved by APRA) to every affected policyholder and make a copy available for public inspection.
- After gaining Court approval, the insurer must give APRA a statement of the nature and terms of the transfer or amalgamation, and the Court order confirming the scheme.

# 1.5 Governance and assurance

## GPS 310 Audit and Related Matters

GPS 310 Audit and Related Matters outlines the roles and responsibilities of a general insurer's and Level 2 insurance group's Appointed Auditor and Group Auditor. It also outlines the obligations of a general insurer or Level 2 insurance group to make arrangements to enable its Auditor to fulfill their responsibilities.

The key requirements of GPS 310 are:

- the general insurer or level 2 insurance group must make arrangements to enable the Auditor to undertake their roles and responsibilities;
- the Auditor must prepare the certificates and reports required in accordance with the requirements of and timeframes specified in the standard;
- the general insurer or Level 2 insurance group must submit to APRA all certificates and reports to be prepared by the Auditor;
- the Appointed Auditor must audit the yearly statutory accounts of the general insurer and review other aspects of their operations on an annual basis.
- the Appointed Auditor must prepare a certificate and report on these matters and provide them to the Board; and
- the Group Auditor must conduct a limited assurance review of the annual accounts of the Level 2 insurance group on an annual basis and review other aspects of the group's operations.

An insurer must submit to APRA certificates and reports, other than those relating to a special purpose review, on or before the day that the insurer's yearly statutory accounts are submitted in accordance with reporting standards made under the Financial Sector (Collection of Data) Act 2001 (Collection of Data Act).

### *APRA targeted reviews*

Both the Insurance Act and the prudential standards stipulate that the Appointed Auditor (or Appointed Actuary) may be required to undertake other functions specified by APRA in consultation with the general insurer.

APRA periodically carries out 'targeted reviews' of general insurers. These reviews highlight a particular area that APRA is interested in and require the general insurer to engage the Appointed Auditor to prepare a report in respect of that selected area of operation. Apart from highlighting areas where further improvement could be sought, these reviews provide APRA with an industry snapshot that helps to identify and promote best practices.

# GPS 320 Actuarial and Related Matters

GPS 320 Actuarial and Related Matters sets out the roles and responsibilities of a general insurer's Appointed Actuary and Level 2 insurance group's Group Actuary (Actuary).

The ultimate responsibility for providing impartial advice in relation to the operations, financial condition and insurance liabilities of a general insurer or Level 2 insurance group rests with the Actuary. This advice is designed to assist the Board and senior management in carrying out their responsibility for the sound and prudent management of the general insurer or Level 2 insurance group.

The key requirements of GPS 320 are:

- the general insurer or Level 2 insurance group must make arrangements to enable the Actuary to undertake their roles and responsibilities;
- the Actuary must prepare the reports required in accordance with the requirements of and timeframes specified in this Prudential Standard;
- for the purposes of the capital standards and reporting requirements under the *Financial Sector (Collection of Data) Act 2001*, a general insurer's or Level 2 insurance group's insurance liabilities must be valued in accordance with this Prudential Standard;
- a general insurer must arrange to have the Insurance Liability Valuation Report of its Appointed Actuary peer reviewed by another actuary; and
- the general insurer or Level 2 insurance group must submit to APRA all reports required to be prepared by its Actuary.

# CPS 510 Governance

CPS 510 Governance sets out minimum foundations for good governance of a regulated institution in the deposit-taking, general insurance and life insurance industries. It outlines what APRA consider as being the minimum requirements which must be met to achieve good governance. A sound governance framework is important in helping maintain public confidence in regulated entities. The actual governance arrangement in place will vary from entity to entity depending on the size complexity and risk profile of each entity.

The key requirements stipulated in CPS 510 are:

- specific requirements with respect to Board size and composition;
- the chairperson of the Board must be an independent director;
- a Board Audit Committee must be established;
- regulated institutions must have a dedicated internal audit function;
- certain provisions dealing with independence requirements for auditors consistent with those in the Corporations Act 2001;
- the Board must have a Remuneration Policy that aligns remuneration and risk management;

- a Board Remuneration Committee must be established; and
- the Board must have a policy on Board renewal and procedures for assessing Board performance.

All regulated institutions have to comply with this Prudential Standard in its entirety, unless otherwise expressly indicated. The obligations imposed by this Prudential Standard on, or in relation to, a foreign ADI, a Category C insurer or a foreign general insurer apply only in relation to the Australian business of that institution.

### *Update effective 1 January 2015*

APRA indicated that an independent Risk Committee of the Board is essential to provide the Board with greater oversight of, and advice on, the risk management framework. Accordingly, APRA proposed new requirements in CPS 510 for the establishment of such a committee to strengthen its requirements in this area. The committee would be responsible for advising the Board on the risk management framework, providing the Board with objective non-executive oversight of implementation of the framework, and ensuring that senior management are appropriately implementing the Board's strategy for managing risk.

APRA proposed that the committee be composed of non-executive directors, chaired by an independent director who is not the chair of the Board, and provide its endorsement prior to the appointment and removal of the CRO. The proposed composition requirements in CPS 510 did not preclude the committee having the same composition as the BAC. APRA noted that many APRA-regulated institutions already have a committee in place.

## CPS 520 Fit and Proper

CPS 520 Fit and Proper sets out minimum requirements for regulated institutions in determining the fitness and propriety of individuals to hold positions of responsibility. It applies to all ADIs, all general insurers (including Category C insurers) and authorised insurance non-operating holding companies.

Persons who are responsible for the management and oversight of a regulated institution need to have appropriate skills, experience and knowledge, and act with honesty and integrity. These skills and qualities strengthen the protection afforded to depositors, policyholders and other stakeholders. To this end, regulated institutions need to prudently manage the risk that persons in positions of responsibility might not be fit and proper.

The key requirements of this standard are that:

- a regulated institution must have and implement a written fit and proper policy that meets the requirements of the standard;
- the fitness and propriety of a responsible person must generally be assessed prior to their initial appointment and then re-assessed annually (or as close to annually as practicable);
- a regulated institution must take all prudent steps to ensure that a person is not appointed to, or does not continue to hold, a responsible person position for which they are not fit and proper;
- additional requirements must be met for certain Auditors and Appointed and Reviewing Actuaries; and
- certain information must be provided to APRA regarding responsible persons and the regulated institution's assessment of their fitness and propriety.

# 1.6 Financial reporting

## Accounting standards

Australian general insurers are required to prepare financial statements that comply with Australian Accounting Standards (AASB). Specific AASB's relevant to general insurance include:

- AASB 4 Insurance Contracts defines what constitutes an insurance contract.
- AASB 1023 General Insurance Contracts defines a general insurance contract (i.e. an insurance contract that is not a life insurance contract as defined in the Life Act), and a non-insurance contract (a contract regulated by the Insurance Act that does not meet the AASB 4 Insurance Contracts definition of insurance).

AASB 1023 prescribes accounting treatment for:

- general insurance contracts (including reinsurance contracts) that a general insurer issues and to reinsurance contracts that it holds;
- certain assets backing general insurance liabilities;
- financial liabilities and financial assets that arise under non-insurance contracts; and
- certain assets backing financial liabilities that arise under non-insurance contracts. The treatment of the remaining balances, transactions and operations of a general insurer are prescribed by the AASB applicable to these transactions or balances.

### *Definition of an insurance contract*

An insurance contract is defined 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.

### *Definition of insurance risk*

Insurance risk is risk other than financial risk transferred from the holder of a contract to the issuer. Financial risk is defined as the risk of a possible future change in one or more of a specified interest rate, financial instrument price, commodity price, foreign exchange rate, index of prices or rates, a credit rating or credit index or other variable, provided in the case of a non-financial variable that the variable is not specific to a party to the contract.

Insurance risk is significant if, and only if, an insured event could cause an insurer to pay significant additional benefits in any scenario, excluding scenarios that lack commercial substance.

A contract that transfers financial risk alone, or only insignificant amounts of insurance risk, is accounted for under AASB 139 *Financial instruments: Recognition and Measurement*, to the extent that it gives rise to a financial asset or financial liability.

## *Definition of premium revenue and earning pattern*

Premium revenue comprises premiums from direct business and premiums from reinsurance. Premium revenue is intended to cover actual and anticipated claims, reinsurance premiums, administrative, acquisition and other costs, and a profit component.

Premium revenue includes fire service levies collected from policyholders as there is no direct nexus between fire brigade charges and the levy that insurers charge policyholders. The fire brigade expense is brought to account in accordance with the earning of the premium to which it relates.

In contrast, stamp duty and Goods and Services Tax (GST) in relation to premium revenue effectively represent the collection of tax on behalf of the government and are therefore not included as revenue of the insurer.

Premium revenue is recognised from the risk attachment date in accordance with the pattern of the incidence of risk. AASB 1023 provides additional guidance on how the pattern of the incidence of risk is determined. Premiums received in advance are recognised as part of the unearned premium liability. Unclosed business is estimated and the premium relating to unclosed business is included in premium revenue. Premium revenue is only recognised as income when it has been earned, which is in proportion to the incidence of the risk covered over the life of the insurance contract.

Measuring premium revenue involves:

- estimating the total amount of premium revenue;
- estimating when claims are expected to occur, and hence estimating the pattern of risk exposure, which provides the earning pattern; and
- recognising the premium when it is earned.

For most contracts the period of the contract is one year and the exposure pattern of the incidence of the risk will be linear. For some reinsurance contracts written on a 'risk attaching' basis, a 12 month contract may result in up to 24 months of exposure.

The insurer must also recognise a liability item on the balance sheet for the unearned premium, where this exists.

## *Measurement of outstanding claims*

AASB 1023 requires that the liability for outstanding claims "… shall be measured as the central estimate of the present value of expected future payments for claims incurred with an additional risk margin to allow for the inherent uncertainty in the central estimate".

Expected future payments include amounts related to:

- unpaid reported claims;
- claims incurred but not reported (IBNR);
- adjustments in light of the most recently available information for claims development and claims incurred but not enough reported (IBNER); and
- claims handling costs.

The liability for outstanding claims reflects the amount that, if set aside at balance date, would be sufficient to enable an insurer to pay claims as they fall due. The standard requires that outstanding claims should be discounted to net present value unless the claims are to be settled within a year and the discounting would not have a material impact. While it does require outstanding claims in all classes of business to be discounted, it recognises that such discounting will have significant application to 'long tail' classes of business (mainly liability, compulsory third party and workers compensation) where a high proportion of such claims are settled outside a 12 month period.

Discount rates selected are required to be risk-free rates that are based on current observable, objective rates that relate to the nature, structure and term of the outstanding claims liabilities. Typically government bond rates may be a relevant discount rate to use or they may be an appropriate starting point to determining such rates.

Expected future payments must account for future claim cost escalation created by inflation and superimposed inflation. Superimposed inflation is defined as the level of inflation in excess of normal economic inflation indices. The disclosure of superimposed inflation assumptions differs between companies. Some companies make explicit disclosures while others include superimposed inflation within composite inflation assumptions.

## *Explicit risk margins*

An additional explicit risk margin is required to be included as part of the outstanding claims liability. The margins are set with regard to the robustness of the valuation models, available data, past experience and the characteristics of the classes of business written. The risk margin should also allow for uncertainty in reinsurance and other recoveries due.

Similar to the APRA requirements, risk margins can allow for diversification. The risk margin for the entire company can then be allocated to individual classes of business.

## *Assets backing general insurance liabilities*

The fair value approach is used to measure assets backing general insurance liabilities or financial liabilities that arise under non-insurance contracts as required by AASB 1023. Where assets are not backing general insurance liabilities or financial liabilities that arise under non-insurance contracts, the applicable accounting standards should be applied by general insurers.

Under AASB 139 Financial Instruments: Recognition and Measurement may only be designated as at fair value through profit and loss when doing so results in more relevant information. General Insurers apply fair value through profit or loss because the financial instruments typically form part of a group of financial assets that are managed on a fair value basis in accordance with a documented risk management or investment strategy and information about the group is provided internally on that basis to the entity's key management personnel.

## *Deferral of acquisition costs and liability adequacy testing for unearned premium*

Acquisition costs, including commission and brokerage paid, incurred in obtaining and recording insurance policies shall be deferred and recognised as an asset if it is probable that they will give rise to premium revenue that will be recognised in the income statement in subsequent reporting periods.

AASB 1023 also requires the application of a liability adequacy test (LAT) to the unearned premium liability. If the present value of the expected future cash flows relating to future claims arising from the current contracts plus an additional risk margin exceeds the unearned premium liability less related intangible assets and related deferred acquisition costs (DAC), then the entire deficiency shall be recognised, first by writing down any intangible assets, then the associated DAC, and then by recognizing a separate unexpired risk liability.

In applying the LAT, general insurers are permitted to use a probability of adequacy that is different to that to be used for outstanding claims, provided that the reasons for using a different rate are disclosed. The LAT shall 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.

## *Accounting for inwards reinsurance*

Inwards reinsurance business should be accounted for in line with the general principles established for direct business. AASB 1023 requires companies underwriting inwards reinsurance to estimate and bring to account 'unclosed premiums' and to recognise such premiums as earned, having regard to the spread of risk of underlying policies ceded under inwards reinsurance treaties. On the claims side, the standard requires inwards reinsurance business to be accounted for in a similar manner to direct business. Outstanding claims should have regard to IBNRs and future claims development, and also be discounted to their net present value.

## *Non-insurance contracts*

Contracts that are regulated under the Insurance Act that fail to meet the definition of insurance risk are referred to as non-insurance contracts. These contracts are accounted for under AASB 139 Financial instruments to the extent that they give rise to financial assets and financial liabilities. The financial assets and the financial liabilities that arise under these contracts are designated as 'at fair value through profit or loss' where this is permitted.

### *Financial Statement disclosure principles and requirements*

AASB 1023 incorporates extensive disclosure requirements in respect of the accounting policies, balances, sensitivities to key assumptions, risk exposures and risk management associated with the insurer's insurance contracts.

GPS 110 Capital Adequacy for General Insurers also requires additional disclosure to be made in the financial statements in respect of the capital base, prescribed capital amounts (as well as the components of prescribed capital amounts) and its capital adequacy.

## Regulatory Reporting

In addition to the compliance declarations and statements described above, the general insurer must also provide APRA with:

- a set of annual statutory accounts prepared in accordance with APRA General Insurance Reporting Standards and forms (GRSs and GRFs);
- a financial information declaration (FID);
- the Appointed Auditor's opinion on the annual statutory accounts;
- the Appointed Actuary's Insurance Liability Valuation Report (ILVR);
- the Appointed Actuary's financial condition report (FCR); and
- quarterly statistical and financial returns.

The general insurer must also arrange for an independent peer review of the Appointed Actuary's ILVR.

### *External peer review*

Under GPS 320, a general insurer must arrange to have the Insurance Liability Valuation Report of its Appointed Actuary peer reviewed by another actuary; and the general insurer or Level 2 insurance group must submit to APRA all reports required to be prepared by its Actuary.

IAA Professional Standard 315 'External Peer Review of General Insurance Liability Valuations' details the responsibilities of the reviewing actuary and the reviewing requirements.

## Key dates

### *Corporations Act 2001*

Audited annual financial statements – a disclosing entity or registered scheme to lodge the complete financial reports within three months after the end of the financial year. All other companies within four months after the end of the financial year.

## *Financial Sector (Collection of Data) Act 2001*

- Annual APRA statutory accounts

  For reporting periods ending on or after 1 January 2013 but before 1 January 2015 – four months after the end of the reporting period to which the information relates, for reporting periods ending on or after 1 January 2015 – three months after the end of the reporting period to which the information relates.

- Quarterly forms

  Within 20 business days of the end of each quarter.

- Directors' certification in respect of the Risk Management Strategy (RMS) or Reinsurance Management Strategy (ReMS), FID, Appointed Actuary's ILVR and FCR, Appointed Auditor's certificate on the annual statutory accounts and APRA prudential compliance review report

  For reporting periods ending on or after 1 January 2013 but before 1 January 2015 – four months after the end of the reporting period to which the information relates, for reporting periods ending on or after 1 January 2015 – three months after the end of the reporting period to which the information relates.

- Business plan

  Annually (when appointed by the Board) and when material changes are made.

- Changes in reinsurance and risk management strategies

  Within 10 days of board approval. The revised ReMS must be submitted to APRA.

- Changes to details in original application for license, including appointment of senior staff, appointed actuary and appointed auditor

  Must be approved by APRA prior to the change taking effect.

- National Claims and Policies Database data (GRS 800.1-800.3 and LOLRS 800.1 to 800.3)

  Data collections must be provided to APRA (or a party authorised by APRA) semi-annually, within four months of the end of the reporting period. The reporting periods cover six calendar months, ending 30 June and 31 December annually. Data is therefore required to be submitted by 30 April and 31 October each year. The submission periods will open at 1 March and 1 September each year.

## *National Claims and Policies Database*

The National Claims and Policies Database requires insurers to submit claims and policies at three different levels of aggregation and analysis. Classes covered by this database include public and product liability and professional indemnity. This database, managed by APRA, supplements databases on CTP and workers compensation in several states and aims to provide transparency in the industry. The data may also help to reduce the volatility through the insurance cycle, as insurers will have access to more information to assess the risks more precisely.

1.7

# Taxation of general insurance

## Corporate Tax

In Australia, general insurance companies are assessed under Division 321 of the Income Tax Assessment Act (ITAA) 1997. Tax is payable on the profits of a general insurer at the corporate tax rate, currently 30 per cent.

### *Premium income*

Division 321 of the ITAA legislates the manner in which premium income is earned by an insurer for taxation purposes.

An insurance premium has a number of components. The gross premium, including components referable to fire services levies, stamp duty and other statutory charges must be included as assessable income. Insurers must recognise premium income from the date of attachment of risk. As a result, unclosed business will be brought to account in calculating tax liability.

Subject to the following comments on unearned premium reserve, all premiums received or receivable in that year are included in assessable income.

### *Unearned premium reserve*

Where part of the premium relates to risk in a future year, an unearned premium reserve (UPR) is established. When the UPR is greater at year-end than it was at the beginning, a deduction is allowed for the increase. Where it decreases over the year, the decrease is included in assessable income.

The legislation prescribes the way UPR is to be calculated. In particular, expenses relating to the issuing of policies, as well as reinsurance, reduce the amount of the UPR.

### *Liability adequacy testing*

Under the accounting standards, an insurer is required to assess at each reporting date whether its UPR is adequate, by considering current estimates of future cash flows under its insurance contracts. If the assessment shows that the carrying amount of its UPR is inadequate, the entire deficiency must be recognised in profit or loss by first writing off related intangibles and deferred acquisition costs and then recognising an unexpired risk liability. This process is known as Liability Adequacy Testing or 'LAT'.

For tax purposes, the LAT adjustment is not deductible and generates a temporary difference.

## *Apportionable issue costs (acquisition costs)*

Costs incurred in obtaining and recording premiums are allowable deductions in the year of income in which they are incurred. These costs include commissions and brokerage fees, processing costs, risk assessment fees, fire brigade charges, stamp duty and other government charges and levies (excluding GST).

The benefit of an immediate deduction for apportionable issue costs incurred during a year of income is effectively restricted, as these costs are taken into account in the determination of the unearned premium reserve. This is achieved by determining the UPR based on premiums net of apportionable issue costs.

## *Prepayments*

The prepayment legislation would normally apply to apportionable issue costs and reinsurance expense. However, as the methodology for calculating the unearned premium reserve includes a reduction component for these expenses, the legislation excludes these expenses from the prepayment rules.

Treaty non-proportional reinsurance, which is not taken into account in determining the UPR, remains subject to the prepayment rules.

## *Outstanding claims*

A deduction is allowed for any increase in the outstanding claims reserve during the year, while decreases in the outstanding claims reserve are assessable. In addition, claims paid during the year are deductible. This effectively mandates a balance sheet approach for determining the claims expense for the year, and with the exception of indirect claims settlement costs, should align with the current accounting treatment of claims.

This means that a deduction is allowed for the estimated cost of settling reported claims and claims incurred but not reported (IBNR) during the year of income. The deduction is based on the costs of claims incurred and paid during the year of income, an estimate of costs to be paid in respect of claims incurred during the year and a revision of previously estimated costs of claims incurred in prior years. These estimates must be soundly based but may take prudential margins into account.

The following factors may be taken into account in determining the quantum of the allowable deduction for outstanding claims and IBNR provisions:

- direct policy costs;
- claims investigation and assessment costs;
- direct claims settlement expenses;
- estimated increased costs of litigation and other factors, such as superimposed inflation; and
- recoverables, including reinsurances, excesses and salvage and subrogation.

These factors allow for the effects of inflation. However, only the present value (i.e. the value after discounting) of costs associated with long-term claims is an allowable deduction. A deduction is not allowed for estimated indirect claims settlement costs (e.g. future claims department costs), until those expenses are paid.

## *Profits or losses on realisation of investments*

The purchase and sale of investments are regarded as part of the income-producing activities of a general insurer. As a consequence, profits or losses on the sale of investments are generally considered to be of a revenue nature. Profits will be assessable as ordinary income, while losses will be allowable deductions. However, a profit or loss arising on the sale of a capital asset that is not part of the insurance business may be treated as a capital gain or loss. It is generally accepted that a building used as a head office or permanent place of business by an insurer is a capital asset.

The Taxation of Financial Arrangements (TOFA) regime has changed the way financial arrangements are taxed for income tax purposes. Prior to the introduction of TOFA, unrealised profits and losses on investments were not brought to account as assessable income or allowable deductions for tax purposes.

However, if TOFA applies to a tax-payer (certain thresholds must be met before TOFA applies), the treatment of unrealised profits and losses on investments would depend on which TOFA elections are made by the tax-payer. If certain TOFA elections are made, the tax treatment of certain financial arrangements may be aligned with the accounting treatment (i.e. unrealised profits and losses may be brought to account as assessable income or allowable deductions for tax purposes).

## *Reinsurance*

Generally, a premium paid for reinsurance will be an allowable deduction in the year in which the premium is incurred. Because such premiums (other than treaty non-proportional reinsurance premiums) reduce gross premiums in calculating the unearned premium reserve, the benefit of the deduction allowed in any year is effectively limited to the proportion of risk covered by the premium that has expired during the year.

Reinsurance recoveries are assessable income and future recoveries must be taken into account in determining outstanding claims reserves (unless the reinsurance is with a non-resident and a section 148(2) election has not been made, see below).

## *Reinsurance with non-residents*

Where a general insurer reinsures the whole or part of any risk with a non-resident, a deduction will not be allowed in the first instance in respect of those premiums.

These reinsurance premiums will not reduce gross premiums in calculating the unearned premium reserve and reinsurance recoveries will not be assessable.

However, an insurer may elect that this principle does not apply in determining its taxable income (section 148(2) election), in which case the insurer becomes liable to furnish returns and to pay tax at the relevant rate (30 per cent) on 10 per cent of the gross premiums paid or credited to these non-resident reinsurers during the year. Where the election has been made, these reinsurance premiums should be included in the calculation of UPR, and recoveries under those reinsurance policies included in the calculation of the outstanding claims reserve.

### *Financial reinsurance*

The ATO considers (in TR96/2) that financial insurance and financial reinsurance arrangements should be treated as the provision and repayment of loans. In determining whether an arrangement constitutes financial insurance or reinsurance, reference is made to two criteria:

- the degree of insurance risk assumed; and
- the possibility of the insurer/reinsurer incurring a significant loss under the arrangement.

An insurer needs to prove both of these to support a claim for a deduction of a reinsurance premium.

## Goods and Services Tax

Under the Australian GST legislation, some classes of insurance are treated differently, leading to different implications for insurers and insured parties.

The provision of general insurance is, in most cases, a 'taxable supply'. Insurers are required to account for GST of one-eleventh of the premium income collected (excluding stamp duty). In most cases, they are also entitled to claim input tax credits for the GST included in the price of expenses they incur that relate to making supplies of general insurance (with certain exclusions which apply to all businesses).

It should be noted that the GST classification of general insurance will be different if a supply is made in relation to a risk located outside of Australia, in which case the supply of these policies may be GST-free (known as 'zero rated supplies' in other jurisdictions).

The GST legislation contains complex provisions in respect of general insurance businesses. The effect of the main provisions is summarised below.

- GST, where applicable, is chargeable on the stamp duty-exclusive amount of the premium. As GST forms part of the 'price' of a supply, it constitutes one-eleventh of the price paid for the premium (based on the prevailing GST rate of 10 per cent). Stamp duty will be calculated on the GST-inclusive amount of the premium.
- At or before the time a claim on the policy is made, the insured must notify the insurer as to the extent of the input tax credit they are entitled to claim on the policy. Failure to do so could adversely affect the GST position for both the insurer and the insured.
- An insurer will not have to account for GST on supplies made in the course of settling a claim if it has received notification from the insured entity of its entitlement to claim input tax credits on the premium paid for the insurance policy. Furthermore, where the insurer has engaged a supplier to provide goods/services that are to be supplied in settlement of a claim, it can generally claim input tax credits in relation to these goods and services (provided the policy was not a GST-free supply).
- Where the insured was not entitled to claim a full input tax credit in respect of the premium, the insurer is entitled to claim decreasing adjustments (DA) in respect of any settlement amount (in the form of cash and/or goods or services) paid out under that policy.

- Where the insured was entitled to claim a full input tax credit for GST included in the premium, there is no entitlement to a DA for the insurer when they make a settlement under the policy.
- If the insured is entitled to partial input tax credits on the premium, the insurer is entitled to a partial DA.
- The receipt of an excess payment may trigger a GST liability as an increasing adjustment for the insurer. The actual extent of the increasing adjustment liability is based on a specific provision in the GST law.

Special rules also exist for a range of common insurance scenarios such as, excesses, insurance settlements and recoveries. The rules and the practical impact on business systems and processes can be are complicated and ongoing systems and process reviews are highly recommended.

Further, there are special GST rules dealing with the various state and territory-based compulsory third party (CTP) insurance schemes. These laws are complicated and generally require careful consideration.

### *Victory Fire Service Levy (FSL)*

The Victorian Government has changed the method of collecting money from households and businesses to pay for fire services from 1 July 2013. FSL in Victoria is no longer collected by insurance companies in property insurance premiums but rather by local councils through a levy included in rates. Any over collection of FSL will be required to be refunded by the companies in accordance with the set guidelines of the Monitor.

The relevance of FSL collection in NSW will probably come under scrutiny as abolishment has now taken place in both Western Australia and Victoria. The ICA also expressed that it remains hopeful the NSW Government will renew its own emergency services levy reform process next year.

## Stamp duty

General insurance is dutiable in all states and territories. General insurance is not defined in the legislation of each jurisdiction, but is generally any insurance that is not life insurance.

Stamp duty on general insurance is generally calculated on the premium paid on the contract of general insurance. The rates of duty vary in each state and territory, up to 11 per cent in South Australia.

### *Reinsurance – South Australia*

An insurer that takes on the initial risk cannot claim a duty exemption where a risk (or a portion of that risk) is reinsured, and therefore must include that premium as premium subject to duty (unless an exemption or deduction were to apply). If the reinsurer is registered within South Australia, the reinsurer can now claim the premium for the reinsured risk as exempt premium.

# 2 Health Insurance

# *Introduction*
# Rod Balding

*The private health insurance industry remains an integral part of the Australian health care system, providing hospital treatment insurance coverage to almost 47 per cent of the Australian population.*

*As at 31 March 2014, there were 34 private health insurers registered in Australia. This includes nine for-profit insurers with the remainder being not-for-profit. The for-profit providers accounted for almost 76 per cent of total market share at 31 March 2014.*

*The recent decision by the Federal government to sell Medibank, currently the largest private health insurer, via an IPO during the 2014-2015 financial year is a significant development in the industry. The recent scoping study commissioned by the government concluded that Medibank is already operating in a very competitive environment and that the sale would not have upwards pressure on premium rates. Indeed, the study concluded that a privately owned Medibank may be freer to pursue more aggressive positions in commercial negotiations and to enter into new business areas, thereby increasing competition. The sale may stimulate demutualization and amalgamation of the other health funds.*

*The performance of the industry over the past year has remained strong, with sustained membership growth and a growing demand for health services which are largely funded through private health insurance.*

*However, there are a number of challenges in maintaining previous levels of profitability. The recent annual change in premium rates saw an average rise of 6.2 per cent, which only partly compensates for the continued increase in benefit outlays. Health insurers are also faced with the impact of ongoing change in distribution channels as aggregators continue to gain traction. This has increased acquisition costs and has led to a rise in lapse rates as customers are now more likely to 'shop around' for lower premiums.*

*In the face of these pressures, the industry remains focused on operational efficiency to cut costs and on diversifying into a broader range of health services. These services not only provide additional sources of revenue, but health insurers anticipate benefit outlays may reduce in the future as a result of improved health of their members.*

*Regulation continues to have an important impact on the industry with insurers starting to feel the downwards pressure on membership levels as a result of rises in thresholds in the Medicare Levy Surcharge as well the result of the introduction of means testing on the government health rebate.*

*There have also been significant recent changes to the PHIAC capital adequacy and solvency standards. These changes are designed to ensure the standards better reflect the risks faced by health insurers, improve the engagement of private health insurers with those risks, and enhance the quality of the information provided to PHIAC to support its regulatory role.*

*As well as changes to the principles by which insurers set capital and solvency requirements, the standards continue to raise the bar on governance with a requirement for insurers to have a formal board-endorsed capital management policy in place.*

*The recent Commission of Audit report proposes a number of changes which would have a significant impact on the industry if implemented. These changes are designed to address continuing growth in demand and cost by creating a more deregulated and competitive market.*

*Overall, the outlook for the industry continues to be positive. The continued increase in private healthcare utilization combined with the capital strength and increasing innovation of Australia's private health insurers should see them well placed to respond to the challenges that lay ahead.*

**Rod Balding**
*Partner*

2.1

# *Statistics*
# Top 15 Private health insurers

| | Entity | Ranking Measure: Contributions Current $m | Prior $m | Current Rank | Prior Rank | % Change | Performance: Membership Current $m | Prior $m | Other revenue Current $m | Prior $m | Result after tax Current $m | Prior $m |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Medibank Private Ltd | 5,192 | 4,914 | 1 | 1 | 6% | 1,804 | 1,785 | 176 | 130 | 251 | 234 |
| 2 | BUPA Australia Health Pty Ltd | 4,972 | 4,651 | 2 | 2 | 7% | 1,639 | 1,584 | 94 | 100 | 294 | 311 |
| 3 | The Hospitals Contribution Fund of Australia Limited | 2,053 | 1,864 | 3 | 3 | 10% | 662 | 636 | 81 | 57 | 100 | 86 |
| 4 | NIB Holdings Limited | 1,187 | 1,096 | 4 | 5 | 8% | 472 | 452 | 33 | 24 | 65 | 63 |
| 5 | HBF Health Limited | 1,177 | 1,096 | 5 | 4 | 7% | 461 | 453 | 92 | 31 | 166 | 83 |
| 6 | Australian Unity Health Ltd | 561 | 519 | 6 | 6 | 8% | 197 | 190 | 17 | 11 | 30 | 30 |
| 7 | Teachers Federation Health | 396 | 361 | 7 | 7 | 10% | 115 | 108 | 13 | 14 | 12 | 30 |
| 8 | GMHBA Ltd | 310 | 280 | 8 | 8 | 11% | 114 | 107 | 12 | 10 | 18 | 13 |
| 9 | Defence Health Ltd | 301 | 274 | 9 | 9 | 10% | 101 | 96 | 21 | 10 | 24 | 25 |
| 10 | CBHS Health Fund Ltd | 269 | 251 | 10 | 10 | 7% | 80 | 77 | 13 | 7 | 14 | 19 |
| 11 | Westfund Ltd | 130 | 124 | 11 | 11 | 5% | 45 | 45 | 6 | 7 | 10 | 13 |
| 12 | Latrobe Health Services Inc | 123 | 116 | 12 | 12 | 6% | 42 | 43 | 7 | 8 | 7 | 8 |
| 13 | Grand United Corporate Health Ltd | 118 | 103 | 13 | 14 | 15% | 26 | 25 | 7 | 3 | 10 | 7 |
| 14 | Health Partners | 118 | 113 | 14 | 13 | 4% | 38 | 38 | 9 | 4 | 13 | 9 |
| 15 | Queensland Teachers' Union Health Fund Ltd | 107 | 101 | 15 | 15 | 6% | 27 | 26 | 6 | 2 | 8 | 8 |

Source: The statistics are in respect of registered health benefit organisations as reported in the PHIAC annual statistics as at 30 June 2013 and 30 June 2012.

Notes: Membership is based on the number of policies in force. Other revenue comprises mainly of investment income. Benefits ratio is benefits paid as a proportion of contributions.
Where there are more than one entity within the group, a weighted average based on net assets is used to estimate the overall solvency ratio, and a weighted average based on contributions is used to estimate overall net margin.

# *Statistics*
## Top 15 Private health insurers (Continued)

| | | Financial position: | | | | | | | | Ratios: | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Net outstanding claims | | Investments | | Net assets | | Total assets | | Solvency | | Benefits | | Net margin | |
| | Entity | Current $m | Prior $m | Current $m | Prior $m | Current $m | Prior $m | Current $m | Prior $m | Current % | Prior % | Current % | Prior % | Current % | Prior % |
| 1 | Medibank Private Ltd | 400 | 366 | 1,974 | 1,879 | 1,420 | 1,868 | 2,844 | 3,102 | 1.81 | 3.08 | 87% | 86% | 3.6% | 5.4% |
| 2 | BUPA Australia Health Pty Ltd | 556 | 477 | 1,316 | 1,483 | 572 | 768 | 1,824 | 2,123 | 2.07 | 2.61 | 85% | 83% | 6.6% | 7.3% |
| 3 | The Hospitals Contribution Fund of Australia Limited | 141 | 134 | 926 | 864 | 888 | 785 | 1,408 | 1,424 | 2.92 | 2.52 | 92% | 91% | 1.3% | 2.0% |
| 4 | NIB Holdings Limited | 71 | 75 | 349 | 383 | 237 | 241 | 497 | 556 | 2.13 | 2.41 | 87% | 85% | 5.0% | 6.0% |
| 5 | HBF Health Limited | 100 | 94 | 1,036 | 915 | 879 | 713 | 1,239 | 1,128 | 5.91 | 4.77 | 84% | 86% | 6.3% | 4.7% |
| 6 | Australian Unity Health Ltd | 41 | 39 | 71 | 67 | 119 | 113 | 311 | 312 | 2.72 | 2.62 | 85% | 82% | 4.8% | 6.9% |
| 7 | Teachers Federation Health | 34 | 25 | 236 | 244 | 216 | 205 | 314 | 299 | 6.18 | 8.03 | 93% | 89% | -0.4% | 4.4% |
| 8 | GMHBA Ltd | 20 | 18 | 191 | 174 | 140 | 123 | 225 | 210 | 5.55 | 5.18 | 88% | 88% | 2.0% | 1.0% |
| 9 | Defence Health Ltd | 32 | 31 | 270 | 252 | 221 | 196 | 290 | 277 | 9.43 | 11.82 | 93% | 89% | 1.2% | 5.2% |
| 10 | CBHS Health Fund Ltd | 28 | 27 | 177 | 167 | 132 | 118 | 198 | 188 | 6.27 | 7.77 | 93% | 90% | 0.3% | 4.8% |
| 11 | Westfund Ltd | 16 | 14 | 125 | 122 | 105 | 96 | 142 | 138 | 7.33 | 7.75 | 85% | 87% | 3.4% | 4.3% |
| 12 | Latrobe Health Services Inc | 10 | 9 | 139 | 127 | 128 | 121 | 160 | 151 | 10.08 | 9.18 | 90% | 91% | 0.5% | 0.2% |
| 13 | Grand United Corporate Health Ltd | 10 | 9 | 18 | 14 | 46 | 36 | 81 | 106 | 2.59 | 1.90 | 79% | 77% | 5.2% | 7.0% |
| 14 | Health Partners | 6 | 6 | 64 | 61 | 90 | 77 | 110 | 100 | 7.42 | 8.32 | 87% | 86% | 3.2% | 4.9% |
| 15 | Queensland Teachers' Union Health Fund Ltd | 7 | 7 | 78 | 68 | 82 | 75 | 105 | 100 | 7.97 | 7.60 | 91% | 85% | 1.4% | 5.9% |

2.2

# Regulation and supervision

## Private Health Insurance Administration Council (PHIAC)

The private health insurance industry is regulated by the Australian Government Department of Health (DH) in conjunction with its private health insurance portfolio agency PHIAC. The DH sets down private health insurance policy in addition to fulfilling other functions such as managing the annual rate review process.

PHIAC is an independent statutory authority which was established as a body corporate under section 82B of the *National Health Act 1953* in 1989. PHIAC continues in existence by force of section 264-1 of the *Private Health Insurance Act 2007* (the Act).

Section 264-5 of the Act sets out PHIAC's broad objectives which are to:

- foster an efficient and competitive health insurance industry;
- protect the interests of consumers; and
- ensure the prudential safety of individual private health insurers.

PHIAC monitors and regulates the private health insurance industry and the provision of private health insurance related information to the Government and other stakeholders.

PHIAC's functions are:

- to administer the registration of private health insurers;
- to administer the Risk Equalisation Trust Fund;
- to oversee information collection, compliance, enforcement, public information, agency cooperation; and
- to advise the Minister about the financial operations and affairs of private health insurers.

PHIAC supervisory objectives are met in the following ways:

- reviewing compliance with solvency and capital adequacy standards;
- examining from time to time the financial affairs of the private health insurers and conducting site visits of insurers;
- reviewing the value of assets and liabilities of each health benefit fund by carrying out independent actuarial assessments;

- the collection and review of audited financial and other returns so that PHIAC can monitor the financial position of individual private health insurers and their ability to meet outstanding claims as they fall due; and
- the collection of signed statements and declarations from the private health insurers and their approved auditors that provide PHIAC with assurance that systems and procedures to meet regulatory requirements are in place, are adequate and have been independently tested.

As at 31 March 2014 PHIAC was supervising 34 private health insurers operating in Australia, which provide private hospital treatment insurance coverage for 47 per cent of the Australian population. Of these 34 insurers, 12 were restricted access and 22 were open access insurers, with 9 operating on a for-profit basis.

The market share of the for-profit insurers has increased to 76 per cent compared to 70 per cent at 30 June 2012.

## *PHIAC and other Australian regulators*

PHIAC has separate memoranda of understanding (MOU) in place with the Australian Prudential Regulation Authority (APRA), the Australian Competition and the Consumer Commission (ACCC) and the Australian Securities and Investments Commission (ASIC). These agreements set out a framework for co-operation in areas of common interest and recognise the importance of close co-ordination and co-operation between PHIAC and the other regulators.

## *Authorisation*

PHIAC has the power, on application, to register as private health insurers, bodies that are registered bodies for the purposes of the *Corporations Act 2001*. PHIAC will take into account the ability of the applicant to comply with the obligations imposed by the *Private Health Insurance Act 2007*. Registration is granted by PHIAC subject to terms and conditions as it sees fit.

Private health insurers must gain approval from the Minister for Health for any fund rule changes, including rate changes.

## *Appointed Actuaries*

All private health insurers are required to have an actuary appointed by the insurer. Under section 160-30 of the Act the appointed actuary is obliged to report both to the insurer and PHIAC. Schedule 2 of the *Private Health Insurance (Insurers Obligations) Rules 2009* specifies the duties of the appointed actuary and defines the notifiable circumstances of which private health insurers are obliged to keep the appointed actuary informed.

## *Community rating principle and risk equalisation*

Private health insurers do not typically carry reinsurance. However, private health insurers participate in the risk equalisation arrangements administered by PHIAC.

The principle of community rating prevents private health insurers from discriminating between people on the basis of their health status, age, race, sex, sexuality, the frequency that a person needs treatment, or claims history. The risk equalisation arrangements scheme supports the principle of community rating as it averages the cost of hospital treatment across the industry. The scheme transfers money from private health insurers with younger, healthier members (with lower average benefits payments) to those private health insurers with older and less healthy membership profile and which therefore have higher average benefits payments. This redistributes the burden of high cost claims across the industry to avoid the financial strain of the costs being borne by individual private health insurers.

The redistribution is calculated based on the average benefit paid by Australian private health insurers (per State) to customers in their aged-based pool (over 55 years old) and the high costs claimants' pool (claims exceeding $50,000 each). The arrangement operates by private health insurers paying/receiving a levy into/from the Health Benefits Risk Equalisation Trust Fund. Private health insurers prepare and submit membership and benefit data to PHIAC on a quarterly basis through the PHIAC 1 returns. Effectively, a health insurer that paid more risk equalised benefits than the State average will have an amount receivable from the Risk Equalisation Trust Fund, whereas a health insurer that paid less will have an amount payable to Risk Equalisation Trust Fund.

## *Medicare Levy Surcharge (MLS) and Australian Government Private Health Insurance Rebate*

The MLS is levied on Australian taxpayers who do not have private hospital cover and who earn above a certain income. The surcharge aims to encourage individuals to take out private hospital cover, and where possible, to use the private system to reduce the demand on the public system. The current surcharge is income tested and ranges from 0 per cent to 1.5 per cent as per the thresholds below.

Most Australians with private health insurance receive The Australian Government Private Health Insurance Rebate. The amount of the rebate is income tested and also adjusted based on the older member's age. This ranges from 0 per cent to 40 per cent.

The below table are the thresholds for 1 July 2013 to 30 June 2014:

| | | *PHI Rebate* | | | *MLS* |
|---|---|---|---|---|---|
| **Single Income** | **Family income** | **Younger than 65** | **Ages 65-69** | **Over 70** | **All ages** |
| **≤$88,000** | **≤$176,000** | 30% | 35% | 40% | 0.00% |
| **$88,001-102,000** | **$176,001-204,000** | 20% | 25% | 30% | 1.00% |
| **$102,001-136,000** | **$204,001-272,000** | 10% | 15% | 20% | 1.25% |
| **≥$136,001** | **≥$272,001** | 0% | 0% | 0% | 1.50% |

Consistent with prior legislation, the new legislation also requires that the thresholds be indexed annually to Average Weekly Earnings. That means that every year on 1 July, a revised threshold level will take effect in line with that index.

## *Removal of the rebate on lifetime health cover loadings*

The Private Health Insurance Amendment (Lifetime Health Cover Loading and Other Measures) Bill 2012 was given assent on 29 June 2013. The primary change under the Bill, was that from 1 July 2013, the private health insurance rebate no longer applies to the lifetime health cover loading component on an individual's premium (where applicable).

## *Private health insurance base premium bill*

The Private Health Insurance Legislation Amendment (Base Premium) bill 2013, was also given royal assent on 29 June 2013. This Bill seeks to decouple the expenditure on the private health insurance rebate from premium increases applied from 1 April 2014.

The Bill legislates that, from 1 July 2013, the rebate is calculated using base premiums as at 1 April 2013. Each year the base premium is indexed by the lesser of the national weighted change in the consumer price index (CPI) or the industry premium increase and the rebate will apply to the base premium. For a policyholder, the level of rebate applicable to the base premium will still be dependent on rebate rates and income thresholds.

## *Commission of Audit proposals*

The recent Commission of Audit Report on the healthcare system sets out a number of measures which would significantly change the private health insurance industry if implemented. These changes are primarily aimed at addressing the increasing burden of healthcare on the Commonwealth and include the following:

- **higher-income earners to take out private health insurance for basic health services in place of Medicare**, and precluding them from accessing the private health insurance rebate. Expanded private health insurance plans would, at a minimum, cover all services provided by Medicare and public hospitals, and would have to pay for all health care expenses of the insured, including the cost of treatment in a public hospital. It is proposed the Medicare Levy of 1-1.5 per cent should be increased to between 3-3.5 per cent to effect this change.
- **reforming the private health insurance market** to provide greater incentives for efficient and cost effective health management through deregulating price setting arrangements, allowing health funds to expand their coverage to primary care, relaxing community-rating to allow health funds to vary premiums to account for a limited number of lifestyle factors, including smoking; and reforming the arrangements by which insurers equalise risks through the sector.

# 2.3 Solvency and capital adequacy

Authorised health insurers are subject to solvency and capital adequacy requirements under Schedule 2 and 3 respectively of the *Private Health Insurance (Health Benefits Fund Administration) Rules 2007*. These requirements were legislated under Divisions 140 and 143 of the Act.

In September 2013, following consultation and comment from stakeholders, PHIAC released new solvency and capital adequacy standards that will replace the previous standards in stages from 31 March 2014 to 1 July 2014.

In their Regulatory Impact Statement PHIAC have noted that *"the changes to the Capital Adequacy and Solvency Standards ensure that the Standards more accurately address the key risks faced by insurers, improve insurers' engagement with those risks and improve the quality of information available to support PHIAC's regulation of the industry. In general the changes to the Standards will lower capital requirements."*

The new standards are designed to make sure a private health insurer will be able to meet its liabilities and carry enough capital for the conduct of the fund in the accordance with the Private Health Insurance Act 2007 (Cth) and in the interests of the members of the fund.

## *The New Capital Adequacy Standard*

Under the new standard private health insurers are required to meet two tests – the quantum of assets test and the concentration of assets test.

The two tests under the new standard are fundamentally designed to have a different objective than the old standard, and provide a more appropriate capital position.

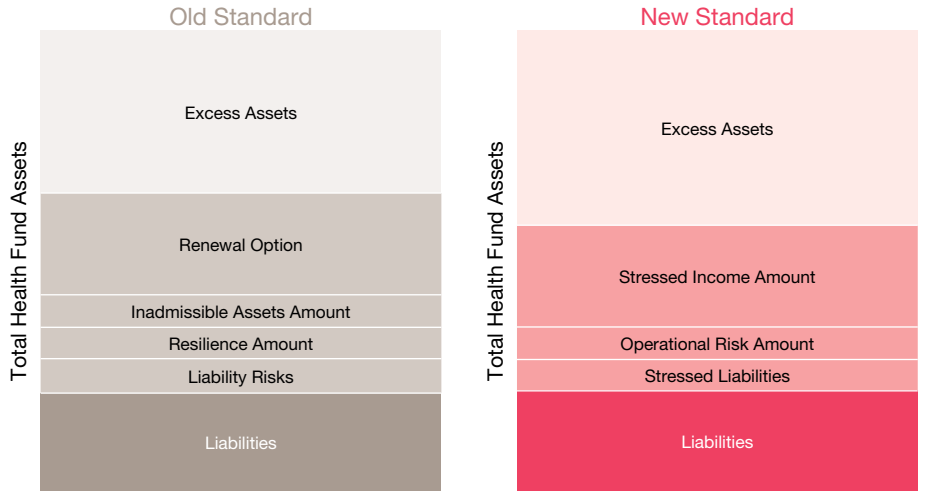
| *Old Standard* | *New Standard* |
|---|---|
| *'Is the health fund's capital greater than the prescribed capital charges in an on-going situation?'* | *'Are the health fund's assets large enough to ensure that it can survive a very bad year with its balance sheet intact?'* |

The objective of the quantum of assets test is to ensure that the fund holds sufficient assets so that, after 12 months of adverse experience, it would still have more assets than its prudent liabilities. This is done by ensuring that assets are greater than the sum of an operational risk charge, supervisory adjustment charge (if any), prudential liabilities and a stressed loss over next twelve months.

The concentration of assets test is separately calculated to address credit and liquidity risks associated with asset concentration. This test ensures that assets less the largest single asset

exposure exceed the stressed liabilities. PHIAC has explicitly stated that assets and liabilities should be calculated in line with the relevant AASB standards.

**Diagram of the old vs new Capital Adequacy standard**




In the above diagram the stressed income amount and operational risk amount is compared against the maximum default loss of the insurer when selecting the actual capital adequacy amount.

## *Capital Management Policy*

In addition to the quantitative asset tests the Capital Adequacy Standard also requires insurers to have a Board-endorsed Capital Management Policy relating to their fund that includes a capital management plan, a pricing philosophy and investment rules. The capital management policy is not a new requirement however this is the first time it has been included within with Capital Adequacy Standard.

## *The New Solvency Standard*

The solvency test is now an explicit test of the liquidity of the insurer and will be backed by a liquidity management plan. The previous standard required sufficient assets to be held to be able to meet all accrued liabilities and obligations in the event the fund was terminated.

The solvency test is now a pure stress test to ensure that the insurer has sufficient cash (cash on hand or on demand) to exceed the sum of the 'cash management account'.

The cash management account has been defined as 1 per cent of expected premium income over the next twelve months plus a stressed net cash outflow amount. The stressed net cash outflow amount is the insurers expected net cash outflow over a 30 day period at the 98th percentile. The stressed net cash outflow should consider the seasonal influences and cash stresses over the 30 days from the valuation or report date, and therefore insurers can adjust it for known seasonal periods of high or low cash outflows.

The solvency test must be supported by a liquidity management plan. The plan will need to consider the extent to which assets can be readily converted to cash, the concentration of assets to individual counterparties, seasonality of cash flows, potential cash flows under stressed situations, the potential to repay borrowings with cash as well as any other matter the health fund deems relevant. There is no longer a specific quantitative concentration test in the solvency standard.

# 2.4 Governance and assurance

Since 2007, PHIAC has had the authority to issue prudential standards, compliance with which is mandatory for all private health insurers.

Current prudential standards on issue are:

- Capital Adequacy standard
- Solvency standard
- Appointed Actuary standard
- Governance standard
- Disclosure standard
- Outsourcing standard

For further discussion of the Capital Adequacy and Solvency standards refer to section 2.3.

The Appointed Actuary standard is set out in Schedule 2 of the *Private Health Insurance (Insurer Obligations) Rules 2009*. The standard articulates the requirements of an appointed actuary of a private health insurer.

The Disclosure standard is set out in Schedule 3 of the *Private Health Insurance (Insurer Obligations) Amendment Rules 2010 (No. 1)* which amend the *Private Health Insurance (Insurer Obligation) Rules 2009*. The Disclosure standard requires insurers to provide information to PHIAC, which will facilitate the ongoing risk assessment of insurers and early detection of prudential issues.

The Governance standard is set out in Schedule 1 of the *Private Health Insurance (Insurer Obligations) Rules 2009* and commenced on 1 January 2010. PHIAC's objectives in relation to governance are to ensure that insurers are managed in a sound and prudent manner by a competent board of directors which is capable of making reasonable and impartial business judgments in the best interest of the insurer and which gives due consideration to the impact of its decisions on policyholders.

The Outsourcing Standard is set out in Schedule 4 of the *Private Health Insurance (Insurer Obligations) Rules 2009* and became effective from 1 October 2012. This standard requires insurers to comply with minimum requirements when entering into, renewing or renegotiating outsourcing arrangements.

2.5

# Financial and regulatory reporting

Private health insurers are required to prepare financial statements that comply with Australian Accounting Standards, in particular AASB 1023 *General Insurance Contracts* (AASB 1023). The key principles and disclosure requirements of AASB 1023 are set out in the General Insurance section of this publication. Guidance was also produced by the Australian Health Insurance Association in 2005 to assist private health insurers in applying AASB 1023.

Key features of accounting for health insurance are set out below.

## *Assessment of insurance risk*

AASB 1023 applies to 'general insurance contracts' defined as a contract under which one party (the insurer) accepts significant insurance risk from another party. Private health insurers may issue contracts that do not transfer 'significant insurance risk' within the meaning of AASB 1023. For example, the benefits under certain products may be restricted to the extent that claims payments are not variable enough for the PHI to have demonstrated the transfer of significant risk.

If no significant insurance risk is transferred, AASB 1023 will not apply and private health insurers would instead 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.*

## *Premium revenue*

Under AASB 1023, premium revenue is recognised from the date on which the insurer accepts insurance risk (attachment date) over the period of the contract in accordance with the pattern of the incidence of risk expected.

Unlike most other forms of insurance contract, a health insurance contract does not typically stipulate a fixed period of cover as contracts typically require payment in advance and include an option for the policyholder to renew. In practice, private health insurers recognise premiums from the date cash is received over the period covered by the payment on a straight line basis. Private health insurers are legally obliged to continue cover (but not pay benefits for the period in arrears) for 63 days if a policyholder's premiums are in arrears. Private health insurers will therefore need to consider past experience to determine whether it is appropriate to accrue for premiums in arrears.

## *Measurement of outstanding claims*

Matters of particular importance to private health insurers are set out below.

***Central estimates***

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

***Risk margin***

AASB 1023 requires that the outstanding claims liability includes a risk margin to reflect the inherent uncertainty in the central estimate of the present value of the expected future payments. It does not specifically prescribe a fixed risk margin or probability of adequacy. 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.

***Discounting***

AASB 1023 requires the liability for outstanding claims to be discounted to reflect the time value of money. As health insurance claims are generally settled within one year, private health insurers may be able to demonstrate that no discounting of claims is required as the difference between the future and present value of claims payments is not material.

## *Deferred acquisition costs ('DAC')*

Acquisition costs can only be capitalized where it is probable that future economic benefits will eventuate and they possess a cost that can be reliably measured. Recently, private health insurers have seen acquisition costs rise due to more business being sourced through aggregator channels. Where these costs are being deferred, a key judgment for insurers is the period over which these costs are to be amortised. This can be difficult given a lack of historical data of the duration of policies sourced from aggregators.

## *Unearned premium liability*

Typically private health insurers have referred to the unearned premium liability as 'contributions in advance'. These are determined in accordance with AASB 1023.

## *Liability adequacy test*

The liability adequacy test typically incorporates an analysis based on the unearned premiums at reporting date and the constructive obligation in relation to projected premiums up to the subsequent 1 April rate review.

# Annual accounts

Audited annual *Corporations Act* financial statements must be lodged with ASIC in line with the requirements of the *Corporations Act*, i.e. within three months for a disclosing entity and four months for a non-disclosing entity. Private health insurers are required to lodge annual audited financial statements with PHIAC by 30 September each year.

# Other returns

All private health insurers must provide a number of other returns under various legislative requirements. These include:

**PHIAC 1 Returns** – Quarterly state and territory-based returns must be prepared for all states under the *Private Health Insurance Act 2007*. The returns must be prepared in accordance with the guidelines established in PHIAC circulars and contain granular data on each health insurer's membership and benefit payment composition. Each quarterly return is audited by the health insurer's external auditor at the end of the financial year.

**PHIAC 2 Returns** – This is the main reporting requirement under the solvency and capital adequacy standards. Quarterly unaudited returns are lodged with PHIAC and the annual return is audited by the health insurer's external auditor. The annual return includes an unaudited certification by directors in relation to the capital adequacy margin, loss ratio and risk management procedures.

**PHIAC 3 Returns** – These quarterly returns contain prostheses reports and are not required to be audited.

**PHIAC 4 Returns** – Specialty gap cover data is required to be provided quarterly to PHIAC. The totals reported on this quarterly PHIAC 4 medical gap report should be consistent with data reported in the quarterly PHIAC 1 return. The returns are not required to be audited.

**Rebate Returns** – Private health insurers are required to lodge a monthly application on or before the seventh day of the following month for the rebate with the Medicare Australia CEO in line with the requirements of the *Private Health Insurance Act 2007* in order to receive the rebate. Under subsection 279-50(6) Medicare Australia may require a health fund to give Medicare Australia an Auditor's Certificate regarding the health insurer's participation in the Premium Reduction Scheme.

**Second Tier Benefits Returns** – The Private Health Insurance Benefit Requirement Rules are amended regularly by the Department of Health. Under schedule 5 of these requirements, if a health facility is accredited with a Commonwealth provider number and it does not have Hospital Purchaser Provider Agreements (HPPA) or a similar agreement with a particular health insurer, it may approach the health insurer for its second tier benefits rates. The private health insurers are required to calculate 85 per cent of the average HPPA rates, effective at 1 August, for procedures that are included in the majority of their HPPAs. The audited second tier benefits return must be lodged with both the Department of Health and PHIAC by 30 September each year.

## *Key dates*

| *Return* | *Due Date* |
|---|---|
| Unaudited quarterly PHIAC 1 and 2 returns | *Within 28 days of the quarter end.* |
| Annual audited quarterly PHIAC 1 returns | *All four quarters returns by 30 September each year.* |
| Annual audited PHIAC 2 return and a statement by the directors in relation to the capital adequacy margin, loss ratio and risk management procedures | *All four quarters returns by 30 September each year.* |
| Quarterly unaudited PHIAC 3 prostheses returns | *Within 28 days of the quarter end.* |
| Quarterly unaudited PHIAC 4 medical gap returns | *Within 28 days of the quarter end.* |
| Annual audited financial statements of the health insurer | *30 September each year.* |
| Unaudited financial condition report prepared by the insurer's appointed actuary | *30 September each year.* |
| ***Risk Equalisation Trust Fund*** | |
| • Letters advising of the distributions to/from the fund are sent out quarterly following the processing of PHIAC 1 returns. | *Approximately eight weeks from each quarter end.* |
| ***Annual levy*** | |
| • Annual levy is based on health insurer membership numbers. | *Payment is due quarterly, within two weeks of the request for payment.* |
| **Medicare Australia**<br>***Lodgement of returns*** | |
| • Audited annual statement regarding the health insurer's participation in the Federal Government's 30 per cent Rebate on Private Health Insurance – Premium Reduction Scheme. | *Within 20 days from the end of the year (approximately).* |
| **Federal Department of Health**<br>***Lodgement of returns*** | |
| • Un-audited Second Tier Default Benefit rates. | *By 31 August each year (where applicable).* |
| • Audited Second Tier Default Benefits rates. | *By 30 September each year (where applicable).* |

2.6

# Health insurance taxation

## Taxation of health insurers

An organisation which is a registered health benefits organisation for the purposes of the *Private Health Insurance Act 2007*, and which is not in business for the purposes of profit or gain for its individual members, is exempt from income tax. The fact that a health fund may offer rebates and/or discounts to members has not been construed as the distribution of profits or gains to members. Accordingly, the scope of this exemption will depend generally on the type of activities carried out by the organisation insofar as they do not disqualify it from registration under the Act. Registered health benefit organisations that operate for the purposes of profit or gain are taxed like normal corporates. Although Division 321 of the Income Tax Assessment Act 1997 (taxation of general insurers) does not apply to health insurers, taxable health insurers generally apply broadly equivalent principles to Division 321.

## Goods and Services Tax

Under the Australian GST legislation, some classes of insurance are treated differently, leading to different implications for insurers and insured parties.

In relation to Health Insurance, special provisions result in most forms of health insurance to be treated as GST free (known as 'zero-rated supplies' in other jurisdictions). This means that health insurers are not required to account for GST on premium income derived from their businesses. In addition, special rules relate to the expenses incurred by GST-free Health Insurers such that they are only entitled to recover input tax credits on the expenses incurred running the business and managing claims. No entitlement to input tax credits will arise for expenses incurred in settling a claim under an insurance policy which is GST-free.

In relation to the investment activities of an insurance entity, it is important to consider if the Financial Acquisitions Threshold test in the GST law applies and if so whether or not the Threshold has been exceeded by the insurer due to the quantum of expenses incurred in relation to their investing activities.

## Stamp duty

Health insurance policies are exempt from stamp duty in all Australian states and territories provided the policies are issued by an organisation registered under Part VI of the National Health Act 1953 or a 'private health insurer' (as defined in the *Private Health Insurance Act 2007* (Commonwealth) Schedule 1) for the Western Australian duty legislation).

# 3 Life Insurance

# *Introduction*
## Voula Papageorgiou

*The life insurance industry continues to operate in a challenging environment but great opportunities through developments in the superannuation industry, as well as challenges stemming from volatile investment revenue, increasing consumer price-sensitivity and higher lapse rates. Consumers are continuing to show increased awareness of the benefits covered by life insurance products, especially disability benefits under their superannuation fund. This higher level of awareness of entitlements, which is reinforced by greater involvement of the legal profession, has led to significantly higher claims rates, particularly in areas such as mental health issues.*

*There is also increasing focus on the financial planning profession with professional conduct and compensation structures under closer examination. There is increasingly a push for life insurers to steer away from high levels of up-front commissions and greater scrutiny on advice provided by financial planners or advisers to customers to switch insurance products.*

*From a regulatory perspective, APRA and other authorities continue their focus on the life insurance industry, in terms of working with the industry to address recent claims experience, improving controls and product design, and in the reviews of the conduct of financial planners and the wholesale business.*

*In the current environment, life insurers need to consider the balance between affordability and the level of cover provided for individuals as well as whether current practices and business models are well suited to the changing preferences. Across the industry the life insurers who are experiencing the highest customer retention rates are no longer relying on the customers' awareness of its products but is also placing greater emphasis on the effectiveness of online marketing and sales efforts.*

*The introduction of MySuper in 2013 has impacted the industry by giving a default option for MySuper funds to include a basic level of life and total permanent disability cover on an opt-out basis. There is further opportunity for insurers to educate superannuation policy-holders on insurance options as most policies obtained by individuals through superannuation products has cover that is below their actual needs.*

*The past year was the first year implementation of the LAGIC requirements under APRA's Prudential Standards. Whilst great strides have been made by boards and management to implement the framework, this continues to be an area of focus for the industry. APRA is continuing to work with life insurers on implementing the broader Internal Capital Adequacy and Assessment Process (ICAAP), with particular emphasis on fully embedding the framework and better use of stress testing to complement other risk management tools.*

*The volatile environment will continue to challenge life insurers in the coming year, especially with increased focus by regulators. Ongoing engagement with customers and awareness of regulatory requirements continues to be important focus areas for life insurers in capitalising on opportunities.*

**Voula Papageorgiou**
*Partner*

3.1

# *Statistics*
# Top 15 Life insurers

| | | | Ranking measure: | | | | | Performance: | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Net insurance premium rev | | | | | Net investment rev | | Result after tax | |
| | Entity | Year end | Current $m | Current Rank | Prior $m | Prior Rank | % Change | Current $m | Prior $m | Current $m | Prior $m |
| 1 | AMP Life | 12/13 | 2,070 | 1 | 2,009 | 1 | 3% | 11,967 | 9,811 | 616 | 684 |
| 2 | MLC (NAB) | 09/13 | 1,479 | 2 | 1,359 | 2 | 9% | 9,778 | 6,340 | 243 | 296 |
| 3 | CBA Life (CMLA) | 06/13 | 1,276 | 3 | 1,189 | 3 | 7% | 1,324 | 744 | 234 | 281 |
| 4 | OnePath Life | 09/13 | 1,113 | 4 | 1,034 | 5 | 8% | 4,272 | 2,849 | 314 | 318 |
| 5 | TAL Life Limited* | 03/13 | 978 | 5 | 1,184 | 4 | -17% | 266 | 202 | 151 | 176 |
| 6 | AIA Australia | 11/13 | 943 | 6 | 816 | 6 | 16% | 112 | 136 | 23 | 69 |
| 7 | Swiss Re Life & Health Australia | 12/13 | 782 | 7 | 609 | 7 | 28% | 32 | 76 | (137) | 61 |
| 8 | RGA Reinsurance Company of Australia | 12/13 | 536 | 8 | 508 | 8 | 6% | 32 | 57 | (73) | 35 |
| 9 | Westpac Life | 09/13 | 532 | 9 | 439 | 9 | 21% | 1,051 | 805 | 224 | 214 |
| 10 | Suncorp Life & Superannuation | 06/13 | 526 | 10 | 311 | 12 | 69% | 792 | 216 | 41 | 137 |
| 11 | Munich Reinsurance Company of Australasia | 12/13 | 515 | 11 | 416 | 10 | 24% | 57 | 73 | (56) | 30 |
| 12 | Hannover Life Re of Australasia | 12/13 | 388 | 12 | 345 | 11 | 12% | 27 | 85 | 38 | 39 |
| 13 | MetLife Insurance | 12/13 | 342 | 13 | 289 | 13 | 18% | 24 | 46 | (51) | 21 |
| 14 | General Reinsurance Life Australia | 12/13 | 220 | 14 | 212 | 14 | 4% | 7 | 16 | 16 | (23) |
| 15 | Zurich Australia | 12/13 | 206 | 15 | 183 | 15 | 13% | 348 | 262 | 35 | 46 |

Source: Published annual financial statements or APRA annual returns for Australian life insurance operations.
Where applicable, comparatives have been updated to be in line with updated comparatives in current year financials reports.

Notes: *TAL Life Limited had a reporting period of 18 months to March 2012, as a result of a change in the year end. The current reporting period is for 12 months from 1/4/12 – 31/3/13.

# *Statistics*
# Top 15 Life insurers (Continued)

| | | | Financial position: | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Net policy liabilities | | Capital adequacy multiple/solvency ratio | | Financial assets held at fv | | Net assets | | Total assets | |
| | Entity | Year end | Current $m | Prior $m | Current Note 1 | Prior Note 2 | Current $m | Prior $m | Current $m | Prior $m | Current $m | Prior $m |
| 1 | AMP Life | 12/13 | 90,943 | 83,355 | 1.82 | 2.10 | 91,832 | 83,097 | 4,302 | 4,548 | 100,514 | 91,821 |
| 2 | MLC (NAB) | 09/13 | 64,251 | 56,357 | 2.0 | 2.0 | 65,225 | 56,843 | 2,855 | 2,967 | 68,627 | 60,266 |
| 3 | CBA Life (CMLA) | 06/13 | 11,405 | 11,643 | 2.5 | 2.0 | 12,914 | 13,245 | 1,640 | 1,643 | 13,554 | 13,719 |
| 4 | OnePath Life | 09/13 | 32,135 | 29,268 | 1.9 | 1.9 | 29,502 | 26,833 | 2,177 | 2,181 | 35,480 | 32,606 |
| 5 | TAL Life Limited* | 03/13 | 1,794 | 1,721 | 1.6 | 2.5 | 2,776 | 2,609 | 1,079 | 929 | 4,140 | 3,651 |
| 6 | AIA Australia | 11/13 | 1,048 | 886 | 1.4 | 1.5 | 1,618 | 1,441 | 557 | 499 | 2,862 | 2,316 |
| 7 | Swiss Re Life & Health Australia | 12/13 | 1,851 | 1,246 | 1.5 | 2.8 | 1,977 | 1,535 | 984 | 434 | 2,978 | 1,851 |
| 8 | RGA Reinsurance Company of Australia | 12/13 | 476 | 378 | 1.2 | 2.8 | 1,003 | 853 | 453 | 413 | 2,019 | 1,574 |
| 9 | Westpac Life | 09/13 | 6,958 | 6,695 | 2.3 | 3.4 | 8,080 | 7,675 | 1,198 | 1,081 | 8,319 | 7,966 |
| 10 | Suncorp Life & Superannuation | 06/13 | 5,044 | 4,978 | 2.8 | 2.8 | 6,508 | 6,187 | 1,701 | 1,733 | 7,443 | 7,481 |
| 11 | Munich Reinsurance Company of Australasia | 12/13 | 553 | 565 | 1.5 | 3.0 | 1,366 | 1,174 | 660 | 379 | 2,079 | 1,847 |
| 12 | Hannover Life Re of Australasia | 12/13 | 997 | 812 | 1.5 | 3.1 | 1,166 | 1,018 | 451 | 337 | 1,755 | 1,352 |
| 13 | MetLife Insurance | 12/13 | 311 | 180 | 2.0 | 4.7 | 526 | 429 | 401 | 372 | 988 | 762 |
| 14 | General Reinsurance Life Australia | 12/13 | 456 | 410 | 4.8 | 1.7 | 551 | 411 | 117 | 101 | 645 | 564 |
| 15 | Zurich Australia | 12/13 | 1,857 | 1,739 | 5.8 | 1.7 | 2,307 | 2,262 | 618 | 599 | 2,674 | 2,537 |

Notes: Note 1 – For Insurance Groups with multiple capital adequacy ratios an average mean has been calculated. Adjustments have been made to the mean if it is skewed by outliers.

Note 2 – Multiples for periods ending on 31 December 2012 and prior were determined using the applicable APRA Prudential Standards that are now suspended.

3.2

# Regulation and supervision

## The Australian Prudential Regulation Authority (APRA)

APRA is the single Commonwealth authority responsible for licensing and prudential regulation for all deposit-taking institutions, life and general insurance companies, superannuation funds and friendly societies. APRA is also empowered to appoint an administrator to provide investor or consumer protection in the event of financial difficulties experienced by life or general insurance companies.

APRA's powers to regulate and collect data from the life insurance industry stem principally from the following acts:

- Life Insurance Act 1995 (Life Act);
- Financial Sector (Collection of Data) Act 2001;
- Financial Sector (Shareholdings) Act 1998;
- Insurance (Acquisitions and Takeovers) Act 1991;
- Financial Sector (Transfers of Business) Act 1999; and
- Life Insurance Supervisory Levy Imposition Act 1998.

As supervisor of life insurance companies, APRA administers the Life Act. The objective of the Life Act is to "protect policy owners and promote financial systems by encouraging a viable and competitive Australian life insurance industry with financially sound participants and fair trading practices".

APRA authorises and supervises life insurance companies under the Life Act with a view to maximising the likelihood that these companies will be able to meet their obligations to policyholders. Prudential requirements for life insurance companies are set out in prudential standards and in prudential rules.

An entity cannot issue life insurance products without being authorised by APRA and only incorporated entities can be authorised under the Life Act. The Life Act does not apply to Eligible Foreign Life Insurance Companies (EFLIC), as defined under the Life Act, in relation to life insurance business carried on outside Australia. The prime responsibility for oversight of the Australian operations of an EFLIC rests with its local management and Compliance Committee. While a foreign life company's home regulators will play a role in supervising the EFLIC, to protect the interests of Australian policyholders, an EFLIC is required to maintain statutory funds in relation to its life insurance business in Australia and have its local operations subject to APRA's prudential supervision.

The requirements on the composition, operation and duties and responsibilities of an EFLIC are set out in Attachment B of Prudential Standard CPS 510 Governance. There are no special restrictions on the number, size or mix of operations of foreign-owned subsidiaries or EFLIC's operating in the Australian market.

Although APRA is responsible for the prudential regulation of insurers, it is not responsible for product disclosure standards, customer complaints or licensing of financial service providers (including authorised representatives and insurance brokers) as these responsibilities fall to the Australian Securities and Investments Commission (ASIC) under its Australian Financial Services Licence (AFSL) regime. Most insurers require an AFSL, and as such, a dual licensing system exists with overlapping requirements under both ASIC and APRA.

Since its establishment in 1998, APRA has been working to harmonise the regulatory framework of regulated institutions. The aim is to apply similar principles across all prudential regulation and to ensure that similar financial risks are treated in a consistent manner whenever possible.

## *Regulatory framework*

Similar to the general insurance regulatory framework, there is a three-tier regulatory system for life insurers:

- Tier 1 – The Life Act contains the high-level principles necessary for prudential regulation;
- Tier 2 – Prudential standards detail compliance requirements for companies authorised under the Life Act; and
- Tier 3 – Prudential Practice Guides accompany most prudential standards, providing details of how APRA expects them to be interpreted in practice.

A summary of the Prudential Standards in effect at September 2014 is as follows:

| *Prudential standard* | *Reference* |
|---|---|
| LPS 100 Solvency Standard | See Section 3.3 |
| LPS 110 Capital Adequacy | See Section 3.3 |
| LPS 112 Capital Adequacy: Measurement of Capital | See Section 3.3 |
| LPS 114 Capital Adequacy: Asset Risk Charge | See Section 3.3 |
| LPS 115 Capital Adequacy: Insurance Risk Charge | See Section 3.3 |
| LPS 117 Capital Adequacy: Asset Concentration Risk Charge | See Section 3.3 |
| LPS 118 Capital Adequacy: Operational Risk Charge | See Section 3.3 |
| LPS 220 Risk Management | See section 3.4 |
| LPS 230 Reinsurance | See section 3.4 |
| LPS 310 Audit and Related Matters | See section 3.5 |
| LPS 320 Actuarial and Related Matters | See section 3.5 |
| LPS 340 Valuation of Policy Liabilities | See section 3.6 |
| LPS 360 Termination Values, Minimum Surrender Values and Paid-up Values | See section 3.6 |
| LPS 370 Cost of Investment Performance Guarantees | See section 3.6 |
| LPS 600 Statutory Funds | See section 3.6 |
| LPS 700 Friendly Society Benefit Funds | See section 3.6 |
| CPS 231 Outsourcing | See section 3.4 |
| CPS 232 Business Continuity Management | See section 3.4 |
| CPS 510 Governance | See section 3.5 |
| CPS 520 Fit and Proper | See section 3.5 |

## *Probability and Impact Rating System*

APRA's primary objective is to minimise the probability of regulated institutions failing and to ensure a stable, efficient and competitive financial system. APRA uses its Probability and Impact Rating System (PAIRS) to classify regulated financial institutions in two key areas:

- the probability that the institution may be unable to honour its financial promises to beneficiaries – depositors, policyholders and superannuation fund members; and
- the impact on the Australian financial system should the institution fail.

As part of its role as a prudential regulator, APRA uses PAIRS to assess risk and to determine where to focus supervisory effort, determine the appropriate supervisory actions to take

with each regulated entity, define each supervisor's obligation to report on regulated entities to APRA's executive committee, board, and, in some circumstances, to the relevant government minister, and to ensure regulated entities are aware of how APRA determines the nature and intensity of their supervisory relationships.

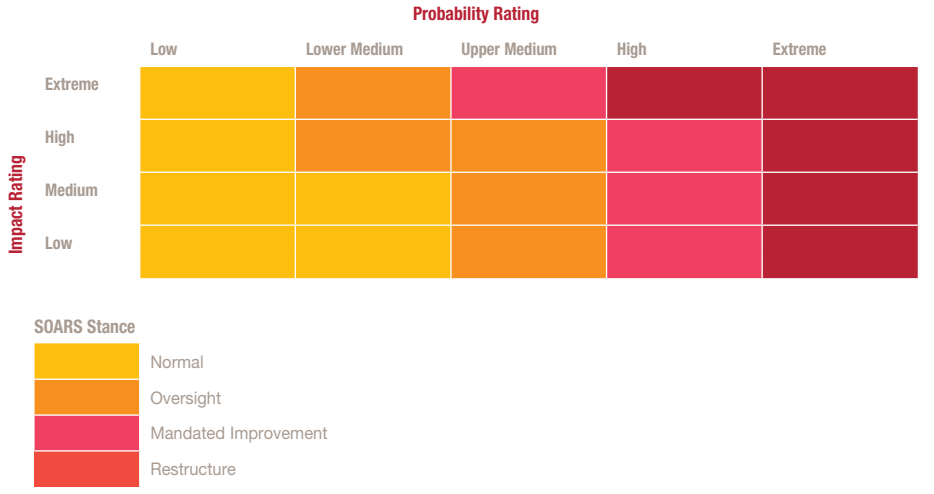
The PAIRS Supervisory Attention Index rises as the probability of failure and the potential impact of failure increase, ranging from 'Low' to 'Extreme'. These ratings are not publicly available, and are used only to identify potential issues and seek remediation before serious problems develop.

## *Supervisory Oversight and Response System*

Supervisory Oversight and Response System (SOARS) is used to determine how supervisory concerns based on PAIRS risk assessments should be acted upon. It is intended to ensure that supervisory interventions are targeted and timely. All APRA-regulated entities that are subject to PAIRS assessment are assigned a SOARS stance. Supervisory strategies vary according to an entity's supervision stance.

The supervision stance of a regulated entity is derived from the combination of the Probability Rating and Impact Rating of the PAIRS process, as illustrated in figure 3.1 below.

**Figure 3.1 – PAIRS and SOARS**



# APRA monitoring and supervision

APRA's supervisory objectives are met in two main ways:

- maintaining a regulatory framework within which insurance companies must operate
- requiring the submission of financial and other returns, insurer declarations and independent reports, so that APRA can monitor the financial position of the insurer and its ability to meet policyholder claims as they fall due.

## *APRA returns*

The financial returns required by APRA are mandated by Life Reporting Standards (LRS) which prescribe the content, timing, and audit requirements for each return. The LRSs are supported by Life Reporting Guides through which APRA provides guidence on the requirements for each return. The return format is mandated in the Life Reporting Forms which are to be completed and lodged to APRA via APRA's D2A electronic lodgement system. The Returns are listed below. A summary of the Prudential Standards in effect at September 2014 is as follows:

| *Form* | *Subject* |
|---|---|
| LRF 110.1 and LRF 110.2 | Prescribed Capital Amount |
| LRF 112.0; LRF 112.1; and LRF 112.2 | Determination of Capital Base |
| LRF 112.3 | Related Party exposures |
| LRF 114.0 | Asset Risk Charge |
| LRF 114.2 | Derivatives Activity |
| LRF 114.3 | Off-balance sheet Business |
| LRF 115.0; and LRF 115.1 | Insurance Risk Charge |
| LRF 117.0 | Asset Concentration Risk Charge |
| LRF 118.0 | Operational Risk Charge |
| LRF 200.0 | Capital Adequacy Supplementary Information |
| LRF 300.1; and LRF 300.2 | Statement of Financial Position |
| LRF 310.1; and LRF 310.2 | Income Statement and Related Information |
| LRF 330.0 | Summary of Revenue and Expenses |
| LRF 340.1; and LRF 340.2 | Retained Profits |
| LRF 400.0 | Statement of Policy Liabilities |
| LRF 420.0 | Assets backing Policy Liabilities |
| LRF 430.0 | Sources of Profit |

In addition to companies' reporting and other obligations, the Life Act grants powers to APRA to monitor and investigate life insurance companies, including the power to conduct surveillance visits at insurers and to appoint a judicial manager. A judicial manager acts in a similar manner to the administrator of a financially troubled company and, in accordance with Section 175 of the Life Act, is appointed by a judge to whom he or she must report the recommended course of action for the insurer.

# Australian Securities and Investments Commission (ASIC)

ASIC is the single Commonwealth regulator responsible for market integrity and consumer protection functions across the financial system. It is responsible for:

- corporate regulation, securities and futures markets;
- market integrity and consumer protection in connection with life and general insurance and superannuation products, including the licensing of financial service providers; and
- consumer protection functions for the finance sector.

## *Australian Financial Services Licence (AFSL)*

The Corporations Act requires all sellers of insurance products to retail clients, including registered insurers and brokers, to obtain an AFSL. To obtain a licence, the applicant must meet the obligations under Section 912A and demonstrate that they will provide financial services efficiently, honestly and fairly. Insurers that are regulated by APRA are exempted from the financial obligations of an AFSL as their financial position is separately monitored by APRA through quarterly statistical reporting.

## *Ownership restrictions*

The Financial Sector (Shareholdings) Act limits shareholdings to 15 per cent of an insurer, unless otherwise approved by the Federal Treasurer. The Insurance (Acquisitions and Takeovers) Act complements this legislation by requiring government approval for offers to buy more than 15 per cent of an insurer.

# 3.3 Capital adequacy

The key elements of the prudential standards that prescribe these capital requirements are outlined below.

## Solvency Standard (LPS 100)

The Solvency standard is designed for the purposes of sections 3, 52, 62, 63 and 159 of the Life Insurance Act 1995 and is satisfied in relation to a statutory fund if the capital base of the fund exceeds 90 per cent of the fund's prescribed capital amount.

Paragraph 3 and 4 of LPS 100 indicated that this Prudential Standard applies to a life company for each of its statutory funds other than friendly society and to business of an Eligible Foreign Life Insurance Company which is carried on through its Australian Statutory funds respectively. APRA may adjust or exclude a specific requirement of LPS 100 for certain life companies.

## Capital Adequacy (LPS 110)

APRA has adopted a three pillar approach to the capital adequacy framework:

| | |
|---|---|
| **Pillar I** | Quantitative requirements for the calculation of a Prudential Capital Requirement (PCR) and the recognition of an eligible capital base to meet this requirement. |
| **Pillar II** | Adequate system of governance including an effective risk management system and prospective risk identification through the Internal Capital Adequacy Assessment Process (ICAAP). |
| **Pillar III** | A set of reporting and disclosure requirements including private reporting to APRA (ICAAP Report), management and public reporting. |

The requirements to address these pillars are set out in Prudential Standards LPS 110-LPS 118. The Capital Adequacy standard LPS 110 requires a life company to:

- have an ICAAP;
- maintain required level of capital within each of its funds and for the company as a whole;
- determine each fund's prescribed capital amount having regard to a range of risk factors that may adversely impact the company's ability to meet its obligations. These factors include insurance risk, asset risk, asset concentration risk and operational risk;
- comply with any supervisory adjustment to capital imposed by APRA;

- make certain public disclosures about the capital adequacy position;
- seek APRA's consent for certain planned capital reductions; and
- inform APRA of any significant adverse changes in the capital position.

## *Internal capital adequacy assessment process (ICAAP)*

A regulated institution must have in place an ICAAP that is adequately documented. The ICAAP documentation is made available to APRA on request and approved by the Board initially and when significant changes are made.

ICAAP must include at a minimum:

- adequate policies, procedures, systems, controls and personnel to identify, measure, monitor and manage the risks arising from the regulated institution's activities on a continuous basis, and the capital held against such risks;
- a strategy for ensuring adequate capital is maintained over time;
- actions and procedures for monitoring the regulated institution's compliance with its regulatory capital requirements and capital targets;
- stress testing and scenario analysis relating to potential risk exposures and available capital resources;
- processes for reporting on the ICAAP and its outcomes to the Board and senior management of the regulated institution;
- policies to address the capital impact of the material risks not covered by explicit regulatory capital requirements; and
- an 'ICAAP' summary statement (discussed below).

## *ICAAP Summary Statement*

This is a high level document that describes and summarises the capital assessment and management process of the life insurer. At the least, it must include the aspects of the ICAAP listed above whilst also including:

- a statement of the objectives, the time horizon and the expected level of financial soundness associated with the capital targets of the ICAAP;
- a description of the key assumptions and methodologies used;
- that identify the need to review the ICAAP arising from changes to the business operations, regulatory, economic and financial market conditions, group structure and other factors impacting the insurer's risk profile and capital resources;
- summary of the policy for reviewing the ICAAP (who is responsible for the review, frequency and scope of the review); and
- a description of the basis of measurement of capital used in the ICAAP and an explanation of the differences where this basis differs from that used for regulatory capital.

An ICAAP review must be conducted at least every three years by an appropriately qualified person who is operationally independent of the conduct of capital management.

### *ICAAP report*

The regulated institution must provide a report on the implementation of its ICAAP annually to APRA no later than three months from the date on which the report has been prepared. The ICAAP report must include:

- detailed information on current and three-year projected capital levels;
- detailed information on the actual outcomes of applying the ICAAP over the period, relative to the planned outcomes in the previous ICAAP report;
- description of the material changes to the ICAAP since the previous ICAAP report;
- detail and outcomes of stress testing and scenario analysis used in undertaking the ICAAP;
- a breakdown of capital usage over the time horizon;
- an assessment of anticipated changes in risk profile or capital management processes;
- details of any review of the ICAAP since the previous ICAAP report; and
- where relevant, references to supporting documentation and analysis.

The report submitted to APRA must be accompanied by a declaration approved by the Board and signed by the CEO stating whether or not capital management has been undertaken in accordance with the ICAAP over the period.

## Capital Adequacy: Measurement of Capital (LPS 112)

This prudential standard sets out the qualities that an instrument must have to be considered for inclusion in the capital base for each statutory fund, general fund and the life company taken as a whole.

The key requirements of LPS 112 are that a life company must:

- comply with minimum requirements regarding the size and composition of the capital base for the life company as a whole and for each of its funds;
- include in the appropriate category of capital (i.e. Common Equity Tier 1 Capital, Additional Tier 1 Capital or Tier 2 Capital) only those capital instruments that meet the detailed criteria for that category;
- all capital instruments are capable of bearing loss; and
- make certain regulatory adjustments to capital, mainly from Common Equity Tier 1 Capital, to determine the capital base.

# Capital Adequacy: Asset Risk Charge (LPS 114)

The Asset Risk Charge (ARC) under LPS 114 is the minimum amount of capital required to be held against the asset risks of the life company. The ARC relates to the risk of adverse movements in the value of the company's on and off balance sheet exposures. Asset risk can be derived from a number of sources, including market risk and credit risk. LPS 114 sets out the method of calculating the ARC by fund. The charge is one of the components of the Standard Method for calculating the prescribed capital amount for Life Company statutory funds and general funds.

# Capital Adequacy: Insurance Risk Charge (LPS 115)

The Insurance Risk Charge (IRC) is the minimum amount of capital required to be held against insurance risks of the life company. The IRC relates to the risk of adverse impacts due to movements in future mortality, morbidity, longevity, servicing expenses and lapses.

This Prudential Standard sets out the method of calculating the IRC and the charge is one of the components of the Standard Method for calculating the prescribed capital amount for Life Company statutory and general funds.

# Capital Adequacy: Asset Concentration Risk Charge (LPS 117)

The Asset Concentration Risk Charge (ACRC) is the minimum amount of capital required relating to the risk of an adverse movement in the life company's capital base arising from unfavourable movements in asset classes to which the company has a significant exposure.

This Prudential Standard sets out the method of calculating the ACRC and the charge is one of the components of the Standard Method for calculating the prescribed capital amount for Life Company statutory funds and general funds.

# Capital Adequacy: Operational Risk Charge (LPS 118)

The Operational Risk Charge (ORC) is the minimum amount of capital required to be held against operational risks of the life company. The ORC relates to the risk of loss resulting from inadequate or failed internal processes, people system or from external events.

This Prudential Standard sets out the method of calculating the ORC and the charge is one of the components of the Standard Method for calculating the prescribed capital amount for Life Company statutory funds and general funds.

3.4

# Requirements for the management of risk and reinsurance

## Risk Management (LPS 220)

LPS 220 aims to ensure that a life company maintains a risk management framework and strategy that is appropriate to the nature and scale of its operations. The key requirements of LPS 220 include:

- maintaining a risk management framework which is aligned with the life company's ICAAP that identifies, assesses, monitors, reports on and mitigates all material risks faced by the company;
- ensuring that its risk management framework is subject to effective and comprehensive review by persons independent to the operation of the company; and
- submitting to APRA an annual Risk Management Declaration approved by the board.

### *Risk management framework*

The risk management framework comprises of systems, structures, policies, processes and people within the life company that identify, assess, mitigate and monitor all internal and external sources of risk that could materially impact the operations of the life company.

Under LPS 220, the risk management framework must include:

- a Risk Management Strategy (RMS) that outlines the company's risk appetite and strategy and framework for managing risk;
- risk management policies, controls and procedures which identify, assess, monitor report on and mitigate all material financial and non-financial risks;
- a written business plan approved by the Board prior to adoption and when it is materially revised (which must be reviewed at least annually);
- clearly outlined managerial responsibilities and controls for the framework; and
- a review process to ensure the framework remains functional.

### *Update effective 1 January 2015*

APRA proposed that each APRA-regulated institution establish and maintain a risk management function headed by a designated CRO to support sound, risk-based decision-making in the institution. To heighten the importance and stature of a CRO within an institution, CPS 220 states that the CRO must:

- be independent from business lines, other revenue-generating responsibilities and the finance function;
- be explicitly excluded from also being the CEO, CFO, Appointed Actuary or the Head of Internal Audit; and
- have a direct reporting line to the CEO, and regular and unfettered access to the Board and Board Risk Committee.

APRA-regulated institutions must have adequate management information systems (MIS) for the purpose of measuring, assessing and reporting on all material risks. CPS 220 states that MIS must be able to produce regular, accurate and timely information on the institution's risk profile to support risk-based decision-making.

CPS 220 has identified key Board responsibilities to establish and maintain a sound risk management framework.

## Reinsurance (LPS 230)

This standard aims to ensure that reinsurance arrangements of a life company are subject to minimum standards of independent oversight. It addresses the regular reporting of reinsurance arrangements to APRA, and APRA's oversight of financial reinsurance contracts.

The key requirements of LPS 230 are:

- a life company must give APRA a report on its reinsurance arrangements for a financial year within 3 months after the end of each financial year; and
- a life company must not enter into reinsurance arrangements of a certain type unless approval has been granted by APRA. These are primarily contracts that contain elements of financial reinsurance. Such contracts and details surrounding the application for approval are outlined in attachment B of LPS 230.

The reinsurance report must set out the particulars of each reinsurance contract or group of reinsurance contracts in force between the company and a reinsurer during the financial year. The report must also set out the opinion of the company's appointed actuary on the adequacy, effectiveness and regulatory accounting of the company's reinsurance arrangements.

## Outsourcing (CPS 231)

This prudential standard aims to ensure that all outsourcing arrangements involving material business activities entered into by a life company are subject to appropriate due diligence, approval and on-going monitoring. The ultimate responsibility for the outsourcing policy rests with the board of directors (or equivalent).

The key requirements of CPS 231 include:

- having a policy relating to outsourcing of material business activity which is approved by the Board;
- having sufficient monitoring processes in place to manage the outsourcing of material business activities;
- having a legally binding agreement in place for all material business activities with third parties, unless otherwise agreed by APRA;
- consulting with APRA prior to entering into agreements to outsource material business activities to service providers who conduct their activities outside Australia; and
- notifying APRA after entering into agreements to outsource material business activities.

### *Offshoring*

APRA should be consulted prior to entering into offshoring agreements involving material business activities. This prior consultation is intended to provide an opportunity for APRA to review the licensee's assessment of offshoring risks, and the processes and controls introduced to mitigate them.

If, in APRA's view, the offshoring agreement involves risks that the regulated institution is not managing appropriately, APRA may require the regulated institution to make other arrangements for the outsourced activity as soon as practicable.

## Business Continuity Management (CPS 232)

This prudential standard aims to ensure that each life company implements a whole of business approach to business continuity management, appropriate to the nature and scale of its operation.

The key requirements of CPS 232 include:

- a regulated institution must identify, assess and manage potential business continuity risks to ensure that it is able to meet its financial and service obligation to its depositors, policyholders and other creditors;
- the Board of a regulated institution must consider business continuity risks and controls as part of its overall risk management systems and approve a Business Continuity Management Policy;
- a regulated institution must develop and maintain a Business Continuity Plan (BCP) that documents procedures and information which enable the regulated institution to manage business disruptions;
- a regulated institution must review the BCP annually and periodically arrange for its review by internal audit function or an external expert; and
- a regulated institution must notify APRA in the event of certain disruptions.

3.5

# Requirements for governance and assurance

## Audit and Actuarial Related Matters (LPS 310 and LPS 320)

LPS 310 sets out the roles and responsibilities of a life company's Auditor. It also sets out the obligations of a life company to make arrangements to enable its Auditor to fulfil his or her responsibilities.

The key requirements of LPS 310 include:

- a life company must make arrangements to enable its Auditor to undertake his or her role and responsibilities;
- the Auditor must audit certain returns of the life company to APRA and provide a report to the Board of the life company;
- the Auditor must review other aspects of the life company's operations on an annual basis and provide a report to the Board of the life company;
- the Auditor may also be required to undertake other functions, such as a special purpose review; and
- a life company must submit to APRA all reports required to be prepared by its Auditor under the standard.

LPS 320 sets out the requirements for the roles and responsibilities of an Appointed Actuary. The key requirements of LPS 320 include:

- the Appointed Actuary must provide an assessment of the overall financial condition of the life company and advise on the methodology and perform the calculation of the prescribed capital amount, capital base and valuation of its policy liabilities on an annual basis. In particular, the Appointed Actuary must prepare a Financial Condition Report and provide this report to the company;
- a life company must submit the Financial Condition Report to APRA;
- the Appointed Actuary may also be required to provide advice to the life company on certain life policies and reinsurance arrangements; and
- the Appointed Actuary may be required to conduct a special purpose review and provide a report to APRA and the life company.

Both LPS 310 and LPS 320 aim to ensure that the Board and the senior management of a life company are provided with impartial advice in relation to the life company's operations, financial condition and internal controls.

# Governance (CPS 510)

In this standard, APRA sets out the minimum foundations for good governance of regulated institutions (including life companies). It aims to ensure that regulated institutions are managed in a sound and prudent manner by a competent Board of directors (or equivalent), which is capable of making reasonable and impartial business judgements in the best interests of the regulated institution and which gives due consideration to the impact of its decisions on policyholders.

The key requirements of this standard include:

- meeting specific requirements with respect to Board size and composition;
- requiring the chairperson of the Board to be an independent director;
- requiring that a Board Audit Committee be established;
- requiring that a Board Remuneration Committee must be established with a Remuneration Policy that aligns remuneration and risk management; and
- requiring the Board to have a policy on Board renewal and procedures for assessing Board performance.

## *Update effective 1 January 2015*

APRA indicated that an independent Risk Committee of the Board is essential to provide the Board with greater oversight of, and advice on, the risk management framework. Accordingly, APRA proposed new requirements in CPS 510 for the establishment of such a committee to strengthen its requirements in this area. The committee would be responsible for advising the Board on the risk management framework, providing the Board with objective non-executive oversight of implementation of the framework, and ensuring that senior management are appropriately implementing the Board's strategy for managing risk.

APRA proposed that the committee be composed of non-executive directors, chaired by an independent director who is not the chair of the Board, and provide its endorsement prior to the appointment and removal of the CRO. The proposed composition requirements in CPS 510 did not preclude the committee having the same composition as the BAC. APRA noted that many APRA-regulated institutions already have a committee in place.

# Fit and Proper (CPS 520)

This standard sets out minimum requirements for the regulated institutions (including life companies) in determining the fitness and propriety of individuals to hold positions of responsibility. The ultimate responsibility for ensuring the fitness and propriety of the responsible persons of an APRA-regulated institution rests with the Board of directors (or equivalent).

The key requirements of this standard are that:

- a regulated institution must have and implement a written Fit and Proper Policy that meets the requirements of the Prudential Standard;
- the fitness and propriety of a responsible person must generally be assessed prior to initial appointment and then re-assessment annually (or as close to annually as practicable);
- a regulated institution must take all prudent steps to ensure that a person is not appointed to, or does not continue to hold, a responsible person position for which they are not fit and proper;
- additional requirements must be met for the Appointed Auditor and the Appointed and Reviewing Actuaries; and
- certain information must be provided to APRA regarding responsible persons and the regulated institution's assessment of their fitness and propriety.

# 3.6 Other life insurance prudential requirements

## *Valuation of Policy Liabilities (LPS 340)*

This standard stipulates the basis on which contracts written by life companies are to be classified as either life investment contracts or life insurance contacts for the purpose of regulatory reporting to APRA. This classification of a policy under this Prudential Standard may differ from its classification under Accounting Standard AASB 1038 Life Insurance Contacts.

Further, this standard prescribes a set of principles and associated actuarial methodology for the valuation of policy liabilities for both life insurance and investment contracts. The valuation of policy liabilities for life insurance and investment contracts are presented to generally comply with the requirements of the relevant accounting standards.

## *Termination Values, Minimum Surrender Values and Paid-up Values (LPS 360)*

This standard prescribes a set of principles and an actuarial methodology for the calculation of termination values of policies which are used in determining capital base of a life company and its statutory funds (refer to Attachment H of Prudential Standard LPS 112 Capital Adequacy: Measurement of Capital). Also, this standard specifies the minimum surrender values and paid-up values when policy owner's request no further premiums to be paid. The objective of this prudential standard is to protect the interests of surrendering policy owners when terminating life insurance policies and to protect the interests of remaining policy owners.

## *Cost of Investment Performance Guarantees (LPS 370)*

This standard prescribes the principles and methodology for calculating the cost of investment performance guarantees where they are provided in association with investment-linked contracts. As prescribed in the Life Act, the cost of investment performance guarantees must not exceed 5 per cent of the policy liabilities of the fund in which the business is written.

## *Statutory Funds and Friendly Society Benefit Funds (LPS 600 and LPS 700)*

These standards aim to ensure that the operations of statutory and benefit funds are restructured to be fair and equitable for policy owners and members.

The requirements outlined in LPS 600 include the operations of statutory funds and the restructure of statutory funds. LPS 700 broadly covers the rules and operation of benefit funds and the restructure and termination of benefit funds.

# 3.7 Life insurance accounting

Life insurers in Australia are required to be incorporated and as corporate, are required to comply with Australian Accounting Standards issued by the Australian Accounting Standards Board (AASB). The following table outlines the key current accounting standards specifically impacting life insurers:

| *Accounting Standard* | *Application* |
|---|---|
| AASB 4 *Insurance Contracts*<br><br>AASB 1038 *Life Insurance Contracts* | Prescribes the accounting methods to be used for reporting on:<br>• life insurance contracts;<br>• certain aspects of life investment contracts;<br>• assets backing life insurance liabilities and life investment contract liabilities; and<br>• disclosures about life insurance contracts and certain aspects of life investment contracts. |
| AASB 7 *Financial Instruments: Disclosures* | Applies to the financial instrument component of life investment contracts. |
| AASB 9 *Financial Instruments*<br><br>AASB 132 *Financial Instruments: Presentation*<br><br>AASB 139 *Financial Instruments: Recognition and Measurement* | Prescribes the accounting methods to be used in recognising, measuring, presenting and disclosing financial assets and financial liabilities. |

## Definitions and key principles

### *Life insurance contract*

An insurance contract is defined 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.

Under AASB 1038, a life insurance contract is an insurance contract or a financial instrument with a discretionary participation feature regulated under the *Life Insurance Act 1995* (Life Act), and similar contracts issued by entities operating outside Australia.

Key principles of accounting for life insurance contracts:

| *Principle* | *Requirement* |
|---|---|
| Basis for valuing policy liabilities | Policy liabilities are calculated as the present value of the best estimate of expected future net cash flows, plus future profit margins. |
| Basis for valuing investments backing life insurance contract liabilities | Investments are valued at fair value through profit or loss where permitted. |
| Deferral of acquisition costs (DACs) | All acquisition costs are deferred and amortised over the period of expected benefit. DACs are to be deducted from policy liabilities. |

### *Life investment contracts*

A life investment contract is a contract which is regulated under the Life Act but which does not meet the above definition of a life insurance contract.

Key principles of accounting for life investment contracts:

| *Principle* | *Requirement* |
|---|---|
| Basis for valuing policy liabilities | Valued at fair value in accordance with AASB 139. In practice, this will likely be on an accumulation basis, but may be adjusted to take account of demand deposit features. |
| Basis for valuing investments backing life investment contract liabilities | Investments are valued at fair value through profit or loss where permitted. |
| Deferral of acquisition costs (DACs) | Only those costs which are incremental and directly attributable to securing the life investment contract can be deferred. DACs are recognised as a separate asset and are tested for impairment at each balance date. |

## AASB 1038 applications

AASB 1038 *Life Insurance Contracts* prescribes the accounting treatment for life insurance contracts. It also mandates the use of certain options available in other accounting standards. AASB 1038 applies to life insurance companies and friendly societies that issue life insurance contracts (life insurers).

The key applications of AASB 1038 to life insurance financial reporting are summarised in the following paragraphs.

## *Profit recognition – Life insurance contracts*

Planned profit margins and life insurance contract liabilities (referred to as policy liabilities) are calculated separately for each 'related product group' using best estimate assumptions at each reporting date. Profit margins are released over the financial year during which services are provided and revenues relating to those services are received. The balance of the planned profits is deferred by including the amount in the value of policy liabilities.

AASB 1038 requires the use of the prospective method (projection basis) to value policy liabilities (including planned profit margins and other components) at each reporting date unless, using the retrospective method (accumulation basis), the results are not materially different. To ensure planned margins are recognised during the financial year in which the relevant services are provided, policy liabilities include a component relating to those margins.

This methodology, which is commonly known as the 'margin-on-services' method, results in reported shareholders' profits comprising:

- the release of planned profit margins on policies in force at the beginning of the year;
- the release of planned profit margins on new business written during the year;
- the impact of differences between assumed and actual experience during the year including mortality, disability, expenses, lapses, inflation, taxation, reinsurance and investment returns;
- loss recognition (or reversal of past recognised losses) as appropriate; and
- investment earnings on shareholders' capital and retained profits. Changes in the assumptions underlying the policy liabilities are spread over future years during which the services to policyholders are rendered, except those for related products groups on which future losses are expected. A record of cumulative losses is kept for each related product group and profit margins are maintained at zero until cumulative losses are fully reversed. The effect of a change to assumed discount rates caused by changes in investment market conditions or where calculation errors occur results in a revenue or expense being recognised in the current financial year.

The income statement includes all premium and policy-related revenue, investment revenues, fair value gains and losses, all claims (including surrenders), and all expenses and taxes, whether they relate to policyholders or shareholders. The change in the value of policy liabilities (including the change of unvested policyholder benefits and discretionary additions/bonuses vested in policyholders during the financial year) is shown as an expense before arriving at the shareholder profit.

Profits or losses may emerge on acquisition depending on whether establishment fees are more or less than the related expenses. Losses may also emerge if expected future income is not considered adequate to cover acquisition expenses.

## *Valuation of life insurance policy liabilities*

Under AASB 1038 the best estimate liability is calculated as the present value of expected future benefit payments, plus expenses, less future receipts. The following factors are generally considered to be material to the calculations:

- discount and inflation rates;
- profit carriers;
- inflation;
- taxation;
- expenses;
- mortality and morbidity; and
- policy discontinuance.

The best estimate liability will normally be determined using projection methods, and the value of future profits calculated as the present value of future profit margins.

A profit margin is determined using a profit carrier, which is a financially measurable indicator of either the expected cost of the services provided to the policyholder or the expected income relating to the services.

Profit carriers are selected and profit margins determined at policy commencement to enable an appropriate emergence of profit over the term of the benefits or services provided. The selection of a profit carrier is critical in determining the timing of profits released. More than one profit carrier may be selected for a product, although the practical implications of selecting multiple carriers should be considered relative to the materiality of the results. Typical profit carriers are identified below:

| *Product* | *Typical profit carrier* |
|---|---|
| Yearly renewable term | Premiums or claims |
| Level premium term | Claims |
| Group life | Premiums or claims |
| Disability income | Claims |
| Immediate annuities | Annuity payments |
| Traditional non-participating | Death claims |
| Traditional participating | Value of bonuses |

## *Revenue recognition – Life investment contracts*

Revenue from investment contracts arises either from explicit fees charged to investment contract holders or from the earning of the management services element (MSE) inherent in the valuation of the investment contract liability.

Explicit fees are measured as the fair value of the consideration received or receivable and are earned in the income statement as the services are provided to the contract holder. This would normally be on a straight line basis over the life of the investment contract but other earning patterns may be more appropriate if they better reflect the provision of services.

An MSE arises when the sum of consideration received or receivable exceeds the fair value of the investment contract liability upon initial recognition. This deferred revenue is recognised as a liability on the balance sheet and earned as the management services are provided, as per the explicit fees above.

Incremental costs that are directly attributable to the acquisition of an investment contract are deferred and recognised as an asset if they can be identified separately, measured reliably, and if it is probable that they will be recovered.

An incremental cost is one that would not have been incurred if the life insurer had not acquired the life investment contract. The asset represents the insurer's contractual right to benefit from providing ongoing services, and is amortised as the insurer recognises the related revenue.

## *Valuation of investment contract liabilities*

Investment contract liabilities are valued at fair value in accordance with AASB 139. As there is generally no active market for investment contract liabilities, these should be valued using an appropriate valuation technique which would normally involve a discounted future cash flow analysis.

For investment contracts with a demand feature, or surrender value, AASB 139 stipulates that the fair value of the liability cannot be less than the current surrender value.

## *Accounting for investments*

AASB 1038 requires life insurers to measure all assets backing life insurance and life investment contracts at fair value through profit or loss as at the reporting date where this option is available. Changes in the fair value must be recognised in the income statement as either income or expense in the financial year in which the changes occur. Where there are choices available in other standards for the measurement of assets, AASB 1038 requires the following to be applied to those assets determined as backing life insurance and life investment contracts.

| *Type of asset* | *Measurement basis* |
|---|---|
| Financial assets | Fair value through profit or loss in accordance with≈AASB 139. |
| Investment property | Fair value using the fair value model under AASB 140 *Investment Property*. |
| Property, plant and equipment (including owner- occupied property) | Revaluation model under AASB 116 *Property, Plant and Equipment*, being fair value less any subsequent accumulated depreciation and subsequent accumulated impairment losses (revaluation movements through equity). |

## *Statutory funds*

AASB 1038 requires life insurers to recognise in its financial report all of the assets, liabilities, and expenses of each statutory fund. It recognises that the interests of policyholders and shareholders are intertwined and form the basis of a single entity. Where a parent entity controls a life insurance subsidiary, the parent in turn controls the assets and liabilities of the statutory funds and the policyholders' interests.

Benefit funds of friendly societies are treated in the same way as life insurance company statutory funds.

## *Acquired life insurance contracts*

When purchasing a life insurance company or a portfolio of life insurance contracts, a life insurer must value the insurance assets and insurance liabilities assumed at fair value. They are permitted, but not required, to split the fair value into two components:

(i) A liability measured in accordance with the insurer's accounting policies for life insurance contracts; and

(ii) An intangible asset, representing the difference between the fair value of the insurance contracts acquired and the liability recognised in (i).

The intangible asset is exempt from the recognition and measurement requirements of both AASB 138 Intangible Assets and AASB 136 Impairment of Assets. It is not exempt from the disclosure requirements. The subsequent measurement has to be consistent with the measurement of the related liability, i.e. it will be amortised over the life of the liabilities, consistent with the profit recognition on those contracts.

## *Disclosure requirements*

AASB 1038 requires specific life insurance contract disclosures. The key requirements are summarised below.

1. A life insurance company is required to disclose "information that identifies and explains the amounts in its financial report arising from life insurance contracts", including:
   - accounting policies for life insurance contracts and related assets, liabilities income and expenses;
   - assets, liabilities income, expense and cash flows arising from life insurance contracts;
   - the process used to determine the assumptions that have the greatest effect on life insurance balances, including, where practicable, quantified disclosure of those assumptions;
   - the effect of changes in assumptions used to measure life insurance assets and life insurance liabilities, showing separately the effect of each change that has a material effect on the financial report; and
   - reconciliations of changes in life insurance liabilities and reinsurance assets.
2. A life insurer must disclose the process they have adopted to determine which assets back their life insurance or life investment contract liabilities.
3. The following split of expenses must be disclosed by life insurers:
   - outwards reinsurance expense;
   - operating expenses;
   - claims expense;
   - policy acquisition expenses, separated into material components including commission;
   - policy maintenance expenses; and
   - investment management expenses. the basis for the apportionment of operating expenses must also be disclosed between:
   - insurance contract acquisition;
   - life insurance contract maintenance;
   - investment management expenses;
   - life investment contract acquisition;
   - life investment contract maintenance; and
   - other expenses.

4. The following disclosures should be made in respect of amount, timing and uncertainty of cash flows from life insurance contracts:
    - objectives in managing risk and policies for mitigating risk;
    - contract terms and conditions which have a material effect on the amount, timing and uncertainty of cash flows; and
    - information about insurance risk (before and after risk mitigation by reinsurance), including:
        a. the sensitivity of profit and equity to changes in variables (for material effects);
        b. insurance risk concentration;
        c. interest rate risk and credit risk disclosures, detailing:
            (i) exposure to interest rate risk by class of asset and liability, including details of contractual repricing or maturity dates and effective interest rates, where applicable; and
            (ii) exposure to credit risk for each class of financial asset or other credit exposure, including the maximum credit risk exposure and significant concentrations of insurance risk.

# Annual and quarterly reporting

In general, a public company must file its annual shareholder accounts (financial statements) with ASIC within four months of year-end (within three months for disclosing entities or registered schemes). Small proprietary companies are normally exempted. The financial statements prepared under the *Corporations Act 2001* must be independently audited by an Australian registered auditor.

Life insurance companies and friendly societies are required to submit quarterly returns (LRF 110.1 – LRF 340.2) and annual returns (LRF 110.1 – LRF 430) to APRA under the *Financial Sector (Collection of Data) Act 2001*. The returns should be submitted using the online 'Direct to APRA' (D2A) software, or on paper where this is not possible. The quarterly returns are due 20 business days after the end of the reporting period. The annual returns are due four months after year-end.

The reporting requirements for the returns are broadly consistent with the requirements for financial statements under the accounting standards issued by AASB. Areas of potential difference are outlined in LPS 340 Valuation of Policy Liabilities for the Purpose of Regulatory Reporting to APRA, and relate to discretionary participation features and participating benefits, and the unbundling of contracts into insurance, investment and service components.

In addition, a life insurer which holds an AFSL is required to submit the forms FS 70 (completed by the insurer) and FS 71 (completed by the appointed auditor) annually to ASIC.

# Other reports due to APRA

(i) Annual Reporting by Appointed Auditor

The annual returns must be submitted in conjunction with the annual auditor's report, as required under Prudential Standard LPS 310 Audit and Related Matters.

The Appointed Auditor provides an audit opinion (reasonable assurance) over annual returns LRF 110 to LRF 340.2. In addition, the Appointed Auditor provides a separate review report (limited assurance) over prudential compliance and systems, processes and controls relating to APRA financial reporting during the year.

(ii) Financial Condition Report

LPS 320 requires life companies and friendly societies to give to APRA a copy of a financial condition report prepared by the appointed actuary within 3 months of the end of the reporting period.

(iii) Reinsurance Report

LPS 230 Reinsurance requires each life company to give APRA a reinsurance report within 3 months of the end of the reporting period.

(iv) Risk Management Declaration

LPS 220 Risk Management requires the Board to provide APRA with a Risk Management Declaration relating to each financial year of the life company. The Risk Management Declaration must be signed by two directors and submitted to APRA on, or before, the due date of the annual returns.

# 3.8 Life insurance taxation

## Taxation of life insurers

The rules governing how life companies are taxed are contained in Division 320 of the Income Tax Assessment Act 1997. Broadly, these rules seek to tax most underwriting profits and fee income at the normal corporate rate, whereas investment income is taxed at varying rates, zero percent for income from assets backing pension portfolio amounts, 15 per cent for assets backing superannuation amounts in accumulation phase and 30 per cent for other investment income.

### *Classes of income*

The income of a life insurance company is effectively divided into three classes: the Ordinary Class, the Complying Superannuation Class or First Home Saver Account (FHSA) Class (both being taxable) and a Segregated Exempt Assets (SEA) Class. The complying superannuation/FHSA class, formerly known as the Virtual Pooled Superannuation Trust (VPST) class, is established for the company's complying superannuation policies.

Life insurance companies must establish a segregated asset pool for their immediate annuity policy liabilities, which is the SEA Class. All other classes of policies and any shareholder capital will form part of the Ordinary Class.

The classification of income and gains among the various classes of income (assessable and exempt) is not determined by reference to statutory funds and the mix of policy liabilities (in the case of mixed statutory funds). Rather, the life insurance company must segregate its assets by allocating these as supporting certain (tax) classes of policies it has issued.

Life insurance companies pay tax on income derived in the Ordinary Class at the rate of 30 per cent and are taxed at a rate of 15 per cent on income derived from complying superannuation/FHSA assets. Any income derived from the SEA Class is exempt from tax.

A life insurance company remains a single entity for taxation purposes. However, the effect of the rules outlined above is that for taxation purposes, the company is effectively divided into three pools, with each segment representing a particular class of business.

A life insurance company can also form part of a tax consolidated group, in which case the head company will be deemed to be a life insurance company.

### *Assessable income*

The assessable income of a life insurer includes fee income and underwriting profits of a life insurer as well as its investment income and realised gains on the disposal of assets.

Assessable income also specifically includes life insurance premiums received and receivable by the company, reinsurance amounts received, refunds of reinsurance paid under a contract of reinsurance and amounts received under a profit-sharing arrangement under a contract of reinsurance.

Amounts representing a decrease in the value of the net risk components of risk policy liabilities and taxable contributions transferred from complying super funds or approved deposit funds (ADFs) are also included in assessable income.

Specified rollover amounts, fees and charges imposed in respect of life insurance policies but not otherwise included in assessable income and taxable contributions made to retirement savings accounts provided by that company also form part of the life company's assessable income.

Furthermore, most transfers of assets from one class to another will have a tax consequence. It is therefore necessary to carefully review and record each transfer to ensure its appropriate tax treatment.

## *Disposal of investments*

Whether a profit or gain realised on the disposal or transfer of an investment is liable to tax (and the rate of tax) depends on the class of income to which it relates.

Gains and losses realised on certain complying superannuation/FHSA assets are determined by reference to the general capital gains tax provisions (which is consistent with the treatment of disposals of investments by superannuation funds).

The legislation also provides that a 'deemed disposal' will arise where there is a transfer between the asset pools of an asset other than money. For tax purposes, an assessable gain may arise for the 'transferor' asset pool.

A different rule, being a deferral mechanism, applies where an asset transfer results in a loss for tax purposes.

Similar to the tax treatment for general insurers, investments in the Ordinary Class are usually held on revenue rather than on capital account. Accordingly, profits on the disposal of such investments would be included in assessable income as ordinary income. However, this treatment may be modified under the Taxation of Financial Arrangements (TOFA) rules depending on which TOFA elections are made by the tax-payer.

Profits and losses on the disposal of investments held in the SEA Class are not taxable or deductible.

Each year, a life company is required to carry out a valuation of its complying superannuation/FHSA liabilities and SEA liabilities. Where the valuation of the corresponding asset pool exceeds the respective value of these liabilities (plus a reasonable provision for tax), the company must transfer the excess out of that asset pool. Where the valuation indicates a shortfall, the company may transfer assets into the pool. Such transfers will have the taxation consequences outlined above.

## *Management fee income*

Where a life insurance company imposes fees and charges on policies included in the asset pools representing the complying superannuation/FHSA and SEA classes, it is required to transfer an amount equal to those fees and charges out of these pools. This will give rise to an assessable amount in the Ordinary Class, as well as a deduction in the complying superannuation/FHSA Class, but no deduction in the SEA Class.

This requirement ensures that any fees and charges imposed by the life insurance company are taxed at the prevailing corporate tax rate.

## *Investment income*

A life insurer is required to separately calculate the investment income from each of its asset pools. This means adequate accounting records must be maintained to separately identify each of these pools, which will differ from the normal statutory fund basis of asset allocation.

## *Allowable deductions*

The current tax provisions are based on the principle that a deduction is allowed for expenses of a revenue nature to the extent they are incurred in gaining or producing assessable income.

A life insurance company is allowed certain specific deductions. These include certain components of life insurance premiums (see below), the risk component of claims paid under life insurance policies, the increase in the value of risk policy liabilities, certain reinsurance premiums and amounts transferred to the SEA Class.

Premiums are fully deductible if they are transferred to the SEA Class, or if they are for policies providing participating or discretionary benefits. Part of the premium may be deductible if they are transferred to the complying superannuation/FHSA Class.

The deductible component of premiums in respect of ordinary non-participating investment policies would normally be determined by an actuary.

In relation to risk-only policies, such as term insurance policies, deductions will be allowed for the increase in the value of those policy liabilities over the financial year (conversely, decreases will be assessable). An actuary would generally assist in calculating these assessable and deductible amounts.

## *Allocation and utilisation of losses*

A life insurance company remains a single entity for tax purposes but in effect will be divided into three separate taxpayers, each representing a separate class of business. The idea of notional separate taxpayers for each class of business limits the way in which tax losses and capital losses can be used by a life company.

Capital losses from complying superannuation/FHSA assets can be applied only to reduce capital gains from complying superannuation/FHSA assets or carried forward to be used in a later year against capital gains derived in the complying superannuation/FHSA Class. Similarly, capital losses from Ordinary Class assets can be applied only to reduce capital gains from Ordinary Class assets or carried forward to be used in a later year against future capital gains generated by that class.

Ordinary Class revenue losses can only be applied against Ordinary Class assessable income. Similarly, complying superannuation/FHSA revenue losses can only be applied against complying superannuation/FHSA assessable income.

No assessable gains or deductible losses (including capital gains and losses) will arise from the SEA pool.

Certain types of income, including SEA income and income from the disposal of units in a pooled superannuation trust, are classified as 'non-assessable non-exempt income'. As a result, tax losses incurred by a life insurance company will not be wasted against these non-assessable non-exempt income amounts before being offset against assessable income.

## *Imputation credits*

A life insurance company is entitled to franking credits in its franking account for the payment of tax on income and/or the receipt of franked dividends attributable to Ordinary Class business. This means that no franking credits are recorded in a life insurance company's franking account for tax paid on income from assets held in the complying superannuation/FHSA Class and SEA Class or franked dividends received from assets held in those classes. In this way, the imputation rules for life insurers are consistent with other non- life corporate taxpayers.

A life insurance company is generally entitled to a tax offset for imputation credits attached to dividends received from assets held in the Ordinary Class and complying superannuation/FHSA Class. Excess imputation credits are refundable to the complying superannuation/FHSA Class. As the SEA Class does not generate taxable income, any imputation credits generated by the assets in this class are also refundable.

There are special rules for life insurance companies which enable the offset of a franking deficit tax liability against the income tax liability attributable to shareholders business in the Ordinary Class. These rules complement the normal franking deficit provisions which apply to all companies.

## *Reinsurance with non-residents*

Where a life insurance company reinsures all or part of any risk associated with disability policies with a non-resident, a deduction will not be allowed in respect of those premiums and an amount will not be assessable in respect of any recoveries.

However, a life insurance company may elect that this principle does not apply in determining its taxable income, in which case the insurer becomes liable to furnish returns and to pay tax at the relevant rate (30 per cent) on 10 per cent of the gross premiums paid or credited to these non-resident reinsurers during the year. Where the election has been made, the company's net risk liabilities do not include the risk component which is reinsured with the non-resident reinsurer.

## Goods and Services Tax

Under the Australian GST legislation, some classes of insurance are treated differently, leading to different implications for insurers and insured parties.

The provision of life insurance is usually an 'input taxed' supply (known as 'exempt supplies' in other jurisdictions), as the supply of an interest in certain life insurance businesses is defined to be a 'financial supply' which, in turn, is input taxed for GST purposes. As a result, while life insurers are not required to account for GST on premium income derived from life insurance businesses, they are usually denied full input tax credits on the expenses incurred in making supplies of life insurance.

However, life insurers may be entitled to recover a reduced input tax credit on certain specified expenses. These are known as 'reduced credit acquisitions' and are specifically listed in the GST Regulations. The rate of reduced input tax credits (RITC) is generally set at 75 per cent of the GST included in the price of particular expenses, however, from 1 July 2012 the rules in the GST Regulations have been amended and now provide for either a 55 per cent or 75 per cent RITC where the expense is incurred by a Registered Trust Scheme (RTS) that meets certain requirements.

It should be noted that the GST classification of life insurance will be different if the supply is made in relation to a risk located outside of Australia, in which case the supply of these policies may be GST-free. Such a scenario will also result in a need to closely examine the expenses related to the life insurance operation to determine the extent to which input tax credits are available. It is common for life insurance entities to develop and apply a GST apportionment methodology in order to calculate their entitlement to input tax credits in respect of the GST incurred. Recently, the ATO has increased its focus on the appropriateness of GST apportionment methodologies in life insurance businesses as well as the robustness of the application of the relevant methodology to expenses incurred.

It is important to note that the meaning of life insurance from a GST perspective is linked to certain provisions of the Life Insurance Act 1995. The GST regulations also stipulate that a supply that is incidental to another financial supply will itself be input taxed, subject to certain criteria being met. Certain products can be declared by APRA to be life insurance, and others will qualify as life insurance due to being related businesses (e.g. certain disability insurance).

In summary, the consequence of input taxed classification is that input tax credits are generally not available for expenditure incurred in connection with making input taxed supplies of life insurance. This means that life insurance companies will not be entitled to recover all the GST included in the price paid for acquisitions of goods and services from suppliers, which has a consequential direct impact on their net costs and profitability. However, the GST law also contains provisions which allow financial supply providers to claim reduced input tax credits on certain acquisitions.

## *Investment activities*

Investment activities for a life insurer are likely to be input taxed in many cases where they are classified as financial supplies for GST purposes.

The effect of this is that, while GST will not be payable on the supplies made, not all of the GST incurred on expenses associated with investment activities will be recoverable unless one of the following exceptions applies:

- the expense relates directly to the purchase or sale of securities or other investments in an overseas market;
- the expenses incurred by the insurer for the purpose of making input taxed financial supplies do not exceed the 'financial acquisitions threshold' (which is a 'de minimus' test to ensure that entities that do not usually make financial supplies are not denied input tax credits on making financial supplies that are not a significant part of their principal activities); and
- the financial supply is a borrowing and the borrowing relates to supplies which are not input taxed.

Where the above exceptions apply, the insurer is entitled to fully recover the GST incurred on related costs. However, where the exceptions do not apply, the insurer will be unable to claim input tax credits in relation to its costs and may need to consider:

- developing an appropriate apportionment methodology to determine the extent to which it is entitled to recover GST incurred on some of its indirect costs; and
- whether some of its acquisitions made qualify as 'reduced credit acquisitions' under the GST law and if so, whether the insurer is entitled to claim a reduced input tax credit equal to 75 per cent or 55 per cent (depending on the type of expense) of the GST included in the price of the expense.

# Stamp duty

## *Life Insurance*

Stamp duty on life insurance (other than term life) is generally calculated on the sum insured. The rates of duty vary in each state and territory.

## *Temporary or Term Life Insurance*

Generally, temporary or term life insurance is subject to duty at the rate of 5 per cent of the first year's premium.

Western Australia no longer imposes stamp duty on life insurance policies entered into after 1 July 2004. Policies entered into prior to this date continue to be subject to life insurance duty at the same rate as New South Wales, Queensland, Tasmania, Australian Capital Territory and Northern Territory. However, life insurance riders which are categorised as a separate policy of general insurance will continue to be subject to duty at general insurance rates in Western Australia.

## *Life Insurance Riders*

A life insurance rider is dutiable in all states and territories. In New South Wales and the Australian Capital Territory, the amount of duty payable on a life insurance rider is 5 per cent of the first year's premium paid for the life insurance rider. In Queensland, a life insurance rider is treated as Class 2 general insurance and duty at the rate of 9 per cent of the premium to the extent that the premium paid for the rider is payable.

In Victoria, Western Australia, Tasmania and the Northern Territory, a life insurance rider will be subject to the applicable life insurance rate unless the rider is characterised as a separate policy of general insurance, in which case duty is payable at the general insurance rate applying in the relevant jurisdiction.

As at April 2014, Victoria, Western Australia, Tasmania and the Northern Territory impose duty at the rate of 10 per cent of the premium paid for the life insurance rider.

Some states have adopted the view that life insurance riders should be characterised as general insurance. The South Australian Court of Appeal handed down its decision in *National Mutual Life Association & Ors v Commissioner of State Taxation* [2011] SASCFC 106 and found that the higher general insurance rate of stamp duty is payable on premiums relating to life insurance riders, and not the lower life insurance rate of duty in South Australia.

The relevant South Australian insurance duty provisions were amended to support the Commissioner's position that any premiums relating to life insurance riders are payable at the higher general insurance rate of duty of 11 per cent.

However, the correct interpretation of policies and riders will depend on the terms of the specific insurance contracts. Some states have issued revenue rulings dealing with life insurance riders. These rulings should be considered when determining the current rate of duty payable on life insurance rider

# 4 Insurance Intermediaries

# *Introduction*
## Roy Clark

*Insurance intermediaries are a key component of the insurance value chain and play an important role in the purchase of insurance and risk products for both the policyholder and the insurer. Intermediaries comprise brokers, managing agents, independent advisers, aggregator platforms, and a variety of other forms of agencies. The nature of intermediaries ranges from being fully independent to being a subsidiary of an insurer.*

*Growing consumer self sufficiency and use of digital technologies by insurers to explore ways of building customer loyalty are trends which are forcing a rapid pace of change in the intermediary market. Intermediaries are increasingly having to look for ways to not just distribute insurance products but also grow customer loyalty themselves through adding valuable insights as part of their service delivery At the same time, services need to be provided at a lower cost, These factors have been driving change in the composition of the intermediary market place, with two examples being the consolidation of broking businesses to achieve scale and reach, for example under locally listed entities such as Steadfast and Austbrokers, and the emergence of product aggregator platforms to target consumer self-sufficiency, such as iSelect and comparethemarket.com.au.*

*Whereas the changes in technology and consumer behaviour could be seen as disintermediating the purchase of insurance, the trends are more to forcing intermediaries and insurers to reconsider where their core skillsets are and where they want to play across the insurance value chain. All the while in the recognition that as the paradigm shifts from insurance being sold to being bought by customers, future success will be how to be as close and relevant to the existing and prospective customer as possible. In this context, intermediaries with their existing customer focused skillsets and who can provide efficient, valuable and easy access to insurance and other risk mitigation services, stand to be successful in a changing business environment.*

**Roy Clark**
*Partner*

4.1

# Regulation and supervision

## Australian Securities and Investment Commission (ASIC)

In Australia, insurance intermediaries that sell insurance products (referred to in this chapter as intermediaries)are required to be licensed by the Australian Securities and Investment Commission (ASIC). ASIC administers a number of laws relevant to intermediaries including the Corporations Act 2001; the Financial Services Reform Act 2001; the Insurance Contracts Act 1984 and the Superannuation (Resolution of Complaints) Act 1993. The Brokers and Agents Administration System (BAS) and Life Unclaimed Monies System are also administered by ASIC.

## Australian Financial Services Licence (AFSL)

The Corporations Act 2001 requires intermediaries to either hold an Australian Financial Services Licence (AFSL) or become an authorised representative of a separate licensee. To obtain a licence, the applicant must meet the obligations under Section 912A and demonstrate that they will provide financial services efficiently, honestly and fairly. The general obligations relate to the insurance intermediaries' responsibilities in the areas of compliance, internal systems, people and resources.

Specific provisions under the Corporations Act require that financial services licensees have in place the following:

- arrangements for managing conflicts of interest;
- a framework to ensure compliance with conditions on the licence and with financial services laws including the prescribed conditions under regulation 7.6.04 of the Corporation Regulations 2001 (Corporations Regulations);
- adequate resources (financial, technological and human) to provide services covered by the licence and to carry out supervisory arrangements;
- adequate risk management systems;
- existence of internal and external dispute resolution procedures (where dealing with retail clients); and
- arrangements to ensure that the competencies of representatives to provide the financial services (as specified on the licence) are maintained and that the representatives are adequately trained to provide those financial services.

Holders of an AFSL are subject to ongoing financial requirements which are described in ASIC's Regulatory Guide 166 – Licensing: Financial Requirements. These requirements include:

- positive net assets and solvency;
- sufficient cash resources to cover next three months' expenses with adequate cover for contingencies;
- surplus liquid funds requirement for licensees that hold client money or property; and
- adjusted surplus liquid funds for licensees that transact with client as principal

Licence holders are required to meet ongoing notification obligations, which include requirements to notify ASIC about:

- breaches and events;
- changes in particulars (form F205 for change of name of corporate entities, form FS20 for all others);
- authorised representatives (forms FS30, FS31, FS32);
- financial statements and audit (forms FS70 and FS71); and
- appointment/removal of auditor (forms FS06, FS07, FS08 and FS09).

Section 989B of the Corporations Act also outlines ongoing financial reporting and audit obligations. A licensee is required to prepare and lodge an audited profit and loss statement and a balance sheet within four months of the end of its financial year for non-disclosing entities and within three months of the end of its financial year for disclosing entities. ASIC has released Class Order 06/68 which grants relief to local branches of foreign licensees from preparing and lodging accounts in accordance with Section 989B of the Corporations Act. This relief is only available where the foreign licensee lodges accounts, prepared and audited in accordance with the requirements of its local financial reporting jurisdiction with ASIC once every calendar year.

In addition to annual financial reporting requirements, under Section 912E of the Corporations Act, ASIC can undertake surveillance checks of AFS licence holders. ASIC has the power to vary licence conditions, as well as issue banning orders that prohibit a person from providing financial services.

## *Other regulations and related matters affecting Insurance Brokers*

Under the Corporations Act 2001, insurance intermediaries are prohibited from dealing in general insurance products unless they are from an authorised insurer, a Lloyd's underwriter or if an exemption is applied. Under these regulations, intermediaries are required to maintain records of business placed with direct offshore foreign insurers (DOFIs) and report their dealings on a regular basis to ASIC.

Intermediaries are subject to the Anti-Money Laundering and Counter-Terrorism Financing Act (AML/CTF Act). Under the AML/CTF Act, the impact on insurance brokers (if providing a 'designated service'), is meeting their statutory obligations in relation to customer identification and verification, record keeping, establishing and maintaining an AMLC/CTF program, customer due diligence and compliance reporting requirements. Insurance brokers are also subject to codes of practice including the Life Insurance Code of Practice and the General Insurance Code of Practice which set standards and responsibilities. The Insurance Brokers Dispute Facility, overseen by the Insurance Brokers Compliance Council, is a national scheme designed to quickly resolve disputes between insurance brokers and their clients. The facility handles general insurance matters up to $10,000 and life insurance matters up to $50,000.

4.2

# Solvency and capital adequacy

The minimum solvency requirements under the AFSL regime are:

- positive net assets;
- sufficient cash resources to meet the anticipated cash outflows under one of the five options set out in RG 166 and the AFS license;
- surplus liquid funds of greater than $50,000 where the licensee holds client money or property valued at $100,000 or more; and
- adjusted surplus liquid funds (ASLF) for licensee that transacts with clients as principal at least the sum of:
  a) $50,000; plus
  b) 5 per cent of adjusted liabilities between $1 million and $100 million; plus
  c) 0.5 per cent of adjusted liabilities for any amount of adjusted liabilities exceeding $100 million.

Further conditions may be set out under the AFSL itself. Compliance with these requirements is tested through audits undertaken by the licensee's auditor both annually and at the request of ASIC.

## *Investment Policy*

Intermediaries are required to hold monies in a trust account with an ADI, cash management trust or an ASIC-approved foreign deposit-taking institution. The intermediary is required to disclose to the insured that they intend to keep any interest earned and must deposit the monies into such an account on the day it is received or on the next business day. Funds held in a trust account can be invested in a broad range of investments, but this in practice is rare and the rules relating to this are complex. Typically, any investment that is not in cash requires a written agreement between as to the arrangements, which will address issues such as how investment earnings and losses are shared.

# 4.3 Insurance intermediaries financial reporting

## Annual accounts

As AFSL holders, authorised representatives and intermediaries are required to lodge forms FS 70 (profit and loss statement and balance sheet) and FS 71 (audit report). Refer to the section below on annual accounts for timing of lodgement. Note that it is possible to apply to ASIC under Section 989D (3) for an extension of time for lodging the forms.

For AFSL holders that are not regulated by APRA, there are audit requirements in respect of compliance with the licence conditions, including:

- ability to pay all debts as and when they become due and payable;
- the minimum solvency requirements as described above;
- tiered requirement to hold $50,000 to $5 million of adjusted surplus liquid funds for licensees that have more than $100,000 of liabilities from transacting with clients as a principal; and
- compliance frameworks and systems of control.

In addition, Section 990(K) contains 'whistle-blowing' provisions that obligate auditors to report to ASIC within seven days if they become aware of a situation that has adversely affected, is adversely affecting or may adversely affect the ability of the licensee to meet its obligations and that may result in a breach of either:

- the conditions of the licence; or
- the requirements pertaining to trust accounts, financial records or financial statements.

## Other returns

Bodies other than ASIC may also require some form of reporting from intermediaries such as:

- Fire Brigade Returns;
- Workers Compensation returns;
- Tax returns such as Fringe Benefits Tax (FBT), Stamp Duty, Business Activity Statements (BAS) etc;
- Insurance Protection Tax; and
- Trust Account Returns.

# 4.4 Taxation of insurance intermediaries

Tax legislation does not contain specific provisions relating to the taxation of intermediaries. One of the important tax issues confronting intermediaries is the timing of recognition of commission and brokerage income, as this income is often taxed at a later point in time than it is recognised for accounting purposes. The ATO has issued Taxation Ruling IT2626 to provide guidance on this issue. The terms of the contract or arrangement between the insurer and the intermediary will be of major importance in determining when commission and brokerage income is derived.

An intermediary is able to recognise an amount of commission or brokerage as income for tax purposes at different points of time.

Examples include:

- When that amount has become a recoverable debt and the intermediary is not obliged to take any further steps before becoming entitled to payment.
- When the intermediary can first withdraw that amount from an insurance broking account.
- When that amount has actually been received from the insurer in those situations where the gross premium has been forwarded by the insured directly to the insurer, provided that the receipt by the intermediary of that amount had not been deferred unreasonably.
- When that amount has been withheld by the intermediary from the net premiums passed onto the insurer.

Which of these different scenarios is most relevant in any particular situation will be influenced by the terms of the contract between the intermediary and the relevant insurer.

The intermediary will be allowed a deduction in the year in which brokerage and commission is refunded where that amount had previously been included in the assessable income of the intermediary.

## *Goods and services tax*

Under the Australian GST legislation, some classes of insurance are treated differently, leading to different implications for insurers and insured parties.

Brokerage and fee income earned by intermediaries will generally be subject to GST regardless of the type of insurance policy involved; however, certain exceptions may exist (for example, brokerage in relation to the arranging of international transport, which may be GST-free in some instances).

It is common place for intermediaries and insurers to use Recipient Created Tax Invoices (RCTIs) in the process of documenting brokerage due for insurance sales. Particular GST rules exist in relation to RCTIs (including that a current and effective agreement is required between the parties) and these should be carefully considered.

## *Stamp duty*

Intermediaries are not liable to pay stamp duty on insurance policies, as the liability to pay duty falls on the registered insurer.

Where the insurance is provided by an unregistered insurer (e.g. overseas insurer), the insured is the person who is liable to remit any duty payable in the relevant jurisdictions. However, if the intermediary has remitted the duty on behalf of the insured, the insured will generally be deemed to have complied with the relevant stamp duty requirements.

# 5 Policyholder Protection

# 5.1 Regulatory framework for the insurance industry

The Australian regulatory framework is designed to provide insurance consumer protection and comprehensive supervision of the insurance industry. Insurers and those entities providing financial services are required to be licensed under relevant legislation as described in earlier chapters of Insurance Facts & Figures. The regulatory framework applicable to those licensed entities is for the most part administered by the Australian Prudential Regulation Authority (APRA), the Australian Securities and Investments Commission (ASIC), the Private Health Insurance Administration Council (PHIAC) and the Australian Competition and Consumer Commission (ACCC). The combined objectives of the framework includes the following:

- solvency of insurance providers – maintaining a competitive and viable insurance industry within Australia;
- policyholder protection –protecting the overall interests of policyholders through product disclosure, insurance business requirements and contracts;
- sales practice regulation – providing an environment for effective and unbiased sales advice;
- ability to pay claims – ensuring insurers maintain sufficient capital and resources to pay claims as they fall due; and
- sources of redress – offering adequate sources of redress in the event of policyholder dissatisfaction.

Over the past year, the framework has continued to evolve through initiatives such as the federal government's changes to the Future of Financial Advice Reforms and APRA's focus on risk management in insurance operations.

An outline of the areas of insurance regulatory supervision, responsible regulatory authority and corresponding Commonwealth legislation is outlined in the following table. How these impact insurer disclosure requirements, sales practices, claims handling and customer redress has also been set out in the following pages.

## Table 5.1 – Overview of policyholder protection

| | | Commonwealth Legislation | | | | | | | | | | | | | | Industry Supervision |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Corporations Act | Life Act | Insurance Act | Insurance Contracts Act | Trade Practices Act | Price Surveillance Act | Privacy Act | FOFA | Financial Services Reform Act | National Health Act | | Lifetime Health Cover | Medical Indemnity Act | Private Health Insurance Act | | General Code of Practice |
| | Regulatory Body | ASIC | APRA | APRA | ASIC | ACCC/ ASIC | ACCC | Privacy Commissioner | ASIC | ASIC | PHIAC | PHIO | PHIAC | Medicare Australia/ APRA | PHIAC | PHIO | FOS |
| Pre Sale | Product and Insurance Business/ contracts | ✓ | ✓ | ✓ | ✓ | | | | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ |
| | Pricing and competition | | | | | ✓ | ✓ | | ✓ | | ✓ | | | ✓ | ✓ | ✓ | |
| Sale | Sales practice regulation | ✓ | | | | ✓ | | ✓ | ✓ | ✓ | | | | | | | ✓ |
| Claim | Ability to pay claims | ✓ | ✓ | ✓ | | | | | ✓ | | ✓ | | | ✓ | ✓ | ✓ | |
| | Sources of redress | | | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | | | | ✓ | ✓ |
| | Use of personal information | | | | | | | ✓ | ✓ | | | | | | | | |

# 5.2 Policyholder protection – Product disclosure, insurance business and insurance contracts

The Corporations Act requires insurers to provide product documentation to consumers before they purchase an insurance product. Product disclosure documentation includes the provision of the following documents:

- Financial Services Guide (FSG) – the FSG contains information about a providing entity's financial services to enable retail clients to decide whether to obtain those financial services.
- Statement of Advice (SoA) – this document contains information about personal advice so that a retail client can make an informed decision about whether to act on that advice.
- Product Disclosure Statement (PDS) – the PDS (and any supplementary PDS documetns) contain information about a financial product to enable a retail client to make an informed decision about whether to purchase the financial product.

In addition to the standard product disclosure documentation, the Insurance Contracts Act places the following requirements on general insurers:

- detailed information pertaining to policy and claim limitations and disclosures must be provided to policy holders;
- when renewing policies, the insured has a duty of disclosure as to matters that would increase the risk of the insurer;
- the insurer must advise the intention and rate of renewal at least 14 days prior to expiry of existing policy, otherwise the policy is automatically renewed with no premium;
- an unpaid instalment can prevent claim payment only if this is made clear to the insured and it is overdue by at least 14 days;
- the insured must be informed if liability cover is on a claims-made basis; and
- insurers must disclose averaging provisions clearly and in writing.

# 5.3 Sales practice regulation

The Corporations Act and FOFA aim to ensure financial advisers act in the best interests of their clients and that policyholders receive quality sales advice and service. This means that advisers need to possess appropriate skills and knowledge and adhere to prescribed conduct and disclosure standards.

In order to demonstrate that sales representatives have appropriate skills and knowledge, insurers are required to:

- have documented procedures to monitor and supervise the activities of representatives to ensure they comply with financial services laws;
- ensure all representatives who provide financial services are competent to provide those services as outlined in ASIC's Regulatory Guide 146 Licensing: Training of financial product advisers;
- meet ongoing educational requirements;
- maintain records of all training undertaken; and
- ensure 'responsible officers' meet ASIC standards for knowledge and skills.

Insurance providers must also adhere to the following procedural requirements as part of their sales practices:

- Confirm, electronically or in writing, the issue, renewal, redemption or variation of policies within a reasonable timeframe.
- Offer a 14-day 'cooling-off' period during which customers has the right of return. For risk insurance products, the amount refunded can be reduced in proportion to the period that has passed before the right of return is exercised.
- Consumers must be given the option to register a 'no contact, no call' request, similar to marketing consents required under the Privacy Act 1988.
- Specify how and where private and personal information will be maintained, disclosed and stored and take reasonable steps to ensure third parties also adhere to privacy principles and requirements.

# 5.4 Ability to pay claims

In addition to applicable capital requirements for insurers which are designed to ensure insurers have sufficient funds to pay valid claims as they arise, the Financial Claims Scheme (FCS) provides additional backstop protection for policyholders.

It enables eligible general insurance policyholders to claim under a dedicated compensation scheme for valid claims against a failed general insurer, instead of having to pursue claims in the normal liquidation process. Eligible general insurance policyholders include Australian individuals insured with an APRA-regulated general insurer, small businesses (annual turnover less than $2million) and not-for-profit organisations. The FCS also allows the appointment of judicial managers to failing general insurers with powers to advance the interests of policy holders and the stability of the financial system.

# 5.5 Sources of redress

The Corporations Act requires all insurance companies to have clearly documented internal dispute resolution procedures for retail clients, and to belong to an external dispute resolution scheme which meets ASIC-approved standards. Health insurance complaints are handled by the Private Health Insurance Ombudsman (PHIO), as authorized by the Government. It also deals with complaints from health funds, private hospitals or medical practitioners regarding health insurance arrangements.

In addition, the Financial Services Ombudsman (FOS) is an independent body that resolves disputes between consumers and member financial services providers relating to general insurance and life insurance. Most insurers will be members of the FOS and are required to refer their retail clients to use the FOS where they are not satisfied with any internal dispute resolution procedures.

# *Abbreviations*

| | |
|---|---|
| AASB | Australian Accounting Standards Board |
| AASBs | AASB Standards |
| ACCC | Australian Competition and Consumer Commission |
| ADI | Authorised Deposit-Taking Institution |
| AFSL | Australian Financial Services Licence |
| AHIA | Australian Health Insurance Association |
| AML | Anti-Money Laundering |
| APRA | Australian Prudential Regulation Authority |
| ARPC | Australian Reinsurance Pool Corporation |
| ASIC | Australian Securities and Investments Commission |
| ASX | Australian Securities Exchange |
| ATO | Australian Taxation Office |
| AUASB | Auditing and Assurance Standards Board |
| AUSTRAC | Australian Transaction Reports and Analysis Centre |
| BCM | Business Continuity Management |
| CEO | Chief Executive Officer |
| CFO | Chief Financial Officer |
| CPI | Consumer Price Index |
| CTF | Counter-Terrorism Financing |
| CTP | Compulsory Third Party |
| DAC | Deferred Acquisition Costs |
| DAM | Decreasing Adjustment Mechanism |
| DOFI | Direct Offshore Foreign Insurer |
| ECS | Exceptional Claims Scheme |
| FASB | Financial Accounting Standard Board |
| FATF | Financial Action Task Force |
| FCR | Financial Condition Report |
| FID | Financial Information Declaration |
| FOFA | Future of Financial Advice |
| FOS | Financial Ombudsman Service |
| FSR | Financial Services Reform |
| GAAP | Generally Accepted Accounting Principles |
| GST | Goods and Services Tax |
| HCCS | High Cost Claims Scheme |
| HPPA | Hospital Purchaser Provider Agreements |
| IAA | Institute of Actuaries of Australia |
| IASB | International Accounting Standards Board |
| IBNER | Incurred But Not Enough Reported |
| IBNR | Incurred But Not Reported |
| ICA | Insurance Council of Australia |

| | |
|---|---|
| ICAAP | Internal Capital Adequacy Assessment Program |
| IFRS | International Financial Reporting Standards |
| ILVR | Insurance Liability Valuation Report |
| KYC | Know Your Customer |
| LAGIC | Life and General Insurance Capital |
| LAT | Liability Adequacy Test |
| LMI | Lenders Mortgage Insurance |
| LVR | Loan-to-Value Ratio |
| MAA | Motor Accidents Authority |
| MCR | Minimum Capital Requirement |
| MDO | Medical Defence Organisation |
| MER | Maximum Event Retention |
| MII | Medical Indemnity Insurer |
| MOU | Memorandum of Understanding |
| MSE | Management Services Element |
| NIBA | National Insurance Brokers' Association |
| NOHC | Non-Operating Holding Company |
| OCR | Outstanding Claims Reserve |
| PAIRS | Probability and Impact Rating System |
| PDS | Product Disclosure Statement |
| PHIAC | Private Health Insurance Administration Council |
| PHIO | Private Health Insurance Ombudsman |
| PML | Probable Maximum Loss |
| PST | Pooled Superannuation Trust |
| RAS | Reinsurance Arrangement Statement |
| RD | Reinsurance Declaration |
| RE | Responsible Entity |
| REMS | Reinsurance Management Strategy |
| RHBO | Registered Health Benefits Organisation |
| RMD | Risk Management Declaration |
| RMS | Risk Management Strategy |
| ROCS | Run-off Cover Scheme |
| SEA | Segregated Exempt Assets |
| SO | Senior Officer from Outside Australia |
| SPV | Special Purpose Vehicle |
| Stage 2 | Stage 2 of APRA's general insurance reforms |
| TOFA | Taxation of Financial Arrangements |
| UPR | Unearned Premium Reserve |
| VPST | Virtual Pooled Superannuation Trust |

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