



Prudential Standard HPS 001

Definitions

Objectives and key requirements of this Prudential Standard

This Prudential Standard defines key terms referred to in other prudential standards which are applicable to private health insurers. All prudential standards applicable to private health insurers must be read in conjunction with this Prudential Standard.

Authority

1. This Prudential Standard is made under paragraph 92(1) of the *Private Health Insurance (Prudential Supervision) Act 2015* (the Act).

Application

2. This Prudential Standard commences on 1 July ~~2019~~2023.
3. Unless the contrary intention appears, definitions in this Prudential Standard apply to all prudential standards made under subsection 92(1) of the Act (collectively '~~HIPHI~~ Prudential Standards').
4. In this Prudential Standard, unless the contrary intention appears, a reference to an Act, Regulations or Prudential Standard is a reference to the Act, Regulations or Prudential Standard as in force from time to time.

Definitions

5. Key terms in the ~~HIPHI~~ Prudential Standards are defined as follows:

~~AASB~~ refers to the Australian Accounting Standards Board.

~~Act~~ means the *Private Health Insurance (Prudential Supervision) Act 2015*.

~~Annual balance date~~ is 30 June each year for private health insurers.

~~Accrued premium~~ for the relevant class of business, is calculated as follows:

~~Accrued premium = Premiums received - A + B~~
where:

- ~~(a) A = Premiums in advance at the end of the specified period - Premiums in advance at the start of the specified period;~~
- ~~(b) B = Unpaid premiums at the end of the specified period – Unpaid premiums at the start of the specified period; and~~
- ~~(c) Premiums must be inclusive of relevant levies, loadings and discounts.~~

~~Additional Tier 1 Capital~~ is as defined in *Prudential Standard HPS 112 Capital Adequacy: Measurement of Capital* (HPS 112).

Appointed ~~actuary~~Actuary has the same meaning as in the Act.

Appointed Auditor means an auditor appointed for the purposes of *Prudential Standard HPS 310: Audit and Related Matters*.

~~Approved loss absorbing subordinated debt of a health benefits fund~~ means a security or other debt instrument, which has been approved by APRA prior to the time of issue. APRA must consider the quantum of the proposed issue and the timing for draw down, in making its decision on approval. APRA must consider that approved loss

~~absorbing subordinated debt must be created by a debt instrument or agreement which meets and continues to meet the following terms and conditions:~~

- ~~(a) it must comprise a mechanism which specifies the conditions and process for loss absorption, through diminution of value, conversion or other means, of the instrument or agreement on a going concern basis, such that prior to non-compliance with Prudential Standard HPS 110 Capital Adequacy (HPS 110) the value of the debt would be reduced to the relevant extent, and if necessary exhausted; and~~
- ~~(b) it must have a minimum term of 10 years from the commencement of the loan; and~~
- ~~(c) there must be no circumstances where repayment may be accelerated or called at the lender's or any third party's option; and~~
- ~~(d) interest payments must not be payable where the payment of these would cause the fund to breach the requirements of HPS 110; and~~
- ~~(e) interest payment obligations may be capitalised and interest may be charged on capitalised interest; and~~
- ~~(f) capital repayments must not be made where repayment would cause the fund to breach the requirements of HPS 110; and~~
- ~~(g) delayed capital repayments may be subject to continuing interest charges on the interest charge and repayment conditions specified in this paragraph.~~

~~Approved loss absorbing subordinated debt of a health benefits fund approved by PHIAC for the purposes of Rule 3A of the Private Health Insurance (Health Benefits Fund Administration) Rules 2007 as it was in effect between 1 April 2014 and 30 June 2015 is taken to have been approved by APRA for the purposes of this Prudential Standard.~~

~~**APRA-regulated institution** includes private health insurers registered under the Act.~~

~~**ASIC** means the **APRA-authorised reinsurer** means an **insurer** carrying on reinsurance business. For the purposes of this definition, a Lloyd's underwriter as defined under the *Insurance Act—1973* is an APRA-authorised reinsurer if it carries on reinsurance business.~~

~~**Asset Concentration Risk Charge** means the risk charge determined under *Prudential Standard HPS 117 Capital Adequacy: Asset Concentration Risk Charge*.~~

~~**Asset Risk Charge** means the risk charge determined under *Prudential Standard HGPS- 114 Capital Adequacy: Asset Risk Charge*.~~

~~**Associate** means an associate as defined under *Australian Securities and Accounting Standard AASB- 128 Investments Commission*.~~

~~**Assets** has the same meaning as in the Act.~~

~~*in Associates has the same meaning as in clause 4 in Schedule 1 of the Financial Sector (Shareholdings) Act 1998 and Joint Ventures.*~~

~~**AASB** refers to the Australian Accounting Standards Board.~~

AUASB refers to the Auditing and Assurance Standards Board.

Australian Accounting Standards is a reference to the Australian Accounting Standards issued by the AASB as may be amended from time to time.

Australian Auditing and Assurance Standards is a reference to the Australian Auditing and Assurance Standards issued by the AUASB as may be amended from time to time.

Authorised deposit-taking institution means a ~~body corporate in relation to which an authority~~ deposit-taking institution authorised by APRA under ~~subsection 9(3) of the Banking Act 1959 is in force~~ (Banking Act). It includes foreign ADIs as defined in the Banking Act.

~~**Billed risk equalisation special account liability** means the amount of risk equalisation special account payments, on the relevant day, for which an invoice from APRA has been received by the private health insurer but that have not yet been paid by the private health insurer.~~

Benefits incurred are the value of all insurance claims incurred during the period for the relevant class of business, net of risk equalisation expense, and include ambulance levies. This is to include the value of services provided in lieu of a benefit payment and movements in the central estimate of outstanding claims liabilities.

Board means the board of directors of an ~~APRA-regulated~~ institution.

Board Audit Committee has the same meaning as in *Prudential Standard CPS 510: Governance* (CPS 510).

Board Remuneration Committee has the same meaning as in CPS 510.

Board Risk Committee has the same meaning as in CPS 510.

Business day means a day that is not a Saturday, a Sunday or a public holiday or bank holiday in the place concerned.

Business plan refers to a written plan as part of ~~an~~ private health insurer's risk management framework as required under *Prudential Standard CPS 220: Risk Management* (CPS 220).

Capital base is as defined in HPS 112.

Capital standards refers collectively to all PHI Prudential Standards relating to capital adequacy.

Cash has the meaning given in Australian Accounting Standards Standard 107.6 as in force from time to time.

Central estimate means an estimate of the mean of the range of possible outcomes of any calculation required under ~~either Prudential Standard HPS 100 Solvency~~ HPS 110 Capital Adequacy (HPS ~~100~~ or HPS 110).

Chief executive officer has the same meaning as in the Act.

Claims component is the central estimate of claims that a private health insurer expects to incur. For the outstanding claims liabilities, this includes:

- (a) claims payable for: claims that have been reported, but are not yet settled at balance date;
- (b) claims that have been incurred, but not yet reported; and
- (c) claims that have been administratively settled, but which may be reopened.

For each outstanding claims liabilities and premiums liabilities, the claims component is to be calculated gross of reinsurance and non-reinsurance recoverables.

Claims handling expenses are the costs that a private health insurer expects to incur in the management and settling of claims, which includes an appropriate allocation of business overheads such as claims department and corporate office overheads. For outstanding claims liabilities, this includes the cost of future claims management, claims administration expenses for all incurred claims outstanding and the establishment expenses of not yet reported claims. For premiums liabilities, this includes claims management and claims administration expenses for claims establishment and run-off.

Claims incurred are the value of all insurance claims incurred during the period for the relevant class of business, gross of risk equalisation. This is to include the value of services provided in lieu of a benefit payment and movements in the central estimate of outstanding claims liabilities.

Common Equity Tier 1 Capital is as defined in HPS 112.

Company means:

- (a) a company within the meaning of the *Corporations Act 2001* (~~Corps~~ Corporations Act); and
- (b) a constitutional corporation.

Complying health insurance product has the same meaning as in the Act.

~~**Constructive obligation** has the meaning given in the liability adequacy test in Australian Accounting Standard Board Standard 137 as in force from time to time.~~

Constitutional corporation has the same meaning as in the Act.

Corporate governance means a system by which an APRA-regulated institution is directed and controlled.

Corporate group is a group of entities comprising two or more companies that are related bodies corporate within the meaning of ~~section~~Section 50 of the ~~Corps~~Corporations Act.

~~Corporations legislation has~~Act refers to the ~~meaning given by section 9 of Corporations Act 2001.~~

Counterparty grade refers to the ~~Corps Act~~ classification applied to an investment or exposure as per the requirements of Attachment A of this Prudential Standard.

~~Director has the same meaning as in the Act.~~

Debt obligations for the purposes of the Asset Risk Charge and Asset Concentration Risk Charge refers to all loans, deposits, placements, interest rate securities and other receivables.

Ensure when used in relation to a responsibility of the board, means to take all reasonable steps and make all reasonable enquiries as are appropriate for a board so that the board can determine, to the best of its knowledge, that the stated matter has been properly addressed.

~~**Executive director**, for a private health insurer, means a director who is:~~

~~(a) — a member of management of the insurer; and~~

~~(b) — an employee of the insurer.~~

~~**Financial condition report** means a report on the financial condition of a private health insurer, including a report on the financial condition of each health benefits fund conducted by the insurer.~~

Expected reinsurance recoveries means any amounts due to a private health insurer from a reinsurer that arise from the recognition of premiums liabilities referred to in the PHI Prudential Standards (including *Prudential Standard HPS 340: Insurance Liability Valuation*). This is distinguished from **reinsurance recoverables**.

Fair value has the same meaning as it does in the Australian Accounting Standards and refers to the amount for which an asset could be exchanged, or a liability settled, between knowledgeable, willing parties in an arm's length transaction.

Financial Condition Report (FCR) is as defined in *Prudential Standard CPS 320: Actuarial and Related Matters (CPS 320)*.

Financial interdependency in relation to a group of related counterparties, means a circumstance in which the financial soundness of one counterparty in the group may affect the financial soundness of another counterparty in the group.

~~FSCODA means the *Financial Sector (Collection of Data) Act 2001*.~~

~~Fit and proper assessment means an assessment of a person's fitness and propriety in accordance with Prudential Standard CPS 520 Fit and Proper (CPS 520).~~

~~Fit and proper policy means a written policy relating to the fitness and propriety of a private health insurer's responsible persons that meets the requirements of CPS 520.~~

General fund consists of the operations of a private health insurer that do not form part of a **health benefits fund** of the private health insurer. This includes assets, liabilities, revenue and expenses not attributed to a health benefits fund.

General treatment has the same meaning as the *Private Health Insurance Act 2007 (PHI Act)*

Gross margin means the difference between accrued premium and benefits incurred (inclusive of State levies), as a proportion of accrued premium.

Group of related counterparties means two or more counterparties which are related parties, or are linked by either of the following:

- (a) financial interdependency; or
- (b) any other connection or relationship that might expose the counterparties in the group to a single risk.

Health benefits fund has the same meaning as in the Act.

~~Health business revenue estimate of a health benefits fund, is its premium income estimate plus a central estimate of the gross revenue that it will earn in relation to its health related business in the 12 months after the relevant day, less any premium ceded to reinsurers in relation to health related business within that 12 month period.~~

Health insurance business (HIB) has the same meaning as in the Act.

Health-related business has the same meaning as in the Act.

Health-related insurance business (HRIB) means the insurance component of health-related business such as insurance for overseas visitors and students.

Hospital treatment has the same meaning as in the PHI Act.

Insurance Risk Charge means the risk charge determined under *Prudential Standard HPS 115 Capital Adequacy: Insurance Risk Charge (HPS 115)*.

Internal Capital Adequacy Assessment Process (ICAAP) is as described in HPS 110.

Management expenses means the expenses associated with the management of the insurer. This includes claims handling expenses, and does not include benefits incurred or taxes.

Material risks are those risks that could have a material impact, both financial and non-financial on the APRA-regulated institution, or on the interests of depositors and/or ~~policyholders~~ policy holders of the APRA-regulated institution. Material risks may include, but are not limited to the examples included in paragraph 26 of CPS 220.

~~New product~~ Non APRA-authorised reinsurer means ~~a product~~ any reinsurer that:

~~has is~~ not previously been offered by a private health insurer; and an APRA-authorised reinsurer.

~~(a) — contains characteristics that are different from other products offered by the insurer.~~

~~Non-executive director~~ is defined in CPS 510.

Officer

Non-operating holding company (NOHC) has the same meaning as in the *Insurance Act 1973*.

~~PHIAC~~ Non-reinsurance recoveries are recoveries relating to claims that do not relate to exposures to a reinsurer.

Operational Risk Charge means the ~~former risk charge~~ determined under *Prudential Standard HPS 118 Capital Adequacy: Operational Risk Charge*.

Outstanding claims risk size margin of a health benefits fund is as defined in HPS 115.

PHI Act means the *Private Health Insurance Administration Council* established under *Act 2007*.

Policy administration expenses are costs that a private health insurer expects to incur in administering policies, which includes an appropriate allocation of business overheads such as corporate office overheads. This includes, but is not limited to, policy management and administration expenses to allow for the ~~National Health Act 1953, whose prudential functions transferred to APRA~~ cost of managing unexpired policies for which the entity is on 30 June 2015 risk.

Policy holder has the same meaning as in the Act.

~~Premium income estimate~~ of a health benefits fund, is the central estimate of the amount of health insurance business premium income that it will earn in the 12 months after the relevant day, where the premium increase assumption is the lesser of:

- ~~(a) — the central estimate of the amount of revenue the private health insurer's health benefits fund will earn in the 12 months after the relevant day; and~~
- ~~(b) — the amount determined in accordance with the methodology published by APRA, as amended from time to time.~~

~~Previously approved subordinated debt~~ of a health benefits fund, means debt of a kind previously approved by PHIAC as subordinated debt, for the purposes of the solvency standard or capital adequacy standard established by the Private Health Insurance (Health

~~Benefits Fund Administration) Rules 2007 (made under the *Private Health Insurance Act 2007*), as in force as immediately prior to 31 March 2014.~~

Prescribed capital amount is as defined in HPS 110.

Private health insurer has the same meaning as in the Act, other than in CPS 320.

Probability of adequacy means the percentile required to meet individual elements of ~~either HPS 100 or~~ 110.

Prudential Capital Requirement (PCR) means the minimum amount of capital that an insurer must hold as defined in HPS 110.

Prudential requirements includes requirements imposed by the Act, prudential standards and APRA rules made under the Act, reporting standards made under the *Financial Sector Collection of Data Act 2001* (FSCODA), conditions imposed at the time of registration under the Act and any other requirements imposed by APRA in writing.

~~**Referable**~~**Reinsurance** refers to all arrangements where some part of individual or aggregate insurance risks are ceded to another company or companies and include cessions of direct writing companies to reinsurance companies or other direct writing companies and parent companies as well as retrocessions of **reinsurers** to their parent companies or other reinsurers.

Reinsurance assets in relation to a private health insurer comprises:

(a) reinsurance recoverables; and

(b) expected reinsurance recoveries.

Reinsurance recoverables means any amounts due to a private health insurer from a reinsurer that arise from the recognition of outstanding claims liabilities referred to in the capital standards and CPS 320.

Reinsurer means any company providing reinsurance, whether a parent company, direct writing company or reinsurance company.

Related body corporate or related company has the same meaning as in section 50 of the Corporations Act.

~~**Related party** has~~**Related entity** means an entity which is a ‘related party’ within the meaning given by of the relevant Australian Accounting Standards ~~Board Standard 124~~ as in force from time to time.

~~**Relevant day** means the day on which the calculation is based for the purposes of assessing compliance with HPS 100 or HPS 110, as the case may be.~~

~~**Remuneration Policy** has the same meaning as in CPS 510.~~

Reporting date is the last day of the relevant **reporting period**

Reporting period is the period that the insurer is required to report under the relevant reporting standards made under the FSCODA.

Responsible persons has the same meaning as in CPS 520.

Risk equalisation is the payments to be made to or receivables expected from the Risk Equalisation Special Account for the relevant period. Risk equalisation special account has the same meaning as in the Act.

Risk management declaration is as defined in CPS 220.

Risk management framework has the same meaning as in CPS 220.

Risk management strategy has the same meaning as in CPS 220.

Senior management means a person who has or exercises any senior management responsibilities ~~means the responsibilities of making, or participating in making, decisions that affect the whole, or a substantial part, of the business of~~ the private health insurer.

Single equivalent units (SEUs) for a policy – if a policy falls into one of the categories of policies specified below, the single equivalent unit for the policy is the number shown next to the category:

- (a) a hospital policy under which only one person is insured – 1;
- (b) a hospital policy under which 2 adults are insured (and no-one else) – 2;
- (c) a hospital policy under which 2 or more people are insured, none of whom is an adult – 1;
- (d) a hospital policy under which 2 or more people are insured, only one of whom is an adult – 1;
- (e) a hospital policy under which 3 or more people are insured, only 2 of whom are adults – 2;
- (f) a hospital policy under which 3 or more people are insured, at least 3 of whom are adults – 2.

~~Size margin of a health benefits fund, is the lesser of:~~

- ~~(a) the margin based on the number of SEUs of the health benefits fund as calculated by the following formula:~~

$$0.75 \times (\text{SEUs})^{0.16}; \text{ and}$$

- ~~(b) 0.25.~~

Subordinated debt means the sum of any previously approved subordinated debt and any approved loss absorbing subordinated debt.

Special Purpose Vehicle (SPV) refers to an entity that is not a related entity and whose activities are restricted to the acquisition and financing of specific assets.

Statutory accounts means the reporting documents that a private health insurer is required to lodge with APRA under Section 13 of FSCODA.

Substantial shareholder means a person with a substantial holding within the meaning given by ~~section~~Section 9 of the ~~Corps~~Corporations Act.

Supervisory adjustment is as defined under HPS 110.

Terminating management has the same meaning as in the Act.

Tier 1 Capital is as defined in HPS 112.

Tier 2 Capital is as defined in HPS 112.

Unclosed business refers to premium revenue from insurance policies that have not yet been processed, but for which the private health insurer is liable at the valuation date. There may be insufficient information available to report an exact amount of premium.

Unpaid premium means the value of premiums due but not received. Premiums are defined as gross of commissions and before profit share rebates (for example included in group insurance and reinsurance contracts issued). Premiums must also be inclusive of stamp duty, policy fees, loadings and discounts.

Valuation date means the reporting date.

Yearly statutory accounts has the same meaning as in ~~the~~FSCODA.

Adjustments and exclusions

6. APRA may, by notice in writing to a private health insurer, adjust or exclude a specific requirement in this Prudential Standard in relation to that private health insurer.

Previous discretions

7. A private health insurer must contact APRA if it seeks to place reliance, for the purposes of complying with this Prudential Standard, on a previous exemption or other exercise of discretion made by APRA under a previous Prudential Standard.

Attachment A

Counterparty grades

1. Assets subject to credit risk must be assigned a counterparty grade using one of the following methods:
 - (a) for publicly rated assets refer to paragraphs 2 and 3 of this Attachment;
 - (b) for non-publicly rated assets secured by a residential mortgage refer to paragraphs 7 to 11 of this Attachment. An asset secured by a residential mortgage comprises an investment held by way of a registered lien, charge or mortgage over residential property. The valuation must have been performed by a qualified valuer. The property cannot be a speculative construction or a property development;
 - (c) assets other than those referred to in (a) and (b) may be rated using private external ratings or a private health insurer's own ratings, but only with the prior approval of APRA; or
 - (d) assets other than those referred to in (a) and (b) that have not been rated using methods approved by APRA must be assigned a counterparty grade of 5.
2. Publicly rated assets are assigned a counterparty grade based on the following tables. The short-term ratings in Table 1 are typically used for assets with original term to maturity of not more than 13 months. For other assets the long-term ratings in Table 2 apply. The credit ratings in Table 1 and Table 2 include structured finance ratings with the (sf) indicator.

Table 1: Short-term ratings

<u>Grade</u>	<u>Standard & Poor's</u>	<u>Moody's</u>	<u>AM Best</u>	<u>Fitch</u>
<u>1</u>	<u>A1+</u>		<u>AMB-1+</u>	<u>F1+</u>
<u>2</u>	<u>A1</u>	<u>P1</u>	<u>AMB-1</u>	<u>F1</u>
<u>3</u>	<u>A2</u>	<u>P2</u>	<u>AMB-2</u>	<u>F2</u>
<u>4</u>	<u>A3</u>	<u>P3</u>	<u>AMB-3</u>	<u>F3</u>
<u>5</u>	<u>=</u>	<u>=</u>	<u>=</u>	<u>=</u>
<u>6</u>	<u>B</u>	<u>NP Vulnerable</u>	<u>AMB-4</u>	<u>B</u>
<u>7</u>	<u>C</u>	<u>NP Currently Vulnerable</u>		<u>C</u>

Table 2: Long-term ratings

<u>Grade</u>	<u>Standard & Poor's</u>	<u>Moody's</u>	<u>AM Best</u>		<u>Fitch</u>
			<u>Debt</u>	<u>FSR¹</u>	
<u>1</u>	<u>AAA</u>	<u>Aaa</u>	<u>aaa</u>	<u>A++</u>	<u>AAA</u>
<u>2</u>	<u>AA+</u>	<u>Aa1</u>	<u>aa+</u>	<u>A+</u>	<u>AA+</u>
	<u>AA</u>	<u>Aa2</u>	<u>aa</u>		<u>AA</u>
	<u>AA-</u>	<u>Aa3</u>	<u>aa-</u>		<u>AA-</u>
<u>3</u>	<u>A+</u>	<u>A1</u>	<u>a+</u>	<u>A</u>	<u>A+</u>
	<u>A</u>	<u>A2</u>	<u>a</u>		<u>A</u>
	<u>A-</u>	<u>A3</u>	<u>a-</u>		<u>A-</u>
<u>4</u>	<u>BBB+</u>	<u>Baa1</u>	<u>bbb+</u>	<u>B++</u> <u>B+</u>	<u>BBB+</u>
	<u>BBB</u>	<u>Baa2</u>	<u>bbb</u>		<u>BBB</u>
	<u>BBB-</u>	<u>Baa3</u>	<u>bbb-</u>		<u>BBB-</u>
<u>5</u>	<u>BB+</u>	<u>Ba1</u>	<u>bb+</u>	<u>B</u> <u>B-</u>	<u>BB+</u>
	<u>BB</u>	<u>Ba2</u>	<u>bb</u>		<u>BB</u>
	<u>BB-</u>	<u>Ba3</u>	<u>bb-</u>		<u>BB-</u>
<u>6</u>	<u>B+</u>	<u>B1</u>	<u>b+</u>	<u>C++</u> , <u>C+</u> <u>C</u> <u>C-</u>	<u>B+</u>
	<u>B</u>	<u>B2</u>	<u>b</u>		<u>B</u>
	<u>B-</u>	<u>B3</u>	<u>b-</u>		<u>B-</u>
<u>7</u>	<u>Below B-</u>	<u>Below B3</u>	<u>Below b-</u>	<u>Below C-</u>	<u>Below B-</u>

3. Where investments are held via a trust that has itself been separately rated by a recognised rating agency, that rating may be applied to all the investments in the trust in lieu of the ratings of the individual trust assets, provided that the trust is treated as a single investment for asset concentration purposes and is not subject to 'look-through'. When a 'look-through' approach is adopted the underlying assets need to be individually rated. If the trust is separately rated, that overall trust rating cannot be applied to the individual underlying assets.
4. A private health insurer must, in general, use the same rating agency for determining all counterparty grades. A private health insurer may depart from this general rule where there are good reasons for doing so, such as under the following circumstances:
- (a) where the rating agencies usually monitored by a ~~regulated institution~~ private health insurer do not issue a solicited credit rating² for a particular debt obligation and only one other rating agency issues a solicited credit rating for that debt obligation, a ~~regulated institution~~ private health insurer may use that solicited credit rating; or
 - (b) where the rating agencies usually monitored by the private health insurer~~regulated institution~~ do not issue a solicited credit rating for a particular debt obligation, the credit ratings issued by all other rating agencies listed in the table above must be reviewed and the rule in paragraph 6 of this Attachment must be used to determine

¹ 'FSR' refers to the Financial Strength Rating issued by AM Best.

² A solicited credit rating is a rating that has been initiated and paid for by the issuer or rated counterparty or a commercial associate of the issuer or rated counterparty.

the rating agency used to determine the counterparty grade and therefore the credit spreads or default factors to be applied; or

(c) ~~the rule in paragraph~~ paragraph 5 of this Attachment may also be applied where a private health insurer monitors multiple rating agencies that provide different solicited credit ratings for a particular debt obligation.

5. For the purposes of paragraph 4 of this Attachment the following rule applies; where a counterparty or debt obligation has solicited credit ratings from multiple rating agencies, the following guidelines must be followed in determining the counterparty grade:

(a) if there are two solicited ratings that correspond to different counterparty grades, the lower counterparty grade must be used for the debt obligation; or

(b) if there are three or more solicited ratings that correspond to different counterparty grades, the ratings corresponding to the second-best of those counterparty grades must be used for the debt obligation.

6. APRA's written approval must be sought if a private health insurer wishes to use the rating determined by a rating agency not included in the tables above.

7. The counterparty grade for assets secured by residential mortgages (as defined in paragraph 1(b)) of this Attachment) is determined from the following table.

Table 3: Assets secured by residential mortgages

<u>Counterparty grade</u>	<u>Standard residential mortgages</u>		<u>Other residential mortgages</u>	
<u>'Loan to value ratio'</u>	<u>No LMI</u>	<u>>40% LMI</u>	<u>No LMI</u>	<u>>40% LMI</u>
<u>≤ 60%</u>	<u>2</u>	<u>2</u>	<u>3</u>	<u>2</u>
<u>> 60% but ≤ 80%</u>	<u>2</u>	<u>2</u>	<u>4</u>	<u>3</u>
<u>> 80% but ≤ 90%</u>	<u>3</u>	<u>2</u>	<u>5</u>	<u>4</u>
<u>> 90% but ≤ 100%</u>	<u>4</u>	<u>3</u>	<u>5</u>	<u>4</u>
<u>> 100%</u>	<u>5</u>	<u>4</u>	<u>5</u>	<u>5</u>

8. 'Loan to value ratio' is the ratio of the value of the asset (i.e. loan) to the market value of the collateral. The market value of the collateral is the value at inception or, where a substantive valuation has subsequently been carried out, this subsequent valuation.

9. A standard residential mortgage is defined as a mortgage on an existing residential property where the private health insurer has:

(a) prior to loan approval and as part of the loan origination and approval process, documented, assessed and verified the ability of the borrowers to meet their repayment obligation;

(b) valued any residential property offered as security;

- (c) established that any property offered as security for the loan is readily marketable; and
- (d) the private health insurer has at all times unequivocal enforcement rights over the mortgaged property (including a power of sale and a right to possession) in the event of default by the borrower.

The private health insurer must also revalue any property offered as security for such loans when it becomes aware of a material change in the market value of property in an area or region.

- 10. Loans that are secured by residential properties but fail to meet the criteria detailed in paragraph 9 of this Attachment must be classified as other residential mortgages. Such loans may be reclassified as standard residential mortgages where the borrowers have met their contractual loan repayments to the private health insurer continuously over the previous 36 months.
- 11. LMI refers to lenders mortgage insurance. '>40% LMI' refers to mortgages where insurance cover has been obtained for all realised losses up to at least 40 per cent of the higher of the original loan amount and outstanding loan amount (if higher than the original loan amount). Such insurance must be with a lenders mortgage insurer that is regulated by APRA.