Members Health
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18 August 2020

General Manager
Policy Development
Police and Advice Division
Australian Prudential Regulation Authority

Dear Sir/Madam

RE: APRA PHI Capital Standards Review

1 About Us

Members Health thanks APRA for providing the opportunity to respond to the regulator's consultation on the PHI capital standards framework following its release of the *Discussion paper: Private Health Insurance Capital Standards Review* on 3 December 2019.

As the peak body for 27 not-for-profit, member owned or community based health insurers, Members Health advocates for a successful and vibrant private health insurance industry (PHI) supported by robust and fit-for-purpose policy frameworks and efficient processes.

Collectively, the alliance of 27 Members Health funds represents more than 28 per cent of the private health insurance market. Our funds consistently lead across key performance indicators, such as policyholder growth, competitive pricing, customer satisfaction, trust and retention.

APRA data demonstrates the prudential and sound market positioning of our funds: they hold capital above the regulatory minimum required; they continue to grow with all age cohorts and importantly, with younger and healthier policyholders; they offer extremely competitively priced products; they return more of the premium dollar back to members as benefits; they offer fewer policies with restrictions or exclusions; and lead the industry when it comes to customer satisfaction and retention.

2 Introduction

Members Health welcomes the opportunity to comment and contribute to APRA's consultation on the PHI capital standards framework.

At this time APRA's proposals are largely conceptual and have not been defined to the degree needed to enable quantitative impacts to be measured. Some of the consultation questions are very open and may result in a diverse range of opinion from our membership, as a result, we have focused

our submission on practical implementation considerations, as well as, feedback that was consistently repeated by our members.

Any capital framework for PHI should:

- Avoid unnecessary complexity and be as easy to implement as possible.
- Be cognisant of the transition issues (time and cost) for insurers, noting that APRA's current intent to align the introduction of the capital standards to the introduction of AASB17 is predicated on the assumption that this will be easier for insurers.
- Be appropriately tailored to the nature of PHI insurance risk.
- Ensure the minimum capital requirements are commensurate with the level of risk inherent in the PHI business model, given the short-tail nature of PHI claims and the absence of catastrophic exposures that are evident in other sectors.
- Suitably justify departures and any 'improvements' on previous capital standards. For example, we believe that many of APRA's requirements could be met with a minimum capital requirement broadly similar to that operating in PHI prior to 2014.

3 Impact of regulation on consumers and competition

Overarching our response, we believe the current capital standards, with a small number of recommended changes in this paper, are fit for future purpose and to date, we have not been provided any compelling justification from APRA for the need for new standards, particularly with the protection of our members and membership in mind. The introduction of new capital standards is both costly and disruptive and in our opinion unnecessary.

We reassert our view that has been previously expressed to APRA (and many of our individual member funds have also provided similar feedback directly to APRA), that private health insurance operates very differently to APRA's other regulated industries., With these differences in mind, combined with the unnecessary additional cost burdens ultimately imposed upon our members, we would argue strongly against any suggestion that private health insurance capital standards be harmonised with other APRA regulated industries using the LAGIC framework.

We encourage APRA to be more mindful of the financial burden that new and increased regulation has on consumers and the long-term impacts to the private health insurance competitive landscape. Furthermore, introducing new standards to our industry at this time is at odds with the Australian Government's stated aim of reducing regulation and red tape, particularly to small and medium sized businesses. New regulation should only be introduced where there is a clear and compelling justification and we do not see a clear and compelling justification in what APRA has presented to date.

It is our strong view that, it is essential that regulatory standards are sensitive to the maintenance of a diverse and competitive private health insurance market. The fact that health insurance caries very low and predicable short tail prudential risk, combined with the effectiveness of the current capital frameworks, has meant that consumers have been well protected. We make the point that

due to sound and sensible prudential regulation established under PHIAC, no health insurer has collapsed to the detriment of consumers in living memory.

The importance to consumers of competition and choice in private health insurance is well documented by the former regulator PHIAC[1], the Australian Competition and Consumer Commission and by the Commonwealth[2]. We are fortunate that there exist 37 health funds in the market for consumers to choose from. These funds range from the very large to the very small, listed and non-listed, overseas owned and Australian Owned, regional and metropolitan based, for-profit and not-for-profit, community based and nationally based. Each health fund fosters an added element of contestability and diversity to the marketplace, which benefits consumers.

The beneficial impact of the competitive landscape on consumer choice is demonstrated in APRA's own data. Over the five years to 2018-19, as a group the Members Health funds have consistently grown their market share and memberships while the larger for-profit health funds have consistently declined. It is also reinforced in data that shows as a group, the Members Health funds return significantly more of the premium dollar back to consumers in health benefits and maintain high customer satisfaction and retention.[3]

Effective competition should reduce the need for costly and cumbersome regulation, and in turn lower the costs borne by insurers and the end consumer. Conversely, higher barriers to entry and more burdensome regulatory requirements raise the prospect of lessening innovation, pushing up premium costs and driving consumers out of the private health system.

When considering regulation, it is important that APRA recognise that Australia's not-for-profit and member owned health funds do not need to deliver profits to shareholders or overseas investors. Therefore they can operate under a very different business model that allows for much narrower margins and a focus on maximising value for money for consumers. This in turn provides competitive tension for the large for-profits.

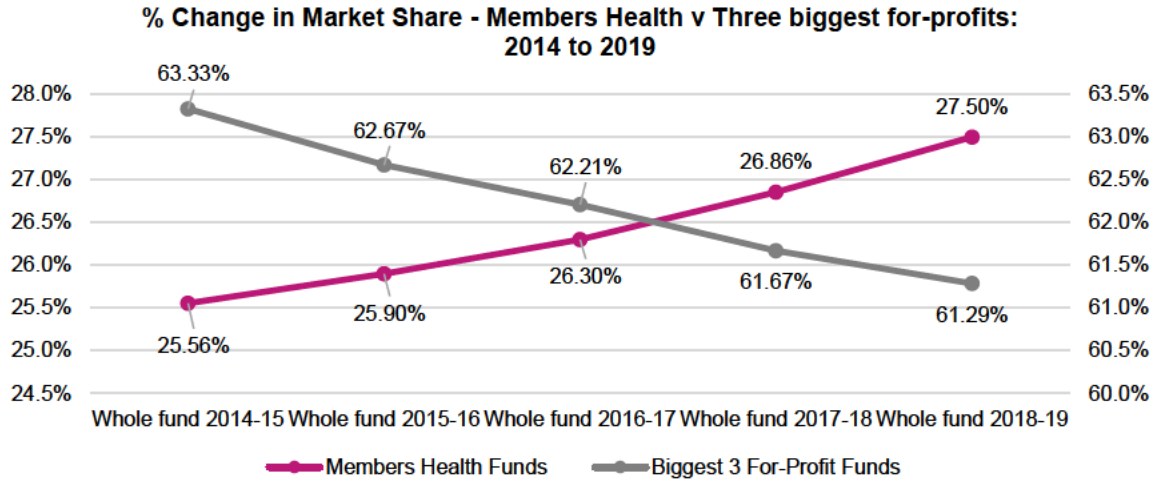
If APRA is to pursue new capital requirements, then it must be done so as not to stifle innovation or lessen the smaller funds' ability to compete on a level playing field. Fewer smaller health funds competing on price and value will leave Australians with fewer choices and higher policy prices. The last thing consumers would want is a consolidated health insurance landscape with just three health funds, as sensationally predicted by APRA earlier this year.[4]

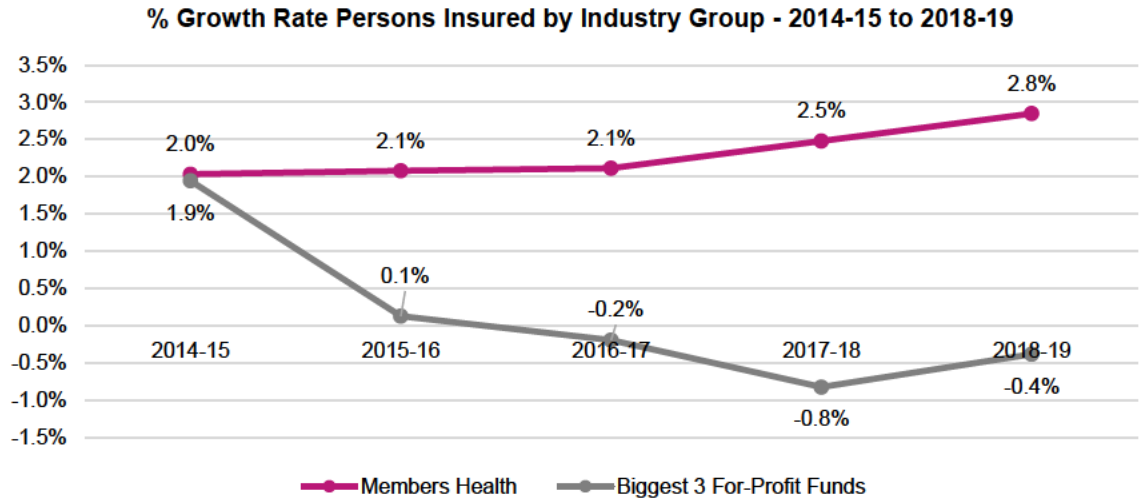
The new capital standards are being developed against a wider backdrop of small but never-the-less declining participation rates in private health insurance. There are affordability challenges and declining incomes among younger and healthier Australians[5]. Costly and burdensome industry regulation will act to exacerbate the underlying policy issue of declining PHI participation rather than alleviate it and this must be a key consideration in the development of new standards and regulation by APRA.

For these reasons above, and given the potential impact of APRA's proposals for new capital standards, Members Health strongly suggests that detailed consideration should be given to the

[1] PHIAC: Competition in the Australian Private Health Insurance Market, 2013: https //www thecie.com.au/wp-content/uploads/2014/06/130603-Competition-in-the-Australian-PHI-market-RP1 pdf
[2] Senate Community Affairs References Committee: *Value and affordability of private health insurance and out-of-pocket medical costs*, December 2017: https://www.aph gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Privatehealthinsurance/~/media/Committees/clac_ctte/Privatehealthinsurance/Report/report.pdf
[3] See: https://membershealth.com.au/wp-content/uploads/2020/07/2020-03-31-Why-Members-Health-funds-in-numbers.pdf
[4] See: https://www.apra gov.au/news-and-publications/apra-member-geoff-summerhayes-speech-to-members-health-directors-professional
[5] Productivity Commission: Why did young peoples' incomes decline? July 2020: https://www.pc.gov.au/research/completed/youth-income-decline

potential impact of any proposed new capital standards on consumers. Moreover, the Australian Competition and Consumer Commission (ACCC) should be included in the consultation process and encouraged to provide inputs and views.





4 Summary of response to APRA key areas

4.1 Scope of capital standard

APRA's capital standard must take care not to hamper the industry's ability to compete with non-regulated entities as it seeks to diversify sources of revenue outside of PHI.

APRA has proposed that the scope of the new capital standards will be broadened beyond the health benefits fund to that of the licenced insurer. At this time, relatively few insurers conduct activities outside the health benefits fund, however, this may change in the future. At this time it is not clear what sort of charges APRA intends to apply to the business conducted outside the health benefits fund, however, we would suggest that any charge will act to reduce the competitiveness of insurers'

offers in marketplaces where non-APRA regulated institutions also compete. Given current challenges being faced by the industry, many insurers are looking to diversify revenue streams and create other value-adding activities in support of their members. Any charges introduced to these activities need to be appropriately risk-sensitive so as not to hamper the industry's ability to compete and deliver better values to the members that they serve.

4.2 Solvency criteria to be met

MHFA agrees with APRA's proposal to remove the quantitative Solvency Standard and address this risk through supervisory activities, including the qualitative requirements set out in CPS 220.

4.3 Capital adequacy criteria to be met

APRA's capital standard and the resultant MCR levels must reflect the nature of PHI.

The life and general insurance industries which APRA regulates are generally multi-line businesses, with high exposures to location-based catastrophic losses, reinsurance partner viability, and potential for long-tailed latent claiming or exposure to long term shifts in economic assumptions. PHI simply does not exhibit these risks. As a result the overall level of capital required in PHI should be significantly lower than the life and general insurance industries. We believe it would be helpful if APRA demonstrates the minimum capital requirements relativities between these industries in making the case for any change to the minimum capital requirements.

We acknowledge that PHI as a form of insurance also shares characteristics with the life and general insurance industries, in particular risks relating to underpricing where the true underlying exposure is not sufficiently well understood by the insurer. However, unlike life and general insurance, PHI claims are very short-tailed by their nature and this coupled with the absence of catastrophe exposures mean that any underpricing can be identified very quickly by insurers, allowing a response strategy to be implemented quickly.

4.4 Capital treatment of insurance risk

4.4.1 Balance sheet – insurance liability risk

APRA liability risk charges should be commensurate with underlying risk.

While not specifically raised in the discussion paper, we urge APRA to review the collection of information undertaken for the assessment of insurance liabilities when setting the capital risk charges. In particular, risk charges should only be applied to amounts that are uncertain. Under the current capital standards, the amount reported as outstanding claims liabilities includes balances of presented but unpaid claims. Such balances are certain and, in the normal course of business, are paid soon after the valuation date. The current standard applies a capital charge to such balances, a charge that is disproportionate to the risk of the liability being mis-estimated.

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4.4.2 Adverse event stress

APRA needs to make clearer the case for and the intent of the adverse event stress.

APRA's proposal for a prescribed event stress considers *"a sudden and significant lapse or growth in membership of between 30 per cent and 50 per cent within one year, with the profile of membership changing in a way that increases the intensity of the stress for the insurer".*

While only in the consultation phase, we believe this prescribed event is poorly conceptualised. For larger insurers a growth or lapse of 50% within one year is almost inconceivable. While it may be more plausible for the smallest insurers, our members believe that any adverse event scenario should be:

1. Consistent with the level of risk inherent in the insurer's business model and the PHI sales/participation environment;
2. Broadly agreed by industry as being consistent with the intended probability of adequacy, and
3. Readily implemented and checked.

The discussion paper notes that the current capital framework does *"not appropriately reflect the risks faced by insurers, and does not adequately allow for consideration of adverse events that could affect their performance, such as extreme adverse events with low probability"*. However, neither APRA nor industry experts have been able to come up with a consistent, meaningful definition and example of such events that would impact insurers, beyond government intervention (i.e. sovereign risks). We do not believe that government policy or interventions in the health system are a matter for minimum prudential capital requirements, and rightly belong in an insurer's target capital assessment.

We observe, generally, significant adverse events over the past 20-30 years that have stressed individual insurers have related to rapid policy growth either in response to significant policy changes or entry into new markets. To some extent, these risk factors can be identified by insurers (or APRA) in advance and are most appropriately included when setting capital targets.

It is important that the capital standards reflect insurance risks relevant to PHI. Unlike the other forms of insurance that APRA regulates, private health insurance:

- Has minimal catastrophe risk;
- Has no specific contract term, and detrimental product changes addressing adverse claiming behaviour can be made with 60 days' notice to affected policyholders.

As a result we believe that there is no explicit need for an adverse event stress, and if APRA insists on including one in the standard, it should be relatively small commensurate with the potential for such a risk and insurers practical ability to respond to that risk.

4.5 Capital Base

APRA must continue to engage with insurers on the transition issues (both time and cost) arising from the changes in capital standards and the parallel changes via AASB17.

We note that APRA's current intent is to align the introduction of the capital standards to the introduction of AASB17. The intent is predicated on the assumption that this will be easier for insurers. However, at this time there is not sufficient information to understand the interaction and alignment of the capital standards with AASB17, and we ask APRA to maintain an open dialogue with insurers on the transition issues associated with both changes and not make assumptions that the system changes required will be identical in each case.

Collections and calculations should be consistent with accounting standards and requirements, with further details if required. Timings are in parallel but not quite aligned to the IFRS17 changes, which we do not support due to the complexity, extra work and uncertainty caused by not aligning them.

4.6 Capital Planning

APRA has expressed that requirements in respect to capital planning for PHI should be harmonised alongside that required for the life or general insurance industries.

MHFA notes APRA's desire to harmonise requirements across the industries it regulates and therefore the proposal to replace the existing capital management plan requirements with an ICAAP consistent with other industries. This is not a view shared by Members Health. Furthermore, it would be unreasonable to burden the industry with a higher regulatory expectation than that borne by other industries.

At present APRA has proposed that the PHI industry move to adopt the ICAAP while also retaining, the requirements of a Pricing Philosophy. Of the insurance industries that APRA regulates, PHI would appear to have the least pricing risks and yet it faces the most onerous pricing prudential regulation.

5 Response to specific discussion questions

5.1.1 Scope of the capital standards (2a)

APRA is proposing to broaden the scope of the standards to cover the insurer, rather than only the health benefits fund (HBF).

Figure 5 in APRA's discussion paper appears to suggest that the intent is to better deal with, for example, health related businesses. In practice almost all health related business is conducted from within the health benefits funds, and so we can see a case for ensuring that treatment of similar businesses within an insurer is consistent regardless of whether that business is conducted from within or outside of the health benefits fund.

The implication of the proposal will depend on the exact arrangements which are ultimately proposed by APRA. Activities sometimes undertaken outside the HBF include general insurance distribution (in exchange for commission), and care co-ordination. The nature and scale of these operations

suggest that any capital requirement need not be significant, and could be zero in the case of general insurance distribution for which there is no financial risk.

5.1.2 Level of sufficiency (2b, 4c)

APRA has proposed that the probability of sufficiency requirement apply on a gone concern basis, rather than a going concern basis. There is considerable confusion in the industry regarding precisely what APRA means by these terms, and suggest it would be helpful to provide definitions and show which elements of the standard are prepared on which basis.

APRA has asked insurers what the quantitative impact is of moving from 98 to 99.5 probability of sufficiency. Many of our members have commented that it is not possible to answer this without a proposal from APRA or indeed any clarity on the probability of sufficient achieved by the current standard which some actuaries have suggested targets a sufficiency greater than 98% given no allowance for diversification between different components of the calculation.

Finally we would add that APRA has regularly stated that they expect no change to the total level of industry capital as a result of the capital standards review. However, we would point out that any increase in the minimum capital requirement will cause insurers to review their capital management plans. APRA is aware that many not-for-profit insurers include consideration of the probability of a breach of regulatory capital (or the MCR) as a key pillar in their target capital calculations. An increase in the MCR is likely to increase the target capital levels adopted by the not-for-profit segment all else being equal. The options available to not-for-profit insurers to fund this increase are limited, and are likely to place upward pressure on premium increases.

5.1.3 Defining the capital base (2c, 2d, 2e)

The majority of MHFA member insurers are mutual organisations where retained earnings comprise a significant proportion, if not all, of the capital of the entity. In these cases, a significant proportion of, if not all, of the capital will be classified as Common Equity Tier 1 Capital (CET1). Consequently, the proposed restrictions on the composition of an insurer's capital that is eligible to be included in the capital base will have minimal, and in most cases, no impact on MHFA insurers.

As APRA has noted Mutual Equity Instruments (MEIs) are new and untested, and there are uncertainties regarding the cost of capital through MEIs. At this time MHFA cannot comment on the impacts of the proposal but is supportive of APRA's intent to allow these instruments to form a part of an insurer's capital base and suggest that the introductory limits or caps applied be revisited at such time as more information on these instruments becomes available.

5.1.4 Insurance risk and insurance concentration risk (2f, 2g, 2h & 2i)

APRA liability risk charges should be commensurate with underlying risk and benchmarked to similar risk charges from short-tailed general insurance lines of business.

While not specifically raised in the discussion paper, we urge APRA to review the collection of information undertaken for the assessment of insurance liabilities when setting the capital risk charges. In particular, risk charges should only be applied to amounts that are uncertain. Under the current capital standards, the amount reported as outstanding claims liabilities includes balances of

presented but unpaid claims. Such balances are certain, and simply waiting to be paid the day or two following the valuation date, however, the current standard applies a capital charge to such balances, a charge that is disproportionate to the risk of the liability being mis-estimated.

5.1.5 Asset risk and asset concentration risk (2j, 2k)

Notwithstanding APRA's statement that asset risks are the same regardless of which industry an insurer operates in, we note that the asset risk charge calibration for LAGIC was conducted a number of years ago and has not been updated. We would suggest the review of the capital standards framework provides a timely opportunity for APRA to conduct an update of the calibration factors or an opportunity to take the PHI industry through the evidentiary support base for the approach adopted.

5.1.6 Operational risk (2l)

MHFA believes that the operational risk charge under the current standard is simple, well understood and achieves an appropriate loading for PHI business. Any change to the calculation methodology should consider these three criteria.

5.1.7 Aggregation benefit (2m)

MHFA does not have any in principle disagreement with APRA's proposed formula or the suggested correlation factor of 0.2. We believe there would be value in APRA sharing any evidentiary support or other justification for the correlation assumption finally adopted.

5.1.8 Minimum prescribed capital (2n, 2o)

While at the time of this submission all Members Health insurers had capital in excess of $5 million, APRA has not made a compelling case as to why a minimum prescribed amount is justified. APRA has stated that the intent of the capital standards framework is to make them more risk sensitive. MHFA suggests that there is no need for a formal minimum capital requirement provided all other elements of the PCA calculation are appropriately calculated. This is achieved under the current standards through the non-linear nature of the operational risk amount. If APRA felt that the $1.2m minimum applied was too low, this could be adjusted through the re-calibrated operational risk charge.

5.1.9 Regulatory reporting

MHFA supports the alignment of APRA's reporting requirements with those of AASB 17, under the assumption that this minimises the systems and reporting burden on insurers. The necessity of aligning implementation with AASB 17 will also depend on the changes APRA ultimately proposes and may lead to a variation in the implementation date if AASB 17 is further delayed as appears likely at the time of writing.

We ask APRA to remain in close contact with insurers to understand the practical transition issues (time and cost) for insurers, noting that APRA's current intent to align the introduction of the capital

standards to the introduction of AASB17 is predicated on the assumption that this will be easier for insurers.

6 Closing Remarks

Members Health appreciates APRA's ongoing engagement with industry on this important subject. We also recognise that, at this time, APRA's proposals are largely conceptual and have not been defined to the degree needed to enable quantitative impacts to be measured.

Considering this, we encourage APRA to pursue a consultative process that ensures a capital framework for PHI that:

- Gives detailed consideration to the potential impact of any proposed new capital standards on competition and consumers.
- Avoids unnecessary complexity and be as easy to implement as possible.
- Is cognisant of the transition issues (time and cost) for insurers, noting that APRA's current intent to align the introduction of the capital standards to the introduction of AASB17 is predicated on the assumption that this will be easier for insurers.
- Is appropriately tailored to the nature of PHI insurance risk.
- Ensures the minimum capital requirements are commensurate with the level of risk inherent in the business model and benchmarked to minimum capital requirements for general insurers after adjusting for risk.
- Suitably justifies departures and any 'improvements' on previous capital standards. For example, we believe that many of APRA's requirements could be met with a minimum capital requirement broadly similar to that operating in PHI prior to 2014.

We look forward to continuing to engage with the regulator throughout this process and invite any further queries relating to our submission.

Yours sincerely,

[redacted]

[redacted]
CEO, Members Health Fund Alliance