



## Prudential Standard HPS 110

### Capital Adequacy

#### **Objectives and key requirements of this Prudential Standard**

This Prudential Standard requires a private health insurer to maintain adequate capital against the risks associated with its activities.

The ultimate responsibility for the prudent management of capital of a private health insurer rests with its Board of directors. The Board must ensure that the private health insurer maintains an adequate level and quality of capital commensurate with the scale, nature and complexity of its business and risk profile, such that it is able to meet its obligations under a wide range of circumstances.

The key requirements of this Prudential Standard are that a private health insurer must:

- have an Internal Capital Adequacy Assessment Process;
- maintain required levels of capital within each of its funds and for the private health insurer;
- determine each fund's prescribed capital amount having regard to a range of risk factors that may adversely impact the private health insurer'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 of each fund and the private health insurer;
- seek APRA's consent for certain planned capital reductions of the private health insurer; and
- inform APRA of any significant adverse changes in the capital position of the private health insurer as a whole or any of its funds.

**Table of Contents**

Authority.....	3
Application and commencement.....	3
Interpretation.....	3
Responsibility for capital management .....	3
Internal Capital Adequacy Assessment Process.....	3
Capital base .....	6
Prudential Capital Requirement .....	7
Prescribed Capital Amount .....	7
Insurance Risk Charge .....	8
Asset Risk Charge.....	8
Asset Concentration Risk Charge.....	8
Operational Risk Charge .....	8
Aggregation benefit .....	8
Tax benefits.....	9
APRA may adjust the Prescribed Capital Amount for calculating the prescribed capital amount .....	10
Supervisory adjustment .....	10
Disclosure .....	10
Reductions in capital base .....	11
Materiality .....	12
Notification requirements .....	12
Adjustments and exclusions .....	12
Transition .....	12
Previous exercise of discretion .....	13
Attachment A – Transitional Arrangements .....	14

**Authority**

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

**Application and commencement**

2. This Prudential Standard applies to all **private health insurers** except where expressly noted otherwise.
3. A private health insurer must apply this Prudential Standard separately to each of its **health benefits funds** and its **general fund**, in addition to the private health insurer as a whole, unless otherwise noted. The term ‘private health insurer’ refers to the private health insurer as a whole. The term ‘fund’ refers to each health benefits fund and the general fund, unless otherwise noted.
4. This Prudential Standard applies to private health insurers from 1 July 2023.

**Interpretation**

5. Terms that are defined in Prudential Standard HPS 001 Definitions appear in bold the first time they are used in this Prudential Standard.

**Responsibility for capital management**

6. Capital is the cornerstone of a private health insurer’s financial strength. It supports a private health insurer’s operations by providing a buffer to absorb unanticipated losses from its activities and, in the event of such losses, enables the private health insurer to continue to meet its insurance obligations.
7. As a consequence of the key role played by capital in the financial strength of a private health insurer, the **Board** of a private health insurer must ensure that:
  - (a) the private health insurer as a whole; and
  - (b) each fund

has capital that is adequate for the scale, nature and complexity of its business and its risk profile, such that it is able to meet its obligations under a wide range of circumstances.

**Internal Capital Adequacy Assessment Process**

8. A private health insurer must have in place an **Internal Capital Adequacy Assessment Process** (ICAAP) that considers each fund as well as the private health insurer as a whole. The ICAAP must:
  - (a) be adequately documented, with the documentation made available to APRA on request; and
  - (b) be approved by the Board initially, and when significant changes are made.

9. A private health insurer's ICAAP must be appropriate to the private health insurer's size, business mix and the complexity of its operations.
10. A private health insurer that is part of a group may rely on the ICAAP of the group provided that the Board of the private health insurer is satisfied that the group ICAAP meets the criteria in paragraph 11 in respect of the private health insurer.
11. The ICAAP must include at a minimum:
  - (a) adequate policies, procedures, systems, controls and personnel to identify, measure, monitor and manage the risks arising from the private health insurer's activities on a continuous basis, and the capital held against such risks;
  - (b) a strategy for ensuring adequate capital is maintained over time, including specific capital targets set in the context of the private health insurer's risk profile, the Board's risk appetite and regulatory capital requirements. This includes plans for how target levels of capital are to be met and the means available for sourcing additional capital where required;
  - (c) actions and procedures for monitoring the private health insurer's compliance with its regulatory capital requirements and capital targets. This includes the setting of triggers to alert management to, and specified actions to avert and rectify, potential breaches of the regulatory capital requirements;
  - (d) stress testing and scenario analysis relating to potential risk exposures and available capital resources;
  - (e) processes for reporting on the ICAAP and its outcomes to the Board and senior management of the private health insurer, and for ensuring that the ICAAP is taken into account in making business decisions;
  - (f) policies to address the capital impact of material risks not covered by explicit regulatory capital requirements; and
  - (g) an 'ICAAP summary statement' as defined in paragraph 12.
12. The ICAAP summary statement is a high level document that describes and summarises the capital assessment and management processes of the private health insurer. It must outline at a minimum the aspects of the ICAAP listed in paragraphs 11(a) to 11(f) and this paragraph. The ICAAP summary statement must also include:
  - (a) a statement of the objectives of the ICAAP, the expected level of financial soundness associated with the capital targets and the time horizon over which the ICAAP applies;
  - (b) a description of the key assumptions and methodologies utilised by the private health insurer in its ICAAP, including stress testing and scenario analysis;

- (c) triggers for reviewing the ICAAP in light of changes to business operations, regulatory, economic and financial market conditions, and other factors affecting the private health insurer's risk profile and capital resources;
  - (d) a summary of the private health insurer's policy for reviewing its ICAAP, including who is responsible for the review, details of the frequency and scope of the review, and mechanisms for reporting on the review and its outcomes to the Board and senior management;
  - (e) 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; and
  - (f) references to supporting documentation and analysis, as relevant.
13. A private health insurer must ensure its ICAAP is subject to regular and robust review by appropriately qualified persons who are operationally independent of the conduct of capital management. The frequency and scope of the review must be appropriate to the private health insurer, having regard to its size, business mix, complexity of its operations, and the nature and extent of any changes that have occurred or are likely to occur in its business profile or its risk appetite. A review must be conducted at least every three years. The review must be sufficient to reach a view on whether the ICAAP is adequate and effective.
14. A private health insurer must, on an annual basis, provide a report on the implementation of its ICAAP to APRA (**ICAAP report**). A copy of the ICAAP report must be provided to APRA no later than three months from the end of the ICAAP annual reporting period to which it relates.
15. The ICAAP report must include:
- (a) detailed information on current and three-year projected capital levels relative to minimum regulatory capital requirements and target levels for the private health insurer and each fund;
  - (b) detailed information on the actual outcomes of applying the ICAAP over the period, relative to the planned outcomes in the previous ICAAP report (including analysis of the private health insurer's actual capital position relative to minimum regulatory capital requirements and capital targets and actual-versus-planned capital management actions);
  - (c) description of material changes to the ICAAP since the previous ICAAP report;
  - (d) detail and outcomes of stress testing and scenario analysis used in undertaking the ICAAP;
  - (e) a breakdown of capital usage over the planning horizon, as relevant, by material:
    - (i) business activity;

- (ii) geographic spread of exposures; and
  - (iii) risk types;
  - (f) an assessment of anticipated changes in the private health insurer's risk profile or capital management processes over the planning horizon;
  - (g) 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
  - (h) references to supporting documentation and analysis as relevant.
16. The ICAAP report submitted to APRA by the private health insurer must be accompanied by a declaration approved by the Board and signed by the CEO stating whether:
- (a) capital management has been undertaken by the private health insurer in accordance with the ICAAP over the period and, if not, a description of, and explanation for, deviations;
  - (b) the private health insurer has assessed the capital targets contained in its ICAAP to be adequate given the size, business mix and complexity of its operations; and
  - (c) the information included in the ICAAP report is accurate in all material respects.

### Capital base

17. In assessing the adequacy of a fund's or a private health insurer's **capital base**, attention must be paid not only to the risks it is likely to face, but also the quality of the support provided by various forms of capital. In assessing the quality of support provided by a particular form of capital, regard must be had to the extent to which it:
- (a) provides a permanent and unrestricted commitment of funds;
  - (b) is freely available to absorb losses;
  - (c) does not impose any unavoidable servicing charges against earnings; and
  - (d) ranks behind the claims of **policy holders** and creditors in the event of the winding-up of the private health insurer.
18. Not all forms of capital meet these criteria equally. Due to the need to ensure that the capital base of a private health insurer provides adequate support for its activities, APRA imposes some restrictions on the composition of the capital base. The forms of capital deemed eligible for inclusion in the capital base, and the conditions as to their inclusion, are specified in *Prudential Standard HPS 112 Capital Adequacy: Measurement of Capital* (HPS 112). HPS 112 defines the different categories and components of the capital base and the restrictions on the

quality of the capital that is used to meet the required level of capital for regulatory purposes.

19. A fund's or private health insurer's balance sheet may contain certain assets (such as deferred tax assets, goodwill and other intangibles) that are acceptable from an accounting perspective. However, for supervisory purposes, such assets are either generally not available, or of questionable value, should the fund or private health insurer encounter difficulties. A private health insurer is therefore required to make certain adjustments in determining the capital base. Details of these adjustments are specified in HPS 112.

### **Prudential Capital Requirement**

20. This Prudential Standard establishes a risk-based approach for measuring the capital adequacy of a private health insurer or its funds. This required level of capital for regulatory purposes is referred to as the **Prudential Capital Requirement (PCR)**. The PCR is intended to take account of the full range of risks to which a fund or private health insurer is exposed.
21. A private health insurer must ensure that the private health insurer and each of its funds have a capital base, at all times, in excess of its PCR.
22. The PCR of a fund equals:
  - (a) a **prescribed capital amount** as determined by this Prudential Standard; and
  - (b) any **supervisory adjustment** determined by APRA under paragraph 41.
23. The prescribed capital amount for a private health insurer is the sum of the prescribed capital amounts of each of its funds.
24. The prescribed capital amount for a health benefits fund of a private health insurer cannot be less than \$5 million. There is no minimum prescribed capital amount applicable to the general fund.
25. The PCR for a private health insurer is the sum of the PCRs of each of its funds (or such higher amount as determined by APRA under paragraph 41).

### **Prescribed Capital Amount**

26. The prescribed capital amount is determined as:
  - (a) the Insurance Risk Charge; plus
  - (b) the Asset Risk Charge; plus
  - (c) the Asset Concentration Risk Charge; plus
  - (d) the Operational Risk Charge; less
  - (e) an 'aggregation benefit' as defined in paragraph 32 to 34; less

- (f) tax benefits.
27. The prescribed capital amount is intended to be sufficient, such that if a fund was to start the year with a capital base equal to the prescribed capital amount, and losses occurred at the 99.5 per cent confidence level then the assets remaining would be at least sufficient to provide for the **central estimate** of insurance liabilities and other liabilities at the end of the year. The other liabilities to be provided for exclude those liabilities that satisfy the criteria for inclusion in the capital base.

#### *Insurance Risk Charge*

28. The Insurance Risk Charge relates to the risk of adverse financial impacts due to movements in existing and future claims, expenses, and other insurance risks such as adverse events. The method for determining the Insurance Risk Charge is set out in *Prudential Standard HPS 115 Capital Adequacy: Insurance Risk Charge* (HPS 115).

#### *Asset Risk Charge*

29. The Asset Risk Charge relates to the risk of adverse movements in the value of on-balance sheet and off-balance sheet exposures. The method for determining the Asset Risk Charge is set out in *Prudential Standard HPS 114 Capital Adequacy: Asset Risk Charge* (HPS 114). Asset risk can be derived from a number of sources, including market risk and credit risk. For the purposes of this Prudential Standard and HPS 114, assets and exposures must be valued in accordance with the relevant reporting standards made under the *Financial Sector (Collection of Data) Act 2001* (FSCODA).

#### *Asset Concentration Risk Charge*

30. The Asset Concentration Risk Charge relates to the risk resulting from concentrations in individual assets or large exposures to individual counterparties or groups of related counterparties. The method for determining the Asset Concentration Risk Charge is set out in *Prudential Standard HPS 117 Capital Adequacy: Asset Concentration Risk Charge*.

#### *Operational Risk Charge*

31. The Operational Risk Charge relates to the risk of loss resulting from inadequate or failed internal processes, people and systems or from external events. The method for determining the Operational Risk Charge is set out in *Prudential Standard HPS 118 Capital Adequacy: Operational Risk Charge*.

#### *Aggregation benefit*

32. The aggregation benefit makes an explicit allowance for diversification between asset and insurance risks in the calculation of the prescribed capital amount.
33. The aggregation benefit formula is:



$$\text{Aggregation benefit} = (A + I) - \sqrt{A^2 + I^2 + 2 \times \text{correlation} \times A \times I}$$

where:

- (a) 'A' is the Asset Risk Charge;
  - (b) 'I' is the Insurance Risk Charge; and
  - (c) 'correlation' is 20 per cent.
34. The Asset Concentration Risk Charge and the Operational Risk Charge are not included in the calculation of the aggregation benefit.

### *Tax benefits*

35. Recognition is able to be made for future shareholder tax benefits arising from losses occurring within the Insurance Risk Charge and Asset Risk Charge of a fund. A private health insurer may reduce the prescribed capital amount by the aggregate amount of any tax benefits that can be netted against deferred tax liabilities as specified in HPS 112.
36. The tax benefits from the Asset Risk Charge are the tax benefits resulting from scenarios modelled by the stress tests in HPS 114, reduced to allow for the reduction in Asset Risk Charge due to the asset risk aggregation formula. The tax benefits are therefore calculated as:

$$\text{tax benefits from asset stress tests} \times \frac{\text{aggregated asset risk charge component}}{\text{sum of asset risk charge components}}$$

37. The tax benefits from the Insurance Risk Charge are the tax benefits resulting from losses in the Insurance Risk Charge in HPS 115.
38. Overall tax benefits are to be reduced to allow for aggregation between the Asset Risk Charge and Insurance Risk Charge. Tax benefit aggregation reduction is calculated as:

$$\begin{aligned} &\text{Tax benefit aggregation reduction} \\ &= (TA + TI) - \sqrt{TA^2 + TI^2 + 2 \times \text{correlation} \times TA \times TI} \end{aligned}$$

where:

- (a) 'TA' is the tax benefits from Asset Risk Charge in Paragraph 36;
  - (b) 'TI' is the tax benefits from Insurance Risk Charge in Paragraph 37; and
  - (c) 'correlation' is 20 per cent.
39. Tax benefits must only be recognised as a deduction from the prescribed capital amount if tax legislation allows them to be absorbed by the existing deferred tax liabilities. For this purpose, the deferred tax liabilities are those liabilities (if any) that remain after netting off the deferred tax assets and liabilities in the calculation of the deductions from **Common Equity Tier 1 Capital** in HPS 112.

*APRA may adjust the Prescribed Capital Amount for calculating the prescribed capital amount*

40. If APRA is of the view that the prescribed capital amount does not produce an appropriate outcome in respect of a particular fund, or a private health insurer has used inappropriate judgement or estimation in calculating the prescribed capital amount, APRA may, in writing, adjust any aspect of the prescribed capital amount calculation for that fund. If such an adjustment is applied to a fund under this paragraph, a private health insurer must comply with the adjusted calculation.

### **Supervisory adjustment**

41. APRA recognises that any measure of the adequacy of a fund or private health insurer's capital involves judgement and estimation, including quantification of risks that may be difficult to quantify. If APRA is of the view that there are prudential reasons for doing so, APRA may, in writing, determine a supervisory adjustment to be included in the PCR of a fund or private health insurer.

### **Disclosure**

42. To improve the understanding of its capital adequacy position by policy holders and other market participants, a private health insurer must publish, at least annually, the following items for the private health insurer:
- (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 of the private health insurer derived from the items (a) to (f);
  - (h) the prescribed capital amount; and
  - (i) the capital adequacy multiple (item (g) divided by item (h)).
43. A private health insurer must also publish, at least annually, the following items for each of its funds:
- (a) the amount of the fund's 'net assets', after applying any regulatory adjustments;

- (b) the aggregate amount of any regulatory adjustments applied to the fund's net assets;
  - (c) the amount of Tier 2 Capital held by the fund;
  - (d) the aggregate amount of any regulatory adjustments applied in the calculation of the fund's Tier 2 Capital;
  - (e) the total capital base of the fund derived from the items (a) to (d);
  - (f) the fund's prescribed capital amount;
  - (g) the components of the fund's prescribed capital amount<sup>1</sup> specified in paragraph 26; and
  - (h) the capital adequacy multiple of the fund (item (e) divided by item (f)).
44. A private health insurer must publish the information specified in paragraphs 42 and 43 so that it is readily accessible to both policy holders and other market participants.
45. A private health insurer must not disclose any supervisory adjustment determined by APRA in accordance with paragraph 41.

### Reductions in capital base

46. A private health insurer must obtain APRA's written approval prior to making any planned reduction in its capital base.
47. A reduction in a private health insurer's capital base includes:
- (a) a share buyback or the redemption, repurchase or repayment of any qualifying Common Equity Tier 1 Capital, Additional Tier 1 Capital and Tier 2 Capital instruments issued by the company;
  - (b) trading in the private health insurer's own shares or capital instruments outside of any arrangement agreed upon with APRA in accordance with HPS 112; and
  - (c) the aggregate amount of dividend payments on ordinary shares that exceeds a private health insurer's after-tax earnings (as reported to APRA in the private health insurer's **statutory accounts**) after taking into account any payments on more senior capital instruments, in the financial year<sup>2</sup> to which they relate.

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<sup>1</sup> This item must separately identify any transition amount approved by APRA under the **capital standards**.

<sup>2</sup> 'Financial year' means the last four quarters for which the private health insurer was required to submit quarterly returns in accordance with reporting standards made under FSCODA to APRA preceding the date of the proposed dividend.

48. A private health insurer proposing a capital reduction must provide APRA with a forecast showing the projected future capital position (including PCR) after the proposed capital reductions. The forecast should extend for at least two years.
49. A private health insurer must satisfy APRA that its capital base will remain adequate for its future needs after a proposed reduction.

### Materiality

50. A private health insurer may take into account materiality when calculating its capital base and prescribed capital amount or the capital base and prescribed capital amount of each of its funds. Particular values or components are considered material to the overall result of a calculation if misstating or omitting them would produce results likely to be misleading to the users of the information.

### Notification requirements

51. A private health insurer must inform APRA as soon as practicable of:
  - (a) any breach or prospective breach of its PCR or the PCR of any of its funds;
  - (b) any significant departure from its ICAAP;
  - (c) any significant adverse changes in the capital base or PCR of the private health insurer or any of its funds; or
  - (d) other necessary notification events under the Act.

The notice must include any remedial actions taken or planned to be taken to address the situation and the timing of these actions.

### Adjustments and exclusions

52. 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.

### Transition

53. From 1 July 2023, the ICAAP requirements in paragraphs 8 to 16 apply to
  - (a) **SFIs**; and
  - (b) any private health insurer that is a **non-SFI** but APRA has determined in writing for prudential reasons, the ICAAP requirements in paragraphs 8 to 16 should apply to it.
54. For all private health insurers that are **non-SFIs** and are not subject to an APRA determination under paragraph 53(b), the ICAAP requirements in paragraphs 8 to 16 apply from 1 July 2025.

55. Subject to paragraph 2 of Attachment A, a private health insurer must notify APRA by 30 June 2023, and provide the data (using a template provided by APRA) described in paragraphs 3(a) and 3(b) of Attachment A by 30 September 2023, if they adopt the transitional arrangements set out in Attachment A. A private health insurer that adopts the transitional arrangements set out in Attachment A may only do so until 30 June 2025.

**Previous exercise of discretion**

56. 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 – Transitional Arrangements

1. The transitional arrangements provide an adjustment to reduce the prescribed capital amount that is phased out over a two-year period.
2. For the transitional requirements to be effective a private health insurer must notify APRA by 30 June 2023 and provide the data described in paragraphs 3(a) and 3(b) by 30 September 2023 using a template that will be provided by APRA.
3. The Transitional Adjustment is:

$$\text{Transitional Adjustment} = -\text{Min}((B - A) * X, C - A)$$

Where:

- (a) A is the capital adequacy requirement calculated under paragraph 9 of the version of Prudential Standard HPS 110 as determined on 26 June 2015 less balance sheet liabilities, as at 30 June 2023
  - (b) B is the prescribed capital amount calculated under this standard as at 30 June 2023
  - (c) C is the prescribed capital amount calculated at the most recent reporting date under this standard (prior to the transitional adjustment being applied)
  - (d) X is a percentage which reduces over time, as set out in Table 1
4. The Transitional Adjustment only applies where it reduces the prescribed capital amount calculated in accordance with this Prudential Standard.

**Table 1: Schedule for X in the Transitional Adjustment**

<b>Quarter commencing</b>	<b>X</b>
1 July 2023	100.0%
1 October 2023	87.5%
1 January 2024	75.0%
1 April 2024	62.5%
1 July 2024	50.0%
1 October 2024	37.5%
1 January 2025	25.0%
1 April 2025	12.5%