Financial Sector (Collection of Data) (reporting standard) determination No. 99 of 2023

Reporting Standard HRS 109.0 Claims

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

I, Michael Murphy, delegate of APRA, under paragraph 13(1)(a) of the *Financial Sector (Collection of Data) Act 2001* (the Act) and subsection 33(3) of the *Acts Interpretation Act 1901*, determine *Reporting Standard HRS 109.0 Claims,* in the form set out in the Schedule, which applies to the financial sector entities to the extent provided in paragraph 3 of the reporting standard.

Under section 15 of the Act, I declare that the reporting standard shall begin to apply to those financial sector entities on the day it is registered on the Federal Register of Legislation.

This instrument commences upon registration on the Federal Register of Legislation.

Dated: 18 May 2023

Michael Murphy

General Manager - Chief Data Officer (Acting)

Technology and Data Division

Interpretation

In this Determination:

APRA means the Australian Prudential Regulation Authority.

Federal Register of Legislation means the register established under section 15A of the *Legislation Act 2003.*

financial sector entity has the meaning given by section 5 of the Act.

Schedule

Reporting Standard HRS 109.0 Claims comprises the document commencing on the following page.

Reporting Standard HRS 109.0

Claims

Objective of this Reporting Standard

This Reporting Standard sets out requirements for the provision of information to APRA relating to a private health insurer's claims.

It includes associated specific instructions.

Authority

1. This Reporting Standard is made under section 13 of the *Financial Sector (Collection of Data) Act 2001*.

Purpose

2. The information reported to APRA under this Reporting Standard is used by APRA for the purpose of prudential supervision including assessing compliance with capital standards.

Application and commencement

3. This Reporting Standard applies to all private health insurers. This Reporting Standard applies for reporting periods ending on or after 1 July 2023.

Information required

4. A private health insurer must provide APRA with the information required by this Reporting Standard for each reporting period.

Method of submission

5. The information required by this Reporting Standard must be given to APRA:

   (a) in electronic format using an electronic method available on APRA's website; or

   (b) by a method notified by APRA prior to submission.

Reporting periods and due dates

6. Subject to paragraph 7, a private health insurer must provide the information required by this Reporting Standard:

   (a) in respect of each calendar quarter (i.e. the periods ending 30 September, 31 December, 31 March and 30 June); and

   (b) in respect of each year ending 30 June.

7. If, having regard to the particular circumstances of a private health insurer, APRA considers it necessary or desirable to obtain information more or less frequently than as provided by subparagraph 6(a) or 6(b), APRA may, by notice in writing, change the reporting periods, or specify reporting periods, for the particular private health insurer.

8. The information required by this Reporting Standard must be provided to APRA:

   (a) in the case of quarterly information, within 28 calendar days after the end of the reporting period to which the information relates;

   (b) in the case of annual information, by 30 September each year; or

   (c) in the case of information provided in accordance with paragraph 7, within the time specified by notice in writing.

9. APRA may, in writing, grant a private health insurer an extension of a due date, in which case the new due date will be the date on the notice of extension.

   Note: For the avoidance of doubt, if the due date for a particular reporting period falls on a day other than a usual business day, a private health insurer is nonetheless required to submit the information required no later than the due date.

Quality control

10. All information provided by a private health insurer under this Reporting Standard must be subject to systems, processes and controls developed by the private health insurer for the internal review and authorisation of that information. It is the responsibility of the Board and senior management of the private health insurer to ensure that an appropriate set of policies and procedures for the authorisation of information submitted to APRA is in place.

Annual audit requirements

11. The information submitted for the purposes of paragraph 8(b) is to be subject to external audit to ensure consistency with the private health insurer's statutory financial accounts and faithful application of the capital standards.

12. Audit certification and opinion must be provided to APRA by 30 September each year.

13. If a private health insurer received a qualified auditor's report for a health benefits fund, the general fund, or the private health insurer for the previous year (previous report), the current year's auditor's report must state whether the auditor has examined the

issues identified and is satisfied that the private health insurer has taken the appropriate steps to rectify the matters raised in the previous report.

14. The auditor's report must:

    (a) state details of the program adopted to carry out the audit; and

    (b) include the name of, and be signed by, the auditor who takes responsibility for the accuracy of the report.

Authorisation

15. A person who submits the information required under this Reporting Standard must be suitably authorised by an officer of the private health insurer.

Variations

16. APRA may, in writing, vary the reporting requirements of this Reporting Standard in relation to a private health insurer.

Interpretation

17. In this Reporting Standard:

    (a) unless the contrary intention appears, words and expressions have the meanings given to them in *Prudential Standard HPS 001 Definitions* (HPS 001); and

    (b) the following definitions are applicable:

    APRA means the Australian Prudential Regulation Authority established under the *Australian Prudential Regulation Authority Act 1998*;

    capital standards means the prudential standards which relate to capital adequacy, as defined in HPS 001;

    officer has the same meaning as in the Act;

    private health insurer has the same meaning as in the Act;

    reporting period means a period mentioned in paragraph 6 or, if applicable, paragraph 7; and

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

18. Unless the contrary intention appears, a reference to an Act, Prudential Standard, Reporting Standard, Australian Accounting or Auditing Standard is a reference to the instrument as in force from time to time.

Reporting Standard HRS 109.0

Claims

General instructions

Reporting tables

Tables described in this reporting standard list each of the data fields required to be reported. The data fields are listed sequentially in the column order that they will appear in the reported data set. Constraints on the data that can be reported for each field have also been provided.

Any specific combination of values in a table must not appear on more than one row in that table when reported.

Definitions

Terms highlighted in ***bold italics*** indicate that the definition is provided in these instructions.

C

Claim payment	Means the benefit paid to the policy holder (gross of risk equalisation trust fund payments/receipts).

H

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

Specific instructions

Table 1: HIB Claim Payments

Reporting basis

Report values on a cash flow basis.

This table applies to ***health benefits funds*** only.

This table applies to ***claim payments*** for health insurance business only, where health insurance business has the same meaning as in the Act.

Units of measurement

Report values in whole Australian dollars (no decimal places).

	Name	Valid values	Description
1	Private Health Insurer Fund Name	Free text	Report the name of the private health insurer fund. This is in the event an insurer has multiple ***health benefits funds***. In the event an insurer has only one ***health benefits fund***, its name should be the same as the insurer.
2	Month Claim Incurred	• 48 Months Prior • 47 Months Prior • 46 Months Prior • 45 Months Prior • 44 Months Prior • 43 Months Prior	Report the month the claim was incurred, using the reporting date as the current date.

	Name	Valid values	Description
		• 42 Months Prior • 41 Months Prior • 40 Months Prior • 39 Months Prior • 38 Months Prior • 37 Months Prior • 36 Months Prior • 35 Months Prior • 34 Months Prior • 33 Months Prior • 32 Months Prior • 31 Months Prior • 30 Months Prior • 29 Months Prior • 28 Months Prior • 27 Months Prior • 26 Months Prior • 25 Months Prior • 24 Months Prior • 23 Months Prior • 22 Months Prior • 21 Months Prior • 20 Months Prior • 19 Months Prior • 18 Months Prior • 17 Months Prior • 16 Months Prior • 15 Months Prior	

	Name	Valid values	Description
		• 14 Months Prior • 13 Months Prior • 12 Months Prior • 11 Months Prior • 10 Months Prior • 9 Months Prior • 8 Months Prior • 7 Months Prior • 6 Months Prior • 5 Months Prior • 4 Months Prior • 3 Months Prior • 2 Months Prior • 1 Month Prior • Same Month	
3	Month Claim Paid	• 2 months prior • 1 month prior • Same month	Report the month the claim was paid, using the reporting date as the current date.
4	Claim Payment Amount	Whole dollars	Report the ***claim payment*** amount.