Private health insurance in Australia: Current issues

Adam Jupp

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Actuaries Institute

Agenda

Introduction

Health system in Australia

Private health insurance in Australia

Making community rating work

The carrots and the sticks

What drives premium increases?

Current hot topics

- Prostheses pricing
- Complexity
- Junk cover

Introduction

1

Who am I?

2003	Bachelor of science (Actuarial Science) at Curtin University (1st intake!)
2004	WA Department of Health graduate program, over next three years worked way up to System modeller
2007	PwC
2010	Fellow of Institute of Actuaries of Australia
2013	Health Practice Committee member
2015	Appointed Actuary to two health insurers and one general insurer

Mandatory disclaimer – these views are my own and do not necessarily reflect those of my employer or the companies I work with.

Health system in Australia

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Health system in Australia
Who pays for what?

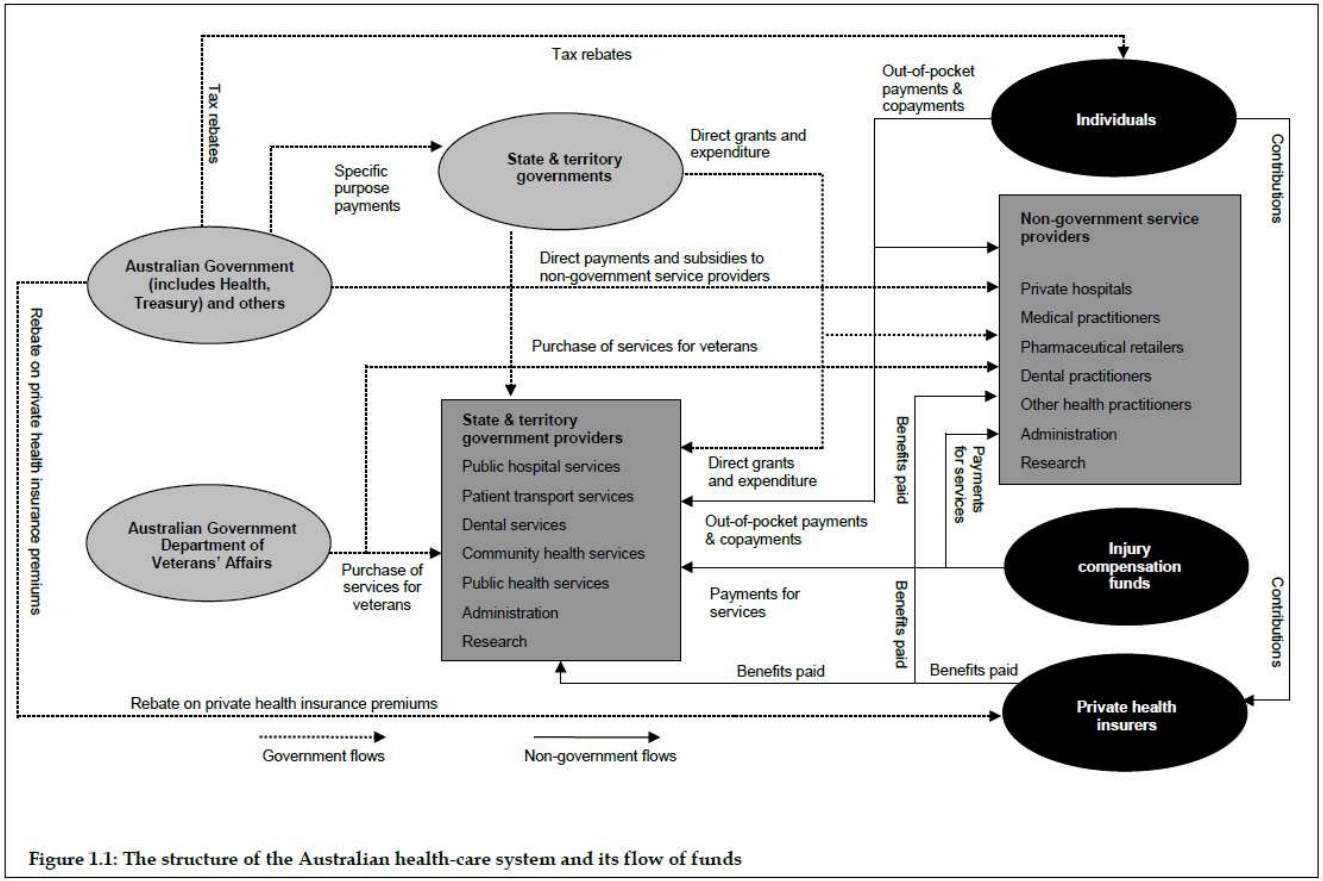
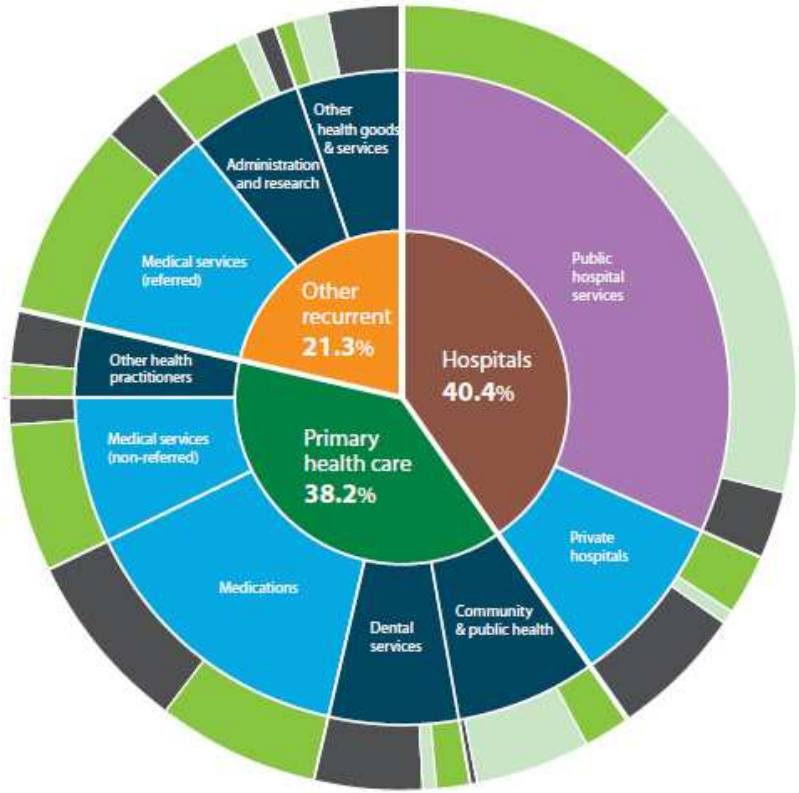


Figure 1.1: The structure of the Australian health-care system and its flow of funds

AIHW, Health expenditure 2013-14

Health system in Australia
Where does the money go?



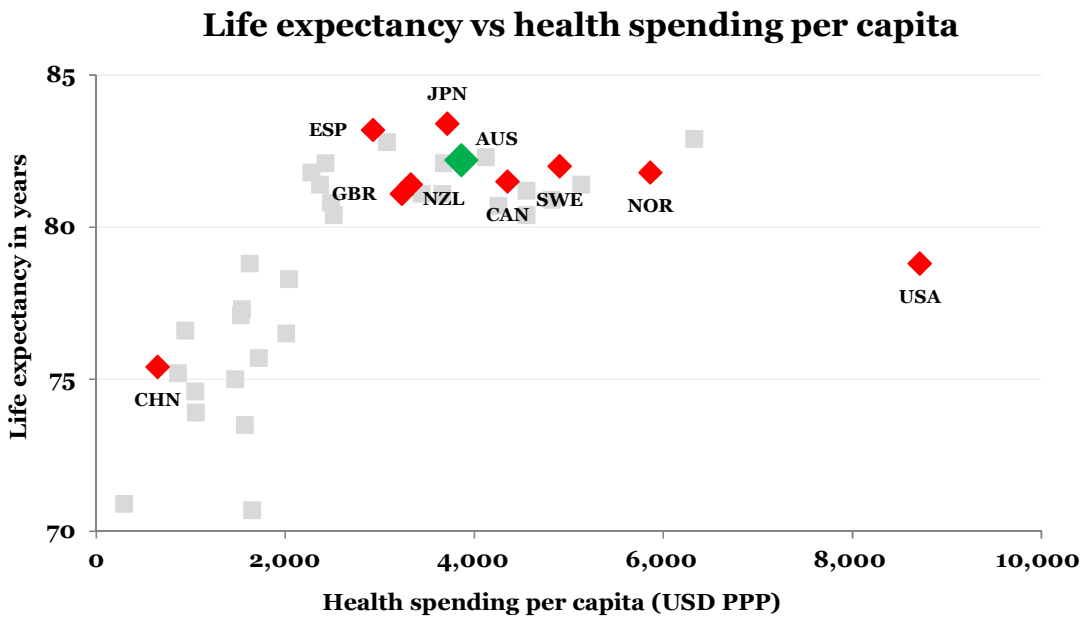
Share of expenditure
- Hospitals
- Primary health care
- Other recurrent

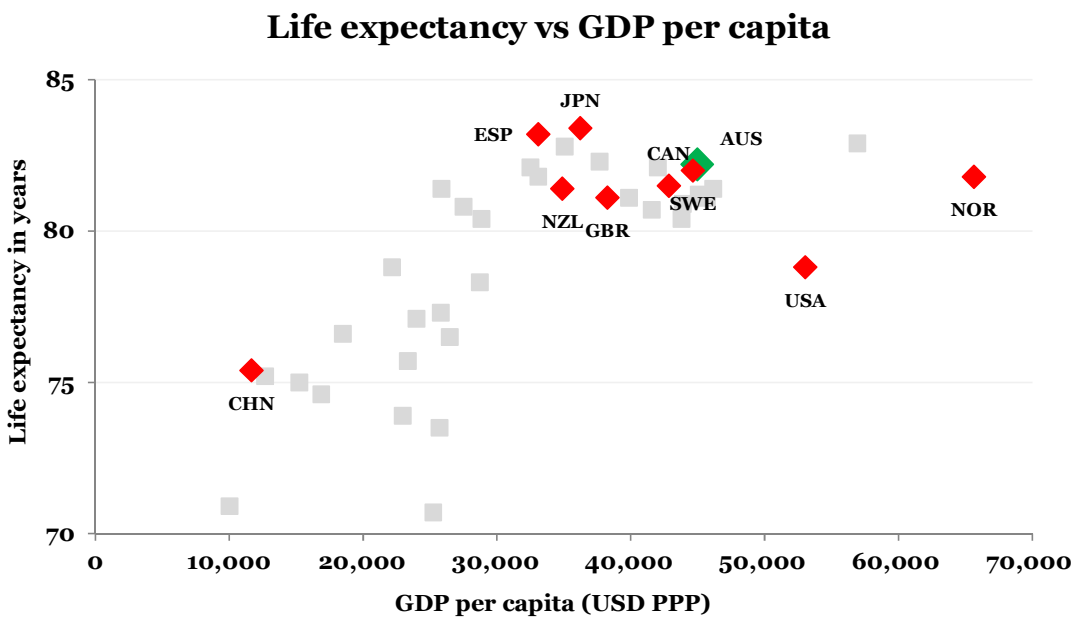
Responsibility for services
- Combined private sector and public sector —all levels of government
- State and territory governments
- Private providers

Funding
- Australian Government funding share
- State/territory government funding share
- Private funding share

AIHW, Australia's Health 2014

Health system in Australia
International comparison





OECD. (2015), Life expectancy at birth and health spending per capita, 2013 (or latest year), in *Health at a Glance 2015*, OECD Publishing, Paris.

Private health insurance in Australia

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Products offered
Complying health insurance products

Hospital

Services provided in a hospital inpatient setting covered by Medicare (e.g. have a MBS item)

Minimum level of rehabilitation, psychiatric and palliative care treatment

Minimum 25% of MBS fee for doctors' services

Provides choice of doctor and setting

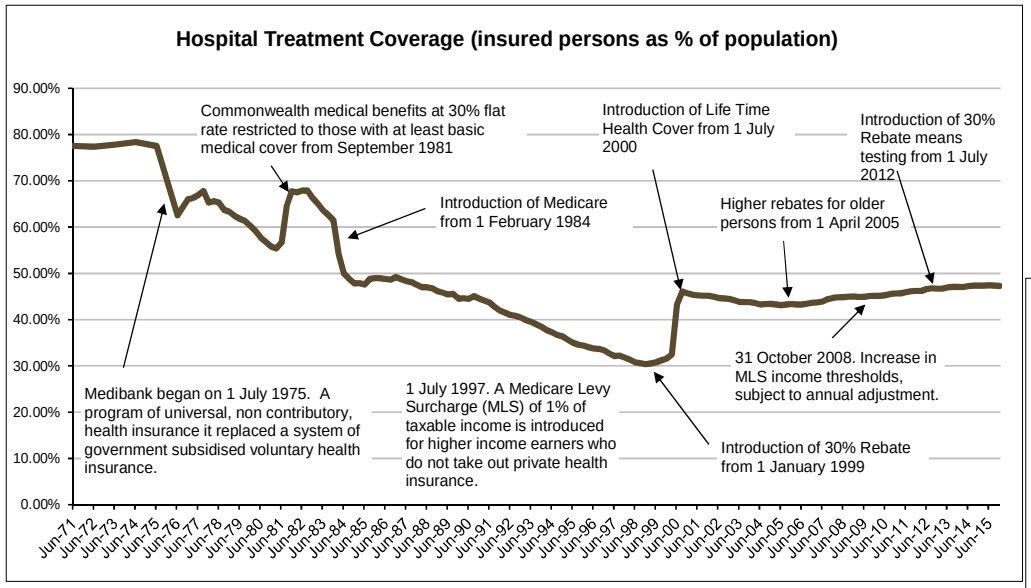
General treatment

Dental and allied health services provided in a non-hospital setting where there is not a Medicare benefit available

Subject to an annual limit

Insurer sets rebate levels or % back per item

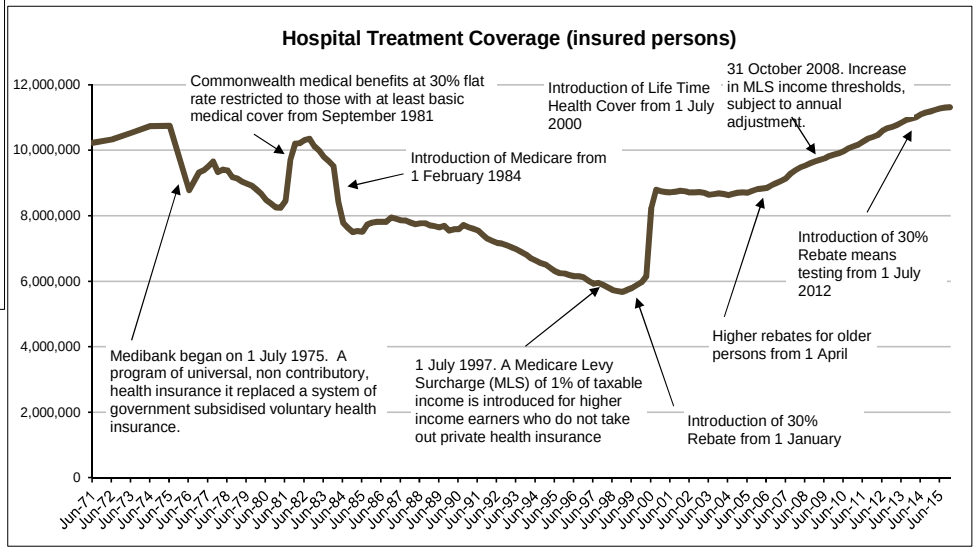
Historical coverage trends
Hospital treatment



Percentage covered is starting to plateau but sits at approximately 47% of the population.

Medicare had a negative impact on private health insurance in Australia.

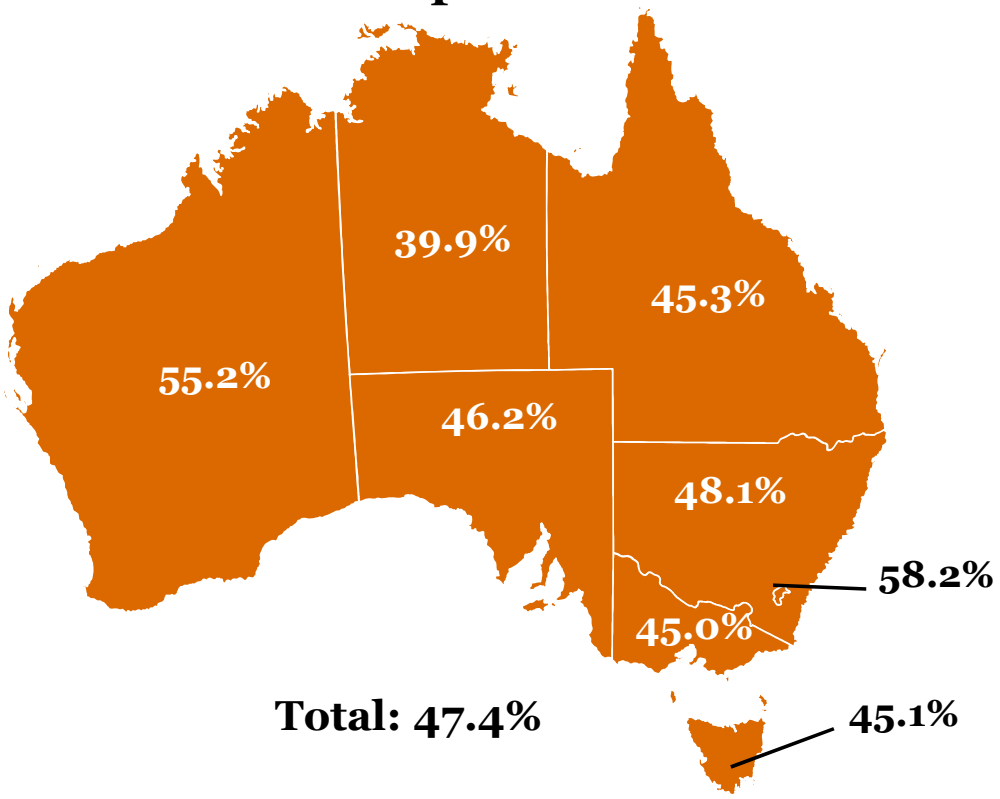
The policy decisions (and marketing campaign) in 1999-2000 reversed this trend.



State based covered

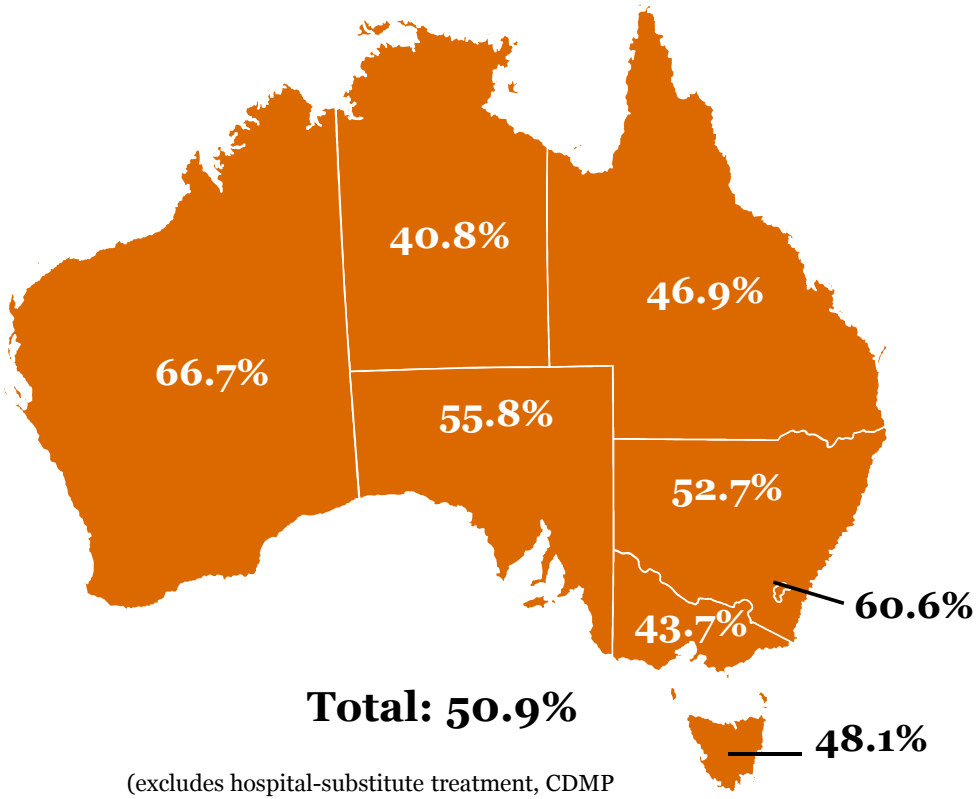
30 June 2015

Hospital



Total: 47.4%

General treatment

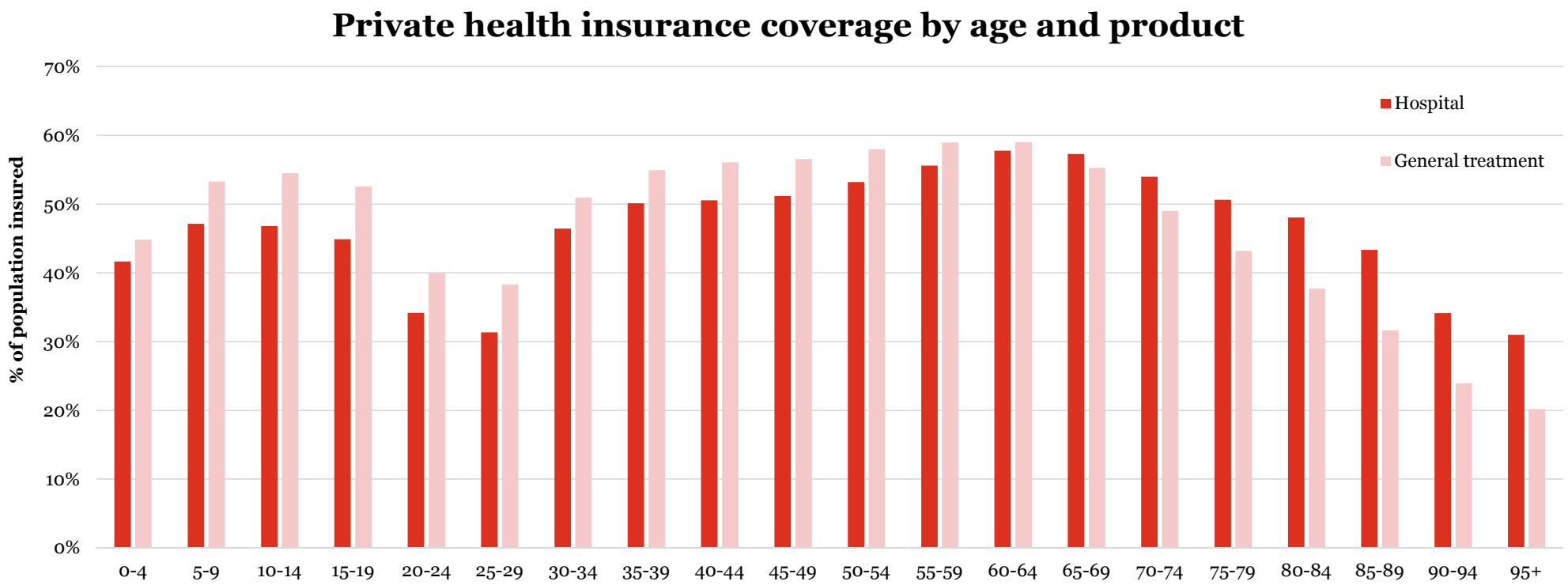


Total: 50.9%

(excludes hospital-substitute treatment, CDMP and hospital linked ambulance)

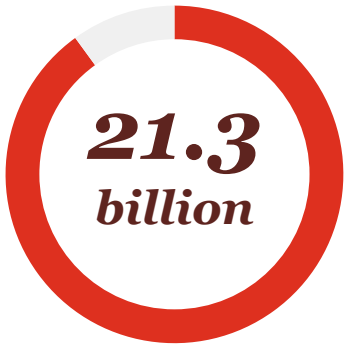
APRA Private Health Insurance Membership and Benefits

Coverage by age
30 June 2015

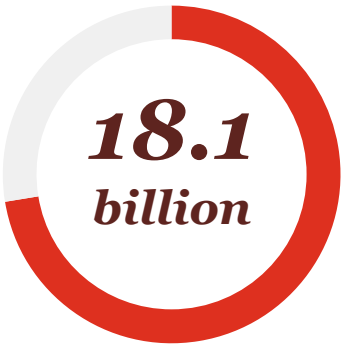


Industry structure
P&L over 2014/15

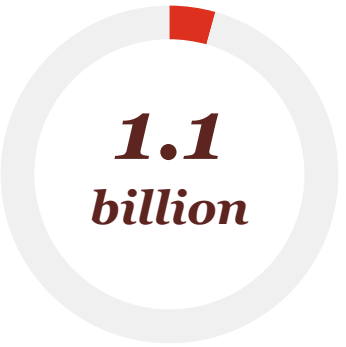
Revenue



Benefits



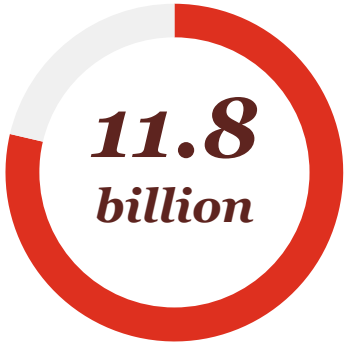
Profit



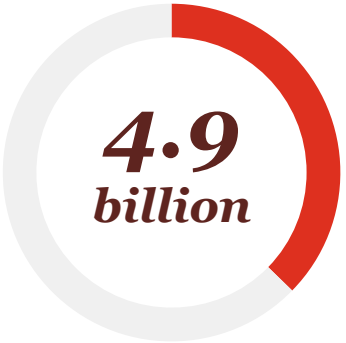
Industry structure

Balance sheet at December 2015

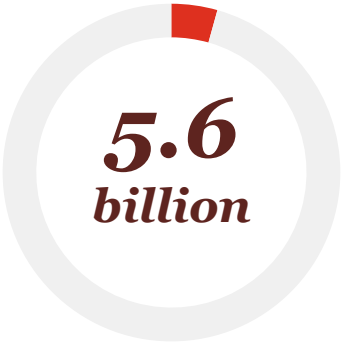
Assets



Liabilities



Excess capital

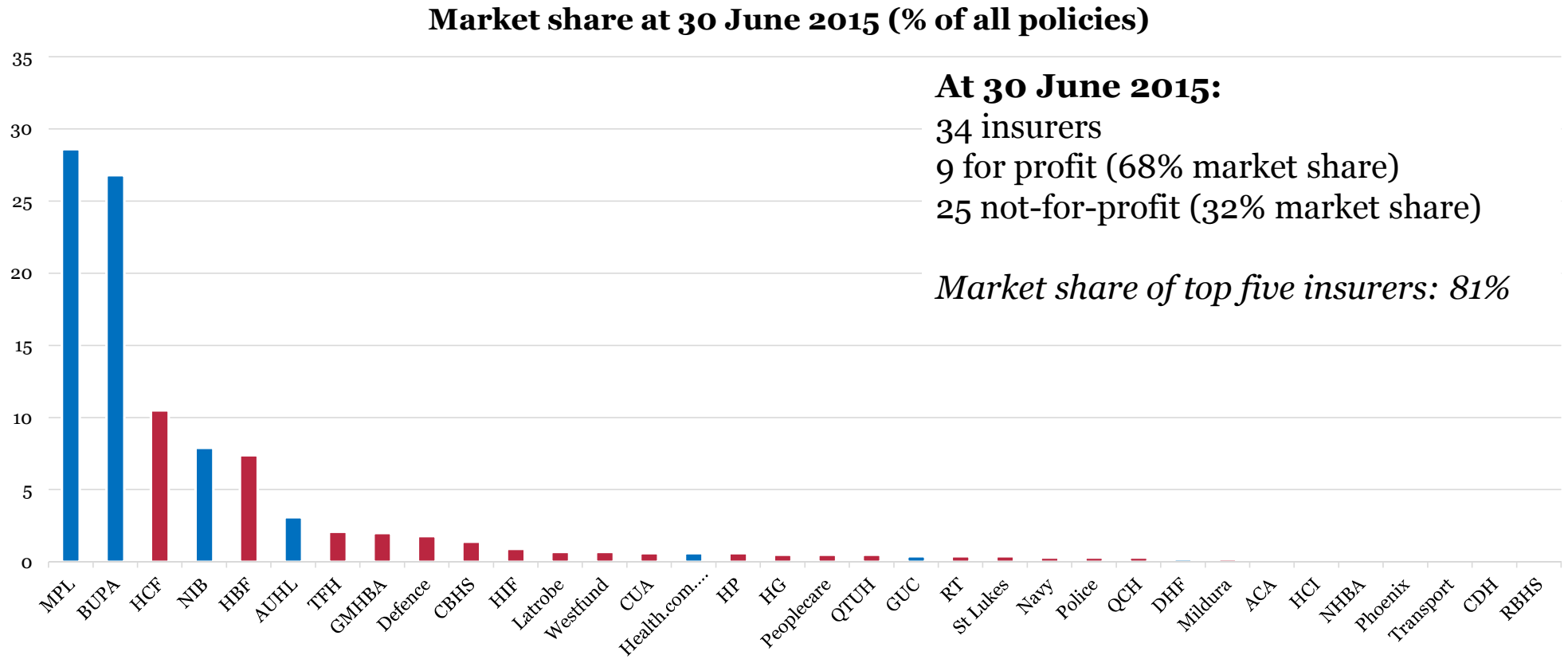


Capital above liabilities and the minimum regulatory capital amount

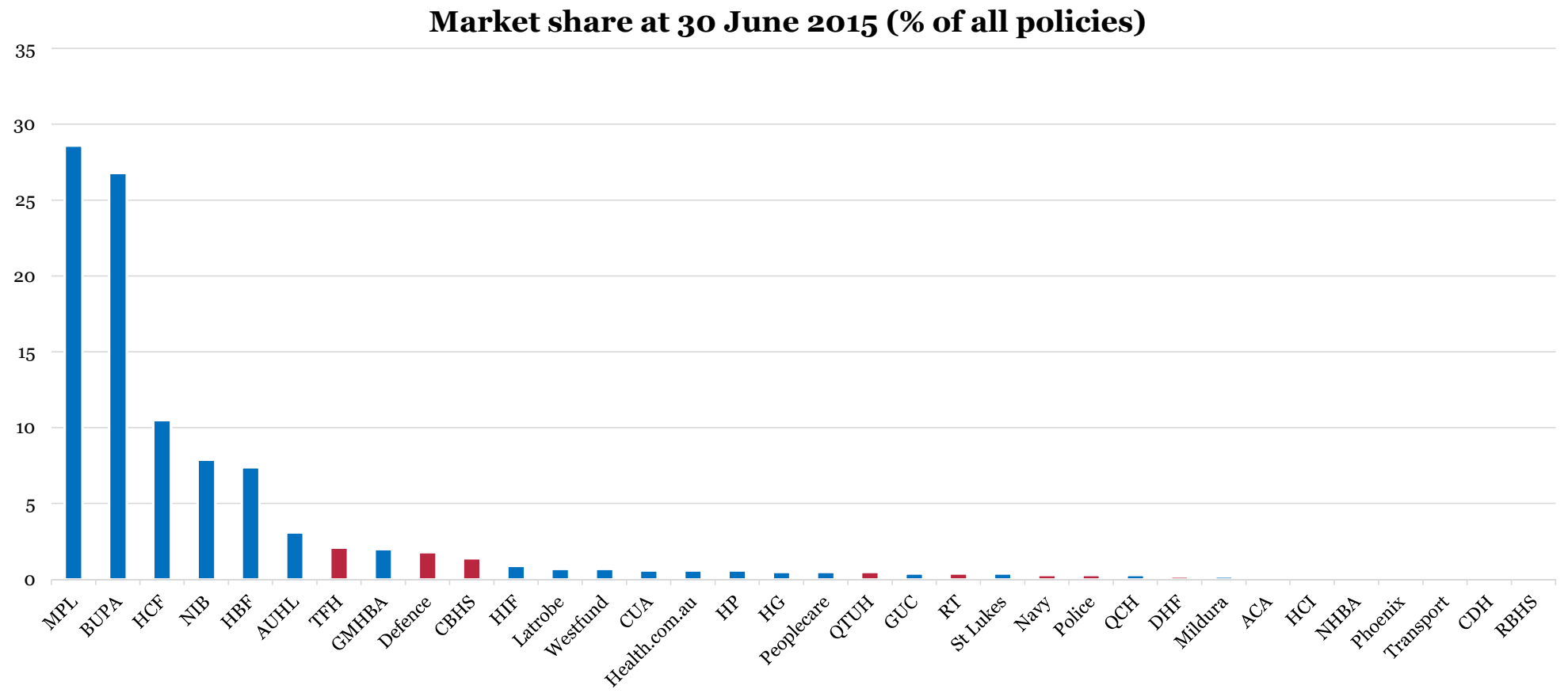
APRA Insight Issue One 2016

Industry Structure

Not for profit vs For profit



Industry Structure
Open versus restricted



Regulation and legislation
Legislation

Private health insurance Act 2007

Aim of Act is to:

(a) provides incentives to encourage people to have private health insurance; and

(b) sets out rules governing private health insurance products.

Private Health Insurance (Prudential Supervision) Act 2015

Registration process

Imposes requirements about how PHIs conduct health insurance business

Deals with other matters in relation to the prudential supervision of private health insurers.

Regulation and legislation
Regulation

Australian Prudential Regulation Authority

Since 1 July 2015, previously the Private Health Insurance Administration Council

Responsible for prudential supervision

Administration of risk equalisation trust fund

Regular data collection and reporting on scheme performance

Department of Health (& Minister for Health)

Approval of annual Premium Round application

Medicare Benefits Schedule and other minimum benefits

Changes to rebate / MLS / LHC

Private health insurance ombudsman

Independent arbitrator

Australian Competition and Consumer Commission

Since 1999 prepare annual report for senate on anti-competitive and other practices by health insurers and providers

Regulation and legislation
Appointed Actuary role

Appointed Actuary

Established in 2004 (after general insurance in 2002)

Statutory role as per 106(1) of the Private Health Insurance (Prudential Supervision) Act 2015

Requirements outlined in HPS 320 Actuarial and Related Matters

Professional Standards PS600 (FCRs) and Guidance PG699.01 (Pricing & projections) and PG699.02 (Insurance liabilities)

Main duties

- Method to calculate insurance liabilities
- Annual valuation of insurance liabilities including risk margins
- Annual Financial Condition Report
- Opinion on annual Premium Round application
- Notifiable circumstances (any proposed change that may have a material impact on the health benefit fund or its policyholders)

Making community rating work

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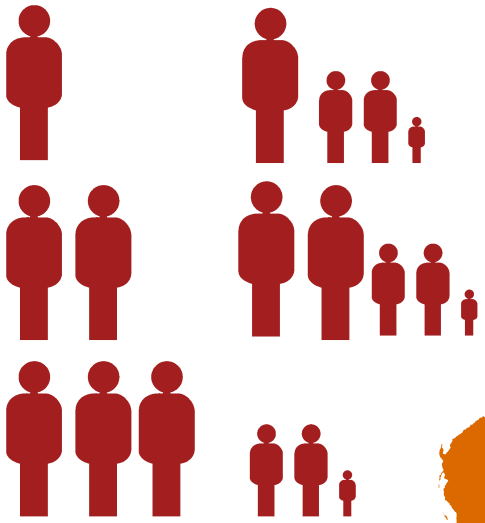
Community rating



Age

Gender

Occupation

Family history

Lifestyle factors (e.g. smoking)

Pre-existing medical conditions

Prior claims history

Suburb (beyond state)

Community rating
Risk equalisation

Mechanism

State-level zero-sum calculation

Based on benefits paid (hospital only) in last quarter only

Quarterly zero-sum retrospective risk equalisation

Aged based pool (97% of payments)

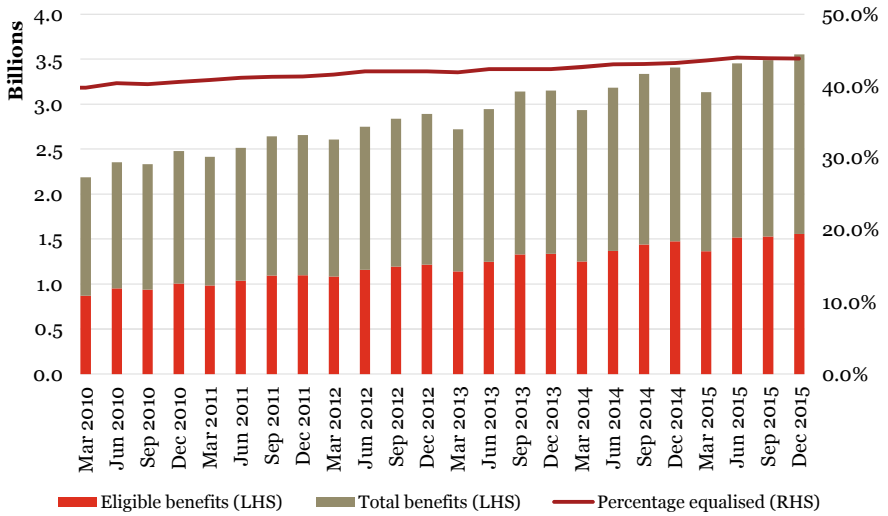
Increasing proportion of hospital benefits based on policyholders age shared across industry

High cost claimants pool (3% of payments)

Claimants who have claimed over $50,000 in a year (not indexed)

82% of benefits paid above the $50,000 shared across industry

Applied after ABP



Age	% eligible for ABP
0 - 54	0%
55 - 59	15%
60 - 64	42.5
65 - 69	60%
70 - 74	70%
75 - 79	76%
80 - 84	78%
85 +	82%

Risk equalisation
Pros and cons

Advantages

Community rating can be sustainable

Protects small insurers from high cost claimants

Limited benefit in targeting specific demographics

Can assist to subsidise high cost claimants and top level cover

Disadvantages

Risk equalisation mechanism isn't perfect

No material incentives for insurers to improve health outcomes of policyholders

Product structure is main way of controlling price

The carrots and the sticks

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Carrot and sticks
AKA The three pillars

Medicare levy surcharge

July 1997

1% of taxable income if above $50,000 and no hospital cover

October 2008

Threshold increased to $70,000 and subject to indexation

July 2012

Size of MLS varies by income threshold

Rebate

January 1999

30% government rebate on ***hospital and general treatment*** products

April 2006

Higher rebates for 65+ and low income earners

July 2012

Rebate means-tested

April 2014

Rebate reduced relative to CPI

Lifetime health cover loading

July 2000

+2% each year over 30 and didn't have health insurance

July 2013

LHC loading do not receive rebate

	Income Tier			
	Standard	**Tier 1**	**Tier 2**	**Tier 3**
Taxable income (Singles)	≤$90,000	$90,001-105,000	$105,001-140,000	≥$140,001
Rebate	26.79%	17.86%	8.93%	0.00%
MLS %	0.00%	1.00%	1.25%	1.50%

What drives premium increases?

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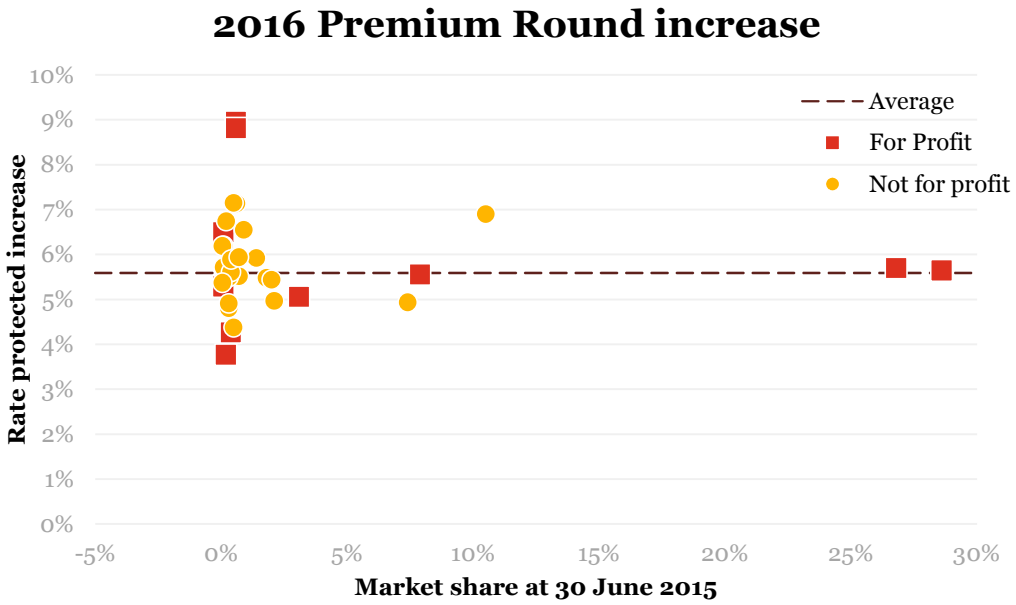
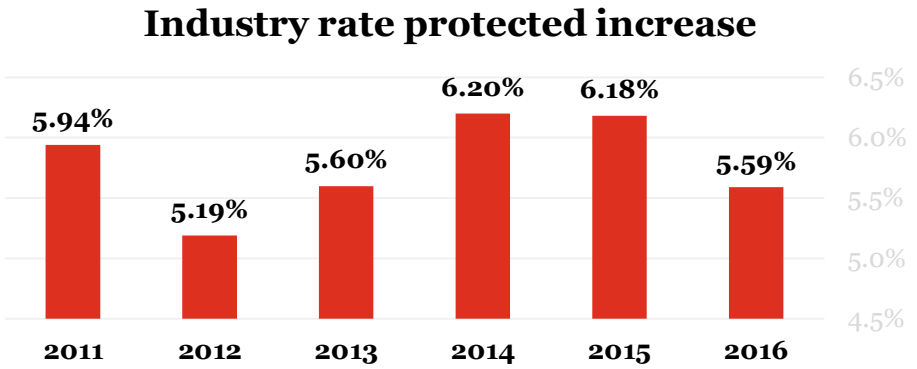
Annual premium round process

1 April





Key drivers

Utilisation

Ageing population

Medical technology advances

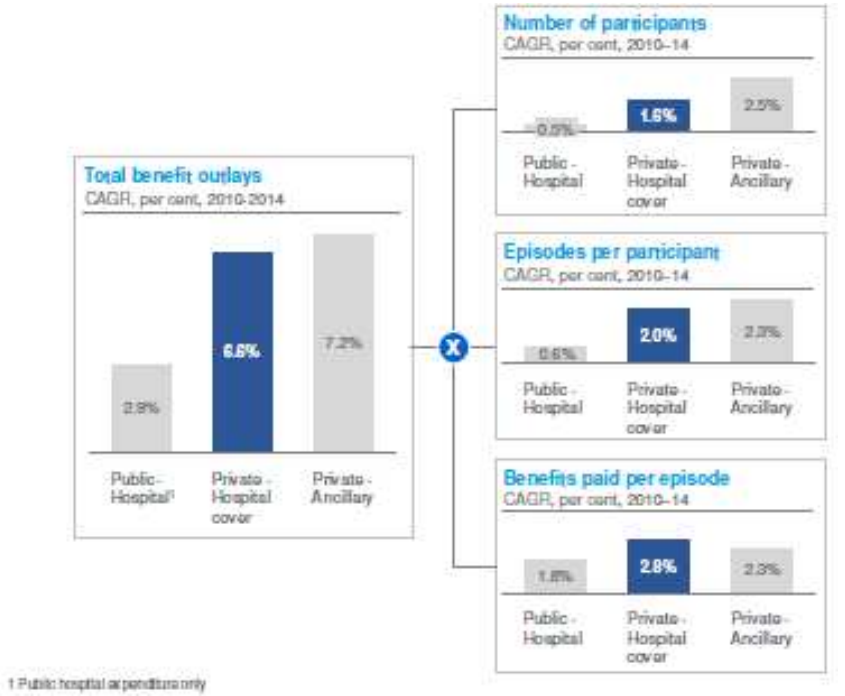
Changing lifestyle

Benefit averages

General inflation

New technologies

Drivers of health care costs 2010-2014



Medibank Private, PHI Consultation 2015-16 Position Statement

Hot topics

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Prostheses pricing
The issue

Device makers have 'siphoned off' $1b a year, says Nib CEO Mark Fitzgibbon

AFR, April 26, 2016

*Ms Ley said there were examples where the current Government pricing process meant the same pacemaker **cost double the price** – or $26,000 more – if it was delivered through the private system rather than public.*

5 February 2016, Minister for Health

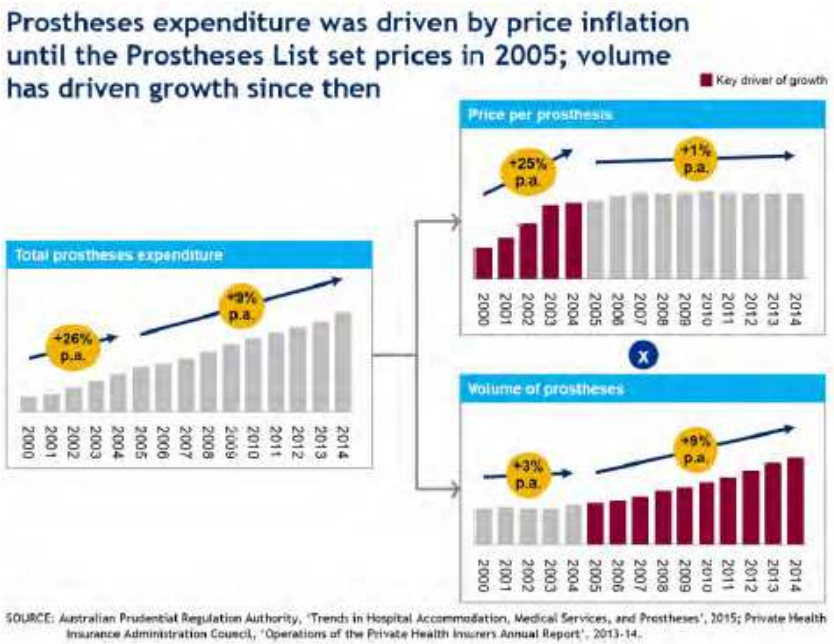
Prostheses pricing
A timeline

1985 – 2001 Department of Health set Prostheses prices

2001 Industry partially de-regulated. Allowed insurers to negotiate with providers / suppliers but under restriction that **no gaps** be charged to consumers

2005 Prostheses List was introduced by government to control benefits

2010 Prostheses Listing Advisory Council (PLAC) established.



PHA, Costing an arm and a leg, 2015

Prostheses pricing
PLAC

Main Roles of the Prostheses List Advisory Committee

- Provide advice to the Minister for Health in a timely manner about prostheses submitted for inclusion on the Prostheses List, having regard to **comparative** qualitative clinical function and effectiveness, **comparative** cost effectiveness and **comparative** safety.
- Provide advice to the Minister for Health in a timely manner about the grouping and description of prostheses included on the Prostheses List, having regard to whether listed prostheses have **comparable** qualitative clinical function and/or similar technical attributes.
- Provide advice to the Minister for Health in a timely manner about appropriate private health insurance benefits for products included on the Prostheses List, having regard to **comparative** qualitative clinical function and effectiveness, **comparative** cost effectiveness, **comparative** safety and whether clinically relevant superiority vis-à-vis similar prostheses has been established.
- Refer evidence of identified concerns about the safety of prostheses in a timely manner to the Therapeutic Goods Administration for action.
- Provide advice about other matters as requested by the Minister for Health.

PLAC, Terms of Reference

Prostheses pricing
Impact of reform

PHA estimates of impact of reforming prostheses pricing

PHA, Costing an arm and a leg, 2015

In the Budget, Federal Government committed $3.2 million establish a Private Health Sector Committee to implement reforms such as this, and will also establish a new Prostheses List Advisory Committee to further develop and advise on the implementation of the recommendations of the Industry Working Group on Private Health Insurance Prostheses Reform created earlier this year.

The Checkout's take on this

Short break

https://www.youtube.com/watch?v=YqPm6IV19Bk

Why so many products?
The issue

*"The main issue I think is that it's a really complex market - there's over **48,000** health insurance products on the market, they're all different, they're all hugely variable," Ms Wells said.*

http://www.abc.net.au/news/2016-01-08/many-people-with-private-healthcare-unsure-of-their-policy/7076202

Most insurers have 3-4 core hospital products and 3 core general treatment products, so with just over 30 insurers there should be about 500 product options.

So how do we get to 48,000?

Complexity
Healthy Helper example

1

Healthy Helper

Complexity
Healthy Helper example

1

3

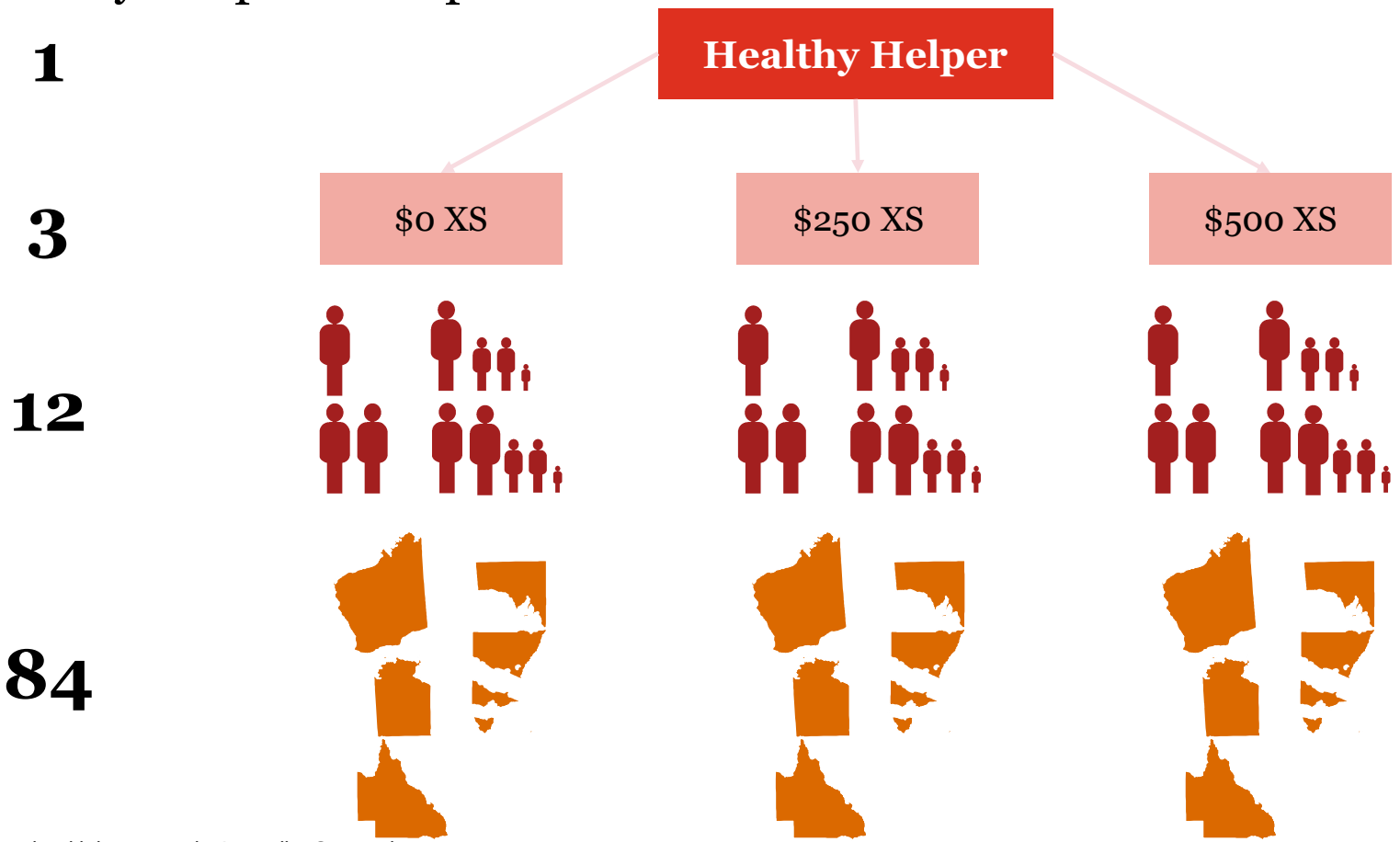
Complexity
Healthy Helper example

1

3

12

Complexity
Healthy Helper example



Junk cover
The issue

https://www.choice.com.au/money/insurance/health/articles/junk-health-insurance

Junk cover
What is it?

Covers for:

- Minimum default benefits only for rehabilitation, psychiatric care and palliative care
- Cover for only a handful of elective procedures to remove unnecessary body parts or patch you up e.g. wisdom teeth, appendicitis, tonsils, gall bladder, joint reconstructions
- Emergency accident cover, but may only cover individual in a public hospital setting.

Junk cover
Resolution

Most stakeholders are advocating for:

- Changes to the Standard Information Sheet structured to assist consumers understand what they are / aren't covered for
- Change in the definition of minimum benefits
- Shift to an inclusionary model for product development (rather than exclusionary model)
- Limiting rebate to products which provide a specified level of cover

Questions?