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The New Private Health Insurance Environment

Prepared by Gayle Ginnane

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The Institute of Actuaries of Australia
Level 7 Challis House 4 Martin Place
Sydney NSW Australia 2000
Telephone: +61 2 9233 3466 Facsimile: +61 2 9233 3446
Email: actuaries@actuaries.asn.au Website: www.actuaries.asn.au

The New Private Health Insurance Environment

Gayle Ginnane
CEO
Private Health Insurance Administration Council

The purpose of this paper is to provide information about the recent changes to legislation governing the private health insurance industry and the regulation of the industry.

In particular I intend to cover the key reforms coming from the legislation:

- broader health cover,
- standard product information,
- changes to Lifetime Healthcover,
- risk equalisation,
- pricing,
- prudential standards,
- re-registration and
- changes to the regulatory environment.

The key changes involving PHIAC can be summarised as follows:

- Price increases are now approved, not disallowed.
- PHIAC regulates the fund not the insurer although there are a number of specific obligations on the insurer.
- Pecuniary penalties for breaches are now in penalty units.
- Insurers are required to re-register by 1 July 2008.
- Insurers are required to be Corporations Law entities by 1 July 2008.
- PHIAC can make prudential standards.
- Funds must comply with those standards.
- Disqualified persons can be excluded from management.
- There are whistleblower powers for appointed actuaries.
- There is AAT review of most of the new powers.

Legislation

The Private Health Insurance Act 2007 (PHIA) came into effect on the 1st of April. It replaced legislation on private health insurance which was part of the National Health Act 1953 (NHA). The private health insurance part of this legislation has now been repealed and for the first time the private health insurance sector is regulated under its own Act of Parliament.

In developing the new legislation, the opportunity was taken to make some broader changes to private health insurance. The aim was to allow the development of innovative products that reflect contemporary clinical practice, and support greater choice in private health care for consumers.

The legislation complements other Government policies implemented in recent years including:

- the 30% Rebate,
- the increased rebate for older Australians,
- Lifetime Healthcover (LHC), and
- the No Gap and Known Gap arrangements.

Specifically, quoting from the Explanatory Memorandum the legislation was intended to:

- clarify and simplify the legislative regime for private health insurance so that organisations can offer private health insurance products with the minimum compliance requirements necessary to achieve the Government's policy objectives and protect the interests of consumers;
- allow private health insurance to provide and include in risk equalisation arrangements benefits for outpatient and out-of-hospital services, including chronic care management for conditions such as diabetes and asthma, and disease prevention programs;
- require insurers to provide standard product information to help people compare policies and to understand their entitlements;
- eliminate Lifetime Health Cover penalties for fund members who have retained their hospital cover for more than ten years continuously;
- provide for the transition from the current regulatory regime;
- repeal redundant parts of the *National Health Act 1953* and amend a range of other Acts to reflect the new regime;
- impose application and listing fees on the sponsors of prostheses; and
- amend the Acts imposing levies on private health insurers.

In this paper I intend to focus on the areas which are of major interest to PHIAC, the financial regulator of the private health insurance industry.

Health Insurance or Hospital insurance?

Health insurance is a bit of a misnomer. It has been, for many years, largely hospital insurance with some ancillary cover. In other words, the health insurers largely covered the costs of in-hospital treatment - which may have included some form of excess such as a front-end deductible or a co-payment. They also covered 25% by law of the Medicare Benefits Schedule (MBS) for medical services, Medicare covered 75% of the MBS and insurers could pay amounts in

excess of the MBS where agreements with practitioners existed to cover some or all of the out-of-pocket costs for the privately insured.

As well, the insurers covered payments towards the cost of ancillary cover such as dental, physiotherapy, optical, chiropractic and other similar allied health services. These payments were either a set amount of the fee for a particular number of visits or services or as a percentage amount of the fee also with a cap. Very few health funds had uncapped ancillary benefits.

Broader Health Cover

Broader Health Cover (BHC) was introduced to allow cover for some services ”beyond the hospital gate”. Policy changes allowed private health insurance to be broadened to include services that form part of an episode of hospital care and substitute for or prevent hospitalisation. This would allow insurers to be able to pay benefits for some medical services that can safely and effectively be provided outside of hospital such as domestic nursing assistance, allied health services, dialysis and chemotherapy. The policy change allowed insurers more flexibility in working with service providers to design products that better suited consumer needs and expectations.

The legislation does not list all the services that could be included in a broader health product. It was deliberately intended to be flexible where appropriate but some specific exclusions apply, such as general practice services and the costs of accommodation in an aged care facility. Services that substitute for or prevent hospitalisation are eligible for risk equalisation subject to meeting criteria set out in subordinate legislation such as the Risk Equalisation Policy Rules. Broader hospital products remain community rated and continue to attract the rebate on premiums.

As well, in that great public service tradition, we have changed the names of some things. Ancillary cover is now general treatment and some services such as a chronic disease management program may be either hospital or general treatment depending on where the services are provided.

Standard Product Information and the PHIO Website

A critical issue that has bedevilled health insurance for many years has been the sheer complexity of the product offering. In a highly regulated market, the insurers have acted rationally by making small changes to what were effectively two products - hospital insurance and ancillary insurance. This has led to a proliferation of differences based on front end deductibles, co-payments and relatively minor differences in benefits. This made it very difficult for consumers to compare the key features of a health insurance product. Health is exempt from the Financial Services Reform Act so there are no requirements for product disclosure statements in this industry.

The PHIA imposed a requirement for a short document providing standard product information. All health funds must produce this standard information statement (SIS) and these statements must be provided to the Private Health Insurance Ombudsman and they appear on the PHIO's web site to allow easier comparison for consumers. There are already many thousands of products on that website, but the PHIO has made search easier through some specific comparisons. The website search criteria include product name, features such as state of residence, type of cover and whether the policy holder would be prepared to have an excess or co-payment.

PHIAC was concerned that the primary sort mechanism may have been by price. While there are genuine reasons why some products are cheaper than others, if a product is selected purely on price, there is a significant risk that a consumer may purchase something that is not adequate to their needs because the price has been kept down by exclusions or limits to benefits.

Lifetime Healthcover Changes

Lifetime Healthcover (LHC) commenced in 2000 with the aim of encouraging consumers to join private health insurance early (at or before age 30) and to stay in private health insurance. It was a combination of a carrot and stick approach. The carrot was the private health insurance rebate of 30% (or the higher rebate for older Australians) and the stick was an increase of 2% per year in the base premium for each year over the age of 30 that a consumer joined private health insurance. This was capped at 70% for persons joining at age 65 and over.

The PHIA allows the LHC loading to be removed after continuous membership of 10 years to recognise loyalty. This won't have any effect until 2010 when the first policy holders who joined with a premium loading reach the 10 year requirement.

Risk equalisation

Private health insurance has been community rated for many years. This effectively means there needs to be some form of risk sharing amongst the industry and this, in the past, has been managed through what was called reinsurance. I hasten to add that this is not real reinsurance but a cost sharing mechanism. Genuine reinsurance is prohibited in the private health insurance industry.

Risk equalisation is a much more accurate name for the process of risk sharing and is:

- a system for sharing the hospital costs and some general treatment costs of high risk groups among private health insurers, and
- allows a more equitable treatment of health funds with different coverage of high risk groups to support community rating.

The reinsurance model in place until 31 March 07 included

- 79% of hospital benefits for persons 65 and over (demographic risk) and
- 79% of hospital benefits for members with more than 35 days in hospital (utilisation risk) during the year.

This scheme, in very simple terms, shared the costs of claims for these categories of insured persons through an averaging mechanism. PHIAC received quarterly information from the health funds, calculated an average claim cost for each State (although the ACT is included in NSW for this purpose) and calculated an average claims cost for each fund operating in each of those States. Where funds had higher than the average claims they received money from the reinsurance pool, and where they had lower than the State average they paid money into the pool. The pool is a quarterly zero sum calculation.

With effect 1 April 2007, the risk equalisation scheme has been implemented. It modified the scheme that existed until 31 March 2007 by including different age categories in the scheme with varying proportions of the claim included in risk equalisation depending on the age of the claimant. There were a number of administrative changes from the earlier scheme. These included:

- changes to the benefits included in calculation,
- change in definition of Single Equivalent Units (SEUs), and
- removal of the 500 SEU rule so that insurers now report in all Risk Equalisation jurisdictions.

Changes to Benefits for Risk Equalisation

The changes to the benefits included in the risk equalisation calculation include:

- benefits for persons aged 55 and over at an increasing rate, from 15% for 55 to 59 year old up to 82% for persons aged 85 and over, and
- benefits paid for very high cost claims, being claims exceeding $50,000 after the age based pool is taken into account.

There are other changes as well. The reinsurance model only included hospital benefits whereas the risk equalisation model includes the following:

- Hospital benefits,
- Hospital substitute benefits,
- Chronic Disease Management Program benefits, and
- High Cost Claimants benefits (after the age based pool).

These are defined as follows:

- Hospital substitute benefits means general treatment that:
    - (a) substitutes for an episode of hospital treatment; and

- (b) is any of, or any combination of, nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition;

(Division 69, Private Health Insurance Act 2007)

- Chronic Disease Management Program - General Treatment that is intended to:
  - reduce complications in a person with a diagnosed chronic disease
  - prevent or delay the onset of chronic disease …
  - requires the development of a written plan that
    - ◊ specifies the allied health service or other goods/services to be provided
    - ◊ specifies the frequency and duration of the provision of those goods and services
    - ◊ specifies the date for review of the plan
    - ◊ has been provided to the patient for consent
  - consent is given to the program, before any services under the program are provided
  - is coordinated by a person who has accepted responsibility for:
    - ◊ ensuring the services are provided according to the plan
    - ◊ monitoring the patient's compliance

Only some Chronic Disease Management Program benefits are eligible for inclusion in Risk Equalisation

- the planning and coordination services described in paragraphs (b) and (c) of the definition of chronic disease management program in the Business Rules; and
- allied health services, as defined in the Business Rules, which are provided as part of the chronic disease management program.

This complicates risk equalisation because any risk sharing arrangement needs to be transparent and fair. Some of the definitions under BHC are still a little unclear for risk equalisation purposes and PHIAC is concerned to ensure that the scheme is robust.

Changes in the definition of Single Equivalent Units (SEU)

Both reinsurance and now risk equalisation use SEUs as the basic unit of measurement. Historically there were two categories of membership, single and family. Singles were 1 SEU and families 2 SEUs. This was expanded to include couples and single parent families some years ago with the SEU as 2. There are now 6 membership categories which have resulted in some specific changes to the way in which SEUs are defined as follows:

- the major change is the counting of Single Parents as 1 SEU (previously counted as 2)
- The definition of policy types has changed which also affects SEU's. There are now 6 policy types instead of 4.
    - a hospital policy under which only one person is insured—1 (single);
    - a hospital policy under which 2 adults are insured (and no-one else)—2 (couples);
    - a hospital policy under which 2 or more people are insured, none of whom is an adult—1;
    - a hospital policy under which 2 or more people are insured, only one of whom is an adult—1 (single parents);
    - a hospital policy under which 3 or more people are insured, only 2 of whom are adults—2 (family);
    - a hospital policy under which 3 or more people are insured, at least 3 of whom are adults—2.

PHIAC has undertaken the first quarter of risk equalisation. The change in the number of SEUs was not significant, resulting in a drop of 1.18% in the number of SEUs. The largest effect was in the two defence related insurers where there are both significant numbers of single parents dropping from 2 to 1 SEU but also the "no parent" family being introduced and counting as 1 SEU (dropping from 2 to 1 SEU as they would previously have been counted as family memberships. This comes about because the Department of Defence covers the medical costs of serving members of the Defence Force and it is only their dependents and/or a non-serving partner who can be insured under the policy.

<u>High Cost Claims Pool (HCCP)</u>

One addition to the risk equalisation process is the high cost claims pool which shares the costs of high cost claimants where they are not otherwise shared by risk equalisation. At the present time the benefits paid in excess of $50,000 are included in the high cost claims pool after any age based risk equalisation is first taken into account.

The HCCP was implemented to protect small funds from large claims in lieu of genuine reinsurance such as some form of "stop loss" insurance.

For the purposes of this paper, I do not intend to provide detailed information on the risk equalisation calculation. I anticipate many of the audience will be involved with the private health insurance industry. If not, I am happy to have PHIAC contacted so that we are able to talk to interested parties about risk equalisation and the processes which support it.

Risk equalisation transfers about $50 million per quarter among the health funds. PHIAC expects this to grow as the insured population continues to age. PHIAC provides audit guidance to ensure, as best we can, the integrity of the scheme.

Pricing

Private health insurance premiums will actually have an increase in regulation under the PHI Act. Prior to 1 April, the Minister for Health and Ageing could disallow a premium increase. PHIAC was involved in assessing pricing and sometimes we sought additional advice from the Australian Government Actuary in forming our view on the merits of a pricing application.

The PHI Act changes the process from a disallowance by the Minister to an approval by the Minister. This is quite a small change in the legislation but could have a significant effect and all registered insurers will need to assess the risk of disallowance as part of their risk management plan.

Registered insurers will need to clearly identify their case in applying to the Department of Health and Ageing for a premium increase. This is a significant area of sovereign risk for health insurers. Under the old regime, if the Minister took no action the rate increase came into effect. Under the PHIA, if the Minister takes no action there is no rate increase (or, very unlikely, no decrease.)

Registration and re-registration

All private health insurers must be registered with PHIAC before they can offer private health insurance in Australia. There are specific requirements for insurers which existed under the NHA but these have been clarified and amended slightly under the PHIA and the Registration Rules. Insurers cannot improperly discriminate and the details of what constitutes improper discrimination are set out in the PHIA. Principally, it is to ensure that anyone can join a health fund and not be discriminated against because of any inherent risk factors in the community rated environment of private health insurance.

Insurers can register as not for profit or for profit and they can also register as open or restricted access if they have a group that meets the requirement of the criteria for defining restricted access.

Change of status

Insurers can change from not for profit to for profit and from restricted access to open under the new legislation. The change from restricted access to open is very straightforward. Basically the insurer has to notify PHIAC of the change.

The change to “for profit” is more complex. The insurer must apply to PHIAC to approve the change of status. PHIAC Council must firstly consider whether or not it is a demutualisation. If it is a demutualisation, then PHIAC must advertise the

application in a national newspaper and await comments. Stage 2 of the process requires PHIAC to consider the application and approve it, provided that there are no financial benefits to anyone other than a policy holder or insured person and the financial benefits of the demutualisation are distributed "not inequitably".

Provided that PHIAC approves the change of status, then it cannot take place until 90 days after the date of the change of status application to PHIAC.

Re-registration

The PHIAC Council must re-register all private health insurers under the *Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007* before 1 July 2008. This legislative change means that all existing providers of private health insurance will continue to be registered until 1 July 2008, or they are registered under Part 4-3 of the *Private Health Insurance Act 2007* (PHI Act), whichever happens first. Insurers who fail to re-register by 1 July 2008 can no longer offer private health insurance.

Insurers must update their rules to meet the requirements of the PHIA. As a minimum, every insurer is reviewing and updating its Constitution and Rules to meet the requirements of the re-registration process.

PHIAC and the Department of Health and Ageing have been working with the industry over the last three months to raise awareness of this compliance issue and the implications of failing to re-register in the required timeframe.

The process is fairly straightforward in principle. Insurers must apply to PHIAC and we must seek input from the Department. In making a decision on each application, PHIAC Council is required to consider each applicant's prudential position, management expense ratio, number of policy holders, premium, and, advice from the Department on whether the insurer's Rules and Constitution are compliant with the insurer's obligations and whether the insurer's Rules permit improper discrimination (an automatic refusal of the application).

To mitigate the risk of an insurer's application being refused, PHIAC and the Department have been working with the industry to assist them through the re-registration process. Insurers are being encouraged to submit their refreshed Rule and Constitutional changes to the Department prior to formal lodgment, in an effort to identify and resolve any issues, before formal application is made.

Re-registration is an administrative law decision and there is a right of review under the Act. In the event of PHIAC refusing an application, we must provide a statement of reasons. The decision is reviewable by the Administrative Appeals Tribunal (AAT). If the decision is not made within the legislated 90 days, then it is deemed to be a refusal to re-register and again it is reviewable by the AAT.

Changes in the PHIAC Regulatory Environment

There have been some significant changes in the PHIAC regulatory environment for private health insurance. These changes include:

- appointed actuaries
- prudential standards
- disqualified persons
- increased enforcement powers including enforceable undertakings
- ability to seek remedies in the Federal Court

Under the NHA, bluntly, PHIAC had fairly limited regulatory actions available to it and those that did exist were quite inflexible. We had limited ability to deal with breaches other than to persuade. If that didn't work then there was a significant leap from persuasion to the point where we could appoint a consultant or inspector. If a fund refused to implement the recommendations of a consultant or inspector then PHIAC's only next step was to appoint an administrator. In effect, the powers that PHIAC had could be described as a slap on the wrist or the nuclear option.

Under the PHIA, PHIAC has been given regulatory powers very similar to those of APRA. We now have a series of staged responses from a regulatory perspective. If PHIAC has concerns about an insurer or a fund, and we are unable to persuade them to rectify the problem, then we can use enforceable undertakings. There are now appropriate and realistic penalties for breaches of the Act. Many of the penalties in the NHA were $500 or $1000 dollars for offences that could run into many hundreds of thousands of dollars in their financial effect. The new Act applies a penalty unit regime with realistic numbers of penalty units for appropriate levels of breaches.

Appointed actuaries

The appointed actuary is now a legal requirement although PHIAC had been encouraging strongly the use of actuaries for some time through the requirement for an annual Financial Condition Report. The legislation now provides a proper regime for the actuaries including whistleblower protections.

Prudential Standards

The NHA allowed PHIAC to develop and implement solvency and capital adequacy standards only. PHIAC has done some work on guidelines, particularly on corporate governance, but the PHIA gives us specifically the power to develop and implement other prudential standards. The first of these standards is included in the Insurer Obligation Rules and deals with appointed actuaries to health funds.

PHIAC is developing further our governance guidelines with a view to implementing them as a prudential standard early in 2008. We are also looking at other standards such as risk management, whistleblowers, and possibly fit and proper although the new fit and proper requirements in PHIA may obviate the need for a specific PHIAC standard in this area.

PHIAC will try not to reinvent the wheel in developing our standards and where possible we will leverage off existing standards and processes from elsewhere.

Disqualified Persons

The PHIA identifies certain categories of persons as disqualified persons. Where someone has been convicted of an offence under:

- the PHIA,
- Corporations Act,
- Financial Sector(Shareholdings) act
- Bankrupt, or
- Disqualified by PHIAC,

then they cannot be involved in the running of a health insurer unless PHIAC specifically approves.

Provisions around Inspections and the Appointment of External Managers

These provisions have been transferred over from the NHA although again the name has changed from administrators to external managers. The intention is to shift health insurance regulation as far as possible into the general Corporations Act regime.

PHIAC Rules

Under the PHIA, PHIAC has the power to make rules. We have made three sets of rules which set out operational requirements in certain areas of the act. The PHIAC rules are :

- Insurer Obligations Rules,
- Health Benefits Fund Rules, and
- The Risk Equalisation Administration Rules

Insurers Obligations Rules

These Rules deal with appointed actuaries. In particular they:

- establish a prudential standard that requires a private health insurer to notify its appointed actuary of certain matters and to prepare a financial condition report to be produced to the Council (section 163-1 of the Act);

- specify eligibility requirements for appointment of a person as an insurer's appointed actuary (subsection 160-50 of the Act);
- specify the basis and process for the Council to make a declaration that a person is ineligible to be appointed as an insurer's appointed actuary (section 160-5(2) of the Act);
- specify requirements for notification of the appointment of actuary (section 160-10 of the Act);
- specify the circumstances in which a person ceases to hold an appointment as an insurer's appointed actuary (section 160-15 of the Act);
- specify duties and standards of skill and diligence to be observed by the appointed actuary (section 160-20 of the Act);
- require the appointed actuary to notify the insurer of certain matters (section 160-20 of the Act);
- require the actuary to prepare a financial condition report on request of the insurer (section 160-20 of the Act); and
- specify certain matters for reporting and notification requirements for insurers, including additional information to be included in annual reporting to the Council (sections 169-1 and 169-5 of the Act).

Health Benefits Fund Administration Rules

The purpose of these rules is to specify requirements for the administration and operation of health benefits funds, including requirements about the expenditure and application of fund assets, restructure of health benefits funds and merger and acquisition of health benefits funds. The rules specify risk equalisation jurisdictions for the purposes of the Act and establish solvency and capital adequacy standards for the conduct of health benefits funds.

The Rules:

- deal with matters relating to borrowings, mortgages and charges which a private health insurer is permitted to enter into for the purposes of its health benefits fund(s) (subsections 137-10 (3) and (4) of the Act);
- specify requirements relating to the restructure of the health benefits funds of an insurer, including what must be included in an application for approval, criteria for Council approval of the restructure proposal, the time when a restructure is taken to have effect and policy holder notification requirements (section 146-1 of the Act);
- specify requirements relating to the merger and acquisition of health benefits funds between insurers, including what must be included in an application for approval, criteria for Council approval of the transfer arrangements, the time when a transfer is taken to have effect,

certification requirements and notification requirements (section 146-5 of the Act);

- specify the areas that are risk equalisation jurisdictions for the purposes of the Act (subsection 146-1 (6) of the Act);
- establish a solvency standard for the purposes of Division 140 of the Act (subsection 140-5 (1) of the Act);
- establish a capital adequacy standard for the purposes of Division 143 of the Act (subsection 143-5 (1) of the Act).

Risk Equalisation Administration Rules

Risk equalisation has two sets of rules setting out different requirements. The Minister makes the Private Health Insurance (Risk Equalisation Policy) Rules to set out the requirements for the operation of the Trust Fund (section 318-10 of the Act). The Council makes the Risk Equalisation Administration Rules to set out the requirements relating to the administration of the Trust Fund and the risk equalisation levy, including the kinds of records to be kept by private health insurers who are required to pay the risk equalisation levy and the form in which those records are to be kept.

The Rules set out the following requirements relating to the administration of the Trust Fund and the risk equalisation levy:

- general requirements for records to be kept by insurers;
- records to be kept by insurers for the purpose of the new high cost claimants pool as part of the risk equalisation arrangements;
- requirements for insurers to provide quarterly returns to the Council which provide the information that is required for risk equalisation purposes;
- the electronic form of the quarterly returns and specify certification to be given by an officer of the insurer
- that an independent annual audit of the quarterly returns must be provided to the Council by 30 September of each year;
- provides interpretation of terms used in the quarterly return; and
- provides a template of the quarterly return.

The Minister for Health and Ageing also has the power to make rules which cover most areas of the PHIA. The rules made by the Minister encompass:

- Incentives
- Lifetime Health Cover
- Complying Product
- Prostheses

- Accreditation
- Health Insurance Business
- Registration
- Health Benefits Fund Policy
- Data Provision
- Health Benefits Fund Enforcement
- Ombudsman
- Council
- Management
- Levy Administration
- Risk Equalisation Policy
- Information Disclosure

Rules are relatively simple to change and so allow flexibility in the regulatory process for private health insurance.

Finally

The intention of the changes in the PHIA is to allow health funds to broaden their coverage and provide a better set of policies to the consumer which reflect the changes in health practice. It is a recognition of the fact that hospital stays are generally becoming shorter, there are considerable changes in technology and that some services are able to be offered in settings outside hospital. A significant objective is to provide an environment where alternative practices may come at a cheaper cost and therefore slow the increasing rate of growth in private health insurance premiums.

Health insurance remains heavily regulated in part due to community rating but also as a result of the influence of the private health insurance rebate. Government will always want to ensure that it has some oversight of health fund expenditure while it is paying 30% or more of the premiums.

The challenge for health funds is to take up the opportunities provided by Government while maintaining control of the costs.