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## Community Rating – More Trouble Than Its Worth?

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# Community Rating – More Trouble Than Its Worth?

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## Part I Executive Summary

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### 1 Is community rating important?

In health insurance, community rating means that two people on the same product pay the same premium, regardless of differences in expected claim cost.

It is a matter of public policy that health insurance should be affordable to most Australians, irrespective of expected claim costs. PHI also allows Australians to finance a greater share of their own health care costs, reducing the cost to government.

We consider these to be important and worthy public policy objectives, and the role of community rating is to support these objectives. An alternative pricing mechanism is better than community rating if, and only if, it can better support the public policy objectives.

### 2 What's the trouble with community rating?

Community rating relies on young, healthy people choosing to insure and subsidise those who need to claim more frequently. The subsidy means that products providing hardly any hospital cover can cost more than \$700 per year – a significant “flag fall” charge when buying insurance.

Community rating is sustained by an array of government “carrots and sticks”, which force healthy people to buy insurance they wouldn’t otherwise want. Without the carrots and sticks, Australia would no longer have community rated PHI, or a high PHI participation rate.

The proportion of Australians with hospital insurance reduced to around 30% in the late 1990s before the introduction of Lifetime Health Cover (LHC), the Medicare Levy Surcharge (MLS) and the premium rebate. These initiatives have been very successful, with around half of Australians now covered by PHI. The question is whether the success of these initiatives is sustainable.

Experience shows that consistent government support of PHI cannot be guaranteed. As ageing and new technology increases the cost of PHI, it becomes more difficult for government to subsidise premiums or force people to insure. It has become unusual for Federal budgets not to include some change to PHI support.

We consider whether an alternative pricing mechanism could make PHI less reliant on the ebb and flow of government support, while still meeting public policy objectives.

### 3 What are the alternatives?

We considered a range of alternative pricing mechanisms, which can be grouped under the following headings:

- Risk rating, with rules to help address affordability concerns. For example, New Zealand health insurance premiums reflect the health of the customer when the policy is taken out, and then increase with age. However, policies are guaranteed renewable, so health problems emerging after the policy is taken out do not change the premium
- Partial community rating, where premiums vary according to expected claim costs, but do not fully reflect differences in risk (for example, Compulsory Third Party motor insurance)
- Other changes to the current system, such as premium loadings based on whether a person smokes.

We assessed each alternative pricing mechanism against the public policy goals noted above.

#### **4 Can we do better than community rating?**

Risk rating of PHI (as in New Zealand) is a step too far for Australia. Risk rating would significantly reduce premiums for younger Australians, and remove some complexity including LHC, MLS and risk equalisation. However, significant premium increases for older Australians are inconsistent with current public policy objectives.

There are advantages to some of the minor changes to community rating such as smoker loadings. However they do not significantly change industry reliance on government support.

We feel it is reasonable for people who get the most benefit from PHI to contribute a greater share of the costs, while ensuring premiums remain affordable. Under partial community rating, premiums for older people would still be less than expected claim costs, but the subsidy from younger people would reduce.

Lower premiums for younger people would result in higher PHI participation and upgrades to comprehensive cover, reducing reliance on the public health system. Because younger people would still subsidise older policyholders, higher participation benefits everyone.

There have been a number of changes to the PHI rebate in recent years. Current government policy to link the rebate funding to CPI would effectively phase out the rebate over many years. An alternative would be combine partial risk rating with the reallocation of rebate funding to those with the highest premiums and claim costs. This could better link rebate funding to public policy objectives, while reducing the effect of higher premiums on older Australians.

We recommend that the industry considers ways to make PHI available to more Australians with less reliance on government.

## Part II Our Findings

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### 1 What's the trouble?

#### 1.1 What is Community Rating?

In health insurance, community rating means that two people on the same product pay the same premium, regardless of differences in expected claim cost. Australian private health insurance (PHI) has been community rated since the early 1950s.

Australian PHI combines community rating with guaranteed acceptance, which means that insurers cannot refuse to provide cover to anyone able to pay the premium. While waiting periods may apply before people are able to claim, insurers are not able to apply individual exclusions.

Australian PHI isn't unique in being community rated. For example, each Australian state uses a form of community rating for compulsory third party (CTP) motor insurance. However, insurance is generally risk rated rather than community rating, meaning that insurers charge premiums reflecting the expected claims cost. If an insurer considers the risk of claims to be very high, it can often exclude cover for certain hazards or refuse to provide cover at all.

#### 1.2 Is Community Rating Important?

Many in the Australian health insurance industry think that community rating is very important. We have heard people say things like “community rating is central to everything we do.”

Our view is that community rating is simply a means to an end. The public policy goal is that health insurance should be available and affordable to most Australians, irrespective of expected claim costs. PHI also allows Australians to finance a greater share of their own health care costs, reducing the costs of the government.

#### **Community Rating In Practice – An Example**

Joe is 30 years old and in good health but, inevitably, will need health care at some point in the future. The government would like Joe to purchase insurance so health costs are transferred to Joe and his insurer.

In theory, this shouldn't be too hard:

- Joe is no stranger to insurance. He has chosen to insure against risks such as his car being stolen or his house burning down, and his employer arranged life insurance. He understands that the premiums charge reflect the risk of a claim.

- Based on expected claim costs Joe's PHI premium might be around \$30 per month, so the cost should compare favourably to his other insurances.

When Joe calls a health insurer, he's shocked by the premium of more than \$160 per month. He is about to hang up when the insurer mentions:

- Premium rebate: The government's private health insurance rebate could cover up to 30% of the premium, depending on Joe's income
- Limited cover: Joe can save money by choosing a product with exclusions and an excess.

The insurer recommends its "Cross Your Fingers" product, with a premium of only \$50 per month (the "flag fall" premium). The insurer admits the policy doesn't really provide any hospital benefits, but has two reasons why Joe should buy:

- Medicare levy surcharge (MLS): Buying insurance could save Joe more than \$50 per month in tax, depending on his income
- Lifetime health cover (LHC): If Joe doesn't purchase PHI now, he will have to pay a penalty if he wants insurance later in life.

Joe reluctantly buys the \$50 product, and drafts an angry letter to his MP.

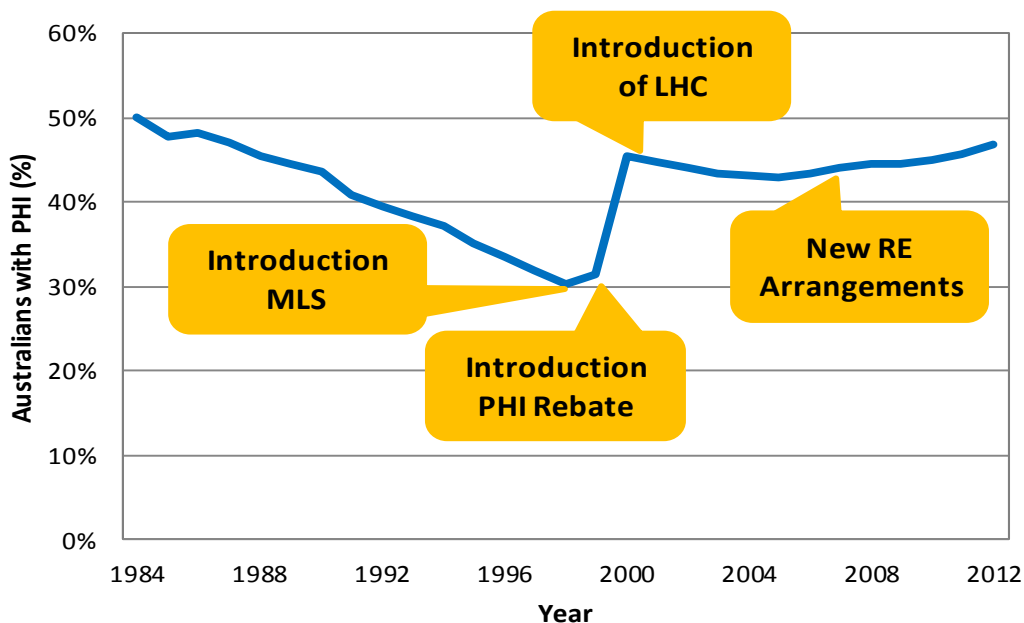
### 1.3 Carrots and Sticks

Many older Australians would not be able to afford PHI if the premium was based on their expected claim costs. Community rating reduces the premiums of older Australians by sharing the expected claim costs with younger people. Community rated premiums will only be affordable premiums if large numbers of young, healthy people choose to insure. The example above shows the importance of carrots and sticks to maintain community rating.

There is also strong correlation historically between these PHI support measures and participation rates. Versions of the following chart have appeared in PHIAC reports for many years:



Figure 1.1 – Australians with Private Hospital Insurance (%)



The figure shows that PHI participation reduced to around 30% in the late 1990s. The sharp increase in PHI participation in 2000 followed the introduction of the premium rebate, MLS and LHC initiatives. The following table summarises each of these initiatives and how they have changed over time.

Table 1.1 – Summary of Government PHI Support Initiatives

Initiative	Initial design	Changes over time
Rebate	A 30% premium rebate was introduced in 1999.  The rebate applied to all health insurance policies and was available to all Australians.	Higher rebates for older Australians were introduced in 2005.  The rebate has been means tested since 2012, with Australians on the highest incomes no longer entitled to any rebate.  The government has recently proposed increasing the rebate by no more than CPI inflation. Since PHI premiums generally increase faster than CPI, the proposal is effectively to phase out the rebate over many years.  Government has also proposed removing the rebate from LHC loadings, and from certain “natural therapies” benefits.  Other changes have sometimes been subject to press speculation around budget time, for example, removing the rebate from all general treatment premiums.
MLS	A surcharge of 1% of taxable income, payable by people on high incomes without private health insurance.	Government proposed to increase the threshold to \$100,000 singles and around \$150,000 for families in 2008, although a lower increase ultimately passed parliament.

	Introduced in 1997, with an income threshold of \$50,000 for singles and around \$100,000 for families.	The thresholds will be \$88,000 for singles and around \$176,000 for families in 2013.  There are now higher surcharges for people on high incomes, to complement rebate means testing.
LHC	People over 30 years old buying health insurance for the first time have to pay a penalty of 2% per year.  For example, a 35 year old purchasing insurance for the first time pays a 10% penalty. The maximum penalty is 70%.	Other than proposals relating to premium rebates on LHC loadings, no significant changes.

The table shows that government support for PHI and community rating changes over time.

The key issue in government support for PHI is affordability. Healthcare spending increases every year, reflecting factors such as price inflation, improving medical techniques, changing patient expectations and an ageing population.

Increasing the role of private health insurance helps government meet the challenge of increasing health costs. However, increasing health costs also make PHI support initiatives more difficult, increasing the cost of the rebate and the political difficulty of forcing people to purchase PHI.

Increasing PHI premiums also reduce the effectiveness of the PHI incentives. The difference between purchasing basic insurance and paying the Medicare Levy Surcharge narrows over time. People are encouraged to consider buying health insurance at age 30 to avoid LHC loadings. As the “flag fall” premiums increase, more people will choose to rely on a free public alternative.

#### 1.4 “Our system is the envy of the world”

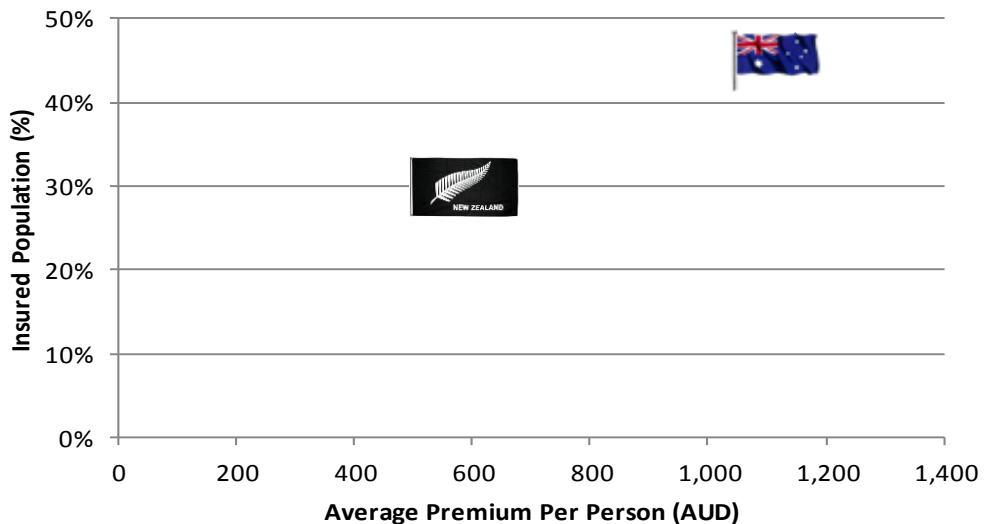
The Minister for Health often cites the increasing number of people insured as evidence that government PHI policy is appropriate. Almost 47% of Australians had some form of hospital insurance at 30 June 2012, with a record number of people covered.

The argument for “no change” in Australian PHI is very clear. Australia has a good health care system, with private health insurance providing significant funding.

While there are significant differences between the Australian and New Zealand health systems, New Zealand always provides an interesting reference point. The following figure compares insurance participation rates and average premium with Australia.



**Figure 1.2 - Premiums and Participation – Australia and NZ**



The proportion of New Zealanders (31%) with private health insurance is far lower than in Australia (47%). However, New Zealand health insurance premiums are risk rated, and there are no premium rebates or tax penalties for not insuring. New Zealanders generally need to purchase insurance while they are in good health, and this will be one reason for the difference in average premiums.

High participation rates suggest Australian PHI is more successful in reducing reliance on public healthcare. However, some Australians hold only basic insurance so as to avoid tax, and use the public system if treatment is required. If we considered only the people with a good level of cover then the difference in participation rates would be smaller.

The 31% NZ participation rate is similar to Australian participation in the late 1990s, before the introduction of MLS, LHC and premium rebates. Perhaps this is the proportion who would be expected to insure in Australia regardless of the level of government support provided?

## 1.5 So what’s the trouble with community rating?

Our argument is as follows:

- Community rating only works because of the array of carrots and sticks, which force healthy people to buy insurance they wouldn’t otherwise want
- Without the carrots and sticks, Australian would no longer have community rated PHI, or a high PHI participation rate. We note that the proportion of Australians with hospital insurance reduced to around 30% in the late 1990s before the introduction of LHC, MLS and the premium rebate
- While initiatives such as LHC, MLS and rebates have been very successful, the question is whether the success of these initiatives is sustainable. Experience shows that consistent government support of PHI cannot be guaranteed.

We consider whether changes to community rating could make the industry less reliant on the ebb and flow of government support. We examine alternative ways of pricing Australian PHI, assessing each against public policy goals of affordability and PHI participation.



## 2 Our Approach

### 2.1 Projection Model

We have projected the cost of a number of alternatives to the current community rated system and summarise our findings in this section. Our modelling has been calibrated to FY12 industry financial results by age group, as reported by PHIAC.

We have limited the modelling to hospital cover, since community rating is more straight-forward for general treatment benefits.

Where the model was used to assess alternative pricing mechanisms, the approach was to:

- adjust pricing by age group (and the level of the rebate)
- consider changes to participation by age group
- adjust risk equalisation cost by age group, so that the net claim ratio (after RE) was similar for each age group.

The table below shows how we assumed participation would change in response to changes in premium rates. Our modelled scenarios involved premium increases for those aged over 60, and premium reductions for those under 60. Our assumed participation changes reflect the view that younger customers will be more sensitive to price reductions than older customers, because older customers have most to gain from insuring.

These assumptions are largely guesswork in the absence of appropriate studies. The scenarios show the potential impact of changes to community rating, and are intended to stimulate discussion in the industry. Our examples demonstrate a range of pricing options, however there would be many more alternatives. We would be interested in hearing other views on each scenario.



**Table 2.1 – Assumed Participation Changes**

	Premium Change	Assumed Change in Participation
<b>Under 60s</b>	-5%	3%
	-10%	6%
	-15%	10%
	-20%	15%
	-30%	20%
	-40%	30%
	-50%	35%
	-60%	40%
<b>Over 60s</b>	5%	-2%
	10%	-5%
	20%	-14%
	30%	-20%
	40%	-26%
	50%	-32%
	60%	-38%
	70%	-44%
	80%	-50%
	90%	-56%
	100%	-62%
	>100%	-75%

## 2.2 Assessment Criteria

Based on the public policy goals outlined in Section 1.2, we assess each alternative pricing mechanism against three criteria:

- **Affordability:** Considers both the average premium, and the range of premiums
- **PHI participation:** Considers both the overall proportion of Australians insured, as well as the total amount of hospital care funded by PHI
- **Complexity:** Considers the complexity of PHI from the perspective of consumers and taxpayers.

Community rating should be changed if, and only if, an alternative system better meets public policy goals.

## 2.3 The Current System

The current system covers around 10.5 million Australians for some level of hospital treatment (just under half the population). The figure below shows, by age band:

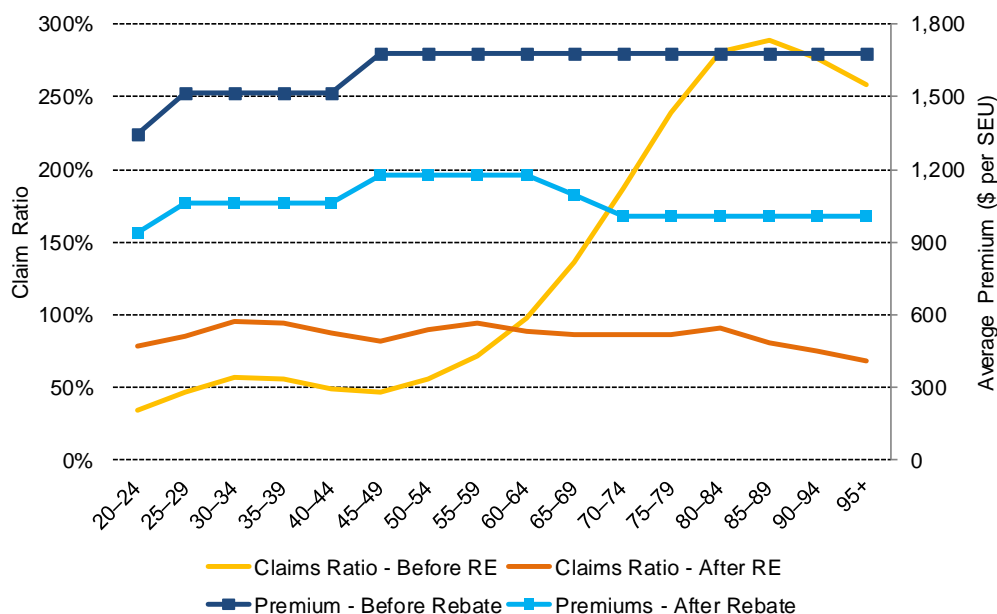
- Premiums – before and after the rebate
- Claim ratios – before and after risk equalisation (RE)



Pre-rebate premium differences between younger and older people reflect our view of the propensity for younger customer to buy the less comprehensive products<sup>1</sup>. Post-rebate premiums also reflect the difference in rebates by age.

Note that we have reallocated children’s claim costs to their parents’ policies. The chart shows the significant differences in underlying claims costs by age, and subsequently how the risk equalisation mechanism complements community rating to “flatten” the claim ratio curve across age bands. After risk equalisation, FY12 claims ratios by age band varied between 69% and 95%, relative to the overall industry claims ratio of around 88%.

**Figure 2.1 – Premium and Claims Experience in Current Scheme (by Age Band)**



The table below summarises some of the metrics reflecting the current position of the industry (noting amounts are for hospital claims only).

**Table 2.2 – Summary of Current System**

Current System - Summary Statistics	
<b>Insured People (m)</b>	<b>10.6</b>
<b>Premiums (\$m)</b>	<b>12,031</b>
<b>Rebate (\$m)</b>	<b>3,817</b>
<b>Benefits (\$m)</b>	<b>10,618</b>
<b>Avg Premium (per adult, net of rebate)</b>	<b>\$1,100</b>
<b>Claims Ratio</b>	<b>88%</b>
<b>Benefits Equalised</b>	<b>42%</b>

Under the current model around 42% of claims are subject to risk equalisation and the Government’s expenditure on the PHI rebate is just under \$4 billion.

<sup>1</sup> The primary reference for this analysis was the ABS expenditure surveys



## 2.4 Summary of Alternatives

We considered a range of alternative scenarios, which can be grouped under the following headings:

- Risk rating
  - ▶ Premiums reflect expected claim costs, however there may be restrictions on the rating factors that can be used or the underwriting process
  - ▶ For example, New Zealand health insurance premiums reflect the health of the customer when the policy is taken out, and then increase with age. However, policies are guaranteed renewable, so health problems emerging after the policy is taken out do not change the premium
- Partial community rating
  - ▶ Premiums vary according to expected claim costs, but do not fully reflect differences in risk
  - ▶ Examples include Compulsory Third Party (CTP) motor insurance
- Other changes to the current system
  - ▶ These include more limited changes to the current pricing mechanism. The lifetime health cover loadings are an example of a previous change to community rating in Australian PHI.

The underlying principle of community rating is that certain groups subsidise the premiums of others. In order to remain sustainable, PHI community rating depends upon the younger population choosing to insure. Lapses by younger people would lead to a “spiral” of rising costs per person, rising premiums and further lapsing of “healthier” people. Conversely, increased participation by younger people reduces price pressures.

Our assessment of alternatives therefore focuses on changes likely to encourage greater participation of younger, healthier people in PHI.



### 3 The Alternatives in More Detail

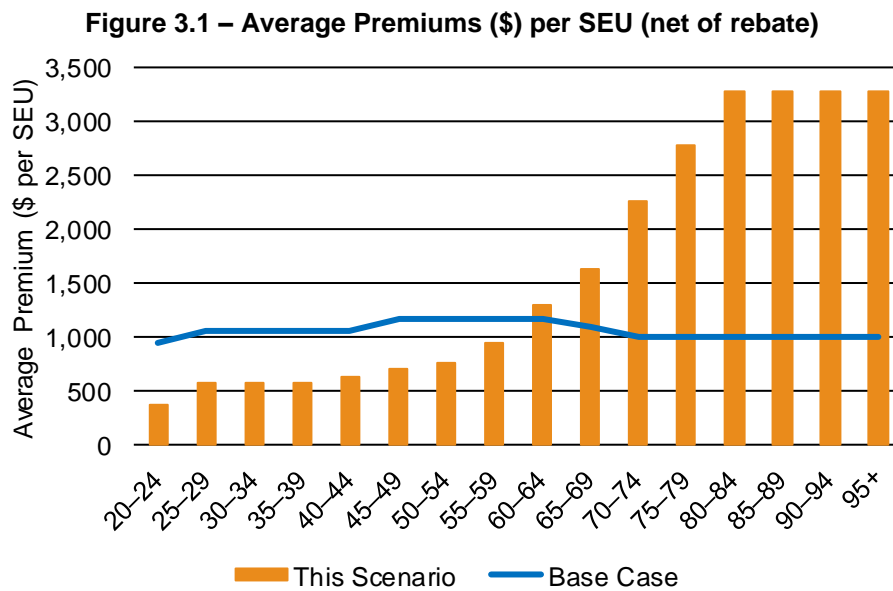
This section provides details on the alternative pricing mechanisms considered, and there is a summary in Section 3.4.

#### 3.1 Risk Rating

In a fully risk rated system, insurers would charge premiums that reflect expected claim costs for each “like group” of customers. We consider the effect of allowing insurers to vary premiums only by age, as this is a significant predictor of claim costs. However a range of other factors may be permitted for risk rated PHI. Risk equalisation would no longer be needed under this system.

##### Risk rating with no change to PHI rebate

In the first of our risk rating scenarios we consider risk rating by age without any changes to the PHI rebate. The figure below shows how average premiums per SEU by age might vary in this risk rated scheme, compared to the current system (base case).



A risk rated model would lead to a significant change in individual dollar premiums paid. Younger people would pay half as much as they currently do, while older people would pay three times as much. In a risk rated system with age as the only rating factor, everyone under 60 would pay less than they do today.

The impact upon participation will be largely dependent upon the price elasticity of older compared to that of younger people. The absence of detailed studies in this area makes it impossible to precisely determine the effect of price changes on participation. However, it seems reasonable to assume that younger people may be more price sensitive than older people. PHI is often a grudge purchase at younger ages, while health concerns become stronger later in life.

The table below summarises our modelled outcomes under such a risk rated system.

**Table 3.1 – Risk Rating Scenario vs Current**

Criteria	Assessment
Participation	Increase of 9% overall 31% increase amongst “subsidisers” (those under 60) 43% decrease amongst people over 60
Average Premium (net of rebate)	\$800 (currently \$1,100)
Range of Premiums	\$400-\$3,000 (currently \$900-\$1,200)
Complexity	Reduced <ul style="list-style-type: none"> <li>✓ Administrative burden of risk equalisation is removed</li> <li>✓ No need for LHC</li> <li>✓ Potential to remove MLS if PHI appears good value to younger customers (no need for the “stick”)</li> </ul>

### Risk rating with changes to PHI rebate

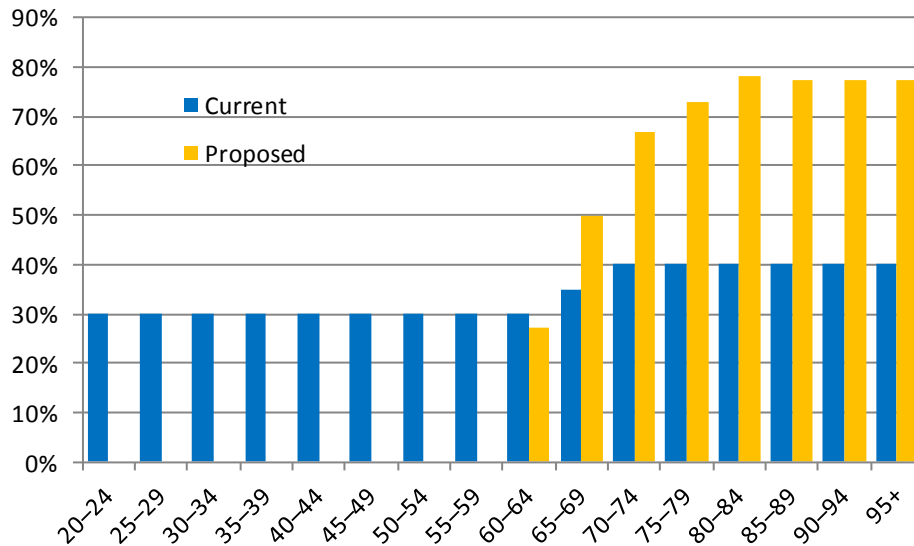
The increased cost of PHI for older people is concerning from a public policy perspective, especially if older people decide to lapse their insurance. Restructuring the PHI rebate could help mitigate these concerns.

One possible modification to the PHI scheme under risk rating would be to remove the rebate for younger people, and increase it for older people. In this way premium rate increases for older people could be moderated (although premium decreases for younger people would also be moderated). The figure below shows the current rebate by age group, as well as what a proposed set of rebates in a risk rated market could look like.



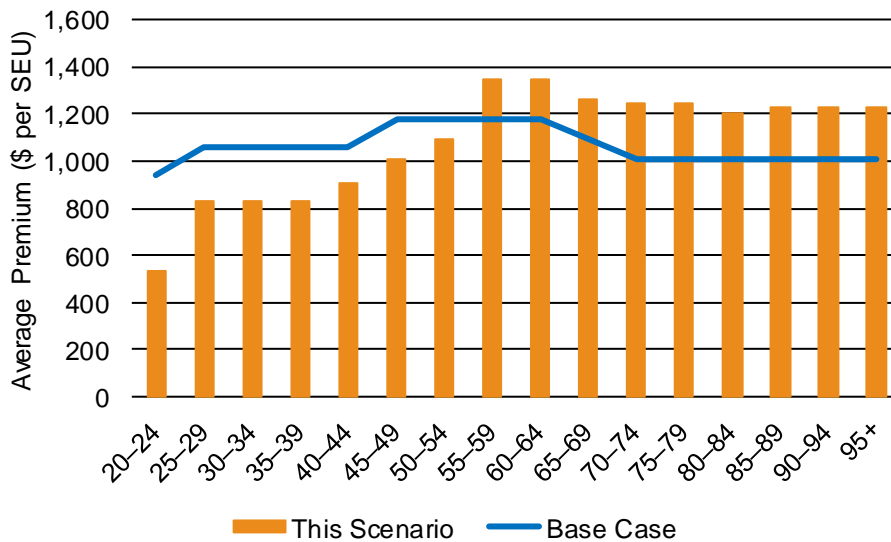


**Figure 3.2 – Rebate – Current and Proposed**



Under this arrangement, people under 60 would receive no rebate, and older people would get increasingly larger rebates of up to 75% (compared to a maximum 40% rebate today). The figure below shows the resulting premiums payable for each age band, after the deduction of the rebate (the base case is the current PHI premium).

**Figure 3.3 – Average Premiums (\$) per SEU (net of rebate)**



Under this revised rebate structure young people still get a discount relative to current premiums (of 10 to 40%), whilst older people would pay slightly more (10 to 20%). Importantly, this adjustment does not change the government’s current dollar expenditure on PHI rebates.

The table below summarises our modelled outcomes under a risk rated system with the removal of rebates for younger people.

**Table 3.2 – Risk Rating Scenario (w/ Rebate Changes) vs Current**

Criteria	Assessment
Participation	Increase of 7% 13% increase amongst “subsidisers” (those under 60) 8% decrease amongst people over 60
Average Premium (net of rebate)	\$1,000 (currently \$1,100)
Range of Premiums	\$550-\$1,350 (currently \$900-\$1,200)
Complexity	Reduced <ul style="list-style-type: none"> <li>✓ Administrative burden of risk equalisation is removed</li> <li>✓ No need for LHC</li> </ul> Increased complexity in rebate structure.

*Rebate changes – The Elephant in the Room*

We have based our modelling on the year ending 30 June 2012, which is the most recent year for which PHIAC financial information is available. The premium rebate has been means tested since 30 June 2012, and government policy is to further reduce rebate funding. These changes will increase the range of premiums paid by different policyholders, as well as the proportion of total premium paid by individuals (rather than the government).

We show examples where rebate funding is reallocated to those with the highest claim costs. This could better link rebate funding to public policy objectives, while reducing the effect of risk rating or partial community rating on older Australians.

**3.2 Partial Community Rating**

An alternative to full risk rating is to allow partial community rating, so that insurers are allowed to vary premiums within certain limits. This is similar to what is currently done in the NSW CTP scheme, where insurers are free to risk rate within predefined limits for discounts and loadings to the average base rate.

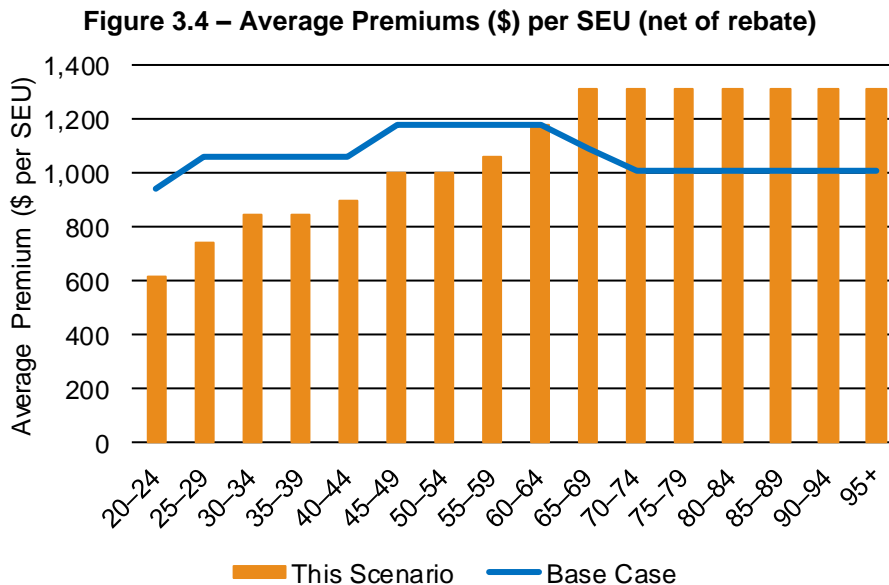
Under a system of partial community rating risk equalisation would need to remain a part of the system, although its role may be diminished.

Again, we consider the changes to community rating both with and without changes to the PHI rebate.



### Partial community rating with no change to PHI Rebate

The figure below shows how average premiums per SEU by age might vary if insurers were allowed to offer discounts of up to 35% for healthier people, and load up to 30% for the poorer risks. For the illustrative purposes of considering this scenario we have assumed that the insurers will only be allowed to vary premiums based on customer age.



The table below summarises our modelled outcomes under a partially community rated system with limits on premium discounts and loadings for age.

**Table 3.3 – Partial Community Rating Scenario vs Current**

Criteria	Assessment
Participation	Increase of 8% 16% increase amongst “subsidisers” (those under 60) 10% decrease amongst people over 60
Average Premium (net of rebate)	\$1,000 (currently \$1,100)
Range of Premiums	\$600-\$1,300 (currently \$900-\$1,200)
Complexity	Unchanged, although role of risk equalisation is reduced.



### *Kids Go Free?*

Businesses run various promotions to attract different groups of customers, including discounts for families, seniors and students. However, most businesses charge more for families with children than for couples. For example, people with children generally buy more than couples at the supermarket, and expect to pay more too.

Private health insurers are able to charge different rates for couples and families, but generally charge the same rate. This reflects both the nature of risk equalisation arrangements as well as accepted market norms.

The partial community rating shown in Figure 3.4 above could be combined with charging child premiums, for example, \$5 or \$10 per child per month. The increases in premiums as the adults age would be partially offset by reductions as children come off their parent's policy.

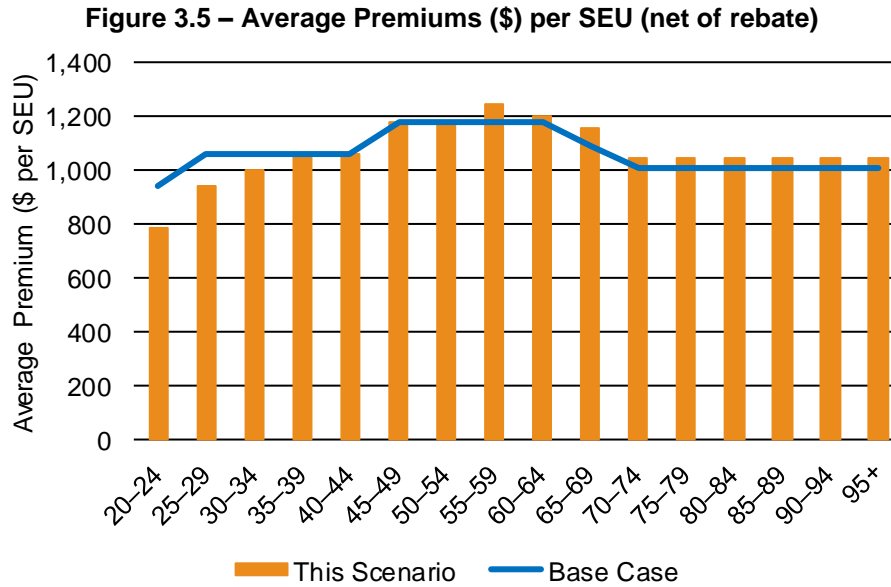
For example, we have assumed premiums of \$2,000 for a 45 year old couple and \$2,622 for a 65 year old couple, an difference of \$622 or 31%. If the 45 year old couple's policy covers three children at an additional \$120 per child per year, the total premium increases to \$2,360. Assuming the 65 year old couple do not have children on their policy, this narrows the difference in price to \$260, or 11%.

### Partial community rating with changes to PHI Rebate

As with the risk rating scenario, Government could combine changes to community rating with a reallocation of the PHI rebate.

It may be more politically palatable to adjust the PHI rebate structure so that premium increases for older people are only marginal. The figure below shows premium per SEU by age if the Government were to alter the PHI rebate such that premium increases for those over 55 were limited to 5% (allowing for the increase in PHI rebate), and under 35s received a discount of 5-20%.





The table below summarises our modelled outcomes under this scenario.

**Table 3.4 - Partial Community Rating Scenario (w/ Rebate Changes) vs Current**

Criteria	Assessment
Participation	Increase of 2% 3% increase amongst “subsidisers” (those under 60) Slight (less than 1%) decrease amongst people over 60
Average Premium (net of rebate)	\$1,100 (currently \$1,100)
Range of Premiums	\$800-\$1,250 (currently \$900-\$1,200)
Complexity	Increase complexity in rebate structure.

### 3.3 Other Changes to the Current System

There remain other, less significant changes that could be made to the existing model which may reduce pressure on claims costs. Options here include:

- Premium loading for certain health factors deemed within control of insured – eg. smoking, or BMI
- Rebalancing the calculated deficit factors to “equalise” claim ratios across age bands
- Risk based capitation – admittedly not minor in execution, but no change to community rating from a customer perspective.

Clearly there are advantages and disadvantages of each scenario. In particular, smoker loadings are well aligned with public health policy. However, these changes would not

significantly change the range of premiums charged, so would not have a significant effect on PHI participation.

If the aim is to make PHI available to more Australians with less reliance on government, the ideas listed above can only form part of the solution.

### 3.4 Summary of Alternatives

The table below summarises the outcomes under each of the alternatives according to our assessment criteria.

**Table 3.5 – Assessment of Alternatives**

	Change in Participation Total	Change in Participation "Subsidisers"	Change in Average Premium	\$ Range of Premium	Complexity
<b>Risk Rating</b>					
Risk Rating	9%	31%	-283	Much wider (\$400 to \$3,000)	Reduced
Risk Rating w/ Rebate Changes	7%	13%	-80	Wider (\$550 to \$1,350)	Reduced
<b>Partial Community Rating</b>					
Partial Community Rating	8%	16%	-114	Wider (\$600 to \$1,300)	Similar
Partial Community Rating w/ Rebate Changes	2%	3%	-8	Slightly wider (\$800 to \$1,250)	Similar
<b>Modifications to Community Rating</b>					
Loadings for health factors (BMI, smoking etc.)	Minor	Minor	Minor	Slightly wider	Increased
Resetting Calculated Deficit Factors	Nil	Nil	Nil	No change	No change
Risk Based Capitation	Minor	Minor	Minor	No change	Increased

In summary, our conclusions are:

Risk rating would clearly result in a wider range of premiums. Most age groups would benefit from lower premiums, so overall participation rates would be likely to increase. Risk rating would allow some of the complexity of community rating to be removed, for example, risk equalisation, and (potentially) lifetime health cover and the Medicare levy surcharge.

Risk rating would result in much higher premiums for older people, which is incompatible with public policy objectives. Restructuring the rebate could help reduce the range of premiums charged under this scenario. The partial community rating scenarios (with and without changes to rebate) have a similar effect on the range of prices.

The scenarios show the trade-off between a wider range of prices (lower premiums for young people) and increasing participation. Changes such as loadings for lifestyle factors (smoking, BMI) do not significantly change the range of premiums charged, so would not have a significant effect on PHI participation.