Private health insurance in Australia: Current issues
Adam Jupp
May 2016
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

Private health insurance in Australia: Current issues
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
Who pays for what?
Health system in Australia
Where does the money go?

Private health insurance in Australia: Current issues

AIHW, Australia’s Health 2014
May 2016
Health system in Australia
International comparison


Private health insurance in Australia: Current issues

May 2016
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

Medicare had a negative impact on private health insurance in Australia.
The policy decisions (and marketing campaign) in 1999-2000 reversed this trend.

Percentage covered is starting to plateau but sits at approximately 47% of the population.
State based covered
30 June 2015

Hospital

Total: 47.4%

- 55.2%
- 46.2%
- 45.3%
- 45.0%
- 48.1%

- 39.9%
- 46.2%
- 48.1%
- 66.7%
- 58.2%

General treatment

Total: 50.9%

- 40.8%
- 46.9%
- 55.8%
- 52.7%
- 43.7%

- 66.7%
- 40.8%
- 46.9%
- 55.8%
- 48.1%

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

Private health insurance in Australia: Current issues

APRA Private Health Insurance Membership and Benefits

May 2016
**Coverage by age**
30 June 2015

Private health insurance coverage by age and product

![Bar chart showing private health insurance coverage by age and product](chart.png)

- Hospital
- General treatment

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May 2016
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Industry structure
P&L over 2014/15

Revenue

21.3 billion

Benefits

18.1 billion

Profit

1.1 billion
Industry structure
Balance sheet at December 2015

Assets
11.8 billion

Liabilities
4.9 billion

Excess capital
5.6 billion

Capital above liabilities and the minimum regulatory capital amount
**Industry Structure**

Not for profit vs For profit

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**Market share at 30 June 2015 (% of all policies)**

- **At 30 June 2015:**
  - 34 insurers
  - 9 for profit (68% market share)
  - 25 not-for-profit (32% market share)

- **Market share of top five insurers:** 81%

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Private health insurance in Australia: Current issues

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Industry Structure
Open versus restricted

Market share at 30 June 2015 (% of all policies)
### Regulation and legislation

#### Legislation

<table>
<thead>
<tr>
<th><strong>Private health insurance Act 2007</strong></th>
<th><strong>Private Health Insurance (Prudential Supervision) Act 2015</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Aim of Act is to:</td>
<td>Registration process</td>
</tr>
<tr>
<td>(a) provides incentives to encourage people to have private health insurance; and</td>
<td>Imposes requirements about how PHIs conduct health insurance business</td>
</tr>
<tr>
<td>(b) sets out rules governing private health insurance products.</td>
<td>Deals with other matters in relation to the prudential supervision of private health insurers.</td>
</tr>
</tbody>
</table>
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
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
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
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

<table>
<thead>
<tr>
<th>Taxable income (Singles)</th>
<th>Standard</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>$≤90,000</td>
<td>26.79%</td>
<td>17.86%</td>
<td>8.93%</td>
<td>0.00%</td>
</tr>
<tr>
<td>$90,001-105,000</td>
<td>17.86%</td>
<td>10.50%</td>
<td>5.25%</td>
<td>0.00%</td>
</tr>
<tr>
<td>$105,001-140,000</td>
<td>8.93%</td>
<td>4.25%</td>
<td>2.125%</td>
<td>0.00%</td>
</tr>
<tr>
<td>$≥140,001</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Rebate

<table>
<thead>
<tr>
<th>MLS %</th>
<th>Standard</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.00%</td>
<td>1.00%</td>
<td>1.25%</td>
<td>1.50%</td>
<td></td>
</tr>
</tbody>
</table>
What drives premium increases?
Annual premium round process
1 April

2016 Premium Round increase

- Average
- For Profit
- Not for profit

Industry rate protected increase

<table>
<thead>
<tr>
<th>Year</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>5.94%</td>
</tr>
<tr>
<td>2012</td>
<td>5.19%</td>
</tr>
<tr>
<td>2013</td>
<td>5.60%</td>
</tr>
<tr>
<td>2014</td>
<td>6.20%</td>
</tr>
<tr>
<td>2015</td>
<td>6.18%</td>
</tr>
<tr>
<td>2016</td>
<td>5.59%</td>
</tr>
</tbody>
</table>
**Key drivers**

**Utilisation**
Ageing population  
Medical technology advances  
Changing lifestyle  

**Benefit averages**
General inflation  
New technologies
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.
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.
**Prostheses pricing**

Impact of reform

**PHA estimates of impact of reforming prostheses pricing**

- 45% reduction in price
- $800M savings per annum
- $150 reduction in annual premium

In the Budget, Federal Government committed $3.2 million to 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.

PHA, Costing an arm and a leg, 2015
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.


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
**Complexity**

Healthy Helper example

1

3

Healthy Helper

$0 XS  
$250 XS  
$500 XS
Complexity
Healthy Helper example

1

3

12

Healthy Helper

$0 XS

$250 XS

$500 XS
**Complexity**

Healthy Helper example

1

3

$0 XS

$250 XS

$500 XS

12

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PwC

May 2016
Junk cover

The issue

Don't waste your money on 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?