Private Healthcare Australia

Better Cover. Better Access. Better Care.

Response to the Private Health Insurance Actuarial Study into Risk Equalisation

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About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have 24 registered health funds throughout Australia as members and collectively represent 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for over 14 million Australians.

Introduction

Private health insurance is highly regulated in Australia, with a range of mechanisms designed to protect provider interests and assist consumer access. As outlined in the discussion paper, there are issues with the existing operation of the risk equalisation pools. These are worthy of reform.

However, risk equalisation reform needs to be supported by policy changes with clear and short-term consumer benefits. PHA have highlighted several reform targets which would deliver significant savings to consumers immediately, including:

- Reducing the costs of overpriced medical devices
- Removing the subsidy program for hospitals, second tier default benefits
- Eliminating low value care
- Allowing funds to provide more services out of hospital, by removing limitations for Chronic Disease Management Programs.
- Restoring the PHI rebate and increasing the Medicare Levy Surcharge

Each of these priorities would significantly improve public value and increase efficiency. Currently, funds have both incentives and means to address operational efficiency. Funds also have significant incentives to improve the population health of their membership, and funds invest heavily in prevention measures. However, they are compromised in doing so by an inability to work with primary care imposed by legislation.

The objectives of increasing efficiency through the risk equalisation pool are significantly compromised by lack of action to ensure consumer value with other reforms. If providers (including medical device companies) are continued to be supported to provide low value care through regulation, the capacity of health funds to capture efficiencies on behalf of their members is limited.

Premiums will continue to remain higher than necessary unless regulations increasing costs are addressed.

Changes to risk equalisation policy settings should provide incentives for:

- Efficiency (where not compromised by other policy settings)
- More comprehensive policy coverage (eg more gold policies)
- Younger members (to improve the risk pool), and

System changes should also deter 'gaming' where products can be designed to take advantage of the risk equalisation pool, and seek to minimise external negative consequences.

The work done to date on risk equalisation provide a theoretical framework with which to move forward. The work to date can be used as a platform to provide a framework for future changes.

PHA recommends that the next stage of this work provide a more tangible set of options for the industry to consider.

Implementation can be based on a platform with an extended range of risk adjustment factors, several of which can be set to zero for the initial implementation phase. Risk adjustment factors to be considered as part of the platform include the customer characteristics identified in the report, as well as product tiers and clinical categories.

By highlighting the factors to be considered for future implementation – a roadmap for the future with clear timeframes - funds will be able to undertake more sophisticated modelling on the effects of future changes and provide better advice to government.

The work to date provides the case for building the platform, but the information provided is insufficient for funds to fully understand the proposal as it stands and make a fully informed assessment.

PHA recommends that the government consider two further stages – first, build the platform based on the existing work and populate three preferred options for first stage implementation with solid data and examine the three preferred options in terms of effects and consider key risks. This process should include the expected financial impacts on each fund, as well as logistical impacts of implementing any new model. Funds can then make informed judgements about whether the objectives of the reform will be met, providing that advice to government.

Then government can, in the next stage, start implementing the option that provides the greatest public benefit. This will be assisted by a strong framework and roadmap pointing the way to further adjustments over time, supported by a strong and well-understood evaluation framework.

Response to the recommendations

1. Replace the current Age-Based Pool (ABP) and High-Cost Claims Pool (HCCP) with a hybrid RE system that combines risk adjustment with a targeted form of risk sharing, and provides a platform for improvement. The new system prospectively redistributes premium revenues on the basis of age, sex and possibly other policyholder characteristics (a form of risk adjustment). In addition, the new system retrospectivity redistributes outliers in policyholder claims costs (a form of risk sharing also known as reinsurance). The new system involves a commitment to evolve that allows for the future addition of new risk adjustors (such as health indicators) and modifications of the claims cost threshold used for risk sharing.
2. Implement a simple hybrid RE system: Replace the current ABP and HCCP with a simple hybrid system that combines risk adjustment and a high degree of risk sharing.

The overall concept is sound but lacks specificity. The conceptual case for change is clear, but the nature of the change and the outcomes it will produce is not clear from the data available in the report.

The report notes the importance of the rest of the regulatory structure, and PHA notes that there are short term measures that the government can introduce that provide material benefit to consumers to reduce low value care. Changes to risk equalisation in isolation will not improve value sufficiently.

3. Risk Adjusters: The analysis indicates risk adjusters of age, sex and state for initial implementation together with a system that allows a platform for adding further risk adjustment when calibrated.

Funds have mixed views on where to start, which is partially due to the lack of specificity in the modelling in the current report. PHA recommends that the department expand the list of possible health indicators – including obstetrics and mental health - and model both age, sex and state as well as preferred health risk indicators. Other adjusters, such as length of membership, may also be considered,

We also recommend the adjusters include investments into health management programs. Helping customers managing their health provides benefits to the individual, the fund and the community as a whole. There is substantial benefit to members if funds increase their focus on prevention and chronic disease management.

Relying on easily divided segments based on age, sex and geography may provide perverse incentives.

4. Risk Sharing involving an attachment point and a proportion shared. The simulation analysis tested a number of options and, while not purporting to be optimum, an attachment of $20,000 annual cost and a 90% proportion shared for costs above this tested well.

These data are not available for funds' assessment and should form part of the consultation at the next stage.

5. The RE pool transfers to insurers continue to operate on a quarterly basis with an annual review process to balance the accounts.

Nil comment.

6. A regulator: Identifying a 'regulator' to take responsibility of setting the risk adjustment parameters based on experience data.

Funds have mixed views but highlight the need for consistent presentation of data to regulators.

7. Evaluation and monitoring: This is a vital part of a successful system that aims to evolve as a platform for improvement. We recommend that an ongoing process of evaluation and monitoring be established.

Agree.

8. Data Imposition and Impact Assessment: We recommend the implementation process confirm the data impost on stakeholders

The costs of collecting the data should be minimal if this process echoes other regulatory data requirements. Collecting the range of data covered by the proposed 'dashboard' approach will also

regulators to quickly determine any unintended consequences as well as provide signposts for future changes to the pool.

9. Product coverage tiers: The recommended approach is to implement a series of risk adjustor variables for coverage tiers in combination with a set of 'constraints' on the coefficients (payment weights) for these variables. A longer-term superior design may include a standard benefit package, however PHI currently includes Gold/Silver/Bronze/Basic product tiers.

Clinical categories (and the resulting product tiers) and deductibles are vital components to be tested and monitored as part of the dashboard. Through the introduction of product tiering, the government has inadvertently set incentives for private health insurers to downgrade product quality to meet other objectives such as lower headline premium increases.

Risk equalisation was designed to protect funds (and their members) against high-cost claims and higher claim frequencies, which were initially more concentrated at older ages. However, high-cost claims data collected by PHA now clearly demonstrates that younger people are strongly represented with high-cost claims, particularly with mental health and obstetrics/neonatal care. The risk equalisation framework needs to encourage younger members and encourage more to join health funds - and not to selectively move between Gold and lower tier products.

10. Stakeholder Impact: Our analysis indicates the financial impact on implementation is not material for most insurers

Without detailed modelling available, it is not possible to comment on this assertion. However, we note that material financial impact will be measured differently by funds.

The changes may be very significant for some members. For example, if the proposed changes result in younger people or lower income families being required to pay more for insurance, that may impact on member retention and attraction.

It is also difficult to envisage a system which improves incentives overall that does not have material benefits and losses for some funds or categories of members.

11. Transition time: Given the need to develop tools for efficiency and adapt to a new system, it is recommended that an appropriate transition time be identified and agreed upon.

PHA recommends an initial three-year implementation period, with 'guard rails' in place to limit the risk to funds. We recommend that changes to contributions be considered as a proportion of the total net hospital claims of the fund (ie claims after risk equalisation). The movement due only to the change in the system should then not drive a difference of more than say 3% in net claims. This will also allow some calibration of the risk adjustment factors and/or the attachment point without dramatic changes affecting funds' risk appetites. The implementation period may need to be longer if the changes are more significant.