KPMG

cutting through complexity

Tour de PHI

David Torrance

29 November 2013

Some observations, thoughts, questions …

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Community Rating

Not defined explicitly but is the backbone of Australian health insurance

Consistent with the funding of healthcare (including PHI) being about the younger, productive members of society funding the older members of society

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Community Rating – Fact or myth ?

(1) A private health insurer must not (a) take or fail to take any action; or (b) in making a decision, have regard or fail to have regard to any matter; that would result in the insurer *improperly discriminating between people who are or wish to be insured under a complying health insurance policy of the insurer.

(2) Improper discrimination is discrimination that relates to:

(a) the suffering by a person from a chronic disease, illness or other medical condition or from a disease, illness or medical condition of a particular kind; or

(b) the gender, race, sexual orientation or religious belief of a person; or

(c) the age of a person,[except LHC & dependant children]; or

(d) where a person lives [except state pricing]; or

(e) any other characteristic of a person (including but not just matters such as occupation or leisure pursuits) that is likely to result in an increased need for *hospital treatment or *general treatment; or

(f) the frequency with which a person needs hospital treatment or general treatment; or

(g) the amount or extent of the benefits to which a person becomes entitled during a period under a *complying health insurance policy, except to the extent allowed under section 66-15; or

(h) any matter set out in the Private Health Insurance (Complying Product) Rules for the purposes of this paragraph.

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Community Rating

Insurers target specific products to particular groups of people via exclusions and/or restrictions

- Is this improper discrimination?
- Discrimination on the basis of age / health / family status?

In reality, do we have a form of group insurance

… that operates at the fund / state / product / scale level

… or at a lower level - what about corporate products?

If community rating is a myth or is not working

- what does it mean for the future of private health insurance?

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Community Rating

Do we need to support older insured persons to the current extent?

Older persons have substantial financial concessions:

- "Community rated" PHI – at least support via the risk equalisation arrangements
- Tax concessions associated with super e.g. no tax on super after age 60
- Seniors and pensioners tax offset & mature age worker tax offset

Increasingly older persons have substantial assets.

Should they be supported by younger persons with significant financial commitments.

What is equitable?

Should older Australians contribute more to their health care?

Can we sustain "community rating" with an ageing population, with disparity of wealth between generations?

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Community Rating

Are the issues created by an ageing population over stated?

Dependency ratio is a commonly used indicator of affordability – ratio of those aged under 15 and over 65 to those in the working age population of 15-65

- No regard to economic, social or medical circumstances
- Commonly, projections show this deteriorating to an unsustainable level.

Have been articles, including a recent one in the BMJ, questioning the appropriateness of the dependency ratio.

- Many persons older than 65 still do some form of work, have substantial assets
- Not all persons 15-65 are working, many dependents in the 15-65 age cohort

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Community Rating

Alternate ratio*:

- Numerator: Number actually employed irrespective of age
- Denominator: People with a remaining life expectancy of ≤15 years

Gives a very different picture

Older Australians are healthier than past generations.

Still require health care, but will the nature of this be different to past generations?

- Greater focus on preventative health care, occupational health care (to keep working)

**** British Medical Journal: Population Ageing The timebomb that isn't? Jeroen Spijker and John MacInnes***

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Insurance

Is private health insurance INSURANCE?

Insurance contracts at their most basic agree to pay for certain unexpected events in exchange for a fixed predictable premium.

This may be true to some extent for hospital benefits …

BUT…

- there is certainly an element of discretionary hospital expenditure albeit often with unknown costs
- doesn't seem true for many ancillary (general treatment) benefits?

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Insurance

Pooling of risks

Due to the inability of an individual/enterprise to deal effectively with her/his own risk as to the frequency, timing and/or the severity of pertinent contingent events, pooling of reasonably homogeneous risks is needed. In this way, the individual contract-owner is able to spread her/his risk by transferring it to a pool of similar risks.

This may be true to some extent for hospital benefits …

BUT…

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Insurance

What are we offering?

Hospital benefits:

- Accommodation benefits with an excess known at the time of purchase
- Medical benefits with an unknown excess at the time of purchase
  - of the in-hospital medical services paid in the September 2013 quarter:
    - 89.6% had ‘no gap’ with a further 3.0% having a ‘known gap’
  - excess (or gap) only identified at the time of claiming
  - excess (or gap) varies considerably depending upon the procedure, location and specialist
- Exclusions and restrictions

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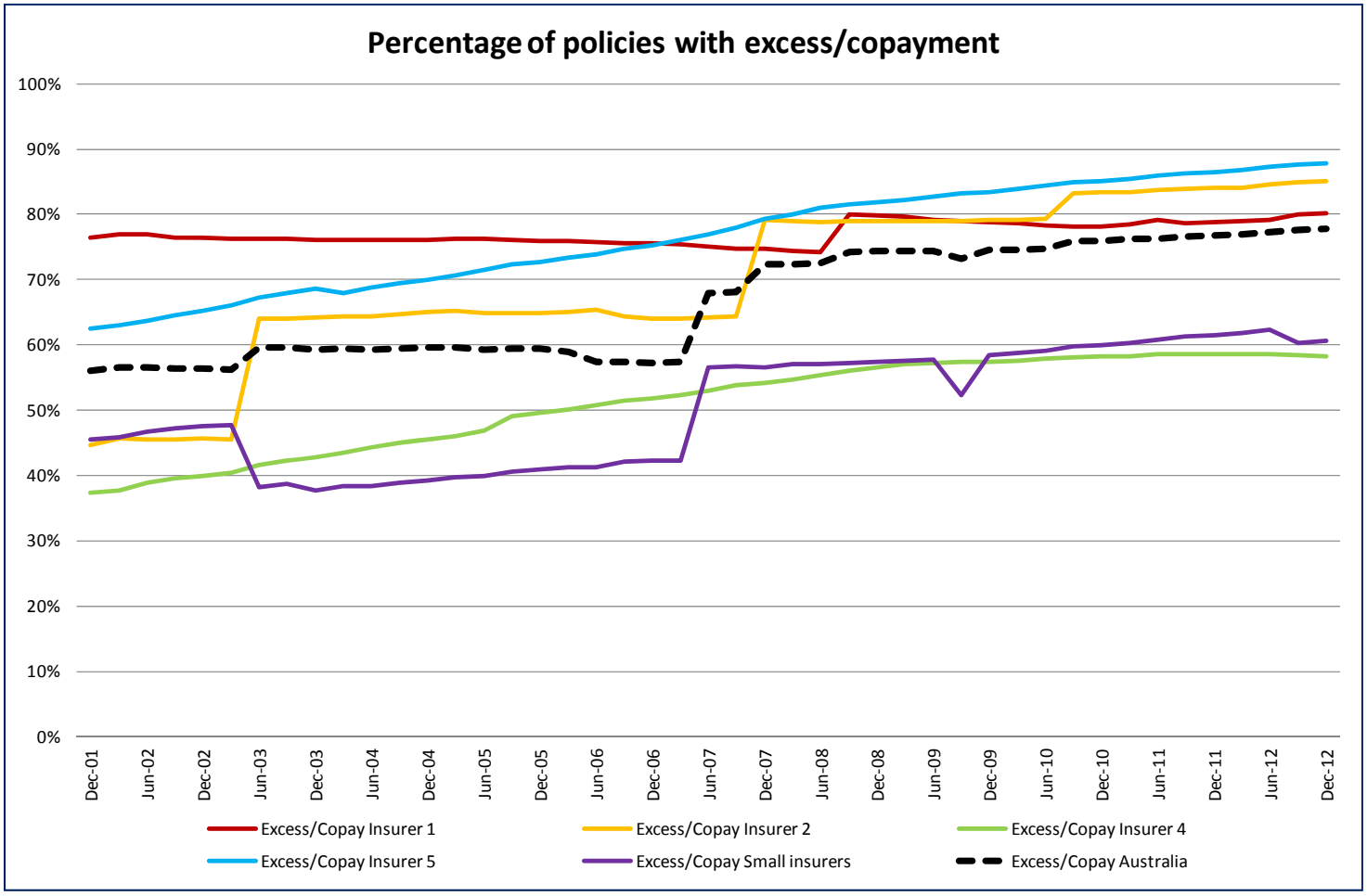
Insurance



The majority of policies sold since 2001 have an excess or co-payment.

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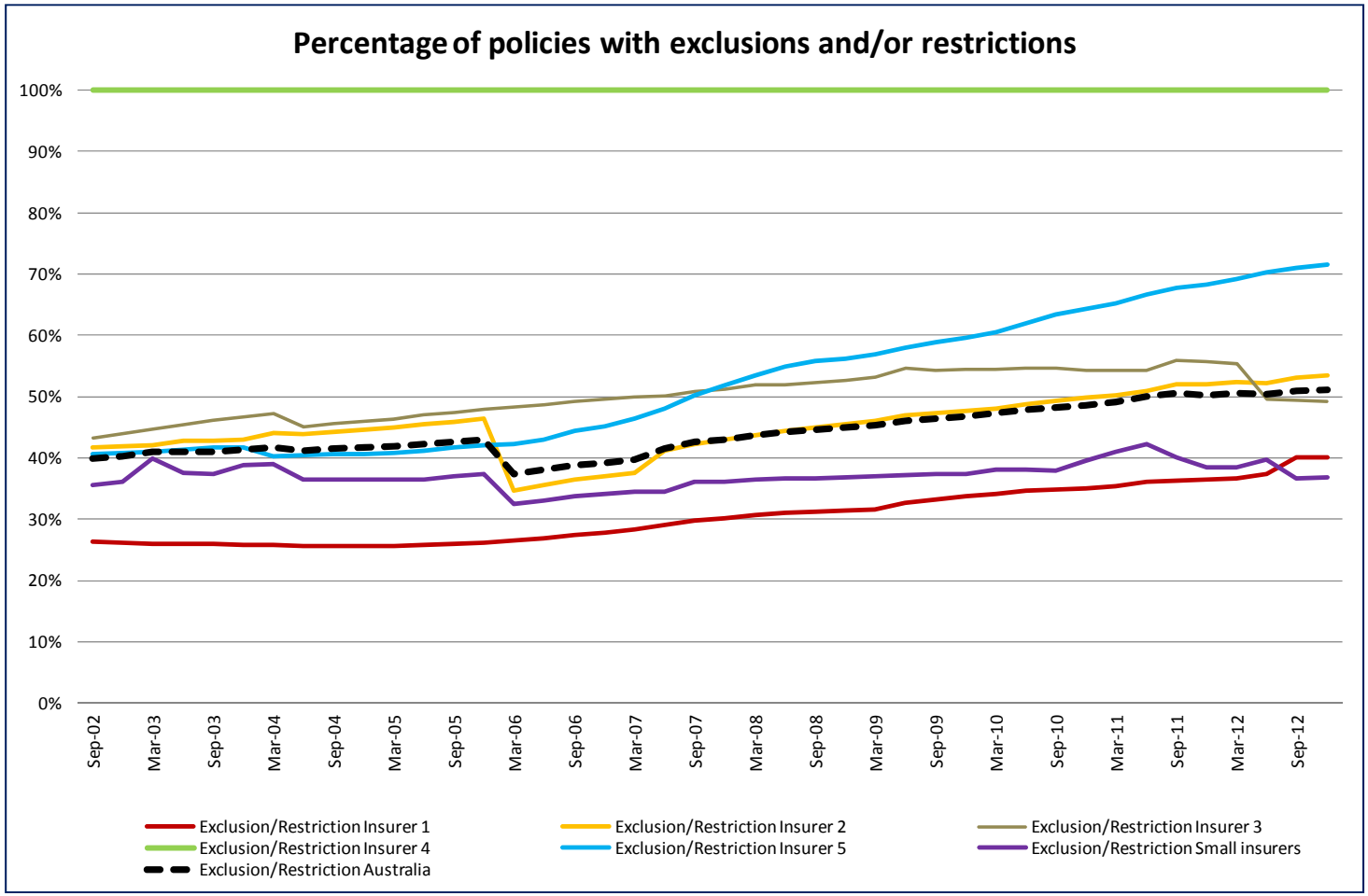
Insurance



Range of consumer views on policy exclusions. Some people don't want to pay for things they don't need, others believe exclusions undermine their cover.

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Insurance

What are we offering?

What is the purpose of ancillary benefits?

- To improve health (e.g. dental, optical, physio)?
- To provide services the government won't (e.g. dental)?
- To get people into health insurance (and then up sell)?

Ancillary benefits:

- Often events are not unexpected
- Often the frequency, timing and severity of the event is known

To what extent do we need to pool the risks for ancillary cover

Should ancillary benefits be risk rated?

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Insurance

Do we need to re-think the hospital v ancillary offering?

- Hospital products provide insurance coverage
- Ancillary products provide a form of pre-funding
- Does pre-funding of ancillary products create a different culture compared with other forms of insurance
  - “the right to claim because I’ve paid my premium” (particularly for ancillary)

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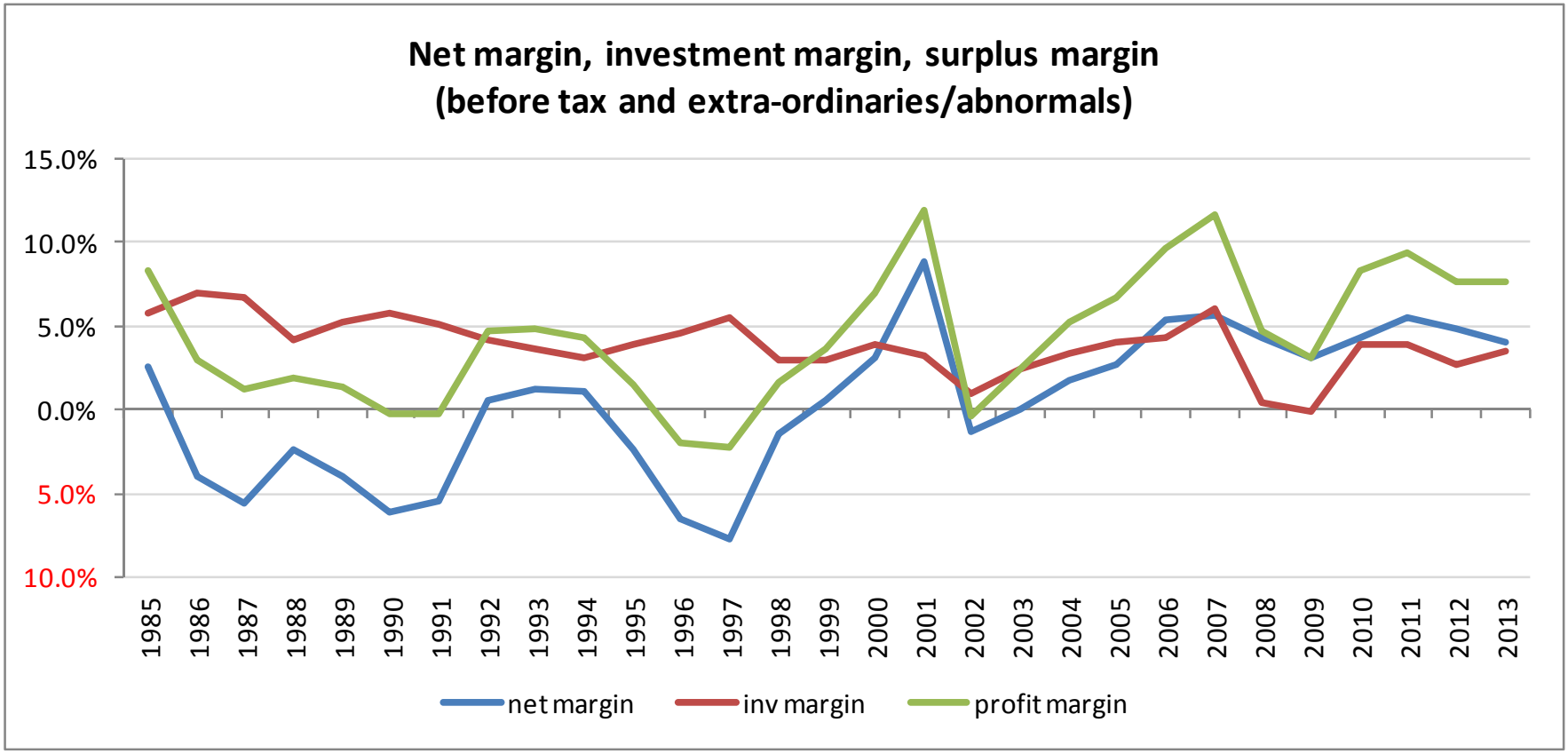
Insurance

Industry profitability - % premiums



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Insurance

For many insurers, ancillary gross margin > hospital gross margin

e.g. industry FY12 gross margin hospital 12% ancillary 24%

How much of the recent industry profitability is due to the 30% rebate and the profitability of ancillary products?

Bit of a leap of faith in this example but …

- Logically, a consumer will pay a $700 premium if they get at least $700 back
- Not all will claim, so average cost is likely to be less than $700
- But let's call the average cost $700
- But premium to the insurer is $1000 as other $300 paid by the government
- So gross margin is 30% !!!

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Insurance

Ancillary benefits contribute significantly to the profitability of PHI:

- Will the rebate changes impact the profitability of ancillary?
- Will the rebate changes impact the profitability of PHI?

- Obviously quite complicated, some ancillary products might actually retain a 30% rebate for some time depending on benefit improvements (given that rate increases are typically lower)

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Guaranteed acceptability and guaranteed renewability

Life insurance

- Acceptance not guaranteed – significant underwriting
- Renewal guaranteed but premiums can change depending upon the contract
- Life insurance is regarded as a long term contract

General insurance (short tail e.g. home and motor)

- Acceptance not guaranteed – significant underwriting
- Renewal not guaranteed - generally a 1 year contract
- General insurance is regarded as a short term contract

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Guaranteed acceptability and guaranteed renewability

PHI Guaranteed acceptability

- Provided you meet any eligibility criteria (restricted access insurers)
- Only underwriting is waiting periods and benefit limitation periods

PHI Guaranteed renewability

- Health insurance is renewable at the option of the policyholder, insurer has no right to deny renewal

BUT

What is the value of this “right”?

- Right to renew is really only as a ‘member’ or ‘policyholder’ of the fund
- Insurer can change premiums
- Insurer can change benefits
- Insurer can migrate policyholder from current product to another product

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Guaranteed acceptability and guaranteed renewal

Is health insurance long term or short term?

- Clearly short tailed – but this relates to time from incurred to reported to paid for claims
- Insurer can change premiums/benefits – does this suggest short term?
- But policyholder has the option to renew – does this suggest long term?

- Does the industry think long term or short term?

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Guaranteed acceptability and guaranteed renewal

Is health insurance long term or short term?

- Does the annual premium cycle encourage short term thinking?
- Does the ability to change premiums and benefits encourage short term thinking?

- Can we blame policyholders for thinking short term and switching?
- Can we blame sovereign risk for not looking long term? How real is the risk?

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Guaranteed acceptability and guaranteed renewal

Does the industry view private health insurance as long term?

- What is the long term sustainable position for PHI?
- Can the industry rely on constantly changing the premiums and (downgrading) benefits?
- May have a different view of the capital held within health benefits fund if we look long term:
- Could lead to a different view on product changes, premium increases, etc

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Portability

- The ability to move between insurers for same level of cover without further underwriting i.e. the imposition of waiting periods
- At a basic level it seems good - promotes competition, supports community rating (?)
- However can lead to adverse outcomes
- Should it apply to both hospital and ancillary products?

- Impact of a longer term view?

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Risk equalisation

Concept is simple really!

- Pool some costs or risks
- Then re-spread these costs or risks across all who participate in private health insurance

CURRENT SYSTEM

- Doesn’t pool expected risks, pools actual costs – impacts on incentives for cost control
- Per capita cost irrespective of premium, level of cover etc
  - Impact on price of low cover and high excess products
  - Impacts price differential for excess products (because of minimum flag fall)

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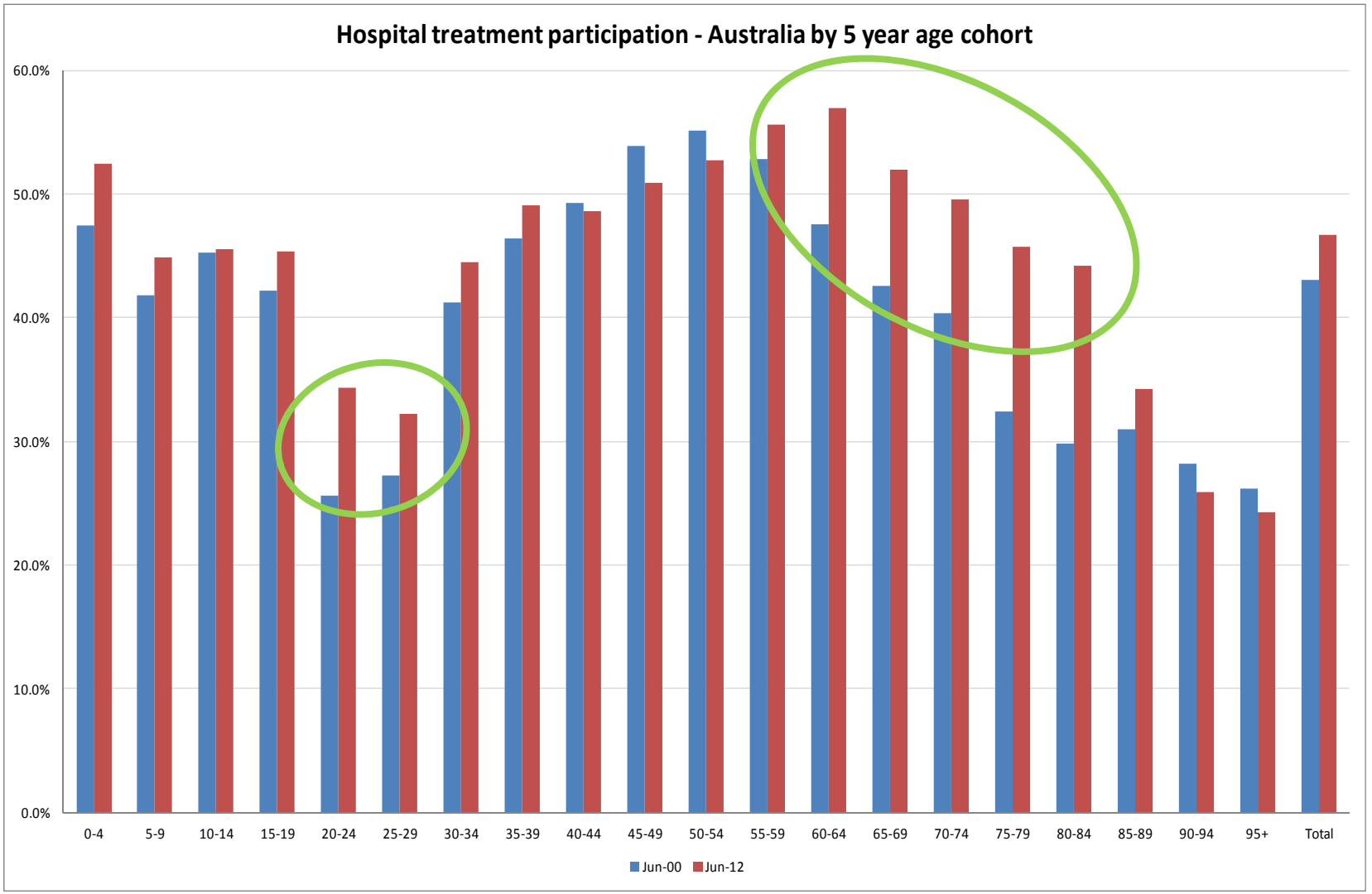
Risk equalisation



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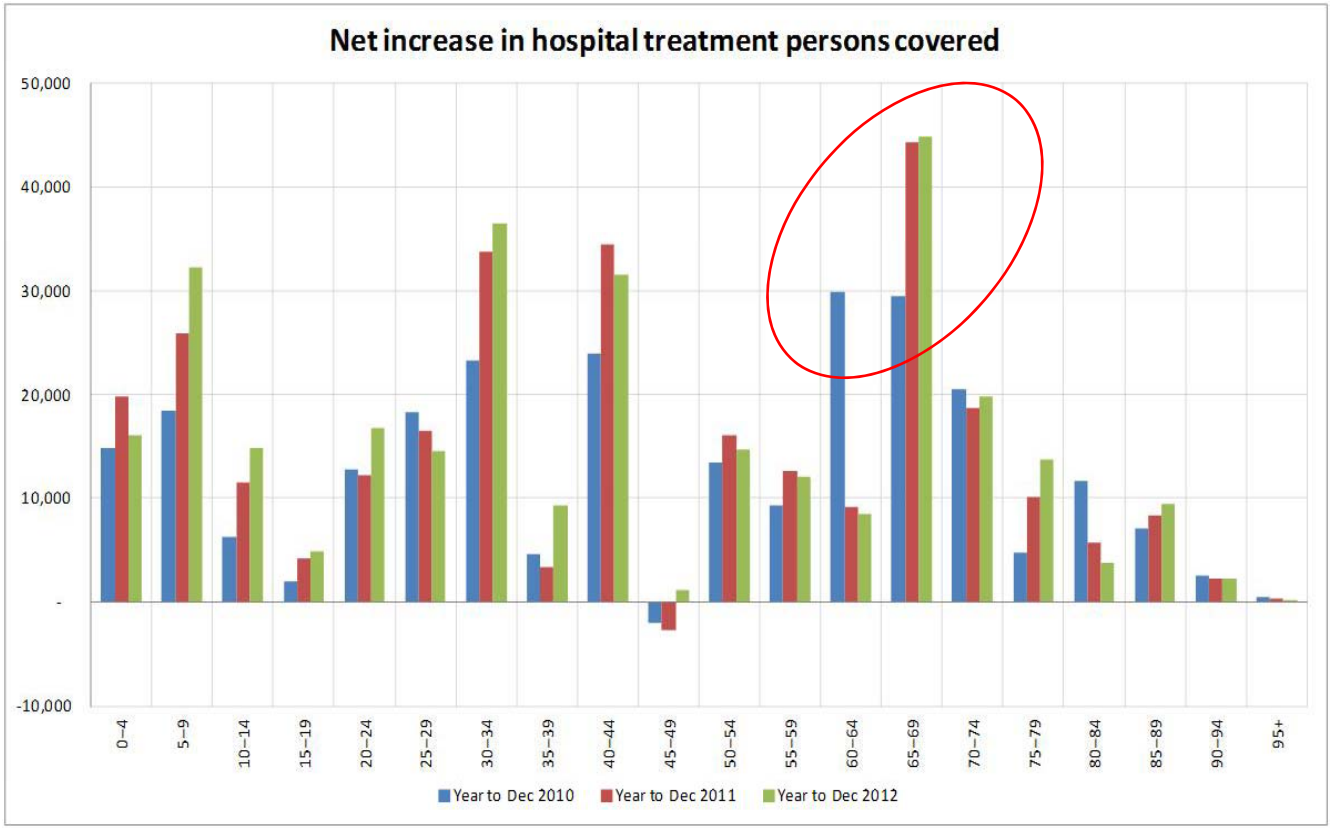
Risk equalisation

Proportion of total hospital claims eligible for risk equalisation has increased from 39.3% in September 2008 quarter, to 41.6% in September 2012 quarter and is projected to keep increasing.



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Risk equalisation

Can make some changes to the current system to “improve” it:

BUT can we make fundamental changes to the current risk equalisation system without making wholesale changes to private health insurance?

My view is that risk based capitation can’t or won’t work in the current environment

- Can determine factors for age and gender …
- … but need factors for health and this is problematic in the current environment

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Community rating and risk equalisation

Should we return to a basic / supplementary product offering?

- Basic product is community rated and risk equalised
- Supplementary product is risk rated with no risk equalisation

But how does this work in conjunction with Medicare?

What would happen to :

- PHI participation?
- Rebate?
- Excesses?

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Complex government support

Key support mechanisms

- Rebate
- Medicare levy surcharge
- Lifetime health cover

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Complex government support - Rebate

Simple concept recently made unbelievably complicated!

- Not just operational issues
- What about pricing issues, particularly relationship between prices for excess options of the same product
- Relationship and therefore incentives to purchase a particular option will depend upon a policyholder's rebate level

- If the aim of the rebate is to keep people out of the public system, why does the rebate apply to public hospital products – why support these?
- Should the rebate apply to ancillary products?

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Complex government support - Rebate

If the government wants to support PHI but with cost containment:

- Why not scrap the rebate …

  … and contribute an amount to the risk equalisation pool?

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Complex government support - MLS

If premiums keep increasing at a rate greater than increases in AWE

- At some stage tax payable < premium

- Implications for attracting younger people to PHI

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Complex government support - Lifetime health cover

Lifetime health cover

- Originated in the 1997 Productivity Commission Report
- Institute of Actuaries paper followed showing how it could be done
  - Had discounts for those younger than age 30 and loadings for those older than age 30
  - No time limit
  - Loadings included in risk equalisation (equitable)

Pragmatic implementation

- No discounts for those younger than age 30
- Loading not included in risk equalisation

- Then 10 year limit imposed

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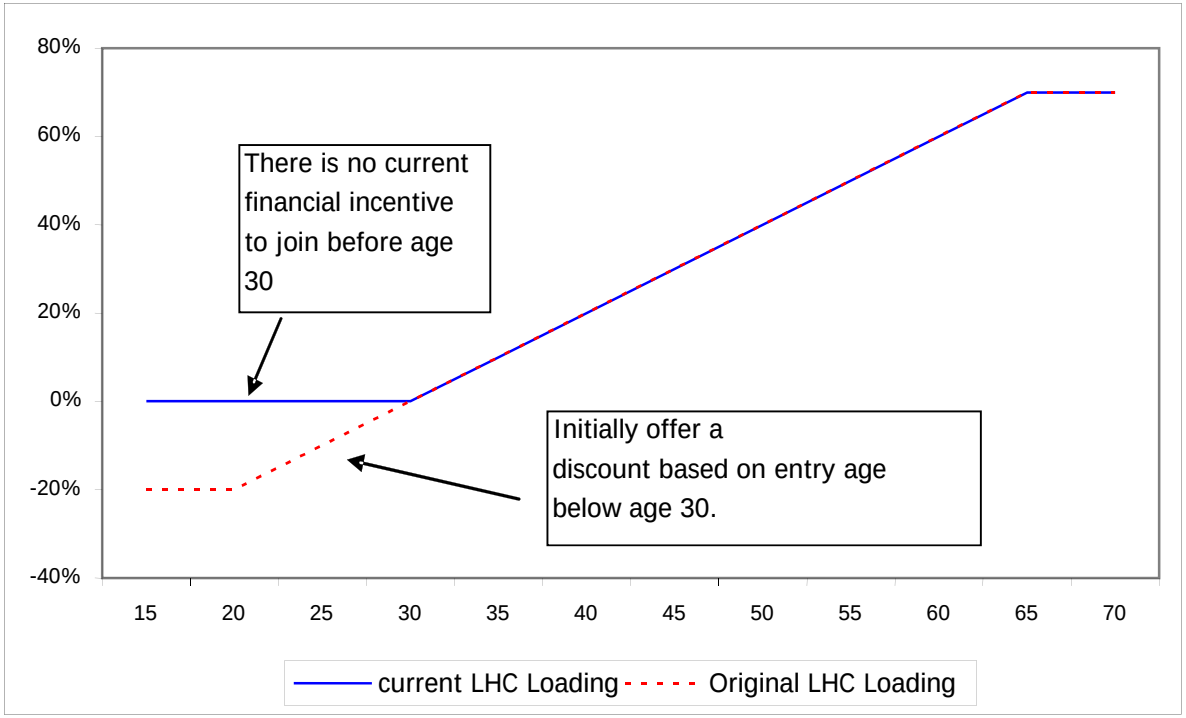
Complex government support - Lifetime health cover

Should consideration be given to discounts below age 30?



Should consideration be given to the 10 year limit?

Is it too late to include the LHC loadings in risk equalisation pool?

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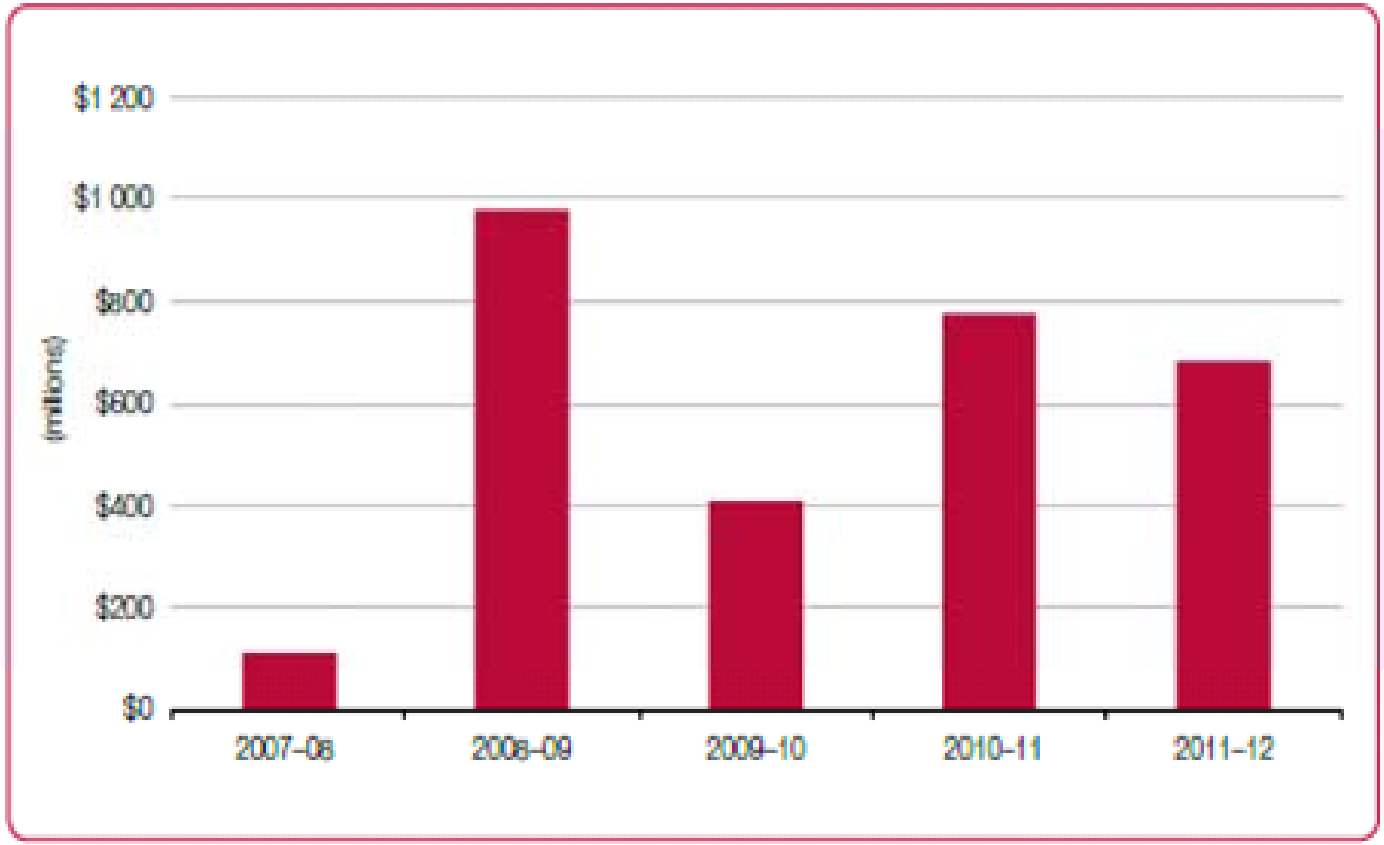
For profit v not-for-profit

Nearly $3bn paid out in the 5 years to June 2012

Figure 14: Dividends paid between 2008–12



Source: PHIAC The Operations of Private Health Insurers Annual Report 2011-12

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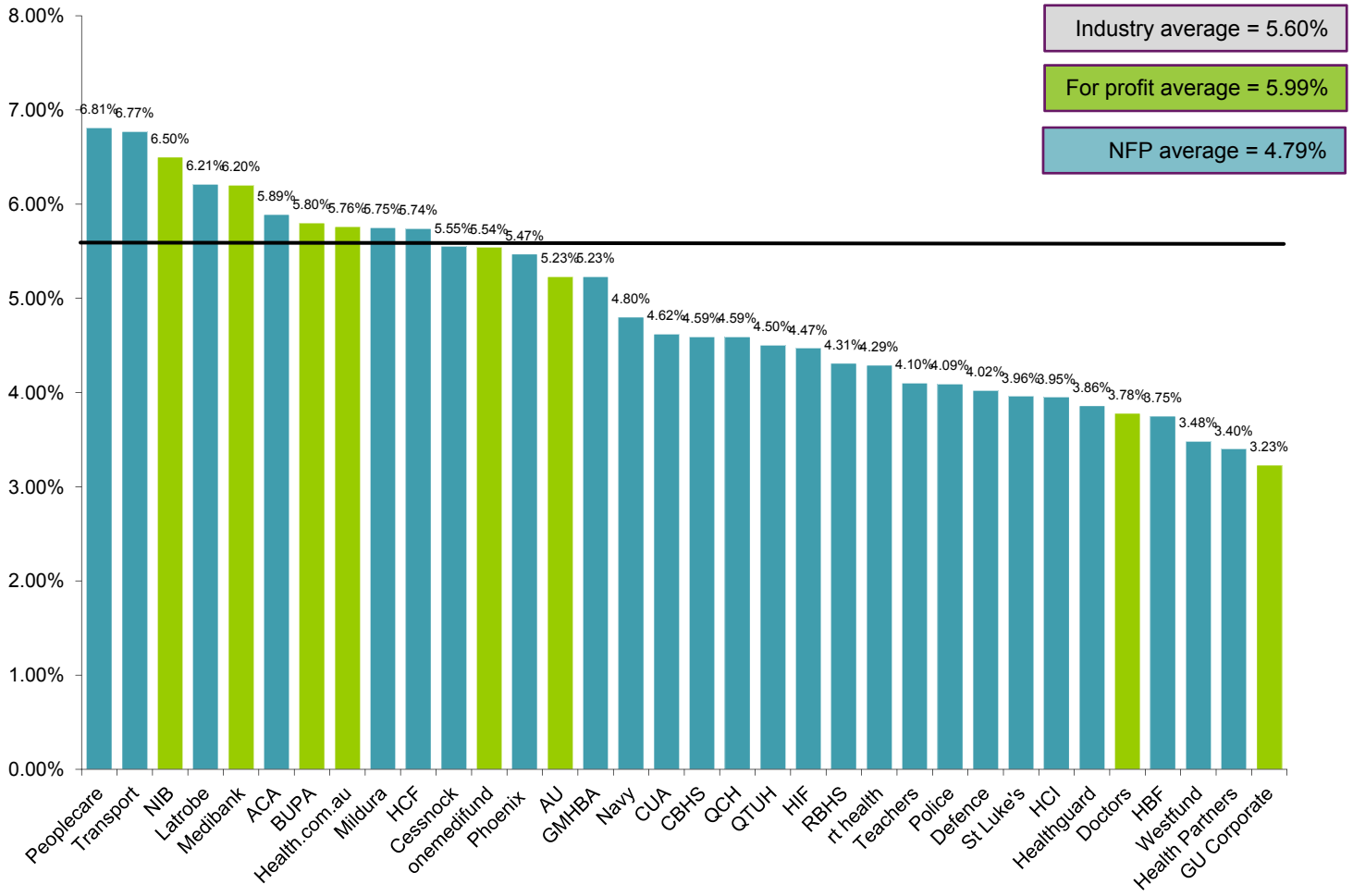
For profit v not-for-profit

Premium increases by insurer April 2013



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For profit v not-for-profit

If prudential capital reduces (and PHIAC suggests a 50% reduction at the industry level) what happens to the “excess” capital?

- For profit insurers - excess capital paid out of the fund.
- Not for profit funds – capital returned to policyholders – but how?

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Sovereign risk

- Talked about as “the” key risk for the industry
- How true is this?
- ***Macquarie Private Wealth in their September 2013 research paper*** noted:
  - Symbiotic relationship with Government means regulatory risk low:
    - Unlike most healthcare sectors which are a cost to government (and a fast growing one), an expanding private system helps promote savings given the Government pays only ~27% of the cost of private volumes vs. 100% in the public system. This dynamic together with the current state of public finances suggests to us
      - (i) low chance of any regulation which disincentivises expansion of the private system, and
      - (ii) that the private system will likely receive a disproportionate share of future growth in health care volumes.

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What is private health insurance …

1. Insurance in the life / general insurance sense?
2. The government's second health insurance system alongside Medicare
3. Something else?

Does the answer influence:

- The type of players in the market – shareholder or mutual
- The level of government support
- The types of products we should be providing?

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Is the current system …

- Community rated?
- Insurance?
- Equitable across insurers?
- Equitable across policyholders?
- Appropriate?
- Sustainable?

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What do we want for the future …

- What is the role/value of private health insurance going to be in the future?
- A combined Medicare Select model?
- A second health system that runs alongside and supports Medicare? If so:
  - What does it provide, and
  - What is the level of government support?
- How do for-profit / shareholder organisations operate alongside not-for-profit organisations?
- Are we moving to provision of health plans by corporate entities - loss of mutuality?
- Will community rating survive?

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Thank you!

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