Medicine, Nursing and Health Sciences

The Operation of Private Health Insurance in Australia

Professor Just Stoelwinder

Chair of Health Services Management
School of Public Health & Preventive Medicine
Monash University

September 2014

MONASH University

M8 Alliance

AUSTRALIA ▸ CHINA ▸ INDIA ▸ ITALY ▸ MALAYSIA ▸ SOUTH AFRICA

Background

Since it's European foundation Australia has had a mixed public/private health care system. Private health insurance has its roots in the Friendly Societies established in the mid 19th Century and voluntary funds in the mid 20th Century. Compulsory universal health "insurance" (*Medibank*) was established in 1975 by the Labor government and reaffirmed in 1985 as *Medicare*. This scheme covering all residents is funded primarily by the Commonwealth from general revenue and funds the Pharmaceutical Benefits Scheme (PBS) the Medical Benefits Scheme (MBS) and free care in public hospitals (operated by State Governments).

Private Health Insurance (PHI) continues to operate as a supplement and duplicate of the Medicare public system. In macro funding terms PHI accounts for some 11% of total health spending.

The main political parties have shown long-term commitment to both Medicare and PHI, with the Labor Party tending to place policy emphasis on Medicare and the conservative Coalition on encouraging PHI through initiatives such as a premium subsidy (rebate), lifetime health cover and an income related tax surcharge for those without PHI.

PHI in Australia – How it works at present

The operation of PHI in Australia is governed by the Private Health Insurance Act 2007.

The Act:

a) "provides incentives to encourage people to have private health insurance; and

b) sets out rules governing private health insurance products; and

c) imposes requirements about how insurers conduct health insurance business."

Incentives incorporate the rebate (currently means tested), lifetime health cover and surcharge referred to above.

Rules require PHI policies be community-rated with open-enrolment (the latter excludes "restricted funds" offered only to members of a specific industry or group and often their families). Community rating means that everyone purchasing the same policy is charged the same premium, irrespective of their health care risk (unlike risk rating, used in general insurance, in which premiums for the same insurance product can be adjusted for the predicted risk of the policy holder). Discounts on premiums of up to 12% are allowed. Open enrolment means funds cannot refuse to insure a person on any policy they offer to the general public, nor refuse to re-insure them. The purpose of these rules is to maintain affordability of PHI, by low-risk members cross-subsidising high-risk members.

PHI products

Permitted coverage by PHI is restricted to hospital admissions as a private patient in private and public hospitals, the payment gap above the MBS for associated medical fees and specified hospital substitution and chronic disease management programs (Broader Health Cover); General treatment (Ancillary or Extras cover); and Ambulance.

Hospital cover: these policies may include *restrictions* limiting the coverage of certain conditions or services and hence potential large out-of-pocket expenses and/or *exclusions* in which specified conditions or services may not be covered at all. On the basis of these product features Hospital policies are classified as:

- Top Private Hospital Cover – covering all services for which Medicare pays a benefit;
- Medium Private Hospital Cover – excludes or restricts one or more of the following: pregnancy, assisted reproductive services, cataract and lens procedures, joint replacement, dialysis, sterilisation.
- Basic Private Hospital Cover – excludes or restricts one or more of: cardiac and related services, non-cosmetic plastic surgery, rehabilitation, psychiatric services, palliative care.
- Public Hospital Cover – covers default benefits for treatment as a private patient in a public hospital only.

As at June 2014 there were only 11,595 "hospital treatment only" policies, 19% with exclusions and 79% with excess and co-payments.

General treatment cover (Extras or Ancillaries): these policies may include a range of treatments including dental (at various levels), optical, physiotherapy, podiatry, psychology, hearing aids. General treatment cover policies are sold as "General Treatment Only" (0.9 million policies) or in combination with Hospital cover (5.37 million policies).

Ambulance cover: may be sold alone (215,000 policies) or in combination with General and Hospital cover. Arrangements differ in the different States.

Excess: policies may include an excess (front-end deductible) on a per episode, or annual basis of up to $500; offset against a reduced premium.

Of the 5.38 million Hospital and Hospital & General treatment Combined policies at June 2014, 25.6% include exclusions of which 85% include an excess or co-payment. 74.5% of policies are non-exclusionary of which 77% include an excess or co-payment. (Policy statistics all sourced from PHIAC A Report Jun14)

Restrictions and exclusions enable funds to stratify the risk pool. For example, a product with cover for pregnancy, but without joint replacement is likely to be attractive to a younger, hence actuarially predicted lower cost, policy holder, while a policy with joint replacement and without pregnancy will be more attractive to older policy holders. More exclusions and restrictions will likely result in lower benefit costs and hence lower premiums making the product more attractive to new, younger entrants and switchers. This risk selection is prevalent in the Australian PHI market.

Risk equalisation

To mitigate some of the effects of risk selection the Act establishes a risk equalisation (RE) regime operated according to a set of rules promulgated by the Minister. In essence it involves claims sharing between funds operating in State based markets. A variable percentage of experienced claims in set age bands are pooled into an aged based pool (ABP).

Table 1: Proportion of total claims contributing to the ABP

Age	% of eligible benefits included in ABP for risk equalisation
0-54	0%
55-59	15%
60-64	42.5%
65-69	60%
70-74	70%
75-79	76%
80-84	78%
85+	82%

To this pool is added the high cost claimants pool (HCCP) made up of 82% of the benefits in excess of $50,000 per person (over the preceding 12 months but excluding inclusion in previous quarter HCCP) above that already allocated according to the ABP, to determine the 'Gross Deficit". HCCP for all its complexity is a minor component of the RE pool, representing less than 2% and is not considered further in the model below.

The Gross Deficit (i.e. claim included in the RE pool) is then divided by the total average Single Equivalent Units (SEU) in the State pool to calculate the average Deficit per SEU. (Each policy with 2 or more adults and/or children counts as 2 SEUs, with a single adult, or policies without an adult counting as 1 SEU.) Multiplying this average Deficit per SEU by a fund's market share of SEUs determines the Calculated Deficit (i.e. the Gross deficit the fund would have if the claims experience per SEU had been at the average of the pool, in other words, equalised).

The difference between the Calculated Deficit and the actual Gross Deficit is transferred between funds. Funds having claims less than average (i.e. Calculated Deficit less than Gross Deficit) cross-subsidise funds with claims above average (i.e. Calculated Deficit greater than Gross Deficit). In the hypothetical example below Fund 2 and the Rest of Industry, with a lower than average Gross Deficit per SEU, are levied $34,227,778 and $21,180,556 respectively, a total of $55,408,333, that is redistributed to Fund 1.

with other funds, the distribution according to their market share of SEUs. Appendix 1 shows the impact of Fund 1 reducing its claims for this age group by 1%, all other results unchanged. In this example Fund 1 retains only 27.8% (its market share of SEUs) of the savings in the RE pool. However, it retains 100% of the savings on claim for this group outside the RE pool, so that overall it retains 55.9% of its savings. Of course, it retains 100% of the savings in claims of those under 55 years and thus outside the RE regime.

Table 2: Hypothetical RE calculation for a quarter for the total Australian pool.

	Fund 1	Fund 2	Rest of Industry	TOTAL
Total Claims (of those age 55 and over)	$620,000,000	$85,000,000	$1,200,000,000	$1,905,000,000
Gross Deficit (calculated at average of 61% of Total Claims)	$378,200,000	$51,850,000	$732,000,000	$1,162,050,000
SEUs	1,500,000	400,000	3,500,000	5,400,000
Average (Gross) Deficit per SEU				$215.194/SEU
Calculated Deficit (Average (Gross) Deficit per SEU * SEUs)	$322,791,667	$86,077,778	$753,180,556	$1,162,050,000
Transfer (Gross Deficit less Calculated Deficit)	$55,408,333	($34,227,778)	($21,180,556)	0

In actuality the ABP varies as the Calculated Deficit is influenced by relative changes in claims, membership and age profiles between the funds.

Impact of RE on incentives to reduce claims

A consequence of the RE as currently structured is that it reduces the incentive to control claims amongst the 55 and over age group -- the main claimers and most amenable to disease management intervention. This occurs because the savings in the ABP are pooled and shared

Regulation

PHI is regulated by both the Department of Health and the Private Health Insurance Administration Council (PHIAC).

Department of Health

The Department of Health administers the Private Health Insurance Act 2007 and associated Rules. In doing so it issues formal PHI Circulars.

The Minister has the power to approve premium price increases, a process involving both the Department and PHIAC. A key consideration in

approving a fund's proposed annual increase is maintaining capital adequacy of the fund, advice on which is provided by PHIAC. The process for price increases that went into effect on April 1, 2014 is described here with individual fund average increases here.

PHIAC

The prudential regulator of private health insurance in Australia has the responsibility "to protect consumers of private health insurance by ensuring an industry which is competitive, efficient and financially sound."

It collects and publicly disseminates data from funds, including that required to operate the RE; sets and ensures compliance with capital adequacy and prudential standards, conducts education programs and coordinates with other financial and competition regulators.

In the 2014-15 Budget the Government announced that PHIAC will be merged into the Australian Prudential Regulation Authority (APRA) during this year.

The Private Health Insurance Ombudsman (PHIO)

A statutory authority established to "protect the interests of private health insurance consumers." It handles complaints about health insurance and provides advice to government and the industry on its performance in regard to the same.

Appendix 1:

Impact of Fund 1 saving 1% of Total claims for age 55 and over on RE calculation for the same quarter as Table 2.

	Fund 1	Fund 2	Rest of Industry	TOTAL
Total Claims (of those age 55 and over)	$613,800,000	$85,000,000	$1,200,000,000	$1,898,800,000
Gross Deficit (calculated at the current average of 61% of Total Claims)	$374,418,000	$51,850,000	$732,000,000	$1,158,268,000
SEUs	1,500,000	400,000	3,500,000	5,400,000
SEU market share (%)	27.8	7.4	64.8	100
Average (Gross) Deficit per SEU				$214.494/SEU
Calculated Deficit (Average (Gross) Deficit per SEU * SEUs)	$321,741,111	$85,797,630	$750,729,259	$1,158,268,000
Transfer (Gross Deficit less Calculated Deficit)	$52,676,889	($33,947,630)	($18,729,259)	0
Saving on Total Claims	$6,200,000	0	0	
Savings outside ABP	$2,418,000	0	0	
Saving in ABP on Gross Deficit	$3,782,000	0	0	
Change to Transfer ammount	($2,731,444)	$280,148	$2,451,296	0
Net saving in ABP	$1,050,555	$280,148	$2,451,296	$3,782,000
% of saving in ABP retained	27.8	7.4	64.8	
Total Saving retained (outside and within ABP)	$3,468,556	$280,148	$2,451,296	$6,200,000
Total saving a % of Savings on Total Claims	55.9	4.5	39.5	100

MONASH University

GROUP OF EIGHT AUSTRALIA

Further information

Monash University
School of Public Health and Preventive Medicine
The Alfred Centre
Melbourne, Victoria 3004
Australia

Telephone: +61 3 9903 0555
Fax: +61 3 9903 0556

facebook.com/Monash.University

@Monash_FMNHS