SUMMARY OF THE SECOND MEETING OF THE RISK EQUALISATION WORKING GROUP
16 October 2017

Attendees

Working Group Member	Organisation
Greg Smith	Chair
Dr Gino Pecoraro	Australian Medical Association
Ian Watts	Australian Physiotherapy Association
Tory Gervasi	Bupa
David Torrance	dbn Actuaries
Jamie Reid	Finity Actuaries
Mario Fortunato	HCF
Bruce Beatson	Latrobe Health Services
Michael Bassingthwaighte AM	Peoplecare Health Insurance
Bronwyn Hardy	Teachers Health
Proxies	
Kristy Domitrovic	Private Healthcare Australia
David Watson	Australian Prudential Regulation Authority
Secretariat	
Charles Maskell-Knight	Vanessa Sheehan
Susan Azmi	Stuart Rodger, Deloitte Actuaries and Consultants

Apologies

- Dr Rachel David, Private Healthcare Australia
- Karl Niemann, Australian Prudential Regulation Authority

Welcome, apologies, proxies and declarations of conflicts of interests

- The Chair opened the meeting, and noted two apologies. The Chair welcomed Mr Watson to the meeting.
- Members did not declare any new conflicts of interests.

Private Health Insurance Reform

The Chair advised the Working Group that the Government had announced a package of private health insurance reforms on Friday 13 October 2017. The Secretariat provided an overview of the announced reforms. The Working Group discussed which components of the reforms may have implications for risk equalisation and the Working Group. The Secretariat confirmed that the policy to allow insurers to provide discounts for younger members will operate on a voluntary basis, and that the provision of a discount would not reduce the risk equalisation liability for a policy holder.

The Chair reminded the Working Group that its purpose is to provide advice to the Private Health Ministerial Advisory Committee (PHMAC) on risk equalisation, and that the group would need to take the reforms into account in its advice to PHMAC.

Prospective Risk Equalisation

The Chair outlined that the current retrospective system equalises based on actual cost, and therefore it shares a proportion of all costs, regardless of whether those costs can be fully or partially controlled by the insurer.

The Working Group considered whether a proportion of the risk equalisation claims pool may actually represent controllable risks. If so, this would increase the argument for moving to a prospective model which could adjust for unavoidable risk while leaving insurers responsible for controllable risks. Following discussion, the Working Group generally agreed that the size of the pool is largely driven by hospital admission rates, over which the health insurer has little control.

Members did not identify controllable risks for further consideration. One member suggested that if insurers could control input costs exclusionary products would not have developed; these products allow insurers to avoid risk, not to manage it.

The Chair put to the Working Group that one option to move towards a prospective system would be to equalise using average claims costs (either fully or set at a percentage of the average cost) rather than actual claims costs. The Chair asked whether a system based on average costs would provide insurers with more incentive to manage the things they could influence.

Members generally agreed that average claims costs would be a suitable measure in a market that had only one product, but would create perverse incentives in the current market which has many products with exclusions and differing excesses.

Members raised that equalising based on average claims cost would likely result in the expansion of exclusionary products, or increases to out-of-pocket medical costs for consumers, as insurers would try to reduce their claims costs below the industry average; and therefore gain from risk equalisation. One member suggested that if risk equalisation was based on average costs it would drive development of 'average' products. One member noted that good management can raise costs in the short term, and basing risk equalisation on average costs may discourage insurers from investing in managing their claims costs.

The Chair put to the group that under a prospective system insurers could be paid an average based on the risk that the insurer has taken on through their product offering. The Working Group discussed the complexity in determining either average cost, or health risk, because they do not currently collect health status information. Members agreed that this is partly why aged-based actual claims costs are currently used as a proxy for claims risk.

Members also generally agreed that while the current retrospective risk equalisation system may blunt the incentive to manage risk, there is still incentive for insurers to reduce their costs where possible because insurers retain a significant portion of the efficiency gain from their investment. One member put forward that insurers are already doing everything possible to reduce costs due to existing market pressures, and other members agreed that this is the case.

The Working Group did not argue for further consideration of prospective risk equalisation models. The Working Group did not conclude its consideration of potentially using average costs to equalise risk.

Proportional Risk Equalisation

The Chair outlined that under the current risk equalisation arrangements the same liability is placed on each 'single equivalent unit' (SEU) (SEUs are used as a standard measure of the different categories of policies) regardless of the value the particular product provides. The Working Group considered the merits of a proportional system, which would apply a risk equalisation liability to a policy in proportion to the value the policy provides.

Proportional risk equalisation could be based on a product's coverage level, for example Gold, Silver, Bronze or Basic, or it could be linked to the actual premium paid (noting the relationship between premiums and the risk equalisation liability per SEU).

The Working Group discussed that a proportional risk equalisation system would make products with many exclusions cheaper and comprehensive products more expensive, because it would effectively only equalise the risk of claims by consumers in a particular 'group'. Members expressed concern about the equity implications of such a change.

It was put to the group that the current arrangements may also present an equity issue because people on basic products, with many exclusions, are not eligible to access the services they are subsidising for other policy holders. It was suggested that exclusionary products may be inconsistent with 'pure' community rating.

One member suggested there is inequity in putting more and more costs of the system onto consumers buying basic products, who may have lower incomes than those buying comprehensive products. Members briefly discussed whether it may be more equitable to base the risk equalisation liability on income, as a measure of an individual's ability to pay.

The Working Group had a detailed discussion around price elasticity of demand for private health insurance for different consumer groups, and how changes in price under a proportional risk equalisation system might affect participation rates. It was generally agreed that younger healthier people were more price sensitive, and that demand for insurance becomes more inelastic as people age. One member noted that price sensitivity could be masked by people downgrading products rather than dropping their insurance altogether, but that the system may have reached a point where people begin to respond to price increases by dropping their cover. The Chair asked members to provide to the Working Group any evidence/analysis they had undertaken on price sensitivity which could assist the Working Group's consideration.

The Working Group discussed the issue of intergenerational equity, and considered whether there was benefit in reducing younger consumers' contribution to the system. This would effectively move further from the application of pure community rating in an attempt to encourage participation of younger people. Members discussed whether there is an optimum level of cross subsidisation, but did not come to a view.

Generally, the Working Group did not advocate for moving to a proportional model.

Current Risk Equalisation Model – consideration of parameters

The Working Group considered whether there were criteria other than the policy holder's age that should be considered in the risk equalisation calculation, for example: gender, ethnicity, or higher risk that may be associated with people transferring from another insurer. One view was that, if the main aim is to equalise for age risk, then the current parameters are effective, but if there are other objectives of risk equalisation then the parameters should be updated.

Members raised that it would be difficult to collect the information from consumers needed to include additional risk criteria in the risk equalisation calculation. The main concern was that consumers would suspect that disclosing risk factors would increase their premiums, even though under community rating this is not the case.

There were differing views about the impact of portability on an insurers risk profile and costs. Members agreed that transfers can be costly to the receiving insurer in the first year because consumers often move specifically to reduce their out of pocket costs for treatment they already require. The counterview was that membership across the industry was relatively stable, with transfers about 10% per year, so this in not a material risk.

The Working Group discussed that the size of the risk equalisation pool is growing faster than total claims (and premium revenue), and whether this is sustainable. The Working Group generally agreed that lower participation by young people and the increasing cost of health care are the main factors reducing affordability. Members agreed that risk equalisation does not increase overall costs, but only equalises existing costs, and therefore cannot be used to fix cost pressures.

However there was still concern that claims being equalised are increasing faster than overall claims costs. One member raised that at some point it may become more profitable for insurers to encourage high acuity policy holders if enough of the cost can be shared.

As the relative size of the risk equalisation pool increases, the level of 'subsidy' that basic policy holders provide to high claimers also increases, with this trend effectively placing a larger proportion of the burden onto young policy holders. Reducing the size of the pool would reduce the subsidy and the price of basic products.

One member put to the group that most consumers on basic products upgrade to products with more cover overtime, meaning they initially contribute to the pool, but then benefit from risk equalisation as they age.

The Working Group considered options for reducing the size of the risk equalisation pool should that be desirable. Options for reducing the size of the pool included;

- Changing the age cohorts – raising the age from which claims can be equalised. One suggestion was using the aged pension age as a proxy for when risks should be equalised;
- Gradually reducing the percentage of an eligible claim that can be pooled – this would slow the growth in the amount of risk shared across the system;
- Capping the size of the pool relative to the total claims.

The Chair put to the Working Group that further consideration of this issue would be assisted by analysing medium to long term impacts on premiums of the following scenarios:

- No change to risk equalisation pool;
- Freezing the ratio between the risk equalisation pool and total claims costs at current levels;
- Reversing the trend of the risk equalisation pool increasing relative to total claims costs.

The Working Group also generally agreed that the High Cost Claim Pool threshold, which has been set at $50,000 since 2007, should be updated. The High Cost Claim Pool makes up only 3% of the risk equalisation pool. The Working Group will further consider at what claims cost the revised threshold should be set.

Other discussion

The Working Group had mixed views on how effective hospital substitute treatment and chronic disease management programs (CDMP) are in reducing future claims costs. Some members argued that CDMP costs should not be included in risk equalisation, while others suggested that removing them from the arrangements would likely increase overall claims costs.

Some members raised that there may be benefit in rewarding other out of hospital services, for example consultations. The Chair noted that it was not possible to include services in the risk equalisation pool that are outside the scope of private health insurance, and that consideration of the scope of private health insurance was not in the Working Group's Terms of Reference.

The Working Group also considered whether the costs of other hospital treatment services, for example obstetrics, should be pooled through risk equalisation. Members had mixed views on whether additional services should be included. The Chair asked members to bring to the next meeting information/evidence supporting their position on factors they thought should be risk equalised to assist the Working Group's consideration of these issues.