ISSUES PAPER: RISK EQUALISATION

Introduction

The Private Health Ministerial Advisory Committee (the Committee) Terms of Reference and Work Plan include the consideration of risk equalisation during 2017. The Committee also agreed to establish a working group on risk equalisation (the Working Group) to bring together key stakeholders with expertise in the private health insurance environment to work in partnership on the development of possible reforms to the current risk equalisation arrangements.

The Working Group will have a key role in advising the Committee on possible reforms to the current risk equalisation arrangements. This includes consideration of:

- the objectives of risk equalisation
- the positive and negative aspects of the current risk equalisation arrangements
- options for possible change, for example:
 - o applying different parameters to the current risk equalisation arrangements
 - replacing the current risk equalisation system in favour of a proportional or prospective arrangement
- implementation issues for any proposed changes
- other related issues as directed by the Committee.

An out-of-session agenda item was circulated to Committee members seeking agreement to the Working Group Terms of Reference and nominations to the Working Group on Friday 4 August 2017. The Terms of Reference are at <u>Attachment A.</u>

Background

Risk equalisation is a central component of the current private health insurance system. The risk equalisation arrangements have historically been a sensitive issue for the private health insurance industry, and the subject of extensive discussion with industry over many years.

Private health insurance in Australia is governed by the principle of community rating. This is different to other types of insurance, such as life insurance, which are risk rated. Community rating requires that health insurers cannot refuse to provide health insurance cover to any individual, and must charge the same premium to each consumer for the same product (with the exception of Lifetime Health Cover and limited discount provisions). This means that health insurers cannot set premiums to discriminate on the basis of age, sex, health status and other factors.

The system of risk equalisation aims to support community rating by taking the 'extra' costs of higher risk people, and spreading them across the industry, across all insurers and all policyholders.

Risk equalisation partially compensates insurers with a riskier demographic profile by redistributing funding from those insurers paying lower than average benefits to those paying higher than average benefits. In theory, this allows insurers to charge competitive contribution rates for similar cover regardless of their membership composition. It means that insurers with higher numbers of older members or high users are not financially disadvantaged compared with those insurers with a younger or healthier membership. In line with the principles of community rating, risk equalisation is a mechanism that provides

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for younger healthier policy holders to subsidise the cost of older less healthy policy holders' claims across the system.

Current Risk Equalisation Arrangements

The current risk equalisation arrangements commenced on 1 April 2007 with the introduction of the *Private Health Insurance Act 2007* (the Act). The system works retrospectively (as have all previous arrangements), based on claims that insurers have actually paid rather than a forecast of expected claims based on the profile of policy holders.

Current risk equalisation comprises an Aged Based Pool and a High Cost Claim Pool. These two pools ensure that no insurer is significantly disadvantaged by having an older age profile or higher risk profile.

Eligible Benefits

The health insurance benefits eligible to be pooled are for:

- hospital treatment benefits
- hospital substitute treatment benefits
- chronic disease management programs comprising benefits for planning, coordination and allied health services.

Aged Based Pool

The Aged Based Pool enables private health insurers to share the risk for claims relating to policy holders over the age of 55, who have higher utilisation rates than the population aged under 55. The current risk equalisation arrangements widened the ages for which contributions to the Aged Based Pool are made (down from 65 years) to 55 years with differing percentages allocated to each age cohort, as shown in the following table:

Age Cohorts	UN O OF
Age	% of eligible benefits included in the pool
0-54	S 0.0%
55-59	15%
60-64	42.5%
65-69	60%
70-74	70%
75-79	76%
80-84	78%
85+	82%

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High Cost Claim Pool

The current arrangements introduced a High Cost Claim Pool which enables insurers to share the cost of high cost claimants by pooling 82 per cent of benefits paid to an individual over 12 months, after allocations to the Aged Based Pool and a \$50,000 threshold have been deducted. The High Cost Claim Pool only accounts for around 3% of claims equalised through risk equalisation.

To assist members' understanding, below is a high level illustrative example of the amount pooled for an 81 year old individual who has claimed \$500,000 in eligible benefits over 12 months. The example does not include all aspects of the calculation.

Example: Amount pooled for 81 year old individual

81 year old policy holder - eligible benefits claimed in 12	\$500,000
months	
78% goes to the Aged Based Pool	\$390,000
Balance after Aged Based Pool	\$110,000
Less \$50,000 threshold	\$60,000
82% of \$60,000 goes to the High Cost Claim Pool	\$49,200
Amount pooled by the insurer	\$439,200

The marginal costs allocated to the Aged Based and High Cost claims pools are notionally allocated across industry, at a state or territory level, based on insurer market share on a weighted policy basis (single policies have a weight of 1 single equivalent unit (SEU), and couple and family policies a weight of 2 SEUs). Each state based SEU has the same risk equalisation liability (currently around \$750 average nationally) regardless of whether a policy provides basic or comprehensive cover. A high level table illustrating these flows is at <u>Attachment B</u>.

Insurers that have paid 'eligible pooled benefits' at a rate per SEU lower than the jurisdictional average pay money into the Risk Equalisation Special Account, and insurers that have paid 'eligible pooled benefits' at a rate per SEU higher than the jurisdictional average receive money from that Account.

The Risk Equalisation Special Account is a zero sum pool calculated quarterly. The pool, calculations and transfers, are managed by the Australian Prudential Regulation Authority.

Risk Equalisation Trends

In 2015-16 the net amount transferred between insurers under the risk equalisation arrangements was \$439 million. Sixteen insurers, covering about 9.2 million people, were net recipients from the pool. Seventeen insurers, covering about 4.2 million people were net contributors to the pool. (Source: APRA). A table showing the risk equalisation beneficiaries and payers is at <u>Attachment C.</u>

Average claim cost increases with age. The graph over the page shows the average claims costs for different age cohorts and the cost attributed to each cohort after risk equalisation. Under risk equalisation, younger policy holders, particularly the under 54 age cohort, are subsidising the higher average claims costs of older policy holders.



Average claims costs for different age cohorts and cost attributed after risk equalisation

Source: Finity Consulting, 2017, *Risk Equalisation Time to think differently*? Available at <u>https://www.actuaries.asn.au/Library/Events/SUM/2017/SUM/17ReidetAlPaper.pdf</u>

Over the past 10 years, the proportion of total benefits that is risk equalised has increased from approximately 36% to 44%, primarily due to an ageing participation profile. The national average risk equalisation liability per SEU has increased from \$360 to \$750 over the same period.



Source: Finity Consulting, 2017, *Risk Equalisation Time to think differently*? Available at <u>https://www.actuaries.asn.au/Library/Events/SUM/2017/SUM17ReidEtAlPaper.pdf</u>

Issues

Under risk equalisation, for low priced basic products, which are more likely to be purchased by younger healthier people, a larger proportion of the premium goes to subsidising high cost claimants than for high priced products. Risk equalisation makes basic products more expensive than they would otherwise be.

Industry actuaries have questioned the long term sustainability of current risk equalisation arrangements. As the proportion of total benefits being equalised increases, the risk equalisation liability per SEU also increases, which means that young healthy basic policy holders are liable for a greater proportion of the total cost. This increases their premiums and may discourage younger healthier people from purchasing private health insurance.

Any reduction in participation by young healthy people will increase premiums for all policy holders, and is a strategic risk to the community rated private health insurance industry.

There is also a longstanding view that retrospective risk equalisation arrangements do not provide incentives for insurers to manage utilisation risk as individual insurers do not gain the full advantage from their increased efficiency. Under the current system insurers retain 100 per cent of the efficiency from keeping under 55s out of hospital, and they retain a portion of the efficiency equal to their jurisdictional market share for those 55 and over.

The issue of reduced incentives is complicated by the widespread existence of exclusionary products. Some products have much lower utilisation rates simply because they cover fewer services, which is otherwise unrelated to the effectiveness of the insurer's management of utilisation. Any system that creates incentives for lowering utilisation will reward both insurers operating effective demand management mechanisms to lower utilisation and also those who lower utilisation by excluding more services. Given the different policy outcomes of these two approaches, this consistent treatment under risk equalisation may be inappropriate.

In 2003 the option of prospective risk equalisation, based on risk rather than retrospective actual claims experience, was considered. Industry concluded that the complexities of a system to address lower utilisation due to exclusions outweighed the benefits that might flow from a prospective system.

Industry views

Insurers

Individual insurers' views of risk equalisation vary significantly. This is mainly because the system is zero-sum (any insurer's gain will come at the expense of another's loss). This will mean that industry-wide support for any proposed changes is extremely unlikely.

Consumers

Consumers are unlikely to be aware of the current risk equalisation arrangements and would therefore not be expected to have strong views on the risk equalisation arrangements *per se*. However, consumers are implicitly concerned about any regulation, or changes to regulation, that may impact on community rating or premiums.

Hospitals

Like consumers, hospitals are not likely to have strong awareness of risk equalisation arrangements but would support any change that improved health insurance participation.

However, hospitals would be concerned about any changes to risk equalisation that encourage health insurers to provide benefits for prevention and chronic disease management programs at the expense of hospital services.

Discussion topics

This section considers a range of issues relating to the operations and possible reform of risk equalisation arrangements. The issues presented are intended to guide and encourage discussion, they are not exhaustive.

Should risk equalisation be retained?

In the absence of a risk equalisation system, community rating would result in insurers with worse risk profiles across all their products being compelled to charge higher premiums to all policy holders. This should lead to consumers using portability arrangements to move to insurers offering lower premiums. In theory, all other things being equal, more efficient insurers should gain market share, while less efficient insurers should lose market share. These consumer movements would theoretically ultimately result in a new market equilibrium in a well informed and fluid market.

However, abolishing risk equalisation would also create an incentive to risk assess and target younger healthier policy holders. It is possible that the reward for "cherry-picking" would be greater than the reward for reducing system costs overall or even for efficient claims management.

There would be considerable instability at least in the short to medium term, and this would likely be ongoing as insurers would continue to focus on reducing their exposure to high cost policy holders (older, sicker consumers). Transition arrangements could be put in place to help manage the change process, but there is no obvious mitigation for the ongoing system incentives.

If some form of risk equalisation should be retained, should it remain solely a risk sharing tool, or should any new arrangements include policy levers to create particular incentives? Historically, risk equalisation has been used as a transfer mechanism to re-balance risk within the industry to support the community rating principle. The inclusion of chronic disease management programs as benefits eligible for risk equalisation was a step toward using risk equalisation as a policy tool to encourage (or at least to reduce the disincentive) to provide these services.

We are presented with the opportunity to consider whether risk equalisation should be used as a policy tool to increase the provision/benefits for particular services that are desirable for policy reasons. This could be achieved by allowing/increasing the proportion of the benefits paid for these services to be risk equalised. Alternatively, changes could be made to how people receiving desirable services are included in the insurer's SEU count to increase the level of advantage that the insurer retains from their investment.

Some services that could be considered include:

- pregnancy and related services
- psychiatric care
- chronic disease management
- rural and regional.

It should be noted that increasing the proportion of benefits equalised, and therefore increasing the deficit per SEU, would increase the cost of private health insurance for young healthier people and may decrease their participation.

Depending on this overarching policy question, changes to risk equalisation could focus on creating positive incentives or on neutralising disincentives created by a purely risk sharing tool (as discussed in the following options).

If some form of risk equalisation is retained, should it be changed to a prospective model?

Prospective risk equalisation, also known as risk based capitation reinsurance or composition reinsurance, is where risk equalisation is calculated based on predicted costs in future periods. This can be distinguished from the current system where risk equalisation is calculated retrospectively based on benefits paid.

Under prospective risk equalisation, payments into the risk equalisation pool would be based on the risk profile of each insurer – which could be assessed on the age, gender and health status of members – rather than utilisation. Incentives for managing utilisation would be stronger under a prospective system because insurers would be able to accrue the savings, or conversely bear the additional costs, associated with their membership base and their management of their membership base.

Health funds would be required to pay to or receive from the risk equalisation pool a 'riskbased' capitation fee per person covered, regardless of the actual claims experience of that individual. The risk based capitation fee per person is based on expected hospital utilisation patterns. In this way actual hospital costs are not directly pooled and shared. The effect this scheme has on individual funds depends on the risk profile of a fund's contributor base. The level of risk equalisation achieved between funds will depend on the demographic categories chosen to be equalised.

Prospective risk equalisation could reward more efficient insurers and encourage better claims management, through promoting prevention programs, better chronic disease management and better contractual arrangements from all insurers. This may result in a slowing of premium growth over time, but premium growth is also dependent on other drivers of total benefit outlays such as participation.

Given the large sums involved, moving to a prospective system would be highly disruptive to the industry, including the need for significant changes to product pricing and prudential management.

If risk equalisation is retained, should the proportion of benefits eligible to be equalised be reduced?

Reducing the proportion of cost that is pooled would mean insurers would retain more of the advantage of their efficiency gains from better claims management. But insurers would also retain more of their gains from cherry-picking younger, healthy policy holders, so the incentive to focus on this group of policy holders would increase.

The proportion of benefits equalised could be reduced by changing existing parameters, for example:

- changing the types of benefits eligible for equalisation
- increasing the high cost claim threshold and/or reducing the percentage of the claim that can be equalised

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• increasing the age that benefits can be equalised and/or reducing the percentage of the claim that can be equalised for each age cohort.

As outlined earlier, the risk equalisation deficit represents a significant portion of the premium for people on basic policies. Reducing the proportion of benefits equalised, and therefore reducing the deficit per SEU, may have the added advantage of reducing the cost of private health insurance for young healthier people and increasing their participation.

On the other hand, reducing the proportion of benefits equalised will mean that people on more comprehensive products will pay higher premiums for these products.

If risk equalisation is retained, should it be changed to a proportional model?

Proportional risk equalisation adjusts the liability of a member in proportion to the benefit rate of their policy, or alternatively their premium rate. This means that a consumer buying a higher priced product would contribute more to the risk equalisation pool, and a consumer buying a lower priced product would contribute less to the risk equalisation pool. This contrasts with the current system, where the same liability is imposed on any policy, regardless of the benefit it offers.

The introduction of proportional risk equalisation would cause the prices of full cover policies to rise and those with fewer benefits to fall.

A proportional risk equalisation system may create incentives for cost-effective innovation, including cheaper products, possibly with some form of patient co-payment which may reduce moral hazard. It may also create incentives for funds to manage costs effectively since funds with lower benefits per age corrected SEU would bear less of the burden of reinsurance than other funds.

However, proportional risk equalisation would be administratively complex as it would involve calculating the risk equalisation liability of each individual member in proportion to the benefit rate of their policy, or alternatively their premiums. There is also the potential for community rating to be undermined.

If retrospective risk equalisation arrangements should be retained without major change, should the parameters be reviewed to ensure they correctly adjust for risk?

The current risk equalisation arrangements have been in place since 2007. If the Committee decides that wholesale change to the risk equalisation arrangements is not required, it may be timely to review the current parameters (for example age cohorts, percentages of benefits equalised and high cost claim threshold) to confirm they correctly equalise risk across the industry.

It should be noted that depending on if/how the current parameters were updated it could lead to an increase or decrease in the proportion of total benefits being equalised.

Timing and implementation

Risk equalisation is intrinsically linked to product design, which is a major piece of work being undertaken by the Committee.

Any changes to risk equalisation will need an extensive development process to identify implementation issues and possible unintended consequences. Due to the complexities and long lead times required, it would not be appropriate to introduce new risk equalisation

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arrangements as an interim measure before expected product design changes are introduced.

Attachments:

Attachment A:	Working Group Terms of Reference
Attachment B:	Risk Equalisation funding flows
Attachment C:	Risk Equalisation Beneficiaries and Payers

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Working Group TORS

Purpose

The Risk Equalisation Working Group (the Working Group) brings together key stakeholders with expertise in the private health insurance environment to work in partnership on the development of possible reforms to the current risk equalisation arrangements.

The Working Group has a key role in advising the Private Health Ministerial Advisory Committee (the Committee) on possible reforms to these arrangements.

Functions

The role of the Working Group is to provide advice to the Committee on possible reforms to risk equalisation arrangements. This includes consideration of:

- the objectives of risk equalisation
- the positive and negative aspects of the current risk equalisation arrangements
- the impact on risk equalisation of other reform proposals being considered by the Committee
- options for possible change, for example:
 - applying different parameters to the current risk equalisation arrangements
 - replacing the current risk equalisation system with a proportional or prospective arrangement
- implementation issues for any proposed changes, including timing
- other related issues as directed by the Committee.

Noting that the Working Group may not come to agreement on all issues, members of the Working Group commit to:

- acting in a collegiate and collaborative manner when discussing and resolving issues; and
- respecting the confidentiality of Working Group and Committee procedures.

The Working Group will report to the Committee.

External Support

The Working Group may be supported through the commissioning of external advice (through the Department of Health) if required. The Working Group Chair must first seek agreement from the Committee Chair.

Membership

The Chair of the Working Group is [to be advised]. Members are appointed for their private health industry knowledge, and expertise and experience in the private health sector.

With the Working Group Chair's prior approval, individuals and organisations who are not members may be invited to participate in the Working Group discussions where they have particular knowledge, expertise or experience.

A quorum for a meeting is the Chair and half the Working Group membership plus one. A quorum of members must be present before a meeting can proceed. A member who is unable to attend a meeting should advise the Chair and the Secretariat as soon as possible.

Confidentiality

Members are required to sign confidentiality agreements and declare any real or potential conflicts of interests at the commencement of each meeting. All working group members have an obligation to maintain confidence of all matters arising within the working group and to maintain this confidence even after their membership of the Working Group has expired. Working Group members are specifically obligated to refrain from making any comment or statement concerning any working group matter to any member of the media. The Chair of the Committee or the Committee secretariat will coordinate all media contact.

Timing

The Working Group will meet in person or via teleconference. The Working Group is expected to meet approximately five times between September and December 2017. The Working Group can meet more or less frequently if required, and will report to the Committee.

Decisions and consideration of issues can be made out of session by the Working Group including by teleconference or videoconference.

Secretariat

The Department of Health will provide the required level of secretariat support for the Chair and the Working Group. Papers will be distributed to the Working Group members at least five working days before a Working Group meeting, except with the Chair's agreement. The agenda for meetings will be agreed between the Chair of the Working Group and the Secretariat. The Chair and/or the Secretariat may consult with the Chair of the Committee in developing any papers.

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Risk Equalisation Funding Flows

Simplified worked example of risk equalisation						
	Arrow	Bonza	Classic	GreyPower	Total or mean	Кеу
	(Young, low utilisation, low cost)	(Young, high utilisation, high cost)	(Old, low utilisation, high cost)	(Old, high utilisation, low cost)		
Membership						
Old members	200	400	375	500	1475	А
Young members	825	1550	900	1000	4275	В
Total members	1025	1950	1275	1500	5750	C = A + B
			~			
Utilisation						
Hospital episodes per old member	0.970	1.030	0.970	1.030	1.007	D
Episodes per young member	0.097	0.103	0.097	0.103	0.101	Е
		St				
Old episodes	194	412	363.75	515	1485	F = A * D
Young episodes	80	~160 ⁰	87	103	430	G = B * C
Total episodes	274	\$72 <	451	618	1915	H = F + G
	Str.	St. C				
Average episodes per member	0.267	0.293	0.354	0.412	0.333	I + H/C
×	$\mathcal{X} \mathcal{A} \mathcal{A}$	6.				
Cost	N OPT					
Cost per old episode (\$)	5050	5250	5250	5050		J
Cost per young episodes (\$)	4750	4900	4900	4750		К
SU FT						
Cost of old members (\$2000)	980	2163	1910	2601	7653	L = F * J
Cost of young members (\$ ¹ 000)	380	782	428	489	2079	M = G * K
Total cost (\$ '000)	1360	2945	2337	3090	9733	N = L + M
Gross premiums (\$)	1327	1510	1833	2060	1693	O = N/C
Relative to average (%)	-22%	-11%	8%	22%		

Simplified worked example of risk equalisation

	Arrow	Bonza	Classic	GreyPower	Total or mean	Кеу
	(Young, low utilisation, low cost)	(Young, high utilisation, high cost)	(Old, low utilisation, high cost)	(Old, high utilisation, low cost)		
Risk equalisation						
Average cost of old members (\$)					5189	P = L/A
Average cost of young members (\$)					486	Q = M/B
Marginal cost of old members (%)					90.6%	R = (P- Q)/P
(Cost of old members less the cost of you	ıng membe	ers, divided k	by the cost	of old men	nbers)	
(In the real world this is set and not chan	nged annud	ally)				
			0-			
Marginal cost of old members debited to r/e pool (\$ '000)	888	1,960	1,731	2,357	6,936	S = R * L
Average amount debited to r/e pool per	capita (\$)	ASY	N'N		1,206	T = S/C
		and the second				
Redistribute r/e pool on a per capita basis (\$' 000)	1,236	2,352	1,538	1,809		U = C * T
	BY (JE JC				
Net r/e payment: redistributed amount less actual marginal cost of old members (\$' 000)	1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A 1 A	ME1 392	-193	-548		V = U - S
CUNCOL	\mathcal{A}					
New total cost: total cost plus r/e payment (\$ '000)	1,708	3,337	2,145	2,542		W = N +V
<h. <h.=""></h.>						
New premiums (\$)	1667	1711	1682	1695	1693	X = W/C
Relative to average (%)	-2%	1%	-1%	0%		

Attachment C

RISK EQUALISATION BENEFICIARIES AND PAYERS

Fund	Percent of market share ¹	Net Transfer to/from Risk Equalisation Pool \$ ²	Net transfer as % of insurer's total hospital benefits	
BUPA	27.59	\$146,884,240	3.73%	
HBF	7.63	\$102,347,510	10.52%	
Medibank Private	26.91	\$68,757,014	1.83%	
Australian Unity Health	2.58	\$63,468,315	15.09%	
Railway & Transport Health Fund	0.36	\$12,652,251	20.36%	
Latrobe	0.63	\$10,895,847	9.09%	
Westfund	0.74	\$7,257,860	6.91%	
CUA	0.6	\$6,429,620	7.43%	
St Luke's	0.43	\$4,086,566	6.29%	
Phoenix	0.11	\$4,071,460	19.08%	
Health Partners	0.62	\$3,991,611	4.87%	
Reserve Bank Health Society	0.04	\$2,118,898	32.53%	
ACA	0.08	\$1,882,557	15.35%	
Cessnock District Health Benefits Fund	0.04	\$1,839,153	22.74%	
Mildura	0.22	S1,746,387	5.97%	
Doctors' Health Fund	0.24	\$129,212	0.32%	
Health Care Insurance	80.08	-\$712,028	6.55%	
Queensland Teachers' Union Health Fund	(D.57)	-\$1,211,059	1.24%	
Navy	0.29	-\$1,707,637	3.77%	
Transport	0.13	-\$1,943,321	12.24%	
National Health Benefits Australia	0.1	-\$1,988,951	12.29%	
Peoplecare	0.57	-\$6,377,114	8.57%	
Queensland Country Health Fund	0.38	-\$6,989,303	11.48%	
Police	0.4	-\$10,977,387	19.10%	
Teachers Federation Health Fund	2.18	-\$14,101,899	4.04%	
Health Insurance Fund of Australia	0.89	-\$16,569,211	15.92%	
HCF	11.05	-\$25,000,756	1.55%	
Grand United Corporate Health	0.56	-\$27,648,051	37.80%	
GMHBA (Geelong)	2.1	-\$28,841,933	10.63%	
Defence	1.92	-\$37,660,494	13.09%	
Health.com.au	0.71	-\$39,559,200	46.56%	
CBHS (Commonwealth Bank)	1.58	-\$39,637,139	17.47%	
NIB	7.67	-\$177,593,017	18.28%	

Key: Black = receive from the Risk Equalisation Pool Blue = pay to the Risk Equalisation Pool

 ¹ Source: PHI Key Statistics Fact Sheet (June 2017, Health Intranet).
² Source: APRA Risk Equalisation Financial Year Results, released 22 February 2017.