RISK EQUALISATION WORKING GROUP REPORT TO THE PRIVATE HEALTH MINISTERIAL ADVISORY COMMITTEE

Key Findings and Recommendations

The Risk Equalisation Working Group's (Working Group) terms of reference, as agreed by Private Health Ministerial Advisory Committee (PHMAC), outlined that the Working Group's consideration would include:

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

While the Working Group's views against different issues are detailed throughout the paper, a summary of the Working Group's findings and recommendations is provided below.

1. Risk equalisation should be retained for private health insurance.
2. Risk equalisation should continue to be, first and foremost, a risk sharing tool to support community rating of the comprehensive range of health risks.
3. The Working Group was concerned that if risk equalisation was used as a policy lever to encourage certain consumer or insurer health care financing behaviour this could undermine risk equalisation's support for community rating. For example:
   a) members expressed concern about portability requirements resulting in higher claims for the receiving insurer, and considered whether insurers should be allowed to equalise claims for 12 months following a consumer transferring to them from another insurer. However, the Working Group agreed this issue would be more appropriately addressed through changes to the portability requirements; and
   b) the Working Group agreed that risk equalisation coverage should not be extended to include any new claim categories (for example where third party benefits exist) because risk equalisation is not the best way to deal with any secondary policy objectives.
4. The objective of risk equalisation is to support community rating by minimising incentives for insurers to discriminate against consumers based on risk, in a way that:
   a) does not put well managed insurers at prudential risk; and
   b) maintains a competitive private health insurance model with incentives for insurers to compete.
5. The supporting principles for risk equalisation are:
   a) Minimise adverse incentives: risk equalisation should as far as possible have minimal adverse impact on the incentive for insurers to invest in the management of their insured persons' claim costs;

b) Encourage participation: as far as possible, risk equalisation should have a positive impact on consumer participation in private health insurance, including by not reducing consumer choice;
c) Low transaction costs: the system needs to be practical with low transaction costs, including implementation and ongoing management costs; and
d) Predictability: the financial outcome should be relatively predictable.

6. Single Equivalent Units (SEUs) should be weighted for the purpose of risk equalisation to reflect premium variation driven by the introduction of aged-based discounts, and this change should be introduced when discounts for young consumers start on 1 April 2019.

7. Members generally agreed that SEUs should be weighted for the purpose of risk equalisation to reflect premium variation from Lifetime Health Cover (LHC) loadings, and that this change should also be introduced on 1 April 2019 to align with the start of aged-based discounts. The impact of this change should be monitored over time to ensure it does not have perverse impacts.

8. It is not possible to make the case for change to a prospective risk equalisation system, or one based on 'average' benefits or utilisation, because modelling of the impact in not likely to be feasible in the current mixed product environment. However, after the 2019 product categorisation changes are well embedded (likely 2 to 4 years after they commence) a study of evidence should be undertaken to demonstrate whether there are clear net benefits available from a prospective model.

9. The Working Group did not support a move to a proportional risk equalisation system at this time. However, after the introduction of the new aged-based premiums discounts, modelling of price elasticities should be undertaken to inform consideration of this option in the future.

10. The size of the risk equalisation pool should not be capped.

11. The Aged Based Pool factors should continue to achieve a drawing rate net of risk equalisation that is broadly similar across age cohorts. This should be based on modelling of the factors currently being undertaken by Deloitte. Following this modelling the factors should be adjusted 5 yearly.

12. The High Cost Claims Pool threshold should be increased to $100,000, and adjusted at 5 yearly intervals to reflect claims inflation.

Introduction

On 9 November 2016, PHMAC agreed to establish the Working Group to advise PHMAC on possible reforms to risk equalisation arrangements.

The Working Group was chaired by Mr Greg Smith and brought together key individuals with expertise in private health insurance to work in partnership on the development of possible reforms. Membership included representatives from insurers, Australian Medical Association, Australian Physiotherapy Association, Private Healthcare Australia and actuaries with risk equalisation expertise. The Working Group's full membership is at Attachment A.

The Working Group met four times from October to December 2017. There was robust discussion at each meeting, and members tabled a range of information to help inform the Working Group's deliberations. The Working Group's deliberations were also supported by a range of modelling commissioned by the PHMAC Secretariat and undertaken by Deloitte Actuaries and Consultants. On 8 November, Mr Smith provided an update to PHMAC on the Working Group's deliberations.

The Working Group was encouraged to focus on possible reforms to risk equalisation and to consider how they might improve the value of private health insurance. The group first looked at the issues from the top down through the prism of equalisation objectives, and subsequently has taken a bottom-up approach analysing the effects of current features of the arrangements.

This paper provides a summary of the Working Group's views against the Terms of Reference for PHMAC's consideration. Given the short timeframe for reporting to PHMAC, not all options or issues could be fully considered/developed, including consideration of implementation issues.

Objectives of Risk Equalisation

Risk equalisation is a central component of the current private health insurance system.

Private health insurance in Australia is governed by the principle of community rating. This is different to most 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 in the same state for the same category of membership (i.e. single, couple, single parent and family), with the exception of LHC and limited discount provisions. This means that health insurers cannot set premiums to discriminate on the basis of age (other than age at entry under LHC), gender, health status and other factors.

The system of risk equalisation has historically aimed to support community rating by taking the 'extra' costs of higher risk people, and spreading them across the industry, across all insurers and all insured persons.

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 frequent 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 for younger healthier insured persons to subsidise the costs of older less healthy insured persons' claims across the system.

There was some discussion by the Working Group around other forms of community rated insurance that operate without an underlying risk equalisation mechanism, such as NSW Compulsory Third Party (Green Slip) insurance. However, members generally agreed that some form of risk equalisation to support community rating in private health insurance is desirable. Members broadly agreed that risk equalisation allows insurers to share across the industry those risks which are largely beyond the control of an individual insurer in a community rated system, such as higher claim costs arising from an adverse demographic profile.

The Working Group was of the view that removing risk equalisation would inappropriately increase the incentive for insurers to seek to reduce the number of older, sicker insured persons and to increase the number of younger, healthier insured persons who are less likely to claim. Insurers who were successful in reducing their overall risk profile would be rewarded through lower claims, which could be passed to consumers as lower premiums, while claims/premiums for insurers with higher risk profiles would increase. Insurers which did not "improve" their risk profile would be disadvantaged, even if they were otherwise well managed and efficient. 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.

Key Finding/Recommendation
1. Risk equalisation should be retained for private health insurance.

The Working Group thoroughly considered possible objectives of risk equalisation, including whether the arrangements should be used as a policy tool (that is, used to encourage or discourage particular activity, rather than simply equalise for different profiles of coverage).

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 insurers to provide these services (or at least to reduce the disincentive). Members were concerned that changes which might be designed to encourage certain consumer or insurer behaviours could instead undermine risk equalisation's support of community rating by providing more, or less, support for different types of consumers.

Members also generally agreed that the design of any risk equalisation system is complicated by the extensive range of products and benefit exclusions and restrictions in the current market.

Key Finding/Recommendation

2. The Working Group agreed that risk equalisation should continue to be considered, first and foremost, a risk sharing tool to support community rating of the comprehensive range of health risks.
3. The Working Group was concerned that if risk equalisation was used as a policy lever to encourage certain consumer or insurer health care financing behaviour this could undermine risk equalisation's support for community rating.
4. The Working Group agreed the objective of risk equalisation is to support community rating by minimising incentives for insurers to discriminate against consumers based on risk, in a way that:
   a) does not put well managed insurers at prudential risk; and
   b) maintains a competitive private health insurance model with incentives for insurers to compete.
5. Members also agreed the following supporting principles:
   a) Minimise adverse incentives: risk equalisation should as far as possible have minimal adverse impact on the incentive for insurers to invest in the management of their insured persons' claim costs;
   b) Encourage participation: as far as possible, risk equalisation should have a positive impact on consumer participation in private health insurance, including by not reducing consumer choice;
   c) Low transaction costs: the system needs to be practical with low transaction costs, including implementation and ongoing management costs; and
   d) Predictability: the financial outcome should be relatively predictable.

The positive and negative aspects of current risk equalisation arrangements

The Working Group considered aspects of the current retrospective risk equalisation arrangements, including:

- that risks are currently equalised through individual state-based pools;
- that risks are currently equalised based on actual claims history within particular age cohorts, rather than a calculated measure related to use/risk;
- that age is currently used as a proxy for risk (i.e. older insured persons typically claim higher benefits than younger insured persons);
- whether the current arrangements create incentives for particular behaviour; and
- the links between risk equalisation and other aspects of private health insurance, such as portability and exclusionary products.

The Working Group agreed that on the primary objective of equalising risk to support community rating, the current arrangements meet this objective quite well in the principal area of concern, namely aged-based risk. Members also generally agreed that changes to the risk equalisation arrangements were not critical for the industry, but that the Working Group should look for opportunities for improvement.

Members noted that when the current risk equalisation arrangements were established in 2007, age was seen as a reasonable, and simple, proxy for health risk. The current arrangements continue to distribute aged-based claims risk fairly evenly across age cohorts. However, the Working Group also considered the impact on premiums should the aged-based pool input factors be calibrated to achieve a completely equal distribution of risk across age cohorts. This is discussed later in the paper.

The Working Group also recognised that the pursuit of equalising risk may come at the expense of dampening:

- the incentive for insurers to invest in the management of their insured persons' claim costs; and
- greater consumer participation, particularly by younger people, in private health insurance.

The parameters for risk equalisation must be balanced against these objectives, considering the available evidence on current performance and scope for improvement.

There is a longstanding view that retrospective risk equalisation arrangements do not provide incentives for insurers to manage appropriately claims risk as individual insurers do not gain the full advantage from their increased efficiency. Some of the efficiency resulting from any improvement in the overall health (risk profile) of an individual insurer's insured persons is instead shared across the industry through risk equalisation. This is because the current system calculates risk equalisation based on benefits paid, and therefore shares a proportion of all costs, regardless of whether those costs can be fully or partially controlled by the insurer.

However, members argued that the current arrangements still provide considerable incentive for insurers to manage risk because there is no age cohort where risks are equalised completely, so individual insurers still bear material risk. Insurers retain 100 per cent of the efficiency from keeping under 55s out of hospital, and for claimants 55 years and over they retain both the unpooled element and a proportion of the efficiency equal to their jurisdictional market share.

The Working Group also noted that under the current arrangements individual insurers may not realise the efficiency of their investment in prevention programs because the pay-offs are longer term and consumers are free to transfer to another insurer without any penalty or cost. It was put to the Working Group that given any efficiencies realised from preventative programs are shared across the industry, the costs should also be shared.

Members generally agreed that the current arrangements may not effectively incentivise hospital substitute treatment or chronic disease management programs (CDMPs) because the percentage of cost allowed to be pooled is highest for the oldest cohort, where these programs are likely to deliver lower benefits. This issue is further discussed later in the paper.

In relation to dampening participation, risk equalisation makes basic products more expensive than they would otherwise be. 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.

Some industry actuaries have questioned the long term sustainability of current risk equalisation arrangements. As the proportion of total benefits being equalised increases (due in large part to ageing of the membership base) the risk equalisation liability per SEU also increases (if participation is not also growing). This means that young healthy people with basic policies 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 insured persons, and is a strategic risk to the community rated private health insurance system.

Some members argued that the current arrangements do not adjust well for the risk to individual insurers of new insured persons claiming benefits soon after joining. Of particular concern was the impact of the mandated portability requirement which allows consumers to freely transfer to a similar policy at a different insurer without re-serving waiting periods.

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, to access higher benefits (often on recommendation from the health service provider) or to avoid product restrictions. Under this circumstance, one insurer collects the majority of the consumer's premium payments over time, but the second insurer bears the claims cost. In some cases, a portion of the claims cost may be eligible for risk equalising, but if the consumer is under the age of 55 none of the cost can be equalised unless it meets the High Cost Claims Pool threshold.

There were differing views on whether the impact of portability on an insurer's risk profile and costs was a material concern. One view was that membership across the industry was relatively stable, with transfer rates only about 10% per year. However there was also a view that in a system with mandated portability requirements, the risk associated with such transfers should be shared by the industry and that insurers should not be "penalised" for offering more attractive products.

Members considered that one way to address the issue of portability was to allow all claims to be equalised for 12 months following a consumer transferring between insurers. However, the alternative view was that the issue around portability may be better addressed through changes to the portability requirements to minimise opportunistic transfers. Overall, the group concluded that risk equalisation arrangements were not the best way to address concerns with portability issues.

Key Finding/Recommendation

3. a) members expressed concern about portability requirements resulting in higher claims for the receiving insurer, and considered whether insurers should be allowed to equalise claims for 12 months following a consumer transferring to them from another insurer. However, the Working Group agreed this issue would be more appropriately addressed through changes to the portability requirements.

The impact on risk equalisation of other reforms to private health insurance

The group considered the package of private health insurance reforms announced by Government on Friday 13 October 2017. The group noted that the reform to allow insurers to offer travel and accommodation benefits under hospital cover would have a direct but immaterial impact on risk equalisation as related benefit claims would be eligible for risk equalising.

The group also thoroughly considered how the risk equalisation arrangements may impact on the introduction of voluntary age-based discounts for young consumers. The Secretariat confirmed that the policy as agreed by the Government was to allow insurers to provide discounts for younger members on a voluntary basis, and that the provision of a discount will not reduce the risk equalisation liability for an insured person.

Members considered whether the introduction of discounts might be more effective in attracting younger people if insurers' risk equalisation liability for each discounted policy was weighted to reflect the lower premium revenue resulting from the discount.

The risk equalisation liability is presently based on equally weighted SEU (SEUs are used as a standard measure of the different categories of policies). This means that SEUs are not weighted in any way to reflect differences in premiums actually paid or the class of policies taken out.

The risk equalisation liability forms a large and increasing part of the cost to insurers of policies, which has implications for the relative profitability of different policies – the liability represents a higher share of cost for any lower premium policy and vice versa. The Working Group argued that this may reduce the incentive for insurers to pursue increased numbers of young consumers who will be likely to seek lower priced policies.

For the purpose of calculating the insurer's risk equalisation liability, a discounted policy could be counted as less than one SEU to reflect the discount being provided. This would lower the insurer's risk equalisation liability, which the insurer then could distribute between insured persons. This would effectively share the costs of discounts across the industry. One member suggested that given offering discounted products will be voluntary, any policy to weight the risk equalisation SEU should not lock in over time a reduced risk equalisation contribution for any individual (that is, the SEU should only be weighted to reflect the lower premium from a discount at that specific point in time).

Members generally agreed that SEUs should be weighted for the purposes of risk equalisation to reflect premium variations driven by the introduction of aged-based discounts, and that this change should be introduced when voluntary discounts for young consumers start on 1 April 2019.

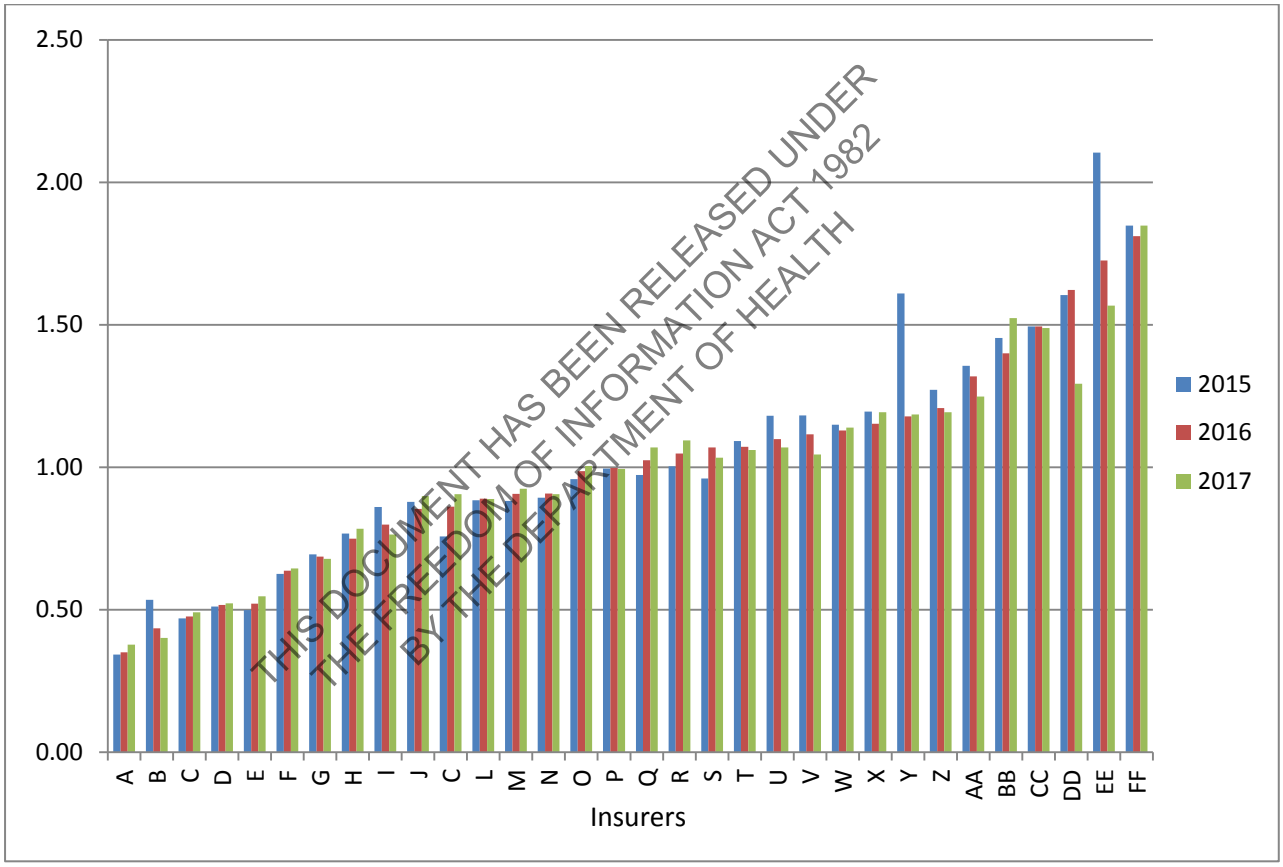
This would require expanding the Australian Prudential Regulation Authority collection to identify and report the number of SEUs subject to an age-based discount to improve the transparency of the risk equalisation calculation to all insurers.

Key Finding/Recommendation

6. SEUs should be weighted for the purposes of risk equalisation to reflect premium variation driven by the introduction of aged-based discounts, and this change should be introduced when discounts for young consumers start on 1 April 2019.

The Working Group considered whether the logic of weighting aged-based discounted SEUs could also be applied to the additional premium revenue insurers receive through LHC loadings. LHC loading revenue is currently retained by the individual insurer so can be considered a 'premium windfall'. Analysis undertaken by the Secretariat (shown in the graph below) showed that LHC revenue per SEU varies between insurers.

Index values: Insurers' Lifetime Health Cover Revenue per SEU



Note: One insurer was removed from the above calculation because it was an outlier with very high LHC revenue per SEU which was caused by unique circumstances when the insurer opened.

To distribute LHC revenue across the industry, SEUs with an LHC loading could be weighted to count for more than one SEU to reflect the premium windfall associated with the loading. Members noted that the net premium income from LHC would differ by the age of the insured person and their likely claims, and that retaining LHC loadings also creates an incentive for insurers to focus on retaining these members. The Working Group also noted that if an insurer has many insured persons with LHC loadings this would be factored into their current pricing and therefore an adjustment period would be necessary if risk equalisation was changed.

Key Finding/Recommendation

7. Members generally agreed that SEUs should be weighted for the purpose of risk equalisation to reflect LHC loadings, and that this change should also be introduced on 1 April 2019 to align with the start of aged-based discounts. The impact of this change should be monitored over time to ensure it does not have perverse impacts.

Options for possible change to the arrangements

Replacing the current risk equalisation system with a prospective arrangement

Based on the limited current evidence, the Working Group does not recommend moving to a prospective risk equalisation arrangement.

Prospective risk equalisation, also known as risk based capitation reinsurance or composition reinsurance, is a system based on defined risk factors, such as age, gender and health status of the person covered. The average risk in each state is calculated for the industry. Each individual insurer's risk is compared with the state average risk. If an insurer's risk is higher than state average they receive from the pool, and if an insurer's risk is less than the average they pay into the pool.

Members generally agreed that using health status as a key rating factor for prospective risk equalisation would be difficult because the system is community rated, and as such insurers do not currently collect information to allow the assessment of health status. Insurers could start collecting data on health status, or alternatively age could continue to be used as a proxy for this factor.

The extensive range of products/policies in the market may also create a significant practical impediment to the introduction of a prospective risk equalisation arrangement.

The group considered whether a proportion of the current 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. However, the group generally agreed that the size of the pool is largely driven by hospital admission rates, over which the health insurer has little control.

In theory, 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 insured person base and their management of those insured persons. However, as outlined earlier, the group considered that existing arrangements retain sufficiently strong incentives for funds to invest in the management of insured persons' claims costs, and that all insurers are already doing so. It did not consider that there was any clear evidence that substantial opportunities exist for insurers to further increase management of controllable risks.

Moving to a system based on 'averages' to calculate risk equalisation.

The group considered an alternative model which would involve paying a proportion of average claims costs by age from the pool (or other variants of a prospective claims model) rather than a proportion of actual claims cost. This would be a move toward a prospective model, but through a relatively simpler adjustment of existing arrangements.

An example of a similar system is the Commonwealth Grants Commission approach to risk sharing across the states and territories (fiscal equalisation). When determining payments to states and territories, only uncontrollable factors that affect costs are taken into account. For example, the assessment of expenditure needs for admitted patients to public hospitals takes account of average spending by age cohort and then jurisdictional differences in age profiles of population. Only in the case of natural disasters, where the Commonwealth Grants Commission takes the view that all expenditure arises from circumstances outside the states' control, is funding based on each State's actual cost.

The group considered whether the application of risk equalisation based on a measure such as average benefits for each age cohort would reward well managed, efficient insurers operating below the average, and create incentives for other insurers to improve. They also considered whether this approach could place downward pressure on contracted prices/benefit paid, and provide an incentive for insurers to invest in improving the health of their insured persons.

Members generally agreed that average claims costs would be a suitable measure in a market that had only one product, but could create perverse incentives in the current multi-product market. Members argued 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. The Working Group also 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 Group considered analysis (shown in Attachment B) that compared, at de-identified individual insurer level, the current system (based on actual claims costs) with a simplified system based on average claim cost and/or average utilisation for each risk equalisation age cohort. The analysis showed that this change would result in substantial reductions in payments from the pool for some insurers which, for reasons that are not known and may not be controllable, have well above average claims.

Likewise, it was put to the group that, with the current data, it is not possible to know what is driving lower than average claims. For example, lower actual benefits could be driven by strong contracting and good CDMPs, or by insurers charging high excesses and excluding services from their products.

In summary, risk equalisation reduces incentives for both potentially desirable (cost managing) and potentially undesirable (discriminatory) insurer behaviours. Proposals for prospective (or average cost) equalisation are based on conceptual arguments that claims based on a share of actual cost reduce incentives for desirable behaviours. This assumes that substantial unmet opportunities exist to increase desirable behaviours without risk of also increasing undesirable behaviours.

However, there is very little independent and reliable evidence that could demonstrate the likely actual effects of changes to arrangements. It is also unclear why some individual funds have much higher claims costs than others for the same age cohorts, and in particular the extent to which this is the result of controllable or uncontrollable risks.

It is not possible to provide an evidence based recommendation unless a study of these questions is undertaken. Members generally agreed that modelling the impact of these potential changes would be difficult in the current mixed market, but that the introduction of new product categorisation in 2019 may provide an opportunity to reconsider this issue.

Key Finding/Recommendation

8. It is not possible to make the case for change to a prospective risk equalisation system, or one based on 'average' benefits or utilisation because modelling of the impact is not likely to be feasible in the current mixed produce environment. However, after the 2019 product categorisation changes are well embedded (likely 2 to 4 years after they commence) a study of evidence should be undertaken to demonstrate whether there are clear net benefits available from a prospective model.

Replacing the current risk equalisation system with a proportional system

Under the current risk equalisation arrangements the same liability is placed on each SEU regardless of the value a 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 adjust the liability of a policy in proportion to the benefit rate of the policy (for example Gold, Silver, Bronze or Basic), or alternatively it could be linked to the product's underlying premium rate, that is the premium rate net of any existing risk equalisation liability. 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.

The introduction of 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 of a particular group with other insured persons in that group; there would be no or reduced equalisation across groups. Members expressed concern about the equity implications of such a change.

The Working Group also considered the counter view: 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 insured persons. It was suggested that exclusionary products may be inconsistent with 'pure' community rating.

However, it could also be argued that consumers have made a conscious decision to purchase low cover products in a community rated system (possibly to minimise tax by avoiding the Medicare Levy Surcharge (MLS)), and there is little argument to support lowering the risk equalisation liability for these policies relative to comprehensive cover.

The consequences for equity of any change in arrangements arise not only from the direct effects of any change in relative costs, but also indirect effects through changes in participation arising from any change in premiums charged. If lower premiums induce higher participation by low risk groups, the funding pool available for cross subsidies is increased. A critical question, then, is how responsive is demand for insurance to changes in price.

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.

The group noted that price sensitivity could be masked by people downgrading products as prices rise 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. Members did not have evidence/analysis on price sensitivity which could assist the Working Group's consideration.

Key Finding/Recommendation

9. The Working Group did not support a move to a proportional risk equalisation system at this time. However, after the introduction of the new aged-based premiums discounts, modelling of price elasticities should be undertaken to inform consideration of this option in the future.

Applying different parameters to the current risk equalisation arrangements

The current risk equalisation arrangement comprises an Aged Based Pool (which supports community rating) and a High Cost Claims Pool (which reduces prudential risk for insurers). These two pools ensure that no insurer is significantly disadvantaged by having an older age profile, a higher risk profile or a catastrophic claim.

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 in part the risk for claims for insured persons 55 and older who have higher drawing rates than the population younger than 55. The current risk equalisation arrangements widened the ages for which contributions to the Aged Based Pool are made (down from 65 years under the previous arrangements) to 55 years with differing percentages allocated to each 5 year age cohort, as shown in the following table:

Risk Equalisation Aged Based Pool

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

Size of the risk equalisation pool

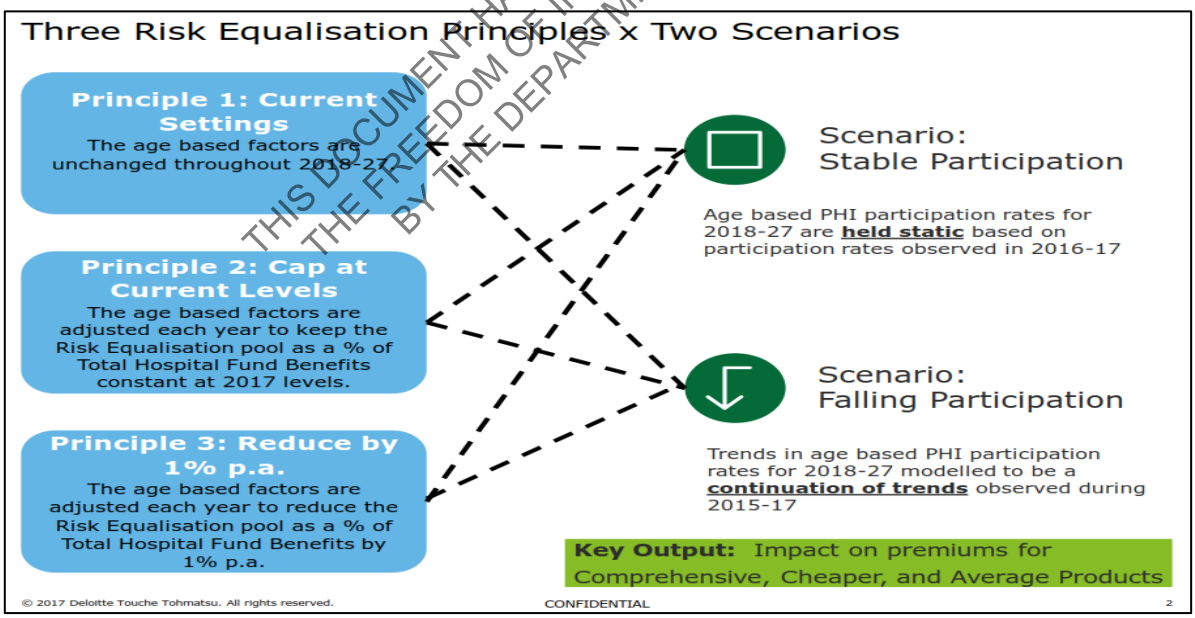
Over the past 10 years, the proportion of total benefits that is risk equalised has increased from approximately 36% to 44%. This increase was primarily due to an ageing participation profile, but it was also noted that a significant component of the increase was due to the effects of Veteran Gold Card population changes which have now worked through the system. The national average risk equalisation liability per SEU has increased from around $360 to $750 over the same period.

As the proportion of total benefits being equalised increases, the risk equalisation liability per SEU also increases. 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 it does in high priced products. Risk equalisation makes low priced basic products more expensive than they would otherwise be in a risk rated system, and may discourage younger healthier people from purchasing private health insurance.

The Group considered the current parameters of the age based scheme, and a range of options to reduce or reverse the rate of growth of the risk equalisation pool. Modelling undertaken by Deloitte demonstrated the long term impact on premiums of three scenarios:

1. Continuation of the current risk equalisation system;
2. Capping the risk equalisation pool at its current proportion of total benefits paid; and
3. Reducing the pool size as a proportion of benefits over time.

Deloitte modelled the landscape in ten years' time to allow time for any policy changes to work through the system, and included analysis for both stable participation (based on participation rates in 2016-17) and falling participation.



The modelling showed that the more the risk equalisation pool is capped or reduced, the lower the subsidy provided by low priced products to comprehensive products becomes. This means that capping the risk equalisation pool would effectively reduce the level of support provided to community rating by risk equalisation. The outcomes of Deloitte's modelling are at Attachment C.

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.

The Working Group was of the view that growth in the risk equalisation pool would be less concerning if participation was also growing. Members agreed that any changes in the price differential between basic and comprehensive policies as a result of capping the risk equalisation pool would lead to changes in the participation profile and potential destabilisation from the increased financial incentives to downgrade cover. However, members also argued that under current policy settings risk equalisation was not a major driver of participation compared with policies such as LHC and the MLS.

While the Working Group noted that there has been some criticism of the absolute size of the risk equalisation pool, reducing the size of the pool would not address the underlying issue of increasing health claim costs. Members were also concerned that capping the risk equalisation pool may provide incentives for undesirable behaviour, such as insurers attempting to reduce benefits inappropriately for older insured persons.

The Working Group was also mindful that any other policy changes that impact differently on different age cohorts would have flow-on implications for the system as a whole.

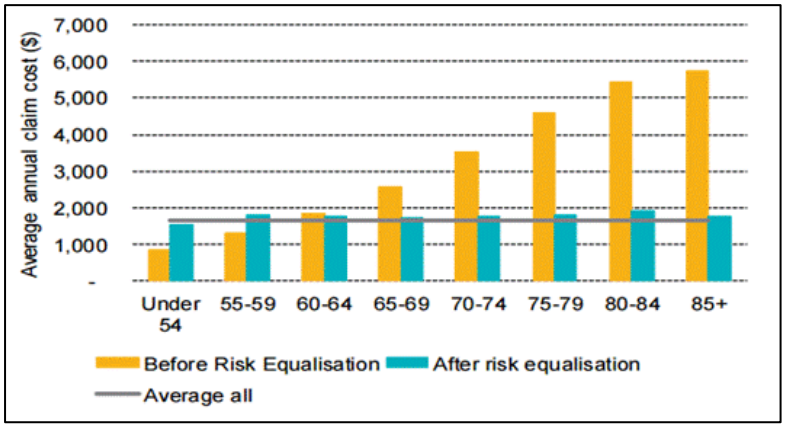
Based on current evidence, the Working Group does not recommend making any parameter changes which are designed to cap the size of the risk equalisation pool at this time, but recommends that this issue continue to be monitored.

Key Finding/Recommendation
10. The size of the risk equalisation pool should not be capped.

Distribution of risk across age cohorts

Notwithstanding the continued increase in age-based costs, the scheme continues on current parameters to broadly equalise costs to funds across the age cohorts, and so to meet its primary objective (as agreed by the Working Group). Members generally agreed that at an industry level the drawing rates following risk equalisation adjustment are fairly flat across all age cohorts as shown in the following graph, but acknowledged that the experience of individual insurers differs.

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 https://www.actuaries.asn.au/Library/Events/SUM/2017/SUM17ReidEtAlPaper.pdf

Over time, demographic change will lead to increased numbers of insured persons entering older age cohorts, and this will increase the average risk equalisation liability per SEU. Members generally agreed that the drawing rate after risk equalisation would increase over time for all age cohorts as total claims costs increase, but that at any point in time it would be desirable for the post-risk equalisation drawing rate to continue to be reasonably similar across the age cohorts.

Members considered whether the current age cohorts eligible for equalisation should be amended to better distribute risk. Some members noted the higher drawing rate for females in the 30-34 and 35-39 age bands due to obstetric claims, although other members did not see this as a risk equalisation issue due to the lower drawing rate for males at these ages which effectively eliminates the impact in the combined drawing rate (male and female combined).

One member suggested that arrangements needed to also account for the claims of dependents, which can be attributed to the risk equalisation pool without a corresponding SEU contribution.

Deloitte has been asked to undertake modelling to calibrate the risk equalisation age based factors to achieve a drawing rate net of risk equalisation that is completely flat across age cohorts. The results were not available for inclusion in this report, so the Chair has asked that the Secretariat provide the modelling separately to PHMAC for consideration.

11. The Aged Based Pool factors should continue to achieve a drawing rate net of risk equalisation that is broadly similar across age cohorts. This should be based on modelling of the factors currently being undertaken by Deloitte. Following this modelling the factors should be adjusted 5 yearly.

High Cost Claims Pool

The current arrangements introduced a High Cost Claims 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 allocation to the Aged Based Pool and a $50,000 per year threshold have been deducted. The $50,000 threshold was set in 2007.

The Group considered that the rationale for the High Cost Claims Pool is to mitigate the financial risk (and hence prudential risk) arising from high claims i.e. effectively true reinsurance. This is a secondary objective of risk equalisation.

The High Cost Claims Pool only accounts for 3.03% of claims equalised through risk equalisation in 2016-17 (up from 1.97% in 2008-09), essentially because most large claims are first covered by the Age Based Pool.

Members considered 2015-16 Hospital Casemix Protocol (HCP) data for individual separations with private health insurance benefits over $50,000. A limitation of the HCP data is that the claims information is de-identified, so it is not possible to look at cumulative claims for an individual where the total over the last 12 months is over $50,000.

The data showed that for 2015-16 there were 9,123 individual separations where the claim was over $50,000. After the Aged Based Pool deductions were applied, only 2,142 individual separations remained with residual claims benefits over $50,000. Most of the remaining high cost claims were for people aged under 60. The Working Group generally agreed that the Aged Based Pool was already adjusting well for aged based risk for individual high cost separations.

The Working Group considered the historical frequency of high cost claims and the associated risk equalisation transfers through the High Cost Claims Pool. Members generally agreed that, while there was variability in the level of high cost claims attributed to the pool between insurers, from a prudential perspective high cost claims were really only a material issue for very small insurers.

Members considered whether increasing the high cost claims threshold, for example to $100,000, would mean insurers would need to hold higher capital because less risk would be shared across the industry. Members generally agreed that even for small insurers an increase in the high cost claims threshold to $100,000 was unlikely to have a material prudential impact on insurers.

The Working Group considered whether the High Cost Claims pool should be abolished altogether, but generally agreed that some insurers would then need to purchase commercial reinsurance, which would likely be more expensive than continuing the current system with a raised threshold.

Key Findings/Recommendations

12. The High Cost Claims Pool threshold should be increased to $100,000, and adjusted at 5 yearly intervals to reflect claims inflation.

Other claims classes considered for risk equalisation

The Group has considered whether new equalisation sub-pools are needed to cover other risks (such as neo-natal claims that are below the high cost claims threshold); or to cover expenditures where third party benefits may predominate because they benefit the system by reducing future claims (such as CDMPs and obesity treatments).

An option considered was to allow a portion of any benefit paid to under 55 years olds for CDMPs or other services with system wide benefit, where there is potential for greatest gain, to be eligible for risk equalising.

One member raised that future health costs are only delayed, not avoided, and are still covered by the industry. The counterview was that because most people remain in the system, and continue to pay premiums, there is still value for the industry overall in delaying/avoiding costs. One member also put forward that the costs associated with future technological advances could be included in risk equalisation if the technology was shown to reduce future claims.

The Working Group further discussed the difficulty with demonstrating that costs now would reduce future costs. Members were generally concerned about increasing the level of risk equalisation for this class of claims without solid evidence that more such programs would reduce or avoid future claims or that current equalisation arrangements are acting to reduce substantively the pursuit of opportunities for such programs.

Members were generally concerned that any additional costs that were allowed to be risk equalised would further increase the per SEU risk equalisation liability, which would transfer more of the industry cost to young basic policyholders.

The Working Group also considered whether claims for some specific services should be equalised even where the claim doesn't meet the high costs claim threshold, for example psychiatric, maternity and neonate care.

The Group concluded that extensions to the coverage of the scheme is not required in any new claim categories, and that risk equalisation is not the best way to deal with any secondary objectives.

Key Findings/Recommendations

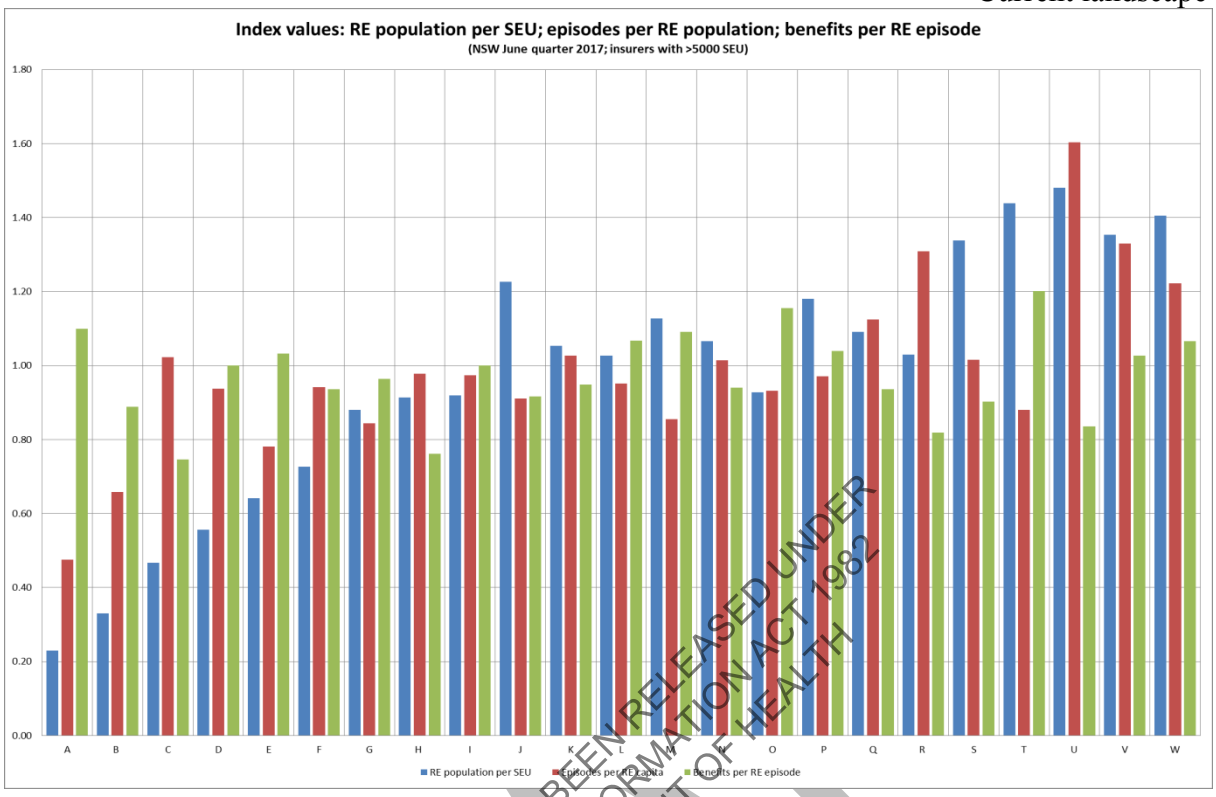
3b). Risk equalisation coverage should not be extended to include any new claim categories (for example where third party benefits exists) because risk equalisation is not the best way to deal with any secondary policy objectives.

Membership – Risk Equalisation Working Group

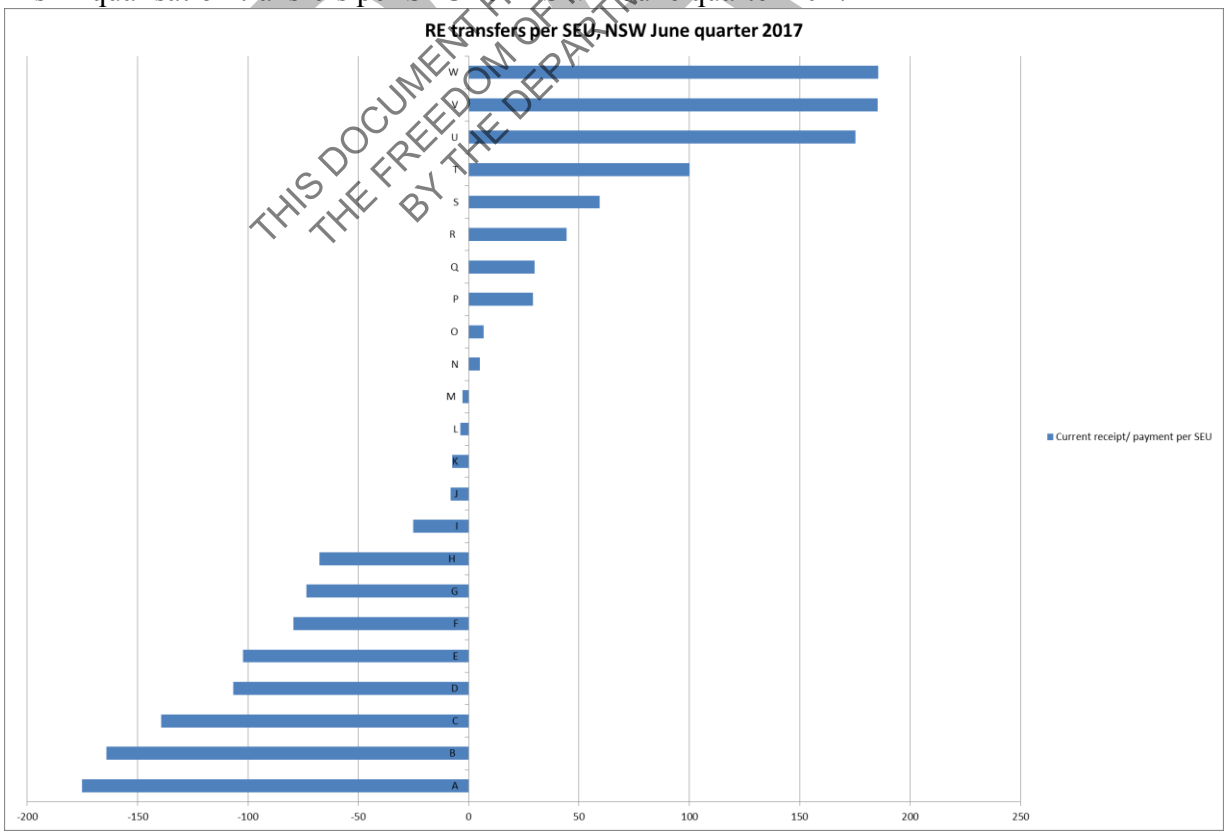
Working Group Member	Organisation
Greg Smith	Chair
Dr Gino Pecoraro	Australian Medical Association
Ian Watts	Australian Physiotherapy Association
Karl Niemann	Australian Prudential Regulation Authority
Tory Gervasi	Bupa
David Torrance	dbn Actuaries
Jamie Reid	Finity Actuaries
Mario Fortunato	HCF
Bruce Beatson	Latrobe Health Services
Michael Bassingthwaighte AM	Peoplecare Health Insurance
Dr Rachel David	Private Healthcare Australia
Bronwyn Hardy	Teachers Health
Stuart Rodger (technical adviser)	Deloitte Actuaries and Consultants

Attachment B

Current landscape

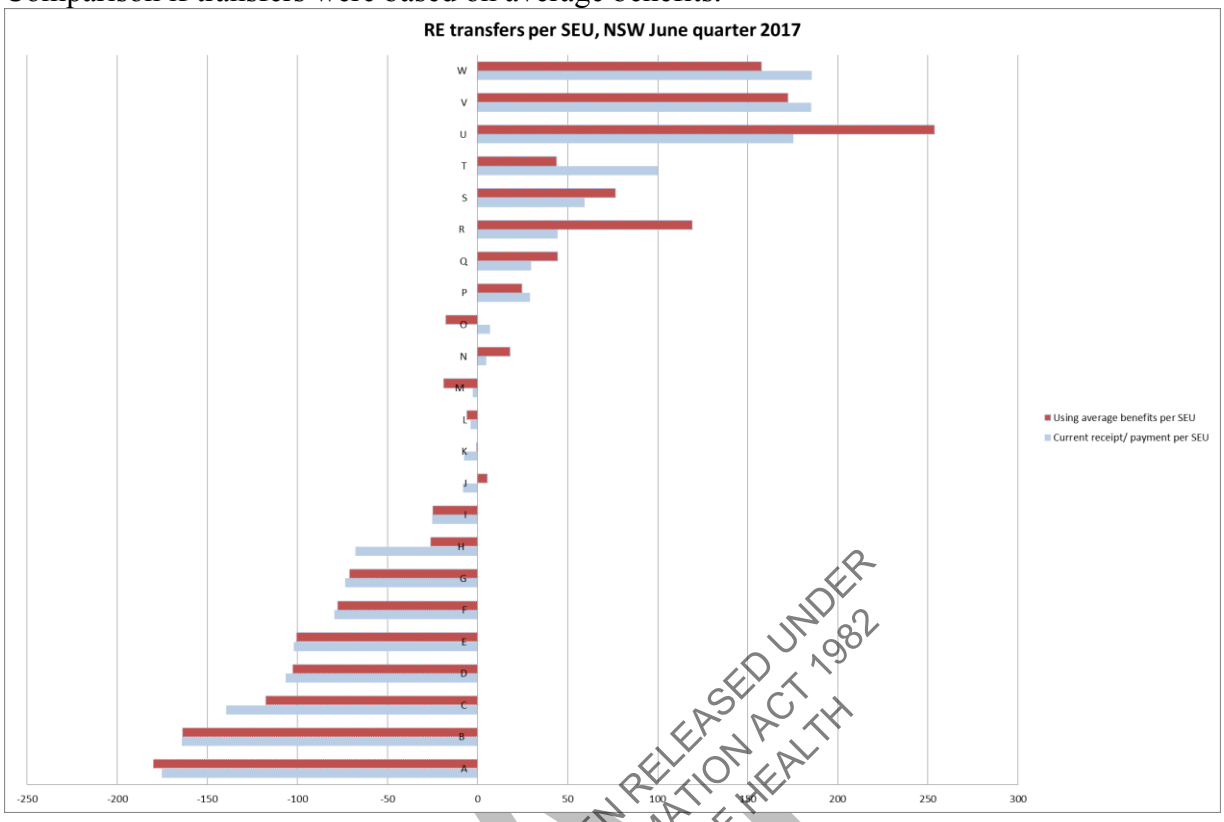


Risk Equalisation transfers per SEU for NSW – June quarter 2017

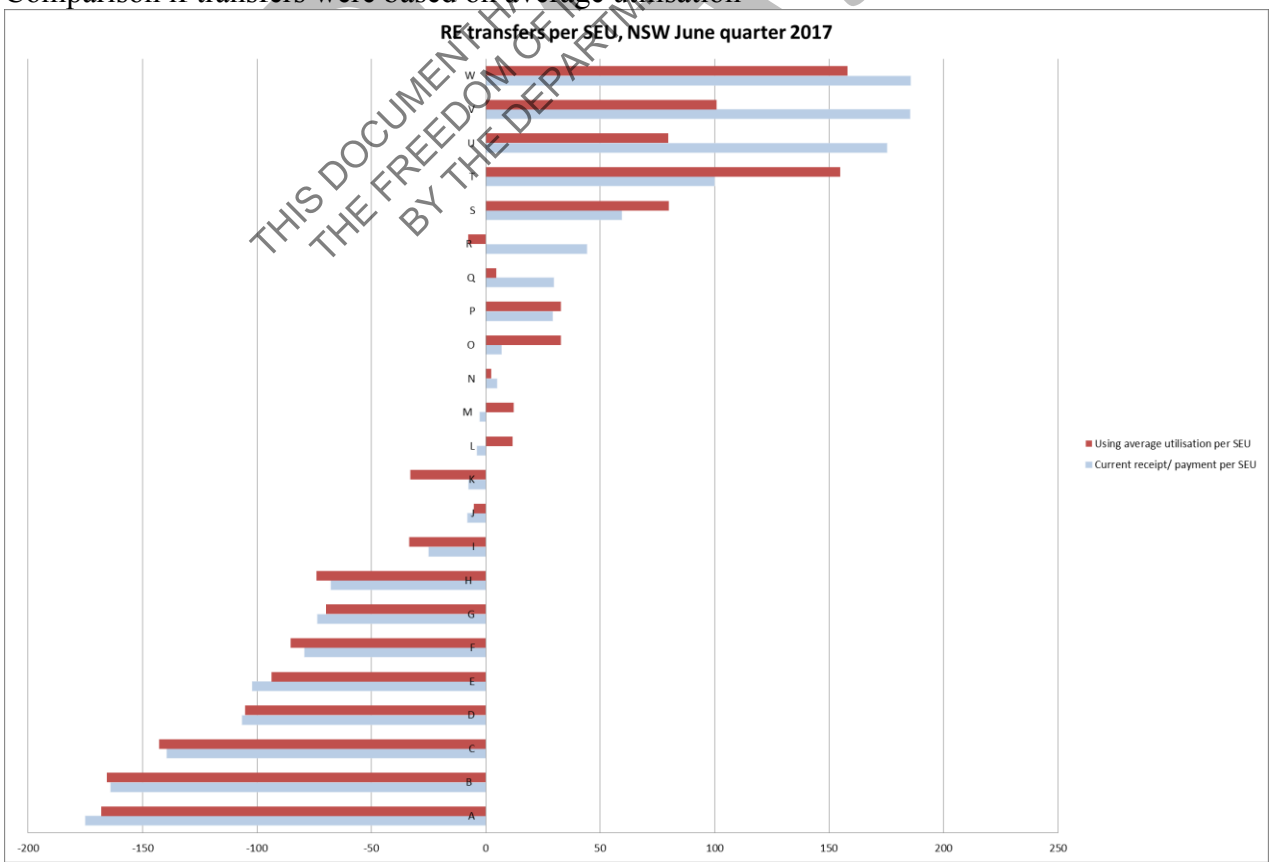


Attachment B

Comparison if transfers were based on average benefits.

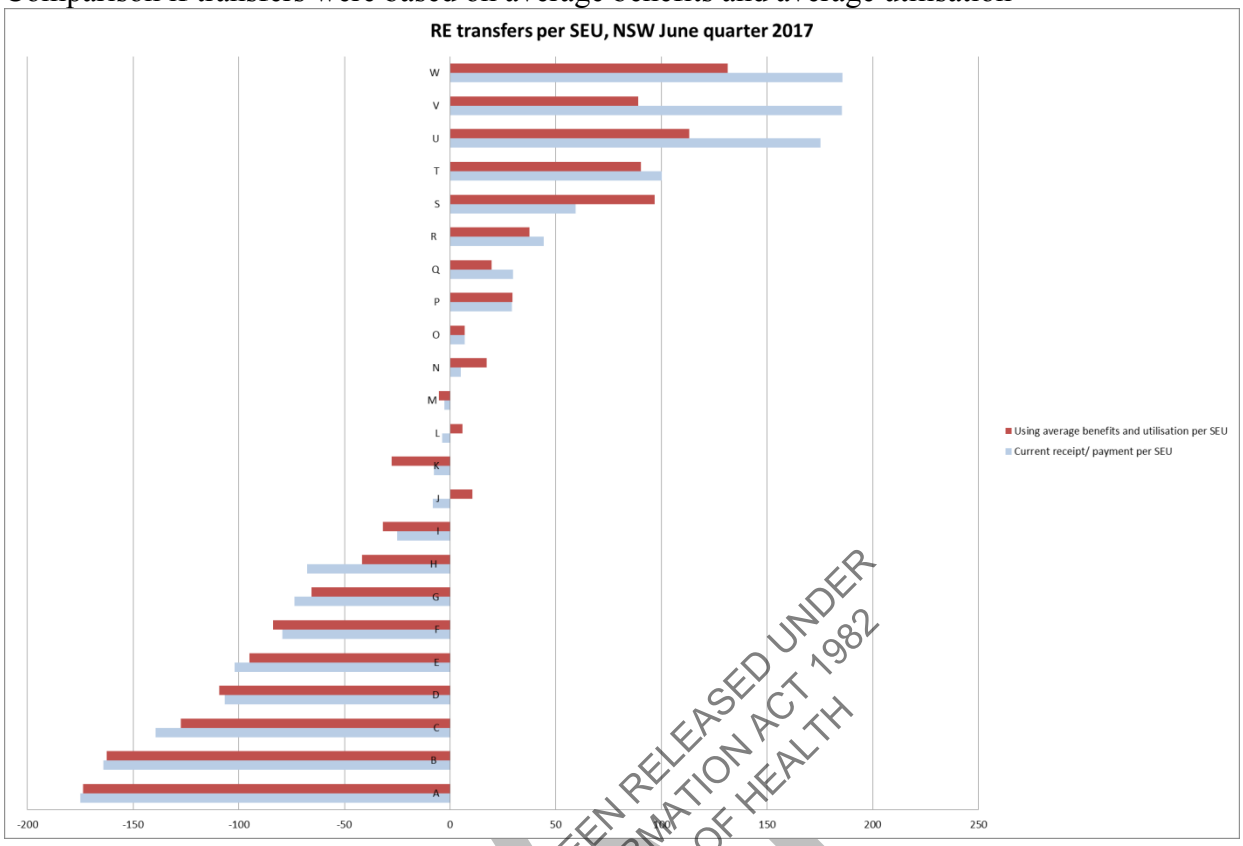


Comparison if transfers were based on average utilisation



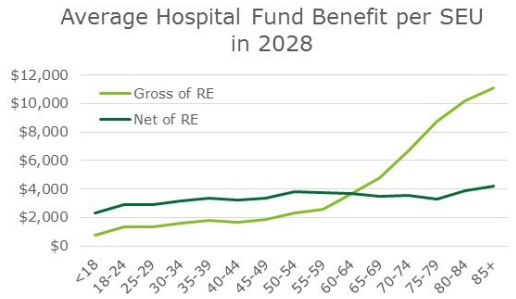
Attachment B

Comparison if transfers were based on average benefits and average utilisation



Attachment C

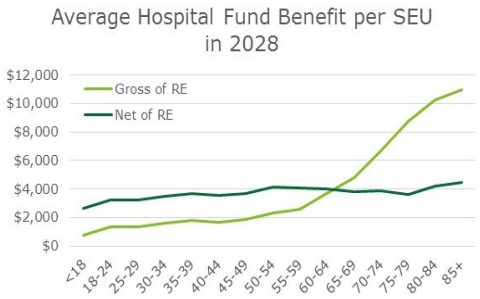
Principle 1 – Current Settings Stable Participation



Premium Impact

	2018		2028	
	Illustrative Premium $ per SEU	% of Prem for RE	Illustrative Premium $ per SEU	% of Prem for RE
Cheapest	1308	63%	2328	66%
Comprehensive	2564	32%	4510	34%
Overall	2150	39%	3693	42%

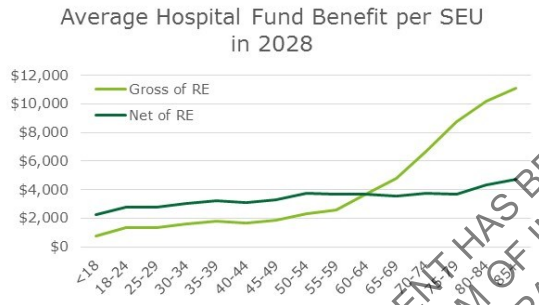
Principle 1 – Current Settings Falling Participation



Premium Impact

	2018		2028	
	Illustrative Premium $ per SEU	% of Prem for RE	Illustrative Premium $ per SEU	% of Prem for RE
Cheapest	1324	64%	2702	69%
Comprehensive	2581	33%	4910	38%
Overall	2167	39%	4088	46%

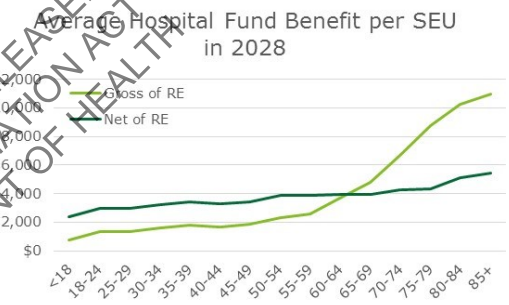
Principle 2 – Cap at Current Levels Stable Participation



Premium Impact

	2018		2028	
	Illustrative Premium $ per SEU	% of Prem for RE	Illustrative Premium $ per SEU	% of Prem for RE
Cheapest	1308	63%	2234	64%
Comprehensive	2564	32%	4566	31%
Overall	2150	39%	3693	39%

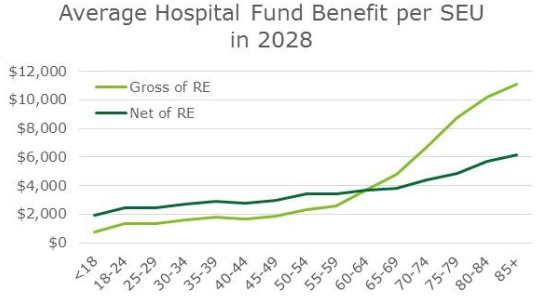
Principle 2 – Cap at Current Levels Falling Participation



Premium Impact

	2018		2028	
	Illustrative Premium $ per SEU	% of Prem for RE	Illustrative Premium $ per SEU	% of Prem for RE
Cheapest	1324	64%	2477	65%
Comprehensive	2581	33%	5042	32%
Overall	2167	39%	4088	39%

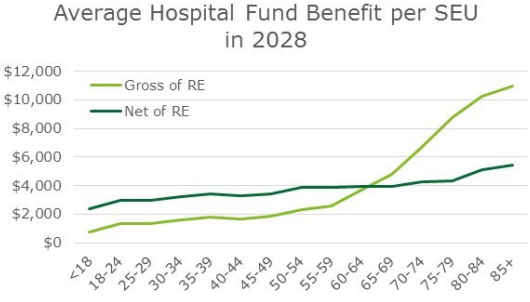
Principle 3 – Reduce by 1% per annum Stable Participation



Premium Impact

	2018		2028	
	Illustrative Premium $ per SEU	% of Prem for RE	Illustrative Premium $ per SEU	% of Prem for RE
Cheapest	1308	63%	1962	56%
Comprehensive	2564	32%	4727	23%
Overall	2150	39%	3693	30%

Principle 3 – Reduce by 1% per annum Falling Participation



Premium Impact

	2018		2028	
	Illustrative Premium $ per SEU	% of Prem for RE	Illustrative Premium $ per SEU	% of Prem for RE
Cheapest	1324	64%	2177	57%
Comprehensive	2581	33%	5219	24%
Overall	2167	39%	4088	30%

Source: Deloitte, 2017, *Risk Equalisation Update*