HEALTH

MARKING GUIDE

While this is a specific question about private health insurance in Australia, an in-depth, comprehensive knowledge of the Australian private health insurance market is not expected in the assessment of this question. Links to a number of resources providing relevant background material on the operation of private health insurance in Australia have been provided to assist those unfamiliar with this market.

PART A – PRIVATE HEALTH INSURANCE PRODUCT CATEGORIES

The answer should be in the form of a report to the Private Health Ministerial Advisory Committee with the following components:

- Identification of two different product categorisation approaches
- How these different approaches could be used in the private health insurance market
- Analysis and modelling of the impact of each approach, including pros and cons for various stakeholders
- Justification for the recommended approach

The report should be set out in a logical structure with clear recommendations.

Considerations that could be identified by students may include:

- Objective of product categorisation – to make it easier to understand and compare products,
- There has been a long term trend away from comprehensive cover and towards products with restrictions or exclusions (may reference APRA data),
- Product categorisation already exists for grouping of health insurance policies on the www.privatehealth.gov.au website.

Detailed numerical analysis is not expected given the time available to complete this assignment; however, students should identify the actuarial analysis to be carried out.

Identification of product categorisation approaches

Discussion of developing a classification system for each of the major product areas: Hospital products and Ancillary (General treatment or Extras) products.

Hospital products vary by what is excluded or restricted and level of member moiety at time of claim (excess, co-payment and front end deductible).

Ancillary products vary by services covered and benefits paid (either as an absolute amount or in relation to fees charged). Students may refer to APRA data which shows the industry benefits paid for each modality, identifying that 84% of benefits are paid for the four modalities of dental, optical, physiotherapy, and chiropractic. This concentration of benefits would likely guide any classification system.

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Other issues that could be considered in the categorisation model are: contracts with health service providers (hospitals, doctors, dentists, optical providers, physiotherapists, chiropractors, etc.), out-of-pocket charges and gaps.

Categorisation decisions required:

- How many categories – 3?
- How will the categories be described? E.g. Gold, Silver, Bronze; Top, Intermediate, Basic

Product Categorisation approach 1:

Build a categorisation model using the typical exclusions/restrictions common in the private health insurance market:

- Childbirth
- Cardio-thoracic (heart)
- Joint replacements (knee, hip)
- Major eye surgery (cataracts)
- Psychiatric
- Rehabilitation

Each medical service is assigned a code and listed in the Government Medical Benefits Schedule (MBS). Health insurers design products by deciding whether they will fully or partly cover hospital episodes associated with each MBS code. There are thousands of individual MBS codes. It is presently up to each individual health insurer to define what specific list of services is part of these restriction/exclusion groups.

A three tier product categorisation model could be constructed, for example, as follows:

- Gold: no services are excluded or restricted
- Silver: only allowable exclusions or restrictions are childbirth, joint replacements, major eye surgery
- Bronze: all other products

Different demographic groups will attach different importance to these depending on their life stage. It will be difficult to define which categories should be mandatory as part of the definition of a bronze, silver or gold category. Students should discuss the criteria for categorising products into categories – no one size fits all solution, different demographic groups / market segments may have different needs - how to decide what minimum level of cover for each tier? Every value laden e.g. cardiac (heart) cover, psychiatric cover.

An outcome of defining product categories may be to achieve consistency of terminology between health insurers to assist with clarity of what is covered and make product comparisons simpler. Students may comment on what data/analysis could be used to assist with deciding upon comment definitions / lists of services to be included in each category.

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Students may discuss whether the introduction of product categories may limit product differentiation in the market and lead to health insurance products becoming homogenised as insurers become reticent to move away from the category product definitions.

Students could also comment on implementation issues associated with introduction of a product categorisation system, including the desirability of transitional arrangements.

There are also other dimensions that could be considered: (1) how to deal with excesses, co-payments, front end deductibles that will be chosen by the purchaser? (Could argue these are consumer choices, not part of the underlying cover; (2) how should restricted cover be considered as it provides partial cover in private hospitals but full cover as a private patient in a public hospital.

Product Categorisation approach 2:

A scoring system where each product is assessed based on its breadth and level of coverage. The aim is to take a more nuanced approach to reflect the different levels of importance to various services covered, and that services can either be fully covered, partially covered or excluded. The aim is for a fairer assessment of a product but it would be difficult to explain categories to consumers as no consistency in what is covered. There would also be value judgements to be made in determining the table of weights to be applied to each product feature.

Other product categorisation approaches are possible. Each product categorisation approach would be assessed against:

- Clarity to consumer (do the categories make it clear what is covered – health is inherently complex and a detailed listing of what is/is not covered will probably still need to be referenced)
- Practical to implement
- Reasonable spread of policies between categories
- Balance between forcing product standardisation and restricting product innovation
- Is regulatory change intended to support the categorisation model chosen

Extra credit may be given where students discuss linkage of categorisation to government policy, including proposing modification of regulations and government subsidies (premium rebate)/penalties (Medicare Levy Surcharge) to achieve certain policy objectives.

Extra credit will also be given for discussion that products have developed within the regulatory framework allowed by the government. Also that hospital product proliferation by use of restrictions and exclusions has led to a stratification of risks across products, watering down community rating.

<u>Use of product categorisation approaches in the private health insurance market</u>

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Product categorisation systems could be used:

- To improve clarity and understanding of what is covered by various health insurance policies
- To simplify product comparison, including via the government website www.privatehealth.gov.au and via aggregators (e.g. Iselect)
- To encourage consistency in product design by private health insurers
- To move towards homogenisation of levels of cover in health insurance products

Analysis of each approach, including pros and cons for stakeholders

Each product categorisation approach should be modelled to determine the potential impact on expected claims and premium rates.

Relevant stakeholders are: Government, consumers, private health insurers, heath service providers (hospitals, doctors, ancillary providers – dentists, optometrists, physiotherapists, chiropractors, etc.)

Impact on premiums: if health insurers are forced (either by regulation, or indirectly by competitive pressure for their products to meet the criteria for categorisation), then products may need to be modified to provide greater levels of cover for some services to meet the definitions. This would give rise to additional expected claims costs which would most likely be reflected in price increases.

Affordability is a central issue for private health insurance consumers and all stakeholders. This is actually why health insurers have developed such a range of products, to respond to increasing affordability issues and provide a number of different product/price options for consumers. Higher prices (especially for the bottom level) risk consumers dropping their cover.

Practical considerations:

Names: Many health insurance policies already include words that indicate a product hierarchy. Examples are: Gold, Silver, Bronze; Top, Comprehensive, Intermediate, Basic. Choosing a categorisation system using words already used by private health insurers may be confusing, especially as it is possible that some products with 'Gold" or "Top" may not meet the definition of the top category in the classification system.

Transition issues: in Australia, private health insurance premiums only increase in April each year. Transitional arrangements should allow insurers time to modify their product coverages and prices.

Application: Expect it would cover all products, not just new products launched after a certain date. Consistent with Minister's statement wanting product coverage to be easy to understand for consumers.

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PART B – PRIVATE HEALTH INSURANCE FOR RURAL AND REMOTE AUSTRALIANS

The answer should be in the form of a short note of around 2-3 pages in length. It should be addressed to the Private Health Ministerial Advisory Committee for consideration at their forthcoming meeting. It should clearly set out the actuarial analysis and modelling that could be carried out to support the committee's consideration of the options it identified in the minutes of the recent workshop to improve the value of private health insurance to Australians living in rural and remote areas.

The options that were identified in the minutes of the workshop, together with possible actuarial analysis and modelling that could be carried out to support consideration of each option, are:

(a) Improve product design:

Introduce a specific product tailored for rural and remote consumers

Examine data for existing rural and remote consumers with private health insurance to identify their risk profile, location of hospital and ancillary services used and profitability.

There will be difficulties (illegalities?) in restricting purchase of a tailored product to rural and remote consumers.

Identify that rural and remote areas have lower/no private hospitals which increases the importance of public hospitals for these customers, but most rural and remote customers generally will travel to capital cities for private hospital treatment for elective services.

Modifying existing products to include more benefits for rural and remote consumers but available to anyone

Increases in travel and accommodation (or any other) benefits for rural and remote customers could be modelled using data from private health insurers.

(b) Directly address affordability

Increase the private health insurance rebate based on location

Possible modelling would include assessment of extra rebate costs for government. A model could be constructed to assess various levels of higher rebate based on place of residence of member. Students should comment on the data that would be required for this modelling.

Reducing out of pocket costs

Modelling of the additional cost for government of increasing in-hospital medical benefits for rural and remote consumers. Data sourced from Medicare and/or private health insurers.

Changes to the risk equalisation scheme

No specific proposal was put forward during the workshop, but could include increasing the level of claims that are eligible for risk equalisation pooling or reduce the risk equalisation levy associated with rural and remote consumers with private health insurance. This would involve simulating alternative risk equalisation pool calculations with these different treatment of rural and remote private health insurance members. However, it is difficult to see how such a change would translate into direct benefits (either in premiums or improved product cover) for rural and remote private health insurance customers.

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(c) Improve access to health care services:

Access to allied health

No specific proposal was put forward, but the extra cost of more services or higher MBS rebates could be modelled using data from Medicare and private health insurers.

Alternative models of care

No specific modelling.

Second tier default benefit arrangements

No specific modelling.

Not expecting students to carry out any of this analysis or put forward opinions or draw conclusions on the merits of each option, but just to identify the possible analysis that could be carried out for each option.

END OF MARKING GUIDE

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