Private Health Insurance
An Appointed Actuary

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Private Health Insurance –

An Appointed Actuary

Overview

PHIAC is considering an appointed actuary for the private health insurance industry. The objective is to ensure that appropriate financial advice is available to support the Board and Management of registered health benefits organisations and to allow PHIAC and the Department of Health & Ageing to carry out their regulatory functions. The need for such a role has been emphasised by the effective financial failure of two health funds over the past year.

PHIAC has circulated a discussion paper within the industry and other interested parties. The objective of the paper was to consider the concept in principle and to encourage discussion about the use of actuaries within private health insurance. Feedback from the discussion paper has been used to develop further PHIAC's thinking on the role for the appointed actuary and in developing this paper.

Some aspects of the appointment of an actuary to a registered private health insurance organisation can be managed under the present National Health Act. Other requirements are likely to require legislative change.

Actuaries in Other Insurance Businesses.

Life Insurance

For over 50 years there has been mandated involvement of actuaries in life insurance. The Appointed Actuary is a statutory role which has specific roles and responsibilities under the Life Insurance Act 1995. The Life Insurance Act 1995:

- Provides a mechanism for appointment of the actuary, which includes notification to the Australian Prudential Regulation Authority (APRA) of the appointment and termination of the appointment.;
- Specifies that the actuary must comply with actuarial standards,
- Details the powers of the actuary,
- Enshrines access of actuaries to a company's Audit Committee, and
- Provides for the actuary of a life company in certain circumstances to report direct to APRA where the actuary believes an officer or director of

the company may have contravened the Life Act or any other law, and that contravention may affect significantly the interest of policy owners.

General Insurance

The statutory role of the actuary in general insurance changed significantly in 2002. All insurers (except for smaller insurers with restricted types of business) now have to appoint an actuary under conditions set by APRA. The approved actuary has a number of specific roles, such as the annual valuation of insurance liabilities, the report on which is provided to the Board of Directors. The approved actuary is required to inform APRA of any problems of an actuarial nature within the organization that may disadvantage policy owners.

The appointed actuary in life insurance or the approved actuary in general insurance can either be employed by the company or be a "non-employed consulting actuary".

Actuarial Involvement in Private Health Insurance

The use of actuaries is a relatively new development in private health insurance. The reality is that the industry is highly regulated and, until the establishment of PHIAC in 1989, the then Department of Health was responsible for regulating and auditing the registered private health insurance organisations. This resulted in a fairly stable mix of products and relatively little complexity. Some larger private health insurance companies used actuaries but it was limited and rare.

It is PHIAC's view that actuaries can add value in assisting the private health insurance industry to manage in the complex financial and regulatory environment which is the private health insurance system.

Value to the Board

The appointed actuary is able to provide an independent view of the business to the Board and where appropriate highlight areas of concern or strain in the business which, if not addressed, could have adverse consequences.

Value to the Fund

The appointed actuary can provide management with independent analysis of the fund data and ensure that the management is aware of and can react to adverse business circumstances in sufficient time to prevent a breach of the prudential standards and particularly a breach of the solvency standards.

Value to the Regulator

The appointed actuary can provide PHIAC with an independent view of the fund and therefore confidence that the reporting to PHIAC is correct and the fund is in an appropriate prudential position.

Regulation of the Private Health Insurance Industry

Just to add to the fun of running a health fund, the industry is highly regulated. Regulation is shared between the Department of Health and Ageing, which regulates products and prices, and PHIAC, which undertakes the prudential regulation and financial reporting of the industry.

Registered health benefits organisations may also come under the purview of APRA where they are part of a larger financial services group. They are also subject to the Trade Practices Act, which has caused more than a few funds to review their advertising and information processes to consumers over the last few years.

A Brief History

The market for private health insurance has changed significantly over the last 14 years. The industry was for many years a price taker acting as a conduit for payments from the members to the hospital and ancillary providers.

Legislative changes, commencing with the Lawrence reforms in 1995, started to change funds from price takers to purchasers of services. The reforms allowed health funds to negotiate hospital purchaser provider agreements (HPPA) and medical purchaser provider agreements (MPPA). The objective of the reforms was to encourage more effective negotiation between health funds and providers and change the focus to a purchaser of services. It was hoped this would improve efficiency in the industry and allow the development of different models of both funding and care. For example, funds had traditionally paid a per diem rate for a private hospital bed with charges such as theatre fees as additional costs. HPPAs allowed for the development of case payment models paying for an episode of care.

There were further reforms with the allowance of payments for the medical gap. Gap payments apply to medical services provided to a private patient in a public or private hospital. Medicare pays 75% of the Medicare Benefits Schedule (MBS) fee and health funds are required to pay 25%. The total reimbursements from the fund and Medicare totalled 100% of the MBS fee.

The Lawrence reforms allowed for payments in excess of the MBS where health funds and doctors negotiated a medical purchaser provider agreement (MPPA). This meant health funds and doctors coming to an agreement. This was anathema to the AMA and doctors vigorously opposed this reform which would have removed patient gaps. Their concern was that this would lead to “US Style managed care”.

MPPAs were relatively unsuccessful and therefore further reform was undertaken in 2000. New legislation was put in place to allow schemes where doctors were

not required to have a contract with a health fund but could reach an agreement on their level of fees. Health funds could then cover the gap in excess of the MBS. This policy has been quite successful and PHIAC statistics indicate that at 31 December 2002 more than 80% of medial services now have no gap. For those services where a gap remains, the average patient out-of-pocket cost is $16.64. However, this is an average and it conceals some quite high gaps.

These gap schemes require informed financial consent. This means that patients should be informed by their medical practitioner prior to a service what the likely out-of-pocket cost is.

Another area of high growth and increasing complexity is prosthetics. Health funds are required to pay the full costs for prosthetics. These are the implanted devices ranging from stents used in heart surgery to cardiac pacemakers to hip and knee replacements, many of which are very expensive. The decision to use these items is taken by the doctor and the health fund must pay the bill.

There is no doubt that the increased technology allows better health outcomes but it comes at a price and if the health fund does not make a good judgement about the likely cost and gets the pricing wrong, then there may be a threat to the financial viability of the fund.

While this history is a bit of a digression, it explains some of the increasingly complex environment in which the health funds are now required to operate. Once they paid a per diem rate for a hospital bed and 100% of the MBS fee. They could estimate with reasonable accuracy the probability of their members' use of services and they knew approximately what they had to pay. Now they are faced with a much more complicated environment. They can negotiate HPPAs which are likely to vary from hospital to hospital. They can also negotiate MPPAs or gap cover schemes which will vary from doctor to doctor. They are faced with a change in usage patterns and additional complicating factors such as the cost of technology for items such as prosthetics with no control over the costs.

A Change in the Industry - Growth

Until 2000, health funds had a declining market. Membership dropped from 45% of the population in 1989 and much higher levels in earlier years prior to the introduction of Medicare. Membership had been cropping at a rate of about 2 percentage points per year and bottomed at 30% of the population with private health insurance.

Registered organisations were trying to compete in a declining market and basically survived by trying to capture market share from each other. The significant growth in the industry in 2000 as a result of the Government's lifetime healthcover (LHC) initiatives resulted in an increase of 50% in the number of persons covered. PHIAC statistics indicate a peak of 44.5 % of the population

with private health insurance. This changed the dynamics in the market as funds competed for a share of the growth. This was the first time that many funds had operated in an expanding market and I think it is fair to say that some of them did not handle it well.

An expanding market requires a reserve against future claims. In health insurance the further claims can arrive fairly quickly. It was anticipated that this LHC membership would be younger and healthier and it proved to be true. LHC lowered the average age of persons covered by two years. What was not anticipated was the significantly increased level of claims once the initial waiting period of 12 months was served. Private health insurance legislation limits waiting periods for pre-existing ailments to a maximum of 12 months. Twelve months after the implementation of LHC there was a significant increase in claims.

The increase in claims was more complex than it appeared. There was an initial surge of claims due to the waiting periods expiring for LHC members. However health funds have informed PHIAC that a significant driver of their increased claims is the pre-LHC members claiming more often. PHIAC is now getting data from the health funds which will, over time, allow us to track the pre-LHC and post-LHC populations to see if their claming patterns are different.

A number of organisations achieved significant growth during LHC by pricing their products below the true cost of benefits plus management expenses. They were running negative net margins. This basic error was compounded by misleading information to consumers by some funds which attracted the attention of the Australian Competition and Consumer Commission. (ACCC). Some funds had also expanded into markets that were very different from the market they were used to. Combined with underpricing, this effectively led to the demise of two funds. Both of these organisations had access to, but did not use, actuaries effectively.

Complexity

There is no doubt that private health insurance is becoming increasingly complex and there are considerable financial pressures on the health sector in general which will inevitably impact on private health insurance. These include but are not limited to:

Pricing

- Prostheses – 41% growth in 2001-02, 28 points of which was price inflation
- Medical indemnity insurance, - collapse of UMP and the need to put medical indemnity insurance onto a proper insurance and financial base
- Remuneration for health professionals – gap cover increases almost double the previous year, wage increases for nurses

- Growth in ancillary service usage – now 30% of health fund benefits (dental benefits are 49.5 % of total ancillary benefits, optical 15%, fitness 3.3% (and gym shoes are a small subset of this))
- Ageing of the population – age is a direct predictor of usage. Members aged 65 and over use private health insurance at a rate 5 times that of the under 65 year olds.
- Contribution rate increases limited to once a year – while good for consumers means the fund cannot easily adjust if their pricing is wrong.

Capital Issues

- Forecasting the capital requirement for new business plans – this is important especially as capital is not readily available to a largely not-for-profit industry
- Advising on alternative forms of capital – prudential standards allow subordinated debt

Business Issues

- Business Planning – complicated by the short from traditional payer to purchaser
- Product Design – this has been a fraught area for some funds which have designed products which effectively cannibalised their own profitable products.

Actuaries can provide advice and support for health funds grappling with changing claims patterns and appropriate provisioning requirements. PHIAC's experience has been that funds using actuarial services tend to spot problems likely to cause a breach of prudential requirements and take corrective action faster than those organisations that do not. As well we have found that where a problem exists, getting independent advice from an actuary using various sections of the National Health Act tends to concentrate a fund's mind on a proper recovery program.

PHIAC has issued guidelines to the private health insurance industry which detail what steps we will take at particular breaches of the prudential requirements. For example, PHIAC can and does appoint an independent consultant under Section 82K of the National Health Act (the Act) to advise us where there is a breach of the capital adequacy standard. PHIAC can appoint an inspector under Section 82R of the Act where there is a substantial breach. The inspector is required to advise PHIAC if there are grounds for appointment of an administrator. Twice in the last two years PHIAC has appointed administrators to health funds. The administrators were able to arrange a merger with another fund in one case and a sale with a view to a merger in the long term in another.

Appointment of an actuary

PHIAC is proposing that each registered organisation would be required to have an appointed actuary to perform specified work.

The appointed actuary would be an appointment rather like the Public Officer. Registered organizations would identify their appointed actuary, inform PHIAC and notify any personnel changes to the role. This could be implemented by specific legislation in the National Health Act (such as found in the Life Insurance and General Insurance legislation) or by a PHIAC rule. This would ensure that PHIAC knew who the appointed actuary of individual organisations was at any given time.

Staff or Consulting Actuary?

There are two ways in which an appointed actuary can work with a registered organization:

- Continuous involvement. A number of organizations either have actuaries on staff or consulting to them, who would have continuous involvement with the Board and management in relation to development of products, pricing, technical provisions, reporting on the solvency and capital adequacy standards, etc.
- Involvement at particular points in time. In this situation, registered organizations could either choose or be required by legislation to seek advice for specific purposes such as pricing, reporting on prudential standards or dealing with breaches of the standards.

PHIAC's view is that either model is appropriate. Small health funds do not need, and could not afford, a full time actuary on staff. Equally, the larger funds may consider that the full time actuary is the most appropriate way for them to manage their business. PHIAC generally sees the appointment as a decision for individual organisations.

The key from PHIAC's perspective is to ensure that whatever model is chosen, that there are sufficient trained and experienced actuaries with the proper Guidance Notes and Professional Standards to provide support to the actuaries. PHIAC has already received considerable support form IAAust in putting in place appropriate guidance not4s and in supporting education programs for actuaries. .

Actuarial Tasks in Private Health Insurance

Rate Applications

Actuaries could be used in a number of ways. The first and foremost use is in providing actuarial certification for the financial projections required to support

rate increase notifications. This is supported by GN 660. This requirement is likely to continue with the Government rebate of 30% for health fund premiums.

Health Fund Actuarial Report (HFAR)

Currently, PHIAC may require registered organisations to obtain a financial report from an actuary when an organisation is perceived as being in a degree of financial difficulty and where there has been a breach of a prudential standard. The report would look at the state of an organisation's finances and its provisions, in particular the outstanding claims provisions and the solvency and capital adequacy requirements.

PHIAC considers it would be of value to the Board and management of a registered organization, as well as to PHIAC, for the HFAR to be an annual report. If this became so, then the requirements would be covered in a Guidance Note of the IAAust, which would be developed in discussion between the industry and IAAust. The HFAR would be based on the set of audited accounts.

A copy of the HFAR would go directly to the Board of the organisation and subsequently to PHIAC. This would become a part of the annual reporting process to PHIAC. However there would need to be a longer time frame allowed for the production of the HFAR. The National Health Act requires the fund's annual accounts to be audited and lodged with PHIAC by September 30 each year. As these accounts are the start point for the HFAR, additional time may be necessary making the due date of this report the end of Novemebr. The HFAR would then be the start point for the pricing round for rate increases which are announced around March to commence in April of each year.

Solvency and Capital Adequacy

The appointed actuary would also be involved in calculations and/or review of the solvency and capital adequacy calculations at the date of the HFAR. There may be other occasions when PHIAC could specifically request such involvement either from the appointed actuary or from an actuary not previously involved with the fund.

Projections and Budgets

Projections and budgets are areas where actuarial involvement is important. PHIAC would anticipate use of the appointed actuary to review the robustness of the projections and the methodology on a regular basis. In essence, the appointed actuary would have a role in stress testing the assumptions and undertaking sensitivity analysis to identify any problems which may emerge over the next 2 or 3 years.

Sign off and certification

PHIAC would need to determine with IAAust the most appropriate format for sign off and certification by the appointed actuary so that it is clear which areas have been subject to actuarial review and comment.

Both Life Insurance and General Insurance legislation require the appointed actuary to report to the Board of the organisation on various matters and PHIAC has a preference for this also to occur in private health insurance. This ensures that the appointed actuary has direct access to the Board. However this provision will require legislation, as would any form of whistleblower requirement. PHIAC is still considering this aspect of the appointed Actuary

Cost

Cost is clearly a factor in this issue. The pricing process for 2002 exempted small registered organisations from the requirement for sign off by an actuary where rate increases were low. The new policy process where rate increases up to CPI receive less scrutiny from the Department of Health and Ageing than those over CPI continues this process. Where larger increases are considered necessary by the fund, actuarial involvement is now effectively mandated. The use of actuaries and therefore the costs of actuarial advice are already in the budget of a number of health funds.

Qualifications or Are There Enough Health Insurance Actuaries?

An issue of some significance for PHIAC is that at the moment there are relatively few actuaries practising in private health insurance and we would both need and encourage more actuaries in this field. The implementation of PHIAC's program for appointed actuaries would need to take into account the training needs for additional actuaries and we certainly see the need to work with the Institute to make sure that the appropriate training is available.

There are currently no specific education or experience requirements for health fund actuaries other than normal professional standards. The IAAust has provided some training since 1998, and two Guidance Notes have been produced for use by actuaries. In the event of mandated involvement of actuaries in private health insurance, then the level of training and experience necessary to fulfil the role of a health fund appointed actuary will need to be determined.

As this is a professional requirement, it would be appropriate for the IAAust to be involved in identification of the specific levels of experience needed and any particular training requirements and programs. PHIAC has been involved in the current training for health insurance actuaries, and is willing to be involved in future training where appropriate.

There may well be a role for some type of mentoring or peer review program. PHIAC will need to take into account the relative level of experience and manage introduction of the appointed actuary requirement in such a way that it did not cause problems because there were insufficient experienced professionals.

Implementation

There would need to be sufficient time to plan for the implementation of such a change. PHIAC is aiming at implementing the appointed actuary for the 2003-04 financial year with the first HFAR reports by the end of November 2004.

Guidance Notes

Guidance Notes are available from the Institute of Actuaries Australia website. The address is :

- http://www.actuaries.asn.au/PublicSite/publications/prof_standards_guidance.htm

Existing Guidance notes are:

GN 650 Actuarial Reports and Advice on Outstanding Claims in Health Insurance

GN 660 Financial Projections for Health Insurers

Summary

Actuaries are able to provide:

- Technical support for contribution rate changes,
- An objective view of the liabilities over the longer term,
- Support and advice in the development of new products,
- Support in risk management strategies and business planning,
- Advice in solvency and capital adequacy management.

PHIAC intends to implement an appointed actuary for private health insurance and is currently developing the implementation plan. We see the use of actuaries as of immense benefit to the industry.

We are aiming to implement the appointed actuary with the first report due by November 2004.

However, the industry needs more of you, so regard this presentation as a commercial.