

Institute of Actuaries of Australia

What Price Health?

Private Health Insurance cost pressures
and product pricing

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1. INTRODUCTION

The price of private health insurance has increased by an average 7.5% per annum over the past four years. This paper studies the increase in private health insurance premiums and the underlying cost pressures over recent years. It also discusses pricing issues associated with a multi-product community rated environment.

2. COST PRESSURES

2.1 Benefit Trends

The following table shows the increases in hospital and ancillary claims paid per single equivalent unit (SEU or adult person) over the past eight calendar years.

Year ended	% increase in Benefits paid per SEU over previous year	
	Hospital	Ancillary
Dec 97	4.9%	3.5%
Dec 98	4.4%	1.6%
Dec 99	0.6%	6.1%
Dec 00	-14.4%	-1.1%
Dec 01	7.6%	13.5%
Dec 02	12.3%	13.8%
Dec 03	9.3%	0.8%
Dec 04	9.0%	1.3%
3 years to Dec 04	10.2% pa	5.1% pa

When interpreting benefit growth trends, it is important to understand the impact that the massive membership growth after the introduction of the 30% rebate and Lifetime Health Cover had on benefits per SEU over the period immediately following June 2000. This reduced the value of data for prior years, and as a consequence, the most relevant data covers only a very short time period. Trends covering this period therefore need to be interpreted with caution.

The increase in total hospital benefits per SEU has averaged 10.2% per annum over the past three years. This analysis is based on all benefits paid under hospital products, including medical and prostheses costs. The increase in total ancillary benefits per SEU has averaged 5.1% per annum over the past three years. Hospital benefits comprise about 72% of total benefits paid.

A significant trend over recent years has been the shift away from overnight hospitalisations toward same day procedures. Same day hospital episodes have stabilised at around 59% of all episodes from 2002, up from 53% in 2000. This trend had contributed to a downward effect on aggregate hospital benefits

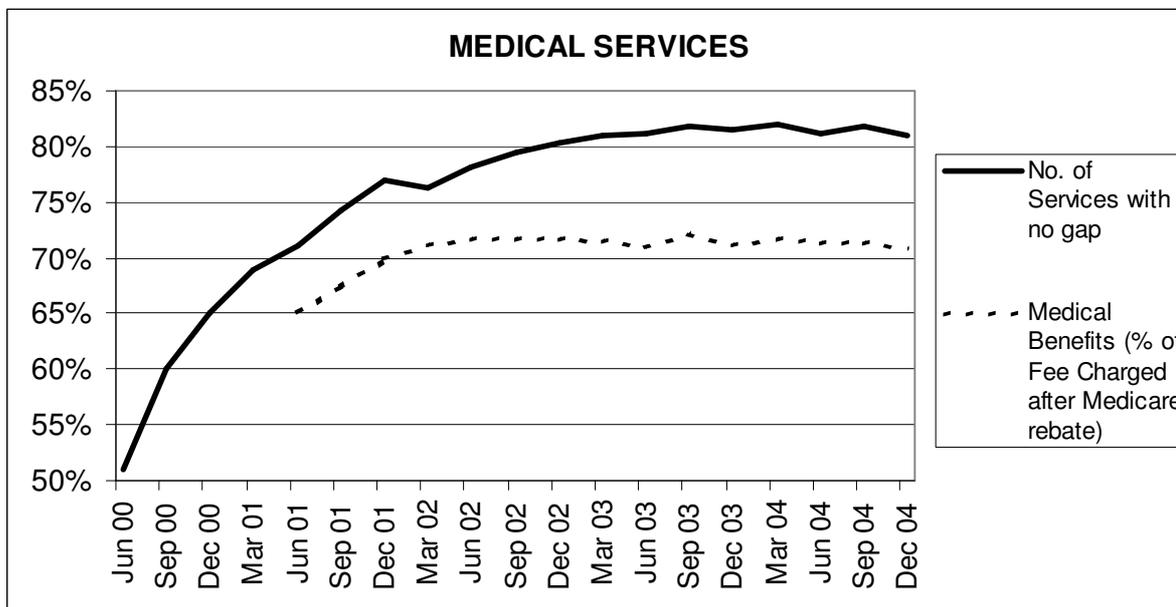
The following table breaks down the growth in hospital benefits into accommodation, medical and prostheses benefits:

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Year ended	% increase in Hospital Benefits paid per SEU over previous year		
	Accommodation	Medical	Prostheses
Dec 97	3.7%	3.7%	27.3%
Dec 98	2.7%	9.2%	22.5%
Dec 99	-1.1%	9.4%	11.0%
Dec 00	-16.0%	1.4%	-14.2%
Dec 01	4.0%	29.7%	16.6%
Dec 02	7.6%	30.4%	28.8%
Dec 03	6.5%	10.7%	28.4%
Dec 04	6.8%	13.0%	18.0%
3 years to Dec 04	7.0% pa	17.7% pa	25.0% pa

This analysis shows that the major growth areas in hospital insurance benefit outlays have been medical and prostheses. Benefits paid per SEU for these categories have increased by 17.7% per annum and 25.0% per annum respectively over the past three years. Growth in accommodation charges would exceed the growth in accommodation benefits due to an increase in member moieties as a result of the significant growth in products with FEDs and other co-payments.

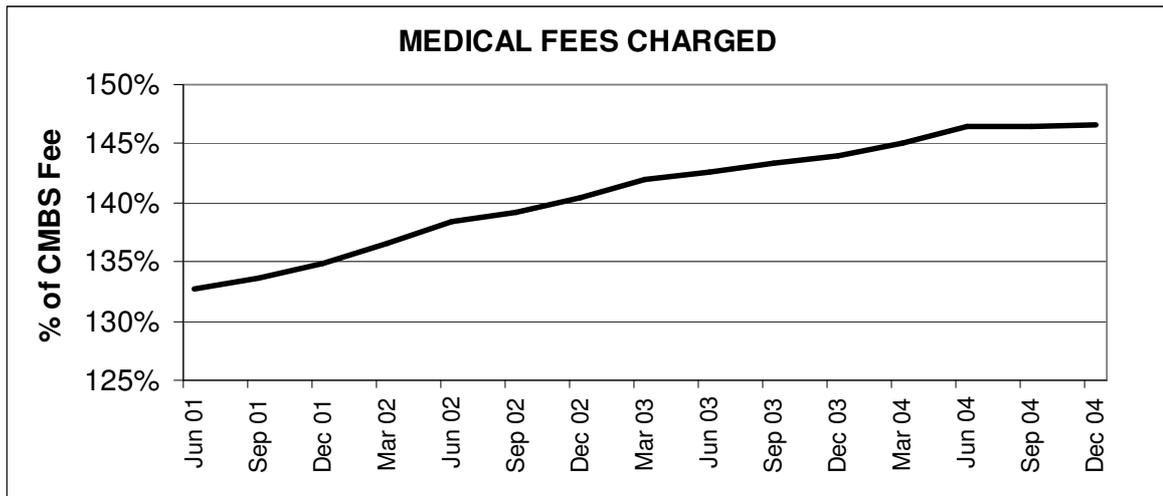
Since July 1995 when health funds were permitted to enter into contracts with medical specialists to pay medical benefits above the Commonwealth Medical Benefit Schedule (MBS) fee for in-hospital services, health funds have been contracting with medical specialists to reduce medical out of pocket costs for members. The proportion of medical services paid by health funds with no member co-payment increased from 50% in June 2000 to 81% at December 2004 as follows:



This reduction in gaps for medical services resulted in very high rates of medical claims growth in the 2001 and 2002 calendar years. These growth rates have reduced in 2003 and 2004 as the level of no gap coverage has reached a plateau.

It is also possible to measure the increase in the level of medical fees charged as a proportion of the CMBS Fee as follows:

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There has been some increase in medical fees as a proportion of the CMBS fee, but this may have more to do with the low level of CMBS fee increase rather than the increase in no-gap arrangements.

Prostheses benefits continue to grow at very high rates. The Productivity Commission is currently conducting a study into the impact of advances in technology on health care expenditure in Australia. A submission to the study by BUPA Australia stated that “There is little control of utilisation of prostheses within the private sector due to a lack of price signals and the requirement for health funds to fully pay for prostheses. Unit prices of prostheses within the private sector are significantly higher than they should be, fuelled by legislative restrictions which prohibit health funds from effectively negotiating prostheses prices”. The submission gives some examples of private sector prices being 50% to 140% higher than those available in the public sector.

The following table breaks down ancillary benefits growth into its major components:

Year ended	% increase in Ancillary Benefits paid per SEU over previous year				
	Dental	Optical	Physiotherapy	Chiropractic	Other
Dec 97	4.2%	5.1%	-0.1%	3.0%	1.0%
Dec 98	1.9%	0.3%	4.7%	2.2%	-0.2%
Dec 99	3.8%	6.3%	10.4%	7.4%	12.2%
Dec 00	-4.7%	5.7%	-0.5%	1.8%	3.2%
Dec 01	13.9%	11.8%	10.8%	12.6%	15.8%
Dec 02	7.3%	10.4%	10.0%	7.7%	42.7%
Dec 03	0.9%	3.4%	1.2%	0.4%	-1.7%
Dec 04	4.1%	3.6%	3.3%	3.9%	-9.5%
3 years to Dec 04	4.1% pa	5.8% pa	4.8% pa	3.9% pa	8.3% pa

This analysis shows that ancillary benefit growth has moderated in recent years after high growth rates immediately following the increase in members from the introduction of Lifetime Health Cover. The Other benefit category increased rapidly from 2001 as many funds introduced loyalty and lifestyle benefits, but this trend reversed recently after lifestyle benefits were removed in December 2003.

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2.2 Demographic Changes

Changes in the demographic mix of insured persons have an important financial impact on benefit growth. The impact of changes in the risk profile over time can be measured by applying weights equal to the average benefit paid per person by risk group to the insured population. Historic rates of drawing rate growth due to changes in the demographic mix of the insured population have been as follows:

Year ended	Hospital Insurance Risk Profile change	Change in Hospital Persons Covered
Dec 98	1.9%	-3.6%
Dec 99	-1.1%	5.2%
Dec 00	-12.0%	46.4%
Dec 01	1.9%	0.2%
Dec 02	1.9%	-0.5%
Dec 03	1.9%	-0.3%
Dec 04	1.9%	0.2%

The introduction of the 30% rebate and Lifetime Health Cover temporarily interrupted the deteriorating risk profile trend of about 2% per annum. This ageing impact would be significantly reduced if there were no change in the private health insurance participation rate across each age group.

The Productivity Commission published a draft report “Implications of the future ageing of Australia’s Population” in November 2004. It commented that “In itself, ageing has been historically a relatively minor driver of rising health costs. Non-demographic factors, particularly increasing utilisation at any given age and the use of new and expensive technologies, have been the main source of rising health expenditure over the last 20 years. Real per capita spending has been increasing for all major components of Government health expenditure. Real average growth rates range from a high of 7.5% for pharmaceuticals to a more modest 2.3% for hospital expenditure. These trends arise because increasing incomes simultaneously provide the capacity for increased government funding of health care, create expectations of better and more expensive treatments and prompt investments in new health technologies. Overall the expansion of treatment is generally considered to have outweighed any unit cost reductions ... to a large extent it reflects the success of modern medicine in improving and prolonging peoples’ lives.... The aggregate expenditure impact of any given increase in costs arising from technology is amplified the greater the aged share of the population.”

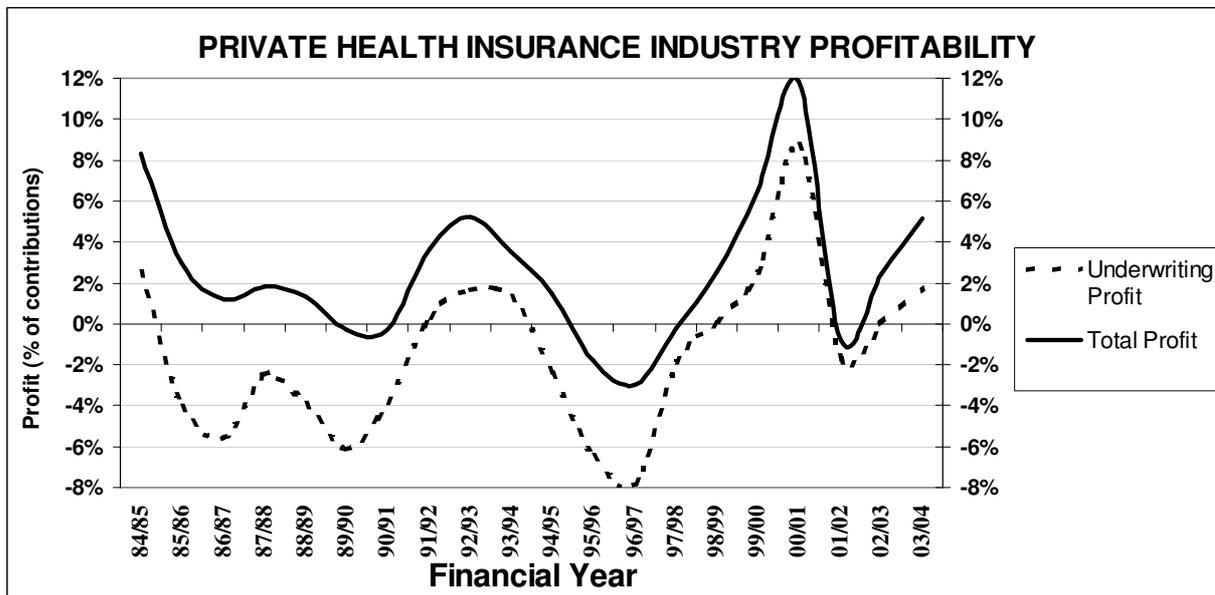
The Private Health Insurance Ombudsman recently published “The State of the Health Funds Report 2004”, which commented that “The cost of providing health insurance benefits continues to rise because more people are becoming entitled to benefits (and more often) and because of cost pressures in virtually all areas of health services. Faced with rising benefit costs, funds have few options for containing prices. Virtually all of the factors leading to increasing costs are outside the funds’ direct control. Given the range of cost pressures faced by funds at present, it seems likely that the level of premium increases experienced over the last two years will continue.”

The most important factor in the increase in health costs over the past few decades has been increased demand for and supply of health services as a result of technological advancements and increased consumer expectations. The impact of an ageing insured population adds to these cost pressures. It is clear from the foregoing that health funds and their members continue to face significant cost pressures.

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2.3 Industry Profitability

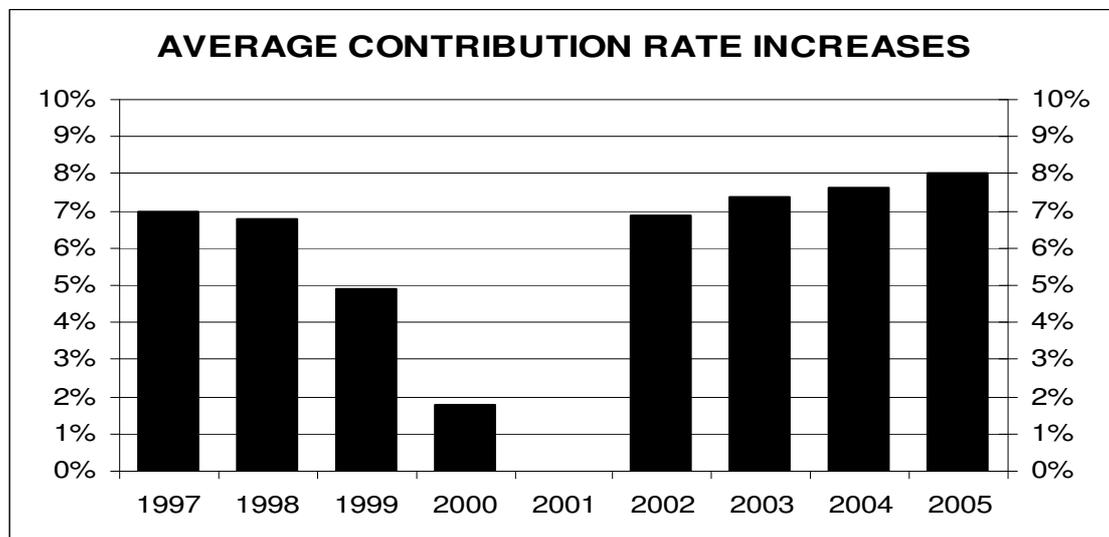
There has been significant variability in the profitability of the private health insurance industry over the past twenty years as shown in the following graph:



While the industry largely operates on a not-for-profit basis, it is important to understand that, even in a stable membership environment, funds need a minimum level of profitability simply to maintain capital adequacy levels. This level may be around 2.5% of contribution income, based on current industry capital adequacy liability reserves and renewal option reserves.

2.4 Historical Contribution Rate Increases

Increases in the price of private health insurance are the subject of significant scrutiny and media attention. Since 1997, funds have generally adjusted contribution rates once per year usually in April, under an agreement with the Federal Government. The Private Health Insurance Administration Council (PHIAC), the industry financial regulator, publishes the average increase across the industry. The following graph shows the industry average contribution rate increase over the past nine years.

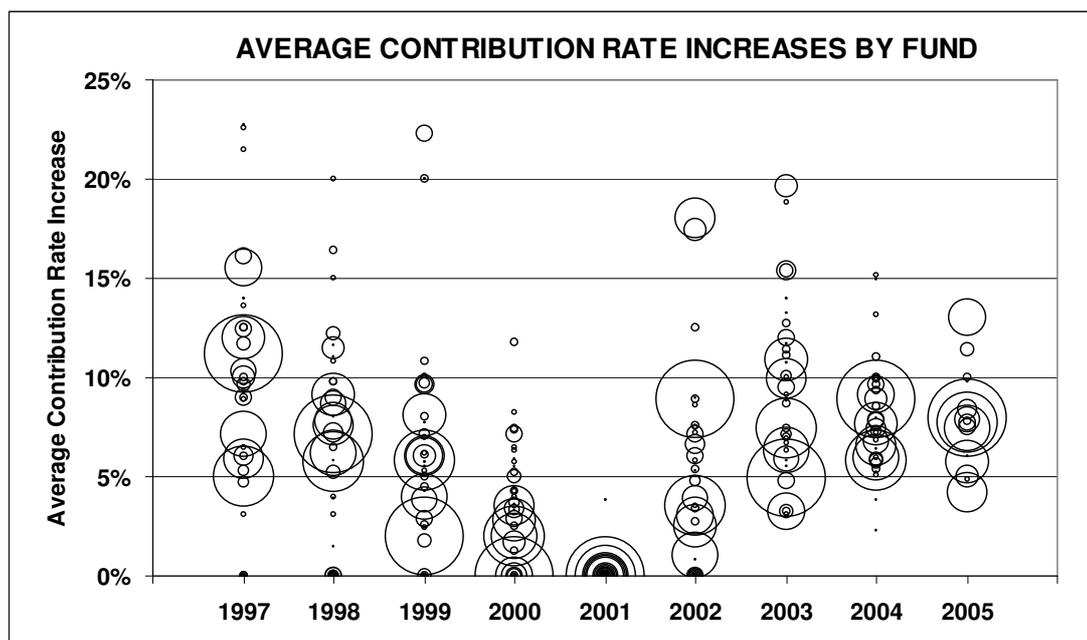


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The low or no rate increases in 2000 and 2001 were associated with the 30% rebate and Lifetime Health Cover that led to a significant increase in membership and improvement in the risk profile.

These average price increases are averaged across both the higher priced hospital and the lower priced ancillary products weighted by the number of contributors. This method, which effectively gives equal weighting to hospital and ancillary price increases, may tend to underestimate the increase in revenue generated due to the higher rates of benefit growth, and therefore contribution rates, of hospital products.

The average contribution rate increases by fund are also published in Parliament each year, and have been graphed below, with the size of the circles representing market share.



It can be seen that there has been wide variation in the average price increase between health funds. Within each fund, there is even more variation in the price increases across products. Based on a survey of fund websites, prices increased for some products by more than 25% within eight funds in 2003 and five funds in 2004. At the extreme, some fund members have experienced price increases in excess of 60%. Presumably these price increases were applied to address undesirable product margin performance. Price adjustments may be necessary if the claims experience of a product is different to that expected. Large price increases have been mainly applied to the least expensive products. However, in some cases, larger than average price increases have also been applied to comprehensive cover products.

High price increases continue to encourage more members to “trade down” to lower priced products to reduce the impact of these price increases. This in turn leads to contributions leakage as some members obtain a cheaper price. This “table drift” and contributions loss is an important factor to taking into account when setting contribution rate increases. Price increases need to compensate for this loss, and therefore lead to price increases being slightly higher than they would be if this table drift did not occur. However, price increases would need to be higher still if more members ceased cover instead of being retained on lower priced products.

The practice of publishing an average increase has led to media focus on individual product increases compared to the average. This may put pressure on funds to limit the maximum rate increase and not address product specific issues that need correction.

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It is possible that the practice of simultaneous annual rate adjustments has reduced competitive pressure, as there is limited scope for responding to competitor pricing. In recent years it appears that average rate increases by fund are generally falling within a narrower range around the industry average.

Contribution Rate increases have generally averaged three times the rate of increase in the Consumer Price Index. While health spending can be viewed as an investment producing outcomes in terms of productivity, health and wellbeing, affordability remains an important issue.

3. PRODUCT DESIGN

3.1 Product Regulation

Product design is heavily influenced by regulation. The industry's experience has been that, in a community rated environment, when prices rise, the first to leave are those who consider themselves to be low risk. Changes to regulations to allow product variation can be seen as the joint response of the regulator and the industry to keep the pool of good risks at all age groups as large as possible.

Prior to 1985, hospital insurance was basically available in only three flavours: top cover, intermediate cover and basic cover. Product differentiation was largely on the basis of the care setting, with basic cover covering costs of treatment in a public hospital, intermediate cover covering costs of treatment in a shared ward of a private hospital, and top cover covering costs of treatment in a private room in a private hospital.

This method of product differentiation is less prevalent today. While basic cover products focussing on public hospital treatment are still available, they are generally not marketed outside of rural areas where they have a niche market. Product differentiation on the basis of excess levels and conditions covered has become more common.

Front End Deductibles (FEDs) were first permitted in September 1985 (HBF circular 47). The circular stated that:

“The actuarial experience of all hospital products should be used to determine contribution rates; the rates for those contributors opting for lesser benefits should reflect the actuarial implications of the deductible. Organisations will not be prevented from ‘loading’ the contribution rate for a deductible table if that seems desirable for actuarial reasons.”

The circular also stated that: “All tables of benefits to be operated should be financially self-supporting with contribution rates based on the community-rating principle.”

However, these statements were not supported by any legislation, and no amendments were made to the risk adjustment (reinsurance) arrangements, which at the time only covered the chronically ill, to ensure the desired behaviour was achieved.

In September 1996 (HBF Circular 461) changes were made to the regulations for front-end deductibles and excesses to allow funds more flexibility in the application of the FED or excess over multiple episodes per year, and waive or halve FEDs or excesses for day procedures performed in day hospital facilities. The maximum FED or excess amount was set at \$1000 for singles and \$2000 for other memberships per year.

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In July 2000 (HBF Circular 636) a maximum FED or excess of \$500 for singles and \$1000 for other memberships per year was set to qualify for exemption from the Medicare Levy Surcharge of 1% of taxable income. There is no provision for this maximum FED level to be indexed.

Reduced cover products in the form of exclusions and benefit limitations were first permitted in June 1995 (HBF circular 410). Funds are required to offer at least one product covering all types of hospital treatment. Every hospital product must provide at least the Ministerial Default benefit for palliative care, rehabilitation and psychiatric care. Default benefits are determined by the Federal Government and generally are sufficient to cover charges for public hospital accommodation.

The circular also directed that “each product is offered at a price reflecting its own true cost and value” and “that no cross-subsidisation between products occurs”.

In September 1996 (HBF Circulars 463 and 468) four categories of membership were introduced: Single, Couple, Single Parent and Family to replace the previous categories of Single and Family. The requirement to charge families twice the rate charged to singles was also removed. Funds were also given the flexibility not to offer all categories of membership for a given product.

Despite this relaxation of the rules, most funds have continued to charge families twice the single price, and there have been only a few instances where funds have offered lower prices for couples and single parents. Some funds have launched new products targetted at singles, couples or families and only offered these products to one category of membership.

Many funds have also launched products that effectively have a fifth category of membership, which covers non-dependent children generally to age 25.

Funds are able to close products to new members or transferring members.

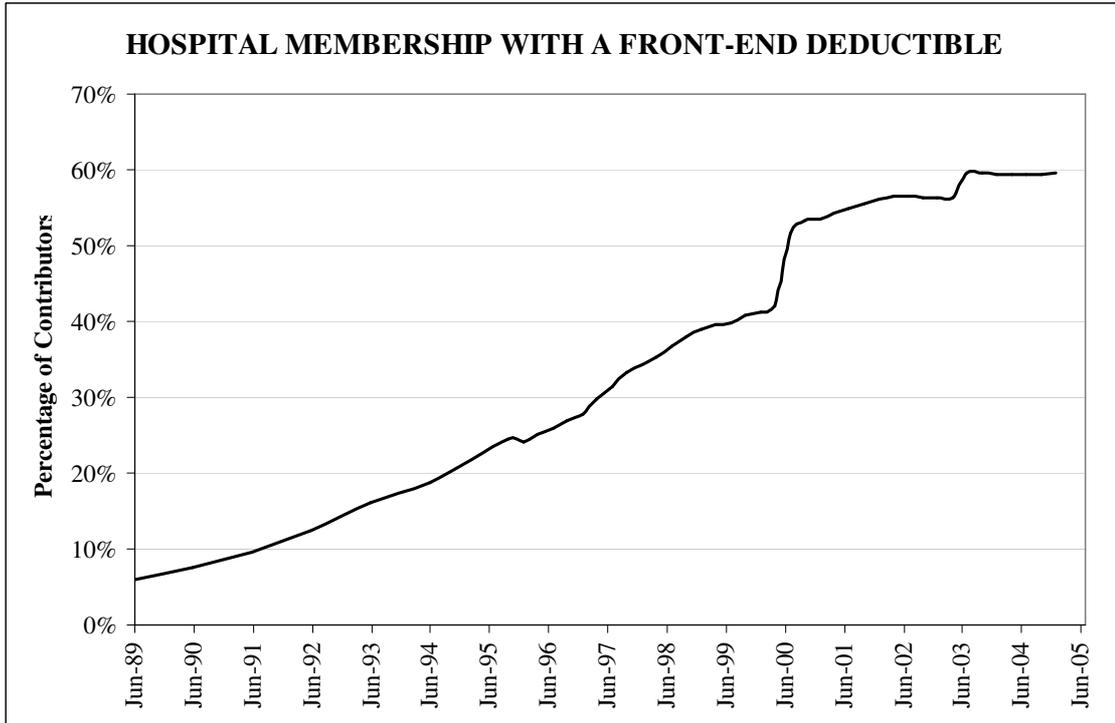
In summary, over the past twenty years, there has been a general trend by regulators and the industry to free up product design while retaining the basic tenets of community rating.

3.2 Product Choice

Health funds now have sufficient product flexibility to tailor products to meet the needs of different groups of members. They can use FEDs, excesses, co-payments, exclusions and benefit limitations to provide lower premium options for those members who are willing to share some risk themselves.

PHIAC statistics provide some information about the changes in product mix of the insured population. The following graph shows the massive growth in the number of members with an FED product increasing from 30% in 1997 to 60% in 2004:

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The product mix at December 2004 can be further analysed as follows:

Product Type	No Exclusions	With Exclusions	Total
Full cover	63%	1%	65%
Restricted cover	33%	3%	35%
Total	96%	4%	100%

Note that many funds offer products that provide cover for all conditions in public hospitals, but have exclusions or limited benefits for some conditions in private hospitals. In the PHIAC statistics these products are not classified as exclusionary. PHIAC statistics report that 4% of contributors have exclusionary products. However only 63% of contributors are reported as having full cover, so products with exclusions or benefit limitations may account for up to 37% of contributors.

The product mix at December 2004 can be analysed by excess/co-payment level as follows:

Excess/Co-Payment Level per annum	% of contributors
Nil	27%
Up to \$500 Single / \$1000 Family	54%
Over \$500 Single / \$1000 Family	19%

This table shows that 73% of contributors have some form of member moiety. This is greater than the 60% of contributors who have a front-end deductible as it includes episodic excesses and co-payments.

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There are a variety of member moiety features common for hospital products:

- Front-end deductibles – members pay a specified amount per year before the fund pays any benefits. The FED can be expressed as a per membership amount or a per person amount – for example a \$200 FED per person with a maximum of \$400 per membership.
- Episodic excesses – members pay a specified amount for each hospital episode before the fund pays any benefits.
- Co-payments – members pay a specified amount for each day in hospital, with the fund paying the balance. These co-payments may have a maximum that applies after a nominated number of days in hospital per episode.

These member moieties are often capped at a maximum of \$500 per single and \$1000 per family per annum to meet the requirements for Medicare Levy Surcharge exemption.

Member moieties may be waived or reduced for day only admissions, accidents requiring hospitalisation or for dependent children requiring hospitalisation.

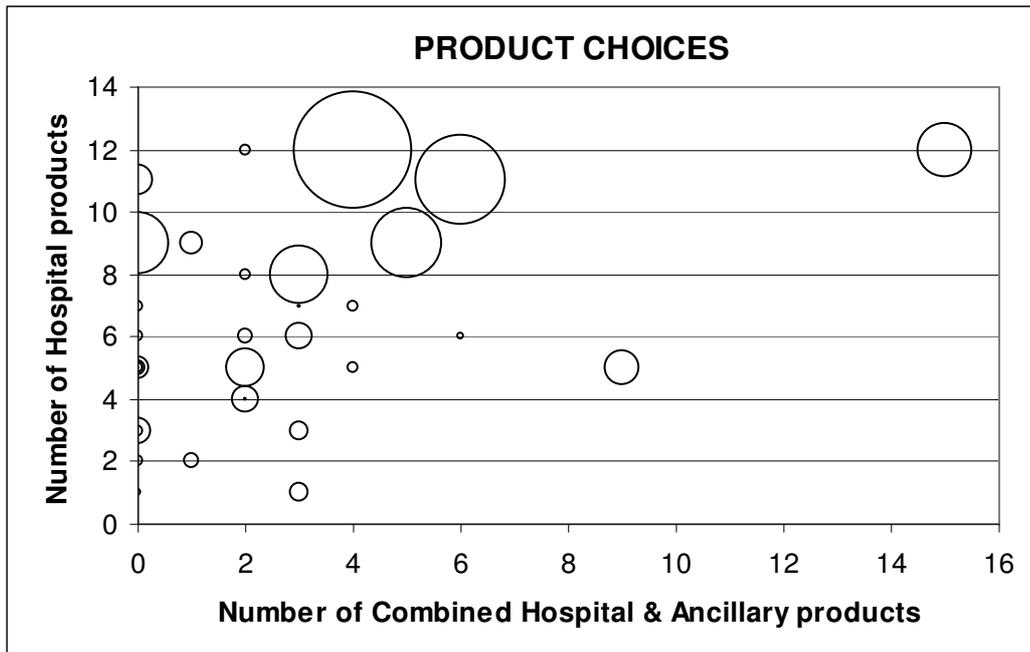
The types of treatments for which funds typically apply exclusions or reduced benefits includes:

- cornea and sclera transplants, eye cataract and artificial lens surgery
- hip and knee joint replacement surgery
- plastic, cosmetic and reconstructive surgery
- dialysis for chronic renal failure
- psychiatric services or conditions
- rehabilitation
- palliative care
- obstetric or pregnancy related services
- assisted reproductive services, infertility investigations, infertility treatments
- cardio-thoracic surgery, invasive cardiac investigations, invasive coronary artery procedures
- bone marrow transplants, stem cell collection, donated blood, collection and storage

Benefits payable for specified services may be sufficient only to cover charges in a public hospital, or there may be no benefits payable at all. These lower levels of benefits may apply for a specified period of time, or may be permanent.

Health insurers use these devices to match the best prices with the best risks. This means that lower cost products can be designed to retain rather than lose the younger and healthier risks. These devices effectively act to filter high risks into higher cover products.

The following graph, showing each fund as a point, illustrates both the number of hospital products and the number of combined hospital and ancillary products currently on offer by each fund, based on information obtained from websites and brochures.



The number of product choices generally increases with the size of the fund. A person requiring hospital cover is presented with between one and twenty-seven options depending on the fund they wish to join. Smaller funds generally have a smaller product range, with a few funds offering only one hospital product.

4. PRODUCT PRICING

4.1 Community Rating

Community rating is a major foundation of private health insurance in Australia. The core tenet of community rating is that persons should not be discriminated against in obtaining or retaining health insurance for hospital coverage. The National Health Act prohibits funds from setting premiums or paying benefits on the basis of health status, age (other than age at entry under Lifetime Health Cover), race, sex, sexuality, use of hospital, medical or ancillary services, or claims history. The Act also expressly permits prices to vary based on state of residence, and allows limits to apply to ancillary benefit payments. Therefore community rating can be defined as pricing irrespective of risk status. It is a deliberate modification of usual premium structures to achieve the intended objective of ensuring affordable access to insurance coverage for high risk individuals, and requires specific regulation to support these objectives.

However product proliferation has led to some relaxation of community rating requirements by allowing risk separation to occur through member self-selection and product marketing.

Community rating requires that the young and healthy subsidise the old and sick. Attracting and retaining the young and healthy is critical to survival of the private health insurance industry. The development of products that appeal to these groups, while giving them some of the benefit of their own better claims experience, may support community rating objectives by encouraging these people to remain in the private health insurance system. Attracting young and healthy members requires funds to offer lower priced products. In a community rated environment where premiums do not vary by usual risk factors, this can only be achieved through product differentiation.

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Community rating is supported by a risk adjustment (reinsurance) system designed to reduce the incentives for risk selection. It is a usage based system that equalises actual claims paid for only two high risk groups: those aged 65 and over, and those members where hospitalisation has exceeded 35 days in the past year.

These risk adjustment arrangements have not been reviewed in the light of the product proliferation that has occurred over the past 15 years, and therefore do not recognise the adverse selection issues that cause age-standardised drawing rates to differ between products.

4.2 Risk Selection in a Multi-Product Market

In most marketing situations the cost of a product does not usually depend on who buys it. However in health insurance the cost of providing the product is crucially dependent on who buys it, in particular on their expected claims experience. For a given product, it is not possible to assume that those who buy that product will have average claims experience, since the risk profile of the product will be affected by risk selection.

The operation of risk selection in voluntary community rated private health insurance is well known. From the insurer's perspective funds are exposed to adverse selection as they cannot set premiums based on the health status of members. Incentives exist for the young and healthy to drop their cover as premiums are high relative to their risk. This reduces risk pooling and increases costs for the remaining members. Premiums rise, and more young and healthy drop their cover, and the adverse selection spiral continues.

Over a number of years, health funds have responded to members concerns about the increasing price of health insurance by developing a range of products that allow members to share part of their risk with the fund through moieties and benefit restrictions. While funds cannot directly risk rate premiums, indirect risk rating can be achieved by providing lower risk members with the opportunity to self-select into less comprehensive products that can be provided at lower prices compared to comprehensive products that attract poorer risks. The premium differences across the product range reflect both differences in benefits covered and the difference in member risk. Therefore prices vary indirectly between high risk and low risk groups. Thus the ability to modify product design has provided funds with the incentive to use product differentiation to select risk.

While the operation of risk selection at an industry and fund level is well understood, it operates with equal if not greater impact at a product level. Those who perceive that their product does not offer value for money can migrate to another product more appropriate to their circumstances generally at a lower price. Higher risk members remain on their current products due to the attraction of benefit levels, however the price of these products will rise due to the worsening risk profile. An increase in the number of product choices available leads to greater risk segmentation, as funds are able to design products that are tailored to specific risk groups.

Risk selection effects are particularly important at the time of the introduction of new products or when prices are adjusted. A new product cannot be considered in isolation, but its position in the product range and the potential for migration from other products must also be considered. Funds can experience adverse financial impacts if they do not give adequate consideration to the potential for product cannibalisation.

It is important to attempt to understand these product interactions and member behaviour, and incorporate them into forecasting models. This highlights that health insurance forecasting can be as much an art as a science.

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Risk selection is a rational response and natural consequence of consumer choice in a voluntary automatic acceptance community rated multi-product insurance environment. It is a quite natural outcome that health insurance members have selected products appropriate to their own risk assessment. Adverse selection has been described as the annoying tendency people have of doing what is best for themselves! This is borne out by different benefit utilisation experience across the product range, even when allowing for different age and sex profiles between product groups. Products with more comprehensive benefits attract members who ultimately have higher utilisation rates. Benefit utilisation, after adjusting for age and sex profiles, for high cover products can be more than twice those for low cover products. These utilisation differences reflect unobserved heterogeneity between members with similar demographic profiles. With other usual rating factors not present, product selection therefore acts as a rating factor.

A study of the experience of the Netherlands voluntary private health insurance market from 1990-94 (Van Vliet) found that the demand for hospital care appeared not to be affected by the presence of FEDs. The role of FEDs in health insurance product design can thus be seen as less about avoiding trivial claims or encouraging members to pursue healthy lifestyles or avoid hospitalisations, and more about risk selection. They provides a member self selection mechanism where the high risk member reveals their risk level by choosing a more comprehensive product while low risk members choose reduced cover.

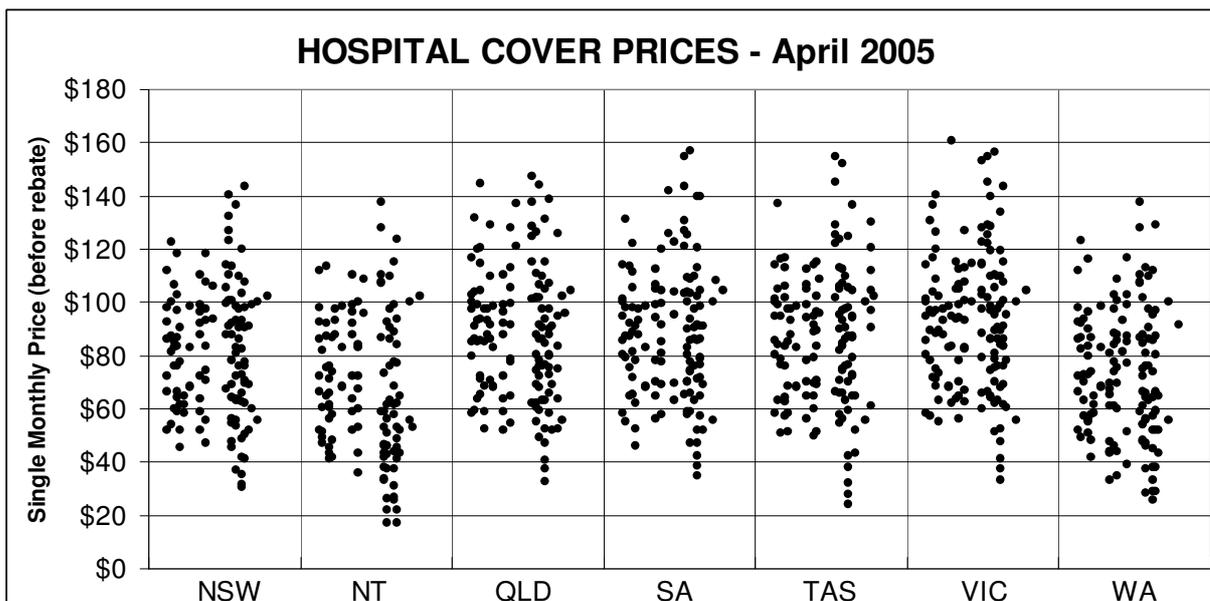
The issue of utilisation differences was highlighted in a recent OECD report “Private Health Insurance in Ireland: A Case Study” which commented that “the development of appropriate and fair risk adjusters is an ongoing technical challenge for governments seeking to equalise risks within social or private health insurance systems. The experiences of other OECD countries show that demographic risk adjusters are inadequate predictors of the variability of individual health expenditure. The Irish scheme is to initially utilise demographic risk adjustment factors (age and gender) as a proxy for their risk profile. It may later include risk adjusters based on utilisation of health care services. While this might reduce incentives for insurers to manage health risk and cost, and may enable insurers to derive benefits from the efficiencies of competitors in this area, it is a better predictor of individual health expenditure.”

With such risk selection occurring across the product range, it is questionable whether a system of risk adjustment can be designed so that health funds cannot find ways to focus on low risk members. Risk adjustment arrangements seek to predict expected utilisation based on observed attributes like age, sex and prior health care utilisation. However there is substantial heterogeneity (risk differences) in health costs even within such groups due to unobservable factors.

4.3 Prices in the Marketplace

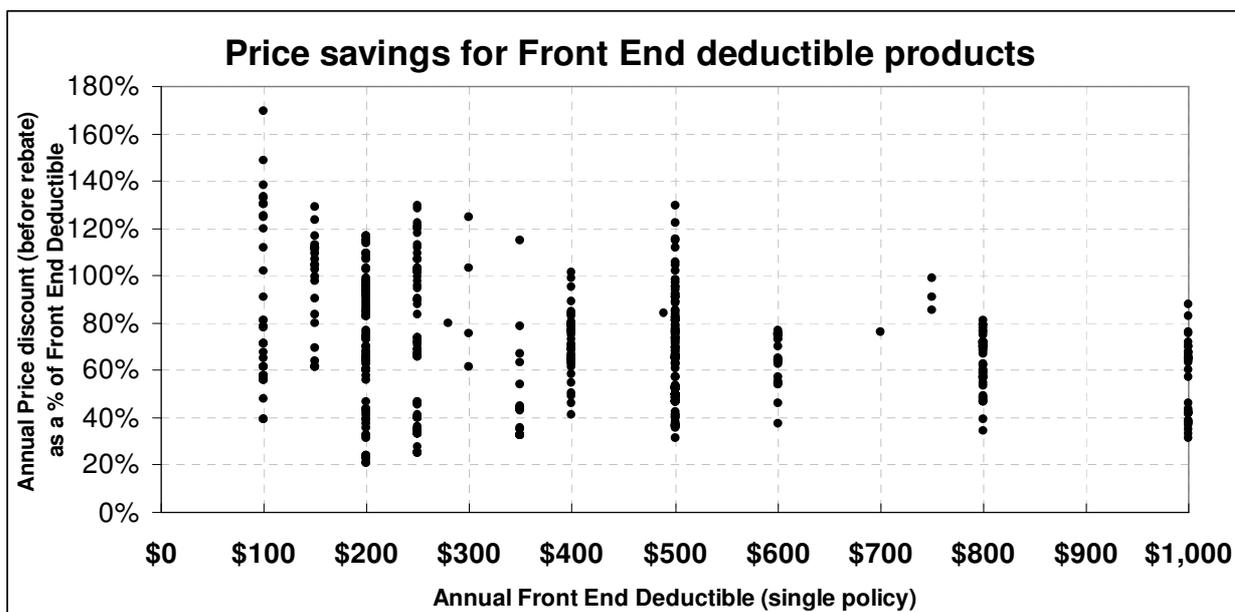
The increase in the number of products available and pricing relativities across the product range is evidence that indirect risk rating is occurring, whether intentional or not. The following graph shows the variation in prices for hospital cover available from 32 funds. While price levels vary by state, it is clear that significant price variations occur due to product design.

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The price of hospital insurance cover varies from around \$20 per month to \$160 per month for a single person before rebate.

The following graph shows the price discounts available for selecting various levels of front-end deductible, based on a survey of the prices of 24 funds.



It is quite obvious from this graph that there is a wide variation in pricing approaches within the industry. The existence of rebates means that not all of the premium saving can be obtained by the member, so the rebate acts to mute the price signals and therefore reduce product cannibalisation / down-sell. However, in many cases the price savings exceed the deductible amount, so it would appear that some funds are relying on the inertia and ignorance of their members to support such pricing structures. These pricing decisions may be the result of the desire to reduce cross-subsidies between products.

It would seem that few funds are choosing to internally cross-subsidise their products by supporting loss-making comprehensive products with more profitable reduced cover products.

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If an aggregate approach to pricing was followed consistent with the guidance of HBF circular 47, involving voluntary cross-subsidisation between products, it could be expected that price reductions would be more like 20% of the FED given aggregate utilisation rates. Therefore the additional discount represents the benefit that members choosing FED products obtain by being treated as a separate risk pool as a result of the risk selection effect of the FED. The risk adjustment arrangements mute this effect but do not eliminate it as it only deals with utilisation variation amongst the elderly.

This risk selection phenomenon is not unique to health insurance. General insurers have responded to adverse selection by exercising their ability to set premiums based on risk factors and by limiting the number of excess options available.

A natural consequence of large price discounts compared to the maximum FED is to provide incentives for good risks to move down to lower levels of cover. This will have an adverse profitability impact on the existing product, and may also have an adverse impact on the new product, depending on the risk profile of those members that transfer. This process of table drift or product down-sell has been occurring for many years as new lower priced products have been developed using FEDs and benefit restrictions.

A pure community rating approach would lead to smaller price differentials between no excess and excess products. However this would require higher price increases on products with excesses, which generally show greater profitability than no excess products.

4.4 Pricing Elements

In simple terms, product pricing needs to take into account expected future costs. The usual expected future cost increases are:

- Utilisation increases (ageing and environmental trends)
- Provider price increases
- Casemix changes
- Increases in Medical fees and coverage
- Increases in the price and utilisation of prostheses
- Ancillary benefit and utilisation increases

However, reinsurance deficit per SEU and the NSW/ACT ambulance levy set a starting price level for hospital cover, before the consideration of claims, expenses and profit margin. The following table sets out these starting prices at April 2005, compared with the cheapest prices available in the market:

State	Minimum Cost = Reinsurance Levy plus Ambulance Levy pa per SEU year ended Dec 2004	Cheapest Product in Market per SEU pa (before rebate) at April 2005	Margin to cover claims, expenses and profit (% of contributions)
NSW	\$347*	\$364	4.7%
NT	\$93	\$205	54.6%
QLD	\$372	\$392	5.1%
SA	\$358	\$417	14.1%
TAS	\$371	\$287	(29.3%)
VIC	\$365	\$397	8.1%
WA	\$276	\$310	11.0%

* includes \$53pa to cover the Ambulance Levy

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These figures do not include any allowance for an increase in the reinsurance levy during 2005, which has historically been around 10% per annum. Clearly there is some business being sold on unprofitable terms, even if no members on these products make any hospital claims. These products should be identified as loss making in any product profitability analysis.

4.5 The Pricing Dilemma: Product Design or Claims Experience?

The above analysis highlights the difficulties that many funds currently experience in balancing the integrity of their price structure across the product range with variations in margin performance. Some level of cross subsidisation between products is inevitable if sensible market pricing is to be achieved. However it is clear that price differentials across the product range are at very high levels relative to the level of risk sharing chosen by the member. Hence many funds do not seem to place a high importance on relative prices, preferring instead to let prices be dictated by margin performance or competitive objectives.

This is likely to be driven by the fact that funds are particularly sensitive to their competitive position and offerings to the young and healthy market segments. Cross subsidisation will only work while funds choose to cross subsidise their comprehensive products with the increased margin on their deductible and exclusion products or from margins on ancillary objectives.

There are obvious risks involved in such a cross-subsidisation strategy. If a sizeable fund chose to reduce the level of cross-subsidisation across its product range in order to deliver better value for good risk members, it would almost be impossible for other funds to resist following suit. Funds that decided to continue cross-subsidies would be at risk of losing their good risk members on profitable exclusion and deductible products who provide the subsidy for the sicker members on comprehensive products. They would also be at risk of not retaining and attracting their market share of younger and healthier risks, which are the lifeblood of the industry. Similarly, a new entrant could target young and healthier members with similar effect. This illustrates that a cross-subsidisation strategy is ultimately unsustainable.

Product development and proliferation has put the responsibility back on to funds to cross subsidise, an objective previously achieved via greater product regulation and the risk adjustment arrangements. This is doomed to failure without a risk adjustment mechanism that recognizes all risk factors.

5. WHAT PRICE HEALTH?

Cost pressures as a result of technology, consumer demand and ageing are likely to see a continuation of recent trends in price increases for private health insurance. Health costs will rise in response to increases in the standard of living and consumer expectations, funding better treatments to the increasing number of people who demand it.

These levels of price increase will see a continuation of the questioning of the value of private health insurance by the young and the healthy, with funds continuing to respond with reduced cover product offerings.

This highlights the continued importance of risk selection, cross subsidisation decisions and the potential for product cannibalisation to the financial sustainability of the private health insurance industry.

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Within a community rated environment, a variety of products have developed in response to regulatory change. This has led to risk separation across the product spectrum. The divergence of industry approaches to price setting and the absence of regulation has led to a wide range of price points. It would appear impossible to turn back the clock to adopt the pricing approach envisaged by HBF circular 47 that the experience of all products be used to determine the discount provided by a deductible, as significant price adjustments would be required. The pricing of reduced cover products would also be significantly affected by adopting a similar approach.

It will therefore remain for funds to resolve these pricing tensions between margin performance and relative product value.

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