



Medibank
The Future of Private Health
Insurance Premium-Setting:
Seeking Integrative Solutions

Foreword

Background and overview

It is a pleasure to write a foreword to this study. Private Health Insurance (PHI) is an indispensable component of Australia's health system, and the efficiency with which it is provided affects the health, comfort and security of millions of Australians of all ages.

The Deloitte Access Economics study sets out a comprehensive and compelling analysis of the market for PHI. It highlights the contribution of PHI to our health system, but also details the challenges the PHI industry faces. Among those challenges are regulatory arrangements whose goals are laudable but whose impacts may be to undermine the achievement of their very objectives. As the study shows, price regulation is a case in point, where the objective of providing some discipline on pricing may have the unintended consequence of inducing greater increases in premiums than would otherwise occur.

Ensuring the regulation of PHI promotes efficient supply of health services is of critical importance. The question this study raises is how regulation should be structured so as to better advance that objective. It presents a number of options for so doing, with the goal of stimulating informed discussion. Ultimately, it recommends replacing the current price control arrangements with a 'lighter touch' system based on supervision of PHI funds by APRA.

There is, in my view, great merit in having the discussion the study seeks to start. Having reviewed the report, it does seem clear that a more light-handed approach to price regulation would be warranted, given the competitive nature of the industry. At the same time, however, price controls have a continuing role to play, for reasons I set out below; but they must be more in the nature of surveillance and better suited to the realities of a competitive market. They must also sit sensibly within the overall framework of our health policy.

To that end, I believe there is a case for centering the price review arrangements in the newly established Independent Hospital Pricing Authority, IPHA, which has responsibility for setting 'efficient prices' for hospital services. While IPHA is still young, it will develop the expertise needed to assess hospital costs, presumably including by comparing costs in the public and private systems. That will make it well placed to assess the largest single component of PHI costs – which are the costs of hospital cover. Moreover, so vesting responsibility would facilitate a longer term move to greater contestability between the public and private hospital sectors. Obviously, this would not replace prudential regulation, where APRA is likely to be best placed; but it seems an option worth considering as far as the assessment of the reasonableness of charges is concerned.

In the remainder of this introduction I set out the main elements that lead me to this suggestion.

The PHI context

It is clear from the Deloitte Access Economics report that PHI has specific features that make the design of efficient regulation especially complex.

Some of the complexities are inherent in any system of voluntary health insurance: these include the difficulties posed by adverse selection¹ and moral hazard², which have long been debated in the economic literature. They are compounded by the specific historical development and place of PHI in Australia – as a form of supplementary insurance to Medicare, with the primary purpose of providing private hospital cover – and by the extensive regulation of Australian PHI. That regulation, as well as defining the scope of the cover PHI provides, includes restrictions on premiums through Community Rating and Lifetime Cover, means tested subsidies for PHI take-up (the PHI rebate) along with means tested tax penalties (the Medicare Levy Surcharge) for the failure to take out cover, and price controls over increases in PHI premiums.

Whatever their merits, there is no doubt this complex of measures affects the ability of consumers to act as informed buyers in the PHI market. In those countries where PHI is central to the health system, the primary purchasers of cover are often employers, who are well placed to bear the high information costs being a ‘smart buyer’ in this market involves; in Australia, that burden falls on final consumers. Yet PHI is a multi-dimensional product whose quality and value are often difficult to assess in advance. The fact that PHI largely involves third party payment of services (such as hospital bills) rather than a known income transfer made in response to an adverse event (as do many other forms of insurance), makes the difficulties of evaluation greater.³ All this cannot but weaken the efficacy of consumer choice as a discipline on PHI suppliers.

Other factors compound the resulting problems. Community rating induces wasteful investment by insurers in risk selection through excess product differentiation, with the incidental potential to make product offerings more opaque. At the same time, community rating can discourage ‘head to head’ price competition, as each insurer fears that unilateral price reductions will attract relatively high-risk customers. While this is partly offset by the ex post risk equalization scheme, the net impact is still likely to be a softening of price-oriented rivalry.

To that impact must be added the effects of the rebate and the MLS surcharge. In itself, a rebate that is proportional to the premium usually reduces the price elasticity of demand faced by individual insurers; in a market where there is extensive product differentiation that raises mark-ups. At the same time, the surcharge is also likely to make demand by high-income consumers less elastic, again possibly increasing mark-ups.

¹ At the time when health insurance is purchased, it is difficult (or costly) for a health fund to observe what type of medical “risk” an individual represents before an insurance arrangement is entered into. To an extent, such risks can be categorised according to known factors such as age and sex. However, information about many other factors that can provide an indication of the likely future health status of an individual (for instance, past illnesses) is “private” to the individual. This can give rise to a phenomenon known as “adverse selection”, in which at given premiums, relatively bad risks seek coverage while good risks do not, compromising cost coverage.

² At the time when an insured actually uses the health service for which insurance has been provided, it is difficult (or very costly) for an individual patient or for a “third party”, such as the Government or a health fund, to discover which health services should be provided in a particular circumstance, for instance, whether extensive testing is warranted, which drug should be prescribed, or whether surgical intervention is needed. This gives rise to a phenomenon known as “moral hazard”, in which insured individuals use services that are valued at less than their cost.

³ Health insurance, in other words, is a form of price-payoff insurance rather than of contingent-claim insurance. This is largely because the cost of an incident is not generally capable of being determined in advance of that incident being dealt with, especially for major treatment needs. As a result, the insurance payment is determined as a rebate off the price of the treatment, rather than as an income transfer in the event of the adverse event occurring. To some extent, stipulated benefits insurance (such as specifying the amount that will be paid for a procedure) is intermediate between conventional price-payoff insurance and contingent-claim insurance, and shifts the risk associated with the difference between the stipulated benefit and the cost of treatment from the insurer to other parties.

Finally, there is the complex interaction between the market for PHI and the other markets in which health-related services are supplied. Those markets are themselves subject to significant distortions, be it from the lack of price signals on the demand side and/or from market power and muted incentives for efficiency on the supply side. PHI is a partial substitute for some of those services (for instance, public hospitals) while competing with them for less than competitively supplied inputs (for instance, of the services of medical specialists). While the resulting interactions are complex, there is a risk of distortions in one market being amplified in others.

Regulation of PHI premiums

The regulation of PHI premiums sits on top of this complex. While its goals of protecting consumers from excessive pricing and the Commonwealth from fiscal risk are understandable, its efficiency is far from obvious. There are two distortions it could readily introduce: it could weaken the solvency of suppliers, undermining the market's stability and long term viability; conversely, where the cap is loose, it could act as a 'focal point' for tacit collusion in price setting and encourage upstream suppliers with market power to exploit their power up to the cap. Given those risks, the policy question is whether there are superior alternatives.

In the long run, there is merit in the competitive social insurance model proposed by the National Health and Hospitals Reform Commission. As applied in the Netherlands, that model ensures affordability through risk equalization and income transfers, while allowing consumers to choose between competing insurers. In such a model, price setting would be disciplined by competition and by the extent of the subsidies provided through the risk- and income-equalisation schemes. However, the transition to such a model is obviously difficult, and even were there a consensus in its favour (which is not currently the case), that transition would be a lengthy process. As a result, there is a need to explore less all-encompassing options that could improve efficiency within the broad confines of current arrangements.

Reforming the price controls is one such option. Given other distortions, simply repealing the controls is unlikely to be desirable, especially if current prices are well below the unilateral profit maximising level. However, that hardly means the current, heavy handed and poorly structured, approach should be perpetuated. Rather, consideration should be given to alternatives that are more closely attuned to the sector's characteristics and that are consistent with the broader thrust of health system reform.

Options for reform

As the report explains, there are several approaches that could be taken in reforming the current price control arrangements. At its simplest, the broad institutional structure of those arrangements could be retained but the mechanics modified to resemble price surveillance – for instance, by deeming increases to be approved unless they exceeded specified thresholds. More complex options would involve changes to the entity administering the controls, as well as the nature of the controls themselves.

One factor in considering these options is the government's decision to limit indexation of the rebate to CPI. Whatever the strengths or weaknesses of that decision, it materially reduces the Commonwealth's fiscal risk and puts greater discipline on price setting in the PHI market itself.

That should facilitate loosening the current price controls on PHI and hence suggests an overall move in the direction of liberalizing the controls themselves.

A further relevant factor is the general desirability of vesting responsibility for price regulation in independent regulators, reducing the risks of political considerations undermining the price control process. PHI is unusual in that the relevant price control decisions are ultimately taken by a Minister, in contrast to the broad approach adopted in Australia since the Hilmer report.

It is worth noting, in this context, the potential that arises from the establishment of the Independent Hospital Pricing Authority (IPHA) to determine 'efficient prices' for public hospital services. It seems reasonable to suggest that those prices should provide a basis for comparisons to services supplied in private hospitals, recognizing the need to take account of relevant differences in the range and quality of services involved. IPHA should have the expertise needed to make such comparisons, all the more as they can usefully inform its assessment of public hospital costs.

As a result, it would be desirable to transfer responsibility for administering a lighter touch regime of price control over PHI to IPHA. As well as making full use of IPHA's expertise, such an allocation of responsibilities could facilitate a move to greater contestability of services between public and private hospitals. Obviously, a role for IPHA would need to be accompanied by prudential regulation of PHI through APRA, and clearly, the two would have to coordinate. That coordination could be underpinned by a requirement on IPHA to ensure its decision were consistent with the financial viability of efficient providers of the service and did not pose unwarranted risks to consumers.

Conclusions

Australia has an efficient, diverse and innovative private health insurance industry. The challenge going forward is to place its regulation on a basis that preserves and strengthens the crucial role it plays for health consumers, for the health sector and for our economy and society more widely. As the Deloitte Access Economics report shows, the current price regulations are likely to have unintended and perverse consequences. It is therefore time to reconsider those regulations and I welcome the contribution this report makes to that discussion.

Professor Allan Fels AO
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Acknowledgements

Deloitte Access Economics would like to thank the following stakeholders for their participation in the stakeholder consultations:

Stakeholder	Organisation	Title
Shaun Gath	Private Health Insurance Administration Council	CEO
Neil Smith	Private Health Insurance Administration Council	General Manager of Industry Operations and General Counsel
Hoa Nguyen	Private Health Insurance Administration Council	Director, Industry Analysis and Compliance
Marcel Canaly	Private Health Insurance Administration Council	Senior Industry Analyst
Josh Edwards	Private Health Insurance Administration Council	Special Advisor, Prudential Standards and Transactions
David Tune	Commonwealth Department of Finance and Deregulation	Secretary, Department of Finance and Deregulation
Susan Page	Commonwealth Department of Finance and Deregulation	Deputy Secretary, Deregulation Group
David Learmonth	Commonwealth Department of Health and Ageing	Deputy Secretary
Richard Bartlett	Commonwealth Department of Health and Ageing	First Assistant Secretary, Medical Benefits Division
Doug Fawns	Commonwealth Department of Health and Ageing	Assistant Secretary, Medical Benefits Division
Nathan Hyson	Commonwealth Department of Health and Ageing	Acting Director, Legal Policy and Consumer Strategies, PHI Branch
Alastair Wilson	Commonwealth Department of Health and Ageing	Director, Pathology Agreements and Schedule Maintenance
Dr John Laker	Australian Prudential Regulation Authority	Chairman
David Haigh	Commonwealth Treasury	Principal Advisor, Health
Emily Hurley	Commonwealth Treasury	Senior Advisor, Health
Amanda Katter	Commonwealth Treasury	Social Policy Division
Johnny Cochrane	Commonwealth Treasury	Analyst
Greg Medcraft	Australian Securities and Investments Commission	Chairman

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Glossary

Term	Definition
Ancillary/extras	Colloquial names for General Treatment cover.
Benefits	The amount consumers can claim from the insurer for a specific service.
Community rating	A requirement that all consumers are entitled to purchase the same product, at the same premium and are guaranteed the right to renew their policy regardless of their health risk profile. Insurers cannot refuse to insure consumers.
Consumer	The private health insurance member.
General Treatment cover	Health insurance to cover non-hospital medical services that are not covered by Medicare. Typically these include ambulance transport, physiotherapy, dental services, natural therapies and optometry.(also known as ancillary or extras)
Gross Margin	The difference between total premium revenue and total cost of benefits (inclusive of state levies) expressed as a percentage of premium revenue.
Hospital cover	A complying health insurance policy that covers hospital treatment costs as a private patient in hospital, including hospital accommodation and medical treatment.
Lifetime Health Cover	For those who defer taking out PHI after the age of 30, annual premiums are increased by 2% for each year of deferral. The increase is payable for ten years.
Management expense ratio	The percentage of a fund's premium income outlaid on management-related expenses.
Medicare Levy Surcharge	Tax surcharge applied to high-income earners without PHI.
Net Margin	Gross margin less management expenses expressed as a percentage of premium revenue.
PHI rebate	A means-tested contribution provided by the Commonwealth to private health insurance members equal to a prescribed percentage of their PHI premium.
Product	Health insurance cover on a specific range of services, with specific levels of excess/co-payment, offered at a set price within one state.
Premium	The fee charged by a PHI fund to its members for private health insurance cover.
Risk equalisation	The system of reinsurance between funds to remove penalties which would otherwise apply to funds with higher representation of higher risk groups.

Term	Definition
Risk equalisation trust fund	A zero sum pool calculated on a quarterly basis where private health insurance funds that have paid “eligible benefits” at a rate per single equivalent unit less than average paid in the Risk Equalisation jurisdiction pay money into the Fund. Those private health insurance funds that have paid “eligible benefits” at a rate per single equivalent unit more than the average paid in the Risk Equalisation jurisdiction receive money from the Fund.
Second Tier Default Benefit rates	The benefits (equal to 85% of average contracted benefits) health insurers must pay to private hospitals with which they do not contract.

Acronyms

Frequently used acronyms

ACCC	Australian Competition and Consumer Commission
AGA	Australian Government Actuary
APRA	Australian Prudential Regulation Authority
ASIC	Australian Securities and Investments Commission
DoHA	Department of Health and Ageing
HHI	Herfindahl-Hirschman Index
MER	Management Expense Ratio
PHIAC	Private Health Insurance Administration Council
PHIO	Private Health Insurance Ombudsman
RMO	Restricted Membership Organisation
SEU	Single Equivalent Unit

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Executive Summary

The purchase of private health insurance (PHI) is one of the most significant purchases a family can make alongside their selection of superannuation fund, life insurance provider and home mortgage supplier. Nearly half of all Australians have some form of PHI cover, and consequently choice and affordability of PHI are major concerns for Australian families.

In addition, the affordability of PHI is also a major concern for government. The rebate on PHI currently accounts for roughly 10 per cent of annual health outlays in the Commonwealth budget. Moreover, high levels of PHI membership underpin the sustainability of the public healthcare system.

PHI smooths the cost of accessing private healthcare, which in turn eases the pressure on public hospital services and waiting times for elective surgery. PHI also enables additional monies to be leveraged into the healthcare system, topping up public funding of healthcare for medical and hospital services by nearly \$8 billion per annum.

Reflecting the large numbers of people covered by PHI and the strong interrelationship among PHI, private providers of healthcare services and the public healthcare system, PHI has become one of Australia's most highly regulated industries. At the same time, both consumers and government have a strong interest in ensuring that the regulatory environment continues to be appropriate, effective and efficient, given ongoing changes in the wider policy context and the structure of the PHI market.

Recent market and policy developments have changed the economics of PHI and regulatory focus

The PHI industry has seen a significant shift in its market structure, moving from a predominantly not-for-profit sector (85% not-for-profit in 2006) to a predominantly for-profit sector (nearly 70% today). The shift was catalysed by the advent of the *Private Health Insurance Act* (2007), which included limitations on how not-for-profit funds allocate assets.

The rapid shift in corporate form over the past five years has increased the risk of regulatory failure. For-profit funds, by definition, serve their shareholders by generating profit. Whereas the regulator once approved premium increases that were the 'minimum necessary' to ensure solvency, regulated premium increases must now consider 'acceptable levels of profit' for the suppliers of capital to for-profit funds. Miscalculations about the level of profit required to meet shareholder demands can destabilise for-profit funds, contrary to the objectives assigned to the PHI regulator.

Moreover, because for-profit funds are generally more cost-efficient than not-for-profits, at least when subject to competitive pressure, the risk of approving premium increases that are *larger than necessary* is heightened.

Protecting the solvency of smaller not-for-profit funds by approving premium increases large enough to cover their (generally) higher costs leaves money in the hands of for-profit

funds and their shareholders (partly funded by the Commonwealth through the PHI rebate) which a competitive market would return to consumers of PHI.

In addition, recent policy changes have increased the need for the Government to ensure its regulatory processes optimise competition and minimise price growth. In November 2012, the Government announced in its Mid-Year Economic and Fiscal Outlook that it would decouple the Medicare rebate from PHI premiums (previously the rebate was determined to be 30 per cent of PHI premiums). Following this rebate reform, from 2014, the Government will index rebates according to CPI, which has historically been significantly less than premium growth, and more importantly, the growth in the underlying costs of care. This will significantly change the economics of PHI and the factors that currently affect premium setting by the industry.

Recognising that the ground has shifted in PHI and that Commonwealth intervention in premium-setting may be partly responsible for higher PHI premiums suggest that a review of regulatory arrangements governing PHI premium-setting is timely.

Medibank Private Limited engaged Deloitte Access Economics to review the appropriateness, effectiveness and efficiency of the regulatory framework governing PHI premium-setting in Australia, and to sketch out a possible pathway to regulatory and policy reform.

As part of the brief, Deloitte Access Economics consulted widely across government, with a view to developing an evaluation framework that reflects public interest considerations rather than focussing exclusively on the interests of the industry.

Key findings

Our report finds that the current regulatory arrangements produce a number of benefits for Australia, particularly with respect to supporting the prudential soundness of funds. The report also finds, however, that more could be done to bring the premium-setting process into line with regulatory best practice, in terms of accountability, transparency, predictability and timeliness.

Reporting requirements and timelines vary year-to-year and definitions for key tests that underpin application rejections or approvals are not available. The entire process generally takes six to eight months out of each year, with multiple iterations in the premium application cycle raising the risk that directors of for-profit funds could be compromised with respect to their market disclosure obligations, and that application data are out-of-date by the time a premium approval is granted.

In addition, the current approach, particularly against the backdrop of an increasingly for-profit industry, does not perform well against community goals for choice and affordability. Funds have an incentive to 'game' the current approach in order to maximise profit by 'pricing up' to an expected regulatory threshold.

This has seen premium increases across funds increasingly concentrate around a narrow premium average, particularly among larger funds. The current 'blind tender' nature of the annual application and approval process also facilitates strategic behaviour by providing funds with 'herd protection'. By synchronising approvals, competitive signals in the market

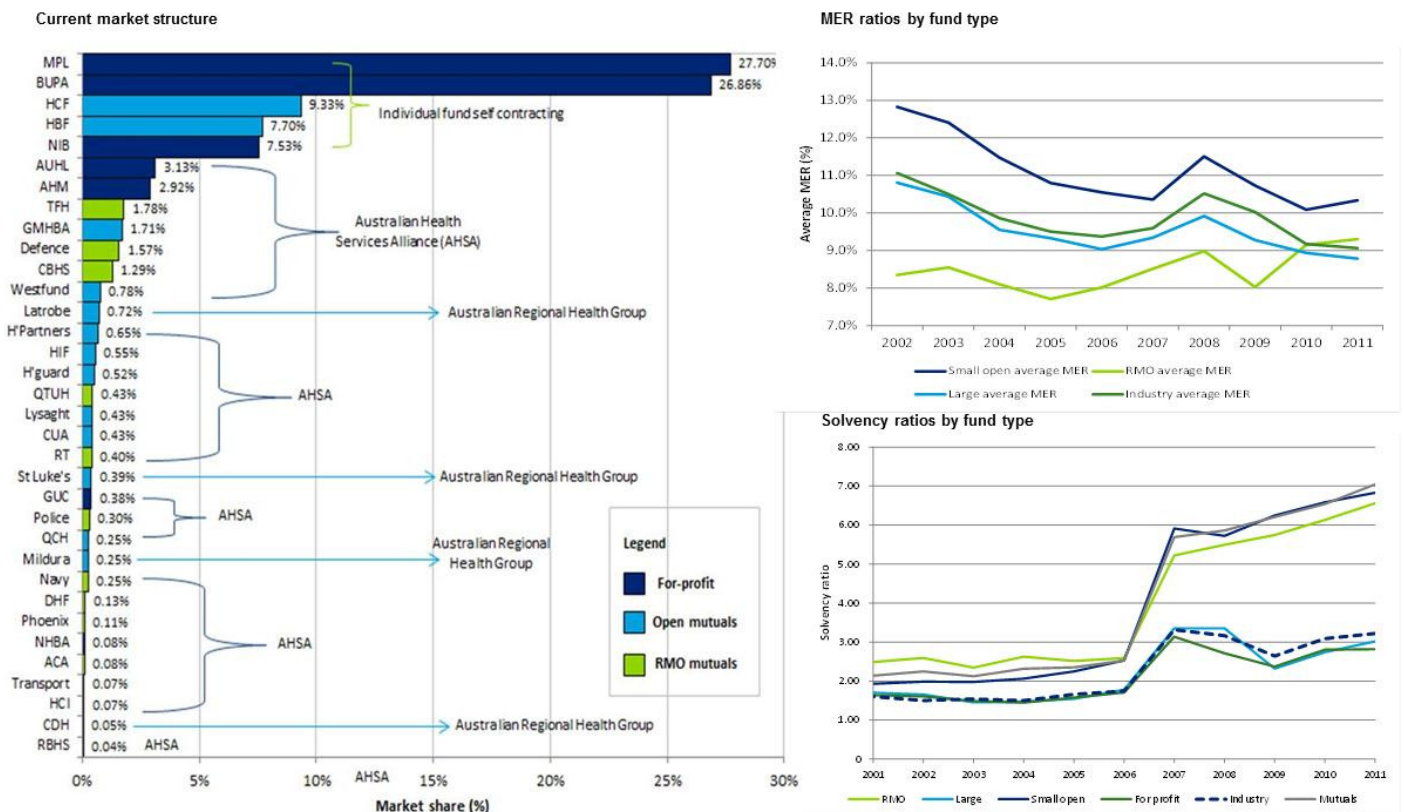
that would otherwise indicate to funds what a reasonable premium might be to secure market share are removed, thereby rendering the safest move to maximise the potential increase and then revise if necessary.

The constraint imposed by the annual application process also means that funds must factor in a risk contingency to allow for unexpected changes in cash flow over the course of the year, which flows through to prices to consumers.

There is also a reduced incentive for funds to minimise management expenses since cost savings simply induce the regulator to grant lower premium increases. With incentives to lower cost switched off or muted, normal commercial imperatives to seek cost savings through merger and acquisition are also derailed and industry structure is entrenched.

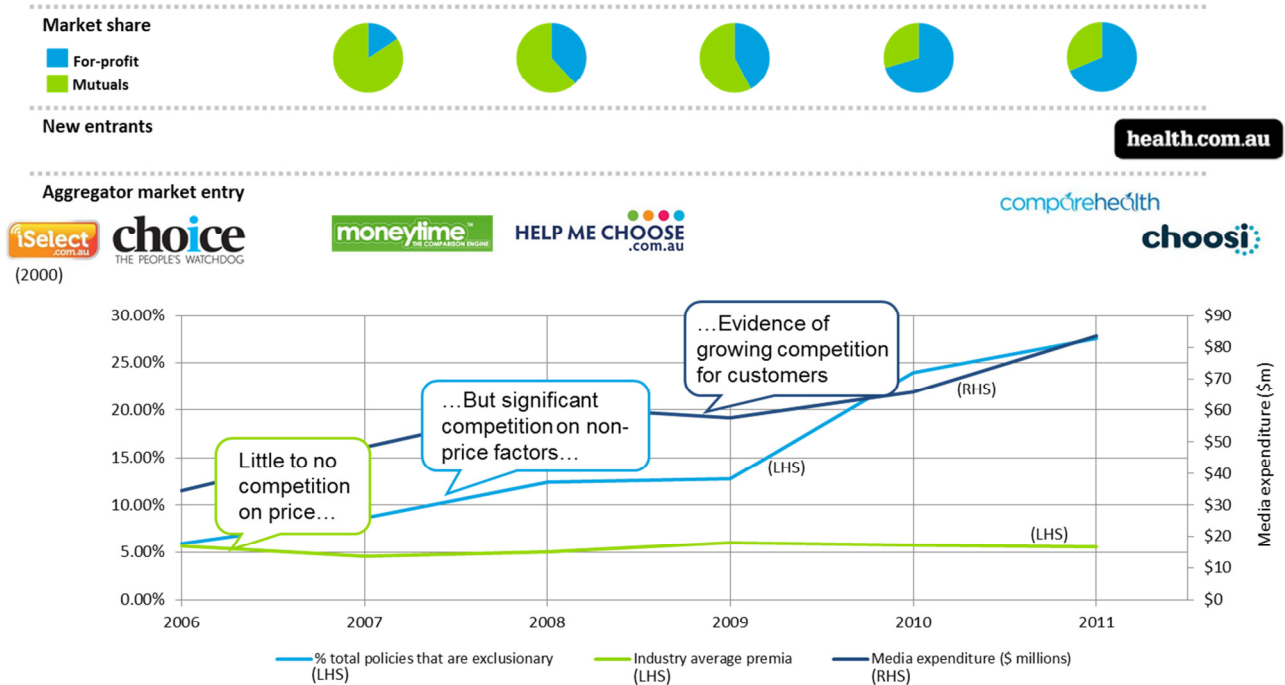
Analysis of average management expense and solvency ratios between 2002 and 2011 (Figure 1) indicates that the 'long tail' of small funds consistently records higher MERs and solvency ratios than the industry average, indicating that the current premium-setting process discourages both technical and dynamic efficiency gains.

Figure 1: Market structure and efficiency by firm size



Denied an incentive to compete on price, funds have responded by competing on their product offerings (Figure 2). Product competition through varying exclusions and cover levels has important anti-competitive implications, including for the cost and value-for-money of PHI to consumers. Stakeholder consultations indicated that consumers are often confused by the plethora of offers in the PHI market and unclear about the effects of exclusionary clauses. This militates against competitive outcomes in PHI.

Figure 2: Where does the industry compete?



While the current premium-setting process may not optimise choice, affordability and sustainability, recent changes in the industry highlight the growing potential for a vigorous competitive environment to emerge. As highlighted in Figure 2, the industry has seen a number of fund aggregators enter the market (the most well-known of which is iSelect) and expenditure on advertising has grown substantially over the past five years.

Given these changing market dynamics, a number of alternatives to current regulatory arrangements are canvassed in this report. All options were required to meet an appropriateness test, namely that the regulatory approach would not risk unravelling the broader policy framework governing PHI.

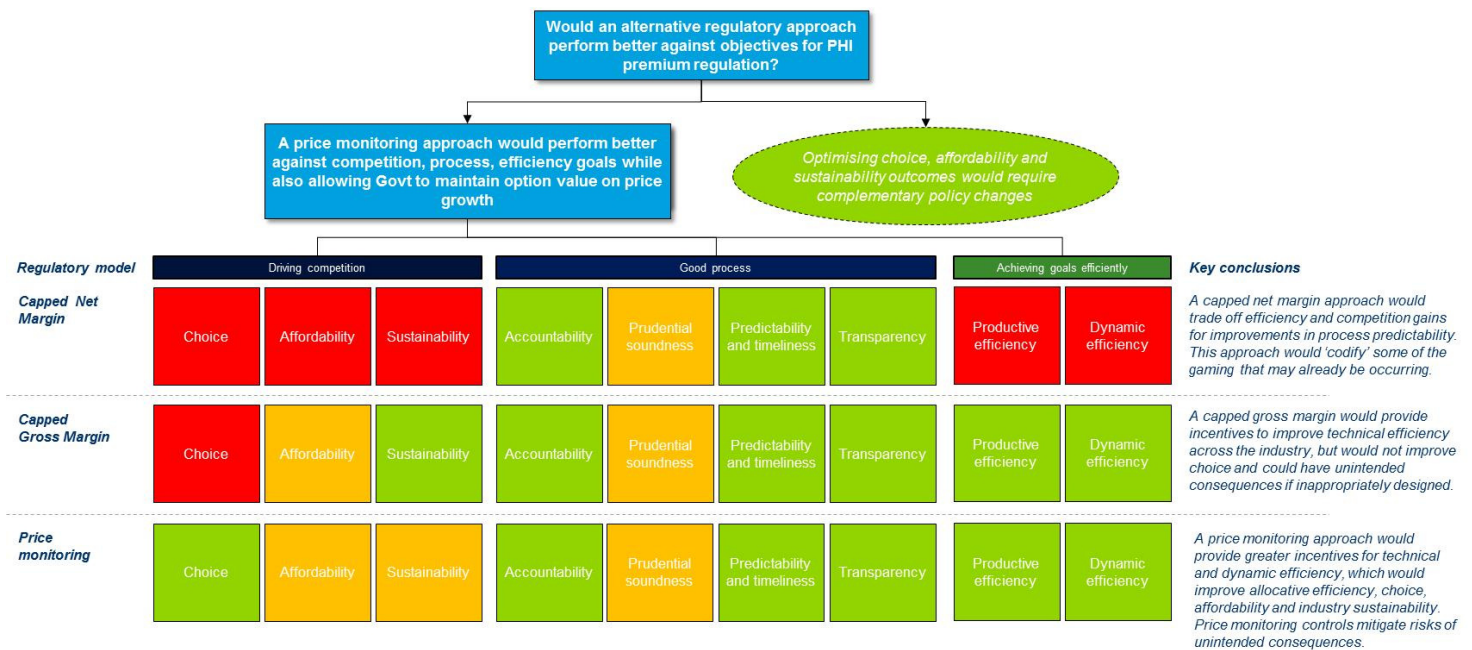
Consequently, full deregulation of PHI, including the removal of regulations designed to secure access and equity to PHI as well as sustainable numbers of members across the community, was not canvassed.

Regulatory options that meet the appropriateness test include:

- **A capped net margin approach**, which is a form of incentive regulation explored by a range of earlier reports into PHI;
- **A capped gross margin approach**, which is a variant form of incentive regulation that has recently been introduced in the United States as part of its recent overhaul of healthcare in the *Affordability Care Act (2010)*; and
- **A price monitoring approach**, which has also been explored by earlier reports, including a 1997 review of PHI by the Industry Commission.

On balance, our analysis indicates that a **price monitoring** approach would optimise community goals for choice, affordability, sustainability and efficiency of PHI relative to the status quo, while also addressing some of the weaknesses inherent in the current Ministerially-directed approach to premium-setting (Figure 3).

Figure 3: Performance of alternative regulatory approaches compared with status quo



Specifically, a price monitoring approach:

- would not in itself be expected to 'undo' the broader policy system in place to ensure high levels of PHI membership, especially in light of the explicit ability to re-exert price control if this outcome were to eventuate; and
- would be expected to drive the industry towards the efficient frontier more cost-effectively than a regulated approach, resulting both in lower premium increases than might otherwise emerge.

The two models of incentive regulation, by contrast, were essentially found to trade off improvements in process predictability and transparency for poorer performance against the goals of choice, affordability and efficiency. Due to the significant influence of regulation design, particularly with respect to industry benchmarks, indexation rates and the impacts of excess profit distribution, both models also raised the risk of unintended consequences.

Mitigating fiscal and political risk

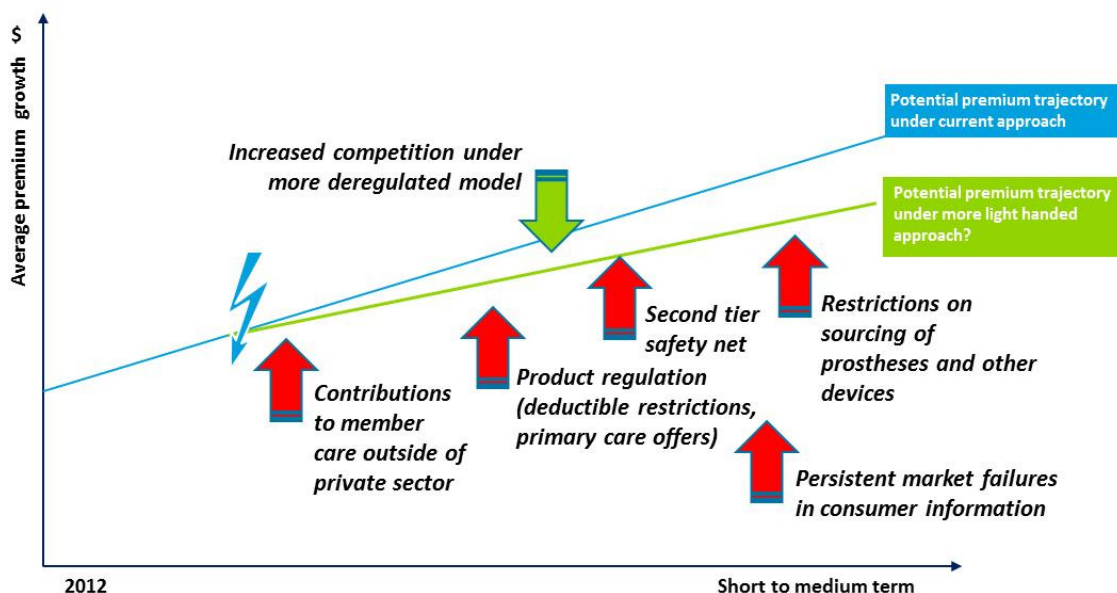
Notwithstanding this conclusion, stakeholders indicated there were fiscal and political considerations which pose significant barriers to change.

Optimising competition and minimising fiscal risk in a price monitoring regulatory arrangement

Even with industry analysis and economic theory pointing to a more deregulated approach producing the most efficient and effective outcome for PHI, there are a number of other policy reforms that the government should consider alongside a reform to premium regulation, in order to maximise competition and minimise prices to consumers. This is particularly critical given the recent changes to the rebate, which under the proposed indexation design (e.g., CPI) will see government support for the industry deteriorate considerably over the medium term. It is now essential that government consider all policy options that could minimise price growth so as to reduce the growth in prices faced by households.

A number of policies place a drag on competition that would be expected to limit the dynamic efficiency gains that could be realised under a price monitoring regime (Figure 4). In particular, 2nd Tier default safety net arrangements, limitations on sourcing of prostheses and product regulations preventing PHI from competing across a wider range of care settings all serve to increase premium growth relative to what might otherwise have been the case. Persistent market failures related to information asymmetries and bounded rationality also potentially limit gains from competition.

Figure 4: Optimising outcomes from competition – potential complementary policy reforms to drive change



It is recommended that government review options to enhance the sector's capacity to compete as part of a transition to a price monitoring regulatory setting, including:

- reforming 2nd Tier default safety net arrangements;
- addressing information asymmetries;
- re-considering services for which public hospitals can claim funding from PHI;

- reviewing regulations that prevent PHI from competing across a wider range of care settings, or determining deductible limits; and
- revising prostheses sourcing rules.

The government should also review the indexation rate proposed in the Mid-Year Economic and Fiscal Outlook, as this poses a significant risk that the adverse selection cycle could re-emerge given the significant difference between CPI and underlying healthcare costs. As a result, the costs of PHI to households could grow significantly, resulting in unintended consequences to PHI membership levels.

Mitigating political risk: considerations for governance

Due to the significant public profile of the Minister's current involvement in premium approvals, stakeholders have indicated that it will be politically difficult for the Minister to withdraw from this involvement under the current governance arrangements.

A solution would be to move the premium regulation functions of PHIAC to an 'independent regulator', such as either the ACCC (e.g., by giving the ACCC a special brief such as it has for monitoring petrol prices), APRA or establishing a new regulatory agency charged with monitoring prices for a specified period of time.

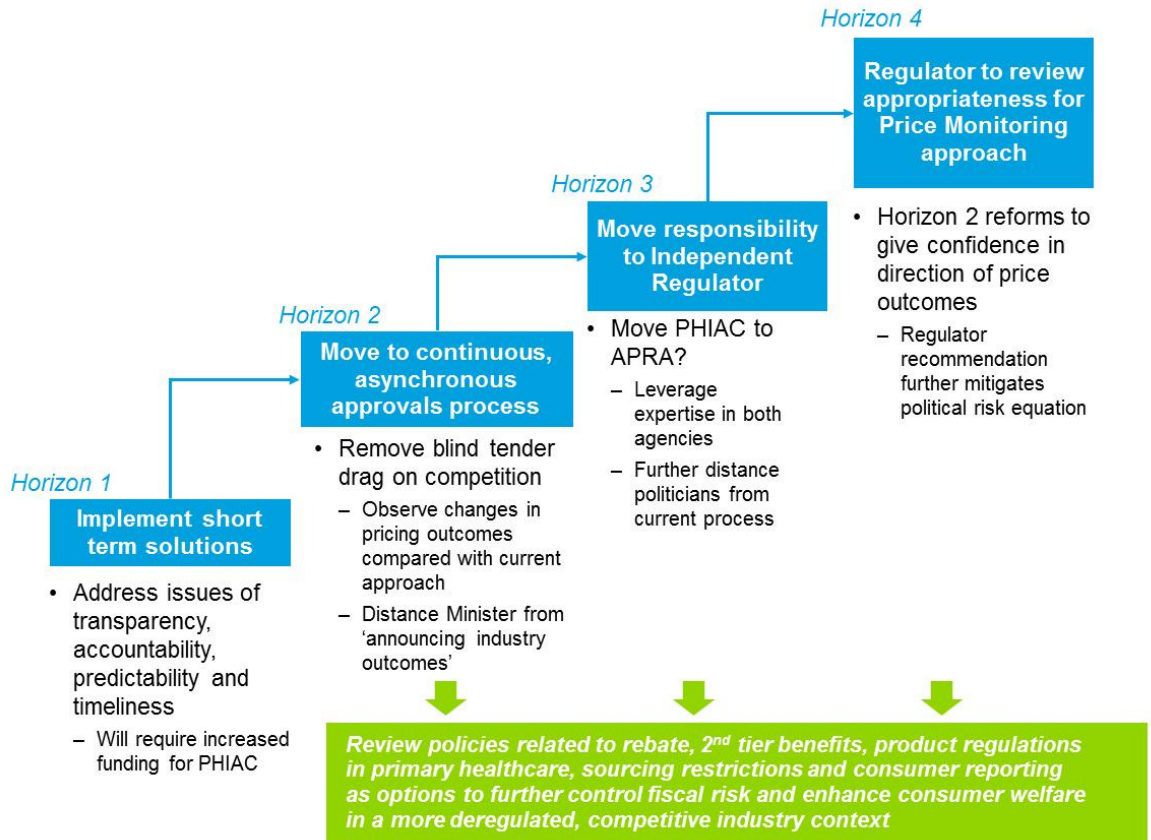
There may also be opportunities for operational synergies from a transfer of prudential oversight to APRA through a merger between APRA and PHIAC. PHIAC would become a sub-unit of APRA that would then report to the Treasury.

Proposed next steps: a staged approach

Reflecting current fiscal and political considerations, as well as stakeholders' uncertainty regarding the sector's potential response to a lighter-handed regulatory approach, it is recommended that government consider a four-stage process to move to a more deregulated industry.

- **Horizon 1: Implement short term process solutions**—A number of process changes could be implemented to address weaknesses of the current approach, including:
 - Adopt a Departmental/PHIAC customer charter
 - Shorten approvals timelines
 - Revise data collection processes
 - Provide additional guidance for decisions.

Figure 5: A staged approach to change



- **Horizon 2: Adopt a continuous, asynchronous approvals process**—A ‘continuous, asynchronous’ approvals process would allow funds to apply for an increase at any time during the year, independent of competitor applications. Moving to such an approach would have the benefit of injecting a degree of competition back into the sector by removing the current ‘blind tender’ nature of the annual approvals process. Funds would be able to observe other funds’ premium changes and consider potential responses to these changes. This would remove some of the ‘herd protection’ currently provided to funds through the annual process.

Moreover, by allowing for changes to premiums to be made more than once per year, this should remove risk contingencies that funds necessarily need to add to provide for potential unexpected events that could impact on cash flows. Finally, this would be a first step towards observing how funds might operate in a less regulated environment, with a view to reducing uncertainty over competition and pricing outcomes in a price monitoring regulatory environment.

- **Horizon 3: Move prudential and premium regulation to an independent regulator**—Increasing the independence of PHIAC (by withdrawing Ministerial involvement) would bring current regulations in line with regulatory best practice, but so long as PHIAC is located within the Department of Health and Ageing portfolio, it will likely be difficult for a Minister to ‘stay out’ of the decision, given the history in the sector.

Merging PHIAC with APRA would produce a number of benefits, first and foremost by putting some political distance between PHIAC and the health Minister, and secondly by potentially unlocking operational synergies between APRA and PHIAC. APRA has extensive experience in overseeing the orderly restructure of financial services, including the banking and credit union industries. PHIAC also brings important knowledge with respect to the operation of the funds. Administration of other health policy implementation under the Act, including community rating and product regulation, would remain the responsibility of DoHA.

- **Horizon 4: Move to price monitoring regulation**—The independent regulator, after observing fund behaviour under the continuous, asynchronous approvals process would also be able to review and make a recommendation for moving to a price monitoring arrangement. This would have the effect of further increasing competition in the sector and driving structural change through the industry.

In addition to the four-step process outlined above, it is recommended that government consider options to enhance competition in PHI and optimise dynamic efficiency gains by reviewing a range of complementary policy reforms for the purpose of minimising premium growth in PHI.

These policies include:

- **Review 2nd Tier default arrangements** which limit PHI's capacity to drive efficiency gains through the private healthcare system and could result in lower premium growth;
- **Review current PHI product regulations** in light of industry restructuring and policy reforms to ensure that the benefits of regulation continue to exceed the costs; in particular, government should consider whether allowing funds to compete in primary care could encourage product designs that reward patients for managing their risk and in turn slow premium growth;
- **Review adequacy of regulatory controls over prostheses** through enhanced pre-market approvals and post-market surveillance reduce unnecessary revision rates for devices that add unnecessary costs and increase PHI premiums;
- **Review the effectiveness of activities aimed at improving consumer information** with a view to better supporting consumers in their selection of funds and their use of the PHIO product information website, which would also serve to limit premium growth.

In addition to these policy reforms, the government may also consider the design of the proposed rebate reforms, to ensure they do not catalyse an adverse selection cycle. While it is valid to reform the rebate to reduce budget *volatility*, particularly as part of a move to a more lighter-handed regulatory approach, the current approach could substantially undermine membership in PHI and the broader policy goals for the sector.

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1 Why review PHI premium regulation – again?

1.1 Recent industry developments have changed the game

Private health insurance is a financing mechanism to help consumers smooth the cost of accessing private healthcare in Australia.

Nearly half of all Australians have some level of private health insurance (PHI) cover, encouraged through a range of policy levers—so-called ‘sticks’ and ‘carrots’. PHI benefits its members by offering them faster access to hospital treatment as well as access to different types of hospital service (e.g., private ward accommodation, choice of medical specialist). PHI also benefits patients in the public hospital system by reducing the pressure of demand on public hospitals and their services.

Given the large numbers of people covered by PHI and the strong interrelationship among PHI, private providers of healthcare services and the public healthcare system, PHI has become one of the most highly regulated industries in Australia. Moreover, the cost of PHI and the regulations that influence this cost and overall value for money are a major focus for the community, industry and governments.

As a consequence, the appropriateness, effectiveness and efficiency of the regulatory arrangements governing PHI, and in particular the mechanisms by which premiums are determined, have been reviewed extensively by a wide range of public and private organisations (Table 1.1).

Table 1.1: Prior reports, findings and evidence

Review authors	Year	Findings regarding current process	Recommended approach	Analysis of industry competition?	Benchmarking of other approaches?
Insight Economics	2011	Current process sub-optimal	Price monitoring	Some consideration – uses PHIAC analysis, ACCC rulings and number of funds as evidence	None
Access Economics	2010	Current process sub-optimal	Price monitoring	None, but suggests that competition is not effective; funds look to regulator rather than competitors	Airports

Review authors	Year	Findings regarding current process	Recommended approach	Analysis of industry competition?	Benchmarking of other approaches?
Port Jackson Partners	2009	Current process sub-optimal	Price Monitoring	Relatively limited – assumes competitive, points to industry fragmentation as evidence	Essential services regulations
Booz Allen Co.	2008	Current process sub-optimal	Modification of current process and consultation on long-term options	Relatively limited – suggests competitive due to similar concentration to general insurance and financial services industries, as well as low barriers to entry	Extensive review of essential services, including telecommunications, gas, water, electricity
Access Economics	2005	Current process sub-optimal	Price monitoring	Relatively limited – assumed lack of competition due to extensive regulation and low profitability	Essential services regulation in Victorian ports and telephony
NERA	2005	Current process sub-optimal	Removal of price regulation	Relatively limited – suggests number of existing providers and low barriers to entry mean the industry is competitive	Considers long-distance telephony, energy, airports and seaports, but suggests none of these are ideal
Industry Commission	1998	Suggests process is sub-optimal	Changes to premia should not be subjected to monitoring or screening	Extensive analysis. Concludes reasonable degree of competition on price and product.	None

Since the Industry Commission review in 1997, there have been another seven reports on the regulation of PHI premium-setting, which equates to a new report roughly every two years. These reports—from a range of parties with a diverse range of operational objectives—draw the same conclusion: that the current process could be improved.

So why add to the list with another report in 2012? The answer is three-fold:

- **The industry business model is changing and changing rapidly**—The *Private Health Insurance Act* in 2007 catalysed a significant restructure of the industry. Given limitations on how not-for-profit funds can allocate assets, the past five years have seen many funds shift to a for-profit model. MBF was one of the largest funds to demutualise and in 2007 was acquired by BUPA. As a consequence, the industry has moved from being 85% not-for-profit in 2006 to nearly 70% for-profit today. This rapid shift in corporate form raises the risk of regulatory failure—specifically that government may be mispricing PHI.

- **The policy framework has evolved**—When the current regulations for premium-setting were introduced in 1996, Australia had very few policies in place to encourage uptake of PHI. Policies were focused on extending the principles of fairness and equity that underpin the public healthcare system into the private sector, through levers such as community rating, risk equalisation and portability. Membership was very low, and given low take-up as well as issues of adverse selection, premiums were high.

The introduction of the current process in 1996 did little to increase membership levels, but was soon followed by the range of ‘sticks’ and ‘carrots’ that make up today’s regulatory system for PHI, including Lifetime Health Cover, the Medicare Levy Surcharge and the rebate of PHI premiums. Given the rapid sequencing of these policies between 1998 and 2000, there is significant debate about which policy lever was most effective in achieving a substantial increase in PHI membership (hospital cover rose from 34% to over 45% of the Australian population in less than one year).

Irrespective of the outcome of this debate, it can be argued that it was primarily these levers, and not the premium-regulation process, that support the PHI membership levels observed today.

Nevertheless, given the recent changes to the PHI rebate, which have decoupled the rebate from PHI premiums, it is now essential that the Government review the regulatory process for PHI premium setting, to ensure it optimises industry competition and efficiency for the purpose of minimising PHI premium growth.

- **The regulatory focus has widened**—With the rapid shift in industry composition, the government’s regulatory focus has widened from determining the ‘minimum necessary’ increase in premiums required to sustain the industry’s prudential soundness to the more challenging question of what ‘acceptable profit’ levels might be. Again, the risk of regulatory failure of mispricing PHI is substantially increased.

Reflecting the change in the industry and the implications for households and regulators, it is timely to consider whether the current approach to premium-setting is delivering the best outcome for consumers and the community.

1.2 What is different about this report?

An obvious question, given the extensive list of previous reports on this issue, is why change has not been effected? In preparing this report, Deloitte Access Economics consulted widely with PHI stakeholders to gain their insight into the current process, options for reform and evidence that would need to be present for policy change to be effected.

Specifically, this report seeks to:

- **Not ‘assume’ that the industry is ‘competitive’**—While there is broad agreement among previous analyses (including the Industry Commission review) that the current approach is unlikely to be optimal, there is material disagreement and uncertainty regarding how competitive the industry is, and in turn, what risks that could pose for price growth in a less-regulated environment. One stakeholder indicated that previous

reports were ‘too purist’ and lacked a realistic view of how the industry operates. Chapter 3 seeks to provide greater insight into the competitive underpinnings of the industry, and the limitations on competition effected by other policies.

- **Consider the analysis from a ‘public interest’ perspective**—Stakeholders have criticised some analyses as serving the interests of the industry rather than the community more broadly. This report seeks to be explicit about the nexus between the public and private healthcare sectors, and in turn the policy objectives that appear to govern PHI. These policy objectives have been organised into an ‘appropriateness, effectiveness, efficiency’ framework with the explicit goal of identifying the trade-offs for the community involved in alternative approaches.
- **Take into account fiscal and political risk considerations**—Related to the above, it was clear from interviews with stakeholders that any change would require phasing of proposed reforms, as well as identifying other policy changes that might mitigate risks to government. Chapters 6 and 7 seek to address this stakeholder concern.
- **Consider parallels in the deregulation of financial services and approaches to the regulation of essential services**—Most prior reports point to regulation of essential services infrastructure as the obvious comparator to PHI regulation. PHI is also located within the financial services sector, being one of the most significant purchases a family can make alongside their selection of superannuation fund, life insurance provider and home mortgage supplier. Deregulation of Australia’s home mortgage sector following the Campbell Report in the early 1980s provides an important insight into the potential opportunities for PHI. Given shared concerns for equity and prudential soundness, these case studies help to outline potential future paths for PHI.

Finally, this report does not attempt to provide all the answers to PHI regulation. Our approach has been to be clear about the various assumptions that could underpin different perspectives on the performance of the current system, and to provide a pathway to increasing levels of competition in the sector, as uncertainty regarding the potential outcomes is reduced.

1.3 Structure of this report

This report is structured as follows:

- **Chapter 2** discusses the historical context and objectives of PHI in Australia;
- **Chapter 3** assesses the level of competitiveness in the PHI industry;
- **Chapter 4** assesses the benefits and risks of the status quo;
- **Chapter 5** presents and assesses each option against the criteria specified in the evaluation framework;
- **Chapter 6** discusses the implications of this analysis for wider policy settings and governance considerations within the premium-setting process; and

- **Chapter 7** draws together the conclusions of this report and identifies potential next steps for government and industry to move forward.

The report is also supported by a number of appendices:

- **Appendix A** provides the references used for this report;
- **Appendix B** presents the evaluation framework used to assess the benefits and risks of alternative premium-setting options;
- **Appendix C** provides a detailed description of the premium-setting process; its historical rationale; the evolution of its regulation; and recent developments in the industry; and
- **Appendix D** outlines the consultation methodology and stakeholders consulted in preparing this report.

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2 What is the role of PHI and why were regulations put in place?

In order to consider the regulation from a public interest perspective, it is necessary to identify the specific policy objectives associated with the regulation. This chapter seeks to isolate the specific purpose of premium regulation within the broader policy system for PHI, and ultimately the health system. At a minimum, it should have the benefit of promoting a dialogue around whether these are in fact the objectives the community seeks from PHI.

The policy context set out in this chapter provides the foundation for the evaluation framework, which is subsequently applied to the current approach and alternative models in Chapters 4 and 5, respectively.

2.1 PHI: an extension of the public health system *and* a financing mechanism

The private healthcare sector is an integral component of Australia's universal healthcare system, increasing total health system capacity and sustainability by offering patients access to a wider range of services and reducing demand on the public health system. For example:

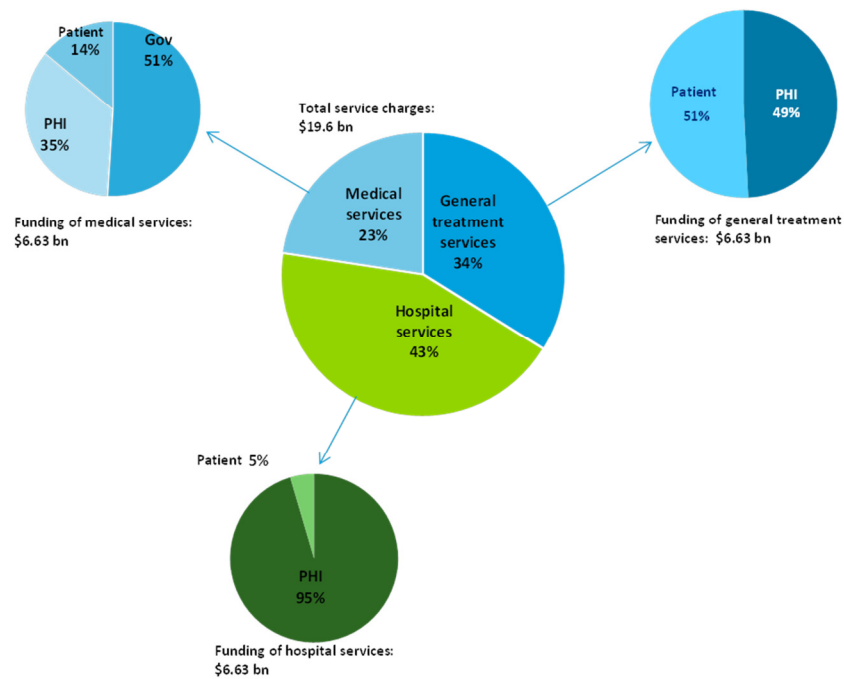
- The private health sector funds 3.4 million hospital episodes each year, which, in its absence, most of which would have needed to be performed in the public healthcare sector.⁴ This substantially reduces waiting times in the public sector for these services.
- Additional private monies were leveraged to fund these services as shown in Figure 2.1. Funding provided by private health insurers for hospital and medical services approximately \$7.7 billion in 2010-11, which, in the absence of the private sector, would have drawn down public monies, and in turn increased taxes on all households.⁵

It is therefore possible to conclude that the primary role of *private healthcare*, from the community's perspective, is to take the pressure off the public sector by moving patients out of public care settings. Within this envelope, there are also goals for ensuring the quality and safety of private services, consistent with community goals for equity and fairness in a universal healthcare system. Nevertheless, from a policy perspective, it could be argued the primary function of private healthcare is to reduce demand for public services by offering patients private care options.

⁴ PHIAC (2012), *Annual Report on Operations 2010-11*, p.22-23. This includes hospital based episodes of care as disclosed in PHIAC; however, no detail is provided as to the nature of the care, or whether or not the care was for necessary treatments ordinarily covered by Medicare

⁵ *Ibid.*

Figure 2.1: Funding for privately insured services, 2010-11

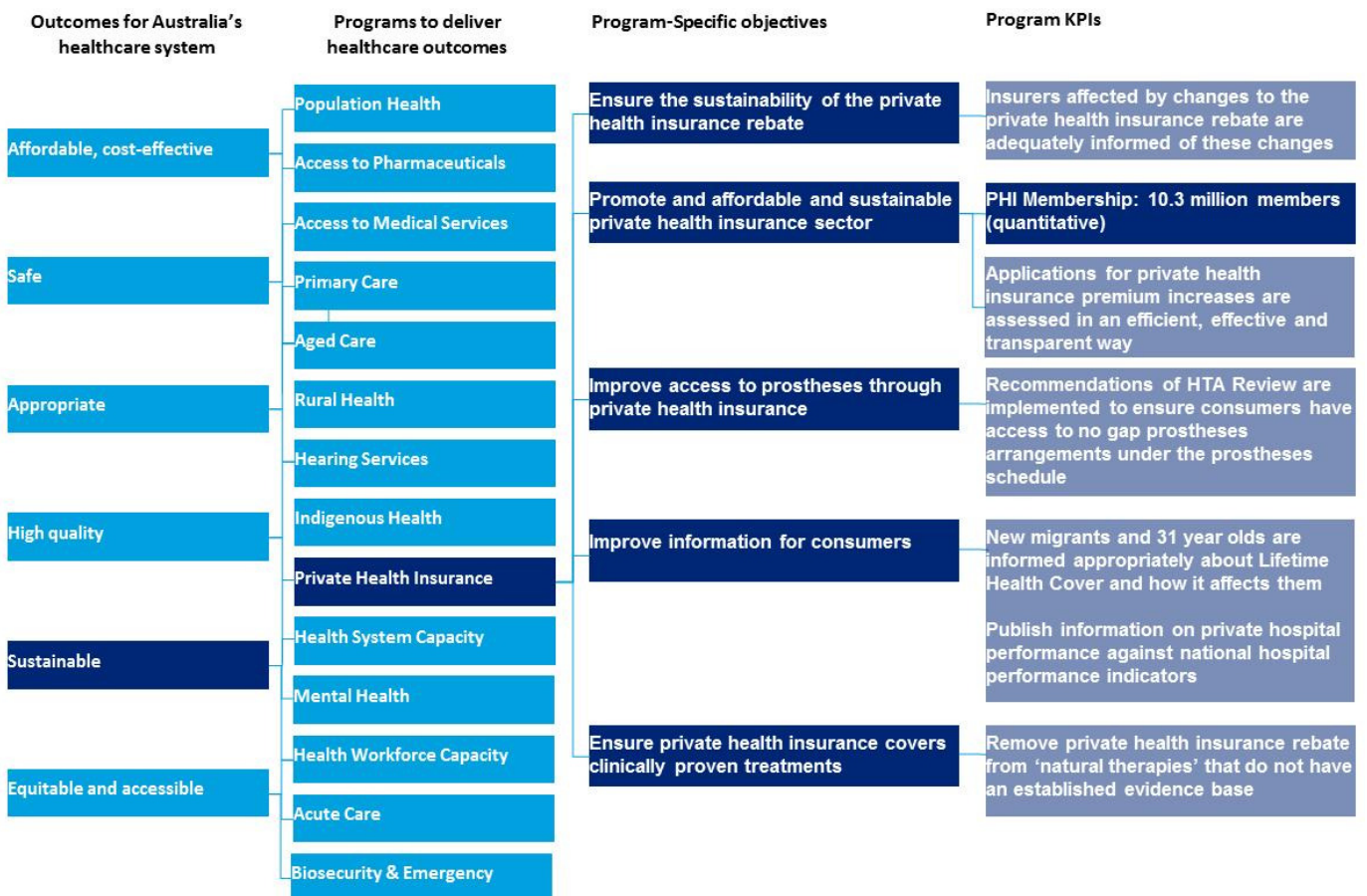


Source: PHIAC (2012), *Annual Report on Operations 2010-11*, p.23

PHI’s role is defined by this broader policy context for private healthcare. PHI enables patients to access private care, by helping consumers to smooth the cost of accessing this care over time. Consequently, the primary objective for PHI is sustaining high membership levels, which increases the likelihood that consumers will access the private healthcare system, rather than the public healthcare system. This is reflected in the Department of Health and Ageing’s Program KPIs, which cite only one quantitative KPI for the sector: PHI membership levels, with a target of 10.3 million members to 2014-15.⁶

⁶ Department of Health and Ageing, 2012, Australian Government 2012-13 Health and Ageing Portfolio Budget Statements, Department Outcomes Private Health Insurance (Outcome 9), http://www.health.gov.au/internet/budget/publishing.nsf/Content/2012-2013_Health_PBS

Figure 2.2 Locating PHI within Health Portfolio



Indeed, arresting premium growth and boosting PHI membership levels, particularly among 'healthier' consumers, was a major motivation for introducing the current premium setting process. At that time an adverse selection cycle had taken hold, as noted by the Chairman of the Industry Commission, Gary Banks, in 1998:

Although ostensibly a private system, [PHI] is enveloped by a thick mantle of social regulation, much of which is designed to sustain 'community rating' and the risk equalisation transfers among funds which underpin it. In recent years, this 'mixed system' has been in trouble:

- PHI premiums have been rising on average at rates three times faster than the consumer price index;
- Affordability has been declining; and
- Membership has been steadily falling. By the time of our review in mid-1996, barely one-third of the population had some form of PHI — down from one-half only a decade before.

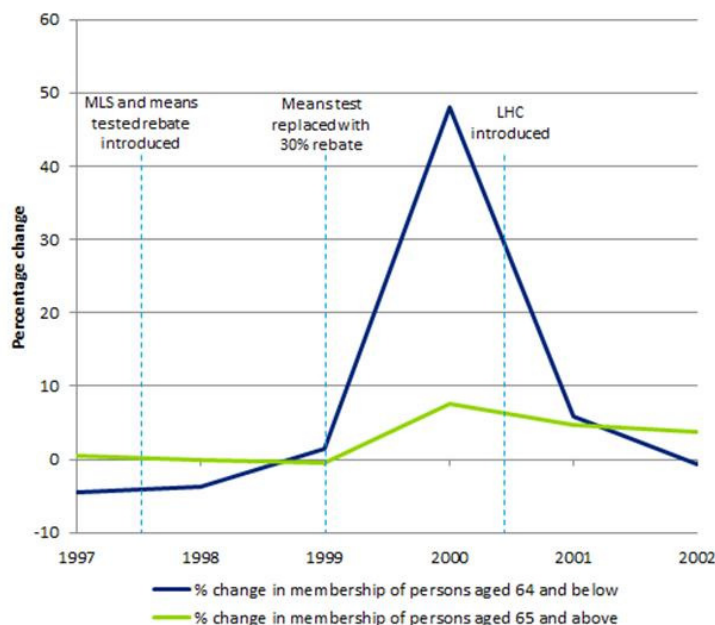
As a consequence, the demands on a public system already beset by funding difficulties have increased.⁷

While this context of falling membership and high premium growth was the major motivation for introducing premium-setting regulation, this did not on its own address membership levels and composition. This was arguably achieved through the combination of ‘sticks’ and ‘carrots’ that followed the premium approvals process (Figure 2.2), including the introduction of:

- A **PHI Rebate (Subsidy) and Medicare Levy Surcharge (MLS)** (1997), which introduced a means-tested subsidy for PHI and a one per cent surcharge charged to medium to high income earners without PHI coverage, respectively;
- The **PHI Rebate**, which was designed to be a 30% rebate on PHI premiums, replacing the means-tested subsidy (1999); and
- **Lifetime Health Cover (LHC)** (2000), in which premiums are 2% higher for each year a person defers entry to the system after age 30.

As a result of these reforms, the PHI consumer profile changed significantly (Figure 2.2). In particular, the introduction of LHC and MLS policies encouraged younger members to take up PHI membership. In 1997, there were 5.07 million members under 65 and 847,254 over 65, compared to 7.72 million and 986,369, respectively, in 2002.⁸ This highlights both the success of the LHC and MLS reforms in increasing PHI membership among younger Australians, as well as the extent to which the membership structure has changed since the annual premium review process was first introduced.

Figure 2.3 Change in membership levels



⁷ Industry Commission, 1997

⁸ PHIAC, (2002), Statistical data tables.

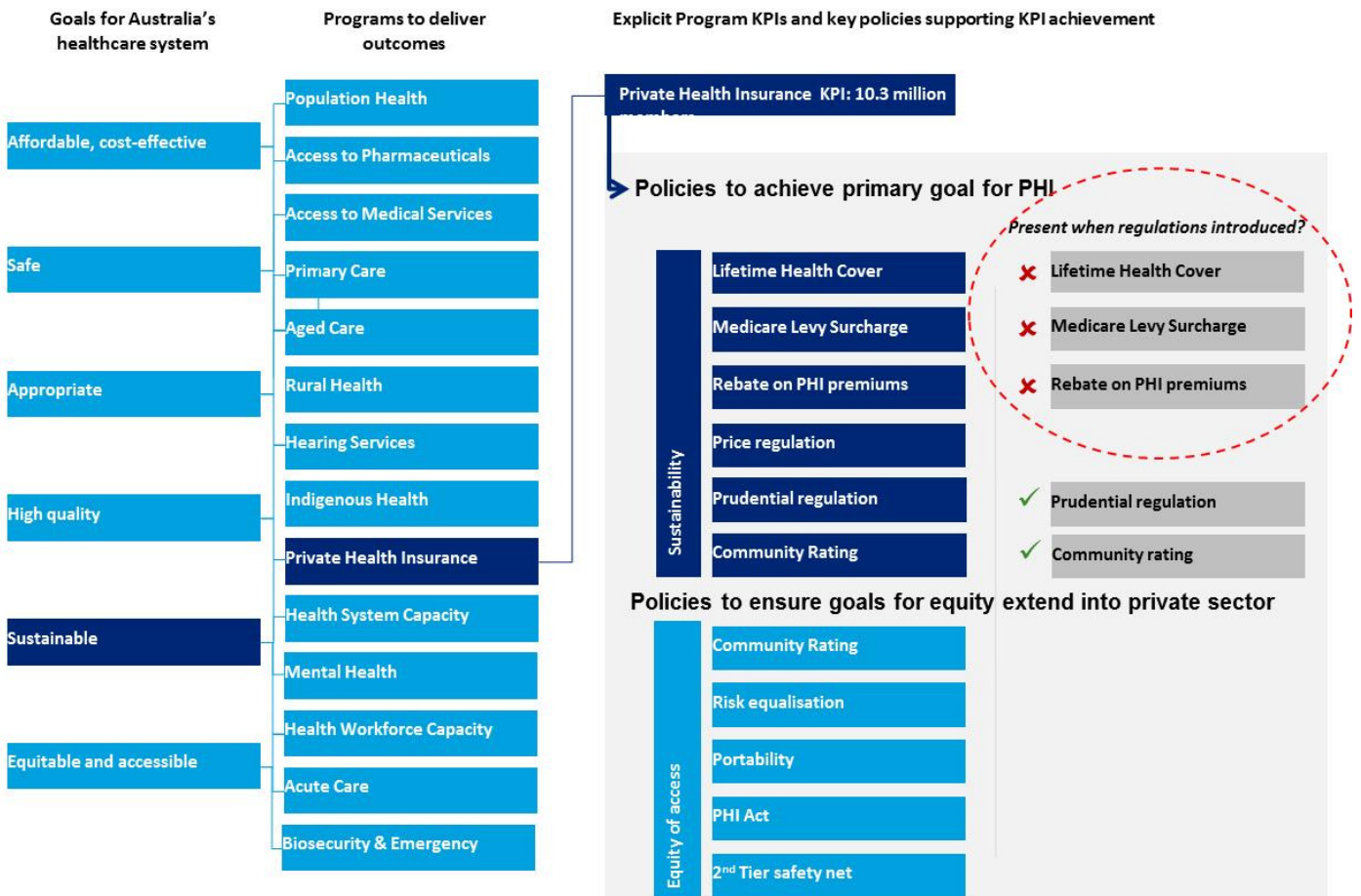
It may seem 'obvious' that the combination of policies introduced after the premium approval regulations were enacted have worked to achieve the high levels of membership enjoyed by PHI and the wider health system today. Nevertheless, it is essential this point is clear because it serves to isolate the specific goals the government is trying to achieve and that premium regulation is distinct from other policy levers. **A major concern of stakeholders appeared to be that if the premium-setting process were revised that this could 'undo' the entire system that has worked to reverse the market conditions that were present in 1996. There is therefore a paradox of sorts at work:**

- **On one level, it is apparent and stakeholders point out that the policies work together as a system, yet**
- **There is also concern that making any change to the premium regulation would pull the entire system apart, rather than the adjustment of one policy enabling the broader system or remain intact.**

Given the available evidence of current PHI membership levels over time in response to major policy changes in PHI, it would appear that the other policy mechanisms have been the primary levers by which the high levels of membership have been achieved (Figures 2.2 and 2.3). Therefore, although the current system was introduced in response to falling membership levels and high premium growth, the policy context has evolved significantly and it is worthwhile to isolate the incremental impact of the premium regulations vis-à-vis other policy levers. Specifically, regulation governing premium-setting should be focused on driving better value for money in PHI. This is consistent with the goals of PHIAC.

Given the more recent changes to the rebate design, introduced in the November 2012 Mid-Year Economic and Fiscal Outlook, which have reversed previous policy reforms to essentially return the rebate to be a lump-sum payment rather than a premium-linked rebate, it is essential to ensure that the regulatory process is optimised to drive efficiencies through the system to minimise potential premium growth.

Figure 2.4 Policy settings for PHI: before and after regulatory change



2.2 Implications for premium setting: key objectives and evaluation framework

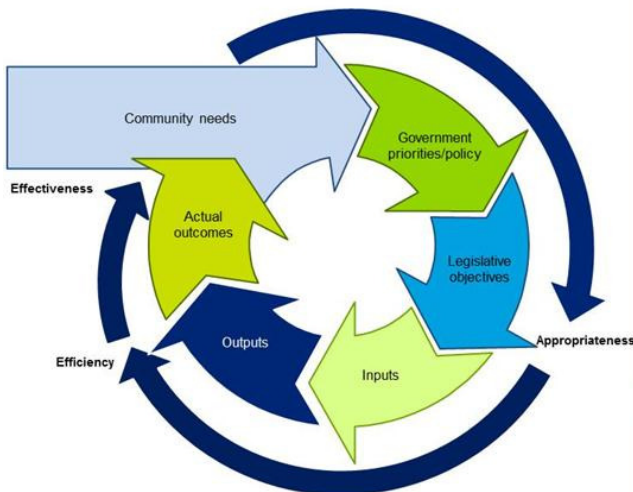
The isolation of the goals for the regulatory process within the broader policy context serves to define and simplify the evaluation framework to be applied to the current regulations and potential alternative approaches.

Adopting an appropriateness, effectiveness and efficiency approach (Figure 2.5), the criteria for measuring regulations against government objectives are the following:

- Appropriateness**—First, a regulatory approach must not risk destabilising current membership levels, as this is the primary function of PHI and the policies that underpin it: to support Australians to access the private sector and by doing so to relieve pressure on the public system. This is a threshold test that all options must meet in order to be considered as a potential alternative. Within the envelope of potentially ‘appropriate’ options, the effectiveness and efficiency criteria grade how well or poorly the option achieves community goals.

- Effectiveness**—Provided that the appropriateness test is met, then a regulatory approach is more effective based on the extent to which it delivers stated objectives and outcomes – in this case, driving competition and efficiency through PHI businesses and meeting best practice regulatory principles. Thus the effectiveness criteria divide into two categories:
 - Measures of increasing competition:** the regulatory approach promotes **choice** in products, the regulatory approach enhances PHI **affordability** for consumers, and the regulatory approach ensures the **sustainability** of the industry.
 - Measures of good process:** the regulatory approach is accountable, transparent, promotes prudential soundness and is both predictable and timely.
- Efficiency**—The efficiency criterion measures how cost-effectively the goals of the regulation are met, with **productive efficiency** measuring whether the regulatory options promote technical and allocative efficiency (that is, scarce dollars going to their best use in the short term) and **dynamic efficiency** measuring whether the regulatory options promote continuous improvements through time.

Figure 2.5 Appropriateness, Effectiveness, Efficiency



Criterion	Definition
Appropriateness	A threshold measure that considers the extent the outcomes and outputs generated by the proposed option align with the community need, government policy priorities, and stated legislative objectives. If public interest and access to health care is jeopardised then the option will not pass the appropriateness threshold.
Effectiveness	
Choice	The extent to which the regulatory approach supports improved choice in health services. This involves ensuring that social or economic disadvantage is not a barrier to participation in, or outcomes from, the Australian healthcare system.
Affordability	The extent to which the regulatory approach supports increased affordability of PHI and private sector care.
Sustainability	The extent to which the regulatory approach ensures the sustainability of the healthcare system and PHI industry
Accountability	The extent to which the regulatory process is accountable for its operation through reporting processes or other governance mechanisms, and ensures that policy administration is consistent with the public interest.
Prudential soundness	The extent to which the government response supports the long term viability of the industry and is underpinned by responsible governance and discipline guiding its actions.
Predictability and timeliness	The extent to which the government response provides stakeholders with sufficient predictability and certainty regarding the rules, processes and actions involved. This would involve a high level of consistency in the process. The extent to which the premium change process occurs in a timely manner.
Transparency	The extent to which the government response is underpinned by an open process and a high degree of transparency for the stakeholders affected by the action. This would be aided by a simple process that facilitates stakeholder understanding.
Efficiency	
Productive efficiency	This measure considers the allocative and technical efficiency of a proposed option. Allocative efficiency is the extent to which resources are distributed in the most efficient manner, by optimally allocating resources where the marginal benefit of the response is equal to the marginal cost. Technical efficiency is the effectiveness with which inputs are utilised to produce a certain level of outputs. In other words, the ability to produce outputs for the lowest cost or allocating to ensure marginal benefit of the response equate to the marginal cost.
Dynamic efficiency	The extent to which the regulatory approach balances short run and long run efficiency concerns, thus enabling the improvement of efficiency over time. This includes the capacity of the Government to flexibly respond to new data and to change its process or allocation of resources in a manner which reflects this new information or circumstance.

Appendix B provides further detail on the development of the evaluation framework.

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3 Untangling PHI: just how competitive is it?

Chapter 3 considers the competitiveness of the PHI industry. It first outlines the current PHI market structure and then assesses ways in which the industry currently competes. It considers the regulatory environment's impact on competitive outcomes, and discusses implications for alternative regulatory approaches to premium-setting.

3.1 What is the market structure for PHI today?

The difference between the PHI market structure prior to increased government involvement in the premium review process and today is significant. These differences are evident in:

- The number and dominant legal structure of funds;
- The profile of PHI consumers;
- The new players in the market; and
- The legislative reforms which have been introduced.

All of these dimensions affect funds' incentives and the competitiveness of the industry.

In 1997, there were 48 registered health insurance funds, of which 18 were restricted membership organisations (RMOs). The number of funds fluctuated between 1989 and 1996 as shown in Figure 3.1, with the introduction of national registration requirements in 1996 causing the number of funds to drop from 91 to 48.

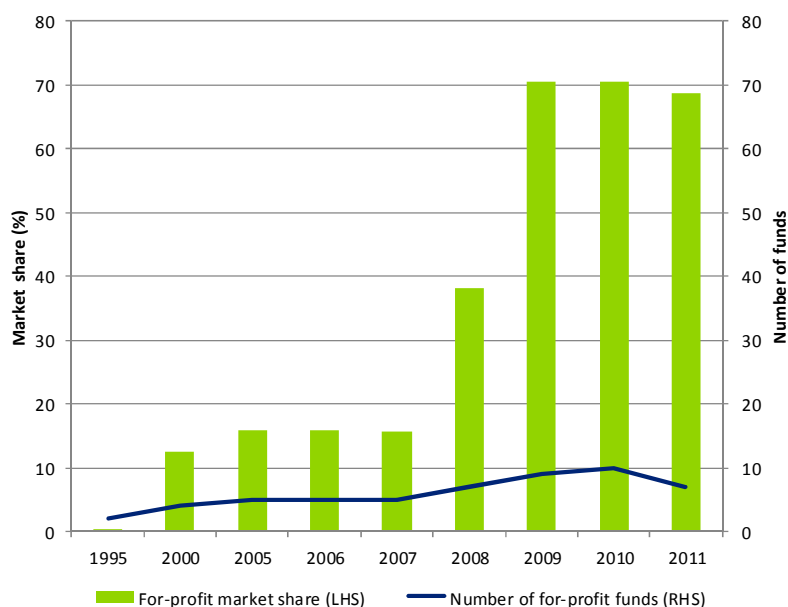
The number of PHI funds in the industry has subsequently declined from 48 to 34, in turn increasing the level of competition, as there are fewer firms in the market competing for a larger and more diverse pool of PHI policyholders. This consolidation can be largely attributed to several mergers and acquisitions of funds. In addition, health.com.au entered the market, becoming the first new health insurance provider in Australia in 23 years.⁹ The number of RMOs has also fallen from 18 in 1997 to 13 today, meaning fewer funds have restricted membership access.

Of the 34 funds, eight now operate on a for-profit basis and comprise 68.6 per cent of the market share.¹⁰ This shift away from mutuals is mainly accredited to the introduction of the *Private Health Insurance Act 2007*, which granted for-profit funds greater flexibility in how they allocate their assets compared to mutuals. The number of for-profit funds and their combined market share is illustrated in Chart 3.1.

⁹ Health.com.au, (2012), 'Media release: First new health insurer for two decades'.

¹⁰ Government and Public Affairs, (2012), 'A premium round reform agenda', p.10.

Chart 3.1: Number of for-profit funds and their cumulative market share



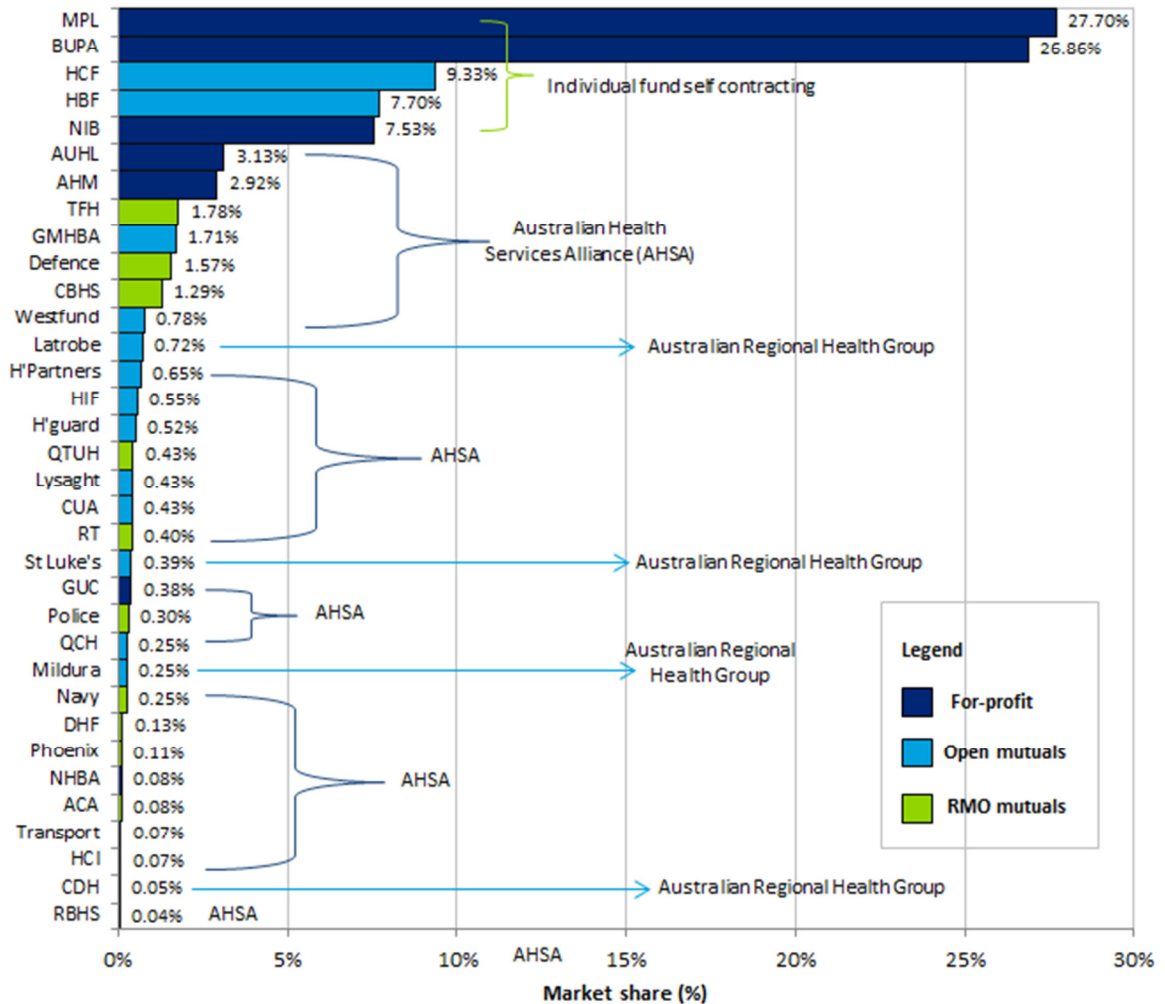
Source: PHIAC, *Operations of Private Health Insurers Annual Reports 2005-2011*; DAE Analysis

The market share of for-profit funds reveals that only a small number of funds control a large proportion of the market, as demonstrated in Chart 3.2. The two major funds, BUPA and Medibank Private/AHM, now comprise over 57% of the membership market, increasing the market share among the top two providers since 1997 by roughly 10 percentage points.

An increasingly significant change to the PHI market structure is the entry of aggregators into the market. Aggregators have become influential, particularly with regard to consumer choice, having entered the PHI market in response to extensive confusion surrounding the multitude of PHI product options. Their role is to compare the offerings of different funds, to enable consumers to compare and help them decide which fund to choose and simplify the process. A key player in the aggregator space is iSelect, which compares premiums and benefits across policies to assist consumers to find a policy from a list of products and insurers available through iSelect, and reportedly accounts for approximately 20% of new PHI policy sales.¹¹ However, aggregators are seldom impartial in their recommendations, as discussed further in Section 3.2 below.

¹¹ Oldfield, (2012), Sydney Morning Herald, 'Health cash flow is key for investors in iSelect offering'.

Chart 3.2: Market share by PHI fund and type, June 2011



Source: PHIAC, *Operations of Private Health Insurers Statistical Tables 2011*, p. 2-3, DAE Analysis.

3.2 On what basis do funds compete?

3.2.1 A divergence of views on the level of competitiveness within the PHI industry

As introduced in Chapter 1, while there is broad agreement among previous analyses (including the Industry Commission review undertaken in 1997) that the current premium-setting approach is unlikely to be optimal in terms of competitive outcomes, there has been material disagreement and uncertainty regarding the competitiveness of the PHI industry. This section seeks to address this divergence by first considering the competitiveness of the industry through the lens of a number of best practice frameworks, and then considering the actual data points and constraints upon the PHI industry in practice which complicate the theoretical view.

A number of approaches exist to consider the competitiveness of an industry. This report has selected three methodologies to apply at a high level to the PHI industry.

The HHI index

The first approach considered is an analysis of the Herfindahl-Hirschman Index (HHI), which is a metric used to estimate the competitive structure of an industry based on the level of concentration in the market. This HHI is calculated by adding the sum of the squares of the market share of each firm in a particular market.¹² The HHI ranges from 0% for the most competitive market, to 100% for a monopoly provider, with an HHI between 15% and 25% generally considered to indicate moderate concentration within a market.¹³

The HHI of the PHI industry has been calculated as 19%, compared to a HHI of 20% within the similarly highly regulated Compulsory Third Party (CTP) insurance market in New South Wales, and 33% in the CTP market in Queensland.¹⁴ This indicates that the PHI market is competitive given a moderate market concentration, but also fragmented. This result can be witnessed in the market share of funds. Despite existence of 34 funds from which consumers can purchase PHI, these are split between the five funds with significant market share and the other smaller and often closed funds that comprise the tail end of the market.

Porter's five forces

An alternative approach to assessing competition is Harvard Business School Professor Michael Porter's Five Forces. This framework rates the impact of five forces on the competitiveness of an industry: the power of suppliers; threat of new entrants; power of customers; threat of substitute products; and level of competitor rivalry.

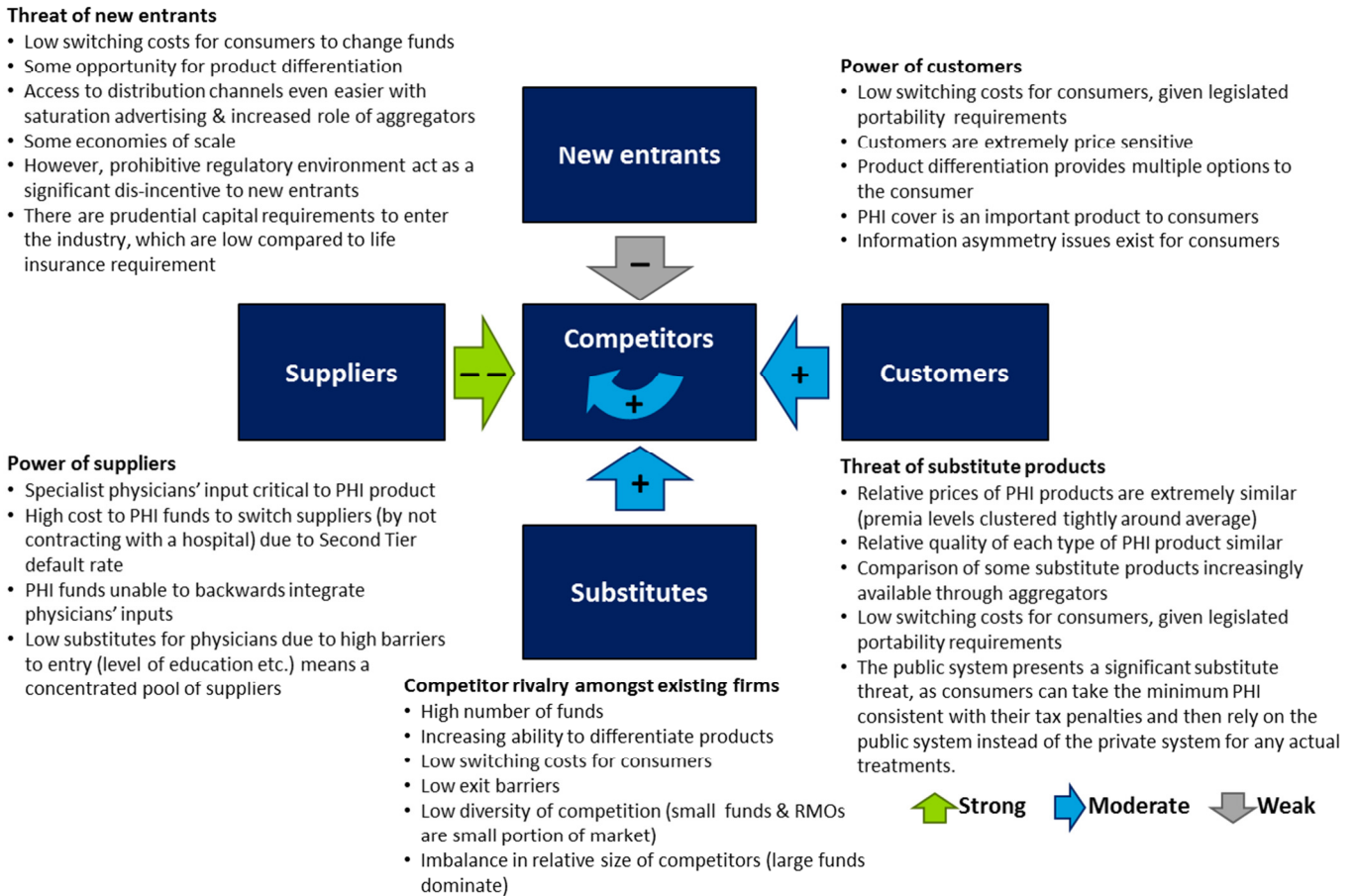
An assessment of the PHI industry against these five forces is presented in Figure 3.1. As this figure demonstrates, the PHI industry is found to be moderately competitive overall. Despite few barriers to entry, new entrants are deterred from entering the PHI market due to the extensive government regulation that shapes the industry. Customers have significant power due to low switching costs, a variety of choice in terms of both funds and policies, and the relative similarity in terms of quality for each PHI product. These factors also create significant rivalry among funds. Finally, suppliers have substantial power as they essential to the delivery of the PHI product. Combined, these indicate the PHI market has a moderate level of competitiveness.

¹² Australian Competition and Consumer Commission, *Merger guidelines – November 2008*, p.67

¹³ Reid, J. "Should Private Health Insurers be more competitive?", *Actuaries*, August 2012, p.10

¹⁴ *Ibid*, p.10

Figure 3.1: Competitiveness of PHI industry against Porter's five forces



ACCC merger factors

The third approach to assessing the competitiveness of the PHI market is to consider the ACCC's merger factors assessment. These have been identified by the ACCC as key market characteristics that could affect the impact of a merger on competition.¹⁵ The merger factors are thus used to assess whether a merger would substantially lessen competition in the market and should therefore be prevented from occurring.

This approach indicates that the PHI market has a moderate level of competitiveness, with the structure of the market as discussed in Section 3.1 in terms of market share and number of funds playing a significant role in determining this outcome. The main impediment to competition according to these guidelines stems from current government regulation, with sets up barriers to entry and limits the extent to which funds can increase their profit margins.

¹⁵ ACCC, (2008), 'Merger guidelines'.

Table 3.1: PHI industry competitiveness against the ACCC 'merger factors' assessment

ACCC merger factors	PHI industry performance against factor
<p>Height of barriers to entry to the market</p>	<p>Moderate – On one hand, there are few barriers to entry in the PHI market. Prudential capital requirements exist but are lower than in life insurance for example, opportunities exist to differentiate products, switching costs for consumers are low, and access to distribution channels is increasing through aggregator players and advertising trends. However, the extensive regulation that constraints the PHI market environment and consequent low profitability are the main dis-incentives, the burden of which deters new entrants.</p>
<p>Level of concentration in the market</p>	<p>Moderate – There are 34 insurance funds in the market, suggesting on the surface a low level of concentration. However, an HHI of 19% indicates a moderate level of market concentration, given the high market share of a small number of large for-profit funds (the two largest funds, BUPA and Medibank, comprise a total of 54.56% market share) At state level there are typically much fewer than 34 funds competing for business.</p>
<p>Degree of countervailing power in the market</p>	<p>Low – The concept of countervailing power was first defined by Galbraith (1952), as the ability of powerful organisations to influence prices and obtain concessions from suppliers, distorting the free market bargaining process in which prices are set according to supply and demand. Despite the high market share of some of the larger funds, a correlating degree of countervailing power does not exist. This is because funds are reliant on specialist physicians and private hospitals for inputs, and are constricted by Second Tier Default rates in negotiations.</p>
<p>Likelihood that funds are able to significantly and sustainably increase prices or profit margins¹⁶</p>	<p>Very low – The extensive regulatory process in place to control premia levels prevents funds from being able to achieve higher profit margins, combined with final competition from public healthcare sector (notwithstanding policy instruments to encourage PHI uptake and use of private sector care).</p>
<p>Extent to which substitutes are available in the market or are likely to be available in the market</p>	<p>Very high – Despite 13 funds being RMOs, there are still a further 21 funds from which consumers can purchase PHI. Within these, there are also numerous policy and product options, depending on the consumer’s requirements. In addition, there switching costs are low for consumers and the relative quality and price of a particular PHI product is similar across the market. The increased role of aggregators has also made consumers more aware of alternative choices. This means there are a substantial number of substitutes both in terms of policies and funds.</p> <p>Moreover, the public sector offers a free competitor service to private healthcare, which necessarily limits final consumer demand for PHI (and cannot be assumed away).</p>
<p>Dynamic characteristics of the market, including growth, innovation and product differentiation</p>	<p>Low/Moderate – The PHI market has displayed varying degrees of growth, product differentiation and innovation.</p> <p><i>Growth:</i> PHI membership has grown, for instance from 30.5% of the population with PHI hospital cover in 1997 to 45.3% in 2011. However growth has also been linked to government reforms, notably the rebates, MLS and LHC and therefore may reflect regulatory, rather than market characteristics.</p> <p><i>Product differentiation:</i> there is a moderate degree of product differentiation, with most funds offering a similar range of policy options based on consumers’ profiles, for instance singles, families or the elderly, at a similar price.</p> <p><i>Innovation:</i> innovation remains very limited, in part due to the uncertainty of premia increases through regulation, reducing funds ability to invest in innovation in the long-term. However some funds have implemented some innovative programs, for instance Medibank’s Mi Health, which enables consumers to speak to nurses 24/7 and access mobile health apps.</p>

¹⁶ Edited from ACCC guidelines from ‘Likelihood that the acquisition would result in the acquirer being able to significantly and sustainably increase prices or profit margins’, to ensure is relevant to the PHI market in a non-merger context.

ACCC merger factors	PHI industry performance against factor
Likelihood of the removal from the market of a vigorous and effective competitor¹⁷	Low – Many of the competitor removals to date have involved mergers or acquisitions of smaller funds by larger funds. The removal of smaller funds has little impact on the competitiveness of the market due to their minimal market share.
Nature and extent of vertical integration in the market	Limited – Funds are reliant on specialist physicians and private hospitals and therefore there is a limit to the extent to which they can vertically integrate. Funds cannot backward integrate physician’s inputs and also face high supplier switching costs due to the Second Tier default rate.
Actual and potential level of import competition in the market	Not applicable

Source: ACCC, *Merger guidelines – November 2008*, p.3; DAE analysis

Ultimately, there is no single algorithm to say: yes, this industry is competitive; or no, this industry is not competitive. What these perspectives demonstrate is that, on balance, the PHI industry has the foundation to be competitive. There may be, however, regulatory constraints in place that prevent the industry from being perfectly competitive, which may be appropriate from a public interest perspective. These are highlighted in Section 3.2.2.

3.2.2 Evidence of uncompetitive outcomes in practice

While the discussion above illustrates that the foundation for competition exists, a number of data points illustrate that these competitive outcomes have not occurred in practice, likely to result from the constraints imposed by the current regulatory environment. Evidence of these uncompetitive outcomes is presented below.

Funds aren’t competing on price...

Within the current regulatory environment, PHI funds are not competing on the price of their products. This is the result of a number of effects. Firstly, the ‘blind tender’ nature, in which funds must submit proposed price changes without knowledge of the actions of their competitors, means that funds are unable to observe and respond to the moves of competitors in the market. In the internal pricing debate between a firm’s marketing and finance departments, this lack of competitor data inevitably weakens any internal pressure to gain market position by reducing prices. Instead, each provider must focus on winning its required increase from the regulator, and rather than having a reasonable position rejected on political grounds, may initially submit a higher request in recognition that the regulatory process has become one of negotiation. Essentially this leads towards “pricing up” to a regulatory benchmark. In addition:

- The iterative nature of the submissions process incentivises further gaming of the system by funds, who will initially propose high increases as part of a bargaining position, with the knowledge that these will likely be negotiated back during the re-submission rounds.
- Lack of information regarding competitors’ actions removes the competitive signals in the market that would otherwise indicate to funds what a reasonable premium level might be in

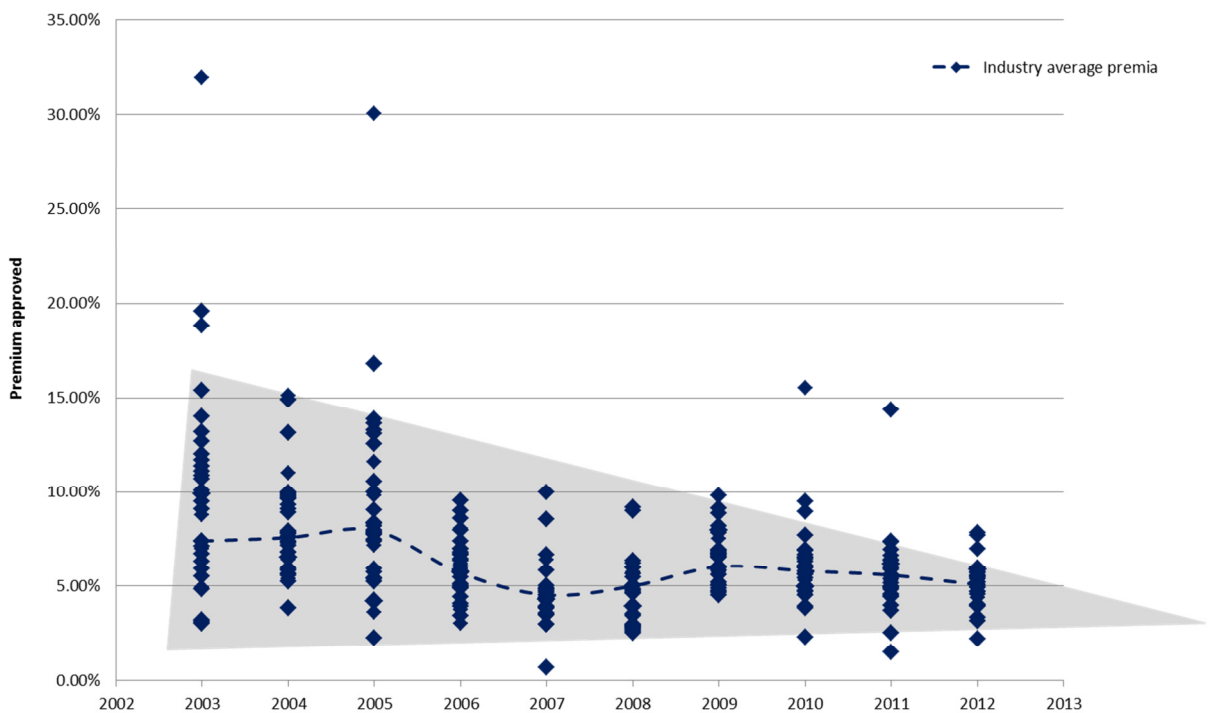
¹⁷ Edited from ACCC guidelines from ‘Likelihood that the acquisition would result in the removal from the market of a vigorous and effective competitor’, to ensure is relevant to the PHI market in a non-merger context.

order to secure its market share, thereby making the safest move to maximise the potential increase and revise if necessary.

- The constraint imposed by the annual application process means that funds must price in a risk contingency to allow for unexpected changes in cash flow over the course of the following 18 months, which flows through to prices.

Chart 3.3 below illustrates the effect of this gaming, as the premium for each fund is seen to be tightly clustered around the announced industry average of each. Moreover, it is evident that this trend has increased since 2008, with the clustering effect becoming more condensed, a likely result of funds choosing to 'price-up' to the perceived regulated benchmark as it is has become more tightly regulated since 2007.

Chart 3.3: Premia approved for each fund, 2003-2012



Source: Data provided by Medibank Private; DAE analysis

Moreover, under the current system, no incentive exists for funds to minimise controllable expenses, as the potential to increase their profitability which should exist as a result of improving their technical efficiency is eliminated through the granting of lower allowable premium increases in the Ministerial approval process.

...and therefore they're competing on products...

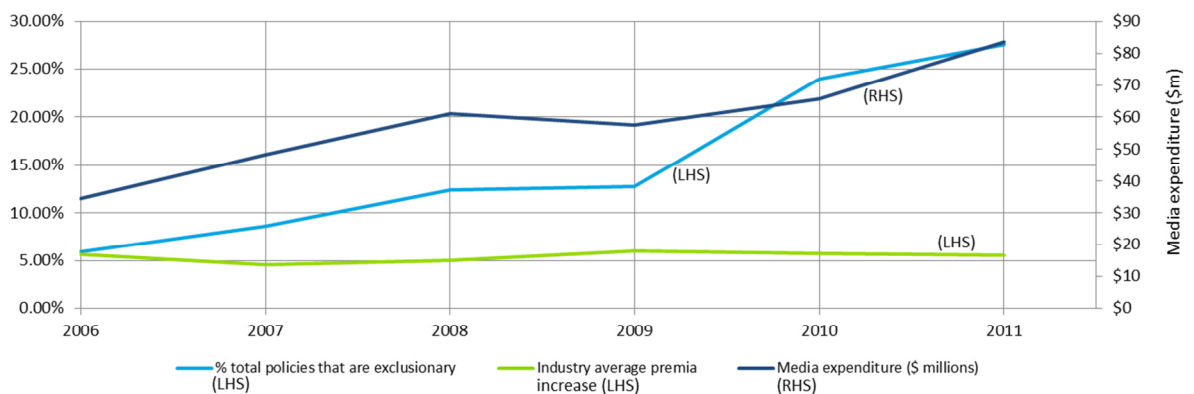
Funds have responded to these significant regulatory controls on premium levels by instead competing within the market on their product offering. Increased variations on products have resulted in a significant expansion of the number of products on offer, with the total number of PHI policies increasing from 2.72 million in 1998 to 4.97 million in 2011. By competing on their ability to provide bespoke products for specific customer segments and differentiated product and service offerings, such as individualised preventive health assessments or 24/7 access to

nurses, funds aim to vie with competitors for new members. Part of this strategy involves a significant investment in advertising, particularly through the internet and saturation advertising on television, as funds aim to target particular customers and promote their differentiated products and offerings.

Chart 3.4 illustrates these effects, demonstrating the almost constant average premium increase across the industry for the past six years as funds are prevented from competing on price within the market. **It also charts the significant increase in advertising expenditure across the industry, which has increased by 160%** during this same time period.

As a result of this competition, various stakeholders estimate that between 22,000 and 28,000 PHI products are currently on offer in the market. However, as also evidenced in Chart 3.4, a significant part of this increase has been generated by variations on the exclusions and level of coverage of existing products. One reason for this may be the constraint of product regulations, which limit the types of product innovations that funds can bring to market. For example, the *Private Health Insurance (Complying Product) Rules* establish minimum coverage requirements and restrictions for all products, and also set a maximum allowable percentage discount on premiums at 12% per annum. As a result, funds are constrained in the extent to which they are able to innovate through entirely new products or the extent to which they can discount the price of products; instead generating 'new' and 'cheaper' products by varying exclusions and restrictions on existing product ranges.

Chart 3.4: Competition in the PHI industry



Source: PHIAC, *Operations of Private Health Insurers Statistical Tables 2006-2011*; average premia and media expenditure provided by Medibank Private; DAE analysis

Chart 3.5 emphasises this impact, charting the significant increase in the percentage of hospital treatment policies with excess and co-payments since 1995, having overtaken the percentage of non-exclusionary policies in 2010. Similarly, the percentage of policies without excess or co-payments is shown to have significantly decreased in parallel with this trend.

When faced with a regulatory demand to keep premium increases below a certain level, one option available to an insurer is to increase the co-payments or excess levels on a product.

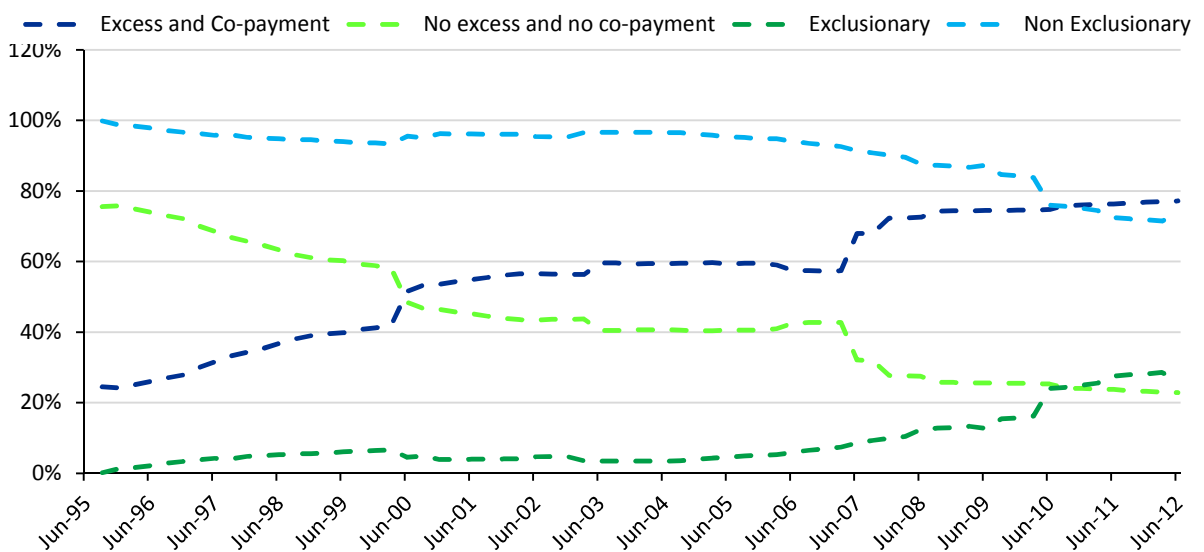
Product competition through varying exclusions and cover levels has important implications for the total cost and value for money of PHI to the consumer/patient, in the form of gap payments that are often only revealed at the time of treatment. There are two issues here – the information asymmetries which mean that consumers may not fully understand the implications of exclusions

and restrictions on their cover, and the appropriateness of these types of products for particular groups – both of which result in reduced consumer welfare.

Stakeholder consultations indicated that consumers are often unclear about the effect of exclusionary clauses. The Consumers Health Forum of Australia has also made the point that exclusionary and restricted products reduce the value of PHI to consumers. It points out that often no clear information is provided about exactly what is restricted on a product list, with this information provided on Standard Information Statements which consumers may not know how to read.¹⁸

Evidence of this impact is seen in the Ombudsman’s most recent annual report, which reports that the most significant area of complaint to the Ombudsman’s office in the 2011-11 year was benefits, with a total of 1,131 complaints – a 16.5% increase on the previous year’s figure of 971.¹⁹ The main areas of concern for consumers within the benefits area were inadequate levels of cover, delays in payment, inadequate benefit amounts, and hospital and medical gaps.²⁰ An example of where this issue has been frequently raised is in relation to gastric banding and other obesity-related bariatric surgeries, which are becoming more common solutions offered to Australian patients.²¹ The procedure is included in the Medicare Schedule of Benefits, but a number of health insurance policies restrict or exclude the service.²²

Chart 3.5: Percentage of total hospital treatment policies, as at June 2012



Source: PHIAC, *Statistical trends in Membership and Benefits Data Tables, June 2012*

...which results in a loss of consumer surplus due to “confusopoly” and lack of switching...

As illustrated above, a wider range of product choice can, in fact, be detrimental to consumers and result in a loss of consumer surplus. This occurs due to the information asymmetries that prevent consumers from making decisions that are in their best interest and makes it more

¹⁸ Consumers Health Forum of Australia, *Restrictions and Exclusions in Private Health Insurance*, October 2010

¹⁹ PHIO, *Annual Report 2011*, p.28-9

²⁰ Ibid.

²¹ Ibid.

²² Ibid.

difficult for them to make comparisons (e.g., where companies exploit market failures of bounded rationality). By confusing consumers through product proliferation rather than competing predominantly on price, funds cause uncompetitive outcomes in the market and reduce consumer welfare.

Literature supports the notion that too much choice can reduce consumer welfare, in what Gans (2005) has termed the ‘confusopoly’ when discussed consumers’ bounded rationality. In reference to mobile phone plans, Gans found that it was difficult for consumers to price compare policies, as there were a wide number of plans available and the prices depended on their personal calling patterns, thereby impeding price competition between companies. This is comparable to PHI, as consumers are faced with a plethora of products but their optimum choice depends on their specific health needs and medical usage patterns.

Wilson and Price (2005) found that consumers make more efficient decisions in markets with fewer competitors, consistent with theories of consumer confusions and “information overload”. They found that consumers suffer from increased decision noise in markets with larger number of competitors, which may limit consumers’ ability to appropriate the potential gains made available through competition. Wilson and Price also make the important point that it may not be access to information per se that is important, but access to information in an easily understood format. Satterthwaite (1979) also identified a negative correlation between the number of firms or products in a market and consumers’ level of information about them, with specific reference to reputation goods. This is because an increase in products or firms in a market decreases consumers’ ability to rely on reputation, instead increasing their search costs as they try to distinguish among product and fund types.

In terms of the PHI market, this ‘confusopoly’ is exacerbated by several factors that impinge on competition:

- The saturation of advertising in the market;
- Funds intentionally ‘muddying the waters’ through product proliferation to exploit consumer’s lack of knowledge or understanding;
- The increasing influence of aggregators – aggregators present a complex interaction in the market. While they do indicate a response to a market failure (information asymmetry), they also often represent various sub-sets of the market, while consumers may think represent the whole of the industry, rather than selling products for a selected number of funds. This represents both a sign of the foundations of competition, but a complication arising from product profusion and the lack of transparent information provided to consumers regarding aggregators’ roles;
- Persistent market failures of bounded rationality for consumers – there is a wealth of information available to consumers, such as through the Private Health Insurance Ombudsman’s (PHIO) www.privatehealth.gov.au website, yet product offerings remain complex and difficult for most people to understand. In many ways the aggregators have entered the market in response to this need, but stakeholders indicated many consumers likely believed these intermediaries represented the whole market rather than a subset of the market.

The findings from the Ipsos Health Care and Insurance Australia 2011 survey also illustrate the confusion experienced by PHI consumers. 78% of respondents believe there is an urgent need to simplify PHI, and 66% of those without PHI who made enquiries about PHI in the last year were deterred from proceeding by the perceived complexity.²³ The top two frequently identified main things that caused confusion about PHI were “what is and what is not covered”, which 29% of those respondents confused about PHI identified as one of the main things they found confusing, followed by “the gap/out of pocket expenses”, which 19% identified as one of the main sources of confusion.

This confusion on the part of consumers is also a likely driver of low switching within the PHI industry. Despite the low switching costs faced by consumers due to legislated portability of cover requirements, evidence points to the fact that consumers are not actually switching frequently in practice. When a sample of 4,017 policyholders was surveyed by Medibank and asked how many times they had switched providers since they first took out PHI, only 15% indicated that they had done so in the past 3 years (Table 3.2). This represents an average of 5% switching per annum – a figure that is generally lower than or the same as comparable industries, such as life insurance and financial products. For instance, the current switching rate of transaction accounts is approximately 8-10%,²⁴ and in 2009, superannuation had a switching rate of 3-5%.²⁵ This may also reflect the fact that, given they are interacting with such a complex system, consumers of PHI products are likely to be risk averse.

Table 3.2: Switching behaviour survey results

Timeframe	Number of consumers who have switched
Within the last 3 years	15%
4 to 10 years ago	11%
Over 10 years ago	16%
Total who have switched fund	42%

Source: Medibank & AHM Segmentation Report - July 2012

Findings from the Ipsos 2011 survey also illustrate a lack of consumer understanding regarding portability protections, as 26% of respondents noted that they would have switched to another health fund in the last couple of years if they had known that there were no penalties or loss involved. In addition, only 2% of respondents to this question indicated that they had switched in the last couple of years.

To some extent, funds can also benefit from consumer confusion by pursuing a “set and forget” approach, which seeks to leverage the fact that consumers do not frequently switch funds. This strategy aims to recruit members when they are younger and healthier through low prices (through exclusions and their less costly nature in terms of benefit outlays) and then ‘retain and upgrade’ them through the course of their life. As consumers’ needs develop as they move into different income brackets, riskier health profiles, and changing circumstances or life phases, funds can try to optimise their trajectory as they migrate into more profitable products.

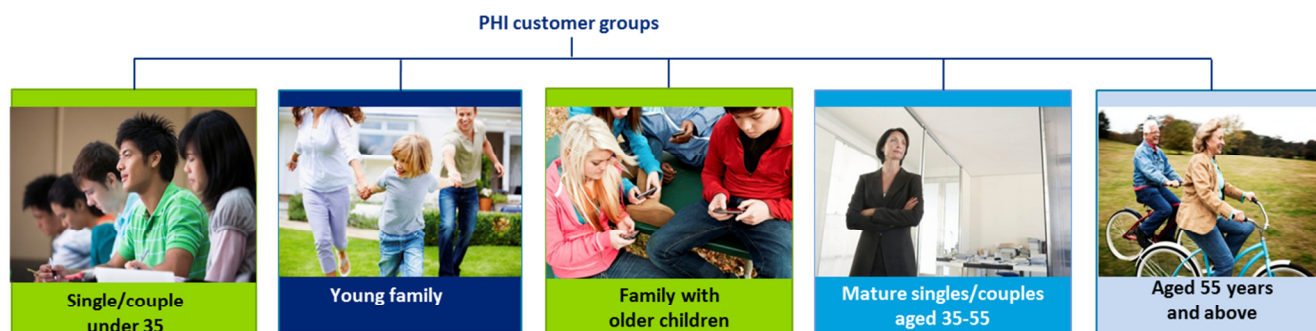
Figure 3.2 illustrates at a high level the profile of customer segments that form the base of this form of competition by funds.

²³ p.29

²⁴ Commonwealth of Australia, (2011), ‘Banking Services: Switching Arrangements’, p.4.

²⁵ Deloitte, (2009), ‘Dynamics of the Australian Superannuation System: The next 20 years 2009-2028’, p.22.

Figure 3.2: PHI customer segments



	Single/couple under 35	Young family	Family with older children	Mature singles/couples aged 35-55	Aged 55 years and above
Research time	Medium	Very low	Low	Low	High
PHI policy coverage / lifestyle requirements	<ul style="list-style-type: none"> Basic hospital cover Dental (wisdom teeth removal) Ancillary – physio, optical Covers injury caused by accidents 	<ul style="list-style-type: none"> Basic hospital cover Obstetrics related services Assisted reproductive services (fertility treatment) 	<ul style="list-style-type: none"> Basic hospital cover Dental Ancillary-physio, optical Covers injury caused by accidents 	<ul style="list-style-type: none"> More comprehensive hospital cover, including more extensive surgery options, non-PBS pharmaceuticals Value of extras cover 	<ul style="list-style-type: none"> Extensive hospital cover Most extensive surgery options – hip & joint replacement, non-PBS pharmaceuticals Palliative care Inclusion of medical aids – hearing/mobility Rehabilitation services
Information requirements / priorities	<ul style="list-style-type: none"> Price Ancillary 	<ul style="list-style-type: none"> Family benefits Waiting periods Price Out of pocket expenses 	<ul style="list-style-type: none"> Price Out of pocket expenses 	<ul style="list-style-type: none"> Family benefits Comprehensiveness of policy Waiting periods and pre-existing ailments policy 	<ul style="list-style-type: none"> Comprehensiveness of policy Ancillary benefits Waiting periods and pre-existing ailments policy Price
Method of information gathering on PHI options	<ul style="list-style-type: none"> Internet Online aggregators / brokers (i.e. i-Select) Word-of-mouth Television 	<ul style="list-style-type: none"> Internet Television Word-of-mouth Workplace benefits policy 	<ul style="list-style-type: none"> Television Internet Workplace benefits policy 	<ul style="list-style-type: none"> Television Word-of-mouth Workplace benefits policy 	<ul style="list-style-type: none"> Television Word-of-mouth
Likely reasons for choice of existing PHI cover	<ul style="list-style-type: none"> Findings of internet search; reliance on aggregators / brokers Peer word-of-mouth Employer's PHI Price 	<ul style="list-style-type: none"> Findings of internet search; reliance on aggregators / brokers Employer's PHI Cover Price 	<ul style="list-style-type: none"> Price Cover Findings of internet search Employer's PHI 	<ul style="list-style-type: none"> Employer's PHI Cover Price 	<ul style="list-style-type: none"> Extensiveness of cover Price
Likely decision points to cause PHI cover or insurer change	<ul style="list-style-type: none"> Poor service experience Marriage/de facto relationship Decision to start a family Change in employer Premia increase 	<ul style="list-style-type: none"> Decision to start a family Expecting another child Change in income/income throttled Poor service experience Change in employer Premia increase Change in product coverage 	<ul style="list-style-type: none"> Children become independent Change in income/income throttled Change in employer Premia increase 	<ul style="list-style-type: none"> Children leave home Change in health Poor service experience Change in employer Premia increase Change in product coverage 	<ul style="list-style-type: none"> Change in health Retirement Poor service experience Premia increase Change in product coverage
Yearly Proportion that switch funds	Very low	Very low	Low	Higher	Very low
Competition by funds for market	High Product exclusions allow funds to target customers in this age bracket	Moderate	Moderate	Moderate	Low
Impact on fund profitability	Positive	Negative	Positive to neutral	Positive to neutral	Neutral due to risk equalisation

...and funds have reduced buying power with hospitals

In addition to the impact of regulation on premium-setting and product development, funds are also affected by regulatory constraints on the supply side of the market, through the increased power of private hospitals as a result of Second Tier Default Rate regulations.

Funds are heavily reliant on their contracting arrangement with private hospitals, as the value that insurers provide to their members is affected by the portfolio of hospital products that they are able to offer—a factor that is entirely within the control of the hospital and its specialist physicians. Stakeholders observed during consultation that their ability to attract and retain customers is greatly affected by this value proposition, and that their purchasing decisions are affected by the “member noise” generated when consumers are dis-satisfied with the services/value for money that they perceive in their PHI cover.

Specialist physicians have significant market power within this supply chain, as they are a small and concentrated group (facing high barriers to entry due to the qualifications necessary in their field). Not only do they have significant market power, but physicians have an incentive to ensure that their patients face the minimum gap payment possible at hospitals (in fact, ideally a zero gap payment), as otherwise this will affect their patients’ ability or willingness to pay the premium they charge for their services. Hospitals therefore face pressure from physicians to negotiate the best outcome possible with insurers.

Second Tier Default Rate regulations require PHI funds to pay to the private hospitals with which they do not reach a contracting agreement benefits equal to 85% of the average contracted benefits. This severely mutes the bargaining power of funds in these contract negotiations with hospitals, essentially introducing a regulatory floor price, leaving a very narrow margin of 15% of rates that hospitals “have to lose”. This gives second tier listed hospitals significantly more bargaining power and security and makes them more aggressive in negotiations.

A number of anti-competitive impacts occur as a result of these Second Tier regulations. In the main, they have the impact of keeping inefficient hospitals in the market, reducing insurers’ ability to increase efficiency or negotiate reasonable prices, and increasing the power of inefficient hospitals with higher than necessary costs to secure the rates needed to cover their inefficient operations.

The premium-setting regulations that constrain the PHI industry’s ability to structurally adjust as required may further exacerbate these outcomes, preventing funds from increasing in size and leveraging economies of scale, which would increase their market power to bargain with hospitals and counter some of these uncompetitive outcomes. Of course, if PHI funds were able to secure a more affordable contracting arrangement with hospitals, they could in turn charge lower premiums to consumers. These impacts likely result in a transfer of economic rent from the consumers (patients) in the market to the producers (doctors).

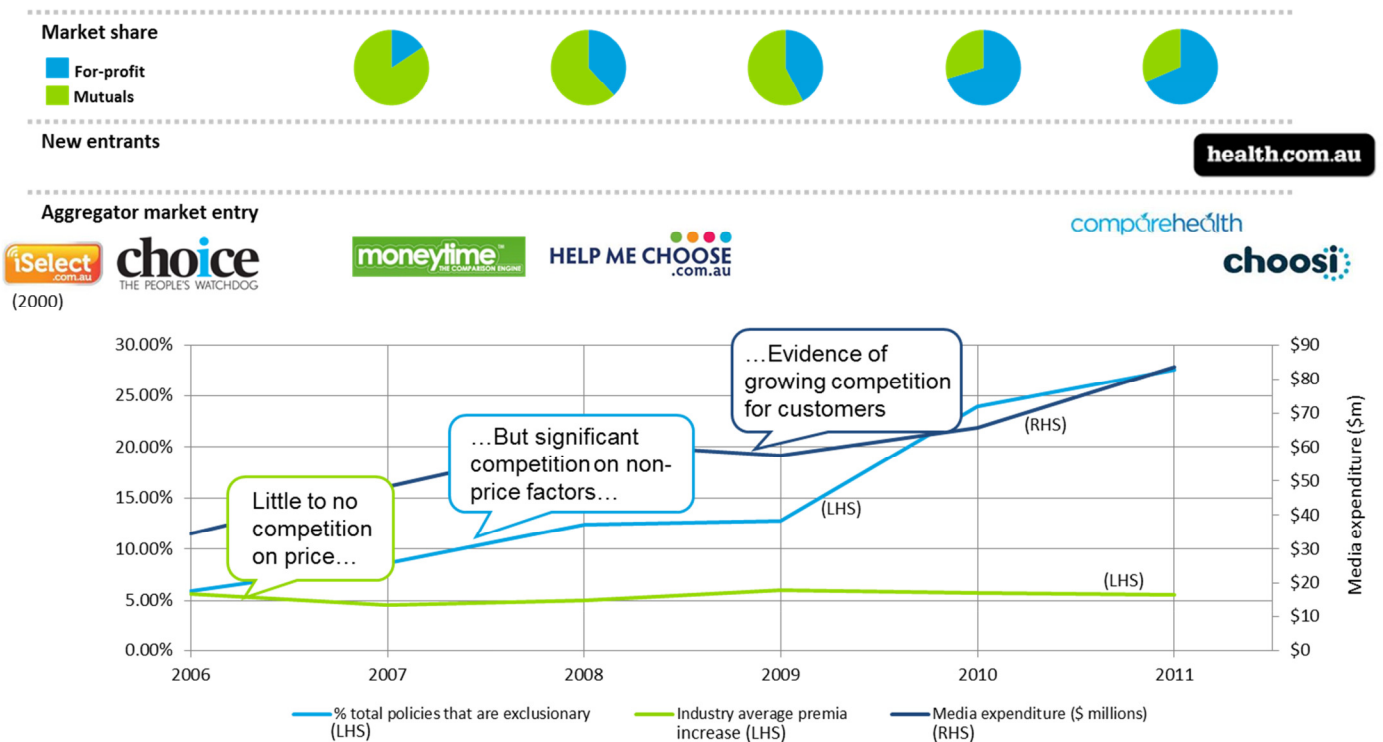
3.3 Conclusions

Overall, this chapter demonstrates that the PHI industry is moderately competitive, and that the elements required to provide a foundation for more significant competition are present. It also demonstrates, however, that this potential for competitive outcomes is muted to a great extent by existing regulation of the industry—most significantly by the impact of the current regulations

of premium-setting, but also by Second Tier Default rate and product regulation. This is further exacerbated by the lack of useful, accessible and comprehensive information for consumers.

Having said this, recent changes within the industry, most notably the shift to a predominantly for-profit industry model and the market entry, in response to market demand, of a range of fund aggregators as evidenced in Chart 3.6, provide the foundation for enhanced competition within the industry, thereby delivering improvements in consumer welfare.

Chart 3.6: Where the industry competes



Source: PHIAC, *Operations of Private Health Insurers Annual Reports and Statistical Tables 2006-2011*; average premia and media expenditure provided by Medibank Private; DAE analysis

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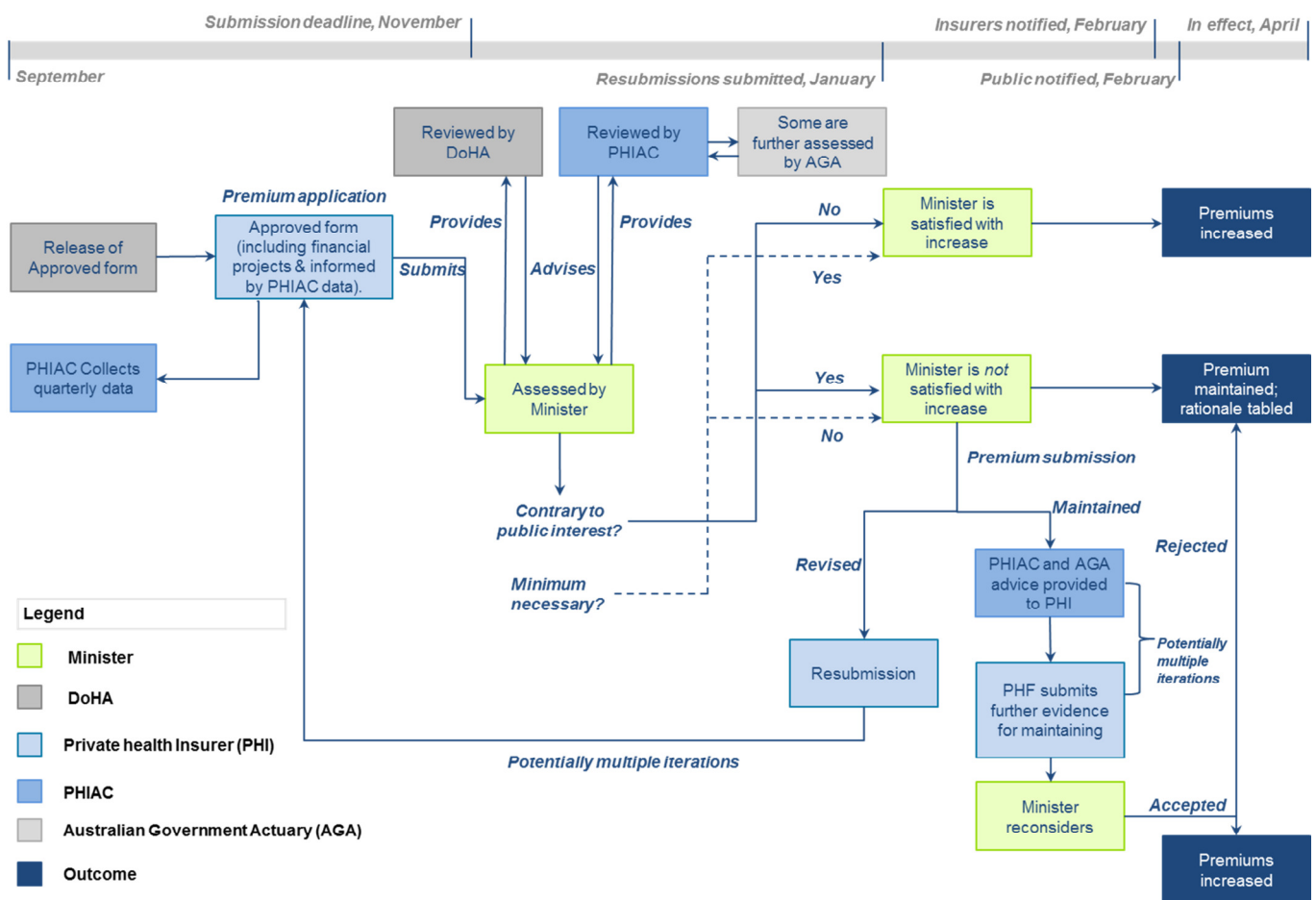
4 The current approach: benefits, risks and opportunities

Chapter 4 describes at a high level the current premium-setting process. This process is then assessed against appropriateness, efficiency and effectiveness criteria. Finally, the chapter discusses short-term opportunities for process improvement within the status quo, to ensure it promotes stakeholder interests as well as competition in the industry.

4.1 How the current approach works

There are several steps that must take place before a health insurer can change the premiums it charges for its products. A short summary of this process is outlined below, with further detail provided at Appendix C. Figure 4.1 depicts the current premium-setting process at a high level. **It should be noted that the timelines are indicative, as the timing for the application review process often changes year to year.**

Figure 4.1: High-level depiction of the current premium-setting process



Application forms for premium changes are released by DoHA in September or October of each year, and must be completed and submitted to the Minister for Health and Ageing by the November deadline. Insurers not applying for premium changes must advise DoHA by this submission date. Applications must meet a number of requirements, including the provision of a letter outlining key details of the premium change, information on the products for which the premium change applies, and relevant financial data, including forecasts of financial and operating data, such as contribution income, gross and net margins, management expenses, dividend payments, policy excesses and membership numbers.

Applications are assessed by the Minister for Health and Ageing. The Act specifies that premium increases must be accepted unless the Minister determines the premium change is not in the public interest, but also that an insurer may not increase premiums until the increase is accepted by the Minister. The Minister may seek advice from DoHA and PHIAC. Some applications are assessed by the Australian Government Actuary (AGA) upon the request of the Minister and, on occasions, additional information is sought from the insurer. Supplementary information, such as more detailed financial data, is assessed along with the private health insurer's application. If accepted, the premium increase applies from 1 April in the following year.

If rejected, insurers are notified and provided with a copy of the advice provided by PHIAC and the AGA to the Minister. Insurers are allowed to resubmit their applications to reduce the proposed premium change or provide further justification for the initial change proposed. If insurers resubmit, the proposed premium change passes through the same process. If the proposed change is eventually denied, the premium is maintained at its current level and a notice to this effect is tabled in Parliament within 15 days, along with the rationale for refusal. If the Minister accepts, the premium change is then implemented.

Changes to premiums are announced to the public towards the end of February, and come into effect on 1 April. This provides health funds with adequate time to notify consumers, which must be at least 30 days. The rationale for this requirement is to enable consumers to respond to changes and potentially seek alternative products or providers before the new premia take effect on 1 April.

4.2 Assessment of the current approach

The current approach is well established and has several strengths. Table 4.1 summarises the advantages and disadvantages of the current system against key performance criteria, which are discussed in detail below.

Table 4.1: Summary assessment of current approach

Criterion	Rating	Benefits	Risks
Appropriateness	✓	Prevents significant reduction in PHI membership and maintains stability in premium levels	Premiums may be higher than necessary if funds are 'pricing up' to regulated threshold
Choice	X	Keeps a range of funds in operation	Funds in operation may not be efficient or incentivised to innovate
Affordability	X	Premium levels are controlled	Funds have incentive to 'price up' to the regulatory threshold, 'game' the process
Sustainability	X	System ensures long-term financial viability of funds	Premia levels may be higher than necessary, to 'prop up' inefficient funds – poor consumer information limits switching between funds
Accountability	X	Funds are required to provide justification for premia increases	No 'right to appeal' for funds Government does not publicly state rationale for decisions For-profit Company Directors compromised with respect to ASIC market disclosure requirements
Prudential soundness	✓	Standards ensure solvency	Industry-wide propping up of funds with poor prudential practice
Predictability & timeliness	X	Consumers are informed of changes in a predictable and timely manner	Variable reporting requirements Lengthy cycle, subject to change and uncertainty
Transparency	X	Consumers receive transparent information on premium increases	Lack of transparent criteria used in assessment, or rationale for decisions
Productive efficiency	X	Funds are required to meet an MER that is low compared to other industries	Propping up inefficient funds No incentive for funds to improve technical efficiency (e.g. MER)
Dynamic efficiency	X		Does not allow structural change No incentive for funds to improve dynamic efficiency
Summary rating	X	Overall, a number of risks have been identified throughout the current process, which introduce uncertainty, inefficiency and risk into the premium setting process. These are discussed in detail below.	

4.2.2 Appropriateness

The current system of reviewing and approving proposed changes to health fund premia supports the underlying goals of government to support and bolster private health insurance membership in Australia. The annual review process serves to ensure that funds remain solvent, while controlling premium increases so as to encourage continued membership.

4.2.3 Performance against effectiveness criteria

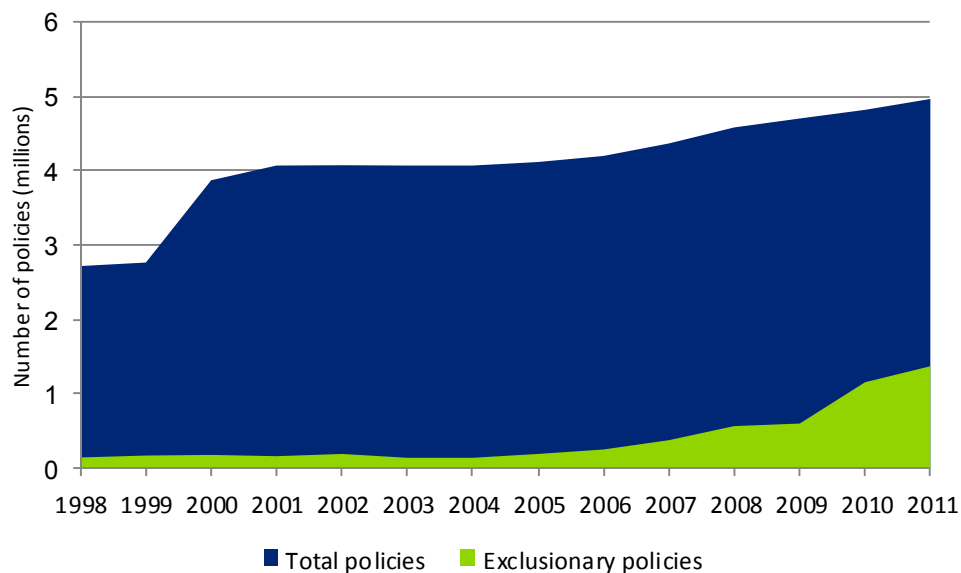
Overall, the current process tends to include best practice from the area of prudential regulation but not from the area of pro-competition regulation. It would appear that the current process could be more effective in encouraging the industry to innovate and compete on price. Our findings are based on analysis of the relevant effectiveness criteria:

- **Choice**—There is currently a significant range of options open to consumers in the PHI market, with 34 funds offering a product range that various stakeholders estimate at between 22,000 and 28,000 PHI products in the market. Stakeholders have indicated that the annual review process serves to prevent funds from becoming insolvent (e.g., ‘what is minimum necessary to stay in operation?’), thereby maintaining this level of choice among products and funds. Incentives to become more efficient, on the other hand, are muted.

A lack of price competition leads to funds competing on other factors, including product variation. Funds have responded to price controls by significantly expanding the number of products on offer, with various permutations of exclusion and coverage. At the same time, other regulations limit the types of product innovations that funds can bring to market.

Chart 4.1 shows the recent rise in the proportion of policies that contain exclusionary elements.

Chart 4.1: Number of exclusionary policies and total policies, 1998-2011



Source: PHIAC data (1998-2011); DAE analysis

The total number of policies increased from 2.72 million in 1998 to 4.97 million in 2011. While this reflects greater choice, the number of exclusionary policies has also increased, most notably since 2007. Stakeholder consultations indicated that consumers are often unclear about the effect of exclusionary clauses. As explained in Section 3.2.2, larger number of policies might widen choice but greater incidence of exclusion adds to confusion among consumers and potentially renders the wider choice ineffectual.

These stakeholder views are consistent with the findings of Section 3.2.2, which posited that a wider range of choice can be detrimental to consumers, as there may be a loss of consumer surplus associated with excessive choice in a market with information asymmetries.

While currently operating funds offer a wide range of products, there are high barriers to entry for any prospective new fund. High levels of risk associated with the regulatory environment, combined with low profit margins, make the market less attractive and more difficult to enter. This limits the choice of funds offered to consumers, even while incumbent funds offer a wider choice of products.

- **Affordability**—At first blush, in aggregate terms, it would appear that the current regulatory process ensures that private health insurance premia do not rise unreasonably. It prevents private health insurance providers from “price gouging” overall—charging unreasonably high premia—by rejecting proposed changes to premiums that are “contrary to the public interest”. The idea is that increases in premia remain stable and affordable over time, thus assuring affordability to households and families.

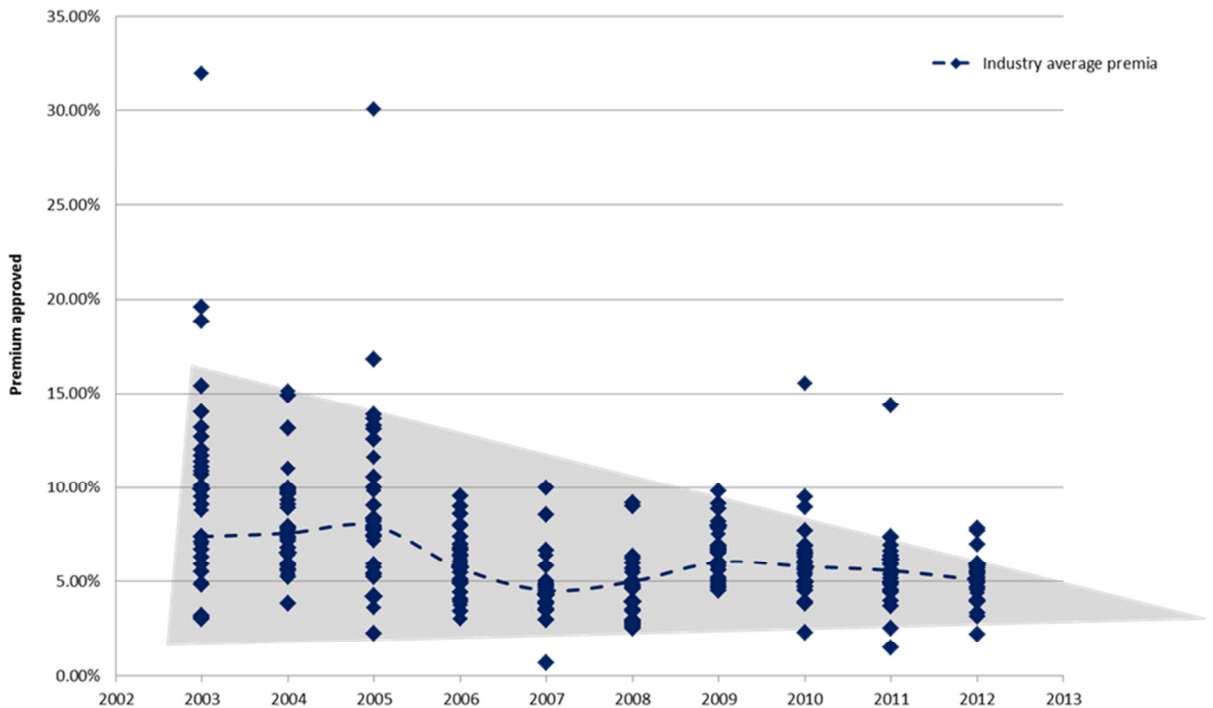
At a product and service level, however, the picture is less certain. The current process does not collect detailed data at a product level. Government cannot therefore consider prices relative to benefits paid by membership class and determine whether prices by consumer group are affordable. Moreover, the current process also does not consider the total cost and value for money of PHI to the consumer/patient because it ignores gap payments that are often only revealed at the time of treatment. With nearly one in five health dollars being contributed by patients directly, on top of PHI contributions, this does raise questions as to whether the system has the capacity to drive efficiencies through PHI into the private health sector.

In addition, even at the aggregate level, there are further uncertainties due to risks of funds ‘gaming’ the system. The current ‘blind tender’ nature of the annual application and approval process facilitates strategic behaviour by providing funds with ‘herd protection’. By synchronising approvals, competitive signals in the market that would otherwise indicate to funds what a reasonable premium might be to secure market share are removed, thereby rendering the safest move to maximise the potential increase and then revise if necessary.

In addition, while the “public interest” test ensures that premia do not increase unnecessarily (e.g., above ~5% per annum as observed historically), given that the ‘game’ has been repeated each year, and data are released quarterly for funds to review other funds’ current aggregate financial positions, there is the real possibility that some funds have started to ‘price up’ to perceived regulated benchmarks.

As introduced in Chapter 3, Figure 4.2 illustrates that premiums for each fund are generally tightly clustered around the announced industry average. Moreover, it is evident that this trend has increased since 2008, with the clustering effect becoming more condensed. This lack of variability suggests that gains in efficiency may not be passed on, with funds choosing to ‘price-up’ to the perceived regulated benchmark.

Figure 4.2: Premia approved for each fund, 2003-2012



Source: Data provided by Medibank Private; DAE analysis

The political nature of the current submissions process gives funds the incentive to propose initially high increases (as a bargaining position), with the knowledge that these will likely be negotiated back. Each provider must focus on winning its required increase from the regulator, and rather than having a reasonable position rejected on political grounds, may initially submit a higher request in recognition that the regulatory process has become one of negotiation. Essentially this leads towards “pricing up” to a regulatory benchmark. This dynamic is supported by the ‘blind tender’ nature of the process, in which funds must submit proposed price changes without knowledge of the actions of their competitors, meaning that funds are unable to observe and respond to the moves of competitors in the market.

In addition, the relatively low frequency of the process means they may not be able to respond to adverse events, such as changes in government policy or market conditions, in a sufficiently timely manner. To hedge against the possibility of these events, providers may submit a higher increase than would be necessary if they had greater pricing freedom.

- **Sustainability**—By assessing proposed premium increases with reference to a fund’s solvency and prudential soundness, the current process supports the financial sustainability of the system. It could also be argued that in the short term the current method helps to sustain membership levels across the community by reducing risks of significant price variation, which in turn supports the system as a whole.

In the longer term, the current process prevents structural changes that could lead to a more competitive market, and in turn lower prices to consumers. At the margin larger scale, consolidated health funds would have increased buying power with hospitals (although the major limit on competition is likely to be a function of 2nd tier safety net arrangements), thus

enabling improved contracting negotiations with hospitals and decreasing the premia paid by consumers.

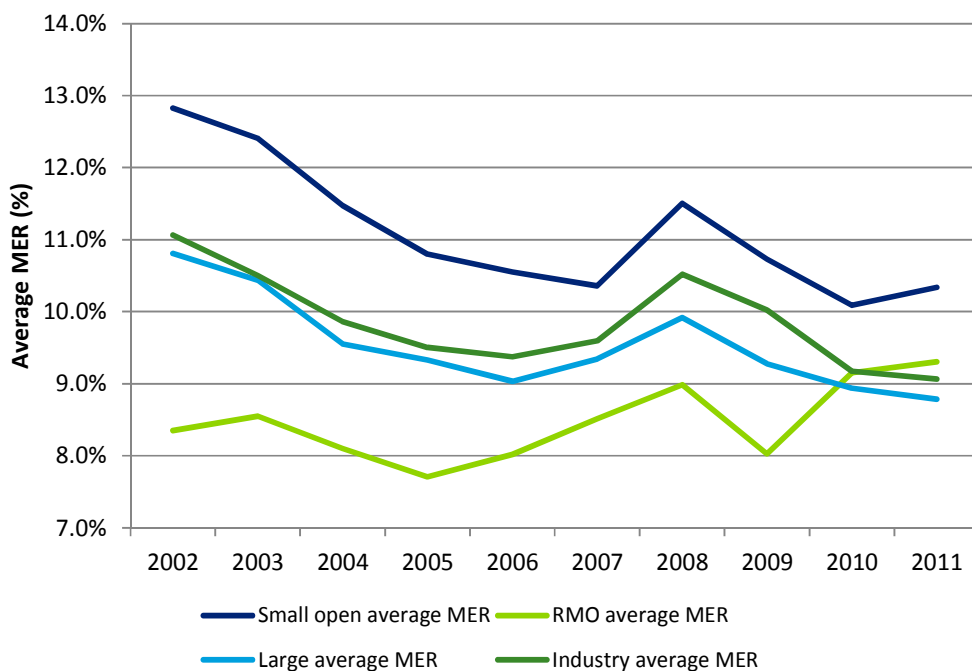
Further, consolidation could result in some of the less efficient funds with higher MERs merging with more efficient funds. This could lead to lower management expenses in the industry through increased economies of scale, making it more efficient and sustainable on the whole. For example, Chart 4.2 presents the average percentage of assets that each fund type has spent on management expenses over the period 2002-2011 (the MER). This illustrates that smaller funds have consistently had a higher MER compared to the industry average over this ten year period, while larger funds and RMO's have operated below the industry average (on average over the same period).

Since RMO's have the ability to exclude consumers, they are consequently more likely to cater for a smaller pool of consumers, and can thus reduce their management costs through fewer product variations and offerings, as well as reduced membership numbers and characteristics. In contrast, larger funds have MERs below the industry average potentially due to economies of scale, and their premia are more constant and less significant in their deviation from the industry average, compared to small funds.

The current process provides for premium increases to ensure solvency. All things being equal the higher the management expenses across the industry, the higher the average approved premium increase to ensure fund solvency.

Small firms also tend to be riskier (Chart 4.3) and have a higher solvency ratio than larger firms.

Chart 4.2: Average MER by fund type



Source: PHIA data; data provided by Medibank; DAE analysis

Muting the ability for structural change may be detrimental to the industry’s long-term sustainability, and in turn the sustainability of the private healthcare sector alongside the public system.

- **Accountability**—The current method of determining increases in health insurance premia seeks to uphold the public interest. This is enshrined in legislation, with the Act stating that “The Minister must approve the proposed changed amount ... unless the Minister is satisfied that a change ... would be contrary to the public interest.”

However, the lack of definition of ‘public interest’ and detail around the criteria or rationale for making decisions (unless a change is disallowed) mean that the Minister cannot be held responsible by the public, or funds, for any decisions. Therefore, while the legislation could be interpreted as requiring the Minister to intervene on a selective basis, in practice, in the absence of more detailed guidelines, the Minister intervenes on every decision.

Insurance core principles, developed by the International Association of Insurance Supervisors, state that best practice enforcement requires supervisory bodies to “enforce corrective action ... based on clear and objective criteria that are publically disclosed”.²⁶

Many similar bodies worldwide involved in regulating, documenting and/or assessing insurers have complied with these guidelines. For example, in Australia, the Institute of Actuaries has set out clear guidelines for its members regarding the methodology, assumptions and reporting standards that should be used in preparing documentation to support a premium variation application. However, the Minister does not provide detail on the data used, assumptions made or methodology employed to come to a decision. The current system thus fails to meet best-practice standards, as the Ministerial review process fails to publicly disclose the rationale and criteria used to come to determinations regarding premium increases.

The Minister has the ultimate power to reject or accept any application to change premia. As detailed in Appendix C, if the Minister rejects a submission, insurers are given the opportunity to revise and re-submit their proposal or provide further justification. Subsequent to this, the Minister is accountable for continued rejection in the sense that the rationale for the decision must be tabled in Parliament. However, Ministerial decisions are not reviewed by an independent body. Further, while health funds may seek judicial review of the Minister’s decision-making process, they do not have the right to appeal a Ministerial decision. Thus the level of accountability of the current system does not meet best-practice requirements, introducing higher risks than necessary.

As explained by the Administrative Review Council (ARC), public bodies, such as the Minister, must be accountable to the public for the use of powers granted to them (ARC, 2007). Table 4.2 shows the performance of the current approach against accountability measures set out by the ARC.

²⁶ International Association of Insurance Supervisors, 2011. “Insurance Core Principles 11: Enforcement.”

Table 4.2: Performance against Decision Making Accountability Guidelines

Measure	Option's performance against measure
Provide reasons for decisions	X
Empower bodies such as the Ombudsman to investigate complaints and to conduct investigations	✓
Provide affected parties with the right to apply to a court or tribunal for review of a decision	X
Provide affected parties with the right of access to agency records under freedom of information legislation	X

Source: Administrative Review Council (2007) p.1

Under the current process, the Minister does not provide the rationale for any decisions made to funds. While funds whose applications are rejected in the first instance are provided with the advice given by PHIAC and the AGA to the Minister, they do not have the right to access internal documents prepared by the Minister relating to the decision. Further, as explained above, while providers have the right to appeal on the basis of procedural errors, they have no right to appeal the decision itself (NERA, 2005).

In addition, the variation year-to-year in the approvals process and common requirements for multiple iterations of price negotiations between DoHA, PHIAC and funds also create accountability concerns for directors of publicly-held funds subject to continuous disclosure obligations under the Corporations Act. Company directors are potentially placed in jeopardy by the PHI Act's requirements for confidentiality regarding premium negotiations and the Corporations Act requirement to continuously disclose developments to the market in a timely manner. Given that funds are expressly required to maintain confidentiality of premium negotiations with the Minister under the PHI Act, this could sustain a defence of directors of publicly-held funds against breach of continuous disclosure requirements, except in the event that the substance of such negotiations was "leaked" and became a matter of public record. If the negotiations became public, then continuous disclosure would require all substance of negotiations to be divulged. Given that the risk of confidential negotiations being leaked always exists, directors are permanently at risk of a conflict between the two sets of obligations, placing them in jeopardy.

- **Prudential soundness**—Each health fund applying to change its premium levels is required to provide actuarially approved financial forecasts. PHIAC assesses these documents in order to ascertain whether the proposed changes could adversely affect the financial stability of the fund.²⁷

This promotes the prudential soundness of funds, by ensuring that the long-term viability of any given fund is assessed and considered on a yearly basis as part of the premium review process. There is evidence of the success of the approach on this front, with no registered health funds having passed into administration since the establishment of the current scheme in 2007.

However, while the current system ensures the prudential stability of individual funds, it may act to the detriment of the industry's soundness as a whole. By granting higher premium

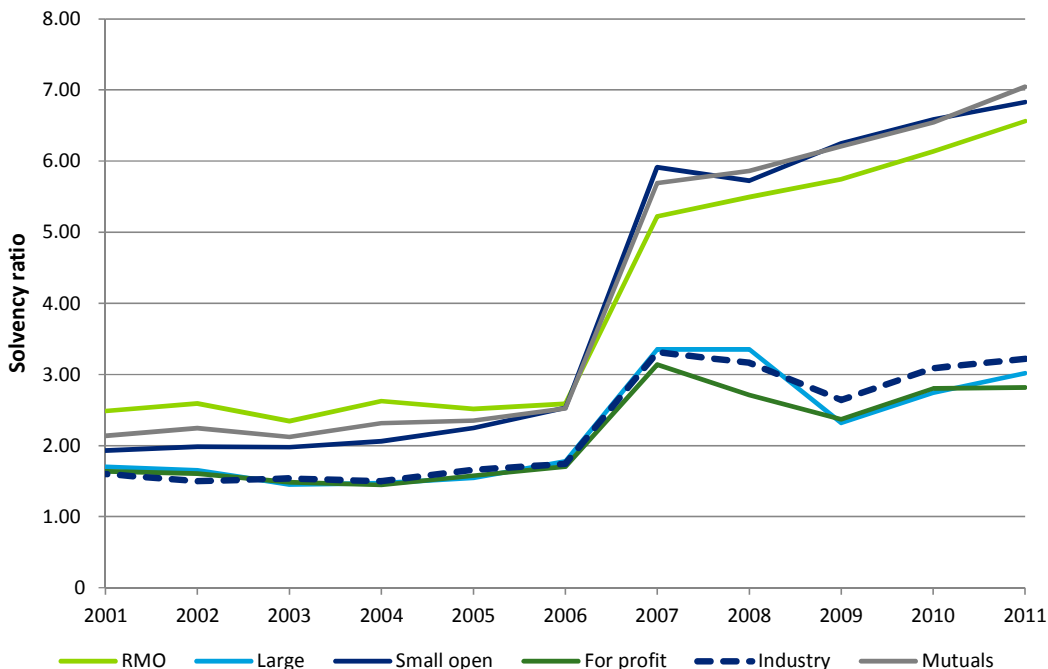
²⁷ National Health Act, 1953

increases to less efficient funds, the process effectively guarantees that all currently registered insurers remain operational indefinitely. Propping up inefficient funds in this manner undermines the long term stability and soundness of the wider industry in that it prevents structural change that might lead to the whole industry being less risky.

The solvency ratio of a fund reflects the number of times a fund can meet its solvency reserve, calculated as the solvency reserve divided by capital. As Chart 4.3 demonstrates, large funds have a solvency ratio that follows the industry average, whereas the smaller firms, comprising both open and RMO funds, have had ratios higher than the industry average from the period 2002 to 2011.

There are several reasons why smaller funds may have more capital in reserve. Firstly, regulators may perceive them as more risky due to their smaller market share and higher MERs, thereby requiring them to carry more solvency reserves. It may also reflect smaller funds pricing up to the regulatory threshold and engaging in gaming, thereby exaggerating their initial premium increase request so as to retain their desired amount after re-submission. It is both unsustainable and inefficient for these smaller funds to be accumulating this level of capital and requesting higher premiums. Similarly, the for-profit funds have a solvency ratio closely aligned to the industry average. This might be explained by their desire to keep the solvency ratio at the necessary amount so that they can maximise dividends to their shareholders.

Chart 4.3: Solvency ratio by fund type



Source:

PHIAC data (2001-2011); DAE analysis

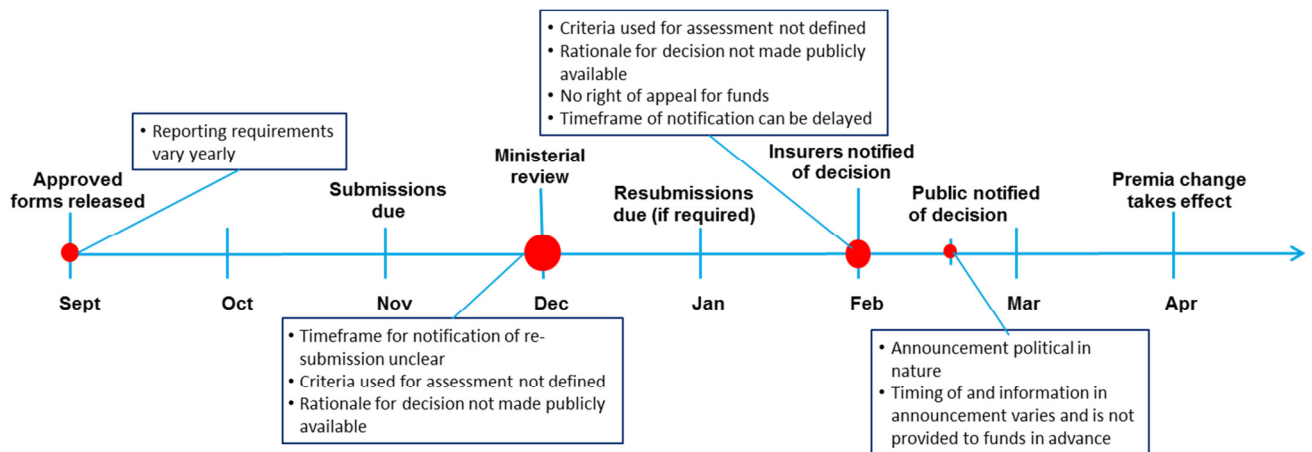
- **Predictability and timeliness**—The annual announcement of changes to health fund premia has been well established, and is widely accepted by consumers. Scheduling changes for the

same time every year increases predictability, as consumers can structure their decisions to switch or join funds around these dates.

For health funds, the process involved in a premium increase is set in legislation and well known. However, the approval form can be changed by the Minister, causing specific reporting requirements for health funds to vary from year-to-year. For instance, the approval form has recently been changed to introduce new criteria, including net margins. Further, health insurers face unpredictability in the timing of decisions, with funds receiving Ministerial approval in dates ranging from January to late March. This lack of predictability and consistency increases the reporting burden on health insurers.

Figure 4.3 depicts the key sources of uncertainty through the premium change approval process, with larger red dots representing greater uncertainty. Ambiguity is introduced at several stages throughout the process. For instance, the schedule of required documentation varies from year to year, meaning that funds are unsure of what information they will be required to provide. The lack of transparency in the Ministerial review process is a significant source of uncertainty; funds are unsure of what criteria the Minister uses to assess applications, and also do not know when, if at all, they will be required to re-submit their proposal. This uncertainty continues after re-submission, as the rationale for final decisions is not provided. Combined, these factors mean that the system is less predictable and timely than desirable. This can cause funds to raise premia more than necessary in order to price in the risks faced through the process.

Figure 4.3: Uncertainty in the current premium-setting process



Source: DAE analysis

- **Transparency**—Having an annual and simultaneous announcement of increases in public health insurance premia by all private healthcare providers provides some transparency to consumers. Consumers who wish to change products or providers may do so on an informed basis after the announcement with certainty that they will not face further rate rises until the following year.

However, the current Ministerial approval process is largely veiled from health funds. As detailed in Appendix C, Section 66-10 (3) of the Act specifies that premium increases must be accepted unless the Minister determines the premium change is not in the public interest.

However, no explanation is provided in the Act or elsewhere on what constitutes the ‘public interest’, or how the Minister determines this.

Similarly, it is specified that the Minister considers whether premium increases are the “minimum necessary” to maintain affordability while maintaining solvency requirements and prudential standards. The metrics and benchmarks used to assess this are unknown to the industry. Further, the rationale for introducing new tests and benchmarks, such as the recent introduction of the ‘net margin’ test, are not provided in a transparent manner.

Thus the lack of explanation regarding the reasoning and process behind Ministerial decisions renders the system opaque rather than transparent both to health funds and the general public.

4.2.4 Performance against efficiency criteria

The current process performs poorly against efficiency goals:

- **Productive efficiency**—The current process of approving proposals has the benefit of monitoring and ensuring the sustainability of individual funds in the short to medium term by ensuring that all funds obtain premium increased needed to ensure their prudential soundness. But by possibly preventing structural change from occurring within the industry, there may be a number of funds in operation that are technically inefficient, and by supporting this inefficient industry structure the regulatory system contributes to productive or technical inefficiency within the healthcare system.

Under the current system, funds which minimise controllable expenses are penalised. Lowering managerial expenses should give firms an opportunity to increase their profits; however, funds with increased profitability are granted lower allowable premium increases in the Ministerial approval process, which discourages them from improving their technical efficiency. Thus, the process encourages funds to be less efficient, retaining a higher level of costs than necessary in order to apply for higher premium increases.

- **Dynamic efficiency**—Similarly, this method of implementing changes to premiums does not support dynamic efficiency, as it supports a static, stable system. It does not facilitate entry to, or exit from the health fund market, as the regulatory burdens and inability to set prices independently constitute a barrier to entry, while the process of approvals keeps less efficient firms in the market. Moreover, the premium approval process does not require PHIAC to determine whether claim payments are most effective and efficient way of providing care, and consequently incentives and rewards for controlling claims costs are reduced. In the current system it is easier to accept regulated price and reduce claims costs by slightly changing co-payments than by finding better clinical paths or by ‘winning big’ in a hospital negotiations (which are also constrained due to 2nd Tier safety net arrangements).

4.3 Opportunities for change

There are several short-term reforms which could be implemented in order to address aspects of the current system identified in Section 4.2. These are outlined below.

Criterion	Summary rating	Benefits	Risks	Short term opportunities for change
Appropriateness	✓	Prevents significant reduction in PHI membership and maintains stability in premium levels	Premia may be higher than necessary if funds are 'pricing up' to regulated threshold	
Choice	X	Keeps a range of funds in operation	Funds in operation may not be efficient	
Affordability	X	Premium levels are controlled	Funds may 'price up' to the regulatory threshold	Improved data collection/analytics
Sustainability	X	System ensures long-term financial viability	Premium levels may be higher than necessary, to 'prop up' inefficient funds	
Accountability	X	Funds are required to provide significant justification for premium increases	No 'right to appeal' for funds Government does not publicly state rationale for decisions Company Directors compromised with regard to ASIC obligations	Establish customer charter Release guidelines outlining definition of assessment criteria and process
Prudential soundness	✓	Standards ensure solvency Process allows an orderly identification of funds in difficulty	Supporting funds with poor prudential practice	
Predictability & timeliness	X	Consumers are informed of changes in a predictable and timely manner	Variable reporting requirements Lengthy cycle, subject to change and uncertainty	Condense approval process Allow for continuous, asynchronous approvals Align approval process with financial year
Transparency	X	Consumers receive transparent information on premia increases	Lack of transparent criteria used in assessment, or rationale for decisions Consumers may be confused by a halo effect from Ministerial approval, discouraging them from researching the market	Release guidelines outlining definition of assessment criteria and process Establish customer charter

Criterion	Summary rating	Benefits	Risks	Short term opportunities for change
Productive efficiency	X	Funds are required to meet an MER that is low compared to other industries	Propping up inefficient funds No systematic incentive for funds to improve technical efficiency (e.g. MER)	
Dynamic efficiency	X		Does not allow structural change No long term reward for funds who improve dynamic efficiency	

4.3.1 Greater transparency

Establishing well-defined guidelines on the metrics used by the Minister in decision-making would improve the transparency and predictability of the process. Guidance could be quantitative or qualitative, and include more detailed information on matters such as:

- the definition of “contrary to the public interest” for the purpose of the Act, what metrics the Minister uses to determine this and when it is to be applied;
- formulae or qualitative guidance as to what constitutes the “minimum necessary” premium increase, and how this is determined; and
- quantitative guidance regarding the net margin cut-offs used and the rationale for the inclusion of this criterion in assessment.

Greater transparency would increase the level of certainty for funds throughout the process, and reduce the necessity for them to factor in large bargaining positions throughout the premium-setting process.

4.3.2 Increased timeliness

As previously discussed, the current premium setting process can take up to 8 months from the release of approval forms to funds being notified of approval (it generally takes close to 6 months), and additional risks to funds arise as a result. These risks could be mitigated by speeding up the processing cycle. If funds were able to submit their applications later in the year due to quicker processing, they could tailor their proposals to more recent market information and policy changes, making pricing more reflective of true costs.

The system’s timeliness could also be improved by having multiple rounds of proposals per year; for instance, applications could be considered and implemented on a bi-annual rather than annual basis. This would allow funds to be more agile and competitive, by enabling quicker price reactions to changes in circumstances or actions by competitors. Further, it may lead to lower premium increases, as funds have less need to price against the risk of unforeseen market

movements. However, this may be undesirable from a consumer perspective, as consumers will be less likely to monitor and respond to price changes if they occur more frequently.

Given the additional work required to undertake an additional round of premia change review and approval, this option may require greater funding of the regulator: currently PHIAC operates on a budget of \$5.4 million in 2011-12, compared with a budget of \$114.8 million²⁸ for APRA.

4.3.3 Continuous, asynchronous approvals

As discussed in Section 3.2.2, the current system has the potential result of inducing funds to seek the highest approved premium increase, rather than competing with each other on price.

To overcome this, the system could be changed so that the annual premium process instead becomes a continuous asynchronous process, in which funds are able to request premium change approval at any time during the year. Similarly, announcements on changes in premia would take place on a continuous and asynchronous basis, after each proposal had been reviewed and approved.

This would introduce greater competition into the system, as funds would be able to review the actions of their competitors before making pricing decisions, and tailor their own reactions accordingly. This should place downward pressure on premiums, as it will enhance funds' ability to compete on price and reduce the need to price in the uncertainty currently associated with being able to change premia only once a year. As a result, affordability would likely increase under this option.

This change will similarly drive improved productive efficiency relative to the status quo, as funds are more likely to respond to competitors' premium levels and compete on price, encouraging them to implement more efficient methods to produce the same level of output at lower cost and reduce their MER. This may also encourage funds to allocate resources in a more efficient manner so as to reduce costs and remain competitive against other funds.

The predictability of the premium approval process may also increase slightly, as funds will gain increased insight into whether funds that applied earlier in the year had their applications accepted, and the level of increase that was accepted by the Minister. However, given the additional work required to undertake continuous premium change review and approval, this option may also require additional funding for PHIAC, as outlined in Section 4.3.2.

Figure 4.4 Case study - CTP insurance and approval staggering

In New South Wales, compulsory third party (CTP) motor vehicle insurance is referred to as the Green Slip scheme. It is a legal requirement for all motor vehicle owners that cover compensation for those injured and killed in motor vehicle accidents. The Motor Accidents Compensation Act 1999 prescribes the scope of cover required under CTP, meaning all insurers are legally required to offer the same policy cover and only differ in terms of price. The system is regulated by the Motor Accidents Authority (MAA) whose role is to ensure fair pricing and scheme viability.

The market for Green Slips is relatively small, with the MAA only providing licenses to seven insurers to sell policies. The MAA therefore has control over market entry. One insurer, NRMA, holds 37.8% of the market

²⁸ Estimated actual for 2011-12, http://www.treasury.gov.au/~media/Treasury/Publications%20and%20Media/Publications/2012/Portfolio%20Budget%20Statements%202012%2013/Downloads/05_APRA.ashx

share, followed by QBE with 16.7%, and Allianz and GIO with 12.9 and 12.2 respectively. It thus has a similar market structure to the PHI industry, with market share dominated by a couple of funds whilst smaller funds comprise the remaining share. Given Green Slip is compulsory, funds similarly to PHI cannot refuse members regardless of their risk profile.

Premiums for CTP insurance are set through a continuous asynchronous price approval process. Prices are set by the individual insurer at any period during the year. It is compulsory for funds to submit premia schedules to the MAA once a year at the same time, in addition to requesting approval when they wish to change the premia during the year. For instance in 2010-11, nine non-compulsory filings were submitted, compared to eight in 2009-10 and eleven in 2008-09. Of the nine voluntary filings in 2011, three came from GIO and two from Zurich. The main reasons for additional changes included inflation, increased estimates pertaining to the number and cost of claims and a lower discount rate which impacted funds' investments.

Insurers must also follow certain rules when implementing changes, as specified in the MAA Premiums Determination Guidelines. This is to ensure changes are transparent and not excessive. It entails basing premium changes on publically available price ranges for vehicle type and garage location as determined by independent actuaries, and the risk profile of the consumer such as driver's age, claims history, demerit points, years licenced and vehicle age.

The price range helps to cross-subsidise younger drivers, who are often required to pay higher premiums which may be unaffordable, which is particularly problematic given the compulsory nature of Green Slip. A fixed percentage of the premium comprises a Medical Care and Injury Services levy, which assists to medical services and the MAA's operating costs.

As part of its role during this submission process, applications are assessed by the MAA to ensure they are compliant with legislation and guidelines, and a decision to reject the change is typically made within six weeks. The MAA has asked funds to refile their submissions, the most recent of which was in January 2012. MAA is able to reject proposed changes to premiums on several conditions:

- If the premium does not fully cover the insurers liability;
- If the premium is considered excessive; or
- If it does not comply with MAA's Premiums Determination Guidelines.

The MAA strongly encourages consumers to price compare, thereby promoting competition within the industry. This is reinforced through a price comparison service operated by the MAA.

Source: Motor Accidents Authority, accessed 2nd October 2012, via <greenslips.com.au> and <www.maa.nsw.gov.au>.

4.3.4 Governance structures

More clarity on the roles and responsibilities of the parties involved in the premium approval process would provide greater certainty and predictability for health funds, as well as improving accountability.

Introducing a PHIAC Departmental 'customer charter' or performance goals for the process could be considered. The adoption of customer charters by regulators is commonplace within Australia today:

- The ACCC has a Service Charter that outlines its commitment to standards of service and actions that the public can take if these standards are not met. The charter addresses areas including responsiveness, information, external review and complaints and feedback.
- APRA's Service Charter explains its supervisory role and what financial institutions and the public can expect with regards to its function. Specifically, it outlines its values, mission, supervisory approach, what it takes into consideration when developing prudential requirements, supervision activities of financial institutions, information to be provided to the public, and performance and accountability reporting practices.

- The Essential Services Commission has a Charter of Consultation and Regulatory Practice, in which it provides information regarding its processes for identifying and conducting inquiries. This Charter states its objectives, functions, work program, consultation processes and principles, approach to regulatory practice and program review.

The department could set similar benchmarks for itself to measure its performance throughout the premium setting process. Releasing these publicly would make the process more accountable, and give funds greater guidance as to what to expect throughout the process.

4.3.5 Reporting frequency

The current system requires annual reporting by the funds to the Minister on a series of metrics as part of the approval process, with required information including, but not limited to:

- solvency reserves;
- capital adequacy reserves;
- gross and net margins;
- capital management;
- management expenses;
- drawing rates; and
- components of premium change.

Similarly, the reporting cycle could be restructured to match the financial year. At present, the timeline means that requests for proposal revisions often come during the Christmas break, when key executives are on leave. This makes it difficult for funds to consult with their Boards before re-submitting premium increase requests, thus impeding good corporate governance practices for insurers. Aligning the reporting cycle to the financial year would ensure that key staff members are available as necessary. Further, it would avoid duplication of effort, as funds would have already prepared appropriate documents as part of their financial reporting.

4.3.6 Data collection and analysis

Another possible short-term reform would be allowing funds to submit data electronically. This may reduce compliance burdens for firms, enhance confidence in the system, and increase the ability of the Minister to process applications in a more timely manner.

Digital data collection could also facilitate more informed decision-making. Funds could submit initial data with their application, and then update as necessary throughout the process as more recent financials become available. This would improve the ability of the process to use up-to-date data. As such the Minister could tailor a decision on premiums to reflect current market circumstances and operations of funds. Given the ability to update key data, this would also reduce the need of funds to price in such a significant level of uncertainty as under the status quo, thereby potentially lowering prices.

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5 Alternative approaches – medium term opportunities

This chapter assesses three alternative options for regulating the premium-setting process: a capped net margin model, capped gross margin model and price monitoring. A fully deregulated model was considered at a high level, but discarded as a viable short-term option as the potential risk of unchecked premium growth was considered to be at odds with the appropriateness test, at least in the short term. For all other options, the chapter describes how each option could work and then assesses each of these against the evaluation framework set out in Chapter 2, relative to the status quo regulatory arrangements. The chapter concludes with a discussion of the advantages and disadvantages of each, as well as the potential policy changes that might ideally complement the regulatory reform, in order to optimise outcomes for the community.

5.1 Options considered

While there are a number of things that could be implemented to improve outcomes within the bounds of the current approval-based regulatory approach (Section 4.3), a number of the weaknesses of the current system can only be addressed through regulatory reform. Following a literature review of potential alternative approaches (See Appendix A), four potential options for reform were identified (Table 5.1). The magnitude of regulatory change varies considerably among these options, from a fully deregulated model, to a light-handed price monitoring approach to a more involved margin cap system, based on formulae to prescribe net or gross margin.

Critically, however, our initial review of the options against the appropriateness test—that is, the reform would pose little or no risk to membership levels in the context of other policy levers—found that the deregulation approach did not meet this test.

Deregulation would involve the removal of all regulatory controls over premiums, enabling premiums to be set through market forces, which has been argued to be the most efficient means to determine prices in a competitive market. Indeed, a number of prior analyses have argued the merits of full deregulation.²⁹ Without any potential levers to arrest unexpected price growth, Australia could risk a return to the adverse selection cycle that could see membership levels decline, even in the context of other policy mechanisms. Given this risk, this is not a meaningful option in the current environment; this option was not therefore considered in significant detail.

²⁹ For example, see NERA (2005), *A Review of Industry Pricing Models: A Report for Medibank Private*.

Table 5.1: Regulatory option definitions

Option	Description	Passes appropriateness test?	Precedents
Deregulation	Removal of all regulatory constraints on the premium setting process so that funds can implement changes when, and to the extent, that they wish.	X—This option is not considered due to the potential risk for price rises that might reduce effectiveness of other policies designed to support high membership levels – can only be considered as a longer term change	<ul style="list-style-type: none"> • PHI, United Kingdom • Banking, Australia
Capped net margin	This approach allows funds to independently set premiums provided final profit margins do not exceed a regulated threshold (expressed as a percentage of revenues, e.g., 5-7%)	✓—Would not undo effects of other policies supporting goal of high membership levels	
Capped gross margin	This approach allows funds to independently set premiums provided gross profit margins (revenues minus claims) do not exceed a regulated threshold (expressed as a percentage of revenues, e.g., 15-20%)	✓—Would not undo effects of other policies supporting goal of high membership levels	<ul style="list-style-type: none"> • Pharmaceuticals, United Kingdom
Price monitoring	Granting funds the ability to change premiums how and when they wish, but monitoring this through an independent regulatory body. Margins are not regulated in this model.	✓—Would not undo effects of other policies supporting goal of high membership levels	<ul style="list-style-type: none"> • Medical indemnity services, Australia

The remaining three options were assessed to meet the appropriateness threshold and were considered against the evaluation criteria to determine their effectiveness and efficiency, relative to the status quo. The development of the evaluation framework is explained in further detail in Appendix B.

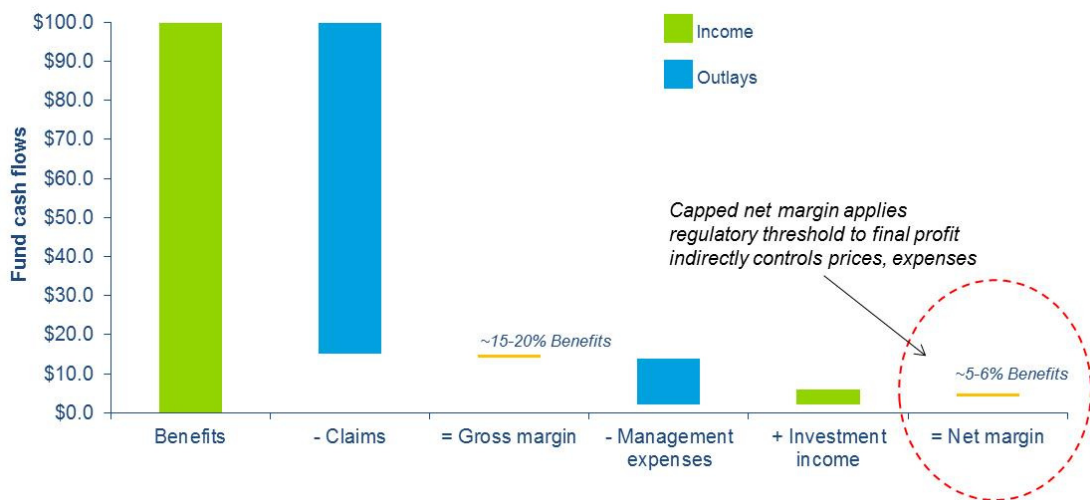
5.2 Option 1 – Capped net margin

A capped net margin approach would limit funds’ allowable net profit for a specified time frame, thereby withdrawing direct government involvement in the premium-setting process. This is commonly referred to as incentive regulation, with the rationale behind implementing a pre-set cap being to encourage competition among funds beneath an

acceptable level, while still also ensuring premiums do not increase substantially year-to-year. This type of model is frequently applied to natural monopoly industries, including essential services sectors.

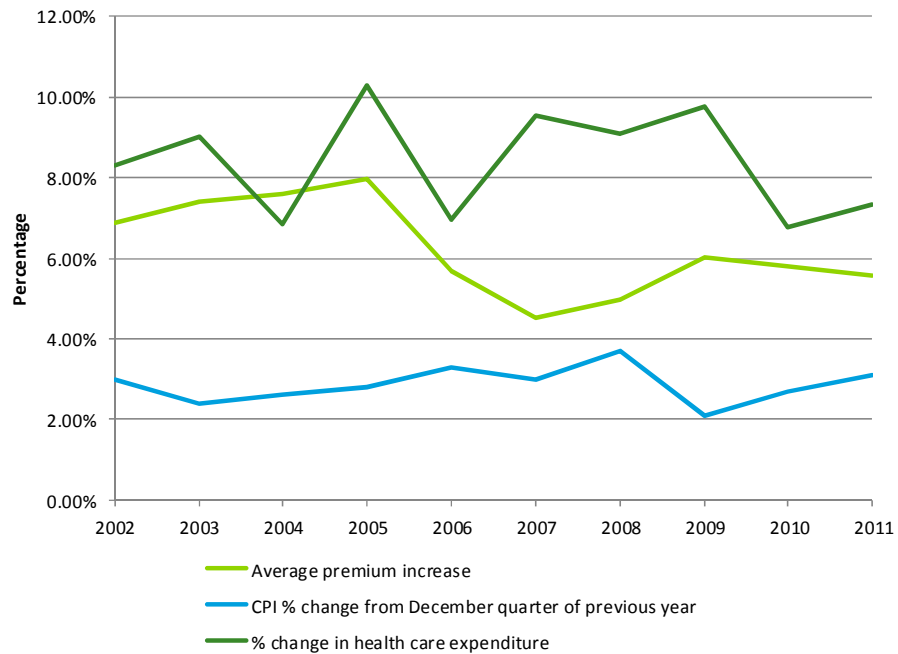
An allowable net margin cap would be calculated using a pre-determined formula which would indirectly control premium growth and potentially reward firms that were able to reduce costs. The regulator would develop a 'net margin path' for the industry over the specified timeframe, based on current profits, expected growth in costs and firm efficiencies, and a reasonable margin expectation. In a net margin approach, the formula is applied to the funds after taking into account management expenses and investment income (Figure 5.1).

Figure 5.1 Net margin regulation – where it applies



Because a regulator would need to set a margin path over several years the rate of indexation incorporated into the final design of the scheme would be important. There are differing views within the relevant literature as to the basis upon which indexation benchmarks should be set, and the method employed to calculate them. In terms of calculating the weighted average increase in price, where incentive regulation is applied to essential services infrastructure, CPI is the most commonly cited benchmark, as it provides a standard annual increase that reflects increased costs across society. While this provides a user-friendly option that may aid consumers' understanding of the process, it is relatively broad and so may not be indicative of cost changes occurring in the health sector, which are substantially higher than CPI (Chart 5.1). Given premiums have generally been above CPI, reflecting significant growth in underlying costs of care, this reiterates that it is not necessarily an accurate measure of costs within the PHI market.

Chart 5.1: Nominal change in healthcare expenditure against average premium increase and CPI



Source: ABS, *Consumer Price Index, Australia*, cat. no. 6401.0, March 2012; AIHW, *National health expenditure, current and constant prices 1985-86 to 2002-03 and 2003-04 onwards*; Average premium increase data provided by Medibank Private; DAE analysis

As a result, others have suggested the use of a ‘Health CPI index’ that is specific to the health sector. For example, Gans (2006) has suggested using the annual rise in PHI costs divided by the increase in government expenditure on equivalent public health services.³⁰ The AIHA suggested a similar benchmark, in which efficiency gains for services covered by PHI are assessed against government spending on the same bundle of services, including taking into consideration changes to waiting list times.³¹ However, it may be contentious to determine which services should be considered as part of this ‘Health CPI index’; nor does this metric take into consideration external factors that may drive changes in costs, such as a greater frequency of claims associated with an ageing population.

In addition there would be options in regulation design to determine whether excess revenues were distributed into the risk equalisation pool (a ‘hard’ approach) or returned to the fund’s policy holders (a ‘soft’ approach).

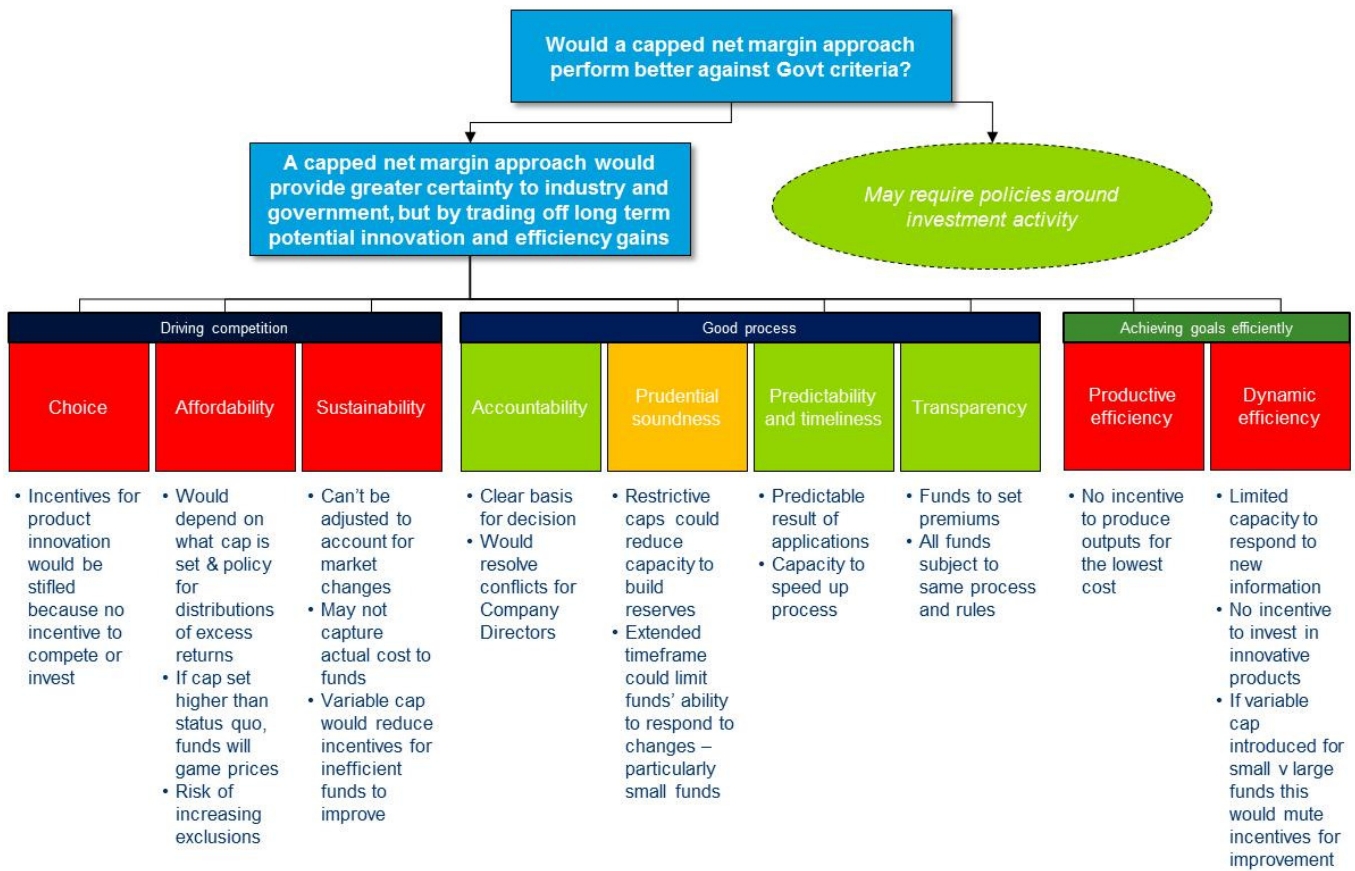
The allowable net margin cap would also need to be periodically reviewed.

Therefore while the final design of the regulation will be important, this section considers the option at a conceptual level for the purpose of drawing out the major differences between this approach and the status quo. Figure 5.3 summarises the key findings of the net margin approach relative to current arrangements against the evaluation framework; each criterion is discussed in turn below.

³⁰ Gans, (2006), ‘Government must put right health insurance pains’, *The Age*.

³¹ AHIA, (2008), ‘Reforming Australia’s health Sector: Annual Premium Adjustment Options’, p.17.

Figure 5.2: Summary of a capped net margin approach rating relative to the status quo



5.2.2 Appropriateness

A capped net margin approach passes the appropriateness threshold, as a margin cap will grant funds the flexibility to adjust premiums according to their needs, without exceeding an upper limit that could possibly be a detriment to consumers. In doing so, this also prevents an adverse selection spiral occurring, thereby preventing a decline in PHI membership, and preventing the public health system from experiencing an increased burden associated with more relocating to the public system.

5.2.3 Effectiveness

Overall, it would appear that the capped net margin approach would substantially reduce consumer choice and PHI affordability in order to provide the industry and government with greater certainty:

- Choice**—Under this option, there is a risk that, rather than produce goods at the most efficient cost, funds will be incentivised to develop a product and pricing model that would enable the fund to ‘price up’ to the regulated threshold, rather than focus on lowering costs and competing on product and price. In this sense the net margin approach would codify what some stakeholders have indicated may be occurring in practice in the current regulatory environment. Moreover, producing at the maximum net margin means funds’ profits will remain fixed, stifling their incentive for product

innovation over time to meet changing consumer trends and thus limiting consumer choice. At the margin, the adoption of a 'soft approach' rule for the distribution of excess profits (back to consumers) would improve funds' incentives to innovate and compete relative to a 'hard approach', which would distribute any gains from innovation across the whole industry. There would also be risks that product innovation might be further hampered if the net margin threshold were set too low, as this would reduce funds' capacity to invest in new product development.

- **Affordability**—The affordability of PHI products will depend on the allowable margin that is set. If the cap is set at an average margin level that is higher than would otherwise have been the case, this would reduce affordability compared with the status quo as funds would be expected to set prices in order to maximise total profit. Moreover, as the margin cap would operate over a several year period, this would be expected to increase prices compared with the status quo, as funds would need a higher risk contingency to respond to potentially unexpected events. The net margin approach could, however, see an increase in gaming by funds to meet prescribed margins, with funds possibly moving the timing of cash flow realisation between different years.
- **Sustainability**—If the margin cap is not set correctly under this option, then it may not accurately capture external cost pressures such as increasing costs of healthcare, as reflected by the high 'health CPI'. Moreover, given the cap is set for a specified timeframe, the cap cannot be adjusted to account for changes in the PHI market. This emphasises the importance, as noted above, of establishing an appropriate and correct benchmark that is reviewed regularly. The alternative, however, is to set the cap a bit higher to allow for these uncertainties to be managed, which would likely result in prices being higher than they might otherwise need to be. Therefore the margin cap may not effectively capture the actual cost to funds, in turn undermining industry sustainability.³²
- **Accountability**—Using a pre-determined formula to determine whether a proposed premium change is appropriate will significantly improve accountability relative to the status quo, as it provides a clear basis for the decision. Overall, accountability would therefore greatly improve under Option 1, relative to the status quo. However past experience in overseas insurance markets where prices were regulated by a formula suggests that the accountability of the company and Board is reduced, as pricing decisions are reduced to "what the regulator set".
- **Prudential soundness**—If caps are not set appropriately and are too restrictive, there would be a risk that funds would not be able to appropriately respond to changes in claims behaviour, which could limit their prudential soundness.³³ Restrictive caps may also reduce funds' capacity to build reserves.³⁴
- **Predictability and timeliness**—Option 1 will result in an improvement in predictability, as the cap applied when assessing proposed premium increases is already pre-determined using a formula. While the actual increase will remain ambiguous, an upper bound ensures no premium changes will exceed the net margin allowed. Timeliness will

³² Access Economics, (2005), 'Regulation of Private Health Insurance Pricing', p.18.

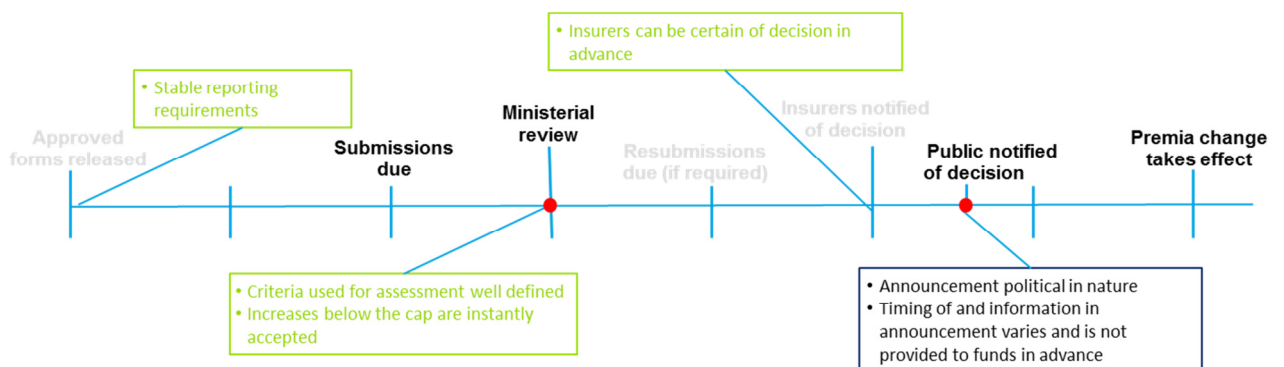
³³ Access Economics, (2010), 'Regulating Private Health Insurance: Options for reforming premium regulation', p.14.

³⁴ AHIA, (2008), 'Reforming Australia's health Sector: Annual Premium Adjustment Options', p.26

also improve under this option compared to the status quo, as premiums will not be directly controlled and funds will work to a several-year profit path.

Figure 5.3 highlights the points throughout the process where Option 1 may mitigate some of the uncertainty within the current process, by potentially resulting in improved predictability or timeliness. Again, the red dots illustrate the presence and scale of uncertainty, and the green text boxes highlight the sources of improvement under Option 1, relative to the status quo. The small red dots in Figure 5.3 reflect an improvement in the level of uncertainty under this option. As illustrated, introducing a specific and quantitative criterion for assessing applications means that funds know in advance whether their proposal will be approved. This net margin criterion also means that decisions can be made in a more timely manner, as it will be immediately obvious whether funds have satisfied the cut-off. However, funds may also face some uncertainty in the timing of decisions without complementary measures to provide certainty around timing (such as a consumer charter). Further, the public notification of decisions would continue to occur, causing some ambiguity for funds; this could be addressed, however, through complementary governance reforms.

Figure 5.3: Uncertainty under the capped net margin approach



Source: DAE analysis

- **Transparency**—By allowing firms to independently set premiums and using a pre-determined formula to control net margin growth, the rationale for pricing outcomes would be highly transparent. It would also remove any political bias or discretion from the premium setting process, as proposed changes will be accepted provided they remain below the designated threshold.

5.2.4 Efficiency

A capped net margin approach would, in effect, trade off efficiency gains for increased predictability in outcomes:

- **Productive Efficiency**—Productive efficiency under Option 1 would be expected to decrease as, rather than producing goods at the most efficient cost, funds would be incentivised over time to price up to the regulated threshold. If funds were already maximising the net profit possible, they would have no incentive to reduce their management costs further, as this will have no impact upon their profit levels. This

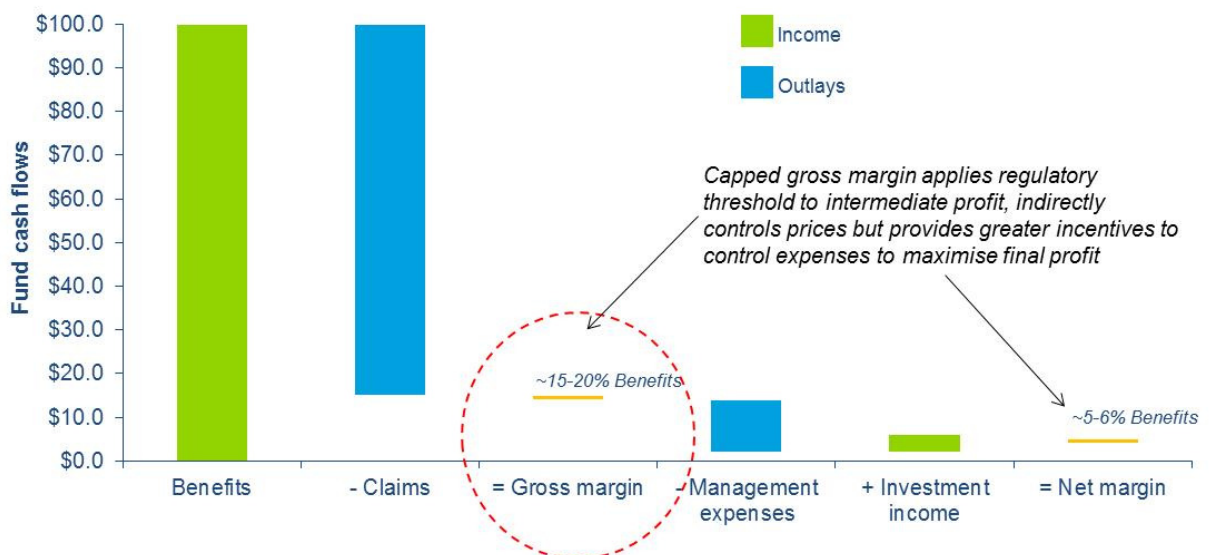
undermines the technical efficiency gains as funds would not have an incentive to produce outputs for the lowest cost given they would not recoup their efficiency gains.

- **Dynamic Efficiency**—A net margin cap would also decrease dynamic efficiency, as caps would be set for a specified timeframe, limiting stakeholders’ capacity to respond to new information or trends. This is particularly problematic if the cap is set too tight in the first instance. In the long-run, funds could be discouraged from investing in innovative products or making other long-term investments, as this would only decrease their profit margin.

5.3 Option 2 – Price cap on gross margin

The gross margin option has a similar basis to the net margin option outlined above, in that it sets a maximum cap for a pre-determined timeframe calculated using a formula, which would have some mechanism included to index gross margins over time. In this instance, however, the benchmark would be set at the gross margin line in funds’ profit and loss statement, in which allowable increases in the gross margin of funds would be indexed at a specified rate. Similar to issues in the design of the net margin approach, important considerations would need to be made regarding the allowable margin percentage, the rate of indexation (with some form of ‘Health CPI’ to be most appropriate) as well as what could be done with revenues that may exceed the allowable margin (with a ‘hard approach’ potentially being to distribute monies into the risk equalisation pool and a ‘soft approach’ being to return excess revenues to fund holders).

Figure 5.4 Gross margin regulation – where it would apply



Considering the approach at a more conceptual level, it would be expected that a gross margin approach would provide for a more competitive regulatory setting than a net margin option, as funds would be incentivised to improve their efficiency by lowering management and other costs, as there would still be an opportunity to maximise total profit. This could drive a broader restructure of the industry which over the longer term. Box 5.1 provides an example in which a gross margin cap has been implemented to regulate

PHI premiums in the United States. While a capped gross margin approach would be expected to inject more competition into PHI compared with a net margin approach, like the net margin approach, there could be a range of unintended consequences that may arise, including a potentially inappropriate shift in funds focus towards investment income, as this would sit outside the regulated frame. Taking larger punts on investments to maximise net margins could adversely affect funds' prudential soundness and could possibly require greater controls on investment activity.

Box 5.1: Case study: Affordable Care Act and gross margin cap

On 23rd March 2010, U.S. President Barack Obama signed the *Affordable Care Act*, introducing affordable health insurance for all Americans. The Act comprised numerous reforms to be implemented over a five-year period, including changes to premium determination using a gross margin price cap.

Changes to the premium setting process came into effect on 1 September 2011, with the goal of limiting the amount funds could raise their premiums, in order to protect the affordability of insurance. The changes comprised both a review process and a gross margin cap.

Initially, the Act provided that funds wishing to increase premiums more than 10% had to apply to the Rate Review program in their respective State prior to the increase taking effect, outlining their justification for doing so. State responsibility for the Rate Review program was extended on 1 September 2012, so that each State was allowed to implement its own minimum premium increase based on State premium trends and health care costs. The Rate Review program determines whether the proposed change is reasonable. It is run by State insurance departments or the Federal government when the State does not have an effective program. For this reason, programs may differ between States, however, many allow the regulator to reject premium changes. The rationale provided by funds for rate increases over the designated amount is publically available, thereby providing transparency to consumers who can comment on the proposed change.

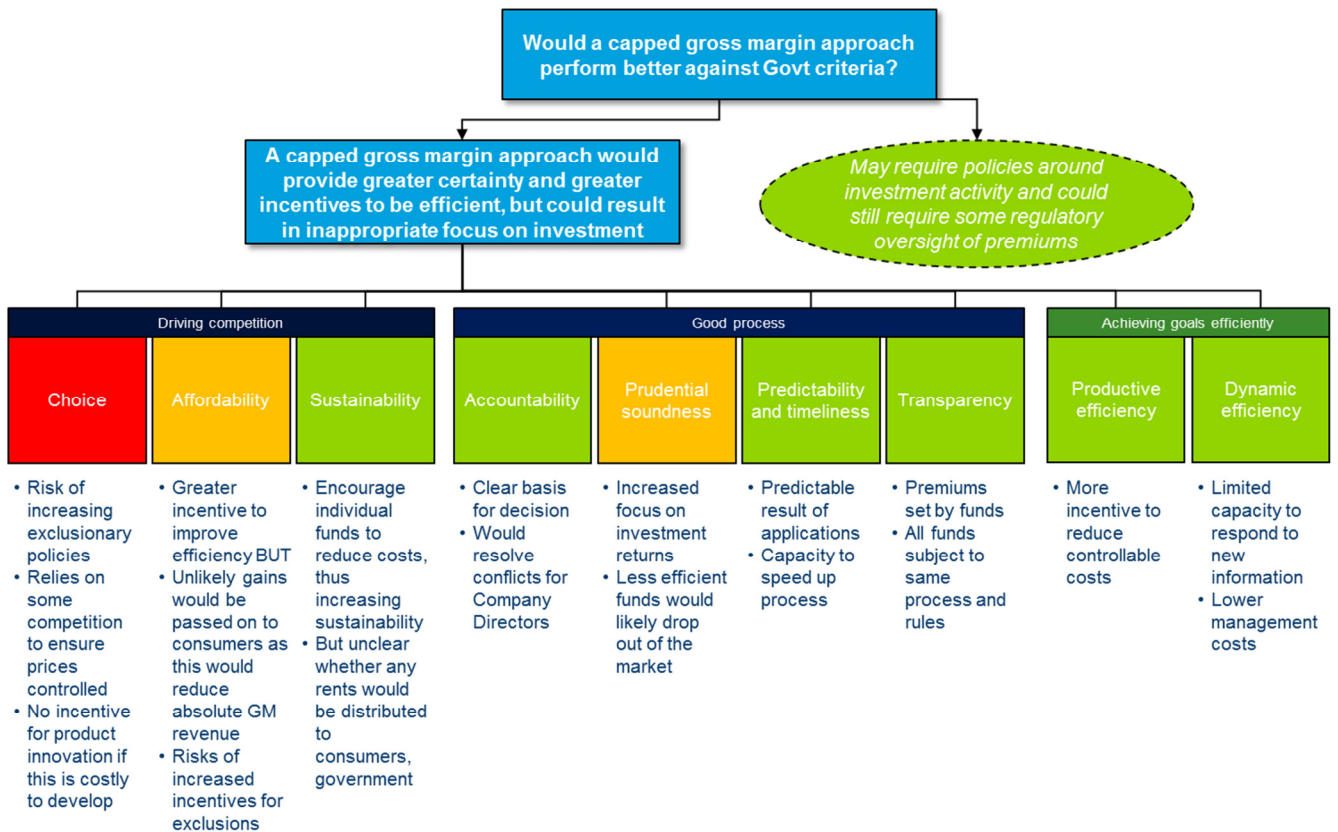
The introduction of a gross margin cap was also part of the premium setting reforms. Funds selling policies to small groups or individuals are required to spend at least 80% of premium dollars on direct costs pertaining to medical and health quality improvement services. This increases to 85% for insurance funds selling policies to large groups, defined as 50 or more people. Funds are therefore operating within a 15-20% gross margin cap, meaning they cannot spend more than this percentage of their revenue on indirect costs such as management and operating costs. The *Affordable Care Act* refers to this as the medical loss ratio.

To ensure funds follow the gross margin requirements, they are required to report the proportion of premium revenue spent on medical services and health care quality improvement to the Secretary of Health and Human Services annually. This information is also made publically available. In addition, funds are required to pay a rebate to consumers of the proportion of premium revenue that exceeds this limit.

Source: U.S. Department of Health & Human Services, *HealthCare.gov* website

Table 5.2 provides a summary of Option 2's rating relative to the status quo.

Table 5.2: Summary of Option 2 rating relative to the status quo relative



5.3.2 Appropriateness

A gross margin cap approach passes the appropriateness threshold, as establishing a maximum cap would likely ensure that premium changes remain stable and in turn would not adversely impact PHI membership levels.

5.3.3 Effectiveness

A capped gross margin approach would improve the regulatory system’s performance against good process criteria and encourage firm efficiency, but there may be a number of unintended consequences with respect to choice and affordability:

- **Choice**—It is unlikely the capped gross margin option would increase choice. Funds may have an incentive to run their operations to bring their gross margin up to the regulated cap. This could lead to higher levels of exclusionary policies (with funds seeking to reduce their claims outlays) and would provide little incentive to pass on cost savings to customers in the form of lower premiums, as this would lower their total revenue intake and in turn the absolute gross margin they would be able to achieve, with gross margin expressed as a percentage of revenue. Consequently, this approach would rely on some competition to be present (or some regulatory oversight similar to the US model where premium increases exceeding 10% are still subject to approval in some States), otherwise firms would seek to increase revenues to maximise the absolute value of the gross margin. Moreover, this model could provide an incentive for funds to

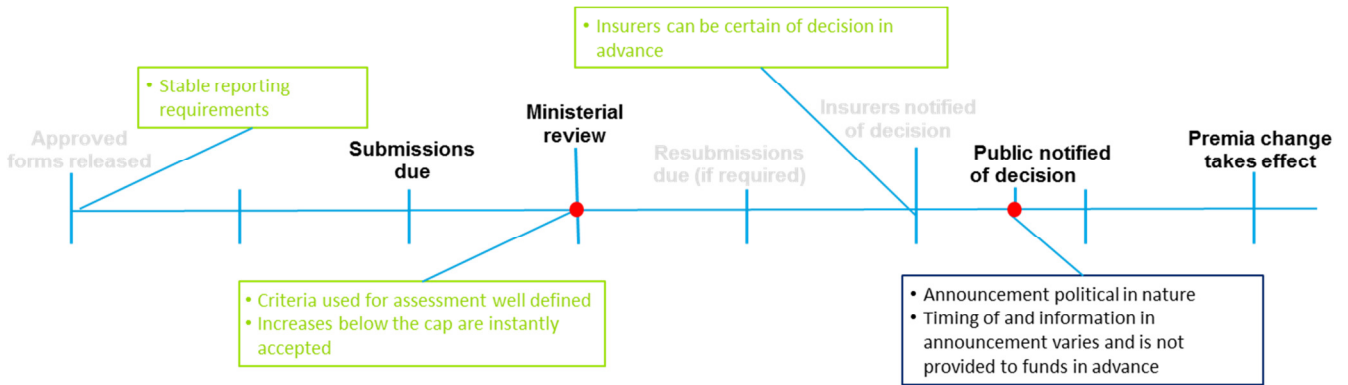
drive down their non-claims costs so as to maximise net profit which, while leading to enhanced technical efficiency, could stifle product innovation, as funds may have reduced incentives to invest in innovations that may lower total profit over the regulated timeframe.

- **Affordability**—It is unlikely that affordability would improve under this option relative to the status quo. In comparison to the net margin option, funds will have a greater incentive to improve technical efficiency through decreasing management expenses, which could have flow-on effects for affordability. This is because when only gross margin is regulated, funds retain any increase in profit, thereby encouraging them to reduce management costs. It is unlikely, however, that funds would pass these efficiencies on to consumers as this would lower their absolute gross margin, which would reduce the potential size of their net profit. There could need to be some ongoing regulatory oversight of premium growth, similar to the US approach, if competition is not sufficient to control price growth.
- **Sustainability**—As mentioned above, the ability to increase profit will encourage funds to improve technical efficiency and reduce their costs. In doing so, this would promote long-term efficiency gains and improve funds' likelihood of being sustainable in the future.
- **Accountability**—Similar to Option 1, the gross margin cap improves accountability relative to the status quo. This is because an approval system which is susceptible to political discretion would be replaced by a system where funds could independently set premiums and gross margins would be controlled through a pre-determined formula to be applied industry-wide. Any premium increase below the margin will be considered appropriate. The gross margin approach could, however, see an increase in gaming by funds to meet prescribed margins, with funds possibly moving the timing of cash flow realisation between different years. Accountability of companies and Boards is better than under Option 1, as they are required to make genuine decisions about profit, management expenses and capital contribution.
- **Prudential soundness**—The prudential soundness of individual funds may not benefit from a gross margin relative to the status quo as, in an attempt to reduce controllable costs, funds may engage in and become increasingly reliant on improved investment returns. The volatility of financial markets could expose funds to increased risk, reducing the financial stability of the industry.³⁵ However, over time the prudential soundness of the industry as a whole may improve, as the increased incentive to improve efficiency discussed under the choice criterion could result in less efficient, riskier funds leaving the market, or potentially through merging with larger, more efficient funds. This will improve overall industry prudential soundness.
- **Predictability and timeliness**—Predictability would be expected to substantially improve under Option 2. Political discretion and ambiguous criteria would be removed from the process, meaning all premium changes would be instantly approved, with excess profits to be distributed either to members, the risk equalisation pool or to government. Timeliness would also be improved under a capped gross margin approach as, similarly to the net margin option, government would not be required to

³⁵ AHIA, (2008), 'Reforming Australia's health Sector: Annual Premium Adjustment Options', p.11.

spend as much time assessing individual applications. Instead, a proposed change to premium levels would be accepted so long as it is within the designated cap.

Figure 5.5: Uncertainty under the capped gross margin approach



Source: DAE analysis

- **Transparency**—Using a formula that is consistent across funds will significantly improve transparency of the premium setting process across the industry. Ensuring the government applies a consistent and publicly stated formula in its assessment also provides more clarity on the criteria by which funds’ premium changes are accepted or rejected.

5.3.4 Efficiency

- **Productive efficiency**—Productive efficiency will improve relative to the status quo under a gross margin cap approach. Placing a cap on the gross margin creates incentives for funds to reduce their management costs which would encourage technical efficiency gains. Funds would therefore strive to produce a given level of output for the lowest cost, in order to retain the maximum profit possible. In addition, specific design considerations may influence the effectiveness of the model. If a differential cap is applied for small versus larger funds (as is the case in the United States), incentives for technical efficiency gains would be reduced.
- **Dynamic Efficiency**—Efficiency gains through lower management costs could also have a positive impact on long-term dynamic efficiency. However a margin cap may discourage innovation, as discussed under the choice criterion, as caps are set for a specified timeframe and limit funds’ capacity to respond to new information or trends and adjust the cap accordingly, as well as discouraging investment in long-term projects.

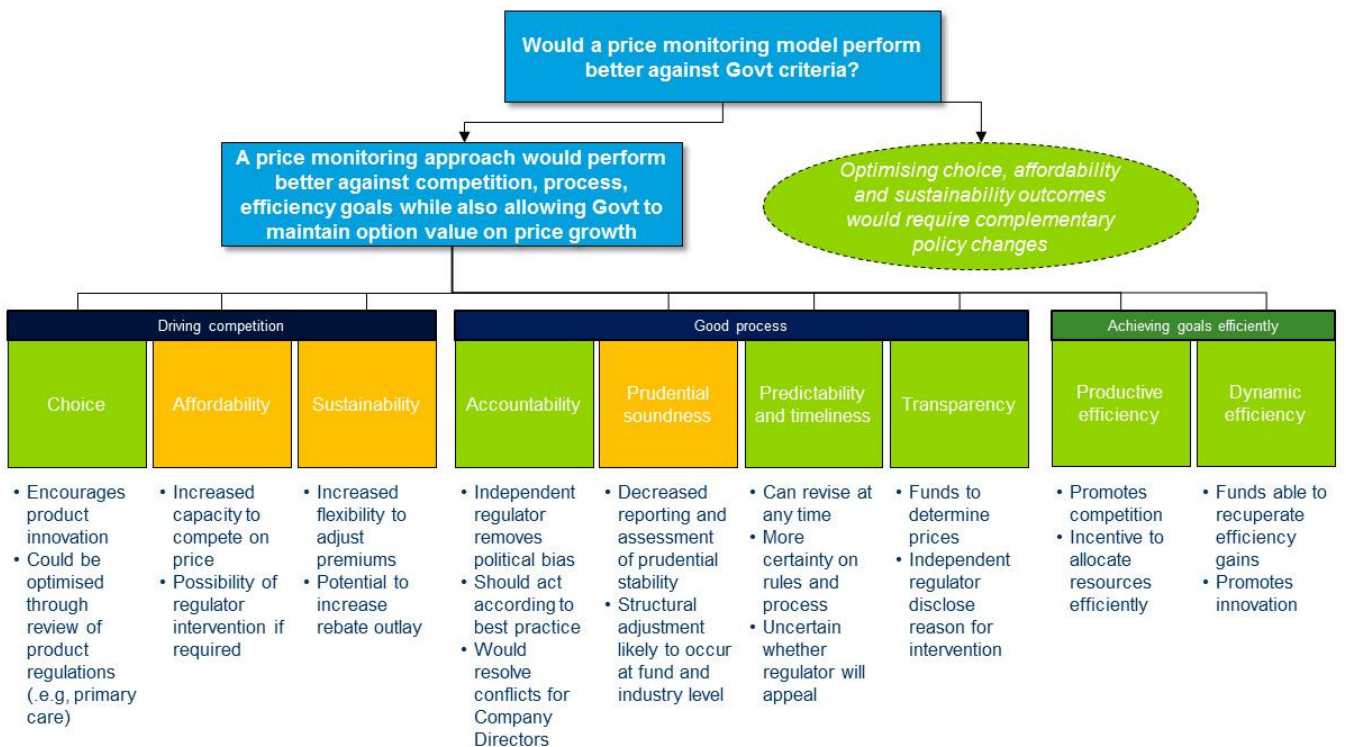
5.4 Option 3 – Price monitoring

A more light-handed approach, price monitoring, would allow firms to set prices as they wish, with premium growth being monitored by an independent regulator.³⁶ There would be a certain degree of flexibility in the system of price monitoring if implemented, but the design could encompass:

- Monitoring prices;
- Comparing prices to costs;
- Monitoring rates of return;
- Monitoring quality of service;
- Publishing information collated; and
- Intervening if changes are not deemed appropriate.

The rationale behind price monitoring is to grant funds the flexibility to decide when premium changes should occur and by how much, thereby promoting competition between funds, which will aim to attract consumers through lower prices relative to another fund.

Table 5.3: Summary of Option 3 rating relative to the status quo



³⁶ Access Economics, (2005), 'Regulation of Private Health Insurance Pricing', p.14.

It also enables funds to respond to competitors' changes, further enhancing competition. However, an independent regulator would ensure that prices are reasonable and not excessive, therefore protecting government and stakeholder interests. A decision by the regulator to intervene would thus be independent and not politically biased.

5.4.2 Appropriateness

A price monitoring system would still ensure a mechanism is in place (intervention by the regulator) to act if premium levels were to exceed an amount that was considered appropriate, or if a vicious cycle effect reappeared. This would prevent soaring premium levels and huge decreases in PHI membership. Regulatory intervention therefore occurs on an as-needs basis to uphold the appropriateness of the system, ensuring the appropriateness threshold is achieved under this option.

5.4.3 Effectiveness

Price monitoring would withdraw most government controls from premium determination and allow the industry to begin competing on price and would be expected to catalyse an industry restructure that would see more innovative firms rewarded with higher levels of market share.

- **Choice**—Consumer choice could be significantly enhanced through the introduction of a price monitoring system due to the incentives created for funds. Funds' flexibility to set prices as desired increases their possibility to gain market share as they price compete with other funds to attract new members and maximise profit. This would encourage them to innovate in ways to attract consumers through other factors in addition to price, be it product design and offering, service quality, or additional features such as prevention or information programs.

Figure 5.6 Case study: Price and product competition in the banking sector

Prior to deregulation of the Australian banking system in the 1980s, banks were subject to interest rate controls which set ceilings on the rates they could charge borrowers and offer lenders. There were also restrictions imposed on the types and volumes of lending they could undertake.

These controls served both macroeconomic and microeconomic objectives. On the microeconomic front, they were intended to prevent banks exploiting the privileged position they enjoyed on account of entry restrictions governing the establishment of new banks. Incumbent banks enjoyed virtual freedom from the threat of new entry and, absent control of loan interest rates, might have exploited their market power more than they actually did.

In addition, deposit interest rate and qualitative lending controls served a prudential function. Banks were prevented from competing too fiercely for deposits, dangerously narrowing their net interest margins, and from lending to poor credits or in too concentrated a fashion.

The Campbell Committee recommended the abolition of these “direct” controls on prices and quantities on account of their distorting effect on the efficient operation of the banking system. The controls were also less effective in keeping a lid on bank profits than had been expected. In 1980 Australian banks had the widest bank margins of any countries in the OECD group and were among the most profitable.

The Committee recommended that direct controls be abolished, competitive entry to the banking system be made freer and a system of formal prudential supervision be introduced to manage risk. These recommendations were steadily implemented over the course of the 1980s.

As a result, Australian banks now have complete freedom to set interest rates on both sides of their balance sheets (i.e., for deposits and loans) and to decide the volume and composition of their borrowing and lending. Criteria to obtain an Authorised Deposit-taking Institution (ADI) licence are published and overseen by APRA in a transparent manner. New banks are created regularly if not frequently.

Competition among banks and between banks and other ADIs, as well as the broader capital markets, provides the competitive tension required to control bank profitability. Bank net interest margins have fallen steadily since the 1980s and Australian banks are no longer excessively profitable by international standards (allowing for movements in the business cycle).

Moreover, Australia operates what is acknowledged globally as a first-class system of prudential regulation and supervision which protects the economy from excessive risk-taking by banks. APRA undergirds the prudential soundness of Australia’s banks and other ADIs while allowing them complete freedom to set interest rates and determine their own lending criteria.

- **Affordability**—PHI affordability would similarly improve under a price monitoring approach, as funds have an increased capacity to compete on price and improve their efficiency. This will drive down premiums as funds vie for customers. Furthermore, the threat of intervention by the regulator should dissuade funds from significantly increasing premiums.³⁷ This is heightened through the threat of re-introducing a highly regulated process should funds not operate in a competitive manner under the price monitoring system.

³⁷ Access Economics, (2010), ‘Regulating Private Health Insurance: Options for reforming premium regulation’, p.12.

Figure 5.7: Case study: Medical Indemnity Services

Medical indemnity insurance is a liability insurance which covers medical practitioners for the financial loss brought about by claims against their professional performance. Price monitoring regulation of medical indemnity insurance was implemented in 2002, in response to a series of challenges faced by the industry.

In 2002, medical indemnity was provided by medical defence organisations (MDO) on a discretionary basis. Many MDOs were mutuals, owned and operated by their members often along State jurisdictions, and fell outside the bounds of APRA regulation. The largest provider of medical indemnity insurance, United Medical Protection Limited, went into liquidation in 2002, leaving many Australian medical practitioners without insurance. This was exacerbated by substantial increases in premiums by 260% between 1996 and 2003. In response, medical practitioners were exiting from high-risk specialisations such as obstetrics or the industry altogether, thereby threatening Australian's access to health care services.

To address these issues, the Australian Government announced in October 2002 that, amongst several reforms, the ACCC would assume a price monitoring role for medical indemnity insurance premiums from 2003. Its primary role was to monitor premiums to ensure they were actuarially and commercially warranted. This role was extended in March 2005 and then again in 2006, to include assessing the actuarial and commercial justification of premiums in each State and Territory in more detail. Furthermore, insurers that provided medical indemnity insurance required authorisation by APRA, and the ability of MDOs to refuse to cover particular practices was eliminated.

To fulfil its price monitoring role, the ACCC annually assessed quantitative and qualitative information on premiums, including funds' cost structures, solvency targets, and the impact of other government reforms in 2003 (such as premium subsidies to eligible medical professionals) and APRA's implementation of minimum capital requirements in 2008. This informed the ACCC as to the processes used to determine premiums and whether these were actuarially justified and necessary to meet fund's commercial obligations to stakeholders. In only one instance, in 2003-04, did ACCC determine that an insurer's premium was not actuarially warranted.

A result of price monitoring has been a consistent decline in premiums and claims experience. Average premiums decreased from their peak at \$7,500 in 2002-03, when price monitoring was introduced, to \$5,392 in 2007-08 – similar to their 1999-2000 levels, when they were \$5,263.

Source: Australian Competition and Consumer Commission, (2009), 'Medical Indemnity Insurance', accessed 16 October 2012 via www.accc.gov.au.

- **Sustainability**—Under this option, individual funds would become more sustainable due to their increased flexibility to adjust premiums to meet their needs and changing market conditions, as well as their incentive to improve efficiency. The industry would also improve its sustainability, as the increased competition and incentives for efficiency gains would result in the necessary structural adjustment required to ensure that only prudentially sound and efficient funds are in operation.
- **Accountability**—It is likely that accountability would improve under a price monitoring system relative to the status quo for several reasons. Firstly, an independent regulator takes into consideration all stakeholders' needs and interests and removes political bias from the premium-setting process. Funds would also still be required to provide reports to the regulator justifying their price changes, ensuring they are accountable to consumers for any premium changes. Because there would not be a significant and variable negotiation period as in the current approach, for-profit Company Directors would not be conflicted in their obligations to the PHI regulator and ASIC. This is because, as explained in Chapter 4, company directors are potentially placed in jeopardy by the PHI Act's requirements for confidentiality regarding premium negotiations and the Corporations Act requirement to continuously disclose

developments to the market in a timely manner, given that the risk of confidential negotiations being leaked always exists. However, under a price monitoring approach, funds would only be required to provide reports to the regulator justifying changes and would not be engaged in any negotiation or iterative round of submissions for approval. As a result, for-profit fund directors would not be placed in a position where they were not disclosing information to the market as required under the Corporations Act.

- **Prudential soundness**—Under Option 3, removing the approval process means funds would have more flexibility to alter their premiums to ensure their long-term viability. However, this would be countered by a decrease in reporting and independent assessment of fund's premium changes compared to the comprehensive application procedure that is currently required. As a result, this may weaken the prudential soundness of individual funds. This could be addressed through prudential standards, however, rather than premium determination processes.

The ability to reprice when required would reduce the prudential risk arising from the current process of annual premiums set up to 23 months in advance of the claim risk being incurred.

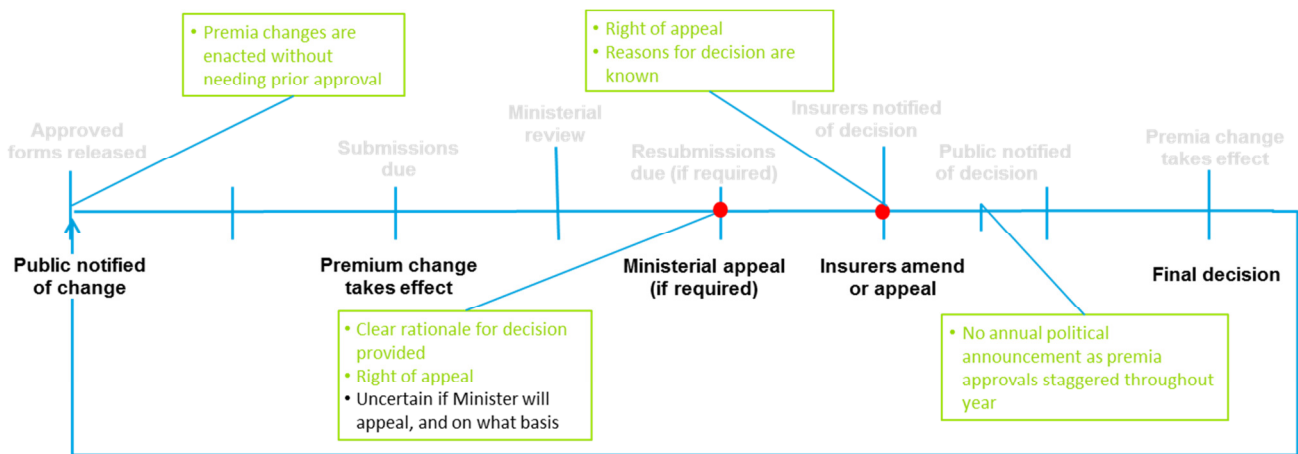
In addition, a price monitoring approach would likely catalyse the necessary structural adjustment will occur through mergers and the exit of inefficient funds in the market, to ensure that only prudentially sound funds are in operation. Overall, this option should result in an improvement to the prudential soundness of the industry and individual funds, providing that appropriate governance arrangements are put in place to mitigate risk.

- **Predictability and timeliness**—Under a price monitoring approach, Ministerial discretion to approve premium changes would be removed, granting funds more certainty as to the rules and process involved, in addition to the likelihood of the change occurring. It also gives them far greater flexibility to action premium changes when they require, enabling them to respond to changing circumstances in a timely manner rather than factor in potential risk as is the case with the current application procedure.

Under the price monitoring option, there would be far less uncertainty of outcomes for industry, as can be seen in Figure 5.8. Funds would be able to act independently to change premiums at any time without needing prior Ministerial approval. If the independent regulator chose to appeal the premium increase, they would, acting under best practice principles, provide clear reasons for the appeal. Further, funds would have the opportunity to dispute these decisions in a relevant court or tribunal.

However, funds would be uncertain as to whether the regulator will appeal any given change to premium in advance. Further, funds may not know on what grounds the regulator would appeal in the first instance, unless guidelines were provided to indicate the level of premium increase that would likely trigger a review. However, overall, these are minor levels of uncertainty relative to the status quo and all other options discussed.

Figure 5.8: Uncertainty under a price monitoring approach



Source: DAE analysis

- Transparency**—It is expected that transparency would improve in comparison to the status quo due to the independence of the regulator, which would remove any political bias or discretion from the process. It would, however, be important to ensure there are defined grounds as to when the regulator is allowed to intervene in the premium-setting process to ensure transparency and consistency are upheld.

5.4.4 Efficiency

By allowing firms to compete on price, and given the price sensitivity of consumers, a price monitoring approach would be expected to improve short and long term efficiency outcomes:

- Productive Efficiency**—Productive efficiency would substantially improve under a price monitoring system, as it would be expected to promote competition between funds. Rather than simultaneously applying for premium changes without knowledge of funds' proposed changes, price monitoring enables funds to more easily compare their premium changes to others, thereby intensifying competition. This means more efficient funds with lower costs would likely retain their efficiency gains by minimising premium increases.³⁸ Those funds that require significant premium increases to meet their costs would in turn be expected to merge with more efficient funds.³⁹ This creates incentives for funds to allocate resources efficiently and produce outputs for the lowest possible cost.
- Dynamic Efficiency**—Enhanced competition as a result of price monitoring will also increase dynamic efficiency. As mentioned above, funds are able to recoup their efficiency gains, promoting innovation particularly with regard to reducing claims and management costs.⁴⁰ The government would also retain the opportunity to outline

³⁸ Access Economics, (2005), 'Regulation of Private Health Insurance Pricing', p.16.

³⁹ AHIA, (2008), 'Reforming Australia's health Sector: Annual Premium Adjustment Options', p.17.

⁴⁰ Access Economics, 'Regulating Private Health Insurance: Options for reforming premium regulation', p.vi.

policy objectives to the independent regulator should it need to respond to new information.⁴¹

5.5 Summary of performance against the status quo

5.5.1 Key findings regarding performance of alternative approaches compared with the status quo

On balance, the analysis indicates that a price monitoring approach would optimise community goals for choice, affordability, sustainability and efficiency relative to the status quo arrangements, while also addressing some of the process weaknesses inherent to the current model of Ministerial premium approvals (Figure 5.10). Specifically, a price monitoring approach:

- Would not itself be expected to ‘undo’ the broader policy system in place to ensure high levels of PHI membership, especially in light of the explicit ability to re-exert price control if this outcome were to eventuate; and
- Would be expected to drive the industry towards the efficiency frontier more cost-effectively than a regulated approach, which would result in lower prices, holding all else constant.

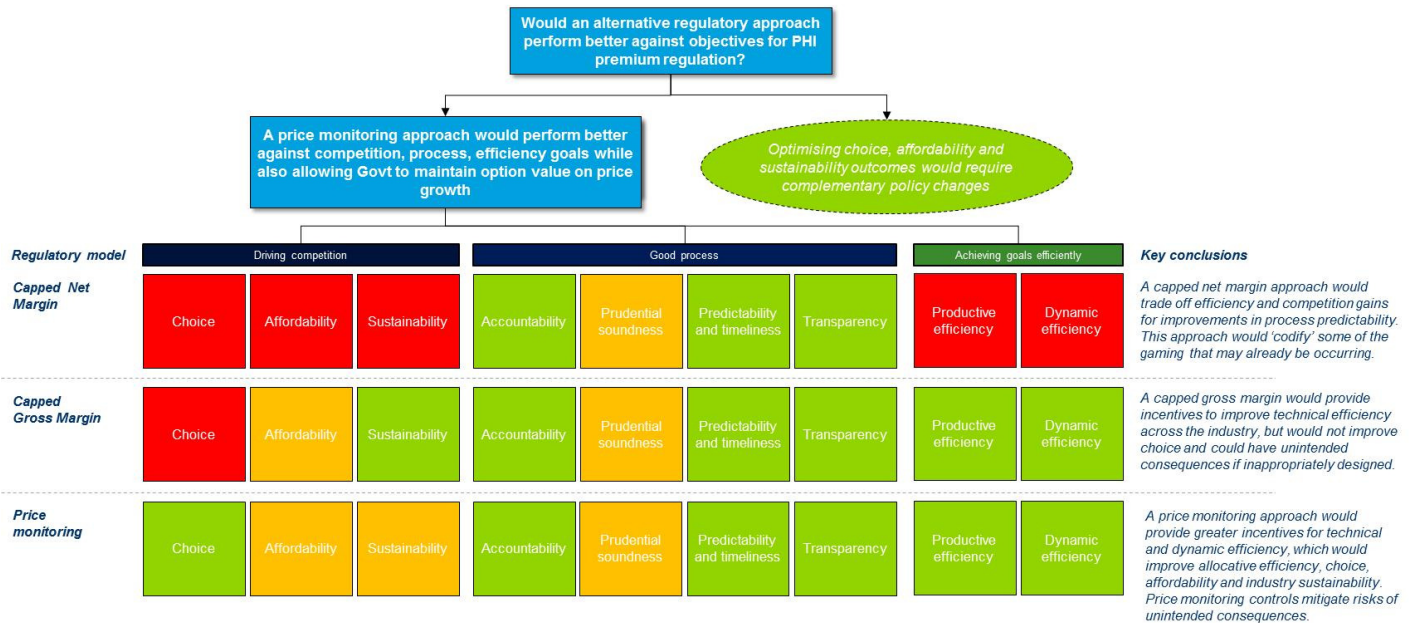
The two models of incentive regulation, by contrast, were essentially found to trade off improvements in process predictability and transparency for poorer performance against goals of choice, affordability and efficiency. Due to the significant influence of regulation design, particularly with respect to industry benchmarks, indexation rates and the impacts of excess profit distribution, both models also raised the risk of unintended consequences emerging:

- The capped net margin approach in particular was found to ‘codify’ the gaming that some industry and government stakeholders indicated could be occurring under the current regulatory approach. On top of this, it would likely introduce new ‘games’ to be played by industry with respect to the realisation of controllable expenditures in different years to maximise profits. PHI premiums would be expected to be higher than under the current regime due to the infrequency of premium setting, which would necessitate a risk contingency to be added to allow for unexpected events. Ultimately a capped net margin approach is a model that best applies to an industry that is closer to a natural monopoly structure and would only be appropriate if there was no real prospect for competition between the funds.
- The capped gross margin approach would similarly create thresholds around which the industry would be expected to respond, which might not produce substantial gains in PHI affordability, although by applying the target at a gross margin level there would be increased incentives for firms and the industry to improve technical efficiency compared with the status quo. However, funds would have very limited incentives to

⁴¹ Port Jackson Partners Ltd, (2009), ‘Improving Regulation of the Private Health Insurance Industry’, p. 53.

invest in innovation or to pass efficiencies on to consumers as this would lower absolute gross margin. It could also see an undesirable focus on investment income which may need to be addressed through regulation design or other policy changes.

Figure 5.9 Performance of alternative regulatory approaches compared with status quo



Therefore on balance the price monitoring approach offers a regulatory option that would be administratively simpler than either incentive regulation approach and likely drive funds towards efficiency frontier, which should improve PHI choice, affordability and efficiency relative to the status quo.

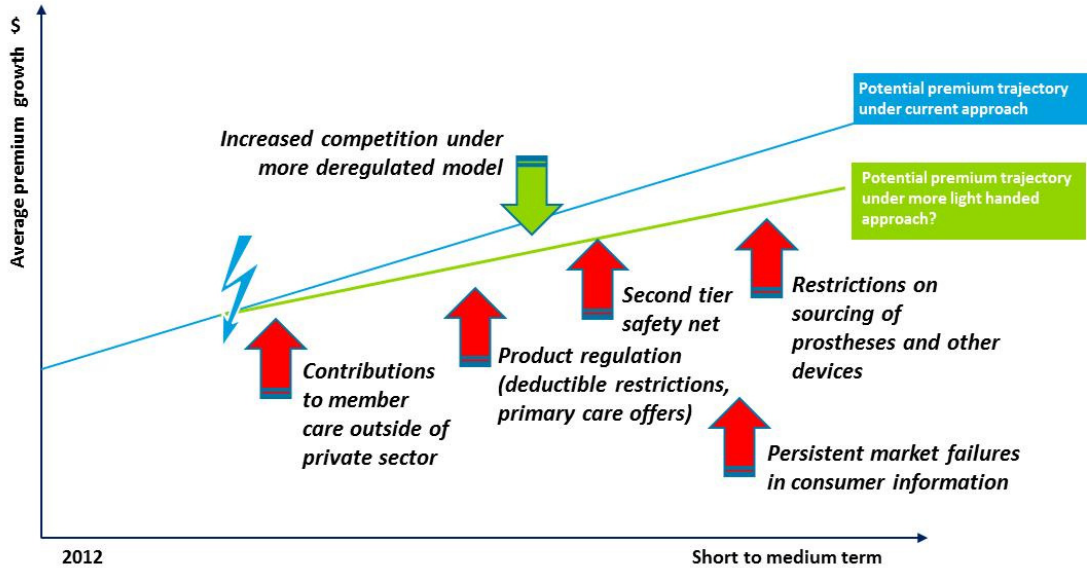
5.5.2 Opportunities for optimising competition

Notwithstanding the potential benefits of a price monitoring approach, there are a number of policies that could optimally be reviewed in a more deregulated environment to enhance competition in the sector and minimise premium growth.

As highlighted in Chapter 3, there are a number of policies in place that put a drag on competition which would be expected to limit the dynamic efficiency gains that could be realised by the sector (Figure 5.11). In particular, 2nd Tier default safety net arrangements, limitations on sourcing of prostheses and product regulations preventing PHI from competing in primary care all serve to increase premium growth relative to what might have otherwise been the case, constraining the potential gains from enhanced fund competition in a deregulated environment. Persistent market failures related to information asymmetries and bounded rationality also potentially limit gains from competition.

Given the recent changes to the PHI rebate, which have decoupled the rebate from PHI premiums, it is now essential that the Government review the regulatory process for PHI premium setting, to ensure it optimises industry competition and efficiency for the purpose of minimising PHI premium growth.

Figure 5.10: Optimising outcomes from competition – potential complementary policy reforms to drive



It is recommended that the government review options to enhance the sector’s capacity to compete as part of a transition to a price monitoring regulatory setting. This is explored further in Chapter 6.

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6 Mitigating fiscal and political risk

Chapter 6 considers options for further mitigating fiscal and political risk, including options for enhanced governance arrangements.

6.1 Policy options to reduce fiscal risk

Taken together, the competition analysis in Chapter 3 and options analysis in Chapters 4 and 5 suggest that a the basis for a competitive PHI industry exists, and that injecting more competition into the sector through a price monitoring approach:

- would not itself be expected to ‘undo’ the broader policy system in place to ensure high levels of PHI membership, especially in light of the explicit ability to re-exert price control if this outcome were to eventuate; and
- would be expected to drive the industry towards the efficiency frontier more cost-effectively than a regulated approach, which would result in lower prices, holding all else constant.

Even with industry analysis and economic theory pointing to a more deregulated approach as producing the most efficient and effective outcome for PHI prices, however, given the recent changes to the rebate, government may want to consider options optimising competition and industry efficiency in a lighter-handed regulatory environment.

A number of things could be done to enhance the sector’s capacity to compete and in turn, minimise PHI price growth, including:

- Review the 2nd Tier default safety net arrangements as mechanism for driving more efficiency through private healthcare sector
- Review policies to address market failures of information asymmetries and bounded rationality
- Review types of services for which public hospitals can claim funding from PHI
- Review product regulations that prevent PHI from competing in primary care or set deductible limits

Each of these options is considered in turn.

6.1.1 Review 2nd Tier default safety net arrangements

Analysis of the industry structure and competition in Chapter 3 indicates there are likely more funds in operation than would be the case in a more competitive environment, which leads to technical inefficiencies that raise the price of PHI holding all else constant. While there will likely be technical efficiencies to be gained through a potential industry restructure (through management expense synergies, for example), the lion’s share of the

industry's cost base is in claims, with 85% of benefits paid out in claims. This indicates that if real dynamic efficiency gains are to be realised through increased competition, a significant contributor would need to be realised through greater buying power *vis-à-vis* private healthcare providers. The PHI industry could be an ally for consumers and the government in driving greater efficiencies through the private healthcare sector.

Consolidation of funds alone, while it should deliver technical efficiencies, is unlikely to increase bargaining power with private hospitals, however. Even though there are significant numbers of funds, there are only seven hospital contracting groups in Australia. The top five funds make their own arrangements, and most of the remainder have outsourced their hospital contracting process to a single company, the Australian Health Services Alliance. Additional efficiency gains could, however, be realised through a review of the 2nd Tier safety net default arrangements, which substantially mute fund competition between each other and with the private hospitals. With a differential of only 15% between their standard rates and the default rates, hospitals arguably do not face a significant penalty if they are not able to come to an agreement with the funds. This in turn limits how hard a bargain can be driven by the funds, which could potentially result in lower prices to consumers and government (although the distribution of rents would depend on a number of factors).

Over time, hospitals will feel some pressure from physicians and specialists to ensure that their patients are not facing higher co-payments as a result of the inability to come to a negotiated arrangement, but the safety net levels very clearly narrow the bargaining space.

Analysis of the consumer's typical purchase decision demonstrates that consumers on their own are not able to drive the efficiency gains that could be realised. Typically admission to a private hospital results from a GP referral to a specialist, who in turn suggests a private hospital. Generally, such discussions centre on the medical and timing issues, and once a hospital is recommended by a surgeon there is little remaining scope for the individual consumer to negotiate costs. Controlling healthcare costs require consumers demand to be aggregated – we have these benefits with monopsony arrangements for the PBS, MBS and public hospitals; private sector patients require PHI to drive down costs on their behalf.

There are obvious equity considerations that would need to be taken into account with respect to any reforms to the 2nd Tier arrangements, so that customers are able to access the services and providers of their choice, whether or not the funds and hospitals are able to come to an agreement. Nevertheless, a review would need to consider whether a negotiated deal would be a common occurrence or whether it would in fact drive parties to a more efficient outcome. There may be other safety net mechanisms that could be put in place, such as arbitration undertaken by an independent regulator, rather than a 'one size fits all' default rate that puts a drag on dynamic efficiency gains.

6.1.2 Review policies to address market failures impacting consumer decisions

As highlighted in Chapter 3, competition in the PHI sector is affected by two major market failures: information asymmetries and bounded rationality. Notwithstanding the fact that consumers are 'bombarded' with information, and there is substantial information available through the PHIO's www.privatehealth.gov.au website, PHI policies remain complex and product comparisons are difficult, even for the most sophisticated consumers.

The most recent Ipsos report analysis highlights persistent confusion among consumers notwithstanding the information that government is making available. At the end of the day it is not about how much information is available but the form that it is in, because people can only analyse so much data. This is partly why people do not switch funds, even when it may be in their interests to do so.

The growth in market share of the aggregators reflects these providers addressing consumers' needs with respect to information. However, as noted in Chapter 3, aggregators present a complex interaction in the market. While they do indicate a response to a market failure (information asymmetry), they also often represent various sub-sets of the market, while consumers may think represent the whole of the industry, rather than selling products for a selected number of funds. This represents both a sign of the foundations of competition, but a complication arising from product profusion and the lack of transparent information provided to consumers regarding aggregators' roles.

There may be a limited role for government in further addressing this issue; ideally, government would prefer the market to resolve information barriers. Nevertheless, improving consumer information is an objective for government with respect to PHI and if a market failure or barrier persists there may be some role for government intervention. Government could consider options for improving consumer engagement with PHIO's www.privatehealth.gov.au service.

6.1.3 Review types of services for which public hospitals can claim funding from PHI

Currently patients with private health insurance cover that are treated in the public hospital system are encouraged to declare their PHI status so that the public hospital can claim funds from PHI for their care. In 2011-12 this added over \$750 million in costs to the PHI sector.

Not all services provided by the public sector are necessarily replicated in the private sector, and arguably PHI members should not be penalised for seeking care in the public sector, to which they also contribute through taxes.

While this practice may be attractive as a means to leverage additional monies to cover a potentially underfunded public sector, it dilutes transparency of the true costs of delivering different services across the health system.

6.1.4 Review product regulations that prevent funds from competing in primary care and limit deductibles

Beyond the major policies that influence the competitive dynamics of PHI, there are also a myriad of product regulations in place that further control the operations of PHI. It may be worthwhile for government to review the benefits and costs of some of these rules, in light of potential increased competition in the sector and broader policy changes in the wider healthcare system. Provided there is a standard 'minimum' product that PHI is required to offer that, alongside community rating, ensures broad health policy goals are met, then arguably government should otherwise allow the sector to compete as this enhances choice and affordability, all other things being equal.

In particular, the PHI sector is prevented from offering products that would cover primary healthcare services, and also face a number of limitations in how some products can be designed, including limitations on deductibles.

- **Allow funds to compete with products across a wider range of care settings**—Allowing funds to compete across a wider range of products would be expected to encourage innovation by PHI funds, and could be designed to encourage patients to better manage their health risks. This could allow funds to design products that would lower the total cost of care, which in turn would be expected to make PHI more affordable for all members. The experience with the Broader Health Cover changes introduced in the PHI Act 2007 shows that this process takes time to gain momentum; but there is now a significant range of “preventive”, “wellness” and other offerings becoming available through insurers, suggesting that appropriate relaxations of product regulations do lead to more innovation.
- **Review deductible limit regulations**—This policy is ostensibly to ensure that consumers do not take on more risk than they can individually afford, because the current minimums governing product design effectively allow consumers to minimise the taxes they would otherwise have to pay if they did not have coverage. Yet the current restriction that deductibles cannot exceed \$1000 may not be reflective of many customers’ capacity to pay and may be unnecessarily reducing product choice for a number of consumers. Reviewing this regulation to possibly provide some additional flexibility in deductible design could serve to reduce PHI cost growth.

6.1.5 Review regulations that limit the sourcing of prostheses

Under the PHI Act, private health insurers are required to pay mandatory benefits for a range of prostheses that are provided as part of an episode of hospital treatment (or hospital substitute treatment) where a Medicare benefit is payable for the associated professional service (surgery).⁴² A Ministerially appointed committee called the Prostheses List Advisory Committee (PLAC) makes recommendations to the Minister for Health and Ageing on the prostheses that should be listed on the Prostheses List, and the benefits insurers should pay for them. There are more than 9,000 products on the Prostheses List.⁴³

The use of prosthetic items has increased significantly in recent years, with the number of prosthetic items paid for through private health insurance having increased 8.5% in 2010–11 to 1.8 million, and related benefits totalled \$1,380 million, an increase of 8.6%.⁴⁴ This trend is due to a rise in utilisation due to the ageing population, advancements in technology and membership growth.⁴⁵ In addition to increased use of prosthetics, the cost of particular items continues to rise due to factors such as advancing technology and more complex manufacturing processes.⁴⁶

While the Prostheses List arrangements were established to control significant increases in the benefits paid for prostheses, recent trends show that increases are still occurring. The

⁴² DoHA, Private Health Insurance – Prostheses List, <http://www.health.gov.au/internet/main/publishing.nsf/content/health-privatehealth-prostheseslist.htm>

⁴³ Ibid.

⁴⁴ PHIAAC, *Annual Report on Operations 2010-11*, p.18

⁴⁵ Ibid.

⁴⁶ Ibid.

Review of Health Technology Assessment in Australia noted that, while the PDC has been successful in controlling PHI expenditure on prostheses, a review of arrangements to develop a more sustainable model was appropriate, as recommended by the Doyle Review to reduce regulatory burden (including costs) imposed on the medical devices industry.⁴⁷ The HTA review pointed out that benefit negotiations are conducted for each new product that is listed and for every product that is being reviewed, amount to thousands of benefit negotiations every cycle, which is an extremely resource intensive approach.⁴⁸

The HTA Review discusses reducing the regulatory costs of prostheses assessment through measures such as reviewing the terms of reference and restructuring the PDC, and changing the arrangements for the Prostheses List. However, the current regulatory approach governing prostheses listing is unable to ensure that new prostheses will perform in a satisfactory manner. Recent additions to the list have not been required to demonstrate improved clinical outcomes and in fact been associated with increased expenditure due to increased revisions and the more expensive nature of new prostheses compared to established ones. A review by the ACHR⁴⁹ proposes a change to the pre-market approval process to require more detailed information on clinical outcomes prior to approval, more effective post-market surveillance to identify poor or changing performance and establish the cause for higher revision rates when they occur (prostheses rather than patient selection), and reviewing the performance of prostheses in different clinical settings. This information could then be integrated with and used by the regulatory and funding bodies within the health system.

6.2 Governance considerations

In addition to fiscal risk, stakeholders indicated that political risk was potentially even more significant. As one stakeholder put it, simply:

‘Why would ministers take the risk [even if it were a better approach]?’

This is a very significant consideration, and reflected in the media reporting of premium approvals over the past five years (Figure 6.1). Therefore while budget risk represents a potential barrier to change, political risk could be even more significant.

Ministerial discretion on whether or not to allow recommended premium increases contributes to poor levels of process transparency, accountability and predictability. It introduces a political overtone to decisions and creates higher levels of uncertainty for industry that inevitably creep into PHI premiums that are passed on to consumers than would otherwise be the case. It has been argued in the past that the large increases in PHI premiums observed in the period following a Ministerial decision in 2001 not to approve any premium increases in that year catalysed high premium growth in subsequent years (averaging some 8 per cent per annum between 2002-2005) and necessitated a capital injection by the government to maintain the solvency of Medibank.

⁴⁷ DoHA, *Review of Health Technology Assessment in Australia*, December 2009, p.18

⁴⁸ Ibid.

⁴⁹ Graves, S. and Wells, V. for Australian Centre for Health Research, *A review of joint replacement surgery and its outcomes: appropriateness of prostheses and patient selection*, October 2006.

Figure 6.1: Examples of recent media coverage of PHI



Due to the significant public profile of the Minister’s current involvement in premium approvals, stakeholders have indicated that it will be politically difficult for the Minister to withdraw from this involvement under the current governance arrangements. As one stakeholder put it, “The Minister could be seen as ‘shirking’ her responsibility”. Therefore to move forward a governance arrangement needs to be put in place that ‘takes it out of the Minister’s hands’.

A solution would be to move the premium regulation functions of DoHA and the Minister to an independent regulator, which is “arm’s length” from Government. This role could be undertaken by PHIAC, the ACCC, APRA or a newly established, independent body. Given PHIAC’s experience in premium regulation, it could potentially be moved to become a sub-unit of APRA. This would ensure that the history and deep understanding of PHI premiums is maintained, while also achieving some operational synergies between APRA and PHIAC, enabling PHIAC to leverage APRA’s scale and experience in facilitating major industry restructures. In addition, given that moving into a reporting structure under APRA would mean that the function ultimately sits under Treasury’s jurisdiction, other synergies could be leveraged through this approach, as the financial nature of PHI premium regulation would again would benefit from Treasury’s expertise and experience in this area.

Figure 6.2: Current and potential governance framework

Elements of governance framework	Premium determination and oversight	Prudential soundness	Consumer protection and information	Monitoring of competition	Health policy components of system (e.g. Community Rating)
Current governance roles	Minister and Department of Health and Ageing	PHIAC	PHIO	ACCC	Minister and Department of Health and Ageing
Potential governance roles	Independent regulator	PHIAC (as a sub-unit of APRA, then reporting to Treasury)	PHIO	ACCC	Minister and Department of Health and Ageing

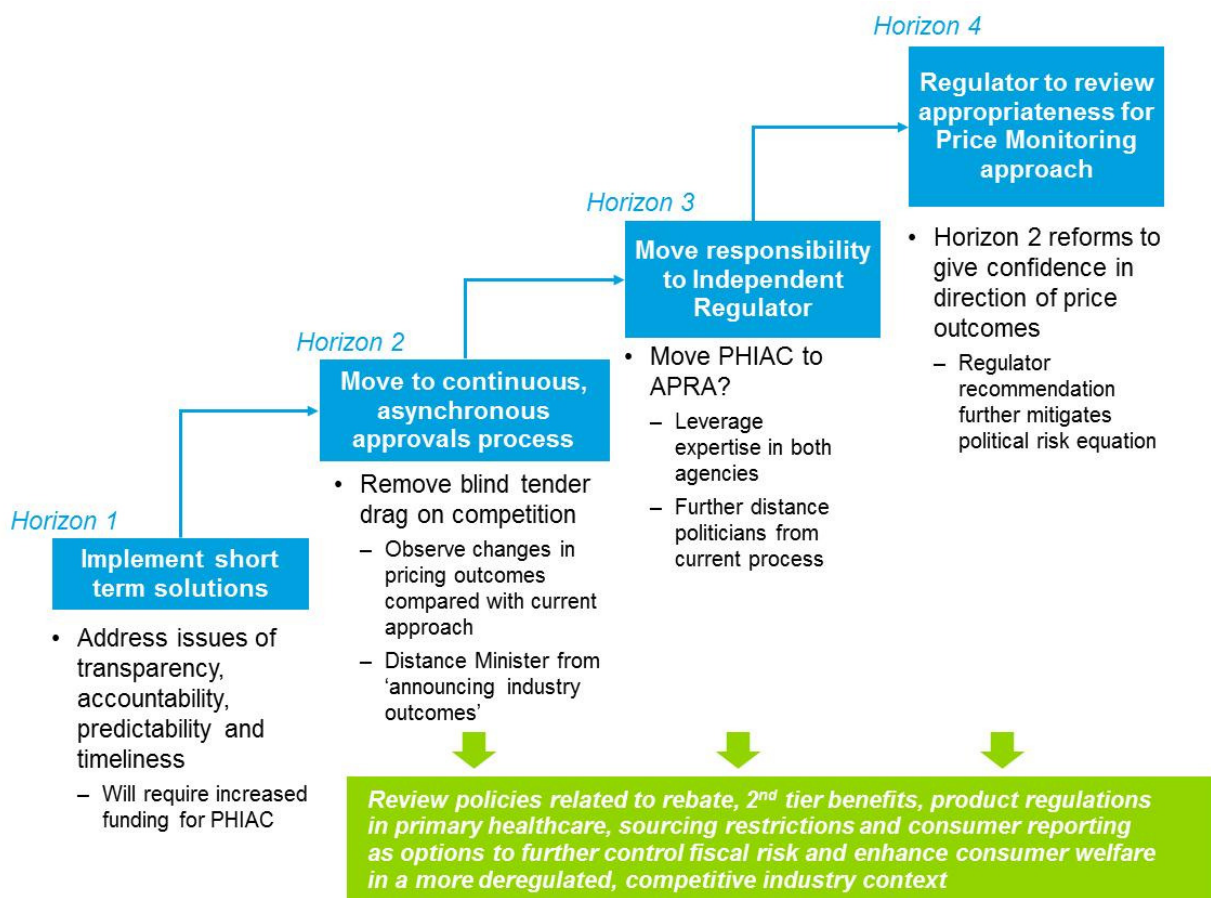
Within this framework, DoHA would retain responsibility for administration of elements of the Act not related to prudential oversight or premium determination, such as community rating, risk equalisation transfers and PHI product regulation.

7 Next steps: a staged approach

Given the recent changes to the PHI industry market structure to a predominantly for-profit industry, the current regulatory arrangements carry a much higher risk of regulatory failure. This could mean that PHI prices are higher than they would otherwise need to be. In addition, with reporting requirements and deadlines varying year-to-year and very limited rationales provided by government for approval or rejection decisions, the current approach could do better with respect to best practice regulatory processes.

This paper has outlined a number of changes that could be made in the short and medium term to address weaknesses in the current processes as well as increase competition in the PHI sector with the goal of improving overall value for money. Reflecting current fiscal and political considerations, as well as stakeholders' uncertainty regarding the sector's potential response to a lighter-handed regulatory approach, we recommend government consider a four-stage process to move to a less intrusive regulatory regime (Figure 7.1). These stages are discussed in turn.

Figure 7.1 A staged approach to change



7.1 Horizon 1: Implement short term process solutions

Chapter 4 identified a number of process changes that could be implemented to address weaknesses of the current approach before potentially embarking on more significant regulatory change. These included:

- **Adopt a DoHA/Ministerial customer charter**—Such a charter would stipulate commitment to standards of service and actions that the industry can take if these standards are not met. The charter would define the timelines for the regulatory process.
- **Shorten approvals timelines**—The current premium setting process can take up to 8 months from the release of approval forms to funds being notified of approval, with timelines and reporting requirements varying year-to-year. As part of the development of a customer charter, PHIAC could reserve rights to approve for a period of time after which the rate increase would be automatically approved. An appropriate length of time could be agreed through discussions between industry and PHIAC. Processing approvals on a shorter time may also require additional funding support for PHIAC.
- **Revise data collection processes**—Data requirements currently change year-to-year, with PHIAC requesting a broad range of data, not all of which are required to be provided. Increasingly, new data analytics techniques are available to industry and government to facilitate more effective and less costly decision making. By collecting data in a digital form, PHIAC could collect up-to-date data to inform approvals process and could review data at a product level to inform decision making in the current regulatory environment.
- **Provide guidance for decisions**—Establishing well-defined guidelines on the metrics used by the Minister in decision-making would improve the transparency and predictability of the process. Guidance could be quantitative or qualitative, and include more detailed information on matters such as the definition of "contrary to the public interest" for the purpose of the Act, what metrics the Minister uses to determine this and when it is to be applied (e.g., when rate rises are above a particular threshold); formulae or qualitative guidance as to what constitutes the "minimum necessary" premium increase (e.g. based on capital requirements), and how this is determined; and quantitative guidance regarding the net margin cut-offs used and the rationale for the inclusion of this criterion in assessment.

7.2 Horizon 2: Move to a continuous asynchronous approvals process

A 'continuous, asynchronous' approvals process would allow funds to apply for an increase at any time during the year, independent of competitor applications.

Moving to such an approach would have the benefit of injecting a degree of competition back into the sector by removing the current 'blind tender' nature of the annual approvals

process. Funds would be able to observe other funds' premium changes and consider potential responses to these changes. This would remove some of the 'herd protection' currently provided to funds through the annual process. Moreover, by allowing for changes to premiums to be made more than once per year, this should remove risk contingencies that funds necessarily need to add to provide for potential unexpected events that could affect cash flows.

Finally, this would be a first step towards observing how funds might operate in a less regulated environment, with a view to reducing uncertainty over competition and pricing outcomes in a price monitoring regulatory environment.

7.3 Horizon 3: Move prudential and premium regulation to an independent regulator

The independence of a regulator underpins the credibility of its decisions. Industries thrive on regulatory and policy certainty and the risk of political interference in premium decisions can dampen incentives for competition and add risk contingencies into the price of PHI that would not otherwise be included. Ministerial involvement contributes to reduced transparency, accountability and predictability of PHI pricing and is therefore not in the best interest of the community.

Increasing the independence of PHIAC would bring current regulations in line with regulatory best practice, but so long as PHIAC is located within the Department of Health and Ageing portfolio, it will be difficult for a Minister to 'stay out' of the decision, given the history in the sector.

Merging PHIAC with APRA would produce a number of benefits, first and foremost by putting some political distance between PHIAC and the health minister (in a sense, it will be out of the Minister's hands), and secondly by potentially unlocking operational synergies between APRA and PHIAC. APRA has extensive experience in overseeing the orderly restructure of financial services industries, including the banking and credit union industries. In addition, as noted in Chapter 6, moving this function under Treasury's oversight would similarly generate benefits, due to the nature of PHI premiums as a financial product. PHIAC also brings important knowledge with respect to the operation of the funds. Administration of other health policy implementation under the Act, including community rating and product regulation, would remain the charge of DoHA.

7.4 Horizon 4: Consider price monitoring regulation

The independent regulator, after observing fund behaviour under the continuous, asynchronous approvals process would also be able to review and make a recommendation for moving to a price monitoring arrangement. This would have the effect of further increasing competition in the sector and driving structural change through the industry.

7.5 Consider options for optimising competition in PHI

In addition to the four-step process outlined above, it is recommended that government consider options to enhance competition in PHI and optimise dynamic efficiency gains by reviewing a range of complementary policy reforms for the purpose of minimising premium growth in PHI. These policies include:

- **Review 2nd Tier default arrangements** which limit PHI's capacity to drive efficiency gains through the private healthcare system and could result in lower premium growth;
- **Review current PHI product regulations** in light of industry restructuring and policy reforms to ensure that the benefits of regulation continue to exceed the costs; in particular, government should consider whether allowing funds to compete across a wider range of care settings could encourage product designs that reward patients for managing their risk and in turn slow premium growth;
- **Review adequacy of regulatory controls over prostheses** through enhanced pre-market approvals and post-market surveillance reduce unnecessary revision rates for devices that add unnecessary costs and increase PHI premiums;
- **Review the effectiveness of activities aimed at improving consumer information** with a view to better supporting consumers in their selection of funds and their use of the PHIO product information website, which would also serve to limit premium growth.

In addition to these policy reforms, the government may also consider the design of the proposed rebate reform, to ensure it does not catalyse an adverse selection cycle by significantly increasing the cost of PHI to consumers above and beyond normal price growth. While it is valid to reform the rebate to reduce budget *volatility*, particularly as part of a move to a more lighter-handed regulatory approach, the current approach could substantially undermine membership in PHI and the broader policy goals for the sector depending on the price sensitivity of consumers.

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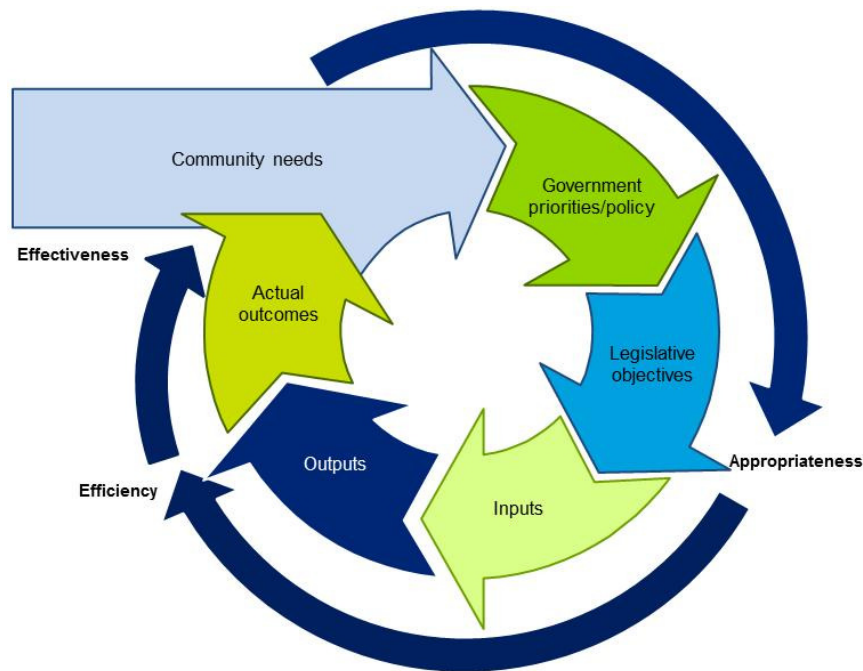
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Appendix B – The evaluation framework



7.5.1 Appropriateness

Appropriateness considers the extent that the outcomes and outputs generated by the proposed option align with the community need, government policy priorities, and stated legislative objectives. It is to ensure that membership will not be adversely impacted so as to uphold access to both public and private health care services. In other words, whether a clear public policy rationale exists for the action. An evaluation of appropriateness typically considers:

1. The problem or problems this government action seeks to address
2. Whether the instrument is capable of addressing the stated problem.

As this is a threshold measure, regulatory options either pass or fail the appropriateness criteria rather than being compared relative to the status quo. If public interest and access to health care is jeopardised then the option will not pass the appropriateness threshold.

7.5.2 Effectiveness

Effectiveness analyses the extent to which the regulatory approach would deliver outcomes to help achieve the stated policy objectives. Because there are multiple policy objectives

governing the PHI sector, this is measured through a number of the sub-criteria outlined below.

Table 7.2: Criteria to measure effectiveness

Criterion	Definition
Choice	The extent to which the regulatory approach supports improved choice in health services. This involves ensuring that social or economic disadvantage is not a barrier to participation in, or outcomes from, the Australian healthcare system.
Affordability	The extent to which the regulatory approach supports increased affordability of PHI and private sector care.
Sustainability	The extent to which the regulatory approach ensures the sustainability of the healthcare system and PHI industry
Accountability	The extent to which the regulatory process is accountable for its operation through reporting processes or other governance mechanisms, and ensures that policy administration is consistent with the public interest.
Prudential soundness	The extent to which the government response supports the long term viability of the industry and is underpinned by responsible governance and discipline guiding its actions.
Predictability and timeliness	The extent to which the government response provides stakeholders with sufficient predictability and certainty regarding the rules, processes and actions involved. This would involve a high level of consistency in the process. The extent to which the premia change process occurs in a timely manner.
Transparency	The extent to which the government response is underpinned by an open process and a high degree of transparency for the stakeholders affected by the action. This would be aided by a simple process that facilitates stakeholder understanding.

7.5.3 Efficiency

Efficiency considers the extent to which the desired outputs and outcomes for the PHI industry are achieved in an efficient manner. Different types of efficiencies can be realised, as outlined in the three sub-criteria below.

Table 7.3: Criteria to measure efficiency

Criterion	Definition
Productive efficiency	This measure considers the allocative and technical efficiency of a proposed option. Allocative efficiency is the extent to which resources are distributed in the most efficient manner, by optimally allocating resources where the marginal benefit of the response is equal to the marginal cost. Technical efficiency is the effectiveness with which inputs are utilised to produce a certain level of outputs. In other words, the ability to produce outputs for the lowest cost or allocating to ensure marginal benefit of the response equate to the marginal cost.
Dynamic efficiency	The extent to which the regulatory approach balances short run and long run efficiency concerns, thus enabling the improvement of efficiency over time. This includes the capacity of the Government to flexibly respond to new data and to change its process or allocation of resources in a manner which reflects this new information or circumstance.

Appendix C – The premium setting process

Historical context for the premia-setting process

Since the introduction of universal health insurance (Medicare) in 1984, the manner in which private health insurance funds set the premium levels for their products has evolved. In particular, the Commonwealth Government's involvement in the process has gradually increased, which can be illustrated in three broad phases as outlined in Figure C.1. Over time, a number of reasons have been identified by both sides of government as to their objectives behind regulating the premia-setting process. These factors have focused on:

- Ensuring changes do not adversely impact the financial stability of the fund
- Preventing funds from charging premiums that undermine the principle of community rating⁵⁰
- Streamlining the process
- Ensuring the affordability of PHI given the increasing cost of living.⁵¹

Figure C.1 Phases of government involvement in premia-setting process

'Light-handed' approach (1980-90s)

During this period, the premia-process was decentralised, with PHI funds notifying the government of their proposed premium changes for approval at any stage during the year. The government retained the right to reject proposed premium changes on two grounds; if the proposed change was considered to have an adverse impact on the rights of members or on the financial sustainability of the insurer. However anecdotal evidence suggests this seldom occurred.⁵² During this period premia increases often exceeded 10% per annum, a result of dwindling membership, adverse selection (see Figure C.3) and 'hit and run' membership, in which consumers purchase insurance when they require it, use PHI services and then leave the market.⁵³

Increased involvement (1996-2007)

In 1996, the decentralised system was replaced with an annual premia-review process. Under this process, funds submitted proposed changes at the same time each year and were not allowed to change premiums throughout the year. As such, they were unaware the extent to which other funds were requesting to change their premiums. Government's involvement further increased in 2001, when a legislative amendment enabled the Minister

⁵⁰ Industry Commission, (1997), 'Private Health Insurance', p.66.

⁵¹ Roxon, (2008), 'DoHA Media release'.

⁵² Port Jackson Partners Ltd, (2009), 'Improving Regulation of the Private Health Insurance Industry', p. 19.

⁵³ HICA, accessed 9th October 2012 via <http://www.hica.com.au/content/regulation-of-health-insurance>

to prohibit premium changes that it considered to be contrary to public interest.⁵⁴ The first and only time this occurred was in 2001, whereby the Federal Minister prevented HBF increasing its premia in part because it was felt this would undermine public confidence in the newly implemented 30% rebate and LHS and because it was not considered a necessary measure to ensure HBF remained competitive.⁵⁵ From 2002, a legislative amendment established that those insurers with proposed changes below the consumer price index (CPI) rate were allowed to implement the change without Ministerial approval.⁵⁶

Formalisation of process (2007)

In 2007, the *Private Health Insurance Act (2007)* again changed the nature of government's involvement in the premia-setting process, with this approach still in use today. Under the current process, PHI funds are required to submit an application form outlining a proposed premia change to the Minister, who must allow changes unless they are considered contrary to public interest.⁵⁷ In the last five years in particular, this has led to numerous Ministerial requests for resubmission of funds' applications. For instance in 2012 there were 24 resubmissions, compared to just six in 2007.⁵⁸ Resubmissions has reduced the average premia increase, for instance in 2008 funds sought an increase of 5.21% however this was reduced to 4.99% following the Minister's request for several funds to resubmit with lower premia increases.⁵⁹ In 2009-10, the premia increases approved and their rationale were made available to the industry in order to increase transparency, and in 2011, PHIAC provided each insurer with the advice that it had provided to the Minister regarding their application.⁶⁰

Even with the aforementioned government regulations, premiums have consistently been increasing, though the extent to which this has occurred varies from year to year. The average increase in premiums dropped in 2006 and again from 2010 as demonstrated in Chart C.2, however these occurred under slightly different premia-setting processes.

⁵⁴ *Health Legislation Amendment Act, (2001)*, p.8.

⁵⁵ Media Release, (2001), 'Minister moves to guard consumers against health insurance premium rises'.

⁵⁶ Access Economics, (2005), regulation of Private Health Insurance Pricing

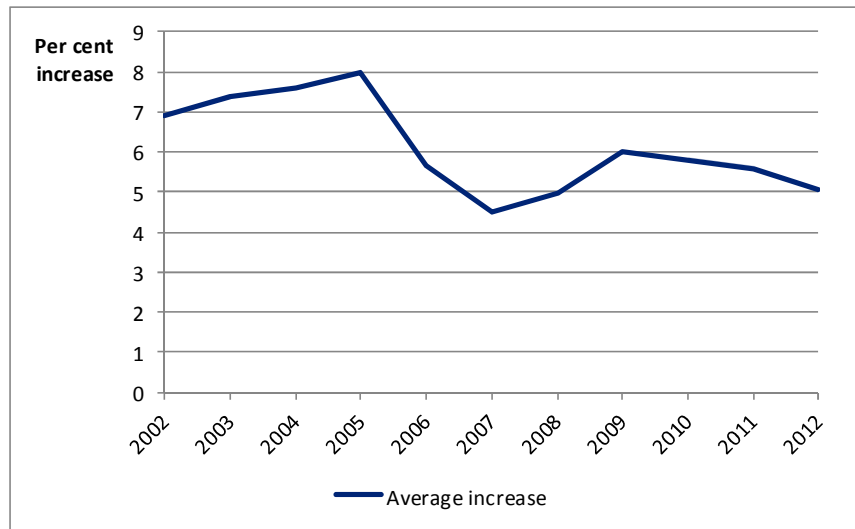
⁵⁷ *Private Health Insurance Act, 2007*. Section 66-10

⁵⁸ Media release, (2012), 'Private Health Insurance Premium Increases at four year low', p.1.

⁵⁹ Roxon, (2008), 'Private Health Insurance Premiums, Sam Newman, Wilson Tuckey Lecture Cruise'.

⁶⁰ Private Health Insurance Circular, (2011), '2011 Private Health Insurance Premium Round –outline of premium approval process', p.9.

Chart C.2: Average annual premia increases



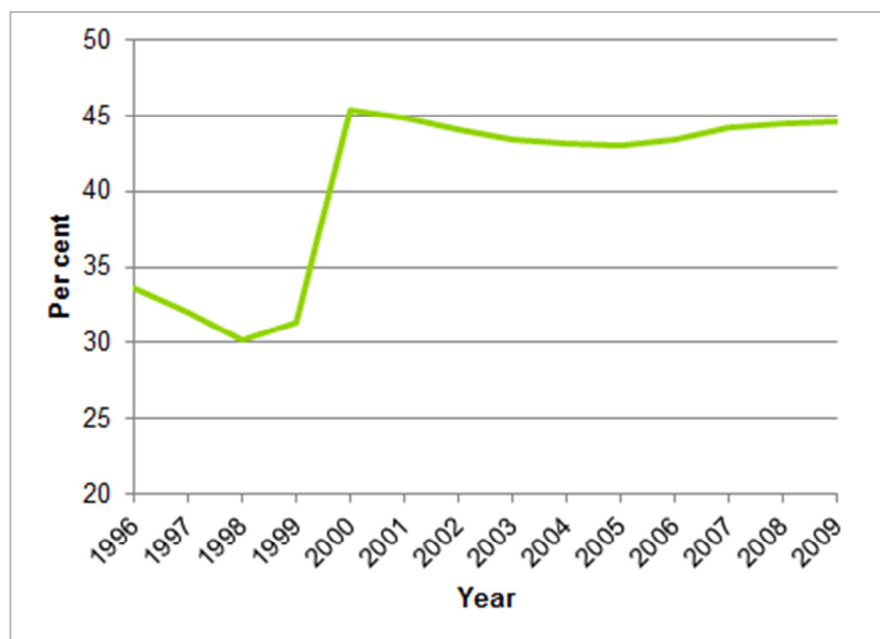
Source: DoHA media releases (2006-12) and Biggs, (2009); DAE analysis

Evolution in the regulation of PHI in Australia

Historical context

The Commonwealth government introduced universal health insurance (Medicare) in 1984, when approximately 50 per cent of the Australian population had PHI coverage. The fall in PHI membership is depicted in Figure C.2.

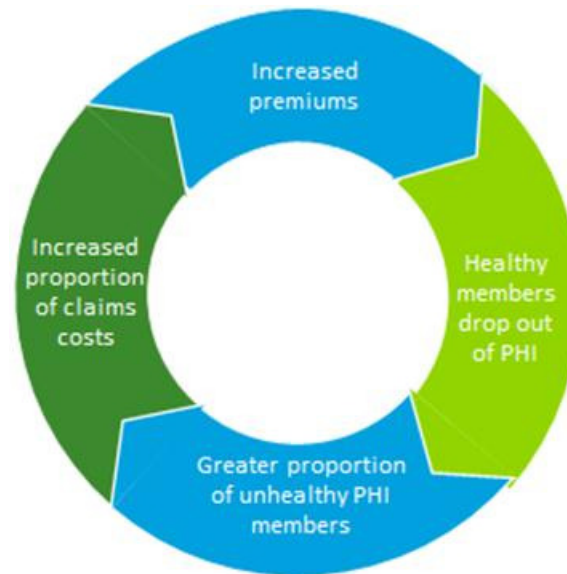
Figure C.2 Per cent of population with PHI hospital cover



Source: PHIAC Annual coverage survey, (2011), DAE analysis

By 1996, PHI coverage had declined to just 33.6 per cent of the population. This in turn placed upward pressure on PHI premiums, as predominantly healthy members ceased their PHI membership as the higher costs made it difficult to justify having PHI given their benefits remained minimal. This left a higher proportion of PHI members making claims, leading to a vicious cycle as demonstrated in Figure C.3.

Figure C.3 PHI vicious cycle of premia increases



This demonstrates the presence of adverse selection in the PHI market. Adverse selection is an example of a market failure, whereby one party has more information than the other regarding the transaction. In the context of PHI, this means that those purchasing PHI have more information than the insurer regarding the state of their health. Those who are unhealthy are therefore more likely to stay in the market to reap the benefits whilst healthy members leave in the face of increased premiums.

In light of these issues and increased community anxiety over high and continually increasing premiums, the government at the time announced a series of reforms to encourage people to switch from the public to private system. This announcement coupled with a trend of increasing premiums prompted an Industry Commission inquiry into the PHI industry in 1997.⁶¹ The report confirmed the presence of adverse selection and the need for regulatory reform. Respective governments have implemented reforms in the PHI industry through both 'carrot' and 'stick' approaches; the former to encourage PHI uptake and the latter to penalise those who do not have PHI. Table C.1 defines the key regulations implemented by the government since the establishment of Medicare.

⁶¹ Industry Commission, (1997), 'Private Health Insurance', p.1.

Table C.1: Government regulations

Regulation	Definition
Community rating	Funds are required to accept and charge all participants the same amount per health insurance product and are therefore not allowed to discriminate according to health status, age, gender, claim history or use of health services. This ensures equal access to PHI.
Risk equalisation	Equalises the risk profiles of insurers so that no consumer is adversely affected through community rating. Depending on their risk profile, funds either contribute to or receive money from the risk equalisation trust, which is administered by PHIAC.
Private Health Insurance Incentives Act (2007)	The Act introduced two policies: Means tested rebate: A subsidy for PHI members based on their income. Medicare levy surcharge: a one per cent tax surcharge for medium to high income earners without PHI.
Private Health Insurance Incentives Scheme	A 30 per cent rebate to replace the means-tested rebate on PHI premia for PHI holders.
Lifetime Health Cover	Two per cent premia increases per year for up to ten years for those over 30 who do not have PHI.
Increased subsidies	Increase in premia subsidies for those aged between 65 and 69 to 35 per cent and to 40 per cent for those aged over 70.
Medicare Rebate	Various forms of a rebate on PHI have been in place overtime. Originally there was a means-tested subsidy, which was replaced in 1999 with the 30 per cent rebate, which in 2012 was reformed to be a means-tested rebate based on income and age, which was revised again in 2012 to become a lump sum payment from 2014 to be indexed at the CPI.

However, the Commonwealth Government’s involvement in the PHI industry is complicated by a number of factors. These include the fact that they have considerable financial exposure in both the public and private health system. One source of this exposure is through the government’s role in providing funding the public system and providing the rebate to PHI members through tax revenue. As PHI members tend to utilise private rather than public health services, PHI membership relieves the financial, capacity and service delivery pressure on the public health system, by reducing the number of Australian’s using the public health system. Furthermore, the Government is the sole shareholder of Medicare and Medibank. In addition, the government is responsible for developing and delivering Australia’s health objectives. All of these issues contribute to government’s complex position as regulator of the PHI industry.

Reforms 1997-2005

Whilst numerous reforms in the PHI have ensued, the first major reform occurred in 1997 with the implementation of the MLS and means-tested rebate. This was the first in a series of three reforms (the other two being the 30 per cent rebate and LHC) to ‘keep private health insurance within the reach of ordinary Australians’.⁶² These policies successfully increased PHI membership, which peaked at 46 per cent in 2000.⁶³ However, as they were

⁶² Industry Commission, (1997), ‘Private Health Insurance’, p.1.

⁶³ PHIAC data (2010), accessed online: <http://www.phiac.gov.au/>.

implemented in relatively quick succession, it is difficult to ascertain and there has been significant debate regarding the respective effectiveness of each policy. This aside, it is broadly accepted that some combination of the 30 per cent rebate and LHC were the most successful at increasing PHI membership.⁶⁴ For instance, analysis by Palangkaraya and Yong found that the LHC accounted for 42-75 per cent of the membership increase.⁶⁵ In 2005, the 30 per cent rebate was increased to 35 per cent and 40 per cent for those aged 65-69 and over 70 respectively.

Proposed sale of Medibank

The sale of Medibank has been a long standing political and public issue which intensified in the mid-2000s. In 2003, a scoping study into the sale was conducted and subsequently followed up in 2005. This second report prompted the government to inject \$85 million in capital to remedy Medibank's 16 per cent capital, despite comprising the majority market share of the PHI market.⁶⁶ In March 2006, the government announced the proposed sale of Medibank Private in order to:

- Contribute to a competitive and efficient PHI industry;
- Ensure quality of service for Medibank Private contributors;
- Remove perceived conflict of interest for the government; and
- Reduce upward pressure on premiums.⁶⁷

In September 2006, it was announced the sale would take the form of a share market float in 2008, and the *Medibank Private Sale Bill* 2006 was consequently passed in Parliament in December.⁶⁸ However following the change of government in 2007, the sale did not proceed.

The capital injection and proposed sale of Medibank were controversial, with opponents arguing the former was to the detriment of other PHI funds and that the latter would not be in the public's interest and have an adverse effect on premiums.⁶⁹

Current system

There are several facets of current government intervention in the PHI industry, the interaction of which is represented in Figure C.4. The current system is overseen by several regulatory bodies, including the Private Health Insurance Administration Council (PHIAC), the PHI Ombudsman (PHIO), the Minister for Health and Ageing and the Department of Health and Ageing (DoHA), whose respective roles comprise:

- **Minister for Health and DoHA** play a crucial role in the premia-setting process as they assess funds' applications for premia changes and ultimately decide whether to accept,

⁶⁴ McAuley, (2005), 'Private Health Insurance: Still Muddling Through'.

⁶⁵ Palangkaray & Yong, (2004), 'Effects of Recent Carrot-and-stick policy initiatives on PHI coverage in Australia', p. 3.

⁶⁶ Medibank Private, (2005), 'Annual Report 2005', p. 5.

⁶⁷ Buckmaster & Davidson, (2006), 'The proposed sale of Medibank Private: historical, legal and policy perspectives', p.2.

⁶⁸ Department of Finance and Administration, (2005), 'Annual Report 2005-06', p.43.

⁶⁹ Gillard, (2006), 'ABC National' accessed <http://www.abc.net.au/pm/content/2006/s1624456.htm>.

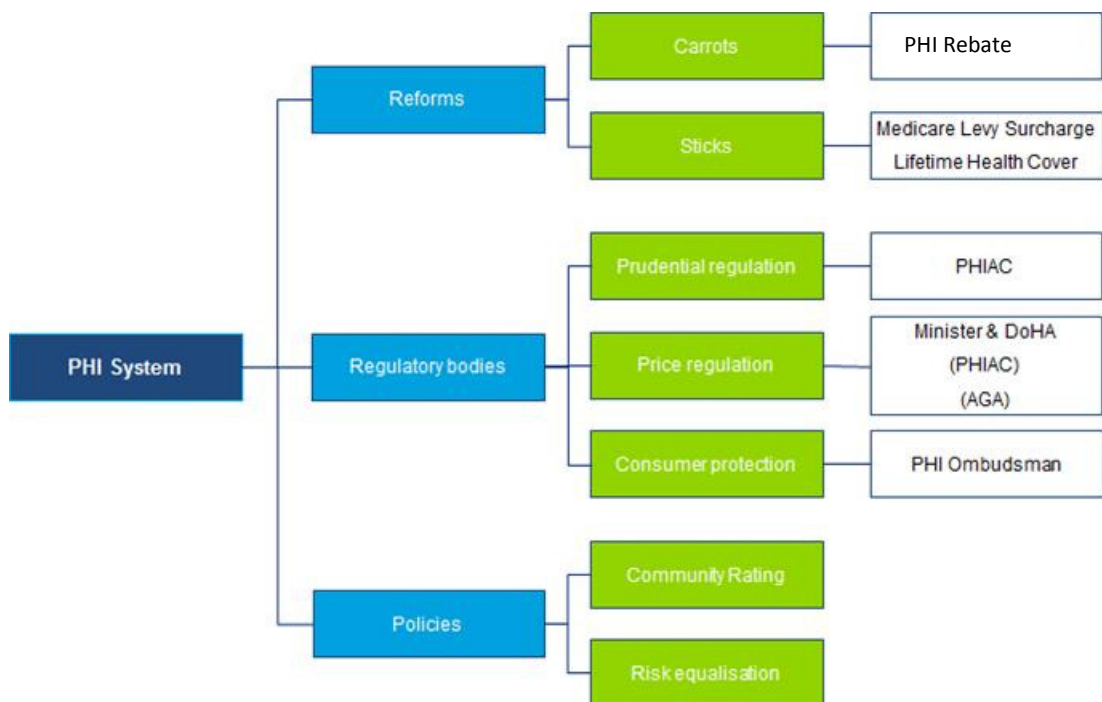
ask for resubmission or reject the proposed premia changes. More broadly, they are responsible for developing national health policies.

- **PHIAC** is responsible for regulating the PHI industry, specifically monitoring and compliance activities, developing operating standards and procedures, administering risk equalisation, collecting and disseminating statistical data, financial and product information on health funds to assist consumers to make informed choices and ensure the prudential safety of funds.⁷⁰
- **PHI Ombudsman** is responsible for protecting consumer interests, including providing information and addressing complaints or concerns.⁷¹

In addition, a means-tested rebate based on income and age replaced the 30 per cent rebate in July 2012, to ensure PHI was both sustainable and equitable.⁷² This was further revised in November 2012 as part of the Mid-Year Economic and Fiscal Outlook, which announced the rebate would be decoupled from premiums starting in 2014 and indexed at CPI thereafter.

As part of the changes to means-test the rebate, the MLS was also increased from what to what for high-income earners without PHI to encourage them to purchase PHI. Community rating, LHC and risk equalisation continue to assist the government’s regulation of the PHI system.

Figure C.4: Regulation in the PHI industry



⁷⁰ Roxon, (2011), 'Letter of statement of intent for PHIAC'.

⁷¹ Roxon (2011), 'Letter of statement of intent for Private Health Insurance Ombudsman'.

⁷² Roxon, (2009), 'Media Release: Rebalancing support for Private Health Insurance'.

The current PHI premia-setting process

Section 66-10 of the Act provides requirements for private health insurers wishing to change the premiums charged (both increases and decreases). Changing PHI premiums is regulated for several reasons, to:

- Place downward pressure on premiums
- Ensure PHI remains attractive to consumers
- Align with government's interest in PHI
- Ensure premium increases occur in a transparent, timely & consistent manner.⁷³

There are several steps before a premium can be changed:



Application

Application forms are released in September and must be submitted by the specified deadline in November. Insurers who do not wish to apply for premium changes must also advise DoHA by the submission date.⁷⁴ Applications are made to the Minister for Health and Ageing and comprise the following information:

- A letter outlining key details pertaining to the premium change, including the date of effect, percentage change and reasons for change. This must be supported by quantitative and qualitative material and certified by an actuary
- Information on the individual products for which the premium change applies
- Financial data including forecasts
- An executive summary to capture the key information.⁷⁵

Assessment and review

Assessment of the application is undertaken by at least three stakeholders; the Minister for Health and Ageing, DoHA and PHIAC. Some applications are also assessed by the AGA and on occasions, additional information from the insurer is requested.⁷⁶ Supplementary information is assessed along with the private health insurer's application, including:

⁷³ Private Health Insurance Premium Round, (2011).

⁷⁴ DoHA letter on premium round, (2012).

⁷⁵ Private Health Insurance Premium Round, (2012).

⁷⁶ DoHA letter on premium round, (2012).

- Appointed actuary report;
- PHIAC operations reports;
- PHIAC quarterly data; and
- Standard Information Statements.⁷⁷

Assessment is undertaken to ensure premium changes are kept to the minimum necessary and protect the affordability of PHI.

Ministerial decision and resubmission

Section 66-10 (3) of the Act specifies that premium increases must be accepted unless the Minister determines the premium change is not in the public interest (though this remains undefined).⁷⁸ If accepted, the premium increase ensues.

If, however, the Minister rejects the application, insurers are notified of the outcome and provided with information by PHIAC and the AGA. Insurers are given the opportunity to resubmit their application with the intention of either reducing the proposed premium change or providing further justification for the proposed change.⁷⁹ If insurers choose to resubmit, the proposed premium change returns to the application stage and undergoes the process again, possibly for multiple iterations.

Upon returning to the ministerial decision stage for reconsideration, the Minister can once again either reject or accept the premium change. The Minister notifies the insurer of their decision in February.

Premium Implemented

If the premium change is rejected, the premium is maintained at its current level and tabled in Parliament within 15 days with the rationale for refusal.⁸⁰ Alternatively, if the Minister accepts the application, then the premium change is implemented.

Changes to premiums are announced towards the end of February and come into effect on 1 April.⁸¹ The delay between announcing and implementing changes occurs as the Act specifies that insurers are required to provide consumers with sufficient notice prior to any premium changes occurring, generally accepted to be 30 days.⁸² The rationale for this is to enable consumers to respond and potentially seek alternative products or providers.⁸³

⁷⁷ Private Health Insurance Premium Round, (2011).

⁷⁸ Private Health Insurance Act, (2007), 66-10 (3).

⁷⁹ Private Health Insurance Premium Round, (2011).

⁸⁰ Department of Parliamentary Services, (2012).

⁸¹ DoHA letter on premium round, (2012).

⁸² Private Health Insurance Premium Round, (2011).

⁸³ Ibid.

Recent developments in the PHI industry

The 1997 Industry Commission report provided an extensive overview of the PHI industry; however, since the report was published, a number of changes have taken place within the PHI industry. These changes are outlined briefly below.

- **Broader healthcare system:** The health care system has transformed since the Industry Commission report, most recently through the introduction of The National Health Reform Agenda (NHRA) in 2011. This agreement between the Federal Government, States and Territories, seeks to improve Australia's health system and ensure its sustainable funding.⁸⁴ This has led to new policy focuses and funding arrangements, such as activity-based Commonwealth funding to public hospitals and the establishment of the National Health Performance Authority (NHPA) to improve performance reporting arrangements. The NHRA has therefore altered the national health policy landscape in which PHI industry operates. Further, new government priority areas in health services such as a focus on disease prevention may influence the products offered by PHI funds. New activity based funding changes also increases competition between public and private hospitals, as government may choose to purchase certain health services from the private sector if they can provide them below the national efficient price as set by the Independent Hospital Pricing Authority (IHPA). In doing so, the private sector could expand its services where it has a competitive advantage.
- **Industry structure:** The structure of the PHI industry has also changed significantly since the Industry Commission report. Historically, the PHI industry predominantly comprised mutuals; however this shifted in 2008 following the introduction of the Private Health Insurance Act 2007. Whereas for-profits have flexibility in how they allocate assets of a health benefits fund, the 2007 Act places limitations on how mutuals allocate assets. Consequently for-profits now dominate the market, with 68.6 per cent of the market share.⁸⁵ This means a greater proportion of funds now seek to earn their shareholders a commercial rate of return. This incentive to create shareholder returns clashes with a process which seeks to minimise premium increases, and threatens to incentivise funds to propose higher premium increases. Moreover, given profits are not retained by the fund but distributed to shareholders, there is less incentive to improve efficiencies or management costs.
- **Membership:** The year prior to the Industry Commission report, PHI members comprised just 33.6 per cent of the population, where in contrast, PHI membership reached 45.7 per cent in 2010.⁸⁶ As previously stated, this surge in membership is due to the government interventions that occurred from 1997, namely the LHC, MLS and rebate. The current nature of membership in PHI therefore differs to that analysed in the report.

⁸⁴ Council of Australian Governments, (2011), 'National Health Reform Agreement'.

⁸⁵ Government and Public Affairs, (2012), 'A premium round reform agenda', p.10.

⁸⁶ PHIAC, (2011), www.phiac.gov.au

Appendix D – Consultation briefing paper and methodology

Consultation methodology

As part of the report, Deloitte Access Economics organised consultations with numerous stakeholders (identified in Table 8.1) from both government and non-government sectors. This included arranging meetings to seek their views on the premium setting process and regulation. Prior to meeting, the stakeholders were provided with the following consultation brief to outline the background of the project and the questions to be discussed during the consultation. In addition, stakeholders were provided with an attachment on **Error! Reference source not found.**, which illustrates the current premium setting process.

Consultation brief

Our approach: seeking ‘integrative’ solutions in PHI regulation

The past several years have been marked by significant debate around the policy settings governing the rebate for private health insurance (PHI). With the changes to the rebate now having been enacted, Medibank is looking to move past this debate to begin a conversation with government regarding possible ‘win-win’ policy reforms for the industry.

Specifically, Medibank would like to explore opportunities for improving the processes, regulations and policies that inform premium setting by the industry and the structure of PHI in Australia. Noting the recent establishment of the Premiums and Competition Unit within PHIAC, it may be that government similarly sees an opportunity to review the premium setting regulations and associated policy framework to enhance competition and choice in PHI.

To this end, Medibank has engaged Deloitte Access Economics with the goal of starting a constructive, evidence-based conversation regarding the merits of potential changes to the status quo, and outlining the major issues that may need to be resolved over time before any changes could be implemented. Our aim is to take into account the concerns of stakeholders with a view to developing a way forward that benefits the broader community, as well as relevant industry stakeholders.

Structure of the consultation

We would like to use our discussion with you as the first in a series of conversations to ensure we are considering any relevant datasets or salient policy considerations in our analysis. Key topics we would like to cover in this consultation include:

- What do you see as the major purpose served by premium regulation in the first place?

- What are the major benefits of the current process?
- Are there limitations to the way the current process operates?
- What are the major health policy objectives served by PHI?
 - How do the current regulations align with these objectives?
- What are your views on competition in the PHI sector?
 - What is the impact on community rating and risk equalisation on competitive outcomes?
 - What data should be considered in evaluating competition in the PHI sector?
- Are there alternative mechanisms for setting premiums that perform better against policy goals for PHI and the health system?
 - What do you think are the potential risks or trade-offs of these alternative approaches?
 - What conditions would need to be present for alternative approaches to premium setting to be implemented?
- What do you see as the major limitations of previous reviews of the premium setting policies?

We would welcome the opportunity to further engage with your team on issues of data to be considered to ensure a balanced, evidence-based approach can be brought to our research.

List of stakeholders consulted

Table 8.1: Stakeholders consulted

Stakeholder	Organisation	Title
Shaun Gath	PHIAC	CEO
Neil Smith	PHIAC	General Manager of Industry Operations and General Counsel
Hoa Nguyen	PHIAC	Director, Industry Analysis and Compliance
Marcel Canaly	PHIAC	Senior Industry Analyst
Josh Edwards	PHIAC	Special Advisor, Prudential Standards and Transactions
David Tune	Department of Finance and Deregulation	Secretary, Department of Finance and Deregulation
Susan Page	Department of Finance and Deregulation	Deputy Secretary, Deregulation Group

Stakeholder	Organisation	Title
Jane Halton (Apologies)	DoHA	Secretary
David Learmonth	DoHA	Deputy Secretary
Richard Bartlett	DoHA	First Assistant Secretary, Medical Benefits Division
Doug Fawns	DoHA	Assistant Secretary, Medical Benefits Division
Nathan Hyson	DoHA	Acting Director, Legal Policy and Consumer Strategies, PHI Branch
Alastair Wilson	DoHA	Director, Pathology Agreements and Schedule Maintenance
Dr John Laker	APRA	Chairman
David Haigh	Commonwealth Treasury	Principal Advisor, Health
Emily Hurley	Commonwealth Treasury	Senior Advisor, Health
Amanda Katter	Commonwealth Treasury	Social Policy Division
Johnny Cochrane	Commonwealth Treasury	Analyst
Greg Medcraft	Australian Securities and Investments Commission	Chairman

Limitation of our work

General use restriction

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Contact us

Deloitte Access Economics
ACN: 49 633 116
Level 1
9 Sydney Avenue
Barton ACT 2600
PO Box 6334
Kingston ACT 2604 Australia
Tel: +61 2 6175 2000
Fax: +61 2 6175 2001

www.deloitteaccesseconomics.com.au/

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