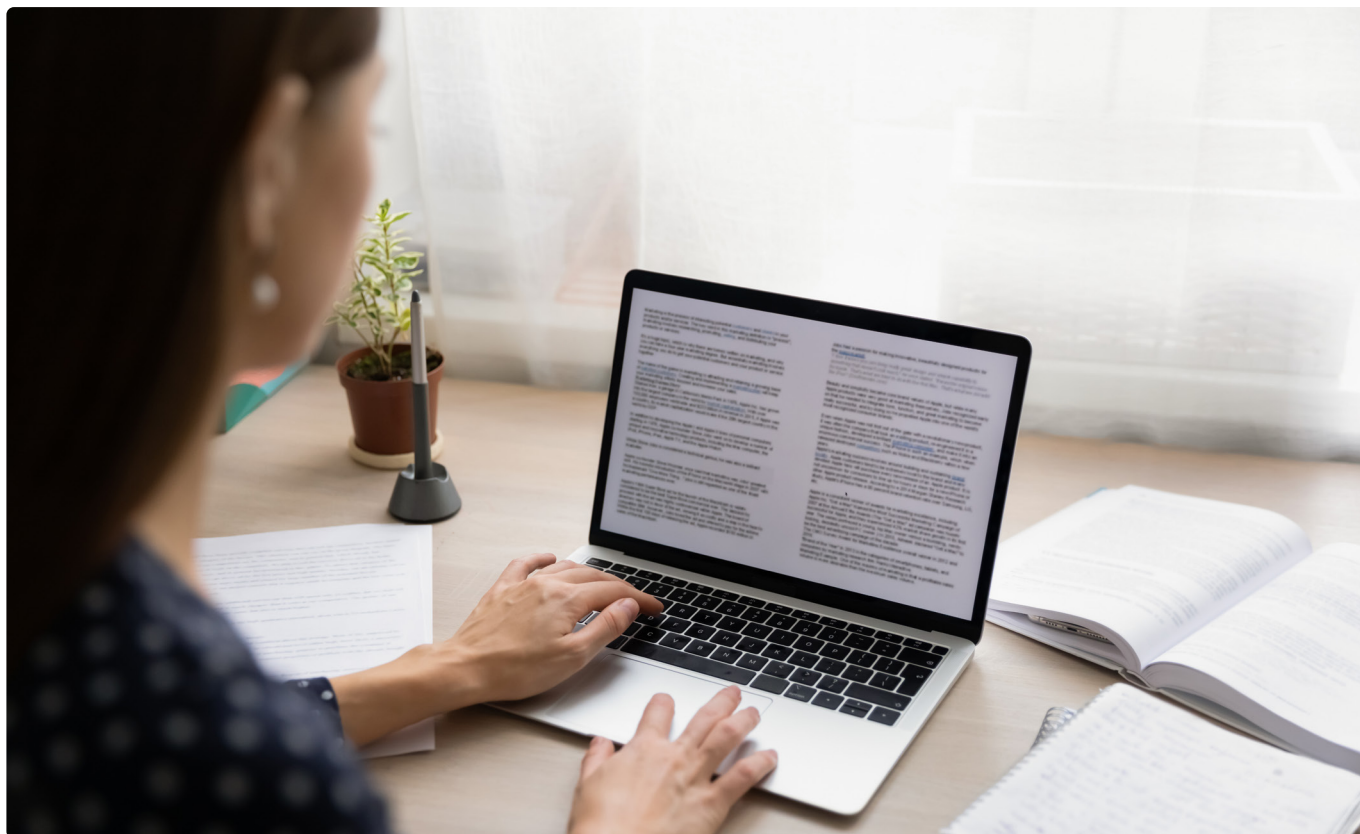


Optimizing private health insurance: findings and possibilities

In this edition

In this article we explore the recent review of incentives for participation in Private Health Insurance (PHI) and encourage input to the consultation. The aim of the incentive policies is to contribute to the sustainability of the mixed delivery model of private and public healthcare in Australia.



Background

The objective for the Australian health system can be summarised as universal access to high quality care that results in the best outcomes at an efficient and affordable cost to individuals and the community.

In context, the core values for any changes are:

- Maintaining community rating
- Maintaining clinical autonomy
- Maintaining the mixed public and private provision of health services

PHI participation contributes to funding the overall sustainability of Australia's health system. Private Health Insurance (PHI) forms a central part of funding in the Australian health system, with over 45% of the population currently holding private hospital coverage according to Australian Prudential Regulation Authority (APRA) numbers.

Since PHI premiums reflect the average claim cost of people insured, and remain community rated, policies would not be affordable if only people with high expected treatment costs are insured. Policies which incentivise participation in PHI result in lower premium rates which in turn make private healthcare more affordable for all Australians.

The policies, known as PHI incentives, which include the Medicare Levy Surcharge (MLS), Lifetime Health Cover (LHC) and the private health insurance rebate (Rebate) have remained largely unchanged for over a decade. Continuing effort to optimise the policy settings is necessary to ensure the best value to consumers and to the community.

In this light, the Department of Health and Aged Care (Department) commissioned Studies to investigate the effectiveness of these tools.



"The objective of PHI incentives is to encourage those who can afford it to contribute more to their healthcare through purchasing PHI."

The PHI incentives, the approach and key findings

The objective of PHI incentives is to encourage those who can afford it to contribute more to their healthcare through purchasing PHI, while also supporting access to private healthcare for others. Each policy has its own particular objectives, for example, the MLS seeks to ensure high participation (or contributions) among high earners, reducing average premiums for PHI and private healthcare. On the other hand, the Rebate attempts to make premiums more affordable for older people, or those on lower incomes, while the LHC incentivizes obtaining hospital cover earlier in life and maintaining it, supporting community rating.

Throughout the project, stakeholder consultation took place through workshops, interviews, written consultations, and regular updates through the Department's communication channels. This allowed for a comprehensive review of the cost, effectiveness, and impact of PHI incentives on the healthcare system, as well as preferences of consumers.

The analysis of the effectiveness of these tools was made possible by insurers, who provided comprehensive claims data that formed a solid foundation for analysis. The report also involved a survey of over 1500 consumers to assess their preferences and the consequences of different scenarios related to PHI policy settings. This allowed for the identification of changes that would have significant impact on expected consumer behaviour.

A summary of key findings is:

Policy	Key Findings from analysis
MLS	Powerful impact on the groups it targets Reduced impact on individuals under 30 years of age or have taxable incomes below \$100k.
Rebate	Provides a net financial offset for government in incentivising individuals to access health care through the private sector. Reduced value to government when provided to high income earners
LHC	LHC continues to make a positive contribution to PHI participation.

After surfacing the key findings and analysis there is room to explore the possible recommended actions. Here are some examples of the types of questions arising...



Is PHI a good financial deal for the government?

Yes. Findings indicate that the PHI subsidy policies are financially advantageous for the government. There are net savings resulting from the Rebate meaning the offsets to public hospital costs are larger than the subsidy costs, considering the MLS recoveries. Net savings increase with age, as the average hospital claims funded exceed the average Rebate. For instance, individuals over 75 years of age receive an average PHI Rebate of \$965 per person, while the average claims funded are over \$7,000 per person. While this is based on assumptions such as moving from private to public if the Rebate is taken away the sensitivity analysis shows the robustness of the findings.

The recommended actions depend on policy balance or trade-off between:

- a. More high cost (likely older) policyholders will give more return for rebate spend.
- b. More non-claimers will increase PHI participation and enable lower premiums

Should the reduction of the percentage rebate by annual indexation be stopped?

Our findings indicate the rebate is effective, though with low elasticity there is little persuasive empirical evidence to increase the total amount spent on rebate. On the other hand, the research indicates that reducing the rebate further may increase the government spend in relation to public hospital costs. The short-medium term approach is to keep the budgeted spend and make the outcomes more optimal.

"Findings indicate that the PHI subsidy policies are financially advantageous for the government."

Would more recent information show increased elasticity?

Regular testing of consumer behaviour is recommended to update on this.



What changes are effective given studies of consumer behaviour?

The report explored consumer behaviour and tested changes to LHC start date, loadings and other rules. It was determined that none of the proposed adjustments represent a significant improvement on the current system. Findings revealed that increasing starting age (from 30 to 35 or 40) would benefit people who take out PHI later in life, but do not result in a materially better outcome overall. Comparatively, the MLS policy has more pronounced impact on the individuals it targets compared to other PHI incentive policies. A key decision revolved around determining when it is fair to apply such a strong incentive to individuals. Even when the MLS appropriately targets specific individuals, it may not be incentivizing the most desirable actions because only the purchase of Basic tier hospital policy is necessary to avoid the MLS.

Other questions that have arisen:

- **What about the trend of more consumers electing to pay MLS rather than buy PHI?**

We note the MLS is effective in that over 90% of consumers on the highest incomes subject to MLS choose to buy PHI. This brings out the policy question of at what level of income you increase the penalty for not contributing via private health insurance.

- **Would an asset measure help rather than just an income measure (for MLS and Rebate)?**

While this may be controversial it is worth exploring possibilities given an objective is that to encourage those who can afford it to contribute more to healthcare. In practice the first step is to explore whether a measure that can be used already exists, thus not adding to burden and complications.

"MLS is effective, but may not incentivise desirable outcomes with some only purchasing Basic tier."



Avenues for change – Optimize and Simplify

Regarding the MLS, it is effective to maintain its application for individuals with the highest capacity to pay for PHI, while excluding those earning less than \$90k. The challenges with the value proposition of PHI for the latter group are evident from their lower participation rate. To optimise the MLS, annual indexing of thresholds based on earnings changes is recommended. For individuals in the highest income brackets (tiers 2 and 3), the requirement for adequate products should be to purchase Silver-tier or higher hospital cover. Increasing the MLS for these high earners to 2% of their income would simplify the system, providing a strong incentive for insurance uptake. The settings can be such that an increased contribution to the health system is achieved from those with higher capacity to pay.

The current or similarly tiered Rebate should continue to be provided for those with high utilisation of services. This is the segment where the Rebate provides greatest value for money for government, that is, the public hospital cost savings are highest. Additionally, removing the Rebate for Tier 2 earners, who are strongly motivated by the MLS, would be beneficial as it offers the least value for money to the government. This recommended action assumes rebate spend is fixed and the policy objective is to get a greater offset.

Consultation

The study into PHI Incentives is published along with a consultation paper on the website of the Department of Health and Ageing. Feedback on the finding and recommendations of the studies is open until 3pm Tuesday 15 August 2023.

The consultation link is below:

<https://consultations.health.gov.au/medical-benefits-division/consultation-on-phi-studies/>



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