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AUSTRALIAN CENTRE FOR ECONOMIC RESEARCH ON HEALTH

Reforming health care financing – allowing opting out of Medicare with risk-adjusted subsidies?

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THE UNIVERSITY OF WESTERN AUSTRALIA

Agenda

1. Private Health Insurance in Australia;

2. Subsidising PHI in Australia:

    - Why?
    - How?

3. How to Proceed?

Part 1.

Private Health Insurance in Australia

Private Health Insurance (PHI)

- Voluntary coverage;
- 44% of the population has PHI (2007);
- PHI share of total health expenditures 7% (2007);
- Fairly competitive market:
  - 38 funds (32 not-for-profit);
  - 60% market share for the 4 largest insurers;
- Heavily regulated (e.g. *mandatory subsidies*).

PHI coverage

- Supplementary coverage for (parts of) the costs of services uncovered by Medicare (e.g. hospital charges levied by private hospitals;
- Duplicate coverage for the costs of services (partly) covered by Medicare
  - Increased choice of doctor for hospital treatment (public patients are assigned a hospital doctor);
  - Shorter waiting times;
  - Better (perceived) quality of care.

Complex system of subsidies in PHI

- 30-40% *ad valorem* premium subsidy to individuals who purchase PHI;
- Claims-equalisation scheme;
- A tax penalty of 1% of income (for incomes exceeding $50,000 p.a. for singles and $100,000 p.a. for couples) if individuals do not hold PHI (the Medicare levy surcharge).
- Lifetime community-rating per product per insurer (with open enrolment).

Part 2.

Subsidising PHI: why & how?

Subsidising PHI: WHY?

- Direct way to achieve the goal of achieving an ***affordable access*** to (the coverage of) health care services for vulnerable groups (e.g. low-income or high-risks individuals).

- The main country-specific policy argument for subsidising PHI in Australia is to ***decrease pressure on public financing*** by:

  1. Increasing consumers' choice of coverage;

  2. Increasingly relying on private resources to finance health care;

  3. Indirect way to achieve affordable access to services for everyone.

Subsidising PHI: not without problems

a. ***Duplication***?

b. ***Effective*** in decreasing the pressure on public financing overtime?

c. ***Adverse selection***: a constant threat to PHI stability?

d. ***Two-tier system***?

e. Is there a stable equilibrium with acceptable ***waiting times*** in the public sector? (Scotton, 1989).

f. Political and regulatory ***instability***.

Interim conclusions

- Subsidising Duplicate PHI appears not to be able to achieve its main policy goals:
  - To decrease the financial pressure on the public scheme;
  - Affordability and fairness in the access to services for everyone.
- Subsidising PHI is *unnecessary* to guarantee affordable access to health care services already covered by Medicare, and *disproportionate* because it results in several problems which create instability and inefficiencies in the market.

Subsidising PHI: How?

- Taking the decision to subsidise PHI as given.

- Four regulatory tools to make PHI affordable in a competitive insurance market:

  1. Risk-adjusted subsidies;
  2. Claims-based subsidies;
  3. Premium-adjusted subsidies;
  4. Premium rate restrictions;

  5. Combination of the above mentioned strategies.

1. Risk-adjusted subsidies

- High-risks receive a risk-adjusted subsidy from a Subsidy Fund, filled with mandatory contributions from the low-risks.

- Risk-adjusted subsidies are equal to the predicted expenses based on the risk factors that insurers use, such as age and health status.

Risk-equalisation

- **Risk-equalisation** refers to a system of *ex-ante* risk-adjusted subsidies that equalises the financial differences between insurers that arise from differences in their risk profile.

Effects

- Risk-equalisation schemes achieve affordability in competitive PHI markets;
- No distortion of premium competition:
  - Insurers are fully free to ask risk-rated premiums;
  - Consumers are fully price sensitive at the margin.

2. Claims-based subsidies

- Claims-based subsidies are based on some or all actual expenses of insurers, e.g. above a certain threshold for each individual.

- Claims-equalisation refers to a system of *ex-post* claims-based subsidies that equalises the financial differences between insurers that arise from differences in their claims.

Effects

- Claims-equalisation schemes result in a reduction of the insurers' financial risk that:
  - » Reduces the premiums, in particular for the high risks (i.e. it increases affordability);
  - » Limits price-competition (i.e. it decreases efficiency);

→ tradeoff affordability - efficiency

3. Premium-adjusted subsidies

- Effective in achieving affordability.
- But, not optimal:
  - They reduce the consumers' and insurers' incentives for efficiency:
    - » Less effective price-competition and risk of premium inflation;
    - » A welfare loss because of the moral hazard due to over-insurance.
  - They create a misallocation of subsidies.

→ tradeoff affordability - efficiency

4. Premium rate restrictions

- An alternative strategy is implicit cross-subsidies enforced by premium rate restrictions (and open enrollment) for a specified insurance coverage.

- Examples of premium rate restrictions:
  - » Community rating;
  - » A ban on certain rating factors;
  - » Rate band.

Premium rate restrictions

- *Goal*: to create implicit cross-subsidies from the low-risks to the high-risks.

- *Effect*: Such pooling of people with different risks creates substantial predictable profits and losses for subgroups → and thereby create incentives for *risk-selection*.

→ **tradeoff affordability - selection**

The preferred strategy

- *Risk-adjusted subsidies* or *risk-equalisation* is the preferred strategy because:

  - In the case of perfect risk equalisation there is no need for any other strategy and no tradeoff exists.

  - Each of the other strategies inevitably confronts policymakers with a tradeoff.

Part 3.

How to proceed?

How to proceed?

- The current system of duplicate coverage and subsidies is not sustainable on economic grounds.
- Duplication can be removed by:

1. Rely entirely on PHI (e.g. confine Medicare to a safety-net role (US-model));
2. Rely entirely on Medicare & reducing the role of PHI (e.g. confine PHI to supplementary coverage);
3. “Medicare/PHI Choice”.

Which direction?

1. 100% PHI

2. 100% Medicare

3. "Medicare/PHI Choice"

1. Only PHI

- An increasing reliance on unregulated competitive markets for PHI results in:
  - » An increasing conflict with society's goal of *affordability;*
  - » A *welfare loss* to society, e.g. if individuals' (altruistic) preferences cannot be met.
- Most OECD countries (including Australia) consider affordability and equity in the access to health care as fundamental goals.
- Only PHI is not an option!

2. Only Medicare

- An alternative to Subsidising Duplicate PHI in Australia could also be to have a universal mandatory coverage scheme for a uniform set of benefits (Butler, 2008).

- More efficient and equitable to invest the 3 billion AUD currently used to subsidise PHI on improving Medicare's responsiveness to consumers preferences and needs.

2. Only Medicare

- Universality and uniformity of coverage does not account for heterogeneity across individuals (especially across income groups) and across treatments:
  - ✓ It does not reflect differences in preferences;
  - ✓ By forcing a level of coverage above the one some groups would have chosen autonomously, it induces moral hazard above the social optimal.

- Universal mandatory coverage for a uniform set of services is <u>not</u> per se a *necessary* and/or *proportionate* measure to achieve the goal of affordable access to (the coverage of) health care services.

c. "Medicare/PHI Choice"

- No duplication of coverage;
- Make Medicare & PHI fully substitutable (i.e. "opting-out"): consumers may choose to either be enrolled in Medicare (zero-premium) or PHI (positive-premium);
- PHI has to pay <u>all</u> health care expenses of their insured.

c. "Medicare/PHI Choice"

- The current forms of subsidy for PHI:
  a. 30-40% premium-related subsidies;
  b. Ex-post claims-based subsidies (= excess loss compensations, although called risk-equalisation);
  c. Community rating per product.

- Effects of a and b: reduction of incentives for efficiency;

- Effects of c: risk selection; and premium differentiation via product differentiation.

Why not risk-adjusted subsidies?

- Why not *ex-ante risk-adjusted* subsidies?

- Risk equalisation should be the primary regulatory tool to escape from the tradeoffs between affordability, efficiency and selection.

c. "Medicare/PHI Choice"

- From the current *ex-post* claims-equalisation to *ex-ante* risk-equalisation (e.g. Risk-Based Capitation - RBC - proposal (2003)) and add to RBC risk-adjusters (e.g. age & gender), predictors implemented in other countries:
  - » Region;
  - » Health status (e.g. DCGs, PCGs, DTCs etc.);
  - » Socio-economic status; etc…
- PHI receives a risk-adjusted "opt-out" subsidy;
- Long run: both PHI and Medicare receive the same risk-adjusted subsidy.
- Allow insurers to risk rate & replace community rating by a premium rate band;
- Reconsider the necessity and proportionality of the 30-40% subsidies *vis a vis* their goals.

Pragmatic solution

- Effects of “Medicare/PHI Choice” :

  » Policy goals achieved;
  » PHI: more tools and incentives for efficiency (consumers, insurers);
  » Substantial reduction of problems;
  » Less selection, both by consumers and by insurers;
  » PHI becomes attractive for low-risks.