

# **REGULATION OF PRIVATE HEALTH INSURANCE PRICING**

REPORT BY  
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FOR

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## EXECUTIVE SUMMARY

Challenger Financial Services Group commissioned Access Economics to report on how the pricing of Private Health Insurance (PHI) should best be regulated. In doing so we have assessed the current form of price regulation and some alternative approaches used in other Australian industries. This has involved considering the current and other possible objectives of price regulation.

PHI is one of the most heavily regulated industries in Australia. The impacts of price regulation cannot be considered in isolation from other policies that affect the PHI industry and the health system more generally. This is because PHI currently operates primarily as a financing system, rather than a genuine insurance market.

The current pricing test is designed to restrict premium growth to the “minimum justifiable” to ensure the continued viability of PHI funds but does not provide any incentive for funds to minimise the costs they incur. This has had the effect of confirming the funds in their “passive payer” role and, in conjunction with the many other forms of regulation of the industry, works against innovative ways of operating health insurance.

Furthermore, private health insurance industry confidence in the system of price regulation has been impaired by the manner of its administration including the high costs of compliance and while the power exists, uncertainty generated by the potential for exercise of Ministerial discretion. The end result is a climate of poor accountability and transparency, which creates considerable uncertainty for existing funds and potential market entrants.

Most sectors of the economy are not subject to price regulation because markets work well enough to deliver relatively efficient and competitive outcomes that best meet society’s consumption needs. Indeed, even imperfect markets are often more effective than heavy-handed government intervention. Price regulation is, for the most part, reserved for markets where there is a real risk of participants abusing their market power to the detriment of consumers (PHI is an exception).

Winding back price regulation of PHI would give funds a greater incentive than at present to compete between each other, moving the market closer to optimal pricing levels. But other government policies would still severely limit the ability of funds to compete vigorously. Removal of the current price regulation would be less effective than a more substantial reform program which also removed other impediments to service efficiency.

Experience with price regulation in industries where there is limited competition has shown that well designed price regulation – that is regulation which is clear, transparent, and directed towards efficient outcomes – can generate economic benefits which outweigh the administrative and compliance costs of regulation. Well designed regulation aims to constrain both costs and prices to efficient levels, and to encourage efficient investment and the efficient use of resources. Increasing efficiency in this way ultimately leads to increased overall living standards.

However, implementation of even the most well-designed price regulatory regime is difficult. The regulator typically needs to invest significant resources into collating, analysing and acting appropriately on information regarding the cost and sales structure of the regulated firm. Price monitoring regimes remove some of the informational burden on the regulator but maintain pressure on the monitored firms to act in a competitive manner.



Access Economics concludes that the current price regulation regime is ineffective and the economic case for its retention is weak. Although they may challenge political doctrines, there is scope for other initiatives which would likely raise efficiency in service delivery, which could be introduced in place of the current ineffective price regulation. A more comprehensive price regulation regime – one that is clear, transparent, and directed towards efficient outcomes – is difficult to implement because there is no monopoly pricing problem and price regulation of private health insurance is too indirect to be an effective way to control costs in the private health sector. It recommends that movement to a price monitoring regime be considered for private health insurance premiums.



## 1. INTRODUCTION

Challenger Financial Services Group commissioned Access Economics to report on the current price regulation of private health insurance (PHI) in terms of its effectiveness in constraining price rises and encouraging the efficient use of economic resources, compared to alternative models of price regulation.

### **Structure of this report**

Part 2 describes the regulatory environment for private health insurance in Australia and sets the context for an examination of price regulation.

Part 3 assesses the effectiveness of the current price regulation regime.

Part 4 discusses the arguments for and against removal of price regulation altogether (option one).

Part 5 examines the option of a “light-handed” price monitoring regime (option two).

Part 6 examines the scope for a system of “incentive regulation” (option three), that is a system of price regulation which provides greater incentives for economic efficiencies.

Part 7 draws together the conclusions of this report.

## 2. THE REGULATORY ENVIRONMENT

Few industry sub-sectors in Australia are subject to as much government regulation as the private health insurance (“PHI”) industry.

Before addressing the specific details of the regulatory regime, it is important to describe where and how PHI fits into the Australian health financing system. The constraints on the private health insurance funds (“the funds”) are by no means limited to the rules and regulations specifically directed towards the funds. They also stem from the broad features of the health financing system.

It is often said of health systems in general that everything depends upon everything else. The Australian health system is no exception. Because of the large number of alternative modes of treatment (substitutability of services), interventions in one part of the system can have unexpected consequences in another part of the system several steps removed. The sheer complexity of the system means that policy makers have considerable difficulty predicting the likely results of new policy.

The system has many contradictions and ambiguities. Some, but not all, of these can be attributed to Australia’s federal system of government. Federal, State and Territory governments are often in conflict over questions of health policy and funding. Inevitably this leads to both cost and blame shifting.

Five large “buckets” typically account for over 80% of the Commonwealth Government’s expenditure on health care, while the State and Territory governments have a much narrower focus with most of their health spending directed to the public hospitals.

The focus and features of the five large Commonwealth buckets are as follows:

### 1 Medical Medicare

Medical Medicare helps finance services that are rendered privately but are subsidised through patient benefit entitlements augmented by a recently enhanced safety net. There is no consistent approach to sharing the financial risk with patients. Discrepancies often exist between the level of the Medicare benefit payable for a service, the cost of provision and the fee charged. The Commonwealth Government has regard to both demand for a service and its own budgetary position when setting benefits.

The Government tries to achieve a high level of bulk-billing (i.e. zero patient contribution) on low-priced services (especially GP services and investigations) while for high priced services the Medicare benefit can be as little as 30% of the average fee charged. For in-hospital services billed to Medicare, an ever higher proportion of the benefit payout is being shifted to the private health funds. The patient-funded component of medical fees (whether met out-of-pocket or through PHI premiums) has outgrown benefit payments by a very large margin. Although medical insurance was nationalised in 1984, the Government was very quick to reinstitute a medical benefit obligation on PHI. Governments of all persuasions have constrained themselves not to levy the higher taxes necessary to turn Medical Medicare into a stand-alone system for ensuring universal access to adequate medical services. PHI must now be regarded as a complementary element of that system even though it is mainly concerned with providing cover for hospital costs.

## 2 Public hospitals

The Commonwealth Government contributes approximately half the costs of running the public hospitals under 5-year agreements with State and Territory governments (the Australian Health Care Agreements). The majority of the public hospitals are owned and operated by State and Territory governments while a minority are owned and operated by churches (the Catholic hospital sector has a material presence). Hospital care is free at point of service to public patients (Medicare patients). Hospital care for private patients is subsidised by governments.

Most of the private patient workload has been shifted to the private hospital sector. Demand for public patient services is managed by non-price rationing (queues, with waits in some areas stretching for years). The public hospitals are showing increasing signs of stress as governments struggle to come to terms with demand boosted by new health technologies (which create new service possibilities and higher levels of service) and an ageing population.

## 3 PBS

The Commonwealth Government acts as a monopsony purchaser and uses its power in the market to force down pharmaceutical company prices for prescription drugs. Wholesale and retail distribution is rendered privately and funded through fee-for-service payments to chemists. Up to a point prices manage demand, with a compulsory co-payment that is moderated by a safety net. However, a high proportion of prescription drugs are used by patients accessing the scheme on a concessional basis. The growth of expenditure has been rapid but, even so, Australia is a modest spender on pharmaceuticals compared with other developed countries. Expensive new drugs are subject to a rigorous process to attain listing, and even then may not necessarily be subsidised.

## 4 Aged care

The Commonwealth government regulates the aged care sector quite heavily with the regulatory regime covering pricing and standards. Unlike Medical Medicare, the PBS and public hospital services, there is no universal non-means tested entitlement to high level residential care (nursing homes). Patient contributions are determined by income and asset tests. Furthermore, the “financially competent” patients are required to put in deposits which effectively provide the operators with their capital.

## 5 PHI incentives

The Government uses a combination of “sticks and carrots” to encourage membership of private health insurance. The prime carrot is a non-means tested tax rebate on premiums paid which ranges from 30 per cent through to 40 per cent for the oldest cohort of members. The cost of the rebate now approaches some \$3 billion per annum. It is supported sturdily by “sticks” in the form of Lifetime Health Cover (penalty premiums for those who do not retain full cover past the age of 30) and the Medicare levy surcharge which applies to high income earners without PHI cover.

### The many PHI interventions

The Federal Government intervenes in PHI at many different levels with:

- ❑ regulations and powers exercised variously by the Minister, the Department and the regulatory authority, the Private Health Insurance Advisory Council (PHIAC), as well as more generic regulation and laws contained in the Trade Practices Act and Corporations Act;



- ❑ a series of “carrot and stick” incentives designed to support take-up of PHI;
- ❑ other policy interventions related to broader aspects of public policy (eg consumer protection); and
- ❑ collateral impacts on PHI from specific health policies that affect the scope and operation of Medicare.

One effect of the regulation is to “fence in” PHI. Only registered funds are permitted to carry on a health insurance business in Australia. This provides the funds with a measure of protection from new players. While there are no significant economic barriers to entry, such as high sunk capital costs or economies of scope, any potential new entrant has to overcome many regulatory barriers to entry.

In carrying out its regulatory and supervisory functions PHIAC is required by the Act to achieve a balance between four objectives which it acknowledges to be potentially conflicting:

- ❑ a financially sound, efficient, competitive and innovative industry;
- ❑ protection of the interests of consumers;
- ❑ minimisation of health insurance premiums; and
- ❑ ensuring the prudential safety of the funds.

State and Territory governments also intervene in PHI but less directly reflecting their particular powers. First of all, PHI funds are exposed to cost-shifting, which results from the rationing of public hospital services and imposition of long waits that induce fund members to go private rather than exercise their right to free treatment as a public patient. Secondly, PHI funds are also subject to State taxation (levies). Finally, State regulation of the private hospital sector adds considerably to the hospital costs that PHI funds end up funding one way or another.

### PHI sits around the edges of Medicare

In the Australian system, one of the main benefits of PHI is expedited access to health services for elective procedures. PHI sits around the edges of Medicare (both hospital and medical Medicare). PHI also provides a mechanism for patients who desire choice: choice of doctor, choice of hospital and some choice in relation to the level and type of care provided.

Many aspects of Medicare in turn define what can and cannot be done in private health insurance. PHI comprises two main products, the co-called hospital cover and ancillary cover. The hospital tables provide for:

- ❑ **Hospital benefits:** By far the largest part of the benefit payout and covering accommodation costs, theatre fees and so forth;
- ❑ **Medical benefits:** Comprising the gap between the Medicare benefit and the schedule fee plus gap cover benefits under no-gap or known-gap policies; and
- ❑ **Prostheses benefits:** Covering a wide range of items from stents to pacemakers to replacement joints; includes many small items.

Ancillary health insurance covers many items for which no Medicare benefits are payable, ranging over private dental care (almost half the benefits paid), optical services (eyeglasses and contact lenses approaching 20% of benefits paid), services by other health practitioners such as chiropractors, physiotherapists and podiatrists (also approaching 20% of benefits





paid) and other items such as ambulance cover. The funds have considerably more scope to manage the cost of ancillary cover, by setting benefit levels as they see fit.

To illustrate the essentially peripheral role of PHI, purely cosmetic procedures are not offered free to public patients and do not attract a Medicare benefit. Therefore, private fund benefits are not payable. However, the scope of services to which PHI medical gap insurance (including gap cover insurance) applies is determined by the scope of the medical benefits schedule. Therefore, if the Federal Government decides to list new services on the MBS, it is implicitly committing the PHI funds to pay benefits unless those services are ruled out by the terms of an insurance policy.

The supplementary role of PHI means that it is difficult for the PHI funds to finance a continuum of care because they cannot control benefit limits for each procedure independently from Government.

### Lifetime Health Cover

Lifetime health cover (LHC) is one of two key planks in the incentives for people to take out PHI. The PHI tax rebate (variously 30% to 40% of premiums paid) is “carrot” (a positive incentive) which lowers the after tax price paid, whereas LHC is a “stick” (a negative incentive) which threatens people with a higher premium if they defer taking out cover. These two core policies are supplemented by the Medicare levy surcharge, another “stick”, which imposes a higher Medicare levy (2.5% of taxable income as opposed to 1.5%) on high income earners without PHI cover. The levy surcharge has led to funds offering “no frills” policies which allow people to obtain the minimum cover necessary to avoid the additional tax impost.<sup>1</sup> In short, all the incentives are financial in nature, seeking to influence current or future prices and taxes.

Lifetime health cover is also a key plank in the regulation of PHI. Lifetime health cover is a variation on the long-standing system of community rating. The key features of the old system of community rating were that the funds were obliged to accept all comers as members regardless of their age, sex, family health history, health status or health risk behaviour and that all the members in each type of cover cohort paid the same price regardless of means.

Lifetime health cover differs from the old system of community rating in its pricing. Members who do not maintain continuous cover from the age of 30 pay higher premiums – up to 70 per cent higher – based upon the age at joining. Lifetime health cover seeks to combat adverse selection (people only joining a fund when they reach the age when their health starts to deteriorate).

The only way in which there can be risk rating of PHI members is when they do it themselves by electing to purchase an exclusionary policy at a lower premium. Thus, PHI is sharply differentiated from other forms of insurance (such as travel insurance) where pre-existing illnesses can result in cover being declined or higher, risk-adjusted premiums being charged.

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<sup>1</sup> For these ‘Claytons members’ the value of the additional 1% surcharge on taxable income forms a de facto “price cap” on how much funds can charge for a basic policy and still retain members. Currently this cap is non-binding, but if costs, and hence premiums, continue to rise these members will no longer find it financially beneficial to retain PHI membership.



Because funds must accept all comers, funds would face risks if they had a preponderance of older (high using) members. To combat this, the Government seeks to equalise the risk through the reinsurance pool. Calibration of the reinsurance pool is a challenging task. If the intergenerational transfers are too large, older members are the more “profitable” and funds will not try to recruit younger members.

The implicit intergenerational transfers are constantly changing and this, in turn, means that the arrangements for the reinsurance pool require frequent revisiting.

### **Prudential regulation of PHI**

Another important leg of the regulatory system is the prudential regulation of the funds: in essence the prescription of minimum reserve requirements. While this form of regulation is not markedly different in purpose or execution from the prudential regulation applied to other financial enterprises, it is important to note that its existence works to limit the scope for price regulation in the longer term. Regardless of the legal interpretation of the powers, there are practical limitations on a Minister’s powers to disallow price rises. There has to be a reconciliation between the minimisation of premium increases and compliance with the prudential requirements. Arguably, the latter has to have precedence. A Minister’s position would rapidly become untenable if the outcome of a pricing review was the financial collapse of a fund.

### **Product regulation**

In years past, the funds were required to seek and obtain approval for every product and for every change in a product. This requirement was relaxed in 2002 as part of the review of the regulation of PHI. Nonetheless, there is still in place a framework of regulation of products with funds required to cover the “basics” and, in addition, each fund is required to offer at least one no-gap or known-gap product. Although the regulation of products is less onerous than was previously the case, it is still open to argument that the regulatory environment stops product innovation outside the narrow boundaries permitted.

### **Competition policy and consumer protection**

There are many other elements to the regulation of PHI including regulation designed to achieve specific government objectives such as informed financial consent. Many of these other elements are directly or indirectly related to competition policy and consumer protection issues. As an example, regulation limits the waiting period that can be imposed for benefits in respect of pre-existing illnesses and when cover is upgraded. However, funds are allowed to impose (unregulated) benefit limitation periods (waiting periods by another name) on members transferring from fund to fund at comparable levels of cover. This anticompetitive feature of the regulation is currently under review. Some of the issues dealt with by the Private Health Insurance Ombudsman (PHIO) also relate to competition policy issues. A recent consumer friendly innovation is an annual PHIO review of the funds.<sup>2</sup>

### **Price regulation**

As noted above, PHIAC is required by the Act to achieve a balance between four objectives, one of which is the minimisation of health insurance premiums. PHIAC has further described the regulation of PHI pricing in the following terms:

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<sup>2</sup> See Private Health Industry Ombudsman (2004) *State of the Health Funds Report 2004*, Sydney.



*No fund can amend its premium without notification to the Minister for Health and Ageing. PHIAC reviews all pricing applications and provides advice to the Minister on the impact of each proposed premium change on the financial viability of the health fund, its competitiveness relative to other funds and the expected impact on consumers. In undertaking its analysis, PHIAC may request additional justification from the fund on the proposed change and may consult the Government Actuary. The Minister has the discretion to disallow any change<sup>3</sup>.*

Since each application is judged on its own merits, different funds can apply for different overall price increases as well as applying for differential price increases for their various products.

In the years prior to September 2002, funds were required to obtain Ministerial approval for all premium increases. The arrangements underwent progressive change with only one adjustment allowed per year, requirements on the funds to substantiate requests for premium increases with reports from independent actuaries, and all approved fund increases to be announced on the same day. From September 2002 (in practical effect, from 2003 onwards), the arrangements were modified slightly in that the funds were able to make cost-of-living adjustments at or below the Consumer Price Index (CPI) without the necessity for Ministerial approval.

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<sup>3</sup> PHIAC (2005) *Regulating Private Health Insurance*, Canberra.

### 3. PRICE REGULATION – DOES IT WORK?

There is much evidence that the current price regulation has not met either the objective of constraining price rises or of encouraging an efficient and competitive private health insurance sector.

Under current arrangements, the funds have few degrees of freedom in relation to the premiums they must charge to remain viable. In particular, we note that:

- ❑ The funds have no effective means or strategies to manage the demand for health care, the key driver being high and rising community expectations as to the quality and quantity of services they can access.
- ❑ The most important factor underlying the growth in demand is the appetite for new and sometimes very expensive health technologies. This drives compositional change in the services provided so that, even though individual prices of many health services are falling in real terms, the average price is rising in real terms.
- ❑ Close behind (and of growing importance) is the ageing of the population. This brings an ever growing burden of chronic disease.
- ❑ The funds also have very few effective means or strategies to create incentives for patients to reduce health risks. The community rating principle prevents them from applying financial disincentives to those who do great self-harm, for example through smoking tobacco and there is relatively little they can do now to provide positive incentives in areas such as diet, exercise, weight control, etc.
- ❑ Given the position of PHI on the fringe of the public health system, the funds are susceptible to cost-shifting, especially from State and Territory governments.
- ❑ Patients, not funds, have discretion over the type and level of cover they take out and, importantly, the extent to which they use it. All enrolled in Medicare retain their rights to free treatment as public patients (in practice, the right to join a queue) and again in theory, every patient has the freedom to choose to be a public or private patient at time of admission. Just because a taxpayer receives the PHI tax rebate, it does not mean that he or she is obliged to claim PHI benefits. Patients can and do consider the private financial implications of seeking treatment as a public or private patient, and act accordingly.
- ❑ The funds have sought to restrain hospital benefits paid through contract negotiations with the private hospitals. However, for PHI itself to be saleable, the private hospitals have to remain viable. PHI is, after all, selling access to the private hospitals. Accordingly, there are limits on the extent to which the funds can squeeze the margins of the hospital operators. They can choose to contract with the more efficient operators but do not always do so. The funds would like to claim success in forcing down private hospital charges in real terms but it is likely that the main driver of these reductions is the economies of scale and efficiencies from achieving higher occupancy rates. In other words, the higher market share for private hospitals has opened the door to price moderation.
- ❑ The funds have been obliged by the Government to offer more insurance in the form of above schedule medical gap cover.

Where do the funds have any significant degree of discretion? The short answer is only with respect to their management fees (on the costs side) while the financial reserves they hold in

response to prudential rules provide them with some investment opportunities to supplement premium income.

Against this background, the current price regulation regime does not provide incentives for funds to minimise costs, even where it is possible for them to do so. There are several reasons for this:

- ❑ Funds are, quite legitimately, able to pass on any actual costs incurred to members, regardless of whether these have been efficiently incurred or not. The progressive removal of gap payments in both hospital and medical costs has engineered an increasing moral hazard for both patients and providers. Patients do have quality choices paid for by PHI and if more of the risk is being shared with other members, the patient is more inclined to demand the best. This incentive compatibility problem encourages patients to seek the best available health care while limiting the possibilities for value for money in PHI;
- ❑ The pressure for price competition between funds is limited and dulled by the operation of the reinsurance pool;
- ❑ The policies designed to create incentives for PHI membership such as the PHI tax rebate, Lifetime Health Cover and the Medicare levy surcharge further dull the response of consumers to any premium increases;
- ❑ Finally, if a fund is able to achieve efficiency savings during a year, when the time comes to assess its next claim for a premium increase, those cost savings will be incorporated into what is assessed as the “minimum justifiable”. The fund will therefore not be able to retain the benefit of the cost savings for a significant period of time and thus will have little or no incentive to achieve them in the first place.

Over the past few years PHI premiums have increased at rates much greater than inflation as measured by the CPI. The average annual contribution per member has grown from \$816 in 2000-01 to \$998 in 2003-04 - a compound annual growth rate (CAGR) of 6.9 per cent per annum. This understates premium increases, however, as there has been a drift to cheaper, front-end deductible policies.

Discussion of health fund premium increases is often clouded by a failure to distinguish between pure price effects on the one hand and volume and quality change on the other. Health funds members are paying more for their cover but getting a great deal more both in terms of quantity and quality. It is always possible to reduce the price of any insurance product by reducing the cover it provides. That also has the effect of reducing the value of the product to the consumer. Indeed, this strategy is often pursued by the funds in the area of ancillary insurance when the extent of cover can be limited by, for example, capping the number of dental services in a year. However, the funds have little freedom with the hospital tables and the scope of cover is dictated by governments and patient choices.

### **3.1 MINISTERIAL DISCRETION IS UNHELPFUL**

The Ministerial discretion whether or not to allow recommended price increases – which is part of a generally low level of transparency, accountability and independence of PHI pricing from government – introduces greater uncertainty into health fund operations. It inevitably introduces a political overtone to decisions. While dealing with uncertainty is, and should be, part and parcel of private sector market activities, additional uncertainty due to government interventions is undesirable. It increases costs and inefficiency that must eventually be passed on to consumers.

It could be argued that large increases in PHI premiums, averaging some 8 per cent per annum since 2002, are in part due to the decision by the then Minister in 2001 not to approve any premium increases in that year who argued that the funds had received the benefit of the PHI tax rebate in the preceding 12 months and therefore they did not need any premium increases. The exercise of discretion in 2001 effectively removed it in the few years that followed, particularly as the timing of the price increase refusal coincided with a large downturn in equity markets and associated fall in the funds' investment incomes.

Reforms have been successfully introduced in other areas to reduce Ministerial influence. For example, the Reserve Bank of Australia has been setting interests rates without political interference for the past decade.

### 3.2 FINDINGS

We conclude that the existing price regulation regime is almost completely ineffective because the funds have no effective way to control health costs. The funds' other alternative, which is to reduce benefits, is severely constrained by other government interventions in the sector.

They are unable to introduce innovative new approaches to health financing (such as health savings accounts) which have the potential to engage the patient more effectively as a cost-conscious partner instead of a cost-consuming centre. Instead of minimising costs, the current regime tends to confirm the funds as "passive payers", simply passing through to the members the costs they themselves have incurred. The lack of positive incentives for funds to achieve efficiencies stands out.

Consideration of these incentive problems leads to a questioning of the current price regulation objectives. PHIAC's objectives are to both foster an efficient and competitive health insurance industry and to minimise the level of health insurance premiums while maintaining prudential safety. But it is not enough to aim for price increases that are merely no higher than required to maintain solvency.

Effective price regulation does minimise price increases but not at the expense of efficient investment and innovation. It seeks to avoid insulating regulated firms from the adverse consequences of their own poor management decisions while allowing them to capture the benefits of superior management – the important twin incentives of profit and loss.

The key issue is to determine whether and why price regulation of private health insurance is necessary. That provides a basis for devising the best form of regulation. Price regulation is shown to be ineffective. What might work to achieve the society's aims of an efficient, competitive and consumer friendly industry and, in the medium to long term, best value for fund members?

There appears to be scope for initiatives which would increase efficiency and improve health outcomes while probably reducing costs at the same time. We point to:

- The lack of competition in the PHI industry, in part due to extensive regulation and low profitability in the sector, which helps keep competitors out (in recent years, there has been considerable consolidation in the industry but only one material new entrant, BUPA);
- Steps that could be taken to reduce costs without impairing safety and quality, for example, private hospitals are subject to licensing requirements which set higher bars than those which apply to public hospitals;



- ❑ Combating the moral hazard of over-utilisation of services by sharing some of the financial risk with patients;
- ❑ Reducing high risk behaviour by fund members such as smoking, poor diet and lack of exercise which contribute to the onset of a number of lifestyle diseases;
- ❑ Hospital cost sharing arrangements could be revisited to look for ways to reduce the incentives for the State and Territory governments to cost-shift.

## 4. OPTION ONE – NO PRICE REGULATION

For most goods and services, prices are set by market forces rather than regulatory intervention. In well working markets the process of competition and the interaction of supply and demand leads to efficient pricing levels. Efficient prices reflect both the value of the product to the consumer and the supplier's production costs. Where competition works well, suppliers have incentives to minimise costs and offer more attractive products to win customers from their rivals. Prices above marginal costs cannot be sustained, as a competitor could make a higher profit by charging a little less, thus creating downward pressure on prices across the industry.

Efficient prices (where the marginal social benefit from purchasing a service equals the marginal social cost of providing the service) are important, because they tend to maximise living standards.

There are some circumstances where markets do not work well and competition cannot be relied on to deliver efficient outcomes, including 'low' prices. Structural factors such as barriers to entry and economies of scale can create relatively concentrated industries and allow particular firms to obtain market power. Market power gives firms the potential to raise prices substantially above costs and not be undercut by competitors. At these higher prices less is produced and consumed than the community as a whole would choose if prices did reflect costs. These efficiency losses harm the community as a whole because resources – labour, physical and human capital – are being wasted. Further, income is being transferred from consumers to the firm with market power. Society as a whole can be made better off by moving to efficient prices.

In addition to the efficiency costs (or dead weight loss) associated with higher prices, the lack of competitive pressure on a firm can also remove the incentive to minimise costs or maintain product quality. Where a firm has sufficient market power that it could impose significant efficiency costs on the economy, some form of price regulation may be appropriate in order to minimise these efficiency costs (bearing in mind that any regulation will itself create further costs).

Other factors that can cause the marginal social cost to depart from the marginal social benefit can include externalities (such as pollution), which are not relevant here; and, information asymmetries, such as adverse selection and moral hazard problems, which typically arise in insurance markets (particularly with community rating). The current regulatory framework for PHI is not capable of addressing these issues, so will only ever equate marginal social cost with the marginal social benefit by accident, rather than by design.

Following economic reform during the 1980s and 1990s, especially those arising under National Competition Policy, explicit price regulation is relatively uncommon in Australia, and is restricted to infrastructure sectors where there remain natural monopoly elements or legacy incumbents with significant market power. It does not seem that private health insurance exhibits any of the economies of scale or scope associated with natural monopolies.

However, government policy and regulatory intervention can also limit the potential of competition by removing incentives for cost minimisation and innovation or creating the possibility of market power, as for example in gambling and parts of broadcasting. This may





be the case with PHI under the existing policy settings which, as mentioned in the previous section, limit the ability of the funds to act in an innovative or competitive manner.

Whether removal of price regulation would be likely to generate better outcomes for consumers of PHI is unclear. We have seen that the current system has not been very effective in encouraging efficient pricing behaviour. The economic case for removing price regulation is simple. It doesn't work, so stop it.

If the price regulation of PHI premiums was removed, we would expect that funds would have a greater incentive to minimise costs and introduce innovative product bundles to attract younger, relatively healthier and more profitable members. This incentive would come from the ability to retain, in the form of higher profit, at least part of the benefit from reduced costs.

However, this incentive may be muted by the competing incentives created by other aspects of the very complex regulatory framework. For example, the compulsory reinsurance scheme reduces the benefit to a PHI fund of attracting new younger (lower cost) members. Moreover, in the longer term PHI premiums would be expected to continue rising due to increased cost and demand for medical and hospital treatment.

The more fundamental issue to consider when deciding to wind back price regulation or not is whether PHI funds have sufficient market power to enable them to raise prices at a faster rate than costs are rising. The potential market power of PHI funds is affected by government policies designed to increase demand for PHI cover such as lifetime health cover and the ultimately limited funding (and hence rationing by queuing) of the public health system. However, any economic rents accruing from the relatively inelastic demand for PHI membership are shared between the fund and the health service providers – including hospitals and medical professionals. There is some evidence that the balance of bargaining power between funds and service providers is more greatly weighted towards providers. If this is true PHI funds will have a limited capacity to retain the profits from higher prices.

Were it not for the regulatory barriers to entry, a new entrant should not face economic barriers to entry such as high sunk capital costs creating economies of scale or scope and the potential for longer term competitive entry into the sector would be relatively high. Even if entry does not occur, the mere threat of entry can impose discipline on the incumbents.

Given the interaction of other Government policies on PHI, it is arguable that there ought to be no move to remove price regulation until the alternative strategies (such as those addressed at the end of the previous section) are in place to produce some real effects on costs. If some form of price regulation is deemed necessary due to both the currently weak state of competition in PHI, and the political concerns to maintain certain levels of PHI membership in the community, is it possible to restructure the regulation to provide greater incentives for efficiency in the sector?

## 5. OPTION TWO – PRICE MONITORING

Price monitoring is a light handed form of regulation used in infrastructure sectors that are considered relatively competitive. In Australia price monitoring is used for major airports, some ports and water utilities. Operators are free to set prices as they see fit, but these prices are monitored by an independent regulator.

At its most simple, prices can be monitored and published to provide information and transparency to consumers. For example, prominent publication of PHI premiums of each fund may facilitate comparison and encourage members of higher priced funds to switch to more efficient funds offering a lower price or higher quality insurance product. This could stimulate competition between funds for members. In practice, anything that restricts switching between funds, such as waiting periods imposed on new or transferring customers, may make such information of limited use in stimulating competition. While it will not be very effective if price differentiation between funds is minimal, it may act to encourage price differentiation, although the difficulty in comparing insurance products with different benefit inclusions could remain a problem.<sup>4</sup>

In infrastructure sectors subject to price monitoring, the responsible regulator does more than simply collate price data. Data on prices or even on movements in prices over time tell a regulator very little about the intensity of competition or possible use of market power. All prices in the economy tend to change over time, and this may be for a variety of factors – general inflation, interest rates, exchange rates, changes in demand for a product or changes in the underlying costs of production due to technological change or productivity improvements. Only a change in prices that can not be justified with reference to one of these explanations is a potential example of anticompetitive pricing.

In order to determine whether price rises are ‘appropriate’, regulators typically compare prices to costs, or price increases to cost increases. This could require regulated firms to provide statements of their actual costs or comparing price rises with changes in other price indexes. These price indexes may be a general price index, such as the Consumer Price Index or a specific price index such as a Producer Price Index for a particular sector of the economy.

Determining what price to monitor can be complex when the regulated entity provides a bundle of product and services or even different bundles to different customers. For example, airports provide both aeronautical services (aircraft landing, parking and passenger processing facilities, each of which has a separate price attached) and non-aeronautical services (parking, shopping). Some services are priced on a fixed fee basis while others vary with the number of passengers, type of plane or time spent by an airline customer. In theory a price index could be constructed based on a weighted basket of airport services and this index used to directly measure prices. In practice, this would be time consuming and contentious exercise, so average revenue per passenger is used as a proxy for price movements.

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<sup>4</sup> The ACCC, who monitors anti-competitive practices by health funds or providers under an Senate order, has noted “consistently adverse comments over several years (that) the key features guides are not an effective means of providing information to consumers” (ACCC (2004) *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance for the period 1 July 2003 to 30 June 2004*, Canberra. November, p.11).

Constructing a price index for PHI is discussed in the following chapter.

Apart from prices, market power may also show up in above-normal profits. Thus as well as monitoring prices, the regulator may want to also monitor rates of return. There are a number of possible ways to measure rates of return, and the most appropriate will depend on the circumstances of the regulated industry. For example, return on (appropriately valued) assets a much more useful measure of returns in the airport industry than returns on equity.

Most price monitoring regimes are complemented by quality of service monitoring to ensure operators do not hold prices constant while allowing quality to deteriorate. Indicators of service quality need to be designed. These could include speed with which claims are settled, number of complaints to private health insurance ombudsman or surveys of fund members and other stakeholders such as medical professionals. PHI funds are currently subject to performance monitoring regarding changes in non-premium related rule changes, in order to identify funds in breach of their obligations under the National Health Act 1953 and alert the Minister to practices which may be contrary to health policy.<sup>5</sup>

In many ways a price monitoring regime has very similar reporting and information requirements as a more heavy-handed incentive regulation system discussed in the next section. It also therefore gives rise to many of the same issues regarding appropriate cost and rate of return benchmarks for monitoring prices. The key difference between the two styles of price regulation is what the regulator does with the information it collects. Under price monitoring the regulator may review information on the cost, including the rate of return on investment, of a service but does not use this information to then set prices or revenue.

Instead the results of information collected under a price monitoring regime are typically published and can be used as evidence in considering a move back to a more heavy-handed price setting regime should that be warranted. For example, the Victorian Essential Services Commission (ESC), which is responsible for the regulation of Victorian Ports has recently moved from direct price cap regulation to a price monitoring regime that includes:

- ❑ A requirement for port operators to publish reference tariffs indicating the standard charge for certain services;
- ❑ Detailed information requirements, including the provision of regulatory accounts to the ESC as part of its price monitoring role;
- ❑ Public reporting by the ESC of port pricing behaviour, service quality and profitability; and
- ❑ The possibility of introducing prescriptive regulation if the price monitoring framework proves to be ineffective in achieving the objectives of the regulation.<sup>6</sup> The regulatory threat is maintained by a scheduled review in five years, and the ability for ESC to initiate an earlier review should it find evidence of a significant misuse of market power by a port operator.

This 'good behaviour bond' style of light-handed regulation with the threat of future heavy handed re-regulation has been relatively effective at achieving good outcomes (sometimes referred to as 'shadow regulation') without all the compliance costs of explicit regulation.

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<sup>5</sup> This monitoring program replaced a previous requirement to submit all rule changes to the Department for approval (ACCC p7).

<sup>6</sup> Essential Services Commission (2004) *Regulation of the Victorian Ports Final Report*, Melbourne, June p108



Price monitoring would allow insurers to pass on increases in costs to consumers without the need for Ministerial approval. It would also allow a more efficient insurer to retain some or all of any efficiency gains, at least for a time, depending on its desire and need to compete with other insurers for policy holders by offering lower prices.

The price monitoring role could be undertaken by PHIAC or potentially referred to the ACCC. The ACCC already monitors costs and premiums in the medical indemnity<sup>7</sup>, public liability and professional indemnity insurance markets and oversees the price monitoring regime for major airports. However, the information requirements of a price monitoring regime are likely to closely mirror the current PHIAC reporting requirements. That is, the funds would still be expected to provide the analytical material, including actuarial reports, underpinning their premium increases. This existing industry knowledge and reporting structure may make PHIAC a more appropriate body to undertake price monitoring, in order to minimise transitional compliance costs.

PHIAC is an independent statutory authority, funded through industry levies, but describes itself as a proactive regulator who has facilitated a number of fund mergers.<sup>8</sup> Should PHIAC take on a price monitoring role, it will need to be undertaken on an arms-length basis from both industry (to ensure that the risk of industry capture is minimised) and government.

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<sup>7</sup> The ACCC, on the direction of the Prime Minister, monitors whether medical indemnity insurance premiums are actuarially and commercially justifiable. Actuarial justification is based on the technical actuarial aspects of pricing, including the approach taken and issues considered in deriving premiums. Commercial justification considers the ability of providers to meet commercial obligations to key stakeholders including APRA's minimum capital requirements and general commercial solvency and asset return targets (ACCC (2004) *Medical Indemnity Insurance: Second Monitoring Report*, Canberra, December, p.x). The ACCC does not specifically consider whether premiums are set at competitive or efficient levels.

<sup>8</sup> PHIAC (2005) *Regulating Private Health Insurance*, Canberra

## 6. OPTION THREE – INCENTIVE REGULATION

Incentive regulation is widely used in Australia and the United Kingdom to regulate monopoly service providers of utilities such as electricity, gas and telecommunications. While there are various types of incentive regulation, one of the most common is a price or revenue cap regime.

Under a price/revenue cap approach the regulator typically sets a price path for the regulated firm. That is, from some initial level, pre-set price increases are allowed each year for a number of years.

The initial price level may simply be whatever the current level is when regulation commences. This was the case with the price-capping of Telstra's telephony prices many years ago. More commonly in true natural monopoly industries, the regulator uses what is known as a building block approach. The revenue requirement of an operator is calculated as the amount needed to recover efficiently incurred operating expenditure, depreciation of capital and receive a reasonable rate of return on capital invested. This revenue requirement then determines the price charged for the service. The translation of the aggregate revenue requirement into a price schedule, based on forecast demand, can be done by the regulator (price caps) or the operator itself (revenue caps).<sup>9</sup>

For convenience we will use the term price cap in the following discussion, bearing in mind that the comments are as relevant to a revenue cap regime.

The underlying assumption of price cap regulation is that prices should reflect costs, so that changes in price should also reflect changes in input costs. Changes in the price of many input costs are outside the control of an operator, driven instead by general economic conditions such as inflation or specific economic shocks (such as a new medical breakthrough). However a firm can control or limit cost increases by using inputs as efficiently and productively as possible, including adopting new technologies or production methods. A price cap is to allow operators to recover uncontrollable costs while still having an incentive to minimise controllable costs as much as possible. The incentive comes from allowing operators to retain the benefit of any additional cost savings (and bear the cost of any cost overruns) made during the regulatory periods.

Price cap regimes are also often referred to as CPI-X regulation. Over the regulatory period prices are also only allowed to increase each year at a rate equal to the general level of price growth (measured by the consumer price index – CPI) less an efficiency factor X. This reflects an assumption that costs in the regulated industry are or should be rising more slowly than in the economy at large, as is typically the case in capital intensive industries and/or where there is rapid technological change. There is no *a priori* reason why productivity improvements, including technological change, should be occurring at a faster rate and hence costs rising at a slower rate in a regulated industry than elsewhere. Indeed, in the private health insurance industry costs have been rising faster than the general price

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<sup>9</sup> In situations where the actual level of demand is uncertain and outside the control of the operator direct regulation of prices rather than revenue allows the operator to deal with volume risk more effectively. This is particularly important in industries which are reaching capacity constraints and require lumpy investments.



index, suggesting that X may be negative.<sup>10</sup> The prime reason for the faster rise is the increase in the quantity and the quality of services that are being accessed through private health insurance.

Price caps are typically used to regulate the prices of monopoly service providers where the lack of competition has removed the incentive for firms to minimise costs leaving greater potential for efficiency gains over time than for other sectors of the economy. Well designed incentive regulation promotes investment, of importance especially in capital-intensive industries (because operators receive a known revenue stream and rate of return on capital), but also encourages operators to incur only efficient costs. In essence, the regulation imposes the discipline of competition on a firm, in markets where structural impediments prevent competition doing the job itself. For example, the company can benefit from a belt-tightening for up to five years before prices are re-based and the efficiency is passed on to customers. Currently PHI companies are re-based every year, so they are not able to benefit from belt-tightening so don't attempt it in the first place. From the customer's perspective, it is better to have the pass-through of the saving delayed rather than it never occurring.

The attraction of well designed incentive regulation is that it promotes the efficient use of resources and the ultimate benefit to consumers of efficient resource use inside and between firms. However, incentive regulation is generally applied to only one firm in a market, either because the market is a natural monopoly (gas distribution) or one firm remains dominant (telecommunications price controls). Regulated services tend to be capital intensive with well understood cost structures and supply a homogeneous product to end users.

PHI is different. Future costs are uncertain, and largely outside the control of the funds. PHI products are typically sold as bundles of hospital, medical and ancillary cover. The type of medical treatment financed under PHI is also changing, with a movement to higher cost but also higher quality services. We now discuss some of the issues that would need to be considered in applying a price cap regime to the PHI market.

## 6.1 COSTS

Private health insurers have one dominant cost component, the payment of benefits to members. Management costs average about 10% of total expenditures. Capital costs are not especially high, the largest requirement now being for IT. Further extension to point of service electronic claiming and electronic payment of benefits to patient or by assignment to provider will cause high cost retail shopfronts to be progressively wound back as they have been for retail banking.

As discussed in Section 2, the level of benefit payouts has increased considerably over the last few years and at a much greater rate than that of general inflation. These increased benefit payments have been caused by a number of factors, including:

- ❑ increased use of technological advancements and new treatments;
- ❑ increased use of elective surgery;
- ❑ ageing population;
- ❑ increased cost and utilisation of prostheses;

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<sup>10</sup> In Australia, the current price cap on business and residential phone line rentals is set at CPI + 4.0%. Line rentals were historically set at below cost levels and cross-subsidised through above-cost call charges. The negative X factor allows Telstra to rebalance tariffs to better approximate the cost of individual service provision.



- ❑ medical gap cover; and
- ❑ increased staff costs due to increased wages for nurses and other health professionals and increased medical indemnity costs.

Moreover, the rate of growth in hospital and medical benefits is largely outside the control of the funds. A question for a price control regime is to what extent these costs can be controlled by the PHI funds. The answer to this question will determine the ex ante efficient level of operating expenses, one of the price regulation building blocks. It will also determine the expected growth of costs over time, which is needed to set the efficiency factor X.

The ability of funds to control benefit payouts is limited, especially for hospital and medical benefits. Funds have much greater control over the level of ancillary benefits, due to greater discretion over the terms and conditions upon which extras cover is offered.

PHI funds and hospitals negotiate directly over the level and cost of hospital care. PHI funds, especially larger ones such as Medibank Private, should have some bargaining power with private hospitals, given their role as a gatekeeper to fund members. Over recent years PHI funds have claimed success in reducing the unit cost of hospital treatment, although this has in part been driven by advances in medical treatments and anaesthetics which have reduced the length of hospital stays. However, the movement to newer, more expensive treatment options and an ageing population will continue to put pressure on the level of hospital benefits.

Control of medical benefits is also difficult because funds are required to offer gap cover products. Both doctors and gap cover patients have an incentive to choose the most expensive and highest quality treatment and, once insurance cover has been offered, the PHI fund has no control over the treatment chosen. The requirement for funds to offer gap cover products also places medical professionals in an advantageous bargaining position when negotiating purchaser provider agreements. The ongoing shortage of medical professionals in some regions of Australia and in some practice specialities will also limit the power of funds to extract cost-savings from providers.

By way of comparison, other forms of insurance (such as motor vehicle insurance) achieve cost control by requiring claimants to obtain three quotes for repairs and by having independent claims assessors – clearly this system is not amenable to PHI.

Unlike benefit payouts, administration costs and management expenses are controllable costs to the funds. Management expenses accounted for around 10% of total PHI industry expenses in 2003-04. Booz Allen Hamilton analysis of Standard and Poor's Australian Health Insurance Report 2003 identified possible efficiencies in claims processing, case management and assessment and funds management. This suggests that an efficient PHI funds would expect to see administration costs to fall as a percentage of total costs over time.

This uncertain and uncontrollable future cost profile creates the first difficulty in imposing either a building block based or a simple CPI-X price cap on the funds. A price cap regime is intended to allow a firm to recover uncontrollable costs, while providing an incentive to minimise controllable costs. To achieve this, prices are allowed to grow in proportion with a price index which appropriately proxies for the rate of change in uncontrollable costs. For a PHI fund, this requires constructing a price index which captures the recent growth in benefit payouts.



We have seen that growth in PHI benefits – and hence premium levels – have grown at rates much higher than the general rate of inflation in final goods and services, as measured by a broad based index like the CPI. This suggests that a CPI based measure would be inappropriate, unless it is combined with a negative X value.

There are price indexes for the health sector. For example, the Australian Institute of Health and Welfare (AIHW) constructs an annual rate of health inflation. The index includes expenditure on hospitals, medical services, pharmaceuticals, other professional services, high-level residential care and dental services. The index is calculated using implicit price deflators, so it is affected by both price changes and changes in the composition of health services consumed in a particular year. An implicit price index also cannot account for changes in the quality of services provided, such as for example the movement from traditional metal stents to higher quality but more expensive drug eluting stents.

The AIHW measured health inflation at 3.8% during 2003-04, compared to 2.9% general inflation, as measured by the implicit price deflator for GDP. This still remains a lower growth rate than observed increases in private health insurance premiums. Another approach would be to benchmark PHI premium increases on the growth in relevant components of Commonwealth Government health spending.

There is no currently available price index which appropriately reflects changes in the operating costs of PHI funds. An alternative is to account for these explicitly by including a cost pass-through variable, known as an exogenous or Z-factor, resulting in a  $CPI+Z-X$  formula. Exogenous costs could be changes in Government policy which affect the scope of PHI and, therefore, benefit payouts, such as the movement to compulsory gap products or approval of new treatment procedures. Exogenous factors are not commonly used, because they can undermine the cost minimisation incentives of price cap regulation and encourage regulatory gaming. That is, the regulated firm may claim that a large number of costs are exogenous, rather than focusing on minimising all costs.

A further imperfect adjustment for unforeseen cost increases outside the control of the PHI funds is to correct for these at the end of each regulatory period, when prices are reset. The viability of this option depends on the length of the regulatory period. A longer period of time between regulatory resets increases the incentive to undertake efficient investment, as any cost savings can be retained by the operator for a longer period of time. However, this needs to be balanced against the risk that unforeseen cost events are also more likely to occur the longer the regulatory period.

## 6.2 PRICE AND QUALITY

As with price monitoring, the regulator needs to decide which products are to be subject to price regulation. For services such as gas or electricity transmission and distribution, where the service is homogenous, this is not difficult. However, where a firm sells a variety of different products to different customers or bundles together different products, decisions need to be made about how to apply a price cap. Private health insurers offer insurance for a range of expenses – hospital, medical and ancillaries. Different policies contain different terms and conditions of cover. The price cap could apply separately to each policy type, such that no premium was to be raised by more than  $CPI-X$  per annum, or to some weighted basket of policies so that the average premium level across the basket did not rise by more than  $CPI-X$ . For example, retail price controls on Telstra consist of a number of related pricing baskets, including different baskets for phone calls, line rentals and connection services. A different price cap is applied to each basket and the operator has flexibility to



change prices of individual services in the basket as they see fit, provided that the weighted average price change of the basket stays within the price cap.

A similar approach may be suitable for private health insurance, given that funds offer consumers a choice of service bundles. Different price caps could apply to ancillaries cover (where costs are more controllable) than to hospital and medical insurance. It may even be possible to allow the price of hospital insurance to rise in real terms over time, reflecting the growth in underlying costs.

A price cap regime cannot provide incentives to reduce costs or minimise price increases at the expense of non-price aspects of the product bundle. An alternative to increasing prices is to restrict benefits paid out under a policy or introduce a new product with a different level of cover. The price cap would need to be complemented by a quality of service monitoring regime (as set out under price monitoring) or include performance benchmarks in the price cap regime.

### 6.3 OPERATION OF THE REGULATORY REGIME

Price caps generally only apply to a monopoly service provider or a legacy incumbent with significant market power. As discussed under Option 1, it does not appear that any one PHI fund has significant market power, suggesting that any price cap regime would have to apply to all funds. A decision would need to be made as to whether the same efficiency targets would apply to all firms or whether these would be tailored to the differing cost structures of each firm. A consistent approach may be easier to implement and would reward the more efficient funds who outperform an industry benchmark.

Once the scope of the regulatory regime was decided, it would also be necessary to appoint a responsible regulator. The regulator should be independent of Government and able to exercise their regulatory responsibility in a clear and transparent manner. As with price monitoring, the most obvious decision is whether to retain PHIAC as the industry-specific price regulator, or move the responsibility to the ACCC, to complement its expanding role in the regulation of utility pricing and monitoring of other insurance products.

While an incentive regulation approach could conceivably be designed and implemented for PHI, there are a number of practical issues which make this form of regulation inappropriate for PHI, namely the lack of homogeneity, multiple firms and limited ability to achieve cost control (other than for the 10% of costs relating to management).

## 7. CONCLUSIONS

Most markets are not perfect, but work well enough to deliver appropriate prices that effectively signal the resource costs and demand for a good or service. Where competition in a market is not sufficient to deliver efficient prices, or where market outcomes differ from those desired from a social viewpoint, there is a temptation for Government to intervene in the market.

Private health insurance is a heavily regulated industry. Competition appears relatively weak, although it is not clear whether this is a cause or an effect of the existing regulatory structure. Social policy considerations are also important, as private health insurance operates as an adjunct to the publicly funded health sector.

The current regulation of private health insurance premiums is far from ideal. The system is not transparent or certain and is subject to Ministerial interference. There are no strong incentives for insurers to minimise costs, undertake efficient investments or act in an innovative or competitive manner. Without these incentives, 'low' premiums will not be sustainable in the long term.

If price regulation was removed, with regulatory oversight limited to prudential supervision, PHI funds would have a greater incentive to act competitively. But merely removing price regulation without reforming other aspects of the health system is unlikely to be enough to stimulate significant improvements in cost minimisation or innovation, and prices will continue to rise in accord with exogenous cost increases.

Given the uncontrollable nature of most of the costs of private health insurers, any movement to a more formal price cap regime would also see prices rise. While a price cap system would provide a clear pricing framework explicitly based on costs and revenue requirements, it would also require considerable regulatory oversight. Ex ante conclusions about future cost profiles would be needed to determine at what rate to set the efficiency factor X, but future benefit payouts are inherently uncertain and not subject to the control of the fund.

An appealing alternative, should some level of price regulation be desired, is price monitoring. Price monitoring allows Government to confirm that price rises are contained to those justified by underlying cost movements without a detailed regulatory price setting mechanism. Price monitoring regimes have typically been overseen by a jurisdiction's general competition regulator, but it may minimise compliance costs if PHIAC undertakes the price monitoring role for PHI, building on its current role in monitoring the solvency and capital adequacy of the funds.