

How to lose your shirt in private health insurance

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Introduction

This paper examines the prudential risks to capital in private health insurance (PHI) in Australia. It is the collaborative output from a group of actuaries that work in the Australian PHI industry, and is intended to supplement the public information available on the topic.

Purpose and approach

The focus questions of this paper are:

- *What are the circumstances that could cause you to 'lose your shirt' in PHI in Australia?*
- *How might you build financial readiness and resilience?*

In order to identify the types of circumstances, we study the drivers of previous occurrences of financial distress for private health insurers. We also consider whether the reasons that general insurers fail are also relevant to private health insurers.

We then look at how capital can be used and managed to avoid an insurer 'losing its shirt'—both from the regulator's perspective and from an insurer's perspective.

As such, the roadmap for this short paper is:

1. Recent history of stresses and failures in PHI
2. Potential causes of failure in general insurance, and the implications for PHI
3. How the regulator (APRA) uses capital to build insurer resilience
4. How private health insurers manage capital to build resilience
5. Conclusions

Our intention is that this paper will help inform discussions around:

- the nature of these circumstances and how they differ to general insurance;
- minimum regulatory requirements; and
- capital management policy considerations for resilience in the face of stresses.

1. Recent history of stresses and failures in PHI

The following table lists the primary contributing factors to and broad themes behind 14 instances of financial distress for Australian private health insurers between 2000 and 2012, derived from an internal study conducted by the Private Health Insurance Administration Council (PHIAC). This is not an exhaustive list of factors—if one studies the instances through other ‘lenses’, other factors such as quality of governance, strategy and relationships could also be identified.

Contributing factors	Rough estimate of the proportion of 14 distressed insurers where this was a factor
Under-pricing	100%
➤ Under-estimation of benefit costs for new products, new markets or new policy holders	>80%
➤ Forecasting did not reflect all the key drivers of experience (in particular drawing rates by duration of membership)	>80%
➤ Intentionally setting low prices to drive growth	30%
➤ Government intervention in pricing (for example, there were 0% increases imposed on most of the industry in both 2000 and 2001)	60%
Capital management	>80%
➤ Thin capital targets	40%
➤ Lack of robust capital management practices (including setting targets and triggers, regular monitoring, and implementing remedial management responses)	>80%
Rapid membership growth (exceeding 10% p.a.)	70%
➤ Intentional strategic growth	40%
➤ Unplanned growth as a result of a Government policy change (for example, the introduction of lifetime health cover loadings in 2000 caused PHI participation to increase by around 50% in the space of a few months)	50%
Membership shrinking – leading to anti-selective lapses and joins and spiralling prices.	10%

All of the 14 instances of financial distress in PHI were caused by deficiencies in at least one of:

- Pricing practices;
- Capital management practices; and
- Growth management practices.

All 14 instances involved weaknesses in pricing practices, and 10 also involved rapid membership growth.

Importantly, financial failure was averted in two instances because the insurers were able to carry out their capital management plans and triggers, and as a result they implemented premium increases of greater than 14%. However, the other 12 instances also involved capital management problems, which led to more serious distress.

Government decisions were a contributing factor in 10 out of 14 instances—either through a policy change leading to a surge in membership, and/or through Ministerial intervention in the annual premium increase process.

Investment losses played a secondary role in only one case, and inadequate provisions played a minor role in one other case.

2. Potential causes of failure in general insurance, and the implications for PHI

The table below sets out the reasons for failure in general insurance and comments on whether these could also be principal causes for failure in PHI.

Principal reasons for failure of general insurers	Are these principal risks of failure for Australian private health insurers?	Comment
Catastrophic events	No	Primary and public healthcare would absorb most of the cost of a catastrophic health event (such as a pandemic).
Inadequate provisions	No	Provisions represent a small proportion of annual claim costs.
Inadequate premiums (*)	Yes	However, the short-tailed nature of PHI means that under-pricing should become apparent quickly. Corrections can be made quickly because private health insurers are allowed to make adverse changes to benefits with only a small amount of notice to customers.
Rapid growth	Yes	Combining rapid growth with inadequate premiums means private health insurers may become insolvent before corrective action can be taken.
Significant change in business	No	Private health insurers are monoline (although a private health insurer's membership base could change rapidly due to inadequate premiums or a new product suite – see above).
Mis-stated accounts / fraud	Yes	However, the short-tailed nature of PHI means that there is less scope for mis-statement of outstanding claims or unearned premiums.
Impaired affiliate	No	Most Australian private health insurers are largely focussed on PHI only. APRA's prudential standards should ensure the insurer remains solvent if a related entity fails (although, the same should be true for Australian general insurers).
Reinsurance failure	No	Private health insurers do not reinsure, except in limited small-scale circumstances.

(*) Includes risks relating to product design changes—i.e. the premium is insufficient for the product.

The key risk that is more significant for private health insurers than for general insurers is the potential for Government decisions (policy and premium approval) and structural reform to drive sudden growth or reduced profitability.

3. How the regulator (APRA) uses capital to build insurer resilience

From APRA's point of view, a private health insurer would 'lose its shirt' if it was (close to) being unable to pay a claim. One of the ways APRA tries to prevent this is through its capital adequacy standard (HPS110), a principles-based standard enacted in 2014 which incorporated learnings from the cases of financial distress outlined above. The capital adequacy standard has two key components:

1. A minimum amount of capital that every insurer must hold—we'll refer to this as the regulatory requirement (RR). This is intended to be enough capital for the insurer to survive the next 12 months at least 49 times out of 50, even if its management took no corrective actions. In other words, it should buy enough time for most potential causes of financial distress to be fended off. On average, the RR in PHI is about 5.5% of forecast annual premium revenue.
2. The effective capital requirement, in practice though, is higher than the regulatory requirement. APRA requires private health insurers to have, and comply with, a Board-endorsed capital management policy (CMP), with appropriately set internal capital targets, triggers and management responses, based on the insurer's own risk assessment. In other words, an insurer breaches the capital adequacy standard if their capital falls below a target or trigger level and they do not carry out the actions specified in their CMP. The focus of this requirement is around insurer practice—as noted above, recent instances of financial distress were averted when the insurer was able to put into practice their capital management plans.

APRA uses the term "Surplus Capital" in its quarterly statistics publications, to refer to the capital amounts over and above the RR. But, in practice, this capital is not "surplus", as insurers are required, through the capital adequacy standard, to hold the majority of this capital (in the form of their capital target), or to rebuild capital if it depletes over time. The term "Surplus Capital" may lead to unintended pressure on insurers to reduce their capital targets or to allow capital to fall below their targets, for example through the premium approval process. This could lead to a higher risk of an insurer 'losing their shirt'.

APRA's RR has the following components for an average private health insurer, giving a rough sense of the size of the various risks:

- A **significant** requirement in relation to *capital management* (through the CMP);
- A **large** component that reflects *under-pricing* risks (part of the RR);
 - a. This requirement becomes significantly larger when insurers are *growing* (or shrinking);
 - b. It also increases as expected profitability reduces, as insurers targeting small profit margins are more likely to end up making a loss than insurers targeting higher profits;
 - c. The impact of differences in fund size on financial volatility are also considered;
- A **moderate** component that reflects *investment* risks (part of the RR); and
- A **small** component that reflects the risk of *inadequate provisions* (part of the RR).

The three largest elements of APRA's capital requirement (relating to under-pricing, growth and capital management) match the three largest contributing factors of recent financial distress.

4. How private health insurers manage capital to build resilience

Private health insurers hold more capital than the RR for a combination of good reasons, including:

- They are required to—through the CMP requirement, APRA compels insurers to manage their capital to internally set targets, with trigger points for corrective actions. Clearly these levels must exceed the RR.
- They have different risk appetites to APRA—an insurer would probably say that it had ‘lost its shirt’ if it breached APRA’s capital adequacy standard (due to the legal and reputational ramifications). Holding more capital than the RR is a way of protecting against this eventuality.

Target capital levels, trigger points and action plans are not public information. However, we attempt to illustrate how this might look for a ‘typical’ private health insurer with a risk appetite for no more than a 1 in 200 chance of breaching the RR within 12 months. The choice of 1 in 200 is illustrative, but is the stated sufficiency of regulatory minimums in a number of other insurance industries around the world, and would also reflect this insurer having a lower risk appetite than the regulator.

We estimate that this insurer would need to hold capital of around 8% to 10% of forecast annual premium revenue on top of the RR. In reality, the size of this buffer would depend on the size and risk profile of the insurer—typically, larger insurers would require less than this amount and smaller insurers more.

In total, this insurer targets around 14% of forecast annual premium revenue—the 5.5% RR plus a buffer of 8.5%. The only two publicly disclosed capital targets in the Australian PHI market are for the funds with listed parent companies—Medibank Private Limited targets 12% to 14%, and nib health funds limited targets 13.8%.

Some general insurers quote capital targets as multiples of the APRA RR for general insurers (which is set at a 1 in 200 probability of sufficiency). For example, Suncorp and IAG quote targets of 1.4 to 1.6 times APRA’s prescribed capital amount, and QBE uses 1.6 to 1.8 as its range.

If an average private health insurer used a capital target multiple of 1.5 times a 1 in 200 RR (estimated above at 8% to 10%), this would be around 12% to 15% of forecast annual premium revenue.

Potentially more important than the amount of capital held, is the management response to a challenging capital situation—including the discipline of the monitoring processes and whether or not the corrective actions included in the plan are followed effectively.

5. Conclusion

Findings: Recent examples of financial distress in PHI have arisen from a consistent set of risk factors—pricing, growth and capital management. An FSA study¹ included a finding that “*Management problems appear to be the root cause of every failure or near failure.*” This indicates a need to focus on underlying internal causes and importance of governance and stewardship such as monitoring trigger points and action plans.

Comparison to General Insurance: Many of the issues that are significant for general insurance (catastrophes, reserves, business changes, impaired affiliates or reinsurance failures) have not been experienced by private health insurers.

On the other hand, Government decisions (through health policy changes, and through its role in the premium increase process) have played a significant role in some instances, which contrasts to their relative lack of influence on general insurers.

While the risks differ, the need to anticipate how risks interact is common for both GI and PHI. For example, correlations between operational risk, underwriting risk and structural change risk could be considered in a ‘group risk map’.

Implications: A risk-based approach brings benefits and implications. Forward-looking tools (such as scenario analysis) are required in order to set capital targets and triggers, and these are inherently subjective in nature. Despite being good practice (and required by law), capital targets and triggers above the RR can be wrongly perceived as being ‘surplus to’ or ‘in excess of’ requirements.

Limitations: This paper explores themes at the industry level. An individual insurer’s own risk assessment and capital stresses can vary significantly by size and qualitative factors.

Possible next steps:

- Shift the focus of insurer practice from regulatory capital calculations towards scenario and resilience planning in relation to a range of different future landscapes
- Benchmarking Australian PHI not just against GI, but also against global leading insurance practices, including Solvency II
- Review the use of the term ‘Surplus Capital’ to refer to the amount of capital that insurers hold above the RR.

Reflection questions:

- To what extent are pricing errors driven by a lack of technical ability/resource, or by inherent bias (e.g. management incentives)?
- Are capital problems usually driven by a poor CMP, or by a lack of adherence to the CMP?
- Is there any correlation between weaknesses in key relationships (e.g. CEO-Board, CEO-Appointed Actuary, pricing team-sales team) and instances of financial distress?

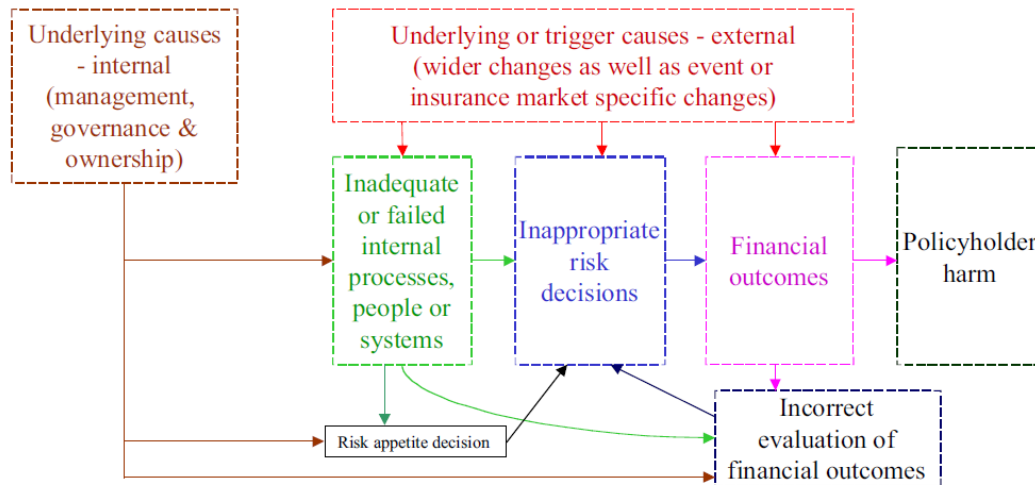
¹ “*Managing Risk: Practical lessons from recent “failures” of EU insurers*”, 2002, William McDonnell, Financial Services Authority Occasional Papers Series

Attachment - Risk map for insurance failures

The following high-level risk map² is a useful illustration of how different risk types can interact and consume capital. Like this paper, it was also compiled using actual instances of financial distress (in insurance companies in Europe).

Practical lessons from recent cases in Europe

Figure 1: high-level risk-map



² "Managing Risk: Practical lessons from recent "failures" of EU insurers", 2002, William McDonnell, Financial Services Authority Occasional Papers Series