



Private Healthcare Australia

Better Cover. Better Access. Better Care.



Submission:

ACCC Report to the Senate 2015-16

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Introduction

After addressing consumer information provided by health insurers in its previous two Senate Reports, the ACCC has this year invited submissions that will assist it to report to the Senate “on the changes health insurers have made to their information provision practices since the publication of these reports”.

PHA has prepared a submission outlining some recent industry initiatives to improve consumer information. This document also briefly comments on the content of the previous Reports and seeks to address some common misconception about private health insurance and consumer attitudes.

As the ACCC notes in its invitation, the Federal Government has commenced a major reform process for private health insurance via the Private Health Ministerial Advisory Council (PHMAC). PHA and a number of its members are actively involved in this process, which includes consideration of proposals by industry. Through PHA, the industry has identified several ways to increase the value of PHI to consumers and improve the quality and timeliness of information available to consumers. While this submission will not address the agenda of the PHMAC, our recent Pre-Budget Submission modelling a number of short and long-term reforms of PHI prepared by PHA and submitted to the Government is attached as Appendix C.

Contents

Introduction.....	2
About Private Healthcare Australia.....	3
Private health insurance in Australia	3
Commentary on previous reports:	3
Ombudsman complaints are not a valid measure of consumer satisfaction with PHI.	4
Insurer practices to communicate coverage and benefits to members.....	4
Private Health Insurance Code of Conduct.....	5
2016 changes to strengthen the Code.....	6
Streamlining the transfer of members from one insurer to another.....	6
APPENDIX A – 2016 changes to the PHI Code of Conduct.....	7
APPENDIX B – Media commentary on industry consumer information initiatives.....	9
APPENDIX C – PHA reform platform 2017.....	10

About Private Healthcare Australia

Private Healthcare Australia (PHA) is the industry association representing Australia's private health insurance industry. Its member insurers provide cover to more than 95% of the 13.5 million people in Australia with private health insurance.

Private health insurance in Australia

PHI is an integral part of Australia's mixed public-private healthcare system. 13.5 million Australians, or 55% of the total population, hold some form of PHI and insurers pay \$20 billion per year in benefits for the treatment of their customers.

In its invitation to submit to this Report process, the ACCC expressed interest in "findings of consumer surveys or testing (which might assist to understand customer behaviour, preference and concerns relating to their private healthcare)". The largest and most comprehensive consumer survey on private health insurance is conducted every two years by Ipsos. The most recent survey found several aspects of PHI where consumer attitudes were different to what many people perceive as a result of public commentary by interest groups and media reporting. Some examples include¹:

- 84% of people with hospital cover and 82% of people with extras cover believe their PHI represents "very good" or "fairly good" value for money.
- When people who had allowed their PHI to lapse were asked for the reasons why, 61% reported the cost of premiums, while only 3% cited a dispute.
- 45% of people would not feel comfortable discussing costs with a specialist doctor.
- 16% of people who received specialist treatment reported being surprised by the costs involved, yet only 8% considered seeing another specialist on cost grounds.
- Of all people who reported having negative feelings about a gap payment, 43% directed those negative feelings toward their health insurer, more than towards the doctor (29%) or hospital (7%).
- 26% of all private hospital patients believe they were not fully informed of all costs involved in their treatment prior to being admitted.

The results of the Ipsos survey clearly indicate that, overwhelmingly, Australians value their private health insurance and believe it represents value for money. The primary concern about PHI relates to its affordability. The PHMAC is addressing many of the significant drivers of premium increases and the industry is hopeful this will improve the sustainability of PHI.

Commentary on previous reports:

PHA noted in its submission to last year's report that customer dissatisfaction involving private health insurance is not isolated to policy changes but more broadly experienced by consumers who experience an unexpected health event, do not receive appropriate pre-treatment Informed Financial Consent (IFC) from their healthcare provider or who may simply forget or be unaware of what is and is not covered by the PHI policy.

When considering the causes of 'bill shock' and misunderstanding about the extent of PHI coverage, it must be acknowledged that some information, such as patient liability for gap payments to doctors, is simply not available to insurers before the patients receive their bills, and is

¹ Ipsos – *Healthcare & Insurance in Australia* (2015)

completely at the mercy of doctors' billing practices. Despite this, APRA's December 2016 statistics showed that 85.6% of all privately insured hospital services resulted in no out of pocket expenses for the patient.

Insurers generally enter into contracts with major hospital operators to ensure certainty over the cost of hospital admissions. Hospitals that do not have a contract with a health insurer may still treat the insurer's patients and are paid using a default benefit based on a formula established by Government regulation. While this default benefit has an overall inflationary effect on PHI premiums by establishing a price floor for hospital/insurer contracting, the cost of hospital accommodation is relatively stable and predictable.

Estimating medical costs is more difficult because, with some exceptions such as preferred provider arrangements, doctors do not enter into contracts with insurers and set their own fees which often vary from patient to patient. Despite this, some insurers are assisting their customers to better understand the potential costs associated with their treatment by publishing information aimed to help patients to better understand any out of pocket costs they may face. Some examples of these initiatives are attached to this submission as Appendix B.

Ombudsman complaints are not a valid measure of consumer satisfaction with PHI.

Last year's Report made a number of references to the Private Health Insurance Ombudsman (PHIO) relating to numbers of complaints received. PHA supports the important role played by PHIO, but does not believe variations in the number of complaints lodged with PHIO is a fair or accurate representation of consumer attitudes towards private health insurance.

For every complaint lodged with PHIO, more than 3,000 people have held PHI cover without complaint. On this scale, there is no significance to statistics on increases or decreases in the number of complaints or in breaking down the categories of complaint. The fluctuations from one reporting period to the next are highly volatile as a result of the small sample size of complaints. To highlight this point, consider that the most recent PHIO report in December 2016 showed a 29% decrease in consumer complaints since the previous report, yet there is no suggestion that insurers have 'solved' whatever problems existed previously.

In reality, the regular publication of complaint statistics by PHIO and the way these are reported has encouraged vested interest groups within the healthcare system to utilise the complaints process as a campaigning tool. This has occurred previously when some provider groups mobilised to facilitate complaints about insurers not covering some types of plastic surgery which insurers found were prone to fraud and similarly with gastric bypass surgery. It has continued with a current campaign by the Australian Dental Association which has resulted in large numbers of dentists (but rarely patients) lodging PHIO complaints about insurers as part of an attempt to gain attention.

PHIO is an important resource which PHA supports, but while its complaint records may reveal individual examples of insurer conduct that should be addressed, these are not reflective of overall consumer satisfaction trends and should not be viewed as a quantitative authority on PHI industry performance.

Insurer practices to communicate coverage and benefits to members

Private Health Insurance is a competitive industry with more than 35 providers, the majority of which are 'open' funds which anyone can join. All insurers go beyond the requirements of legislation and the PHI Code of Conduct to communicate coverage and benefits to their members, although they differ in the way they achieve this. Some examples of how insurers seek to keep their members informed about their cover include:

- Providing comparative (tick/cross) matrices online allowing for the simple comparison of coverage between different insurance policies.
- Developing a consistent 'join process' across the various consumer channels (eg, online, telephone, in-store) including a needs analysis prior to product recommendation.
- Carefully considered and tailored 'Welcome Packs' for new members and those changing to different levels of cover.
- Annual cover reviews
- 'Losses & Gains Statements' provided to people who downgrade their cover.
- Developing online calculator tools to help members determine any gaps they may be liable for ahead of treatment.
- Some insurers have responded to substantial variation in medical fees by publishing charges levied by specialist doctors²³⁴, giving policy holders some basis for comparison and negotiation, facilitating an improved understanding how to avoid incurring out of pocket health costs and, hopefully, reducing incidents of bill shock.

Private Health Insurance Code of Conduct

While the *Private Health Insurance Act 2007* establishes minimum requirements for health insurers to communicate policy changes to affected members, the industry has established the *Private Health Insurance Code of Conduct* (the Code), which binds all but two of Australia's health insurers and covers over 99% of policies issued. The Code covers four main areas of conduct in private health insurance:

1. Ensuring the correct information on private health insurance is provided from appropriately trained staff;
2. Promoting awareness of the internal and external dispute resolution procedures available in the event a consumer becomes involved in a dispute with an insurer;
3. Ensuring policy documentation contains all the information required to make a fully informed decision about the purchase and that all communications between policy holders and insurers are conducted in a way that the appropriate information flows between the parties. This includes staff, agents and brokers; and
4. Ensuring that all information between policy holders and insurers is protected in accordance with national and state privacy principles.

With respect to communicating policy changes to affected members, the Act requires insurers to maintain an up to date Standard Information Statement (SIS) for each product subgroup (S93) and to inform a member of a detrimental change to their policy "a reasonable time before the change takes effect" (S93-20 and 93-25).

The concept of "a reasonable time" is not defined nor is the method for initial communication of the change. In place of this, the Code stipulates that policy holders should be provided with 30 days' written notice ahead of any detrimental change, and 60 days' written notice ahead of any detrimental change affecting benefits payable. The Code does not impose specific communication requirements on insurers in circumstances when changes to hospital contracting arrangements affect a policy holder in acknowledgement that "requirements for notification of consumers of such changes and transition arrangements are included in the relevant agreements and the Code of Conduct for Health Fund and Hospital Negotiations."⁵

² *Bupa goes after high charging surgeons* – Australian Financial Review, 16 December 2015 (attached)

³ *NIB puts heat on surgeons by exposing fees* – Australian Financial Review, 15 February 2016 (attached)

⁴ *Medibank reveals the fees of Australia's highest charging doctors* – News.com.au, 30 April 2016 (attached)

⁵ *Private Health Insurance Code of Conduct, July 2016, Version 6*

The provisions of the Act for communicating detrimental changes combined with the relevant principles of the code provides a sound framework for ensuring consumers are not misled or deceived about what their policy covers. If an insurer complies with this framework, any policy holders affected by a detrimental change will be informed with at least 30 days' notice of the change taking effect. Since legislation also provides portability rights, any informed policy holder is provided with ample opportunity to switch to an alternative insurance policy before they are affected.

2016 changes to strengthen the Code

Following the ACCC's previous commentary around the need for the industry to improve customer communication around policy changes, the most recent of the regular reviews conducted by the Code Compliance Committee in 2016 incorporated resulted in 13 changes to the Code. These include changes affecting:

- Transferring members between insurers
- Dispute resolution
- Policy documentation
- Welcome letters
- Communicating benefit limits
- Improving links to Product Disclosure Statements
- Communicating product changes
- References to preferred providers
- Simpler navigation of fund rules & by-laws
- Offering a review period following a cover downgrade
- Clarifying communication requirements

A full schedule of these changes including commentary is attached to this submission as Appendix A.

Streamlining the transfer of members from one insurer to another

A number of health insurers and PHA are actively involved in the Transfer Certificates Working Group, a joint project involving the Department of Health, Health Direct Australia (HDA), the National Health Service Directory (NHSD), the Private Healthcare Ombudsman. The project aims to improve the timeliness and reliability of the way customer switching between insurers is processed.

The creation of a fully electronic solution is important because the current system of manually produced Transfer Certificates is antiquated and prone to delays. Members typically switch insurers without notifying their 'Old Health Fund' requiring the 'New Health Fund' to make a formal request to the Old Health Fund for the member's Transfer Certificate. Delays in the processing of Transfer Certificates mean the customer is delayed from accessing benefits from their new insurer.

The Working Group has identified an XML solution for implementation, which is the first step towards integrating the transfer certificate process with ECLIPSE, the Medicare platform that facilitates billing and claiming by healthcare providers.

A commercial messaging provider has been engaged and a small number of insurers have indicated implementation will occur in the second quarter of 2017. It is expected that all funds will have adopted the new electronic system by the end of 2017.

Private Health Insurance Code of Conduct 2016 Amendments

The Code Compliance Committee proposed the below changes to the PHI Code of Conduct, which were endorsed by the Private Healthcare Australia Board in May 2016 and took effect from 1 July 2016.

Issue Identified		Change to Code of Conduct or Self Audit
1	Strengthen requirements on transfer certificates	Self-Audit Guide: <i>E17 Do you have a formal process of identifying and addressing any issues if monitoring shows Transfer Certificates have not been issued within 14 days of request?</i>
2	Dispute resolution promotion needs some strengthening to more closely align with the Australian Standard	Self-Audit Guide: <i>B3 Is information on your internal dispute resolution process freely available wherever a consumer might be expected to find it?</i>
3	The requirement for a fund to have a formal process of requirements in policy documentation has been dropped from the Self-Audit Guide	Self-Audit Guide: Include a new clause to question E6: <i>E6 Do you have a formal process of ensuring people responsible for the development of policy documentation and product summaries are advised of their responsibilities under the Code; and</i> <i>E6-1 Does your Policy documentation and/or product summaries accurately reflect the cover offered?</i>
4	Welcome letter requirements at E5 require tightening	Self-Audit Guide: <i>E5 Does your fund provide members with a letter containing written confirmation of the consumer's entitlement to benefits, including any waiting periods and pre-existing conditions, exclusions, restrictions, benefit limitation periods and co-payments and/or excesses and limits following joining or upgrading cover with your Fund?</i>
5	'Limits' missing from E4 questions in the Self-Audit Guide	Self-Audit Guide: E4 question has the word 'limits' included after. ...and/or excesses and limits...
6	Check that the Code documents have been updated to the latest Dispute Resolution Standard AS/NZS	Self-Audit Guide: <i>B2Dispute Resolution Standard AS/NZS 10002:2014</i>
7	Funds should provide clearer information and links to Product Disclosure Statements	Code Part E: 1 (d) (xiv) <i>where to find any additional rules or product disclosure statements.</i> Self-Audit Guide: <i>E8-8 where to find any additional rules or product disclosure statements</i>

Issue Identified		Change to Code of Conduct or Self Audit
8	More tailored communication on product changes	Code Part E: 1 (g) – review words to: <i>provide in a timely manner to consumers specific information on any changes to their policy, being made in plain language and in a format aimed to assist comprehension by consumers; and</i> Self-Audit Guide: E11 <i>Does your fund provide specific details of changes to policy terms:</i>
9	Some consumers are concerned that some funds refer to preferred providers in a way that may indicate that these are the only providers	Code Part E (d) (x) <i>how to find out if an ancillary provider is either a preferred provider or is recognised by our fund</i> Self-Audit Guide: E8-3 <i>how to find out if an ancillary provider is either a preferred provider or is recognised by our fund</i>
10	Some fund rules and/or by-laws are difficult to find and ancillary item numbers difficult to locate	Code Part E 1 (d) by inserting (xv) <i>where to find information on other fund rules not covered in policy documentation'</i> Self-Audit Guide: E8-8 <i>where to find information on other fund rules not covered in policy documentation.</i>
11	Request that a fund member be given a limited time to review cover in the case of a downgrade	Self-Audit Guide: E6: <i>Does your fund advise a member reducing their cover to review their decision within 7 days of receipt of confirmation of their change?</i>
12	E5 Clarify that written confirmation can include electronic communication	Important information must be included in the email sent to the member although detail could be contained in the member only site provided the email is electronically linked to the member's site via the email. A suitable definition could be included in either the question or the Definitions
13	Change reference from PHIO to Commonwealth Ombudsman (also check other agencies)	<u>Agreed:</u> Changes will be required to all documents



back

Nib puts heat on surgeons by exposing fees

Exclusive

Tim Binsted

Surgeons should brace for increased scrutiny after nib said it would be the second player in the \$21 billion private health insurance sector to expose the wide variation in price charged for surgeries, leading to shock extra costs for patients.

The listed health fund will pressure doctors to reduce excessive fees and help prevent shock out-of-pocket costs for its policyholders, by publishing a range of information on its website. Alongside the amount Medicare covers for surgeries, such as a knee replacement or removal of the prostate, nib will publish its standard "no gap" rate, as well as the rate the doctors lobby recommends its members charge for those procedures.

The move follows a similar initiative by Bupa, expected to start in late March, to expose fee-gouging surgeons. "Greater transparency will be good for consumers, particularly around avoiding out-of-pocket costs, and it puts great pressure on doctors to charge prices that are reasonable," nib managing director Mark Fitzgibbon said.

Bupa, which is the second-largest player behind Medibank Private, controls about 28 per cent of the market, and nib commands about 8 per cent.

Analysis of nib's 2014-15 claims data, obtained exclusively by Fairfax Media, reveals huge variation in fees paid to medical specialists, with top-end prices often double or three times the relatively high fee recommended by the Australian Medical Association, which lobbies for doctors.

Through Medicare the government pays a rebate of 75 per cent of the MBS

price. The private health insurer will cover the other 25 per cent, or in nib's

case, the full amount above the MBS price up to its "MediGap" rate. If a surgeon charges above nib's no-gap rate, the individual pays the entire cost above the MBS price.

According to nib's data, specialist fees for a prostatectomy (surgical removal of the prostate) ranged from \$2,000 to \$10,000. The Medicare Benefits Schedule price for this procedure is \$1935, nib's MediGap (no gap) offer is \$2941 and the AMA's recommended fee is \$4465. The MBS fee for a knee replacement is \$1318, nib's no-gap rate is \$2014 and the AMA's recommended fee is \$3690. In 2014-15 a cluster of surgeons was charging \$4500 to \$5500.

"We want GPs and consumers to be able to make a more informed decision choosing their specialists. Some surgeons were charging \$6000 more than the AMA recommended price, which is a huge impost," Mr Fitzgibbon said. "Most specialist surgeons accept the MediGap price as fair and reasonable so we are talking about relatively few doctors, but those relatively few doctors who charge prices we believe are excessive are causing a fair bit of pain out there."

Shock out-of-pocket costs are a key cause of customer anger in private health insurance and often leads to switching health funds, downgrading cover, or ditching private health cover altogether. Fee data, including average fees and ranges, MediGap participation, and patient feedback by specialist, will be replicated on nib's website "in the near future" for the benefit of nib members. The different fees charged by individual specialists will not be published.

The information will subsequently be made available to the broader public

on the Whitecoat website. Whitecoat, a nib initiative, allow consumers to
Continued p20

From page 15

Heat on surgeons as Nib to expose fees

search for healthcare professionals online and to read and write reviews of their experience.

The insurer will also be encouraging its members to ask their GPs for as much information as possible when referring to specialists.

Mr Fitzgibbon said that prior to his preventive colonoscopy, his doctor was able to provide only a list of surgeons he believed were good quality.

"He [the doctor] should have been able to show me his [the surgeon's] volume, readmission rates, and infection rates.

"He should have been able to show me what other patients have said about them [the surgeons] and he should

have been able to give me an indication of whether he would accept the MediGap price," he said.

"We are starting to introduce some transparency around costs. We are starting to tackle these information asymmetries [between users and providers of healthcare]."

The move comes as health funds are due to resubmit their requested annual premium increases.

Health Minister Sussan Ley wrote to insurers last month asking them to trim their premium increases or provide reasons they could not go lower.

In response, health funds have



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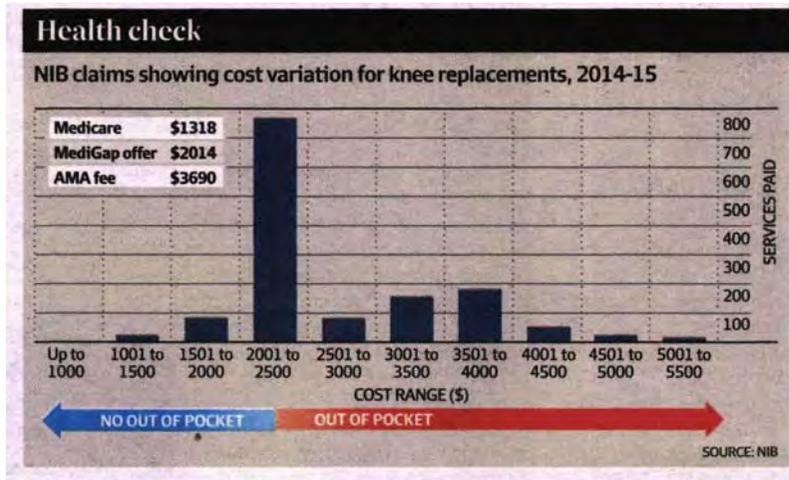
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Page 2 of 2

 back

demanded that Ms Ley crack down on the rising cost of care, which is putting upward pressure on premiums, prompting an accelerated federal review of medical devices pricing and regulation.

On Friday Ms Ley extended the deadline for revised premiums to Monday.





Bupa goes after high-charging surgeons

Tim Binsted

Health fund Bupa will start publishing price information on surgical procedures such as hip replacements to put pressure on fee-gouging surgeons and reduce customer anger in relation to shock out-of-pocket costs.

The nation's second-biggest private health insurer plans to have price data by procedure, on a state-by-state basis, in the hands of consumers in the first three months of 2016.

Bupa private health insurance managing director Dwayne Crombie said that most doctors do the right thing, but there is a "small but significant minority" who are being unreasonable.

"Every surgeon is their own sole trader so they are free to charge whatever they think the market will bear ... what we are trying to do here is get a bit of peer pressure. People are getting quite significant fees," he said.

"If you are going for a knee replacement you are probably interested to know how much docs Medicare pay, how much does the health fund pay and how often are there out-of-pocket costs."

Dr Crombie said it is not uncommon for cardiologists and orthopaedic surgeons to be earning "well over seven figures" and Bupa wants to expose the most expensive operators.

"An out-of-pocket for a knee procedure might have a big difference of \$500 to \$10,000. If you go along to your doctor and they tell you that you need a hip operation you usually just go where you are told. If that guy says that will be \$8000 and you thought you had insurance, that is pretty hard," he said.

Bupa covers just over 3.9 million Australians, a little more than 27 per cent of the market.

The health fund's data shows a huge variation in costs for the same surgery.

Over the past 12 months, costs for an oesophagoscopy ranged from \$177 to \$2000; selective coronary angiography from \$532 to \$2104; knee arthroscopic surgery from \$674 to \$4375; prostatectomy from \$1042 to \$5702; hip replacement from \$1317 to \$8000; and knee replacement from \$1317 to \$9999.

Dr John Quinn, executive director of the Royal Australasian College of Surgeons, said there are a small number of

surgeons charging "exorbitant" fees.

"We think it is an ethical issue. Surgeons should not be charging very large fees for people in need."

He said GPs may change their referral patterns if they are aware of the pricing policies of certain surgeons, to better protect patients from out-of-pocket costs.

"There is a problem with overcharging. The referring GPs often don't know the pricing schedule of the surgeon," Dr Quinn said.

"It is not going to alter the healthcare ... just because someone charges a very high fee doesn't mean they are providing the best surgery."

Bupa's Dr Crombie said consumers are quite comfortable shopping around for the best quote when getting a car fixed and he hopes to inject similar price competition to the surgical world.

Between 80 and 85 per cent of Bupa's member interaction involves zero out-of-pocket costs, about 10 per cent involves a small gap fee in the order of \$500, and the remaining 5 per cent have significant gap fees in the thousands of dollars.

Policyholder shock over large and unexpected out-of-pocket costs is one of the biggest drivers of extreme customer dissatisfaction.

In a business where rising premiums are already pushing consumers to downgrade their policies or leave the private health system altogether, preventing shock out-of-pocket charges is a big priority for insurers.

Rival health fund nib has been pushing to get more information into the hands of consumers and to give them more choice through its Whitecoat website, which nib boss Mark Fitzgibbon calls "Trip Advisor for healthcare".

Health funds have become increasingly vocal of late about the need to get a better deal for consumers. Most of these initiatives would, of course, boost the insurer's own bottom line as well.

The most high-profile example has been Medibank Private's refusal to pay for what it calls "hospital-acquired complications" and unplanned hospital readmissions.

Key points

Insurer will release price details for procedures to clarify out-of-pocket fees.

Bupa and other industry players say some surgeons are charging too much.



16 Dec 2015

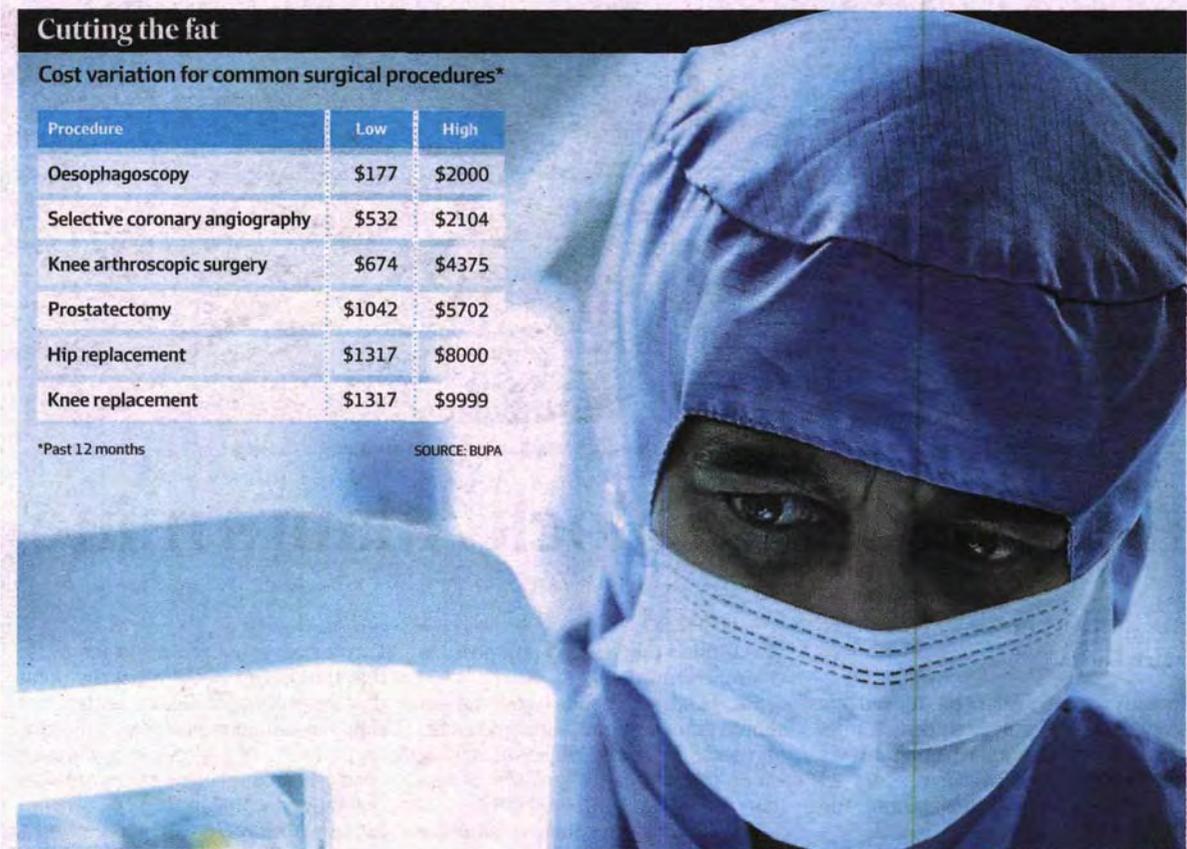
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LATEST IN LIFESTYLE

health

Medibank reveals the fees of Australia's highest charging doctors.

APRIL 30, 2016 9:31PM



The new report will allow patients to compare prices of different surgeons. Picture: iStock

Sue Dunlevy News Corp Australia Network

SSSSEn

MEDIBANK has revealed the fees charged by Australia's highest billing doctors in a move that could shame those overcharging into cutting their high costs.

A report released today reveals some doctors are charging patients up to \$17,000 more than their peers for the same operation and its one of the reasons patients are left with hefty gap fees not covered by their health funds.

The Medibank report analyses fee differences and patient outcomes in eight general surgical areas including gall bladder, hernia, lap bands, gastroscopy and colonoscopy.

The fund says it wants to share the data with surgeons so they can reflect on it and it hopes it may drive behaviour change.

However, patients will be able to use the information as a guide to whether they are being overcharged and it could help them negotiate a better fee with their surgeon.

Medibank says this is not the reason it prepared the report and the reason some doctors charge more is they may deal with more complex patients.

The report shows in gall bladder surgery the lowest charging doctor had a bill of \$4,543 for while some surgeons charged up to \$21,419.

This massive difference means some doctors are charging \$16,876 more for the same operation than others.

Half the doctors did not charge a gap for this surgery but the maximum out of pocket fee for patients was \$1,754.

— ADVERTISEMENT —



Patients who had this surgery also faced out of pocket fees for other medical services (including charges raised by the anaesthetist, assistant surgeon and for diagnostics) in 91% of cases.

The average out of pocket charges received by their patients for other medical services ranged up to \$709.

A gastroscopy where a tube with a camera attached is inserted to diagnose intestinal problems cost \$809 with the cheapest doctor but \$7,815 when patients saw the highest charger.

This is a difference of \$7006 in fees.

Patients were charged an out of pocket fee of up to \$482 by the surgeon in 7 per cent of cases and the average out of pocket charge was \$174.

Patients were charged additional out of pocket fee of up to \$634 pocket fee for other medical services (including charges raised by the anaesthetist, assistant specialist surgeon and for diagnostics) in 25 per cent of cases.

The median cost of a hernia operation was \$4,686 but some doctors charged over \$10,000.

Patients were charged an out of pocket fee of up to \$1,380 by the surgeon in 27 per cent of cases, the average out of pocket charged was \$588.

Gastric band surgeons charged between \$8,960 and \$30,953 with a median fee of \$12,675.

Patients were charged an out of pocket fee by the surgeon in one in three cases. One in three doctors did not charge a gap fee for this procedure but some charge gaps of up to \$3,472, with a median of \$25.

The cheapest colonoscopy surgeon charged \$1,144 and the highest \$10,990 while the average \$1,845.

Patients were charged an out of pocket fee by the principal specialist in just one in ten cases with the average out of pocket \$271 and the highest \$692.

The Royal Australian College Surgeons is giving the data to its members so they can tell if they are among those with the biggest fees or the worst surgery outcomes.

“These reports will provide surgeons with information that may help them gain a better understanding of, and learn from, variations, for the benefit of the service they

provide to their patients and the community,” RACS President, Professor David Watters, said.

“Information sharing is key to improving the delivery of healthcare, and ultimately to improving patient outcomes,” Medibank Chief Medical Officer, Dr Linda Swan, said.

“These reports will enable surgeons to reflect on their practice, both as an individual clinician, as well as part of a specialty field, and consider what could be improved or changed,” she said.

PRIVATE HEALTH CARE AUSTRALIA

Ideas for improving the value and affordability of private health insurance

2017-2018



Private Healthcare Australia
Better Cover. Better Access. Better Care.



Table of Contents

EXECUTIVE SUMMARY	4
BACKGROUND	14
The PHI Rebate	18
The PHI rebate on ‘Extras’	23
Policy measures	26
SHORT-RUN MEASURES TO IMPROVE THE AFFORDABILITY AND SUSTAINABILITY OF PHI	28
The Commonwealth Protheses List	28
The second-tier default benefit	32
Premium round deregulation	53
Review of Lifetime Health Cover settings	63
LONG-RUN MEASURES TO IMPROVE THE AFFORDABILITY AND SUSTAINABILITY OF PHI	74
The Medicare Benefits Schedule (MBS) Review and improved payment integrity and compliance mechanisms	74
Funding for out-of-hospital care	76
CONCLUSION	78
ABOUT PRIVATE HEALTHCARE AUSTRALIA	80

EXECUTIVE SUMMARY

Australia's dual private-public health care system is highly regarded by most Australians. The private and public sectors are intrinsically interconnected and having private health insurance has largely become part of the Australian way of life. Despite the additional costs, 84% of Australians with private health insurance value the product and want to keep it.

Our health system is also well regarded in terms of clinical outcomes. Australia has the fourth highest life expectancy in the world and is among the world's best in terms of other outcomes like infant mortality. The majority of the population (65%) believe the quality of the health system in their State or Territory is very high.

Still, there is definitely concern among some Australians around the sustainability of the current health system, with 44% of people believing the mixed public and private health system will not be around in 15 years, and a further 52% of people lacking confidence that the public hospital system, in its current form, will still be around in 15 years.

This concern comes largely from the fact that health care costs have risen at a rate much higher than the Consumer Price Index (CPI) over the last decade, which has led to higher premiums and therefore greater pressure on household budgets.

For example in 2014-2015, health system input costs (hospital accommodation costs of 7.6%, medical specialist gap costs of 7.1%, medical device costs of 9% and allied health costs of 6.3%) rose by close to 8%, while household incomes rose by just 1.8%. In 2016, to take account of this health funds were awarded an average premium rise of 5.59%, and public hospitals were awarded a 6.5% annual funding increase through the COAG process.

Market research has repeatedly shown that the cost of premiums is the main reason why many people decide not to take out private health insurance and also the main driver of dropouts and downgrades from existing levels of cover.

Australian health funds are acutely aware of the need for budget repair, and are not asking for one dollar of additional government funding. What funds are asking is that every dollar of waste in the sector is reduced or eliminated, and every piece of toxic and outdated regulation currently reducing market transparency and competition, is removed to put downward pressure on premiums and consumer out-of-pocket costs.

As part of the process of improving the consumer experience in private health, health funds have committed to work with government on ways to assist consumers to choose and get the most out of their health insurance. PHA member funds have already made a considerable financial investment in this.

This paper identifies practical and achievable policy adjustments to ensure the sustainability of the Australian health system into the future.

The Private Health Insurance (PHI) Rebate

In the late 1990s, following removal of support by the Federal Government for those with chronic illness who had PHI, combined with an economic downturn, the private hospital system was in crisis.

To stabilise the PHI market and give public hospitals a chance to recover, the Howard government introduced a package of reforms known as Lifetime Health Cover (LHC); the Medicare Levy Surcharge (MLS); and, the 30% PHI Rebate.

In recent years, there have been many changes to the regulations governing the rebate that have been aimed at controlling government spending in this area.

These include:

- Means-testing introduced in the 2009-10 Budget;
- Indexation to CPI, uncoupling the rebate from premium increases legislated in 2012;
- Removal of the rebate from LHC loadings, announced in 2009-10 Budget; and
- Freezing income thresholds for rebate eligibility and the MLS at 2014-15 levels through 2017-18.

The effect of these measures has been to slow the growth of PHI rebate outlays, and expenditure on the rebate is expected to decrease even further with time. We should not underestimate the impact of indexation of the rebate on consumers. If we don't fully index the rebate on premiums, it is essentially the same as compound interest at the difference between general CPI and health/premium inflation. If health inflation continues at the same rate, the value of the rebate as a percentage of the premium will be 16% in a decade, down from 30% when it was introduced.

Health funds appreciate the need for budget repair and are not, at this stage, asking for the rebate to be returned to its original form. We do, however, strongly believe that should the rebate be phased-down too soon, this would make it even more difficult for many Australians, already experiencing financial stress, to be able to afford PHI.

Recommendation 1: In the interests of maintaining affordability of PHI for low and middle income earners, and reducing complexity in the sector, no further changes are made to the rebate on PHI premiums.

The Commonwealth Protheses List

The Federal Government currently regulates the benefits health funds should pay if an implantable medical device or 'prosthesis' is used in a procedure. The effect of 'benefit fixing' has meant that private health fund members now pay between 2-5 times public medical device prices, and those in comparable economies. This is reflected in premium increases.

A 2015 report commissioned by the industry, "Costing an Arm and a Leg" determined if Australian public hospital prices are used as a benchmark, \$800 million is being wasted annually on excess benefits paid for medical devices. The report estimated two thirds of this waste is going straight to excess profit for the large multinationals dominating the Australian medical device market.

During the 2016 Budget negotiations, PHA supported the Federal Government's phased approach to correcting regulations around medical device prices and agreed to pass on all savings as a reduction in the 2016-17 first round. This process should now be fast tracked.

Recommendation 2: The reform of Protheses List benefit setting by the Commonwealth must progress rapidly in 2017-18 with the implementation of reference pricing to State Government tender prices and international reference prices from comparable economies, as well as the introduction of price disclosure. The Commonwealth should have an explicit deadline to exit regulation of medical device benefits in the private health sector.

The second-tier default benefit

Recommendation 3: Abolish the 85% benefit requirement, other than for rural and regional overnight stay providers or networks operating at under 3% market share

The second tier default benefit, introduced in 1998, is the level of benefit payable by a health fund for a period of hospital treatment provided by an eligible private hospital with which it does not have a negotiated agreement.

The second tier default benefit is 85% of the average charge for the equivalent episode of hospital treatment under that health fund's negotiated agreements with comparable facilities in that State or Territory.

When introduced, the Government believed the larger market size held by health funds allowed them too much negotiating power over private hospitals that were less concentrated in terms of market share.

The aim of the second tier default benefit was to support smaller providers and re-balance the market between health funds and private hospital providers. By 2003, the balance of negotiating power shifted back to private hospital providers, with Ramsay Healthcare and Healthscope holding 37% market share at this time.

The Federal Government then proposed abolishing the second tier default benefit but this proposal was defeated after intense opposition from vested interest groups who argued policyholders would be adversely affected by a reduced choice of hospital providers, particularly with small and regional hospitals. Since then, the private provider market has further consolidated with the two largest providers (Ramsay and Healthscope) increasing their ownership from 37% to 44% market share.

In an environment where there is almost no regulation on the introduction of new hospital beds, the second tier default benefit is anti-competitive and has an inflationary effect on premiums.

While there are clearly concerns with the current benefit, it is also acknowledged that some smaller and regional facilities rely on the benefit as an option. These providers would be at risk if the benefit were to be eliminated. For example, over 75% of small facilities with less than 50 beds are not aligned with a large provider network - which is defined as a provider group earning sufficient revenue to hold greater than 3% market share.

Public hospital (State Government) cost-shifting

Public hospital 'cost shifting' or transferring the cost of public services to health funds in Australia is in the order of \$1 billion dollars a year. This accounts for about 6% of premiums.

For most patients attending a public emergency department, using their private health insurance is not a planned decision. In fact, many patients are signed up after they are admitted. The end result is PHI policyholders are now subsidising the cost of public hospitals, despite having already contributed to these through their taxes. In the 2014-15 financial year, the private health industry provided 2.1% of all public hospital funding.

This has been growing at an average rate of 12% every year since 2009, driven by two factors: the number of public hospital stays charged to private health per patient, growing at 7.5% per annum; and the historical increase in private health membership, growing at 3% per annum.

In other words, public hospital cost shifting to health funds adds more to premium costs than the average year's premium increase.

At a state level, an unspoken encouragement of public hospital cost shifting seems to be growing. If every State and Territory achieved cost shifting at the same level as NSW, which is 3.2% of all public hospital costs, it would cost an additional \$500 million annually. This would potentially drive premiums up a further 2.8%.

Recommendation 4: Remove state government quotas for non-source revenue with increased monitoring of private patient flows through public hospitals; enhance informed consent processes to protect customers, and greater transparency on care being provided.

Premium round deregulation

As a result of health cost inflation, premiums increased at an average rate of 6% each year between 2007 and 2015. Today, the Federal Government regulates the PHI industry's overall premium increase through a centralised review process. This means that each health fund must apply to the Minister for Health for approval of all premium changes.

These proposed changes are submitted by health funds in November of each year, and are closely scrutinised by the Minister, the Department of Health and the Australian Prudential Regulation Authority (APRA) before notifying consumers of a change in premiums towards the end of February, with changes actually taking effect on the 1st of April.

The process places pressure on health funds to respond to the market as it creates a time lag between market signals, the approval of premium changes and the premium change then taking effect. The way the process is synchronised poses a challenge as the simultaneous change to premiums for all health funds, as announced by the Minister in late February each year, sparks seasonal churn which can be seen as a spike in people changing funds and level of cover at this time.

Recommendation 5: Establish an independent price monitoring system with a desynchronised price regulation process. An independent statutory authority would monitor premium changes by assessing health funds' adherence to a set of guidelines, such as Benefits Loss (Claims) Ratio, that ensures price changes do not have an inappropriately adverse impact on policyholders. A desynchronised process would replace the current annual round of increases.

Review of Lifetime Health Cover settings

Australia's ageing population directly impacts the Australian PHI industry as older age groups are more highly represented than younger age groups and cost significantly more in healthcare than younger groups.

This membership imbalance is not a new problem. In 2000, Lifetime Health Cover (LHC) loadings were introduced to encourage younger people to purchase PHI and address this imbalance.

Under LHC regulations, anyone purchasing PHI for the first time after the age of 30 pays a loading on their premium equal to 2% for each year of age older than 30 (with a maximum loading of 70%). The loading lasts for 10 years. For example, a 40 year-old purchasing PHI for the first time will pay 20% more than the listed premium price for 10 years.

PHA believes it is time to re-examine the LHC policy settings in line with demographic and economic changes that have occurred over the last two decades. We have considered a number of reform options for rebalancing the age profile of consumers in Australia.

Recommendation 6: Provide a lifetime health cover discount to individuals commencing membership between the ages of 18 and 30 years. Offer a graded discount increasing at 2% per year under 30 years, but cap at 10%. Allow recipients to retain the discount for life, but remove the discount if the recipient exits PHI. The discount is portable between funds.

Longer-term measures

There are two key longer-term measures that will also improve the affordability and sustainability of PHI.

- **MBS Review:** PHA is strongly supportive of the Government's MBS Review as every dollar of waste and every episode of inappropriate practice threatens the sustainability of private health. However a robust mechanism to manage compliance in the MBS program, and to ensure services are provided appropriately, will be as important as the changes to the MBS schedule of fees arising from the Review in ensuring the sustainability of this program as well as PHI.
- **Funding for out-of-hospital care:** Legislation currently prevents private health insurance from covering medical services that are provided out-of-hospital and covered by Medicare. The Federal Government should review relevant legislation with the objective of permitting health funds to provide funding for services provided out-of-hospital which are either a substitute for hospital care, or have the potential to prevent avoidable hospital admissions or readmissions. Avoidance of unnecessary hospitalisation is a key factor in keeping premiums down.

The PHI Industry shares the commitment of the Federal Government to budget repair and reducing national debt. While the sector understands the climate is not right for the introduction of sweeping or fundamental reform of Australia's health system, there is scope to address the sustainability of healthcare through sensible policy correction.

Some of the regulatory measures that apply to the private health sector are no longer relevant, do not protect consumers, have inflated costs and decrease the efficiency and transparency of the sector. Addressing the measures outlined in this submission does not require any additional funding but will reduce waste, increase competition and put downward pressure on premiums and consumer out-of-pocket costs.

PHA estimates if the over-regulation of private health insurance was addressed, as above, including reform of the Prostheses List already commenced, health fund members would save just over \$1.5 billion a year on premiums as a result of increased competition and transparency.

BACKGROUND

Australia's health system in its current form ('Medicare') has, since 1984, successfully comprised both publicly funded and private elements as part of its fundamental design. Commonwealth and State governments contribute funding to public hospitals where treatment is provided free of charge, and through the Medicare Benefits Schedule (MBS) provide reimbursement for services provided by private doctors and certain allied health professionals.

Private health funds insure for treatments provided in private hospitals and some treatment in public hospitals on top of that, and in addition, the fee-for-service system builds in the potential for doctors to charge a co-payment as part of or above a scheduled fee-for-service.

It is wrong and unhelpful to characterise Australia's health system as having two mutually exclusive parts – one private and one public, as both are intrinsically interconnected.

Private Health Insurance (PHI) is embedded in Australian culture, it has persisted for over 150 years since the introduction of the friendly societies from the UK, which were mutual structures designed to spread the risk of health care costs over a community of the young and old.

The vast majority (84%) of Australians with private health insurance value the product and want to keep it.¹ This is because of the control it gives them over the timing and location of medical treatments in hospital, and the security of knowing one fully trained health professional is responsible for their care, in contrast to a variety of shift workers, for example.

Australia has a health system, which is well regarded in terms of measurable clinical outcomes. We enjoy the fourth highest life expectancy in the world and are among the best in terms of other outcomes such as infant mortality. The mixed private/public health system is also very highly regarded by the Australian community, with 65% of the population believing the quality of the health system in their State or Territory is very high.²

¹ IPSOS Health Care and Insurance Australia survey 2015 (n=5500)

² IPSOS Health Care and Insurance Australia survey 2015 (n=5500)

There is concern among Australians, however, around the issue of health system sustainability, with 44% of people believing the mixed public and private health system will not be around in 15 years, and 52% of people lacking confidence that the public hospital system will be around in its current form in 15 years time.³

The underlying dynamic behind these numbers is inflation of health input costs, which have risen at a rate much higher than CPI over the last decade. The impact on household budgets of rising health costs, perceptions of strain on the public hospital system like rising waiting times and media reports of poor outcomes, mean people are acutely aware the status quo may not be sustainable under current economic conditions.⁴

For example, in the year 2014-2015, health system input costs rose by close to 8%. This area incorporates hospital accommodation costs of 7.6%, medical specialist gap costs of 7.1%, medical device costs of 9% and allied health costs of 6.3%. To put this in perspective, in the same year household incomes rose by just 1.8%.

In 2016, to take account of this, health funds were awarded an average premium rise of 5.59%, and public hospitals were awarded a 6.5% annual funding increase through the COAG process. In 2015-2016 a slowing of the economy has meant 'health' inflation has eased slightly so that input cost growth is currently around 5-6%, but this is still well above the Consumer Price Index and household income growth.

The ratio of health expenditure to GDP has remained reasonably stable at 9.8%, which is average for an OECD economy. Over the last decade however, health expenditure has tended to grow faster in real terms than GDP, with an average annual real growth of 5.0% being 2.2 percentage points higher than the 2.8% for GDP.

The strain on the health system has been revealed in two ways which impact health fund members; The first is the increasing consumer contribution to the cost of health care through premium increases and rising medical out-of-pocket costs.

The second is through public hospital waiting times, which have more than doubled since the turn of this century.⁵

The average waiting time for non-emergency treatment in a public hospital has doubled since the year 2000, with 10% of patients still waiting nearly a year for surgery.⁶

³ IPSOS Health Care and Insurance Australia survey 2015 (n=5500)

⁴ Australian Institute of Health and Welfare (AIHW) 'Health expenditure Australia 2014-15'

⁵ IPSOS Health Care and Insurance Australia survey 2015 (n=5500)

⁶ AIHW Australian Hospital Statistics 'elective surgery waiting times' 2014-15

Most of the reasons for health inflation are beyond the control of health funds.

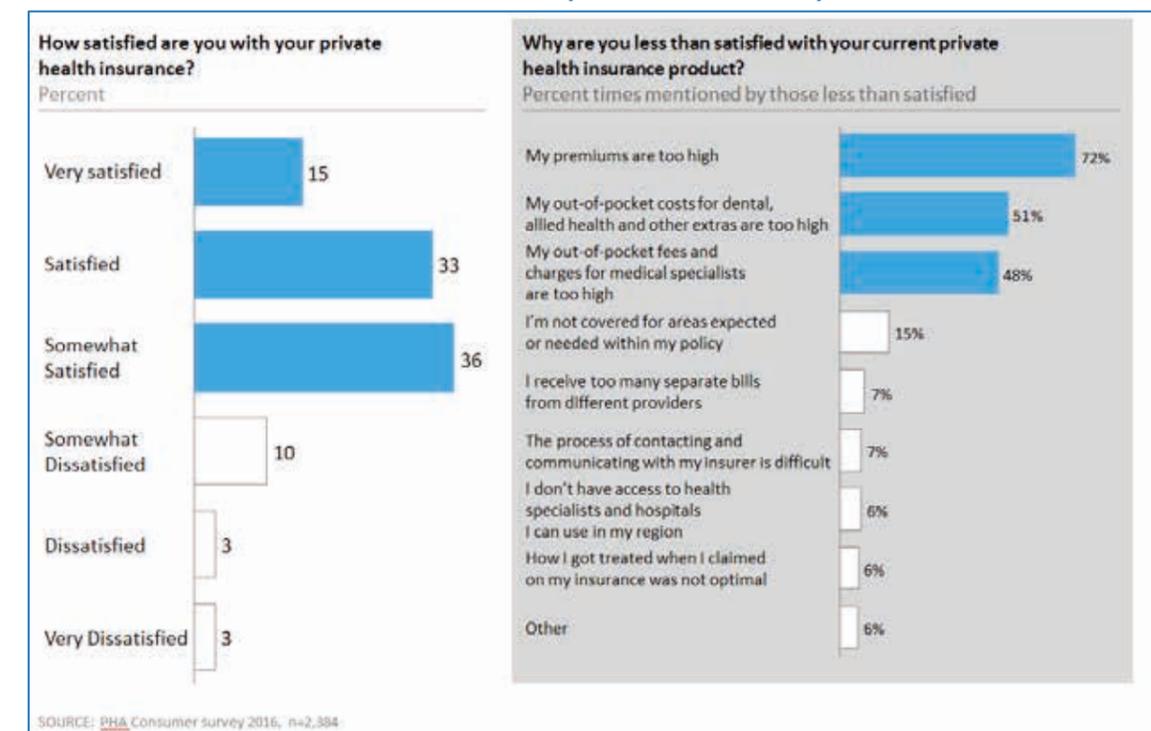
Some of the drivers are a challenge for the whole economy, in fact, for developed economies all around the world. Take, for example, the fact that we have gained an extra 30 years of life expectancy over the last 100 years, and with that, the prevalence of disease has shifted from acute self-limiting conditions to chronic illnesses, which can be treated, but not cured.

Utilisation of health services has increased dramatically as a result. Improvements in health technology have tended to add to health costs, not substitute for them, leading to a situation where the majority of health expenditure on a single patient occurs in the last year of their life.

In the 1960's public hospitals had wards filled with 'very old' 50 and 60 year olds who were expected to die shortly after retirement age. Now the average age of a hospital medical patient is in their 80s.

Consumer expectations of what the health system should deliver are increasing in line with economic growth and increased life expectancy. Many people who have a hip or knee replacement these days do so with the expectation of returning to work, not retiring.

Consumers are satisfied with PHI but worry about affordability



Market research has repeatedly shown that the cost of premiums is the main reason deterring people from taking out PHI, and premium increases are the main driver of dropouts and downgrades from existing levels of cover.

In response to consumer concerns about affordability, health funds have increasingly created entry level, and life stage appropriate products with particular exclusions like pregnancy and diseases of old age. While this has led to an increase in uptake by younger people and spread the claims risk, it has resulted in a level of complexity in the system, which has created confusion for consumers both at the time of taking out cover and at the point at which they use their health insurance. It has also left many consumers questioning whether PHI offers value for money.

When it comes to the value of private health insurance, industry data shows that almost two-thirds of non-emergency surgery is funded by Australians with private health insurance, 90% of day admissions for mental health care and 50% of all mental health admissions, 70% of joint replacements, 60% of chemotherapy and 88% of retinal procedures take place in the private health sector.

In addition, under 'extras' cover, health funds pay out more for dental care than the federal government. So, for every \$1 collected in premium income, an average of 86c is passed back to consumers in benefits.⁷

Australian health funds are acutely aware of the need for budget repair, and are not asking for one dollar of additional funding. Funds are asking, however, that every dollar of waste in the sector is reduced or eliminated, and every piece of toxic regulation reducing market transparency and competition is removed to put downward pressure on premiums and consumer out-of-pocket costs.

⁷ Australian Prudential Regulation Authority (APRA) Private Health Insurers operations Report Data 2016.

The PHI Rebate

In the late 1990s, following an economic downturn and a banking crisis in particular impacting South Australia and Victoria, the hospital system was in crisis. Public hospitals had been hit hard by funding cuts and the rapid introduction of activity-based 'Casemix' funding which had been introduced as a savings measure. This meant that funds were allocated to hospitals based on the treatments they performed and the types and numbers of patients being treated. As a direct result, they were struggling to recover and were experiencing waiting list blowouts, industrial action and significant quality and safety problems. Newspaper headlines reported 20,000 avoidable deaths per year in Australia's public hospitals.

At the same time private health insurance had become unaffordable for the average family as a result of young people withdrawing from the market leaving a risk pool of high claimers. This created a toxic cycle of high premium increases, followed by further dropouts of low claimers.

This coincided with people being allowed to join a fund for the first time late in life when they were certain to claim, and pay the same premium as a young person who had just joined.

These events had been precipitated by a withdrawal of Federal Government support for the reinsurance pool in the late 1980s. This had allowed the cost of older and chronically ill patients to be shared. It was dealt with by cross-subsidisation within funds; in essence a voluntary cross subsidy.

Multiple double figure premium rises were common in a 12 month period and hospital cover fell to an all-time low of just under 30% of the population. As a direct result, both small and large funds required intervention to stop them falling over. Government market research estimated that over 700, 000 people on full pensions were going without food and other essentials to be able to maintain private health cover because they knew they were going to need to claim.

To stabilise the PHI market and give public hospitals a chance to recover, the Howard Coalition government introduced a package of reforms, which included the following measures:

1. Lifetime Health Cover (LHC) which penalises people who join a health fund over the age of 30 through a sliding scale of higher premiums proportional to

age;

2. The Medicare Levy Surcharge (MLS) which penalises higher income earners (singles earning over \$90 000, and families earning over \$180 000) with a higher Medicare levy if they do not take out PHI; and
3. The 30% rebate on premiums, which was a government rebate paid as a percentage of the premium in its original form to all private health policyholders with hospital cover.

Subsequent market research estimates that these measures underpin 75% of demand for PHI⁸, and successfully stabilised the uptake of private health insurance to its current level of approximately 50% of the population.

Since these changes came into being, there have been multiple variations to the regulations governing the rebate, all aimed at controlling government spending in this area.

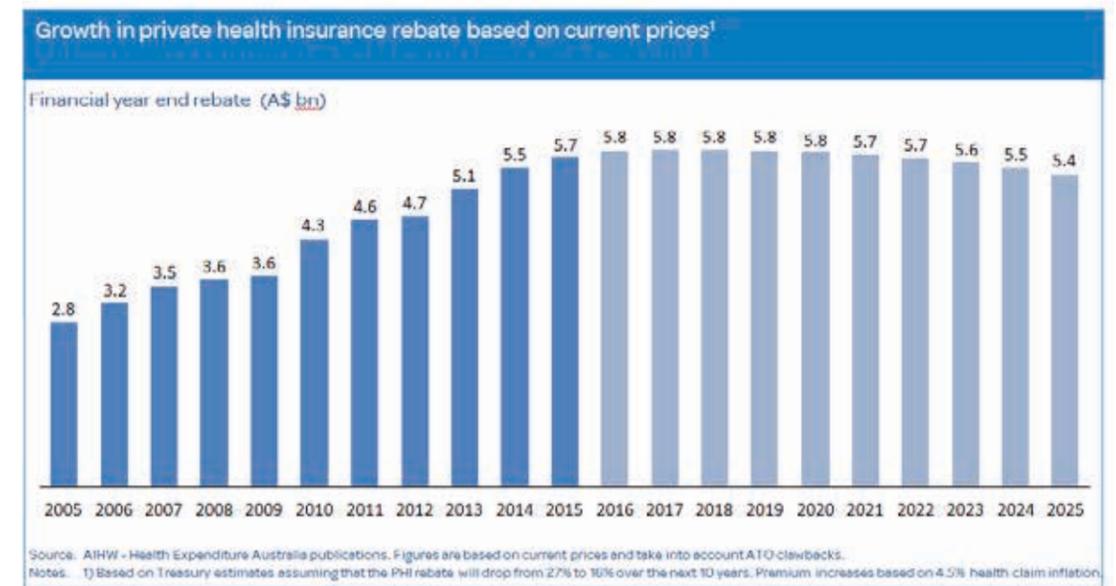
These include:

- Means testing introduced in the 2009-10 Budget, which commenced in July 2012, saving \$6.78 billion over four years;
- Indexation to CPI, uncoupling the rebate from premium increases legislated in 2012, which commenced in July 2014, saving \$700 million over four years;
- Removal of the rebate from LHC loadings, announced in the 2009-10 Budget, which commenced on the 1st of July 2012, saving \$386 million over four years; and
- Freezing of the income thresholds for rebate eligibility and the MLS at 2014-15 levels through 2017-18, saving \$370.9 million from 2018-2021.

The end result of these measures is to greatly slow the growth of PHI rebate outlays, and in fact, taking into account a decline in numbers of people with rebate-eligible policies, expenditure on the rebate is expected to decline not increase with time.

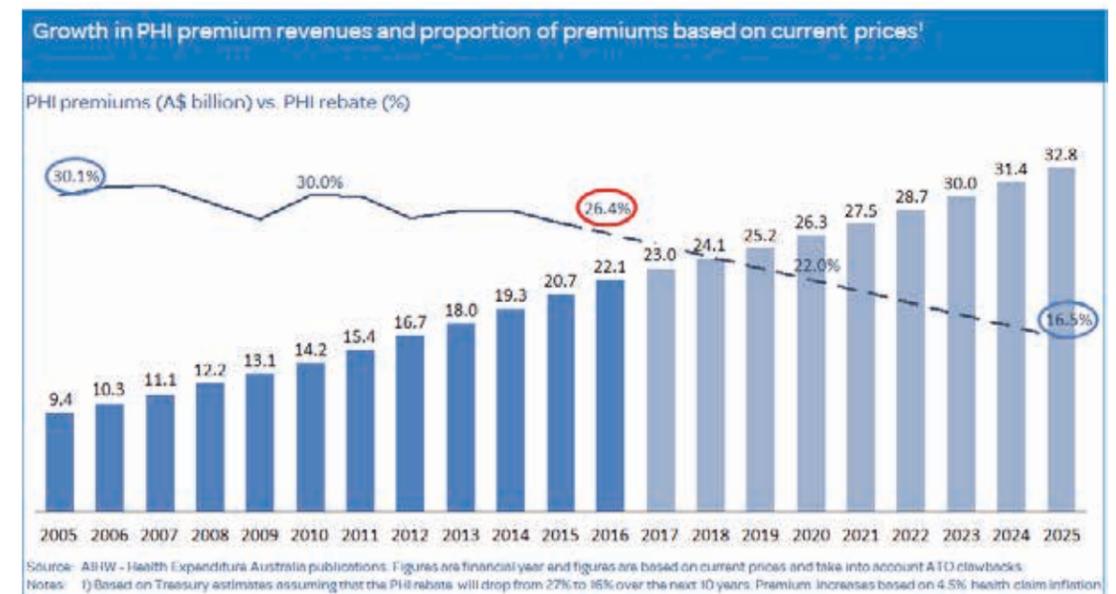
⁸ IPSOS Health Care and Insurance Australia survey 2015 (n=5500)

The private health insurance rebate is expected to decline



The impact of indexation of the rebate on consumers cannot be underestimated. The impact of non-full indexation of the rebate on premiums is essentially compound interest at the difference between general CPI and health/premium inflation. If health inflation continues at the same rate, the value of the rebate as a percentage of the premium will be 16% in a decade.

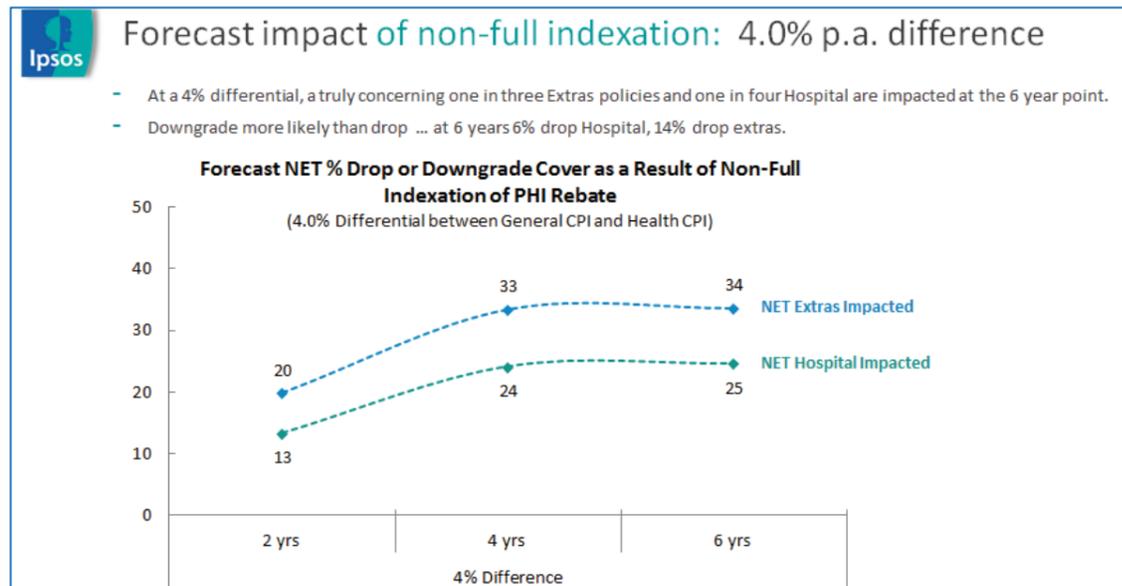
The rebate as percentage of premiums will continue to decrease



IPOS has used consumer behaviour surveys to model two scenarios - the impact of either a 2.5% or 4% difference over a 6-year period. At 2.5%, one in four Extras policies and one in five Hospital policies are either dropped or downgraded at the 6-year mark. At 4%, one in three Extras policies and one in

four Hospital policies are impacted at the 6-year point. This is quite concerning, and is the most likely outcome if nothing else changes.

Price Impact and Consumer Reaction simulation model 2015



Further measures eroding the rebate, particularly if they disproportionately impact younger, healthier members will hasten an affordability crisis in private health insurance which will immediately impact the public sector in the key areas of non-emergency surgery waiting lists, mental health and dental care.

The combined effect of the PHI rebate budget measures is complex, and as a result the significance of expenditure on the rebate is frequently misunderstood and misquoted in the public domain.

The most common errors greatly exaggerate the level of government expenditure on the rebate.

Over the last 12 months the following errors in media reporting about the rebate have been detected:

Assuming the rebate is still 30% of the premium. The introduction of means testing has resulted in many PHI customers receiving either a significantly reduced rebate or losing their rebate entirely. In addition, the rebate is indexed to CPI, and given the gap between CPI and health inflation, it is actually diminishing as a proportion of the premium. Even at the highest level, the rebate is currently just under 27% of the premium and if nothing else

changes, this will diminish to 16% by 2026;

Assuming the rate used to index the rebate is higher than it actually is. The PHI rebate is indexed by a Rebate Adjustment Factor (RAF) representing the difference between the Consumer Price Index and the industry weighted average increase in premiums. The CPI factor for 2014 is 1.0275. The industry weighted average premium increase for 2014 (including rate protection) is 6.20%. The RAF for 2014 is 0.968. Frequently statements have been made like 'the rebate is indexed to CPI which is 3%';

Quoting the forecast rather than net (actual) expenditure. This occurs because the rebate can be claimed in two ways, first as a discount on the premium, and second as a tax deduction in an annual tax return. During the year, if income is higher than expected, resulting from freezing of the thresholds and bracket creep, a number of people may need to pay the money back. These claw-backs are dealt with by the Australian Taxation Office (ATO) and published in its annual report the year after the health budget estimates are reported. For example, in the year 2013-14 the forecast figure for rebate expenditure was \$5.5 billion, but the net expenditure published by the ATO the following year, was \$3.7 billion;

Assuming the number of people with rebate-eligible policies will continue to grow. For the first time in 15 years PHI regulators have detected a fall in the percentage of people with hospital cover, and this does not take account of people downgrading to cheaper policies because of affordability concerns. Even taking population growth into account, this impact is eroding expenditure on the rebate.

The PHI rebate is an important component of the measures stabilising PHI coverage in the community. Health funds appreciate the requirement for budget repair and are not asking for rebate to be restored to its original form. We do however strongly believe that further accelerating the phase down of the rebate will be detrimental to affordability of PHI for Australians already experiencing financial stress.

The PHI rebate on 'Extras'

The PHI rebate is payable on any complying health insurance product (CHIP) that provides hospital treatment, general treatment (also known as ancillary or extras) cover or both.

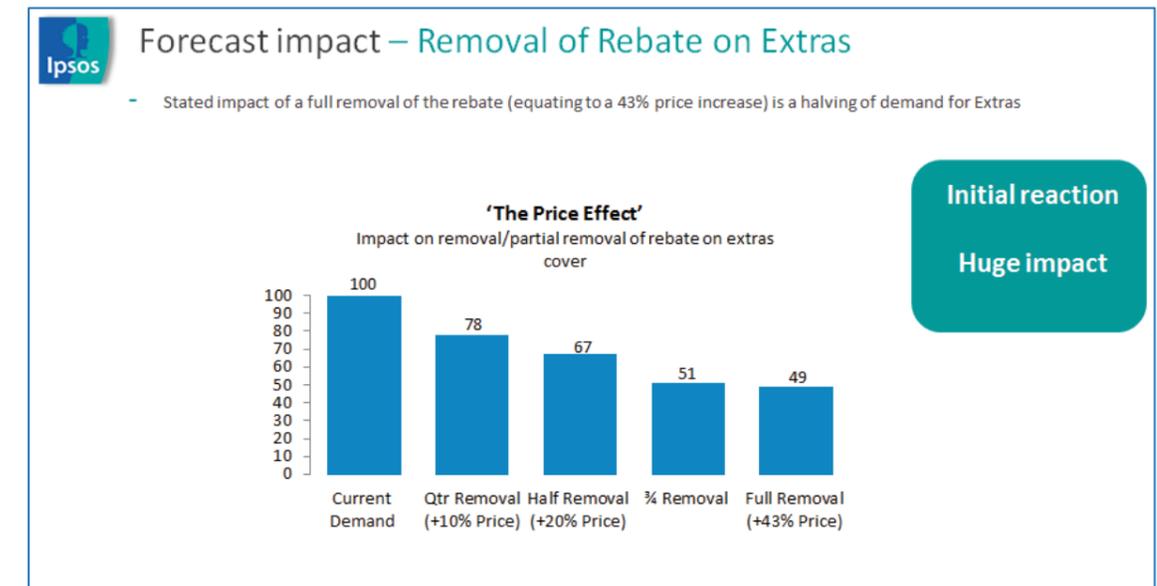
From time to time, government and other stakeholders have proposed removing of all or part of the rebate on the general treatment component as a savings measure. There is no evidence that such a proposal would work in practice or result in any budget savings.

There are also a number of risks in taking this approach. Firstly, it would increase the complexity of an already complicated measure. Secondly, the use of extras cover to deliver value to younger people who are less likely to make hospital claims, but who gain considerable value from cheaper access to dental and allied health services in the community.

It is worth noting when asked about choosing a health fund for hospital cover, many consumers mention attributes related to extras cover, which reinforces the relevance of this product to consumers. Maintaining coverage in this age group is critical for the funds to be able to spread their risk. The third risk is undermining support for dental care, of which health funds are a major funder and provider.

The immediate consequences of the removal of the rebate on extras can be seen below. This equates to a price increase of 37%, which will cause the demand for extras to be halved. This will have a detrimental impact on younger people taking up private health insurance if they are more interested in extras benefits in general than in hospital cover.

Price Impact and Consumer Reaction simulation model 2015



There is also potential for a very negative impact on preventive dental care, as one-in-two Australians claim for dental services through a health fund. Health funds pay out over \$2.5 billion annually in dental benefits, which is more than Federal Government dental programs. Of the total benefits paid for 'Extras', 53% goes to dental care.

More and more health funds are contracting with dentists and purchasing dental practices, in order to consolidate and create economies of scale. This has helped to reduce out-of-pocket costs and improve quality for consumers, particularly for preventive dentistry. Australian Institute of Health and Welfare (AIHW) data has consistently shown people with private health insurance have better dental health outcomes than the uninsured in Australia.

Savings measures that could potentially undermine the positive system health funds have created in dental health, will not save money in the long run.

Poor dental health and decay are a cause of pain, poor nutrition and personal embarrassment.

When appearance and speech are affected by dental disease, education, employment and social interactions can all suffer. Poor oral health can also cause systemic health problems like heart infections, coronary heart disease, stroke, poor outcomes in pregnancy and pneumonia.

In [2010-11](#) (which is the most recent data) there were 60,590 potentially preventable hospital admissions for dental conditions and more than 129,000 cases of general anaesthesia for dental procedures. This is already very costly, and reducing access to preventive dentistry will only increase the cost burden of these conditions, as well as reduce the productivity and quality of life of those affected individuals.

Recommendation 1: In the interests of maintaining affordability of PHI for low and middle income earners, and reducing complexity in the sector, no further changes are made to the rebate on PHI premiums.

Policy measures

The PHI industry shares the commitment of the Federal Government to budget repair and reducing national debt. While the sector understands the climate is not right for the introduction of sweeping or fundamental reform of Australia's health system, there is an opportunity to address sustainability through policy correction.

The private health sector is highly regulated, and much of that regulation has been put in place with the best of intentions and serves its purpose. There are, however, a number of regulatory measures that with time have inflated costs and lessened the efficiency and transparency of the sector. While these consequences have been unintended, they must be addressed to ensure the longevity of the private health sector.

Many of the issues below have been raised in the context of the Minister's Review of Private Health Insurance and Review of the Medicare Benefits Schedule. There is some urgency in implementing reform of this sector given the pressure on households from rising prices. This is not without its challenges as some of the proposed changes will result in 'winners and losers' should they be implemented.

It should be noted that there are some powerful vested interests in the health sector that are capable of running scare campaigns should their historical income streams being threatened. The sustainability of private health in the long run however, fully depends on the system operating at maximum efficiency.

Health funds are therefore committed to working with government to remove every dollar of wasted expenditure in private health, and every piece of toxic regulation driving up premiums.

In return, the PHI sector is actively engaged in a process with government to greatly improve consumer understanding of health fund products and transparency of information on key issues identified by consumers as a major problem, like medical out-of-pocket costs. PHA member funds have already made a significant financial investment as a sector towards implementing the government's consumer transparency election policy measures laid out in 2016.

PHA estimates if the over-regulation of private health insurance is addressed as described below, including reform of the Prostheses List (which has already commenced), health fund members will save just over \$1.5 billion a year on premiums as a result of increased competition and transparency.

Vested interests will claim the red tape is in place to 'protect consumers', however, the reality is that tying the PHI sector up in regulation has forced up prices. Any health fund exploiting a deregulated environment by dramatically reducing benefits, will experience a loss of members to competitors. This is how a market is supposed to work.

SHORT-RUN MEASURES TO IMPROVE THE AFFORDABILITY AND SUSTAINABILITY OF PHI

The Commonwealth Prostheses List

As a result of concern about out-of-pocket costs for medical devices being passed on to patients, early this century the Federal Government took the unusual step of regulating the benefits health funds should pay if an implantable medical device or 'prosthesis' is used in a procedure. This was unusual because device benefits are completely separate from MBS reimbursement for the surgical procedure or the bundled hospital benefits. This does not occur in most other comparable economies.

By 2006, on the eve of the global financial crisis (GFC), the Commonwealth Prostheses List (PL) had ballooned into a list of over 10,000 products with minimum fixed benefit levels set by regulation. The majority of these are products like artificial hip and knee implants, which had been in use for many years with minimal changes. There are currently 48 hip implants on the PL, which according to the National Joint Replacement Registry (NJRR) have identical clinical functions and outcomes. Only the top 15% of items on the PL are regularly used, and there is no clear process in place to remove underperforming or obsolete items from the list.

The usual trend with regard to commodity technology products is that prices move down with time. Particularly after the GFC, and with more sophisticated procurement processes introduced by State Governments, the effect of benefit fixing has meant that private health fund members now pay 2-5 times more in public medical device prices than in Australian public hospitals or comparable economies.

This is reflected in premium increases. Medical device prices account for 14% of the health fund premium. In 2014-15 this grew at 9% and a further 6% in 2015-16 as a result of high demand for procedures requiring an implantable medical device.

As mentioned previously, a 2015 report commissioned by the private health insurance industry found \$800 million is being wasted per annum on excess benefits paid for medical devices.⁹

A further third of the excess benefit value has been transferred to large hospital companies as a result of procuring medical devices at much lower prices than the benefits they receive from health funds as determined by the PL.

The multinational hospital companies are exposed to real global prices for commodity medical devices. For example, a hospital company also purchasing medical devices from one of the big multinationals in Europe can also insist that the Australian subsidiary of that company sells its products at the same (lower) price. It then receives the PL benefit from the health funds and keeps the difference.

Other problems with the PL in its current form are as follows:

1. It locks out small to medium enterprises that want to compete on price. The list is subject to a rule that smaller companies must be able to guarantee 25% market share in a particular category if they want to enter the market at a lower price. The effect is highly inflationary and anticompetitive. List suppliers are currently dominated by the large US- based multinationals. Many smaller companies are locked out, and this was the subject of the Applied Medical court case that ran against the Commonwealth in 2015¹⁰;
2. It stifles innovation. With inflated benefits set at global high prices guaranteed for older, commoditised products, there is no incentive for providers to improve their offering or negotiate the provision of lower cost options. The list rigidly defines eligible products as implantable devices only and excludes modern technologies which may be non-implantable like remote monitoring and 3D printed devices;
3. There is no clear path to reimbursement for new procedure-based technologies due to the system in Australia, which separates, private from public, and device reimbursement from the MBS-funded procedure.

⁹ 'Costing an Arm and a Leg' 2015

¹⁰ Australian Financial Review 'Applied Medical sues federal government over price of keyhole surgery clip guns' Ben Potter April 27, 2015

Graeme Samuel AC, who chaired the Health Minister's Review of Private Health Insurance in 2015, has been a vocal opponent of the Commonwealth setting benefits through the PL, and has been a constant advocate for the removal of this dysfunctional process.¹¹

PHA strongly supports the removal of the Federal Government's regulation of medical device pricing as a separate measure, over time. In this environment, where the use of implantable devices is also increasing rapidly, fixed benefit setting by the Commonwealth has had disastrous unintended consequences, stifling innovation and putting significant upward pressure on premiums. The taxpayer has also been directly exposed as a result of regulations connecting the acquiring of medical devices by the Department of Veterans' Affairs to PL benefits.

In an effort to avoid a shock to the sector resulting in unexpected costs being passed on to patients, health funds have needed to compromise and take a pragmatic approach. As part of a pre-Budget negotiation process within the sector prior to May 2016, the following mechanisms were agreed on with the Government to deflate PL benefits in line with real market prices for medical devices.

1. The Prostheses List Advisory Committee (PLAC) would be reappointed with a new membership, with a greater focus on economic health technology assessment and introducing dynamic market pricing to this area;
2. A reference pricing mechanism taking into account Australian public hospital prices and international comparator prices from similar economies;
3. A price disclosure process similar to the one operating in the subsidised prescription pharmaceutical sector to take account of rebates paid by suppliers to customers against PL benefits.

In addition to the above measures, as a show of good faith, Federal Cabinet agreed to a small up-front benefit reduction across four key categories where there is high utilisation, and where the differences between the PL benefits payable by health funds and State Government tender prices are large – these are cardiac devices, hips, knees and intraocular lenses. Health funds agreed to pass on all savings as a reduction in the 2016-17 premium round.

Considerable further benefit reductions are expected as the agreed pricing processes are implemented, and further downward pressure on premiums will result. With time it is anticipated the Commonwealth should be able to exit price regulation for medical devices used in the private sector all together.

¹¹ The Australian 'Graeme Samuel urges cuts to price-fixing prostheses list' Pamela Williams November 8, 2016

Recommendation 2: The reform of Prostheses List benefit setting by the Commonwealth must progress rapidly in 2017-18 with the implementation of reference pricing to State Government tender prices and international reference prices from comparable economies, as well as the introduction of price disclosure. Health funds have agreed to a process to pass on all savings made as a result of this measure back to members. The Commonwealth should have an explicit deadline to exit regulation of medical device benefits in the private health sector.

The second-tier default benefit

CONTEXT AND CORE ISSUE

The second tier default benefit is the level of benefit payable by a health fund for an episode of hospital treatment provided by an eligible private hospital facility with which it does not have a negotiated agreement.

The benefit is 85% of the average charge for the equivalent episode of hospital treatment under that health fund's negotiated agreements with comparable facilities in that state or territory.¹²

It was introduced in 1998, when the private hospital provider market was fragmented, and the PHI industry was adjusting to federal legislation introduced in 1995, which allowed contracting between health funds and hospital providers.

At the time, it was felt health funds' larger market size allowed them too much negotiating power over private hospitals that were less concentrated in terms of market share. The Federal Government introduced the second tier default benefit with a view to supporting smaller providers, and re-balancing market dynamics between health funds and private hospital providers.

By 2003, private hospital ownership had become more concentrated and the balance of negotiating power shifted back to private hospital providers, with Ramsay Healthcare and Healthscope holding 37% market share at this time.

The Federal Government proposed abolishing the second tier default benefit on the following grounds:

- Private hospital providers no longer required the protection of the second tier default benefit since the health fund-provider contracting environment had stabilised as both health funds and private hospital providers had matured in their approaches to commercial negotiation;

¹² The average charge for the equivalent episode includes the sum payable under the negotiated agreement and any excess or co-payment payable by members in accordance with the health fund's rules; and excludes charges for prostheses and nursing-home type patients. Where a health fund has less than 5 negotiated agreements with comparable facilities in a state, then the benefits will be based on all of that health fund's negotiated agreements in that state. Where the second tier default benefit is below the minimum benefit outlined in schedule 1, 2 or 3 of the Private Health Insurance (Benefit Requirements) Rules 2011, the minimum benefits applies.

- Health funds had strong incentives to enter contracts with private hospitals because their members would move to other health funds with full portability if there were a narrow contracted provider network; and
- The second tier default benefit had an undesirable effect of setting a price floor.

The Federal Government's proposal was defeated after intense opposition from vested interest groups, who argued policyholders would be adversely affected by a reduction in choice of hospital providers, particularly with small and regional hospitals. Since this time, the private provider market has further consolidated, with the two largest providers (Ramsay and Healthscope) increasing their ownership from 37% to 44% market share.

Between 2003 and 2015, three of the top five largest overall receivers of second tier default benefit payments from health funds were large provider networks, including Ramsay, St Vincent's and Cabrini. In combination, they account for 39% of second tier default benefit payments.

Today, the four main major concerns about the second tier default benefit regulations are as follows:

- First, it provides too much information on pricing data to contracted private hospital providers, which strengthens the providers' negotiating positions. Health funds are obliged to provide private hospital providers with a schedule of second tier default benefit rates. This applies when a provider has been granted second tier eligibility by the Second Tier Advisory Committee (STAC)¹³ and is out of contract with the fund. There is no equivalent obligation on private hospital providers to publish or share financial or clinical data with health funds. This creates an imbalance of information sharing between the two negotiating parties.
- Second, the second tier default benefit creates a price floor at 85% of the charge for comparable facilities in the same state. This encourages some hospitals to use the 85% as a "fall back" for negotiations. As the 85% rate is a price floor, rather than a ceiling, in some cases it results in higher out-of-pocket expenses for policyholders. This is because second tier eligible

¹³ This is a committee which is defined by regulation and which consists of three nominees of private hospitals and three nominees of health funds. Under current arrangements it is administered by the Australian Private Hospitals Association (APHA) which is a peak body representing private hospitals.

hospitals can either accept the second tier default benefit as full payment from the health fund or can charge out-of-pocket expenses to patients. There is no limit to the patient out-of-pocket that can be charged.

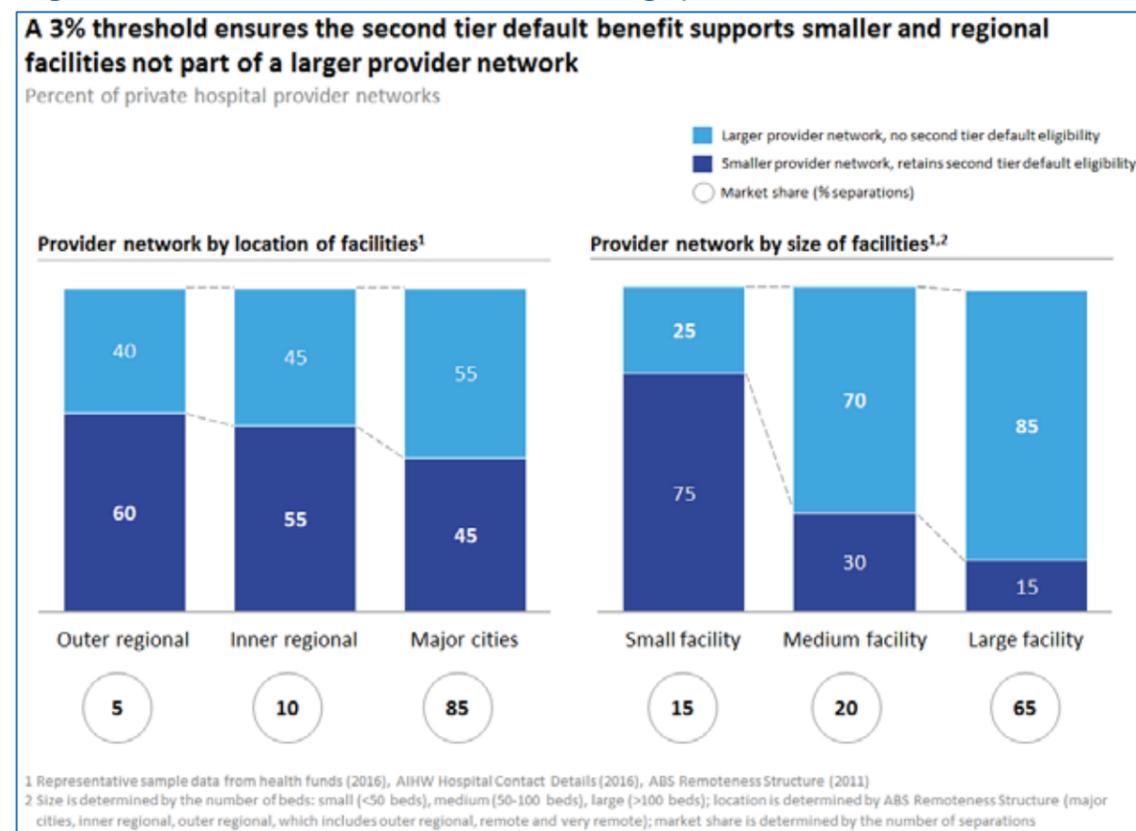
- Third, it limits the ability of health funds to negotiate to improve hospital quality. Currently when health funds agree to pay a higher charge per instance to private hospital facilities that demonstrate high quality patient outcomes, they indirectly reward facilities with lower quality outcomes that may decide to utilise the second tier default benefit. The higher charge to the high performing facility will increase the health fund's average charge per case, and thereby increase the second tier default benefit.
- Fourth, the intent of government regulation in this sector should be to protect consumers from unanticipated out-of-pocket costs or loss of access to essential facilities. It should not be designed as a market intervention to boost the negotiating power of providers. Currently consumers are not protected as there is no limit to the out-of-pockets hospitals can charge if they access the second-tier default benefit.

While there are clearly concerns with the current benefit, it is also acknowledged some independent rural and regional facilities do rely on the benefit and would be at risk in circumstances where the benefit might be abolished. For example, over 75% of small facilities with less than 50 beds are not aligned with a large provider network, which is defined as a provider group earning sufficient revenue to hold greater than 3% market share.

Only 30% of medium, with 50-100 beds, and 15% of large facilities, with over 100 beds, are owned by small provider networks. Outer regional, remote and very remote facilities are mainly outside the large private hospital provider networks and tend to have less negotiating power than providers in more populated areas such as inner regional areas and major cities. So, for example, 60% of outer regional facilities are not aligned with a large provider network.

In these circumstances, the second tier default benefit potentially supports outer regional facilities and smaller negotiating networks in securing quality outcomes for policyholders. The graphic image below demonstrates the proportion of facilities that are aligned with large provider networks that earn revenue above 3% market share, according to location of facility (outer regional, inner regional and major cities) and size of facility (small, medium and large).

Alignment of small and medium facilities with large provider networks



The core issue to consider is: is the second-tier default benefit still relevant, and should government regulation continue to support smaller providers with limited negotiating power?

OPTIONS AND RECOMMENDATION

PHA has considered four potential regulatory reform options for the second tier default benefit.

- Option 1: Abolish 85% benefit requirement** Abolish the 85% benefit requirement for all providers by removing it from the Private Health Insurance (Benefit Requirements) Rules (2011). All existing private hospital providers using the second tier default benefit would be required to either enter into negotiated agreements with health funds or use the basic minimum default benefit in the Private Health Insurance (Benefit Requirements) Rules (2011).
- Option 2: Abolish 85% benefit requirement, other than for rural and regional overnight stay providers or networks operating at under 3% market share** Abolish the 85% benefit requirement by removing it from the Private Health Insurance (Benefit Requirements) Rules (2011), except for rural and regional overnight stay providers, including provider networks and negotiating alliances, which have an operating revenue at under 3% market share.
- Option 3: Reduce second tier default benefit for all providers** Second tier default benefit is reduced from 85% to a new, lower default benefit for all providers (for example, 60%). This option does not include any exceptions for providers operating below the 3% market share threshold, mentioned in option 2.
- Option 4: Continue the second tier default benefit and introduce a ceiling on out-of-pocket charges** Continue the second tier default benefit but introduce a ceiling on the total out of pocket costs that a private hospital provider can charge policyholders and still claim the second tier default benefit. This ceiling should be equivalent to 15% of the average contracted price of an equivalent stay so that provider charges under the second tier default benefit is limited to 100% of the industry average, and policyholders are protected.

Recommendation 3: Adopt option 2; abolish the 85% benefit requirement, other than for rural and regional overnight stay providers or networks operating at under 3% market share.

Reform Schedule 5 of the Private Health Insurance (Benefit Requirements) Rules (2011) to ensure appropriate application of the requirements for second tier eligibility.

This is recommended for the following reasons:

- It removes visibility on pricing data and access to a fall back negotiating positions, and thereby rebalances the negotiating power of contracted private providers. This would place downward pressure on benefit outlays to private providers;
- It decreases invoicing certainty of uncontracted private providers, which would improve levels of service and reduce invoiced costs. This would further help reduce premiums and out-of-pocket expenses; and
- It ensures smaller providers maintain a fair negotiating position, and maintains policyholders' access to these services.

The negotiating power between health funds and contracted facilities would be rebalanced as large provider networks would no longer be able to use the 85% price floor as a fallback position during negotiations. In addition, access to transparent pricing information for a health fund's average episodic charge would be largely removed for large providers. This reduces the degree of the current price information imbalance and so increases competitiveness in the negotiating cycle.

APPLYING A REVENUE MARKET SHARE THRESHOLD

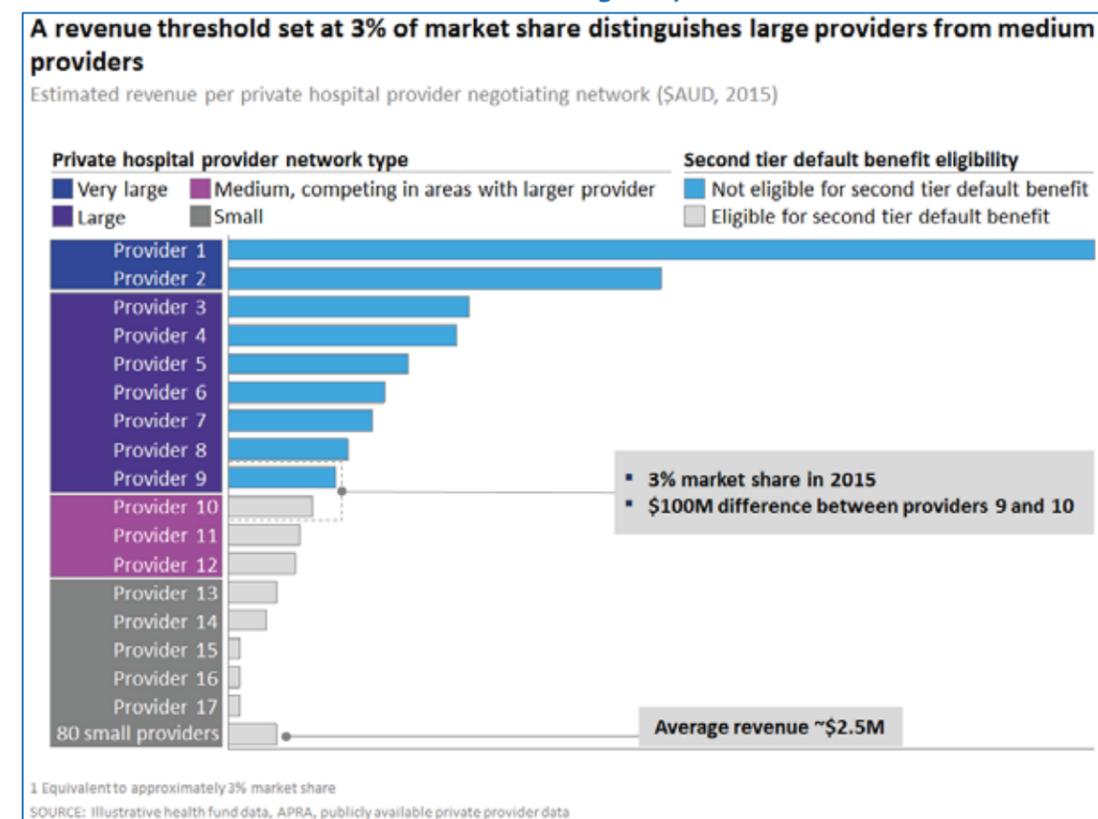
A revenue market share threshold of 3% would ensure rural and regional overnight stay private provider networks, or negotiating networks, with a market share less than 3% would be eligible for the second tier default benefit. A revenue market share threshold is the preferred measurement for differentiating second tier eligibility for providers. Although the number of separations and the number of beds are two potential markers, these do not

account for differences in the type of care provided or the hospital's status as a freestanding day-only facility.

In contrast, a revenue threshold accounts for the care type and the average episodic cost, which explains the significant difference in the negotiating positions, for example, between day and overnight facilities. This threshold should be reviewed annually by the Department of Health to ensure it is still appropriate in a dynamic and changing market.

The image below lists private provider networks ranked by revenue size, to provide an indication of the type of provider networks the proposed 3% market share threshold would apply to.

Recommended second tier default benefit eligibility threshold



Second tier eligibility criteria

Reforming Schedule 5 of the Private Health Insurance (Benefit Requirements) Rules (2011) provides the opportunity to review the criteria for second tier eligibility. Schedule 5 of the Rules states that to be considered a second tier eligible facility, the hospital must be assessed by the Second Tier Advisory Committee (STAC) as:

- Being a private hospital within the meaning of subsection 121-5(8) of the Act.
- Being accredited.
- Providing simplified billing.
- Providing informed financial consent.
- Submitting Hospital Casemix Protocol Data to health funds electronically, where possible, with claims.

In recent years there has been a proliferation of second-tier eligible facilities, particularly in the day surgery space. While day-only beds, which have a lower average cost per case than overnight stays can provide better value, this needs to occur as a genuine substitute for overnight stays for the value to be realised. Because entry barriers are low, and providers are protected by the second-tier default benefit, this part of the sector is particularly susceptible to supplier-induced demand. Supplier-induced demand is demonstrated in the health sector when demand increases in proportion to the number of available providers, rather than the prevalence of disease in the community.

This is putting upward pressure on premiums in the absence of evidence to show that these services are required or consumer outcomes are improved by their existence. Retention of second-tier arrangements for the day facility sector risks continued uncapped proliferation of facilities, regardless of the level of real demand. In rural areas specifically, this can have the perverse impact of cannibalising the market for adjacent overnight facilities, which become unviable and may be forced to close.

As of June 2016, 458 private hospitals, or 74% of all private hospitals, held second-tier eligibility status. The Rules and Supplementary Administrative Arrangements for the Second Tier Default Benefits for Overnight and Day-Only Treatment, at very least warrant a detailed review to ensure the original intent of these regulations is being met.

Specifically, it is recommended that the eligibility process be reviewed and that supplementary regulations and documents be amended to reflect the meaning of the Rules.

STAKEHOLDER IMPACT AND RISKS – IMPACT OF REFORM

Abolishing the 85% benefit requirement, other than for rural and regional overnight stay providers or networks operating at under 3% market share, could potentially result in significant gains for PHI policyholders and the Federal Government.

As a starting point, private hospital charges per separation could decrease by up to 2%. This would result in a potential reduction of PHI benefit outlays of up to \$260 million, assuming health funds passed 90% of this benefit to consumers via lower premiums.

The pass-through of savings would result in an estimated initial gain for existing consumers of up to \$180 million and a gain for health funds of up to \$20 million. The lower premiums could result in the Federal Government saving an estimated \$60 million due to lower rebate outlays.

The subsequent effect would be that new members would enter the market and purchase PHI policies due to the improvements in affordability via lower premiums and lower out-of-pocket expenses. This increased volume of policyholders would lead to an increase in expenditure by consumers on PHI and an increase in revenue for private providers.

IDENTIFIED RISKS AND MITIGATION

To ensure maximum value for new and existing policyholders, the following approach to mitigating risks is recommended:

- First, new and existing policyholders may switch to PHI policies that offer a broader provider network, which is likely to be characterised by lower out-of-pocket expenses. While this shake-up may cause policyholders inconvenience in the short term as they switch policies, it should not be mitigated. Market forces would likely encourage providers to reduce out-of-pocket expenses and health funds to reduce premiums and widen their contracted provider network in order to retain policyholders. The longer-term impact of this would be greater PHI affordability for consumers and more choice with respect to hospital facilities.
- Second, private providers may attempt to regain a stronger bargaining position by not contracting with health funds and charging higher fees to policyholders. Again it is felt an attempt to lessen the impact would not be required as it is expected that policyholders would soon avoid uncontracted providers that have high out-of-pocket expenses in favour of contracted

providers who are working with health funds to improve healthcare affordability. Market forces would then encourage providers exhibiting such behaviour to engage in negotiations in order to prevent loss of market share.

- Third, there is a risk some private hospital providers could split their networks to fit the criteria for a smaller provider under the second tier default benefit. This fragmentation could increase the number of private hospital providers able to access the 85% price floor, and could limit the incentive for these providers to reduce cost inefficiencies. It is felt that this risk is low, as the majority of providers would benefit more from their stronger bargaining position as larger facilities under open market conditions, rather splitting their networks to access the second tier default benefit.
- Fourth, some health funds may over emphasise their rebalanced negotiating power by encouraging private hospital providers to significantly reduce charges. Private hospital providers could retaliate by going out of contract and increasing charges, which would result in higher out-of-pocket expenses and a narrower provider network. This risk is unlikely to be significant due to the ability of private hospital providers to respond quickly. It also has a low potential for impact because market forces would quickly correct as consumers switch to health funds that are working with providers to negotiate the best outcomes for consumers.
- Fifth, in 2003, some stakeholders raised concerns that abolishing the second tier default benefit would result in a reduction in consumer choice. In contrast today, with the retention of the second tier default benefit for smaller rural providers, the recommended reform actively protects increased consumer choice. Additionally, health funds have a strong incentive to enter contracts with private hospitals that are geographically connected to their member base. For this reason, this risk is assessed as low. Portability between health funds has greatly improved over the years and there would likely be an exodus from any fund that used deregulation to aggressively narrow its network.

IMPLEMENTATION

To ensure the above-mentioned risks can be properly alleviated, a three-phase implementation plan over 18 months is recommended.

- **Phase 1: Announce reform agenda and prepare implementation pathway**
Initially, support from the Department of Health would be encouraged to prepare the pathway for implementation. This would involve consultation between stakeholders, drafting and tabling of legislation for Private Health Insurance (Benefit Requirements) Rules (2011). The Department of Health should also review the robustness of the current criteria for second tier eligibility and the eligibility application process.
- **Phase 2: Implement full reform program**
Legislative changes are recommended to come into effect by end 2017. This would allow health funds and providers sufficient time to adjust. Health funds would implement strategies to operate in new market dynamics by improving communication with consumers about provider networks. Each health fund would continue to annually submit a list of second tier default benefits to the Department of Health by 31 August and arrange for an independent audit to determine if the listed benefits comply with Schedule 5 of Benefit Rules. It is also recommended that new eligibility conditions include all current factors in addition to operating at under 3% market share threshold.
- **Phase 3: Monitor and evaluate reform impact**
It is recommended that by June 2018, the industry enter an ongoing process of monitoring and evaluation of the impact of the second tier default benefit arrangements, including annual reviews of the appropriateness of the 3% industry revenue threshold.

INTERDEPENDENCIES

The implementation of a second tier default benefit revenue threshold would also support the introduction of the below proposed regulatory reforms:

Premium deregulation and public hospital cost shifting: the recommended reforms for premium deregulation and public hospital cost shifting would be likely to increase the negotiating power of private providers. The recommended reform to the second tier default benefit would ensure private provider networks do not have greater negotiating power than health funds to an extent that would be detrimental to PHI affordability for policyholders.

PUBLIC HOSPITAL (STATE GOVERNMENT) COST-SHIFTING CONTEXT AND CORE ISSUE

“Cost shifting” is a common term used in the Australian healthcare system. It can be defined as one party transferring the costs of incurred services to another party in order to avoid a cost, which would usually fall to them. Public hospital cost shifting from State Governments through to the Commonwealth has been a feature of health care in Australia for nearly three decades. More recent, is cost shifting to health funds in Australia, which is in the order of \$1 billion dollars per year. This accounts for about 6% of premiums. Public hospital cost-shifting to health funds adds more to premium costs than the average year’s premium increase.

Many informed consumers intentionally decide to be private patients in a public hospital.

PHI products that offer this option have traditionally been part of private health insurance in what was formerly called the ‘basic’ table. For example, public hospitals play an important role for private patients in rural areas, and there are a number of patients with severe chronic illnesses who need particular specialists who prefer to practice in this setting.

This is not what this section refers to, rather it relates to the deliberate establishment of procedures and business models by state governments to divert patients presenting to public sector emergency departments and outpatients, to private funding options.

For most patients attending a public emergency department, using their private health insurance is not a premeditated choice.

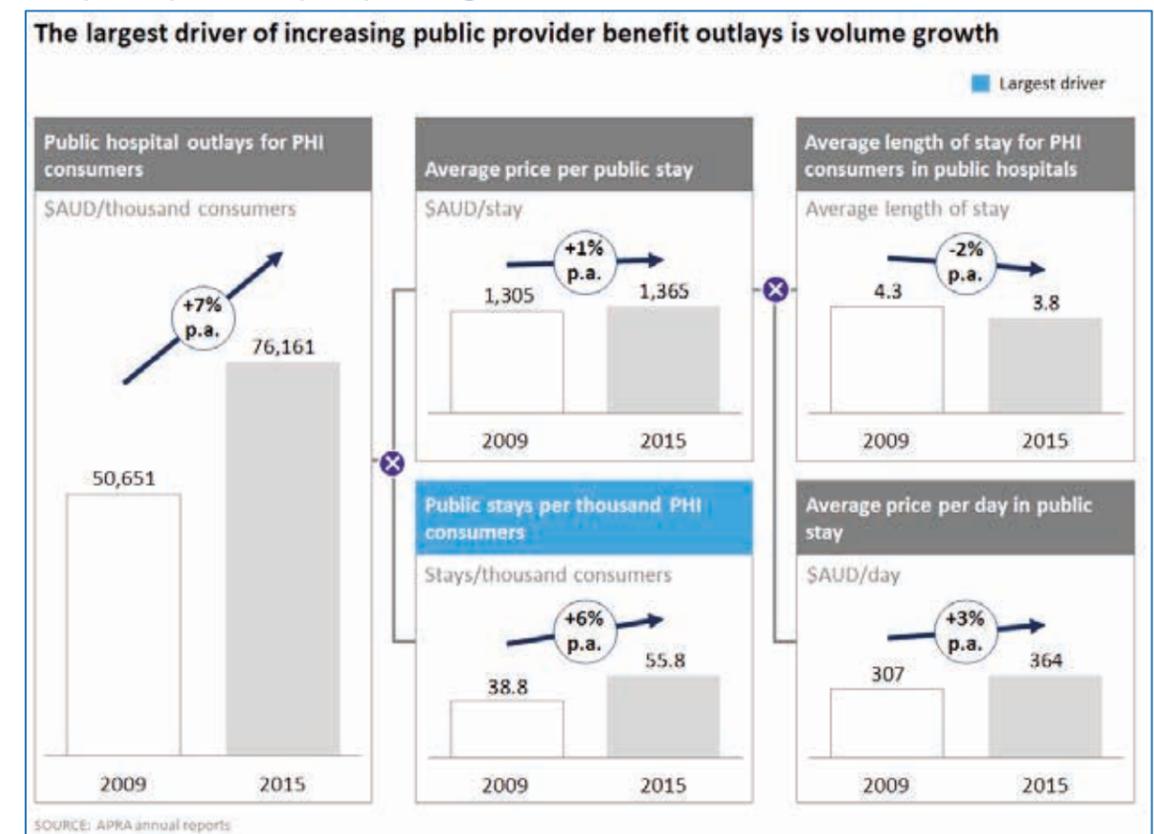
In fact, many patients who intended to be treated as a public patient are signed up after they are admitted. The end result is PHI policyholders are now subsidising the costs of public hospitals, despite having already contributed to these through their taxes.

Nationally, in the 2014-15 financial year, the PHI industry provided 2.1% of all public hospital funding.¹⁴

This has been growing at an average rate of 12% every year since 2009, driven by two factors: the number of public hospital stays charged to PHI per patient, growing at 7.5% per year, and the historical increase in PHI membership, growing at 3% per annum.

In contrast, the price per stay has been growing marginally at 1% annually. The chart below illustrates the drivers of public hospital patient growth.¹⁵

Analysis of public hospital patient growth



The year-on-year growth of 7.5% in public hospital stays per PHI member is significantly higher than the growth in private hospital stays per PHI member, which is 1.6% per annum.

¹⁴ Australian Institute of Health and Welfare (AIHW) 2015 'Health Expenditure Australia 2013-14'

¹⁵ APRA (2009 and 2015) 'Private Health Insurers Operations Report Data - total outlays to public hospitals'

At a State level, an unspoken encouragement of public hospital cost shifting seems to be growing.

In recent years, at least two states have set quotas for public hospitals to seek “own-source revenue”, which is a combination of PHI, veteran’s affairs, and other non-State Government funding.

The impact was most evident in 2011 and 2012, after the Queensland State Government brought in quotas in 2010. Annual growth in public hospital stays for private patients changed from 7% per year before 2010, to 12% per year after 2010.

Some public hospital organisations are adopting new provision models to capitalise on PHI income. For example, the new Fiona Stanley Hospital in Western Australia and the new Royal Adelaide Hospital both have significantly more single occupancy rooms than traditional public hospitals.¹⁶ States are able to charge health funds more for single rooms by issuing regulation by a ‘circular’, which is very difficult for funds not to comply with without adversely impacting members.

At the Northern Beaches public hospital in NSW, a private hospital, patients may elect to be public patients, in place of attending a public hospital.¹⁷ But the NSW Health Minister says the business model is that 86% of medical patients presenting to the emergency department will be persuaded to use their private health insurance.

Case study: public hospitals have created significant capacity to charge PHI

Several new hospitals have financial pressures and new capability, which may lead to increased cost shifting to PHI patients

	Sydney Northern Beaches Hospital	Fiona Stanley Hospital	Royal Adelaide Hospital
New build	✓	✓	✓
Bed numbers	488	783	800
Single rooms proportion	75%+	75%	100%
Approach to recruitment of patients to use private insurance	Private hospital giving patients choice to elect to become public	Clear message on website and in-person that PHI helps hospital financially	Recruitment of ‘counselors’ to identify patients with private health cover
Drivers of public hospital cost shifting	For-profit hospital operator dependent on filling private beds for operating model	Closing operational financial deficit presently at ~\$150m	Closing financial deficit ~\$400m and cost blow out of new build

SOURCE: Official websites for the respective hospitals

New public or private hospitals bring an added complication: they only use one provider number. As a result, health funds are finding themselves paying full private rates for a patient who was treated in the public portion of the hospital. In addition, patients using their PHI in a public hospital are at risk of potentially triggering out-of-pocket expenses, unlike public patients. The average out-of-pocket expense faced by a private patient treated in a public hospital is \$400 (not including health fund excess payments).

If every State and Territory achieved cost shifting at the same level as NSW, which is 3.2% of all public hospital costs, it would cost an additional \$500 million in outlays each year. This would potentially drive premiums up a further 2.8%. The Federal Government would be impacted with an expected \$75 million due to additional MBS payments, which are triggered once a ‘private’ specialist is appointed to care for the patient.

Patients electing to be private patients in the public system are required to give informed financial consent. It can be explained as members electing to be private in a public hospital who have been made fully aware and understand the financial implications of their decision.

¹⁶ Fiona Stanley Hospital: 83% single occupancy rooms. See Fiona Stanley Hospital 2016 ‘About us’ www.fsh.health.wa.gov.au. Royal Adelaide Hospital has over 700 single occupancy rooms. See SA Health (2016) The New Royal Adelaide Hospital www.sahealth.sa.gov.au.

¹⁷ Northern Beaches Hospital (2015) ‘Your new Northern Beaches Hospital’ www.nbhsredev.health.nsw.gov.au.

Research conducted by the Australian Bureau of Statistics (ABS) in 2010 states that 11% of patients did not feel adequately informed about the financial decision they were making when electing to be a private patient in a public hospital.

This ties in with earlier research by IPSOS in 2006, which stated 10% of patients felt explicitly coerced into signing up as a private patient. This is despite clear consent rules outlined in the National Health Reform Agreement, with anecdotal evidence suggesting hospital staff commenting on the official consent forms in ways explicitly banned by the rules.

Common reports include statements such as "...it really helps fund your local public hospital", "consider it a donation to the hospital" and "...we need it to continue research into your condition".

In relation to poorly informed financial consent, some public hospitals are paying consumers' excesses and offering other financial incentives (for example free meals), thereby removing the disincentive to use PHI, put in place by health funds.

The current consent form is insufficiently detailed and does not require the signature of a witness or appropriate staff member. At very least, the form needs to make clear the following:

- Out-of-pocket expenses may occur which would not be payable if the patient does not elect to go private; and also,
- Amenities like private rooms are not necessarily guaranteed and are dependent on availability.

Additionally, informed financial consent should not occur until eligibility is established and it is known whether the health fund cover includes the treatment required.

Another enabler of cost shifting is poor transparency of public hospital invoicing.

Often invoices received from public hospitals have minimal detail, with only a name and a length of stay, and total cost. In comparison, itemised invoices from private hospitals usually include each test, medical service, and diagnosis. Public hospitals arguably have the ability to already do this, as they provide detailed invoices to the States under activity based funding models.

It goes without saying that health funds should be able to understand the reason for their members' stays in public hospitals in the same level of detail as is currently obtainable for private hospital stays.

Although some hospitals supply more information, more than two thirds of invoices randomly sampled by health funds had no more information other than the patient's personal details and length of stay. This low level of detail prevents two important processes from occurring:

- (1) a review of invoices for accuracy, and
- (2) a follow up with members by the health funds through their chronic disease management programs.

It is recommended that public hospitals provide health funds with Hospital Casemix Protocol (HCP) data, or admitted patient care National Minimum Data Set data.

Reporting DRGs and MBS items on invoices, as well as estimated medical cost versus accommodation cost for the stay, would allow more robust discussion between health funds and public hospitals and would be likely to assist in further driving down unnecessary costs.

The Independent Hospital Pricing Authority (IHPA) is also able to provide assistance in generating transparency on the care being provided, with input on the data systems and fair pricing.

Core question:

What relationship between PHI and public hospitals will generate the best value for consumers?

OPTIONS AND RECOMMENDATION

There are four potential regulatory reform options, which have been considered to improve the relationship between PHI and public hospitals.

- **Option 1: Formalise contracting processes between public hospitals and health funds**
Continue to cost shift as per the status quo, while formalising contracting between health funds and public hospitals to ensure appropriate pricing for services and allow for additional value creation for PHI members.

- **Option 2: Eliminate public-PHI cost shifting**
Prevent public hospitals from billing health funds for Medicare cardholders.
- **Option 3: Eliminate public-PHI cost shifting except for small / regional providers**
Prevent public hospitals from billing health funds for Medicare cardholders, but provide an exception for all hospitals defined as small and / or regional.
- **Option 4: Status quo plus remove quotas with increased monitoring of private patient flows through public hospitals, enhance informed consent processes to protect customers, and greater transparency on care being provided**
Governments to agree public hospitals may not have non-source revenue quotas, health funds to begin recording and publishing cost shifting behaviour, while communicating the impacts to their members. In addition, health funds seek to sign agreements with public hospitals and State Governments to achieve improved financial consent for their members, and improved transparency in the public hospital invoices (e.g. HCP data). These changes are then integrated into the National Health Reform Rules to protect consumers.

Recommendation 4: Adopt Option 4. This does not change the status quo directly, but non-source revenue quotas are not permitted. This can be done either through the COAG National Health Reform Agreement rules, or through legislation. There should be a Code of Conduct introduced through the COAG process to ensure consumers are treated appropriately, are provided fully informed financial consent and are not approached to elect their status while vulnerable or cognitively impaired. Public hospitals will be required to share an appropriate level of data with health funds, and there will be no regulatory barriers to health funds contracting with Local Hospital Networks to ensure the best outcomes for their members if treated in a public hospital. The practice of hospitals offering public patients financial incentives to use their PHI is inappropriate and should be not be permitted.

This recommended option will encourage Commonwealth and State Governments to increase transparency and reduce cost-shifting by highlighting the impact on health fund premiums and out-of-pocket costs for consumers.

Summary of options considered:

Option 1 is preferred option for reform of Risk Equalisation scheme			
Option 1	Option 2	Option 3	Option 4
Prospective with enhanced criteria	Prospective with same risk pool	Retrospective with enhanced criteria	Hybrid
<ul style="list-style-type: none"> Encourages preventative health care Maintains community rating process Total budget for Risk Equalisation Special Account set according to enhanced criteria (e.g. gender/morbidity) Ensures transfers reflect actual risk profile of membership (e.g. obstetrics) 	<ul style="list-style-type: none"> Encourages preventative health care Maintains community rating process Administratively easier to establish and maintain necessary database of cost 	<ul style="list-style-type: none"> Encourages health funds to equally insure all patients, beyond current system Maintains community rating process 	<ul style="list-style-type: none"> Encourages health funds to equally insure all patients, beyond current system Maintains community rating process Chronic condition is high cost and predictable once diagnosed, enabling relatively accurate prediction of a standardised cost
<ul style="list-style-type: none"> Some PHA members benefit more than others: funds pool is zero sum, so any benefit comes at others' expense Amount distributed may differ from actual incurred costs in the short term Prospective model requires high quality risk stratification data 	<ul style="list-style-type: none"> Fund pool is zero sum, so any benefit to some PHA members comes at others' expense Amount distributed may differ from actual costs in short term Ignores disproportionate claim burden factors other than age 	<ul style="list-style-type: none"> Does not encourage preventative health care 	<ul style="list-style-type: none"> Encourages only preventative health care for selected chronic conditions Does not solve for the current lack of incentive for health funds to minimise treatment costs for over 55 policyholders

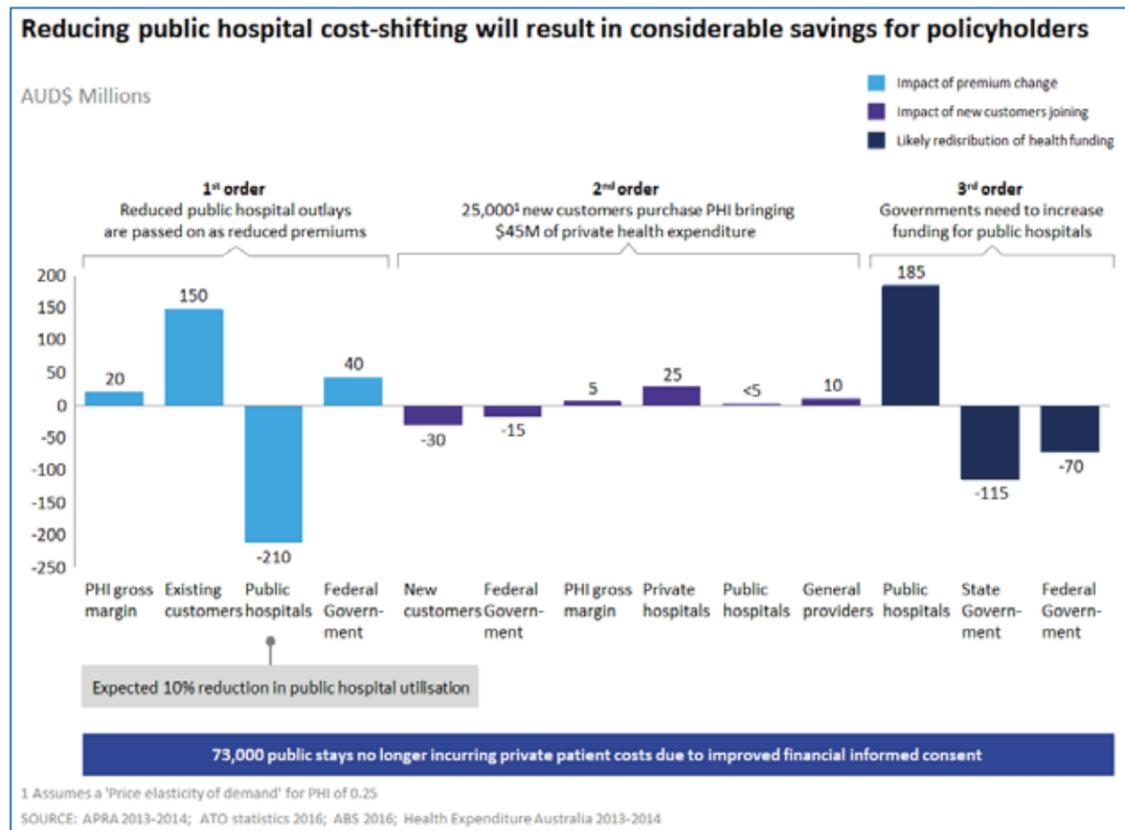
STAKEHOLDER IMPACT AND RISKS – IMPACT OF REFORM

Achieving the removal of quotas, increased monitoring of private patient flows through public hospitals, an enhanced informed consent processes to protect customers and greater transparency on care being provided would result in significant savings for PHI policyholders and the Federal Government in the short term, and avoided further cost increases in the future through a reduction of cost shifting.

The first order impact is an estimated saving of up to \$150 million for existing PHI policyholders, and a saving of up to \$40 million to the Federal Government due to reduced rebates payable.

An expected reduction in premiums would likely result in an estimated additional 25,000 new PHI consumers. It is estimated that up to 73,000 policyholders per year would no longer elect to use their PHI in public hospitals due to improved informed consent.

The Impact of reform



- Third, health funds should communicate with their policyholders more frequently about what electing to be private in public hospitals actually means, to ensure members are fully informed decision makers when choosing providers.

There are also several smaller risks that need to be avoided to maximise the value from these changes. These include:

1. A moderate risk that policyholders would ignore health funds' advice and continue to elect to be private in public hospitals. This would require more frequent and pertinent communications regarding public hospital cost shifting, potentially including direct communication with any members who elect to use public hospitals to ensure they are fully aware of the costs.
2. Public hospitals may use invoice accuracy to push up the price they charge health funds. However, unless an agreement was in place, health funds would be under limited obligation to pay more than the value dictated by the minimum benefit.

INTERDEPENDENCIES

The implementation of the public hospital cost shifting initiative would be supported by also introducing the below proposed regulatory reform:

Second tier default reform: the abolition of the second tier default for large providers would place additional competitive pressure on private providers to improve their service levels and therefore attract more patients who may currently be encouraged to use their PHI in a public hospital. This would especially be the case in metropolitan areas.

IDENTIFIED RISKS AND MITIGATION

The most significant risk in implementing these changes is that hospital executives continue to seek 'own source' revenue beyond current levels, or that the State Governments continue to implicitly require it of hospitals, through funding them below their operating costs.

In order to protect members from ongoing cost shifting, if this behaviour continues, there are several potential mitigation options:

- First, the Federal Government could support the reforms of COAG, as the cost shifting increases are MBS codes and premium rebate;
- Second, health funds should consider entering into agreements with selected public providers allowing them to seek pre-authorisations before a patient may elect to be private in a public hospital; and

Premium round deregulation

CONTEXT AND CORE ISSUE

The issue of premium growth is a contentious one. As a result of health cost inflation, premiums have increased at an average rate of 6% year-on-year between 2007 and 2015.¹⁸

Today, the Federal Government regulates the PHI industry's overall premium increase through a centralised review process, where each health fund applies to the Minister for Health for approval of all premium changes.

These proposed changes are submitted by health funds in November, and closely scrutinised by the Minister, the Department of Health and the Australian Prudential Regulation Authority (APRA) prior to public premium change announcements towards the end of February.

Although legislation allows health funds to change premiums at any time, the current process is followed by convention. It is rigid, with a prescribed deadline of November for submission of changes and with approved changes taking effect on April 1st.¹⁹

The process is time consuming for all involved, including the Minister, the Department of Health and APRA, as well as for health funds that prepare their submissions.

The process places pressure on the ability of health funds to respond to the market, as it creates a time lag between market signals, the approval of premium changes and the premium change actually taking effect.

This lag can take between five months - if the price signal is received and acted upon just prior to premium submissions in November, and a maximum of seventeen months, if the price signal is received immediately after November's premium submission and not made effective until April in the second year following.

Due to the heavily regulated process controlling premium increases, health funds are at high risk if they increase premiums by anything below their experienced cost increase.

Changing to a deregulated market would allow health funds to take the risk with their pricing in favour of more affordable PHI, knowing they can alter their premiums later if necessary.

The synchronised nature of the process poses a challenge as the simultaneous change to premiums for all health funds, as announced by the Minister in late February each year, sparks seasonal churn which can be seen as a big spike in people changing funds and level of cover at this time.

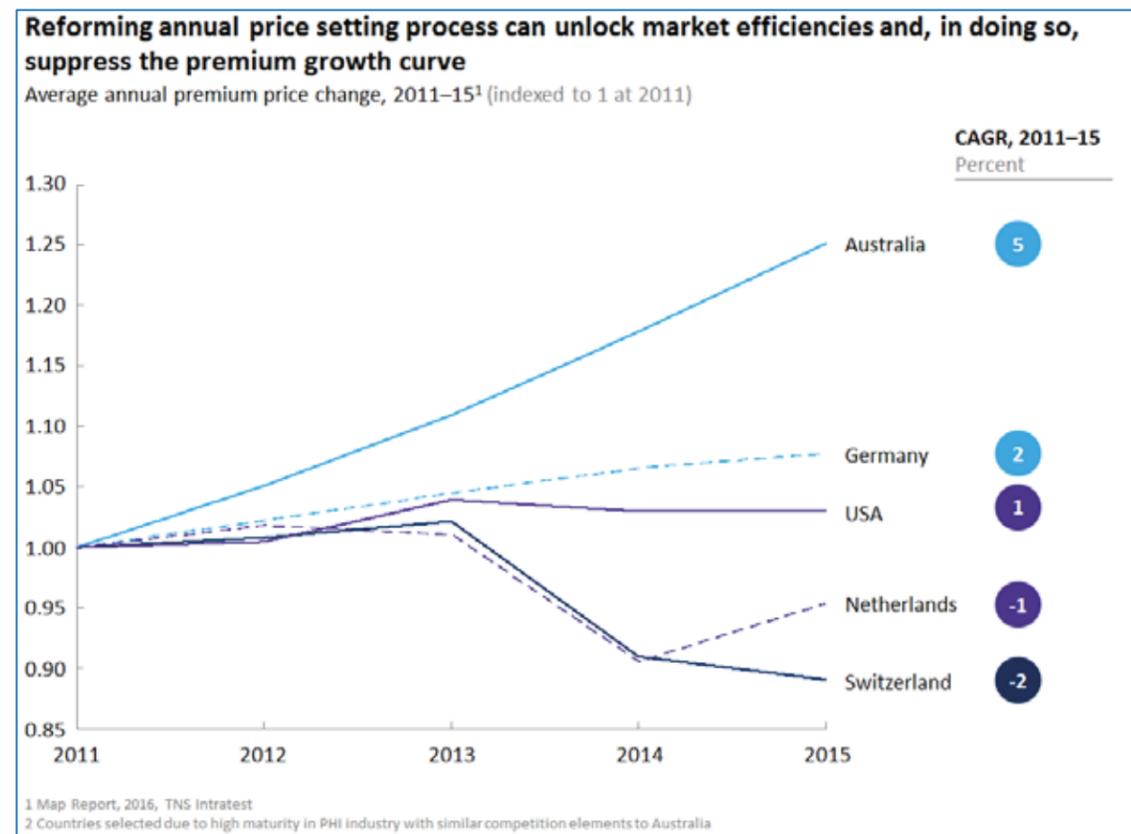
The annual average growth rate in PHI premiums between 2011 and 2015 was 5% per year. This is significantly higher than several international examples that have successfully developed a more market-driven approach to PHI regulation. Some examples are briefly discussed below:

- **Germany:** Follows a compulsory statutory health insurance system under which contributions are income based. Individuals earning above a threshold level are able to opt out of this system and insure themselves through PHI. Premiums in this private system are risk-rated at the age of entry and increase in accordance with health care inflation and age. Germany's annual premium growth between 2011-2015 was 2%.
- **Netherlands:** Basic health insurance is mandatory in the Netherlands. There are three funding methods for the insurance pool: an income-based payment, a flat premium that cannot be risk-rated, set by health funds, and a government contribution that covers about 5% of the national insurance pool. Annual premium growth between 2011-2015 was -1%.
- **Switzerland:** Has established a mandatory basic health insurance system with a supplementary PHI system. Premiums can vary based on policy benefits, three defined age groups (0-18, 19-25 and 26 and older), and geography. Switzerland's annual premium growth between 2011-2015 was -2%.

¹⁸ APRA (2009 and 2015) private Health Insurers Operations Report Data

¹⁹ Private Health Insurance Act 2007 (Commonwealth) s66-10.

Average annual premium prices changes in a range of countries vs Australia



Six per cent annual premium increases are not sustainable in the medium-term, given that household income growth is currently at 1.8%.²⁰

If these rates were maintained, PHI would soon be unaffordable for many Australians. Policyholders would be unable to supplement their public health services with private health services, and the Federal Government would need to support higher public health expenditure.

Core question

What regulatory reform will create the optimal conditions in premium setting that can unlock greater market efficiency?

OPTIONS AND RECOMMENDATION

There are four regulatory reform options, which have been considered to improve the regulation of PHI premiums in Australia.

Potential reform options:

- Option 1: Full deregulation**
 Option 1 involves abolishing all premium regulations, which would allow health funds to set premiums at any time. Full deregulation would require an amendment to the PHI Act to abolish the current Ministerial approval process.
- Option 2: Independent monitoring, desynchronised price variation**
 Option 2 involves establishing an independent price monitoring system with a desynchronised price regulation process. An independent statutory authority would monitor premium changes by assessing health funds' adherence to a set of guidelines, such as Benefits Loss (Claims) Ratio, that ensures price changes do not have an inappropriately adverse impact on policyholders.²¹ A desynchronised process would replace the current annual approval process.
- Option 3: Independent monitoring, synchronised price variation**
 Option 3 would establish an independent price monitoring system equivalent to the system outlined in Option 2. An independent statutory authority would monitor, but not approve premium changes in accordance with set guidelines. The authority would publicise premium changes by health funds, and intervene only in the event that a health fund changed premiums contrary to guidelines. However, health funds would only be able to change prices according to a synchronised cycle managed by the regulatory body. This cycle could be quarterly, semi-annual or annual.
- Option 4: Ministerial approval with more transparent guidelines**
 Under Option 4, regulatory responsibility would remain with the Minister for Health. However, the conditions on which premium prices changes are approved would be made more transparent by introducing standard pricing parameters. The possible parameters are the same as those introduced under the independent monitoring system, with one or more of the following: a BLR, minimum and /or maximum capital thresholds, a capped return on equity or a capped profit margin.

²⁰ ABS (2015) 6523.0 Household income and wealth

²¹ Department of Health (2016) Premium round individual private health insurer average premium increases

Recommendation 5: Option 2, independent monitoring with desynchronised price variation, is recommended for the following reasons:

- Independent price monitoring removes adverse political risk of Ministerial involvement in PHI price setting, and ensures a regulatory body best suited to ensuring fair pricing behaviour is making the assessments. This is similar to changes the Federal Government has previously made in the finance sector.
- Desynchronisation ensures health funds price dynamically according to changing policyholder preferences, while allowing market competition to reduce premiums. It would also decrease the seasonal churn spike.
- One of the primary reasons for introducing Ministerial approval was the risk of premium inflation leading to the PHI rebate increasing above sustainable levels. However, as the rebate is now means-tested and CPI adjusted, outlays are reducing, thereby alleviating the core need for Ministerial approval.

ABOLISHING THE ANNUAL SYNCHRONISED ROUND OF PREMIUM INCREASES (DESYNCHRONISATION)

It is recommended that price setting be desynchronised. This would do away with inefficiencies arising from the current practice of coordinated increases. In contrast to the present system, which sees regulatory efforts between November and February, ending synchronisation would enable the regulatory body to evenly disperse its regulatory activities, prioritise significant compliance and enforcement matters, and conduct multiple smaller compliance investigations or “spot checks” throughout the year.

Desynchronisation would expose health funds to market forces and signals at the time at which they occur. This exposure should increase competition between health funds since policyholders would have sufficient movability to switch between health funds if premium changes are considered high. The market would reward those funds that rapidly remodel product, price and value for policyholders.

A benefit of desynchronisation from a health funds’ perspective is that it enables them to change premiums at times relevant to their needs (e.g. on policy anniversaries). This new process would lead to each health funds focusing more on monitoring premiums and their product positioning. Policyholders would be protected from unexpected rate changes through rate protection mechanisms.

Rate protection means if a policyholder has paid for a policy in advance, they do not pay the increased premium during the period for which they have paid.²² Although rate protection is not currently legislated, section 93-20 of the PHI Act requires health funds to provide policyholders with a reasonable period of notice before policy changes, such as premium increases, take effect. This is reinforced by the industry developed Private Health Insurance Code of Conduct.²³

A desynchronised process would also require the Department of Health to change its calculation of industry weighted average premium increases, which is used as part of the annual PHI rebate adjustment calculation. In this regard, it is recommended that the current prospective system be changed to a retrospective system. This would consist of taking the total premium revenue, divided by average number of policies for the most recent financial year, and comparing that to the equivalent for the previous year.

For example, in the 2014-15 financial year, if the average value per policy was \$3,260, and in the prior year it was \$3,117, that’s a year-on-year increase of 4.6%. This number would then be used as the weighted industry average for rebate calculations for the next 12 months.

Currently the rebate adjustment is announced on the 1st of April each year, with the other input, CPI comparison, being taken at December. This date could either continue, or it may be preferable to consider moving to a new date such as the 1st of August, so that the inputs can run with Australian financial years.

²² Rate protection is currently practiced by most health funds. See Department of Health (2015) 2015 Private Health Insurance Premium Round Outcome and Outline of Process.

²³ Private Healthcare Australia 2014 Private Health Insurance Code of Conduct

INDEPENDENT PRICE MONITORING

A pre-existing independent statutory authority, such as APRA, the Australian Competition and Consumer Commission (ACCC), or the Private Health Insurance Ombudsman (PHIO) could be considered to take on this function. The Governing Board of the appropriate statutory authority would be accountable to the relevant Minister and would provide financial, governance and operational updates to that office.

APRA’s suitability as a prudential body could be worthy of consideration as it focuses on financial soundness and risk management. APRA already has a fundamental understanding of PHI industry due to its absorption of PHIAC in 2015, and already collects the financial data.

The ACCC has less of an understanding of the PHI industry as its role has traditionally been to implement compliance and enforcement remedies, and so would be less appropriate in this role. While PHIO, despite having an understanding of the PHI industry, currently does not have the capabilities to monitor or enforce fair pricing compliance. Instead, PHIO protects PHI consumers through complaints handling, education and advice services, and it also advises industry and government.

The recommended standard for the independent regulator to monitor is the Benefit Loss (Claims) Ratio. Additional standards could include capped gross profit margins, capped return on equity, and minimum or maximum capital thresholds.

SUMMARY OF RECOMMENDATIONS

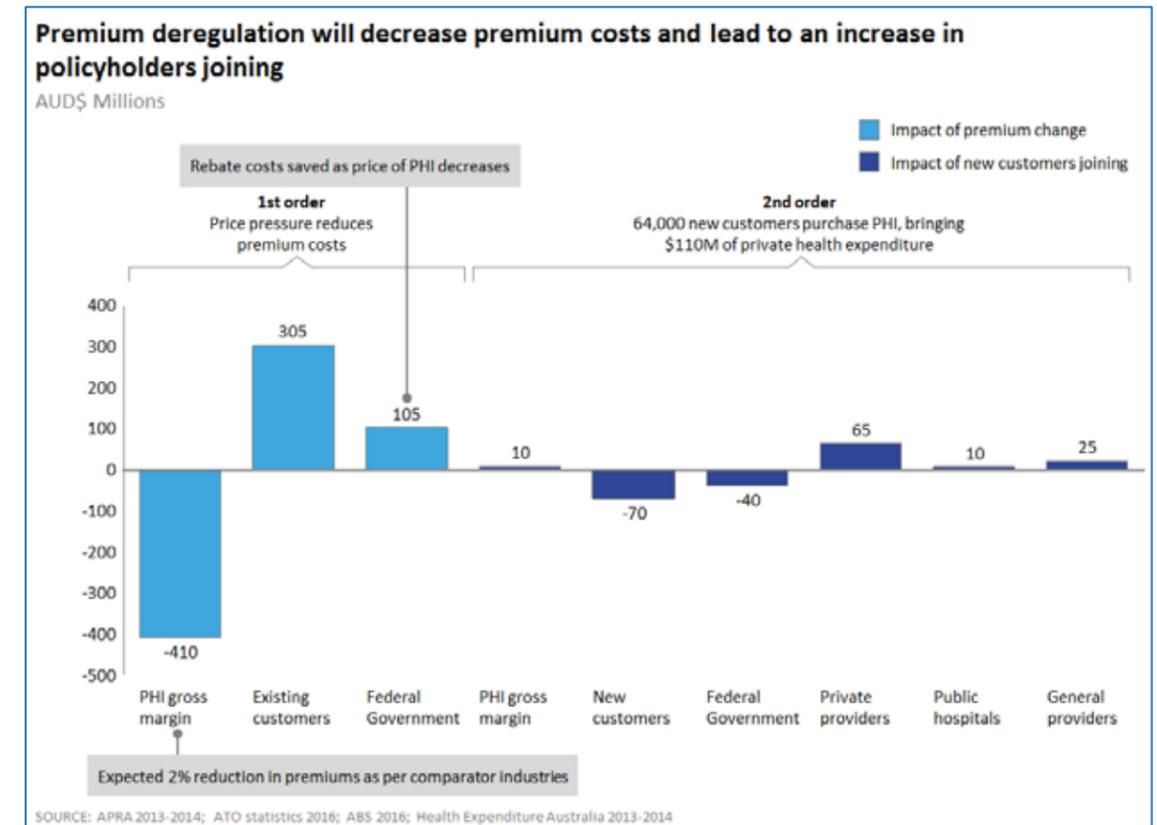
- Establish an independent price monitoring system where health funds can change premiums without submitting changes to the Minister for Health for approval;
- Appoint an independent statutory authority to monitor premium changes by assessing health funds' adherence to guidelines, such as the Benefit Loss (Claims) Ratio, to ensure price changes do not inappropriately impact policyholders; and,
- Promote a desynchronised process whereby health funds can change premiums at times relevant to their needs rather than on a prescribed date annually (e.g. policy anniversary).

STAKEHOLDER IMPACT AND RISKS – IMPACT OF REFORM

Premium deregulation is likely to deliver significant benefits to policyholders. Increasing competitiveness between health funds may lead to lower premium increases than would have occurred under the current system, creating up to \$305 million of value for policyholders and up to \$105 million in cost savings on the Medicare rebate for the Federal Government.

An anticipated 2% reduction in premium growth could lead to a reduction in revenue to the PHI industry of up to \$410 million. The second-order effect on premium deregulation would be the uptake of PHI by approximately 64,000 new policyholders due to lower premiums, which could bring up to \$70 million of new revenue to the PHI industry.

The impact of the recommended reform option on the wider PHI industry



IDENTIFIED RISKS AND MITIGATION

To ensure that maximum value is obtained for new and existing policyholders, the following approach to mitigating identified risks is recommended:

- First, the risk with the highest likelihood of occurring and the greatest impact is price competition between health funds leading to significant premium price decreases, which could place the current business models of health funds under stress. While policyholders would obviously benefit from this price competition, some health funds would struggle. To mitigate this risk, sufficient time is needed for health funds to be able to adapt their business models prior to the introduction of full price deregulation;
- Second, there is a lower risk that health funds would increase premium prices to the detriment of PHI affordability. With current portability rules allowing policyholders to switch to health funds with lower premium increases, this creates a strong incentive for health funds and should largely mitigate this risk. The independent regulatory body could also monitor and intervene on the basis of price fairness if necessary;

- Third, private providers might seek to take advantage of the deregulated conditions pushing for increased payments. This is a moderate risk given the growing market power of private providers with two networks collectively comprising approximately 44% of the private provider market. Health funds would need to mitigate this by locking in contracts early, as well as pursuing other measures such as reforming the second tier default benefit;
- Fourth, there is a moderate risk that the newly appointed regulatory body would overregulate health funds. The result of this would be a reduced ability to respond to market signals and less price competition between health funds. This could be mitigated by defining clear guidelines against which health funds should be monitored, such as the BLR/Claims Ratio, and ensuring that the guidelines are appropriately adjusted for the variety of business structures that function in the PHI market;
- Fifth, there is a risk of private providers attempting to acquire health funds, which would result in consolidation within the healthcare market. While this risk is assessed as small, in reality health funds would have limited ability to mitigate this. The ACCC, in its role as Australia's competition regulatory, would likely evaluate the impact of consolidation on the competitiveness of the industry;
- Finally, policyholders may seek to prepay policies annually at a higher rate than they do currently, in order to reduce their exposure to price changes in the desynchronised market. This could lead to reduced churn within the industry, as individuals are linked to a health fund for longer. It could also lead to lower premium income as individuals are prepaying at the pre premium increase price. This should not be mitigated, as the health funds are able to manage their own payment terms with their policyholders.

funds and the Minister for Health could collaboratively develop a community information program to ensure policyholders are informed about the reforms and the expected positive impact on their premiums.

Phase 2: Implement transitional program to prepare industry and regulatory body for changes

In the second phase, a transitional program would be implemented in which the Minister would decline to approve premium increases only in exceptional circumstances. This would allow health funds to adapt to the greater market flexibility than the current premium approval process. During this time, the new regulatory body would begin to develop premium regulation capability by establishing performance guidelines for the health funds to adhere to, and starting a first review of premium changes.

Phase 3: De-synchronise and transfer regulatory powers to the regulatory body

In the third phase, the full reform program would be implemented by transferring the power to regulate premium changes to the regulatory body as an independent price monitoring authority. It is recommended that the regulator coordinate research of health funds' pricing behaviour following implementation of the full reform, and examine differences between behavior before and after the changes. The regulator should also refine the monitoring process if needed by consulting with policyholders, health funds, the Department of Health and the Minister.

IMPLEMENTATION

To ensure the aforementioned risks can be properly mitigated, a three-phase implementation plan over three years is recommended.

Phase 1: Announce reforms to inform policyholders and industry

The first phase would focus on legislative change, announcements to the public, and developing the implementation plan for the transitional Ministerial approval process. It is recommended that the Minister for Health engage in consultations with stakeholders and draft legislative changes that would enable implementation of the full reform program by April 2019. By this time also, it is recommended that the Minister announce the changes, including the transition program throughout 2017-18 and the full reform roadmap. Health

Review of Lifetime Health Cover settings

CONTEXT AND CORE ISSUE

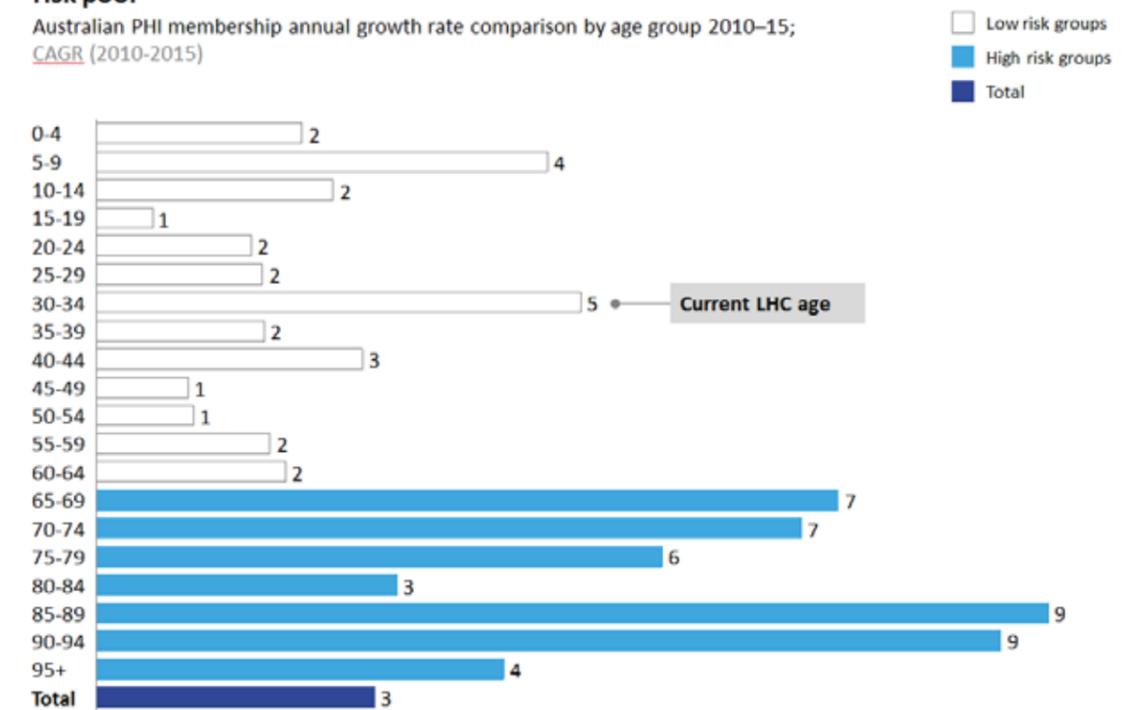
Australia's ageing population directly impacts the Australian PHI industry as older age groups are more highly represented in PHI than younger age groups. This is problematic, as older age groups cost significantly more in healthcare than younger groups.

A further challenge is that the growth rate in the older age groups is increasing at a higher rate than younger groups due to age bracket creep. Also concerning is the impact of Australia's community rating system on younger individuals in this context, in which younger, healthier individuals subsidise the cost of health insurance of older, less healthy individuals.

A comparison of the PHI growth rate by age group

Incentives are required to encourage younger policyholders to buy PHI and balance the risk pool

Australian PHI membership annual growth rate comparison by age group 2010–15;
CAGR (2010-2015)



SOURCE: 2010 to 2015 APRA data

Membership imbalance is not a new problem. Prior to 2000, it was possible for a person to join a health fund for the first time at the age of 85, and pay the same premium as a 20 year-old, which was both inflationary and unfair. In 2000, LHC loadings were introduced to encourage younger people to purchase PHI and address this imbalance.

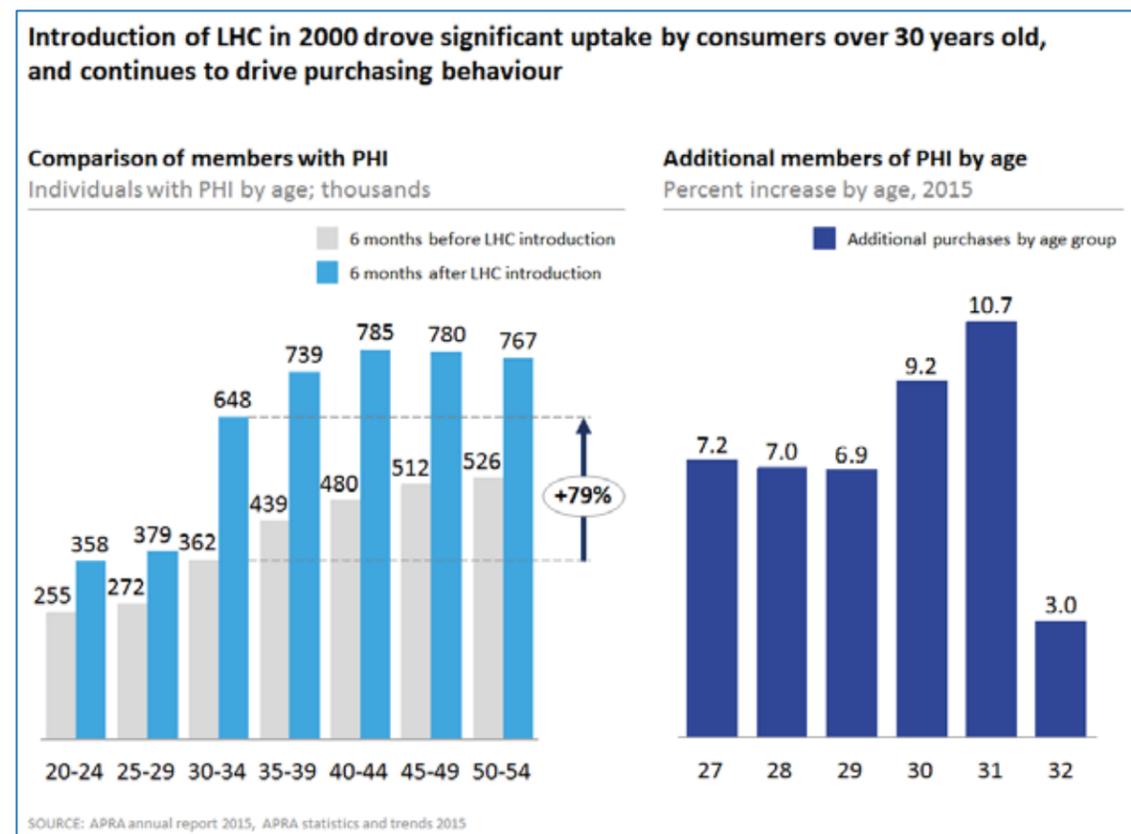
Under LHC regulations, anyone purchasing PHI for the first time after the age of 30 pays a loading on their premium equal to 2% for each year of age older than 30 (with a maximum

loading of 70%). The loading lasts for 10 years. For example, a 40 year-old purchasing PHI for the first time will pay 20% more than the listed premium price for 10 years.

The impact of introducing LHC in 2000 resulted in a 79% increase in individuals aged between 31-35 years old. Within six months after the introduction of the LHC loading, the total PHI membership in Australia increased from 32% to 46%, significantly expanding the overall risk pool of PHI members.

The graph below explains how this effect continues today. On the right hand side, the additional increase in members for PHI uptake between the ages of 27, 28 and 29 averages 7%. The additional uptake between the age of 30 and 31 is 10%. This difference is arguably directly due to the LHC loading that would take effect after 31 years.

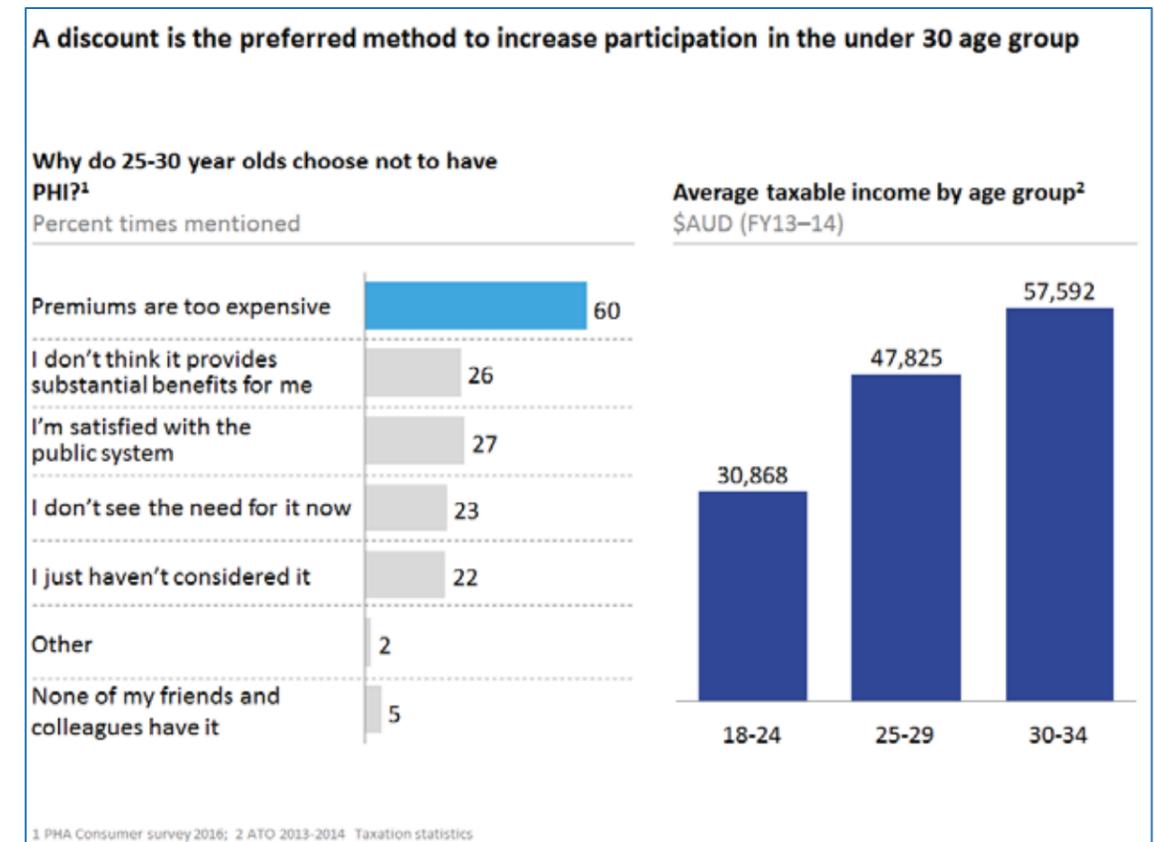
The impact of LHC on purchasing behavior



An expansion of the PHI membership pool through an extension of LHC to a younger age group has been considered before, both in terms of extending the loading or offering a discount.

Market research suggests a discount would be more effective. A recent PHI consumer survey (2016) found that for individuals aged 25-29 years, their main reasons for not purchasing PHI was the high cost. A discount encourages PHI uptake without imposing penalties on a group with an average annual income of less than \$50,000. The ability to hold the discount for several years is also likely to decrease churn.

Younger age survey and income analysis (IPSOS July 2016 commissioned by PHA n=3600)



OPTIONS AND RECOMMENDATION

PHA believes it is time to re-examine the LHC policy settings in line with demographic and economic changes that have occurred over the last two decades. We have identified four potential regulatory reform options for rebalancing the age profile of consumers in Australia.

Potential reform options

- Option 1: Lifetime graded premium discount of up to 10% for individuals aged under 30 years.**
 Introduce a lifetime health cover discount (LHCD) for independent individuals who take up PHI between the years of 18 and 30. This discount is 2% per year under 30 years old, up to a maximum of 10%. Recipients retain the discount for life, unless they exit the PHI industry. The discount is portable between funds.
- Option 2: Lower the LHC penalty to age 25**
 Continue with the current LHC system, but alter it to begin taking effect at 25 years old instead of 30.
- Option 3: Increase LHC penalty to 5% from age 30**
 Continue with the current LHC system but alter it to increase prices by 5% per year after age 30, instead of the current 2%.
- Option 4: 10 year graded premium discount of up to 20% for individuals aged under 30**
 Introduce a LHCD for independent individuals who take up PHI between the years of 18 and 30. This discount is 4% per year under 30 years old, with a ceiling at 20%. The discount is kept for 10 years, or until 35 years of age, whichever is later.

Recommendation 6: Option 1, Lifetime graded discount of up to 10% for 18-30 year olds is recommended because it:

- Improves the affordability of PHI, which is the primary concern of under 30s.
- Avoids the negative perception of health funds trying to profit by increasing penalties on younger individuals.
- Lifetime discount is likely to be a strong purchasing incentive and mechanism for retention.

Summary of LHC policy variations considered

Option 1 is preferred option to improve LHC and encourage greater participation in PHI			
Option 1	Option 2	Option 3	Option 4
Lifetime graded premium discount of up to 10% for individuals aged 18-30 years	Lower the Lifetime Health Cover penalty to age 25	Increase LHC penalty to 5% from age 30	Graded premium discount of up to 20% for 10 years
<ul style="list-style-type: none"> Improves affordability which is the primary concern of under 30s purchasing PHI Improve average risk profile of insurance pool Provides a very strong purchasing incentive, with ~60 years of discounts 	<ul style="list-style-type: none"> Provides incentive to adopt PHI earlier than the current system of a penalty over the age of 30 Value accretive in the long term 	<ul style="list-style-type: none"> No financial burden for age 25-30 cohort Increases incentive for age 30-55 cohort, which includes high risk obstetrics claimants, while maintaining community rating 	<ul style="list-style-type: none"> Improves affordability which is the primary concern of under 30s purchasing PHI Improve average risk profile of pool and provides a mechanism for lowering premiums as younger cohort subsidises higher risk older cohort
<ul style="list-style-type: none"> Behavioural economics suggests a penalty system could be more effective Over years, a significant portion of the insured pool may be on a discount, driving up the premiums 	<ul style="list-style-type: none"> Increase financial burden for 25-30 year olds who may develop "grudge" mentality against insurance Results in a reasonably negative public perception towards the PHI industry by consumers 	<ul style="list-style-type: none"> Regressive penalty that disproportionately burdens low income earners Likely to contribute to significantly negative perceptions towards the PHI industry by consumers 	<ul style="list-style-type: none"> Behavioural economics suggests a penalty system could be more effective in nudging members to adopt PHI earlier Uptake of new policyholders is very unlikely to outweigh losses from discounts to current policyholders, creating an unsustainable system

A discount of up to 10% increases the affordability of PHI for individuals under 30. This is fairer than penalising or prematurely burdening young individuals who may not be able to take out PHI due to low disposable income. It would also maintain a consistent age-based risk-rating approach, in line with the current LHC.

Targeting the program at independent adults under 30 years ensures all adults currently not incentivised by the LHC are now impacted by the LHCD. Applying it from 18 years old is fair, and prevents an arbitrary age boundary (e.g. 25 years) from leading to discrimination

against a portion of independent adults. The program would apply to independent adults only, as the discount is not intended to decrease the cost of family policies with adult dependents.

Extending the discount for as long as the member retains their PHI is in contrast to the current LHC program, where the penalty expires after 10 years. It is thought this would provide a stronger purchasing incentive to individuals under the age of 30 than a 10-year discount.

The temporary window to obtain the lifetime discount should also increase the perceived value. The threat of losing an irrecoverable discount may also reduce churn over a member's lifespan in the industry.

Current portability rules would remain in place to continue enabling competitive movement of members seeking the best value products. There would be no direct change to the current discounting legislation, other than to provide an exception for the LHC discount.

FURTHER ANALYSIS AND RESEARCH NEEDED

While initial modeling indicates there is high potential upside with a 10% lifetime discount, there is also a high potential downside if membership growth and churn reduction assumptions do not hold true. Given the complexity of this analysis, further detailed actuarial analysis will be undertaken by PHI health funds in order to more precisely predict and understand the impact of a 10% discount for life, with market research also needing to be undertaken to quantify the expected impact on purchasing behaviour.

SUMMARY OF RECOMMENDATIONS

- Provide a lifetime health cover discount to individuals commencing membership between the ages of 18 and 30 years.
- Offer a graded discount increasing at 2% per year under 30 years, capped at 10%.
- Allow recipients to retain the discount for life, but remove the discount if the recipient exits PHI, (discount remains if member changes funds).

STAKEHOLDER IMPACT AND RISKS – IMPACT OF REFORM

Reducing premiums for individuals under the age of 30, with the promise of a prolonged discount, could be expected to result in a significant uptake of PHI by younger individuals. Estimates take into account gross margin of younger consumers, purchasing power of individuals in the 18-30 age group, and purchasing propensity of PHI for different income groups.

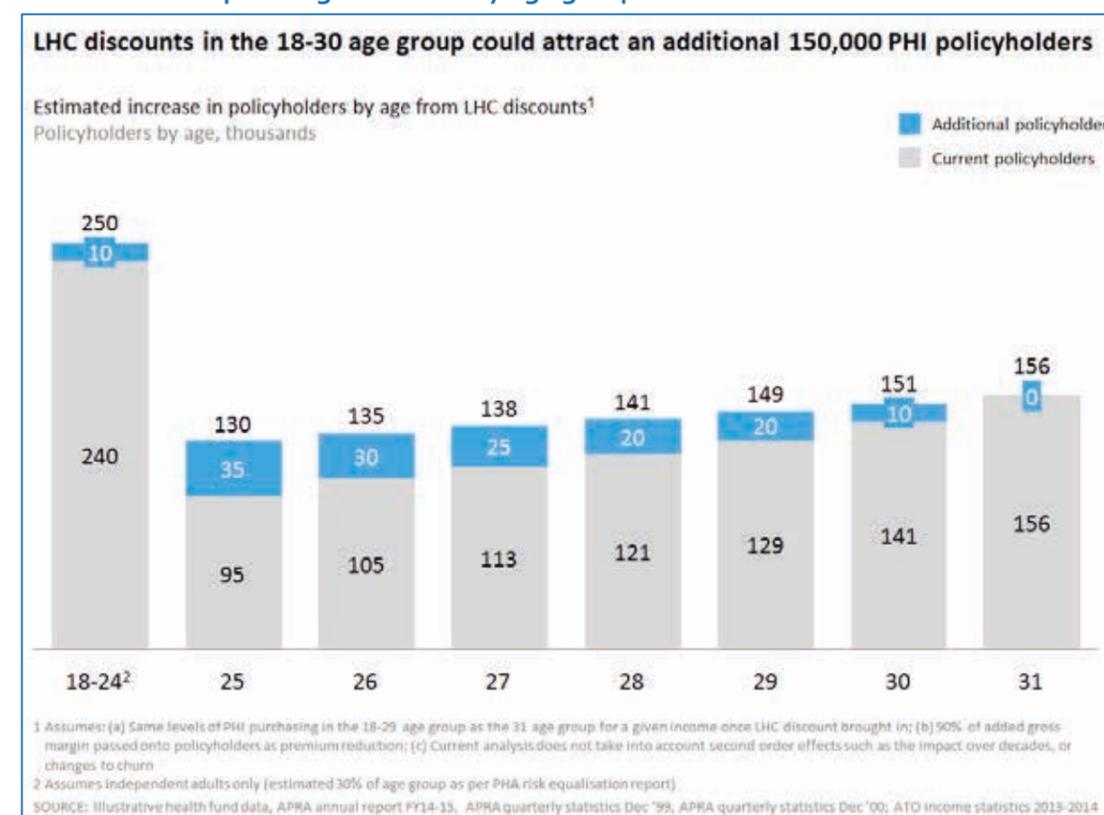
The largest increases are expected to be among 25 and 26-year-olds. Despite 18 to 24-year-olds being a small portion of the available market, it is important to include individuals aged under 25 as many individuals in this category may not be able to access dependent-based coverage and should therefore be entitled to the reduced premiums.²⁴ Under 25-year-olds are also considered lower risk than the 25 to 30 age group.

While these estimates are based on reasonable growth assumptions, further refinement with additional market research is recommended to fully understand purchasing behaviour of members under 30 years.

What is clear is that younger individuals have, on average, a much higher gross margin than the average customer.

Adding an additional 150,000 members could be expected to bring in up to \$130 million in total gross margin. Given the competitive market place, approximately 90% (or \$120 million) of this additional gross margin could be expected to be passed on to existing policyholders in the form of lower premiums.

LHC discount expected growth rate by age group



²⁴ In 2014, 20% of 18-24 year-olds held PHI policies. See ABS (2014) 3101.0 Australian Demographic Statistics.

IDENTIFIED RISKS AND MITIGATION

The primary risk in implementing these changes is an increase in “exclusionary” policies. This would lead to a lower value proposition of PHI in the community, and deliver poor value to consumers.

In order to mitigate this, it is recommended that the Federal Government implement an acceptable minimum standard product, with an appropriate level of coverage. This is currently a major part of the policy negotiation being undertaken by the Private Health Ministerial Advisory Committee (PHMAC).

Three other risks also require mitigation to ensure success of an LHC discount:

- First, there is a moderate risk that the uptake by under 30-year-olds would be lower than expected. Health funds, however, would be able to target marketing and products as required to increase uptake. Legislation could have a sunset clause if the LHC discount is considered to be ineffective;
- Second, there is also a moderate risk of increased targeting of general products to 20-30-year-olds by providers, as a response to market size growth. Should this occur to the point where it creates financial problems, health funds could mitigate this through targeted changes to product extras for general products;
- Third, there is a low risk that individuals older than 30 years who had PHI before they turned 30, may request the discount retrospectively. This can be avoided with any alteration to the legislation having an explicit clause stating that the discount cannot be applied retrospectively to those over 30 years.

INTERDEPENDENCIES

The changes to lifetime health cover can be supported by also introducing the below proposed regulatory reform:

- **Risk equalisation:** An altered risk equalisation process may change the discount level that can be offered as part of the LHC and remain profitable for health funds. This is under consideration by a working group of the PHMAC.

In addition, the following transparency solution (currently under consideration by PHMAC) has interdependencies:

- **Product standardisation:** Implementation of product standardisation, through a minimum acceptable product, would prevent health funds from expanding their exclusionary products in order to attract more individuals under 30 years.

IMPLEMENTATION

To ensure the aforementioned risks can be properly mitigated, a phased implementation plan over two years is recommended.

PHASE 1: LEGISLATIVE CHANGE, FURTHER ANALYSIS AND MARKET PREPARATION

Before the end of 2017, should the PHMAC consider this policy direction, PHA would complete an actuarial analysis along with market research to better understand expected take-up rates due to the discount. In 2017, an amendment to Part 2-3 of the PHI Act 2007 introducing the discount could be introduced into the Federal Parliament. A market announcement of the decision would be made, with stakeholder consultation, including health funds, PHIO and consumer groups commencing.

PHASE 2: INTRODUCTION OF CHANGE TO MARKET

The change would be legislated to take effect late in 2018. This would allow any discounts to be publicised as part of regular pricing announcements. The time between the legislative change and the introduction of the discount would allow health funds to develop marketing plans and implement any other business strategies to adjust to the discount.

LONG-RUN MEASURES TO IMPROVE THE AFFORDABILITY AND SUSTAINABILITY OF PHI

Australian health funds are highly aware of the current political environment, particularly the fact that radical change to the health system is unacceptable to the public.

There are, however, two key measures that should be addressed in both the short and the long term which represent substantial change, but which will not be perceived as threatening the fabric of Medicare.

The Medicare Benefits Schedule (MBS) Review and improved payment integrity and compliance mechanisms

Under Australian government regulations, it is very difficult for health funds to pre-approve claims, and any attempt to do so is strongly resisted by health professional representative groups.

The 'trigger' for health fund hospital claims is the MBS claim. While this protects the consumer from unexpected out-of-pocket expenses due to claims not being approved, it means health funds are highly dependent on the appropriate management of the MBS program to be able to manage their costs.

PHA is strongly supportive of the MBS Review and its associated processes, as every dollar of waste and every episode of inappropriate practice threatens the sustainability of private health.

The increasing use of services is largely what drives health system cost increases. A large part of this is related to the ageing of the population and the emergence of chronic diseases. There is also a significant incentive created by the MBS fee-for-service reimbursement system for doctors to drive up procedure and consultation volumes.

Information disparity between providers and consumers is high in this sector, and as a result, provider-induced demand accounts for a significant proportion of services provided. This is likely to have been accelerated by the 'freeze' on MBS rebate indexation.

A robust mechanism to manage compliance in the MBS program, and to ensure services are provided appropriately, will be as important as the changes to the MBS schedule of fees arising from the Review in ensuring sustainability of this program as well as PHI. Traditionally MBS payment integrity has been managed through the Professional Services Review (PSR) process, as well as fraud and compliance activities undertaken by the

Department of Human Services.

PSR was established in July 1994 as an Agency within the Health Portfolio to protect the integrity of Medicare and the PBS. Part VAA of the Health Insurance Act 1973 establishes the agency, sets out its role and powers and the process it must follow when conducting its work.

Through the performance of its statutory role, PSR protects patients and the community from the risks associated with inappropriate practice, and protects the Commonwealth from having to meet the cost of medical / health services provided as a result of inappropriate practice. Appropriate practice describes healthcare that is both medically necessary and clinically relevant. For example, billing a cosmetic surgery procedure to the MBS and a health fund would be considered inappropriate practice.

In its administration of the Scheme, PSR is responsible for reviewing and examining possible inappropriate practice by practitioners when they provide Medicare services or prescribe Government subsidised medicines under the PBS.²⁵

The main problem with the PSR process is that it relies heavily on the retrospective pursuit of financial gains by practitioners with the goal of recovering costs. This is cumbersome, involves long-drawn-out legal and administrative processes and is rarely successful.

Modern data analytics provides the opportunity to better use data to give health professionals generating MBS claims feedback, thereby giving them the opportunity to proactively modify behaviour and prevent fraud and inappropriate practice occurring in the first place.

Health funds have already demonstrated the effectiveness of feedback in reducing inappropriate claims. Health professionals are aware 'someone is watching' and are given data about how they are claiming relative to their peers before any punitive action is taken.

In 2016, compliance personnel in the Department of Human Services were merged into a single unit with MBS compliance at the Department of Health. This presents a unique opportunity to begin a preventive data analytic-based payment integrity and compliance regime, to leverage and back up the good work on the MBS Review.

Any such payment integrity program will have to move beyond assessing the validity of individual claims and address the claiming behaviour of individuals and groups of individuals. A comprehensive, behavioural analytics approach requires capabilities beyond the traditional skill set of the PSR and a mandate that goes from recovery of erroneously paid money to transparent monitoring and education of the provider population as well as claiming citizens. As the Government recently experienced with the Centrelink payment integrity effort, a thoughtful and pro-active communications and stakeholder management plan is imperative to the success of any such programs.

²⁵ About the PSR scheme (2016) www.psr.gov.au

Funding for out-of-hospital care

Since the beginning of Medicare in its current form, health funds have been excluded from funding care provided outside of a hospital. This means legislation specifically prevents private health insurance from covering medical services that are provided out-of-hospital and which are covered by Medicare. These services include GP visits, consultations with specialists (in their rooms) and diagnostic imaging and tests.

In the initial construction of Medicare this made sense, but over time two things have occurred which makes this inflexible aspect of the system both inflationary and impractical. First, the emergence of chronic health conditions as the predominant burden of disease, and second the emergence of new technology, particularly information and communications technology (for example home monitoring of chronic conditions), which means health services can be safely and effectively delivered in many more care settings than a hospital.

Hospitals remain the most expensive setting of care, and are not always the safest care setting for a number of conditions.

In addition, the legislation directly creates perverse incentives driving up the cost of care and hence premiums. In previous years, health funds were able to subsidise doctors performing minor procedures in their rooms with a small 'procedure fee'. This enabled doctors to keep these patients out of hospital, and covered their costs of treatment. Now this is not permitted, there is an incentive for doctors to treat the patient as a day surgery admission, where the health fund accommodation or theatre fee reimbursement is much higher.

It is recommended the Federal Government review relevant legislation with the objective of permitting health funds to provide funding for services provided out-of-hospital which are either a substitute for hospital care, allow for better integration of care for the elderly and the chronically ill, or which have the potential to prevent avoidable hospital admissions or readmissions. Avoidance of unnecessary hospitalisation is a key factor in keeping premiums down.

Examples of the types of health services that could be better funded as a result include:

- Integrated (coordinated) care of people with multiple chronic conditions registered with a GP healthcare home;
- Provision of improved health care for people in residential aged care, and the frail aged living at home;
- Improved healthcare options for people in rural and remote Australia.

A number of health funds have made a significant investment in better care of people at risk of complications from chronic disease, with a view to preventing avoidable hospital admissions, prolonged length of stay in hospitals and unplanned readmissions. For example, CarePoint, operating in Victoria and WA, is an integrated healthcare pilot supporting both public and private patients battling chronic disease and complex health

issues. (Designed by Medibank and supported by HBF).

GPs and allied health professionals are critical of this care model, which helps patients navigate available healthcare and social services. Australian Unity's preventive health arm, Remedy Healthcare, has recently launched its 'Mindstep' program, which targets people with anxiety and depression who have recently been discharged from hospital, with view to preventing readmission.²⁶

Removal of the outdated red tape preventing health funds from financing out-of-hospital care will enable this type of program to expand and flourish, will enhance the role of primary care in addressing chronic disease and will put downward pressure on premiums.

As an additional measure, the risk equalisation²⁷ regulations underpinning community rating should also be reviewed. This is to prevent the possible unintended consequence of funds, which successfully prevent hospital admissions, being penalised. This issue is currently being examined by the PHMAC.

²⁶ Remedy Healthcare has spent seven years researching and developing its first in kind mental health program. (November 2015 <http://www.australianunity.com.au/thoughtplus/health-latest/2015/december/remedys-mental-health-first#sthash.4s0RPQMp.dpuf>)

²⁷ Risk equalisation is a regulated process, which redistributes the risk of insurance for members so that high cost individuals, such as the elderly, can still be covered under community rating without paying a higher premium. There is a pool of money to which all health funds contribute. Health funds with higher risk members receive value through the process, whereas health funds with lower risk members pay value into the pool. At the moment, risk is defined retrospectively based on hospital claims – this may need to change if the focus shifts to out-of-hospital care.

CONCLUSION

This pre-Budget submission identifies practical and achievable policy adjustments that will ensure the sustainability of the Australian health system into the future. There is no ask for additional Government funding, but there needs to be the political will to work proactively with health funds and other private health stakeholders to improve the quality and affordability of the sector for future generations.

The former Minister for Health, Sussan Ley, has made a worthwhile start with the work of the Private Health Ministerial Advisory Committee (PHMAC) and the MBS Review well underway. Full implementation of the short and long run reforms we have proposed, however, will ensure private health in Australia remains affordable, valuable and sustainable for consumers as the Australian healthcare system confronts the challenges of an ageing population.

Health funds have consistently indicated that any savings generated through regulatory reform will be passed back to health fund members as a reduction in premiums. In addition to this commitment, we are actively working with government, and investing in ways to help consumers navigate the private health system and manage out-of-pocket medical costs.