Private Health Insurance: restoring affordability.

Submission by Russell Schneider AM GAICD (former CEO Australian Health Insurance Association,) to the 2018 Senate Community Affairs References Committee inquiry into Private Health Insurance Legislation Amendment Bill 2018 and related Bills

EXECUTIVE SUMMARY

- *Community rating is collapsing and that is driving up the price of PHI particularly for those who need it most: the old, the sick, and the infirm.*

- *The destruction of community rating (along with the rising costs of health care, which affect both private and public sectors) is one of the prime drivers of health insurance inflation. The creation of exclusion products has encouraged consumers to risk rate themselves. It transfers risk from the insurer to the insured. This not only creates under insurance but, ironically, also creates an inflationary driver within the private marketplace*

- *Exclusionary products have increased the price of top cover and led to healthier members cascading down to lower cost products, or dropping cover. In effect these products have cannibalized the industry*

- *To hold the price below the surcharge cost, Funds have stripped value out of their products, diminishing the overall attraction of private health care.*

- *"Gold, Silver. Bronze and basic" products will still encourage individuals to make a judgement on their own health status, forcing the price of full cover ever higher*

- *Allowing upgrading to full cover for mental treatment is more likely to encourage under insurance, as most people will choose to use products with minimal or even no coverage for mental health, knowing that if they ever require admission (and few expect to) they can instantly receive full coverage. It will add to the tendency and the temptation to cannibalize the overall pool and drive costs, and therefore premiums, higher*

- *A more important contribution to affordability and quality would be to allow health funds to pay for what they consider to be effective treatment outside hospital rather than creating incentives for admission.*

- *Brokers promoting comparison websites are major contributors to the shredding of community rating. They often make more money from encouraging people to shift to "cheaper" products than the consumer saves. They should be required to (a) disclose the commission paid on each sale (b) compare the commission the website receives with the saving the consumer gains and (c) which funds are NOT included in the comparisons.*

- *Unknown gap problems can be overcome by requiring hospitals to limit admitting rights to those doctors who agreed to accept health fund "gap" benefits in full payment, or limit their charges to health fund "known gap" rates. The hospital would be free to pay, out of its own income, doctors who it believed were entitled to above insured rates and who would either bring more patients to the hospital or provide more efficient and better quality treatment.*

- *Discounts for 18 to 29 year olds are unlikely to be successful and more likely to be counter productive. Indeed, rather than the twin goals of making health insurance simpler and more affordable the likelihood is they will make it more complex and expensive.*

- *Hospitals are likely to use 2nd tier arrangements to allow them to opt out of contracts and impose higher charges on individual patients, exacerbating current perceptions of lack of value. The government should insist that hospitals which opt out of contract only receive 2nd tier benefits if they agree to accept them as full payment, thus protecting consumers.(pp18-19)*

- *Higher excesses will further undermine community rating by continuing to cannibalise the system.*

- *the Government could achieve a much better and more affordable health insurance product by adopting the following recommendations(see pp 23-24):*

o *Restore the 30 (35/40 or older persons) rebate for hospital insurance products which cover all in-hospital conditions covered by Medicare, and treatments which avoid or minimize hospitalization. This should include GP or specialist services outside hospital if they are a clinically appropriate alternative to an admission.*

o *The rebate would be applied on a "break even" premium basis, i.e., benefits paid, administration costs (up to say, 10 % o benefits paid) and prudential requirements.*

o *a direct relationship between rebate and "break even" imposes a discipline on insurers to minimize administration costs and aim for realistic margins. To the extent funds may have strategic reasons for building reserves (or, if for profit, paying higher dividends) they will have to deal with this in a competitive marketplace.*

o *Products with exclusions do not qualify for the rebate. This would, in effect, restore community rating.*

o *Insurers could still offer exclusion products but these would not attract any rebate, nor remove liability for the Medicare levy surcharge.*

o *The Medicare levy surcharge should be increased to 2 percent, making PHI a rational alternative to paying the surcharge for higher income earners.*

o *Income from the surcharge should be redirected either to part fund the rebate or contributed to risk equalization.*

o *The government should recognize that one person's discount is a subsidy from another, and withdraw the proposed discounts for people under 30.*

o *Excess or front end deductible products at current levels ($500 single, $1000 family) which otherwise provide full cover could retain rebate eligibility as this would be unlikely to reduce total dollars in the risk pool. This would be easier for consumers, who are accustomed to paying an excess with other insurance, to understand than the proposed "bronze, silver, gold". Products with higher excesses would not be eligible for the rebate nor escape the MLS.*

o *A new "comprehensive" hospital product extended to cover for preventative dental and remedial physiotherapy services should be allowed and qualfy for the rebate. This would allow people cover for appropriate dental and physiotherapy services, within a hospital product, thereby minimizing adverse selection (more likely to apply in respect to stand alone dental/physio).*

o *Current waiting periods should be retained, protecting consumers from under insurance.*

o Coverage for other health care services would be optional for insurers to offer, but would have to be within a separately costed package from hospital or "comprehensive"cover and the additional premiums would not be eligible for the rebate.

o Risk equalization should be modified as outlined in the submission to reward activities which minimize hospitalisation.(p 16-18)

o Portability of benefit entitlement should be limited to the previous fund's contracted benefits for 12 months after transfer.

o More data should be available to allow GP's, health insurers, and ultimately consumers to ascertain provider performance and outcomes.

o Hospital entitlement to health fund benefits should be contingent on their ensuring patients do not experience any unknown medical gaps.

o Prostheses suppliers should be required to provide warranties for their products.

o Health funds (and public hospitals if they wish) should be able to enter into financial arrangements with GP's and other primary care providers to deliver care which keeps members out of hospital.

o Any perverse incentives which encourage admission to hospital for financial rather than clinical reasons should be eliminated.

o Proposals to cap premium rises to 2 percent a year would represent an attack on the private health care system.

Health Insurance: Restoring Affordability

Submission by Russell Schneider AM GAICD (former CEO Australian Health Insurance Association,) to the 2018 Senate Community Affairs References Committee inquiry into Private Health Insurance Legislation Amendment Bill 2018 and related Bills

As the former Chief Executive Officer of the Australian Health Insurance Association (AHIA) from 1983 to 2006 I welcome this inquiry into the latest measures claiming to provide a better health insurance product. Since retiring from the industry association I have maintained a close interest in private health issues. I have just retired after 12 years as a director of a major not for profit private health fund and remain a member of a public sector health board to which I was appointed in 2011, thus having an interest in both sides of our hospital financing and delivery system. However the views I express in this submission are totally my own and do not necessarily represent any organization with which I have been or am associated.

During my time with AHIA I was deeply involved with policies relating to private health insurance, and the record will confirm I either developed or was intimately involved in the development, promotion and passage of legislative measures which formed the four pillars of support for the private health system, reducing demand on the public health sector and ensuring those who wished to have private cover could afford to do so. The erection of these four pillars was an outstanding achievement which had a significant impact on affordability and made private health insurance a much more important part of the overall health system.

The four pillars to which I refer are essential, but unique, components of a well constructed financing system for private health care. They are the 30 percent rebate on premiums; the Medicare Levy surcharge; Lifetime Health Cover; and hospital contracting and medical gap cover. Underpinned by an effective form of risk equalization these four columns have provided Australia with one of the more unique and beneficial health insurance systems in the world: community rating.

Unfortunately these pillars have been crumbling for several years, largely as a result of Government action or inaction, but in part eroded by insurers and providers of care. The current legislation is no doubt a sincere attempt to restore a firm foundation for private health financing.

Unfortunately, however, the proposed measures are merely tinkering with the system. My very grave concern is not only that these “reforms” might not correct the situation, but may well make matters worse. As has been the case with many Government interventions in health insurance since the late 1960’s perverse outcomes all too often undermine positive initiatives.

One of the unfortunate aspects of many health systems, including Medicare, is the extent to which they involve perverse incentives. These drive up costs, encourage admission to hospitals, and rarely promote quality of care. The fact is Medicare is a payment system, not a health care system. This needs to change, and health insurance can and should be an essential component of that change. I doubt the current measures will create a better health care system. But they may make insurance more expensive.

This submission deals with the various initiatives in the legislation, but insofar as the author considers them inadequate proposes a range of more fundamental reforms which should be much more effective.

Affordability

Insurers, providers and consumers all complain about "affordability" of Private Health Insurance (PHI), but in terms of average household income, the average price of health insurance (including the PHI rebate) is in fact more "affordable" than in 1989. At that time, the "average" family premium) was 3.07 percent of average household incomes. At the beginning of 2017 it was (after rebate) 2.27 percent. (it should be noted, however, that reductions in the rebate over recent years are progressively reducing affordability which will inevitably drive people out of the private sector and put more pressure on public hospitals).

The problem isn't the "average" but the fact that successive Governments and insurers have allowed members to assess their own risk, and purchase accordingly. As a result the Government's website shows the spread of family premiums in NSW ranges from $1400 per year (virtually no cover) to more than $10,000.(top, top cover). This spread has come about due to the introduction of exclusionary policies which are contrary to community rating. In 1998 exclusionary products totalled 142,332 or 4.1 percent of total policies. By March 2017 they totalled 2.17 million policies, or 33 percent of the market.

This is unsustainable. The average cost for a family for full cover (both hospital and allied health services) in a genuinely community rated system should be around $2600-2800 p.a ($1300 per single).in NSW after rebate **(see Attachment 1**). Hospital cover alone should be about $2000-2200. The unfortunate fact is that, without Government action, community rating is collapsing and that is driving up the price of PHI particularly for those who need it most: the old, the sick, and the infirm. If community rating is to be restored it needs bipartisan commitment from all sides of politics. Those who are the first to exploit or complain about "rising premiums" should be the first to commit to restoration of community rating.

A community rated health insurance system imposes considerable responsibility on health fund managers, because they have to apply their efforts to minimizing costs without transferring risks to their members. It also requires a regulatory environment which assists insurers to contain costs rather than yield to pressure to increase them.

On the other hand "selective" or exclusionary products are the lazy manager's way of providing "cheap" premiums while correspondingly reducing coverage. Such "fine print" restrictions are bad enough in the general insurance environment, but when they extend to people's health care should be regarded by law makers as totally unacceptable. Health insurance should not be about making the policy holder carry risk. And, to the extent a person with an exclusion may have to go to a public hospital as a Medicare patient they undermine the principle that health insurance should reduce demand for public care.

This inquiry provides an excellent opportunity for all political parties to indicate their support, or otherwise, for community rating and in doing so achieve greater stability in affordability and remove the temptation for individuals to gamble, or be induced to gamble, on their health risk by buying selective products.

Community rating

Community rating is an unnatural insurance principle in that insurers cannot "underwrite", i.e., select and price those risks that they will cover. It means that every person can take out cover for

private treatment in hospital regardless of their age, sex, state of health, or potential health risk without a cost penalty. Premiums are set on the basis of a large pool of mixed risks. As a result people who would be uninsurable (or have to pay a high price) because of their health status are able to opt into the private health care system reducing demand and costs for taxpayers and freeing up public bed spaces for those who cannot afford or do not wish to take out private cover.

It is relatively unique to Australia, but combined with other Government measures, has led to large numbers of sick and elderly people being insured and being treated in the private sector—and therefore relieving demand on public resources. This is in marked contrast to the UK, for example, where insurance is "risk rated" and only 10-12 percent of the population (mostly low risk) have health insurance, or the USA where millions remain unable to be insured because risk factors make coverage unaffordable.

Community rating is the policy glue that binds private health insurance to Australia's overall health system.

Encouraging people to determine their own likely health risk doesn't really work, and if it did it wouldn't be insurance, for insurance doesn't mean betting on a sure thing: insurance is about uncertainty and unpredictability. Even genetic testing does not, and will not, establish every illness an individual is likely to suffer or the age or time at which it will occur. I challenge any member of the Committee to predict with 100 percent accuracy what their health situation will be in twelve months time, but that impossible task is being imposed on thousands of prospective health fund members.

The destruction of community rating (along with the rising costs of health care, which affect both private and public sectors) is one of the prime drivers of health insurance inflation. The creation of exclusion products has encouraged consumers to risk rate themselves. This not only creates under insurance but, ironically, also creates an inflationary driver within the private marketplace.

Exclusions make health insurance more complex, both to consumers, providers and health fund administrators, result in misunderstandings between funds, their members and providers as to benefit entitlements, and devalue perceptions of the product. All members pay a higher price to allow some to opt out of collective risk sharing. And as more and more are encouraged to opt out the position worsens. Rather than the healthy subsidizing the sick the sick are subsidizing the healthy!

Background:

When Medicare was introduced funds provided two levels of cover: "basic" which covered choice of doctor in a public hospital, and "supplementary" which provided higher benefits for private hospital care. The only selection a consumer could make was whether they wished to use a private hospital instead of being treated in a public one. Queuing in the public system made private cover attractive, as well as offering those who wished it to have a choice of doctor. Private hospitals saw this and invested in developing surgical facilities in the private sector, which now provides more services in many areas than the public system.

Naturally, with the introduction of "free" Medicare those who considered themselves healthy dropped out of the PHI system, and as community rated health insurance is fundamentally dependent on good risks subsidizing bad risks, prices rose.

In 1992, with the support of the then Government, Medibank Private, chasing good risks at low prices, introduced a new product "Select and Save" which allowed consumers to opt out of certain

treatments in private hospitals. In 1995 the Government opened the system further, allowing funds to exclude cover for certain types of care in both public and private hospitals. As one official commented to me at the time "we're going to stretch community rating till it breaks." He has achieved that objective.

As health care inflation continued and more surgery was being performed the industry progressively introduced more and more exclusionary products, inviting consumers to assess their own health risk. This increased the price of top cover and led to healthier members cascading down to lower cost products, or dropping cover. In effect these products have cannibalized the industry.

More risk pools, less risk sharing

What should have been two risk pools within each fund (hospital and ancillary) have become thousands. As Choice recently put it, there are 40,000 different health insurance products on the market today. That means, in effect, 40,000 different risk pools (indeed, there are probably more than 40,000 different products; one estimate puts the various combinations at 75,000). And the risk pools are now selected by individuals based on their own health assessment rather than being homogenous. Rather than sharing risk over large populations it is becoming concentrated in individual products.

The size of each risk pool within each fund has been reduced without affecting overall drawings significantly: i.e. consumers reduce their cover to treatments they expect they may need and exclude those they feel they won't. Thus a healthier person on a limited cover product will still draw the benefits they would use if on full cover, but pay a much lower price (and make a much lower contribution to the overall risk pool). Not only does the health insured community lose the cross subsidization that should occur between the healthy and the sick but benefit costs do not reduce and prices across the board rise.

This product fragmentation has forced the price of full cover products higher and higher, encouraging healthier persons to drop down to lower levels of cover targeted to their own health requirements or expectations, and this cannibalization of the fund forces prices of all its products up. The situation is compounded as funds, aggregators and the media deliberately encourage better risks to downgrade and eliminate cover "they don't need". (The most absurd example is the encouragement of older couples to take products which exclude maternity: as a result they are lured into products which comprise more older people who draw heavily without the compensating offset of younger members, and their costs are unnecessarily inflated. A single product which included all women, regardless of age, would be cheaper for all because it would provide a better spread of risk. Another example is the claim that "young people don't need joint surgery"….just tell that to young netball players, footballers, skiers, even swimmers and athletes etc.)

The Medicare levy surcharge was intended to minimize this problem by encouraging higher income earners to take out PHI or pay the surcharge. It was intended to be a measure of equity: to ensure higher income earners who chose to not be insured still contributed as much to the total health budget via a levy surcharge as those on much lower incomes who paid both levy and private health premiums.

Unfortunately marketing departments trying to recruit more members promoted taking out health insurance as a way of avoiding tax. As a result the industry response has been to increasingly offer "junk" products which cover virtually nothing at a price lower than the surcharge. This does allow individuals some tax saving, but does little or nothing to increase the overall pool. To hold the price

below the surcharge cost, Funds have stripped value out of their products, diminishing the overall attraction of private health care. In allowing them to do so successive Governments—indeed, the Parliament--- has compounded the problem . (Not all funds wish to offer these products: however it is generally regarded even by those who would rather not have them that they are necessary to remain competitive).

Unfortunately very few in the industry seem to realise this cannibalization is the source of pricing problems. All too often the decline in profitability is hidden by the fact that reduced cover products may appear to have high percentage gross margins and show high growth rates; but if this is converted to dollar net margins a quite different picture emerges: the lower priced products aren't profitable enough to cover total drawings, and prices of individual products are forced up increasing the propensity of consumers to only insure for what they expect to claim, which further inflates the price. That is not insurance. It is a form of lay-by. It represents adverse selection.

And, of course, brokers are paid commissions to shift bargain hunters between funds. The commissions plus benefits can, when closely examined, show members on these products remain unprofitable for some time, possibly years, after they are taken up.

The problem is even greater when those who have selected cheap cover find it doesn't cover them when the unexpected occurs. Young people do need hip and knee replacements (partly because of their activity) and they do have heart attacks. They should not be lured into Clayton's cover which excludes them when they need it most and are forced into the public system by default. This is neither socially acceptable nor economically sound. It devalues the product. It should be remembered that any form of insurance is about unpredictable risk, not a sure thing, but exclusion products effectively encourage people to invest in a "sure thing".

As Private Health Care, successor to AHIA, recently disclosed in its Annual Survey Report of High Cost Claims

- Health funds paid more than $6.4 billion in benefits for individual claims for which the benefit payment was more than $10,000 during 2016, representing an increase of 6.7% compared to 2015.

- Nearly half of all payments for hospital treatment by Australian health funds (45%) are now for claims where the benefit payment for the episode of care was more than $10,000.

- In total, health funds paid out 311,692 claims where the benefit payment for the episode of care was more than $10,000, the highest benefit paid being $406,566 for pancreatic cancer treatment

    - **more than 16,000 high claims (benefits exceeding $10,000) were paid for members under the age of 30 during 2016 . So an uninsured younger person could face crippling hospital bills if, like 16,000 others, they had a sudden, unpredicted illness.**

Although many do not realise it, young people are vulnerable to sudden, unexpected, high health costs, and it is in both theirs and the community's interests that they should be fully covered, including for mental illness, and not lured into low cost, low coverage insurance. This is another reason to restore bona fide community rating.

In relation to the legislative package I have the following comments:

Reform 1: "Gold Silver Bronze and Basic"

The Government's proposal to make products more transparent by creating "Gold, Silver. Bronze and basic" products (whatever that may mean) may or may not reduce the fragmentation of risk pools. Supporters of this proposal claim it is necessary to allow low cost level entry into the health insurance marketplace. This will only continue the problem of cannibalisation which already afflicts the system.

It will still encourage individuals to make a judgement on their own health status, forcing the price of cover --"Gold?"-- for those who are most likely to need it out of their reach. Healthier individuals will continue to be encouraged to guess their own health risk status and be able to opt out of participation in the overall risk pool. However they will continue to claim for the risks they have assessed themselves, and the $ margins on these products will continue to be marginal even though the percentage may be impressive. As a result the stratification of risk will continue and community rating will be undermined further.

This is not only inequitable but it also places more strain on the public sector, as these individuals would invariably have to be given higher priority for admission than many currently waiting for a public hospital bed. And it is unlikely to halt the decline in participation rates.

Genuine simplification of health insurance would see a single product covering all hospital admissions, with price competition being based on administration costs, investment policies, and profit/surplus targets, and capacity to negotiate better rates with providers.

Reform 2:Remove waiting period for mental health

Allowing a person requiring admission to a psychiatric hospital to upgrade their cover at the hospital gate would superficially appear to be a positive and compassionate measure, but as the explanatory memorandum itself concedes,

"Removing limitations on the number of mental health sessions or treatments a consumer can access will have an additional cost and premium impact, but that impact is unable to be quantified because it depends on the consumer and provider response, which are both unknown."

This provision is more likely to encourage under insurance, as most people will choose to use products with minimal or even no coverage for mental health, knowing that if they ever require admission (and few expect to) they can instantly receive full coverage. It will add to the tendency and the temptation to cannibalize the overall pool and drive costs, and therefore premiums, higher.

One does not need to be too cynical to expect that this will provide a very perverse incentive for providers of care to admit patients to hospital knowing that they will be fully covered. It undermines the overall package's commitment to improve affordability.

It is also likely to be misunderstood by many prospective purchasers who may think they can upgrade on admission for any form of care. And, indeed, why not? Why should an admission for mental health treatment be different from admission for a heart attack? Those who need admission for mental health treatment would be better served by the restoration of a genuine community rated system.

A more important contribution to affordability (and, perhaps, quality) would be to allow health funds to pay for what they consider to be effective treatment ***outside*** hospital rather than creating incentives for admission. For this reason I would support Reform 3:

Reform 3: Product Design Reforms –Improved Models of Care Working Group

This working group will provide advice to Government on options to replace admitted mental health and rehabilitation services which deliver inefficient care. I welcome the suggestion that It is expected that the issues and options identified by the working group may extend beyond mental health and rehabilitation to other areas which have admission rates that are higher than clinically necessary or inefficient.

For many years I have argued that confining health fund reimbursement for medical services outside hospital adds to costs without improving quality or outcomes. I am please the government says "*There is evidence to suggest that the existing funding arrangements for private health insurance provide inappropriate incentives for patients to be admitted to hospital for mental health and rehabilitation services when it may be more clinically appropriate and efficient to deliver services in a non-admitted or community based setting. This adds to the cost of care and leads to higher private health insurance premiums."*

There are many treatments outside mental health which can be effectively provided outside hospital, in doctor's treatment rooms or other, lower cost facilities. Our existing arrangements simply encourage admissions to higher cost settings for financial rather than medical reasons. This is compounded by doctor ownership of day surgeries and private hospitals. We should acknowledge that in many respects admission to hospital is a failure of the primary health care system, and rethink and redirect our funding mechanisms to encourage good treatment with good outcomes in the lowest cost setting.

Reform 4: Standardised Clinical Definitions

The explanatory memorandum suggests " *Introducing standard clinical definitions for both inclusions and exclusions will assist consumers in making an informed choice about private health insurance and what services different products do, and do not,cover*". This will be an interesting exercise, as those involved may find creating "clinical definitions" which the lay consumer can understand may be a challenging task, to put it mildly. Nevertheless it would seem a reasonable endeavor and should be supported, although I have no doubt the capacity of health fund marketing departments to continue "creative' product design will continue.

I note the Government believes "*private health insurance brokers will be impacted by these changes. It is likely they will need to update their IT systems and websites to reflect the new product category labels applied to products. "*

The growth in brokers using comparator web sites has exacerbated the problem of health insurance affordability and cannibalisation. Most comparators only provide comparisons between a relatively narrow number of insurers, each of whom pays a commission per member recruited. The business plan of most, if not all, these websites depend very much on encouraging customers to switch from one fund to another as they earn income (perhaps up to 12 percent of the premium sold) for each switch, or "churn" as it is known in the trade. In most cases the broker earns more in commission than the customer saves in premium.

At the same time as the Government requires website brokers to update their systems it should also require them to (a) disclose the commission paid on each sale (b) compare the commission the website receives with the saving the consumer gains and (c) which funds are NOT included in the comparisons.

This would be a major contribution to transparency in the sector and could well assist affordability as brokers would be encouraged to reduce the commission they charge the Fund to the saving they provide the customer! It would also help consumers understand that funds outside the websites clients may offer a better deal.

Reform 5: Improved access to travel and accommodation benefits for regional and rural areas

There are very few high level health care facilities in most regional and rural areas, so for many people the only treatment option is travel to a major centre or capital city. The certainty of being able to arrange treatment dates in a private facility rather than risk being turned away from a public hospital booking due to unexpected circumstances is a good reason for taking out PHI. However the cost of travel can be a very significant factor in deciding whether the cost of insurance plus travel may outweigh the benefit. Including the benefit in risk equalisation is a positive step to ensure community rating applies regardless of the insured person's location.

Reform 6: Information Provision Reforms

For many years well meaning politicians and bureaucrats have called for "improved consumer information", so it is not surprising this should be included in the package. Of course, a genuine community rated system without exclusions would significantly reduce the need for "improved consumer information." However I find it quite disturbing that the Explanatory Memorandum says :

"*The redevelopment of privatehealth.gov.au will help consumers to choose the best private health product for their health needs. Consumers will have a choice in how they elect to receive information as insurers will be able to use the minimum data set in whichever format the consumer prefers. The information can be tailored to individuals, which will be more meaningful for consumers".*

This will simply add to the problem of cannibalisation by encouraging consumers to look to products which meet their risk perception. In the name of improved information it will result in under insurance and further dissatisfaction with what should otherwise be an excellent product.

I note that the Memorandum says*:"Providing access to private health insurance product data will allow brokers to provide consumers with advice on products across all health funds."*

I would again suggest the Committee recommend that all brokers be required to advise consumers of the names of the health funds they do ***not*** represent and the commissions they charge.

Reform 7: Consultation on measures to support transparency of out-of-pocket costs

The Explanatory Memorandum says *"Out-of-pocket costs have been a long standing concern for private health insurance policy holders."* They have also been of extreme concern to insurers and, indeed, anyone seriously concerned with good public policy on health care since at least 1969 when the Gorton Government introduced the "most common fee" and flirted with a participating doctor's scheme.

Providing information to consumers on doctor's charges is at best a band aid solution to a hemorrhaging problem. Regulators have given lip service to the concept for many years, without

much success. The first problem is a reluctance on the part of a sick person to ask about financial matters, and once a patient has been referred to a surgeon they are understandably reluctant to query price. Gap cover was initially intended to resolve the problem, but resistance from the medical profession to coming to contractual arrangements with insurers on fees charged (even though these would have allowed individual doctors to secure higher fees based on performance and outcomes) prevented this from occurring. As a result insurers were forced down the "one size fits all" gap or "known gap" system, where benefits may vary by specialty but not by individual doctor.

A subsequent attempt was made by requiring hospitals seeking 2nd tier default status to ensure systems of "informed financial consent" were in place. This has not worked well either. While a house builder aggregates all the charges from sub contractors to give a quote to a prospective buyer, the same rules do not apply in the medical profession, and the "sub contractors"—anaesthetists, assistants, pathologists, etc insist on their right to separately bill the patient, often without prior advice.

A solution to this problem is beyond the capacity of health insurers. Successive governments have tried(sometimes) and failed (always) to take effective measures to end the problem of unexpected bills and unpredictable out of pocket expenses.

Governments invariably use the health insurance system to influence how the private health sector works, but this is at best a very imperfect device. However the Federal (and State) Governments do have considerable capacity to exert influence through their ability to licence (State) and declare private hospitals as eligible to receive health fund benefits (Federal). At the moment, however, this ability used to achieve policy objectives. Once a State Government licences a hospital it is virtually automatically recognized, without any substantive conditions being applied by the Commonwealth.

As the then CEO of the Catholic Health Care Association pointed out to a Senate committee many years ago, hospitals do not see patients as their customers: they see doctors as their customers. Nothing has changed in the intervening years.

If the Parliament was serious in wishing to eliminate medical gaps it would encourage the Government to use its power to declare hospitals (which means they are entitled to health fund benefits) to eliminate unexpected gaps.

Under this proposal hospitals would only secure recognition If they limited admitting rights to those doctors who agreed to accept health fund "gap" benefits in full payment, or limit their charges to health fund "known gap" rates. The hospital would be free to pay, out of its own income, doctors who it believed were entitled to above insured rates and who would either bring more patients to the hospital or provide more efficient and better quality treatment.
I suspect the unknown gap problem would disappear overnight.

There is another problem which remains to be addressed and that is the propensity of some specialists to charge "booking fees" which are not covered by either Medicare or PHI. In many cases patients are advised not to tell either Medicare or their health fund of this fee. This is obviously an attempt to by- pass gap arrangements and should be outlawed.

Reform 8: Discounts for 18 to 29 year olds

I find this the most bizarre proposal in the entire package. It is unlikely to be successful and more likely to be counter productive. Indeed, rather than the twin goals of making health insurance simpler and more affordable the likelihood is they will make it more complex and expensive.

Allowing health funds to offer youth discounts (paid for by older members) of between 38 cents and $2 a week for people under 30 isn't going to result in a massive increase in demand. And when they do turn 40 they'll baulk at the extra cost when the discount is removed. This policy is not only going to be ineffective today, but is set up for disaster in 10 years time.

But the real problem is not so much that it is unlikely to encourage a higher take up, but the fact that the discount can't be quarantined from more than 1 million (1 in 3 people in the 20-35 age group are already insured) existing members. Although the Government claims these discounts are "voluntary" the fact is once one fund provides a discount all will follow: to maintain purity would risk losing younger members who would be tempted to switch to gain the discount, and, in fact, actively encouraged by brokers and those funds that decided to offer the discount. So while it is unlikely to lure many new members into the system it will almost certainly create more churn.

To cover the loss in revenue the industry will need to recruit 100,000 and probably many more totally healthy new members (at least ten times as many as dropped out in the last 12 months); if it can't do that older, sicker members will end up paying more. Rather than improve affordability it is more likely to increase costs, certainly for older and sicker members of health funds. It is a further nail in the cross on which community rating has been suspended..

Reform 9: Prostheses List benefit reductions and reforms

The growing cost of prostheses has bedeviled the industry for many years. Just before my retirement in 2006 we thought we may have had the problem under control and the Government introduced a purchasing system which was based on the PBS arrangements of technical assessment and payment negotiation.

The problem is, of course, any saving for health funds and their contributors represents a loss to those who provide the service or the device, and in the case of prostheses both hospitals and device providers stood to lose considerable income if any purchasing or benefit arrangement worked effectively.

Prostheses suppliers and private hospitals will not take the impact on their profitability lightly. As the Department notes *" It is likely that private hospitals will seek to regain lost revenue through higher prices in their contracts with private health insurers*". If this proposal is to be successful the Parliament will need to resist pressure from hospitals to assist them negotiating higher rates: otherwise it will be a waste of effort. Unless the Government is very careful, hospitals are likely to use 2nd tier arrangements to allow them to opt out of contracts and impose higher charges on individual patients, exacerbating current perceptions of lack of value. The government should insist that hospitals which opt out of contract only receive 2nd tier benefits if they agree to accept them as full payment, thus protecting consumers.

One of the problems with many devices is the lack of any warranty. If a device does not work effectively the supplier may blame the doctor for failing to install it properly. When devices are faulty or need replacement the supplier does not usually meet the cost: the health fund is required to do so. The committee might like to recommend that device suppliers provide precise information

on the performance expectations of their products with a warranty to meet the total cost of replacement if it fails to meet their predictions.

Reform 10: Increasing permitted excess levels

Excesses are a more appropriate way of reducing health fund premium costs to price sensitive consumers than exclusion products as the policy holder's risk is limited to the size of the excess. They are also more easily understood as they are consistent with other forms of insurance. The question arises, however, as to how much of a reduction in premium is justified by an ever higher excess.

Higher excesses are more likely to be taken out by persons on higher incomes with less likelihood of needing treatment: in the unlikely (in their perception) need for hospitalization they can afford the higher excess. Increasing the excess will simply reduce the size of the risk pool, leading to higher premiums.

People on lower incomes, or lower health status, are more likely to need higher levels of cover: they may be more likely to be hospitalized, thus having to pay the excess, and less able to afford it. In my view the current excess levels are realistic and should be retained. As the Department itself points out, this proposal could have very substantial adverse consequences:

" Consumers who move to higher excess products will tend to be healthier people who do not expect to claim. With healthier consumers contributing less to the overall premium pool, insurers will need to ensure that aggregate premiums paid by all members remain sufficient to cover expected claims. Therefore, it is expected that insurers will need to increase premiums for consumers who choose to purchase zero or low excess products. Insurers may also choose to close zero or low excess products in order to manage adverse selection risks (that is the risk that these products will predominantly be purchased by those consumers who most frequently use their insurance). Consumers who previously held these products will benefit from paying lower premiums, but will face higher excess payments if they are admitted to hospital."

The above (Explanatory Memorandum, p 21) is itself a strong argument for retaining the status quo. In effect the Department is conceding higher excesses will further undermine community rating by continuing to cannibalise the system.

Reform 11: Removing coverage for some natural therapies

Health funds have generally been reluctant to cover most of the natural therapies which are proposed for removal. The main reason for providing cover has been an assumption that this would encourage lower claiming people to take out cover. More likely the take up of cover for these therapies is adverse selection.

Given the government proposes that private health insurers may still choose to fund natural therapies as incentives, which do not attract the Private Health Insurance Rebate the measure does not seem unreasonable.

Reform 12: Improvements to second tier default benefit administrative arrangements

When introduced the 2nd tier benefit was intended to encourage private hospitals to introduce simplified billing, informed financial consent, and meet high quality requirements. It is not clear that it has achieved that policy outcome.

What it has achieved is strengthening the bargaining position of private hospitals, especially large private hospital chains, who can rely on the 2nd tier benefit as a fall back when negotiating rates with health funds. As indicated above, a hospital can go out of contract and, as has occurred on a number of occasions, demand patients pay the difference between 2nd tier and their charges in advance of admission, blaming the health fund which may not be at fault. This leverage increases benefit payments which flow back to premiums.

The committee might recommend that any change to the administration of 2nd tier must confirm the original intent of requiring simplified billing and fully informed financial consent on the part of all providers, as well as meeting continually improved quality standards. If a hospital opts to be out of contract its charges must be limited to 2nd tier benefits during the dispute.

The above comments relate to the Bills in question. In the short term the Government could achieve a much better and more affordable health insurance product by adopting the following recommendations:

Community Rating

If confidence in the health insurance system is to be restored the Parliament cannot allow the ongoing destruction of community rating. Community rating ensures people who would otherwise have no choice but to rely on the public system can, if they wish, access private health treatment at a price they can afford. This affordability can be reinforced by returning to the original 30/35/40 percent rebate which assists older Australians, who are the greatest users of health care, to remain insured and access private care.

Exclusion products should not be entitled to any rebate from the taxpayer.

However the rebate is intended to benefit consumers. It was never intended to subsidise profits. It was never intended to flow on to health fund shareholders. Nor was it intended to allow health funds to unreasonably increase reserves. It should relate to **benefits paid** and necessary expenses incurred in maintaining the fund and ensuring its solvency…a "break even" position. The rebate should be limited to the original age based percentages per contributor of hospital and related benefits paid by each insurer plus an allowance of up to 10 percent for administration costs and an actuarily determined surplus margin necessary to maintain adequate reserve levels (roughly 3 -5 months contribution income). As the rebate is, for convenience, provided to insurers rather than direct to consumers, any amount in excess of the relevant percentage of benefits would be recouped from the fund at the end of each financial year. Contributors would continue to receive a 30, 35 or 40 percent rebate depending on their age.

How would this work? Take the following broad example: Health Fund A sets its premiums based on a total "break even"$100 million in hospital benefits, administration and actuarial surplus, and over the year claims $30 million passed on in rebates for its members. But if the funds breakeven payout is less than projected, making its total spend $95 million (benefits, 10% admin and actuarial surplus)

the Fund would repay 30% of its saving—i.e., the extra rebate amount of $1.5 million-- to the Commonwealth. If, on the other hand, claims are $5 million higher than expected the Fund receives an additional $1.5 million in rebates for its members. These adjustments could be made annually or, as with risk equalization, quarterly (noting benefit payments vary on a seasonal basis.)

Funds wishing to make higher margins would be free to do so, but this would be reflected in premiums and impact on their competitive position without added cost to taxpayers.

This would provide a positive incentive for funds to minimize administration costs, invest wisely, and maintain pressure on benefit outlays while contributors would still receive the value of the rebate. It would acknowledge the need for insurers to maintain adequate reserves which are essentially a protection for the contributor base while the building of higher reserves would be a matter for commercial judgement. A fund wishing to increase its reserves or pay higher dividends could do so, but would have to that into account when setting premiums Affordability would be improved and competition encouraged.

Competition:

Removal of "exclusion" and similar products would remove unhealthy competition and the incentive to "dumb down" health insurance as the combination of all-inclusive insurance and properly constructed risk equalization should make premiums relatively similar between funds. This should not stop Funds competing in other health related areas, however. Price competition would shift from product limitations to administrative efficiency, investment policy, and profit margins rather than risk being shifted from insurer to policy holder. Retention of an effective risk equalization system would discourage funds from attempting to "cream off" good risks to keep prices lower than funds which accepted older and sicker members. As well as allowing choices via FED's, **Funds could be expected to compete on the range and value of their non- hospital services, especially services aimed at keeping people OUT of hospital**. It would include what they may offer in respect of allied health service coverage and provision, and other member benefits which(for rebate purposes) would be costed separately from community rated hospital cover. Competition should be based on offering better cover, not risk selection by insurer or insured.

Better cover

Health funds remain trapped in a high cost environment. Successive governments have maintained Medicare's monopoly on payments for medical treatment outside hospital. As a result perverse incentives act to encourage admission to hospital rather than treatment outside.

This includes minor procedures which can, and often should, be provided in doctor's rooms or other settings. Health funds should be allowed to enter into arrangements with specialists, GP's and primary care organisations to provide services, including wellness and health maintenance services, outside hospital.

Today a health fund cannot pay a benefit to a GP to ensure a diabetic receives proper foot care. But if the diabetic's foot develops gangrene they have to pay for a hospital admission to remove the foot. This is absurd. It is not only financially intolerable but grossly inadequate health care.

Risk Equalisation

Insurers, particularly those who pay into the Risk Equalisation (RE) pool, demand it be changed, but it needs to be remembered RE is a fundamental component of community rating, and certainly

essential to ensure older, sicker people can be insured at prices they can afford. (Otherwise some funds would find ways of minimizing enrolment of older, sicker people, corralling them into higher priced funds. I vividly recall a consultant suggesting the best way insurers could reduce premiums was by having rock music played in service centres or locating those centres on the 2nd floor of a building without lifts!)

Nevertheless there is a flaw in the current arrangements in that any savings a fund may achieve via preventative measures tend to be lost, as any reduction in their overall benefit outlays reduces the amount they can claim from the pool (or increases what they pay in). As a result many Funds are reluctant to invest in Disease Management Programs (DMP) which avoid hospitalization.

(Risk equalization is intended to share the cost of people aged more than 55 between all insurers. Put simply Funds which have higher elderly membership, which results in higher drawing rates, are compensated by those which, by accident or design, have a lower age and risk profile.)

This disincentive to invest in hospital avoidance (and health improvement) services can be overcome very simply with a minor adjustment to the Risk Equalisation formula: include all eligible benefits (hospital AND DMP payments) in the total pool but remove from the single equivalent unit (SEU) count those persons enrolled in DMP programs from the deficit calculations in respect of both average and calculated deficit.

This is illustrated by the different experiences of Funds and A and B shown in the (very simplified) example in which Fund A has a substantially older and sicker population than Fund B. Before considering DMP the risk equalization situation) is as follows:

	Fund A	Fund B
Total seu's	100,000	200,000
Total eligible benefits	$250 m	$300 m
Avge benefit /seu($550m/300,000)	$1.83	
Calc deficit	$183 m	$367 m
Transfer	+$67 m	-$67 m

Suppose Fund A decides to invest $10 m in DMP for 10,000 members, which reduces its total eligible hospital benefits by $20 million, to $230 m, but the program costs $10 m so its total outlays on eligible members (hospital benefits +DMP program) is $240 m($250m-$20m= $230m +$10 m (DMP cost).

Assuming all costs of the DMP can be included in the risk equalization formula, the result is:

Fund A	Fund B	
Total seu's (non DMP)	90,000	200,000
plus	10,000 (DMP enrolees)	nil DMP
Total	100,000	200,000

Total eligible benefits (inc DMP)	$240 m		$300 m
Avge /seu($540 m/300,000)		$1.80	
Calc deficit	$180 m		$360 m
Transfer	+$60m		-$60m

After investing $10 m in disease management and reducing its direct hospital outlays by $20 million after risk equalization Fund A saving from DMP is only $3 million while Fund B's RE payment has reduced by $7million.So Fund B benefits more by not having a DMP while its competitor Fund A, invests in keeping members out of hospital!

Fund A may well rethink whether this is worthwhile. It would actually do better to cancel its DM programs and claim more from risk equalization.

But if the seu's enrolled in DMP were excluded from the count, while total eligible benefit costs (including CDMP) remained the result would be

Total non CDMP seu's	90,000		200,000
Total eligible benefits	$240 m(inc CDMP)		$300 m
Avge/seu ($550m/290,000)		$1.86	
Calc deficit (90,000 seu			
For fund A)	$166 m		$372 m
Transfer	+72 m		-$72m

Fund A receives a significant improvement which should encourage it, and its competitors, to invest in keeping their at risk members healthier and out of hospital, as Fund B, which hasn't invested in DMP's, is now paying more to Fund A. Fund B will find it worthwhile to invest in the same or better DMP's.

To avoid gaming, eligible DMP's would need to be approved by the Department based on advice from a relatively independent external agency: e.g., a panel including a departmental representative, a health economist, industry representative, expert in hospital avoidance treatments), and subject to regular audit. They would have to prove they reduced hospital admissions for the enrolled group without adverse results. This should, however, encourage providers to develop programs which do in face achieve better outcomes at lower costs, and as this should flow on to the public sector would benefit the health system overall.

Portability

Prior to the introduction of Medicare people were free to transfer between funds without waiting periods for the same level of cover, but were not permitted to upgrade without the same waiting period as new joiners. This worked quite well as cover was divided into basic and supplementary and the amount each fund paid was publicly available. A receiving fund could therefore limit benefits for the first 12 months after transfer to the amounts paid by the losing fund. This removed the incentive

for members or providers to arbitrage the system while allowing them to transfer without loss of their original entitlement.

Hospital and medical contracting has removed this transparency, and benefits paid are now strictly confidential (although they are reported to the Department). But while insurers do not know what their competitors have negotiated, providers, both hospitals and doctors, do know what each fund pays for each service and have an incentive to encourage patients to transfer from a lower paying fund to a higher paying fund virtually at the time of or immediately before treatment. This is unfair to existing members of the relevant fund as it distorts that Fund's expected drawing rates, from which its premiums are determined.

The problem is made worse if the parties go out of contract, at which time the providers can (and do) urge prospective patients to transfer to those funds with whom the provider retains a contract.

This can impose an unreasonable burden on any fund which does have a contract with the relevant provider as it is called on to pay the bills for a large number of new members, who may well transfer back to their original fund after the event. (It also acts in favor of the original fund which reduces its benefit payouts while the dispute continues).

Recommendations:

- Require the Department, on request, to advise a fund which has received transfers of patients of the amount the former fund would have paid the provider for the specific service in the 12 months after the transfer and limit the Fund's liability to that of the previous insurer.
- Make it a condition of recognition of private hospitals that they accept the former Fund's rates for 12 months after transfer and do not charge the patient additional fees (other than those involving FED's).
- Include all claims(regardless of age) made by those who have transferred from a fund once a contract dispute between their original fund and a private hospital has arisen to be included in risk equalization for, say, three to six months after the transfer.

Perverse incentives

Health financing is separated into three distinct areas: medical out of hospital, which is confined to the Commonwealth; medical in hospital (private patients shared between the Comonwealth and PHI) and public in hospital (where both medical and other costs are paid by the State which, in turn, receives Commonwealth transfers). This split payment system results in various perverse incentives all aimed at shifting cost from one payer to another. It also tends to drive treatments into the higher cost hospital arena, as neither PHI nor public hospital operators are positioned or permitted to pay doctors to keep patients out of hospital or to treat them in lower cost settings. Indeed, while they cannot pay medical benefits to keep patients out of hospital they are required to pay them when they treat them in hospital.

This provides an incentive to admit a patient who could be treated in a doctor's rooms (rebate 85 percent of MBS) to a day hospital facility (especially if the doctor owns the day hospital) where the combination of Medicare 75 % and health fund (25%) PLUS "gap" benefit pays significantly more.

Medicare is a payment system, not a health system. But the data it contains could be used to provide a much better, more efficient and more effective system if it could be harnessed to

encourage better treatment, earlier interventions to avoid hospitalization, and proper care at both primary and secondary levels.

Recommendation:

A data agency should be established to consider and report on how best to develop and analyse Medicare data from a clinical rather than financial perspective, and this should be combined with similar data from the health insurance industry.

Provider performance

Consumers and GP's are entitled to much more information about provider performance than they currently receive. Compared with other countries, particularly the USA and UK, Australia is taking baby steps towards providing this data to the public even though a wealth of such information is available but held within Medicare, health fund and Government departments.

In New York, for example, the performance and mortality rates of individual cardiac specialists is available to consumers, severity adjusted to eliminate the argument that the best doctors get the hardest cases. Even more information is provided about hospital performance. For example:

> *"hospitals where cardiac surgery is performed provide information to the Department of Health for each patient undergoing that procedure. Cardiac surgery departments collect data concerning patients' demographic and clinical characteristics. Approximately 40 of these characteristics (called risk factors) are collected for each patient. Along with information about the procedure, physician, and the patient's status at discharge, these data are entered into a computer and sent to the Department of Health for analysis. Data are verified through review of unusual reporting frequencies, cross-matching of cardiac surgery data with other Department of Health databases, and a review of medical records for a selected sample of cases. These activities are very helpful in ensuring consistent interpretation of data elements across hospitals. Mortality rate is based on deaths occurring during the same hospital stay in which a patient underwent cardiac surgery and on deaths that occur after discharge but within 30 days of surgery.*
>
> *Performance Categories: The risk-adjusted mortality rate (RAMR) represents the best estimate (based on the associated statistical model) of what the provider's mortality rate would have been if the provider had a mix of patients identical to the statewide mix. Thus, the RAMR has, to the extent possible, ironed out differences among providers in patient severity of illness, since it arrives at a mortality rate for each provider for an identical group of patients. If the RAMR is significantly lower than the statewide mortality rate, the provider has a significantly better performance than the state as a whole. If the RAMR is significantly higher than the statewide mortality rate, the provider has a significantly worse performance than the state as a whole.*

There are plenty of other examples of performance information given to consumers overseas.

In 1995 the Commonwealth introduced the Hospital Casemix Protocol which, in effect, requires private hospitals to supply health funds with extensive details of each episode, including length of stay, unexpected readmissions, etc. This information is also provided to the Commonwealth Department of Health which can, as a result, identify a wide range of performance indicators for every hospital. Individual funds can take this further by matching the HCP information with medical claims for their members. However no single fund has sufficient utilisation to obtain a total picture

of provider performance, and Privacy laws make its provision to the general public or shared between funds difficult if not impossible. The Department is able to consolidate this data and could, if it wished, provide considerable information to GP's, specialists, consumers and the general public about private hospital performance based on this regular census of activity. At the moment, however, Departmental reporting is confined to financial information: interesting, but not terribly useful in judging performance.

The HCP should be extended to include medical provider number as well as hospital, allowing either the Department or a specific agency established for the task to provide details of individual provider outcomes, which could then be collated and distributed either to providers for comparison purposes, GP to assist in referrals, health funds, and, once the accuracy of the information was achieved and accepted, the general public. This would allow consumers to determine whether charges were justified by likely outcomes. In addition Medicare could ask individual patients whether, six months after the event, they considered the procedure was worthwhile. Such information could well lead to a significant reduction in surgery that, from the patient point of view, has little real value.

Cost Containment

The Commonwealth has handed responsibility for health cost containment to PHI and the States, but denied them the capacity to achieve this. This cannot go on. Both State Governments and health funds have to be given freedom to achieve reductions in unnecessary health care costs by being allowed to encourage best practice, deal with perverse incentives, facilitate and fund alternatives to hospital admissions, and reward better health outcomes. The artificial division between in hospital and community/primary care has to be eliminated, and an environment which encourages providers to be rewarded based on outcomes and not outputs must be introduced.

Governments (and, by legislation, health funds) at both State and Federal level reward piece work. Fee for service payment may be justified in some circumstances, but in others it simply encourages the delivery of more services. Governments should be creating an environment which rewards excellence, and health insurers should be encouraged to set the pace because, unlike governments, they have to compete in the market place.

The Committee should note that under present rules health funds have very little capacity or opportunity to reduce health care costs. While their income is subject to control by government, no such discipline applies to providers, who are free to set their fees at whatever level they wish. If the Fund does not meet those charges the patient is forced to do so. Nor can health funds choose who they must pay. Minimum benefits are determined by the Government, all registered (by government) medical and hospital providers are entitled to be paid for every patient they can capture, financial incentives to encourage medical services which avoid hospitalization are outlawed. If health funds try to keep their benefits (and premiums) low it simply transfers costs to the patient. The system encourages admission and development of day care facilities (sometimes owned by doctors) to deliver services at higher prices which could be provided in rooms. Insurers struggle to achieve cost containment with both hands tied behind their backs. Little wonder that they move to "junk" products in a bid to recruit younger members even though they cannibalise their membership because the Commonwealth Parliament denies them the capacity to achieve genuine cost containment or reward better outcomes. This has to stop.

The cost of health insurance has to cease being a political football, and needs a realistic, sensible pragmatic and bi partisan approach by law and policy makers. The fact is any saving in spending on health in either the private or public sectors results in an equal loss to those who provide care, and, whether we like it or not, they will resist any such reductions and find ways around them. Care providers are very adept at the managed scare, and even more adept at winning political support. In my experience they find, one way or another, strong support from whichever political party believes it can gain advantage from backing their demands at both the State and Federal levels.

In the absence of a realistic bi partisan approach to achieving cost savings, then, In the short to medium term there is little real prospect of reducing the cost of health, whether in the private or public sectors, and this is a reality that politicians of all sides should be prepared to accept. The real prospect for reducing the cost of health is to look to, and encourage, the development of new models of care, those which emphasise prevention where possible and practical and offer lower cost alternatives to hospital admission. This inevitably involves greater emphasis on, and support for, primary care, which extends beyond the boundaries of Commonwealth medical benefits and the Commonwealth monopoly on payments to GP's. A hospital admission should, in many respects, be regarded as a failure of the health care system. Those providers who are able to provide lower cost care with better results should be rewarded, and those who cannot do so should not have their income underwritten by government decree.

Financial incentives drive behavior in health care as any other endeavor. The question is whether the current financial incentives drive behavior in the direction of a high quality health care system. I do not believe they do. They encourage quick GP consultations, use of the highest cost treatment centre rather than the lowest. Screening for all sorts of problems has become fashionable, but one must ask who really benefits? Those screened or those who make an income from screening more and more people, regardless of whether they are likely to benefit? Is screening which may encourage unnecessary interventions desirable?

One of the biggest problems in health care cost containment is the reality that providers of care can produce arguments to provide more and more services which increase their incomes, without necessarily producing better results. They are aided and abetted by a media more concerned with entertainment than seriously questioning the cost and benefits of the treatments they promote.

All too often the media and politicians embrace "new" and exciting interventions, placing pressure on both public and private systems to fund them: but rarely, if ever, do they insist on proper cost benefit analysis or validation of the claims of those who stand to gain financially.

Many politicians like to raise the issue of how many services are bulk billed without consideration as to what the outcomes of such services may be, or how many additional costs may be loaded into the system without any quality improvement or beneficial outcome. It may be politically useful or convenient to talk about bulk billing rates but it might make a greater contribution to health care to look at what financing mechanisms might achieve better outcomes. Of course, it is much easier for a politician to take the low road on these issues than try to argue for a genuinely better health care model. In the last resort providers will always try to "play the patient" by sending them a bill.

And we should remember medical costs are no real guide to quality: higher charges don't necessarily equal good outcomes. While it's important for patients to know costs, it's more important they (and their GP) know results, based not just on objective data but also on patient experience: there is no point performing a medical procedure which, while technically excellent, provides the patient with no perception of benefit.

Both health funds and local public health administrations need appropriate legislative backing to allow them to maintain and improve the health of those dependent on them at a cost the individual and community can afford. There is no logical reason why insurers (or public hospitals) should not be able to make arrangements with primary health care networks to provide services which avoid hospital admission while still achieving good outcomes, and sharing the savings that result. They should be encouraged to develop and fund models of care which reduce costs and achieve better outcomes. If the members of this committee have the wit and perspicacity to endorse such a policy approach the nation's health and its finances will benefit enormously.

In the short term the Government could achieve a much better and more affordable health insurance product by adopting the following recommendations (see pp 23-24):

- Limit the rebate to hospital insurance products which cover all in-hospital conditions covered by Medicare, and treatments which avoid or minimize hospitalization. This should include GP or specialist services outside hospital if they are a clinically appropriate alternative to an admission.
- The rebate would be applied on a "break even" premium basis.
- A direct relationship between rebate and hospital benefits (plus administration and prudential requirements) imposes a discipline on insurers to minimize administration costs and aim for realistic margins. To the extent funds may have strategic reasons for building reserves (or paying shareholders more) they will have to deal with this in a competitive marketplace.
- Products with exclusions do not qualify for the rebate. This would, in effect, restore community rating.
- Insurers could still offer exclusion products but these would not attract any rebate, nor remove liability for the Medicare levy surcharge.
- Restore the PHI rebate to 30 percent (35/40 percent for older persons) of hospital benefits paid, plus an allowance for administration and prudential requirements . This will pump prime affordability which has been affected by the reductions in the rebate. The reduction did not save as much as expected but has had a dramatic impact on membership.
- The Medicare levy surcharge should be increased to 2 percent, making PHI a rational alternative to paying the surcharge for higher income earners. This should ensure the 156,000 who paid the surcharge in 2016 rethink their insurance options rather than relying on the public system, and have a much better impact than offering discounts to people who don't yet see the product as worthwhile. It would add to the total pool and reduce pressure on premiums. Higher income earners would therefore be encouraged to "play or pay".
- Income from the surcharge should be redirected either to part fund the rebate or contributed to risk equalization.
- The government should recognize that one person's discount is a subsidy from another, and withdraw the proposed discounts for people under 30.
- Excess or front end deductible products at current levels ($500 single, $1000 family) which otherwise provide full cover could retain rebate eligibility as this would be unlikely to reduce total dollars in the risk pool. This would be easier for consumers, who are accustomed to paying an excess with other insurance, to understand than the proposed "bronze, silver, gold". Products with higher excesses would not be eligible for the rebate nor escape the MLS.
- Hospital cover could be expanded to "comprehensive" and include preventative dental and remedial physiotherapy services (with benefits or level of cover determined by individual

funds, ensuring competition on product design continued). This would allow people to obtain the rebate for appropriate dental and physiotherapy services, within a hospital product, thereby minimizing adverse selection.

- Current waiting periods should be retained, protecting consumers from under insurance.
- Coverage for other health care services would be optional for insurers to offer, but would have to be within a separately costed package from hospital or "comprehensive"cover and the additional premiums would not be eligible for the rebate.
- Risk equalization should be modified as outlined above (p 16-18) to reward activities which minimize hospitalisation.
- Portability of benefit entitlement should be limited to the previous fund's contracted benefits for 12 months after transfer.
- More data should be available to allow GP's, health insurers, and ultimately consumers to ascertain provider performance and outcomes.
- Hospital entitlement to health fund benefits should be contingent on their ensuring patients do not experience any unknown medical gaps.(p.18-19)
- Prostheses suppliers should be required to provide warranties for their products.
- Health funds (and public hospitals if they wish) should be able to enter into financial arrangements with GP's and other primary care providers to deliver care which keeps members out of hospital.
- Any perverse incentives which encourage admission to hospital for financial rather than clinical reasons should be eliminated.

This package imposes disciplines on all involved: governments, health funds, doctors, private hospitals, with a view to putting patients first. As is invariably the case those affected by such discipline will object, in many cases strongly. However the various parties should see it as being in their interests to have an attractive, affordable and equitable health insurance system which is sustainable. The above package improves the coverage for all concerned, both in terms of price and protection against unexpected events. It deserves the support of health consumers, private hospitals, the AMA and responsible health insurers

While the current legislation falls far short of a sensible response to the problems facing the private health sector, and therefore those who wish to access private health care, they have to be seen in the context of alternatives, one of which is the Labor Party's proposal to cap premium rises to 2 percent per year. This proposal is, at best, hazardous, at worst disastrous, unless a Labor Government was prepared to provide insurers with much greater capacity to control costs than has been the situation to date, and even then it is doubtful that health inflation can be kept to 2 percent per year (as a former Labor State Treasurer noted, health inflation runs at more than double the cpi). Previous Labor Governments were singularly unsuccessful in reducing cost pressures on those with private health insurance, refused to give insurers greater capacity to control costs, and there is no sign that current policy has changed. Labor's greatest contribution to private health insurance affordability was to reduce the 30 percent rebate forcing consumers to pay more and began the membership downward spiral.

If the measures proposed in this legislation are a band-aid on a hemorrhage, then a 2 percent cap on premiums would be equivalent to a power failure in an Intensive Care Unit.

The last time Governments attempted to cap premiums was in 1977 when then Prime Minister Malcolm Fraser ordered a freeze on rises pending an election. By election date the then largest fund in Australia, MBF, was reduced to less than 2 days reserves. After the election Fraser had no choice

but to lift the freeze, and, to ensure they had adequate reserves, the insurance industry was forced to make massive increases in premiums. This set in train a series of failed attempts to deal with affordability problems, destabilized the system, and led to the introduction of Medicare.

In the absence of any serious measures to allow health funds to achieve realistic cost containment, the proposal to cap premium increases to 2 percent per annum will be a disaster for the health system, public and private. It will lead to massive increases once the 2 percent cap is lifted. In the meantime, of course, a number of small not for profit funds and possibly hospitals may be forced to close.

If Labor is serious about imposing this cap it must spell out exactly what powers it will give to private health insurers to minimize cost increases, and guarantee it will support those measures despite resistance from health care providers. Will it, for example, limit price rises by hospitals, doctors, and medical device manufacturers to 2 percent or less? Will it put a cap on utilization, which in part determines total benefit payments? Will it also make a commitment that Federal payments to the States for hospital services will also be capped at 2 percent per annum?

I doubt whether the providers or the health service unions will tolerate such measures, but it is essential that the Labor Party clarify its position on this proposal.

Russell Schneider AM GAICD July 2018

Should the Committee wish I would be happy to answer questions on the above, however I would note that I will be unavailable from August 10 2018 till late September.

Attachment 1

Health insurance price comparison 1989-2016

	1989-90	2015-16
Total contributions	$2,979,865,595	$22,054,223,288
Total SEU	5,860,060	9,614,136
Average ann. Contribution/SEU	$508.36	$2294.90
(i.e., single premium, assuming drawing rates are as for the then existing population)		
Average household income	$33,075 p.a.	$145,400 p.a. (source ABS)
Av. Family cover (inc any rebate		
i.e., /seu contrib x 2-rebate	$1016 (no rebate)	$3304 (28% rebate avg)
Premium % average household income	3.07%	2.27%

SEU= single equivalent unit: family cover =2 seu's.

The above figures include income from hospital and general cover. Income from hospital cover is roughly 60 percent of total income. Assuming a 30 percent rebate, family cover in a genuine community rated environment should have been about $2000 per annum in 2016,or even with a 10 percent increase $2200 today.

In 1990 there was no Medicare surcharge, no rebate, no Lifetime Health Cover. Membership was relatively stable after the sudden drop in membership that occurred at the introduction of Medicare in 1984. There were no exclusion products, no 100 percent medical cover, few if any FED's. Premiums hovered around the community rated average: the major difference was between "basic" (fully covering public hospital, part cover for private, potential for very large "gaps") and supplementary (with private hospital charges often exceeding benefits, and significant medical gaps). But people paid more than 3 percent of their household income presumably because they valued the product.

And housing mortgage rates were 17 percent !

In 1992 Medibank Private, which had always set its sights on the youth market, introduced Select and Save, covering all conditions in public hospitals but excluding or paying only minimal benefits for some private hospital treatments, most commonly orthopeadics and cardiac procedures. (Ironically, much of the savings it achieved were taken away by reinsurance, but it created a new marketing concept which sooner or later was followed by other funds). That was the start of the slide which gathered pace in 1995 when legislation allowing full exclusion products was passed.

The expansion of exclusion products, FED's, and "tailor made" products has reduced the size of each individual risk pool. And because of the range of products rather than a single community rated premium the spread between lowest and top cover has widened. The Government website in NSW shows the spread is between $1400 (public hospital only) to $11,200 for full cover for a couple).