# Ensuring Seniors have Choice

*"It is in the community's interest, and the interest of younger members as well as older ones, to keep the pool of insured good risks at all aged groups as large as possible. The increased rebate will assist achieve this goal."*

Submission from the Australian Health Insurance Association to the Senate Community Affairs Legislation Committee reference December 1, 2004:

## Private Health Insurance Incentives Amendment Bill

1. The Australian Health Insurance Association welcomes this opportunity to support this legislation which provides an increased private health insurance rebate for Australians aged more than 65. AHIA is the industry Association representing 26 registered health benefits organisations which together cover 93 percent of the privately insured population. These funds also cover 95 percent of insured people aged more than 65.

2. The Private Health Insurance Rebate has been one of the most significant success stories in Australian health financing. Since its introduction in December1998 health insurance numbers have increased very dramatically, with the insured population now stable at more than 9.97 million people (50.2 percent of the population) holding some form of health cover and 8.67 million (43.0 percent) insured for hospital cover. As a result private hospital admissions of insured patients have increased equally dramatically, from 1.24 million in 1998, the year before the rebate was introduced, to 1.96 million in the 12 months ended September 2004. Total hospital admissions (public and private) by privately insured patients have risen from 1.50 million in 1998 to 2.25 million in the most recent 12 month period.

3. The increase in insured patient admissions has taken considerable strain off public hospitals. This reduction would have been even more striking had State Governments not continued to close public hospital beds despite increasing allocations of health funding from the Commonwealth Government. Despite these bed closures the ratio of public acute beds to uninsured persons is almost 0.5 beds per thousand greater than in 1998 (from 3.88 per thousand to 4.34 per thousand today).

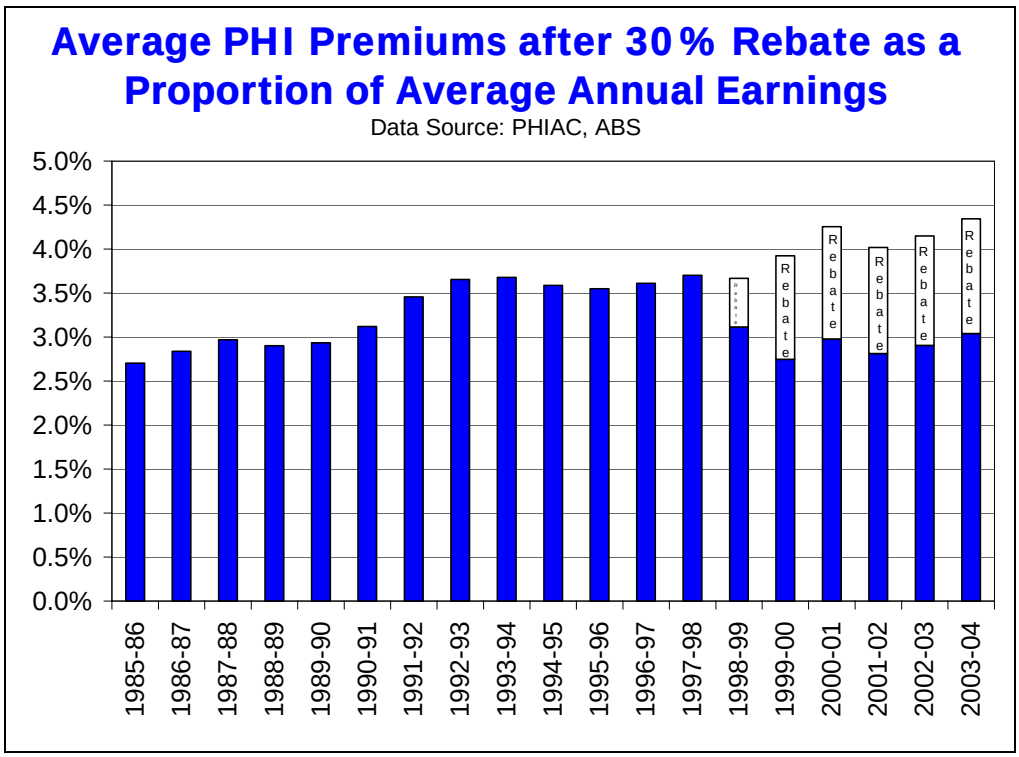
4. Nor can it be said that the treatments now delivered in private hospitals and funded by private health insurance are trivial. As the attached table shows, more than 50 percent of significant, and in many cases lifesaving, procedures, including chemotherapy are now performed in the private health sector. Many Australians can walk, see and in some cases remain alive as a direct result of the contribution of private hospitals, private health insurance, and to the extent it has assisted millions take advantage of private health options, the 30 percent rebate.

# Private Sector Contribution

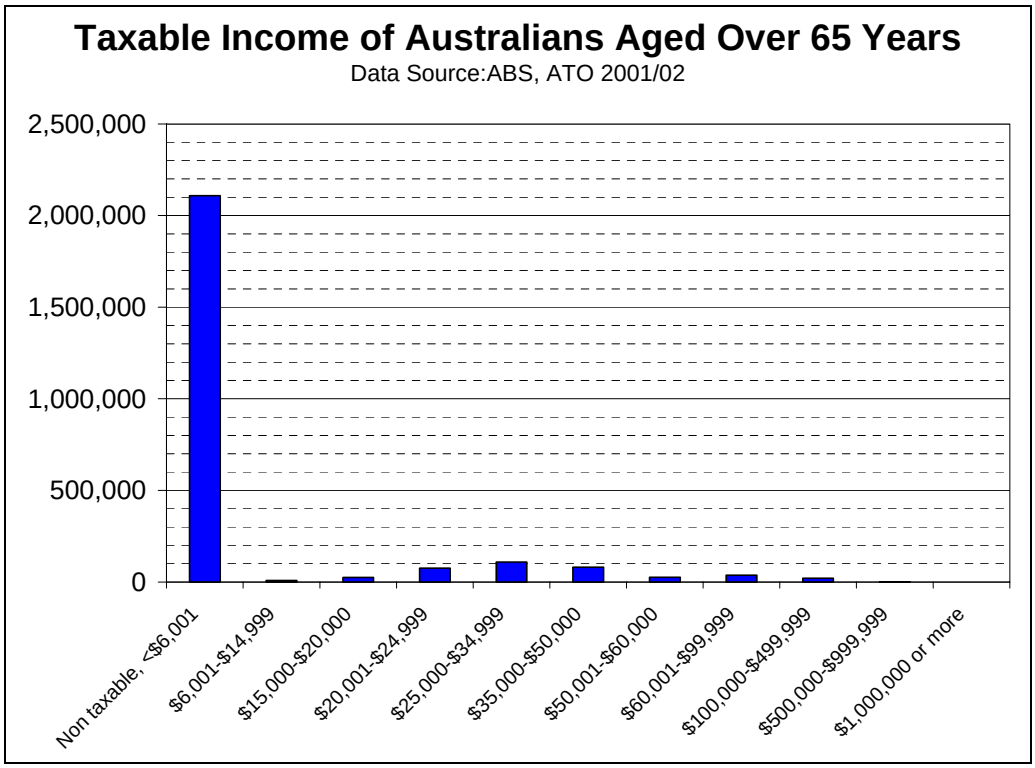
Selected Episodes: Proportion Performed in Private Hospitals
Data Source: AIHW 2002-03

| | |
|---|---|
| Chemotherapy | 52% |
| Major procedures for malignant breast conditions | 54% |
| Hip Replacements | 55% |
| Other major joint replacement & limb reattachment | 64% |
| Mental health treatment, sameday | 68% |
| Cataract operations | 70% |
| Major wrist, hand & thumb procedures | 71% |
| Knee procedures | 77% |

5. The rebate has had a very significant impact on the relative proportionate out of pocket cost of private health insurance for consumers. As the following graph shows, the average cost of health insurance as a proportion of average annual earnings has been reduced by the rebate to the level it was at in 1990/91. In other words the rebate now means that the average premium cost is 3.0 percent of average earnings, compared with 3.7 percent before its introduction. This increased affordability has made it possible for large numbers of people to remain insured or take it up (indeed, it was the improved affordability of health insurance brought about by the rebate which made Lifetime Health Cover possible).




6. This increased affordability has obviously benefited all participants in the private health insurance system, particularly older Australians most of whom are on relatively low and fixed incomes, and who in most cases have little opportunity or capacity to increase their earnings. Today more than one million people aged more than 65 have private hospital insurance (1,067,259, or 42 percent of the over 65 population). This is despite the fact that most are on very low incomes. The following graph showing the taxable incomes of people aged more than 65 years confirms that the overwhelmingly majority are on very low incomes.



7. In the year ended September 30 2004 health funds paid more than $2.3 billion for hospital care for people aged more than 65. However it should be remembered that they also contributed significantly towards their own health costs via premiums. AHIA estimates that the over 65 population pays more than $1 billion per year in premiums. Many have chosen high levels of cover, no doubt reflecting their own risk assessment or their desire to maximise choice, options and control should they need treatment.

8. People over 65 accounted for more than 3 million bed days in the year ended September 2004. The majority of hospital treatment for insured over 65's was in private hospitals, and about half the procedures involved an overnight stay. These are the people under the greatest potential financial strain with rises in contribution rates. They are also the people who benefit from private health insurance the most.

9. As premiums rise due to the complex of factors driving hospital costs, the cost to people on fixed incomes also goes up. If this leads to a situation where all people over 65 had to give up their private health cover the community would have to find at least $2.3 billion for their care and put even more strain on the public system. Given that such care would be taxpayer funded rather than based on voluntary contributions the likelihood is it would be matched by conditions and controls which would, at the very least, require people who were formerly insured to give up the choices and options which their insurance provided. The outcome would be both economically undesirable and socially inequitable, particularly for those who found, in their latter years, the choices they had struggled to purchase were to be denied. This was, of course, one of the fundamental flaws of "Medicare Gold."

10. An increase in the rebate, as proposed by this legislation, will help further cushion people over 65 against existing premium costs and against inevitable price rises brought about by health care cost inflation and developing technology. This will not only assist all people over 65 to remain insured, but it should also encourage the healthier people in this age group to retain their health insurance, thus maximising the benefits of community rating in which the healthier group in the population assist in cross subsidising the costs of the less healthy.

11. It should be noted that while age is generally seen as a proxy for risk, risk itself varies widely within age groups. Some elderly people may suffer a variety of illnesses and, in actuarial terms, be regarded as high risks, while others may be much healthier and use far less hospital and related health services than their juniors. Indeed, recent experience shows the benefit cost of people under 65 is rising at a faster rate than for those over 65: In the most recent 12 month period, the number of hospital admissions per person aged less than 65 increased by 14.4 percent, compared with an increase of 1.9 percent for those over 65. Similarly prostheses benefits paid per person for the under 65 age group rose by 18.4 percent compared with 13.2 percent for people over 65.

12. Health fund experience has always been that if prices rise beyond the community's general preparedness to pay the first to leave are those who consider themselves to be low risk. It is therefore in the community's interest, and the interest of younger members as well as older ones, to keep the pool of good risks at all aged groups as large as possible. The increased rebate will assist achieve this goal.

13. It should not be assumed that old people are the only "high risks" in the health insurance system. Very many large claims are paid to people under 65. Indeed, the odds of the stereotypical "good "risk, a male aged between 20 and 30, are still relatively higher, given that they have a one in seven chance of going to hospital this year, while females in the age group 30-40 have a one in three chance. The cochlear implant is frequently provided to young people at a cost of $21,300 for the implant and the initial speech processor alone. A variety of other devices are now commonly provided at younger ages, in many cases involving funds in long term liabilities. Some devices require replacement every few years, adding to this liability cost.

14. The impact of technology, both in benefits and costs, is no longer affected by age. Indeed it is likely that new technological innovations will apply as much to the younger as the older population. To put this into context, the highest priced cardiac prosthesis in 1988 was a cardiac pacemaker, priced at $4200, the then equivalent of 10 single average premiums. Today the most expensive cardiac device is a defibrillator priced at $49,000, or 50 average premiums. In other words insurers now need to recruit or retain 50 members who do not claim to cover the cost of one defibrillator…which may be replaced in a few years at an even higher price. Health funds accept their responsibilities in this area, but must make the point that these long term liabilities will have a significant impact on price which needs to be understood. This is all the more reason to ensure the prices paid for technology are no greater than absolutely necessary in a proper competitive market in which the regulatory environment neither allows nor encourages unnecessary cost inflation.

15. AHIA considers the proposed extended rebate for people over 65 as essentially a retention measure, aimed at encouraging and making it financially possible for older people on fixed incomes to retain their private health cover. To this extent we would expect it would have virtually no impact on prices charged younger age groups. Even if it did lead to some recruitment Lifetime Health Cover will ensure premium income from new entrants helps reduce the impact of their drawing rates on the overall pool. In any event we would not expect there to be such a great increase in new members (beyond what could be expected anyway) brought about by the new rebates to have much, if any, impact on price.

16. While ageing of the population does, of course, affect demand for and cost of all health services it is only one of a number of drivers, and if the Senate is seriously concerned about the price of PHI there are a number of very important steps which need to be taken. Inaction on, or resistance to these essential measures will have far more adverse impact on the price of health insurance than any rebate increase.

17. Senators are reminded that in the 21 years since Medicare was introduced the way medicine and medical treatments are delivered have changed dramatically. But due to largely ideological regulatory constraints, the way it is paid for in the private sector has hardly changed at all. As a result the private system is riddled with perverse incentives which prevent the efficiencies which should arise from allowing market forces to operate effectively, assist or encourage cost shifting, discourage activities aimed at prevention or reduction of illness, and add unnecessarily to costs.

18. Health insurance cost drivers are often complex and interlocking, where regulatory anomalies compound the natural increases in costs brought about by improved technology, innovation and increasing patient expectations. These currently include inappropriate utilisation, particularly including inappropriate settings; funding arrangements for medical devices which have created a seller's marketplace; legislative barriers to payment of benefits for medical services outside hospital, whether for acute or emergency treatment or for prevention; reinsurance strictures which discourage development of early discharge or post discharge arrangements and so on. In addition providers seeking higher benefits from funds frequently enjoy strong political support regardless of the cost to the consumer, with the same politicians who impose higher costs on health funds being the first to complain when premiums rise, often as a direct result of their own efforts.

19. The way to minimise private health insurance cost increases is NOT to deny an increase in the private health insurance rebate for older Australians. The way to minimise cost increases for all privately insured people is to change the regulatory environment to allow insurers to exercise more effective cost control measures without compromising quality or safety of care, and to permit them to more effectively provide services for their members which reduce the incidence, and burden, of disease.

20. Such measures would include, but not be limited to, the following:

    - Remove the 2nd tier default benefit. This simply provides a guaranteed minimum for providers and is used to leverage higher benefits in the negotiating process. It

    - Ensure prostheses purchasing arrangements apply genuine market forces and create greater price competition between suppliers, ensuring benefits are directed to bona fide clinical and cost effectiveness. While this can assist in reducing or slowing cost pressures, it does nothing to reduce the pricing power of monopoly suppliers. Consideration will need to be given to how consumers can receive the benefits of such technology at prices they can afford to pay. Allowing suppliers to set whatever price they believe the market—or part of it—can bear is unsustainable. AHIA is willing to support the current proposals to improve the prostheses negotiating process in the hope they will lead to a more effective funding system. However if they do not AHIA will have no choice but to seek changes which ensure health fund consumers are able to access the right technology at realistic prices.

- Provide funds with more data on hospital performance, both clinical and financial, to improve the negotiating process. At the moment hospitals are able to access exhaustive data about health fund financial performance, review Ombudsman data about complaints, and generally secure a comprehensive picture of a fund's position and activities which can be used, among other things, in direct negotiations. Funds are currently denied much of this information about individual hospitals and groups. Even publicly listed hospital groups only provide global information about individual hospital performance. Given the fact that hospitals inevitably point to their own cost pressures and the alleged inadequacy of benefits the provision of such data in publicly accessible arenas would provide both funds and the Parliament with much more information than is currently available, and this may assist in some ways to reduce growth in costs.

- Prevent hospitals abusing portability entitlements as a negotiating strategy in ways which were never intended. Recently a health fund and hospital endured a lengthy contract dispute which involved considerable negative publicity for both parties. Fund members were led to believe they would not be covered if they accessed hospitals owned or operated by the group in question and they were encouraged, actively or passively, to transfer membership to other funds with which the hospital group had long term contractual relationships. As a result the original fund lost a significant proportion of members who transferred to other funds which, under portability, were required to pick up liabilities for which they had made no provision. The head of the company concerned made no secret of the fact that portability was "fundamental" to the hospital group's strategy of forcing funds to pay higher benefits. If the Parliament is to allow hospitals or other providers to abuse portability of benefit entitlements to force funds to pay higher benefits the Parliament is responsible for higher costs to consumers.

- Improve reinsurance to allow health funds to provide cost effective treatment options which substitute or shorten hospital stays. At the moment insurers are unable to include many substitutional treatments, which may involve better care, in the reinsurance pool (which ensures the costs of people over 65 are shared between insurers). In some cases these may be provided from ancillary tables (e.g., physiotherapy, home nursing, etc). However the nett cost (including reinsurance) to the insurer of providing the service may, in fact, be greater than the cost of the patient remaining in hospital. AHIA believes a range of treatments could be included within the reinsurance system to the benefit not just of the fund providing the service but all participants in the reinsurance pool, as overall hospital costs should be reduced. These could include, for example, dialysis and/or chemotherapy in the home; intravenous therapy in the home; home births; palliative care in non hospital settings; occupational and or speech therapy for stroke victims; step down accommodation for members who, although medically stable, are unable to return home for social reasons; nursing care in the home to assist with wound management, dispensing of medication, and or general patient care.

- Allow funds to target benefits to treatments outside hospital when clinically appropriate to ensure they can be provided in the most appropriate and cost effective setting. This would eliminate current perverse financial incentives which offer a better financial outcome for both doctor and patient if, for example, a patient is treated in a day surgery rather than a doctor's own rooms.

- Support health fund activities which reduce or prevent the incidence of disease and/or avoid hospitalisation. Encouragement, including the removal of legislative barriers, for funds to provide health management style programs in asthma, diabetes and cardiac conditions, would yield very real benefits not just to the insured community and individual contributors but also to the public sector as many of the costs associated with unmanaged chronic conditions flows into government funded services like Accident and Emergency and GP services.

- Encourage the development of effective informed financial consent arrangements. The best way of doing this is to ensure that any medical bill which has not been agreed by the patient in advance cannot be subject to legal enforcement for recovery.

- Create greater awareness of Lifetime Health Cover among young, uninsured persons, particularly those about to turn 31. Market research indicates this age group is still relatively uninformed about the impact of LHC on them and the potential costs they may incur if they unwittingly postpone taking out PHI. More than 87,000 people currently paying a LHC loading are aged between 31 and 35, which suggests to AHIA that, had they been more aware of the situation, could have been avoided. To some extent this may be reduced by the implementation of June 30 as the deemed date for LHC birthdate purposes, which will allow funds to concentrate their own marketing activity more specifically. AHIA believes, however, that as Parliament has approved this measure all parties, including Government and its agencies, look to ways of ensuring young Australian citizens are better informed about their health insurance options and the impact of LHC on them.

- Support any industry proposals which would encourage the recruitment of younger, low risk members provided they do not impose unnecessary costs elsewhere. All too often members of Parliament, for what could be considered short term political gain, attack health funds for introducing arrangements which are specifically aimed at encouraging membership by young, low risk members. It would be helpful if such criticism could be preceded by consultation with individual funds and/or the industry to see what is actually intended rather than demonise the activity in the media without understanding the background.

- Consider ways of reducing compliance costs. Health funds are required to meet the costs, both directly and indirectly, of regulation and regulators, as well as dealing with regular changes to reporting requirements etc.

21. In conclusion AHIA repeats its support for the measure which we believe is aimed, specifically and sensibly, at reducing the cost burden of retaining private health insurance to the most vulnerable groups in our society, i.e., people aged more than 65 on low and/or fixed incomes. AHIA does not believe this will have any significant cost impact on other health insurance consumers or prospective consumers, and indeed consider rather the reverse, should the measure be rejected and older people be forced to pay more for their health insurance than would be the case if the measure is approved.

**R. Schneider**
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**Australian Health Insurance Association**
**7 December 2004**

**Appendix A:**

**Example 1**

*Bill (65) and Mary (67) have hospital cover with XYZ Health insurance. Under the current system of private health insurance incentives Bill and Mary receive a 30% rebate on the cost of their health insurance. If the cost of Bill and Mary's hospital policy is $2,000 per year, under the current arrangements Bill and Mary would pay:*

*70% of $2000 = $1400*

*Under the proposed amendment Bill and Mary would pay:*

*65% of $2000 = $1300 (ie 35% Rebate via Government)*

*So Bill and Mary's direct cost is $100 less under the proposed amendment. Therefore their PHI cover would be more affordable.*

**Example 2**

*Duncan (75) and Patsy (70) have hospital cover with XYZ Health insurance. Under the current system of private health insurance incentives Duncan and Patsy receive a 30% rebate on the cost of their health insurance. If the cost of Duncan and Patsy's hospital policy is $2,000 per year, under the current arrangements Duncan and Patsy would pay:*

*70% of $2000 = $1400*

*Under the proposed amendment Duncan and Patsy would pay:*

*60% of $2000 = $1200 (ie 40% Rebate via Government)*

*So Duncan and Patsy's direct cost is $200 less under the proposed amendment. Therefore their PHI cover would be more affordable.*

**Example 3**

*Bob (83) and Nancy (80) do not have hospital insurance. If they decide to purchase cover under the current system of private health insurance incentives Bob and Nancy are entitled to a 30% rebate on the cost of their health insurance. If the cost of Bob and Nancy's hospital insurance is $2,500 per year, under the current arrangements Bob and Nancy would pay:*

*70% of $2500 = $1750*

*Under the proposed amendment Bob and Nancy would pay:*

*60% of $2500 = $1500 (ie 40% Rebate via Government)*

*So Bob and Nancy's direct cost would be $250 less under the proposed amendment. Therefore their option to purchase PHI cover becomes more affordable.*

**Example 4**

*Mark (70) and Julia (66) do not have hospital insurance. If they decide to purchase cover under the current system of private health insurance incentives Mark and Julia are entitled to a 30% rebate on the cost of their health insurance, but as they were born after 1 July 1934 they are not exempt from the Lifetime Health Cover provisions and must pay a loading on their premium.*

*If the cost of hospital insurance is $2,500 per year, Mark and Julia must pay a 70% loading on their premiums at a cost of $1,750 – a total cost of $4,250 .*

*Under the current arrangements Mark and Julia would pay:*

*70% of $4250 = $2975*

*Under the proposed amendment Mark and Julia would pay:*

*60% of $4250 = $2550 (ie 40% Rebate via Government)*

*So Mark and Julia's direct cost would be $425 less under the proposed amendment. Therefore their option to purchase PHI cover becomes more affordable.*