PHIIA
Private Health Insurance Intermediaries Association Inc

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Private Health Insurance Intermediaries Association

Submission

Review

of the

Private Health Insurance Industry.

Date: 4th December 2015

PHIIA was formed to establish and implement standards for independent intermediaries, agents and brokers selling health insurance on behalf of registered health insurance organisations, and to represent the industry in the development of that standard.

The following is a response provided on behalf of the Private Health Insurance Intermediaries Association (PHIIA), a Not for Profit organisation guided by a **Code of Conduct** which members are signatory to and are assessed against.

PHIIA membership includes the vast majority of Health Insurance Retail Brokers, Corporate Brokers, and other Intermediaries.

The future of private health insurance

While short-term reform is important, these consultations are also seeking to explore long-term, strategic reform options. This includes questions of what the role of private health insurance should be in our mixed system; whether insurers should be financial organisations or service providers; and what is the best way for the Australian Government to support the private health industry.

We are seeking your views on the future of private health insurance, and what stakeholders and the Government need to do together to achieve that vision. The intent of the consultation is to have a positive, solutions-based discussion focussed on ways to deliver an affordable and sustainable private health industry that delivers value for money to consumers.

Key areas for discussion

1. Improving value of private health insurance for consumers, including through the consideration of changes to regulation.
2. Broader system reform including the Reform of the Federation (RoF) and Primary Health Care Advisory Group (PHCAG) and mental health processes – implications for private health insurance.
3. Stakeholder directed discussion on possible private health insurance reform options.

Issues for discussion

Information and complexity

Many consumers have expressed concerns about the complexity of private health insurance products and the lack of information provided by insurers. The ACCC has also highlighted concerns about this issue.

Can the complexity of policies be simplified and information be provided to consumers in a more transparent and convenient way to allow informed choice? If so, how?

PHIIA believes that:

- The core complexity is in the system not the products. For example, having the highest level of hospital cover has no impact on whether the customer needs to pay a surgeon a medical gap of $100 or $5000, or whether they pay a significant fee upon entry to a Private Emergency Room, or whether they secure a private room or the right to rehabilitation following a procedure.
- If complexity can be reduced without removing choice for consumers, then well and good. However if reducing complexity is about singular hospital products that are comprehensive, then such a change will add massively to the affordability problem. It is critical that the consumer is given choices about what is to be included and/or excluded on their policies. Policy diversity allows consumers to find policies that match their need at an affordable price. For example: single males or female pensioners are able to purchase a policy that excludes pregnancy or young people can keep the premiums down with cover that excludes joint replacements or cataract surgery. "Simplifying" private health insurance policies risks depriving consumers of a level of choice for which they have indicated a need.
- Procedures are either 'included', 'excluded' or 'restricted'. The category of a 'restricted benefit' is not well understood or explained. Whilst this level of cover can provide a useful benefit for consumers, particularly people in regional areas without access to private facilities, the implications of having a 'restricted' benefit are not well explained by the funds. It would be helpful to have an industry wide definition that funds could share with consumers.
- Ambulance cover is poorly explained by insurers and it is difficult to be certain whether the insurer will pay for an ambulance service or reject the claim. One fund limits the number of ambulance services to a single use per customer each year, which seems to run against the community rating principal. Again, an industry definition would be helpful and given the modest cost compulsory inclusion of a comprehensive cover as part of a hospital product would remove the ambiguity.
- Intermediaries play a critical role in breaking down the complexity for consumers. They are better placed to do this when compared to an individual fund, because they represent the consumer and once they understand their needs they can help to identify and explain suitable policies from the 6-8 funds they typically work with. The PHIIA Code of Conduct provides a regulatory framework through which intermediaries are held accountable for training and education of their staff to ensure that the fullest possible range of options is presented to the consumer. It is largely for this reason that comparators have been so successful in recent years, adding value by allowing individuals to more closely match product with need. Brokers also provide this service in the form of consultation to corporate clients.
- There is a definite need to provide the public with more information on the nature of the medical Gap, and for its impact on the consumer to be clarified.

Exclusionary products

Some health insurance policies have exclusions or restrictions. This means that particular services are not covered by those policies. In 2014-15, the number of policies for hospital cover that exclude certain medical services and also require patients to pay an excess and co-payment increased significantly. These consultations will explore the pros and cons of exclusionary products.

Are exclusionary products currently delivering value for money to consumers?

PHIIA believes that

- Insurers should be allowed to sell products with higher excesses and co-payments. The $500 per person and $1000 per policy was set as an upper limit >15 years ago. These amounts should be at least doubled. This will allow insurers to reduce premiums for customers who are prepared to pay the higher excess. Impact of this is that people will take policies will fewer exclusions.
- Restrictions can indeed cause consumer confusion, and exclusions are also often a very grey area. However, with the ever-increasing cost of the health system as a whole – and therefore also health insurance – they are necessary to allow members to make a choice about how to manage the cost of their cover. The issue is mainly in the area of consumer understanding of restrictions and exclusions, rather than a generic problem with the restrictions and exclusions themselves.

Effective use of Government incentives

There are three major Australian Government incentives in place to encourage take-up of private health insurance: the Private Health Insurance Rebate; the Medicare Levy Surcharge; and Lifetime Health Cover. Some stakeholders have suggested that the current rebate model is not effective in supporting the affordability of private health insurance.

Is the current government funding model of the Private Health Insurance Rebate maximising the benefit for consumers? If not, what other models could be implemented to maximise the benefit to consumers?

PHIIA believes that

- The PHI Rebate should be maintained. Without it, Hospital cover would become prohibitively expensive for a greater proportion of the lower-paid, placing an increased burden on the public system.
- Removing the rebate from ancillary products would see a massive decline in the use of these services, while the use of these services actively reduces costs being incurred elsewhere in the system. For example, dental cover encourages regular attendance at the dentist, and the link between poor dental health and chronic disease is well documented. Similar links exist between back pain and productivity, dietetics and obesity etc. The subsidy in Australia to ancillary is relatively modest, but critical to the overall PHI value proposition and to general health. Ancillary being critical to the value proposition of PHI is particularly true for the 'healthy' people who rarely use the hospital cover. Losing them would have a disproportionate impact on the system.
- Lifetime Health Cover (LHC) loading is an effective mechanism to encourage people to take insurance when they are younger. The unintended consequence is that older people and migrants who have been here for more then 12 months are 'locked out' because the premium is prohibitively expensive. This was made considerably worse when the previous government decided to remove the rebate on the loading component of the cover. PHIIA suggest a moratorium in which people who don't have hospital cover can take it out without a loading, and for people who have cover with a loading can have the loading removed or reduced if there cover is at a minimum level. I.e. a cover that includes all or most hospital services.
- The erosion of the rebate level, together with the annual changes to the rebate; add further confusion to the consumer's comprehension of the overall offering.
- Encouraging corporate Australia to provide health insurance to employees would provide another avenue for increased system participation. The current model does not take into account corporate funded programs and provides a barrier to funding rather than an incentive. The rebate model at the moment means that if a company funds to Tier 3, the consumer collects on behalf of a company, since it does not take into account who is paying for the insurance.
- Corporate Australia could play a greater role in the health of the nation if the restrictive impact of FBT on premiums were to be removed. While on the one hand, assistance with PHI premiums might be seen as a "fringe benefit" to the employee, the bigger picture would recognize the value in providing a more health-conscious workplace.

Value for rural and remote consumers

These consultations should consider how to maximise the value of private health insurance for rural and remote consumers, who often question the purpose of having private health insurance when it can be difficult to access private hospital services.

Are rural and remote consumers currently getting value for money from private health insurance? If not, how could this be improved?

PHIIA believes that:

- Rural Australia does not get value for money from the current system, and this is related to access.
- A significant cost for rural PHI is when transport/accommodation needs to be taken for a carer to accompany the patient to the city.
- Rural communities often don't get access to private hospitals or ancillary providers. Better access to triage services over the phone through private health insurance tele-centres would help considerably. A rural product could be created at a lower cost that would be targeted to this group of people.

Aboriginal and Torres Strait Islander people

These consultations should consider how to maximise the value of private health insurance for Aboriginal and Torres Strait Islander consumers.

How could private health insurance be improved for Aboriginal and Torres Strait Islander people?

PHIIA believes that:

- Yes PHI could be improved for the Aboriginal and Torres Strait Islander people
- With a population close to 700,000, only 20% live in remote and very remote areas. The majority live in major urban and inner regional areas. Therefore the issue is again about access at a fair value.
- PHI could be improved by being more responsive to the cultural issues affecting access to care. This could involve registered health funds, supporting distinct services within private provider practices.
- By the government and registered health funds getting a better understanding of the health of the Aboriginal & Torres Strait people, i.e. by utilising the OCHREStreams portal developed by the Improvement Foundation, which captures data from over 320 providers in the Aboriginal and Torres Strait Islander sector. This data could/should be used to enhance policy development and quality improvement strategies to not only "Close the Gap" but also improve access to services, both public and private.

Private patients in public hospitals

Many insurers offer policies that only cover patients for treatment in a public hospital. Some stakeholders have argued that these policies are inconsistent with the objective of reducing pressure on public hospitals and do not provide value for money.

Do these policies adversely impact public patients in public hospitals? Is there any value in them for consumers?

PHIIA believes that:

- Policies that only offer cover in a public hospital are a tiny percentage of the total policies in the market and an even smaller percentage of the policies that are sold.
- Private patients rarely chose to attend a public hospital. Rather, some Doctors direct them to a public hospital. Further ambulances are often not prepared to take patients to private hospitals even where the private hospital has an emergency department. Bureaucratic issues will often preclude or extensively delay the transfer of a patient from a public to private hospital.
- Private patients only interrupt services to public patients to the extent that the hospitals will advance their elective surgery in order to realise the revenue benefits that private patients give them. It's an interesting example of how an organisation funded by the States can indirectly access funds from Insurers and the Federal Government. To make this attractive to patients they will often waive the excesses payable under the policy.

Prostheses listing and reimbursement processes

Insurers are required to pay a benefit for all prostheses listed on the Prostheses List, with that benefit set by the Prostheses List Advisory Committee. The prostheses listing process is administratively complex. Stakeholders have raised many issues with the Department, including that the process results in inflated prices which are passed onto consumers in premiums.

Can these processes be improved to decrease the costs being borne by consumers through premiums and gaps, while still offering consumers access to appropriate prostheses? If so, how?

PHIIA believes that:

- The Prostheses List Advisory Committee requires a thorough review of their process to ensure excessive costs are not borne by insurers and consumers. Further orthopaedic surgeons are amongst the group of surgeons most likely to charge consumers excessive booking fees, and further visibility of these practices should be made available.
- Improving the relationship (through policy development & joint working parties) with the AMA, and the specialist Colleges who can exert considerable influence over the costs increases at a workforce level.

Risk equalisation

Some stakeholders have suggested that the current arrangements reduce the insurers' incentive to manage their own costs and focus on prevention.

Can the risk equalisation arrangements be improved to increase the incentive for prevention and, at the same time, not inflate premiums for consumers? If so, how?

PHIIA believes that:

- Insurers in Australia don't currently play an active role in improving the long term health of the nation and this is because the current system doesn't support, promote or incentivise this. Insurers need to be incentivised to manage health risks over the long term. This would provide them with motivation to put health management programs in place. Again, corporate Australia could play a huge role in this if incentivised. In other markets around the world, corporates and insurers are engaged in improving health outcomes for their membership base as they can see a return on investment in doing so.
- By improving joint activity between the Government (Federal and State) to encourage more public private partnerships not only in the Secondary sector but also the primary sector. With the roll out of the PHNs there is a wonderful opportunity to take some bold steps in building partnerships between the public and private sector if managed properly.
- To reduce the high cost hospital interventions, primary care should be rewarded for playing a more active role in prevention and maintenance. This is particularly true for the 2% of the insured population who account for 50% of the hospital outlays. Insurers should be allowed to incentivise practitioners to do this.

Coverage of selected non-admitted hospital procedures

Private health insurance does not routinely cover medical services that are provided out-of-hospital. Some of these services were previously provided to admitted hospital patients, but due to developments in clinical practice can now be provided in outpatient, community or home settings. Some stakeholders have suggested that private health insurance should be able to cover these services. They have also suggested the division between admitted and non admitted services adds to confusion over what is and is not covered by their policy.

Would consumers benefit if private health insurance was able to cover non-admitted hospital procedures; for example, private hospital emergency departments, renal dialysis, radiation therapy, medical oncology or chemotherapy?

PHIIA believes that:

- Yes, private health insurance should definitely look to include the listed services. When a patient is seeking these services they are at the most need and insurance should cover them for this.
- There is confusion and the line between a covered procedure and one that isn't often appears to be arbitrary. Further in order to have a procedure covered by insurers there may be over servicing, e.g. admission as a day patient where the procedure could have been done in the Drs rooms. There is considerable confusion because health insurers are not able to cover the costs associated with attendances at Emergency Departments, and these directly lead to people choosing to attend public hospital Emergency Departments.

- Patients with chronic conditions should have their primary care covered by their insurer. At a very minimum the insurer should fund someone to co-ordinate their care.
- Non-resident coverage usually provides a higher return on out-patient services than Medicare does and when a non-resident becomes a resident and switches cover they are usually surprised by the minimal coverage provided in this area.

Purchasing / contracting arrangements

These consultations should consider whether there are hurdles to innovative purchasing / contracting arrangements for accommodation and services in hospitals, prostheses and devices and out of hospital ancillary services. One example raised by stakeholders is default benefits - levels of reimbursements that insurers are required to pay in instances where a hospital does not have a negotiated contract with an insurer. While these were designed to assist stand-alone rural and regional hospitals with which insurers may not have wished to contract, some stakeholders have

suggested that their application to all hospitals places an artificial restriction on contracting, leading to inflated private hospital prices and premiums for consumers.

Do the current purchasing/contracting arrangements deliver value for money for consumers? Can these be improved? Are there hurdles or impediments to innovative purchasing / contracting models for hospital and out of hospital services which add cost to consumers' premiums and out of pocket expenses?

PHIIA hears few complaints in relation to this. Medical Gaps associated with hospitalisation is a more common cause of angst.

Other regulatory issues

Insurers are subject to a range of regulations through the Private Health Insurance Act 2007. Stakeholders have raised premium increases and the Government's role in annual premium setting as an issue. These consultations will consider the effectiveness of the current regulatory regime and how it could be improved.

What regulatory issues are driving up costs to consumers of private health insurance? Can these be addressed? If so, how?

PHIIA believes that:

- The inability to provide policies with higher excesses or co-payments and excesses is driving up the cost to consumers.
- Regular changes to the system hold back health funds from reducing operational costs.

Broader health system reforms

These consultations will need to consider private health insurance reforms in light of other current health system reform processes the Government is undertaking, including the Reform of the Federation, the Primary Health Care Advisory Group, and mental health reform.

PHIIA believes that:

From a Corporate perspective

- Thought should be given to corporate Australia and how we incentivise employers to take a more active role in promoting health management to lower lifestyle related diseases and ultimately reduce claims.
- Thought should also be given on the current rebate and incentives systems. Could we remove the obstacles for companies funding health insurance (such as the FBT)? When we are looking at rebate structures we need to take into account the fact that a corporate might be sponsoring the plan.

From a Population basis

- The current system of funding the public health system is now out dated and flawed. The issues of State and Federal responsibilities re the funding of services causes duplication and cost shifting, and patients bouncing around health providers. Capitation funding as close to the patient as possible is a solution for "bending the cost curve" and also bundling of services to those who most need care. This should be a shared responsibility with the private sector as well. If a service cannot be provided in the public sector then it should be purchased from the private sector.
- Australia has lagged behind many countries in regards the development of an electronic health record, the work of NEHTA is both "sketchy" and slow. However the building blocks are there, with regards standards and interoperability. It will now take leadership and especially consultation with the medical profession and the often excluded groups involved with Allied Health Professionals Australia + of course consumers to take this forward. Whilst we acknowledge there are privacy risks; the daily deaths and massive cost associated with not having medical records are of far greater concern.
- About 25% of PHI top claimers have mental health problems resulting in a revolving door with institutions, long term care and a variety of providers. The bundling of care and an emphasis of supportive strategies is well called for. PHIIA recommends closer ties with PHNs to initiate care. A revisit by the Commonwealth on the *positives* gained from the "Coordinated Care Trials of the 1990s" would not go amiss.
- Insurers should have a responsibility to reviewing claims and working with state and national governments to improve health outcomes for the population. Only through long term projects and support will we see any long term change with a lasting impact on claims and costs in the health system.

Additional Comments:

- There should be an investigation into the 'booking fees' being charged by surgeons. PHIIA members are regularly told by consumers that they need to pay several thousand dollars to engage the services of a surgeon. These payments are over and above the fees paid by Medicare and the insurer and exist even where the Dr has a 'known gap' or 'no gap' arrangement with the health fund. They have the impact of undermining confidence in the system and putting further pressure on the public system.
- The GP referral system prevents consumers shopping for value for their surgery. A referral should offer several options due to variances in costing. There should be clarity and disclosure between doctor and specialist for the consumer
- Funds should provide more notice of their intention to negatively change a product.
- The GAP with some funds is extremely high considering they all work off the same MBS

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For further information or clarification.

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