



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



Pre-Budget Submission 2017-18

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EXECUTIVE SUMMARY

Australia's mixed private - public health system is highly regarded by the Australian community. The private and public sectors are intrinsically interconnected and private health insurance is embedded in Australian culture. 84% of Australians with private health insurance value the product and want to keep it.

Our health system is also well-regarded in terms of clinical outcomes. We enjoy the fourth highest life-expectancy in the world and are among the best in terms of other outcomes like infant mortality. 65% of the population believe the quality of the health system in their State or Territory is very high.

There is concern among Australians however around the issue of health system sustainability. 44% of people believe the mixed public and private health system will not be around in 15 years, and 52% of people are not confident the public hospital system will be around in its current form in 15 years. This unease is driven by the fact that inflation of health input costs have risen at a rate much higher than CPI over the last decade, which in turn increases pressure on premiums and in turn household budgets.

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

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

Australian health funds are acutely aware of the need for budget repair, and are not asking for one dollar of additional government funding. Funds are asking however that every dollar of waste in the sector is reduced or eliminated, and every piece of toxic and outdated regulation reducing market transparency and competition is removed to put downward pressure on premiums and consumer out-of-pocket costs. As part of the process of improving the consumer experience in private health, health funds have committed to working with government on mechanisms to help consumers choose and use their health insurance. PHA member funds have made a considerable financial investment in this already.

This Budget submission identifies practical and achievable policy adjustments that will ensure the sustainability of the Australian health system in to the future.

The PHI Rebate

In the late 1990s, following an economic downturn the hospital system was in crisis. To stabilise the PHI market and give public hospitals a chance to recover, the Howard Coalition government introduced a package of reforms: Lifetime Health Cover (LHC); the Medicare Levy Surcharge (MLS); and, the 30% PHI Rebate.

In recent years there have been multiple variations to the regulations governing the rebate aimed at controlling government outlays in this area. These include:

- means-testing introduced in the 2009-10 Budget;

- indexation to CPI, uncoupling the rebate from premium increases legislated in 2012;
- removal of the rebate from LHC loadings, announced in 2009-10 Budget; and
- freezing of the income thresholds for rebate eligibility and the MLS at 2014-15 levels through 2017-18.

The net effect of these measures is to slow the growth of PHI rebate outlays, and in fact, taking into account a decline in numbers of people with rebate-eligible policies, expenditure on the rebate is expected to decline not increase with time. The impact of indexation of the rebate on consumers cannot be underestimated. The impact of non-full indexation of the rebate on premiums is essentially compound interest at the difference between general CPI and health/premium inflation. If health inflation continues at the same rate, the value of the rebate as a percentage of the premium will be 16% in a decade.

Health funds appreciate the need for budget repair and are not at this stage arguing for restoration of the rebate in its original form. We do however strongly assert further hastening the phase down of the rebate will be detrimental to affordability of PHI for Australians already experiencing financial stress.

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

The Commonwealth Protheses List

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

A 2015 report commissioned by the industry, "Costing an Arm and a Leg" determined if Australian public hospital prices are used as a benchmark, \$800 million is being wasted per annum on excess benefits paid for medical devices. The report estimated two thirds of this waste was going straight to Wall St in excess profit for the large multinationals dominating the Australian medical device market. During 2016 Budget negotiations, PHA supported the Federal Government's phased approach to correcting regulations fixing medical device prices and agreed to pass on all savings as a reduction in the 2016-17 premium round. This process should now be fast tracked.

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

The second-tier default benefit

The second tier default benefit, introduced in 1998, is the level of benefit payable by a health fund for an episode of hospital treatment provided by an eligible private hospital facility with which it does not have a negotiated agreement. The second tier default benefit is 85% of the average charge for the equivalent episode of hospital treatment under that health fund's negotiated agreements with comparable facilities in that State or Territory.

When introduced, the Government believed health funds' larger market size allowed them too much negotiating power over private hospitals that were less concentrated in terms of market share. The aim of the second tier default benefit was to support smaller providers, and re-balance market dynamics between health funds and private hospital providers. By 2003, the balance of negotiating power shifted back to private hospital providers, with Ramsay Healthcare and Healthscope holding 37% market share at this time.

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

In a market environment where there are almost no controls on the introduction of new hospital beds, the second tier default benefit is anticompetitive and inflationary on premiums.

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

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

Public hospital (State Government) cost-shifting

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

For most patients attending a public emergency department, using their private health insurance is not a premeditated choice, many patients are signed up after they are admitted. The end result is PHI policyholders are now subsidising the costs of public hospitals, despite having already contributed to these through their taxes. In FY14-15 the PHI industry provided 2.1% of all public hospital funding.

This has been growing at an average rate of 12% every year since 2009, driven by two factors: the number of public hospital stays charged to PHI per consumer, growing at 7.5% per annum; and the historical increase in PHI membership, growing at 3% per annum. Public hospital cost-shifting to health funds adds more to premium costs than the average year's premium increase.

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

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

Premium round deregulation

As a result of health cost inflation, premiums have increased at an average rate of 6% year-on-year between 2007 and 2015. Today, the Federal Government regulates the PHI industry's overall premium increase through a centralised review process, whereby each health fund applies to the Minister for Health for approval of all premium changes. These proposed changes are submitted by health funds in November, and closely scrutinised by the Minister, the Department of Health and the Australian Prudential Regulation Authority (APRA) prior to public premium change announcements towards the end of February, with changes taking effect 1 April.

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

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

Review of Lifetime Health Cover settings

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

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

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

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

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

Longer-term measures

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

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

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

Some of the regulatory measures that apply to the private health sector are no longer relevant and have inflated costs and decreased the efficiency and transparency of the sector. Addressing the measures outlined in this submission does not require any additional funding but will reduce waste, increase competition and put downward pressure on premiums and consumer out-of-pocket costs. PHA estimates if the over-regulation of private health insurance was addressed as above including reform of the Prostheses List already commenced, health fund members would save just over \$1.5 billion a year on premiums as a result of increased competition and transparency.

BACKGROUND

Australia's health system in its current form ('Medicare') has, since 1984, successfully comprised both publicly funded and private elements as part of its fundamental design. Commonwealth and State governments contribute funding to public hospitals where treatment is provided free of charge, and through the Medicare Benefits Schedule (MBS) provide reimbursement for services provided by private doctors and certain allied health professionals. Private health funds insure for treatments provided in private hospitals and some treatment in public hospitals on top of that, and in addition, the fee-for-service system builds in the potential for doctors to charge a co-payment as part of or above a scheduled fee-for-service.

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

Private Health Insurance (PHI) is embedded in Australian culture, it has persisted for over 150 years since the introduction of the friendly societies from the UK, which were mutual structures designed to spread the risk of health care costs over a community of the young and old. 84% of Australians with private health insurance value the product and want to keep it.¹ This is because of the control it gives them over the timing and location of medical treatments in hospital, and the security of knowing one fully trained health professional is responsible for their care, in contrast to a shift worker for example.

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

There is concern among Australians however around the issue of health system sustainability. 44% of people believe the mixed public and private health system will not be around in 15 years, and 52% of people are not confident the public hospital system will be around in its current form in 15 years.³ The underlying dynamic behind these numbers is inflation of health input costs, which have risen at a rate much higher than CPI over the last decade. The impact on household budgets of rising health costs, perceptions of strain on the public hospital system like rising waiting times and reports of poor outcomes mean people are acutely aware the status quo may not be sustainable under current economic conditions.⁴

For example, in the year 2014-2015, health system input costs (incorporating hospital accommodation costs of 7.6%, medical specialist gap costs of 7.1%, medical device costs of 9% and allied health costs of 6.3%) rose by close to 8%. In the same year household incomes rose by just 1.8%. In 2016, to take account of this health funds were awarded an average premium rise of 5.59%, and public hospitals were awarded a 6.5% annual funding increase through the COAG process. In 2015-2016 a slowing of the economy has meant 'health' inflation has eased slightly so that input cost growth is currently around 5-6%, but this is still well above the Consumer Price Index and household income growth.

The ratio of health expenditure to GDP has remained reasonably stable at 9.8%, which is average for an OECD economy. Over the last decade however, health expenditure has tended to grow

^{1, 2, 3} IPSOS Health Care and Insurance Australia survey 2015 (n=5500).

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

faster in real terms than GDP, with an average annual real growth of 5.0% being 2.2 percentage points higher than the 2.8% for GDP.

The strain on the health system has manifest itself in two ways which impact health fund members, the first is the increasing consumer contribution to the cost of health care through premium increases and rising medical out-of-pocket costs. The second is through public hospital waiting times, which have more than doubled since the turn of this century.⁵The average waiting time for non-emergency treatment in a public hospital is over 100 days Australia-wide, with waits for many procedures like joint replacements extending for over a year in some States.

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

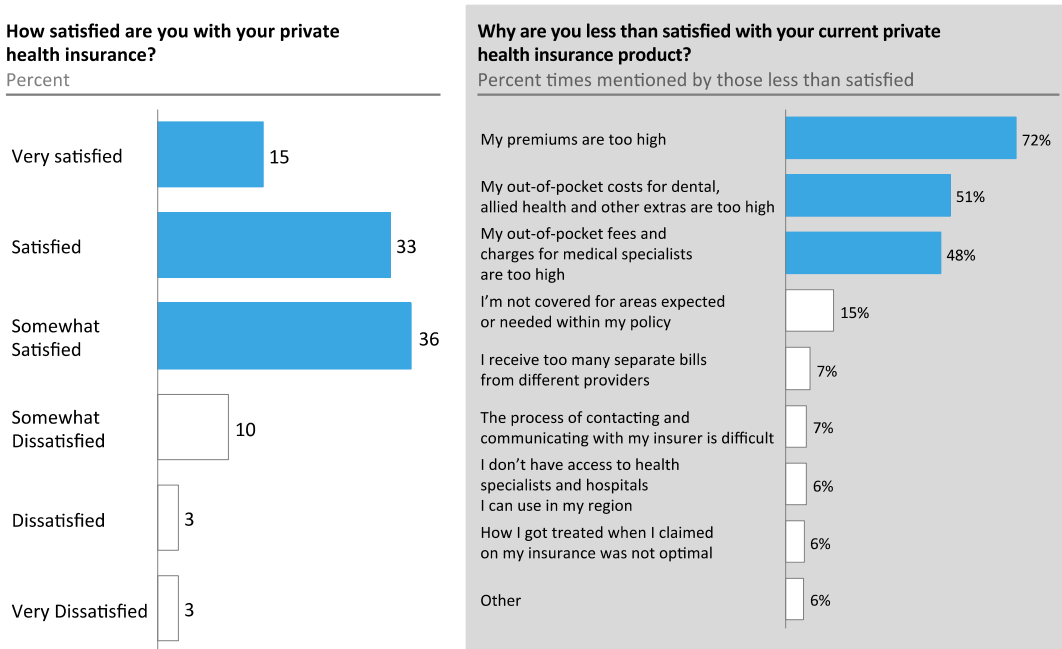
Utilisation of health services has increased dramatically as a result. Improvements in health technology have tended to add to health costs, not substitute for them, leading to a situation where the majority of health expenditure on a single patient occurs in the last year of their life. In the 1960's public hospitals had wards filled with 'very old' 50 and 60 year olds who were expected to die shortly after retirement age. Now the average age of a hospital medical patient is in their 80s.

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

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

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

Most people are satisfied with their PHI, but affordability is a problem



SOURCE: PHA Consumer survey 2016, n=2,384

In response to consumer concerns about affordability, health funds have increasingly created entry level, and life stage appropriate products with particular exclusions like pregnancy and diseases of old age. While this has increased uptake in younger cohorts and spread the claims risk, it has generated a level of complexity in the system, which has created confusion for consumers at the point of purchase, and also the point at which they use their health insurance. It has also led to concerns about whether PHI offers value for money.

On the value question, industry data confirms close to two-thirds of non-emergency surgery is funded by Australians with private health insurance, 90% of day admissions for mental health care and 50% of all mental health admissions, 70% of joint replacements, 60% of chemotherapy and 88% of retinal procedures take place in the private health sector. In addition, under ancillary (extras) cover, health funds pay out more for dental care than the federal government. For every \$1 collected in premium income, an average of 86c is passed back to consumers in benefits.⁶

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

The PHI Rebate

In the late 1990s, following an economic downturn and a banking crisis in particular impacting the Southern States, the hospital system was in crisis. Public hospitals had been hit hard by funding cuts and the rapid introduction of activity-based 'Casemix' funding as a savings measure. They

⁶ Australian Prudential Regulation Authority (APRA) Private Health Insurers operations Report Data 2016.

were struggling to recover and were experiencing waiting list blowouts, industrial action and significant quality and safety problems. Newspaper headlines reported '20 000 avoidable deaths per year' in Australia's public hospitals.

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

At this time regulation permitted a person to join a fund for the first time late in life when they were certain to claim, and pay the same premium as a young person who had just joined. Multiple double figure premium rises were common in a 12 month period and hospital cover fell to an all-time low of just under 30% of the population. Both small and large funds required intervention to stop them falling over. Government market research estimated that over 700 000 people on full pensions were going without food and other essentials to be able to maintain PHI cover because they knew they were going to claim.

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

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

Together market research estimates these measures underpin 75% of demand for PHI⁷, and successfully stabilised uptake of private health insurance at its current level of approximately 50% of the population.

Since the introduction of this regulatory regime, there have been multiple variations to the regulations governing the rebate aimed at controlling government outlays in this area.

These include:

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

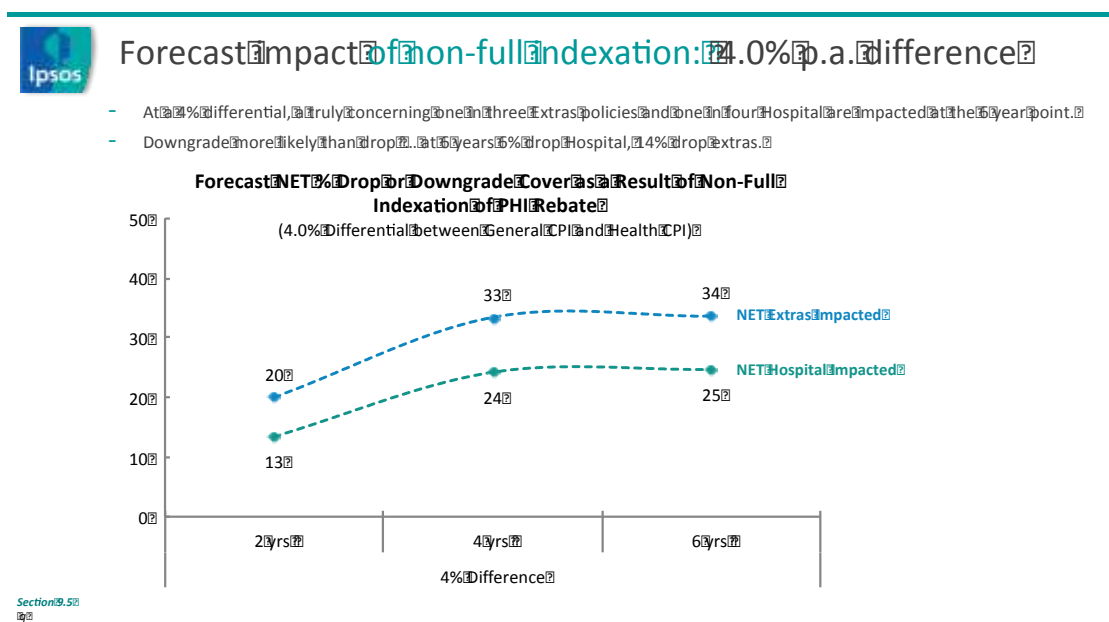
⁷ IPSOS Health Care and Insurance Australia survey 2015 (n=5500).

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

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

IPSOS has used consumer behaviour survey work to model the impact if the difference is 2.5% and also 4.0% over a 6-year period. At a 2.5% differential, one in four extras policies and one in five hospital policies are dropped or downgraded at the 6 year mark. At a 4% differential, a truly concerning one in three Extras policies and one in four Hospital are impacted at the 6 year point - this is the most likely outcome if nothing else changes.

Exhibit 2: IPSOS Price Impact and Consumer Reaction simulation model 2015



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

The combined effect of the PHI rebate budget measures is complex, and as a result the quantum of expenditure on the rebate is frequently misunderstood and misquoted in the public domain. The most common errors greatly exaggerate the level of government expenditure on the rebate.

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

1. Assuming the rebate is still 30% of the premium. The introduction of means testing has resulted in many PHI customers receiving either a significantly reduced rebate or losing their rebate entirely. In addition, the rebate is indexed to CPI, and given the gap between CPI and health inflation, it is actually diminishing as a proportion of the premium. Even at the highest tier, the rebate is currently just under 27% of the

premium and if nothing else changes, this will diminish to 16% by 2026;

2. Assuming the rate used to index the rebate is higher than it actually is. The PHI rebate is indexed by a Rebate Adjustment Factor (RAF) representing the difference between the Consumer Price Index and the industry weighted average increase in premiums. The CPI factor for 2014 is **1.0275**. The industry weighted average premium increase for 2014 (including rate protection) is **6.20%**. The RAF for 2014 is **0.968**. Frequently statements have been made like 'the rebate is indexed to CPI which is 3%';
3. Quoting forecast rather than net (actual) expenditure. This occurs because the rebate can be claimed in two ways, first as a discount on the premium, and second as a tax deduction in the annual tax return. During the year, if income is higher than expected, resulting from freezing of the thresholds and bracket creep, a number of people need to pay the money back. These clawbacks are aggregated by the Australian Taxation Office (ATO) and published in its annual report the year after the health budget estimates are reported. For example, in the year 2013-14 the forecast figure for rebate expenditure was \$5.5 billion, but the net expenditure published by the ATO the year after was \$3.7 billion;
4. Assuming the number of people with rebate-eligible policies will continue to grow. For the first time in 15 years PHI regulators have detected a fall in the percentage of people with hospital cover, and this does not take account of people downgrading to cheaper policies because of affordability concerns. Even taking population growth into account, this impact is eroding expenditure on the rebate.

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

The PHI rebate on 'Extras'

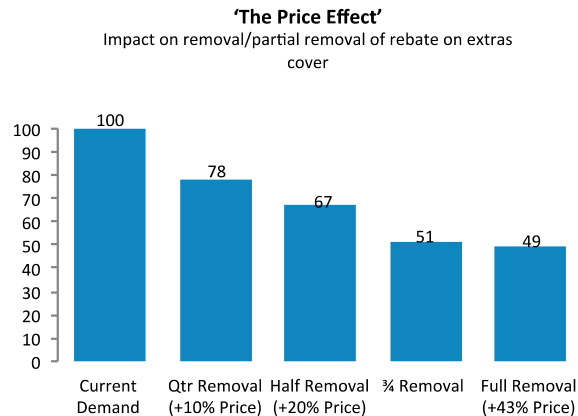
The PHI rebate is payable on any complying health insurance product (CHIP) that provides hospital treatment, general treatment (also known as ancillary or extras) cover or both. From time to time, government and other stakeholders have proposed removal of all or part of the rebate on the general treatment component as a savings measure. There is no evidence that such a proposal would work in practice or realise any Budget savings.

There are a number of risks in taking this approach. It would increase the complexity of an already complicated measure. The second is the use of extras cover to deliver value to younger people who are less likely to make hospital claims, but who derive considerable value from cheaper access to dental and allied health services in the community. It is worth noting that when asked about choosing a health fund for hospital cover, many consumers mention attributes related to extras cover, which reinforces the relevance of this product to consumers. Maintaining coverage in this age cohort is critical for the funds to be able to spread their risk. The third is undermining support for dental care, of which health funds are a major funder and provider.

The immediate consequences of the removal of the rebate on extras can be seen below. This equates to a price increase of 37%, which will cause a halving of the demand for Extras. This will have a detrimental impact on PHI take up by younger people who are more interested in Extras benefits in general than hospital cover.

Forecast impact – Removal of Rebate on Extras

- Stated impact of a full removal of the rebate (equating to a 43% price increase) is a halving of demand for Extras



Section 9.5

If the premium for your ancillary or extras cover for things like optical, dental, physiotherapy and the like were to increase by XX%, which of the following would summarise your likely behaviour?

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

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

Savings measures which could potentially undermine the positive ecosystem health funds have created in dental health will not save money in the long run. Poor dental health and decay are a cause of pain, poor nutrition and embarrassment. When appearance and speech are impaired by dental disease, opportunities for education, employment and social interactions are impacted. Poor oral health can also cause systemic health problems like heart infections, coronary heart disease, stroke, poor outcomes in pregnancy and pneumonia.

In [2010-11](#) (the most recent data) there were 60,590 potentially preventable hospital admissions for dental conditions and 129,084 cases of general anaesthesia for dental procedures. This is already very costly, and reducing access to preventive dentistry will only increase the cost burden of these conditions, as well as reduce the productivity of impacted individuals.

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

Policy measures

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

The private health sector is highly regulated, and much of the regulation has been put in place with the best of intentions and serves its purpose. There are however a number of regulatory measures that with time have inflated costs and decreased the efficiency and transparency of the sector. While these consequences are unintended, they must be addressed to secure its sustainability. Many of the issues below have been raised in the context of the Minister's Review of Private Health Insurance and Review of the Medicare Benefits Schedule. There is some urgency in implementing regulatory reform of this sector, given the pressure on households from rising prices. This is not without its challenges as some of the proposed changes will result in 'winners and losers' should they be implemented.

There are powerful vested interests in the health sector that are capable of running scare campaigns should their historical income streams be threatened. The sustainability of private health in the long run however, depends on the system operating at maximum efficiency. Health funds are thus committed to working with government to remove every dollar of wasted expenditure in private health, and every piece of toxic regulation driving up premiums. In return, the PHI sector is actively engaged in a process with government to greatly improve consumer navigation of health fund products and transparency of information on key issues identified by consumers as a major problem, like medical out-of-pocket costs. PHA member funds have already made a significant financial investment as a sector towards implementation of the government's consumer transparency election policy measures in 2016.

PHA estimates if the over-regulation of private health insurance was addressed as described below, including reform of the Prostheses List already commenced, health fund members would save just over \$1.5 billion a year on premiums as a result of increased competition and transparency. Vested interests will claim the red tape is in place to 'protect consumers', the reality is tying the PHI sector up in regulation has forced up prices. Any health fund exploiting a deregulated environment by dramatically reducing claims value, will experience an exodus of members to competitors. This is how a market is supposed to work.

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

The Commonwealth Prostheses List

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

in most other comparable economies.

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

The trajectory of commodity technology products is prices trend down with time. Particularly after the GFC, and with more sophisticated procurement mechanisms introduced by State Governments, the effect of benefit fixing has meant that private health fund members now pay 2-5 times public medical device prices, and those in comparable economies. This is reflected in premium increases. Medical device prices account for 14% of the health fund premium. In 2014-15 this grew at 9% and a further 6% in 2015-16 as a result of high utilisation of procedures requiring an implantable medical device.

A 2015 report commissioned by the private health insurance industry "Costing and Arm and a Leg" determined if Australian public hospital process were used as a benchmark, \$800 million is being wasted per annum on excess benefits paid for medical devices.⁸ The report estimated two thirds of this waste was going straight to Wall St in profit for the large multinationals dominating the Australian medical device market.

A further third of the excess benefit value has been transferred to big hospital companies as a result of arbitrage of their real procurement prices against the benefits they receive from health funds as required by the PL. The multinational hospital companies are exposed to real global prices for commodity medical devices. For example, a hospital company also procuring medical devices from one of the big multinationals in Europe, can also insist in its Australian procurement process the Australian subsidiary of that company sells its products at the same (lower) price. It then receives the PL benefit from the health funds and keeps the difference.

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

1. It locks out small to medium enterprises that want to compete on price. The list is subject to a rule that smaller companies must be able to guarantee 25% market share in a particular category if they want to enter the market at a lower price. The effect is highly inflationary and anticompetitive. List suppliers are currently dominated by the large US-based multinationals. Many smaller companies are locked out, and this was the subject of the Applied Medical court case that ran against the Commonwealth in 2015⁹;
2. It stifles innovation. With inflated benefits set at global high prices guaranteed for older, commoditised products, there is no incentive for providers to innovate or negotiate the provision of lower cost options. The list rigidly defines eligible products as implantable devices only and excludes modern technologies which may be non-implantable like remote monitoring and 3D printed devices;
3. There is no clear evidence-based path to reimbursement for new procedure-based technologies due to fragmentation of the system in Australia, which separates, private from public, and device reimbursement from the MBS-funded procedure.

⁸ 'Costing an Arm and a Leg' 2015.

⁹ Australian Financial Review 'Applied Medical sues federal government over price of keyhole surgery clip guns' Ben Potter April 27, 2015.

Graeme Samuel AC, who chaired the Health Minister's Review of Private Health Insurance in 2015, has been a vocal opponent of the Commonwealth setting benefits through the PL, and has been an uncompromising advocate for the removal of this dysfunctional process.¹⁰

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

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

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

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

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

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

¹⁰ The Australian 'Graeme Samuel urges cuts to price-fixing prostheses list' Pamela Williams November 8, 2016.

The second-tier default benefit

CONTEXT AND CORE ISSUE

The second tier default benefit is the level of benefit payable by a health fund for an episode of hospital treatment provided by an eligible private hospital facility with which it does not have a negotiated agreement. The second tier default benefit is 85% of the average charge for the equivalent episode of hospital treatment under that health fund's negotiated agreements with comparable facilities in that state or territory.¹¹

The second tier default benefit was introduced in 1998, when the private hospital provider market was fragmented, and the PHI industry was adjusting to federal legislation introduced in 1995, which allowed contracting between health funds and hospital providers. At the time, it was felt health funds' larger market size allowed them too much negotiating power over private hospitals that were less concentrated in terms of market share. The Federal Government introduced the second tier default benefit with an eye to supporting smaller providers, and re-balancing market dynamics between health funds and private hospital providers.

By 2003, private hospital ownership began to concentrate and the balance of negotiating power shifted back to private hospital providers, with Ramsay Healthcare and Healthscope holding 37% market share at this time. The Federal Government proposed abolishing the second tier default benefit on the following grounds:

- Private hospital providers no longer required the protection of the second tier default benefit since the health fund-provider contracting environment had stabilised as both health funds and private hospital providers had matured in their approaches to commercial negotiation;
- Health funds had strong incentives to enter contracts with private hospitals because their members would move to other health funds if there were a narrow contracted provider network; and
- The second tier default benefit had an undesirable effect of setting a price floor.

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

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

Considered today, the three main major concerns about the second tier default benefit regulations are as follows:

- First, it provides too much visibility on pricing data to contracted private hospital providers, which strengthens these providers' negotiating positions. Health funds are obliged to provide private hospital providers with a schedule of second tier default benefit

¹¹ The average charge for the equivalent episode includes the sum payable under the negotiated agreement and any excess or co-payments payable by members in accordance with the health fund's rules; and excludes charges for prostheses and nursing-home type patients. Where a health fund has less than 5 negotiated agreements with comparable facilities in a state, then the benefit will be based on all of that health fund's negotiated agreements in that state. Where the second tier default benefit is below the minimum benefit outlined in schedules 1,2 or 3 of the Private Health Insurance (Benefit Requirements) Rules 2011, the minimum benefit applies.

rates. This applies when a provider has been granted second tier eligibility by the Second Tier Advisory Committee (STAC)¹² and is out of contract with the fund. There is no equivalent obligation on private hospital providers to publish or share financial or clinical care data with health funds. This creates information asymmetry between the two negotiating parties.

- Second, the second tier default benefit creates a price floor at 85% of the episodic charge for comparable facilities in the same state. This encourages some hospitals to use the 85% as a “fall back” for negotiations. As the 85% rate is a price floor, rather than a ceiling, in some cases it results in higher out-of-pocket expenses for policyholders. This is because second tier eligible hospitals can either accept the second tier default benefit as full payment from the health fund or can charge out-of-pocket expenses to patients. There is no limit to the patient out-of-pocket that can be charged.
- Third, it limits the ability of health funds to negotiate to improve hospital quality. Currently when health funds agree to pay under contract a higher charge per episode to private hospital facilities that demonstrate high quality patient outcomes, they indirectly reward facilities with lower quality outcomes that may decide to utilise the second tier default benefit. The higher charge to the high performing facility will increase the health fund’s average charge per episode, and thereby increase the second tier default benefit.

While there are clearly concerns with the current benefit, it is also acknowledged some smaller and regional facilities do rely on the benefit and would be at risk in circumstances where the benefit was abolished. For example, over 75% of small facilities with less than 50 beds are not aligned with a large provider network, which is defined as a provider group earning sufficient revenue to hold greater than 3% market share. Only 30% of medium, with 50-100 beds, and 15% of large facilities, with over 100 beds, are owned by small provider networks. Outer regional, remote and very remote facilities are mainly outside the large private hospital provider networks and tend to have less negotiating power than providers in more populous areas such as inner regional areas and major cities. For example, 60% of outer regional facilities are not aligned with a large provider network.

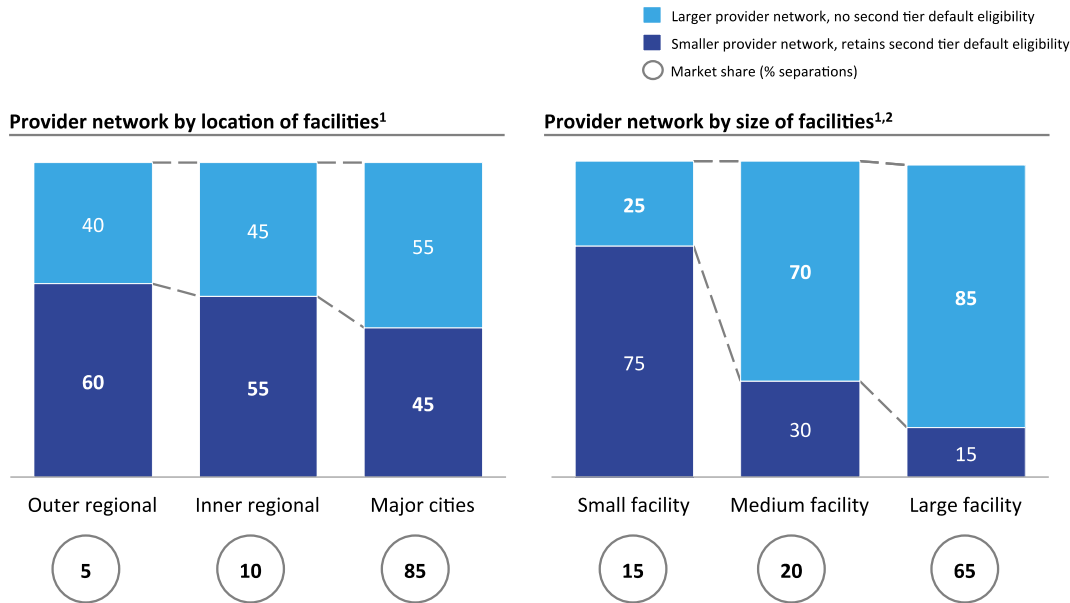
In these circumstances, the second tier default benefit supports outer regional facilities and smaller negotiating networks in securing quality outcomes for policyholders. Below, Exhibit 4 demonstrates the proportion of facilities that are aligned with large provider networks that earn revenue above 3% market share, according to location of facility (outer regional, inner regional and major cities) and size of facility (small, medium and large).

¹² This is a committee which is defined by regulation and which consists of three nominees of private hospitals and three nominees of health funds. Under current arrangements it is administered by the Australian Private Hospitals Association (APHA) which is a peak body representing private hospitals.

Exhibit 4: Alignment of small and medium facilities with large provider networks

A 3% threshold ensures the second tier default benefit supports smaller and regional facilities not part of a larger provider network

Percent of private hospital provider networks



¹ Representative sample data from health funds (2016), AIHW Hospital Contact Details (2016), ABS Remoteness Structure (2011)
² Size is determined by the number of beds: small (<50 beds), medium (50-100 beds), large (>100 beds); location is determined by ABS Remoteness Structure (major cities, inner regional, outer regional, which includes outer regional, remote and very remote); market share is determined by the number of separations

The core issue to consider is: what is the optimal reform of default benefits that will improve the sustainability and affordability of PHI while continuing to support smaller providers with limited negotiating power.

OPTIONS AND RECOMMENDATION

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

- **Option 1: Abolish 85% benefit requirement** Abolish the 85% benefit requirement for all providers by removing it from the Private Health Insurance (Benefit Requirements) Rules (2011). All existing private hospital providers using the second tier default benefit would be required either to enter into negotiated agreements with health funds or use the basic minimum default benefit in the Private Health Insurance (Benefit Requirements) Rules (2011).
- **Option 2: Abolish 85% benefit requirement, other than for providers or networks operating at under 3% market share** Abolish the 85% benefit requirement by removing it from the Private Health Insurance (Benefit Requirements) Rules (2011), except for providers, including provider networks and negotiating alliances, which have an operating revenue at under 3% market share.
- **Option 3: Reduce second tier default benefit for all providers** Second tier default benefit is reduced from 85% to a new, lower default benefit for all providers (e.g, 60%). This option does not include any exceptions for providers operating below the 3% market share threshold, mentioned in option 2.

- **Option 4: Continue the second tier default benefit and introduce a ceiling on out-of-pocket charges** Continue the second tier default benefit. However, introduce a ceiling on the total out of pocket costs that a private hospital provider can charge policyholders and still claim the second tier default benefit. This ceiling should be equivalent to 15% of the average contracted price of an equivalent stay so that provider charges under second tier default benefit is limited to 100% of the industry average, and policyholders are protected.

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

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

This is recommended for the following reasons:

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

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

Applying a revenue market share threshold

A 3% revenue market share threshold would ensure private provider networks, or negotiating networks, with a market share less than 3% would be eligible for the second tier default benefit. A revenue market share threshold is the preferred metric for differentiating second tier eligibility for providers. Although number of separations and number of beds are two potential metrics, these metrics do not account for differences in the type of care provided or the hospital's status as a free-standing day only facility.

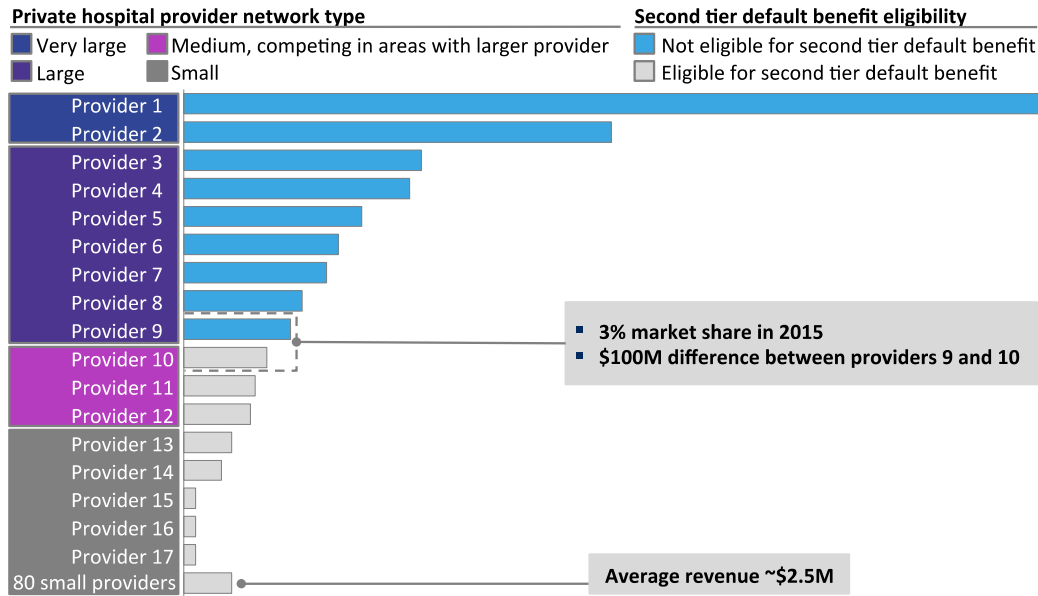
In contrast, a revenue threshold accounts for the care type and the average episodic cost, thereby accounting for the significant difference in the negotiating positions (e.g. between day and overnight facilities). It motivates providers to promote better patient outcomes by increasing patient use of day only beds, which have a lower average episodic cost than overnight stays and are correlated with higher quality outcomes. This threshold should be reviewed annually by the Department of Health, to ensure it is still appropriate in a dynamic and changing market.

Below, Exhibit 5 lists private provider networks ranked by revenue size, to provide an indication of the type of provider networks the proposed 3% market share threshold would apply to.

Exhibit 5, Recommended second tier default benefit eligibility threshold

A revenue threshold set at 3% of market share distinguishes large providers from medium providers

Estimated revenue per private hospital provider negotiating network (\$AUD, 2015)



1 Equivalent to approximately 3% market share
 SOURCE: Illustrative health fund data, APRA, publicly available private provider data

Second tier eligibility criteria

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

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

In recent years there has been a proliferation of second-tier eligible facilities, this is putting upward pressure on premiums in the absence of evidence these services are required or consumer outcomes are improved.

As of June 2016, 458 private hospitals, or 74% of all private hospitals, held second-tier eligibility status. The Rules and Supplementary Administrative Arrangements for the Second Tier Default Benefits for Overnight and Day Only Treatment, warrant a detailed review to ensure the original intent of these regulations is being met. Specifically, it is recommended that the eligibility process be reviewed and that supplementary regulations and documents be amended to reflect the meaning of the Rules.

STAKEHOLDER IMPACT AND RISKS

Impact of reform

Abolishing the 85% benefit requirement, other than for providers or networks operating at under 3% market share, could potentially result in significant gains for PHI policyholders and the Federal Government. In the first-order, private hospital charges per separation could decrease by up to 2%. This would result in a potential reduction of PHI benefit outlays of up to \$260 million, assuming health funds passed 90% of this benefit to consumers via lower premiums. The pass-through of savings would result in an estimated first-order gain for existing consumers of up to \$180 million and a gain for health funds of up to \$20 million. The lower premiums could result in the Federal Government saving an estimated \$60 million due to lower rebate outlays.

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

Identified risks and mitigation

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

- First, new and existing policyholders may switch to PHI policies that offer a broader contracted provider network, which is likely to be characterised by lower out-of-pocket expenses. While this increase in churn rate may cause policyholders inconvenience in the short term as they switch policies, it should not be mitigated. Market forces would promptly encourage providers to reduce out-of-pocket expenses and health funds to reduce premiums and widen their contracted provider network in order to retain policyholders. The longer term impact of this would be greater PHI affordability for consumers and more choice with respect to hospital facilities.
- Second, private providers may attempt to regain a stronger bargaining position by not contracting with health funds and charging higher fees to policyholders. Again it is felt a mitigation strategy is not required as it is expected that policyholders would soon avoid uncontracted providers that have high out-of-pocket expenses in favour of contracted providers who are working with health funds to improve healthcare affordability. Market forces would therefore encourage providers exhibiting such behaviour to engage in negotiations in order to prevent loss of market share.
- Third, there is a risk some private hospital providers could split their networks to fit the criteria for a smaller provider under the second tier default benefit. This fragmentation could increase the number of private hospital providers able to access the 85% price floor, and could reduce the incentive for these providers to reduce cost inefficiencies. It is felt that this risk is low, as the majority of providers would benefit more from their stronger bargaining position as larger facilities under open market conditions, rather than from undergoing fragmentation to access the second tier default benefit.
- Fourth, some health funds may over emphasise their rebalanced negotiating power by encouraging private hospital providers to significantly reduce charges. Private hospital providers could retaliate by going out of contract and increasing charges, which would result in higher out-of-pocket expenses and a narrower provider network. This risk is unlikely to be significant due to private hospital providers' ability to respond quickly. It also has a low potential for impact because market forces would quickly correct as consumers switch to health funds that are working with providers to negotiate the best outcomes for consumers.

- Fifth, in 2003, some stakeholders raised concerns that abolishing the second tier default benefit would result in a reduction in consumer choice. In contrast today, with the retention of the second tier default benefit for smaller providers, the recommended reform actively protects increase consumer choice. Furthermore, health funds have a strong incentive to enter contracts with private hospitals that are geographically proximal to their member base. Therefore, this risk is assessed as low.

IMPLEMENTATION

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

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

Interdependencies

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

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

Public hospital (State Government) cost-shifting

CONTEXT AND CORE ISSUE

“Cost shifting” is a common term used in the Australian healthcare system. It can be defined as a party transferring the costs of incurred services to another party in order to avoid a cost, which would usually fall to them. Public hospital cost shifting to health funds in Australia is in the order of \$1 billion dollars per annum. This accounts for about 6% of premiums.

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

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

For most patients attending a public emergency department, using their private health insurance is not a premeditated choice. In fact, many patients who intended to be treated as a public patient are signed up after they are admitted. The end result is PHI policyholders are now subsidising the costs of public hospitals, despite having already contributed to these through their taxes. Nationally, in FY14-15 the PHI industry provided 2.1% of all public hospital funding.¹³

This has been growing at an average rate of 12% every year since 2009, driven by two factors: the number of public hospital stays charged to PHI per consumer, growing at 7.5% per annum, and the increase in PHI membership, growing at 3% per annum. In contrast, the price per stay has been growing marginally at 1% per annum.¹⁴

The chart below illustrates the drivers of public hospital patient growth:

¹³ Australian Institute of Health and Welfare (AIHW) 2015 ‘Health Expenditure Australia 2013-14’

¹⁴ APRA (2009 and 2015) ‘Private Health Insurers Operations Report Data - total outlays to public hospitals

The largest driver of increasing public provider benefit outlays is volume growth

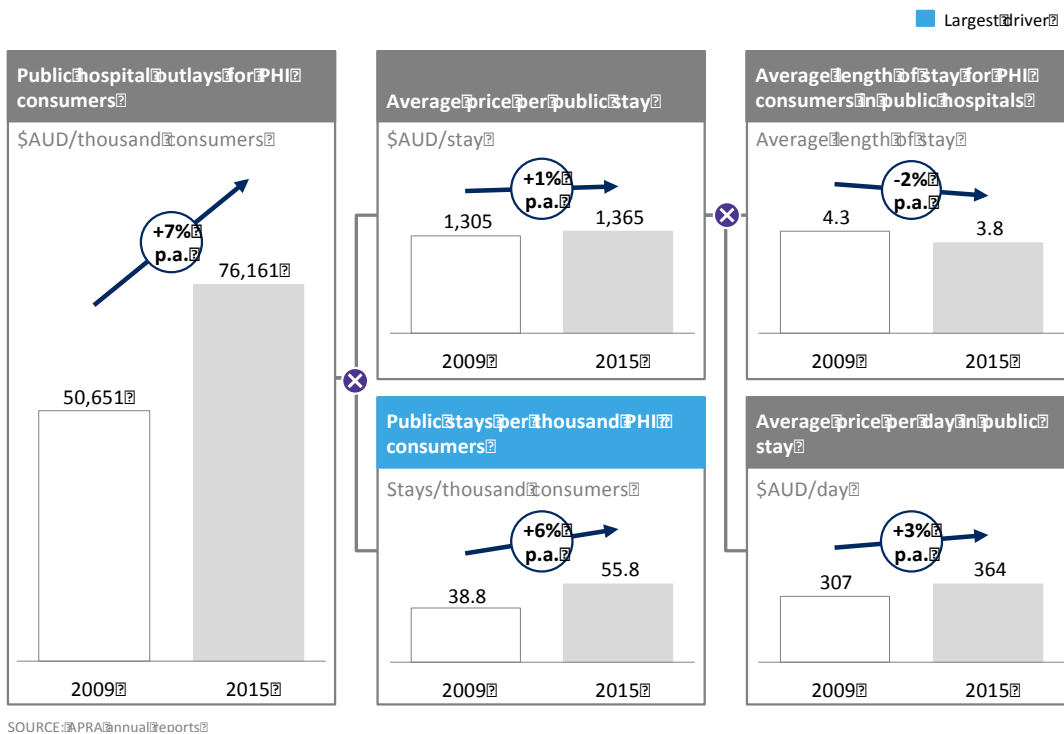


Exhibit 6: Analysis of public hospital patient growth

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

At a State level, a tacit encouragement of public hospital cost shifting seems to be growing. In recent years, at least two states have set quotas for public hospitals to seek “own-source revenue”, which is a combination of PHI, veteran’s affairs, and other non-State Government funding.

The impact was most evident in 2011 and 2012; after the Queensland State Government brought in quotas in 2010. Annual growth in public hospital stays for private patients changed from 7% per annum before 2010, to 12% per annum after 2010. Some public hospital organisations are adopting new provision models to capitalise on PHI income. For example, the new Fiona Stanley Hospital in Western Australia and the new Royal Adelaide Hospital both have significantly more single occupancy rooms than traditional public hospitals.¹⁵ States are able to charge health funds more for single rooms by issuing regulation by a ‘circular’, which is very difficult for funds not to comply with without adversely impacting members.

In one case, the Northern Beaches public hospital in NSW is a private hospital where patients may elect to be public patients, which is replacing a public hospital.¹⁶ The NSW Health Minister says the business model is that 86% of medical patients presenting to the emergency department will be persuaded to use their private health insurance.

Exhibit 7: Case study: public hospitals have created significant capacity to charge PHI

¹⁵ Fiona Stanley Hospital: 83% single occupancy rooms. See Fiona Stanley Hospital 2016 ‘About us’ www.fsh.health.wa.gov.au. Royal Adelaide Hospital has over 700 single occupancy rooms. See SA Health (2016) The New Royal Adelaide Hospital www.sahealth.sa.gov.au.

¹⁶ Northern Beaches Hospital (2015) ‘Your new Northern Beaches Hospital’ www.nbhsredev.health.nsw.gov.au.

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

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

SOURCE: Official websites for the respective hospitals

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

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

Informed financial consent is a requirement of patients electing to be private patients in the public system. It can be defined as members electing to be private in a public hospital who have been made fully aware and understand the financial implications of their decision. Research conducted by the Australian Bureau of Statistics (ABS) in 2010 states that 11% of patients did not feel adequately informed about the financial decision they were making when electing to be a private patient in a public hospital. This aligns with earlier research by IPSOS in 2006, which stated 10% of patients felt explicitly coerced into signing up as a private patient. This is despite clear consent rules outlined in the National Health Reform Agreement, with anecdotal evidence suggesting hospital staff voicing over the official consent forms in ways explicitly banned by the rules.

Common reports include statements such as “...it really helps fund your local public hospital”, “consider it a donation to the hospital” and “...we need it to continue research into your condition”. Further to improper informed financial consent, some public hospitals are paying consumers’ excesses and offering other financial incentives (e.g. free meals), thereby removing the disincentive to use PHI, put in place by health funds.

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

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

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

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

Health funds should be able to understand the reason for their members' stays in public hospitals at the same level of detail as currently obtainable for private hospital stays. Although some hospitals supply more information, more than two thirds of invoices randomly sampled by health funds had no more information than patient person details and length of stay. This low level of detail prevents two important processes from occurring:

(1) a review of invoices for accuracy, and

(2) a follow up of members by the health funds through their chronic disease management programs.

It is recommended is that public hospitals provide health funds with Hospital Casemix Protocol (HCP) data, or admitted patient care National Minimum Data Set data. Reporting DRGs and MBS items on invoices, as well as estimated medical cost versus accommodation cost for the stay, would allow more robust discussion between health funds and public hospitals and would likely assist in driving down unnecessary costs further. The Independent Hospital Pricing Authority (IHPA) is also able to provide support to transparency on care being provided, with input on the data systems and fair pricing.

Core question

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

OPTIONS AND RECOMMENDATION

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

- **Option 1: Formalise contracting processes between public hospitals and health funds** Continue to cost shift as per the status quo, while formalising contracting between health funds and public hospitals to ensure appropriate pricing for services and allow for additional value creation for PHI members.
- **Option 2: Eliminate public-PHI cost shifting** Prevent public hospitals from billing health funds for Medicare card holders.
- **Option 3: Eliminate public-PHI cost shifting except for small / regional providers** Prevent public hospitals from billing health funds for Medicare card holders, but provide an

exception for all hospitals defined as small and / or regional.

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

Exhibit 8 includes a summary of the positive and negative impacts of the four options considered.

Exhibit 8: Summary of options considered

Option 4 is preferred option for reform of public hospital cost shifting

■ Recommended solution

| Option 1 | Option 2 | Option 3 | Option 4 |
|---|---|--|--|
| Encourage contracting between public hospitals and health funds to optimise cost shifting | Eliminate public-PHI cost-shifting | Eliminate public-PHI cost-shifting except for small/regional hospitals | Status quo plus removed quotas, increased monitoring of patient flows, enhanced informed consent processes, and greater transparency on care provided |
| <ul style="list-style-type: none"> + Health funds contract with public hospitals to improve hospital cost and out-of-pocket transparency + Ensure ethical behaviour is upheld with informed consent + Facilitates potential co-funded value added services | <ul style="list-style-type: none"> + Members benefit from lower premiums due to direct cost savings + Some members will shift to private hospitals, creating better access to public services for public patients | <ul style="list-style-type: none"> + Most members benefit from lower premiums due to direct cost savings + Some members will shift to private hospitals, creating better access to public services for public patients + Protect regional and rural members' choice to access private treatment in local public hospitals | <ul style="list-style-type: none"> + Allows greater price transparency in the public system for both consumers and health funds + Ensure consumers have stronger informed financial consent + Curtails trend of State Governments encouraging cost shifting |
| <ul style="list-style-type: none"> - Costs are still shifted to health funds, leading to increased premiums, but to a lesser extent than the status quo - May contravene rules regarding equal access to service provision in public hospitals | <ul style="list-style-type: none"> - Politically challenging to implement as cost savings for health funds and members will be transferred as costs to public hospitals - No consideration for low accessibility to alternative providers in regional areas | <ul style="list-style-type: none"> - Politically challenging to implement as cost savings for health funds and members will be transferred as costs to public hospitals | <ul style="list-style-type: none"> - Costs are still shifted to health funds, leading to higher premiums, but to a lesser degree than the status quo - Could reduce total funding to the public system - Improved transparency on public hospital charges could impact prices in either direction |

¹ Agreement between Commonwealth and State Governments regarding health funding

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

This will encourage Commonwealth and State Governments to increase transparency and reduce cost-shifting by highlighting the impact on health fund premiums and out-of-pocket costs for consumers. Public hospital cost-shifting to health funds adds more to premium costs than the average year's premium increase.

STAKEHOLDER IMPACT AND RISKS

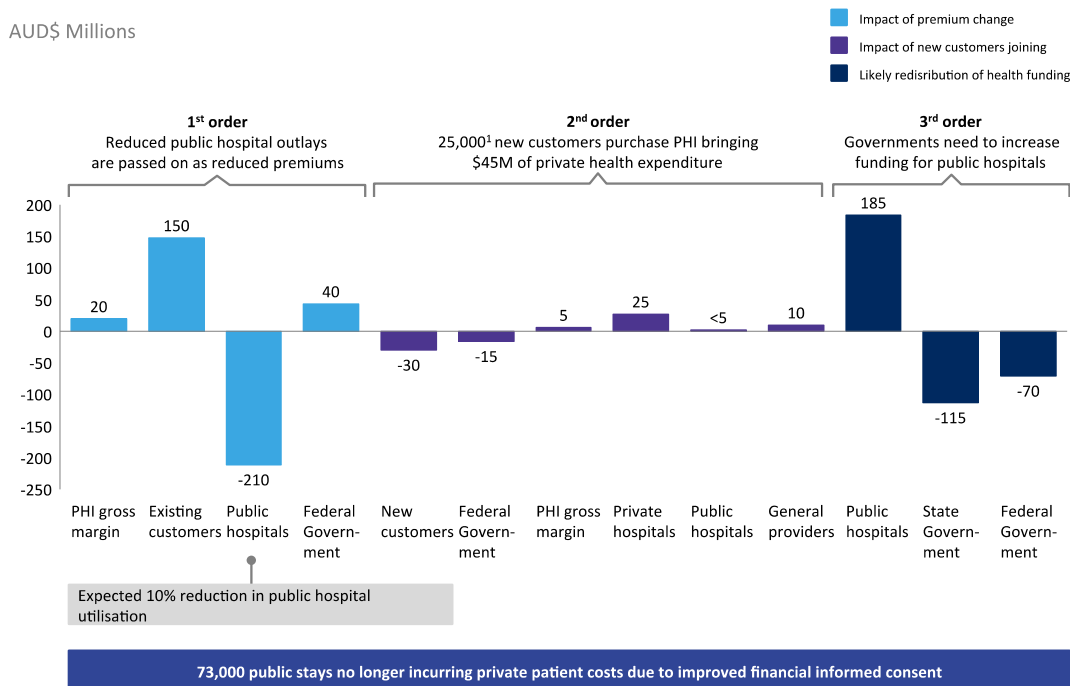
Impact of reform

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

The first order impact is an estimated saving of up to \$150 million for existing PHI policyholders, and a saving of up to \$40 million to the Federal Government due to reduced rebates payable. Reduced expected premiums would likely result in an estimated additional 25,000 new PHI consumers. It is estimated that up to 73,000 policyholders per year would no longer elect to use their PHI in public hospitals due to improved informed consent.

Exhibit 9: Impact of reform

Reducing public hospital cost-shifting will result in considerable savings for policyholders



¹ Assumes a 'Price elasticity of demand' for PHI of 0.25

SOURCE: APRA 2013-2014; ATO statistics 2016; ABS 2016; Health Expenditure Australia 2013-2014

Identified risks and mitigation

The most significant risk in implementing these changes is that hospital executives continue to seek "own source" revenue beyond current levels, or that the State Governments continue to implicitly require it of hospitals through funding them below their operating costs. In order to protect members from ongoing cost shifting, if this behaviour continues there are several potential mitigation options:

- First, the Federal Government could support the reforms of COAG, as the cost shifting

increases are MBS codes and premium rebate;

- Second, health funds should consider entering into agreements with selected public providers allowing them to seek pre-authorisations before a patient may elect to be private in a public hospital; and
- Third, health funds should communicate with their policyholders more frequently about what electing to be private in public hospitals actually means, to ensure members are fully informed decision makers when choosing providers.

There are also several smaller risks which require mitigation to maximise the value from these changes, including:

1. There is a moderate risk that policyholders would ignore health funds advice and continue to elect to be private in public hospitals in situations without a value proposition. This would require more frequent and impactful communications regarding the impact and value of public hospital cost shifting, potentially at the level of direct communication with any members who elect to use public hospitals frequently to ensure they are fully aware of costs.
2. Public hospitals may use increased invoice accuracy to increase the price they charge health funds. However, unless an agreement was in place, health funds would be under limited obligation to pay more than the value dictated by the minimum benefit.

Interdependencies

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

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

Premium round deregulation

CONTEXT AND CORE ISSUE

Premium growth is a contentious issue. As a result of health cost inflation, premiums have increased at an average rate of 6% year-on-year between 2007 and 2015.¹⁷ Today, the Federal Government regulates the PHI industry's overall premium increase through a centralised review process, whereby each health fund applies to the Minister for Health for approval of all premium changes. These proposed changes are submitted by health funds in November, and closely scrutinised by the Minister, the Department of Health and the Australian Prudential Regulation Authority (APRA) prior to public premium change announcements towards the end of February.

Although legislation allows health funds to change premiums at any time, the current process is followed by convention. It is rigid with a prescribed deadline in November for submission of changes and approved changes taking effect 1 April.¹⁸ The process is time consuming for all involved, including the Minister, the Department of Health, and APRA, as well as for health funds

¹⁷ APRA (2009 and 2015) private Health Insurers Operations Report Data

¹⁸ Private Health Insurance Act 2007 (Commonwealth) s66-10.

that prepare their submissions.

The process places pressure on the ability of health funds to respond to the market as it creates a time lag between market signals, the approval of premium changes and the premium change taking effect. This lag can be between a minimum of five months, if the price signal is received and acted upon just prior to premium submissions in November, and a maximum of seventeen months, if the price signal is received immediately after November's premium submission and not made effective until April in the second year following.

Due to the heavily regulated process controlling premium increases, health funds are at high risk if they increase premiums by anything below their experienced cost increase. Changing to a deregulated market would allow health funds to take the risk with their pricing in favour of more affordable PHI, knowing they can alter their premiums later if required.

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

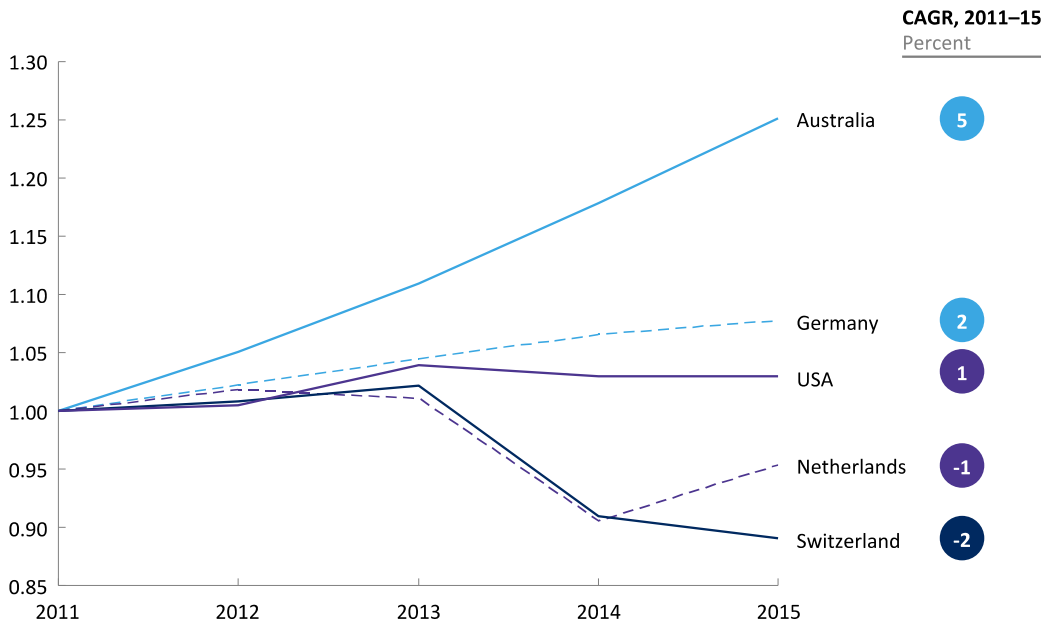
The annual average growth rate in PHI premiums between 2011 and 2015 was 5%. This is significantly higher than several international examples that have successfully developed a more market-driven approach to PHI regulation. Some examples are briefly discussed below:

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

Exhibit 10: Average annual premium prices changes in a range of countries vs Australia

Reforming annual price setting process can unlock market efficiencies and, in doing so, suppress the premium growth curve

Average annual premium price change, 2011–15¹ (indexed to 1 at 2011)



¹ Map Report, 2016, TNS Intrade
² Countries selected due to high maturity in PHI industry with similar competition elements to Australia

Six percent annual premium increases are not sustainable in the medium-term, given that household income growth is currently at 1.8%.¹⁹ If these rates were maintained, PHI would soon be unaffordable for many Australians. Policyholders would be unable to supplement their public health services with private health services, and the Federal Government would need to support higher public health expenditure.

Core question

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

OPTIONS AND RECOMMENDATION

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

Potential reform options

- **Option 1: Full deregulation.** Option 1 involves abolishing all premium regulations, thereby allowing health funds to set premiums at any time. Full deregulation would require an amendment to the PHI Act to abolish the current Ministerial approval process.
- **Option 2: Independent monitoring, desynchronised price variation.** Option 2 involves establishing an independent price monitoring system with a desynchronised price regulation process. An independent statutory authority would monitor premium changes by assessing health funds’ adherence to a set of guidelines, such as Benefits Loss (Claims)

¹⁹ ABS (2015) 6523.0 Household income and wealth

Ratio, that ensures price changes do not have an inappropriately adverse impact on policyholders.²⁰ A desynchronised process would replace the current annualised approval process.

- **Option 3: Independent monitoring, synchronised price variation.** Option 3 would establish an independent price monitoring system equivalent to the system outlined in Option 2. An independent statutory authority would monitor but not approve premium changes in accordance with set guidelines. The authority would publicise premium changes by health funds, and intervene post-hoc by exception in the event that a health fund changed premiums contrary to guidelines. However, health funds would only be able to change prices according to a synchronised cycle administered by the regulatory body. This cycle could be quarterly, semi-annual or annual.
- **Option 4: Ministerial approval with more transparent guidelines.** Under Option 4, regulatory responsibility would remain with the Minister for Health. However, the conditions on which premium prices changes are approved would be made more transparent by introducing standard pricing parameters. The possible parameters are the same as those introduced under the independent monitoring system, with one or more of the following: a BLR, minimum and /or maximum capital thresholds, a capped return on equity or a capped profit margin.

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

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

Independent price monitoring

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

²⁰ Department of Health (2016) Premium round individual private health insurer average premium increases

APRA’s suitability as a prudential body could be worthy of consideration as it focuses on financial soundness and risk management. APRA already has a fundamental understanding of PHI industry due to its absorption of PHIAC in 2015, and already collects the financial data. The ACCC has less of an understanding of the PHI industry as its role has traditionally been to implement compliance and enforcement remedies, and would thus be less appropriate in this role. While PHIO, despite having an understanding of the PHI industry, currently does not have the capabilities to monitor or enforce fair pricing compliance. Instead, PHIO protects PHI consumers via complaints handling, education and advice services, and it also advises industry and government.

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

Exhibit 11: Rationale for use of the BLR or claims ratio over other metrics

Key monitoring lever for regulation is the Benefit Loss Ratio (BLR) because it best ensures positive policyholder outcomes

| Metric | Description | Suitability | Rationale for recommendation for or against element |
|--|--|-------------|---|
| Benefit Loss Ratio | <ul style="list-style-type: none"> Benefit loss ratio (BLR) is the proportion of premium revenue paid as benefits to policyholders¹ BLR was 86% in FY14/15² | | <ul style="list-style-type: none"> BLR is the key metric that reflects value for money to policyholders <ul style="list-style-type: none"> Ensures any proportional increase in revenue due to price rises are passed on to policyholders via benefit outlays; and reduced benefit outlays are passed on to policyholders via premium reductions However, BLR does not account for infrequent but significant investment events that require one-off spikes to non-benefit outlay costs. Consequently, BLR must be a flexibly monitored guideline In 2011 the US Affordable Care Act successfully implemented a BLR, resulting in an increase from 79% to 86% for the individual market, and 89% to 90% for the large group market. This was significantly above the minimum BLR of 80% and 85% for the respective markets³ |
| Premium capped based on Return on equity | <ul style="list-style-type: none"> Return on equity (ROE) is calculated as net profit divided by total equity PHI return on equity was 16% in FY14/FY15 | | <ul style="list-style-type: none"> ROE an inadequate metric for comparison and tends to generate variable and potentially misleading results amongst Australian PHI Health funds due to the following reasons: <ul style="list-style-type: none"> PHI is not capital intensive, which tends to inflate ROE ratios Health funds’ differing company and holding structures influence equity structure <ul style="list-style-type: none"> For Profits are able to return capital to shareholders, Not for Profits are not able to do so |
| Premium capped based on excess capital | <ul style="list-style-type: none"> Minimum capital for adequate solvency for Australian PHIs is 4-5% Total capital held is 2-5 times minimum depending on PHI size and company structure | | <ul style="list-style-type: none"> Some PHIs hold significant capital to ensure they do not need to increase premium prices to offset losses, and to protect themselves from insolvency Restricting capital to a certain limit above minimum threshold would severely disadvantage smaller health funds, especially Not for Profits which have greater difficulty raising capital than For Profits, which could lead to a wave of industry consolidation If excess capital were to be regulated, it would be necessary to introduce potentially complex legislation to enable Not For Profits and mutual funds to return capital to members <ul style="list-style-type: none"> Akin to For Profit return capacity via shareholder dividends |
| Absolute capped premium increases | <ul style="list-style-type: none"> Industry average premium increase was 5.6% in 2016 and averaged 5.7% between 2010 and 2015⁴ | | <ul style="list-style-type: none"> PHI premium increases are currently below the increase to provider costs of 8–9% Absolute capped premium increases creates two undesirable incentives: <ul style="list-style-type: none"> Health funds are encouraged to increase premiums to upper limit instead of competing on price Health funds may increase volume and type of exclusionary policies to maintain margins |

1 APRA, Private Health Insurance Operations Report data 2014-2015 (BLR = premium revenue / fund benefits)
 2 Health funds commitment to pay policyholders rebate to be codified in PHA Code of Conduct
 3 National Association of Insurance Commissioners, Supplemental Health Care Data. The US term for BLR is Medical Loss Ratio (MLR)
 4 <http://www.health.gov.au>

Desynchronisation

It is recommended that price setting be desynchronised. This eliminates inefficiencies arising from the current convention of an annualised process. In contrast to the current system, which concentrates regulatory efforts between November and February, desynchronisation would enable the regulatory body to evenly disperse its regulatory efforts, prioritise significant compliance and enforcement matters, and conduct multiple smaller compliance investigations or “spot checks” throughout the year.

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

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

Rate protection means if a policyholder has paid for a policy in advance they do not pay the increased premium during the period for which they have paid.²¹ Although rate protection is not currently legislated, section 93-20 of the PHI Act requires health funds to provide policyholders with a reasonable period of notice prior to policy changes, such as premium increases, taking effect. This is reinforced by the industry developed Private Health Insurance Code of Conduct.²²

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

For example, in FY14-15 if the average value per policy was \$3,260, and in the prior year it was \$3,117, a year-on-year increase of 4.6%. This number would then be used as the weighted industry average for rebate calculations for the next 12 months. Currently the rebate adjustment is announced on April 1 each year, with the other input, CPI comparison, being taken at December. This April 1 date could either continue, or it may be preferable to consider moving to a new date such as August 1, so that the inputs can occur on Australian financial years.

Summary of recommendations

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

STAKEHOLDER IMPACT AND RISKS

Impact of reform

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

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

²¹ Rate protection is currently practiced by most health funds. See Department of Health (2015) 2015 Private Health Insurance Premium Round Outcome and Outline of Process.

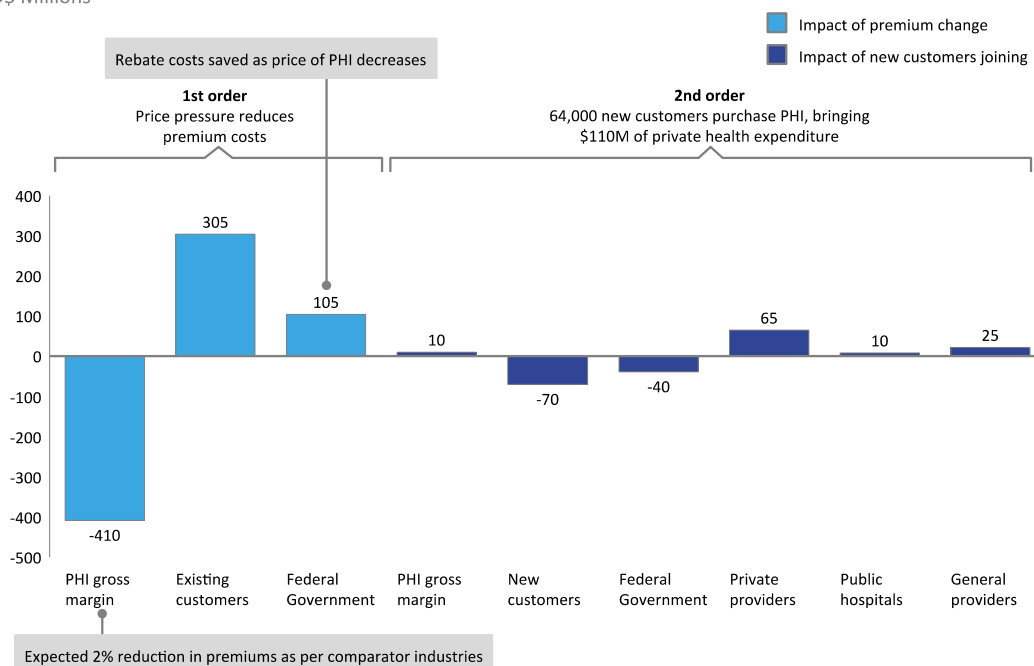
²² Private Healthcare Australia 2014 Private Health Insurance Code of Conduct

bring up to \$70 million of new revenue to the PHI industry.

Exhibit 12 describes the impact of the recommended reform option on the wider PHI industry

Premium deregulation will decrease premium costs and lead to an increase in policyholders joining

AUD\$ Millions



SOURCE: APRA 2013-2014; ATO statistics 2016; ABS 2016; Health Expenditure Australia 2013-2014

Identified risks and mitigation

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

- First, the risk with the highest likelihood of occurring and the greatest impact is price competition between health funds leads to significant premium price decreases, which could place the current business models of health funds under stress. While policyholders would obviously benefit from this price competition, some health funds would struggle. To mitigate this risk, sufficient time is needed for health funds to be able to adapt their business models prior to the introduction of full price deregulation;
- Second, there is a lower risk that health funds would increase premium prices to the detriment of PHI affordability. While current portability rules allowing policyholders to switch to health funds with lower premium increases, which creates a strong incentive for health funds and should largely mitigate this risk. The independent regulatory body could also monitor and intervene on the basis of price fairness if necessary;
- Third, private providers might seek to take advantage of the deregulated conditions pushing for increased payments. This is a moderate risk given the growing market power of private providers with two networks collectively comprising approximately 44% of the private provider market. Health funds would need to mitigate this by locking in contracts early, as well as pursuing other measures such as reforming the second tier default benefit;
- Fourth, there is a moderate risk that the newly appointed regulatory body would

overregulate health funds. The result of this would be a reduced ability to respond to market signals and less price competition between health funds. This could be mitigated by defining clear guidelines against which health funds should be monitored, such as BLR, and ensuring that the guidelines are appropriately adjusted for the variety of business structures that function in the PHI market (Not-for-profits vs. for-profits);

- Fifth, there is a risk of private providers attempting to acquire health funds, which would result in consolidation within the healthcare market. While this risk is assessed as small, in reality health funds would have limited ability to mitigate this. The ACCC, in its role as Australia's competition regulatory, would likely evaluate the impact of consolidation on the competitiveness of the industry;
- Finally, policyholders may seek to prepay policies annually at a higher rate than they do currently, in order to reduce their exposure to price changes in the desynchronised market. This could lead to reduced churn within the industry, as individuals are linked to a health fund for longer. It could also lead to lower premium income as individuals are prepaying at the pre premium increase price. This should not be mitigated as the health funds are able to manage their own payment terms with their policyholders.

IMPLEMENTATION

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

Phase 1: Announce reforms to inform policyholders and industry

The first phase would focus on legislative change, announcements to the public, and developing the implementation plan for the transitional Ministerial approval process. It is recommended that the Minister for Health engage in consultations with stakeholders and draft legislative changes that would enable implementation of the full reform program by April 2019. By this time also, it is recommended that the Minister announce the changes, including the transition program throughout 2017-18 and the full reform roadmap. Health funds and the Minister for Health could collaboratively develop a community information program to ensure policyholders are informed about the reforms and the expected positive impact to their premiums.

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

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

Phase 3: Desynchronise and transfer regulatory powers to the regulatory body

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

Review of Lifetime Health Cover settings

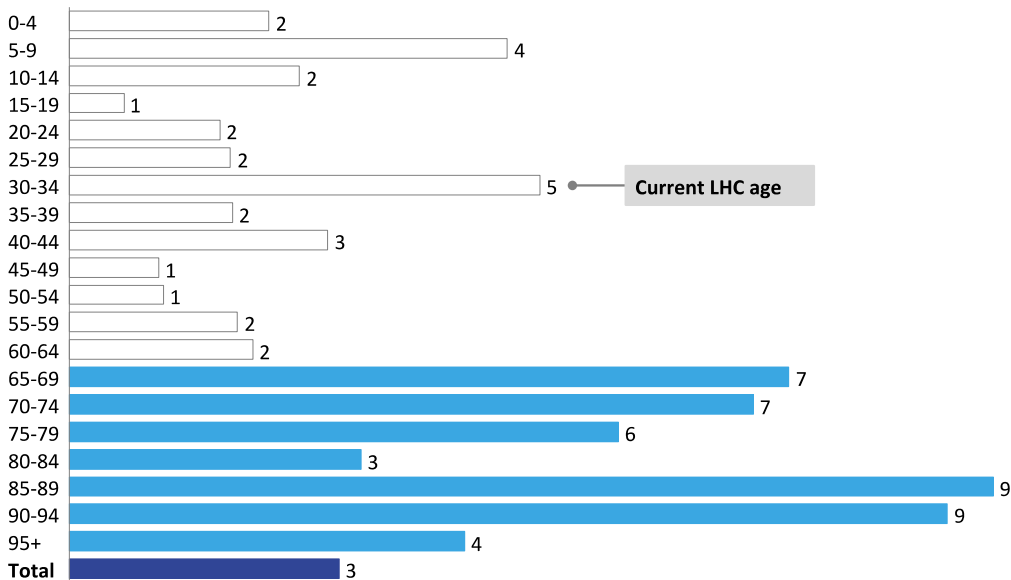
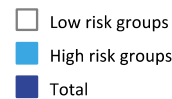
CONTEXT AND CORE ISSUE

Australia’s ageing population directly impacts the Australian PHI industry as older age groups are more highly represented in PHI than younger age groups. This is problematic, as older age groups cost significantly more in healthcare than younger groups. A further challenge is that the growth rate in the older age groups is increasing at a higher rate than younger groups due to age bracket creep. Also concerning is the impact of Australia’s community rating system on younger individuals in this context, in which younger, healthier individuals subsidise the cost of health insurance of older, less healthy individuals.

Exhibit 13: Compares the PHI growth rate by age group

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

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



SOURCE: 2010 to 2015 APRA data

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

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

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

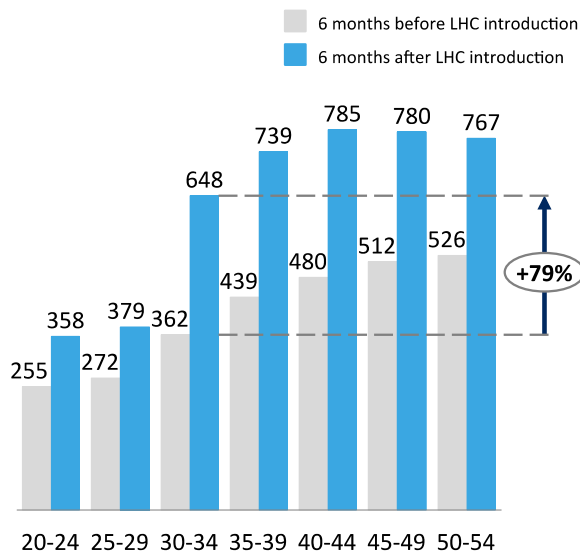
Below, Exhibit 14 explains how this effect continues today. On the right hand side, the additional increase in members for PHI uptake between the ages of 27, 28 and 29 averages 7%. The additional uptake between the age of 30 and 31 is 10%. This difference is arguably directly due to the LHC loading that would take effect after 31 years.

Exhibit 14, Impact of LHC on purchasing behaviour

Introduction of LHC in 2000 drove significant uptake by consumers over 30 years old, and continues to drive purchasing behaviour

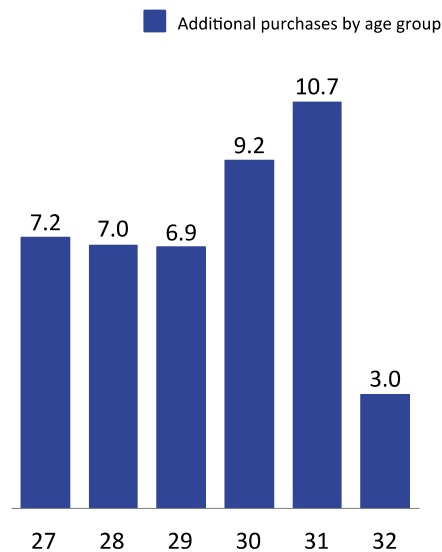
Comparison of members with PHI

Individuals with PHI by age; thousands



Additional members of PHI by age

Percent increase by age, 2015



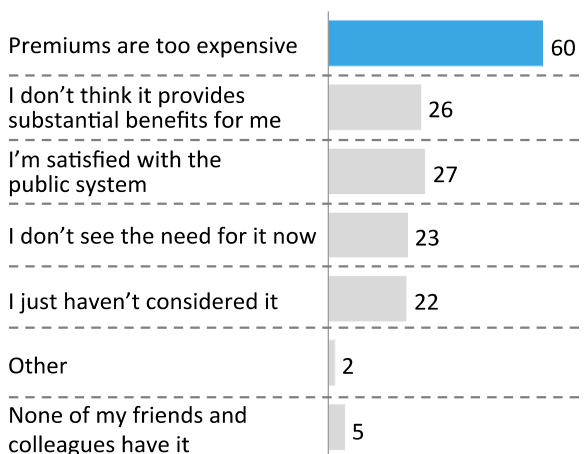
SOURCE: APRA annual report 2015, APRA statistics and trends 2015

An expansion of the PHI membership pool through an extension of LHC to a younger age group has been considered before, both in terms of extending the loading or offering a discount. Market research suggests a discount would be more effective. A recent PHI consumer survey indicated that for individuals aged 25-29 years, their main reasons for not purchasing PHI was high cost. A discount encourages PHI uptake without imposing penalties on a group with average annual income less than \$50,000. The ability to hold the discount for several years is also likely to decrease churn.

A discount is the preferred method to increase participation in the under 30 age group

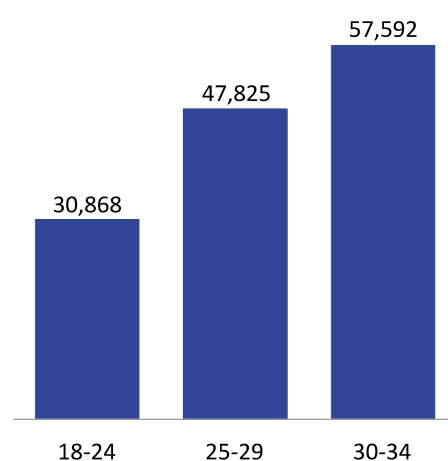
Why do 25-30 year olds choose not to have PHI?¹

Percent times mentioned



Average taxable income by age group²

\$AUD (FY13-14)



¹ PHA Consumer survey 2016; ² ATO 2013-2014 Taxation statistics

OPTIONS AND RECOMMENDATION

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

Potential reform options

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

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

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

Exhibit 16: Summary of LHC policy variations considered

Option 1 is preferred option to improve LHC and encourage greater participation in PHI

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

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

Targeting the program at independent adults under 30 years ensures all adults currently not incentivised by the LHC are now impacted by the LHCD. Applying it from 18 years old is fair, and prevents an arbitrary age boundary (e.g. 25 years) leading to discrimination against a portion of independent adults. The program would apply to independent adults only as the discount is not intended to decrease the cost of family policies with adult dependents. Extending the discount for as long as the member retains their PHI is in contrast to the current LHC program, where the penalty expires after 10 years. It is envisaged this would provide a stronger purchasing incentive to individuals under the age of 30 than a 10-year discount. The temporary window to obtain the lifetime discount should also increase the perceived value. The threat of losing an irrecoverable discount may also reduce churn over a member's lifespan in the industry. Current portability

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

Further analysis and research needed

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

Summary of recommendations

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

STAKEHOLDER IMPACT AND RISKS

Impact of reform

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

The largest increases are expected in the 25 and 26 year olds. Despite 18 to 24 year olds being a small portion of the available market, it is important to include individuals aged under 25 as many individuals under 25 may not be able to access dependent-based coverage and should therefore be entitled to the reduced premiums.²³ Under 25 year olds are also lower risk than the 25 to 30 age group.

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

What is clear is that younger individuals have on average a much higher gross margin than the average customer. Adding an additional 150,000 members could be expected to bring in up to \$130 million in total gross margin. Given the competitive market place, approximately 90% (or \$120 million) of this additional gross margin could be expected to be passed on to existing policyholders in the form of lower premiums.

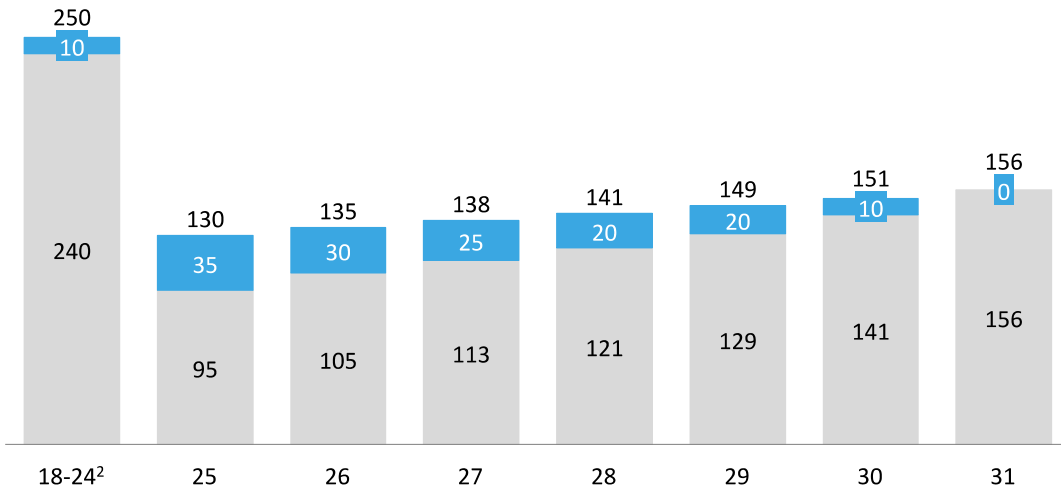
²³ In 2014, 20% of 18-24 year-olds held PHI policies. See ABS (2014) 3101.0 Australian Demographic Statistics.

Exhibit 17: LHC discount expected growth rate by age group

LHC discounts in the 18-30 age group could attract an additional 150,000 PHI policyholders

Estimated increase in policyholders by age from LHC discounts¹
 Policyholders by age, thousands

■ Additional policyholders
 ■ Current policyholders



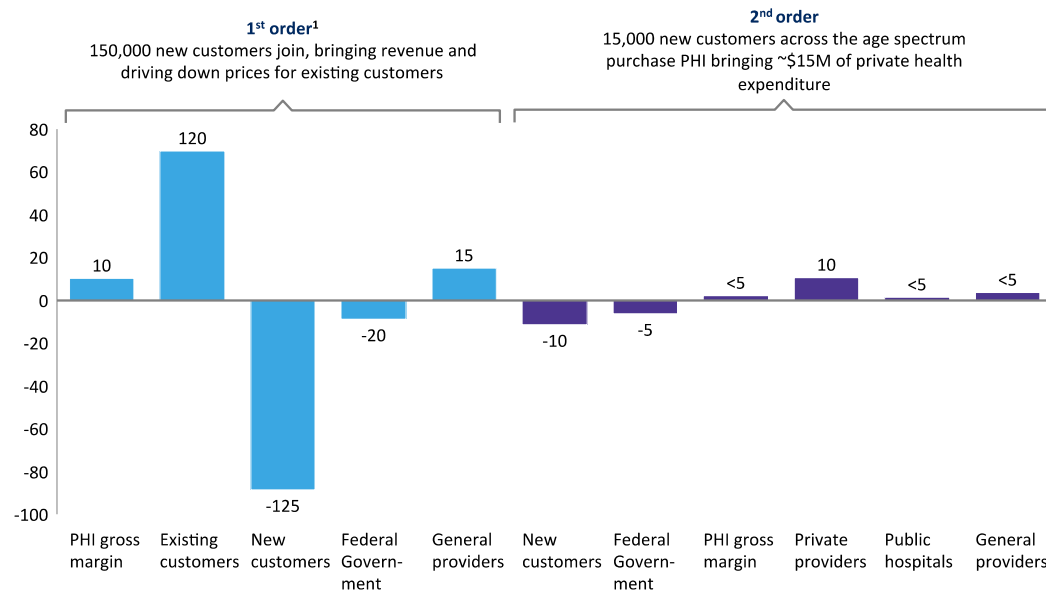
¹ Assumes: (a) Same levels of PHI purchasing in the 18-29 age group as the 31 age group for a given income once LHC discount brought in; (b) 90% of added gross margin passed onto policyholders as premium reduction; (c) Current analysis does not take into account second order effects such as the impact over decades, or changes to churn
² Assumes Independent adults only (estimated 30% of age group as per PHA risk equalisation report)
 SOURCE: Illustrative health fund data, APRA annual report FY14-15, APRA quarterly statistics Dec '99, APRA quarterly statistics Dec '00; ATO income statistics 2013-2014

Exhibit 18: Financial impact on PHI stakeholders

Existing customers save ~\$55M due to reduced risk of PHI pool and ~\$65M due to direct discount

AUD\$ Millions

■ Impact of premium change
 ■ Impact of new customers joining



¹ Current analysis does not take into account second order effects such as the impact over decades, or changes to churn
 SOURCE: APRA 2013-2014; ATO statistics 2016; ABS 2016; Health Expenditure Australia 2013-2014

Identified risks and mitigation

The primary risk in implementing these changes is a proliferation of “exclusionary” policies. This would lead to a lower value proposition of PHI in the community, and deliver poor value to consumers. In order to mitigate this, it is recommended that the Federal Government implement an acceptable minimum standard product, with an appropriate level of coverage. This is currently a major part of the policy negotiation being undertaken by the Private Health Ministerial Advisory Committee (PHMAC).

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

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

Interdependencies

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

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

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

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

IMPLEMENTATION

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

Phase 1: Legislative change, further analysis and market preparation

Before the end of 2017, should the PHMAC consider this policy direction, PHA would complete an actuarial analysis along with market research to better understand expected take up rates due to the discount. In 2017, an amendment to Part 2-3 of the PHI Act 2007 introducing the discount

could be introduced into the Federal Parliament. A market announcement of the decision would be made, with stakeholder consultation, including health funds, PHIO and consumer groups commencing.

Phase 2: Introduction of change to market

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

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

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

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

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

Under Australian government regulations, it is very difficult for health funds to pre-approve claims, and any attempt to do so is strongly resisted by health professional representative groups. The 'trigger' for health fund hospital claims is the MBS claim. While this protects the consumer from unexpected out-of-pockets due to claims not being approved, it means health funds are highly dependent on the appropriate management of the MBS program. PHA is thus strongly supportive of the MBS Review and its associated processes, as every dollar of waste and every episode of inappropriate practice threatens the sustainability of private health.

Increasing utilisation of services predominantly drives health system cost increases. A large part of this is related to the ageing of the population and the emergence of chronic diseases as the predominant presenting condition. There is however, a significant incentive created by the MBS fee-for-service reimbursement system for doctors to drive up procedure and consultation volumes. Information asymmetry between providers and consumers is high in this sector, and as a result, provider-induced demand accounts for a significant proportion of services provided. This is likely to have been accelerated by the 'freeze' on MBS rebate indexation.

A robust mechanism to manage compliance in the MBS program, and to ensure services are provided appropriately, will be as important as the changes to the MBS schedule of fees arising from the Review in ensuring sustainability of this program as well as PHI.

Traditionally MBS integrity has been managed through the Professional Services Review (PSR) process, as well as fraud and compliance activities undertaken by the Department of Human Services.

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

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

In its administration of the Scheme, PSR is responsible for reviewing and examining possible inappropriate practice by practitioners when they provide Medicare services or prescribe Government subsidised medicines under the PBS.²⁴

²⁴ About the PSR scheme (2016) www.psr.gov.au

The main problem with the PSR process is it relies heavily on retrospective pursuit of financial gains by practitioners with the goal of cost recovery. This is cumbersome, involves prolonged legal and administrative processes and is rarely successful. Modern data analytics provides the opportunity to better use data to give health professionals generating MBS claims feedback, thereby giving them the opportunity to proactively modify behaviour and prevent fraud and inappropriate practice occurring in the first place. Health funds have already demonstrated the effectiveness of feedback in reducing inappropriate claims. Health professionals are aware 'someone is watching' and are given data about how they are claiming relative to their peers before punitive action is taken.

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

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

Funding for out-of-hospital care

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

In the initial construction of Medicare this made sense, but over time two things have occurred which makes this inflexible aspect of the system both inflationary and impractical. First, the emergence of chronic health conditions as the predominant burden of disease, and second the emergence of new technology, particularly information and communications technology e.g. home monitoring of chronic conditions, which means health services can be safely and effectively delivered in many more care settings than a hospital. Hospitals remain the most expensive setting of care, and are not always the safest care setting for a number of conditions.

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

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

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

- Improved healthcare options for people in rural and remote Australia.

A number of health funds have made a significant investment in better care of people at risk of complications from chronic disease, with view to preventing avoidable hospital admissions, prolonged length of stay in hospitals and unplanned readmissions. For example, CarePoint, operating in Victoria and WA, is an integrated healthcare pilot supporting both public and private patients battling chronic disease and complex health issues. (Designed by Medibank and supported by HBF). GPs and allied health professionals are critical to this care model, which helps patients navigate available healthcare and social services. Australian Unity's preventive health arm Remedy Healthcare has recently launched its 'Mindstep' program, which targets people with anxiety and depression who have recently been discharged from hospital, with view to preventing readmission.²⁵

Removal of the anachronistic red tape preventing health funds from financing out-of-hospital care will enable this type of program to expand and flourish, will enhance the role of primary care in addressing chronic disease and will put downward pressure on premiums. As an accompanying measure, the risk equalisation²⁶ regulations underpinning community rating should also be reviewed. This is to prevent the possible unintended consequence of funds, which successfully prevent hospital admissions, being penalised. This issue is currently being examined by the PHMAC.

CONCLUSION

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

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

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

²⁵ Remedy Healthcare has spent seven years researching and developing its first in kind mental health program. (November 2015 <http://www.australianunity.com.au/thoughtplus/health-latest/2015/december/remedys-mental-health-first#sthash.4s0RPQMp.dpuf>)

²⁶ Risk equalisation is a regulated process, which redistributes the risk of insurance for members so that high cost individuals, such as the elderly, can still be covered under community rating without paying a higher premium. There is a pool of money to which all health funds contribute. Health funds with higher risk members receive value through the process, whereas health funds with lower risk members pay value into the pool. At the moment, risk is defined retrospectively based on hospital claims – this may need to change if the focus shifts to out-of-hospital care.

ABOUT PRIVATE HEALTHCARE AUSTRALIA

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body that currently has 19 registered health funds throughout Australia and collectively represents 96% of people covered by private health insurance.

PHA member funds today provide healthcare benefits for over 12.8 million Australians. Private health insurance is provided through organisations registered under the *Private Health Insurance Act 2007*. The financial performance of registered health funds is monitored by the Australian Prudential Regulation Authority (APRA), an independent Australian Government body, to ensure solvency and capital adequacy requirements are met.

All members of Private Healthcare Australia are registered as health benefits organisations with the Commonwealth Government and comply with Government standards and regulations on benefits and solvency.