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Submission to the Private Health Insurance Consultations 2015-16

The AMA welcomes the opportunity to provide a submission to the Private Health Insurance Consultations 2015-16.

The Review will no doubt reveal what medical practitioners experience on daily basis when treating privately insured people:

- that people expect to be covered for the most common procedures, and often don't understand that, because of the policy they hold, they are not.

The Review should conclude that:

- the majority of confusion and disappointment, and in some cases hardship, could be prevented by eliminating policies that exclude the very procedures for which patients expect to be covered, or that provide cover only for treatment in public hospitals; and
- community rating is essential to maintain the delicate balance between the public and private hospital sectors in the Australian healthcare system.

The current health system in Australia has served Australians well in terms of health outcomes and affordability, as acknowledged in the National Commission of Audit report (chapter 9.3).

The Australian health system continues to be affordable. In the 2015-16 Commonwealth Budget, health was 15.97% of the total, down from 18.09% in 2006-07[1,2]. There have been two consecutive years of modest, sustainable growth with 3.1% growth in 2013-14 following 1.1% growth in 2012-13 (a year with the lowest growth rate in health expenditure since the Government began reporting it in the mid-1980s). This is now two years in a row where health expenditure has been below projections and below the long term average annual growth in health expenditure (5% over the last decade).

While recent growth in outlays by private health insurers is higher (6.2% in 2013-14 and 10.3% in 2012-13), the long term growth rate matches that of overall health expenditure (5%)[3]. Further, the proportion of total health funding by private health insurers has remained relatively static over the past decade from 8.1% in 2003-04 to 8.3% in 2013-14[4].

Gross and net margins were slightly higher for the industry for the 12 months to June 2015,

[1] Australian Institute of Health and Welfare: *Health Expenditure Australia* 2013-14, Table 2.1
[2] Australian Government: *Budget Overview 2015-16*: page 30
[3] Australian Institute of Health and Welfare: *Health Expenditure Australia* 2013-14, Table 3.9
[4] Australian Institute of Health and Welfare: *Health Expenditure Australia* 2013-14, Table 3.2

resulting in an after-tax profit of $1.1 billion, and $5.3 billion in excess of the capital adequacy requirements. Premium revenue increased 7.3%, whereas total benefits increased by a slightly smaller proportion of 7.1% for the financial year to June 2015, indicating a healthy industry[5]. Management costs have reduced from 10.5% in 2008 to 8.5% in 2014 showing an increased efficiency in the sector, although there is still significant variation between insurers.

The issues paper distributed by the Department of Health offers no analysis of the effectiveness of the current arrangements through which the Commonwealth supports the private health sector, either through the private health insurance rebates or the regulation of private health insurers and private health insurance products. Nor does the issues paper clearly articulate the specific problems that need addressing. Consequently, the AMA is not in a position to provide informed commentary on all of the issues in the paper.

From the consultation forum on 16 November, it appears that the Commonwealth is contemplating withdrawing the PHI rebate and diverting this expenditure into a hospital benefit (i.e. Option 2 in the *Reform of the Federation* Discussion Paper 2015). It also appears that the Commonwealth intends to de-regulate the private health insurance sector in terms of premium setting to encourage competition.

The material question therefore is whether the current Commonwealth expenditure on the rebates is an appropriate investment to support the private health sector as an alternative to, or support for, the public hospital sector.

The Balanced Health System

In Australia, the public and private systems work together as a part of a health system that provides universal access for patients to affordable health care.

The balance between the private and public system cannot be overlooked by this Review. The public system relies on a strong and innovative private health system. Through the MBS Review, the private system is at risk of limitations imposed by a MBS that constrains holistic medical care. Through the PHI Review, the private system is at risk if people choose to be uninsured, or underinsured if premiums increase. Both Reviews provide a very real threat of additional pressure being placed on public hospitals already struggling to meet ever growing demand.

The private health sector is a large contributor to the system. In 2013-14, 42% of all hospital separations were funded by private health insurance; where 50% were public patients and the remainder were self-funded[6]. Not only is it a large contribution, but it is a cost effective one. In 2013-14 there were 4.1 million privately insured hospital separations for $12.6 billion (approximately $3,100 per separation), compared 4.8 million separations in the public sector for a combined government outlay of $46.0 billion (or $9,500 per separation) [7,8]. While the service mix differs between the sectors, the private sector very efficiently complements the public sector. If consumers withdraw from the private sector, these services will need to be provided by the

[5] Australian Prudential Regulation Authority: *Private Health Insurance Quarterly Statistics – June 2015*, page 11
[6] Australian Institute of Health and Welfare: *Australia's Hospitals – at a Glance 2013-14*, page 25
[7] Australian Institute of Health and Welfare: *Admitted Patient Care: Australian hospital statistics 2013-14*, Table 7.5
[8] Australian Institute of Health and Welfare: *Health Expenditure Australia 2013-14*, Table A6

public sector, which under current capacity, will not meet the additional demand or only at a higher cost to governments.

Concerns with Current Arrangements

There are some worrying trends that, if left unchecked, may undermine the private health system and these trends require further analysis.

Despite recent changes to the private health insurance rebate, there continues to be strong support for the private health sector with 47.3% of the population covered for hospital treatment. There were increases in both policies undertaken and persons covered from June 2009 to June 2015. However, the proportion of people with an exclusion policy has also increased from 9.8% in June 2009 to 35% in June 2015[9,10]. The quantum of covered and excluded services are not included in the data.

The issues paper mentions improving the value of private health insurance, implying that consumers generally perceive private health insurance, as a product, to be poor value for money. The perception of poor value of insurance may be influencing the type of policies consumers are purchasing. Whether this is a causal relationship should be examined. Notwithstanding, consumers will choose based on what they can use to differentiate a product, and given the constant changes in policy coverage, consumers are mostly likely using price as the differentiator. The consequence is that consumers are purchasing products with considerably more exclusions.

When determining value, it would also seem prudent to examine the price elasticity of demand for insurance to determine the impacts of increased costs of premiums, either through increased premiums or a reduction in the rebate. This modelling should determine the potential impact upon future purchasing of private health insurance and consider whether the shift in coverage (downgrading policies) will increase demand for public hospital services when consumers realise they are not covered for treatment they need in the private sector. It would seem appropriate to fully understand the impact of the last round of changes to the rebate before making further amendments.

There is a rapidly declining situation with private health care in Australia, caused by the aggressive behaviour of the larger private health insurers that has been left unchecked by the Government. The behavior includes:

- Excluding treatments from existing policies.
- Removing services from schedules of medical benefits, with the result that the insurer will only pay the required 25% of the MBS fee for the service with patients incurring an out-of-pocket cost.
- Entering into contracts with private hospitals that interfere with the established safety and quality system achieved by the accreditation arrangements.
- Making direct calls to members encouraging them to downgrade their cover.

[9] Private Health Insurance Administration Council: *Operations of the Private Health Insurers – Operations Report 2013-14 Data,* Table: Policies by type

[10] Private Health Insurance Administration Council: *Private Health Insurance Membership and Benefits – June 2015*, Table: Australia

- Selling inappropriate policies, such as cover for obstetrics but not arthroplasty to older people, or cover for neonatal care but not if it is for cardiac or respiratory issues.
- Requiring detailed clinical information and justification to be submitted at the time of booking hospital treatment.
- Rejecting claims unless and until they are disputed by the patient or their doctor.

On their own, these activities reduce the value of the private health insurance product. Collectively, they are having a destabilising effect on privately insured in-hospital patient care and treatment. The decisions of some insurers to not pay private hospitals for hospital acquired complications and re-admissions within 28 days as a part of their contracting arrangements has serious implications for high risk patients. Private hospitals may not be willing to bear the risk imposed by the contract with the patient's insurer, and refuse to admit the patient. This directly compromises the ability of the doctor to care for their patient. Should the doctor not have admitting rights to other hospitals, patients may have to be referred to other doctors or admitted to public hospitals.

These activities are serious enough to warrant strong and swift intervention by the Federal Government before consumer confidence in the private sector is undermined such that people drop their private cover altogether and/or turn to the public hospital sector for treatment.

The activities listed above directly interfere with patient care, and fail to honour the policies that the insurers have sold to consumers and that consumers have purchased in good faith and with the expectation they will be covered if they need hospital treatment. The AMA cannot accept that insurers are behaving appropriately to manage their outlays. They are simply taking steps to get out of paying benefits for care and treatment that their members expect them to cover, given the policies they have purchased.

In 2010, CHOICE (Are you covered August 2010) found that most people expect their private health insurance to cover them for heart surgery, hips and knee replacements, eye surgery, psychiatric care, rehabilitation and palliative care. AMA members report that they often need to cancel booked procedures when it becomes apparent that the patient is not covered. Commonly, patients believe they purchased cover and cannot recall being advised by their insurer that their policy had changed.

The growth in the number of policies that cover admission to a public hospital as a private patient, but excludes admission to a private hospital and policies that contain important exclusions, such as joint replacements and cardiac treatments is concerning[11]. A high rate of "insured" people with exclusion policies is effectively creating a risk rating system, as insurers reduce their exposure by offering products that are less likely to require them to pay benefits.

It would appear that many consumers are inadvertently purchasing policies that are there to satisfy requirements to avoid the Medicare levy surcharge and do not meet their expectations. The AMA calls these 'junk' policies. People think they have purchased a product that will allow them choice of doctor and to 'jump the public waiting list', but this is unlikely in reality.

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[11] Private Health Insurance Administration Council: *Operations of the Private Health Insurers Report 2013-14,* page 5

It is increasingly difficult for a consumer to determine what will be covered when purchasing an insurance policy. Primarily this is because:

- Coverage changes after purchase. Exclusions are added and benefit payments change without advice. Last year, Medibank reduced the benefits it will pay for pathology and diagnostic imaging services to the level only of the Medicare schedule fee. It did this without any advice to its health fund members. In addition, patients with ongoing conditions are finding that treatments for their particular condition are suddenly not covered. These policy holders have a vested and current interest in ensuring that their policies continue to cover their conditions, but are inexplicably unaware of policy changes. Overall, it is reasonable for consumers to expect that the product continues to provide the same cover as it did at the time of purchase;
- Doctors' independent clinical decision making is undermined by the requirement for pre-approval of surgery and other pre-surgery requirements. Consumers expect coverage for what a doctor deems medically necessary, but the preapproval processes erode patient choices, when they are considering the options informed by their doctor's application of the best available evidence to their individual clinical and social circumstances; and
- A lack of sufficient and comparable information. Imperfect and asymmetric information makes it difficult for consumers to choose a product that meets their needs. The information provided by insurers is convoluted and terms are not standardised across the industry. Moreover the terminology used is ambiguous and difficult to interpret.

Further the value of PHI is being undermined by public hospitals encouraging people to use their private health insurance instead of electing to be a public patient. The number privately insured acute hospital treatments provided in public hospitals has grown 37.7% from 2010-11 to 2013-14[12]. The priority and treatment provided to those people does not change as a result of 'electing' to be a private patient, but their insurer is now required to meet the costs.

The complexity of policy offerings and behaviour of the insurers should be examined to determine the level of impact they have upon consumers' perceptions of value and therefore engagement with the private system. The devaluing of policies by insurers has been allowed to occur in an already limited regulatory environment for the insurers. Further deregulation will only further undermine the value of the private health insurance product for consumers.

Substantial changes to the system are unwise until a full and transparent economic assessment of the potential outcomes of the current suite of health reviews is conducted. This analysis should be conducted within the context of the vision for healthcare in Australia, which is currently difficult to ascertain.

Community Rating

The AMA is very concerned that the online survey asks consumers if premiums should be charged according to a person's smoking status, age, or gender. Charging premiums according to risk undermines the central tenet that supports the community rating system for private health insurance. The community rating system ensures that private health insurance is equitably available to all in the community who seek it[13].

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[12] Private Health Insurance Administration Council: *Operations of the Private Health Insurers 2013-14,* page 30
[13] Australian Prudential Regulation Authority: *Private Health Insurance Quarterly Statistics – June 2015*, page 23

It is important that any regulatory adjustment does not move from a community rating system to one based upon risk where different premiums are charged based on age, gender, and lifestyle factors such as smoking and obesity. True risk rating will leave high risk people uninsurable.

Private health insurance must remain an option for consumers to make an active decision to insure for their particular needs regardless of risk, particularly if the public hospital sector is not adequately funded to meet demand and rations the treatment it provides. Today, an obese person who wants to change their life can purchase private health insurance for bariatric surgery and use the 12 month waiting period to lose the required amount of weight to prepare for surgery. This is unlikely to be an option if private health insurance is risk rated.

Summary

It would appear that the current system is delivering the goals of promoting affordable private health insurance as per the Government's strategy outlined in the Health Portfolio Budget Statement 2015-16[14].

> The Australian Government, through Outcome 6, aims to promote affordable quality private health insurance, and provide more choices for consumers. This will help improve the sustainability of the health system as a whole.

However, whilst currently affordable, it appears to be of questionable quality. The nature of the current policy offerings and behaviour of the insurers needs to be examined to determine the impact they have upon consumers' perceptions of value and therefore engagement with the private system.

If consumers withdraw from private health insurance, there will be additional pressure placed upon the public health system, which is already struggling to meet demand. The balance between the private and public system cannot be overlooked by this Review and the AMA argues that community rating is essential to maintain the delicate balance between the public and private hospital sectors in the Australian healthcare system and should be maintained.

As a part of this Review, a detailed analysis of the effectiveness of the current arrangements through which the Commonwealth supports the private health sector, through the private health insurance rebate and Medicare Levy Surcharge and the regulation of private health insurers and private health insurance products should be conducted prior to making changes.

Finally, changes to the private health insurance system are unwise until a full and transparent economic assessment of the potential outcomes of this Review, within the context of the current suite of health reviews underway, is conducted.

[14] The Australian Government Department of Health: *Portfolio Budget Statements 2015-16, Budget Related Paper No.1.10*, page 107