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PROPOSED INQUIRY INTO THE PRIVATE HEALTH SECTOR

Submission to the Australian Labor Party in response to the Discussion Paper: Proposed Productivity Commission Inquiry into the Private Health Sector

ABOUT US

Set up by consumers for consumers, CHOICE is the consumer advocate that provides Australians with information and advice, free from commercial bias. CHOICE fights to hold industry and government accountable and achieve real change on the issues that matter most.

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INTRODUCTION

CHOICE welcomes the opportunity to provide comments in response to the discussion paper on potential terms of reference for a Productivity Commission (PC) inquiry into private health insurance. CHOICE is a strong supporter of an independent inquiry into this sector that is causing significant consumer confusion and harm.

Australians need equitable, affordable access to quality healthcare. However, individuals are currently facing high costs, low value and high levels of complexity. To resolve these issues, the structural problems within Australia's private health system need to be urgently investigated. We need a deep and comprehensive examination into private health and its interaction with the public system to ensure Australia's health system can change in real and meaningful ways.

We strongly support the overarching proposal in the discussion paper for a PC inquiry to focus on how to improve the affordability, value and quality of private health insurance for consumers. Reform to this sector needs to be led by the needs of Australians .

Successive governments have failed to approach the failures of the private health sector with a critical lens, resulting in policies that have not been assessed for their effectiveness since their inception. A PC inquiry that looks beyond the surface issues of private health insurance and examines whether the current structures are delivering positive health outcomes for all Australians, including those relying on the public system,is the first step.

The proposed inquiry must have bold Terms of Reference and seek to answer deep questions on the structure of private health insurance and its interaction with the public system. This combined with an overarching lens of addressing affordability, value and quality of private health insurance for consumers will ensure that reforms to Australia's health system address health and consumer needs as a priority.

Recommendations

A PC inquiry should investigate:

- Patterns of cross-subsidisation across the private health insurance system, including between:
    - younger and older consumers; and
    - rural and urbanised populations.
- How private health insurance arrangements can be set up in a mixed private and public system to be equal and fair for all Australians.
- The net costs and/or benefits of public expenditure on private health insurance.
- The impact of current private health insurance arrangements on demand for services through the public health system, noting the original objective of private health insurance

to reduce pressure on the public system. This should include impacts, both positive and negative, that the private system may be having on waiting lists, access to specialists and quality of care in the public system.

- The impact of the Basic, Bronze, Silver and Gold categorisation and whether there are better options for reducing the complexity of policies.
- The interactions between hospital and extras insurance, including the impact of these interactions on health insurer profits, and costs and benefits to consumers.
- How consumer information can be improved so that individuals are empowered to make informed decisions in the marketplace.
- The arrangements between private health insurers and providers of health services and the degree to which these relationships are influencing economic and health outcomes for consumers.
- Measures that would improve transparency in pricing and increase demand-side competition.
- Direct measures that curb out-of-pocket costs.
- Options for developing a best practice informed financial consent model for specialists and hospitals to ensure private health insurance patients are fully informed of all out-of-pocket costs in advance.
- Factors contributing to premium increases in excess of the Consumer Price Index in recent years, and the effectiveness of current mechanisms for controlling premium increases, in the context of an industry that benefits from high levels of public subsidy.
- The impact of premium increases on costs and benefits of private health insurance to consumers and profitability of private health insurers.

Community Rating

Community rating is the requirement for private health insurers to charge the same for each product to every customer irrespective of their age, health or claiming history. CHOICE agrees with the underlying principles of community rating - that is, principles of fairness and equity. However, whether current private health insurance arrangements are actually delivering fair or equitable outcomes needs to be investigated.

Community rating only works when there is a large pool of people of good health or people who do not claim on a regular basis. Premiums from these people are used to subsidise private health insurance for older or more costly members. To achieve this, previous governments have implemented reforms to encourage people who do not need or are not likely to use private health insurance pay for policies in order to keep premiums affordable for older or higher volume members.

In seeking to achieve community rating via these policy levers, the opposite is in effect achieved. Through the introduction of the Lifetime Healthcare Loading and most recently the aged-based discount, people's premiums are affected by their age or when they decide to purchase private health insurance. Similarly, the Federal Government's recent categorisation of policies into Basic, Bronze, Silver and Gold discriminates against people based on their age and life stages as services required by older people (e.g. joint replacement) are only available under Gold policies. Different tiers of cover mean that the sicker or older you are and the more cover you need, the more you need to pay.

Community rating is also at risk of being further eroded by an emerging trend of insurers offering rewards or discounts on premiums based on a person's level of activity and health. Medibank has just launched a new app where customers can lower their premiums by taking a range of healthy actions.[1] Similarly, myOwn and GMHBA have partnered with AIA Vitality to offer premium discounts and rewards based on a person's health status and their level of physical activity. For example, you can earn 1,000 points for a 'no smoking declaration' or 50 points for walking 7,500 steps in a day.[2]

While the principles are sound, in practice pure community rating does not exist in the private health insurance market. The insurers are the beneficiaries of this. The result is that current private health insurance arrangements are not achieving fair or equitable outcomes. If you are older or sick, you need to buy a more expensive policy to ensure you are covered. If you are young, you are forced into a product that you don't need and may not be able to afford. Or if you

[1] Medibank Media Release 28 January, 2019, *Medibank to launch new health and wellbeing technology*
[2] myOwn Health Insurance, 2019; http://www.aia.com.au/en/adviser/our-products/myOwn.html and GMHBA 2019; https://www.gmhba.com.au/aia-vitality

are in a regional or remote area, you may be forced into a product that provides you with almost no value, as you may not be able to actually access it.

A PC inquiry should closely examine if and how community rating can work in a mixed private and public system to ensure that the system is fair and equitable for all Australians.

Recommendations 1 and 2

A PC inquiry should investigate:

- Patterns of cross-subsidisation across the private health insurance system, including between:
  - younger and older consumers; and
  - rural and urbanised populations.
- How private health insurance arrangements can be set up in a mixed private and public system to be equal and fair for all Australians.

Incentives and penalties

It is necessary to take a long hard look at the current carrot and stick initiatives used to encourage take up of private health insurance. While these measures were successful in terms of increasing uptake of private health insurance from the early 90s, take up is now decreasing, especially among young people.[3] More worrying, these initiatives are now resulting in perverse outcomes, and creating barriers for consumers who may wish to take up a private health insurance policy later in life.

Australians are increasingly choosing private health insurance to avoid financial penalties rather than choosing insurance that meets their health needs. In response, the health insurance industry has responded by offering a growing amount exclusionary or junk policies with co-payments and/or high out-of-pocket costs. In just three years, the amount of people on exclusionary policies has dramatically increased, from 35% in 2015 to 57% in 2018.[4] CHOICE estimates the number of people on low value policies to be even higher as some junk policies

[3] Parnel, S. 2017, 'Health insurance reforms to lower premiums, *The Australian,* https://www.theaustralian.com.au/national-affairs/health/health-insurance-reforms-to-lower-premiums/news-story/0f56f678fce80c32db80b75437af6eac and The Parliament of the Commonwealth of Australia, 2018, *Explanatory Memorandum* http://parlinfo.aph.gov.au/parlInfo/download/legislation/ems/r6081_ems_c61892cf-b3b6-4472-b0a2-07200230af52/upload_pdf/668043.pdf;fileType=application%2Fpdf

[4] According to APRA, the term "exclusionary" is covered in the Reporting Standard HRS 601.0 Statistical Data by State (F2016L01394) as meaning "no coverage at all … in a public or private hospital or any other setting for that condition". There has been no change to this definition in the transition from PHIAC to APRA. Data sourced from APRA's Private Health Insurance Membership and Benefits report, September 2018 & PHIAC's Member Coverage report, March 2015

(hospital only policies) are counted in APRA and PHIAC's definition of full cover and are therefore not accounted for.

We have no reason to believe exclusionary policies will decrease, especially considering the Federal Government's recent reforms do not address these policies. Under the new Basic, Bronze, Silver and Gold categorisation, basic coverage only requires insurers to offer restricted (public hospital) access to just three treatments: rehabilitation, hospital psychiatric services and palliative care.

When seeking treatment, people with low-value, basic or junk policies either need pay out of their own pocket, rely on the public system despite being private health insurance users, or delay or cease seeking treatment. These policies are not only poor value for consumers, but are poor value for the Australian community who subsidise junk policies that do not reduce the strain on the public healthcare system.

A PC inquiry needs to look into the current incentive and penalties structure and examine if it is efficient and producing positive health outcomes. It should also take into account that the initial intent of private health insurance was to take pressure off the public system and ask whether that is currently being achieved.[5]

Recommendations 3 and 4

A PC inquiry should investigate:

- The net costs and/or benefits of public expenditure on private health insurance.
- The impact of current private health insurance arrangements on demand for services through the public health system, noting the original objective of private health insurance to reduce pressure on the public system. This should include impacts, both positive and negative, that the private system may be having on waiting lists, access to specialists and quality of care in the public system.

Gold, Silver, Bronze and Basic tiers

While the four tiers of private health coverage are being sold as a solution that will make health insurance simpler for consumers, the reality is far from that. The four categories only stipulate minimum requirements, leaving insurers to choose to cover additional treatments (allowing their products to be called 'basic plus', 'bronze plus' or 'silver plus'). The result is millions of iterations of policies that could potentially exist.

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[5] Community Affairs Reference Committee, 2017, *Value and affordability of private health insurance and out-of-pocket medical costs,* https://aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Privatehealthinsurance/Report/c01

This is in large part due to the number of treatment categories. Previously there were around 12 often excluded treatments, but now there are 38 categories of treatments. The likely outcome of this is that health insurers will be able to cherry-pick treatments and tick more boxes of coverage than they previously could - without necessarily providing greater coverage in real terms. These categories were meant to help make purchasing private health insurance simpler for consumers, but in fact the categories just make it easier for insurers to market these products. The problem of consumer confusion, rather than being addressed, has been worsened.

CHOICE is also concerned that people will experience an unexpected reduction in coverage upon moving to new tiers of coverage. Namely, that minimum requirements for Basic, Bronze and Silver tiers may be lower than current equivalent low and medium cover policies. This means that private health insurance products could reduce in value and deliver less than what consumers currently receive on an equivalent product. For example, current medium-tier policies cannot restrict cover for rehabilitation, hospital psychiatric services and palliative care. However, Silver tier product will restrict cover for these three treatments.

Recommendation 5

- A PC inquiry should investigate the impact of the Basic, Bronze, Silver and Gold categorisation and whether there are better options for reducing the complexity of policies.

Coverage

As the discussion paper notes, more Australians were covered by general treatment policies (extras) than hospital policies in 2017. Extras coverage is the most common reason consumers purchase private health insurance. In a CHOICE survey, 57% cited cover for extras as a key reason for taking out private health insurance.[6]

CHOICE is concerned that there is some confusion between hospital and extras coverage. We believe affordability and complexity could be addressed by helping consumers to better understand the difference between hospital and extras coverage, and to assess the value of their extras based on data about how they use their policy. For example:

- Some people may believe extras coverage is required for tax benefits, when it is not;
- Many people are unaware that it is possible to purchase hospital and extras policies from separate insurers, rather than as combined policies (and that it can frequently be better value to buy these policies separately); and
- Extras cover is essentially a budgeting tool. Perceptions of value would be enhanced if consumers could quickly assess the benefits of their extras policies against the costs.

[6] CHOICE conducted a national survey of 1,027 Australian private health insurance policyholders in April 2017

They could use this data to explore the potential savings of other policies, from their own and other insurers. The Federal Government can support this by enabling easier access and use of this information through open data initiatives such as the Consumer Data Right.

In many cases, extras insurance is not good value for consumers because of the low dollar amount allocations for 'set benefits'. This is unsurprising considering the extras business model is to take more in premiums than people claim back in rebates. These products should be investigated further, especially in regard to the costs and benefits to consumers.

Recommendation 6

- A PC inquiry should investigate the interactions between hospital and extras insurance, including the impact of these interactions on health insurer profits, and costs and benefits to consumers.

Consumer information

Choosing and switching policies needs to be made much more simple. One of the biggest issues consumers have with private health insurance is the complexity of the market. With over 48,000 policies available, it is extremely difficult for people to find a policy that meets their needs and make meaningful comparisons. This is especially pertinent considering the 60% of Australians who have low health literacy.[7]

We are concerned that the Federal Government's reforms do not improve people's ability to make informed decisions and meaningful comparisons. Changes to the Private Health Information Statement (PHIS) further erode the ability for people to make informed decisions in the marketplace:

- Removing the requirement for the PHIS to be standardised means that consumers will find it difficult to compare policies from different insurers. It is not in insurers' interests for consumers to switch policies. Insurers should not be given the autonomy to decide how they display policy information to consumers. Rather, consumers should be provided with consistent and standardised information so that they are able to easily compare policies and understand what they are covered for.
- Removing the requirement for the PHIS to only be provided to consumers on request diminishes the portability protections afforded to them under the Private Health Insurance Act. Consumers need to have access to clear information about their policy at the right time and in a convenient formula to compare their product to others that meet their needs. The decision to switch health insurance is often triggered when consumers

[7] Australian Commission on Safety and Quality in Health Care, 2014, *National Statement on Health Literacy*
https://www.safetyandquality.gov.au/wp-content/uploads/2014/08/Health-Literacy-National-Statement.pdf

receive their premium increase notice. At this point, they need to know what they're covered for and being sent a standardised presentation of information on a policy is an important way of finding this out.

A functioning mixed private and public health care system should easily facilitate people to switch policies and select levels of coverage depending on their unique circumstances. Similar to the banking and energy sectors, there should be a priority on measures that encourage consumers to regularly test their products against the market, re-evaluate their needs and make it easier to switch combined with appropriate protections to ensure a minimum quality of service to people who remain with an insurer over time. A standardised information sheet proactively sent to consumers via their preferred channel (i.e. mail or email) would help people better understand their coverage and encourage switching. A PC inquiry should look into how information can be best presented to consumers to ensure they are empowered and engaged to find the best insurance product for their needs.

Recommendation 7

- A PC inquiry should investigate how consumer information can be improved so that individuals are empowered to make informed decisions in the marketplace.

Transparency and unexpected out-of-pocket costs

To predict the out-of-pocket costs associated with a procedure or treatment, consumers currently have to consult a variety of sources as these costs are typically not provided in a simple or single format. This can be a difficult process as many people do not have the information or capacity to properly understand the quality or function of each specialist or hospital, the difference between individual item numbers, or the timeliness within which a procedure must be performed. These costs can be unpredictable, ranging from a few hundred dollars to thousands of dollars. Variations include:

- Room charges (overnight or day) between hospitals;
- Other specialists involved in the procedure such as assistant surgeon;
- Pathology and other tests;
- Changes can occur during a procedure, changing or adding additional item numbers charged; and
- Fees for follow up visits with specialists or ongoing allied health services.

Further complicating matters are gap contracts or arrangements between insurers and health providers. Not only can these arrangements restrict choice of care, they have implications for people's healthcare. People are incentivised to choose a healthcare provider that their insurer has a relationship with, rather than choosing a provider that meets their particular health needs.

Policy solutions that drive competition in the private health care market need to be investigated. User-orientated information would better empower patients in the private health sector and encourage competition. As a first step, transparency in pricing for common procedures would allow consumers to compare the cost of their surgeon and specialist and encourage shopping around. Consumers could then consult their first specialist of choice, and compare that price against a listed average treatment cost, or the treatment costs of alternative specialists provided to them by their general practitioner. These costs could be provided by either requiring the doctor to make average prices available online (through a professional body) or over the telephone. This would then reduce costs for the consumer, who would not need to see multiple specialists (and pay for each separate consultation).

While greater transparency and reduced transaction costs is important, it is far from a complete solution and still relies on consumers to be engaged in a complex system. It is not realistic or in fact reasonable to expect people with acute health needs, many of them vulnerable, to spend additional time engaging with the market. Therefore CHOICE believes there is a case for considering measures that curb unexpected or excessive costs for consumers. We appreciate this issue is currently being looked at by the Ministerial Advisory Committee on Out-of-Pocket Costs and strongly emphasise the need for out-of-pocket costs to be addressed with reference to consumers' needs and concerns.

Recommendations 8, 9 and 10

A PC inquiry should investigate:

- The arrangements between private health insurers and providers of health services and the degree to which these relationships are influencing economic and health outcomes for consumers
- Measures that would improve transparency in pricing and increase demand-side competition.
- Direct measures that curb out-of-pocket costs.

Informed financial consent

Consumers are confused about the financial arrangements of specialists, hospitals, Medicare and insurers. While they sign paperwork for their procedure, it is highly unlikely that this would constitute 'informed financial consent'.

Much clearer information should be provided to consumers about the cost of a treatment, the cost covered by their fund, the cost covered by Medicare and the out-of-pocket costs. If a consumer were fully informed of their financial obligations well in advance of a procedure, it would empower them to negotiate costs or shop around, increasing competition and lowering costs for all consumers

A best practice informed financial consent model should be developed for specialists and hospitals to ensure private health insurance patients are fully informed of out-of-pocket costs in advance.

Recommendation 11

A PC inquiry should investigate:

- Options for developing a best practice informed financial consent model for specialists and hospitals to ensure private health insurance patients are fully informed of all out-of-pocket costs in advance.

Rising premiums

The issue of rising premiums should also be investigated by a PC inquiry. The cost of healthcare is a significant concern for Australians with insurance premiums rising by 70% in the past decade. This has outstripped the Consumer Price Index almost three-fold. In a CHOICE survey, 70% of people with private health insurance said that they received average or poor value for money. Of those that do not hold private health insurance, 68% said the reason why was because it is too expensive.[8]

As a direct result of rising premiums, many people can no longer afford to stay insured when they reach an age when they will need it most. After many years of paying into the private health insurance 'pool' they are being forced out by rising premiums and are unable to use the system they have spent many years contributing to. 72% of people aged between 50 and 74 said the reason they do not hold private health insurance is because it is too expensive.[9]

Recommendations 12 and 13

A PC inquiry should investigate:

- Factors contributing to premium increases in excess of the Consumer Price Index in recent years, and the effectiveness of current mechanisms for controlling premium increases, in the context of an industry that benefits from high levels of public subsidy.
- The impact of premium increases on the cost and benefits of private health insurance to consumers and profitability of private health insurers.

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[8] CHOICE Consumer Pulse Survey, September 2018, n=1,057
[9] CHOICE Consumer Pulse Survey, September 2018, n=1,057