We are hirmaa

4 December, 2015

Ms Janet Quigley
Assistant Secretary
Department of Health
GPO Box 9848
CANBERRA ACT 2601

Dear Ms Quigley

Consultations on issues pertaining to the private health insurance industry

Thank you for the opportunity to provide a submission to the Department of Health as part of the Government's consultations on the value of private health insurance for consumers and its long-term sustainability.

hirmaa commends the Government's leadership on health reform and its recognition that private health insurance forms an important part of Australia's health policy mix.

hirmaa represents 18 member-owned, not-for profit and community-based private health insurers, comprising both industry or employer focused "restricted access" insurers and "open" insurers serving particular regions. Collectively, hirmaa funds provide health insurance to over one million Australians.

hirmaa member funds are distinguished by their value-based business model as member-owned not-for profit and community based, which sees close to 90 per cent of all premiums returned to members in benefits. Despite their smaller size and scale, hirmaa insurers consistently outperform the big for-profits across most key indicators including lower premium rises, higher retention rates and faster than industry average membership growth.

Private health insurance is a vital element of Australia's health mix and an important contributor to the country's health outcomes. Health spending in Australia accounts for 9.1 per cent of GDP, slightly below the OECD average of 9.3 per cent. This is coupled with superior health outcomes such as increased average life expectancy of 82, which is among the highest in the OECD.

Almost half of all Australians hold private hospital cover while more than 55 per cent have some form of ancillary or extras cover. Private health insurers paid a record $17.2 billion in benefits in 2014 and are on track to exceed that figure in 2015.

About 41 per cent of all procedures occurred in one of Australia's many private hospitals where patients receive quick access to quality treatment. That's in contrast to the public system where patients are forced to endure long waiting lists that in some jurisdictions extend beyond a year.

hirmaa acknowledges that opportunities exist across the health system for significant reform. In its submission, hirmaa has focused on five key principles: Consumer empowerment; Improving transparency; Reducing complexity; Enhancing competition; and, Improving affordability.

At the outset it is important to note that the Private Health Insurance Act 2007 imposes very strict requirements on private health insurers around transparency and accountability.

Most aspects of a private health insurers operations are made publically available through the 'State of the health funds report' published by the Commonwealth Ombudsman. This report details the financial and operational performance of health insurers including their Management Expense Ratio. It is unfortunate that

this level of transparency and accountability around performance does not extend to all service providers in the health sector including hospitals, prostheses and specialists.

As Government would be well aware, private health insurers operate on paper-thin margins. There is vigorous competition between the 33 private health insurance funds currently operating in the marketplace and the cause of health inflation lies squarely with health service providers.

Rising prostheses costs represent a major contributor to annual premium price increases with private health insurers paying more than $1.7 billion for prostheses in 2013/14 alone (or 14% of all benefits paid). hirmaa research indicates that for some common prostheses items such as pacemakers and hip replacement parts, Australian health insurers are forced by government regulation to pay up to 300 per cent more than they would in comparable countries, such as France.

Affordability of private health insurance in Australia has historically been underpinned by the principle of Community Rating, which keeps the system affordable for both older and/or less healthy people.

The declining Australian Government Rebate on private health insurance undermines this vital principal, making it less attractive for people at the healthier end of the spectrum, which in-turn discourages membership take up rates and throws off the Community Rating balance.

hirmaa suggests that with the decline of the rebate, private health coverage will decrease to such an extent that the public hospital system will be forced to accommodate greater volumes of cases.

hirmaa is a strong advocate for retaining the Australian Government Rebate on both hospital and Ancillary/Extras. The rebate on extras is well founded, without government incentives on extras, younger individuals, who have historically been drawn to health insurance through extras cover, could diminish. This threatens the balance and cross-subsidy between younger, healthier groups of policyholders and high-claiming groups, and therefore Community Rating.

For those in good health, extras cover is often the only tangible benefit they receive and extras cover for services such as dental and optical have proven highly effective in enhancing health outcomes. If only people in poor health choose to remain insured, the required premium rates would become unaffordable. The resulting spiral of increasing premiums followed by the lapsing of relatively healthy policyholders would push additional costs onto public hospitals.

Improved transparency measures, a fixed Australian Government rebate on private health insurance and prudent market instruments will encourage competition and empower consumers, delivering both improved health outcomes and savings to government and the public by to curbing inflationary factors within the health system that are impacting affordability.

hirmaa member-owned, not-for profit and community-based funds have a long and respected history of improving healthcare outcomes for their members, out-performing the big for-profit funds on almost every measure.

Over the past five years hirmaa funds' premium increases averaged 5.1 per cent, compared to almost 6 per cent among the big for-profit insurers. Member retention rates among all 18 hirmaa funds, meanwhile, remain consistently higher than the industry average at 89.7 per cent.

hirmaa strongly believes that meaningful reform can be achieved to improve the value of private health insurance and alleviate cost pressures on the Government and we are pleased to be able to present our ideas in this submission.

If you require further detail on any of the material contained within this submission, please do not hesitate to contact our offices on 03 9896 9372

Yours sincerely

MATTHEW KOCE
Chief Executive Officer

We are hirmaa

Contents.

Executive summary

The Department of Health's current review of Private Health Insurance (PHI) legislation and regulation is the first significant and comprehensive re-examination of PHI industry governance since 2007.

While there have been piecemeal changes since then, particularly to the PHI Rebates and the Medicare Levy Surcharge, this review is booth timely and welcome.

As the industry association of 18 member-owned, not-for-profit and community-based private health insurers, hirmaa covers over one million Australians for their hospital, general treatment and ancillary needs.

As an association we emphasise our common belief in fairness. That belief applies to what we stand for and what we advocate.

Therefore, while we welcome the possibility of legislative, regulatory and governance reform, hirmaa believes that it must be fair: to people covered by PHI; to the insurers and providers who pay and deliver the services PHI covers; and the taxpayers who support PHI through government incentives.

In the same way, we believe that regulation needs to be "lighter-touch" than now, to allow a greater role for market forces, including competition on price and quality, in PHI premium setting, purchaser-provider contracting negotiating and fostering a greater emphasis on satisfactory quality of provision and outcomes.

PHI works

This submission makes a number of points and suggestions for improving PHI and the private health sector.

It does so, however, from the starting point that private health insurance is the most efficient, fair and affordable way of giving Australians access to private hospital, medical and ancillary services.

In terms of PHI rebates, the taxpayer's investment in them increases the efficiency of overall health spending. Professor Ian Harper, who went on to conduct the Government's recent competition policy review, found in 2003 that every dollar spent on the PHI Rebate saved two dollars of federal and state health spending.

In terms of provision, one in three patient days are provided in private hospitals, and six out of ten elective surgical procedures are performed in the private setting. Most of these episodes are for patients funded by PHI. Similarly, privately-insured patients are a very big component of demand for ancillary services, particularly dental and optical.

When it comes to fair access and keeping the full healthcare cost burden off the shoulders of taxpayers, PHI works.

Support for the "three pillars" of PHI should continue

hirmaa believe that the "three pillars" of PHI since 1998 – the PHI Rebates; the Medicare Levy Surcharge and Lifetime Health Cover – together have worked very well to increase and stabilise PHI participation, deepen the risk pool of insured persons and therefore sustain Community Rating.

Each pillar has benefited PHI and private health choice, and together they have boosted participation from around 30 per cent in 1997 to around 50 per cent today. That result speaks for itself.

While each of these pillars can be fine-tuned, the removal of any one of them would, in hirmaa's view, be disastrous for not only the PHI industry but the whole private healthcare sector since it is dependant on PHI benefits as a principal source of revenue.

Reform should not compromise the future of PHI

There are those who do not believe in the private health sector and private health insurance. They prefer that public money should be solely for the public system, especially public hospitals. To listen to those calls would be a mistake as they fail to understand the contribution the private health sector actually makes to the sustainability of the public system.

Moreover, policy innovations should complement PHI, not undermine or destroy it. For that reason, hirmaa opposes the Commonwealth's Option 2 for hospital funding reform whereby the Commonwealth would pay 40 per cent of the cost of a hospital episode regardless of whether it is public or private, and abolishing PHI rebates to help pay for the change.

We believe that the unintended consequence of Option 2 is not only the viability of PHI for general treatment, but the viability of private hospital and medical services. Any incentives for individuals to choose to "go private" in the private sector would be lost. PHI itself would become a marginal product, except for ancillary cover.

Similarly, hirmaa has reservations about the concept of Health Savings Accounts (HSAs). While the intention is commendable, how HSAs work in the Australian context of a mixed public-private/Commonwealth-State system needs to be thought through and modelled very carefully, so that it compliments PHI and upholds the principle of Community Rating.

PHI Rebates

hirmaa supports the retention and simplification of PHI rebates, as a key part of keeping the private health choice affordable to Australians on middle and lower incomes.

As stated earlier, the Rebates take pressure off both public hospitals and taxpayer-funded health funding. When seen against those savings and efficiencies, the cost to the Commonwealth budget is reasonable, provided that the PHI Rebates themselves are applied appropriately and wisely.

hirmaa believes that since means testing was introduced to the PHI Rebates they have become unduly cumbersome and costly to administer for not only the Government, but insurers and especially PHI consumers. We do, however, recognise that the cost of the PHI Rebates needs to be kept manageable for taxpayers.

We therefore propose that the PHI Rebates are fixed at current levels at a minimum, simple and free of means tests. This would ensure a stable and reliable premium relief for all PHI member age groups.

Furthermore, this submission proposes that consistent product standards for general treatment and ancillary products are set under the label *MyHealthCover*. In our view, this would make inferior-quality products – especially public hospital only and extensive exclusion policies – unviable.

Restraining provision cost growth

hirmaa notes that much of the Government's concern over the consumer experience of PHI is squarely focused on policies carrying restrictions and exclusions, which have proliferated in recent years.

Our members share the Government's concern, but we note that the main reason for restrictions and exclusions is the need to keep PHI policies and premiums as affordable as possible for consumers.

Given that around 90 cents in each premium dollar goes on benefits, and this proportion continues to increase, provider costs growth needs to be tackled in order to ensure affordability of high quality policies.

Reining in premium growth and minimising exclusions and restrictions therefore means tackling the cost side of the equation. That means scrutinising the cost structures and practices of private hospitals, doctors and the supply and utilisation of prostheses.

Purchaser-provider arrangements are central to cost reform. The current hospital and medical purchaser-provider agreement legislation has survived relatively unchanged since it was first passed in the "Lawrence Legislation" reforms of 1995. It needs to reflect modern commercial and clinical best practice, rather than be a time capsule of 20 years ago.

In this submission, hirmaa urges the Government to consider:

- Liberalising the unduly strict regulation of hospital and medical purchaser-provider agreements to allow insurers to drive better contracting outcomes in the interests of their members.
- Allowing insurers greater freedom to contract with providers for quality outcomes with pay-for-quality conditions;
- Removing the Second-Tier Default benefit to level the contracting playing field between insurers and private hospitals, and deterring predatory private patient elections by public hospitals.
- Reforming the payment regime for prostheses to ensure that patients can continue to access the best-quality and fit-for-purpose prostheses at fair prices with the opportunity for excessive price-taking by providers and suppliers eliminated.

Removal of the Second-Tier Default Benefit is especially important. It would introduce a far greater commercial edge into the contracting process. It would also end the practice where providers can open a facility and expect insurers to come to the party simply because the facility exists. Above all, it would underpin the message that contracting should be about quality outcomes, not quantity inputs.

Additionally, removal of Second-Tier Default Benefits would put a brake on public hospitals using unfair inducements to persuade insurer patients to elect private status on the assumption they claim the default benefit and bill medical services to Medicare, and still save on the full episodic cost to them.

The high cost of prostheses is a major contributor to annual premium price increases with private health insurers paying more than $1.7 billion for prostheses in 2013/14 alone (or 14 per cent of all benefits paid). Evidence shows that for some common prostheses items, such as pacemakers and hip replacement parts, Australian health insurers are forced by government regulation to pay up to 300 per cent more than they would in comparable countries, such as France. Benefit clearly does not reflect the true price, and the "profits" are being taken by the providers and suppliers at the expense of insurers, patients and Government.

hirmaa understands that targeting provider costs is politically more difficult than simply focusing on insurers, especially given the powerful vested interests involved. If, however, the Government truly is serious about reforming PHI to make it more consumer-friendly, targeting product coverage and price alone is pointless.

Other efficiency, coverage and price reforms

PHI may work well, but it can always be improved. In addition to the key proposals outlined above, this submission makes a number of practically and relatively easy to implement suggestions.

These include:

- Increasing the Medicare Levy Surcharge thresholds to encourage higher income earners to make the private health choice rather than rely on the public system.
- Doing more to address the problem of excessive specialist out-of-pockets, ideally to eliminate patient bill shock when a specialist does not accept what is offered by their insurer.
- Increasing the allowable excesses in PHI policies, to keep excesses up with current prices and to allow consumers a greater choice of products with their own needs and budgets.

- Widen the open door between PHI and primary care – especially General Practice – to allow insurers to play a greater part on supporting their members to manage their health and chronic conditions, while not compromising GPs' clinical independence.
- Encouraging Commonwealth, State and Territory governments to work together to standardise access to ambulance services around Australia, giving national consistency to patients and to payers, including insurers; and
- Deregulating the PHI premium-setting process to improve competition and reduce unnecessary red tape.

Conclusion

PHI regulation is necessary, but it does not need to be excessive. The private health choice is generally working well, while under sustained provision cost pressures that won't be reduced without some regulatory intervention.

Notwithstanding this, PHI is, however, one of the most heavily regulated industries in Australia. It needs a "lighter touch" and more flexibility if it is to improve its value to consumers and remain affordable.

Besides what is proposed specifically in this submission, hirmaa recommends that in 2016 the Government does a root and branch review of the Private Health Insurance Act 2007 and Rules, to eliminate or moderate regulatory requirements that are obsolete, anti-competitive and anti-consumer.

The overall goal of policy reform in the private health "space" should always be better consumer choice and empowerment, greater consumer satisfaction and, above all, fair access to all Australians to the high-quality and affordable private healthcare services and facilities.

Matthew Koce, CEO, hirmaa

Brad Joyce, Chair, hirmaa

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Michael Oertel, CEO, Police Health

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Chris Williams, CEO, St Lukes Health

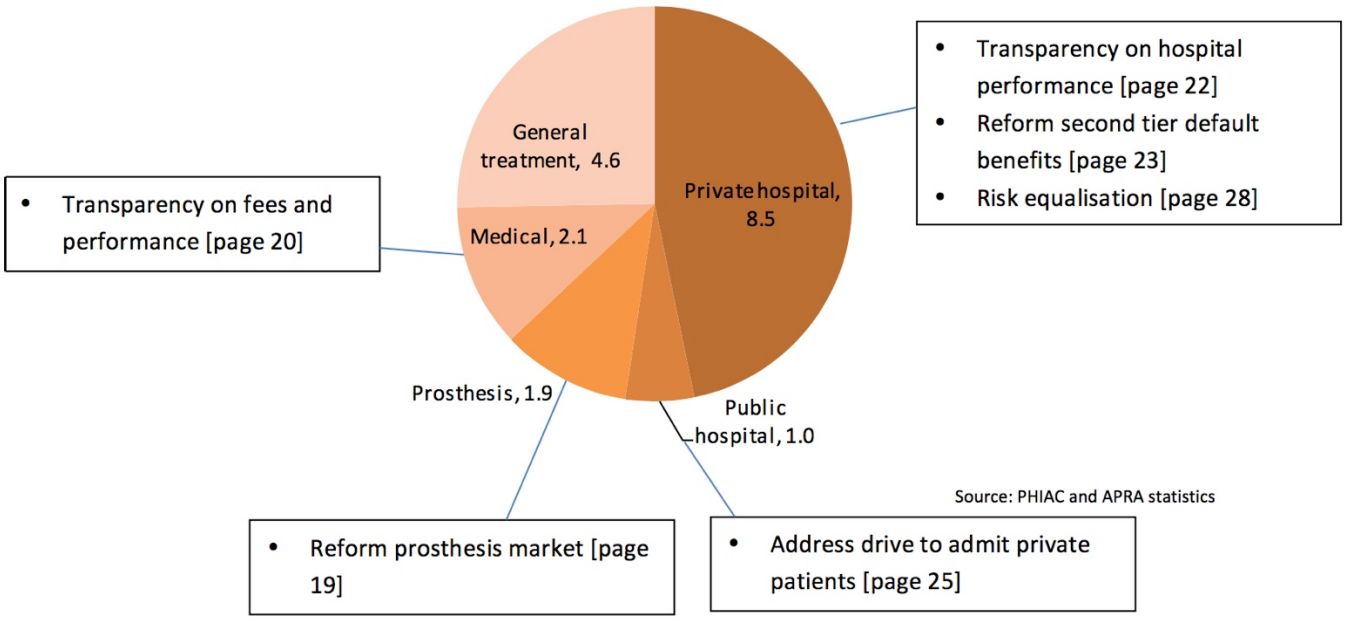
Rob Seljak, CEO, Teachers Union Health

Grahame Danaher, CEO, Westfund

Michael Bassingthwaighte AM, CEO, Reserve Bank Health Society

Private health industry at a glance.

Services funded in year to 30 September 2015 ($bn)



Source: PHIAC and APRA statistics

The benefits of member-owned to PHI industry competition.

Consumer empowerment ✓

Enhancing competition ✓

Improving affordability ✓

Key point

- Not-for-profit PHI insurers provide better outcomes for consumers than for-profit insurers, and play a vital role in driving choice and competition.

Since its formation in 1978, hirmaa has advocated for the preservation of competition and choice in the private health sector, believing it to be fundamental to Australians having access to best-value health care.

hirmaa funds are vital to retaining healthy competition in the private health market, have consistently proven to deliver best value health care services and consistently demonstrate the highest levels of integrity and viability in the industry.

hirmaa funds are distinguished by a number of key characteristics. These include their value-based business model as member-owned, not-for-profit and community-based organisations. They offer various levels of insurance at highly competitive premiums with optimised benefit entitlements and have proven their capacity to tangibly grow their membership numbers year after year.

Australia's 27 member-owned, not-for-profit and community-based funds of which hirmaa represents 18, make a notable contribution to the wider Australian economy, constituting about 35 per cent of the private health market and providing health insurance to almost 4.6 million Australians.

Unlike for-profit funds, member-owned insurers pay out almost 90 per cent of premiums received back to members as healthcare benefits. During the 2013-14 financial year, mutual/member-owned health funds paid 88.5 per cent of premiums back to members and ran average net surpluses of 1.7 per cent. Meanwhile, for-profit health funds paid back less than 85 per cent of premiums and banked an average net-profit margin for external shareholders of 6.8 per cent.

By retaining net-surpluses, member-owned, not-for-profit and community-based funds build healthy and prudential capital reserves, which provide added security against external economic shocks such as stock market fluctuations. It also allows them to operate at lower net profit margins and leaves them better equipped to provide consistent top-tier cover and beat the market on premium increases.

Notable achievements of Australia's 27 member-owned, not-for-profit and community-based private health organisations include;

- Between 2010 and 2015, hirmaa funds averaged a premium increase of 5.14 per cent compared to for-profit funds' increases averaging 5.51 per cent.
- Private health Insurance Ombudsman's data indicates 89 per cent of member-owned, not-for-profit and community-based fund policyholders have stayed with the same organisation for two years or more, compared to 81 per cent across for-profits insurers.
- Combined annual compounded growth rates of 4.17 per cent for member-owned private health funds, compared to 2.05 per cent for for-profit funds in 2013/14.
- hirmaa insurers deliberately operate lean, yet prudent margins in order to pay higher benefits back to members. hirmaa funds averaged a net profit margin of 4.5 per cent in 2013/14 compared to

more than 5.3 per cent among the big 3 for-profit funds.

- hirmaa funds consistently outperform the industry in customer service, accounting for just five per cent of complaints reported to the Private Health Insurance Ombudsman.
- Independent research undertaken by Discovery Research based on close to 18000 responses from hirmaa member fund policyholders in 2015 shows satisfaction rates are above 97 per cent.

The evidence clearly suggests that not-for-profit insurers provide better outcomes for consumers than for-profit insurers and play a vital role in driving choice and competition. It is essential that any reform of private health recognises the important contribution small and medium-sized insurers make to the market and it is crucial that reform is not detrimental to competition and choice.

Further reading see:

- Appendix 1: hirmaa Member Satisfaction Research
- Appendix 2: hirmaa submission to Senate inquiry into cooperative, mutual and member-owned firms in the Australian economy
  Appendix 3: The Facts. Private health insurance

My Health Cover.

Consumer empowerment ✓

Improving transparency ✓

Reducing complexity ✓

Enhancing competition ✓

Improving affordability ✓

Key points

- Maximum PHI subsidies for general treatment products should apply to endorsed comprehensive products.
- A *MyHealthCover* standards regime administered by or on behalf of Government that certifies PHI policy products as sufficiently comprehensive and eligible for the maximum subsidy.
- PHI rebates should in future only be applied to endorsed general treatment and ancillary products.

Confidence in the PHI industry is being undermined by its ever-increasing complexity.

There are more than 46,000 open and closed (currently offered and sold, and no-longer offered but still held by consumers) PHI products in the Australian market provided by 33 different insurers. The number of PHI products in the market has increased in recent years with the rise of low-cover policies, which focus more on exclusions rather than inclusions and offer low premiums to bring in new members.

The Australian Competition and Consumer Commission's (ACCC) sixteenth report to the Australian Senate on the state of the private health insurance industry[1], published October 20, 2015, raised concerns over the industry's complexity and its inability to communicate policy terms and conditions effectively with consumers.

The ACCC listed the ever-increasing and overly-complex pool of PHI policies, and the growing number of variable policy benefits, exclusions, variations and differing terminology as key impediments to consumers' decision-making capabilities, which in-turn is rendering the market uncompetitive.

Similar to the *MySuper* strategy introduced by the Gillard government in 2011, hirmaa suggest that an industry-wide, Government endorsed level of comprehensive cover would resolve these concerns.

A *MyHealthCover* requirement would dictate either a minimum standard or a defined standard of top-tier comprehensive hospital cover, which would cover consumers for what a 'normal person' would expect to receive coverage for - all normal therapeutic and diagnostic services.

Policy products would require a *MyHealthCover* endorsement from the Government, a regulatory body such as the Australian Prudential regulation Authority (APRA) or the Commonwealth Ombudsman in order to receive a fixed, non means-tested, non-indexed Australian Government rebate in order to incentivise consumers to upgrade their cover.

It would also drive insurers to close down non-complying products, particularly those with exclusions as they would become not only unprofitable, but unviable.

Health insurers would be allowed to offer these products provided they meet the industry and government agreed standard. It is imperative that prior to implementation the Government consult extensively with health insurers to determine:

- The most effective and comprehensive minimum or standard level of private health that would be eligible for the qualification

[1] ACCC report to the Senate on private health insurance: https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2013-14

- The fixed maximum rebate; and
- Simplified product terminology and product disclosure standards for consumers.

Benefits of a MyHealthCover regime for consumers and Government:

Clarity and assurance to consumers

Consumers would be assured that all policies with the *MyHealthCover* endorsement provide a set level of comprehensive hospital cover without any unexpected exclusions and restrictions.

Instead of being overwhelmed by complexity and caught out by nasty surprises at time of need, consumers will be able to more easily compare insurers and products on a like for like basis that meets a benchmark for quality, and assurance.

Improved customer engagement

A *MyHealthCover* standard would improve customer engagement with private health products, which was a major concern of the ACCC's latest report on the industry, by providing an effective information and comparison tool that uses standardised terminology and presentation.

Better customer incentives

As consumers take up *MyHealthCover* products, the price is likely to fall as younger, healthier members move into the product and cross-subsidise older, less healthy members who are more inclined towards top-cover policies. This is wholly consistent with the core principle of Community Rating of which hirmaa funds are strong supporters, while keeping the price burden on younger and healthier members.

This burden would, of course, be further mitigated by a consistent PHI rebate attached to the endorsed products.

Having a fixed rebate attached to the *MyHealthCover* standard while the remainder of private health products in the market receive only the existing, means-tested and indexed rebate would further incentivise consumers to upgrade their cover. This gradual uptake could subsequently see a reduction in the amount of exclusionary policies and reduce pressure on the public system and deliver savings for government. Presently the rebate costs the Australian Government $6 billion annually yet leverages around $17 billion private health insurance benefits.

Incentives must remain on ancillary

Ancillary or 'Extras' cover would not be included in a *MyHealthCover* product but would be available as a separate, 'bolt on' product.

Ancillary benefits should continue to receive the Australian Government Rebate. Ancillary benefits such as optical and dental provide a gateway to further, comprehensive hospital cover policies. Industry experience is that once consumers experience the benefits of private health cover through ancillary, they tend to upgrade policies to combined hospital and extras policies.

These also give something tangible to younger and healthier people who are unlikely to see the inside of a hospital for many years, but who encounter dental, optical, physiotherapy and other services covered by ancillary products.

Additionally, the health services provided through extras such as dental and optical – and especially dental as a prime determinant of good all-round health – can help reduce hospitalisations and result in improved health status for consumers.

Higher minimum standards on complying private health products.

Consumer empowerment ✓

Improving transparency ✓

Reducing complexity ✓

Enhancing competition ✓

Improving affordability ✓

Key points

- Policy restrictions and exclusions undermine and potentially destroy the entire private health choice's value proposition.
- hirmaa funds support a review of the minimum standards on complying health insurance policies to ensure that all complying products are fit for purpose and meet consumer expectations.
- Providing consumers with access to quality care is core to the business model embraced by hirmaa funds, which are member-owned, not-for-profit and community-based.
- Ensuring higher minimum product standards means addressing factors causing PHI costs to increase well ahead of CPI.

hirmaa funds return 90 per cent of all premiums back to member benefits and consistently record a 98 per cent customer satisfaction score (See Appendix 1). This very high benefits to expenses ratio highlights a major efficiency difference between PHI and other major insurance sectors including life, home and general insurance.

Given this, the main driver of PHI premiums is the cost of medical, hospital and other healthcare services that premiums purchase for consumers.

Cost factors and restrictive/exclusionary PHI products

At present, a private health insurance policy must offer a certain level of benefits for psychiatric care, rehabilitation and palliative care in order to qualify as a complying health insurance product and receive the Government Rebate.

In addition, hospital and medical provider costs continue to grow well in excess of CPI, being driven heavily by utilisation, technology and labour factors over which insurers have little or no control.

Restrictions and exclusions are among the few tools available for lowering premiums in response to consumers' affordability concerns. The growth in popular comparator websites that focus consumer attention on price; affordability pressures stemming from the decline of the Australian Government Rebate; and growing service provider costs have all acted to exacerbate this exclusionary trend.

Based on APRA data, hirmaa estimates that low-cover, exclusionary products account for about 15 per cent of the private health insurance market.

Furthermore, consumers tend to 'set and forget' their policies, which leaves the hospital or doctor to inform the policyholder that they are not covered during what is often a time of personal or family crisis. Insurers do their best to notify members of cover changes, but in many cases these are either not received or fully understood.

In summary, restrictive and exclusionary products damage the private health insurance market because:

- Consumers are unable to accurately assess the risk of requiring or excluding a service.
- They are complex and consumers lack awareness of their restrictions.
- They undermine Community Rating.

Above all, however, they inflict severe damage on not just PHI as a value proposition for consumers, but on the whole private health choice. Private hospitals and private practice medical specialists' reputations are damaged when a patient finds that his or her cover is not as comprehensive as they thought. If patients decide to drop their PHI and rely on the public system, insurance providers and the Government lose.

Impact on hirmaa insurers

hirmaa insurers pride themselves on offering high-value products. Competitive forces, however, are increasingly compelling hirmaa insurers to offer policies with exclusions and restrictions, to remain competitive on price and product.

Unless those cost growth pressures are contained, partly by levelling the price negotiating playing field between payers and providers (discussed elsewhere in this submission), the pressure to increase restrictions and exclusions will only grow more strongly.

We note that the public consultation on private health insurance has questioned the application of the Government rebate to 'public hospital only' policies. Such policies can encourage cost-shifting by the states to Commonwealth-subsidised PHI and shut more cost-efficient private hospitals out of competing with public hospitals.

However, hirmaa strongly suggests that any change in minimum standards and/or the application of the rebate, as detailed above, must be done so in conjunction with improved incentives to take out high value, high quality private health insurance policies.

The establishment of a *MyHealthCover* regime combined with streamlined PHI rebates (as detailed earlier in this submission) would adequately provide this incentive.

Further reading:

- Appendix 1: hirmaa Member Satisfaction Research
- Appendix 2: hirmaa submission to the Senate inquiry into cooperative, mutual and member-owned firms in the Australian economy
- Appendix 3: The Facts. Private health insurance

Reducing the Government rebate on private health

Enhancing competition ×

Improving affordability ×

Reducing complexity ×

Key points

- Regular changes to PHI Rebates since 2008, decreasing their value and peoples' eligibility for them, has created uncertainty and contributed to the real cost of PHI increasing well ahead of CPI for consumers.
- Further reductions to the Rebates' value and eligibility would be counter-productive.
- hirmaa proposes fixing the PHI rebate to current levels, at a minimum – i.e., comparable to the average per capita rebate after means testing – if means tests are removed.

Private health insurance in Australia is underpinned by the principle of Community Rating which serves to keep the private health system affordable for older and/or less healthy people.

Such affordability can only be ensured by encouraging large numbers of young, healthy Australians to insure. Policy measures such as the 30 per cent private health rebate and the Lifetime Health Cover loading were introduced with this explicit intention. In light of the future challenges faced by the health system, the private health industry must retain the support of Government to encourage younger Australians to insure and to help alleviate the future burden on public finances.

The private health industry has been hit by a string of government policies that *reduce* support for the industry. The means-testing of the rebate, the indexation of the rebate to CPI and the removal of the rebate from life time health cover loadings were all made as short-term cost savings, without consideration of the broader context of the interplay between the private and public health systems and without regard for the medium or long-term financial consequences.

Policies that have reduced the value of the rebate serve only to undermine support for the private health system, leaving private health consumers (over 50 per cent of the population) facing an increasingly complex system with gradually diminishing financial support. For example, the CPI indexation legislation serves to effectively phase out the rebate over time, as rising health care costs cause premiums to rise at a rate above CPI.

This poses significant challenges to the private health system and by extension, the public health system. It is not unreasonable to suggest that with the decline of the rebate, private health coverage will decrease to such an extent that the public hospital system will have to take on a significantly greater volume of cases.

One only needs to observe the decline in private health coverage throughout the 1990s, where coverage reached a low of around 30 per cent and looked set to decline further until the 30 per cent rebate, the lifetime health cover legislation and Medicare Levy Surcharge legislation arrested the trend.

hirmaa argues that in 2015, a similar trend is emerging, but underneath the surface. In her media release of 8 November, 2015, the Health Minister referred to how Australians have dumped or downgraded around 500,000 comprehensive policies in 2014-15. There is no denying that the trend toward cheaper, lower cover policies, is a direct consequence of a declining Australian Government Rebate on private health.

"The latest statistics also showed that for the 12 months to September, 60-79 year olds accounted for 50 per cent of policyholder growth, while the number of 20-29 year olds with hospital cover declined by 1 per cent."

If this trend is not arrested, worse if it is exacerbated by reducing support through the Australian Government Rebate, the impact on public hospitals could be significant.

hirmaa suggests that no changes are made to the rebate that increase its complexity or diminish its value. This applies in both the case of the rebate on hospital policies and the rebate on ancillary or 'extras' policies which provide benefits for crucial services such as dental and optometry.

Ideally, PHI rebates should be applied without means tests. This is administratively much simpler (with attendant cost and efficiency savings) for governments, insurers and, most importantly, consumers. Given the impact of means testing has reduced the average per capita rebate on premiums, hirmaa suggests that at a minimum a standardised, non-means tested PHI Rebate fixed at current levels for a qualifying product such as MyHealthCover, would be both fair and provide a sufficient incentive to consumers to choose private health and private health insurance.

Ancillary policies and PHI Rebates

It is important to reiterate that ancillary benefits should continue to receive the government's private health rebate. Ancillary benefits such as optical and dental provide a gateway to further, comprehensive hospital cover policies. That is to say that once consumers experience the benefits of private health through ancillary, they tend to upgrade policies to combined hospital and extras policies.

Additionally, the health services provided through extras such as dental and optical help to reduce hospitalisations and result in improved health outcomes for consumers. Reclaiming the rebate from extras could act as a price signal discourage consumers from accessing ancillary services resulting in worsening health outcomes and greater expense for government over the longer term for few short term savings.

The rebate on extras encourages Australians who cannot afford to do so, to take responsibility for their health and reduces pressure on the public system.

Health insurers paid more than $17 billion in benefits during 2014 with that figure set to increase in 2015. While 47 per cent of all Australians hold hospital treatment insurance, more than 55 per cent of the population hold an extras insurance policy on services such as dental, optical and ambulance services.

It is important to note that significant actuarial and administrative costs would result if the rebate were to be reduced or removed from one aspect of a product. For example, hospital / general treatment combined products are treated as a single item for the purposes of rebate application. A removal of the rebate from the general treatment portion of the product would be extremely difficult to implement from both and actuarial and IT perspective.

Further reductions in support for private health will only reduce the public's willingness to take personal responsibility for their healthcare and will increasingly shift cost pressures to the public system. At a minimum, the rebate should be set at a fixed percentage to address growing affordability challenges in private health insurance, uncertainty in premium costs and complexity for the consumer.

Access to private health for rural and remote Australians.

Consumer empowerment ✓

Enhancing competition ✓

Improving affordability ✓

Key points

- PHI does and should continue to play a valued and relevant role in ensuring regional Australians' access to affordable private health choices, including hospital, medical, dental and optical services.

hirmaa funds are leaders in rural and regional private health services and together welcome the Minister's efforts to improve access for Australia's most remote communities.

hirmaa funds are member-owned, not-for-profit and community-based. All hirmaa member funds have long and trusted histories improving the health outcomes for regional or restricted member communities with many having significant memberships in rural areas.

The importance of Australia's 27 member-owned, not-for-profit and community-based private health funds is undeniable with a combined contribution to the wider economy of more than $6 billion. But their importance is further emphasised by the unfortunate fact that regional Australia is under-serviced for healthcare by comparison to metropolitan Australia.

This is a major issue for the living standards of people living in regional Australia. At the forefront of this is issue are the mutual / member-owned insurers, which have proven with their strong regional presence that they do make a notable contribution to improving health outcomes in rural and remote communities.

Restricted access funds such as Teachers Federation Health, TUH, Defence Health and Navy Health have large rural memberships as do a number of open funds such as Westfund and Queensland Country Health, all of which are hirmaa members.

These funds that provide vital private health services for communities that face significant pressures associated with drought and the downturn in Australia's minerals and resources industries.

Westfund operates branches, eye and dental care services in towns across New South Wales and Queensland including Lithgow, Bathurst, Dubbo, Mudgee, Orange, Wollongong, Maroochydore, Rockhampton, Moranbah, Townsville, Emerald, and Mackay.

Similarly, Queensland Country Health Fund provides access to branches in many of the state's regional and rural communities, from Weipa in the north to Mount Isa in the west and many small communities in Regional Queensland extending south to Stanthorpe. In addition, Queensland Country Health Fund offers dental services in Townsville and Mount Isa.

The examples presented by Westfund Health and Queensland Country Health Fund represent just a snapshot of hirmaa funds' wider contribution to Australia's regional and rural health needs. And together they make significant economic and social contributions to their respective communities, which is only poised to grow bigger through member expansion, good-value private health products, direct employment and investments in healthcare facilities and health related businesses.

hirmaa would support the development of the following initiatives to encourage private health insurance take-up rates in rural, remote and indigenous communities:

- The installation of additional MBS items that relate specifically to procedures and consultations that take place in rural and remote areas.
- Greater, fixed subsidies and rebates for individuals living in rural or remote areas, and indigenous populations.
- The Australian Government could trial allowing private health insurers to run GP practices in remote and rural areas in conjunction with any of the above recommendations to encourage

take-up rates in those remote areas.

With travel and health service delivery costs in mind, it is vital that Community Rating continues to underpin Australia's private health industry for the benefit of rural and remote communities – providing health care services for all facets of Australian society, regardless of health, geographical or socio-economic boundaries.

Furthermore, some form of risk equalisation is essential in supporting Community Rating, which is fundamental to ensuring affordable health cover for all Australians.

Deregulating the premium setting process.

Reducing complexity ✓

Improving transparency ✓

Enhancing competition ✓

Improving affordability ✓

Key points

- The conditions that led to Ministerial approval of PHI premiums, and a single annual rate change date, have long passed.
- Ministerial approval of premiums should be discontinued, and insurers free to set premiums at their own discretion, with competitive forces in the PHI market playing the major role in price setting.

The current approvals system came into being in 1996 with subsequent related changes made 1 April, of each year the one day annually when premium changes can be made.

Given this, and as an organisation that supports deregulation, hirmaa encourages an environment where private health insurers are afforded more flexibility in price-setting. Consistent with the National Commission of Audit report and the Harper Competition Policy Review, insurers should be permitted to change prices as they determine necessary without regulator and Government approval.[2]

The flaws of the current process of pricing oversight in the private health industry are well documented. A recent report[3] noted that seven separate studies of private health pricing had concluded the process was sub-optimal. The studies have been prepared by Australia's leading competition experts, including leading firms of economists and the Industry Commission.

hirmaa agrees that market efficiency is impeded where the Government decides the amount and timing of any price change. We believe that if the market is to set prices, the right conditions must be in place to ensure the market can react efficiently:

- Prudential oversight: to monitor the impact of pricing strategies on the financial positions of insurers. APRA monitors the financial positions of insurers – so the essential prudential oversight is already in place.
- Low search costs and information symmetry: so that consumers have knowledge of alternative insurers and the policies available to them. The consumer website privatehealth.gov.au and the emergence of online aggregators provides for low search costs and sufficient information symmetry for consumers.
- Effective portability arrangements: to ensure that customers can effectively respond to price changes. There is full portability in the market for private health insurance.
- Effective consumer protections: to ensure anti-competitive pricing strategies are not pursued. The ACCC presently acts as the competition watchdog in the industry, meaning the requisite consumer protections are in place.

Taking this into account, hirmaa believes that the requisite conditions are in place to deregulate the premium setting process. We believe that allowing insurers more scope to compete on price will only result in better outcomes for consumers, as market forces, rather than a ministerial approval, will impose a downward pressure on premium increases.

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[2] Competition Policy Review Final Report March 2015, http://competitionpolicyreview.gov.au/files/2015/03/Competition-policy-review-report_online.pdf

[3] The Future of Private Health Insurance Premium-Setting: Seeking Integrative Solutions, Deloitte Access Economics / Medibank Private, 2012; retrieved: http://www.medibank.com.au/Client/Documents/Pdfs/The_future_of_private health _premium-setting.pdf

Reforming the market for prostheses.

Improving transparency ✓

Deregulation ✓

Enhancing competition ✓

Improving affordability ✓

Key points

- **The cost of prostheses is one of the biggest cost drivers on the price of PHI premiums.**
- **The current prostheses reimbursement is outdated, inefficient and vulnerable to price-taking by doctors and hospitals.**
- **Sensible reforms of prostheses reimbursements could conservatively save up to $500 million in PHI costs every year.**
- **Processes and listing/price-setting frameworks similar to those for the Pharmaceutical Benefits Scheme should be considered for prostheses.**

One of the key drivers of health inflation within the private healthcare system is the unsustainable cost of prostheses.

In 2013-14, $1.74 billion was spent by private insurers on listed prostheses. Modelling by the Australian Health Service Alliance estimates that if public sector prices were to apply to identical items purchased in the private system, some $534 million would be saved annually.

Given the rapidly escalating utilisation of prostheses, this difference is expected to reach $1 billion annually by 2018-19.

This difference in prices is a consequence of an inefficient regulatory structure has caused a market failure with:

- Benefits paid by insurers not reflecting net prices paid for prostheses by hospitals.
- Lower cost and innovative competitors being restricted in their ability to compete with incumbent suppliers, due to the current method of determining group benefits for prostheses items.
- Benefits paid by insurers for prostheses items being substantially higher than benefits paid for identical items in international markets and the Australian public health system.

hirmaa suggests that when considering reform of prostheses pricing, the government should look to the success of the Pharmaceutical Benefits Scheme (PBS). The PBS listing a prise-setting processes have been highly effective in driving the efficacy and affordability of pharmaceuticals. We see no reasonable justification for why a similar system would not work for the regulation of prostheses pricing.

We encourage Government to consider establishing a PBS equivalent as a national price-setter of prostheses. The role of this body would include determining uniform national maximum prices for all devices provided across all hospitals – public and private. The body would also function as a national authority, available to all public and private hospitals.

Given the anticipated volume of devices purchased by a national supplier, covering public and private sectors, it would be reasonable to assume a significant reduction in prices across both sectors. Additionally, the present administrative burden of both private and public hospitals would be reduced substantively.

Appendix 4 – hirmaa and AHSA analysis of prostheses item costs; 2015
Appendix 5 – hirmaa analysis of selected prostheses device costs across Australia and France

Transparency on fees & performance of medical practitioners.

Consumer empowerment ✓

Improving transparency ✓

Reducing complexity ✓

Enhancing competition ✓

Improving affordability ✓

Key points

- Notwithstanding generous provisions on current regulations to offer doctors PHI payments well above Medicare item rebates, bill shock from medical out-of-pockets (OOPs) is still a real problem for many patients.
- Insurers should have greater scope to inform and advise their members on likely medical costs when they choose their doctor.
- Doctors should be made responsible under PHI regulation to alert their patients if they will not accept the PHI benefit offered by the patient's insurer.
- MBS data should be used more effectively to alert consumers to OOP variations between providers.

hirmaa funds have grown their membership numbers year after year through their unrivalled focus on member satisfaction and above-average retention rates.

'Bill-shock' remains, however, a significant issue for consumers as a direct consequence of opacity surrounding the costs of medical practitioner fees. hirmaa submits that health providers/practitioners should publicly provide standardised cost estimates to consumers and average or maximum fee rates.

The ACCC has made specific reference to this issue in its recent report to the Senate on private health, noting that complaints to regulatory bodies about unexpected out-of-pocket expenses and 'bill shock' are rising. The ACCC also notes that insurers often have limited control over the out-of-pocket costs imposed by hospitals or practitioners.

Consumers face substantial barriers to pre-determining the cost of a procedure. Of particular concern, the cost of a procedure is commonly not disclosed to a patient until after a specialist consultation. A specialist consultation typically costs the patient well over $300. If a patient wishes to 'shop-around' and ascertain the cost of an alternative specialist, they must pay for each additional consultation, which adds a further financial burden to the consumer and therefore discourages them from exercising choice and competition.

hirmaa funds are strong supporters of transparency, consumer engagement and informed financial consent (IFC) being provided to patients. We believe that IFC is not being provided to patients where they are unable to ascertain the out-of-pocket costs that will result from medical consultations or treatments. Informed financial consent is crucial to empowering consumers and allowing them to participate fully in their healthcare decisions.

Regulatory reform that makes doctors responsible for notifying their patients if they will not accept the patient's insurer's PHI benefit is highly desirable.

Data on MBS claiming and billing patterns, including bulk-billing rates and out-of-pocket charges is already collected through the Government's monitoring of MBS activity. The Government's MBS Review Taskforce notes the following:

> *"The potential value of MBS data to consumers is also not being fully exploited. In particular, information on the variation of billing practices between providers (potentially de-identified but provided in a*

geographically-meaningful way) could be useful in making decisions about, for example, which specialist to see."

hirmaa strongly agrees with these comments and suggest that the effective use of MBS data pertaining to practitioner billing and out-of-pocket costs would substantially improve the consumer's empowerment and ability to participate in their healthcare decisions.

Specifically, hirmaa believes health providers/practitioners should reveal standardised cost estimates to consumers that include specific information such as: MBS item numbers for each part of the procedure into the public domain, and whether they will accept the PHI benefits offered by a consumer's insurer.

Average or maximum rates for all procedures for the MBS item numbers covered should be accessible through a national and publicly available online portal.

There have been a number of private sector led initiatives to form online platforms for the rating and comparison of medical practitioner quality and costs. However, hirmaa believes that in order to ensure the provision of fair, timely, impartial and sufficient information by doctors, initiatives in this space need to be led by the Government.

We note the success of the Ombudsman's *privatehealth.gov.au* website in providing fair and unbiased comparisons of private health policies and suggest a similar model would work well to compare medical practitioners on price and performance.

Greater transparency on the performance of hospitals.

Consumer empowerment ✓

Improving transparency ✓

Reducing complexity ✓

Enhancing competition ✓

Improving affordability ✓

Key points

- In a pay-for-service culture, the performance of private and public hospitals is largely opaque not just to consumers, but to insurers as payers.
- More hospital performance information should be in the public domain, and available to consumers.

hirmaa funds' ability to remain competitive and provide affordable high quality cover is reliant on contracting with hospitals on a level playing field.

hirmaa therefore supports greater transparency around the performance of public and private hospitals, with regard to key performance indicators such as infection rates, hospital errors and waiting times at an individual hospital level.

At present, performance information is highly limited and as such, consumers do not have timely access to the information they need to participate constructively in their healthcare decisions, or in the specific case of the privately insured, their choice of hospital and surgeon.

Digital technologies should be leveraged to collect and report quality and performance information in such a way that is accessible and understandable. For example, the National Health System in the United Kingdom has launched 'My NHS' across all hospitals. The system provides highly accessible performance information on a range of healthcare providers while free Wi-Fi in all hospitals will allow patients to publically provide real-time feedback on the quality of their care.

We suggest that:

- Consistent, regular and mandatory reporting frameworks should be in place for all hospitals to provide transparency and allow benchmarking around performance, pricing and the consumer experience for the benefit of the public and policy makers.
- Real-time patient feedback on hospital performance should be shared over the Internet.
- All patient records should be digital and in an interoperable format and belong to the patient.

We note that the most recent Productivity Commission report into the performance of public and private hospitals was published in 2009 and suggest it would be timely to for the Productivity Commission to undertake an updated review in this area.

To drive improved quality and value, hirmaa would also look to the Hospital Value Based Purchasing model (VBP) used in the United States for Medicare and Medicaid services.[4]

[4] Centres for Medicare and Medicaid Services, USA: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/hospital-value-based-purchasing/

Reforming second-tier default benefit legislation.

Enhancing competition ✓

Improving affordability ✓

Improving transparency ✓

Key points

- Second-tier default benefits distort the negotiating environment between hospitals and insurers; and between private and public hospitals.
- They do not encourage hospital providers to improve the quality and efficiency of what they are paid to do.
- Removing second-tier default benefits would reduce the growth rate of hospital costs and there benefit consumers though a lower growth rate for premiums.

Since the "Lawrence legislation" of 1995, second-tier default benefit legislation compels private health insurers to pay any accredited health facility (private hospital or day surgery) at least 85 per cent of the state average.

Insurers are obliged to pay these facilities irrespective of whether that facility is required or whether the insurer believes the services provided are of sufficient quality to warrant paying for members being treated there.

The second-tier default benefit legislation disrupts competition by providing results in the following consequences:

- Innovations in quality and efficiency of service is obstructed
- It is difficult for insurers to negotiate purchaser-provider agreements on quality, patient comfort or other non-price factors. Increasing rates for high-performing hospitals will increase the average and therefore also increase rates for second tier hospitals
- It stifles competition and price tension amongst private hospitals/day surgeries- since they all know that they will have some kind of arrangement with each insurer – so why innovate or try to control prices
- It is more difficult to control cost inflation: Regulations strengthen the position of hospitals when negotiating with insurers by granting them 85 per cent of average rates without agreements, and by allowing them to avoid the various non-price requirements in agreements
- It results in an inefficient use of health funding: Access to insurer funding through second tier rates allows new facilities to open in areas that are already well-serviced, and effectively subsidised poor commercial, entrepreneurial and investor judgments.
- It distorts normal market dynamics: the artificial floor price drives up contract costs, impacting both consumers and the Government (via the premium rebate)

It is hirmaa's strong view that private health insurers should not be forced to in effect contract with every single private hospital and that the second-tier default benefit legislation in its current form urgently requires review.

Removing the second tier default benefit would result in:

- Lower premium rises for consumers with the restoration of normal market dynamics
- Higher quality and more innovative facilities would be rewarded whereas service deficient facilities would be required to lift their performance

- Unnecessary administrative costs to insurers and the Department of Health of managing these schemes being removed

At a minimum, only regional and rural hospitals – where there is limited competition and choice - should have access to the minimum default benefits safety net.

Further information:
Appendix 6 – Second Tier Default Benefits – prepared by Finity Actuaries consulting for the AHSA; September, 2014

Addressing private patients in public hospitals.

Consumer empowerment ✓

Improving affordability ✓

Key points

- PHI is about financing consumers' choices of doctor and hospital and is not a revenue stream for cash-hungry state governments and public hospitals.
- Cost shifting and inducement practices in public hospitals that induce patients to elect private patient status, should be stamped out.

Public hospitals are active in inducing patients to use private health insurance in a public hospital by electing to be private patients.

What originated as an issue confined to a small number of public hospitals has now evolved into standard practice, even an art form. There are many incentives in place for public hospitals to persuade patients to elect to be treated as private patients. This results in cost shifting from State health budgets to the Commonwealth and to private health insurers and is putting upward pressure on premiums via the following:

1. Accommodation fees

In the case of private rooms for private patients, State Governments publish recommended rates. While insurers are only obliged to pay the lower, Commonwealth Default rate, they are under immense pressure to pay the higher amount charged through the State Government published recommended rate, otherwise their policy-holders could face significant out-of-pocket costs.

Often public hospitals offer inducements to patents for a private election, including guarantees of no out-of-pocket costs and excesses. While expensive to their budgets, such inducements are often cheaper for public hospitals than bearing the full episodic cost as a public admission.

State Governments exploit this as an additional revenue stream to prop up state finances. In the 2013-14 financial year, $915m in accommodation fees were paid by insurers to public hospitals, up 16 per cent from the previous year.

2. Diagnostic Imaging and Pathology

If an individual agrees to elect to be a private patient, the public hospital can invoice Medicare for 75 per cent of the schedule fee for these services. In addition, the public hospital can bill the insurer for the remaining 25 per cent of the schedule fee.

3. Revenue from (and for) Medical Practitioners

Once an individual has elected to be treated as a private patient, bills can be raised against Medicare, transferring costs from the State to the Commonwealth. In addition to the payments made by Medicare, there are also payments made to the doctors by the private health funds themselves.
Once a patient has elected to be treated as a private patient the doctor has the right to charge the patient fees as he/she deems appropriate. Medical specialists welcome the private election of patients in public hospital settings as a way to effectively supplement their normal public hospital income.

4. Prostheses

Public hospitals are able to profit significantly from the imbalance in prostheses prices between the public and private markets. Quite simply, public hospitals are able to purchase prostheses devices through the public system (paying the lower public system prices) and then charge health insurers the inflated private price. The Australian Health Services Alliance and the Australian Centre for Health Research estimated that in 2012, public hospitals benefited from this arbitrage to the effect of $55.4m.

The financial model for funding private patients in public hospitals is distorts the market and encourages State and Territory Governments to prioritise the treatment of privately insured patients ahead of those without private health insurance. This runs counter to the Australian tradition of basic equality of access to health care regardless of age, means or health status, and contributes to the entrenching of a two-tiered public hospital system.

Second tier default benefits, which is what public hospitals can claim for private patients in lieu of a contract with a patient's insurer, helps fuel predatory conduct by public hospitals and therefore helps underwrite cost-shifting. Their removal would be a big contributor to reining in these bad practices.

hirmaa therefore supports reform minimising the cost shifting activities of public hospitals.

Further reading: AHSA / ACHR report into Private patients in public hospitals, April 2013; retrieved: https://www.ahsa.com.au/web/freestyler/files/Privateper cent20Patientsper cent20inper cent20Publicper cent20Hospitalsper cent20Mayper cent202013.pdf

Support private health in primary care.

Improving affordability ✓

Enhancing competition ✓

Consumer empowerment ✓

Key points

- PHI insurers should have greater opportunity to engage in primary care planning and management on behalf of their members.
- Broader Health Cover (BHC) has been a good start but more can be done.
- The principle that GPs remain at the centre of primary care, and have independence of clinical judgment, remains essential.
- hirmaa supports the establishment of Primary Health Networks as a means of increasing efficiency and effectiveness of medical care and improving coordination.

Considering the ageing population, the worrying trajectory of health spending and the increasing incidence of chronic diseases, hirmaa believes that Australian Governments need to be more open to private sector involvement and innovation in primary care. This is consistent with the Ian Harper Competition Policy Review and National Commission of Audit Report.[5][6]

Recent figures from the Australian Institute of Health and Welfare show that across the population, there were 413,258 potentially preventable hospitalisations due to chronic conditions in 2012-13. Private health insurers offer a range of chronic disease management programmes and this statistic indicate that there are enormous gains to be made in health system effectiveness and patient outcomes by better engaging the private sector.

Unless specifically exempted under the *Private Health Insurance (Health Insurance Business) Rules*, insurers are unable to pay benefits for out of hospital services where there is a Medicare benefit payable.

hirmaa supports Medicare, and supports Medicare continuing to cover out-of-hospital medical practitioner services. We do not think, however, this should preclude insurers from playing a complementary role, if it is in the interests of the patient.

In particular, hirmaa supports insurers forming closer relationships with General Practitioners, Primary Health Networks and other stakeholders in primary care. It is important to note that, in saying this, hirmaa supports GPs being at the centre of the relationship with the patient. Similarly, it is important that insurers do not interfere with GPs' clinical judgment.

As a simple first step, hirmaa suggests that insurers and GPs form closer relationships to better leverage the existing BHC programmes offered by insurers.

At present, GPs are most often unaware of the insurance status of their patient, and of the range of BHC programmes offered by their patient's insurer. Better information sharing between insurers, patients and GPs about insurance status and about programmes available would allow earlier and more targeted use of these programmes, with the full knowledge and support of the GP.

hirmaa suggests that Government works to facilitate and support initiatives and/or trials in this space, including through engagement of the Primary Health Networks.

[5] Competition Policy Review Final Report March 2015, http://competitionpolicyreview.gov.au/files/2015/03/Competition-policy-review-report_online.pdf

[6] National Commission of Audit Report http://www.ncoa.gov.au/report/index.html

Risk Equalisation.

Improving affordability ✓

Enhancing competition ✓

Key points

- A workable and fair risk equalisation regime, flattening out the impacts of high-cost claims and the overall PHI risk pool, are needed to keep Community Rating sustainable.
- Growth in the size of the risk equalisation pool is unsustainable.
- A detailed review of risk equalisation is highly desirable, but separate from this policy review.

hirmaa, the peak body for 18 member-owned private health funds, which are a mix of both net payers and recipients of the existing risk equalisation (RE) pool, welcomes a review of the current arrangements, with key conditions.

Of the 18 hirmaa members (Australia's small – medium sized health insurers), eight are net-payers into the risk equalisation pool and ten are net-recipients. hirmaa insurers support Community Rating and understand that some form of risk equalisation is necessary to underpin and support the Community Rating principle.

However, hirmaa funds acknowledge that the risk equalisation (RE) pool is growing at a rate that is unsustainable.

RE is growing in such a way that it is affecting affordability, especially for younger people as such a high portion of premiums are now being allocated to the RE pool.

At present, RE subsidies vary depending on the age of the claimant: from 15 per cent of claims for 55-59 year olds, up to 82 per cent of claims for over 85 year olds.

Over the past few years, the dollar amount of benefits included in the risk equalisation pool has increased at an average annual rate of 10 per cent. Allowing for membership growth, this translates into an annual increase in the per policy cost of risk equalisation of more than 7 per cent p.a. over the past few years.

For many policies, and particularly those targeted at younger persons, risk equalisation is a major component of the premium and hence a driver of the premium increase for those policies.

The Actuaries Institute of Australia (AIA) undertook a projection of risk equalisation benefits back in 2011. They estimate that by 2020, the proportion of claims shared through RE is expected to increase to 47 per cent, where it was 40 per cent in 2010. In 2020, over 40 per cent of the premium paid by younger policyholders is expected to subsidise the claim costs of older policyholders, compared to 34 per cent in 2010.

The AIA notes that the highest level of benefits equalised in the last 20 years was 46 per cent in 1994, just prior to a change in RE arrangements. The AIA's projections show that by 2020, RE will be reaching a level where the system was previously considered unsustainable and was changed.

hirmaa is supportive of a review of RE and substantive change, so long as this is not undertaken as part of this review. A review of RE should be run separately to the private health review process to allow for the necessary modelling and consultation on this highly significant, complex and important issue.

hirmaa would at a minimum, be open to a reduction of the proportion of claims equalised for each age cohort, i.e. decreasing the percentage of claims equalised for 85+ policyholders, from 82 per cent issue.

We suggest that this would slow the growth in the pool and that it would improve the incentive for funds to better manage health care costs.

hirmaa strongly suggests that any changes must be considered with thorough industry consultation. We would also suggest that if any stakeholder makes a proposal to significantly change risk equalisation, that such a proposal be considered in light of the stakeholder's vested financial interest

Increase the Medicare Levy Surcharge.

Improving affordability ✓

Key point

- That 2014 National Commission of Audit recommendation to increase the Medicare levy Surcharge should be adopted.

In 2014, the National Commission of Audit recommended increasing the Medicare Levy Surcharge (MLS) to between 3-3.5 per cent of taxable income to increase the uptake in private health, effectively mandating it for all Australians earning over $90,000.

hirmaa believes that any increase in the Medicare Levy Surcharge would result in positive outcomes for consumers, industry and Government. Australian Governments pay for 90.9 per cent of the cost of treatment in the public system, yet only 34 per cent of the cost of treatment in the private system (inclusive of the rebate on private health).[7]

Incentivising more people to take out private health is therefore highly beneficial for the Australian Government, and to taxpayers. Australian Tax Office statistics indicate that as of 30 June 2013, 199,295 people have chosen to pay the MLS and not take out private health [8].

Encouraging those that can afford to purchase private health by increasing the MLS is an easily achievable outcome that will reduce the burden of health spending on the Government, improve the overall sustainability of the health system and is consistent with Community Rating.

In return for this MLS incentive, the PHI industry and the private health sector generally would be expected to strive still harder to improve their quality, efficiency and value for money. Indeed, hirmaa sees that as an obligation that the industry has in return for public subsidy.

[7] Australian Institute of Health and Welfare, Australian Hospital Statistics – Private Hospitals, 2012-13., p.23
[8] *Taxation statistics 2012–13 Individual tax: Selected items, for income years 1978–79 to 2011–12*; Australian Tax Office; retrieved: https://www.ato.g
ATO/Research-and-statistics/In-detail/Tax-statistics/Taxation-statistics-2011-12/?anchor=indiv_detailed

Reforming the funding and provision of ambulance services.

Reducing complexity ✓

Improving transparency ✓

Improving affordability ✓

Key point

Simplifying payment arrangements for ambulance services, making them consistent across Australia, will benefit consumers and keep down administrative costs for governments and insurers

.

Complexity and inconsistency in the models for funding and delivery of ambulance services across Australia is imposing an unfair and costly financial and administrative burden on patients and their health insurers.

States and Territories manage their own ambulance services in Australia and there are a range of different models of funding. These range from universal coverage (i.e. Queensland and Tasmania), voluntary subscription schemes (i.e. Victoria, South Australia and the Northern Territory), and fee-for-service models where the charges differ significantly across States and Territories. Private health insurance is a funding source across most States and Territories.

If a patient requires an ambulance service in their home state, it is (generally) a straight-forward process. However, this breaks down entirely when patients need services outside of their home state, or if they require inter-state transport / repatriation.

In cases where States and Territories have signed reciprocal agreements, clarity over liability for funding and potential out-of-pocket costs is greatly improved. Unfortunately, reciprocal arrangements are severely lacking in many instances (in particular in the cases of QLD and SA) and historically, these arrangements have been subject to change, often without forewarning.

While hirmaa believes that a nationally-coordinated ambulance scheme is the ultimate long-term solution, in the short-term, we support reform to ensure reciprocal arrangements are in place across all States and Territories.

Some of the benefits of reform in this area would be:

- Improved clarity for patients over the liability for funding
- Reduced out-of-pocket expenses for patients
- Reduced red-tape and administrative costs for private health insurers
- Enhanced simplicity and transparency for insurers in communicating with their members
- Enhanced capacity for insurers to design appropriate products for their members

Appendix 7 – hirmaa research paper re ambulance reform; October 2015

Reform of other red-tape and regulations.

Deregulation ✓

Improving affordability ✓

Reducing complexity ✓

Key point

- Remove the requirement to send the Private Health Insurance Standard Information Statement (SIS) to members on an annual basis

The current SIS contains generic information not including details of rebates, loadings or insurer discounts. Therefore, it often causes confusion amongst policy holders and generates a high volume of customer enquiries. Inconsistencies between the SIS and Product Disclosure Documents provided by funds, means that it is of no practical value to the policy holder and is in fact detrimental.

Instead of requiring insurers to physically mail SISs annually, private health insurers should be required to:

- Publish product specific SISs on their websites
- Reference the availability of SISs on product disclosure documents; and
- Make copies of the SIS available upon request.

If the mailing of SISs is made optional for private insurers, this would deliver significant administrative cost saving and improve the customer service experience for policy holders.

Allow premium change letters to be send as a hyperlink in an email

Following representations from hirmaa, the Department of Health has agreed to a change in interpretation of the rules to allow premium change letters to be sent as an email attachment to those members specifically electing communication by email.

To achieve further efficiency gains and improved security, hirmaa is seeking a further change in interpretation of the rules to allow health funds to send to members a hyperlink to the premium change letter via email so that it is available through a website portal as opposed to email attachment.

Provided it is the member's expressed choice, this would save considerable administrative costs to insurers, which could be passed on to members by reducing management expenses' influence on premium levels

Remove the requirement to send out the Annual Lifetime Health Cover (LHC) Statement

Industry experience is that the annual LHC Statement is costly to produce and distribute and of no value to policy holders.

While our ultimate aim remains to have the obligation to send the annual LHC statement removed, as an interim step we seek a change in interpretation of the rules to allow health funds to send to members a hyperlink to the LHC Statement via email so that it is available through a website portal.

Make the provision of Private Health Insurance Statements optional

Mandating that private health insurers send a health insurance statement to policy holders for tax purposes creates an unnecessary duplication. All the relevant tax data is already available electronically online and through the ATO.

Streamlining the rebate registration process: remove the Medicare rebate application form

Rebate registration generally requires that consumers manually complete and submit an approved Medicare form.

This is both complex and time-consuming with private health funds expending considerable time and effort chasing new customers to complete the forms. There is ample scope to simplify and streamline the process for rebate registration.

Allowing private health insurers to register rebate information, without requiring the completion of an approved Medicare form by the consumer, will greatly enhance efficiency, reduce costs associated with regulation and improve the customer experience. Any inadvertent under/over claiming of the rebate will continue to be reconciled when the policy holder lodges their tax return.

Appendix 8: hirmaa research paper regarding red-tape reduction, June 2015

Engage private health insurers in national e-health strategy.

Consumer empowerment ✓

Improving transparency ✓

Improving affordability ✓

Reducing complexity ✓

Key point

- E-health has a big future in Australian healthcare in terms of increasing quality of care and outcomes, while reducing costs.
- Responsible information sharing that includes PHI insurers, through a reliable and consumer-friendly e-health network, has a real value to consumers.

hirmaa believes that an effective e-health strategy is crucial to achieving better health outcomes that:

- Empowers patients to participate in their electronic health record, take a keener interest in their health and management of their health.
- Enhances patient health-literacy.
- Effectively shares data across practitioners to avoid costly re-testing.
- Collects and reports data in such a way that is interoperable, facilitating its use and value across a range of platforms.

hirmaa supports the Government's decision to proceed with the *MyHealth* record and to implement a number of the key recommendations flowing from the Review of the Personally Controlled Electronic Health Record.

hirmaa believes that insurers can contribute positively to the success of the *My Health* record and that their involvement will improve health outcomes across the population – the over-arching goal of a national e-health strategy.

Where consent is given by the patient, private health insurers should be allowed access to their My Health Record. This will improve insurers' capacity to propose effective early interventions with their funded Broader Health Cover (BHC) services and to track the care paths of patients using these programmes.

It is important to acknowledge that the interests of patients and private health insurers do align. The Community Rating principle underpinning private health insurance in Australia means that insurers cannot discriminate on the basis of risk factors or illnesses and therefore insurers cannot raise the premiums of high risk or chronically-ill patients. Better managing the health of patients and reducing risk factors is therefore highly important to the insurer, to avoid unnecessary and costly hospital admissions.

Greater access to information allows insurers, in collaboration with medical practitioners, to better understand the appropriateness and effectiveness of their BHC services. Improving the capacity of insurers to measure the performance of the BHC services, will significantly enhance confidence, driving increased innovation as the benefits of early intervention and preventative care plans are quantified.

Health insurance is made accessible and affordable to all individuals irrespective of their risk factors because of Community Rating. With this principle upheld, the private health industry is well placed to use patient information to the advantage of the patient.

Reform of allowable excess on private health policies.

Enhancing competition ✓

Improving affordability ✓

Key point

Legislative rules on excesses should be brought up to date.

Consumers desiring private health cover can reduce their premiums by choosing a policy with an excess or co-payment. In order to qualify for the Medicare Levy Surcharge (MLS) exemption, policies must have a maximum annual excess no greater than $500 for singles or $1,000 for couples/families (regardless of the number of claims made in a year).

This maximum excess has not changed for around 15 years, despite continued claims and general inflation. In other words, keeping the maximum excess fixed in dollar terms means the proportion of claim costs borne by insurers has increased, which is passed on through premiums. Additionally, both insurers and insured have had to increasingly rely increasingly on policy exclusions / restrictions to keep premiums affordable.

hirmaa supports a review of the current arrangements governing excesses and suggests that consumers of private health insurance may appreciate the ability to moderate their annual premium increases each year by having greater flexibility to take on higher excesses.

hirmaa appreciates that a significant amount of actuarial modelling would be required to come to a firm view on reform in this area, but we suggest that at a minimum, **reform should take place to allow maximum excesses to be indexed over-time alongside premium increases**. This would retain the real value to the consumer of the excess over time.

Health Savings Accounts.

Consumer empowerment ✓

Improving affordability ✓

Key points

- hirmaa supports further investigation into the role of Health Savings Accounts (HSAs) as an innovative financing mechanism to help Australian's provide for their private health insurance premiums upon retirement.
- hirmaa does not, support HSAs as a replacement or a substitute for PHI but rather as a way to complement and improve sustainability of PHI.
- hirmaa would not support HSAs if they undermined or threatened Community Rating in any way.

An HSA in the Australian context should allow the consumer to commit a portion of their pre-tax income (similar to superannuation) to a health account, which can in-turn be drawn on to pay for private health insurance premiums, when the consumer is no longer able to participate in the workforce.

We believe that this has the potential to provide significant benefits to the community, particularly the elderly population, which are both most in need of private health cover, and often least able to afford it.

The World Health Organisation cites the rapid increase in health spending during retirement years as a key reason to consider HSAs. With that in mind, it is critical to consider the pace at which Australia's population is aging and what challenges it will impose on the country's health system.

The older age cohorts are by-far the largest users of Australia's health system. While only constituting 16.5 per cent of the insured population, people aged 65 years and over accounted for more than 70 per cent of all hospital-related private health benefits throughout the June, 2015 quarter. The Australian Bureau of Statistics forecasts the number of people aged over 65 years to double and the number of people aged over 85 years to almost triple by 2040.

Meanwhile, affordability is worsening. Over the last five years, premiums have increased between 5.56 - 6.2 per cent as a result of rising medical service costs. The latest data from the Australian Prudential Regulatory Authority shows that since 2010, benefits have increased at a faster rate than that of annual premium increases – in the case of prostheses devices, the annual benefits bill is increasing at twice the pace of premiums.

Furthermore, the previous Government's decision to means-test the private health rebate, index it to CPI and remove it from the lifetime health cover loading has only added to the affordability issue and resulted in a notable shift in consumer attitudes when it comes to selecting cover - from prioritising top cover to seeking out basic, cheaper cover.

With an ageing population, rising private health premiums and increased downgrading, it is important to investigate additional health financing instruments such as HSAs and understand how they could encourage consumers to continue purchasing adequate health insurance cover at a stage in life when they need it most.

hirmaa sees HSAs as an opportunity for the Federal Government to incentivise individuals to take up and maintain private health policies, but suggests that significantly more research and consultation is required to define how such a savings model might fit within Australia's unique health system, given it is fragmented between primary and acute, public and private, and Commonwealth and state.

Among other considerations, it is vital to understand first:

- How HSAs would be managed in addition to Australia's existing financial industries.
- Whether HSAs would be provided by the state, by private health insurers or by third parties; and
- Whether HSAs would be mandatory or voluntary.

Generally, it must be understood how private health affordability and consumer empowerment will be improved by such a system. It is especially important that HSAs not threaten or undermine the principle of Community Rating and be complementary to PHI. If HSAs are to be considered seriously, detailed and extensive modelling must be undertaken in partnership with private health insurers to understand how they would contribute to a more sustainable PHI system.

Reform of the Federation: Option 2.

Consumer empowerment ×

Improving transparency ×

Enhancing competition ×

Improving affordability ×

Reducing complexity ×

Key points

- hirmaa does not support Option 2 as it stands.
- Option 2 needs to be spelled out and examined comprehensively and carefully with consultation across the whole of the Australian healthcare community, both private and public.
- In respect of the whole private healthcare sector – providers as well as funders – there are risks of damaging unintended consequences, possibly to the future viability of the sector as a whole.

hirmaa, as the representative body for 18 private health insurers, is concerned about the Federal Government's consideration of a blanket Commonwealth Benefit as outlined in Option 2 of the Reform of the Federation on the country's health system.

To date, consultation with industry on Option 2 has been both rushed and superficial.

Given the scale and potential consequences of the Option 2 reform, industry expects the Department of Health to provide much more detailed information to enable industry to form a considered view and come to an informed position. That detail has not been forthcoming to date.

Our understanding of the plan

As we understand it, the proposed scheme would see episodic acute care funding provided directly through the Commonwealth.

The funding would cover a portion (about 40 per cent) of the cost of each procedure, whether that be undertaken in a private or a public setting. The government would no longer provide private health insurance rebates, with funding redirected to the new hospital benefit.

The Commonwealth benefit would be determined as a percentage of the National Efficient Price (NEP) for services in both public and private settings.

State governments would fund the residual costs for public patients in public hospitals and private health funds would fund the residual costs for private patients, whether in a private or public hospital.

The Commonwealth Hospital Benefit would involve pooling the existing Commonwealth public hospital funding from in-hospital Medicare benefits and the private health rebate. If adopted, Option 2 would result in neither existing Commonwealth funding model continuing. The Medicare Levy Surcharge would remain in place.

Concerns: PHI cover

While we recognise the Governments good intentions in seeking long-term solutions to perennial problems of keeping Australian healthcare – particularly acute healthcare – sustainable, hirmaa is concerned that without comprehensive Government modelling and consultation with industry, Option 2 could give way to a raft of dire and unintended consequences.

Firstly, it questions not only the need for the PHI rebate, but for general/ hospital private health cover itself. Regardless, scrapping the private health rebate would exacerbate existing premium affordability and exclusionary coverage, which the Government has identified as its top concerns about PHI.

If PHI becomes marginal in hospital and related treatment services, the industry's future would be as ancillary insurers rather than as comprehensive health insurers.

Indeed, a blanket benefit could incentivise individuals to self-insure, which would destroy Community Rating and render PHI unsustainable. We do not believe that this is the Government's intention.

Secondly, without government incentives on ancillary/extras, younger individuals, who have historically been drawn to health insurance – and the private health choice – through extras cover, could diminish. This threatens the balance and cross-subsidy between younger, healthier groups of policyholders and high-claiming groups, and therefore Community Rating.

If only people in poor health choose to remain insured, the required premium rates would become unaffordable. The resulting spiral of increasing premiums followed by the lapsing of relatively healthy policyholders would push additional costs onto public hospitals.

History has shown the detrimental impact of increasing premiums as the healthy dropped out and the percentage of people with Private Health Insurance in Australia dropped to the low 30's in the late 1990s. It took the vision and strength of the Howard Government to address these problems via the sticks and carrots approach implemented in 1999/2000.

During a time when information asymmetry is contributing to consumer disengagement in private health, hirmaa believes that Option 2 would add further complexity issues and uncertainty, increase premium costs and deter Australians from taking out private health insurance.

Thirdly, in respect of private hospital and medical providers for whom PHI currently is their major income source, Option 2 seems unashamedly to favour state governments and public hospitals. It is public hospital-centric. Private hospitals will find it much harder to compete with public hospitals, and surgeons and other medical specialists' rights of private practice may well be undermined.

Concerns: service price/cost ramifications

It is imperative any financial or membership impacts are thoroughly explored by COAG and the Federal Government before progressing with Option 2.

Option 2 proposes a complete overhaul of how Commonwealth payments will be processed and managed. The reform looks to redesign how doctors and medical practitioners are paid, and who by. This raises concerns over the administrative burden it would impose on the health industry and inflation pressures on medical and specialist costs.

On the other hand, such concerns may become irrelevant if the private health sector, particularly the private hospital industry, atrophies in relation to public hospitals. That, in our view, is a real risk of these changes given the staunch policy and ideological commitments, with few exceptions, of Australian governments to the principle that state governments own and operate public hospitals.

hirmaa therefore urges the Government to investigate thoroughly how this payment model will address glaring concerns over health inflation pressures, listen to the private healthcare sector and not just the pleading of state governments who have little incentive to improve the efficiency of their Commonwealth funding now, nor would they under Option 2.

Concerns: the NEP

Government has expressed that the National Efficient Price (NEP) will act as a universal pricing benchmark for both private and public hospitals in Option 2 despite it being designed specifically for the public health system.

While hirmaa agrees that service cost growth is a major problem in both public and private sectors, it is critical that any new system be fit-for-purpose across the whole acute sector, not just in relation to public hospitals.

Furthermore, price-setting needs to be based on adequate evidence and data. We note that in its current form the NEP only provides data more than three years old. This may be an insufficient base for a reform as fundamental as Option 2.

If it is to be seriously considered, let alone adopted, more time, data, analysis and modelling is needed.

Moreover, Option 2 does not discuss how the National Weighted Activity Unit (NWAU) payment model, which by necessity must be implemented if the NEP is to be the basis of payment, would be integrated in such a model. Significantly more information is needed to understand how the Government intend to apply the NEP as a fit-for-purpose pricing benchmark for public and private hospitals operating in both rural/regional and urban areas.

Concerns: promoting Option 2 contradicts this policy Review

Option 2 represents very fundamental reform. Yet the available details are still very sketchy and there is a notable lack of detail, which raises significant questions over potential inflationary impacts on private health insurance, future contractual negotiating relationships between private health insurance funds, health service providers, specialists and consumers, and overall affordability.

hirmaa suggests that if the focus of the current review is the consumer, as the Government's messaging has indicated, long-standing issues requiring government reform, have higher priority. These include:

- Consumer-provider information asymmetry
- Prostheses pricing
- Second Tier Default arrangements
- Improving hospital transparency; and
  Improving competition between insurers, between providers, and between public and private sectors.

Issues discussed in the public consultation on private health insurance.

Key points

- hirmaa welcomes the constructive engagement between the Department and stakeholders in the public consultations rounds of this policy review.
- While noting the merits of modifying Community Rating to allow for rewards and penalties around certain factors, such as voluntarily-assumed health risks (such as smoking), hirmaa restates its unequivocal support for unqualified Community Rating with no discrimination on the basis of age or health risk.

Higher minimum standards on policies: *"If insurers were required to always provide cover for additional services, and knowing this would lead to an increase in the price of premiums, which services should be covered?"*

hirmaa would be open to a review of minimum standards on private health policies. However, we would only support such a reform in conjunction with improved incentives to take out better value, better quality private health insurance policies. We suggest that the establishment of a *MyHealthCover* style policy (as detailed earlier in this document) would adequately provide this incentive.

The coverage of additional healthcare services: *"If insurers were permitted to extend coverage to health care services not currently covered, and knowing that this would lead to an increase in the price of premiums, which services should be covered?*

The consumer consultation explores the idea of insurers providing coverage for a range of additional health services, including GP consultations, specialist consultations and diagnostic imaging, among others.

When it comes to out-of-hospital medical practitioner services, hirmaa supports Medicare and wishes to see that Medicare continues to cover these services.

Reform to Community Rating: *"If insurers were permitted to vary their premiums for different customers, which factors should be considered?"*

hirmaa is a strong supporter of the community-rating system in private health insurance and its role in ensuring private health insurance is accessible and affordable for all Australians.

hirmaa does not support the charging of different premiums based on a person's age, gender, health or health risk.

hirmaa does not support the concept of behavioural loadings (i.e. charging a higher premium for smokers), we believe the most effective way to encourage healthier lifestyles is through positive incentives such as broader health cover programs and coaching, as opposed to financial penalties.