We are hirmaa

15 September 2017

To: phiconsultation@health.com.au

To whom it may concern,

Re: Options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals

Thank you for the opportunity to comment on the paper: Options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals released 15 August 2017.

hirmaa represents 24 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 1.7 million Australians across the country. hirmaa funds are predominantly not-for-profit and community based, and identify as mutual and/or member-owned insurers.

Since its formation in 1978, hirmaa has advocated for the preservation of competition, believing it to be fundamental to Australians having access to the best value health care services. hirmaa has done this by:

- promoting legislation, regulations, policies and practices which increase the capacity of its member organisations to deliver best value health care services; and,
- advocating for the preservation of a competitive market, which we see as essential to the integrity and viability of the PHI industry.

hirmaa funds, which are not-for-profit, member-owned and community based organisations, play a crucial role in upholding the competitiveness of the private health insurance market place.

We are pleased to provide the following response to the terms of reference given to the Committee.

Yours sincerely

MATTHEW KOCE
Chief Executive Office

601 Canterbury Road
Surrey Hills VIC 3127
(PO Box 172) Box Hill Vic 3128
Telephone (03) 9898 9370
Facsimile (03) 9896 9393
Email info@hirmaa.com.au
www.hirmaa.com.au

We are hirmaa

---

rt health FUND

stlukeshealth

Phoenix Health Fund

Defence Health

Latrobe HEALTH SERVICES

doctors health fund an AVant company

healthcare insurance

TUH It's my health fund

Mildura HEALTH Fund

WESTFUND HEALTH Insurance

Teachers Health Fund

Queensland COUNTRY HEALTH FUND

Health Partners

ACA HEALTH BENEFITS FUND

Peoplecare

Police Health

rbhs reserve bank health society simply better benefits

CDH

Transport Health

NAVY HEALTH

NURSES MIDWIVES HEALTH Caring for the carers

cua Health

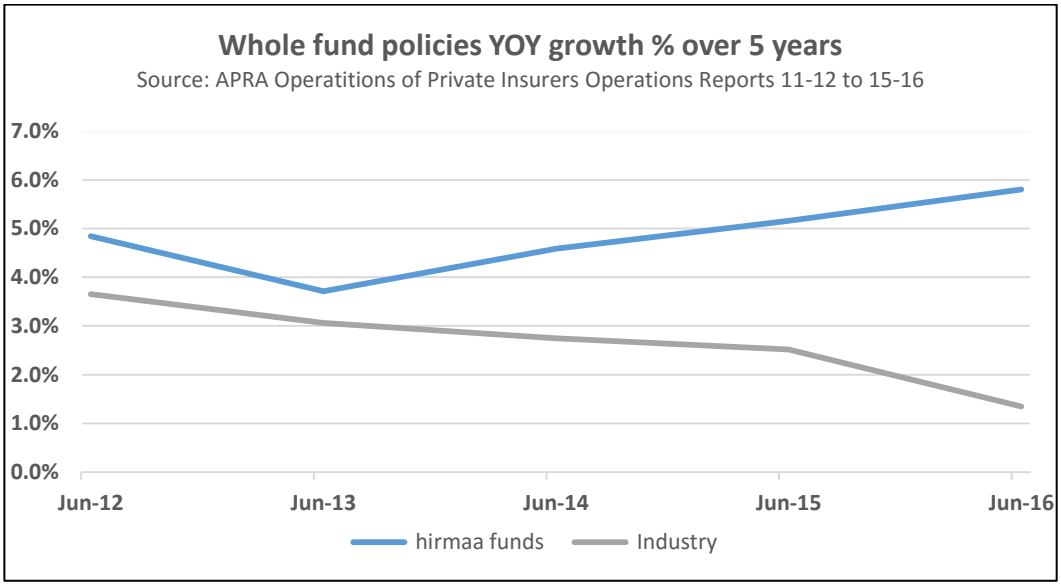
EMERGENCY SERVICES HEALTH

CBHS HEALTH FUND

About hirmaa funds

hirmaa funds make up 24 of the 37 registered private health insurers. Collectively these insurers provide health insurance to over 1.7 million Australians and ensure a diverse and competitive health insurance sector that offers real choice for consumers.

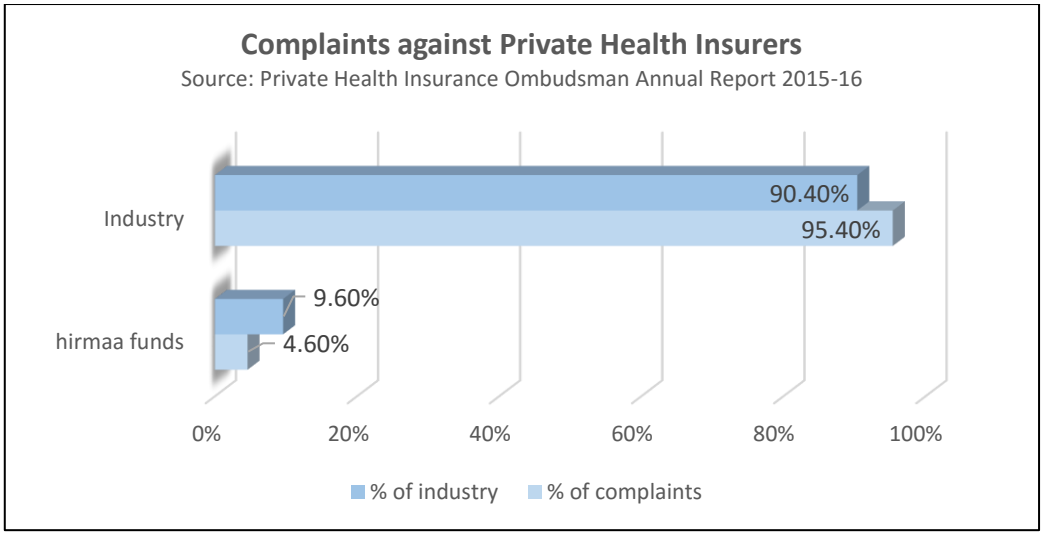
Existing solely to serve their membership, not shareholders, hirmaa funds are growing much faster than the industry average, enjoy significantly higher retention rates and return around 90 per cent of all premiums back to policyholders as benefits.



The consumer ethos and focus of hirmaa funds is reflected in the findings of independently conducted surveys and reports. For eleven consecutive years, hirmaa funds have participated in an independently run annual customer satisfaction survey undertaken by Discovery Research. The latest survey received responses from more than 15,100 policyholders with a staggering 97% of respondents registering that they are satisfied with their health fund membership.

These surveys provide hirmaa funds with an important tool for continual improvement and benchmarking and provide a further demonstration of their ongoing long term commitment to meeting the changing needs and expectations of consumers.

The strong customer service performance of the hirmaa funds is also reflected in PHIO statistics, which show that while hirmaa member funds represented 9.6% of the private health insurance market in 2016, they attracted only 4.6% of annual complaints, well below their market share. To put this into further context, the 4,416 complaints received in total by the Private Health Insurance Ombudsman in 2016 represented just 0.03% of all those Australians with private health insurance.



While hirmaa funds continue to grow strongly and are valued by consumers, there is growing concern around the ongoing affordability of private health insurance. Once key aspect of this is the significant upwards pressure being placed on private health premiums from the rapid growth in benefit use within public hospital settings. hirmaa welcomes the Commonwealth Government's recognition of this issue and looks forward to contributing to reform efforts.

The need to address benefit growth in public hospital settings

One of the key drivers placing upwards pressure on private health insurance premiums is the rapid growth in benefit use in public hospital settings.

Between 2002 and 2016 benefit growth in public hospitals increased from $295.6 million to $1,062 billion, this represents an average cost to the average private health insurance hospital policy of around $150 and a total cost of to the Commonwealth Government of around $2 billion.

This growth is being actively driven by public hospital administrations seeking to cost shift of public services to private health insurance policy holders and the Commonwealth Government.

This opportunistic behavior is not being undertaken with the objective of improving medical outcomes but rather revenue creation at the expense of fair engagement with the patient. Patients with private health insurance are often led to believe that they will be provided with preferential treatment in public hospital settings if they use their insurance, including priority of treatment and provision of single rooms. This is despite the fact that public hospital systems are required to prioritise treatment and accommodation based on clinical need. Either patients with private health insurance are being misled or public hospitals are undermining the universality of public health.

These practices are not limited to individual public hospital administrators seeking to exploit a revenue source. These practices are often driven by deliberate policy settings established by State and Territory governments, especially though the setting of targets for 'own source' revenue which several jurisdictions have adopted. Key targets for 'own source' revenue includes Commonwealth sources as well as private health insurance policy holders.

The active emphasis being placed on enticing holders of private health insurance to activate their policies for publicly available services is such that there is anecdotal evidence of:

- consumers being approached by hospital administrators following their hospital treatment in order to have them retrospectively elect to be treated as a private patients;
- patients being asked for information about what health fund they are a member of and this information being used as an "election" to be treated as a private patient;
- patients being asked to sign election forms when they are in a vulnerable position, for example, laying on a stretcher waiting to be wheeled in for surgery;
- patients being encouraged to elect to be treated as a private patient on the basis that the money from their private health fund will be used to research treatments to illnesses like the one they are suffering from;
- patients being encouraged to elect to be treated as a private patient on the basis that they are making a donation to the hospital.

Collectively these practices allow public hospitals to bill insurers at the ultimate expense of the consumer. Such activities are not justifiable in either a medical or patient care sense.

In order to ensure that patients are properly respected and that private health consumers are not being unfairly pressured to pay through multiple streams for healthcare to which they are entitled for free through the public system it is essential that any and all reform place accountability and transparency at the fore. Additionally, effort must be undertaken to eliminate those practices which actively encourage the use of private health insurance as opposed to simply informing policy holders of their entitlements.

hirmaa has warned of the significant consequences to the continued growth of benefit use of public hospital settings in a number of submission including in:

- hirmaa's submission to the Senate inquiry into the value and affordability of private health insurance and out-of-pocket costs 14 August 2017.
- hirmaa's submission to the Australian Competition and Consumer Commission's annual Report to the Senate on Private Health Insurance 5 April 2017.
- hirmaa's Submission to the Australian Government's Department of Health consultations on the value of private health insurance for consumers and its long-term sustainability 4 December 2015.
- hirmaa's submission to the Australian Competition and Consumer Commission (ACCC) regarding the practices by health funds and providers in relation to private health insurance (PHI) 21 January 2015.

Once again, hirmaa welcomes the opportunity to contribute to this very important policy issue. Further, we congratulate the Commonwealth Government, and the Minister for Health in particular, for actively engaging on this policy issue as demonstrated by the release of this options paper.

Key areas of benefit growth in public hospital settings

Public hospital administrators achieve economic advantage from patients with private health insurance through a number of billing streams. Below are the key cost areas for benefits utilised in public hospital settings.

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, free car parking and free meals for visitors, and free in room TV. While these services come at a cost to hospitals budgets, such inducements are much cheaper than bearing the full episodic cost as a public admission.

It is important to note that room allocation in public hospital settings should be undertaken based on medical need and therefor commitments to provide such accommodations based on insurance status are either deceptive or being made at the expense of uninsured patients.

The cost of this practice is significant with accommodation for private patients representing approximately 70% of the total benefits paid to public hospitals.

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. This represents a significant cost shift from State and Territory jurisdictions to the Commonwealth and private health consumers.

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. There have been instances of State Government Auditors reporting on this practice as a source of hidden incomes for doctors employed by the State Government.

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 set by the Prostheses List Advisory Committee.

The Independent Hospital Pricing Authority has recently reported to the government that on average, cardiac devices were 119 per cent more expensive in private hospitals, urogenital prostheses 109.9 per cent more expensive, ophthalmic implants 92.9 per cent more expensive and neurosurgical parts 68.3 per cent more expensive.

The financial model for funding private patients in public hospitals 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.

Discussion of proposed options to reduce pressure on private health insurance premiums by addressing the growth of private patients in public hospitals

hirmaa welcomes the decision by the Australian Government to release a detailed paper outlining a range of options to address the continued growth in benefits in public hospital settings.

This paper outlines five reform options as follows:

1- Limit private health insurance benefits to the medical costs of private treatment in public hospital with no benefits paid to the hospital
2- Prevent public hospitals from waiving any excess payable under the patient's policy
3- Remove the requirement for health insurers to pay benefits for treatment in public hospitals for emergency admissions
4- Remove the requirement on health insurers to pay benefits for episodes where there is no meaningful choice of doctor or doctor involvement
5- Make changes to the NHRA NEP determination and funding model

The merits of these options will be discussed in this response, however it is important to note that the implementation or further investigations of any of the identified options should be undertaken with ongoing consultation with hirmaa and the private health insurance sector.

It is also important to note that public hospital operators will remain well placed to identify and pursue revenue generating measures at the expense of the Commonwealth and holders of private health insurance. As such, hirmaa sees it as essential that any reform actions ultimately pursued allow for accountability and oversight based on the transparent review of all invoices by insurers, and ultimate oversight by the Commonwealth Government. This will not only serve to identify existing practices but will help to ensure that similar practices are not developed and implemented in the future.

DISCUSSION OF PREFERRED OPTIONS

For the reasons discussed in the following section, hirmaa broadly supports Option 1 and Option 3 as the most achievable and likely to result in notable reductions to the public hospital benefit.

Option 1: Limit private health insurance benefits to the medical costs of private treatment in public hospital with no benefits paid to the hospital

hirmaa position: hirmaa broadly supports Option 1 as the most appropriate reform direction.

Discussion of proposal

hirmaa is broadly supportive of Option 1 as the most appropriate reform direction outlined within the Options Paper and believes that high reduction in public hospital benefits could be expected as a result of the implementation of this reform.

Accommodation and other non-medical costs represent over 70% of the average benefit used in a public hospital setting. Under this option private health insurers will not be required to pay for the cost of

accommodation, prostheses devices or other non-medical charges that are available to a patient in public hospital as of right. Such an arrangement would enhance the centrality of doctor/ specialist choice for private health consumers in public hospital settings.

It would be essential, however, to ensure that State and Territory jurisdictions did not seek to replace existing revenue streams at the expense of patients. In order to ensure that the policy response did not result in any out-of-pocket costs for a patient, it would be necessary to clearly mandate that all patients be treated as a Medicare patients (i.e. not subject to any out of pocket costs). Additionally the requirement for clear rules around informed financial consent would be essential.

If adopted, this policy change would be relatively simple for public hospitals to implement and administer and for private health insurers to communicate to their membership.

Summary

Expected reduction on public hospital benefit	**High**
Expected impact on private health policy holder	**Member retains ability to choose preferred doctor/ medical specialist.**
hirmaa position	**Preferred option provided that charges for out of pocket costs are prohibited.**

Option 3: Remove the requirement for health insurers to pay benefits for treatment in public hospitals for emergency admissions

hirmaa position: hirmaa broadly supports Option 3 as a positive reform direction.

Discussion of proposal

hirmaa is broadly supportive of Option 3 as an appropriate reform direction and believes that a medium reduction in public hospital benefits could be expected as a result of the implementation of this reform.

The reform would eliminate the pressure placed on patients entering emergency departments to use their private health policy. In entering an emergency department a patient is likely to be extremely vulnerable and open to influence and suggestion, and it is unfair that patients are targeted at this stage of their hospital experience.

The reform would also reinforce the centrality of 'neutral status' in these settings - that is the premise that all patients accessing an emergency department in a public hospital should be treated based on clinical need alone.

In order for this reform to be effective, transparency will be of critical importance. Appropriate arrangements would have to be established in order to ensure that coding measures could be checked and verified.

Further, the reform would require clear delineation between private health insurance for elective admissions and Medicare for Emergency admissions. Specifically, there would be a clear need for guidelines regarding the discharge/ release of patients from an emergency department and their readmission as an elective patient. As a starting point hirmaa suggests that Hospital Case mix Protocol (HCP) data be provided to private health insurers in order to allow for the verification of cost allocations.

It is currently not mandatory for public hospitals to supply HCP data to funds for private patients. This hampers efforts to understand casemix and benefits management. HCP data also includes a field called

"Urgency of admission", which helps to identify "emergency" status.

Such transparency is important as there is currently no way for an insurer to know whether an episode is "emergency", unless they undertake an "after the fact" audit. That opens up an opportunity for "miscoding" to maximise private patient revenue in public hospitals. The provision of appropriate data would allow insures to review hospital activities in the interests of both private health consumers and the Commonwealth.

Expected reduction on public hospital benefit	**Medium**
Expected impact on private health policy holder	**Member retains ability to choose preferred doctor/ medical specialist.** **Members will not be pressured to disclose insurance status upon entry to an emergency department.**
hirmaa position	**Generally support subject to appropriate transparency including the provision of HCP data to private health insurers.**

DISCUSSION OF REMAINING OPTIONS

For the reasons discussed in the following section hirmaa does not believe that Option 2, Option 4 or Option 5 offer strong reform outcomes due to either the likely limited impact to the public hospital benefit or difficulty of implementation.

Option 2: Prevent public hospitals from waiving any excess payable under the patient's policy

hirmaa position: hirmaa does not believe that Option 2 will result in significant positive reform.

Discussion of proposal

hirmaa is not generally supportive of Option 2 as a reform direction and believes a low reduction in public hospital benefits could be expected as a result of the implementation of this reform.

It is not clear that the implementation of policy based on Option 2 would result in a real change to inappropriate practices seeking private health activation, particularly in emergency departments. Additionally the proposal would not impact those patients' with $0 excess products or public hospital only products.

Of particular concern, however, is the likely increase in out of pocket expenses for patients through excess. This is of particular concern for patients using emergency departments who might choose to enact their private health insurance, whether as a result of pressure or legitimate choice, without being fully aware of gap implications later on.

Another potential issue is the potential for patients in public hospital settings being offered other incentives such free entertainment, parking vouchers and other items to the value of the excess in order to encourage the use of insurance. Such actions would not only undermine the intent of the reform but would add another layer of complexity in decision making for patients.

Expected reduction on public hospital benefit	**Low**
Expected impact on private health policy holder	**Member retains ability to choose preferred doctor/ medical specialist.** **Members without $0 excess or public hospital only product likely to see out of pocket costs.**
hirmaa position	**Not generally supported due to potential adverse impacts to policy holders.**

Option 4: Remove the requirement on health insurers to pay benefits for episodes where there is no meaningful choice of doctor or doctor involvement

hirmaa position: hirmaa does not believe that Option 4 will result in significant positive reform.

Discussion of proposal

hirmaa is not generally supportive of Option 4 as a reform direction and believes that while a modest reduction in public hospital benefits that could be expected as a result of the implementation of this reform, the benefits are outweighed by complexity and confusion associated with the option.

The notion of a 'meaningful choice of doctor' is circumstantial in nature and is open to different interpretation. Specifically, 'meaningful choice' could change based on a number of contexts including the time (either hour or calendar day), location or individual hospital. The circumstantial nature of 'meaningful choice' is likely to require clear regulation that will likely be subject to change pressures on a frequent basis given the evolving and ever changing definitions and policy arrangements within public hospital settings.

Further, the proposal is likely to result in administration costs for both public hospital administrators and private health insurers as data will be required to ascertain whether there was a 'meaningful choice of doctor' at the time of the patient's admission and selection. The proposal would also result in additional complex red tape as members and doctors work to ascertain whether an individual procedure is to be paid by Medicare or a private health insurer.

If pursued the option could be amended to remove the requirement on health insurers to pay benefits for episodes where there is no *choice* of doctor or doctor involvement, i.e. where there is only one option for a patient, however the potential for confusion and complexity would likely remain.

Expected reduction on public hospital benefit	**Modest**
Expected impact on private health policy holder	**Member retains ability to choose preferred doctor/ medical specialist.** **Likely confusion around definition of 'meaningful choice of doctor' and subsequent red tape requirements in determining service payer.**
hirmaa position	**No generally supported due to complexity.**

Option 5: Make changes to the NHRA NEP determination and funding model

hirmaa position: hirmaa does not believe that Option 5 will result in significant positive reform.

Discussion of proposal

hirmaa is not supportive of Option 5 as a reform direction and believes that a very limited reduction in public hospital benefits could be expected as a result of the implementation of this reform option.

The option does not nominate real change to inappropriate practices seeking private health activation, particularly in emergency departments. Further, the option retains strong incentives for public hospital administrators to pursue alternative revenue sources by maximising private health benefits.

Expected reduction on public hospital benefit	**Very Limited**
Expected impact on private health policy holder	**Member retains ability to choose preferred doctor/ medical specialist.** **Member will not be pressured to disclose insurance status upon entry to an emergency department and be subject to existing recruitment practices.**
hirmaa position	**Not generally supported due to potential adverse impacts to policy holders.**

Conclusion

The growth in private patients using private health insurance in public settings is a significant threat to the long term affordability of private health insurance. In 2016 private health insurers were required to pay over $1 billion for health services in public settings, representing an average cost to a hospital policy of around $150. While insurers believe that patients should have the option to use their insurance in such settings there is growing evidence that public hospital administrators are using pressure tactics in order to actively encourage the activation of insurance policies.

In addition to pressure tactics there is also evidence that patients with private health insurance are often led to believe that they will be provided with preferential treatment in public hospital settings if they use their insurance, including priority of treatment and provision of single rooms. This is despite the fact that public hospital systems are required to prioritise treatment and accommodation based on clinical need alone.

These pressure tactics are being actively driven by public hospital administrations seeking to shift the cost of public services to private health insurance policy holders and the Commonwealth Government. In addition to localised efforts to cost shift there are examples of deliberate policy settings established by State and Territory governments that encourage this, especially the setting of targets for 'own source' revenue which several jurisdictions have adopted. Key targets for 'own source' revenue includes Commonwealth sources as well as private health insurance policy holders.

hirmaa congratulates the Commonwealth Government, and the Minister for Health in particular, for seeking to explore options that can serve to address this issues. The Options Paper released has raised a number of viable options that can be taken while retaining the value proposition of private health insurance. However, in order to ensure that patients are properly respected and that private health consumers are not subject to unfair and misleading proactive by public hospital operators it is essential that any and all reform place accountability and transparency front and center.