We are hirmaa

14 November, 2014

Professor Ian Harper
Chairman, Competition Policy Review Panel
c/o- Competition Policy Review Secretariat
The Treasury
Langton Crescent
PARKES ACT 2600

Dear Professor

Re: Response to Competition Policy Review Draft Report

We welcome the opportunity to comment on the Competition Policy Review Draft Report (henceforth 'The Report'), regarding regulations and other impediments to competition in the private health insurance (PHI) industry.

By way of introduction, hirmaa is a peak industry body representing ten (10) restricted access insurers and eight (8) open access regional private health insurers, collectively providing cover for over one million Australians nation-wide.

Since its formation, 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.

A number of characteristics distinguish the hirmaa member funds (member list attached). They:

- are value-based and exist solely to deliver benefits to members;
- continue to offer various levels of insurance at highly competitive premiums;
- optimise benefit entitlements and premiums;
- continue to tangibly grow their membership numbers, in recent years above the overall industry trend;
- in terms of the restricted insurers, have their unique nature acknowledged in the *Private Health Insurance Act 2007.*

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As The Report identifies, private health insurance is among the most heavily regulated industries in Australia.[1] As such, there is significant scope for sensible and practical deregulation to achieve enhanced competition for the benefit of consumers.

hirmaa agrees with the overall direction of The Report and generally supports the reform opportunities highlighted in The Report so far. However, we also believe that there are a number of additional reform opportunities that are crucial to improving competition in the industry.

We will take this opportunity to comment on the issues already identified in The Report as well as highlighting additional issues for The Panel's consideration.

Thank you for your consideration of this submission.

Yours sincerely

MATTHEW KOCE
Chief Executive Officer

[1] Competition Policy Review Draft Report, page 112

A. Response to competition issues identified in the Draft Report

i. Prostheses pricing arrangements

hirmaa considers the current prostheses pricing arrangements to be among the most patent examples of inappropriate regulation in the PHI industry and we are pleased that The Panel has identified this as an area of review.

hirmaa recommends an urgent review of prostheses pricing arrangements to remove the large and unnecessary disadvantage imposed on private hospitals and private health insurers.

Unlike public hospitals, private hospital are subject to regulation that limits their choice of prostheses to items on the Prostheses List, with a minimum price set for these products. As noted in The Report, these regulations see devices on the Prostheses List sold at prices that are often multiple times more expensive than prices in the public health system. Indeed, the Productivity Commission reported that in 2009, the average prosthesis cost was $542 in private hospitals, compared to $131 in public hospitals.[2]

The notion that this regulation is inconsistent and flawed is confirmed by the opportunistic actions of public hospitals. Where patients in public hospitals are being treated as private patients, public hospitals can purchase prostheses at public rates, yet charge insurers at private or near private hospital rates. A joint study by the Australian Health Services Alliance (AHSA) and the Australian Centre for Health Research (ACHR) estimates that the resulting profit from this activity was $55 million in 2012.[3]

Across 2012-13, $1.57 billion, or 13.85% of all hospital benefits paid were payments for prostheses.[4] Prostheses indeed constitute a significant proportion of benefit outlays each year and as such, the current arrangements are a significant impediment to market efficiency and competition, with costs inevitably passed onto consumers.

ii. Price monitoring of premiums

We note The Panel's recommendation to replace current price regulation of premiums with a price monitoring scheme, in line with the National Commission of Audit's recommendation.

hirmaa encourages an environment where private health insurers are afforded more flexibility in price setting. We suggest that insurers have the freedom to change prices at their discretion, without the approval processes of the regulator and Government.

We believe that if the market is to set prices, the right conditions must be in place to ensure the market can react efficiently:

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[2] *Performance of Public and Private Hospital Systems,* p. XLII, Productivity Commission, 2009; retrieved: http://www.pc.gov.au/__data/assets/pdf_file/0015/93030/hospitals-report.pdf

[3] *Private Patients in Public Hospitals,* p. 3, Australian Health Services Alliance / Australian Centre for Health Research, 2013; retrieved: https://www.ahsa.com.au/web/freestyler/files/Private%20Patients%20in%20Public%20Hospitals%20May%202013.pdf

[4] *The Operations of Private Health* Insurers, Annual Report 2012-13, Private Health Insurance Administration Council

1. Prudential oversight: to monitor the impact of pricing strategies on the financial positions of insurers.

   PHIAC (and in the near-future, APRA) already effectively monitors the financial positions of insurers – so the essential prudential oversight is already in place.

2. 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 in PHI purchasing decisions.

3. Effective portability arrangements: to ensure that customers can effectively respond to price changes.

   With Clearance Certificate arrangements, portability across insurers is provided for. The Private Health Insurance Ombudsman recently noted the positive work done by industry on clearance certificate processes to "*enable a smoother transition for consumers transferring between insurers"*[5]

4. Effective consumer protections: to ensure anti-competitive strategies are not pursued.

   Between the Ombudsman and the ACCC, 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. Indeed, the flaws of the current process of pricing oversight in the PHI industry are well documented. A recent report[6] noted that seven separate studies of PHI 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 with the economists that market efficiency is impeded where insurers do not have full discretion to decide price changes.

iii. Expanding the scope of products offered by PHI

We note The Panel's suggestion that health funds could be allowed to expand their coverage into primary care settings.

hirmaa agrees that there is scope for a greater role for PHI in the health system. However hirmaa sees the role for PHI as one that complements rather than replaces Medicare and we favour Medicare continuing to fund out-of-hospital medical practitioner services in primary care settings.

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[5] Media release: *PHIO releases 2013-14 Annual Report,* p.2, retrieved: http://www.phio.org.au/downloads/file/PublicationItems/PHIOMEDIARELEASEFINAL-AnnualReport2013-14.pdf

[6] *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_PHI_premium-setting.pdf

hirmaa suggests the focus should be on increasing insurer involvement in prevention, rather than the funding of medical practitioner consultations.

Sustainability issues in our health system largely stem from a combination of demographic factors (an ageing population) coupled with a rising incidence of chronic diseases across the population. Private health insurers are well placed to assist in improving sustainability, however their involvement and investment would be most effectively served in prevention rather than the funding of primary care consultations.

The focus of deregulation should be on improving the capacity of insurers to invest in prevention and management of chronic conditions. Since 2007, when insurers were first given the opportunity to cover Broader Health Cover (BHC) services, we have seen significant growth in this area, with the number of Chronic Disease Management Programs (CDMPs) rising from 6,472 with $2,049,605 in benefits paid, to 75,893 programs, with $53,890,227 in benefits paid in 2013.

These CDMPs provide for the management of cardiovascular, diabetic, mental health and other conditions and the growth in these services demonstrate that insurers are eager to invest in the better health of their members.

However, the effectiveness of insurers' involvement in this space is limited by restrictions on information sharing across providers. Often, the first time an insurer is aware of the health of a policy-holder is when they present at hospital. Given the magnitude of the issue at hand, we suggest restrictions are lifted on insurers, to facilitate improved management of chronic diseases with earlier and more targeted CDMP interventions.

hirmaa encourages an environment of more open access to patient information, where there are beneficial health-outcomes for patients. hirmaa suggests that the sharing of patient information should include both Medicare Benefit and Pharmaceutical Benefit Scheme data.

A recent *Australian Institute of Health and Welfare* (AIHW) report noted that chronic diseases are the leading cause of illness, disability and death in Australia, accounting for 90% of all deaths in 2011.[7] The COAG Reform Council's report – *Healthcare in Australia 2012-13* states that in 2011-2012 there were 1,131.40 potentially preventable hospitalisations due to chronic conditions per 100,000 people. When extrapolated across the population, there are well over 250,000 potentially preventable hospitalisations due to chronic conditions, per year.

The problem is obvious and will only worsen over time – the AIHW report notes that the incidence of chronic diseases is increasing largely due to changes in lifestyles. The COAG report notes that 62.7% of Australian adults were overweight or obese in 2011-12, suggesting an increase in the incidence of type 2 diabetes in the future.

It is evident that we need to take innovative steps to improve health-outcomes with respect to chronic diseases. By improving the capacity of insurers to track the performance of the services they invest in, deregulating information sharing will have the positive effect of increasing investment and innovation by

[7] *Australia's Health 2014;* June 2014, Australian Institute of Health and Welfare; retrieved: http://www.aihw.gov.au/australias-health/2014/

the PHI industry in Broader Health Cover programs – as the benefits of early intervention and preventative care-plans are verified.

hirmaa represents member-owned and not-for-profit insurers that only want the best outcomes for their members. Deregulating information sharing settings will improve the capacity of hirmaa funds to achieve this. With the principle of community rating, health insurance is made accessible and affordable to all in the community who seek it, irrespective of their risk factors. With this principle upheld, the PHI industry is well placed to use patient information to the advantage of the patient.

B. Additional competition enhancing reforms

i. Removing second-tier default benefits

The second-tier tier default benefits policy is a highly anti-competitive and market-distorting arrangement. It obliges health insurers to pay any accredited health facility at least 85% of the average charge for hospital treatment services under that insurer's negotiated agreements with comparable facilities in the State.

hirmaa strongly suggests that The Panel considers the effect of second-tier default benefits as an impediment to competition in the private health system.

The Australian Health Services Alliance recently commissioned leading actuarial firm Finity Consulting to report on the competitive impacts of this legislation.[8] The high-level findings of this report are as follows:

1. Second tier arrangements distort normal market dynamics:

- The artificial price floor price drives up cost, impacting both consumers and the Government (via the premium rebate)

2. Second tier arrangements obstruct innovation:

- The policy makes it more difficult for insurers to negotiate agreements on quality, patient comfort or other non-price factors: increasing rates for high-performing hospitals will also increase rates for second tier hospitals

- The policy stifles competition and price tension amongst private hospitals/day surgeries- since they all know they will have some kind of arrangement with each insurer – so why innovate or try to control prices

[8] *Second Tier Default Benefits*, Australian Health Services Alliance / Finity Consulting; September 2014; *available on request*

3. Second tier arrangements make it more difficult for insurers to control premium inflation:

- Regulations strengthen the position of hospitals when negotiating with insurers, since without an agreement they still receive 85% of average rates and avoid the various non-price requirements in agreements

4. Second tier arrangements result in an inefficient use of health funding:

- Access to insurer funding through second tier rates allows new facilities to open in areas which are already well-serviced

Instigated nearly twenty years ago in a completely different PHI environment, second tier default benefits are archaic, bureaucratic and no longer relevant. It is important to note that when second tier default benefits were introduced, PHI membership was in decline (falling to coverage of around only 30% of the population) and health funds and Private Hospitals/Day Surgeries were under financial strain.

With approximately 50% of the population now covered by PHI, second tier default rates are now an outdated legacy which is unnecessary and only serves to increase costs, drive innovation away from health insurers and hospitals and creates complex and unnecessary 'red tape'.

The benefits of removing second-tier default benefits would be:

- 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
- The unnecessary administrative costs to insurers and the Department of Health of managing these schemes would be removed

ii. <u>Policy excesses reform and indexation</u>

In order to qualify for the Medicare Levy Surcharge exemption, PHI policies must have a maximum annual excess no greater than $500 for singles or $1,000 for couples / families.

The maximum excess has not changes for around 15 years, despite continued claims inflation. It is therefore unlikely that a maximum excess set around 15 years ago is still the most appropriate amount today, or will always be appropriate in the future.

Indeed, a fixed maximum excess has the effect of increasingly restricting policy-design. As the value of the excess is eroded over time, insurers are increasingly forced to use policy restrictions and exclusions as tools to keep insurance products affordable.

Competition is enhanced where market participants have improved scope to differentiate products - reforming excesses legislation, by increasing and indexing the maximum excess, would arrest the erosion in its value and improve competitive dynamics in the PHI industry.

Attachment A – hirmaa member funds

- ACA Health Benefits Fund Ltd
- Defence Health Ltd
- The Doctors' Health Fund Pty Ltd
- Healthcare Insurance Ltd*
- Health Partners Ltd*
- Lysaght Peoplecare Health Ltd*
- Mildura District Hospital Fund Ltd*
- Navy Health Ltd
- Phoenix Health Ltd
- Police Health Ltd
- Queensland Country Health Ltd*
- Teachers' Union Health Ltd
- Teachers Federation Health Ltd
- Railways and Transport Health Fund Ltd
- Reserve Bank Health Society Ltd
- St Luke's Medical and Hospital Benefits Association Ltd*
- Transport Health Pty Ltd*
- Westfund Ltd*

*denotes open fund