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BE POSITIVE

SUBMISSION TO THE

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO

HEALTH FUNDING

by

MBF Australia Limited

May 2005

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EXECUTIVE SUMMARY

MBF Australia Limited (which is also ultimately the holding company for MBF Health Pty Limited) is the largest privately owned health insurance company in Australia with a combined market share of around 20%. In financial year 2003-4, we received almost $1.7 billion in premiums and paid $1.4 billion in claims benefits on behalf of our members.

Rising health care costs (as a result of technology, increasing demand and ageing) and the ability for the funders of health (ie, government, private health insurance companies, society, individuals) to meet demand for these health care services is a major global issue.

Recent Productivity Commission figures highlight that current government health expenditure has been rising in real terms and is now nearly 6% of GDP and health expenditure (excluding aged care) will rise from 5.7% of GDP in 2002-3 to 10.3% to 2044-5. Ageing is projected to account for half of this increase.[1] Projections by the Australian Bureau of Statistics indicate that by the middle of the century, the median age of the population will rise from the current 35.9 years to 49.9 years. Life expectancy for men will increase from 77 years to 82 and from 84 years to 87 for women. The over 65 population will increase from 13% to up to 30%. Up to 9% of the population will be in the "old-old" category of 85 and over, compared to just 1.4% currently.[2] This indicates a growing role for private sector provision and individual responsibility for health care expenses.

Private health insurers contributed $7.6 billion in financial year 2004 to the economy, $6.7 billion of which was paid to hospitals, doctors and medical suppliers.[3] As pressures on government expenditure on all social services increase, the private health sector will need to continue to assist the government in coping with the increased demand for health services. It is our submission that even the current level of 43% of the population being privately insured will not be sufficient to spread the funding burden of the future demand for health services. At 50 to 60% the contribution by the private sector will better enable the overall health system to be kept in proper balance, allowing those who need it to have better access to public sector services.

The combined public and private health sectors must also focus on how health care costs can be managed across the whole system in light of rising costs caused by increased utilisation and increased costs of treatment. We see that there are three main ways in which this may be achieved:

- Reversing the increase in demand for health care services by managing the health of the population, particularly chronic illness.
- Increased efficiency and effectiveness in the delivery of health care services.
- Enhancing consumers' ability to pay for the costs of their premiums/health care services into the future.

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[1] Productivity Commission, "Economic Implications of an Ageing Australia, Research Report", page 143. The Federal Government Rebate on private health insurance is included in government spending.
[2] As quoted in the Centre for Economic Development of Australia, Policy Statement, "Australia's Ageing Population: Meeting the Challenge" February 2004. See www.ceda.com.au.
[3] Figures calculated from Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04* (Canberra, 2004).

MBF is committed to ensuring the sustainability of Australia's mixed public/private model. In particular, we wish to ensure that the private sector, which complements and substitutes the public sector and offers greater choice and access in many important ways, remains viable, attractive and affordable for consumers.

Given MBF's position as one of Australia's major private health funders, this submission particularly focuses on the last two items of the terms of reference provided to the Committee for its inquiry:

d) *how best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government; and*

e) *while accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.*

We make the following recommendations:

TOR (D) – ENHANCING PRIVATE HEALTH THROUGH POSITIVE RELATIONSHIPS WITH PRIVATE HEALTH FUNDS, PROVIDERS AND GOVERNMENT

A. *OPTIONS FOR MORE EFFICIENT AND COST-EFFECTIVE WAYS OF PROVIDING CARE*

1) Need for a continuum of care in health funding

The ways in which a person moves through the system should be reviewed, allowing for **appropriate multidisciplinary care, care continuity and discharge planning**. GPs should have the role of being the central manager of a patient's healthcare and ensuring that continuity of care between episodes of hospital treatment is provided.

Funding should create appropriate incentives for GPs to undertake these services and this should be facilitated by appropriate information sharing. This will ensure that preventive care is given and chronic conditions are managed, achieving improved outcomes for members of the public and acute inpatient services for those who truly need them.

2) Disease management and appropriate incentives

It is essential that funds be able to manage conditions in the appropriate setting and by the appropriate discipline. This would include both **substituted care following an episode but also preventive health management techniques**. The current **reinsurance** arrangements and the *National Health Act 1953* need to be reviewed as a matter of urgency to provide the correct incentives for funds to engage in this behaviour.

3) **Appropriate care settings**
Provision for step down, rehabilitation, transitional and alternative care arrangements should be further developed. This may require some amendments to the *National Health Act 1953.*

B. ***HOSPITAL EPISODE STRATEGIES***

1) **Need for enhanced competition with hospitals**
The requirement for health funds to pay second tier default benefit rates to non-agreement hospitals that meet certain quality criteria greatly inhibits competition and appropriate negotiation with hospitals. Second tier is often used as a negotiating fall back by hospitals. This makes it difficult for health funds to negotiate pay for performance criteria, both for quality and financial performance. **Removal of second tier default benefits** would enable funds to contract more effectively in the interests of members as a whole.

Allied to this is that there is little **mandatory reporting of information** by hospitals; if hospitals were required to publish financial and clinical data, health funds would have a basis on which to negotiate contracts and to provide essential information to consumers about the hospitals to which they are being admitted.

The combined removal or second tier and mandatory reporting of information would enable funds to better contract on the grounds of quality and performance, ensuring optimal use of scarce health resources and appropriate consumer information.

2) **Prostheses**
We consider that further **reform in a similar way to PBS** would be desirable. This would include a more rigorous clinical and economic application process to be placed on the prostheses list, as well as indications and restrictions on use. Health funds, hospitals and suppliers could **work with the Colleges to ensure that clinical guidelines and protocols are developed** for prostheses.

C. ***MEDICAL GAP***

1) **Publication of gap doctors**
A requirement should be placed on health funds to **publish lists of their no and/or known gap doctors**, together with an analysis of the **percentage of times** that the doctor has opted into the gap arrangements for that fund's members. This will educate members about which doctors are using gap cover and give consumers the ability to choose a doctor who is more likely to use the arrangements.

2) **IFC by treating doctor**
The onus should also squarely be placed on the **treating doctor to obtain informed financial consent** to the costs of all the doctors involved in the patient's care, otherwise no doctor should not be able to charge above CMBS for the treatment.

D. *E-HEALTH STRATEGIES*

1) Information Sharing

All aspects of the health system require greater information sharing to improve the delivery of health services and would also greatly facilitate the GP as person responsible for ensuring overall continuity of care. There are significant benefits in funds receiving a deidentified dataset of MBS and PBS data.

2) E-Health initiatives

We fully support the Government's Electronic Health Record initiatives and consider that all aspects of the health sector should be included in this, including the private sector.

3) Appropriate electronic billing systems to allow true simplified billing

We support the **implementation of shared electronic systems for claiming and payment** for all private inpatient medical services without exception. This should provide significant operational efficiencies to the industry by having just 'one bill' to the member / health fund with all expenses related to the episode of care rather than the current multiple bills system, which creates inefficiencies in terms of identifying overall cost of the episode of care and its appropriate analysis.

TOR (E) – ENHANCING THE ATTRACTIVENESS OF THE PHI PRODUCT

A. *MEDICAL SAVINGS ACCOUNTS*

We recommend that a savings style product be investigated as an option for an alternative offering by private health insurers in the Australian health care system. Private health insurance funds are the natural fit to offer medical savings accounts as a PHI product. As an industry, we already have provider relationships and, more importantly, benefits payments administrative systems and processes for the consumer to have simple direct payment of funds from their account. This should allow the provision of cost effective products to consumers through existing relationships. MBF is committed to further investigate this option at the present time.

B. *REMOVAL OF FBT ON EMPLOYER SUBSIDISED PREMIUMS*

The corporate sector holds the greatest potential for growth and is largely untapped in terms of the opportunity it represents. We advocate incentives for health plans when subsidised or fully funded by employers. Current tax arrangements are a disincentive to workplace health plans and we believe that exempting them from the Fringe Benefits Tax regime would have an almost immediate and positive impact.

We also suggest linking access to FBT incentives to the national drive to encourage Australians to be physically active to deal with the epidemic of obesity and exposure to weight-related diseases.

C. ***GREATER REWARDING OF LOYALTY***

MBF is strongly of the view that funds should have greater freedom to influence retention of our members with tenure of between 1 and 5 years, or those who experience long periods between claiming and subsequently do not see the value of their PHI product. These members also tend to be the young and/or healthier members who support the risk profile of the actuarial pool. We propose that legislation be introduced that provides a parameter for which a discount could be given based on claims behaviour within an ancillary table.

A. *INTRODUCTION*

1) Who is MBF Australia Limited?

MBF Australia Limited ("**MBF**") has provided private health insurance to Australians for nearly 60 years. MBF has a strong, long established brand associated with peace of mind, security and hope for a healthy future. MBF as ultimate parent company also owns MBF Health Pty Limited and is the largest privately owned health insurance company in Australia with a combined market share of around 20%. Our purpose is to provide trusted solutions that protect and enhance health and financial wellbeing.

Through both MBF and MBF Health Pty Limited we provide private health insurance cover to around 879,000 policyholders, with a total of 1.8 million persons covered. In financial year 2003-04 we received almost $1.7 billion in premiums and paid $1.4 billion in claims benefits on behalf of our members.

Our financial health protection services to our members include a full range of products including hospital products covering inpatient treatment in hospitals, extras products covering ancillary services such as dental, optical and physiotherapy and combinations of hospital and extras cover, as well as health insurance products for non-Australian residents.

Through our subsidiaries we provide financial services offerings including travel insurance, life risk products such as trauma and term life insurance and wealth management products and services such as retirement planning, personal investment plans, annuities and pensions.

Our products are distributed through our retail branches, call centres and financial advisers and by direct mail to our own and our partner's customers.

2) Our commitment to industry sustainability and affordability

Rising health care costs (as a result of technology, increasing demand and ageing) and the ability for the funders of health (ie, government, private health insurance companies, society, individuals) to meet demand for these health care services is a major global issue. This affects the entire Australian health care system of which private health insurance is an essential part. In Australia, the ratio of health expenditure to GDP has risen from 8.1% in 1991-2 to 9.5% in 2002-3.[4]

In Australia, government expenditure forms a major part of the total percentage of GDP spend. Recent Productivity Commission figures highlight that current government health expenditure has been rising in real terms and is now nearly 6% of GDP and government health expenditure (excluding aged care) will rise from 5.7% of GDP in 2002-3 to 10.3% in 2044-5.[5] Ageing is projected to account for half of this increase.[6]

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[4] Australian Institute of Health and Welfare, *Health Expenditure 2002-03*, see table 2, page 9.

[5] Productivity Commission, *Economic Implications of an Ageing Australia, Research Report, page 143.* The Federal Government Rebate on private health insurance is included in government spending.

This indicates a growing role for private sector provision and individual responsibility for health care expenses.

Having dropped to just 30.1% in the mid-1990s, the health insured population in Australia rose to a high of 45% following the combined impacts of the introduction of the Federal Government Rebate for all eligible policy holders, and Lifetime Health Cover to encourage Australians into private health insurance by the age of 31. The insured population has now stabilised at around 43%. For some time there was slight membership slippage taking place from quarter to quarter, however, in the September and December quarters 2004, there were slight increases in hospital membership.[7]

Private health insurers contributed $7.6 billion in financial year 2004 to the economy, $7.6 billion of which was paid to hospitals, doctors and medical suppliers.[8] As pressures on government expenditure on all social services increase, the private health sector will need to assist the government in coping with this increased demand for health services. It is our submission that even the current rate of 43% of the population being privately insured is not high enough to spread the funding burden of the future demand for health services. At 50 to 60%, the contribution by the private sector will better enable the health system to be kept in proper balance, allowing those who need it to have better access to public sector services.

This submission details information highlighting the significant upward pressures on health care costs for the country and, more particularly, on claims costs faced by the private health insurance industry. It is our submission that the industry must focus on how health care costs can be managed across the whole health care system. We see that there are three main ways in which this can be achieved for the health system and particularly in the area of private health:

- Reversing the increase in demand for health care services by managing the health of the population, particularly chronic illness.
- Increased efficiency and effectiveness in the delivery of health care services.
- Enhancing consumers' ability to pay for the costs of their premiums/health care services into the future.

MBF is committed to ensuring the sustainability of Australia's mixed public/private model. In particular, we wish to ensure that the private sector, which complements and substitutes the public sector and offers greater choice and access in many important ways, remains viable, attractive and affordable for consumers.

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[6] Productivity Commission, see footnote 5, page 143.

[7] Private Health Insurance Administration Council ("**PHIAC**") Membership Statistics, www.phiac.gov.au.

[8] Figures taken from Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3.

3) Private Health Taking On Greater Responsibility

Evidence that private health is already taking on greater responsibility is becoming apparent and we would submit that encouraging participation in private health insurance is producing positive results. Private hospitals now perform 55% of surgery in Australia. Seventy-six per cent of knee procedures are done in private hospitals and so are 70% of cataracts, 55% of hip replacements and 52% of chemotherapy.[9]

Demand on public health services is being relieved although not as fast or dramatically as some might hope. Between 1997-8 and 2001-2002, for example, after adjusting for changes in age and size of the population, the number of separations per 1000 population increased by 25.6% for private hospitals, whereas the number for 1,000 population for public acute hospitals fell by 1.2%.[10] There is also compelling evidence that the Federal Government Rebate on health insurance premiums is public money well spent. In a report on the rebate's impact, Professor Ian Harper, the Dean of the Melbourne Business School, found that every rebate dollar saved two dollars governments would have to spend on providing health care for the uninsured.[11]

There is evidence to show that private health insurance is purchased by people on a wide range of income levels. As stated on the private health insurance industry association ("**AHIA**") information website for consumers:[12]

> *The latest ABS survey confirmed that more than 1 million people on household incomes less than $18,200 per annum have private health insurance, 2.3 million on household incomes less than $33,000 are privately insured. Almost half of the insured population have gross household incomes less than $51,000. So nearly 4 million people with hospital cover earn less than average weekly earnings.*

4) Government objectives

The Government has shown a strong commitment to ensuring access to high quality health care to all Australians. This commitment has led to a strong public hospital system, Medicare and the PBS. In addition, the value of private health insurance is supported by current Commonwealth government policies such as direct premium rebates to policyholders, Lifetime Health Cover loadings for those who do not have cover after 30 years of age and an additional Medicare levy for high income earners who do not have private health insurance.

The critical task for the Government is to manage the budget in light of increasing pressures on public and private hospitals given the ageing of the population, increase in chronic diseases, significant advances in medical technology and changing consumer expectations. As stated above, health expenditure (excluding aged care)

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[9] Australian Institute of Health and Welfare, Australian Hospital Statistics 2002-3.
[10] Australian Institute of Health and Welfare, *Australia's Health 2004* (Canberra, 2004) p 277. Please note that separations following admission after a completed episode of care is commonly used as a measure of admissions.
[11] Harper I, "Preserving Choice, A Defense of Public Support for Private Health Funding in Australia", Harper Associates (March 2003).
[12] www.privatehealth.com.au.

will rise from 5.7% of GDP in 2002-3 to 10.3% to 2044-5.[13] With the Federal Government rebate forming part of this expenditure, it is essential for this money to continue to be spent in a cost-effective manner.

Recent statements by Minister Abbott have placed importance on improving the value proposition of private health insurance, together with minimising premium increases, in order that Australians who are able, can contribute further to their health care costs. Key aspects of improvement that have been identified are through simplifying the billing process and the benefits provided under the product, particularly the out-of-pocket costs faced by consumers.[14]

Other key government initiatives are around quality health care, particularly in evidence based medicine, preventive care and chronic disease management is in place together with improved sharing of health information through electronic health records.

B. *INDUSTRY ENVIRONMENT*

1) Registration is required to sell PHI

To sell private health insurance, an entity must be registered under the National Health Act 1953 ("**NHA**") as a registered health benefits organisation ("**RHBO**"). Such RHBOs are more colloquially referred to as health funds.

The NHA and its regulations (including conditions of registration placed on funds) regulate product features, maximum waiting periods that can be imposed prior to benefits being paid, portability of entitlements between funds, categories of membership and the types and levels of benefits. In large measure, these are to ensure community rating is upheld.

Funds are subject to prudential regulation of their capital adequacy and solvency by the industry financial regulator, the Private Health Insurance Administration Council ("**PHIAC**").

2) Membership rights

Members have guaranteed acceptance and renewal for their membership. Funds have no right of refusal or differentiation for members joining their fund.

A member transferring to another Australian registered health fund has continuity of membership for the same level of benefit entitlement, for services provided common to both funds.

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[13] Productivity Commission, *Economic Implications of an Ageing Australia, Research Report*, page 143.
[14] Speech by Minister Abbott at the Financial Review, 7th Annual Health Congress on 24 February 2004.

3) Pricing - Community Rating

Health funds are required to adhere to a community rating system which means that they are not allowed to discriminate between health fund members on the basis of their health, age (with the exception of Lifetime Health Cover loadings), race, sex, sexuality or claiming history. In effect, this means that health funds must offer the same products at the same rate to all members and cannot refuse to insure anyone or offer differentiated rates based on age, sex or any other matter as other insurers (eg car insurers) can do.

Community rating keeps premiums affordable for those who are older or chronically ill. Community rating relies on people who do not claim cross subsidising those who do. To be sustainable PHI requires a strong value proposition for the non-claimers to keep them in the system and for premiums to remain at an affordable level relative to value provided.

Underpinning community rating is the reinsurance rules that redistribute the costs of the high risk members of the community across all hospital memberships in all funds in all states. Reinsurance seeks to balance out the cost to funds of certain claims. In general terms, eligible claims are hospital claims relating to persons over 65 years of age and to lengthy hospitalisations. Where a fund has a higher value of eligible claims than the average, it will receive a reimbursement from the reinsurance pool. If a fund has a lower value of eligible claims it will be required to make a payment into the reinsurance pool.

Health funds may only increase their prices once a year and this can only be done by way of submission to the Department of Health and Ageing ("**DHA**"). Submissions may be disallowed by the Minister who may do so on grounds including "the public interest" or the "interests of contributors". The submission can be referred to the government actuary for advice and this advice was in fact sought in the most recent round of premium changes announced in March of this year.

4) What can health funds cover?

The health services for which health funds can offer insurance cover are set out in section 67 of the NHA and cover in-hospital services and ancillary cover.

In-hospital services occur once a patient completes a hospital's formal admission process. Very broadly, these include:

- The cost of **in-patient** hospital accommodation, theatre fees and nursing care as a **private** patient in either a public or private hospital
- Specialists, pathology and radiology services, other diagnostic services provided in hospital
- Surgically implanted prostheses provided in-hospital
- Pharmaceuticals provided in hospital.

All funds are required to have one hospital product that will pay benefits towards the costs of all in-patient procedures covered by Medicare. (Please see below for a further explanation of exactly how benefits are determined.) All hospital products must also

provide some benefits towards the cost of palliative, rehabilitation and psychiatric services. Subject to these requirements, funds are able to exclude benefits for certain conditions and include time limitations before members may claim.

Ancillary services include dental, optometry, physiotherapy and complementary therapies (eg acupuncture). There must be a health component. Health funds are also not able to provide benefits for non-health related expenses, for example, travel insurance.

Funds are not permitted to pay a benefit for out-patient medical fees. Nor are benefits for services provided outside the hospital walls eligible for distribution in accordance with the mandatory claims equalisation scheme – "reinsurance" - referred to above.

These requirements determine the design of the products that health funds offer.

5) Product innovation?

Comprehensive hospital cover results in a high price for two reasons: those who are most likely to require a wide range of treatments on a frequent basis (the elderly and the chronically ill) will "self-select" and choose a product that will provide a high level of cover. Secondly, there is significant moral hazard around such products i.e. there is a risk of over utilisation due to the lack of any requirement for the consumer to contribute any amount from their own pocket.

Therefore, there are limited ways in which health funds attempt to differentiate their hospital products and make them more affordable to consumers., These include the amounts consumers agree to pay towards the costs of their health care (front end deductibles), time limits on when benefits can be paid, and exclusions for certain conditions, such as heart conditions, hip replacements, obstetrics and cataracts. These procedures are either generally elective in the sense that a person can make an assessment of their likelihood of needing that procedure or people under a certain age have less likelihood of requiring the procedure.

Exclusion products are becoming increasingly available in the market place in response to consumer demand. Customers will self assess the risk they wish to accept. Product research conducted by MBF shows that there is a demand for products with exclusions that is skewed towards those in earlier life stages. Of those surveyed, 30% of young singles and couples prefer an exclusionary product compared to 7% of older families and 2% of empty nesters.

6) Benefits for in-hospital treatment

a) Benefits for in-hospital treatment

Where a privately insured patient is treated in a public hospital, the fund pays a rate determined by the Commonwealth, set under the Medicare agreements, covering accommodation and surgically implanted prosthesis. The set rate includes theatre costs but does not include surgeons' fees above the schedule that are separately billed to the member (see section on doctors' fees below).

For private hospitals, following changes to the NHA in 1995, funds have a regulatory structure under which they are able to enter into agreements with hospitals for the benefit that will be charged for the hospital treatment, known as hospital purchaser provider contracts ("**HPPAs**").[15] Under these contracts, the amount that will be charged to a consumer is agreed, together with the amount that the fund will pay towards such expenses. In MBF's case, we provide 100% cover for those expenses agreed with the hospital, following any amount the consumer has agreed to pay up front, such as an excess.

If the fund does not have a HPPA with the private hospital, it must pay either default benefits at either the Ministerial Default Rate or if the private hospital meets certain criteria at the Second Tier Default Benefit rate. The Second Tier Rate is generally 85% of the average contract rate for similar hospitals.[16]

b) Doctors' fees

For inpatient professional services, Medicare pays 75% of the Commonwealth Medicare Benefits Schedule ("**CMBS**") with funds able to cover the remaining 25% of the schedule fee. Without an arrangement with the doctor, health funds may not pay any amount above CMBS. Doctors have no constraint on charging over this amount and the consumer pays any amount above CMBS (see pillar 1 over).

Arrangements were introduced whereby funds could enter agreements with doctors to cover either all (no gap) or a set amount (known gap) of the cost of the service above the CMBS fee known as a Medical Purchaser Provider Agreement ("**MPPAs**"). The practitioner had to either accept the amount in full satisfaction (no gap) or specify the amount that is payable by the patient over and above the amount of the health fund benefit (known gap). See pillars 2 and 3 over. Most of these contracting arrangements were established so that doctors could choose to "opt in" to the scheme on a case-by-case basis. Health funds were required to have at least one product on which these arrangements were available to continue to offer Federal Government Rebate on their products.

In part because of a strong mistrust of contracts by the AMA, the NHA was amended to introduce gap cover schemes, under which funds would offer a gap arrangement (either no or known gap), where doctors could choose to opt in on a case-by-case basis. Regulations introduced requirements for these schemes, particularly that they must be non-inflationary in relation to doctors' fees.

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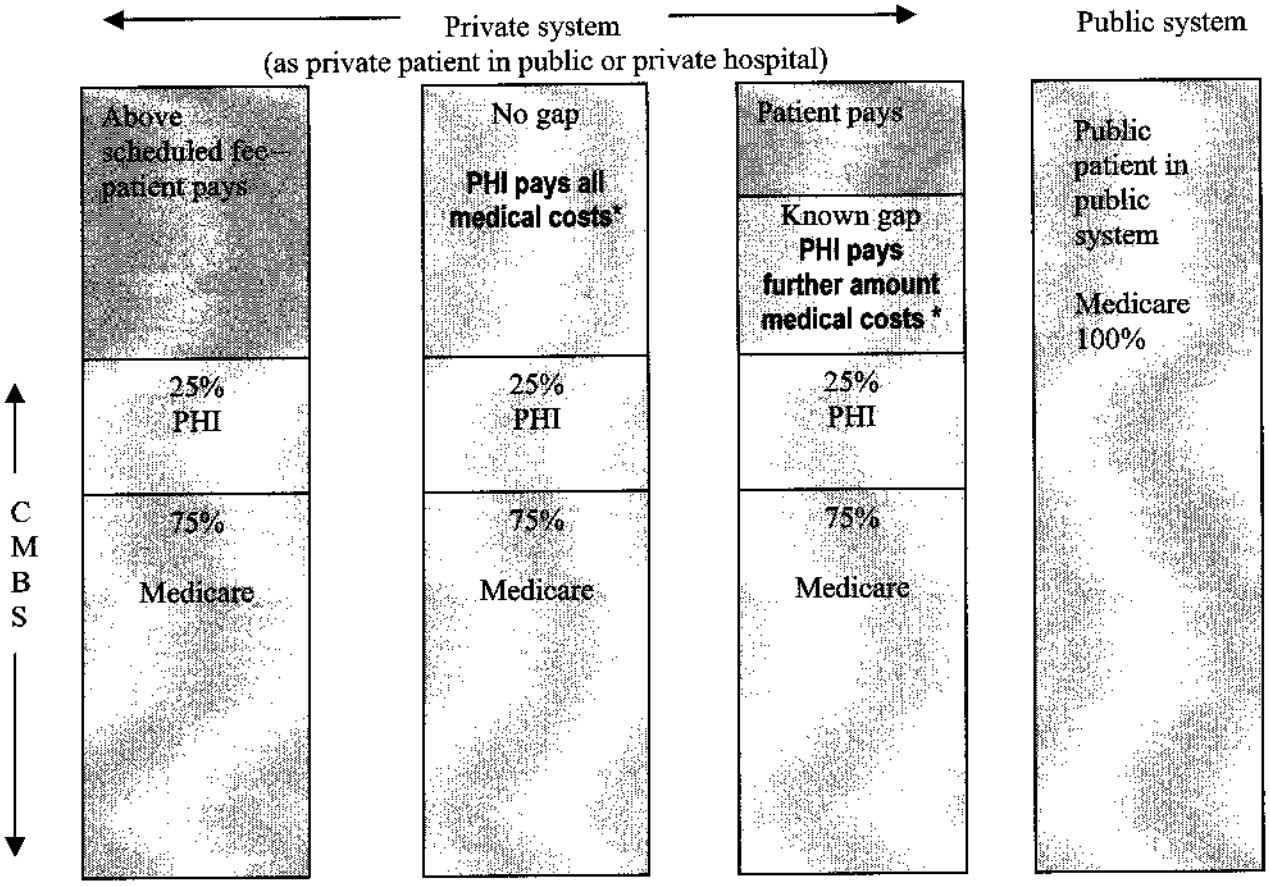
[15] Section 73BD of the NHA. HPPAs allow funds:

- to pay benefits directly to hospitals for treatment received by members, rather than the member paying all costs to the hospital and then seeking reimbursement from the health fund; and
- to agree with hospitals on an all up charge for an episode of treatment to minimise out of pocket costs for members. That charge will include accommodation, theatre fees, physiotherapy, allied health, pharmacy, disposables and prostheses.

[16] In an emergency, a fund must pay benefits equalling or exceeding the average level of benefit payable by the fund in respect of treatment at hospitals with which the fund has an HPPA.



* Please note that this graph is only on an individual doctor basis. There may be many doctors involved in a patient's care in addition to the main treating doctor, eg, anaesthetist, assistant surgeon. Only if all specialists involved in the episode of care opt in to apply no-gap terms with the health fund for that particular patient will the patient face no gaps. The patient would have to ensure individually with each doctor that he or she is prepared to use the no-gap arrangements. For patients that only see the anaesthetist and/or assistant surgeon immediately prior to the operation, if at all, this can be very difficult, if not impossible.

c) *Surgically implanted prostheses*

One of the most inflationary areas of claims benefits for funds over recent years has been prostheses. The items for which benefits were paid and the actual benefits for surgically implanted prostheses were previously determined by the Commonwealth Government, and published as Schedule 5 of the NHA. Reform in 2002 "de-regulated" the pricing aspect of this process and health funds, suppliers and hospitals were to jointly negotiate the price of prostheses. However, funds were still required to ensure that consumers had no out-of-pockets, making negotiations difficult and sometimes impossible with suppliers. The intention was to create competition in the prostheses market but the effect was to substantially increase costs (see section C. 2) of this paper.

The *National Health Amendment (Prostheses) Act 2005 (Cth)* was passed by both Houses of Parliament on 10 March 2005. This legislation changes the manner in which prostheses are paid for by health funds with the intention of ameliorating spiralling prostheses costs by creating a far more competitive market place arrangement and introducing more tension into supplier pricing arrangements.

In short, Schedule 5 - being the list of prostheses items - is to be re-drafted and prostheses will be split into 2 major areas. Prostheses with no gap attached to them and prostheses where a gap is payable by the consumer (with a minimum and maximum benefit amount attached to the prostheses). As the list currently stands, the majority of prostheses fall into the no gap category.

7) Ancillary Cover

Funds may offer benefits for services such as physiotherapy, dental, optometry and complementary therapies. These ancillary services are generally not covered by Medicare.

Funds usually pay a set benefit per consultation with an upper total limit on claims per calendar year.

Ancillary cover does not generally work on a true insurance basis. Most customers can work out their likely need for such services at the beginning of the year and make a decision whether this represents value for money. As the cover is a sunk cost, many consumers will claim the annual maximum benefit for services. To the extent that this encourages consumers to expect to consume health services as a result of owning private health insurance, there is a concern that this behaviour might cause some members to feel they should consume hospital services as well. It is essential for health industry sustainability that consumers see private health insurance for hospital as a true risk product which value is 'peace of mind' rather than 'value for money'. For example, most people would be happy not to claim on their life, car or house insurance.

C. ***CURRENT INDUSTRY ISSUES***

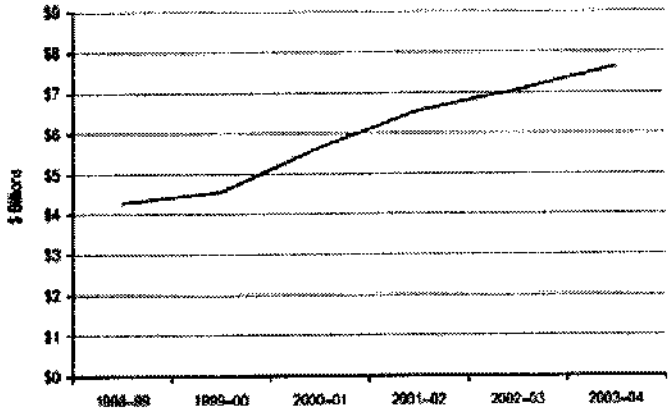
1) Claims inflation

Industry trends show that the costs of privately insured claims are increasing as a result of both increases in utilisation and volume of claims, with the main drivers of these increases being technology advances, increasing consumer expectations, provider behaviour and ageing.

Growth in benefit outlays remained strong during 2003–04 with benefit outlays growing by $575 million (8.2%) over the year and totalling $7.630 billion.[17]

[17] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3, p 16.

Benefit Outlays 1998-99 to 2003-04[18]



Benefits for in-hospital treatment increased 9.6% in 2003-4, marginally higher than the 2002-2003 increase of 8.9%[19]. Factors such as medical indemnity, health professional wages, increased utilisation, technology costs and cost of prostheses and increased consumer expectations have increased the benefits paid. PHIAC's Commissioner, Garry Richardson considers that these factors are likely to result in further increases over the coming year.[20]

Benefits paid for surgically implanted prostheses, such as heart pacemakers, cochlear implants, artificial hips and vein stents, are a significant driver of this increase. These account for about 12 percent of PHI hospital benefits. In contrast, prostheses benefits accounted for only 1.7 percent of total hospital benefits in 1989-90.[21] Between 2001-02 and 2003-04, there has been a 29 percent increase in prostheses benefits.[22]

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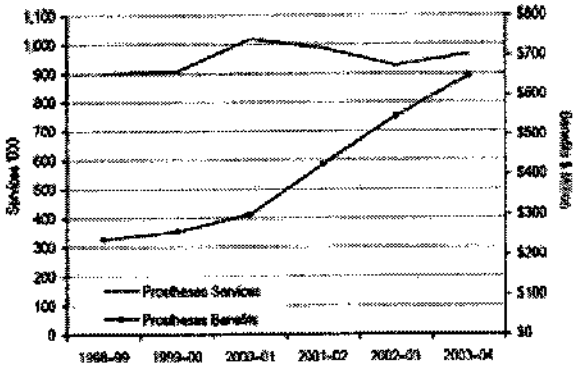
[18] Figure 3, Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3, p 16.
[19] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3, p 1.
[20] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3, p 1.
[21] Parliament of Australia 2004, *National Health Amendment (Prostheses) Bill 2004*, Bills Digest No. 79 2004-05, page 4 accessed at www.aph.gov.au on 16 February 2005.
[22] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3, p 33.

Prostheses Services and Benefits and Annual Percent Change 1998–99 to 2003–04[23]

Financial Year	Prostheses Services	Prostheses Benefits	% Change in Prostheses Services	% Change in Prostheses Benefits
	'000	$'000		
1998–99	902	$239,237	25.4%	15.8%
1999–00	908	$257,477	0.6%	7.6%
2000–01	1,019	$300,966	12.3%	16.9%
2001–02	987	$425,864	-3.2%	41.5%
2002–03	927	$545,475	-6.1%	28.1%
2003–04	967	$647,534	4.4%	18.7%

Prostheses Services and Benefits 1998–99 to 2003–04[24]



2) Drivers of claims inflation

The main drivers for increased numbers of services are:

- Increased utilisation rates (claims/1000 policies).
- Ageing population consuming more services.
- Medical/technology advances stimulating demand. Consumer expectations of quality and availability of the newest and latest medical advances feeds into supplier driven demand created by prostheses manufacturers, hospitals and other medical services resulting in increasing complexity, frequency and cost of services.

From 2001-02 onward, after the full implementation of Lifetime Health Cover ("**LHC**") and the end of waiting periods experienced by those enrolling in PHI with LHC. Private health utilisation has increased, for example, the total number of privately funded days in hospital grew 3.3 percent between 2001-02 and 2003-04, and days per average person covered increased 4.1 percent during the same time. There was a

[23] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3,Figure 31, page 33

[24] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3,Figure 32, page 33.

corresponding increase in medical services between 2001-02 and 2003-04, with the number of services up to the Medicare Schedule Fee growing 14.1 percent and the number of services above the Schedule Fee growing 52.7 percent.[25] Ancillary utilisation has also grown, increasing 3.4 percent in 2003-04.[26]

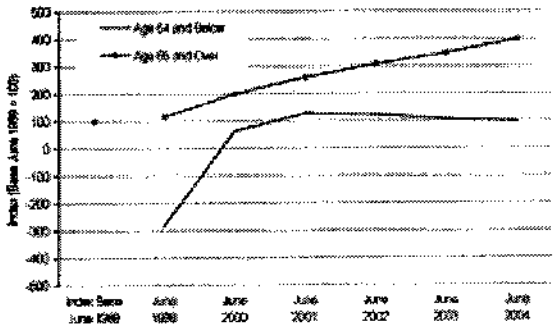
The main drivers for the increased average cost of claims are:

- Unit cost increases to providers. Again, medical technology is becoming more costly.
- Ageing population receiving higher cost services.

The health services industries and private health insurance industries have unique features that result in cost pressures that are not experienced by other industries. Health funds are directly affected by the ageing of the Australian population. Use of medical services is directly related to age. The average age of persons insured increased last year from 38.3 to 38.7 years.[27] Of greater concern is not only the private health insurance population but that the number of persons aged over 65 has trended upwards whereas the coverage of persons aged 64 and below (needed to support older people) has for the last two years trended downwards.[28]

The figure below shows the change in coverage by age category from 30 June 1989 to 31 December 2004. The year ending 30 June 1989 has been used as the base year with the following years indexed in relation to the base year.

Change in Number of Persons with Hospital Cover by Age Category 30 June 1989 to 30 June 2004[29]



With the insured population ageing by approximately half a year, each year, our estimates prepared for the last rate review submission estimate that funds are subject to a 2% inflationary cost per year due to ageing alone. This is before the effects of

[25] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3, pp. 27-28.
[26] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3, p 1.
[27] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3, p 14.
[28] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3, p 44.
[29] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3, Figure 45, p 45.

price increases to providers and the more general supply driven demand of hospital services.

3) Sustainability of PHI premiums

As the growth in the cost of claims is significantly greater than consumer CPI[30], sustainable affordability of private health insurance over the long term is an issue. With PHI funding a considerable portion of treatment in private hospitals, this could leave the private hospital sector similarly vulnerable. This has flow on implications to the health sector as a whole.

Community rating is a benefit to the system as it keeps premiums affordable for those who are older or chronically ill. Community rating relies on people who won't claim cross subsidising those who do. To be sustainable PHI requires a strong proposition for the non-claimers to keep them in the system and for premiums to remain at an affordable level relative to value provided.

4) Pricing must account for claims costs and not rely on volatile investment returns

Hospital cover is a form of risk insurance such that funds must be prudent in managing reserves so that they can ensure that they have sufficient capital to cover this risk. Prices increases must be sufficient to cover the underlying increases in cost of claims described above as well as ensure that there are sufficient profits to add to reserves to meet future unanticipated increases in claims. The industry regulator supports efforts by funds to ensure that they price to ensure that there is an underwriting profit. Their latest report states:[31]

> *Private health insurance organisations have achieved a welcome improvement in their financial position in 2003-4. However this improvement has been largely through improved investment returns in a time of buoyant market conditions. Funds need to be positioning themselves now for a potentially less favourable investment environment.*

Health insurance funds do not make high margins. PHIAC in its 2003-4 Report states at page 1 that the net margin for the industry as a whole last year was 1.8%. Many funds record an underwriting loss and rely on investment income to cover expenses and capital requirements.

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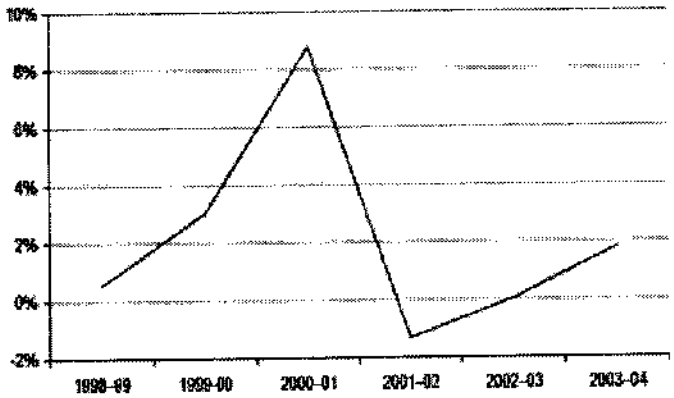
[30] Headline CPI measures increases in prices of a very wide range of goods and services. There are separate CPI measures across different industries including a "health CPI" measuring increases in the provision of hospital and medical services. For the 12 months to September 2004, the health CPI grew by 7.7% compared to a headline CPI rate of around 2.3%. This was not a one off phenomena as there has been a reasonably constant trend of the past few years for health CPI to run at more than twice headline CPI. (see ABS http://www.abs.gov.au/Ausstats/abs@.nsf/0/938da570a34a8edaca2568a900139350?OpenDocument)

[31] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3, p 1.

The PHIAC report states at page 17 that an increase in benefit outlays of 3.9% in 2003–04 would have eliminated the surplus generated by investment and other revenues for the industry as a whole.[32]

Net Margin 1998-99 to 2003-04[33]



The table clearly shows that the usual position for the industry is around breakeven on an underwriting basis, with high margins only being associated with the abnormal profits following the introduction of LHC where many new entrants to PHI were on waiting periods, thus not allowing them to make claims.

In terms of operating expenses, these now represent 9.9% of contribution income[34]. Compared to other insurance industries, health funds run with low operating expense ratios. The latest industry statistics for general insurance published by the Australian Prudential Regulatory Authority ("**APRA**") on underwriting expense ratios highlight that the general insurance industry had a 24% underwriting expense ratio for the quarter ended December 2004.[35]

Table 3 Industry key performance ratio trends

	Quarter end					Year end
	Dec 2004	Sep 2004	Jun 2004[a]	Mar 2004[a]	Dec 2003	Dec 2004
Underwriting expenses ($m)	1,189	1,312	1,317	1,178	1,217	4,996
Net premium revenue ($m)	4,939	5,532	5,598	4,738	4,939	20,808
U/W expense ratio	24%	24%	24%	25%	25%	24%

[32] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3

[33] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3

[34] Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2003-04*, see note 3 p 2.

[35] Issued 7 April 2005, APRA.

Given the low margins the industry is already operating at and the large volumes of services processed, efficiency gains within the operations of the funds will not derive significant long-term benefits; they will simply assist premium management in the short term. An inappropriate focus on operating expenses could also inhibit innovations that will lead to efficiencies and improvements in health outcomes in the long run. For example, encouraging electronic data exchange will obtain efficiencies and improve quality of care.

5) Restrictions on managing claims costs

In terms of managing hospital costs, health funds have very little influence over the number of hospital services that are used. It is essentially up to the treating doctors to decide when a patient requires care and what treatment should be given.

We welcome the ability to negotiate with our agreement hospitals as this enables us to negotiate a price for the particular hospital treatment. As funds and information systems become more sophisticated, tiered arrangements based on quality and performance (both clinical and financial) will become more widespread. However, the existence of the requirement to pay second tier benefits and the lack of information significantly impact on our ability to negotiate.

We also have limited ability to manage the increases in doctors' fees and the cost of new technologies that are often untried and untested is difficult to manage.

6) Complexity and product innovation

One of the criticisms of PHI is that when someone becomes ill, they may not understand what it is they are covered for. Equally, the product is criticised because it is hard to understand. We agree that there is indeed a case for simplifying the requirements around what health funds may and may not offer. Much of the difficulty comes from the need to clearly explain what it is that PHI may cover under the legislation as well as what is covered in an individual product. Restrictions on product development also require funds to differentiate products on the grounds of front end deductibles and exclusions, to ensure that they remain relevant and affordable for consumers. It would be prohibitively expensive and uncompetitive for funds to offer only products with "no gaps".

One of the main issues is unexpected gap payments when members have a hospitalisation. We consider that government initiatives around informed financial consent are of paramount importance and also support greater uptake of medical gap arrangements to increase members' certainty of their medical bills at the time of treatment. Simplified billing initiatives, including electronic solutions will also greatly aid this.

CHAPTER TWO - TOPIC - ENHANCING PRIVATE HEALTH SECTOR THROUGH POSITIVE RELATIONSHIPS WITH PRIVATE HEALTH FUNDS, PROVIDERS AND GOVERNMENT

A. OPTIONS FOR MORE EFFICIENT AND COST-EFFECTIVE WAYS OF PROVIDING CARE

1) Need for a continuum of care in health funding

One of the key issues in Australian health care funding is the division of different responsibilities into different areas, both in the Federal Government and between the Federal and State governments. This causes difficulties because different parts of the system can be responsible throughout the health care needs of members of the public. We recommend a review of the ways in which a person moves through the system allowing for **appropriate multidisciplinary care, care continuity and discharge planning**. GPs should have the role of being the central manager of managing a patient's healthcare between episodes of care. Government funding should be directed to creating appropriate incentives for GPs and appropriate information sharing should facilitate this.

What does this address?

i) If GPs are provided with appropriate incentives to manage a patient's healthcare, this will enhance preventive care, care continuity and also ensure care is undertaken in the most cost effective setting, leading to decreased costs.

ii) This should achieve improved outcomes for members of the public and ensure that acute inpatient services are available for those who truly need them.

2) Disease management and appropriate incentives

It is essential that funds be able to manage conditions in the appropriate setting and by the appropriate discipline. This would include both **substituted care following an episode but also preventive care and disease management techniques**.

The current **reinsurance** arrangements and the NHA need to be reviewed as a matter of urgency to remove obstacles to this. We note that there have been efforts to alter the current reinsurance arrangements and there is currently a proposal being considered. We consider that the key feature of any new reinsurance system is that it properly encourages appropriate benefit management. However, at the same time funds should not be "penalised" simply for having an older age profile.

We submit that properly developed criteria should be developed to determine when such substituted care and disease management programs would be eligible to participate in the reinsurance pool. These criteria should include a requirement that the substituted care must lower the cost of the episode of care or improve health outcomes for the same cost. Funds should not benefit from the reinsurance pool where there is no demonstrable evidence that their outpatient and disease management programs provide improved or more cost-effective care.

A substitute in-hospital care program initiated by MBF and Toowong Private Hospital in Brisbane was intended to assist members diagnosed with moderate mental health problems. Members participating in the program were recruited through the hospital and psychiatrists. In place of hospitalisation, these members took part in a program of assertive community treatment. Preliminary information showed that the program's objectives – offering members treatment options and reducing claims costs with the same or improved health outcomes – were being met.

What does this address?

i) Increased health outcomes (including improved patient satisfaction) and decreased costs.

3) Appropriate care settings

As discussed in the recent meeting between the Minister, the AHIA, the APHA and the AMA, considerable improvements can be made in the areas of psychiatric care, appropriate use of office based surgery, out of hospital nursing and admission and discharge arrangements. One way of achieving this is to include **provision for step down, rehabilitation, transitional and alternative care arrangements**. This may require some amendments to the NHA.

What does this address?

i) Increased health outcomes (including improved patient satisfaction – as per the Toowong Assertive Community Treatment Mental Health Pilot).

ii) Reduced costs to the overall health system, including PHI, as costs should be lower in less intensive care settings.

B. *HOSPITAL EPISODE STRATEGIES*

1) Need for enhanced competition with hospitals

Fund members have benefited from HPPAs through:

- certainty of fee coverage for services at hospitals with an HPPA ("known" gap);
- higher benefits for services at hospitals with an HPPA, including "no-gap" policies for hospital accommodation; and
- lower premiums than would otherwise have been the case, due to the ability of health funds to manage the cost of hospital services through negotiating the HPAAs and efficiencies introduced into the private hospital system as a consequence.

The benefit of entering into an HPPA for a hospital is that it reduces its debt problems. It need only collect excess, co-payment and incidental extras from the contributor. There is also a benefit where a fee has been negotiated but the hospital can, over time, provide that service more cost effectively.

The major benefits of entering into HPPAs for funds are the ability to manage the cost of benefits paid and the ability to provide contributors with hospital services that do not require any payment from them other than excess, co-payment and incidental extras,

such as newspapers. Does it also provide more certainly around annual pricing of products?

The requirement for health funds to pay second tier to non-agreement hospitals that meet certain quality criteria greatly inhibits the competition and appropriate negotiation with hospitals. Second tier is often used as a negotiating fall back by hospitals. This makes it difficult for health funds to negotiate pay for performance criteria. Our recommendation would be to **remove second tier default benefits**.

Allied to this is that there is little **mandatory reporting of information** by hospitals; if hospitals were required to publish financial and clinical data, health funds would have an improved basis on which to negotiate contracts and to provide essential information to consumers about the hospitals in which they are being admitted.

Funds are currently required to provide a significant amount of financial and benefit information to PHIAC, a significant amount of which is made public. Recent legislative changes now require funds to provide further information on performance indicators to the DHA and the Private Health Insurance Ombudsman ("**PHIO**"). The PHIO is under a statutory obligation to publish an annual state of the health funds' report, which contains a wide range of information from financial performance to product information. There are no similar obligations on hospitals.

What does this address?

i) Decreased cost of episodes - ability for funds and hospitals to negotiate more appropriate care settings and for funds to pay for quality health care.
ii) Increased health outcomes as hospitals are rewarded for financial and clinical performance.
iii) Consumers empowered to make decisions about appropriate care settings.

2) Prostheses

We support the recent initiatives to ensure appropriate regulation of surgically implanted prostheses. However, given that surgically implanted prostheses are a significant driver of increasing claims costs, we consider that more structured reform is required. We have concerns that the new legislation will not achieve its intended purpose, in particular address the spiralling cost of prostheses.

We consider that further **reform in a similar way to PBS** would be desirable. This would include a more rigorous clinical and economic application process to be placed on the prostheses list, as well as indications and restrictions on use. Health funds, hospitals and suppliers could **work with the Colleges to ensure that clinical guidelines and protocols are developed** for prostheses.

What does this address?

i) Ensuring that only appropriate prostheses are listed and appropriate **indications/restrictions for use will reduce cost without reduction in health outcomes**. In fact, with an appropriate evidence base, in many cases health outcomes will be enhanced.

ii) Facilitates relationship with doctors, hospitals and health funds. Establishing mutually agreeable clinical guidelines likely to encourage constructive working relationships, although a longer-term solution.

C. ***MEDICAL GAP***

Doctors play an important role in the health system in terms of clinical care, cost and utilisation. As mentioned above, funds currently have very little ability to manage doctors' costs. Doctors may charge a member what they choose and funds may only pay 25% of the CMBS. Funds may only provide greater benefits to members where the doctor chooses to use a gap arrangement (see section B. 5) in Chapter One above).

The objectives of gap reform were to improve the value proposition for consumers and also allow doctors to receive greater than 100% of CMBS for medical services from health funds. Unfortunately, because some doctors have not been willing to contract with health funds and will only opt in to gap cover schemes on a limited and inconsistent basis, this has to a large extent not met the objectives of reform. This has also led to another significant drawback, which is that funds have found it difficult to provide members with information on "gap" doctors.

Doctors' gaps therefore remain a significant issue for health insurance and create disappointment for consumers as they are often unexpected.

The options that we consider would commence the dialogue necessary with doctors to address these issues are:

1) Published lists of no gap doctors

A requirement should be placed on health funds to **publish lists of their no and/or known gap doctors**, together with an analysis of the **percentage of times** that the doctor has opted into the gap arrangements for that fund's members.

What does this address?

i) This will educate members about which doctors are using gap cover and provide consumers with information to enable them to choose a doctor who is more likely to use the arrangements.

2) Informed Financial Consent ("IFC") by treating doctor

The onus should also squarely be placed on the **treating doctor to obtain IFC** to all the doctors involved in the patient's care, otherwise no doctor should not be able to charge above CMBS for the treatment.

What does this address?

i) The issue of certainty of doctors' gaps would be addressed by this.
ii) Enhanced consumer experience through informed financial consent.

D. *E-HEALTH STRATEGIES*

1) Information Sharing

All aspects of the health system require greater information sharing to improve the delivery of health services.

There are significant benefits for health funds in receiving a deidentified dataset of MBS and PBS data.

Health funds are able to protect the privacy of this information as they already have in place secure systems to manage sensitive health information.

2) E-Health initiatives

We fully support the Government's Electronic Health Record initiatives ("**EHR**") and consider that all aspects of the health sector should be included in this, including the private sector.

Health funds are able to ensure that the private sector is represented in development of standards. As outlined above, private hospitals now perform over 50% of all surgery and private health insurance is a significant funder for this surgery. The collaboration of the public/private sector is essential for an optimal outcome. MBF wishes to work with the industry in developing open standards that include both the public and private sectors.

The flexibility of our systems makes it possible for us to integrate with EHR initiatives. MBF wishes to consider the ways in which it can get involved in these projects and what type of data sharing on a deidentifiable basis may be involved. The nature and extent of our involvement will depend upon business cases that are developed.

What does this address?

i) Greater information sharing (with appropriate privacy restrictions) will lead to less duplication of services, care in the appropriate setting and improved health outcomes.

3) Appropriate electronic billing systems to allow true simplified billing

As noted in the recent meeting between the AMA, AHIA, APHA and the Minister to discuss issues with the PHI product, all parties strongly support the **implementation of shared electronic systems for claiming and payment** for all private inpatient medical services without exception

What does this address?

i) Such electronic systems support high quality informed financial consent, which helps patients and improves the value of PHI.

ii) This should provide significant operational efficiencies to the industry by having just 'one bill' to the member / health fund with all expenses related to the episode of care rather than the current multiple bills system, which creates

inefficiencies in terms of identifying overall cost of the episode of care and its appropriate analysis.

CHAPTER THREE - TOPIC 3 - ENHANCING THE ATTRACTIVENESS OF THE PHI PRODUCT

A. CURRENT ISSUES

Private health insurance coverage levels are primarily determined by three factors:

i) premium levels;
ii) perceived value from the insurance product; and
iii) perceived quality of care in the public health system.

Taking these into account, we have set out three potential options below. Medical savings account and removal of fringe benefit tax are intended to address the issue of premium levels. Allowing funds greater flexibility to reward loyalty for low claiming we believe would be instrumental in addressing the perceived value of the product.

B. MEDICAL SAVINGS ACCOUNTS

As this submission has discussed, escalating health costs is a worldwide phenomenon. The response to increasing costs differs from jurisdiction to jurisdiction. One method of managing costs adopted in other jurisdictions has been the introduction of a health insurance product designed to cover health costs from a savings vehicle, often in conjunction with payouts from a risk product. These products are referred to as Medical Savings Accounts ("**MSAs**").

The common feature of these products across jurisdictions is that the consumer pays into a fund and then draws against the accumulated fund in order to pay for specified health services. We would emphasise that the details of the product and its place in the health system shows substantial variation across countries, differing according to the particular features of the health industry in the jurisdiction, such as the public/private mix and extent of corporate subsidies.

The advantages of such products are:

i) These accounts may mitigate against moral hazard – with payment directly from a person's account, greater responsibility may be taken in deciding what medical services to consume. We strongly acknowledge that a system should not be set up in such a way that discourages necessary or reasonable medical treatment as recommended by a medical practitioner.
ii) They may facilitate the operation of competitive forces in health markets, as consumers are more likely to seek a better price when the treatment is more directly at their expense.
iii) They may encourage the self insured into the insurance system and for more Australians to save for their future health expenses.

PHI funds are the natural providers of such products, having the ability to manage transactions surrounding such products eg payments to providers and also the ability to monitor overall health service utilisation. This is essential to ensure that the funds are only spent on appropriate health expenditure. Some funds, such as MBF, would

also have the ability to manage the savings component of the product. We would submit that in these circumstances, it is a natural extension of the definition of "health insurance business" in the NHA.

We consider that further investigation of these savings style products in the Australian context is warranted. This investigation should carefully consider how to manage any negative consequences, such as a severe adverse effect on the existing insurance pool. An adverse effect could occur if the healthier and less risky consumers were to move from traditional PHI products to a savings style product. This could significantly impact on the existing pool and also on the public system if these members had not saved enough to meet unexpected health expenses (which is what PHI guards against). A requirement to maintain a level of "catastrophe" health cover may mitigate against this.

A tax incentive (such as that for superannuation savings) would also be advisable as otherwise there would be little appeal compared to self insurance. Such a formula need cost no more than the current Federal Government Rebate and may given it follows existing practices, provide consumers understanding and comfort with this process.

Whilst there are undoubtedly hurdles to designing and introducing such a product, MBF is committed to investigating into the option of introducing a savings style health insurance product suitable to the Australian health system.

C. ***REMOVAL OF FBT ON EMPLOYER SUBSIDISED PREMIUMS***

The corporate sector holds the greatest potential for growth and is largely untapped in terms of the opportunity it represents. In an issues paper we submitted to the Federal Government, we advocated incentives for health plans when subsidised or fully funded by employers. Current tax arrangements are a disincentive to workplace health plans and we believe that exempting them from the Fringe Benefits Tax regime would have an almost immediate and positive impact.

We also suggested linking access to FBT incentives to the national drive to encourage Australians to be physically active to deal with the epidemic of obesity and exposure to weight-related diseases. MBF proposed that exemption from FBT for employer-funded or subsidised health plans should be conditional on these companies introducing workplace health and well being programs. Promoting preventative health care in the workplace will take on greater importance as, inevitably, Australians live and work longer. As the workforce ages, it will be in the interests of employers to help keep their people healthy and productive. The Secretary to the Treasury, Dr Ken Henry, referred to this dynamic shift in the Australian workplace, in a recent fascinating presentation. Dr Henry made it clear that maintaining the health of an ageing workforce is going to be vital if Australia expects to achieve projected growth in Gross Domestic Product in future decades[36].

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[36] Dr Ken Henry, Secretary to the Treasury "Policy Strategies for Future Growth", speech given to the Australian Industry Group's National Industry Forum at Parliament House, 9 August 2004, see http://www.treasury.gov.au/contentitem.asp?NavId=008&ContentID=873.

We note that there are already exemptions in the FBT regulations for in-house health care facilities[37]. It would appear that the rationale for this is to enhance workforce participation and productivity. We argue that removing FBT on health insurance premiums serves similar policy goals.

What does this address?

i) This would enhance the value proposition to employees to whom the real cost of health care would decrease.

ii) If the assumption that younger, fitter members are in the workforce holds true, this could increase our risk profile, overall decreasing claims costs relative to premiums.

D. *INCREASED PERCEIVED VALUE*

1) Retention a major industry issue

A key issue in PHI is the retention of younger and/or healthier members who have some difficulty with the PHI value proposition. While we think that there needs to be a shift in focus on PHI from getting "value for contributions" to a true "insurance for catastrophes model", it is likely to assist retention and attraction of a healthier profile if a form of **discounting for low claiming members** was allowed. We have advocated this only for ancillary cover.

As outlined there have been a number of initiatives introduced by the Federal Government that have had a very positive impact on the uptake of PHI, such as the Federal Government rebate, LHC and the additional 1% Medicare levy. These measures have been very successful in increasing the number of members taking out private health insurance, by making it more attractive, flexible and affordable. However, following these initiatives, the industry has not experienced ongoing significant growth, and retention is the industry's prime focus.

The most recent of those initiatives, increasing the Federal Government rebate for older Australians (who are likely to have held PHI for some time) achieves, aside from any other objective a very strong loyalty reward program based on tenure for older members of PHI. Therefore, the logic of loyalty is already built into PHI and does not require a separate scheme.

While the industry needs to work together in many areas to enhance the value proposition of private health insurance, alternative bonus measures are critical to further enhance the value to members. In particular, there is a need for focus on members with membership tenure of between 1 and 5 years or those who have long periods between claiming. For example, in the MBF customer satisfaction survey (using a sample size of 100 members who left MBF) members were asked why they left. Of the 44% who left for 'one big issue' (generally a price related reason), 33% mentioned 'insufficient value for money'. This response is in keeping with the TQA

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37 http://www.ato.gov.au/businesses/content.asp?doc=/content/25452.htm&pc=001/003/006/001/006&mnu=853&mfp=001/003&st=&cy=1

research where value for money was also borne out as a major retention issue within PHI.

Another significant finding from the customer satisfaction survey was the relatively poor rating applied to recognition and rewarding loyal customers. In the TQA research, only 11% (average across all funds) of respondents felt that their health fund offered benefits for long-term loyalty.

MBF is strongly of the view that funds should have greater freedom to influence retention of our members with membership of between 1 and 5 years or those who experience long periods between claiming and do not see the value of their PHI. These members also tend to be the young and/or healthier members who support the actuarial pool.

2) Proposal

We propose that legislation be introduced that provides a parameter for which a discount could be given based on claims behaviour within an ancillary table. We have based our proposal largely on the CTP insurance model, where apart from a given limited parameter on pricing, the spirit of community rating is unaffected.

By way of example, legislation could be effected providing for a maximum of a percentage discount (say 5%) where a 'Loyalty Bonus' is awarded via a discount in premiums if a member claims less than a certain dollar value per annum or where claims have been reduced by say 10% compared to the previous year. This also follows the same spirit as the current discounting rules.

Funds would need to be given the discretion and flexibility in determining the actual discount for this type of reward, however we would be happy for the parameters to be legislated.

We believe that an innovative policy developed along theses lines would have a very positive effect on retention, giving both the Federal Government and funds an enhanced value proposition that is appealing and meaningful to members.

What does this address?

i) This would enhance the value proposition to members who do not usually claim, enhancing sustainability by retaining lower or no claiming members, essential for a viable actuarial risk pool.
ii) It may also encourage more careful use of health insurance benefits, and such behavioural change may appropriately influence use of hospital products.