We are hirmaa

30 June, 2015

Committee Secretary
Senate Standing Committees on Economics
PO Box 6100
Parliament House
Canberra ACT 260

Dear Committee secretary

Re: Senate inquiry into cooperative, mutual and member-owned firms in the Australian economy

Thank you for the opportunity to comment on the matters as referred to the Committee by the Senate on 2 March, 2015.

hirmaa represents 18 community-based private health insurers, comprising both industry or employer focused "restricted access" insurers and "open" insurers serving particular regions. Collectively, hirmaa funds provide health insurance to over one million Australians across the country. hirmaa funds are predominantly not-for-profit and identify as mutual and/or member-owned insurers. One of hirmaa's constituent members is a for-profit insurer wholly owned by a mutual, not-for-profit organisation.

A full list of hirmaa members is included as Annexure A.

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

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

A number of characteristics distinguish the hirmaa member funds. They:

- are value-based as opposed to being profit-based;
- continue to offer various levels of insurance at highly competitive premiums;

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- optimise benefit entitlements and premiums;
- continue to tangibly grow their membership numbers, in recent years above the industry average;
- in terms of the restricted insurers, have their unique nature acknowledged in the Private Health Insurance Act 2007.

hirmaa funds which are member-owned and mutual organisations, play a crucial role in upholding the competitiveness of the private health insurance market place.

While there are 18 hirmaa funds, there are in total, 27 mutual and member-owned insurers in a market place of 34 competitors.*^

Mutual and member-owned insurers constitute around 35% of the market, providing health insurance to almost 4.6 million Australians across the nation. They paid over $6.2bn in benefits in 2013-14. By consequence of their collective scale, mutual and member-owned insurers play an important role in the industry and an important role in the Australian economy.

hirmaa is supportive of the *Members Own Health Funds* initiative and its objective of communicating the benefits of the member-owned and mutual model.There is strong evidence to suggest that not-for-profit insurers provide better outcomes for consumers than for-profit insurers and this submission will provide a detailed comparative analysis to demonstrate this (*the data used to conduct this analysis is referenced in Annexure B).* This submission will also convey, in detail, the extent to which mutual and member-owned health insurers contribute to the market.

Yours sincerely

MATTHEW KOCE
Chief Executive Officer

**Included in this definition are three for-profit insurers which are wholly owned by Australian domiciled mutual organisations and thus treated as mutual insurers in this analysis.*
^ The analysis uses data prior to the demutualisation of Transport Health (effective 1 July, 2014). Transport Health is therefore also included in this analysis as a mutual insurer.

a. The role, importance, and overall performance of cooperative, mutual and member-owned firms in the Australian economy.

Australia's Health system and the role of private healthcare

Expenditure on Australia's health system was estimated at $147.4b in 2012-13.[1] The Commonwealth Government spends 16% of total expenditure on health while the State Governments spend on average 26% of their expenditure on health.[2]

The private health system plays an important role in reducing the burden on Government finances:

- In 2012-13, 41% of all procedures occurred in private hospitals, including 2 out of every 3 procedures involving elective surgery.[3]

- In 2012-13, private hospitals accounted for 45% of Australia's hospitals and 34% of all hospital beds.[4]

- Australian Governments pay for 34.5% of the cost of treatment on the private system[5], but 90.9% of the cost of treatment in the public system.[6]

- In the 2014 calendar year, private health insurers paid $17.2b in benefits for hospital and general treatments.[7] This is $17.2b that would otherwise be picked up by the public health system.

Policy settings make Private health insurance accessible to all Australians and accordingly, it is an important product for almost 50% of the population:

- PHI in Australia has been 'community-rated' since 1953, meaning consumers pay the same premium for a product, regardless of their age, gender or health condition.

- Underpinning community rating, insurers participate in 'risk equalisation' so that insurers are compensated for having members with higher health risks. This ensures higher-risk policy-holders can access affordable health insurance.

- As at March 2015, 47.3% of the Australian population had hospital treatment insurance and 55.6% of the population had general treatment insurance, this amounts to over 13.1 million Australians nation-wide.[8]

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[1] Australian Institute of Health and Welfare, *Health Expenditure Australia,* 2012-13*.,* p.6.
[2] National Commission of Audit, *Phase One report*, February 2014., p. 17.
[3] Australian Institute of Health and Welfare, *Australian Hospital Statistics – Private Hospitals,* 2012-13*.,* p.14
[4] Ibid.
[5] Ibid*.,* p.23
[6] Australian Institute of Health and Welfare, *Health Expenditure Australia,* 2012-13*.,* p. 85
[7] Derived from Private Health Insurance Administration Council, *PHIAC quarterly statistics*, 2014.
[8] Private Health Insurance Administration Council, *PHI Quarterly Statistics,* March 2015*.,* p.3

The role and importance of mutual and member-owned insurers in the private health system

High standards in customer service, innovation and value for money are primarily driven by competition and choice in the marketplace. With 34 registered health insurance funds to choose from, there are a variety of offerings available for consumers. Across the market, there are for-profit insurers, not-for-profit insurers, regional or community based insurers, national and even international insurers, very small insurers with around 3,000 members and very large insurers with over 1.8 million members.

Mutual and member-owned firms make up 27 of the 34 health funds across Australia. hirmaa represents 17 of these insurers and one for-profit insurer which is wholly owned by a mutual, not-for-profit organisation. Regarless of size and scale, all hirmaa private health insurers are run efficiently, prudentially and are highly competitive.

Mutual and member-owned insurers have a long and well established history in Australia. Privately funded healthcare orginated with the establishment of mutual societies in the 1800s which continued into the early part of the 20th century.[9] Hospital based health funds started to emerge in the 1930s, with the Metropolitan Hosptial Contributions Fund of New South Wales the first to establish private hospital based insurance. Many other mutual societies followed suit and for the majority of the 20th century, the industry remained exclusively of a not-for-profit, mutual nature.

The PHI industry was opened to for-profit companies after the introduction of Medicare in 1984 but continued as a primarily non-profit industry. This has changed to a certain extent in recent years, with a number of acquisitions and conversions in registration to for-profit status. Nevertheless, 24 health insurers remain non-profit and mutual or member-owned by structure, with three for-profit insurers wholly owned by Australian domiciled mutual organisations. Underlying this is an awareness by these organisations, that the mutual and member-owned model is sustainable, and that these mutual and member-owned insurers make an important contribution to the communities they serve.

Typically, member-owned and mutual insurers are linked to particular industries or particular geographical regions. As such, they have longstanding and inherently close relationships with their communities:

Restricted access insurers:

Health insurer	Industry / organisation	hirmaa member
ACA Health Benefits Fund ltd.	The Seventh-day Adventist Church	Yes
CBHS Health Fund ltd.	Commonwealth Bank Group	No
Defence Health ltd.	The Australian Defence forces	Yes
The Doctors' Health Fund Pty ltd.	Medical Practitioners	Yes
Navy Health ltd.	The Australian Defence forces	Yes
Police Health ltd.	State, Territory or Federal police associations	Yes

[9] Gale, A. P., and Watson, D. 2007, 'Adventures in Health Risk: A History of Australian Health Insurance', presented to the Institute of Actuaries of Australia, September, Christchurch, New Zealand, P 3.

Queensland Teachers' Union Health Fund ltd.	All unions	Yes
Railway & Transport Health Fund ltd.	Railway, transport and energy industries	Yes
Reserve Bank Health Society ltd.	Reserve Bank of Australia or Note Printing Australia	Yes
Teachers Federation Health ltd.	Teachers Federation and education unions	Yes

Regionally focused member-owned / mutual insurers

Health insurer	Primary Region	hirmaa member
Health Care Insurance ltd.	Northern Tasmania	Yes
Health Partners ltd.	Adelaide / South Australia	Yes
Lysaght Peoplecare ltd.	Wollongong / Illawarra	Yes
Mildura District Hospital Fund ltd.	Mildura / Sunraysia	Yes
Phoenix Health Fund ltd.	Newcastle	Yes
St Lukes Medical & Hospital Benefits Association ltd.	Tasmania	Yes
Westfund ltd.	Lithgow / Blue mountains	Yes
Latrobe Health Services ltd.	Latrobe valley	Yes
Cessnock District Health Benefits Fund ltd.	Cessnock	No
GMHBA ltd.	Geelong	No
HBF Health ltd.	Western Australia	No
The Hospitals Contribution Fund of Australia ltd.	Sydney	No
Health Insurance Fund of Australia ltd.	Western Australia	No

The performance of member-owned and mutual insurers.[10]

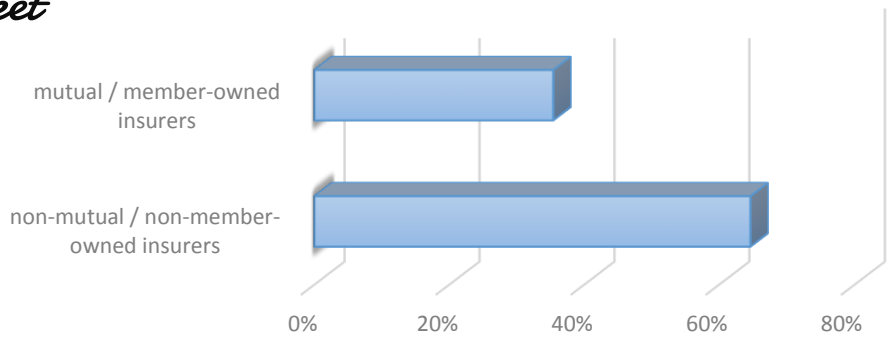
The mutual / member-owned business model is efficient and effective, as evidenced by a range of performance measures detailed below. Mutual / member-owned insurers contribute strongly to the competitive landscape by ensuring consumers have choice and access to a range of competitive products.

Scale: Across an industry of 34 competitors, there are 27 mutual and member-owned insurers*^. These 27 insurers comprise around 35% of the market and last financial year, contributed over $6bn to the Australian economy in the form of benefits paid for hospital and ancilliary treatments.

**Three for-profit insurers are wholly owned by Australian domiciled mutual organisations and are treated as mutual insurers in this analysis.*
^ The analysis uses data prior to the demutualisation of Transport Health (effective 1 July, 2014). Transport Health is therefore also included in this analysis as a mutual insurer.

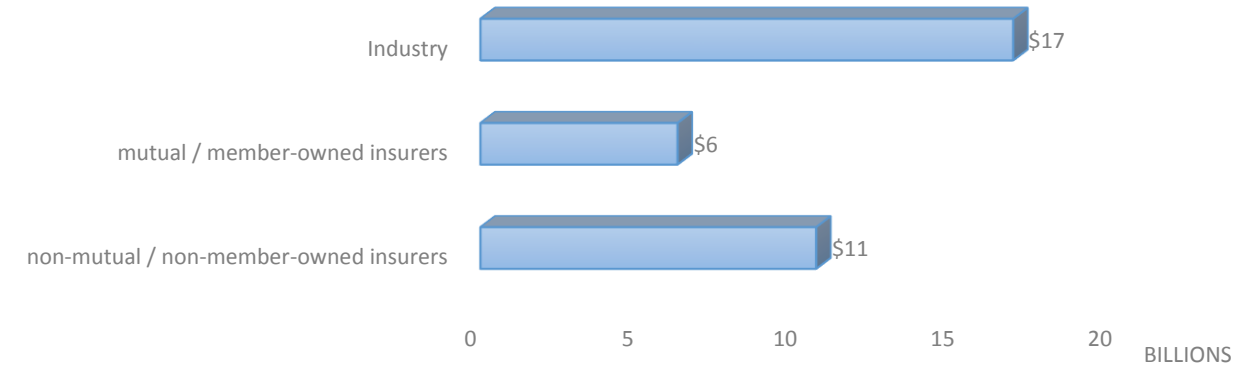
[10] The data used to conduct the following analysis is included in Annexure B.

"These 27 insurers comprise around 35% of the market"



	non-mutual / non-member-owned insurers	mutual / member-owned insurers
Collective market share (as at 30 June 2014)	64.61%	35.39%

"they contributed over $6bn to the Australian economy"



	non-mutual / non-member-owned insurers	mutual / member-owned insurers	Industry
Benefits paid 2013-14	$10,637,291,404	$6,245,437,483	$16,882,728,887

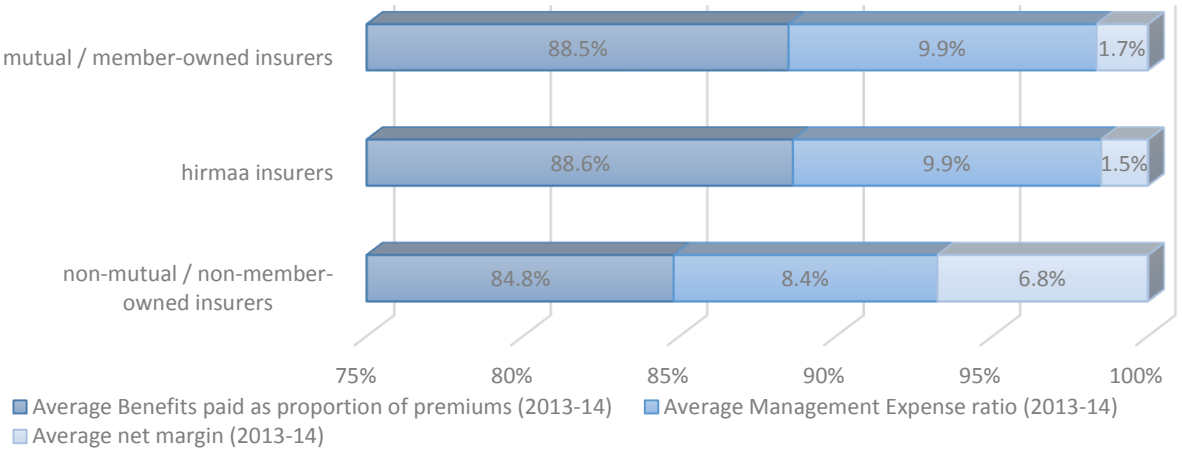
Performance: The mutual / member-owned model is highly effective and in the context of private health insurance, this is reflected across a number of performance measures. In the case of mutual / member-owned health funds, member-contributions are used solely to benefit the healthcare of members with surpluses reinvested into the health fund and again, into the healthcare of members.

This is in distinct contrast to the for-profit model, where the goal is to generate a dividend for the financial benefit of external shareholders.

Mutual / member owned insurers are free from the obligation to return surpluses to shareholders and therefore run lower net-margins and reinvest a higher portion of premiums to members as benefits. In the 2013-14 financial year, mutual and member-owned health funds paid back to members 88.5% of premiums received and on average ran net surpluses of 1.7%.

For-profit health funds paid back less than 85% of premiums, choosing to bank a much larger net-profit margin for external shareholders – 6.8%.

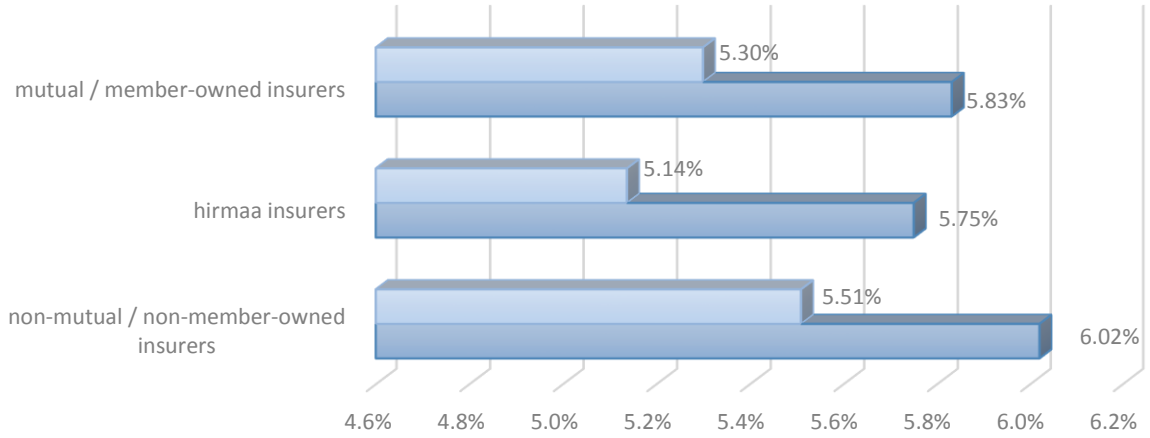
"member contributions are used solely to benefit the healthcare of members"



The mutual / member-owned model also benefits the consumer through lower premium inflation. Industry data suggests that for-profit insurers have a greater inclination to increase premiums as a means of driving financial returns to shareholders. Free from the imperative of delivering a return on invesmtment to shareholders, mutual / member-owned insurers prioritise member satisfaction and member-value ahead of profits and are more likely to beat the market on average premium rises.

Mutual and member-owned insurers had lower average premium rises in 2015. This is also the case across the last five years of premium rises. The sub-set of hirmaa funds, generally comprising the smaller funds, have performed even better - the scale benefits of operating a large for-profit health fund are experienced by the shareholder ahead of the member.

"the scale benefits of operating a large for-profit health fund are experienced by the shareholder ahead of the member"

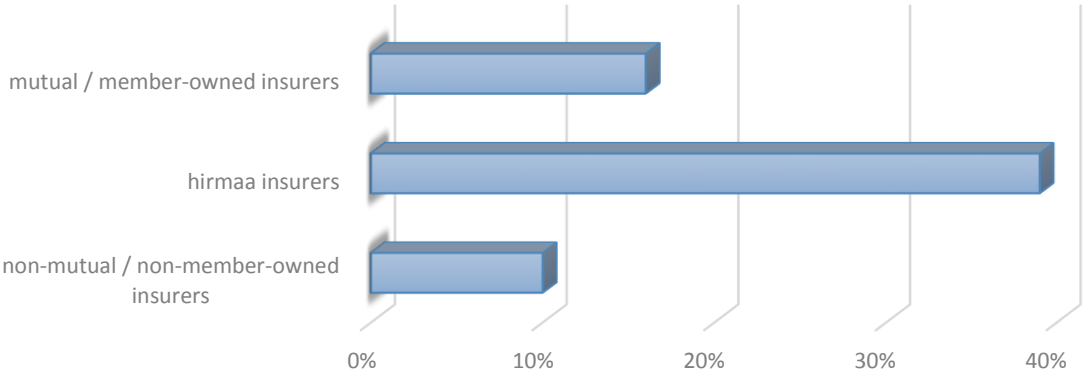


	non-mutual / non-member-owned insurers	hirmaa insurers	mutual / member-owned insurers
Average premium rise – 5 year	5.51%	5.14%	5.30%
Average 2015 premium rise*	6.02%	5.75%	5.83%

Average premium rise – 5 year Average 2015 premium rise*

The trend towards lower-cover policies with greater restrictions and exclusions is driven by the large for-profits in the industry. hirmaa funds in particular offer more policies with high levels of cover, giving members greater certainty of coverage and better value.

"hirmaa funds in particular offer more policies with high levels of cover"

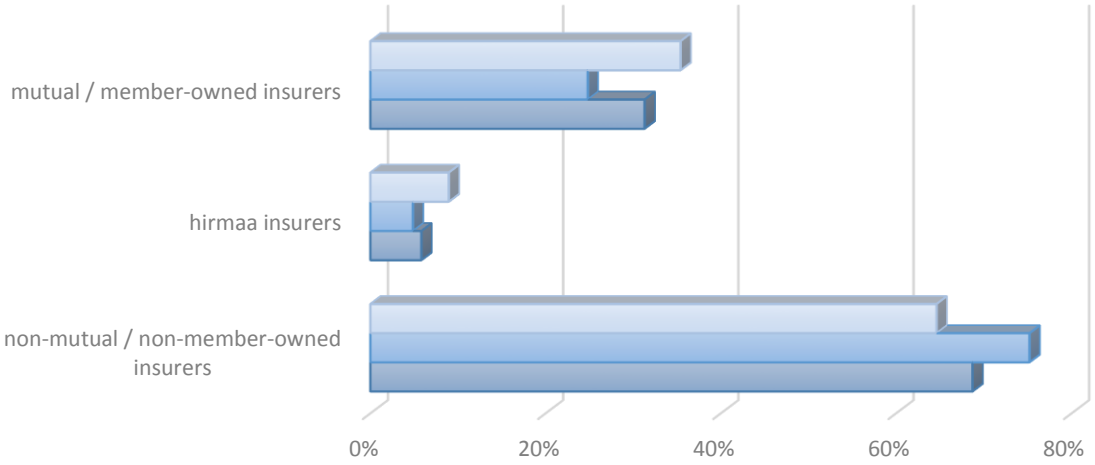


	non-mutual / non-member-owned insurers	hirmaa insurers	mutual / member-owned insurers
% of policies that are fully comprehensive (as at 31 December, 2014)	10%	39%	16%

Results: With more benefits paid back to members, lower premium rises and more comprehensive policies, members of mutual and member-owned health funds are the benficiaries.

The members of mutual and member-owned health funds are less given to complain to the Private Health Insurance Ombudsman. In 2013-14, mutual and member-owned health funds received significantly less complaints relative to their market share.

"mutual and member-owned health funds received significantly less complaints relative to their market share."



	non-mutual / non-member-owned insurers	hirmaa insurers	mutual / member-owned insurers
Market share	64.61%	8.94%	35.39%
% of industry Level 3 Complaints 2013-14	75.20%	4.84%	24.80%
% of total industry complaints 2013-14	68.71%	5.81%	31.29%

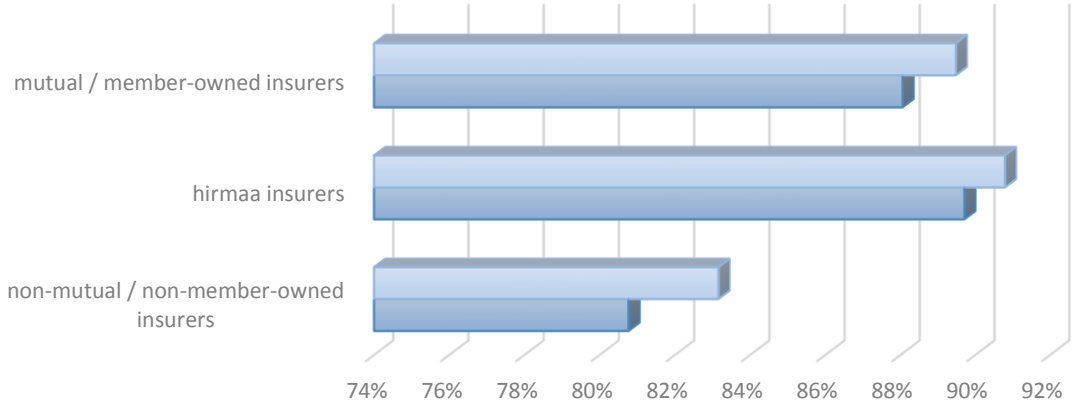
hirmaa funds in particular, consistently experience very high levels of customer satisfaction. Independent research conducted by Discovery Research demonstrates an average of 98% satisfaction among the members of participating hirmaa funds.[11]

These very high levels of customer satisfaction are reflected in very strong customer retention rates. The Private Health Insruance Ombudsman's measure of member-retention demonstrates this – indicating the percentage of fund members that have remained with the fund for two years or more.

In 2013-14 this figure was close to 89% retention for the mutual / member-owned insurers, falling to less than 81% across for-profits insurers.

[11] Available on request: Discovery Research, *hirmaa member satisfaction research*, 2015

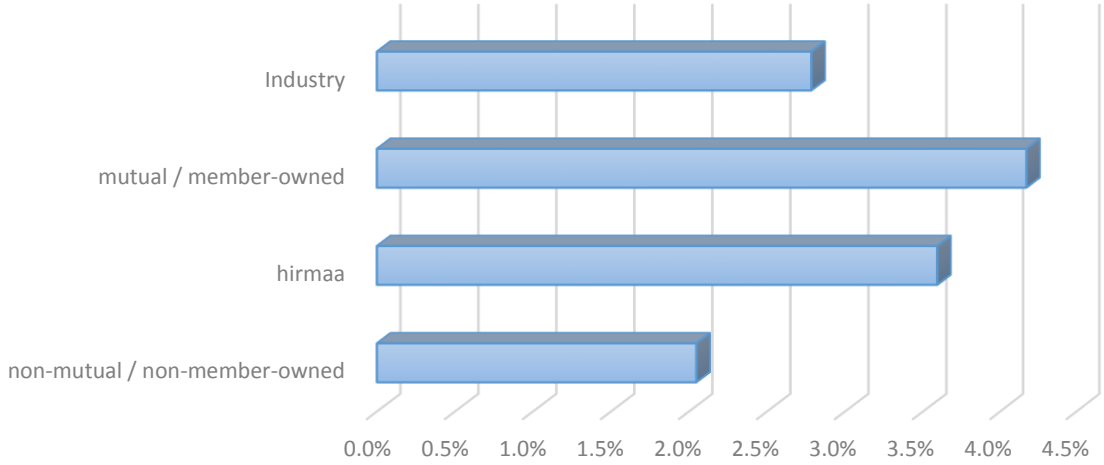
"this figure was close to 89% retention for the mutual / member-owned insurers, falling to less than 81% for the others"



	non-mutual / non-member-owned insurers	hirmaa insurers	mutual / member-owned insurers
Member retention 5-year average	83.16%	90.79%	89.48%
Member retention 2013-14	80.77%	89.71%	88.05%

With the big for-profits struggling to retain members, mutual and member-owned funds benefit. Australians are increasingly realising the value of the member-owned / mutual model and these funds continue to grow faster than the others.

"Australians are increasingly realising the value of the member-owned / mutual model"



	non-mutual / non-member-owned	hirmaa	mutual / member-owned	Industry
5-year compound annual growth rate	2.05%	3.59%	4.17%	2.78%

a. The operations of cooperatives and mutuals in the Australian economy, with particular reference to:

i. Economic contribution.

In addition to the $6 billion in benefits (and growing) they pay each year, mutual / member-owned health insurers make large economic and social contributions to their communities through employment and investments in healthcare facilities and health related businesses.

The mutual / member-owned model facilitates investment as surpluses created in the fund are directed only for the benefit of members. In regional communities, the economic impact of investment from mutual / member-owned health insurers is particularly significant, boosting commerce in regional areas and creating meaningful employment opportunities for residents.

The important contributuion of mutual / member-owned insurers is emphasised by the fact that regional Australia is under-serviced for healthcare by comparison to metropolitain Australia. This is a major issue for the living standards of people living in these regions and mutual / member-owned insurers with a strong regional presence make an enormous contribution to improving health outcomes.

The same is also true of industry-based restricted-access insurers, which are able to make targeted investments into healthcare and related businesses for the benefit of members who form part of a particular industry or group.

Taking the example of hirmaa member Westfund health below, it is evident that mutual and member-owned insurers can have a highly positive economic impact on local economies. The economic contribution of mutual and member-owned insurers extends far beyond the $6 billion in benefits paid annually.

Westfund Health.

Head office:

- Lithgow, NSW

Branches:

- Lithgow, NSW
- Lithgow, NSW
- Bathurst, NSW
- Dubbo, NSW
- Mudgee, NSW
- Orange, NSW

- Wollongong, NSW
- Maroochydore, QLD
- Mackay, QLD
- Mackay, QLD
- Moranbah, QLD
- Rochkampton, QLD
- Townsville, QLD
- Emerald, QLD

Westfund Eye care:

- Lithgow, NSW
- Dubbo, NSW
- Mackay, QLD
- Orange, NSW
- Rockhampton, QLD

Westfund Dental care:

- Lithgow, NSW
- Mackay, NSW

ii. Current barriers to innovation, growth, and free competition.

The major barriers to innovation, growth and free competition in the private health insurance industry, are regulation and sovereign risk. Almost every aspect of an insurer's business is regulated and with numerous Government policies to incentivise the uptake of PHI, the industry is highly sensitive to changes in government policy.

hirmaa is fully supportive of appropriate regulation in the PHI industry to protect the interests of consumers. However, we believe there are a number of areas where regulation or Government policy is sub-optimal, resulting in uncertainty and diminished business confidence for insurers that want to innovate and grow. These areas of regulation will be detailed in section b. iii. below.

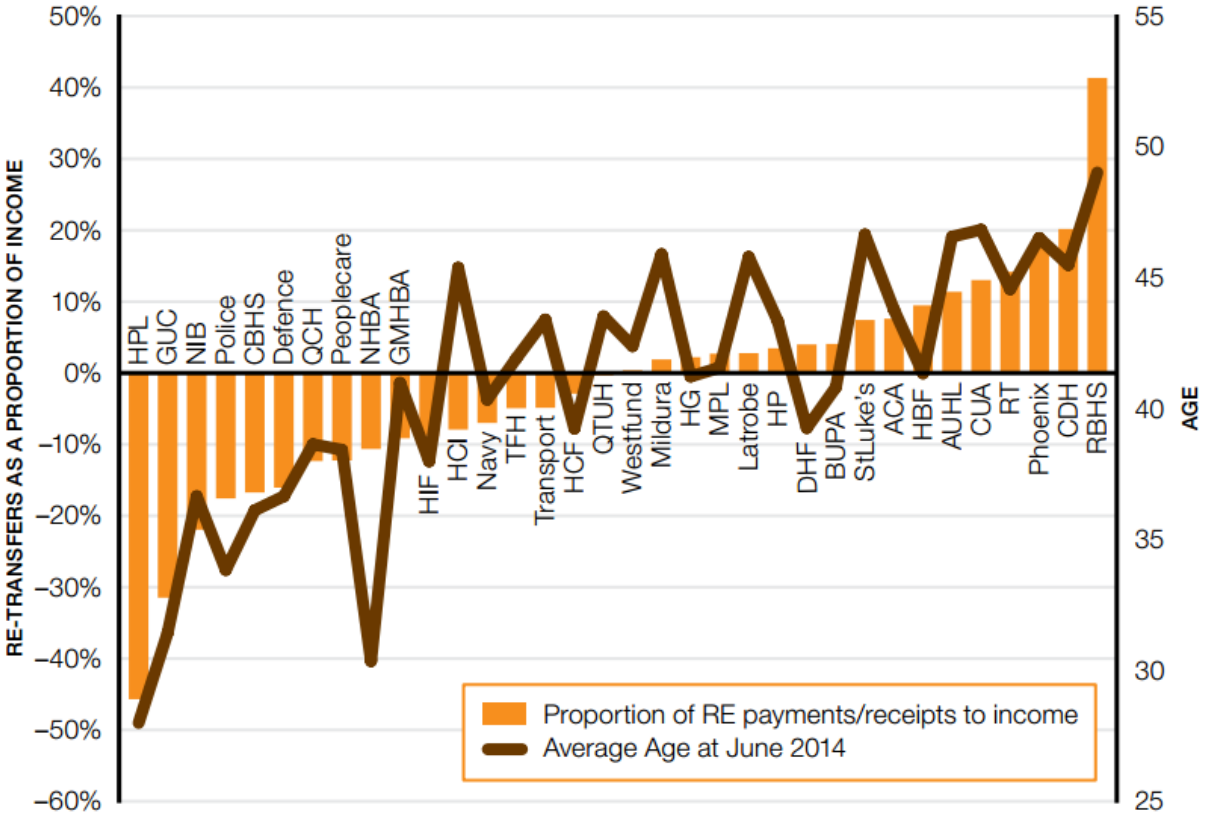
We are aware of the views of some self-interested parties that risk equalisation arrangements in PHI are a barrier to growth and innovation, with said parties often claiming that smaller mutual / member-owned insurers depend on the arrangements for their survivial.

hirmaa disagrees with this view, noting that of the 18 hirmaa members, eight are net-contiributors to the risk equalisation scheme. It is also worth noting that the two largest

recipients from the risk equalisation shceme are the two largest for-profit health insurers in the industry, Medibank Private and Bupa.[12]

As demonstrated by the analysis in earlier sections of this submission, mutual and member-owned insurers are not propped up by risk equalisation arrangements, rather, they out-perform their for-profit counterparts on most commercial measures and are a key driver of competition.

Figure 5: Transfers to and from the RETF as a percentage of hospital premium revenue and average age profile of insurer—2013–14



[13]

Some form of risk equalisation is essential to support community rating, which is fundamental to ensuring afforable health cover for all Australians. Both issues must be considered together and amending or diminishing risk-equalisation arrangements would have a material impact on community rating and the accessibility of private health cover. As an organisation that supports community rating, hirmaa is a strong supporter of risk equalisation in the private health system.

[12] Private Health Insurance Administration Council, *Risk Equalisation Financial Year Results by Insurer and State*, 2013-14
[13] Private Health Insurance Administration Council, *Operations of Private Health Insurers Annual Report,* 2013-14., p. 18

We disagree with views held by other parties that risk equalisation diminishes the incentives to innovate and invest in disease prevention and management. In particular, we are aware of views that investment in Broader Health Cover (BHC) initiatives (such as Chronic Disease Management Programs) is lessened as a consequence. 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 BHC services rising from under 10,000[14] with just over $2 million in benefits paid[15], to more than 450,000 services in 2014[16], with over $47 million in benefits paid.[17] Reducing hospital admissions is in the interests of both the insurer and the patient - risk equalisation arrangements do not negate this.

iii. The impact of current regulations.

As noted earlier in this submission, the regulatory environment in PHI is the major barrier to innovation, growth and competition. There are a number of areas where regulations and/or policy settings could be changed in order to improve the dynamics of compeitition and to improve the operating environment for mutual / member-owned insurers.

Policy settings: Freeze the Australian Government rebate on PHI

hirmaa is of the view that the rebate on private health insurance provides a significant return on investment for the Government, given its role in incentivising the uptake of private health insurance and the cost-shifting from the public sector that follows. However, we acknowledge that the PHI rebate is a large and growing area of Government spending.

The approach of the previous Government was to reduce support for the rebate with a string of cost-saving measures that reduced the incentive to take out and maintain private health cover:

- The legislative package of 2011/12 (Fairer Private Health Insurance Incentives 2012 and allied legislation) introduced three new PHI incentive tiers reducing the amount of rebate for an eligible person with a complying policy.

- The Private Health Insurance Legislation Amendment (Base Premium) Bill 2013 resulted in the rebate being indexed annually by the lesser of CPI or the actual increase in commercial premiums. (The '30%' rebate reduced to 29.04% in 2014, then to 27.82% in 2015 and will continue to fall annually).

- The Private Health Insurance Amendment (Lifetime Health Cover Loading and Other Measures) Bill 2012 amended the PHI Act so that the Australian Government rebate on PHI is no longer payable on the component of PHI premiums that have been increased because of the LHC loading.

[14] Private Health Insurance Administration Council, *Operations of Private Health Insurers Annual Report,* data, 2006-07

[15] Private Health Insurance Administration Council, PHIAC A reports, all quarters, 2007

[16] Private Health Insurance Administration Council, *Operations of Private Health Insurers Annual Report,* data, 2013-14

[17] Private Health Insurance Administration Council, PHIAC A reports, all quarters, 2014

These measures have had an adverse effect on affordability of health cover resulting in downgrading trends. When members downgrade, costs invariably shift back to the public health system – while the Government has made savings on the rebate through these measures, the net savings to Government can only be considered in the context of increased public hospital costs, as yet unquantified.

hirmaa believes that seeking savings through a reduction in the rebate is counterproductive to Government. Rather, a regulatory review should take place to find areas where efficiencies can be realised in order to reduce the pressure on premiums and temper growth in the rebate on PHI.

With the rebate reducing by around 1% each year, affordability will continue to decline. hirmaa advocates that a floor for the rebate should be set in place, until budgetary circumstances permit its full restoration.

Deregulation: red-tape in the private health insurance industry

There is an unnecessary amount of red-tape in the PHI industry which we estimate costs industry at least $24 million annually. We have previously made representations on these matters and will not go into any significant detail in this submission, however our recommendations are as follows:

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

2. Remove duplication regarding the updating of company and/or director details to ASIC and PHIAC

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

4. Make the provision of Private Health Insurance Statements optional

5. Streamline the rebate registration process – remove the Medicare rebate application form

Deregulation: the premium-setting process in the private health insurance market

As an organisation which supports deregulation, hirmaa encourages an environment where private health insurers are afforded more flexibility in price setting.

We suggest that the industry moves toward a ‘price monitoring’ arrangement whereby premium changes do not require the costly approval process of both the regulator and the Minister for Health.

Our experience is that the current premium setting process inhibits competition, is open to politicisation and lack clarity and certainty for insurers. This places a significant and unnecessary administrative burden the industry – the cost of which is necessarily passed on to the consumer.

We believe that if deregulation is to occur, the right conditions must be in place to ensure the market acts efficiently:

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.

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

   With Clearance Certificate arrangements, full portability across insurers is provided for.
4. Effective consumer protections: to ensure anti-competitive pricing strategies are not pursued

   The ACCC presently acts as the competition watchdog in the industry, meaning the requisite consumer protections are in place.

Taking this into account, hirmaa believes that the requisite conditions are in place to allow a serious discussion on deregulating the premium setting process.

hirmaa supports a review of the premium setting process to facilitate greater competition and an improved business environment for mutual and member-owned insurers.

Deregulation: second-tier default benefit arrangements

Second tier default arrangements provide a safety net to hospitals and therefore should be considered an unfair advantage in contract negotiations.

The second tier default legislation means that private health insurers have an obligation to pay any accredited health facility (be it a private hospital or day surgery) at least 85% of the average charge for an equivalent treatment under the health insurer's negotiated agreements with facilities in the same State.

Insurers are obligated to pay these facilities irrespective of whether that facility is required, or whether the insurer believes the services provided are of sufficient quality to warrant sending members there.

Second tier default benefit arrangements distort normal market dynamics and restrict competition, innovation, choice, service and efficiency.

Indeed, health facilities that meet higher standards, are innovative and deliver better health outcomes deserve to be compensated commensurately, but perversely, when insurers pay more

for higher performing facilities, they inadvertently reward low performing facilities as a direct result of second tier default benefits.

It is hirmaa's strong view that second tier default legislation in its current form is burdensome on insurers and distorts normal market dynamics, ultimately affecting service and pushing up the price of premiums for the consumer purchasing private health insurance.

hirmaa recommends a review of second-tier default benefits arrangements as a way to restore normal market dynamics and improve the operating environment for mutual and member-owned insurers.

Deregulation: The market for prostheses in the private health system

It is the strong view of hirmaa that inefficient regulatory settings in the market for prostheses has resulted in market failure with:

a. Benefits paid by insurers not reflecting net prices paid for prostheses by hospitals

b. Lower cost and innovative competitors being restricted in their ability to compete with incumbent suppliers, due to the current method of determining group benefits for prostheses items

c. Benefits paid by insurers for prostheses items being substantially higher than benefits paid for identical items in international markets and the Australian public health system.

Given that in 2013-14, $1.74 billion in benefits were paid for prostheses[18] (14.1% of all hospital benefits paid), this is an issue of significant importance to Government, industry and consumers of health insurance and health services. Our initial modelling demonstrates that inefficiencies associated with the current regulations could range upwards of $534 million annually.

hirmaa supports a review of prostheses pricing arrangements to improve affordability for the members of mutual and member-owned insurers and to achieve significant savings for Government.

Deregulation: Information sharing arrangements between insurers and medical professionals

Currently, regulations prevent the sharing of patient information between medical professionals and private health insurers. hirmaa encourages an environment of more open and transparent access to information.

The sharing of patient information between medical professionals and insurers has enormous potential to help insurers to better manage the healthcare needs of policy holders through earlier and more targeted care plans for policy-holders.

Mutual and member-owned insurers only want the best health outcomes for their members. Deregulating information sharing will improve the capacity of mutual and member-owned

[18] Private Health Insurance Administration Council, *Operations of Private Health Insurers Annual Report,* data, 2013-14

insurers 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.

In many cases, the first time the insurer is aware of the health status of their policy-holder is upon presentation at hospital. Considering the range of Chronic Disease Management Programs (CDMPs) and Hospital Substitute Treatment options available through insurers, there is scope to achieve better health-outcomes for policy-holders and significant reductions in avoidable hospital admissions.

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.[19] 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.[20] 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. 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 the PHI industry in Broader Health Cover programs – as the benefits of early intervention and preventative care-plans are verified.

[19] Australian Institute of Health and Welfare, *Australia's Health 2014;* June 2014., p.94
[20] Council of Australian Governments Reform Council, *Healthcare in Australia 2012-13: Five years of performance.*, p. 10

Annexure A – hirmaa members

ACA Health Benefits Fund Ltd

Defence Health Ltd

Health Care Insurance Ltd

Health Partners Ltd

Latrobe Health Services Ltd

Lysaght Peoplecare Ltd

Mildura Health Fund

Navy Health Ltd

Phoenix Health Fund Ltd

Police Health Ltd

Queensland Country Heath Ltd

Queensland Teachers' Union Health Fund Ltd

Railway and Transport Health Fund Ltd

Reserve Bank Health Society Ltd

St Luke's Medical & Hospital Benefits Association Ltd

Teachers Federation Health Ltd

The Doctors' Health Fund Ltd

Westfund Ltd

Annexure B – source data used in this analysis

- Private Health Insurance Administration Council, *Operations of Private Health Insurers Annual Report historical data*

  retrieved: http://phiac.gov.au/industry/industry-statistics/previous-years/

- Private Health Insurance Administration Council, *PHIAC A historical data*

  retrieved: http://phiac.gov.au/industry/industry-statistics/data-tables-phiac-a/

- Private Health Insurance Administration Council, *PHIAC B historical data*

  (not publically available)

- Department of Health, *Private Health Insurance Premium Round data*

  retrieved: http://www.health.gov.au/internet/main/publishing.nsf/Content/privatehealth-average-premium-round

- Private Health Insurance Ombudsman, *State of the Health Funds historical data*

  retrieved: http://www.phio.org.au/publications/publications/state-of-the-health-funds.aspx