

We are hirmaa

17 August 2017

Jeanette Radcliffe
Committee Secretary
References Committee
The Senate
PO Box 6022
Parliament House
CANBERRA ACT 2600

Dear Ms Radcliffe,

Please find attached response to four Questions on Notice asked by Senator Xenophon at the Senate Community Affairs References Committee's public hearing held in Canberra on Wednesday 5 July 2017.

If you require anything else please do not hesitate to contact me.

Yours sincerely,

MATTHEW KOCE
Chief Executive Officer, hirmaa

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STANDING COMMITTEE ON COMMUNITY AFFAIRS References Committee

Responses to Questions on Notice

Question 20

Hansard page reference: p. 33.

Senator XENOPHON: I just have some questions I will have to put on notice, given time constraints. Earlier in your opening statement, you talked about second-tier default benefits and the lack of innovation given the way our framework operates now. Presumably, you will be making a written submission to this inquiry. Could I invite you to go into some detail in respect of that, the sorts of things you think ought to be done and whether that would potentially lead to the managed care that we have managed to avoid here in Australia, which is a big part of the US system. I think many Australian consumers would be reluctant to go down that path. I would interested to hear your perspective in respect of that.

Response

Since the “Lawrence legislation” of 1995, Second-Tier Default Benefit legislation has compelled private health insurers to pay any accredited health facility (private hospital or day surgery) at least 85 per cent of the state average.

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

The Second-Tier Default Benefit legislation disrupts competition in the following consequences:

- Innovations in quality and efficiency of service is obstructed.
- It is difficult for insurers to negotiate purchaser-provider agreements on quality, patient comfort or other non-price factors. Increasing rates for high-performing hospitals will increase the average and therefore also increase rates for second tier hospitals.
- It stifles competition and price tension amongst private hospitals/day surgeries- since they all know that they will have some kind of arrangement with each insurer.
- It is more difficult to control cost inflation: Regulations strengthen the position of hospitals when negotiating with insurers by granting them 85 per cent of average rates without agreements, and by allowing them to avoid the various non-price requirements in agreements.
- It results in an inefficient use of health funding: Access to insurer funding through second tier rates allows new facilities to open in areas that are already well-served, and effectively subsidising poor commercial, entrepreneurial and investor judgments.

- It distorts normal market dynamics: the artificial floor price drives up contract costs, impacting both consumers and the Government (via the Australian Government Private Health Insurance Rebate).
- The inability to set a price signal for consumers makes it impossible for insurers to drive volume to higher performing hospitals that would reduce costs and improve patient outcomes.

hirmaa does not believe that removing or Second-Tier Default Benefits will result in managed care and hirmaa does not support managed care. The removal of Second Tier Default Benefits will allow hospitals and private health insurers to negotiate contracts on a more equal and level playing field.

Specifically, removing the second tier default benefit would result in:

- Lower premium rises for consumers with the restoration of normal market dynamics.
- Higher quality and more innovative facilities being rewarded and service deficient facilities being required to lift their performance.
- Unnecessary administrative costs to insurers and the Department of Health of managing these schemes being removed.

Regional and rural hospitals, where there is limited competition and choice could retain access to a minimum default benefits safety net such as Second-Tier Default Benefits, however in well serviced metropolitan areas where there is significant choice, the Second-Tier Default Benefit is not a justifiable policy arrangement.

Question 21

Hansard page reference: pp.33–34.

Senator XENOPHON: ...I note Medibank Private has new processes for identifying complications following hospitalisation. This involves not paying hospitals for care following complications that could be prevented, unless the hospital demonstrates how it meets clinical guidelines. Are hirmaa funds also looking at this initiative?

Response: As a peak advocacy body for 22 health insurers, it would be inappropriate for hirmaa to involve itself in commercial contract negotiations on behalf of its member funds. Arrangements among health funds and service providers are likely to be commercial in confidence between each individual health fund and service provider.

Question 22

Hansard page reference: p. 34.

Senator XENOPHON: ...Hospitals have changed staffing ratios. Twenty years ago, all nursing staff were registered nurses. Now, we have enrolled nurses and patient care assistance, et cetera.

So,

- (1) do your agreements specify the mix of staff to qualify for the daily ward rate,
- (2) what is to stop a private hospital from having one RN per ward or even shared between wards and
- (3) are there minimum standards for nursing staff levels that the funds insist on—for

instance, what is the situation for staffing levels at night? Also, do you do any post-discharge quality surveys of your membership? That is, assess their experience of their stay in hospital, on how quickly staff might respond to when the buzzer is pressed and that sort of thing. Can you address that final one: are you aware whether your members do post-discharge quality surveys?

Response: As a peak advocacy body for 22 health insurers, it would be inappropriate for hirmaa to involve itself in commercial contract negotiations on behalf of its member funds. Arrangements among health funds and service providers are likely to be commercial in confidence between each individual health fund and service provider.

Question 23

Hansard page reference: p. 34.

Senator XENOPHON: ...The annual report of the Ombudsman says that the health insurance industry returned 86.1 per cent of contributions to policyholders compared to the previous year, 2014-15, when 87.1 per cent of contributions were returned. How different is the figure, and do you have figures as to what the difference is for hirmaa funds—the not-for-profit funds, your members—compared to the for-profit funds in terms of payout rates?

Response

The figures identified in Question 23 appear to have been collected from Annual Private Health Insurance Operations reports published by the Australian Prudential Regulation Authority as opposed to the annual report of the Ombudsman. The question will be answered on this basis.

The Annual Private Health Insurance Operations report published by the Australian Prudential Regulation Authority for 2014-15

The Annual Private Health Insurance Operations report published by the Australian Prudential Regulation Authority for 2014-15 shows that 87.1 per cent of contributions to the private health insurance industry were returned to policy holders as contributions.

For current hirmaa member funds as of 17 August 2017, compared to non hirmaa member funds, this figure was 90.3% compared to 86.7%.

It is also noted that the figure for the 'Big 3' health funds being Bupa, Medibank and NIB is 85.9%.

The Annual Private Health Insurance Operations report published by the Australian Prudential Regulation Authority for 2015-16

The Annual Private Health Insurance Operations report published by the Australian Prudential Regulation Authority for 2015-16 shows that 86.1 per cent of contributions to the private health insurance industry were returned to policy holders as contributions.

For current hirmaa member funds as of 17 August 2017, compared to non hirmaa member funds, this figure is 89.5% compared to 85.6%.

It is also noted that the figure for the 'Big 3' health funds being Bupa, Medibank and NIB is 84.7%.

Difference between year on year figure at industry level

Having looked at the underlying data for 2014-15 and 2015-16 there does not appear to be a notable or unusual cause for the variation in the percentage of contributions returned to policyholders as benefits.

This figure does vary year on year based on a number of external factors such as hospital utilisation for which a specific breakdown cannot be provided at this time.

Given APRA collect and compile very granular and detailed statistics across the private health insurance sector, we would suggest approaching them with this question.