SHOULD EXCLUSIONARY PRODUCTS BE EXCLUDED?

A REPORT BY
ACCESS ECONOMICS PTY LIMITED

FOR

AUSTRALIAN PRIVATE HOSPITALS ASSOCIATION

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EXECUTIVE SUMMARY

- Exclusionary private health insurance products offer members lower premiums as a *quid pro quo* for excluding cover for hospital care for nominated conditions or procedures such as maternity, cardiac surgery or hip replacements.
- Exclusionary products are targeted primarily at younger members who might perceive that they have minimal risk of needing the excluded categories of care. That said, there is also demand for these products from those who are looking for the lowest cost option to avoid paying the Medicare Levy surcharge.
- In 1992, Medibank Private pioneered the forerunner to the current exclusionary products with "Select and Save". This covered all conditions in public hospitals (as required by the regulations) but excluded private hospital costs for nominated types of care;
- The private health insurance reforms of 1995 widened the ambit, allowing the funds to offer products which excluded cover for nominated types of care in both public and private hospital settings. The regulatory limitations ensure that all hospital tables must provide cover for psychiatric, rehabilitation and palliative care. Since the 1995 reforms, products which exclude cover in both public and private hospital settings have been classified as exclusionary while those which exclude cover in private hospitals only have been classified as non-exclusionary;
- The appetite for exclusionary products is limited and falling. We estimate they covered 3.2% of the privately insured population as at 30 June 2004, down from an estimated 5.8% as at 30 June 1999. In sharp contrast, front-end deductible products have secured large acceptance and covered almost 60% of the privately insured population as at 30 June 2004;
- The introduction of exclusionary products and their forerunners hastened the inevitable demise of community rating as we knew it and its replacement with Lifetime Health Cover;
- Exclusionary products pose a challenge to members, funds and providers. They increase the complexity of private health insurance choices, add to administration costs, leave providers carrying bad debts and result in misunderstandings between fund and their members as to benefit entitlements. All members pay a price to extend choice to a few but that choice is often poorly informed;
- In most markets, consumers attach a value to choice over what they buy, where they buy it and when they buy it. Private health insurance is a constrained market. The exclusionary products create a tension between the value of choice to the individual and value of health insurance to the wider community in terms of its overall functionality and the ease or otherwise with which it allows people to share the financial risk of poor health;
- If funds were no longer permitted to offer exclusionary products, private health insurance would be more effective as means of sharing risk. The complexity of funds' administration would be reduced and the choices for consumers would be less daunting. Ultimately, the issue reduces to an assessment of the merits of a policy that enhances personal choices as opposed to one that enhances co-operative activity;
- It is timely for the community to reconsider whether there is a worthwhile role for exclusionary products in private health insurance in the future.

1. PURPOSE

This report addresses the rationale for exclusionary products in private health fund membership.

Part 2 sets the broader scene, recounts the emergence of exclusionary products, the regulatory framework and its extension and the limited extent of their acceptance.

Part 3 states the “for” case.

Part 4 states the “against” case.

Part 5 draws together the threads of the debate and concludes that a reconsideration of the rationale for exclusionary products would be timely.

Part 6 makes some practical observations on the implementation of a new policy, were policy makers to decide that there is no compelling case for retaining exclusionary products in the private health insurance fabric.

2. EMERGENCE OF EXCLUSIONARY PRODUCTS

In 1992, Medibank Private introduced its 'Select and Save' product. As required by the private health insurance regulatory framework, this product covered all conditions in public hospitals. However, it excluded private hospital costs for nominated types of care. 'Select and Save' was the first product which allowed members to self-assess their risk and, if they wished, to purchase a cheaper form of insurance. Aimed squarely at younger people, the excluded cover related to procedures which they would not expect to need at that stage of their lives such as cardiac procedures or hip replacements.

'Select and Save' followed a period of turmoil for private health insurance. Coverage was on a downwards trend, interrupted only briefly by a debilitating price war at the end of the 1980s. A range of government subsidies had been removed, increasing the cost of private health insurance to the consumer. Premiums were rising quite sharply and the demand for private health insurance was starting to show greater sensitivity to price. Funds were heavily promoting supplementary insurance (insurance which offered cover for the use of private hospitals). Although this helped shore up funds' revenue, it also increased benefit payments.

'Select and Save' looked like a breath of fresh air. It was innovative in a regulation-bound industry not known for its innovation. It attracted younger members, although the lower premiums they paid meant that there was less scope for them to cross-subsidise the older and sicker members. The reinsurance pool system was said also to have confiscated most, if not all, of Medibank Private's net gains from the new product.

Some other funds followed suit with similar products.

The 1995 reforms of private health insurance opened the door to exclusionary products as they are known today. New regulations allowed the funds to offer products which excluded cover for nominated types of care in both public and private hospital settings, subject to certain limitations. The regulations prescribe that all hospital tables must provide cover for psychiatric, rehabilitation and palliative care.

In the current framework, products like 'Select and Save' would be classified as non-exclusionary. Nonetheless, the two types of products have a lot in common and there can be no doubt that in 1992, Medibank Private planted the seeds which burst forth as exclusionary products three years later.

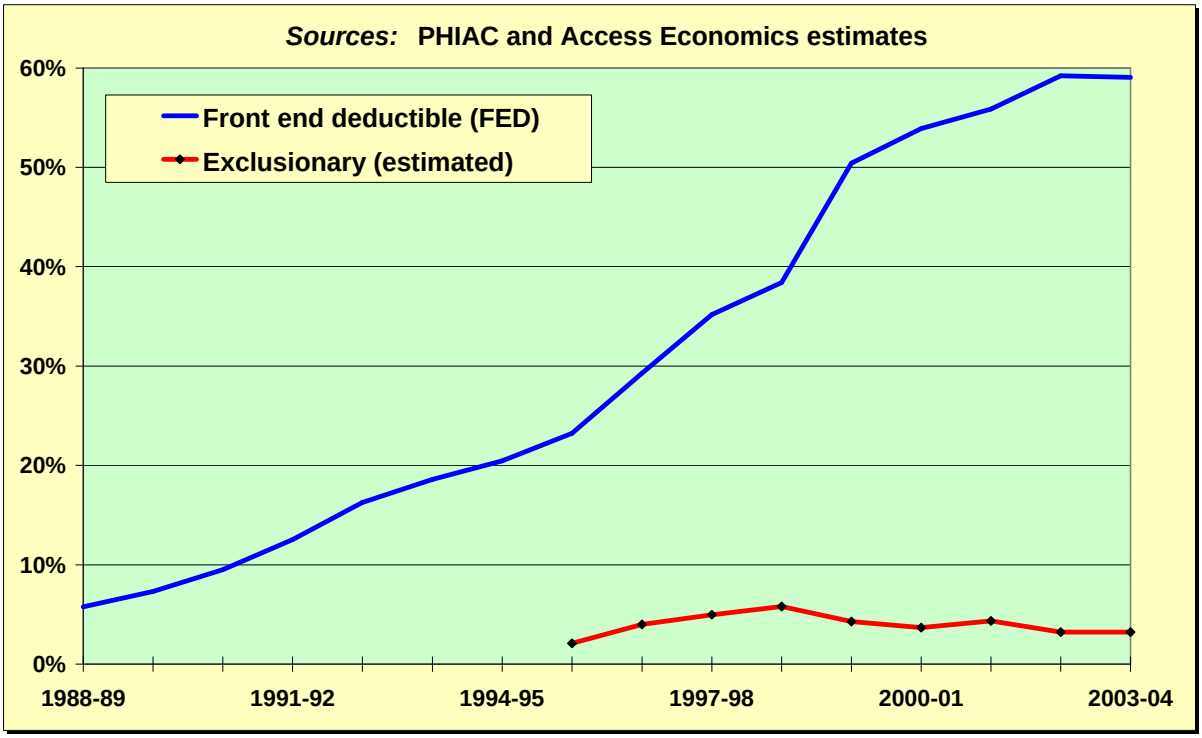
'Select and Save' and the exclusionary products which followed exposed a deep flaw in the design of private health insurance. The central principle in private health insurance was that of community rating. Community rating meant that everyone paid the same price regardless of their health status or income. Community rating did not allow price discrimination against the sick. The community rating principle enjoyed bilateral political support as well as the support of all the major health lobby groups.

Although most agreed that community rating was a good idea, it was failing …

It was failing because private health insurance was voluntary. A voluntary system allows people to self-assess their risk and, if they feel the risk is acceptable, the ultimate sanction is to drop their cover. And that was precisely what was happening. People were bailing out of private health insurance, younger people in particular, choosing not to share their financial risk with older sicker people who generally consumed a good deal more in health resources.

In this context, it might have been expected that the demand for exclusionary products would take off. However, exclusionary products never achieved much penetration of the market. At their peak in June 1999, they covered 6.1% of members and an estimated 5.8% of the privately insured population. By June 2004, this had sloped off to 3.4% of the members and an estimated 3.2% of the privately insured population.

CHART 1: COVERAGE[1] OF FRONT END DEDUCTIBLE AND EXCLUSIONARY PRODUCTS



Why is it the case that exclusionary products have not made much impact? There are several plausible explanations. One is the complexity of their benefit entitlements. Another is that people find it hard to assess the risks and, accordingly, find it difficult to know whether or not the products offer good value for money.

There is one small cohort within the community who see exclusionary products as the easy choice—the younger high income earners. Before the introduction of the Medicare levy surcharge in 1996, few in this cohort were inclined to take out private health insurance. The least risk averse among these people would have based their decision whether or not to take out private health cover simply on the basis of whether or not the premium was less than the Medicare levy surcharge. For these people, the rational choice was an exclusionary product with the highest possible front-end deduction. Since they were not intending claimants under their policies, they were not concerned to assess the chances that they might need cover for an excluded service. Indeed, they often styled themselves as reluctant "Clayton's members".

The "Clayton's members" responded to the regulatory framework. We make no explicit or implicit judgments about their responses. If these outcomes are seen as unpalatable, then it is the regulatory framework itself which requires examination, not the actions of the members.

[1] Per cent of all persons covered.

3. THE CASE FOR EXCLUSIONARY PRODUCTS

The case for exclusionary products is based on two major tenets:

- **the importance of choice:** Consumers do place a value on choice. Views about the degree to which protection from risk will be sought vary from person to person as well as from age to age; and
- **the appeal to younger members:** Funds are naturally concerned to attract younger members. Exclusionary products are seen as products which widen the appeal of private health insurance.

3.1 THE CONSUMER AS KING

Consumers place a value on choice between different products and providers. People do not have identical wants and needs. Henry Ford's solution[2] may have been right for the time but it would not be a powerful marketing tool today. The extent to which producers will seek to ascertain, and meet, consumer preferences will depend in part upon the extent to which the products are differentiated. Consumers may not differentiate between the different brands of petrol. They may choose the petrol which is the cheapest on the day, or they may choose the petrol station which is most convenient.

As a general rule, the wider the choices on offer, the more likely we will see a high degree of consumer satisfaction. If consumers want black ones or white ones and only black ones are currently produced, it is only a matter of time before an existing producer or a new entrant perceives the demand for white ones and seeks to gain a business advantage by meeting it.

Where a producer has a monopoly over the supply, consumers may have no option but to accept the product(s) the monopolist produces. Powerful producers will always seek to influence consumer preferences so that the people want what they prefer to provide. The more competitive the market, however, the more likely that it will accommodate the full gamut of consumer wants and needs.

As with any other good or service, consumers will make various trade-offs between the monetary cost of health insurance and the protection provided. The decision to purchase (or not to purchase) health insurance is influenced by perceptions of risk as well as by the various monetary incentives and disincentives (the PHI tax rebate, the Medicare levy surcharge for high income earners and Lifetime Health Cover):

- Young healthy people are naturally less risk averse than older, less healthy people (adverse selection); while
- Those with family histories of health problems tend to be more risk averse.

Those decisions (to purchase or not to purchase health insurance) also need to be seen in the wider context of consumer strategies to minimise or manage health risks. These responses may include:

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[2] "*You can have any colour you want as long as it is black.*" Henry Ford, 1910. It has been argued that at the time, Henry Ford was trying to provide what consumers wanted - affordable, reliable, available, individual mass transportation. With the technology at the time, black paint was the easiest colour to apply and the quickest to dry. These attributes made the manufacturing process more efficient, which kept costs down and made the product affordable - which was important to the buyers of that era.

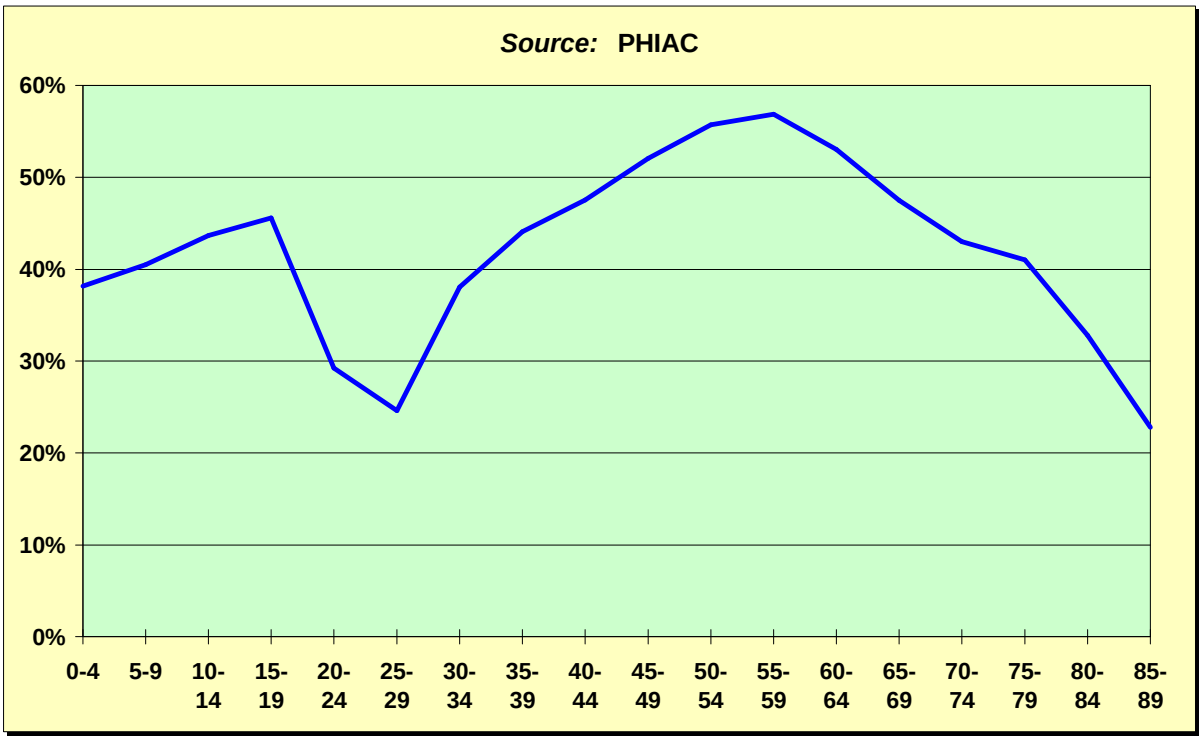
- seeking health care from health professionals when ill or concerned;
- health prevention strategies (such as diet and exercise, avoiding obesity);
- avoiding activities with high risk (eg, not consuming tobacco, not using hard drugs);
- purchasing life insurance to provide for dependents in case of premature demise; and
- purchasing other types of insurance (such as trauma cover) or seeking terms of employment with provision for sick leave and disability benefits to deal with the financial risks where ill health prematurely shortens a working life.

In summary, a strong part of the case for exclusionary products is that they meet member wants and needs that would otherwise be unmet. The diversity of wants and needs reflects the diversity of health experiences, perceived health risks and diverse strategies to address them.

3.2 APPEALING TO YOUNGER MEMBERS

Private health insurance funds have always found it something of a struggle to persuade younger people to take out private health insurance. Indeed, once younger people are no longer covered by their parents' policies, there is a distinct fall off in coverage for those aged 20 to 30.

CHART 2: PHI COVERAGE BY AGE COHORT



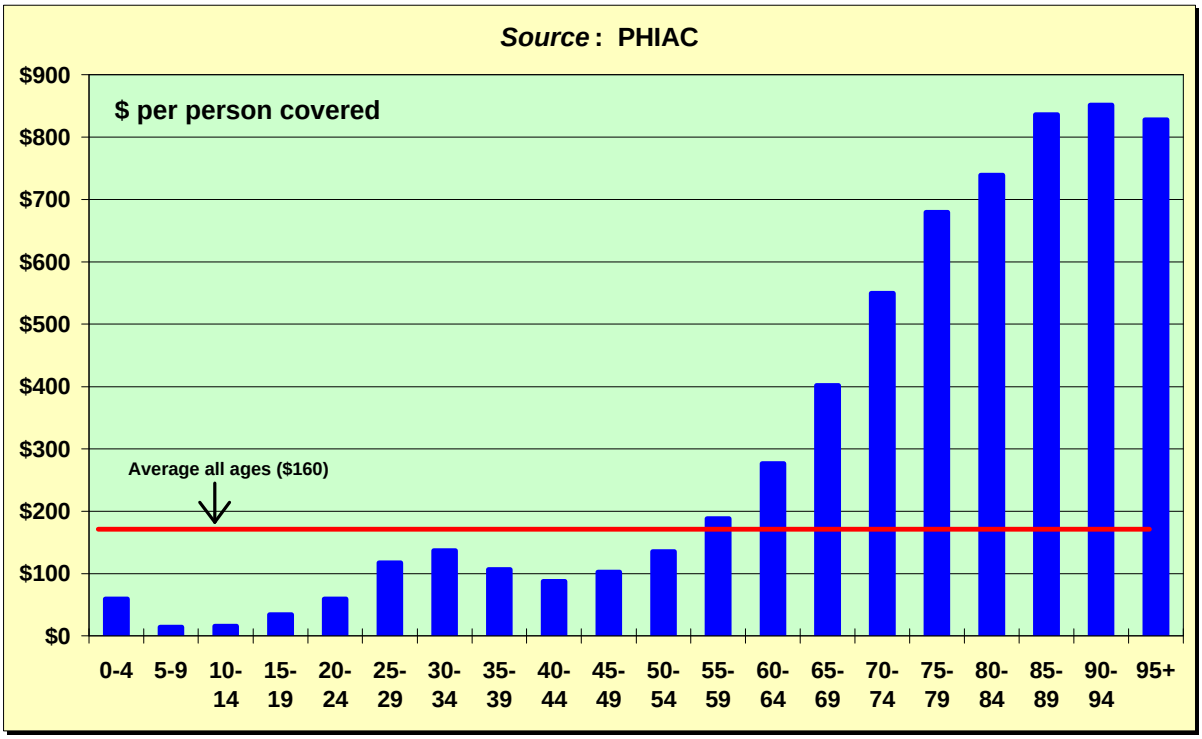
The factors in this age-related dip in coverage rates are that:

- as a general rule, young people enjoy good health and therefore do not see any compelling reason to take out private health insurance;
- closely related to their good health status young people tend, on average, to be less risk averse than older people;
- young people may not be easily able to afford health insurance while studying or early in their career and may be unlikely to earn enough to be subject to the Medicare levy surcharge which, as noted in Part 2, can be the deciding factor for some "Clayton's members"; and
- the disincentives of Lifetime Health Cover cut in at age 30 which may be the first point at which many younger people seriously consider taking out private health insurance.

The funds have seen the exclusionary products as having greater appeal to younger people and have aimed those products at the youth market. Note, however, that the funds do not release data on the age profile for the different types of products so it is not possible to assess the effectiveness of their targeting.

Younger members are appealing to the funds because they tend not to be high claimants. As Chart 3 shows, rates of claiming under the hospital tables are below average for all those aged up to about 50 and exceptionally low for those aged under 25. There is, however, a higher rate of claiming in the child-bearing years.

CHART 3: HOSPITAL BENEFITS BY AGE COHORT, JUNE QUARTER 2004



4. THE CASE AGAINST EXCLUSIONARY PRODUCTS

The case against exclusionary products also rests on two major tenets:

- **exclusionary products are beset by a series of practical problems which harm private health insurance in general:** They increase the complexity of private health insurance choices, add to administration costs, leave providers carrying bad debts and result in disputes and misunderstandings between fund and their members as to benefit entitlements; and
- **exclusionary products corrode the risk-sharing role of health insurance:** The prime purpose of insurance is to provide a mechanism by which people can share financial risks of poor health which are difficult to anticipate or quantify. By allowing members to select insurance on their own terms, exclusionary products undermine that role.

4.1 PRACTICAL PROBLEMS WITH EXCLUSIONARY PRODUCTS

Despite their low level of take-up by private health insurance fund members, exclusionary products fight above their weight in terms of the problems they contribute to the efficient operation of private health insurance. The practical problems have an impact on all private health insurance stakeholders: the funds, the health care providers and the members. The key issues are:

- **Complexity:** The exclusionary products increase the complexity of choices for members or would-be members and they increase the complexity and the cost of fund administration. These additional costs must be carried by the entire membership. All fund members pay a price to extend choices to a very small minority but those choices are often poorly informed. Consumers are rarely, if at all, able to make a fully informed and reliable assessment of their own risk of encountering the excluded conditions. For example, younger people experience a higher rate of injury (and they may be disadvantaged by orthopaedic exclusions). They may have unplanned pregnancies having excluded delivery from their policies;
- **Disputes:** Members who take out exclusionary products are, too often, poorly informed about the implications of the product they have purchased. They can and do end up in disputes with their fund over their benefit entitlements. Health care providers can find themselves as the meat in the sandwich, left with bad debts they are unable to recover because the fund member sought treatment in a private hospital without being fully aware that the cost were excluded for the particular condition or treatment. This can be exacerbated by the current lack of 24/7 eligibility checking; and
- **Inappropriate marketing** of exclusionary products can have the outcome that members find themselves with cover that is not at all suited to their needs. They can be faced with waiting/benefit limitation periods when switching to something that does meet their needs. Such problems reflect the information imbalance between health insurance funds and their members, as well as the reluctance of members to read and master the complexity in the fine print relating to the level of cover they have chosen.

In his 2003-04 annual report, the Private Health Insurance Ombudsman noted as follows:

> "*Nearly all funds offer hospital products that include restrictions (or exclusions) on some types of treatment. Where a treatment is identified as "restricted" the fund will pay a very limited benefit (usually the minimum amount allowable under the National Health Act), leaving patients with a large gap to pay themselves if they choose to be*

treated as a private patient. If a treatment is "excluded" the fund will not pay any benefit for that treatment. The patient must then meet any and all charges for that treatment (other than the amount covered by any Medicare rebate).

The types of treatments that are typically restricted (or excluded) under such arrangements include cardiac procedures, joint replacements and eye surgery. Such treatments can be very expensive, leaving patients with very large bills to pay if they decide to proceed with private treatment, not understanding the implications of these restrictions on their policy.

Products that include such restrictions can be attractive to consumers because they are considerably cheaper than products that provide a more comprehensive cover. However, such arrangements have been, and remain, a major cause of complaint to my office.

While there has been some improvement in the way these matters are explained in fund brochures and other general information products, inevitably our complainants say they were either unaware of the restriction on their cover or at least had no understanding of the implications of those restrictions.

Given our complaints experience and the considerable disadvantage experienced by fund members who do not understand the implications of such restrictions, my view is that funds need to take more action to explicitly disclose such restrictions and exclusions to consumers. This should include providing separate, clear and explicit information about the implications of any product restrictions (a "product disclosure statement") and ensuring that, on joining, members acknowledge that they are aware of the restrictions (or exclusions) and their implications."

In his 1999-00 annual report, the Private Health Insurance Ombudsman illustrated by example the problems and the pitfalls that followed from the inappropriate marketing of exclusionary policies to aged members, as follows:

"*Mr and Mrs Gold (both in their eighties) were on a bus excursion in rural New South Wales when Mrs Gold suffered an injury to her hip when alighting from the bus and sustained a broken hip.*

The patient and her husband were subsequently transported to a regional public hospital. Mr Gold was asked if they had private health insurance and he responded yes and Mrs Gold was then on-carried and admitted to the local private hospital.

Her significantly distressed 84 year old husband was asked at the hospital if they had private health insurance and he produced his card and said his wife's was the same.

Mrs Gold remained a patient for 14 days, having undergone a hip replacement. At no stage during the whole of the 14 days, did the hospital seek confirmation from the fund of her insurance status, instead relying on the initial word of her aged and distressed husband.

Six months prior to the incident, the couple had gone to the local fund office seeking ways to reduce the cost of their full cover family insurance. They were advised they could do this by taking out two single memberships with some exclusions. As it transpired the benefit limitations were much more extensive than the maternity they

laughingly spoke about and actually had restrictions on joint replacements, lens procedures, cardiac procedures and obstetrics.

The fund denied full benefits on the basis that the policy held by Mrs Gold did not cover joint replacement in a private hospital. The fund paid $14,000 of the total $20,000 account and the hospital sought to recover the remaining $6000.

It took a considerable amount of persuasion by the Ombudsman for the hospital to admit they had not fulfilled their obligations under contract nor the spirit of the legislation requiring hospitals to inform eligible contributors, even though Mrs Gold had been a patient for 14 days."

4.2 CORROSION OF RISK SHARING

Insurance is a mechanism through which people share the financial consequence of risk exposure. In that regard, health insurance is similar to house or car insurance. If there is a difference between health insurance and other types of general insurance, then it relates to the wider spread of claims experience. Older and sicker members claim much higher levels of benefits on average than younger healthier members.

A range of strategies are used to cope with risk, to mention two;

- **Copayments** are commonly used by health funds and medical practitioners to constrain the moral hazard of over-utilisation of services because they are either free or involve a minimal cost to the consumer. Some of the growth in private health insurance benefit outlays is undoubtedly due to the policy changes to encourage gap insurance cover for both hospital and medical services; and
- **Front-end payments** are virtually universal for general insurance and, as noted earlier, FED products have won wide acceptance in private health insurance with coverage approaching 60%. FED products reduce administrative costs by reducing the number of low dollar claims. Many members find appeal in the trade-off between a known and manageable front-end payment and a lower premium.

From the point of view of the individual member, an exclusionary product can also be a risk management strategy, although not always an effective one because members face difficulty in making an informed choice as to whether and when they may encounter the need for an excluded service. However, from the point of view of the insured community, these products actually corrode risk sharing. Risk sharing is a two-way street. Exclusionary products establish a one-way street mindset. The key motivational factor is to avoid sharing in the risk, or to avoid sharing in as much of the risk, of a person who may be older and sicker.

Can members have their cake and eat it too? In other words, can they receive the benefit of other members sharing their risk while avoiding sharing in the risk (or part of the risk) of those other members? That might splutter along for a while for as long as the number of people using exclusionary products remains very low. However, there would still be a cost carried by the membership in general.

5. TIME TO RECONSIDER?

There are two sides to this story. At least in theory, greater choice over the cover purchased increases consumer satisfaction. At the same time, the right to choose can itself trigger a situation where the viability of the private health insurance system is impaired because

- it is failing to perform its risk sharing role; and
- it has become too complex, engaging administrative costs that are too high and offering consumers a maze of choices, choices that are so complex that a fully informed decision is simply not possible.

Ultimately, exclusionary products fragment risk sharing. What we end up with is a series of narrow cohorts who share their risk with each other but with quite limited scope to share their risk with other cohorts. That outcome presents a significant challenge to the aims of Lifetime Health Cover which seeks to retain community rating in a modified format.

Insurance works better if everyone is in the pool sharing their risk with each other. It builds on a notion of social, co-operative activity. It is human nature that individuals will seek to game the system if they can to avoid carrying a share of the cost or to extract greater benefits. That tension exists in all insurance markets. However, it is more marked in health insurance because of the greater variability in claims experience.

We postulate that the system has evolved too far down the path of individual freedom to choose without regard to the underlying viability or otherwise of the system of insurance.

It is timely for the Government to reconsider the role of exclusionary products in consultation with consumers and other stakeholders (funds and providers). If the role of these products is little more than providing the vehicle for the "Clayton's members" to sidestep the Medicare Levy surcharge at least cost, then the wider interests of the privately insured committee may best be served if exclusionary products are removed from the landscape in future. That may mean that some "Clayton's members" drop their cover. However, a private health insurance industry with lower administrative costs and offering less complex choices to consumers will be more attractive to other potential members.

It is certainly time to re-examine the cost and complexity that the exclusionary products add and to assess whether the additional costs imposed on some 97% of members are justified by the benefit of cheaper premiums for 3% of the members.

6. PRACTICAL CONSIDERATIONS

In the event that policy makers were of the view that exclusionary products no longer play any useful role in Private Health Insurance, there are some practical issues to be considered. From time to time we see situations where the tail wags the dog and desirable policy change is not tackled because the practical difficulties in a new direction are seen as too great or the process of change too disruptive. The practical difficulties of putting an end to the exclusionary products are relatively minor. They do not constitute a case for eschewing the change.

The key issue requiring consideration is whether or not to "grandfather" those members now using exclusionary products.

Options include:

- allowing these people to stay in the current table for as long as they choose and for as long as they maintain continuous cover; or
- prescribing a "sunset clause", allowing those grandfathered to remain with their current policy for a period (say, up to 5 years).

Private health insurance is term insurance, not whole of life insurance. There are no regulations applying to general insurance (car, house, etc) which requires the insurers to offer a particular product unchanged. The general insurance companies make regular changes in the terms of their policies, changes which take effect upon annual renewal. Provided that consumers are fully informed, there is no reason to prevent the products evolving over time. In private health insurance, however, we have seen the funds required by the regulators to keep offering old tables for as long as a member wants to remain on a particular table.

Some might argue that a change in the regulations to disallow exclusionary products is a retrospective change of sorts given Lifetime Health Cover. This is, however, a difficult argument to sustain in a term insurance framework.

It is more plausible to suggest that those now using exclusionary products should be allowed a period of grace to determine what type of non-exclusionary product might best fit their needs under a new regulatory framework.

A supplementary issue arises with the second, sunset clause, option. Should funds be allowed to offer some kind of financial inducement to persuade people to migrate to non-exclusionary products? This might technically violate the underlying principle (Lifetime Health Cover) but it might allow for a more efficient and ultimately lower cost transition process. It would be worth considering.

7. REFERENCES

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