PRIVATE HEALTH INSURANCE PRODUCT DESIGN – GOLD, SILVER, BRONZE

Introduction

There is an extensive range of products available in the Australian private health insurance market. Consumers face considerable difficulty when trying to compare private health insurance products. They also find it difficult to understand what services different policies do, and do not, cover.

The Australian Government has announced that the Private Health Ministerial Advisory Committee will be tasked with implementing a variety of reforms, including proposals to:

- simplify private health insurance by developing easily-understood categories of health policies – e.g. labelled gold, silver, bronze – so that consumers know what they are, and are not, covered for;
- weed out 'junk' policies by ensuring consumers have access to a product with a mandated minimum level of cover; and
- develop standard definitions for medical procedures across all insurers so that consumers can compare policies more easily.

This paper outlines some of the issues facing consumers and potential options for improving the design of private health insurance products.

Consumer issues and concerns

The Australian Government's 2015 private health insurance consultations revealed widespread community and industry concern around the complexity of private health insurance and the inability of consumers to easily access understandable information about what their policy will and will not cover.

Concern was also raised around the growth in the number of low-value products on the market, particularly policies which only cover treatment in a public hospital or which exclude a majority of hospital services, referred to by some as 'junk' products.

The way in which product information is presented was cited as a particular source of confusion for consumers. There is significant variability in the terminology used to describe what is covered by insurance. This makes it very difficult for consumers to understand and compare policies.

Numerous submissions from consumer groups and providers suggested that increasing numbers of consumers are purchasing products without a proper understanding of what is covered, with the result that when they require hospital treatment they are surprised to find they are not covered and/or face considerable out-of-pocket costs. This was identified

as a major issue which is eroding consumers' perceptions of value in private health insurance.

The Department of Health's private health insurance consumer survey also highlighted considerable dissatisfaction in this area with:

- 39 per cent of respondents with insurance indicating that a major concern with private health insurance was related to the difficulties they face trying to understand and compare different policies; and
- 13 per cent of respondents without insurance indicating that a main reason for not having insurance was: 'It is difficult to understand private health insurance policies and to find a policy which meets my needs'.

Separate to the Australian Government's private health insurance consultations, the Australian Competition and Consumer Commission (ACCC) identified similar concerns regarding the complexity of private health insurance for consumers. In its 2015 annual report to the Senate, the ACCC identified a number of market failures in the private health insurance industry due to asymmetric and imperfect information. The ACCC found that these market failures have reduced consumers' ability to compare policies and make informed choices about their future medical needs.

Information provision and the regulatory landscape

Consumers access information on insurance products from a range of sources including:

- insurers (websites, brochures and marketing materials, call centres);
- intermediaries, brokers and third party comparators;
- tax agents and financial planners;
- friends and family; and
- the Australian Government's consumer website www.privatehealth.gov.au, operated by the Private Health Insurance Ombudsman (PHIO).

Insurers are required to provide information to consumers on their products in accordance with the Australian Consumer Law (ACL). The ACL protects consumers from misleading or deceptive conduct, unconscionable conduct and false or misleading representations by businesses. The ACCC has recently sought to pursue legal action against some private health insurers for alleged contraventions of the Australian Consumer Law regarding false or misleading representations made to consumers about their products.

Standard Information Statements (SIS)

The Government regulates the provision of information to consumers on private health insurance products by requiring insurers to produce Standard Information Statements for all of their policies. This requirement was introduced in 2007 through the *Private Health Insurance Act 2007 (Cth)*. A Standard Information Statement is a one page summary outlining the main features of a policy, including any restrictions or exclusions that apply, waiting periods, gaps and excesses and the cost of the premium. Insurers are required to provide a copy of the statement to consumers when first insured, at least once every 12

months, and as soon as practicable when 'a proposed change to insurance rules will be detrimental to the policy holder'.

Standard Information Statements are publicly accessible at www.privatehealth.gov.au and on private health insurers' websites.

Standard Information Statements were introduced to allow consumers to understand their policies and make informed comparisons of different products. However, stakeholders have generally expressed the view that the statements provide limited value in assisting consumers because they contain insufficient information about policy exclusions, waiting periods and benefit limits. Specific details of any exclusions, waiting periods or benefit limits are contained within separate product documentation issued by insurers. This information is sometimes difficult to access, and when found, is presented in various ways by different insurers.

Insurers often use inconsistent terminology to describe certain services. Such examples include: "cardiac services" versus "heart related services"; or "obstetrics" versus "pregnancy and birth related services". This makes it difficult for consumers to compare different products on a like-for-like basis. In addition, the clinical definitions applied by insurers for clinical services such as 'major eye surgery' or 'back surgery' vary widely across insurers. Consumers can often be surprised to learn that their surgery is not covered as a result of the particular definition used by an insurer.

www.privatehealth.gov.au

The Australian Government's consumer website for private health insurance, www.privatehealth.gov.au, enables consumers to compare selected features for all private health insurance products offered in Australia. Consumers are able to use the website to search a database of all policies to help them review their current policy or choose a new one. Information on these policies is drawn from Standard Information Statements.

In 2014-15, the website received over one million unique visitors. However, consumer research undertaken by the ACCC suggests that overall consumer awareness of the website is low, with only 26 per cent of surveyed consumers being aware of its existence.

The ability for consumers to compare and select products on www.privatehealth.gov.au is made difficult by the sheer number of policies that are on the market. Using the current search filters, consumers are faced with a very large number of search results which can be unmanageable for many consumers. For example, a search for a single hospital policy in NSW, under the 'Basic' classification will return 92 different policies. The PHIO is undertaking a project to improve the search functionality of the website. The aim of this project is to provide consumers with more targeted and specific search filters that return a smaller number of more relevant products for consumers to consider.

Product Classification Categories

Hospital products are categorised by the PHIO into one of four categories: Top, Medium, Basic and Public Hospital Cover according to the level of cover they provide. The PHIO also categorises general treatment products (also known as ancillary or extras cover) into one of three categories: Comprehensive, Medium, and Basic. The classifications assigned for each product are based on the services that are shown as covered on Standard Information Statements. The criteria used for categorising products are at Attachment A.

The classifications do not take into account whether a policy includes an excess and/or co-payment or benefit limitation period. The criteria also allow for considerable variation in the types of services that are covered within each category of cover.

On the basis of the feedback provided through the Government's 2015 consultations it is clear that the current approach to classifying products is not providing consumers with a useful basis upon which to compare different products and understand the level of cover that different products provide.

Intermediaries, Brokers and Third Party Comparators

Consumer research suggests that 44 per cent of people accessed broker or comparator websites when taking out cover (Ipsos, 2015). These organisations are now a major channel through which consumers obtain information and compare different products. These organisations may have established a role in the private health insurance market due to the growing complexity of private health insurance and number of products that are available.

Unlike the Australian Government's comparison service (www.privatehealth.gov.au), these organisations do not aggregate information on all products available on the market. There are currently 34 private health insurers and most intermediaries' typically aggregate policy information from 3-12 insurers.

Minimum Product Requirements

The *Private Health Insurance Act (2007)* sets out the minimum coverage that a complying health insurance product must provide. It requires that private health insurance policies that cover hospital treatment must provide a benefit for any part of hospital treatment for psychiatric care, palliative care, or rehabilitation if the treatment is provided in a hospital setting (or in a community-based setting if the individual is covered for hospital-substitute treatment).

The Government has indicated an intention to "weed out 'junk' policies by ensuring consumers have access to a product with a mandated minimum level of cover". Consideration will be required to assess whether the current minimum product standards are adequate and whether they should be changed.

Hospital and Insurer Contracting – no gap and known gap arrangements

The existence of preferred provider arrangements between insurers and hospitals or practitioners, further complicates the range of matters a consumer must consider when purchasing and using private health insurance. For instance, a consumer must consider

whether their insurer has a particular agreement with their practitioner/doctor or hospital, and the associated gap and charging arrangement. These arrangements mean that having top cover does not provide a guarantee that a patient will not have any out-of-pocket costs if they require hospital treatment.

Reform suggestions

Some industry participants have provided suggestions on ways to improve the design of private health insurance products. Two such contributions have come from the Consumers Health Forum (CHF) and hirmaa. These proposals are outlined in the box below.

Industry suggestions to improve the design of private health insurance products

The following extracts are sourced from submissions made by CHF and hirmaa to the Australian Government's 2015 private health insurance consultations. The submissions were also published by these organisations on their respective websites.

Consumers health forum (CHF) - mycover

CHF believes that there ought to be a legislated, national standard for basic or default hospital coverage (myCover) that would be required by all health funds to offer to consumers. The suite of myCover packages should be tailored to accommodate different stages of the life course. The services covered under this basic package ought to be evidence-based and in relatively widespread use by the medical community. It should have minimal exclusions, standard excess arrangements and be fit for purpose.

CHF calls for the Rebate to be redesigned and better targeted to only apply to hospital products that meet as a minimum the myCover standard for hospital cover as recommended above.

Source: https://www.chf.org.au/pdfs/chf/CHF-PHI-Review-Submission-FINAL.pdf

hirmma - MyHealthCover

Similar to the MySuper strategy introduced by the Gillard government in 2011, hirmaa suggest that an industry-wide, Government endorsed level of comprehensive cover would resolve these concerns [*referring to findings of ACCC, 2015*].

A MyHealthCover requirement would dictate either a minimum standard or a defined standard of top-tier comprehensive hospital cover, which would cover consumers for what a 'normal person' would expect to receive coverage for - all normal therapeutic and diagnostic services.

Policy products would require a MyHealthCover endorsement from the Government, a regulatory body such as the Australian Prudential Regulation Authority (APRA) or the Commonwealth Ombudsman in order to receive a fixed, non means-tested, non-indexed Australian Government rebate in order to incentivise consumers to upgrade their cover.

It would also drive insurers to close down non-complying products, particularly those with exclusions as they would become not only unprofitable, but unviable.

Health insurers would be allowed to offer these products provided they meet the industry and government agreed standard.

Source: http://www.hirmaa.com.au/app/uploads/2016/02/2015.12.04_hirmaa_phi_review_submission_.pdf

Approaches for categorising private health insurance products

This section considers possible options for change. It may be possible to combine or integrate various aspects of these options. The options presented are intended to guide and encourage discussions, they are not exhaustive.

1. ***Scope of services covered*:** Hospital products are categorised according to the range of clinical services they cover. Products providing minimal coverage would receive a 'Bronze' rating. Products with increased levels of coverage would receive a 'Silver' rating and products providing comprehensive cover would receive a 'Gold' (or 'Platinum') rating. This could be achieved through a variety of methods:

    a. *Standard products:* New standard products are established specifying the specific range of services that must be covered in Gold/Silver/Bronze products and insurers are only permitted to issue products that comply with the standards. Insurers would differentiate products within these categories on the basis of excesses or co-payments. This option would provide greater consistency and standardisation of products and simplify product selection for consumers. It would require substantial work to determine the services covered in each category. In the short term, it would also have a substantial regulatory impact for insurers which would need to reconfigure many products.

    b. *Product assessment criteria*: Product assessment criteria would be set such that all products in the market could be assessed as: 'Gold', 'Silver', 'Bronze' (or possibly 'not rated'). The criteria could be set empirically, based on existing market differentiation points, or objectively based on some sort of expert assessment. The desire for insurers to achieve 'Silver' or 'Gold' ratings on products may, at the lower end of the market, encourage insurers to compete more strongly on offering more comprehensive cover. This option is unlikely to deliver greater consistency or standardisation of products or reduce the number of products for consumers.

    c. *Age based categories:* In recognition that consumers' health needs change over their lifetime, it may be appropriate to create a series of Gold/Silver/Bronze categories for different age groups (for example: 18-35 years; 30-50 years; 45-65 years; 55-70 years and 65+ years). The Gold/Silver/Bronze ratings would be based on different clinical services criteria for each age category. The determination of the clinical services criteria would be informed by examining hospital casemix data (public and private) to identify the most commonly utilised services by patients in each age group. This system would encourage consumers to give greater consideration to the type of cover they purchase at each stage of their life. It could also help to address the 'set and forget' approach adopted by many consumers to their cover. However, such an approach could also introduce additional complexity for consumers and insurers.

2. ***Strengthening the current product classification system:*** the Private Health Insurance Ombudsman currently classifies hospital cover into one of four categories: Top, Medium, Basic and Public Hospital Cover. The criteria used for applying these classifications are at

Attachment A. There are some shortcomings with the current arrangements. There is limited standardisation or consistency in the services that are included or excluded within these categories of cover, and insurers use inconsistent terminology to describe inclusions and exclusions. Work could be undertaken to enhance the current product classification arrangements to provide consumers with more consistent information and support to select the product that best suits their circumstances (e.g. a government approved 'purchase decision framework'). This option would have lower regulatory impact on industry.

3. ***Percentage level of benefits paid by insurer:*** Products are categorised according to the average percentage of expenses that are be paid by the insurer (similar to the model operating in the United States under the *Affordable Care Act*). The higher the value of a policy (e.g. 'Gold'), the more the insurer will pay towards a patient's bill and, therefore, the lower the out-of-pocket costs for consumers via excesses or co-payments. Attachment B shows the minimum percentage covered by each 'metal plan' in the United States. This approach will require consideration of the continued role of exclusions, and may only be feasible if insurers are required to provide coverage for all in-hospital services. Depending on how the base level of expenses was calculated this approach could require major regulatory changes and a shift in the way in which insurers contract with hospitals, and could have some inflationary impacts.

4. ***Exclusions, restrictions, excesses and co-payments:*** Products are categorised according to whether they contain exclusions, restrictions, excesses or co-payments. For example:
   a. *Bronze:* products may include any combination of exclusions, restrictions, excesses or co-payments;
   b. *Silver:* products must provide coverage for all in-hospital services (i.e. no exclusions) but insurers would be able to impose any combination of various excesses or co-payments; and
   c. *Gold*: products must provide coverage for all services, with insurers not able to charge excesses or co-payments or impose restrictions.

It is unlikely this approach would allow consumers to effectively compare products. It is also unclear that such a scheme would provide consumers with a useful assessment of the relative value or worth of a particular product.

Issues

There are many issues to be considered in assessing any system of product categorisation. Some of these are:

- ***Improvement on current arrangements***: A system currently exists for classifying private health insurance products into the categories of: Top, Medium, Basic and Public hospital cover. It will be important to ensure that any new system represents a true improvement for consumers. This will require extensive engagement and cooperation with insurers.

- ***Challenges in classifying products***: Services commonly excluded in policies include: cardiac, cataracts, obstetrics, assisted reproductive services, hip and knee replacements, other joint replacements, dialysis, gastric banding or psychiatric services. Determining which combination of services is necessary to classify a product Silver or Gold will be particularly challenging task (where are boundaries set?). How will different exclusions be rated: e.g. is a cardiac exclusion "better" or "worse" than a joint replacement exclusion?
- ***Contracting issues***: In instances where an insurer does not have a contract with a private hospital, a 'Gold' product provides no guarantee that the patient will be fully covered for their treatment service. In this instance, the patient will likely face out of pocket costs.
- ***Maintenance costs***: Developments in clinical practice and other innovations are likely to require changes to the classification scheme over time. Some insurers may also attempt to 'game' the system to ensure their products achieve a 'Gold' or 'Silver' rating. This will require ongoing effort to ensure that the integrity of the system is maintained.
- ***Transition issues***: Moving to a new classification scheme will require significant effort from government, insurers, doctors and private hospitals and will likely take some years to implement. Depending on the model, it is possible that insurers may be required to reconfigure all of their product offerings. The timing of implementation would need to link in with the annual premium round.
- ***Consumer decision making***: Consumers will still need to make a personal decision on the type of cover most suitable for their circumstances. Within any category of cover, it is possible that there will still be some variance in the products offered (e.g. exclusions, excesses and co-payments). Regardless of the categorisation system chosen, it is likely that consumers will still face challenges in selecting cover that suits their needs.
- ***Product needs for different age groups***: Consumers' health needs and risks for certain conditions change over their lifetime. This could make a 'one size fits all' approach problematic. For example, a product designed for a person in their 30s – for example, covering obstetrics but excluding cataracts, hip and knee replacement – could perhaps be judged as a high value product for people in this age cohort and, worthy of a 'Silver' (or 'Gold') rating. However, for a 65 year old this product is unlikely to provide cover for the services they are most likely to require, and at best, may only warrant a 'Bronze' rating.
- ***General treatment (ancillary) policies***: The Gold/Silver/Bronze model has primarily been considered for application on hospital policies. It is not clear whether it would be appropriate (or possible) to use the same approach for categorising hospital and general treatment policies. The Private Health Insurance Ombudsman currently classifies general treatment cover into three categories: Comprehensive, Medium and Basic (see details at Attachment A).
- ***Copyright issues*****:** Consideration may need to be given around whether there are trademark/ownership issues around the use of the terms Gold, Silver and Bronze. Also, a number of insurers already use Gold/Silver/Bronze terminology (e.g. one insurer markets

a product called “Bronze Hospital & Silver Extras Set Benefits”). The ongoing treatment of such products would require consideration.

- ***Regulation:*** Will the new scheme be regulated by government, or will it be a self-regulation model? This will have implications for timing, administration, and consumer confidence.
- ***Impact on premiums*****:** Depending on the model adopted, there may be differential impacts on premiums for different groups which will need to be taken into account in assessing the implications for membership and industry sustainability.

Attachment A

PRIVATE HEALTH INSURANCE OMBUDSMAN – CURRENT CATEGORIES OF COVER

Hospital cover

Hospital policies help cover the cost of in-hospital treatment by your doctor and hospital costs such as accommodation and theatre fees. Generally, any medical services listed under the Medicare Benefits Schedule (MBS) can be covered on some form of private hospital insurance. Some services which are not listed on the MBS, such as elective cosmetic surgery or laser eye surgery, are only covered by private hospital insurance to a limited extent or not at all.

Hospital policies fall into four general categories. The classifications are based on the services that are shown as covered, excluded or restricted on standard information statements.

- *Top Private Hospital Cover* - must cover all services where Medicare pays a benefit;
- *Medium Private Hospital Cover* - excludes or restricts one or more of the following but includes any services in the basic classification: Pregnancy and birth related services, Assisted reproductive services, Cataract and eye lens procedures, Joint replacements i.e. shoulder, knee, hip and elbow including revisions, Hip and knee replacements, Hip replacements, Dialysis for chronic renal failure and Sterilisation.
- *Basic Private Hospital Cover* - excludes or restricts one or more of the following: Cardiac and cardiac related services, Non-cosmetic plastic surgery, Rehabilitation, Psychiatric services, Palliative care;
- *Public Hospital Cover* - covers minimum benefits for treatment in public hospital only. Public hospital waiting lists still apply.

The classifications do not take into account Hospital treatment for which Medicare pays no benefit (e.g. most cosmetic surgery or other services with are not listed on standard information statements); and do not take into account whether a policy includes an Excess and/or Co-payment or benefit limitation period.

General treatment cover

General treatment policies (also known as ancillary or extras cover) provide benefits for ancillary services - for example, physiotherapy, dental and optical treatment.

General treatment policies may be offered separately or combined with hospital cover. There are three general categories of policies. The classifications are based on the services that are shown as covered on standard information statements.

- *Comprehensive Cover* - must include cover for General dental, Major dental (benefit limit must be average or above average for the industry), Endodontic, Orthodontic (benefit limit must be average or above average for the industry), Optical, Non-PBS Pharmaceuticals, Physiotherapy, Podiatry, Psychology;
- *Medium Cover* - must include cover for General dental, Major dental, Endodontic AND any five of the following: Orthodontic, Optical, Non-PBS Pharmaceuticals, Physiotherapy, Chiropractic, Podiatry, Psychology, Hearing aids;
- *Basic Cover* - all other policies.

Affordable Care Act - Minimum Percentage Covered by each Metal Plan

Metal Plan	Percentage Covered (%)
Platinum	90% +
Gold	80% - 90%
Silver	70% - 80%
Bronze	60% - 70%

Note: There is a 2% leeway to each of the bands

Actuarial value

The metallic rating system is based on the "actuarial value" of health insurance. The actuarial value of a product is calculated as the average amount of out-of-pocket costs that is covered for a standard population on the plan.

STANDARDISED CATEGORIES OF COVER – COMPARISON OF OPTIONS

<table>
<tr><th>Approach</th><th>Method for categorising</th><th>Pros</th><th>Cons</th></tr>
<tr><td rowspan="3">1. Scope of services covered</td><td>Standard products</td><td>• Provides greater standardisation and product consistency.
• Simplifies product selection for consumer.
• May provide mechanism for removing low value products from the market.</td><td>• Considerable work required to settle on clinical services to be covered in each category.
• Would have substantial regulatory impact for insurers who need to reconfigure large number of products.</td></tr>
<tr><td>Product assessment criteria</td><td>• No new or additional regulatory burden for insurers.
• At lower end of the market, may encourage insurers to compete more strongly on offering more comprehensive cover.</td><td>• Considerable work required to settle on clinical services to be covered in each category.
• Unlikely to deliver greater consistency or standardisation of products.
• Would still have complexity of products available.</td></tr>
<tr><td>Age based Gold/Silver/Bronze categories (for example 18-35; 30-50; 45-65; 55-70 and 65+ years)</td><td>• Encourages/assists consumers to select a product that meets their health needs.</td><td>• Considerable work required to settle on clinical services to be covered in each age category.
• May raise issues around community rating.
• Could further encourage adverse-selection.
• Likely to involve some additional regulatory burden for insurers.
• Would need to incorporate adaptations for different family types, which would create some new forms of complexity for consumers.</td></tr>
<tr><td>2. Strengthening current classification system</td><td>Utilise Private Health Insurance Ombudsman’s classifications: Top; Medium; Basic; and Public Hospital Cover. Strengthen the system with more consistent terminology, supported by ‘purchase decision framework’.</td><td>• No new or additional regulatory burden for insurers.
• Could leverage the work being undertaken by the Ombudsman to improve and enhance the www.privatehealth.gov.au interface.</td><td>• Unlikely to meet political expectations for new and simplified categories of cover.</td></tr>
<tr><td>3. Percentage level of benefits paid by insurer</td><td>Examples of potential categories
<table><tr><th>Metal Plan</th><th>Minimum % of costs Covered</th></tr><tr><td>Platinum</td><td>90% +</td></tr><tr><td>Gold</td><td>80% - 90%</td></tr><tr><td>Silver</td><td>70% - 80%</td></tr><tr><td>Bronze</td><td>60% - 70%</td></tr></table></td><td>• Provides greater standardisation and product consistency.
• If introduced in the context of no exclusions, would provide greater transparency to consumers on what they are covered for.</td><td>• Will be challenging to overcome consumer expectations that private health insurance should cover the full cost of treatment (despite the reality that many insured patients already face out-of-pocket costs).
• Lower categories of cover could drive people into the public system because the cost differential will become clearer.
• In the Australian context it would be difficult to implement enforceable caps on specific medical providers’ bills. Also, relies on the insurer having contracts with hospitals.
• Lower income earners may be attracted by the cheaper premiums of Bronze or Silver products, but may be unable to utilise cover at time of need due to the large out-of-pocket costs they will face via excesses or co-payments.</td></tr>
<tr><td>4. Exclusions, restrictions, excesses and co-payments</td><td>Example categories of cover could include:
• Gold: covers all services, with excesses, co-payments or restrictions not allowed.
• Silver: covers all services, with excesses or co-payments allowed.
• Bronze: allows any combination of exclusions, restrictions, excesses or co-payments.</td><td>• This option would involve minimal regulatory impact on industry.</td><td>• Unlikely to deliver greater consistency or standardisation of products.
• Unlikely to reduce complexity for consumers.
• It is unclear that such a scheme would provide consumers with a useful assessment of the relative value or worth of a particular product.</td></tr>
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