ISSUES PAPER: PRODUCT DESIGN (PAPER NO. 2) – ITEMS FOR FURTHER CONSIDERATION AND DECISION

Introduction

At its meeting of 29 September 2016, the Private Health Ministerial Advisory Committee (the Committee) considered a product design issues paper which identified a number of approaches that could be taken to categorise private health insurance products (Product Design Issue Paper No 1). The Committee discussed the potential approaches and considered that some options would not be viable or practical.

This paper explores a number of issues raised during the Committee's earlier discussion and identifies a number of decisions that will need to be taken to progress the development of advice to the Government on a potential approach (or approaches) for private health insurance product design and categorisation.

Preferred approaches for product design and categorisation

The Committee has agreed it will give further consideration to approaches based around: product criteria; and exclusions, restrictions, excesses and co-payments. These two approaches are outlined in further detail below.

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Approach 1: Product criteria

Private Healthcare Australia (PHA) has undertaken work in conjunction with a number of its member funds to develop a potential hospital product design and categorisation approach based around product criteria. While the PHA model does not necessarily reflect the Committee's endorsed or preferred approach, it provides a useful starting point and foundation for further discussion and development.

Under the PHA model, hospital products would be categorised as 'Gold', 'Silver' or 'Bronze' on the basis of the scope of clinical services covered. Attachment A shows the services that would be covered within each of the categories under the PHA model.

The PHA model also proposes that restricted cover would no longer be permitted. It is generally acknowledged that restricted cover, where a service is covered but only to a limited extent, is a source of confusion for consumers. The removal of restricted cover could provide greater transparency and certainty for consumers.

The PHA model would be underpinned by standard clinical terminology applied by all insurers. The Committee will shortly establish a working group to progress work on developing standard clinical definitions.

Approach 2: Product categories based on exclusions, restrictions, excesses and co-payments

An alternative approach to product criteria could be to categorise products on the basis of exclusions, restrictions, excesses and co-payments. The model could be based on the following approach:

a) *Bronze*: products may include exclusions, restrictions, excesses or co-payments;
b) *Silver*: products must cover all hospital services (i.e. no exclusions) but insurers would be able to impose any combination of excesses or co-payments; and
c) *Gold*: products must cover all hospital services (i.e. no exclusions), with insurers not able to charge excesses or co-payments or impose restrictions.

At this point, Approach 2 is significantly less developed option than Approach 1, with the Committee having only considered the option at a high-level. Should the Committee see merit in this approach, it will require significant further development. Key issues that would require consideration include:

- *Bronze cover*: will this category include a minimum product requirement, such as limiting the number of exclusions and restrictions that would be permitted?
- *Silver cover*: should restrictions be permitted in this category and should there be limits on excesses permitted?
- *Gold cover:* should excesses be permitted, or should excesses instead be limited to a low level?

Approaches not being pursued

The Committee has agreed that a number of the approaches outlined in the Product Design Issue Paper No 1 would not be viable or practical and will not be considered for further investigation or development. These approaches and associated issues are included at Attachment B.

Assessing the approaches

It would be appropriate for the Committee to consider how it intends to assess the merits of different approaches by agreeing assessment criteria. The criteria could also aid in refining the design of the Committee's preferred approach (or approaches).

The Secretariat has identified potential assessment criteria that could be used by the Committee to assess different product classification approaches. The criteria are framed as questions and are listed below for the Committee's consideration.

1. *Would the approach simplify the product comparison and purchasing decision process for the consumer?*
2. *Would the approach deliver greater transparency for consumers?*
3. *Would the approach improve minimum product standards for consumers?*
4. *Would the approach be difficult to implement (e.g. what is the regulatory impact, timeframe for implementation)?*
5. *Would the approach impact premium levels (within and across market segments)?*
6. *Would the approach impact private health insurance participation?*

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Members are asked to consider the criteria and indicate if there are any changes or additional criteria required.

The criteria have been applied to the two approaches being further examined by the Committee. The application of the potential criteria is set out for the Committee's consideration and discussion in Table 1 over the page.

Table 1: Application of potential assessment criteria

Assessment Criteria	**Approach 1: Product criteria** (Note: the PHA model has been used for this exercise)	**Approach 2: Categories based on exclusions, restrictions, excesses and co-payments**
Would the approach simplify the product comparison and purchasing decision process for the consumer?	Yes, noting: • This approach has potential to deliver a greater degree of product standardisation which would aid consumers when comparing and purchasing products. However, insurers would be able to offer Bronze *plus* / Silver *plus* type products, which, over time, could lead to increased product proliferation and complexity for consumers.	Would depend upon the design of the model. • Unlikely to deliver simplification if the approach simply slots the current product offering (around 50,000 products) into three categories. The diversity/proliferation of products on the market would be largely unchanged and complexity would remain.
Would the approach deliver greater transparency for consumers?	Yes. • This approach could deliver greater transparency (and certainty) for consumers around level of cover offered, particularly in the Bronze category.	Would depend upon the design of the model. • The introduction of a minimum standard that limited the number of exclusions and restrictions that would be permitted in the Bronze category could help to provide greater transparency and certainty for consumers at the entry point of the market.
Would the approach improve minimum product standards for consumers?	Yes, noting: • Consideration is required as to whether the PHA Bronze category is the correct/most appropriate minimum standard to adopt.	Yes, assuming the introduction of a minimum standard limiting the number of exclusions and restrictions that would be permitted in the Bronze category.
Would the approach be difficult to implement (low/medium/high difficulty)? What is the: • industry and regulatory impact? • timeframe for implementation?	Medium difficulty • Bronze minimum standards would require legislative change/replacement of the Complying Health Insurance Product (CHIP). • PHA estimate a substantial number of consumers currently on 'sub-bronze' products would be impacted. Insurers would need to reissue a substantial number of entry-level products. • PHA suggests 24 month transition/implementation period.	Low difficulty • Likely to have a lower industry and regulatory impact than Approach 1. • If the approach is to include a minimum standard limiting the number of exclusions and restrictions, it may require legislative change/replacement of the CHIP. • Timeframe for implementation may be shorter than Approach 1.
Would the approach impact premium levels (within and across market segments)?	Yes • PHA estimates premiums for Bronze products would be approximately 20% higher than basic entry-level hospital products currently on the market (around $250 higher for a single adult policy), *ceteris paribus*. • Impacts on premiums for mid and top tier products not modelled.	No modelling undertaken at this time, as approach requires further development. • A minimum standard limiting the number of exclusions and restrictions permitted for Bronze cover may increase premiums for entry-level products.
Would the approach impact private health insurance participation?	Likely There is a significant risk that price increases for Bronze cover may result in a reduction in participation.	No modelling undertaken at this time, as approach requires further development

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Minimum product standards

The Government has indicated it will seek to "*weed out junk policies by ensuring consumers have access to a product with a mandated minimum level of cover*" (2016 Election media release, 12 June 2016). The Committee will need to consider how to incorporate this objective into a product design and classification system. A number of issues related to this matter are discussed below.

'Junk' products

The issue of low-value private health insurance products, referred to by some as 'junk' policies, has been a significant point of contention. There is no clear definition of what constitutes such a product. Some stakeholders have attempted to identify the types of products they consider fall within the definition of 'junk' and the action required to remove them from the market. For example, Choice has recommended the following action in relation to such products.

Choice suggestion to address 'junk' insurance

4. Junk insurance

a. Two types of policies fall into this category:

- Public hospital insurance policies
- Very low cover health insurance policies covering less than 10 MBS items (often including accident cover)

b. Public hospital insurance policies cover treatment in public hospitals only and some items may be fully excluded. This insurance does not relieve usage of the public health system in a meaningful way and therefore should not be entitled to a tax rebate.

c. Very low cover health insurance, including 'accident policies', exclude the majority of treatments and only cover a small number of treatments in private hospital. This insurance is problematic as consumers are often unaware that their policy excludes the vast majority of treatments. Like public hospital policies this insurance does not relieve usage of the public health system in a meaningful way and therefore should not be entitled to a tax rebate.

Source: Choice briefing note (September 2016)

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Low-cost, entry-level products often allow younger healthier people to take out an affordable insurance product that enables them avoid the Government's private health insurance incentives (penalties) of the Medicare Levy Surcharge and Lifetime Health Cover. The contribution these policies make to the Risk Equalisation Pool, cross-subsidising higher care costs for older and sicker people, is a factor which contributes to the viability of Australia's community-rated private health insurance system.

Changes which significantly raise the cost of entry level products could result in people dropping their insurance. Large scale falls in membership would result in a scenario that would require the remaining insured population to make increased contributions to the Risk Equalisation Pool via increased premiums.

Appropriateness of current minimum product standards

The minimum level of cover that insurers are permitted to offer is regulated by Australian Government legislation. The *Private Health Insurance Act (2007)* sets out the minimum coverage that a Complying Health Insurance Product (CHIP) 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).

A range of stakeholders (including consumer groups, insurers and private hospitals) have indicated that the current minimum product standards are no longer appropriate or adequate and should be changed.

PHA's product design model proposes that the current minimum product requirements for CHIP be replaced by its 'Bronze' minimum level of cover. This would involve the removal of the CHIP requirement for insurers to cover psychiatric care, palliative care and rehabilitation services. Minimum product requirements would instead be defined as a 'Bronze' product covering: chemotherapy/radiotherapy; ear, nose and throat surgery; brain surgery; palliative care; and a selection of other general surgery procedures.

The Committee will need to carefully consider the implications and 'optics' of changing or removing any of the current mandatory services from the minimum cover requirements. Previous discussion by the Committee identified that the potential removal of psychiatric care from the minimum 'bronze' category of cover, as proposed by PHA, is likely to be a contested change. The Committee recognised that many existing entry-level products place significant restrictions on psychiatric services. Formalising an arrangement to regulate for the removal of psychiatric services could be viewed by consumers as a 'backwards step' rather than an improvement.

The Secretariat is currently examining Departmental data to identify the number and types of psychiatric services currently funded through private health insurance (including the severity of these episodes). The Secretariat intends to provide analysis of this data to the Committee at its December 2016 meeting.

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'Sub-bronze' products

The Committee will need to consider whether, under a new product categorisation regime, insurers should be permitted to issue products that do not meet the bottom tier product category requirements (i.e. 'sub-bronze' products).

While some stakeholders have called for low-value products (such as 'public hospital only' policies or products which exclude a majority of hospital services) to be prohibited, others have instead suggested that changes be made to the Australian Government's private health insurance incentives[1] to discourage consumers purchasing such products. For example, hirmaa, the Consumers Health Forum and Choice have suggested that the Private Health Insurance Rebate not apply to such products. These stakeholders consider that the removal of the Rebate from such products would drive insurers to close down non-complying products, as they would become uncompetitive with products eligible for the Rebate. An alternative position is for the Government to regulate so insurers would be prohibited from offering any products lower than the 'Bronze' standard.

The Committee needs to consider whether direct action, such as prohibiting 'sub-bronze' products, is preferable to indirect action, such as removing the Rebate from these products.

[1] There are three Australian Government incentives in place to encourage participation in private health insurance:
1. The Private Health Insurance Rebate which subsidises consumers' premiums.
2. The Medicare Levy Surcharge is imposed on higher income earners who do not hold appropriate hospital cover.
3. The Lifetime Health Cover loading encourages people to take out hospital insurance by the age of 30 and maintain it.

Contracting arrangements

The Committee may wish to consider whether the introduction of Gold/Silver/Bronze categories of cover may lead to a scenario where insurers are less likely to contract with providers leading to negative impacts for consumers.

Presently, the majority (97 per cent) of private health insurance funded separations in private hospitals are paid under contractual agreements between insurers and hospitals, with only a small proportion paid through the second-tier or minimum default benefits. This would suggest that the current market environment has resulted in a situation where, in general terms, most insurers typically have contracts with most hospitals.

A new product classification regime may create perverse incentives for insurers to 'game' the system by changing the way they contract with hospitals. For example, an insurer may issue a product providing sufficient coverage of clinical services to earn a 'Silver' or 'Gold' product rating, but in the interest of minimising its benefit outlays, chooses to limit the number of hospitals it contracts with, or only contracts for selective procedures. This would lead to consumers purchasing 'Silver' or 'Gold' products that hold limited value because they would be liable for large out-of-pocket expenses at most hospitals they may seek to receive treatment. At the extreme, it may also result in the policy only being able to be utilised in public hospitals.

The average consumer is likely to expect that by purchasing a 'Gold' product they will have access to a comprehensive range of services, and that the product will limit their exposure to significant out-of-pocket costs.

Under current arrangements, having top cover does not provide a guarantee that a patient will not have any out-of-pocket costs if they require hospital treatment. The level of out-of-pocket costs that a patient faces is dependent upon a range of factors including contracting or preferred provider arrangements and the charging practices of doctors.

The Committee is asked to consider whether new products would reduce incentives for insurers to contract in such a way as to negatively impact consumers, and identify if this is an issue that requires special consideration in designing a new product design and categorisation system.

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Number of product tiers

The Government's election commitment suggests the new product classification model will take the form of a three-tiered, Gold/Silver/Bronze system. However, some members have noted that the ideal solution may not be a three-tiered model. The Committee has agreed it would be open to consider alternative models such as a two-tiered system if this proved more workable and beneficial for consumers. The Committee is asked to give further consideration, and if possible, reach agreement on this issue.

Table 2 over the page lists some of the 'pros' and 'cons' associated with two or three tiered product categorisation approaches.

Table 2: 'Pros' and 'cons' of two and three tier product classification arrangements

No of product tiers	Pros	Cons
Two tiers	• Potentially easier to define two categories, rather than three. • Historical precedent exists for having two categories. Previously policies were either: ○ basic, covering cost of treatment in a shared ward; or ○ supplementary, covering the cost of single room accommodation and other charges made by private hospitals.	• Unlikely to meet political expectation for three tiered Gold/Silver/Bronze system. • Base tier is likely to have a large number of highly diverse products which would increase complexity for consumers. • Potentially may limit consumer choice for products covering different personal/family health needs. • Potentially limits consumer choice of different products at different price points.
Three tiers	• Provides more transparency for consumers. • Potentially provides more certainty around services covered.	• Defining Silver and Bronze categories will be particularly challenging (gold is theoretically easy if it provides coverage for all services).

Out-of-pocket charges and gaps

For consumers, a significant concern commonly raised is the level of fees charged by doctors. These concerns relate to both the actual out-of-pocket-costs that patients face following treatment and a lack of informed financial consent by patients prior to treatment. One option could be to expand no gap or known gap arrangements. However, any such expansion would lead to medical price inflation, in turn, increasing premiums for consumers.

Legal constraints and the overarching structure of the Medicare Benefits Schedule prevent the Government from determining fees charged by individual practitioners. As such, there are few regulatory options available to Government in this area.

While the issues of product design and out-of-pocket expenses are related, out-of-pocket expenses encompass a range of factors and considerations beyond product design. The Committee has agreed under the work plan to examine the issue of out-of-pocket expenses in late 2016. At that time, the Committee may wish to give consideration to industry-led changes or initiatives that could be introduced through greater cooperation of industry players to deliver sustainable outcomes which benefit patients.

Standard clinical terminology

The Committee has agreed that the development of standard clinical terminology will be a critical element of any new product design and categorisation system. The development of standard clinical terminology will be a complex and potentially time consuming task requiring specialist input, including from clinical experts. For this reason, the Committee has agreed to establish a Standard Clinical Definitions Working Group to take this work forward and report back to Government by July 2017.

Accordingly, it would be appropriate for the Committee to focus its efforts at this time on preparing advice on the overarching design principles and structure of the product design and classification regime. Operational details for the scheme, including standardised clinical terminology will be able to be incorporated into the proposed model at an appropriate point in the future.

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General treatment (extras)

For many consumers, general treatment cover is often the most frequently utilised (and valued) component of their health insurance. For this reason there is likely to be a political and community expectation that the new categorisation arrangements will also apply to general treatment products. However, to this point, the Gold/Silver/Bronze product classification concept has primarily been considered for application on hospital products.

Some members, acknowledging the complexities that will be involved in developing a new product classification scheme, have suggested that it would be appropriate to defer work on the development of product arrangements for general treatment cover until a hospital product classification scheme is developed and bedded down. While there is legitimacy to this point of view, noting the political and community expectations, the Chair and the Secretariat recommend that the Committee agree to include reforms to general treatment in its advice to the Government on a new product classification scheme. The Committee will need to come to a decision on this.

Possible approaches for categorising General Treatment cover

The Private Health Insurance Ombudsman presently categorises general treatment products into one of three categories: Comprehensive, Medium, and Basic. The criteria used for categorising general treatment products are at Attachment C. The current approach is based on the scope of services covered, and for comprehensive cover, level of benefits paid (where insurers must pay average or above industry average benefits for major dental, endodontic and orthodontic services).

PHA has explored a potential product classification approach for general treatment cover based on the current product categories. This potential approach is at Attachment D.

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Combined products

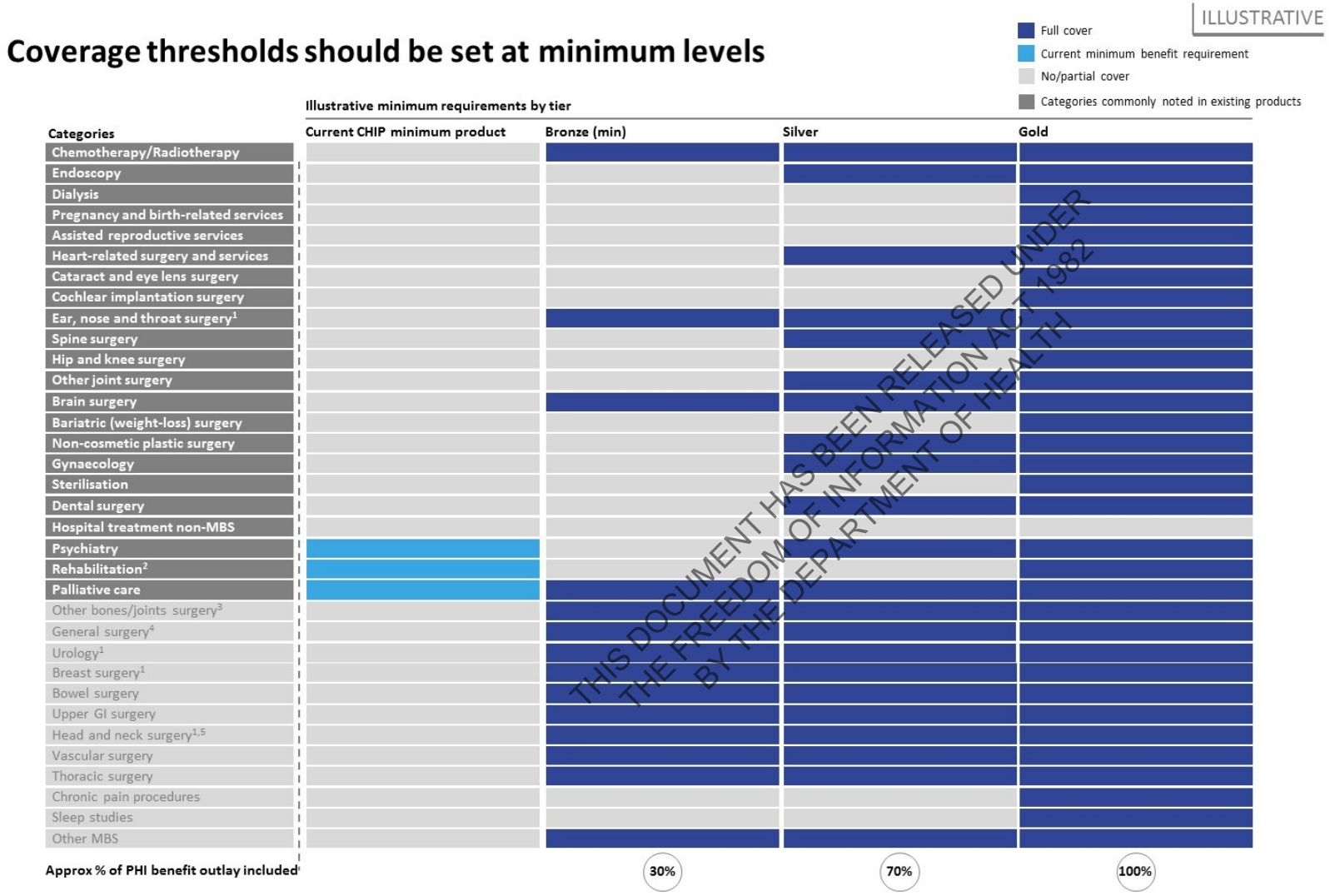
Should the Committee agree that the product classification scheme will extend to general treatment; an issue that will need to be addressed is how the arrangements should treat combined products (i.e. policies covering both hospital and general treatment). It appears that there would be two possible approaches that could be taken for combined products:

1. modular rating arrangements – for example a consumer may be able to purchase a 'Gold Hospitals with Bronze general treatment' product; or
2. combined product rating arrangements – for example a product offering may be a 'Silver Hospitals and general treatment' policy.

The first option would provide more flexibility for insurers and consumers, while the second option may serve to limit the range of products which could be offered (noting consumers could still purchase separate hospital and general treatment policies if they wished).

Attachment A

Private Healthcare Australia: possible Gold/Silver/Bronze classifications (Hospital cover)



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1 Should include reconstruction MBS items where reconstruction is a direct consequence of the initial surgery required
2 Rehabilitation to be included as part of the required care from providers for related episodes of acute care
3 Includes cover for fractures, hand surgery, tendon surgery and other miscellaneous orthopaedic MBS item numbers
4 Includes appendicectomy, hernia repair, haemorrhoid surgery, and gall bladder removal
5 Includes traditional head and neck surgery, thyroid surgery, jaw and maxilla surgery
SOURCE: HCP data collection 2014-15, Health fund data

Attachment B

Product design and categorisation approaches not being pursued

Approach	Issues
Standard products	• Would have a substantial regulatory impact for industry and would constrain product innovation.
Age-based Gold/Silver/Bronze categories	• Would substantially increase complexity, particularly from an actuarial perspective, including developing policies for diversity of family groups.
Strengthening the current product classification system (i.e. Private Health Insurance Ombudsman categories: Top, Medium, Basic and Public Hospital Cover)	• Unlikely to meet community and political expectations for new and simplified categories of cover.
Financial metric (e.g. Percentage level of benefits paid by insurer)	• Difficult to implement enforceable caps on specific medical providers' bills. • Depending on how the base level of expenses is calculated this approach could require major regulatory changes and a shift in the way in which insurers and hospitals contract, and could have inflationary impacts.

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Attachment C

PRIVATE HEALTH INSURANCE OMBUDSMAN – CURRENT CATEGORIES OF 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.

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Attachment D

Private Healthcare Australia: possible Gold/Silver/Bronze classifications (General Treatment cover)

For general (extras) products, classifications of basic, medium and comprehensive coverage could be used as a starting point

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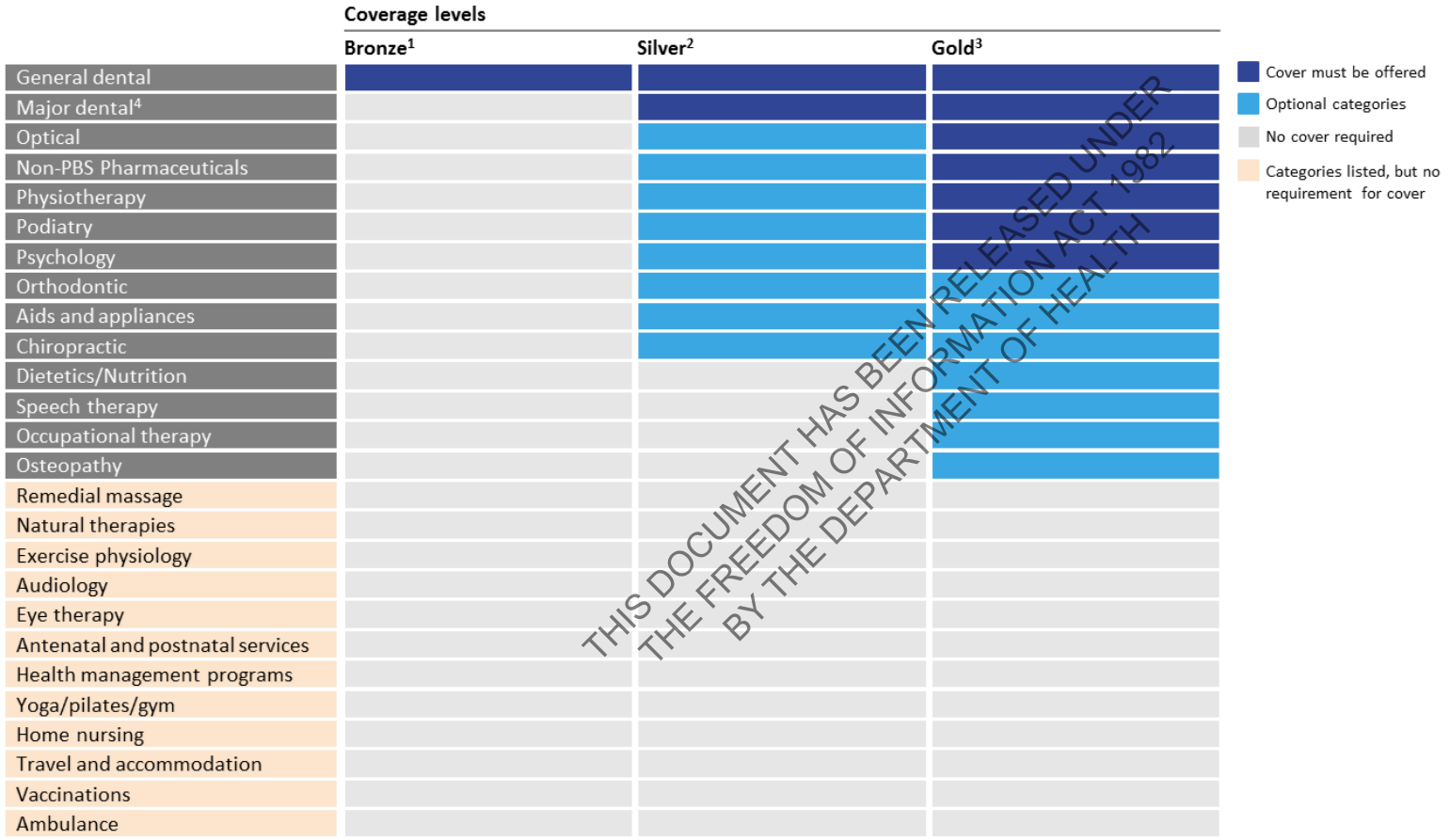

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1 Current privatehealth.gov.au classification has no fixed criteria for a 'Basic' product
2 Must include 5 of 8 additional categories, categories should be made available to consumers, but consumers could have the ability to 'opt-out' of cover for alternative coverage
3 Must include 3 of 7 additional categories, categories should be made available to consumers, but consumers could have the ability to 'opt-out' of cover for alternative coverage
4 Includes endodontic

SOURCE: Privatehealth.gov.au; health fund product analysis