31 May 2024

Via email: PHIconsultation@health.gov.au

Catholic Health Australia Submission: Annual Private Health Insurance Premium Round

Catholic Health Australia (CHA) would like to thank you for the opportunity to provide feedback on the annual private health insurance premium round. CHA, our members, and the broader private health sector share significant concerns regarding the viability of private hospitals and the private sector. Recent closures are diminishing access to care, particularly for regional and rural communities, and are shifting burden onto public hospitals and taxpayers. On top of this, there is a considerable program of reform being imposed upon hospitals that, whether intentional or not, adds further financial and administrative burden onto the sector, including underfunded costs for each hospital entity impacted by compliance with the Security Legislation Amendment (Critical Infrastructure Protection) Act 2022, as well as imposing additional unfunded compliance associated with the Prescribed List.

The primary purpose of the private health sector is to provide value and choice to patients while alleviating strain on the public sector. Furthermore, the Catholic health sector has consistently supported the health and wellbeing of individuals who often have no other means of accessing care. These purposes are under threat. The existing regulations overseeing private health services are not fit-for-purpose, with some insurance profits flourishing while hospitals continue to close and patient access deteriorates.

Premium round offers a unique opportunity to address these issues. It provides an annual review platform to ensure accountability is being appropriately shared by health insurers, decision makers, and hospital operators to address the challenges collectively facing the sector and to make thoughtful, sensible, and measured updates accordingly.

We look forward to continuing to work with government, the community, and the sector to enhance premium round and consider the sustainability of the private health sector as an important pillar of Australia's health system.

If you wish to discuss anything further, please contact Dr Katharine Bassett, Director of Health Policy on 0420 727 709 or at katharineb@cha.org.au.

Yours sincerely,

Jason Kara
Chief Executive Officer
Catholic Health Australia

Dr Katharine Bassett
Director of Health Policy
Catholic Health Australia

Catholic Health Australia

Submission: Annual Private Health Insurance Premium Round

May 2024

Catholic Health Australia
www.cha.org.au

Catholic Health Australia (CHA) is Australia's largest non-government grouping of health, community, and aged care services accounting for over 15 per cent of hospital-based healthcare in Australia. Our members operate hospitals in each Australian state and in the Australian Capital Territory, providing about 30 per cent of private hospital care and 5 per cent of public hospital care in addition to extensive community and residential aged care. CHA Members also provide approximately 12 per cent of all aged care facilities across Australia, in addition to around 20 per cent of home care provision.

CHA not-for-profit providers are a dedicated voice for the disadvantaged which advocates for an equitable, compassionate, best practice and secure health system that is person-centred in its delivery of care.

Overview

The primary purpose of the private health sector is to provide value and choice to patients while alleviating strain on the public sector. In recent years, the rules and regulations governing private health services have not sufficiently protected patients from service closures, which are on track to deteriorate further. The current system has neither prevented private health insurers from banking huge profits nor ensured an adequate flow of funding to struggling private hospitals.

Premium round offers a unique opportunity to address this. It provides an annual review platform to ensure accountability is being appropriately shared by health insurers, decision makers, and hospital operators to address the challenges collectively facing the sector and to make thoughtful, sensible, and measured updates accordingly.

Process and timeframes

1. *Suggested changes to the administration of the premium round, including the timelines and process for the 2024 premium round. For example,*
   a. *the timeframe by which insurers provide information to the department,*
   b. *the format of the approved forms,*
   c. *the date at which changes to premiums commence, and*
   d. *whether the premium year should be aligned with the financial year and PHI incentive policies (i.e. 1 July to 30 June) and, if so, how this transition would be managed (for example, via a transition year that included an additional quarter, such as 1 April 2025 to 30 June 2026, with following years being 1 July to 30 June).*

CHA has no specific feedback on the process and timeframes, other than in the 2024 premium round there was a delay between insurers being notified of premium increases and the increase being announced, delaying insurers being able to notify consumers.

Information

2. *Suggested changes to the content and format of the annual forum with private health insurers. The annual forum is typically held in August and is intended as an opportunity for the department to outline to insurers potential changes to the process and approved forms.*

CHA has no specific feedback on the annual forum with private health insurers.

3. *Whether it is necessary for all insurers to be required to offer and price every product in each risk equalisation jurisdiction.*

CHA has no specific feedback on whether it is necessary for all insurers to be required to offer and price every product in each risk equalisation jurisdiction. CHA however recommends that if insurers choose to offer at least one type of product in a particular jurisdiction, then all products need to be offered in this jurisdiction to support fairness, transparency, and uniformity in the availability and pricing of insurance products.

More broadly, the uniformity that was created through the Gold, Silver, Bronze, Basic classification reforms as part of the Private Health Ministerial Advisory Committee has eroded over time, with increasing

complexity and differences in insurance products. Furthermore, there are several instances where insurers have closed products and opened new products which are largely the same cover but with significant increases in cost,[1] which effectively prices these products out of the market and creates further complexity and confusion for patients. CHA recommends any endeavour aimed at examining product offerings in risk equalisation jurisdictions should also address these issues.

4. *In considering the information requested in the 2024 application forms:*
    a. *what information would be useful to collect from all insurers that is not currently collected, for example: actual benefits paid, premium revenue and management expenses for the previous premium year; out of pocket costs associated with products / product tiers; products that had been closed in the previous premium year,*
    b. *what information requires clearer definition / specification to ensure consistency and comparability, and*
    c. *what information is redundant and why.*

CHA recommends the following information be requested and **considered** as part of assessment:

- actual benefits
- premium revenue
- management expenses, including greater granularity regarding the makeup of insurer management expenses, as management expenses have been increasing year-on-year and there needs to be more transparency for policyholders and regulators regarding what these expenses are and why they have been increasing at a rate faster than benefits[2]
- overall annual insurer profits, as these have also been increasing year-on-year[3] and there needs to be more transparency for policyholders and regulators, particularly amidst rising insurance premiums and private hospital viability concerns
- out-of-pocket costs associated with products/product tiers, which would enable improved transparency regarding the affordability and accessibility of health services
- products that had been closed in the previous premium year (including the cost), and what new products have been released (including the cost), as (as outlined above) insurers are closing products and opening new products which are largely the same cover but with significant increases in cost (i.e. more than the specified annual premium round increase).[4]

---

[1] CHOICE (2024). *Health insurers are increasing their top-level policy prices by over 30%.* Retrieved 09/05/2024 from: https://www.choice.com.au/about-us/media/media-releases/2024/feb/gold-cover-sneaky-tactics
[2] Australian Medical Association (2024). *Where do your private health insurance premiums go?* Retrieved 26/05/2024 from: https://www.ama.com.au/media/patients-cop-brunt-private-healths-soaring-management-expenses
[3] Australian Medical Association (2024). *Where do your private health insurance premiums go?* Retrieved 26/05/2024 from: https://www.ama.com.au/media/patients-cop-brunt-private-healths-soaring-management-expenses
[4] CHOICE (2024). *Health insurers are increasing their top-level policy prices by over 30%.* Retrieved 09/05/2024 from: https://www.choice.com.au/about-us/media/media-releases/2024/feb/gold-cover-sneaky-tactics

Catholic Health Australia

5. Whether the application process should provide for a formal presentation by each insurer of its application to the department and if so at what point in the process.

CHA supports any activities that will provide the Department with more transparency throughout the premium round process and opportunities to seek further information from insurers. CHA has no specific view on when this should occur in the process.

Assessment

6. The key metrics, measures or criteria that should form part of the assessment of each private health insurer's applications including for:
   a. premium and investment revenue returned to policy holders including through agreements with private hospitals and other health providers and to limit out of pocket costs,
   b. nature, extent and financing of proposed discounting allowable under the Act,
   c. assessing insurer capital, including target capital in addition to the Prescribed Capital Amount, and
   d. savings associated with prostheses reforms.

See response to question 4 for metrics that should be considered as part of the assessment.

7. The value of comparing insurers' forecasts from previous premium rounds (including premium revenue, benefits paid, management expenses and net margins) with insurers actual results.

CHA understands that private health insurer applications to change premiums use forecasts. CHA recommends comparison of insurers' forecasts with actual results should be performed to identify where there are significant differences between forecasts and actuals and improve the process for determining annual premium round increases.

Transparency

8. Additional information the department could publish as part of the communication of the outcomes to the public (in addition to the currently published average insurer and industry premium changes). For example:
   a. average change by insurer, including by product type (hospital/general/combined/ambulance only), product tier (Gold/Silver/Bonze/Basic) and open/closed status,
   b. the range of percentage changes to individual policies for each insurer, and
   c. a short justification for the premium increases prepared by the insurer (with a draft to be provided in the application form).

CHA recommends the following information be published as part of communicating the outcomes to the public:

- average change by insurer, broken down by product type and product tier
- products that had been closed in the previous premium year (including the cost), and what new products have been released (including the cost)
- the range of percentage changes to individual policies for each insurer

- the information categories that were considered by the Department as part of the assessment process (i.e. not the specific data, but just what was requested from insurers as part of the application process)
- a short justification for the premium increases prepared by the insurer.

Additionally, financial and membership data that is considered as part of the application process should also be published or referenced as part of communicating the outcomes (noting that some of this information is also published by the Australian Prudential Regulation Authority) to ensure complete transparency. As outlined in Question 4, this should also include communication of overall insurer profits for the previous premium year.

Other

9. Feedback on the impact any current PHI incentives or regulations have on the process, available information and assessment of premium round.

Given the significant cost pressures private hospitals are facing (with decreasing funding from health insurers and increasing costs of delivering high-quality care), CHA recommends the following:

Depoliticise the premium round application process

The cost pressures faced by private hospitals must be integrated through an external cost model to ensure premium increases account for hospital cost pressures. While data relating to cost pressures have been provided by hospitals in the past as part of the premium round process, this process has been *ad hoc* with poor clarity over how the data was considered as part of the application process. CHA recommends a formalised and standardised approach to integrating hospital cost data into the premium round process, with transparent pathway of how this advice is considered with equal weighting to other contributions. If hospitals are to provide cost data, this process must be well designed and resourced, with a formal agreement on how commercially sensitive information will be collected, stored, and used.

The annual DVA cost report[5] would be a simple and sensible first integration into premium round of the cost pressures private hospitals are facing. CHA can provide further insights on refining cost weights, such as agency staff in the wage cost category. Even when considered as is (acknowledging that it focuses on historical cost impacts rather than forecasts and therefore would require adjustments for anticipated changes in costs for the upcoming year), the report offers a robust, evidence-based, independently generated annual overview of cost pressures in private hospitals. Additionally, it is available for no cost or administrative burden. This report could be considered as part of the premium round each year, with funders expected to reference it within their application, explaining how they will ensure health service providers are sufficiently reimbursed to meet these accepted cost pressures.

CHA believes that there needs to be evolution of the Ministerial involvement in premium round. The Minister for Health and Aged care should be setting the parameters and principles (such as affordability, value for money, sector wide sustainability, sector efficiency) that guide an independent and objective private health sector pricing process. This pricing process could be entrusted to an independent panel/body (such as the

[5] KPMG. 2023-24 Private Hospital and Day Procedure Centre Cost Indexation Report. Department of Veterans Affairs. 24 March 2023.

Independent Health and Aged Care Pricing Authority (IHACPA)) that could, in their decision-making process, take into account the evidence and data across the sector (i.e. not just insurers) to deliver better outcomes for patients, hospitals, and funders. This could include considering changes, challenges, and issues in the sector that will have an impact on the sector (for example, the requirement for private hospitals to increase award wages for nurses, midwives, and assistants in nursing if the Australian Nursing and Midwifery Federation's application to the Fair Work Commission is successful). The Australian Prudential Regulation Authority would continue to contribute financial solvency analysis, but additional inputs would ensure the independent panel/body are also able to consider the financial solvency of the service providers delivering the services funded, and therefore ensure premium setting is delivering patient access to services and value.

While delivering a more robust premium round in the short-term, this would also lay the groundwork for a careful and considered longer term move towards an independently set, nationally consistent, activity-based funding model for private hospitals. A key aspect of this reform would see an independent pricing body, such as IHACPA, determine a National Efficient Private Price for private health services. This price would be determined based on cost data provided by private health providers, meaning that price growth would mirror cost growth, similar to what has been the case for public hospitals over the past decade.

Directly link premium indexation approval to the level of benefits paid

Data from the Australian Prudential Regulatory Association shows that the industry is failing to meet its own gold standard of returning 90 per cent of premiums to patients,[6] with only 83 per cent of premiums returned to patients in 2022–2023. Of the top ten health insurers (in terms of premium revenue), all failed to meet this standard (Table 1), with Bupa, nib, Australian Unity, Defence, and GMHBA providing the worst value for consumers. Over the last five years, the proportion of premiums returned to patients has largely been declining year on year (Figure 1).

[6] In their submission to Senate Inquiry into Private Health Insurance Legislation Amendment Bill 2018 and related Bills, the Members Health Fund Alliance, which represents 26 health insurers, said *"Members Health funds are unashamedly customer centric in their ethos. They return on average around 90 per cent of all premiums paid, back to policyholders, as benefits. This is in contrast to the for-profit insurers, which operate primarily for the benefit of shareholders and return on average around 85 per cent."*

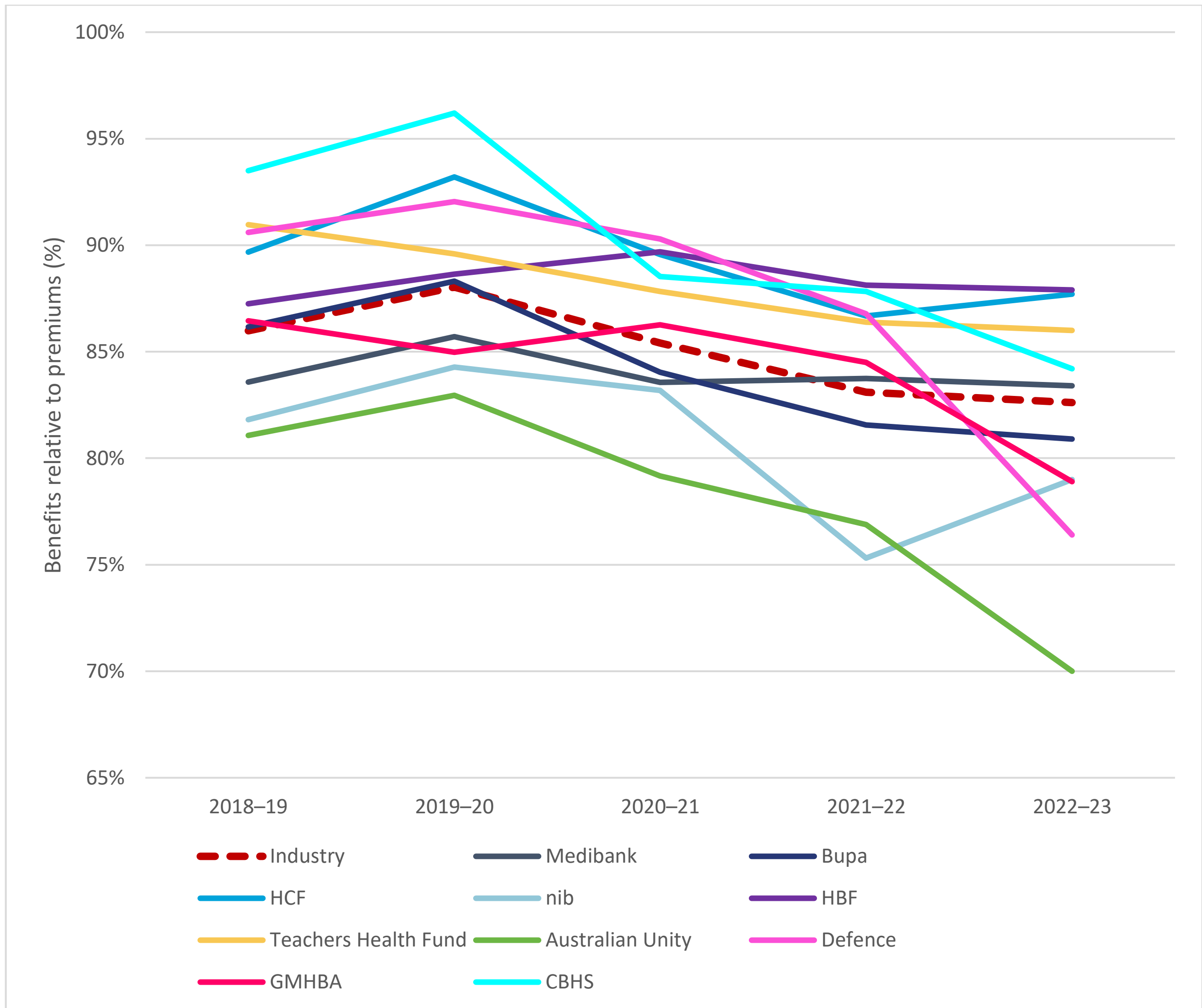
Table 1: Premium revenue and benefits paid to patients, 2022–23

	Premium revenue (billion)	Benefits paid (billion)	Benefits relative to premiums
Medibank	7.0	5.8	83.4%
Bupa	6.6	5.4	80.9%
HCF	3.7	3.2	87.7%
nib	2.4	1.9	79.0%
HBF	1.9	1.7	87.9%
Teachers Health Fund	0.9	0.8	86.0%
Australian Unity	0.7	0.5	70.0%
Defence	0.7	0.5	76.4%
GMHBA	0.6	0.5	78.9%
CBHS	0.5	0.4	84.2%

Major health funds (~50% of the market)

Catholic Health Australia

Figure 1: Benefits relative to premiums, 2018–19 to 2022–23



Coupling premium indexation approvals to the transparent reporting of direct increases in benefits paid to patients and hospitals would deliver a formal and easy to implement incentive for funders to return at least a minimum level of funding to health service providers and patients. This offers a simple short-term fix to improve funding flows to service providers and could be achieved by establishing threshold tiers that are expected to be met to achieve a premium increase above a specified level. For example, key metrics could include:

- benefits returned to patients through services
- management expense ratios
- money spent on sponsorships etc.

Funders with the lowest returns to patients and hospitals would then only quality for a limited increase in premiums the following year (X per cent), while those with the highest returns would quality for the maximum (Y per cent) increase in premiums the following year.