Actuaries Institute Podcast – Green Paper – How to Make PHI Healthier
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Vanessa: Hello, and welcome to the Actuaries Institute podcast. I'm Vanessa Beenders. I'm the Practice Excellence Advisor as part of the Public Policy team at the Actuaries Institute. Today, I'm joined by Bevan Damm, an Actuary and financial services partner at EY, and Matt Crane an Actuary at EY working as a senior manager. Together they co-wrote the latest Green Paper for the Actuaries Institute on private health insurance. It's called How To Make Private Health Insurance Healthier. Today they join me to discuss their research and key messages in the paper.

Bevan and Matt thank you for joining me.

Bevan: Thanks Vanessa. It's great to be here.

Matt: Thanks Vanessa, and it's great to be here.

Vanessa: The paper does a great job at highlighting how complex private health insurance is, or PHI. For the listeners who are not familiar with the workings of PHI, can you summarize for us please, Matt? That complexity and why it exists?

Matthew: Thanks Vanessa. I think the main reason it's complicated is because it's one of just three ways that health services are funded in Australia. So obviously the government pays quite a lot of money towards it, through your Medicare rebates and so on. Also, individuals have to pay for a lot of services themselves and out of pocket costs and finally there's health insurance that pays the money too. So, if you're somebody that needs to access health services in Australia, typically you're being funded in all three of those ways so that makes it very complicated to understand what the health insurance contribution is and sort of the relative size of it compared to the other parts. And often when you're left with a large out of pocket cost yourself, you wonder why doesn't health insurance cover that.

There's defined regulations that set where the boundaries are, of what the government will pay for and what health insurance will pay for and it gets really hard to understand the way they interact. In the end, health insurance only pays about 9% of the total costs of the health services in Australia.

Then once you get into health insurance itself, it's also complicated. It's community rated, which means that everybody pays the same price for the same product and so that can be hard to understand, and then obviously you need more people that are unlikely to claim just to keep the average premiums down, so you've got to find ways of getting those people to buy health insurance and in Australia, just to make things even more complicated, it's not mandatory, it's voluntary. You've got that choice of whether you buy it or not, so to get around that, the government has got a variety of different incentives and Medicare levy

surcharge, there's a rebate, and lifetime health cover, they're all different, complicated, tax-related add-ons that make it even harder to understand health insurance.

And then yet complexity doesn't stop there. Once you're insured with health insurance, there's a thing called risk equalization which is the way that risk is shared around the industry. So risk equalization is a way of just sharing that around so they make sure that insurers do cover the more risky people.

Vanessa: PHI is an area of insurance where more so than most areas of insurance, there are strong philosophical views about its role and merits. In fact, this adds to its complexity that you've just described there Matt. Bevan, can you please talk us through the different viewpoints?

Bevan: Thanks Vanessa. So, we really focused the paper around how to make private health insurance work better. But if we do take a step back and talk about those philosophies, one is certainly that there should only be one system and that's the public system, and that the public system can handle all things and provide everyone with appropriate care based on the priorities of their needs. But what that doesn't talk to is, first of all, if some people can afford to pay more, should they be asked to pay a bit more and really the current system does some of that through some of the pieces that Matt mentioned, Medicare levy surcharge for example.

The other piece of that is if it means that someone can be treated sooner and not necessarily need to ever come into the public system, does that also mean that other people who have greater needs in the public system can also access those services without the impasse of, while it might've been a higher priority, someone who could've paid for their services outside of that system, not even coming into the system.

So, there are different philosophies around that, but our paper really just focuses on how can we make the existing private health system better, to improve outcomes and the perception of private health insurance industry as well.

Vanessa: So, against that backdrop, the Institute commissioned this paper on the basis that PHI's role in the overall healthcare system more or less stays the same. The Institute has done so because PHI has been a part of the Australian healthcare system for a long time and overall healthcare system outcomes are generally high-ranking by international standards. Given that, as a very important starting point, what have you identified then as the key issues with the current system that need to be addressed? Thanks Bevan.

Bevan: Thanks Vanessa. So one of the key things we identified was lack of ability for a patient to choose, first of all, what's the right care and how to get to that right care and who should be providing that care for them. So typically when someone's sitting with their GP, they've identified something needs to be done, fixed, operated on, that there's a specialist going to be involved, they may be at

hospital at some point, but from then on, the GP doesn't really have all the information to make the best choices.

So quite often their choices may be limited to where do you want the surgery, what hospital do you want to be operated on, and then, "Well, I know these two surgeons at this hospital," but it doesn't talk to what's the cost of the surgeon or what's the out of pocket that person is going to be faced with [and also] what's the average outcomes for that kind of surgery with particular surgeons.

From a consumer perspective, if they think they're going into that process and they've got health insurance, and then they discover that there's a significant portion of the surgeon's fees that aren't covered by health insurance, whether it's because the surgeon didn't use the access gap cover or the gap cover that the health insurer had agreed to, or the surgeon charged fees at such a level that the regulations that are in place actually prevent the health insurer from paying anything above 100% of the Medicare benefits schedule and so both those complexities, you would never expect a consumer to even understand those, walking into that environment. So, who can actually help them? A GP actually won't be talking about those elements because they're related to the funding and to the health insurance. The GP will be trying to navigate where should you go and who should do it, which is the second part, and how does a GP make those decisions.

So, that's really one of the key issues that was identified through this process.

Vanessa: Thanks. Matt, did you want to add anything?

Matthew: There are also problems in terms of when you're actually buying health insurance, the main one obviously being the cost and that's certainly something that we see a lot of every first of April, and regularly in the media in between. It's not too much of a surprise to Actuaries working in health insurance that the costs go up as much as they do, but it's probably something that's not as understood as well around the community.

Something like 85% of premiums cover claims, and so it’s a big chunk of the cost and they do go up quite high each year, and the main reasons for that is, as well the actual costs per service which go up higher than inflation because of the labor component of that cost and also improving technology meaning that the average pitch cost of each service increases more than your general CPI. There's also the volume of claims, so the average premium reflects the average amounts of times people actually claim. And that's got a couple of aspects to it as well, partly because we're an ageing population, the average person gets a bit older each year and so they claim a bit more as they get less healthy in older age and also for people within a given age-span, we're seeing an inflationary component, so that might be driven by their general health or expectations around the types of services they maybe want to see.

So, we're seeing lots of different components of inflation, all of which add up to something like 5 or 6% under the surface, and so insurers need to deal with this.

Vanessa: From a policy holder's point of view, they're seeing wage rises which are short of that amount obviously, so this feeds into the affordability problem that you've identified.

Matthew: Well that's exactly right. If we do nothing, the costs will have to go up more than wage increases and it's going to just become less affordable and then community rating, which I talked about earlier, is just going to compound the issue. So, the fact that someone who's unhealthy pays the same as someone who's very healthy means that that healthy person is going to start to question more and more, "Why should I keep buying this thing when it's going up by so much?" And so, they'll drop out, and just the very fact they've dropped out will in and of itself push up the average claims cost even more. So, it's a bit of spiral unless we do something about it. The challenge is how do we find parts of claims costs that we're covering that are inefficient and potentially target those to reduce them and there's a few areas that we've talked about in the paper that may lend themselves to a reduction.

Vanessa: Just to explore one more of the problems that you've identified in this paper here, Bevan and Matt, it's about changing pathways for treatments. So more modern forms of care can often involve more treatment out of a hospital than they used to in previous years. Can you just elaborate on that for a bit for us please?

Bevan: The key issue there is traditionally health insurance used to be a private hospital kind of process with a surgeon. But what's been identified is some of those procedures don't necessarily need to be made inside a private hospital anymore. So then the next step was day surgery hospitals, but the subsequent step after that is actually in the providers' rooms and so the issue here is the specialist may say, "Actually it's going to be a better outcome for the patient if I can do it in my room. It's quicker, it's a simple procedure, it doesn't really need all the process of going to hospital or a day surgery.

However, the flip side of that is health insurance isn't then paying for that service. So, it actually becomes a differential for the customer who's bought their health insurance thinking they're going to be covered. They're undergoing surgery by a surgeon but not in a hospital. The issue then is well, how do they feel about that? Are they actually happier to go in to a day surgery process or are they happy to pay more out of their own pocket? It might actually be several hundred dollars more or a bigger difference like that to have it done there and then. The surgeon obviously would prefer that because they're going actually, "I can probably treat more people. I can change my operating model to actually do some more days in my own surgery where I can line these up to be quicker." Better recovery, better outcomes, but really the system hasn't really kept up with that.

Vanessa: So that's a lot of issues that both you, Bevan and Matt, have just taken us through, that you've identified in the paper. But thankfully you don't leave us with

just problems, you have started to think through potential solutions. And you've put them into five broad categories, so if we can just go through each of those categories, what they look like, and any issues that you foresee with implementation and we'll take them one by one.

So the first one, Bevan, is enable better choices between treatment options and fees. What's that one about?

Bevan: So, it really comes back to the point of sitting with your GP, working out that you need something. What's missing is a tool for someone, now whether it's the GP or whether it's a care coordinator, to actually help guide the patient through, "Actually, medically, these are the best choices, then you've got the financial considerations of this, what choice do you want?" But at the moment, you end up going from the GP to the selected surgeon. You see the surgeon two months later because that's how long the queue was to get in, and the surgeon will go, "That's fine. You're in now, my process takes… we can be operating next week and here are my fees." Well at that point the patient really has little choice.

They've either got to queue up for another two months with another surgeon or say, "Okay, thanks, and we'll go ahead." And the fees just become, "I have no choice." And it turns out the health insurer may not have choice about what they pay, depending on what the doctor's charging. So, that piece is really missing. It's not clear where the answer lies, but certainly the GP is very well placed to help advise patients. Alternatively, a care coordinator or something like that, that may be funded by the health insurers, but independent to the health insurers, could also support that process.

Vanessa: Your other suggestion is greater transparency then around the costs and the outcomes.

Bevan: First of all, the costs would be known upfront or at least the decision could be made around expected cost. But part of that is also if there was an outcome type of measure that was available for the GPs, now of course that is a very challenging area. Different surgeries historically and different surgeons may take on higher or lower risk cases and all of that needs to be considered, if there were some metrics around outcomes and that was put at the point where the GP was able to access that. But it certainly needs to be done in such a way that it is a fair treatment of the actual outcomes of our surgeries from the various providers.

Vanessa: The second category that you've identified is to incentivise insurers to reduce unnecessary claims costs. Can you elaborate on that one please?

Bevan: Yeah, so that's really a focus on the term "risk equalization," which has been alluded to earlier. The major challenge around risk equalization is if an insurer invests in creating an efficiency or identifying ... "This claims cost didn't need to be paid, it could've been done in a different way, more efficient way." Then whatever that investment was or the saving was that, that insurer identified was actually spread very quickly to the other insurers in the market.

So, what it means is the incentive for an insurer to be investing heavily in innovation and driving change, they're actually not getting the full benefit of that and it's quite diluted, quite quickly.

Risk equalization, as talked about in the paper, has been talked about by the industry for more than a decade. It's kind of in the hard basket, because if there's a transition to a new type of system, there's always winners and losers, whether that's a large or small amount. Typically it was relatively modest but certainly financial differences from the current system. But essentially why that can be talked about, again, now after a decade really, is because with the move to gold, silver, bronze and basic categories, now those are quite strongly codified and previously there wasn't any codification of different product levels.

Every insurer has to provide that level or they'll fund those services at the minimum. Now that there's a floor under each level of product, then really the natural flow of the risk equalization sub-pool becomes the gold, the silver, the bronze, and the basic.

So that's really why that's back on the agenda.

Vanessa: You talk about making it prospective and it's because of that consumer protection element, that it would be a fair thing to put back on the table.

Bevan: The prospective element is really a change in the technical way that pool operates. If you underwrite or you provide a policy to a high-risk person, now typically you might say that's an older person who's more likely to claim. Under the prospective system, you might get, "Here's 500 dollars for writing that risk." Full stop, they get the money when they write the policy. Whatever the claims are, that doesn't then impact that 500 dollars, so they keep that. So, if they save 100 dollars, they get to keep it. They might have invested to get to that 100 dollar saving. So, there's a one to two period where those numbers flow through the system and as insurers do save money, then that does spread to the other insurers over time. But it's a slower process to occur, so the incentive to be doing it is there for that initial period for each insurer.

Vanessa: Thank you Bevan. Matt, another one is target inefficiencies in the supply side of private healthcare services. What is that one about?

Matthew: Sure. So, this is about just trying to tackle the cost of a specific service. So, there's a few areas that lend themselves to at least a light being shone upon them. What the cost is, to identify areas where savings could be found. I think the main one is prosthetics and it's not a new idea, that's something the government and insurers have been already trying to reduce the cost, but it's still the case that the private healthcare sector in Australia pays a lot more for prosthetic items than the public system does. And also, on global standards, we're paying a lot of money for these things, so there's definitely still the opportunity to reduce the amount we pay for prosthetic items in private hospitals. We think at the very least there should be more of an investigation into it.

Other areas include administration fees and add-on fees and various other hidden fees that occasionally occur from specialists and also even if a buyer is inside the rules, perhaps so more transparency as we talked about earlier might just help compete away some of those excessive charges where they exist. Other areas in the public sector, when you go to a public hospital it's all in one place. Everyone works under the same roof and there's kind of a budget for all of their different costs, whereas on the private side of things you've got doctors, surgeons, the hospital accommodation, the prosthetic items, all very separate, all set in their own fees, without regard to the costs of the fees set by the other parts of the process.

Full on regulation around what that total cost should be, would possibly get to be a bit too extreme and we expect that would be met with some resistance, but we think at the very least getting these people to sit down together and sort of think through what the relative contributions of each is, could at least identify some areas where efficiency could be driven.

And the final one is just around linking the funding of services to the actual proven clinical outcomes. Again, not a new idea and something that some of the insurers are trying to work with hospitals in terms of the items they'll actually cover, but we think that more could be done again and a bit of a collaborative effort from both the medical profession and insurers, hospitals and the government, to really try and identify those types of procedures that work best and only funding those ones that really do drive the outcomes that the patient needs at the end of the day.

Vanessa: Great suggestions worth putting on the table. You've also put as another potential solution or area is to focus on the health of people that do have private health insurance. Can you elaborate on that one please?

Matthew: Well this is probably the most obvious of all of them. At the end of the day, if everybody was healthier, we would claim less the average cost of your premium would come down. So, it's not surprising, it obviously wouldn't be a surprise to the government that they should try to improve the health of the nation and obviously there are much broader benefits from doing so than reduced health insurance premiums, but nevertheless we think it's something that is super important, well worth including in our paper, and would be most effective from a health insurance perspective. If it was part of a broader push to get people exercising more and eating more healthily and so on. Then there's getting the more healthy people to join health insurance, which is always an uphill battle when you've got community rating, but the current sticks and carrots were designed and the formulas were calculated a few years ago, so it's something that always needs to stay on the radar and just consider whether they're doing the job they should be doing.

Other areas potentially offering additional benefits to try and incentivize younger and healthier people to join and so insurers are obviously thinking in this space a lot of the time, and the problem is that if you give someone an additional benefit,

you're going to have to fund it somehow. But we do see that people really value having something on their product that they can actually use as well as the coverage, and so we do think potentially in this digital world there might be areas where insurers can do a bit more, with a health platform and that kind of thing that younger people might really value and it might encourage them to take out health insurance, even if they don't expect to claim.

Vanessa: Thank you. The last one is about improving the perception of private health insurance. Thoughts on that or how that can be done?

Matthew: Well this one's not easy. I think it's just worth the whole private sector just taking a step back and realizing that they do already need each other, so if it wasn't for surgeons, private health insurers wouldn't have a product to sell. And at the same time, if it wasn't for insurers, there wouldn't be very many people that would be able to afford the cost of private treatment and hospitals of course obviously need surgeons to come and do the procedures that they do, so they do all need each other and so we do see a lot of finger pointing from within the sector. Perhaps it might be time for them to kind of get together and establish some kind of group that works through some of these issues for everybody's benefit.

I think insurers and generally the government can also do more just to promote the value of having health insurance. Too often we hear about the cost and the fact that people have had these products for many years and haven't claimed them and how that's not fair and that sort of thing but often the discussion gets lost around the fact that you're covered and if something did go wrong, you'd have had access to treatment quickly and some level of choice around who performs that treatment. There are parallels with other insurance industries where covered is the thing that's valued and not the fact whether or not you've claimed. So, there's certainly a lot more that can be done to make health insurance a bit better understood and appreciated.

Vanessa: Thank you. So last question to each of you, do you have any final observations or comments to make, having delivered a fantastic green paper?

Bevan: Thanks Vanessa. So, in going through the process for this private health insurance green paper for the Actuaries Institute, we certainly were talking to all of the stakeholders, and talking to other Actuaries around health insurance and their experiences over decades, but really, the overall objective that we were thinking about was, "How do you make the whole system stronger? How do you make the whole community stronger? What we tried to do is provide some evidence based around how do we improve health insurance, to then contribute to a stronger overall health system How do we think the biggest changes can be made? and then where do we put the time, how should we focus policy.

Matthew: Just to reiterate what Bevan said, really. It will be difficult, all of these changes would affect different stakeholders differently, there will be winners and losers and plenty of pushback and controversy. We've just got to keep the health of the nation first and foremost in what we're doing and make sure we always come

back to the evidence, because at some point we're going to need to start making some more bold changes to the way health insurance works in order to maintain its value.

Vanessa: Fantastic. Thanks for joining me, Bevan and Matt. It's great to hear about your insights and we sincerely appreciate your time today discussing this latest green paper from the Actuaries Institute. Thank you.

Bevan: Thanks Vanessa.

Matthew: Thank you.

Vanessa: We hope you enjoyed this discussion. Listeners, check out our Actuaries Institute podcast for more thought leadership content. Write in with your questions and comments on the show, we love to hear from you and we will get in touch. I'm Vanessa Beenders. Bye for now.