medibank
For Better Health

Medibank Submission

Submission to the Commonwealth Health Department – Consultation Paper: Private Health Insurance Reforms (Second Wave)

8.02.2021

Contents

Executive Summary

Medibank welcomes the opportunity to inform the finalisation and implementation of a 'second wave' of private health insurance reforms.

The Commonwealth's objective 'to promote affordability, quality, sustainability and greater choice for consumers' necessitates reforms that encourage more out-of-hospital and alternative care, boost consumer participation in private health insurance, and remove unnecessary inefficiencies, regulations and costs from the health system.

Medibank shares the Commonwealth's objective and strongly supports reforms that enhance the value, affordability and sustainability of private health insurance in the long-term.

Importantly, the proposed second wave reforms are an ongoing recognition by the Commonwealth of the need for change so that Australia's dual public-private health system remains sustainable.

The proposed second wave of private health insurance reforms go some way to achieving the Commonwealth's objective, provided their implementation does not result in unintended consequences for the industry and consumers. As such, Medibank notes:

- *Increasing the Age of Dependents to 31 and Removing the Age Limit for Dependents with a Disability*: Medibank supports the objective of this reform, but concerns with the implementation options are outlined on pp.7-9.
- *Expanding Home and Community Based Rehabilitation Care*: This reform is supported, noting several additional changes that should occur (specified on pp.11-12 of this submission) and Medibank's opposition to any proposal to mandate a minimum benefit for community-based rehabilitation services.
- *Out of Hospital Mental Health Care*: This reform is supported, noting Medibank does not support compelling private health insurers to fund community-based or preventative treatments, nor do we support the establishment of minimum benefits for any such services.
- *Applying Greater Rigour to Type B and C Certificates for Private Hospital Care*: This reform is supported, noting Medibank's views on how specific aspects of this reform should be implemented.

Medibank also notes that reforms will take time to implement and they will require changes to internal systems and processes, which some funds may take longer to implement than others given limited resources. The Government should therefore be aware that the scope of reforms outlined in the Department of Health's consultation paper cannot be expected to be implemented overnight and, in many instances, may require at least the full 2021 calendar year to allow sufficient time for changes to internal systems.

Given the world-leading outcomes of Australia's mixed health system,[1] any changes should be considered with caution to avoid unintended consequences that could erode a system that, on balance, operates well and in the interest of all Australians.

It is also critical that the Commonwealth recognises that the second wave of private health insurance reforms is not an end point – further reforms are needed to ensure sustainable cost growth across both the private and public health systems over the long-term.

Therefore, while Medibank welcomes the second wave of proposed private health insurance reforms, more must be done if greater downward pressure is to be applied to limit cost growth in the health system.

Private health insurance is a critical element of Australia's healthcare system. Australia's health system is strong precisely because it is a mixed system that relies on both public and private providers.

All Australians benefit from private health insurance as it takes pressure off the public health system, provides greater consumer choice, and reduces costs for taxpayers. Private health insurance funds two in every five hospital admissions in Australia – admissions whose costs would otherwise be borne by an already pressured public health system.

About Medibank

Medibank is one of Australia's largest providers of private health insurance, with more than 40 years' experience delivering better health to Australians. We look after the health cover needs of 3.7 million Australians through our Medibank and ahm brands and deliver a range of programs to support health and wellbeing in the community.

Medibank is committed to improving the value of health insurance for Australians and to strengthening our health system.

Our Business

Headquartered in Melbourne, Medibank has corporate offices in Canberra, Brisbane, Perth, Sydney, and Wollongong. We have more than 80 retail stores across Australia, with over 20 in regional areas, employ over 3,900 people, and handle more than 40,000 phone inquiries a week.

For the 2019-20 financial year, Medibank recorded a net profit of $315 million and paid $134 million in tax. A round 270,000 Australians own shares in Medibank.

In addition to private health insurance, Medibank employs over 1,500 clinicians across Australia, delivers 800,000 nurse advice calls for Australians and 70,000 GP tele-consultations per year as part of the more than 1.8 million interactions a year we deliver through our telehealth services, delivers the beyondblue support service, and provides telephone and online counselling services for those experiencing sexual assault or domestic and family violence through 1800RESPECT.

Medibank is focussed on delivering health services, not just health insurance, with our CareComplete program supporting around 37,000 people with chronic disease in partnership with numerous State Governments.

Half of our Board and more than half of our senior managers are women. We are committed to increasing the representation of people with disabilities, Indigenous Australian Peoples, and those aged over 55 within our workforce.

Medibank's Commitment to Deliver Value for Our Customers

Medibank has a fundamental stake in the health and wellbeing of our 3.7 million customers. We spent $5.5 billion on our customers' healthcare in 2020, covering more than 1.3 million hospital admissions, 22 million ancillary services like dental and optical, and more than half a million surgeries.

Medibank knows that affordability of private health insurance is a real issue for many Australians. That is why our premium increase for 2021 is the lowest in 20 years. We are working hard to deliver greater value to our customers and to address the affordability challenges that the private healthcare industry faces. Some of our recent initiatives to bring greater value for our customers include:

- Providing more than $185 million in support for our customers during the COVID-19 pandemic.
- Delivering more personalised services to our customers to improve their quality of life, help them to stay out of hospital (e.g. non-hospital palliative care, rehabilitation and chemotherapy), and take pressure off premiums and the healthcare system.
- Investing in our CareComplete program to improve chronic disease management, collaborating with more than 3,600 GPs to reduce avoidable hospitalisation for people with chronic health needs.
- Managing our own costs to help keep premiums low – we have delivered around $20 million of savings through our productivity program in 2020 and are targeting a further $50 million over the next three years.

Supporting the Community

Medibank is investing $1.5 million to support the Stephanie Alexander Kitchen Garden programme, which seeks to tackle childhood obesity and promote healthier diets across more than 1,200 primary schools across Australia. Medibank also provides $500,000 each year through our Medibank Community Fund to support health and wellbeing projects across Australia that help people help themselves to better health and wellbeing. Schools and community groups are eligible to apply for support from the Medibank Community Fund. Our Medibank Better Health Foundation has provided $4 million in funding for more than 20 health research projects since 2013. We aim to support more than 1.5 million Australians to become more active in mind, body and community through our Free + Active program. We also gave more than $2 million last year to support hundreds of free, active and social activities throughout Australia as part of our Live Better program.

The Value and Importance of Private Health Insurance

Private health insurance is fundamental to the effectiveness and strength of Australia's health system – a point recognised by the Commonwealth.[2]

The majority of Australians – 13.74 million people, representing 53 per cent of all Australians – hold an insurance policy covering them for hospital and/or extras cover.[3]

The average income of Australians with private health insurance is $50,000 per year.[4]

Private health insurance delivers tangible benefits for all Australians by taking pressure off the public system, providing greater consumer choice (e.g. choice of doctor, choice of procedure timing, choice of hospital), and reducing costs for taxpayers.

Taking Pressure off the Public Health System

Private health insurance relieves pressures on the public health system by improving the quality, affordability, and access to healthcare in Australia.

As the Commonwealth Department of Health states, a key community benefit of private health insurance is to reduce pressure on the public hospital system:

> 'The Government has reduced the pressure on the public hospital system by supporting individuals to purchase private health insurance.'[5]

Private health insurance funds two in every five hospital admissions in Australia, representing 33 per cent of all days of hospitalisation that would otherwise be borne by the public system.

Around 90 per cent of day admissions for mental healthcare, 50 per cent of all mental health admissions, 70 per cent of joint replacements, 60 per cent of chemotherapy, and 88 per cent of retinal procedures take place in the private health system.[6]

The majority of elective surgeries (around 67 per cent) in Australia are performed in private hospitals, which reduces waiting times for elective surgery and lowers demand for hospital beds in the public system.[7]

More than $2.5 billion in dental care is paid for by private health insurance, more than the Commonwealth pays for dental care. Around 90 per cent of dental health services provided to low and middle income earners are subsidised by private health insurance.[8]

The statistics demonstrate the role of private health insurance in taking pressure off the public health system.

Consequently, any consumer shifts from private health insurance – and any adverse policies that undermine the affordability and value of private health insurance – will only increase pressure on our public health system. As the Australian Medical Association notes:

> 'If consumers withdraw from the private sector, demand for these services will move to the public sector, which under current capacity, will not meet the additional need or only at a higher cost to governments.'[9]

Private health insurance plays an important role strengthening Australia's health outcomes by taking pressure off the public system and, consequently, reducing waiting times for patients and reducing costs for taxpayers.

Providing Greater Consumer Choice

Private health insurance provides consumers with greater choice – choice of doctor, choice of hospital, and choice of timing for health procedures. As the Productivity Commission observes:

> 'Private health insurance allows consumers to insure for a level of service above that which governments would usually provide through universal health care arrangements. While any Australian can seek 'free' treatment in a public hospital, those with private hospital cover can choose to be treated as a private patient, and typically have shorter waiting times for elective surgery and greater choice of doctor.'[10]

Consumers with private health insurance benefit from greater choice and control, such as choosing to be treated by one's own doctor, shorter waiting times for elective surgery, and financial support for services not typically covered by Medicare (such as dental, optical and physiotherapy), and having more say over when and where to be treated.

Private health insurance is fundamental for consumer choice and a stronger public health system.

As the Commonwealth Department of Health states:

> 'Australia's mixed and balanced model of private and public health insurance is integral to the provision of universal access to high quality affordable health care services for all Australians. People have a choice about whether to use the public or private systems. The decision to purchase private health insurance is a personal choice. People who cannot afford private health insurance or who do not wish to take out private health insurance for any other reason, continue to have the right to access free treatment in public hospitals.
>
> Private health insurance has many benefits such as providing access to private in-hospital services. Private health insurance members can be treated in a private or public hospital as a private patient. This means that depending on the circumstances, they can choose the doctor that treats them, the hospital they are treated in and at a time that suits them.
>
> Private health insurance also provides cover for non-MBS services such as physiotherapy, dental and podiatry services, and some aids and appliances. Many people rely on private health insurance to access services they would otherwise be unable to afford.'[11]

Providing consumers with greater choice and control means there is more competitive pressure in the health system, which promotes greater innovation, better health outcomes, and downward pressure on costs. Consumer choice through private health insurance means consumers have greater control over their treatment options.[12]

Reducing Costs for Taxpayers

By taking pressure off the public hospital system, private health insurance delivers cost value for taxpayers. As the Productivity Commission observes:

> 'Private health insurance plays a major role in supplementing public funding in some areas, and replacing public funding in others.'[13]

Private health insurance paid over $20 billion in healthcare benefits in the twelve months to September 2020 – this is $20 billion that would otherwise have to be paid by government and taxpayers. For every dollar that people spend on private health insurance, the industry returns 86 cents back in benefits – a higher benefit return than for other insurance products.[14]

The Commonwealth Government encourages private health insurance through a means-tested rebate, but the rebate delivers significant returns to taxpayers. Given private health insurance pays nearly $20 billion in benefits to consumers, this means that for every $1 spent on the rebate, around $3 does not have to be spent in the public system.[15]

The private health insurance system delivers tangible benefits for all Australians by taking pressure off the public system, providing greater consumer choice, and reducing costs for taxpayers.

Affordability of Private Health Insurance and the Need for Reform

The affordability of private health insurance is critical to the sustainability of Australia's health system.

Concurrently, charges for health services have increased and the portion of those charges beyond the benefits or rebates that consumers can claim from private health insurance or from Medicare have increased, leading to higher out-of-pocket amounts that consumers are required to bear themselves.

The Australian Prudential and Regulatory Authority has clearly stated that rising health costs – not industry profits – are the key reason private health insurance premiums are increasing:

> 'While debate about the rising cost of health insurance is both appropriate and legitimate, it's important the conversation is informed and correctly focused. APRA does not consider industry profits or capital levels to be the primary drivers of rising premiums. The underlying cost of Australia's health system is the ailment; rising insurance premiums are just a symptom. Specifically, the fundamental forces pushing premiums up are higher claims costs experienced by insurers, through such factors as a greater uptake of medical services among policyholders and the rising cost of treatments and procedures. It is very much in the community's interest that the current reform process continues, and private health insurers need to be an influential voice in that debate.'[16]

The Australian Prudential and Regulatory Authority has also noted that private health insurer have more than halved over the past two years.[17]

The Commonwealth Treasury estimates that real health expenditure per person will double over the next 40 years, with the Commonwealth Government's expenditure on health to increase from 4.2 per cent to up to 7.1 per cent of GDP by 2054.[18] This excludes expenditure by state governments, insurers, and consumers.

Some of the cost drivers are unavoidable, such as population growth, increased life expectancy, and improvements in technology and treatment methods.

But costs are also being driven by inefficiencies in the health system, including poor information transparency and well-intended regulations that are unfortunately resulting in higher costs and poorer outcomes for consumers.

These regulations create perverse incentives where some providers in the private system pursue an inefficient growth strategy, regardless of the inflationary impact on the Australian health consumer.

By way of example, there has been double digit annual growth in private inpatient rehabilitation over the previous five years. There is also significant variation in inpatient rehabilitation rates across States, with New South Wales and Victoria having twice the rates of inpatient rehabilitation compared to Queensland and nearly four times the rates in Western Australia – and 43 per cent of private patients are referred to inpatient rehabilitation following knee replacement in private hospitals compared to only five per cent in public hospitals.[19]

As the MBS Review is demonstrating, there are many areas where low/nil value care is driving unnecessary utilisation and cost growth, yet without significant reform these procedures continue to be performed and government and private insurers are compelled to fund them in the current regulatory environment.

More significantly, costs are being driven by waste, unnecessary and/or low value care, which are estimated to account for around 20 per cent of hospital episodes[20] and an estimated $7 billion a year across the public and private healthcare systems,[21] and with the chair of the MBS Review Taskforce noting that:

> '…roughly 25 per cent of all items on the [MBS] schedule do not have some form of evidence to support them.'[22]

While the Government has taken some welcome steps to address these problems (such as through the MBS Review), more must be done, including steps to enhance payment integrity of the MBS.

Implications of Unaffordable Private Health Insurance

Australians have access to excellent healthcare, due in large part to the complementary public and private health systems.

However, a combination of demographic trends, industry dynamics and regulatory issues is making private health insurance less affordable, creating a need for careful and balanced reform.

As private health insurance becomes increasingly unaffordable, the public health system will face greater strain and the Commonwealth will have to spend an ever-greater proportion of its budget on health.

More importantly, an unaffordable private health insurance system will place added burdens on the public system, resulting in a lack of timely access to services and poorer health outcomes for Australians, as well as significantly higher outlays for the Commonwealth.

Unless reforms are taken to address cost pressures, government and private insurers will invariably need to continue increasing expenditure on health, which can only be funded in the public system via higher taxation or rationing and in the private system by increased premiums.

The impact of increasing premiums has been to drive downgrading to more exclusionary and lower cost products by consumers. This will inevitably result in greater pressure on the public health system.

Medibank is of the view that a series of clear and immediate reforms can be realised that will deliver unequivocal savings, produce better health outcomes for consumers, and make private health insurance more affordable.

What Further Reforms Need to Happen

Reforms need to enhance the value, affordability, and sustainability of private health insurance in the long-term, which will consequently place more downward pressure on premiums and help boost participation.

It is critical to recognise that reforms that enhance the value, affordability, and sustainability of private health insurance will fundamentally strengthen Australia's dual public-private health system and can significantly reduce health cost growth for taxpayers and consumers.

Consequently, the Commonwealth should pursue reforms that:

- Address the inexplicable and unnecessary uplift in prostheses costs in the private healthcare system versus the public system, as such reform will have material and near immediate impact on premiums.
- Encourage more out-of-hospital and alternative care, especially for chronic diseases. The private health insurance regulatory regime in this area is suboptimal and discourages growth of out of hospital care that could lower premiums and deliver enhanced outcomes and experience for patients.
- Tackle problems in out of pocket costs created by the second-tier default.
- Promote greater cost, price and quality transparency in the health system.
- Removes the prohibition upon private health insurance covering outpatient medical care, which lessens the capacity of insurers to invest more in upstream preventative care with a view to diminishing avoidable utilisation in the hospital system – particularly for mental health and chronic disease.
- Accelerate value-based funding of healthcare, which rewards providers for outcomes and for addressing the underlying causes of avoidable hospital utilisation.
- Address system fragmentation and a suboptimal funding model which are particularly problematic for chronic and complex patients that require coordination of care yet are confronted by a system that is largely unconnected.
- Provide more incentives for employers to fund private healthcare for employees and their families.

Medibank will continue to pursue programs that deliver value for our customers, as well as further cost saving measures to place downward pressure on premiums. But substantive reform by the Commonwealth is necessary to ensure the value, affordability and sustainability of private health insurance in the long-term.

Responses to Discussion Paper Questions – Consultation 1: Increasing the Age of Dependents to 31, and Removing the Age Limit for Dependents with a Disability

Medibank supports the objective of this reform proposal to 'improve the affordability, value, and attractiveness of PHI, particularly for younger Australians.'

Boosting private health insurance participation is important to industry sustainability, ensuring downward pressure on premiums, and the long-term viability of community rating.

Nevertheless, neither increasing the age of dependants to 31 nor removing the age limit for dependants with a disability are expected to have a significant material impact on headline premium increases in the absence of other policy reforms. As this reform will allow insurers to offer lower premiums to dependents aged over 24 and/or with a disability, it is important that the implementation options chosen will support a sustainable reform that will not lead to the costs (lower premiums, increased disability coverage) outweighing the benefits (increased participation). If the implementation options lead to higher than expected costs, then this may put upward pressure on premium increases to fund this reform which is not a desired outcome.

With this context, Medibank recommends the following implementation options in order to sustainability support the intent of this reform. If these options are not adopted, Medibank may not be able to support this reform as it would mean that we would need to raise premiums for other customers to cover the lower premiums and improved coverage for dependents.

Recommended Implementation Options

Key options recommended by Medibank to support sustainability of this reform:

- Implementation Option 3 from the consultation paper, to enable differential pricing for dependents age 25 and older including disabled dependents (for both family and single parent scales). This will enable insurers to price depending on the take-up and cannibalisation cost of introducing this lower premium option, without having to increase premiums for other customers. Medibank estimates that the potential cost of this reform for the PHI industry may be c.$100m without the ability to differentiate price with the introduction of new scales.
- Disability definition to be aligned with the NDIS definition, or even simpler, such as 'being in receipt of an NDIS plan', with a clear mechanism to administer the eligibility of disabled customers for the industry. It is important that the definition is specific and easily assessable to reduce administrative burden on insurers, as well as to ensure this option of lower premiums is available only to disabled persons that meet the criteria.
- Changes to eligible ages and additional scales represent a material adjustment to system rules and downstream outputs that affect customers' premiums and benefit coverage (Youth Discounts, Lifetime Health Cover, transfer certificates, waiting periods and portability, tax statements). Consequently, it is unlikely these reforms can be implemented by funds until late 2021.

Medibank's responses to each of the questions in the consultation paper are as follows:

1. Should the maximum age for child dependents be 31 or when LHC typically applies (i.e. 1 July following an individual's 31st birthday)?

The maximum age for child dependents should be 31.

2. Should eligibility of a dependent continue to be limited to people without a partner?

Yes – Medibank supports retaining the no partner eligibility requirement.

3. Should the age ranges of different categories of child dependents be standardised for all private health insurers?

The age ranges of different categories of child dependents should be standardised. Medibank is supportive of Option 3 from Table 3 on page 9 of the consultation paper:

3	infant	0 - 17	no	no	Single parent (1) Family (2)
	student dependent	0 - 24	no	yes	Single parent (1) Family (2)
	non student dependent	18 - 24	no	yes	Single parent non student (1) Family non student (2)
	new category of dependent	25-31	no	yes	New single parent (1) New family (2)

The new category of dependent to also include any disabled dependants of any age.

Standardised age ranges provide greater transparency and certainty for the industry and consumers. A standardised system will also ensure a smooth transition for consumers who wish to transfer from one insurer to another.

4. Should the conditions of dependence for the different categories of child dependents be standardised for all private health insurers?

To be a classified as dependants all dependents should be living at home and not have a partner

It should continue to the be the case that a person can be insured as a Student Dependant or as an Adult Dependant only under a policy that also insures at least one Adult.

5. Should the definition of 'dependent child' be simplified?

Other than replacing 'not aged 25 or over' with 'not aged 31 or over' and changes to include disabled dependents aged 31 or over, there is no imperative for change to the definition in the PHI Act of 'dependent child'. As such, Medibank supports limiting the changes to the above to avoid complexities or confusion that may arise from introducing further changes.

6. What purpose does the distinction between non-student and student dependents serve and should this be retained?

Once a person turns 18 it can be assumed that they are actually or potentially employed full-time and earning a wage, so they can be treated as an Adult unless it is shown that they are *not* employed full-time because of being in full-time education (or at least treated as belonging to that category of Dependant whose coverage under a parent's policy continues to allow a 'loading' to be charged). The distinction remains relevant by allowing insurers to treat older students as still being coverable under their parents' insurance policies without that 'loading' consequence. Therefore, the distinction should be retained.

7. Should the current 10 insured groups be rationalised by removing groups not being used by insurers?

The existing insured groups need to be modified to cover the new dependents category.

Table 1: Current Insured Groups

Common name	Rule reference#	Description of type of coverage	Single equivalent unit*
single	5(1)(a)(i)	only one person	1
couple	5(1)(a)(ii)	2 adults and no-one else	2
children only	5(1)(a)(iii)	2 or more people, none of whom is an adult	2
single parent	5(1)(a)(iv)	2 or more people, only one of whom is an adult	1
single parent non student	5(1)(b)(i)	2 or more people, only one of whom is an adult, including at least one dependent child non student	1
not in use	5(1)(c)(i)	" but dependent children non students must have their own general treatment cover	1
family	5(1)(a)(v)	3 or more people, only 2 of whom are adults	2
family non student	5(1)(b)(ii)	3 or more people, only 2 of whom are adults, including at least one dependent child non student	2
not in use	5(1)(c)(ii)	" but dependent children non students must have their own general treatment cover	2
not in use	5(1)(a)(vi)	3 or more people, at least 3 of whom are adults	2

Private Health Insurance (Complying Product) Rules; * Single equivalent units (SEU) impact on premium cost, the more SEU the greater the cost.

Modification:

- Single parent non-student 5(1)(b)(i): 2 or more people, only one of whom is an adult, including at least one dependent child and no dependent child aged 25 or older.
- Family non-student 5(1)(b)(ii): 3 or more people, only 2 of whom are adults, including at least one dependent child and no dependent child aged 25 or older.

New insured groups of:

- Single parent non-student aged 25 or older: 2 or more people, only one of whom is an adult, including at least one dependent child aged 25 or older (but not older than age 31 unless the dependent is a disabled person).
- Family non-student aged 25 or older: 3 or more people, only 2 of whom are adults, including at least one dependent child aged 25 or older (but not older than age 31 unless the dependent is a disabled person).

The definition in the PHI Act would limit the maximum age of dependent child to 31, unless the dependent is a disabled person.

These two new insured groups can replace two of the three insured groups not currently in use.

8. What is the preferred criteria and mechanism for determining eligibility of people with a disability?

Medibank is supportive of the definition to be that of the National Disability Insurance Scheme, and is of the view that there needs to be a mechanism in place that administers/assesses this eligibility for insurers - it can't be up to individuals or individual insurers to make the assessment.

Medibank's view is that the criteria and mechanism should be simple and clear across the private health insurance industry. To this end, we suggest adopting 'being in receipt of an NDIS plan' as a simple and unambiguous criterion.

9. Should there be standardised arrangements for determining eligibility of people with a disability, or is it preferable to allow each insurer to determine its eligibility criteria?

As per response to question 8 above.

10. Should eligibility of a dependent with a disability be limited to people without a partner?

Medibank supports a no partner eligibility requirement.

11. What are appropriate metrics for measuring the impact of this proposal?

Three metrics could be used:

- Total lives covered.
- Affordability (effective premium discount given to adult dependents aged 25+ covered on extended family or extended single parent policies – that could be measured as part of the premium round process each year).
- Sustainability (participation of younger adults).

12. What is the regulatory burden associated with this proposal?

There will be an increase in regulatory burden resulting from the amendment to scales and age ranges (i.e. communication of changes in terminology and conditions to customers will be a regulatory impost). Reclassification of existing policies from their existing insured groups to updated groups can be expected, which may or may not involve changes in premiums.

The proposed reforms will also take time to implement and will require changes to internal systems and processes. As such, a start date of 1 April 2021 may not be achievable for the industry.

Insurer Specific Question 1: In the context of this proposal, what changes do you intend to make to your current arrangements for dependents and the timing of these changes?

Medibank will only implement this reform if the additional scales are made available to enable a sustainable implementation of the model.

However, it is not possible to implement this reform by 1 April 2021, even if amendments to the *Private Health Insurance Act 2007* and to relevant Private Health Insurance Rules made under that Act were in effect by that date. We consider

that amendments to the Act will be necessary given that some of the proposals would require modification of terms defined in the Act and that an express modification to the s.55-5 prohibition upon improper discrimination is likely to be essential for the proposals connected with disability.

Changes to eligible ages and additional scales represent a material adjustment to system rules and downstream outputs that affect customers' premiums and benefit coverage (Youth Discounts, Lifetime Health Cover, transfer certificates, waiting periods and portability, tax statements).

Insurer Specific Question 2: What will be your likely approach to pricing products with dependents?

Medibank will make no changes to its approach to pricing products with dependents. While we anticipate the new insured groups to be priced higher than the existing extended family and extended single parent insured groups, this will be commensurate with the transferred risk to ensure sustainability of these insured group. Despite the higher prices for the new insured groups, we expect that our pricing approach will improve the affordability of coverage for adult dependents aged 25-31 compared to the current arrangements. Our likely approach to offer lower premiums to dependents aged 25-31 will help support improved policyholder participation at younger ages.

Insurer Specific Question 3. What is the anticipated impact on your overall premium revenue if you implement this proposal?

The impact on overall premium revenue will depend on the implementation approach permitted (i.e. the new scales).

Our modelling suggests that if new insured groups are created to permit sustainable pricing (as per Option 3 without impacting the existing Extended family and Extended Single Parent policies) and there is an uplift in participation, Medibank's annual gross margin will be breakeven ($0 million) or reduce marginally (-$5 million). This reflects an estimated $10-$20 million increase in annual premium revenue offset by an increase in claims of $15-20 million from the additional lives covered.

Our modelling also shows that, without the new scales, implementation of the reforms will likely lead to a $20-50 million reduction in Medibank's annual gross margin. Under this scenario, an average premium increase of 30-75bp higher than normal would be needed to cover the cost of this reform.

Insurer Specific Question 4. What will be the expected impact on the number of people and/or policies covered if you implement this proposal?

The impact on the number of people covered will depend on the implementation approach permitted (i.e. the new scales).

Assuming new insured groups are created and priced to support both affordability and sustainability, our modelling suggests a 20k-25k increase in lives covered by Medibank.

Responses to Discussion Paper Questions – Consultation 2: Expanding Home and Community Based Rehabilitation Care

Medibank supports the intent of this proposed reform as 'a step towards encouraging insurers and providers to consider an expanded range of models of care that are cost-effective and specifically designed for their patients.' However, addressing inpatient rehabilitation in parallel will be necessary, as will reforms that allow private health insurers to fund rehabilitation physicians to participate in community-based rehabilitation programs where appropriate. Reform changes that encourage new models of care need to include elements that also discourage the use of inefficient models of care and consider the roles of stakeholders involved in the care models.

Medibank already funds a range of home-based rehabilitation services allowable under the *Private Health Insurance Act 2007*. Many other health insurers also make this option available to their customers. While the number of Medibank customers accessing home-based rehabilitation is not high, Australian private hospitals maintain some of the highest rates of inpatient rehabilitation internationally.

In order for the Australian Government to encourage in home rehabilitation as the preferred option for appropriate patients, there should be clear criteria describing which patients are suitable for inpatient rehabilitation, medical practitioner involvement in assessing the patient's suitability and informed consent between patient and practitioner. Documented evidence of such needs to be available to funders.

Medibank supports the following changes in order to support this policy intent:

Requirements for admission to inpatient rehabilitation to be eligible for hospital benefits

Several key changes should be made:

- Pre-operative (for elective admissions) referral from a treating medical specialist to a rehab physician. The referral must be written, signed by the referring practitioner and dated (consistent with Health Insurance Regulations).
- Pre-operative (for elective admissions) consultation between a rehab physician and a patient where their need for a rehabilitation program and the likelihood of needing inpatient rehabilitation is assessed (using evidence-based criteria, see below), treatment options discussed, and a plan made for their post-operative rehabilitation.
- This assessment against the evidence-based criteria/tool and the development of a plan must be documented and available for audit.
- The plan should include the multidisciplinary care required and any specific nursing requirements, expected length of stay, and rehabilitation goals.
- Where inpatient rehabilitation is the planned rehabilitation pathway, the rehabilitation physician that has accepted the referral must complete a rehab 'Type c equivalent certificate' and this must be submitted to the fund when the patient eligibility is assessed (consistent with the Private Health Insurance Benefit Rules and explanatory statement definition of rehabilitation and that a rehabilitation program is to be deemed relevant and appropriate by the insurer).

Requirements for the rehabilitation certification process

Several key changes should be made:

- The certificate must be completed by the rehabilitation physician who accepts the referral from the treating medical specialist, following a consultation with the patient.
- The certificate must be submitted to the fund at the time of eligibility checking and receive its own approval, if required by the fund.
- If the provider admits a patient for inpatient rehabilitation without supplying a certificate at the time of admission, it must be able to provide a copy of the relevant certification upon request.
- This rehabilitation certificate must outline the clinical indication for inpatient rehabilitation and must include specific medical conditions, co-morbidities, or other special circumstances that necessitate inpatient delivery of rehabilitation.
- The certificate must include a signed statement from the rehabilitation physician which certifies that it would be contrary to best practice to provide the rehabilitation in a setting other than as an inpatient.

- Incomplete certificates that do not make the clinical indication for inpatient rehabilitation clear, will be a sufficient reason to deem the admission as not eligible for benefits.

Criteria for admission to inpatient rehabilitation

Several key changes should be made:

- Criteria which may indicate a need for inpatient rehabilitation: the overarching principle should be that the consultant physician that completes the Type C certificate has assessed the patient as requiring 24-hour nursing care (consistent with the current industry guidelines for admission to inpatient rehabilitation). This should be in reference to specific criteria (to be developed by rehab physicians) which may include patients with high fall risk or physical/mobility impairment requiring specialised handling or transfer equipment clearly evident at initial consultation.

- The definition of 'rehabilitation patient' in the Private Health Insurance (Benefit Requirements) Rules 2011 should be changed to make it clear that a patient in hospital for rehabilitation must receive a minimum standard of care in line with the Royal Australasian College of Physicians (RACP) Australasian Faculty of Rehabilitation Medicine (AFRM) Standards.

As Medibank and other funders have been able to successfully introduce community-based rehabilitation programs, we do not believe that there are significant barriers to funding these services in the community. However, the current settings make it difficult to reimburse rehabilitation physicians for their involvement in these community rehabilitation programs – where appropriate – and we believe this is a barrier to increasing referrals into these programs. Medibank is supportive of greater flexibility for private health insurers to fund rehabilitation physicians for their involvement in community-based rehabilitation programs. This may include telehealth consults – or other services delivered remotely – that the rehabilitation physician could deliver as part of a multidisciplinary team.

Importantly, we do not support any proposal to mandate a minimum benefit for community-based rehabilitation services.

Funders must retain the ability to ensure high quality, patient focused, cost efficient care is being delivered in the community. Minimum benefit payments will mean funds lose the ability to control the quality of the services provided, the experience of their customers and to manage the growth in the cost of these services so that they don't put upwards pressure on private health insurance premiums.

1. Which procedures and/or MBS item numbers should have a rehabilitation plan?

All rehabilitation programs should have a rehabilitation plan that includes the multidisciplinary care provided and the rehabilitation goals. If the rehabilitation plan includes inpatient rehabilitation it should document that the patient meets the agreed criteria, include expected length of stay and specific nursing requirements.

2. How prescriptive should the plan be, regarding the type of care services to be included? What exemptions if any should be available?

As noted above, all rehabilitation programs should have a rehabilitation plan that includes the multidisciplinary care provided and the rehabilitation goals. If the rehabilitation plan includes inpatient rehabilitation it should document that the patient meets the agreed criteria, include expected length of stay and specific nursing requirements.

Rehabilitation plans should align with evidence-based and published standards – such as the Royal Australasian College of Physicians and Australian Faculty of Rehabilitation Medicine's *Standards for the provision of Inpatient Adult Rehabilitation Medicine Services in Public and Private Hospitals February 2019.*

For community-based rehabilitation, funds should determine which services are funded and which providers are funded to deliver these services as this will better ensure high quality, patient-focused and cost-effective care is being delivered. Such an approach could be achieved through negotiations and contracts with providers.

3. What mechanisms should be in place to ensure compliance with developing and reviewing a rehabilitation plan?

Any MBS or private health insurer funded PHI payment for community rehabilitation needs to be linked to the requirement that an appropriate care plan is documented.

As noted above, a certification process should precede any admission to inpatient rehabilitation. This certificate should be available to the fund if required, and any evidence supporting the certification process maintained by the provider for audit by the fund.

4. It is expected that the plan would be developed in consultation with the patient and potential rehabilitation providers. Which parties should the rehabilitation plan be made available to once created?

The rehabilitation plan should be developed by the rehabilitation provider in consultation with the patient and carers, the referrer, treating doctor and multidisciplinary team as appropriate. The rehabilitation plan should be made available to the referring practitioner and the fund (as required in contractual arrangements between the fund and the rehabilitation provider). As previously noted, if inpatient rehabilitation is required this should be documented by the medical practitioner through a certification process and made available to the fund on request.

5. What arrangements, if any, should be in place to assist medical practitioners identify appropriate home or community-based rehabilitation services and oblige insurers to fund these services?

If inpatient rehabilitation is determined by the medical practitioner as necessary for the patient, then this needs to be documented in the rehabilitation plan and a certification process (as described above) should be followed and, if necessary, made available to the fund.

If the patient only requires out-of-hospital rehabilitation, the process for reviewing the rehabilitation plan should be subject to the contractual arrangements between the fund and the rehabilitation provider. As noted above, which providers are funded to deliver these services needs to remain at the discretion of the funds and subject to negotiations between funds and rehabilitation providers.

Appropriate home or community-based rehabilitation services should be easily identified and accessible. At a minimum, such services should be outlined on private health insurer websites. Ideally, a consolidated and comprehensive list of such services would be managed by the Department of Health and made publicly available.

6. What transition arrangements and timeframe would be appropriate to implement this reform?

Transition arrangement would depend on the scope of reforms for expanding home and community-based rehabilitation care, but it is likely any changes will take around 12 months to implement (noting it can take longer for existing contractual arrangements to be renegotiated).

7. What are appropriate metrics for measuring the impact of this proposal?

Four metrics could be used:

- Annual volume/cost of inpatient rehabilitation episodes.
- Annual volume/cost of community-based rehabilitation services/episodes.
- Clinical outcomes, including FIM/PROMS from inpatient and community-based rehabilitation services/episodes.
- Customer satisfaction from community-based services.

8. What is the regulatory burden associated with this proposal?

There is likely to be some additional regulatory burden, depending on the scope of reform implemented.

9. Service providers: what services would you deliver under this proposal?

Medibank currently funds home-based rehabilitation services – see additional comments under Insurer Specific Question 1.

Insurer Specific Question 1: In the context of this proposal, what changes do you intend to make to your current funding arrangements for home and community-based rehabilitation care and in hospital care, and the timing of these changes?

Medibank currently funds home-based rehabilitation services, which are delivered by Home Support Services (HSS) to ensure national availability for all our customers. HSS works in partnership with several rehabilitation providers, including some private hospitals. Medibank expects demand for these services to increase with effective policy measures that promote community-based rehabilitation as the appropriate model of care unless a medical practitioner – in consultation with the patient – determines that continued hospitalisation is required.

Changes to our funding and contracting arrangements will ultimately depend on the nature of the policy introduced, which may include:

- Changes to our contracts for inpatient rehabilitation to ensure that the provider can demonstrate the appropriate setting for inpatient rehabilitation, and that any requirements regarding the services to be provided to an inpatient rehabilitation patient are met (if this is in line with policy changes to promote appropriate use of inpatient rehabilitation).
- Changes to our funding for community-based rehabilitation models, including potential expansion of the scope of services funded (e.g. rehabilitation for certain conditions or following certain procedures that is currently exclusively provided in hospital) and funding.
- Consideration of alternative funding models for episodes of care, including care models that include inpatient and community-based rehabilitation models.
- Updates to rehabilitation provider contracts to align with legislative requirements and/or evidence-based published standards for admission to a rehabilitation program and/or requirement around minimum service provision.

Insurer Specific Question 2: What is the anticipated change in the number of rehabilitation services delivered in and out of hospital?

Much of the rehabilitation that is currently being delivered as an inpatient service in hospital could be safely, effectively and efficiently delivered in the community. The key to achieving more community care is addressing inappropriate referrals to inpatient rehabilitation, which will increase demand for community-based rehabilitation programs and encourage providers to innovate with new service delivery models.

Insurer Specific Question 3: What is the anticipated impact on your overall premium revenue if you implement this proposal?

Medibank does not believe that there is any material impact on premium revenue from this proposal or indeed broader reforms to address unnecessary referrals to inpatient rehabilitation.

Insurer Specific Question 4. What will be the expected impact on the number of people and/or policies covered if you implement this proposal?

As noted in response to question 2 above, Medibank considers that a significant proportion of rehabilitation that is currently delivered as an inpatient service in hospital could be delivered through a community-based model.

Responses to Discussion Paper Questions – Consultation 3: Out of Hospital Mental Health Care

Medibank welcomes the Commonwealth's recognition that:

> 'The opportunity to access timely and convenient mental health treatment is important to many consumers and can make PHI attractive to consumers, including younger consumers. There are some limitations to an insurer's ability to pay benefits for non-MBS eligible mental health treatments and services delivered out of hospital. There are also limitations on the ability to pay benefits for services where there is an MBS item for this service in the out of hospital setting.'

Medibank and ahm paid more than $190 million in 2019-20 in benefits for mental health related hospital admissions.

In principle, Medibank supports the Government's policy intent to allow private health insurers greater flexibility to:

- Fund preventative mental health treatment.
- Make funding for chronic disease management programs to be available to a wider range of professional groups.
- Expand the range of services that private health insurers could fund under a chronic disease management program (CDMP).

However, to encourage greater uptake of community-based mental health services, reforms are needed to ensure that patients are admitted to inpatient facilities only when assessed by a psychiatrist as requiring inpatient care (as opposed to care in the community). Medibank supports reforms that would require:

- Any patient who is admitted for inpatient mental health care to have been referred by their treating clinician (e.g. a GP, psychologist or psychiatrist) to the treating psychiatrist at the inpatient facility.
- The psychiatrist to assess the patient prior to their admission (similar to what occurs in the public system). This could be done in person or via telehealth, as suitable. Carve outs could be available in emergencies (e.g. when a patient presents at an emergency department and then is referred to an inpatient facility).

The psychiatrist should be responsible for deciding whether the patient requires hospitalisation, or whether treatment in the community is appropriate. Additionally, Medibank supports reform that provides greater flexibility for private health insurers to fund doctors (including but not limited to psychiatrists and GPs) to be involved in community mental health care. This could include a program that is a substitute for hospital (Hospital Substitute Treatment) – in which case insurers should be able to fund doctors using inpatient MBS items, or a CDMP in which benefits paid by private health insurers to doctors involved in these programs should be eligible for risk equalisation.

Medibank does not support any proposal to compel private health insurers to fund community-based or preventative treatments, nor do we support the establishment of minimum benefits for any services outside the hospital (other than those that would already apply for services that constitute hospital-substitute treatments). As a key principle, private health insurers must retain the right to decide what preventative treatments and community-based services they wish to fund, with respect to the evidence that those treatments are beneficial for their customers.

1. What additional mental health services funded by insurers under this proposal would be of value to consumers?

A range of community-based support services may be of value to consumers and should be considered for funding. These are likely to include peer support groups and community mental health interventions delivered by community health services.

To help ensure the funding of those services did not drive unsustainable increases in premiums for customers, private health insurance funding would need to be limited to people that need intensive support to prevent admission/readmission and which supports their initial discharge from hospital.

2. Should an expanded list of allied health services available for direct PHI benefits as part of a CDMP be limited to only mental health conditions?

Regulations are currently excessively restrictive regarding:

- The list of health professionals at sub-rule 12(2) that can provide services for CDMPs.

- Those components of a CDMP whose costs can be risk equalised in accordance with rule 5 of the Private Health Insurance (Risk Equalisation Policy) Rules 2015 (Risk Equalisation Policy Rules).

To allow greater flexibility in the CDMPs that insurers can design and offer to consumers, the following changes should be implemented:

- The reference to 'allied health service or services, and any other' at sub-rule 12(1) *and* the list of eligible allied health professionals at subrule 12(2) of the Health Insurance Business Rules should be removed. In removing the list, the quality assurance requirements set out in division 81 of the *Private Health Insurance Act 2007* will still apply to prohibit the payment of benefits towards healthcare services that do not meet the Private Health Insurance (Accreditation) Rules 2011 (the Accreditation Rules).
- Paragraph 5(1)(a) of the Risk Equalisation Policy Rules should be amended so that eligible benefits for a CDMP should be stated to include (i) benefits paid towards general treatment provided as part of a CDMP and (ii) the cost of the planning and coordination services. Corresponding amendments to paragraph 5(1)(d) should be considered as well. This would enable additional costs associated with CDMPs to be eligible for risk equalisation. This will reduce the administrative burden on insurers and increase the financial incentives for insurers to offer CDMPs to their customers.

3. To be eligible for direct CDMP related funding from insurers, should professions have additional requirements, such as accreditation standards, professional memberships or educational levels?

Private health insurers should have greater flexibility to determine the providers they wish to fund under CDMP. As noted above, we support the application of the quality assurance requirements in division 81 of the *Private Health Insurance Act 2017*.

Insurers could provide a CDMP in conjunction with the patient's treating psychiatrist, which may include a non-MBS payment to the psychiatrist as part of the program.

4. How should the definition of coordination and planning be expanded to best support the funding of out of hospital, non-MBS related mental health services?

It is important that the definition of coordination and planning be clear and prescriptive, with compliance readily verifiable and capable of being audited.

Planning could incorporate documented outputs, such as: care plans, changes to care plans or working with a client for at least 30 mins.

Coordination could incorporate documented outputs, such as: patient conferences, multidisciplinary team meetings, and referral and integration into out-of-hospital services.

A distinction also needs to be made between coordination and case management.

5. Are there any mental health services insurers should not be permitted to fund?

Medibank supports the principle of allowing private health insurers greater flexibility in determining the preventative treatments and community-based services that improve health outcomes for their customers and help to reduce unnecessary hospitalisation for mental health conditions. Ideally, only evidence-based treatments and services should be funded.

6. How should the relevant patient cohort be identified as eligible for services?

The patient cohort should be determined by the provider with reference to the contract for service between the private health insurer and provider. Different interventions will be appropriate for different patient cohorts, and evidence that a particular treatment is effective may apply only to a particular patient cohort.

7. Who should identify relevant patient cohorts and should insurers set criteria for which members would be eligible?

As noted above, this should be done by a healthcare provider with reference to the service agreement between a private health insurer and a provider.

8. What are appropriate metrics for measuring the impact of this proposal?

Four metrics could be used:

- Annual volume/cost of inpatient mental health episodes.
- Annual volume/cost of community-based mental health services/episodes.
- Clinical outcomes/PROMS from inpatient and community-based mental health services/episodes.
- Customer satisfaction from community-based services.

9. What is the regulatory burden associated with this proposal?

There is likely to be some additional regulatory burden, depending on the scope of reform implemented.

10. Service providers: what services would you deliver under this proposal?

Medibank is exploring community-based mental health treatments with providers that have a service model in place.

Insurer Specific Question 1: In the context of this proposal, what changes do you intend to make to your current funding arrangements for mental health services and the timing of these changes?

Medibank is exploring community-based mental health treatments with providers that have a service model in place.

Effective and proven service delivery models need to be in place before funding arrangements can be determined.

Insurer Specific Question 2. What will be your likely approach to pricing products with expanded mental health service benefits?

As noted above, effective and proven service delivery models need to be in place before funding arrangements can be determined.

Insurer Specific Question 3. What will be the anticipated impact on your overall premium revenue if you implement this proposal?

As noted above, effective and proven service delivery models need to be in place before funding arrangements can be determined.

Insurer Specific Question 4. What will be the expected impact on the number of people and/or policies covered if you implement this proposal?

If access to preventative and community-based mental health treatments was made available to any customers with mental health cover then potentially all customers with a hospital policy could take advantage of these additional services. The number of customers that use the services will depend on the nature of treatments funded and the relevant patient cohorts for that service

These alternative treatments should be available on all policies covering hospital treatment, but that will depend upon whether and how the government seeks to establish the relevant framework (i.e. whether coverage remains optional, whether there are to be any minimum benefits, the classification of the treatment under the *Private Health Insurance Act 2007* and risk equalisation purposes).

Responses to Discussion Paper Questions – Consultation 4: Applying Greater Rigour to Type B and C Certificates for Private Hospital Care

Any reforms to the certification for hospital admission process should have the core principle of facilitating patient treatment in the most clinically appropriate setting.

Medibank is supportive of:

- Reforms that provide greater clarity over the circumstances in which a patient should be admitted to hospital for a procedure not normally requiring a hospital admission and evidence-based clinical guidelines.
- A medically-led model, whereby the treating medical practitioner would be required to certify with reference to the evidence-based guidelines that their patient requires hospitalisation.
- Referral of medical practitioners that continue to refer patients to hospital outside of accepted medical practice to the Professional Services Review (PSR).

To ensure compliance with this process, providers should be required to maintain records to provide evidence to funds that the appropriate criteria have been met. In addition, the criteria for admission should be specific and unambiguous.

1. Should an industry mediation panel be established to resolve hospital certification disputes?

Medibank has several concerns with the proposal to establish a self-regulated industry panel to review Type C certificates and manage hospital disputes, including:

- The potential administrative cost, dependent on the number of disputes referred each year.
- The impact that this panel could have on negotiations between providers and health funds.
- Whether a panel would be effective at challenging medical practitioners.

Medibank does not believe that the National Procedure Banding Committee (NPBC) is an appropriate model to follow – in that instance the NPBC helps to mediate the appropriate classification of a procedure that both funds and providers agree should be funded.

2. If an industry mediation panel is established, what process should be undertaken to establish it, including determining membership?

If a panel is established, there should be clear steps that providers and funders need to work through prior to any dispute being escalated to the mediation panel. Careful criteria will be needed to determine when a case can be referred, to ensure that both parties are still incentivised for resolving disputes internally without referral where possible (to minimise the volume of cases to the panel).

The selection of panel members should be approved by the peak bodies for both providers and funders to ensure credibility of the panel with all parties. The terms of appointment should be fixed but able to be extended by agreement.

The scope of factors the panel can consider in assessing a referred case should be specified and agreed by hospitals and funders as part of the establishment of the panel.

Importantly:

- Patients should not subject to any financial disadvantage while matters are being considered by a mediation panel.
- The panel should only be empowered to address disputes.
- Panel members should be independent of providers and funders.
- The panel's accountability and reporting should be clear and transparent.

3. What parties should be involved in the development of advice on the appropriate criteria for certification?

The key parties involved should be appropriate medical colleges and representatives from private health insurers and hospitals.

4. Should PSR, or another regulatory body, provide a regulated and enforceable process for reviewing Type C certification?

Medibank is supportive of the PSR providing a regulated and enforceable process for Type C certification. Referral to the PSR could be effective, but it is not clear whether hospital providers could be referred to PSR or whether this is only applies to medical practitioners.

5. Should there be a specified list of 'special circumstances' allowable for Type C certificates?

Medibank is supportive of providing great certainty around the limited special circumstances allowable for Type C admissions.

Type C certificates should be limited to hospital procedures and should not include consultations – there is no reason why a patient should be admitted if they only require a consultation.

Medibank acknowledges that there are a wide range of factors unique to a patient that could influence whether an inpatient stay is the best setting to perform the procedure for that individual. This should be a clinically led decision predominantly informed by the unique factors about the individual's medical condition.

In relation to 'special circumstances' that do not relate to the individual's medical condition/s (e.g. a patient remains an inpatient overnight due to lack of support being available at home), there is some value in considering a pre-authorisation model for these specific circumstances. Such an approach would allow funders to work with providers to develop support services (such as in-home support) that could be deployed where the 'special circumstance' is that the patient does not have a support person at home. To be clear, this pre-authorisation process would not apply to situations where the reason for the Type C admission is due to individual's medical condition/s (e.g. unique health factors which make it unsafe to perform the procedure outside a hospital setting).

6. Should hospitals be potentially liable for Type C certificate statements, and if so, in what circumstances?

This should be medically led with the medical practitioner who signs the certification process responsible for ensuring that the admission to hospital is appropriate. The practitioner certifying the certificate should be the one directly involved with the treatment of that patient.

While the medical practitioner is responsible for the certificate itself, the hospital will be partly responsible for the consequences where a certificate that upon complaint or upon audit is determined to have lacked sufficient foundation for being issued will cause a change in the minimum benefits applicable towards hospital charges. For a Type C certificate, these go to zero. For a Type B certificate, these go to a same-day rate only.

It could, perhaps, be a made a condition of hospitals' declarations as facilities for the purposes of the *Private Health Insurance Act 2007* that they have adequate processes in place to prevent certificates being issued inappropriately by those whom they credential to conduct their practices at those hospital locations.

7. What is the likely impact upon premiums of this proposal?

This will depend on the success of the measures in addressing aberrant behaviour. Assuming this is successful, the volume of the invalid Type C admissions would reduce, and therefore place downward pressure on premiums for consumers. However, any savings are likely to be minimal.

Like any reform, there is a risk (depending how the changes are operationalised) of causing unintended consequences. In this circumstance it may result in an increased volume of Type C admissions, placing further pressure on premium affordability.

8. What is the likely impact on the number of people and/or policies covered of this proposal?

The proposal will impact on all customers admitted to hospital.

9. What are appropriate metrics for measuring the impact of this proposal?

The number of Type C certificates regulated and reviewed by the PSR.

10. What is the regulatory burden associated with this proposal?

There is likely to be some additional regulatory burden, depending on the scope of reform implemented. But any incremental regulatory burden ought properly to fall on health care practitioners, not upon insurers.

11. Are there any other reform options that should be considered?

Several additional reforms should be considered, as follows:

- Remove all consultation items from Type C classification such that a same day admission requires a procedural MBS item to be performed to trigger the Type C provisions, as well as addressing the situation where the consultation happens *after* a procedural service has been performed – for which the admission or overnight admission was required (e.g. where the consult is pre-discharge).
- Establish a forum to periodically review the MBS item classification for Type A and Type B to consider whether recent advances in technology and medical practices meanthat the procedure is safe to provide in outpatient settings (except for reasons that would justify a Type B or Type C certificate).
- As outlined in question 5 above, Medibank considers there is an opportunity to uncouple the 'special circumstances' provision from the Type C certification process and move this to a pre-authorisation process that would better support providers and funders assessing other non-hospital settings or support that might limit the time the patient needs to remain an inpatient given the clinical risks faced by patients who remain in hospital longer than necessary (e.g. exposure to pathogens).
- As outlined in question 6 above, consideration should be given to aligning this declaration in legal standing with other official Commonwealth documents and including an offence for false declarations, to further reinforce the importance of the declaration process.

Conclusion

The private health insurance system delivers tangible benefits for all Australians by taking pressure off the public system, providing greater consumer choice, and reducing costs for taxpayers.

Australia's health system, our public hospitals, and our health outcomes are stronger because of private health insurance.

Medibank welcomes the opportunity to inform the finalisation and implementation of a 'second wave' of private health insurance reforms, and we strongly support reforms that will enhance the value, affordability, and sustainability of private health insurance in the long-term.

Medibank supports the proposed second wave of reforms, provided that their implementation does not result in unintended consequences for the industry and consumers. As such, Medibank notes:

- *Increasing the Age of Dependants to 31 and Removing the Age Limit for Dependants with a Disability*: Medibank supports the objective of this reform, but concerns with the implementation options are outlined on pp.7-9.
- *Expanding Home and Community Based Rehabilitation Care*: This reform is supported, noting several additional changes that should occur (specified on pp.12-13 of this submission) and Medibank's opposition to any proposal to mandate a minimum benefit for community-based rehabilitation services.
- *Out of Hospital Mental Health Care*: This reform is supported, noting Medibank does not support any proposal to compel private health insurers to fund community-based or preventative treatments, nor do we support the establishment of minimum benefits for any such services.
- *Applying Greater Rigour to Type B and C Certificates for Private Hospital Care*: This reform is supported, noting Medibank's views on how specific aspects of this reform should be implemented.

Medibank also notes that reforms will take time to implement and they will require significant changes to internal systems and processes, which some funds may take longer to implement given limited resources. The Government should therefore be aware that the scope of reforms outlined in the Department of Health's consultation paper cannot be expected to be implemented overnight and, in many instances, may require at least the full 2021 calendar year to allow sufficient time for changes to internal systems.

It is critical that the Commonwealth recognises that the second wave of private health insurance reforms is not an 'end point' – further reforms are needed to ensure sustainable cost growth across both the private and public health systems over the long term.

Therefore, while Medibank welcomes the second wave of proposed private health insurance reforms, more must be done if greater downward pressure is to be applied to limit cost growth in the health system.

Endnotes

1 Many studies demonstrate that Australia's mixed health system matches or performs better than most comparable countries on selected health measures. See, for example, Australian Institute of Health and Welfare (2018) *Australia's Health 2018: In Brief*, p.7; OECD (2019) *OECD Health Statistics*, accessible at: http://www.oecd.org/els/health-systems/health-data.htm.

2 Department of Health (2014) *Submission to the Senate Inquiry into Out-of-Pocket Costs in Australian Healthcare*, p.9.

3 Australian Prudential Regulatory Authority (2020) *Private Health Insurance Quarterly Statistics*, September, p.4.

4 Private Healthcare Australia (2020) *Budget Submission*, p.2.

5 Department of Health (2016) *Annual Report 2015-16*, p.125.

6 Private Healthcare Australia (2017) *Pre-Budget Submission*, p.16.

7 Australian Institute for Health and Welfare (2017) *Admitted Patient Care 2015-16*, p.ix.

8 Private Healthcare Australia (2017) *The Value of Private Health Insurance*, p.1.

9 Australian Medical Association (2017) *AMA Submission – ACCC Report to the Senate on Private Health Insurance*, pp.1 and 11.

10 Productivity Commission (2015) *Efficiency in Health*, p.64.

11 Department of Health (2014) *Submission to the Senate Inquiry into Out-of-Pocket Costs in Australian Healthcare*, p.9.

12 Australian Medical Association (2017) *Private Health Insurance Report Card 2017*, p.2.

13 Productivity Commission (2015) *Efficiency in Health*, p.63.

14 Private Healthcare Australia (2017) *The Value of Private Health Insurance*, p.1.

15 Department of Health (2017) *Portfolio Budget Statement*, p.90. The Commonwealth will spend $6.1 billion on the private health insurance rebate in 2017-18, increasing to $6.6 billion in 2020-21.

16 Australian Prudential and Regulatory Authority (2018) *Health Insurer Heal Thyself: APRA'S Prescription for Financial* Sustainability, p.7.

17 Australian Prudential and Regulatory Authority (2018) *Quarterly Private Health Insurance Statistics – September 2020*, p.12 and *Quarterly Private Health Insurance Statistics – September 2018*, p.10. Industry net margins were 5.18 per cent in the twelve months to September 2018, compared to 2.14 per cent in the twelve months to September 2020.

18 Treasury (2015) *Intergenerational Report*, p.60.

19 Based on internal Medibank data.

20 Badgery-Parker, T., Pearson, S.A, Chalmers, K., Brett, J., Scott, I.A, Dunn, S., Onley, N., and Elshaug, A.G. (2018) Low Value Care in Australian Public Hospitals: Prevalence and Trends Across Time, *BMJ Quality and Safety*, August.

21 Productivity Commission (2017) *5 Year Productivity Review: Supporting Paper No.6*, pp.17-18.

22 Cited in The Australian (2015) *Medicare Review Chief Says 30pc of Treatments of Little Benefit*, p.1.