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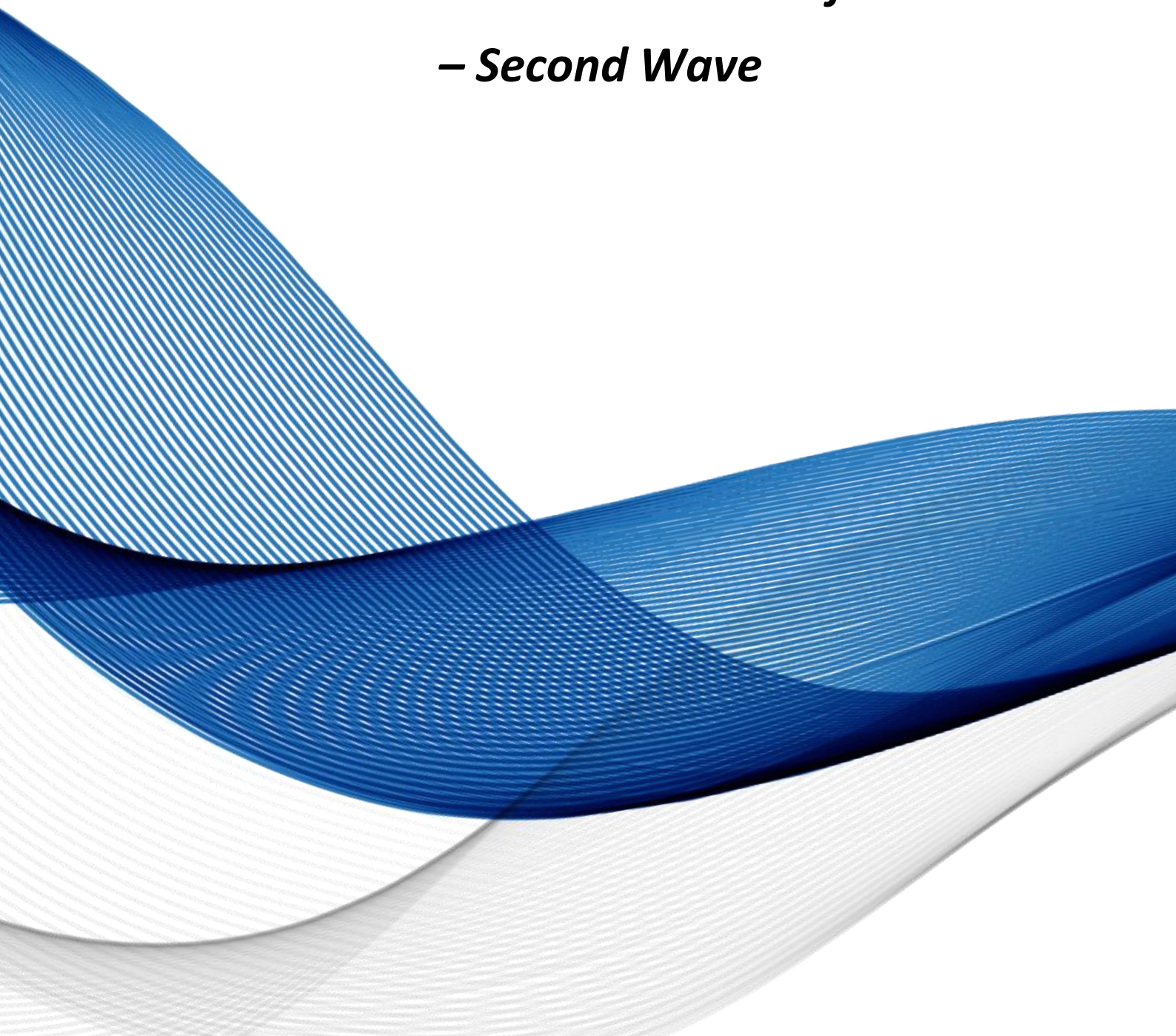
MTAA SUBMISSION

Private Health Insurance Reforms – Second Wave



Executive Summary

On 06 October 2020, the Australian Government announced the second wave of reforms to private health insurance with the aim of improving the affordability, value and attractiveness of private health insurance, particularly for younger Australians.

The Medical Technology Association of Australia (MTAA) welcomes the opportunity to make a submission to the Government with respect to its Consultation Paper: Private Health Insurance Reforms – Second Wave – December 2020.

As the peak body representing Australia's medical technology (MedTech) industry, whose member companies supply a wide range of products used in settings such as hospitals, homes and medical and allied healthcare practices, MTAA believes positive reforms to Australia's private health insurance (PHI) industry to be vital to ensuring that value, choice and access are maintained.

MTAA notes that since 2015 the Government has implemented a series of changes to private health insurance designed to address concerns about its financial sustainability, within the envelope of a static tax expenditure on the insurance rebate. These reforms have

- reduced insurer outlays for hospital medical devices by $1.1 billion through reductions to benefits on the Prostheses List
- Implemented categorisation of hospital policies ostensibly to reduce consumer confusion over the 50,000 combinations of policies on the market
- Streamlined coverage for allied health offerings.

The current set of reforms propose to increase the total accessible market for private health insurance or enable coverage for alternative models of care that could lower overall cost. Further reforms to the medical device benefit environment are also in train.

Once implemented, it should be understood and recognised by Government that the policy environment for private health insurance has been created to ensure the sustainability of insurers and reduced premium increases for consumers. Over time, the effectiveness of insurers in addressing the decline in participation in private health insurance is a matter for them, and not the result of any particular policy impediment. The environment for private health insurance is now fully supportive of the interests of insurers, and any shortcomings in market participation is a business and not a policy matter.

Any reform to the existing PHI system needs to achieve a balance between keeping PHI costs down for consumers, while offering maximum value to consumers. Any reforms which improves insurer's positions (such as reducing PHI costs) whilst diminishing the overall value of PHI to consumer is likely to be detrimental to consumer, either through reduced choice or increased out-of-pocket costs. This is likely to be detrimental to the objectives of broader reform which is to sustain PHI.

Extending family coverage to persons under 31, and retaining coverage for Australians with disabilities

MTAA supports proposals to expand the total addressable market for private health insurance by extending age and disability related eligibility. Young Australians are the cohort most likely to exit private health insurance. Their participation, given the fact they are typically in lower income brackets, facing high housing costs and generally less exposed to healthcare risks, is a tenuous economic proposition. Enabling continuation of coverage under pre-existing family policies is one method to increase and retain coverage and insurer premiums modestly without harming the overall risk pool. It also helps to expand choice of treatment for young Australians who do need or want private health insurance but may otherwise not be able to afford it.

Similarly, extending eligible coverage for Australians with disabilities is a welcome reform. This would assist such vulnerable people to obtain timely access to therapies potentially not covered in any NDIS plan.

These extensions of cohorts of Australians whose health risks can be efficiently covered by PHI help to broaden the scope of insurable health risks. Australians' health needs are changing as the variety of health services available to them changes. Medicine is now not so much delivered through episodic care as a lifelong path of services, particularly as chronic disease prevalence grows with an aging population. Insurable risks should encompass the spectrum of healthcare needs and the spectrum of potential services, as a means of backstopping and limiting pressures on the public health system, rather than artificially separating insurance into "hospital" and "non-hospital" services. Whole of health insurance should be the intention of policy reform, with appropriate protection of Australians' fundamental right of access to health services funded by Medicare.

Expanding Home-Based Care in the Private Setting

MTAA believes there is strong potential for improvements in the health system through the expansion of home-based care, with MedTech innovation playing a critical role in the success of these therapies.

The objective of expanding home-based care must be focused on improving outcomes for patients and delivering cost-effective care tailored to patient needs.

Background – the case of home-based care

Home-based care has been found to be appropriate for a broad range of acute, sub-acute or post-acute conditions as well as chronic conditions such as renal dialysis and intestinal failure.

Healthcare services traditionally provided in hospitals that are now provided in the home include IV antibiotics, parenteral nutrition, renal dialysis, and other injections and infusions. Importantly, post-operative rehabilitation, for example for orthopaedic or cardiac procedures, is amenable to home or community based delivery, based on a clinical assessment of risk and patient preference.

Home health may not be an option for all patients, but when appropriate, its advantages can include:

- Improved (or at least equal) patient outcomes
- Lower costs and improved cost-effectiveness
- Greater healthcare capacity and improved patient access
- Patient and carer preference

Growth of Home-Based Care

Several factors have contributed to the migration of hospital services to the home, including budget constraints due to an ageing population and increasing costs of medical services, patient preferences for receiving car at home, and growing evidence of the clinical effectiveness, safety, and cost-effectiveness of healthcare in the home.

In most cases patients will be admitted to home-based care after a period of hospitalisation although, increasingly, pathways are being developed that allow direct admission to home-based care programs via an Emergency Department or referral from the patient's own GP.

Direct ED admission of HITH patients has been associated with cost savings, greater patient satisfaction and safety and efficacy outcomes that are at least equivalent to those association with hospital-based care.

Case Study: Remote Patient Management (RPM) with Baxter Sharesource

According to the 2019 ANZDATA report, there are 13,399 people receiving dialysis across Australia. 26% receive dialysis in their home, of which 18% receive peritoneal dialysis with the majority on automated peritoneal dialysis (APD). Adherence to treatment has traditionally been a concern for home dialysis patients and infrequent clinic visits means that treatment complications can go unrecognised for months at a time.

'Sharesource' is a revolutionary RPM software program that is integrated into Baxter's 'HomeChoice Claria' APD platform. It creates a constant, two-way connection that allows clinicians to access and interpret critical data and when necessary, remotely adjust prescriptions. This technology is increasing adherence, preventing complications, and improving patient outcomes.

A recent international study[1] also showed that treatment including Sharesource can lower hospitalisation rates when compared to traditional APD patients. When these effects were costed for the Australian environment, Sharesource has been estimated to save the health system between $855 -$3245 per patient, per year.

[1] Cost Consequence Analysis of Remote Monitoring with the HomeChoice Claria® with Sharesource® Platform for Automated Peritoneal Dialysis Patients in the Australian Setting. McElduff, PSarros &. s.l.: ISPOR Seoul, 2020, Vol. PUK3.

Medical Technology and Home-Based Care

Technology is the enabler of clinically effective home based care, and service models have evolved to make such care accessible to consumers and cost-effective. Therefore, in enabling insurer coverage of home based care, particularly for chronic conditions, clinical quality standards need to ensure that there is adequate coverage and inclusion of the right mix of technologies to ensure the optimal delivery of such care.

The benefits from the use of MedTech in the home are numerous. For example, telehealth, the NSW agency for clinical innovation has identified the following benefits:

- Connect clinicians to patients and their family, carers or guardians,
- Support assessment, intervention, consultation, therapy and supervision, and
- Improve communications and collaboration between health professionals.

The rapid expansion of telehealth has been central to the Commonwealth's response to the COVID-19 pandemic. Commencing 13 March 2020, temporary MBS telehealth items were made available to all 'Medicare-eligible persons for the treatment of any condition, provided by a practitioner qualified to provide the service in line with normal MBS arrangements'. This was one to help reduce the risk of community transmission of COVID-19 and provide protection for patients and healthcare providers.

Additionally, many provide health insurers have enabled telehealth access to a range of extras treatments for members with appropriate existing coverage.

However, the existence of coverage gaps in the current configuration of health insurance policies means technology is often not adequately covered. A good example is cardiac remote monitoring. Patients with active implanted cardiac devices can be monitored on a continuing basis via a remote monitor at home. Recently a Bluetooth-enabled monitoring system was approved for coverage. Remote monitoring is well recognised as providing improved outcomes through more timely awareness of arrythmias and enabling improved interventions.

At present, patients are only eligible for insurer coverage of such devices if they are provided at time of implant during a hospital admission, despite the fact that remote monitors can be provided at any time to patients. Requests to insurers to provide ex gratia coverage for high risk patients during the COVID pandemic were frequently denied.

In considering insurance coverage for home-based care and rehabilitation services, it will be important to ensure that the technologies appropriate to such care are part of mandatory coverage.

Home based post-operative rehabilitation does offer potential efficiencies for insurance by eliminating the need for rehabilitation hospital bed costs. Home or outpatient-based rehabilitation can potentially be as clinically effective as inpatient rehabilitation. One unanswered question, however, is how to ensure the optimal outcomes from guaranteed patient compliance with a course of community rehabilitation. Research demonstrates that completion of a full 12-week course of cardiac rehabilitation after an ischemic event results in better outcomes than non-completion. Cardiac rehabilitation is also ranked as one of the most cost-effective interventions in improving patient outcomes. In designing private insurance coverage, both insurers and care providers need to design a system with the correct balance of incentives (and costs) to ensure patients participate fully in rehabilitation.

This is an important issue for technology providers. MTAA member companies active in cardiac therapy have made significant breakthroughs in treating heart disease through minimally invasive approaches for ischemic heart disease and structural heart disease, among others. Transcatheter based approaches, in avoiding open heart surgery, lead to significantly shorter inpatient stays even for quite severe cardiac disorders including aortic stenosis and mitral regurgitation – of an order of 5 days compared to 21. The cost effectiveness of such therapies includes assessments of outcomes at 6-, 9- and 12-months post procedure. The effective completion of cardiac rehabilitation is a factor influencing the assessment of the outcome of the procedure. So incentives for rehabilitation directly affect both the clinical outcome and the perceived comparative cost-effectiveness of minimally invasive interventions.

We note that Australia lags comparable countries in coverage of transcatheter approaches for structural heart disease, both for aortic stenosis (via TAVr) and mitral regurgitation (TMVr). Australia only enables coverage of TAVr for high risk patients, and TMVr is not yet included on the MBS (though has been positively recommended by MSAC). Expanding coverage to medium or low risk cohorts could reduce total costs of care for treating major forms of heart disease, providing years of healthy life to

a growing group of Australians. However, capitalising upon this benefit requires a commitment both to adequate and timely funding of such technologies and a recognition of rehabilitation's role in the outcome, independent of the device therapy.

Available savings to insurers

A report by Alpha Beta (now owned by Accenture) found that by establishing home health services for as little as 10% of hospital admissions by determining those whose outcomes would be improved and private health insurers could save $8 million by FY2022. Early discharge to home health, for recovery, rehabilitation, medication monitoring not only delivers better health and patient outcomes but delivers savings as well. Transitioning 10% of hospital stays by FY2022 is forecast to save insurers $15 million. An example is with rehabilitation following total knee arthroplasty (uncomplicated) - instead of remaining in hospital for rest and rehabilitation, the patient can return home sooner, and receive rehabilitation services in the home, without the associated costs of hospital care (e.g., occupying a bed, medication management, service coordination for an otherwise well patient).

Deciding to utilise HITH

The decision to transition a patient to home or community health care rests with the physician and the patient, so that the best outcome can be achieved. It could be financially tempting to transfer additional patients to home based care or to incentivise patients to shift to home based care however as stated earlier, shifts to care practices that prioritise financial motivations over health motivations are short term solutions that will ultimately erode the value proposition of PHI.

It is not for insurers or other stakeholders to predetermine the service delivery model based on financial reasonings, rather, the choice to treat a patient in the home setting should lie with the patient in consultation with their treating clinician.