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Commentary

Reflections on the role of less-than-comprehensive (exclusionary) private health insurance hospital products in the Australian healthcare system

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Abstract. The number of people in Australia that are currently covered by a hospital private health insurance product continues to rise every quarter. In September 2010, for the first time since the introduction of the public universal social insurance scheme, Medicare, more than 10 million persons in Australia are covered by private health insurance. Although the number of persons covered by private health insurance continues to grow, the quality and level of cover that members are holding is changing significantly. In an effort to limit premium rises and to reduce the benefits paid for treatment, private health insurers have introduced, and moved a large number of existing members to, less-than-comprehensive private health insurance policies. These policies, known as 'exclusionary' policies, are changing the dynamics of private health insurance in Australia. After examining the emergence and prevalence of these products, this commentary gives three different examples to illustrate how such products are changing the nature of private health insurance in Australia and are now set to create a series of policy issues that will require future attention.

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Introduction

The role of private health insurance in Australia has been the subject of much academic, policy and political debate. Discussions have tended to focus on either the overlapping role of private health insurance within a system that also has a full social insurance scheme (Medicare),[1] or on government initiatives designed to encourage the uptake of private health insurance.[2,3] In particular, there has been much debate about the role of the private health insurance rebate.[4,5] Significantly, much analysis of private health insurance treats products as homogenous. The debates and analysis, within both the political and the policy sphere, have invariably used the headline figure of the percentage of persons with private health insurance and the total number of insured persons as a measure of the state of the private health insurance market,[6,7] and so assumed coverage uniformity. Less-than-comprehensive cover is set to change the dynamics of the debates that surround private health insurance.

Recent developments within the private health insurance industry have started to complicate the concept of the private health insurance product, such that it is becoming less useful to consider the proportion or total number of insured persons as an indicator of industry strength. Unlike in some other countries which also have a significant private health insurance component, universal entitlement to private health insurance at a community-rated premium is guaranteed by law in Australia. In addition to this, some of the more consumer unfriendly insurance concepts seen elsewhere such as 'lifetime benefit ceilings', 'cancelling the insurance of high claimants', and 'managed care' are alien to the Australian private health insurance system by virtue of tight regulation. This has meant that private health insurers have few health policy coverage options available to them in terms of managing premium costs and benefits payable. The emergence of 'exclusionary products' and 'restricted products' can be seen as one of the most significant responses by insurers to this challenge. These products are significantly changing the nature of private health insurance in Australia, but the repercussions of these products on the landscape of private health insurance and healthcare in Australia is poorly understood from both a policy and a consumer perspective.

What are exclusions and restrictions on private health insurance products?

Policies that do not cover a specific treatment are said to have an 'exclusion', and policies that only pay the minimum amount of benefits specified by law (also known as the default benefit) are said to have a 'restriction', and within this article such policies are referred to as less-than-comprehensive policies. The exclusion on the policy will specifically state the services that are not covered, but this can be in language unfamiliar to many consumers. It is assumed that unless the policy specifically excludes the stated treatment, then it is included. Insurers can exclude any medical services except for psychiatric, rehabilitation and palliative care services. These services must always be covered to some extent on a policy. There is no limit as to how many different services can be excluded on a policy. Restricted benefit policies only cover the default benefit payable by law for the stated restricted service. Such an amount generally only covers a fraction of the cost of treatment in a private hospital. From a consumer and a private

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hospital perspective, exclusions and restrictions work in a near identical manner, in that they both effectively exclude treatment for the service within a private hospital.

Until recently, these products have remained niche. However, over the last 5 years, the number of policies with an exclusion has grown from 5 to 24%. This gradual growth is likely to have only been partially driven by active member choice, with either new or existing members seeking out lower cost policies in the face of rising insurance premiums. The recent spikes in growth that can be seen in Fig. 1 have coincided with the announcement by several large insurers that several exclusions and restrictions were being added to some of their existing policies.[8,9] This has led to the number of policies with an exclusion jumping up from 16 to 24% between March and June 2010 (see Fig. 1). Given the significant proportion of the market that such policies cover, they can no longer be considered niche and attention needs to be focussed upon how they are changing the dynamics of private health insurance in Australia. In the remaining space in this commentary, I focus on three specific aspects of private health insurance policy and show how they might be affected by exclusionary products.

Three areas of change

Community rating

The community rating and guaranteed universal availability of private health insurance products is one of the most defining features of private health insurance in Australia and is guaranteed in the Private Health Insurance Act (2007). Each policy that an insurer sells must be available to all persons within the state in which it is on sale, and also must be sold at the same price to all consumers. Essentially, this means that the premiums a young and healthy person pays are the same as an older person with greater health risks. The purpose of community rating is to ensure that private health insurance is universally available to all and at a relatively affordable price, and furthermore, to prevent insurers from refusing or withdrawing cover from the 'bad risks'.

Exclusionary and restricted policies are an unintended consequence of community rating. Providing health insurance at a universal price and with universal coverage availability, limits the ability of insurers to make insurance more attractive to lower risk groups through lower premiums. The cost of health insurance for these groups is made more expensive as they indirectly subsidise the premiums of higher risk groups.

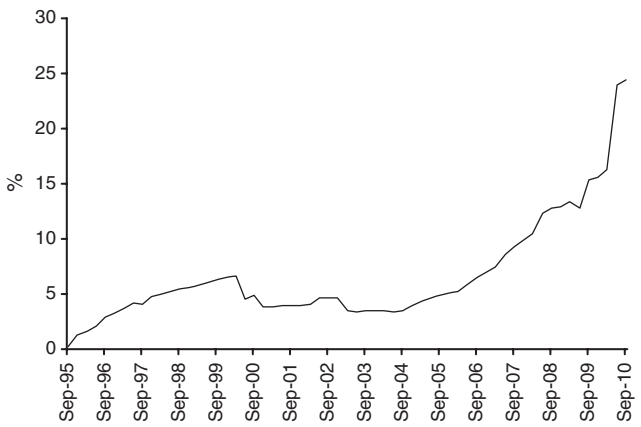

Fig. 1. The percentage of private health insurance policies which exclude a specified medical treatment. Source of data: Private Health Insurance Administration Council (2010).[14]

Insurers have responded to the community rating requirements by introducing lower cost policies that exclude or restrict specified treatment. In practice, what this means is that instead of insurers refusing to cover high risk individuals, those who assess themselves as low risk can choose to reduce their cover in return for a lower premium.

Exclusionary and restricted products have the potential to cause harm to the community rating principle. This is a process of 'reverse community rating'. The effect that this has is that those who perceive their health risk to be lower might pay lower premiums than those who perceive their risk to be higher. The important principles of community rating are undermined as coverage open to all is damaged by the price differential that has been artificially created through self-assessed health risk. The more people that are persuaded by insurers that they do not need cover for important services such as cardio, hip and knee replacement, eye surgery, for example, the more such services will cost for those who perceive that they should hold such cover. If community rating is to remain a central feature of private health insurance in Australia, then the long-term implications of less-than-comprehensive products on community rating sustainability needs to be explored.

Regulation of premium rises

Under the Private Health Insurance Act (2007), the Minister for Health and Ageing has the power to disallow any premium rise that they feel is not in the public interest. The Minister has stated that this power is being used to ensure that premium rises are being kept to a minimum.[10] However, an unintended consequence of the Act is that, through the use of exclusions and restrictions, insurers can instigate a back-door premium rise. One of the key reasons why the number of exclusionary and restricted policies has been increasing has been that insurers are adding exclusions and restrictions to the policies of existing members. To negate the problem of not being able to apply the premium increase of choice, insurers can add additional exclusions and restrictions to existing products and sometimes, close products to new members. Should a member wish to retain the same level of cover they enjoyed previously, they have to migrate to a different product. This has the effect of a member having to pay beyond the stated premium increase to maintain the same level of cover. Shortly after the premium increases were announced for 2010, a number of insurers moved to change the level of cover offered by several of their policies.[9,11]

Government initiatives to encourage private health insurance

The Howard government introduced three key initiatives to encourage a higher uptake of private health insurance. These were the Private Health Insurance Rebate, the Medicare Levy Surcharge, and Lifetime Health Cover. The relative social, economic and health system outcomes of these have been discussed in significant detail elsewhere[2–5] and this commentary does not intend to revisit the specifics of such analyses. However, it is

worth considering how less-than-comprehensive private health insurance products are set to redefine some of the issues associated with these government initiatives.

According to the Private Health Insurance Ombudsman, the Medicare Levy Surcharge is levied on Australian taxpayers who do not have private hospital cover and who earn above a certain income.[12] The stated purpose of the surcharge being to '. . .encourage individuals to take out private hospital cover, and where possible, to use the private system to reduce the demand on the public system'.[13] However, there is now a failing in this policy if the purpose of the Medicare Levy Surcharge is to reduce demand on the public hospital system. Holding a less-than-comprehensive private health insurance policy (that is, a policy that excludes and restricts access to specified treatments within private hospitals) still exempts Australian taxpayers from paying the Medicare Levy Surcharge. To avoid paying the surcharge, a taxpayer need only take out a policy that provides public hospital benefits for palliative, psychiatric and rehabilitation services only, and excludes all treatment within private hospitals. Such policies do exist within the market, and given that Australia has a full social insurance system for its public hospitals, it is difficult to see the purpose of these products beyond avoiding the Medicare Levy Surcharge. Exclusionary and restrictive policies run counter to the purpose of the surcharge. The Medicare Levy Surcharge policy is now failing because the Australian Tax Office takes its definition of a complying product from the Private Health Insurance Act 2007. The requirements of this Act are very weak in terms of what a policy must cover. This is allowing people to avoid the surcharge by paying premiums on a policy they are very unlikely to be able to use. If the person requires hospital treatment, they will have to use the public system.

The debate over the effectiveness and fairness of the Private Health Insurance Rebate has been well played out in the pages of this and other journals, and looks set to continue to be a sensitive political issue. However, less-than-comprehensive private health insurance products, particularly those that exclude nearly all types of treatment within private hospitals, and in some cases, public hospitals too, still receive a 30% subsidy from the government, and exist primarily for the purpose of avoiding the Medicare Levy Surcharge. A serious policy question arises over whether the government is getting good value for money in subsidising policies that have little or no prospect of being used in the private system and so cannot relieve pressure on public hospitals.

Suggestions

The above examples are just a few areas whereby less-than-comprehensive private health insurance products are developing new policy challenges. In addition to this, there are significant questions covering the marketing of products to consumers; the efficacy of forced migration of members to inferior policies; the suitability of such products for at-risk groups; and future demand forecasting for services within the private sector. However, before such concerns can be addressed policy makers need a much fuller understanding of the nature of the problem. Despite such products now making up over one-fifth of the industry, very little is known about the scale of impact they are having on the healthcare system. This is because there is a distinct lack of data in this area.

The only available data in the public domain on less-than-comprehensive private health insurance products are those made available each quarter by the Private Health Insurance Administration Council. These data show the number of policies that contain at least one excluded treatment, with no differentiation made as to whether a policy has one or multiple excluded services. There are also no available data that show the types of excluded services on such policies. Furthermore, there is no reporting whatsoever on the number of policies that restrict the benefits payable for stated items to the minimum (public) hospital level. This makes determining how such policies will affect the above stated issues impossible to decipher. However, perhaps most pressing of the data availability issues is the lack of demographic information on the uptake of such products. This would go some way towards indicating whether higher-risk groups are inadvertently taking on too much risk.

Conclusions

This commentary has identified several policy questions that now merit further enquiry. Sound policy responses require access to high quality data. Given the premium price pressure that insurers are facing, and the need for consumers to try and limit their necessary expenditure on private health insurance, the prevalence of such products is likely to continue to grow. There is now a real need for the Private Health Insurance Administration Council to start collecting and publishing data on the number and type of exclusions and restrictions, and the demographic uptake of such policies. This will assist researchers in understanding the actual private hospital coverage for different treatments and what this means for the healthcare system, and furthermore, will assist policy makers in assessing the role and function of government support for private health insurance in Australia.

Competing interests

There are no competing interests.

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