

Private Healthcare Australia

Better Cover. Better Access. Better Care.



BALANCING TRANSPARENCY AND AFFORDABILITY

Product design, standardisation and the minimum benefit

Fenasaude

Sao Paulo October 2017

Over 13.5 Million Australians Strong



Who we are:

- Australian private health insurance industry's peak representative body
- Represents 22 health funds consisting of for-profit and not-for-profit health funds in Australia
- Member funds collectively represents 96% of people covered by private health insurance



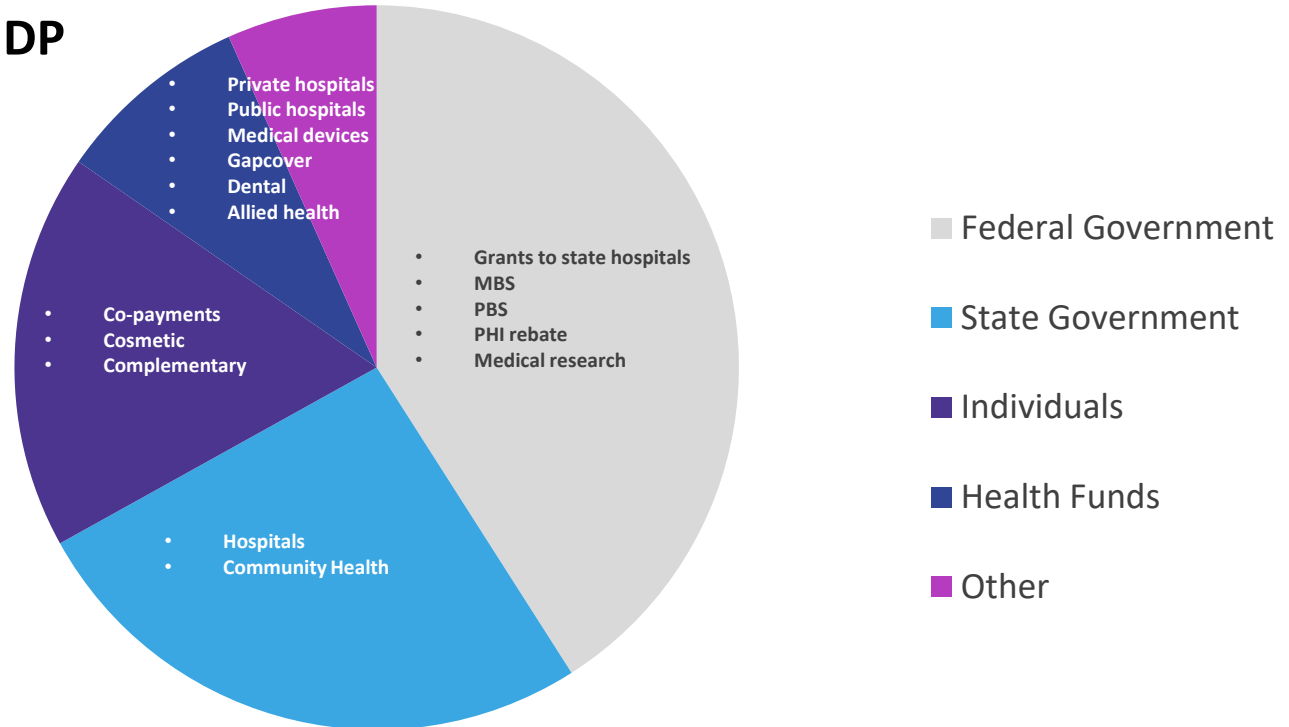
Medicare Benefits Schedule



Australia has a mixed private and public health system



Sources of funding - \$AUD160 billion or 9.3% of GDP



SOURCE: AIHW - Total health expenditure, by source of funds as a proportion of total health expenditure, 2004-05 to 2014-15

Government funding responsibilities:

Federal Government – revenue from income tax and value-added tax:

- Medicare Benefits Schedule (MBS)– reimbursement for services provided by doctors including primary care and specialist care
- Some funding for public hospitals
- Pharmaceutical funding
- Funding for medical research
- Private health insurance rebate

State and Territory Governments – some state taxes – payroll and stamp duty:

- Balance of public hospital funding
- Some community health centres

Individuals:

- Cosmetic and complementary therapies
- Co-payments against pharmaceutical and Medicare benefits



Primary Care in Australia

- Family doctors called General Practitioners provide most of the primary care;
- Services are provided in the community, not in hospital;
- The government's Medicare Benefits Schedule (MBS) ensures people are reimbursed for GP visits for all or most of the cost;
- It is not possible to consult a medical specialist or have diagnostic tests without a referral from a GP – they act as 'gatekeepers' to the more expensive medical services;
- Health funds are not permitted to directly fund GP services where a Medicare Benefit is payable, but they can supplement the care of people with multiple chronic conditions to prevent hospitalisation.



PHI is an important part of Australia's health ecosystem

Private health, public benefit

37

competing health insurance funds

13.5

MILLION
Australians (55%) rely on PHI for
treatment when they need it

\$19.8

BILLION
in annual benefits paid to members

96%

of the PHI industry is represented by
Private Healthcare Australia (PHA)

2 of 3

non-emergency procedures are
performed under PHI cover

86c

Australians get 86 cents back for every \$1
premium paid, compared to only 66
cents in general insurance



The health funds provide:



Insurance

for medical treatment provided in hospital only



Reimbursement

of dental and allied health under Extras cover



Services

vertical integration into dental, optical, wellness and aged care



PRIVATE HEALTH, PUBLIC BENEFIT

IS PRIVATE HEALTH INSURANCE JUST FOR THE WEALTHY?

More than **1 in 4 people** with PHI have an annual income of **less than \$30,000**

Almost half of all people with Private Health Insurance have an annual income of **less than \$50,000**

92% of people with Private Health Insurance have an annual income of **less than \$150,000**



Health funds play a vital role in better health and hospital services for all Australians

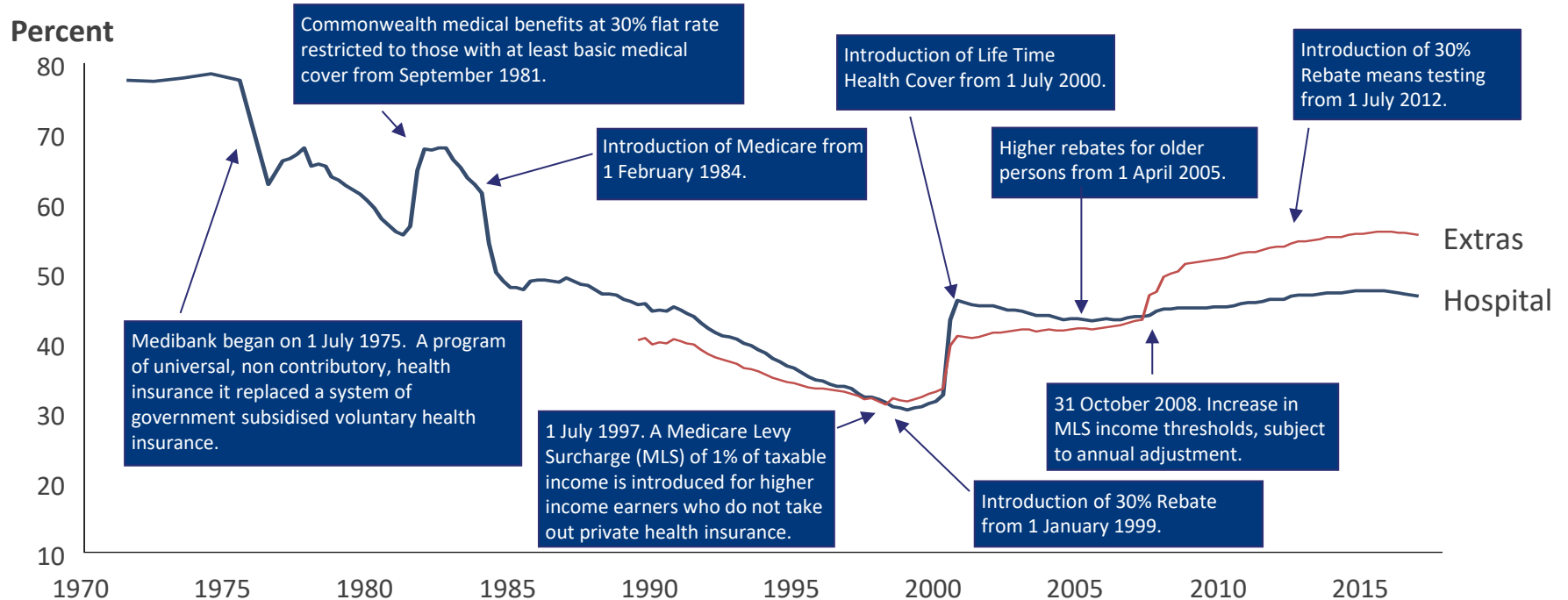


Private Healthcare Australia
Better Cover. Better Access. Better Care.

More information at www.privatehealthcareaustralia.org.au

PHI membership levels have been stable since 2000 but are at risk of falling due to these affordability concerns

Hospital and Extras coverage as percentage of population



Regulation 1996 – 2001

‘Three pillars’ stabilised PHI membership: taking the pressure off public hospitals



Lifetime health cover



Medicare levy surcharge



30% rebate on premiums

Underpins 75% of demand

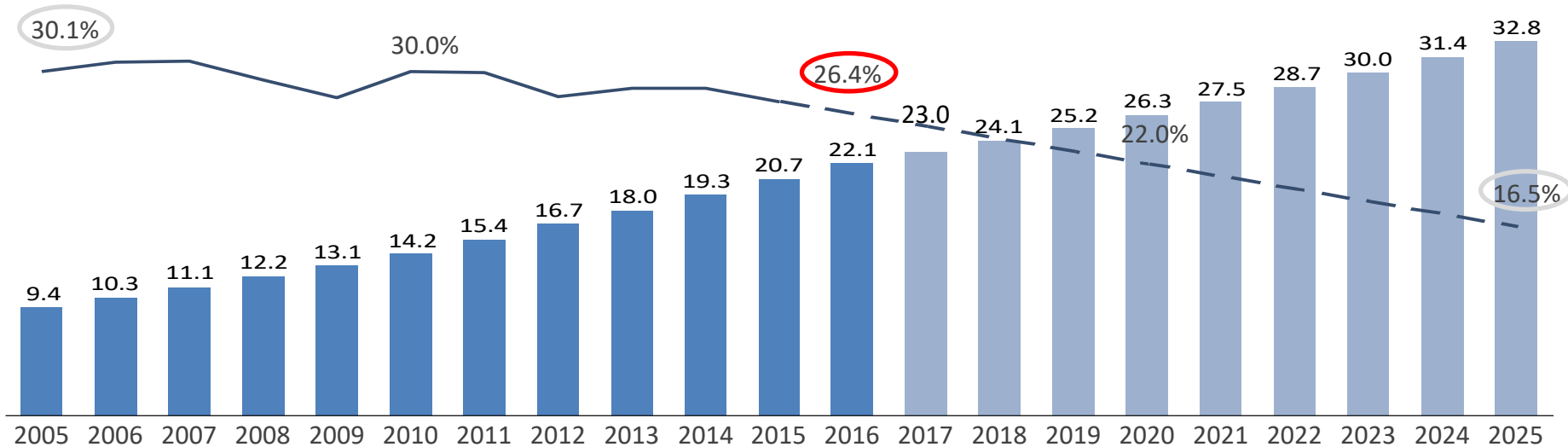
Successful in putting a floor under the premium increase ‘death spiral’



No further changes to rebates on PHI premiums as the re-bate as percentage of premiums will continue to decrease

Growth in PHI premium revenues and proportion based on current prices¹

PHI premiums (A\$ billion) vs. PHI rebate (%)



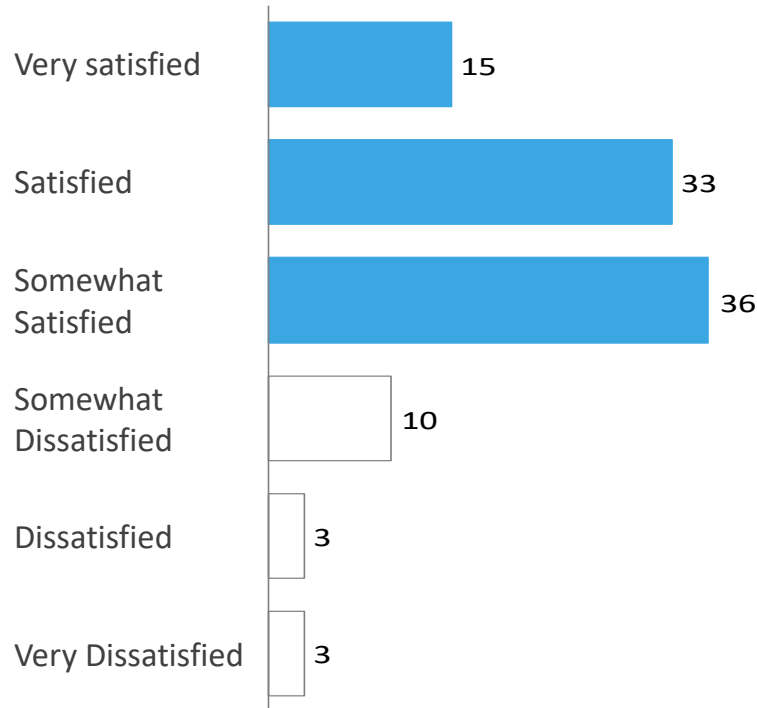
Notes: 1) Based on Treasury estimates assuming that the PHI rebate will drop from 27% to 16% over the next 10 years. Premium increases based on 4.5% health claim inflation.

Source: AIHW - Health Expenditure Australia publications. Figures are financial year end figures are based on current prices and take into account ATO clawbacks

Most people are satisfied with their PHI, but affordability is a problem

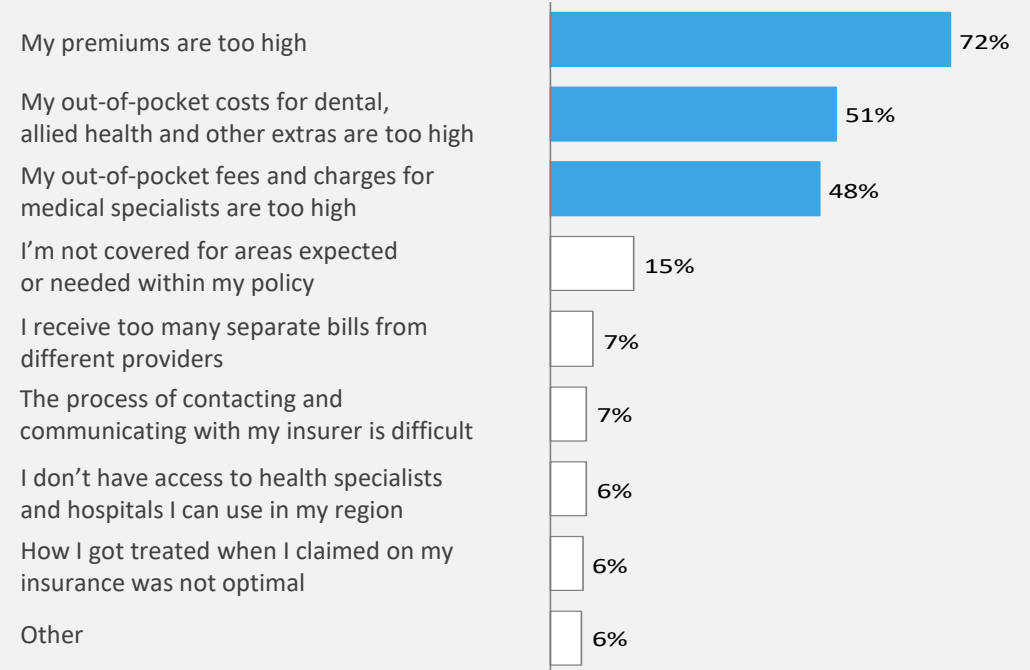
How satisfied are you with your private health insurance?

Percent



Why are you less than satisfied with your current private health insurance product?

Percent times mentioned by those less than satisfied



The external issues



Increasing utilisation by fund members relating to ageing and chronic disease



Erosion of PHI rebate due to means testing & indexation

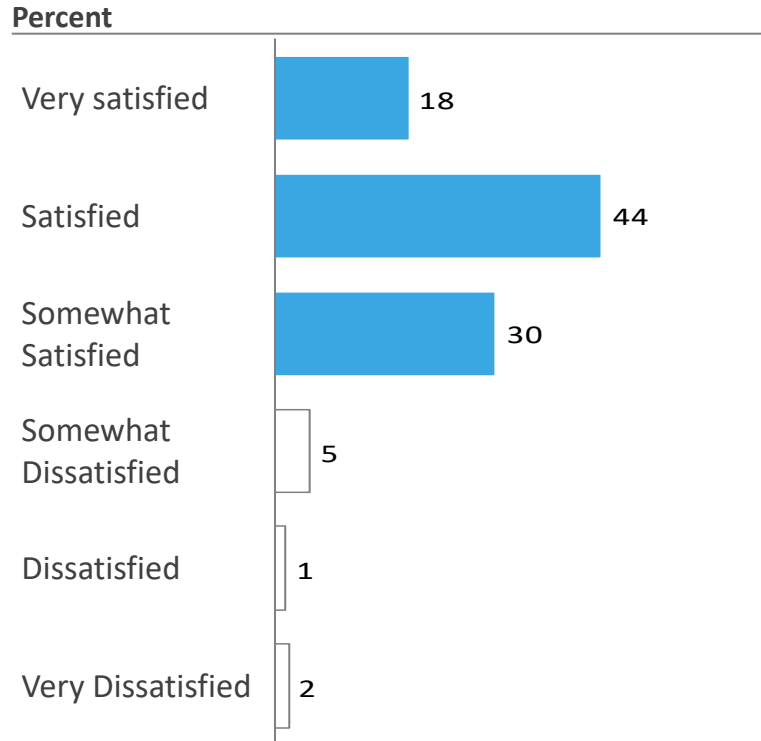


New medical technology



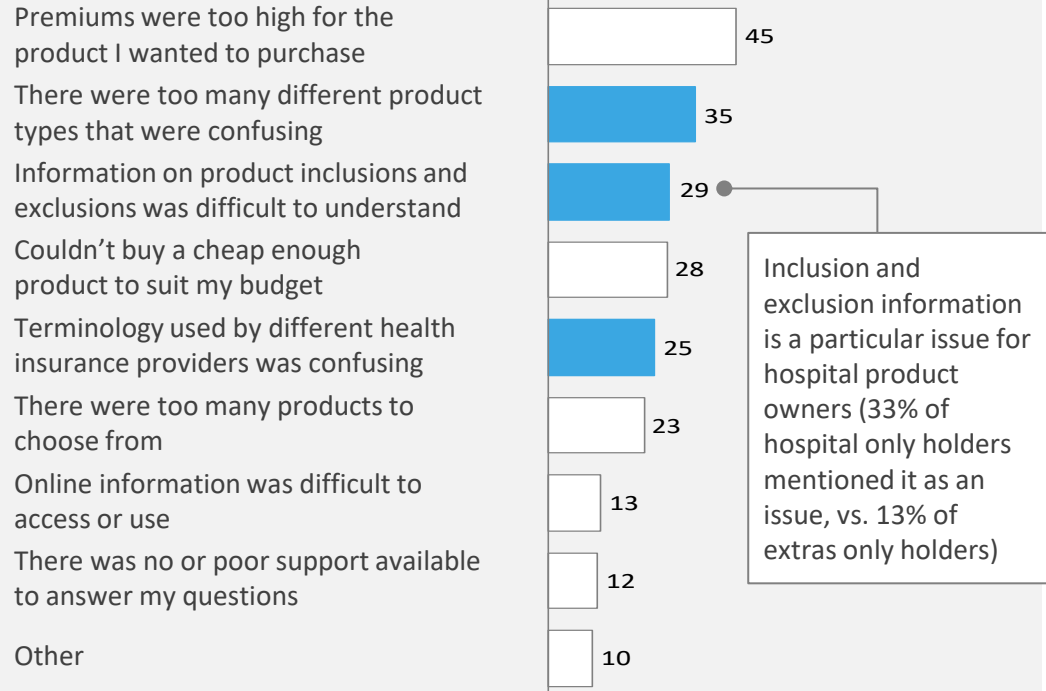
Most people are satisfied with their experience purchasing PHI, but some are confused by product features

How satisfied were you with your experience purchasing private health insurance?



Why were you less than satisfied with your experience purchasing private health insurance?

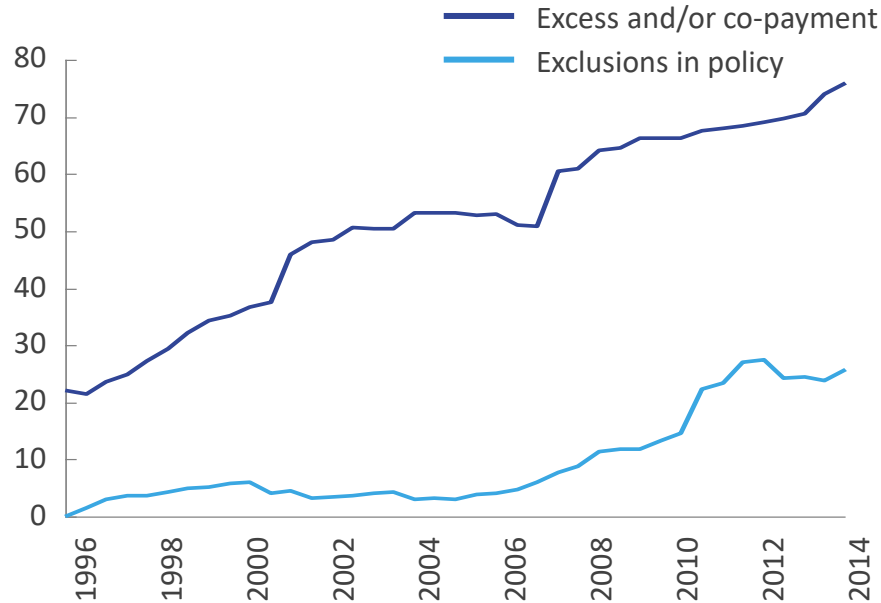
Percent times mentioned by those less than satisfied



The last two decades have seen an increase in the complexity of available PHI products

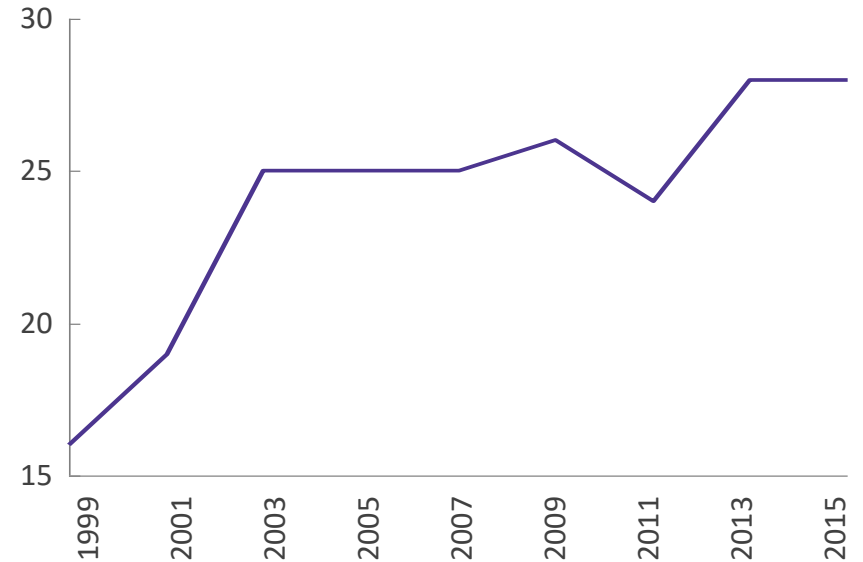
Proportion of hospital cover policy holders with excess and/or co-payment or exclusions¹

Percent



Proportion of people not taking up private health insurance because 'I don't understand the different policies and it is just too hard'

Percent



¹ The increase in exclusionary products in June 2010 is partly due to a re-classification of policies between exclusions and restrictions by some insurers. Further, there is a break in the excess and co-payment data in June 2007 due to a change in the definition used.

SOURCE: PHIAC (2015) Competition in the Australian Private Health Insurance Market; IPSOS 2015



“Health Minister Sussan Ley attacks 'junk' private health insurance”

- The Sydney Morning Herald

“Coalition launches private health cover survey, setting sights on 'junk' policies”

- The Guardian

“Worst health insurance ‘junk policies’ named”

- News.com.au

“The 'worst' health insurance policies named and shamed”

- Australian Doctor














Standard Medical Terms



Current terminology is inconsistent across PHI policies: standardisation is needed

Current categories used by insurers for common procedures

	Example procedures			
	Partial gastrectomy	Knee replacement	Cataract	Dialysis
	Gastric banding and obesity related services	Hip and knee replacement (including arthroplasty, revision and resurfacing procedures)	Cataract and eye lens procedures	Renal dialysis for chronic renal failure
	Obesity related treatment (e.g. gastric banding)	Joint replacements	Cataracts, glaucoma and laser eye surgery	Dialysis for renal failure
	Gastric banding and all obesity surgeries	Joint replacements including hips and knees	Cataract and corneal transplants	Haemodialysis
	Surgical weight loss procedures	Joint replacement surgery (partial or total)	Cataract and eye lens procedures	Dialysis (in hospital)
	Gastric banding & obesity surgery	Joint replacements (e.g. hip replacements, knee replacements)	Cataract and other lens related surgery	Dialysis for chronic renal failure
	Surgical weight loss procedures	Joint-replacement procedures	Cataract surgery	Dialysis for chronic kidney failure
	Weight loss surgery (e.g. Bariatrics)	Hip & knee joint replacement surgery	Major eye surgery—including cataract & lens-related services	Renal dialysis
	Obesity surgery	Joint replacements	Eye treatments	Renal dialysis
	Bariatric procedures (weight loss surgery, including repair, replacement, removal and adjustment)	Joint replacement	Cataract and eye lens procedures	Dialysis for chronic renal failure
	Bariatric surgery	Hip, knee, shoulder & ankle replacements	Major eye and eye lens surgery	Dialysis procedures & treatments
	Gastric banding and obesity surgery	Hip, knee and joint replacements	Eye surgery, including cataracts	Dialysis

Developing terminology for use in hospital products

Key

Original SIS category adjusted for common terminology used by funds
Extra terms used by health funds

Use SIS categories as a starting point to understand current exclusion terminology

- Psychiatry
- Rehabilitation
- Palliative care
- Dialysis and chronic renal failure
- Cardiac and cardiac-related services
- Pregnancy and birth related services
- Assisted reproductive services
- Cataract & eye lens procedures
- Gastric banding and related services
- Sterilisation
- Non-cosmetic plastic surgery
- Hospital treatment for which Medicare pays no benefit, e.g. most cosmetic surgery
- Hip and knee replacements
- Joint replacements, i.e. shoulder, knee, hip and elbow including revisions
- Other services (see insurer for details)

Identify additional terminology used by funds and standardise where possible¹

- Psychiatry
- Rehabilitation
- Palliative care
- Dialysis and chronic renal failure
- Cardiac and cardiac-related services
- Pregnancy and birth related services
- Assisted reproductive services
- Cataract and eye lens procedures
- Bariatric (weight-loss) surgery*
- Sterilisation
- Non-cosmetic plastic surgery
- Hospital treatment for which Medicare pays no benefit, e.g. most cosmetic surgery
- Hip and knee replacements
- Other joint surgery (excl. hip and knee replacements)*
- Spinal surgery (spinal fusion, scoliosis)**
- Cancer treatment (including surgery)**
- Gynaecology (major and minor)**
- Colonoscopy**
- Brain surgery**
- Appendicectomy**
- Removal of tonsils and adenoids**
- Cochlear implantation surgery**
- Dental surgery**
- Podiatric surgery**
- Other services covered by MBS (non-differentiators)

Regrouped terminology categories for use in hospital products²

Medical	<ul style="list-style-type: none"> Chemotherapy/Radiotherapy Endoscopy Dialysis
Medical/Surgical	<ul style="list-style-type: none"> Pregnancy and birth-related services Assisted reproductive services Heart-related surgery and services
Surgical	<ul style="list-style-type: none"> Cataract and eye lens surgery Cochlear implantation surgery Ear, nose and throat surgery³ Spine surgery Hip and knee surgery Other joint surgery Brain surgery Bariatric (weight-loss) surgery Non-cosmetic plastic surgery Gynaecology Sterilisation Dental surgery Hospital treatment for which Medicare pays no benefit, e.g. most cosmetic surgery
Psych/Rehab/Palliative	<ul style="list-style-type: none"> Psychiatry Rehabilitation Palliative care
Other MBS	<ul style="list-style-type: none"> Other services covered by MBS (e.g. Urology; Breast surgery; Bowel surgery)

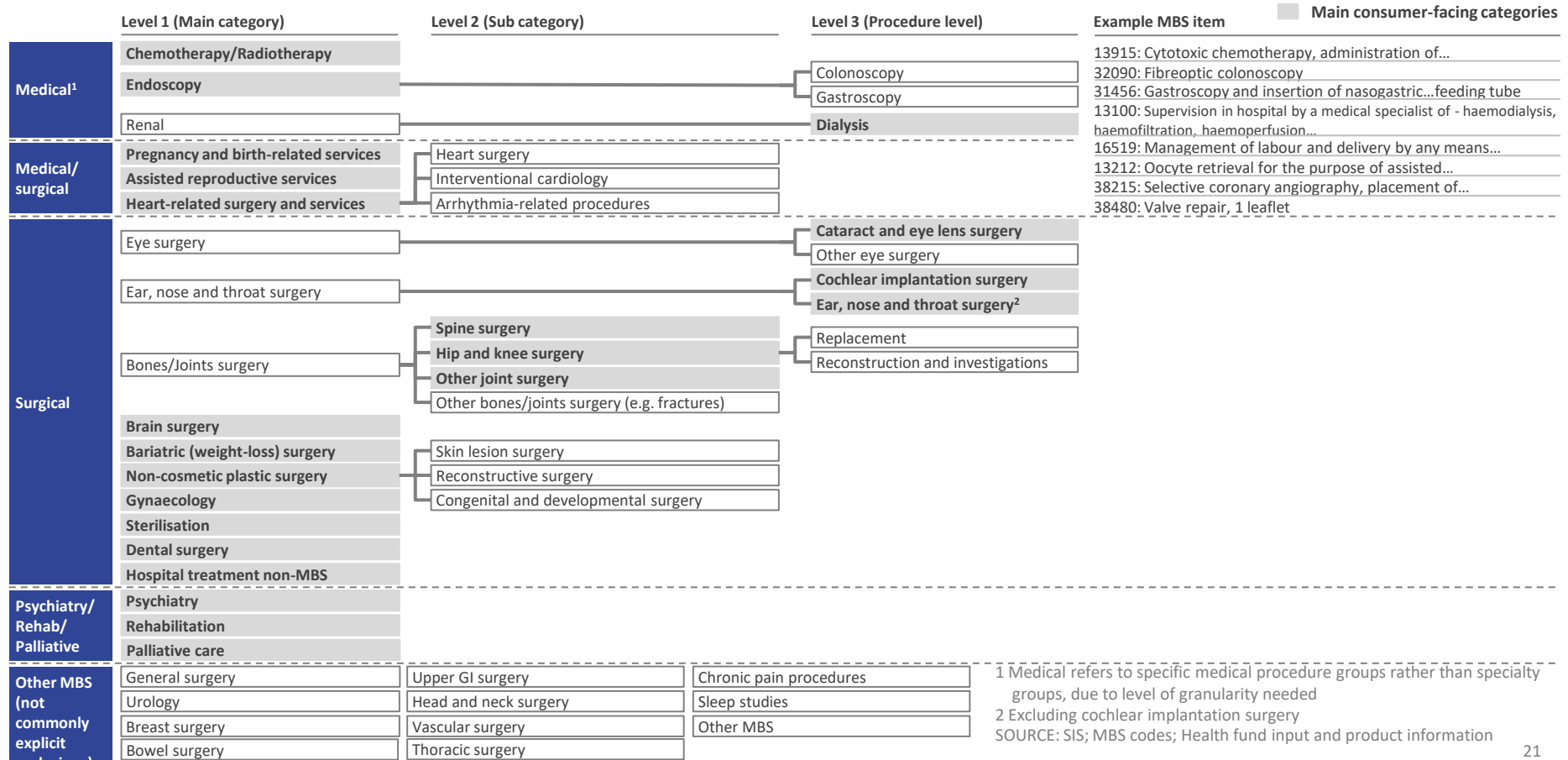
¹ Involves rewording with common terminology currently used by funds

² Only consumer-facing categories shown

³ Excludes cochlear implantation surgery

SOURCE: SIS; MBS codes; Health fund input and product information

Terminology reference tree



Terminology for general (extras) cover

ILLUSTRATIVE

Use current SIS categories as a starting point

- General dental
- Major dental
- Endodontic
- Optical
- Non-PBS pharmaceuticals
- Physiotherapy
- Podiatry
- Psychology
- Orthodontic
- Hearing aids
- Blood glucose monitors
- Chiropractic
- Remedial massage
- Naturopathy
- Acupuncture
- Ambulance

▪ Other services (see insurer for details)

Additional terminology used by insurers to define categories for use in general (extras) products¹

- General dental
- Major dental²
- Optical
- Non-PBS pharmaceuticals
- Physiotherapy
- Podiatry
- Psychology
- Orthodontic
- Aids and appliances³
- Chiropractic
- Dietetics/Nutrition
- Speech therapy
- Occupational therapy
- Osteopathy
- Remedial massage
- Natural therapies⁴
- Exercise physiology
- Audiology
- Eye therapy
- Antenatal and postnatal services
- Health management programs
- Yoga/pilates/gym
- Home nursing
- Travel and accommodation
- Vaccinations
- Ambulance

¹ Involves rewording with common terminology currently used by health funds to standardise across SIS and health funds

² Includes endodontic

³ As a minimum, must include hearing aids and blood glucose monitors; can include all other devices including blood pressure monitors, breathing devices (nebulisers, spacers and CPAP machines/accessories)

⁴ Includes coverage such as Acupuncture, Naturopathy, Homeopathy, Aromatherapy, Reflexology, Traditional Chinese medicine, Herbalism, etc.

SOURCE: SIS; Health fund input and policies

Terminology updates would require a grace period for adoption by health funds

	Up to 6 months	6–24 months	24+ months
	Design and plan implementation	Implementation and roll-out	Maintain and update
Health funds	<ul style="list-style-type: none"> Engage working group (PHA, member funds, medical community) Refine and align on standardised terminology to be used in products as needed 	<ul style="list-style-type: none"> Grace period during which funds update terminology across all products Roll out new terminology across all insurers e.g., on 1 June 2018 Update existing IT systems and product specifications as required Notify members of changes 	<ul style="list-style-type: none"> Help inform updates of terminology definitions over time and maintain IT systems Review and agree terminology to describe exclusions on an ongoing basis (e.g., every 5 years)
Medical community	<ul style="list-style-type: none"> Refine technical definition of medical inclusions and exclusions—build on newly defined categories 	<ul style="list-style-type: none"> Align systems to new terminology where needed 	<ul style="list-style-type: none"> Help inform updates of terminology definitions over time
Government	<ul style="list-style-type: none"> Inform and support working group processes 	<ul style="list-style-type: none"> Support implementation and roll-out 	<ul style="list-style-type: none"> Support the maintenance and update of technical definitions on an ongoing basis with insurers and medical community

There are three broad options for defining product ‘classifications’ for comparability

 Recommended solution

Option 1	Option 2	Option 3
<p>Procedure or service coverage only</p> <ul style="list-style-type: none"> Define product classification based on inclusions/exclusions across procedure or service groups 	<p>Service coverage and financial metrics</p> <ul style="list-style-type: none"> Define product classification based on a combination of inclusions/exclusions, and financial metrics (e.g. excesses, co-pays, expected out-of-pocket costs) 	<p>Financial metrics only</p> <ul style="list-style-type: none"> Define product classification based only on financial metrics (e.g. proportion of health expenses a product would pay for on average), with limited flexibility in service coverage
<ul style="list-style-type: none"> + Simple methodology, easy to understand to ensure clarity for consumers + Consistent with existing approach through privatehealth.gov.au and current approach of some PHIs 	<ul style="list-style-type: none"> + Considers both service coverage and potential costs for consumers within classifications + Allows for some flexibility in product design compared to financial value only 	<ul style="list-style-type: none"> + One metric (cost) used to define product classification that attempts to incorporate both coverage and financial value + Consumer certainty over inclusions/exclusions in policy
<ul style="list-style-type: none"> - Potentially highly restrictive method of defining classification (depends on restrictiveness of procedure group criteria) - May require significant changes to product design 	<ul style="list-style-type: none"> - Potentially complex for consumers to compare and understand across both procedure and financial dimensions - Challenging for insurers to control financial metrics related to OOP cost, due to specialist charging variability - May require significant changes to product design 	<ul style="list-style-type: none"> - Very restrictive and high cost for consumers—does not allow consumers to exclude services that they are unlikely to use, or opt for lower coverage products - Limited scope for product innovation and differentiation - Would require significant changes to product design

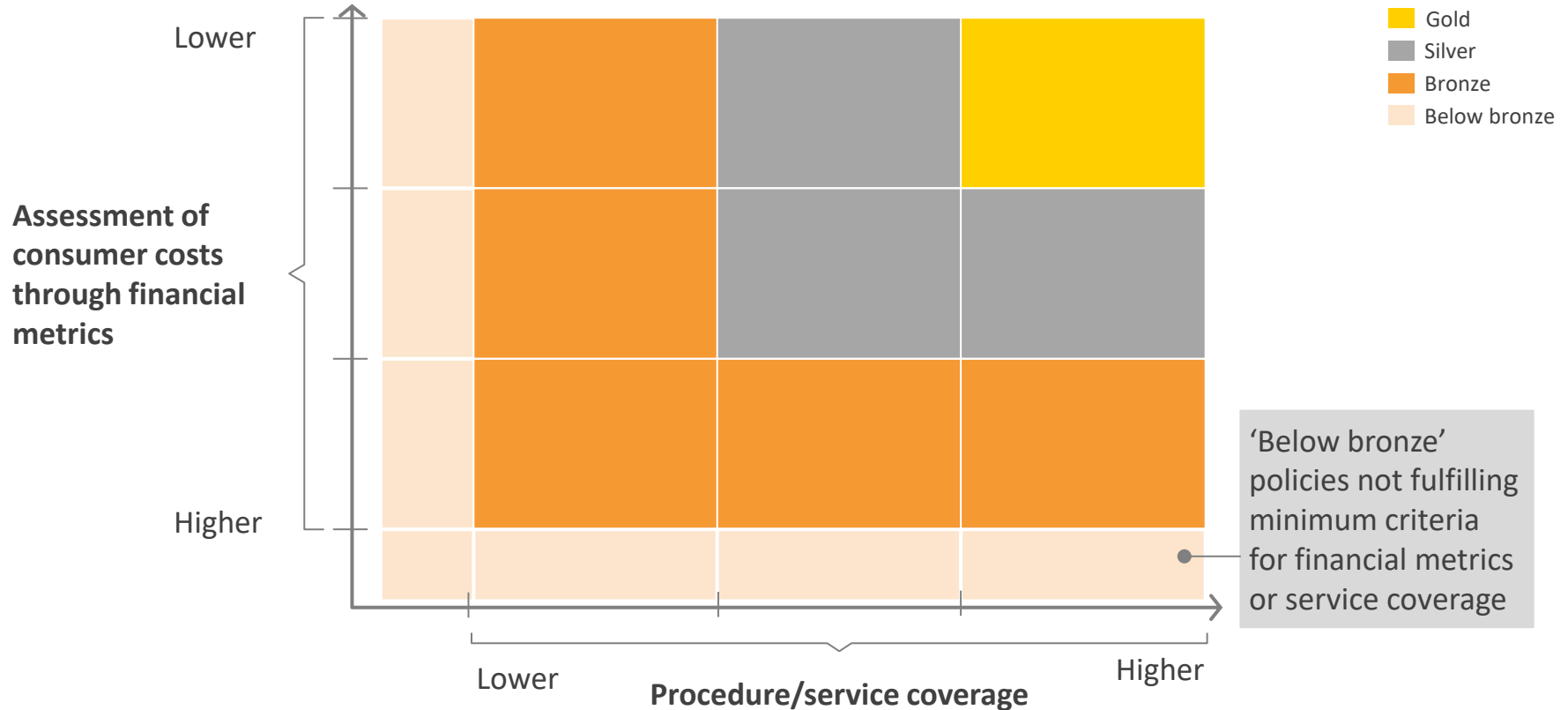
The Health Fund Olympics 'Gold/Silver/Bronze'



Product classification taking into account financial metrics and coverage

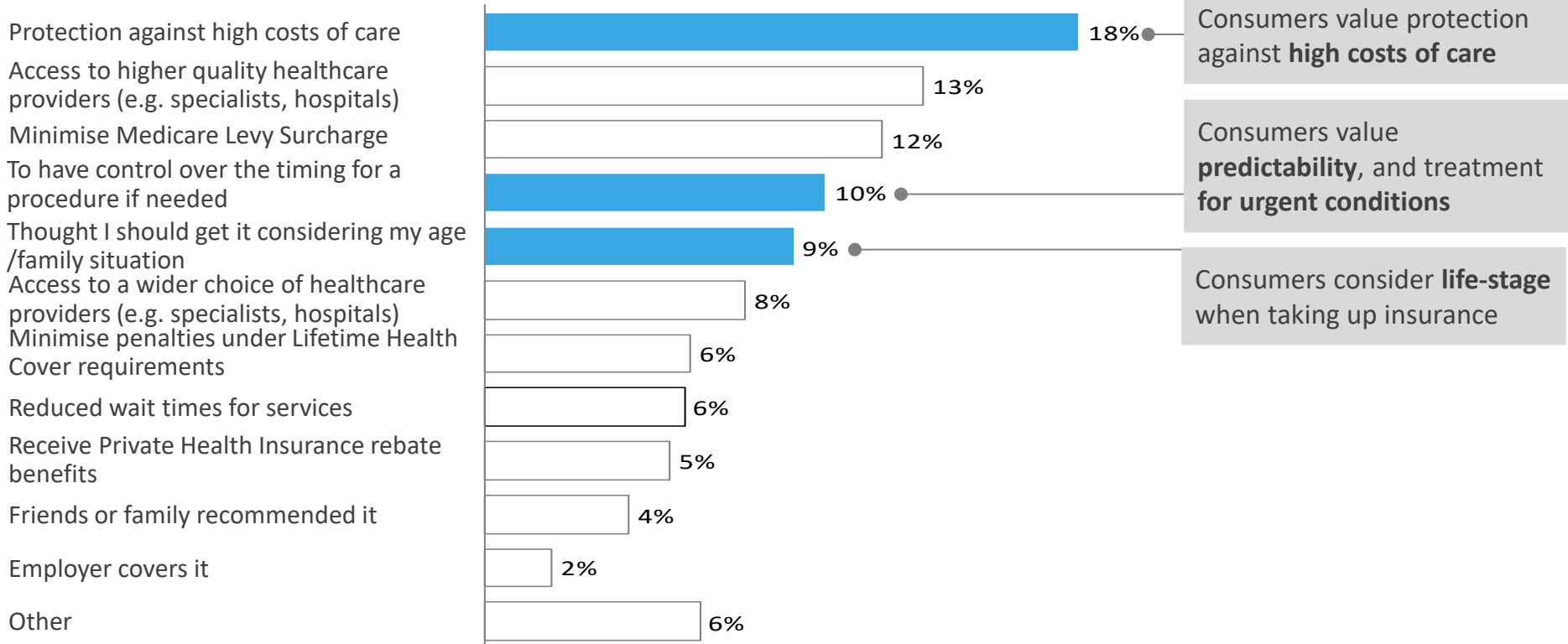
Factors for classification of Bronze—Gold tiers

ILLUSTRATIVE



Coverage levels should take into account factors of importance to consumers

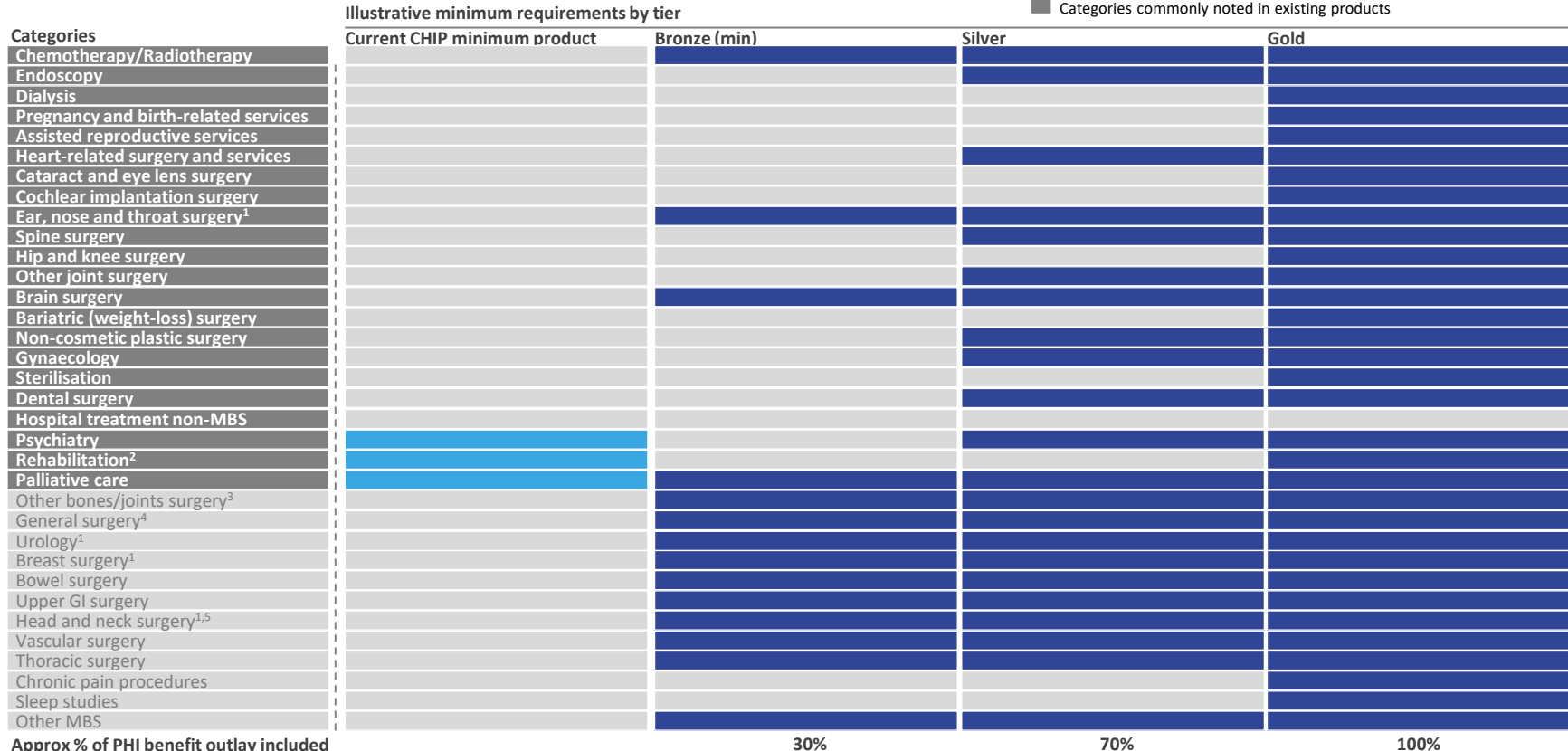
What is the main reason you purchased PHI? Percent



Coverage thresholds should be set at minimum levels

ILLUSTRATIVE

- Full cover
- Current minimum benefit requirement
- No/partial cover
- Categories commonly noted in existing products



1 Should include reconstruction MBS items where reconstruction is a direct consequence of the initial surgery required
 2 Rehabilitation to be included as part of the required care from providers for related episodes of acute care
 3 Includes cover for fractures, hand surgery, tendon surgery and other miscellaneous orthopaedic MBS item numbers

4 Includes appendicectomy, hernia repair, haemorrhoid surgery, and gall bladder removal
 5 Includes traditional head and neck surgery, thyroid surgery, jaw and maxilla surgery
 SOURCE: HCP data collection 2014-15, Health fund data

Predictability and urgency are useful for defining allowable exclusions

Category	Predictability Degree to which patient could predict need	Urgency (acuity) Urgency to have a procedure once diagnosed	Excludable from minimum? ¹
Chemotherapy/Radiotherapy	Unpredictable	Urgent	No
Endoscopy	Predictable	Urgent	Yes
Dialysis	Predictable	Urgent	Yes
Pregnancy and birth-related services	Predictable	Urgent	Yes
Assisted reproductive services	Predictable	Urgent	Yes
Heart-related surgery and services	Unpredictable	Urgent	Yes
Cataract and eye lens surgery	Predictable	Urgent	Yes
Cochlear implantation surgery	Predictable	Urgent	Yes
Ear, nose and throat surgery	Unpredictable	Urgent	Yes
Spine surgery	Unpredictable	Urgent	Yes
Hip and knee surgery	Unpredictable	Urgent	Yes
Other joint surgery	Unpredictable	Urgent	Yes
Brain surgery	Unpredictable	Urgent	No
Bariatric (weight-loss) surgery	Predictable	Urgent	Yes
Non-cosmetic plastic surgery	Unpredictable	Urgent	Yes
Gynaecology			
Sterilisation	Predictable	Urgent	Yes
Dental surgery	Unpredictable	Urgent	Yes
Hospital treatment non-MBS			Yes
Psychiatry	Unpredictable	Urgent	Yes
Rehabilitation	Predictable	Urgent	Yes
Palliative			Yes
Other bones/joints surgery ²	Unpredictable	Urgent	No
General surgery ³	Predictable	Urgent	Yes
Urology	Unpredictable	Urgent	No
Breast surgery	Unpredictable	Urgent	No
Bowel surgery	Unpredictable	Urgent	No
Upper GI surgery	Unpredictable	Urgent	No
Head and neck surgery	Unpredictable	Urgent	No
Vascular surgery	Unpredictable	Urgent	No
Thoracic surgery	Unpredictable	Urgent	No
Chronic pain procedures	Predictable	Urgent	Yes
Sleep studies	Predictable	Urgent	Yes
Other MBS			No

ILLUSTRATIVE

Predictability
 Unpredictable
 Predictable

Urgency
 Urgent
 Non-urgent

1 Category is excludable in minimum product if not the highest unpredictability, silver and higher classifications also consider acuity

2 Includes cover for fractures, hand surgery, tendon surgery and other miscellaneous orthopaedic MBS item numbers

3 Included in this category are appendicectomy, hernia repair, haemorrhoid surgery, and gall bladder removal

SOURCE: Health fund data; Expert assessment



Including financial metrics in product classification is challenging

Type of metric	Options	Description	Suitability for use in product categorisation	Rationale
PHI policy-defined metrics	Excess	<ul style="list-style-type: none"> Either per year or per admission cost (e.g. \$0, \$250, \$500 depending on policy chosen) 		Excess could be a relevant metric to include in assessment of consumer cost, but on its own is relatively clear to consumers
	Co-payments	<ul style="list-style-type: none"> Per day cost (e.g. \$100 per day) that applies to some policies, at times used instead of an excess 		Co-payments not commonly used in policies ¹
	Restrictions	<ul style="list-style-type: none"> Condition or services which insurance policies cover to a limited extent, and will pay reduced benefits on hospital admissions 		Restrictions indicate areas of additional costs to consumers, but impact on cost is variable based on treatment area
	Benefit limitation periods	<ul style="list-style-type: none"> Initial period of time during which only a minimum benefit is paid for some types of hospital treatment Applies to new PHI members 		Benefit limitation periods are not commonly used in policies
	Waiting periods	<ul style="list-style-type: none"> Time an insured person may have to wait before being eligible for health insurance benefits 		Waiting periods are similar between providers due to existing regulations ²
Hospital network defined metrics	Network of facilities/providers available	<ul style="list-style-type: none"> Network coverage in terms of hospitals that are contracted by a PHI and accessible by members 		Tends not to vary significantly by PHI ³
	Additional hospital costs (e.g. incidentals)	<ul style="list-style-type: none"> Incidentals and additional costs that vary by hospital 		Costs difficult to assess uniformly by policy, due to particular contractual arrangements with hospitals
Specialist Gap cover metrics	% of providers using gap scheme	<ul style="list-style-type: none"> Proportion of providers using a gap cover scheme for services 		Would tend to vary by PHI (not product) and does not take into account magnitude of cost
	% of services with no OOP (SIS)	<ul style="list-style-type: none"> % of services a product covers on average that has no out-of-pocket costs 		Would tend to vary by PHI (not product) and does not take into account magnitude of cost
Combined metric to measure consumer cost	Average out-of-pocket	<ul style="list-style-type: none"> Average out-of-pocket cost for hospital separation for insured persons with product 		Does not factor in differences in cost of procedures claimed in each product type
	Average % of charges covered by PHI	<ul style="list-style-type: none"> Average proportion of total hospital and medical charges that PHI benefits would cover 		Potentially appropriate metric to include in categorisation, although includes a large element of uncontrollable medical gap

¹ Estimated 4% of marketable products use co-payments according to SIS data

² The proportion of policies applying the full regulatory waiting period varies between 96 and 100% depending on the type of waiting period (based on SIS data June 2016)

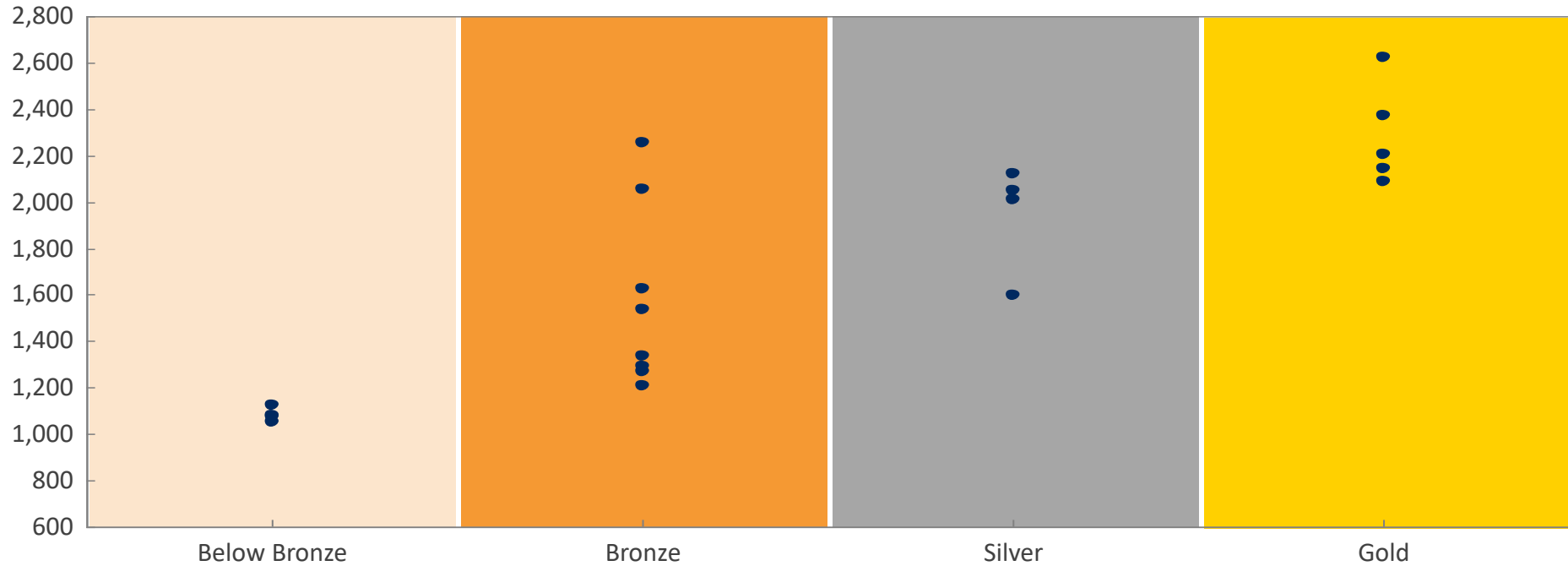
³ Number of private hospitals with agreements varies between 229 and 284 by PHI (privatehealth.gov.au information)

SOURCE: Health fund complaint data; Health fund websites and product information; privatehealth.com.au; SIS information June 2016

Classification would broadly fit the existing product landscape

Preliminary assessment of hospital product landscape¹

Premium per year², \$



- Gold
- Bronze
- Silver
- Below Bronze
- Each point is one product

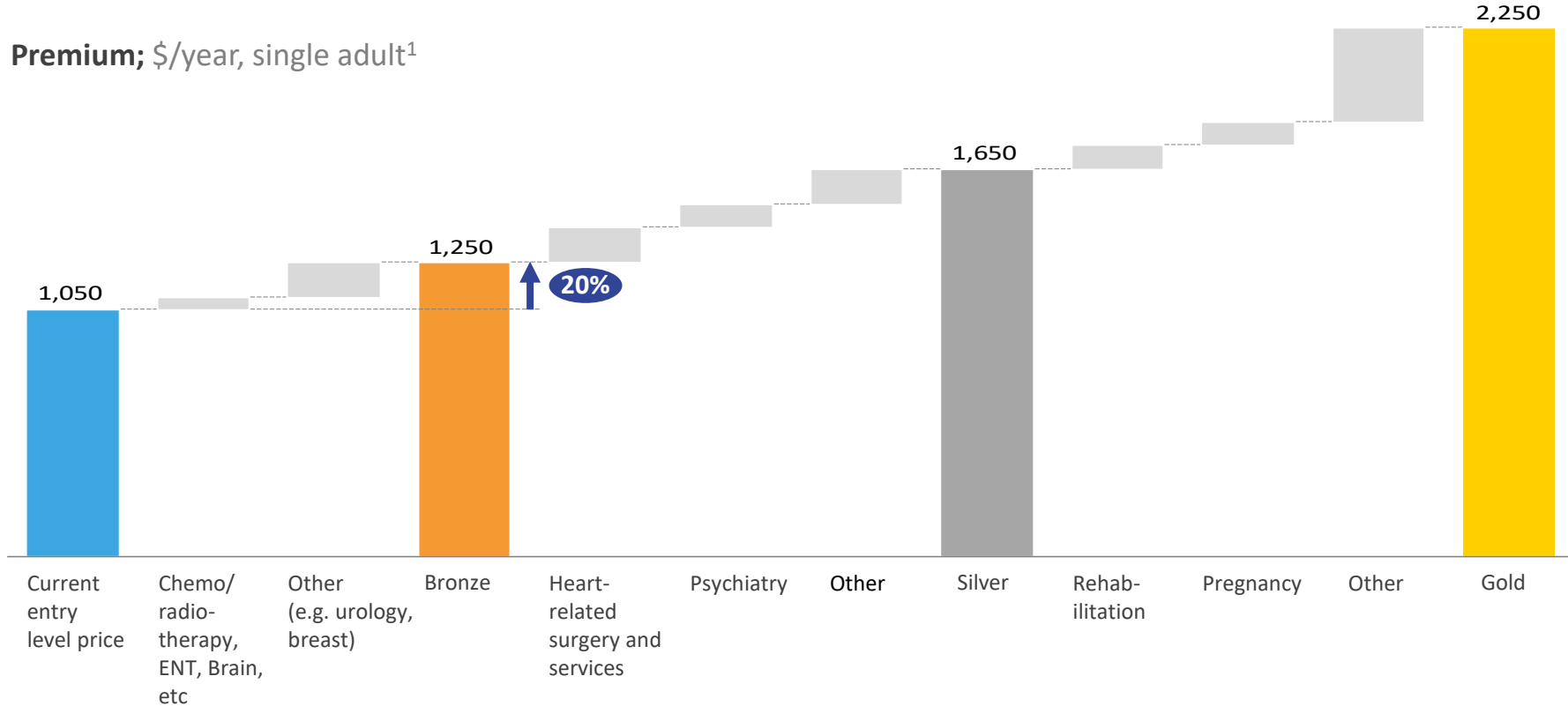
Coverage level

¹ Assumed unrestricted cover for Palliative care, Psychiatry and Rehabilitation
² Premium based on Single adult cover, \$500 excess, NSW, before rebate
 SOURCE: Publicly available product information (marketable products, 5 funds only), SIS information June 2016

Introduction of a 'bronze' minimum standard would increase the price of entry level products

INDICATIVE ONLY

Premium; \$/year, single adult¹



¹ Example related to \$500 excess, NSW, before rebate, actual prices would vary by state, customer mix, portfolio
 SOURCE: Estimation based on health fund input

For general (extras) products, classifications of basic, medium and comprehensive coverage could be used as a starting point

	Coverage levels		
	Bronze ¹	Silver ²	Gold ³
General dental	Dark Blue	Dark Blue	Dark Blue
Major dental ⁴	Dark Blue	Dark Blue	Dark Blue
Optical	Light Blue	Light Blue	Dark Blue
Non-PBS Pharmaceuticals	Dark Blue	Dark Blue	Dark Blue
Physiotherapy	Light Blue	Light Blue	Dark Blue
Podiatry	Light Blue	Light Blue	Dark Blue
Psychology	Light Blue	Light Blue	Dark Blue
Orthodontic	Light Blue	Light Blue	Light Blue
Aids and appliances	Light Blue	Light Blue	Light Blue
Chiropractic	Light Blue	Light Blue	Light Blue
Dietetics/Nutrition	Light Blue	Light Blue	Light Blue
Speech therapy	Light Blue	Light Blue	Light Blue
Occupational therapy	Light Blue	Light Blue	Light Blue
Osteopathy	Light Blue	Light Blue	Light Blue
Remedial massage	Light Blue	Light Blue	Light Blue
Natural therapies	Light Blue	Light Blue	Light Blue
Exercise physiology	Light Blue	Light Blue	Light Blue
Audiology	Light Blue	Light Blue	Light Blue
Eye therapy	Light Blue	Light Blue	Light Blue
Antenatal and postnatal services	Light Blue	Light Blue	Light Blue
Health management programs	Light Blue	Light Blue	Light Blue
Yoga/pilates/gym	Light Blue	Light Blue	Light Blue
Home nursing	Light Blue	Light Blue	Light Blue
Travel and accommodation	Light Blue	Light Blue	Light Blue
Vaccinations	Light Blue	Light Blue	Light Blue
Ambulance	Light Blue	Light Blue	Light Blue

ILLUSTRATIVE

- Cover must be offered
- Optional categories
- No cover required
- Categories listed, but no requirement for cover

¹ Current privatehealth.gov.au classification has no fixed criteria for a 'Basic' product

² Must include 5 of 8 additional categories, categories should be made available to consumers, but consumers could have the ability to 'opt-out' of cover for alternative coverage

³ Must include 3 of 7 additional categories, categories should be made available to consumers, but consumers could have the ability to 'opt-out' of cover for alternative coverage

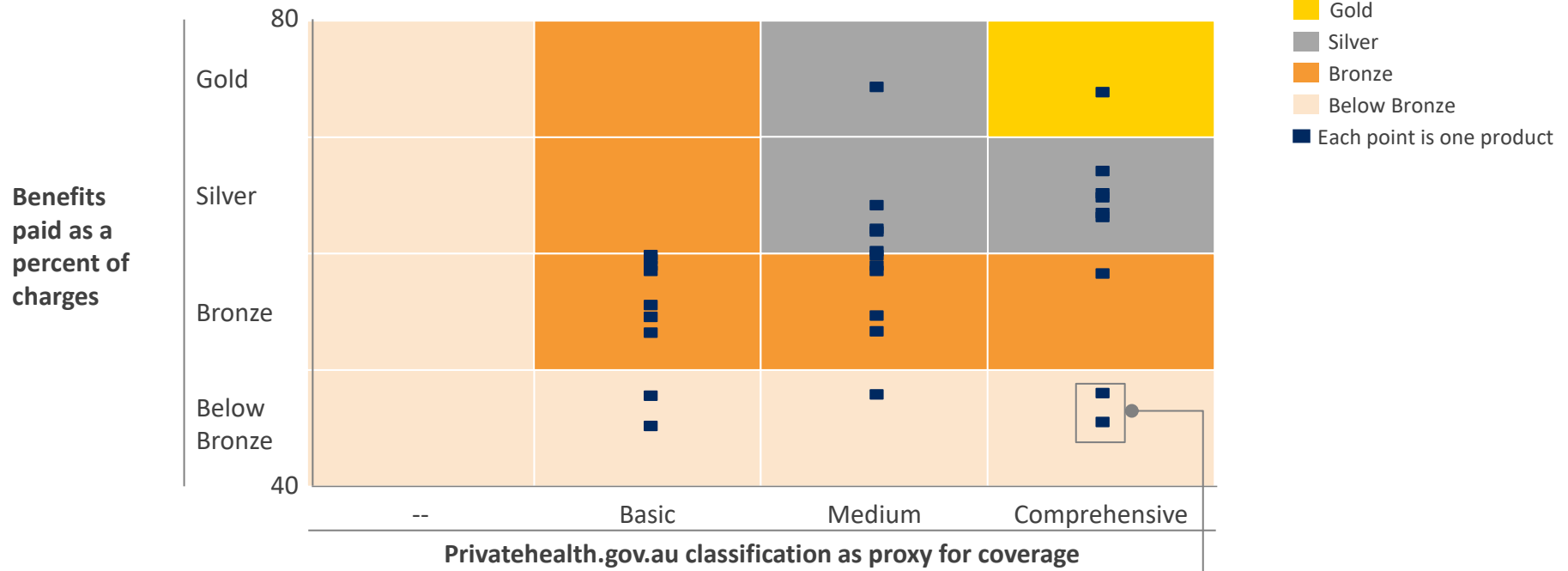
⁴ Includes endodontic

SOURCE: Privatehealth.gov.au; health fund product analysis

Benefits paid as a proportion of charges is a relevant metric for general (extras) cover

Classification of Bronze—Gold products

ILLUSTRATIVE



Products theoretically have full classification for a comprehensive product but have very low sub-limits by modality

Implementation of product standardisation would require further design and testing and a gradual transition

	Up to 12 months	12–24 months	24+ months
	Align on approach and testing	Development and implementation	Transition and maintain
Health funds	<ul style="list-style-type: none"> Engage working group (PHA, health funds, government) Agree approach for standardisation Agree minimum product specification and clear definition of gold/silver/bronze classification Undertake pricing work and testing 	<ul style="list-style-type: none"> Develop new products in line with categorisation needs, test with consumers Implement changes required to deliver new products Close existing products not meeting standards 	<ul style="list-style-type: none"> Inform consumers holding policies of new product classification Update policy communications Transition those on products below the minimum product to appropriate marketable products over a 3 year period
Government	<ul style="list-style-type: none"> Agree approach for standardisation and recommendations to take forward Agree minimum product specification and clear definition of gold/silver/bronze classification 	<ul style="list-style-type: none"> Support changes to legislation or regulation where needed Support with policies to ease the transition for policy holders 	<ul style="list-style-type: none"> Continue to review impact on market and update standards as needed
Consumers	<ul style="list-style-type: none"> Test concepts with consumers 	<ul style="list-style-type: none"> Consumers made aware of upcoming changes to products 	<ul style="list-style-type: none"> Consumers informed of product classifications, and transitioned over a 3 year period

Timelines for implementing changes would depend on terminology and product standardisation



Design and plan implementation

Implementation and roll-out

Maintain and update

Health funds

- Establish working group (Government and insurers) to align on changes needed, in line with terminology and product standardisation recommendations
- Test potential changes with consumers

- Establish systems to implement changes to product communications and information
- Gradually implement changes to product information provided on websites and other channels to reflect new standards

- Update insurer communications on an on-going basis to respond to consumer needs

Government

- Agree on redesign of Standard Information Statements (SIS) and government comparison website
- Test potential changes with consumers

- Enact legislative changes as required, including allowing greater flexibility to update SIS
- Implement changes to product information provided on Government websites

- Update SIS and Government communications on an on-going basis to respond to consumer needs

Conclusions and risks in product design for transparency

- ☑ There is a significant risk if poorly implemented, Gold/Silver/Bronze classification could decrease consumer transparency and increase complexity. PHA is committed to development of an affordable solution;
- ☑ Limiting exclusions and redefining the minimum benefit will create affordability risk for consumers – can we mitigate this through a package of regulatory reform, or more fundamental changes to inputs eg cover less expensive new models of care for mental health, obstetrics in bronze?;
- ☑ Rigid product classification beyond defining a minimum benefit in each category anticompetitive and may push up premiums further;
- ☑ Be careful of what is defined as a ‘junk’ policy. Basic table legacy products have value for some segments, especially in regional areas;
- ☑ Consider ‘hospital’ and ‘extras’ cover separately.



Where we have ended up....

- ✓ We will retain a 'Basic' minimum benefit under the product classification policy;
- ✓ This will remain a low cost policy that will cover the member for treatment in a public hospital with a doctor of choice, as well as restricted benefits for palliative care, rehabilitation and mental health;
- ✓ This will retain an appropriate option for people on low incomes with a chronic condition requiring specialist care, and people living in a rural area;
- ✓ There will be a 'safety net' for people on this level of cover who are unexpectedly admitted to hospital with a serious mental health condition, so they do not have an excessive co-payment;
- ✓ 'Hospital' and 'extras' cover will be classified separately.

