Australian Government

Department of Health

Senate Community Affairs Legislation Committee – Inquiry into the Private Health Insurance Legislation Amendment Bill 2018 and related Bills

AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH SUBMISSION

July 2018

Introduction

The Department of Health (the department) provides the following submission for the consideration of the Senate Community Affairs Legislation Committee Inquiry into the Private Health Insurance Legislation Amendment Bill 2018 (the Bill) and related Bills.

This submission should be read in conjunction with the Explanatory Memorandum which sets out the policy context for the legislation and its impacts on different groups, as well as explanatory material on each measure.

After providing some background on the private health insurance reform package and implementation so far, this submission focuses on three matters raised in the House of Representatives when the Bill was being debated on 31 May 2018:

1. Increasing the maximum excess levels;
2. Age-based discounts for hospital cover; and
3. Terminating products.

Background

On 13 October 2017, the Minister for Health, the Hon Greg Hunt MP, announced significant reforms to private health insurance designed to simplify private health insurance and make it more affordable for consumers.

The package consists of the following reforms:
- product design reforms, including:
  - a new system for categorising health insurance products (Gold/Silver/Bronze/Basic product categories);
  - enhancing mental health support to improve patient access to mental health services;
  - establishing the Improved Models of Care Working Group to provide advice on improving the funding arrangements for private health insurance funded mental health and rehabilitation services;
- introducing standard clinical categories;
- improved access to travel and accommodation benefits which will benefit regional and rural patients and their carers;
- strengthening the powers of the Private Health Insurance Ombudsman;
- establishing the Ministerial Advisory Committee on Out-of-Pocket Costs to consider best practice models for transparency of out-of-pocket costs;
- information provision reforms, including upgrading the Government's website (privatehealth.gov.au) and the development of a Private Health Information Statement;
- allowing private health insurers to offer discounted private hospital cover to people aged 18 to 29 years;
- $1.1 billion in prostheses list benefit reductions, achieved under an agreement with the Medical Technology Association of Australia, with the first tranche commencing on 1 February 2018;
- increasing maximum voluntary excess levels;
- changing coverage for some natural therapies; and
- second tier administrative reforms.

These reforms will provide consumers with greater certainty about what is, and is not covered by their policy. Importantly, the changes will also allow consumers to more easily and effectively compare different products.

The Private Health Insurance Complying Product Rules will identify the *minimum* coverage requirements for each category of hospital cover. As is currently the case, insurers will have flexibility to cover additional non-mandatory services within each product category. Insurers do commonly cover a variety of services in entry to mid-range products that may not be mandatory coverage requirements in the proposed Basic, Bronze and Silver categories. It is not the intention of the Government that the new regulations would require insurers to remove cover for such services from their policies. These changes will not increase overall prices for consumers.

Further information about the reforms, including fact sheets for each reform, is available on the department's website: http://www.health.gov.au/internet/main/publishing.nsf/Content/private-health-insurance-reform.

The private health insurance reform package was informed by extensive consumer and industry consultation, including through the Private Health Ministerial Advisory Committee (PHMAC). PHMAC was established to bring together key groups in the private health sector, including consumers, hospitals, clinicians and insurers, to work in partnership with government on the development and implementation of reforms to private health insurance.

PHMAC agreed to the establishment of working groups on a number of topics including standard clinical definitions, information provision and second tier and default benefits. Additionally, PHMAC agreed to hold a rural private health insurance workshop that was attended by some 32 participants from a range of stakeholder groups, including consumers, doctors, hospitals and insurers, to discuss improving the value of private health for regional and rural consumers.

The department publishes PHMAC meeting summaries, summaries from working group meetings and other information (for example, research commissioned on product design) on its website: http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac.

PHMAC continues to provide advice to the Minister on the implementation of the reforms.

The department continues to engage in ongoing consultation with industry on legislative amendments and implementation arrangements. The table below lists the key consultation activities undertaken since the announcement of the reforms in October 2017.

Table 1: Broader consultation activities on the private health insurance reforms

Consultation activity	Date	Groups consulted
Insurers Reform Forum	29 November 2017	All insurers PHMAC members
Exposure draft of the *Private Health Insurance (Complying Product) Amendment (Psychiatric Care) Rules 2018*	7 – 16 February 2018	All insurers PHMAC members
Draft hospital product categories (product grid) and clinical definitions	13 February – 9 March 2018	Private Healthcare Australia Members Health Care Alliance PHMAC
Mental Health Reforms rules amendments roundtable	26 February 2018	Insurers (selection) Private hospitals (selection) Mental health consumer representatives

Minimum data set workshop	27 February 2018	Insurers (selection) Private hospitals (selection) Consumer representatives Australian Competition and Consumer Commission Private Health Insurance Ombudsman
Exposure draft of the *Private Health Insurance Legislation Amendment Bill 2018*	5 – 13 March 2018	Open public consultation Targeted consultation (insurers and private hospitals)
Clinical definitions consultation	16 April – 4 May 2018	All medical colleges All insurers Private hospitals PHMAC members
General treatment product categories consultation paper	20 April – 4 May 2018	Private Healthcare Australia Members Health Care Alliance
Product design modelling	25 May 2018	Actuaries from selected insurers

Several important reforms have already been implemented.

The Government has signed an agreement with the Medical Technology Association of Australia to support the affordability of private health insurance. Reductions in benefits for a range of prostheses will generate savings to insurers of about $1.1 billion over four years. The first tranche of these reductions took place in February 2018, and was passed on by insurers to consumers in the form of lower premium increases applying from 1 April 2018. The national industry weighted average private health insurance premium increase of 3.95 per cent for the 2018 premium year is the lowest in nearly two decades.

Changes to make it easier for policy holders to access mental health services when they need it also took place on 1 April 2018. Patients with limited mental health cover are now able to upgrade their cover on a once-off basis to access mental health services in a private hospital setting without serving a waiting period. This is a particular benefit for younger people who are more likely to need mental health services compared with other health services, and are more likely to be purchasing cheaper insurance policies with restricted mental health cover.

A number of other reforms can be implemented through amendments to Private Health Insurance Rules (subordinate legislation made under the *Private Health Insurance Act 2007* (the Act)). These include changes to product design (product and clinical categories) and coverage of natural therapies.

Other reforms require amendments to the Act and associated taxation laws. In many cases amendments to the Act will create a policy framework, with details to be set out in the Private Health Insurance Rules. This is consistent with the current operation of the private health insurance legislation, where much of the detailed regulation is contained within the Rules.

The measures contained in the Bills under consideration by the Senate will:
- allow for insurers to offer age-based premium discounts for hospital cover;
- allow private health insurers to cover travel and accommodation costs as part of a hospital treatment;
- strengthen the powers of the Private Health Insurance Ombudsman;
- improve information provision for consumers;
- reform the administration of second tier default benefits arrangements for hospitals;
- allow insurers to terminate products and transfer affected policy holders to new products;

- increase maximum voluntary excess levels for products providing individuals an exemption from the Medicare Levy Surcharge; and
- protect consumers who may have purchased benefit limitation period inclusive policies following the Government's decision to improve transparency for consumers by removing the use of benefit limitation periods in private health insurance policies.

An Exposure Draft of the Private Health Insurance Rules which was released for public comment on 16 July 2018 is attached to this submission for the information of the Senate. Further information on the Exposure Draft is available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/exposure-draft-subordinate-legislation-private-health-insurance-reforms-amendment-rules-2018.

Monitoring of reforms
The department is working with the Australian Prudential Regulation Authority (APRA) to develop data requirements related to the reforms. This will ensure that the department can accurately monitor and analyse the effects of the reforms. These new arrangements will be in place by 1 April 2019 when the bulk of the reforms take effect. APRA is already collecting data on the mental health reforms, which took effect on 1 April 2018.

COMMENTS ON SPECIFIC SCHEDULES OF THE BILL

Schedule 1 – Increase to maximum excess levels

The amendments in Schedule 1 will allow consumers to purchase products with increased maximum voluntary excess levels that exempt the holder from the Medicare Levy Surcharge (MLS). This means that insurers can offer lower premium prices, which improves affordability for consumers as well as providing a greater choice of products.

From 1 April 2019, the increased levels of voluntary excess that insurers can apply are $750 in any 12 month period in relation to a policy under which only one person is insured, or $1,500 in any 12 month period in relation to any other policy. This is an increase from $500 for single policies and $1,000 for couple and family policies. There is no requirement for insurers to offer products with higher excesses or for consumers to move to products with higher excesses.

Affordability is a key concern for many consumers. Increasing excesses will place downwards pressure on premium growth for consumers who move to new maximum voluntary excess products. The Department's analysis of existing product's suggest that a single person on a mid-range policy could save over $200 a year if they choose to move from a product with a $500 excess to one with a $750 excess, while a family could save over $350 from moving from a product with a $1,000 excess to one with a $1,500 excess.

A concern raised when the Bill was introduced was, in the short term, consumers will opt for higher excesses, and they will not be able to afford to pay these excesses when they need care.

People purchasing private health insurance already make the considered choice to either pay a higher premium at point of purchase, in exchange for a lower excess at time of use, or a lower premium upfront and a higher excess at time of use. This is consistent with other insurance products and is clearly outlined in insurance policies.

The majority of policies held do have excesses. Data from the 2018 premium round shows that currently most consumers do not purchase products with the highest allowable excesses. This indicates that consumers already make informed decisions based on their personal circumstances and capacity to pay, both in terms of premiums and excesses should they need to go to hospital.

There is no reason to believe that allowing higher maximum voluntary excesses would change consumers' consideration of this choice.

Voluntary maximum excess levels have not been increased since 2001. Increasing maximum excesses as proposed broadly reflects the growth in health costs over the period to 2018. It will approximately restore the level of co-insurance that existed when the current maximum voluntary excesses were set for those policy holders wishing to assume this level of co-insurance.

Excess levels are not a significant area of confusion or concern identified by consumers in complaints to the Private Health Insurance Ombudsman (PHIO). In 2016-17, excesses accounted for around 1 per cent of total complaints to the PHIO.

Schedule 2 – Age-based discounts for hospital cover

The amendments in Schedule 2 will enable insurers to offer premium discounts on hospital cover for people who first purchase hospital insurance when they are aged 18 to 29. Insurers will be able to offer premium discounts on hospital cover of two per cent for each year that a person is aged under 30, to a maximum of 10 per cent for 18 to 25 year olds. For example, this means that a young person purchasing a policy with a premium of $1,500 could save up to $150 per annum with a discount up to 10 per cent, and a young family purchasing a policy with a premium of $3,000 could achieve a saving of up to $300 per annum.

Insurers will be allowed to offer products which provide age-based discounted hospital cover from 1 April 2019. It will not be mandatory for insurers to offer these products. Insurers will be able to make commercial decisions about whether to offer products with age-based discounts and will be responsible for how this policy is operationalised.

The age-based discounts will apply in addition to the maximum discount percentage currently specified in the Private Health Insurance (Complying Products) Rules.

The viability and sustainability of the private health insurance system relies on a broad membership base, including participation by young Australians who generally have lower claiming rates than older policy holders. Encouraging more young people to take out private health insurance will support our community rated system by keeping premiums affordable for all Australians.

Younger Australians, particularly those under the age of 30, have far lower rates of private health insurance participation than most other age groups. This means that many young people are currently missing out on the benefits of private health insurance – greater choice in the provision of treatment, access to shorter waiting times, and coverage for some services not funded by Medicare.

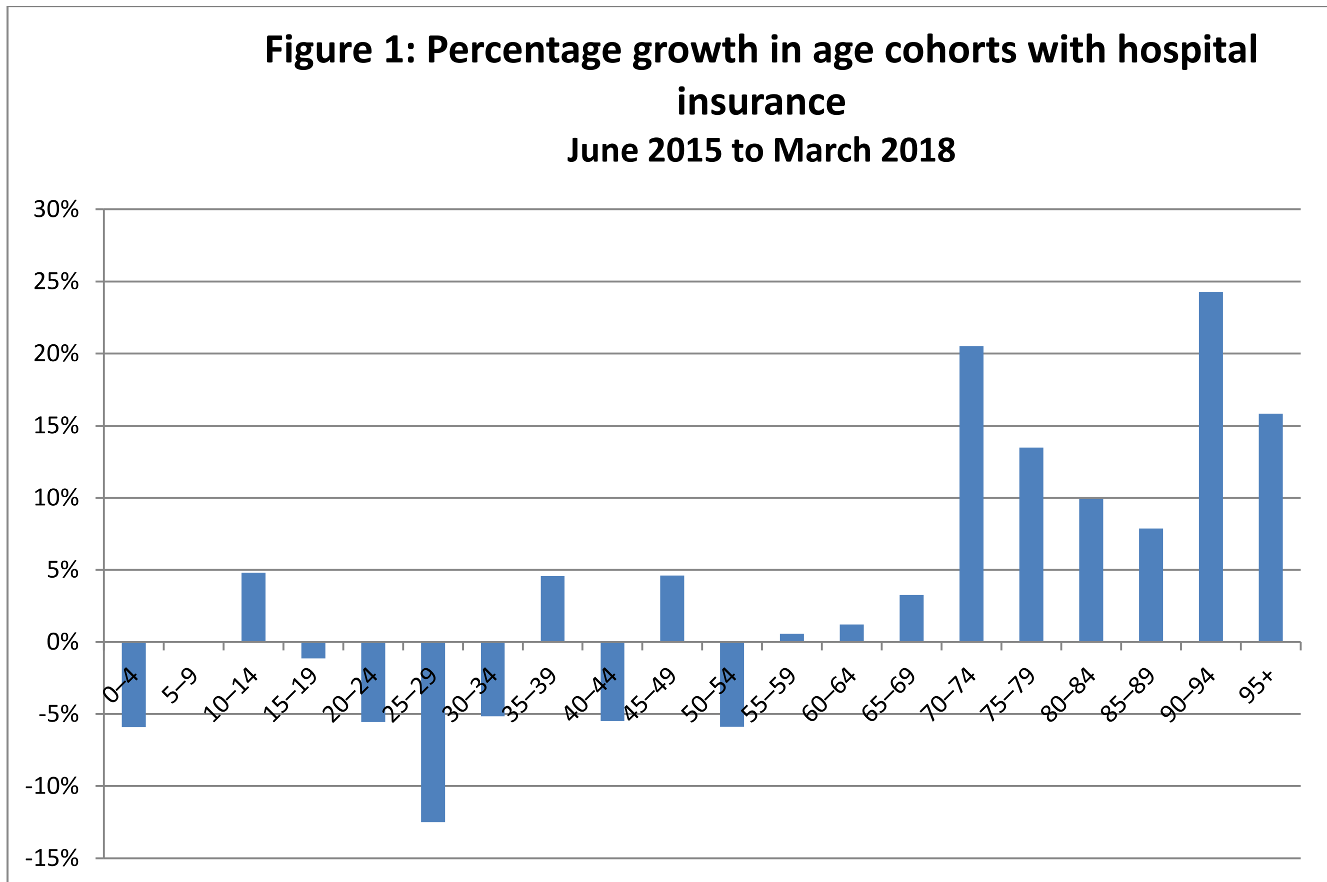
Figure 1 shows the change in the growth of people with hospital treatment policies by age category over the past three years. This chart shows the decline in private health insurance coverage, in particular, of people aged 20-24 and 25-29.

There are currently no explicit positive incentives to encourage younger people to join private health insurance. Industry groups have suggested that introduction of well-designed discounted products could encourage in the order of 100,000 more young Australians to purchase private health insurance.

Allowing age-based discounts will help to improve the affordability of private health insurance for young Australians, increasing their access to private hospital services. Young Australians could

save hundreds of dollars on premiums each year, which would be a significant saving by the time they turn 41 and the discount starts to phase out.

To limit consumers' one-off exposure to large premium increases when the person turns 41, any age-based discount that a person holds will reduce at the rate of 2 percentage points per year for up to five years, so that no age-based discounts are available after the age of 45.



Source: Data from the Australian Prudential Regulation Authority

Schedule 5 Part 4 – Closed and terminated products

The amendments in Schedule 5, Part 4 introduce important consumer protections for when a policy holder's product is terminated, and clarifies the requirements on insurers when terminating a product and transferring people to different policies.

The Act already allows insurers to terminate a product and transfer policy holders to other products. Under subsection 75-15(3) of the Act, insurers are already able to transfer policy holders from a closed product to an open product.

The amendments clarify for industry that the principle of community rating does not prevent insurers from:

- closing a product (by making it no longer available to new policy holders); or
- terminating a product by ceasing to make it available to any policy holder, even those already insured under the product; and
- transferring policy holders from a terminated product to a new policy.

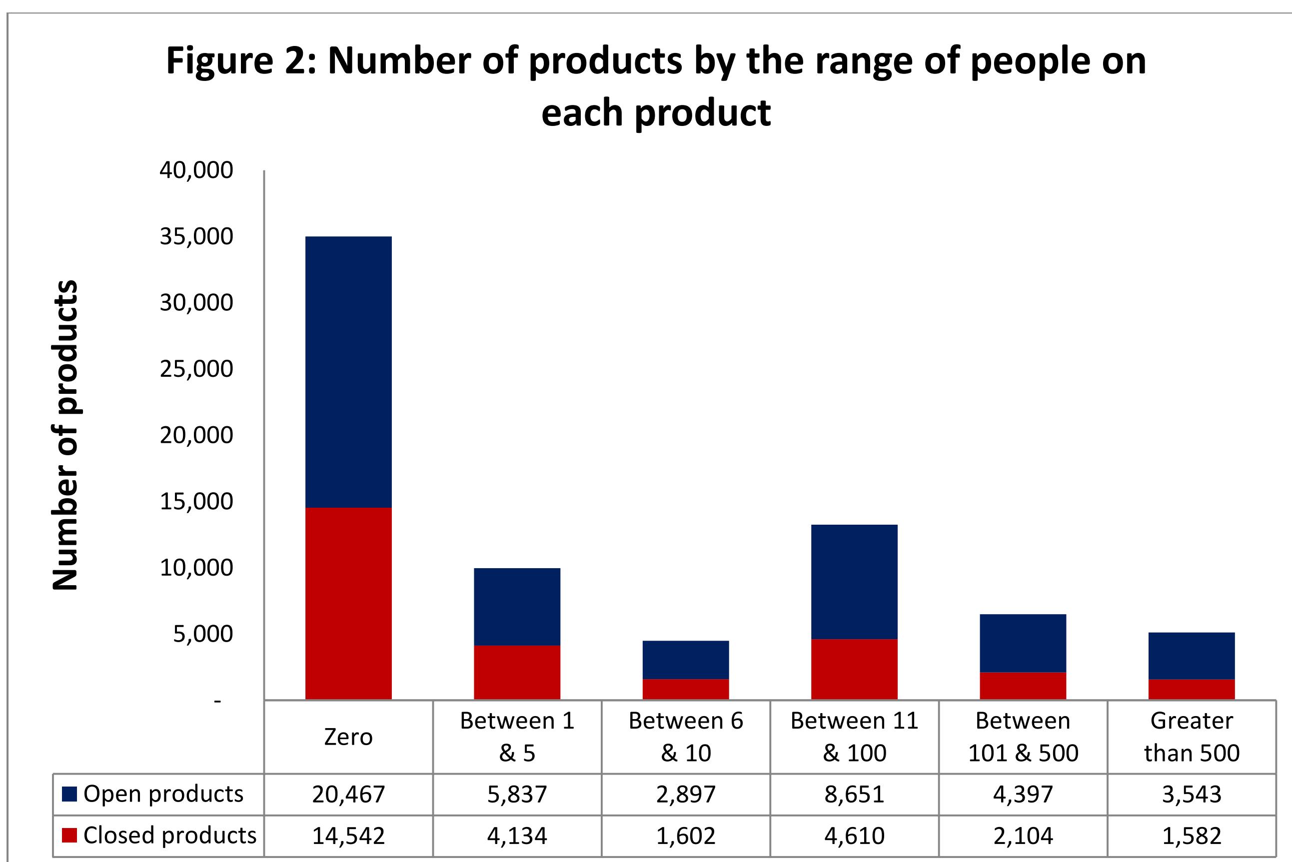
The amendment will also introduce important new consumer protections by requiring insurers to provide adequate information to policy holders of the planned termination of their product and the associated transfer to a new policy.

The information that an insurer must provide will be set out in the Private Health Insurance Rules and will include:

- details about the new policy, including:
    - any services that are covered under the terminating policy that will not be covered under the new policy;
    - differences between the excesses or co-payments payable under the terminating policy and the new policy; and
    - relevant details about waiting periods that might apply under the new product;
- details of the premium that will be payable for their new policy; and
- advice that any person covered under the terminating policy may choose to transfer to a different policy instead of the one chosen by the insurer.

While an insurer will move policy holders whose product is terminating to a new product, the insured person can choose to move to any product that is available from their current insurer or a new insurer using the existing “portability” provisions. This means that when a consumer transfers to a new policy covering the same treatments as their old policy, all of the hospital waiting periods they have already served will be honoured.

This amendment will make it easier for people to compare products and will generate considerable efficiencies in the system. Currently, insurers have a practice of closing a product to new entrants but maintaining it for existing policy holders. This means that, at the moment, there are over 25,000 closed products. Of these closed products, as Figure 2 shows, about half have no people on the product.



	Zero	Between 1 & 5	Between 6 & 10	Between 11 & 100	Between 101 & 500	Greater than 500
Open products	20,467	5,837	2,897	8,651	4,397	3,543
Closed products	14,542	4,134	1,602	4,610	2,104	1,582

Source: 2018 premium round data

Being able to move individuals from terminated products to current products will assist insurers in implementing new product classifications of Gold/Silver/Bronze/Basic.

Consumers will still be eligible to receive the benefits of universal health care under the Australian public health system and may continue to choose to access the private health system as private self-funded patients.