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

Submission to Senate Community Affairs Legislation Committee

Private Health Insurance Legislation Amendment Bill 2018

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Introduction

Private Healthcare Australia (**PHA**), the peak body representing Australia's major health funds, welcomes the opportunity to provide this submission on the *Private Health Insurance Legislation Amendment Bill 2018* (**the Bill**).

The Bill is the culmination of more than two years of consultation by the Government on private health insurance (**PHI**) reform. Private health funds have contributed to the process, in collaboration with other stakeholders in the private health sector. PHA welcomes the Bill, which introduces a broad-ranging package of reforms important to the sustainability of PHI and the private health sector. The reforms in this Bill will put downward pressure on premiums and make it easier for consumers to choose and use their health insurance. These reforms will critically support the industry to deliver high-value, affordable care to Australians.

PHI is an integral part of Australia's mixed public-private health care system. PHI pays for close to two thirds of non-emergency surgery in Australia, 76% of same day mental health treatments and 56% of all mental health care type admissions, 61% of joint replacements, 59% of chemotherapy and 86% of retinal procedures. Currently, three in seven hospital admissions in Australia are funded by PHI, and PHI pays for five out of six admissions in private hospitals. In addition, under general treatment cover, health funds pay out more than $2.628 billion for dental care each year, substantially more than is paid towards dental care by the Federal Government. The majority of dental health services provided to low and middle income earners are subsidised by health funds in some way.

More than 13.5 million Australians, or 55% of the total population, hold some form of PHI and almost half of them have an annual income of under $50,000. Community support for PHI is longstanding and strong with more than 80% of Australians with PHI valuing the product and wanting to keep it.[1]

A strong private health system delivers economic efficiencies. A dollar spent by the Commonwealth via PHI delivers up to 15% greater public benefit than a dollar spent directly into the health system.[2] PHI provides choice, access to timely care, and reduces pressure on the public health system. Maintaining affordability and high participation in PHI is critical to the sustainability of Australia's health system. Due to indexation and other changes to the PHI rebate made by previous Governments, the value of the rebate as a proportion of premiums is declining and will continue to do so over time. This will exacerbate an affordability crisis in PHI that will have flow-through impacts on the public sector in key areas of non-emergency surgery waiting lists, mental health and dental care. A 'tipping point' has been reached for the sector. This is no idle comment, but rather is supported by substantial market research.

In October of 2017, the Productivity Commission released its five-year productivity review report entitled 'Shifting the Dial' in which it directly refers to 'removing some shackles from private health insurance'. Data from the Australian Prudential Regulation Authority (**APRA**) clearly demonstrates that health fund premium increases track rising input costs. For decades, an inflexible regulatory environment has locked health funds into paying claims whether or not evidence supports the quality, clinical outcomes and cost-effectiveness of the services provided. This has the effect of protecting vested interests, but now more than ever, with flat wages growth and cost of living pressures impacting households, this inflationary dynamic needs to be addressed.

[1] Ipsos – *Healthcare & Insurance in Australia* (2017).
[2] Evaluate, *The relative efficiency of the private health insurance rebate v direct public health expenditure* (2017).

The measures in this Bill will enable health funds to offer greater choice and flexibility to members, and to innovate by designing products that are more affordable and better meet the needs of members having regard to their particular circumstances, such as age or location. These reforms are an important step in putting downward pressure on premiums and in ensuring the sector is more transparent to consumers. This in turn supports the long term viability of the health system both directly and through the flow-through effects on the PHI rebate. Without this impact, the subsequent decline in PHI membership would result in pressure on the Federal Budget across other areas of health and undermine the overall sustainability of Australia's health care system.

The remainder of this submission addresses the provisions of the Bill in detail, with a focus on those which were the subject of concerns raised at second reading stage.

Increasing maximum excess levels

The Bill, together with the *Medicare Levy Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018* and *A New Tax System (Medicare Levy Surcharge – Fringe Benefits) Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018*, increases the maximum permitted excesses for PHI policies from:

- $500 to $750 for singles; and
- $1000 to $1500 for couples/families.

The following concerns were raised about this measure at second reading stage:

- consumers may opt for higher excesses that they cannot afford to pay; and
- the new proposed excess limits are high, and exceed that of other types of insurance.

Increasing maximum excess limits improves choice and affordability at the consumer level, as consumers may choose to purchase products with higher excesses in return for lower premiums. Excesses allow consumers to select their level of risk with respect to their healthcare expenditure, though it is health funds' experience that it does not lead to consumers failing to address their health needs. It is important to note that the Bill does not mandate that health funds must offer, nor that consumers must take up, higher excess products. The provisions deliver greater flexibility that may help to reduce costs for consumers.

The current maximum excess levels have not changed for almost 20 years. The proposed increases to excess limits are in line with the level of excess that would be in place if the current limits had been indexed at CPI since 2001 when they were introduced. As noted in the Explanatory Memorandum to the Bill, this will restore the risk sharing relativities for consumers to those that existed when the current levels were set. The proposed excess limits are also in line with other types of insurance which offer excesses of up to $2000 (for motor vehicle insurance) and $5000 (for home and contents insurance).

Improving choice and affordability may have a positive impact on PHI participation and the sustainability of PHI, as policyholders with high excesses typically are lower than average claimers. Although excesses are generally well understood by consumers, the improved information provisions in the Bill will help to ensure that consumers are well-informed about what they are buying, ie. there will be a co-payment at the point of service.

Updating the treatment of the maximum excesses for Medicare Levy Surcharge purposes will help to ensure that policy settings remain relevant to consumer preferences over time, and provide a slight price offset for potential policyholders who wish to take up policies with a higher excess.

Age-based discounts for hospital cover

The Bill amends the *Private Health Insurance Act 2007* (**PHI Act 2007**) and the *Age Discrimination Act 2004* to allow health funds to offer age-based discounts for people aged 18 to 29 for hospital cover. A discount of up to 10% can be offered which phases out after the policyholder turns 41. A framework regulating the provision of age-based discounts will be introduced through amendments to the *Private Health Insurance (Complying Product) Rules 2015*.

The following concerns were raised about this measure at second reading stage:

- the discount provides an insufficient incentive for individuals to take out PHI;
- the discount may lead to premium increases for other policyholders if it does not increase participation;
- the discount undermines community rating.

This measure will support health funds to attract new and younger members and improve participation and affordability. Recent health fund data has again shown the risk pool is deteriorating as premiums increase, with growth in health fund membership and claims in people aged over 65, and membership growth in people aged under 35 flat lining.

Because of community rating, the contribution of younger policyholders (who generally have lower claim costs than older policyholders) to the risk pool is critical to the affordability of premiums for all policyholders. When someone with lower than average claim costs decides to take out PHI, premiums for everyone else reduce slightly. New joiners under 30 have the lowest average costs, so have a greater impact on affordability than older joiners. One of the most difficult challenges we face in the sector is the cost pressure on younger and healthier people, which is creating headwinds against participation in PHI. Under a community rated system, this causes a risk-pool of higher claimers to develop, which in itself puts upward pressure on premiums.

Market research shows there is pent-up demand for PHI in people aged under 30 and the age-based discount will help put private health cover in the reach of younger people. This is particularly important as people under 30 often need preventative dental care, treatment of sports injuries and cover for mental health problems treated in hospital, all things which are difficult to access without PHI. Rebalancing PHI membership with younger people will also assist in keeping downward pressure on premium increases.

Currently around 45% of people aged 30-34 have PHI, compared to 30% of people aged 25-29, according to APRA statistics. PHI is most popular for 55-75 year olds, and least popular for 20-40 year olds. The graph in Appendix 1 shows the clearly higher participation rates for ages subject to Lifetime Health Cover (**LHC**).

Market research shows the introduction of an age-based discount is likely to have a positive impact on participation and retention of younger policyholders. A consumer survey conducted by Ipsos for PHA in 2017 of 2100 people showed that:

- two thirds (66%) of members aged 18-30 years said the policy would make them more likely to maintain their private hospital insurance;
- a majority (57%) of 18-30 year olds without PHI said they would be more likely to take out hospital insurance before turning 31 as a result.

The above results were based on offering a lifetime discount and PHA's view is that a lifetime discount would provide a stronger incentive for young people to take up PHI. However, PHA

supports the measure as set out in the Bill and believes this is also likely to have a positive impact on participation.

Age-based discounts are likely to represent a small cost to the industry offset by additional participation, improving affordability for all policyholders. Notably, the discount is discretionary so in the unlikely event that the discount does not enhance affordability funds could choose to cease offering the discount to new policyholders.

Contrary to undermining community rating, increasing participation by young people in PHI will support the ongoing sustainability of Australia's community rated system. Australia's ageing population directly impacts the Australian PHI industry as older age groups are more highly represented in PHI than younger age groups and cost significantly more in healthcare than younger groups. As noted in the Explanatory Memorandum to the Bill, the ongoing viability of community rating requires the retention of a broad membership base. Without this, premiums would need to increase to cover the cost of insuring higher risk consumers who maintain their health insurance.

Membership imbalance is not a new problem. There is already effectively an age-based exemption to community rating in the form of LHC loadings, which were introduced in 2000 to encourage younger people to purchase PHI and address imbalance. Under LHC regulations, anyone purchasing PHI for the first time after the age of 30 pays a loading on their premium equal to 2% for each year of age older than 30 (with a maximum loading of 70%). The loading lasts for 10 years. For example, a 40 year-old purchasing PHI for the first time will pay 20% more than the listed premium price for 10 years. LHC has been a very effective measure driving PHI participation by the over-30s. Age-based discounts represent an extension of this principle by providing a 'carrot' incentive for under-30s to take up PHI. PHA submits that this reform is necessary to help rebalance the age profile of PHI consumers in Australia in line with demographic and economic changes that have occurred over the last two decades.

The introduction of age-based discounts for 18-29 year olds is likely to increase PHI participation in this critical demographic and improve the affordability and sustainability of PHI.

Closed and terminated products

The Bill clarifies the application of provisions of the PHI Act 2007 with respect to closed and terminated products, and introduces new information requirements.

At second reading stage, concerns were raised about this measure on the basis that it represents a change to the law which may limit choice in access to health services for people who hold a terminating product and do not wish to transfer to a new product.

PHA submits that the PHI Act 2007 already permits health funds to close or terminate products for existing and new policyholders, and that the provisions of the Bill merely clarify the law in this regard. Section 55-10 of the Act currently provides that "the principle of community rating in section 55-5 does not prevent a private health insurer from refusing to make available to a person a *complying health insurance product that the insurer is no longer making available to anyone." PHA submits that this includes circumstances where a health fund closes a product and migrates all existing members to a new product.

PHA welcomes the new section 55-10 proposed by the Bill which clarifies any ambiguity in the current legislation. The ability for health funds to close or terminate products and migrate policyholders from existing products will be critical to the implementation of new product categories

(gold, silver, bronze and basic) in 2019. Health funds have been criticised for the large number of different products in the market, and the ability to discontinue products over time is important if this concern is to be addressed. The new information requirements in section 78-1(5A) will enhance consumer protections throughout this process and complement the existing portability requirements in the PHI Act 2007.

Transitional provisions relating to the treatment of certain health insurance policies

The Bill removes the use of benefit limitation periods in PHI policies.

At second reading stage, the concern was raised that holders of policies with benefit limitation periods should be offered new policies that continue to offer them value.

PHA supports the removal of benefit limitation periods as a measure enhancing the transparency of PHI policies for consumers. PHA confirms that from 1 July 2018, none of PHA's members are offering policies with benefit limitation periods. Policyholders who previously held such policies have either maintained their policies with benefit limitation periods removed or been offered new policies with a similar level of benefits, and which comply with the portability requirements of the PHI Act 2007.

Private Health Insurance Ombudsman's powers

The Bill strengthens the powers of the Private Health Insurance Ombudsman (**PHIO**) to enable inspections and audits at the premises of private health insurers or brokers as part of complaint handling or in the context of investigations by the PHIO at his or her own initiative.

PHA supports enhancing the PHIO's oversight powers in principle as an important measure to protect consumers. However, we are concerned about the broad scope of the proposed audit and inspection powers. The Bill gives the PHIO the power to enter premises without the consent of the occupier or a search warrant, and without issuing a notice in relation to the exercise of inspection and audit powers. Such an unfettered ability to enter premises is unprecedented and exceeds the inspection powers of other regulators such as the Australian Competition and Consumer Commission, the Australian Securities and Investments Commission and the Australian Communications and Media Authority. These regulators require occupier consent or a warrant to enter premises, and notice of the exercise of inspection powers to be given.

PHA is concerned that the audit and inspection provisions of the Bill are inconsistent with principles of natural justice, and prevent health funds from being able to determine whether the inspection/audit is consistent with powers under the *Ombudsman Act 1976*, and provide access to materials sought. PHA submits it is important to get the legal provisions supporting these powers right to avoid legal challenges in future. This is particularly so where these powers are new to the PHIO and the PHIO does not already have an established search/inspection regime.

PHA recommends that the Bill be amended to restrict the PHIO's powers of entry to circumstances where the occupier has consented to the entry or the entry is made under a search warrant. It is also recommended that the entry powers only be exercised where a complaint has met a threshold 'reasonableness' or 'reasonable belief' test and where the PHIO has given the occupier written notice of his or her intention to enter the premises. These changes would help to align the PHIO's audit and inspection powers with those of other regulators, and reduce the risk of audit or inspection being initiated as the result of a vexatious complaint or campaign.

Other measures

PHA supports the other measures in the Bill which will enhance the value proposition of PHI and consumer choice.

Benefits for travel and accommodation

Allowing health funds to provide benefits for travel and accommodation under hospital treatment cover will enable product innovation and design that better meets the needs of consumers, particularly those living in rural and remote areas who need to access hospital services not available locally.

Information requirements

Replacing Standard Information Statements with Private Health Information Statements will provide flexibility around the format, content and delivery of information, enabling health funds to provide information in a more consumer-friendly way. This will provide consumers with a clear statement about the treatment areas included in, and also excluded from, their product of choice.

Benefit requirements according to class of hospital

PHA supports the abolition of the Second Tier Advisory Committee and the Department of Health becoming responsible for the administration of second tier default benefits. This measure will help ensure that the regime for second tier default benefits is administered in independent and impartial way.

ABOUT PRIVATE HEALTHCARE AUSTRALIA

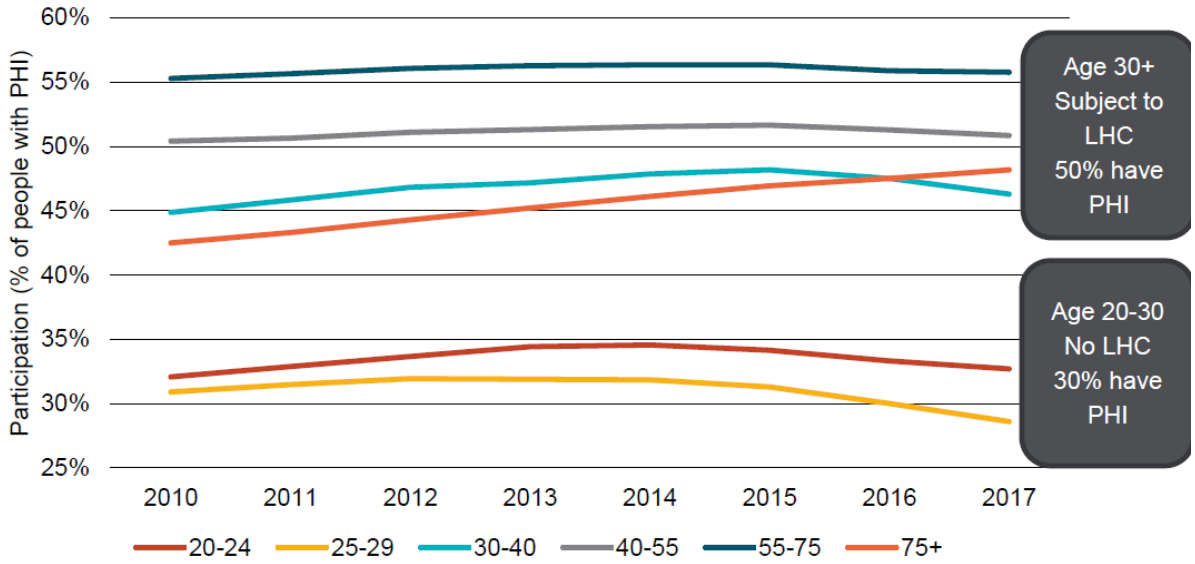
PHA is the Australian PHI industry's peak representative body that currently has 20 registered health funds throughout Australia and collectively represents 96% of people covered by private health insurance.

PHA member funds today provide health care benefits for over 12.96 million Australians. PHI is provided through organisations registered under the *Private Health Insurance Act 2007.* The financial performance of registered health funds is monitored by APRA, an independent Australian Government body, to ensure solvency and capital adequacy requirements are met.

All members of PHA are registered as health benefits organisations with the Commonwealth Government and comply with Government standards and regulations on benefits and solvency.

Appendix 1

PHI participation by age[3]



[3] Source: APRA data 2017.