Narrabundah Partners
Consultants and Advisers

3 July 2018

The Secretary
Senate Community Affairs References Committee
Parliament House
Canberra ACT 2600

Dear Ms Radcliffe

Reference: Inquiry into the Private Health Insurance Legislation Amendment Bill 2018 and related Bills

Thank you for your letter of 21 June inviting me to provide a written submission to this inquiry.

I am the former CEO of the now defunct Private Health Insurance Administration Council (**PHIAC**). PHIAC was the prudential regulator of the PHI industry for over 25 years until its abolition in 2015. I had the privilege of serving as CEO for the last seven years of PHIAC's operation from May 2008 until June 2015.[1]

Given the purely technical character of the related bills, I have confined my comments to the substantive proposals contained in the Private Health Insurance Legislation Amendment Bill 2018. I should point out that, in offering these remarks, I have not engaged in a detailed legal analysis of the legislation, so my observations should not be read as conferring any particular sanction or approval from that perspective.

In substance, my thoughts are as follows:

Schedule 1: Increasing maximum excess levels

Most commentary on this measure, which would see a 50 percent increase in the permissible excess levels available on products which attract the rebate, has focused on the fact that there has been no adjustment to these levels for many years. This is true, and from that perspective some adjustment seems warranted. Further, there is little doubt that, when made, an immediate consequence of this change will be that a range of products with larger excesses, but lower premiums, will become available in the market. Generally speaking, I favour choice and in a previous submission to this committee explained why I was, and remain, in favour of the retention of low-cost products as a key element of consumer choice.[2]

While the premium relief this change will deliver is welcome, the measure does add further to a concern that the principles of community rating are being increasingly eroded. With public interests discernible on both sides of the argument, striking an appropriate balance between these two objectives is not an easy process and will need to be continuously monitored.

[1] Some further biographical information is attached at **Attachment A**.
[2] Senate Community Affairs References Committee, *Value and affordability of private health insurance and out-of-pocket medical costs,* The Senate, Canberra, December 2017. S. Gath, Submission No 5.

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The issue is a fundamental one which goes to the overall design and long-term viability of the community rated model we have had in Australia for many years. In my view, it, along with the associated question of risk equalisation, are both in need of close and expert examination to ensure that settings remain appropriate to the needs of our system of mixed public and private funded health care.

With that observation, in my view the committee should support the amendments.

Schedule 2: Aged based discounts for hospital cover:

While I do not oppose this amendment,[3] I am skeptical that it will result in much change to the overall level of coverage. As the evidence demonstrates,[4] many Australians find the period when they are aged 25 to 30 financially challenging as they struggle with the costs of paying down student debt and/or saving for real estate purchases, often with relatively low incomes. In more recent times the vicissitudes of casual employment and the so-called "gig economy" have merely added to these challenges.

In these circumstances, private health insurance is often seen as a lower order priority, particularly when many at this age see their contributions as little more than an income stream supporting the claims of older and sicker people.[5]

Having closely observed movements in PHI membership over many years, I do not expect that the discounting measures proposed will result in any significant change in either the:

- level of coverage; or
- profile of those covered.

The continuation of discounting entitlements up to the age of 40, as an element of this policy, are unlikely to alter this outcome in my view.

That said, I do acknowledge that in the hands of an adept marketer a campaign which targets the 25 to 30 age group with messages built around ancillary products and treatment associated with sporting or other injuries could result in a relatively small "uptick" in coverage levels within that demographic. In addition, I suspect that there will be a small group of well-off parents who will be willing to support the continuing fund membership of their children during the traditional gap period between termination of cover under a parent's policy and the child's first policy as a stand-alone member.

In my view, the committee should support the amendments.

Schedule 3: Private Health Insurance Ombudsman's Powers

Following the structural changes to PHI regulatory arrangements made in 2015,[6] the PHIO as it then existed was abolished with the function folded into a larger agency, the Commonwealth Ombudsman. The formal position of PHI Ombudsman was also abolished with the role instead

[3] The detail of the proposal is to be set out in amendments made to the PHI (Complying Product) Rules which have not yet been published. Schedule 1 of the Bill merely enables those changes to be made. My comments relate to the policy as described in the Explanatory Memorandum.
[4] Melbourne Institute, Household, Income and Labour Dynamics in Australia (HILDA) Report, 2017; Australian Bureau of Statistics, Mean Weekly Earnings by Age, in *6333.0 Characteristics of Employment, Australia, August 2016.*
[5] See generally, S Parnell, "Private health insurance a hard sell to Medicare generation", *The Australian*, 30 June 2018.
[6] *Private Health Insurance (Prudential Supervision) Act 2015*.

assigned to the Commonwealth Ombudsman to be performed as merely one of a range of functions conferred on that person.

The changes made at that time were a mistake in my view. All the more so, since they appear to have been made in the pursuit of what were, relatively speaking, small savings. As a result, a well-regarded and highly experienced statutory occupant of that role was driven from that office and instead the function was subsumed into an agency (itself in a period of rebuilding after controversy and restructuring) with an historical focus on the resolution of public sector grievances and disputes.

The unsurprising consequence, in my assessment, has been that the PHIO's role has been diluted and diminished in a setting of cultural disconnection and ambiguous strategic direction. To the extent that these amendments seek to repair some of the damage done at that time they are worthy of support.

I do note, however, that the Standing Committee for the Scrutiny of Bills[7] has raised for consideration the issue of compulsory powers of entry and search which are now to be extended to the PHIO. The circumstances in which such powers might be employed are not clearly defined, nor are the rights to review of such powers by the parties affected (primarily health insurers and brokers). Such powers sit somewhat jarringly with the long-standing relationship PHIO has had with the PHI sector and are likely to require the formulation of new policies governing appropriate use and engagement of additional staff experienced in the exercise of such powers, with associated budgetary implications.[8]

Some clarity around the minister's capacity to instruct PHIO in the use of coercive powers may also be warranted. The recent experience concerning BUPA and its decision to restrict access to gap cover arrangements is a example where concerns of this nature may have arisen with a different set of powers.[9]

In my view, the committee should support the amendments.

Schedule 4: Transitional provisions relating to the treatment of certain health insurance policies

Schedule 4 deals with the position of so-called "irregular health insurance policies". These are policies where there has been a statutory irregularity in relation to the operation of benefit limitation periods.

While I have not reviewed those provisions closely (in accordance with my disclaimer at the beginning of this submission) I support the proposals on the ground that they do not

[7] Senate Standing Committee for the Scrutiny of Bills, *Scrutiny Digest 5 of 2018* at page 48.
[8] The MYEFO document released in December 2017, provides additional funding of almost $33 million over the forward estimates to the Department of Health in connection with implementation of the package announced by the Minister in October 2017. The bulk of these costs will be incurred next financial year ($11.9 million) and in 2019/20 ($12.3 million) and includes matters not yet brought to legislation such as the implementation of the new nomenclature "Gold", "Silver", "Bronze" and "Basic" for compliant health insurance products. Further, an amount of $4 million has been provided to the Commonwealth Ombudsman. According to MYEFO a slightly larger amount will offset over the forward estimates from the budget of the Department of Veterans Affairs in the outyears 2019/20 and 2020/21. The precise basis for the recovery is not apparent in the MYEFO documentation. On the question of costs, more generally, I note the document *Attachment A – Estimated Regulatory Costs of the Explanatory Memorandum* estimates costs for the industry of about $3.3 million over ten years for insurers with about $1.9 million for brokers.
[9] The report of that investigation is at http://www.ombudsman.gov.au/__data/assets/pdf_file/0029/84791/Bupa-Health-Insurance-Hospital-Policy-Changes-June-2018.pdf .

disadvantage consumers, resolve a potential liability for the insurers and rectify an error through what is, in effect, a retrospective deemed-validity process.

In my view the committee should support the amendments.

Schedule 5: Miscellaneous

This schedule deals with a number of matters.

On the issue of allowing private health insurers to cover travel and accommodation costs for Australians in rural and regional areas. One of the great challenges of PHI is ensuring and maintaining its relevance to persons located in regional and remote areas. Indeed, at PHIAC, we regularly sought to take account of the special concerns of persons who are often many hundreds of kilometers away from the nearest private hospital. This concern included indigenous Australians.

The measure proposed will allow the insurers greater flexibility in meeting the travel and accommodation costs of such persons. By so doing it will obviously improve the attractiveness of the product to regional and remote Australians. The principles of community rating will protect them from facing additional or onerous costs associated with the use of the product. I strongly support this initiative

In my view, the committee should support the amendments.

On the issue of changing the name of standard information standards to "private health information standard". This is a sensible change and should remove some confusion. The substantive changes to the statements themselves are not canvassed in this legislation, instead that will be dealt with through changes to the PHI (Complying Product) Rules. Those changes will, in turn, merit some scrutiny at the time they are made to ensure they improve access to and understandability of the new PHIS.

In my view the committee should support the amendments.

On the issue of reforming the administration of second-tier default benefits arrangements for hospitals. This is a technical adjustment which will have relatively minor benefits for contributors. The main impact will be the decision to bring the assessment process for second tier eligibility within the minister's authority. This will mean that eligibility decisions will no longer be in the hands of the industry run Second Tier Advisory Committee. The larger issue, in my view, is the continuing suitability of the second-tier policy itself. In a recent speech[10] I called for its abolition on the grounds that it was anti-competitive and merely resulted in consumers subsidizing costs that a properly functioning market would not permit. In this context, I note the minister's comments in his second reading speech to this very bill:[11]

> *Above all else, I want to note that it is essential for the health of our nation that we continue to maintain a strong and competitive private health insurance market.*

If those words are to have the meaning that most Australians would want them to have, this is an area calling for the government's early attention.

[10] S Gath, Address to the Annual Private Health Summit, "PHI in 2018 -Some Reflections from the Sidelines", Sydney, 1 June 2018. Full text viewable at www.slideshare.net/slideshow/embed_code/key/2naMljcSxip2wg .
[11] Mr Greg Hunt, House of Representatives *Hansard*, 28 March 2018 at page 3031.

Subject to the preceding paragraph, in my view the committee should support the amendments

On the issue of facilitating the termination of closed products and migration of people to new products. This too is a largely technical measure. I support a clean up of products to assist consumers to make clearer and better choices. There are far too many redundant or virtually redundant products which, despite being largely irrelevant, continue to draw down on insurer resources. Their removal and consolidation will deliver savings which the system broadly should welcome.

It is important however that no extant policy-holder be disadvantaged by this transition. I am not aware whether this risk has been thoroughly analysed.

The committee should, in my view, seek assurances from the Government that no person will be disadvantaged by these proposed changes, or if such a person or group exists what arrangements are in place to advise them of the change to take appropriate steps to ensure that their position is not unduly affected.

Subject to the preceding paragraph, in my view the committee should support the amendments.

Further, with the Committee's indulgence, I wish to avail myself of the opportunity provided by this document to restate the core recommendation of my submission to last year's inquiry into the private health insurance system more generally,[12] namely:

There should be a full and broad Productivity Commission inquiry into all aspects of the private health insurance sector forthwith. Such inquiry to examine, amongst other things:

- **whether PHI can and should be more integrated into the general health system;**
- **effectiveness and value for money of government rebates and other forms of non-financial support for participants in the industry (e.g. second-tier arrangements for private hospitals, prosthetics pricing and Lifetime Health Cover);**
- **the state of competition within the industry and barriers to better competition;**
- **the needs of consumers at all stages of the PHI cycle including access to reliable and timely information about premiums, preferred provider arrangements and alterations to coverage; and**
- **operation of the portability scheme.**

I am pleased that this suggestion, which has a number of proponents, has since drawn support from the Australian Labor Party and now forms part of their election manifesto in the health area. In my view, the need for a clear eyed, expert and *non-partisan* examination of our private health system has been apparent and growing for quite some time. I call on all parties and independent senators to support a process which will ensure that future governments of Australia, whatever their colour, will have the benefit of an evidence-based and expert consideration of this industry in the interests of patients, taxpayers, fund contributors and, of course, those many people (doctors, nurses, paramedical and non-technical staff) who work in this crucial sector.

[12] Senate Community Affairs References Committee, *Value and affordability of private health insurance and out-of-pocket medical costs,* The Senate, Canberra, December 2017. S. Gath, Submission No 5.

Should the committee wish, I would be happy to expand upon these views at a hearing of the committee, although I should point out I will unavailable between 9 August and 20 September.

Yours sincerely

Shaun Gath
Principal, Narrabundah Partners
(former CEO, Private Health Insurance Administration Council)

Attachment A

Narrabundah Partners

Consultants and Advisers

Shaun Gath
Principal

SHAUN GATH is the Principal of Narrabundah Partners, a consultancy specializing in the financial and regulatory aspects of private health insurance and the broader Australian health sector. NP's clients include merchant banks, hedge funds, investment houses and private equity firms.

Prior to NP, Shaun spent seven years as the CEO of PHIAC, the Australian government agency responsible for prudential regulation of the private health insurance industry. In that capacity he oversaw the financial soundness of a $22 billion industry. PHIAC operated for 26 years but was closed in 2015 following machinery of government changes made by the Coalition Government.

Shaun also has extensive experience as a senior lawyer working both as a partner in a major Australian law firm and as in-house general counsel in a large government enterprise. His time as a lawyer took him around Australia and the world and included work for the World Bank assisting in the legal redesign of health systems in post-communist economies. In his earlier career, Shaun worked as an adviser to an Australian government minister where he was involved in key changes to Australian consumer, privacy and corporations laws which continue in force today.

In his spare time, Shaun enjoys endurance cycling, swimming, and travelling to new and exotic places as often as circumstances allow. He lives in Australia's capital city Canberra with his wife and two children.

Education:
University of California, Berkley: Global Health Leadership Program
Massachusetts Institute of Technology: Sloan School Executive Management Program
Australian National University: Master of Laws
Australian National University: Bachelor of Laws (Honours)
Australian National University: Bachelor of Arts (Honours)