ahm
Australian Health Management

Thursday, 25 January 2007

Committee Secretary
Community Affairs Committee
Department of the Senate
Parliament House
Canberra

Dear Sir/Madam

Re: Private Health Insurance Bill 2006

The Australian Health Management Group Limited (ahm) thanks the Senate Committee for the opportunity to comment on the Private Health Insurance Bill 2006 (Bill).

Our attached submission addresses the following issues.

- The rules applying to the introduction of broader health cover
- The meaning of health insurance business
- The entitlement to conduct health insurance business
- The meaning of health related business
- Consequential amendments to the Corporations Act 2001

ahm is generally supportive of the direction of the Bill. It is however concerned that the rules for broader health cover will be so restrictive as to discourage innovation in the alternative delivery of health care.

ahm is also concerned that some business which the Bill purports to be health related business is actually health insurance business.

ahm's submission has been authorised by the Chief Executive Officer. Should you have any questions please contact Dan Hook, CEO on 4221-8876 or Greg Rheinberger, Deputy CEO on 4221-8740.

Yours truly,

Greg Rheinberger
Acting CEO

SUBMISSION TO THE AUSTRALIAN SENATE COMMUNITY AFFAIRS COMMITTEE – PRIVATE HEALTH INSURANCE BILL (*Bill)*

MADE BY AUSTRALIAN HEALTH MANAGEMENT GROUP LIMITED (ahm)

1. Executive summary

ahm welcomes the opportunity to make a submission to the Senate Committee on Community Affairs on the Bill. This submission is based on our review of the Bill, the guidelines and the Private Health Insurance Circular 78/06 (Broader Health Cover: Regulatory Framework).

This submission focuses on each of the following:

(a) Broader Health Cover initiatives complementing, rather than duplicating, programs available within the public sector and encouraging the private health insurance industry to expand its thinking around delivery channels.

(b) The Broader Health Cover: Regulatory Framework released in the PHI Circular 78/06, in particular, the decision to exclude most of Broader Health Cover from risk equalisation arrangements.

(c) Important consequential amendments that are needed to the *Corporations Act* 2001 and the *Corporations Regulations* 2001.

(d) The entitlement to conduct health insurance business and particularly the possible exclusions that may be allowed under clause 121-30 and relevant rules.

(e) Certain "health related businesses", particularly those health related businesses that clearly would be, but for the definition of that term in the Bill, health insurance business. These include overseas student health cover and health insurance for temporary residents or persons present otherwise than permanently in Australia and entitled to work. These are significant changes to the current regime that will have significant adverse effects.

In summary, ahm makes the following submissions:

Broader Health Cover

1. *Rather than rules defining the individual components of a Broader Health Cover program,* ahm *proposes that the framework define the following principles:*

   (a) Evidence – a program funded under Broader Health Cover should be capable of demonstrating a link to an accepted clinical pathway or published evidence base.

   (b) Accreditation – program providers should be independently accredited under either ACHS or ISO9000.

   (c) Evaluation Framework – a program should be required to contain a clearly documented evaluation framework, which measures its impact on health, behaviour and member satisfaction.

   (d) Reporting and/or publication of the impact on health – a program should be required to periodically report (at a population level) on health outcomes.

   (e) Enrolment – a clearly documented enrolment/approval process should be in place to ensure that only eligible members participate in the program.

2. *Individual health funds be permitted to determine which providers to recognise and for which programs they will pay a benefit.*

3. *The principles for the framework should be reviewed at 12 months. The scope of the review should include:*

(a) Impact on Risk Equalisation Arrangements

(b) Participation at both an industry and member level

(c) Health Outcomes (short term)

(d) Member Satisfaction

(e) Benefit outlays

4. Broader Health Cover should allow multiple points of access to an intervention.

5. Allowable identification and referral methods into a program should include:

(a) Health risk assessment surveys, which incorporate a valid triage model capable of targeting an intervention

(b) Promotional activities designed to target eligible members and offer a program and;

(c) Analysis of claims data resulting in an offer of a program to suitable members.

6. The requirement for a medical practitioner to undertake the health assessment and be involved in the review of a Chronic Disease Management Program should be removed.

7. The requirement for the inclusion of at least two allied health professionals in a Chronic Disease Management Program should be removed.

8. Risk identification should be included in risk equalisation arrangements.

Health Insurance Business

9. Only a private health insurer (registered under the Bill) must be able to carry on any part of a business that undertakes liability, by way of insurance, for the costs of any hospital or general treatment in or connected with Australia, other than those costs incurred by short-term temporary visitors.

10. This is the only way that there can be a necessary level of assurance that the products that are offered comply with the regulatory regime and that the interests of consumers in Australia (and the Australian health system) are properly protected.

11. The Bill significantly expands the ability of a general insurer[1] to provide private health insurance in respect of medical and hospital treatment costs incurred in Australia. The expansion is not justified.

12. Any exceptions or exclusions to the definition of "health insurance business" must be limited to those that are absolutely essential and that are consistent with (and vigorously tested against) the public policy framework and objectives of the Bill.

13. Having regard to those requirements very few exceptions can be made.

14. Whilst it may be appropriate for a general insurer to provide insurance cover for medical and hospital expenses incurred outside Australia, there is no justification for allowing that to occur in respect of any hospital or medical treatment in Australia for persons other than tourists or short-term business travellers.

15. Only a private health insurer should be allowed to carry on the business of undertaking liability by way of insurance for hospital treatment or general treatment that occurs in Australia in respect of all eligible persons. There is no reason why any person who is resident in Australia and who incurs a liability in respect of medical or hospital treatment in Australia should be denied the protections under the Bill.

16. It is proposed under the Bill to allow general insurers to insure all persons who are ineligible for Medicare, and not only those ineligible persons who are "temporarily

[1] In this submission, this refers to any insurer who is not a private health insurer registered under the Bill.

present" in Australia. No justification for this unnecessary extension has been provided.

17. *Current arrangements do not allow a general insurer to provide health insurance in respect of costs incurred in Australia for any persons other than tourists. Any person who is in Australia under a visa, and has an unfettered ability to enter and leave and who can work here, cannot be insured by a general insurer. This must be maintained.*

18. *Any exception for dependents of persons engaged temporarily overseas should only apply to those dependents who themselves are outside Australia as a result of the temporary employment of the person on whom they are dependant.*

Overseas Student Health Cover

19. *The current provisions of the Bill will significantly affect overseas student health cover.*

20. *There will be no prohibition on any person providing overseas student health cover.*

21. *There will be no requirement that any person doing so complies with the current obligations that a RHBO contractor has under its deed with the Commonwealth.*

22. *The provisions of the Bill must be amended so as to do each of the following:*

    (a) *Exclude overseas student health cover from the definition of "health related business".*

    (b) *Confirm that the provision of overseas student health cover is "health insurance business" and, consequently, must only be undertaken by a private health insurer.*

    (c) *Further provide that only a private health insurer that has entered into a deed with the Commonwealth must provide overseas student health cover.*

Corporations Act 2001

23. *Currently, private health insurance is excluded from the definition of "financial product" under the Corporations Act 2001. The consequential amendment provisions do not amend that provision. This is required.*

24. *Similarly, overseas student health cover is currently excluded from that definition (by regulation). That regulation must also be amended.*

2. Introduction

2.1 Broader Health Cover: Regulatory Framework

The Broader Health Cover: Regulatory Framework focuses on defining inputs and processes for individual product categories. This is unnecessarily restrictive and ahm recommends that the regulatory framework retains a broad approach by articulating principles for Broader Health Cover and the requirements for safety and quality standards. The regulatory framework should ensure that funds purchase evidence-based care packages from accredited providers which provide measurable improvements to health. These packages should be purchased and regulated under a new table separate from hospital and ancillary tables.

Enrolment and access requirements for Chronic Disease Management Programs should acknowledge the different relationship between a health fund and its members and that of a GP. Health funds need to be able to leverage their unique relationship and identify and refer members to different levels of intervention separate to the traditional medical-centric model of care. Without recognition of the nature of this relationship the implementation of Broader Health Cover programs will be compromised.

The requirement for a medical practitioner to undertake the health assessment and be involved in the review and the inclusion of at least two allied health professionals in a Chronic Disease Management Program (CDMP) is problematic. These requirements are inconsistent with the National Chronic Disease Strategy and will force CDMPs to be managed along the

same lines as multi-disciplinary patient care teams that exist in the public sector. This model has proven to be costly, requires a high degree of coordination and is likely to be difficult to gain traction in larger populations.

Evidence and best practice in the management of chronic disease emphasises self management and behaviour change around modifiable risk factors. It is the approach rather than the type of clinician or number of clinicians that determines the health outcome. CDMPs offered under Broader Health Cover should be able to be delivered under a variety of models. ahm's experience in conducting telephonic case management for members with chronic and complex disease illustrates the effectiveness of a single case manager in achieving health outcomes and subsequent reductions in health care costs. ahm's programs are consistent with the National Chronic Disease Strategy and are based on the principle of care planning that is person rather than health professional centred.

The proposed regulatory framework excludes risk identification and programs that are not structured around defined inputs and processes. This is likely to incentivise funds to retain the status quo rather than pursue innovation. The result will be that the few funds, who are already actively managing the health of their members, will continue to do so and the impact of Broader Health Cover on private health insurance members as a whole, will be minimal at best.

2.2 "Health Insurance Business"

ahm's position is that only a private health insurer registered under the Bill can carry on any part of a business that undertakes liability, by way of insurance, for the costs of any hospital or general treatment in or connected with Australia. This is the only way that there can be a necessary level of assurance that the products and services that are offered comply with the regulatory regime and that the interests of consumers in Australia and the Australian health system are properly protected.

The Bill establishes the proposition that only a private health insurer is able to undertake "health insurance business". Health insurance business is defined in clause 121-5 as the business of undertaking liability by way of insurance for hospital treatment or general treatment, unless excluded under clause 121-30 (and the *Private Health Insurance (Health Insurance Business) Rules*.

There is no indication currently of what activities may be excluded from "health insurance business" by the rules. It is critical that any exceptions or exclusions are limited to those that are absolutely essential and that are consistent with (and vigorously tested against) the public policy framework and objectives of the Bill. Having regard to those requirements, ahm believes that very few exceptions can be made under that provision. This is dealt with further in section 5 below.

2.3 "Health related business"

A registered health fund can also carry on (as part of its fund) "health related business". Under clause 131-15(2), "health related business" is not "health insurance business".

"Health related business" includes the business of undertaking liability by way of insurance to indemnify people who are ineligible for Medicare costs associated with providing treatment, goods or services provided to those people in Australia that is provided to prevent or manage diseases, injuries or conditions. Without this provision, (and from the diagram that is included in clause 115-10) it is clear that any health insurance products or services for persons who may be ineligible for Medicare costs would be part of health insurance business. However, with these provisions, it will be necessary for this insurance business to be excluded by the rules from "health insurance business". Without that exclusion, there is an inconsistency and overlap between health insurance business that undertakes liability by way of insurance for hospital or general treatment for people who are not eligible for Medicare and the definition of "health related business".

The Bill does not prevent any person from providing a "health related business". The Bill only regulates "health insurance business". Consequently, there will be no controls over health

related business services and no protection for consumers under the Bill. This is dealt with further in section 6 below.

2.4 Financial services licensing

Section 765A(i)(c) of the *Corporations Act* 2001 excludes health insurance provided as part of "health insurance business" under the *National Health Act* 1953 from Australian Financial Services Licensing requirements.

Similarly, regulation 7.1.07C of the *Corporations Regulations* 2001 excludes insurance under an overseas student health insurance contract, under Regulation 48 of the *National Health Regulations* 1954.

To deal with these matters further, consequential amendments are needed in the consequential amendments bill. This is dealt with in section 7 below.

3. Broader Health Cover

3.1 General Treatment – Certification and Accreditation (page 5)[2]

Currently there is no nationally recognised accrediting body for disease management programs. Therefore, in the lead up to implementation of minimum safety and quality standards for privately insured services from 1 July 2008, and to better distinguish chronic disease management programs from one-off ancillary services, ahm recommends that:

- Chronic disease management program providers are accredited by an external body such as ACHS or ISO9000, and
- Health service deliverers (who may provide a component of a program) be qualified, licensed and insured.

ahm supports that chronic disease management programs be accredited to ensure they are soundly based. Accreditation efforts should ensure that programs include a balanced evaluation process addressing health and behavioural outcomes, cost and member satisfaction. In the first instance, accreditation criteria should err on the side of breadth facilitating innovation. Later reviews can refine the appropriate criteria.

3.2 Hospital-Substitute treatment – Home care (pages 5-6)

The framework states that Hospital-substitute treatment – Home Care is a *'direct substitute for the patient being accommodated within a hospital for treatment or care'*, and that *'it is any of, or any combination of, nursing, medical, diagnostic, therapeutic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition'.*

Whilst omitted from this definition ahm supports that certain non-medical services that form an important component of a hospital episode, and are subsequently charged to the in-patient, be included in Home Care so that the service can provide a similar level of treatment or care and result in equivalent clinical outcomes for the patient. These services include personal care (such as showering), the provision of meals and cleaning services. ahm would expect that these services be included in the category of *'other services or goods intended to manage a disease, injury or condition.'*

3.3 Chronic Disease Management Programs

(a) Requiring the provision of at least two allied health services from two or more disciplines (page 8)

This requirement appears to be based on a particular interpretation of the National Chronic Disease Strategy (NCDS). The NCDS is based on the principle of multi-disciplinary care planning that is person centred, incorporates prevention and self-management, and is responsive to changing patient needs. (NCDS page 10) Care planning and delivery requires skills in interviewing and communicating effectively, assisting people to change health related

[2] Pages referenced are contained in the Broader Health Cover: Regulatory Framework document.

behaviours, supporting self-management, and using a proactive and forward looking approach to ongoing disease management. (NCDS page 35)

In ahm's experience, this approach can be achieved by delivering structured and tailored disease management programs that have been designed via multi-disciplinary input and include an assessment of multidisciplinary care needs. Each program can be delivered and coordinated by one allied health professional, with referral to a medical practitioner forming a required component, and referral to other allied health services as necessary.

For example, a client with diabetes enrolled in a CDMP should be assessed for compliance with guidelines for self-management. This includes reviewing their condition with their doctor and having had their eyes checked by a specialist. However, the provision of the GP visit or the optical review is not a direct delivery component of the program. The program deliverer refers the patient to these services and follows-up to ensure they have been carried out.

Stipulating the provision of at least two allied health services per patient program requires CDMPs to be managed along the same lines as multi-disciplinary patient care teams that exist in the public health sector. This model of preventative health management has proven to be very costly, requires a high level of coordination and is likely to be difficult to gain traction in larger populations.

Furthermore, pre-defining the number of health professionals involved in the program shifts the focus away from the needs of each individual. While a provider defined service has been a traditional focus for private health insurance, the recognition of CDMPs should facilitate a shift in focus of treatment from the *provider* to the *individual* with the primary driver of programming being 'a personalised care plan tailored to individual needs'. These are the tenets of self-management that have underpinned chronic disease management practice for the last fifteen years. For example, they frame the Flinders Model of Chronic Condition Self-Management developed by the Flinders Human Behaviour and Health Research Unit. This is a leading model of chronic disease management in Australia.

The National Chronic Disease Strategy (NCDS) recognises that 70-80% of the Chronic Disease population can achieve effective health outcomes through self-management. (NCDS pages 3-4) Making self-management a key focus of the NCDS recognises that many of the health behaviours required to effectively manage chronic disease are the daily responsibility of people themselves. (NCDS page 12)

(b) Requiring that a medical practitioner undertake the health assessment, formulate the plan and be involved in the review process of a patient's CDMP (page 9)

This requirement places CDMPs within the public, GP-centric model of health care coordination. General Practitioners are central to the effective community management of chronic disease. GP's are well positioned to take a proactive role in managing the health care requirements of their patients through the existing Chronic Disease Management Medicare items. As such, Chronic Disease Management Programs should focus on the central role of the GP and assist in the use of the CDM MBS items where appropriate.

However, it is not necessary to prescribe the involvement of medical practitioners in CDMPs beyond these principles. The regulatory framework should support flexible delivery models that are focused on individuals needs and provided by accredited program deliverers.

The original intention of BHC was to broaden the current delivery channels for private health care and enhance the value proposition and efficiency of Private Health Insurance. It was intended to complement existing channels of health care but not duplicate them. Programs offered under BHC should therefore be in addition to current programs available to general practice. If not, the intention of the National Chronic Disease Strategy (the NCDS) to provide disease prevention outcomes to a greater proportion of the Australian population will not be achieved.

The relationship leveraged under BHC is different to the relationship with a GP. The relationship is that of a member with their health fund. BHC programs should be an initiative of the fund and should not be dependent on the traditional referral mechanisms (ie GPs and hospitals). Funds should be able to leverage their relationship with members to identify those

members who are suitable for programs. Identification methods could include, but not be restricted to, health risk assessment surveys and claims data analysis. The fund can then triage members into an appropriate level of intervention. Unless this relationship is upheld under BHC, the utilisation of BHC programs will be compromised.

The medical practitioner should not constitute the exclusive mechanism for access to CDMPs. Private health insurers, as well as other providers, can be equally well positioned to identify appropriate individuals for disease management programs.

It is ahm's view that unless multiple access points are available, the effective prevention and management of chronic disease will not extend across a health insurers membership base. Multiple access points will not compromise program quality and patient suitability. Indeed a member may identify his/her own risk factors and seek to enrol in a CDMP. In such instances, a health fund determines:

- whether it will recognise the program and consequently provide a benefit for program participation,
- the eligibility of the member via the type of cover provided by the fund and purchased by the member, and
- whether the member is suitable for program enrolment (assessing severity, capacity for self-management etc)

Private Health Insurers can define within their individual contracts with providers:

- Defined program elements
- Costs, and
- Clinical eligibility criteria eg disease or risk factors addressed through programs

A health fund should retain the discretion to apply rules on the specific risks and conditions (including their severity) for determining program eligibility. This capacity sets chronic disease management programs apart from ancillary services, which are predominantly based on self-selection. Whilst a member can identify their own health risk factors or express an interest in a particular program, the fund ultimately determines program recognition, eligibility and access.

These controls apply equally to the diagnosis of risk and chronic disease by the medical practitioner. Whilst funds are not in a position to define clinical status, a fund should retain the discretion to recognise programs and determine rules on the specific risks and conditions (including their severity) for program eligibility and access.

As with individual members, a GP could express an interest in a particular program however, the above controls would apply.

(c) The impact of the above two CDMP requirements

A literal interpretation of the Regulatory Framework results in many existing chronic disease management programs, as currently configured, being ineligible for inclusion in *general treatment* (refer clause 121-10 of the Private Health Insurance Bill). It also throws into question the legitimacy of telephonic intervention as the primary mechanism for the delivery of care in a CDMP.

The Broader Health Cover: Regulatory Framework paper suggests that services not meeting the minimum requirements in the *general treatment* for hospital-substitute treatment and chronic disease management programs, could be provided under an ancillary product. Should this position remain unchanged then the BHC initiative will be significantly eroded. Consumers will be less able to differentiate between BHC and ancillary products. This will result in a lower utilisation of BHC among the privately insured population and constrain health insurers from fully realising the potential cost saving of avoided hospital admissions. This effect will be compounded by a decreased likelihood of such programs being offered by funds outside of risk equalisation arrangements.

ahm recommends that the Regulatory Framework retains a broad approach by articulating principles for Broader Health Cover and avoiding prescriptive rules on the inputs and processes for individual product categories.

3.4 **Safety and Quality** (pages 10-11)

ahm accepts implicitly that clinical decision-making is the domain of medical professionals and that government has a legitimate role in determining industry-wide clinical quality and safety standards. The responsibility to recognise a program provider under BHC should remain that of the payer (the health fund). Insurers need the capability to assess the various program elements to ensure they are purchasing quality services for their members. This is distinct from approving clinical treatment, which is the domain of health professionals and in no way perceived here as the role of the health fund.

Chronic Disease Management Programs require four essential elements:

1. Collaborative problem definition
2. Targeting, goal setting and planning
3. Self management training and support services
4. Active and sustained follow up.

(Flinders Model of Chronic Condition Self-Management)

Providers should ensure their programs address each of the above dimensions. In particular programs should instruct on disease management as a part of self-management training and base this on national guidelines for management where they exist.

Chronic Disease Management Providers should be able to demonstrate that they have (or can) achieve the following health outcomes for targeted population groups:

- Chronic disease is being prevented or the onset delayed
- The progression and complications of chronic disease have been reduced
- The wellbeing and quality of life of individuals living with chronic disease and their families and carers has been improved
- Avoidable hospital admissions and health care procedures have been reduced

These outcome indicators are included in the National Chronic Disease Strategy. (page 45)

3.5 **Risk Equalisation** (pages 11-12)

Whilst concerns have been expressed that Broader Health Cover will increase the costs of the Risk Equalisation Pool, international evidence indicates that well designed risk and disease management programs reduce the costs of health care. ahm, through its Total Health division, currently delivers health management programs to over 11 funds in the industry. Based on ahm's experience of engagement rates within these funds, it is estimated that the total impact on the pool would be less than 1%. This assumes that the consequent improvement to member's health is not realised through reduced claims on the pool.

Those funds who actively manage the health of their members through Broader Health Cover through evidence-based health interventions should not be required to subsidise the health care costs of funds that choose to fund the increasing costs of an ageing population. Care needs to be taken in the implementation of BHC that issues relating to the impact on risk equalisation arrangements do not thwart genuine innovative initiatives.

(a) Risk Factor Identification

Unless the BHC framework provides a financial incentive, risk identification will not become a mainstream health insurance practice. The cost of health risk identification is minimal compared to the cost to insurers of hospital episodes that contribute to current risk equalisation arrangements.

The development of BHC products should not be inhibited by current indemnity processes of reporting. The cost of risk identification should be included in risk equalisation arrangements

and reported as a benefit to the entire membership rather than attached to individual memberships.

4. The nature of a product offered by a general insurer

Currently, cover by registered health benefits organisations (***RHBO'***s) (and complying health insurance products under the Bill) is subject to the principle of community rating, and so no application can be refused. This is a fundamental principle of private health insurance, and one that ahm supports. However, there is no requirement on a general insurer to comply with the principle of community rating. A general insurer can engage in "improper discrimination", set different premiums, risk rate, provide differential products and waiting periods, and provide significant premium discounting or bonuses, including "no claim" bonuses. A RHBO, and a private health insurer under the Bill, are prohibited from engaging in these activities.

Any health insurance cover that can be offered by general insurers will be risk rated and so will be much cheaper to the young and low risk insured. This places a significant burden on private health insurers. It is an anathema to allow risk rating to compete in a community rated environment. This will have the effect of transferring the poorer risks on to community rated private health insurers. Alternatively, the treatment of long term visitors or "ex-patriate" Australians in Australian who are older, infirm or with significant or chronic health problems and who will find it difficult or more expensive to obtain cover from a general insurer, will create significant added stress to the public hospital system.

Products and services of a general insurer will not be regulated by or subject to any supervision of PHIAC or the Department of Health & Ageing (***Department***). Whilst providers may be subject to APRA oversight, this will create a system of 2 separate and distinct regulators. Further, APRA has no experience with or expertise in health insurance regulation. The issues are complex and different to those of general insurance. It is not appropriate or efficient to require APRA to regulate activity that is dealt with adequately by an existing regulatory environment. This may lead to very different regulatory environments, which may lead to further confusion, and to unfair and unjustified competitive markets.

It is not known whether APRA has the resources or skills to be able to effectively regulate this new field of activity with which it has no previous experience.

Further, products provided by a RHBO give consumers access to the Private Health Insurance Ombudsman where required.[3] There is no right to this important protection for any cover provided by a general insurer.

Each of these matters will have significant adverse affects on the level and quality of health insurance for those people not covered by registered health insurers. This will create a situation where there are marked differences of treatment between categories of persons in relation to health insurance cover for the costs of hospital or general treatment in Australia that cannot be justified. This will lead to confusion and uncertainty and will result in two different and potentially inconsistent regulatory frameworks.

The simple solution (rather than duplicating the regulatory regime) is to provide that only private health insurers (who already are subject to those regulatory requirements) provide these services. This will require the deletion of clause 131-15(1)(b), and very careful consideration of any exclusion that may be made under clause 121-30.

5. Exclusions under the definition of "Health Insurance Business"

Under the current regime, regulation 48 of the *National Health Regulations* 1954 excludes a number of activities from the regulatory framework for private health insurance. This provision allows health insurance to be provided to those excluded persons by organisations that are not RHBO's. Some general insurers have suggested to us that there is currently doubt

[3] We note that the *Health Legislation Amendment (Private Health Insurance) Act* 2006 has closed this loophole in relation to Overseas Student Health Cover.

surrounding the position in relation to Australian residents who are working overseas and who return to Australia "temporarily". ahm believes that with the introduction of the Bill, any doubts surrounding these matters should be addressed. It is important to ensure certainty and consistency of treatment for all Australian residents in respect of treatment that takes place in Australia, and the provision of the private health insurance to those individuals.

On a related matter, the position in relation to dependents of an Australian resident who is working overseas where the dependants are still in Australia, should also be clarified.

5.1 Australian residents working temporarily overseas

Under regulation 48, a person who is not a RHBO is able to provide private health insurance to a person who is:

> *"a resident of Australia and engaged in **temporary employment outside Australia**, or a dependant of that person, in respect of whom a contract of insurance provides that liability for hospital treatment or an ancillary health benefit may arise"*

in Australia or outside Australia, if **the absence** is due to the temporary employment. (Our emphasis).

There has been no indication from the Department as to whether this exclusion will be included in any exclusions made under clause 121-30 of the Bill and the relevant rules. In any event, ahm submits that, whilst it may be appropriate for a general insurer to provide insurance cover for medical and hospital expenses incurred **outside Australia**, there is no justification for allowing that to occur in respect of any hospital or medical treatment **in Australia** that is provided to an Australia resident. ahm also submits that on its proper interpretation the current regulation does not extend to any Australian resident present in Australia or in respect of treatment costs incurred in Australia. As soon as a resident returns to Australia, (even if there is an intention to leave again) that person is no longer, at that point, "*engaged in **temporary employment outside Australia***".

Even if that interpretation is not accepted (and we understand that it is contrary to the Department's current view), there is no valid distinction to be made between an Australian resident who has returned to Australia for a brief period within a larger period of (temporary) absence overseas, and an Australian resident permanently present in the country. Those residents are entitled to receive all of the protections that are provided under the Bill that are provided to residents permanently present here, including protections in relation to the prohibition of improper discrimination, premiums, waiting periods, discounting of premiums and the level of cover. There is no basis for making any distinction between different Australian residents or exposing some Australian residents who are present in Australia and receiving hospital treatment to different treatment or improper discrimination, simply because they happen to be temporarily engaged on a short term assignment overseas.

Further, the creation of two very different systems, with different rules and levels of protection, will only create confusion and lead to continuing consumer uncertainty and a lack of confidence in the system. This is particularly the case in respect of those residents who are subject to pay the Medicare Levy Surcharge under the *Medicare Levy Act* 1986.

The Medicare Levy Surcharge

Any Australian resident who is temporarily overseas, and who meets the threshold requirements, is still liable to pay the Medicare Levy Surcharge unless that person has an appropriate level of hospital insurance (as an "applicable benefits arrangement" under the current regime and a policy that provides private patient hospital cover under the new regime).

As with the Medicare Levy, the Medicare Levy Surcharge applies only to Australian resident taxpayers. This means that a resident (for tax purposes) who is working temporarily overseas is liable to pay both the Medicare Levy and, if their taxable income is greater than the Medicare Levy Surcharge threshold and the person does not have an applicable benefits arrangement (or private patient hospital cover), the Medicare Levy Surcharge.

Whilst under present arrangements a general insurer is entitled to provide a policy that covers medical expenses incurred by an Australian resident during the time the resident is temporarily overseas (in accordance with regulation 48) that insurance is **not** an "applicable benefits arrangement". It will also not be complying private patient hospital cover for the purposes of the Medicare Levy Surcharge. This means that, even though an Australian resident who is working temporarily overseas may obtain insurance from a general insurer, that Australian resident also needs to retain private patient hospital cover from a private health insurer for the period spent overseas in order to comply with obligations under the Medicare Levy Surcharge. If that person's existing cover is cancelled or suspended, relying only on the arrangement with the general insurer, there will be a liability for the Medicare Levy Surcharge if their taxable income (and any relevant FBT amounts) is greater than the Medicare Levy Surcharge threshold.

ahm is aware of a number of instances where insureds have taken out insurance with a general insurer in respect of medical or hospital treatment costs incurred whilst overseas temporarily, and it has not been explained to them, and they have not understood, that they will be exposed to the Medicare Levy Surcharge. There has been significant confusion and misunderstanding in relation to this issue. Consumers have mistakenly believed that they have obtained private health insurance to cover expenses and charges and, therefore, they are not required to pay the Medicare Levy Surcharge. Alternatively, they mistakenly believed that they are entitled to suspend current arrangements and still avoid any obligation to pay the Surcharge.

In either situation, this is not the case.

An Australian Tax Office interpretive decision states that where a taxpayer is overseas for part of the year and substitutes normal health insurance cover with one obtained from general insurer and **suspends** the private patient hospital cover (for Australia) whilst overseas, the taxpayer will still be liable to pay the surcharge on 1% of their taxable income and reportable fringe benefits in accordance with the *Medicare Levy Act.* According to this decision, there is no provision that provides the Commissioner with a discretion to exempt a taxpayer from the surcharge where the taxpayer's health insurance (**even if it is equivalent health insurance**) is with a general insurer whilst suspending any arrangement that is held with a private health insurer (or RHBO). It is clearly the view of the Commissioner of Taxation that suspension of private patient hospital cover does **not** entitle an Australian resident who is working temporarily overseas to avoid any liability for the Medicare Levy Surcharge.

We agree with this view.

This approach is different to the rules that apply to Lifetime Health Cover, which allows suspension of cover without any adverse affect. This difference in treatment creates additional confusion.

Our experience has been that many general insurers do not understand these complex rules or the issues involved. As a result, the potential liability is not explained (or not explained adequately) by general insurers to individuals when "substitute" insurance is taken out and private patient hospital cover is suspended for a temporary period overseas. This results in the insured incurring an unexpected liability, and in becoming disaffected with the private health insurance regime. This can lead to a lack of confidence in the system.

ahm does not consider that any change to the taxation rules is required (or that such a change is within the scope of the current reform process). However, we do believe strongly that this issue must be addressed.

It is best addressed by reserving all health insurance business (in respect of costs incurred in Australia) for any Australian resident to experienced private health insurers that are regulated by an experienced regulator and that understand the complexities involved.

Extent of exception in Regulation 48

The current wording of the exclusion in regulation 48 has created a number of difficulties in determining whether a person is "engaged in temporary employment" and, if so, when that engagement has ended.

A person who is engaged in temporary employment outside Australia and who returns to Australia is no longer engaged in that temporary employment **outside Australia**. Further, that person is not, at that time, "absent" from Australia. This means that there is **no ability** for any person other than a RHBO to cover any Australian resident for any liability to pay any medical or hospital costs in or incurred in Australia. This applies even to those persons who, for example, work overseas for a 6 month period and during that period return to Australia for a short period other than as a result of the engagement (for example a client meeting as part of the engagement overseas, but where the meeting takes place in Australia) and later return overseas to complete the engagement overseas. During the period that the person is in Australia the engagement outside of Australia has ended and the person is not absent from Australia. When the person subsequently leaves Australia, the person recommences the engagement, or commences a subsequent engagement of temporary employment outside Australia.

Even if that interpretation is not correct (and ahm submits that it is correct), from our experience there is currently doubt amongst many general insurers as to what is meant by the term "temporary", and who can be covered by a general insurer. This must be clarified.

We understand that the Department is of the opinion that any person who is working overseas and who intends to return to Australia to live **at any time in the future** is engaged in temporary employment. This is not dependant on whether the posting is for a predetermined period. We do not agree.

The concept of "temporary" is one that is not lasting or needed for very long. It must be for a limited, and relatively short, period of time. An engagement that is for a period of time that is **not fixed** or **predetermined** cannot be "temporary". It may not be permanent but it can be something other than temporary, even though it is not permanent. The length of time in and the person's degree of connection with the other place and with Australia are all relevant.

ahm submits that any confusion over this matter is best addressed by ensuring that only a private health insurer can carry on any business of undertaking liability, by way of insurance, for hospital treatment or general treatment that **occurs in Australia** in respect of **all eligible persons**.

5.2 Dependents of residents engaged overseas

Under the current provisions, any dependent of a person who is engaged in temporary employment outside Australia can be covered by a general insurer. There is no requirement that the dependant is also outside Australia. This means that dependants, who are residents of Australia and currently resident in Australia, can be insured by a general insurer, in respect of liability to pay costs of medical and hospital treatment incurred in Australia. If that occurs, none of those dependants has any right to any of the protections available to other Australian residents, in respect of their private health insurance (we refer to section 4 above). Those persons will be at a significant disadvantage, and may be exposed to behaviour, in relation to that insurance, that would not be acceptable or allowed by a private health insurer.

There is no reason why any person who is resident in Australia and who incurs a liability in respect of medical or hospital treatment in Australia, should be denied the protections under the Bill.

Accordingly, ahm submits that any exception for dependents of persons engaged temporarily overseas should only apply to those dependents who themselves are outside of Australia as a result of the temporary employment of the person on whom they are dependant. The provisions should not allow a general insurer to provide health insurance to any person who is a resident of Australia simply as a result of the fact that that person is a dependent of another person who is temporarily outside Australia.

6. Health insurance that is part of "Health Related Business"

6.1 Overseas Student Health Cover

Currently overseas students studying in Australia (including those who are ineligible for Medicare) must obtain private health insurance from an RHBO. Whilst the provision of

overseas health cover is excluded from the definition of "health insurance business", regulation 48 makes it clear that overseas student health cover must only be provided by a RHBO that has entered into a deed with the Commonwealth. This structure has operated efficiently and competitively. The present arrangements ensure that the Minister is able to track and monitor the level of participation and costs.

However, under the proposed definition of "health related business", overseas student health cover (being a liability, by way of insurance, to pay for medical or hospital treatment in Australia in respect of persons who are "ineligible for Medicare") is a "health related business". Further, it is not "health insurance business". Whilst the provision **allows** a private health insurer to provide overseas student health cover, there is no longer any requirement or restriction on overseas student health cover **only** being provided by a private health insurer. Further, there is no longer any requirement that the provider of the overseas student health cover (whether a private health insurer or not) must enter into a deed with the Commonwealth.

As a result, the provision of overseas student health cover will be significantly (and adversely) changed.

ahm submits that this is unacceptable. There are good public policy and consumer protection reasons for the current requirements. We can see no reason for making this change, to allow others, with no experience in private health insurance, and who will not be subject to the regulatory requirements of the Bill or oversight of PHIAC or the Department, to undertake this business.

Further, the structure of these arrangements will mean that there will be a sharp distinction drawn between overseas students who are from countries with which Australia has a reciprocal health care agreement (who will be eligible for Medicare)[4] and those students from countries that have no such reciprocal arrangements. A private health insurer must cover students from countries with reciprocal health care arrangements, as those persons are eligible for Medicare. The provision of that insurance is clearly "health insurance business" under the Bill and is not "health related business". Those students will have all of the consumer and other protections that apply to the provision of complying health insurance products. Other students who, as a result of nothing that is within the students' control, are residents of a country that does not have a reciprocal health care agreement, will have no such protections. This is unacceptable.

It will also create additional administrative and other difficulties for educational institutions. Currently, **all** overseas students studying in Australia on a student visa (including those students from countries with which Australia has reciprocal health care agreements) must maintain health insurance (and the family members present must also maintain insurance) while in Australia. The Department of Immigration and Multicultural Affairs advises students, including those students from countries that have reciprocal health care agreements (for example the United Kingdom) that insurance can be provided by obtaining overseas student health cover. Many educational providers collect the overseas student health cover premium from overseas students enrolling at their institution and arrange to pay the health insurance cover on behalf of the students.[5]

Currently, educational providers that undertake this service do not need to differentiate between students from countries that have a reciprocal health care agreement and those students from countries that do not have such an agreement. The process is simple and straightforward and allows an education provider to arrange and pay for health insurance with a minimum of administrative oversight or complexity. That will change significantly under the current proposals in the Bill.

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[4] ahm agrees with this change to the existing rules that requires these people to be insured by a registered health insurer, and now prohibits others from providing this insurance.

[5] We note that it is not mandatory for providers to organise overseas student health cover for intending students.

If an education provider wishes to provide a service to its overseas students of arranging or paying for overseas student health cover, it will need to differentiate between classes of students and will need to have arrangements in place with any number of private health insurers (for students from countries with reciprocal health care agreements) and general insurers (for other students). We expect that this will mean that education providers will cease providing this service. This may lead to increases in defaults, with the removal of an effective check for ensuring that an enrolled overseas student has appropriate health insurance cover.

Accordingly, ahm submits that the provisions of the Bill are amended so as to do each of the following:

1 Exclude overseas student health cover from the definition of "health related business".

2 Confirm that the provision of overseas student health cover is "health insurance business" and, consequently, must only be undertaken by a private health insurer.

3 Further provides that overseas student health cover must only be provided by a private health insurer that has entered into a deed with the Commonwealth (so that the current restrictions in relation to provision of this specialised cover continue to apply).

6.2 Persons "ineligible for Medicare"

The provisions in the Bill significantly expand the ability of a general insurer to provide private health insurance in respect of medical and hospital treatment costs incurred in Australia.

ahm's position is that any person who is present in Australia other than as a tourist and who obtains private health insurance must do so from a private health insurer, or the insurance must be underwritten (that is the risk is assumed and the liabilities are met) by a private health insurer.

ahm submits that there is no public benefit in further opening the market to organisations that are unregulated, and allow them to provide health insurance products in respect of costs incurred in Australia to a person who is ineligible for Medicare. Those people may be long-term residents of Australia. Further, as is the case with the proposed changes to overseas student health cover, the proposals will create a distinction between persons who are from countries that Australia has a reciprocal health care agreement (who will be eligible for Medicare) and those from countries that have no such reciprocal arrangements.

Under current arrangements, a general insurer is able to provide health insurance to a person who "at the time of entering into the relevant contract of insurance" is or expects to be "temporarily present in Australia" **and** is not "an eligible person" (or is only an eligible person as a result of the operation of reciprocal health care agreement) (see regulation 48(a)(i)).

ahm submits that the current arrangements do **not allow** a general insurer to provide health insurance in respect of costs incurred in Australia for any persons other than tourists or short-term business visitors. Any person who is in Australia under a visa, and has an unfettered ability to enter and leave, and who can work here, cannot be insured by a general insurer. The relevant provisions do **not** permit a general insurer to provide private health insurance to persons who are in Australia for fixed, pre-determined or lengthy periods of time (on any form of visa that is other than a permanent visa that allows the person unrestricted entry into Australia and the ability to work in Australia). This includes 457 visas or business migration visas.

This is significantly different, and much more restrictive, than the situation that is proposed as a result of the definition of "health related business" in the Bill. All persons who are ineligible for Medicare, whether present temporarily or otherwise than temporarily, will be able to be insured by a person other than a registered health insurer.

No justification for this unnecessary extension has been provided.

ahm submits that if a person other than a registered health insurer is to be permitted to provide health insurance at the very least both current criteria must be satisfied.

7. Financial Services Licensing

Section 765A(1)(c) of the *Corporations Act* 2001 provides that health insurance provided as part of a health insurance business as defined in subsection 67(4) of the *National Health Act* 1953 is not a financial product for the purposes of Australian Financial Services Licensing requirements. RHBOs are not required to hold an Australian Financial Services Licence in respect of the health insurance business that they conduct.

ahm supports the continuation of this exemption.

However, section 67 (including subsection (4)) of the *National Health Act* 1953 will be repealed on the implementation of the Bill (see section 3 and Item 53 of Schedule 1 of the *Private Health Insurance (Transitional Provisions and Consequential Amendments) Bill* 2006 (***Consequential Amendments Bill***)). Accordingly, health insurance provided as part of a health insurance business under the Bill will **not** be excluded from the definition of financial products. Without an amendment to section 765A(1) of the *Corporations Act*, health insurance business conducted by a private health insurer will require a financial services licence.

This will mean that health insurance business will be regulated **both** under the Bill and by APRA under the *Corporations Act*. That dual regulation is not appropriate or required. This is to be contrasted with the position of general insurers, who are able to provide health insurance to persons present in Australia without any regulatory oversight of PHIAC or the Department, and without any of the protections of the Bill.

ahm submits that the Consequential Amendments Bill must also provide (in Schedule 2) that section 765A(1)(c) of the *Corporations Act* 2001 is amended, to repeal the paragraph and substitute:

> "(c) health insurance business within the meaning of Division 121 of the *Private Health Insurance Act* 2006 carried on by a private health insurer within the meaning of that Act;"

Similarly, Regulation 7.1.07C(1) of the *Corporations Regulations* 2001 provides that insurance under an overseas student health insurance contract is not a financial product. Sub-regulation (2) defines overseas student health insurance contract as having the same meaning as in Regulation 48 of the *National Health Regulations* 1954. Under those regulations, an overseas student health insurance contract is a contract of insurance made in accordance with an agreement between a RHBO and the Commonwealth that allows the RHBO to pay benefits in respect of fees and charges incurred by an overseas student in relation to the provision in Australia of certain health services and hospital treatment.

We have set out above our concerns in relation to the current definition of "health related business" and the extent to which it allows a general insurer to provide overseas student health cover. If our submission in respect of that matter is accepted, it will be necessary to amend Regulation 7.1.07C(2) and replace it with the following:

> "In this regulation **overseas student health insurance contract** is a contract of insurance made in accordance with an agreement between a private health insurer and the Commonwealth that allows the private health insurer to pay benefits in respect of the whole or part of the fees and charges incurred by an overseas student, or by a dependent of an overseas student, in relation to the provision in Australia of any hospital or general treatment."

Even if our submission is not accepted, the regulation will need to be amended so as to remove the reference to Regulation 48.

I thank you for the opportunity to submit ahm's opinion with respect to the Bill.

Authorized

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