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Australian Senate
Community Affairs Committee
Parliament House
Canberra ACT 2600

Dear Committee

On 7 December 2006, the Senate referred a range of Private Health Insurance Bills to the Community Affairs Committee for inquiry and report.

BUPA Australia Health Pty Ltd (**'BUPA Australia'**) wishes to provide this submission to the Committee in support of its inquiry.

BUPA Australia operates a private health fund nationally with a market share of approximately 10.2%, with almost 500,000 policies covering over 1 million lives.

BUPA Australia welcomes and supports the proposed health insurance reforms, which will encourage innovation, competition and improved services for members through the introduction of Broader Health Cover.

BUPA Australia also supports the efforts of the Department of Health and Ageing (**'the Department'**) in consolidating the private health insurance legislation, which over the years has become disjointed and overly burdensome.

Following are comments on various aspects of the Bills:

Exposure Draft

Prior to the introduction of these Bills, the Department made the associated Exposure Draft available to the Industry and conducted several valuable consultation processes to enable Industry's input into the new legislation. It is pleasing to note that, following these consultations, a number of unfavourable inclusions in the Exposure Draft have subsequently been deleted from the Bills. These include the following:

- the new premium requirement restricting premium adjustments to the anniversary date of the member's date of joining,
- the requirement to send information to each adult member covered under a policy, and
- the change to the definition of a pre-existing ailment.

These inclusions would have had major cost and administrative implications on the operations of health funds, therefore the Department's consultation process has proved to be a worthwhile and valuable exercise.

PHI Rules

There are many references to the Private Health Insurance Rules contained in the Bills, however, many of these Rules are not yet available to Health Funds. Accordingly, the impact of the Bills cannot be fully assessed until the Rules are available.

It is important that these Rules do not provide any constraint to the achievement of the Government's objectives, namely to add value to private health insurance products and to support the long term sustainability of the private health industry.

It is vital that industry has input into the content of these Rules and that an appropriate consultation process is put in place prior to the finalisation of this component of the legislation.

Division 152, Duties and Liabilities of Directors

BUPA Australia notes that Division 152 appears to mirror the directors duties provisions of the Life Insurance Act 1995 (Cth). This is inappropriate for the following reasons:

- private health insurance involves uncapped liability for a future occurrence. Life insurance is not a contract of indemnity and is capped in its nature;
- the requirements of portability and community rating mean that private health insurers cannot refuse to insure, unlike life insurers;
- the directors' duties owed to policyholders differ markedly between health insurers and life insurers; and
- the competing interests between those of policyholders and the company will mean that directors will not be able to satisfy their duties at common law and satisfy their obligations as set out in the Bill in Division 152.

BUPA Australia submits that the common law adequately covers this field, and given the key differences between the life insurance and health insurance contexts, the introduction of principles designed for life insurance is inappropriate. For this reason, Division 152 should be removed.

Penalties

The Bills include severe penalties for non-compliance. Many of these penalties impose criminal liability and seem to far outweigh the degree of transgression associated with non-compliance. In most cases, they are strict liability offences.

There are several examples of this, including:

- Section 84-1 imposes a significant penalty on individuals (5years imprisonment and/or 1000 penalty points), for advertising or offering a non-complying policy. This is inappropriate and unduly onerous. Such severe penalties are more appropriate at the Company level;
- Section 93-30, penalty of 60 units applies for each time a person does not receive a standard information statement;
- Section 99-1, penalty of 60 units applies for each time an old insurer does not give a transfer certificate or a new insurer does not ask the old insurer for the same document.

On the other hand, section 118-1 applies a penalty of only 40 units for each day a person carries on health insurance business without registration.

There are also many sections where non-compliance with the Private Health Insurance Rules is an offence. At this stage there is no detail about these Rules,

however, given the reference to strict liability that applies to offences within the legislation, it is vital that the details within the Rules are unambiguous.

The penalties for non-compliance must be equitable and match the severity of the offence. Attributing strict liability to these offences is unduly onerous and should be deleted from the Bills.

Discount Arrangements

Section 66-5 (2) describes circumstances under which a discount to premiums is allowed.

Part (f) of this section states: '*the same discount is available for the same reason under every policy in the product'.*

This new part affects the discounts available to different corporate groups (referred to as 'contribution groups' in the legislation).

Under current legislation, different discounts (up to 12%) are available to different contribution groups. The only proviso is that each year, Health Funds are required to report on the varying discounts that apply to each contribution group, with a reasonable assessment of the savings in management expenses attributable to the discount arrangement within each contribution group.

Part (f) prescribes that this will no longer be permitted and that all contribution groups must receive the same discount irrespective of administration savings attributable to the group.

Further consultation is required to better understand the ramifications of this change. Given that the Department is currently undergoing a complete review of corporate products, it would be appropriate to postpone this change in the legislation until the findings of the review are known.

Broader Health Cover

Broader Health Cover (BHC) is an integral part of the Government's reforms. BHC will allow Health Funds to offer products that pay benefits for services that are part of, substitute for or prevent hospital services. This will allow members to receive the best care in the most appropriate setting and further enhance the value of health insurance. However, we need to ensure that the regulatory framework that surrounds BHC does not in any way impede its successful implementation. Following are some issues with the current draft of this regulatory framework:

Chronic Disease Management Programs

Effective chronic disease management programs (CDMP) will provide significant benefits to members with chronic diseases or those at risk of chronic diseases. The efficient funding of such programs is an important step forward and will form a vital part of the success of the BHC reforms that will commence in April.

In spite of this, the current framework provides a restriction that will obstruct the implementation of many valuable programs. The minimum requirements for CDMPs include the provision of at least two allied health services from two or more disciplines. The framework paper states that this restriction has been included because it ensures a multi-disciplinary approach and it also reflects the CDMP items included in the Medicare Benefits Schedule (MBS).

However, these two reasons for the restriction do not correlate to the value of CDMPs or the overarching objectives for CDMPs, described in the framework paper as:

- to reduce complications in people with (pre-diagnosed) chronic disease; and
- to prevent or delay the onset of chronic disease for people with (pre-determined) multiple risk factors.

Having a multi-disciplinary approach may be valuable for some chronic diseases, but in itself, does not mean that the overarching objectives of CDMPs will be achieved. Similarly, reflecting the MBS items for chronic disease does not mean that the program will be effective. It should be noted that not all the MBS items for chronic disease have this restriction. There are several GP Management Plan items that only require GP involvement.

Each CDMP will have a treatment regime and provider structure that reflects the unique requirements and risk factors associated with the particular chronic disease. The value of a CDMP cannot be judged on the basis of how many allied providers are involved in the program.

Rather, the value of a CDMP should be judged on the effectiveness of the program to achieve the objectives of reducing complications and preventing the onset of disease for people with multiple risk factors.

BUPA Australia is currently trialing a voluntary 12 month program for members that have recently undergone hospital admissions for psychiatric illness. This program includes the following:

- Initial assessment by a mental health provider;
- Development of a relapse prevention plan;
- Ongoing intervention calls, frequency of which is based on the initial risk assessment;
- 24 hour access to a support line which includes triage and crisis support;
- A review after 12 months.

BUPA Australia also has a cardiac program for members that have recently undergone cardiac surgery. This program includes a diet and exercise program and periodic calls by a cardiac nurse.

BUPA Australia believes that both these programs offer substantial benefits to our members. However, given the current framework, both programs do not have the required number of providers and as such would not be categorised as CDMPs. Both programs would be considered as ancillary services and therefore, not re-insurable.

This restriction may discourage some Health Funds from implementing valuable programs for their members. This would not be in accord with the intent of the BHC reforms, which is to encourage the expansion of valuable BHC services. To enable this expansion, this restriction must be removed.

CDMP Reporting

Page 12 of the draft PHIAC 1 return includes data reporting requirements for CDMPs. There is detailed reporting for CDMPs including planning, coordination and a large range of allied health services. This presents a significant administration burden, which may provide another hindrance to CDMP implementation. It should be noted that a $50,000 hospital admission has minimal reporting requirements within the PHIAC1 return. This would be reported as one episode, cost $50,000. However, a $1,000 CDMP requires several lines of reporting. This is not logical.

The large list of allied health services is taken from the MBS guidelines for its chronic disease management guidelines. This may not be the most appropriate list for the private health insurance sector. For example, no mention is made of nursing services, which would be an integral part of many CDMPs.

It is also unclear how this reporting system will work. Take for example the psychiatric program that is mentioned above and assume that it is classified as a CDMP. The cost of the program covers the items mentioned above, namely, assessment, planning, ongoing intervention calls, access to support and a review. The cost does not include benefits for other provider services that might emanate from intervention calls or advice from the support service. For instance, a person may ring the 24 hour crisis line and be advised to seek consultation with a psychologist. The cost of this psychology visit is not included in the cost of the CDMP, however, if the person has ancillary cover, benefits may be payable. This psychology visit cost should be reported in the normal ancillary service tables, however some Funds may report it in the CDMP tables.

On the other hand, BUPA Australia could bundle a psychology visit component within the cost of the program and therefore claim the same psychology visit via reinsurance. The reinsurance status of this psychology visit should not be dependent upon the way the visit is funded.

The purpose, complexity and need of this reporting system requires questioning in the context of what the Industry is trying to achieve in relation to CDMPs. The perceived value of this reporting system is far outweighed by the administrative burden and confusion it may cause. This reporting system must be reviewed.

Same Day Procedures

Same day procedures are defined as those procedures in Groups T1-T11 and O1-O11 of the MBS, but not those items with the symbol (H) or items that expressly require that the service be performed in hospital.

These items may be performed outside hospitals and may be part of a Fund's BHC benefits. However, it should be noted that it is not mandatory for a Fund to offer such benefits. Accordingly, it not the doctor's decision whether or not a BHC benefit is payable for a same day procedure as defined in the framework paper. This should be made clear.

If a Fund does pay a BHC benefit for a same day procedure, there is an option for Medicare benefit of either 75% or 85%. It remains unclear on how this will administratively work. Further administrative guidelines are required for such benefits.

I trust that the above is useful to the Committee's inquiry. BUPA Australia looks forward to further involvement in the evolution of the proposed legislation.

Yours sincerely

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