SUBMISSION TO THE

SENATE COMMUNITY AFFAIRS COMMITTEE

INQUIRY INTO PRIVATE HEALTH INSURANCE BILL 2006 [PROVISIONS] AND RELATED BILLS

by

MBF Australia Limited

January 2007

CONTENT

EXECUTIVE SUMMARY

MBF Australia Limited ("**MBF**") welcomes the opportunity to provide a submission to the Senate Community Affairs Committee inquiry into the Private Health Insurance Bill 2006 (the "**Bill**") and related bills.

MBF commends the Minister and the Government on the measures introduced by the Bill and is fully supportive of the objectives of the Bill which are to:

- give Australian's greater choice in health care;
- ensure a sustainable and balanced health system by supporting a viable private health sector that complements the public health system; and
- make private health insurance more competitive and attractive to consumers.

The Government has focused on 3 key components to achieve these objectives:

Component 1 – improving private health insurance products;
Component 2 – enhancing private health insurance choices; and
Component 3 – ensuring there is appropriate regulation of private health.

Recommendations

We have adopted the above structure as the framework for this submission and make the following recommendations. In making recommendations MBF has considered the overall objectives of the reforms and the Bill as stated by the Government.

Component 1

1) **Supporting consumers choice to be more engaged in their health**

Recommendation 1: That a commitment be given to continue to review and develop the BHC framework and to work with industry to support innovation particularly in the area of prevention and early intervention. This will ensure the BHC framework is sufficiently flexible to:

- enable insurers to be innovative in the development of options to support their members' choices to be more actively involved in their health including those who are undertaking activities to maintain or improve their health status; and,
- to assist all consumers not just those at immediate health risk or currently suffering a chronic disease.

2) **Effective communication of the reforms to ensure that consumer's expectations are met**

Recommendation 2: That the key messages to the Australian community in relation to the reforms should emphasise the expansion of health insurers ability to offer coverage for a wider range of services beyond hospital-based care. Importantly however the community should be aware that this bold vision and opportunity for health system change will take time and involve co-operation between health insurers, health care

providers and the medical profession to realise its full potential. Similarly any potential for health cost control through more innovative models of care are unlikely to be reflected in premiums over the short term.

Component 2

3) **Proposed disclosure regime**

Recommendation 3: The Committee request that consistent with the recommendations of the Taskforce on Reducing Regulatory Burden, the Government commit to conducting an early post implementation review of the effectiveness to consumers of the new disclosure regime, including the regulatory compliance costs incurred by the industry, by June 2008.

Component 3

4) **Chapter 4 of the Bill – Statutory Funds**

Recommendation 4: MBF recommends that the provisions relating to the financial structure of funds be reviewed and amended to provide specifically for:

- a general or shareholders fund;
- provisions for the transfer of amounts between funds; and,
- provisions attaching regulation appropriately to the statutory fund.

General Recommendations

5) **Requirements for making of Rules to be established**

Recommendation 5: That the requirement for proper consultation such as contained in section 33 of the Insurance Act should be included in the Bill regarding the Rules which PHIAC is able to make.

Recommendation 6: In relation to the Rules that the Minister is able to make, MBF again submits that the following requirements should attach in relation to any such Rules, and the only situations where these requirements should be excused are for matters which require urgent action especially in relation to any prudential or other risks to the industry or consumers:

- any change resulting from the Rules must not have an adverse impact on insurers or policy holders;
- a proper cost analysis must be undertaken on the change and provided to all stakeholders;
- consultation of 12 months be provided for any change that is likely to have a significant impact; and
- adequate notice must be provided to all stakeholders of the change.

MBF AND CURRENT INDUSTRY ENVIRONMENT

Who is MBF Australia Limited

MBF has provided private health insurance to Australians for over 60 years. MBF has a strong, long established brand associated with peace of mind, security and hope for a healthy future.

MBF as ultimate parent company also owns MBF Alliances Pty Limited and is the largest privately managed health insurance company in Australia with a combined market share of around 19%. Our purpose is to provide trusted solutions that protect and enhance health and financial wellbeing. Through both MBF and MBF Alliances Pty Limited we provide private health insurance cover to around 903,000 memberships, with a total of 1.9 million persons covered. In financial year 2005-06 we received almost $2.0 billion in contributions and paid $1.7 billion in claims benefits on behalf of our members.

Our financial health protection services to our members currently include a full range of products including hospital products covering inpatient treatment in hospitals, extras products covering ancillary services such as dental, optical and physiotherapy and combinations of hospital and extras cover, as well as health insurance products for non-Australian residents.

Through our subsidiaries we provide financial services offerings including travel insurance, life insurance products such as trauma and term life insurance and wealth management products and services such as retirement planning, personal investment plans, superannuation and pensions.

Our products are distributed through our retail branches, call centres and financial advisers and by direct mail to our own and our partners' customers.

Current Industry Environment

Currently under the National Health Act 1953 ("**NHA**") an entity must be registered as a health benefits organisation ("**RHBO**") to be able to sell private health insurance. The requirement for registration is to continue under the provisions of the Private Health Insurance Bill ("**Bill**"). RHBOs are more currently colloquially referred to as health funds and are referred to as private health insurers under the Bill.

Under the current regulatory regime, the NHA and its regulations (including conditions of registration placed on funds) regulate product features, maximum waiting periods that can be imposed prior to benefits being paid, portability of entitlements between funds, categories of membership and the types and levels of benefits.

The Bill replaces the regulation of the health funds via conditions of registration with regulation more focused on the health insurance product itself. Under the Bill private health insurers will not be able to sell products unless they are complying health insurance products ("**CHIPS**"). To be a CHIP the product must meet certain criteria set out in the Bill and Rules.

Consumers have, and will continue to have under the Bill, guaranteed acceptance and renewal for their membership as well as continuity of membership when transferring from another insurer. Private health insurers have no right of refusal or differentiation for members joining their fund.

Health funds are required to adhere to a community rating system which means that they are not allowed to discriminate between health fund members on the basis of their health, age (with the exception of Lifetime Health Cover loadings), race, sex, sexuality or claiming history.

Currently private health insurers are only able to offer cover for in-hospital services and ancillary services. Under the NHA funds are not permitted to pay a benefit for outpatient medical fees. Nor are benefits for services provided outside the hospital walls eligible for distribution in accordance with the mandatory industry claims equalisation scheme.

The proposed legislative reforms seek to extend the services for which private health insurers can provide benefits through the introduction of broader health cover ("**BHC**") services. In April 2006, the Minister announced that BHC would enable private health insurer to cover services which either:

- prevent a hospitalisation; or
- are part of an episode of care; or
- are substitutional to an episode of care.

The intent of the reforms to provide private health insurers with the option of offering cover for health services provided outside of the hospital such as home care including home nursing, dialysis and chemotherapy in the home, some surgical procedures performed in doctor's rooms and chronic disease management programs. In most part these services will also be able to be included in the reinsurance scheme.

PRIVATE HEALTH INSURANCE BILL

Introduction

MBF is committed to ensuring the sustainability of Australia's mixed public/private health system. In particular, we wish to ensure that the private sector, which complements and substitutes for the public sector – and offers greater choice and access in many important ways – remains viable, attractive and affordable for all consumers.

Rising health care costs (as a result of technology, increasing demand and ageing of the population) and the ability for the funders of health (ie Government, private health insurers, society and individuals) to meet demand for these health care services is a major global issue.

Without significant policy changes, government health expenditure (excluding aged care) was projected by the Productivity Commission to rise significantly in real terms, from 5.7% of GDP in 2002-3 to 10.3% in 2044-5. Ageing is projected to account for half of this increase[1]. Projections by the Australian Bureau of Statistics indicate that by the middle of the century the median age of the population will rise from the current 35.9 years to 49.9 years. Life expectancy for men will increase from 77 years to 82 years and from 84 years to 87 years for women. The over 65 population will increase from 13% to up to 30%. Up to 9% of the population will be in the "old-old" category of 85 and over, compared to just 1.4% currently[2]. All this highlights the importance of a sustainable private sector, and of private health insurance, which helps individuals to manage the cost of accessing private services and contributing to the cost of their own health care.

Private health insurers received total contributions of $10.2 billion in financial year 2005-06 to the economy, $8.7 billion of which was paid to hospitals, doctors and medical suppliers[3]. As the pressures on government expenditure on all social services increase, the private health sector will need to continue to assist the government in coping with the increase demand for health services. MBF believes that an increase from the current level of 43% of the population being privately insured to 50 – 60% would enhance the contribution of the private sector and better enable the overall health system to be sustainable.

It is therefore clear that the ongoing attractiveness and viability of private health insurance is essential for Australians to continue to access the same quality and range of services in the future.

To this end MBF commends the Government's decision to implement reforms for private health insurance through the introduction of the Private Health Insurance Bill 2006 (the "Bill").

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[1] Productivity Commission 2005, *Economic Implications of an Ageing Australia* page 143
[2] Centre for Economic Development of Australia, Policy Statement, *Australia's Ageing Population: Meeting the Challenge* February 2004
[3] Figures calculated from Private Health Insurance Administration Council, *Operations of the Registered Health Benefits Organisations Annual Report 2005-6* (Canberra 2006)

The Government's reforms and the Private Health Insurance Bill 2006

MBF is fully supportive of the Government's stated objectives for the introduction of the Bill and believes that the objectives if met, represent a very important step in an on-going process necessary to improve the long-term viability of private health insurance and the health system as a whole.

MBF acknowledges and appreciates the industry consultation process that was undertaken by the Department of Health & Ageing (DoHA) on behalf of the Government from June 2006. MBF also commends the Government and the DoHA for releasing an Exposure Draft of the parts of the Bill for industry comment and for taking on board many of the industry's concerns in relation to the Exposure Draft and reflecting those in amendments to the Bill prior to its introduction. MBF remains committed to continuing to work with the DoHA to ensure that the Bill when passed meets the Government's objectives.

A. COMPONENT 1 – IMPROVING PRIVATE HEALTH INSURANCE PRODUCTS

MBF has for sometime identified the importance of providing its members with more choices and information that they can use to be more engaged in their health options and, if they choose, to take action to maintain or improve their health status. MBF believes that this is key to improving the value proposition of health insurance for all consumers regardless of their age or health status.

Until recently the legislative environment restricted the private health insurance system to be focused on the acute medical and surgical treatments in hospital. The introduction by the Government of the Broader Health Cover ("**BHC**") changes as part of the Bill are a significant and important step towards recognising the importance of prevention, early intervention and the appropriate and effective management of chronic disease outside the hospital setting.

MBF also notes that the Minister set an objective of the reforms providing insurers with the ability to offer cover for services which prevented a hospitalisation.

MBF commends the Minister and the Government on the measures introduced by the Bill and notes the substantial potential of the introduction of BHC to increase the attractiveness of private health insurance for older consumers and individuals with chronic disease.

MBF also acknowledges that the change to Lifetime Health Cover loading application will also have some positive impact on the attractiveness of joining or rejoining private health insurance for those after the age of 30 years.

MBF welcomes the opportunity to expand its product offering in order to ensure that its members receive the most appropriate care, in the most appropriate location at the most appropriate time for them. MBF has for sometime been working on developing offerings and member benefits which aim to encourage and support its members to be more actively involved in their health.

The reforms represent an excellent opportunity for MBF to build on its existing offerings and initiatives.

The changes proposed in the Bill are an important step towards allowing insurers to play a more enhanced role in the funding of the health system in Australia. It is important to bear in mind that this is an on-going and evolving process and we must not lose sight of the fact that further work and refinement will be required.

1) Supporting consumers choice to be more engaged in their health

MBF believes the extension of the coverage that private health insurers are able to offer to BHC and in particular Chronic Disease Management Programs ("**CDMP**") is the initial step towards providing insurers the flexibility to be innovative in their product offering.

MBF believes that with the long-term commitment of all players the Government's reforms open the way for a more effective health system for Australia. MBF is committed to the Government's aim to enhance the overall health of the Australian population and believes that private health insurers also has a vital role to play working closely with all health care providers together with the active involvement of consumers.

To this end MBF supports the introduction of the ability to cover CDMP for those at risk and those who are currently suffering from a chronic disease. Further MBF notes that the DoHA has proposed to align the CDMP under the BHC framework to the National Chronic Disease Management Strategy (the "**strategy**"). As the strategy correctly identifies chronic disease is associated with high health care expenditure as people with chronic disease tend to use health services and medicines frequently and over an extended period of time[4]. Therefore there is no doubt that this is a sensible approach to help manage the costs of chronic disease in the community.

However, MBF believes that maintain good health, disease prevention and early intervention are also vital to the future health of the community and containing health care costs. Health insurers can play an active role in encouraging and supporting our members towards healthy behaviours and targeted interventions relevant to their health risks.

The strategy also states the incidence and prevalence of many chronic diseases are attributable to a range of factors including:

(a) smoking
(b) risky and high alcohol use
(c) physical inactivity
(d) poor diet and nutrition
(e) excess weight
(f) high blood pressure
(g) high blood cholesterol[5]

In the US a study has shown that physical inactivity, overweight and obesity are associated with 23% of health insurance charges and 27% of the national health care charges. The same study also found that while the highest charges associated with these risk factors were related to those aged 65 years plus and those with a chronic

4 National Chronic Disease Management Strategy pg 2
5 National Chronic Disease Management Strategy pg 2

condition, a significant amount of the charges were also generated from the age group 40 to 64 years who did not have a chronic disease[6].

Therefore Government and the industry should continue to work together to develop further measures which not only focus on those with a chronic disease but enable the private sector to be involved in and provide benefits for all points along the continuum of health and disease prevention. MBF believes that insurers should be able to develop and make available tools, information and programs to assist our members of all ages and health status to manage their health and health risks. This in turn will ensure that private health insurance remains relevant and attractive to all Australians no matter what their age or health status thereby further supporting the principles and effectiveness of Community Rating.

Recommendation 1: That a commitment be given to continue to review and develop the BHC framework and to work with industry to support innovation particularly in the area of prevention and early intervention. This will ensure the BHC framework is sufficiently flexible to:

- enable insurers to be innovative in the development of options to support their members' choices to be more actively involved in their health including those who are undertaking activities to maintain or improve their health status; and,
- to assist all consumers not just those at immediate health risk or currently suffering a chronic disease.

2) Effective communication of the reforms to ensure that the consumer's expectations are met

MBF believes that at least in the short to medium term, the expansion of the services which can be covered will inevitably result in an increase in benefits paid by insurers.

MBF submits that the following principles should be noted in relation to the potential impact on benefits paid by insurers as a result of the introduction of BHC:

- To the extent that hospital claims may be substituted for less expensive out of hospital procedures, a downward pressure on benefit payments would be expected.

- To the extent that costs may shift from the Public to Private sectors due to the ability to now cover these additional events, an upward pressure on benefit payments would be expected.

- The benefit of preventive programs in reducing costs will be long term in nature (in fact some research suggests there may be no cost savings[7] however the benefits for the health of the population still remain), but costs of covering these activities will be upfront, resulting in a potential upward pressure on prices in the short to medium term.

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6 Anderson LH, Martinson BC, Crain AL, Pronk NP, Whitebird RR, Fine LJ, et al. Health care charges associated with physical inactivity, overweight, and obesity. Prev Chronic Dis [serial online] 2005 Oct

[7] An Analysis of the Literature on Disease Management Programs 13 October 2004, Addressed to the Committee on the Budget, United States Senate

- In addition MBF cautions against relying on any calculations on the future cost of these initiatives which do not take into account the on-going administrative costs of providing the new benefits.

- Importantly the development, assessment and adoption of new models of care will take time and require collaboration between health funds, health care providers and the medical profession.

While it may appear that immediate savings are achievable as a result of the ability of funds to pay benefits for out of hospital services as part of an episode of care, including early discharge, it is worth noting that the majority of hospital services are paid by case payments which currently allow hospitals to provide substitutional care if they consider it is more appropriate or cost effective. Many of the contractual arrangements between insurers and hospitals are currently on the basis of a "case episode payment". That is insurers agree to pay a set amount for an episode of care regardless of the services included in the episode and particularly the length of the patient's stay in hospital.

Unless hospitals are willing to renegotiate the basis for payment with insurers, the fact that a patient is accommodated as part of their episode outside of the hospital will not translate into savings in the short term.

Further more as the success relies upon the effective collaboration between hospital providers, health professionals, the medical professionals and insurers we anticipate it may take around 5 years from the implementation date to see major changes in the way health care is delivered in the private sector. So care must also be taken in communicating what the impact of the changes are likely to be to the products and premiums in the short to medium term.

The potential impact on the perceived value of private health insurance is likely to be substantial if consumers feel as though their insurers have failed to deliver on any unrealistic expectations raised.

Recommendation 2: That the key messages to the Australian community in relation to the reforms should emphasise the increase in insurers' ability to offer coverage for a wider range of services beyond hospital-based care. Importantly however the community should be aware that this bold vision and opportunity for health system change will take time and involve co-operation between health insurers, health care providers and the medical profession to realise its full potential. Similarly any potential for health cost control through more innovative models of care are unlikely to be reflected in premiums over the short term.

B. COMPONENT 2 – ENHANCING PRIVATE HEALTH INSURANCE CHOICES

1) Disclosure Regime

We strongly support the Minister's objective of ensuring greater transparency and understanding for consumers in relation to private health insurance. MBF believes it is most important that consumers are given useful information in an appropriate and clear format, which will enable them to make best use of the information they are provided.

We believe that it is important to highlight that currently MBF and presumably other funds have in place measures to ensure that members are provided with clear and concise information regarding their level of cover. For example, in its annual premium round mailing to members, MBF incudes a product sheet that outlines details of the benefits, exclusions and limits available for that product. In addition the ACCC in its 8th Report to the Senate on the private health insurance industry noted that there had been a drop in the number of complaints to both the ACCC and PHIO in relation to information provided by insurers to consumers during the period 1 July 2005 to 30 June 2006. The ACCC believes this was due to a number of factors including:

(a) ACCC action taken in the industry between 2000 and 2006; and
(b) the Private Health Insurance Code of Conduct (the "Code"), further discussed below.

Given this finding we are unsure that the imposition of the disclosure regime in the Bill is necessary to meet the Government's objectives. MBF is concerned that the imposition of the regime as currently set out in the Bill together with the suggested templates (as have been provided to the industry) have in fact the potential to result in more confusion for consumers and may result in more consumers making incorrect product purchase decisions.

Recommendation 3: MBF request that the Committee request that consistent with the recommendations of the Taskforce on Reducing Regulatory Burden, the Government commit to conducting an early post implementation review of the effectiveness to consumers of the new disclosure regime, including the regulatory compliance costs incurred by the industry, by June 2008.

C. COMPONENT 3 – ENSURING THERE IS APPROPRIATE REGULATION OF PRIVATE HEALTH

1) Chapter 4 of the Bill

Private Health Insurers

A viable, efficient and commercially sound industry is to the benefit of the entire health sector. But this requires that the industry be able to manage its affairs internally in a way that allows it to apply modern methods of business development, capital management and investment techniques. The legislative framework must provide the ability for private health insurers to manage risk appropriately. It is not in the interests of consumers for any insurer to fail.

Regulatory frameworks that provide consumer protection whilst allowing insurers to operate commercially exist for other insurance industries. At the commencement of the consultation process, the DoHA advised that new legislation would include the adoption of a statutory fund model based on the life insurance model for private health insurance. MBF strongly supported that proposal.

Unfortunately, the draft legislation does not implement that proposal completely, consistently or effectively. In legislating for statutory funds without creating the full supporting regulatory framework, unnecessary complexities and potential failings

have been created. Implementing a complete model would reduce the potential for the framework to fail.

An opportunity to modernise the industry through a legislative regime that encourages better transparency in the operations of private health insurers has been lost.

MBF recommends amendments to the proposed financial structure of funds which would provide the optimal basis for commercial efficiency and maximise consumer protection.

All health funds currently operate one statutory fund

Although not referred to as a "statutory fund" all Registered Health Benefits Organisations ("**RHBOs**") currently operate a statutory fund by virtue of section 68 of the NHA. All assets are credited to "the fund" and only certain liabilities may be paid from "the fund". In the case of 'for profit' insurers, liabilities properly payable from the fund include payment of dividends and returns of capital.

The NHA distinguishes between the licensed organisation and the fund but, the distinction is largely eliminated by the fact that the entity cannot carry on any business other than the business of health insurance through the fund. Arguably, the corporate entity and the fund are contiguous: the corporation cannot have any assets that are not "the fund's".

This model of a single statutory fund may have been appropriate in the past when health insurers operated nothing but health insurance businesses. It reflects past views of regulatory supervision. It neither reflects the modern commercial environment in which funds operate nor does it provide the optimal basis for balancing commercial efficiency against policyholder protection.

The current model was stretched when some health insurance funds wished to not only reimburse the costs of health services, but to diversify into the provision of those health services. The solution at that time was an administrative one to allow funds to operate businesses which were sufficiently related to the provision of health insurance (as allowed by the DoHA) from within the fund. Any other business, such as a general insurance, marketing or other services venture must be operated from an incorporated subsidiary.

Issues with NHA model

The current arrangement poses a number of regulatory issues which are potentially detrimental to the interests of consumers:

a) Reduced policyholder protection due to the potential for the failure of any business undertaking to bring about a failure of the fund and the corporate entity that operates it;
b) A lack of transparency that may result in funds charging higher premiums to support loss-making businesses; and,
c) A lack of incentive for true competition and innovation through RHBOs successfully diversifying business operation and thereby supporting premiums from other revenue sources.

These issues would be mitigated by the refinement of the statutory fund model currently within the NHA to one based on the life insurance model.

The Life Insurance Model

MBF supported the introduction of a framework based on the life insurance model as it would remove the problems with the current model and achieve the stated objectives of the legislative review. In particular the life insurance model offers the following advantages:

- It affords better policyholder protection;
- It provides a basis for better regulation over the long term and enables the entities to carry on other business outside of the regulated health insurance business;
- It facilitates the entry of new players particularly life insurers by providing a commonly understood framework;
- It adopts a life insurance model that is well understood by actuaries, accountants, market analysts and the like;
- It is well understood so that problems can be more easily identified and addressed for the purposes of applying that model to the health insurance industry; and,
- It more easily facilitates the adoption of APRA type standards and therefore consistency between different types of prudentially regulated vehicles.

Such advantages are essential in creating a more innovative and commercially robust industry.

The basic elements of the Life Insurance model

The chief difference between the structure proposed by the Bill and the Life Insurance model is that there is a separate and distinct fund for non-policyholder assets in addition to the statutory fund or funds. The statutory fund holds those assets required to cover the policyholder liabilities i.e an amount calculated to be sufficient to cover future claims and regulatory capital requirements. The statutory fund quarantines the insurance business by accounting for it separately. Dealing with the assets of the statutory fund is strictly controlled for the protection of policyholders. Transfers in and out of the statutory fund are permissible if strict legislative requirements are met.

The fundamental concept is that the statutory fund protects the insurance business. It does this by clearly identifying assets and liabilities relevant to the conduct of that business. By definition, if a health fund wishes to carry out any other business other than writing health insurance it will require a separately identified fund. This general fund for the business of the company is the “shareholders fund” in life insurance companies.

Possible improvements to the proposed model

The proposed legislation is missing an essential component for good regulation. Policyholder protection is only achieved if there is a segregation of the health insurance business from other business. MBF does not know the policy reason for the failure to provide this policyholder protection.

This flaw in the new model is compounded by an express permission that business other than the business of writing health insurance may be carried out from the statutory fund. Allowing non-insurance business to be operated from the statutory fund directly contradicts the purpose of a statutory fund. The concept of the statutory fund is to protect assets from depletion and it is therefore not usual to allow for the operation of the business from the statutory fund.

Again, we are unsure of the policy behind this decision. At the initial industry consultations, several industry participants expressed concern for the effect on their profitability if operating businesses became taxable. It may have been this concern that lead to a decision to allow the operation of other business from the statutory fund.

This concern is largely unfounded and does not need to be addressed in this way. To retain income tax exemption, it is not necessary for the business to be within the statutory fund. For 'not for profit' health insurers, there will be no income tax on the operations of other businesses carried out in the general fund. The income tax exemption available to 'not for profit' funds applies where the organisation is not carried out for the gain of individual members. MBF believes that, under the tax regime contemplated in the Bill, other businesses can be carried out in a general fund without affecting the income tax position of the private health insurer.

Policyholder protection is lessened by dual structure

The internal structure of funds is different depending on whether the fund is 'for profit' or 'not for profit'. During initial consultations, the DoHA advised that this distinction would be removed. MBF does not know the policy reason for the different treatment of insurers.

The proposed legislation replicates the current NHA model for 'not for profit' funds. That is, there is essentially a statutory fund that is arguably contiguous with the private insurance entity. In this respect there has been no reform for "not for profit" private health insurers and no improvement in policyholder protection.

A separate model has been created for 'for profit' private health insurers. A 'for-profit' insurer has a statutory fund but may hold within the corporate entity any other assets it chooses. More significantly, it may deal with the assets of the statutory fund above regulatory capital requirements in any way it chooses. There are no controls around the transfer of monies between the statutory fund and the company's own money. There is a real risk that the fund could subsidise other undertakings of the corporate entity.

As an organisation that operates both a 'for profit'" and a 'not for profit' health insurance business, MBF does not understand why it will need to apply two different internal structures in operating a health insurance business.

The only distinction between 'for-profit' funds and 'not-for-profit' funds is that there are distributions of capital and dividends to shareholders. These payments out of the corporate entity should not result in any distinction in the internal operation of the private health insurer. There is no credible reason why the tax-status of the entity operating the private health insurer should determine its internal financial structure.

Objectives of the legislative review are to reduce complexity and provide greater efficiency in the operations of private health insurers. Therefore, this unnecessary

distinction between private health insurers should be removed on this basis alone if not for the more important objective of consumer protection.

The inclusion of provisions creating a general fund in addition to the statutory fund would give 'for profit' insurers any benefits they may desire in terms of capital management from the proposed legislation whilst providing for one internal structure for all private health insurers.

The proposed private health insurance model requires the addition of a general or shareholders fund to apply to both for profit and not for profit insurers if it is to operate efficiently and protect consumers.

Specific areas for review

a) Borrowings

Issues arise where regulation wrongly attaches to the entity rather than the statutory fund. An example is the prohibition against borrowing by the private health insurer i.e the entity in s137-10 (4). It does not make any sense to prohibit a 'for-profit' fund that may hold its own assets within the corporation from borrowing against its own assets. Logically, the prohibition against borrowing should attach only to the assets in the statutory fund. A better solution is to include within the framework a general or shareholders fund so that those assets which should be protected, are protected.

b) Liabilities appropriately paid from the statutory fund

Where there is no general fund, the only source of monies to pay the obligations of the private health insurer is the assets of the fund. However, insurers may only pay expenses incurred for the purposes of the business of the fund. This has lead some commentators to question whether a 'not for profit' entity can incur certain costs expenses or charges that are not directly related to the business written from the fund. At its most extreme such a view would result in a restricted access insurer being unable to advertise, as the costs cannot be referred to the current policyholders. MBF does not hold this view and believes a very wide meaning can be given to what is the business of the fund.

The practical difficulties that arise if the argument that only certain expenses are allowed are highlighted by the provisions in the Medibank Private Sale Act 2006 clarifying that the costs of the sale are properly payable from the fund. The Explanatory Memorandum to the Bill clearly states these provisions are merely for the avoidance of any doubt. However, the argument has been raised but at this time has only been solved for Medibank Private
MBF recommends that the effect of the amendments made in the Medibank Private Sale Act clarifying the proper payment of expenses should be included in the current proposed legislation for the benefit of all private health insurers. This issue can also be easily removed by adopting a model based on life insurance.

c) Insolvency of statutory funds

MBF understands from the DoHA that it is an intended effect of the legislation that where a private health insurer has multiple statutory funds and one of those statutory funds becomes insolvent, excess capital in other statutory funds cannot be transferred to the insolvent fund. All funds are to be wound-up where one fund becomes insolvent.

This does not reflect good prudential management as it brings about insolvency unnecessarily. The difficulty can be cured by the implementation of a framework based on the life insurance model.

Recommendation 4:

MBF recommends that the provisions relating to the financial structure of funds be reviewed and amended to provide specifically for:

- a general or shareholders fund;
- provisions for the transfer of amounts between funds; and,
- provisions attaching regulation appropriately to the statutory fund.

Such amendments to the proposed financial structure of funds would provide the optimal basis for commercial efficiency and maximise consumer protection.

D. GENERAL RECOMMENDATIONS

1) Requirement for Rule making

MBF is concerned about the number of provisions under the Bill which can be modified substantially in whole or in part through the making of Rules by the Minister or PHIAC (as the case may be).

MBF notes that the Rules are reviewable by Parliament, however MBF submits that the Bill should be amended to provide some requirements regarding any changes made to the provisions of the Bill through the Rules, in accordance with the recommendations of the Taskforce on Reducing Regulatory Burden.

Recommendation 5: That the requirement for proper consultation such as contained in section 33 of the Insurance Act should be included in the Bill regarding the Rules which PHIAC is able to make.

Recommendation 6: In relation to the Rules that the Minister is able to make, MBF again submits that the following requirements should attach in relation to any such Rules, and the only situations where these requirements should be excused are for matters which require urgent action especially in relation to any prudential or other risks to the industry or consumers:

- any change resulting from the Rules must not have an adverse impact on insurers or policy holders;
- a proper cost analysis must be undertaken on the change and provided to all stakeholders;
- consultation of 12 months be provided for any change that is likely to have a significant impact; and
- adequate notice must be provided to all stakeholders of the change.