Chapter 2

Issues

2.1 The committee received evidence from submitters and witnesses who expressed concerns about various aspects of the Private Health Insurance Legislation Amendment Bill 2018 (Bill), the A New Tax System (Medicare Levy Surcharge-Fringe Benefits) Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018 (A New Tax System Bill) and the Medicare Levy Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018 (Medicare Levy Amendment Bill).

2.2 However, even where concerns were raised, submitters broadly supported the intent of the Bills.[1] The following chapter outlines the key provisions of the Bills and concerns raised.

Schedule 1: Increasing maximum excess levels

2.3 Schedule 1 increases the maximum excess permitted in a complying private health insurance policy that provides hospital cover, from $500 to $750 in any 12 month period for a policy that covers an individual and from $1000 to a maximum excess of $1500 for any other policy.[2]

2.4 The Consumers Health Forum of Australia raised concerns that requiring policy holders to pay a higher excess may make them more reluctant to use their private health insurance and that these policy holders may instead elect to be admitted to a public hospital as a public patient.[3]

2.5 Mr Shaun Gath, a former private health insurance industry regulator, explained that there is a connection between a policy's excess and the amount of the premium charged to the policy holder, because the insurer is required to cover less risk:

> …what you're doing by increasing the excess is removing risk, because the insurer only has to recover a reduced amount of potential claim. That therefore will sound in the cost of premiums. That's the way risk and premiums are always linked together.[4]

2.6 Mr Michael Roff, Chief Executive Officer of the Australian Private Hospitals Association, noted that the Private Health Insurance Ombudsman previously provided

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1 See for example Mr Shaun Gath, *Submission 1*, pp. 1–5; Consumers Health Forum of Australia, *Submission 7*, p. 4; Australian Society of Ophthalmologists, *Submission 31*, p. 7.

2 Private Health Insurance Legislation Amendment Bill 2018 (Bill), Schedule 1, item 1.

3 Consumers Health Forum of Australia, *Submission 7*, p. 5.

4 Mr Shaun Gath, *Committee Hansard*, 7 August 2018, p. 17.

advice to consumers that they should take out the highest level of cover they could afford and then moderate the premium by taking out a policy with a higher excess.[5]

2.7 Other witnesses, such as the Consumers Health Forum of Australia and the Members Health Fund Alliance, noted that consumers generally understand what an excess is because it is a feature that is common to other types of general insurance.[6] These witnesses considered that the reforms would empower consumers to be able to make an informed choice about whether they wished to take out a policy with a higher excess to moderate their premium.[7]

2.8 Mr Matthew Koce, Chief Executive Officer of the Members Health Fund Alliance, and the Department of Health noted that the current excess level had not increased in 18 years, meaning that the higher excesses were simply being adjusted to account for inflation.[8]

2.9 Private Healthcare Australia, which was involved in the Private Health Ministerial Advisory Committee discussions, advised that the increased excess levels proposed in the Bill were arrived at after careful consideration to ensure that excesses would not result in adverse effects on private health insurance premiums.[9]

2.10 The Department of Health confirmed that currently about 40 per cent of policy holders elect for the maximum excess of $500 or $1000.[10] The Department of Health explained that another 40 per cent of policy holders purchase a policy with some level of excess and it considers that this indicates that 'consumers already make informed decisions based on their personal circumstances and capacity to pay'.[11]

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5 Mr Michael Roff, Chief Executive Officer, Australian Private Hospitals Association, *Committee Hansard*, 7 August 2018, p. 28.

6 Ms Josephine Root, Policy Director, Consumers Health Forum of Australia, *Committee Hansard*, 7 August 2018, p. 4; Mr Matthew Koce, Chief Executive Officer, Members Health Fund Alliance, *Committee Hansard*, 7 August 2018, p. 23; Ms Penny Shakespeare, Acting Deputy Secretary, Health Financing Group, Department of Health, *Committee Hansard*, 7 August 2018, p. 33.

7 Ms Root, Consumers Health Forum of Australia, *Committee Hansard*, 7 August 2018, p. 4; Mr Koce, Members Health Fund Alliance, *Committee Hansard*, 7 August 2018, p. 23; Ms Shakespeare, Department of Health, *Committee Hansard*, 7 August 2018, p. 33.

8 Mr Koce, Members Health Fund Alliance, *Committee Hansard*, 7 August 2018, p. 23; Department of Health, *Submission 4*, p. 5.

9 Dr Rachel David, Chief Executive Officer, Private Healthcare Australia, *Committee Hansard*, 7 August 2018, p. 23.

10 Ms Susan Azmi, Acting Assistant Secretary, Private Health Insurance Branch, Department of Health, *Committee Hansard*, 7 August 2018, p. 33.

11 Ms Azmi, Department of Health, *Committee Hansard*, 7 August 2018, p. 33; Department of Health, *Submission 4*, p. 4.

2.11 The Department of Health does not expect that there will be an increase in the proportion of policy holders who elect for the highest excess because of amendments made by the Bill.[12]

Schedule 2: Age-based discounts for hospital cover

2.12 Schedule 2 permits private health insurers to offer discounted premiums to consumers aged 18–29.

2.13 Throughout the inquiry the committee received evidence from submitters, such as Finder.com.au and Mr Russell Schneider AM, that the age-based discounts may not achieve the intended policy outcome, but may instead have a negligible or a deleterious effect on private health insurance affordability.[13]

2.14 These submitters were concerned that the discounts that the younger cohort receive may not be sufficient to attract enough new healthy members to moderate premiums.[14] Mr Schneider explained that the discounts would mean that less money would flow to funds and the industry as a whole would need to attract potentially up to 100 000 new members to ensure that premiums do not rise.[15]

2.15 Consumers Health Forum of Australia, the National Rural Health Alliance and CHOICE expressed concerns about the effects the age-based discount policy may have on community rating.[16]

2.16 Community rating is the principle that insurers cannot discriminate between people on the basis of, among other things, their health status, age or place of residence.[17]

2.17 Mr Schneider, former Chief Executive Officer of the Australian Health Insurance Association, explained how community rating makes private health insurance affordable for people who would otherwise be forced to rely on the public system:

> Premiums are set on the basis of a large pool of mixed risks. As a result people who would be uninsurable (or have to pay a high price) because of their health status are able to opt into the private health care system

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12 Ms Shakespeare, Department of Health, *Committee Hansard*, 7 August 2018, p. 35; Department of Health, *Submission 4*, p. 5.

13 Ms Root, Consumers Health Forum of Australia, *Committee Hansard*, 7 August 2018, p. 2; Finder.com.au, *Submission 15*, [p. 1]; Mr Russell Schneider AM, *Submission 18*, p. 13.

14 Mr Alan Kirkland, Chief Executive Officer, CHOICE, *Committee Hansard*, 7 August 2018, p. 4.

15 Mr Schneider, *Submission 18*, p. 13.

16 Ms Root, Consumers Health Forum of Australia, *Committee Hansard*, 7 August 2018, p. 8; Mr Mark Diamond, Chief Executive Officer, National Rural Health Alliance, *Committee Hansard*, 7 August 2018, p. 8; Mr Kirkland, CHOICE, *Committee Hansard*, 7 August 2018, p .8.

17 For the definition of improper discrimination with a complete list of protected attributes see *Private Health Insurance Act 2007*, s. 55-5(2).

> reducing demand and costs for taxpayers and freeing up public bed spaces for those who cannot afford or do not wish to take out private cover.[18]

2.18 The Australian Healthcare and Hospitals Association expressed concern that the age-based premium discounts, and to a lesser extent the travel and accommodation benefits, may erode or undermine the principle of community rating by allowing insurers to consider age or place of residence in determining the cost of, or entitlement to, particular benefits.[19]

2.19 For example, CHOICE noted that a factsheet on the Department of Health's website suggests that the policy holder may need to continue to hold the same policy to receive the age-based discount.[20]

2.20 Other submitters considered that the age-based discounts would bolster community rating. Private Healthcare Australia submitted that increasing the membership base of private health insurance would support the sustainability of community rating:

> Australia's ageing population directly impacts the Australian PHI industry as older age groups are more highly represented in PHI than younger age groups and cost significantly more in healthcare than younger groups. As noted in the Explanatory Memorandum to the Bill, the ongoing viability of community rating requires the retention of a broad membership base. Without this, premiums would need to increase to cover the cost of insuring higher risk consumers who maintain their health insurance.[21]

2.21 The Australian Medical Association and the Australian Healthcare and Hospitals Association both considered that while the Bill may have some effect on community rating, they recognised that it was also important to try to make private health insurance more affordable for younger Australians.[22] Because of the difficulty in balancing these competing objectives, both organisations suggested that a review of the policy be conducted to examine how the discounts are implemented.[23]

2.22 In addition, Private Healthcare Australia noted that the age-based discounts are very similar to the existing Lifetime Health Cover loadings which make policies more expensive if they take out a hospital policy for the first time after the age of 30. Age-based discounts simply extend that principle:

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18 Mr Schneider, *Submission 18*, p. 6.

19 Australian Healthcare and Hospitals Association, *Submission 8*, pp. 5–6.

20 CHOICE, *Submission 10*, [p. 3].

21 Private Healthcare Australia, *Submission 13*, p. 5.

22 Dr Linc Thurecht, Senior Research Director, Australian Healthcare and Hospitals Association, *Committee Hansard*, 7 August 2018, p. 12; Dr Tony Bartone, President, Australian Medical Association, *Committee Hansard*, 7 August 2018, p. 12.

23 Dr Bartone, Australian Medical Association, *Committee Hansard*, 7 August 2018, p. 12; Dr Thurecht, Australian Healthcare and Hospitals Association, *Committee Hansard*, 7 August 2018, p. 12.

> [Lifetime Health Cover loading] has been a very effective measure driving PHI participation by the over-30s. Age-based discounts represent an extension of this principle by providing a 'carrot' incentive for under-30s to take up PHI. PHA submits that this reform is necessary to help rebalance the age profile of PHI consumers in Australia in line with demographic and economic changes that have occurred over the last two decades.[24]

2.23 The Royal Australian and New Zealand College of Psychiatrists also recognised that there was a need to recruit younger and healthier members (such as those aged under 30) to help balance the risk pool and provide a broad base to maintain downward pressure on premiums.[25]

2.24 Nib provided the committee with data that demonstrated that the rate at which policy holders let their policies lapse is consistently higher for policy holders aged under 30 than for those aged over 30 and that the key reason given by the under 30 cohort for giving up their policies is affordability.[26] Nib considers that 'the ability to provide discounts based on age may help to reverse falling participation'.[27]

Committee view

2.25 The committee acknowledges that some submitters and witnesses hold concerns about the maximum excess increases and the age-based discounts. The committee notes that some submitters are concerned that increasing the maximum excess may discourage people from using their private health insurance. The committee considers that allowing consumers to choose a policy with a higher excess is an appropriate way to allow consumers to moderate their premiums. The committee considers that consumers are familiar with excesses and that consumers will continue to select policies that are suitable for their needs and budget.

2.26 The committee notes that some submitters were concerned that age-based discounts may undermine community rating. The committee understands these concerns but recognises that the affordability of insurance premiums for all Australians requires more young Australians to participate in private health insurance. The committee considers that this incentive extends the principle of the lifetime health cover loading that is already in place for people aged over 30 and that it is necessary to encourage younger Australians to participate in private health insurance.

Schedule 3: Private Health Insurance Ombudsman's powers

2.27 The committee received a mixed response from submitters about the entry and inspections powers proposed to be granted to the Private Health Insurance Ombudsman by Schedule 3 of the Bill.

2.28 The Australian Society of Plastic Surgeons considered that the powers granted to the Private Health Insurance Ombudsman should have gone further than those

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24 Private Healthcare Australia, *Submission 13*, p. 5.

25 RANZCP, *Submission 11*, [p. 3].

26 Nib, *Submission 23*, p. 3.

27 Nib, *Submission 23*, p. 3.

proposed by the Bill.[28] The Australian Society of Plastic Surgeons expressed concerns that some insurers reject insurance claims on the basis that the procedure does not have an applicable Medicare item number and that even with the powers proposed by the Bill, the Private Health Insurance Ombudsman is only able to make a recommendation to the insurer.[29] The Australian Society of Plastic Surgeons considered that strengthening the Private Health Insurance Ombudsman's power to make a direction would do more to engender confidence in the role of the Private Health Insurance Ombudsman.[30]

2.29 Day Hospitals Australia noted that other areas of the health sector, such as private and day hospitals, were already subject to inspection by regulators and considered that permitting the Private Health Insurance Ombudsman to enter premises and inspect documents would make insurers similarly accountable.[31]

2.30 However, other submitters raised concerns that the powers being granted to the Private Health Insurance Ombudsman were too expansive. Private Healthcare Australia and the Members Health Fund Alliance expressed concern that the Bill does not require the Private Health Insurance Ombudsman to obtain a search warrant or provide the private health insurer or broker with notice.[32] Private Healthcare Australia claimed that, if passed, the Bill would provide wider powers to the Private Health Insurance Ombudsman than is provided to regulatory agencies:

> …an unfettered ability to enter premises is unprecedented and exceeds the inspection powers of other regulators such as the Australian Competition and Consumer Commission, the Australian Securities and Investments Commission and the Australian Communications and Media Authority. These regulators require occupier consent or a warrant to enter premises, and notice of the exercise of inspection powers to be given.[33]

2.31 The Members Health Fund Alliance submitted that the breadth of the powers appeared to be excessive and inconsistent with the *Guide to Framing Commonwealth Offences, Infringement Notices and Enforcement Powers* which, on the advice of the Scrutiny of Bills committee, suggests that entry and seizure powers without a warrant should only be authorised where there are 'exceptional circumstances'.[34]

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28 Australian Society of Plastic Surgeons, *Submission 22*, [p. 2].

29 Australian Society of Plastic Surgeons, *Submission 22*, [p. 2].

30 Australian Society of Plastic Surgeons, *Submission 22*, [p. 2].

31 Mrs Jane Griffiths, Chief Executive Officer, Day Hospitals Australia, *Committee Hansard*, 7 August 2018, p. 27.

32 Private Healthcare Australia, *Submission 13*, p. 6; Members Health Fund Alliance, *Submission 9*, p. 7.

33 Private Healthcare Australia, *Submission 13*, p. 6.

34 Members Health Fund Alliance, *Submission 9*, p. 8; Attorney-General's Department, *Guide to Framing Commonwealth Offences, Infringement Notices and Enforcement Powers*, September 2011, p. 86.

2.32 To remedy these concerns, Private Healthcare Australia recommended that the Bill be amended to restrict the Private Health Insurance Ombudsman's powers of entry.[35]

2.33 Medibank suggested that more extensive changes needed to be made to the Bill. In addition to changes to procedural requirements to enter premises, Medibank expressed concern about the ability to enter the premises of service providers (proposed sections 20SA(a)(ii) and 20TA(a)(ii)), that there were no protections for legal professional privilege or privacy, that the Ombudsman's powers could be delegated very broadly and that there appeared to be no requirement for the Ombudsman to report on the use of his powers under proposed section 20TA.[36]

2.34 Former Chief Executive Officer of the now defunct regulator the Private Health Insurance Administration Council, Mr Shaun Gath, also noted that the Bill did not provide clear rights of review to parties that may be affected by the use of the new powers:

> The circumstances in which such powers might be employed are not clearly defined, nor are the rights to review of such powers by the parties affected (primarily health insurers and brokers).[37]

2.35 The Explanatory Memorandum notes that it is not anticipated that the proposed powers will be required because private health insurers and brokers have almost always complied with requests from the Private Health Insurance Ombudsman.[38] The addendum to the Explanatory Memorandum (addendum) states that there have been occasions when the Private Health Insurance Ombudsman has discovered, upon further investigation, that letters, emails or phone calls relating to the complaint have been overlooked by an insurer responding to a complaint.[39] The addendum notes that providing the Private Health Insurance Ombudsman with entry and inspection powers provides investigating officers with ability to independently verify the accuracy of the information that has been provided.[40]

2.36 The Commonwealth Ombudsman and Private Health Insurance Ombudsman, Mr Michael Manthorpe, informed the committee that the new powers were analogous to the entry and audit powers that the Commonwealth Ombudsman already possessed elsewhere in his jurisdiction.[41]

2.37 The Private Health Insurance Ombudsman acknowledged that having the new powers would be useful and that it may encourage private health insurers to be more

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35 Private Healthcare Australia, *Submission 13*, p. 6.

36 Medibank, *Submission 20*, pp. 3–4.

37 Mr Gath, *Submission 1*, p. 3.

38 Explanatory Memorandum—Addendum, p. 1.

39 Explanatory Memorandum—Addendum, p. 1.

40 Explanatory Memorandum—Addendum, p. 1.

41 Mr Michael Manthorpe, Commonwealth Ombudsman, *Committee Hansard*, 7 August 2018, p. 37.

diligent in their cooperation with his office, but that the powers would be exercised only where there was a real need to do so:

> We don't see ourselves as a sort of heavy-handed entity. We seek to work as collaboratively and as collegiately as we sensibly can while maintaining an impartial and independent approach with the various entities that we have oversight of—and the same applies to private health insurers. But, from time to time, in various parts of our jurisdiction, we really do need to go and have a look at documents, and it would be, from my point of view, useful to have, if you will, a reserve power up our sleeve in this space.[42]

2.38 The Department of Health confirmed that the additional powers had been provided to the Private Health Insurance Ombudsman to remedy concerns from consumer groups that there appears to be a disproportionate power imbalance between private health insurers and the Ombudsman who is attempting to resolve complaints on behalf of consumers.[43]

2.39 Most submitters supported the stronger powers of the Private Health Insurance Ombudsman as proposed by the Bill because they considered that it would deliver better results for consumers.[44]

Committee view

2.40 The committee recognises that there are a range of viewpoints on the new powers proposed to be granted to the Private Health Insurance Ombudsman. The committee recognises the scrutiny concerns that have been raised by the Scrutiny of Bills committee and by some members of the private health insurance sector.

2.41 The committee has had the opportunity to examine the Commonwealth Ombudsman and his staff about whether and how these new powers may be used. The committee considers that, whilst the Commonwealth Ombudsman conducts himself with professionalism, the committee considers that it would be beneficial for some thought to be given to establishing a decision-making framework for the appropriate delegation of such powers to properly trained and experienced officers. The committee considers that the government should examine the recommendations of the Scrutiny of Bills committee as to possible safeguards on the Ombudsman's delegation of powers.

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42 Mr Manthorpe, Commonwealth Ombudsman, *Committee Hansard*, 7 August 2018, p. 37.

43 Ms Shakespeare, Department of Health, *Committee Hansard*, 7 August 2018, p. 37.

44 Mr Shaun Gath, *Submission 1*, p. 3; Day Hospitals Australia, *Submission 2*, p. 3; Australian and New Zealand Academy of Periodontists, *Submission 3*, p. 1; Consumers Health Forum of Australia, *Submission 7*, p, 6; Australian Healthcare and Hospitals Association, *Submission 8*, p. 4; CHOICE, *Submission 10*, [p. 1]; Medical Technology Association of Australia, *Submission 12*, p. 2; Johnson and Johnson Medical Pty Ltd, *Submission 14*, p. 5; Finder.com.au, *Submission 15*, [p. 1]; Nib, *Submission 23*, p. 6; Australian Society of Ophthalmologists, *Submission 31*, p. 5; Royal Australasian College of Surgeons, *Submission 32*, p. 2.

2.42 Overall, the committee considers that the new powers will make private health insurers more diligent in resolving complaints and will provide the Private Health Insurance Ombudsman with the ability to provide a better service for consumers.

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

2.43 Schedule 4 removes benefit limitation periods in private health insurance policies, including limitations on psychiatric treatment after 31 March 2018.

2.44 Submitters, including the Royal Australian and New Zealand College of Psychiatrists, Consumers Health Forum of Australia and the Australian Healthcare and Hospitals Association and Breast Cancer Network Australia broadly supported the measure.[45]

Schedule 5 Part 1: Benefits for travel and accommodation

2.45 Schedule 5 Part 1 of the Bill provides insurers with the option of including travel and accommodation benefits in hospital treatment cover policies.

2.46 Some submitters expressed concern that insurers would be allowed to determine to whom travel and accommodation benefits would be offered.

2.47 The National Rural Health Alliance told the committee it considered that travel and accommodation benefits for country people should be a mandatory feature of all private health insurance policies.[46]

2.48 The National Rural Health Alliance explained the importance of private health insurance to country people:

> [T]he transport and accommodation cost provision is very important for country people. Service access is the biggest single issue, as far as health care is concerned, that country people will tell you about. That's what they're concerned about: access to health services. They're very much aware that either they access the local public hospital or they have to travel hundreds of kilometres by some means or other to access the next biggest hospital services and, in a lot of cases, allied health and community based services as well. The dislocation that occurs with families, removal from communities, inpatient admissions in a remote location and the impact that has on the family unit all need to be recognised as part of that transport and accommodation provision, which we think should be mandatory as part of the private health insurance policies.[47]

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45 Consumers Health Forum of Australia, *Submission 7*, p. 6; Royal Australian and New Zealand College of Psychiatrists, *Submission 11*, [p. 2]; Breast Cancer Network Australia, *Submission 24*, p. 5. See also Dr Thurecht, Australian Healthcare and Hospitals Association, *Committee Hansard*, 7 August 2018, p. 11; Mr Gath, *Submission 1*, pp. 3–4; Australian Medical Association, *Submission 5*, p. 3.

46 Mr Diamond, National Rural Health Alliance, *Committee Hansard*, 7 August 2018, p. 2.

47 Mr Diamond, National Rural Health Alliance, *Committee Hansard*, 7 August 2018, p. 7.

2.49 Private Healthcare Australia and Members Health Fund Alliance both noted that providing private health insurers with flexibility would allow them the ability to provide innovative and affordable products that better meet people's needs.[48] For example, HCF advised the committee that it was intending to use its discretion to also cover travel and accommodation benefits for carers as part of the patients' hospital policy:

> HCF also supports providing a benefit for a carer of a patient (HCF member) being treated. Our approach will be that additional benefits for the carer will be part of the patient's claim. As such, the claim will be part of risk equalisation.[49]

2.50 Evidence to the inquiry demonstrates that insurers are likely to include travel and accommodation in hospital treatment policies. Nib advised the committee in its submission that the Bill would allow Nib to offer such benefits to the 34 per cent of its members who live in a regional or rural area.[50]

2.51 Mr Russell Schneider noted that offering travel and accommodation benefits may make private health insurance more attractive to people who live in rural areas:

> The certainty of being able to arrange treatment dates in a private facility rather than risk being turned away from a public hospital booking due to unexpected circumstances is a good reason for taking out PHI. However the cost of travel can be a very significant factor in deciding whether the cost of insurance plus travel may outweigh the benefit. Including the benefit in risk equalisation is a positive step to ensure community rating applies regardless of the insured person's location.[51]

2.52 A survey conducted by the Haemophilia Foundation of Australia found that 50 per cent of respondents who lived in a rural or regional area thought that including travel and accommodation benefits in hospital cover policies would be beneficial, however some respondents were concerned about rising premiums. The Haemophilia Foundation of Australia concluded that travel and accommodation benefits needed to be offered in policies at a range of price points so that people in regional and rural areas can choose their preferred level of cover.[52]

2.53 The Australian Healthcare and Hospitals Association noted that the travel and accommodation benefits could erode community rating because it could allow private health insurers to make decisions about eligibility for benefits based on a person's place of residence, depending on how insurers funded the benefits.[53] The Australian Healthcare and Hospitals Association considered that travel and accommodation

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48 Dr David, Private Healthcare Australia, *Committee Hansard*, p. 20; Mr Koce, Members Health Fund Alliance, *Committee Hansard*, 7 August 2018, p. 22.

49 HCF, *Submission 26*, [p. 1].

50 Nib, *Submission 23*, p. 5.

51 Mr Schneider, *Submission 18*, p. 11.

52 Haemophilia Foundation of Australia, *Submission 21*, p. 10.

53 Australian Healthcare and Hospitals Association, *Submission 8*, p. 6.

benefits should be funded through risk equalisation rather than using differentiated premiums based on the policy holder's place of residence.[54]

2.54 Most submitters strongly supported the travel and accommodation benefits because it removes an access barrier for patients who live in regional, rural and remote areas.[55]

Schedule 5 Part 2: Information requirements

2.55 Schedule 5 Part 2 substitutes the 'standard information statement' for the 'private health information statement' in the *Private Health Insurance Act 2007*. The requirements for the new 'private health information statement' will be provided for in the Private Health Insurance (Complying Product) Rules.[56]

2.56 CHOICE was concerned about the requirements for the new 'private health information statement' as expressed in the exposure draft of the rules. In particular, CHOICE noted that that the information statements may not be standardised and that side by side comparison may only be available on request.[57]

2.57 Many submitters noted that there is currently a lot of confusion in the private health insurance market about what people are covered for under a private health insurance policy. To that extent, many submitters welcomed the new 'private health information statement' because it will provide consumers with certainty about their private health insurance product.[58]

Schedule 5 Part 3: Benefit requirements according to class of hospital

2.58 Schedule 5 Part 3 allows the Minister to make rules about whether private hospitals are eligible for second-tier default benefits. Currently, decisions about

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54 Dr Thurecht, Australian Healthcare and Hospitals Association, *Committee Hansard*, 7 August 2018, p. 11.

55 Mr Roff, Australian Private Hospitals Association, *Committee Hansard*, 7 August 2018, p. 28; Mr Gath, *Submission 1*, p. 4; Day Hospitals Australia, *Submission 2*, p. 2; Australian Medical Association, *Submission 6*, pp. 3, 9; Consumers Health Forum of Australia, *Submission 7*, p. 6; CHOICE, *Submission 10*, [p. 1]; Royal Australian and New Zealand College of Psychiatrists, *Submission 11*, [p. 3]; Private Healthcare Australia, *Submission 13*, p. 7; Johnson and Johnson Medical Pty Ltd, *Submission 14*, p. 5; Mr Schneider, *Submission 18*, p. 11; Medibank, *Submission 20*, p. 1; Australian Society of Plastic Surgeons, *Submission 22*, [p. 1]; Biotronik Australia, *Submission 27*, p. 2; Australian Society of Ophthalmologists, *Submission 31*, p. 5; Royal Australasian College of Surgeons, *Submission 32*, pp. 3–4.

56 Explanatory Memorandum, p. 51.

57 Mr Kirkland, CHOICE, *Committee Hansard*, 7 August 2018, p. 8; Mr Kirkland, additional information received 13 August 2018, [p. 1].

58 Mr Shaun Gath, *Submission 1*, p. 4; Day Hospitals Australia, *Submission 2*, p. 2; Australian Medical Association, *Submission* 5, p. 8; Consumers Health Forum of Australia, *Submission 7*, pp. 6–7; Australian Healthcare and Hospitals Association, *Submission 8*, p. 4; Private Healthcare Australia, *Submission 13*, p. 7; Johnson and Johnson Medical Pty Ltd, *Submission 14*, pp. 4–5; Australian Society of Plastic Surgeons, *Submission 22*, [p. 1]; Nib, *Submission 23*, p. 6; Australian Society of Ophthalmologists, *Submission 31*, p. 5.

second-tier default benefits are made by the industry-led Second Tier Advisory Committee.[59]

2.59 Day Hospitals Australia raised concerns that the exposure draft of the rules did not differentiate between two different types of day hospitals—six-hour facilities and 23-hour facilities—which have different needs:

> There are actually two types of day hospital. There's a day hospital where the patient is just admitted for the day over a few hours—four to six hours or more—but there's also a day hospital category where the patient is admitted for up to 23 hours. At the moment, they are lumped into the same group, which is inappropriate because obviously the cost for running a hospital that has overnight beds for a 23-hour licensed facility is going to be very different to the day hospital that just has the patients in for a few hours.[60]

2.60 The Department of Health explained that the task of classifying day hospitals depended upon whether the hospitals should be classified based on the number of beds or the patient's length of stay:

> The issue is around, for the purpose of second-tier benefits, grouping like hospitals. Benefits are calculated for groups of hospitals that share similar attributes. There has been an ongoing discussion across the sector about whether 23-hour hospitals are best grouped with day hospitals or with hospitals that have the same number of beds as those hospitals. The proposal that has gone out for consultation is to include those 23-hour hospitals in the day hospital category, because they are licensed only to admit patients for periods of less than 24 hours—so less than one day. It's a matter of which category best captures the like attributes of those hospitals.[61]

2.61 The Department of Health advised the committee that it was currently consulting on the exposure draft of the rules and that it would consider any and all feedback it received in formulating the final rules.[62]

Schedule 5 Part 4: Closed and terminated products

2.62 Schedule 5 Part 4 explicitly allows private health insurers to close private health insurance policies, including policies that consumers currently hold.

2.63 The Australian Healthcare and Hospitals Association raised concerns that the Bill may allow private health insurers to terminate a private health insurance policy

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59 Explanatory Memorandum, p. 51.

60 Mrs Griffiths, Day Hospitals Australia, *Committee Hansard*, 7 August 2018, p. 30.

61 Ms Azmi, Department of Health, *Committee Hansard*, 7 August 2018, p. 36.

62 Ms Azmi, Department of Health, *Committee Hansard*, 7 August 2018, p. 36.

and transfer them to a different policy which may have different cover, premiums or excess and that this may lead to poorer outcomes for consumers.[63]

2.64 The Australian Healthcare and Hospitals Association noted that the Explanatory Memorandum provided the example of a private health insurer that may, for example, elect to close low or no excess policies.[64]

2.65 Other submitters considered that likelihood of insurers making substantial changes to policies that people held was limited. Mr Shaun Gath, the former private health insurance regulator, considered that this was a 'housekeeping' provision:

> I don't think that's a major concern. Most of the policies that are subject to the termination arrangements are small and obscure and little used... There's going to have to be a proper oversight and fairness issue addressed there. I don't believe it's going to be a major issue. Most of the policies that the vast majority of Australians are in are going to remain open. This is really a housekeeping and tidying up exercise.[65]

2.66 Mr Koce from the Members Health Fund Alliance considered that closing products was so rare that he was unaware of policies being terminated or cancelled:

> As far as I'm aware, I don't think anyone has ever terminated a policy. Some policies out there have very small numbers of consumers on them because they're very, very old, and there are literally thousands of policies out there. The industry hasn't previously gone to close policies, even though they could. They've tended to leave people on them... Terminating policies has never been an issue in the past, and I don't think it will be in the future.[66]

2.67 The Department of Health provided a visual representation of the number of policies that currently have only a few members.[67] A copy of the graph is included below. The Department of Health further advises that being able to move individuals from terminated products to current products will assist in implementing the new product classifications.[68]

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63 Dr Thurecht, Australian Healthcare and Hospitals Association, *Committee Hansard*, 7 August 2018, p. 11.

64 Dr Thurecht, Australian Healthcare and Hospitals Association, *Committee Hansard*, 7 August 2018, p. 11.

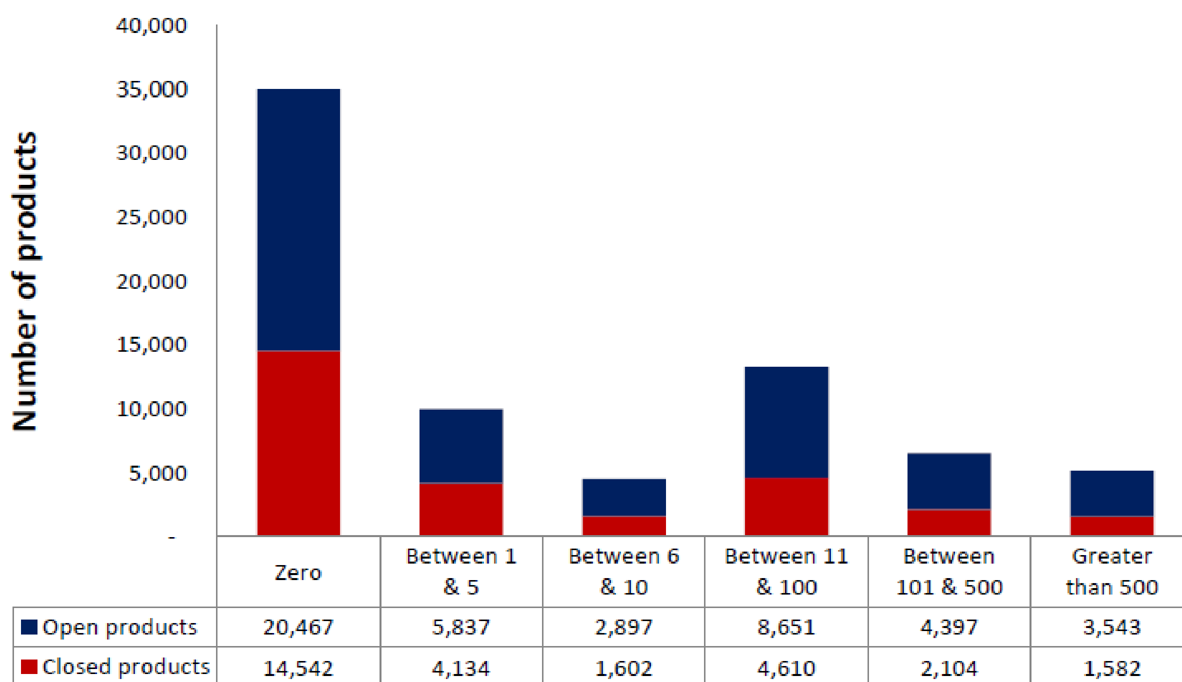
65 Mr Gath, *Committee Hansard*, 7 August 2018, p. 18.

66 Mr Koce, Members Health Fund Alliance, *Committee Hansard*, 7 August 2018, p. 24.

67 Department of Health, *Submission 4*, p. 7.

68 Department of Health, *Submission 4*, p. 7.

Figure 2.1: Number of products by the range of people on each product



	Zero	Between 1 & 5	Between 6 & 10	Between 11 & 100	Between 101 & 500	Greater than 500
Open products	20,467	5,837	2,897	8,651	4,397	3,543
Closed products	14,542	4,134	1,602	4,610	2,104	1,582

Source: Department of Health, *Submission 4*, p. 7 (based on 2018 premium round data).

2.68 In any event, members of the insurance industry advised the committee that guidelines issued by the Australian Competition and Consumer Commission and the Private Health Insurance Ombudsman already made it difficult to close policies.[69]

2.69 The Department of Health told the committee that the amendments would clarify what information consumers could expect to receive if a private health insurer was to close an existing policy and transfer the policy holder to a new policy:

> It's also to be very clear about the consumer protections, the information that we would expect insurers to provide to their customers if a product is being terminated and people are being moved. There are some important consumers protections in terms of clarifying the information that will be available to consumers in these cases.[70]

Committee view

2.70 The committee understands that some submitters have concerns about Schedules 4 and 5 of the Bill and the rules that will support those reforms. The committee understands that the Department of Health is still consulting with stakeholders about the draft rules. The committee thanks the Department of Health for providing the committee with a copy of the exposure draft of the rules to assist with its inquiry. The committee expects that the Department of Health will consider the views of submitters in finalising the rules that will be presented to Parliament.

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69 Mr Koce, Members Health Fund Alliance, *Committee Hansard*, 7 August 2018, p. 24; Dr David, Private Healthcare Australia, *Committee Hansard*, 7 August 2018, p. 25.

70 Ms Azmi, Department of Health, *Committee Hansard*, 7 August 2018, p. 38.

2.71 The committee considers that, while some submitters had concerns about whether the travel and accommodation benefits would be mandatory or could potentially lead to a decline in the delivery of other patient travel services, the committee considers that the new travel and accommodation benefits will be beneficial to Australians living in regional and remote areas. The ability of private health insurers to include travel and accommodation benefits in a hospital policy means that the costs of providing those services can be shared through the risk equalisation pool.

2.72 Submitters broadly supported the new private health information statements. The committee considers that the new information statements will make it easier for consumers to understand what procedures their private health insurance covers them for.

2.73 The committee recognises that some submitters raised concerns about the closure or termination of products. The committee understands that the purpose of the provisions are to allow private health insurers to close policies that have only limited membership and to assist in transitioning people to policies under the new product categorisation system.

Product design reforms – Gold/Silver/Bronze/Basic

2.74 Throughout this inquiry, submitters have reminded the committee that consumers find private health insurance to be a complex product that is difficult to understand.[71]

2.75 In October last year, the Minister for Health, the Hon. Greg Hunt MP, on the advice of the Private Health Ministerial Advisory Committee, announced that from 1 April 2019 private health insurance policies will need to be categorised into Gold, Silver, Bronze and Basic policies, where minimum coverage requirements apply to each category.[72] The categorisation and the minimum inclusions for each policy are contained in the exposure draft of the Private Health Insurance (Reform) Amendment Rules 2018 that is attached to the Department of Health's submission.[73]

2.76 Some submitters disagreed with the inclusion of a Basic policy. CHOICE, the Australian Medical Association, the Australian Private Hospitals Association and Day Hospitals Australia objected to the category on the basis that these policies provide low value cover to consumers and exist to take advantage of the financial incentives provided by government.[74]

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71 See for example Ms Root, Consumers Health Forum of Australia, *Committee Hansard*, 7 August 2018, pp. 1–2; CHOICE, *Submission 10*, [p. 1].

72 Explanatory Memorandum, p. 4.

73 See Department of Health, *Submission 4—Attachment 1*, pp. 20–37.

74 See Mr Kirkland, CHOICE, *Committee Hansard*, 7 August 2018, p. 3; Dr Bartone, Australian Medical Association, *Committee Hansard*, 7 August 2018, p. 10; Mr Roff, Australian Private Hospitals Association, *Committee Hansard*, 7 August 2018, pp. 27, 31; Mrs Griffiths, Day Hospitals Australia, *Committee Hansard*, 7 August 2018, pp. 27, 31.

2.77 While it may be the case that these policies provide low-cost and low-value care, the Department of Health told the Community Affairs References Committee last year that the Basic category was retained because the policies make a contribution to the risk-equalisation pool, help to keep premiums affordable and because some consumers see value in the products.[75]

2.78 Submitters also expressed concerns that, if the draft rules were adopted, particular products or services may only be available in higher product tiers. For example:

- Cochlear Limited and Neurosensory were concerned that hearing services will only be available in a Silver policy[76]
- the Australian Medical Association considered that as 50 per cent of pregnancies are unplanned, pregnancy should be covered in Bronze instead of Gold[77]
- the Australian and New Zealand Society of Vascular Surgery questioned what will happen if vascular surgery (which is covered in Silver) is required for an operations that would otherwise be covered in Bronze[78]
- the Breast Cancer Network of Australia expressed concern about whether breast reconstructive surgery and associated surgeries would be covered in Bronze.[79]

2.79 While there may still be some debate about the rules, the committee considers that the reforms will make it clearer to consumers what they are covered for.

2.80 The Consumers Health Forum of Australia highlighted why the reforms were necessary:

> We also know, from our surveys, that people do not understand private health insurance. They often don't know what they are covered for and have no idea that they may have significant out-of-pocket costs. So we want the reforms to address the complexity issue, to make it easier for people to shop around for the best value and to understand exactly what they are and aren't covered for. The product categorisation into basic, bronze, silver and gold, flagged in the legislation and outlined in the rules, was designed to make it simpler for people to see what they are covered for and to compare products.[80]

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75 Community Affairs References Committee, *Value and affordability of private health insurance and out-of-pocket costs*, December 2017, pp. 36–37.

76 Cochlear Limited, *Submission 17*, p. 2; Neurosensory, *Submission 19*, [p. 1]

77 Dr Bartone, Australian Medical Association, *Committee Hansard*, 7 August 2018, p. 10; Australian Medical Association, *Submission 5*, pp. 3–4.

78 Australia and New Zealand Society of Vascular Surgery, *Submission 29*, p. 2.

79 Breast Cancer Network Australia, *Submission 24*, pp. 2, 4–5.

80 Ms Root, Consumers Health Forum of Australia, *Committee Hansard*, 7 August 2018, pp. 1–2.

2.81 The Australian Medical Association pointed out that even doctors are confused by the current array of choices and policies on offer and suggested that a categorisation system would make it clearer for both doctors and consumers:

> It is for that reason that we support the concept of developing gold, silver and bronze insurance categories. Doctors are intelligent people. But I can tell you that we are all bewildered by the many different definitions, the carve-outs and exclusions from some 70,000 policy variations—70,000, that's not my figure; it's the government's. It's unbelievable. No wonder we're always being caught out.[81]

2.82 The Australian Private Hospitals Association noted that these reforms will mark a considerable shift in the private health insurance landscape and that it is important that all consumers under the changes to private health insurance:

> The only other point I wanted to make by way of introduction is that these changes will necessarily lead to a degree of disruption with health insurance products, and we think it's essential that the government conduct a comprehensive consumer information campaign to ensure that all these changes are well understood by those with private health insurance and those who may be interested in taking it out.[82]

Committee view

2.83 The committee recognises that some submitters have some concerns with the rules that will implement the product reforms. The committee understands that the Department of Health is still working with stakeholders to finalise the rules. The committee looks forward to seeing the final rules when they are tabled in Parliament.

2.84 The committee understands that private health insurance can be a complex product that is confusing to many people. The committee considers that categorising products into Gold, Silver, Bronze and Basic will assist to help consumers compare products and to help people understand what is covered in each category by using clear, standard clinical definitions. The committee considers that this will empower consumers to find a product that suits their needs and their budget.

2.85 The committee considers that a public information campaign to help consumers understand the product design reforms would allow more consumers to be better informed about the product tiers and their inclusions in the lead up to the commencement of the reforms.

2.86 Following the passage of the Bill, the committee believes the Government should undertake an information campaign to inform consumers about the changes to private health insurance.

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81 Dr Bartone, Australian Medical Association, *Committee Hansard*, 7 August 2018, p. 9.

82 Mr Roff, Australian Private Hospitals Association, *Committee Hansard*, 7 August 2018, p. 27.

Recommendation 1

2.87 The committee recommends that the Senate pass the Bills.

Senator Slade Brockman

Chair