The Senate

Community Affairs Legislation Committee

Private Health Insurance Legislation Amendment Bill 2018 and related bills

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45th Parliament

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ABBREVIATIONS

addendum	addendum to the Explanatory Memorandum
A New Tax System Bill	A New Tax System (Medicare Levy Surcharge-Fringe Benefits) Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018
Bill	Private Health Insurance Legislation Amendment Bill 2018
committee	Senate Community Affairs Legislation Committee
Medicare Levy Amendment Bill	Medicare Levy Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018
Minister	The Hon. Greg Hunt MP, Minister for Health
Scrutiny of Bills committee	Senate Standing Committee for the Scrutiny of Bills

LIST OF RECOMMENDATIONS

Recommendation 1

2.87 The committee recommends that the Senate pass the Bills.

Chapter 1

Private Health Insurance Legislation Amendment Bill 2018 and two related Bills

Purpose of the Bills

1.1 On 13 October 2017, the Hon. Greg Hunt MP, Minister for Health (Minister), announced a package of reforms to improve the value and affordability of private health insurance. The below listed bills give legislative effect to parts of the reform package announced by the Minister:

(a) Private Health Insurance Legislation Amendment Bill 2018 (Bill)

(b) A New Tax System (Medicare Levy Surcharge-Fringe Benefits) Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018 (A New Tax System Bill)

(c) Medicare Levy Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018 (Medicare Levy Amendment Bill).

Background

1.2 Private health insurance funds part of Australia's mixed public and private healthcare system.

1.3 In 2015–16, Commonwealth Government consultation on private health insurance found that consumers and stakeholders held concerns about the complexity and transparency of private health insurance products, the high out-of-pocket costs being incurred by consumers and questioned whether private health insurance provided value for money and was sustainable.[1]

1.4 These concerns may explain a drop in participation in the private health insurance market. The Explanatory Memorandum notes that the reforms are aimed at arresting the decline in private health insurance participation:

> …in the past nine consecutive quarters coverage has declined in proportion terms…If this trend continues, it may signal the start of a decline in coverage similar to that seen in the 1990s where hospital insurance dropped from 45 percent to 30 percent of the population over the decade.[2]

1.5 As noted above, on 13 October 2017 the Minister announced a package of 13 reforms to address community concerns about private health insurance. The reforms announced were:

- product design reforms including categorising policies as Gold, Silver, Bronze or Basic

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1 Explanatory Memorandum, p. 10.

2 Explanatory Memorandum, p. 5.

- improving patient access to mental health services
- establishing a working group to provide advice on improving models of care to fund mental health and rehabilitation services
- introducing standard clinical definitions
- improving access to travel and accommodation benefits to benefit regional and rural consumers
- strengthening the powers of the Private Health Insurance Ombudsman
- establishing an advisory committee to consider best practice models for transparency in out-of-pocket costs
- information provision reforms, including the development of a minimum data set for consumers
- allowing private health insurers to offer discounted private hospital cover to people aged 18 to 29
- Prosthesis List benefit reductions
- increasing maximum excess levels
- changing the coverage for some natural therapies
- implementing second-tier administrative hospital reforms.[3]

1.6 Some of the reforms that do not require legislative amendment have already been implemented.[4]

1.7 Other reforms will require rules to be made after the Bills have been passed. On 16 July 2018 the Department of Health released exposure drafts of the Private Health Insurance (Reforms) Amendment Rules 2018 and the Private Health Insurance (Complying Product) Amendment (Terminating Products) Rules 2018. Copies of the exposure drafts are attached to the Department of Health's submission.[5]

Provisions of the Bill

1.8 The Bill contains five schedules.

1.9 **Schedule 1** amends the *Private Health Insurance Act 2007* to insert a new Part 2-4 to specify that from 2018–19 a complying private health insurance product can only have a maximum excess of $750 in a 12 month period if the policy covers one individual or $1500 in a 12 month period for any other policy.

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3 Explanatory Memorandum, p. 4.

4 For example, the $1.1 billion of Prosthesis List benefit reductions was achieved through an agreement with the Medical Technology Association of Australia on behalf of device manufacturers. Department of Health, *Submission 4*, p. 1.

5 See Department of Health, *Submission 4—Attachment 1*, pp. 1–46; Department of Health, *Submission 4—Attachment 2*, pp. 1–3.

1.10 **Schedule 2** amends the *Private Health Insurance Act 2007* and the *Age Discrimination Act 2004* to allow age-based discounts for hospital cover.

1.11 **Schedule 3** amends the *Ombudsman Act 1976* to provide inspection and audit powers to the Private Health Insurance Ombudsman, including powers to enter the premises of a private health insurer or broker, to inspect and copy documents and require persons to render assistance and facilities to allow the Ombudsman to exercise those powers.

1.12 **Schedule 4** contains transitional provisions relating to irregular private health insurance products.

1.13 **Schedule 5** contains four discrete parts. **Schedule 5 Part 1** amends the *Private Health Insurance Act 2007* to provide that the principles and requirements of community rating do not prevent an insurer from assessing a person's entitlement for travel or accommodation benefits based on the distance between the person's place of residence and place of treatment.

1.14 **Schedule 5 Part 2** amends the *Private Health Insurance Act 2007* by substituting the phrase 'standard information statement' in favour of 'private health information statement'.

1.15 **Schedule 5 Part 3** amends the *Private Health Insurance Act 2007* to allow the Minister to make Private Health Insurance (Health Insurance Business) Rules relating to the inclusion of hospitals in particular classes. This facilitates the second tier default benefits reforms.

1.16 **Schedule 5 Part 4** amends the *Private Health Insurance Act 2007* to allow private health insurers to close a product, including for those people who currently hold the product, after notice. The Explanatory Memorandum states that this part will also allow an insurer to close a national product or a product in a particular state by ceasing to make it available.[6]

Key provisions of the A New Tax System Bill and the Medicare Levy Amendment Bill

1.17 The operative items of the A New Tax System Bill and the Medicare Levy Amendment Bill amend sections in the *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999* and the *Medicare Levy Act 1986*, respectively, to remove provisions that define when a person is covered by an insurance policy that provides private patient hospital cover for the purposes of those Acts.

1.18 The relevant sections of the current Acts provide that a policy must only contain a particular excess and makes some transitional provisions. The Bills replace the existing provisions with a reference to the excess amounts specified in section 45-1 of the *Private Health Insurance Act 2007* (to be inserted by Schedule 1 of the Bill).

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6 Explanatory Memorandum, p. 53.

1.19 The Explanatory Memorandum notes that subsections 4(4)-(5) of the *A New Tax System (Medicare Levy Surcharge – Fringe Benefits) Act 1999* and subsections 3(6)-(7) of the *Medicare Levy Act 1986* are being repealed because they were made redundant by the *Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007*.

Financial impact

1.20 The total financial impact of the measures for the period 2017–18 to 2020–21 is $6.2 million.[7]

Legislative scrutiny

Standing Committee for the Scrutiny of Bills

1.21 Standing Order 25(2A) provides that legislation committees considering bills shall take into account comments published by the Senate Standing Committee for the Scrutiny of Bills (Scrutiny of Bills committee).

1.22 The Scrutiny of Bills committee published initial comments on the Bill in *Scrutiny Digest No. 5 of 2018*.[8] The Scrutiny of Bills committee raised concerns about powers proposed to be granted to the Private Health Insurance Ombudsman by the Bill. In particular, the Scrutiny of Bills committee requested advice from the Minister about the following matters:

- why it was necessary to allow the Private Health Insurance Ombudsman to enter premises and inspect documents without a warrant
- whether the explanatory memorandum ought to be amended to include a justification for reversing the evidential burden of proof in proposed section 20ZIA (requiring a defendant to produce evidence to demonstrate that an identity card was lost or destroyed) and
- why is was necessary to allow broad delegation of the Private Health Insurance Ombudsman's entry and inspection powers and whether it would be appropriate to amend the Bill to require the Private Health Insurance Ombudsman to be satisfied that people performing delegated functions have the expertise appropriate to the function or power delegated.[9]

1.23 The Minister responded to the Scrutiny of Bills committee and subsequently tabled an addendum to the Explanatory Memorandum (addendum).[10] The addendum responded to each of the concerns raised by the Scrutiny of Bills committee.

1.24 In relation to the Scrutiny of Bills committee's concerns about the entry and inspection powers proposed to be granted to the Private Health Insurance Ombudsman

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7 Explanatory Memorandum, p. 4.

8 Senate Standing Committee for the Scrutiny of Bills (Scrutiny of Bills committee), *Scrutiny Digest No. 5 of 2018* (9 May 2018) pp. 47–51.

9 Scrutiny of Bills committee, *Scrutiny Digest No. 5 of 2018* (9 May 2018) pp. 48, 49, 51.

10 *House of Representatives Votes and Proceedings*, No. 116, 31 May 2018, p. 1581.

by Schedule 3, the addendum notes that respondents to complaints have nearly always provided full records to the Private Health Insurance Ombudsman voluntarily.[11] The new power, which is not expected to be used, provides the Private Health Insurance Ombudsman with the power to enter premises with 48 hours' notice in the event a respondent does not voluntarily consent to the Private Health Insurance Ombudsman entering their premises.[12] The proposed entry and inspection powers complement the existing power of the Private Health Insurance Ombudsman to issue a notice to provide relevant information relating to an investigation.[13]

1.25 In relation to the need to reverse the evidential onus of proof in proposed section 20ZIA(5) the addendum noted that proposed section 20ZIA(5) only applied where the identity card was lost or destroyed. The addendum noted that knowledge of the card's destruction or loss was likely to be uniquely known to the card holder and it was therefore appropriate to impose an evidential burden on the defendant to produce evidence.[14]

1.26 The addendum lastly addressed the question of delegation of the Private Health Insurance Ombudsman's proposed powers. The addendum clarified that the power to delegate functions was necessary 'to ensure the function is staffed at the appropriate level and provides flexibility to reduce staffing levels'.[15] The addendum also noted that the Private Health Insurance Ombudsman would put in place procedures to ensure that only those with appropriate qualifications and experience are delegated key functions.[16]

1.27 The Scrutiny of Bills committee addressed the Minister's reply and the offer of an addendum in *Scrutiny Digest No. 6 of 2018*.[17] In *Scrutiny Digest No. 6 of 2018* the Scrutiny of Bills committee reiterated its concern about the entry and inspection powers being granted to the Private Health Insurance Ombudsman and drew its scrutiny concern to the attention of the Senate.[18] With regard to the question of delegation, the Scrutiny of Bills committee considered that it may be appropriate to amend the Bill in the following terms:

> …to require that the Private Health Insurance Ombudsman's [sic] (PHIO) be satisfied that persons performing delegated functions and exercising delegated powers have the expertise appropriate to the function or power delegated.[19]

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11 Explanatory Memorandum—Addendum, p. 1.

12 Explanatory Memorandum—Addendum, p. 1.

13 Explanatory Memorandum—Addendum, p. 1.

14 Explanatory Memorandum—Addendum, p. 1.

15 Explanatory Memorandum—Addendum, p. 2.

16 Explanatory Memorandum—Addendum, p. 3.

17 Scrutiny of Bills committee, *Scrutiny Digest No. 6 of 2018* (20 June 2018) pp. 118–127.

18 Scrutiny of Bills committee, *Scrutiny Digest No. 6 of 2018* (20 June 2018) p. 122.

19 Scrutiny of Bills committee, *Scrutiny Digest No. 6 of 2018* (20 June 2018) p. 127.

1.28 The Scrutiny of Bills committee had no comments on the A New Tax System Bill or the Medicare Levy Amendment Bill.[20]

Parliamentary Joint Committee on Human Rights

1.29 The Parliamentary Joint Committee on Human Rights had no comments on the Bill, the A New Tax System Bill or the Medicare Levy Amendment Bill.[21]

Conduct of the inquiry

1.30 The Bills were introduced and read a first time in the House of Representatives on 28 March 2018 and were passed without amendment on 31 May 2018.[22] The Bills were introduced and read a first time in the Senate on 18 June 2018.[23] On the same occasion, the Bills were read a second time and the debate was adjourned.

1.31 On 19 June 2018, pursuant to a notice of motion, the Bills were referred to the Senate Community Affairs Legislation Committee (committee) for inquiry and report by 13 August 2018.[24]

1.32 The committee advertised the inquiry on its website and wrote to 94 organisations inviting submissions by Friday, 20 July 2018. The committee received 33 submissions. A list of submissions to the inquiry can be found on the committee's website[25] and at Appendix 1.

1.33 The committee held a part-day hearing in Canberra on the Bills on Tuesday, 7 August 2018. For the duration of this hearing, the committee telecommuted via video-link from Perth. A list of witnesses who gave evidence to the committee can be found at Appendix 2.

1.34 The committee thanks those submitters who contributed to the inquiry.

Notes on references

1.35 In this report, references to *Committee Hansard* are to proof transcripts. Page numbers may vary between proof and official transcripts.

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20 Scrutiny of Bills committee, *Scrutiny Digest No. 5 of 2018* (9 May 2018) pp. 1, 33.

21 Parliamentary Joint Committee on Human Rights, *Human Rights Scrutiny Report No. 4 of 2018* (8 May 2018) p. 96.

22 *House of Representatives Votes and Proceedings*, No. 106, 28 March 2018, p. 1477; *House of Representatives Votes and Proceedings*, No. 116, 31 May 2018, pp. 1581–1582, 1586.

23 *Journals of the Senate*, No. 98, 18 June 2018, p. 3149.

24 *Journals of the Senate*, No. 99, 19 June 2018, pp. 3171–3172.

25 Committee, *Private Health Insurance Legislation Amendment Bill 2018 and related Bills,* https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/PrivateHealthInsur2018 (accessed 23 July 2018).

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

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.

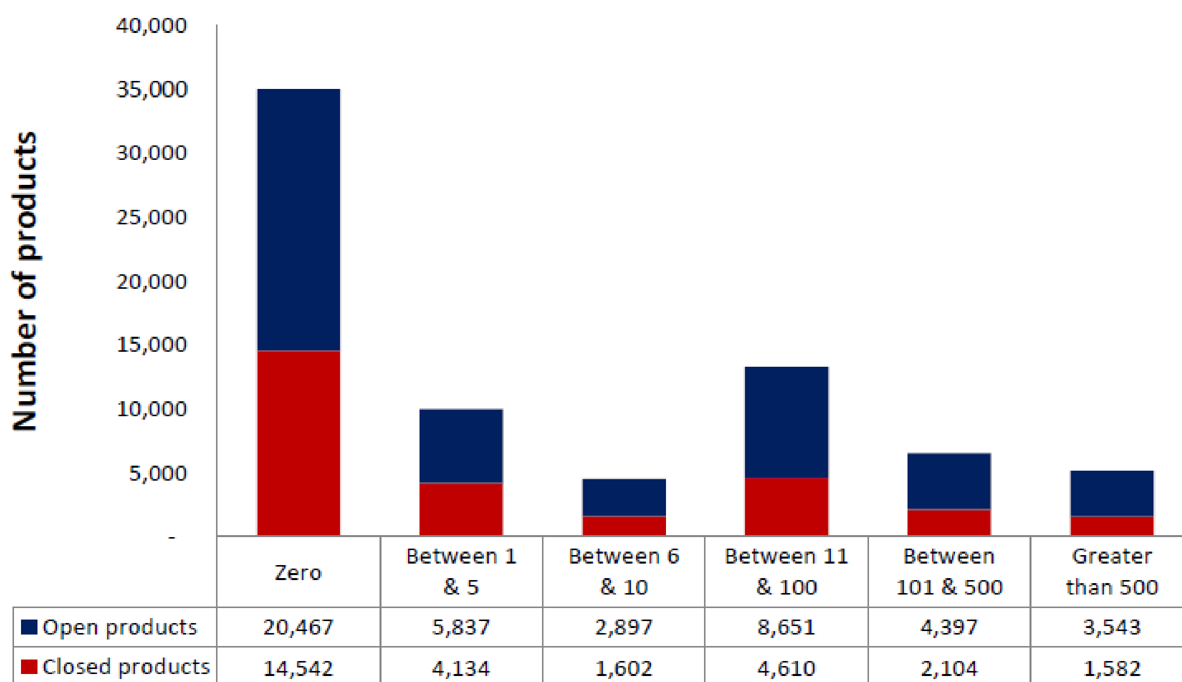
65 Mr Gath, *Committee Hansard*, 7 August 2018, p. 18.

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

Additional Comments by Labor Party Senators

1.1 Labor Senators support the Committee's recommendation that the bills be passed.

1.2 However, Labor Senators remain concerned that the bills could have significant unintended consequences – including making it easier for insurers to cancel policies and harder for Australians to afford care when they need it.

1.3 Labor Senators therefore support calls by the Australian Medical Association, Australian Healthcare and Hospitals Association and others for the measures in this bill to be reviewed after implementation.

1.4 Labor Senators note that these bills do little to address the affordability crisis in private health insurance. Labor Senators call on the Government to adopt Labor's policy of capping premium increases at two per cent for two years and tasking the Productivity Commission with the biggest review of the sector in 20 years.

Senator the Hon Lisa Singh **Senator Murray Watt**

Dissenting Report by the Australian Greens

1.1 The Australian Greens have been campaigning for significant reform to the private health insurance market for some time. As noted by Mr Alan Kirkland, CEO of CHOICE:

> It's hard to imagine any other area of public expenditure where you have the same number of Australians contributing from their own pockets, with significant public expenditure and subsidies backing that up, without us having clear data on what we're getting in return.[1]

1.2 Private health insurance premiums continue to climb for consumers, with greater exclusions meaning policyholders receive less care for their money, and with scant evidence the subsidy is taking any pressure off the public health system. The government's bill attempts to deal with a public policy failure of an enormous scale by tinkering at the edges.

1.3 This inquiry has shown that this series of reforms, ostensibly designed by the government to address rising premiums for consumers and restore value to private health insurance products, will have little effect in improving the sustainability of the market. What we are instead seeing is an ideological commitment to throw good money after bad. The private health insurance system operates only through the generosity of vast public subsidies of more than $6.5 billion each year. There is no argument that without these subsidies, the market would collapse.

Increasing maximum excess levels

1.4 Schedule 1 of the bill 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.

1.5 This will allow consumers to take out products that are low-premium and low-value. The prospect of a high excess will deter consumers from utilising their cover. While the Committee notes that this may promote choice, we argue that this is not the form of choice the Private Health Insurance rebate is intended to promote. Instead, this change pushes consumers towards taking out low-value options that are designed purely to avoid the Medicare Levy Surcharge, while policyholders continue to rely on health care through the public health system. As noted by Mr Michael Roff, CEO of the Australian Private Hospitals Association:

> **Senator SIEWERT**: So would it be fair to say that it would be fairly rare for somebody with a basic policy or low-premium policy to be using that policy in a private hospital?
>
> **Mr Roff** : I think that would be fair to say, yes.

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

1.6 The effect is to make tax minimisation easier. Lower-premium products simply require a greater share of the cost of a procedure or admission to be covered at the event point, rather than across the life of the product. The greater the share of costs to be met at the incidence of an unforeseen health event, the lower the probability that the policyholder will opt to claim against their product. This does not take pressure off the public health system. It directs tax dollars away from the public health system towards the private insurance market, without reducing the demand for the public health system itself. This is the only stated reason for the subsidy. It is misaligned and misguided.

Product design reforms

1.7 CHOICE, the Australian Medical Association, the Australian Private Hospitals Association and Day Hospitals Australia made clear to this Committee their objections to the inclusion of a 'Basic' category of cover on the basis that these policies provide low value cover to consumers and exist to take advantage of the financial incentives provided by government.

1.8 The Committee's view, that the Basic category of product should be included because some consumers find this product to have value, is simplistic and misleading. There is no 'inherent' value to these products. They exist to reduce tax for consumers. The rationale that they should continue as a way to maintain a broad distribution of risk throughout the insurance pool simply points to how poorly the current system is designed. The government is encouraging low-risk consumers to take up a form of private health insurance to prop up higher-risk consumers, using tax penalties and price rebates. They do this at enormous cost to the taxpayer. The risk pool is artificially inflated with low-value products simply because these premiums contribute to the financial viability of private health insurers. The role of supporting the cost of older or less healthy Australians in living long, meaningful and productive lives is one for government, not for companies.

Aged-based discounts

1.9 The Australian Medical Association has made clear its concerns about the risk to community rating posed by the provision of aged-based discounts for private health insurance customers between 18 and 29:

> **Senator SIEWERT**: I want to go back to the community rating issue. Do both of your organisations acknowledge that the young people's discount will undermine the concept of community rating?
>
> **Dr Bartone**: It certainly has the potential if not implemented correctly or if not further reviewed carefully in the fullness of time to see the effect it's having. It is a watch-out area; it is a risk area.[2]

1.10 The Committee argues that aged-based discounts are necessary to improve the appeal of private health insurance for young people. Fundamentally, there are two key

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2 Dr Tony Bartone, President, Australian Medical Association, *Committee Hansard*, 7 August 2018, p. 12.

ways to boost take up of private health insurance amongst young people, who are critical to the sustainability of the market overall. The first is to reduce the cost of participation, which aged-based discounts are designed to do. The second is to improve the value of offerings. Combining the impact of aged-based discounts with increases to maximum excesses, we see the preferred approach of the Government is the former rather than the latter. This is disappointing. A product with little value is not appealing at any price point. Value seems to be artificially produced by various carrots and sticks within the tax system, along with the Lifetime Health Cover Loading. In this way, young people see value in private health insurance principally as a tax minimisation vehicle. To this point, there is no value in the product itself. It is only what purchasing the product allows the consumer to avoid that any value is realised. The same impact could be achieved by strengthening the 'stick' of the tax penalty. This is not the preferred approach of the Australian Greens, but it demonstrates how little is actually achieved by these reforms.

1.11 The principle of community rating underpins the functioning of our private health insurance market. The impact of allowing discounts to certain cohorts based on demographic factors such as age has potentially no impact on participation in private health insurance. If there is no improvement in participation among young people in particular, then the provision of aged-based discounts will have no benefit from a public policy perspective. It will have a potentially deleterious impact on the market as a whole (by eroding the principle of community rating), as well as represent a greater cost to the taxpayer, with no demonstrable benefit for these significant costs.

Inspection powers

1.12 While it is supported that oversight of private health insurance companies should be increased for the benefit of consumers, it is quite unusual to grant the Private Health Insurance Ombudsman the power to enter a private premise without requiring a warrant beforehand. Arguments proposed by the Department that these powers are justified because there is an equivalent power available to the Australian Tax Office are alarming. The Australian Tax Office has a far broader remit than the Private Health Insurance Ombudsman. Their powers and their responsibilities are not equivalent. The Tax Office frequently cooperates with law enforcement agencies in criminal investigations. It is imaginable that such an investigation may necessitate the power of inspection without warrant, in extraordinary circumstances. No evidence has been submitted that the Private Health Insurance Ombudsman would require similar powers under anywhere approaching similar circumstances.

Conclusion

1.13 The Private Health Insurance Rebate represents a transfer of wealth from the taxpayer to the private health insurance industry. It has been justified by the government on the grounds that we need a well-functioning private health insurance system to take pressure off the public health system. There is no evidence that this is achieved, or that this package makes any reforms which can be said to take pressure off the public health system.

1.14 Through the rebate, taxpayers subsidise the taking out of private health insurance products. Taxpayers cover the cost of these private health insurance

customers nonetheless opting to use the public health system. Finally, the $6.5 billion in taxpayer dollars which is currently diverted to private health insurance companies, could be better spent in the public system, improving the care available to all.

1.15 The cumulative cost to the taxpayer is tremendous. It is unprecedented that such a cost would be inflicted on the taxpayer with so little evidence to suggest that any value is being created from such an investment of public money.

Recommendation 1

The Australian Greens recommend that the Senate does not pass these Bills.

Senator Rachel Siewert **Senator Richard Di Natale**

APPENDIX 1

Submissions and additional information received by the Committee

Submissions

1 Mr Shaun Gath

2 Day Hospitals Australia

3 Australian and New Zealand Academy of Periodontists

4 Department of Health (plus two attachments)

5 Australian Medical Association

6 Commonwealth Ombudsman

7 Consumers Health Forum of Australia

8 Australian Healthcare and Hospitals Association

9 Members Health Fund Alliance

10 CHOICE

11 Royal Australian and New Zealand College of Psychiatrists

12 Medical Technology Association of Australia

13 Private Healthcare Australia

14 Johnson & Johnson

15 finder.com.au

16 Medtronic Australasia Pty Ltd

17 Cochlear Ltd (plus an attachment)

18 Mr Russell Schneider AM

19 Neurosensory (plus an attachment)

20 Medibank

21 Haemophilia Foundation Australia

22 Australian Society of Plastic Surgeons

23 nib

24 Breast Cancer Network Australia

25 Occupational Therapy Australia

26 HCF

27 Biotronik Australia Pty Ltd

28 Australian Dental Association (plus an attachment)

29 Australian and New Zealand Society for Vascular Surgery (plus an attachment)

30 Australian Traditional-Medicine Society (plus two attachments)

31 Australian Society of Ophthalmologists

32 Royal Australasian College of Surgeons

33 Australian Research Centre in Complementary and Integrative Medicine

Additional Information

1 Opening statement, from Choice, received 13 August 2018

Answers to Questions on Notice

1 Answers to Questions taken on Notice during 7 August public hearing, received from Private Healthcare Australia, 9 August 2018

2 Answers to Questions taken on Notice during 7 August public hearing, received from Department of Health, 10 August 2018

3 Answers to Questions taken on Notice during 7 August public hearing, received from Choice, 13 August 2018

APPENDIX 2

Public hearings

Tuesday, 7 August 2018

Parliament House, Canberra

Witnesses

Consumers Health Forum of Australia
ROOT, Ms Josephine, Policy Director

CHOICE
KIRKLAND, Mr Alan, Chief Executive Officer
DAY, Ms Katinka, Campaigns and Policy Team Lead

National Rural Health Alliance
DIAMOND, Mr Mark, Chief Executive Officer

Australian Healthcare and Hospitals Association
THURECHT, Dr Linc, Senior Research Director
TABUR, Mr Matthew, Executive Officer

Australian Medical Association
BARTONE, Dr Tony, President
RAIT, Associate Professor Julian, President of AMA Victoria
TOY, Mr Luke, Director, Medical Practice Section

GATH, Mr Shaun, Private capacity

Private Healthcare Australia
DAVID, Dr Rachel, Chief Executive Officer
DOMITROVIC, Ms Kristy, Director of Engagement, Policy and Strategy

Members Health Fund Alliance
KOCE, Mr Matthew, Chief Executive Officer

Australian Private Hospitals Association
ROFF, Mr Michael, Chief Executive Officer

Day Hospitals Australia Ltd
GRIFFITHS, Mrs Jane, Chief Executive Officer
MORELAND, Ms Gabrielle, ACT Director, Board of Directors

Department of Health
SHAKESPEARE, Ms Penny, Deputy Secretary
WEISS, Mr David, First Assistant Secretary, Medical Benefits Division
AZMI, Ms Susan, Acting Assistant Secretary, Private Health Insurance Branch

Office of the Commonwealth Ombudsman
MANTHORPE, Mr Michael, Commonwealth Ombudsman
WALSH, Dermot, Senior Assistant Ombudsman, Industry Branch
McGREGOR, Mr David, Director, Private Health Insurance Ombudsman