



Private Health Insurance Bill 2006

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Private Health Insurance Bill 2006

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Portfolio: Health and Ageing

Commencement: 1 April 2007

Purpose

This Bill replaces the current regulatory regime for private health insurance (contained mainly in the *National Health Act 1953*, *Health Insurance Act 1973* and *Private Health Incentives Act 1998*) with a new regime contained within the one Act.

Changes proposed as part of the new regulatory regime include:

- broadening the range of services that can be covered by private health insurance to include out of hospital services that substitute for or prevent hospital care
- removal of Lifetime Health Cover loadings for members with ten years continuous membership
- requirements on insurers to provide standard information statements for consumers about their private health insurance products, and
- clarified and simplified legislation.

This Bill was introduced with six other Bills that amend a range of Acts to reflect the new regulatory regime. These six Bills are examined in separate Bills Digests.

Background

State of the private health sector¹

The private health insurance sector in Australia comprises 37 operational funds. The industry is dominated by the six largest health insurers, which share 76.2 per cent of the market.² Twenty-five health insurers each have less than 1.0 per cent of market share and, when combined, comprise 7.8 per cent of the market.³

The private health insurance industry is subject to tight regulation, primarily through the National Health Act. The main industry regulator is the Private Health Insurance Administration Council (PHIAC). A central pillar of the regulation of private health insurance in Australia is community rating—the principle that health funds may not

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discriminate on the basis of age (other than age at which health cover is first purchased), gender, sexuality, health status or claims history. Rather, they must charge the same premium to everyone, regardless of individual health risk.

Ratings agency Standard and Poor's regards the private health insurance environment in Australia as competitive and highly volatile.⁴ According to PHIAC, the industry's financial performance remained strong in 2005–06, recording a surplus of \$984 million.⁵ PHIAC suggests that this result was 'a combination of lower-than-expected claims outlays, and the buoyant economy, which has contributed significantly to investment income'.⁶ Nevertheless, PHIAC has raised concerns that the industry continues to be 'heavily reliant' on non-premium sources of revenue for its surplus, arguing that 'the sustainability of this reliance is open to question because investment income, though important, cannot be expected to fund the benefits outlays growth anticipated by the industry'.⁷

Benefits paid by private health insurance funds grew by 6.2 per cent, continuing the trend of increasing by more than the consumer price index (CPI) (although, PHIAC notes, this does represent a decrease in the rate of increase over recent years).⁸ Significantly, PHIAC has argued that the continuing growth in health costs 'can only result in ongoing pressure on premium rates'.⁹ Private health insurance funds were granted permission by the Minister for Health and Ageing to increase premiums by an average of 5.7 per cent in January 2006, a decrease from the average increase of more than seven per cent per year since 2002 (7.9 per cent in 2005). Media reports have suggested that premium increases will be 'smaller than normal' in 2007 as a result of the increased 2005-06 industry surplus.¹⁰

Membership numbers have remained stable since 2003. Hospital coverage at September 2006 was 43.2 per cent, with 8.928 million persons covered, a marginal increase over the previous year. The average age of the industry's customer base continues to increase at a rate similar to that of the Australian population.¹¹ This is a continuing concern for the industry given that greater use of hospital services and increased benefit outlays are associated with persons aged over 65 years. For example, while comprising only 13.1 per cent of the insured population, benefits paid to persons aged over 65, amounted to 44 per cent of total benefit outlays.¹²

In recent years, some commentators have questioned the sustainability of the private health insurance sector in Australia in its current form. For some, the problem is that private health insurance does not contain sufficient mechanisms to control the cost and utilisation of health services.¹³ Others have pointed to the way in which increased premiums lead to a 'downward spiral' in which low-risk members leave because they contribute more than they claim, the proportion of high-risk members increases, premiums rise to make up the difference between income and benefits paid, in turn causing low-risk members to leave.¹⁴ Still others have argued that the current stringent regulatory framework for private health insurance provides very little opportunity for enhanced competitiveness through administrative and product innovation.¹⁵

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Basis of policy commitment

This Bill is the largest of a package of seven Bills that implement reforms to private health insurance announced by the Government on 26 April 2006. These reforms were developed following a review of the private health insurance sector in 2005.¹⁶ The Government had identified a number of problems with private health insurance, including:

- existing regulation inhibited insurers from ‘developing flexible health care products that better meet consumers’ needs and expectations’
- forecasts from analysts such as Standard and Poor’s, suggesting that there is currently little scope for growth in the private health insurance sector
- research indicating that consumers wanted a wider range of services covered by private health insurance (particularly preventative health services), and
- the ‘unwieldy, out of date’, and difficult to interpret’ nature of current private health insurance legislation.¹⁷

The purpose of the review was to ‘address concerns about the participation rate, the value and attractiveness of the [private health insurance] product and to explore opportunities to invigorate [private health insurance]’.¹⁸

Reforms developed in response to the review were announced in April 2006. This was followed by a period of further consultation with the private health insurance sector and the release of an exposure draft of the Private Health Insurance Bill 2006 on 20 October 2006. A number of changes to the Bill were made following consultation with the sector in relation to the exposure draft. These are outlined in the Department of Health and Ageing circular *Introduction of Private Health Insurance Legislation Package (PHI76/06)*.

The Government has described the package of reforms as the ‘most significant change to health insurance legislation in more than a decade’.¹⁹ The reforms are composed of three types of measures:

- those aimed at ‘improving’ private health insurance as a product
- those aimed at ensuring consumers are better informed about private health insurance products, and
- those aimed at reforming the structure of private health insurance regulation.

Improved private health insurance products

Broader Health Cover

The most significant change in this category is Broader Health Cover. Broader Health Cover expands the range of services that can be covered by private health insurance to include out of hospital services that substitute for or prevent hospital care. This will allow

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insurers to pay benefits for such services as domestic nursing assistance, allied health services, dialysis, chemotherapy and programs that support and sustain healthy lifestyles.²⁰ Some out-of-hospital services will be specifically excluded from Broader Health Cover, including general practice services and the costs of accommodation in residential aged care facilities. These are to be specified in the Private Health Insurance (Health Insurance Business) Rules.²¹

The Minister for Health and Ageing, Mr Abbott, describes this as the ‘most significant new measure’ in the package and a ‘groundbreaking change’.²² He argues that it will improve private health insurance by enabling health insurers to offer ‘more flexible and innovative products that reflect modern clinical practice and consumer expectations’.²³

Under the new regulations for complying health insurance products in the Bill, health insurers will offer policies that cover:

- hospital treatment; or
- hospital treatment and general treatment; or
- general treatment only (but not hospital-substitute treatment only).

Treatment will be defined in relation to who provides the service, rather than where the service is provided.

Hospital treatment is defined in section 121-5 of the Bill as treatment which is intended to manage a disease, injury or condition, including the provision of goods and services, provided by or under the management or control of a person who is authorised by a hospital to provide the treatment. The treatment must also be provided at a hospital or be provided, or arranged, with the direct involvement of a hospital.

General treatment is defined in section 121-10 as treatment intended to manage a disease, injury or condition, including the provision of goods or services, and that is not hospital treatment. As noted previously, general treatment cannot include a professional service for which a Medicare benefit is payable unless allowed by the Rules. General treatment includes, but is not limited to, hospital-substitute treatment, chronic disease management programs and ancillary services.

Broader Health Cover products will be those covered by the second point above (‘hospital treatment and general treatment’).

Lifetime Health Cover change

The other significant change designed to ‘improve’ private health insurance as a product is the proposal to remove of Lifetime Health Cover loadings for members with ten years continual membership.

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Lifetime Health Cover was introduced by the Howard Government in July 2000 in order to encourage young people to take out private health insurance whilst still relatively young (rather than later in life when their use of health services is generally higher) and maintain that coverage. Under LHC, health funds are permitted to charge different premiums depending on the age at which people take up private health insurance.

Broadly, Lifetime Health Cover operates as follows:

To lock in the lowest premiums for life under Lifetime Health Cover, a person needs to take out hospital cover with a registered fund by the 1st of July following their 31st birthday. If a person does not have hospital cover on the 1st of July following their 31st birthday and decides to take out hospital cover later in life, they will pay a 2% loading on top of their premium for every year they are aged over 30. For example, someone who first takes out hospital cover at age 40 will pay 20% more than someone who first took out hospital cover at age 30. The maximum loading allowed is 70%.²⁴

Further, under current LHC arrangements, health fund members can drop their health insurance cover for a cumulative period of 24 months within their lifetime without affecting their loading. These are referred to as 'permitted days'. For 365 days without cover after that, the person's loading increases by 2 per cent. In effect, this allows the person 1,094 days or almost 3 years during which they are not penalised for dropping their health insurance. In addition current arrangements provide for various exemptions, for example, Australians who were overseas or resident in another country on their 31st birthday.

Section 34-10 of the Bill removes LHC loadings for persons who have maintained cover continuously for ten years. This is intended as a reward for those who have maintained cover, having first joined after the age of 30. As the Minister argued in his Second Reading speech, this measure 'recognises and rewards people who have made the effort to maintain their cover over time, having first joined after the age of 30. They have made the effort and they deserve the credit for their commitment and loyalty'.²⁵ It is expected that this measure will benefit up to 60,000 consumers a year.²⁶

Standardised information for consumers

This refers to the proposal in Division 93 of the Bill for the introduction of requirements on insurers to provide standardised information statements for consumers about their private health insurance products. The purpose of this measure is to assist consumers in comparing health insurance products and to understand their entitlements under them.

The standardised information is likely to cover such things as the cost of premiums, waiting periods, exclusions, gaps and excesses.²⁷ These will be specified in forthcoming PHI (Complying Product) Rules, rather than the PHIB 2006.

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This information will be included in a consumer information website being developed by the Private Health Insurance Ombudsman (PHIO). Funding for the website was included in the 2005-06 federal budget.

Regulatory reform

Clarified and simplified legislation

This Bill (and the other six bills in the package) proposes to ‘clarify and simplify’ legislation relating to private health insurance.

According to the Explanatory Memorandum:

Currently, the regulatory regime for private health insurance is expressed in nine primary Acts, nine sets of regulations, several schedules to Acts and numerous determinations. Under this option this existing regulation (with the exception of the taxing provisions) would be consolidated into one primary Act, which will set out the requirements for the conduct of private health insurance business, one primary set of regulations and a systematic, uniform approach to developing and expressing subordinate legislation.²⁸

As such, this Bill recasts the existing regime into themes including:

- incentives to purchase insurance
- rules for private health insurance products
- obligations on private health insurers, and
- provisions for enforcement of the Bill.

The Bill also co-locates and consolidates related provisions and removes redundant provisions. The Bill also contains offence provisions for breaches of the new product standards. These include penalties for failing to provide the required standardised product information introduced in this Bill.

Broadly, the new regulatory regime shifts the focus of regulation from *insurers* to insurance *products*. This means that private health insurance products are regulated directly, rather than through conditions of registration imposed on health insurers. The Government argues that this measure will reduce the compliance burden on private health insurers and that this may place ‘downward pressure on the price of premiums’.²⁹ Mr Abbott has also suggested that by regulating products, rather than providers, the Government is ‘opening the door more widely to potential new entrants into the private health insurance industry’. This is not explained but may refer to the possibility that the current focus of regulation on insurers acts as a barrier to entry for organisations that may otherwise have sought to offer health insurance.

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Risk equalisation

The Government is also planning to change the arrangements relating to risk equalisation (currently known as reinsurance). Note that these changes, due to commence on 1 April 2007, will be made through Regulation, rather than directly through this Bill.

Under current reinsurance arrangements, insurers are required to contribute to a 'reinsurance pool' (administered by PHIAC), which is redistributed to those insurers who have a disproportionate number of over-65 year olds or extremely high users of health services. Reinsurance is integral to the principal of community rating in that it ensures that organisations are not disadvantaged by being required to charge the same premium to all members regardless of health risk. \$182 million was transferred amongst RHBOs in 2005–06 through reinsurance arrangements.³⁰

The current approach to reinsurance arrangements has been the subject of debate in the private health insurance sector for some years. For example, they have been criticised by insurers as too administratively complex and inflexible.³¹

The key features of the new approach, to be known as risk equalisation, are improved pooling of risk and the introduction of a compulsory high cost claims pool. This approach was originally proposed by the Australian Health Insurance Association (AHIA) and is supported by the industry.

The Government has decided to pursue this approach rather than its own preferred approach known as demographic risk-based capitation. In essence, this approach would differ from current arrangements in that financial transfers between funds would be on the basis of their membership risk profiles, rather than as a subsidy for actual benefits paid. The Government has argued that such an approach would promote efficiency in the industry:

... funds that are more efficient [would be] able to retain cost-savings. The proposed model rewards funds that are more efficient and will encourage all funds to have better claims management, contractual arrangements and/or preventative programs.³²

However, the Government has decided to pursue the AHIA's favoured approach because demographic risk-based capitation is not supported by the industry. According to the Explanatory Memorandum, the Government 'will continue to consult with the industry' about the possibility of implementing demographic risk-based capitation at some time in the future.³³

Position of significant interest groups or commentators

The following have indicated that they are broadly in favour of the reforms introduced through this Bill: the Australian Medical Association (AMA), the Australian Private

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Hospitals Association (APHA), the Australian Health Insurance Association (AHIA), and health insurers MBF and BUPA. Nevertheless, as can be seen from the following section, each has also raised concern about specific aspects of the reform package and made recommendations for change.

The Centre for Health Economics Research and Evaluation (CHERE), Doctors Reform Society (DRS) and academic commentator on health financing, Ian McAuley have all raised significant concerns about the impact of the Bill. Their main concern is with the impact of the introduction of Broader Health Cover. Specific concerns are discussed in the following section.

Analysis of significant features of Bill

The analysis in this section draws from submissions to the Senate Community Affairs Legislation Committee *Inquiry into Private Health Insurance Bill 2006 and related Bills* and other relevant material.

Copies of the submissions can be obtained from the Inquiry website at http://www.aph.gov.au/Senate/committee/clac_ctte/pte_hth_2006/submissions/sublist.htm.

Broader Health Cover

As noted above, under Broader Health Cover health funds will be allowed to insure for out-of-hospital care-management programs. One advantage of this approach is that it will allow health insurers to become further involved in activities that may prevent illness and alleviate chronic disease among health fund members. This could also have the effect of reducing costs for both patients and the health funds (though, as will be discussed below, some commentators contest this proposition).

Further, Broader Health Cover will enable private health insurers to develop services more consistent with patient needs and contemporary clinical practice. According to the Centre for Health Economics Research and Evaluation (CHERE) in its submission to the Senate Inquiry into the Bill:

Currently, private hospital insurance can only cover those services that are performed inside the four walls of a hospital.³⁴ As a result, many patients seek in-hospital treatment in order to use their private health insurance when safe and suitable out-of-hospital services may exist at less cost for that particular treatment. The longstanding demarcation between what constitutes inpatient and outpatient care has, to some extent, prevented private hospital providers from introducing modern clinical practice care, for example, enabling a person with cancer to have chemotherapy in or out of hospital and still be covered by their private health insurance.³⁵

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CHERE describes the Government's intentions in allowing for private health insurance for non-hospital services as 'laudable' but suggests that they 'also carry the risk of some fairly fundamental (unintended) consequences'.³⁶ Concerns and criticisms identified by CHERE and others in relation to the implications of Broader Health Cover are discussed in the remainder of this section.

A two-tier health system?

Several commentators have raised the concern that 'general treatment' benefits under Broader Health Cover will create a 'two-tier' system because (apart from a small number of examples of hospital substitute treatment) benefits will not be available to those without private health insurance and hence reliant on Medicare.

For example, according to Dr John Deeble (one of the original architects of Medicare), Broader Health Cover may lead to:

... the development of a range of new medical services that could benefit patients but will not be available to those reliant on Medicare—and this could be primary care stuff like preventive health checks or what has traditionally been done in hospital, like chemotherapy or dialysis, but which can now be done outside hospitals in the community.³⁷

Similar concerns have been raised by Professor John Dwyer, former chairman of the Australian Healthcare Reform Alliance:

The real concern about extending the benefits to those with private health insurance is that you extend the inequality that is already in the system.

Allowing health funds to finance new ambulatory care is obviously going to be attractive to those rich enough to afford insurance, but in most cases it will only be attractive if the same care is not available under Medicare, where the subsidies are bigger—and that is where the problem lies.

In this respect, Broader Health Cover could be seen as an erosion of the principle of universalism in health care—a longstanding and fundamental principle of the health system.

A spokeswoman for the Minister for Health and Ageing responded to concerns about Broader Health Cover establishing a two-tier health system by stating that Medicare would continue to cover a 'comprehensive range of benefits', and that there are already items covered by private health insurance 'that are not picked up by Medicare, like optical and dental cover'.³⁸

This is correct, though it could be argued that the establishment of Broader Health Cover represents a significant expansion in the list of items covered by private health insurance but not by Medicare. Indeed, this may well be one of the advantages of Broader Health

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Cover from the point of view of the Government and the industry. Broader Health Cover is one way of making private health insurance more attractive to consumers—however, the attraction would be significantly diminished if the services in question could be accessed through Medicare.

As such, to some extent, the debate about Broader Health Cover represents a contest between the imperatives of universalism in healthcare and the need to ensure the future sustainability of the sector (by making private health insurance a more attractive product).

CHERE has also raised concerns that Broader Health Cover will blur the lines between inpatient and outpatient care and that this may cause/allow service providers and health insurers to respond with practices that segregate those with private insurance from those without.³⁹

Erosion of community rating

As noted above, private health insurance in Australia is regulated according to the principle of community rating—meaning that health funds may not discriminate on the basis of individual health risk.

The CHERE submission argues that Broader Health Cover will give health insurers greater flexibility to design products targeted at specific populations and set different prices for different products.⁴⁰ CHERE suggests that this would enhance the ability of insurers to engage in reducing the risk profile of the insured population.⁴¹ This is known as ‘cream-skimming’ because it involves attracting low-risk/low-cost members to a fund through financial or other incentives not available to high-risk/high-cost members. Such practices could be regarded as contrary to the principle of community rating in that they are inconsistent with the principle that those with higher risk-profiles should not be disadvantaged in relation to other purchasers of private health insurance.

Not far enough—further deregulation needed

Some commentators have suggested that the provisions in relation to Broader Health Cover are too restrictive and will inhibit insurers from being as innovative in product design as they might have been in a less regulated environment. For example:

- health system analyst Paul Gross has described the regulations surrounding Broader Health Cover as ‘excessive’ and suggested that they ‘may limit the full potential’ of the proposal,⁴²
- AHIA and BUPA have criticised the regulatory framework for Chronic Disease Management Programs for mandating a multi-disciplinary approach.⁴³ AHIA has described the framework as ‘too prescriptive’ and suggested that health funds should be allowed to ‘determine the most appropriate services required by their members’,⁴⁴ and

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- APHA argues that the definition of ‘hospital treatment’ in subclause 121(5)(1) is ‘unnecessarily restrictive’ and does not reflect the fact that private hospitals currently provide services that prevent hospitalisation and assist patients in managing their condition.⁴⁵ APHA has recommended an amendment to this clause to include the term ‘prevent’ (thereby making the definition: ‘hospital treatment is treatment that is intended to manage or prevent a disease, injury or condition and...’)⁴⁶

Interference in clinical decision-making

The AMA has argued that the Bill creates a number of opportunities for health funds to interfere in decision-making by healthcare providers. These include:

- ‘a good deal of discretion to the health funds under the General Treatment heading’
- ‘there are no default benefits for ‘general treatment’ so there is no certainty to providers of even minimum health insurer support without explicit health fund approval of arrangements’, and
- ‘the health funds will have increased capacity to support one provider over another based on criteria other than quality of care and outcomes’.⁴⁷

It is also worth noting that the regulatory framework for Broader Health Cover also specifies that there will be no default benefits for hospital-in-the-home care. The absence of default benefits raises the possibility that health insurers could seek to shift costs to the non-hospital sector. The Government has responded to these concerns by including clause 172(5), a clause aimed at ensuring the clinical independence of practitioners. However, the AMA believes that this clause needs to be strengthened by the addition of more detailed requirements that refer explicitly to the new types of arrangement facilitated by the Bill.⁴⁸

Quality and safety

APHA has raised concerns about the quality and safety arrangements for complying products in the Bill. While there are no details available, it appears that a uniform regime of quality and safety standards to apply to all privately insured services will be introduced in (yet to be drafted) Private Health Insurance (Accreditation) Rules. This regime will not commence until 1 July 2008. APHA’s concerns relate to the absence of information in the Bill concerning the ‘quality and safety regime that is to apply for the 15 month period from 1 April 2007 other than ensuring that a hospital is accredited (proposed subsection 121-5(7)(d))’.

APHA suggest that the absence of suitable interim arrangements (such as an interim certification requirement) ‘raises the prospect of services being funded under BHC for 15 months with no commitment to quality improvement and no guarantee of patient safety’. APHA also proposes that the accreditation arrangements include ‘services’ in addition to facilities and practitioners, in recognition of the fact that many Broader Health Cover services will not necessarily be delivered within a facility.⁴⁹

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In contrast, the AMA has urged caution in developing the new accreditation arrangements, suggesting that 'insisting that every program is accredited could be bureaucratically cumbersome, very expensive and only marginally improve the quality of care'.⁵⁰

Will not help contain costs

Several commentators have contested the proposition that Broader Health Cover will enable health insurers to contain costs through, for example, reducing the demand for acute hospital care.

For example, the AMA suggests several factors that it says will lead to increased costs under the new regime:

First, health funds have a very poor record of containing their own management costs. As they move to cover a wide range of diverse services, administration costs may rise even more quickly. Second, notwithstanding the intended limitations on what they can cover, the private health funds will be targeted for cost shifting by the public system as a result of the changes. Third, the Federal Government will find it very difficult to resist the temptation to put more financial responsibility on the private funds and therefore, ultimately, fund members.

In summary, these changes are not a panacea for financial stress facing the private health insurance industry. In fact, they may raise costs. Real sustainable change requires that insurers be able to offer fundamentally different products, for example, medical savings accounts.⁵¹

From a slightly different angle, academic, Ian McAuley, argues that extending private health insurance to illness prevention and health maintenance services under Broader Health Cover creates an incentive for people to rely on higher-cost, institutional modes of healthcare:

Whatever guidelines are developed, there will be a financial incentive for people to use those services which are covered by insurance, while there will necessarily be equally effective or better services excluded from insurance. For example, it appears to be the Government's intention to see insurance cover supervised exercise régimes, or dietary consultations, but these are high cost compared with self-help, such as unsupervised exercise or, say, internet-based diet research. Far from encouraging self-reliance, insurance for such services directs people's choice towards institutional means of attending to their health needs, with accompanying misallocation of resources. Such services, because of their discretionary nature, should not be covered by insurance.⁵²

In other words, McAuley suggests that, rather than reducing the overall cost of healthcare, Broader Health Cover actually may bring the possibility of higher cost into new areas of the health system.

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Comparative product information

Accessibility, usability

As noted above, Division 93 of the Bill requires health fund insurers to inform consumers on aspects of their policies. This information will be included in a consumer information website run by the PHIO. It is proposed that the website will provide up-to-date comparisons of private health insurance products and premiums.⁵³ A commercial online website that compares health insurance products is already operating; however it does not include all registered health funds.⁵⁴

One concern that might be raised relates to the accessibility of online information. For example, people in areas poorly served by broadband or internet access may find a website difficult to access, as might people on low incomes without computer access, and the elderly or vision impaired who may find computer-based services difficult to use. Alternative sources of information could also be considered to ensure as many consumers as possible will benefit from this measure. For example, Consumers' Health Forum of Australia (CHFA) has suggested that 'for people without web access, and for help with the website, an ongoing independent telephone support service will be needed'.⁵⁵ The Government could also consider a brochure available through Medicare offices as a further option. CHFA has also suggested that an interrogation function on the website would be welcomed by consumers.

Certainty about costs

Lack of certainty about the actual costs of using private health services has long been a source of concern among consumers. AHIA has also argued that cost certainty is an important issue that should have been addressed by the Bill:

Health funds strongly support all patients being given information prior to medical treatment in order for them to give Informed Financial Consent (IFC), in all but emergency cases. Unexpected out of pocket costs, caused by lack of informed financial consent—an area outside the control of health funds—is currently one of the major causes of discontentment with private health insurance ...

... In our view obtaining IFC should be required by legislation rather than relying on self-regulation, because of the importance of the issue and the need to ensure that it is resolved permanently, not just for the period of an education campaign.⁵⁶

CHFA has suggested that the PHIO website be used as part of a detailed communications strategy to better inform consumers about the expected costs of private health services.⁵⁷

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Extend information requirements to providers

AHIA has recommended that private health service providers (such as hospitals and doctors) also be required to provide certain types of information in order to better inform consumers:

Consumers should have access to information about the performance or success rates of hospitals and doctors so that they can make informed decisions about their own health. Such information should recognise the different types of patients and conditions involved, so that clinicians undertaking more complex or risky treatments are not penalised. We note that this approach has been recommended by the recent House of Representatives Standing Committee Report into Health Funding.⁵⁸

Such a requirement would most likely face opposition from health service providers concerned with issues such as privacy.

Premium increases

Approvals process

Possibly in light of continuing community concern over premium rises, the Private Health Insurance Exposure Draft Bill released in October 2006 proposed that health insurance premiums be set for one year.⁵⁹ This measure was likely to have protected consumers against irregular premium rises and ensure that 'insured persons can be sure of the costs of their health insurance for 12 months'.⁶⁰ In effect the Draft Bill proposed an 'annual contract' guaranteeing 12 month protection to consumers on premium rates.

However, when the final Bill was introduced to Parliament in December 2006 this measure had been dropped. In his second reading speech the Health Minister acknowledged that the government had previously announced that it would legislate to provide annualised health insurance contracts, 'so that a member would not face more than one rate adjustment in any one premium year'.⁶¹ But following 'extensive consultation' the government had decided not to proceed with the measure 'on the grounds of expense and efficiency' and rely instead on industry to practice 'responsible self-regulation'.⁶²

It should be noted, though, that (as can be seen from the Chart below) premium rises have continued to be above CPI under the current self-regulation arrangements. The current arrangement, whereby annual premium increases for private health insurance are announced by the Minister early each year, attract considerable media attention and often trigger complaints to the Private Health Insurance Ombudsman when larger rises occur.

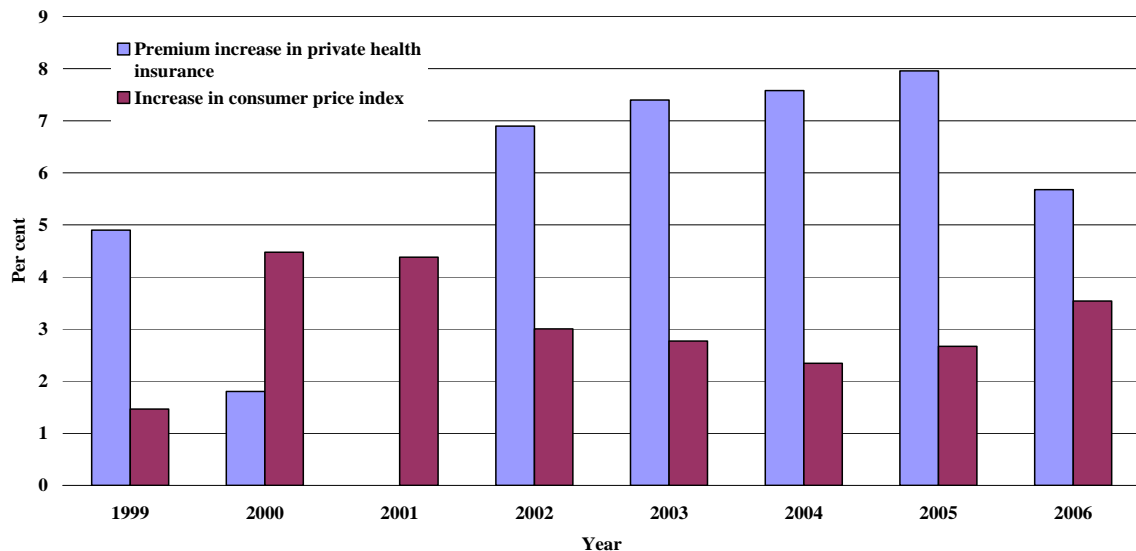
Under the Bill there is no restriction on the number of premium rises that can be sought by a health fund in any one year. Arguably, the dropping of the annualised contract measure represents a missed opportunity to improve consumer protection and restrict irregular, or multiple, premium rises.

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Chart 1: Comparison between annual percentage increases in private health insurance premiums and the consumer price index⁶³



The current arrangements governing premium increases were the result of reforms introduced in September 2002. These reforms allowed health funds to make annual adjustments to their premiums at or below the Consumer Price Index (CPI) with little fear that the Minister would disallow the increase.⁶⁴

Health funds seeking annual premium increases above the CPI rate were required to submit reasons to the Department for the premium change.⁶⁵ Further, the Health Minister was empowered under section 78 (4) of the National Health Act to disallow any premium increase if it was deemed not to be in the public interest. However, since 2001 no premium increases have been disallowed (although some have been subject to adjustment⁶⁶).

While the reforms announced in 2002 aimed to address consumer concerns over premium rises, some concerns remained. The Private Health Insurance Ombudsman (PHIO) continued to receive complaints over premium rises, although these declined in 2005.⁶⁷ However, PHIO viewed this decline in complaints as an indication that consumers “now expect health fund premiums to rise”.⁶⁸ Further, PHIO notes that price remains ‘the most important factor in consumers’ ‘key decisions about private health insurance’.⁶⁹ Premium rises are also extensively reported in the media, with a number of commentators criticising the last round of premium increases in 2006.⁷⁰ Premium rises for 2007 are yet to be announced, although media reports suggest they are expected to be lower than in previous years.⁷¹

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Ministerial approval of premium rises is retained under this Bill in Clause 66-10. Under the Bill any private health insurer wishing to change the premium amount for a complying health insurance product must apply to the Minister for approval at least 60 days before the change is due to come into effect. The Bill requires the Minister to approve the change unless any increase 'would be contrary to the public interest' (although this is not defined).⁷²

While the Minister retains final authority over premium rises, the Bill does not specify that funds must show justification for these rises. Nor does the Bill provide details of any criteria to be used by the Minister in making his decision, although the Health Minister has previously made a commitment to developing 'clear criteria' against which premium increases will be considered.⁷³

The AMA has questioned the retention in the Bill of the Government's power to regulate premiums, arguing that 'direct price regulation is ultimately distorting' and that the best method of price control is vigorous competition.⁷⁴

PHIAC and minimising premiums

Section 82BA(2)(c) of the National Health Act makes 'minimising the level of health insurance premiums' an objective of PHIAC. However, the Australian Physiotherapy Association (APA) notes that this clause has been removed from the Bill to the 'less explicit' requirement that PHIAC 'protect the interests of consumers'.⁷⁵ APA argues that minimising premiums remains 'vitaly important' and recommends that this remain an objective of PHIAC.⁷⁶

Regulation of funds

Registration issues

This Bill changes the registration requirements for private health funds. Section 126-10 requires that health insurers be registered corporations under the *Corporations Act 2001*, as well as with PHIAC. Under current arrangements health funds are required to be a company limited by shares, by guarantee, or by both shares and guarantee and registered as a health benefits organisation (RHBO) with PHIAC. This shift to registration under the *Corporations Act 2001* is not expected to be a problem for the industry as most funds are already incorporated. Further, the PHI transitional provisions and consequential amendments Bill (s 18-2 (b)) allows for those funds not registered with ASIC to do so by 1 July 2008.⁷⁷

Section 134-1 allows health insurers to have more than one health benefits fund, but also restricts them to one health insurance benefits fund per risk equalisation jurisdiction, unless the funds were established and registered before commencement of the Act (risk equalisation jurisdictions will be defined in the subordinate rules, but would be generally

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equivalent to current state and territory boundaries). Currently some health insurance funds operate only in one state, others operate nationally with varying levels of market share in each state, and some funds use different brand names in different jurisdictions (for example the national fund BUPA is branded as Mutual Community in South Australia and the Northern Territory and HBA in the other states).

While restricting health insurers to one fund per jurisdiction, the Bill allows for exemptions to the rule restricting health funds to one business per jurisdiction ‘to allow insurers flexibility’.⁷⁸ Under the exemption provisions it will be allowed to restructure the national fund into smaller entities while also keeping its separate state ‘branded’ funds.⁷⁹ These exemptions will be specified in the yet to be released subordinate Private Health Insurance (Health Benefits Fund Policy) Rules.

Arguably, smaller jurisdictions with fewer health funds will be more affected by the exemption provisions than larger jurisdictions. This could potentially have an impact on competition in these jurisdictions.

Other businesses allowed

A health fund must have as its dominant purpose the health insurance business, but Clause 134 allows for a health fund to operate other health related businesses (this was not previously allowed). The kinds of businesses that will be allowed can be any (or any combination) of the following:

- health related goods and services—for example, clinics and hospitals
- health insurance for people in Australia who are not eligible for Medicare – such as overseas students or visitors
- health related financial products—such as savings products to assist people meet the cost of healthcare.⁸⁰

By allowing for a wider range of health related business activity the Bill addresses industry suggestions for greater flexibility in developing products outside the current scope of health benefits.⁸¹ This broadening of business activity will be limited; the health insurer must divest itself of any health-related businesses as directed, if PHIAC is of the view that the health insurance business is no longer the dominant business.⁸²

Even so, allowing a health insurer to own medical clinics or hospitals while offering health insurance products raises some issues of potential concern. For example, it is unclear what impact any ownership might have on Hospital Purchaser Provider Agreements (HPPA). This is where health funds negotiate an agreement with a hospital or health provider on the price payable by the fund for an episode of care so that patients thus covered do not pay a ‘gap’. In the past Australian Competition and Consumer Commission (ACCC) has raised concerns over ongoing disputes between providers (mainly private hospitals) and the health funds, and the ‘disuse’ of the voluntary code of conduct that is meant to govern

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these negotiations.⁸³ While ownership arrangements may assist policy holders who are covered by a health fund that has an ownership interest in a particular hospital or with a particular provider, it may disadvantage policy holders from other health funds who maybe shut out of an agreement, particularly those in regional locations where hospital choice is limited. Under the current Bill there are no disclosure provisions requiring the health insurer to advise consumers of all their other health related business activities. Arguably, such disclosure would assist consumers in making an informed choice.

The AMA has raised concerns about the involvement of private health insurers in the provision of care, arguing that there are 'fairly obvious conflicts of interest'.⁸⁴ It has recommended that provisions be added to the Bill to 'more clearly establish this separation', arguing that 'it is not sufficient to do this via business rules or other subsidiary legislation'.⁸⁵

Mergers and Acquisitions

The Bill allows for an insurer to restructure, merge or acquire a health benefits fund by gaining approval from PHIAC. Provisions under section 146 allow for a fund to restructure or merge by changing the health benefits fund to which a health fund policy is referable. PHIAC is required to approve an application as long as it is reasonable and will not result in unfairness to the current or future policy holders, and provided it does not breach any solvency or capital standards. Any acquisition of a fund by another fund must also meet the requirements under section 134-1 that limit the number of health benefits funds that can exist in a particular risk equalisation jurisdiction.

In addition to these provisions, any merger and acquisition activity would most likely attract the attention of the ACCC. Whilst the Bill does not expressly preserve the operation of Section 50 of the *Trade Practice Act 1974*, there does not appear to be any intention to exclude it. Mergers of private health insurers have come under ACCC scrutiny in the past. Most recently the ACCC approved the acquisition of NRMA Health by MBF in July 2003.⁸⁶ A former Commissioner has suggested that any merger activity between the market leaders would attract 'very close scrutiny' from the ACCC:

We would be concerned in respect of merger proposals by any of the top five or six of the health funds, particularly amongst themselves ... It would require very close scrutiny. And in some instances, depending on whether the market is state or national, even one of the top five or six merging with one of the smaller funds may require us to have a look at it.⁸⁷

Divisions 140 and 143 of the Bill provides for PHIAC to set standards in relation to solvency and capital adequacy (which may be different for different health funds), and to grant exemptions and give directions. The Bill requires health insurers to comply with solvency and capital standards, and for PHIAC to enforce these standards.

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Making of rules

Clauses 333-20 and 333-25 of the Bill provide for the making of subordinate private health insurance rules as legislative instruments by the Minister and PHIAC (respectively). Health insurer MBF has recommended that requirements be included in the Bill relating to how and when these rules can be made.⁸⁸

Financial implications

According to the Explanatory Memorandum, there will be no financial impact for government from this legislation. Funding for these initiatives was announced in the last Budget by the Health Minister.⁸⁹ According to the Budget papers more than \$61 million has been allocated over four years to implement the private health insurance reforms.

The Table below shows the budget breakdown of the \$61.8 million total allocated for the package.

| Measure | 2006-07 | 2007-08 | 2008-09 | 2009-10 |
|-----------------------------|---------|---------|---------|---------|
| PHI Regulation | 1.3 | 1.1 | 0.7 | 0.3 |
| PHI enhanced choices | 9.7 | 18.1 | 10.7 | 15.3 |
| PHI improvement to products | 1.9 | 1.0 | 0.7 | 1.0 |
| Total | 12.9 | 20.2 | 12.1 | 16.6 |

Source: 2006-07 Budget⁹⁰

Main provisions

As noted above, this Bill replaces the current regulatory regime for private health insurance (contained mainly in the National Health Act, Health Insurance Act and Private Health Incentives Act) with a new regime contained within the one Act.

Chapter 1 addresses preliminary matters such as commencement of the Bill (Clause 1-5), definitions (Clause 1-10), the structure of the Bill (Clauses 3-1 to 3-30) and Constitutional matters (Division 5).

Chapter 2 provides for the measures designed to encourage people to purchase private health insurance. These include the Private Health Insurance Rebate (Divisions 23 and 26)

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and Lifetime Health Cover (Division 31). The provision (outlined above) removing Lifetime Health Cover Loadings from people who have paid a loading for ten continuous years is in Clause 34-10.

This Division also seeks to simplify the rules for determining a person's status for the purposes of Lifetime Health Cover. A flow chart for working out a person's Lifetime Health Cover 'base day' can be found in Clause 34-25.

Chapter 3 sets out the rules for complying health insurance products under the new regime. These include adherence to the principle of community rating, and requirements relating to premiums, benefits, waiting periods, portability, quality assurance and the provision of certain information.

Community rating provisions (Part 3-2) are essentially the same as in the National Health Act but with minor changes, such as the addition of a new provision allowing insurers to determine a person's entitlement to benefits for general treatment (other than hospital substitute treatment) by reference to the amount already claimed by that person during 'a period' (unspecified in the PHIB) (Division 55-5(2)(g)).

The role of the Minister for Health and Ageing in approving premium increases for complying health insurance products (discussed above) is set out in Clause 66-10.

Coverage requirements for complying health insurance products are established in Clause 69-1. Broader Health Cover is introduced in 69-1(1)(b) ('specified treatments that are hospital treatments and specified treatments that are general treatment').

The requirements on insurers to provide certain types of information to consumers, the Department of Health and Ageing, PHIAC and PHIO can be found in Division 93. These include the new standard information statements discussed above (Clauses 93-1, 93-5, 93-10, 93-15 and 93-20).

Chapter 4 provides for various obligations on those registered to carry out private health insurance. Key provisions include:

- prohibition on carrying on health insurance business without registration (Clause 118-1)
- definition of health insurance business, including the meanings for 'hospital treatment' and 'general treatment' (Division 121)
- the process for registering a health insurance business (Division 126)
- the requirement that those registered to carry out private health insurance must have health benefits funds (Clause 134-1)
- requirements related to the establishment (Clause 134-5), operation (Division 137), merger (Division 146) and termination (Division 149) of health benefits funds.

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These provisions largely replicate provisions in existing private health insurance legislation but in simplified and clarified form.

Chapter 5 provides for enforcement of the Bill by the Minister and PIAC. It includes a new broad offence provision in Clause 84-1, directed at dealing in non-complying health insurance policies. Offenders will be liable for a fine of up to 1000 penalty units (\$110 000) or 5 years imprisonment. Where a corporation commits this offence, its directors or CEO can be personally liable to the same penalties but only where they ‘failed to exercise due diligence to ensure that adequate systems were in place to prevent the insurer from committing the offence’ (Clause 84-5).

Chapter 6 includes a range of administrative provisions. These include establishment of PHIO (Part 6-2) and PHIAC (Part 6-3) and the making of subordinate private health insurance rules as legislative instruments (Clauses 333-20 and 333-25). As noted above, health insurer MBF has recommended that the Bill be amended to include requirements regarding any changes to the Bill through the rules.⁹¹

Schedule 1 provides a dictionary defining terms used in the Bill.

Concluding comments

This is a large and comprehensive Bill that creates a new regime for the regulation of private health insurance. The Bill has been developed over many months following consultation with the industry. Much of the Bill is relatively uncontroversial but some changes have attracted criticism.

The creation of a new (simplified and clarified) regulatory regime appears to be broadly supported by the industry and other groups, though (as discussed above) not without reservation in relation to particular provisions. The provisions requiring health insurers to produce standard information statements for consumers also appear to be supported by consumers (though, the CHFA has suggested some improvements) and others but the health insurance industry body (AHIA) would like to see similar requirements extended to private health care providers. While this would most likely be opposed by providers, it could be argued that such requirements would be consistent with the Government’s objective to improve the nature and extent of information available to consumers.

The proposed introduction of Broader Health Cover has been the most controversial aspect of the Bill. The Government argues that this is a ‘groundbreaking change’ that will allow health insurers to ‘develop more flexible and innovative products that reflect modern clinical practice and consumer expectations’.⁹² Much of the industry appears to support the general thrust of Broader Health Cover, though some have concerns about particular aspects of the regulatory framework within which it is being introduced. For example, the private hospitals industry body (APHA) have concerns about the quality and safety regime and (along with the AMA) the potential for interference in clinical decision-making, while

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the health insurance industry and others have argued that aspects of the rules for Broader Health Cover are too restrictive and may inhibit innovation.

Some critics of Broader Health Cover have emphasised what they see as significant technical problems and/or unintended consequences. These include possible erosion of the principles of universality and community rating and rejection of the proposition that Broader Health Cover will help restrain health system costs.

Given the above, there are two fundamental questions in relation to Broader Health Cover that may be worth asking. First, will it deliver the kinds of improvements (for example, in relation to industry sustainability) foreshadowed by the Government and industry supporters of the Bill? Second, does Broader Health Cover amount to a significant erosion of universality and/or community rating or just small changes of emphasis (perhaps justifiable by the potential gains)?

Endnotes

1. Information in this section adapted from L. Buckmaster and J. Davidson, *The proposed sale of Medibank Private—historical, legal and policy perspectives*, pp. 14-15.
2. PHIAC, *Operations of the Registered Health Benefits Organisations Annual Report 2005–06*, Canberra, 2006, p. 21.
3. PHIAC, *Operations of the Registered Health Benefits Organisations Annual Report 2005–06*, op. cit., p. 21.
4. Standard and Poor's, *Australian Health Insurance Report 2006*, Standard and Poor's, Melbourne, 2006, p. 24.
5. PHIAC, *Operations of the Registered Health Benefits Organisations Annual Report 2005–06*, op. cit., pp. 1, 23.
6. *ibid.*, p. 1.
7. *ibid.*, p. 23.
8. *ibid.*, p. 1.
9. PHIAC, *Operations of the Registered Health Benefits Organisations Annual Report 2004–05*, op. cit., p. 3.
10. For example, see J. Breusch, 'Soaring sharemarket keeps lid on health premiums', *Australian Financial Review*, 3 January 2007.
11. PHIAC, *Operations of the Registered Health Benefits Organisations Annual Report 2005–06*, op. cit., p. 21.
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13. P. Gross, 'Radical reform of Medicare and private health insurance inevitable, says Gross', *Healthcover*, December 2002—January 2003, pp. 40–41; I. McAuley, *Stress on public hospitals—why private health insurance has made it worse*, Discussion paper for the Australian Consumers' Association and the Australian Healthcare Association, January 2004, p. 14.; S. Leeder and I. McAuley, 'Why health insurance is unsustainable', *New Matilda*, 1 June 2005, p. 1. See also the discussion in A. Pratt, *Public versus private? An overview of the debate on private health insurance and pressure on public hospitals*, Parliamentary Library, Research Note, 20 June 2005, no. 54, 2004–05.
14. See, for example A. Kinna, 'Private health insurance: the sad history of a system in crisis', *Online Opinion*, 26 February 2003, p.3. Ian Harper has described this situation, in which, the 'sick' members of PHI funds are increasingly required to fund the 'healthy' as inconsistent with the principles of community rating and has used this as a defence for government measures to increase PHI coverage such as the PHI and Lifetime Health Cover. See I. Harper, *Preserving choice: a defence of public support for private health care funding in Australia*, Harper and Associates (for Medibank Private), 1 January 2003, p. 6.
15. P. Gross, 'Radical reform of Medicare and private health insurance inevitable, says Gross', op. cit., p. 41; I. McAuley, 'Behind the smokescreen—here comes the nanny corporation to manage our bodies', *New Matilda*, 3 May 2006, p. 1; K. Harvey, 'The sale of Medibank Private', *New Matilda*, 1 March 2006, p. 3; Standard and Poor's, *Australian Health Insurance Report 2006*, op. cit., p. 9.
16. Explanatory Memorandum, p. 5.
17. Explanatory Memorandum, p. 5.
18. Explanatory Memorandum, p. 5.
19. Explanatory Memorandum, p. 2.
20. Hon. Tony Abbott, 'Private Health Insurance Bill 2006—Second reading speech', House of Representatives, *Debates*, 17 December 2006, p. 2.
21. A draft of these Rules is available from the Department of Health and Ageing website at [http://www.health.gov.au/internet/wcms/publishing.nsf/Content/C7D79F13DA8CE477CA257273001C5DED/\\$File/1170222156-MicrosoftWord-115820894_0418121_KLR01_HealthInsuranceBusinessRules2007.DOC.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/C7D79F13DA8CE477CA257273001C5DED/$File/1170222156-MicrosoftWord-115820894_0418121_KLR01_HealthInsuranceBusinessRules2007.DOC.pdf) (accessed 7 February 2007).
22. Hon. Tony Abbott, 'Private Health Insurance Bill 2006: Second reading speech', op. cit., p. 2.
23. *ibid.*
24. PHIAC, *Insure? Not sure? Your guide to private health insurance*, at <http://www.phiac.gov.au/insurenotsure/pdf/insure.pdf>, accessed 16 January 2007.
25. Hon. Tony Abbott, 'Private Health Insurance Bill 2006—Second reading speech', op. cit., p. 3.
26. *Private Health Insurance Bill 2006: Explanatory memorandum*, p 17.
27. Explanatory Memorandum, pp. 9, 12-13.

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28. Explanatory Memorandum, p. 13.
29. Explanatory Memorandum, p. 2.
30. PHIAC, *Operations of the Registered Health Benefits Organisations Annual Report 2005–06*, op. cit., p. 12.
31. Explanatory Memorandum, p. 12
32. *ibid.*
33. *ibid.*
34. The CHERE submission notes that ‘whilst ancillary insurance covers some outpatient services such as optical products, dental care and physiotherapy, they typically do not cover services that could be regarded as substitutes for in-hospital care such as dialysis and chemotherapy’. Centre for Health Economics Research and Evaluation (CHERE), *CHERE Submission to the Senate Community Affairs Committee Inquiry into the Private Health Insurance Bill 2006 [Provisions] And Related Bills*, Submission no. 13, January 2007, p. 4.
35. *ibid.*
36. *ibid.*, pp. 9, 4.
37. Quoted in P. Smith, ‘Fears of two-tier medical system’, *Australian Doctor*, 3 November 2006.
38. *ibid.*
39. CHERE, op. cit., pp. 8-9.
40. CHERE, op. cit., p. 6.
41. CHERE, op. cit., p. 6.
42. P. Gross, *Demutualisation of Medibank Private and new government push for health insurance for out-of-hospital care might accelerate medical savings accounts and healthier lifestyles*, media release, 21 October 2006.
43. See DoHA, *Broader Health Cover Regulatory Framework*, Private Health Insurance Circular, PHI 78/06, 15 December 2006, p. 4.
44. Australian Health Insurance Association (AHIA) *AHIA Submission to the Senate Community Affairs Committee, Private Health Insurance Bill 2006*, Submission no. 7, 25 January 2007, p. 2.
45. Australian Private Hospitals Association (APHA), *Submission by the Australian Private Hospitals Association for the Private Health Insurance Bill 2006*, Submission no. 11, 25 January 2007, p. 5.
46. *ibid.*
47. *ibid.*
48. Australian Medical Association (AMA), *Submission to the Senate Community Affairs Committee on the Private Health Insurance Bill 2006 (provisions) and related Bills*, Submission no. 14, January 2007, p. 6.

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49. APHA, op. cit., p. 2.
50. AMA, op. cit., p. 8.
51. *ibid.*, p. 3.
52. Ian McAuley, *Private Health Insurance Bill 2006 and related Bills: Submission by Ian McAuley, Adjunct Lecturer in Public Sector Finance, University of Canberra*, Submission no. 2, January 2007, p. 2.
53. Hon. Tony Abbott, *Greater choice in private health*, media release, 9 May 2006.
54. The website URL is www.iselect.com.au accessed 18 January 2007. It currently provides product recommendations for 4 health funds.
55. Consumers' Health Forum of Australia (CHFA), *Inquiry into Private Health Insurance Bill 2006 (provisions) and related Bills Senate of Australia (Community Affairs Committee)*, Submission no. 10, January 2007, p. 2.
56. AHIA, op. cit., p. 5.
57. CHFA, op. cit., p. 2.
58. AHIA, op. cit., p. 4.
59. *Private Health Insurance Bill 2006 (Exposure Draft)*, Clause 66-5.
60. Department of Health and Ageing (DoHA), *Private Health Insurance Bill 2006: Guide to the Exposure Draft*, October 2006, p 6.
61. Hon. Tony Abbott 'Private Health Insurance Bill 2006: Second Reading Speech', op. cit. p. 3.
62. *ibid.*
63. Note that no premium increases were allowed in 2001. Chart produced by Greg Baker, Statistics and Mapping Section, Parliamentary Library.
64. Senator the Hon. K Patterson, *Private health reforms to deliver better value for money for fund members*, media release, 11 September 2002.
65. DoHA, Private health circulars HBF 796 PH525 and HBF 805; See Schedule 1B, HBF 805.
66. See for example, Hon. Tony Abbott, *2006-07 Private Health Insurance Premiums*, media release, 24 February 2006.
67. Private Health Insurance Ombudsman (PHIO), *State of the health funds report 2005*, PHIO, Sydney, p. 6.
68. *ibid.*
69. *ibid.*
70. See for example Ruth Pollard 'Health fund fees up 33% in five years' *Sydney Morning Herald*, 25 February 2006; Annabel Stafford 'Health premiums streak past inflation' *Australian Financial Review*, 25 February 2006.
71. See for example John Breusch 'Medicare surcharge income test to stay' *Australian Financial Review* 10/1/2007; Laura Anderson 'Huge claims on health funds' *The Advertiser*, 10/1/2007.

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72. *Private Health Insurance Bill 2006*, Clause 66-10(3).
73. 'The requirement of ministerial approval for premium increases will remain but there will be clear criteria against which applications for increases will be considered'. Hon. Tony Abbott and Hon. Nick Minchin, *More innovations, greater choice in private health*, Media release, 26 April 2006.
74. AMA, op. cit., p. 4.
75. Australian Physiotherapy Association (APA), *APA Submission to the Senate Community Affairs Committee Inquiry into the Private Health Insurance Bill 2006 [Provisions] and Related Bills*, Submission no. 5, January 2007, p. 11.
76. *ibid.*
77. As far as we can determine two funds are not currently incorporated; these are ACA Health (a restricted membership fund) and HIF WA.
78. DoHA, *Private Health Insurance Bill 2006: Guide*, December 2006, p. 6.
79. *ibid.*
80. *ibid.*
81. DoHA, *Discussion paper – private health insurance: cover innovation and regulatory reform*, Private Health Insurance Circular, PHI 34/06, 15 June 2006, p 11.
82. See the Bill, Clause 134-10.
83. The Australian Competition and Consumer Commission (ACCC) has noted ongoing problems with HPPA contracting in its most recent Report to the Senate: *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance for the period 1 July 2005 to 30 June 2006*, ACCC, Dickson, ACT, 2006, p 20. For specific examples see its comments on 'take it or leave it' threats in negotiations between health funds and hospitals in its 2003 report. ACCC, *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance for the period 1 January 2002 to 30 June 2003*, ACCC, Dickson, ACT, 2003, section 4.3.
84. AMA, op. cit., p. 9.
85. *ibid.*
86. ACCC, *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance for the period 1 January 2002 to 30 June 2003*, op. cit.
87. S. Bhojani, 'The sale of Medibank Private: gone but not forgotten', *HealthCover*, 13:4, 2003, p. 44.
88. Medical Benefits Fund of Australia (MBF), *Submission to the Senate Community Affairs Committee Inquiry into the Private Health Insurance Bill 2006 [Provisions] And Related Bills*, Submission no. 13, January 2007, p. 15.
89. Hon. Tony Abbott, *Greater choice in private health*, op. cit.

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90. Hon. Peter Costello, *Budget Measures 2006-07: Budget Paper no. 2*, pp 278-279.
91. MBF, op. cit., p. 17.
92. Hon. Tony Abbott, *Second reading speech*, op. cit., p. 2.

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