

EXPLANATORY STATEMENT

Issued by the Authority of the Minister for Health

Private Health Insurance Act 2007

Private Health Insurance (Complying Product) Amendment (Psychiatric Care) Rules 2018

Authority

Section 333-20 of the *Private Health Insurance Act 2007* (the Act) authorises the Minister for Health, by legislative instrument, to make *Private Health Insurance (Complying Product) Rules*, providing for matters required or permitted by Chapter 3 and/or section 188-1 of the Act, or providing for matter necessary or convenient in order to carry out or give effect to Chapter 3 and section 188-1 of the Act (refer to Item 3 of the Table).

The purpose of the *Private Health Insurance (Complying Product) Amendment (Psychiatric Care) Rules 2018* (the Amendment Rules) is to implement the mental health reform announced by the Government on 13 October 2017 as part of a package of reforms designed to make private health insurance simpler and more affordable for Australians. The mental health reform introduces enhanced mental health support from 1 April 2018 to make it easier for policyholders to access mental health services when they need them. These rules cover psychiatric treatment that is mental health treatment or addiction medicine.

The Amendment Rules establish revised “waiting period” requirements for benefits for hospital treatment or hospital-substitute treatment that is psychiatric care. Psychiatric treatment covered by these Rules is treatment provided to a person who is admitted to hospital and under the care of an addiction medicine specialist or consultant psychiatrist. Patients with limited cover for psychiatric care will be entitled to upgrade their cover without serving a waiting period to access higher benefits for specialist psychiatric treatment on a once-off basis¹ under the new policy. This entitlement is described throughout this Explanatory Statement as the “waiting period exemption”. The Amendment Rules also prevent an insurance policy from imposing conditions within a policy that limit the number of psychiatric treatments a patient can access, or limit the number of a particular kind of psychiatric treatment a patient can access, during a period of time.

The Amendment Rules commence on 1 April 2018.

The Amendment Rules are a legislative instrument for the purposes of the *Legislation Act 2003*.

Details

Details of the Amendment Rules are set out in **Attachment A**.

Consultation

On 7 February 2018, private health insurance funds and their peak associations were provided a ten day period to review and provide comment on an exposure draft of the Amendment Rules. The Department of Health received comment from nine private insurance funds and the industry’s two peak associations. The Department sought to incorporate the relevant drafting feedback that was received into the final version of the Amendment Rules.

¹ “Once-off basis” means a person is only entitled to access a waiting period exemption once in their lifetime.

Regulatory impact assessment

The Department of Health has prepared a Regulatory Impact Statement (RIS) on the Private Health Insurance Reform Package announced by the Government on 13 October 2017. This is at **Attachment B**.

Statement of Compatibility with human rights

Subsection 9(1) of the *Human Rights (Parliamentary Scrutiny) Act 2011* requires the rule-maker in relation to a legislative instrument to which section 42 (disallowance) of the *Legislative Instruments Act 2003* applies to cause a statement of compatibility to be prepared in respect of that legislative instrument. The Statement of Compatibility has been prepared to meet that requirement. The Statement of Compatibility is included at **Attachment C**.

DETAILS OF THE *PRIVATE HEALTH INSURANCE (COMPLYING PRODUCT) AMENDMENT (PSYCHIATRIC CARE) RULES 2018*

Section 1 Name

Section 1 provides that this instrument is the *Private Health Insurance (Complying Product) Amendment (Psychiatric Care) Rules 2018* (the Amendment Rules).

Section 2 Commencement

Section 2 provides that the Amendment Rules commence on 1 April 2018. Subsection 2(2) provides that any information in column 3 of the table in this section is not part of this instrument. However, information may be inserted in this column, or information in it may be edited, in any published version of this instrument.

Section 3 Authority

Section 3 provides that the Authority for this instrument is the *Private Health Insurance Act 2007* (the Act).

Section 4 Schedules

Section 4 provides that an instrument that is specified in a Schedule to the instrument (the Amendment Rules) is amended or repealed as set out in the applicable items in the schedule concerned. There is only one schedule contained within the Amendment Rules.

Schedule 1 – Amendments

Private Health Insurance (Complying Product) Rules 2015

Item 1 Rule 4

This item inserts definitions of the following terms: addiction medicine specialist, consultant psychiatrist, period of pre-upgrade hospital cover, psychiatric treatment, specialist psychiatric treatment, and upgrade to rule 4 of the *Private Health Insurance (Complying Product) Rules 2015* (the Principal Rules).

Note: ‘Psychiatric treatment’ is identified as meaning hospital treatment, or hospital substitute treatment, that is psychiatric care. Psychiatric treatment encompasses services that are mental health treatment and addiction medicine (drug and alcohol treatment). As such, the waiting period exemption applies to both mental health treatment and addiction medicine.

Item 2 Rule 4 (note)

This item inserts the word “transfer” into the Note under Rule 4 of the Principal Rules, which sets out a range of defined terms that have the meaning set out in the Act.

Item 3 Subrule 5A Psychiatric treatment – limitations

This item inserts a new Rule 5A to the Principal Rules which prevents an insurance policy from imposing as a condition of the policy, limitations on the number of psychiatric benefits a person can access during a period (for example over a 12 month period). A policy must not impose limitations, in the form of a reduction in benefit for psychiatric care, because of the number of treatments a patient has accessed, or the number of a particular kind of treatment a patient has accessed, during a period of time.

Sub-rule 5A does not extend to regulating the commercial terms of agreements or contracts between private health insurers and health care providers. For example, it does not preclude a private health insurer and a hospital from negotiating step-down payment arrangements as part of an agreed psychiatric treatment program.

Item 4

This item inserts new Rules 9A and 9B to the Principal Rules outlining the conditions and requirements for the application and utilisation of the once-off waiting period exemption.

Subrule 9A Specialist psychiatric treatment – portability requirements

The waiting period exemption is portable. That is, a person may choose to use the exemption when upgrading to new policy with their current insurer or a new policy with a different insurer. Subrule 9A establishes four portability requirements that apply to the waiting period exemption.

Consumer choice to elect to utilise the waiting period exemption

Subrule 9A(1)(a)(ii) identifies there is a requirement for a consumer to choose to utilise the waiting period exemption. This means that utilisation of the waiting period exemption is not compulsory. A person has the ability to choose whether the waiting period exemption is activated for specialist psychiatric treatment occurring within two months of a transfer that is an upgrade. That is, a person has the ability to choose to either:

- utilise the once-off exemption and receive higher benefits for the admission; or
- not use the exemption, receive the lower benefits they were entitled to under their old policy for that admission, and retain the ability to exercise the exemption at a later time.

Subrule 9B (discussed below) provides further detail on the evidence which is taken to show that a person has chosen to utilise the exemption.

Policy transfer that is an upgrade

Subrule 9A(2) specifies that a transfer between private health insurance policies is considered to be an upgrade for the purposes of the waiting period exemption if the benefit for psychiatric treatment under the new policy is higher than the benefit for psychiatric treatment under the old policy.

Subrule 9A(3) deals with instances where a person upgrades to a new policy with a different co-payment and/or excess than their old policy. For clarity, this subrule indicates that, for the purposes of determining whether a transfer is an upgrade, any excess or co-payment under the old or new policy is to be disregarded.

Period of pre-upgrade hospital cover

Subrules 9A(4) and 9A(5) establish a definition of a “period of pre-upgrade hospital cover”. This term refers to the length of prior hospital coverage that must exist for a person to become entitled to higher benefits for specialised psychiatric treatment following an upgrade to a new policy.

Under these sub-rules the new policy must not apply any waiting period for the higher benefit if the person had hospital cover immediately before the upgrade for two months or more, that is, where the length of the person’s period of pre-upgrade hospital cover is two months or more.

In instances where a person’s period of pre-upgrade hospital cover is less than two months, an insurer is permitted to require that the person serve the remaining balance of the two month psychiatric care waiting period permitted under the section 75-1(b) of the Act before that person is eligible for higher benefits for specialist psychiatric treatment.

Retrospective cover provisions

Subrules 9A(6) to (8) establish retrospective cover provisions for the waiting period exemption. If a person upgrades their policy within five business days of their admission for specialist

psychiatric treatment, then their increased cover and payment of higher benefits will apply retrospectively to the day of the admission. The person must pay the appropriate premium to cover the retrospective period.

The retrospective period will only apply for policy upgrades that occur within five business days starting on the day the person was admitted to hospital for psychiatric treatment. If the day of admission is not a business day, then the day of the admission is not included in the count of five days for the purpose of retrospective cover. The intent of including a five day retrospective period as part of the waiting period exemption is to allow people who have been newly admitted to hospital time to:

- decide whether to upgrade their policy;
- decide whether to utilise the once-off exemption; and
- facilitate transferring from their old policy to a new policy.

The five day retrospective period is intended to help balance flexibility for consumers, who may not be able to make a decision about upgrading their policy before or at the point of their admission, against financial risk and uncertainty for hospitals and insurers.

After the first five business days of an admission have passed, consumers would still be able to choose to upgrade their policy and to utilise their waiting period exemption, but they would only be eligible for higher benefits paid under the new policy from the date they purchase the upgraded cover, (that is, there would be no retrospective cover).

Subrule 9B Specialist psychiatric treatment – choice to have upgraded in accordance with rule 9A

Subrule 9B specifies the once-off nature of the waiting period exemption and the evidence taken to show the waiting period exemption has been utilised.

Once off utilisation of the waiting period exemption

Subrule 9B(1) specifies that a person may choose to have an upgrade treated in accordance with subrules 9A(4) to (8) if they have not previously made such a choice in relation to any upgrade. This subrule means that a person can only utilise the waiting period exemption once in their lifetime. However, it should be noted that Section 75-1 of the Act specifies the *maximum* waiting periods that an insurance policy may apply for particular types of treatments or conditions. The identified waiting periods are not mandatory and an insurer may choose to waive these waiting periods at any time. Subrules 9A and 9B do not prevent an insurer from choosing to waive waiting periods for a benefit for hospital treatment or hospital-substitute treatment that is psychiatric care. Insurers have discretion to waive psychiatric care waiting periods, including for persons who have already utilised the waiting period exemption established by subrules 9A and 9B. However, where this occurs, it would not be considered as a waiting period exemption under subrule 9B(3).

Subrule 9B(2) sets out the conditions for establishing whether a person has chosen to utilise the exemption and the evidence which is taken to show that the exemption has been utilised. There are three conditions identified within this subrule:

- a person transfers to an insurance policy (the new policy), and the transfer is an upgrade in relation to psychiatric treatment; and
- a claim is made under the new policy for a benefit for specialist psychiatric treatment provided to the person; and
- a benefit of the amount claimed would only have been payable under the new policy for the treatment if the person had chosen to have the upgrade treated in accordance with subrules 9A(4) to (8).

The making of a claim for higher specialist psychiatric benefits under the new policy is taken as sufficient evidence that a person has chosen to utilise the exemption.

Part 5 – Transitional provisions

Rule 19 Transitional provisions relating to the Private Health Insurance (Complying Product) Amendment (Psychiatric Care) Rules 2018

Rule 19 is a new Rule within the Principal Rules which establishes transitional provisions regarding policy upgrades and/or admissions for specialised psychiatric treatment which occur prior to the commencement of the Amendment Rules on 1 April 2018.

Policy upgrades prior to 1 April 2018

Subrule 19(2) clarifies that the waiting period exemption established by subrule 9A(4) applies whether an upgrade occurs before, on, or after 1 April 2018. The primary purpose of this subrule is to make clear if a person upgraded their policy prior to 1 April 2018, and their length of pre-upgrade hospital cover at that time was longer than 2 months, the person is eligible to utilise the waiting period exemption and to access higher benefits for specialist psychiatric treatment from 1 April 2018.

Where a person upgraded their policy prior to 1 April 2018, and their length of pre-upgrade hospital cover at that time was less than 2 months, an insurer is permitted to require that the person serve the remaining balance of the two month psychiatric care waiting period permitted under the section 75-1(b) of the Act before that person is eligible for higher benefits for specialist psychiatric treatment.

Retrospective cover for upgrades occurring before 1 April 2018

Subrule 19(3) clarifies that the retrospective cover provisions established in subrules 9A(6) to (8) only apply to an upgrade that occurs on or after 1 April 2018. This means that the retrospective cover arrangements do not apply to upgrades that occurred prior to 1 April 2018.

Persons already admitted and receiving specialist psychiatric treatment on 1 April 2018

Subrule 19(4) requires that in instances where an upgrade has occurred and a person was admitted to hospital for specialist psychiatric treatment before 1 April 2018, and is still an admitted patient in relation to the treatment on 1 April 2018, higher benefits for the treatment are only payable from 1 April 2018. Higher benefits for the period of the admission before 1 April 2018 will not be paid.

Subrule 19(5) specifies that if the application of the retrospective cover provisions were to result in the starting date of a new policy's cover being prior to 1 April 2018, the starting date of the cover is taken to require the coverage to start no later than 1 April 2018. This has the effect that higher benefits are not paid for any part of an admission prior to 1 April 2018.

Below are some example scenarios of how the retrospective cover provisions would be applied in the following scenarios where a person upgrades their policy and is admitted for specialist psychiatric treatment prior to 1 April 2018.

- If a person was in hospital receiving specialised psychiatric treatment on 30 March 2018 and upgraded their policy on 31 March 2018, they would only be eligible for higher benefits under the new policy from 1 April 2018.
- If a person upgraded their policy on 10 March 2018, and was admitted to hospital for specialised psychiatric treatment on 28 March 2018, they would only be eligible for higher benefits under the new policy from 1 April 2018.

- If a person was in hospital receiving specialised psychiatric treatment on 30 March 2018, and upgraded their policy on 3 April 2018, their retrospective cover under the new policy (that is eligibility for higher psychiatric benefits) would only go back to 1 April 2018.

Regulation Impact Statement (RIS)

Name of Proposal: Private Health Insurance Reforms

Office of Best Practice Regulation (OBPR) ID number: 22741

Note: The announcement of the reform package (described in detail in Section 3) limits the scope of this RIS. This RIS considers two options: the implementation of the reform package as a whole, and the status quo.

1 What is the policy problem you are trying to solve?

Decline in private health insurance participation

Private Health Insurance is a key part of Australia's health system providing choice for 13.5 million Australians. As at 31 December 2017, 11.3 million Australians were covered by hospital treatment cover (45.6 per cent of the population) and 13.54 million Australians had some form of general treatment cover (54.6 per cent of the population). General treatment is also known as extras or ancillary cover which includes services such as optometry and dental. While in 2018, there was the lowest average weighted premium increase in almost 17 years, at 3.95 percent, in the past nine consecutive quarters coverage has declined in proportion terms and in the December 2017 quarter has declined by about 20,000 people compared with the same quarter in 2016. If this trend continues it may signal the start of a decline in coverage similar to that seen in the 1990s when hospital insurance dropped from 45 percent to 30 percent of the population over the decade. That decline was only arrested by the introduction of the premium rebate (which lowered the cost), the Medicare Levy Surcharge (MLS) and Lifetime Health Cover (LHC) (which created incentives for higher income earners and younger people to purchase insurance).

Table 1 below includes a comparison of the number of people and the percentage of the population with hospital and general treatment policies over the past four years. Table 1 shows that the percentage of the population with hospital treatment and general treatment has declined over the past three years.

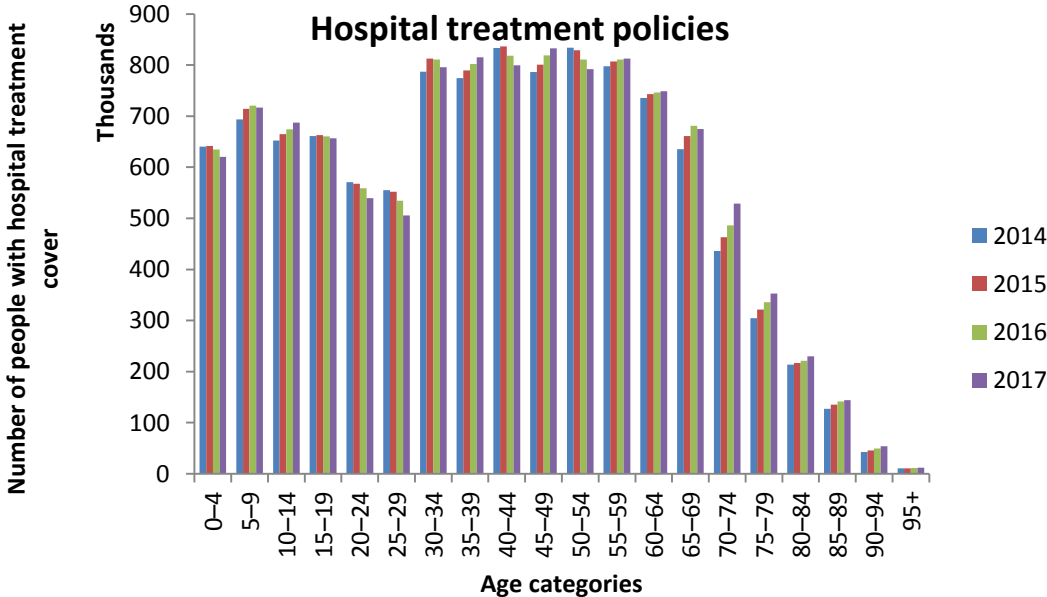
Table 1: Hospital treatment and general treatment health insurance policies

Year	Number of people with hospital treatment	% population with hospital treatment	Number of people with general treatment	% of population with general treatment
As at 30 June 2017	11,318,742	46.1	13,509,160	55.0
As at 30 June 2016	11,328,577	46.8	13,426,697	55.5
As at 30 June 2015	11,276,328	47.3	13,276,992	55.7
As at 30 June 2014	11,091,439	47.2	12,986,541	55.3

The current decline in participation is attributed to the cost to consumers growing on average by 68 per cent in 10 years and the confusing product offerings. In addition, the two thirds of the population that are aged under 50 have been born or reached adulthood under Medicare. Many people in this age group regard health insurance as a supplement rather than a necessity, and they are therefore more likely to respond negatively to increasing premiums.

Figure 1 below shows the change in the number of people with hospital treatment policies by age category over the past four years. This graph shows the decline in participation rates, particularly for the 20-24 and 25-29 age groups.

Figure 1: Private health insurance participation (hospital cover) by age category²



If no changes are made to the current arrangements, it is expected that private health insurance premiums will continue to increase and people may choose to downgrade or cancel their health insurance or not take out private health insurance at all.

Falling membership, particularly among younger Australians (who cross subsidise the premiums of older people), risks the overall stability of Australia’s health system as people dropping out or not taking out insurance must use the public hospital system which significantly increases cost to governments.

In the 12 months to 31 December 2017 health insurers paid \$14,812 million in hospital treatment benefits. This included more than 4.6 million episodes and 11.9 million hospital treatment days.³

Industry data shows that private health insurance pays for almost two-thirds of non-emergency surgery, 90% of day admissions for mental health care and 50% of all mental health admissions, 70% of joint replacements, 60% of chemotherapy and 88% of retinal procedures.

Background

Australia’s health system is funded by a mixture of public and private funding and service delivery. The role of private health insurance in Australia is unique among OECD countries, in that it operates as a Commonwealth supported and regulated industry, but is complementary to a universal public insurance system – Medicare. Most medical practitioner services are funded or subsidised through Medicare and state public hospital services are generally provided free to public patients. Private health insurance covers some or all of the costs of healthcare for private

² Australian Prudential Regulation Authority, Private Health Insurance Membership Trends, June 2017.

³ Australian Prudential Regulation Authority, Private Health Insurance Statistical Trends – Benefit Trends, December 2017.

patients and provides consumers with greater choice in the provision of treatment, access to shorter waiting times, and coverage for some services not funded by Medicare.

A key feature of Australia's private health insurance industry that makes it different from many other forms of insurance is that it is community rated. This means insurers are prohibited from discriminating between people who wish to be insured on the basis of their health or likelihood to claim. Under community rating, everyone is entitled to buy the same product, at the same price (except for Lifetime Health Cover) and an insurer cannot refuse to insure an individual.

By requiring that the premium paid for a person's chosen health insurance product, and the cover available under that product, are the same regardless of the health or demographic characteristics of the individual seeking coverage community rating imposes a cross-subsidy from low risk to high risk policy holders. Community rating prohibits insurers from discriminating on the basis of past or likely future health or risk factors such as age, pre-existing condition, gender, race or lifestyle in the premiums that they charge. Although community rating means that people who are older or sicker do not have to pay higher premiums commensurate with their risk, it also means that younger and healthier people pay more than they otherwise would.

Community rating is underpinned by a system of risk equalisation. Risk equalisation attempts to adjust for the risk of adverse selection. It is designed to spread the burden of high cost claims across all insurers, helping to keep them all financially viable. Under risk equalisation, a proportion of claims for older and high claiming members are 'pooled' and are redistributed between insurers retrospectively through the risk equalisation arrangements. In 2015-16, annual net transfers were around \$439 million.⁴ These arrangements are designed to ensure that insurers (and policy holders with those insurers) with higher numbers of older members or high users are not financially disadvantaged compared with those insurers with a younger or healthier membership.

The ongoing viability of the community rating requires the retention of a broad membership base. Rather than target certain age segments (e.g. younger members), the current system encourages insurers to compete for both younger and older members. Without a broad membership base, premiums would need to increase to cover the cost of insuring higher risk consumers who maintain their health insurance.

If private health insurance participation rates continue to decline, private health insurance will no longer cover the cost and number of hospital treatment days mentioned earlier. This will therefore impact on tax payers and public hospital waiting times.

Current government initiatives

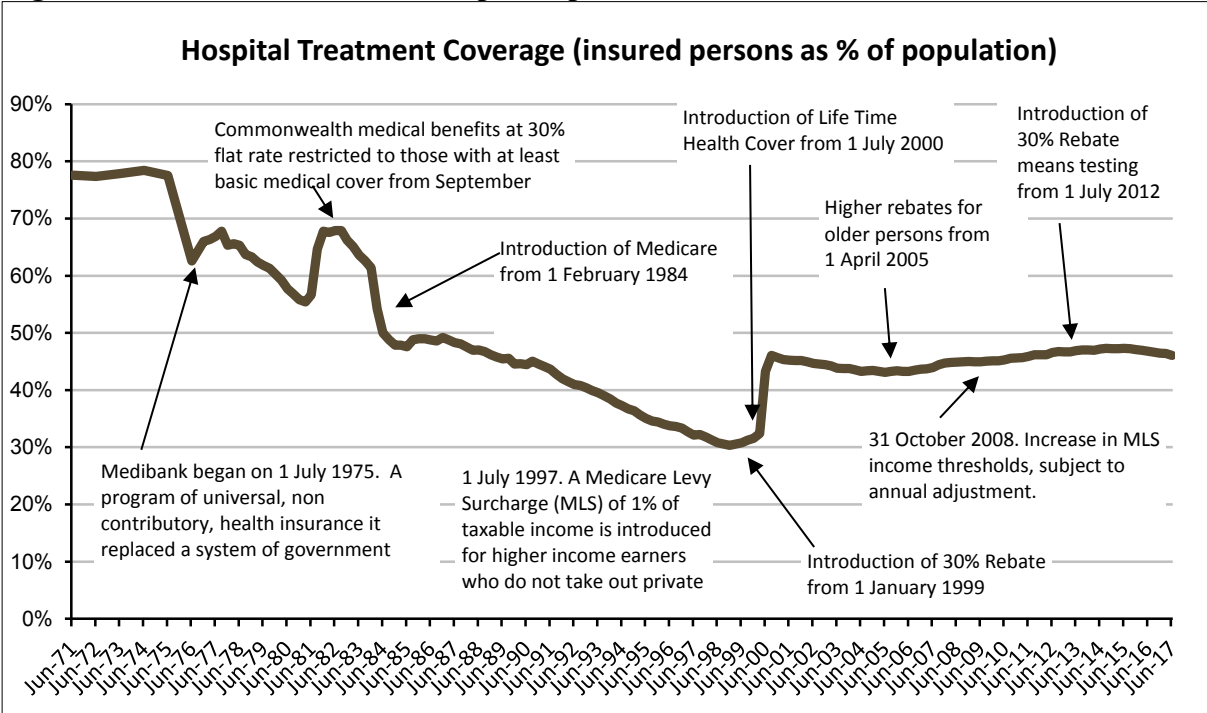
The Australian Government has three major initiatives in place to encourage take-up of private health insurance, the Medicare levy surcharge, Private Health Insurance Rebate and Lifetime Health Cover.

Following the introduction of private health insurance incentives between 1997 and 2000, there was large growth in the proportion of Australians holding private health insurance (Figure 2). The Medicare Levy Surcharge, the 30 per cent premium rebate, and Lifetime Health Cover saw

⁴ Australian Prudential Regulation Authority, *Private health insurance – Risk equalisation financial year results 2015-16*, February 2017.

the percentage of the population with hospital coverage increase from 30.5 per cent to over 45 per cent in 2001. Participation peaked at 47.3 per cent in June 2015.

Figure 2: Private health insurance participation in Australia since 1971⁵



Medicare levy surcharge

The Medicare levy surcharge (MLS) is a tax on higher income earners who do not hold appropriate hospital insurance. It is designed to encourage individuals to take out private hospital cover.

The MLS is payable in addition to the Medicare levy.

The base income threshold (under which the MLS is not liable to be paid) is \$90,000 for singles and \$180,000 for families. Table 2 provides details of the MLS tiers.

Table 2: MLS income thresholds from 2014-15 to 2017-18

Singles Families ⁶	≤\$90,000	\$90,001-105,000	\$105,001-140,000	≥\$140,001
	≤\$180,000	\$180,001-210,000	\$210,001-280,000	≥\$280,001
	Base Tier	Tier 1	Tier 2	Tier 3
	0.0%	1.0%	1.25%	1.5%

Table 3 shows the number of people and amount of MLS paid in 2015-16.

⁵ Australian Prudential Regulation Authority, Private Health Insurance Membership Trends, June 2017.

⁶ Single parents and couples (including de facto couples) are subject to family tiers. For families with children, the thresholds are increased by \$1,500 for each child after the first.

Table 3: Payments under the Medicare Levy Surcharge during 2015-16⁷

Rate	Number of taxpayers	Amount of Payment
1.0%	70,571	\$61,720,785
1.25%	55,041	\$69,793,906
1.5%	29,943	\$74,340,999
Others	592	\$313,957
TOTAL	156,147	\$206,169,647

Note: The 'Others' category is for taxpayers who were liable for MLS for part of the year only.

As part of the 2014-15 Budget, the Australian Government announced that from 1 July 2015 the income thresholds used to determine the MLS and the private health insurance rebate (discussed below) would be kept at the 2014-15 rates for three years.

As part of the 2016-17 Budget, the Australian Government announced the continuation of the pause on indexation of income tiers for the MLS and the private health insurance rebate for a further three years until 30 June 2021.

Private Health Insurance Rebate

The Australian Government provides an income tested and age related rebate to encourage people to take out and maintain private health insurance. The Government's estimated expenditure on the Private Health Insurance Rebate will amount to more than \$6.4 billion in 2017-18.⁸

Most people who hold private health insurance are eligible for a rebate on their insurance costs. A person may claim the private health insurance rebate if they:

- are eligible for Medicare;
- have a complying health insurance product that provides hospital treatment or general treatment, or combined cover; and
- have an income for MLS purposes below Tier 3 (see Table 4 below). The Private Health Insurance Rebate Percentages are as follows:

Table 4: Private Health Insurance Rebate effective from 1 April 2017 to 31 March 2018

	≤\$90,000	\$90,001-105,000	\$105,001-140,000	≥\$140,001
Singles				
Families	≤\$180,000	\$180,001-210,000	\$210,001-280,000	≥\$280,001
Rebate				
	Base Tier	Tier 1	Tier 2	Tier 3
< 65	25.934%	17.289%	8.644%	0%
65-69	30.256%	21.612%	12.966%	0%
70+	34.579%	25.934%	17.289%	0%

The rebate percentage is adjusted on 1 April each year based on the Rebate Adjustment Factor, which has the effect of increasing the rebate in line with the Consumer Price Index rather than the growth in premiums. The Rebate Adjustment Factor is set out in the *Private Health Insurance (Incentives) Rules 2012 (No.2)*.

⁷ Data from the Australian Taxation Office, September 2016.

⁸ Australian Government, *Budget Paper No. 1, Budget strategy and outlook 2017-18*, Statement 6, Table 8.1.

Lifetime health cover

Lifetime Health Cover (LHC) is an Australian Government initiative that started on 1 July 2000. It was designed to encourage people to take out hospital insurance earlier in life, and to maintain their cover throughout their life. LHC is a financial loading that can be payable in addition to the premium for private health insurance hospital cover.

LHC loadings apply only to hospital cover. They do not apply to private health insurance general treatment cover. To avoid incurring the LHC loading, residents of Australia must ensure they hold appropriate hospital cover before they reach their LHC deadline (also known as the LHC base day which is 1 July following a person's 31st birthday).

A person's loading is determined by the number of years they are aged over 30 at the time they commenced hospital cover. Each year will attract an extra two per cent to their hospital cover premium, up to a maximum of 70 per cent loading. Once a LHC loading on private hospital insurance has been paid for 10 continuous years, the loading is removed.

New migrants to Australia who have already reached the 1 July following their 31st birthday do not incur a LHC loading if they purchase hospital cover with an Australian registered insurer before the first anniversary of (or within 12 months after) being registered as eligible for Medicare.

The Department conducts an annual mail-out specifically targeting people who are approaching their LHC deadline. The mail-out is intended to serve as a reminder for the recipients that they have an opportunity to avoid extra costs on private health insurance should they wish to purchase it before their approaching deadline.

2 Why is government action needed?

In 2015-16 the Government consulted on private health insurance to identify key issues of consumers and stakeholders across the sector. The consultations raised common themes around people's concerns:

- poor value for money;
- high out-of-pocket costs for consumers;
- lack of transparency;
- lack of sustainability; and
- complex regulation.

In response to these findings, the Government established the Private Health Ministerial Advisory Committee (PHMAC), consisting of key representatives of interest groups in the private health sector to consider and develop possible reforms to private health insurance with the aim of improving the value of private health insurance to consumers, as well as protecting the long-term efficiency and sustainability of the sector. Additional information about the PHMAC is available at <http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac>.

Government action is needed to help strengthen the viability of the private health system by addressing concerns about affordability, complexity, and lack of transparency of private health insurance.

Without Government action, there is a risk that participation in private health insurance will continue to decline. As mentioned above, continued falling participation will have an impact on access to services. An increased impact on the demand for services in the public hospital

system will result in greater pressure on Commonwealth and state funding for public hospitals. It will also have an impact on funding levels under the National Health Reform Agreement and implications for the contributions to public hospitals required from tax payers.

The Australian Government considers that a healthy and stable private health insurance system is essential for the stability of Australia's overall health care system. Encouraging private health insurance cover provides consumers with a greater choice of care options and relieves pressure on the state public hospital system.

3 Government Announcement

On 13 October 2017, the Government announced a wide ranging package of reforms to make private health insurance simpler and more affordable for Australians. The key aim of these reforms is to make private health insurance better value for consumers and make policies easier to understand. The Government is helping to reduce the rising costs for health insurers – which would otherwise be passed on through higher premiums. These reforms include:

- Younger Australians will be encouraged to take up private health insurance by allowing insurers to offer products which discount hospital insurance premiums for 18 to 29 year olds by up to 10 per cent. This discount will phase out after people turn 41.
- People with hospital insurance that does not offer full cover for mental health treatment will be able to upgrade their cover and access mental health services without a waiting period on a once-off basis. This will significantly enhance the value of private health insurance for young people.
- To support Australians in regional and rural areas, insurers will be able to offer travel and accommodation benefits for people in regional and rural areas that need to travel for medical treatment.
- An agreement has been entered into with the Medical Technology Association of Australia to lower the price of implanted medical devices from 1 February 2018. This has had immediate benefits for consumers in contributing to the lowest premium rise in seventeen years.
- Consumers will be able to select a higher excess in exchange for a lower premium. This will be the first increase in the maximum excess since 2001.
- Private health insurance will be simplified as insurers will be required to categorise products as gold/silver/bronze/basic, and use standardised definitions for treatments to make it clear what is and isn't covered in their policies.
- The privatehealth.gov.au website will be upgraded to make it easier to compare insurance products, and insurers will be able to provide personalised information to consumers on their product every year.
- The powers of the Private Health Insurance Ombudsman will be boosted and its resources increased to ensure consumer complaints are resolved clearly and quickly.
- Following consultation with the private health insurance and medical sector, the Government has agreed to stop insurers from offering benefits for a range of natural therapies.
- The Improved Models of Care Working Group will consider how to better support privately insured people's access to efficient and clinically appropriate mental health and rehabilitation services.
- The Ministerial Advisory Committee on Out-of-pocket costs will provide options to improve the transparency of medical out-of-pocket costs.
- The second tier default benefit, providing a safety net for consumers attending non-contracted hospitals, will continue, but the administration of eligibility will be transferred to the Department of Health.

4 Policy options

In light of the Government's announcement of the private health insurance reform package (outlined in Section 3 above), two options have been considered:

1. Implement private health reform package; and
2. Maintain current arrangements (status quo).

1. Implement private health reform package

This consists of a suite of reform options, which must be implemented as a whole, to achieve the above objectives include:

Reform 1: Product Design Reforms – Gold, Silver, Bronze, Basic

Private health insurance products will be simplified for consumers through the creation of easy to understand categories of cover. From 1 April 2019, there will be four categories of hospital products (Gold, Silver, Bronze and Basic) and three categories of general treatment (extras) products (Gold, Silver and Bronze). The minimum coverage requirements for each product category will be developed by the Government during 2017-18 in consultation with the Private Health Ministerial Advisory Committee and industry more broadly before being implemented. Insurers will be required to identify which product category an insurance product fits into according to minimum product requirements specified in Commonwealth secondary legislation.

The Private Health Ministerial Advisory Committee and industry have been consulted on the minimum standards for each product category.

The Department expects to finalise the product categories by April 2018.

Reform 2: Product Design Reforms – remove waiting period for mental health

Support access to mental health by providing an enhanced safety net for policy holders requiring urgent hospital care for mental health conditions, by removing the two month wait period for upgrading psychiatric cover on a once off basis. This change will take effect from 1 April 2018.

Reform 3: Improved Models of Care Working Group

Establish the Improved Models of Care Working Group to provide advice to the Private Health Ministerial Advisory Committee on options to improve the delivery of mental health care and rehabilitation funded by private health insurance.

Reform 4: Standardised Clinical Definitions

The Government will introduce standard clinical definitions for insurers to use across all of their documentation across all platforms. This proposal will assist consumers in knowing their own products and being able to compare and understand different health insurance policies. The Department is close to finalising a draft list of clinical definitions. Focus groups and consumer testing is scheduled for March 2018 to ensure the list of clinical definitions is meaningful to consumers.

Reform 5: Improved access to travel and accommodation benefits for regional and rural areas

This will help privately insured regional and rural patients and their carers who need to travel for hospital/medical treatment undertaken away from where they live. Travel and

accommodation benefits will be made eligible for risk equalisation, this creates an incentive to insurers to include (or improve) these benefits.

Reform 6: Information Provision Reforms

The Private Health Insurance Ombudsman (PHIO) website, *privatehealth.gov.au*, will be redeveloped to better assist consumers to choose a private health insurance product that best meets their health needs.

The role of the PHIO will also be expanded to enable it to conduct inspections of private health insurers.

A minimum data set will replace the current Standard Information Statement (SIS) as the regulated method by which insurers provide information to consumers.

Insurers will need to make system and/or process changes to undertake the minimum data set requirements. Information will need to be regularly updated by insurers to ensure data integrity on *privatehealth.gov.au*.

Reform 7: Consultation on measures to support transparency of out-of-pocket costs

The Government has established an expert committee to work with consumers, the medical sector and private health insurers on best practice models to make information on out-of-pocket costs charged by doctors more transparent to help consumers with private health insurance better understand out-of-pocket costs.

Reform 8: Discounts for 18 to 29 year olds

From 1 April 2019, insurers will be able to choose to offer products which provide premiums discounts for people aged 18 to 29 for hospital cover. The provision of discounted products by insurers will be voluntary. The maximum discount will build to 10% for people aged 18-25, and will remain until the person turns 41 after which time it will phase out at a rate of 2 percentage points per year for up to five years.

Reform 9: Prostheses List benefit reductions and reforms

This proposal will offer immediate relief for private health insurers by reducing benefits paid for medical devices on the Prostheses List, while the Department continues to work with the Prostheses List Advisory Committee (PLAC) to deliver medium to longer term better value for consumers of private health insurance.

Reform 10: Increasing permitted excess levels

From 1 April 2019 the legislated annual voluntary excess limits for private health insurance hospital products will be increased from \$500 to \$750 for singles and from \$1,000 to \$1,500 for couples/families. The updated legislation will allow, but not mandate, insurers to offer higher excess products with lower premiums.

Reform 11: Removing coverage for some natural therapies

From 1 April 2019, private health insurers will not be permitted to provide cover for natural therapies, with the exception of traditional Chinese medicine, chiropractic and massage therapy. Private health insurers will be required to remove cover for natural therapies from all general treatment products that provide cover for these therapies. The Commonwealth, through the Private Health Insurance Rebate, will therefore no longer subsidise these non-permitted therapies.

However, insurers can continue to offer access to these therapies as inducements for people to purchase cover, as long as the cost is not more than 12 per cent of the premium.

Reform 12: Improvements to second tier default benefit administrative arrangements

There will be a number of improvements to the second tier administrative arrangements to provide simplified administration and improved transparency and consistency of second tier default benefit arrangements. Second tier default benefit administrative arrangements refers to the process by which private hospitals without a contract with an insurer are assessed as eligible to receive no less than 85 per cent of the average charge for the equivalent episode of hospital treatment from insurers. This will include the Department of Health assessing private hospital applications for second tier default benefit eligibility on a cost recovery basis alongside its existing (delegated) role of declaring private hospitals for health insurance purposes. The existing industry-based Second Tier Advisory Committee (STAC) will be abolished.

2. Maintain current arrangements (status quo)

Maintaining the status quo would not impose additional regulatory burden on insurers or consumers as the existing arrangements would continue. While maintaining the current arrangements was considered, this option was not preferred as it would not meet the objective to improve the affordability of private health insurance and increase the information available to consumers. The continued decline in private health insurance participation would also be likely to continue. This would place pressure on the public health system, and increase costs to governments.

5 What is the likely net benefit of each option?

1. Implement private health reform package

Implementing a suite of reforms would improve private health insurance and participation, and the information available to consumers in the short to medium term.

Benefit

Implemented in full, these reforms aim to:

- increase affordability of private health insurance;
- improve information available to consumers to allow them to more easily compare products and choose the most appropriate product for their needs/circumstances; and
- maintain the sustainability of the private health system to ease the burden on the public health system.

The impacts of each reform are outlined in the table below:

Reform 1: Product Design Reforms – Gold, Silver, Bronze, Basic

This reform aligns with making information simpler for consumers, and more easily comparable.

Consumers

The 13.5 million people with private health insurance will be affected by the product categorisation changes. These changes will help to simplify private health insurance so that consumers know what they are, and are not, covered for. They will also make it easier for consumers to shop around and compare products, and find a product that meets their needs. Consumers who are considering purchasing private health insurance will also benefit from

these changes. In conjunction with the other reform measures in this submission, this change will simplify private health insurance and help to restore consumers' perceptions of the value of private health insurance.

When consulted, consumers revealed that they find health insurance products complex and difficult to understand. They also reported experiencing considerable difficulty when trying to compare private health insurance products, and understand what services different products do, and do not, cover.

The new product categories will provide consumers with greater certainty about the services covered by each type of product. This reform aligns with the objective of making information simpler for consumers to understand.

Insurers

All private health insurance funds will be affected by these changes. The product categorisation changes should generate competitive pressures for insurers to reconfigure and enhance their products in such a way to acquire a product categorisation above Basic. PHMAC is well progressed in the development of the minimum product requirements for the product categories. The minimum coverage requirements for each product category (Gold, Silver and Bronze) will continue to be developed by the Government during 2017-18 in consultation with PHMAC and industry more broadly before being implemented. The two peak private health insurance bodies support these changes so the risks of achieving this aspect of the package are low.

Brokers

Private health insurance brokers will be impacted by these changes. It is likely they will need to update their IT systems and websites to reflect the new product category labels applied to products. Brokers are also likely to need to deliver training to sales staff on the new product categories that have been applied to products.

Reform 2: Product Design Reforms – remove waiting period for mental health

This reform aligns with the objective of improving access to private health and increasing the value of private health insurance.

Consumers

The enhanced mental health 'safety net' arrangements will help improve access to mental health services for privately insured patients. The 'waiting period exemption' will ensure that people with basic health cover (approximately 5 million people) are supported if they suffer an episode of mental illness and wish to upgrade their cover to immediately access higher benefits for care in a private hospital. The introduction of a waiting period exemption is likely to be utilised by approximately 1,400 patients each year.

Private mental health services are highly valued by people, particularly younger people. However, most basic and medium level hospital products provide limited cover for mental health services. Patients with these products who require overnight or multi-day care in a private hospital for a serious mental health condition will usually face large-out of pocket costs. Waiting periods for upgrading cover can prevent patients from accessing timely care.

Insurers

Removing limitations on the number of mental health sessions or treatments a consumer can access will have an additional cost and premium impact, but that impact is unable to be quantified because it depends on the consumer and provider response, which are both

unknown. Addressing low value or inefficient mental health care and rehabilitation is likely to generate savings for private health insurers which can be passed on to consumers via lower premium increases. It can also provide options for services which better meet the needs of consumers. The two peak private health insurance bodies support these changes so the risks of not achieving this aspect of the package are low.

Reform 3: Product Design Reforms –Improved Models of Care Working Group

While the establishment of the Improved Models of Care Working Group will not have any direct impacts, advice provided to government may inform future policy decisions which could benefit consumers, carers, insurers and/or hospitals/providers.

This working group will provide advice to Government on options to replace admitted mental health and rehabilitation services which deliver inefficient care.

The working group will be comprised of consumers, clinical experts and representatives from the health insurance and private hospital sectors.

It is expected that the issues and options identified by the working group may extend beyond mental health and rehabilitation to other areas which have admission rates that are higher than clinically necessary or inefficient.

There is evidence to suggest that the existing funding arrangements for private health insurance provide inappropriate incentives for patients to be admitted to hospital for mental health and rehabilitation services when it may be more clinically appropriate and efficient to deliver services in a non-admitted or community based setting. This adds to the cost of care and leads to higher private health insurance premiums.

Reform 4: Standardised Clinical Definitions

This reform aligns with making information simpler for consumers, and more easily comparable.

Consumers

Standardising clinical definitions will have a positive impact on consumers as the current clinical definitions are inconsistent across different private health insurance products and are therefore can be confusing for consumers. By simplifying clinical definitions and mandating the use of the standard clinical definitions across all insurer material, consumers will be able to more easily compare health insurance policies and understand their own product. This proposal is also not expected to increase premiums.

Consultation showed that a key concern for consumers was product complexity and poor understanding of private health insurance products. Introducing standard clinical definitions for both inclusions and exclusions will assist consumers in making an informed choice about private health insurance and what services different products do, and do not, cover.

Insurers

While private health insurers agree that clinical definitions should be standardised for the benefit of consumers, it will reduce their flexibility in product design. Insurers will also need to update their systems in order to use the new standard clinical definitions. It is likely this will be done when insurers are also making changes to introduce the ‘Product Design’ and ‘Information Provision for Consumers’ initiatives.

Brokers

Private health insurance brokers will be impacted by these changes. It is likely they will need to update their IT systems and websites to reflect the new product category labels applied to products.

Reform 5: Improved access to travel and accommodation benefits for regional and rural areas

This reform aligns with the objective of improving access to private health insurance, in particular for people in regional and rural areas.

Consumers

This measure will improve the value of private health insurance products for regional and rural consumers. This change may result in an increased uptake for private health insurance in rural areas, where participation rates are lower than in urban areas. There is a small risk that additional costs to insurers of paying benefits for travel and accommodation will lead to a rise in overall premium costs but the increase is likely to be negligible.

Many consumers living in regional and rural areas believe that private health insurance provides lower value for money compared with urban consumers due to lack of available services. Improving transport and accommodation benefits will provide a direct benefit to people living in regional and rural Australia who need to travel to access treatment that is not available in their local region.

Insurers

Insurers are likely to support this change, particularly as benefits will be eligible for risk equalisation. This provides an incentive to insurers to include (or improve) travel and accommodation benefits. Insurers who attended the PHMAC rural workshop in December 2016 were broadly supportive of improving travel and accommodation benefits for regional and rural consumers. Some insurers raised concerns about changing risk equalisation to favour rural and remote consumers as they felt that making adjustments to benefit rural and remote consumers could set a precedent and lead to other segments wanting to receive similar benefits. It will not be mandatory for insurers to offer travel and accommodation benefits. Currently around half of all private health insurers offer benefits for travel and accommodation for members who must travel to access medical services. Generally, travel and accommodation are only claimable by members with top level general treatment (extras) cover and the benefits offered are minimal.

Reform 6: Information Provision Reforms

These reforms align with the objective of making private health insurance simpler for consumers to understand, as well as affording greater consumer protections.

Consumers

This reform will benefit all private health insurance consumers. The redevelopment of *privatehealth.gov.au* will help consumers to choose the best private health product for their health needs by making it easier to compare multiple products. Consumers will have a choice in how they elect to receive information as insurers will be able to use the minimum data set in whichever format the consumer prefers. The information can be tailored to individuals, which will be more meaningful for consumers. The redeveloped website will be presented to consumers for focus group testing, user acceptance testing and assistance in developing the comparator functionality. Making private health insurance product data available to third parties in a malleable format will benefit consumers who choose to use a broker when looking to purchase private health insurance. The PHIO will be able to conduct inspections and audits

of private health insurers to ensure they meet their regulatory obligations in relation to private health consumers. They will employ six additional staff members as investigators to focus on verifying customer activity records and addressing complaints by consumers in respect of private health and private hospital contractual arrangements, including prostheses. Having access to a health insurer's records directly within their premises, investigating officers will be able to ensure that an insurer is not overlooking records in responding to enquiries by the PHIO. This will also provide assurance to complainants that the PHIO are able to verify the accuracy of the information provided by insurers and not rely solely on the health insurer to respond to the PHIO without making any errors. PHIO's expanded role will strengthen their ability to protect consumers' interests and assist consumers to have confidence in PHIO's processes and the outcomes of their investigations. The government will seek to work in cooperation and partnership with the sector as an overarching principle.

Insurers

A minimum data set, the Private Health Insurance Statement, will replace the current Standard Information Statement (SIS) as the regulated method by which insurers provide information to consumers.

This new minimum data set, regulation regarding provision of this information (referred to in current legislation as the SIS) will be made technology neutral to reflect how consumers access information. This means that as well as post mail-outs, consumer information can also be provided via email, as a hyperlink and on the insurer's member portal, as long as it is provided according to the regulated timeframes in a format agreed by the consumer.

Product data provided by insurers to the PHIO for use on *privatehealth.gov.au* will be made publicly available in a consolidated and downloadable format. It will be optional for insurers to provide consumers with a Private Health Insurance Statement, which provides information on the amount of premium paid for the policy during a financial year and the amount (if any) under the premiums reduction scheme. Updated regulation will require the statement to be provided to a consumer on request.

Insurers will be able to provide the annual Lifetime Health Cover Statement with the premium change communication instead of as a separate item.

The costs incurred by insurers in changing the way in which information is provided to consumers will be mitigated by the removal of the regulatory requirement for all SIS, Lifetime Health Cover and Private Health Insurance Statements to be mailed out. The saving to insurers of not having to mail out this paperwork has been estimated to be in excess of \$8 million.

There will be a small cost to insurers associated with these enhancements by way of increase to the Complaints Levy for the cost of the redevelopment and ongoing maintenance of *privatehealth.gov.au* and the cost of employing investigators to undertake the PHIO inspection function. Insurers will need to make system and/or process changes to undertake the minimum data set requirements. Information will need to be regularly updated by insurers to ensure data integrity on *privatehealth.gov.au*, so there will be costs associated with this initiative. These costs are mitigated by the removal of the regulatory requirement for insurers to mail out particular information including the Standard Information Statement at certain specified times (including annually), the annual Lifetime Health Cover Statement and the Private Health Insurance Statement.

Insurer representatives on the Private Health Ministerial Advisory Committee and the

Information Provision for Consumers Working Group showed support for the redevelopment of *privatehealth.gov.au* and a minimum data set as they will benefit their members (and consumers more broadly) by making it easier to compare products and providing the appropriate information to make informed decisions.

Brokers

Providing access to private health insurance product data will allow brokers to provide consumers with advice on products across all health funds.

Reform 7: Consultation on measures to support transparency of out-of-pocket costs

While the establishment of the committee will not have a direct impact on consumers, it is likely that recommendations from the committee will be of benefit to consumers through increasing transparency of information and reducing information asymmetry.

Consumers

Out-of-pocket costs have been a long standing concern for private health insurance policy holders. While 86 per cent of services are covered under ‘no’ or ‘known’ gap arrangements, the remaining 14 per cent of services incur out-of-pocket costs not covered by insurers. One in seven patients is required to pay out-of-pocket costs which are often large and unexpected. The average out-of-pocket cost for spinal surgery is \$2,250 and for brain surgery is \$1,500. Patients often incur multiple out-of-pocket costs for the same procedure depending on the costs of the surgeon, assistant surgeon and anaesthetist who each bill the patient separately.

Making doctors’ out-of-pocket costs more transparent will allow consumers to compare doctors’ fees more easily and make an informed choice knowing the expected out-of-pocket costs.

Insurers

While the establishment of the committee and subsequent reporting will not have any direct impacts, advice provided to government may inform future policy decisions to benefit consumers, insurers and doctors.

The Government has established an expert committee to ensure a collaborative approach in determining the best model to make information on out-of-pocket costs charged by doctors more transparent and to help consumers with private health insurance better understand out-of-pocket costs.

This committee consists of experts representing medical craft groups, insurers and consumers.

Reform 8: Discounts for 18 to 29 year olds

This reform aligns with the objective of maintaining a viable and sustainable private health system. As discussed earlier, the viability and sustainability of the private health insurance system relies on a broad membership base. Encouraging more young people to take out private health insurance will benefit everyone.

Consumers

Consumers aged between 18 and 29 may be able to purchase a policy that offers an age-based discount and will pay lower premiums than would otherwise be the case. However, consumers may also find it more difficult to compare products if the sector introduces a variety of discount arrangements.

Younger Australians, particularly those under the age of 30, have far lower rates of private

health insurance participation than most other age groups. This means that many young people are currently missing out on the benefits of private health insurance.

This reform aligns with the objective of improving access to private health insurance for a cohort of people who will be able to access private health insurance products at a lower premium amount than would otherwise be the case.

Insurers

Insurers may be able to encourage people aged under 30 years old to purchase private health insurance by providing age-based discounts for hospital products.

From 1 April 2019, insurers will be able to offer discounted private hospital cover to people aged 18 to 29. Legislation currently prevents insurers from offering premium discounts to people on the basis of their age.

Insurers will be able to offer premium discounts on hospital cover of two per cent for each year that a person is aged under 30, to a maximum of 10 per cent for 18 to 25 year olds. These discounts will gradually be phased out after an insured person turns 41.

Reform 9: Prostheses List benefit reductions and reforms

This reform aligns with the objective of reducing the cost of private health insurance for consumers.

Consumers

Consumers of private health insurance will benefit from lower premium increases than in previous years. They will continue to benefit from certainty of access to medical devices funded by private health insurance which the Prostheses List provides.

Private health insurers have publicly stated that every \$200 million in prostheses benefits reductions will decrease private health insurance premiums by one per cent.

Insurers

Minimum benefits payable for almost all medical devices listed on the Prostheses list have been reduced since 1 February 2018 (reductions may vary). The 2018 round of benefit reductions is estimated to save private health insurers \$188 million on prostheses expenditure in the 2018 premium year.

Further reductions to some devices' benefits will also occur on 1 February 2019 and 1 February 2020. Total estimated savings to private health insurers over the next four premium years (2018-2021) are more than a billion dollars.

Expenditure on prostheses accounts for 14 per cent of private health insurance hospital benefits paid annually. Evidence suggests that Prostheses List benefits are generally inflated when compared to the equivalent prices paid for devices in the public sector. Reducing prostheses expenditure places downward pressure on premium increases.

Medical device sponsors

Medical device sponsors will be impacted by lower prices in the private sector. To offset these impacts the government will look to introduce measures to deliver price stability, faster access to the private market through more efficient and transparent application and listing processes, and innovation support.

Hospitals

Although private hospitals will continue to benefit from certainty of reimbursement for medical devices supplied to patients, some hospitals currently obtain an additional revenue stream from supplying prostheses due to the difference between the price at which they buy prostheses and the charge to insurers based on the Prostheses List Benefit. Some hospitals are likely to object to this proposal on the basis it will reduce this revenue stream. It is likely that private hospitals will seek to regain lost revenue through higher prices in their contracts with private health insurers.

Reform 10: Increasing permitted excess levels

This reform aligns with the objective of reducing the cost of private health insurance for consumers.

Consumers

Maximum permitted excesses for private hospital insurance will be increased from \$500 to \$750 for singles and from \$1000 to \$1,500 for couples/families. Maximum voluntary permitted excesses have not changed since the year 2000 and increasing excesses to these levels will restore the risk sharing relativities for consumers to those that existed when the current levels were set. Consumers could choose to pay lower premiums by moving to a new maximum voluntary excess product. Actuarial analysis suggests increasing excess levels will reduce overall premiums on average by about 1 per cent. The premium impact for basic hospital products is expected to be slightly greater with an average premium reduction of around 1.2%. While consumers on higher excess products would pay reduced premiums, they would be subject to higher excess payments if they are admitted to hospital.

There is no requirement for consumers to move to products with higher excesses. It is expected that more affordable private health insurance will encourage more people to take out cover, which will result in \$8 million expenditure over four years on the Private Health Insurance Rebate.

Insurers

There will be an incentive for insurers to offer higher excess products on the basis that premiums for these products would be more affordable for consumers. Consumers who move to higher excess products will tend to be healthier people who do not expect to claim. With healthier consumers contributing less to the overall premium pool, insurers will need to ensure that aggregate premiums paid by all members remain sufficient to cover expected claims. Therefore, it is expected that insurers will need to increase premiums for consumers who choose to purchase zero or low excess products. Insurers may also choose to close zero or low excess products in order to manage adverse selection risks (that is the risk that these products will predominantly be purchased by those consumers who most frequently use their insurance). Consumers who previously held these products will benefit from paying lower premiums, but will face higher excess payments if they are admitted to hospital. Actuarial analysis suggests that in 2019 approximately 8,300 additional people would be covered by private health insurance as a result of increasing maximum voluntary excess levels. Annual participation levels are expected to be a further 300 people higher each year after the year of introduction. Insurers will be permitted to offer products with higher excesses from 1 April 2019.

State and Territory public hospitals

As an incentive to encourage private patient election, public hospitals often waive the excess that would otherwise be payable under a patient's health insurance policy. Maximum voluntary excess levels are currently set at \$500; therefore the highest amount of revenue a public

hospital could forgo by waiving the excess is limited to \$500 per admission. Increasing maximum excess levels would result in public hospitals waiving excesses and forgoing revenue of up to \$750 per admission. Public hospitals that continue to waive the excess will face reduced revenue, and will therefore have a slightly reduced incentive to continue with their policies of encouraging patients to elect to be treated as private patients.

Reform 11: Removing coverage for some natural therapies

This reform aligns with the objective of reducing the cost of private health insurance for consumers.

Consumers

Removing the Private Health Insurance Rebate from some natural therapies may reduce the perceived value of general treatment products for some consumers wishing to continue accessing natural therapies. The Rebate will be maintained for chiropractic, Chinese medicine and massage therapy.

Consumers will still be able to choose to access these natural therapies outside the private health insurance system. The approximately 55 per cent of the Australian population who hold coverage for general treatment (extras) insurance will benefit as changing coverage for the listed natural therapies will remove costs from the system and contribute to reducing private health insurance premium growth.

Insurers

Removing some natural therapy benefits from general treatment will result in reduced benefit outlays (savings) for insurers. Insurers may choose to pass the benefit of these savings to consumers through reduced premiums or enhanced general treatment benefits. Removing some natural therapy cover could reduce overall premiums (hospital and general treatment) by up to 0.1 per cent in 2019. Insurers have argued that the group of consumers which highly values natural therapies may choose to drop their private health insurance altogether if natural therapies are not covered and/or subsidised through the Private Health Insurance Rebate. However, it seems unlikely that there will be a material impact on membership, as relatively few members access benefits for natural therapies and many of these members will purchase private health insurance for a combination of reasons, not just to access benefits for natural therapies. In addition, about two-thirds of all benefits paid for natural therapies relate to massage, so this risk is largely mitigated by continuing to allow benefits for massage. Some private health insurers provide access to gym services and other products as incentives for consumers to purchase private health insurance. Private health insurers may choose to fund natural therapies as incentives, which do not attract the Private Health Insurance Rebate.

However, insurers can continue to offer access to these therapies as inducements for people to purchase cover, as long as the cost is not more than 12 per cent of the premium.

Providers

The following natural therapies will be removed from general treatment products: Alexander technique, aromatherapy, Bowen therapy, Buteyko, Feldenkrais, herbalism, homeopathy, iridology, kinesiology, naturopathy, Pilates, reflexology, Rolfing, shiatsu, tai chi, and yoga. The decision to remove the above listed Natural Therapies was taken following a review conducted by the former Commonwealth Chief Medical Officer, who found there was no clear evidence demonstrating the efficacy of those therapies. Affected providers may be financially impacted by this proposal as the removal of coverage for natural therapies by general treatment products is likely to dampen demand. Natural therapy providers are considered a small occupation group with charges related to private health insurance totalling

around \$45 million (compared with the largest category of general treatment benefits, dental services, with private health insurance charges of \$4.8 billion). The largest sub-group of natural therapy providers affected by this change would be Naturopaths (approximately 50 per cent of affected benefits), followed by exercise physiology (approximately 30 per cent of affected benefits).

Reform 12: Improvements to second tier default benefit administrative arrangements

This reform aligns with the objective of reducing administrative burden for hospitals and insurers, which in turn, may have a positive impact on consumers as they may have increased information available to them.

Consumers

Consumers may be better informed about hospitals' average out-of-pocket costs, increasing information transparency and reducing information asymmetry.

Insurers

Insurers will benefit from: reduced administrative burden as they will no longer need to categorise hospitals themselves for second tier purposes; and improved transparency from increased provision of HCP data. In the longer term, insurers will use significantly less resources to calculate second tier benefit schedules as these will only be fully calculated every third year.

Private Hospitals

Private hospitals will need to reapply for continued second tier eligibility less often than under current arrangements which will significantly reduce the resources required to maintain eligibility. From 1 January 2019, private hospitals will be able to apply directly to the Department of Health for recognition that they are eligible for second tier default benefits. This will replace the existing industry-based second tier advisory committee. The length of a private hospital's second tier eligibility approval will also be increased to align with the hospital's independent hospital accreditation cycle. Private hospitals will also have confidence that hospitals are being grouped consistently for the purposes of calculating and paying second tier default benefits across the health insurance sector. The Department of Health will also work with the Australian Commission on Safety and Quality in Health Care, the Australian Institute of Health and Welfare and the private health insurance and private hospital sectors to further streamline second tier administrative arrangements.

Private Hospitals choosing to apply for second tier eligibility will pay an application fee to cover the cost of assessing their application.

Regulatory Costs

There are regulatory costs associated with some of the options (Reforms 1, 2, 4, 6 and 11). Regulatory costs for these options are one-off costs, which primarily involve system changes and changes to information provided to consumers (both verbal and written) (e.g. labelling of products as "Gold, Silver, Bronze or Basic" and updating information to use standard clinical definitions).

There are regulatory savings associated with Reform 6 as there will be savings from making the provision of information to consumers technology neutral and allowing insurers to transmit information via email.

Other options do not have regulatory impacts as:

- they are voluntary for insurers to participate in:
 - introducing travel and accommodation benefits into hospital treatment policies (Reform 5); and
 - discounts for 18-29 year olds (Reform 8);
- are changes to currently existing arrangements with no additional regulatory burden:
 - changing maximum excess level amounts (Reform 10); and
 - moving second tier assessment to the Department from industry (Reform 12); or
- are wholly government funded with no regulatory impact
 - options which establish committees (Reform 3 and 7).

In relation to Prostheses List benefit reductions (Reform 9), the department has a RIS exemption for making and amending the Prostheses Rules (OBPR RIS reference number 12116).

Detailed information about estimated regulatory costs is at [Attachment A](#).

In summary:

- Consumers will experience no regulatory cost.
- Doctors will experience no regulatory cost.
- Brokers will have a regulatory cost of \$1.88 million annually over 10 years.
- Insurers will have a regulatory cost of \$3.27 million annually over 10 years.

Average annual regulatory costs (from business as usual)				
Change in costs (\$ million)	Business	Community organisations	Individuals	Total change in costs
Total, by sector	\$5.14 million	\$0	\$0	\$5.14 million
Cost offset (\$ million)	Business	Community organisations	Individuals	Total, by source
Agency	\$0	\$0	\$0	\$0
Are all new costs offset?				
<input type="checkbox"/> Yes, costs are offset <input checked="" type="checkbox"/> No, costs are not offset <input type="checkbox"/> Deregulatory—no offsets required				
Total (Change in costs – Cost offset) (\$ million) = \$5.14 million				

The regulatory burden to business, community organisations and individuals has been quantified using the Regulatory Burden Measurement framework. Offsets will be found through identified regulatory savings and the portfolio’s net regulatory objective will be met at the end of year reporting period.

2. Maintain current arrangements (status quo)

While under this option arrangements would be the same and there would be no additional regulatory burden on industry, it is also likely that there will be a continued decline in participation and continued consumer complaints about information provision arrangements.

Assessment

If the current arrangements are maintained there is a risk that private health insurance participation will decrease, putting pressure on premiums for remaining private health insurance customers and increasing pressure on the public health system.

In order to be successful at achieving the objectives to ensure affordable and simpler private health insurance, the reforms need to be implemented as a complete package. Taken as a complete package, these reforms will have the greatest impact as they are complementary, with some reforms focused on increasing affordability and product value, while other reforms are focused on making information simpler and more transparent for consumers. Through implementing Reforms 1-12, there would be changes to the current private health insurance arrangements to contribute to the ongoing viability of the system. If successful, it will help to mitigate the recent trend of a decline in private health insurance participation, assist in reducing private health insurance premium rises, compared with what they would have been without the reforms, and also result in improved access to information by consumers.

6 Consultation and implementation

Establishment of the Private Health Ministerial Advisory Committee

Extensive consultation has been undertaken in the development of the reforms outlined in this RIS.

One of the key mechanisms for consultation with the sector has been through the PHMAC. PHMAC was established to bring together key groups in the private health sector to work in partnership on the development and implementation of possible reforms to private health insurance.

PHMAC agreed to the establishment of working groups on a number of topics including standard clinical definitions, information provision and second-tier and default benefits. Additionally, PHMAC agreed to hold a rural private health insurance workshop that was attended by some 32 participants from a range of stakeholder groups, including consumers, doctors, hospitals and insurers, to discuss improving the value of private health for regional and rural consumers.

Sector views

In general, the main concern of service providers is that people are covered for (i.e. receive a benefit for) more services. Insurers are concerned with product price and consumers are concerned with product affordability and transparency of information. The reform package strikes a balance between these objectives.

While there are diverse sector views, the package is broadly supported by stakeholders, who have been, and continue to be, consulted throughout the process. The table below lists the consultation undertaken to date.

Consultation to date

Time period	Activity
2015	
8 November – 7 December	40,408 responses to the online consumer survey
November	Eight stakeholder roundtables attended by approximately 117 organisations
December	181 written submission received
2016	
8 September – present	Establishment of the Private Health Ministerial Advisory Committee, consisting of key representatives from major organisations the private health sector
12 December	Rural and regional private health insurance workshop attended by 32 participants
2017	
February-April	Contracting and default benefits working group
February-April	Information provision for consumers working group
March-April	Clinical definitions working group
February, March, April, May, June, September and November	Private Health Ministerial Advisory Committee meetings
October-December	Risk equalisation working group
2018	
8 February – present	First meeting of Ministerial Advisory Committee on Out-of-pocket Costs
13 February	Private Health Ministerial Advisory Committee meeting
26 February	Roundtable with small group of insurers, hospitals and consumers to discuss mental health reform operational issues
27 February	Minimum data set workshop
5-13 March	Exposure draft of Private Health Insurance Legislation Amendment Bill 2018 released for comment
20 March – present	First meeting of the Improved Models of Care Working Group

Implementation

During the implementation phase, there will be continued consultation with affected parties through the PHMAC, other committees (e.g. the Ministerial Advisory Committee on Out-of-pocket Costs and Improved Models of Care Working Group and its sub-groups) and focus groups/consumer testing.

The table⁹ below provides a guide to when the reforms will be implemented.

⁹ Available on the Department's website at <http://www.health.gov.au/internet/main/publishing.nsf/Content/private-health-insurance-reform-timeline>.

Implementation timetable

Date	Action
October 2017	<ul style="list-style-type: none"> • Prostheses Rules made reducing benefits by \$188 million annually from 2018 and further \$115 million in 2020
November to December 2017	<ul style="list-style-type: none"> • Establish advisory committees on: <ul style="list-style-type: none"> • Mental health care and rehabilitation care • Transparency of out-of-pocket costs. • Mental health waiting period Rules made.
February 2018	<ul style="list-style-type: none"> • Reduced prostheses benefits come into effect.
March 2018	<ul style="list-style-type: none"> • Legislation introduced to Parliament to support: <ul style="list-style-type: none"> • Regional and rural travel and accommodation benefits • Discounts for young people • Increased excesses • Increased PHIO powers • Changes to standard information provision • Cost recovery for second tier eligibility.
April 2018	<ul style="list-style-type: none"> • Mental health waiting period Rules come into effect.
June 2018	<ul style="list-style-type: none"> • Legislation passed. • Rules made to: <ul style="list-style-type: none"> • Give effect to Gold/Silver/Bronze/Basic and standardised clinical definitions • Remove benefits for natural therapies • Set detailed framework for second tier eligibility • Increase Complaints Levy funding the PHIO.
October to December 2018	<ul style="list-style-type: none"> • Advice to government from advisory committees on mental health care and rehabilitation care and transparency of out-of-pocket costs received.
January 2019	<ul style="list-style-type: none"> • New second tier administrative arrangements begin.
April 2019	<ul style="list-style-type: none"> • Upgraded privatehealth.gov.au begins. • Gold/Silver/Bronze/Basic and standardised clinical definitions begin to operate. • Insurers can offer: <ul style="list-style-type: none"> • Discounts for young people • Increased excesses and can no longer offer benefits for natural therapies
February 2020	<ul style="list-style-type: none"> • Second tranche of reduced prostheses benefits come into effect. • Establish clinical definitions review committee.

Evaluation

These reforms aim to:

- mitigate the recent trend of a decline in private health insurance participation. This will be measured from quarterly reports by the Australian Prudential Regulation Authority;
- reduce private health premium rises, compared with what they would have been without the reforms. The reforms aim to keep average premium increases below 4.0 per cent in each year between 2018 and 2020, maintain membership levels at 55 per cent and above. Data from the yearly premium rounds will demonstrate the success of this. For example, in the recent 2018 premium round, there was the lowest average weighted premium increase in almost 17 years, at 3.95 percent; and

- improve access to information by consumers. This will be measured by a reduction in complaints to the Private Health Insurance Ombudsman about complexity and costs of insurance.

Attachment A - Estimated Regulatory Cost

Private Health Insurers

IT system update costs (Reforms 1, 2, 4, 6, 11)

Private health insurers will require updates to their IT systems to be able to support the changes to product categories and information provision.

The Department of Health understands that the majority of the 37 insurers are supported by 3 system developers, and that 4 insurers have their own in-house system developers.

The estimated cost for IT system updates is \$46.25 million.

This figure was based on each of the 37 insurers incurring a cost of \$1.25 million for these IT changes based on similar updates made by the industry for other required changes.

Staff training costs (Reforms 1, 2, 4, 6, 11)

The estimated cost for staff training is \$1.92 million. This figure is based on:

- there being 2 large, 3 medium and 32 small insurers;
- staff receiving an estimated 6 hours of training each;
- each large insurer would train 1,200 staff;
- each medium insurer would train 400 staff;
- each small insurer would train 5 staff;
- staff wage cost is \$68.79/hour¹⁰; and
- develop training materials: 2 weeks per insurer for 1 person (8 hours/day at \$126/hour – based on \$150,000 annual salary plus on-costs). Total cost per insurer is \$10,080.

Table 1: Cost of training by insurer size

Size	Cost of Training per Insurer	Total Cost of Training
Large	\$505,368	\$1,010,736
Medium	\$175,176	\$525,528
Small	\$12,144	\$388,598
Total		\$1,924,862

Re-design of private health insurance products (Reforms 1, 2, 4, 6, 11)

The estimated cost to re-design private health insurance products is \$5.8 million. This figure was based on:

- there being 2 large, 3 medium and 32 small insurers;
- a large insurer would require a team of 3 actuaries and 10 marketing specialists;
- a medium insurer would require a team of 2 actuaries and 8 marketing specialists;
- a small insurer would require a team of 1 actuary and 4 marketing specialists;

¹⁰ Regulatory Burden Measurement Framework Guidance Note: Appendix 2 Default work-related and non-work-related labour rates.

- the cost of each actuary and marketing specialist at \$168/hour (\$96/hour plus \$72/hour for on-costs – based on \$200,000 annual salary); and
- each actuarial team and marketing team would be required for 4 weeks.

Table 2: Cost of product design by insurer size

Size	Actuarial Team	Marketing Team	Total Cost
Large	\$161,280	\$537,600	\$698,880
Medium	\$161,280	\$645,120	\$806,400
Small	\$860,160	\$3,440,640	\$4,300,800
Total	\$1,182,720	\$4,623,360	\$5,806,080

Standard Information Statement updates (Reforms 1, 2, 4, 6, 11)

The estimated cost to update the Standard Information Statement is \$137,580. This figure is based on:

- updating 2000 products; and
- 1 hour per product at a rate of \$68.79/hour.

Website updates (Reforms 1, 2, 4, 6, 11)

The estimated cost for insurers to update their websites is \$2.5 million. This figure is based on:

- large and medium size insurers updating their websites in-house using existing web teams. Team of 4 people for 4 weeks (\$126/hour – based on \$150,000 annual salary plus on-costs) = \$80,640 per insurer; and
- small size insurer will need to outsource the work to update their websites. This is a higher cost but generally lower complexity product offering and therefore the estimate is 80% of the cost of large and medium insurers. 80% of \$80,640 = \$64,512 per insurer (the cost for small insurers is based on data from the 2017 premium round).

Table 3: Cost of website updates by insurer size

Size	Cost of website updates per insurer	Total Cost of website updates
Large	\$80,640	\$161,280
Medium	\$80,640	\$241,920
Small	\$64,512	\$2,064,384
Total		\$2,467,584

Updating promotional/marketing material (Reforms 1, 2, 4, 6, 11)

The estimated cost for updating and re-printing brochures is \$420,000. This figure is based on:

- large insurers updating and re-printing 10,000,000 brochures at \$0.01/brochure¹¹;
- medium insurers updating and re-printing 1,000,000 brochures at \$0.02/brochure; and
- small insurers updating and re-printing 100,000 brochures at \$0.05/brochure.

¹¹ Based on information from the Department of Health's Communication Branch.

Information provision (Reforms 1, 2, 4, 6, 11)

The estimated savings for the standard information statement, lifetime health cover and tax statement mail outs is \$29.3 million. This figure is based on:

- a cost of \$2 per letter, \$0 per email (based on advice that the cost of sending an email is negligible);
- an administration cost (fixed) for each insurer per mail out to set up email distribution (\$2752 per insurer per mail out - 1 person for 40 hours at \$68.79/hour);
- an estimate of 75% of private health insurance policy holders (75% of 9.75 million¹² individuals) receive information via mail (\$14.6 million per mail out);
- an estimate of 25% of private health insurance policy holders already receiving this information via email (\$101,824 administration cost);
- an estimate of an additional 50% of policy holders will choose to receive this information via email (cost per mail out will be reduced to \$4.9 million);
- an estimate of 25% of policy holders will continue to receive this information via mail (\$101,824 administration cost); and
- information is required to be sent to 9.75 million individuals for each mail out (standard information statement, lifetime health cover and tax statement).

In relation to changes to coverage of natural therapies, a mail out will be required for general treatment policy holders to inform them of a change that is or might be detrimental.¹³ The estimated cost for this mail out is \$4.98 million. This figure is based on:

- an estimated 25% of policy holders will receive this information via mail and 75% of policy holders will receive this information via email;
- 2.44 million people will receive this information via mail (25% of 9.75 million individuals);
- a cost of \$2 per letter, \$0 per email (based on advice that the cost of sending an email is negligible); and
- an administration cost (fixed) for each insurer to set up email distribution (\$2752 per insurer - 1 person for 40 hours at \$68.79/hour).

Ongoing costs

No ongoing costs are required.

Estimated annual regulatory costs over 10 years

Table 4: Summary of regulatory costs for insurers

Size	Cost/Saving	Cost over 10 years
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¹² Australian Prudential Regulation Authority, quarterly statistics, June 2017. This figure only includes adults that have a private health insurance policy for the purpose of a mail out.

¹³ A private health insurer must ensure that, if a proposed change to the insurer's rules:

- a) is or might be detrimental to the interests of an insured person; and
- b) will require an update to the standard information statements for a complying health insurance product of the insurer;

an adult insured under each complying health insurance policy in the product:

- c) is informed about the proposed change a reasonable time before the change takes effect; and
- d) is given the updated standard information statement for the product subgroup that the policy belongs to as soon as practicable after the statement is updated.

IT system changes	\$46,250,000	\$4,625,000
Training staff	\$1,924,862	\$192,486
Re-design of products	\$5,806,080	\$580,608
Standard Information Statement	\$137,580	\$13,758
Website updates	\$2,467,584	\$246,758
Updating marketing material	\$420,000	\$42,000
Information provision	-\$24,273,176	-\$2,427,318
Total	\$32,732,930	\$3,273,293

Brokers

IT system update costs (Reforms 1, 2, 4, 6, 11)

Brokers will require updates to their IT systems to be able to support the changes to product categories and information provision required to be implemented by insurers.

The estimated cost for IT system updates is \$17.5 million.

This figure was based on each of the 14 brokers incurring a similar cost of \$1.25 million for IT changes based on similar updates made by the industry for other changes.

Staff training costs (Reforms 1, 2, 4, 6, 11)

The estimated cost for staff training is \$310,343. This figure is based on:

- there being 3 large and 11 small brokers;
- staff receiving an estimated 6 hours of training each;
- each large broker will train 100 staff;
- each small broker will train 10 staff;
- staff wage cost is \$68.79/hour;
- develop training materials: 2 weeks per broker for 1 person (8 hours/day at \$126/hour – based on \$150,000 annual salary plus on-costs). Total cost per broker is \$10,080.

Table 5: Cost of training by broker size

Size	Cost of training per broker	Total cost of training
Large	\$51,354	\$154,062
Small	\$14,207	\$156,281
Total		\$310,343

Website updates (Reforms 1, 2, 4, 6, 11)

The estimated cost for brokers to update their websites is \$0.95 million. This figure is based on:

- large size brokers updating their websites in-house using existing web teams. Team of 4 people for 4 weeks (\$126 per hour – based on \$150,000 annual salary plus on-costs) = \$80,640 per broker; and
- small size brokers will need to outsource the work to update their websites. This is a higher cost but generally lower complexity product offering and therefore the estimate is 80% of the cost of large brokers. 80% of \$80,640 = \$64,512 per broker.

Table 6: Cost of website updates by broker size

Size	Cost of website updates per broker	Total cost of website updates
Large	\$80,640	\$241,920
Small	\$64,512	\$709,632
Total		\$951,552

Ongoing costs

No ongoing costs are required.

Estimated annual regulatory costs over 10 years**Table 7: Summary of regulatory costs for brokers**

Size	Cost/Saving	Cost over 10 years
IT system changes	\$17,500,000	\$1,750,000
Training staff	\$310,343	\$31,034
Website updates	\$951,552	\$95,155
Total	\$18,761,895	\$1,876,190

Summary of Estimated Regulatory Cost**Table 8: Summary of regulatory costs for insurers and brokers**

Size	Cost/Saving	Cost over 10 years
Private Health Insurers	\$32,645,168	\$3,264,517
Brokers	\$18,761,895	\$1,876,190
Total	\$51,494,826	\$5,149,483

Statement of Compatibility with Human Rights

Prepared in accordance with Part 3 of the Human Rights (Parliamentary Scrutiny) Act 2011

Private Health Insurance (Complying Product) Amendment (Psychiatric Care) Rules 2018

This Legislative Instrument is compatible with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011*.

Overview of the Legislative Instrument

The *Private Health Insurance (Complying Product) Amendment (Psychiatric Care) Rules 2018* amend Rules 4, 5 and 9 of the *Private Health Insurance (Complying Product) Rules 2015* (the Principal Rules) which commenced on 1 July 2015. The Amendment Rules also establish a new Rule 19 within the Principal Rules outlining transitional provisions relating to admissions and/or policy upgrades which occur prior to the commencement of the Amendment Rules on 1 April 2019.

Human rights implications

This legislative instrument engages Articles 2 and 12 of the International Covenant on Economic, Social and Cultural Rights by assisting with the progressive realisation by all appropriate means of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Private health insurance regulation assists with the advancement of these human rights by improving the governing framework for private health insurance in the interests of consumers. Private health insurance regulation aims to encourage insurers and providers of private health goods and services to provide better value for money to consumers, to improve information provided to consumers of private health services to allow consumers to make more informed choices when purchasing services and requires insurers not to differentiate the premiums they charge according to individual health characteristics such as poor health.

Conclusion

This legislative instrument is compatible with human rights because it advances the protection of human rights.

Julianne Quaine

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Private Health Insurance and Pharmacy Branch

Department of Health