Private Health Insurance Legislation Amendment Bill 2018 [and related bills]

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House: House of Representatives
Portfolio: Health
Commencement: Schedules 1 and 2, and Parts 1 and 2 of Schedule 5 of the Private Health Insurance Legislation Amendment Bill 2018 commence on 1 April 2019; Schedule 3 commences 1 July 2018; Schedule 4 and Part 4 of Schedule 5 commence the day after Royal Assent; and Schedule 5, Part 3 commences 1 January 2019. The substantive provisions of the other two Bills commence on 1 April 2019.

Links: The links to the Bills, their Explanatory Memoranda and second reading speeches can be found on the Bills' home pages for the Private Health Insurance Legislation Amendment Bill 2018, the A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018 and the Medicare Levy Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018, or through the Australian Parliament website.

When Bills have been passed and have received Royal Assent, they become Acts, which can be found at the Federal Register of Legislation website.

All hyperlinks in this Bills Digest are correct as at May 2018.
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Purpose of the Bill

The purpose of the Private Health Insurance Legislation Amendment Bill 2018 (the Bill) and two related Bills is to amend legislation to implement a package of reforms around private health insurance. Specifically, the Bill amends the Private Health Insurance Act 2007 (PHIA), the Age Discrimination Act 2004 (ADA) and the Ombudsman Act 1976 (OA), to:

- allow for age-based premium discounts for hospital cover
- allow private health insurers to cover travel and accommodation costs for regional Australians as part of a hospital treatment
- strengthen the powers of the Private Health Insurance Ombudsman
- improve information provision for consumers
- reform the administration of second tier default benefits arrangements for hospitals
- allow insurers to terminate products and transfer affected policy-holders to new products
- increase maximum voluntary excess levels for products providing individuals an exemption from the Medicare levy surcharge and
- remove the use of benefit limitation periods in private health insurance policies.\(^1\)

Two related bills A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Amendment (Excess Levels For Private Health Insurance Polices) Bill 2018 and Medicare Levy Amendment (Excess Levels For Private Health Insurance Policies) Bill 2018 make minor amendments that give effect to the increased maximum excess levels that are proposed in Schedule 1 of the Bill. Provisions relating to these two related bills will also be discussed in this Bills Digest.

Structure of the Bill

The Bill is divided into five schedules:

- Schedule 1 increases maximum excess levels on private health insurance policies
- Schedule 2 allows health insurers to offer age-based discounted private health insurance policies
- Schedule 3 enhances the powers of the Private Health Insurance Ombudsman
- Schedule 4 removes benefit limitation periods from private health insurance policies and makes transitional arrangements so that consumers who purchased benefit limitation period inclusive policies since 2007 are exempt from repayments and liabilities and
- Schedule 5 contains miscellaneous provisions:
  - Part 1 allows for health insurers to offer travel and accommodation benefits as part of hospital treatment cover
  - Part 2 introduces a new Private Health Information Statement to replace the Standard Information Statement
  - Part 3 proposes administrative reforms to a private hospital’s eligibility for second tier default benefits and
  - Part 4 allows insurers to terminate a product and to transfer all people insured under that product to new policies.

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Background

Australia’s health system is a mix of publicly and privately financed health care. All Australians are eligible for the national health insurance scheme Medicare. Medicare subsidises the cost of many medical and allied health services. In addition, public hospital treatment is provided free to public patients. However, private health insurance is available to assist with the cost of medical treatment provided in a private hospital, ancillary treatments not covered by Medicare such as dental, optical and physiotherapy and allows for a choice of doctor.\(^2\)

There are two types of private health insurance: private hospital and general (sometimes called ancillary or extras)—or a combination.\(^3\) Private health insurance is not mandatory. However, membership is encouraged through government incentives, such as the private health insurance rebate (the rebate), and penalties such as the Medicare Levy Surcharge (MLS) and Lifetime Health Cover (LHC) loadings.\(^4\)

One of the key features of private health insurance in Australia is that, unlike other forms of insurance, it is not risk rated. Instead, it uses community rating, which requires that private health insurers offer policies in the same jurisdiction at the same price irrespective of an individual’s risk factors such as age,\(^5\) health status, previous claiming history or how frequently they need health care. Private health insurers participate in a risk equalisation scheme which partially compensates insurers with a riskier membership profile.\(^6\)

There are 37 registered private health insurers comprising a mix of not-for-profit insurers (mutual organisations), for-profit insurers and restricted membership funds (which provide cover to members of a specified industry or group).\(^7\) Private health insurers are regulated under the Private Health Insurance Act 2007 (PHIA) and the Private Health Insurance (Prudential Supervision) Act 2015, and related rules and regulations. The Australian Prudential Regulation Authority (APRA) is responsible for overseeing the sector, while the Private Health Insurance Ombudsman (PHIO) aims to protect consumers.

Private health insurance funds around 8.8 per cent of Australia’s total health expenditure.\(^8\)

Issues

A number of issues around private health insurance have emerged in recent years. In 2015–16, the Government undertook an extensive consultation process involving consumers and other stakeholders.\(^9\) As well as an online survey, which attracted some 40,000 responses, targeted industry stakeholder roundtables were held and an issues paper released.\(^10\) The consultation process revealed consumer concerns around the cost of private health insurance and value for

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3. Private hospital insurance only covers services for which a Medicare benefit is payable; it does not cover services that are provided out of hospital and which are covered by Medicare, such as general practitioner (GP) services.
4. The private health insurance rebate is an income-tested government rebate on the cost of private health insurance premiums for hospital, general treatment and ambulance policies. The MLS is an additional levy (on top of the two per cent Medicare levy) imposed on high-income earners who decline to purchase private health insurance. LHC is a two per cent annual loading on the cost of premiums for people over 31 who delay taking out private health insurance. See Biggs, *Private health insurance: a quick guide*, op. cit.
5. Other than the age-based LHC loadings that are permitted.
money.\textsuperscript{11} Other issues raised by consumers included complexity of policies and a lack of information.\textsuperscript{12} These and similar issues were also canvassed in the 2016 Senate Committee inquiry into the \textit{Value and affordability of private health insurance and out-of-pocket medical costs}.\textsuperscript{13}

**Membership trends**  
In recent years, a decline in private health insurance membership has raised concerns. As a proportion of the population, private hospital membership has been in decline for some time. In June 2014, 47.2 per cent of the population were covered for private hospital treatment; by June 2017 this had declined to 46.1 per cent.\textsuperscript{14}

There are concerns that unless this decline in membership is arrested it will have a negative impact on the viability of private health insurance (as fewer people are insured premiums will need to rise to cover the cost of those making claims; it is feared that higher premiums would drive further declines in membership), and on public hospital waiting times.\textsuperscript{15}

Geoff Summerhayes from APRA recently explained the impact this trend is likely to have on policy holders and premiums:

> After growing steadily for the past decade, the percentage of the population covered by insurance for hospital treatment has declined over the past two years to 46 per cent. But those choosing to leave the private system and rely on Medicare aren’t equally distributed across the population; they are typically the younger and healthier policyholders needed in a community-rated system to subsidise the old and sick. Remaining policyholders must carry an increasing share of these costs through higher premiums, adding further pressure to their household budgets and raising the risk of them also leaving the system.\textsuperscript{16}

The Government blames the decline in membership on the increasing cost to consumers of taking out private health insurance and consumer confusion over product offerings.\textsuperscript{17}

Private health insurance membership tends to be higher among older age cohorts. More detailed data on membership by age is provided in the \textit{Explanatory Memorandum} (EM).\textsuperscript{18} Unfortunately, membership data by electorate is not published.

**Costs**  
Consumer concerns around the cost of private health insurance were raised in the consultation process and with the Senate Committee. Costs can include the annual premiums paid for private health insurance. Premium increases have been higher than the Consumer Price Index (CPI) for many years, although the latest average increase at 3.95 per cent was the lowest since 2000.\textsuperscript{19} Costs can also include out of pocket costs such as patient co-payments, excesses and higher than expected medical fees not fully covered by private health insurance.

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\textsuperscript{11} Ibid.  
\textsuperscript{12} Department of Health (DoH), ‘\textit{Issues for consideration at roundtables on private health insurance - November 2015}’, DoH website, last updated 13 November 2015.  
\textsuperscript{13} Senate Community Affairs References Committee, \textit{Value and affordability of private health insurance and out-of-pocket medical costs}, The Senate, Canberra, December 2017.  
\textsuperscript{14} \textit{Explanatory Memorandum}, op. cit., p. 5.  
\textsuperscript{15} Ibid., p. 7.  
\textsuperscript{16} G Summerhayes, \textit{Health insurer, heal thyself: APRA’s prescription for financial sustainability}, speech, Sydney, 7 February 2018.  
\textsuperscript{17} \textit{Explanatory Memorandum}, op. cit., p. 5.  
\textsuperscript{18} Ibid., pp. 5–6.  
\textsuperscript{19} DoH, ‘\textit{Average premium increases by insurer by year}’, DoH website, last updated 10 February 2017. See also A Biggs, \textit{Private health insurance premium increases—an overview and update}, Background note, Parliamentary Library, Canberra, 1 March 2012.
While gap insurance (known as ‘no gap’, or ‘known gap’) can help protect patients against high medical fees, not all medical practitioners participate in these arrangements.\(^{20}\) Nationally, the proportion of in-hospital services with no medical gaps was 88.1 per cent in the December 2017 quarter.\(^{21}\)

The proportion of medical services with no gap payments has been relatively stable in recent years; however, the level of gap payments where a gap is payable has been rising. Statistics from the regulator APRA show that in the December quarter 2016, the average out of pocket payment by patients for services where there was a gap was around $125.53. By the December quarter 2017, this amount had risen to $165.28.\(^{22}\)

The recent Senate Committee inquiry into the *Value and affordability of private health insurance and out-of-pocket medical costs*, heard evidence on patient co-payments and ‘gaps’:

The committee heard evidence regarding the influence that co-payments and ‘gaps’ have on driving up medical costs. While some health funds have 'no gap' arrangements with certain providers, these may not be the providers the patient is referred to. A patient diagnosed with breast cancer experienced the financial impact of this gap:

“I queried the gap with the private health fund and they said to me: ‘Well you've got the wrong surgeon’ and I said: 'Well when you're told you've got breast cancer, you don't say "hold on a minute, I'll go find another surgeon"'. You're sort of overwhelmed by the diagnosis and you want to get the treatment. I had confidence in him (the surgeon) but not in his bills. It was a lot of money we weren’t expecting to pay".\(^{23}\)

The Committee concluded that the excessive fees charged by some specialists warranted further attention and called for doctors’ fees to be available via a publicly searchable database.\(^{24}\)

A recent survey *Out of pocket pain* conducted by the Consumers Health Forum (CHF) found that among the 1,200 respondents, significant numbers reported incurring high out of pocket costs over the past two years.\(^{25}\) Some 38 per cent of respondents with autoimmune conditions, 27 per cent with breast cancer and 18 per cent with chronic conditions reported out of pocket costs associated with their condition in excess of $10,000.\(^{26}\)

Consumers may face other costs in using their health insurance, for example depending on their policy they may be required to pay an excess up-front or a co-payment for some services. Some policies exclude certain procedures (known as exclusions) or restrict benefits for these.\(^{27}\)

**Complexity of products**

The consultations revealed that consumers often found the range and number of private health insurance products complex and difficult to compare. Compounding this is that the number of

\(^{20}\) Private Health Insurance Ombudsman (PHIO), *‘Out of pocket expenses (gap cover)’*, PrivateHealth.gov.au website for further information. See also, U Mihm, *‘How to avoid surgery out-of-pocket costs’*, Choice, 11 December 2017.

\(^{21}\) Australian Prudential Regulation Agency (APRA), *‘Medical gap’*, Table TA, APRA website, 17 May 2018.

\(^{22}\) Ibid., Table TB.

\(^{23}\) Senate Community Affairs References Committee, *Value and affordability of private health insurance and out-of-pocket medical costs*, op. cit., pp. 8–9.

\(^{24}\) Ibid., Recommendation 3 “The committee recommends that the Minister for Health instruct the Department of Health to publish the fees of individual medical practitioners in a searchable database”, p. 64.

\(^{25}\) Consumers Health Forum of Australia (CHF), *Out of pocket pain*, Research report, CHF, Canberra, 5 April 2018.

\(^{26}\) E Han, *‘Patients hit with huge out-of-pocket care costs’*, *The Age*, 5 April 2018, p. 8.

\(^{27}\) Commonwealth Ombudsman, *‘Policy exclusions and restrictions’*, Commonwealth Ombudsman website, see also PHIO, *Choosing a health insurance policy*, brochure, PHIO, Canberra, August 2014.
policies available in any jurisdiction at any one time is large, although the precise number is difficult to determine.

Standard Information Statements (SISs) provide a summary of the key features of a policy and are meant to allow consumers to compare policies.28 As such they can be a crude measure of the numbers of policies available. The Private Health Insurance Ombudsman (PHIO) estimated there were more than 40,000 SISs on the Privatehealth.gov.au website as at January 2017, although PHIO argued that policies that were no longer available should be deducted from this total. Deducting these brings the number down to 27,281. However, according to PHIO ‘this number does not take into account that one product available for purchase will generate several SISs, as a new SIS must be generated for each premium variation: for example, different excess options, seven state/territories (noting ACT-NSW is counted as one state), four main scales (single, couple, family, single parent family, plus single/young adults, couple/young adults and children only) and three types of policy (Hospital, General treatment, Combined)’.29

The Australian Medical Association (AMA) claims there is ‘a bewildering number of policy options out there for patients; we’ve counted 20,000 variations’.30

Consumers consistently report finding it difficult to compare policies. According to the findings of a 2017 Consumer’s Health Forum awareness campaign:

   A strong theme arising from the comments was that complexity of policies makes comparing and moving between policies a significant challenge. Consumers report that they find the process of comparing policies time consuming and difficult. When they are able devote sufficient time and effort to compare policies they often find they are able to purchase a comparable product for a considerably lower price.31

**Package of reforms announced**

A package of reforms to private health insurance was announced on 13 October 2017. This package was described by the Health Minister Greg Hunt as making private health insurance ‘simpler and more affordable’.32 The major reforms proposed included:

- requiring insurers 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;

- upgrading the privatehealth.gov.au website to make it easier to compare insurance products, and allowing insurers to provide personalised information to consumers on their product every year;

- boosting the powers of the Private Health Insurance Ombudsman and increasing its resources to ensure consumer complaints are resolved clearly and quickly;

- reducing the benefits paid for implanted medical devices under an agreement with the Medical Technology Association of Australia;

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29. PHIO, *‘Clarification on the number of policies available to consumers’*, Private Health Insurance Ombudsman Quarterly Bulletin, 81, 1 October–31 December 2016, p. 4.
30. Dr M Gannon (AMA President), *Interview with Gareth Parker, 6PR Mornings, Private Health Insurance*, transcript, Canberra, 21 August 2017.
31. R Randall, *‘Low value, confusing and time consuming - findings from CHF’s 2017 Awareness campaign’*, Health Voices, 13 April 2017, p. 2.
32. G Hunt (Minister for Health), *Major reforms to make private health insurance simpler and more affordable*, media release, 13 October 2017.
• requiring insurers to allow people with hospital insurance that does not offer full cover for mental health treatment to upgrade their cover and access mental health services without a waiting period on a once-off basis;

• allowing insurers to discount hospital insurance premiums for 18 to 29 year olds by up to 10 per cent, with the discount phasing out after people turn 40;

• allowing insurers to expand hospital insurance to offer travel and accommodation benefits for people in regional and rural areas that need to travel for treatment;

• increasing the maximum excess consumers can choose under their health insurance policies for the first time since 2001;

• preventing insurers from offering benefits for a range of natural therapies, such as Bowen therapy or Rolfing;

• continuing to support private hospitals, including transferring administration of the second tier default benefit, which provides a safety net for consumers attending non-contracted hospitals, to the Department of Health.  

In addition to these reforms, the Government added two further reforms to the package:

• 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.

A series of fact sheets on of these reforms was published on the Department’s website at the time.

Some of the proposed reforms, such as the creation of gold/silver/bronze/basic categories, removal of natural therapies and standard clinical definitions are yet to be finalised and are likely to be enacted through legislative instruments. Some reforms have already been enacted. The removal of the two month waiting period for mental health treatment has been enacted through a legislative instrument, while the cost of implanted medical devices (prostheses) has been lowered under an agreement with the medical devices industry.

**Previously unannounced measures**

The Bill includes two previously unannounced measures relating to benefit limitation periods (BLPs) and closed policies.

**Benefit limitation periods**

A BLP can be variously defined, but ‘commonly (but not definitively) a benefit limitation period is a period (often of 12 or 24 months, but sometimes longer) during which a private health insurer will pay minimum benefits for a treatment, and after which it will pay the full benefits available under the policy.’ Policies with BLPs have been offered by some insurers in return for lower premiums. However, it has recently emerged that such policies may not comply with the PHIA. The Bill

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34. Explanatory Memorandum, op. cit., p. 11.
36. Explanatory Memorandum, op. cit., p. 47.
proposes to remove all BLPs from policies and includes provisions to ensure that policy holders of such products do not incur repayments or liabilities.

**Closed policies**

A closed policy is one which is no longer available for sale, but which continues to cover existing members. The Bill proposes provisions that would allow a health insurer to terminate a policy so that it would no longer be available to anyone, even to those who currently hold a product and transfer them to a new policy.

**Committee consideration**

**Senate Standing Committee for Selection of Bills**

The Bills have not been referred to a committee for inquiry, with the Senate Standing Committee for the Selection of Bills deferring consideration of the Bills at its last two meetings.

**Senate Community Affairs References Committee**

The Senate Community Affairs References Committee considered the Government’s package of private health insurance reforms in its inquiry, *Value and affordability of private health insurance and out-of-pocket medical costs*. In its final report, the Committee commended some of the proposed changes, including travel and accommodation benefits for consumers in rural and regional areas, allowing patients with limited mental health benefits to upgrade their cover without serving a waiting period and reforms to the Prostheses List to constrain the cost of medical devices.

The Committee approached some of the other proposed reforms ‘with caution’. In terms of increasing the maximum excess, the Committee was concerned it ‘may compound’ the difficulty consumers face in understanding what their policy covers them for.

Although the Committee noted support among submitters of a product categorisation system such as the proposed Gold, Silver, Bronze and Basic categories, it received conflicting advice on the role of ‘junk policies’. It recommended an evaluation of the fourth product category, ‘Basic’ be undertaken before including it in the product categorisation system.

**Senate Standing Committee for the Scrutiny of Bills**

The Senate Standing Committee for the Scrutiny of Bills raised a number of concerns with Schedule 3 to the Bill, which proposes amendments to the *Ombudsman Act 1976* (OA) to provide the PHIO with enhanced investigatory powers.

The first area of concern relates to the amendment to allow the PHIO to enter premises occupied by a private health insurer or broker, or where documents or other records relating to the

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40. Ibid., p. 62.
41. Ibid., p. 14. The term ‘junk policies’ is widely used, but broadly refers to policies that offer cheap premiums and minimal benefits (often only in a public hospital) but that exempt the policy holder from incurring a MLS liability.
42. Ibid., pp. 62–3.
business of a private health insurer or broker are kept, without warrant or consent.\textsuperscript{44} Noting that \textit{A Guide to Framing Commonwealth Offences, Infringement Notices and Enforcement Powers} provides that ‘legislation should only authorise entry to premises by consent or under a warrant. Any departure from this general rule requires compelling justification’,\textsuperscript{45} the Committee sought the Minister’s advice as to why it is considered necessary to allow the PHIO to enter premises and inspect documents without consent or a warrant.

The Committee’s second point of concern relates to \textit{proposed section 20ZIA} of the \textit{OA}, at \textit{item 5 of Schedule 3}. This provision will require the PHIO to issue an identity card to a person exercising powers under \textit{proposed sections 20SA} or \textit{20TA} (discussed above) and require that person to carry the card when exercising powers under those sections. \textit{Proposed subsection 20ZIA(4)} requires a person who ceases to be entitled to an identity card to return it to the PHIO within 14 days. Failure to comply with this requirement is an offence of strict liability, with a maximum penalty of one penalty unit ($210).\textsuperscript{46} \textit{Proposed subsection 20ZIA(5)} provides that the offence does not apply if the identity card was lost or stolen, but places an evidential burden on the defendant in relation to this matter. This means that the defendant will be required to adduce or point to evidence that suggests a reasonable possibility that the identify card was lost or stolen.\textsuperscript{47} If the defendant does so, the prosecution must then discharge its legal burden to prove the matter beyond reasonable doubt.\textsuperscript{48} The Committee was concerned that the burden of proof placed on the defendant by proposed subsection 20ZIA(5) impinges on the common law right to be presumed innocent, by removing the need for the prosecution to prove an element of the offence.\textsuperscript{49} The Committee stated that any such reversal should be justified, but is not addressed in the Explanatory Memorandum to the Bill. Accordingly, the Committee considers that it would be appropriate for the Explanatory Memorandum to be amended to incorporate such a justification, which should ‘explicitly address’ the relevant principles set out in \textit{A Guide to Framing Commonwealth Offences, Infringement Notices and Enforcement Powers}.\textsuperscript{50}

The final issue raised by the Committee concerned the broad delegation of administrative power proposed by \textit{item 6 of Schedule 3}. Subsection 34(2C) of the \textit{OA} allows the PHIO to delegate most of his or her powers to a member of staff. \textit{Item 6 of Schedule 3} proposes to amend subsection 34(2C) to allow the PHIO to delegate most of his or her powers to ‘a person’ rather than a member of staff. The Committee sought the Minister’s advice as to:

- why it is considered necessary to allow for the delegation of the PHIO’s functions or powers, including powers of entry and inspection, to any person, including persons outside the APS; and
- the appropriateness of amending the bill to require that the PHIO be satisfied that persons performing delegated functions and exercising delegated powers have the expertise appropriate to the function or power delegated.\textsuperscript{51}

At the time of writing, the Committee had not received a response from the Minister.\textsuperscript{52}

\textsuperscript{44} \textit{Proposed sections 20SA} and \textit{20TA} of the \textit{OA}, at \textit{item 1 of Schedule 3} to the Bill.
\textsuperscript{45} \textit{Attorney-General’s Department (AGD), A guide to framing Commonwealth offences, infringement notices and enforcement powers}, [AGD], [Canberra], September 2011, p. 76.
\textsuperscript{46} Under section 4AA of the \textit{Crimes Act 1914} a penalty unit is currently equal to $210. The prosecution is not required to prove fault for any of the physical elements of a strict liability offence, but the defence of mistake of fact is available: see sections 6.1 and 9.2 of the \textit{Criminal Code Act 1995}.
\textsuperscript{47} Section 13.3 of the \textit{Criminal Code Act 1995}.
\textsuperscript{48} Subsection 13.1(2) of the \textit{Criminal Code Act 1995}.
\textsuperscript{49} Senate Standing Committee for the Scrutiny of Bills, \textit{Scrutiny digest}, 5, 2018, op. cit., p. 49.
\textsuperscript{50} Ibid.
\textsuperscript{51} Ibid., p. 51.
\textsuperscript{52} Senate Standing Committee for the Scrutiny of Bills, \textit{Ministerial responses}, Australian Parliament website.
The Committee had no comment on the other two Bills in the package.\(^{53}\)

**Policy position of non-government parties/independents**

**Labor**

When the Government’s package of reforms was announced in October 2017, Labor acknowledged there were ‘some positive things in this announcement’ including savings from reducing the cost of medical devices on the Prostheses List, the removal of the rebate for natural therapies and getting more young people into private health insurance.\(^{54}\) However, it criticised the proposal for higher permitted excesses, arguing it would expose vulnerable and low income people to unexpected medical costs:

> The Government has traded off increases in excesses for the prospect of slightly lower premiums. Maximum permitted excesses for private hospital insurance will increase from $500 to $750 for singles and from $1,000 to $1,500 for couples/families. As a result, vulnerable and low-income people could face unexpected medical expenses when they need their private health insurance.\(^{55}\)

Labor also criticised the Government for failing to act on ‘junk policies’ and that ‘as a result, patients will continue to be caught out by products that don’t cover essential procedures’.\(^{56}\)

More recently in relation to the Bill, Opposition Health spokesperson Catherine King raised concerns around the issue of policies with non-compliant benefit limitation periods and the Government’s decision to write to health insurers before advising the public of the issue:

> This is another example of Turnbull putting his big business mates ahead of Australian consumers - the Government wrote to insurers but hid it from the Australian public. It reeks of a cover-up.\(^{57}\)

Labor is also concerned there are ‘serious consequences and unanswered questions’ around these non-compliant policies.\(^{58}\)

**Greens**

No specific commentary from the Greens on this Bill was identified at the time of writing. The Greens have been calling for the removal of the private health insurance rebate with savings to be reinvested into the public health system.\(^{59}\)

**Cross benchers**

No specific commentary from cross bench Senators on this Bill was identified at the time of writing.

**Position of major interest groups**

There was broad support overall for the package of private health insurance reforms that was announced in October 2017, although concerns linger among some stakeholders over so-called

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\(^{54}\) C King (Shadow Minister for Health and Medicare), *Turnbull’s private health fail - 70 cents a week for young people, premiums to increase for everyone else*, media release, 13 October 2017.

\(^{55}\) Ibid.

\(^{56}\) Ibid.

\(^{57}\) Ibid.

\(^{58}\) Ibid.

'junk policies' and some remain unconvinced of the decision to offer premium discounts to young people. There has been less commentary on the contents of this Bill.

When the package was announced in October 2017, the Australian Medical Association (AMA) said it welcomed the reforms as 'a long overdue opportunity to bring much-needed transparency, clarity, and affordability to the private health sector.'60 President Dr Michael Gannon said he welcomed the introduction of Gold, Silver, and Bronze categories and the application of standard clinical definitions. While previously calling for so-called ‘junk policies’ to be banned, Dr Gannon said the AMA ‘will watch closely to ensure that any junk policies that remain on the market are clearly described so that people know exactly what they are buying and are not subject to unexpected shocks of non-coverage for certain events or conditions’. The removal of natural therapies, better coverage for mental health services and for people in rural and regional Australia, and enhancements to the Private Health Insurance Ombudsman (PHIO) were also broadly welcomed by the organisation.

The Consumers Health Forum (CHF) described the package of reforms as announced in October 2017, as a ‘welcome response to consumer dissatisfaction with the current pitfalls of private health cover’ that was ‘likely to deliver not only lower premium increases in the medium term but hopefully clearer consumer-friendly policies.’61 It welcomed specific measures including: the introduction of simpler categories of policies (Gold, Silver, Bronze, Basic), the exclusion of treatments such as natural therapies which have no evidence of efficacy, changes to allow better access to mental health care, measures that improve inclusions for those living in rural and regional areas and boosting the powers and resources of PHIO. It also welcomed the establishment of the two expert committees to review out of pocket costs and low value policies.62 However, it was critical of the plan to provide discounts on premiums to younger people, arguing that it would ‘undermine the community rating principle fundamental to Australian health insurance which is meant to treat everybody equally regardless of age or health status’.63 Further, it questioned whether young people would take up the discounted policies:

> Given the cost burdens and modest wages many young people have, it would seem likely that this measure is only likely to be taken up by a minority of young adults who have the means, with the result that the two tiered health system emerging in Australia is entrenched at an even earlier time of life.64

Consumer group CHOICE also welcomed elements of the Minister’s announcement last October including that mental health patients would be able to upgrade their cover immediately, that Gold, Silver, Bronze and Basic categories would be introduced, that price reductions for medical devices were implemented and that additional resources would be given to PHIO. However, it expressed concern the Government would incentivise young people to take up private health insurance, particularly for ‘junk policies’.65 It has also questioned whether people under 31 or those on incomes below $90,000 and who are fit and healthy, really need health insurance.66

The Australian Healthcare and Hospitals Association (AHHA), representing public and not-for-profit hospitals, welcomed many of the components of the health insurance reform package when it was

60. Australian Medical Association (AMA), AMA welcomes government reforms as good start to bringing much-needed transparency, clarity, and affordability to private health insurance, media release, 13 October 2017.
61. Consumers Health Forum (CHF), At last, good news on health insurance, media release, 13 October 2017.
62. Ibid.
63. Ibid.
64. Ibid.
announced. In particular AHHA welcomed the discounts offered to young people to take up health insurance, allowing mentally ill people to upgrade their hospital cover with no waiting period, the removal of ‘natural therapies’ and the extra resources and powers for PHIO. However, it raised concerns that mental health cover and obstetrics might not be included in basic and bronze category products and called for a comprehensive Productivity Commission inquiry into the costs and benefits of private health insurance.

The Australian Private Hospitals Association (APHA), representing private hospitals, also welcomed key elements of the package, including discounts to attract young people into private health insurance and better access to mental health cover. But it continued to have concerns about the availability of ‘junk policies’:

But Mr Roff [APHA CEO] said concerns remain about the issue of ‘junk’ policies.

“It’s disappointing. Not only has the Government not addressed the issue of junk policies, it has, in fact, entrenched them with the new ‘basic’ category. Junk policies are a major cause of consumer dissatisfaction when they discover they don’t have cover for private hospital treatment when they need care.

“If the intent of the private health insurance rebate is to take pressure off public hospitals, then there is no policy justification for applying the rebate to junk policies,” he said.

Catholic Health Australia (which operates a number of private not for profit hospitals) was also broadly supportive of the package. While welcoming the reforms to mental health access, standardised product categories, travel and accommodation benefits for rural Australians, and discounts on premiums to young people, CHA expressed concerns over the decision to allow ‘junk policies’ to continue to be available, describing them as ‘unfit for purpose’.

The private health insurance peak body, Private Healthcare Australia (PHA), indicated broad support for the package when it was announced.

Today’s announcement is a major step in ensuring the sustainability of Australia’s highly regarded mixed private public health system, by improving the value proposition for people at all stages of life. 84% of Australians with private health insurance value the product and want to keep it, however their main concern is affordability. There are 13.5 million Australians with private health insurance and almost half of them have an annual income of less than $50 000. The measures announced by the Government with cooperation from industry and other stakeholders will go a long way towards addressing consumer concerns.

More recently PHA has described the issues around non-compliant benefit limitation periods as ‘fake news’ and ‘conspiracy laden’ and argues that no consumers will be negatively affected.

According to a recent article in an industry newsletter, the Government’s decision to act on BLPs was due to a ‘recent reinterpretation of legislative changes introduced in 2007’. The article claims

67. Australian Healthcare and Hospitals Association (AHHA), Private health insurance shake up welcome, but should only be the beginning of reforms, media release, 12 October 2017.
68. Australian Private Hospitals Association (APHA), Better access: private health insurance reform, media release, 13 October 2017.
69. Catholic Health Australia (CHA), Private health insurance reforms improve value and access, media release, 13 October 2017.
70. Private Healthcare Australia (PHA), PHI Reform delivers value to Australians young and old, media release, 13 October 2017.
71. PHA, PHI rebate keeps Australia’s health system sustainable, media release, 2 April 2018.
that some private health insurers are ‘furious and seeking an explanation over the Department of Health’s handling of changes impacting policies with benefit limitation periods’.  

**Financial implications**

According to the EM, the total financial impact of the measures in the Bill is $6.2 million over the period 2017–18 to 2020–21.  

The *Mid-Year Economic and Fiscal Outlook 2017–18* provided $4.0 million in funding to the Commonwealth Ombudsman (which is responsible for PHIO) and $32.8 million to the Department of Health over the period 2017–18 to 2020–21 to implement the entire package of reforms. These expenses were to be offset by $39.4 million in savings from the Department of Veterans’ Affairs.

There are likely to be regulatory costs on industry, although as the EM notes, many of these will be ‘one off’ costs primarily involving system changes and changes to information for consumers. The EM also notes there may be regulatory savings for the industry. Estimates of these costs are provided in Attachment A of the EM. In total, the regulatory cost to private health insurers over ten years is estimated to be $3.3 million, and to health insurance brokers $1.9 million.

**Statement of Compatibility with Human Rights**

As required under Part 3 of the *Human Rights (Parliamentary Scrutiny) Act 2011* (Cth), the Government has assessed the Bills’ compatibility with the human rights and freedoms recognised or declared in the international instruments listed in section 3 of that Act. The Government considers that the Bills are compatible.

However, the Statement notes that in relation to amendments proposed in Schedule 5, Part 4 (closed and terminated products), these provisions ‘may limit choice in access to health services for people who hold a terminating product and do not wish to transfer to a new product’. It further notes that ‘these people will still be eligible to receive the benefits of universal health care under the Australian public health system and may continue to access the private health system as privately self-funded patients’.

**Parliamentary Joint Committee on Human Rights**

The Parliamentary Joint Committee on Human Rights considers that the Bills do not raise human rights concerns.

**Key issues and provisions**

**Schedule 1—Increasing maximum excess levels**

The *Medicare Levy Act 1986* (MLA) specifies the operation of the Medicare Levy Surcharge (MLS). The MLS applies to higher income earners who do not purchase private hospital cover.

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74. Australian Government, *Mid-Year Economic and Fiscal Outlook 2017–18*, p. 160. The savings from Veterans Affairs may be due to the expected significant savings from the lowering of the cost of implanted medical devices.
76. Ibid., p. 33.
77. The Statement of Compatibility with Human Rights can be found at pages 34–38 of the *Explanatory Memorandum* to the Bill. The Statement of Compatibility with Human Rights for the two related Bills can be found at pages 39–40.
78. Ibid., p. 35.
Subsection 3(5) of the MLA specifies the type of private health insurance that is required to be held in order to be exempt from paying the MLS. Paragraph 3(5)(b) specifies that if any excess is payable under a complying health insurance policy, it must be no higher than $500 per annum for coverage of a single person, and no more than $1,000 per annum for other types of cover (couples or families). These voluntary maximum excess levels have not been adjusted since 2000.\textsuperscript{81}

An excess is an amount of money the policy holder agrees to pay for a hospital stay before benefits from health insurance are payable. An excess is sometimes also called a ‘front end deductible’.\textsuperscript{82}

Private health insurers can offer a policy with an excess, usually in return for charging a lower premium. However, consumers who purchase products with an excess will face up-front costs when they are admitted to hospital. Typically a policy with a higher excess is best suited to healthier consumers, who are less likely to be hospitalised.\textsuperscript{83} It is recommended that policies with an excess be regularly reviewed, particularly as the policy holder ages.\textsuperscript{84} As of June 2017, just under 83 per cent of policies included an excess or co-payment, up from 77.2 per cent in 2012.\textsuperscript{85}

Because consumers will be able to choose a policy with a higher excess in exchange for a lower premium, it is expected to result in an increase in health insurance participation and put downward pressure on premiums.\textsuperscript{86} The EM notes that if the number of consumers taking out policies with higher excesses increases as expected from this measure, it will result in $8 million in additional expenditure over four years on the Private Health Insurance Rebate.\textsuperscript{87}

**Amendments to the Private Health Insurance Act 2007**

**Item 1** of **Schedule 1** to the Bill inserts **new Division 45** in the PHIA, which sets out the increased maximum voluntary excess that can be applied is $750 in any 12 month period for a policy covering a single person, and $1,500 in any 12 month period for other types of cover.

**Item 2** specifies that the new excess levels apply to the 2018–19 income year and later income years.

Associated amendments are proposed for the MLA and **A New Tax System (Medicare Levy Surcharge–Fringe Benefits) Act 1999**, in the two related Bills.

**Medicare Levy Amendment (Excess levels for Private Health Insurance Policies) Bill 2018**

**Schedule 1** of the Medicare Levy Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018 proposes to replace paragraph 3(5)(b) of the MLA (discussed above) to specify that, to qualify for an exemption from the MLS any excess payable under the policy is not more than the amount set out in **new section 45-1** of the PHIA.
A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Amendment (Excess Levels for Private Health Insurance Policies Bill 2018

The *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999* imposes the MLS on the reportable fringe benefits of higher income earners. Paragraph 4(1)(b) of that Act currently provides that a person will be exempt from paying the MLS on reportable fringe benefits if they are covered by a private health insurance policy under which any excess payable is no higher than $500 per annum for coverage of a single person, and no more than $1,000 per annum for other types of cover.

Schedule 1 of A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018 proposes to replace paragraph 4(1)(b) of the *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act* to specify that, to qualify for an exemption from the MLS any excess payable under the policy is not more than the amount set out in new section 45-1 of the *PHIA*.

Schedule 2—Age-based discounts for hospital cover

Declining private health insurance membership, particularly among young people, has emerged as a key issue of concern, given that younger members cross subsidise the premiums of older, less healthy members.  

Figure 1 from the Explanatory Memorandum clearly shows the decreasing rates of participation among young people:

![Figure 1: Private health insurance participation (hospital cover) by age category](image)


The Government argues that if no changes are made to address participation levels ‘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’.  

88. Ibid., p. 6.
89. Ibid.
This issue was also highlighted in the Senate Committee report on the value and affordability of private health insurance. Some submitters to the inquiry warned of a ‘death spiral’ if younger people failed to take up private health insurance, although this view was not shared by the regulator, APRA.90 It was suggested to the Committee that discounted premiums for people under 30 would be an incentive for young people to take up private health insurance.91

Some commentators have questioned whether age-based discounts will be effective in attracting enough young people to private health insurance. For example, Stephen Duckett from the Grattan Institute has cautioned that many young people might still be unable to afford health insurance:

The big winner from the changes is a 25-year-old, living in a small rural town, who already has health insurance. They could get a 10% discount and improved benefits. But of course, few Australians fall into this category. And whether a 10% discount is enough to increase health insurance take up by young people, many of whom are in precarious employment arrangements or unemployed, is a question for the marketeers.92

Schedule 2 proposes provisions to allow insurers to offer age-based discounted private health insurance. Details of the age-based discounts are not detailed in the Bill but will be specified in the Complying Product Rules. The Minister has previously indicated that discounts of up to ten per cent will be permitted and will phase out after people turn 40.93

Items 1 and 2 propose amendments to the Private Health Insurance Act 2007. As explained above, the private health insurance system incorporates the principle of community rating, which prevents private health insurers from discriminating between people on the basis of their health or for any other reason set out in Part 3-2 of the PHIA.94 Such action is termed ‘improper discrimination’ and is defined at subsection 55-5(2) of the PHIA to include discrimination based on gender, race and the frequency with which a person needs health treatment. Within this definition, paragraph 55-5(2)(c) provides that discrimination that relates to the age of a person is improper discrimination, except to the extent allowed under Part 2–3 of the PHIA (which deals with LHC95) and subsection 63–5(4), which allows a higher premium to be charged for a policy that includes a dependent child aged between 18 and 24 who is not studying. Item 1 amends paragraph 55-5(2)(c) to also permit discrimination based on age to the extent allowed under new paragraph 66-5(3)(ea). Item 2 inserts new paragraph 66-5(3)(ea), which specifies that an age-based discount as set out in the Private Health Insurance (Complying Product) Rules is allowed.

Because the provisions propose an age-based component, items 3 and 4 propose amendments to the Age Discrimination Act 2004, which, as currently relevant, makes it unlawful to discriminate against someone on the basis of age in the provision of goods, services and facilities unless an exemption applies.96 Currently an exemption exists for action taken in compliance with specified provisions of the PHIA, including Part 2–3 and subsection 63–5(4). This will be extended to also exempt action taken under new paragraph 66-5(3)(ea) and the Complying Product Rules.

90. Senate Community Affairs References Committee, Value and affordability of private health insurance and out-of-pocket medical costs, op. cit., p. 35.
91. Ibid. NIB and BUPA were both cited as having made this suggestion.
92. S Duckett, ‘Changes to lure young people into private health insurance won’t slow increase in premiums’, The Conversation, 13 October 2017.
93. Hunt, Major reforms to make private health insurance simpler and more affordable, op. cit.
94. Section 55–1 of the Private Health Insurance Act 2007.
95. LHC imposes a two per cent annual loading on the cost of premiums for people over 31 who delay taking out private health insurance. See Biggs, Private health insurance: a quick guide, op. cit.
Schedule 3—PHIO’s powers

The Private Health Insurance Ombudsman (PHIO) has been an office under the Ombudsman Act 1976 (OA) since 2015. The office had existed before that time as a separate statutory agency, with its functions and powers then set out in the Private Health Insurance Act 2007. The office was merged into the office of the Ombudsman to give effect to a 2014 budget commitment to streamline the number of government agencies.97

While the PHIO was abolished as a statutory agency in 2015, the PHIO, as with a number of other Ombudsman roles under the OA,98 remains a separate statutory office. Thus its particular functions and powers are also specified separately in the OA, rather than just sharing the general powers of the Ombudsman. The primary purpose of Schedule 3 of the Bill is to strengthen the PHIO’s powers. It will have no effect on any other statutory office in the OA.

A basic role of the PHIO is to investigate complaints about private health insurers.99 To perform this task effectively, the PHIO needs adequate powers to force private health insurers to cooperate with the PHIO’s investigations.

Currently the OA allows the PHIO to investigate a complaint that has been made (normally by a consumer),100 or to initiate an investigation him or herself (commonly called an ‘own motion investigation’).101 To assist the PHIO in an investigation, he or she can require a person, by notice in writing given to the person, to give information or access to records of an insurer.102 However, while the OA ‘requires’ a person to provide such information, it is silent on what happens if they do not.

The proposals in Schedule 3 enhance the PHIO’s ability to gain relevant information in the course of investigations, by giving the PHIO the power to enter the premises of private health insurers or of brokers of such products, and to examine and copy records at those premises (proposed sections 20SA and 20TA of the PHIA, at items 1 and 2 of Schedule 3). Item 4 contains penalties for persons who fail to assist the PHIO in the exercise of the PHIO powers under proposed sections 20SA and 20TA.103 To safeguard the private health insurers and brokers, and to ensure that it is only PHIO staff who enter premises and examine documents, item 5 also introduces identity card provisions for PHIO staff.104

The ‘right to entry’ provisions are similar to powers already available to the Commonwealth Ombudsman,105 although the Commonwealth Ombudsman’s powers are not underpinned by specific penalty provisions. This difference can be explained by the Commonwealth Ombudsman’s powers basically only giving the power to enter the premises of a Commonwealth agency or a Commonwealth service provider. Specific penalty provisions are presumably deemed unnecessary, as staff of those agencies could be penalised for non-compliance under code of conduct provisions in the Public Service Act 1999. However, the proposed provisions will give the PHIO the power to

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98. For example the Defence Force Ombudsman and the Postal Industry Ombudsman.
100. Ombudsman Act 1976, section 20P.
101. Ombudsman Act 1976, section 20T.
102. Ombudsman Act 1976, section 20ZE.
103. Proposed section 202HB.
104. Proposed sections 20HZA and 20ZIA.
enter the premises of private businesses in the health insurance sector. The proposed maximum penalty is 30 penalty units – a penalty unit is currently a fine of $210. The penalty could only be applied by a court.

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

Some health insurers impose Benefit Limitation Periods (BLPs) which are periods of cover, usually from one to three years, during which time only a minimal benefit is paid for treatment. Division 75 of the PHIA specifies maximum waiting periods for hospital benefits that apply for certain conditions. A maximum 12 month waiting period normally applies to pre-existing conditions and to obstetrics, while for most other conditions (including psychiatric care) the maximum waiting period is two months. Waiting periods apply at the start of a new private health insurance policy or if the level of cover is increased. The Government committed to removing the two month waiting period for psychiatric treatment when it announced its package of reforms in October 2017. This was implemented by the Private Health Insurance (Complying Product) Amendment (Psychiatric Care) Rules 2018, which commenced on 1 April 2018.

It has recently emerged that policies with BLPs may be non-compliant with the waiting period requirements of the PHIA. The Government acknowledges the legal status of these BLPs is ‘confusing’, so is proposing to remove all such BLPs from future use. Transitional provisions will make existing policies with BLPs, so-called ‘irregular’ policies sold between 1 April 2007 and 30 June 2018, compliant with PHIA, so that consumers remain eligible for the private health insurance rebate and exempt from the Medicare Levy Surcharge (MLS) and Lifetime Health Cover (LHC) loadings and will not be required to repay any rebate they may have received or be liable for the MLS or LHC. It would appear that policies with BLPs that cover the time period between the Bill’s introduction and the BLP withdrawal date of 1 July 2018 would remain in force. The Bill does not specify that these policy holders be exempted from BLP provisions during this period.

According to a media report, some 12 health funds have been asked by the Department to withdraw their irregular BLP policies. However, it is not clear how many policy holders have purchased such non-compliant policies over the years. Another media report suggests that some 25,000 current policy holders will have their BLPs removed.

It has also been suggested that the removal of BLPs from the market could result in a ‘marginal increase’ in premiums in 2019.

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106. [Crimes Act 1914](https://example.com), section 4AA. Accordingly, the maximum penalty is $6,300.
107. [Explanatory Memorandum](https://example.com), op. cit., p. 47. See also PHIO, [‘Waiting periods’](https://example.com), PrivateHealth.gov.au website. Following the limited benefits period, benefits revert to the full amount. BLPs are in addition to mandated waiting periods.
108. PHIO, [‘Waiting periods’](https://example.com), op. cit.
109. [Hunt](https://example.com), [Major reforms to make private health insurance simpler and more affordable](https://example.com), op. cit.
110. [Private Health Insurance (Complying Product) Amendment (Psychiatric Care) Rules 2018](https://example.com).
111. [Department of Health](https://example.com), ‘[Private health insurance benefit limitation periods – changes to improve information for private health insurance members](https://example.com), DoH website, last updated 16 March 2018. The waiting period requirements specified in the Act will remain unchanged.
112. Ibid.
113. [R Baxendale](https://example.com), [‘Cover up’ claims on health](https://example.com), The Australian, 2 April 2018, p. 5. Insurers will have until 30 June 2018 to remove benefit limitation periods from their policies, see [Explanatory Memorandum](https://example.com), op. cit., p. 48.
115. Ibid. This is because the removal of these longer waiting times will allow consumers to make claims for full benefits when the legally mandated waiting periods have expired. Consequently, claims outlays could increase.
Items 1–2 of Schedule 4 to the Bill provide a simplified outline and definitions, including a definition of benefit limitation periods, which is broadly defined as ‘having the meaning generally accepted within the health insurance industry’. This is intended to cover all possible definitions of BLPs in use, as there are many. Item 3 re-defines a health insurance policy with one or more benefit limitation periods as an irregular policy, for transitional purposes. Subitem 3(3) applies to policies with BLPs for psychiatric care applying between 1 April 2018 and 30 June 2018 and relates to the Government’s (already implemented) measure to remove the two month waiting time for psychiatric care from 1 April 2018. Item 4 provides that an irregular policy be treated as if it were a compliant policy during the period 1 April 2007 to 30 June 2018. The effect of making these policies retrospectively compliant is to protect the holders of those policies from legal risk. If it was found that these persons had not held complying health insurance policies in that period, they could become liable, at least theoretically, to pay the Medicare Levy Surcharge and to attract penalties under Lifetime Health Cover, among other things. Making the policies retrospectively compliant removes that risk to consumers.

Item 5 operates to waive any debts arising from payments to an insurer under the Premium Reduction Scheme, which allows an insurer to offer a discounted premium to a consumer for which they are then reimbursed. Similarly, item 6 waives any debts arising from rebate payments to a person under the Private Health Insurance Incentives Scheme, that might otherwise be payable.

Subitems 4(2)–4(4) allow the Minister to seek remedies in the Federal Court against an insurer and for common law action to be brought by a policy holder.

Schedule 5—Miscellaneous

Part 1—Benefits for travel and accommodation

Currently, private health insurers are unable to offer benefits for the cost of travel and accommodation when a policy holder needs to travel for hospital treatment, meaning that the policy holder may incur significant out of pocket costs. This particularly disadvantages people living in rural and regional areas who often must travel significant distances to access hospital treatment. Travel and accommodation benefits are currently only offered under top level general (extras) treatment policies. 116 The proposed provisions would allow insurers to offer travel and accommodation benefits for hospital policies, and make these eligible for risk equalisation purposes. 117

Item 1 replaces paragraph 55-5(2)(d) of PHIA, which bans insurers discriminating on the basis of where a person lives except as allowed under subsection 66-10(2) or section 66-20, with a new paragraph that includes the existing exceptions but adds new section 66-25 to the list of exceptions.

Item 2 inserts new section 66-25 which allows an insurer to pay different amount of hospital and general treatment benefits based on the distance between a person’s home and the facility where treatment is provided.

116. Department of Health, Private health insurance reforms: improved access to travel and accommodation benefits for regional and rural areas, Fact sheet, Department of Health, Canberra. Around half of all health insurers offer benefits for travel and accommodation.

117. Risk equalisation is a key component of the ‘community rating’ principle, as it balances the cost of high claiming hospital policy holders across the sector through the operation of the Risk Equalisation Trust Fund (RETF). All private health insurers participate in the RETF. The Private Health Insurance (Risk Equalisation Policy) Rules 2015 specify what benefits are eligible for risk equalisation purposes.
Item 3 inserts new subsection 121-5(2A) to specify that benefits for travel and accommodation can be included in the meaning of ‘hospital treatment’, which is defined in existing subsections 125-5(1) or (2).

Item 4 adds a reference to new subsection 121-5(2A) in subsection 121-5(4), which allows the Minister to exclude specified travel and accommodation benefits from the definition of hospital treatment in the Private Health Insurance (Health Insurance Business) Rules.

Item 5 inserts new subsection 121-10(2A) to specify that benefits for travel and accommodation can be included in the meaning of ‘general treatment’.

Item 6 adds a reference to new subsection 121-10(2A) in subsection 121-10(3), which allows the Minister to exclude specified travel and accommodation benefits from the definition of general treatment in the Private Health Insurance (Health Insurance Business) Rules.

Part 2—Information requirements

This Part changes the nomenclature of the method used by private health insurers to provide information to consumers about their policy. Currently, private health insurers must provide current information about a policy in a ‘standard information statement’. The Private Health Insurance (Complying Product) Rules set out the requirements of these statements and the method of their communication. This Part proposes the name of the statement be changed from 1 April 2019 to ‘private health information statement’.

The Rules currently specify that these statements follow a specific format. However, it is intended that the Rules will be amended to allow for a technology neutral format. Allowing private health insurers to provide product information in a format such as email, or electronically, should lead to lower administrative costs for insurers.

Items 7–21 replace the term ‘standard information statement’ with ‘private health insurance statement’ in the specified subsections of Division 93 of the Act, which relates to giving information to consumers.

Items 22–27 replace the term ‘standard information statement’ with ‘private health insurance statement’ in the specified subsections of Division 96 of the Act, which relates to giving information to the Department of Health and the PHIO.

Items 28–30 amend Schedule 1 of the PHIA (the dictionary). Item 28 specifies that private health information statement is defined in section 93–5 of the Act, while item 29 repeals the definition of standard information statement. Item 30 replaces the term standard information statement with private health information statement in the definition of ‘up to date’.

Part 3—Benefit requirements according to class of hospital

Schedule 5 of the Private Health Insurance (Benefit Requirements) Rules 2011 specifies arrangements around second tier default benefits. A second tier default benefit is the benefit a private health insurer must pay for an episode of hospital treatment that is provided to a policy

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118. As set out in Schedules 1–4 of the Private Health Insurance (Complying Product) Rules 2015, the format of the statement is required to fit on an A4 page (except for combined hospital/general treatment).
120. Department of Health, Private health insurance reforms: information provision, Fact sheet, Department of Health, Canberra.
holder in a hospital with which the insurer does not have a contractual arrangement. Facilities participating in second tier default benefit arrangements must comply with certain quality and service criteria, as set out in the Rules.

Second tier benefits are calculated according to a formula specified in the Rules. The formula requires that the benefit paid be ‘no less than 85% of the average charge for the equivalent episode of hospital treatment, under that insurer’s negotiated agreements in force on 1 August of the first year with all such comparable private hospitals in the State in which the facility is located.’

Currently, a facility wanting to apply for second tier default benefit status must apply to the Second Tier Advisory Committee (STAC), an industry body which determines the applicant’s eligibility against the criteria set out in the Rules. The provisions in this Part propose to change application arrangements so as ‘to streamline processes and reduce the administrative burden on both private hospitals and health insurers’.

Item 31 of Schedule 5 to the Bill specifies the new application arrangements by inserting new sections 121-8 to 121-8D into the PHI Act. Instead of applying to the STAC, a facility wanting to be classified as second tier default benefit eligible, will be required to apply to the Minister for Health, on the form and in the manner to be set out in the Private Health Insurance (Health Insurance Business) Rules 2017, and pay an application fee. The new sections would require the Minister to make a decision as to whether the facility satisfies the assessment criteria as specified in the Rules within 60 days. If an application is approved, the facility must be notified in writing of its inclusion and the time the inclusion begins and ends. If unsuccessful the Minister must still notify the facility within 60 days and provide reasons.

The new section also allows the Minister to revoke a facility’s status if it no longer satisfies the assessment criteria. In addition, Schedule 5 allows for a negative decision to be reviewed by the Administrative Appeals Tribunal (AAT). Item 32 amends a table at section 328-5 of the PHI Act, which lists decisions that are reviewable by the AAT, to include decisions made under the new sections.

Part 4—Closed and terminated products

Currently, private health insurers are allowed to close a policy to new policy-holders while allowing it to provide benefits for existing members. The EM does not specify how many closed policies exist, nor is this easy to determine. However, based on PHIO figures, it is estimated there could be some 12,791 closed SISs as at January 2017.

These provisions would allow insurers to terminate a policy, even if it is currently held by a policy holder, provided the policy holder is informed in a reasonable timeframe. A policy holder who has their existing policy closed may be offered an associated product. However, this would not prevent a policy holder from changing their policy or switching funds.

121. Private health insurers may enter contractual arrangements with hospitals where the fund agrees to meet the cost of treatment so that the patient has no or minimal out of pocket costs. See PHIO, Choosing a health insurance policy, op. cit., p. 2.
122. Schedule 5, section 3(4) of the Private Health Insurance (Benefit Requirements) Rules 2011.
124. PHIO, ‘Closed policy’ Glossary, op. cit.
125. PHIO, ‘Clarification on the number of policies available to consumers’, op. cit., p. 4. This calculation was made using estimates of the number of available Standard Information Statements (SISs) which describe the key features of a policy. SISs can act as a crude proxy measure of the number of policies available. However, PHIO cautions against relying on this methodology for accuracy as it is likely to overstate the number.
This part also relates to Schedule 4 of the Bill, which provides transitional provisions for the removal of BLPs. Allowing insurers to close off policies to existing policy holders, should facilitate the removal of BLPs, as policies with BLPs could be closed to existing policy holders altogether.

Item 33 repeals and replaces section 55-10 of the PHIA. Proposed paragraph 55-10(a) specifies that the principle of community rating is not breached if a private health insurer closes a complying policy to anyone except those who are already insured under the policy. New paragraph 55-10(b) similarly specifies that the principle of community rating is not breached if a private health insurer terminates a complying policy for those who are insured under the policy.

Section 78–1 of the PHIA sets out the portability requirements for health insurance policies. Item 35 inserts new subsection 78-1(5A) which allows insurers to transfer an adult policy holder to an alternative policy if their policy is terminated, provided the policy holder is informed in writing in a ‘reasonable time’ of the matters set out in the Private Health Insurance (Complying Product) Rules. However, it remains unclear if the ‘reasonable time’ would provide a policy holder with sufficient time to shop around if they decide they don’t want the replacement policy being offered.

Concluding comments

Private health insurance plays a major role in the Australian health system and attracts significant government support, for example, in the form of the private health insurance rebate. Issues around consumer affordability, transparency and declining membership have been identified as significant issues in recent years.

The package of private health insurance reforms announced by the Government attracted broad support; but some stakeholders have expressed concerns around the continued availability of ‘junk policies’ and discounts to young people. Concerns around BLPs and closed/terminated products may also emerge.

The Bill and the two related Bills, propose to enact some of the reforms that were previously announced, in order to make health insurance ‘simpler and more affordable’. While the Minister announced a package of reforms in October 2017, only some will be enacted by the passage of this Bill. Specifically, the Bill proposes:

- to allow maximum excess levels of products to be increased
- to allow health insurers to offer age-based discounts for hospital insurance to young people
- to strengthen the powers of the Private Health Insurance Ombudsman which oversees consumer issues
- to remove benefit limitation periods from health insurance products and make transitional provisions
- to allow health insurers to offer benefits for travel and accommodation under hospital cover
- to enhance information provision arrangements
- to reform second tier default benefit arrangements and

126. Portability rules mean that if a policy holder transfers to a policy with the same or lower benefits no additional waiting periods apply. However, if the policy they transfer to has higher benefits waiting periods may need to be served. PHIO, ‘Leaving or moving funds’, PrivateHealth.gov.au website.

• to allow health insurers to close terminated products and transfer policy holders to a new policies.

Other promised reforms have been, or will be, enacted through legislative instrument or other means.

Although the provisions in this Bill may address some concerns around private health insurance it seems likely the debate on private health insurance and its role in funding our healthcare needs into the future is set to continue. This will also be driven by concerns over funding the health needs of our ageing population into the future.