PRIVATE HEALTH INSURANCE LEGISLATION AMENDMENT BILL 2018
A NEW TAX SYSTEM (MEDICARE LEVY SURCHARGE – FRINGE BENEFITS) AMENDMENT (EXCESS LEVELS FOR PRIVATE HEALTH INSURANCE POLICIES) BILL 2018
MEDICARE LEVY AMENDMENT (EXCESS LEVELS FOR PRIVATE HEALTH INSURANCE POLICIES) BILL 2018

EXPLANATORY MEMORANDUM

(Circulated by authority of the Minister for Health, the Honourable Greg Hunt MP)
OUTLINE

This package of three Bills supports the implementation of reforms to private health insurance announced by the Government on 13 October 2017. The Private Health Insurance Legislation Amendment Bill 2018 (the Bill) contains the primary amendments that will amend the Private Health Insurance Act 2007 (the PHI Act), the Ombudsman Act 1976 and the Age Discrimination Act 2004.

The measures contained in the Bills will:
- 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
- improve consumer transparency by removing the use of benefit limitation periods in private health insurance policies.

The private health insurance reform package was the result of extensive consultation, including through the Private Health Ministerial Advisory Committee.

Private Health Insurance Legislation Amendment Bill 2018

This Bill will amend the Private Health Insurance Act 2007 (the Act) and associated legislation to support reforms enabling private health insurers increased flexibility to offer hospital cover products with improved value in terms of lower premiums through the application of age-based discounts, increased maximum voluntary excess levels, and allowing insurers to offer benefits for travel and accommodation as part hospital treatment cover. The Bill also includes amendments to the Act to facilitate the introduction of reforms that improve information provided to consumers; streamline second tier default benefit arrangements for private hospitals; and allow insurers to terminate products and transfer affected policy-holders to new products. It includes transitional provisions to address issues arising from possible non-compliance with the Act.

The Ombudsman Act 1976 is also amended under this Bill to strengthen consumer protection through the expansion of the powers of the Private Health Insurance Ombudsman (PHIO). The PHIO’s existing powers will be strengthened to enable inspections and audits at the premises of private health insurers or brokers as part of complaint handling or in the context of investigations by the PHIO at his or her own initiative.

Schedule 1- Increase to maximum excess levels
Insurers will be able to offer products with increased maximum voluntary excess levels that exempt the holder from the Medicare levy surcharge. This will be enabled by amendments in the three Bills which contain amendments to the Private Health Insurance Act 2007, A New Tax System (Medicare Levy Surcharge – Fringe Benefits) Act 1999 and Medicare Levy Act 1986.

Consumers will have the opportunity to purchase products with a larger excess, in return for lower premiums.

Schedule 2 – Age-based discounts for hospital cover
Insurers will be permitted to offer products which provide age-based discounts which meet the conditions to be set out in the Private Health Insurance (Complying Products) Rules. It is intended that, in line with the announced policy, the Private Health Insurance (Complying Product) Rules will be amended to introduce a framework for insurers to offer products with age-based discounts.

This is intended to improve the affordability of private health insurance for young Australians, increasing their access to private hospital services.

An amendment to the Age Discrimination Act 2004 has also been included to allow for these discounts to be made available to younger people.

Schedule 3 – Strengthening the powers of the Private Health Insurance Ombudsman
The Private Health Insurance Ombudsman will have the power to conduct inspections, and investigations associated with complaints or compliant related matters and conduct audits at the premises of private health insurers or brokers. Offence provisions have been established to support the enforcement of these powers.

Schedule 4 – Transitional provisions relating to the treatment of certain health insurance policies
The Government will improve consumer transparency by removing the use of benefit limitation periods in private health insurance policies. The Bill ensures that consumers who have purchased benefit limitation period inclusive policies since the Private Health Insurance Act 2007 was introduced:
• do not need to repay premium rebates they have received;
• are not retrospectively liable for the Medicare Levy Surcharge; and
• are not liable for Lifetime Health Cover loadings.

Schedule 5 Part 1 - Benefits for travel and accommodation for hospital treatment cover
Insurers will be allowed to offer travel and accommodation benefits as part of hospital treatment cover. As part of hospital treatment benefits for travel and accommodation are eligible for risk equalisation. This provides an incentive for insurers to offer travel and accommodation benefits as part of the hospital treatment cover. Risk equalisation supports community rating by sharing much of the costs for high risk members between all insurers. This change benefits people (particularly those that live in rural and remote areas) who need to access hospital services not available locally.

Schedule 5 Part 2 Information requirements
A ‘Private Health Information Statement’ will replace the current ‘Standard Information Statement’ (SIS) as the required method by which an insurer must provide information to consumers.
The SIS will be discontinued from 1 April 2019 and insurers will be required to maintain and provide up to date information about complying health insurance products in the form of a Private Health Information Statement, the requirements for which will be set out in the Private Health Insurance (Complying Product) Rules. This updated Information Statement will provide insurers with more flexibility surrounding the format, content and delivery of information, and give consumers access to better information.

**Schedule 5 Part 3 Second tier administrative reforms**
A legislative framework will be established in which the Minister for Health will assess and determine whether or not to include a private hospital in a class of hospitals eligible for second-tier default benefits. This is a departure from the current decision making process which is administered by the industry-based Second Tier Advisory Committee.

Under the new arrangements, a hospital can apply to the Minister to be included in a class set out in the Private Health Insurance (Health Insurance Business) Rules. 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. There will be provision for certain decisions to be subject to review by the Administrative Appeals Tribunal.

**Schedule 5 Part 4 – Closed and terminated products**
The Bill includes amendments to allow insurers to terminate a product and to transfer all people insured under that product to new policies. The insurer will be required to inform the person being transferred of a range of matters which are intended to be included in the Private Health Insurance (Complying Product) Rules. These provisions do not reduce an insured person’s other portability entitlements such as not having to re-serve waiting periods when moving to a new policy.

**Medicare Levy Surcharge exemption and related matters**
In order to give effect to the increased maximum voluntary excess levels which is included as part of Schedule 1 of the Bill, this package also includes two additional Bills containing amendments to taxation laws:

1. The A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018 (Medicare Levy Surcharge Amendment Bill) to amend the A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999; and


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

This Bill amends the principal Act to provide that the maximum voluntary excess level a policy can have to exempt the holder from the Medicare Levy Surcharge is set out in the Private Health Insurance Act 2007.

The Bill also removes grandfathering provisions that provided the Medicare Levy Surcharge exemption for certain health insurance policies that pre-date the commencement of the Private Health Insurance Act 2007. Individuals will need to migrate to a policy that has an excess no more than the new maximum in order to remain eligible for the Medicare Levy Surcharge exemption.
Medicare Levy Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018
This Bill amends the principal Act to provide that the maximum voluntary excess level a policy can have to exempt the holder from the Medicare Levy Surcharge is set out in the Private Health Insurance Act 2007.

The Bill also removes grandfathering provisions that provided the Medicare Levy Surcharge exemption for certain health insurance policies that pre-date the commencement of the Private Health Insurance Act 2007. Individuals will need to migrate to a policy that has an excess no more than the new maximum in order to be eligible for the Medicare Levy Surcharge exemption.

Policy Background
On 13 October 2017, the Government announced reforms to private health insurance designed to simplify private health insurance and make it more affordable for consumers. The package consists of the following reforms:
- Product design reforms, including:
  - A new system for categorising health insurance products (Gold/Silver/Bronze/Basic product categories);
  - Enhancing mental health support to improve patient access to mental health services;
  - Establishing the Improved Models of Care Working Group to provide advice on improving the funding arrangements for private health insurance funded mental health and rehabilitation services;
- Introducing standard clinical definitions;
- Improved access to travel and accommodation benefits which will benefit regional and rural patients and their carers;
- Strengthening the powers of the Private Health Insurance Ombudsman;
- Establishing the Ministerial Advisory Committee on Out-of-Pocket Costs to consider best practice models for transparency of out-of-pocket costs;
- Information provision reforms, including upgrading the Government’s website (privatehealth.gov.au) and the development of a minimum data set for consumers;
- Allowing private health insurers to offer discounted private hospital cover to people aged 18 to 29;
- Prostheses List benefit reductions;
- Increasing maximum excess levels;
- Changing coverage for some natural therapies; and
- Second-tier administrative reforms.

Financial Impact Statement
The total financial impact of the measures contained in the Bill from 2017-18 to 2020-2021 is $6.2 million.
Regulation Impact Statement

A Regulation Impact Statement is not required for Schedule 4 (OBPR ID 23453).

The following Regulation Impact Statement covers the remaining Schedules.

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

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 category**

![Graph showing hospital treatment policies by age category](image)

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.

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

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1. Australian Prudential Regulation Authority, Private Health Insurance Membership Trends, June 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.³ 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 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.

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

<table>
<thead>
<tr>
<th>Singles Families</th>
<th>≤$90,000 &lt;=$180,000</th>
<th>$90,001-105,000</th>
<th>$180,001-210,000</th>
<th>$105,001-140,000</th>
<th>$210,001-280,000</th>
<th>≥$140,001 ≥$280,001</th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Tier</td>
<td>0.0%</td>
<td>1.0%</td>
<td>1.25%</td>
<td>1.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 3</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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4 Australian Prudential Regulation Authority, Private Health Insurance Membership Trends, June 2017.
5 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 2015-16

<table>
<thead>
<tr>
<th>Rate</th>
<th>Number of taxpayers</th>
<th>Amount of Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0%</td>
<td>70,571</td>
<td>$61,720,785</td>
</tr>
<tr>
<td>1.25%</td>
<td>55,041</td>
<td>$69,793,906</td>
</tr>
<tr>
<td>1.5%</td>
<td>29,943</td>
<td>$74,340,999</td>
</tr>
<tr>
<td>Others</td>
<td>592</td>
<td>$313,957</td>
</tr>
<tr>
<td>TOTAL</td>
<td>156,147</td>
<td>$206,169,647</td>
</tr>
</tbody>
</table>

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.

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

<table>
<thead>
<tr>
<th>Singles</th>
<th>Families</th>
<th>≤$90,000</th>
<th>$90,001-105,000</th>
<th>$105,001-140,000</th>
<th>≥$140,001</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>≤$180,000</td>
<td>$180,001-210,000</td>
<td>$210,001-280,000</td>
<td>≥$280,001</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rebate</th>
<th>Base Tier</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 65</td>
<td>25.934%</td>
<td>17.289%</td>
<td>8.644%</td>
<td>0%</td>
</tr>
<tr>
<td>65-69</td>
<td>30.256%</td>
<td>21.612%</td>
<td>12.966%</td>
<td>0%</td>
</tr>
<tr>
<td>70+</td>
<td>34.579%</td>
<td>25.934%</td>
<td>17.289%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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).

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6 Data from the Australian Taxation Office, September 2016.
7 Australian Government, Budget Paper No. 1, Budget strategy and outlook 2017-18, Statement 6, Table 8.1.
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](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:

<table>
<thead>
<tr>
<th>Reform 1: Product Design Reforms – Gold, Silver, Bronze, Basic</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>The Private Health Ministerial Advisory Committee and industry have been consulted on the minimum standards for each product category.</td>
</tr>
<tr>
<td>The Department expects to finalise the product categories by April 2018.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reform 2: Product Design Reforms – remove waiting period for mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reform 3: Improved Models of Care Working Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reform 4: Standardised Clinical Definitions</th>
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<tbody>
<tr>
<td>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.</td>
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<thead>
<tr>
<th>Reform 5: Improved access to travel and accommodation benefits for regional and rural areas</th>
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<tbody>
<tr>
<td>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</td>
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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.
<table>
<thead>
<tr>
<th>Brokers</th>
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<tr>
<td>Providing access to private health insurance product data will allow brokers to provide consumers with advice on products across all health funds.</td>
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**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
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...
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.

<table>
<thead>
<tr>
<th>Average annual regulatory costs (from business as usual)</th>
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<tbody>
<tr>
<td>Change in costs ($ million)</td>
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<tr>
<td>Business</td>
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<tr>
<td>Total, by sector</td>
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<table>
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<tr>
<th>Cost offset ($ million)</th>
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<tbody>
<tr>
<td>Business</td>
</tr>
<tr>
<td>Agency</td>
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</table>

Are all new costs offset?
- Yes, costs are offset
- No, costs are not offset
- 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

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

### 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 table 8 below provides a guide to when the reforms will be implemented.

---

### Implementation timetable

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 2017</td>
<td>• Prostheses Rules made reducing benefits by $188 million annually from 2018 and further $115 million in 2020</td>
</tr>
</tbody>
</table>
| November to December 2017 | • Establish advisory committees on:  
  • Mental health care and rehabilitation care  
  • Transparency of out-of-pocket costs.  
  • Mental health waiting period Rules made. |
| February 2018         | • Reduced prostheses benefits come into effect.                                                                                                                                   |
| March 2018            | • Legislation introduced to Parliament to support:  
  • 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            | • Mental health waiting period Rules come into effect.                                                                                                                             |
| June 2018             | • Legislation passed.  
  • Rules made to:  
    • 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 | • Advice to government from advisory committees on mental health care and rehabilitation care and transparency of out-of-pocket costs received. |
| January 2019          | • New second tier administrative arrangements begin.                                                                                                                               |
| April 2019            | • Upgraded privatehealth.gov.au begins.  
  • Gold/Silver/Bronze/Basic and standardised clinical definitions begin to operate.  
  • Insurers can offer:  
    • Discounts for young people  
    • Increased excesses  
    and can no longer offer benefits for natural therapies |
| February 2020         | • 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/hour\(^9\); 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>
<thead>
<tr>
<th>Size</th>
<th>Cost of Training per Insurer</th>
<th>Total Cost of Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large</td>
<td>$505,368</td>
<td>$1,010,736</td>
</tr>
<tr>
<td>Medium</td>
<td>$175,176</td>
<td>$525,528</td>
</tr>
<tr>
<td>Small</td>
<td>$12,144</td>
<td>$388,598</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$1,924,862</td>
</tr>
</tbody>
</table>

**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;

---

\(^9\) 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>
<thead>
<tr>
<th>Size</th>
<th>Actuarial Team</th>
<th>Marketing Team</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large</td>
<td>$161,280</td>
<td>$537,600</td>
<td>$698,880</td>
</tr>
<tr>
<td>Medium</td>
<td>$161,280</td>
<td>$645,120</td>
<td>$806,400</td>
</tr>
<tr>
<td>Small</td>
<td>$860,160</td>
<td>$3,440,640</td>
<td>$4,300,800</td>
</tr>
<tr>
<td>Total</td>
<td>$1,182,720</td>
<td>$4,623,360</td>
<td>$5,806,080</td>
</tr>
</tbody>
</table>

**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>
<thead>
<tr>
<th>Size</th>
<th>Cost of website updates per insurer</th>
<th>Total Cost of website updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large</td>
<td>$80,640</td>
<td>$161,280</td>
</tr>
<tr>
<td>Medium</td>
<td>$80,640</td>
<td>$241,920</td>
</tr>
<tr>
<td>Small</td>
<td>$64,512</td>
<td>$2,064,384</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$2,467,584</td>
</tr>
</tbody>
</table>

**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/brochure;  
• 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.

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10 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 million \(^{11}\) 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.\(^{12}\) 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.

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\(^{11}\) 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.

\(^{12}\) 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.
Estimated annual regulatory costs over 10 years

Table 4: Summary of regulatory costs for insurers

<table>
<thead>
<tr>
<th>Size</th>
<th>Cost/Saving</th>
<th>Cost over 10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT system changes</td>
<td>$46,250,000</td>
<td>$4,625,000</td>
</tr>
<tr>
<td>Training staff</td>
<td>$1,924,862</td>
<td>$192,486</td>
</tr>
<tr>
<td>Re-design of products</td>
<td>$5,806,080</td>
<td>$580,608</td>
</tr>
<tr>
<td>Standard Information Statement</td>
<td>$137,580</td>
<td>$13,758</td>
</tr>
<tr>
<td>Website updates</td>
<td>$2,467,584</td>
<td>$246,758</td>
</tr>
<tr>
<td>Updating marketing material</td>
<td>$420,000</td>
<td>$42,000</td>
</tr>
<tr>
<td>Information provision</td>
<td>-$24,273,176</td>
<td>-$2,427,318</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$32,732,930</strong></td>
<td><strong>$3,273,293</strong></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Size</th>
<th>Cost of training per broker</th>
<th>Total cost of training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large</td>
<td>$51,354</td>
<td>$154,062</td>
</tr>
<tr>
<td>Small</td>
<td>$14,207</td>
<td>$156,281</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$310,343</strong></td>
</tr>
</tbody>
</table>

**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

<table>
<thead>
<tr>
<th>Size</th>
<th>Cost of website updates per broker</th>
<th>Total cost of website updates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large</td>
<td>$80,640</td>
<td>$241,920</td>
</tr>
<tr>
<td>Small</td>
<td>$64,512</td>
<td>$709,632</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$951,552</strong></td>
</tr>
</tbody>
</table>

**Ongoing costs**

No ongoing costs are required.

**Estimated annual regulatory costs over 10 years**

Table 7: Summary of regulatory costs for brokers

<table>
<thead>
<tr>
<th>Size</th>
<th>Cost/Saving</th>
<th>Cost over 10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>IT system changes</td>
<td>$17,500,000</td>
<td>$1,750,000</td>
</tr>
<tr>
<td>Training staff</td>
<td>$310,343</td>
<td>$31,034</td>
</tr>
<tr>
<td>Website updates</td>
<td>$951,552</td>
<td>$95,155</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$18,761,895</td>
<td>$1,876,190</td>
</tr>
</tbody>
</table>

**Summary of Estimated Regulatory Cost**

Table 8: Summary of regulatory costs for insurers and brokers

<table>
<thead>
<tr>
<th>Size</th>
<th>Cost/Saving</th>
<th>Cost over 10 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Health Insurers</td>
<td>$32,645,168</td>
<td>$3,264,517</td>
</tr>
<tr>
<td>Brokers</td>
<td>$18,761,895</td>
<td>$1,876,190</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$51,494,826</td>
<td>$5,149,483</td>
</tr>
</tbody>
</table>
Statement of Compatibility with Human Rights

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

PRIVATE HEALTH INSURANCE LEGISLATION AMENDMENT BILL 2018

The Private Health Insurance Legislation Amendment Bill 2018 (the Bill) 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 Bill

This Bill amends the Private Insurance Act 2007 (the Act), the Ombudsman Act 1976 and the Age Discrimination Act 2004 in relation to a range of matters, including in supporting the implementation of reforms designed to improve the value of private health insurance, strengthening the powers of the Private Health Insurance Ombudsman and making policy information easier to understand.

In October 2017 the Government announced a number of reforms to private health insurance. This legislation supports the following reforms:

Improving the value of private health insurance

The Bill contains three measures designed to improve the value of private health insurance either in the form of lower premiums and/or improved cover for certain benefits.

1. Increased to maximum excess levels
   The amendments in Schedule 1 will allow consumers to purchase products with increased maximum voluntary excess levels which are eligible for the Medicare levy surcharge exemption. Additional related changes will be applied in separate Bills containing amendments to A New Tax System (Medicare Levy Surcharge – Fringe Benefits) Act 1999 and the Medicare Levy Act 1986.

2. Age-based discounting for hospital cover products
   The amendments in Schedule 2 will enable insurers to voluntarily offer products that provide additional premium discounts under a new age-based discount framework. It is intended that, in line with the announced policy, the Private Health Insurance (Complying Products) Rules will be amended to permit insurers to offer discounts to persons aged 18 to 29 years when they become insured under a policy that offers aged-based discounts. An amendment to the Age Discrimination Act 2004 has also been included to allow for these discounts to be made available to younger people.

3. Improved cover for travel/accommodation for hospital treatment
   The amendments in Schedule 5, Part 1, enable insurers to provide benefits for travel and/or accommodation under hospital treatment. People living in regional and remote Australia who need to travel to access treatment that is not available in their local region will benefit most from this measure.
Making private health insurance easier to understand
The amendments in Schedule 5, Part 2 support the introduction of the private health information statement which will replace the standard information statement. Consumers will be involved in developing the format of the private health information statement to ensure that the policy details provided in the statement are more meaningful and simpler to understand.

Strengthening the powers of the Private Health Insurance Ombudsman
Under amendments the Ombudsman Act 1976 contained in Schedule 3 the complaint handling and investigative functions of the Private Health Ombudsman (PHIO) will be augmented by formal powers to conduct inspections and audits at the premises of a private health insurer or private health insurance broker. Offence provisions have been established to support the use of these powers.

Second Tier administrative reforms
The Bill also includes amendments in Schedule 5, Part 3 establishing a legislative framework for the Minister to assess and determine whether or not to include a private hospital in a class of hospitals eligible for second-tier default benefits.

Under the new arrangements, a hospital can apply to the Minister to be included in a defined class. If a hospital satisfies the assessment criteria, it is included in a class for the period determined by the Minister. If the Minister considers that the hospital has ceased to meet the assessment criteria, she or he may revoke its inclusion in the class. This decision may be reviewed by the Administrative Appeals Tribunal (AAT). A decision not to include a hospital in a class may also be reviewed by the AAT.

Closed and terminated products
The amendments in Schedule 5, part 4 allow insurers to terminate products as well as close them to new policy-holders. While this 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, 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.

Addressing benefit limitation period inclusive policies
The amendments in Schedule 4 improve consumer transparency by removing the use of benefit limitation periods in private health insurance policies. They effectively deem benefit limitation period inclusive policies to be compliant for the period from 1 April 2007 until 30 June 2018 for the purposes of the Act and all Commonwealth primary or subordinate legislation (other than some specified enforcement provisions). It also waives any associated debts or repayments to the Commonwealth owed by insurers or policy-holders.

The amendments validate benefit limitation inclusive policies covering psychiatric treatment until 31 March 2018 is in line with the Government’s commitment to provide better access to psychiatric treatment under private health insurance from 1 April 2018.

Human rights implications
The Bill engages, or has the potential to engage, the following human rights:
• Right to health - Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR);
• Right to privacy and reputation – Article 7 of the International Covenant on Civil and Political Rights (ICCPR);
• Right to a fair trial/fair hearing - Article 14 of the ICCPR; and
• Right to the presumption of innocence - Article 14 (2) of the ICCPR.

The right to health
The right to health – the right to the enjoyment of the highest attainable standard of physical and mental health is contained in article 12(1) of the International Covenant on Economic, Social and Cultural Rights to which Australia is a signatory. Article 12(2)(d) provides for “steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for…the creation of conditions which would assure to all medical service and medical attention in the event of sickness.”

Schedules 1 and 2 provide various mechanisms designed to improve private health insurance participation rates, these include increased maximum voluntary excess levels (schedule 1) and age-based discounting (schedule 2). These measures are intended to increase the uptake of private health insurance. Although older or less healthy people may now be at a relative disadvantage in terms of paying higher premiums for the same product, it is also recognised that viability and sustainability of the private health insurance system relies on a broad membership base.

Schedule 5, part 1 allows private health insurers to offer travel and accommodation benefits under hospital treatment cover, is intended to benefit persons in rural and regional Australia to assist them in accessing hospital treatments that are not available locally.

In summary, the amendments in this Bill do not derogate a person’s right to health and to the extent that they improve the uptake of private health insurance (Schedules 1, 2 and 4) they are intended to promote access to health services.

Right to not be subjected to arbitrary or unlawful interference with privacy
These rights are contained in article 17 of the International Covenant on Civil and Political Rights (ICCPR) to which Australia is a signatory. This article prohibits the unlawful or arbitrary interference with a person’s privacy.

This Bill engages the right to privacy, the items in Schedule 3 amends the Ombudsman Act 1976 (the Act) by inserting a new division 3A in Part IID of the Act. The division contains provisions to allow the Private Health Insurance Ombudsman (the PHIO) to enter the premises of a private health insurer or private health insurance broker and conduct inspections and audits or investigations.

These powers relate to premises which may be considered to form part of a person’s workplace or home (to the extent that it constitutes a premises in which the work of a private health insurer or broker is carried out) within the scope of Article 17.
exercise of the inspection and audit powers is constrained to cases where entry to premises is pursuant to a PHIO complaint or investigation.

An authorised PHIO officer cannot enter premises unless their identity card is shown to the occupier of the premises prior to entry (section 20ZHA). This provides for the transparent utilisation of the PHIO’s inspection powers and mitigates arbitrariness and risk of abuse.

In respect of the power to inspect documents of a private health insurer or private health insurance broker, the PHIO is bound to observe the requirements of the Privacy Act 1988. The Ombudsman's Privacy Policy covers in detail its personal information handling practices and provides further transparency of Ombudsman operations. The Policy gives effect to the Australian Privacy Principles contained in the Privacy Act 1988. In summary, the provisions of the Bill are neither arbitrary nor unlawful where they engage the right to privacy.

**Fair trial and fair hearing rights**

Fair trial and fair hearing rights are contained in article 14 of ICCPR. This article provides a guarantee of respect for the principle of ‘equality of arms’, which requires that all parties to a proceeding must have a reasonable opportunity of presenting their case under conditions that do not disadvantage them against other parties to the proceedings. Those charged with a criminal offence have the rights set out in Article 14(2) to (7), including the presumption of innocence and the guarantees set out in Article 14(2).

Schedule 3 amends the Ombudsman Act 1976 by inserting a new division 3A in Part IID of the Act. The division creates a two fault-based offences (subsection 20ZHB(1) applies in the context of inspections and audits; and 20ZHB(2) applies in the context of investigation commenced under section 20TA) for an occupier or person in charge of such premises to fail to provide reasonable facilities and assistance.

In summary, a person who is the subject of an offence to which subsection 20ZHB(1) or 20 ZHB(2) applies, has a right to a fair hearing before a competent, independent and impartial court, this position is therefore compatible with the right to a fair hearing under Article 14(1) of the ICCPR.

**Right to the presumption of innocence – Article 14(2)**

Article 14(2) of the ICCPR provides that everyone charged with a criminal offence shall have the right to be presumed innocent until proven guilty according to law. The right to presumption of innocence is also a fundamental common law principle.

When ‘strict liability’ applies to an offence, the prosecution is only required to prove the physical elements of an offence, not the fault elements, beyond reasonable doubt in order for the defendant to be found guilty. The defence of honest and reasonable mistake of fact is available to the defendant (see section 9.2 of the Criminal Code).

Strict liability is used in circumstances where there is public interest in ensuring that statutory schemes are observed and it can reasonably be expected that the person was aware of their duties and obligations. Strict liability offences can be considered a
limitation of the presumption of innocence because the defendant can be found guilty without the prosecution being required to prove fault.

Strict liability offences will not necessarily be inconsistent with the presumption of innocence provided that removal of the presumption of innocence pursues a legitimate objective and is reasonable, necessary and proportionate to achieving that objective. Whether a strict liability provision impermissibly limits the right to the presumption of innocence will depend on the circumstances of the case and the particular justification for an offence being a strict liability offence.

Schedule 3 amends the Ombudsman Act 1976, and includes the creation of a strict liability offence (subsection 20ZIA(4)). Persons who are former staff members or other people engaged by the Private Health Insurance Ombudsman and have been delegated with inspection powers are required to return their identity cards within 14 day of ceasing employment with the PHIO.

This strict liability offence provision has been created to reflect the strong public interest in maintaining public confidence in the PHIO. It serves the purpose of mitigating a risk of former PHIO officials falsely impersonating public officials or misusing public power, and they are reasonable and proportionate in achieving that outcome.

In the main, the offence provision applies to former PHIO officials, who can reasonably be expected to understand the conditions of their employment including the return of public property upon cessation of employment. The strict liability offence is not punishable by imprisonment. It is punishable by a fine of up to 1 penalty units. It is a defence if the defendant can prove the identity card was lost or stolen.

The strict liability offence in the Bill acts as a deterrent to behaviour that would compromise the integrity of the functions of the PHIO’s office. They are compatible with Article 14(2) of the ICCPR, as they pursue a legitimate objective.

Conclusion
The Bill is compatible with human rights because it promotes the right to health, and to the extent that it may limit human rights, those limitations are reasonable, necessary and proportionate.

The Honourable Greg Hunt MP, the Minister for Health
Statement of Compatibility with Human Rights

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

A NEW TAX SYSTEM (MEDICARE LEVY SURCHARGE – FRINGE BENEFITS) AMENDMENT (EXCESS LEVELS FOR HEALTH INSURANCE POLICIES) BILL 2018

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

This Bill is part of a package of three bills each containing necessary amendments relevant to implementing reforms relating to increased maximum voluntary excess levels for private hospital cover.

This Bill deals solely with taxation-related aspects of this reform and amends the A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999. The amendments ensure that individuals purchasing private health insurance products with increased maximum voluntary excess levels will be eligible for the Medicare Levy Surcharge exemption.

Conclusion

This Bill is compatible with human rights as it does not raise any human rights issues.

The Honourable Greg Hunt MP, the Minister for Health
Statement of Compatibility with Human Rights

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

MEDICARE LEVY AMENDMENT (EXCESS LEVELS FOR PRIVATE HEALTH INSURANCE POLICIES) BILL 2018

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

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Conclusion

This Bill is compatible with human rights as it does not raise any human rights issues.

The Honourable Greg Hunt MP, the Minister for Health
NOTES ON CLAUSES

Clause 1 – Short Title
This clause provides that the Bill, once enacted, may be cited as the *Private Health Insurance Legislation Amendment Act 2018*.

Clause 2 – Commencement
This clause sets out when the Private Health Insurance Legislation Amendment Bill 2018 and various provisions within it commence.

Schedules 1 and 2 commence on 1 April 2019, aligning with the new premium year and in the case of Schedule 1 the amendments apply in relation to 2018-19 and later income years.

Schedule 3 commences 1 July 2018

Schedule 4 commences the day after this Act receives Royal Assent

Schedule 5, parts 1 and 2 commences 1 April 2019 to align with the next premium year.

Schedule 5, part 3, commences 1 January 2019.

Schedule 5, part 4, commences the day after this Act receives Royal Assent.

Clause 3 – Schedule(s)
This clause provides that legislation that is specified in a Schedule to the Act is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item has effect according to its terms

SCHEDULE 1 — Increasing maximum excess levels

Amendments in this schedule increase the current maximum voluntary excess levels that are permitted for a policy to exempt the holder from the Medicare levy surcharge, and involve amendments to associated provisions in taxation legislation (*A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999* and *Medicare Levy Act 1986*) to apply the new maximum voluntary excesses levels which are specified in the amendments to the *Private Health Insurance Act 2007* as set out below.

*Private Health Insurance Act 2007*

**Item 1**
This insertion after Part 2-4 sets out the increased maximum voluntary excess levels for complying health insurance products that relate to whether an individual is liable to pay the Medicare Levy Surcharge. The increased levels of voluntary excess that insurers can apply are: $750 in any 12 month period in relation to a policy which only
one person is insured, or $1,500 in any 12 month period in relation to any other policy. This is outlined in Divisions 42 and 45.

**Item 2**
The item is an application provision which provides that the amendments made by item 1 of Schedule 1 apply in relation to the 2018-19 and later income years.

**SCHEDULE 2 – Age-based discounts for hospital cover**

This Schedule will allow insurers to offer products which provide age-based discounted cover, from 1 April 2019. It will not be mandatory for insurers to offer discounted products.

The amendments alter the definition of “improper discrimination” in section 55-5 of the PHI Act to allow age-based discounts in accordance with Private Health Insurance (Complying Product) Rules (Complying Product Rules) made under section 66-5. It is intended that, in line with the announced policy, the Complying Product Rules will be amended to reflect the introduction of age-based discounts that insurers will be able to offer people aged 18 to 29. The aged-based discounts will apply in addition to the maximum discount percentage currently specified in the Complying Product Rules.

The Bill amends the *Age Discrimination Act 2004* to allow for these discounts to be made available to younger people.

**Items 1 and 2**
Item 1 repeals paragraph 55-5(2)(c) and substitutes the repealed paragraph with a new paragraph which provides an additional exception to the improper discrimination provisions that prevent insurers discriminating against people on the basis of their age. The current exceptions provide for age based discrimination in the context of higher premiums associated with the application of Lifetime Health Cover loadings under Part 2-3 of the Act and higher premiums because a policy covers a dependent child non-student. The new exception only applies in relation to the new age-based discount arrangements to be established under new paragraph 66-5(3)(ea) inserted by item 2.

The parameters of age based discounts will be provided in the Private Health Insurance (Complying Product) Rules.

*Age Discrimination Act 2004*

**Items 3 to 4**
These items will extend the existing age discrimination exemption provided to the *Private Health Insurance Act 2007* to new section 66-5(3)(ea) and the aged-based discounting provisions in the Private Health Insurance (Complying Product) Rules to permit insurers to offer an age based discount to encourage younger people to hold private health insurance.
SCHEDULE 3 – Private Health Insurance Ombudsman’s powers

This schedule amends the Ombudsman Act 1976 to empower the Private Health Insurance Ombudsman (PHIO) to conduct inspections and audits at the premises of a private health insurer or private health insurance broker and make recommendations relating to their activities. The PHIO will also be subject to new reporting requirements, including where the PHIO reports to the Minister on the use of the new inspection powers, it must also notify the affected provider unless doing so would, or could be reasonably expected to, prejudice the conduct of an investigation. The PHIO will also be required to report annually on the use of the new powers.

Ombudsman Act 1976

Item 1
This item inserts a new Division 3A and Subdivision A in Part IID of the Act which includes new subsection s20SA and 20SB. Subsection 20SA establishes the power to conduct inspections and audits at the premises of a private health insurer or private health insurer broker (broker). Subsection 20SB establishes new reporting requirements for the PHIO and powers to make recommendations to private health insurers or brokers following the exercise of powers under section 20SA.

Subsection 20SA empowers the PHIO to enter a premise that is: (i) a place occupied by a private health insurer or broker; or (ii) a place occupied by a person predominantly for the purpose of performing services for, or on behalf of private health insurer or broker; or (iii) a place where the documents or other records relating to a private health insurer or broker or the carrying on of health insurance business are kept.

In accordance, with subparagraph 20SA(b) the PHIO’s powers at these premises are limited to inspecting any documents or other records to verify evidence provided in relation to a complaint made under Part IID, Division 3 of the Act. The PHIO may also take extracts from, or make copies of said document or other record. For the purposes of Division 3, the subject of a complaint may involve a private health insurer, a private health insurance provider or a health care provider.

Subsection 20SB provides for the PHIO to make recommendations to private health insurers or brokers after exercising its powers of inspection or audit (subsection 20SB(1). They may recommend (subsection 20SB(2)) any or all of the following:

- to a private health insurer, that they take a specific course of action or make changes to its rules;
- to a health care provider or private health insurance broker, that they take a specific course of action.

Subsection 20SB(3) provides that the PHIO may by written notice given to the person to whom the recommendation was made, or an officer of that person, require the person to report to the PHIO, before action is taken to give effect to the recommendation, on the action proposed to be taken. The notice must specify the period within which the report is to be given. This provision mirrors the existing functions and powers PHIO has in relation to investigations.
Subsections 20SB(4) and (5) establish new reporting obligations for the PHIO to report and make recommendations to the Minister for Health following an inspection or audit conducted under subsection 20SA. The PHIO may report to the Minister for Health on the outcome of the inspection or audit (including any recommendations made to a private health insurer or broker and any responses to those recommendations. The PHIO may also report to the Minister for Health on any recommendations to general changes in regulatory practice or industry practices relating to the kind of issues raised as a result of the exercise of those powers.

**Item 2**
This item inserts a new subsection 20TA which follows from section 20T. Section 20TA establishes new powers to enter premises and inspect documents during the conduct of investigations and apply in the context of investigations initiated by the PHIO at his or her initiative (own motion), in all other respects the scope and nature of these powers are intended to mirror the powers described at Item 1 for new subsection 20SA.

An investigation initiated at the PHIO’s own motion may be an investigation to a private health insurer, a private health insurance broker or health care provider. The inspection powers established under 20TA do not apply in the case of investigations into health care providers.

**Item 3**
This item amends subsection 20ZG(6) in respect of the content of reports relating to the operations of the PHIO during a period. The content requirements of such reports are increased by the addition of new subparagraph 20ZG(6)(ca) requiring a summary of the exercise of powers under new section 20SA.

**Item 4**
This item inserts new subsection 20ZHA and 20ZHB. Subsection 20ZHA is inserted following section 20 ZH and applies in the context of inspection and audits at premises mention in paragraph 20SA(a) and investigations under section 20T at premises mentioned at paragraph 20TA(a). As a precondition before entry to such premises, subsection 20ZHA(2) establishes a requirement on the PHIO to show the PHIO’s identity card to the occupier of the place or other suitable persons.

Subsection 20ZHB includes two offence provisions each with a penalty of maximum 30 penalty units in relation to new subsection 20SA and 20TA.

Subsection 20ZHB(1) creates an offence that applies where the occupier or person in charge of the premises (mentioned in paragraph 20SA(a)) does not provide the PHIO with reasonable facilities and assistance for the effective exercise of the PHIO powers under subparagraph 20SA(b).

Subsection 20ZHB(2) creates an offence that applies where the occupier or person in charge of the premises (mentioned in paragraph 20ST(a)) does not provide the PHIO with reasonable facilities and assistance for the effective exercise of the PHIO powers under subparagraph 20TA (b).
Item 5
This inserts a new subsection 20ZIA which follows section 20ZI. Under section 20ZIA the PHIO must issue an identity card to each officer who is authorised to exercise document inspection powers (subparagraph 20SA(b) or 20TA(b)) The card must be in the form approved by the PHIO (subsection 20ZIA(2)(a)) and contain a recent photograph (subsection 20ZIA(2)(b)). An inspector must carry the card at all times when exercising their powers (subsection 20ZIA(3)).

It is an offence if a person who ceased to be an officer of the PHIO and does not return their identity card to PHIO within 14 days after ceasing to be an officer. This does not apply if the card was lost or destroyed (subsection 20ZIZ(4)).

Item 6
This item amends subsection 34(2C), which will enable for the PHIO to either generally, or as provided by the instrument of delegation or instrument in writing, delegate any and all of his or her powers or functions under the Act to a person. The amendment to subsection 34(2C) is intended to provide the PHIO with flexibility to delegate powers to suitable qualified officers, in cases where they do not come within the scope of persons described at section 31 of that Act. This amendment also ensures consistency with the other subject matter specific roles held by the Commonwealth Ombudsman.

Item 7
This item amends subsection 34(2C) to prevent the PHIO from delegating his/her responsibility to report to the Health Minister with respect to the requirements (at Item 1) established under new subsection 20SB(4).

Item 8
This item is an application provision which provides that new Division 3A applies in relation to a complaint made under Division 3 of Part IID of the Act on or after 1 July 2018.

Item 9
This item preserves the validity of any delegations in force that have been made under subsection 34(2C) immediately before 1 July 2018.

SCHEDULE 4 – Transitional provisions relating to the treatment of certain health insurance policies

Some private health insurers impose benefit limitation periods (during which an insurer will pay minimum benefits for a treatment, and after which it will pay the full benefits available under the policy) of 12, 24, or 36 months for hospital treatment.

The Government recognises that benefit limitation periods can be an area of confusion for some private health insurance members. The Government is improving consumer transparency by removing the use of benefit limitation periods in private health insurance policies. This will assist in making private health insurance products easier to understand for consumers.
Benefit limitation periods have been applied under the current Act since 2007 and under previous Acts. The Bill ensures that consumers who have purchased benefit limitation period inclusive policies since 2007:

- do not need to repay premium rebates they have received;
- are not retrospectively liable for the Medicare Levy Surcharge; and
- are not liable for Lifetime Health Cover loadings.

The amendments in this Schedule seek to ensure that people who purchased benefit limitation period inclusive private health insurance policies and insurers who sold those products between 1 April 2007 and 30 June 2018 are effectively in the same legal position, that they would have been in if the products had complied with the Act.

The amendments will effectively deem benefit limitation period inclusive policies to be compliant for the period from 1 April 2007 until 30 June 2018 for the purposes of the Act and all other Commonwealth primary or secondary legislation (other than some specified enforcement provisions). It also waives any associated debts or repayments owed to the Commonwealth by insurers or policy-holders.

The amendments validates benefit limitation period inclusive policies covering psychiatric treatment until 31 March 2018 is in line with the Government’s commitment to provide better access to psychiatric treatment under private health insurance from 1 April 2018.

The amendments will operate retrospectively from 1 April 2007 and until 30 June 2018 by which time insurers are expected to have updated their rules to remove benefit limitation period inclusive polices. The Government will ensure that benefit limitation periods will no longer be applied to any treatments under any hospital policy from 1 July 2018.

**Item 1 – Simplified outline of this Schedule**

This item provides an outline. This includes that:

- an irregular health insurance policy shall be treated as a complying health insurance policy from 1 April 2007 to 30 June 2018;
- that an irregular health insurance policy is a type of health insurance policy that includes one or more benefit limitation periods inconsistent with the waiting period requirements under Division 75 and portability requirements under Division 78 of the *Private Health Insurance Act 2007*;
- where an amount has been paid by the Commonwealth to a private health insurer is otherwise to be repaid because of the irregular health insurance policy that repayment is waived by the Commonwealth;
- where a person was not entitled to an incentive payment and that amount is to be repaid because of the irregular health insurance policy that repayment is waived by the Commonwealth.
Item 2 – Definitions
This clause provides for a number of definitions, including:

**benefit limitation periods** has the meaning generally accepted within the health insurance industry. This is to allow for all forms of benefit limitation periods to be covered by the legislation, noting that across the industry the definition may vary significantly.

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.

This definition is only for the purpose of giving effect to the transitional arrangement for validating irregular health insurance policies. The definition is not intended to apply in any other context.

**hospital substitute treatment** has the same meaning as in the *Private Health Insurance Act 2007*.

**hospital treatment** has the same meaning as in the *Private Health Insurance Act 2007*.

**irregular health insurance policy** has the meaning given by item 3.

**private health insurer** has been defined to ensure that any insurer that may have been registered at any time between 1 April 2007 and 30 June 2018 are covered. As such a private health insurer means any of the following:

- an insurer that was a registered health benefits organization under the *National Health Act 1953* as it applied before the *Private Health Insurance Act 2007* came into effect;
- an insurer that was registered under the *Private Health Insurance Act 2007* as it applied before the *Private Health Insurance (Prudential Supervision) Act 2015* came into effect; and
- an insurer that is or was registered under the *Private Health Insurance (Prudential Supervision) Act 2015*.

Item 3 – Irregular health insurance policy

Subitem 3(1)
This subitem defines an irregular health insurance policy as an insurance policy at a particular time from 1 April 2007 until 30 June 2018 that:

- includes one or more benefit limitation periods; and
- is not a complying health insurance policy (within the meaning of section 63-10 of the *Private Health Insurance Act 2007*); and
- would have been a complying health insurance policy (within the meaning of section 63-10 of the *Private Health Insurance Act 2007*), if Division 75 and Division 78 of the *Private Health Insurance Act 2007* did not prevent the policy from including those benefit limitation periods.
The definition operates to confine the operation of the legislation to health insurance policies that had a benefit limitation period inconsistent with waiting period requirements in Division 75 of the *Private Health Insurance Act 2007* and the portability requirements in Division 78 of the *Private Health Insurance Act 2007*.

The definition covers the period from the commencement of the *Private Health Insurance Act 2007* on 1 April 2007 through until 30 June 2018, after which time policies with benefit limitations periods in excess of Divisions 75 and 78 will be treated as unlawful. Insurer will have until 30 June 2018 to change their rules to remove benefit limitation periods.

**Subitem 3(2)**
This subitem provides that subitem (1) has effect subject to subitem (3).

**Subitem 3(3)**
This subitem provides that for period 1 April 2018 to 30 June 2018 an irregular health insurance policy is not an insurance policy that included one or more benefit limitation periods that relate to hospital treatment or hospital-substitute treatment for psychiatric care.

This provision operates to ensure that benefit limitation periods applying to psychiatric treatment are removed from 31 March 2018, 2018 is in line with the Government’s commitment to provide better access to psychiatric treatment under private health insurance from 1 April 2018.

**Item 4 – Irregular health insurance policy to be treated as a complying health insurance policy**

**Subitem 4(1)**
This subitem provides that for the purposes of:

- the *Private Health Insurance Act 2007* (including associated secondary legislation)(but subject to sub-clauses (2) and (3)); and
- any other law of the Commonwealth (including primary and/or secondary legislation)

an irregular health insurance policy is deemed to have been a complying health insurance policy, in accordance with section 63-10 of the *Private Health Insurance Act 2007*, during the period 1 April 2007 to 30 June 2018.

Commonwealth Acts covered by the operation of this clause include (but are not limited to):

- the *Medicare Levy Act 1986*
- the *A New Tax System (Medicare Levy Surcharge – Fringe Benefits) Act 1999*
- the *Dental Benefits Act 2008*
- the *Veteran’s Entitlements Act 1986*
- the *Private Health Insurance (Complaints Levy) Act 1995*
- the *Health Insurance Act 1973*
- the *National Health Act 1953*, and
- the *Income Tax Assessment Act 1936*. 
This operates to treat irregular policies as complying health insurance policies across all Commonwealth statutes between 1 April 2007 and 30 June 2018.

This means that a person who purchased an irregular health insurance policy will be exempt from the Medicare Levy Surcharge and from any Lifetime Health Cover loadings that they might have faced because they had not purchased a complying health insurance policy.

Subitems 4(2) and (3)
These subitems provide that subitem 4(1) does not apply in relation to the enforcement provisions of the *Private Health Insurance Act 2007* set out in Division 84 and Chapter 5.

This means that subitem 4(1) does not have the effect that a private health insurer will not have committed an offence under section 84-1 by offering an irregular health insurance policy, and it will remain open to the Minister for Health to seek remedies in the Federal Court under section 84-15 of the *Private Health Insurance Act 2007*.

Subitem 4(2) also provides that subitem 4(1) does not apply in relation to the jurisdiction or power conferred on the Federal Court by the application of Division 84 of the *Private Health Insurance Act 2007*.

Subitem 4(3) provides that subitem 4(1) does not apply for the purposes of any enforcement action taken under Chapter 5 of the *Private Health Insurance Act 2007*, and does not limit the exercise by the Federal Court of its jurisdiction and powers under Chapter 5.

Subitem 4(4)
This sub-clause provides that subitem 4(1) does not preclude any common law action that (apart from that sub-clause) could have been brought by the holder of an irregular health insurance policy against a private health insurer.

Subitem 4(5)
This sub-clause provides that this clause has effect subject to the debt waiver provisions in items 5 and 6.

Item 5 – Waiver – reimbursement of private health insurer
This item operates to waive any debts arising from payments to an insurer under the Premium Reduction Scheme under Subdivision 279-A of the *Private Health Insurance Act 2007* that ought not have been made because the policy was an irregular health insurance policy.

Clause 6 – Waiver – incentive payment
This item operates to waive any debts arising from payments to a person under the Private Health Insurance Incentives Scheme under repealed Division 26 of the *Private Health Insurance Act 2007* that ought not have been made because the policy was an irregular health insurance policy.
SCHEDULE 5 – Miscellaneous

Private Health Insurance Act 2007

Part 1 – Benefits for travel and accommodation
These amendments will allow insurers from 1 April 2019 to offer travel and accommodation benefits under hospital treatment cover. Currently, insurers can only offer travel and accommodation benefits under general treatment policies. Travel and accommodation benefits under hospital treatment are eligible for risk equalisation which provides an incentive for insurers to offer these benefits. Travel and accommodation benefits offered under general treatment cover will remain not eligible for risk equalisation. Travel and accommodation benefits under general treatment cover can be capped by insurers but those under hospital treatment cannot be capped.

It will not be mandatory for private health insurers to offer travel and accommodation benefits under either hospital or general treatment products.

Item 1
This item repeals paragraph 55-5(2)(d) and substitutes a new paragraph to extend the exceptions to the improper discrimination provisions that prevent insurers discriminating against people on the basis of where a person lives to new subsection 66-25 inserted by item 2.

Item 2
This item inserts a new subsection 66-25 providing that an insurer may choose to pay different amounts of benefits under a hospital treatment or general treatment policy based on the distance between the person’s principal place of residence and the facility where the treatment is provided.

Items 3 to 4
These items amend the meaning of ‘hospital treatment’ provided in subsection 121-5.

Item 3 inserts new subsection 121-5(2A) which states that hospital treatment also includes benefits for travel or accommodation relating to treatment covered by the existing subsections (1) or (2). Travel or accommodation benefits paid in respect of treatment covered under a hospital treatment policy will therefore be eligible for risk equalisation.

Item 4 amends subsection 121-5(4) by inserting a reference to new subsection 121-5(2A). This provision enables the Minister to exclude specified travel or accommodation from the definition of hospital treatment in the Private Health Insurance (Health Insurance Business) Rules.

Items 5 to 6
These items amend the meaning of ‘general treatment’ provided in subsection 121-10.

Item 5 inserts new subsection 121-10(2A) which states that general treatment can also include benefits for travel or accommodation including for those related to hospital
treatment. General treatment travel or accommodation benefits are not eligible for risk
equalisation as provided in the Private Health Insurance (Risk Equalisation Policy)
Rules.

Item 6 amends subsection 121-10(3) by inserting a reference to new subsection 121-
10(2). This provision enables the Minister to exclude specified travel or
accommodation from the definition of general treatment in the Private Health
Insurance (Health Insurance Business) Rules.

Part 2 – Information requirements
A ‘private health information statement’ will replace the current ‘standard information
statement’ as the required method by which an insurer must provide information to
consumers.

The Standard Information Statements will be discontinued from 1 April 2019 and
insurers will be required to maintain up to date information about complying health
insurance products in the form of a ‘private health information statement’, the
requirements for which will be set out in the Private Health Insurance (Complying
Product) Rules.

Under existing arrangements, private health insurers are required to provide paper-
based standard information statements about complying health insurance products.
The ‘private health information statement’ is intended to be technology neutral, which
means that insurers have greater flexibility to communicate product information in
accordance with consumers’ preferences (subject to any applicable requirements
specified in the Private Health Insurance (Complying Product) Rules.

These amendments do not alter existing policy in regards to an insurer’s obligations to
provide information to consumers about complying health insurance products.

Item 7 to 30
These items substitute references to ‘standard information statement’ with ‘private
health information statement’ in all relevant provisions within Divisions 93 and 96
and the Dictionary at Schedule 1 of the Act

Part 3 – Benefit requirements according to class of hospital
Under existing arrangements, an industry-based Second Tier Advisory Committee is
responsible for receiving applications from private hospitals and determining their
eligibility to receive second-tier default benefits provided in schedule 5 of the Private
Health Insurance (Benefit Requirements) Rules.

These amendments establish a legislative framework for the Minister to assess and
determine whether or not to include a private hospital in a class of hospitals eligible
for second-tier default benefits.

Under the new arrangements, a person can apply to the Minister for a hospital to be
included in a class set out in the Private Health Insurance (Health Insurance Business)
Rules. The application must be accompanied by the application fee set out in the
Private Health Insurance (Health Insurance Business) Rules.
The Minister must consider the application to determine whether a hospital satisfies the assessment criteria set out in the Private Health Insurance (Health Insurance Business) Rules, and notify the applicant accordingly. A negative decision may be reviewed by the Administrative Appeals Tribunal.

If a hospital satisfies the assessment criteria, it is included in a class for the period determined by the Minister. If the Minister considers that the hospital has ceased to meet the assessment criteria, she or he may revoke its inclusion in the class. This decision may be reviewed by the Administrative Appeals Tribunal.

**Item 31**

This item alters existing arrangements by inserting new sections 121-8 to 121-8D into the *Private Health Insurance Act 2007*.

Under the new arrangements, a person will make an application to the Minister for a hospital to be included in a class set out in the Private Health Insurance (Health Insurance Business) Rules (new subsection 121-8(1)) and the application must be in the approved form (new subsection 121-8(2)(a) and accompanied by the relevant application fee (new subsection 121-8(2)(b)) imposed under the Private Health Insurance (Health Insurance Business) Rules.

The purpose of new subsection 121-8A is to establish (i) a time limit for the Minister to decide on an application and, (ii) obligations to notify applicants about the outcome of the application.

An application made in accordance with the requirements in new subsection 121-8(1) is considered by the Minister in order to determine whether a hospital satisfies the assessment criteria set out in the Private Health Insurance (Health Insurance Business) Rules (new subsection 121-8A(1)). If a hospital satisfies the assessment criteria, the Minister must within 60 days after the day the application is made, approve the application and notify the hospital, in writing, of:

- the hospital’s inclusion in a class set out in the Rules; and
- the day that the hospital is included in that class and the day that the hospital’s inclusion in that class ends.

If the Minister decides not to approve an application made in accordance with new subsection 121-8(1) because the hospital does not satisfy the assessment criteria, the Minister must within 60 days after the day the application is made, notify the hospital, in writing, of that fact (subparagraph 121-8A(3)(a)) and provide reasons for the decision (subparagraph 121-8A(3)(b)).

A private hospital included in a class as a result of an application approved under new subsection 121-8A may be included in that class for a finite period of time under new subsection 121-8B. This period commences on the day specified in the notice referred to in subparagraph 121-8A(2)(b)(ii) and expires on the day specified in that notice, unless it is revoked earlier.

Subsection 121-8C enables the Minister to revoke the inclusion of a private hospital from a class set out in the Private Health Insurance (Health Insurance Business) Rules, if the Minister considers that the hospital ceases to satisfy the assessment
criteria set out in the Rules (for example, the hospital may have failed to re-new or lost its accreditation status as required under the assessment criteria).

The purpose of subsection 121-8D is to enable Private Health Insurance (Health Insurance Business) Rules to be made for the following purposes:
(a) set out one or more classes of hospital for the purposes of Part 4-2 (Health Insurance Business) and Division 72 (Benefit requirements for policies that cover hospital treatment);
(b) impose an application fee for the purposes of section 121-8;
(c) set out assessment criteria for including a hospital in a particular class; and
(d) set out matters of a transitional nature relating to the current arrangements for hospitals and the new application process provided for by section 121-8.

**Item 32**
This item amends the table at section 328-5 which provides a list of decisions that may be reviewable by the Administrative Appeals Tribunal. This item extends the list to include decisions made under new section 121-8A (where an application is not approved) and new section 121-8C (where an approval is subsequently revoked).

**Part 4 – Closed and terminated products**
These amendments clarify that an insurer can not only close a product (by making it no longer available to new policy-holders), but can also terminate a product nationally or in a particular state by ceasing to make it available to any policy-holder.

**Item 33**
This item amends the community rating requirements in respect of closed and terminated products. Subsection 55-10 is amended to provide that the community rating principle does not prevent an insurer from: closing a product so that the product is no longer made available to new policy-holders; or terminating a product so that the product will no longer be available to anyone, even people who currently hold the product.

**Item 34 and 35**
Item 34 amends subsection 78-1(1) to include a reference to new subparagraph 78-1(5A) which is additional portability requirements included at item 35.

Item 35 amends the portability requirements by inserting new subparagraph 78-1(5A) which follows subsection 78-1(5). The new subparagraph applies in the context of transfers initiated by insurers in respect of people closed and terminating products. Subparagraph 78-1(5A) establishes new obligations on insurers to adequately inform insured adults of the planned termination of a product and the associated product transfer. Insurers are required to provide written information to insured adults in accordance with the requirements set out in the Private Health Insurance (Complying Product) Rules. These obligations are intended to serve as safeguards to ensure people have continuity of cover and do not need to re-servive waiting periods for hospital treatment.
NOTES ON CLAUSES

Clause 1 – Short Title
This clause provides that the Bill, once enacted, may be cited as the *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Amendment (Excess Levels for Private Health Insurance Policies) Act 2018*.

Clause 2 – Commencement
This clause sets out when the *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018* and various provisions with it commence. The commencement date is 1 April 2019.

Clause 3 – Schedule(s)
This clause provides that legislation that is specified in a Schedule to the Act is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item has effect according to its terms.

Schedule 1 – Amendments

The amendments give effect to new maximum voluntary excess levels that are permitted for a complying health insurance policy to exempt the holder from the Medicare Levy Surcharge. They also remove transition provisions designed to deal with the replacement in 2007 of the concept of “applicable benefit arrangements” under the *National Health Act 1953* with the concept of a “complying health insurance policy” under the PHI Act.

The amendments also remove the grandfathering provision that provide an exemption from the Medicare Levy Surcharge for individuals who had policies with excesses greater than the maximum permitted excess who have been insured continuously since May 2000 as long as their excess amount has not increased since that time. This exemption from the Medicare levy surcharge will no longer be available.

*A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999*

*Item 1* – This item will amend the numbering of section 4 to omit the subsections as all but sub-section 1 have been repealed over time.

*Item 2*
This item repeals paragraph 4(1)(b) of the Act that limits excess levels to $500 in any 12 month period in relation to a policy which only one person is insured, and $1000 in any 12 month period in relation to any other policy. A new paragraph 4(1)(b) will substitute for the repealed paragraph, and it will define the applicable excess levels by referencing the applicable excess levels specified in section 45-1 of the *Private Health Insurance Act 2007*. 
Item 3
This item repeals subsection 4(2), (4) and (5). Subsection 4(2) is a grandfathering provision that extended the Medicare levy surcharge exemption allowing individuals who has been insured continuously since the end of May 2000 as long as their excess amount had not increased in that time. As a result of the repealing of subsection 4(2), certain individuals may become liable for the Medicare levy surcharge if they do not transfer to a product with an excess no more than the new maximum levels.

Subsections 4(4)-(5) have been repealed as these provisions were made redundant by the Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007 Part 3 section 10.

Item 4
This item is an application provision which provides that for taxation purposes, the amendments made by items 2 and 3 in Schedule 1 apply in relation to the 2018-19 and later income years.
NOTES ON CLAUSES

Clause 1 – Short Title
This clause provides that the Bill, once enacted, may be cited as the Medicare Levy Amendment (Excess Levels for Private Health Insurance Policies) Act 2018.

Clause 2 – Commencement
This clause sets out when the Medicare Levy Amendment (Excess Levels for Private Health Insurance Policies) Bill 2018 and various provisions with it commence. The commencement date is 1 April 2019.

Clause 3 – Schedule(s)
This clause provides that legislation that is specified in a Schedule to the Act is amended or repealed as set out in the applicable items in the Schedule concerned, and any other item has effect according to its terms.

Schedule 1 – Amendments

Medicare Levy Act 1986

Item 1
This item repeals paragraph 3(5)(b) that limits excess levels to $500 in any 12 month period in relation to a policy which only one person is insured, and $1000 in any 12 month period in relation to any other policy. A new paragraph 3(5)(b) will substitute for the repealed paragraph, and will define the maximum voluntary excess levels by referencing the applicable excess levels specified in section 45-1 of the Private Health Insurance Act 2007.

Item 2
This item repeals subsections 3(5A) (6) and (7). Subsection 3(5A) relates to a grandfathering provision that extended the Medicare levy surcharge exemption allowing an exemption for individuals on products with higher excesses who has been insured continuously since May 2000 as long as their excess amount had not increased since that time. As a result of the repealing of subsection 3(5A), certain individuals may become liable for the Medicare levy surcharge if they do not transfer to a product with an excess no more than the new maximum levels.

Subsections 3(6) and (7) are repealed as they were made redundant by the Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007 Part 3 section 10.

Item 3
This item is an application provision which provides that for taxation purposes, the amendments made by items 1 and 2 in Schedule 1 apply in relation to the 2018-19 and later income years.