Members Health
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16 February 2018

Secretariat
Private Health Ministerial Advisory Committee
Department of Health

PHMAC.Secretariat@health.gov.au

Dear Sir/Madam

Exposure Draft Rules Amendment: Mental Health Reforms

Thank you for the opportunity to comment on the Exposure Draft Rules Amendment: Mental Health Reforms released 7 February 2018.

Members Health represents 23 community-based private health insurers, comprising both industry or employer focused "restricted access" insurers and "open" insurers serving particular regions.

Collectively, Members Health funds provide health cover to over 1.7 million Australians across the country. Members Health funds are predominantly not-for-profit and community based, and identify as mutual and/or member-owned insurers.

Since its formation in 1978, Members Health has advocated for the preservation of competition, believing it to be fundamental to Australians having access to the best value health care services. Members Health has done this by:

- Promoting legislation, regulations, policies and practices which increase the capacity of its member organisations to deliver best value health care services; and,

- Advocating for the preservation of a competitive market, which we see as essential to the integrity and viability of the PHI industry. Member Health funds, which are not-for-profit, member-owned and community based organisations, play a crucial role in upholding the competitiveness of the private health insurance market place.

We note that the most common procedures with a Benefit Limitation Period are: Psychiatry, Dialysis; IVF, and; and Bariatric surgery – running for a period of 12-24 months.

Where Benefit Limitation Periods are used by the small not-for-profit health funds, it is primarily to protect policyholders against the risk of *'hit and run'* adverse claims selection. If Benefit Limitation Periods were removed, those products affected would have to undertake a commercial review. This could involve increasing their price to at least their next highest competitor or introducing '*restrictions'* to reduce the risk of adverse selection. This will affect each product differently and will depend on the Benefit Limitation Periods treatment categories.

We have the following comments on the Private Health Insurance Mental Health Rule amendments (Exposure Draft).

1) The amendment seems to be enacting the Minister's request as per the covering email from the Secretariat (noting Benefit Limitation Payment amendments are yet to come).

   We observe the scope is wider than the 29 November 2017 announcement which included: *"The waiting period exemption is not available for services associated with alcohol and other substance use disorders"*. Expanding the scope is anticipated to have a significant inflationary impact on health insurance premiums, further contributing to affordability pressures for consumers and accelerating the decline in health insurance participation.

2) We are concerned that the exposure draft does not deal with several key practical issues such as:
   - If a policyholder is a voluntary patient to a mental health unit and is then detained as an involuntary patient by a psychiatrist, does that mean an upgrade is not possible as the criteria *"the referral was made at or before the time the person was so admitted"* is not met?
   - If a policyholder has serious mental health issues and is not competent to trigger an upgrade within 5 working days, is the option to upgrade lost? What are the requirements for a family member requesting such a change without a power of attorney and if the policy is not in the family member's name (particularly for a single or single parent policy)?
   - How will transfer certificates work? Is it likely that transfers at the date of admission will become more common if psychiatrists provide suggestions to patients on which health funds offer better benefits for a particular facility? Are there any privacy or Private Health Insurance Act issues if the transfer certificate records that the waiver has been used, as it is disclosing past mental health issues?

Effect on Insurers

Assuming Benefit Limitation Periods are not allowed on any hospital product (Gold, Silver, Bronze and Basic), the available information on the reforms states insurers have the following options to reduce costs:

- For all products – introduce an excess or a co-payment.
- For products other than Gold – reduce benefits, such as paying the minimum psychiatric benefits as specified under Private Health Insurance (Benefit Requirements) Rules 2011.

In practice this may result in the following adverse outcomes for the product types:

- For Gold Products – if no insurer in the market can offer a Benefit Limitation Period, then theoretically the risk of anti-selection for a particular insurer is lower compared with the current situation where insurers without a Benefit Limitation Period have a higher risk of anti-selection.

- An insurer may have introduced a Benefit Limitation Period for a specific reason (e.g. a new psychiatric hospital was opened in a region where a high number of the insurer's policyholders reside) and insurers will need to consider how to mitigate such as risk without using Benefit Limitation Periods. Mitigating actions may include introducing an excess or co-payment.

- Introducing an excess or co-payment will be detrimental to existing policyholders so an insurer may need to close any existing products and introduce a new product or products to mitigate the risk.

- For Basic Products – insurers may need to set the benefit at the level of minimum psychiatric benefits, possibly in conjunction with an excess or co-payment. Again, this may involve closing existing products and introducing a new product or products with the new benefits.

- For Bronze and Silver Products – the approach may lie somewhere between the approach for Gold and Basic, and may vary depending on whether the insurer currently includes Benefit Limitation Periods in its product offering.

Benefit Limitation Periods should be retained for Basic, Bronze and Silver Products

1) Without the risk mitigation effect of Benefit Limitation Period the market is anticipated to move towards reducing benefits and introducing an excess or co-payment for products other than Gold. <u>This may mean policyholders who seek to maximise their mental health cover have little choice but to purchase a Gold product. This additional cost (i.e. higher premium) for mental health patients is likely to be an unintended consequence of the changes.</u>

2) This may not be what the Department (or Minister) was expecting. Generally Benefit Limitation Periods are introduced by insurers to discourage policyholders with short tenure from claiming (i.e. introduced to mitigate anti-selection risk / hit and run behaviour) and it may have been thought there was no need for such risk mitigation if a policyholder can upgrade to Gold and waive any Benefit Limitation Periods (once having served a 2 month waiting period, if applicable). However in the absence of Benefit Limitation Periods, some level of risk mitigation is required on lower cost products to maintain price relativity.

3) The administrative costs and disruption associated with the redesign of products, including actuarial work and consumer communication, is expected to be significant and will have a considerable impact on premiums. This will further add to affordability pressures and accelerate already declining participation in private health insurance.

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In summary, the removal of Benefit Limitation Periods will reduce consumer choice and are expected to result in higher premium costs for policyholders. Benefit Limitation Periods protect policyholders from anti-selection/hit and run behaviour and allow insurers to offer higher cover policies at a lower price than would otherwise be possible.

Members Health supports innovation, competition and choice within the private health insurance marketplace and therefore our position is to strongly encourage the retention of Benefit Limitation Periods, at a minimum, across the proposed Basic, Bronze and Silver product categories.

The current drafting of Private Health Insurance Mental Health Rule amendments (Exposure Draft) will need to be altered if Benefit Limitation Periods are retained for Basic, Bronze and Silver Products so that:

1. In the event of the one off upgrade for mental health (use of the waiver), no waiting periods or benefit limitations can be applied
2. Benefit Limitation Periods can be applied to the proposed product categories below '*Gold*' in the usual way. That is, they apply to new entrants.
3. One off upgrade for mental health cover only applies to existing policyholders. Those new to private health insurance still have to serve waiting periods i.e. 2 months for mental health, cover before they can use the mental health waiver on waiting periods.

In principal, our position aligns with the views expressed by the Federal Health Minister to the PHMAC. The once in a lifetime upgrade to mental health cover should only apply to those already with private health insurance cover. This is entirely consistent with the retention of Benefit Limitation Periods.

Yours sincerely

Matthew Koce, CEO

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