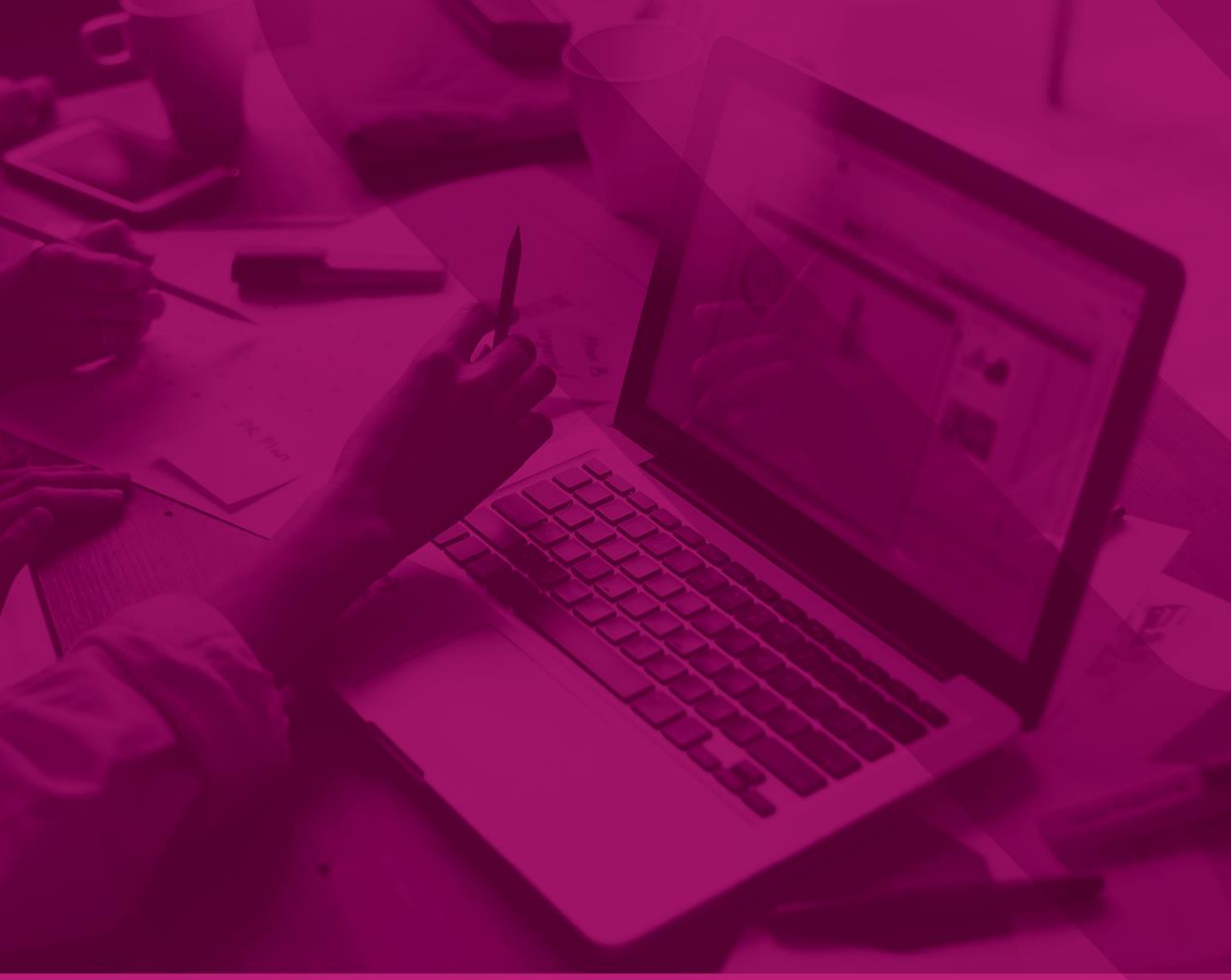

# Members Health Fund Alliance

**Submission to Senate Inquiry into Private Health Insurance Legislation Amendment Bill 2018 and related Bills**

**Date: 18/07/2018**

Members Health FUND ALLIANCE

Putting members' health before profit

Members Health
FUND ALLIANCE

# TABLE OF CONTENTS:

Members Health
FUND ALLIANCE

## INTRUDUCTION:

Members Health funds make up 23 of the 37 registered private health insurers and share one or more of the following attributes; being not-for-profit, member owned or community based. Combined, Members Health funds provide health cover to more than 1.7 million Australians.

We welcome the opportunity to contribute to the Senate Inquiry into Private Health Insurance Legislation Amendment Bill and related Bills.

Members Health funds provide highly valued services to regional communities and key industry groups, including military families, teachers, police, nurses and midwives, transport, mining and doctors. Regional communities where Members Health insurers are headquartered include Townsville, Lithgow, Wollongong, Newcastle, Latrobe Valley, Launceston, Burnie and Mildura.

Members Health and the broader private health insurance industry has been actively consulted in the development of government reforms enabled by proposed legislation contained in the following Bills:

- 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.
- Private Health Insurance Legislation Amendment Bill 2018.

The overarching intent of those reform initiatives facilitated by each of these Bills is to improve the value and affordability of private health insurance for Australian consumers.

Members Health has been broadly supportive of the reform agenda outlined by the government to date, and we support all appropriate efforts to encourage Australians to access to high quality health insurance products.

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## OUR FUNDS:

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# KEY ISSUES:

## Increasing the maximum policy excess to $750 for singles and $1500 for families

The proposed adjustments to maximum excess levels represent the first such changes in 18 years, during which time the health insurance industry has endured notable cost increases, rising inflation and higher claim levels.

Having maximum excesses fixed in dollar terms means the proportion of claim costs borne by insurers has risen, resulting in higher premiums. Consequently, insurers and policyholders have increasingly had to turn to policy exclusions or restrictions as a cost-saving measure.

This reform does not alter private health consumers' ability to obtain excess-free products or for insurers to continue offering products with existing maximum excess levels.

Members Health supports choice in the health insurance market, and believes consumers should be trusted to select the right balance of premium and excess to suit their needs, budgets and health expectations.

Given the aforementioned increase in health costs, higher maximum excesses are sure to provide that choice, whichever way the consumer opts to tailor their policy. This flexibility is also likely to appeal to younger people who may be generally healthy but fear sustaining a high-cost accidental injury for which a higher excess remains reasonable (i.e. a sports injury).

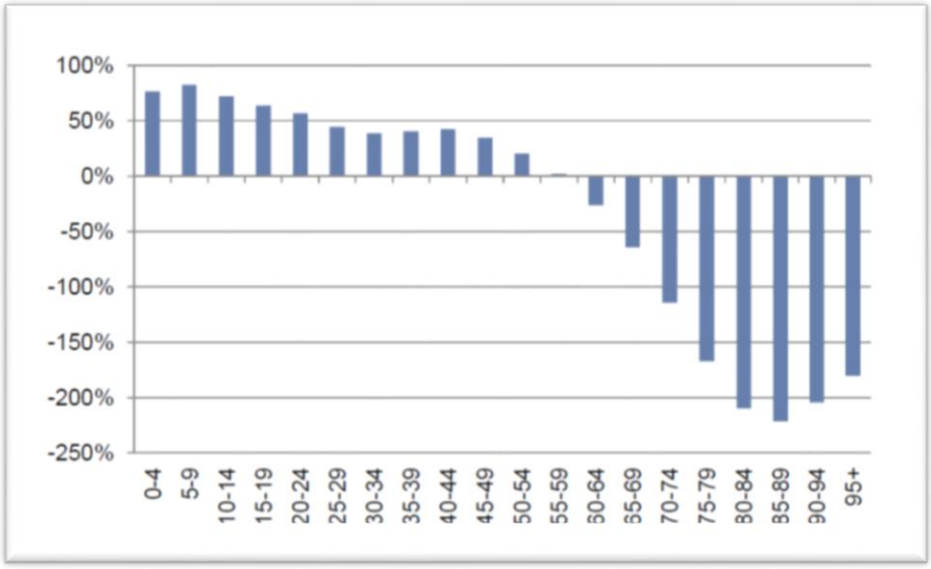
## Discounts to younger consumers

Private health insurance relies on a system of Community Rating in which younger, healthier members cross-subsidise older members who are more likely to claim benefits. If younger people continue to leave the system, private health insurance will become more expensive, thus exacerbating affordability further and potentially driving more people out.

This potential trend could drive many people into the public health system and onto already overstretched public hospital waiting lists.

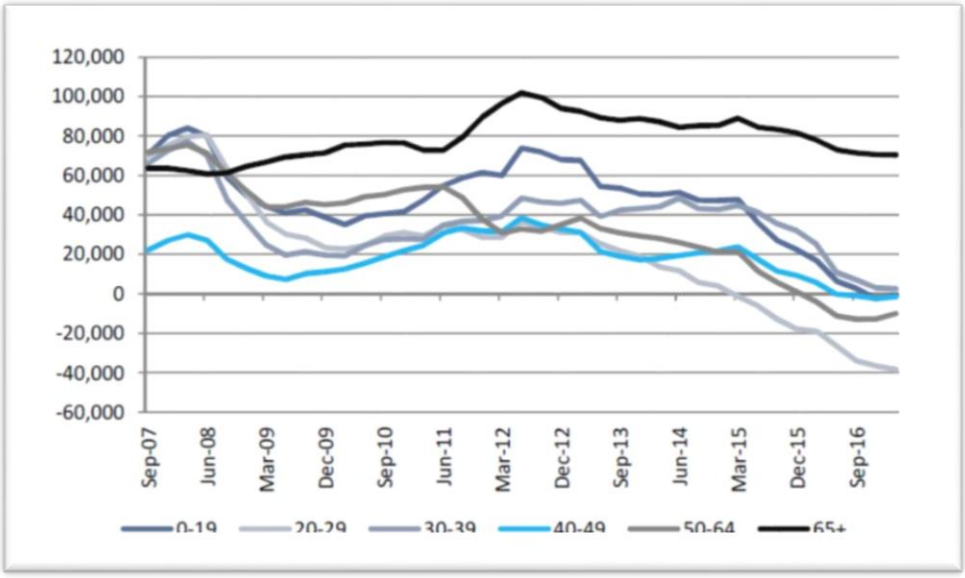
With affordability widely recognised as a major cause for some Australians to exit the private health insurance system, Members Health supports any initiative that seeks to reduce consumer costs and encourages accessibility for younger people.

**Cross-subsidisation of policy holders (5 year average)**




Source: APRA data prewpared by Goldman Sachs

**Trends in policy holder age**




Source: APRA data prepared by Goldman Sachs

## The reform allows insurers to terminate products and transfer all people covered by those products into new policies

Presently there are about 75,000 private health insurance policies in the market. Under the existing legislative framework, private health funds can close access to existing policies for new members and transfer existing policyholders of terminated products into new products.

Meanwhile, all relationships in the private health insurance industry, including member transfers, are governed by the statutory protections offered to consumers by the Competition and Consumer Act, including the Australian Consumer Law. These include relationships between consumers and health insurers, hospitals, medical facilities, health providers and practitioners[1].

The application of these oversights are actively monitored by the Australian Competition and Consumer Commission (ACCC), which presents an annual report on private health instance to the Australian Senate. This provides a significant degree of oversight to the industry, particularly with regards to insurer transparency towards consumers and policy changes.

Health funds' ability to cease existing policies is part of a voluntary and informed business decision-making process, which requires that consumers are fully aware of their options in such a circumstance. The process must be conducted in a manner consistent with ACCC expectations and requirements, and should rightly remain so.

## New powers to the Private Health Insurance Ombudsman

Members Health has a strong working relationship with the Private Health Insurance Ombudsman. Our funds also perform strongly against key data released in the PHIO's annual report, including that Members Health funds as a group receive fewer complaints than the remainder of the combined industry.

In the most recent PHIO quarterly report, released May 2018, Members Health funds, which account for 12.6 per cent of industry, received just 9.9 per cent of total complaints.

With this in mind, Members Health sees no compelling need for the Private Health Insurance Legislation Amendment Bill 2018 (the Bill) to grant the PHIO powers to enter the premises of a private health insurer without consent or warrant.

[1] Private Health Insurance Ombudsman: Private Health Insurance Report 2016-17.

The PHIO's principal objective is to assist people who have made complaints relating to private health insurance. The proposed sections 20SA and 20TA – in effect – amount to a power of warrantless search and seizure, which would appear excessive.

Furthermore, the Attorney-General's department states that the *Guide to Framing Commonwealth Offences* specifies that powers of entry and search without a warrant are only appropriate in 'exceptional circumstances'[2] and require 'compelling justification'.[3] Examples include 'situations of emergency, serious danger to public health, or where national security is involved.'[4]

With Members Health funds' high performance in providing positive outcomes for consumers, both in PHIO reports and external research showing a 96 per cent policyholder satisfaction rate[5], unless 'compelling justification' is identified and subject to parliamentary scrutiny, we encourage the provisions be amended in line with the *Guide to Framing Commonwealth Offences,* or removed from the Bill altogether.

[2] Attorney-General's Department, *A Guide to Framing Commonwealth Offences, Infringement Notices and Enforcement Powers*, September 2011, p. 86.
[3] Attorney-General's Department, *A Guide to Framing Commonwealth Offences, Infringement Notices and Enforcement Powers*, September 2011, p. 76.
[4] Attorney-General's Department, *A Guide to Framing Commonwealth Offences*, Infringement Notices and Enforcement Powers, September 2011, p. 86.
[5] Members Health Media Release: Members Health funds record 96% satisfaction

Members Health
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# ABOUT MEMBERS HEALTH FUNDS

There is a notable difference between for-profit health insurers and not-for-profit, member owned health insurers represented by Members Health.

Members Health funds make up 23 of the 37 registered private health insurers and share one or more of the following attributes, being: Not-for-profit; Member owned; Regional or community based. Combined, Members Health insurers provide health cover to over 1.7 million Australians nation-wide.

Members Health funds a very highly valued service to key communities of interest spanning regional populations and industry groups, including: Military families; Teachers; Police; Nurses and Midwives; Transport; Mining and Doctors. Regional communities in which Members Health insurers are headquartered include: Townsville; Lithgow; Wollongong; Newcastle; Latrobe Valley; Launceston; Burnie and Mildura.

The data supplied by APRA, the Commonwealth Ombudsman and independently run surveys all consistently points to the Members Health funds as being the success story of the health insurance industry. On average they provide highly competitive policies with lower than average premium increases, offer excellent customer service, valued products and are intimately connected to their communities of interest.

Members Health funds have consistently experienced average policyholder grow that is much faster than the rest of the industry. They also experience much higher policyholder retention rates. If it were not for the superior performance of the Members Health funds, participation in private health insurance would be much lower than it is today, highlighting the importance of the not-for-profit, member owned and community based health funds to the ongoing sustainability of private health insurance.

Recognising the importance of value for money, on average Members Health funds have achieved smaller premium increases over the past five years than the rest of the industry. All Members Health funds operate on narrow margins. Notably, several Members Health funds operate on premiums that have a net negative margin, making a small profit only after accounting for returns on investments.

Members Health funds also lead in terms of customer satisfaction. Independent research by Discovery Research showed a customer satisfaction level of 96% amongst the over 21,000 consumer responses received in 2018.

It is clear that without the superior performance, diversity and competition provided by Members Health funds, Australian consumers and the private health industry as a whole would be significantly worse off in terms of both participation levels, cost and the quality of private health insurance.

Attached is a snapshot benchmarking the performance of the Members Health funds across a range of industry metrics.

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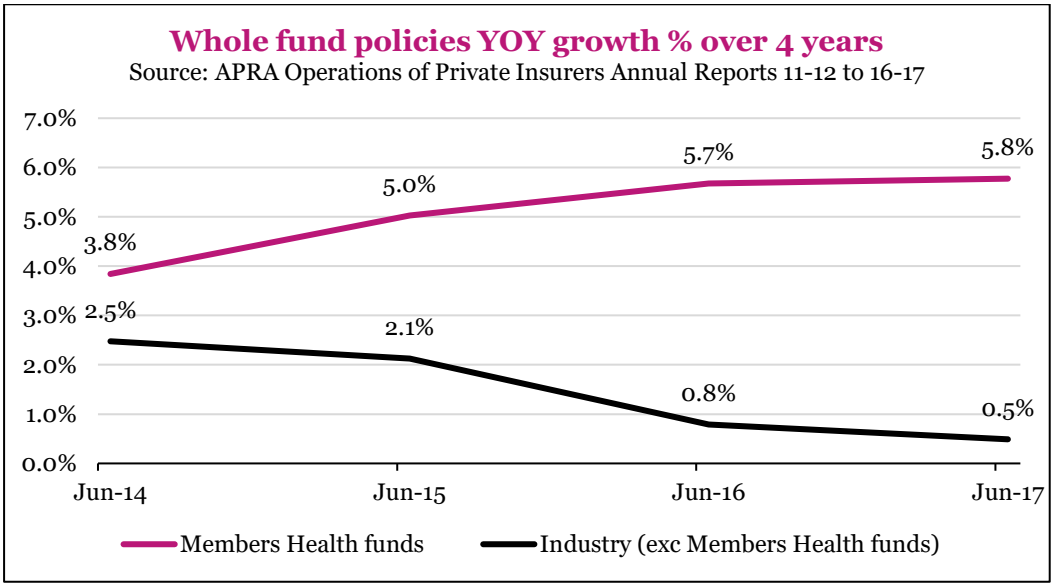
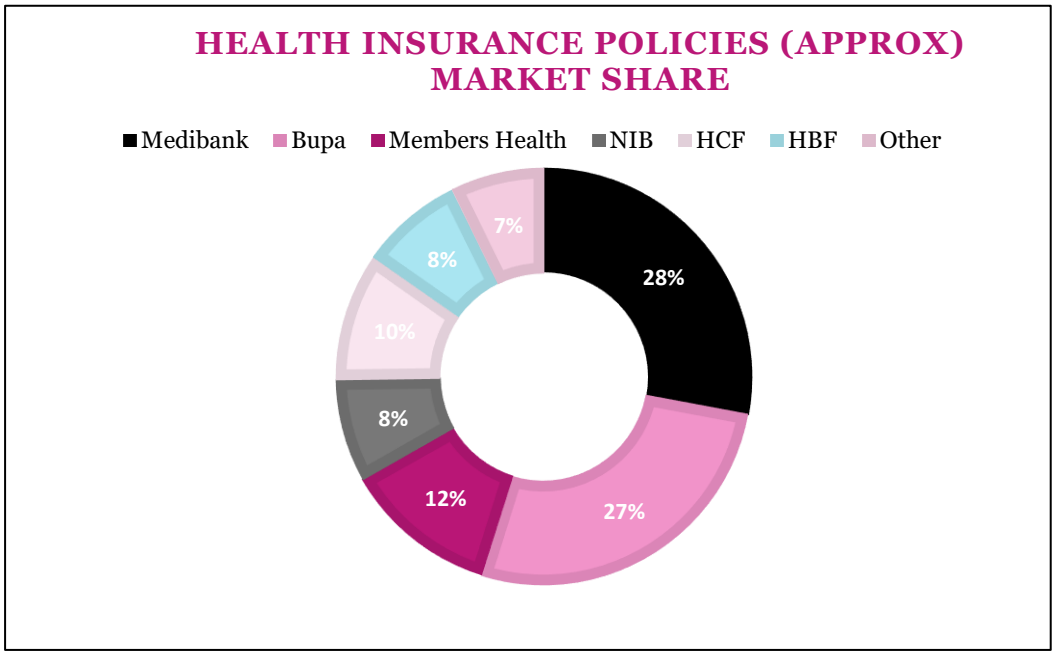
## Higher levels of growth than industry average

Policyholder growth has for many years been well above the industry average, highlighting that consumers are increasingly recognising the superior value proposition of the not-for-profit, member owned and community based health insurers. Today Member Health funds accound for 12% of the private health insurance industry.




**Putting members' health before profit**

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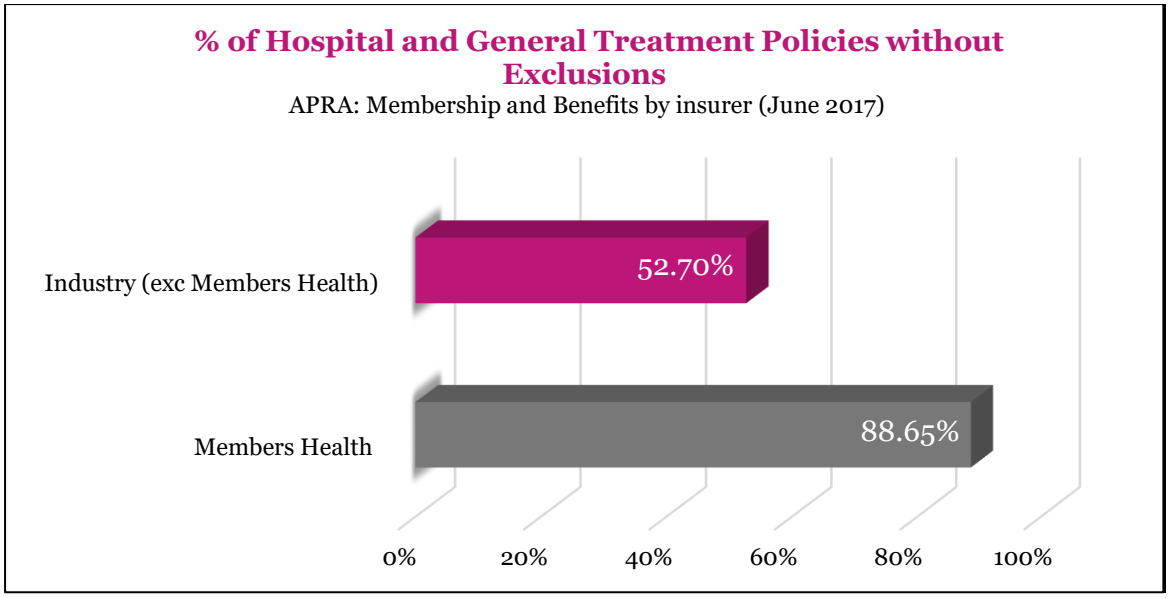
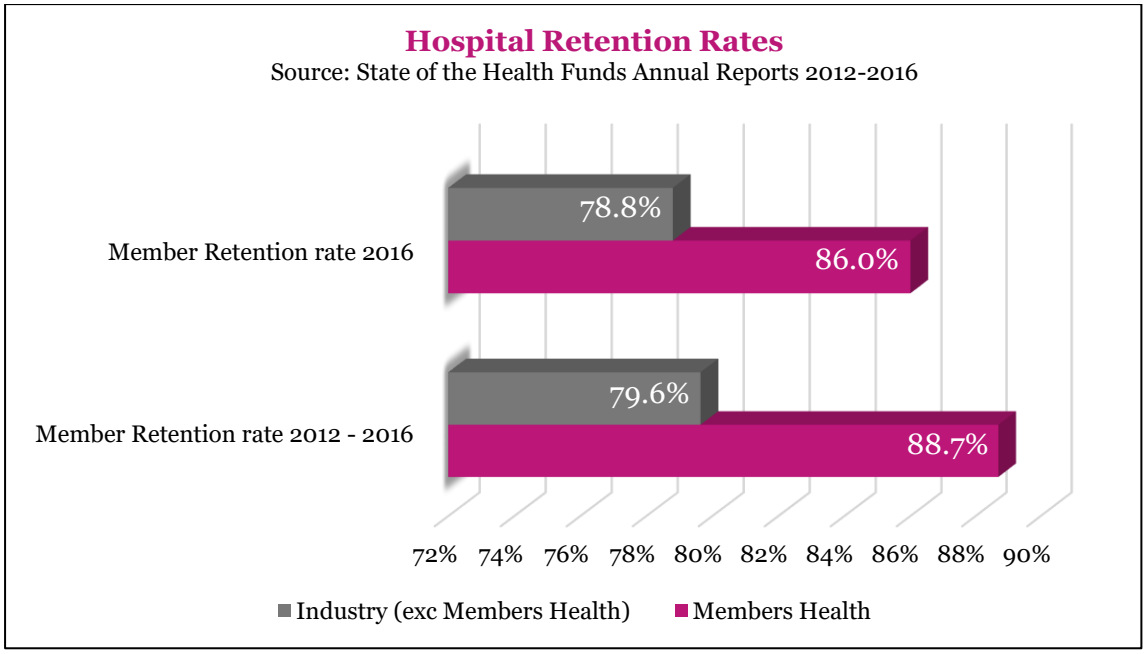
## Members Health funds have fewer exclusionary policies

Industry data indicates that Members Health insurers are leaders when it comes to high cover polices. The overwhelming majority of policies provided by Members Health funds are free of exclusions.




## High rates of customer retention with Members Health funds

Customer retention rates that are significantly higher than the industry average, further highlights the strong customer perfomance of Members Health funds.

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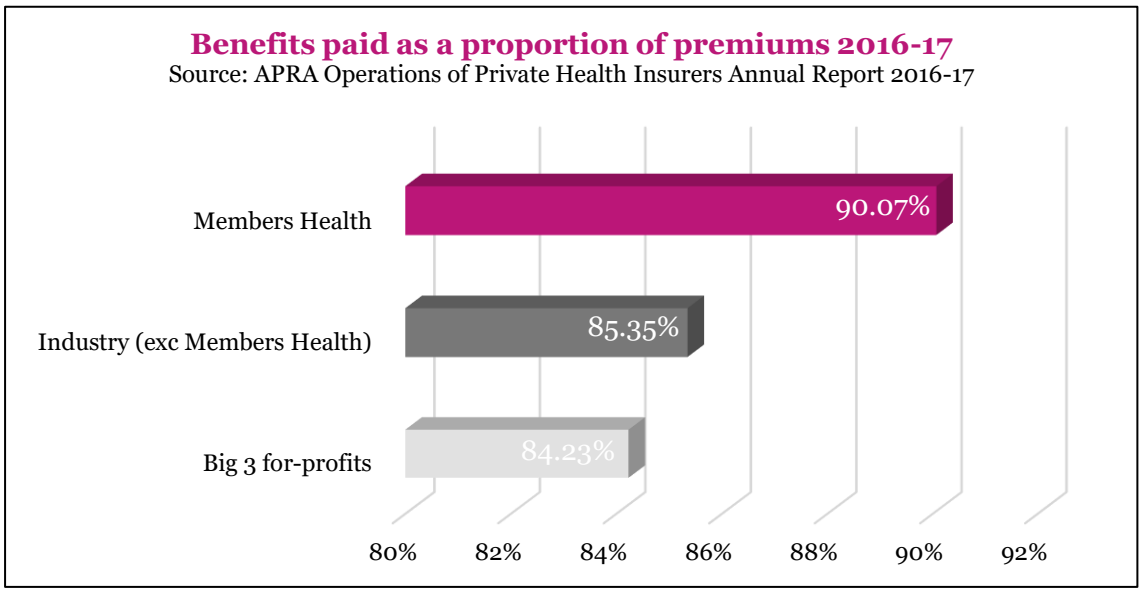
## Higher proportions of premiums go to benefits for consumers

Members Health funds are unashamedly customer centric in their ethos. They return on average around 90 per cent of all premiums paid, back to policyholders, as benefits. This is in contrast to the for-profit insurers, which operate primarily for the benefit of shareholders and return on average around 85 per cent.




## High levels of customer satisfaction

Members Health funds consistently experience very high levels of customer satisfaction. This is reflected through the Discovery Research customer satisfaction survey, which has been running for the last 12 years and is conducted independently.

Participating Members Healthfunds have consistently recorded over **97 per cent customer satisfaction** rates among their policyholders. In 2017 over 15,000 survey responses were received from policyholders.

### Members Health fund membership satisfaction

| | |
|---|---|
| **Overall Member Satisfaction**<br>**Overall, how satisfied are you with your health fund membership?** | **2018: 96% satisfied** |

Source: Discovery Research 2018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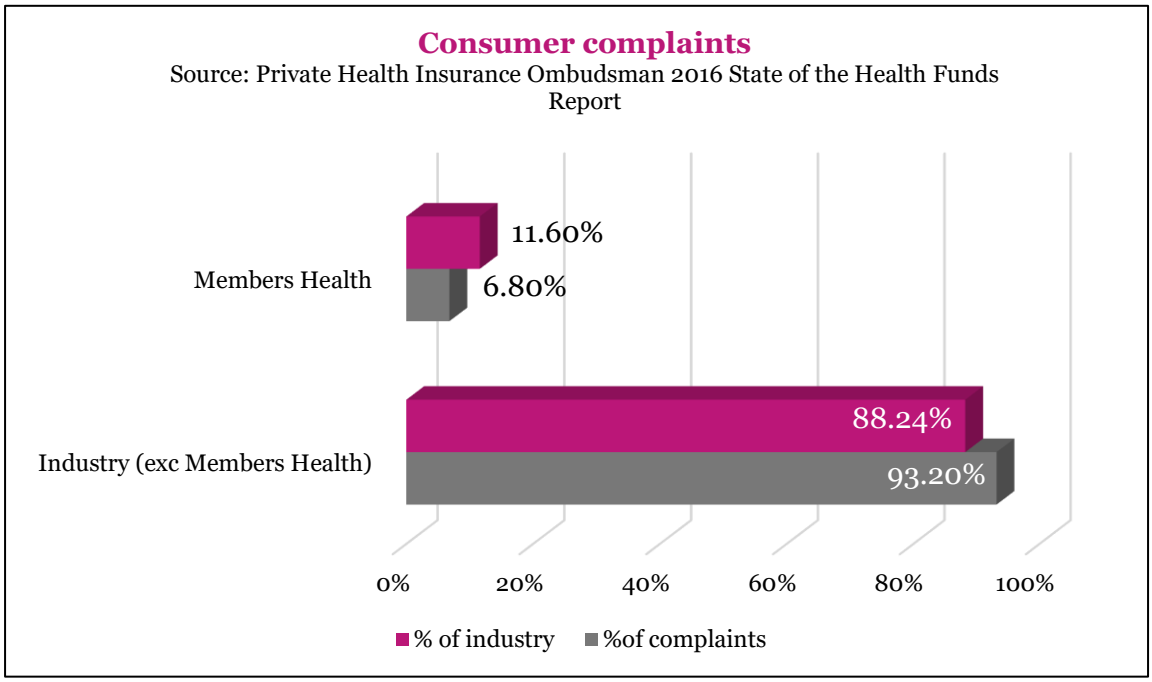
# Commonwealth Ombudsman statistics reinforce the customer centric ethos of Members Health funds

Commonwealth Ombudsman figures show that while funds belonging to Members Health represent around 10 per cent of the market, they account for less than 5 per cent of all complaints received in 2015-16 by the Commonwealth Ombudsman relating to health insurance products and service.



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COMMONWEALTH OF AUSTRALIA

# Proof Committee Hansard

# SENATE

## COMMUNITY AFFAIRS LEGISLATION COMMITTEE

**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**

(Public)

TUESDAY, 7 AUGUST 2018

CANBERRA



BY AUTHORITY OF THE SENATE

**[PROOF COPY]**

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**SENATE**

**COMMUNITY AFFAIRS LEGISLATION COMMITTEE**

**Tuesday, 7 August 2018**

**Members in attendance:** Senators Brockman, Pratt, Siewert.

**Terms of Reference for the Inquiry:**

To inquire into and report on:

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

## WITNESSES

**DAVID, Dr Rachel, Chief Executive Officer, Private Healthcare Australia**

**DOMITROVIC, Ms Kristy, Director of Engagement, Policy and Strategy, Private Healthcare Australia**

**KOCE, Mr Matthew, Chief Executive Officer, Members Health Fund Alliance**

***Evidence of Dr David and Ms Domitrovic was taken via teleconference—***

**CHAIR:** I welcome representatives of the Members Health Fund Alliance and, via teleconference, representatives from Private Healthcare Australia. Could you please confirm information on parliamentary privilege and the protection of witnesses and evidence has been provided to you?

**Dr David:** Yes.

**Ms Domitrovic:** Yes.

**Mr Koce:** Yes.

**CHAIR:** The committee has your submissions. I now invite each group to make a short opening statement and then we will ask you some questions. We'll begin perhaps with Private Healthcare Australia.

**Dr David:** We're here on behalf of Private Healthcare Australia, which is the peak representative body for the private health insurance industry, representing over 20 health funds. These are both for-profit and not-for-profit, large and small. Our organisation covers over 96 per cent of Australians who hold private health insurance. The Private Health Insurance Legislation Amendment Bill 2018 is the combination of more than two year's consultation with the government on private health reform. Private health funds has contributed to the process in collaboration with other stakeholders in the private sector. Therefore, in this light, we welcome the bill, which introduces a broad-ranging package of reforms important to the sustainability of private health insurance in the private health sector. The reforms in this bill will help make it easier for consumers to choose and use their health insurers and this is the purpose of the legislation. The reforms will critically support the industry to deliver high-value affordable care to Australians.

It has been a challenging process to get to this point over the last 24 months as a result of the increasing complexity of the health system. As representatives of health funds, we have recognised we have a problem with consumers' understanding the system so we have been prepared to invest considerable time, money and effort into helping improve transparency for health fund members in the community. In doing so, we have been happy to work with private health stakeholders including consumers, medical specialists and hospitals.

Private health insurance is an integral part of Australia's mixed public and private health system. Thirteen and a half million Australians rely on private health insurance and more than half of them have disposal incomes under $50,000 a year. This is a not a luxury market in Australia. We know that over 80 per cent of people believe they get value for money from their private health insurance and cite piece of mind, choice of specialist and continuity of care, choice of hospital and timing of medical treatment as the main reasons they do this. Private health insurance pays for close to two-thirds of non-emergency surgery in Australia, 76 per cent of same-day mental health admissions, 56 per cent of all mental health admissions, 70 per cent of joint replacement, 60 per cent of chemotherapy and 88 per cent of retinal eye procedures. In addition, health funds pay out more than $2.6 billion for dental care every year, which is more than dental care expenditure by the federal government or state government.

For decades, an inflexible regulatory environment has locked health funds into paying claims whether or not evidence supports quality critical outcomes and cost effectiveness of the services provided. This has had the effect of protecting vested interests but now, more than ever, with flat wages growth since 2009 and cost of living pressures impacting households, this inflationary dynamic needs to be addressed.

The measures in this bill will enable health funds to offer great choice and flexibility to members and to innovate by designing products that are more affordable and better meet the needs of members having regard to their particular circumstances such as age or location. These reforms are an important step in putting downward pressure on premiums and ensuring the sector is more transparent to consumers. This in turn supports the long-term viability of the health system both directly and through the flow-through effects on the private health insurance rebate. Without this impact, the subsequent decline in private health insurance membership would result in pressure on the federal budget across other areas of health and undermine the overall sustainability of Australia's healthcare system. We're not in any way suggesting the current bills will solve all of the challenges facing private health or Australia's health system, but the changes are a much-needed step in the right direction and should be supported by the Senate.

**CHAIR:** Thank you very much. Mr Koce, do you have an opening statement?

**Mr Koce:** I do. The Members Health Fund Alliance thanks the committee for the opportunity to speak on the Private Health Insurance Legislation Amendment Bill and related bills. By way of background, the Members Health Fund Alliance is a peak body for 23 of the 37 registered private health insurers. All our funds share one or more of the following attributes: being not for profit, member owned or community based. Our funds represent Australia's military families, teachers, police, nurses and doctors. Many are headquartered in key regional communities such as Townsville, Lithgow, Newcastle, the Latrobe Valley, Mildura, Burnie and Launceston, just to name a few. In total, the members health funds provide cover to more than 1.7 million Australians, or about 12 per cent of the insured population. It's pleasing that consumers are increasingly discovering the value delivered by our funds, which as a group are growing at around four times the industry average. On average, the members health funds return around 90c in every premium dollar back to consumers in benefits. In contrast, general insurers return around 64c in the premium dollar.

The focus of our funds is on community value and affordability, and that's consistently seen as smaller health funds outperform on customer satisfaction and retention. Earlier this year, we surveyed around 20,000 policyholders from participating members health funds. They were independently surveyed by Discovery Research, and we got a net promoter score of 38.1 on average across the group and a 96 per cent overall customer satisfaction rate, which is very impressive. This highlights the importance of the smaller health funds to consumer competition and choice, and it is a very competitive marketplace out there. Our funds also run dental practices and optical clinics, providing 51 dental chairs, many in regional areas where, if it not for the health fund, there would be no local dentist or optical service or there wouldn't be appropriate services there.

Having a vibrant and successful private health insurance industry is vital for the longer term sustainability of Australia's health system, and the smaller health funds are a key component of that. Last year, private health insurers funded $20 billion in healthcare services that would otherwise have been paid for by taxpayers and which would further overstretch waiting lists at public hospitals. Over 40 per cent of all procedures take place in the private hospital setting. Even the most complex health conditions are covered, including two in three elective surgeries, more than 45 per cent of chemotherapy treatments, seven in 10 eye surgeries, nearly half of heart surgeries and seven in 10 rehabilitation admissions.

The Australian health system consistently performs better than the OECD average, and private health is a key component of that success, along with our private hospitals, who perform outstandingly. Around 13.5 million Australians choose to have private health insurance, which provides them with immediate access to high-quality and affordable care. We know that countries with nationalised health services often look to our mixed public and private system with envy. The fact that the Australian government continues to recognise the value of private health and support the interests of consumers through its suite of reforms is commendable. The Members Health Fund Alliance has been an active party in the government's consultations and is broadly supportive of the agenda to date. We see the proposed legislation as part of a holistic package to improve value, affordability and informed choice in private health insurance.

**CHAIR:** Thank you very much. I'll kick things off with a question to both organisations. Obviously both organisations are broadly supportive of the legislation before us. We've had some issues raised by previous witnesses about the potential undermining of the principle of community rating. Could I have the perspective of both organisations on the issue of community rating? Perhaps we could start with Private Healthcare Australia.

**Dr David:** We broadly support the principle of community rating whereby people across a number of age ranges and types of health status contribute to the pool and no-one is discriminated against on the basis of their health status. That's a really key feature that distinguishes private health insurance in Australia versus other countries and other types of insurance. But we do have a lifetime health cover system in place at the moment where there's a loading for people who join over the age of 30. That dates from an era when the private health sector was really in crisis in the late nineties. At that time it was possible for someone to join private health insurance at the age of 85, serve their 12-month waiting period and have a number of procedures, and they would pay the same premium as someone who joined at the age of 25. That was found, after an actuarial analysis, to be unsustainable and a contributing factor to double-digit rises in premiums.

We need to keep the system affordable for younger people. You cannot sustain community rating without younger people joining. In this economic era, younger people are under an almost unprecedented amount of pressure as a result of flat wages growth, the housing market and the casualisation of the workforce. So, although we have got about 30 per cent of people with some form of private health insurance who are aged under 30, that is a considerable part of their household budget and they still, we believe, based on research, are going to need some more help to afford private health insurance if community rating is to be supported.

**Mr Koce:** We absolutely support the principle of community rating, which means you can't discriminate against anyone based on their health condition or broadly on their age. We see a major challenge is retaining younger people in private health insurance. I've provided some charts that show you the importance of bringing younger people into private health insurance and balancing out the private health insurance pool. If we can grow the number of younger people in private health insurance, it will bring down the overall cost of premiums. We would support anything that would bring younger people into private health insurance, and that's why we're broadly supportive of the discount for younger people as proposed.

**CHAIR:** Do your members believe that the basics policies are of value to consumers? Could you explain why?

**Dr David:** I might start, and I'm sure that the Members Health Fund Alliance has some more comments on this. There has always been a basic table option, at least since the 1970s, for a lower cost form of private health insurance. Initially, this was really for the rural and regional market, where people with chronic diseases would have their particular specialist of choice, who was a fully qualified specialist, but the only option for treatment was in the local public hospital. This was a suitable form of insurance for people who were getting treatment from a physician in some of the large regional centres like Wangaratta, Ballarat and similar-sized towns.

As the market has evolved, particularly when you have the incentives that are currently in place—the lifetime health loading starting at 30 and the Medicare levy surcharge—there is a group of people who take out a low-cost form of health insurance, because they are younger and are at less risk of a health problem, so they can avoid paying the higher Medicare levy. We don't believe that's actually a problem. Those young people are in the market at a time which helps them avoid the lifetime loading, and their premiums are helping to contribute to the risk equalisation pool and therefore support community rating as a whole. If the lower cost policies, for any reason, were eliminated, they wouldn't be able to get a foothold in the market until a later time and, by that stage, the lifetime loading would have kicked in and again they would be locked out by higher premiums. So we ask you consider that there is a logical role for lower cost policies and we'd like to see that continue.

**Mr Koce:** I'd echo a lot of those comments. Affordability is at the top of the agenda at the moment. Consumers are very concerned around affordability. We wouldn't support anything that would damage affordability of private health insurance. The basic product is an affordable policy for many people. It's particularly important in regional and rural Australia where often only the public hospital is available and you still get your choice of specialist in that hospital. It's a valued service to many in regional and rural Australia. The basic category, as proposed under the gold, silver and bronze, allows for tailoring of products. You can offer products above the absolute minimum in that category. It allows for private health insurers to design and innovate policies that suit the very different needs of Australia, which is a very diverse marketplace. We know policies with restrictions are very popular in some regional and rural communities. We also know that, even if a consumer is on the most basic product available, they are contributing to risk equalisation, which is about the first $800 of the policy. So they are contributing to the risk equalisation pool. Often consumers make a very logical choice. They might consider themselves in good health condition, they might consider that the risk of them needing hospitalisation is low or they might not have the financial means at that particular time to purchase a higher cover of policy, so they're making a very logical and informed choice with a view to upgrading their cover in the future. Then they can remain in the pool and they're not going to be hit with lifetime health cover loading later on. We believe that it's important for consumer choice and the market is doing the right thing. Our funds get a 96 per cent to 97 per cent customer satisfaction score among their members. They're at pains to make sure consumers are very well informed about the policies they are taking out.

**CHAIR:** Thank you.

**Senator SIEWERT:** I want to go to the issue around dental services. We haven't really talked about dental services during the inquiry today. Private Healthcare Australia, in your submission you say the majority of dental health services provided to low- and middle-income earners are subsidised by health funds in some way, but that's not broken down. I will understand if you need to take it on notice. Are you able to tell us the proportion of the cost of health services for low- and middle-income earners that is covered by private health insurance?

**Dr David:** It will vary between funds and location. I'm going to give the broader response and then we'll take the detail on notice. Overall, 41 million dental services per annum are subsidised to some degree by private health insurance, either through the extras rebate or through a subsidised corporate dental service that the fund actually operates. The comparison is the combined state and federal government dental schemes, which account for about 1.7 million services per annum.

**Senator SIEWERT:** Thank you. You'll take on notice the issue around low- and middle-income earners?

**Dr David:** Yes.

**Senator SIEWERT:** Thank you. Can we go to the maximum excess issue? Do you believe it's appropriate that the maximum excess is fixed in legislation? And do you think that's best practice?

**Mr Koce:** Perhaps I can jump in there. We do support the increase in excess. I note that it's not mandatory. Some health funds will continue to offer no excesses in their policies; others will offer higher excesses. We believe it will help put downward pressure on premium costs, and consumers will make an informed choice. It lines up with other types of insurance, whether it's automotive or other kinds of insurance where there are excesses, as consumers understand excesses very well. There hasn't been any adjustment to excesses in 18 years. They've been at their current level for 18 years. This just reflects a CPI adjustment. We think it's very sensible.

**Dr David:** The Private Health Ministerial Advisory Committee did discuss this issue, and this was where the combined committee landed in terms of its recommendation to government. The prospect of having a completely uncapped excess system was actually raised, but the risk is, if the excesses creep up to being too high, that could mean that some people who are good risks can effectively pay a very, very low premium and could lead to premiums rising for everyone else in the fund. It could, paradoxically, create upward pressure on premiums, so it was thought that this level was an appropriate compromise to avoid that happening but also to index the excess over a period of time.

**Senator SIEWERT:** Thank you. This question's to the Members Health Fund Alliance. You outlined some concerns in your submission around the Private Health Insurance Ombudsman and the expansion of their powers. Could you outline your concerns a bit further for us, please.

**Mr Koce:** I'm happy to do that. There is really only one aspect of the legislation that we have concerns about. Consistent with the Standing Committee for the Scrutiny of Bills, we are concerned that the new powers given to the ombudsman around compulsory powers of entry and search appear to be excessive. I point out that only 0.04 per cent of those with PHI have registered any kind of complaint with the ombudsman—and that's in the 2016-17 ombudsman's annual report.

In the standing committee report, they say—it's in *Scrutiny Digest 5 of 2018* dated 9 May 2018:

> The committee notes that the Guide to Framing Commonwealth Offences states that legislation should only authorise entry to premises by consent or under a warrant and that '[a]ny departure from this general rule requires compelling justification … Where a bill seeks to allow entry without consent or a warrant, the committee would therefore expect a detailed justification to be provided in the explanatory memorandum.
>
> …
>
> The committee therefore seeks the minister's advice as to why it is considered necessary to allow the Private Health Insurance Ombudsman to enter premises and inspect documents without consent or a warrant.

Having read the explanatory memorandum, Members Health Fund Alliance does not feel there is adequate justification for authorising the Private Health Insurance Ombudsman to enter the premises of a private health insurer without consent or a warrant. The Private Health Insurance Ombudsman's principal object is to assist people who have made complaints relating to private health insurance. The proposed sections 20SA and 20TA, in effect, amount to a power of warrantless search and seizure for the purpose of resolving consumer complaints. When the reform package was announced the government said:

> In most cases, health insurers voluntarily provide full records to the Private Health Insurance Ombudsman in order to investigate complaints. However, there are some instances where further investigation reveals additional records such as phone calls or letters and emails have previously been overlooked by insurers in responding to the Private Health Insurance Ombudsman. By being able to access a health insurer's records directly within their premises, investigation officers will be able to assure themselves that an insurer is not overlooking records in responding to the Private Health Insurance Ombudsman. The Private Health Insurance Ombudsman will also be able to provide assurance to complainants that they are able to verify the accuracy of the information provided by insurers to the Private Health Insurance Ombudsman and not rely solely on the health insurer to respond to the Private Health Insurance Ombudsman without making a mistake. The government will seek to work in cooperation and partnership with the sector as an overarching principle.

In our view, if the justification for the powers to be extended under proposed sections 20SA and 20TA is that private health insurers sometimes overlook records or make a mistake, the powers are wholly disproportionate and unjustified. Unless a compelling justification for warrantless search and seizure in this context is identified and subject to parliamentary scrutiny, we consider that the provisions should be amended for consistency, with a guide to framing Commonwealth offences, or removed from the bill altogether. Across the industry, health insurers do cooperate with the Ombudsman. We don't see any compelling reason for this power.

**Senator SIEWERT:** You made two points. You said words to the effect 'either amended or removed'. If it were amended to include a warrant, as you've outlined, would you still have concerns?

**Mr Koce:** That would be a step in the right direction. I think requiring a warrant makes a lot of sense. It's quite unprecedented for the power to come in without a warrant and inspect the premises of a business. It would be unprecedented.

**Senator SIEWERT:** I want to go to both of the organisations to ask about the termination of products. It's an issue that has come up, and, in particular, we talked about it earlier this morning. Concerns have been raised around being able to terminate products. Are you supportive of that approach? I'll ask that first, and then I have a follow-up question. Do both your organisations support allowing private health insurers being able to terminate products and transfer people onto other products?

**Dr David:** I think the current Private Health Insurance Act does commit health funds to close products and transfer people to other products, but the critical issue is ensuring that health funds comply with the Consumer Law and fully inform consumers about the transition. We don't really see that anything in this bill overrides the Consumer Law, and nor should it.

**Mr Koce:** From the Members Health Fund Alliance's perspective, the act already allows insurers to terminate a product and transfer policy holders to other products, and we note that there are very strict provisions under the ACCC around disclosure and that fair and reasonable notice must be given to consumers. We also note that funds operate in a highly competitive environment where portability between health insurers is guaranteed under legislation and that closing and terminating products has never been an issue in the past. We don't expect it to be an issue going forward.

**Senator PRATT:** In that context, why are the changes to this area in this legislation actually needed?

**Mr Koce:** I think the explanatory memorandum points to making the provisions clearer. I just don't see this as being an issue at all.

**Dr David:** We concur with that. This legislation is simply tidying up the wording around a process that's already working well.

**Senator PRATT:** So we could delete that from the legislation and you wouldn't mind?

**Dr David:** Well, the provisions—

**Senator PRATT:** You haven't provided a rationale for the tidying up.

**Ms Domitrovic:** The provisions include some additional consumer protection around notification of termination of products. At the very least, we'd support those remaining in the legislation.

**Senator PRATT:** How often are policies currently cancelled or transferred?

**Mr Koce:** As far as I'm aware, I don't think anyone has ever terminated a policy. Some policies out there have very small numbers of consumers on them because they're very, very old, and there are literally thousands of policies out there. The industry hasn't previously gone to close policies, even though they could. They've tended to leave people on them, and the process for most funds is that they will communicate regularly with policy holders, check that their health condition hasn't changed and make sure that they're on the appropriate policy for their health conditions, and as people get older people health funds will say, 'Are you sure you don't want to upgrade to a higher level of cover?' So it's about keeping consumers informed. Terminating policies has never been an issue in the past, and I don't think it will be in the future. The most important principle is that there's full portability between health insurers and that there's a competitive market with consumer choice.

**Senator PRATT:** You can't point to any specific examples where policies have been cancelled recently?

**Mr Koce:** No. I'm not aware of there ever having been a policy cancelled, ever.

**Senator PRATT:** I'm still a little unclear about why this needs clarification if there's nothing in the past to compare its implementation to. Does that mean that insurers do want to make more use of this provision but the current provision is not really enabling you to do that?

**Mr Koce:** It's not an easy process anyway to close a policy. You'd need to comply with the ACCC provisions. You'd need to provide consumers with lots of notice and information. I don't think funds have a desire to close policies.

**Senator PRATT:** Insurers and government have claimed there are a high number of policies with only one or two people on them. How many policies are like this?

**Mr Koce:** I'd have to take it on notice. Do you know, Rachel?

**Dr David:** Not off the top of my head. That did come up at the Private Health Ministerial Advisory Committee in the context of discussions around complexity and the concern that there was a large range of health fund products that were available. But then it became clear that most of the products which were counted were

actually back-book products that were no longer on offer. It was the Department of Health that stated at the time that some of those products had very few remaining members—five to 10 remaining members. So we may not have that information to hand, but we'll take the question on notice and confer with the Department of Health to see whether it is possible to inform the Senate of that number.

**Mr Koce:** The Commonwealth Ombudsman would know how many policies there are, because the SIS statements are all on the privatehealth.gov.au website. They'd know how many policies are in existence, but they may not know how many individuals are on each policy. That would only be known on a fund-by-fund basis or perhaps by the Department of Health.

**Senator PRATT:** What's the relationship between that issue and the need for clarity around the cancellation of policies?

**Mr Koce:** I guess it just highlights that health funds haven't terminated policies in the past, that the policies have remained.

**Senator PRATT:** Who is making assessment of whether that policy is in the best interests of the holder of that policy?

**Mr Koce:** It would be the consumer. The consumer is given an SIS statement every year, which has the details of their policy. They pay their premiums. It's the consumer that has to ultimately make a decision about whether they want to change to a new policy. Health funds do regularly communicate with their members to make sure they're on the right policy for their stage of life. A lot of those old policies out there would probably provide excellent cover, and consumers have made a sensible decision to remain with their policy.

**Senator PRATT:** I want to clarify what there will be to stop an insurer signing people up on a policy then cancelling it 12 months later and moving to a policy with a greater number of exclusions. I note the AMA has expressed concerns about this in their submission, where they've said—

**Dr David:** That would be directly against the Consumer Law. Both the Ombudsman and the ACCC have issued quite strict guidelines about how consumers are to be treated under those circumstances.

**Senator PRATT:** Okay.

**Senator SIEWERT:** Dr David, in the background of your submission you say:

Currently, three in seven hospital admissions in Australia are funded by PHI, and PHI pays for five out of six admissions in private hospitals.

Do you have the figures around the extent to which private health insurers are covering these admissions to private hospitals? In other words, do you have more detail around what you're saying in your submission around the proportion of these admissions that is paid by private health insurance?

**Dr David:** I'm just looking for the reference, Senator. Three in seven hospital admissions in Australia are funded by private health insurance, and private health insurance pays for five out of six admissions in private hospitals. We are the majority funder in private hospitals. The three in seven hospital admissions refers to the large proportion of non-emergency or elective surgery and inpatient mental health care which is funded by private health insurance.

**Senator SIEWERT:** What proportion of the cost of these admissions is paid by PHI?

**Dr David:** In terms of the hospital stay, it depends on the level of cover, but for the most part it's 100 per cent of a hospital stay. For the medical treatment for people who have surgery or a medical procedure, we cover the gap for the 25 per cent up to the level of the scheduled fee, or some more above the gap if the surgeon is signed up to the health fund's no gap agreement

**Senator SIEWERT:** In your submission you say:

A dollar spent by the Commonwealth via PHI delivers up to 15% greater public benefit than a dollar spent directly into the health system.

Who commissioned the report that those comments are based on?

**Dr David:** We did.

**Senator SIEWERT:** Was it peer reviewed?

**Dr David:** No, it was an independent economic analysis that was undertaken by a range of people with different qualifications and experience in economics.

**Senator SIEWERT:** In your opinion, how does this finding compare to broader literature on this issue?

**Dr David:** I think it compares very well. We undertook a robust analysis that included not just desktop research but a review of the current literature, including the international literature. So the document is robust and we believe it compares very well.

**Senator SIEWERT:** Thank you.

**CHAIR:** Thank you all very much for your time today. We really appreciate it.