

# Submission

to the Senate Community Affairs Legislation Committee  
on the Health Legislation Amendment (Private Health  
Insurance Reform) Bill 2003

Australian Consumers' Association

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April 2003

## ***About the ACA***

The Australian Consumers' Association (ACA) is a non-profit, non-party-political organisation. We are completely independent. We are not a government department or agency and we receive no funding from any government. Neither do we receive subsidies from industry, manufacturers, unions or any other groups, and we don't take advertisements in any of our printed magazines or on our website. We get our income from the sale of CHOICE magazine, CHOICE Online and our other publications and products and currently have over 145,000 subscribers to our products.

We represent and act in consumers' interests. We lobby and campaign on behalf of consumers to promote their rights, to influence government policy, and to ensure consumer issues have a high profile in the public arena.

We are committed to providing information on a whole range of consumer issues including health, financial services, IT & communications, travel, food & nutrition, computer technology and consumer policy.

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## **Summary**

The ACA supports some of the measures proposed in the Bill but has serious misgivings about others:

- We oppose measures to replace mandatory reporting of all rule changes with a system of random or “strategic” monitoring.
- We have serious concerns about the close involvement of the Minister in processes that should not be subject to political control.
- Rather than being abolished, the mandatory reporting process should be replaced with an independent process supervised by PHIAC, at arms length from the political involvement of the Minister. Transparent guidelines should be developed against which proposed rule changes are evaluated.
- Funds should be required to give consumers at least 60 days’ notice of any major rule changes (including premium changes) and 30 days notice of any minor changes.
- We support measures to increase the powers *and resourcing* of the Private Health Industry Ombudsman to enable it to make regular reports on the performance of the funds in terms of their responsibilities to consumers and the community.
- We oppose measures to introduce a notional Lifetime Health Cover birthday. This measure would only benefit the industry and would disadvantage all other stakeholders. It would lead to the recruitment of increased numbers of younger, healthier customers whose premiums are likely to be much more than their claims for several decades after they join. From the individual’s point of view, this is highly cost-ineffective. There is also substantial fiscal risk, because 30% of these new premiums will be borne by the government through the 30% rebate.
- The standard of public reporting by PHIAC of premium changes should be greatly improved. The bald annual announcement of an average figure is misleading. Details of premium changes to individual products should be available to journalists and the public at the time of each annual announcement.

## ***Introduction***

The ACA's principles on Medicare and health funding can be summed up this way:

- For all Australians, access to comprehensive, high quality health care is not a privilege but a right. The community has the right to demand that its elected governments will act effectively to satisfy this expectation.
- Any program that discriminates between patients on any basis other than need is ethically intolerable. However, programs may be needed to address inequities of access by particular groups of patients, such as indigenous people, those living outside of major population centres and people with chronic illness.
- Price signals do not work. These notoriously have the perverse effect of deterring people from seeking needed medical care, with the potential of producing serious and expensive consequences.
- The only fair and cost-effective mechanism for ensuring the rich pay more for health care than the poor is the tax system.
- Any system that does not ensure available resources are used to produce the greatest possible health benefit is ethically unacceptable.
- As a general rule in health care funding, the public sector is more economically efficient than the private sector.

## ***Private health insurance***

The ACA opposes both the 30% private health insurance rebate and the Lifetime Health Cover measure. As many health economists have attested, the \$2.3 billion spent on the rebate is neither efficient nor equitable. That money would be much better spent in other ways – helping to fund Medicare and public hospitals, and allowing the government to buy cost-effective services directly from public hospitals. Lifetime Health Cover is a major blow to the fundamental principle of community rating in health insurance, and therefore to the fundamental principle of equal access to health care. It helps to trap people in health fund products they no longer want. Despite all these shortcomings, it also fails to satisfy insurers because it falls short of bringing premiums into line with actuarial risk.

At the time the present private health insurance measures were introduced, the government and the funds set, in public and parliamentary statements, four benchmarks by which the success of the policy could be assessed. These promises were:

- **The rebate would restore high levels of fund membership.** But when the rebate came in, almost nothing happened to membership. What made people join was not the expensive rebate but the threats in the later Lifetime Health Cover policy, which meant that if you didn't join straight away you'd have to pay much more later.
- **Once large numbers of people joined the funds, premiums would go down.** They've gone up, sharply.
- **Waiting lists in public hospitals would be shortened** because patients would prefer the newly accessible private hospitals. But as the health economist Professor John Deeble has found, the number of people making the switch accounts for only about 7% of public hospital patients. Public hospital waiting lists are almost entirely unaffected.
- **The rebate would encourage large amounts of private cash into the health system.** In fact, Deeble found the amount of private money in health has decreased by 26% because government cash has replaced private cash. As several economists have pointed out, the system could become far more cost-effective and better targeted to real health need if Medicare bought services direct from private hospitals, bypassing the funds.

The ACA, then, approaches the whole question of policy development in this area from the standpoint that the only effective initiative the government could make, in terms of ensuring better health for Australians, would be to abandon the rebate and Lifetime Health Cover, use the savings to restore confidence in the core public system, restore community rating, and purchase services directly from private hospitals. We are sceptical that minor changes to the present system, such as those envisaged in the present Bill, will have any serious effect on improving the efficiency, fairness or sustainability of the health system, improving health, or getting a better deal for health consumers.

We also believe private health insurance policies are among the most unfair contracts to be found in any area of commerce. One party to the contract can vary these contracts at any time, without any reference to the other party apart from a letter telling them that a change is taking place. Since the introduction of the 30% rebate and Lifetime Health Cover, unilateral changes to the detriment of consumers have become rife. Benefits have been removed, premiums have risen sharply, copayments and excesses have been introduced or increased, and direct debit discounts removed.

Nevertheless, we have concerns about some of the changes in the Bill and we commend the Senate and the Committee for being prepared to consider these.

### ***Ministerial power in determining changes to fund rules***

Both the present system of regulating changes to health insurance policy rules, and the system proposed in the Bill, give a great amount of power to a single individual, the Minister for Health. This politicisation of the system is of concern. It is a principle that when a legal contract is to be varied, that both parties to the contract should agree. No such requirement exists in private health contracts. Health insurance consumers are now painfully aware of the impact of the fine print in the policy contracts they signed, and the annual premium rises represent only half the picture of declining value. The other half – which is seldom debated publicly – is the increases in excesses and co-payments, and the removal of particular benefits. We are informed that the Minister has allowed almost all these changes to go through as requested by the funds. The absence of public debate means there is little or no political cost to the government in presiding over, and facilitating, this slide in value; and the funds find it very much easier to degrade conditions than to increase premiums.

It is inappropriate and impractical for a Minister to become personally involved in the minutiae of private health contracts. It is the job of ministers and governments to set policy, and for the micro-regulation of funds to be left to administrators and expert advisers. Ministerial decisions can be worth large amounts of money to commercial organisations, inevitably politicising what should be an objective process, and leading to ministers becoming the target of intense lobbying by well-resourced commercial interests. This is not in the government's long-term interests, and both the funds and their customers deserve a greater level of certainty and impartiality than any politicised process can deliver.

We do not accept the argument that seeking approval for all changes to contract conditions is an unreasonable administrative burden on the funds. The explanatory memorandum to the Bill argues that:

Thousands of individual rules changes are effected annually as any change of rule, no matter how insignificant, or semantic, must be notified to Government. Notifications normally include many changes to rules, including complete rewrites of the health fund rules. Some 100 or so bundles of rule changes are assessed by the Government annually.<sup>1</sup>

Given the size and social importance of the industry, the very large public subsidy and the unfair nature of private health contracts, a requirement to seek approval for all rule changes is essential.

For the same reasons, it would be unacceptable to consumers for a comprehensive evaluation process to be replaced with a system of “strategic monitoring” by the Department of Health and Ageing, as envisaged in the Bill. Such a process would have few or no effective teeth to prevent or rectify actions that were contrary to the interests of

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1. Health Legislation Amendment (Private Health Insurance Reform) Bill 2003. Explanatory memorandum p 10. Parliament of the Commonwealth of Australia March 2003.

consumers or the public at large. We are not convinced that the mere reporting of those breaches which might be detected by such a process would prevent the interests of consumers from being even further eroded than they are at the moment.

The sanctions for breaches of policy on community rating are impractical. It is proposed to provide a maximum fine of \$10,000 for breaches by individual and to threaten funds with the loss of the 30% government subsidy. Senior executives and directors of major funds have very high remuneration packages, and the possibility of a fine of a few thousand dollars is unlikely to be a serious deterrent. Decisions taken by funds about major rule changes are seldom taken solely by individuals, and it is doubtful whether actions brought against individuals would be likely to succeed. At the same time, the Minister is unlikely to take a decision that, by depriving a fund of its subsidy, would effectively drive it out of business. The effect on such a fund's customers would not be to right a wrong but to compound it: they would immediately find their premiums rising by 30% and would have to rely on claiming this money as a tax deduction – a delay of some months and involving potentially increased tax agent's fees – or would have to apply for an incentive payment. Consumers are likely to be unfamiliar with these processes and may be deterred from making such claims because of the administrative complexity.

The experience of the broadcasting industry is instructive: no television station has ever lost its licence as a result of breaches of the *Broadcasting Act*, despite the clear power of regulators to seek such a sanction and of the courts to impose it. Nor is the model of fines in the *Trade Practices Act* easily applicable here. Very large fines imposed on funds would have to be paid for by that fund's customers in the form of higher premiums or degraded benefits. Rather, funds in breach of conditions should be required to make financial restitution to consumers with a punitive loading being imposed on top of the actual financial loss suffered. The potential loss of access to the 30% subsidy should remain but only as a last resort. We believe it will never be used.

Comprehensive and publicly available guidelines should be established, enshrining a set of detailed principles against which decisions about rule changes will be allowed or disallowed. If necessary, these guidelines could divide proposed rule changes into two or more categories, depending on the level of likely impact on consumers or the financial sustainability of the funds. Less significant changes could be subject to less rigorous processes of reporting and evaluation. This process should be conducted by the Private Health Insurance Advisory Council, which should make details of all changes publicly available as soon as possible after a decision is made. Funds should be required to give policyholders notice of at least 30 days before minor changes take effect, and for major changes (including premium increases) this period of notice should be at least 60 days. PHIAC should be required to report to Parliament on all major rule changes at least yearly and to give reasons why changes were allowed or disallowed.

The measure to prevent discrimination should include religious belief as well as gender, race and sexual orientation.

It is worth noting that the worst breach of the community rating principle is made by the government itself in the form of Lifetime Health Cover.

### ***Community rating and the notional birthday***

While the proposed notional birthday for Lifetime Health Cover has some minor attractions in terms of administrative simplicity, it has serious drawbacks:

- It can be expected to confuse consumers;
- It will form the basis of massive annual scare campaigns by health funds, telling 30-year-olds that they must join now or face penalties;
- The recruitment of new customers will increase the fiscal burden of the 30% rebate.

People know when their birthdays are. Any move to an artificial birthday has the potential for massive confusion. People who misunderstand their LHC liability are likely to incur financial disadvantage. Merely explaining this issue to the public will require extensive and regular advertising campaigns, either by the government or by the funds. If the government undertakes these, there will be a direct cost to the Commonwealth's budget. If the funds undertake them, 70% of the cost will be borne by existing fund customers through their premiums, and 30% by the government through the rebate.

In 2000, though the introduction of the 30% rebate had little effect on fund membership levels, the scare campaigns by the government and the funds associated with the introduction of Lifetime Health Cover were extremely potent. Since then, similar scare campaigns have not been feasible because older potential customers find themselves locked out of private insurance by the LHC policy, and people nearing the "crunch point" of their 30<sup>th</sup> birthdays are difficult to reach because birthdays are spread through the year. The ACA believes this measure is being introduced not to benefit consumers but to facilitate the industry's flagging recruitment drives.

Even though LHC has taken government policy away from the principle of community rating, it falls short of applying actuarial risk to individual consumers. Even with the penalties inherent in LHC, the average annual payouts to customers are still, on average, less than their premiums until they reach the age of about 65. Recruiting younger, healthier customers is in the fund's financial interests but is usually not in the interests of those younger customers unless they are chronically ill. Private health insurance represents poor value for most consumers but very poor value for the young.

The funds and the government will argue that recruiting younger customers – who are presently somewhat under-represented in fund membership – will benefit existing members. But similar promises have been made in the past and have proved illusory. In 2000, the government and the funds claimed that when large numbers of new customers

joined the funds, premiums would either come down or stay stable for a long time. Instead, premiums have risen sharply, co-payments and excesses have gone up, customers have been shunted from good-value products into poorer-value cover, discounts have been ended and benefits have been deleted. Existing consumers have every right to be sceptical about promises that recruitment drives will benefit them.

There are many reasons for the funds' failure to deliver the promised benefits of increased membership, but one reason is moral hazard. This refers to the tendency of insured people to change their behaviour to incur greater risk. The very high level of moral hazard being experienced in private health insurance was apparently not foreseen when the government's private health measures were introduced in 2000. There is no excuse for not foreseeing it now. The greater the gap between the cost of a person's premium and the year-to-year benefits they derive, the greater their temptation to get their money back by making claims for items they might not previously have considered and which they may not need. This is one reason why so much of the increased demand on private hospitals and other private-sector health care facilities is for low-level and, in some cases, unnecessary intervention. And the low-level nature of much of the new demand is one reason why public hospital waiting lists have not benefited as the government promised. As the Minister for Health has recently said, the number of cases presenting to private hospitals has risen by 245,000 separations (episodes of hospital care) but the demand on public hospitals has fallen by only 15,000. She presented these figures as a vindication of government policy; we believe they demonstrate the opposite. But even these figures do not present the whole picture. In Victoria, for example, the number of public hospital separations has increased by 12.2% since the introduction of the rebate the LHC, from 950,000 in 1999-2000 to a predicted 1,066,000 in 2002-2003.<sup>2</sup>

Under the private health rebate, 30% of the premiums payable by new members will be a cost to the Commonwealth budget. Because 30-year-olds seldom become ill, and because of the inefficiencies inherent in the private health system, recruiting these younger customers represents a cost-ineffective use of the limited amount of Commonwealth money available for health expenditure.

### ***Transparency: the ombudsman***

The ACA supports an increase to the powers of the Private Health Industry Ombudsman. Of all ombudsmen and regulators at the national level, the very limited powers of this ombudsman have put it among the weakest of all such offices, and one of the least able to protect the interests of consumers.

The granting of powers to demand information and to make a broad-based report at least annually ought to have been a central feature of the original legislation. From the public's point of view, this presents an opportunity to discover the extent to which consumer value is being degraded. The increases in co-payments and excesses, and the removal of

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2. Department of Treasury and Finance. Budget paper no. 3 (2002-2003). Canberra 2003.

items from the schedules of benefits, may be as important as rising premiums in reducing the value consumers are getting for their money. But public discussion is largely limited to premium changes, neglecting the other half of the picture. A comprehensive and fearless ombudsman's report is unlikely to redress the decline in consumer value, but may at least expose it to public view.

The ombudsman should also be required to report on the effect of government legislation and regulations on the funds, on consumers and on the functioning of the health system. Changes to the law and to regulations are made quite frequently but consumers are seldom aware of how these changes may impact on them, or even that changes are being made.

### ***Transparency: PHIAC reporting***

The ACA is dissatisfied with elements of the public reporting performance of the Private Health Insurance Advisory Council.

In particular, we are concerned about the inadequacy of information made available by PHIAC at the time of annual premium reviews. The information available to the media and the public lacks essential detail and is misleading. The reporting of rises as a weighted average is particularly troublesome. This year, a 7.4 per cent average increase, was reported and widely repeated in the media. This gave little hint of what was in fact being experienced by some consumers, who found themselves facing increases of up to 50 per cent; customers of the nation's most widely held product, Medibank Private's AdvantagePlus, were hit with increases of around 10 per cent and substantial downgrades in conditions.

The ombudsman has noted that:

The major concern of consumers with respect to contribution increases, was not that they occurred, but that media reports led them to believe the Minister had only approved single digit increases and their health fund was now applying much higher increases.<sup>3</sup>

Commissioner Sitesh Bhojani of the ACCC has been reported as saying:

There seems to be a general tendency to portray these in a minimalist way, supposedly to sell them to the community, by packaging them up as being increases of "on average, 5 per cent." Well, for those of you that are involved with health funds, I can assure you that we are going to get complaints if the ACCC experience and the Private Health Insurance Ombudsman's experience is any guide. We are going to get a mass of complaints from consumers yet again for those who are above  $x$  per cent. So whilst a particular health fund's fee increases may only be "on average, 5 per cent", those consumers whose fee increases are above 5 per cent will be contacting the ACCC or the Private Health Industry Ombudsman alleging misleading or deceptive behaviour by the health funds because their premium has not increased by 5 per cent but has in fact increased by 10 or 12 per

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3. Private Health Industry Ombudsman. Annual Report 2002. Sydney 2002.

cent. So I would urge you to be cautious in how you're presenting these premium increases to the community at large.<sup>4</sup>

The worst offender is the regulator itself, PHIAC. When asked by a *Sydney Morning Herald* reporter why PHIAC did not supply information on the full range of premium changes, he was told by a spokesperson that there were too many funds, too many products and that detailed reporting would be "impossible". But one person in the ACA annually reviews almost all health fund products for a private health cover calculator on the *Choice* website. This calculator helps consumers identify the "best buys" in each state according to their particular needs for level of cover, copayment and excess. After detailed announcements by the funds, the ACA takes six to eight weeks to collate and analyse this information for its website. This year, the funds' applications were being received by PHIAC in January; the Council had until 17 March to report to the public. If one person at the ACA can do this in a little over a month, it is difficult to see why the far better-resourced industry regulator could not provide comprehensive and meaningful information in a similar time. But instead of making adequate information available, it issued a one-page media release with the single, misleading figure of 7.4%.

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4. Bhojani S. Reported in *Healthcover* (policy newsletter), vol 13 no 2, p 2. Sydney, April-May 2003.