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HOUSE OF REPRESENTATIVES

NATIONAL HEALTH AMENDMENT (LIFETIME HEALTH COVER) BILL 1999

EXPLANATORY MEMORANDUM

(Circulated by authority of the Minister for Health and Aged Care,
the Hon. Dr Michael Wooldridge, MP)

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NATIONAL HEALTH AMENDMENT (LIFETIME HEALTH COVER) BILL 1999

OUTLINE

This Bill makes a number of amendments to the *National Health Act 1953* to introduce Lifetime Health Cover into private health insurance. These reforms will stabilise health fund membership numbers and improve the membership profile of health funds by providing incentives for consumers to take out private hospital cover early in life and maintain this cover throughout their lifetime.

The Bill makes it a condition of registration of registered organisations ("health funds") that they comply with proposed new Schedule 2 of the Act. Proposed new Schedule 2 deals with the Lifetime Health Cover scheme which will:

- require registered organizations ("health funds") to increase the amount of contributions payable for hospital cover by 2% of the base rate if an adult beneficiary does not have hospital cover by the time they turn 31;

- allow adult beneficiaries who have hospital cover to cease to have hospital cover for an aggregated period of 1094 days without incurring any additional increase in contributions payable and to transfer from one health fund to another retaining their Lifetime Health Cover entitlements;

- allow health funds, in cases such as where an adult beneficiary is unemployed or travelling overseas, to increase the number of days an adult beneficiary is allowed to cease to have hospital cover, without any additional increase in contributions, beyond an aggregated period of 1094 days;

- exempt adult beneficiaries born on or before 1 July 1934 from additional contributions that would otherwise be payable either because they did not have hospital cover before they turned 31 or because they ceased to have hospital cover for an aggregated period of more than 1094 days;

- exempt adult beneficiaries who have hospital cover on 1 July 2000 from additional contributions that would otherwise be payable because they did not have hospital cover when they turned 31, but not from additional contributions payable because they ceased to have hospital cover for an aggregated period of more than 1094 days after 1 July 2000;

- allow regulations to specify classes of persons, such as members of the Australian Defence Force, who for the purposes of the Lifetime Health Cover scheme are to be treated as if they had hospital cover;

- prevent health funds from increasing by more than 70% of the base rate the additional contributions payable by an adult beneficiary because they did not have hospital cover when they turned 31 and/or they ceased to have hospital cover for an aggregated period of more than 1094 days;

- allow the Minister for Health and Aged Care to determine, in cases of demonstrated hardship and exceptional circumstances, that an adult beneficiary is exempt from liability

to pay additional contributions for taking out hospital cover after the age of 31, provided that the Minister makes such a determination before 1 July 2002;

allow regulations to be made dealing with the administrative aspects of the Lifetime Health Cover scheme, such as the provision of information and evidentiary matters.

FINANCIAL IMPACT STATEMENT

The matrix of private health insurance reforms currently being implemented are designed to stabilise health insurance participation rates. There is no financial impact on the Commonwealth Government unless participation rates rise above 33%, a figure which has been used only as a basis for costings.

REGULATION IMPACT STATEMENT

Background

At 1 January 1999 there were forty-four registered health benefits organisations in Australia, of which twenty-eight were available to the public generally and sixteen were operated by restricted membership organisations.

Forty out of the forty-four registered organisations operate their health funds on a 'not-for profit' basis where any surpluses generated from carrying on business remain in the fund to be used for the benefit of contributors, either in the form of reserves or to fund part of future increases in benefits or operating costs. The four organisations operating on a 'for-profit' basis may use any moneys in excess of the statutory minimum reserves level for payment of dividends and other commercial activities.

The current rating basis for private health funds in Australia can be referred to as unfunded uniform community rating. This system of community rating in private health insurance ensures that people cannot be discriminated against in obtaining health insurance on the basis of their health risk, ie age, sex, race, health status and claims history. Under this system of community rating every member is charged the same premium regardless of these characteristics. A reinsurance system underpins the community rating principle by requiring health funds to cross-subsidise each other to spread the burden of high claim members. The principle of community rating and the reinsurance system are contained in the *National Health Act 1953* and are administered by the Private Health Insurance Administration Council.

Problem

The private heath insurance industry is under pressure. Since the introduction of Medicare in 1984, the number of Australians with private health insurance has fallen from approximately 50% to 30%. This drop in membership numbers has in turn created pressures on the public health system, substantially increasing Medicare costs for the Government by increasing the number of public patients.

The system of community rating works well when health insurance membership numbers are higher and while the membership profile closely reflects the general community profile. Problems can arise if people with lower risks drop their private health insurance in response to premium increases, leaving a residual of increasingly higher risk groups which results in declining income and increasing claims for health funds. This is turn leads to further increases in premiums and so on. This problem is known as adverse selection and is a major cost driver behind increases in private health insurance premiums.

The Productivity Commission's inquiry into private health insurance early in 1997 considered that the long-term future of private health insurance under the current system of community rating is uncertain because of the increasing degree of adverse selection. As a result, one of its major recommendations was the introduction of an 'unfunded lifetime community rating' (ULCR) scheme.

The Government has made a significant financial commitment to the 30% rebate on private health insurance premiums. As flagged at the time, further initiatives will support this commitment. One proposal is the introduction of ULCR as recommended by the Productivity Commission. Other current initiatives include developing criteria for no gap and known gap policies, promotion of simplified billing and allowing health funds to offer loyalty bonuses to long term members.

Objectives

The Government's objectives are to provide Australians with access to affordable private health insurance by improving the risk profile of health fund members while maintaining the basic principles of community rating.

Options

Option 1: Introduce a prescribed and regulated ULCR scheme, to be known as Lifetime Health Cover

Under Lifetime Health Cover, health funds would be able to offer lower premium rates for people entering insurance early in their lives and higher premiums for people who join later. This system therefore rewards membership loyalty and early joining. The premium paid by people entering health insurance would be based on the age at which they enter. Once set, it remains at that rate relative to premiums for people entering at different ages. However, the base rate premium on which loadings are set could vary between funds, as it does now, due to cost pressures.

It is proposed that Lifetime Health Cover be introduced with the relativities of the contribution rates for all the ages at entry prescribed by legislation. This approach requires legislation to define the rating formula and the determination of the notional entry age under various possible circumstances (such as initial entry and change of table).

The model comprises a prescribed threshold age and a prescribed age step for all health funds, together with a certified age at entry for every member. These would be the same across the industry. In addition, each fund would set its own base rates for the threshold age in the same way as funds set their own premium rates under the current system. Base rates would therefore vary from fund to fund. For each individual member, the age steps would be applied to the base rate for the number of years by which the certified age at entry is above the threshold age.

Option 2: Introduce a regulated ULCR scheme without prescriptions

Under this approach, it would be the claim rates after adjustment for reinsurance that would drive pricing strategies. Regulations would still be required to ensure all members who entered the health insurance system at a particular age had the same community rate relativity applied in determining their contribution rate. While regulations would ensure that people entering a particular fund at the same age would be charged the same premium, irrespective of their individual health status, no regulation would be required to prescribe the threshold age, the rules for determining the notional entry age, or the formula for determining penalties for late entry.

Option 3: Maintain the current community rating system

The current system of community rating is contained in the *National Health Act 1953*. This Act makes it is illegal for health funds to discriminate on the basis of age, sex or sexuality, health status or claims history. Therefore, health funds have to charge the same premium to everyone, regardless of their individual risk. This system is designed to eliminate barriers to access to private health insurance.

Impact Analysis

Identification of groups affected

The groups primarily affected by the problem of declining health fund membership are:

- consumers, including health fund members and non-members;
- private health insurance funds;
- the Commonwealth Government, through increasing pressure on Medicare.

In addition, other groups such as health professionals, private hospitals, public hospitals and State and Territory governments are affected by any shift in demand betweenprivate and public sector health care corresponding with a decline or increase in health fund membership.

Option 1: Introduce a prescribed and regulated ULCR scheme, to be known as Lifetime Health Cover

The Government is facing rising Medicare costs which are in part a result of falling private health insurance membership. Lifetime Health Cover, when combined with other current reforms, is designed to have a positive impact on membership numbers and the composition of membership, and therefore on premium costs by removing some of the incentives for adverse selection and producing a more balanced pool of risks. Lifetime Health Cover will also maintain the essential principles of community rating.

Over time, Lifetime Health Cover will make insurance more affordable for all members than it would have been under the existing community rating system. Actuarial projections indicate that, after 5 years, the average contribution under Lifetime Health Cover, excluding administration and profit loading, could be lower by around 15% compared to the projected rate under the current system, primarily as a consequence of the improved participation rate.

A grace period will ensure that every person has a fair opportunity to take out health insurance with an entry age equal to the threshold age. The main risk for consumers is that the scheme will not be easily understood which could result in people 'missing out' during the grace period. However, an intensive publicity campaign will accompany the introduction of the new legislation.

Option 2: Introduce a regulated ULCR scheme without prescriptions

Under this approach the Government will only need legislation to ensure all members who enter the health insurance system at a particular age have the same community rate relativity applied in determining their contribution rate.

While this approach initially appears attractive due to its relative simplicity to introduce and lack of government intervention, the insurance funds do not have the data needed to determine their premium rates on this basis. This approach would most likely result in unstable and differential contribution rates; create confusion in the community; and result in a lack of clear incentive for joining early. It is possible this situation may change in the future, but at this stage introducing ULCR without prescribing the way the system would operate could lead to industry and consumer chaos.

Under a non-prescriptive approach, premium rates for each age at entry would be subject to constant change as the health funds chased the market, resulting in confusion among consumers about which product offered by which fund was the most appropriate to choose.

It would be extremely difficult for a regulator to supervise and monitor a ULCR system if the age steps are not stipulated in legislation. Given that most of the insurers are mutual organisations and, therefore, do not have ready access to capital, there would be little margin for error, which could potentially work against the interests of consumers.

Option 3: Maintain current community rating system

The existing system of community rating was designed to ensure access to private health insurance for all members of the community irrespective of their individual health risk.

However, it has a number of major flaws, particularly a susceptibility to adverse selection. Adverse selection is one of the key drivers of premium increases and instability in the system.

If the current system of community rating is maintained, the number of Australians with private health insurance is likely to continue to drop. By increasing the number of public patients, this will create further pressures on the public health system and substantially increase costs for Governments. Health funds will have to continue to increase their premiums, thereby creating a vicious cycle of increasing costs and decreasing membership. In the long-term, this will lead to instability in the industry. It is projected that premiums will rise faster under the current system than they would under Lifetime Health Cover, so that after 5 years the average contribution would be 15% higher under the current system than it would be if Lifetime Health Cover were introduced.

Despite the membership decline, community rating principles, together with the reinsurance arrangements, still act to bring about significant redistribution of health costs. While the Productivity Commission's inquiry did not consider that the current community rating system would precipitate an immediate crisis for private health insurance, the long-term prognosis was uncertain.

Consultation

Consultation has been undertaken with key industry and consumer groups, and also with other relevant Government agencies. Focus groups were also conducted to gauge public reaction to the scheme.

Consultation with the industry indicated that they generally support the introduction of a prescribed and regulated Lifetime Health Cover scheme over maintaining the current system.

Consultation with consumer groups indicated that they generally support the introduction of a prescribed and regulated Lifetime Health Cover scheme.

Recommended option

It is recommended that Lifetime Health Cover be introduced as an effective measure for containing the worst aspects of adverse selection while maintaining the broad objectives of community rating.

Implementation and review

Transition arrangements will include: 'grandfathering' all existing members at the threshold age; offering a grace period of 12 months at the outset for non-members to become members; and a permanent 'grandfathering' of all those born before 1 July 1934 to enable them to take out private health cover at the threshold age at any time in the future.

The introduction of Lifetime Health Cover will be on 1 July 2000. A review is proposed one year after implementation and at regular intervals in the future.

CONSULTATION STATEMENT

National Health Amendment (Lifetime Health Cover) Bill 1999

Consultations with industry and peak consumer groups indicate that there is broad support for the Lifetime Health Cover scheme. It is generally perceived as being fair, equitable and an important structural reform of private health insurance, reaping medium to long term benefits. Where there was disagreement, this was mainly on the details of the scheme.

Groups consulted were:

Peak health fund bodies
Australian Health Insurance Association
Health Insurance Restricted Members Association of Australia
Australian Health Service Alliance

Larger health funds
Medibank Private
Medical Benefits Fund of Australia
National Mutual Health Insurance
Hospital Benefits Fund of WA
Hospital Contribution Fund of Australia

Peak consumer groups
Australian Consumers' Association
Consumers' Health Forum of Australia
Council on the Ageing
Association of Independent Retirees
Australian Pensioners' and Superannuants' Federation

Other Groups
Australian Private Hospitals Association
Australian Healthcare Association
Australian Catholic Health Care Association
Australian Medical Association
Institute of Actuaries of Australia

NOTES ON CLAUSES

Clause 1: Short Title

This clause provides that the amending Act may be cited as the *National Health Amendment (Lifetime Health Cover) Act 1999.*

Clause 2: Commencement

This clause provides that the *National Health Amendment (Lifetime Health Cover) Act 1999* commences on 1 July 2000. The delay in commencement will provide a statutory "grace period" for anyone to join a health fund and be treated as an existing member.

Clause 3: Schedule(s)

This clause provides that the *National Health Act 1953* (the Act) is amended as set out in Schedule 1.

SCHEDULE 1 – AMENDMENT OF THE NATIONAL HEALTH ACT 1953

Item 1

Item 1 inserts a definition of *adult beneficiary* at subsection 4(1) of the Act. *Adult beneficiary* is used instead of *contributor* in amendments proposed by the *National Health Act (Lifetime Health Cover) Bill 1999* in order to clarify that each adult, other than a dependent student child over the age of 16, who is covered by joint hospital cover is considered separately for the purpose of calculating any increase in premiums payable as a result of the operation of the Lifetime Health Cover scheme. This is the case whether or not each adult who is covered by joint hospital cover is regarded as a *contributor* under the rules of the health benefits fund providing the joint hospital cover.

Item 2

Item 2 inserts a signpost definition at subsection 4(1) of the Act referring to the definition of *base rate* in subclause 1(2) of proposed new Schedule 2 of the Act.

Item 3

Item 3 inserts a signpost definition at subsection 4(1) of the Act referring to the definition of *hospital cover* in clause 4 of proposed new Schedule 2 of the Act.

Item 4

Item 4 inserts a definition of *joint hospital cover* at subsection 4(1) of the Act. *Joint hospital cover* means hospital cover in respect of which there is more than one adult beneficiary.

Item 5

Item 5 inserts a signpost definition at subsection 4(1) of the Act referring to the definition of *permitted days without hospital cover* in clause 3 of proposed new Schedule 2 of the Act.

Item 6

Item 6 inserts a signpost definition at subsection 4(1) of the Act referring to the definition of *Schedule 2 application day* in clause 5 of proposed new Schedule 2 of the Act.

Item 7

Item 7 inserts a new section 73BAAA making it a condition of registration of a registered organization that it must comply with proposed new Schedule 2 of the Act. Schedule 2 contains detailed provisions governing the Lifetime Health Cover scheme.

Item 8

Item 8 inserts a new subsection at the end of section 105AB of the Act. New subsection 105AB(14) permits an application to be made to the Administrative Appeals Tribunal for the review of a decision of the Minister refusing to make a determination under clause 10 of new Schedule 2, which deals with hardship cases.

Item 9

Item 9 repeals subparagraph (m)(v) of Schedule 1 of the Act and substitutes two new subparagraphs. New subparagraph (m)(v) allows health funds to have regard to the age of a contributor as provided in new Schedule 2, but not otherwise, in determining the amount of contributions payable for hospital cover. New subparagraph (m)(va) prohibits health funds from having regard to the age of a dependant of the contributor in determining the amount of contributions payable for hospital cover.

Item 10

Item 10 amends paragraph (q) of Schedule 1 to allow health funds to charge differential contributions within each of the membership categories available within each applicable benefits arrangement if premiums are increased for some contributors in accordance with the Lifetime Health Cover scheme set out in Schedule 2.

Item 11

Item 11 introduces a new Schedule 2 into the Act which contains the general rules governing the Lifetime Health Cover scheme, exceptions to those rules and administrative matters.

Clause 1

Clause 1 of new Schedule 2 sets out a general rule that after 1 July 2000 health funds must increase the amount of contributions payable for hospital cover in respect of an adult beneficiary if he or she does not have hospital cover by the time he or she turns 31, but later chooses to take out hospital cover. The amount of the increase in contributions is 2% of the base rate for each birthday that has passed since the adult beneficiary's 30th birthday at the time he or she takes out hospital cover. The base rate is the rate that a health fund would charge a 30 year old joining for the first time, or an adult beneficiary who took out hospital cover at the age of 30 and has maintained that cover ever since. The base rate is also the rate payable by an adult beneficiary who takes out hospital cover before turning 30. Any increase in contributions payable as a result of the operation of Schedule 2 is to be calculated as a percentage of the base rate before an adjustment is made for any applicable discounted rate of contributions or loyalty bonus payable in the form of reduced contributions.

Clauses 2 and 3

Clauses 2 and 3 set out a general rule that, after 1 July 2000, if an adult beneficiary who has had hospital cover ceases to have hospital cover for an aggregated period of 730 days or more, health funds must increase his or her contributions by 2% of the base rate for every aggregated period of 365 days without hospital cover over and above the first 730 days, unless the adult beneficiary's hospital cover has been suspended in circumstances set out in regulations. This means that an adult beneficiary who has had hospital cover after 1 July 2000 may cease to have hospital cover, for any reason, for a total of 1094 days during their lifetime and resume hospital cover without being liable to pay increased contributions as a result of the period(s) they have spent without hospital cover. In addition, regulations under clause 3(1)(b) will allow health funds to suspend an adult beneficiary's hospital cover for reasons such as unemployment, overseas travel or extended overseas postings. Periods during which an adult beneficiary's hospital cover has been suspended by agreement with their health fund will not count towards the total of 1094 days without hospital cover that every adult beneficiary is allowed before his or her contributions are increased as a result of the operation of clauses 2 and 3.

Clause 4

Clause 4 specifies that a person has *hospital cover* if the person is covered by an applicable benefits arrangement as defined in section 5A of the Act and the person is an adult beneficiary. As Lifetime Health Cover applies to all types of hospital cover, an adult beneficiary is able to upgrade or downgrade their level of hospital cover as they wish as well as transfer between health funds while retaining their Lifetime Health Cover entitlements. Dependent children of contributors are not taken to have hospital cover for the purposes of this schedule. Regulations will specify classes of people, such as members of the Australian Defence Force, who are taken to have hospital cover for the purposes of this schedule.

Clause 5

Clause 5 provides that any adult beneficiary who is aged 31 or over on 1 July 2000 and who has hospital cover on that date will be entitled to pay contributions at the base rate for as long as he or she maintains hospital cover. Any adult beneficiary who turns 31 after 1 July 2000

and who has hospital cover on their 31st birthday will be entitled to pay contributions at the base rate for as long as they maintain hospital cover. An adult beneficiary whose hospital cover is suspended, by agreement with his or her health fund, will be taken to have hospital cover for the purposes of this clause.

Clause 6

Clause 6 provides that adult beneficiaries who are required to pay increased contributions either because they did not have hospital cover when they turned 31 or because they ceased to have hospital cover for an aggregated period of more than 1094 days are still eligible for any applicable loyalty bonus schemes or discounted rates of contribution. In assessing the amount of increased contributions payable by an adult beneficiary because of late entry or a period without hospital cover, health funds should calculate the additional 2% or multiple of 2% as a percentage of the base rate before an adjustment is made for any applicable discounted rate of contributions or loyalty bonus payable in the form of reduced contributions.

Clause 7

Clause 7 allows any person born on or before 1 July 1934 to pay contributions for hospital cover at the base rate at any time in the future whether or not they have hospital cover on 1 July 2000 and whether or not they cease to have hospital cover for an aggregated period of more than 1094 days. If a person who was born before 1 July 1934 has joint hospital cover with another adult beneficiary who was born after 1 July 1934 and the other beneficiary is required to pay increased contributions because of late joining or a period of absence, the total contributions payable for joint hospital cover may increase as a result of the operation of clause 9 of this Schedule.

Clause 8

Clause 8 prevents health funds from increasing by more than 70% of the base rate the additional contributions payable by an adult beneficiary because they did not have hospital cover when they turned 31 and/or they ceased to have hospital cover for an aggregated period of more than 1094 days. For example, if Syd, who was born on 30 September 1935, takes out hospital cover when he turns 65 on 30 September 2000, he will pay 170% of the contributions that would be payable by a 30 year old who also takes out hospital cover on that date. If Syd does not take out hospital cover until he turns 70 on 30 September 2005, he will still pay 170% of the contributions payable by a 30 year old who takes out cover on the same day. If Syd ceases to have hospital cover for an aggregated period of more than 1094 days, he will pay 170% of the contributions payable by a 30 year old when he resumes payment of contributions.

Clause 9

Clause 9 specifies how health funds should calculate any additional contributions payable for joint hospital cover as a result of the operation of this Schedule. The total contributions payable for joint hospital cover where there are two adult beneficiaries should be notionally split in half and any additional contributions payable in respect of each of the adult beneficiaries are to be calculated on the basis of a percentage of one half of the total

contributions payable, then added together. For example, Peter and Sarah choose to take out joint hospital cover after 1 July 2000. The base rate for the cover that they wish to take out is $2000. Peter was born before 1 July 1934 and therefore is not required to pay any increase in contributions as a result of the operation of this Schedule – see clause 7. Sarah did not have hospital cover on 1 July 2000 and is 60 years of age, so her contributions increase by 60% of the base rate as a result of the operation of this Schedule - that is, by 2% for every birthday since her 30th birthday. The contributions for Peter and Sarah's joint hospital cover are calculated as follows:

Peter's notional share of the contributions payable is
($2000 divided by 2) + his increased contributions ($1000 x 0%) = $1000

Sarah's notional share of the contributions payable is
($2000 divided by 2) + her increased contributions ($1000 x 60%) = $1600

Therefore the total contributions for their joint hospital cover are $1000 + $1600 = $2600

Clause 10

Clause 10 allows the Minister to determine, in circumstances specified by regulation, that a person is to be treated for the purposes of this Schedule, but not for other purposes such as the payment of benefits, as if they had hospital cover on 1 July 2000. Regulations under this clause will define exceptional circumstances of demonstrated hardship under which the Minister may make such a determination. If the Minister determines that a person is to be treated as if they had hospital cover on 1 July 2000, and the person does not resume paying contributions until more than 1094 days have elapsed since 1 July 2000, the normal period of absence rules set out in clauses 2 and 3 of this Schedule will apply. An application under this clause must be made before 1 July 2002. If the Minister does not determine that an applicant is to be treated as if they had hospital cover on 1 July 2000, section 105AB provides that the applicant may apply to the Administrative Appeals Tribunal for a review of that decision.

Clause 11

Clause 11 provides that the exceptions to the general rules that are set out in Part 2 of this Schedule override the general rules that are set out in Part 1 of this Schedule wherever the rules are inconsistent.

Clause 12

Clause 12 specifies that health funds must comply with any requirements that are set out in regulations regarding the provision of information to health fund members or to potential members and other health funds about any increase in premiums that would be payable if they were to take out hospital cover with the health fund after they turned 31 or were to cease hospital cover for a cumulative total of more than 1094 days during their period of membership. Regulations may permit this information to be provided in the form of a certified age at entry, that is, an age notionally attributed to an adult beneficiary as the age from which he or she will be treated as having had continuous hospital cover. For example, if Eileen was born before 1 July 1934 a health fund may notionally attribute to her a certified

age at entry of 30, which would mean that she would pay the same contributions as a 30 year old or someone who has had continuous hospital cover since they were 30.

Clause 13

Clause 13 specifies that health funds must comply with any requirements specified in regulations regarding the kinds of evidence that health funds must accept as proof of an individual's age, or as a record of the periods during which an individual has had hospital cover. This information will be necessary to allow members to transfer between funds and maintain their Lifetime Health Cover entitlements.