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Department of Health

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PRIVATE HEALTH INSURANCE REFORMS CONSULTATION

Thank you for the opportunity to provide feedback on the second wave of private health insurance (PHI) reforms.

We are very supportive of measures designed to provide additional value to policyholders and to encourage greater participation in PHI, particularly by younger Australians.

Introducing AIA Health

At AIA Health, we promote **healthier, longer, better lives** to our members. We believe that insurance should not only protect our members when things go wrong, but also reward and motivate them to live a healthier lifestyle. We aim to achieve this through our shared-value approach to insurance, where all stakeholders benefit as the system improves. Shared value in this context means that our members are healthier, we have a stronger healthcare system, and there is more affordable access to PHI.

We believe in educating and incentivising our members to understand their health better, and to take steps to improve this over time, through our science-backed health and wellbeing program, AIA Vitality. The program provides members with financial rewards and premium discounts based on their engagement, which attracts younger, healthier PHI entrants. Over half our customers are below the age of 34, and many of these are entering the market for the first time.

We have focused our feedback below on specific areas within the reforms in which we have a particular interest.

Consultation One: Increasing the age of dependents

We support the Government's policy intention to increase the allowable age of dependents to encourage younger people and those with a disability to maintain PHI through continuity of cover.

Increase in maximum allowable age for dependents

It is our view that the maximum age for child dependents should be when Lifetime Health Cover (LHC) typically applies – that is, 1 July following a person's 31st birthday. This will ensure that there is no gap in cover prior to LHC loadings commencing, which is the time at which 31-year-olds are most likely to take out cover.

In order to achieve this reform, it is our preference that the Department implement Option 3 of its proposed options. This will maintain the current dependent categories, and simply add an additional category for dependents aged 25-31. This has the benefit of simplicity in implementation, and importantly will allow insurers flexibility in pricing through the three-stepped pricing approach for insured groups with dependents.

Without clarity on how youth premiums may be determined, it is not clear whether extending the dependent age will have a positive or detrimental impact to funds. Existing fund members under the age of 31 who are on their own policy may wish to cancel their policy to join their family's policy. This would result in termination of policies, and potential transfers from one fund to another to join a family policy. Under this arrangement, the family policy total premium may increase.

It is also unclear the extent to which risk equalisation payments would change. Increases to risk equalisation payments by policy could have a significant impact to funds, specifically those that are high-growth or attracting a younger demographic.

There are a number of areas in which we would welcome further clarity from the Department:

- Can a fund determine the products for which it will offer coverage for dependents over the age of 24, or must a blanket approach be taken?
- Can different prices be charged for different dependent groups or number of dependents?
- Can a fund charge per dependent?
- Can the fund increase the price by age up to 31 years?
- Can dependents have different Hospital and/or Extras products to their parents, in order to take up cover that is appropriate to them and their age? It is our view that the industry should minimise the likelihood of unnecessarily over-insuring young people, who can have different risks and needs than their parents.
- What will be the impact on the age-based discount (ABD)? If someone remains on a policy as a dependent up to the age of 30 or 31, will that mean they will not be eligible for the ABD? The Department may wish to consider altering the eligibility requirements for the ABD in order to incentivise the take up of PHI after someone has aged out of their dependent category.

Removal of age limit for dependents with a disability

In order to give effect to this reform, we recommend that the Department create a new category of adult dependent limited to people with a disability who are over 17 years old. This acknowledges that this category of dependent may not just be covering the policyholder's children, and allows insurers to most effectively price for the risk associated with adult dependents with a disability.

We anticipate that an unintended consequence of implementing in this way will be a disincentive for policyholders to switch any children with a disability over to the new disability category, if they can instead remain as a child dependent, with the associated cheaper premium, up to the age of 31.

Standardisation

We suggest that the Department seeks to standardise the detail of this reform to the greatest extent possible, in order to ensure consistency between insurers. This will be simpler and clearer for policyholders to understand and for funds to implement and will better allow for portability between funds. For example:

- Standardised age ranges for different categories of dependents
- Standardised conditions of dependence for different categories of dependents
- Standardised arrangements for determining eligibility of people with a disability, aligned with the definition used by the Government's National Disability Insurance Scheme
- Clarity on qualification criteria, including supporting evidence, and standardisation of any requirement for reassessment over time.

Likely impacts of the reforms

It would be helpful to understand the Department's modelling on the likely impact of the dependent reforms on risk equalisation contributions to better assess the potential impact on our own fund.

It is our view that extending the categories of dependents to cover children up to the age of 31, which will mean that these children will not be taken into account for the purposes of calculating risk equalisation contributions, will create a two-tier PHI system for young adults depending on whether they are dependents or not, with significant differences in the premiums charged.

As the Department's consultation paper notes, *"[p]urchasing a singles policy for a young adult is more expensive than when they were covered as a dependent on their family's policy."*

We suggest that the Department may wish to consider removing policyholders 31 years and under from the risk equalisation calculation, in order to make PHI more attractive to younger people. Otherwise this reform has the potential unintended consequence of disincentivising under 31s who are not dependents from entering the PHI market, as the cost of their cover will be higher to compensate for the additional category of dependents.

Consultation Three: Out-of-hospital mental health services

We are hugely supportive of any measures that will allow insurers to make greater contributions to prevention and early intervention. This is a core pillar of our purpose at AIA Health and one of the functions of our AIA Vitality program.

We provide our AIA Vitality members with points for utilising mental wellbeing and mindfulness services such as Mentemia and Headspace.

Covering only in-hospital mental health treatments could lead to someone being hospitalised for something that could be more effectively and economically treated on an out-patient basis. This could lead to over-servicing and higher overall healthcare costs.

Scope of insurer offer

In order to give effect to the reform, we would welcome the ability to offer preventative mental health services to all customers. This acknowledges that every Australian can benefit from a regular check-in with their own wellbeing. Giving insurers flexibility in this respect will allow the industry to provide a wide range of services as appropriate to their membership.

We believe that a focus on prevention and early intervention can help reduce the need for in-hospital mental health treatment, and we welcome the opportunity to invest more in wellbeing initiatives.

Scope of preventative treatment

We support taking the broadest possible approach to the range of preventative services that insurers may fund as part of the reforms. As the consultation paper notes, we strongly believe that the more at-home or community services the industry can invest in, the greater the likelihood of reduced hospital admissions, readmissions and length of hospital stays.

The Vitality program reflects these outcomes, with data from South Africa (where Vitality has operated for more than 20 years) showing that the more engagement members had with the health and wellbeing program, the lower the rates of hospital admissions, time spent in hospital and healthcare costs. AIA Health Insurance, while still new, is already beginning to see claims improvements among engaged members, driven by hospital experience.

We suggest that programs like AIA Vitality should come within the scope of services allowed within the reforms. While the program focuses on health and wellbeing more broadly than just mental health, it is based on scientific research that establishes the clear linkages between physical activity and mental wellbeing. It is our

view that the scope of preventative treatment should cover physical health and wellbeing as well as mental health.

Implications for risk equalisation

The consultation paper notes that *"[a] form of risk equalisation is essential to community rating, but may decrease the benefits an individual insurer receives from funding preventative treatments."*

We believe that this is a fundamental flaw of the current risk equalisation settings, in that they disincentivise insurers from investing in their customers' health and wellbeing, which is the foundation upon which AIA Health Insurance operates. This has meant that we are a net payer as part of risk equalisation, albeit that we are focused on the best outcomes for our customers.

Noting that there is a review of the risk equalisation settings forthcoming, we would suggest that the Department consider broadening the definition of "health-related business" for the purposes of risk equalisation, to capture chronic disease management and preventative health programs, such as AIA Vitality.

This would mean that the more that we invest in and encourage our customers to improve their health outcomes to improve the risk pool, the more we can recoup from risk equalisation.

We would welcome the opportunity to discuss our views with you in more detail. If you would like any further information, please contact Sarah Phillips, GM Communications and Corporate Affairs in the first instance, at sarah.phillips@aia.com or 0498 494 791.

Yours faithfully

Damien Mu
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AIA Australia and New Zealand