PRIVATE SUBMISSION

24 June 2024

By email only: OSHC@health.gov.au

Dear Department of Health and Aged Care

Subject: CBHS Corporate Health trading as CBHS International Health (CBHSC or CBHSi) responses to the Issues Paper: Overseas Student Health Cover May 2024 (Issues Paper)

Thank you for the opportunity to provide our views on the matters raised. Please note we have used the same headings, order and numbering as stated in the Issues Paper.

Potential Changes to the Deed

Change 1. *Publication of OSHC product information on privatehealth.gov.au*
Questions for Stakeholders.

1. *Is the proposal supported?*

Response. Yes, please see our response under 2.b.

2. *What is the likely impact on:*

a. *Premiums*

Response. No impact expected.

b. *Purchasing behaviours*

Response. We would like to better understand the reasoning behind this proposal. Is it to encourage switching between OSHC insurers by students already onshore; or is it to make this information available to international students so they can make an informed decision about their OSHC prior to arrival? Due to the large number of students who purchase the cover recommended by agents, it is possible that students may only become aware of this information after their arrival to Australia unless the government invests in promoting this information in a way that students are aware of it before purchasing cover.

3. *What are appropriate metrics for measuring the impact?*

Response. Utilisation of website and potential to expand website to capture and analyse student feedback.

4. *What is the anticipated:*

a. *Regulatory burden*

Response. If this requirement was included as part of the OSHC premium submission, there may be minimal impact from a regulatory perspective.

b. *Implementation timeframe*

Response. If the templates were made available in advance of the new Deed, and completion of the templates were included in the OSHC premium submission, it would be reasonable to expect this to occur for the August / September 2025 round.

5. *Are there differences between OSHC and CHIPs which must be considered?*

Response. There are significant differences between OSHC and CHIPs templates. While the use of a template to compare the offerings is achievable, considerable work is required to ensure that the templates are fit for purpose. Examples of additions required include the addition of medical services and MBS eligible allied health services fields and the removal of template fields such as age-based discount, product tier, excess information and extras products.

Change 2. *Caps on certain payments by insurers to third party agents. Questions for Stakeholders.*

1. *Is the proposal supported?*

Response. Yes. The payment of commissions accounts for a significant portion of the OSHC premium and without a cap, the commission rates increase in the bid for OSHC insurers to win business, which in turn increases the acquisition cost, which in turn contributes to increased premiums for students.

The following are situations and examples of payments that may not have previously been considered as a typical commission arrangement or payment. [redacted]

[redacted]

<u>Financial Contributions from OSHC Insurers to Education Providers</u>

In addition to education providers appointing preferred OSHC insurers, anecdotally "preferred" arrangements may include financial contributions from an OSHC insurer to fund on campus medical facilities. Notwithstanding this may have some positive impacts, there is a lack of clarity as to whether students holding cover with an alternative OSHC insurer receive the same level of access and service to these facilities as those students holding cover with the preferred insurer, or whether they are charged at a higher rate. We respectfully submit that these types of contributions are commissions, and both the amount and the conditions attached should be disclosed and calculated as part of the cap.

<u>Migrating Students to a New Insurer</u>

Additionally, some education providers and agents who change their preferred OSHC insurer, may migrate their students to a new insurer (often without consultation) in order for the education provider or agent to benefit from a

higher commission rate (e.g. double their commission) if the original insurer does not include a commission clawback clause for policies terminated before the original end date.

As an example, an education provider or agent has an arrangement with OSHC insurer 1 who pays a 25% commission. If the education provider or agent moves to OSHC provider 2, who pays a commission of 27% and insurer 1 does not have a clawback commission clause in their agreement, the education provider / agent will be paid commission twice for the same policy and insurer 1 will not receive the revenue for the full duration of the policy even though they have paid commission for the full duration.

If referral fees or commission payments were excluded from OSHC sales where a student moves to an alternative OSHC insurer, it could mitigate the risk of students being 'force migrated' when an agent or education provider changes their preferred OSHC insurer and also have a positive impact on premium increases.

[redacted]

[redacted]

2. *What is the likely impact on:*

a. *Premiums*

[redacted]

b. *Purchasing behaviour*

Response. It is unclear how purchasing behaviour would be impacted, as students often rely heavily on the guidance provided by their agent or education provider. [redacted] there is a general reluctance in our experience on the part of the student to report the agent due to a misapprehension/fear of deportation or other perceived consequence.

3. *What are the appropriate metrics for measuring the impact?*

Response. Suitable metrics will depend on the detail of the proposal and the operationalisation of change. The creation of and adherence to a strong governance framework is equally important.

4. *What is the anticipated:*

a. *Regulatory burden*

Response. All OSHC insurers should already have governance and internal reporting processes in place regarding their commercial partners.

b. *Implementation timeframe.*

Response. CBHSC could implement these processes within a reasonable timeframe in consultation with the Department of Health.

5. *Regarding third party agents:*

a. *How should agents be defined?*

Response. For the purposes of this paper and from a practical industry perspective, we suggest an agent should be defined as follows: Agent means a third party engaged by or on behalf of an overseas student intending to study in Australia, to arrange education course guidance and enrolment, arranging the purchase of Overseas Student Health Cover, visa applications and other administrative functions on behalf of the overseas student.

b. *How should types of payment be defined?*

Response. The historic practice has been to pay an agreed percentage of the lump sum premium for the duration of the policy, payable in advance. It may be more equitable to pay a flat referral fee regardless of course duration.

CBHSC also believes that other payments and financial incentives should also be considered as being "commissions"– see response under heading ***Change 2.*** *Caps on certain payments by insurers to third party agents.*

c. *What is an appropriate maximum amount or percentage that could be applied to a payment?*

Response. OSHC commission rates tend to increase year on year. That said, the level of effort required to take out an OSHC policy varies but it is moderate. On this basis, (accepting that effort deserves payment) it is our view that a commission rate in the range [redacted]

d. *What issues should be considered to take account for differences in the marketing and/or business acquisition strategies between insurers?*

Response. Preferred provider arrangements generally exclude all other OSHC insurers from education provider websites or from having an on-campus presence.

e. *What transition period should be applied?*

Response. Until the detail of the proposal is fully understood, a transition period is unable to be suggested.

Change 3*: Waiting periods for pregnancy-related care*
Questions for Stakeholders.

1. *Is the proposal supported?*

Response. No. The removal of pregnancy waiting periods means that international students are potentially afforded more favourable benefits than domestic private health insurance policy holders who must serve a minimum 12 month waiting period before being admitted to hospital. There is also the potential for there to be an increase in medical tourism which could entail illegal, unethical, or questionable conduct.

2. *What is the likely impact on:*

a. *Premiums*

Response. If pregnancy waiting periods are reduced or abolished, we anticipate a higher volume of students arriving in Australia for the primary purpose of availing themselves of maternal health services. Due to the high cost of pregnancy related care, we would anticipate material increases to premiums for all policy holders, which unfairly burden students who are genuinely coming to Australia to pursue their studies.

b. *Purchasing behaviour*

Response. Unknown at this time, however it is of concern that the Senate Standing Committee on Community Affairs' paper on the universal access to reproductive healthcare (Section 4.49) states:

"the Multicultural Centre for Women's health claim 70 per cent of pregnancy-related claims for international students occur within the first 12 months of cover, thereby negatively impacting international students on a vast scale'.

With such a high percentage of pregnancy-related claims occurring within the first 12 months of arrival, are there any other measures under consideration or planned apart from the proposed removal of waiting periods by OSHC insurers (which are also applied to Australian residents)?

3. *What are appropriate metrics for measuring the impact?*

Response. Number of pregnancies/births per year; average hospital stay costs; additional costs associated with high-risk/complicated pregnancies/births.

4. *What is the anticipated:*

a. *Regulatory burden*

Response. CBHS makes the following comments:

- Currently, there is no mechanism for OSHC insurers to report to the Department of Home Affairs circumstances where there is a birth and the infant is not added to the policy.
- Are there proposed mechanisms by the Australian government to mitigate the medical tourism risk, including unethical and illegal practices, in particular for OSHC providers?

These points are discussed in further detail below.

b. *Implementation timeframe*

Response. Unknown until detail is available.

5. *Regarding pregnancy related care:*

a. *How should pregnancy related care be defined?*

Response. Pregnancy related care should follow the clinical category definition as provided on the https://www.privatehealth.gov.au/ website and utilise the same MBS list used by private health insurers for domestic policies. Excerpt provided below:

"Hospital treatment for investigation and treatment of conditions associated with pregnancy and child birth. Treatment for the baby is covered under the clinical category relevant to their condition. For example, respiratory conditions are covered under Lung and chest.

Female reproductive conditions are listed separately under Gynaecology.

Fertility treatments are listed separately under Assisted reproductive services.

Miscarriage and termination of pregnancy is listed separately under Miscarriage and termination of pregnancy.

b. *What has been the previous experience when there are no waiting periods for pregnancy related care?*

Response. CBHSC makes the following comments:

Historical Background

During 2009 – 2011, it is our understanding that there was a growing number of students and/or their dependants entering Australia already pregnant causing the assumption to be formed that these individuals were entering Australia for the primary purpose of health/pregnancy/birth care.

At the time, there was a relatively high number of high-cost pregnancies/births likely due to the lack of health service availability/expertise in the student's home country or pregnancy complications (such as pre gestational diabetes) where services were unavailable or unaffordable.

Some health conditions also impacted the newborn – often requiring NICU support. It was not uncommon for the total benefits for this category of pregnancy to exceed $50k (pre 2011).

For this reason, some OSHC insurers heavily lobbied the Department of Health at that time to include waiting periods for pregnancy in the 2011 Deed – in line with domestic private health insurance waiting periods.

Since 2011, the costs for pregnancy-related services have increased year-on-year. The current charge for birthing (excluding the costs for neo natal and ante natal care) per State/Territory in the public system is significant for Medicare ineligible patients.

Current State

The table below provides a cost indication per State/Territory for public hospital birth and infant services for Medicare ineligible patients. These rates are typically higher than the minimum amount a public hospital can charge under the *Private Health Insurance (Benefit Requirements) Rules* for Australian residents treated as private patients in public hospitals. In Victoria, each individual hospital and health service can set its own rates. It should be noted in the table below that these are the daily rates for accommodation only.

State/Territory Gazetted Rates for Medicare Ineligible Patients in Public Hospitals:

	Accomodation rate (daily)	Theatre charge	Critical care NICO	Neonatal special care
ACT	$2,395.65	$3,331.30	$6,071.50	Varies between hospitals
NSW	$1,595	Varies between hospitals	$3,963	
WA	$2,865			
TAS	$2,876		$7,466	$4,283
NT	$2,595		$6,280	Varies between hospitals
VIC	Varies between hospitals generally + $1,500 per day		$6,070	$103 per hour
QLD	$2,510.55	$1,147.90	$1,147.90	$4,066.55

There are additional in-patient charges spanning from diagnostic services to charges by medical staff (doctors, anaesthetist etc) and medication.

In 2024, the average public hospital accommodation charge to CBHSC for a birth claimed under an International student or worker policy is [redacted] At a high level (assuming no pregnancy complications) an average pregnancy in total for an insured student or worker costs CBHSC [redacted]; and approximately [redacted] if there are difficulties with the birth and neo-natal critical care needs.

Per the table below, when considering the 12 month premium per scale (Single, Couple, Sole Parent and Family), removal of the 12 month waiting period exposes OSHC insurers to considerable losses – especially if there are no other measures in place or planned by the Australian government to assist students who are pregnant when entering Australia or within the first 12 months of arriving (e.g. access to Medicare for pregnancy-related care only).

The table below displays the current 12 month premium per scale as at 24 June 2024.

	CBHSi	ahm	nib	MPL	Allianz	BUPA
Single	$569.40	$598.00	$640.00	$651.00	$652.00	$692.00
Couple	$4,500.45	$4,845.00	$4,850.00	$4,856.00	$4,787.00	$4,480.00
Sole Parent	$9,500.95	$4,845.00	$12,632.00	$4,856.00	$4,787.00	$4,480.00
Family	$9,500.95	$10,422.00	$12,632.00	$11,163.00	$9,034.00	$9,763.00

Source: OSHCAustralia.com.au

Further, if waiting periods are abolished and a Single policy holder can claim pregnancy-related benefits without having to upgrade to a Sole Parent or Family policy prior to the infant's birth, the cost of a 12 month OSHC policy at a range of $569.40 to $692 is significantly cheaper than comparable CHIPs which include a 12 month waiting period for pregnancy.

The removal of pregnancy waiting periods and increased exposure to medical tourism will force premiums to increase significantly, meaning that most overseas students will be effectively penalised by paying higher rates to cross subsidise a small group of policy holders.

Access to Reproductive Healthcare

As a separate issue, while we acknowledge the research and recommendations of the Senate Standing Committee on Community Affairs inquiry into the universal access to reproductive healthcare, pregnant women in Australia already have access to health services regardless of waiting periods or OSHC status. There is no prohibition on overseas students accessing a public hospital, at their own cost. However, as is the case for many CHIPs, OSHC policies generally require a 12 month waiting period in order to claim a benefit. Emergency treatment during pregnancy within the 12 month waiting period is already covered by OSHC insurers.

In this response, we note that we have not considered the further topic of the financial or mental health impacts on the overseas student remaining in Australia and continuing their studies while being a parent.

c. *How should waiting periods be applied to newborns?*

Response. CBHSC makes the following comments:

For background information, students intending to study in Australia can confirm family members when the student visa application is lodged. An applicant must also declare family members for the student visa application even if the dependants do not plan to travel with the Primary applicant to Australia.

Upgrading a Policy Prior to Birth – where 12 month waiting period has been served

In the case of a student who has served their 12 month pregnancy-related waiting period, CBHSC requires a policy to be upgraded to either a Sole Parent or Family policy at least three months before the expected birth of a child and waiting periods in respect of the newborn child will then be waived. Otherwise, a waiting period applies to the infant.

Once the policy is upgraded and the additional lump sum premium is paid, the infant will then be covered from birth. This will enable the parent to apply for the infant to be added as a dependant to the student visa (and apply for the infant's passport).

Subject to completing the 12 month pregnancy-related waiting period, this additional premium assists CBHSC with covering pregnancy-related care costs prior to the birth and any complications that may occur including specialist services for the infant.

Upgrading a policy prior to birth also allows insurers to offer students maternal health programs and other neo natal support which may de-risk potentially high-cost pregnancies and direct students from public hospitals to CBHSC's network hospitals which manages overall costs.

We believe our current approach works well for all stakeholders.

Potential to Improve Processes to Ensure Visibility of Newborn Children

While there has been a suggestion of allowing an infant to be added to a policy up to 2 months after birth, CBHSC's view is that this is more applicable to the domestic setting where the Australian government has greater visibility of the infant through Medicare. Most international visitors are Medicare ineligible.

If there is a grace period for adding an infant to a policy, we suggest there should be a tightening of Government processes for the reporting and recording of births to ensure the welfare and visibility of these infants and avoid the potential for child trafficking, which is prevalent in other countries.

d. *Should there be a differentiation of waiting periods based on product duration type?*

Response. CBHSC makes the following comments:

Current State to be Maintained

CBHSC does not agree to the proposal for a reduction of the maximum waiting period to 6 months, 2 months or abolished completely for the reasons outlined above (including the historical information provided). It is our view that the status quo should be maintained as per the current Deed, that is, OSHC insurers should have the flexibility to set a maximum waiting period of 12 months if they so wish.

Insurers are already able to offer multiple student OSHC products, including products with no waiting periods for pregnancy.

Unless a student feels locked in by an education institution or agent to take OSHC insurance with a preferred OSHC provider, students are currently able to "shop around" prior to applying for their Visa to determine cover (and waiting periods) which is appropriate for their circumstances, including if they require immediate cover for pregnancy. Arguably, this should become even easier for students if publication and promotion of OSHC product information on privatehealth.gov.au is introduced in accordance with proposed ***Change 1.*** *Publication of OSHC product information on privatehealth.gov.au*

Portability of Cover

If waiting periods were reduced or abolished, portability of cover means that an OSHC insurer could receive a number of high-cost claims relating to a pregnancy within the first few months of a policy before that member decides to leave and move to a different OSHC insurer with the balance of the premium paid to CBHSC in advance having to be refunded to the student.

Administrative Burden

CBHSC does not agree to differentiating waiting periods based on product duration, as this would be a highly complex administrative burden requiring significant investment in changing and implementing new systems and processes.

End of document.