THE AUSTRALIAN

Health insurance cost pain after rules glitch

- Sean Parnell
- The Australian
- 12:00AM March 29, 2018

HEALTH EDITOR

Private health insurance premiums will climb and thousands of members will need legal protection from unexpected tax debts, after an extraordinary 11-year misinterpretation of insurance rules.

As Health Minister Greg Hunt yesterday introduced legislation for the first tranche of the Turnbull government insurance reforms, *The Australian* discovered the urgent need for further amendments to allow for policies with non-compliant benefit restrictions as far back as 2007.

Twelve insurers still offering such policies have been ordered to withdraw them from the market by July 1. While that will mandate a higher level of cover for members with conditions such as mental illness, obesity and joint deterioration, it will come at a cost, contributing to higher premiums from next year.

The problem emerged when the Department of Health looked to remove benefit limitation periods (BLPs) and waiting periods for members wanting to upgrade their cover for psychiatric treatment, as Mr Hunt promised in October. *The Australian* understands the department found “many policies” had BLPs that, on the most recent interpretation of the rules, exceeded the waiting periods allowed under 2007 legislation introduced by then health minister Tony Abbott.

Insurers were allowed to impose a 12-month waiting period on claims for obstetrics and pre-existing conditions, and two months for other conditions including psychiatric treatment. However, some have also imposed BLPs of up to two years, possibly longer.

The long waits have also been imposed on other procedures including weight-loss surgery, and hip and knee replacements.

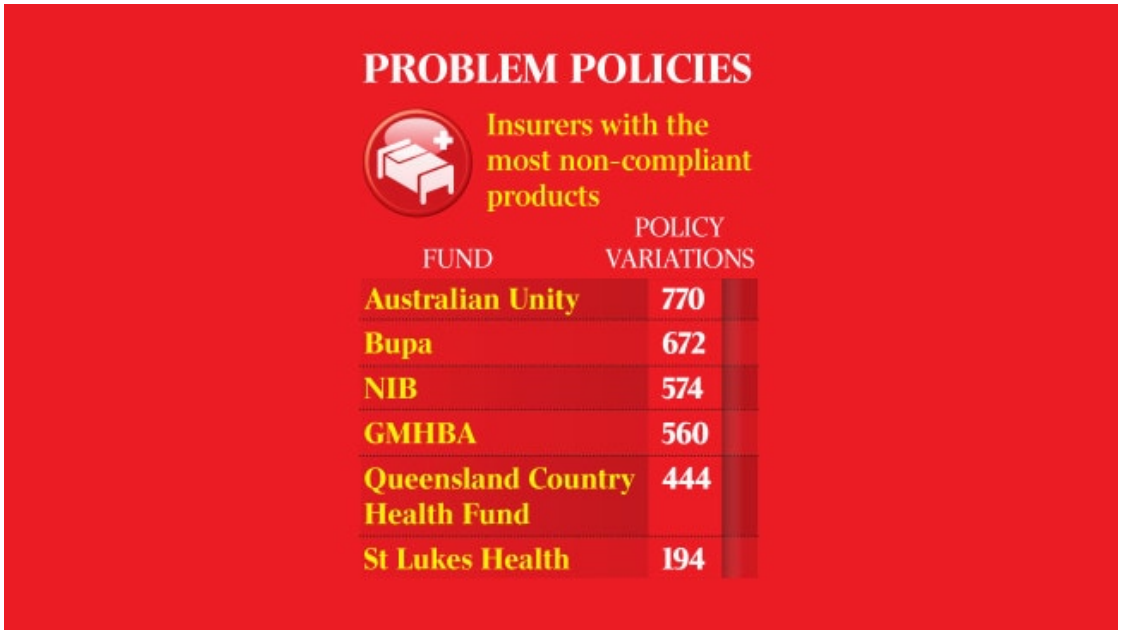
Not only have members with those policies had their benefits restricted for up to 22 months longer than allowed, the BLPs effectively rendered their insurance non-compliant with tax laws. The department has issued an alert to insurers. “There are three main areas for concern regarding consumers: the premium rebate ought not to have been paid on these policies; people subject to the Medicare levy surcharge were not exempted by buying these policies; and people buying these policies were still subject to any applicable lifetime health cover loadings.”

The department advised health fund chief executives on March 9 that legislative amendments were required to protect members from having to repay rebates or being held liable for the surcharge or age-related loadings on premiums. All BLPs will have to be removed by July 1.

While health funds had factored the loss of BLPs for psychiatric treatment into their sums for 2018 premium increases, which come into effect on Sunday, the department acknowledged the broader changes “may lead to a marginal increase in premiums in 2019”.

The number of members affected by the non-compliant policies was unclear last night but a spokesman for Mr Hunt said removing BLPs altogether would lift restrictions on about 25,000 policyholders.

“These limitations were in place across the entire Rudd-Gillard-Rudd governments and it is the Coalition who has taken action to remove them, for the benefit of consumers,” the spokesman said.



Australia’s largest health fund, Bupa, has about 1200 members subject to a non-compliant BLP. The second largest, Medibank, removed BLPs from products in 2010, while a spokeswoman for HCF — which plans to merge with HBF to become the third largest insurer — said none of its policies were affected.

Actuary Jamie Reid, principal of Finity Consulting, said Australian Unity had the largest number of policy variations with BLPs, followed by Bupa and NIB, but data did not show how many members were affected currently or had been affected over time.

Mr Reid said the conditions most likely to be subject to a current non-compliant BLP were psychiatric treatment (3035 policy variations), hip and knee replacement (1573), gastric band surgery (1554), dialysis (1510), assisted reproductive technology (1077) and cataract surgery (861).

“At first glance, removing BLPs looks like a win for members, reducing complexity and increasing benefits,” Mr Reid said. “In practice, it’s really a win for people who want to ‘hit and run’, and could end up costing long-term members more.”

He said insurers had sought to deter “hit and run” claims from members who waited until they needed insurance before taking out a policy and then dropped their cover once it had been funded. “For example, people often know more than 12 months in advance that they are likely to need gastric banding surgery, or a major joint replacement,” he said.

“Similarly, if the public hospital waiting list for cataract surgery is more than 12 months people might be steered towards getting health insurance.”

BLPs, along with restrictions and exclusions, have become more common in recent years as insurers helped members claw back their cover in an effort to reduce premiums. This has coincided with an increase in complaints about a lack of cover.

Health funds will still be allowed to impose 12-month waiting periods for obstetrics and pre-existing conditions and two months for other treatments (not psychiatric).