Private Healthcare Australia
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Hon Dr Michael Armitage
CHIEF EXECUTIVE OFFICER

Dr Kathleen Dermody
Committee Secretary
Senate Economics Legislation Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Dr Dermody

Inquiry into the Private Health Insurance (Prudential Supervision) Bill 2015 and Related Bills

Thank you for the opportunity to comment on Senate Economics Legislation Committee's inquiry into the legislative package to transfer the functions of the Private Health Insurance Administration Council (PHIAC) to the Australian Prudential Regulation Authority (APRA).

Private Healthcare Australia is the Australian private health insurance industry's peak representative body that represents 21 health funds throughout Australia and collectively covers approximately 97% of the private health insurance industry. Private health insurance today provides healthcare benefits for over 13 million Australians.

Our goal is to ensure that private health insurance members receive the best possible healthcare at the best possible prices.

We note that the PHIAC-APRA transition is a "machinery of government" change with no intended impact on the industry, apart from reducing the impost on the industry.

Throughout the consultation process regarding the PHIAC-APRA transition, the industry has maintained a strong position that our preference is to retain the status quo. This position has been backed by all stakeholders, including APRA.

APRA has, however, asked for legislative changes to ensure "consistency" with other industries that it regulates. Wherever possible, and for the most part, the private health insurance industry has compromised and accepted APRA's "consistency" positions.

Unfortunately, the drive for "consistency" with other industries regulated by APRA is likely to result in an increase in red tape for the private health insurance (PHI) industry.

PHI is a "social" not "financial" good, with very different underpinnings from other industries regulated by APRA. Unlike other industries, PHI has had NO major failures that have impacted detrimentally on consumers. In fact, a number of consumer protections provisions are inbuilt into product design and operation of private health insurance (eg community rating, portability, etc.) outside of the pure prudential framework.

We note APRA's publicly stated position that there will be "no substantive changes to the prudential standards, rules or reporting arrangements".

We note that the Treasury and Department of Health have worked to address the industry's concerns during the consultation period. However, due to the rushed nature of the consultation process, which only began in January this year, some important issues have not

been addressed. A number of new provisions that significantly impact industry compliance costs have been introduced since the Exposure Draft legislation, without consultation.

We have attached our submissions on the consultative process to date. Our main concerns continue to be:

1) Data provision and confidentiality;

2) Continued transparency of prudential decisions;

3) Increased regulation, including new custodial penalties related to information;

4) Increased scope for confusion; and

5) Important questions unanswered.

We continue to look forward to a rapid resolution of these issues to allow a 1 July 2015 start date for the legislative changes, with any changes effective from 1 July 2016,[1] in line with Government's commitments.

We would be happy to provide you with our simple proposed solutions that would quickly and easily resolve many of these issues.

1 Data Provision & Confidentiality

We believe there should be a simple legislative provision to ensure that the regulator continues to provide detailed quarterly data provided for over 25 years to the individual health funds and Private Healthcare Australia, while ensuring this data remains confidential and unable to be the subject of any Freedom of Information requests.

The data provision and confidentiality issue was introduced in the draft legislation proposed by APRA/Treasury that seeks to capture PHI data collection requirements under the Financial Sector (Collection of Data) Act.

The industry has asked for this to be changed since it was proposed in January. The industry has accepted APRA and Treasury's assurances that there will be no change to the current arrangements and that including the industry in these Acts simply allows APRA to collect data using the same processes as it does for other industries it regulates. Given these repeated assurances, it is appropriate to request that this issue be addressed so that the status quo can continue.

The industry wants to continue the current arrangements, which are important for transparency. For example,

- data/calculation anomalies are immediately picked up by other insurers and/or Private Healthcare Australia; and
- to provide contemporary data as requested by consumers, other regulators, Members of Parliament and others to show industry returns to members.

[1] The Medibank prospectus, released on 25 November 2014 by the Australian Government states "As at the Prospectus Date, APRA has not determined its approach to prudential regulation of the PHI industry except that it does not intend to make any changes to the existing capital and solvency standards for private health insurers before 1 July 2016."

APRA's proposals are a fundamental change to longstanding, accepted practice (over 25 years). The Private Health Insurance Act 2007 (PHI Act) was drafted to permit existing practice to continue (with some specific exclusions that are not relevant to data provision). We believe that APRA's current interpretation of the PHI Act is overly narrow.

Please introduce a simple legislative provision to ensure this longstanding practice continues and that the data shared continues to be confidential. This simple legislative provision could largely echo clause 169 of the Private Health Insurance (Prudential Supervision) Bill 2015, with appropriate confidentiality arrangements. Clause 169 was inserted to ensure that current public reporting from PHIAC continues under APRA.

We have detailed the uses and purposes of this data provision in our submission to APRA dated 18th May (refer to Attachment Two).

2 Reduced Transparency of Prudential Decisions – Reduction in AAT Reviewable Decisions

The number of decisions that are AAT reviewable has decreased while regulatory powers have increased. As stated in our submissions to date, we believe that all existing decisions that are AAT reviewable should remain so and new regulatory powers should be AAT reviewable.

Treasury states that all decisions (except one) that are currently AAT reviewable remain so. However, we note that the APRA consultation package says that AAT reviewability has been removed for some decisions, including HPS 100, 110 and 510 (proposed new solvency, capital adequacy and governance standards).

We note that in addition to these three grounds for AAT reviewability, the Bills presented to Parliament also remove a fourth ground for AAT reviewability under section 152 of the PHI(PS) Bill (former item 12 of the table in section 168). We are confused why an additional ground for AAT reviewability would be removed, given assurances from Treasury that AAT reviewability has been retained for all currently AAT reviewable decisions.

In addition, as noted in our initial submission to Treasury, the number of grounds for AAT review of decisions has been reduced.

Please reinstate the current AAT reviewability of decisions, including those made under HPS 100, 110 and 510. This accords with APRA's commitment of "no substantive changes from the status quo". We would be happy to work with you to draft a quick, easy legislative change to this purpose.

To assist the industry to understand the proposed changes, we look forward to Treasury/APRA providing a document mapping all decisions and their review process currently and under the proposed new regime, under the legislation, any subordinate legislation or otherwise.

3 Increased regulation, including new custodial penalties

The industry is concerned that the proposed PHIAC-APRA transition is likely to increase prudential regulation. In particular, the Financial Sector (Collection of Data) Act introduces custodial sentences, of up to 5 years, for certain offences relating to information, including sections 13B and 17D.

We do not understand why these new custodial sentences have been introduced to a compliant industry that has had no major failures to the detriment of consumers. We would like to see these additional penalties removed from the PHI industry.

At a minimum, ensure section 13B and its new custodial sentence for disclosing an APRA regulatory standard does not apply to private health insurers – the provision reduces transparency.

In addition, we note new subclause 77(3) of the PHI(PS) Bill which allows APRA to determine that any person should pay external manager fees. We are uncertain as to why this new, onerous and broad power has been introduced. This seems to expand available Directors Penalty provisions in other legislation beyond Directors.

4 Additional Scope for Confusion Between APRA/Health/Treasury Roles

Some of the APRA Rules deal with areas that we have been informed come under the Department of Health's (DoH) responsibility. To have an area of DoH responsibility dealt with by an APRA Rule introduces unnecessary scope for confusion. We need to be careful to ensure that policy lines are clear and respected to avoid unnecessary overlap that doesn't correspond with APRA's prudential supervision role.

For example, we are concerned that clause 85(4) of the PHI(PS) Bills requires APRA to consult with the Health Secretary. However, newly inserted words provide that failure to consult does not affect the validity of APRA's rules.

This introduces significant uncertainty for the industry, which is now subject to three separate regulatory regimes that have the potential to interact in new and complex ways.

5 Important Questions Unanswered

5.1 Standard Operating Procedures

The Standard Operating Procedures (SOPs) were drafted by PHIAC in consultation with the industry and provide the following benefits:

- reduce confusion; and
- increased goodwill between the regulator and the industry.

The SOPs detail how conflicts will be dealt with by the regulator.

We note that APRA has stated the SOPs align with its enforcement approach. Given these parallels, it should be a simple process for APRA to update the SOPs and/or map them to its proposed approach.

We have asked APRA to provide the proposed new process for dealing with regulatory issues and a map of how the SOPs align with APRA's proposed approach and await a response.

Any attempt to remove/not update the SOPs introduces unnecessary confusion.

The industry has a strong preference to continue using the SOPs, as they have been a useful and successful regulatory tool.

5.2 Risk Equalisation

Risk Equalisation is an important support for community rating, which underlies the Australian private health insurance system. It deals with large amounts of money on a quarterly basis. It differs significantly from other APRA-regulated industries.

We would like to understand how the system will be administered/managed going forward, including how insurers will continue to be given the appropriate data to:

- benchmark and understand risk equalisation outcomes; and
- note if it is out of kilter with the rest of the industry on a State-by-State and quarter-by-quarter basis (may indicate eg data/business issues).

The data currently provided under Section 1 above is key to the risk equalisation process and we look forward to legislative confirmation that the current process will continue.

5.3 Impost Reduction for Industry

We note that the changes are proposed to reduce the impost on the industry. However, despite a large reduction in PHIAC staff, APRA proposes no reduction in the levy before 2017/18.

In addition, we note an additional provision has been included in the Consequential Amendments Bill which was not in the exposure draft reviewed by industry. The proposed new Division 2, Section 22 of the Private Health Insurance (Council Administration Levy) Act gives the Assistant Treasurer the power to determine in writing that a specified asset will become the asset of the Commonwealth before the transition occurs.

We seek confirmation that the entire current reserves of PHIAC will be transferred to APRA and noted against the PHI industry.

5.4 Industry's Work on Streamlining Rules

Since 2014, the industry has been discussing with Government its proposals to streamline the Private Health Insurance Rules, to remove outdated provisions and unnecessary red tape.

We understand that the proposed legislative package has been updated to ensure that references to all Private Health Insurance-related Rules are flexible enough to accommodate these changes.

We note that APRA has introduced changes from the PHIAC Rules to introduce "consistency" with other industries it regulates.

We are disappointed that the industry's work has not been included in the current Rule changes, in particular quick, easy red tape reductions. For example, it would be quick and easy to remove double notification requirements to separate Government agencies in different formats/timeframes. Further information on double notification requirements is in Attachment Two.

We look forward to progressing this work with APRA at the earliest available opportunity.

We seek a commitment that APRA will seek to implement this important work by 31 March 2016.

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We remain concerned that the PHIAC-APRA transition, as presented to Parliament, will result in increased industry regulation, contrary to the Government's stated objective to reduce red tape and regulation. Given that there is no proposed reduction in the levy on the industry, we query whether the proposed documentation as currently drafted will fulfil the Government's objectives.

We are keen to meet with you to further discuss ways to ensure that the PHIAC to APRA legislative package reduces red tape and unnecessary regulation. Please contact me on 6202 1000 with any queries.

Sincerely,

HON DR MICHAEL ARMITAGE

CHIEF EXECUTIVE OFFICER

Attachments:	One	Table of Issues Raised by Industry
	Two	Previous Submissions to Treasury and APRA on the PHIAC-APRA transition

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ATTACHMENT ONE – Table of Issues Outstanding

This table summarises issues the industry has raised with APRA, Health and Treasury and remain outstanding.

Issue	Solution	Treasury/APRA Response	Proposed Bills
Data Provision and Confidentiality	Simple legislative fix – mirror current clause 169 with confidentiality safeguards	Treasury – administrative issue, requires APRA response. Treasury earlier stated it was looking at introducing new clause 169 for public information and a similar provision for industry-only information. APRA – legislative issue	No proposed resolution to date.
Reduced Transparency of Prudential Decision-making – AAT reviewability	Simple legislative fix – (a) add 3 new items to the table at clause 168; (b) reinstate ground 12 review decisions under section 152 of the PHI(PS) Bill (which has disappeared since the consultation draft Bill).	Treasury - all currently AAT reviewable decisions remain so. APRA – 3 decisions are no longer AAT reviewable. No explanation for removing ground 12 for AAT reviewability	Removes AAT reviewability for 4 decisions.
Reduced Transparency of Prudential Decision-making – new regulatory powers have limited reviewability.	Simple legislative fix – add new and increased regulatory powers to the list of AAT reviewable decisions at clause 168.	Treasury – will consider ensuring all non AAT reviewable decisions are subject to internal APRA review process.	Only AAT reviewable decisions are subject to internal APRA review process.
Increased Scope for Confusion between APRA, Treasury and Health roles	Insert obligations for APRA and Treasury/Treasurer to consult with Health before changing regulation.	Unnecessary because they will consult and Memoranda of Understanding will be put in place.	Requirement for APRA to consult with Health Secretary in clause XXX has been watered down.

Reduced Transparency in Industry Levies	Reduce industry levies from 2015/16in line with reduced PHIAC staff and back office efficiencies. Ensure entire PHIAC reserves are transferred to APRA and quarantined for PHI industry. Ensure monies associated with levies and the Risk Equalisation Pool are transparently applied for the PHI industry's benefit.	No change until 2017/18. PHIAC reserves can be transferred to Commonwealth. Will increase transparency.	No proposed resolution to date.
New Industry Levies have been introduced	Remove new Levies. PHIAC has successfully regulated the industry for over 25 years without the need for additional levies.	APRA needs to be able to impose new levies in case they are necessary.	No proposed resolution to date.
It is generally acknowledged that private health insurance is NOT a financial service and should not be treated as such by APRA or the Bills	Remove PHI from the Financial Sector (Collection of Data) Act. Instead, replicate current legislative provisions. At a minimum, ensure section 13B and its new custodial sentence does not apply to private health insurers – the provision reduces transparency.	References to PHI as part of the financial services industry have been removed.	PHI has been brought under the Financial Sector (Collection of Data) Act, which has introduced numerous issues to the Bills.
Increased prudential regulation powers, some of which could cause insurers to breach obligations under the Private Health Insurance Act	Clarify that a private health insurer is not required to comply with an APRA direction that may put the insurer in breach of its obligations under other Acts. Introduce a requirement for APRA/Treasury/Treasurer to consult with Health before issuing such a direction.	Unnecessary because they will consult and Memoranda of Understanding will be put in place.	No proposed resolution to date.

Increased prudential regulation powers – commence investigations that are likely to increase compliance costs and be passed onto members in increased premiums	Insert a requirement that investigations can only be commenced if a breach of the PHI(PS) Act is detected.		No proposed resolution to date.

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ATTACHMENT TWO: Previous Submissions to APRA and Treasury

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Hon Dr Michael Armitage
CHIEF EXECUTIVE OFFICER

Ms Laura Johnson
Manager, Insurance and Superannuation Unit
Financial System and Services Division
The Treasury
Langton Crescent
PARKES ACT 2600

Dear Laura,

Private Health Insurance Changes

Thank you for the opportunity to comment on part of the proposed legislation to transfer the functions of the Private Health Insurance Administration Council (PHIAC) to the Australian Prudential Regulation Authority (APRA).

Private Healthcare Australia is the Australian private health insurance industry's peak representative body that represents 21 health funds throughout Australia and collectively covers approximately 97% of the private health insurance industry. Private health insurance today provides healthcare benefits for over 13 million Australians.

Our goal is to ensure that private health insurance members receive the best possible healthcare at the best possible prices.

The exposure draft material introduces significant uncertainty for no proposed gain to either the industry or its members. In fact, the exposure draft material is likely to increase costs for private health insurers, which must be passed on to members through premium increases.

The exposure draft material represents a fundamental shift in the prudential regulation of the Australian private health insurance industry by including the industry as part of the financial system for prudential regulatory purposes. It is vital that the industry is given the opportunity to fully understand the proposed changes and provide input on them before the changes come into effect.

The policy decision was to move the PHIAC functions to APRA to reduce costs and regulation. However the proposed Bill goes much further than this and proposes to regulate the private health insurance industry as part of the Australian financial services industry.

We are particularly concerned that there is little or no explanation of why the individual changes in the proposed Bill are thought to be necessary and how they are likely to affect the industry and its members.

It seems incongruous for the industry to only see one small part of the package, with very short response timeframes, 5 months before the changes are due to take effect. In fact, we understand that it is unprecedented for the entire prudential regulation of an industry to change within such short timeframes.

We are concerned that the exposure draft material will result in increased industry regulation, contrary to the Government's stated objective to reduce red tape and regulation. Given that there is no proposed reduction in the levy on the industry, we query whether the proposed Bill as currently drafted will fulfil the Government's objectives.

It is important to note that the Australian private health insurance has had no major industry failures to the detriment of consumers. Therefore, the current regulation is working and **no additional regulation is warranted**. In fact, if anything, regulation should reduce NOT increase.

We note that a key objective of the Australian Department of Health is to create better health and wellbeing for Australians. It is important to align the prudential regulation of private health insurance with these core goals for the Australian health system and any changes should be structured to increase the health and wellbeing of Australians.

We request full consultation on the full package of changes well before they come into effect. This would include all the documents listed below and sufficient time to read, understand, discuss and incorporate feedback internally and with the various Government departments involved. A fairer timeframe would involve consultation now for introduction in early 2016, with changes applying from 1 July 2016.

We understand that the transfer of PHIAC's functions to APRA will include the following regulatory changes:

- transitional provisions - not available for analysis and comment;
- provisions to ensure no changes will take effect before 1 July 2016[1] - not available for analysis and comment;
- a regulatory impact statement to explain the changes and how they will affect Government administration of the industry, including costs to the industry and members and the industry's goals of providing access to the best possible care at the best possible prices – not available for analysis and comment;
- changes to the *Private Health Insurance Act 2007* – not available for analysis and comment;
- changes to the relevant *Private Health Insurance Rules* – not available for analysis and comment;
- APRA's proposed regulatory Standards – not available for analysis and comment;
- full explanatory material that details the proposed changes, why they are considered necessary, how they differ from current regulation, etc – not available for analysis and comment;
- Rules that will sit under the proposed Bill – not available for analysis and comment; and
- the proposed Bill.

It is very difficult to provide comments on one isolated part of this package of changes without access to the complete package.

The stated purpose of the changes is to achieve cost savings. However, there is no explanation of what the expected cost savings are, or how these will be achieved. The cost of the levy on the industry will not change, despite staffing cuts in PHIAC.

The materials released for consultation do not give the industry an opportunity to understand what changes are being proposed, compared to the current regulatory regime or why those individual changes are proposed.

[1] The Medibank prospectus, released on 25 November 2014 by the Australian Government states "As at the Prospectus Date, APRA has not determined its approach to prudential regulation of the PHI industry except that it does not intend to make any changes to the existing capital and solvency standards for private health insurers before 1 July 2016."

The current exposure material does not provide details about some fundamental aspects of private health insurance industry regulation or how its regulation will be affected, including:

- premium change process;
- current standard operating procedures issued by PHIAC after substantial industry consultation;
- industry analysis performed by PHIAC but not yet finalised or published;
- annual report on insurers – which has been published every year for 40 years and should be published every year by December;
- state of the health funds report – which would probably better fit under the PHIAC/APRA role;
- risk equalisation; and
- reporting/industry statistics.

We asked these questions during the consultation sessions. The Treasury, the Department of Health and APRA are unable to provide clarity on these issues, as much of the necessary detail has not been finalised. It is concerning that the scope of the changes seem to not be fully comprehended by either the new nor the old regulator, just a few short months before the changes are proposed to take effect.

Given that we have access to only part of the package, our current comments are interim in nature. We look forward to receiving the rest of the package of regulatory changes so that we can provide you with our full comments and feedback.

We have structured our interim feedback as follows:

- general comments – these comments cover the regulatory change package as a whole; and
- comments on specific clauses of the Exposure Draft Bill – detailed in Attachment One.

General Comments

The Bill fundamentally changes the regulation of private health insurance going forward and therefore requires full consultation with sufficient time for everyone to understand the changes and their implications.

Lack of Consultation and Overly Short Timeframes

It is disappointing that Government has only chosen to release for consultation one small part of the proposed changes to the prudential regulation of the private health insurance industry. We are informed that some other aspects of the change may (or may not) be released for consultation separately. If they are released, we understand the timeframes for reading, understanding them and providing comments will be significantly less than the current 13 business days.

The exposure draft material is a profound shift in the prudential regulation of private health insurers. Currently, private health insurers are regulated as part of the health industry. The exposure draft material proposes to regulate private health insurance as a financial service. As discussed further below, **the private health insurance industry has several legal obligations that make it very different from financial services, including a lack of risk rating business decisions in relation to members, guaranteed portability, community rating, a collapsed insurer levy and risk equalisation.**

Despite this fundamental shift, there has been a disappointing lack of industry consultation. The industry has not been consulted on whether it should be regulated as a financial service. The industry has not been provided with an overview of the proposed changes to prudential regulation and how these will affect the industry, its operations and members.

In fact, the only consultation is the current exposure material, which has been presented in isolation from the whole new regulatory package and does not explain why or how the new regime will apply to private health insurers, or how it differs from the current regulation. We have been given less than 13 business days to provide our comments. We have not been provided with the consequential amendments, or the amendments to the current Acts and Rules, which would help us better understand the proposed changes from the current regime.

The new regulatory regime is proposed to occur in two stages.

1. Transfer PHIAC functions to APRA from 1 July 2015. We have been advised that there will be no changes to the prudential supervision of the industry until 1 July 2016. However, we are also told that there will need to be some changes to accommodate the new Act and structure. We look forward to receiving an explanation of these changes and why they are necessary.
2. New APRA regime from 1 July 2016. We have been promised that any changes to prudential regulation of the industry will involve extensive industry consultation. However, we have also been told that some changes are non-negotiable, as APRA needs to align its regulation across the industries that it regulates. As noted elsewhere, we have not been provided with explanations of why the individual changes are thought to be necessary.

We are concerned that the industry is being subjected to two changes in its prudential regulation in less than twelve months with minimal consultation and notice of what the changes will be and why. APRA has stated that the first stage will involve changes. The second stage must also involve changes.

Implications of Treating Private Health Insurance as a Financial Service

Currently, private health insurance is part of the Australian health system. The Bill, however, proposes to regulate the private health insurance industry as part of the Australian financial services sector. This is a substantial change to the way the industry will be regulated and is likely to have flow-on effects to private health insurers and the premiums their members pay. In particular, it is likely to increase the costs of doing business as a private health insurer and therefore flow-on to premium increases.

In contrast, it is commonly acknowledged that private health insurance is not part of the Australian financial sector.[2]

By treating private health insurance as a financial service, the Bill increases regulation of the private health insurance sector. This appears incongruous given that there have been no systemic market or regulatory failures to the detriment of consumers in the private health insurance sector. On the other hand, the financial services sector has experienced several high profile failures.

We are concerned that there is little explanation of why the individual changes (such as treating private health insurance as a financial product) are proposed and a lack of exploration of how these changes may impact the private health insurance industry, its members and its

[2] For example, see the *Financial System Inquiry 2014* (The "Murray Review").

fundamental tenets, e.g. community rating. Aligning regulation with that of other insurance types and the financial services sector does not recognise that unlike private health insurers, organisations in other insurance forms and banking risk rate their decisions to provide insurance and/or other financial services to particular individuals. Other insurance types also have reinsurance and underwriting. Unlike other insurance types, private health insurance also has a collapsed insurance levy, risk equalisation, portability among other issues.

This increase in regulation is at odds with the Government's stated intention to cut red tape and remove and streamline unnecessary regulation.

Increased Regulation and Increased Red Tape

The Government's stated intention is to cut red tape and remove and streamline unnecessary regulation. However, the impact of the move from PHIAC to APRA will increase red tape on both the industry and affected government departments and regulators.

Between now and 1 July 2015, the entire health insurance industry (as well as affected governments departments and regulators) - a significant number of people and resources - will need to spend time reviewing a suite of draft legislation, rules, standards as well as new associated legislation that does not currently apply to the industry. In addition, the industry will need to consider and action the resulting business impacts.

Until 1 July 2015, the industry will be forced into an ongoing cycle of reviewing potential amendments to that legislation, standards and rules, and considering and actioning the resulting business impact of those changes.

This comes at a significant cost in terms of time and resources, distracting the attention of management and Boards from the core functions of private health insurance - improving the health outcomes and cost of health management of Australians.

The explanation we have received for many of the changes is a perceived need to ensure APRA aligns regulation to make it easier for them to regulate and achieve potential cost savings. There is no explanation how the changes relate to these potential cost savings – we note however that there are no cost savings for the industry in the foreseeable future and ultimately there will be less transparency in cost recovery than currently exists for PHIAC.

We are concerned that both the industry's resources and the Government's resources are being diverted from "creating better health and wellbeing for Australians". Given that there are currently no projected savings for the industry from the changes, but rather increased regulatory costs for the foreseeable future, we query whether the mooted changes are necessary.

Financial Sector (Collection of Data) Act

We understand that the *Financial Sector (Collection of Data) Act* (CoD Act) will be broadened to apply to private health insurance. This is more complex than simply setting out reporting requirements under the new APRA Rules.

The CoD Act only applies to a small number of APRA-regulated sectors and currently excludes the following sectors:

- approved deposit taking institutions;
- life insurance; and
- general insurance.

In fact the CoD Act only seems to apply to finance bodies, investment banks and financial sector business subsidiaries.[3] It is inappropriate to extend this Act to private health insurance given a lack of similarities between private health insurance and the sectors regulated by the CoD Act.

Including private health insurance in the small number of sectors governed by the CoD Act appears to run counter to division of Ministerial responsibilities in the proposed Bill. Under the proposed Bill, the Treasurer (the Minister under the CoD Act) has the power to make determinations regarding prudential regulation alone for private health insurance. All other policymaking powers for private health insurance remain with the Minister for Health. However, the objects of the CoD Act (section 3) enable the collection of information to assist the "Minister to make financial policy". It seems inappropriate to empower APRA to collect private health insurance information that does not relate to the prudential regulation of private health insurers. The responsibility to collect general private health insurance information resides with the Minister for Health. Any additional powers will result in duplication and additional regulation and red tape.

References to the CoD Act should be removed from the Exposure Draft and replaced with a section stating what data the industry needs to supply. A section, rather than a whole new Act, is far simpler and involves less red tape than applying a whole new Act to the industry.

Penalties and Defences

From the limited information available to us, it appears that proposed Bill is likely to result in increased regulation for the industry. Due to significant director liabilities outlined in the proposed Bill, directors will seek additional assurances that compliance is achieved and this will likely often result in additional unnecessary compliance costs for internal compliance and regulatory systems. This will add an unnecessary overlay of compliance costs for little additional value/benefit to the organisation and/or policyholder/consumer benefit.

It is essential for private health insurers to be able to attract and maintain directors and other officers of high calibre, without the disincentive of an overly onerous liability regime being imposed.

We are concerned that the Bill removes the current procedural fairness defences for failing to comply with regulation, for example if the insurer is not notified of a requirement, or a change in requirement. In addition, the Bill does not require APRA to notify insurers, e.g. s 92. This may mean that when APRA provides a direction to a particular insurer, but does not notify that insurer, the insurer has no defence for non-compliance with a direction it never knew about. As discussed at the 16th January industry consultation session, this result seems to run counter to natural justice.

Strict liability offences should be removed and a materiality threshold should apply for all breaches – this simple change will help reduce the compliance burden on industry and the administrative burden on Government, by ensuring that time is not spent on non-material breaches.

All penalties for failure to comply should specify that penalties can only be applied after notification has been provided and a reasonable period of time has elapsed.

[3] http://www.apra.gov.au/NonReg/Pages/Registered-Financial-Corporations-list.aspx

Levies

We note that one of the Government's stated aims for moving the regulatory role of PHIAC to APRA is to "remove duplication and reduce impost on industry."[4] However, the Exposure Draft Bill does not reduce the industry levy, but rather proposes to continue previous increases. In addition, contrary to the Government's increased efficiency dividend, the Exposure Draft material proposes to index the levy's cap by the Consumer Price Index plus an unexplained amount of 0.03. The levy should continue to be linked to the actual costs of regulating the industry and the actual number of policies issued by the industry, overseen by the Minister for Health, rather than CPI and an arbitrary number.

Given that the costs of running PHIAC are known, and the proposed PHIAC staffing reductions are also known, we would expect to see a cost saving for the industry of the changed regulatory environment. According to the public PHIAC annual report, the levy should reduce by over $1 million to reflect staff and Council reductions - proposed back office efficiencies would increase this saving.[5]

Prudential regulation of the industry is funded by the industry. The proposed Bill will substantially increase penalties for late payment of these levies, from a maximum of 15% to a flat 20%. In addition, the proposed Bill removes current protections for insurers that allows waiver of the late payment penalty. Under the proposed Bill, a simple bank error could result in insurers paying a substantial penalty with no room for the penalty to be waived.

Given the Government's intention to better align industry regulation, the General Interest Charge, at the regulator's discretion, would seem a more appropriate penalty for late payment.

Timeframes for Prudential Regulation Changes

To help provide certainty for the industry, the transitional provisions should clearly state there will be no changes to the way the industry is prudentially regulated (as opposed to by whom) until at least 1 July 2016. This will give the Department of Health, APRA, Treasury and the industry time to settle into the new arrangements and help provide stability.

Regarding changes post 1 July 2016, the Explanatory Memorandum states that APRA will substantially use the current PHIAC standards. APRA confirmed at the industry meeting of 16th January that it will essentially replace the word "Council" with "APRA" through the Standards and Rules, and not make other changes or impose additional regulation without extensive industry consultation.

Consultation

Prudential regulation of private health insurers impacts how the industry goes about its business and the benefits it can offer members. Any change to regulation involves changing systems and processes. To help maintain the Government's goal of reducing red tape and not increasing it, it is important to ensure:

- full, timely consultation with the industry to help reduce unintended consequences; and
- sufficient timeframes to allow the industry to update its systems and processes before the change comes into effect.

We note that the prudential standard for capital adequacy has recently changed and insurers have made the relevant changes to their systems and practice. Moving regulators is another

[4] Budget Related Paper no. 1.10 p 119.
[5] Based on PHIAC annual report 2013/14, pages 71-73. For example, the Council will go.

significant regulatory change and open discussion between APRA and the industry is necessary to ensure a smooth transition for both APRA and the industry.

APRA noted during the industry consultation sessions that it will publish its standards and Rules for the industry and consult broadly with the industry while developing those standards. We look forward to working closely with APRA to develop those standards to help reduce unintended consequences and ensure that the new standards meet the Government's goal of reducing red tape, rather than increasing red tape.

We are pleased that APRA and the Treasury have committed to joining the work that Private Healthcare Australia and the Department of Health are doing to streamline the Private Health Insurance Rules. As discussed on 16th January, given that the Department and Private Healthcare Australia have already commenced substantial work on this issue, it makes sense for APRA and the Treasury to join the Working Group, rather than doing separate work on the same Rules. We look forward to meeting APRA and the Treasury on 5th February.

Structure

The Exposure Draft is for a new Bill. We urge you to use this opportunity to modernise the legislation that governs private health insurers and their regulators. The current Act and Rules contain many exceptions and some exceptions to exceptions. This results in legislation that is overly complex and difficult to follow for both regulators and the industry.

The following changes would help streamline the Exposure Draft Bill and make it easier to administer and comply with.

1. Definitions should refer directly to section numbers, rather than just referring to an Act and users then having to look up the dictionary in that other Act.
2. A logical structure would help make the Act more readable, so that it tells a story and is easier to follow for all users – we suggest the following structure:
   - Insurers obligations – what insurers are required to do;
   - Regulatory powers and triggers - What powers do regulators have if insurers don't comply with their obligations? And what triggers those powers to operate?
   - Worst case scenario – external management, termination, Federal Court
3. Simpler legislative drafting would make the provisions easier to follow. The Act should be written in the modern legislative style:
   - state the principle/what it is meant to do;
   - give example/notes if necessary; and
   - provide exceptions if necessary.
4. Ensure terminology is consistent across all legislation that applies to private health insurers. For example, Part 5 of the Exposure Draft Bill uses both the terms "Appointed Actuary" and "Actuary". If there is a substantive difference between the two terms, this should be made clear.

Please find attached our interim specific comments on the *Private Health Insurance (Prudential Supervision) Bill 2015*.

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We are keen to meet with you to further discuss ways to ensure that the PHIAC to APRA legislative package reduces red tape and unnecessary regulation. Please contact me on (02) 6202 1000 with any queries.

Yours sincerely,

Michael Armitage

HON DR MICHAEL ARMITAGE

CHIEF EXECUTIVE OFFICER

30.1.15

Attachments: ONE: Interim Specific Comments on *Private Health Insurance (Prudential Supervision) Bill 2015*

ATTACHMENT ONE: Interim Specific Comments on *Private Health Insurance (Prudential Supervision) Bill 2015*

Part 1

4: definition of "business rules" - the Exposure Draft includes a definition of "business rules" which does not refer back to the PHI Act. It would be clearer to refer to the PHI Act, rather than create a new definition, as the Bill does for other definitions.

Part 2

12: The equivalent section in the PHI Act 2007, section 126-10(3), states "the applicant must also provide a copy of its rules to the Secretary of the Department." Where will this requirement sit in the new legislation package?

15(1): This section states that APRA may grant the application subject to such terms and conditions as APRA considers appropriate. Previously this has been based on the PHI (Registration) Rules and the ability to comply with obligations under the Act. The regulations (Act, Explanatory Memorandum or Rules) should provide more clarity on the terms and conditions APRA will expect and consider in granting applications for registration.

15(3): This section seems to be related to restricted access insurers, however this is not clear. Please clarify.

15(5): The current *PHI (Registration) Rules* set out restricted access groups for restricted access insurers. Please clarify where this will be catered for in the new legislative package.

19(3)(b): This refers to the Private Health Insurance Ombudsman. As this function is moving to the Office of Commonwealth Ombudsman. We suggest using this opportunity to update this. This also applies to section 19(6)(b).

This demonstrates the issues associated with presenting the Bills to change private health insurance regulation separately. No doubt, there will be other such issues that have not yet been discovered in the current and future proposed Bills and subordinate legislation.

Part 4

91(1): This appears to increase regulation of the industry. Div 163 of the PHI Act provides for Prudential Standards to be complied with by insurers. The proposed subsection relates to standards "that must be complied with by, or *in relation to*, private health insurers". The additional words "in relation to" are unnecessary and likely to create additional confusion – please remove them.

91(9) and 172(4): The power to make, vary and revoke standards and rules is able to be delegated to APRA staff at an executive level. This is very different from current regulation, which can only be changed by a majority decision of independent Council members, who are much more senior than executive level staff. This power should be limited to APRA members.

If you proceed with this change, please explain in the Explanatory Memorandum the reasons behind this change and how the new regulation will ensure there is a sufficient level of scrutiny of these decisions and also consultation with industry during the development/changing of standards.

92: This is a significant change and has the potential to tie up time and resources of both the regulators and industry dealing with non-material breaches. The section states that a standard is still valid whether or not APRA fails to fulfil its obligation to advise those affected. Defences

for non-compliance, however, seem to have been omitted from the Bill. Notification requirements should be inserted back into the Bill. In addition, the Bill should codify current regulatory practice and state that only material breaches of prudential standards will be punished. This will reduce both Government and industry resources tied up in dealing with non-material breaches.

94(1)(a)(i): Please insert a materiality threshold, as is the case for paragraph (ii) and elsewhere in the Bill.

96: Again, this section provides broader and more explicit directions powers. It is unnecessarily broad and unclear (further details below).

96(1)(b): This is another significant expansion of regulatory powers. APRA would be empowered to remove a director from office, including a CEO or senior management member. This is not currently possible, even when a fund is being externally managed. Please revert to the current powers.

96(1)(f): The terminology "financial accommodation" is unnecessarily vague and needs clarification. For example, does it include granting suspensions to policy cover and the waiving of waiting periods?

96(1)(g): "undertake any liability under any policy" is unclear and requires clarification. For example, private health insurers do not "undertake" liability when they assess and pay a benefit according to existing policy conditions. If APRA will have the power to direct an insurer *not* to pay benefits contractually required under its policies, then this must be stated expressly in the legislation and explained in the Explanatory Memorandum.

An APRA direction in relation to (1)(g) could contravene community rating, one of the fundamentals of the Australian private health insurance system.

103: The obligation for Directors and Officers to ensure insurers comply with regulator directions was covered under s163-20 of the Private Health Insurance Act. Under the proposed Bill these offences can now occur continually over multiple days and criminal liability has been applied without a corresponding requirement for dishonesty. Please remove the criminal penalty and ensure a one-off penalty, unless exceptional circumstances exist.

As stated above, any changes/differences should be fully explained in the Explanatory Memorandum.

Part 5

This Part is largely based on *Life Insurance Act* and brings private health insurance appointed actuaries under APRA's existing processes. This Part again appears to impose additional regulation on the industry.

Various sections of this Part compel the disclosure of information and documents without referring to the protection of legal privilege. This Part should be amended to include a specific provision to ensure the protection of legal privilege in the same manner that Part 6 includes section 149.

Part 6

126: APRA can investigate risk equalisation trust fund issues. Please provide further details in the Explanatory Memorandum of how risk equalisation will work under the new regulatory environment.

127, 128 and 131: enforcement of these sections could include imprisonment (see s147). This seems overly harsh for failure to provide information or a report in a reasonable time and should be replaced with a financial penalty.

129: The powers under this section are too broad and introduce significant uncertainty and duplication. The role of the Department of Health is to protect consumers, by overseeing portability, community rating, etc. However this section appears to expand the powers of APRA to overlap those of the Department of Health. This imposes additional, unnecessary red tape and regulation on the industry.

Subsection (1) introduces new uncertainty for insurers and seems to conflict with other legal requirements. For example, directors have a fiduciary duty to shareholders, rather than policy holders under the Corporations Law.

This power may be exercised in circumstances where APRA reasonably suspects that the affairs of the insurer are being carried on in a way "that is not in the interests of the policy holders of a health benefit fund" conducted by the insurer. This appears to contradict the following actions that are legal under the Private Health Insurance Act:

(a) alter a private health insurance product to no longer cover a particular treatment;
(b) reduce the benefits that apply under a particular product for a particular treatment;
(c) cease to offer insurance under particular products and migrate current policyholders to different products offered by the insurer (i.e., 'forced migration');
(d) make payments out of the health benefits fund in circumstances that take advantage of and comply with the conditions in subsection 137-10(5) of the PHI Act;
(e) risk-rating for health-related business comprising the insuring of persons who are not eligible persons under the Medicare regime (excluding, of course, holders of overseas student health cover policies); or
(f) changes in the non-regulated business affairs of a private health insurer, i.e., activities undertaken by the same entity that are neither health insurance business nor health-related business and which have no connection to the insurer's health benefits fund(s).

Section 129 should be altered as follows:

- introduce a materiality test;
- add a requirement that APRA suspect breaches of the Prudential Regulation Act or the PHI Act; and
- ensure that APRA discusses issues prior to commencing an investigation.

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Hon Dr Michael Armitage
CHIEF EXECUTIVE OFFICER

Ms Laura Johnson
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The Treasury
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PARKES ACT 2600

Dear Laura,

Private Health Insurance Changes

Thank you for the opportunity to comment on the latest package of proposed legislation to transfer the functions of the Private Health Insurance Administration Council (PHIAC) to the Australian Prudential Regulation Authority (APRA).

Private Healthcare Australia is the Australian private health insurance industry's peak representative body that represents 21 health funds throughout Australia and collectively covers approximately 97% of the private health insurance industry. Private health insurance today provides healthcare benefits for over 13 million Australians.

Our goal is to ensure that private health insurance members receive the best possible healthcare at the best possible prices.

Thank you for the consultation sessions that you have run to help explain the changes to the industry and your many discussions with our staff. This letter steps through the issues we raised during those meetings and discussions and some of the action items you agreed to take away.

Following review of the exposure draft material, we are keen to continue to work with you to ensure

- cost savings are fully passed on to industry and not diluted by additional implementation costs;
- regulation on the industry decreases rather than increases;
- the risk of unintended consequences are reduced, given the highly technical nature of consequential and transitional amendments; and
- all current appeal rights are maintained and ongoing appeal rights are in proportion to the proposed expanded regulatory powers in the exposure draft material.

We note in the absence of an Explanatory Memorandum to accompany the Bills it has been challenging to understand the impact of the Bills and potential flow on impacts. This results in a higher risk of unintended consequences.

Match Appeal Powers with Regulatory Powers

The number of APRA decisions that are reviewable by the Administrative Appeals Tribunal (AAT) has decreased. In the context of increased regulatory impost on industry as part of the PHIAC to APRA transition, we would argue that a decrease in AAT reviewable decisions is unfair

and inappropriate. We acknowledge that in some instances judicial review is available; however, we note this is a more costly and time consuming process than the AAT process. We suggest:

- all decisions that are currently reviewable by the AAT should continue to be fully AAT reviewable (on all grounds); and
- all NEW regulatory powers should be fully AAT reviewable (on all grounds).

Examples

- We understand that under section 95 of the *Private Health Insurance (Prudential Supervision) Bill*, APRA will be able to give certain directions to health funds where it has formed a reasonable view that one of the grounds in subsection 95(1) has been met. This replaces the current ability of PHIAC to give solvency, capital and prudential directions (sections 140-20, 143-20 and 163-20 of the Private Health Insurance Act 2007 (PHI Act)). The decision to give such a direction (or to refuse to vary or revoke such a direction) will only be reviewable by the AAT (pursuant to Items 9 and 10 in the table at section 167) if the basis for the direction was subsection 95(1)(a) to (c). The implication is that a direction given by APRA on a ground in subsection 95(1)(d) to (i) cannot be reviewed by the AAT. This narrows the scope of when such directions can be challenged when compared to the current ability to challenge directions given by PHIAC. We respectfully request that the text from "...on a ground..." to the end of the paragraph be deleted (as shown in red below). This change will restore the right for health insurers to challenge the direction irrespective of the basis for it being given.

Item	Decision	Provision under which decision is made
...		
9	to give a direction under section 95	section 95
10	to refuse to vary or revoke a direction that was given under section 95	section 98
...		

- We understand that under subsection 91(4) of the PHI(PS) Act, prudential standards can allow APRA the discretion to (among other things) adjust or exclude specific prudential requirements in relation to a specific health insurer or class of health insurers. This appears to mirror the current ability of PHIAC to make a declaration that either solvency or capital standards do not apply to a particular health insurer (see sections 140-15 and 143-15 of the PHI Act 2007). However, we cannot find an equivalent right within the PHI(PS) Act that allows a health insurer to seek an AAT review of the decision to refuse to grant such relief or to challenge any conditions imposed on such a declaration. We respectfully request that the ability to seek AAT review of such decisions be reinstated.

Reduce Regulatory Powers

The proposed legislation increases the regulatory powers of APRA, comparted to current PHIAC powers. Noting that the industry has had no failure to the detriment of members, this is unnecessary and seems to contravene the "reducing red tape" objectives behind the change.

1. APRA has been given new powers to change insurers' registration by notification. As discussed at consultation, this is inappropriate and the status quo should remain.

Schedule 2, Part 1, Division 1 of the proposed Private Health Insurance (Prudential Supervision)(Consequential Amendments and Transitional Provisions Bill 2015 gives APRA the power to vary the registration terms and conditions of the Private Health Insurer (s3(3)). At the Roundtable held on 8 April 2015, APRA clarified that the intention of this section was to "clean up" any old terms and conditions that were no longer applicable.
The current mechanism remains appropriate, whereby the onus to vary any registrations terms and conditions falls with the private health insurer.

2. We note APRA's powers have been extended beyond PHIAC's current powers regarding Rules that are not related to prudential regulation. The Minister now must consult APRA regarding health insurance Rules. There is no explanation for this additional power nor is there a corresponding right for private health insurers to be consulted.
On the other hand, we understand from our discussions with the relevant Government agencies that consultation by APRA and/or Treasury with the Health portfolio will exclusively be addressed in the Statement of Expectations and Memoranda of Understanding.
Could you please explain this difference?

3. The provision allowing PHIAC to waive the late payment penalty has been removed. However, APRA has assured us that they powers still remain. Please explain clearly in the Explanatory Memorandum where penalty waivers are now covered.

Financial Sector (Collection of Data) Act

The Bills continue to apply the Financial Sector (Collection of Data) Act ("CoD Act") to health insurers. We understood from our discussions with you previously that this would be removed, given the health insurance is not part of the financial sector. Our previous comments are attached for your information.
Health is widely acknowledged not to be part of the financial sector. As noted in our submission on the last Bill, it is inappropriate to apply the CoD Act to health insurers.

4. We remain concerned around the potential impacts in the longer term on the industry of its inclusion under the regulation of the CoD Act, particularly around the potential for a substantial increase in penalties. The penalties under the CoD Act for failure to provide information are considerably higher than those that apply under the current PHI Act, and include new custodial sentences for some offences.
We seek confirmation that the current penalties for offences around the provision of information, statistics and data to PHIAC will not be increased in any way as a result of the application of the CoD Act to the industry.

5. It looks like the CoD Act's application to private health insurers has been extended and now covers information disclosure.
This is likely to create confusion as information disclosure is covered under the Minister for Health.
Please remove this additional impost on the industry.

Collapsed Insurer Levy – Remove Additional Charges and Regulation

The legislation introduces new levies and regulation. This is contrary to the legislations objectives and should be removed.

6. Additional capacity for APRA to increase its impost on the industry by charging to administer the collapsed insurer levy. This is inappropriate given that the purpose of the changes is to reduce, not increase impost on the industry.

We understand that it is more expensive to explore other options, all of which are paid for under the current levy.
Please remove this additional cost.

7. Additional regulation can now be implemented around the collapsed insurer levy without Parliamentary scrutiny.
We note that the levy has never been applied. Therefore, it is concerning that the Bill is imposing so many additional regulations around this previously unnecessary and therefore unused levy.
Please remove the additional regulation or provide context on why such additional, new regulation is deemed necessary.

Reinstate Transparency Regarding Industry Monies

The legislation significantly reduces transparency around monies paid by the industry to APRA. We note that at our recent consultation meeting, Treasury undertook to ensure that transparency remains.

8. Section s318-5 of the PHI Act provides that proceeds from the investment of Risk Equalisation Funds are credited to the Risk Equalisation Trust Fund. However, the proposed amendments to s318-no longer require proceeds from the investment of risk equalisation funds to be credited to the risk equalisation account. Please restore crediting of proceeds from the investment of Risk Equalisation funds.
If this is not the case, please clarify in the legislation or EM how the interest will be treated.

9. Monies paid by the industry will be credited to the generic APRA Special Account.
To meet Government's objectives for the legislation, a special PHI account should be created and this account must be transparent to payers (the industry).

Reduce Costs to Industry

The Bills introduce no cost savings either for Government or the industry. However, they impose additional compliance and administrative costs on Government and the industry. This seems incongruous.

We note that significant savings will occur through PHIAC staff redundancies, Board fees, and other administrative savings.

Please reduce the industry levies, in line with the policy decision behind these Bills. Using the Government "efficiency dividend" would be a useful comparator.

Reduce Red Tape

The policy decision was to move the PHIAC functions to APRA to reduce costs and regulation. However the proposed Bill goes much further than this and proposes to regulate the private health insurance industry in line with regulation of the Australian financial services industry. APRA states that this significant increase in red tape is for "consistency" with the financial services it regulates. As an established and experienced regulator, APRA is able to differentiate between its regulated industries. PHI is already heavily regulated, more so than many other APRA-regulated industries. Regulation of PHI should not further increase.

It is important to note that the Australian private health insurance industry has had no major industry failures to the detriment of consumers. Therefore, the current regulation is working and no additional regulation is warranted. In fact, if anything, regulation should reduce NOT increase.

Please Provide an Explanation for Changes

As we noted for the PHIPS Bill, the industry continues to be concerned that there is little or no explanation for why the individual changes in the proposed Bill are thought to be necessary and how they are likely to affect the industry and its members.

Given the lack of explanation for the changes, it is unclear whether these are unintended consequences, or clear policy decisions to expand Government's regulatory powers, combined with a reduction in appeal rights for insurers being regulated. We query why an increase in regulatory power would be matched by a decrease in appeal rights?

Reduce Industry Levies

The stated purpose of the changes is to achieve cost savings. However, there is no explanation of what the expected cost savings are, or how these will be achieved. The cost of the levy on the industry will increase, due to additional levies and charges.

Complete Legislative Package

We note that time is running very short for a 1 July 2015 start date and various parts of the legislative package are still outstanding:

- provisions to ensure no changes will take effect before 1 July 2016;[1]
- explanatory memorandum to the current exposure draft documents;
- a regulatory impact statement to explain the changes and how they will affect Government administration of the industry, including costs to the industry and members and the industry's goals of providing access to the best possible care at the best possible prices;
- changes to all of the relevant *Private Health Insurance Rules*;
- full explanatory material that details the proposed changes, why they are considered necessary, how they differ from current regulation,
- updated *PHIPS Bill*, as per our discussions with the Minister's Office; and
- updated Standard Operating Procedures, invaluable tools which have greatly benefited both PHIAC and the industry. APRA has acknowledged that some of PHIAC's procedures are better than APRA's and the industry views Standard Operating Procedures are one of these better procedures.

It is very difficult to provide comments on one isolated part of this package of changes without access to the complete package.

The currently available material still does not provide details about some fundamental aspects of private health insurance industry regulation or how its regulation will be affected, including:

- premium change process – we discussed a "statement of best practice" with the Department and Minister, with in-principle agreement;
- current standard operating procedures issued by PHIAC after substantial industry consultation;
- industry analysis performed by PHIAC but not yet finalised or published;
- annual report on insurers – which has been published every year for 40 years and should be published every year by December;

[1] The Medibank prospectus, released on 25 November 2014 by the Australian Government states "As at the Prospectus Date, APRA has not determined its approach to prudential regulation of the PHI industry except that it does not intend to make any changes to the existing capital and solvency standards for private health insurers before 1 July 2016."

- state of the health funds report;
- risk equalisation;
- how the current $6.5m PHIAC surplus will be applied – noting that $6.5m is approximately twelve full months of levies on the industry; and
- reporting/industry statistics.

We asked these questions during the consultation sessions. The Treasury, the Department of Health and APRA are unable to provide clarity on these issues, as much of the necessary detail has not been finalised. It is concerning that the scope of the changes seem to not be fully comprehended by either the new nor the old regulator, just a few short months before the changes are proposed to take effect.

At the latest consultation session, the Government agencies present agreed to provide the following information. Clearly, this information is necessary for us to provide detailed feedback:

- map decisions and grounds that are currently AAT reviewable compared to proposed regime;
- map current versus proposed money paths and ensure that transparency is maintained (including what is done with interest on all monies collected, repayment mechanisms to insurers, etc); and
- ensure that current information provided to insurers and publicly are retained.

We remain concerned that the exposure draft material will result in increased industry regulation, contrary to the Government's stated objective to reduce red tape and regulation. Given that there is no proposed reduction in the levy on the industry, we query whether the proposed Bill as currently drafted will fulfil the Government's objectives.

Given that we have access to only part of the package, our current comments are interim in nature. We look forward to receiving the rest of the package of regulatory changes so that we can provide you with our full comments and feedback.

We are keen to meet with you to further discuss ways to ensure that the PHIAC to APRA legislative package reduces red tape and unnecessary regulation. Please contact me on 6202 1000 with any queries.

Yours sincerely,

Michael Armitage

HON DR MICHAEL ARMITAGE
CHIEF EXECUTIVE OFFICER

15.4.15

Attached: previous comments regarding Financial Sector (Collection of Data) Act
Technical errors

ATTACHMENT ONE - Financial Sector (Collection of Data) Act

We understand that the *Financial Sector (Collection of Data) Act* (CoD Act) will be broadened to apply to private health insurance. This is more complex than simply setting out reporting requirements under the new APRA Rules.

The CoD Act only applies to a small number of APRA-regulated sectors and currently excludes the following sectors:

- approved deposit taking institutions;
- life insurance; and
- general insurance.

In fact the CoD Act only seems to apply to finance bodies, investment banks and financial sector business subsidiaries.[2] It is inappropriate to extend this Act to private health insurance given a lack of similarities between private health insurance and the sectors regulated by the CoD Act.

Including private health insurance in the small number of sectors governed by the CoD Act appears to run counter to division of Ministerial responsibilities in the proposed Bill. Under the proposed Bill, the Treasurer (the Minister under the CoD Act) has the power to make determinations regarding prudential regulation alone for private health insurance. All other policymaking powers for private health insurance remain with the Minister for Health. However, the objects of the CoD Act (section 3) enable the collection of information to assist the "Minister to make financial policy". It seems inappropriate to empower APRA to collect private health insurance information that does not relate to the prudential regulation of private health insurers. The responsibility to collect general private health insurance information resides with the Minister for Health. Any additional powers will result in duplication and additional regulation and red tape.

References to the CoD Act should be removed from the Exposure Draft and replaced with a section stating what data the industry needs to supply. A section, rather than a whole new Act, is far simpler and involves less red tape than applying a whole new Act to the industry.

[2] http://www.apra.gov.au/NonReg/Pages/Registered-Financial-Corporations-list.aspx

ATTACHMENT TWO – Technical Errors in the PHI(PS)(CATP) Bill

During our review we identified what we believe are three typographical errors as follows:

- On page 31 of the exposure draft at paragraph 135, it seeks to insert additional bullet points (d) and (e) **after** s323-10(1A)(c) in the PHI Act. There is not currently a s323-10(1A) within the PHI Act. We are not sure what this reference should read and would appreciate your clarification on what the correct reference should read so that we can assess the impact.
- On page 36 at paragraph 160, it seeks to change a reference in the PHI(PS) Act [note we understand this is still in draft form] to the "*Legislation Act 2003*" – we were unable to find any such Act. We believe the original reference to the *Legislative Instruments Act 2003* is correct but would appreciate your clarification.
- On page 48 at section 16(**2**), it appears that subsection (c) should be moved to section 16(**3**) which deals with the Collapsed Insurer Special Purpose Account. We would appreciate if you could clarify if our understanding is correct.

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Hon Dr Michael Armitage
CHIEF EXECUTIVE OFFICER

Mr Pat Brennan
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Australian Prudential Regulation Authority
GPO Box 9836
SYDNEY NSW 2001

Dear Mr Brennan,

Private Health Insurance Changes

Thank you for the opportunity to comment on the latest batch of proposed documentation to transfer the functions of the Private Health Insurance Administration Council (PHIAC) to the Australian Prudential Regulation Authority (APRA).

Private Healthcare Australia is the Australian private health insurance industry's peak representative body that represents 21 health funds throughout Australia and collectively covers approximately 97% of the private health insurance industry. Private health insurance today provides healthcare benefits for over 13 million Australians.

Our goal is to ensure that private health insurance members receive the best possible healthcare at the best possible prices.

We note that the PHIAC-APRA transition is a "machinery of government" change with no intended impact on the industry, apart from reducing the impost on the industry.

Throughout the consultation process regarding the PHIAC-APRA transition, the industry has maintained a strong position that our preference is to retain the status quo. This position has been backed by all stakeholders, including APRA.

APRA has, however, asked for legislative changes to ensure "consistency" with other industries that you regulate. Wherever possible, and for the most part, the private health insurance industry has compromised and accepted your "consistency" positions.

Unfortunately, the drive for "consistency" with other industries regulated by APRA is likely to result in an increase in red tape for the private health insurance (PHI) industry.

PHI is a "social" not "financial" good, with very different underpinnings from other industries regulated by APRA. Unlike other industries, PHI has had NO major issues that have impacted detrimentally on consumers. In fact, a number of consumer protections provisions are inbuilt into product design and operation of private health insurance (eg community rating, portability, etc.) outside of the pure prudential framework.

We note APRA's publicly stated position that there will be "no substantive changes to the prudential standards, rules or reporting arrangements".

This letter confirms our discussions to date on the following concerns in your consultation package:

1) Data provision and confidentiality;

2) Continued AAT reviewability of prudential decisions;

3) Other; and

4) Important questions unanswered.

1 Data Provision & Confidentiality

Please provide a simple legislative provision to ensure that the regulator continues to provide detailed quarterly data provided for over 25 years to the individual health funds and Private Healthcare Australia, while ensuring this data remains confidential and unable to be the subject of any Freedom of Information requests.

The issue was introduced in the draft legislation proposed by APRA/Treasury that seeks to capture PHI data collection requirements under the Financial Sector (Collection of Data) Act.

The industry has asked for this to be changed since it was proposed in January. The industry has accepted APRA and Treasury's assurances that there will be no change to the current arrangements and that including the industry in these Acts simply allows APRA to collect data. Given these repeated assurances, it is appropriate to request that this change be removed so that the status quo can continue.

The industry wants to continue the current arrangements, which are important for transparency. For example,

- data/calculation anomalies are immediately picked up by other insurers and/or Private Healthcare Australia; and
- to provide contemporary data as requested by consumers, other regulators, Members of Parliament and others to show industry returns to members.

APRA's proposals are a fundamental change to longstanding, accepted practice (over 25 years). The Private Health Insurance Act 2007 (PHI Act) was drafted to permit existing practice to continue (with some specific exclusions that are not relevant to data provision). We believe that APRA's current interpretation of the PHI Act is overly narrow.

Please introduce a simple legislative provision to ensure this longstanding practice continues and continues to be confidential.

Please confirm that APRA will continue to publish the Quarterly Statistics, currently published at http://phiac.gov.au/industry/industry-statistics/quarterly-statistics/

2 AAT Reviewability of Decisions

The number of decisions that are AAT reviewable has decreased while regulatory powers have increased. As stated in our submissions on the exposure draft legislation, we believe that all existing decisions that are AAT reviewable should remain so and new regulatory powers should be AAT reviewable.

Treasury states that all decisions (except one) that are currently AAT reviewable remain so. However, we note that the APRA consultation package says that AAT reviewability has been removed for some decisions, including under HPS 100, 110 and 510 (proposed new solvency, capital adequacy and governance standards).

Please reinstate the current AAT reviewability of decisions made under HPS 100, 110 and 510, in line with APRA's commitment of "no substantive changes from the status quo".

Please ensure that all new prudential powers are AAT reviewable.

Please clarify how AAT reviewability could have been removed for some prudential decisions when Treasury states that all currently AAT reviewable decisions remain so.

To assist the industry to understand the proposed changes, please provide a document mapping all decisions and their review process currently and under the proposed new regime, under both the legislation, any subordinate legislation or otherwise.

3 Other issues

3.1 Additional Powers for APRA

The consultation documents state that APRA will now have the power to make 'adjustments and exclusions' to governance standards for individual insurers. This power does not currently exist for PHIAC. We understand that this power would enable additional governance standards to be imposed on an individual insurer without the need for consultation and further that such a decision would not be reviewable within APRA or by the AAT.

The discussion paper states that this change is being made because 'APRA adopts this approach in its prudential standards applying to other regulated industries and it is a valuable tool to ensure flexibility in, and proportionate application of, the prudential framework.' However, this is another fundamental change to the status quo and is likely to increase the red tape on the PHI industry.

We query how this aligns with APRA's publicly stated position that there will be "no substantive changes to the prudential standards, rules or reporting arrangements".

Please provide an explanation of the possible issues that APRA considers would warrant the inclusion of these new, additional regulatory powers.

Should you retain these additional powers, please ensure they (a) require industry input and discussion beforehand and (b) are reviewable within APRA and by the AAT.

3.2 Additional Scope for Confusion Between APRA/Health Roles

Some of the APRA Rules deal with areas that we have been informed come under the Department of Health's (DoH) responsibility. To have an area of DoH responsibility dealt with by an APRA Rule introduces unnecessary scope for confusion. We need to be careful to ensure that policy lines are clear and respected to avoid unnecessary overlap that doesn't correspond with APRA's prudential supervision role.

- Rule 15 of the disclosure standard comes under the DoH portfolio, not APRA. It specifically relates to community rating and is usually used because a policyholder is committing fraud.
- Registration Rule –now includes a criterion for registration that is worded differently to the current Rules and has a substantially different outcome to the current criteria. The criterion is:

  > APRA can be satisfied that the rules of the applicant do not permit improper discrimination in relation to the applicant's complying health insurance policies;

  This is to be contrasted with the following in the current Rules:

  > information on the application provided in writing by, or on behalf of, the Secretary of the Department, including information as to whether the applicant is likely to be able to comply with the obligations imposed by or under the Act on private health insurers.

This seems to provide APRA with a role in determining whether or not the rules of the insurer are in breach of the community rating principle set out in the PHI Act. This is clearly the responsibility or role of the Health Minister and therefore the Department of Health.

The note to the provision states that APRA will consult with DoH in relation to this matter. However, given that community rating is a clear Health responsibility, it would seem more appropriate to retain responsibility for community rating within the Health portfolio and therefore DoH should provide advice to APRA on community rating, and any other Health responsibilities.

Please revert to the wording in the current Rules.

Please remove community rating from APRA's Rules so that it remains a clear responsibility of the Department of Health.

3.3 Impost Reduction for Industry

We note that the changes are proposed to reduce the impost on the industry.

Please provide details on how the impost on industry will reduce, and how PHIAC's remaining operating surplus will be returned to industry.

3.4 Cost-Benefit Analysis Information

We note your comments in Chapter 6 of your Discussion Paper. We are concerned that the current changes are being proposed to reduce the impost on the industry but that no details of this impost reduction have been provided in the consultation documents to date. We note that Treasury regularly performs this analysis for the Government as part of the Budget and Regulatory Impact Statement processes.

Please provide your estimated cost-benefit analysis for the proposed changes.

3.5 Industry's Work on Streamlining Rules

Since 2014, the industry has been discussing with Government its proposals to streamline the Private Health Insurance Rules, to remove outdated provisions and unnecessary red tape.

We understand that the proposed legislative package has been updated to ensure that references to all Private Health Insurance-related Rules are flexible enough to accommodate these changes.

We note that APRA has introduced changes from the PHIAC Rules to introduce "consistency" with other industries it regulates.

We are disappointed that the industry's work has not been included in the current Rule changes, in particular quick, easy red tape reductions. For example, it would be quick and easy to remove double notification requirements to separate Government agencies in different formats/timeframes. Further information on double notification requirements is in Attachment Two.

We look forward to progressing this work with APRA at the earliest available opportunity.

We seek a commitment that APRA will seek to implement this important work by 31 March 2016.

3.6 Changes from PHIAC Standards

The APRA Rules have introduced changes from the PHIAC Standards. It is unclear whether the changes are policy decisions or simple oversights. I have listed these below.

First, in the Governance Standard HPS 510, APRA have introduced a new adjustment and exclusions power (s46) (a similar power does not appear in the PHIAC Governance Standard). However, in the Disclosure, Actuaries and Outsourcing Standard, APRA has kept the PHIAC wording of "exemptions and modifications". This creates an inconsistent wording of the power across the standards.

We note that the adjustment and exclusions power in HPS 510 refers to a "regulated institution", where elsewhere in the Standard, "private health insurer" is used.

Please provide an explanation for why these changes were thought necessary and remove the identified inconsistencies.

Secondly, the proposed new Governance Standard has taken the example objectives for Board performance assessment from the PHIAC standard and made them into numbered sections (see s31 and s32 of HPS 510).

Under the PHIAC Governance Standard, these examples were for guidance only, and not enforceable as they were not a formal part of the instrument. Given they are now numbered sections under HPS 510, their status as guidance material only may have changed.

Please ensure that the examples retain their "guidance" nature.

On the other hand, the example under s22 of HPS510 has not been numbered. We don't understand the reason for this inconsistency, or is it a simple oversight?

Please provide an explanation how this operates.

Thirdly, the new PHI (Risk Equalisation Administration) Rules do not specifically detail risk equalisation jurisdiction rules. This area was captured previously under Section 5 of the outgoing PHI (Health Benefit Fund Administration) Rules 2007.

Please clarify where the governing authority for risk equalisation jurisdictions will now be found.

We assume that they will be covered now under the Department of Health's updated Private Health Insurance Rules. Could you please advise us when we will see, and be provided with the opportunity to provide feedback on, this important part of the proposed legislative change package?

Fourthly, the "Part 3 – Transition" section within APRA's draft Private Health Insurance (Risk Equalisation Administration) Rules. The current rules as detailed by Part 3 of the outgoing Private Health Insurance (Health Benefit Fund Administration) Rules 2007 refer to quarterly returns and the requirement pertaining to both the form of these reports, as well as independent audit requirements.

However, the definition of "Quarterly Return" within the new rules now refers to the Financial Services (Collection of Data) Act 2001.

Please confirm that, as stated within Part 3 – Transition, the quarterly returns and independent audit process will remain as is.

4 Important Questions Unanswered

The current exposure material does not provide details about some fundamental aspects of private health insurance industry regulation or how its regulation will be affected. These include the following issues.

4.1 Premium Change Process

The annual premium change process is another area that differs significantly from other APRA-regulated industries. The process begins around August each year, ahead of an announcement before March.

The premium change process is a significant part of the current operation of private health insurers and it is vital that the industry understands exactly how this process will be managed going forward, including for the 2015/16 year.

This uncertainty is likely to increase compliance costs for the industry, impacting premiums.

We would like to understand how the system will be administered/managed going forward, noting the fundamental differences between health (a social good) and the financial goods that APRA currently regulates.

Our understanding is that the Department of Health will undertake this process. Please confirm so that we can request further details from DoH regarding the 2016 premium setting process and beyond.

4.2 Standard Operating Procedures

The Standard Operating Procedures (SOPs) were drafted by PHIAC in consultation with the industry and provide the following benefits:

- reduce confusion; and
- increased goodwill between the regulator and the industry.

The SOPs detail how conflicts will be dealt with by the regulator.

We note that APRA has stated the SOPs align with its enforcement approach. Given these parallels, it should be a simple process for APRA to update the SOPs and/or map them to its proposed approach.

Please provide the proposed new process for dealing with regulatory issues and a map of how the SOPs align with APRA's proposed approach.

Any attempt to remove/not update the SOPs introduces unnecessary confusion.

The industry has a strong preference to continue using the SOPs, as they have been a useful and successful regulatory tool.

4.3 Risk Equalisation

Risk Equalisation is an important support for community rating, which underlies the Australian private health insurance system. It deals with large amounts of money on a quarterly basis. It differs significantly from other APRA-regulated industries.

We would like to understand how the system will be administered/managed going forward, including how insurers will continue to be given the appropriate data to:

- benchmark and understand risk equalisation outcomes; and
- note if it is out of kilter with the rest of the industry on a State-by-State and quarter-by-quarter basis (may indicate eg data/business issues).

Please provide details on how this will be managed going forward.

4.4 Any Industry Analysis Performed By PHIAC But Not Yet Finalised Or Published

We note that PHIAC engages in a considerable amount of industry analysis and not all of this has been finalised or published.

Please provide details on what will be done with this industry analysis.

We remain concerned that the exposure draft material will result in increased industry regulation, contrary to the Government's stated objective to reduce red tape and regulation. Given that there is no proposed reduction in the levy on the industry, we query whether the proposed documentation as currently drafted will fulfil the Government's objectives.

Given that we have access to only part of the package, our current comments are interim in nature. We look forward to receiving the rest of the package of regulatory changes, including DoH's proposed Rule changes, the updated APRA documents and the final draft legislation, so that we can provide you with our full comments and feedback.

We are keen to meet with you to further discuss ways to ensure that the PHIAC to APRA legislative package reduces red tape and unnecessary regulation. Please contact me on 6202 1000 with any queries.

Yours sincerely,

Michael Armitage

HON DR MICHAEL ARMITAGE
CHIEF EXECUTIVE OFFICER
18.5.15

Attachment One: Data – More Information
Attachment Two: Double Notification Requirements
Cc: Martin Codina, Chief of Staff for the Assistant Treasurer
Martin Bowles PSM, Secretary, Department of Health
John Fraser, Secretary, Treasury

ATTACHMENT ONE: Data – More Information

PHIAC has provided industry data back to the industry for benchmarking and monitoring purposes around Risk Equalisation (formerly known as reinsurance) for over 25 years.

Data Uses

The funds and Private Healthcare Australia use the data to:

- understand, benchmark and estimate risk equalisation outcomes;
- estimate trends in the drivers of quarterly risk equalisation payments (which can vary greatly depending on system issues in the big insurers);
- respond effectively to consumer, media and MP enquiries;
- inform epidemiological research within industry in the pursuit of efficacious quality healthcare;
- protect consumers of private health insurance;
- rapidly identify any data quality anomalies; and
- rapidly identify formula/calculation errors the regulator may have made.

Private Healthcare Australia compiles the data to provide consumers and health funds with key industry statistical information, including:

- hospital benefits and out of pocket per person/episode;
- breakdown of hospital treatment costs;
- breakdown of ancillary treatment costs;
- trends in chronic disease management programs;
- trends in policies with co-payments and exclusions; and
- trends in extras/ancillary benefits and out of pocket.

Data Content

- membership and benefits paid by private health insurers and details on key membership, utilisation, benefit and financial statistics on a quarterly basis;
- number of insured persons for hospital treatment and general treatment and the proportion of the population these persons represent, on both a quarterly and an annual basis, including hospital treatment by age cohort;
- data on in-hospital medical services - the proportion of services for which there was no gap or known gap and the average gap payment by State;
- data on prosthetic benefits paid by private health insurers by major prosthetic category;

- data on services, benefits paid and gap payments by MBS Specialty Block Groupings for medical services paid by private health insurers; and
- statistical trends in membership and benefits paid in two separate publications that detail trends since September 1997 in the number of insured persons and benefits paid for hospital and general treatment.

More Information

PHIAC collects four quarterly returns:

- PHIAC1 on membership and benefits paid;
- PHIAC2 on financials and capital adequacy;
- PHIAC3 prostheses stats; and
- PHIAC4 medical-service statistics.

PHIAC publishes:

- PHIACA state/national aggregates from the P1 template;
- PHIACB regurgitated PHIAC1 sets - only to insurers, with insurer-v-industry benchmarking;
- PHIAC3 state/national aggregates from the P3 template (very close);
- PHIAC4 state/national aggregates from the P4 template;
- National last-4-quarters financial performance and prudential position (as part of quarterly statistics);
- Insurers also get a financial statistical report analysis of performance across the last five quarters against rest, size peers, access peers; and
- Membership stats on policies and persons by HT/GT by state/national.

ATTACHMENT TWO: Double Notification Requirements

	Notifications Required
Notify of a change in CEO or contact details	**HPS350 – Disclosure** Rule 8(d) requires ASIC Form 484 to be lodged with APRA. This form contains the details of the change in CEO/contact details **Timing**: Immediate/At same time as lodging the form with ASIC
	Private Health Insurance (Prudential Supervision) Rules Part 5 Rule 16 Requires change in CEO or contact details to be notified to APRA on an APRA Form (assuming it will be the rebadged PHIAC form. Qualifications/Skills and Experience need to be attached to the form. This detail is not included in the ASIC form **Timing**: Within 28 days of the change
Notify of a change in Director or Contact details	**HPS350 – Disclosure** Rule 8(d) requires ASIC Form 484 to be lodged with APRA This form contains the details of the change in CEO/contact details **Timing**: Immediate/At same time as lodging the form with ASIC
	Private Health Insurance (Prudential Supervision) Rules Part 5 Rule 16A Requires change in CEO or contact details to be notified to APRA on an APRA Form (assuming it will be the rebadged PHIAC form. Qualifications/Skills and Experience need to be attached to the form. This detail is not included in the ASIC form **Timing**: Within 28 days of the change