Private health insurance reforms: Summary

The Minister for Health, the Hon Greg Hunt MP, announced a series of reforms to private health insurance on 13 October 2017 to make private health insurance simpler and more affordable for Australians. These included:

- requiring insurers to categorise products as gold/silver/bronze/basic, and use standardised definitions for treatments to make it clear what is and isn't covered in their policies;
- upgrading the privatehealth.gov.au website to make it easier to compare insurance products, and allowing insurers to provide personalised information to consumers on their product every year;
- boosting the powers of the Private Health Insurance Ombudsman and increasing its resources to ensure consumer complaints are resolved clearly and quickly;
- reducing the benefits paid for implanted medical devices under an agreement with the Medical Technology Association of Australia;
- requiring insurers to allow people with hospital insurance that does not offer full cover for mental health treatment to upgrade their cover and access mental health services without a waiting period on a once-off basis;
- allowing insurers to discount hospital insurance premiums for 18 to 29 year olds by up to 10 per cent, with the discount phasing out after people turn 40;
- allowing insurers to expand hospital insurance to offer travel and accommodation benefits for people in regional and rural areas that need to travel for treatment;
- increasing the maximum excess consumers can choose under their health insurance policies for the first time since 2001.
- preventing insurers from offering benefits for a range of natural therapies, such as Bowen therapy or Rolfing;
- continuing to support private hospitals, including transferring administration of the second tier default benefit, which provides a safety net for consumers attending non-contracted hospitals, to the Department of Health.

The government will work with the medical profession on options to improve the transparency of medical out-of-pocket costs, and establish committees to review funding methodologies for rehabilitation care and day-only mental health care to ensure that insurers fund the most efficient models of care. The issue of private patient patients in public hospitals will be considered as part of the next National Health Agreement to be negotiated in 2018.

Fact sheets providing further information on each of these reforms are available.

Private health insurance reforms: Gold/Silver/Bronze/Basic product categories

A new system for categorising health insurance products will be introduced in 2019

- Private health insurance products will be simplified for consumers through the creation of easily understood categories of cover.
- There will be four categories of hospital products – Gold, Silver, Bronze and Basic – and three categories of general treatment (extras) products – Gold, Silver and Bronze. Where insurers offer combined hospital and general treatment products, separate ratings will apply to each component of the product.
- These product categorisation arrangements will take effect from 1 April 2019.
- Minimum requirements for each category of cover will be finalised during 2017–18 in consultation with industry and the Private Health Ministerial Advisory Committee.

Why is this important?

- Private health insurance is an important issue to many Australians, with 55 per cent of the population covered by some form of health insurance.
- The Government's private health insurance consultations revealed that consumers find health insurance products complex and difficult to understand.
- Consumers face considerable difficulty trying to compare private health insurance products. They also find it difficult to understand what services different products do, and do not, cover.

Who will benefit?

- The new product categories will provide consumers with greater certainty about the services covered by each type of product.
- The changes will make it easier to shop around and compare different products and find a product that meets their needs.

How much will this cost?

Funding of $2.5 million has been allocated over three years (2017–18 to 2019–20) to support the development and introduction of the new product categories, and to establish an expert committee to examine opportunities to address low value and inefficient care. Further information on the expert committee is included in a separate fact sheet.

What impact will this change have on private health insurance?

This change is designed to help consumers compare different products more easily and shop around for a better deal.

Private health insurance reforms: Supporting mental health

Enhanced mental health support will be introduced in 2018 to improve patient access to mental health services

- The Government will introduce changes to make it easier for policy holders to access mental health services when they need it.
- Patients with limited mental health cover will be able to upgrade their cover to access in-hospital mental health services without serving a waiting period. Policy holders will only be able use this exemption from the existing two month waiting period once.
- So-called 'Benefit Limitation Periods' sometimes applied for mental health cover will also be removed.
- The enhanced arrangements will take effect from 1 April 2018.

Why is this important?

- Private mental health services are highly valued by people, particularly by younger people. However, most basic and medium level hospital products provide limited cover for mental health services.
- Patients with these products who require overnight or multi-day care in a private hospital for a serious mental health condition will usually face large out-of-pocket costs. Waiting periods for upgrading cover can prevent patients from accessing timely care.
- The waiting period exemption will make it easier for patients to access care when they most need it, without facing substantial out-of-pocket costs.

Who will benefit?

- Patients with basic or medium level hospital cover products will benefit by being able to upgrade their cover and immediately access in-hospital mental health services.

How much will this cost?

These changes do not involve any cost to the Budget.

What impact will this change have on private health insurance?

These changes are very important for people at risk of mental illness, particularly younger people.

Private health insurance reforms:
Expert committee on addressing low value care

An Expert Committee will be established to examine opportunities to address low value care funded by private health insurance

- The Expert Committee on Addressing Low Value Care will provide advice to Government on options to eliminate or replace admitted mental health and rehabilitation services which deliver low value or inefficient care.
- The Committee will comprise consumers, clinical experts and representatives from the health insurance and private hospital sectors.
- It is expected that the issues and options identified by the Committee may extend beyond mental health and rehabilitation to other clinical areas which have admission rates that are higher than clinically necessary or inefficient.
- The Committee will be established in late 2017.

Why is this important?

- There is evidence to suggest that the existing funding arrangements for private health insurance provide inappropriate incentives for patients to be admitted to hospital for mental health and rehabilitation services when it may be more clinically appropriate and efficient to deliver services in a non-admitted or community based setting.
- This adds to the cost of care and leads to higher private health insurance premiums.

Who will benefit?

- The elimination or replacement of admissions that deliver low value or inefficient care will help to deliver better standards of care to patients. It will also generate savings which will lower premium increases for policy holders.

How much will this cost?

Funding of $2.5 million has been allocated over three years (2017–18 to 2019–20) to establish the Expert Committee and to support the development and introduction of the new product categories. Further information on new product categories is included in a separate fact sheet.

What impact will this change have on private health insurance?

This change will support the Government in considering future reforms to provide improved care to Australians with private health insurance.

Private health insurance reforms: Standard clinical definitions

A new list of standard clinical definitions will be introduced in 2019

- Private health insurers will be required to use standard clinical definitions across all of their documentation and across all platforms.
- The Clinical Definitions Working Group, established by the Private Health Ministerial Advisory Committee, has developed a list of standard clinical definitions which is consumer-friendly, easy to understand and designed to cover all services.
- Consumer testing in 2017–18 will ensure that the list of clinical definitions is appropriate for use by consumers before implementation on 1 April 2019.

Why is this important?

- The Government's private health insurance consultations revealed that a key concern for consumers was product complexity and poor understanding of private health insurance products.
- Introducing standard clinical definitions for both inclusions and exclusions will assist consumers in making an informed choice about private health insurance and what services different products do, and do not, cover.

Who will benefit?

- The new standard clinical definitions will assist consumers in knowing their own products and being able to compare and understand different health insurance policies.

How much will this cost?

Funding of $0.46 million has been allocated over four years (2017–18 to 2020–21) to support the development of standard clinical definitions before implementation, and for an independent review committee to review the list to ensure the clinical definitions remain relevant and effective.

What impact will this change have on private health insurance?

This change is designed to help consumers compare more easily different products and understand what they are, and are not, covered for.

Private health insurance reforms: Improved access to travel and accommodation benefits for regional and rural Areas

Travel and accommodation benefits can be offered under hospital cover from 2019

- Insurers will be able to offer travel and accommodation benefits under hospital cover instead of only under general treatment policies.
- This change allows travel and accommodation benefits to be included in risk equalisation calculations, providing an incentive for insurers to offer these benefits as it will allow them to better spread their risk.
- It will not be mandatory for private health insurers to offer travel and accommodation benefits.
- These arrangements will take effect from 1 April 2019.

Why is this important?

- Many consumers living in regional and rural areas believe that private health insurance provides lower value for money compared with urban consumers due to lack of available services.
- Currently around half of all private health insurers offer benefits for travel and accommodation for members who must travel to access medical services. Generally, travel and accommodation are only claimable by members with top level general treatment (extras) cover and the benefits offered are minimal.
- Improving transport and accommodation benefits will provide a direct benefit to people living in regional and rural Australia who need to travel to access treatment that is not available in their local region.

Who will benefit?

- This will improve the value of private health insurance products for regional and rural consumers.
- This will benefit regional and rural patients and their carers who need to travel for hospital treatment undertaken away from home.

How much will this cost?

There is no financial impact as a result of this measure.

What impact will this change have on private health insurance?

This change is designed to improve the value of private health insurance for consumers in regional and rural Australia.

Private health insurance reforms: Strengthening the powers of the Private Health Insurance Ombudsman

The Private Health Insurance Ombudsman's role will be expanded, strengthening its ability to protect consumers' interests

- The Private Health Insurance Ombudsman (PHIO) will be able to conduct inspections and audits of private health insurers to ensure they meet their regulatory obligations in relation to private health consumers.
- Investigators will focus on verifying customer activity records and addressing complaints by consumers in respect of private health and private hospital contractual arrangements, including prostheses.
- Under this measure an additional six staff will be employed by the PHIO in investigatory roles.

Why is this important?

- In most cases, health insurers voluntarily provide full records to the PHIO in order to investigate complaints. However, there are some instances where further investigation reveals additional records such as phone calls or letters and emails have previously been overlooked by insurers in responding to the PHIO.
- By being able to access a health insurer's records directly within their premises, investigation officers will be able to assure themselves that an insurer is not overlooking records in responding to the PHIO.
- The PHIO will also be able to provide assurance to complainants that they are able to verify the accuracy of the information provided by insurers to the PHIO and not rely solely on the health insurer to respond to the PHIO without making a mistake.
- The government will seek to work in cooperation and partnership with the sector as an overarching principle.

Who will benefit?

- This will benefit all private health insurance consumers.
- The PHIO's expanded role strengthens its ability to protect consumers' interests.

How much will this cost?

Six additional inspectors will be employed to undertake the inspection, audit and other functions at a cost of $1.1 million per annum. The additional staff and activity will be funded through an increase to the Private Health Insurance Complaints Levy, paid by industry.

What impact will this change have on private health insurance?

This change is designed to strengthen the PHIO's ability to protect consumers' interests.

Private health insurance reforms: Out-of-pocket costs

An expert committee will be established in 2017 to consider best practice models for transparency of out-of-pocket costs

- The Government will establish an expert committee to ensure a collaborative approach in determining the best model to make information on out-of-pocket costs charged by doctors more transparent and to help consumers with private health insurance better understand out-of-pocket costs.
- The committee will consist of experts representing medical craft groups, insurers and consumers.

Why is this important?

- Out-of-pocket costs have been a long-standing concern for private health insurance policy holders. While 86 per cent of services are covered under 'no' or 'known' gap arrangements, 14 per cent of services incur out-of-pocket costs not covered by insurers.
- One in seven patients is required to pay out-of-pocket costs which are often large and unexpected. For example, the average out-of-pocket cost for spine surgery is $2,250 and for brain surgery is $1,500.
- Patients often incur multiple out-of-pocket costs. For example, the medical procedure may require a surgeon, assistant surgeon and anaesthetist who each bill the patient separately.

Who will benefit?

- Making doctors' out-of-pocket costs more transparent will allow consumers to compare doctors' fees more easily and make an informed choice knowing the expected out-of-pocket costs.

How much will this cost?

Funding of $1.1 million has been allocated over three years (2017–18 to 2019–20) to establish an expert committee to consider best practice models for transparency of out-of-pocket costs.

What impact will this change have on private health insurance?

This change is designed to improve consumers' understanding of private health insurance and its value to them.

Private health insurance reforms: Information provision

Upgrade to the Government's website – privatehealth.gov.au – the development of a minimum data set for consumers and making private health insurance product data publicly available

- The Private Health Insurance Ombudsman (PHIO) website privatehealth.gov.au will be redeveloped to improve the assistance it provides consumers to choose a private health insurance product that best meets their needs.
- A minimum data set will replace the current Standard Information Statement (SIS) as the regulated method by which insurers provide information to consumers.
- With the introduction of a new minimum data set, regulation regarding provision of this information (referred to in current legislation as the Standard Information Statement) will be made technology neutral to reflect how consumers access information. This means that as well as post mail-outs, consumer information can also be provided via email, as a hyperlink and on the insurer's member portal, as long as it is provided according to the regulated timeframes in a form agreed by the consumer.
- Product data provided by insurers to the PHIO for use on privatehealth.gov.au will be made publicly available in a consolidated and downloadable format.
- It will be optional for insurers to provide consumers with a Private Health Insurance Statement, which provides information on the amount of premium paid for the policy during a financial year and the amount (if any) under the premium reduction scheme. Regulation will require the statement to be provided to a consumer on request.
- Insurers will be able to provide the annual Lifetime Health Cover Statement with the premium change communication instead of as a separate item.

Why is this important?

- Consultations conducted by the Department of Health in 2015 revealed that a key concern for consumers related to product complexity and poor consumer understanding of private health insurance products.
- Consumers will have a choice in how they receive information as insurers will be able to use the minimum data set in whichever format the consumer prefers. The information can be tailored to individuals, which will be more meaningful for consumers.
- Providing access to private health insurance product data will allow brokers to provide consumers with advice on products across all health funds.

Who will benefit?

- The redevelopment of privatehealth.gov.au will enhance its functionality and help consumers to choose the best private health insurance product for their health needs by making it easier to compare multiple products.

- These regulatory changes to how information is provided (including replacing the SIS with a minimum data set requirement) allow insurers the flexibility of providing product information to consumers in a variety of formats so that consumers are able to select how they receive information.
- Making private health insurance product data publicly available in a flexible format will benefit consumers who choose to use a broker when looking to purchase private health insurance.

How much will this cost?

- The PHIO website will cost $1.04 million in 2018-19 for redevelopment, including consumer focus testing, user acceptance testing and developing the comparator functionality. Ongoing maintenance of the website will cost $200,000 per annum from 2019-20. The website upgrades will be funded through an increase in the Private Health Insurance Complaints Levy, paid by industry.
- These costs are mitigated by the removal of the regulatory requirement for insurers to mail out the SIS, the Lifetime Health Cover Statement and the Private Health Insurance Statement. One large insurer estimated that it spends around $1 million in administration costs on its annual SIS mailout. The savings to the industry of not having to mail out the SIS annually has been estimated by hirmaa to be in excess of $8 million. The savings to insurers of not having to mail out the Lifetime Health Cover Statement and the Private Health Insurance Statement would be similar to the annual savings of not mailing out the SIS.

What impact will this change have on private health insurance?

This change is designed to strengthen consumer information.

Private health insurance reforms: Discounts for 18 to 29 year olds

Insurers will be supported to make private health insurance more affordable for young Australians

- From 1 April 2019, insurers will be able to offer discounted private hospital cover to people aged 18 to 29. Legislation currently prevents insurers from offering premium discounts to people on the basis of their age.
- Insurers will be able to offer premium discounts on hospital cover of up to two per cent for each year that a person is aged under 30, to a maximum of 10 per cent for 18 to 25 year olds.
- These discounts will be gradually phased out once a policy holder turns 40.

Why is this important?

- Private health insurance provides consumers with greater choice in the provision of treatment, access to shorter waiting times, and coverage for some services not funded by Medicare.
- Younger Australians, particularly those under the age of 30, have far lower rates of private health insurance participation than most other age groups. This means that many young people are currently missing out on the benefits of private health insurance.
- The viability and sustainability of the private health insurance system relies on a broad membership base. Encouraging more young people to take out private health insurance will benefit everyone.

Who will benefit?

- This will help to improve the affordability of private health insurance for young Australians, increasing their access to private hospital services.

How much will this cost?

Lower premiums will encourage more young Australians to purchase private health insurance. With lower premiums, taxpayers will save $16 million over four years on the Private Health Insurance Rebate.

What impact will this change have on private health insurance?

Premiums for hospital cover for young Australians will be up to 10 per cent cheaper.

Private health insurance reforms: Prostheses List benefit reductions

Reductions in minimum benefits for prostheses paid by private health insurers will commence on 1 February 2018

- Minimum benefits payable for almost all medical devices listed on the Prostheses List will be reduced on 1 February 2018 (reductions vary by category).
- The 2018 round of benefit reductions is estimated to save private health insurers $188 million on prostheses expenditure in the 2018 premium year.
- Further reductions to some devices' benefits will also occur on 1 February 2019 and 1 February 2020.
- Total estimated savings to private health insurers over the next four premium years (2018 to 2021) are more than a billion dollars.

Why is this important?

- Expenditure on prostheses accounts for 14 per cent of private health insurance hospital benefits paid annually.
- Evidence suggests that Prostheses List benefits are generally inflated when compared to the equivalent prices paid for devices in the public sector.
- Reducing prostheses expenditure places downward pressure on premium increases.

Who will benefit?

- Private health insurers will benefit from reduced expenditure on prostheses.
- Consumers will benefit from lower private health insurance premium increases.

How much will this cost?

Prostheses List benefit reductions will result in a small saving to Government through a reduction in expenditure by the Department of Veterans' Affairs, which uses Prostheses List benefits as the basis for its benefit payments.

What impact will this change have on private health insurance?

These benefit reductions are expected to flow to consumers in reduced private health insurance premium increases. Private health insurers have publicly stated that every $200 million in prostheses benefits reductions will decrease private health insurance premiums by one per cent.

Private health insurance reforms: Agreement between the Government and the Medical Technology Association of Australia

A compact to support sponsors and suppliers of medical devices by committing to maintain Prostheses List benefits for a period of four years and implementing process improvements by:

- improving time to market by reducing the evidence requirements for some devices and increasing listings on the Prostheses List from two to three times a year;
- assessing the expansion of the Prostheses List to include non-implantable devices such as high-cost cardiac catheters;
- continuing the reforms under the Prostheses List Advisory Committee's (PLAC) reform work with major reforms to commence from 1 February 2022; and
- establishing a $30 million med-tech and biotech grants program for small to medium size enterprises (SMEs) and researchers who partner with SMEs for activities that support the development of new and innovative device technologies, clinical trials and associated registries, researcher exchanges and workforce development.

Why is this important?

The Agreement outlines the medical devices industry's commitment to:

- support the affordability of private health insurance by rebalancing the costs of medical devices to privately insured patients; and
- participate in and support the collaborative work with the Government and the PLAC to develop a world-class, evidence-based and value-based reimbursement process for medical devices.

Who will benefit?

- Consumers will benefit from lower private health insurance premium increases.
- The medical devices industry benefits from sector stability and sustainability, along with improved time to market and improvements in the transparency and efficiency of the prostheses listing arrangements.

How much will this cost?

Improvements to the web-based Prostheses List Management System (PLMS) to support faster application processing, will cost approximately $2.6 million.

Developing a framework for setting benefits on the Prostheses List into the future, based on evidence of their cost effectiveness and prices in other markets and improving processes to achieve this, will cost approximately $1.2 million.

Innovation support will be delivered through the Medical Research Future Fund.

What impact will this change have on private health insurance?

The Prostheses List benefit reductions that are part of the Agreement (see separate fact sheet) will result in reduced private health insurance premium increases.

Private health insurance reforms: Increasing maximum excess levels

Consumers will be able to choose higher excesses to lower the premiums they pay for private health insurance

- The Government will increase permitted excess levels, allowing consumers to choose products with higher excesses in return for lower premiums.
- Maximum permitted excesses for private hospital insurance will be increased from $500 to $750 for singles and from $1,000 to $1,500 for couples/families.
- Private health insurers will be permitted to offer products with the new higher excesses from 1 April 2019.
- There is no requirement for consumers to move to products with higher excesses.

Why is this important?

- More than 80 per cent of people with hospital cover already choose products with excesses.
- Excesses have been limited to $500/$1,000 since the year 2000.
- Insurers will be permitted to offer products with higher excesses, providing consumers with greater choice.
- Increasing excess levels will place downward pressure on premium price increases.

Who will benefit?

- Consumers will have the opportunity to purchase a higher excess product in exchange for lower premiums.

How much will this cost?

It is expected that more affordable private health insurance will encourage more people to take out cover. This increased participation will result in $8 million expenditure over four years on the Private Health Insurance Rebate.

What impact will this change have on private health insurance?

This change will contribute to reducing private health insurance premium price increases.

Private health insurance reforms:
Removing coverage for some natural therapies

Private health insurance will no longer cover some natural therapies from 2019

- Cover for the following natural therapies will be removed from all private health insurance products: Alexander technique, aromatherapy, Bowen therapy, Buteyko, Feldenkrais, herbalism, homeopathy, iridology, kinesiology, naturopathy, Pilates, reflexology, Rolfing, shiatsu, tai chi, and yoga.
- Consumers can still choose to access these services, but they will not be able to claim benefits from their insurer.
- This change will take effect from 1 April 2019.

Why is this important?

- A review undertaken by the former Commonwealth Chief Medical Officer found there is no clear evidence demonstrating the efficacy of the listed natural therapies.
- Removing coverage for the listed natural therapies will ensure taxpayer funds are expended appropriately and not directed to therapies lacking evidence.

Who will benefit?

- Around 55 per cent of the Australian population is covered by general treatment (extras) insurance. Removing coverage for the listed natural therapies will remove costs from the system and contribute to reducing private health insurance premium growth.

How much will this cost?

These changes do not involve any cost to the Budget.

What impact will this change have on private health insurance?

This change will contribute to reducing private health insurance premium price increases.

Private health insurance reforms: Second Tier administrative reforms

Simplified administration and improved transparency and consistency of second tier default benefit arrangements

- The Government will make a number of administrative improvements to the second tier default benefit arrangements to streamline processes and reduce the administrative burden on both private hospitals and health insurers.

Why is this important?

- The current second tier arrangements are complex and administratively burdensome for both private hospitals and health insurers.

Who will benefit?

- Private hospitals and health insurers will benefit from a reduced administrative burden associated with the second tier arrangements.
- From 1 January 2019, private hospitals will be able to apply directly to the Department of Health for recognition that they are eligible for second tier default benefits. This will replace the existing industry-based second tier advisory committee. The length of a private hospital's second tier eligibility approval will also be increased to align with the hospital's independent hospital accreditation cycle.
- Private hospitals will also have confidence that hospitals are grouped consistently for the purpose of calculating and paying second tier benefits.
- The Department of Health will also work with the Australian Commission on Safety and Quality in Health Care, the Australian Institute of Health and Welfare and the private health insurance and private hospital sectors to further streamline second tier administrative arrangements.

How much will this cost?

Private hospitals choosing to apply for second tier eligibility will pay an application fee to cover the cost of assessing their application. There will be additional small net cost to government of $0.5 million over 4 years to implement and manage the overall improvements to the second tier administrative arrangements.

What impact will this change have on private health insurance?

This change will improve the administrative efficiency of the second tier process without compromising the protection it provides to consumers attending out-of-contract hospitals.

Private health insurance reforms: Private patients in public hospitals

The impact of privately insured patients in public hospitals will be considered in the broader National Health Agreement context, to ensure the best outcome for a sustainable balance between public and private health systems.

- The government is consulting with the community on options to better support patient access to public hospitals. Options related to privately insured patients in public hospitals will be discussed with jurisdictions as part of the negotiations for the next National Health Agreement.

Why is this important?

- The Australian Government is committed to ensuring a sustainable balance between our public and private health systems.
- The use of private health insurance by patients in public hospitals has increased significantly in recent years, apparently driven by state and hospital policies to encourage patients to use their private health insurance to increase hospital own source revenue.
- Growth in the number of patients utilising their insurance in public hospitals over the last five years has contributed about 0.5% a year to premium increases.

Who will benefit?

- Patient's rights will continue to be protected and respected when it comes to their choice to elect to access public hospital services as a public patient, free of charge, or choose to be treated as a private patient in a public hospital.
- The premiums paid by people holding private health insurance may decrease if options agreed on reduce the number of privately insured patients in public hospitals.
- The rights of doctors' to treat privately insured patients in public hospitals will be supported.

How much will this cost?

Funding will be discussed and finalised as part of the National Health Agreement negotiations.

What impact will this change have on private health insurance?

Any changes to patients using their private health insurance in public hospitals will seek to continue the sustainability of the public and private health systems. It is important that any actions taken by one part of the system does not inappropriately change the balance and inadvertently disadvantage patients and other parts of the system.

Private health insurance reforms: Support for private hospitals

Improved arrangements to support private hospitals

- As part of the reform package the Government will make a number of administrative improvements to the second tier default benefit arrangements to streamline processes and reduce the administrative burden on both private hospitals and health insurers.
- The Private Health Insurance Ombudsman will look into and advise the Government of complaints made on an individual basis arising from disputes between prostheses suppliers and hospitals that affect privately insured patients.
- The Government will continue discussions with the jurisdictions on the issue of the privately insured patients in public hospitals and it will also be considered in the broader National Health Agreement context.

Why is this important?

- Private hospitals provide an important and valuable part of Australia's overall health care system. The Government's reforms will support private hospitals as they address private health insurance affordability and participation.

Who will benefit?

- Private hospitals and health insurers will benefit from a reduced administrative burden associated with the second tier arrangements.
- Private hospitals will also have confidence that hospitals are grouped consistently for the purpose of calculating and paying second tier benefits.
- Consumers will benefit from the Private Health Insurance Ombudsman's increased powers to investigate private health and private hospital contractual arrangements, including prostheses.
- The Government will continue working with the jurisdictions around the issue of private patients in public hospitals as growth in the number of patients utilising their insurance in public hospitals over the last five years has contributed about 0.5% a year to premium increases. This will benefit consumers, private hospitals and health insurers.

How much will this cost?

Private hospitals choosing to apply for second tier eligibility will pay an application fee to cover the cost of assessing their application. There will be additional small net cost to government of $0.5 million over 4 years to implement and manage the overall improvements to the second tier administrative arrangements.

The new arrangements for the Private Health Insurance Ombudsman will be funded through an increase to the Private Health Insurance Complaints Levy, paid by industry.

What impact will this change have on private health insurance?

This package of reforms addresses private health insurance affordability and participation which will provide stability to the private health system