Private Mental Health Consumer Carer Network (Australia) Limited
engage, empower, enable choice in private mental health

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The Hon Greg Hunt MP
Minister for Health,
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Parliament House
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Sent via Email: Greg.Hunt.MP@aph.gov.au

Dear Minister Hunt,

Our Network represents Australians who have private health insurance or who receive their treatment and care from private and office based settings for their mental illnesses or disorders and also represent their carers**.** We have over 1,000 members around Australia.

As our title implies, the Network is the representative voice for consumers and carers in private mental health settings. We have a high level of knowledge about consumer and carer concerns and the funding and operations of private providers and we are regularly called by the Department of Health and other government agencies to provide consumer advice to the Australian Government on key mental health issues and reforms.

The Network is committed to working with the Australian Government and relevant others in addressing the needs of people with a mental illness including their family or carers and we welcome the reform which will take place on 1st April, 2018 regarding the once in a lifetime opportunity to immediately upgrade to a policy which covers inpatient admission for people needing psychiatric care. However we are most concerned that further to your announcement of this reform in October last year, no approach has been made to our Network by the Department of Health to provide a mental health consumer and carer perspective on the implications that this and other reforms pose.

This reform is particularly important in view of the fact that, as recognised by the Australian Government, consumers find it extremely difficult to interpret health insurance products and ensure that they select products appropriate to their needs:

- Despite Government awareness of the vast number of policies currently available, the allocation of these into gold, silver, bronze and basic will not occur until 2019.
- People who hold policies are not often fully aware of what they are or are not covered for and while there has been progress on some issues through the Private Health Ministerial Advisory Committee, these have yet to actually translate into greater clarity for consumers.
- Contracts (HPPAs) between health insurers and private psychiatric hospitals are 'commercial in confidence', and as patients and policy owners, we do not have any access to details of the services which impact on our care. Nor do we have any information on the contracting environment. We are therefore at the mercy of what health insurers will and will not pay for services provided by private psychiatric hospitals. Even if a consumer holds a policy which says psychiatry is 'fully covered', provisions in HPPAs may still limit the coverage provided in ways which are not disclosed to the consumer.
- Important matters such as cooling off periods are subject only to a voluntary Industry Code of Conduct. There are no mandatory minimum standards in a number of areas of customer service including criteria for covering dependents and so rules can vary widely between

insurers adding to the complexity of consumer decision making when selecting a health insurance policy.

These difficulties mean that it is not uncommon for people in the midst of a mental health crisis and in need of a hospital admission to find that they are not adequately covered for psychiatric services. These difficulties also mean that if such a person is to avail themselves of the opportunity to immediately upgrade their cover, they must be afforded the supports and protections necessary in order for them to navigate the upgrade process which in itself entails an expensive, complex and difficult decision.

The decision to allow a once in a lifetime opportunity to immediately upgrade is a wonderful initiative, however in practical terms there are some important issues which need to be flagged. Many consumers requiring urgent admissions are frequently unaware of government or funder/provider policies which directly impact on their access to and practical experiences of hospital admission. As mental illness impacts on a person's mental state, they may not have the capacity, at the time of admission, to understand or be responsible for actions they are consenting to. We believe that in order to implement the announced change there is an urgent need to introduce regulations that will ensure that health insurers are more accountable to their members and deliver the intent of this important reform. The Network is also concerned that if a number of key matters are not clarified through regulation people in a mental health crisis who require emergency admission, might find themselves involved in an administrative nightmare.

We would like to raise with you some of the issues from our perspective:

- How will consumers be able to exercise their rights under this reform if admission is required after hours or on weekends when detailed information and confirmation of an upgrade or switch in policy from health insurers would be unobtainable?
- No details have yet been released, but will the health insurers be precluded from requiring immediate payment prior to entering hospital? Will consumers exercising this immediate upgrade be assured of being able to access the same rights and options as other consumers (eg the option to pay premiums by monthly instalments)? If so, how will this be enforced?
- Will consumers be assured of adequate cooling off periods, particularly if they are too ill to attend to administrative matters? Currently cooling off periods are covered by an industry code of conduct but in this particular instance we believe that people with a mental illness need the assurance of a mandatory period of grace or cooling off period of a least 30 days notwithstanding the fact that they will have made a claim for psychiatric hospital admission during this cooling off period.
- If a consumer finds that their insurer does not cover the services that they require at their hospital of choice, will they be able to switch to another insurer and obtain immediate coverage?
- If a consumer finds that their initial upgrade choice is inappropriate for any reason, will they be assured that they can switch to another product and still retain immediate access (ie no two month waiting) to psychiatric cover?
- Students can be covered under their parents' policy until aged 25 in most cases. What if that person because of illness has suspended or ceased study and they require immediate upgrade from a policy which may have lapsed?
- What if the consumer's coverage has lapsed due other reasons outside their reasonable control: non-payment of premiums due to illness, the actions or in-actions of another person (eg parent, partner, guardian or attorney)?
- Informed financial consent is required upon admission with the consumer required to sign that consent accepting liability for any charges not covered by their insurer. How will this be

implemented if the person is seeking to exercise an immediate upgrade especially after hours?

Whilst as consumers we have the Private Health Insurance Ombudsman (PHIO), this office does not have the power to regulate or solve the issues raised herewith. The Ombudsman can merely mediate and recommend a resolution to individual complaints and provide advice, after the fact, where it perceives a trend or emerging issue for the industry as a whole. The effort involved in taking a complaint to the Ombudsman (after first exhausting other avenues) is time-consuming and stressful. It is not a process easily undertaken by consumers living with a mental illness.

As a once in a lifetime opportunity, this reform could significantly improve clinical outcomes for particularly vulnerable consumers – especially those experiencing their first acute mental health crisis. However, the reform as proposed only applies to people who have a health insurance policy. This requirement could lead to perverse outcomes:

- A person whose cover has lapsed, even by a day would be ineligible
- A person whose circumstances had changed voiding their cover, even by a day, would be ineligible
- A person who had no previous health insurance would be ineligible and yet another who had taken out a basic policy, even if only immediately prior to requiring an upgrade, would be eligible.

The Network recognises that the health insurance industry must be protected from the risk of 'free-loading' however in this instance that risk is low because the immediate upgrade is only available once in a lifetime and it will require clinical approval. Furthermore, consumers once diagnosed with a serious psychiatric condition are well aware that the risk of future acute episodes cannot be ruled out. Those who can do so, often make great sacrifices to afford private health insurance knowing that in many instances this can mean the difference between accessing the services they require and not being able to access hospital care at all because of the severe pressure on public hospital mental health services. Additionally the benefits of this reform flow not only to consumers but also to the health system as a whole, including insurers, because timely access to hospital care, particularly for people experiencing their first mental health crisis, could potentially reduce the need for more costly healthcare down the track.

We recognise that we have raised many complex issues but these issues arise out of the experience of our members. If this reform is to avoid the unintended consequences of distress and confusion to consumers and added administrative burden to insurers, hospitals and government agencies such as the Ombudsman it needs to be as clear and simple as possible. We would suggest that in the interests of simplicity and fairness, the Government consider:

- Regulation of minimum service standards such as cooling off periods.
- Regulation allowing consumers to exercise the opportunity to access the once in a lifetime immediate upgrade retrospectively if they are eligible but not able to exercise this right at the point of admission either due to incapacity or due to needing admission outside of business hours.
- Regulation precluding insurers from imposing special conditions that would impose unreasonable barriers on consumers legitimately exercising the option of a once in a lifetime immediate upgrade, for example, requiring that a full year's premium be paid immediately and in advance.
- Extension of this option to people who do not have insurance cover recognising that the requirement to establish whether or not a person has insurance cover adds complexity to

the implementation of this reform and that people with a serious mental illness are at risk finding that their cover may have lapsed.

Finally it is important to recognise that while this important reform will provide great benefit to some consumers, it is still essential to at least retain the mandatory maximum of a two month waiting period for those consumers who are ineligible for the immediate one in a lifetime upgrade.

- Many people on Centrelink benefits hold lower level policies in order to have some cover. A large and increasing number of health insurers are moving their full cover for psychiatry to their top cover. The reform from 1st April, 2018 will provide members with the ability upgrade immediately to the cover they require, however many will find they are unable to sustain this level over an extended period due to the associated costs.
- Health insurers increase their premiums annually as regulated by the Australian Government. What is not widely recognised is that when these increases take place, the advertised amount of increase is often an industry or insurer average. Top cover policies can increase by a much higher percentage making it even harder for consumers to retain this level of policy.

As the peak private mental health consumer and carer advocacy organisation, we would welcome the opportunity to discuss these issues further. My contact details are below.

Yours faithfully,

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