Consumer Dissatisfaction with Private Health Insurance for the Elderly: Implications for Public Health and Stewardship

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Presented at the New Zealand Society of Actuaries Conference

November 2012
Executive Summary

There has been substantial public dissatisfaction with private health insurance (PHI) premiums for the elderly and warnings that the elderly are reducing insurance cover due to premium increases. In a study of seven insurers, the lowest increase in standard monthly premiums from age 55 to age 65 was 174% with the highest being 246%. Health insurers in New Zealand are able to risk-rate by age and gender as well as by health status and other risk factors, which further increases premiums.

The largest insurer, Southern Cross, investigated whether it could ameliorate the increases for long-standing older members but was unable to find any solutions that could be implemented by the Society alone. The issue is one that faces all health insurers in New Zealand and it will only be exacerbated by the ageing population in years to come. As people fall off PHI, so they fall back on the public sector for healthcare. A similar problem exists with the Accident Compensation Corporation cutting back on long-term claimants who then rely on the public sector for treatment.

The supervision of healthcare is currently in four separate silos. The supervision of private health insurance is currently dealt with by the Reserve Bank as a separate policy issue unrelated to public health care. Prudential supervision of insurers was introduced in 2010 but this is aimed at the stability of the insurance and financial markets. Consumer protection and the attainment of predefined social goals are not part of the supervision by the Reserve Bank.

The lack of regulation of PHI leads to consequences which are at odds with public sector health policy in New Zealand. As PHI coverage is strongly related to income, there is a consequent difference in coverage by ethnicity. This leads to differential access to elective surgery by Maori and Pasifika populations, which is at odds with explicit equity goals in the public health sector.

The World Health Organization and the Organization for Economic Co-operation and Development advocate that ministers of health take stewardship of the whole health system, including private health insurance. PHI is explicitly regulated in Australia and Ireland, where PHI plays a similar role. Research has begun in the UK on the role of PHI.

The Ministry of Health has not set any “rules of the game” for the operation of private health insurance in New Zealand. The public dissatisfaction with increases in premiums for the elderly should be a catalyst for circumscribing the unusual freedoms under which health insurers are allowed to operate. With an ageing population, the consequences of not acting will only exacerbate the situation.

The Ministry of Health should acknowledge the need for stewardship of all healthcare, including private health insurance, and begin to explore the need for formal regulation of PHI. A discussion document on the role of PHI in the New Zealand health system and on models adopted in similar markets is needed in order to initiate wide consultation and stimulate research.
1. Statement of the Problem

In 2012 there has been substantial public dissatisfaction with private health insurance premiums for the elderly and warnings that the elderly are reducing insurance cover. Reductions in health insurance coverage impact on both utilisation and perceptions of the public health system. The supervision of private health insurance is currently dealt with by the Reserve Bank as a separate policy issue unrelated to public health care. Consumer protection and the attainment of predefined social goals are not part of the supervision by the Reserve Bank. The issue highlights the need for the Ministry of Health to act as steward of both public and private healthcare and to develop policy for the conduct of private health insurers in order to meet health system goals.

2. Background to the Issues with Private Health Insurance

2.1 Southern Cross Investigation

Health insurers operating in New Zealand include (Southern Cross Health Society, 2012) “for-profit companies like Tower, Sovereign and OnePath; and not-for-profit organisations like Southern Cross, Unimed and Accuro.” Eleven health insurers, including those named, belong to the Health Funds Association of New Zealand [HFANZ]. The market share of Southern Cross was 61% in 2012.

Public dissatisfaction with health insurance premiums being paid by older members came to a head at the Annual General Meeting of Southern Cross in December 2011 and a Member Tenure Project team was appointed in March 2012. Stock (2012) reported there had been “a week of complaints in the media over the soaring cost of health insurance. Elderly people with health insurance have been struggling to cope with rising premiums that, in some cases, are consuming more than 20 per cent of their income and many have switched to [policies with co-payments] so they can pay lower yearly premiums.”

Gibson (2012) described Southern Cross as having some 90,000 society members aged over 65, “paying big premiums and upset about the high costs.” Southern Cross (2012) quote another health insurer saying that the size of the health insurance market was shrinking “simply because more people can’t afford it.”

Southern Cross undertook an investigation into whether member longevity and loyalty could be recognised or whether rates to long term members could be reduced. A final report was released in August 2012 (Southern Cross Health Society, 2012) which did not find any solutions that could be implemented by the Society alone. The issue is one that faces all health insurers in New Zealand and it will only be exacerbated by the ageing population in years to come.
2.2 Expenditure on Private Health Insurance

Total public funding of healthcare in 2009/10 was 83.2% of total health expenditure (Ministry of Health, 2012). Public expenditure has been increasing since 2001 and the Ministry of Health share of public expenditure has been growing, as shown below.

Private funding includes private health insurance (PHI), household out-of-pocket spending and private funding of not-for-profit organisations. PHI accounted for only 4.9% of total health expenditure in 2010, while out-of-pocket expenditure was more than double that amount at 10.5%.

![Figure 1: Health Expenditure by Source of Funds, 2000 to 2010](image)

Data source: Health Expenditure Trends in New Zealand (Ministry of Health, 2012)

Public funding of health expenditure by the Accident Compensation Corporation (ACC) has declined from a high of 16.0% in 2001 to 10.5% of total health expenditure in 2010. A “60 Minutes” television show (McRoberts, 2012) dealt with the alleged ACC campaign to "exit" long-term claimants, which would mean their future treatment was no longer funded by ACC but by the public health service. The relationship between ACC and the public health system is dealt with in a separate policy brief but it raises similar issues about spill-over effects on public health and the need for the Ministry of Health to act as steward of all healthcare in New Zealand.
2.3 Increases in Premiums for the Elderly

The table below shows the impact on health insurance premiums as people age. The lowest increase from age 55 to age 65 was 174% with the highest, from Southern Cross, being 246%. The premiums are then shown graphically by age.

Table 1: Monthly Premiums for a Male Non-Smoker, with Cover for Hospitals, Specialists & Tests and with No Excess in September 2012. Data source: Life Direct1.

<table>
<thead>
<tr>
<th>Health Insurer</th>
<th>Accuro</th>
<th>AIA</th>
<th>OnePath</th>
<th>Partners Life</th>
<th>Southern Cross</th>
<th>Sovereign</th>
<th>Tower</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 55</td>
<td>$122.82</td>
<td>$168.05</td>
<td>$154.11</td>
<td>$151.65</td>
<td>$142.77</td>
<td>$171.58</td>
<td>$149.99</td>
</tr>
<tr>
<td>Age 65</td>
<td>$213.34</td>
<td>$320.85</td>
<td>$265.13</td>
<td>$243.73</td>
<td>$351.37</td>
<td>$302.76</td>
<td>$289.15</td>
</tr>
<tr>
<td>Age 75</td>
<td>$288.61</td>
<td>not available</td>
<td>not available</td>
<td>$372.06</td>
<td>$351.37</td>
<td>not available</td>
<td>$345.49</td>
</tr>
<tr>
<td>Increase from Age 55 to age 65</td>
<td>174%</td>
<td>191%</td>
<td>152%</td>
<td>161%</td>
<td>246%</td>
<td>176%</td>
<td>193%</td>
</tr>
</tbody>
</table>

Figure 2: Comparison of Private Health Insurance Premiums for a Male Non-Smoker, with Cover for Hospitals, Specialists & Tests and with No Excess in September 2012.

1 http://www.lifedirect.co.nz/health-insurance/?gclid=COmB8pOitriCFFBUpgodyAEABQ
Figure 2 above shows that Southern Cross has a higher escalation in premiums from age 55 to age 65 because they have community-rated all those over age 65. In other words, all those over age 65 a treated as a separate “community” and are charged a common rate. Accuro begins community-rating of the elderly from age 80, while Tower and Partners Life do so from age 85 onwards. Sovereign and OnePath do not provide cover for aged 75 and older while AIA does not provide cover from age 70 onwards.

Southern Cross (2012) cautions that it is difficult to compare premiums between insurers:
- There are differences in the benefits offered by different insurers;
- Each insurer has its own premium review cycle and these are not synchronised; and
- Insurers may under-price a new product to get business, only to increase rates later.

Despite these issues, the general patterns adopted by age by the insurers are likely to remain intact. These patterns of charging by age have changed over time. Southern Cross (2012) describe the history of their own experience with premium bands as follows:

“Another significant development during the 1990s was the approach taken by competing health insurers to attract younger, “low risk” customers. Instead of Southern Cross’s community rating approach, competitors typically used five or single year “age bands” to calculate premiums that were significantly more attractive to younger people. The result ... was that insufficient younger members were joining (and/or remaining) with the Society, and the average age of the membership increased rapidly ....”

Southern Cross currently maintains age-rating as one its principles of charging, saying that “Premiums should generally be rated by age based on cost of claims. Premiums for members under 21 and over 64 are “community” rated, while working-age adult members are rated in one year age bands.”

This illustrates the difficulty that any one insurer will have in charging on a basis different from the others. In the absence of industry conduct rules set by the Ministry of Health, the market will settle, as it has done, on risk-rating applicants and charging by a variety of risk-factors, including age and gender. What is not apparent from new business premiums is that insurers will also underwrite potential members and take into account pre-existing conditions as well as risk factors for chronic disease and charge higher premiums to those with the poorest health.

### 2.4 Insurance Coverage and Utilisation by Age and Gender

The consequences of these high escalations in premiums for older people are that private health insurance cover drops off steeply from age 65 onwards, as shown overleaf. Coverage falls at the same age bands where health system utilisation is increasing. The graphs below show hospital discharges funded from public and private sources. Hospital discharges for injuries, paid for by ACC, are also illustrated.
Figure 3: Proportion of Population in New Zealand Covered by Private Health Insurance
Data source: Health Funds Association, Health Insurance Statistics July 2010

Figure 4: Hospital Discharges by Age and Gender, July 2009 to June 2010
Data source: Ministry of Health
2.5 Impact of an Ageing Population on Public Sector Healthcare

The impact of demographic changes on the future costs of healthcare have been modelled in New Zealand (Bryant, et al., 2004; Graham, et al., 2004; Bell, et al., 2010). However the modelling dealt exclusively with government health expenditure, and made no attempt to model private health expenditure or the interaction between the two.

The New Zealand Retirement Expenditure Guidelines (Matthews, 2012) provide a more personal understanding of the interaction between public and private cover and the implications for the public health service. Mathews found that while 93% of retirees have contents and car insurance, only 35% have medical/health insurance. “[It] appears that medical/health insurance is seen as something that is nice to have if you can afford it, with the cost of health insurance being commented on by several respondents. Some respondents reported having cancelled this insurance due to the steep increase in premiums from around age 65.”

“Retirement is often seen as being a time of increasing health issues, but most retirees are in reasonable health, although their doctor isn’t a stranger:

- I’m in excellent health and only rarely visit my doctor 8%
- I’m in good health but have occasional visits to my doctor 35%
- My health is okay, but I visit my doctor several times a year 50%
- My health is poor, and I have to visit my doctor at least once a month 7%”

“However, more than half (58%) of retirees have had some form of surgery since the age of 65, ranging from minor surgery not requiring an overnight stay in hospital (15%) to major surgery, such as a heart bypass (8%). Not having health insurance can mean delays in getting necessary surgery undertaken, with one respondent commenting that ‘Have had to cancel medical insurance and now am waiting, in pain, for knee replacements’.”

Comments like this make it clear that private health insurance and public health insurance cannot be considered in isolation.

Goals to reduce elective surgery waiting times (Minister of Health, 2012) are currently reported without any reference to the role or impact of the health insurers as the major funders of elective surgery. The HFANZ has funded some modelling work (Von Lanthen, 2009) on the interaction between the public and private sectors which quantifies the relationship. The HFANZ argues (2011) that a small change in the use of PHI will have a substantial effect on public demand for elective procedures. “The present trajectory [is for] an almost flat level of private elective demand over the next two decades, but an increase in public elective demand of over 100,000 events.”
3. Options for the Stewardship of Private Health Insurance

3.1 Maintenance or Reduction of Silos

Healthcare in New Zealand could continue as a series of separate silos or the role of the Ministry of Health could be acknowledged to encompass stewardship of private health insurance.

From the perspective of the New Zealand public, healthcare is provided in four separate silos, with responsibility across four different entities as shown below.

Table 2: Healthcare Funding and Supervision in New Zealand

<table>
<thead>
<tr>
<th>Health Service</th>
<th>Public Health Service</th>
<th>Accident Compensation Corporation</th>
<th>Private Health Care</th>
<th>Disability and Long-Term Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Cover provided</td>
<td>Public emergency care, most cancer care, specialist care and elective surgery in public hospitals; GP visits and prescriptions are subsidised. Some long-term care and palliative care through DHBs.</td>
<td>Treatment and rehabilitation costs arising from accidents.</td>
<td>Private elective surgery and cancer care in private facilities and private specialist care; the un-subsidised portion of GP visits and prescriptions.</td>
<td>Residential care subsidy, household assistance, health related assistance.</td>
</tr>
</tbody>
</table>

| Funding | Tax-payers | ACC levy payers (employers, employees and vehicle licensees) | Private individuals out of their own pockets or via health insurance. | Tax-payers. Some disability insurance but not long-term care insurance. |
| Responsibility | Ministry of Health | Ministry of Business, Innovation and Employment (formerly Labour) | Reserve Bank (regulator and supervisor of insurers) | Ministry of Social Development |

There was an attempt to include PHI in a vision of the health system in the policy document “Your Health & the Public Health” (Minister of Health, 1991) but the ideas were not taken further. The danger of continuing with four separate silos is that decisions are taken that make sense in one area but where the impact on public healthcare is not a priority.
3.2 Current Supervision of Private Health Insurance

The Reserve Bank administers the Insurance (Prudential Supervision) Act (New Zealand, 2010) and is the prudential regulator and supervisor of all insurers carrying on insurance business in New Zealand. Insurers are not required to separate their health business from life business.

The Reserve Bank explains the role and limitations as follows: (Fiennes & O’Connor-Close, 2012) “Prudential supervision is about the regulation and monitoring of financial institutions and infrastructure, in order to enhance the soundness and efficiency of the financial system. .... The most compelling reasons for regulating and supervising financial institutions are to prevent the failure of one institution from affecting the financial system and the economy more widely (spill-overs and negative externalities), and to offset the negative consequences of players not bearing the full cost of their actions when things go wrong (moral hazard).”

“Consumer protection, the attainment of predefined social goals and constraining market power are also often cited as rationales for public intervention – but prudential supervision is not generally the best tool for addressing these issues and they do not form the basis for prudential supervision in New Zealand.”

Thus the market conduct of health insurers and the impact of the actions of those insurers on the public health system are not taken into account at all. Unless the Ministry of Health steps into this role, no other government body or ministry is likely to do so.

At present, the only constraint on how health insurers charge is the Human Rights Act (New Zealand, 2003). As Southern Cross explains (2012), health insurance can only be provided on different terms and conditions to people of different ages, provided those differences can be justified by relevant actuarial or statistical data. In the absence of health policy requiring community-rating of PHI, individual insurers cannot charge young people more in order to charge a common rate to all applicants as this would be treated as discrimination under section 65 of the Human Rights Act.

3.3 The Importance of Stewardship

The World Health Organization (WHO) discusses the role of governments as stewards of health resources (WHO, 2000): “Stewardship is the last of the four health systems functions examined in this report, and it is arguably the most important. It ranks above and differs from the others – service delivery, input production, and financing – for one outstanding reason: the ultimate responsibility for the overall performance of a country’s health system must always lie with government. Stewardship not only influences the other functions, it makes possible the attainment of each health system goal: improving health, responding to the legitimate expectations of the population, and fairness of contribution.”

“The notion of stewardship over all health actors and actions [emphasis added] deserves renewed emphasis. .... The harm caused by market abuses is difficult to remedy after the fact.”
“Stricter oversight and regulation of private sector providers and insurers must be placed high on national policy agendas. Good policy needs to differentiate between providers (public or private) who are contributing to health goals, and those who are doing damage or having no effect, and encourage or sanction appropriately. Policies to change the balance between providers’ autonomy and accountability need to be monitored closely in terms of their effect on health, responsiveness and the distribution of the financing burden.”

3.4 Stewardship of Private Health Insurance in OECD Countries

The Organization for Economic Co-operation and Development (OECD) (2004) provides a useful diagram for considering how government policy on private health insurance fits into health policy and other government policy, as shown below.

![Figure 5: Government Policy on Private Health Insurance](source)

Source: Private Health Insurance in OECD Countries (OECD, 2004)

The OECD (2004) recommends formally evaluating the impact of PHI on the health system in the following areas:

- **Equity**: financing equity, equity of access for those without PHI.
- **Cost/efficiency**: impact on utilisation in the public and private sector (volume / mix of services), impact on health prices, cost of subsidies (if any), insures / providers incentives to consume.
- **Quality**: impact on evidence-based medicine and quality of care.
- **Responsiveness**: public satisfaction, choice, impact on waiting times, perceptions of quality of care.”
3.5 Consequences of Not Regulating PHI

An example where the lack of regulation of PHI leads to consequences which are at odds with public sector health policy in New Zealand is illustrated below. As PHI coverage is strongly related to income, there is a consequent difference in coverage by ethnicity. This leads to differential access to elective surgery by Maori and Pasifika populations, which is at odds with explicit equity goals in the public health sector.

Figure 6: Health Insurance and Ethnicity
Data source: Ministry of Health, New Zealand Health Survey 2006/7

Without clear public policy on the role of private health insurance there will be experiments to satisfy patient demand. For example, Fenton (2011) described a pilot “bridge the gap” scheme proposed by the Southern District Health Board “in which patients seeking treatments that are approved for use but not funded through the public health system can receive those treatments in a public hospital, provided that they pay for the treatments, and any additional any additional incurred costs, with their own funds”. Such unregulated insurance experiments are not subject to any supervision and will also result in inequity between regions.

The existence of the PHI market has an effect on the reimbursement levels of surgeons. In a discussion about the introduction of a relative value scale for reimbursement (Brown, et al., 2005) the statement is made that “[p]rivately funded surgical services constitute a major source of income for practicing surgeons.” Thus the willingness of surgeons to work in public health may be influenced by the extent of private reimbursement they receive.
While the standard argument for the existence of PHI in New Zealand is that it takes some of the burden off the public health sector, some research has indicated the reverse. Blumberg (2006) found that “those covered by comprehensive private health insurance tend to increase costs within the public system”. “Private insurance tends to increase the use of GP services, specialist services, and pharmaceuticals among those most likely to have comprehensive health insurance – high-income individuals.” Blumberg used data from the New Zealand Health Survey 2002/2003 and had to make assumptions on the type of health insurance policy. This analysis should be repeated once data is available from the New Zealand Health Survey that is currently in the field.

3.6 Regulating Private Health Insurance in Other Countries

The role of private health insurance in New Zealand is currently considered to be duplicative by the OECD (2004). Australia and Ireland are considered the most significant cases of duplicate insurance in OECD countries, followed by New Zealand, Portugal and the United Kingdom.

Both Australia and Ireland have specific regulators for PHI: the Private Health Insurance Administration Council (PHIAC) in Australia (Colombo & Tapay, 2003) and the Health Insurance Authority (HIA) in Ireland (Colombo & Tapay, 2004). Both countries have an environment in which health insurers are required to community-rate contributions which ensures that the elderly do not face unaffordable escalations in premiums. Both countries continue to have voluntary insurance but have defined minimum benefits and have developed systems of risk-adjustment between competitive insurers (Armstrong, 2010; Armstrong, et al., 2010; Connelly, et al., 2010).

While the UK has not yet developed a separate regulator, an attempt has been made to describe PHI and the role it plays (Foubister, et al., 2006). This is likely to lead to further analysis of concerns and a greater focus on the consequences of PHI in that country.

Further discussion on the range of policy levers in use in different countries are beyond the scope of this short paper and will require a more substantial document. For preliminary information on the scope of PHI regulation, the policy levers in use in Australia are given in Appendix A.

4. Recommendations for the Stewardship of PHI in New Zealand

The Ministry of Health has not set any “rules of the game” for the operation of private health insurance in New Zealand. This brief has shown that there can be unintended consequences for consumers and for the public health system. The public dissatisfaction with increases in premiums for the elderly should be a catalyst for circumscribing the unusual freedoms under which health insurers are allowed to operate. With an ageing population, the consequences of not acting will only exacerbate the situation.
The oversight of healthcare in four separate silos creates conditions for unintended consequences which can severely impact the public health sector.

The Ministry of Health should acknowledge the need for stewardship of all healthcare, including private health insurance, and begin to explore the need for formal regulation of PHI.

A discussion document on the role of PHI in the New Zealand health system and on models adopted in similar markets should be prepared. This can be used to initiate wide consultation with stakeholders and to stimulate research in what is currently an under-researched area of public policy in New Zealand.

References


Organization for Economic Co-operation and Development (2004). Private Health Insurance in OECD Countries. URL: http://www.oecd.org/document/10/0,3343,en_2649_37407_33913226_1_1_1_1,00.html


# Appendix A: Regulation of PHI in Australia

Source: Private health insurance in Australia: a case study (Colombo & Tapay, 2003)

<table>
<thead>
<tr>
<th>Main policy goal of regulation</th>
<th>Type of regulation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure sustainable and fair</td>
<td>Coverage of services</td>
<td>Funds cannot offer cover for out of hospital medical services for which Medicare already pays a benefit.</td>
</tr>
<tr>
<td>public health insurance</td>
<td>allowed to PHI</td>
<td>Funds are required to cover medical fees on private in-patient stays for 25% of MBS rates. Funds can also cover any remaining medical gap above the MBS rate. Funds cannot cover co-payments on pharmaceuticals listed in the PBS.</td>
</tr>
<tr>
<td>Provider coverage</td>
<td></td>
<td>Funds can cover stays in public hospitals by private patients.</td>
</tr>
<tr>
<td>FINANCIAL REGULATION</td>
<td>Solvency</td>
<td>At any time, the value of the assets of the Fund must be of an amount considered sufficient to meet the obligations of the Fund at that date.</td>
</tr>
<tr>
<td>Promoting fund’s financial</td>
<td>Capital adequacy</td>
<td>At any time, the value of the assets of the Fund must be of an amount considered sufficient to allow the Fund to continue to meet, into the future, its obligations.</td>
</tr>
<tr>
<td>stability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>REGULATION OF HEALTH FUNDS</td>
<td>Open enrolment</td>
<td>Insurers have to accept all applicants within certain membership categories. Risk selection/discrimination of the basis of sex, age, health status, etc. is prohibited.</td>
</tr>
<tr>
<td>OFFERINGS AND ACTIVITIES</td>
<td>Community rating</td>
<td>Premiums are community-rated (Health Insurance Act, 1983) for each product. Automatic renewal of membership.</td>
</tr>
<tr>
<td></td>
<td>Product approval</td>
<td>New products or changes in existing products must be filed with the Department for Health and Ageing, which may disapprove them.</td>
</tr>
<tr>
<td></td>
<td>Minimum benefits</td>
<td>All funds are required to provide Federal Government Default Benefits, although they may have policies covering those only as private patients in a public hospital.</td>
</tr>
<tr>
<td>Guaranteeing affordable</td>
<td>Premium approval</td>
<td>Premiums must be filed with the Department for Health and Ageing, which may disapprove them.</td>
</tr>
<tr>
<td>coverage and financing equity</td>
<td>Gap cover scheme</td>
<td>The Gap cover schemes – Act (2000) allows funds to cover part or the entire medical gap for private in-patient care above scheduled MBS fees.</td>
</tr>
<tr>
<td>Protecting consumers and</td>
<td>PHI Ombudsman</td>
<td>Deals with consumer complaints. Publishes aggregate data about complaints. Makes available and publicises the Private Patients’ Hospital Charter.</td>
</tr>
<tr>
<td>building confidence</td>
<td>Informed financial</td>
<td>Medical practitioners charging patient an amount above the benefit provided by the health fund must inform the patient of this cost, and obtain written financial consent. Funds have an obligation to include in their agreements with hospitals a clause according to which providers apply informed financial consent requirements.</td>
</tr>
<tr>
<td></td>
<td>consent</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Information disclosure</td>
<td>Funds can change premiums or rules on PHI coverage but are required to inform members of any change adversely affecting the scope, level or nature of the benefit, including premium increases.</td>
</tr>
<tr>
<td></td>
<td>requirements</td>
<td></td>
</tr>
<tr>
<td>Protecting insurers against</td>
<td>Waiting period</td>
<td>Health funds may impose waiting period on hospital treatments where it is apparent that there was a pre-existing ailment. Waiting periods for pre-existing conditions consists of: i) 12 months for pre-existing ailments; ii) 12 months for obstetrics; iii) 2 months for all other circumstances.</td>
</tr>
<tr>
<td>adverse selection</td>
<td>Pre-existing ailments</td>
<td>A pre-existent ailment is an ailment, illness or condition, the signs of symptoms of which, in the opinion of the medical practitioner appointed by the fund, existed at any time during the 12 months prior to joining or upgrading a hospital PHI product.</td>
</tr>
<tr>
<td></td>
<td>Exclusions and front-end</td>
<td>Insurers are allowed to have exclusions in policies (for example a disease condition such as maternity, hip replacement, knee replacement, etc.). Since 1996, insurers can offer policies with front-end deductibles specifying the amount that an individual has to pay before health fund benefits are payable.</td>
</tr>
<tr>
<td></td>
<td>deductibles</td>
<td></td>
</tr>
<tr>
<td>Ensuring fair competition</td>
<td>Reinsurance</td>
<td>A reinsurance pool exists, which equalised the cost of the elderly and chronically ill (i.e. hospitalised for over 35 days) across funds.</td>
</tr>
</tbody>
</table>