Private Healthcare Australia
Better Cover. Better Access. Better Care.

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Hon Dr Michael Armitage
CHIEF EXECUTIVE OFFICER

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Senate Standing Committees on Community Affairs
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Dear Dr Holland

Re: Inquiry into the *Private Health Insurance Legislation Amendment (Base Premium) Bill 2013*

Thank you for the opportunity for Private Healthcare Australia to make this submission to the Senate Community Affairs Legislation Committee Inquiry into the *Private Health Insurance Legislation Amendment (Base Premium) Bill 2013*.

Private Healthcare Australia represents 24 private health funds, which collectively insure approximately 95 per cent of the 12.5 million Australians who hold some form of private health cover.

Private Healthcare Australia opposes this legislation as it will adversely affect all Australians with private health insurance.

The importance of private health

Private health insurance plays an important role in delivering Australians access to affordable health care. In the last 12 months, private health funds have paid benefits of $14.8 billion to their members for care, including $11 billion for treatment in hospitals.

The private health sector was responsible for performing two-thirds of all elective surgery in 2011/12, and 57 per cent of all surgical episodes over the same period, including treatments for:

- 81% of same-day mental health;
- 78% of complex middle ear infections;
- 60% of cancer Chemotherapy;
- 57% of hip replacements; and
- 55% of major procedures for malignant breast conditions.

An additional $3.7 billion was provided by funds in the way of benefits for consumers to access services through General Treatment Cover in the last 12 months, including dental, optical and physiotherapy.

To manipulate the present private health insurance system in a detrimental fashion risks these indicators being negatively influenced, to the detriment of all Australians.

The dismantling of private health policy settings

This legislation continues the dismantling by this Government of the successful private health policy settings implemented by the previous Howard government. Those policy settings were responsible for restoring balance to Australia's health system.

The Howard government policies made private cover more affordable, and therefore more accessible for all Australians. Information from the Australian Tax Office and the Australian Bureau of Statistics indicates that of the 12.5 million Australians with private health insurance almost one-half of those live in households with an annual income of less than $50,000. These households especially will be disproportionately affected by the indexation of the Rebate as the real decline in their Rebate amount will represent a greater increase in their household budget compared to the impact on wealthier households.

The introduction of the Medicare Levy Surcharge, Lifetime Health Cover and the 30% Rebate on Private Health Insurance all contributed to a reversal in the long-term decline of private health membership. Since those policies were all implemented by mid-2000, the number of Australians with private health cover has increased from 39.9 per cent of the population at 1 January 2000 to 54.7 per cent today (March quarter 2013). This represents an additional 4.8 million Australians with private cover over that period.

All three policy settings have been altered by this Government in recent years, and these changes all work to undermine consumer confidence in private health. The means-testing of the Rebate and the removal of the Rebate from the Lifetime Health Cover component of private health, which was subject to a separate review by the Committee earlier this year, combined with this legislation all complicate an already complex product.

This legislation represents poor health policy as its only purpose is to allow the Government to cost-shift towards those individuals who hold private health insurance. This means the 12.5 million Australians who take responsibility for their own health care needs, in addition to paying the Medicare Levy, will confront an increase in the cost of their private cover, contributing to an increase in their cost of living.

In the Explanatory Memorandum accompanying this legislation, the Government suggests that an increase in private health insurance membership in recent years has resulted in a corresponding "substantial growth" in Rebate expenditure. This is fallacious. In 2012 a report by Booz & Co concluded that the Rebate:

- represents the same 3.5% of total healthcare expenditure that it did ten years ago;
- is a small component of government health expenditure (8.1%) and has only increased by 0.2% over the decade; and
- has been growing at a rate comparable to other health costs, and is not the fastest growing component of health expenditure.

<u>The effects of indexing the Rebate:</u>

1. <u>Fewer Australians with private cover, higher premiums</u>

This legislation will result in a decline in private health insurance membership. As a result of this legislation:

- fewer Australians will hold private health cover;
- cover will be more expensive for those who remain than it otherwise would have been; and
- more people will rely on our public hospitals for treatment, increasing hospital wait times.

A recent paper on the impact of indexation by Port Jackson Partners released in May 2013 **(Attachment 1)** concluded that:

> *"Rebate indexation leads to a severe impact on the Private Health Insurance industry. The number of hospital insured persons plateaus almost immediately, and starts to decline only a few years after the Rebate is indexed.*
>
> *"This would result in a significant decline in the percentage of people insured. Under indexation of the Rebate the per cent of population covered would be 10% less by 2022, compared to base case.*
>
> *"Indexing the Rebate would also mean that in the future consumers would pay much more out of their own pockets…consumers will pay nearly 30% more for private health insurance by 2022.*
>
> *"Finally, indexation also leads to an immediate net increase in public sector costs as public hospital costs exceed Rebate saving. Furthermore, the net cost to public sector increases over time as public hospital costs grow faster than Rebate savings".*

It is expected that, based on most recent years' premium adjustments and inflation increases, premiums will be 1.2 per cent higher <u>each year and compounded</u> than they otherwise would have been expected to be as a result of this legislation.

2. <u>A more complicated system</u>

The means-testing of the Rebate in 2012 has now created 12 different pricing structures to premiums, where previously there were three Rebate levels (30, 35 or 40%) based simply on a consumer's age.

The proposed changes to the indexation of the Rebate, to be introduced from 2014, will create additional confusion for those with private health cover. Under this legislation the price of private health cover to a consumer will depend on:

(i) their age (under 65, 65-69 or over 70);
(ii) when the person joined private health (if over the age of 30 they are subject to a Lifetime Health Cover loading, which dependent on the passage of other legislation may or may not be eligible for the Rebate);
(iii) their income (depending on which, they may be eligible for a 40%, 35%, 30%, 25%, 20%, 15%, 10% or no rebate); and

(iv) their fund product (for which any eligible Rebate will now be adjusted against the lower of CPI or the premium adjustment).

This legislation will make it even more complicated for consumers to understand private health insurance. A product specific Rebate, as proposed, will make it significantly more complex for consumers to understand how the Rebate is applied, and for them to be aware of how that level is diminished over time. A consumer changing any of their policy details, such as fund, state or scale will encounter a change in their Rebate and, therefore, contribution rate as the Rebate will no longer transfer with the consumer at a flat rate like it does now, at say 30%.

3. <u>Disincentive to innovate</u>

This legislation will result in a number of disincentives for funds to innovate, especially those funds with products with lower-than-Industry-average premiums, as their members will be perversely penalised over time as the indexation of the Rebate is off a lower rate (assuming the annual premium adjustment is greater than the CPI change).

The legislation may also result in a decline in innovation in the area of chronic disease management programs and hospital-substitute treatments as these areas often require an investment amount which will require higher premium prices to underwrite those costs. Under this legislation funds will be reluctant to offer higher priced products given the relative decline in the value of the Rebate over time and as it is applied on an individual product basis.

4. <u>Poorly-defined legislation</u>

Private Healthcare Australia holds significant concerns about the drafting of the legislation and the practicalities of its implementation. For example, the definition of “base premium” disregards any discounts given to policy holders. This would have the effect of giving discount-eligible customers a larger Rebate than otherwise would apply.

Further, in relation to the base premium, paragraph 22-50 establishes the base premium for all products as 1 April 2013. This paragraph specifically assumes premium increases took effect on that date. However, there are some funds that may not have introduced their premium increases on 1 April, but shortly after, as is permitted under current arrangements.

For example, there is one fund which aligned its premium adjustment this year on a public service payroll schedule, given its mandate is to serve a particular public vocation, meaning it took effect from 3 April 2013. Under the current drafting of the legislation, this fund’s base premium will be established on premiums set in April 2012. The effect of this legislation will be to significantly disadvantage the members of this fund by applying a lower base premium than for other health funds.

The use of the Consumer Price Index (CPI) carries another anomaly with regards to the indexation of the Rebate in future years as is proposed by this legislation. Consumer price movements are reflections of changes in prices for past periods. In the context of the proposed Base Premiums they will be applied to future periods.

Private Healthcare Australia queries, given the use of CPI in this legislation, why the Government has not chosen to use a state-specific application of the CPI given how funds offer products based on state of residency, as the use of this CPI figure would better align with product pricing, risk equalisation pools and the administration of public hospitals by state governments.

Further, Private Healthcare Australia also queries as to why the Government has not chosen to match the indexation of the Rebate against Health CPI, given this index is a greater measure of price movement in the sector. For example, according to the ABS, in the 12 months to 31 March 2013, the Health CPI grew at 6.1 per cent, compared to funds' annual premium adjustment on 1 April 2013 of 5.6 per cent.

Private Healthcare Australia also has concerns around the definition of some of the components of the legislation. For instance, what is a 'product subgroup' as described in the legislation? If a consumer purchases combined (Hospital and General Treatment) cover is this a product subgroup, or are they two separate product sub-groups based on separate Hospital and General Treatment policies?

Further, how are the weightings of new products determined for the application of the Rebate? Private Healthcare Australia is concerned that under subsection 22-50 (6) of the legislation the Private Health Insurance Administration Council "may assist in determining weighted average ratios". The Industry would prefer an objective method of determining new product weightings applied consistently across all insurers.

There is also a severe lack of detail in the legislation making assessments about implementation difficult, including the legislation's application to tax statements, new products and new entrants to the market.

5. Cost of implementation

Private Healthcare Australia is concerned about the increased administration and compliance this legislation will necessitate, and how ultimately this increased burden will result in higher premiums. Private health funds will be required under this legislation to establish systems to handle multiple and different Rebate rates by product subgroup. In addition, with the passage of the *Private Health Insurance Amendment (Lifetime Health Cover Loading and Other Measures) Bill 2012* funds will also be required to split rates into Rebate and non-Rebate contributions.

Health funds will also have to establish systems to calculate premiums and Rebate entitlements based on a multitude of factors including:

a) Age;
b) Income level;
c) Base premium compared against Lifetime Health Cover premium; and
d) Rebate-able base premiums against non-Rebate base premiums.

The administrative burden which will be placed on the Industry is estimated to be around $15 million in implementation costs, including new systems development, staff training and amended communication materials. The costs associated with the system changes required will ultimately be reflected in future increases in private health premiums.

Given the highly complex nature of this legislation, Private Healthcare Australia has concerns that programs will not be able to be developed to allow funds to reconcile payments and entitlements with Australian Government agencies such as the Department of Human Services and the Australian Taxation Office. This is therefore a significant threat to the integrity of an important Australian Government program, and one that is likely to raise the interest of the Auditor-General given the poorly-designed policy nature of this legislation.

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Conclusion
This legislation will have the same detrimental impact on the Australian health system as canvassed by this Committee recently when you considered the *Private Health Insurance Amendment (Lifetime Health Cover Loading and Other Measures) Bill 2012.*

The legislation will make private health insurance less affordable for all Australians, further restricting peoples' access to health care services, while increasing public hospital waiting lists. This legislation is a poor piece of public policy, and on behalf of those 12.5 million Australians with private health insurance – all of whom will be adversely affected by it - I urge the Committee to oppose it.

Yours sincerely

HON DR MICHAEL ARMITAGE
CHIEF EXECUTIVE OFFICER

11 June 2013

Private Health Insurance: Impact of indexing the rebate to CPI

Private Healthcare Australia

Final Report

27 May 2013

Port Jackson Partners

Port Jackson Partners Limited ACN: 052 145 392

IMPACT OF INDEXATION OF THE REBATE

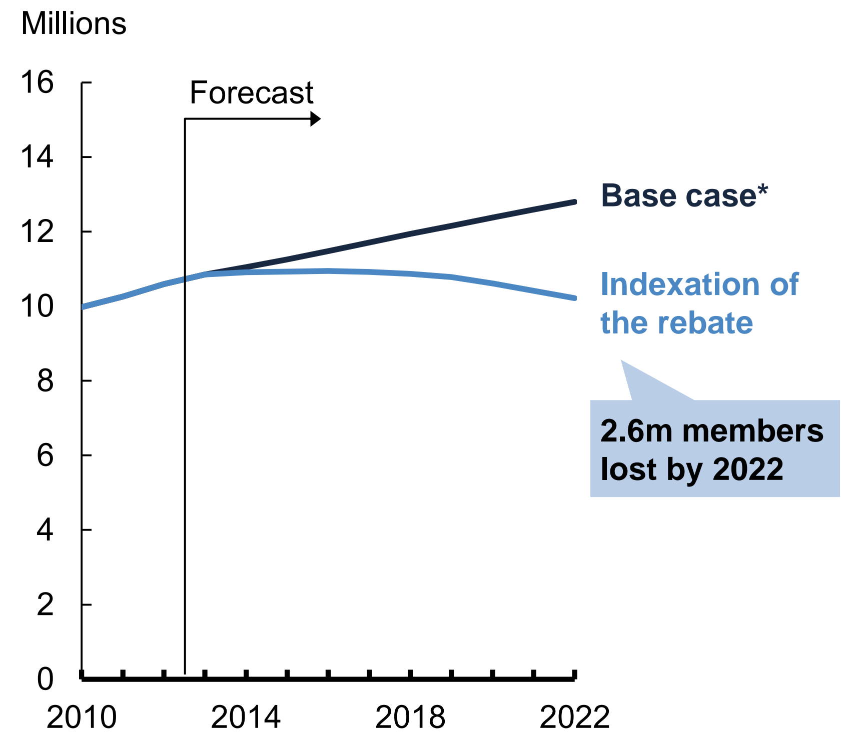
Rebate indexation leads to a severe impact on the Private Health Insurance industry. The number of hospital insured persons plateaus almost immediately, and starts to decline only a few years after the rebate is indexed. Indexation could see the number of private hospital insured people fall by ~2.6 million people by 2022 (versus base case), translating to a cumulative revenue loss of ~$40b over the same period.

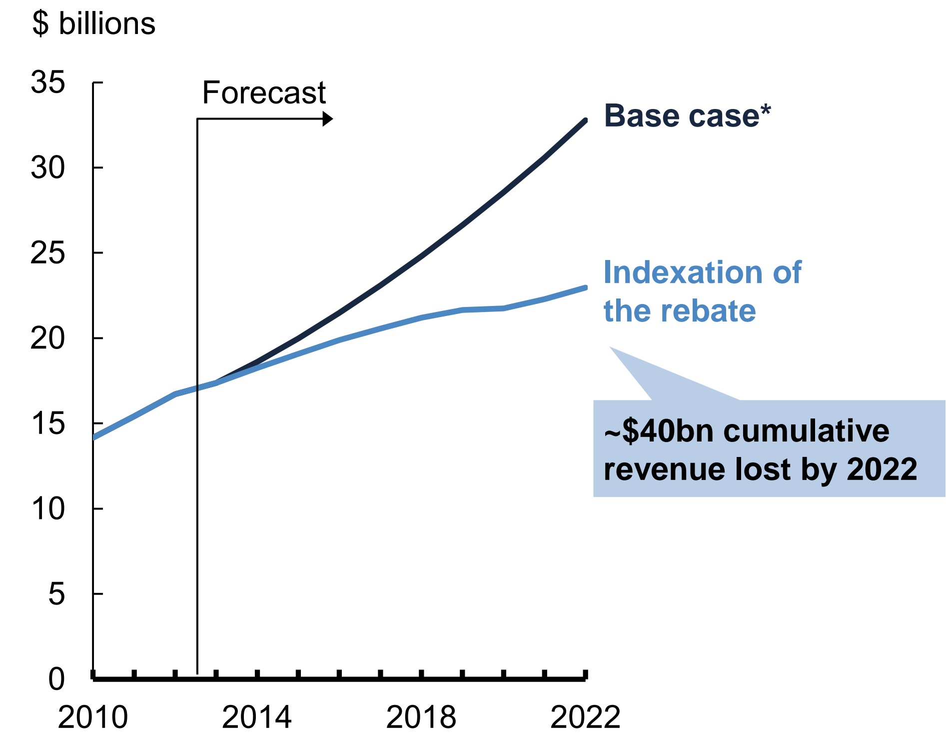
This would result in a significant decline in the percentage of people insured. Under indexation of the rebate the per cent of population covered would be 10% less by 2022 (compared to base case).

Indexing the rebate would also mean that in the future PHI consumers would pay much more out of their own pockets. This would drive consumers to trade down to lower coverage products (which also includes moving to products with higher excess amounts or co-payments). Members who downgrade or dropout will typically be lower than average claimers and the industry will therefore need to raise prices in order to maintain current economics. Due to both of these effects, consumers will pay nearly 30% more for PHI by 2022 (compared to base case).

Finally, indexation also leads to an immediate net increase in public sector costs as public hospital costs exceed rebate savings. Furthermore, the net cost to public sector increases over time as public hospital costs grow faster than rebate savings.

PHI INDUSTRY IMPACT – HOSPITAL INSURED PERSONS AND REVENUE

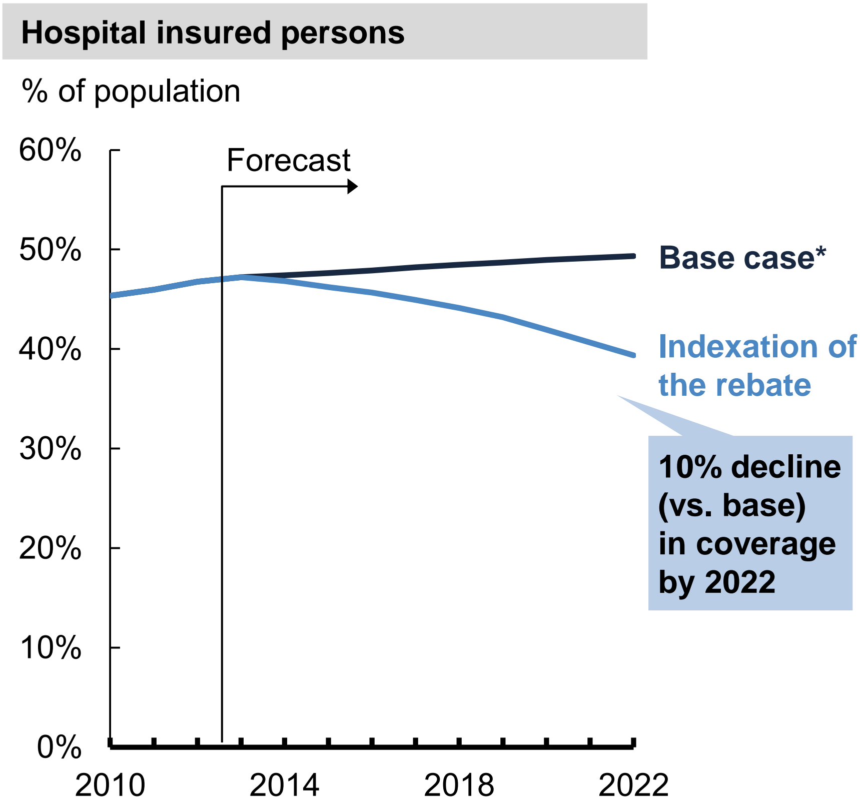


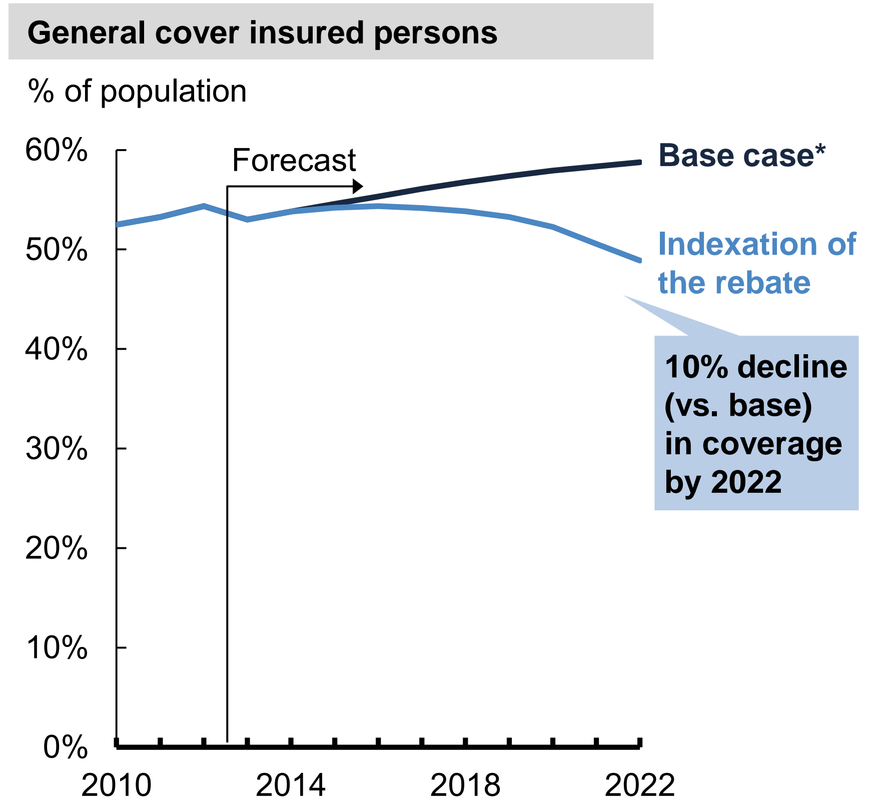


* The Base case includes the impact of rebate means testing

Source: PHIAC; PJP analysis

PHI INDUSTRY IMPACT – PERSONS INSURED AS A PERCENT OF POPULATION

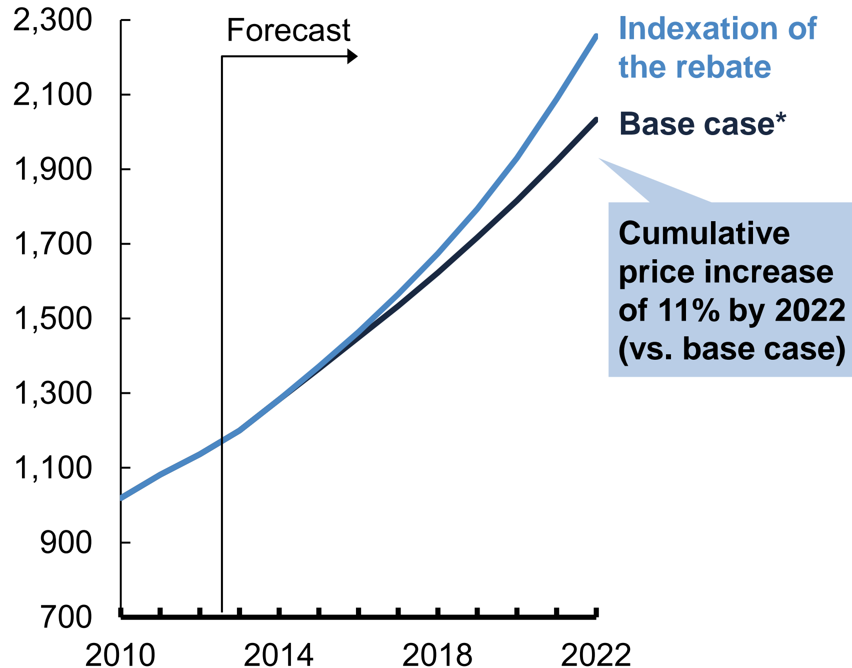


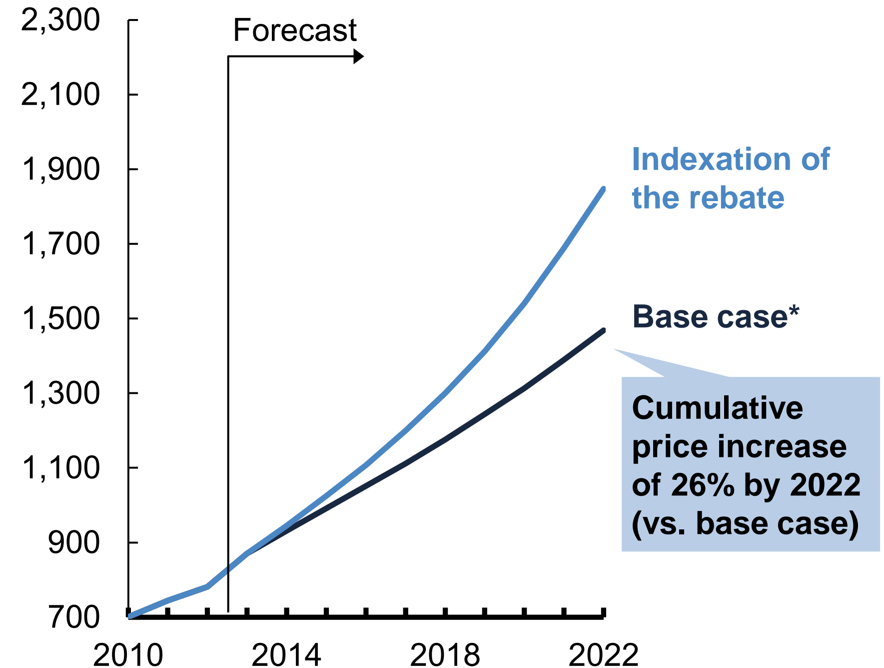


* The Base case includes the impact of rebate means testing

Source: PHIAC; PJP analysis

AVERAGE PRICE OF HOSPITAL COVER



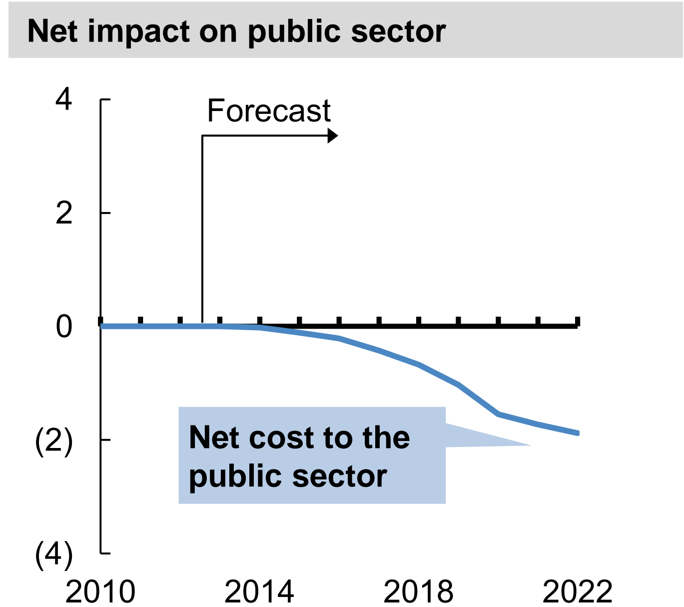


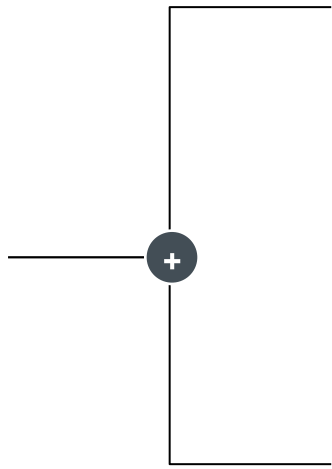
* The Base case includes the impact of rebate means testing
** Weighted average rebate of the membership base in the relevant scenario

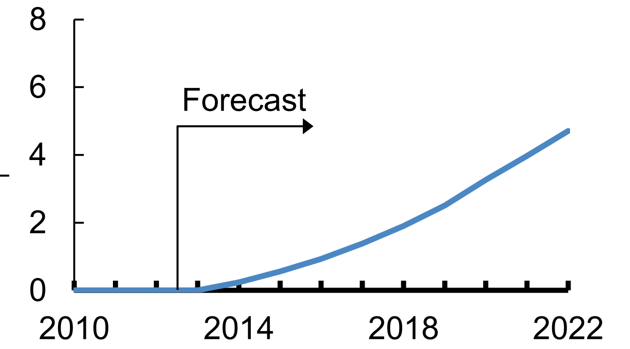
Source: PHIAC; PJP analysis

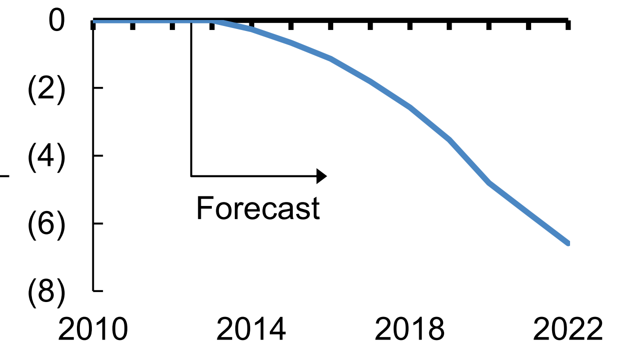
NET IMPACT OF INDEXATION ON THE PUBLIC HEALTH SECTOR (RELATIVE TO BASE CASE*)

$ billions









* The Base case includes the impact of rebate means testing but no further changes to rebate rules

** Rebate savings also includes a very small amount of additional MLS revenues

*** Estimated as the entire amount of claims shifted out of the PHI sector by PHI dropouts and downgrades. Assumes no difference in cost efficiency between public and private sectors

Source: PHIAC; PJP analysis