SUBMISSION NO. 47
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The Secretary
House of Representatives Standing Committee on Health and Ageing
Parliament House
Canberra.

31 May 2005

Dear Secretary

Inquiry into Health Funding

I wish to make this submission to the Committee on the Inquiry's fifth term of reference, namely **(e) Making Private Health Insurance still more Attractive.**

[redacted]

Background

My comments are made assuming a continuation of the Lifetime Health Cover (LHC) community rating framework (at least for hospital cover), and assuming continuity of the 30% and Seniors Rebates (although I raise the possibility of these rebates being used differently in the future). Also I assume continuation of the current Medicare Levy Surcharge, and of the (tax penal) FBT regime for employer paid private health insurance premiums, as this issue has been well canvassed previously.

This submission raises eight issues under the numbered headings below.

1. Complete the Work from the Productivity Commission Report

The Productivity Commission's 1997 Report was made against a background of cost pressures and declining membership (see the Report's terms of reference). The Report made 16 recommendations for change in private health insurance (PHI). Only 6 of these have been implemented (Lifetime Health Cover, For-profit tax status, risk based prudential standards, PHIAC independent Board, removal of requirement for nursing home benefits, smoother phasing for tax rebates).

In my opinion, each of these changes has been a success. For example, LHC was independently assessed in December 2003 by the South Australian Centre for Economic Studies ("Review of Lifetime Health Cover Scheme") which concluded "LHC was successful in providing a very major boost to membership numbers and a major improvement in the membership profile" (page (V)), and

LHC is "encouraging consumers to take out private hospital cover early in life and to maintain it" – early in life means in the 30s ages.

Given the success of the implemented measures, and the purpose of the Report, I urge the Committee to **consider the remaining 10 recommendations, which were as follows:-**

1. Ancillary cover not community rated
2. Premium increases not subject to screening
3. Compulsory cover for rehabilitation no longer required.
4. Review pre-existing ailment rules
5. Extend waiting time for "hit and run"
6. Introduce composition based reinsurance (see below)
7. Ease takeovers of mutual funds
8. Funds to act as agents of Medicare
9. No requirement to pay non-contracted hospitals the default benefit
10. Tax rebates on ancillaries removed

I do not necessarily endorse each of these recommendations. Rather, I feel that each recommendation needs to be considered further, to allow for developments since the recommendations were made.

2. Contain Private Health Insurance Costs

There are 3 key elements in containing PHI costs (specifically costs for hospital products which are the main reason for recent cost increases):-

1. Increasing the participation rate amongst persons in their 20s and 30s – currently this is around 20 to 30% for persons in their 20s and around 30 to 40% for persons in their early to mid 30s.

   The Committee might consider requesting the Australian Government Actuary to estimate the potential reduction in overall contribution rates if participation rates were raised to 50% at these younger ages, based on PHIAC data.

2. Ensuring those with PHI maintain continuous cover – I have no basis for estimating the cost savings which would be expected to arise from introducing this change, but I feel that the Committee could ask the private health insurance industry to provide an estimate (see point 5 below). Note that no reliable estimate was available to the Productivity Commission.

3. Ensuring costs are controlled, by introducing efficiencies (see point 3 below).

3. Changes to the Reinsurance System

After years of work, it has not been possible to finalise the major change to replace the current claims based reinsurance system for in-hospital insured costs, with a composition based system which would promote greater efficiency. The reinsurance system is essential to maintain community rating, so that private health insurers with a greater percentage of older policyholders are able to price their hospital products competitively with funds which have a lesser percentage of older members. The subsidy paid through the PHI Tax Rebate is essential for maintaining the affordability of PHI, and has recently been extended to address the pricing issue for older members. One of the problems of community rating is that older Australians generally have no knowledge of the (substantial in some cases) extent to which they are subsidised in their private hospital insurance premiums by younger Australians.

Linking of these two issues might be made to redirect the current tax rebates for hospital cover into Government financed risk equalisation payments to each fund, based on an agreed equalisation framework, which would determine a composition model, which would then allow a subsidy to be determined for each private hospital insurance member, based on that member's specified characteristics (eg age, gender, family status, etc). In turn, such a system would permit disclosure of the subsidy to each member who is subsidised. The total of these subsidies would be equal to the total of the current tax rebates. The effect on individual members with hospital insurance would need to be analysed carefully. If significant changes in premiums were likely to result from the changes to reinsurance, the changes would need to be introduced over a number of years.

Changes to the Government payments each year would need to be based on an agreed cost benchmark for private hospital services, and the members covered. Disclosure of the subsidies to individual PHI members should assist in both the recognition, and the longer term integrity of such a system.

The outline above would need to be tested in detail.

4. Tax Penalties

The Medicare Levy Surcharge (MLS) thresholds are not indexed, and therefore are becoming relevant to a greater number of taxpayers over time. I am not aware of how many taxpayers pay the MLS each year. However, if the numbers warrant it, it may be appropriate for the Tax office to draw these taxpayers' attention to the alternative to paying the MLS, namely effecting private hospital cover.

To make it easier for taxpayers at the income levels at which the MLS commences to effect private hospital cover, higher excess products ($1,000 / $2,000 p.a.) which have cheaper premiums could be permitted to qualify for MLS exemption (as was originally permitted). These hospital products without exclusions generally have net of rebate premiums at around the minimum annual MLS cost currently ($500 pa currently for a single income earner).

5. Lifetime Health Cover

The independent review of LHC commented "there are some signs of deterioration in the membership profile since September 2000" – page (v). I suggest that LHC be amended in minor ways to address this issue as follows:-

- Time out of LHC penalties – remove the current 2 year exemption;
- All new joiners become subject to LHC loadings (the current age exemption is removed, after an appropriate notice period).

6. Incentives for Health Maintenance

There are few financial incentives (or penalties) in the current health care system overall for a person to take action to maintain good heath status. While it might be possible to consider penalties such as higher private health insurance premiums for those with particular features which are proven to lead to higher heath care costs (eg possibly smokers), singling out particular characteristics for penalty in a community rated environment is problematic.

Rather, it is more appropriate to concentrate on incentives.

One suggestion would be to permit private health insurance funds (at their discretion) to meet through their hospital tables the out-of-pocket costs arising from a comprehensive medical check-up (discretion as to amount, tests, frequency etc). Such costs would be reimbursed, only if the person was following actions recommended in the test (eg, ceased smoking). The person's GP would certify observance of the results.

Potential abuses of this proposal would need detailed consideration.

7. Presentation of Private Hospital Insurance

More needs to be done to emphasise the importance of the private hospital industry to the Australian public, especially younger Australians, so that the importance of having private hospital insurance and of LHC is appreciated. Three items could be included in a Government regular communication program:-

- emphasise the links between the private and the public hospital systems in providing a spectrum of treatments;
- subject to any privacy issues, every Australian could receive a letter around their 30th birthday pointing out the effects of LHC on hospital premiums, should they not have effected cover at that time; and
- the effect of the MLS could be illustrated.

8. Permit Release of Superannuation Assets from Income Products in Prescribed Circumstances of Health Care Need

Over coming years, I feel that many Australians, rather than taking their super as a lump sum, for tax reasons will commence to take their super as a regular income through either Allocated Pensions or Term Allocated Pensions. These products either determine the amount, or set the maximum amount which can be taken as an income in any one year, while maintaining the tax status of the regular amounts drawn from the product.

One of the reasons for the increasing cost of private health insurance is the introduction of new, expensive technologies. Provided control is exercised, private health insurers might be permitted not to cover such procedures (at each insurer's option), with permission being given (subject to appropriate proof) for amounts to be drawn down from either an allocated or a term allocated pension to meet such approved costs, in excess of the permitted maximum (or specified) draw down rates while maintaining the tax status of the drawdown.

Drawdowns from super assets in the event of hardship are currently permitted, subject to specified procedures being met. These procedures could be modified as appropriate to include specified heath care needs and the associated proofs.