Chapter 3

The impact of the bills

3.1 This chapter summarises the evidence the committee has received on the likely impact of the legislation. It is divided into four sections:

- the impact of the lower private health insurance (PHI) rebate and the higher Medicare Levy Surcharge (MLS) on the financial options for different income groups;
- the impact on private health fund membership including Treasury's modelling, objections to this analysis, and behavioural and historical observations on the factors that motivate the buying and retaining of private health insurance;
- the impact on public hospitals; and
- the process of implementing the means tested rebate.

The bills' impact on different income groups

3.2 Treasury estimates that means testing the PHI rebate will impact 'on around the top 23 per cent' of those with private health insurance.[1] Within this group, nine per cent (870 000 people) are in Tier 1 ($75 000–$90 000), seven per cent (720 000 people) are in Tier 2 ($90 001–$120 000) and a further seven per cent (690 000 people) are in Tier 3 ($120 000+).[2]

3.3 In terms of the impact of the higher MLS, Treasury estimates that there are currently 310 000 taxpayers who are liable for the surcharge (earning over $70 000 and without PHI). Of these, 180 000 MLS payers are in Tier 1 and will not be affected by the MLS changes. The higher surcharge will be borne by the remaining 130 000 MLS payers in Tiers 2 and 3 (those without PHI earning more than $90 000).

3.4 The committee received some analysis of the likely impact of the bills' measures on the financial position of those with PHI in Tiers 1, 2 and 3. This indicated that the increase in premiums as a direct consequence of a reduced PHI rebate will be minimal. Further, the countervailing increase in the MLS for higher income groups would encourage the uptake of cheap PHI policies.

3.5 In his written and verbal evidence to the committee, Dr John Deeble downplayed the effect of the bills' measures on PHI premiums. He noted that the average PHI premium for a family hospital cover policy in 2007–08 was $1905. Based on past trends, premiums for hospital cover will increase by five per cent over the

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1 —measured at single equivalent units by income level

2 Mr Mark O'Connor, *Proof Committee Hansard*, 14 July 2009, p. 1; Mr Marty Robinson, *Proof Committee Hansard*, 14 July 2009, p. 11.

three years to 2010–2011, which gives a projected family policy premium for 2010–2011 of $2000. If current arrangements continue, therefore, all those privately insured with an average family policy would receive a $600 rebate (30 per cent of $2000) leaving them a $1400 premium.[3]

3.6 Dr Deeble noted that under the bills' measures, those families earning the midpoint in Tier 1 ($165 000 per annum) will receive a $400 PHI rebate (20 per cent) on a $2000 policy. This equates to an average increase of $200 a year or only $4 a week. Families earning the midpoint in Tier 2 ($210 000) will receive a $200 rebate (10 per cent) on the same policy, which equates to a $400 a year increase in premiums or $8 a week. Dr Deeble concludes:

> …for a family earning $165,000 a year, private hospital insurance would rise by only $4 per week – about the price of one cup of coffee. For a family with a $300,000 income, it would still amount to only three cups. It is impossible to believe that such minor changes could ever lead to the kind of consequences for membership and premiums that the private health insurers have claimed.[4]

3.7 Mr Ian McAuley, a Fellow at the Centre for Policy Development, extended this analysis by taking into account both the rebate reductions and the higher MLS (see Appendix 3). He argued that if people act rationally and are calculating in response to the bills' measures, two trends would be evident. The first is an uptake in PHI among taxpayers currently paying the MLS.[5] The second is a preference for cheaper PHI policies with incentives for all income groups to drop their ancillary cover.[6]

3.8 Mr McAuley's submission noted that for singles with a relatively cheap policy ($1000 a year), the current and proposed arrangements offer an incentive for almost every taxpayer with an income over $75 000 to remain privately covered. For example, under current arrangements, a single person earning $100 000 a year with a $1000 policy receives a net benefit of $300 from having PHI; the full extent of the 30 per cent rebate. Under the proposed arrangements, this person faces a 1.25 per cent MLS ($1250) and a reduced rebate of $100 (leaving $900). The net benefit from having a $1000 policy, therefore, is $350. Mr McAuley wrote in his submission:

> …in effect, both the "old" and "new" incentives provide free PHI for people with high incomes, with change left over, and the higher one's income the greater is the overcompensation.[7]

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3 Dr John Deeble, *Supplementary submission*, 5 July 2009, p. 3.

4 Dr John Deeble, *Submission 6a*, p. 4.

5 Mr Ian McAuley, *Submission 10*, p. 2.

6 Mr Ian McAuley, *Proof Committee Hansard*, 9 June 2009, p. 16. Ancillary cover refers to extras such as physiotherapy and chiropractic treatment.

7 Mr Ian McAuley, *Submission 10*, p. 1.

3.9 Mr McAuley also noted that for singles with incomes between $75 000 and $115 000 per annum (double for couples), there is less incentive under the proposed arrangements to hold high price policies. Under current arrangements, a single person earning $100 000 a year holding a $2000 policy faces a net payment of $400 from having PHI ($1400 after the $600 rebate compared with a $1000 MLS). Under the proposed arrangements, this person faces a 1.25 per cent MLS ($1250) and a reduced rebate of $100 (leaving $1800). There is a net payment from having a $2000 policy of $550.

3.10 Mr McAuley acknowledged that the incentive to hold a $2000 a year policy increases with income for those earning over $120 000 per annum.[8] BUPA Australia expressed concern that with more expensive policies, the rise in premium costs from the reduced rebate would only be outweighed by the higher MLS impost at high income levels. It used Australian Health Insurance Association (AHIA) data to illustrate the point (see Appendix 4). Assuming an average single rebate of $1813 per annum (and an average family premium of $3626 per annum), higher premiums would only exceed the higher MLS impost at incomes over $120 000 per annum (over $240 000 per annum in the case of the family).[9]

3.11 The committee recognises that for those in Tiers 1 and 2 ($75 001–$120 000), the more expensive the PHI policy, the more that premium increases—from the lower rebate—will exceed the increase in the MLS if they were to drop private cover. The AHIA data in Appendix 4 does seem to be based on fairly expensive policies, however. Even so, it is well to apply Dr Deeble's observation: a $181 increase in premiums annually (for singles in Tier 1) is only an extra $3.50 a week for an individual earning well above the average annual income.[10]

The bills' impact on private health fund membership and the level of cover

3.12 Having considered the effect of the bills' measures on individuals and families in different income groups, the issue then becomes the extent to which overall PHI membership will be affected.

3.13 Economists measure the likely effect on consumer demand from a change in the price a good or service through the concept of 'price elasticity'. Price elasticities will differ depending on the nature of the good or service in question. The consultancy, Access Economics, has recently estimated that the price elasticity of the

8 Mr Ian McAuley, *Submission 10*, pp. 7–8.

9 BUPA Australia, *Submission 11*, p. 5.

10 Over the year to the March Quarter 2009, average weekly earnings for full-time adult employees was $1181.60. This equates to an average annual income of $61,612. See Monthly Statistical Bulletin, *Parliamentary Library*, http://www.aph.gov.au/library/pubs/MSB/21.htm (accessed 23 July 2009).

demand for private health insurance is –0.335.[11] In other words, a 10 per cent increase in the price of private health insurance will result in a 3.35 per cent drop in PHI membership.

Treasury's modelling

3.14 Treasury has modelled the number of people who are likely to drop their private health insurance in response to the reduced private health insurance rebate. It estimates that for Tier 2 ($90 001–$120 000) and Tier 3 ($120 001+), there will be no net change in PHI coverage.

3.15 Treasury calculates that for a person aged under 65 in Tiers 2 and 3, the percentage increase in out-of-pocket PHI costs from the reduced rebate is similar to the percentage increase in out-of-pocket costs from the increase in the MLS. Table 3.1 shows that for those in Tier 2 ($90 001–$120 000), a 20 per cent reduction in the PHI rebate represents a 28.6 per cent increase in their PHI outlay, which is roughly equivalent to the higher MLS (1.25 per cent) if they drop their policy. Similarly for those earning more than $120 000 (and under 65 years of age), the increase in out-of-pocket PHI costs (42.9 per cent) is similar to the increase in out-of-pocket costs from the increase in the MLS (50 per cent).

Table 3.1: Effect of higher MLS and lower PHI rebate on Tiers 2 and 3

MLS income range	% increase in out-of-pocket PHI cost*	% increase in out-of-pocket MLS cost
$75,001 - $90,000 $150,001 - $180,000	14.3%	0%
$90,001 - $120,000 $180,001 - $240,000	28.6%	25%
$120,001+ $240,000+	42.9%	50%

Source: Treasury, Tabled document, Senate Estimates, 3 June 2009. * This is based on those currently receiving a 30 per cent PHI rebate (ie: those under 65 years of age)

3.16 Treasury thereby focused its estimate of those likely to drop PHI in Tier 1 ($75 000 to $90 000). It noted in its submission that it used in its calculations a price elasticity for private health insurance of –0.2 for those in Tier 1: for insurees earning between $75 000 to 90 000 per annum, a 1 per cent increase in PHI premiums will result in a 0.2 per cent drop in PHI membership.[12] Mr Marty Robinson, Manager of Treasury's Household Modelling and Analysis Unit, explained how Treasury arrived at the figure of –0.2:

11 Treasury, 'Private Health Insurance—Fair and Sustainable support for the future', *Senate Estimates*, Document tabled 3 June 2009, p. 2.

12 See Treasury, 'Private Health Insurance—Fair and Sustainable support for the future', *Senate Estimates*, Document tabled 3 June 2009, p. 2.

> We consulted some of the academic literature about price elasticities on the basis of observed historical behaviour—of which there is not much evidence in the public arena. The evidence that we found indicated some estimates in the vicinity of about minus 0.3 as a price elasticity for private health insurance…When we undertook our modelling, we felt, however…—that higher income households are less price sensitive to health insurance and that in fact incomes are the main driver of people's decision to purchase private health insurance. On that basis, we made the decision to discount the assumed price elasticity for our modelling and assumed a price elasticity of minus 0.2. So, for example, for every 10 per cent increase in the price of health insurance for a consumer, we would assume about a two per cent drop in cover in the affected ranges.[13]

3.17 Treasury then multiplied this elasticity by the proportional increase in PHI cost for those in Tier 1 (14.3 per cent: see Table 3.1) to estimate the drop out rate. This rate was multiplied by the number of singles and couples within the affected income range.[14]

3.18 On this basis, Treasury estimates that around 25 000 adults (6500 singles and 5500 couples and families) with PHI cover and earning between the MLS thresholds and $90 000 (singles) and $180 000 (couples) will opt out of PHI. This represents a percentage decrease in the number of people with PHI of around 0.26 per cent.[15]

Support for Treasury's views

3.19 Treasury's estimates have received support from significant quarters. For example, Dr Deeble has concluded:

> …on the basis of all the Australian and international evidence, that it [the proposed legislation] will have almost no effect on the underlying structure of the health care industry. In that respect, I agree entirely with the Treasury's calculations. People concerned about maintaining the status quo can rest easy.[16]

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13 Mr Marty Robinson, *Proof Committee Hansard*, 14 July 2009, p. 13.

14 Treasury drew attention to the following data that it used to estimate the likely fallout from PHI as a consequence of the bills' policy measures:

- its income tax micro-simulation model to estimate the number of people in the affected income ranges and age ranges;
- Private Health Insurance Administration Council (PHIAC) data on private health insurance membership as at 31 December 2008); and
- PHI rebate expenditure as outlined in the Department of Health and Ageing Portfolio Additional Estimates Statements provided by DoHA.

Treasury, *Senate Estimates*, Document tabled 3 June 2009.

15 Treasury, 'Private Health Insurance—Fair and Sustainable support for the future', *Senate Estimates*, Document tabled 3 June 2009, p. 3.

16 Dr John Deeble, *Submission 6*, p. 1.

3.20 Mr Rob Wells, Director of the College of Medicine, Biology and Environment at the Australian National University, told the Senate Economics Legislation Committee that in terms of the bills' effect on drop out from private health insurance:

> …all the evidence suggests the impact will be at the low end of the scale—that is, closer to what the Treasury estimates are, and therefore, effectively, have a negligible impact I would say on public hospitals and on premiums. I base my assessment of the situation on a number of factors. First of all, the reduction in the rebate for high-income earners does not cut out until singles earn $120,000-plus per annum and families earn $240,000-plus per annum. That is where you would expect most of the impact to occur because for incomes below that it is tapered. For those groups, the Medicare levy surcharge increases quite significantly.
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> I think the Treasury's estimate is that the Medicare levy surcharge and the extra payment because of the reduction in the rebate would more or less cancel each other out. Therefore, it is only very high-income earners who would bear the full effect of the measure. We have seen in a previous budget, the 2007 budget, where the Medicare levy surcharge thresholds were increased, that people at lower incomes than we are talking about, who could well have dropped their insurance, did not. In effect, there has been no reduction in private health insurance since the 2007 budget measure. In fact, there has been a slight increase.[17]

The Access Economics report

3.21 Catholic Health Australia commissioned Access Economics to discuss the impact of means testing the rebate and the related changes to the MLS. A copy of this report was provided to the Economics Legislation Committee on 11 June 2009.[18] Its findings were discussed by various witnesses in evidence to the Community Affairs Legislation Committee.

3.22 Access Economics was in broad agreement with Treasury's analysis on several key issues. The report:

- supported the use of Treasury's personal income tax micro-simulation model describing it as 'an appropriate tool' for forecasting the impact of the bills' measures;[19]

17 Mr Rob Wells, Senate Economics Legislation Committee, *Proof Committee Hansard*, 9 June 2009, p. 27.

18 'Impact of means-testing the PHI rebate and changing MLS parameters', Report by Access Economics for Catholic Health Australia, June 2009.

19 'Impact of means-testing the PHI rebate and changing MLS parameters', Report by Access Economics for Catholic Health Australia, June 2009, p. i.

- accepted that 'it is intuitively correct' that higher income earners will have a lower price elasticity of demand for PHI than the population generally. On this basis, 'Treasury's assumption does not appear unreasonable';[20]
- found that 'surcharge avoiders will, for the most part, find it worthwhile continuing to hold a low cost policy'. This aligns with Treasury's analysis (Table 3.1) and that of Mr McAuley (Appendix 3); and
- reached 'broadly the same conclusions' as Treasury regarding the likely fall out from private health insurance.[21]

3.23 On other matters, however, Access Economics reserved some caution and doubt for Treasury's analysis. Most notably, it suspected that Treasury's estimate of PHI fallout 'may be at the lower end of the range of possibilities' and it 'would not rule out' a fall in coverage of 100 000 people (from where PHI membership levels would otherwise have been).[22] This is because, unlike Treasury, Access Economics factored in a higher price elasticity for people in Tier 1 than those in the higher-earning Tiers 2 and 3.[23]

3.24 Access Economics also argued that people in Tier 1 would be most affected by the bills' measures and would face a net cost of between 25 and 40 per cent. Although people in Tier 2 could face even larger percentage changes in the net cost, they are less likely to drop their PHI because their premiums represent a smaller proportion of their income.

3.25 The Access Economics report also queried Treasury's not modelling that some PHI fund members would switch their cover to a lower priced policy. It noted that should this downgrading occur, there could be greater increases in premiums and 'further negative impact' on membership levels.[24] These concerns have been put more forcefully by other organisations (see below).

Criticism (and counter criticism) of Treasury's modelling

3.26 The committee received submissions and took verbal evidence from a few organisations which expressed concern with various aspects of Treasury's

20 'Impact of means-testing the PHI rebate and changing MLS parameters', Report by Access Economics for Catholic Health Australia, June 2009, p. 9.

21 'Impact of means-testing the PHI rebate and changing MLS parameters', Report by Access Economics for Catholic Health Australia, June 2009, p. 13.

22 'Impact of means-testing the PHI rebate and changing MLS parameters', Report by Access Economics for Catholic Health Australia, June 2009, p. 9.

23 'Impact of means-testing the PHI rebate and changing MLS parameters', Report by Access Economics for Catholic Health Australia, June 2009, p. 9.

24 'Impact of means-testing the PHI rebate and changing MLS parameters', Report by Access Economics for Catholic Health Australia, June 2009, p. ii.

modelling.[25] Two criticisms deserve particular mention: Treasury's failure to measure the income elasticity of PHI demand and its failure to model the 'downgrading' of PHI cover. In both cases, the committee is satisfied with Treasury's approach given the absence of reliable data and uncertainty as to how people may respond to the bills' measures.

Income insensitive price elasticity

3.27 In his evidence to the committee, the Chief Executive Officer of Catholic Health Australia, Mr Martin Laverty, asked rhetorically why Treasury's estimate of PHI fallout was 75 000 fewer people fewer than the AHIA's estimate of 100 000. He answered:

> It is a very simple explanation. Treasury is assuming that an income earner on $75,000 a year has the same spending power as an income earner on some $250,000 a year. Treasury has applied a price elasticity formula to someone on $75,000 as it has to someone on $250,000. If you think about that for a moment, it is assuming that, if there is a 10 per cent increase in the cost of private health insurance for someone on $75,000, that would mean an average policy is going to be about $2,000. That would represent 3.4 per cent of the take-home income of someone on $75,000 as opposed to 1.2 per cent of the take-home income of someone on $250,000.[26]

3.28 Treasury has defended its discounted price elasticity of –0.2. Mr Robinson told the committee:

> The literature upon which we base our price sensitivity is not available by income level. As I mentioned earlier, the price elasticity of minus 0.3, which we subsequently discounted to minus 0.2, is basically a broad estimate of aggregate price sensitivity in the market. Where we do have the detail within our microsimulation model is in knowing how many taxpayers fall into each of the income gap categories, broken down by age group as well so that we can model the impact of the rebate for individual taxpayers on an aggregate average premium assumption. [27]

3.29 The committee accepts Treasury's position. It highlights Access Economics' observation in its report for Catholic Health Australia that 'we are not aware of any specific studies of higher income earners' price elasticity of demand for PHI'.[28]

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25 See submissions 2, 5 and 7.

26 Mr Martin Laverty, *Proof Committee Hansard*, 14 July 2009, p. 1. See also Senate Economics Legislation Committee, *Proof Committee Hansard*, 9 June 2009, p. 43.

27 See Mr Marty Robinson, *Proof Committee Hansard*, 14 July 2009, p. 18.

28 'Impact of means-testing the PHI rebate and changing MLS parameters', Report by Access Economics for Catholic Health Australia, June 2009, p. 8.

Failure to consider 'downgrading'

3.30 APHA, AHIA and the Western Australian health fund HBF have all argued that Treasury should have factored into their model the impact of people downgrading their cover and opting for cheaper policies. HBF's Managing Director, Mr Rob Bransby, offered anecdotal evidence that in response to the bills:

> …people will be looking at the whole proposition and will be looking at every opportunity to downgrade. If you do not see value in ancillary, for example, and you are in that middle-income bracket, you would probably struggle to find value and maybe you would self-insure. I would also suggest that if you did get a substantive increase on an already relatively expensive product you would look at the proposition again to see whether you could take some cost out of it.[29]

3.31 APHA's Chief Executive, Mr Roff, also indicated that in contrast to the Treasury's assumptions, the 'rational' response to higher premiums will be for people to adjust their PHI cover:

> They [Treasury] have assumed that people will either keep their insurance or drop their insurance and there will be no other decisions made, where obviously a rational decision would be to try and lower the premium. There are two key ways that that can happen: either by taking out a front-end deductible or an excess, or by taking a policy with exclusions that does not provide benefits for treatment of particular services. Both of those cause problems for my members.[30]

3.32 AHIA's Chief Executive Officer, Dr Michael Armitage, told the committee:

> …we are very fearful that…the biggest effect of this legislation…will actually be people downgrading their cover, because again people can downgrade with no Medicare levy surcharge penalty. If the argument is, 'This will happen because we have increased the stick,' if people can take what is a legitimate financial decision in difficult financial times without the stick being there, we think logically the government must acknowledge that there will be a lot of people who will downgrade.
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> …
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> We think that the downgrading is a major effect. For Treasury not to model it is disingenuous because it just does not reflect the reality of what is going to happen.[31]

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29 Mr Rob Bransby, *Proof Committee Hansard*, 10 July 2009, p. 6.

30 Mr Michael Roff, *Proof Committee Hansard*, 8 July 2009, p. 16. Mr Roff explained that collecting deductibles from their patients is an administrative burden for private hospitals, while exclusionary policies lead people to underestimate their risk for needing particular services. If they are not adequately covered, they are not able to access private hospitals.

31 Dr Michael Armitage, *Proof Committee Hansard*, 8 July 2009, p. 5.

3.33 AHIA supported the survey-based opinion polling process arguing that this is a superior tool to the Treasury modelling. AHIA has estimated the number of people likely to downgrade their cover based on IPSOS and Roy Morgan surveys. Dr Armitage explained that the surveys give an income spread for those with private health insurance and indicate the intent to leave and downgrade PHI.[32] AHIA's submission noted that 730 000 people with private hospital cover are likely to downgrade their cover and 775 000 people with private health cover are very likely to exit their ancillary cover.[33]

3.34 In evidence to the committee, Dr Armitage defended the integrity of these surveys. He contrasted this approach with Treasury's methodology:

> …Treasury has modelled with a computer chip what it thinks might happen. We have actually gone out and asked people, through the Ipsos survey and through Roy Morgan et cetera: what will you do if your private health insurance cover increases by X per cent? We know what people will do because of that.[34]

3.35 This confidence was not shared by Catholic Health Australia. In his evidence to the committee, Mr Laverty emphasised that it is uncertain the extent to which those with PHI might downgrade:

> …the only opportunity we have had to scrutinise their [Treasury's] numbers is around the level of price elasticity that Treasury has applied, and that does not give consideration to this much larger prospect of downgrading and what it means for out-of-pocket costs. I think it is quite important to consider that we are likely to see more consumers complaining about the out-of-pocket costs or the gaps that they are likely to pay. We have not been able to assess what that impact will be and Treasury has not been able to assess what that impact will be. It is an uncertainty, and in that context we would ask: if it is that uncertain, should we support this particular measure?[35]

3.36 Treasury explained at a Senate Estimates hearing in June 2009 that it was unable to model the effects of the rebate changes on General Treatment cover as it does not have the income data for those who hold ancillary cover exclusively.[36] It noted at that hearing, and again before this committee, the Treasury's view that the majority of people with ancillary cover would be under the Medicare levy threshold (currently set at $70 000).[37]

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32 Dr Michael Armitage, *Proof Committee Hansard*, 8 July 2009, p. 9.

33 Australian Health Insurance Association, *Submission 5*, p. 5.

34 Dr Michael Armitage, *Proof Committee Hansard*, 8 July 2009, p. 4.

35 Mr Martin Laverty, *Proof Committee Hansard*, 14 July 2009, p. 4.

36 Mr Marty Robinson, *Senate Estimates*, 3 June 2009, pp. 82–83.

37 Mr Marty Robinson, *Proof Committee Hansard*, 14 July 2009, p. 10.

3.37 Still, Mr Robinson told the committee that in the absence of reliable data:

> …there is a lot of uncertainty. The private health insurers themselves do not, as you have mentioned, have income information for their members. There is no empirical evidence based on observed behaviour which estimates any price elasticity for people downgrading health cover. That is not to say that it will not happen, but…there are in the order of 20,000 health insurance products out there and the government's policy may induce people to reassess the policy they currently have.[38]

3.38 Dr Deeble also questioned the availability of a reliable data source to measure downgrading:

> …Treasury has not considered downgrades…But I cannot see how anybody else could assess what the downgrades might be. They have no data on people's incomes. They have done some surveys, I am sure, but I am quite certain that the question was asked in such a way that the person would have thought that they were going to lose all their rebate and not just a little bit. I think there is an effect that is not calculated, but I do not know how anybody would do it and I would not say that that should be a reason for deferring the whole consideration on the possibility that some people might downgrade their cover.[39]

3.39 Mr McAuley told the committee that under both the existing and the proposed systems, there is an incentive to downgrade cover (to buy a cheap policy for less that the MLS). He notes that despite the incentive to downgrade currently in place, 'people are not doing that'.[40]

3.40 The committee shares doubts as to the accuracy of market research in gauging the likelihood that people will downgrade their PHI cover. It disputes the claims that downgrading 'will happen' and that it should therefore have been modelled.[41]

Behavioural observations

3.41 The preceding discussion on the likely impact of the legislation has noted that while the rational response to higher premiums is to drop or downgrade PHI cover, this will not necessarily be the case. Indeed, it would be wrong to suggest that those who hold PHI do so solely based on comparing the cost of premiums with the cost of incurring the surcharge. Surveys show that people buy private health insurance for a variety of reasons. The 2007–08 National Health Survey found that 'security, protection and peace of mind' was the most common reason for having private health

38 Mr Marty Robinson, *Proof Committee Hansard*, 14 July 2009, p. 18.

39 Dr John Deeble, *Proof Committee Hansard*, 8 July 2009, p. 35.

40 Mr Ian McAuley, *Proof Committee Hansard*, 8 July 2009, p. 24.

41 Dr Michael Armitage, *Proof Committee Hansard*, 8 July 2009, p. 5.

insurance (54 per cent of those insured).[42] Interestingly, the category 'cannot afford it/too expensive' was the most commonly reported reason for not insuring (58 per cent of those without private health insurance).[43]

Inertia—overinsurance and the 'endowment effect'

3.42 Mr McAuley, while observing the bills' incentives for people to take up and to downgrade their cover, argued that 'there will be little change in PHI coverage, and similarly not a great deal of switching to lower price policies'.[44] He cited several reasons for this 'inertia' including tendencies for people to 'hang on to' what they have (the 'endowment' effect) and for higher income groups to overinsure:[45]

> Even though there is very good behavioural research and even though theoretically those who have more wealth should need less insurance because they can cover more of their own risks, the reality is that those with more wealth take more insurance and tend to cover themselves to the hilt.[46]

3.43 Mr Wells told the Senate Economics Legislation Committee that DoHA had suggested in recent evidence at a Senate Estimates hearing that most people who hold private health insurance now hold it because they want to hold it. He added: 'that makes it even less likely that people will drop it simply because of some rearrangement of surcharges and levies'.[47]

3.44 A related aspect of private health insurance is that it is more sensitive to income than to price. Dr Deeble wrote in his submission that richer people are more likely to hold private health insurance than poorer people and changes in income have a significant affect on membership.[48] He added:

> It is, in fact, almost impossible for people to understand all of the various products that the health insurers offer and decide whether they represent value for money. That is not to say that price would never be important, only that people buy private health insurance for a variety of reasons, including custom, amenity, perceptions of social position and concerns

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42 This point was raised in evidence by both Treasury and DoHA officials. Mr Marty Robinson, *Proof Committee Hansard*, 14 July 2009, p. 19; Ms Penny Shakespeare, *Proof Committee Hansard*, 14 July 2009, p. 20.

43 Australian Bureau of Statistics, *National Health Survey: Summary of Results 2007–08*, http://www.abs.gov.au/ausstats/abs@.nsf/Products/4364.0~2007-08~Main+Features~Private+Health+Insurance?OpenDocument (accessed 10 June 2009).

44 Mr Ian McAuley, *Submission 10*, p. 2.

45 Mr Ian McAuley, *Submission 10*, p. 3. Mr Ian McAuley, *Proof Committee Hansard*, 9 June 2009, p. 21.

46 Mr Ian McAuley, *Proof Committee Hansard*, 9 June 2009, p. 21.

47 Mr Rob Wells, Senate Economics Legislation Committee, *Proof Committee Hansard*, 9 June 2009, p. 30.

48 Dr John Deeble, *Submission 6*, p. 3.

> about the availability and quality of the public alternative. Both the statistical evidence and practical experience suggest that cost is rarely the dominant factor and that, for the highest income groups, even quite large variations are irrelevant.[49]

3.45 Dr Deeble told the committee that Treasury's estimate of price elasticity (-0.2) 'may even be a little high'.[50] He told the committee that based on his experience on the board of Medibank Private:

> …we could vary up to 10 to 15 per cent away from our competitors with no marked effect on our market share; and when we all raised prices, together or separately, we lost no market share and the total market share did not vary…I can confirm from personal experience that the effect price on demand and market share for any individual company or the whole industry is very, very low indeed—it has very little effect.[51]

Historical observations

3.46 Two historical observations add to the argument that the drop out rate from means testing the PHI rebate will be relatively small. First, that given a third of the population was privately insured prior to the introduction of the 30 per cent private health insurance rebate (Chart 3.1), it seems likely that many (if not most) of those people will retain their cover even if the rebate is withdrawn completely. Indeed, as Mr McAuley told the committee:

> …since 1999 the increases in private health insurance, in real terms, have wiped out the original 30 per cent rebates, yet there has been no significant net change. So empirically we find that people do hang on to insurance in spite of what has been in the order of a 40 per cent rise in real terms, inflation adjusted.[52]

3.47 The second historical observation is that fund membership levels did not increase markedly in response to the 30 per cent rebate in early 1999 (Chart 3.1). Why, then, would partial withdrawal of the subsidy lead people to drop their cover? The significant increase in membership between the December 2000 and December 2001 quarters is widely attributed to the 'Run for Cover' campaign in the lead up to the 1 July 2000 introduction of the Lifetime Health Cover initiative.[53] Indeed, the Australian Healthcare and Hospitals Association has argued that in light of this

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49 Dr John Deeble, *Submission 6*, p. 4.

50 Dr John Deeble, *Submission 6*, p. 3.

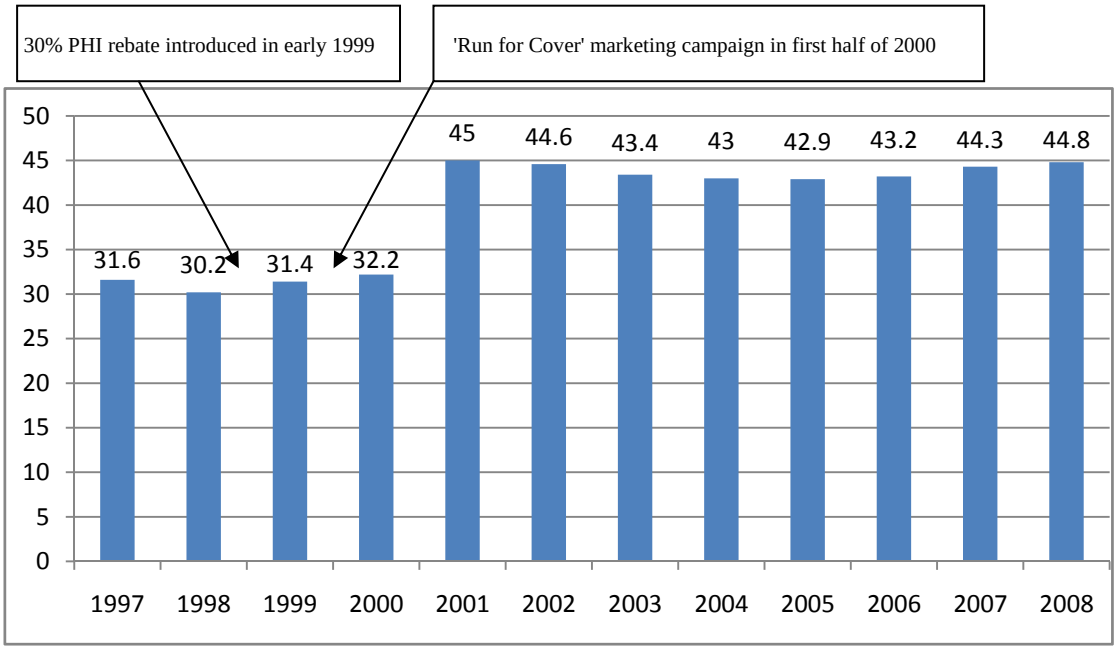
51 Dr John Deeble, Senate Economics Legislation Committee, *Proof Committee Hansard*, 8 July 2009, p. 32.

52 Mr Ian McAuley, Senate Economics Legislation Committee, *Proof Committee Hansard*, 9 June 2009, pp. 16–17.

53 See Dr John Deeble, *Submission 6*, p. 3. Also, Mr Ian McAuley, *Submission 9*, p. 3.

experience, Lifetime Health Cover is the 'main measure that would have any impact on hospital usage'.[54]

Chart 3.1: Proportion of population (per cent) with PHI, 1997–2008



Source: *Private Health Administration Council*, Part A Report, March Quarter 2009.
Figures are for December quarters. The data is reproduced from a table presented in Submission 1 by Dr John Deeble.

3.48 The influence of the 2000 'Run for Cover' marketing campaign suggests that the impact of this legislation on insurance levels will largely depend on the information that people receive. In anticipation of this legislation being passed, some health funds and health insurance brokers have conducted marketing campaigns encouraging people to take up private health insurance lest they should have to pay 'an extra 1% in tax'.[55] This may persuade some people to take up, or at least remain in, a private fund.[56]

3.49 However, many people will be either unaware of the changes or disinterested in them. As Dr Deeble noted during last year's Senate inquiry into the MLS thresholds, a combination of 'ignorance, apathy and uncertainty' will potentially limit

54 Australian Healthcare and Hospitals Association, *Submission 8*, p. 2. The Department of Health and Ageing described the Lifetime Health Cover initiative as 'the most effective component of the existing incentive structure'. *Submission 4*, p. 2.

55 See 'Stone the crows, you could be hit with the Medicare Levy Surcharge', *Sydney Morning Herald*, 27 May 2009, p. 6.

56 See Mr Ian McAuley, Senate Economics Legislation Committee, *Proof Committee Hansard*, 9 June 2009, p. 21.

the immediate fallout from the funds.[57] The same could be said of these bills' measures. Insurees would need to know their taxable income and calculate the likely increase in their premiums from a lower rebate relative to the increase they would incur in the surcharge if they dropped their insurance. It seems unlikely that too many accountants will advise their clients to drop their PHI. Treasury's calculations support this view (see Table 3.1).

The impact on the public (and private) hospital system

3.50 The committee received evidence expressing concern that the fallout from private health insurance as a response to the lower rebate would place pressure on the public hospital system. This would be exacerbated as premiums increased in response to the initial loss of members, causing further loss of members and greater reliance on public hospitals. This pattern is known as the 'second and third round effect'.

3.51 Mr Mark Engel, Director of Marketing at BUPA Australia, explained the likely impact on the public hospital system of those who leave PHI or downgrade their cover:

> The impact of these decisions by customers will be felt in two ways: firstly, those people who downgrade or drop will increasingly rely on the already stretched public sector for their health care needs, which are no longer covered by their health insurance; and, secondly, it has the potential to price choice in health care beyond the reach of low to middle income earners. Those Australians who are forced to drop their health cover for financial reasons will be forced into a public system under greater pressure with even longer waiting lists.[58]

3.52 AHIA argued that based on its market research, 'up to 240,000 Australians with private hospital insurance are likely to exit their cover as a result of this legislation'.[59] In terms of the impact of the bills' measures on the public hospital system, AHIA estimated:

> …a loss of almost 75,000 episodes from the private sector, representing nearly 190,000 bed days a year. The transfer of these procedures to the public hospital system reflects an additional annual cost burden of $195 million on State and Territory governments, as more Australians exit their private cover to depend solely on the public system for care.[60]

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57 Senate Economics Committee, *Tax Laws Amendment (Medicare Levy Surcharge Threshold) Amendment Bill 2008*, August 2008, p. 19. A similar point is made in the Report by Access Economics, 'Impact of means-testing the PHI rebate and changing MLS parameters', June 2009, p. 10.

58 Mr Rob Bransby, *Proof Committee Hansard*, 9 July 2009, pp. 10–11.

59 Australian Health Insurance Association, *Submission 5*, p. 1.

60 Australian Health Insurance Association, *Submission 5*, p. 6.

3.53 Catholic Health Australia told the committee that based on AHIA's survey-based estimate of 100 000 people exiting PHI, it anticipated 36 000 people joining public hospital waiting queues. Forecasts aside, Mr Laverty told the committee that:

> …any pressure on public hospital waiting lists is an unwanted one, and why would we be taking a risk without putting in place a safety net, a monitoring mechanism or a compensation arrangement to ensure that those public hospital waiting lists are not increased? That is the principal concern that I put before this inquiry. Because we have a foot both in private hospitals and in public hospitals and because the mission imperative of Catholic hospital services in Australia is ultimately for low-income earners, for those poor and marginalised, any pressure on public hospital waiting lists is not something that we would be comfortable with.[61]

3.54 Mr Laverty told the committee that at a minimum, the government should commit to monitoring the impact of the legislation on public hospitals. And if necessary, he argued, there should be a 'compensatory measure' through the health care agreements to the states and territories.[62]

3.55 The committee notes that an ex post facto analysis to isolate the effect of the legislation on public hospitals would be highly complex. As Ms Penny Shakespeare, Assistant Secretary of DoHA's Acute Care Division, told the committee:

> It is also very difficult to work out what the impact would be on public hospitals because everybody who is eligible for Medicare is entitled to be treated as a public patient in a public hospital whether or not they have private health insurance and whether or not they have comprehensive private health insurance. It would be quite difficult for us to tell if somebody were presenting to a public hospital because this measure had resulted in them taking out a product with an exclusion or whether they would have decided to be treated as a public patient anyway.[63]

Treasury and DoHA's view

3.56 In evidence to the committee, Treasury explained that it was not required under the Charter of Budget Honesty to model the second and third round effects.[64] These effects include the impact of the measures on the use of public hospitals.

3.57 In its submission to this inquiry, the Department of Health and Ageing (DoHA) noted that the legislation will lead 40 000 people to drop their private health cover, resulting in an extra 8000 public hospital visits or 'episodes'. The figure of 40 000 people comes from 25 000 who are expected to drop their hospital and/or

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61 Mr Martin Laverty, *Proof Committee Hansard*, 14 July 2009, p. 2.

62 Mr Martin Laverty, *Proof Committee Hansard*, 14 July 2009, p. 6.

63 Ms Penny Shakespeare, *Proof Committee Hansard*, 14 July 2009, p. 24.

64 Mr Marty Robinson, Senate Economics Legislation Committee, *Private Briefing*, 9 June 2009, p. 6. Mr Marty Robinson, *Proof Committee Hansard*, 14 July 2009, p. 15.

general treatment cover, 10 000 who will keep their hospital cover but drop their general treatment cover and 5000 who have a general treatment policy only and drop that cover.[65]

3.58 This rate of PHI cover to public hospital 'episodes'—roughly 3 to 1—is corroborated by Catholic Health Australia's estimates.[66] Access Economics also accepts Treasury's analysis that if the drop out figure is 25 000 adults, then the impact on public hospitals will be roughly 8000 'episodes'. It also recognised that some privately insured patients now use the public system (as private patients). If they drop their cover, the effect on public hospitals is a loss of revenue rather than extra cost associated with extra volume.[67]

Other views on the impact of the bills on public hospitals

3.59 Several submitters to this inquiry downplayed the effect that the government's measures may have on the public hospital system from a fall in PHI membership. Mr Wells told the Senate Economics Legislation Committee that if people keep their cover and drop their hospital cover there would be no impact on the public hospital system because 'ancillary cover does not cover the sorts of things you get in a public hospital'.[68]

3.60 Mr McAuley has argued that the support given to private health insurance over the past decade has had the effect of shifting resources—surgeons, nurses, etc.—to the private sector. It has not taken pressure off the public system because it has taken these scarce resources away from public hospitals and to the private sector.[69] Private hospitals, financed heavily by the private insurance funds, tend to offer a limited range of elective surgeries and tend to over treat patients.[70] Mr McAuley noted that the private funds cannot achieve effective cost control because the service providers will seek out those insurers willing to cover the higher cost. The same problem has been observed internationally.[71]

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65 Department of Health and Ageing, *Submission 4*, p. 2.

66 See also Mr Martin Laverty, Senate Economics Legislation Committee, *Proof Committee Hansard*, 9 June 2009, p. 38; Mr Martin Laverty, *Proof Committee Hansard*, 14 July 2009, p. 3.

67 'Impact of means-testing the PHI rebate and changing MLS parameters', Report by Access Economics for Catholic Health Australia, June 2009, p. 12.

68 Mr Rob Wells, Senate Economics Legislation Committee, *Proof Committee Hansard*, 9 June 2009, p. 30.

69 Mr Ian McAuley, Senate Economics Legislation Committee, *Proof Committee Hansard*, 9 June 2009, p. 19.

70 Mr Ian McAuley, Senate Economics Legislation Committee, *Proof Committee Hansard*, 9 June 2009, p. 22.

71 Organisation for Economic Cooperation and Development, *Private Health Insurance in OECD Countries*, 2004.

3.61 Access Economics has noted that the impact of the measures on the public hospital system will depend on an assessment of those most likely to drop their cover. Intuitively, this group will be a combination of those least likely to need it and those least able to afford it. The impact will be minimal if the drop outs are concentrated among 'surcharge avoiders' who are in PHI for monetary reasons and attach little or no value to any potential fund benefits. On the other hand, the impact on public hospitals may be substantial if those who leave the funds are among the older, high service using cohort.

Committee view

3.62 The committee agrees with Treasury that the impact of the bills' measures on private health fund membership, and any subsequent impact on public hospitals, will be relatively minor. It emphasises that the bills will only impact directly on the wealthiest quartile of those with private health insurance. This reflects the rationale for the legislation: that those who have the capacity to pay for their PHI should properly do so from their own pocket. In terms of whether this cohort will drop or downgrade their cover, the behavioural evidence indicates that not only do the wealthy overinsure, they place high value on retaining this cover. Private health insurance is more responsive to income than to price. For these reasons, the committee believes that the legislation is fair and largely undisruptive.

3.63 To the extent that those on higher incomes do downgrade their policies, the committee believes the legislation will promote an equitable adjustment. Those with PHI (often on higher incomes) are currently subsidised through the 30 per cent rebate for their ancillary treatment, while those without PHI (often on lower incomes) pay for this treatment without any taxpayer assistance. However, the committee thinks that in the absence of a significant marketing campaign, it is unlikely that many people will drop their ancillary cover.[72]

3.64 The committee has not had the benefit of assessing the methodology of the AHIA-commissioned market research. It does emphasise, however, the well-known limitations of this type of approach which is heavily dependent on question format.[73] How people respond to the prospect of higher premiums in a survey will often differ to how they respond in practice.

3.65 More particularly, the committee queries AHIA's assumption that there will be a direct and absolute transfer of private hospital 'episodes' to the public system. It highlights research indicating the over treatment of patients in private hospitals and the fact that private hospitals offer many treatments which are non-essential and may

72 The Department of Health and Ageing noted in its submission that the government will conduct a general communications campaign during 2009–2010 in the lead up to the 1 July 2010 changes. *Submission 4*, p. 6.

73 See Mr Rob Wells, *Proof Committee Hansard*, 9 June 2009, p. 31.

be forgone. Many people with private insurance are already treated in public hospitals and some of those who drop their ancillary cover will self insure in a private hospital.

The process of implementing the means tested rebate

3.66 In its tabled opening statement to the committee, DoHA gave several examples as to how a person might claim the rebate under the proposed means testing arrangements.

3.67 A person (or family) with PHI in the affected income range (>$75 000) can advise their insurer to deduct a lower rebate level from their premium. The person would nominate his/her new rebate level according to their income and age (although they need not provide these precise details to their insurer). The insurer would reduce the premium charged by the lesser rate (either 10, 20 or 30 per cent). The share met by the Government—through rebate payments provided by Medicare Australia directly to the insurer—would be reduced accordingly, and the insuree would pay a higher a premium to cover the lower rebate.[74]

3.68 Alternatively, a person could decide not to inform the insurer of their details. In this case, s/he will continue to receive the 30 per cent rebate (or higher if they are over 65 years). Having been overpaid for the rebate, the person will incur a tax debt of the amount for which they were overcompensated.[75]

3.69 A third option is to change the way the rebate is claimed. If a person is unsure of the income they might earn in a given financial year and did not want to incur a tax liability, they could advise their insurer not to deduct any rebate from their premium payments. The appropriate rebate could then be claimed through a tax return. This option of claiming the rebate as a tax deduction already exists.[76]

3.70 A fourth possibility is to claim the rebate as a refund at a Medicare office. In this case, a person pays their PHI premium on a quarterly basis and claims the full (non-means tested) rebate at the Medicare office. If his/her income for that year exceeds the amount eligible for the full rebate, the difference between the rebate claimed and the rebate to which they are entitled would be repaid as a tax debt.[77]

Concerns with the proposed process for means-testing the rebate

3.71 The committee has received comment that means testing the private health insurance rebate may create uncertainty for consumers and complexity for administrators. Dr Deeble, for example, qualified his support for the bill by

74 Department of Health and Ageing, *Opening Statement*, 14 July 2009, p. 2.

75 Department of Health and Ageing, *Opening Statement*, 14 July 2009, pp. 2–3.

76 Department of Health and Ageing, *Opening Statement*, 14 July 2009, p. 3.

77 Department of Health and Ageing, *Opening Statement*, 14 July 2009, p. 3.

commenting: 'like all means-tested arrangements, the system will be more complex to administer than at present'.[78] Various organisations have voiced their own concerns.

3.72 The AHIA has expressed its fear that:

> …additional burdens will be placed on our Fund Members as part of the implementation and administration of this legislation. A briefing to Industry from the Department of Health and Ageing following the Budget announcement suggests that Private Health Funds will be required to request that fund members self-identify which rebate level they are entitled to, before their eligibility is then reconciled by the Australian Taxation Office as part of the individual's annual tax assessment. This process is likely to lead to confusion amongst policy holders as to their entitlement if their income level varies from year-to-year and will also add cost imposts on Private Health Funds as they implement new systems to accommodate the policy change.[79]

3.73 In its submission to this inquiry, BUPA Australia commented:

> For the industry, the lack of clarity around administration of the scheme means the costs of start-up, systems, communication and ongoing administration of this far more complex proposed rebate scheme cannot be estimated. This is of considerable concern, as we are still unclear on the degree to which these costs could ultimately impact on our customers through their premiums. The proposed changes will…serve to increase complexity for a very large number of PHI customers. To ensure this is managed as smoothly and effectively as possible, the Federal Government should commit to a significant annual consumer communications campaign, incorporating mailings and production of printed material and forms.[80]

3.74 The Health Insurance Restricted Membership Association of Australia (HIRMAA) has also expressed concerns with the administration of the means tested rebate. In particular, it stressed that no health insurers are expected or obliged to act as agents of the Australian Taxation Office (ATO) and consumers must be able to access their rebate through an upfront deduction by the insurer, through a Medicare office or through their tax return.[81]

3.75 DoHA assured the committee that the administrative cost to insurers from implementing the incentive tiers would be minimal. Ms Shakespeare told the committee that the major cost to the funds would be to change their systems to recognise the additional rebate tiers. She noted that the funds have had experience in this process when the previous government a higher rebate for higher age groups.

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78 Dr John Deeble, *Submission 6*, p. 2

79 Australian Health Insurance Association, *Submission 5*, p. 6.

80 Bupa Australia, *Submission #*, p. 7.

81 Health Insurance Restricted Membership Association of Australia, *Submission 3*, p. 4.

> We have actually had a look back to see what happened last time we introduced additional rebate tiers that their systems needed to recognise…in 2005. For premium submissions made in that year no insurer mentioned additional administrative costs associated with the introduction of the additional rebate as a reason for additional premium increases. In fact, management expense ratios decreased.[82]

3.76 The Government has in place plans to deal with all these issues. When claiming the rebate as a premium deduction or through a refund at Medicare, a person will need to nominate a premium rebate level that they are entitled to based on their 'adjusted taxable income'. If they over-estimate their income, they will receive a rebate refund through their tax return for that year; if they under-estimate their income, they will incur a rebate debt through their tax return which will be recoverable as a normal tax debt.[83]

3.77 DoHA's submission also noted that funding for a communications campaign about the changes has been provided to the ATO through the 2009–10 budget. It will be coordinated by the ATO with support from DoHA. DoHA will concentrate its efforts on assisting industry to implement the changes through the development of 'information and guidance material'.[84]

Committee view

3.78 The committee is satisfied that the Government has set aside adequate funding and resources to inform and instruct the industry and the public as to how the means tested private health insurance rebate will operate.

Recommendation

3.79 The committee recommends that the bills be passed.

Senator Claire Moore
Chair

August 2009

82 Ms Penny Shakespeare, *Proof Committee Hansard*, 14 July 2009, p. 20.

83 Department of Health and Ageing, *Submission 4*, p. 5.

84 Department of Health and Ageing, *Submission 4*, p. 6.