The Senate

Community Affairs Legislation Committee

Fairer Private Health Insurance Incentives Bill 2009 and two related bills

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42nd Parliament

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Chapter 1

Introduction

Background

1.1 On 12 May 2009, the Treasurer the Hon. Wayne Swan and the Minister for Health and Ageing, the Hon. Nicola Roxon, announced that the government would:

> …rebalance the suite of policies supporting private health insurance – so that those with a greater capacity to pay for their own private health insurance do so… high income earners will receive less Government payments for their private health insurance, but will face an increase in costs should they opt-out of their health cover.[1]

1.2 The Fairer Private Health Insurance Incentives Bill 2009, the Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009 and the Fairer Private Health Insurance Incentives (Medicare Levy Surcharge—Fringe Benefits) Bill 2009 ('the bills') were introduced into the House of Representatives on 27 May 2009 to give effect to this proposal. The bills are intended to ensure that those with a greater capacity to pay make a larger contribution towards the cost of their private health insurance.

Purpose of the bills

1.3 Currently, people who have a private health insurance policy receive a 30 per cent rebate on the cost of this policy: those without private health insurance earning more than $70,000 per annum are liable for a one per cent Medicare levy surcharge on their taxable income.

1.4 The bills taper the rate of the private health insurance rebate and increase the Medicare levy surcharge for higher income earners.

1.5 The bills give effect to three new Private Health Insurance Tiers. For those under 65 years of age with a private health insurance policy:

(a) singles earning more than $75,000 per annum and couples/families earning more than $150,000 per annum will have their private health insurance rebate reduced by 10 per cent. The Medicare levy surcharge will remain at 1 per cent for those singles and couples/families that do not hold appropriate private health insurance;

(b) singles earning more than $90,000 per annum and couples/families earning more than $180,000 per annum with a private health insurance policy will have their private health insurance rebate reduced by 20 per

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1 Treasurer and Minister for Health and Ageing, *Press Release*, 12 May 2009.

cent. The Medicare levy surcharge will be increased by 0.25 percentage points for those singles and couples/families that do not hold appropriate private health insurance;

(c) singles earning more than $120,000 per annum and couples/families earning more than $240,000 per annum will no longer receive any private health insurance rebate. The Medicare levy surcharge will be increased by 0.5 percentage points for those singles and couples/families that do not hold appropriate private health insurance; and

(d) existing private health insurance rebate arrangements will remain unchanged for singles with income of less than $75,000 per annum and couples/families with a combined income of less than $150,000 per annum.

1.6 These amendments apply to income years starting on or after 1 July 2010.

Conduct of the inquiry

1.7 Under a Senate Resolution of 14 May 2009, the bills were referred to the Senate Economics Legislation Committee on their introduction into the House of Representatives on 27 May 2009. The resolution required the Committee to report to the Senate on 16 June 2009.

1.8 On 9 June 2009, the Senate Economics Legislation Committee held a public hearing into the provisions of the legislation. The same day, the Economics Committee held a private briefing with officials from the Treasury and the Department of Health and Ageing.

1.9 On 15 June, the Senate transferred the inquiry from the Economics Committee to the Senate Community Affairs Legislation Committee and extended the reporting date until 5 August 2009. The transfer also included the submissions and evidence received by the Economics Legislation Committee during its period in control of the inquiry.

1.10 The committee received 13 submissions, which are listed at Appendix 1 of this report. These submissions are also available at the committee's webpage: http://www.aph.gov.au/Senate/committee/clac_ctte/fairer_private_health_09/submissions/sublist.htm

1.11 In addition to the hearing held by the Economics Committee, the Community Affairs Committee held four further public hearings: on 8 July in Canberra, 9 July in Melbourne, 10 July in Perth and 14 July in Canberra. The committee thanks all the witnesses who appeared these hearings to give evidence.

Outline of the report

1.12 Chapter 2 of this report details the purpose, cost and comments in support of the legislation. Chapter 3 investigates the likely impact of the legislation, including Treasury's modelling and concerns that the measures will lead to a significant cut in private health insurance membership and place corresponding stress on public hospitals.

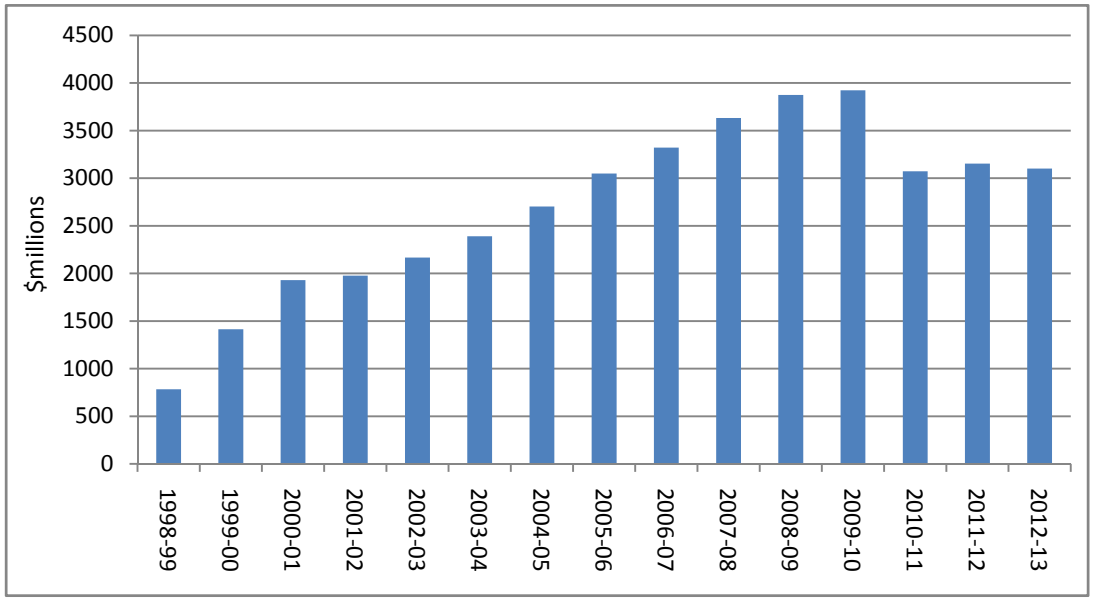
Chapter 2

The bills

Background

2.1 In his Budget Speech of 12 May 2009, the Treasurer the Hon. Wayne Swan noted that 'spending on the private health insurance rebate is growing unsustainably [Chart 2.1], and disproportionately favours those on higher incomes'. He announced that from 1 July 2010, the 30 per cent private health insurance (PHI) rebate will be reduced for higher income earners and the Medicare Levy Surcharge (MLS) will be increased for those in higher income brackets.[1] Mr Swan added that Treasury modelling shows that private health insurance coverage 'will remain at more than 99 per cent of its current levels'.[2]

Chart 2.1: Payments under the Private Health Insurance Act 1998



Source: Data taken from Department of Health and Ageing, Portfolio Budget Statements 2009–10, p. 254; Department of Health and Ageing, Annual Reports, various years.

2.2 The Minister for Health, the Hon. Nicola Roxon, explained that the bill brings Government support for private health insurance in line with the principle that the

1 The Medicare Levy Surcharge is imposed on all people who earn over $70,000 per annum and do not hold private health insurance. It is levied at a rate of 1 per cent of total income. For example, a person earning $75,000 per annum without PHI would be liable to pay an MLS of $750 per annum.

2 The Hon. Wayne Swan, *Budget Speech*, 12 May 2009.

largest benefits be provided to those on the lowest incomes.[3] In evidence to the committee, Mr Mark O'Connor from Treasury's Revenue Group highlighted the inequity of current arrangements to finance the 30 per cent rebate, and the bill's redress:

2.3 Under current projections, by 2010-11 it is estimated that approximately 14 per cent of single tax-filers who have incomes above $75,000 would receive about 28 per cent of the total private health insurance rebate paid to singles. Under the new reforms introduced via these bills, they will receive around 12 per cent. Similarly by 2010-11, it is estimated that approximately 12 per cent of coupled tax-filers who have incomes above $150,000 would receive approximately 21 per cent of the total private health insurance rebate paid to couples. Under the new reforms, they will receive around nine per cent.4

The bills' measures

2.4 The Fairer Private Health Insurance Incentives Bill 2009, the Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009 and the Fairer Private Health Insurance Incentives (Medicare Levy Surcharge—Fringe Benefits) Bill 2009 taper the rate of the PHI rebate and increase the MLS for higher income earners.5 The bills are intended to ensure that those with a greater capacity to pay make a larger contribution towards the cost of their private health insurance. The amendments will apply to income years starting on or after 1 July 2010.

2.5 Table 2.1 summarises the measures in these bills. It also notes that the higher PHI rebate currently given to insurees aged 65–69 (35 per cent) and insurees over 70 (40 per cent) will also be reduced for the three income tiers.

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3 The Hon. Nicola Roxon, Second Reading Speech, *House of Representatives Hansard*, 27 May 2009, p. 3.

4 Mr Mark O'Connor, *Proof Committee Hansard*, 9 June 2009, p. 3.

5 The Fairer Private Health Insurance Incentives Bill 2009 proposes amendments to five Acts: the *Income Tax Assessment Act 1936*, *Income Tax Assessment Act 1997*, *Private Health Insurance Act 2007*, *Taxation Administration Act 1953* and *Taxation (Interest on Overpayments and Early Payments) Act 1983*. The bill introduces new income tiers for the private health insurance rebate, allows the Commissioner of Taxation to require the provision of certain information and allows for the recovery of payments that are recoverable as debts due to the Commonwealth and pay interest on overpayments.

The Fairer Private Health Insurance Incentives (Medicare Levy Surcharge) Bill 2009 proposes amendments to the *Medicare Levy Act 1986* which determines whether an individual is liable to pay the Medicare Levy Surcharge on their taxable income.

The Fairer Private Health Insurance Incentives (Medicare Levy Surcharge—Fringe Benefits) Bill 2009 proposes amendments to *A New Tax System (Medicare Levy Surcharge) Act 1999*. This Act determines whether an individual is liable to pay the Medicare Levy Surcharge in respect of a reportable fringe benefit they or their spouse may have.

See Mandy Biggs, *Bills Digests nos. 152, 153 and 154*, Parliamentary Library, 5 June 2009.

Table 2.1: The bill's measures

	Current surcharge thresholds	Tier 1	Tier 2	Tier 3
Single	$0 - $75,000	$75,001 - $90,000	$90,001 - $120,000	$120,001+
Families	$0 - $150,000	$150,001 - $180,000	$180,001 - $240,000	$240,000+
Medicare levy surcharge	Nil	1%	1.25%	1.5%
Private health insurance rebate				
Less than 65 years	30%	20%	10%	nil
65 to 69 years	35%	25%	15%	nil
70 years or over	40%	30%	20%	nil

Source: Budget Paper No. 2, p. 311.

2.6 Table 2.2 shows that these measures will save $1.9 billion over five years. Government expenditure on the private health insurance rebate will reduce by $1.8 billion over four years, while revenue through the surcharge will increase by $145 million between 2011–12 and 2012–13. It will cost the Australian Taxation Office $67 million over five years to implement the measure.

Table 2.2: Impact on cost from the bill's measures

Expense ($million)	2008–09	2009-10	2010–11	2011–2012	2012–2013
Department of Health & Ageing	-	119.3	-713.5	-613.8	-614.9
Australian Taxation Office	1.0	4.8	18.1	33.6	9.1
Medicare Australia	-	0.3	-	-	-
Total	**1.0**	**124.3**	**-695.4**	**-580.2**	**-605.8**

Source: Budget Paper 2, p. 310.

2.7 Treasury told the committee that means testing the PHI rebate will affect the top 23 per cent of the privately insured population (measured as Single Equivalent Units (SEU) by income level). It estimates that nine per cent of those with PHI are within Tier 1, around seven per cent are in the second income tier and a further seven per cent are in the top tier. Treasury also noted that while people aged 65 or over

constitute 12 per cent of privately insured SEU's, the proportion of this age group affected by the measure will be less than two per cent.[6]

Support for the bill

2.8 Several witnesses and submitters were supportive of the bill's measures on the grounds that they offered greater equity in the structure of taxpayer support for health insurance and health service funding.

2.9 Underpinning this support was pointed criticism of the current private health insurance rebate. Dr John Deeble, notably, argued that the PHI rebate has been 'wasteful' and 'ineffective in raising more private money for health'.[7] In the context of the Government's pledge to retain the rebate, however, he argued that the bill's measures go 'some way towards a more equitable and sustainable system'.[8]

2.10 Similarly, the Australian Nursing Federation 'strongly' supported the legislation, but in the broader context that 'it should not be the Government's responsibility to provide incentives for the private health insurance industry to attract buyers to its membership products'.[9]

2.11 The Australian Healthcare and Hospitals Association also offered strong support for the legislation. It also refuted claims that the rebate had either attracted members to the funds or that it had taken pressure off the public hospital system.[10] Moreover, the Association highlighted that the rebate has been an 'extremely inefficient' use of taxpayer dollars in that it funds a commercial insurance industry rather than health service delivery.[11]

2.12 Ms Michelle Kosky, Executive Director of the Health Consumers Council of Western Australia, expressed her support for the bill's intent:

> I have no problem at all with taking the view that people who can afford it should have private health insurance to enable people who cannot afford it

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6 Mr Mark O'Connor, Senate Economics Legislation Committee, *Private Briefing*, 9 June 2009, p. 3.

7 Dr John Deeble, AO, was co-author of the original proposals for universal health insurance in 1968, Special Adviser to the Ministers for Health in the Whitlam and Hawke governments, Chairman of the Planning Committees for both Medibank and Medicare and a Commissioner of the Health Insurance Commission for 16 years to 1999. See http://www.health.act.gov.au/c/health?a=da&did=10084012&pid=1192599114 (accessed 23 July 2009).

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

9 Australian Nursing Federation, *Submission 8*, p. 1.

10 The Association's submission cites V. Sundararjan, K. Brown and D. Hindle, "Effect of increased private health insurance on hospital utilisation in Victoria", *Australian Health Review*, Vol. 28, No. 3, 2004, pp. 320–329.

11 Australian Healthcare and Hospitals Association, *Submission 9*, p. 1.

> to access the public hospital system…I also think that means-testing a private health insurance rebate for wealthy people is not an unreasonable attitude for government to take at this time. By wealthy, I suppose I mean people on over $100,000 a year.[12]

2.13 Dr Deeble also praised the legislation for introducing a more progressive Medicare levy structure. In last year's Senate inquiry into the Medicare Levy Surcharge thresholds, Dr Deeble noted the MLS is unique among income-related charges in that it sets an extraordinarily high marginal tax rate. He noted in his submission to this inquiry that 'the proposed changes will not remove that problem but when the new surcharges are included, they will make the Medicare levy structure more progressive and much more like the income tax'.[13]

2.14 The following chapter presents a closer analysis of the likely impact of the legislation, including the Treasury's modelling and concerns that the measures will lead to a significant drop in PHI membership and place corresponding stress on public hospitals.

12 Ms Michelle Kosky, *Proof Committee Hansard*, 10 July 2009, p. 17.

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

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.
>
> 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.
>
> …
>
> 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.

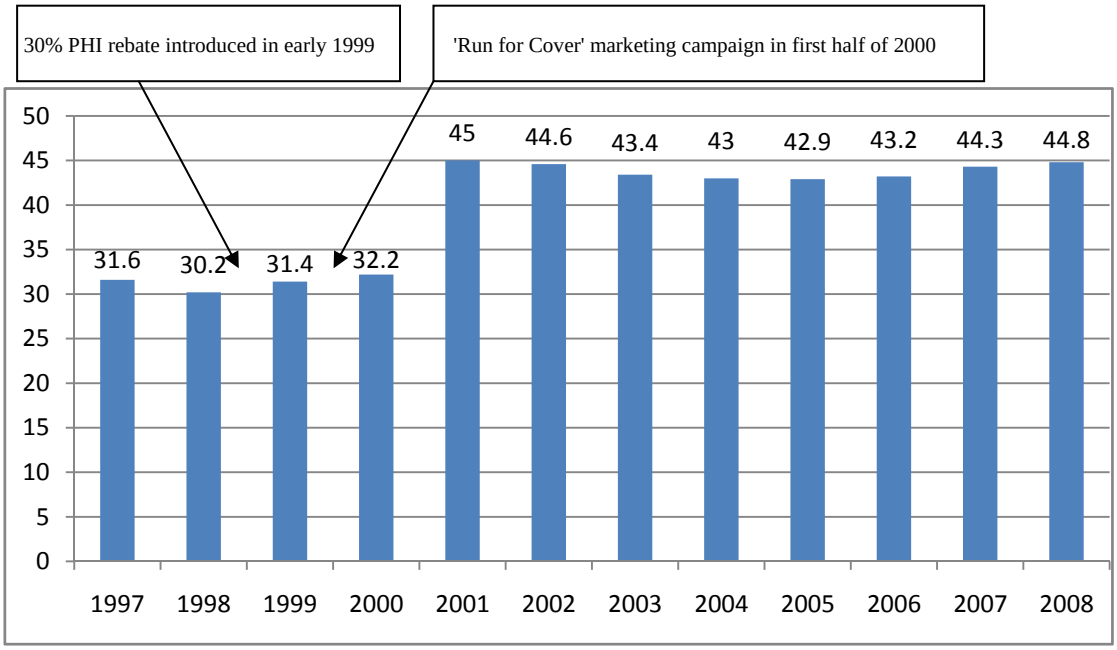
51 Dr John Deeble, Senate Economics Legislation Committee, *Proof Committee Hansard*, 8 July 2009, p. 32.

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.

SENATE SHOULD REJECT CRUSADE AGAINST PRIVATE HEALTH

COALITION SENATORS DISSENTING REPORT

Coalition Senators recommend the Senate reject the government's proposal to reduce or scrap private health insurance rebates for millions of privately insured Australians.

This measure is the Rudd government's second strike in two budgets against the important private health component of our mixed public and private health system. It is a blatant breach of one of the most emphatic pre-election commitments of the government, driven by ideology rather than the pursuit of good public health policy.

The overarching policy objective in health funding and service delivery should be to ensure timely and affordable access to quality health care for all Australians. There are not sufficient publicly-funded sources to meet current and projected future demand for acute and chronic care services. To achieve this we need, therefore, the right balance between a strong public and a strong private system.

The private system is underpinned by private health insurance. The more people take out and retain private health insurance over the long term the more affordable it is for everyone and the more additional (private) resources are channelled into our health system.

At present more than eleven million Australians take additional responsibility for their own health care needs taking out private health insurance. At the end of the March 2009 quarter about 9.7 million Australians were privately insured. This was up from a mere 5.7 million Australians with private hospital cover when the last Labor government induced a serious downward spiral in private health insurance participation rates which bottomed out in December 1998.

Under the Hawke and Keating governments, private health insurance participation rates dropped from 63.7% in 1983 down to 33.5% in 1996. It took the Howard government another two years and a number of sound policy initiatives like the Medicare Levy Surcharge, the 30% Private Health Insurance rebate, and Lifetime Health Cover *working together* to turn things around and restore the balance in our health system.

Equally, the impact on private health insurance participation of changes to the Medicare Levy Surcharge thresholds last year and private health insurance rebates this year will not be immediate. Impacts of health policy changes are rarely immediate. Over the past two years private health insurance participation rates have continued to grow (albeit more slowly), as a result of the ongoing impact of the sound private health policy framework put in place by the Howard government. There is no doubt

however that this upward trend will continue to slow and soon start to reverse again, as it did under previous Labor administrations.

In 2007, the Australian Labor Party promised that on coming to government it would not change the existing arrangements for private health insurance rebates introduced by the Howard Government. This promise already has been broken twice in less than two years. This will result in fewer people choosing private health and more pressure on public hospitals.

Indeed, if this measure is passed there is no doubt (and even the government agrees) that it would:

- add further pressure on public hospitals;
- increase the cost of private health insurance for millions of Australians ; and
- result in fewer people with private health cover.

The argument between the government and the Coalition is not about *whether* there will be more pressure on public hospitals and other publicly-funded services. The government has conceded that point. The question is *how much* additional pressure, and whether the government has properly assessed what that impact on public hospitals will be.

More pressure on public hospitals means more people will have to wait for longer to access much needed public hospital treatment.

Given the combined effect of the rebate reduction/abolition and the increases in the Medicare Levy Surcharge in this proposal (if implemented), many privately insured Australians would be left with no option other than to drop or downgrade their level of cover. This in turn would put even more pressure on public hospitals (pressure not accounted for in any of the government's assessments or modelling).

Over time this measure, together with last year's changes to the Medicare Levy Surcharge thresholds, will put further upward pressure on private health insurance premiums. Every increase in premiums over and above what would have happened otherwise will force more people to leave private health or not take it up. This was the experience in the 1980s and 1990s until the Howard Government intervened.

The policy shifts of the Rudd Government are not based on rationality or common sense. They are part of an ideologically-driven crusade against private health and private health insurance and will take Australia back into the downward private health membership spiral experienced under the previous Labor administration between 1983 and 1996.

THOSE WHO DO NOT LEARN FROM HISTORY…

As previously mentioned, private health insurance participation rates plummeted under the Hawke/Keating governments from 63.7% in 1983 down to 33.5% in 1996.

This was with the blessing of the then Labor government, which wanted to see Medicare take over the role played until then by the private health sector.

Rationality only entered Labor's thinking towards the end of its period of government. Alarmed about the impact of 10 years of Hawke and Keating government policy on the private health system, then Federal Health Minister Graham Richardson released a discussion paper on private health insurance reform in December 1993.

In it he observed that[1]:

> *"It was anticipated that the introduction of a high quality universal health car system would result in a significant decline in the number of people with private health insurance. Indeed, the Medicare levy was introduced to help finance the shift of large numbers of people from the private to the public system.*

However:

> *"There was an initial drop* (in private health insurance participation rates) *from 63.7% in 1983 to 50% in 1984. The decline has continued ever since, with particular pressure being put on the participation rate as a result of the recession. From 1984 to 1993 the average decrease in the proportion of the population has been 1.2%. However in the last two years the fall has accelerated to an average of almost 2.2%."* (emphasis added).

And unlike the first-term Rudd Labor government, backed up with ten years of data, then Senator Richardson was acutely aware of the impact reductions in private health insurance participation rates would have on the public hospital system.

Indeed, in his 1993 discussion paper he said:

> "*…declining rates of private health insurance membership have significant implications for the public system.*
>
> *As more people drop out of private insurance the demands on the public system grow. Already there are problems – the most obvious being waiting lists. There are too many people waiting too long, in pain, for vital operations.*"[2]

The discussion paper should be compulsory reading for any member of the Rudd government intent on pursuing an outdated and misguided ideological agenda against private health.

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[1] Reform of Private Health Insurance, A Discussion Paper, Australian Government Publishing Service, December 1993, p.5;

[2] Reform of Private Health Insurance, A Discussion Paper, Australian Government Publishing Service, December 1993, p. 3;

The introduction to the discussion paper includes this damning assessment of the impact of ten years of Hawke/Keating policy on health[3]:

> "*We have now reached the point where private coverage has fallen below 40%. This is not an immediate problem as those who have dropped out are mostly young and healthy. However, as time goes on, an increasing number of older, high users of health services will give up their insurance.* (emphasis added).
>
> *These are people who do not currently use the public system much or at all. Should they come to rely on it, money and resources will have to be found to provide for them.*
>
> *There are also a great many low income families who maintain private health insurance. As premiums continue to rise these people will come under increasing pressure to drop their cover.* ***This gives rise to the real possibility that a flash point will be reached where the gradual decline of the last couple of years becomes an avalanche****. (emphasis added)*
>
> ***This would have critical implications for both the private and public systems and would require significant additional expenditure by governments****." (emphasis added)*

Why does the Rudd government think that going down the same old ideological path again will result in different outcomes?

Senator Richardson was forced by Paul Keating to take his recommendations on how to restore better balance in our health system – including consideration of a Medicare Levy Surcharge – to a Federal ALP Caucus/ACTU working party. This is where his proposals were buried, and it wasn't until the election of the Howard government in 1996 that sensible reform of the private health insurance policy framework was seriously pursued.

The reality is that the Rudd government is already expecting and budgeting for a reduction in private health insurance participation rates.

Indeed, the Rudd government expects the proportion of the Australian population with private health insurance to drop by more than 2.6% over the forward estimates period. However they have hidden that in the budget fine print.

In previous Health and Ageing Portfolio Budget Statements the budget targets and reference points for the 'number of people with private health insurance' were always expressed as both a total number of privately insured and as a proportion of the population (that is as a percentage).

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[3] Reform of Private Health Insurance, A Discussion Paper, Australian Government Publishing Service, December 1993, p. 1;

There is a longstanding convention over many decades to monitor the proportion of Australians with private health cover.

Even during the Hawke/Keating years private health insurance participation rates were measured as a proportion of the population. Indeed it is a more meaningful measure as it takes the effect of population growth into account.

In this budget, and contrary to previous budget papers, the Rudd government no longer includes a percentage target or reference point, but only states the government's expectation that the 'number' of Australians with private health insurance will stay at 9.7 million over the forward estimates.

Even a very conservative assessment of ABS population growth forecasts (using the median projection out of the three available ABS scenarios) means that the government expects the proportion of the population with private health insurance to drop from 44.6% to 42% over the forward estimates period.

This is a worrying trend, and one can only assume that the reason the Rudd government have removed the percentage reference in the budget papers is to hide the fact that they expect it to go down over the forward estimates and they did not want to draw any attention to that.

EXISTING PRIVATE HEALTH INSURANCE REBATES IMPORTANT

The Federal Government's moves on the private health insurance rebate and the Medicare Levy Surcharge in the last two Budgets have shaken the underpinnings of the industry, even if the full premium and participation effects are still to be seen.

The National Health and Hospitals Reform Commission, which reported in June 2009, has also recommended further sweeping changes to private health insurance. We haven't even seen the results of the Preventive Health Taskforce, the Health Technology Assessment Review or the Human Tissue Review, each of which has the potential to make significant additional regulatory changes affecting private health insurance coverage.

It is obvious that under Labor the benign policy settings and relationships that benefited the private health sector in the previous decade are going if not gone.

There is a view once again prevalent in government that the private health sector and private health insurance supplement the public system, that they are optional extras not vital components of our overall health infrastructure. They fail to recognise that the private health sector handles well over half of all Australian hospital procedures, many of these of great complexity. Whether the Rudd government likes it or not, each of these procedures potentially could be done in the public sector at full public cost.

As Professor Ian Harper and Chris Murphy demonstrated as far back as 2004, each dollar spent on the private health insurance rebates saves two dollars of Federal and

State outlays. Incentivising people through the private health insurance rebate system draws private dollars into the system to fund billions and billons of dollars in private hospital care.

AUSTRALIANS WERE CONNED BY LABOR ON PRIVATE HEALTH

The Rudd Labor government does not have a mandate to pursue this measure.

The question of what Labor would do in relation to the private health insurance policy framework in general and private health insurance rebates in particular was extensively canvassed before the last election.

Kevin Rudd and Nicola Roxon, approaching an election from Opposition, considered the issue politically sensitive and material enough to provide strong and clearly worded public and private commitments that a Rudd Labor government would retain the existing rebates.

In a letter to the Australian Health Insurance Association dated 20 November 2007 then Opposition Leader Kevin Rudd wrote:

> *"Both my Shadow Minister for Health, Nicola Roxon, and I have made clear on many occasions this year that Federal Labor is committed to retaining the existing private health insurance rebates, including the 30 per cent general rebate and the 35 and 40 per cent rebates for older Australians."*

As stated in the Prime Minister's letter, that same iron-clad guarantee had been provided by both himself and his then Shadow Minister on 'many occasions'.

In a speech to the Annual Australian Health Insurance Association Conference in Melbourne on 10 October 2007, then Shadow Health Minister Nicola Roxon said:

> *"This is why we have committed to the current system of private health insurance incentives – including the package of rebates, the Lifetime Health Cover and the surcharge.*
>
> *Labor understands that people with private health insurance – now around 9 million Australians – have factored the rebate into their budgets and we won't take this support away."*

When the Coalition had previously dared to question the sincerity of that emphatic pre-election commitment we were accused of running a dishonest scare campaign. This is what the then Shadow Minister for Health and Ageing Nicola Roxon had to say on 26 September 2007:

> *"Federal Labor rejects the Liberal scare campaign around the Private Health Insurance rebates… The Liberals continue to try to scare people into thinking*

> *Labor will take away the rebates. This is absolutely untrue. The Howard Government will do anything and say anything to get elected".*

Of course we now know that this is exactly what has happened for more than two million Australians.

The Howard Government was telling the truth, while Labor conned people into believing that it had changed its ways; that it would no longer be driven by its longstanding ideological agenda against private health.

THE CON CONTINUED IN GOVERNMENT

When the Coalition questioned the newly elected government's commitment to private health insurance, the government accused us of perpetuating the scare campaign. The Parliamentary Secretary for Health and Ageing read the now discredited September 2007 press release into the Hansard record and reconfirmed the Rudd government's commitment to the retention of the existing private health insurance rebates[4].

On many occasions since has the government reconfirmed its commitment to retain the existing private health insurance rebates.

As late as 24 February 2009, confronted with media inquiries about government plans to scrap the private health insurance rebates, Federal Health Minister Nicola Roxon reassured people that:

> *"The Government is firmly committed to retaining the existing private health insurance rebates."*[5]

Yet, during Senate Estimates it was revealed that while Minister Roxon was giving these public assurances, behind closed doors she and other senior members of the government were seeking and obtaining advice on how to progress changes to those private health insurance rebates. 'Firmly committed' to retain the existing rebates in public, while secretly working on plans how to reduce and scrap them.

Minister Roxon first obtained advice from her Department on 12 January 2009[6]. Advice on how to change the rebate had been sought by the Health Minister's office as early as December 2008[7].

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[4] Senator McLucas, Parliamentary Secretary to the Minister for Health and Ageing, *Committee Hansard,* 20 February 2008, p. CA122;

[5] Leo Shanahan, *Scrap health rebate: Treasury,* The Age, 24 February 2009, page 1;

[6] Ms Jane Halton, Secretary of the Department of Health and Ageing, *Committee Hansard,* 3 June 2009, p.CA43;

[7] Mr Eccles, Acting Deputy Secretary of the Department of Health and Ageing, *Committee Hansard,* 3 June 2009, p.CA44;

We also know that Treasury provided advice on means testing the rebate on 20 February 2009 at the request of the Treasurer[8], that the Department of Finance and Deregulation provided advice on the same measure on 22 February 2009[9] and the Prime Minister's Department on 23 February 2009[10].

Yet after all of that was going on within the Rudd Labor government, on 24 February 2009 the Minister for Health and Ageing told Australians that the government remained firmly committed to retaining the existing rebates.

How can anyone believe anything the Rudd government will say about commitments on private health insurance now or in the future?

Dr Armitage, the Chief Executive of the Australian Health Insurance Association put it very succinctly:

> *"It would be difficult to have 100 per cent trust before any budget, given what has happened to us in the last two – particularly this decision…*
>
> *It would be difficult to have 100 per cent trust given that we have such a definitive letter from the Prime Minister, which has now been shredded."*[11]

Mr Michael Roff, Chief Executive of the Australian Private Hospitals Association put it this way:

> *"…these proposals constitute a fundamental breach of promise by the government. This entails reneging on clear commitments that were made not just in the lead-up to the last election but were repeated by a range of senior government figures, from the Prime Minister down, on numerous occasions both in public statements and private meetings since the election.*
>
> *There are now serious concerns within the APHA membership about what further changes may be made in subsequent budgets when commentators concur that substantial cuts to expenditure will be required to meet government spending targets."*[12]

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[8] Mr Nigel Ray, Executive Director, Fiscal Group, Treasury, *Committee Hansard*, 3 June 2009, p.E78;

[9] Dr Ian Watt, Secretary of the Department of Finance and Deregulation, *Committee Hansard*, 28 May 2009, p.F&PA22;

[10] Ms Yael Cass, Acting First Assistant Secretary, Social Policy Division, Department of Prime Minister and Cabinet, *Committee Hansard*, 25 May 2009, p.F&PA72;

[11] Dr Michael Armitage, Chief Executive Officer, Australian Health Insurance Association, *Committee Hansard*, 8 July 2009, CA2;

[12] Mr Michael Roff, Chief Executive Officer, Australian Private Hospitals Association, *Committee Hansard*, 8 July 2009, CA13;

Privately insured Australians and the broader private health sector are indeed being asked to pay the price for the Rudd government's reckless spending sprees since coming to office.

IMPACT ON THE COST OF PRIVATE HEALTH INSURANCE

As a direct result of these changes the cost of private health cover will increase for more than 2.3 million Australians by between 14.3 and 66.7 per cent.

People of all ages with private health insurance in the first income tier will see their rebate reduced by 10 per cent, people of all ages in the second tier by 20 per cent – yet people in the third tier will be treated differently depending on how old they are.

The older you are the steeper the increased cost you will face as a result of this measure.

Those in the third income tier aged less than 65 will see the cost of their health insurance increase by 42.9 per cent. Those in the same tier, 65 years and over but less than 70 years old will see the cost of their health insurance go up by 53.8 per cent, and those 70 years and older will see the cost of their health insurance go up by a staggering 66.7 per cent.

Treasury and Health Department officials have pointed out that there are only a small number of people in these higher categories. But what does that prove? It seems inequitable that older Australians are being hit extra hard.

In any event, these are steep increases in the cost of private health insurance, which come on top of any ordinary increase in private health insurance premiums. In the current economic climate, and given the ongoing impact of last year's changes to the Medicare Levy Surcharge thresholds those premium increases are likely to be higher on average than what they have been in the final years of the Howard government.

Furthermore, while 2.3 million Australians with private health insurance will see a direct, immediate and automatic increase in the cost of their private cover by up to 66.7 per cent, all of the eleven million privately insured Australians will be faced with additional increases in private health insurance premiums as a result of this measure.

Of course any increases in premiums expected by the government as a result of this and last year's measure (and their related impact on the Budget), are conveniently hidden in the contingency reserve. The published budget papers do not include any information on what the government expects to happen to the cost of premiums as a result of this or last year's measure over the forward estimates.

IMPACT ON PRIVATE HEALTH INSURANCE MEMBERSHIP

The government has stated that a total of 40,000 people will drop private cover as a result of this measure. That number is made up of:

- 25,000 people who are expected to drop their hospital and general treatment cover;
- 10,000 people who have hospital and general treatment cover who are expected to keep their hospital cover and drop their general treatment cover;
- 5,000 people with general treatment cover who will drop that cover;[13]

Catholic Health Australia commissioned research by Access Economics which showed that[14]:

> *"Four times more people than predicted by Treasury may go without private health insurance as a result of changes to the private health rebate and Medicare Levy Surcharge...*
>
> (Catholic Health Australia) …*published independent research that shows the Government's new private health insurance changes could result in up to 100,000 people going without insurance."*

Given the way the measures in these Bills are structured, the most rational response for anyone seeking to minimise the additional cost imposed as a result of the reduced (or lost) rebate would be to go for a cheaper policy and to drop general treatment cover. That is to downgrade their level of private health cover. The government has increased the size of the stick for those in Income Tiers 2 and 3 who may want to drop their private cover to avoid the increase in cost of their private health insurance caused by the government's changes to the rebates.

Indeed, Mr Ian McAuley, who was very supportive of the government's proposed measures nevertheless recognised that:

> *"If we were all rational, the most rational response would be to shift to a cheaper policy – the previous witness said it was downgrading, but I would not necessarily call it that – and to drop ancillary cover."*[15]

Yet, the Government has not assessed the impact of this most likely and most rational response of privately insured Australians in those income brackets on the private and public health system at all. This is illustrated by the following exchange during Senate Estimates:

> **Senator CORMANN**—On top of the people that are dropping cover, how many people do you expect will downgrade their cover?

[13] Ms Penny Shakespeare, Assistant Secretary, Private Health Insurance Branch, Department of Health and Ageing, *Committee Hansard*, 3 June 2009, CA73

[14] Report by Access Economics Pty Limited for Catholic Health Australia, *Impact of means-testing the PHI rebate and changing MLS parameters,* June 2009 and Catholic Health Australia, Media Release, *Waiting lists to grow: 216,000 extra public hospital admissions expected*, 12 June 2009;

[15] Mr Ian McAuley, Fellow, Centre for Policy Development, *Committee Hansard*, 9 June 2009, E16;

> **Ms Shakespeare**—The government does not actually expect that people will downgrade their cover as a result of this measure.[16]

This assertion by the government is quite unbelievable and completely irrational.

The consequence is that the government's assessment of this measure underestimates its impact, in particular on public hospital waiting lists.

There are two ways people can go for a cheaper policy:

1) By increasing the level of 'front-end deductible', that is by agreeing to pay a larger out-of-pocket expense at the time of accessing a hospital service in return for a lower premium today; this increases the incentive for a patient to seek admission as a public patient in a public hospital to avoid the increased out-of-pocket expense;

2) By exclusions, that is exclude certain hospital procedures from their private cover, eg heart surgery, orthopaedic surgery or mental health services; if such a service is required by patients having excluded it from their cover they will most likely present at a public hospital;

None of this has been taken into account by the government when assessing the impact of this measure on private health insurance participation rates or on public hospitals.

Furthermore 1.4 million Australians with general treatment cover only have been completely excluded from any assessment of the impact of this measure on the basis that Treasury did not have access to any personal income tax data for that cohort of privately insured Australians.

Finally, the government has been suggesting (after the release of one quarter of membership data) that the Coalition's pessimistic suggestions about private health insurance participation rates after last year's changes to the Medicare Levy Surcharge thresholds had not occurred.

The not so subtle suggestion by the government is that given the Coalition supposedly got it wrong last time, any predictions about membership impacts this year had to be treated with caution.

The Coalition of course had merely pointed to Treasury estimates (initially of 644,000 fewer Australians with private health insurance) when criticising the impact of the government's changes last year to the Medicare Levy Surcharge thresholds.

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[16] Ms Penny Shakespeare, Assistant Secretary, Private Health Insurance Branch, Department of Health and Ageing, *Committee Hansard*, 3 June 2009, CA73

After the Senate eventually passed the twice watered down measure in October 2008, the Coalition pointed out again that the government expected nearly 500,000 fewer Australians to have private hospital cover as a result. This was based on advice provided by the Government during the debate in the Senate.

The Minister for Health and Ageing herself said at the time that there would be 492,000 fewer Australians with private hospital cover as a result of the change. The $740 million in estimated savings over the forward estimates were in fact based (and contingent) on that reduction in the expected number of people with private hospital cover (and taking their private contributions to the health system with them).

Based on one quarter of membership data the Minister for Health has been arguing that this wasn't happening. Some government Senators sought to press this point with witnesses during this inquiry. Yet both Treasury and the Department of Health and Ageing confirmed that the estimated impact of the measure had *"not been revised"* and that (the impact) was *"over the forward estimates period"* and that *"we have had one quarter of data since the measure took effect"*. [17]

In fact, Mr Peter Robinson, Principal Adviser in the Social Policy Division of Treasury said *"it was probably safe to say it was a little bit too early to tell after the first quarter"*[18]. Asked directly whether the government had revised the estimated savings from the changes to the Medicare Levy Surcharge thresholds legislated in October 2009, Mr Robinson's answer was a clear no.

That is, for the purpose of assessing the impact of this measure on public hospitals we have to consider the combined impact of last year's change to Medicare Levy Surcharge thresholds and this year's proposed change to the rebates.

IMPACT ON PUBLIC HOSPITALS

For obvious reasons, the Rudd government is keen to downplay the impact of its broken rebate promise on public hospitals.

The fact that this time around the government recognised any impact on public hospitals at all was an improvement on last year. Indeed, when introducing last year's changes to the Medicare Levy Surcharge thresholds no assessment or modelling was done by the Federal government of the impact of that measure on public hospital demand. Any impact on public hospitals was dismissed as a 'second round effect' not relevant to the consideration of the budget measure at hand.[19]

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[17] Ms Penny Shakespeare, Assistant Secretary, Private Health Insurance Branch, Department of Health and Ageing, *Committee Hansard*, 3 June 2009, CA79 &

[18] Mr Peter Robinson, Principal Adviser in the Social Policy Division, Treasury, *Committee Hansard*, 3 June 2009, E85;

[19] Mr Nigel Ray, Executive Director, Fiscal Group, Treasury, *Committee Hansard*, 3 June 2008, E85;

In her Second Reading Speech on these Bills the Minister for Health and Ageing stated in the House of Representatives that:

> *"It is estimated that approximately 25,000 people may no longer be covered by private health insurance hospital cover, and that it might therefore result in 8,000 additional public hospital admissions over two years. When considered against the fact that public hospitals have around 4.7 million admissions per year, the impact of the measure will be insignificant."*[20]

During Senate Estimates the question was put to the Department of Health and Ageing on how the Minister had derived that figure of 8,000 additional public hospital admissions over two years:

> ***Senator CORMANN**—Have you assessed the impact of this measure on public hospitals?*
> ***Ms Shakespeare**—We have had a look at that, yes.*
> ***Senator CORMANN**—Can you just talk us through how you went through that assessment and how you came to the conclusions you have reached.*
> ***Ms Shakespeare**—The figure of 25,000 people expected to drop their hospital cover is the starting point. There is Ipsos survey data that indicates 35 per cent of people will require hospital treatment over a two-year period. Using that data, we estimate that there may be up to an additional 8,000 presentations at public hospitals over a two-year period.*[21]

It is a matter of simple maths that 35 per cent of 25,000 equals 8,750. It is curious, and perhaps indicative of the government's overall attitude, as to why 8,750 was rounded down to 8,000 rather than round up to 9,000 public hospital admissions. Spin over substance invariably is the modus operandi of this Rudd Government.

Even more concerning is the impact on public hospital demand of last year's Medicare Levy Surcharge thresholds measure combined with this year's broken promise on private health insurance rebates.

The Rudd government's own budget estimates indicate that even twice watered down, the Medicare Levy Surcharge threshold changes eventually passed by the Senate in October 2008, will result in 492,000 fewer people with private health insurance.

If we apply the government's own methodology to its own numbers, that means about 181,000 additional public hospital admissions over two years as a direct result of last years and this years changes to private health insurance policy.

172,200 additional admission as a result of the changes to the Medicare Levy Surcharge thresholds last year (= 492,000 x 35%), plus the 8,750 additional admissions as a result of the broken promise on private health insurance rebates.

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[20] Hon Nicola Roxon MP, Minister for Health and Ageing, *House Hansard*, 27 May 2009, p.4435;

[21] Ms Penny Shakespeare, Assistant Secretary, Private Health Insurance Branch, Department of Health and Ageing, *Committee Hansard*, 3 June 2009, CA75;

Catholic Health Australia pointed out that:

> *"The analysis, by Access Economics, found the rebate and Medicare Levy Surcharge changes could stretch public hospital waiting lists by an additional 36,000 people who would otherwise have been treated in private hospitals."*[22]

And:

> *"When you combine the number of people likely to forgo their insurance as a result of this new change and last year's changes, we will see 600,000 fewer people insured than would otherwise been the case… This means some 216,000 extra admissions to public hospitals."*[23]

Government Senators suggested that additional funding commitments announced at COAG would offset the impact of this measure on public hospitals. That is completely disingenuous of course given that those funding increases were to deal with pre-existing demand pressures unrelated to either last year's changes to the Medicare Levy Surcharge or this year's proposed changes to the rebates.

IMPACT ON PRIVATE HOSPITALS

Policy changes like the Rudd government's broken private health insurance rebate promise have to potential to have significant flow-on consequences for the private hospital sector.

In recent years private hospitals have absorbed a significant proportion of the growth in demand for hospital services as a result of the growth in private health insurance participation rates.

Private hospital operators expressed serious concern to the Committee about the impact of sovereign risk given the approach taken by the Rudd government on measures like this one.

Dr Shane Kelly, CEO of St John of God Subiaco told the Committee that recent policy changes had left them with *"a lack of confidence going forward for capital investment in private facilities"*[24].

He expanded further in this exchange:

> ***Dr Kelly**—Clearly our ability to invest in capital to continue to provide the services in contemporary facilities and to expand those services to meet*

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[22] Catholic Health Australia, Media Release, *Waiting lists to grow: 216,000 extra public hospital admissions expected*, 12 June 2009;

[23] Catholic Health Australia, Media Release, *Waiting lists to grow: 216,000 extra public hospital admissions expected*, 12 June 2009;

[24] Dr Shane Kelly, CEO, St John of God Hospital Subiaco, *Committee Hansard*, 10 July 2009, CA34;

demand is reliant on how well our business is tracking. If we get to the point where we do not have sufficient capital to invest in capital, then obviously we cannot do that.

***Senator CORMANN**—In that context, perhaps you can talk us through the experiences, as far as you are aware of them, of the private hospital sector in Western Australia in the eighties and early nineties in terms of utilisation and viability as compared to what they are now. And perhaps you could look forward—what the impact is likely to be if changes like this continue to be introduced.*

***Dr Kelly**—The private hospital sector was in dire straits in the mid- to late eighties and, really, capital investment was unheard of. There was not really the possibility or opportunity to invest or reinvest, and it was only the trilogy of changes to private health insurance that reinvigorated the industry and enabled it to once again invest in contemporary facilities. There has been considerable investment. For example, St John of God Health Care, even at my campuses, made a very substantial investment in upgrading the hospital and providing services to Western Australians, something that is now in doubt for the future.*

Mr Michael Roff, Chief Executive Officer of the Private Hospitals Association put it this way:

> *"A range of service planning and infrastructure development decisions have been made by private hospital operators in both the for-profit and not-for-profit segments of the sector on the basis of the repeated commitments given by the government that they would maintain the current policy settings. If these legislative proposals proceed for developments planned but not yet underway, there are now doubts over whether they will go ahead. For those already underway, there are now doubts over whether they will prove to be viable."*[25]

In short, implementing these changes would undermine confidence in the private hospital sector. This will affect investment in new and refurbished facilities, new medical and other capital investment, and staffing.

A BETTER ALTERNATIVE – INCREASE EXCISE ON TOBACCO

Instead of pursuing its broken promise on private health insurance rebates, the government should support the Coalition proposal to increase the excise on tobacco as a better more positive alternative measure for our health system.

Increasing the excise on tobacco by 12.5% instead of means testing private health insurance rebates would have a positive rather than a negative impact on our health system.

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[25] Mr Michael Roff, Chief Executive Officer, Australian Private Hospitals Association, *Committee Hansard,* 8 July 2009, CA13;

Clearly it would have a positive public health effect, it would lead to less pressure on public hospitals not more, it would not force millions of Australians to pay between 14.3 and 66.7 per cent more for their private health insurance and it would have a $300 million positive effect on the budget bottom line over the forward estimates period[26].

Indeed Treasury confirmed during Senate Estimates on 2 June 2009 that the proposal to increase the tobacco excise by 12.5 per cent would more than offset the expected savings from means testing private health insurance rebates.

Treasury confirmed that a 12.5% increase in the excise on tobacco would raise $2.2 billion over the forward estimates, which would more than offset the $1.9 billion estimated saving from means testing private health insurance rebates over the same period.

The analysis the government asked for assessing the Coalition proposal over a ten year period was exposed during Senate Estimates as completely deficient.

The Treasury analysis quite reasonably assumes that consumption of tobacco would go down over a ten year period if the measure was to go ahead. While that assumption was fed into the ten-year revenue forecast, no assessment was done of any related health savings over the same period.

Officials confirmed that the government did not ask Treasury to assess the obvious public health benefits of a reduction in smoking or any related savings for our public health system.

The government dismissed those public health benefits and related savings for our public health system as ‘second round effects’. As if, over a ten year period, beneficial second round effects are somehow irrelevant.

It is completely unbelievable that the Government never asked Treasury to consult with the Health Department in finalising their advice on the Coalition's alternative proposal to increase taxes on tobacco.

And while the government has provided a copy of Treasury's analysis to selected media outlets on 17 May 2009[27] (no doubt to help push a political line), the copy of that advice has still not been provided to the Senate Economics Committee for scrutiny. That is despite a specific request on notice on 2 June 2009. Specific answers to specific questions on notice and what appears to be a selective extract from the Treasury analysis was provided to the Senate Economics Committee. Why is the

[26] Treasury Evidence, *Committee Hansard*, 2 June 2009, E105-E110;

[27] Note for example the story in The Australian by Lenore Taylor and Siobhain Ryan on 18 May 2009 on page 1, *Private health calculations up in smoke – Shortfall in Turnbull health tax alternative;*

government refusing to provide a copy of the advice given to the media? What has the government got to hide?

PROCESS CONCERNS

No consultation with the States and Territories

Before the last election the Prime Minister committed that he 'would end the blame game' and that he would ensure a new era of 'cooperative federalism in health'.

The Rudd government has now introduced major changes to the private/public health balance with serious implications for State and Territory governments without any consultation.

The States and Territories are expected to improve the performance of their public hospitals, yet the Rudd government keeps shifting more demand to public hospitals that are already under significant pressure.

Industry stakeholders were misled

Private health industry stakeholders, along with more than eleven million privately insured Australians were seriously mislead by the Rudd government.

Submissions for rate change applications by health funds, planning for future infrastructure and workforce requirements by hospitals, are but some of the decisions which were erroneously based on the Rudd government's firm commitments before and after the election that the existing private health insurance policy framework would be maintained.

The first the industry heard about the government's change in direction was when the Minister for Health and Ageing called stakeholders on the Thursday night before the budget to let them know that a story in the paper the next day about a government plan to means test the private health insurance rebates was in fact correct[28].

Mr Roff from the Australian Private Hospitals Association told the Committee that *"these proposals constitute a fundamental breach of promise by the government"*.[29]

Dr Armitage from the Australian Health Insurance Association said *"we are disappointed. The explicit letter* (from the Prime Minister) *stated that there would be no change to the present system – it is still the present because it has not yet been*

[28] Dr Michael Armitage, Chief Executive Officer, Australian Health Insurance Association, *Committee Hansard,* 8 July 2009, CA1 and Mr Michael Roff, Chief Executive Officer, Australian Private Hospitals Association, *Committee Hansard,* 8 July 2009, CA14;

[29] Mr Michael Roff, Chief Executive Officer, Australian Private Hospitals Association, *Committee Hansard,* 8 July 2009, CA13;

legislated – of the rebate. We felt that that was, if you like, a cast-iron guarantee, so we are disappointed about that."[30]

No Regulatory Impact Statement

The government did not conduct a regulatory impact statement of this measure. The Prime Minister made a specific decision to exempt this particular measure from the requirement for a regulatory impact statement[31].

Why? Nobody was able to answer that question. It remains unanswered to this day.

Means testing private health insurance rebates will be complex and bureaucratic

Michael Roff from the Australian Private Hospitals Association put it best when he said:

> *"I think one of the key problems with it is the sheer complexity. We are now moving*
>
> *to a system with effectively 10 tiers. You have what I call tier zero which is where there is no change and then in each of the other three tiers different surcharges apply and different levels of rebate depending on age. I think one of the things that is going to happen is that this may lead to an increase in employment in the tax agency sector. People are going to need someone to explain to them exactly what it means if they fall within a particular income bracket and whether or not it is worthwhile to have health insurance and what sort of things they should consider. I think a lot of people are going to throw their hands up in the air and say, 'This is all too hard.' I know because I was involved in some of the discussions around the design of the original rebate scheme that one of the key considerations was to keep it simple. The administration of this scheme is going to be enormously complex. The tax office is receiving $60 or $70 million to administer it and tell people about it, how is the average punter supposed to react?*

CONCLUSION

This measure is bad public policy.

Any measure that puts additional pressure on public hospitals and will see fewer people take additional responsibility for their own health care needs is a bad measure.

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[30] Dr Michael Armitage, Chief Executive Officer, Australian Health Insurance Association, *Committee Hansard,* 8 July 2009, CA1 and Mr Michael Roff, Chief Executive Officer, Australian Private Hospitals Association, *Committee Hansard,* 8 July 2009, CA1;

[31] Ms Penny Shakespeare, Assistant Secretary, Private Health Insurance Branch, Department of Health and Ageing, *Committee Hansard,* 3 June 2009, CA68;

Yes this measure will have the most immediate impact on the 2.3 million Australians with private hospital insurance and incomes above $75k/$150k per annum. They will see the cost of their health insurance go up by between 14.3 and 66.7 per cent as a direct result of Labor's broken rebate promise.

However, all Australians will be negatively impacted in one way or another.

7.4 million Australians with private hospital insurance and incomes below the 'rebate reduction' thresholds will be faced with increased premiums to cover the cost flowing from those downgrading their cover or leaving private health altogether.

Those without private cover will have to compete for access to public hospital care with the increasing number of those no longer covered by the private system.

This is yet another step in the wrong direction. It was a step the government promised before the election they would not take.

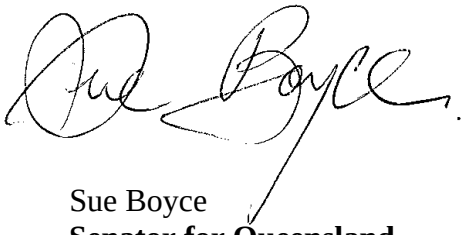
Instead of fixing public hospitals, Labor has been distracted by its ideological agenda against private health – even though it is putting more pressure on public hospitals not less.

Recommendation

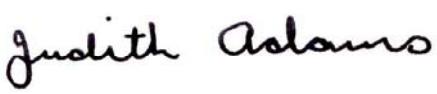
That the Senate:

1) Reject the legislation implementing the government's broken private health insurance rebate promise;
2) Urge the government to increase the excise on tobacco by 12.5 per cent as an alternative to means testing private health insurance rebates.

Mathias Cormann
Senator for Western Australia



Sue Boyce
Senator for Queensland



Judith Adams
Senator for Western Australia

John Williams
Senator for New South Wales

Additional Comments

By Senator Rachel Siewert, the Australian Greens

Fairer Private Health Insurance Incentives Bill 2009
Fairer Private Health Insurance Incentive (Medicare Levy Surcharge) Bill 2009
Fairer Private Health Insurance Incentives (Medicare Levy Surcharge – Fringe Benefits) Bill 2009

The Australian Greens recognise that these Bills introduce a measure of equity into the private health insurance rebate, through the Private Health Insurance Tiers by means testing the private health insurance rebate. However, the Greens do not support the private health insurance rebate system, believing that these significant funds would be better spent in the under-resources public health system. Notwithstanding these concerns, the Greens are broadly supportive of the new tiered rebate which will ensure that the rebates are better targeted to those on lower incomes.

Furthermore, the Greens believe that the Medicare Levy Surcharge is an unfair and inappropriate mechanism to force people to take out private health insurance. While once again, we acknowledge that these Bills introduce a tiered scheme of levies which are related to income level, the Greens are opposed to the levy surcharge in principle. Private health insurance should be a matter of personal choice to be made with neither incentives nor compulsion. We are concerned that the private health insurance rebate operates as a government subsidy for the health insurance industry, removing the need for the industry to develop products which are attractive to a full range of customers. In general, it is the view of the Australian Greens that the private health insurance rebate has a detrimental effect on both the public health system and the health insurance industry.

Senator Rachel Siewert
Australian Greens

APPENDIX 1

Submissions received by the Committee

1 Private Health Insurance Intermediaries Association

2 Australian Private Hospitals Association

Supplementary information

- Opening statement tabled at hearing 8.7.09

3 Health Insurance Restricted Membership Association of Australia (HIRMAA)

4 Department of Health and Ageing

5 Australian Health Insurance Association (AHIA)

6 Deeble, Dr John

7 iSelect Pty Ltd

8 Australian Nursing Federation

Supplementary information

- Supplementary submission received 28.8.09

9 Australian Healthcare & Hospitals Association

10 McAuley, Dr Ian

Supplementary information

- Responses to questions on notice received 10.6.09

11 BUPA Australia Group

12 Menadue, Dr John

13 Ramsay Health Care

14 Australian Unity

15 Department of Health and Ageing

Additional information

Catholic Health Australia
Document received by the Senate Economics Committee on 11.6.09 on a matter raised at the Economics Committee public hearing on 9.6.09, *Impact of means-testing the PHI rebate and changing MLS parameters,* June 2009

Menzies Centre for Health Policy
Response arising from hearing 9.6.09, dated 12.6.09

Australian Medical Association (WA)
Statistics – Commonwealth Medical Scheme, tabled at hearing 10.7.09

HBF
Opening statement tabled at hearing 10.7.09

APPENDIX 2

Public Hearings

On 15 June, the Senate transferred the inquiry from the Economics Legislation Committee to the Senate Community Affairs Legislation Committee. The Economics Legislation Committee had commenced the inquiry with a hearing and private briefing in Canberra on 9 June 2009.

Tuesday, 9 June 2009
Parliament House, Canberra

Economics Legislation Committee Members in attendance

Senator Annette Hurley (Chair)
Senator Doug Cameron
Senator Louise Pratt
Senator Rachel Siewert
Senator Nick Xenophon

Witnesses

Australian Health Insurance Association
Dr Michael Armitage, Executive Director

Mr Ian McAuley, Fellow, Centre for Policy and Development

Mr Rob Wells, Director, Menzies Centre for Health Policy and Executive Director, ANU College of Medicine, Biology and Environment

Catholic Health Australia
Mr Martin Laverty, Chief Executive Officer
Mr Patrick Tobin, Director, Policy

Private Briefing
Department of the Treasury and the Department of Health and Ageing

Wednesday, 8 July 2009
Parliament House, Canberra

Community Affairs Legislation Committee Members in attendance

Senator Claire Moore (Chair)
Senator Rachel Siewert (Deputy Chair)
Senator Sue Boyce
Senator Mathias Cormann
Senator Mark Furner

Witnesses

Australian Health Insurance Association
Dr Michael Armitage, Chief Executive Officer

Australian Private Hospitals Association
Dr Michael Roth, Executive Director
Dr Barbara Carney, Director, Policy and Research

Mr Ian McAuley, Fellow, Centre for Research in Public Sector Management

Dr John Deeble, Private Capacity

Thursday, 9 July 2009
St James Court Conference Centre, Melbourne

Community Affairs Legislation Committee Members in attendance

Senator Claire Moore (Chair)
Senator Rachel Siewert (Deputy Chair)
Senator Sue Boyce
Senator Mark Furner

Witnesses

Australian Unity Health Limited
Amanda Hagan - Group Executive, Healthcare

BUPA Australia
Mr Mark Engel, Director Marketing, Product and Corporate Affairs
Ms Brooke Lord, Head of Industry Relations

Health Insurance Restricted Membership of Australia (HIRMAA)
Mr John Rashleigh, President
Mr Ron Wilson, Executive Director

Private Health Insurance Intermediaries Association
Mr Peter Kerestes, Chief Executive Officer

Friday, 10 July 2009
Mercure Hotel, Perth

Community Affairs Legislation Committee Members in attendance

Senator Claire Moore (Chair)
Senator Rachel Siewert (Deputy Chair)
Senator Mathias Cormann
Senator Mark Furner

Witnesses

HBF

Mr Rob Bransby, Managing Director

Mr Andrew Walton, Manager, Public Affairs

Health Consumers Council of Western Australia

Mr Timothy Benson, Chairman

Ms Michele Kosky, Executive Director

Australian Medical Association, Western Australian Branch

Mr Peter Jennings, Deputy Executive Director

St John of God Health Care

Dr Shane Kelly, Deputy Executive Director

Tuesday, 14 July 2009
Parliament House, Canberra

Community Affairs Legislation Committee Members in attendance

Senator Claire Moore (Chair)
Senator Sue Boyce
Senator Carol Brown
Senator Mathias Cormann
Senator Mark Furner
Senate John Williams

Witnesses

Catholic Health Australia

Mr Martin Laverty, Chief Executive Officer

Mr Patrick Tobin, Director, Policy

Department of Treasury

Mr Mark O'Connor, Principal Adviser, Personal and Retirement Income Division, Revenue Group

Mr Tony Coles, Manager, Individuals Tax Unit

Mr Rob Montefiore Gardner, Manager, Health Policy Unit

Mr Marty Robinson, Manager, Household Modelling and Analysis Unit

Department of Health and Ageing

Mr Richard Eccles, Deputy Secretary

Professor Rosemary Calder, First Assistant Secretary, Acute Care Division, Division Executive

Ms Penny Shakespeare, Assistant Secretary, Acute Care Division, Private Health Insurance Branch

APPENDIX 3

Modelling effect of incentives

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Source: Mr Ian McAuley, Submission No.10, pp.8-9.

Modelling of effects of incentives

Single	Current subsidies				New subsidies				Increased incentive	
Income	Rebate	MLS	Net payment for $1000 policy	Net payment for $2000 policy	Rebate	MLS	Net payment for $1000 policy	Net payment for $2000 policy	$1000 policy	$2000 policy
75 000	30%	1.00%	-50	650	20%	1.00%	50	850	-100	-200
80 000	30%	1.00%	-100	600	20%	1.00%	0	800	-100	-200
85 000	30%	1.00%	-150	550	20%	1.00%	-50	750	-100	-200
90 000	30%	1.00%	-200	500	10%	1.25%	-225	675	25	-175
95 000	30%	1.00%	-250	450	10%	1.25%	-288	613	38	-163
100 000	30%	1.00%	-300	400	10%	1.25%	-350	550	50	-150
105 000	30%	1.00%	-350	350	10%	1.25%	-413	488	63	-138
110 000	30%	1.00%	-400	300	10%	1.25%	-475	425	75	-125
115 000	30%	1.00%	-450	250	10%	1.25%	-538	363	88	-113
120 000	30%	1.00%	-500	200	0%	1.50%	-800	200	300	0
125 000	30%	1.00%	-550	150	0%	1.50%	-875	125	325	25
130 000	30%	1.00%	-600	100	0%	1.50%	-950	50	350	50
135 000	30%	1.00%	-650	50	0%	1.50%	-1 025	-25	375	75
140 000	30%	1.00%	-700	0	0%	1.50%	-1 100	-100	400	100
145 000	30%	1.00%	-750	-50	0%	1.50%	-1 175	-175	425	125
150 000	30%	1.00%	-800	-100	0%	1.50%	-1 250	-250	450	150

Couples	Current subsidies				New subsidies				Increased incentive	
Income	Rebate	MLS	Net payment for $2000 policy	Net payment for $4000 policy	Rebate	MLS	Net payment for $2000 policy	Net payment for $4000 policy	Net payment for $2000 policy	Net payment for $4000 policy
150 000	30%	1.00%	-100	1 300	20%	1.00%	100	1 700	-200	-400
160 000	30%	1.00%	-200	1 200	20%	1.00%	0	1 600	-200	-400
170 000	30%	1.00%	-300	1 100	20%	1.00%	-100	1 500	-200	-400
180 000	30%	1.00%	-400	1 000	10%	1.25%	-450	1 350	50	-350
190 000	30%	1.00%	-500	900	10%	1.25%	-575	1 225	75	-325
200 000	30%	1.00%	-600	800	10%	1.25%	-700	1 100	100	-300
210 000	30%	1.00%	-700	700	10%	1.25%	-825	975	125	-275
220 000	30%	1.00%	-800	600	10%	1.25%	-950	850	150	-250
230 000	30%	1.00%	-900	500	10%	1.25%	-1 075	725	175	-225
240 000	30%	1.00%	-1 000	400	0%	1.50%	-1 600	400	600	0
250 000	30%	1.00%	-1 100	300	0%	1.50%	-1 750	250	650	50
260 000	30%	1.00%	-1 200	200	0%	1.50%	-1 900	100	700	100
270 000	30%	1.00%	-1 300	100	0%	1.50%	-2 050	-50	750	150
280 000	30%	1.00%	-1 400	0	0%	1.50%	-2 200	-200	800	200
290 000	30%	1.00%	-1 500	-100	0%	1.50%	-2 350	-350	850	250
300 000	30%	1.00%	-1 600	-200	0%	1.50%	-2 500	-500	900	300

APPENDIX 4

Medicare Levy Surcharge and Private Health Insurance Rebate Changes

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Source: Australian Health Insurance Association cited in Bupa Australia Submission No.11, p.5.

Average Single (Pre Rebate) $1,813

Income	Current Rebate	Premium Cost	MLS now	Future Rebate	Premium Cost	MLS Then	Change in Premium	Change in MLS
$75,000	$544	$1,269	$750	$544	$1,269	$750	$0	$0
$75,001	$544	$1,269	$750	$363	$1,450	$750	$181	$0
$90,000	$544	$1,269	$900	$363	$1,450	$900	$181	$0
$90,001	$544	$1,269	$900	$181	$1,632	$1,125	$363	$225
$120,000	$544	$1,269	$1,200	$181	$1,632	$1,500	$363	$300
$120,001	$544	$1,269	$1,200	$0	$1,813	$1,800	$544	$600
$250,000	$544	$1,269	$2,500	$0	$1,813	$3,750	$544	$1,250

Average Family Premium (Pre Rebate) $3,626

Income	Current Rebate	Premium Cost	MLS now	Future Rebate	Premium Cost	MLS Then	Change in Premium	Change in MLS
$150,000	$1,088	$2,538	$1,500	$1,088	$2,538	$1,500	$0	$0
$150,001	$1,088	$2,538	$1,500	$725	$2,901	$1,500	$363	$0
$180,000	$1,088	$2,538	$1,800	$725	$2,901	$1,800	$363	$0
$180,001	$1,088	$2,538	$1,800	$363	$3,263	$2,250	$725	$450
$240,000	$1,088	$2,538	$2,400	$363	$3,263	$3,000	$725	$600
$240,001	$1,088	$2,538	$2,400	$0	$3,626	$3,600	$1,088	$1,200
$500,000	$1,088	$2,538	$5,000	$0	$3,626	$7,500	$1,088	$2,500

Example of a Family Premium $5,000

Income	Current Rebate	Premium Cost	MLS now	Future Rebate	Premium Cost	MLS Then	Change in Premium	Change in MLS
$150,000	$1,500	$3,500	$1,500	$1,500	$3,500	$1,500	$0	$0
$150,001	$1,500	$3,500	$1,500	$1,000	$4,000	$1,500	$500	$0
$180,000	$1,500	$3,500	$1,800	$1,000	$4,000	$1,800	$500	$0
$180,001	$1,500	$3,500	$1,800	$500	$4,500	$2,250	$1,000	$450
$240,000	$1,500	$3,500	$2,400	$500	$4,500	$3,000	$1,000	$600
$240,001	$1,500	$3,500	$2,400	$0	$5,000	$3,600	$1,500	$1,200
$500,000	$1,500	$3,500	$5,000	$0	$5,000	$7,500	$1,500	$2,500

CHANGE IN PREMIUMS HIGHER THAN CHANGE IN MLS

PREMIUM COST HIGHER THAN MLS