Private Health Insurance Incentives Bill 2009

Submission by Ian McAuley, Fellow, Centre for Policy Development and Adjunct Lecturer, University of Canberra

Summary

The proposals in these Bills increase the financial incentives for people with high incomes to hold private health insurance. They provide some incentive for people to switch to lower price policies. But, because few people make "rational" calculations about insurance matters, there is unlikely to be any significant change in coverage.

That is the very problem with the proposals: they do nothing to reduce Australians' reliance on private health insurance, which is a high cost, inflationary and divisive means of funding health care. From neither a "left" or "right" perspective is private insurance an efficient or equitable means of funding health care.

Likely effects of changes – minor

In increasing the Medicare Levy Surcharge (MLS) while decreasing direct subsidies, the changes generally *strengthen* the financial incentives for people with high incomes to hold private health insurance (PHI).

The attachment models the "old" and "new" incentives for holding low-price ($1000 a year for singles) and high-price ($2000) policies. That shows:

- under both the "old" and "new" arrangements almost every taxpayer with an income above $75 000 has an incentive to hold at least a low-price policy:
  - e.g. a singler taxpayer with an income of $100 000 taking a $1000 policy:
    - under the "old" incentives has a $1000 MLS incentive and a $300 rebate, resulting in a net benefit of $300
    - under the "new" incentives has a $1250 MLS incentive, and a $100 rebate, resulting in a net benefit $350
  - (the results for couples taking are simply twice the single results)
- 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 over-compensation[1];
- there remains a general incentive for all switch to take low-price policies, a feature of both the "old" and "new" arrangeents;.

1. There is a very small group, with incomes between $75 000 and $80 000, who could be up to $50 a year better off from not holding PHI

- for singles with incomes between $75 000 and $115 000 (double for couples) there is a decreased incentive to hold high-price policies;

Treasury modelling suggests a minor drop out of PHI – around 25 000 people. To put this figure into perspective, there are 9.7 million people covered by PHI, and the average growth in coverage per quarter is around 67 000.

The Industry Association claims that there will be a significant fall in PHI coverage, and substantial "downgrading" – their term for switching to a low-price policy.

A "rational" response – some growth in PHI and more self-reliance

If all consumers were rational and calculating, the response to increased incentives would be to hold on to PHI, and some of the 290 000 taxpayers currently paying the MLS would take up PHI under the increased incentives.

Another rational response would be for many to switch to lower priced policies. In particular many would drop ancillary cover. Some would move to policies with exclusions and some would move to policies with high deductibles. Such policies should be particularly appealing for high income earners, for, interpretation of ABS data on income and wealth[2], suggests that households with incomes above $130 000 have, on average, about $500 000 in financial assets:

- $200 000 of which is in superannuation, meaning that for those still accumulating superannuation they still have $300 000 in reasonably liquid assets.

This means moving to a low-price policy, with higher co-payments and deductibles, and without ancillary cover, makes a great deal of sense, but only within a model of "rational" consumer behaviour. Reality likely to be different.

A likely response – little change

More probably there will be little change in PHI coverage, and similarly not a great deal of switching to lower price policies. Research by behavioral economists shows consumers do not always respond "rationally" to changes in prices, particularly in insurance:

- there is an "endowment" effect; we tend to hang on to what we have;
- we do not carefully calculate our costs and benefits; few consumers are likely to undertake the calculations required to guide their decisions;
- we have a tendency to over-insure. By pure economic theory people with higher incomes should take policies with high deductibles because they can afford some

2. ABS *Household Wealth and Wealth Distribution* 2005-06, Cat 6554.0. Income figures updated by changes in AWE. Wealth figures not updated.

level of self-insurance. But, in reality, insurance is what economists call a "superior" good – the better off we are the more do we seek cover;

- fear is a major factor in promoting insurance.

These general findings are supported in Australia's experience with PHI:

- following the introduction of financial incentives in 1997 (the MLS and the means tested rebate) coverage continued to fall;
- abolition of the means test a year later saw only a feeble response;
- the "lifetime rating" incentives and the "Run for Cover" campaign, did lift PHI membership – even though, rationally, even with the two percent steps in premiums, PHI does not return a benefit, on average, to people aged less than 55. The financial incentives of "lifetime rating" were far more mild than the MLS and the subsidies, but the response was stronger, which suggests that the real driver was the "Run for Cover" campaign, which implied that without PHI one would be "uncovered". It worked through fear;
- a survey by the ABS in 1998, found "security, protection, peace of mind" to be the dominant reason (47 percent of respondents) for holding PHI, while only one percent nominated the financial incentives (which included the MLS and the means-tested rebate).[3] Fear was the driver;
- since 1999, when the present arrangements have been in place (with some minor changes), coverage has been sustained at around 45 percent of the population, even though, in real (inflation adjusted) terms, the original value of the 30 percent subsidy has been eliminated by real premium rises;
- there has been no discernable effect from the raising of the income threshold for the MLS (in spite of claims from the industry that there would be around 900 000 fewer people covered).

In all, inertia is likely to dominate.

Comment on the policy

This analysis is not to suggest that the proposed changes are well-considered public policy.

There is a common but ill-considered belief that it is desirable to have a substantial proportion of the population covered by PHI.

This assumption needs re-examination.

PHI carries the same moral hazard as public insurance, but none of its offsetting benefits. In particular:

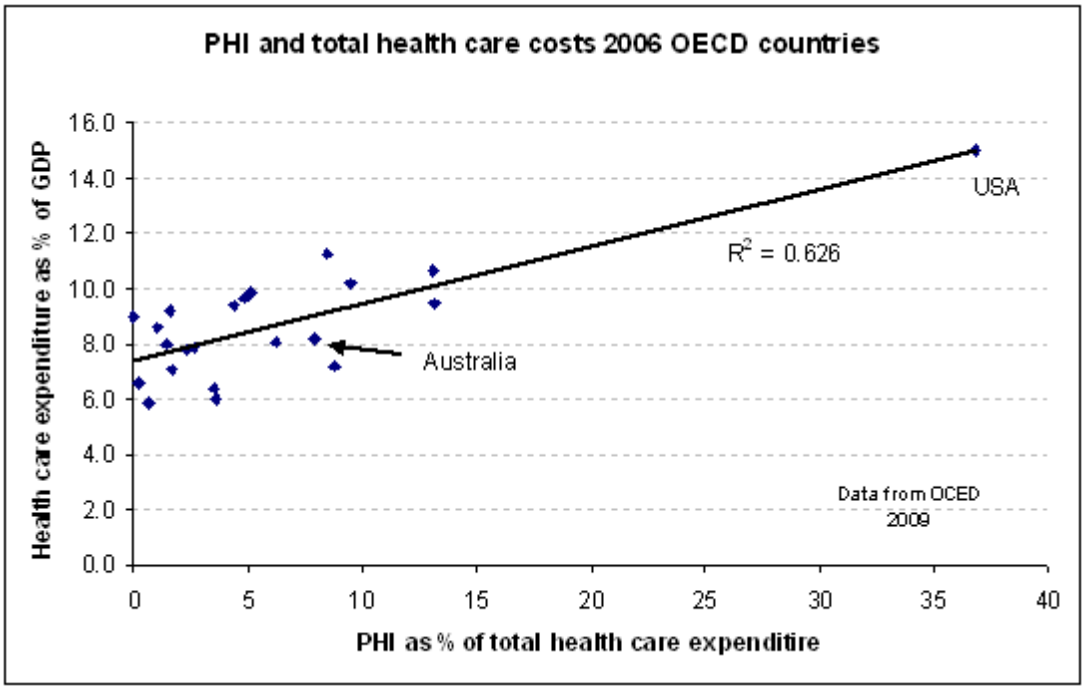
3. ABS *Health Insurance Survey* 1998, Cat 4335.0.

- it does not provide a "market" solution to health financing. Markets operate through price signals at the time a consumer makes a decision whether or not to buy a service. There is no difference in the thinking "Medicare will pay for it" and "HCF/MBF/Medibank Private" will pay for it:
  - a "market" approach would be to encourage more self-reliance through direct and uninsured payments, as has occurred in Sweden, while retaining a public insurer as a safety net;
  - in fact, in Australia, since 1999 when PHI coverage rose to over 40 percent, the proportion of people using private hospitals paying their own way without insurance has fallen from 25 percent to around 13 percent (ABS private hospital surveys).
- it lacks the capacity to control costs and ultilization, leading to price inflation. To quote from the OECD:

  > Private health insurance has also often added to total health expenditure. Most OECD countries apply less tight governmental control over private sector activities and prices, compared to public programmes and providers. Private insurers tend to have less bargaining power over the price and quantity of care as compared with public systems, particularly single-payer ones. Countries that have multiple sources of primary coverage, including those with significant PHI market size, tend to be those with the highest total health spending levels per capita, such as the United States, Switzerland, Germany and France. Cost control is more problematic to achieve in multiple payer systems because payers have less bargaining powers over providers on the price and quantity of care.
  >
  > PHI has also added to public health spending in some cases, Countries that grant significant public subsidies to private health insurance, as Australia, France and the United States, have faced considerable pressures on their public budgets. Where PHI covers cost-sharing on public coverage systems, as in France, utilisation increases raise the cost of publicly financed health systems. There is also evidence of Pill-induced utilisation increases in the public sector of systems where PHI plays a duplicate or supplementary role. Public and private financing do not operate in isolation. Rather, they are intertwined by complex financial and real flows, as well as incentive structures.[4]

  This relationship between reliance on PHI and the total cost of health care is illustrated in the figure on the next page;
- as the OECD stresses, PHI is only a *funding* mechanism. It does not provide any extra resources for health care. In Australia incentives for PHI have certainly shifted demand from public to private hospitals, but it has also shifted resources, particularly the services of professional staff, from public to private hospitals:

4. OECD *Private Health Insurance in OECD Countries* 2004.



– that is why waiting lists remain a problem;

– in effect, all that PHI does is to re-arrange the queues, promoting some and shifting others to the back of the queue

and, to the extent that it may help some with low priority needs, it may actually lengthen waiting time for those with greater needs;

it is extraordinary that public policy should promote queue-jumping.

- as a funding mechanism it is bureaucratically expensive, costing around $1.3 billion a year in management expenses, and a further $0.6 billion in surplus, some of which is for profit of de-mutualized funds:

  – its gross margin of management expenses and accumulation of surplus is around 15 percent, compared with around 4 percent for Medicare plus the Australian Taxation Office.

- it may offer choice of funder, but there is little to distinguish one insurer from another, particularly when there are heavy regulations in an attempt to establish community rating:

  – in effect, it is choice without variety.

- it is an inequitable way to fund health care. Even though official tax systems are far from perfect, they do achieve a degree of equity. PHI as a "privatized tax" builds in inequities.

- it has no incentive to provide "public good" services, such as promotion of healthy lifestyles:

  - any such public campaigns by one insurer will benefit its competitors, who will enjoy a "free rider" benefit. Therefore no insurer has any incentive to provide such services;
  - if, through promotion and education, an insurer can improve the health of its own members, it runs the risk of their believing they don't need insurance.
- it has promoted a "gated community" of health care, particularly with the incentives for people with higher incomes to hold PHI, and with the separation of funding channels:
  - private hospitals funded mainly through PHI, public hospitals funded through government revenue

    and with an artificial separation of "medical" and "hospital" services in private hospitals;
  - an alternative model would be for all hospitals, private and public, to compete with one another, with public funding coming from one channel

    as is the case with services funded by the Department of Veterans' Affairs, which operates as a single funder model.

The PHI industry has been successful in conveying the impression that without PHI there would be collapse of the "private system", and that Australia would be on the path to "socialized medicine". Policymakers need to think about funding and providing health care separately, however. Even without PHI, there can be a thriving private sector delivering health care:

- a "left" policy would be to have a tax-funded single national insurer providing free services for all;
- a "right" policy would be to require people to become more self-reliant, paying more from their own pockets without the moral hazard of insurance, while having the tax-funded single insurer providing a safety net for those with low means or high needs;
- the present arrangements are incompatible with the Labor Party's stated policy of "social inclusion" (in that it promotes a two tier system) and with the Liberal Party's recognition of "the need to encourage initiative and personal responsibility" (in that PHI is simply a corporate variant of the "nanny state").

Assessment of the Government's proposals

In that they are unlikely to reduce coverage of PHI, and actually increase the financial incentives for people to hold PHI, these proposals can be described as poor public policy.

To the extent that they may encourage some to switch to lower-priced policies, there will be some specific effects among those who take policies with higher co-payments and deductibles:

- those who intend to use private services will be more subject to more influence of price signals and therefore subject to less moral hazard;
- those who use such policies, particularly policies with exclusions, while relying on free public hospitals, will give a windfall to the insurance firms, while maintaining demand pressure on public hospitals.

Removal of the rebate on ancillaries (for those with incomes above $120 000) restores a modicum of justice to health care payments. Under present arrangements it is grossly inequitable that those who pay for their own dental and other ancillary services receive no subsidy, while those with private insurance receive a subsidy between 30 and 40 percent.

The proposals are undoubtedly sound on public revenue grounds. They will do nothing to reduce dependence on PHI, however, and for that reason they should be taken back for fundamental re-design by those who understand the economics of health care and who are not burdened by an assumption that support for PHI is a unquestionably desirable policy.

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