Australian Unity

Health

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Committee Secretary
Senate Community Affairs Committee
PO Box 6100
Parliament House
Canberra ACT 2600

Dear Secretary

Re: Inquiry into the Fairer Health Insurance Incentives Bill 2009 and two related bills

On Thursday 9 July 2009, I provided evidence to the Committee on behalf of Australian Unity in relation to the above inquiry.

You requested that we provide you with additional information on differential downgrading and whether I had read Dr John Deeble's submission and evidence to the Enquiry. In particular, reference was made to the paper submitted by Dr John Deeble on the impact of the proposed changes to the Private Health Insurance rebate in which he equated the average increase to be equivalent to the price of one cup of coffee for a family earning $165,000.

Dr Deeble presents two aspects in his papers, "Private Health Insurance financial analysis" and "equity". We address our response on these two premises as we have noted substantial limitations in what Dr Deeble says in relation to the issue of differential downgrading.

1. Private Health Insurance Financial Analysis

Private Health Insurance (PHI) is community rated and economic analysis of PHI take-up needs to be considered from at least four perspectives—income, price, age of person, and MLS impact. Analysis which does not take account of all these variables is unlikely to obtain reliable results. Therefore, Dr Deeble's assertions about the income and price effects of the costs of PHI are not conclusive, as he has ignored other important aspects of the PHI purchasing decision.

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The price penalty for not joining hospital cover by 1 July 2000 was a 2 percent increase in premium for every year by which a person's age at the date they joined hospital cover exceeded age 30 (maximum 70 percent premium increase). The potential future penalties faced by people at July 2000 were in the range up to 70 percent of hospital premiums annually. These penalties swamp Dr Deeble's 5 percent per annum discounted future cost deflator (see page 3 of Dr Deeble's original submission). Therefore, Dr Deeble's conclusion that price was unlikely to have been a factor in the increased PHI coverage from July 2000 is unlikely to be true.

To be sustainable in the longer term, a community rated PHI system must have a regular inflow of new persons covered at lower risk profiles. Any proposed changes to the PHI system must be assessed as to their impact on people who may join the PHI system. Dr Deeble's second submission addresses persons who have existing PHI cover, but does not address those who would otherwise have taken out PHI if there had been no change to the policy settings (due to population growth, and to replace those who leave PHI for whatever reasons). It is these people joining who help to keep a community rated system viable in the longer term. Therefore, Dr Deeble's analysis is incomplete in a material matter.

Within the current PHI system, Dr Deeble's analysis makes no allowance for downgrading of Hospital cover, as a result of some couple or family premiums increasing substantially, or the downgrading or dropping of General Treatment cover for the same reasons. It is unrealistic to make no allowance for downgrading or dropping of such covers, which will reduce amounts available to subsidise the comprehensive hospital products which most older hospital policyholders have. Therefore, Dr Deeble's analysis is incomplete in a material matter.

Dr Deeble's second submission is based around the likelihood of people dropping their cover altogether as a result of the immediate cost increase which will arise from the means testing of the rebate. Such analysis may be appropriate in a system where each person "pays their own costs", and either purchases the product or doesn't purchase. However, such analysis is not appropriate for Australia's community rated PHI system with its large premium variations between policyholders and substantial cross subsidies between policyholders (due to age, level of coverage, type of coverage, etc). Therefore, Dr Deeble's analysis is incomplete in a material matter.

Page 2 of Dr Deeble's second submission uses a rate of premium increase of 5 percent (above price inflation) over three years (ie 1.6 percent per annum). Health care expenditure increased by 4.2 percent per annum over price inflation (excluding population growth) over the 10 years to 30 June 2007, based on AIHW data. Dr Deeble's examples should be based on 4 percent to 5 percent per annum price increases. While this would not affect Dr Deeble's general "first round" conclusions, analysis which puts into the public domain health cost increases substantially below appropriate long term levels needs to be corrected.

Pages 182 to 185 of the Productivity Commission Report No 57 dated 28 February 1997 covers the reasons that the affordability of PHI became an important public policy issue at that time, and comments in part "The combined impact of income and premium changes has seen a dramatic reduction in the affordability of PHI for all classes of households" (p184). The PHI means test free premium rebate was introduced in the late 1990's to address the affordability of PHI which was becoming too expensive for younger people to join the system due to a deterioration of the risk profile of the policyholder base at that time. The means test free rebate replaced a previous means tested rebate (which had been unsuccessful in increasing PHI participation).Dr Deeble's paper does not address the effects of the proposed means testing on the overall community rated PHI system in the context of an ageing system. Therefore, Dr Deeble's analysis is incomplete in a material matter.

Dr Deeble's analysis ignores the effect on PHI premiums which will result from younger policyholders (say below age 60) being much more affected by the proposed means testing of the PHI rebate than older policyholders (say over age 60). Such younger policyholders have substantially higher average incomes than such older policyholders. Therefore, Dr Deeble's analysis is incomplete in a material matter.

Dr Deeble states on page 1 of his submission that "PHI per se now raises a lower proportion of total health expenditure than it did ten years ago". It is not appropriate to compare PHI to "total health expenditure" as PHI is prohibited from covering out of hospital medical and most pharmaceuticals for Australian residents, both of which are substantial components of total health expenditure. Comparing one measure with an unrelated measure over a long period of time does not allow for shifts which may occur in the relativities between the measures over time.

On the same point, it is reasonable to assume that Dr Deeble has based the PHI contribution on AIHW 2006/07 data (the most recent year when the AIHW data is available). This data reduces the PHI contribution by the 30% rebate to allow for the rebate being "paid by the Government, not by PHI". The PHI rebate was introduced means test free in the late 1990's to make PHI a more affordable and easy to understand product. To make an appropriate comparison between 2006/07 and 1996/97, the 1996/97 health expenditure would also need to be reduced as if a PHI rebate had applied at that time. It is unclear from his submission that Dr Deeble has been able to adjust the AIHW data to do this. Dr Deeble's conclusion that the PHI rebate has been a failure because of this measure is therefore not proven because the measurement is inappropriate, for both these reasons.

Dr Deeble's analysis also ignores the effects of the additional administration costs and reduced policyholder understanding which will result from the substantial complexity of the proposed means tested rebate. Note that a means tested system was introduced in the mid to late 1990's with the objective of increasing PHI participation, with little effect. Therefore, Dr Deeble's analysis is incomplete in a material matter.

2. Equity

The Australian Private Health Insurance system is based on the principle of community rating which promotes equity of access. Community rating also means that no one is turned away from health insurance on the basis of their age, income level, race, gender or health status. Nor are the chronically ill charged higher premiums.

The private healthcare rebate ensures that community rating is maintained as health insurance is about equalising risk. This means that any changes to the average risk is shared equally. Community rating equalises this risk and coupled with the rebate attracts a mix of healthy and unwell members to keep private health insurance affordable. For every person that drops private health insurance there are less people left to bear the burden of the overall claims pool. Generally, it is the healthier people who drop out which compounds the effect (of those leaving) on those who remain in the system. So private health insurance becomes progressively more unaffordable—and this disproportionately impacts those on lower incomes, who are usually those who need it the most.

We are already seeing some disturbing trends in the PHI policyholder risk pool as changes are made to the system. For example, we note that by 31 December 2008, just three months after the change to the MLS threshold, there was an increase in average age to 39.9 years from 39.8 years. If this trend continues it is reasonable to expect an increase in claims costs, and therefore in the premiums.

The last point I would like to make is on price not being a major element in competition. This may well have been the case up until 2000, however consumer behaviour has been considerably impacted by the arrival of online comparators and other intermediaries which simply did not exist prior to 2000.

We know that consumers do more research prior to making their final purchase decision and that they now have visibility into the prices and benefits for all products in the market. Online tools and comparators have provided price transparency that did not exist even 5 years ago and this is driving consumers to chose more on price. This is evidenced through the volume of new policies and switching that is being driven through intermediary channels.

We also know that in 2000 PHI had a relatively low take-up of "new to industry" customers compared to the more recent experience. "New to industry" customers tend to be younger and they tend to be far more sensitive to price.

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You also requested that I provide information on our Corporate business.

We own and operate a corporate health fund that provides tailored health plans to some of Australia's leading corporations. We tailor health plans specific to the needs of individual companies.

News of the proposed changes to the PHI rebate has had an immediate impact on our corporate customers who include blue chip companies. They are now questioning whether they can afford to continue to either fully or partial fund PHI for their employees. Companies that were looking at introducing either fully or partially funded PHI as a benefit to their employees are understandably not moving with these plans until they know what unfolds.

While we are not able to disclose their names for confidentiality reasons, we can inform you that these companies have an employee base that ranges from 500 to over 4,000. Collectively, there are potentially tens of thousands of employees and their families who may be left without private healthcare cover as a result of industry-wide impacts on the partially and fully funded corporate market from the proposed changes to the rebate.

As I previously asked the Committee: has the department or any other agency considered this impact not just on these customers and their employees, but also the revenue the Government derives from businesses that fully or partially fund their employees' health insurance?

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In summary, it is obvious that the proposed changes to the private healthcare rebate will jeopardise the principle of equity and choice. What we should be doing is looking measures that make private healthcare more affordable to all Australians.

Yours faithfully

Amanda Hagan
Group Executive – Healthcare
Australian Unity Limited