Submission to the Senate Inquiry into tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008

Elizabeth Savage
Associate Professor in Health Economics
Centre for Health Economics Research and Evaluation
University of Technology, Sydney

In this submission I will address the impact of changes to the Medicare Levy Surcharge (MLS) thresholds on:

a. the number of Australians with private health insurance (PHI) and the groups most likely to abandon their private cover;

b. the level of PHI premiums;

c. the public hospital system including waiting lists and the ongoing viability of PHI and private hospitals.

Background and modelling underpinning the arguments in this submission

Between 1984, when universal public insurance was established and the late 1990s, the percentage of Australians with PHI declined steadily and the risk pool aged relative to the population. During the ten years to 1996-97, the private hospital share of acute hospital admissions was increasing despite the fall in PHI coverage. Private admissions increased at almost double the rate of public admissions; private bed-days increased at eight times the public growth rate (Hall and Savage, 2005). The private hospital share of admissions continued to increase after the implementation of the insurance incentives. Between 1997-98 and 2001-02, total private hospital admissions increased by 7.9 percent per year, compared with 1.3 percent for public hospital admissions. However, given the earlier trends, it would be difficult to attribute growth in private admissions to the insurance incentives.

Prior to the introduction of the insurance incentives introduced between 1997 and 2000, the PHI pool was older than the general Australian population. Buchmueller (2008) establishes that as a consequence of this age difference, average PHI premiums in the late 1990s were only 10% higher than they would have been if the private insurance risk pool had been representative of the entire Australian population. This indicates that adverse selection (increasing concentration of high risk individuals in the pool of privately insured) was not a major factor driving the decline in private insurance coverage from the mid-1980s to the late 1990s.

The description of the decline in PHI as an adverse selection death spiral and the characterisation of the implications of this (collapse of the PHI market, unsustainable levels of demand for public hospital treatment) were overstated.

In fact, there is empirical evidence that the privately insured are a favourable selection of the Australian population with respect to health risk, indicated either by self-reported health status (Doiron, Jones and Savage, 2008) or probability of hospitalisation (Buchmueller, Fiebig, Jones and Savage, 2008). This means that those with PHI have a lower expected need for health care than those without PHI. There is also evidence that favourable selection preceded the insurance incentives has been a feature of the Australian private health insurance market since the late 1980s.

The population who took up their private cover in response to the (largely financial) insurance incentives do not use the private hospital system to the extent of those who had chosen PHI

without financial incentives. While the insurance incentives substantially increased the proportion of the population with supplementary private insurance, Lu and Savage (2006) find the impact on the pressures on the public hospital system to be quite modest. Hospital use, measured by expected public patient and private patient lengths of stay, differs significantly depending on how long an individual has held their private insurance cover. New enrollees use the public hospital system slightly less than those without insurance but considerably more than the long-term insured. Their use of the private system is much higher than for those without insurance and outweighs the lower public usage. They estimate that the Australian private insurance incentives cost approximately 10 times more than directly funding public patient admissions.

The results in Lu and Savage (2006) reinforce the findings of moral hazard in Savage and Wright (2003). They investigate the impact of PHI on use of the private hospital system and find that the length of hospital stays of some groups can be twice as long as those who are paying for the cost of private treatment out-of-pocket.

There is not a simple relationship between insurance status, the demand for hospital treatment and the choice between being a public or private patient. It cannot be assumed that the insured population will behave homogeneously in response to policy measures. Fiebig, Savage and Viney (2006) identify different types of PHI consumers on the basis of their stated reason for choosing PHI. They find that individuals who purchased their PHI in response to the incentives are most likely to have joined for financial reasons, and that financial types are less likely to choose the private system when admitted to hospital than those who joined before the insurance incentives.

The analysis in Ellis and Savage (2008) provides evidence that the major driver of the increased enrollment in response to Lifetime Health Cover, LHC, was a response to the LHC deadline and advertising blitz, rather than a pure price response. This suggests a relatively fragile attachment for many recent enrollees. This is reinforced by Knox, Savage, Fiebig and Salale (2008) which investigates churning in the private insurance market from 2001. Those who dropped their insurance cover after 2001 are relatively young and appear to have been motivated by financial difficulties. Those who have purchased cover after LHC tend to be younger childless couples or singles, who appear to be motivated by he LHC age-related premium surcharges, but who may drop their cover if there are financial incentives to do so.

References:

Buchmueller TC, 2008, Community Rating, Entry-Age Rating and Adverse Selection in Private Health Insurance in Australia, *Geneva Papers on Risk and Uncertainty*, forthcoming

Buchmueller TC, Fiebig D, Jones G, Savage E, Advantageous Selection in Private Health Insurance: The Case of Australia, *CHERE Working Paper 2008/2*, CHERE, Sydney, 2008

Doiron D, Jones G, Savage E, Healthy, Wealthy and Insured? The Role of Self-Assessed Health in the Demand for Private Health Insurance, 2008, *Health Economics*, **17**: 317-334

Ellis R, Savage E, 2008, Run for Cover Now or Later? The impact of premiums, threats and deadlines on supplementary private health insurance in Australia, International *Journal of Health Care Finance and Economics* (accepted February 7, 2008)

Fiebig D, Savage E, Viney R, Does the reason for buying health insurance influence behaviour (*CHERE Working Paper 2007/1*, CHERE, Sydney, 2007)

Hall, J, Savage E, The role of the private sector in the Australian health care system, Maynard A (ed) *The Public- Private Mix for Health*, 2005, Radcliffe Publishing Ltd, Abingdon, 247-278.

Lu M, Savage E, Do financial incentives for supplementary private health insurance reduce pressure on the public system? Evidence from Australia, (*CHERE Working Paper 2006/11*, CHERE, Sydney, 2006)

Savage E, Wright D, 2003, Moral Hazard and Adverse Selection in Australian Private Hospitals: 1989-90, *Journal of Health Economics*, 22: 331-359

SUBMISSION

a. The impact on number of Australians with private health insurance (PHI) and the groups most likely to abandon their private cover

The increase in coverage of the population following the previous government's insurance incentives was predicted to cause premiums to fall. Despite the population covered by insurance after 2000 being younger and healthier, premiums increased in real terms. This was driven by higher claims, in particular higher benefits per day. It is difficult to determine whether this resulted from more procedures per day, increases in fees for those services or some combination of the two. Just as the impact of increased cover on premiums was difficult to predict, the impact of changes to the Medicare Levy Surcharge (MLS) threshold can be complex.

The MLS makes the price of health insurance negative for many singles and families above the threshold. The effective premium will change for those whose incomes fall between the old and the new thresholds. However, it cannot be assumed that all these groups will drop their cover because this depends on their motivation for purchasing insurance and the value that insurance provides to them. In many markets, there is considerable evidence of persistence (habit) in behaviour despite changes in incentives.

Those most likely to drop their cover will be younger individuals and families whose attachment to the product is low, and for whom the benefits of PHI without the financial incentives are unclear. Older individuals and families will be less likely to drop their cover if they foresee that insurance may provide more benefits as they age. The LHC surcharge will also provide a continuing incentive for them to maintain continuous cover. The population that first enrolled after 2000 and whose premiums include the surcharge may also maintain their cover despite a short term financial incentive to drop it. They may prefer to keep their PHI to take advantage of the LHC policy change whereby 10 years of continuous cover allows them to purchase insurance without paying the surcharge.

b. The impact on PHI premiums

The impact on premiums is also not straightforward. As healthier, younger people drop their cover, there will be pressure for premiums to increase because these individuals rarely use their PHI for private hospital treatment. However, there is evidence that young healthy PHI consumers purchase relatively cheap policies with high deductibles. There may be little impact on the premiums of policies providing higher levels of cover unless insurers are cross-subsidising these policies from the revenues obtained from the young and healthy. This is probably an unlikely direction for cross subsidies, between plans but empirical evidence would be necessary to establish this.

A further consideration is the role played by ancillary cover (now termed 'general' cover) particularly for relatively young consumers. Currently hospital only and ancillary only policies are relatively small shares of the PHI market. Consumers tend to purchase both or nothing. Insurers may be able to able to encourage younger enrolees to maintain their hospital cover with more attractive ancillary packages. The impact will depend on the ways insurers

respond to the changes.

The impact of the changes on premiums may actually be less than the annual premium increases of recent years which have been generated by a combination of technological advances (more complex and more expensive procedures), higher rates of procedure and higher fees to providers. Again, the impacts will depend on the degree of competition and strategic behaviour in provider and insurance markets, in particular how insurers negotiate contracts with hospitals and medical providers.

c. The impact on the public hospital system including waiting lists and the ongoing viability of PHI and private hospitals

As the background evidence shows, there is no simple relationship between insurance status and private hospital utilisation. The insured population cannot be assumed to behave homogeneously in response to policy changes. There is considerable heterogeneity among the privately insured population not only with regard to demographics and income but also their motivation for purchasing insurance. While government measures to increase private health insurance coverage in Australia increased cover by around 50%, they achieved far less in terms of changing the mix of public and private utilisation.

The Australian private hospital system is large and growing and its growth has been sustained for over two decades. Over 50% of elective surgery in Australia is performed in private hospitals and there is no evidence that would lead to the conclusion that the private hospital system is at all under threat from changes to the MLS thresholds. Those who are most likely to drop their insurance are relatively young and healthy individuals who rarely need hospital treatment, either in the public or private sectors. This is also the reason that there is unlikely to be a significant impact on waiting lists for public hospital treatment.

There is also no evidence to conclude that the MLS threshold changes will threaten the ongoing viability of the private health insurance market. The sector has been profitable and has been able to maintain a high level of population coverage despite free public hospital treatment. The policy changes may increase the incentives for insurers to respond to clients and provide more innovative policies and to investigate ways of reducing their administrative costs. Both may result in net benefits.

My expertise

I am an Associate Professor and senior researcher in the Centre for Health Economics Research and Evaluation, at the University of Technology Sydney, an Honorary Associate Professor, School of Public Health, University of Sydney and an invited research affiliate, Centre for Applied Economic Research, UNSW. Between 2005 and 2007 I was elected President of the Economic Society of Australia, NSW Branch. I am on of the Editorial Board of the Economic Record. My prominent role in health economics in Australia is recognised by my election as a Board Member of the ARC-funded Economic Design Network (EDN) and an invitation to establish the Health Economics subgroup of the Network. I am an invited member of the Resource Distribution Formula Technical Committee for the NSW Department of Health. I am a member of a Health Economics Advisory Panel for the Australian Department of Health and Ageing. Internationally I have been an invited member of the Scientific Committee of the International Health Economics Association (iHEA) and am currently on the Finance Committee for iHEA.