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7 July 2008

The Committee Secretary
Senate Economics Committee
Department of the Senate
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Secretary

Re: Inquiry into the Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008

This submission is made by iSelect in respect of the Senate Inquiry into the Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008. iSelect has addressed the relevant terms of reference, focusing primarily on terms a, c and f.

iSelect trusts that this submission will be of assistance to the Committee and would be pleased to attend and provide oral evidence at the Melbourne hearings scheduled for Wednesday 6 August 2008.

Background to iSelect

iSelect is Australia's largest health insurance advisory and comparison service, helping Australians choose the health insurance cover which suits their needs and budget. Based in Melbourne, iSelect is an Australian owned company, which has been operating for eight years and is independent of any single health insurance fund. The company is also a founding member of the Private Health Insurance Intermediaries Association.

iSelect represents close to 10% of all private health insurance policy sales in Australia, with its prime markets being Victoria, New South Wales and Queensland.

Importantly, in excess of 70% of iSelect's sales are to people who are new to private health insurance, with around 50-55% of these sales being single's policies and the balance residing with families/couples/single parent policies. Last year **1.1 million Australians** visited iSelect's website at www.iselect.com.au.

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Aside from enabling consumers to compare various policy options in one location, iSelect's expertise is in helping people to reduce the complexities associated with private health and to ultimately assist in finding cover which most appropriately suits their needs and life stage.

In doing so, iSelect has developed a strong understanding of the private health insurance market, and can provide the Committee with insights into what motivates Australian's to take out private cover, and the level of importance they ascribe to it. Our submission includes several illustrative cameos in order to help demonstrate the likely impact of the proposed MLS threshold amendments on a range of private health insurance customer segments.

Overview

iSelect is supportive of the continual review and improvement of our healthcare system, including both the private and public sectors, for the long term benefit of Australians. We believe that to simply hold the status quo of the system, and its central tenements such as private health, will ultimately be at the detriment of those who rely on it most.

That being said, iSelect is concerned that the proposed 100 per cent increase in the Medicare Levy Surcharge (MLS) threshold (for singles) may disrupt the fundamental role that the surcharge plays:

- In encouraging people, including higher income earners, into private health insurance;
- In supporting the community rating principle upon which Australia's private health system is founded;
- To reduce pressure on an already overloaded public health system and ensure an appropriate mix of public and private healthcare, and
- To help fund Medicare.

We are equally concerned that this change appears to have been made without the benefit of significant modeling on its impact on the behaviour of private health insurance policy holders, both existing and potential, and the flow on effects to the Australian health system.

We also query the Government's positioning of this proposed change as a tax cut for working families, rather than as a significant change to the incentive structure for private health insurance.

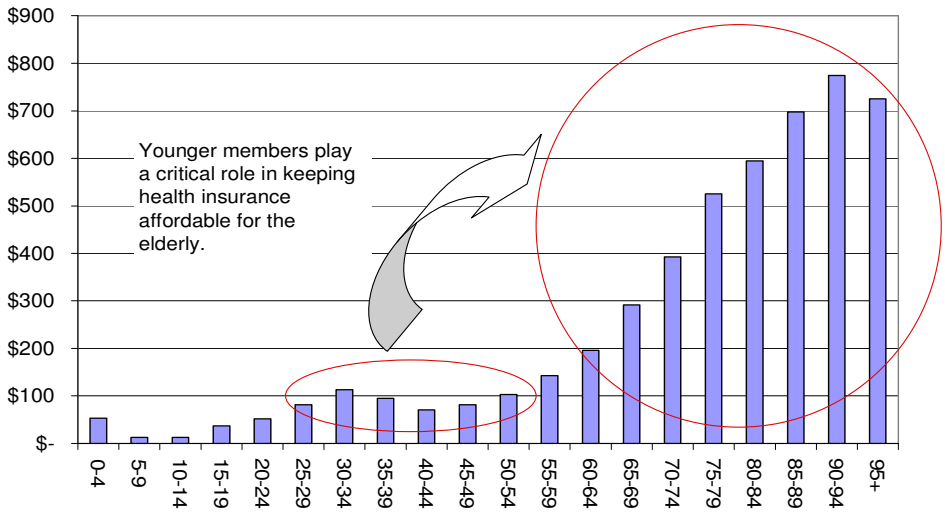
It is important to recognise that the MLS was not originally introduced as an extra tax, but as part of a package of incentives for people (and particularly younger people) to take out private health insurance and thereby support the principle of **community rating**.

Philosophically, we understand it was also designed to recoup public system costs associated with those that could afford but did not wish to take out PHI. With the other main elements of the 30% Health Insurance Rebate and Lifetime Health Cover (LHC), this package was designed to restore and sustain the public/private mix in health care delivery that is generally agreed to be a cornerstone of Australia's health system.

Due to community rating, a policy issued by an insurer has the same premium for each class of insured regardless of the age or the health of the insured. Classes of insured's are essentially singles, families, couples or single parent families. An essential part of this approach is the risk equalization arrangement which assists with claims of older Australians and other extremely large claims. Every health insured unit including those who are young and healthy contributes to the risk equalization arrangements. The risk equalization component makes up a large share of a young persons policy[1] and as such younger, healthier insured persons are contributing not just for their own risk but for those of many other higher risk Australians.

This highlights the importance of the MLS in encouraging healthier and younger members to invest in PHI not just for their own health requirements but to support many other Australians with such investment returned to them later in life. The table below helps to highlight how typical benefit payments increase as member's age and they require increased hospitalisation/treatment, thereby relying on the cross-subsidisation from younger/healthier members in order to keep premiums affordable:

Hospital Benefits per Insured Person (March 08 Quarter - Source PHIAC)



Importantly, since the introduction of this package of reforms, the percentage of the Australian population with private hospital cover has increased from **31.9%** as at June 1997 to **44.6%** as at March 2008 [Source: PHIAC].

The table below demonstrates the strong growth in membership exhibited within the private health industry in the last two years (note that growth in hospital coverage for persons under 30 years of age is experiencing the strongest growth):

[1] Based on PHIAC data, we understand that the average risk equalization contribution per single SEU across Australia is currently around $400 per annum, which in many cases would represent upwards of 50% of the total annual premium that a single would pay for an average hospital only treatment policy.

Private health insurance growth rates [source: PHIAC, nib ASX Announcement 19 May 2008]

	31 March 2006	31 March 2008	Growth (Policyholders)	Growth (%)
Industry				
Policyholders – All	4,778,916	5,163,573	384,657	8.0%
Policyholders - Hospital	4,181,403	4,540,112	358,709	8.6%
Persons – All	10,160,708	10,868,214	707,506	7.0%
Persons – Hospital	8,829,427	9,476,921	647,494	7.3%
Persons – Hospital < 30	3,025,351	3,281,412	256,061	8.5%
Persons – Hospital > 30	5,804,076	6,195,509	391,433	6.7%

We believe the current level of private insurance participation has enabled a more appropriate load and cost sharing between the public and private hospital system, affordable health insurance premiums for Australians, continuation of appropriate community rating, a more sustainable private health sector, and the continued necessary investment in medical technology, infrastructure and services.

Movement of the MLS thresholds as proposed will in effect make redundant the fundamentals upon which the MLS was introduced and reverse the growth in health insurance participation and associated benefit that Australians receive.

Accordingly, we recommend that in-depth analysis and modeling, including a thorough analysis of the potential 2nd and 3rd round long-term impacts of any movement, be completed prior to a decision being made relating to threshold movement or otherwise.

In the absence of appropriate analysis and understanding of potential 2nd and 3rd round impacts we believe that the Bill as drafted, and indeed the policy of increasing the contribution threshold for singles in particular to $100,000, may:

- Remove one of the critical factors in encouraging people (in particular those most able to afford it) from contributing fairly to Australia's healthcare costs;
- Create additional demand on the public hospital system without additional resources provided for the system to cope with the additional demand;
- Create a significant pool of younger Australians who refrain from appropriately contributing to their short and longer term healthcare costs;
- Place significant upward pressures on health insurance premiums, making private health ultimately less **affordable** for some Australians;
- Impact premiums for those who rely on private health insurance to protect their basic quality of life and who are not able to rely on the public system alone;
- Create significant leakage of funding from the total health system (including significant levels of voluntary funding from individuals), and
- Potentially detrimentally impact community rating and the ongoing sustainability of the private health sector.

Basis of Threshold Movement

Given the increase in private health membership and most importantly the delicate balance between public and private healthcare that has been achieved under the current $50,000 and $100,000 MLS thresholds, the question must be raised as to the policy validity of any change to the existing thresholds.

If, however, further analysis supported the case that some form of indexation would produce a meaningful **net benefit for Australia's long-term health care needs**, iSelect believes that the increases as proposed to the threshold levels are well in excess of what would be required to necessarily maintain the original policy intent.

iSelect understands that in setting the new thresholds, the Government sought to restore the relativity with the level it was set at in 1997 - being that it only applied to the top 8% of single taxpayers. However, we note from the transcript of the **Senate Economics Estimates Committee held on 3 June 2008** and comments attributed to Mr. Nigel Ray, Executive Director, Fiscal and Corporate, Department of Treasury, that if the new thresholds were implemented, a target of 9% of single taxpayers will not be achieved until the end of the Budget estimates period in 2011-12 – well beyond the life of this Parliament.

The following table indicates relationship of the existing and proposed threshold to average salaries in 1997 and in 2008 respectively:

MLS penalty threshold vs. average weekly earnings 1997-2008

	1997	2008
Average Salary	$35,000^	$58,490^
MLS Threshold	$50,000	$100,000^^
Threshold above average weekly earnings	42.9%	71%

^Source – Australian Bureau of Statistics, Average Weekly Earnings
^^ Proposed by the Federal Government, May 2008

For the 2008 year, parity with 1997 levels could be achieved by increasing the thresholds to around $65,000 for singles, and $130,000 for families by linking the indexation to the CPI.

iSelect believes that an increase in the threshold to $75,000 for singles would more than accommodate any CPI growth since 1997 and reinstate the original policy intent. Such a level of indexation, if deemed necessary, would help to ensure that new MLS qualifying thresholds:

- took into account wages growth since 1997;
- more than matched the growth in the CPI since 1997; and
- reflect the Government's policy intent as articulated in the 2008-09 Budget.

Importantly, we contend that if movement of $50,000 to $75,000 occurred (and likewise for families/couples), it would need to be pegged at this level for a similar period of say five to ten years so as to enable consumer awareness and understanding of such threshold levels to permeate throughout the Australian community.

Response to the Terms of Reference

A: The impact of changes to the thresholds on the number of Australians with private health insurance (PHI), including an examination of how many will abandon their policies as a result and how many will not take up PHI in the future;

iSelect Response

iSelect believes that the proposed threshold movements will impact a significant number of Australians. To illustrate, based on official 2005/6 Australian Taxation Office statistics, some **1,010,615 single taxpayers** [source: ATO] alone were earning between $50,000 and $100,000. The proposed new threshold, in isolation, will therefore no longer encourage these individuals into PHI or to retain their existing cover.

iSelect notes recent comment from the Federal Treasurer that the Treasury estimates approximately **485,000** people will exit private health insurance on the back of the proposed threshold increases.

We are concerned that this estimated movement out of PHI does not equate with the claimed 30% Private Health Insurance rebate savings by the Government as contained within the Budget papers, and that '485,000' refers to **taxpayers** rather than people, therefore not taking account of family structures (i.e. Children/dependents).

In any regard, we believe the Government estimate may be conservative given comprehensive independent research conducted by the Social Research Institute, Ipsos-Eureka in late 2007 (Health Care & Insurance 2007).

The Ipsos-Eureka research based on a survey 5,500 Australians - indicated that if the MLS thresholds went to **$75,000 and $150,000** respectively, **around 7% of current policy holders would withdraw out of private cover.** Given thresholds are proposed to rise to $100,000 and $150,000, and in consideration of tightened economic conditions for consumers, it is not unreasonable to conclude that this number could rise to close to **10% or greater**.

Of the total proportion of people within the Ipsos-Eureka research that stated they would drop out if the MLS income threshold rose to $75,000 for singles and $150,000 families, approximately 40%^ were families and 60%^ singles, with the following age breakdown of those stating they would drop their cover:

Age	% of Total
30 or under	18%
31-40	13%
41-50	29%
51-60	31%
61-70	7%
Over 70	3%
Total	100%

^ Source: Report Author, Health Care & Insurance 2007, Ipsos-Eureka

Of interest is that the Ipsos-Eureka research revealed that **48% of survey respondents** mentioned that the MLS had been one of the factors influencing them to maintain their PHI, and that government policy/taxation initiatives (other than the 30% Rebate) are impacting **47% of new joiners** to PHI.

We also note work conducted by Access Economics which estimates that some **800,000 people** would need to exit private cover next financial year in order to achieve the government's projected private health rebate savings of $232 million [Source: Access Economics, Health and the 2008-09 Federal Budget, May 2008].

Impact on the Future New Sales Growth (Take up) in Private Health Insurance

We note that the Ipsos-Eureka estimate of around a 7% withdrawal from PHI does not include diminished future growth in PHI take up which is to be expected from such an amendment.

We also note estimates from leading health fund and iSelect participant, nib, which in its ASX Announcement of 19 May 2008 estimated that the additional 'shock loss' from the proposed threshold changes in FY09 could be up to **6-8%** and that its future new sales growth over the near term could be up to **13-17%** lower than it had been experiencing.

iSelect believes these estimates present a fair prediction of the likely impacts. However, given the number of new memberships which are currently likely to be less than 30 years of age, and that the Ipsos-Eureka report found that **1 in 4 young people** stated they have taken out PHI specifically to avoid the MLS, it is reasonable that the nib estimate may also be conservative. This is reinforced with the fact that for the period 31 December 2006 to 31 December 2007, according to the PHIAC Annual Coverage Survey, the largest increase in membership for hospital treatment membership occurred in the **25-29 Age Group** which had a **13.56% increase (representing 53,315 insured persons)** over the 12 month period. The next largest increase (relatively) was 8.88% for the 80-84 Age Group.

As a key driver of new to private health sales in Australia, iSelect can also attest that MLS has been an important motivator in encouraging people to enter private health, particularly for younger members (singles). Single policies represent around 50-55**%** of all new to private health insurance sales which iSelect generates, with the remaining pertaining to couples/family/single parent policies.

We note some commentary post the Budget which claimed that a significant number of individuals taking up PHI to avoid the Surcharge were doing so with no real intention of using their private cover or had purchased policies of minimal value. This has generally not been the experience of iSelect, with a majority of policies purchased through iSelect containing both hospital cover and general treatment (i.e. for services such as Dental, Physiotherapy, Natural Therapies, Chiropractic, etc.).

To illustrate, we have provided below a 'typical' profile of the three key new to PHI customer segments that purchase insurance via the iSelect service:

- **Singles (Generally Under 30**)

These customers generally fall into two categories:

1. Those looking at private health cover for the first time for relief from MLS, but also wanting to learn more about what general treatment benefits (extras) are available. They often seek policies containing natural therapies, physiotherapy, chiropractic and general dental services and in the main they assess if purchasing PHI will be financially viable for them;
2. Those who either have been previously covered on family covers (i.e. their parents) or have had exposure to the public system either via family members or friends; they want the peace of mind that if they need a hospital admission they have a choice of which hospital they attend and the doctor that treats them.

Both groups in this category (under 30 years of age) recognise the value in the general treatments service, with more than 70% purchasing a hospital and extras policy with iSelect during the period May 2007 – April 2008. This further illustrates the value that is being derived via PHI relating to claims such as dental, physiotherapy and so forth.

The premiums sought by this group are often around the cost of the MLS and slightly higher if they are more frequent users of general treatments. They view purchase of PHI as a way to offset the MLS and gain value for outgoings they already pay.

Anecdotal evidence suggests that these customers do use private hospitals more than they may have expected. We understand the treatments are mostly for elective procedures (e.g. removal of wisdom teeth, tonsils, minor knee, hip and shoulder investigations and diagnostic investigations).

The policies aimed at young singles generally need to offer a range of services that provide the opportunity for the member to claim on services that are relevant to their lifestyles. This would include the trend towards natural therapies, and the "keep fit" and health prevention benefits that are offered by some health funds.

We believe that whilst this group are receiving benefits and value for their contributions they are more likely to maintain their PHI. However, in the absence of the MLS we believe a number of these individuals will still **not** seek to renew their private health insurance, leading to a drop in fund membership from a lower service use group. This could mean that premiums rise at a higher rate than if other higher usage groups withdrew, leading to a disproportionately higher upward impact on premiums.

- **Families 30-50 years**

These members are often living in the growth corridors of their state and have a concern over the increasing demand for public hospital services. They want their families to get treatment when they need it and do not want to be subjected to extended waiting lists should they require treatment in the nearest public hospital.

Private Hospitals are visible in their suburbs, and generally they want to be able to access these hospitals if needed.

They are also generally either starting or extending their families; and therefore they want to be able to access a private hospital of their choice for obstetric services.

The general treatments are important to them not only for their own treatment but for the treatment of their children. Benefits for Speech Therapy, Dietetics, Audiology, Orthotics and Orthodontics are often requested. This group is also often interested in the health prevention benefits that are being offered by health funds and see these services as a way they can be proactive in managing their health and wellbeing.

Once again the majority of customers in this grouping (who utilise iSelect) purchase hospital and extras policies as indicated by the fact that 71.7% of couples/families/single parents who used iSelect during May 2007 to April 2008 and who were new to PHI, purchased hospital and extras policies.

iSelect believe that many of these families will find it a harder decision to drop their cover as their service usage tends to be higher than younger singles. In all likelihood they will be susceptible to premium increases, and may look at ways they can marginally reduce the cost of their policies.

- **Older Couples (50 plus)**

These customers are again generally in two main categories:

1. People under 65 who do not see themselves as requiring full hospital cover, are looking more for products tailored to their needs, they want to have policies that do not include birth related services and depending on family history, may not require total joint replacements and dialysis covered on their policy.
2. Those looking for total peace of mind, who want full cover, no restrictions or exclusions.

We find both of these groups are interested in the more traditional general extras treatments such as general and major dental without orthodontics, high level optical benefits, podiatry and physiotherapy. They generally feel that they will not use the 'more alternate' natural therapies. These customers are more likely to purchase a hospital only policy.

Both groups are interested in excesses or co-payment options to reduce the cost of the premiums. iSelect believes that these groups will be more susceptible to premium increases as they will see they have little other option but to maintain their cover in an attempt to protect their quality of life.

Overall it is reasonable to expect that the young singles will be the group most likely to opt out of private health insurance if the MLS no longer applies to them. To many of them this will be a financial decision, as they may not see their current need for private health insurance as compelling as some of the other groups. Others may well drop hospital cover or other features in a desire to reduce the cost of premiums.

Families will probably be torn between the desire to maintain their cover and the other pressures on the family budget. We consider they are more premium cost sensitive, and will be at risk of exiting if the cost of premiums rises higher relative to other family budget pressures.

Older couples are possibly the most likely to maintain their cover regardless of premium rises, as long as the private hospital service levels remain higher than those in the public system. This is primarily driven by quality of life concerns and speedy access to services when they require, placing them at the mercy of rising premium costs.

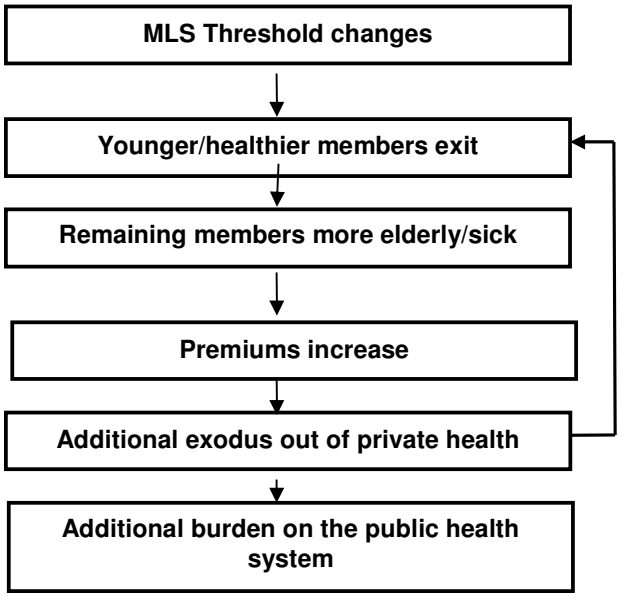
C. The anticipated impact on PHI premiums and PHI products offered

iSelect Response

iSelect is concerned that the proposed Budget threshold changes could start a cycle of **unaffordable** private health insurance.

Even if we assume that estimates of the exodus from PHI are an over-estimation and that minimal additional pressure is placed on the public health system, such a decision will still mean that the **private health system will lose many of those people who provide the cross-subsidy from the healthy to the ill that is the central element of community rating in Australia.**

Those people remaining with private cover will comprise a higher percentage of the elderly and seriously ill, who have the strongest incentive to buy private cover. These are the highest cost members for a health insurance fund and as the mix of fund members shifts towards them, premiums must inevitably rise. The rising cost of insurance is likely to then drive additional people out of private cover, and a repeating cycle is likely to emerge as shown diagrammatically below:



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It is not unreasonable to assume that such a cycle is likely given:

- the loss of contribution revenue that health funds will incur (and therefore funding for risk equalization arrangements) - accordingly forcing them to increase premium levels for remaining members. Our private health system in Australia is founded on the young and health contributing towards the cost of the more elderly/less healthy
- that **more than one million** of the overall hospital insured population reside in households where annual gross income is less than **$26,001^** and
- **that 27%** of the overall hospital insured population – **2.34 million people**, reside in households where gross annual income is less than **$48,049^**.

The impact of premium increases on these people and others with PHI is likely to diminish/negate any savings from altering the thresholds.

The ability of such households ('working families') earning less than $50,000 per annum to absorb premium increases given their levels of income and that such incomes maybe more likely to be fixed, is surely minimal. Furthermore, given their income it is reasonable to assume that a strong percentage of these individuals/families have private insurance out of necessity rather than as a result of Government incentives.

Therefore if they are forced to drop cover, these policyholders will be more likely to use and rely on the public health system.

^ Source - Australian Health Insurance Association, Media Release, 15 May 2008.

D. The impact of the change on the cost of living and the consumer price index;

iSelect Response

With the information and time available, iSelect is not able at this point in time to provide an estimate of the impact on the cost of living and the consumer price index however it is reasonable to assume that premium increases will have an impact.

That being said, iSelect believes it is reasonable to assume that the proposed threshold increases, if implemented, would impact negatively on Australia's rising rate of inflation given the significant numbers of Australians who would receive a de-facto tax cut through the amendments.

F. The anticipated impact of changes to the threshold on :

i. the public hospital system including waiting lists and the financial requirements of state governments;

ii. the ongoing viability of PHI, and

iii. private hospitals.

iSelect Response

If a significant decrease in privately insured persons occurred, it may place the viability of some smaller health funds into question and for public patients, the over stretched public health system would likely get significantly worse in future years once those exiting from private health ultimately require treatment.

Already there are around 17,000 Australian's who were waiting more than 365 days for elective, but necessary, surgery during 2006/7 [Source: Australian Government, Department of Health and Ageing, The State of our public hospitals, June 2008 Report].

Of further concern is that the **State of our public hospitals June 2008 Report** (as mentioned above) shows that public hospitals are under strain, with public hospital admissions increasing faster than population growth and that there are high numbers of people waiting for elective surgery. The report evidenced that amongst other matters:

- In 2006-07, public hospital admissions grew by around three per cent - this is more than twice the rate of population growth.
- The number of patients presenting to emergency departments between 1998-99 and 2006-07 increased by over 34 per cent.
- On average, the longest waits for elective surgery procedures are for Knee Replacement (162 days median wait), Septoplasty (median 113 days), and Hip Replacement (median 106 days).

Whilst understanding that the Federal Government is investing significant resources in order to improve the public hospital system and reduce elective surgery waiting lists, the exodus of private patients will create additional demand on the public system that it may simply not be able to service.

Also of relevance to Australian's future healthcare needs, is that depending on the level of exodus from private health, we estimate that anywhere between $400 million and around $800 million per annum in health insurance contributions revenue that is voluntarily contributed is likely to be lost to Australia's health system and insurance funds alike – over four years this amount is in the vicinity for **$1.6 billion to $3.2 billion,** far exceeding the estimated government savings in reduced expenditure related to the rebate.

As briefly outlined earlier, aside from the loss of these funds within the healthcare system, without a corresponding reduction in benefit payments from health funds (likely given the age/demographic of those expected to exit private health), this is likely to deplete health funds capital reserves and produce a premium increase over and above any increase required to cover normal cost increases.

Access Economics estimates that Australia's health funds could be short by as much as $500 million per annum in total, implying a premium increase of **5%** over and above any premium increase needed to cover costs [Source: Access Economics, Health and the 2008-09 Federal Budget, May 2008].

In conclusion:

iSelect welcomes the opportunity to provide this submission and to be of assistance to the Committee.

We remain concerned that the proposed 100 per cent increase in the Medicare Levy Surcharge (MLS) threshold (for singles) may disrupt the fundamental role that the surcharge plays in Australia's healthcare system.

We are equally concerned that this change appears to have been made without the benefit of significant modeling on its impact on the behaviour of private health insurance policy holders, both existing and potential, and the flow on effects to the Australian health system.

We therefore recommend that in-depth analysis and modeling, including a thorough analysis of the potential 2nd and 3rd round long-term impacts of any movement, be completed prior to a decision being made relating to threshold movement or otherwise.

If we can provide any assistance with this matter or additional information, please contact me on 03 9276 8210 or iSelect's General Manager of Corporate Affairs, Rohan Martin, on 03 9276 8208 or at rmartin@iselect.com.au.

Yours faithfully

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