We are
hirmaa

6 June, 2013

Committee Secretary
Senate Standing Committee on Community Affairs
PO Box 6100
Parliament House
CANBERRA ACT 2600

Dear Committee Secretary

We are pleased to present our submission to the Senate inquiry into the Private Health Insurance Legislation Amendment (Base Premium) Bill 2013 (the Bill). Thank you for inviting our submission.

hirmaa is an industry body representing eighteen community-based funds which provide a valuable alternative to larger, for-profit funds. Seventeen of these funds are not-for-profit while the eighteenth is owned by a mutual, not-for profit organisation.

This letter provides a brief summary of our submission.

Summary of Submission

The private health insurance premium rebate (PHI rebate) covers 30% of premiums for most Australians. There are higher rebates for older people, and a means test results in lower rebates for people on higher incomes.

The PHI rebate was introduced in 1999, when the proportion of Australians with private hospital cover was around 30% and falling. The introduction of the rebate marked a turning point for private health cover in Australia, with almost 50% of the population now insured.

The Bill will increase premiums for most Australians

If the Bill becomes law the PHI rebate will increase in line with CPI (the consumer price index), rather than in line with PHI premiums. Since health costs (and therefore premiums) increase faster than CPI, the proposal is effectively to reduce and ultimately remove the rebate for all Australians.

This is not the first reduction in Government support for PHI, following means testing the PHI rebate and changes to the Medicare Levy Surcharge. However, while previous changes were targeted at higher income earners, the Bill currently before Parliament requires those on lower incomes to pay more.

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Allowing for the reduction in the rebate, we would expect premium increases of 8% per year to become the norm. Because the proposal will impact directly on people on lower incomes, we expect many will drop their cover and rely on the public health system.

The changes need not be so complex

The proposal is highly complex. There are thousands of PHI products for sale and within a few years each could have a different level of rebate. The costs of making the changes will be considerable, and ultimately borne by members (as our funds are community-based). Most importantly, these changes will be difficult for many of our members to understand.

The level of rebate for new products and new insurers is an important consideration. The fact that details cannot be provided now is evidence of the proposal's complexity. Our view is that it will be very difficult (and perhaps even impossible) to find a formula which balances the various competitive issues around new products and new insurers.

While we oppose reducing the rebate, we suggest that the savings could be achieved in a more simple and transparent way. The same rebate could apply to every policy as it does now, but that rebate percentage would reduce over time. For example, the 30% rebate could reduce to 29% in 2014, 28% in 2015 and so on. Our proposal would result in the same savings for Government, but be simple for funds to implement and easier for members to understand.

Conclusion

PHI premiums need to increase faster than CPI, in common with other areas of Government health spending. By linking the PHI rebate to CPI, the Bill effectively phases out the rebate over many years.

Premium increases of 8% per year will become the norm, as members pay more to make up for lower rebates. Unlike previous changes to PHI support, premiums will increase most for those on lower incomes. We therefore expect people to drop their private cover as a result of this Bill.

If the rebate is to be reduced, the change should be practical and easy for members to understand. We have suggested an alternative that achieves the same savings for Government in a simple, transparent way.

Yours sincerely

RON WILSON
Executive Director

Why do PHI premiums need to increase faster than CPI?

Summary

It is well known that health costs increase faster than CPI, whether those costs are part of the public or private health systems. This reflects our ageing population, advances in technology and the labour-intensive nature of healthcare.

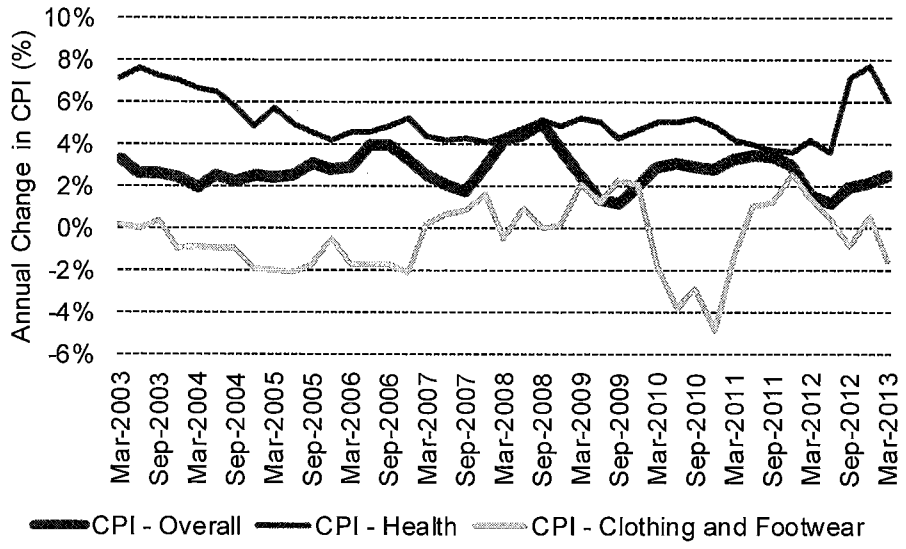
What is CPI, and how does it compare to health cost inflation?

CPI measures the quarterly changes in price of a basket of goods and services which account for a high proportion of expenditure by metropolitan households[1]. It is compiled by the Australian Bureau of Statistics (ABS).

Although the CPI is the best known price index, it is but one of many produced by the ABS. According to the ABS, "having determined that a price index is required for a particular application it is important to carefully consider the range of available indexes and select the index which best meets the specific requirement."[2]

The table below shows overall CPI for the last ten years, together with CPI for two price groups, health and clothing & footwear. Note that PHI premiums are part of the health grouping within the CPI calculations.

Figure 1 – Historical CPI – Overall and for Selected Groups



The CPI measures changes in the price of a basket of goods and some industries will be consistently higher or lower than average. The figure demonstrates that health costs tend to increase faster than CPI, and costs in other sectors (such as clothing and footwear) tend to increase by less than CPI.

The graph clearly shows that CPI is a very poor benchmark for health costs.

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[1] Definition from Australian Bureau of Statistics, index number 6401.0 at March 2013

[2] From "A Guide to the CPI", section 2.13, item number 6440.0 from the Australian Bureau of Statistics

What drives PHI premium increases?

Our members value their health insurance but premium increases often stretch family budgets. PHI premium increases are therefore subject to considerable scrutiny. The process includes certification by each insurer's actuary, review by PHIAC (the health insurance regulator) and the Department of Health and Ageing. Ultimately premium increases must be approved by the Minister unless she/he is satisfied that an increase would be contrary to the public interest.

The level of premium increases has been the subject of extensive analysis, including by Parliament. A report by the Parliamentary Library in 2009[3] identified the following major drivers of higher premiums:

- "an ageing population that increases utilisation and benefit outlays;
- adverse selection, which sees younger, healthier people foregoing health insurance, but not those most likely to need treatment;
- rising costs associated with advances in medical technology and new treatments, and,
- unavoidable cost pressures, such as provider costs rising faster than CPI, prosthesis costs and Medicare Benefit Schedule increases not in line with other cost increases."

In summary, health costs increase due to ageing and medical advances, which insurers refer to as utilisation inflation. Even without utilisation inflation, many costs are linked to doctors and nurses wages and so increase faster than CPI.

We note that most of the factors listed above apply to both public and private healthcare. **If people choose not to insure, the cost pressures transfer to the public health system.**

Health Insurers Operate Efficiently

PHI premium increases reflect high claims inflation for the reasons listed above. We understand members want their health funds to operate efficiently and not make excessive profits.

While its easy to suggest health funds are inefficient or excessively profitable, the evidence is strongly to the contrary. In particular, we note that:

- Across the industry as a whole, management expenses average around 9% of premium and profit around 5% of premium;
- Much of the profit is required to meet increasing regulatory capital requirements, a legal requirement to protect the financial soundness of insurers;
- PHI compares favourably to general insurance, where expenses alone generally exceed 25% of premium;
- Most hirmaa funds are not-for-profit[4], meaning any surplus is used for the benefit of members, and

[3] "Private Health Insurance Premium Increases – An Overview", Amanda Biggs, Parliamentary Library, Parliament of Australia

[4] 17 of the 18 of the hirmaa funds are not-for-profit. Doctors Health Fund is a for-profit but is owned by a not-for-profit

- Government scrutinises each insurer's expenses and profit margins as part of the annual pricing process.

Insurers are always looking for ways to improve efficiency and would appreciate any efforts to reduce the costs charged by providers. However, any suggestion that high premium increases are due to inefficiency would be simply untrue.

What would be the effect of premiums of linking the rebate to CPI?

Summary

Because PHI premiums necessarily increase faster than CPI, the rebate will reduce each year as a percentage of premium. Members will need to pay extra premiums to allow for the reduction in rebate. We show detailed calculations below.

Assuming funds increase premiums by 6% per year (in line with costs) and CPI inflation is 2.5%, the amount paid by most members will need to increase by 8%. As a percentage of premium, the rebate reduces from 30% to 29% in just one year, and is expected to reduce to 20% by 2025. The bill is therefore gradually phasing out the rebate – a death by a thousand cuts.

Because the changes impact people on lower incomes, some will drop their cover or reduce their cover. Those in good health are more likely to drop cover than those in poor health, and these "selective lapses" increase average premiums for those remaining insured. **There is therefore the potential for a spiral of increasing premiums and people dropping cover to use the public health system.**

8% annual premium increases become the norm - our calculations in detail

We first show the relevant historical premium and CPI increases, then set out the calculations for Australians currently with 30% or 40% rebates.

Historical Data

PHI premium increases have averaged 5.9% over the last 10 years, and CPI has averaged 2.7%, as shown in the following table.

Table 1 – Industry Average Premium Increases and CPI – Last 10 Years

Year	Industry Average Premium Increase	CPI
2013	5.6%	2.5%
2012	5.1%	1.6%
2011	5.6%	3.3%
2010	5.8%	2.9%
2009	6.0%	2.4%
2008	5.0%	4.3%
2007	4.5%	2.5%
2006	5.7%	2.9%
2005	8.0%	2.4%
2004	7.6%	2.0%
Average	**5.9%**	**2.7%**

Our calculations assume future average premium increases of 6.0% per year, in line with the historical data. We assume CPI of 2.5% based on current economic forecasts, noting this is also consistent with the historical data.

hirmaa funds do not have any shareholders to pay and so can keep premiums as low as possible. The 2013 average premium increase for hirmaa funds of 4.4% compares favourably to the overall industry average increase of 5.6% shown in the table. However, health cost pressures mean that even hirmaa funds would be highly unlikely to increase premiums by less than CPI.

How much more will members pay?

Most Australians receive a rebate of 30% of premium, and the table shows how the Bill will impact their 2014 premiums. We base the calculations on a typical $3,000 per year premium, 6.0% premium increase and CPI inflation of 2.5%.

Under the current legislation, both the rebate and amount paid by the member increase at the same rate, so the rebate remains at 30%.

Under the proposed legislation, the rebate increases by only 2.5% and so the member will need to make up the difference. This results in a premium increase for the member of 7.5% rather than 6.0%. In effect, the rebate now only covers 29% of premium.

Table 2 – Estimated 2014 Premium – Current Rebate 30%

Assumptions	
Current annual premium (before rebate)	$3,000
Premium increase	6%
Current rebate	30% of premium

Calculations

	Total	Rebate	Paid by Member	Rebate as % of Total Premium
2013 Premium	3,000	900	2,100	30.0%
Current legislation	Premium and rebate increase by same amount (6% assumed)			
2014 Premium	3,180	954	2,226	**30.0%**
Increase over 2013	*6.0%*	*6.0%*	***6.0%***	
Proposed legislation	Rebate increases by only CPI (2.5% assumed)			
2014 Premium	3,180	923	2,258	**29.0%**
Increase over 2013	*6.0%*	*2.5%*	***7.5%***	
Increase over current legislation	0	(32)	32	

We note that the percentage premium increase often receives considerable public attention. Australians have not experienced industry-average increases of 7.5% for almost ten years, and we therefore expect this to cause considerable public comment.

Over one year, the Bill increases the average member's out-of-pocket costs by $32 (and reduces the Government contribution by the same amount). While this is a fairly small amount, we note that the financial impact increases over time.

The following table shows the effect on premiums in 2025. Again we assume 6.0% premium increases and 2.5% CPI inflation, in line with the historical average.

Table 3 – Estimated 2025 Premium – Current Rebate 30%

	Total	Rebate	Paid by Member	Rebate as % of Total Premium
2013 Premium	3,000	900	2,100	30.0%
Current legislation	Premium and rebate increase by same amount (6% pa assumed)			
2025 Premium	6,037	1,811	4,226	**30.0%**
Increase over 2013	*101.2%*	*101.2%*	***101.2%***	
Proposed legislation	Rebate increases by only CPI (2.5% pa assumed)			
2025 Premium	6,037	1,210	4,826	**20.1%**
Increase over 2013	*101.2%*	*34.5%*	***129.8%***	
Increase over current legislation	0	(601)	601	

By 2025 members will be paying around $600 per year in additional premiums, and the rebate will only cover 20% of premiums on average.

The Bill therefore results in years of high premium increases, with the rebate representing an ever smaller proportion of premium.

The increases are greatest for older Australians

Older Australians currently receive higher premium rebates of 35% (for 65 to 69 year olds) or 40% (for people 70 or over). Older Australians therefore have the most to lose from this Bill, and will experience higher premium increases than others.

The tables below show our calculations based on a 40% initial rebate. Our conclusions are:

- Assuming health funds increase premiums by 6.0% in 2014, people over 70 will need to pay 8.3% more for their insurance (allowing for the lower rebates);
- By comparison, people with a 30% rebate pay 7.5% more if health funds increase premiums by 6.0%;
- After just one year, the rebate as a percentage of premium falls to 38.7% from 40%, and
- By 2025, the rebate falls to only 27% of premium, and older Australians are paying $800 more per year for health insurance.

Table 4 – Estimated 2014 Premium – Current Rebate 40%

Assumptions	
Current annual premium (before rebate)	$3,000
Premium increase	6%
Current rebate	40% of premium

Calculations

	Total	Rebate	Paid by Member	Rebate as % of Total Premium
2013 Premium	3,000	1,200	1,800	40.0%
Current legislation	Premium and rebate increase by same amount (6% assumed)			
2014 Premium	3,180	1,272	1,908	**40.0%**
Increase over 2013	*6.0%*	*6.0%*	***6.0%***	
Proposed legislation	Rebate increases by only CPI (2.5% assumed)			
2014 Premium	3,180	1,230	1,950	**38.7%**
Increase over 2013	*6.0%*	*2.5%*	***8.3%***	
Increase over current legislation	0	(42)	42	

Table 5 – Estimated 2025 Premium – Current Rebate 40%

	Total	Rebate	Paid by Member	Rebate as % of Total Premium
2013 Premium	3,000	1,200	1,800	40.0%
Current legislation	Premium and rebate increase by same amount (6% pa assumed)			
2020 Premium	6,037	2,415	3,622	**40.0%**
Increase over 2013	*101.2%*	*101.2%*	***101.2%***	
Proposed legislation	Rebate increases by only CPI (2.5% pa assumed)			
2020 Premium	6,037	1,614	4,423	**26.7%**
Increase over 2013	*101.2%*	*34.5%*	***145.7%***	
Increase over current legislation	0	(801)	801	

Can the current proposal be practically implemented?

Summary

The level of rebate is to be calculated separately for each "product subgroup". There are several product subgroups for each of the thousands of products available, and each could have a different rebate level. The proposal is therefore highly complex and will be difficult for members to understand.

The rebate for new products and new insurers is an important consideration and the fact that details cannot be provided now is evidence of the proposal's complexity. Our view is that it will be very difficult (and perhaps even impossible) to find a formula which balances the various competitive issues around new products and new insurers.

While we oppose reducing the rebate, if the Government is determined to achieve these savings, then the changes could be achieved in a simpler and more transparent way. We suggest an alternative below.

How the Proposal Will Be Implemented

The legislation will apply at a "product subgroup" level. This term is defined in legislation and we explain its meaning below.

There are thousands of health insurance products on the market. This is because every insurer caters to a range of customer requirements and budgets. Where a product is available in several states these are considered to be different products for regulatory reasons (largely due to the state based risk equalisation legislation).

The most material "product subgroups" are single, couple, family and single parent family policies, although others are permitted by legislation. Therefore, there are several product subgroups for each of the thousands of products available.

The level of rebate is to be calculated separately for each product subgroup. Because premiums for each product subgroup will increase by a different amount, each could end up with a different level of rebate.

For example, while the average premium increase is typically around 6% per year, some product subgroups receive much higher or lower increases. Each year there are a small number of products which receive no premium increase, so would retain a 30% rebate in 2014. Products requiring a very large premium increase in 2014 will immediately have much lower rebates, for example, a 20% increase reduces the rebate from 30% to 25%.

The example shows that, by the end of 2014, rebates are expected to vary between 25% and 30% at the product subgroup level. The range of rebates would get wider each year.

New Products and New Insurers

Insurers regularly launch new products in response to customer needs and new insurers enter the market from time to time. Noting the various levels of rebate on existing products (from 25% to 30% in 2014 and wider in later years), it is not obvious what rebate should be available to new products or new insurers.

The Bill says the level of the rebate will reflect some kind of weighted average rebate on other products. However, the details of the calculation will be specified at a later date.

The level of rebate for new products and insurers is important for the following reasons:

- If new insurers are able offer higher rebates than existing insurers, this would give new insurers an unfair competitive advantage.
- Alternatively, new insurers may end up with lower rebates than existing insurers, reducing competition in the industry.
- New product rebates can be no higher than rebates on similar existing products, or customers could simply be transferred across. However, rebates should not be lower than existing products, as this would stifle innovation.

The rebate for new products and insurers is therefore an important consideration and its omission from the Bill is much more than an administrative detail. We do not see how Parliament can reasonably consider the legislation without details on this issue.

The fact that details of the weighted average cannot be included in the Bill is evidence of the proposal's complexity. Our view is that it will be very difficult (and perhaps even impossible) to find a formula which balances all of the considerations listed above. Difficulties with new products and insurers are therefore another example of why the proposed legislation is unworkable.

The Practical Challenges for Members

Members will find it difficult to understand why different products get different levels of rebate. For example:

- Members would find they get a different percentage rebate if they choose to upgrade or downgrade their cover, or change insurers.
- Higher rebates might also be available by buying two single policies rather than a couple policy, even if the cover was otherwise identical (because single and couple are different product subgroups).
- Similarly, members would get a different rebate by purchasing a combined hospital and extras policy, compared to buying separate hospital and extras policies, even if the benefits obtained are the same.

The Practical Challenges for Funds

The challenges for funds include:

- Significant costs for system changes, noting that existing systems cannot handle multiple and different rebate rates by product subgroup.
- Noting the challenges for members, there will be costs involved in explaining the changes. These include costs associated with changing websites, brochures and staff training.
- In particular, complexity will add significantly to the call volumes and the call times, thereby impacting member service, member satisfaction and company productivity.

The costs associated with this Bill are expected to be significant. Because hirmaa funds are community-based mutuals, these costs are ultimately borne by members through higher premiums or lower benefits.

Is there a better way?

While we oppose reducing the rebate, if the Government is determined to pursue these changes, then the same savings could be realised in a much simpler and more transparent way. The same rebate could apply to every policy as it does now, but that percentage would reduce over time.

We have estimated the change in average rebate to attain the same level of savings as the Government's proposal. The detailed calculations provided earlier in the submission show how the rebate reduction can be determined. We have assumed an industry average premium increase of 6.0% and CPI inflation of 2.5%.

We estimate that Government could achieve the targeted cost savings by reducing the 30% rebate to 29.0% from 1 April 2014, 28.1% from 1 April 2015, 27.1% from 1 April 2016 and 26.2% from 1 April 2016. We show these figures in the table below, together with the PHI rebate estimates from the May 2013 Federal Budget.

Table 6 – Estimated Change in Rebate to Achieve Budget Savings

Year	Budget for PHI Rebate ($m) [1]	Change on Prior Year		Estimated rebate level to achieve budget savings
		Due to CPI (2.5%)	Due to Other Factors [2]	
2012-13	5,564			*30.0%*
2013-14	5,399	139	(304)	29.0% [3]
2014-15	5,578	135	44	28.1%
2015-16	5,748	139	31	27.1%
2016-17	5,912	144	20	26.2%

Notes:

[1] Source: Table 8.1, Budget Paper No1 2013-14, 14 May 2013

[2] The change in PHI rebate is different from forecast CPI, and the budget papers explain these differences as follows:
The reduction between 2012-13 and 2013-14 is atributed to pre-payment of premiums in 2011-12
The budget papers identify increased take up of PHI as the reason for above CPI increases in later years
Refer to page 6-26 of the budget papers for further details

[3] The Bill is effective 1 April 2014, however budget papers show June years and members may be able to pre-pay. Therefore the allocation of savings to financial years is approximate.

If there must be changes to the rebate, applying the same change to every policy would be a better solution because:

- The Government can specify a change in rebate to achieve the **same savings** as anticipated in the Bill.
- Health insurance policyholders benefit because this proposal is **easier to understand** than the Government's proposal.
- Funds will find our proposal **easier to administer**, reducing the cost of computer system changes. Government should also benefit from a proposal that is easier to administer.

If required, the rebate could be calculated so that the impact on older Australians is no worse than for younger people. We would also suggest that the legislation include a sunset clause, so that once the budget position improves, Government could return to the current 30% rebate.

Conclusion

We repeat our opposition to any changes that will increase premiums for members and force people out of private health care. However, if there must be changes to Government support to PHI, those changes should be easy for members to understand and simple for funds to implement.

We have suggested an alternative that achieves the same savings for Government in a relatively simple and transparent way.

We hope our submission demonstrates our commitment to work in good faith with Government to achieve the best outcome for Australians with private health insurance.