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THE SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE
INQUIRY AND REPORT

VALUE AND AFFORDABILITY OF PRIVATE HEALTH INSURANCE AND OUT-OF-POCKET MEDICAL COSTS

SUBMISSION BY

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IN RESPONSE TO THE TERMS OF REFERENCE

e) the take-up rates of private health insurance (PHI), including as they relate to the Medicare levy surcharge (MLS) and Lifetime Health Cover (LHC) loading;

i) the current government incentives for private health;

KEY POINTS

- We discuss the findings from a scientific publication that directly address the above terms of reference
- The study uses a microsimulation approach to model the effects of various adjustments to the PHI incentive mechanisms
- Adjustments to the LHC parameters can moderately increase the PHI uptake at **a low cost** to the federal budget however they shift the costs to Australians who will face higher penalties for not insuring
- Incentives that rely on individual income tax can influence uptake rates across all age groups but come at a **high incremental cost** per additional person insured
- We find in many modeled scenarios that **the additional cost of incentives is higher than the direct purchase of PHI cover** by the government on behalf of the individual
- By increasing the means testing thresholds or decreasing the MLS **substantial budget savings** can be achieved at a relatively small loss in the number of persons insured
- Maintaining a balance of low and high risk individuals in the insurance pool is an important policy goal alongside maintaining PHI uptake rates

INTRODUCTION

The purpose of this submission is to bring to the Committee's attention the results of our study entitled '*Private Health Insurance Incentives in Australia: In Search of Cost-Effective Adjustments*'. The study, which directly addresses the two above-listed terms of reference, has been peer-reviewed and published in the journal Applied Health Economics and Health Policy on 12 July 2017. Below we show the relevance of the study to the inquiry and discuss its main findings. The manuscript is enclosed with the submission[1].

The study constitutes academic work and as such does not represent interests of any particular party. The authors' links to the industry, namely previous paid consultancy work for Private Healthcare Australia, have been fully disclosed in the publication.

SCOPE, METHODS AND CAVEATS

The study was based on the premise that policy mechanisms which incentivise the uptake of private health insurance (PHI) may differ in economic efficiency. For the purpose of the study, efficiency (cost-effectiveness) was defined narrowly, taking into account the sole effect of changing the PHI uptake rate (number of Australians holding hospital cover PHI) and selected costs falling on the Commonwealth government. Specifically, these costs were related to the changing levels of budget income and expense on the PHI Rebate, Medicare levy surcharge (MLS), and other instrument-specific tax revenues or concessions.

We defined a number of scenarios that represented credible, incremental changes to the structure of incentives using the 2014-15 financial year (FY) as a reference. The model has the capacity to simulate other scenarios and we are able to perform additional analyses upon request.

All results were reported as relative to the baseline of the FY2014-15 simulated levels of cost and insurance uptake (the status quo). Hence, for the purposes of the study, a lower tax revenue from MLS resulting from a policy change was considered a cost to the government

[1] Full version of the article can be accessed online without restrictions at http://rdcu.be/t9RN

(i.e. a loss of revenue). Conversely, a scenario which led to a higher MLS revenue was considered to be cost-saving (i.e. improving the budget position).

An important cost component that was left out of our analysis was the implication of changing PHI uptake for the demand and utilisation of services in public hospitals. Accounting for the reliance on public hospital services as a function of the PHI uptake is a complex issue that would require additional and dedicated analyses.

In our simulation study individuals were assumed to make rational choices about insuring under various incentive scenarios. The purpose of the model was to **demonstrate how various incentive mechanisms may perform in a simulated environment in terms of influencing the rates of PHI uptake, and at what cost to the taxpayer**. In our simulation the complexity of insurance products, the population and the decision context have all been reduced when compared to reality. Consequently, the results of actually introducing the policy scenarios, which depend on a number of implementation factors, would likely to differ from those reported in the study. The results are best interpreted in relative (comparing between scenarios) rather than in absolute terms. For this reason, in the discussion that follows we focus on the broader conclusions rather than any specific result.

INCENTIVE MECHANISMS

Changes to the Lifetime Health Cover

Modifications to the Lifetime Health Cover mechanism may include the age when the penalty applies and the value of the loading. We also considered an amnesty nullifying the accumulated penalty and a negative loading (i.e. a premium discount) applying from an age of 25. Overall, because this policy instrument does not involve government spending as a direct incentive[2], it can achieve increases in PHI uptake at a relatively low cost to the government per additional insured individual. Higher uptake rates can be achieved by

[2] The fiscal implications for the government are indirect, i.e. the Rebate paid and MLS collected may increase or decrease as a result of the changing PHI uptake. Importantly, a major part of the cost of this policy is shifted onto Australians who will face higher penalties for not insuring. As a result, some of them may be unable to afford PHI at an older age.

lowering the age at which the LHC applies, however, the magnitude of this effect is restricted due to the fact that people age 25 years or less can rely on their parents' insurance cover.

In our model the baseline value of the loading, set at 2%, was close to optimal in stimulating PHI uptake. Increasing it to 3% elevated the PHI uptake by a small margin (70,000 individuals) at the same time modestly reducing the government spending in this area (by $21 million). Decreasing the value of the loading parameter or increasing it above 3% led to a lower than baseline PHI uptake.

In our model a one-off LHC amnesty resulted in a modestly higher PHI uptake (by 392,000 individuals) at a relatively low cost per person added ($659). However, a real-life implementation of this scenario would have to consider the consequence of creating an expectation that further amnesties could be granted in the future, undermining the overall credibility of this incentive system.

Changes to the PHI Rebate

Adjusting the parameters of the PHI Rebate gives the government an opportunity to expand or reduce its extent of market intervention, influencing the PHI uptake up or down, respectively. In our simulation, the cost to the government per person added ($1816) and the saving per person lost to insurance ($1587) were relatively close the model's premium of $1829 per year[3].In other words, the cost of inducing a person to take out PHI through the Rebate was similar to the cost of the government directly purchasing PHI cover on behalf of those individuals – a far from optimal outcome.

The simulated removal of this incentive resulted in a 21.3 percentage point reduction in PHI uptake (which appeared to be reasonable given the pre-incentive trend from the 1990s) and saving the government nearly $4 billon. Finally, setting the Rebate at 30% for all Australians, as originally defined in The Private Health Insurance Incentives Act 1998, added little uptake at a prohibitively high cost of $22,624 per additional person insured.

[3] Calculated using industry data as the average premium for hospital cover PHI in the FY2014-15

Changes to the Medicare levy surcharge

All of our MLS scenarios resulted in a substantial change of the budget position. This was due to the fact that altering the value of the surcharge affects all individuals who are subject to the MLS regardless of their decision to purchase PHI being affected by the incentive scenario. In particular, as a result of lowering the surcharge some people might give up their PHI cover and choose to pay the MLS instead. On the other hand, high income individuals who remain uninsured would face a smaller penalty, decreasing the MLS revenue. In our model reducing the surcharge by 0.5 percentage points considerably improved the budget position, by $1.7 billion. Conversely, increasing the surcharge resulted in the loss of MLS revenue of a similar magnitude.

We also investigated the possibility of setting a surcharge of 0% or 1% that applies to all incomes, with both measures showing the capacity to considerably affect the PHI uptake[4].

MEANS TESTING THRESHOLDS

We considered the means testing thresholds to be an independent policy instrument even though it can only affect the PHI market when combined with other incentive mechanisms. Adjusting the threshold levels up or down will reversely affect the level of PHI uptake. However, we found that the incremental cost per additional person insured was in excess of that produced by other measures available to the government.

HYPOTHETICAL INCENTIVE MECHANISMS

In addition to the incentives existing in the Australian PHI market we explored two new mechanisms that offer tax benefits associated with insuring. Those mechanisms were 1) tax credit, i.e. a reduction in taxable personal income by a set proportion of the premium in eligible groups, and 2) fringe benefits tax exemption, that is, an opportunity for employers to offer PHI as part of a benefit package exempted from income tax. The latter was necessarily dependent on the share of employers passing on the benefit to their employees. The strength

[4] MLS can be seen as either concession for insuring or penalty for not insuring. This interpretation will determine whether a change in the budget position is considered to be cost or cost-savings.

of the two mechanisms was in their capacity to increase the insured population by large numbers, up to a simulated 2.6 million people, at the budget expense of $5.6 billion, in the case of a tax credit of 20% premium offered to all Australians. However, we also found that in those scenarios the incremental cost per additional person insured was higher than in some alternative approaches such as increasing the PHI Rebate.

In the course of our research we also discussed a number of other incentive instruments such as the inclusion of PHI in superannuation alongside life cover, and establishing health savings accounts with mandatory funds that could be spent toward purchasing PHI. However, due to complex design of such scenarios their simulation would rely on critical assumptions which we were not informed to make. Should the Committee be interested in exploring these or other possibilities, our model can accommodate such requests where reliable inputs can be provided.

AGE STRUCTURE OF THE INSURANCE POOL

An important consideration regarding the incentive policy is the age structure of the insurance pool it generates. Generally speaking, in order to maintain a sound risk structure and affordable premiums, low risk insurees are required to balance out the high risk insurees. An imbalance in the insurance pool toward high risk individuals will drive the premiums up which may cause more low risk persons to drop out, leading to further premium increases. This process is known as the insurance market ‘death spiral’. It is an important goal of the incentive policy to prevent such a market collapse, and policy scenarios can lend to this goal in various extents. We considered the impact of each scenario on the age profile of the insurance pool; results are provided in Table 6 of our article. Notably, lowering the age when LHC applies and offering a negative loading (i.e. a premium discount) to people in their 20s have the capacity to selectively attract a younger demographic into the insurance pool. Lowering the means test thresholds would attract new insurees of all age groups but, according to our model, it would result in decreasing the average age of the insurance pool. These outcomes are important because, when compared to older insurees, younger

individuals on average represent a lower risk and a lower cost associated with health care use.

CONCLUDING THOUGHTS

The existence of multiple incentive instruments opens many possibilities for the government to influence the PHI market. Options exist for scaling up and down the current extent of government intervention, with varying effects on the budget and the size of the insured population. Our study, while subject to some limitations, demonstrates the performance of conceivable policy scenarios in terms of achieved PHI uptake, their cost to the federal government, and the cost per additional person insured relative to the status quo.

The government should be particularly interested in the scenarios that increase PHI uptake at a low cost to the government per person added, and those that decrease PHI uptake at a large cost-saving per person removed. The potential for large cost-savings to the federal budget that can be achieved at a small loss of uptake, and the possibility of compensating for such a loss of uptake at a relatively low per-person cost, suggest that opportunities exist for optimisation of the government policy in the area of PHI incentives. While offsetting scenarios can be bundled together it is important to keep in mind that the total effect might differ from the sum of separate effects, due to various incentives simultaneously influencing the insurance decision.

The resulting age structure of the insurance pool is another important consideration for the policy-makers, insofar as the participation of young people is a prerequisite for affordable premiums.

REFERENCES

Sowa PM, Kault S, Byrnes J, Ng SK, Comans T, Scuffham PA (2017) Private Health Insurance Incentives in Australia: In Search of Cost-Effective Adjustments. *Applied Health Economics and Health Policy,* doi:10.1007/s40258-017-0338-6