Private Health Insurance Legislation Amendment (Base Premium) Bill

The referral

1.1 On 16 May 2013, on the recommendation of the Selection of Bills Committee, the Senate referred the provisions of the Private Health Insurance Legislation Amendment (Base Premium) Bill 2013 to the Community Affairs Legislation Committee for inquiry and report by 17 June 2013.[1]

Conduct of the Inquiry

1.2 The committee advertised the inquiry in the national press on 22 May, as well as on its website. The committee wrote to stakeholders, inviting them to make submissions. The committee received 12 submissions relating to the bill (listed at Appendix 1), which are available for viewing on the inquiry website:

http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=clac_ctte/phi_base_premium/index.htm

1.3 The committee thanks all those submitters for their contribution to the inquiry process.

The bill

1.4 Around one half of all Australians currently have private health insurance cover to assist in managing the costs of their health care. This level of insurance has in part been achieved through a number of Commonwealth policies directed at encouraging people to take up and maintain private cover. One of these policies, introduced in 1999, is a rebate for people taking out such insurance, lowering its cost to the consumer.

1.5 As health care costs have risen, and the number of people taking out insurance has also increased, the cost to government of the rebate has increased significantly. This has presented a long-term budget issue to which the current bill is one response, as the Department of Health and Ageing (the department) explained:

> On the basis of the long-term trend for participation rates, the Government has decided that a rebalance of the mechanism to continue this objective is required to ensure that maximum value for expenditure on the rebate is obtained and is kept sustainable. This Bill will help to ensure the sustainability of the rebate into the future by helping to reduce the long

1 *Journals of the Senate*, 16 May 2013, p. 3954.

> term costs in an area of health expenditure which is experiencing substantial growth.[2]

1.6 The bill proposes to change the value of the health insurance rebate over time, by removing the direct link between the rebate and the price of a health insurance policy, and replacing it with a link to cost-of-living increases:

> The provisions in this Bill do not propose to alter the premium setting process. This will continue to occur as per current arrangements. Rather, the provisions would change the manner in which the rebate itself is calculated so that it would cease being automatically linked to commercial increases in premiums. Instead, the rebate calculation would be directly linked to a new indexation factor (the 'base premium' amount…). This indexation factor would be the lesser of the CPI (the 'CPI indexation factor'…) and the actual commercial premium increase (the 'premium indexation factor'…).[3]

1.7 The new mechanism would take effect from April 2014.

Views about the bill

1.8 Consumer organisations opposed the bill. National Seniors Australia considered that:

> The decision to increase the rebate each year in line with the lower of the CPI or the Government-approved increase to premiums is discouraging to older Australians who have attempted to provide for their own health care.[4]

1.9 Hirmaa was also particularly concerned about the effect on older Australians because they receive higher premium rebates than those under 65, and would therefore experience proportionately higher effects from the bill.[5]

1.10 The Consumers Health Forum of Australia understood the need to find savings in the budget. Nevertheless it identified a number of problems with the bill. The Consumers Health Forum argued that scenarios that look only at the cost difference to consumers in the first year of operation do not reflect the longer-term impact of the compounding effect of the increases in annual premiums. It considered that the complexity of private health insurance would be increased, making it harder for consumers to understand, and that this may lead to 'decisions to discontinue, downgrade or not take up private health insurance at the margins'.[6] The Consumers Health Forum was also concerned that the growing cost to consumers might

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2 Department of Health and Ageing, *Submission 11*, p. 3.

3 *Bills Digest No. 123*, 2012–13, pp. 4–5.

4 National Seniors Australia, *Submission 1*, p. 2.

5 Hirmaa, *Submission 3*, p. 8.

6 Consumers Health Forum of Australia, *Submission 4*, p. 2.

encourage insurers to offer products with more exclusions and restrictions, increasing the risk that consumers will purchase products that are inappropriate to their needs.

1.11 Insurers were also concerned about complexity for consumers. HBF Health Limited submitted that:

> Private health insurance is incredibly complex to consumers. The industry already experiences a barrier for new entrants for this reason. Explaining pricing with rebate indexation will further confuse and potentially isolate consumers.
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> Ipsos research shows that 44% of people without private health insurance "just don't even think about it because it is too complex and confusing" and that 66% of people who made inquiries about private health insurance in 2010 were deterred from proceeding due to the complexity.[7]

1.12 Australian Unity made a similar argument:

> For consumers, health insurance will be more expensive and more opaque because of the proposed legislative changes. To determine their costs, consumers must now apply the relevant [Australian Government Rebate] (AGR) percentage to the 'base premium' for the relevant product, which is directly linked to general CPI. After determining their AGR entitlement, it is deducted from the 'commercial' premium to finally calculate the level of direct contribution they are required to make to their health insurer.
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> The situation is further complicated for consumers who incur a lifetime health cover (LHC) loading. The LHC loading is calculated with reference to the 'commercial premium', not the 'base premium' and added to the direct contribution the consumer must make.[8]

1.13 As well as being concerned about the effects on consumers, private health insurers foreshadowed increased administrative costs for their businesses. Hirmaa for example argued that 'there are thousands of PHI [private health insurance] 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'.[9] Bupa described some of the consequences it anticipated from the changes:

> Bupa is concerned that the Government has not considered the considerable regulatory burden that the proposed implementation of CPI indexation will have on industry. Annual rebate certificate audits will be progressively more complex and expensive, this alone will add significant cost for all insurers, which they have no control over.
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> Further, the proposed method of CPI indexation will lead to complexities in PHI not before experienced and therefore not understood by customers. Consequently, Bupa expects customer queries to multiply. This will have a

7 HBF, *Submission 10*, p. 8.

8 Australian Unity, *Submission 5*, p. 5.

9 Hirmaa, *Submission 3*, p. 2.

> major impact on front line services and an inevitable flow through increase in management expenses.[10]

1.14 The Parliamentary Library's Bills Digest observed that 'the technical requirements the provisions will impose on health insurers (who calculate the rebate in most instances) could be burdensome'.[11]

1.15 The department's submission described the responsibilities of insurers under the scheme:

> Individual insurers will be required to develop and maintain a schedule which includes both the base premium and full premium for each product they offer. This will need to be adjusted for products which are removed and new products they bring to the market.
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> From 1 April 2014 onwards, insurers will be required to annually adjust the base premium by the lesser of the prescribed CPI rate or approved premium increase.
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> Insurers will be required to provide base premium information for their available product subgroups to the Australian Taxation Office (ATO) and the Department of Human Services for the purposes of claiming the rebate through the tax offset and premium reduction scheme. Insurers will also need to provide the base premium as part of the statement provided to policyholders on 15 July in each income year, as this is the amount on which the rebate will be calculated.
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> Insurers will be required to advise consumers about policy details as well as the base premium and associated rebate in line with this measure.[12]

1.16 Medibank queried whether the bill's approach to setting baseline premiums would undermine community rating, one of the key policy principles of Australia's health insurance system:

> The concept of community rating underpins private health insurance in Australia. Community rating ensures that customers are not discriminated against on the basis of their health status by mandating all customers pay the same price for a given product. For example older people who are more likely to consume healthcare services and who in a risk-rated insurance environment would be considered a bad risk and charged a higher premium are, in a community rated system, charged the same premium as a younger person less likely to consume healthcare services.
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> An effect of the Base Premium Bill will be to undermine this principle. This will occur because…product based indexation will accelerate the direct cost to customers on the products most used by older and less healthy people.

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10 Bupa, *Submission 9*, p. 5.

11 *Bills Digest No. 123*, 2012–13, p. 5.

12 Department of Health and Ageing, *Submission 11*, p. 9.

> To grasp this impact it is first necessary to understand that due to the phenomenon of adverse selection higher priced comprehensive products tend to attract members who are more likely to claim – i.e. older and less healthy people. All other things being equal these products will tend to see higher premium increases over time than products with restrictions and exclusions that attract customers who are less likely to claim.[13]

1.17 Professional organisations had a particular concern with the consequences of premium rises for the types of coverage that consumers will adopt. As consumers pay an increasing proportion of their health costs, both the Australian Physiotherapy Association and the Optometrists Association of Australia argued that more consumers may drop any ancillary cover and confine their insurance to hospital cover. The Optometrists Association commented that the reform may:

> negatively affect consumer choice to access prescription spectacles, that is, the support they need to correct vision loss and, in many cases, avoid further deterioration of sight…Given that 75% of vision loss and blindness is preventable or treatable if detected early, the impact on patient access to eye care should be considered.[14]

1.18 The Australian Private Hospitals Association expressed concern that:

> It will be exceedingly difficult to directly measure the impact of this measure on the numbers of people holding PHI and on the level of cover purchased by these people. This is for a number of reasons:
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> - the introduction of successive changes to the PHI Rebate, make it difficult to ascribe causation to any one measure.
> - the impact of changes already introduced has been mitigated to date by a loophole that allowed high income earners to maintain the full 30% rebate for 12 to 18 months through pre-payment. This means the impact of the proposed Bill will be concurrent & cumulative with the means-testing impact.
> - Data collected by [Private Health Insurance Administration Council], while reporting the number of policies held and the number of people covered, reveal little about the level of cover other than the number of policies withone or more exclusion. This data is insufficient to measure the extent of policy downgrading in response to government policy changes.[15]

Alternative implementation models

1.19 Most submitters appeared to accept that the government is committed to making changes that will lead to budget savings. Within this context, the private

13 Medibank, *Submission 6*, p. 5.

14 Optometrists Association of Australia, *Submission 8*, p. 2.

15 Australian Private Hospitals Association, *Submission 7*, p. 5.

insurance sector offered a range of alternative implementation models that they argued would have fewer implementation problems or costs than the approach taken in the bill.

1.20 Medibank suggested indexing the premium at industry level rather than at the level of individual products:

> We suggest the concept of the Base Premium be removed from the Bill and the methodology of indexing be lifted from the product level to an industry wide level. This would see the current Australian Government Rebate levels adjusted annually. Each year the Rebate levels would be reduced by the difference between the growth in premiums and the change in CPI.[16]

1.21 Medibank argued that this would simplify implementation, increase transparency, boost competition and preserve community rating. Australian Unity also favoured adjustments based on 'average premium increases across the industry'.[17]

1.22 HBF suggested indexation at fund level rather than industry level:

> Applying the indexed rebate at a fund level would be a much simpler method for reducing the Government's expenditure on the rebate. This will incentivise funds to keep their overall premium increases to a minimum, to protect the amount of rebate their members receive whilst still encouraging competition between funds. There will also be greater transparency for members as each fund will have a set rebate percentage across all of their product offerings.[18]

1.23 Hirmaa suggested that instead of introducing the concept of a base premium and calculating this each year for each product or group of products, the government could simply reduce the rebate percentage each year to deliver the same budget saving. Hirmaa estimated this would be achieved by approximately a one per cent per annum reduction.[19]

1.24 Bupa did not put forward an alternative implementation model, but did suggest that the indexation should be on a different index to CPI.[20] Australian Unity made a similar suggestion,[21] as did Private Healthcare Australia, which recommended using Health CPI.[22]

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16 Medibank, *Submission 6*, p. 6.

17 Australian Unity, *Submission 5*, p. 7.

18 HBF, *Submission 10*, p. 5.

19 Hirmaa, *Submission 3*, p. 12.

20 Bupa, *Submission 9*.

21 Australian Unity, *Submission 5*, p. 3.

22 Private Healthcare Australia, *Submission 12*, p. 5.

Discussion

1.25 The committee is aware of ongoing concerns, which it has heard in previous inquiries, about the effect on private health insurance levels of various changes to policies that affect the cost of insurance. The committee reiterates the observation it made in its last report on a private health insurance bill, that there have been no reductions in private health insurance levels following other policy changes. The one policy which triggered significant increases in private health insurance was not the government's private health insurance rebate, but the introduction of lifetime health cover.[23] The department indicated that it did not expect the bill to affect participation levels, and noted that numbers of policy holders have increased since the introduction of income testing.[24]

1.26 The committee noted Medibank's argument that the current policy could undermine community rating. This argument was based on the fact that 'higher priced comprehensive products tend to attract members who are more likely to claim' and that these tend to be older people. This however is already the case, and it is not relevant to the policy of community rating. Medibank's point is premised on the argument that there will be higher premium increases on products that are subject to higher claims. This however is the case regardless of the policy proposal in the current bill. The principle of community rating is unaffected, because it will remain the case that individuals will not be risk assessed by insurers.

1.27 It was suggested that the base on which to calculate indexation should be something other than CPI, with Health CPI being suggested by some submitters. There are two problems with this proposal. First, health insurance premium increases themselves are a significant component of the Health CPI measure. Using Health CPI to determine the future base premium would have a circular logic. Second, it would undermine the policy rationale for the change:

> Over time, the Government’s contribution, through the rebate, will diminish if premium increases are consistently higher than CPI. The intention of this measure is, in part, to encourage greater competition between insurers on price and product innovation to mitigate this outcome.[25]

1.28 A policy objective of promoting competition by focussing on the gap in price increases in healthcare compared to the broader economy requires indexation to be based on a measure of that broader economy.

1.29 The committee considered some of the alternatives proposed by stakeholders for structuring the reform, and correspondence received from the department in relation to these (Appendix 2). It considered the approach of indexing the rebate at the

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23 *Bills Digest No. 123*, 2012–13, p. 4.

24 *Submission 11*, p. 10.

25 Department of Health and Ageing, *Submission 11*, pp. 4–5.

industry level (reducing the percentage rebate each year), as suggested by Medibank. The committee was concerned that, while it could deliver the savings, it would not contribute to fostering innovation and competition. It would also not deliver the same incentive to funds to limit their premium increases. Under this model, large insurers would have a disproportionate level of control over the rebate adjustment.

1.30 Another alternative was to formulate the rebate at the level of insurers, rather than at the level of individual products. This appeared to present several challenges. It would be less transparent because insurers would have discretion as to how they applied rebates across a basket of products. The implementation could be more complex than the current model, and require closer monitoring. Unlike other models, it could also put the savings at risk, depending on consumer behaviour in moving between types of funds.

Recommendation 1

1.31 The committee recommends that the bill be passed.

Senator Claire Moore

Chair