Chapter 3

Private health insurance premiums

3.1 This chapter considers the economic structures that increase and constrain private health insurance premiums in Australia.

Factors driving premium increases

3.2 As discussed in the previous chapter, submitters told the committee that some Australians have been dropping or downgrading their private health insurance because of affordability or because they perceive that the product is not value for money.[1]

3.3 However, submitters held differing views about what was causing significant premium increases.

3.4 Submitters told the committee that increases in underlying cost pressures are largely to blame for rising premiums.[2]

3.5 The Australian Healthcare Reform Alliance told the committee that private health insurers were experiencing increased costs in a number of areas, but questioned insurers' ability to control those costs:

> Premiums are rising due to both the growth in consumer demand for services and increased health technology and pharmaceutical costs. Private insurers have little or no capacity to influence either of these factors and so have argued for more control over provider behaviour, in order to reduce inflated costs and low value care.[3]

3.6 The factors that private health insurers say they cannot control include utilisation, medical costs, private patients in public hospitals, management costs and intermediaries.

Utilisation

3.7 Utilisation measures the rate at which insured persons demand hospital services.[4] Some submitters considered that increased utilisation had caused premiums to increase by 50 per cent between 2010 and 2016.[5]

3.8 According to research conducted by the Australian Private Hospitals Association (APHA), the rate at which consumers accessed services increased by

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1 For more discussion of affordability for consumers see Chapter 2.

2 Mr Charles Maskell-Knight, Principal Adviser, Department of Health (Department), *Committee Hansard*, 31 October 2017, p. 72; Private Healthcare Australia, *Submission 18*, p. 25; NIB, *Submission 24*, p. 2; HBF, *Submission 63*, pp. 7–10.

3 Australian Healthcare Reform Alliance, *Submission 67*, [p. 2].

4 Australian Private Hospitals Association (APHA), *Submission 80—Attachment 2*, p. 9.

5 Johnson and Johnson Medical Pty Ltd (Johnson and Johnson), *Submission 62*, p. 3. See also Private Healthcare Australia, *Submission 18*, p. 25; NIB, *Submission 24*, p. 2; HBF, *Submission 63*, p. 7.

20 per cent between 2010 and 2016.[6] In 2010, the rate was 321 hospital episodes per 1000 insured people.[7] In 2016, that rate had steadily increased to 384.8 hospital episodes per 1000 insured people.[8]

Table 3.1—Annual ratio of episodes per 1000 persons insured 2010–16

Year	2010	2011	2012	2013	2014	2015	2016	Change 2010-2016
Utilisation ratio	321.0	328.9	337.4	347.1	365.7	374.8	384.8	63.8

Source: APHA, based on APRA data.

Source: Australian Private Hospitals Association, *Submission 80—Attachment 2*, p. 9.

3.9 The APHA told the committee that the 20 per cent increase in the utilisation rate over this period accounted for 'forty percent [sic] (40.2%) of the growth in benefits paid out over 2010–2016'.[9]

3.10 Private Healthcare Australia explained to the committee that the increase in utilisation could be directly attributed to rising consumer expectations about what the health system ought to deliver:

> Consumer expectations of what the health system should deliver are increasing in line with economic growth and increasing life expectancy. Many people who have a hip or knee replacement these days do so with the expectation of returning not only to work, but also to an active lifestyle.[10]

3.11 Other submitters pointed to Australia's ageing population to explain the increase in utilisation.[11] Specifically, older Australians make up a larger proportion of the insured cohort.[12]

3.12 Representatives from the Department of Health (Department) suggested that Australia's ageing population and the ability to safely provide a wider range of medical services to an older cohort was leading to increased utilisation:

> I think the underlying cost pressures driving premiums up are that people are getting older. Doctors and technology companies are inventing more

6 APHA, *Submission 80—Attachment 2*, p. 9.

7 *Submission 80—Attachment 2*, p. 9.

8 *Submission 80—Attachment 2*, p. 9.

9 *Submission 80—Attachment 2*, p. 9.

10 Private Healthcare Australia, *Submission 18*, p. 14.

11 Ms Alison Verhoeven, Chief Executive, Australian Healthcare and Hospitals Association (AHHA), *Committee Hansard*, 5 July 2017, p. 19; Ms Penny Shakespeare, Acting Deputy Secretary, Health Benefits Group, Department, *Committee Hansard*, 31 October 2017, p. 72; Bupa Australia, *Submission 43*, p. 3; Johnson and Johnson, *Submission 62*, p. 4; HBF, *Submission 63*, p. 7; Australian Physiotherapy Association, *Submission 74*, p. 21.

12 APHA, *Submission 80—Attachment 2*, p. 9.

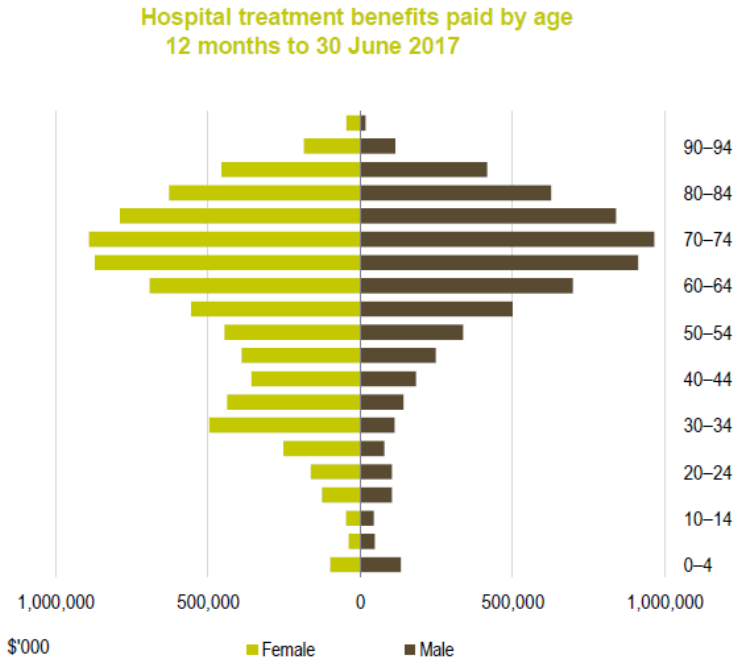
> and more things that can be done to folk, especially as they get older. Anaesthetic technology has now advanced to the point that 80-year-olds can be anaesthetised safely for things that wouldn't have been done 15 years ago.[13]

3.13 The Grattan Institute agreed with the Department's assessment.[14]

3.14 Private Healthcare Australia also explained to the committee that an ageing population has an effect on private health insurers because older Australians are 'more highly represented in PHI [private health insurance] than younger age groups and cost significantly more in healthcare than younger groups'.[15]

3.15 Private Healthcare Australia's observation about the demand and cost of healthcare in older populations is supported by data published by the Australian Prudential Regulation Authority (APRA) that demonstrates that greater hospital benefits are paid to persons in older age groups.

Graph 3.1—Hospital treatment benefits by age



Source: APRA, *Private Health Insurance Quarterly Statistics*, June 2017, p. 6.

Medical costs

3.16 Private Healthcare Australia and its members told the committee that medical costs were also contributing to health inflation and placing pressure on private health insurance premiums.[16]

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13 Mr Maskell-Knight, *Committee Hansard*, 31 October 2017, p. 72.

14 Grattan Institute, *Submission 72*, p. 7.

15 Private Healthcare Australia, *Submission 18*, p. 36.

16 Private Healthcare Australia, *Submission 18*, p. 9.

3.17 Hirmaa, which represents not-for-profit and restricted membership funds, similarly told the committee that the rising cost of medical services was placing pressure on private health insurance premiums:

> We would love premiums to be even lower, but unfortunately insurers have to set premiums in line with the growing cost of medical services.[17]

3.18 The Australian Medical Association (AMA) disagreed that the increased cost of medical services was a substantial contributor to private health insurance premiums, saying:

> Medical expenses are a small proportion of total benefit outlays for private health insurers. Medical expenses have remained static at around 16 per cent since 2007. In fact, administration expenditure by private health insurers is around 10 per cent. So it is costing insurers almost as much to run their business as it is to pay the doctors who treat their customers.[18]

3.19 The APHA also disagreed that medical expenses were significantly impacting premiums. According to APHA's research, once adjusted for inflation, increased medical costs only accounted for 1.1 per cent of the growth in benefits paid to patients.[19] The APHA considered that utilisation, inflation and the number of insured people had a greater effect on premiums.[20]

Private patients in public hospitals

3.20 Another factor that may be placing pressure on premiums is the practice of insured patients being treated privately in public hospitals. The committee heard that consumers are often encouraged to use their private health insurance to 'help the hospital' or to obtain benefits like a private room, their choice of doctor or faster admission to surgery.[21]

3.21 The APHA told the committee that it believes that this practice has contributed significantly to pressure on premiums:

> Private Healthcare Australia has equated that to a six per cent increase in premiums; premiums are six per cent higher than they would otherwise be if that outlay wasn't there.[22]

3.22 Bupa Australia explained that whilst using their private health insurance in a public hospital may not leave the consumer out-of-pocket, consumers are not necessarily informed that using their private health insurance in a public hospital

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17 Mr Matthew Koce, Chief Executive Officer, hirmaa, *Committee Hansard*, 5 July 2017, p. 29.

18 Dr Michael Gannon, President, Australian Medical Association (AMA), *Committee Hansard*, 31 October 2017, p. 31.

19 APHA, *Submission 80—Attachment 2*, p. 8.

20 *Submission 80—Attachment 2*, p. 8.

21 Independent Hospital Pricing Authority (IHPA), *Submission 2*, p. 27; Haemotology Federation of Australia, *Submission 50*, p. 7; Bupa Australia, *Submission 43*, pp. 11–12.

22 Mr Michael Roff, Chief Executive Officer, APHA, *Committee Hansard*, 31 October 2017, p. 44.

contributes to the overall pressure on premiums.[23] This practice will be discussed further in Chapter 4.

Remuneration and management

3.23 Several submitters to this inquiry highlighted that private health insurance companies have moved from being structured as member-owned not-for-profit mutuals to being large corporations.[24] The effect of that change is that profit becomes a substantial consideration for companies.[25]

3.24 Of Australia's 37 private health insurers, 13 operate as for-profit companies.[26] Those for-profit companies have been generating 'substantial' profits in recent years.[27]

3.25 In 2015–16, Australia's 37 private health insurers made $1596 million in profit before tax and $1252 million after tax.[28]

3.26 In 2016–17, Australia's 37 private health insurers made $1822 million before tax and $1396 million after tax.[29]

3.27 Some submitters to the inquiry argued that the need to generate a profit and a return to shareholders has fuelled a rise in premiums. The AMA told the committee:

> The shift to a full-profit industry has created the need to ensure that there are sufficient profits to allow a return to shareholders. This is driving much of the growth in increased premiums.[30]

3.28 Other stakeholders, such as the Medical Technology Association of Australia (MTAA), suggested that private health insurers' rising profits indicated that private health insurers had capacity to reduce premiums further:

> The evidence of private health insurers' increasing profits, increasing cash reserves and increasing CEO salaries suggests that they should do some belt tightening of their own to keep premium growth to a CPI [consumer price index] level.[31]

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23 Bupa Australia, *Submission 43*, p. 11.

24 Dr Gannon, *Committee Hansard*, 31 October 2017, p. 37; Council of Procedural Specialists, *Submission 41*, [p. 1].

25 Dr Gannon, *Committee Hansard*, 31 October 2017, p. 37.

26 Department, *Submission 127*, p. 3.

27 Dr Gannon, *Committee Hansard*, 31 October 2017, p. 37.

28 Australian Prudential Regulation Authority (APRA), 'Financial performance', *Private Health Insurance Operations Report 2015–16*, http://www.apra.gov.au/PHI/Publications/Pages/Operations-of-Private-Health-Insurers-Annual-Report.aspx (accessed 9 November 2017).

29 APRA, 'Financial performance', *Private Health Insurance Operations Report 2016–17*, http://www.apra.gov.au/PHI/Publications/Pages/Operations-of-Private-Health-Insurers-Annual-Report.aspx (accessed 9 November 2017).

30 Dr Gannon, *Committee Hansard*, 31 October 2017, p. 32.

31 Mr Ian Burgess, Chief Executive Officer, Medical Technology Association of Australia (MTAA), *Committee Hansard*, 31 October 2017, p. 2.

3.29 According to APRA, the industry average for management expenses was 8.5 per cent in 2015–16 and 8.8 per cent in 2016–17.[32]

3.30 Private health insurers disagreed that management expenses were contributing to rising premiums.[33] Instead, private health insurers indicated that their management expenses were relatively low compared to other types of insurance.[34]

3.31 Representatives of hirmaa told the committee that:

> My funds operate on very narrow management expense ratios, and that includes salaries for running the fund. There's been no jump-up in MER [management expense ratio] within my funds. It's very narrow, and you don't have that MER for anyone else in the health supply chain. If there were a jump in the MER, the management expense ratio, I would say, yes, you'd have every right to question why there is an increase in the management expense ratio, but there's not.[35]

3.32 Representatives of Bupa Australia similarly indicated that they were committed to keeping their management costs down:

> We have committed internally next year to have our costs grow by no more than one per cent. The only reason those costs are growing is because we face rental costs with landlords and commission costs for some of the things we do for people, like students and so on. There's just no way I can easily get out of some of those costs.[36]

3.33 As the representative from hirmaa noted, management expense ratios are published by APRA but submitters noted that there is currently a difference between the levels of transparency required of insurers depending on whether they are listed on the Australian Stock Exchange (ASX).[37]

3.34 One of those transparency factors is executive remuneration. Currently, only the two ASX listed companies, Medibank Private and NIB, are required to disclose what their senior executives are paid.[38]

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32 APRA, 'Financial performance', *Private Health Insurance Operations Report 2015–16*; APRA, 'Financial performance', *Private Health Insurance Operations Report 2016–17*.

33 Mr Koce, *Committee Hansard*, 5 July 2017, p. 30; Dr Dwayne Crombie, Managing Director, Health Insurance, *Committee Hansard*, 31 October 2017, p. 50; Private Healthcare Australia, Submission 18, p. 6; NIB, *Submission 24*, p. 4; hirmaa, *Submission 75*, p. 7.

34 Private Healthcare Australia, *Submission 18*, p. 7.

35 Mr Koce, *Committee Hansard*, 5 July 2017, p. 31.

36 Dr Crombie, *Committee Hansard*, 5 July 2017, p. 50.

37 Mr Koce, *Committee Hansard*, 5 July 2017, p. 32; Dr Stephen Duckett, Director, Health Program, Grattan Institute, *Committee Hansard*, 31 October 2017, p. 18; Mr Shaun Gath, *Submission 5*, p. 14.

38 Mr Koce, *Committee Hansard*, 5 July 2017, p. 32.

3.35 Some submitters, such as Dr Stephen Duckett, Director of the Health Program at the Grattan Institute, considered that all private health insurers ought to disclose these amounts:

> My view is that we should have requirements on health insurance funds in the same way we have requirements on listed companies about disclosure and about transparency of how they're spending the money.[39]

3.36 Some of the private health insurers the committee spoke to did not consider that revealing executive remuneration would be a problem, but wanted it to be consistent across the industry. Representatives of Bupa Australia told the committee that:

> We don't have a problem if it's done for the industry. People could reasonably argue that where public money is being spent—as long as there is consistency involving suppliers, medical device companies, even industry associations and all the rest of it—it should be a matter for the public record.[40]

3.37 Dr Rachel David, Chief Executive Officer of Private Healthcare Australia, the peak body representing private health insurers, agreed that executive remuneration ought to be disclosed in more areas of healthcare:

> What you'd need to do is ensure that in the hospitals—whether they be church, charitable or publicly listed—their senior executives do the same; and I also believe quite strongly medical specialists and dental practices as well.[41]

3.38 Whilst not all submitters agreed that the disclosure of remuneration ought to necessarily extend to individual medical practitioners, Private Healthcare Australia suggested that its members would not oppose greater transparency:

> Should our elected representatives or our regulators agree it's in the community interest for a heightened level of disclosure to occur, we certainly will not oppose that. We will comply with anything along those lines that is required of us.[42]

Intermediaries

3.39 In Chapter 2, the committee considered the role of the privatehealth.gov.au website in helping consumers select a policy. In that chapter, the committee noted that the privatehealth.gov.au website was one of the only independent comparison websites and that many other websites operate on a fee-for-placement basis. On a fee-for-placement website, the private health insurer pays a fee or commission to the website when an individual takes out a private health insurance policy after using the

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39 *Committee Hansard*, 31 October 2017, p. 18.

40 Dr Crombie, *Committee Hansard*, 31 October 2017, pp. 51–52.

41 *Committee Hansard*, 31 October 2017, p. 52.

42 Dr Rachel David, Chief Executive Officer, Private Healthcare Australia, *Committee Hansard*, 31 October 2017, p. 51.

intermediary's website.[43] Bupa Australia and other submitters suggested that commissions paid to intermediaries to facilitate consumers switching private health insurers may also be contributing to rising premiums.[44]

3.40 The Private Health Insurance Intermediaries Association (PHIIA) told the committee that the mission of its members was to increase market competition and improve consumer outcomes.[45]

3.41 However, Bupa Australia told the committee that the commissions claimed by intermediaries were large and did not assist consumers:

> Comparators claim as much as 40 per cent of the first year's premium as their commission for informing people of their choice. This fee doesn't go to buying health services, it must be absorbed, and inevitably leads to higher premiums. This causes further pressure on premiums each year.[46]

3.42 Bupa Australia suggested that removing commissions to intermediaries would reduce pressure on private health insurance premiums:

> Eliminating commissions that would have otherwise been paid to on-line brokers, who currently capitalise on this gap, would flow through to lower premiums for all customers.[47]

3.43 PHIIA however rejected suggestions that commissions paid to comparison websites were increasing pressure on premiums:

> In reality the comparators are just another sales channel, such as TV, Facebook, Google etc., among various marketing costs. In many instances, the cost of member acquisition via comparison sites is more cost-effective – particularly for smaller funds – than undertaking their own marketing activities and sales channels.[48]

Constraining factors

3.44 While all the factors mentioned in the previous section play a part in increasing premiums, a combination of regulation, incentives and market factors act to constrain rising premiums.

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43 Choice, *Comparing the comparators*, https://www.choice.com.au/money/insurance/insurance-advice/articles/insurance-comparison-sites (accessed 30 November 2017).

44 Bupa Australia, *Submission 43*, p. 19.

45 Private Health Insurance Intermediaries Association (PHIIA), *Submission 221*, [p. 2].

46 Bupa Australia, *Submission 43*, p. 19.

47 *Submission 43*, p. 20.

48 PHIIA, *Submission 221*, [p. 4].

Regulation

3.45 The Commonwealth Government encourages people to take up private health insurance to relieve pressure on state public hospitals and to 'provide consumers with a greater choice of care options'.[49]

3.46 To ensure that patients with a high risk profile are not charged prohibitive private health insurance premiums and insurers are not discouraged from insuring high risk consumers, Australia's private health insurance market is based on the principles of community rating and risk equalisation.

Community rating and risk equalisation

3.47 Community rating is the principle that private health insurers cannot discriminate between consumers seeking coverage on the basis of their health, age or likelihood to claim.[50]

3.48 Community rating guarantees that anyone who wants to take out private health insurance has access to it.[51] In its *Efficiency in Health* report, the Productivity Commission noted that 'community rating and other price regulations effectively act to cross-subsidise private health insurance premiums'.[52] The Department clarified that:

> Community rating prohibits insurers from discriminating on the basis of past or likely future health or risk factors such as age, pre-existing condition, gender, race or lifestyle in the premiums that they charge. Although community rating means that people who are older or sicker do not have to pay higher premiums commensurate with their risk, it also means that younger and healthier people pay more than they otherwise would.[53]

3.49 Community rating is supported by a system of risk equalisation. In its submission, the Department explained the rationale for risk equalisation in the private health insurance market:

> Risk equalisation attempts to adjust for the risk of adverse selection. It is designed to spread the burden of high cost claims across all insurers, helping to keep them all financially viable…These arrangements are designed to ensure that insurers (and policy holders with those insurers) with higher numbers of older members or high users are not financially disadvantaged compared with those insurers with a younger or healthier membership.[54]

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49 Department, *Submission 127*, p. 1.

50 *Private Health Insurance Act 2007* (Cth), s. 55-5; Department, *Submission 127*, p. 2.

51 Department, *Submission 127*, p. 2; Explanatory Memorandum, Private Health Insurance Bill 2006, cl. 55-1.

52 Productivity Commission, *Efficiency in Health*, April 2015, p. 68.

53 Department, *Submission 127*, p. 2.

54 Department, *Submission 127*, p. 2.

3.50 Submitters to this inquiry were almost unanimous in their agreement that community rating and risk equalisation are important to the effective operation of the existing private health insurance regime.[55]

Private health insurance rebate

3.51 Two other elements of the existing regulatory regime are designed to help to control the price of private health insurance premiums: the premiums reduction scheme—commonly known as the private health insurance rebate—and the Minister for Health's approval of premiums.

3.52 The private health insurance rebate was introduced from 1 January 1999 as one of three government incentives to encourage people to take out private health insurance cover during the late 1990s and early 2000s.[56]

3.53 Today, the existing structure of the rebate is based on the age and income of the beneficiary/beneficiaries of the private health insurance policy.[57] Since 2014, the rebate has also been reduced by up to one percent per year.[58]

3.54 Some submitters considered the rebate to be an inefficient use of public money.[59] For these submitters, the inefficiency stemmed from the fact that a plurality of private health insurers lacked the efficiency of scale of a universal health system.[60]

3.55 The Grattan Institute questioned the value of the rebate and stated that other factors, such as the lifetime health cover loading, had a much more significant effect on participation than the introduction of the rebate.[61]

3.56 The Grattan Institute also noted that changes to the rebate for older and wealthier Australians in 2005 and 2014 did not appear to change their participation rate in private health insurance.[62] Therefore, the Grattan Institute advocated for gradual curtailment of the rebate.[63]

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55 See for example: Ms Leanne Wells, Chief Executive Officer, Consumers Health Forum of Australia, *Committee Hansard*, 31 October 2017, pp. 7, 10; Dr Gannon, *Committee Hansard*, 31 October 2017, p. 32; Dr Crombie, *Committee Hansard*, 31 October 2017, p. 50; AHHA, *Submission 3*, p. 16; Australian Association of Practice Management, *Submission 16*, p. 4; Consumers Health Forum of Australia, *Submission 17*, p. 4. For submitters that considered that some amendment could be required see: Mr Shaun Gath, *Submission 5*, pp. 15–17; Private Healthcare Australia, *Submission 18*, p. 10.

56 Department, *Submission 127*, p. 24.

57 *Private Health Insurance Act 2007* (Cth), s. 22-15.

58 *Private Health Insurance Act 2007* (Cth), s. 22-15.

59 Public Health Association of Australia (PHAA), *Submission 49*, p. 4; Consumers Health Forum of Australia, *Submission 17*, p. 52; Australian Health Care Reform Alliance, *Submission 67*, [pp. 2–3]; Grattan Institute, *Submission 72*, p. 5.

60 Consumers Health Forum of Australia, *Submission 17*, pp. 6–7; PHAA, *Submission 49*, p. 4.

61 Grattan Institute, *Submission 72*, p. 18.

62 *Submission 72*, p. 19.

63 *Submission 72*, p. 25.

3.57 Some private health insurers expressed concern about the impact of the annual reduction in the rebate: representatives of hirmaa called for a price floor to be set to ensure that the rebate does not drop below 25 per cent.[64] Private health insurers want a price floor to be established as the diminishing rebate is compounding the affordability problem caused by rising premiums:

> …the Australian government rebate is no longer at 30 per cent; it is in the 25 per cent zone and it is dropping by a per cent every year, and it is means-tested. That means that only those who really deserve it receive the rebate and it is dropping by a per cent a year. So, if a health fund puts up premiums by four per cent, you can add another per cent through the Australian government rebate dropping as well, and that is causing a lot of cost pressures.[65]

Minister's approval of premiums

3.58 The Minister for Health (Minister) is required to approve private health insurance premium increases, unless there is an overriding public interest reason not to do so.[66]

3.59 Mr Shaun Gath, the former head of the Private Health Insurance Administration Council, suggested that the law was drafted to reflect a compromise:

> There is little doubt that their purpose was to reflect *a compromise*, namely that insurers could reasonably *expect* that their application would be approved (the Minister "must" approve …) subject only to some quite exceptional event where a decision to approve would actually be "contrary to the public interest". In practice, however, ministers of both political persuasions continued to regard themselves as primarily responsible for an approval process where intense micro-scrutiny was applied to the applications (often with little transparency) with a view to approving the lowest increase prudentially acceptable.[67]

3.60 Dr Duckett explained that it seemed to be contrary to private health insurers' interests to propose higher than needed fee increases, which led him to conclude that price may not be the most important factor for private health insurers:

> When Minister Ley, I think it was, knocked them back…they came back with lower proposals, which suggests that there was padding in their initial proposal. That suggests they don't care about fee increases, because they have a whole lot of other structures which stop people dropping out as much.[68]

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64 Mr Koce, *Committee Hansard*, 5 July 2017, p. 28. The base tier rebate for under 65-year-olds is currently 25.934 per cent.

65 Mr Koce, *Committee Hansard*, 5 July 2017, p. 28.

66 *Private Health Insurance Act 2007* (Cth), s. 66-10(3).

67 Mr Shaun Gath, *Submission 5*, p. 18 (emphasis in original).

68 Dr Duckett, *Committee Hansard*, 31 October 2017, p. 17.

Medicare levy surcharge and Lifetime health cover

3.61 Other structures that encourage individuals to maintain coverage are the Medicare Levy Surcharge (MLS) and the Lifetime Health Cover (LHC) loading.

3.62 The MLS is a tax applied to persons who earn over a threshold amount and do not hold private hospital insurance.[69] Between 2014–15 and 2017–18 the MLS was calculated in accordance with the table below.[70]

Table 3.2—MLS income thresholds 2014–15 to 2017–18

Singles **Families**[44]	**≤$90,000** **≤$180,000**	**$90,001-105,000** **$180,001-210,000**	**$105,001-140,000** **$210,001-280,000**	**≥$140,001** **≥$280,001**
	Base Tier	**Tier 1**	**Tier 2**	**Tier 3**
	0.0%	1.0%	1.25%	1.5%

Source: Department, *Submission 127*, p. 24.

3.63 The Department explained that the LHC was an incentive that was introduced on 1 July 2000 to 'encourage people to take out hospital insurance earlier in life, and to maintain their cover throughout their life'.[71]

3.64 It works by applying an extra two per cent loading to their private hospital insurance premium for each year after the age of 30 that the person did not hold an appropriate level of cover and allows the insurer to charge the person the premium plus the loading for the next ten years.[72]

3.65 Together, the LHC loading and the MLS are intended to encourage younger, healthier people to enter the private health insurance risk pool earlier than they otherwise might.

3.66 According to Private Healthcare Australia the MLS and the LHC provide stability to Australia's private health insurance market:

> Market research estimates these measures together, underpin 75% of demand for PHI [private health insurance], and successfully stabilised uptake of private health insurance at its current level of approximately 50% of the population.[73]

3.67 Consumer surveys also confirmed that the MLS and the LHC were important factors in individuals' decision to maintain coverage. A survey by Choice found that 34 per cent of respondents considered avoiding paying the MLS to be a key reason to take out private health insurance while another 24 per cent of respondents considered avoiding LHC loading to be a key reason.[74] Among households earning over

69 Department, *Submission 127*, p. 24.

70 *Submission 127*, p. 24.

71 *Submission 127*, p. 26.

72 *Submission 127*, p. 26; *Private Health Insurance Act 2007* (Cth), ss. 31-1, 34-10.

73 Private Healthcare Australia, *Submission 18*, p. 16.

74 Choice, *Submission 207*, p. 9.

$150 000, 55 per cent cited avoiding the MLS as a key reason for taking out private health insurance.[75]

Market factors

3.68 As noted above, an older insured cohort that is more likely to claim will put upward pressure on premiums. Therefore, to reduce pressure on premiums, private health insurers, collectively, need to attract younger, healthier people to join the insured pool who are less likely to make a claim.[76]

3.69 Some submitters raised concerns that a failure to attract younger people to take up private health insurance may lead to a 'death spiral':

> 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'.[77]

3.70 While participation numbers are down, APRA disagrees that the insurance market is headed for a 'death spiral'.[78] However, some private health insurers suggested that the existing incentives—the rebate, LHC and the MLS—are not sufficient to encourage younger, healthier people take out private health insurance:

> Current sticks and carrots, including the Medicare Levy Surcharge, Lifetime Health Cover and even the PHI [private health insurance] Rebates, don't do enough to make the product sufficiently attractive to healthy under 30s. It is this group that is essential to deepening the community rated risk pool and therefore keeping premium growth down.[79]

'Reverse' Lifetime health cover

3.71 Some private health insurers suggested that the government implement a 'reverse' LHC to provide a financial incentive for people under 30 to take out private health insurance.[80]

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75 *Submission 207*, p. 10.

76 Private Healthcare Australia, *Submission 18*, p. 37; NIB, *Submission 24*, p. 2; Bupa Australia, *Submission 43*, p. 25.

77 Dr Marcin Sowa, Dr Joshua Byrnes and Prof Paul Scuffham, *Submission 106*, p. 7. See also Mr Koce, *Committee Hansard*, 5 July 2017, p. 28.

78 Mr Louis Serret, Acting Executive General Manager, Specialised Institutions Division, Australian Prudential Regulation Authority, *Committee Hansard*, 31 October 2017, p. 65.

79 NIB, *Submission 24*, p. 2. See also Bupa Australia, *Submission 43*, pp. 25–26.

80 NIB, *Submission 24*, p. 2; Bupa Australia, *Submission 43*, pp. 25–26.

3.72 On 13 October 2017, the Minister announced that the insurers would be allowed to discount premiums for people who take out private health insurance between the ages of 18 and 29.[81]

3.73 Under the plan, a discount of up to 10 per cent could be applied to premiums until the person turns 40 when the discount would start to be phased out.[82]

3.74 The Department confirmed that the purpose of this plan was to lower premiums.[83]

3.75 However, some submitters raised concerns that an additional incentive may not be sufficient for young people to take out private health insurance.[84] Dr Duckett explained to the committee that even under the recently announced plan he would not advise his daughter to take out private health insurance:

> …it's not good value for money. She's 22, relatively healthy, and until she turns 30 there's no particular reason for her to take out health insurance at all. As the health insurers know, and as the government knows, the whole point of the deductions is to encourage people into health insurance who will not use their health insurance. That's the whole point of it.[85]

Junk/basic policies

3.76 The low value that junk/basic policies provide to consumers was considered in Chapter 2. However, submitters to the inquiry explained that the benefit of these policies is that their policyholders contribute to the risk equalisation pool and place downward pressure on premiums:

> They all contribute to the risk equalisation pool and, therefore, the total pool of funds available to members, thereby keeping overall premiums stable.[86]

3.77 The Department agreed that one reason junk/basic policies are allowed to continue is because they play a role in placing downward pressure on premiums.[87] Some submitters also observed that people may see some value in a policy that allows them to be treated as a private patient in a public hospital or allows them to contribute to the risk equalisation pool.[88]

3.78 The Department agreed that some people do see value in the product:

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81 Department, *Submission 127—Attachment 1*, [p. 1].

82 *Submission 127—Attachment 1*, [p. 1].

83 *Submission 127—Attachment 2*, [p. 11].

84 Dr Duckett, *Committee Hansard*, 31 October 2017, p. 14.

85 Dr Duckett, *Committee Hansard*, 31 October 2017, p. 16.

86 Dr David, *Committee Hansard*, 31 October 2017, p. 56.

87 Mr Maskell-Knight, *Committee Hansard*, 31 October 2017, p. 70.

88 Dr David, *Committee Hansard*, 31 October 2017, p. 58; Dr Crombie, *Committee Hansard*, 31 October 2017, p. 58.

> …there are a greater or lesser number of people who do see value in those products. They do offer cover for some things. You can question whether you get your money back. Most people with health insurance don't get their money back in the short run, but that's what insurance is.[89]

Prostheses

3.79 Some submitters also raised concerns about the price of prostheses increasing pressure on private health insurance premiums.[90]

3.80 The term 'prosthesis' specifically refers to a surgically implantable device, such as a cardiac pacemaker or an intraocular lens in a cataract surgery.[91]

3.81 Earlier this year, the Community Affairs References Committee completed an inquiry into *Price regulation associated with the Prostheses List Framework*.[92] The inquiry examined the impact of benefit-setting on the price of prostheses available and used for privately insured patients.

3.82 Submitters to both inquiries noted that prostheses benefits amount to approximately 14 per cent of hospital rebate expenditure for private health insurers.[93] The committee also heard evidence that the different prices were being charged for prostheses in public and private hospitals and that the differential between the price paid in public and private hospitals was having a substantial impact on premiums.[94]

3.83 In its inquiry into *Price regulation associated with the Prostheses List Framework*, the committee made 16 recommendations including that the 'the nature and costs of services associated with a medical device on the Prostheses List be disclosed separately to the cost of the device'.[95]

3.84 Prior to the conclusion of the committee's inquiry, the Commonwealth Government announced and implemented an initial review and reduced the benefits for certain groups of items on the Prostheses List, signalling that this would represent an initial saving of $86 million and $500 million over 6 years.[96]

3.85 The government's response to the inquiry report agreed to ensure that there is greater transparency in relation to decisions and benefit setting by the Prostheses List

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89 Mr Maskell-Knight, *Committee Hansard*, 31 October 2017, p. 72.

90 Mr Koce, *Committee Hansard*, 5 July 2017, p. 30.

91 Community Affairs References Committee (Committee), *Price regulation associated with the Prostheses List Framework*, May 2017, pp. 3–4.

92 Committee, *Price regulation associated with the Prostheses List Framework*, May 2017.

93 Mr Burgess, *Committee Hansard*, 31 October 2017, p. 3; Department, *Submission 127—Attachment 2*, [p. 13].

94 Mr Koce, *Committee Hansard*, 5 July 2017, p. 30.

95 Committee, *Price regulation associated with the Prostheses List Framework*, May 2017, p. 63 (Recommendation 16).

96 The Hon. Sussan Ley MP, Minister for Health and Aged Care, 'Turnbull Government to ease pressure on private health insurance premiums', *Media release*, 19 October 2016.

Advisory Committee, and to continue the process of refining the number, range and benefit level of items available on the Prostheses List.[97]

3.86 On 13 October 2017, the Minister announced that a round of benefit reductions would commence on 1 February 2018 to save private health insurers $188 million in 2018.[98] Combined with further benefit reductions in subsequent years, the government announced that:

> Total estimated savings to private health insurers over the next four premium years (2018 to 2021) are more than a billion dollars.[99]

3.87 This agreement with the MTAA, who represent device manufacturers, is designed to place downward pressure on premiums. The Minister announced that:

> Private health insurers have publicly stated that every $200 million in prostheses benefits reductions will decrease private health insurance premiums by one per cent.[100]

3.88 To ensure that the Prostheses List savings were passed on, the MTAA suggested that the Australian National Audit Office should audit the books of all private health insurers:

> MTAA would like to propose that private health insurers be required to open up their books to the Australian National Audit Office, to verify that they are passing on all of these savings, and to publish revenue and claims payout ratios. This would be entirely appropriate for an industry in receipt of $6 billion in taxpayer funds. We would encourage the committee to consider this as a recommendation that should be enshrined in legislation. A simple amendment to the Private Health Insurance Act should be able to facilitate this.[101]

3.89 Dr Duckett also suggested that an audit would be possible:

> I think the Auditor-General has follow-the-dollar powers, and may be able to initiate an audit of that kind. It would possibly be impossible to tell what the impact of the prostheses changes are going to be. If I were a health insurance fund I'd say, 'Yes, we made all those savings and we've ploughed them back because our fees aren't increasing next year as much.'[102]

3.90 The private health insurers did not oppose the suggestion of an audit:

> In the premium round you have to be very specific about the claims on medical devices, how they've decreased, get the actuaries to do the

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97 Australian Government, *Australian Government response to the Senate Community Affairs References Committee report: Pricing regulation associated with the Prostheses List framework*, September 2017, [p. 4] (tabled 14 September 2017).

98 Department, *Submission 127—Attachment 2*, [p. 13].

99 *Submission 127—Attachment 2*, [p. 13].

100 *Submission 127—Attachment 2*, [p. 13].

101 Mr Burgess, *Committee Hansard*, 31 October 2017, p. 2.

102 Dr Duckett, *Committee Hansard*, 31 October 2017, p. 17.

> modelling, put it in the premium and ensure they have been passed on. If that was found not to be sufficient, and it was suggested by the government that the ANAO's involvement would add something, we would open our books and show them. There is absolutely nothing to hide. We were the ones who put this issue on the table—that we would pass on all the savings in the prostheses list negotiation. We were the ones who put our hands up and said that we would do it. There is nothing to hide.[103]

3.91 However, APRA was less certain that an audit would be a significant benefit as it considered that it would be clear if additional funds were being held by the private health insurers:

> In terms of whether they have passed on savings, I think we again understand that, if you look at the numbers over the last 10 years, the MERs [management expense ratios], the amount of benefit payments made each year happen to have remained relatively the same over that period. So it would suggest that, if the costs are going up and premiums are going up, there are no excess profits being held within the institutions, given that the benefit payments have stayed around 85 to 86 per cent, the MERs have been at the same per cent and the net margin has been at 4½ or thereabouts…I personally don't think there's a lot to be gained.[104]

Will premiums go down?

3.92 Despite the government's recent announcement, no submitter to the inquiry expected that health insurance premiums were likely to drop in the short term as costs will continue to rise.[105]

3.93 The Department summarised the position of many of the submitters:

> [Private health insurance premiums] will not go up as fast as they otherwise would have done.[106]

3.94 Instead, submitters suggested that upward pressure would continue to be placed on private health insurance premiums. APRA noted that over the longer term rising premiums had the potential to be a significant issue:

> We've identified [the private health insurance business model] as an emerging risk. We see it as a long-term challenge for the industry. With the participation rates coming down amongst the younger cohort, it's going to put pressure on pricing and, of course, that's a long-term structural issue that the industry needs to face. Our role, obviously, is to understand how the industry is actually going to cope with that to ensure that it remains sustainable going forward.[107]

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103 Dr David, *Committee Hansard*, 31 October 2017, p. 53. See also Dr Crombie, *Committee Hansard*, 31 October 2017, p. 53.

104 Mr Serret, *Committee Hansard*, 31 October 2017, p. 64.

105 Mr Serret, *Committee Hansard*, 31 October 2017, p. 65.

106 Mr Maskell-Knight, *Committee Hansard*, 31 October 2017, p. 72.

107 Mr Serret, *Committee Hansard*, 31 October 2017, pp. 64–65.

Committee view

3.95 The committee acknowledges that there are a number of factors that are increasing underlying costs for private health insurers including utilisation, an ageing demographic, intermediaries, prostheses costs and operating margins.

3.96 The committee considers that the existing principles of community rating and risk equalisation are key to ensuring equity in Australia's private health insurance market and supports their continuation.

3.97 The committee notes the reforms announced by the government on 13 October this year. The committee's comments on these reforms are included in Chapter 5.

3.98 The committee also notes the substantial profits that private health insurers are recording which to a certain extent undermines their argument that underlying costs are driving up premiums.