



AMA Pre-Budget  
Submission 2022-23  
Chapter 3: Private healthcare

## OVERVIEW

This chapter of the *AMA Pre-Budget Submission 2022-23* draws on a recent paper by the AMA – *Prescription for private health insurance* – with some of the modelling adapted and extended to give estimates of impact over the four year forward estimates. More detail on some aspects is contained in the paper. All figures presented are current at the time of submission to government September 2021.

## PROBLEM STATEMENT

Private Health Insurance (PHI) has been a cornerstone funding mechanism of part of Australia’s hospital and health system for decades. PHI has always complemented and supported Medicare and public hospitals, with 66 per cent of all elective surgeries conducted in the private system.<sup>1</sup> Australia’s unique PHI system offers ‘community rating’ (two people on the same product pay the same premium, regardless of differences in expected claim cost/risk), which allows all Australians to ‘buy into’ the high-quality private system, regardless of their age or pre-existing health conditions.

Health activity funded through PHI helps to make our health system sustainable by taking pressure off our public hospital system, which is already at breaking point. But PHI membership is still at risk of a ‘death spiral’, because premiums are too high and do not represent value to younger Australians. Pre-COVID, from June 2015 to June 2020, PHI membership fell for 20 successive quarters.<sup>2</sup>

The main driver is that people are waiting until they get older to take up PHI just before they need it the most, and then utilise it heavily in old age. Without a diverse insurance pool (which all insurance relies upon) that includes younger Australians, there is upwards and unsustainable pressure on premiums.

### Government erosion of PHI rebate

- The Government effectively ‘froze’ the PHI rebate, by indexing it by the Consumer Price Index rather than premium growth since April 2014.<sup>3</sup>
- The value of the average rebate has fallen from 30 per cent in April 2013 to 24.61 per cent in April 2021.<sup>4</sup>

### Value for money

- The for-profit funds have been growing as a proportion of the market - they now have 66 per cent of all members.
- Payout ratios (amount paid in premium relative to amount received through benefit claims) among for-profit providers (83%) are lower than not-for-profit providers (90%).
- In a survey, 76 per cent of people identified as not having PHI but being able to afford it, gave “premiums too expensive/out of pocket costs too high” as the main reason for not having PHI.<sup>5</sup> This indicates that it is not just an issue of affordability – people are looking for value for money and returned benefits.

### Affordability

- Premium growth (61%) has outstripped income growth (29%) over the past decade.
- Income growth specifically among younger people is even slower. Among 21-34 year olds, it is only a quarter for ‘Professionals’ and 62 per cent for ‘Technicians and trades workers’ of what it is for all ages.<sup>6</sup>
- PHI is one of many costs facing younger people as they struggle to repay education debts, contribute to superannuation, save for a house deposit, and pay high rent. Without strong incentives to engage younger members and keep them engaged throughout their working life, the PHI structure will fail.

## POLICY PROPOSAL

To stem the exodus of PHI policy holders, we need to increase the value and decrease the pressure on premiums, at the same time. Careful reform will be required both in the short and long term. In the short term, all the policy levers operated by government will need to be recalibrated.

Since the AMA’s Prescription for private health insurance was published, work to review some of these policy levers is now underway. A slightly revised policy proposal is outlined below to recognise that some work has been commenced, but reform is yet to occur.

### Premium rebate restored

- Restore the PHI rebate to 30 per cent for targeted groups to make PHI affordable for younger Australians and those in the workplace on lower incomes.

### Medicare Surcharge Levy (MLS)

- Reconsider the MLS levels and thresholds, in order to determine what settings are required to deliver on the policy intent. A government review is now underway. For the purposes of the forward estimate costing, the AMA has set a threshold of a 2 per cent MLS for those earning over \$105,000 per year.

## Minimum payout

- To improve the value proposition of PHI, mandate a minimum return amount (e.g. 90 per cent) to the health consumer for every premium dollar paid. There needs to be a standardised return that is higher than the current PHI industry average.

## Lifetime Health Cover (LHC) loading

- Review the LHC loading and penalties to make it an easy choice for Australians to stay in PHI for life.
- A government review is now underway. This should ensure that LHC loading can fulfil its original intent to act as an incentive for early purchase rather than a barrier, such as by raising the age at which it first applies.

## Youth Discounts

- Better promote existing government youth discounts on PHI, and extend the age of eligibility to align with reformed LHC loading that stems from the review presently underway.

## Transparency and out of pocket costs

- Develop a consumer-focused government website to improve transparency, assist consumers to purchase better value products, and restore consumer confidence in PHI. This should aim to improve health financial literacy and at minimum show medical practitioner fees and insurers' rebates, by fund, state and procedure – noting that the Gold, Silver and Bronze system does not assist consumers with transparency of rebates.

## Establishment of a Private Health System Authority (previously referred to as a regulator)

- Establish an independent, well resourced, statutory body to oversee the private health system, and to safeguard patient choice which is central to its value proposition alongside speed to entry.

# RISKS AND IMPLEMENTATION

## Impact of premium rebate

- It is possible that extra expenditure on the premium rebate will only result in a moderate uplift in PHI membership. This is a risk given the current public perception around PHI, particularly that younger people perceive it as a low value proposition.
- This risk could be minimised with better promotion of youth discounts and reformed incentives for younger people to join. The risk is also inversely proportional to the scale of reform and new investment; if funding reform lacks ambition the risk of moderate impact will be greater.

## Public and stakeholder opinion

- Among the suite of reforms that are required to steer PHI out of crisis, are a range of policies affecting different sectors of society. For example, older people will not be eligible for youth discounts and incentives, higher wage earners could pay more MLS than previously, and PHI companies may resist greater transparency, a mandated minimum payout, and/or a new Private Health System Authority.
- However, the risks to each of these groups (as well as the general population) of taking no action are too high. Careful stakeholder management should involve communication of these risks. The medical profession supports a move to greater transparency, provided all players partake.

## Private Health System Authority

- An independent authority would consolidate regulatory functions previously carried out by other parts of government/agencies so that they operate in a more cohesive and effective way (including relieving the Department of Health of its conflicted role as regulator and policy maker). But it would also incorporate new functions (and skills) to fill gaps in areas that are currently neglected such as: whether the private health system is changing in the way government policy intends; whether it serves the best interest of patients; and how it can best complement public hospitals in the broader health system.
- Therefore, there would be some cost transfer of existing functions as well as additional costs associated with providing new functions. Sufficient transition time and resource should be allocated to make sure this is done effectively. Overall costs are not anticipated to be high, however.

## The risks of not taking action

The risks of not taking action are significant and overall would make the private health sector unsustainable, in turn plunging the public hospital system into deeper crisis:

- It is likely that with no intervention, the value proposition for younger people will not improve and the downwards trend in their membership numbers will continue.
- This in turn will see premiums continue to rise, exacerbating the 'death spiral' as more young people drop out, and premiums rise further.
- Long term, this risks a more radical reform agenda becoming necessary, such as abandoning community rating to bring younger and healthier people back into PHI, but making premiums unaffordable for older and sicker people. This in turn would put pressure on the public system, while abandoning the principles of fairness and access that are the hallmark of the Australian health system.
- The public hospital system is already at breaking point (see Chapter 1). More people in the public system means longer waiting times for emergency and non-emergency treatment, and significant unmet demand for health services in the population, impacting on population health, productivity and the economy.

## TIMEFRAMES AND COSTING OVER FOUR YEARS

### Explanatory note

Throughout the costings provided below, the 'premium' refers to the 'average base premium' that insurers set. The 'price' refers to the retail price that consumers pay for that premium after any applicable rebate.

Some policies will affect the base premium, which is then assumed to also be passed onto consumers through the price. Policies involving the rebate will have a direct effect on the price but may also have an indirect effect on the premium through change in the underlying PHI membership.

In the costings below it is assumed that the 'additional PHI policies', which arise in response to incentives to either retain PHI or join, claims experience will be at a reduced average rate to existing members (60% of the average rate).<sup>7</sup> This is based on most of the incentives targeting people aged 65 and under, who have a much lower average claim profile.

There are also additional benefits to individuals and government which are not costed directly. The claims which are made against the additional PHI policies, even if at a reduced rate, still offer direct benefit to the individual claiming. Those benefits paid also offer care which otherwise would have to be carried out in the public hospital system. The benefits are most likely to accrue to reduced wait times for public hospital patients given the capped public hospital funding model.

### Adjustment of PHI rebate levels

Costing is provided below for restoring the PHI rebate to its previous levels, only for people aged under 65: 30 per cent for those earning \$90,000 or less, 20 per cent for those earning between \$90,001 and \$105,000, and 10 per cent for those earning between \$105,001 and \$140,000. For family policies the rebate levels used are the same as for singles. However, the equivalent household income thresholds for couples are double those of singles.

The income thresholds for singles and couples match the existing MLS thresholds.

The price elasticity of demand for the impact of the change in the rebate was estimated at -0.5 ceteris paribus, specifically among those under the age of 65.<sup>8,9</sup>

The total cost to government across the forward estimates is calculated as \$5.31 billion. The number of additional PHI policies are measured as the difference between the baseline and the policy scenario at each year across the forward estimates.

Table 1: Impact of an increase to the PHI rebate (to restore to previous levels) for people under 65

	2022-23	2023-24	2024-25	2025-26	Total across forward estimates
Additional PHI policies (above baseline)	340,709	348,224	360,322	371,606	371,606
Rebate for additional PHI policies (\$m)	343	360	383	407	1,494
Additional rebate for existing PHI policies (\$m)	982	1,050	1,136	1,222	4,390
Change in MLS revenue (\$m)	-7	-8	-8	-9	-32
Reduction in average premiums because of new members	1.82%	1.92%	2.04%	2.16%	2.16%
Clawback rebate from lower premiums (\$m)	138	146	155	164	603
Reduction in the price of PHI policies for members with \$90,000 or lower income (including rebate and lower premiums)	9.07%	9.42%	9.78%	10.15%	10.15%
<b>Net cost to government (\$m)</b>	<b>1,194</b>	<b>1,272</b>	<b>1,373</b>	<b>1,474</b>	<b>5,312</b>

## TIMEFRAMES AND COSTING OVER FOUR YEARS

### Increase of MLS

Costing is provided below for increasing the MLS to 2 per cent for those earning \$105,001 or greater. If applied without matching incentives to Lifetime Health Cover, the effect will be to raise more revenue but reduce the number of additional PHI policies. The total cost to government across the forward estimates is an estimated \$1.01 billion. This policy cost estimate does not include the simultaneous increase in the PHI rebate.

Table 2: Impact of increasing MLS to 2% for people earning \$105,001 or greater (without LHC change)

	2022-23	2023-24	2024-25	2025-26	Total across forward estimates
Additional PHI policies	138,270	169,373	183,397	189,313	189,313
Rebate for additional PHI policies (\$m)	38	52	59	58	206
Change in MLS revenue (\$m)	-163	-201	-216	-227	-808
Reduction in average premium	0.7%	0.9%	1.0%	1.1%	1.1%
<b>Net cost to government (\$m)</b>	<b>200</b>	<b>253</b>	<b>275</b>	<b>285</b>	<b>1,014</b>

### Increase of MLS alongside changes to Lifetime Health Cover

As LHC is currently under review with many different options being considered to encourage PHI membership, it is not possible to provide a detailed costing for as yet unknown changes. Instead, we have provided costing below for the higher MLS rate of 2 per cent for people earning \$105,001 or greater, if introduced alongside a change in LHC.

If implemented alongside improvements to LHC, the change in the MLS rate would drive more people who are over the \$90,001 income threshold but under the \$105,001 income threshold to take up a PHI policy.

The changes to LHC itself are not included in cost estimate below because this won't cost the government directly (same as for changes to youth discounts). Rather, improvements to LHC will cause indirect costs to government from:

- an increase in the cost of the PHI rebate due to more people taking out PHI policies
- a decrease in MLS revenue due to more people taking out PHI policies

These indirect costs are included in the estimate below. When the MLS policy change (increase to 2 per cent for people earning \$105,001 or greater) is introduced alongside improvements to LHC, the cost to government rises to \$1.42 billion over the forward estimates.

Table 3: Impact of increasing MLS to 2% for people earning \$105,001 or greater (with LHC change)

	2022-23	2023-24	2024-25	2025-26	Total across forward estimates
Additional PHI policies	197,910	229,014	247,495	262,169	262,169
Rebate for additional PHI policies (\$m)	70	85	96	101	352
Change in MLS revenue (\$m)	-223	-261	-281	-301	-1,066
Reduction in price of PHI policies	1.1%	1.3%	1.4%	1.5%	1.5%
<b>Net cost to government (\$m)</b>	<b>293</b>	<b>346</b>	<b>377</b>	<b>402</b>	<b>1,418</b>



## Minimum payout

The direct cost to government of an increase in the minimum payout ratio is zero. There would however be indirect costs – the main one being that additional PHI policies would cost the government additional PHI rebate. A behaviour shift towards more PHI policies would mainly be seen among those currently not subject to tax penalties or incentives – those earning \$90,000 or less.

With more people taking out PHI policies, there would be 'second round effects' of lower premiums further boosting the number of people taking out policies, including those earning over \$90,000. These second-round effects are not estimated or included in the costs.

The policy itself would not encourage as many people over the age of 65 and those subject to MLS to take out PHI as these people already receive a larger benefit on average (through greater use) or a much larger price incentive through existing policies.

The impact of a 90 per cent minimum payout ratio is costed below, at \$560 million over the forward estimates.

Table 4: Impact of implementing a 90% minimum payout ratio

	2022-23	2023-24	2024-25	2025-26	Total across forward estimates
Direct change in premium	-3.8%	-3.8%	-3.8%	-3.8%	-3.8%
Additional PHI policies	173,171	170,641	170,498	170,117	170,117
Rebate for additional PHI policies (\$m)	138	138	141	143	560
<b>Net cost to government (\$m)</b>	138	138	141	143	<b>560</b>

## Private Health System Authority

The direct cost of an independent authority which currently doesn't exist is difficult to estimate. At present, the Australian Prudential Regulation Authority (APRA) provides prudential regulation of private health insurers. APRA reports that its total operating expenditure for the 12 months to 30 June 2020 was \$196.2 million.<sup>10</sup> Using the number of private health insurers it prudentially regulates (37 during 2019-20) and comparing that to the total number of entities it regulates (2,273), we could apportion the cost to a sensible approximation of \$3.2 million per year.

This role currently performed by APRA is only one of an expanded set of roles envisioned for the proposed authority; additional funds would be required to fulfil these extra functions. The total annual cost of the proposed authority is estimated in the table below, which includes the \$3.2 million cost reallocated from assuming responsibilities from APRA.

The government could choose to recover the ongoing cost of the authority through charges to insurers. This would represent approximately 0.1 per cent of revenue taken by private health insurers (\$25m per year in 2019-20).<sup>11</sup> This would likely see the cost passed on to consumers through higher premiums in the order of 0.1 per cent.

An additional \$10 million is estimated to be required to establish the new authority and consult with stakeholders regarding its ongoing roles and responsibilities. If cost recovery was undertaken, this \$10 million would be the only net cost to government across the forward estimates.

Table 5: Cost of a Private Health System Authority

	2022-23	2023-24	2024-25	2025-26	Total across forward estimates
Establishment cost (\$m)	10	-	-	-	10
Ongoing cost (\$m)	28	29	30	32	119
Cost recovery through charges to insurers (\$m)	28	29	30	32	119
<b>Net cost to government (\$m)</b>	10	-	-	-	<b>10</b>

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<p><sup>7</sup> This is a very conservative assumption based on the average hospital treatment expenditure for those aged 25-64 being approximately 26% of the expenditure of those aged 65 and over. This is based on data from: Australian Prudential Regulation Authority \(2021\). Quarterly Private Health Insurance Membership and Benefits March 2021. Table: hospital treatment by age, Australia. Retrieved 18/08/2021 from: <a href=\). Direct link to download: <https://www.apra.gov.au/sites/default/files/2021-05/Quarterly%20Private%20Health%20Insurance%20Membership%20and%20Benefits%20March%202021.xlsx>](https://www.abs.gov.au/statistics/labour/earnings-and-work-hours/employee-earnings-and-hours-australia/latest-release; 2016 edition: https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/6306.0Main+Features1May%202016?OpenDocument=)
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