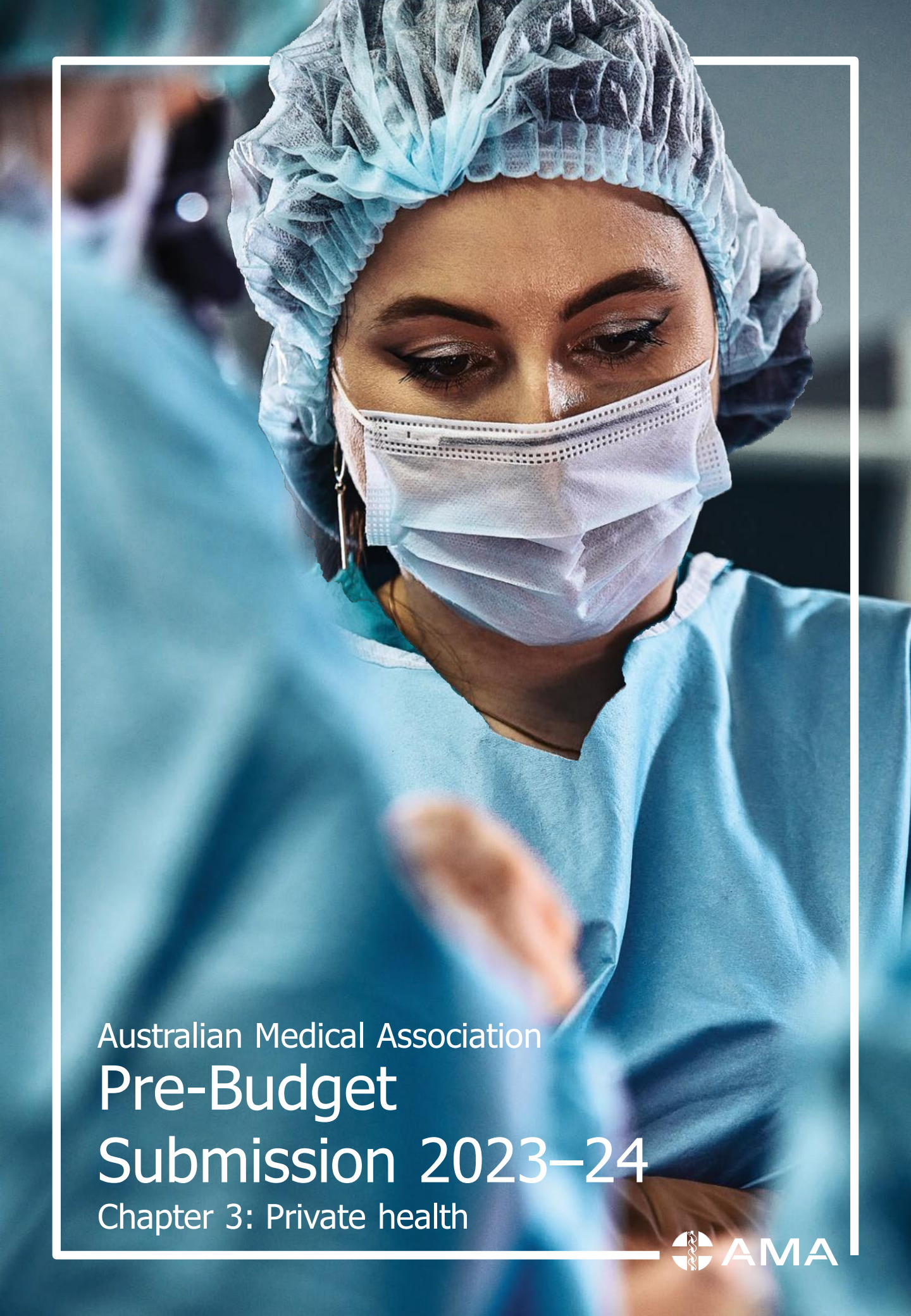

Australian Medical Association

Pre-Budget Submission 2023–24

Chapter 3: Private health

AMA

CHAPTER 3: PRIVATE HEALTH

Overview

This chapter of the *AMA Pre-Budget Submission 2023–24* draws on the AMA research report *Prescription for private health insurance*, and the AMA's discussion paper with some of the modelling adapted and extended to give estimates between 2022–23 and 2025–26.

Problem statement

The private health system is an essential component of Australia's healthcare system, offering patients access to a wider range of services and reducing demand on the public sector. One of the unique strengths of the Australian healthcare system is the equilibrium that exists between the public and private sectors, which work in partnership to provide high-quality healthcare to Australians. The equilibrium relies on a strong private healthcare sector which complements the public sector to:

- reduce demand on the public health system, with 66 per cent of all elective surgeries conducted in the private system[1]
- enable consumers to have more control over their healthcare, including selecting their preferred practitioner, accessing care more quickly (through reduced wait times for elective treatment), and having access to a wider range of services outside of the public sector
- encourage innovation and quality improvement in healthcare services.

Australia's unique private health insurance 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.

The last couple of years have shown how quickly a sector can come under financial pressure. In the lead up to the COVID-19 pandemic, insurers were increasingly under fiscal threat as participation rates had dropped for 20 successive quarters and their outlays were continuously increasing. Through the pandemic participation rates have now climbed for 8 successive quarters and outlays have decreased due to the impact of lockdowns and workforce shortages. Private hospitals have now faced 3 years of decreased activity which has significantly impacted on their ability to generate income

Notwithstanding the recent increase in insurance uptake, those over 60 years of age are set to become the largest insured population in the foreseeable future, with younger and healthier Australians no longer seeing the value in insurance. This decline in membership is due to several factors, including:

- The private health insurance rebate has eroded over time, as rebate was effectively frozen when government indexed it by the Consumer Price Index rather than premium growth since April 2014.[2] The value of the average rebate has therefore fallen from 30 per cent in April 2013 to 24.61 per cent in April 2021.[3]
- Many consumers no longer see the value for money of private health insurance. In a survey, 76 per cent of people identified as not having private health insurance but being able to afford it, gave "premiums too expensive/out of pocket costs too high" as the main reason for not having private health insurance.[4] Payout ratios (amount paid in premium relative to amount received through benefit claims) among for-profit providers (83 per cent) are also lower than not-for-profit providers (90 per cent), with 66 per cent of all those insured with for-profit funds.
- Premium growth (61 per cent) has outstripped income growth (29 per cent) over the past decade. Additionally, income growth 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.[5]
- Private health insurance 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, and there is a lack of incentives to engage young members.

These factors are resulting in a shift in demographic composition of the insured pool, placing insurers and the private health system more broadly under increased financial pressure.

Policy proposals

Establish a Private Health System Authority

The current regulatory arrangements were designed at a time when private health insurance was in a relatively healthy position with strong membership, when most insurers operated on a not-for-profit basis, and when private hospitals had a greater profit margin. While the arrangements are effective at protecting the interests of consumers by maintaining insurer solvency, managing consumer complaints, and ensuring the safe delivery of healthcare, there are limited mechanisms in place that ensure the private health system is changing in a lasting way as government policy intends. There are also limited whole-of-system mechanisms to ensure the needs of patients, day hospitals, private hospitals, private health insurers, medical device manufacturers and doctors are considered and balanced.

The AMA is calling for the establishment of an independent and well-resourced Private Health System Authority (the authority) to fill the gaps in the current regulatory environment and oversee the private healthcare system. This 'independent umpire' would have the capacity, objectivity, and expertise to ensure the system evolves as government policy intends, balancing the interests of patients, day hospitals, private hospitals, private health insurers, medical device manufacturers, and doctors. It would also create a platform for all the players in the sector to come together and agree on the necessary once-in-a-generation reforms which are required to ensure the future viability of private healthcare in Australia. Refer to the AMA's discussion paper *A whole of system approach to reforming private healthcare* for more information.

Recalibrate the private health insurance policy levers

To stem the exodus of private health insurance 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 begun and the reform that is still required.

Restore the private health insurance premium rebate

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

Increase the Medicare Levy Surcharge

Reconsider the Medicare Levy Surcharge 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 costing, the AMA has set a threshold of a 2 per cent Medicare Levy Surcharge for those earning over $105,000 per year.

Mandate a minimum payout ratio

To improve the value proposition of private health insurance, 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 private health insurance industry average.

Lifetime Health Cover loading

Review the Lifetime Health Cover loading and penalties to make it an easy choice for Australians to stay in private health insurance for life. A government review is now underway. This should ensure that Lifetime Health Cover 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 private health insurance, and extend the age of eligibility to align with reformed Lifetime Health Cover loading that stems from the review presently underway.

Risks and implementation

Establish a 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). It would also incorporate new functions and skills to fill the gaps in the current regulatory environment, as well as supporting the regulatory and advisory functions currently performed by other agencies. Cost transfer for existing functions carried out by other agencies as well as additional costs would be required. Sufficient transition time and resource should be allocated to make sure this is done effectively, however overall costs are not anticipated to be high.

Recalibrate the private health insurance policy levers

Impact of premium rebate

It is possible that extra expenditure on the premium rebate will only result in a moderate uplift in private health insurance membership. This is a risk given the current public perception around private health insurance, 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, as a lack of ambition in funding reform will increase the risk of suboptimal impact.

Public and stakeholder opinion

Among the suite of reforms that are required to steer private health insurance out of crisis are a range of policies that may disproportionally impact different populations. For example, older people will not be eligible for youth discounts and incentives, higher wage earners could pay more Medicare Levy Surcharge than previously, and private health insurance companies may resist greater transparency, a mandated minimum payout, and/or a new Private Health System Authority. The risks to each of these groups (as well as the general population) of taking no action however are too high, and therefore careful stakeholder management should be undertaken and involve communication of these risks. The medical profession supports a move to greater transparency, provided all players partake.

The risks of not taking action

The risks of not taking action are significant and would overall make the private health sector unsustainable. This would impact the delicate balance that exists between the public and private sectors, and would result in increased burden on our already struggling public hospital system. Without intervention, the value proposition for younger people will not improve and the downwards trend in their membership numbers will continue. This will result in rising premiums, which in turn will result in more people dropping their insurance cover. If this is not addressed now, more radical reform may be required in the future, such as abandoning community rating to bring younger and healthier people back into private health insurance, while making premiums unaffordable for older and sicker people. This in turn would put pressure on the public system and result in longer waiting times for care emergency and non-emergency treatment, and result in significant unmet demand for health services which will ultimately impact population health, productivity, and the economy. It would also contradict the principles of fairness and access that are the hallmark of the Australian health system.

Timeframes and costing over four years

Establish a 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.[9] 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).[10] 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 between 2022–23 and 2025–26.

Table 8: Cost of a Private Health System Authority

	2022–23	2023–24	2024–25	2025–26	Total
Establishment cost ($m)	10	-	-	-	10
Ongoing cost ($m)	28	29	30	32	119
Cost recovery through charges to insurers ($m)	28	29	30	32	119
Net cost to government ($m)	10	-	-	-	**10**

Recalibrate the private health insurance policy levers

Explanatory note

In the costings, 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 private health insurance membership.

In the costings it is assumed that the 'additional private health insurance policies' claims experience, which arise in response to incentives to either retain or join private health insurance, will be at a reduced average rate to existing members (60 per cent of the average rate).[6] 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 private health insurance 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.

Restore the private health insurance premium rebate

The costings for restoring the private health insurance rebate to its previous levels are 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 Medicare Levy Surcharge thresholds.

The price elasticity of demand for the impact of the change in the rebate was estimated at -0.5 ceteris paribus (with no other simultaneous changes a 1 per cent decline in price increases policies by 0.5 per cent), specifically among those under the age of 65.[7,8] The total cost to government between 2022–23 and 2025–26 is calculated as $5.31 billion. The number of additional private health insurance policies are measured as the difference between the baseline and the policy scenario at each year.

Table 9: Impact of an increase to the private health insurance rebate (to restore to previous levels) for people under 65

	2022–23	2023–24	2024–25	2025–26	Total
Additional private health insurance policies (above baseline)	340,709	348,224	360,322	371,606	371,606
Rebate for additional private health insurance policies ($m)	343	360	383	407	1,494
Additional rebate for existing private health insurance policies ($m)	982	1,050	1,136	1,222	4,390
Change in Medicare Levy Surcharge 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 private health insurance policies for members with $90,000 or lower income (including rebate and lower premiums) (%)	9.07	9.42	9.78	10.15	10.15
Net cost to government ($m)	1,194	1,272	1,373	1,474	**5,312**

Increase the Medicare Levy Surcharge

Costing is provided below for increasing the Medicare Levy Surcharge 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 private health insurance policies. The total cost to government between 2022 – 23 and 2025 – 26 is an estimated $1.01 billion. This policy cost estimate does not include the simultaneous increase in the private health insurance rebate.

Table 10: Impact of increasing Medicare Levy Surcharge to 2 per cent for people earning $105,001 or greater (without Lifetime Health Cover change)

	2022–23	2023–24	2024–25	2025–26	Total
Additional private health insurance policies	138,270	169,373	183,397	189,313	189,313
Rebate for additional private health insurance policies ($m)	38	52	59	58	206
Change in Medicare Levy Surcharge revenue ($m)	-163	-201	-216	-227	-808
Reduction in average premium (%)	0.7	0.9	1.0	1.1	1.1
Net cost to government ($m)	200	253	275	285	**1,014**

Mandate a minimum payout ratio

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 private health insurance policies would cost the government additional private health insurance rebate. A behaviour shift towards more private health insurance 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 private health insurance 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 Medicare Levy Surcharge to take out private health insurance 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 between 2022–23 and 2025–26.

Table 11: Impact of implementing a 90 per cent minimum payout ratio

	2022–23	2023–24	2024–25	2025–26	Total
Direct change in premium (%)	-3.8	-3.8	-3.8	-3.8	-3.8
Additional private health insurance policies	173,171	170,641	170,498	170,117	170,117
Rebate for additional private health insurance policies ($m)	138	138	141	143	560
Net cost to government ($m)	138	138	141	143	**560**

Increase the Medicare Levy Surcharge alongside changes to Lifetime Health Cover

As Lifetime Health Cover is currently under review with many different options being considered to encourage private health insurance membership, it is not possible to provide a detailed costing for as yet unknown changes. Instead, the AMA has provided costing for the higher Medicare Levy Surcharge rate of 2 per cent for people earning $105,001 or greater, if introduced alongside a change in Lifetime Health Cover.

If implemented alongside improvements to Lifetime Health Cover, the change in the Medicare Levy Surcharge rate would drive more people who are over the $90,001 income threshold but under the $105,001 income threshold to take up a private health insurance policy.

The changes to Lifetime Health Cover 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 Lifetime Health Cover will cause indirect costs to government from:

- an increase in the cost of the private health insurance rebate due to more people taking out private health insurance policies
- a decrease in Medicare Levy Surcharge revenue due to more people taking out private health insurance policies.

These indirect costs are included in the estimate below. When the Medicare Levy Surcharge policy change (increase to 2 per cent for people earning $105,001 or greater) is introduced alongside improvements to Lifetime Health Cover, the cost to government rises to $1.42 billion between 2022–23 and 2025–26.

Table 12: Impact of increasing Medicare Levy Surcharge to 2 per cent for people earning $105,001 or greater (with Lifetime Health Cover change)

	2022–23	2023–24	2024–25	2025–26	Total
Additional private health insurance policies	197,910	229,014	247,495	262,169	262,169
Rebate for additional private health insurance policies ($m)	70	85	96	101	352
Change in Medicare Levy Surcharge revenue ($m)	-223	-261	-281	-301	-1,066
Reduction in price of private health insurance policies (%)	1.1	1.3	1.4	1.5	1.5
Net cost to government ($m)	293	346	377	402	**1,418**

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Direct link to 'Data Cube 1': https://www.abs.gov.au/AUSSTATS/subscriber.nsf/log?openagent&63060do001_201605.xls&6306.0&Data%20Cubes&6D5796E828A739DDCA2580AC00137556&0&May%202016&19.01.2017&Previous; 2014 edition: https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6306.0May%202014?OpenDocument, Direct link to 'Data Cube 1': https://www.abs.gov.au/AUSSTATS/subscriber.nsf/log?openagent&63060do001_201405.xls&6306.0&Data%20Cubes&579D9C93BCEDC1A3CA257DD400758DF6&0&May%202014&22.01.2015&Previous

[6] 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: https://www.apra.gov.au/quarterly-private-health-insurance-statistics. Direct link to download: https://www.apra.gov.au/sites/default/files/2021-05/Quarterly%20Private%20Health%20Insurance%20Membership%20and%20Benefits%20March%202021.xlsx

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