The AMA Prescription for Private Health Insurance

AMA

INTRODUCTION

Private health insurance is in trouble.

Even before the impact of the COVID-19 pandemic has been fully realised, private health insurance was in trouble. Membership has fallen continuously for the last 19 quarters or almost 5 years[1], and none of the Government's recent reforms have reversed this decline. Younger people continue to drop their private hospital insurance, while people over 65 years are taking it up in increasing numbers, further jeopardising the stability of the system.

Demographic shifts have created a trend which places upward pressure on premiums for those who maintain their insurance, leading the Australian Prudential Regulation Authority (APRA) to state that private health insurance is in a 'stable but serious condition, with that stability under threat'[2]. The AMA is concerned that the likely financial impact resulting from the COVID-19 pandemic including unemployment, underemployment and a slowing economy, will result in even more young people giving up their insurance, increasing pressure on an already unstable system.

To stem the exodus of policy holders, we need to *increase* the value and *decrease* the pressure on premiums, at the same time. This is a difficult task in a complex policy environment, where multiple policy levers over many years have been introduced - but are no longer fit for purpose.

The policy settings to support private health insurance in Australia are not set and forget. Demographics, wages, chronic disease, technology and health care all change, and we need to respond to these changes to ensure Australia's private health system remains stable. To fix the private health system 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.

It is not an impossible task. Utilising publicly available data the AMA has developed a list of policy prescriptions to improve the health of the system. Some of these policy proposals will require further modelling and development by Government, due to the limitations of publicly available data. But some of these steps can be undertaken by the Government in the forthcoming October budget.

Each proposal has one of two ultimate goals – to either make private health insurance more affordable for those who currently cannot afford it, or to improve its value proposition for consumers, and the wider health system.

Impact of the COVID-19 pandemic

Businesses across all industries have been affected by the COVID-19 response. Almost half of all businesses have been affected directly by government restrictions, and almost 70 per cent have suffered a reduction in demand. Business and consumer confidence are at record lows[3].

1 https://www.apra.gov.au/sites/default/files/2020-05/Quarterly%20private%20health%20insurance%20statistics%20March%202020.pdf
2 https://www.apra.gov.au/news-and-publications/apra-member-geoff-summerhayes-speech-to-members-health-directors-professional
3 https://grattan.shinyapps.io/covid-econ-tracker/ Business activity viewed 2 July 2020

2.7 million people either lost their jobs or lost hours of work in April. The official unemployment rate reported by the Australian Bureau of Statistics for May had increased to 7.1% but is likely to climb higher[4]. Also reported in the May statistics is the underemployment rate, currently sitting at 13.1%[5]. It is likely to be several months before the full extent of the employment shock is known, let alone how long the road to recovery will be.

The COVID-19 pandemic has disrupted routine hospital services globally. This was also the case in Australia when on 1 April 2020 all nonurgent elective procedures in both the public and private sector were cancelled due to the concerns around the level of personal protective equipment and the continued depletion of the National Medical Stockpile[6]. This announcement saw the surgery levels plummet across Australia immediately, with significant impact on the viability of private hospitals.

Private health insurers responded to the pandemic by delaying their premium increases for at least six months and offering hardship provisions for any customers adversely affected by the pandemic[7]. But cancelling elective surgery impacted the value proposition for private health insurance products, and even in the early stages of this pandemic, recently released private health insurance quarterly statistics indicate that more people have turned their back on private hospital products[8].

The Commonwealth Government announced the easing of elective surgery restrictions from 27 April and further on May 15. Elective surgery has been resumed in an incremental and cautious way starting with the most critical surgeries. However, postponing elective surgery during the pandemic in Australia has created a backlog of almost 400,000 cases[9] [10].

In global terms Australia has been among the better countries in its management and reduction of COVID-19 spread. This effective management allowed some jurisdictions in Australia to wind back restrictions and restore our lives to their 'normal' settings, while other jurisdictions have maintained or even tightened their controls in the face of a second wave of infections. Either way, the effects of the pandemic will be felt for some time to come. The International Monetary Fund (IMF) has warned Australia could be one of the worst-hit economies in the Asian region, with the Australian economy forecast to shrink 4.5% this year[11].

This economic impact will be felt by many, if not all Australians. Reductions in employment and in wages are likely to translate into Australians having to cut back on expenditure – this may translate to more people forgoing private health insurance as they struggle to make ends meet.The AMA believes that the policy prescription we have outlined below will help to counter this trend. It is critical that we do reverse the decline of private health insurance. For without a strong private hospital sector, our public hospitals will be placed under an increased burden for elective surgeries. The AMA's series of Public Hospital report cards[12] highlight how waiting times are getting longer and performance continues to decline year on year.

The AMA believes that our policy recommendations are viable and need urgent consideration for this year's Commonwealth Government budget. Our recommendations reflect a deep understanding of why private health insurance has started to fail, the demographic changes we have undergone in the last decade, and the interplay with economic factors such as health inflation, wages growth and emerging technology.

The AMA also understands that this is not the end of the story. It is also time for all of us in the private health sector to set aside our differences and work together. As a sector we need to address underlying issues in order to make private health insurance sustainable into the future. The changes to policy, outlined in this paper do not comprise the complete answer. They are the beginning of a process. Further reform and engagement with all players will be crucial, and the AMA stands ready to lead the medical profession in that effort.

4 https://grattan.shinyapps.io/covid-econ-tracker/ Jobs and unemployment viewed 2 July 2020
5 Labour Force, Australia, May 2020 statistics released 18/6/2020 https://www.abs.gov.au/ausstats/abs@.nsf/7d12b0f6763c78caca257061001cc588a8e6e58c3550090eca2582ce00152250!OpenDocument#:~:text=Australia's%20seasonally%20adjusted%20estimate%20of,0.7%20pts%20to%2013.1%25%3B
6 https://www.health.gov.au/news/australian-health-protection-principal-committee-ahppc-advice-to-national-cabinet-on-24-march-2020
7 https://www.privatehealthcareaustralia.org.au/health-funds-committed-to-providing-financial-relief-for-members-impacted-by-covid-19/
8 https://www.apra.gov.au/sites/default/files/2020-05/Quarterly%20private%20health%20insurance%20statistics%20March%202020.pdf
9 https://www.afr.com/policy/health-and-education/australia-faces-a-backlog-of-400-000-elective-surgery-cases-20200515-p54ta5
10 https://bjssjournals.onlinelibrary.wiley.com/doi/abs/10.1002/bjs.11746
11 https://www.imf.org/en/Countries/AUS viewed 2 July 2020
12 https://ama.com.au/ama-public-hospital-report-card-2019

AMA'S CALL FOR ACTION

Premium rebate restored

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

Medicare Surcharge Levy

The Government should reconsider the MLS levels and thresholds, in order to determine what settings are required to deliver on the policy intent, in a coordinated way with all future reforms.

Minimum payout

A minimum amount returned 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 right now.

Lifetime Health Cover loading

Review of the Lifetime Health Cover loading and penalties – especially the starting age to make it an easy choice for Australians to stay in private health insurance for life. Review the way in which penalties ramp up for late entrants who join later in life and pay premiums just before they are most likely to claim.

Youth Discounts

Government youth discounts need to be enhanced and promoted. They also need to be aligned with our recommended change to Lifetime Health Cover loadings and premium rebate increases for targeted sections of the community.

Transparency and out of pocket costs

There needs to be a higher standard of transparency applied to health insurer policy documentation to clarify insurer policy benefit entitlements. Under policy fine print, benefit entitlements change according to the patient's choice of doctor(s), choice of treating hospital, timing of treatment and insurer hospital/doctor contracting strategies. Private health insurance benefit variability generated by these factors is not addressed by Gold, Silver, Bronze and Basic.

The AMA considers transparency essential to restoring consumer confidence in private health insurance.

Regulation of Private Health Insurers

The AMA calls for the establishment of an independent, well resourced, statutory body to regulate the legal conduct of the private health insurance industry. Although we have a well-resourced Ombudsman, a greater level of oversight will help instil confidence in the system, especially during periods of policy change.

BACKGROUND

Private Health Insurance – a Key Part of Public Health Policy

The unique balance between the public and private sectors makes the Australian health system one of the best in the world. The AMA supports a system where the public and private sectors work side by side to provide high quality health care for Australians.

The decline in private health insurance membership is threatening the delicate balance of our combined public and private hospital capacity. The determination of governments to go on underfunding our public hospitals relative to demand is pushing public hospitals to the brink, as they struggle to cope with demand for public hospital treatments[13].

In 2017-18 private hospitals boosted the number of elective surgeries available to Australian patients – providing nearly 60 per cent of all elective surgery admissions[14]. Private health insurance is critical in this equation providing patients with affordable access to a private hospital, choice of practitioner, and often shorter treatment waiting times.

For Government, private health insurance provides a mechanism to co-fund a large number of hospital treatments to expand total hospital capacity in response to the treatment needs of an ageing, sicker and increasing Australian population.

Private Health Insurance – Demographic Dilemma

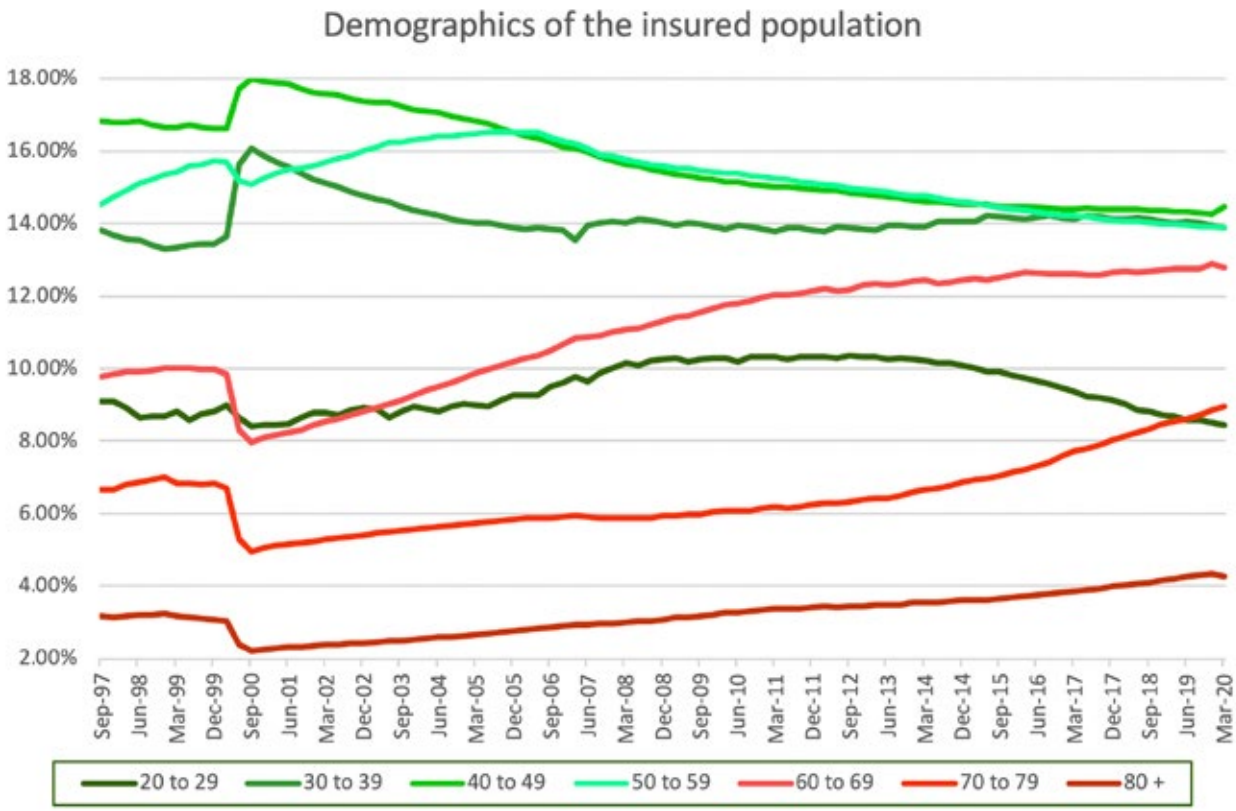
Despite the incentives and subsidies for private health insurance, in recent years the total number of people with private hospital insurance has fallen. APRA data shows the proportion of the population with private hospital insurance has dropped from 47.4 per cent in the June quarter of 2015, to 43.8 per cent by March 2020 – 19 quarters of continuous decline[15].

While total decline in private health hospital insurance is 3.6 per cent in a nearly five-year period, the impact on private health insurance stability is exacerbated further by the changing composition of the insured pool. As younger people drop their private hospital insurance, people in older cohorts over 65 years are taking it up in increasing numbers. Those in age groups between 25 and 34 are a full 6 per cent lower in 2018 than in 2015. At the same time, older Australians 75 and older have increased their membership by 3 per cent, while those 85 and older have increased their membership by 2 per cent, as demonstrated in Figure 1.

On current trends, without any intervention, APRA predict the level of hospital cover to drop another 1.6 per cent, or 184,000 hospital policy holders by 2025. Importantly, APRA anticipate a further 345,000 persons in the 20-34 age group to drop private health insurance while an additional 298,000 new members in the 70-84 age cohort are expected to join[16] [17].

13 Australian Institute of Health and Welfare shows access to public elective and emergency treatments are getting worse not better. Over the recent four-year period from 2014-15 to 2018-19 the volume of public elective surgery per 1,000 population has stagnated - increasing by just 0.5 per cent on average.
14 Australian Institute of Health and Welfare (AIHW) 2019. Australian Hospital Statistics: Admitted Patient Care 2017-18 Table 4.2, viewed 3 July 2020, https://www.aihw gov.au/reports/hospitals/admitted-patient-care-2017-18/data
15 https://www.apra.gov.au/sites/default/files/2020-05/Quarterly%20private%20health%20insurance%20statistics%20March%202020.pdf
16 Estimates based on APRA quarterly statistics, analysis provided by Pioneering Economics.
17 https://www.apra.gov.au/news-and-publications/apra-member-geoff-summerhayes-speech-to-members-health-directors-professional

Figure 1: Age groups as a percentage of the insured population[18]



This is a critical point and is a large part of the rationale for the AMA's policy recommendations. These demographic shifts create a private health insurance membership pool skewed towards older patients. Analysis completed for the AMA indicates in the year to December 2018, Australians aged 55-64 received around 88 per cent of the overall insured person average benefits, while those aged 65-74 received around 160 per cent of the average. The figures at this point then increase dramatically – those aged 75-84 received 260 per cent, while those who have insurance and are 85 years or older received a staggering 310 per cent of the average benefits[19].

The greater the mix of older Australians in the insured pool, the greater the claims and the greater the premiums. As premiums increase, they price out of the market those least able to afford it – including large number of younger Australians, and families. The rate of premium escalation may also undermine the effectiveness of current Lifetime Health Cover settings as delayed private hospital insurance purchase with a ten-year premium penalty becomes increasingly rational for older people.

18 Source: Private health insurance membership trends Mar 2020 https://www.apra.gov.au/quarterly-private-health-insurance-statistics
19 Source: APRA, https://www.apra.gov.au/quarterly-private-health-insurance-statistics, private_health_insurance_membership_and_benefits_statistics_december_2018.xlsx, "AUSTRALIA" worksheet, Page 2, "Hospital Treatment and General Treatment Combined"

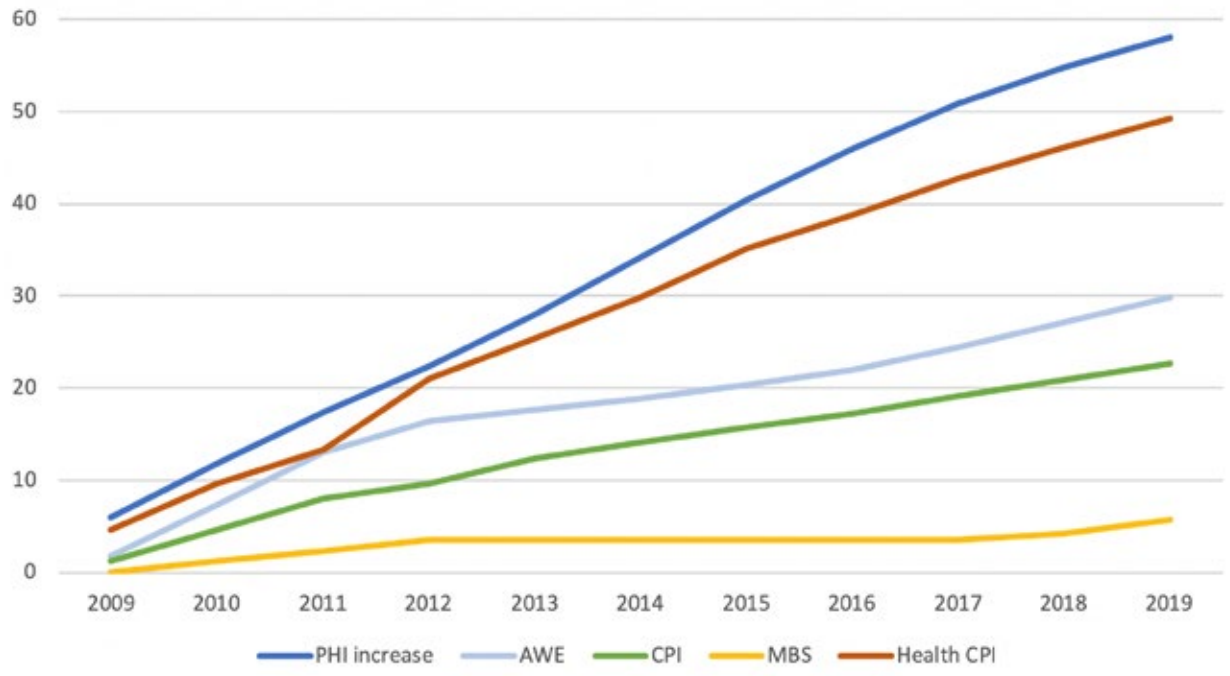
Private Health Insurance – No Longer Affordable?

AMA's analysis indicates the combined effect of the *decline* in younger members and the *increased* uptake of cohorts aged 65 years and older, and the general ageing of the population means premiums were approximately 5 per cent higher in 2018 than they would have been if the membership profile in 2015 had been maintained.

Whether private health insurance is affordable is not just how much premiums rise, but how that relates to wages. Our analysis indicates the decline in the proportion of insured young people, especially cohorts 25-29 and 30-34, has occurred at the same time as low wages growth for these cohorts. As a result, the gap each year widens between the health insurance premiums people face, and their wages – bearing in mind the increased cost of living and housing pressure this group also face.

Outside the ageing demographic and changing mix of insured Australians, one of the other reasons for premium increases is that health inflation typically outstrips the consumer price index, and average weekly earnings. In addition, there has been a reduction in funding for the private health system by the Australian Government (and following that, insurers) via the Medical Benefits Schedule (MBS). The change to a lower indexation rate for the MBS, and then the MBS freeze, has compounded the impact on the funding of patient services. Past research conducted by the AMA[20] has shown how the shift to the current indexation method for the MBS (known as WCI5), generated consistently lower indexation rates than what was required. For example, between 2000-01 to 2002-03, Average Weekly Ordinary Time Earnings was around 5.2 per cent while, WCI5 was an average of 2.3 per cent. In just two years this indexation gap created a cumulative difference of around 8.5 per cent.

Figure 2: Percentage growth of wages, MBS and private health insurance premiums



PHI increase – increase in premiums:

https://www1.health.gov.au/internet/main/publishing.nsf/Content/0B815BFEB8EDECA7CA257BF000195929/$File/Premium-Round-Individual-Insurer-Average-Premium-Increases%E2%80%931997-to-2020.pdf
AWE – Average Weekly Earnings: 6302.0 - Average Weekly Earnings, Australia 2009-2019
MBS – Medical Benefit Schedule: https://feeslist.ama.com.au/resources-ama-gaps-poster
CPI – Consumer Price Index and Health CPI – Health Consumer Price Index: ABS data 2009 - 2019 6401.0 - Consumer Price Index, Australia

20 https://ama.com.au/sites/default/files/documents/160604_Indexation_of_MBS_Rebates_FINAL.pdf

What does this mean for the consumer?

As illustrated in Figure 2, it means that in addition to premiums increasing at a rate faster than wages, the difference between increasing costs and the MBS rebate generates out of pocket medical gaps. This is effectively a cost shift from Government to healthcare providers and privately insured patients. This is because what insurers pay towards a patient's procedure is both based on, and built upon, the MBS. If there is less Commonwealth Government funding going towards each MBS item funded under private health insurance, there is less money going towards the patient's procedure. Likewise, we have seen insurers link their own indexation rates for their contribution towards medical services to the MBS. Meaning the other payer in the system, the insurer, has also been "under-indexing" in many cases and passing these costs onto the patients and clinicians.

Community rating – a fair system for all, when all are part of the system

Not all private health insurance systems around the world are as compassionate and work in the interest of the consumer as Australia's.

Our private health insurance system is unique in this regard and the envy of many, due to the fact it is underpinned by community rating. Patients can transfer between insurers without penalty, patients cannot be excluded outright from joining a policy or charged premium penalties on the basis of their health status, previous claims history, gender or genetic predisposition to disease.

Community rating is enacted through the *Private Health Insurance Act 2007*. The Government introduced the Community Rating System because it was viewed as unfair that someone with a higher number of claims in the past, a poorer health status, or simply by virtue of their age, should be discriminated against via pricing for the same level of insurance coverage. It works by spreading the risk, and thus the cost, equally among members of the community.

Of course, this makes private health insurance (with its goal of providing health services) unlike other types of insurance such as car and life insurance, which are generally risk-rated. Community rating means health insurers must:

- charge everyone the same premium for the same product
- provide cover to anybody who seeks it
- not charge different premiums based on:
  - past or likely future health;
  - claims history; or
  - age related health risk, pre-existing condition, gender, race or lifestyle.

Community rating works best when people join the private hospital insurance pool early and remain insured. However, recent years have shown that when there is a reduction in young people in the insurance pool, and an increase in older people and higher claim rates, it can push up the price of insurance for everyone.

The AMA strongly supports community rating, and the below policy proposals are designed to restore affordability and improve value for all policy holders, without abandoning the key protections in private health insurance that Australians value.

A REFORM AGENDA

Any reform agenda is going to require all the players in the private health system to work together to reverse the decline we are seeing. The below reform agenda is not just about increased Government funding.

But having diagnosed both an affordability, and an increasing outlays issue, this paper does seek to re-examine how the existing Government policy levers can be recalibrated to stop this spiral. It also prescribes additional action Government can, and should, take. The paper then moves to consider how the non-government players in the private health system can contribute to more efficient service delivery, reduce unnecessary cost or return greater value to the patient and policy holder.

Only by all stakeholders working together will meaningful, integrated and lasting reform achieve the positive outcome the community deserves. The paper therefore proposes reforms that are more extensive than published to date.

1. Private Health Insurance Premium Rebate

Current Policy

The Commonwealth Government introduced the Private Health Insurance Rebate on 1 January 1999, to support people in taking out private health insurance, providing a non-income tested financial support for individuals and families via a 30 per cent reimbursement of premiums paid, or a 30 per cent premium reduction.

The Government has since introduced means testing of the rebate and it has lowered the *maximum* rebate a policy holder can get. Through a complex, inadequate indexation process, the Government lowered the maximum rebate a policy holder under 65 can receive from 30 per cent to 24.808 per cent, as of April 2020.

The Commonwealth's original estimate of the rebate was $1.09 billion in 1999-2000; $1.8 billion in 2000-01; $1.27 billion in 2001-02 and $1.36 billion in 2002-03[21]. By 2015-16 this had risen to $6.2 billion[21]. However, the introduction of means-testing, indexation and the recent decline in the take up of private health insurance policies, have slowed this growth considerably. While spending on the rebate was projected to increase to $6.8 billion in 2021-22, the actual growth in the last few years has not matched projections and in 2019-20 was $6.17 billion[22]. As a result of these policy decisions by Government, the average rebate had fallen to 25.3 per cent across all ages and income tiers.

The obvious public policy question to ask is – does the Government still get value from the rebate? Does supporting Australians to take out private health insurance generate a better outcome for the whole health system?

Private households contribute out of pocket expenses and excess payments, adding an additional $1.29 billion per annum to the $12.9 billion in hospital premiums paid. Meaning households contribute $14.2 billion in private contributions to their own health[23].

21 https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/1999-02/pubhosp/report/c05
22 From budget papers 2014-5 to 2019-20 https://www.health.gov.au/resources/publications/health-portfolio-budget-statements-2019-20
23 Based on the analysis of Pioneering Economics

This says that private health insurance members contribute $3.78 of additional care delivered for every $1 that the Government directs to the rebate for hospital treatment.

But sadly, it is not that simple. The private system encourages those who can afford it, to take out private health insurance. Under a public only model, increased taxation would need to be on everyone. And as economists have pointed out, raising taxes on an economy causes what is known as a 'dead weight loss'. Put simply, extra taxation slows down the spending capacity of an individual, slows demand, and by extension, has a measurable negative economic impact. The ANU estimates in an Australian context this loss to be $0.34 for every $1 in tax collected through income tax[24].

Of course, there might be some efficiencies by having a single government administrator in a public hospital only environment, such as lower administration costs and no profits (or retained earnings), and these have been factored into this analysis. But even so, the net effect is an additional welfare loss of $3.1 billion based on financial year 2017-18, or around 16%, if the government were to become the sole funder of care.

Put simply it means that the public only model would not be as cost effective for government, or society. And of course, for those unlucky sick individuals there are additional losses of waiting in queues, losing their choice of doctor and choice of care delivery setting. There are also flow on losses of potential lost earnings while awaiting treatment. These costs are significant and grow with the length of public hospital waiting times.

Future Policy Direction

Lifting the rebate from the current base rates up to 30 per cent for those aged under 65 and for those aged 65-69 will have a significant impact on Government rebate expenditure. Lifting the base rebate from 25.06 per cent to 30 per cent will lift the average rebate for this cohort from 22.5 per cent to 26.9 per cent. For those aged 65-69 it will increase from 27.8 per cent to 28.5 per cent, while the 70+ cohort will remain unchanged.

Applying the higher rebate only to hospital policies will cost approximately $640 million based on June 2019 membership. This cost will increase, if done in conjunction with other policies that increase membership (which is the goal), which is likely.

If the target membership rate was to increase by an assumed flat 5 per cent for all under 65 cohorts, this would add a further $415 million to the cost of the rebate. But importantly, the AMA analysis indicates it would add an additional 675,000 paying members and add approximately $1.5 billion in additional premium revenue to the sector.

Additional members to the insurance pool will of course assist in putting downwards pressure on the premiums themselves, and start to generate benefits for insurers, the Government and consumers. The analysis prepared for the AMA suggests that in this scenario, the benefits paid out against the $1.5 billion revenue would only be $850 million – which would potentially allow premiums to fall by around 3 per cent.

Given the limited public data and difficulty in assessing price sensitivity for potential members, there needs to be additional work to establish a likely up-take of private health insurance given this rebate change. One option is to further support those on lower incomes who are also in younger age cohorts.

24 Based on the analysis of Pioneering Economics

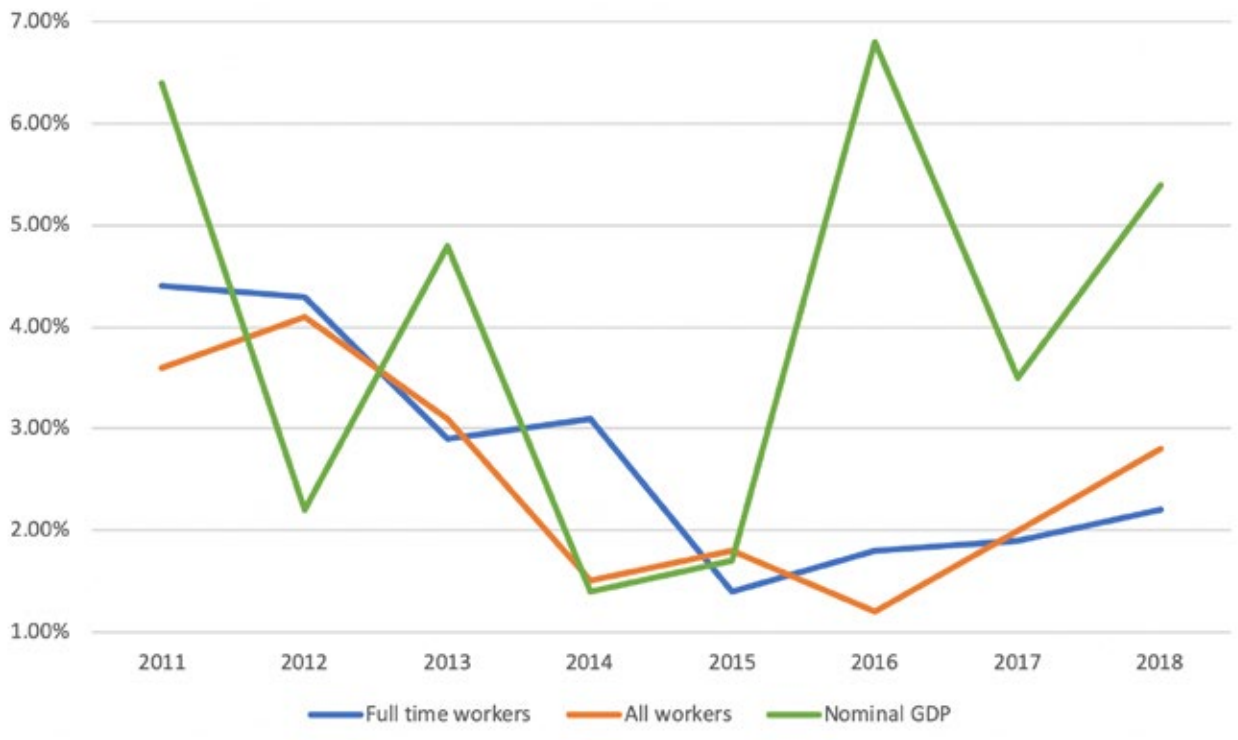
2. Lifetime Health Cover loading

Current Policy

Lifetime Health Cover (LHC) is a Government initiative that started on 1 July 2000. It was designed to encourage people to take out hospital insurance earlier in life and encourage them to maintain it. People who do not take out hospital cover before the 1st of July following their 31st birthday, but then decide to take out hospital cover later in life, will pay a 2 per cent loading on top of their premium for every year they are aged over 30. LHC loadings only apply to hospital cover, and the maximum loading that can be applied is 70 per cent, and once you have paid the loading for 10 years of continuous cover, it is removed.

The four years of decreasing hospital treatment coverage between June 2015 to March 2020, translates to 52,965[25] less people insured – which considering population growth over the period, and an increase in older people taking out insurance, is clearly problematic. Not only are young professionals dropping out of private health insurance up to age 34 years, due to lack of affordability and low wages growth, there is some risk LHC penalties (which take effect from age 30), could begin to *lock them out* of private health insurance long term, rather than encourage them to "get in" before the penalties start.

Figure 3: Annual growth in average weekly earnings[26] and nominal GDP[27], 2011-2018

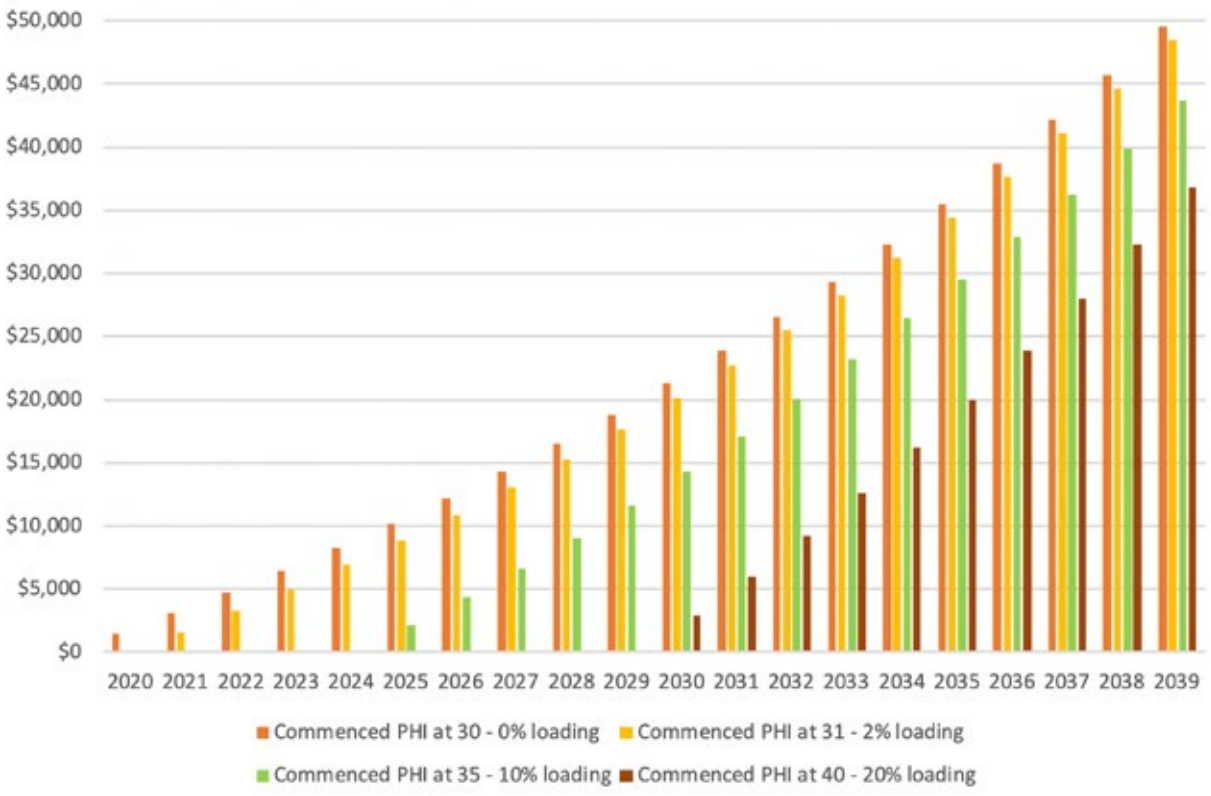


25 https://www.apra.gov.au/quarterly-private-health-insurance-statistics Private health insurance statistical trends March 2020 viewed 30 July 2020
26 ABS, 6302.0 Average Weekly Earnings, Australia, Nov 2018
27 ABS, 5206.0 Australian National Accounts: National Income, Expenditure and Product

More simply, what was once a signal to buy into insurance when you turn 30 may now be acting as a barrier– for if you aren't in a position to buy insurance until the age of 35 (due to starting a career later and low wages growth), you'll face some significant penalties under LHC at a time when many young people are also saving to buy a house, repaying Higher Education Contribution Scheme (HECS) debt and raising children. It is not surprising that younger people are questioning the value of private health insurance. When considering the cost of paying for insurance at this period of their lives, versus the costs they incur taking up insurance later and paying the LHC loading – over a long period it is economically better (by almost $13,000) to delay private health insurance, as illustrated in Figure 4.

This also points to a bigger issue at the other end of the demographic – the LHC penalties do not appear to be deterring older people joining up far later, and for the purposes/intent of claiming as soon as the waiting period is complete – which undermines the basis of how insurance should operate.

Figure 4: Increased cumulative cost of hospital insurance starting at 30 or if delaying commencement until 40



Cumulative cost for under 65 single silver insurance purchased in NSW, hospital cover only (average cost from 4 different insurers), increasing 5% annually with no rebate applied[28].

Case Study: Under current LHC settings Mary delays taking out private health insurance until age 50 when she knows she is more likely to need hospital treatment, and will pay a 40 per cent premium loading for ten years (2 per cent premium loading for each year after age 30). This means joining at age 50 incurs an effective four years additional premium penalty. This tells us that current LHC settings make it financially attractive for some older cohorts to avoid paying premiums from age 30 and delay private health insurance purchase until later in life and only pay a relatively short period of premium penalties when their likelihood of claiming is high. This defeats the LHC objective to pay community rated premiums from age 30 in return for community rated premiums later in life when high cost health treatments are far more likely.

28 This figure is based on the work of the ABC https://mobile.abc.net.au/news/2018-07-06/cost-of-hospital-insurance-if-delaying-beyond-age-30/9944322?pfm=sm-*

Future Policy Direction

LHC is a valuable Government incentive that supports our community rated private health insurance system.

But the LHC loadings should be recalibrated to line up with the age of decision when more people have the income to afford private health insurance. It should be a clear signal to those who can afford private health insurance that they should take it out. Consideration should be given to whether the starting age for LHC is appropriate, or whether it needs to be raised from 30 to a point where it can again act as an incentive for early purchase rather than a barrier. To the extent young people still purchase private hospital insurance after 30, the current LHC penalty revenue to Government would fall. This cost is more than outweighed by the benefits of restoring more people in their early 30s to the private health insurance pool.

Noting the influx of older members to the pool, clearly current LHC settings are no longer protecting the community rating system by acting as an incentive to take out insurance earlier in life and keep it. One option is to revisit projections as to what a policy holder would have paid in premiums in those years where insurance was not held and use this to better inform varying LHC rates for each age cohort. There are significant revenue opportunities here for Government.

Such modelling, updated to account for the cost of premiums today, as well as the changing demographics (such as current wages growth) would reinvigorate LHC for the current economic environment. Revised policy settings, tailored to each age bracket, would ensure LHC again offers a strong incentive to join before the cut-off age, but also a strong disincentive to join at older ages. Government, as the holder of more complete data on historical LHC movements, should consider modelling alternative models against the updated demographic information.

Combatting the COVID impact

The AMA believes that the economic impacts of the COVID pandemic are likely to increase the number of Australians relinquishing their private health insurance in the short term. But as the economy recovers, we need to reduce any impediments to people wanting to return to private health insurance. The AMA believes that the Commonwealth Government should consider providing a window of opportunity (for example 12 months) where anyone who drops insurance now due to financial difficulties can rejoin later without being penalised by losing Lifetime Health Cover.

3. Youth Discounts

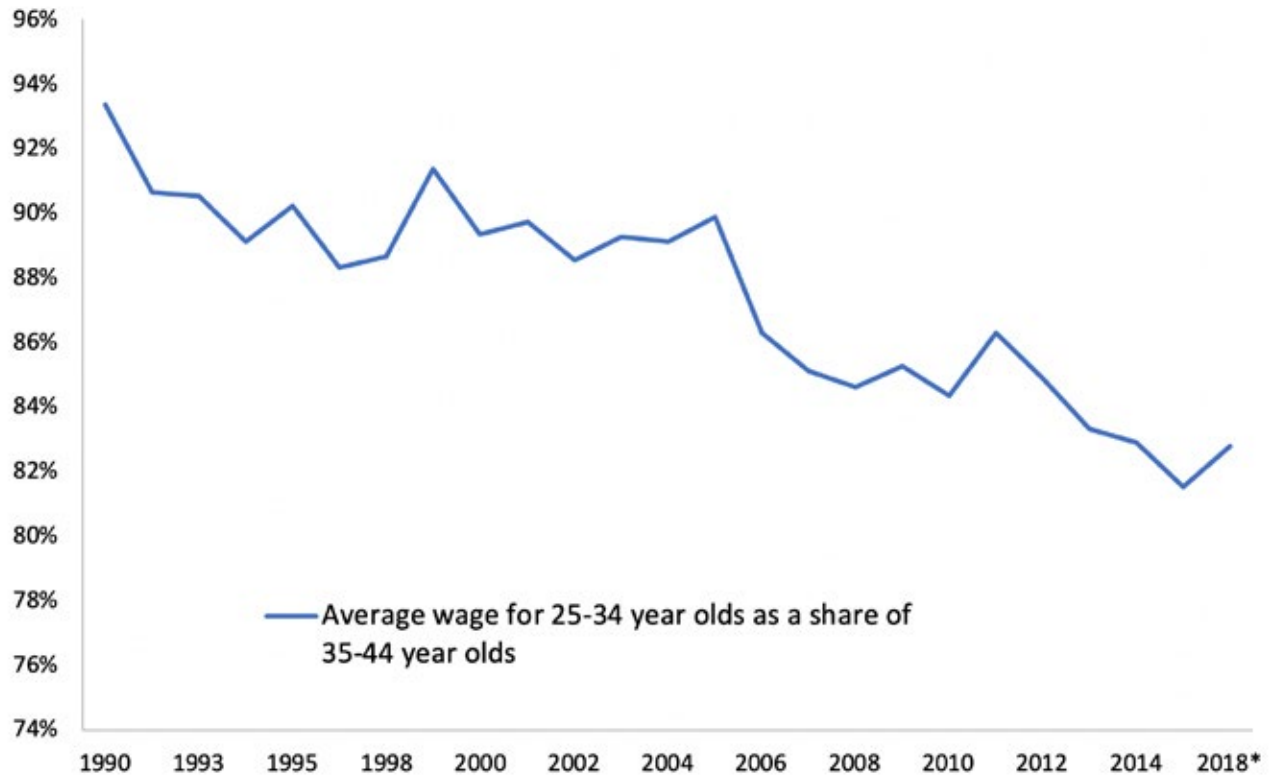
Current Policy

While the AMA strongly supports community rating (combined with risk equalisation) supported by LHC, it does mean that younger Australians pay higher premiums than if they were to be "risk rated", while older Australians pay premium rates that are more affordable than they would be if risk rated. The affordability proposition is increasingly under threat for younger Australians under 35.

Data from the ABS[29] 'Employee Earnings, Benefits and Trade Union Membership, Australia' publication from 1990 to 2013, and supplemented by the ABS Employee Earnings and Hours Publication for 2014, 2016 and 2018[30] shows a persistent decline in the proportion of full-time wages of 25-34 year-olds receive relative to the full-time wages of 35-44 year-olds (shown in Figure 5). The average wage for a 25-34 year-old has fallen from 93 per cent of a 35-44 year-olds wage in 1990, to 83 per cent in 2018. Overall wage growth is slow and younger workers are getting less of what little wages growth there is.

The Government through its latest reforms recognised that the largest fall in private health insurance has been in the 20-29 year-olds[31]. While seeking to protect community rating, the Government introduced a new policy lever - youth discounts for insurance premiums – essentially a "reverse" LHC.

Figure 5: Average wage for 25-34 year-olds as a share of wages of 35-44 year-olds



29 'Employee Earnings, Benefits and Trade Union Membership, Australia' publication from 1990 to 2013, and supplemented by the ABS Employee Earnings and Hours Publication for 2014, 2016 and 2018

30 Employee Earnings and Hours publication for 2016 and 2018 has age groups 21-34 rather than 25-34. Estimates have been adjusted using the 2014 EEH publication relative wage of 21-24 year olds to 25-34 year olds.

31 Figure 4 ACCC Report to the Australian Senate 1 July 2017- to 30 June 2018 https://www.accc.gov.au/system/files/1494_Private-Health-Insurance.pdf

Under the reforms, insurers can offer a discount of 2 per cent on premiums for every year someone is under 30, up to a maximum of 10 per cent for people aged 18 to 25 (Figure 6). Once a policy holder has an age-based discount, they will retain that discount rate until they turn 41, if they remain on the same policy. These discounts will then be gradually phased out after a policy holder turns 41[32].

Figure 6: Age discounts the insurers can offer (introduced in 2019)

Your age	Max discount
29	2%
28	4%
27	6%
26	8%
18–25	10%

Future Policy Direction

Whilst it is still too early to really determine the effect of this policy initiative, the AMA believes that the wages data for this cohort indicates a clear need for greater promotion of it.

Furthermore, if the Government were to increase the age of LHC loading from 30 to 35, it would make sense to increase, and align the age which the 'youth discount' applies to match this. If the Government does consider changing the rate of LHC across different age cohorts, again, consideration could be given to more aggressive discounts under the youth discount policy.

Is it time to change the dependent age on family policies?

The proportion of young adults living in the parental home has been growing over time. In 2001, 47.2% of men aged 18 to 29 and 36.5% of women aged 18 to 29 were living with their parents, while in 2017, 56.4% of men and 53.9% of women in this age range were living with their parents[33]. All these results suggest that young adults in Australia today are taking more time before leaving education and entering living and working arrangements that have long defined adulthood. If we look at raising both the LHC and the youth discount age, it would make sense to also consider changing the dependent age on family policies which currently covers dependent children until they turn 25.

Health insurers themselves have recently flagged this as an idea as well calling for this age to be raised to 30[34].

The AMA believes that the Government should undertake detailed modelling on this policy setting to determine what the best age defining a dependent on a family policy is.

32 https://www.health.gov.au/resources/publications/private-health-insurance-reforms-discount-for-18-to-29-year-olds
33 The Household, Income and Labour Dynamics in Australia Survey: Selected Findings from Waves 1 to 17p 112 https://melbourneinstitute.unimelb.edu.au/__data/assets pdf_file/0011/3127664/HILDA-Statistical-Report-2019.pdf
34 https://membershealth.com.au/members-health-calls-for-higher-children-and-dependent-ages-on-family-health-insurance-policies/

4. Minimum Private Health Insurance Returns

Current Policy

Private health insurers will generally aim to set premium levels to cover the expected costs of benefits (that is, coverage paid for members' medical treatment), plus the fund's management costs. As a result, if management expenses as a proportion of payments are higher, a smaller proportion of premiums is being spent on treatment. Naturally, such calculations are complex, but it is likely that a greater proportion of premiums being paid towards benefits is one indicator of value and return on investment.

Management expenses comprise the amount of premiums per policy that are used to manage the business of the fund. All funds have management expenses and depending on their position in the market and whether they are "for profit", they can have varying marketing costs, salaries, overheads and profit margins that need to be built into these expenses.

Currently there is no policy regarding the amount of premiums (consumer and Government investment combined to purchase a policy) that should be returned in the form of health services. It is worth bearing in mind, past AMA Private Health Insurance Report Cards have highlighted, there can be a considerable variation in the percentage of hospital charges covered across Australian and between funds, and likewise for medical fees. The same can be said for the percentage of funds returned overall as benefits.

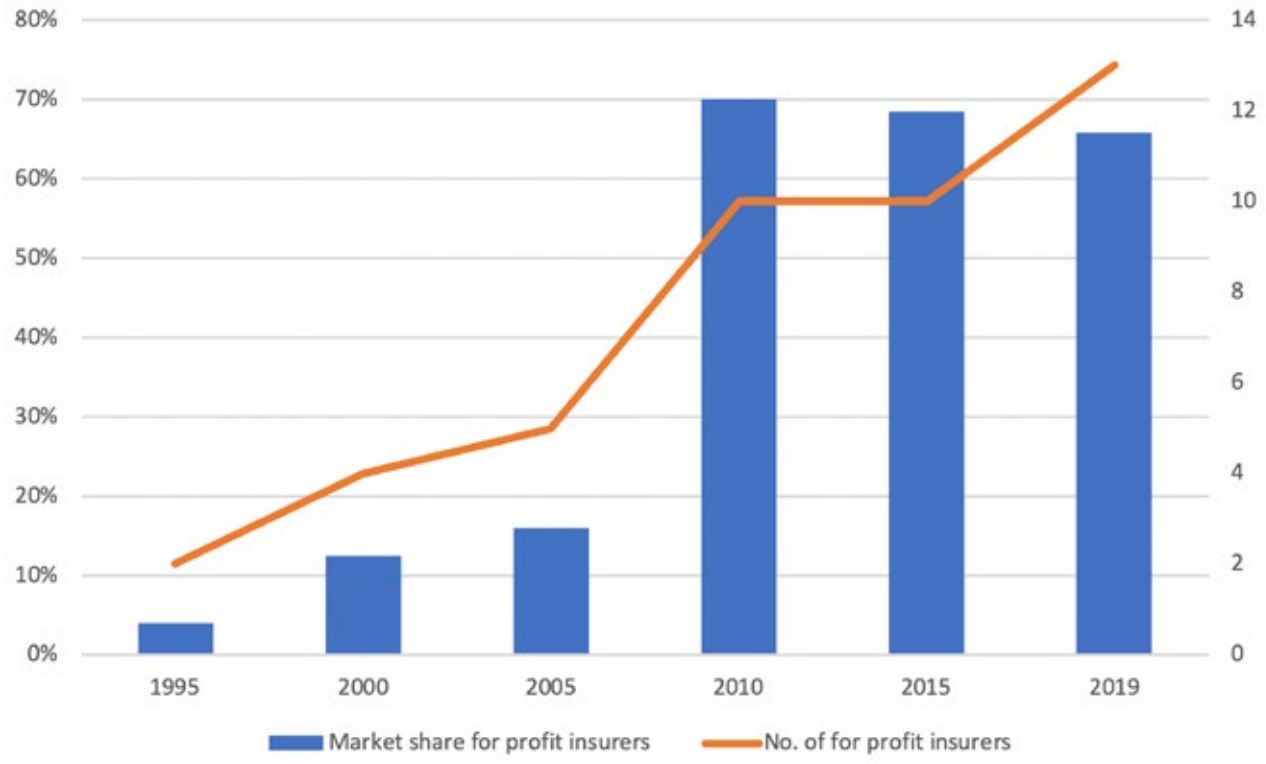
There has also been a marked change in the last decade regarding the composition of private health insurance companies as illustrated in Figure 7. Private health insurers have moved from primarily not-for-profit organisations, to the current situation where almost 70 per cent of the insured population are now covered by for-profit funds (although we are seeing a small drift away from the larger for profits in recent times)[35] [36].

This shift to larger for-profit insurers has been accompanied by a move from funds acting as passive payers to 'active funders' – in some cases as reported in the media, producing sizable profits from the sector for shareholders and executive remuneration.

35 Table 3 https://patch.australiancentre.muhosting.com.au/publication/private-health-insurance-in-australia-policy-reform-approaches-towards-greater-competition-and-efficiency-to-improve-health-system-performance-2/

36 https://www.apra.gov.au/operations-of-private-health-insurers-annual-report

Figure 7: Changes in market share of for-profit health insurance funds – 1995 to 2019



In 2017-18 private health insurers collected in total $17.3 billion in revenue for hospital treatment, $12.9 billion in hospital premiums, and a further $4.37 billion via the Government rebate. Funds paid out $15.19 billion in benefits, $1.5 billion (8.9 per cent on average) in administration expenses and $520 million in profit (retained earnings for not-for-profits).

There is high degree of variability in how much each insurer pays for their benefits and their administrative expenses.

Figure 8 shows the amount returned to consumers by insurers in terms of benefits. Across the industry premium income paid in benefits varies from 78.1 per cent through to 104.2 per cent. Not unsurprisingly, on average the forprofit funds returned 83.07 per cent of members contributions as benefits, whilst the not for profit funds returned 89.98 per cent. There is also a large variation in what each fund pays in terms of their administrative costs.

Figure 8: Benefits and managements expenses by insurance fund[37].

Fund Name	Benefits as % of contributions	Management expenses as % of contribution income	Surplus (- Loss) from health insurance
	For Profit Funds		
Australian Unity	81.1%	10.7%	8.2%
BUPA	86.2%	7.8%	6.1%
CBHS Corporate	n/a	n/a	n/a
CUA Health	85.7%	9.3%	5.1%
Doctors' Health	82.0%	9.9%	8.1%
GU Health Corporate	74.8%	14.2%	11.0%
Health.com.au	88.6%	6.2%	5.2%
Medibank	83.6%	8.3%	8.1%
MO Health	n/a	n/a	n/a
NIB	81.8%	11.2%	6.9%
Onemedifund	78.6%	8.7%	11.8%
QCH	87.7%	10.5%	1.8%
Transport Health	83.7%	13.1%	3.2%
	83.07%	9.99%	
	Not for Profit Funds		
ACA	88.5%	12.1%	- 0.6%
CBHS	93.5%	8.4%	- 1.9%
CDH	79.5%	14.9%	5.7%
Defence Health	90.6%	6.2%	3.2%
Emergency Services	98.4%	n/a	n/a
GMHBA	86.4%	11.9%	1.7%
HBF	87.3%	11.3%	1.5%
HCF	89.7%	9.7%	0.6%
HCI	86.5%	10.4%	3.1%
Health Partners	87.7%	10.0%	2.3%
HIF	90.8%	12.7%	- 3.5%
Latrobe	89.4%	10.1%	0.5%
MDHF	88.8%	8.5%	2.7%
Navy Health	88.4%	9.5%	2.1%
Nurses and Midwives	125.6%	19.2%	- 44.8%
Peoplecare	89.4%	9.7%	1.1%
Phoenix	88.2%	9.0%	2.8%
Police Health	90.6%	6.7%	2.7%
Reserve Bank	82.2%	12.4%	5.4%
RT Health Fund	84.9%	13.8%	1.2%
St Lukes	89.3%	11.2%	- 0.5%
Teacher's Health	91.0%	7.4%	1.7%
TUH	88.8%	8.7%	2.6%
Westfund	84.0%	12.8%	3.2%
	89.98%	10.72%	

90+	85+	80+	75+

13+%	12%	11%	10%	9%	8%	7%	6%

.>-2%	-2 to -1%	-1 to 0%	0 to 2%	2 to 4%	4 to 6%	6 to 8%	>8%

37 Data from Table 6 https://www.ombudsman.gov.au/publications/reports/state-of-the-health-funds/all-reports/docs/2019-state-of-the-health-funds-report

Future Policy Direction

Negative media coverage about the lack of value in private health insurance, coupled with a focus on the profit margins of the for-profit providers has, to some degree, further eroded the perceived value of private health insurance in the eyes of the community. This is something that needs to be urgently addressed, especially if Government is called upon to invest additional taxpayer funds in the private health system. Australians will need assurances that their investment, via the Government, is going to be returned in the form of appropriate coverage for services, when it is needed.

Furthermore, there is an argument that with the standardisation of clinical categories, and the reforms to standardise and simplify policies across the entire industry via gold, silver and bronze, that Government increasingly has a role in promoting private health insurance, which it could expand further. Therefore, a reduction in marketing and administration costs by each fund trying to replicate this could be expected, especially since policies are now easier to explain.

The current system based on APRA data indicates a payout ratio of 88 per cent. The AMA suggests that increasing the target to a higher figure such as 90 per cent, and mandating it across the industry, would build confidence in the eyes of consumers, return a greater share of funds to patients, and provide justification to the taxpayer for the additional Government funding outlined in the rest of this paper.

5. Transparency and Out of Pocket costs

Current Policy

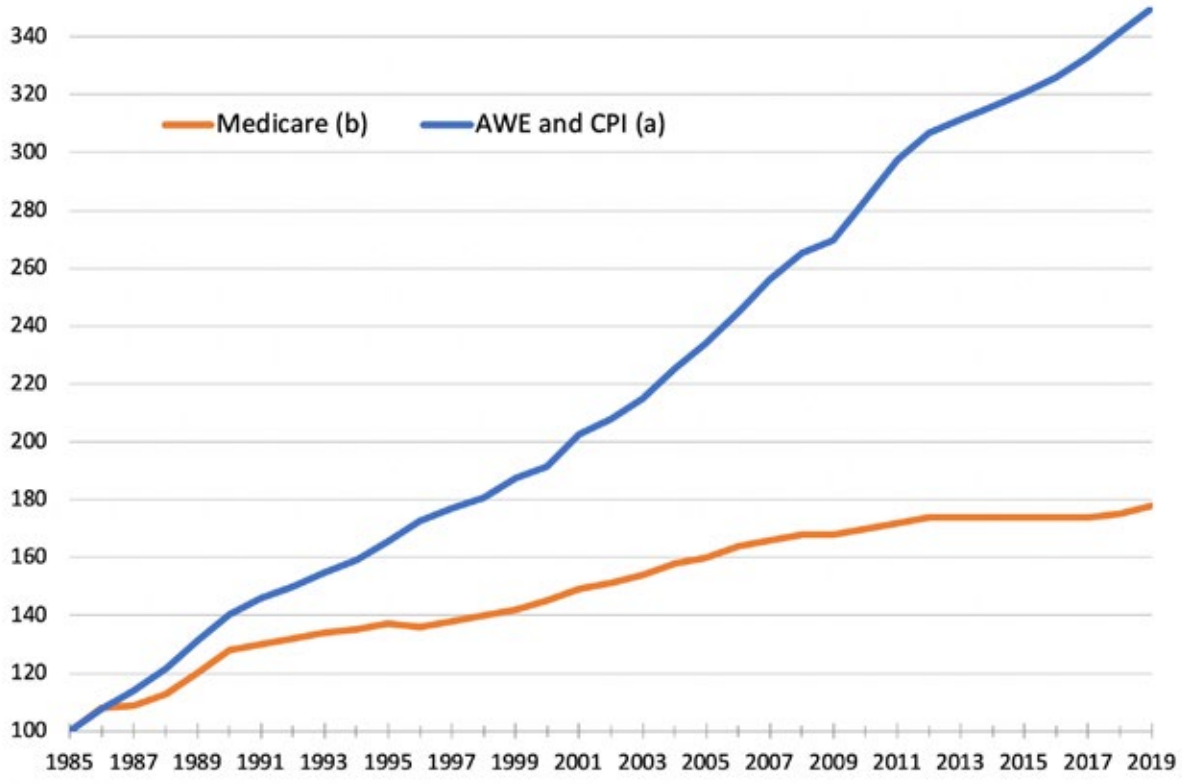
There has been ongoing, sustained debate about out of pocket costs, their impact on patients and on the value proposition of private health insurance more broadly. In some cases, these out of pockets have either been egregious, or have involved booking fees – both of which the AMA condemns, and agrees further action is required.

But in other cases, out of pockets can be caused by a range of factors, beyond just the practitioner fee. These have been outlined in detail in the AMA's Private Health Insurance Report Card[38]. These can include:

- varying private health insurance benefit schedules;
- different payment rates in different regions or states;
- the linking of gap payments to facility contracts;
- different policy details and fine print;
- the operation of gap and known gap rates; and
- inadequate indexation of the MBS and consequently, insurance benefit schedules.

When Medicare was established, the MBS was roughly commensurate with the AMA fee level for doctors' services. Overtime however, there has been a clear separation between the two, with the resulting difference going a large way to explaining some of the out of pocket concerns consumers now face.

Figure 9: Economic indices from 1986 showing the gap between MBS and Average Weekly Earnings/ Consumer Price Index.



(a) Index comprising of Average Weekly Earnings (AWE) and Consumer Price Index (CPI) (70:30) reflecting the average cost structures in medical practices.

(b) Index of Medicare fees as determined by the Commonwealth Government.

38 https://ama.com.au/article/ama-private-health-insurance-report-card-2019

Exacerbating this issue is that private health insurers use the MBS rebate level as the starting point to set their own benefit amounts, on top of the MBS. Those private health insurance rebates all vary significantly. The latest AMA report card showed that the rebates for the same procedure could vary by nearly $600 dollars, and nearly 40 per cent[39], across different funds and different states and territories[40]. Indexation across funds, and within a funds schedule also varies, and in many cases were also frozen alongside the MBS.

Yet to date, the issue of out of pockets has primarily been blamed on doctors[41], despite APRA statistics continuing to highlight that the overwhelming majority of medical services are carried out under a 'no' or 'known gap' billing arrangement (97.5 per cent)[42]. Clearly, the majority of medical practitioners continue to faithfully bill at the varying fees set by the insurers.

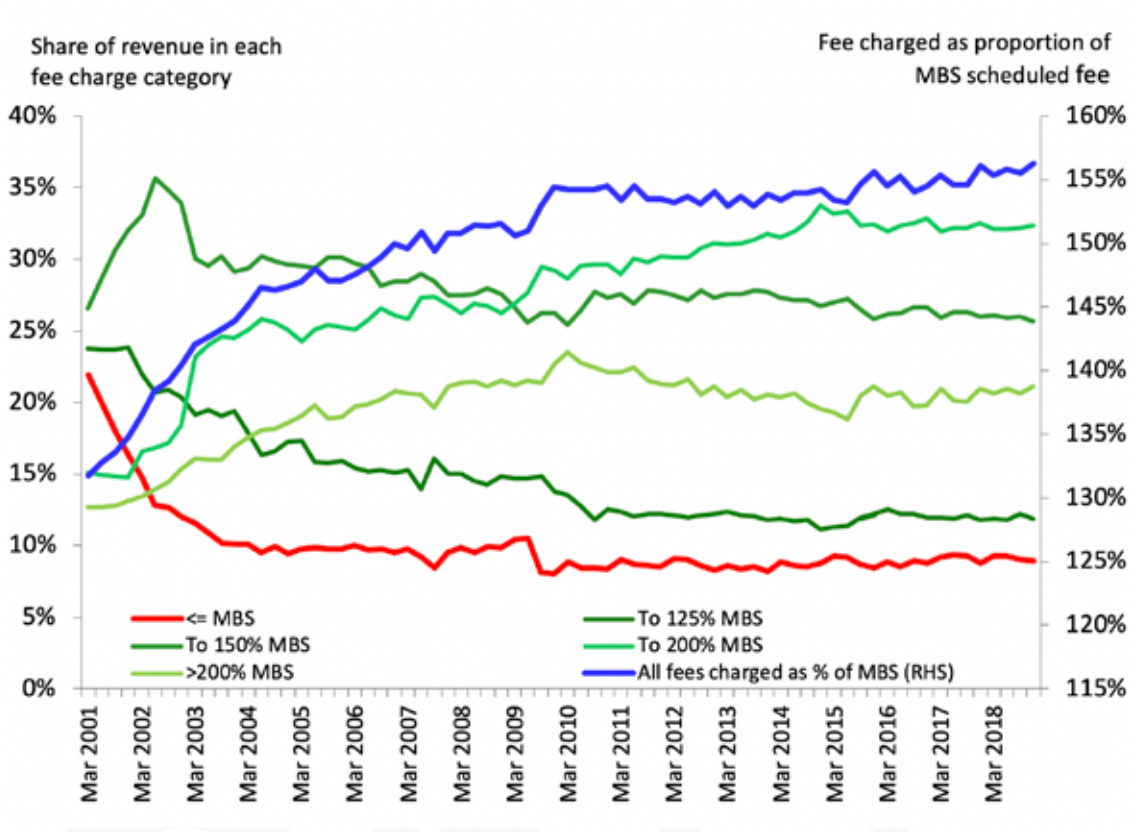
A doctor's fee combined with an inadequate policy can lead to an out of pocket experience for a private health insurance member. Aggregate data on all private health insurance charges shows that fees charged as a proportion of the MBS scheduled fee have risen from 154 per cent in December 2010 to 156 per cent in December 2018.

Fees charged under a 'no-gap' policy have remained consistent between 135 per cent and 140 per cent of the MBS scheduled fee since 2010[43], starting at 136.7 per cent in December 2010 and rising marginally to 137.4 per cent in December 2018. This demonstrates remarkable restraint by medical practitioners, considering the freeze in the MBS during almost half of this time period.

Fees charged are higher for policies without a no or known gap provision. They have increased for those without a no-gap or known-gap, from 246 per cent of the MBS scheduled fee in December 2010 to 258 per cent in December 2018. The increase in the share of policies without no-gap or known-gap provisions, could lead to an increase in the complaints about out-of-pocket experiences. Fee disclosure from doctors and policy transparency from insurers combined are needed to address this issue.

39 Table 3 https://ama.com.au/article/ama-private-health-insurance-report-card-2019
40 Table 4 https://ama.com.au/article/ama-private-health-insurance-report-card-2019
41 https://grattan.edu.au/news/how-greedy-doctors-make-private-health-insurance-more-painful/
42 https://www.apra.gov.au/sites/default/files/2020-05/Quarterly%20private%20health%20insurance%20statistics%20March%202020.pdf
43 https://www.apra.gov.au/quarterly-private-health-insurance-statistics, Private health insurance medical gap statistics

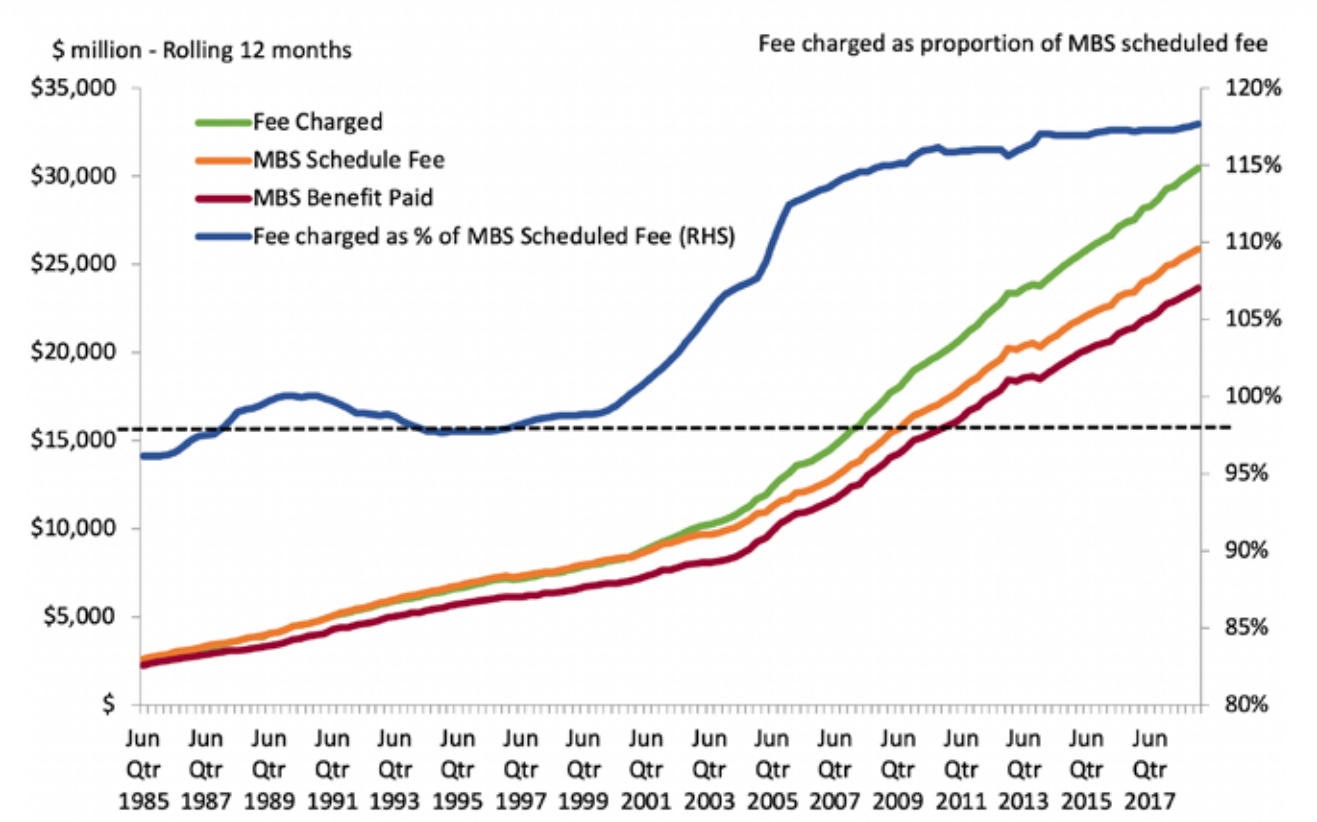
Figure 10: Fees charged in private health insurance relative to the MBS, 2001-2018



Pressure in the private health insurance system actually stems from an overarching pressure building from inadequate MBS indexation. Prior to the indexation change in 1996, we can see the fees charged were closely aligned with the MBS scheduled fee. After this time, every time there is a spike in wage growth, such as the introduction of the GST, or the mining boom, there is an associated spike in the fee charged relative to the MBS. The long term solution must be to base MBS indexation on average wages or some combination of wages and CPI in the general economy.

Analysis of Medicare data back to 1985 highlights some of the broader issues. On average, doctors' fees have increased relative to the MBS. The increase in fees charged by doctors on average have been a direct response to inadequate indexation of Medicare as discussed earlier.

Figure 11: Doctors fee charged as a proportion of the MBS scheduled fee



But medical practices have to work hard to ensure their patients can access the wide number of no gap or known gap schemes from the full range of insurers, medical practitioners must have multiple fee schedules (sometimes up to 17 different rates) for the same procedure, simply to comply with the different rebates paid by health funds to meet their no gap requirements for that one procedure, to make sure that patients are not left out of pocket.

Even when a customer has a Gold Level Policy with a chosen insurer – this can still deliver them significant out of pocket costs. The below example (where a doctor bills a flat fee based on the costs of delivering a quality service) tries to highlight this variation.

Figure 12: Example - Uncomplicated baby delivery with a medical specialist fee of $2025 (Figures correct as at 30 June 2020)

MBS No. 16519	MBS Fee: $705.05 Benefit: 75% = $528.80			
Insurer	Insurer A	Insurer B	Insurer C	Insurer D
Insurer rebate	$2058.95	$1575.75	$1630.30	$2068.15
Insurer pays	$1,496.20	$176.25	$1,101.50	$1,496.20
Medicare pays	$528.80	$528.80	$528.80	$528.80
Patient pays	0	$1,319.95	$394.70	0

1. For this example, Insurer C has a known gap limit of $400

This clearly shows that the idea of the MBS fee being the appropriate rebate for a medical service is not accepted by the profession, nor by the insurers themselves. The MBS fee is not set at the cost of doing quality medicine – therefore a gap may not be the doctor charging egregiously but simply the doctor trying to cover the cost of delivering a quality medical service.

Nor does the idea that doctors are causing the cost and premium issues with private health insurance hold true. Only 16 per cent of private health insurance benefit outlays for hospital treatments come from medical services, of which over 97 per cent are billed at the no or known gap level[44] - despite the indexation issues.

Clearly the problem is therefore not a cost to insurers issue, but rather one of an erosion of indexation to the patient rebates, transparency for the patient (of the fee, and their rebate), health literacy (to understand the fee/rebate relationship, other unrelated out of pocket costs such as excesses or hospital costs), and policy complexity (the operation of the gap rates and how the insurer rebate drops to 25 per cent of the MBS).

Future Policy Direction

In March 2019 the Commonwealth Government announced that it would launch a national strategy to tackle excessive out of pocket costs charged by medical specialists, including by developing a website to provide Australians with transparency about the costs of specialist services[45].

The AMA supports and actively encourages full transparency of doctors' fees, and unreservedly condemns egregious billing, which occurs in a very small percentage of cases. But informed financial consent requires *total* transparency. Unlike the growing range of privately funded fees websites that now exist, a Government-developed website must be impartial and backed by the Commonwealth's extensive data set. However, a website that does not have the full information is not in anyone's interests.

For admitted hospital treatments, the level of benefits paid by the insurer will depend on the insurer, the particular insurance policy, and the insurer's arrangements with the treating doctor, and the treating hospital.

Therefore, the AMA calls for the Government to develop a website which:

- Shows not only medical practitioner fees, but the insurers rebates, by fund, state and procedure
- Provides health financial literacy around how insurance operates
- Provides advice on how to ensure that the hospital is also covered and any excesses
- Gives consumers examples of the right questions to ask their practitioner and their insurer
- Shows consumers how the rebate can drop when the no and known gap is exceeded, by even a small amount
- Provides consumers with avenues to seek further advice.

The AMA believes that a complete resource, which provides transparency all around, while assisting the consumer to understand the health system, would go a long way to exposing where excessive or egregious out of pockets occur and assist consumers to purchase better value products.

Furthermore, to highlight the content and approach required for such an online resource, the AMA has developed a comprehensive guide which could be the basis for the Government's online resource – the AMA Guide to Informed Financial Consent.

Finally, the AMA calls on Government to commit to looking at a new, more appropriate indexation model for the MBS, less variation in insurer rebates and some standardisation around offering a known gap product. Furthermore, the AMA calls for insurers to stop the practice of linking gap rates to facility contracts – a process that has simply added complexity for patients and practitioners alike.

44 https://www.apra.gov.au/quarterly-private-health-insurance-statistics
45 https://www.greghunt.com.au/national-strategy-to-tackle-specialist-out-of-pocket-costs/

Ongoing financial impact of COVID

As patients return to medical practices and elective surgery resumes normal levels, like the rest of Australia, practices have and will continue to change to meet the requirements of managing COVID into the future. As Australia begins to work out how health care will be delivered, there are some things we know need to change:

- increased physical distancing in waiting rooms;
- sufficient supply of general supplies including protective equipment;
- extra cleaning when required;
- extra time for greater precautions when they are required; and
- more testing of patients for COVID:

These increased costs will be largely unfunded, particularly if governments withdraw or wind back COVID related resources in circumstances where the virus appears to be contained.

In the absence of health funders coming to the table and increasing their share of these costs the gap between the cost of delivering quality service and payments from Governments and insurers will increase. This difference will fall to patients, out of pockets costs are likely to increase further undermining the value proposition of private health insurance.

6. Regulation of Private Health Insurers

Current Policy

The Government is responsible for regulating the industry to ensure a fair and equitable system. These regulations express the consumer protections of community rating, new protections for patients who are affected by mental illness, regulated maximum waiting periods, patient freedom to switch insurers without the loss of waiting periods already served, patient freedom to upgrade a policy without the loss of the previous level of policy entitlements and minimum benefit payments for uncontracted hospitals.

Currently, there are three bodies that are involved in overseeing aspects of private health insurance, in addition to the Australian Competition and Consumer Commission (ACCC).

Private Health Insurance Complaints

The *Private Health Insurance Reform Amendment Act 1995* established the Private Health Insurance Complaints Commissioner. The name was changed in 1998 to become the Private Health Insurance Ombudsman (PHIO). The original functions of the ombudsman were to deal with complaints, to investigate practices and procedures, to publish data about complaints; to provide information to the public; and to make recommendations about regulatory and/or industry practices[46].

On 1 July 2015, the PHIO merged with the Commonwealth Ombudsman, as part of the *Smaller Government – additional reductions in the number of Australian Government bodies* announced in the 2014 federal budget[47].

The functions of the Commonwealth Ombudsman remain similar to PHIO and aim to protect the interests of private health insurance consumers through resolving their complaints – but not regulating. The Commonwealth Ombudsman also retained the ability to advise Government and industry about issues affecting consumers and the performance of the sector. The Commonwealth Ombudsman is responsible for managing PrivateHealth.gov.au[48], and did receive a boost in its powers last year.

46 https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/1996-99/health/report/c04
47 https://www1.health.gov.au/internet/main/publishing.nsf/content/health-phicirculars2015-02
48 https://www.ombudsman.gov.au/How-we-can-help/private-health-insurance

Private Health Insurance Regulation – APRA and the Department

The Private Health Insurance Administration Council (PHIAC) was established in 1989 under the *National Health Act*[49]. It was established to monitor the financial performance of private health funds and ensure statutory reserve requirements are met, to administer the reinsurance account arrangements, and to collect and disseminate financial and statistical data[50]. Also, as part of the *Smaller Government* initiative in the 2014-15 Budget, PHIAC ceased to operate as a separate body and its prudential supervisory functions were transferred to the Australian Prudential Regulation Authority (APRA)[51].

APRA is an independent statutory authority that supervises institutions across banking, insurance and superannuation, and is accountable to the Australian Parliament. APRA was established by the Australian Government on 1 July 1998 and is responsible for protecting the interests of depositors, policyholders and superannuation fund members[52].

This leaves the Department of Health, which under the *Private Health Insurance Act 2007* has the power to also act as a regulator of private health insurers, as it is responsible for private health insurance legislation (and rules and regulation), it's interpretation and its application.

Future Policy Direction

The regulation that underpins the interaction between private health insurers, hospitals and patients must promote the effective and efficient supply of health services. Private health insurance has specific features that make the design of efficient regulation especially complex. Current regulation, as well as defining the scope of the cover private health insurance provides, includes restrictions on premiums through community rating and LHC, means tested subsidies for private health insurance take-up, along with means tested tax penalties (the Medicare Levy Surcharge) for the failure to take out cover, and price controls over increases in private health insurance premiums.

APRA's role is focused on the financial stability of the private health insurance system, not the patient, practitioner and hospital related concerns with private health insurance. This is left to the Department of Health, and the AMA does not believe this is appropriate or effective.

The AMA believes that as a regulator in this area, the Government does not support or fund the Department appropriately. Additionally, the Department is significantly conflicted and is not best placed to manage this responsibility – particularly as it is required through policy development to work with the insurance funds on the development and implementation of new policy. Once such conflict could be seen in the matter of MBS review implementation issues which generated an issue with private health insurers – in this instance the Department would have been required to consider its own behaviour as part of the detrimental outcomes. The AMA experience has been that where complaints require immediate action and intervention – be they relating to a consumer's need for pre-approval for a procedure, the behaviour of a fund, or issues between a fund and facility – that there is a regulatory 'hole'. Key to navigating private health insurance successfully into the future is the ability to manage the complex range of policy and regulatory issues, but in such a way that the community is supported.

The AMA believes that an independent body or at least an independent statutory position with adequate resources should be created to accomplish this task to support consumers in their interactions with the private health system, particularly now we are undergoing significant changes to the policies held by consumers.

49 https://actuaries.asn.au/Library/Events/Conventions/2003/7b-conv03presginnane.pdf
50 https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Completed_inquiries/1996-99/health/report/c04
51 https://www.legislation.gov.au/Details/F2015L01037/bad5c974-5bad-4dfc-9a7d-6d2adcca7c57
52 https://www.apra.gov.au/about-apra

7. Medicare levy surcharge

Current Policy

Originally introduced in July 1997 for income earners over $50,000, the 1 per cent Medicare Levy Surcharge (MLS) aimed to encourage those that could afford it, to take up private health insurance membership. At the time an income of $50,000 was the threshold for the highest income bracket of taxation, a marginal rate of 47 per cent. The comparable threshold is now $180,000 where marginal tax is paid at 47 per cent. The MLS rate is now levied at the rates of 1%, 1.25% or 1.5% depending on taxable income.

Due to several periods of frozen indexation and high annual wage growth of 4.7 per cent during the years 2000 to 2010[53], the MLS threshold now cuts in at the same income bracket as the 30 per cent marginal taxation rate. It is also now much closer to being applied to the average wage, than what is considered to be a 'high income earner'.

The key policy principle behind the MLS was that higher income earners who did not have private health insurance were penalised with a higher surcharge. This position has been eroded by Government who have both frozen and applied low indexation to the threshold over many years. But also, we have seen a growth in premiums outstripping low wage growth, which has compounded the impact.

For some cohorts we see the perverse outcome of the MLS apply to people at a lower income than originally intended, but the amount levied is less than the rate likely to be paid for a reasonable private health insurance product, due to increased premiums.

Future Policy Direction

The Government should reconsider the MLS levels and thresholds, in order to determine what settings are required to deliver on the policy intent, in a coordinated way with all future reforms. In calibrating the MLS rates, the AMA believes that Government needs to be mindful of the current progressive tax scales, and what impact an increase at higher tax levels might be needed to align with current premium levels.

53 4 ABS, 6302.0 Average Weekly Earnings Australia, Nov 2010, https://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6302.0Nov%202010?OpenDocument

CONCLUSION

Private hospital insurance membership has fallen continuously for the last 19 quarters[54]. It is a disturbing trend that, without intervention, looks to continue.

However, the decline in private health insurance can be turned around, to reinstate stability and maintain a viable public hospital sector alongside it.

Outlined here is the AMA blueprint for private health insurance reforms that can be undertaken in the October 2020 Budget. The proposals are clear, concrete policy solutions for the consideration of the Australian Government. The reform proposals first and foremost identify and address the erosion of private health insurance affordability to tackle the short-term issues.

The policy settings and environment supporting private health insurance in Australia are not "set and forget". Demographics, chronic disease, technology and health care are all changing rapidly. This is even more the case due to the impact of the COVID-19 pandemic. Accordingly, we need to respond to this private health insurance crisis in an equally dynamic and robust manner. To that end, the AMA calls on Government to consider using the latest data to recalibrate the existing policy levers, and consider news ones, such as minimum fund payouts and a true regulator.

But the AMA also understands that this is not the end of the story. Private health insurers need to continue their supportive response to the COVID-19 pandemic, they need to extend the help beyond what they have offered so far and beyond the first six months of the pandemic. In the hard-economic times that Australia is facing now and into the foreseeable future many people are not going to be able to afford their premiums, and then additional out of pocket costs and excesses. Private health insurers have seen their income stream relatively unaffected by COVID-19, but their expenses have been significantly reduced, at least in the short term. The same is not true for medical practitioners. Many lost significant amounts, if not all their income, with the cessation of elective surgery. But they have still had to pay costs such as rent and medical indemnity insurance.

In response to the COVID-19 pandemic almost overnight, Australia's medical professionals adopted and implemented telehealth and ePrescribing. Private health insurers enhanced and encouraged their hospital in the home programs delivering more home-based chemotherapy and rehabilitation – allowing patients to continue their care, despite physical isolation requirements.

These changes in practice have been discussed but had in many cases never eventuated before the COVID-19 measures were implemented. One positive aspect to come from the COVID-19 response has been the rapid development and adoption of these new forms of care delivery. Patients are voting for these new ways of operating by taking them up in increasing numbers.

Better uses of technology such as these need to be further supported and expanded. Having cleared the first hurdles for telehealth and home-based hospital care, we need to develop them further as part of a deliberate design of a better system. A system that provides the right programs which are cost effective, clinically advantageous, medical practitioner led and insurer funded.

The changes outlined in this paper are just the start of this process; reform to both health insurance and to the health sector more broadly needs to be ongoing. We will all need to work together on continual improvement – including, but not limited to prostheses, addressing the issue of private patients in public hospitals, new and improved clinician led models of care and the adoption of new technology. The AMA and Australia's doctors stand ready to talk constructively. We can and must fix the system. Because at the end of the day, if we don't, it is our patients that will lose the most.

54 https://www.apra.gov.au/sites/default/files/Quarterly%20Private%20Health%20Insurance%20Statistics%20September%202019.pdf

LIST OF FIGURES

55 ABS, 6302.0 Average Weekly Earnings, Australia, Nov 2018
56 ABS, 5206.0 Australian National Accounts: National Income, Expenditure and Product

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Pioneering Economics has been proud to assist the AMA by conducting in-depth analysis of private health insurance in Australia over the past year. All analysis has been conducted using public data and papers. Pioneering Economics thanks the AMA and member doctors that dedicate their time to examine this policy area with considered research.

Disclaimer

Notice

Pioneering Economics was engaged by the Australian Medical Association to provide advice on a range of issues effecting the medical profession. The request for assistance with 'The AMA Prescription for Private Health Insurance' ("Project") came as part of a suite of requests following the engagement by the AMA in February 2019. Pioneering Economics was requested to examine the implication of the current policy settings on the recent decline in membership of younger Australians.

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