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Saving private health 2

Making private health insurance viable

Stephen Duckett and Matt Cowgill



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Overview

The Australian private hospital insurance system is unsustainable in its present form. The system faces a death spiral – younger and healthier consumers get a bad deal, so they're dropping their insurance, which means premiums need to rise, so even more young and healthy people drop out, and the cycle continues.

This youth exodus means the recent moderation of premium increases is likely to end, and premiums will probably return to increasing at 5 per cent or more each year. By 2030 private health insurance is likely to cover less than 40 per cent of the population.

Private health insurers are strangled by red tape. The government requires that insurers charge everyone in each state – young and old, sick and healthy – the same insurance premium, under the 'community rating' principle. Insurers' incentives are blunted by regulation. If an insurer bargains hard with hospitals, acts to keep members healthy, or innovates to reduce treatment costs it loses much of the benefit to other insurers through a process called risk equalisation.

The Commonwealth spends nearly \$5 billion a year subsidising private hospital insurance – and another billion or so on 'general' or 'extras' insurance – at questionable value for money. Subsidising private health care might be worth it if it takes the pressure off the public system. But the evidence suggests that the cost of the subsidy to the budget is much larger than the amount it saves in public health care.

This report proposes policies that will help the private health insurance industry become sustainable as the population ages. Change is needed, but a gradual industry transition will ensure there is no disruption to the health care, including the public system.

Young people's premiums have to get cheaper. In the short term, a cost-neutral reshuffling of the Private Health Insurance Rebate among the age groups will help. In the longer term, more structural reform is needed. Australia should move further along the spectrum away from community rating – where all insured people pay the same premium for the same product – towards a system where premiums vary by age.

Premiums should be partially deregulated, with insurers free to charge younger people less than older people for the same level of coverage. Premiums should remain regulated, and should not vary by age, for people aged 55 and over. The private hospital insurance rebate should be redirected towards older patients. The rebate should not be increased and should be withdrawn from low-coverage policies. The general ('extras') insurance rebate should be withdrawn. Part of the proceeds should fund dental care and part should keep hospital insurance premiums for older people at acceptable levels.

Overall, the net premiums paid by older people would rise a little, while younger people would pay less. If the proposals in our previous report are implemented, older people will pay less too.

Lifetime Health Cover and the Medicare Levy Surcharge should be gradually phased down. Risk equalisation among funds should be reduced so that insurers can keep more of the benefits of any efficiency gains they're able to achieve, helping to keep costs down.

Private health insurance is an important industry facing challenging times. Innovation in the industry has been stifled by excessive regulation and a handout mentality. The industry should rely more on customers seeing value in their product, rather than being prodded into taking out insurance. Just as in any other industry, private insurers should compete based on the value they provide to their customers.

Recommendations

Move away from community rating to make hospital insurance sustainable

Deregulate premiums for people aged below 55

The Commonwealth Government should remove the requirement that health funds charge the same premium to all customers in each state, and instead allow age-based risk rating of premiums for people under 55. Funds should not be allowed to charge different premiums to people of the same age based on their health status or other characteristics.

Charge everyone aged 55 and over the same premium

Everyone aged 55 and over should be charged the same regulated premium for the same product.

Fewer carrots and sticks

Don't increase the rebate

The Commonwealth Government should resist calls to increase the rebate. Growth in the rebate should continue to be capped at CPI inflation.

Scrap the rebate on general insurance ('extras') and 'junk' policies

The Commonwealth should remove the general insurance subsidy, re-directing part of the proceeds to the hospital insurance rebate and part to publicly funded dental care. General insurance should be deregulated. The rebate should be removed from products which only cover public hospital care.

Re-direct the hospital insurance rebate towards older people

The hospital insurance rebate should only be paid to fund members aged 55 and over.

Phase down Lifetime Health Cover and the Medicare Levy Surcharge

Lifetime Health Cover and the Medicare Levy Surcharge should be gradually reduced.

Help funds help themselves

Reduce risk equalisation between funds

The amount that funds are required to share through age-based equalisation should be phased down, though some equalisation should remain.

A first step to stop the death spiral

Equalise the rebate across age groups

Pending major structural reform to community rating, the current age-based variation in the hospital insurance rebate should be redesigned to reduce the subsidy for people aged 65 and over and increase, on a cost-neutral basis, the subsidy for younger people.

Table of contents

Overview	3
Recommendations	4
1 Consumers are paying more and getting less	8
2 Premiums are rising because young people are dropping out	14
3 What is government doing to support private health insurance?	22
4 Helping the industry help itself	32
A Projecting PHI membership	43
B Does the PHI rebate take pressure off the public system?	46
C Potential options to address youth exodus	51

List of Figures

1.1	Premiums have grown much faster than wages	8
1.2	Fewer people now have ‘top cover’	11
2.1	Insurers are paying out as much as they always have	14
2.2	The Australian population is ageing, but the PHI membership is ageing faster	15
2.3	Younger people are leaving PHI, older people are not	16
2.4	PHI members are going to the hospital more than they used to, especially older members	17
2.5	Health prices have risen much faster than overall inflation	18
2.6	Ageing, utilisation, and inflation have all contributed significantly to rising PHI benefits	19
2.7	The spiral is likely to continue	20
3.1	Young people pay a lot more in premiums than they get back in benefits	23
3.2	The proportion of costs shared through risk equalisation has increased over the past decade	28
3.3	The premium floor has been increasing	30
4.1	To make health insurance more sustainable, older people must pay a little more	34
4.2	Older PHI members should get a base rebate plus a means tested component	37

List of Tables

3.1 Medicare Levy Surcharge Income thresholds 2014-15 to 2018-19	25
3.2 Age bands and proportion of benefits shared through risk equalisation	31
C.1 Other options to address the youth exodus from PHI	52

1 Consumers are paying more and getting less

Consumers are spending more on private hospital insurance but are getting less value for their money.¹ Rising premiums and unexpected out-of-pocket costs have diminished the value of private health insurance for many Australians, especially the young and healthy. Although, as we show in Chapter 2, health insurers continue to pay out a stable proportion of revenue as benefits to members, these benefits cover a shrinking share of patients' health costs.

Some people have responded to rising premiums by downgrading their cover – choosing policies that exclude many services and require them to pay a minimum amount upfront when they make a claim. The average policy holder is covered for fewer treatments and must pay a higher excess than the average policy holder 20 years ago. Many people – particularly younger people – are dropping cover entirely.

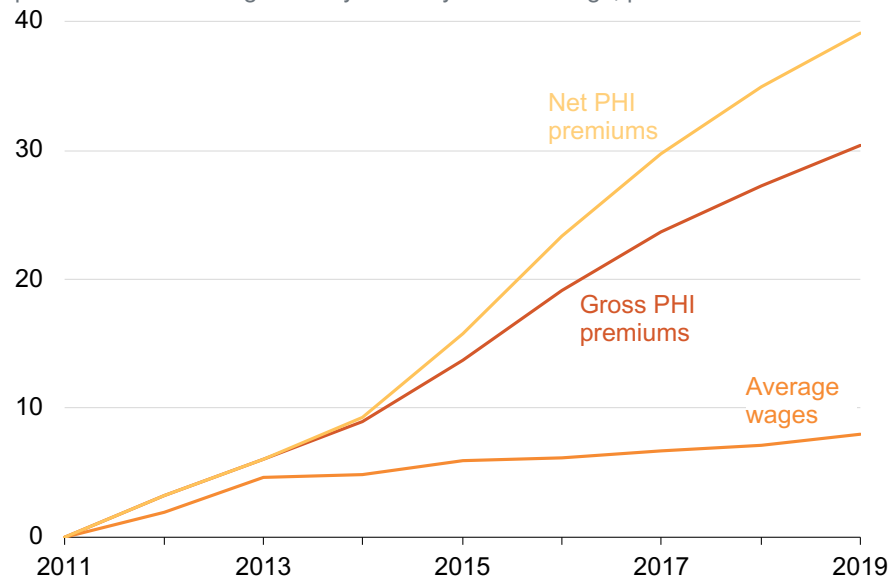
As younger and healthier people drop private health insurance, premiums have to rise for the remaining members, which drives even more young and healthy people to leave. This is a downward spiral – a 'death spiral' – for the industry.

This chapter shows that consumers are paying more for private health insurance and, in many cases, getting less for their money. Subsequent chapters show why premiums have been rising so rapidly, and what government should do about it.

1. There are two types of private health insurance – 'hospital insurance', and 'general insurance' which covers extras and ancillaries. This report does not focus on 'general insurance', so any references to private health insurance should be taken as references to private hospital insurance unless otherwise stated.

Figure 1.1: Premiums have grown much faster than wages

Cumulative increase in inflation-adjusted average private health insurance premiums and average weekly ordinary time earnings, per cent



Notes: 'Net PHI premiums' shows the change in premiums after the PHI rebate is taken into account. Net premium shown is for people aged under 65, in the base income tier (in 2018-19, below \$180,000 for families and \$90,000 for singles). Annual average rebate percentages used to calculate net premiums.

Sources: Grattan calculations based on ABS (2019a), ABS (2019b), ATO (2019) and Department of Health (2019a).

1.1 Private hospital insurance is becoming increasingly unaffordable

PHI premiums have grown faster than wages in recent years (see Figure 1.1).² Since 2010-11 premiums have increased by 30 per cent, after adjusting for inflation, compared to total real wages growth of 8 per cent. The gap between growth in wages and premiums is even bigger when the reduced rebate is taken into account.

In the past decade, the number of people eligible for the rebate has fallen. For those who receive it, the value of the rebate has been reduced as a percentage of premiums. This means that the net premium paid by consumers – the premium after the rebate is deducted – has grown even faster than the gross premium. For people of working age, in the lowest income tier (under \$180,000 for couples or \$90,000 for singles), the net premium has grown by around 39 per cent in real terms since 2010-11. The reduction in the rebate has exacerbated the affordability problem with private insurance – but the bulk of the increase in the cost of insurance to consumers is due to rises in gross premiums, not the reduced rebate.

1.2 Surprise and large out-of-pocket costs are diminishing the value of PHI

The size of premiums is not the only factor causing more and more consumers to question whether they get value for money from PHI. Even many consumers with ‘top level cover’ are left paying large and often unexpected out-of-pocket costs when they use their health insurance. Consumers see these costs as diminishing the value of health insurance.³

2. This is also discussed in a recent Grattan Institute working paper; see Duckett and Nemet (2019a).

3. Private Healthcare Australia notes that the number of people who cite medical out-of-pocket costs as a reason for dropping PHI has more than tripled over the past

Research by Roy Morgan shows that out-of-pocket costs are the second major concern among consumers when it comes to decisions about renewing PHI. In the year to March 2018, the proportion of consumers that gave out-of-pocket costs as the reason for dropping their PHI increased from 12.8 per cent to 19.1 per cent.⁴

Grattan Institute’s report on private hospitals showed that a handful of greedy doctors are responsible for 90 per cent of out-of-pocket costs. Patients have no certainty about the total costs they will have to pay, and, after paying health insurance for years, are left still having to pay thousands of dollars above the ‘maximum’ excess they signed up for.⁵

1.3 More people have low-value insurance

With premiums rising rapidly, insurers have created a plethora of new products that allow people who are concerned about the affordability of insurance to downgrade, rather than entirely drop, their coverage. These include basic policies with many exclusions and high excesses, and those which only cover care in a public hospital (sometimes called ‘junk policies’).

But the growing range of products – with many combinations and variations – has added to the complexity facing consumers when they buy and use their PHI, making it more difficult for people to fully evaluate the value of a product. The products are opaque and complicated. In some cases, policies with lower levels of cover are, perversely, priced higher than policies with better cover.⁶

five years, and has now reached 32 per cent of participants: Private Healthcare Australia (2019, p. 20).

4. Roy Morgan (2018).

5. Duckett and Nemet (2019b).

6. Richard (2019).

1.4 A complex mix of PHI products and offerings

Since 1 April 2019 all hospital insurance products have been classified as Gold, Silver, Bronze, or Basic.⁷ Gold policies provide full cover for hospital accommodation and in-hospital medical charges, with no exclusions. Other policies may require an additional payment, or provide lower cover, in exchange for a reduced premium.

Policies with exclusions mean that no benefits are payable for certain services if the patient chooses to be treated privately,⁸ or the insurer may pay only limited benefits.⁹ In either case, if a private patient is admitted to hospital for treatment that is excluded or restricted by their policy, they could incur large out-of-pocket costs.

Policy holders may agree to pay a specified amount each time a service is provided (referred to as a co-payment). For a hospital policy, it is the amount a patient agrees to pay for each day they are in hospital. A patient may also be required to pay an amount towards the cost of hospital treatment, in the form of an excess. The excess payable will depend on the policy – it may be required every time the patient goes to hospital, subject to a maximum limit, or only the first time.

Consumers cannot make an informed decision about their cover – and upgrade where necessary – unless they are provided with the right

7. Insurers have until 1 April 2020 to complete the transition of existing products to the new system.
8. Medicare will pay 75 per cent of the schedule fee for eligible services.
9. There is no limit on the number of services that can be restricted or excluded, providing that the product meets the minimum coverage requirements set out in the *Private Health Insurance Act 2007*. The Act requires that hospital policies provide minimum benefits for psychiatric, rehabilitation, and palliative care services if treatment is provided in a hospital setting (or community-based setting if the patient is covered for hospital substitute treatment): s.72-1(2). Insurers must provide a benefit for hospital treatment for which a Medicare benefit is payable.

Box 1: PHI is a worse deal outside the major cities

People living outside the major cities generally get a poor deal from PHI. Fewer private hospitals and doctors in regional areas means people may have to travel long distances to receive treatment, often at an additional financial cost.^a Limited access to 'preferred providers' means that people living in remote areas effectively pay the same premium as people in metropolitan areas, but may face higher out-of-pocket costs.

Unsurprisingly, PHI policies are less attractive to people in remote Australia. These people pay the same premiums but get less value for their money. They are effectively subsidising people who live in the major cities and inner regional areas.^b

- a. Since 1 April 2019 insurers can offer accommodation and travel benefits under hospital cover for people in rural and regional areas: Department of Health (2019b).
- b. Lokuge et al (2005); and Bourke et al (2012).

information to consider the impact of any changes.¹⁰ People find it hard to understand and compare policies. A survey by Choice found that 44 per cent of consumers found it difficult to compare policies, compared to only 28 per cent who found it easy. Reasons provided were trouble comparing policies side by side, including comparing out-of-pocket costs if admitted to hospital, as well as inconsistent information across insurers, and confusing terminology and language.¹¹ The new system of categorising hospital policies into Gold, Silver, Bronze, and Basic is intended to simplify health insurance by making it easier for consumers

10. This can have significant consequences, including unexpected out-of-pockets, inadequate coverage, lost switching opportunities, and limited access to health care: ACCC (2015).
11. Choice (2017, pp. 12–13).

to compare products and understand what is and isn't covered.¹² It is a good first step to achieving greater transparency of product offerings, but the addition of 'plus' categories (Silver plus, Bronze plus) has complicated the simple scheme, almost returning the product offerings to the same complicated mess the system replaced.¹³

1.5 Consumers are taking on more risk

Consumers have increasingly saved money on their premiums by downgrading their cover. There has been a marked increase in the proportion of policies with 'excesses' and/or 'exclusions'. Twenty years ago, only one third of policies had any exclusion or excess. Today, more than 84 per cent of policies have some form of excess or exclusion (see Figure 1.2).

Consumers often do not understand what they have opted out of by downgrading to a cheaper policy, and then find that they are not covered when they need it. Consumer complaints about hospital exclusions and restrictions have been the main source of complaints to the Private Health Insurance Ombudsman over the past decade (See Box 2).

Consumers save money upfront on their premiums with low-value plans – the higher the excess and/or greater the exclusion, the lower the premium. But they pay more if they are admitted to hospital under policies with an excess or, depending on the procedure, under policies with exclusions.

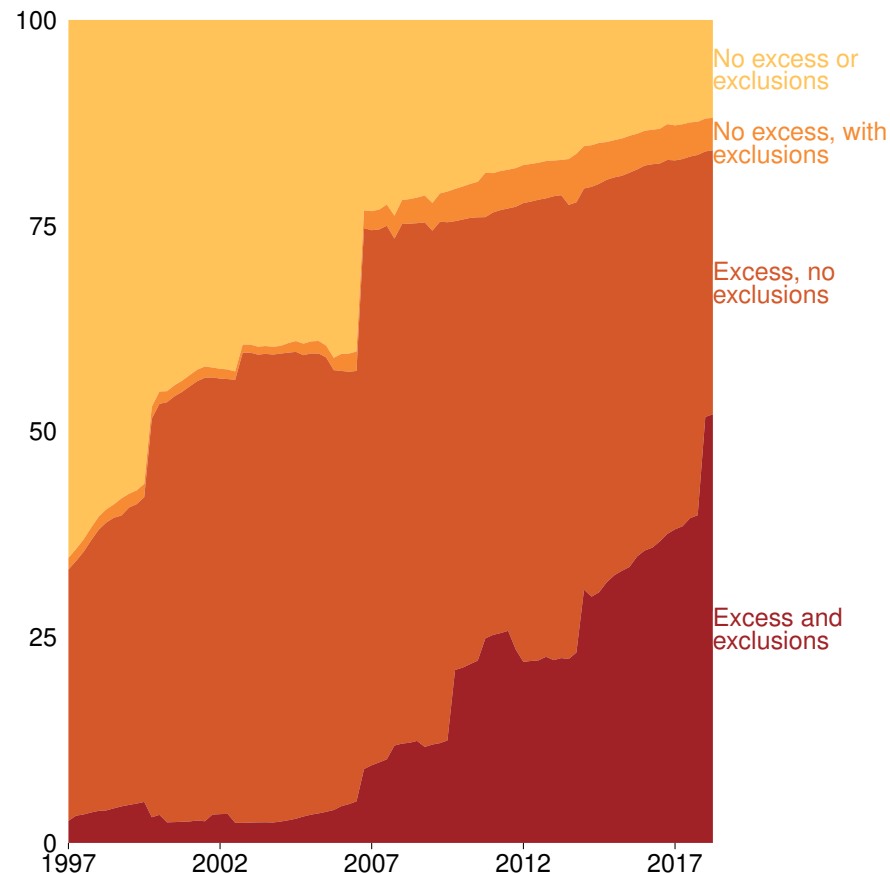
The nature of private health insurance has changed dramatically for many consumers. It represents a shift in risk from insurers to consumers who may not be able to make informed choices about the risks they are taking. Consumers are taking on substantial risks, which are difficult for an individual to judge, including:

12. Department of Health (2018).

13. Mihm (2018).

Figure 1.2: Fewer people now have 'top cover'

Proportion of hospital treatment policies, per cent



Notes: Policies with an excess require a payment by the contributor towards their hospital admission. A policy with exclusions designates certain treatments or procedures not covered by the policy.

Sources: APRA (2019a) and Grattan analysis.

- liability for excess or co-payment (which may not represent good value relative to the lower premium, depending on the probability of having hospital treatment);
- liability for medical billings from out-of-pocket costs;
- forgoing medical coverage for some procedures (which may or may not represent good value, depending on the person's propensity for that condition).

As a result, it is not surprising that consumer dissatisfaction with health insurance has increased and participation rates are declining.

1.6 Junk policies are only adding to the problem

As more people have opted for 'junk' policies, complaints to the Ombudsman regarding benefits have increased (see Box 2). Choice identified 'junk policies' which may offer limited benefits to consumers, such as

- Private hospital policies that provide cover only for a small number of procedures – such as accidents, appendix surgery, knee investigations, and wisdom teeth removal – but exclude all other services or offer cover only in a public hospital;
- Policies that only provide cover only as a private patient in a public hospital.¹⁴

Some people take out junk policies in response to incentives for buying insurance such as the Medicare Levy Surcharge, a tax penalty paid by people with moderate to high income who do not have PHI.

14. Ibid.

1.7 Consumers don't always get what they pay for

Sometimes the rules of the game are changed without consumers being properly informed. Changes to products after purchase, including insurer rules, benefit entitlements, and provider arrangements, have also undermined consumer confidence in PHI. For example, consumers may not be aware – either due to a lack of information or ambiguous information – of changes to their policy reducing cover until they are admitted to hospital, at which point they may already be facing large out-of-pocket costs.

The ACCC has identified a number of cases where it says consumers received no notification of changes to their benefits, or where notification was given but was poorly communicated. The ACCC has taken legal action against several insurers for allegedly misleading consumers.¹⁵

15. *Australian Competition and Consumer Commission v Medibank Private Limited* [2017] FCA 1006; *Australian Competition and Consumer Commission v Medibank Private Limited* [2018] FCAFC 235.

Box 2: Unexpected exclusions, restrictions, and out-of-pocket costs are major concerns for consumers

In 2017-18, the office of the Commonwealth Ombudsman received a total of 4,553 complaints relating to PHI. Benefits continued to be the major concern, accounting for 34 per cent of complaints in 2017-18. Complaints relating to membership (18 per cent), information (10 per cent), and service (14 per cent) were also prominent.

The main concerns about benefits were hospital policies with unexpected exclusions, restrictions, and out-of-pocket costs. The share of complaints relating to exclusions has been rising since 2013-14. Basic policies can restrict and/or exclude services which consumers assume are routine treatments and included in their cover. Complaints relating to out-of-pocket costs reflected consumer dissatisfaction with the additional costs for treatment being higher than expected.

Concerns about insurer rules also represented an increasing share of complaints relating to benefits. This involved disputes regarding changes to policies that reduced the level of cover and services provided.

2 Premiums are rising because young people are dropping out

The rapid rise in average private health insurance premiums in recent years is not due to the private insurance industry paying out more in profits to their shareholders or soaking up a larger proportion of revenues in management expenses. Premiums are rising rapidly because the amount that funds are paying out in benefits to members is rising rapidly.

Benefits are rising because the population is ageing, and the privately insured population is ageing even faster. This is the PHI downward spiral: as the pool of insured people gets ever older, the amount that funds must pay out in benefits increases. To cover this cost, funds must raise premiums, which leads younger and healthier people to drop out, which perpetuates the cycle.

Benefits are also rising because Australians of all ages are using more health services, and because the price of health services has risen faster than inflation.

2.1 Premiums are rising because benefits are rising

A common perception is that private health insurance premiums are rising because of an excessive increase in insurance funds' profits, or management expenses, or both. This is not the case.

In 2017-18, private health insurers took in \$23.9 billion worth of revenue from members' premiums. They paid out 85.8 per cent of this – \$20.5 billion – to members as benefits.¹⁶ This is a little up on a decade earlier, when funds paid out 85.2 per cent of premium revenue to members in the form of benefits. In total across the industry,

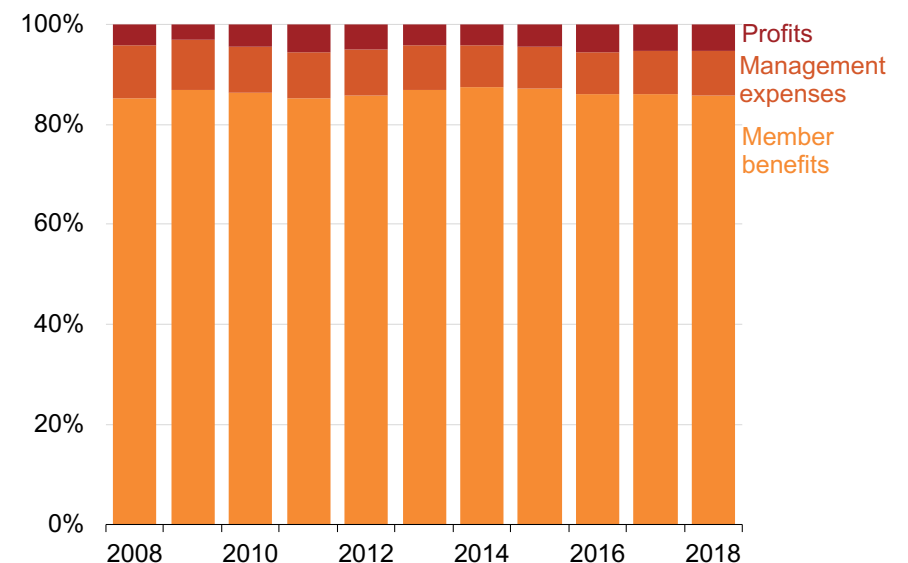
16. APRA (2019b). Premium revenue amounted to \$23.9 billion, with the balance coming from investments and other sources. Figures include general insurance revenue and benefits.

management expenses and profits are little changed, as a proportion of revenue, from a decade ago (see Figure 2.1). Of course, some individual funds have increased their margins over this period, while some have reduced their margins.

Premiums have risen more or less in line with the rise in member benefits. Those benefits, in turn, are rising because the average age

Figure 2.1: Insurers are paying out as much as they always have

Profits, management expenses, and member benefits as a percentage of premium revenue



Notes: 'Profits' refers to net margin; this is the surplus from insurance activities before tax and investment income. It includes the surplus of not-for-profit funds.

Sources: APRA and PHIAC Operations of Private Health Insurers annual reports, various years.

of PHI members is rising, because PHI members of all ages are using more health care services, and because health care prices have risen faster than inflation.

2.2 Benefits are rising because the pool of insured people is getting older

Australians are living longer. A baby born in 2017 could expect, on average, to live for 82.6 years – compared to just 76.3 years for a baby in 1987, or 71.2 years in 1967.¹⁷ This rise in life expectancy in part reflects advances in the quality and quantity of health services Australians receive. Longer lives also mean that people use more health services.

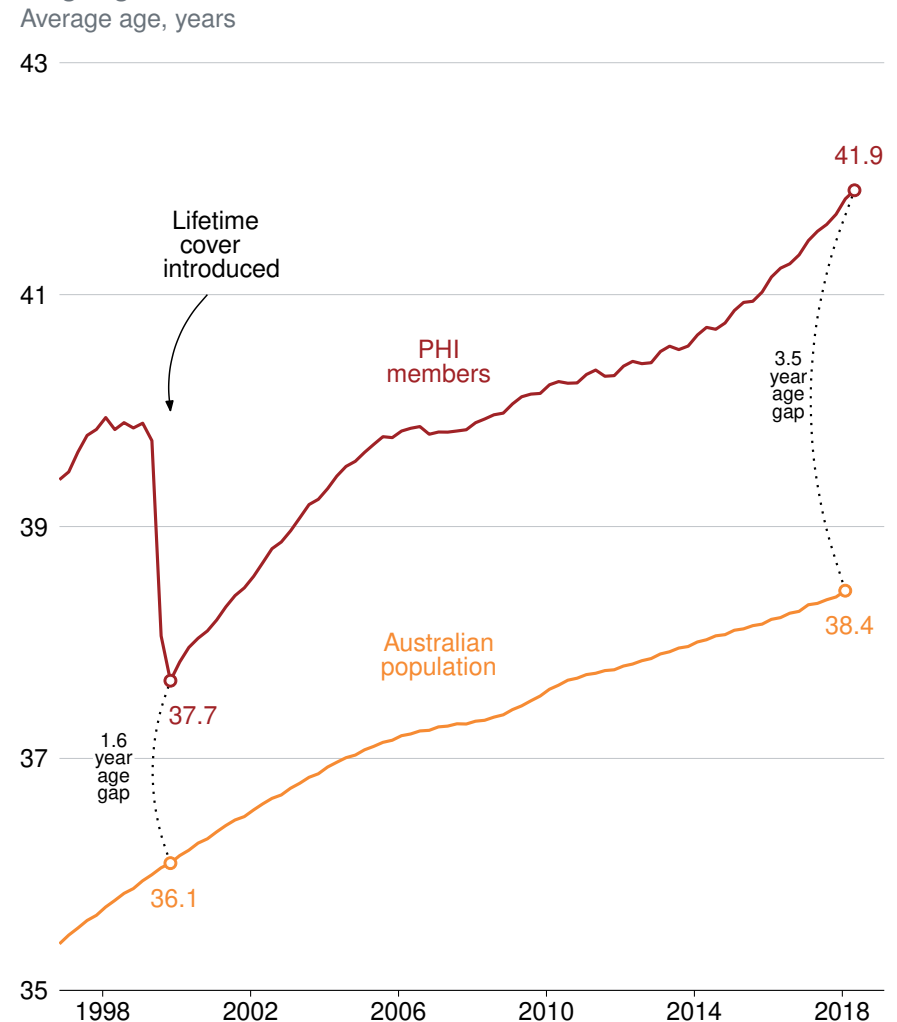
The Australian population is ageing, and the membership base of private health insurers is ageing even faster. After Lifetime Health Cover was introduced in 2000, the average age of people with private hospital insurance was 37.7, just 1.6 years older than the Australian population as a whole. In 2019, the average PHI member is about 3.5 years older than the average Australian (see Figure 2.2). The gap has grown particularly rapidly since 2014.

This rising average age of PHI members is a problem. Healthier – typically younger – members cross-subsidise the benefits of sicker – typically older – members. This has always been the case, but the size of the cross-subsidy has grown as the insurance pool has aged. Each working-age PHI member now has to cross-subsidise many more older people than in the past.

When Lifetime Health Cover was introduced in 2000, there were 8.5 PHI members aged under 65 for every member aged 65 or older. By 2009, this had fallen to 6.3 members, and in 2019 the figure was just 4.3 members.

17. OECD (2019).

Figure 2.2: The Australian population is ageing, but the PHI membership is ageing faster



Note: 'PHI members' refers to people with hospital insurance.

Sources: ABS (2019c) and APRA (2019a).

A dwindling number of working-age private insurance members are supporting the claims of an ever-growing number of older members. Over the 10 years to September 2019, the number of people aged 65 and older who are members of a private health insurance fund increased by nearly 60 per cent.¹⁸ All other age groups have grown by 10 per cent or less. The number of people aged 20-39 with private insurance is lower in 2019 than it was in 2015 (see Figure 2.3). The fall in membership since 2015 is also evident in the older 40-64 group.

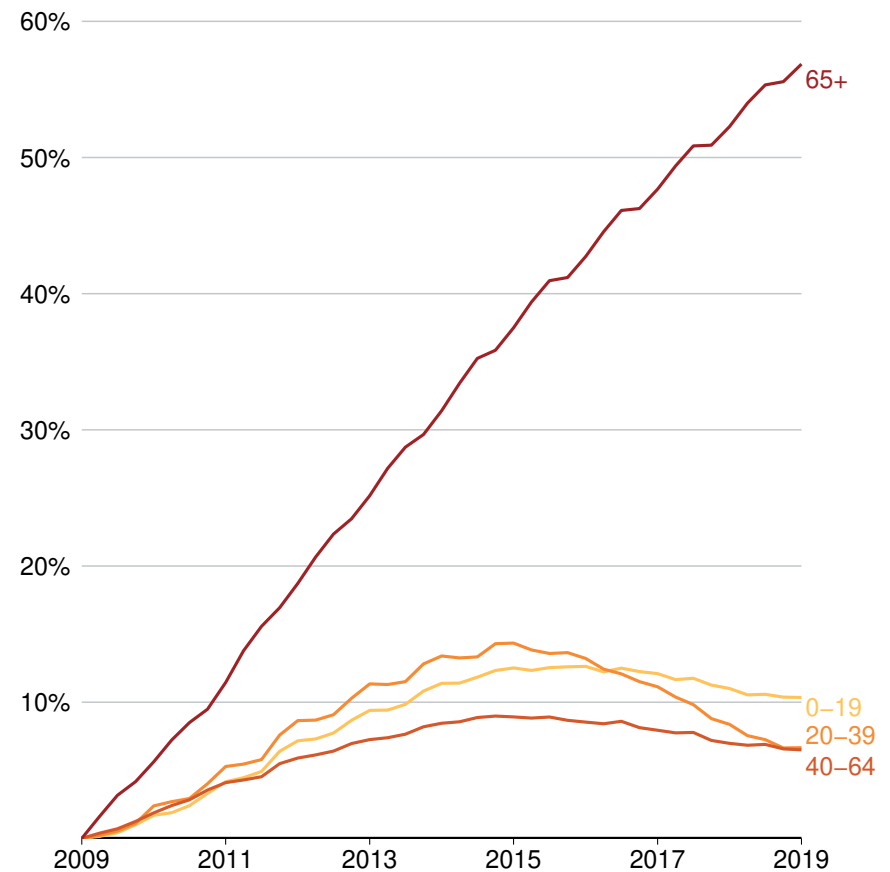
The number of older people with private health insurance has grown rapidly, but the share of PHI benefits going to older people has grown even faster. In 2009, 46 per cent of PHI benefits were paid to people aged 65 and older; by 2019 this had risen to 55.4 per cent. More than half of the funds that private insurers pay out in hospital benefits goes to people aged 65 or older.

These trends are unsustainable. They are also self-reinforcing. As older people come to represent a larger share of the insured population and claim an even larger share of PHI member benefits, insurers must respond by increasing the premiums charged to all members – because funds’ ability to charge different premiums to people of different ages is severely curtailed by government regulation, in line with the principle of ‘community rating’. (Community rating is the requirement that people are charged the same premium for the same insurance product, regardless of their age).¹⁹ This increase in premiums induces younger and healthier people – for whom private

18. Some of the rise in coverage among older people may be explained by the diminishing proportion of older Australians who are entitled to government-funded treatment under Veterans’ Affairs Gold Cards. Membership rates among working-age Australians may be somewhat inflated by an increase in the number of short-term migrants, who are required to hold private insurance. See Gale (2019) for discussion of these issues.

19. Since 1 April 2019, PHI funds have been able to offer discounted membership to people aged 18-29, which represents a loosening of the community rating principle.

Figure 2.3: Younger people are leaving PHI, older people are not
Cumulative change in the number of people with private hospital cover, per cent



Source: APRA (2019a).

insurance offers less value for money – to drop their cover, or not take it out in the first place. This exacerbates the ageing of the insurance pool, with older people now representing an even larger share of the insured population.

Without some kind of intervention to break the cycle, it's likely that the average age of people with PHI coverage will continue to rise rapidly, as shown in Section 2.6. This will continue to put upward pressure on premiums.

2.3 People are using more health services

Australians are using the health system more as they get access to new technologies, treatments, and services.²⁰

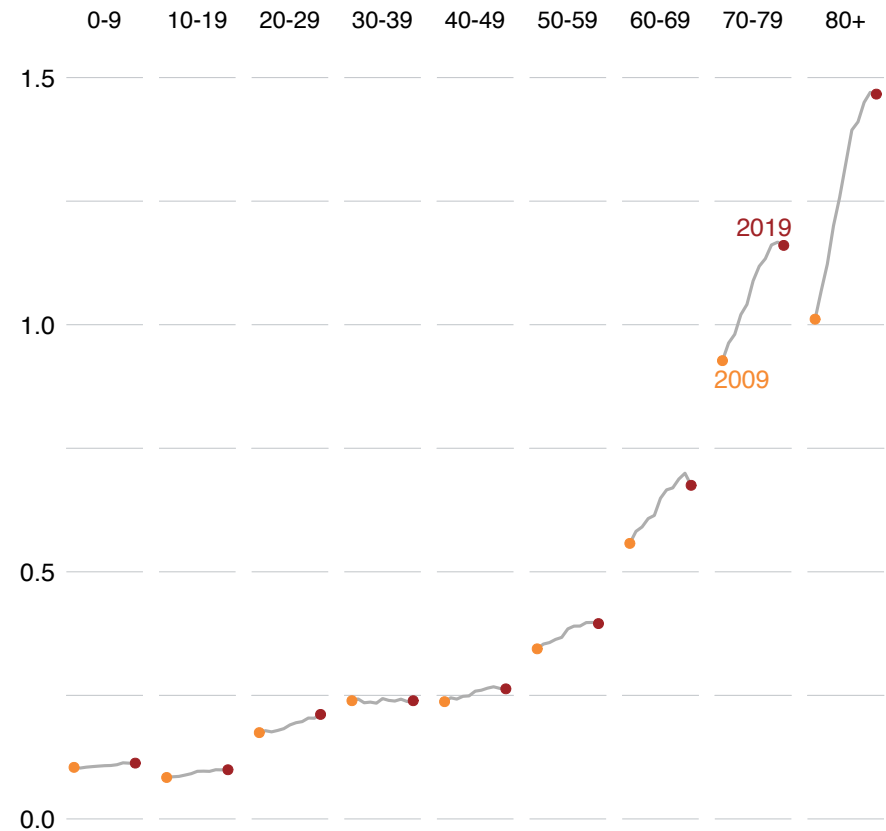
Australians – particularly, but not only, older Australians – are going to hospital more often. Figure 2.4 shows the average number of private hospital episodes per PHI member per year over the past decade.

Within each age group, the average number of episodes per person has risen. Private hospital episodes have risen most sharply for older age groups, particularly for PHI members aged 70 and above. In 2008-09, PHI members aged 70 to 79 had an average of 0.93 private hospital episodes per year; by 2018-19, this had risen to 1.16, an increase of nearly 25 per cent. The increase in private hospital utilisation was even larger among PHI members aged 80 and above.

The increase in the volume of health care services people are receiving adds to the cost pressures on PHI funds, which in turn puts pressure on premiums. The fact that rising hospitalisations are concentrated among older people means that a rising share of premium revenue must be directed towards these older members, adding to the erosion of value for younger members.

Figure 2.4: PHI members are going to the hospital more than they used to, especially older members

Average number of private hospital episodes per PHI member per year by age, 2009 to 2019



Note: Includes all hospital and hospital-substitute treatments for which a benefit was paid by a private insurer.

Sources: APRA (2019a) and Grattan calculations.

20. Productivity Commission (2017a); and AIHW (2016).

2.4 Health care prices are rising faster than inflation

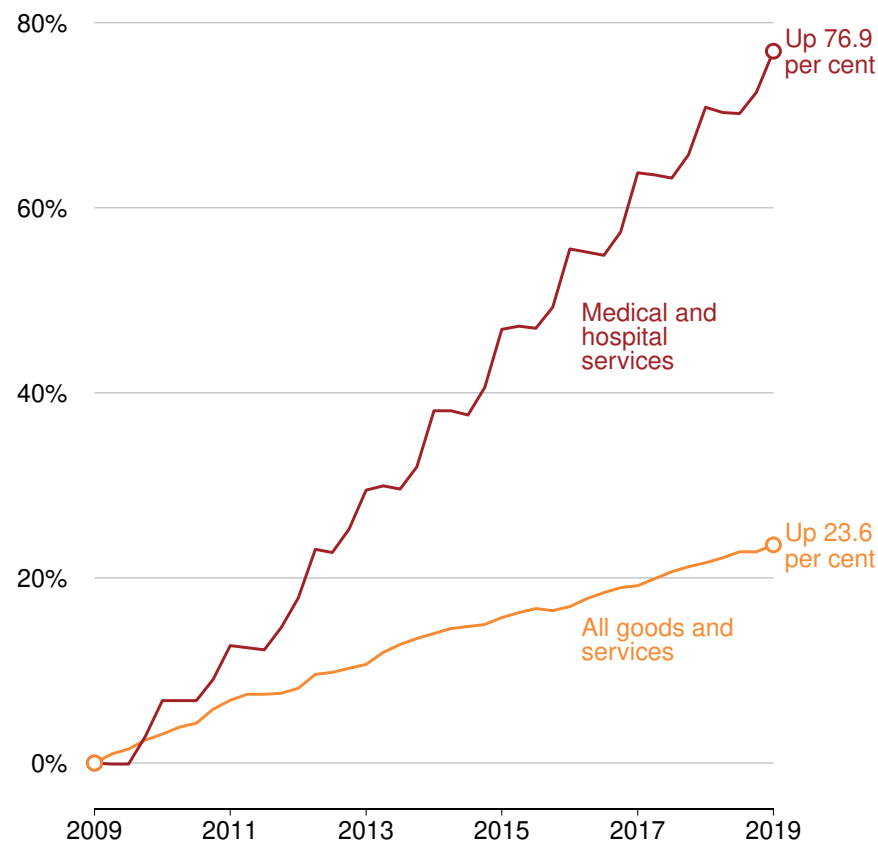
Australians are using more healthcare services. The price of those services is also growing much faster than overall inflation. Over the past decade, the Consumer Price Index (CPI) for all goods and services has risen by an average of 2.1 per cent per year. Over the same period, the price of medical and hospital services rose nearly three times as fast – an average of 5.9 per cent per year.²¹

The result of this ‘excess’ health cost inflation is that the price of medical and hospital services is nearly 80 per cent higher than it was a decade ago, while the overall price of goods and services in Australia has risen by only about a quarter (see Figure 2.5).

The rising price of health services is not confined to the private system. Health cost inflation also affects the public system, as well as areas of health spending that are funded mostly from patients’ pockets. But the price rises contribute to the pressure on private health insurance premiums.

Even if the population had not aged, and even if people had not used more health services, real spending on benefits to PHI members would still have risen, due to this ‘excess’ health cost inflation. It is highly likely that health prices will continue to rise faster than overall inflation, so the pressure on PHI premiums from excess health cost inflation will continue.

Figure 2.5: Health prices have risen much faster than overall inflation
Cumulative change in consumer price index since June 2009



Sources: ABS (2019a) and Grattan calculations.

21. Compound annual growth rate over the decade to June quarter 2019: Grattan calculation based on ABS (2019a).

2.5 Ageing is the most important factor in premium growth

Rising premiums have been driven by rising benefits (see Figure 2.1). Benefits have risen due to the ageing population and the even-more-rapid ageing of the PHI membership base (Figure 2.2), the increase in health service use (Figure 2.4), and health price inflation that has outstripped general inflation (Figure 2.5).

Each of these factors has been important. The contribution of each of these factors to the growth in real benefits per member over the past decade is shown in Figure 2.6. In 2008-09, PHI funds paid out an average of \$1,027 per member, in inflation-adjusted 2019 dollars. By 2018-19, they paid out \$1,351 per member, a real increase in benefits of \$324 over the decade.

Nearly half of this increase in inflation-adjusted benefits – \$158 – was due to ageing, both of the population as a whole and of the PHI membership base in particular. The increased use of hospital services by PHI members contributed \$109 to the increase, with the remainder due to health costs rising faster than the CPI.

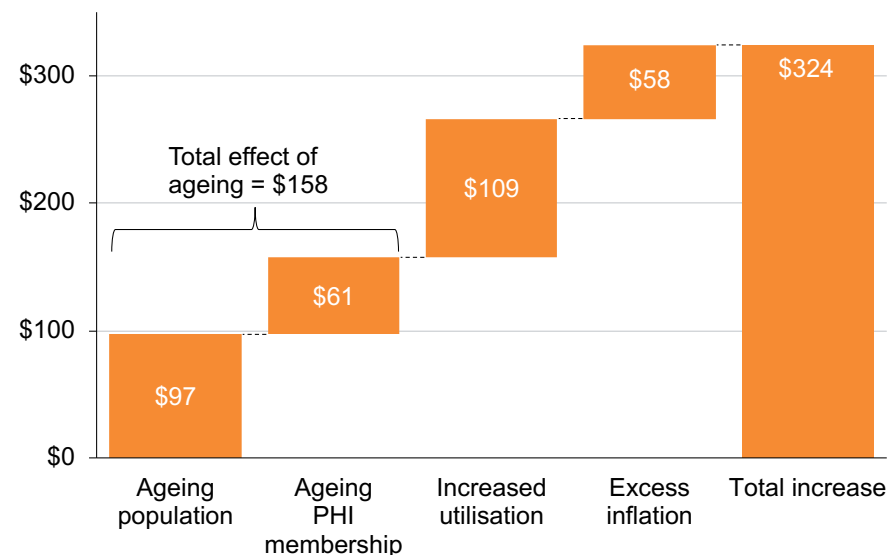
2.6 The affordability problem will only get worse

All the trends contributing to rising benefits – and in turn rising premiums – are likely to continue. The Australian population will continue to age; people of all ages will use more health services; and the price of health services will continue to outstrip overall inflation.

If current trends continue, PHI membership for people under 65 will drop by nearly 10 percentage points from its peak by 2030, membership of people aged 65-69 will also decline marginally, while the highest use group, people over 70, will likely maintain their membership. This changed age composition represents a significant deterioration of the risk pool for insurers.

Figure 2.6: Ageing, utilisation, and inflation have all contributed significantly to rising PHI benefits

Change in inflation-adjusted PHI benefits per member, 2009-09 to 2018-19



Notes: Benefits include hospital and hospital-substitute treatments. 'Utilisation' measured as days per member. 'Excess inflation' is the change in CPI-deflated cost per day. Uses decomposition method set out in Productivity Commission (2005).

Sources: Grattan calculations based on ABS (2019c), APRA (2019a) and ABS (2019a).

Our projection of future health insurance membership

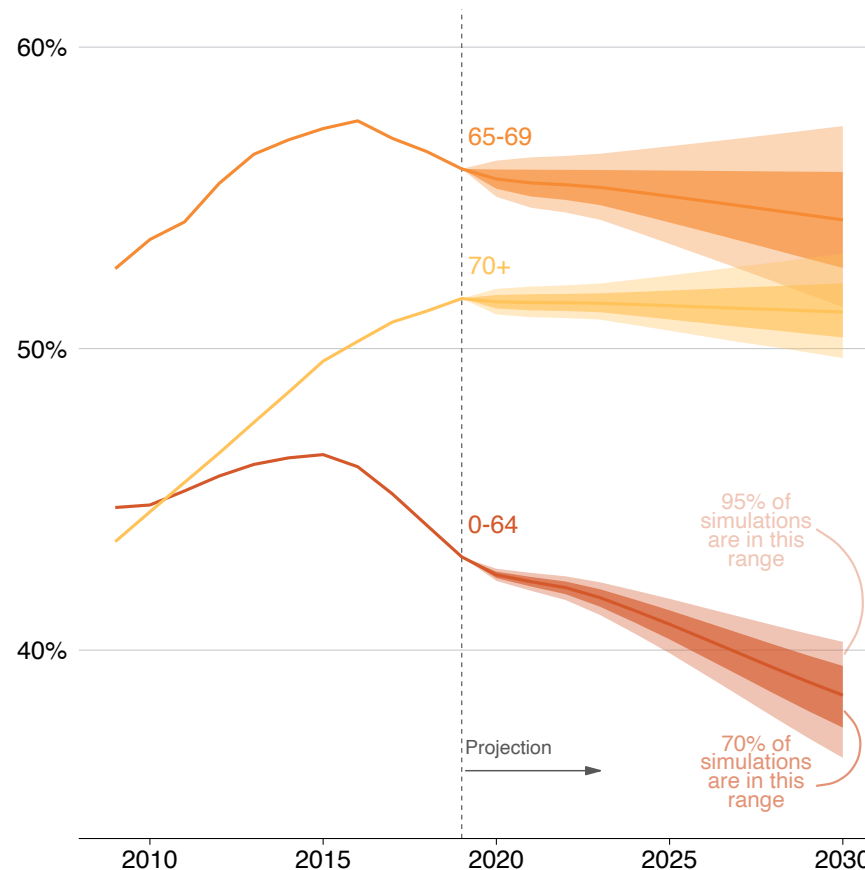
Figure 2.7 shows a projection of the proportion of people in each age group who are likely to have private hospital insurance in the future if there is no change to the way the industry operates. If the private health insurance industry carries on with business as usual, premiums will keep rising, younger people will continue to drop out, and community rating will become unsustainable.

On our central projection, less than 41 per cent of the population will be covered by private hospital insurance in a decade's time. The recent pause in rapid premium growth is projected to come to an end, with premiums set to rise by over 5 per cent per year once again. The ageing of the PHI membership base is set to continue – we project that there will be around 3.3 PHI members aged under 65 for every member aged 65 and over by the end of the decade, compared to a ratio of 4.3 today.

The projections shown in Figure 2.7 are based on a relatively simple framework, which is set out in detail in Appendix A. The projections are likely to be somewhat optimistic for private hospital insurance, as they do not incorporate the effect of people moving into higher income brackets, which reduces their PHI rebate and therefore increases the price of insurance, which will cause at least some people to drop their coverage.

We project the average hospital bed-days per member, and the cost per bed-day, within each age group, assuming that future growth in these will reflect growth in recent years. We also use ABS projections of population growth of different age groups. We then calculate the premium that would be required to meet expected benefits plus a standard industry mark-up in each year. Individuals choose whether or not to remain a member of a PHI fund each year based on the change in the price of insurance, which is the net premium divided by expected benefits for a person of their age.

Figure 2.7: The spiral is likely to continue
Projected PHI membership by age, per cent of population



Note: See Appendix A for projection methodology.

Sources: Grattan calculations based on ABS (2019a), ABS (2019c) and APRA (2019a).

We use a plausible range of estimates of the impact of these price changes on fund membership of different age groups, informed by the academic literature. This projection framework captures the feedback loop between rising benefits (and therefore premiums) and falling membership among younger members, and provides a plausible path for future PHI membership under unchanged policy settings. These projections are 'conservative', because they understate the increase in net premiums that consumers will face as they move into higher income brackets that receive a lower rebate.

2.7 Conclusion

Premiums are rising rapidly, driven by an increase in benefits, which is in turn due to demographic trends, increased use of health services, and the fact that health prices have risen faster than inflation. The rise in premiums is causing young people to downgrade, drop, or not take out private hospital insurance. The loss of younger and healthier members from the pool means that premiums have to increase even faster, spurring even more people to drop their cover. Without policy change, these trends will continue.

These trends make community rating unstable. Yet community rating has historically been seen as the bedrock of the current private health insurance system in Australia.

The private health insurance industry needs to undergo a major transition, to put it on a more sustainable footing. This transition should be gradual, so there is no disruption to the delivery of health care, including in the public system.

3 What is government doing to support private health insurance?

Private health insurers are required to charge all members the same premium, regardless of their age, health status, or other characteristics.²² This principle is known as ‘community rating’ and is designed to enable people with poor health status to purchase health insurance at a reasonable price.

Community rating has been part of the health insurance landscape since the introduction of subsidies for health insurance in the early 1950s. Its place in insurance policy was not re-examined as part of the policy shift from voluntary private to universal health insurance in the 1970s and 1980s.²³

Community rating exists to ensure that younger, healthier people cross-subsidise older, sicker people. This necessarily makes health insurance a less attractive proposition for the young and healthy. Community rating was designed to facilitate access to private health insurance for everyone; it is now effectively deterring younger people from taking out insurance.

A burdensome regime of regulatory requirements designed to support community rating restricts the operation of insurers. These rules are supplemented by subsidies and penalties to encourage participation in PHI. PHI coverage over the past two decades has been maintained largely due to these carrots and sticks.²⁴

22. Individuals can self-select into different levels of cover, such as ‘Gold’ or ‘Basic’, with different premiums; the premium for the same level of cover cannot vary by age. Premiums vary by state. The Lifetime Health Cover loading for people who obtain hospital insurance after they turn 31 is paid on top of the premium.

23. This is just another example and consequence of the failure to conduct a comprehensive review of the role and functioning of private health insurance in Australia; see Duckett and Nemet (2019b).

24. See Duckett and Nemet (2019a).

3.1 Community rating

For most types of insurance, the premium a person pays is related to the risk they pose to the insurer. If your house is at a high risk of being robbed, or burning down, you’ll pay more for house insurance. Policyholders pay different premiums based on the risk they’ll make a claim, and the expected size of that claim.

Health insurance is different. Private health insurers are not allowed to charge different premiums for the same product to people with a different risk of making a claim.²⁵

Systems for setting insurance premiums lie on a spectrum. At one end of the spectrum is a pure community rating system – everyone pays the same premium for the same level of coverage. At the other end is a system based on risk rating, in which each member’s premium reflects the benefits that someone with their risk profile can expect to receive from the policy.

Australia’s current system is close to the pure community rating end of the spectrum. Government regulations require that funds charge the same premium for the same product to people of different ages. However, funds offer a range of different products and, in practice, the premiums paid by people at different ages are not identical. Younger and healthier people typically opt for cheaper products with lower benefits.²⁶ Private health insurance funds also segment their marketing strategies to entice people with a lower risk profile into their

25. From April 2019, insurers have been able to offer discounts of up to 10 per cent to members who join before age 30. Insurers can also charge different premiums in different states and territories.

26. The exception being people contemplating having a baby in the immediate future, who may drop their insurance shortly after they have completed their families.

products. Since 1 April 2019, funds have also been able to offer slightly discounted membership to people aged 18-29, which also represents a departure from the community rating principle. Lifetime health cover (discussed in Section 3.2.1) also means that people who first take out health insurance after turning 31 pay a higher premium.

As noted in Chapter 2, community rating is unstable.²⁷ It relies on cross-subsidies from people with low expected use of health services to people with high expected use. The bigger the cross-subsidy the less attractive insurance becomes for people least likely to need it.

In the absence of any alternative, people who don't expect to use health care might still take out insurance if they are concerned about catastrophic costs of an unexpected illness. In Australia, however, Medicare ensures that bankruptcy is not the alternative to private insurance, which further diminishes the appeal of private health insurance.

Community rating is one of the underlying causes of the recent youth exodus from private health insurance. Older people generally receive more in benefits than the premiums they pay, while younger people pay much more than they get back. On average, PHI members aged 25-30 received \$713 per person in benefits from their insurance funds in 2018-19.²⁸ People aged 40-45 got even less – an average of \$690 per member. This is substantially less than the average premium. By contrast, PHI members aged 65-70 received an average of \$2624 per person in 2018-19, and people aged 85-90 got \$6374, substantially more than the community-rated premium.

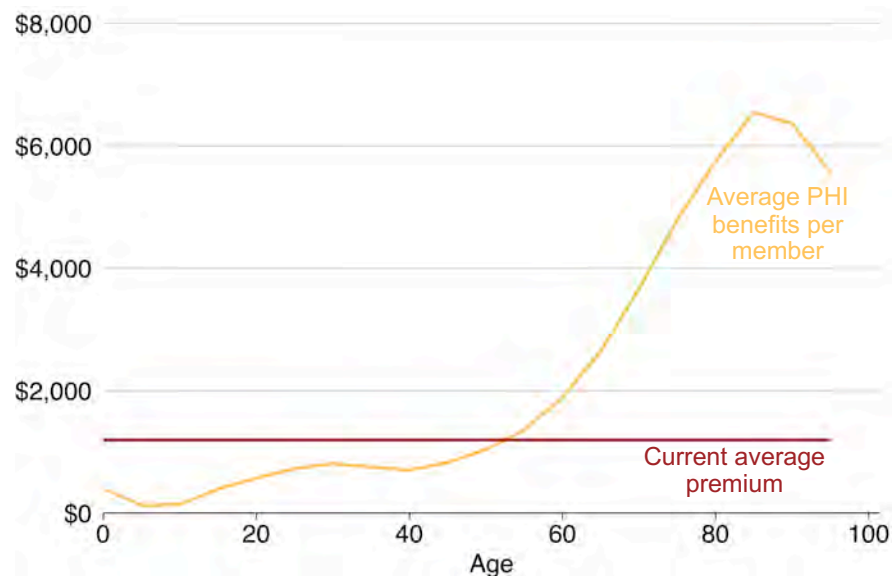
The difference between the community-rated premium and the average amount that people of different ages receive in benefits is shown in Figure 3.1.

27. Butler (2003). Zweifel and Frech (2016). Barrett and Conlon (2003).

28. APRA (2019a). Figures include benefits for hospital and hospital-substitute treatments; they do not include general benefits.

Figure 3.1: Young people pay a lot more in premiums than they get back in benefits

Private hospital insurance net premium and average benefits received, dollars per member per year, 2019-20



Notes: Current premium is a simple average that does not account for differences in product type or rebate levels across the population. The actual premiums paid by individuals vary due to different levels of coverage, and variation in the level of the rebate, which is means tested and varies by age.

Sources: Grattan calculations based on APRA (2019a).

Community-rated premiums are only viable if large numbers of young people choose to insure and so subsidise those with high claims costs. But, as shown in Chapter 2, fewer young people are cross-subsidising the old, and this trend is worsening.

Community rating has also created some perverse effects. For instance, it has dampened the incentives for funds to control costs, particularly in those risk categories covered by risk equalisation.²⁹

3.2 Carrots and sticks

Private health insurance relies on a range of policy carrots and sticks that encourage people, particularly younger people, to sign up. In the late 1990s, only around 30 per cent of Australians had private hospital cover, and coverage among younger people was much lower than current levels.³⁰

Three main policies have been responsible, to varying degrees, for boosting the PHI participation rate since then: Lifetime Health Cover, the Medicare Levy Surcharge, and the Private Health Insurance Rebate.

3.2.1 Lifetime Health Cover

Membership rose to around its current levels, as a proportion of the population, after the introduction of Lifetime Health Cover in July 2000.

Lifetime Health Cover (LHC) is designed to boost membership among young people by penalising them for taking out health insurance later in life. It applies a 2 per cent loading³¹ on top of the standard premium for every year a person remains uninsured after the age of 31.

29. Risk equalisation is the process where some costs of claims on a health insurer are shared across all health insurers. We discuss this issue in Section 3.3.

30. APRA (2019a); see discussion in Duckett and Nemet (2019a).

31. The maximum loading is 70 per cent and is removed after 10 years of continuous membership.

The most effective of the carrots and sticks introduced during the Coalition government of the 1990s-2000s, LHC led to a significant increase in hospital insurance among young people and a decline in the average age of the insured population (see Figure 2.2).³² But the recent decline in membership among people aged 20-39 suggests that LHC may no longer be as strong an inducement as it once was.

Indeed, LHC may act as a disincentive for people aged over 30 to take out private hospital insurance. For example, if a person decides to take out hospital insurance at age 40, they will pay 20 per cent more than someone who first took out cover at age 30, making insurance more expensive and so a worse proposition if they are healthy. The policy might induce some people to take out insurance at age 30, but those who choose not to may feel 'locked out' of insurance by the LHC loading.

Since April 2019, insurers have been permitted to offer people aged 18-29 discounts of up to 10 per cent on their hospital insurance premiums. The discount is retained until the age of 41. The allowable discount is 2 per cent for each year that a person is under the age of 30, to a maximum of 10 per cent for those aged 18-25. There was no evidence in its first quarter of operation that this policy reduced the youth exodus from health insurance.³³ It is unlikely that the discount will be enough to induce young people to buy a product that they consider poor value for money.

3.2.2 Medicare Levy Surcharge

Moderate to high-income earners who do not have hospital insurance must pay a Medicare Levy Surcharge – the biggest of the sticks introduced during the Howard era. The surcharge is means tested and

32. Butler (2002).

33. Duckett (2019a).

different surcharge amounts are applied at different income levels (refer to Table 3.1 for the surcharge thresholds).

The surcharge policy design produces some bizarre outcomes.³⁴ High-income earners can avoid paying extra tax by taking out cheaper policies with large excesses, which ultimately costs them less than the extra tax penalty for not taking out hospital insurance. But such policies provide little benefit to the holder and are unlikely to take much pressure off the public system.

More than 14 per cent of Australians with private health insurance say they are only insured because of the surcharge.³⁵ If the income level at which the surcharge takes effect is lowered, more people will be forced into insurance, but they are likely to take out cheaper policies and continue to rely on the public system for care.

Increasing penalties while retaining current income thresholds would probably not substantially increase the number of people insured since those paying the current lowest level of the surcharge (1 per cent) can already purchase PHI to avoid their existing tax penalty.

If the surcharge were abolished the 14 per cent of the insured population coerced into insurance by the surcharge would likely drop their policies. People in this group likely have no intention of using private hospitals anyway, so if they were to drop their insurance it would probably have no impact on public hospital use.

However, the people most likely to drop out are generally healthier and lower users of private health insurance,³⁶ so if they did drop out the risk pool of insurance would worsen, increasing premiums. A knock-on effect of this scenario would be that other, less healthy people

34. See the discussion in Duckett and Nemet (2019b).

35. Roy Morgan (2019).

36. Buchmueller et al (2019).

Table 3.1: Medicare Levy Surcharge Income thresholds 2014-15 to 2018-19

	Base tier	Tier 1	Tier 2	Tier 3
Single threshold	\$90,000 or less	\$90,001 – \$105,000	\$105,001 – \$140,000	\$140,001 or more
Family threshold	\$180,000 or less	\$180,001 – \$210,000	\$210,001 – \$280,000	\$280,001 or more
Medicare Levy Surcharge	0%	1%	1.25%	1.50%

Source: ATO (2019).

might then drop their insurance and so increase demand on the public system.

To the extent that the MLS compels healthy people who otherwise wouldn't purchase private insurance to do so it may help to reduce premiums, because such members are likely to contribute more than they take out in benefits. By reducing premiums relative to where they otherwise would have been, the surcharge may help to make private hospital insurance attractive to more consumers. Given that it does not cost the Commonwealth money – and indeed raises money from people who choose to pay the tax penalty rather than take up insurance – the surcharge may be seen as a cheap way to encourage participation and thereby reduce the demand on the public system.³⁷

But there are arguments to be made against the surcharge. Because it means people on high incomes are effectively forced into health

37. Consistent with the approach adopted by Commonwealth Treasury, this assumes the MLS exemption is not a tax expenditure; for discussion see Smith (2001).

insurance, the price of the product becomes less relevant in their decision to insure. This could result in higher prices for private healthcare and higher mark-ups in both the private insurance and care industries.³⁸

3.2.3 The Private Health Insurance Rebate

Most people with private health insurance are eligible to receive a Commonwealth subsidy on their premiums known as the Private Health Insurance Rebate.³⁹ Since 2012, the rebate has been means tested, with single people earning under \$90,000 (\$180,000 for families) eligible for a maximum rebate of around 25 per cent.⁴⁰ The rebate is reduced as income increases. Singles earning more than \$140,001 and families more than \$280,001 are ineligible.⁴¹

The Commonwealth spent \$5.9 billion on premium rebates in 2017-18 – representing almost 8 per cent of Commonwealth Government health expenditure.⁴² Reforms to the rebate since 2012, including means testing, changes to indexation and removal from Lifetime Health Cover loading, have decreased growth in Commonwealth expenditure on rebates by \$216 million from 2012-13 to 2017-18.⁴³

Private health insurers have argued that the problems facing the industry can be addressed through more subsidies, and there have been regular calls for the Commonwealth to restore the rebate for

38. Robson et al (2011).

39. The rebate may be claimed for premiums paid for a policy which provides hospital cover, general cover, or a combination of both.

40. Growth in value of the PHI rebate per member is capped at inflation. With premiums increasing faster than inflation, the proportion of premiums met by the rebate has declined.

41. The income thresholds for the Rebate and MLS have been frozen until 2020-21.

42. The cost of the rebate, in constant dollar terms, increased from \$0.6 billion to around \$6 billion in 2018. Refer to Figure 2.1.1 in Duckett and Nemet (2019a). AIHW (2018).

43. AIHW (2019).

people under 65 to the former 30 per cent.⁴⁴ While such a move might ease affordability pressures for existing members, it is unlikely to provide value for taxpayers' money.

Is the rebate value for money?

The crucial question in assessing the value of the PHI rebate is: does it take the pressure off the public system?⁴⁵ More specifically, does the money that the Commonwealth spends on the PHI rebate reduce spending on public hospital activity to such an extent that total government expenditure on hospital care is lower than it would be if the PHI rebate did not exist? Another way to phrase this question is: does the rebate pay for itself?⁴⁶

It is a difficult question to answer. Our conclusion based on the academic literature (see Appendix B) is that the rebate probably does not provide value for taxpayers' money – it costs more than it saves in reduced public activity.⁴⁷

When the price of insurance goes up – such as because of a reduction in the rebate – some people respond by dropping their insurance, or by not taking out insurance in the first place. Younger people, and

44. Most recently this came in the form of a bid for increased tax expenditure, through a reduction in Fringe Benefits Tax for those with employer-sponsored private health insurance. This is a bad idea for a number of reasons; see Duckett (2019a). There is no reason why an indirect handout through tax expenditure should be regarded differently from an increase in the direct subsidy.

45. We have shown in our previous report that another argument for subsidising private hospital use – that private hospitals are more efficient than public hospitals – is not relevant, as private hospitals are in fact less efficient than public hospitals; see Duckett and Nemet (2019b).

46. Generally phrased in the academic literature as: is the rebate self-financing?

47. We have referred here to public activity rather than public hospitals. To the extent there is an increase in public demand from reduction of the PHI rebate, this could be met in private hospitals under contract to the state government, easing industry transition.

people on lower incomes, are most responsive to changes in the price of insurance. But the key question is one of degree – how responsive are people to changes in premiums?

Academic studies, both in Australia and elsewhere, have found that consumers overall are relatively unresponsive to changes in the price of insurance. This means that if the rebate is reduced – pushing up premiums – the number of people who would be expected to drop insurance would be small. If this is the case, then the rebate is simply subsidising the insurance of a lot of people who would continue to hold insurance even without a subsidy.

If few people drop out of insurance as a result of a cut in the rebate, then only a small number of hospitalisations would be expected to move from the private to the public system. The extra cost of public care arising from a reduction in the rebate would be outweighed by savings on the rebate. Studies suggest that the money saved from a reduced rebate would be at least double the extra spending required on public care.⁴⁸

The overwhelming weight of the academic research suggests that the PHI rebate is not 'self-financing'. If this is correct, the Commonwealth could reduce spending on the rebate, fund the extra demand on the public system and still save money.⁴⁹

However, there is some uncertainty regarding this finding. A number of the studies of the health insurance rebate are quite old, some dating back to the period when the rebate was introduced. There are also reasons to suspect that the consumer response to increases in the

48. See literature review in Appendix B.

49. This assumes a change to the existing Commonwealth-state funding arrangements so that the Commonwealth becomes responsible for all the increase in public activity. We are therefore effectively treating the policy issue of the value of the rebate as cost to government rather than cost to the Commonwealth or state.

price of insurance might be stronger today, in a period of persistent low wage growth and pressure on household budgets, than in the past.

The consequences of getting this wrong could be serious. If the rebate does, in fact, take some pressure off the public system, withdrawing it could disrupt the health care system overall. Even if the rebate is not self-financing, removing it in one fell swoop could cause short-run pressures in the public health system. It is vital that policy changes do not provoke any such disruption.

For these reasons, we favour a conservative approach. The weight of the evidence suggests that the rebate is far from self-financing – it therefore should not be increased. But given the uncertainty around the evidence, and the desire to avoid disruption, we propose that the rebate be slowly reduced, relative to overall healthcare spending, through a combination of CPI indexation and means testing arrangements.⁵⁰ These arrangements are already in place, which is why the recommendations in this report focus on a cost-neutral re-allocation of the rebate rather than changes in its total size. A gradual reduction in the rebate is also supported by the literature.⁵¹

The means testing arrangements can also be justified on the basis that lower income people are likely to be more responsive to changes in the price of insurance than people on higher incomes. Means testing concentrates the subsidy on the more price-sensitive group, and

50. The effects should be monitored closely so that the relationship between the rebate, health insurance, and public hospital usage can be quantified more accurately.

51. For example, Cheng (2013, p. 8) concludes that 'means testing of rebates is a positive first step. . . The gradual removal of rebates would be a logical and fiscally responsible next step. This should not happen quickly as the public hospital system currently has a fixed capacity and workforce which would require time to expand. It is essential that the savings generated from means testing be wisely invested into the public hospital system to ensure public hospitals have additional resources to expand their capacity.'

therefore does more to increase PHI membership than an alternative rebate that does not vary by income (for a given total expenditure on the rebate).

Another reason to think that reducing the rebate would save more than the extra cost of public care is that public hospitals are generally more efficient than private hospitals. Not every private hospital admission meets the standards for admission to a public hospital.

As we demonstrated in our previous report,⁵² more low-value and unnecessary care occurs in private hospitals than in public hospitals. We estimated that low value care cost the private health care system about \$1.7 billion a year, with a potential range of \$1 billion to \$2.2 billion (a range of from 6 per cent to 14 per cent of private hospital spending). Although unnecessary care also occurs in public hospitals, it occurs much less often. Private hospitals are about 9 per cent less efficient than public hospitals,⁵³ which means that, on average, each private hospitalisation that is avoided because of reduced PHI coverage results in less than one extra public hospitalisation.

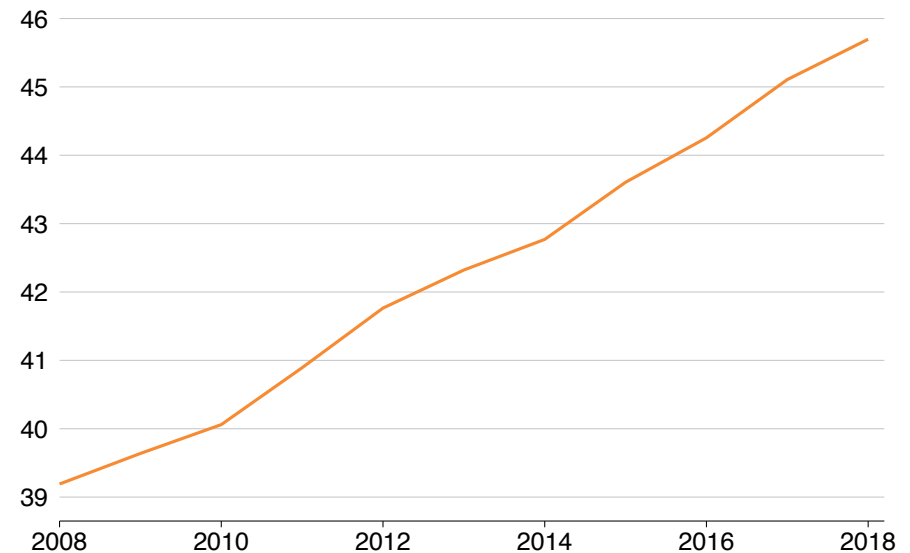
3.3 Risk equalisation – a zero-sum game which supports community rating but undermines efficiency

Community rating is made possible not only by ‘carrots and sticks’ that induce people to take out health insurance, but also by risk equalisation between private insurers. Under risk equalisation, the costs of claims from older people and people with expensive hospitalisations are shared between insurers, through a ‘risk equalisation pool’. Risk equalisation transfers funds from insurers with lower than average claim costs to those with higher than average claim costs. The system is

‘zero-sum’ in the sense that the contributions insurers collectively make into the scheme exactly equal the payments they receive.⁵⁴

Figure 3.2: The proportion of costs shared through risk equalisation has increased over the past decade

Benefits eligible for risk equalisation as a proportion of hospital benefits, financial year, per cent



Notes: Benefits eligible for risk equalisation include hospital benefits, hospital substitute benefits, and some CDMP benefits.

Sources: APRA (2019a) and APRA (2019c); and Grattan analysis.

52. Duckett and Nemet (2019b).

53. Ibid.

54. Taking effect from 1 April 2007, the current scheme replaced the former reinsurance scheme, dating back to 1956. The equalisation of funds under the former scheme was based on 79 per cent of insurers’ hospital claims costs for people aged over 65 and for all members (including those under 65) with more than 35 days in hospital during the year: Fouda et al (2017) and Connelly et al (2010).

Risks are equalised based on actual ('ex-post') hospital and treatment costs,⁵⁵ with a 'basic' policy making the same contribution as a fully comprehensive 'Gold' policy.⁵⁶ Nearly 46 per cent of hospital claims are shared between insurers. This figure increased significantly over the past decade – from 39 per cent in 2007-08 (see Figure 3.2).

Risk equalisation means that insurers have less incentive to engage in 'risk selection' by targeting younger and healthier members ahead of older and less healthy members. Overt risk selection is not permitted in Australia. Nonetheless risk selection may covertly occur by various strategies – such as selective advertising that targets young people and offers lower cost policies – aimed at attracting and/or discouraging certain groups based on their perceived risk profiles.⁵⁷

When funds share a large proportion of their claims costs, they have less incentive to manage their own costs.⁵⁸ Any cost savings made by one fund would benefit all, including funds operating inefficiently.⁵⁹ Any reduction in overall benefit outlays reduces the amount a fund can

claim from the pool (or increases the amount they contribute to the pool).⁶⁰

Risk equalisation also acts as a barrier for preventive care because it reduces the incentives for insurers to manage chronic conditions.⁶¹ The full cost of any investments in prevention are met by the fund, but few of the benefits flow to the fund once they are washed through the Risk Equalisation Pool and shared among all funds in line with the rules of the pool.

Insurers are subsidised for age-related risks (the Age Based Pool) and for the most expensive policy holders (the High Cost Claimants Pool). Differences within age groups such as gender, family size, geography, income and health status do not affect the contributions funds are required to make.

The share of claims pooled based on age varies from 15 per cent for a 55-year-old to 82 per cent for someone over 85 years old (see Table 3.2).

In 2017-18, the pool of benefits eligible⁶² for risk sharing was equal to \$6.8 billion, of which \$430 million was redistributed from funds with lower than average claims costs to funds with higher risk policy holders.⁶³

55. Risk equalisation does not apply to general treatment benefits, such as dental, optical, and other allied health services.

56. A fund's contribution to the cost of shared claims is made in proportion to its market share. To determine their market share, insurers calculate their customer base in terms of Single Equivalent Units (SEU). Single policies count as one SEU, and couple or family policies count as two SEUs. All other policy types count as either one or two SEUs. The average claims cost is calculated separately for each state, and each fund operating in each of those states. The allocated deficit per SEU is the same for all hospital policies in a state.

57. Shamsullah (2011); Gale (2005); and Donato and Onur (2018).

58. Fouda et al (2017); Reid et al (2017); and Productivity Commission (2015).

59. This reflects an implicit tax imposed on investment activities undertaken by funds. The Productivity Commission noted that the implicit tax rate imposed by risk equalisation can be as high as 50 per cent; see Productivity Commission (2017b, p. 52).

60. Any savings would result in a lower claims deficit which will result in the insurer having to pay more into the claims pool to offset the claims costs incurred by those who did not engage in cost saving activities: Stoelwinder (2014).

61. Portability rules also mean that the returns (i.e. long run reduction in claims) to an insurer from investments in preventative care can be lost if the member changes to another insurer before the benefit of lower claims costs to the insurer has been realised.

62. Eligible benefits include hospital benefits, hospital substitute benefits and chronic disease management programs.

63. The largest contributor to the pool was nib: it contributed 43.9 per cent of the redistributed funds, which is equal to 13 per cent of the benefits it paid. In comparison, BUPA and HBF were the two largest recipients of the pool; receiving

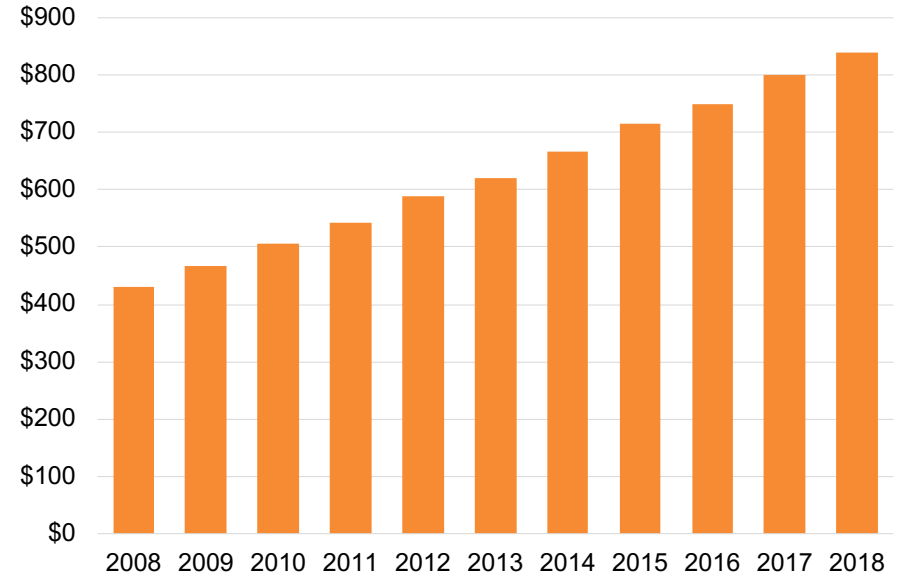
The effect of risk equalisation on participation and affordability

As Table 3.2 shows, a proportion of the benefit payments for each person 55 and over is contributed to the risk equalisation pool. Similarly, a proportion of the premium for each person is contributed to the pool to cover the benefit payments.⁶⁴ Since every policy premium has to cover the minimum payment into the pool, this contribution sets a minimum floor payment.

This premium floor – effectively the cross-subsidy from young to old – has been increasing faster than inflation and faster than premiums. Figure 3.3 shows how this premium floor has increased annually since 2008, at an average rate of 7.3 per cent per year.⁶⁵ For young people with basic policies, the premium floor cross-subsidy can represent up to 70 per cent of the total premium.⁶⁶

Figure 3.3: The premium floor has been increasing

Calculated deficit per SEU for hospital treatment only, dollars per year



Note: The calculated deficit per SEU represents the national average. There is variation among states.

Sources: APRA (2019c) and Grattan analysis.

30.3 per cent and 25.6 per cent of the redistributed funds. This was equal to 2.3 per cent and 7.1 per cent of the benefits paid by the two funds.

64. The premiums charged by insurers must at a minimum cover the calculated deficit per SEU. In addition, insurers must also cover operating expenses and profits.

65. Analysis by Reid et al (2017) suggests this is likely to increase at a faster rate (9.2 per cent per year) into the future.

66. Ibid.

Table 3.2: Age bands and proportion of benefits shared through risk equalisation

Age	% of eligible hospital benefit included in risk equalisation calculation
0-54	0
55-59	15
60-64	42.5
65-69	60
70-74	70
75-79	76
80-84	78
85+	82

Note: This table shows contributions to the Age Based Pool.

Source: Private Health Insurance (Risk Equalisation Policy) Rules 2015.

4 Helping the industry help itself

Private health insurance, in its current form, is unsustainable. The industry is in a downward spiral, as shown in Chapter 2. Younger people are dropping their insurance, or not taking it out in the first place, because their premiums are too expensive relative to the benefits they receive.

This chapter sets out a direction for reform of the private health insurance system. The central element is a partial move away from community rating. The premium that a person pays should more closely reflect the benefits that someone of their age can expect to receive from hospital insurance.

The Commonwealth should deregulate premiums for people aged below 55.⁶⁷ Under our long-term reform proposal, everyone aged 55 and over would pay the same premium for the same level of product, but insurers would be free to charge younger people lower premiums.

The amount that the Commonwealth spends on the health insurance should not be increased, but the rebate should be redirected towards people aged over 55. Lifetime Health Cover and the Medicare Levy Surcharge should both be phased out and the system of risk equalisation between funds substantially scaled back. These reforms would help to arrest the demographic death spiral facing private insurance funds and make the industry more sustainable, ultimately benefiting all members.

67. Age 55 was chosen as the transition point as it best balances the various considerations – the desire to reduce premiums while constraining the increase for older people at no extra cost to government. Age 55 is also around the age when people shift from net contributors to net beneficiaries. An interactive web app is available on the Grattan Blog that allows users to change the values for various parameters to determine alternative premium structures.

If these recommendations were adopted, we expect that older private health fund members would, other things being equal, pay a little more than they do now, while younger people would pay less.

In our previous report we proposed a number of changes which would make private health care premiums more efficient and, if implemented, would reduce premiums by about 7-10 per cent.⁶⁸ We have not taken those potential premium reductions into account in the calculations we describe here, but if we did, our proposals would be roughly cost neutral for people aged 55 and over.

The proposals we outline in this chapter are designed to make private health insurance viable by addressing the youth exodus and the downward spiral in the risk profile of the industry. The proposals are practical, and not driven by self-interest, unlike the ‘zombie’ proposals that are occasionally floated in the media.⁶⁹

The flavour of our proposals is deregulatory. Part of the industry’s problem is that it is tied up in unnecessary red tape. Regulation is piled on regulation creating an administrative nightmare that inhibits the industry’s ability to respond to changing market conditions and weakens incentives for funds to reduce costs.

This mollycoddling and over-regulation also fosters complacency. Too often insurers assume that government will provide solutions, typically in the form of increased direct or indirect subsidies,⁷⁰ instead of focusing on making their products attractive to consumers.⁷¹

68. Duckett and Nemet (2019b).

69. Duckett (2019b).

70. Duckett (2019c).

71. As discussed by Summerhayes (2019).

4.1 Principles for reform

Our proposals were developed subject to two main constraints. The first was budget neutrality for government. As discussed in Section 3.2.3, the Private Health Insurance Rebate is probably not self-financing and the subsidy to the industry should not be increased. We therefore do not recommend policy reforms that would come at a net cost to government.

The second constraint was the desire to ensure that PHI remains affordable for older members. If Australia were to move all the way along the spectrum to risk rating, therefore eliminating cross-subsidies from young to old, premiums would skyrocket for older people, particularly people aged 70 and older. Our proposals result in only moderate premium increases for people over 65.

In developing our recommended approach to addressing the youth exodus, we framed our proposals in a way that acknowledges the need to help the industry manage its own transition. For that reason, our recommendations are often expressed as 'phase-down'. Gradual phasing also allows the impact of the recommendations to be assessed to ensure they are having the desired effects. This will also ensure there is minimal disruption to the public hospital system as the private insurance system adjusts.

4.2 A direction for reform

The Commonwealth Government should:

- Move away from community rating by deregulating premiums for people aged below 55, allowing private insurers to compete based on the value they provide for younger members;⁷²

72. Funds should not be allowed to charge different premiums to people based on characteristics other than age, such as health status.

- Require that insurers charge the same premium to everyone aged 55 and over for the same level of cover, and continue to require that premium increases for this group are approved by the Minister;
- Redirect the hospital insurance rebate and part of the general insurance rebate towards hospital insurance for people aged 55 and over;
- Not increase the Private Health Insurance Rebate;
- Deregulate general ('extras') insurance completely;
- Phase down the Lifetime Health Cover arrangements;
- Phase down the Medicare Levy Surcharge, to reflect the principle that people should take up insurance if they feel it provides value for them, not because they're effectively compelled by the tax system; and
- Overhaul the system of risk equalisation between PHI funds, so funds have more of an incentive to manage costs and are better able to compete on value.

Government should not consider 'zombie' reform ideas, such as the creation of a Hospital Benefits Schedule or Medicare Select.⁷³

4.3 Towards fairer premiums

As outlined in Section 3.1, community rating relies on healthy people paying more into a fund than they take out in benefits. The difference between their amount in and their amount out is used to cross-subsidise premiums for sicker people. The system of community rating becomes unsustainable if there are too few healthy people in the fund. That is the situation facing private insurers now.

73. See Duckett (2019b).

At the other end of the spectrum is a fully risk-rated system, which would involve charging each fund member a premium that reflects expected benefits, plus a standard mark-up to cover funds' administrative and capital costs. Adopting a fully risk-rated system in Australia would not be tenable. It would entail older Australians paying premiums that are five or six times their current levels, as shown in Figure 3.1, or even higher, if funds were able to charge premiums based on individual health status.

Our proposal would move Australia along the spectrum away from community rating and towards risk rating, without going all the way to the extreme. It goes further than the policy which came into effect on 1 April 2019 which allows discounts for people under 30. Australia should adopt a 'hybrid' model for premiums, with constant premiums above age 55 and lower and substantially deregulated premiums for younger people.⁷⁴

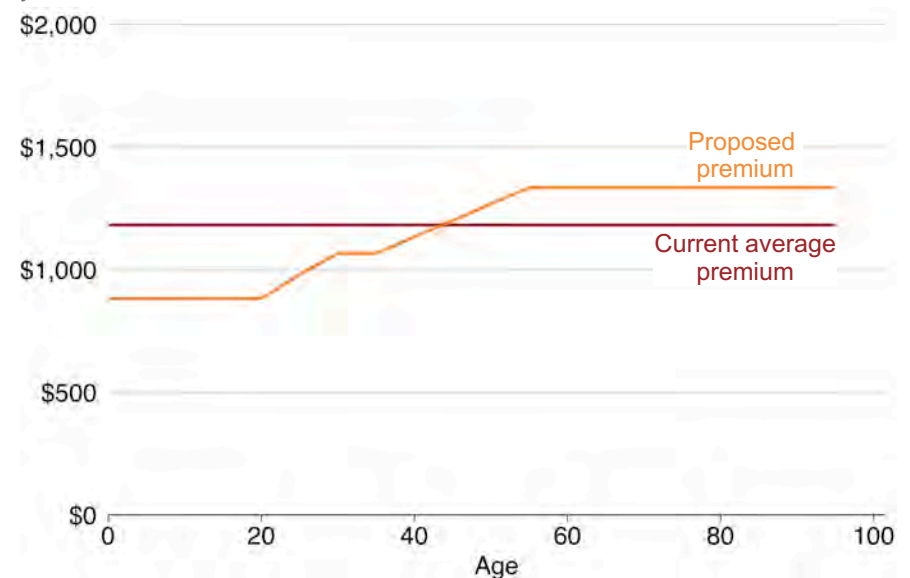
Figure 4.1 depicts a stylised example of the recommended premium structure. In practice, the shape of the premium curve for people aged below 55 would vary by insurer. The current premium, and the proposed premium for people aged 55 and over, varies based on income due to the means testing of the PHI rebate.⁷⁵

4.3.1 Deregulate premiums for younger people

Insurers should be free to set premiums for people aged below 55 based on competitive market rates. We expect that competitive pressure will lead to substantially reduced premiums for younger people compared to current levels, though the need to continue

Figure 4.1: To make health insurance more sustainable, older people must pay a little more

Private hospital insurance premiums net of rebate, dollars per member per year



Notes: Figures reflect projected 2019-20 premiums, in inflation-adjusted 2018-19 dollars. Current premium includes PHI rebate, divided equally among all members; proposed premium includes PHI rebate divided among members aged 55+.

Sources: Grattan calculations based on APRA (2019a).

74. A similar structure was proposed by Reid et al (2013).

75. For the purposes of this analysis, premiums are calculated on a 'per-member' basis. This does not reflect the fact that some funds do not charge extra to cover children above the cost of covering couples. This simplification partly reflects the lack of publicly available data that would enable calculations on a 'per-Single Equivalent Unit' basis.

some cross-subsidy of older people's insurance will put a floor under premiums. The only requirement should be that people of the same age must be charged the same premium for the same product.⁷⁶

The premium structure outlined in Figure 4.1 for people aged under 55 is only an indicative proposal. But it strikes a balance between reducing premiums for younger people, retaining sufficient cross-subsidy from young to old, and ensuring that there is not a sharp jump in premiums at age 55. The proposal has been calibrated based on industry-wide data.⁷⁷

In practice, the premium charged for people at each age group below 55 would be up to individual insurers, subject only to competitive pressure and the need to charge a regulated premium for older people.

The indicative proposal in Figure 4.1 was calculated on the assumption of no behavioural change. In other words, the calculations assume that, despite the premium increase for older people and the premium reduction for younger people, the number of people in each age group who choose to have insurance will not change. In practice, this is unlikely – more young people will be enticed to join (or remain a member of) private funds, while some older people will drop out. If this occurs, funds will be able to offer even larger premium reductions for younger people than shown in Figure 4.1.

4.3.2 A constant premium for people over 55

The Commonwealth should require that all people aged 55 and above are charged the same premium. Community rating should be

76. Insurers could not charge higher premiums for women than men, or for sick people than healthy people. The proposal therefore represents a move towards age-based risk rating, but not full risk rating.

77. An interactive web app is available on the Grattan Blog which allows users to make different assumptions about the age threshold, the size of the rebate, and other parameters affecting the structure of premiums.

maintained for this age group, otherwise it is likely that older people would be priced out of the insurance market.

Premiums will still be subject to regulation, as they are under the current community rating system. Ministerial approval of increases in the over-55 premium will be required to ensure that insurers do not impose dramatic premium increases on older people and so effectively vacate this part of the insurance market.

Our proposal would result in an increase in premiums for people over 55, as a consequence of the reduced cross-subsidy from people under 55, of around 10 per cent. Our previous report identified ways in which premium savings of about 7 to 10 per cent could be achieved.⁷⁸ Implementing the proposals in both reports in a coordinated way could ease transition issues, and moderate the increase in premiums for older people.

Even if the proposals in our previous report are not introduced, people over 55 still benefit from our proposed changes to premiums in the long run. Unless the current disincentive for young people to take out health insurance is addressed, the risk pool will continue to deteriorate, premiums for old people will only increase further, and the system will not be sustainable.

4.3.3 Redirect the rebate

Taxpayers probably do not receive value for money from the Private Health Insurance Rebate, as shown in Section 3.2.3. Substantial academic work has found that each dollar spent on the rebate is likely to deliver less than a dollar in reduced public sector hospital activity and thus represents bad value. However, there is uncertainty surrounding this conclusion. There are reasons to suspect that the

78. Duckett and Nemet (2019b).

removal of the rebate could add to pressure on the public system, particularly in the short run.⁷⁹

Since the weight of evidence suggests that the rebate is poor value for money, the rebate should not increase. However, given the uncertainties and the desire to avoid sudden, disruptive shifts in the health care sector, we recommend that the total amount spent by the Commonwealth on the Private Health Insurance Rebate should be maintained at around its current level in the medium term, adjusted for inflation, minus the portion of the general rebate that goes to dental care.⁸⁰ There should be a reduction in the total expenditure due to the removal of the dental portion of the general insurance rebate.

There is no compelling case for public subsidy of private care that is clearly a complement to, rather than substitute for, public care.⁸¹ For that reason, the rebate for general insurance (known as ‘ancillaries’ or ‘extras’) should be removed. The portion of the general rebate that subsidises dental care – \$710 million in 2017-18⁸² – should be

79. The effect of the rebate on public activity depends on the behavioural response of people with private health insurance. If PHI members are very sensitive to changes in the price of insurance, the removal or reduction in the rebate would lead to a large reduction in the number of people with private health insurance and a large increase in public sector hospital activity. There are reasons to suspect that households have become more sensitive to changes in the price of insurance in recent years, and that reductions in the rebate would therefore come at greater cost in the form of public activity than has been estimated in past academic work. The contemporary value of the rebate and the other ‘carrots and sticks’ would be a fruitful focus for further academic work.

80. In Duckett and Nemet (2019b) we argued that the MBS rebate could also be redistributed to be paid through private health insurers. If that proposal were accepted, that funding would be added, on a cost neutral basis, to the restructured Private Health Insurance Rebate discussed here.

81. Duckett and Nemet (ibid). Similar arguments are advanced in Deeble (2003) and Frech and Hopkins (2004). Furnival et al (2017) argue that ‘non-hospital insurance will have no material effect on waiting lists and therefore does not meet stated welfare goals.’

82. AIHW (2019).

redirected towards publicly funded dental care, as recommended in a previous Grattan report.⁸³ The rest of the general rebate should be added to the private hospital insurance rebate.

Abolishing the rebate for general insurance would increase the price of this product. Given that most consumers purchase general insurance along with hospital insurance, this may put downward pressure on membership of hospital insurance, particularly among younger people. However, removing the public subsidy for general insurance would allow deregulation of this product. General insurance products should be risk-rated, which would reduce their price for healthy people. Private health insurers could then design insurance products attractive to young people, including products which cover services that do not meet the evidence base required to attract a public subsidy.

The rebate should not be paid for ‘junk’ hospital insurance products which only cover care in public hospitals and so do not substitute for public hospital care. We argued in our previous working paper that where private care substitutes for public care, there may be an argument for subsidising insurance.⁸⁴ However, in the case of junk policies which only cover care in a public hospital, there is no substitution, and no justification for a subsidy.⁸⁵ Any savings from abolishing the rebate on junk policies should be redirected on a cost neutral basis to support policies which may substitute for public activity.

Under our hybrid model of age-based risk rating for people under 55, the government rebate for private hospital insurance should be removed for all people aged under 55 and redirected to people aged 55 and above.

83. Duckett et al (2019).

84. Duckett and Nemet (2019a).

85. In any case, using the framework outlined in our working paper, there is no justification for subsidising general insurance (for ancillary services and extras), which is clearly a complementary product.

This will limit the increase in premiums for older people that will result from the shift away from community rating and towards lower, deregulated premiums for younger people. The average premium currently paid by Australian hospital insurance members, after deducting the hospital insurance rebate, is around \$1182 per member per year.⁸⁶ If people aged 55 and over were charged a premium based on the average benefits they receive and a standard industry mark-up, the premium would be around \$3500 per member per year. Increasing premiums to this level would be politically untenable. It would also arguably be unfair to people who have, for the most part, been private health insurance members for decades and have, on average, paid more than they received in benefits when they were young.

4.3.4 The new hospital insurance rebate

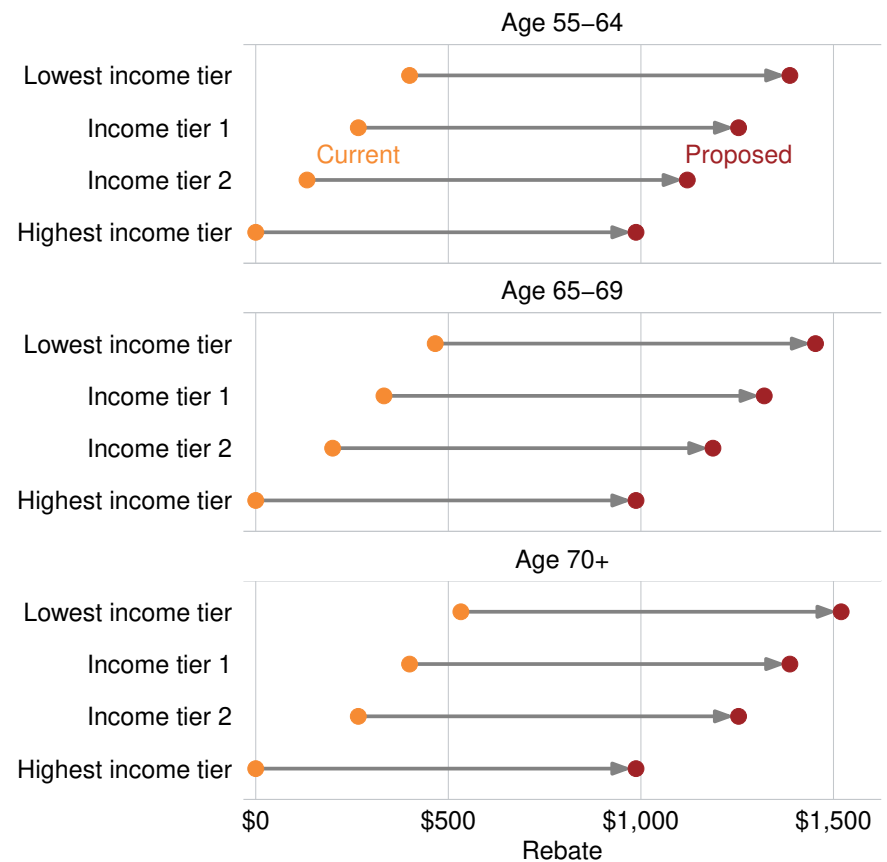
The redirected hospital insurance rebate should be split into two components: a non-means tested rebate that is paid to all PHI members aged 55 and above; and a means tested supplement. Both components of the rebate should be specified in dollar terms (rather than as a percentage of the gross premium) and adjusted annually in line with the CPI.⁸⁷

86. Grattan projection to 2019-20 based on APRA (2019a). Includes hospital-substitute treatments. Excludes general benefits. Calculated based on average projected benefits of \$1405, average premium including mark-up of \$1594, and average rebate of \$411.

87. Both components of the rebate should be set at a standard price for Gold, Silver, Bronze, and Basic packages with no supplement for 'plus' (+) packages. Setting a standard ('efficient package price') would strengthen incentives for more competition between funds. The absence of a supplement for + packages would effectively discourage these packages, enhancing the ability of consumers to compare packages; see Mihm (2018).

Figure 4.2: Older PHI members should get a base rebate plus a means tested component

Proposed rebate for private hospital insurance, dollars per member per year



Note: Income thresholds differ for singles and families; lowest income tier is up to \$90,000 for singles and \$180,000 for families. Current rebate calculated based on average gross premium and average industry mark-up.

Sources: Grattan calculations. APRA (2019a) data used to calculate current average premium. ABS (2019d) used to calculate the number of PHI members in each age-income segment.

The means tested component of the rebate should be set equal to the average value of the current rebate for older people. For example, a person in the base income tier who is aged 55-64 is currently entitled to a 25.059 per cent rebate.⁸⁸ The average premium, pre-rebate, is \$1,594 per year.⁸⁹ The current rebate is therefore worth \$399.44 to a person in this age and income range. Under our proposal, the means tested component of the rebate would be equal to the same dollar amount. The base rate subsidy could vary by policy type (Gold, Silver, Bronze, and Basic).

The non-means tested rebate, which would be paid to all hospital insurance members aged 55 and above, would initially be set at \$987 per member per year.⁹⁰ This value has been calculated so that the total expenditure on the rebate by government will equal \$5.2 billion, assuming no change in the number or composition of the insured membership base aged 55 and above. Figure 4.2 shows the rebate that people aged 55 and over receive, at present and under the proposed change.⁹¹

The age and income thresholds for the rebate means test should remain unchanged, other than removing the rebate for under 55s. For couples and families, the means test is currently based on the

age of the oldest person covered by the policy.⁹² Under our proposal, each PHI member's eligibility for the means tested component of the rebate would be assessed based on their own age and their household income. A couple with one 60 year old and one 54 year old would receive the rebate only for the 60 year old. The measure of income used for means test purposes should be broadened to mirror the income measure used to determine eligibility for the Commonwealth Seniors Health Card.⁹³

4.4 Reduce the scope of risk equalisation among funds

Under the community rating system, risk equalisation has three key objectives. These are:

1. To maintain a competitive private health insurance model with incentives for insurers to compete;
2. To reduce incentives for insurers to discriminate among consumers based on risk; and
3. To ensure that well-managed insurers are not put at risk.⁹⁴

There is a tension between these objectives, as discussed in Chapter 3. The current system gets the balance between these objectives wrong. Nearly half of all hospital benefits are shared across insurers through the risk equalisation pool and this amount is growing each year, as shown in Figure 3.2. Equalisation substantially dulls the

88. ATO (2019).

89. Grattan calculation based on projected membership and benefits in 2019-20, based on APRA membership and benefits statistics. Average premium is calculated as the average hospital and hospital-substitute benefits per person, plus the industry average mark-up.

90. An alternative option is for the non-means tested rebate to vary by age. This does not affect the costing of our proposal as the total amount paid to insurers is unchanged, but it does change the distribution of payments within the industry.

91. Figure 4.2 is based on the assumption that the differential rebates for people 65 and over are retained. We have proposed a phasing-in of our proposal which removes these; see Section 4.8. The introduction of the additional rebates for people over 65 had no impact on insurance take-up: Kettlewell et al (2018). Figure 4.2 also assumes that the non-means tested rebate does not vary by age.

92. ATO (2019).

93. See further discussion of this issue in Section 4.6. See Department of Human Services (2019) for the income definition used to assess eligibility for the Commonwealth Seniors Health Card eligibility.

94. Risk Equalisation Working Group (2017a). Participants in the working group 'were not able to agree on final objectives' but agreed that these are 'possible objectives of risk equalisation.'

incentive for funds to increase efficiency and cost-effectiveness. It also reduces incentives for funds to invest in innovation and prevention.⁹⁵

If our recommendation to partially move away from community rating is adopted, the degree of cross-subsidy from younger to older PHI members within each fund will be reduced, although not eliminated. The risks to a PHI fund associated with having an older membership base will therefore be reduced.

The degree to which funds are required to share risk through the age-based equalisation pool should be reduced over the medium term. At present, the percentage of hospital benefits that are shared through the age-based risk equalisation pool ranges from 15 per cent (for people aged 55-59) to 82 per cent (for people aged 85 and above); see Table 3.2. We recommend that these percentages are significantly reduced – potentially halved – over the next five years.

Some funds will benefit from the reduced role for age-based equalisation, while other funds with an older membership base will lose. For this reason, we recommend that the reduction in the required contributions to the age-based pool are phased in incrementally over the five-year period.

While the age-based pool provides support for community rating, the high-cost claimants pool provides prudential support for insurers against the risk of high-cost claimants.⁹⁶ Funds – particularly the smaller funds – face the risk of financial volatility from high cost claimants. While a large insurer is better able to manage significantly higher than expected actual claims costs, the impact on smaller funds may be more significant.

While we propose reducing risk equalisation for age-based risks (Age Based Pool), we recommend that risk sharing for high cost claimants

be retained. The current threshold of \$50,000 for high-cost claims should be reviewed to determine if this amount is still appropriate given the reduction of contributions to the age-based pool.

The effect of the reduction in age-based risk equalisation should be closely monitored and fully reviewed at the end of the five-year period.⁹⁷

4.5 Phase down Lifetime Health Cover

Under community rating, the premium paid by younger people substantially cross-subsidises the benefits received by older people. This means that someone who chooses not to be a member when they are younger and healthier, and instead joins when they are older and sicker, receives the benefits of the cross-subsidy without having paid into the system. Lifetime Health Cover was imposed in the late 1990s to correct this anomaly, by adding an extra loading to the premium for people who join after age 30. It was successful at increasing private health insurance membership among younger people, it may now be discouraging some older people from taking up insurance.

Under the proposed reforms to premiums, the within-fund cross-subsidy from young to old through insurance premiums will be decreased substantially. As a result, Lifetime Health Cover will be less necessary to manage the risk profile of the membership base. Under the proposed changes to premiums, a 35 year old will pay an amount that is much closer to their expected benefits. Someone who joins at age 40 will therefore not be 'free riding' to the nearly same extent as they would under a community rating system.

LHC was the most important of the carrots and sticks to encourage people to take out private health insurance. It serves a second purpose by encouraging people to consciously consider the potential benefits

95. Stoelwinder (2014).

96. Risk Equalisation Working Group (2017b).

97. The Australian Prudential Regulation Authority should be tasked with doing this monitoring.

of private health insurance before turning 31. For this reason, it is not proposed to abolish lifetime cover, but rather to phase it down by reducing the size of the loading from 2 per cent over time.

Additional penalties for people who join PHI later in life could be considered. These could come in the form of longer waiting times for benefit eligibility – say 18-24 months. Under the current system, a 12 month waiting period is already imposed for claims for treatment of pre-existing conditions.

4.6 Phase down the Medicare Levy Surcharge

Private health insurers should be free to compete based on the value they provide to their members. If they are not seen to provide value by consumers, it is difficult to justify compelling people to join by imposing tax penalties on non-members.

The Medicare Levy Surcharge is a double whammy both for those who pay it and for those who are forced to take out insurance because of it, since everyone also pays for public care through their taxes. Private health insurance is the only product in Australia where government has intervened in the market to force people to purchase a product consumers regard as unnecessary, and for which a public alternative exists. It reflects badly on the industry that such coercion is necessary.

Nonetheless, the surcharge does help to sustain the industry. It induces some people to join a fund who otherwise wouldn't; and these people are likely to be relatively healthy, on average, and therefore contribute more in premiums than they take out in benefits.⁹⁸ This lowers premiums for all members, which helps to prevent the 'death spiral' dynamic from emerging. For this reason, the surcharge should

98. Buchmueller et al (2019) find that younger individuals are more responsive to changes in MLS liability, though they do not find a statistically significant relationship between health and responsiveness to MLS changes when controlling for other factors.

not be abolished in the short term. Rather, the size of the tax penalty should be progressively reduced from its current level (between 1 and 1.5 per cent, depending on income). The pace of the reduction should be subject to a review of the effect of the proposed premium changes on health fund membership for different groups.

The definition of income used to determine the size of the surcharge, or entitlement to the PHI rebate, should also be amended. In an inequitable anomaly, the definition of income used for these purposes does not include superannuation income. This means a single person with \$150,000 a year income from superannuation will receive a subsidy of 33 per cent of their premium, but another person on the same income, but derived from other sources, will receive no subsidy at all.⁹⁹ The definition of income for rebate eligibility should be broadened. This would align the income test for the MLS and PHI rebate with the income test used for the Commonwealth Seniors Health Card.¹⁰⁰

4.7 Roads not travelled

A number of options for changing PHI have been advanced in recent years.¹⁰¹ These include:

- Increasing the rebate;
- Creating a fringe benefits tax exemption for employees for PHI products for people under 30;
- Full age-based risk rating;

99. Assuming the person is over 70. The subsidy for a person aged 65 to 69 is 29 per cent.

100. Eligibility for the Commonwealth Seniors Health Card is based on 'adjusted taxable income', which includes superannuation income stream benefits, as well as a deemed amount from account-based superannuation income streams; see Department of Human Services (2019).

101. In addition to the 'zombie proposals' of Medicare Select and the Hospital Benefit Schedule; see Duckett (2019b).

- Reducing rebates for people 65 and above, and increasing the rebate for people under 30;
- Commencing lifetime cover at age 25;
- Extending family cover to include people 25–30 in their parents' policies.

All of these are inferior to the proposals put forward in this report. Some are not cost-neutral, some have significant transition issues, some have a significant adverse impact on the very old, and for some, the overall impact is uncertain (see Appendix C). Reducing the rebate for older people and using the proceeds to increase the rebate for younger people would have some benefits – we propose it as a first step – but would not do enough to make the industry sustainable.

4.8 The scheme overall, and how to phase it in

The essence of our proposed reforms is a cost-neutral restructuring of the way government subsidises and regulates the private health insurance industry. The intent of our proposal is to align more closely what a person under 55 pays for private health insurance with what they would expect to get in benefit payments. This should help to arrest, and possibly reverse, the youth exodus which is undermining the long-term viability of the industry.

The current cross-subsidies within funds, and contributions to risk equalisation by private health insurers, will be reduced. More of the responsibility for the higher health costs of older people will be managed through revised subsidy arrangements from government rather than within funds.

We recognise that our proposals represent a significant upheaval for health insurance funds. But they would also bring significant benefits for the industry. The restructuring we propose will allow funds to unleash their creative capacity to design new products attractive to

younger cohorts. This may create a virtuous cycle that recruits more young people into insurance. Funds will also keep more of the benefits of cost control and so will have added incentives to drive efficiencies in private care.

These recommendations should be seen as a medium term direction for reform. If they were implemented, a key result would be lower premiums for younger people and slightly higher premiums for older people. An interim policy reform that would also help to stem the youth exodus would be to increase the subsidy for younger members. This could be achieved in a cost-neutral way by eliminating the age-based variation in the PHI rebate that currently exists.

In a bizarre policy change, the rebate for people aged 65 and over was increased in 2005. This has had no impact on insurance take up in this age group.¹⁰² This additional subsidy could be abolished and redirected to create a new, higher subsidy for people under 55 without increasing the rebate's total cost to government.¹⁰³ This approach would reduce the effective price for people under 55 but would not have the deregulatory benefits that our policy creates.¹⁰⁴ This interim option should deliver the largest subsidy increase for people aged under 30; the additional subsidy should slowly reduce over higher age ranges.¹⁰⁵

Private health insurance is in a death spiral, albeit a slow-moving one. The youth exodus is continuing. The average age of the insured population is increasing. The choice before the government and industry is stark:

102. Kettlewell et al (2018).

103. This was also recommended in previous Grattan Institute reports; see Daley et al (2016) and Wood et al (2019).

104. The net premium increase for people over age 65 could be offset by implementation of the reforms we identified in our previous report which will reduce premiums; see Duckett and Nemet (2019a).

105. This approach ensures there is no 'cliff' at which people face a substantially higher premium when they turn a certain age.

- Do nothing and sit idly by as the death spiral inexorably continues;
- Increase industry subsidies, continuing the tradition of fostering complacency and learned helplessness, and probably not addressing the causes of the death spiral; or
- Change industry fundamentals and incentives as part of systematic industry reform.

Only the last option option can save private health insurance in an economically responsible way.

Appendix A: Projecting PHI membership

This report includes projections of the proportion of the population that is likely to have private hospital insurance in the future (see Section 2.6). The projections are designed to illustrate the circular relationship between rising premiums and adverse demographic trends among the PHI membership base. As premiums rise, more young people drop PHI, which causes premiums to rise further.

Importantly, the decision by people in a particular age group to retain or drop PHI depends not only on that group's price elasticity of demand and the change in the price of insurance, but also on every *other* group's behavioural response. This reflects the fact that in a community rating system, the price paid by each group depends on the overall demographic composition of the insured population.

These projections are intended to highlight plausible future paths for PHI membership under certain assumptions. This appendix sets out those assumptions and the data used for the projections.

A.1 Approach to projecting PHI membership

We use the following accounting identity to decompose the total amount of hospital benefits (*ben*) paid out by private insurers each period (*t*):

$$ben_t = \sum_{i=1}^n \frac{days_{it}}{memb_{it}} \times \frac{memb_{it}}{pop_{it}} \times pop_{it} \times \frac{ben_{it}}{days_{it}}$$

In this decomposition, *days* refers to the number of hospital bed-days, *memb* is the number of people with private hospital insurance, and *pop* is the number of people in the Australian population. The subscript *i* denotes an age group.

The total expenditure of private insurers (*exp*) is equal to the benefits they pay to members, plus a fixed percentage mark-up (*mark-up*) that accounts for management expenses and net margin:

$$exp_t = ben_t \times (1 + markup)$$

Private insurers set the insurance premium (*prem*) for the current period based on the premium in the previous period and growth in expenditure per member to the previous period. Gross premiums, without taking into account the PHI rebate, are identical for all insured persons.¹⁰⁶

$$prem_t = prem_{t-1} \times \left(\frac{\frac{exp_{t-1}}{memb_{t-1}}}{\frac{exp_{t-2}}{memb_{t-2}}} \right)$$

The effective premium is the gross premium minus the PHI rebate (*rebate*). The size of the rebate varies by age and income and is adjusted each year. Our model does not incorporate income variation. This means it is likely to understate the size of future declines in PHI membership, as it does not capture the increase in the effective premium experienced by people who move into higher income brackets and therefore receive a lower rebate.

106. In reality, private insurers are able to set different premiums in different states of Australia, as community rating is applied at the state level. There is also some age-based variation in average premiums, because individuals are able to self-select into different levels of cover ('Gold', 'Silver', and so on) and because insurers are able to offer discounted premiums to people under 30. For modelling purposes, we ignore these details.

$$effective_prem_{it} = prem_t \times (1 - rebate_{it})$$

Over the projection period, the rebate varies in line with the indexation arrangements set out in the *Private Health Insurance (Incentives) Rules* and the *Private Health Insurance Legislation Amendment Act 2014*.

The rebate values used for the 2019-20 financial year are 25.059 per cent (for persons under 65), 29.236 per cent (65-69) and 33.413 per cent (70 and over). The CPI is used to calculate the change in the rebate from year to year.

$$rebate_{it} = rebate_{it-1} \frac{\frac{CPI_t}{CPI_{t-1}}}{\frac{prem_t}{prem_{t-1}}}$$

The price of insurance is the effective premium per expected dollar of benefits (*expected_ben*).¹⁰⁷ Although gross premiums are constant across age groups, the price varies across age groups, because expected benefits and the rebate both vary across age groups. For each age group, expected benefits in time period *t* are equal to the prior year's benefits, times the growth in benefits in the prior year.

$$expected_ben_{it} = \frac{ben_{it-1}}{memb_{it-1}} \times \left(\frac{ben_{it-1}}{memb_{it-1}} \frac{ben_{it-2}}{memb_{it-2}} \right)$$

$$price_{it} = \frac{effective_prem_{it}}{expected_ben_{it}}$$

107. This definition of the price of insurance is also used in Cheng (2014) and Butler (1999) among others.

The number of PHI members in each age group reflects the change in premiums in the current period, the age-specific price elasticity of demand (*PED*), and population growth.

$$memb_{it} = (1 + PED_i \times \left(\frac{price_{it}}{price_{it-1}} - 1 \right)) \times memb_{it-1} \times \frac{pop_{it}}{pop_{it-1}}$$

These equations provide a tractable framework for projecting future private health insurance membership of different groups under a system with community rating. They capture the essential dynamic – as insurance premiums rise, different groups make decisions about whether to hold insurance, and those decisions affect premiums in the following period.

A.2 Data used in the projections

The primary source of data is the APRA *Private Health Insurance Membership and Benefits* statistics.¹⁰⁸ From this source, we calculate the number of people with hospital insurance in each age group, the total number of hospital bed-days used by each age group, and the total amount paid in benefits in respect of hospital care to each age group, in each financial year to 2018-19.¹⁰⁹

We use a range of assumptions about future growth in hospital utilisation (hospital bed-days per member), benefits per bed-day, the size of each population subgroup, and future consumer price inflation.

- We use the forecast of consumer price inflation from the RBA *Statement of Monetary Policy* to calculate the CPI for each financial year.¹¹⁰ Beyond the end of the forecast period, we assume 2.5 per cent annual inflation.

108. APRA (2019a).

109. APRA (ibid). The figures include hospital-substitute treatment.

110. RBA (2019).

- For the size of the population in each age group, we use the ABS' central projection of population by age ('Series B').¹¹¹
- Beyond 2018-19, we project the average benefits-per-day and days-per-member for each age group in each year. For this, we assume that the future growth in these series within each group will be equal to the compound annual growth rate over the past five years.

111. ABS (2018).

Appendix B: Does the PHI rebate take pressure off the public system?

The Private Health Insurance rebate costs around \$6 billion per year – nearly 8 per cent of all the money the Commonwealth Government spends on health care.¹¹² A crucial policy question is whether this spending delivers value for money.

There is evidence that private insurance relieves pressure on the public system. A recent study using data from the HILDA survey finds that if a person has private insurance, this reduces the probability they will be admitted to a public hospital by 13 percentage points, all else being equal.¹¹³ This is consistent with prior work which found that private insurance reduces the probability of a public hospital admission by around 11 percentage points.¹¹⁴

However, the relevant policy question is not whether private insurance *per se* reduces demand for public care. The policy question is whether the rebate takes sufficient pressure off the public sector to offset the cost of the rebate. This is described in the literature as the question of whether the rebate is ‘self-financing’. If the rebate is not self-financing, government could reduce it, redirect the funds into public care, and experience a net increase in the amount of care delivered in the public system with no increase (or even a reduction) in government expenditure.

The question of whether the rebate is self-financing depends on a number of factors. Perhaps the most central is the responsiveness of consumers to changes in the price of health insurance – the price elasticity. If consumers are very responsive – if the price elasticity is

large¹¹⁵ – then the price increase flowing from a reduction in the rebate would lead to a large exodus of people from private insurance. This would, in turn, likely lead to large increases in public hospital activity. Conversely, if consumers are not very responsive to changes in the price of insurance, then any reduction in the rebate would be expected to induce only a small change in PHI membership and consequently public hospital usage.

The effect of the rebate on PHI membership

The general consensus of the academic literature is that consumers are relatively unresponsive to changes in the price of health insurance. Studies have generally found elasticities in the range of -0.35 to -0.5, which means that a 10 per cent increase in the price of insurance would be expected to lead to a 3.5 to 5 per cent fall in private health insurance membership.¹¹⁶ For example:

- Using data from the late 1990s, Butler found that the own-price elasticity of demand for hospital insurance in Australia is -0.50 for people aged under 65 and -0.12 for people 65 and over.¹¹⁷
- Using the 2004 wave of the HILDA survey, Cheng found price elasticities in the range of -0.32 to -0.35.¹¹⁸

115. The own-price elasticity of demand for an ordinary good is negative; ‘large’ in this context means a large absolute value.

116. Note that the price of insurance is typically defined as the ratio of the effective premium to expected benefits, where the effective premium is the net-of-rebate premium. This means that although everyone pays the same premium for the same product, people of different ages and health status face different ‘prices’ for insurance, based on the benefits they can expect to receive from holding the policy.

117. Butler (1999).

118. Cheng (2014).

112. AIHW (2019). In 2017-18, the latest year for which there is complete data, the rebate cost \$5.88 billion, out of total Commonwealth recurrent health expenditure (including health-related payments to the states) of \$76.98 billion.

113. Doiron and Kettlewell (2018).

114. Eldridge et al (2017).

- Frech et al calculated an implied price elasticity of -0.37, based on consumers' response to the introduction of the PHI rebate.¹¹⁹

A range of studies have found that the introduction of the PHI rebate was a relatively unimportant factor in the rise of insurance coverage in Australia in the late 1990s. The general view in the academic literature is that most of the increase in PHI membership in the late 1990s was due to Lifetime Health Cover, with the rebate only having a modest effect.¹²⁰

A paper by Palangkaraya and Yong found that the Lifetime Health Cover 'accounts for at least 42 per cent and at most 75 per cent of the overall rise in PHI coverage,' with the balance due to the Medicare Levy Surcharge and the rebate.¹²¹ This ascribes a larger share of the increase in coverage to the MLS and rebate than other studies. While these findings imply that the rebate may have been more effective than is commonly found or assumed, they do not imply that the rebate is self-financing.

One paper found that the effect of the rebate on PHI membership is modest – removing the rebate would reduce the proportion of singles with PHI from 39 to 37 per cent, but would have the opposite effect on families (with coverage going from 53 to 55 per cent) due to the interaction with Lifetime Health Cover.¹²²

The fact that people are paid different levels of rebate depending on their age has created an opportunity to study whether the rebate affects the PHI membership. A recent study examined people aged just below and just above 65 and 70 years of age.¹²³ People above these age thresholds get a larger rebate, as a percentage of their PHI premiums.

119. Frech et al (2003).

120. Butler (2002), Frech et al (2003), Frech and Hopkins (2004) and Quinn (2002).

121. Palangkaraya and Yong (2005).

122. Ellis and Savage (2008).

123. Kettlewell et al (2018).

If the rebate has an effect on the take-up of PHI, this should be evident in a 'discontinuity' at these age thresholds, with higher rates of PHI membership above the thresholds compared to below. There is no discontinuity – people above the age thresholds are no more (or less) likely to have PHI. The authors therefore conclude that 'the policy has little effect on take-up of PHI and is best interpreted as a wealth transfer to elderly Australians who already have insurance.'¹²⁴

The finding that subsidies for supplementary insurance in systems with universal public coverage are not self-financing is not unique to Australia. Emmerson et al find that subsidies for private medical insurance in the UK would be far from self-financing.¹²⁵ Any subsidy would induce only a small number of additional members, and thus a small switch from public to private care, but the subsidy would need to be paid to all members. The cost of the subsidy therefore vastly exceeds the savings from reduced public care. They estimate that the price elasticity of demand for private insurance would need to be 'at least -1.28' if the subsidy were to be self-financing.¹²⁶ The finding that changes to the subsidy induce relatively small behavioural response is supported by other work.¹²⁷

Like Australia, Spain has a universal healthcare system funded from general taxation revenue, as well as supplementary private insurance. Researchers examined a policy change in the Spanish tax subsidy for private health insurance to examine whether the subsidy is self-financing, by estimating how the insurance premium affects the probability of having insurance and how having insurance affects health care use in the private and public systems. They find a price elasticity of -0.5, which is consistent with the Australia literature. They find no statistically significant increase in costs for public health care

124. Ibid.

125. Emmerson et al (2001).

126. Ibid.

127. For example, D. King and Mossialos (2005).

associated with removing the PHI subsidy in Spain and therefore ‘reject the self-financing hypothesis by a very large margin.’¹²⁸

In Quebec, a 1993 policy change reduced tax subsidies for private insurance by almost 60 per cent. By comparing Quebec to other provinces of Canada, which did not change policy, Finkelstein was able to estimate the effect of this policy change on insurance coverage. The implied elasticity is around -0.5.¹²⁹

Studies of insurance subsidies in the US have generally found a ‘very small elasticity of insurance take-up with respect to its after-tax price’ and that as a result, subsidies do not have a significant effect on insurance coverage.¹³⁰

Most studies find that few PHI members would be expected to drop their insurance in response to a reduction in the rebate. If the change in PHI membership in response to changes in the rebate is small, then the number of hospital admissions that are shifted from private to public hospitals would also likely be small. This implies that the extra spending on public care that would be required would be less than the savings from a reduction in the rebate; the rebate is not self-financing.

Is the PHI rebate self-financing?

The elasticities found in the academic literature, around -0.35 to -0.50, are much smaller than what they would need to be for the PHI rebate in Australia to be self-financing. A widely-cited Australian study found that the price elasticity of demand for private health insurance would have to be -1.43 for the subsidy to be self-financing.¹³¹ This is similar to an estimate for the United Kingdom, which found that an elasticity of at

least -1.28 would be required for subsidies of private health insurance to be self-financing.¹³²

Consumers’ relatively small response to price changes in the price of insurance is just one reason to doubt that the rebate is self-financing. There are others. An extensive review for the OECD concluded that in countries including Australia, ‘PHI has removed little cost pressure from public health financing systems,’ because the ‘privately insured often continue to use publicly financed health services’ and because ‘private hospitals concentrate on treating minor risks and elective care,’ leaving more expensive care to the public system.¹³³ Even if private patients use their insurance, their privately-financed care is sometimes performed in a public hospital, which may not ‘take the pressure off’ the system. Vaithianathan also notes that some people ‘self-insure’ – pay for private care without insurance – and that a premium subsidy may cause some such people to join PHI funds.¹³⁴ This does not cause a substitution of public for private care. If the supply of health care services in the private sector is relatively inelastic, a subsidy may merely lead to higher private health care prices, rather than a substitution of care; a second-round effect of this is that self-insured people may be more likely to seek public care.¹³⁵

A broad range of empirical work finds that the PHI rebate is not self-financing. Frech and Hopkins find that in the short-run, 16.5 per cent of the cost of the PHI rebate is offset by savings in public care.¹³⁶ This is comparable to an estimate by Deeble, whose findings imply that 13 per cent of the rebate is offset by savings in the public system.¹³⁷

128. López Nicolás and Vera-Hernández (2008, p. 1296).

129. Finkelstein (2002).

130. Gruber and Washington (2005).

131. Frech and Hopkins (2004).

132. Emmerson et al (2001).

133. Colombo and Tapay (2004).

134. Vaithianathan (2002).

135. Vaithianathan (ibid).

136. Frech and Hopkins (2004).

137. Deeble (2002). Note that this is Frech and Hopkins (2004)’s adjusted version of Deeble’s estimate; the original estimate that 26 per cent of the subsidy is offset by reduced spending on public care is adjusted down in light of the fact that this

Using data for 2007-08, Cheng simulates a reduction in the PHI rebate of 10 per cent, from its (then) level of 30 per cent to 27 per cent.¹³⁸ He shows that this would be expected to lead to an increase in public expenditure on hospital care of \$144 million, but that the Commonwealth would save \$359 million from the rebate reduction. In related work, Cheng found that removing the rebate entirely would have cost \$1.38 billion in extra public care in 2004-05, compared with the \$3 billion cost of the rebate in that year.¹³⁹ The rebate is therefore far from self-financing – a reduction in the rebate would save more than enough government money to cover the extra public activity. In short, ‘the cost of treating patients who drop private cover and rely on the public system is substantially lower than the cost of subsidising private insurance for the whole [insured] population.’¹⁴⁰

Lu and Savage find that the ‘carrots and sticks’ to induce PHI membership have had a ‘quite modest’ effect on public care and that the rebate is ‘an extremely costly way of reducing pressure on the public system.’¹⁴¹

Though recent work by Doiron and Kettlewell finds that PHI does induce substantial shifting of public hospital activity into the private sector, they conclude that these effects ‘may not be sufficient to offset the direct cost of the rebate.’¹⁴²

Frech and Hopkins find that the elasticity of demand for PHI is much smaller than would be required if the subsidy were self-financed. However, they note that the long-run consumer response would be larger. Using some plausible assumptions, they conclude that

figure reflects consumers’ response not only to the subsidy, but to the Lifetime Health Cover changes that were made around the same time.

138. Cheng (2013); see also Cheng (2014).

139. Cheng (2011).

140. Cheng (2014).

141. Lu and Savage (2006).

142. Doiron and Kettlewell (2018).

the long-run elasticity is around -1; much larger than the short-run effect, but still short of their estimate of what would be required to be self-financing (-1.43).¹⁴³

A summary of the research for the Parliamentary Library found that ‘there is no clear correlation between increased levels of private health insurance membership and the extent of pressure on public hospitals’.¹⁴⁴

Contrary views

Not all research finds that the PHI rebate is unjustified. Gans and S. P. King argue that some public subsidy of private insurance is warranted.¹⁴⁵ They outline a theoretical model in which people with poor health self-select into private insurance but are still required to contribute to the cost of the public system through taxes. As a result, people with poor health are subsidising the healthy; this can be corrected through a subsidy. They advocate a lump sum, rather than a percentage (*ad valorem*) rebate. The findings that emerge from their model are, of course, dependent on the assumptions that are made, such as identical base income across individuals.

Work commissioned by private insurers also does not always come to the same conclusions as the academic literature. For example, a report by Deloitte for the Australian Health Insurance Association in 2011 concluded that means testing the PHI rebate would lead to a substantial increase in demand for public care, and the cost of servicing this increased demand would outweigh the savings from the reduced rebate.¹⁴⁶ In the academic literature, consumers’ responsiveness to changes in the price of insurance is generally estimated using data

143. Frech and Hopkins (2004).

144. Pratt (2005, p. 3).

145. Gans and S. P. King (2003).

146. Deloitte (2011).

on individuals' actual PHI membership rather than their response to hypothetical scenarios. The Deloitte report, by contrast, surveyed a representative sample of households and asked them how they would respond to a price increase of a given size. They find larger price elasticities than previously estimated. The work also finds that a large proportion of PHI members state they would downgrade their cover in response to higher PHI premiums.

Another report, commissioned by Private Healthcare Australia, relies on a survey by *Ipsos*, which asked consumers how they would respond if the rebate were to be reduced by various amounts. The authors calculate implied elasticities from these responses of between -0.68 and -0.95, markedly higher than the -0.35 to -0.5 range found in the literature both in Australia and elsewhere. They find that reallocating funds from the PHI rebate to public care would be likely to reduce the efficiency of the health system; the large elasticity used in their calculation is important in driving this result.¹⁴⁷

Elasticities estimated based on consumers' actual behaviour – their revealed preference – are likely to be more informative than those derived from surveys that specifically draw a person's attention to an issue.

147. Furnival et al (2017).

Appendix C: Potential options to address youth exodus

A range of policy options could achieve the goal of increasing the proportion of young people that have private hospital insurance. Some of the more prominent proposals are listed in Table C.1, along with the reasons they were not advanced as recommendations in this report. Each of them conflicts with one or all of the principles for reform outlined in Section 4.1.

Table C.1: Other options to address the youth exodus from PHI

Option	Budget neutral?	PHI remains affordable for older people?	Comments
Increase rebate	No	Yes	Rebate likely not self-financing; increasing it is bad value for taxpayers' money.
Fringe benefits tax exemption for employees for PHI products for people under 30	No	Yes	This represents an increase in the subsidy through other means.
Age-based risk rating	Yes	No	Highly disruptive to industry, difficult transition.
Equalise rebate by reducing rebates for people 65 and over, and increasing rebate for people under 30	Yes	Mostly	There will be a marginal increase in the cost of PHI for people 65 and over. This may be a suitable transition arrangement.
Commence lifetime cover at age 25	No	Yes	This policy would increase take up of PHI in younger people so would increase rebate expenditure. However, the policy would also increase the 'lock out' effect where PHI becomes less attractive for people to join PHI at age 40 or above.
Extend family cover to include people aged 25-30 in the family policy	Yes	Yes	This would require family premiums to increase to cover the cost of people aged 25-30 in the family home and would reduce the number of people aged 25-30 who buy independent policies. The net effect may not be revenue-positive for PHI funds.

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