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Australian Unity's Submission:
Productivity Commission Issues Paper
Performance of Public and Private Hospital Systems

Background

Australian Unity Limited is a national health, financial services and retirement living organisation with more than 400,000 customers, including 185,000 members and more than 1,200 employees. We operate the sixth largest private health insurance fund in Australia and provide cover for more than 300,000 people. We also operate a corporate private health fund, GU Health, which provides tailored products to corporate clients.

We welcome the opportunity to respond to the Performance of Public and Private Hospital Systems, Productivity Commission Issues Paper dated June 2009. We understand that the private health industry peak body, The Australian Health Insurance Association and The Australian Health Services Alliance, of which Australian Unity is a member organisation, have both provided comprehensive responses to this Issues Paper that fundamentally address our views.

However, Australian Unity would like to make the following observations to highlight our specific concerns as they relate to Australian Unity business needs.

Data Collection

In line with the recommendations of the recently released NHHRC Final Report, Australian Unity endorses the needs for more comprehensive, consistent and accessible data collection that crosses both the public and private health sectors.

We know that this may be a challenge at present as data collection requirements and practices vary widely across and between public and private hospitals. We believe that if consistent comparative frameworks are not available or there are significant issues with data quality or integrity, it is better to exclude such information from any performance measure. If these issues can be addressed over time, the performance comparison framework and complexity of the performance measures could then be

expanded accordingly. We expect that any information collected should be able to be analysed accurately and be valuable to the end user.

Australian Unity believes that using Diagnostic Related Groupings (DRG's) would be more accurate that comparing procedures. The DRG recognises the other factors, like co-morbidities that influence the cost outcomes of, at face value, similar procedures.

Australian Unity would expect that comparisons be made using DRG's that are common to both public and private hospitals and that this is done on more than just a subset of the 600+ DRGs. We would recommend that DRG's that are not applicable in both public and private hospitals should not be included.

Payment methods differ significantly between public and private hospital. There are also a range of payment methods between private hospitals (eg fee for service or episodic funding) that influence the way data is captured. As a result, we believe that it would be accurate to use hospital cost rather than hospital charge data to better reflect the actual cost of admissions.

The current data collection arrangements are complex and captured across different agencies. Australian Unity believes that the National Hospital Cost Data Collection data should be the source of truth for public and private hospital information. This information is based on hospital cost rather than hospital charge and therefore aligns with our view that this is a more accurate reflection of actual costs.

However, we note that this collection methodology is not available for associated hospital medical costs, which is only captured via the Hospital Casemix Protocol (HCP) data for the private sector. In addition, this is recorded as a charged amount rather than a hospital cost amount. As such, it is not as accurate as we would prefer.

Australian Unity also notes that public hospital payments, through State Government funding agreements, include allowances for capital developments. We believe that these amounts should be captured and declared.

Informed Financial Consent (IFC)

Australian Unity fully supports the need to provide our members with IFC. We support the recommendation to access the data from the IPSOS survey as a means to measuring the degree of IFC provided.

Indexation Factor for the Medicare Levy Surcharge (MLS) Thresholds

The Productivity Commission has also been asked to advise the Government on the most appropriate indexation factor for the MLS thresholds. This is a very important issue as it is one of the policy tools the Government has that will determine progressively over time, the risk profile of the Private Health Insurance (PHI) policyholders as a group, and therefore the extent to which PHI premiums need to increase.

The data and evidence presented in this submission show that the MLS thresholds (and therefore the future indexation of those thresholds which is the subject of the Commission's enquiry) are an important determinant of the rates at which people aged 25 to 39 will elect to be covered by hospital insurance in the future, and that this rate of coverage by younger people will be an important determinant of the rate at which premiums for hospital insurance will need to be increased in the future. All other things being equal, the lower the MLS threshold, the lower will be the amount of a community rated hospital premium which is needed to cover costs of hospital treatment.

The persons covered by hospital insurance were ageing at about 0.3 years to 0.4 years per year from 2003 to 2006. By contrast, the average age of all persons covered for hospital treatment has remained relatively stable at about 39.8 years from June 2006 to March 2009, due to increased coverage at younger ages (which has offset the natural Australian population ageing effect of about 0.2 years per year). This age stability has assisted in keeping hospital claims increases at lower levels since June 2006 than had applied over the previous few years, and this has been reflected in lower premium increases over this period than had applied up to June 2006.

All hospital insurance policyholders are expected to benefit from lower premium increases in the future if the rate of increase in the MLS thresholds is reduced (or if no automatic indexation is included), compared to a position if high rates of indexation are applied automatically to the MLS thresholds.

All income earners will benefit from an increased understanding of the MLS system if the MLS thresholds are maintained at "round numbers", and then indexed periodically to other "round numbers" as circumstances require.

We therefore propose that the MLS thresholds are not indexed automatically, but are increased from time to time to amounts which are consistent with maintaining the numbers of younger people who are covered by hospital insurance, such that increases in the community rated premiums for hospital insurance can be maintained at affordable levels.

The remainder of this submission provides the background to the conclusion set out above.

Purpose of the MLS

The purpose of the MLS is to provide a financial incentive for people to be covered by private hospital insurance (for those people who have "sufficient" income). The MLS does not apply to those persons who do not have General Treatment cover (also called "ancillary" cover or "extras" cover) which provides insured benefits against the costs of eligible non-hospital treatments such as dental, optical, physiotherapy, etc.

The MLS threshold (income) determines the number of people who are affected by the MLS.

Determining Premiums for Hospital Insurance: Community Rating

The Private Health Insurance Act 2007 requires that premiums for hospital insurance are "community rated" (as defined in the Act). Although the costs of hospital insurance increase steadily as the average age of the persons covered increases (females of child bearing ages are an exception), community rating requires that all persons covered by a hospital product are charged the same premium (subject to additional premiums which are required to be charged under Lifetime Health Cover (LHC), see below for detail on LHC). The effect of community rating is that hospital premiums over the whole PHI industry reflect the (claim weighted) average age of those who are covered by hospital cover (and hospital premiums increase as the average age of those who are covered by hospital cover increases over time). Data over recent years illustrating this feature are set out below.

If the current persons who are covered for hospital insurance in Australia were to remain stable over time (and therefore to increase in average age by one year for each year which passed), costs covered by hospital insurance would increase by about 4% to 5% each year currently (in addition to cost increases due to general price increases, excess healthcare price increases above general price increases, and increases in costs arising from increased utilisation at each age group due to increased availability of medical services, increased requirement for treatments, etc). Such cost increases would be expected to average about 9% to 10% each year in the long term, based on average price inflation of 2.5%pa. Cost increases at this level would translate into similar levels of increases in the premiums for hospital insurance, which would rapidly erode the affordability of hospital insurance over time (and especially so for younger policyholders who already on average subsidise the costs of older policyholders under the community rated premium requirements, see below).

To be sustainable in the longer term, a community rated PHI system must have a regular inflow of persons taking out hospital cover at ages under the (claim weighted) average age (under age 50 currently). Therefore, any Government policies which will have an effect on the PHI system must be assessed as to their impact on these under average age people who may join (or elect to maintain their coverage under) the PHI system.

Link of MLS with Hospital Insurance Premiums

The level of the MLS thresholds (which will be determined by their future indexation) has an important effect on the take up of hospital insurance by persons who are younger than the average age both because older people are more likely to take out hospital cover because the premiums (determined under community rating) represent good value for older people, and also because many older people have relatively low taxable incomes and therefore are not affected by the MLS thresholds. It is reasonable to ask, in a community rated premium system, why financially rational younger people in average (or better) health would join the community rated system which requires them to pay premiums which so heavily subsidise the costs of older persons. The major financial reasons are the MLS penalty which applies if the person does not join the system, and to a lesser extent Lifetime Health Cover premium loadings.

The average subsidy paid by the average younger hospital policyholder (age 25 to 49) as a result of community rating of their hospital insurance premium is in the

order of one-third of the community rated cost of the hospital insurance. The level of these subsidies varies substantially depending on the policyholder's family status, gender, age, residence, level of hospital insurance coverage, etc.

The Commission will likely have access to Treasury data that should confirm that the majority of people whose income is such that the MLS will apply to them do elect to take out hospital cover, and therefore do not pay the MLS. Evidence by Treasury to recent Senate hearings confirms that the position is approximately as follows:-

Estimated Numbers of Taxpayers			
Annual Income for MLS	**With Hospital Insurance**	**Without Hospital Insurance**	**% with Hospital Insurance**
$75,000 to $90,000	900,000	180,000	83%
$90,000 to $120,000	700,000	130,000	92%
$120,000+	700,000		
Total	2,300,000	310,000	88%

The table shows that while analysis of PHIAC data shows that approximately 43% of persons at March 2009 who are aged between 25 and 49 hold hospital insurance, about 88% of those with incomes over $75,000pa are estimated by Treasury to hold hospital insurance. Material below provides evidence that the MLS is a contributor to the decision made by income earners in these income brackets to hold hospital cover.

One reason for the position in the table above is that the MLS thresholds (and the level of the MLS itself) have been set by the Government at levels which make it financially attractive for most persons who are affected by the MLS to avoid the MLS tax by taking out hospital insurance (the person will likely outlay less in premiums than the alternative of paying the MLS if no hospital insurance was held, and as a bonus may even make use of their hospital insurance cover).

The economics of the Government's recently announced means test of the PHI premium rebate and introduction of new MLS thresholds with associated increased MLS tax rates are summarised in the table below for single taxpayers (based on an average "comprehensive coverage" Hospital premium in NSW of $900 per annum, and a "restricted coverage" Hospital premium of $600 per annum, both premiums being after reduction by 30% for the current means test free premium rebate, and including a $500 annual excess, and no Lifetime Health Cover loading to the premium):-

Single Taxpayer		**Annual Premium Net of Rebate Person Under Age 65**	
Annual Taxable Income	Medicare Levy Surcharge *	Comprehensive Hospital	Restricted Hospital
$70,000 - $75,000	$700	$900	$600
$75,001 - $90,000	$750	$1,029	$686
$90,001 - $120,000	$1,125	$1,157	$771
$120,001 +	$1,800	$1,286	$857

***** On lowest taxable income in range

All amounts in the table above are doubled for couples.

The table shows that single taxpayers (in NSW) with incomes over $70,000 pa will generally remain (as currently) better off financially by purchasing a “restricted coverage” Hospital product compared to the alternative of paying the MLS. Those policyholders who have a “comprehensive coverage” Hospital product and incomes in the range $75,000 to $100,000 may (if the proposed means testing of the PHI premium rebate proceeds as announced) consider trading down to a “restricted coverage” Hospital product, as a result of the Government’s announcement.

These conclusions do not allow for Lifetime Health Cover (LHC) which requires the insurer to charge an additional 2% of the community rated premium for each year by which a person’s age on **first purchasing Hospital Insurance from any Insurer** exceeds age 30 (eg, a person first purchasing at age 35 would pay a premium equal to 110% of the community rated premium for the person’s chosen product). The maximum LHC additional premium is 70%. When LHC was introduced, all persons who were covered by hospital insurance at 30 June 2000 were “grandfathered” into the system, and do not pay LHC premium additions (subject to maintaining cover within prescribed limits). The interaction of LHC with both the MLS and with the community rated premium system is complex, (eg, those persons who were over age 30 at June 2000 and who did not become covered by hospital insurance at that date can face much higher premiums than the community rated premium if they elect to take up hospital insurance now, and these much higher premiums may explain why it is financially appropriate for these people to pay the MLS rather than take up hospital insurance). At 31 March 2009, only 10% of hospital insurance policyholders were paying a LHC additional premium.

We conclude that the potential MLS payment is most relevant to the decision to first purchase hospital insurance at ages below say age 40, and that the significance of the MLS significantly exceeds the significance of LHC premium additions in the decision to purchase hospital insurance for the average person at these younger ages.

Data on Hospital Insurance Coverage and Premium Increases

Until October 2008, the MLS thresholds were maintained at the levels at which they were introduced from July 1997 (namely $50,000 for a single and $100,000 for a couple). No indexation was applied through this period. In October 2008, the MLS thresholds were increased to $70,000 for a single (and to $140,000 for a couple). Changes have also been made in recent years to the definition of the income which applies for MLS purposes.

Because the MLS thresholds were fixed from 1997 to 2008, progressively more people became affected by the MLS thresholds through this period as incomes increased, especially when average incomes approached, then exceeded the single person MLS threshold from about the mid 2000’s. The effect of this increasing relevance of the MLS for hospital insurance participation by younger people is shown in the table.

Period	Coverage for 25-49 age band
June 2003	42.9%
June 2004	41.8%
June 2005	41.2%
June 2006	41.0%
June 2007	42.0%
June 2008	43.3%
March 2009	43.3%

PHIAC provides data by age for persons covered for hospital treatment. Analysis of this data from June 2003 to March 2009 is in the following table:-

Hospital Insurance : History of Average Age & Premium Increase

Year	Average PERSON Weighted Age (years at end of year)	Average CLAIM Weighted Age (years at end of year)	Average Premium Increase Which Applied for Year (%)	Persons Age 25-49 who have Hospital Insurance (% population)
FY03	38.8	57.7	6.9	42.9%
FY04	39.2	58.2	7.4	41.8%
FY05	39.5	58.5	7.6	41.2%
FY06	39.8	58.8	8.0	41.0%
FY07	39.9	58.8	5.7	42.0%
FY08	39.8	59.2	4.5	43.3%
FY09 (March)	39.9	59.2	5.0	43.3%
FY10	??	??	6.0	??

The Table above shows that persons covered by hospital insurance were ageing at about 0.3 years to 0.4 years per year from 2003 to 2006. By contrast, the average age of all persons covered for hospital treatment has remained relatively stable at about 39.8 years from June 2006 to March 2009, due to increased coverage at younger ages (which has offset the natural Australian population ageing effect of about 0.2 years per year). This age stability has assisted in keeping hospital claims increases at lower levels since June 2006 than had applied over the previous few years, and this has been reflected in lower premium increases over this period than had applied up to June 2006.

The Table above shows no material increase in the average age of hospital policyholders has arisen to March 2009 from the increase in the MLS thresholds from October 2008. This is not surprising, as policyholders can be expected to make decisions based on MLS considerations at the time that their tax returns are lodged, and even then will drop their insurance progressively as their perceived need for the insurance becomes lower.

While the calculation of the average premium increase percentage involves many assumptions, the amount of the average premium increase does appear to be lower if the average age of hospital policyholders increases at a lower rate. As shown above, the increase in the average age of hospital policyholders is determined (in part) by the proximity of the MLS thresholds to the general income levels of younger hospital policyholders.

Conclusion

Australian Unity supports the establishment of comprehensive, accurate and consistent data collection, analysis and reporting requirements for both public and private hospitals.

We welcome the opportunity to be part of this discussion following the release of the Productivity Commission's Issues Paper and wish to actively contribute towards a solution to better understand and compare the performance of public and private hospitals. We see this as the platform for greater transparency in other areas of performance that will provide our members with information to facilitate choice and better health outcomes.

With regard to the indexation of the MLS thresholds, there was a very desirable effect on the risk profile of PHI policyholders overall (and therefore on PHI premium increases) which arose from 2006 to 2008 from having the MLS thresholds at a relatively low level compared to average wages. This period of relatively low premium increases cannot be expected to continue under the new policy settings.

We believe the Productivity Commission should include in its report the estimated effect of its recommendation for indexation of the MLS thresholds on PHI premium increases over time.