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cc "senator.wong@aph.gov.au" <senator.wong@aph.gov.au>
bcc
Subject Correspondence from George Savvides [SEC=No Protective Markir

22/11/2012 14:18

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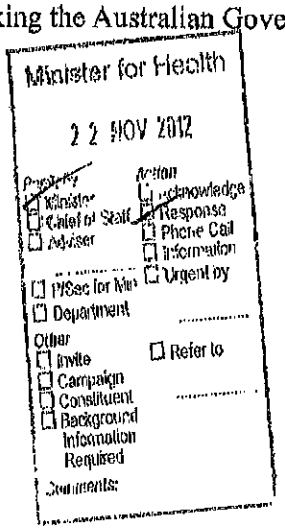
Dear Minister

Please find attached correspondence and paper on indexing the Australian Government rebate for your attention.



Regards

George

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22 November 2012

The Hon Tanya Plibersek MP
Minister for Health and Ageing
Parliament House
Canberra ACT 2600

Dear Minister

If ever there was a time to make the most of Medibank Government ownership, then this is it! My team has taken the initiative and put together a thought leadership piece that explores the pros and cons of indexing the Australian Government Rebate at a product, fund or industry level. We hope that this will assist you to consider implementation options that best meet the needs of the Government, industry and public.

As you will see the paper makes interesting reading and strongly recommends implementation at an industry level to avoid confusion for the public and minimise implementation expense.

As always, my team is willing and available to meet with you and your staff at any time to talk through the implications.

Yours sincerely

George Savvides
Managing Director

cc. Senator the Hon. Penny Wong MP, Minister for Finance and Deregulation

medibank
For Better Health

Indexing the Australian Government Rebate
Implementation implications

Corporate Affairs Team
November 2012

Executive Summary

Reforms to the Australian Government Rebate (AGR) for private health insurance (PHI) were announced in the Mid-Year Economic and Fiscal Outlook on 22 October 2012. The Government is yet to announce how it will implement the AGR reforms. Medibank's interest in the implementation of the AGR reforms is driven by a desire to minimise implementation costs and disruption of competitive forces in the PHI industry.

There is significant concern that the Government is considering introducing a rebate for each of the 20,000 products currently in the PHI market. This option would not guarantee Government savings, would have high implementation costs compared to alternatives and will increase the regulation of an already highly regulated industry.

While not exhaustive, Medibank has analysed options which would index the rebate at the individual, fund and industry level with either a fixed or a proportional rebate. A proportional rebate is one that is applied as a percentage of premiums determined either at a product, fund or industry level. For example, the current rebate model is a proportional one whereby a percentage of premiums is paid as a rebate (those percentages are currently set at an industry level and are dependent on age and income). A fixed rebate is a pre-determined rebate amount available to members at either a product, fund or industry level. For example, a fixed rebate amount at an industry level might mean that all single members aged up to 65 receive $500 per year rebate, and single members aged over 65 receive $750 per year rebate. A fixed rebate approach would potentially be more complex for PHI funds to administer given IT systems are established on a proportional payment model.

Medibank's analysis has been undertaken on the basis that implementation would ensure that the following objectives are met:

- The forecast savings are delivered (certainty of savings);
- The costs of implementation are minimised (transaction costs);
- The rebate is viewed as fair (equity);
- The policy objectives of the rebate are maintained (efficiency); and
- The AGR is easy for consumers to understand (transparency).

Medibank considers that the implementation mechanism which best meets these objectives are an industry wide proportional rebate. Through maintaining the fundamental design elements of the current AGR implementation costs for private health insurance funds will be minimised, the policy objectives of the AGR maintained and consumers will readily understand the system.

This briefing sets out a number of possible implementation options. The analysis focuses on implementation of the new indexation arrangements, but includes assessment of how the removal of the AGR on the lifetime cover loading could also be implemented.

Background

The Government announced reforms to the AGR in the 2012-13 Mid-Year Economic and Fiscal Outlook. These reforms are forecast to deliver the Budget $1.09 billion in savings over the forward estimates. Importantly, the reforms will help ensure that the cost of the AGR grows at a sustainable rate beyond the forward estimates.

The AGR rebate was introduced in 1999 with the objective of supporting Australians to purchase PHI and reduce pressure on the public hospital system. Under current arrangements individuals receive a rebate of between 10 and 40 per cent based on their income and age. The current design of the AGR provides a higher rebate the higher the premiums, supporting individuals who cover more of their health care risks.

From 1 April 2013 the rebate will no longer be set as a fixed percentage of PHI premiums, but will be increased by the lesser of CPI or the increase in commercial premiums. The AGR will also no longer apply to the lifetime cover (LHC) loading on policies for individuals that take out PHI over the age of 31 from 1 April 2013.

Issues

The challenge now facing Government is how to implement the AGR reforms in a manner that will guarantee the forecast savings, minimise implementation costs, ensure equity, maintain the policy objectives of the AGR and be easily understood by consumers. The 'higher' the level of implementation, the less complex the implementation will be. For example, implementation at a product level, therefore, will have a significant impact on the complexity of the system from both an insurer and customer perspective. Implementation at a system level will have minimal implementation implications.

1. Implementation mechanism

The current AGR provides a proportional rebate of the total premium costs based on age and income. For example, members receive a rebate that ranges from 10 % to 40 % depending on their age and income level. The Government could choose to maintain this mechanism or move to a fixed dollar rebate. Both of these options are outlined below.

1.1 Proportional Rebate

The current proportional rebate levels could be adjusted annually. Each year the rebate levels would be reduced by the difference between the growth in premiums and the change in CPI. For example, assuming annual inflation of 2.5 per cent and annual premium rises of 5 per cent, then over 5 years the base rebate level would be reduced as illustrated below:

Year commencing 1 April	CPI Increase	Premium Increase	PHI Rebate Adjustment	PHI Rebate Percent
	[A]	[B]	(1+[A])/(1+[B])	
2012				30
2013	2.6	6.0	0.968	29.04
2014	2.6	6.0	0.968	28.11
2015	2.6	6.0	0.968	27.20
2016	2.6	6.0	0.968	26.33
2017	2.6	6.0	0.968	25.49

*Note figures in table have been rounded up.

The other rebate levels across the age and income categories would likewise be reduced. For example, under the scenario above from 1 April 2013 the rebate for a 35 year old earning $90,000 would be reduced to 19.52 % (Current Rebate*PHI Rebate Adjustment = 20 *0.98 = 19.52 %).

1.2 Fixed Rebate

The Government could choose to move away from a proportional rebate and implement its reform through a fixed dollar rebate. This would require using 1 April 2013 AGR levels, adjusted annually for CPI or average premium rises across the industry. The Government could choose the base as: the AGR paid on individual policies; the average AGR paid to members of individual funds; or the average AGR paid across the industry.

The current differentials between individuals based on age and income could be maintained, and the rebate would work in a similar way to other Government payments. Complications would arise when the individual changed policies, funds or their circumstances changed and they were entitled to a different rebate level.

2 Indexation Base

In order to implement the Government's proposed reforms to the AGR the base to which indexation will be applied must be considered. There are three broad 'bases' for CPI indexation:

- Product;
- Fund; and
- Industry.

Each of these will be considered from both a fixed and a proportional rebate approach.

2.1 Product

CPI indexation could be applied to the current AGR level for individual PHI products. The dollar rebate received by individuals for each policy would be the same under a fixed and proportional rebate at the product level. However, tracking individual AGR levels across all products in the

system would be more costly and complex to implement than tracking individual rebate levels across products in the system.

In order to implement indexation at the product level, information on the premium levels across the 20,000+ products currently in the market would be required. If the current system of differential rebates based on age and income were maintained there would be 140,000 different AGR levels. This option would lead to significant additional regulation of the PHI industry. A process for assessing new products and ongoing tracking of any changes to products (that may warrant adjustment of the underlying AGR (or AGR percentage) would need to be developed. PHI funds would also need to implement fundamentally new IT systems to administer such an approach.

Medibank has estimated that this would require up to $6 million in set up costs alone and a significant burden annually in ongoing expenditure for its operations. Each of the 35 funds across the industry would have similar costs, regardless of size, and these will ultimately be passed onto consumers in the form of higher premiums. ***Implementation at a product level is the most complex and costly to administer.***

2.2 Fund

Average AGR benefits paid on policies by individual PHI funds could be the base for CPI indexation. To implement indexation at the *fund level*, current premium levels and changes across the 35+ PHI funds would be required. If introduced as a proportional rebate, then new IT systems would not be required but annual adjustments to the rebate levels currently in the system would be needed. A move to a fixed rebate at the fund level would require new IT systems, but this would be relatively straight forward as there would only be a single rebate level for each fund to implement.

2.3 Industry

The final option is that CPI indexation could be applied to average AGR benefits paid across the *industry*. To implement industry wide indexation, premium levels and changes across the industry would be required. A *proportional rebate* at the industry level would work in the same way as the current rebate and would not require a new IT system. Annual adjustments to the rebate levels would be needed, resulting in significant expenditure to administer. However, a fixed rebate would require new IT systems, but as with the fixed fund rebate this would be relatively straight forward due to the use of a single rebate level.

Analysis

The different implementation options have been assessed against the following policy objectives using a matrix:

- Meeting the Government's savings objectives (certainty of savings);
- PHI fund costs of implementation are minimised (transaction costs);
- The rebate is viewed as fair (equity);
- The policy objectives of the rebate are maintained (efficiency); and

- The AGR is easy for consumers to understand (transparency).

Each option is assessed by the degree to which these objectives are met (HIGH, MEDIUM and LOW).

			Issues				
			Certainty of Savings	Transaction Costs	Equity	Efficiency	Transparency
Level and Mechanism	1.Product *The base for indexation would be the AGR associated with individual products as at 1 April 2013*	*1.1 Fixed Rebate* *The AGR for individual insurance products across each age and income bracket would be indexed by CPI each year*	Medium A fixed dollar rebate linked to individual policies may result in fewer savings if individuals switch to policies with a higher base rebate. The removal of the AGR on the LHC would automatically be implemented as the base for indexation could exclude the lifetime loading.	Low PHI funds would need to keep track of the AGR level for each product across all the age and income brackets. A process would be needed to set the AGR for new products and to make changes to existing products. This would significantly add to regulatory oversight, and limit innovation.	Medium Individuals would continue to receive a higher AGR based on the premiums paid, adjusted for age and income.	Low Individuals would continue to be provided with greater support for higher cost products with more comprehensive coverage, reducing demand for public hospital services. However, there would be no incentive for funds to lower premium increases. Innovation in the PHI market would be stifled due to the additional regulation and oversight required. This will lead to higher premiums in the	Low Rebates that vary across products, age and income brackets would result in 140,000+ rebate levels and are likely to confuse consumers, especially as premium increases vary across products over time.

			Issues				
			Certainty of Savings	Transaction Costs	Equity	Efficiency	Transparency
						future.	
		*1.2 **Proportional Rebate** The AGR percentages would be adjusted for each product individually based on premium increases Policies with lower premium increases over time would have higher rebate percentages*	Medium If individual policies are used as the base for indexation, there would be no difference in the dollar rebate for each policy under a proportional or fixed rebate. As with a fixed rebate, a proportional rebate linked to individual policies will deliver fewer savings if individuals switch to policies with a higher base rebate. Funds could implement the removal of the AGR of LCH by applying the AGR to the base premium, excluding	Very Low PHI funds and the Government would need to keep track of the individual AGR percentages for each product across all the age and income brackets. This would be approximately 140,000 separate AGR percentages across the system. This would add significantly to the costs and complexity of implementation. As with a fixed rebate, a process would be needed to set the AGR for new products and to make changes to existing products.	Medium Individuals would continue to receive a higher AGR based on the premiums paid, adjusted for age and income.	Medium Individuals would receive greater support for higher cost products with more comprehensive coverage, helping reduce demand for public hospitals. There would be stronger incentives for funds to lower premium increases, as customers would appear to benefit from a higher AGR percentage (although the actual dollar rebate would not be affected). Innovation in the PHI market would be stifled due to the	Low AGR percentages would vary across products, age and income brackets would result in 140,000+ AGR levels. This is likely to confuse consumers, especially as premium increases vary across products over time. It may be difficult to explain why different policies attract a different percentage rebate from the Government.

			Issues				
			Certainty of Savings	Transaction Costs	Equity	Efficiency	Transparency
			the lifetime cover loading.	This would significantly add to regulatory oversight, and limit innovation.		additional regulation and oversight required. This will place upward pressure on premiums.	
Level and Mechanism	2. Fund *The base for CPI indexation would be the average AGR across individual funds as at 1 April 2013*	*2.1 Fixed Rebate* *Average AGR payments across PHI funds for each income and age group would be indexed by CPI*	Low Savings may not be realised as individuals switch to PHI funds with higher fixed rebates. To implement the removal of the LHC, the calculation of average AGR payments would need to exclude this component of current AGR payments.	Medium PHI funds would have to implement new systems for a fixed rebate. In addition to the current age and income categories, it may require changes to take into account variation in product (hospital, ancillary) and family type (single, couple, family).	Low Individuals would receive higher or lower AGR based on their PHI fund not the premiums paid, undermining horizontal equity. Adjustments made for age and income would maintain vertical equity.	Low There would be an incentive for individuals to switch to lower levels of coverage, increasing reliance on the public health system. However, there would be a direct incentive for funds to lower premium increases.	Medium There would be over 300 fixed rebate levels across all the funds, income and age categories.
		2.2 Proportional Rebate *The AGR percentages would be adjusted for each fund*	Medium Savings may be undermined by individuals switching between funds and levels of cover. Adding to costing uncertainty, the	High While funds would have to adjust the rebate annually, it would work in the same way as the current system at the fund level.	Medium Individuals would receive a higher proportional rebate based on the ability of their chosen PHI fund to keep premium increases	High Individuals would be supported in taking out more comprehensive insurance, reducing demand on the public system.	Medium There would be over 300 proportional rebate percentages across all the funds, income and age categories.

			Issues				
			Certainty of Savings	Transaction Costs	Equity	Efficiency	Transparency
		individually based on premium increases Funds with lower premium increases would have higher rebate percentages	average premium on policies at a fund level may not reflect the actual premiums paid, Funds could apply the AGR to the base premium, excluding the lifetime cover loading.		low. This would undermine horizontal equity. Adjustments made for age and income would maintain vertical equity.	In addition, funds would be incentivised to limit premium increases and provide members a higher proportional rebate.	
Level and Mechanism	**3. Industry** *The base for CPI indexation would be the average AGR across the industry as at 1 April 2013.*	*3.1 Fixed Rebate Average AGR payments across the industry for each income and age group would be indexed by CPI*	High A fixed rebate would provide certainty to the Government on the level of expenditure under the AGR, with the only variable the number of individuals taking out coverage.	Medium PHI funds would have to implement new systems for a fixed rebate. Likely to require changes which take into account variation in product (hospital, ancillary) and cover type (single, couple, family).	High Adjusting for age and income all individuals would receive equal assistance from the Government.	Low There would be an incentive for individuals to switch to lower levels of coverage, increasing reliance on the public health system. However, there would be an incentive for funds to lower premium increases.	Medium A fixed rebate across the industry would result in a minimum of 9 rebate levels, however these may need to be augmented to account for variation in product (hospital, ancillary) and cover type (single, couple, family).

			Issues				
			Certainty of Savings	Transaction Costs	Equity	Efficiency	Transparency
		*3.2 **Proportional Rebate** The AGR percentages would be adjusted each year based on average premium increases across the industry.*	High Assuming the proportional rebate was set with knowledge of annual premium increases the only variables would be the level of cover and number of individuals taking out cover.	High While funds would have to adjust the rebate annually, it would work in an identical way to the current system.	Medium Individuals would receive a higher rebate amount based on the premiums paid. Adjustments made for age and income would maintain vertical equity.	Medium Individuals would be supported in taking out more comprehensive insurance, reducing demand on the public system. However, there would be no incentive for funds to lower premium increases.	High As with the current system there would be 9 different proportional rebate levels based on the age and income of individuals.

Conclusion

Medibank's analysis of the implementation options available to the Government supports the following conclusions:

- A proportional rebate will more effectively meet the broad policy objectives of certainty of savings, low transaction costs, equity, efficiency and transparency than a fixed rebate;
- An industry wide indexation base would deliver greater certainty of savings, lower transaction costs, a more equitable and transparent than either a fund or product level indexation base; and
- From an industry and policy perspective the least favourable option would be introducing either a fixed or proportional rebate at the product level.

Medibank therefore strongly urges the Government to consider impact when determining how the indexation of the AGR will be implemented. It is recommended that the most cost effective and efficient way to do this is to maintain an industry wide proportional rebate which is adjusted annually to take into account average premium rises and increases in the CPI.

The Hon Tanya Plibersek MP
Minister for Health

The Hon Dr Michael Armitage
Chief Executive Officer
Private Healthcare Australia
Unit 17G
Level 1
2 King Street
DEAKIN ACT 2600

Dear Mr Armitage

My Department will be consulting with the industry over the coming months on a number of other issues facing the private health sector including discussions on options for further simplification of premium setting that will drive competition and continue to deliver strong consumer protection from 2014.

As discussed during our meeting on 16 October, I believe that we can work together co-operatively on many of these issues. I look forward to working with you further.

Once again, thank you for writing.

Yours sincerely

Tanya Plibersek

15-12-12

Parliament House
CANBERRA ACT 2600

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The Hon Tanya Plibersek MP
Minister for Health

Mr George Savvides
Managing Director
Medibank Private Limited
GPO Box 9999
MELBOURNE VIC 3001

Dear Mr Savvides

Thank you for your letter of 22 November 2012 regarding changes to the Australian Government rebate on private health insurance (the rebate) as announced in the 2012-13 Mid-Year Economic and Fiscal Outlook.

As you are aware, the Government will undertake discussions with industry and consumer groups on options for further simplification of premium setting that will drive competition and continue to deliver strong consumer protection from 2014.

I appreciate the offer for your team to talk through the implications of the recently announced changes to private health insurance with me and my staff. I understand a preliminary discussion with my Department occurred on 30 November 2012, at which time it was indicated that any information provided will be considered in the course of the aforementioned consultation process that will take place following the conclusion of the 2013 premium setting round.

I look forward to your involvement in these discussions.

Once again, thank you for writing.

Yours sincerely

Tanya Plibersek

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