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National Commission of Audit
Commonwealth Government of Australia
Email: submissions@ncoagov.au

Dear Commission

nib health funds limited (nib)

We welcome the opportunity to make a submission to the National Commission of Audit.

nib is Australia's fourth largest private health insurer providing health cover to almost 1.2 million people in Australia and New Zealand. Established more than 60 years ago, our vision is to help people finance and access healthcare. Today nib provides health and medical cover to international students, skilled migrant workers as well as Australian and New Zealand residents.

nib is also the first Australian health fund to demutualise and list on the Australia Securities Exchange (ASX: nhf).

In this submission we have identified opportunities for the National Commission of Audit to review the scope, efficiency and functions of the Commonwealth Government, including:

1. Taxing the non-mutual income of mutuals
2. Private Health Insurance (PHI) price deregulation
3. Changes to Risk Equalisation arrangements
4. Removal of mandatory second tier hospital payments
5. Expand PHI coverage to include General Practitioners
6. Privatisation of Medibank Private Limited

1. Taxing of non-mutual income of mutuals

In the context of the PHI industry of Australia, nib submits that the tax concessions presently extended to Not-For-Profit (NFP) health insurers is not appropriate in today's increasingly competitive commercial environment.

We submit it is more appropriate that tax treatment for NFP health insurers be consistent with the underlying and original intent of the common law Principle of Mutuality, in so far as tax concessions only apply to any surpluses generated from direct member contributions and not from income derived from other third party sources such as bank interest on deposits.

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Removal of inappropriate income tax concessions

1. Many Australian NFP organisations are provided with tax exemptions or concessions through the operation of the Income Tax Assessment Acts and application of the common law Principle of Mutuality.

2. Present legislative arrangements provide that all surpluses generated by NFP health insurers, including underwriting profit and income from third party sources, are exempt from income tax (ITAA 1997 Division 50-30 Item 6.3).

3. Historically, a significant portion of enterprise value generated by private health insurers is attributable to revenue from third party sources. As at 30 June 2012, 26 of the 35 registered and operating health insurers were NFP entities. A major component of revenue from third party sources includes returns on the investment of prudential and surplus capital among others. We submit that the application of the common law Principle of Mutuality was never intended to apply to income from third party sources and that this concession for NFP health insurers unfairly disadvantages other insurers and further exacerbates the allocative efficiency implicit in mutual structures.

We recommend that the Commonwealth Government:

1. Amend the specific tax exemption (ITAA 1997 Division 50-30 Item 6.3) to reflect the underlying and original intent of the common law Principle of Mutuality, in so far as tax concessions only apply to surpluses generated from direct member contributions and not from income derived from third party sources.

2. Alternatively, remove the specific tax exemption (ITAA 1997 Division 50-30 Item 6.3) and clarify that the common law Principle of Mutuality only applies in line with above.

This proposal is not new to the Australian taxation landscape. It is presently in use by registered and licensed clubs.

2. PHI price deregulation

From 1 April 2014 the Commonwealth Government's will have no direct fiscal exposure to premium changes in the industry due to the CPI indexing of the Australian Government Private Health Insurance Rebate.

Furthermore, the current premium control does not encourage competitive pricing. It effectively creates a "price floor" as much as it does a "price ceiling" and amounts to a form of price fixing. All insurers roughly know what competitors are likely to do each pricing year as they know their competitors

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will be wary of aggressive pricing tactics for fear they will not be able to later recover profit margins if necessary.

For these reasons we propose that the industry and Government should work together to remove the existing pricing regulations. This should also include debate on the definition of "improper discrimination". We strongly believe insurers should be able to vary premiums based upon deliberate behaviours that materially improve or reduce the inherent health risk of the insured. The ability to offer premium discounts to non-smokers stands out as an opportunity.

3. Risk Equalisation

Risk equalisation is a fundamental component of our system of community rating – a system nib supports.

In its current form however, it is a limiting factor on the better management of medical risk. The retrospective entitlement for reimbursement for claims already paid means insurers have very little if any incentive to actively invest in cost reduction especially via disease prevention and management.

International research has already established the business case for investing in disease prevention and management is challenging. The doubtful efficacy of some interventions, spending money on screening and assisting those who aren't otherwise going to cost the insurer that much and the lack of "buy in" by GPs are just a few factors that worldwide appear to work against the business case.

But the business case is made infinitely more difficult for insurers here in Australia as effectively the benefits achieved by better risk management (or other forms of cost reduction such as with provider service fees) leak under our dual funding system to Medicare (and other public funding) and because of risk equalisation, to other health insurers. Conversely, "wasted" spend on unsuccessful chronic disease management programs is paid for by all private health insurance customers through risk equalisation, not just the offending insurer/s.

A prospective system of risk equalisation as proposed by the Department of Health in 2002 would greatly improve incentives to invest in disease prevention and management and provider price control. We believe past and current opposition to moving to a prospective system is largely grounded in a self-interested view amongst some insurers that they do well under the status quo and any change could be commercially damaging. It's a "boiling frog" perspective as the unbridled growth in claims costs across the entire insured population eligible for equalisation is threatening the affordability of PHI, price competition and long term industry sustainability.

A move to such a prospective system could be approached in phases to enable insurers to adjust to the changes over time.

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The growing impost caused by the current risk equalisation scheme on younger policyholders is a threat to the viability of the private health insurance system. In the past 12 months, almost 40% of premiums paid by nib policyholders aged 20-39 were to cover the cost of subsidising older customers throughout the industry. While we recognise cross-subsidisation of risk is part-and-parcel of any form of insurance, it will become increasingly difficult to justify the value proposition to younger customers as more and more of their premium is used to subsidise others. And without younger customers providing such subsidies, the full cost of treatment for older customers will need to be passed to them through premium increases, thus making private health insurance unaffordable to those who are most in need of health care services.

4. Removal of mandatory second tier hospital payments

Another threat to the affordability of PHI, price competition and long term industry sustainability are the various requirements that dictate what insurers must pay for healthcare providers and suppliers.

Second tier hospital contracts, where insurers are forced to pay uncontracted hospitals amounts equal to 85% of the agreed rates at similar contracted hospitals, increase benefit payments and subsequently premiums, and provide a safety net to private hospitals who are unable to, or choose not to, meet an insurers requirements for such things as patient safety, clinical outcomes, readmission rates and operating efficiency.

We believe this requirement should be abolished.

5. Expand PHI coverage to include General Practitioners

Under current legislation, PHI does not cover medical services that are provided out-of-hospital and which are covered by Medicare, including General Practitioners (GPs).

This limits the ability of health funds to assist in the improvement of health outcomes of the elderly and chronically ill at the point of diagnosis (principally being when the patient visits the GP). This is due to the fact that in most cases health funds are typically the last to know and are only informed of the ailment after the customer has been treated in a hospital setting (being when we pay the benefit).

Allowing health insurers to remunerate through the payment of benefits is likely to bring effort and investment for the purposes of improving the health outcomes of the elderly and chronically ill.

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Allowing health insurers to cover GPs in the manner contemplated would:

- Likely improve clinical management and health outcomes with consequential cost savings for both the private and public sectors.
- Bring additional funding to primary care which arguably suffers supply side constraints.
- Enhance the value proposition of private health insurance.

6. Privatisation of Medibank Private

We believe the privatisation of Medibank Private Limited would be beneficial to the private health insurance industry. We support the sale objectives as framed by the Government when it announced the recent scoping study process. There is no policy or economic logic to the Commonwealth owning a private health insurer especially given its own (and possibly conflicting) regulatory responsibility and the high level of competition within the market.

Yours sincerely

[redacted]

[redacted]
Chief Executive Officer
[redacted]