

We are hirmaa

1 June, 2015

Mr Roger Brake
Tax White Paper Task Force
The Treasury
Langton Crescent
PARKES ACT 2600

Re: Tax reform discussion paper

Dear Mr Brake

Thank you for the opportunity to comment on the Tax System Discussion Paper (the Paper).

hirmaa represents 18 community-based private health insurers, comprising both industry or employer focused "restricted access" insurers and "open" insurers serving particular regions. hirmaa constituents are predominantly not-for-profit and generally identify as mutuals. One of hirmaa's constituent members is a for-profit insurer wholly owned by a mutual, not-for-profit organisation.

Since its formation, hirmaa has advocated for the preservation of competition, believing it to be fundamental to Australians having access to the best value healthcare services. hirmaa has done this by:

- promoting legislation, regulations, policies and practices which increase the capacity of its member organisations to deliver best value health care services; and,
- advocating for the preservation of a competitive market, which we see as essential to the integrity and viability of the PHI industry.

A number of characteristics distinguish the hirmaa member funds (member list attached). They:

- are value-based and exist solely to deliver benefits to members;
- continue to offer various levels of insurance at highly competitive premiums;
- optimise benefit entitlements and premiums;
- continue to tangibly grow their membership numbers, in recent years above the overall industry trend;
- in terms of the restricted insurers, have their unique nature acknowledged in the *Private Health Insurance Act 2007*.

Given the numerous Government policies to incentivise and regulate private health insurance (PHI), our industry is heavily intertwined with the tax system. With over 47% of the population holding hospital

cover¹, modifications to these policy settings can have a significant impact on tax receipts and on Government outlays.

Considering this relationship, we have taken a broad approach to this submission, with a view to providing the Task Force with a comprehensive overview of the context that private health insurance operates within, with respect to the tax system.

Our submission is divided into four sections:

- A. The private health system in Australia – background and context
- B. Response to discussion question 47: *Are the current tax arrangements for the NFP sector appropriate? Why or why not?*
- C. Response to discussion question 51: *To what extent are the tax settings for the GST appropriate?*
- D. Refining and improving policy settings in private health insurance to achieve a more effective and efficient tax system and more efficient use of Government resources
 - i. Retaining and refining current policy levers in private health insurance
 - ii. Additional opportunities for reform in private health insurance

Thank you once again for the opportunity to comment on these important issues.

Yours sincerely



MATTHEW KOCE
Chief Executive Officer

¹ Private Health Insurance Administration Council (PHIAC) *Quarterly Statistics*, March 2015.

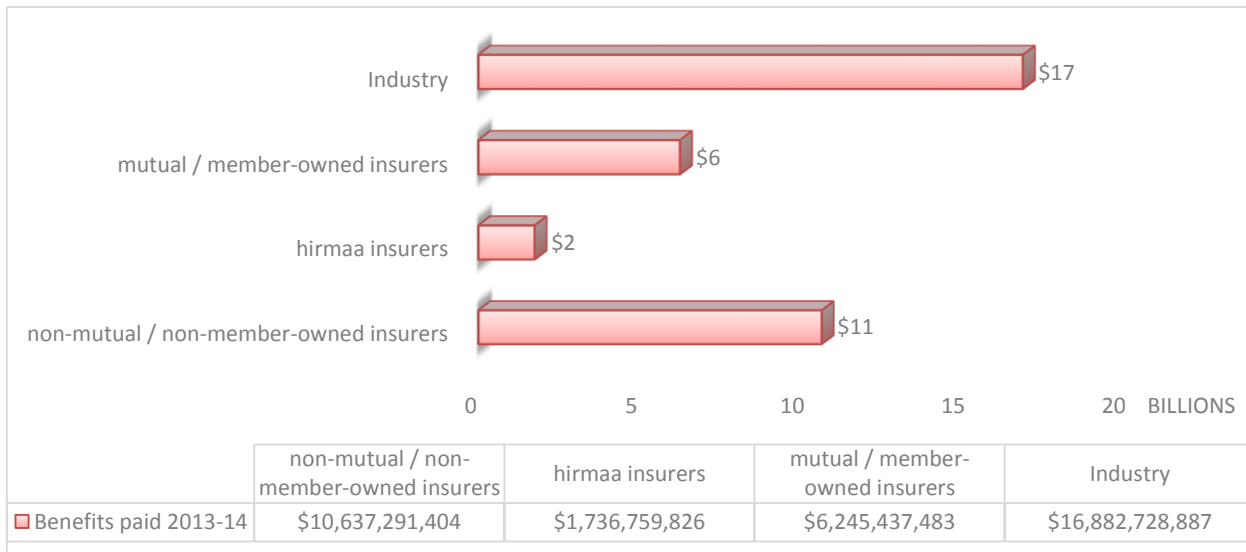
A. The Private health system in Australia – background and context

The role and importance of private health

Australia’s health outcomes compare favourably across other developed countries. A wide range of important health indicators point to a country well supported by a mixed system of public and private healthcare. The role of private healthcare in Australia’s health system should not be underestimated.

The Private Health Insurance Administration Council (PHIAC) reports that 47.3% of the population have private hospital cover and 55.6% have cover for ancillary services, such as dentistry and optometry.²

As a consequence of this wide coverage, the private sector makes a significant contribution to health care funding. In 2013-14, private health insurers paid almost \$17 billion in benefits for hospital and ancillary treatments.³ This is \$17 billion that would otherwise be picked up by the Commonwealth and States. In 2013-14, 41% of all separations* occurred in private hospitals, including two out of every three elective surgery procedures.⁴



Australian Governments pay for 91.6% of the cost of treatment in the public system, as opposed to 34.5% of the cost of treatment in the private system (inclusive of the Government rebate on PHI).⁵ It is therefore no surprise that the uptake of PHI has been encouraged by government through an array of ‘sticks’ and ‘carrots’ policy measures. The rationale being that in order to ensure the sustainability of public health expenditure, appropriate incentives should be in place to encourage individuals to take personal responsibility for meeting their health needs, where they can afford to do so.

*The process by which an episode of care for an admitted patient ceases – <http://meteor.aihw.gov.au/content/index.phtml/itemId/327268>

² Ibid.

³ The Operations of the Private Health Insurers Annual Report data, 2013-14; PHIAC

⁴ Australian Hospital Statistics 2012-13 - Private hospitals, Australian Institute of Health and Welfare (AIHW), p. viii & p. 14

⁵ Australian Hospital Statistics 2012-13 - Australian Institute of Health and Welfare (AIHW), p. 10

Accessibility of the private health system

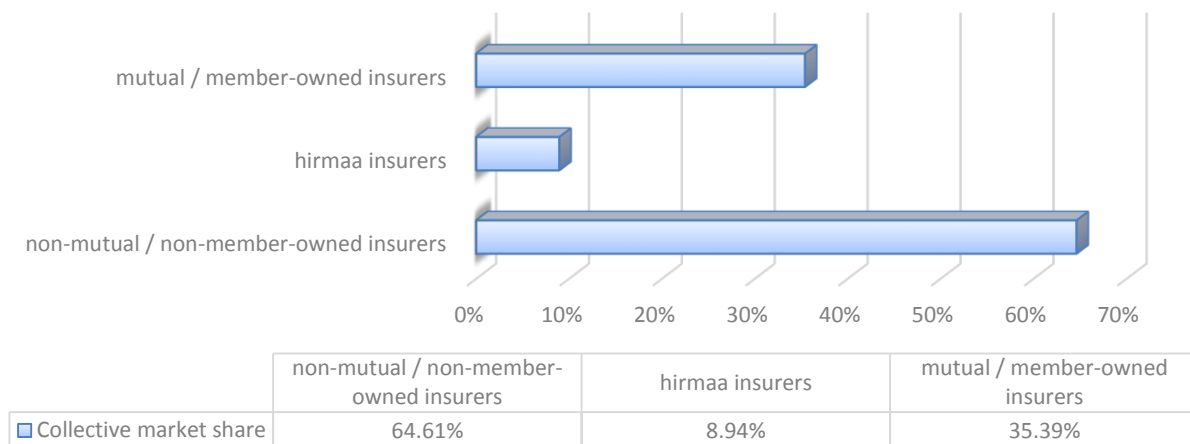
PHI in Australia has been *community-rated* since 1953, meaning consumers pay the same premium for a product, regardless of their age, gender or health condition.

Underpinning community rating, insurers participate in a *risk equalisation scheme* which compensates insurers for having members with higher health risks. This ensures higher-risk policy-holders can access affordable health insurance.

A competitive and diverse market-place

The private health insurance market has a wide range of 34 competitors, ranging from the very small to the very large. Each is run efficiently and prudentially and each contribute to a highly competitive industry.

Mutual and member-owned firms make up 24 of the 34 health funds across Australia*[^]. hirmaa represents 17 of these insurers and one for-profit insurer which is wholly owned by a mutual, not-for-profit organisation.

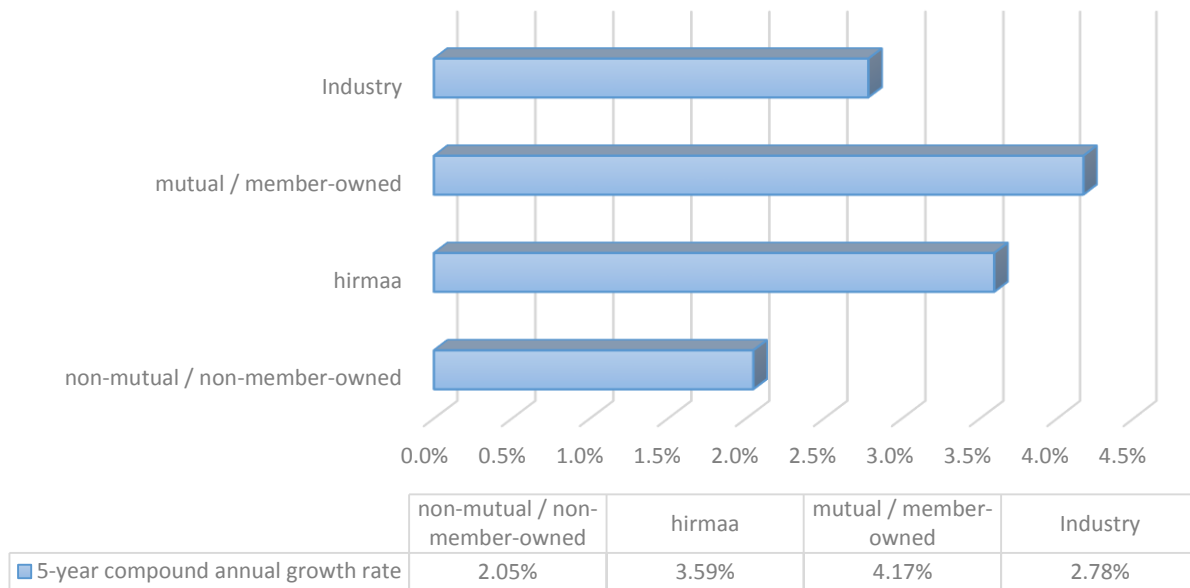


The small and medium sized mutual / member-owned insurers are dynamic and out-perform their for-profit counterparts on a number of measures. This is ultimately reflected in higher growth rates for the small-medium sized end of the market.⁶

*Additionally, three for-profit insurers are wholly owned by Australian domiciled mutual organisations and are treated as mutual insurers in this analysis.

[^] The analysis uses data prior to the demutualisation of Transport Health (effective 1 July, 2014). Transport Health is therefore also included in this analysis as a mutual insurer.

⁶ Derived from PHIAC Operations of the Private Health Insurers annual report data; years 2009-10 through 2013-14



The history and context of current policy settings in private health insurance

With the introduction of Medicare from 1 February 1984, the publically-funded health insurance scheme quickly became the major funder of the Australian health system. This resulted in a significant and consistent decline in private hospital insurance membership until the late 1990s, where PHI reached an historic low of 30.5% coverage.⁷

The Government at the time, led by Prime Minister John Howard and Treasurer Peter Costello, saw the need to arrest this trend, given the significant transfer of cost pressures to the public sector – with less people choosing to privately insure.

At this time, the Government was also establishing a blueprint for the GST. Health was exempted from the GST, with the recognition that “*applying taxes to health care would place the private health sector, with its heavier reliance on direct fees, at a competitive disadvantage with the public health system*”.⁸

Exempting health from the GST was one for four fundamental ‘pillars’ set in place by the Howard / Costello Government to arrest the decline in private health cover:

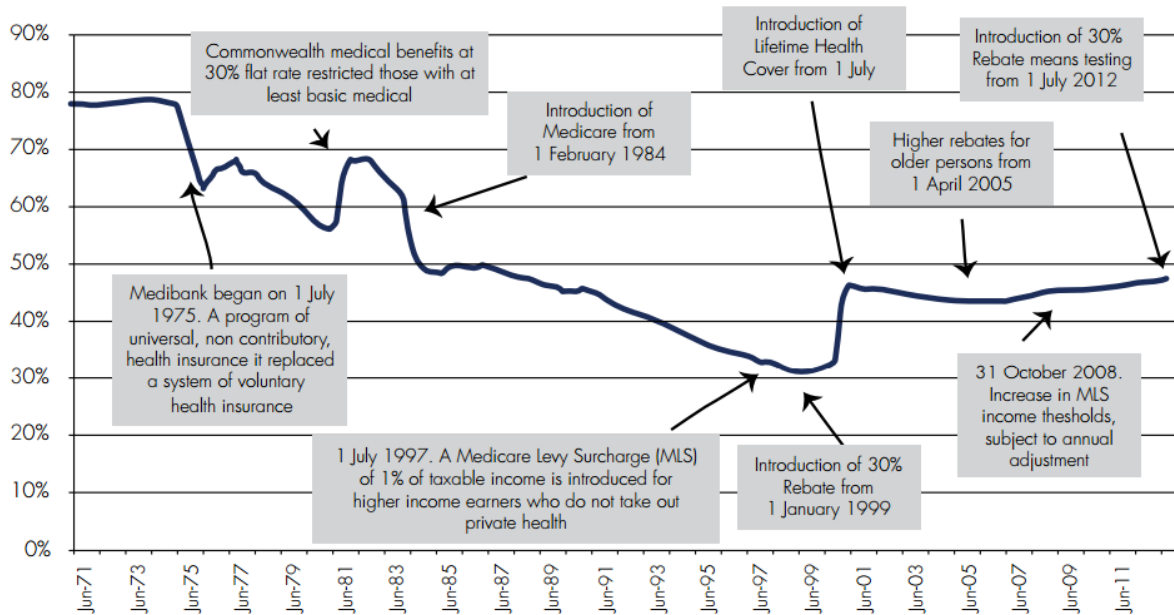
1. Exempting health from the GST.
2. Introduction of the Medicare Levy Surcharge in 1997, set at 1% of taxable income, to penalise higher-income earners who choose not to take out private hospital cover.
3. Introduction of the Government rebate on private health insurance (the rebate) in 1999, set at 30% of the cost of a policy (and the introduction of higher rebates for older Australians in 2005).

⁷ Derived from *Operations of the Private Health Insurers annual report data; 1998-99, PHIAC*

⁸ *Tax Reform: not a new tax, a new tax system: The Howard Government’s plan for a New Tax System*, p.93.

4. Introduction of Lifetime Health Cover (LHC) loadings in 2000 to incentivise the early take-up of private hospital cover

As demonstrated by the timeline below, these four policies in combination, were highly effective in re-balancing the private and public health insurance systems, with private health insurance membership now closer to 50% of the population.



Source: PHIA.

The need to support PHI

As outlined, when people decide against privately insuring, cost pressures transfer to the public system. Australian Governments pay for 91.6% of the cost of treatment in the public system, as opposed to 34.5% of the cost of treatment in the private system (inclusive of the Government rebate on PHI).⁹

Given the forecasted ageing of Australia’s population, growing costs of new medical technology and increased utilisation rates, the role of the PHI industry in relieving pressure on public finances is only expected to grow.

Reduced government incentives for PHI

Under the Rudd/Gillard Governments, a major reshaping of the Australian Government Rebate took place, with:

1. Means testing of the rebate on private health insurance
2. Indexing of the rebate to the lesser of CPI or the actual increase in commercial premiums
3. Removing the rebate from the lifetime health cover loading portion of premiums

⁹ Australian Hospital Statistics 2012-13 - Australian Institute of Health and Welfare (AIHW), p. 10

These measures have had a detrimental impact on the affordability of private health insurance. Reducing the Australian Government rebate over time means that private health insurance is becoming progressively more costly than would otherwise be the case. This has already resulted in a growing shift towards cheaper, lower cover policies that contain restrictions, excesses and exclusions and the trend is expected to accelerate.

hirmaa suggests that when considering reform of the tax system, that the Panel considers affordability issues in PHI and the sensitivity of PHI to policy settings. We suggest that reform of the tax system should look to further incentivise the take-up of PHI and not adversely impact on affordability.

B. Response to Discussion question 47: Are the current tax arrangements for the NFP sector appropriate? Why or why not?

We note that in reference to the income tax exemption for not-for-profit organisations, the Paper asserts that “*there appears to be no clear rationale underlying this exemption*”.

hirmaa represents 18 not-for-profit, mutual structured health funds*, each of which utilise the ‘mutuality principle’ such that surplus created in the fund is not considered income for tax purposes. There are 24 mutual structured health-funds in the market in total, holding a combined market share of around 35%. They play a highly significant role in the market, paying over \$6 billion in benefits to members in 2013-14.¹⁰

When considering not-for-profit health funds, hirmaa strongly disagrees that there is no rationale underlying the income tax exemption.

The basis for the income-tax exemption of not-for-profit health funds

The Income Tax Assessment Act 1997 (Division 50-30 item 6.3)¹¹ explicitly defines not-for-profit private health insurers as exempt from income tax:

50-30 Health

Health		
Item	Exempt entity	Special conditions
6.1	public hospital	see section 50-55
6.2	hospital carried on by a society or association	not carried on for the profit or gain of its individual members, see also section 50-55
6.3	private health insurer within the meaning of the <i>Private Health Insurance Act 2007</i>	not carried on for the profit or gain of its individual members

We note and support the Paper’s acknowledgement of the role and importance of the not-for-profit sector:

“In recognition of the NFP sector’s contribution to the Australian community, it has been a longstanding policy of successive governments to provide support to the sector in the form of tax concessions.”

*one hirmaa member is a for-profit health fund, wholly owned by a not-for-profit, mutual organisation

¹⁰ Derived from the *Operations of Private Health Insurers annual report data, 2013-14; PHIAC*

¹¹ Income Tax Assessment Act 1997, Division 50-30, item 6.3

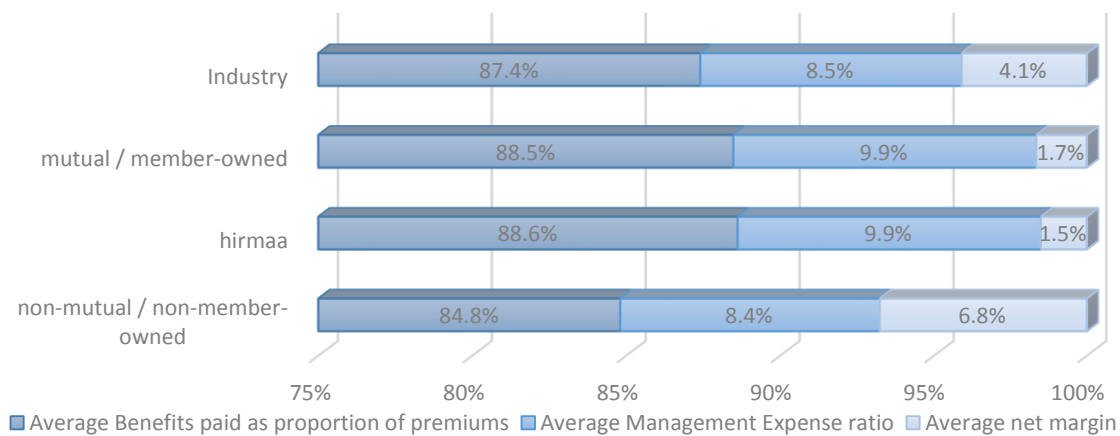
“Recognising the wider benefits of NFP activity (particularly where a NFP provides services that for-profit private sector organisations do not), these tax concessions arguably help to both improve societal outcomes and ensure that the overall level of activity in the NFP sector is closer to optimal.”

hirmaa agrees that the not-for-profit sector makes an important societal contribution to the community and we suggest that this is especially the case in the provision and funding of healthcare services – a genuine public good.

In the case of mutual health funds, member-contributions are used solely to benefit the healthcare of members with any surplus generated reinvested into the health fund and again, into the healthcare of members.

This fits squarely within the concept of ‘mutuality’, as set out by the Australian Tax Office, where surplus arising from the use of a common fund is re-invested to a common purpose.¹² This is in distinct contrast to the for-profit model, where the goal is to generate surplus to direct to external shareholders.

Given this re-investment of surplus, and without the need to return surpluses to shareholders, mutual funds run lower net-margins and pay a higher portion of premiums to members. This is the mutuality principle in action.



We are aware of the views of some self-interested parties which argue that mutual health funds should have their investment income taxed. hirmaa disagrees with this view - mutual structured health funds invest surplus capital that is built up exclusively from direct member contributions. The investment returns derived from these activities are reinvested into the health fund and used exclusively to the benefit of members, not re-directed to shareholders. Again, this is wholly consistent with the principle of mutuality and should be retained.

Additionally, unlike listed for-profit insurers, it is much more difficult for mutual not-for-profit health funds to raise capital so it is vitally important they remain tax free in order to grow and remain prudentially sound.

¹² Australian Tax Office, retrieved: <https://www.ato.gov.au/non-profit/expenses-and-purchases/in-detail/claiming/Mutuality-and-taxable-income/?page=12>

hirmaa strongly supports the status-quo which exempts mutual not-for-profit health funds from income tax.

It is important to note that changes to the exemption status of mutual health funds would profoundly impact the private health insurance industry. It would place additional pressure on premiums, exacerbating affordability issues, exacerbating downgrading by members and ultimately resulting in costs shifting to the public system.

C. Response to Discussion question 51: *To what extent are the tax settings for the GST appropriate?*

We note in the Paper:

“Any change to the GST rate or base would require the unanimous support of the state and territory governments, the endorsement of the Australian Government and the passage of relevant legislation by both Houses of the Australian Parliament.” And that “the Australian Government will only consider progressing any such proposals if there is a broad political consensus for change, including agreement by all state and territory governments.”

Nevertheless, given recent debate in the media around expanding the GST to areas such as private education and private health, we would like to outline our position on the matter.

In direct response to discussion question 51, hirmaa believes the tax settings for the GST, in respect to private health, are appropriate.

As outlined earlier in this submission, the private health sector was consciously exempted from the GST after its introduction in 2000 with the recognition that *“applying taxes to health care would place the private health sector, with its heavier reliance on direct fees, at a competitive disadvantage with the public health system”*.¹³

Since 2000, the reasons for making private health services GST-free have not changed: the imposition of a 10 percent GST on the non-government health sector would significantly escalate costs, reducing affordability and undermining the ability of the non-government health sector to compete against the public system.

International experience shows that the Howard and Costello Government’s rationale for exempting the health sector from the GST is entirely justifiable. The European Union specifically allows its member countries to exempt health and health insurance from Value Added Taxes on grounds that it is considered a public good and would distort competition. Interestingly in New Zealand, where private health is taxed under a GST, private health insurance coverage is at a historical low of just under 30 per cent and continues to fall.¹⁴

History has demonstrated that the decision not to tax health was the correct decision. Today almost 11 million Australians or around 50% of the population are covered by private health insurance, a far cry from 1999 when coverage had plummeted to just 30.5%.

hirmaa is of the strong view that private health should continue to be exempted from the GST.

¹³ *Tax Reform: not a new tax, a new tax system: The Howard Government’s plan for a New Tax System*, p.93.

¹⁴ *Quarterly statistical summary; March 2015*; Health Funds Association of New Zealand, retrieved: <http://www.healthfunds.org.nz/pdf/Mar2015%20Quarterly%20statistical%20summary.pdf>

D. Refining and improving policy settings in private health insurance to achieve a more effective and efficient tax system and more efficient use of Government resources

As noted earlier in this submission, the policy reforms introduced in the late 1990s were highly effective in restoring private health insurance participation. These policy settings are highly intertwined with the tax system and hirmaa believes they should be considered as part of the Panel’s review. In particular, the Panel may wish to consider how these policy settings could be refined in order to improve the effectiveness and efficiency of the tax system and to achieve a more efficient use of Government resources.

Given that Australian Governments pay for 34.5% of the cost of treatment in the private system, compared to 91.6% of the cost of treatment in the public system,¹⁵ hirmaa believes policy settings in PHI should be enhanced with a view to increasing private health insurance participation further.

i. Retaining and refining current policy levers in private health insurance

The Medicare Levy Surcharge (MLS)

The MLS is a tax on personal income, applied if a person is earning over a certain threshold and has not taken out private hospital insurance.

The tax rates are currently set as outlined below.¹⁶

Table 1: Income thresholds

	Unchanged	Tier 1	Tier 2	Tier 3
Singles	\$88,000 or less	\$88,001 - \$102,000	\$102,001 - \$136,000	\$136,001 or more
Families	\$176,000 or less	\$176,001 - \$204,000	\$204,001 - \$272,000	\$272,001 or more
Medicare levy surcharge rate	0%	1%	1.25%	1.5%

According to the Australian Tax Office, there were 199,295 Australians paying the Medicare Levy Surcharge in 2012-13.¹⁷ While this raised \$249m in tax revenue, conservative estimates would suggest that this tax revenue does not offset the public hospital expenditure attributed to these 199,295 Australians:

¹⁵ *Australian Hospital Statistics 2012-13* - Australian Institute of Health and Welfare (AIHW), p. 10

¹⁶ Australian Tax Office; retrieved: <https://www.ato.gov.au/Individuals/Medicare-levy/Medicare-levy-surcharge/>

¹⁷ Australian tax Office; retrieved: <https://www.ato.gov.au/About-ATO/Research-and-statistics/In-detail/Tax-statistics/Taxation-statistics-2012-13/?anchor=Individualstables#Individualstables>

According to the Australian Institute for Health and Welfare, expenditure on public hospital services was \$43.9 billion in 2012-13.¹⁸ Assuming a population of 23.58 million¹⁹, this would suggest an average annual spend per person of \$1,861.75.

This figure is not adjusting for the fact that many millions of Australians have private health insurance and do not receive treatment in a public hospital – in actuality, the average spend per public health-system patient is likely to be much higher than \$1,861.75.

Given that 91.6% of the cost of treatment in a public hospital is Government funded, Government outlays on public hospital treatment for the \$199,295 people not paying the Medicare Levy Surcharge is conservatively estimated at **\$339.87m** annually, well in excess of the MLS tax receipts.

hirmaa advocates for an increase in the Medicare Levy Surcharge to incentivise greater take-up of private health insurance.

hirmaa believes that any increase in the Medicare Levy Surcharge would result in positive outcomes for both industry and Government. We note that the National Commission of Audit recommended increasing the MLS to between 3-3.5%.²⁰

Lifetime health cover (LHC) loadings

LHC loadings are applied when an individual takes out private hospital insurance, for the first time, after the age of 30. The loadings are applied to the individual's insurance premiums and increase at 2% increments (up to a maximum of 70%) depending on their age of entry. The loadings continue at the defined rate for 10 years before being removed.

As at the end of the December 2014 quarter, there were 1,184,615 people with a certified age of entry of more than 30 and subject to a LHC loading.²¹

hirmaa supports the retention of the Lifetime Health Cover loading, noting its effectiveness in incentivising the uptake of private health insurance.

However, we suggest that given over 1m Australians are paying a loading, more could be done to incentivise early uptake of PHI. hirmaa suggests the Panel consider options to improve LHC policy settings, including, but not limited to, the option of discounts for those joining under the age of 30.

¹⁸ *Health Expenditure Australia, 2012-13*; Australian Institute of Health and Welfare (AIHW)

¹⁹ Australian Bureau of Statistics, retrieved: <http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0>

²⁰ *Phase one report, Australian Government National Commission of Audit*, p. 97

²¹ PHIAC quarterly statistics, December 2014

The rebate on private health insurance

hirmaa is of the view that the rebate on private health insurance provides a significant return on investment for the Government, given its role in incentivising the uptake of private health insurance and the cost-shifting from the public sector that follows. However, we acknowledge that the PHI rebate is a large and growing area of Government spending.

The approach of the previous Government was to reduce support for the rebate with a string of cost-saving measures that reduced the incentive to take out and maintain private health cover:

- The legislative package of 2011/12 (Fairer Private Health Insurance Incentives 2012 and allied legislation) introduced three new PHI incentive tiers reducing the amount of rebate for an eligible person with a complying policy.
- The Private Health Insurance Legislation Amendment (Base Premium) Bill 2013 resulted in the rebate being indexed annually by the lesser of CPI or the actual increase in commercial premiums. (The '30%' rebate reduced to 29.04% in 2014, then to 27.82% in 2015 and will continue to fall annually).²²
- The Private Health Insurance Amendment (Lifetime Health Cover Loading and Other Measures) Bill 2012 amended the PHI Act so that the Australian Government rebate on PHI is no longer payable on the component of PHI premiums that have been increased because of the LHC loading.

These measures have had an adverse effect on affordability of health cover resulting in exacerbated downgrading trends. When members downgrade, costs shift back to the public health system – while the Government has made savings on the rebate through these measures, the net savings to Government can only be considered in the context of increased public hospital costs, as yet unquantified.

hirmaa believes that seeking savings through a reduction in the rebate is counterproductive to Government. Rather, a regulatory review should take place to find areas where efficiencies can be realised in order to reduce the pressure on premiums and temper growth in the rebate on PHI.

With the rebate reducing by around 1% each year, affordability will continue to decline. hirmaa advocates that a floor for the rebate should be set in place, until budgetary circumstances permit its full restoration.

Consider exempting private health insurance from the Fringe Benefits Tax

The Fringe Benefits Tax Assessment Act (FBTAA) provides for a wide range of exemptions that have been introduced by the Government either on social, political or administrative convenience grounds. The payment of an employee's PHI premiums by their employer (or associate or third party by arrangement) should be exempted.

²² Department of Health; retrieved: <http://www.health.gov.au/internet/main/publishing.nsf/Content/phi-rebate&medicarelevy-surcharge>

The reasons for such an exemption are the same as the grounds for retaining and enhancing the policy levers outlined above, that is, incentivising the uptake of PHI to shift cost pressures away from the public system.

hirmaa suggests that the rationale for providing tax concessions to superannuation apply also to private health insurance, that is, reducing dependency on public finances, encouraging individual responsibility and preparing for future costs.

ii. Additional opportunities for reform in private health insurance

Deregulation of the private health insurance industry

A more efficient and effective use of government resources allows for a more efficient tax system and policy reform in portfolio areas such as private health insurance can have a significant impact on Government finances.

As noted, hirmaa believes that the best way to make savings in the health portfolio, is through incentivising individual responsibility for health care financing, this means retaining policies such as the Government rebate. However, reforms can also be made to improve the efficiency of the private health system, which in turn means less pressure on premiums and by consequence, moderated growth in the Government rebate.

hirmaa believes there are a number of deregulation opportunities available in the private health insurance industry:

1. Deregulate the market for prostheses in the private health system

It is the strong view of hirmaa that inefficient regulatory settings in the market for prostheses has resulted in market failure with:

- a. Benefits paid by insurers not reflecting net prices paid for prostheses by hospitals
- b. Lower cost and innovative competitors being restricted in their ability to compete with incumbent suppliers, due to the current method of determining group benefits for prostheses items
- c. Benefits paid by insurers for prostheses items being substantially higher than benefits paid for identical items in international markets and the Australian public health system.

Given that in 2013-14, \$1.74 billion in benefits were paid for prostheses²³ (14.1% of all hospital benefits paid), this is an issue of significant importance to Government, industry and consumers of health insurance and health services. Our initial modelling demonstrates that inefficiencies associated with the current regulations could range upwards of \$534 million annually.

²³ *The Operations of Private Health Insurers annual report data, 2013-14; PHIAC*

hirmaa supports a review of prostheses pricing arrangements to achieve significant savings for consumers through their health insurance premiums and significant savings for Government through reduced outlays on the PHI rebate.

2. Deregulate the premium-setting process in the private health insurance market

As an organisation which supports deregulation, hirmaa encourages an environment where private health insurers are afforded more flexibility in price setting. We suggest that the industry moves toward a 'price monitoring' arrangement whereby insurers' prices do not require the burdensome approval process of both the regulator and Government.

Our experience is that the current premium setting process inhibits competition dynamics, is open to politicisation and lack clarity and certainty for insurers. This places a significant and unnecessary administrative burden the industry.

We believe that if deregulation is to occur, the right conditions must be in place to ensure the market acts efficiently:

1. Prudential oversight: to monitor the impact of pricing strategies on the financial positions of insurers.

PHIAC (and in the near-future, APRA) already effectively monitors the financial positions of insurers – so the essential prudential oversight is already in place.

2. Low search costs and information symmetry: so that consumers have knowledge of alternative insurers and the policies available to them.

The consumer website privatehealth.gov.au and the emergence of online aggregators provides for low search costs and sufficient information symmetry for consumers.

3. Effective portability arrangements: to ensure that customers can effectively respond to price changes.

With Clearance Certificate arrangements, full portability across insurers is provided for.

4. Effective consumer protections: to ensure anti-competitive pricing strategies are not pursued

The ACCC presently acts as the competition watchdog in the industry, meaning the requisite consumer protections are in place.

Taking this into account, hirmaa believes that the requisite conditions are in place to allow a serious discussion on deregulating the premium setting process.

hirmaa supports a review of the premium setting process to facilitate greater competition and to reduce pressure on premiums and temper growth in the rebate on PHI.

3. Deregulate second-tier default benefit arrangements

Second tier default arrangements provide a safety net to hospitals and therefore should be considered an unfair advantage in contract negotiations.

The second tier default legislation means that private health insurers have an obligation to pay any accredited health facility (be it a private hospital or day surgery) at least 85% of the average charge for an equivalent treatment under the health insurer's negotiated agreements with facilities in the same State. Insurers are obligated to pay these facilities irrespective of whether that facility is required, or whether the insurer believes the services provided are of sufficient quality to warrant sending members there.

Second tier default benefit arrangements distort normal market dynamics and restrict competition, innovation, choice, service and efficiency.

Indeed, health facilities that meet higher standards, are innovative and deliver better health outcomes deserve to be compensated commensurately, but perversely, when insurers pay more for higher performing facilities, they inadvertently reward low performing facilities as a direct result of second tier default benefits.

It is hirmaa's strong view that second tier default legislation in its current form is burdensome on insurers and distorts normal market dynamics, ultimately affecting service and pushing up the price of premiums for the consumer purchasing private health insurance.

hirmaa recommends a review of second-tier default benefits arrangements as a way to reduce pressure on premiums and temper growth in the rebate on PHI.

ANNEXURE A
HIRMAA MEMBERS

ACA Health Benefits Fund Ltd

Defence Health Ltd

Health Care Insurance Ltd

Health Partners Ltd

Latrobe Health Services Ltd

Lysaght Peoplecare Ltd

Mildura Health Fund

Navy Health Ltd

Phoenix Health Fund Ltd

Police Health Ltd

Queensland Country Health Ltd

Queensland Teachers' Union Health Fund Ltd

Railway and Transport Health Fund Ltd

Reserve Bank Health Society Ltd

St Luke's Medical & Hospital Benefits Association Ltd

Teachers Federation Health Ltd

The Doctors' Health Fund Ltd

Westfund Ltd