Department of Health and Ageing submission to:

The Senate Community Affairs Legislation Committee Inquiry into the Fairer Private Health Insurance Incentives Bills

The Senate transferred the inquiry into the Fairer Private Health Insurance Incentives Bill and related Bills from the Economics Committee to the Community Affairs Legislation Committee.

1) The Government's decision to means-test the private health insurance rebate

The Government is rebalancing the suite of policies supporting private health insurance – so that those with a greater capacity to pay for their own private health insurance do so.

Spending on the private health insurance rebate is growing quickly and is expected to double as a proportion of health expenditure by 2046-47[1]. The Government is proposing changes that will support the sustainability of rebates and allow future Governments to continue offering rebates for private health insurance.

Consistent with the Government's commitment to maintaining the balance between public and private health systems, high income earners will receive less in Government payments for their private health insurance, but will face an increase in costs should they opt out of their hospital cover.

Across the tax and payments system the largest benefits are provided to those on lower incomes – except for private health insurance. These changes are consistent with the principle underpinning the tax and transfer systems – the greatest support should be provided to those on lower incomes.

Singles
Without reform, the Treasury estimates that in 2010-11 approximately 14 per cent of single tax filers will have incomes of greater than $75,000, but this group would receive about 28 per cent of the total private health insurance rebate paid to singles. Under the new reforms, this group is estimated to receive about 12 per cent of the total private health insurance rebate paid to singles.

Couples/Families
By 2010-11, about 12 per cent of couples/families are expected to have incomes above $150,000, but this group would receive about 21 per cent of the total private health insurance rebate paid to members of couples/families. Under the new reforms, this group will now be estimated to receive about 9 per cent of the total private health insurance rebate paid to couples/families.

[1] Australia's second Intergenerational Report (IGR2) released by the Treasurer on 2 April 2007

2) Impact on the private health insurance industry

It is estimated that 99.7% of people with private health insurance hospital cover will retain their insurance after the introduction of the Private Health Insurance Rebate Tiers.

Over the last decade several incentive measures have been introduced to encourage people to purchase private health insurance. These are the rebate (including the higher rebates for older Australians), Lifetime Health Cover (LHC) and the Medicare levy surcharge.

The most effective component of the existing incentives structure, LHC, will remain in place. This increases the premiums for hospital cover for people who do not take out insurance until later in life by 2% for each year they are aged over 30.

LHC is supported by annual mailouts to people approaching their LHC deadlines. This includes people who will be aged 31 on 1 July each year and new migrants who have registered for Medicare in the previous 12 months. The mailouts include information about private health insurance and LHC and are conducted by Medicare Australia with support from the Department of Health and Ageing.

The Government is increasing the Medicare levy surcharge for higher income earners. For many above average and higher income earners, it will be more expensive to drop their hospital insurance than to keep it, even with the lower (or nil) government rebate.

It is expected that some people will drop some form of private health insurance. The anticipated breakdown of people who will drop their cover is:

- up to 25,000 people who had either hospital or combined hospital and general treatment cover are estimated to drop all of their cover; and
- up to 15,000 people with general treatment cover only are estimated to drop their cover.

It is important to note that individuals earning $75,000 or less and couples and families earning $150,000 or less will not experience any change, with the existing 30%, 35% and 40% rebates continuing to apply:

Table: Rebate levels for those people unaffected by the tier income thresholds

Age	**Under 65**	**65 – 69**	**70 and over**
Earning $75,000/$150,000 or less	30%	35%	40%

The following charts show the proportions of insured people by income that will not be affected by the changes, and those who will be affected in each of the proposed Private Health Insurance Incentives Tiers. The majority of all people who currently receive a rebate will continue to receive their current rebate (ie. No Tier).

Chart: Proportion of people affected by tier

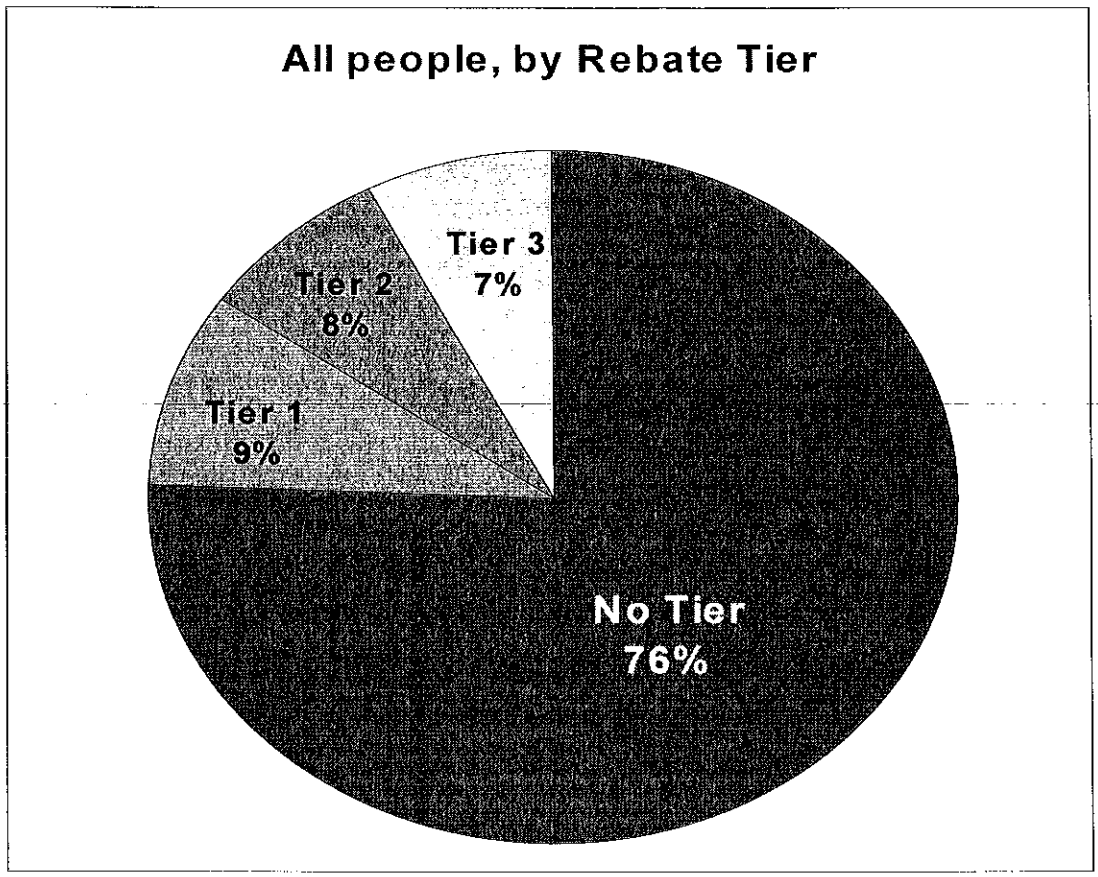
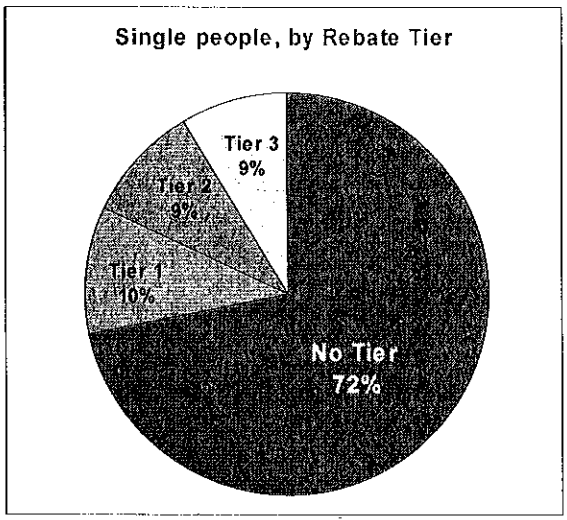
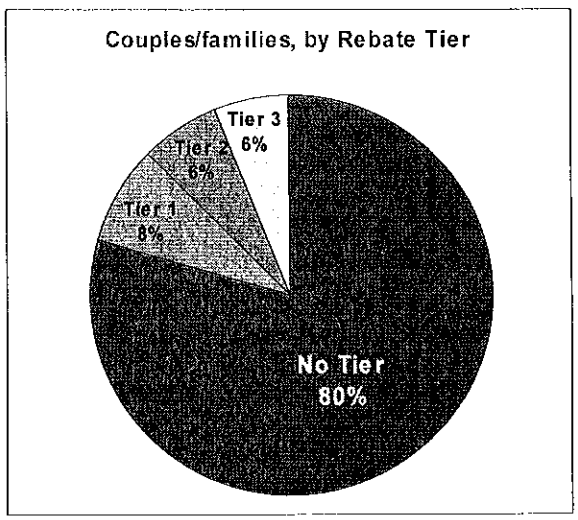


Chart: Proportion of singles and couples/families affected by tier





3) Impact on premiums

It is not anticipated that this measure will flow on to increased premiums. As it is expected that 99.7% of people with private health insurance hospital cover and 99.6% of people with general treatment cover will retain their insurance, there would be very little increase in premiums due to people dropping their insurance. Any drop in membership levels would also lead to a drop in claims against the insurer.

Similarly, it is not anticipated that significant additional administrative costs to insurers. Australian private health insurers are well managed, with low management expense ratios compared with other types of insurance, and this will continue to be the case.

The Department has examined the impact on insurers of the introduction of two additional rebate levels in 2005 (when the higher rebates for older Australians were introduced). Additional administrative costs associated with the introduction of the two additional rebate levels were not reported in insurer rate change applications for 2005 as a reason for premium increases, and average management expenses decreased in the years following the introduction of the additional rebate levels.

This suggests that insurers were able to make system and process changes to recognise additional rebate level without significant costs.

Table: Management expense ratio for private health insurers 2000-2008

Period	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08
MER	11.8%	11.1%	10.5%	9.9%	9.5%	9.4%	9.6%	10.5%

4) Impact on insured people

Treasury estimates that 2.3 million people will be affected by the changed rebate levels. This is the number of people covered by private health insurance hospital treatment policies where the policy holder will receive a lower rebate or no rebate after the changes, and comprises:

- 630,000 singles;
- 490,000 couples (980,000 people); and
- 690,000 dependents.

It is estimated that 7.4 million people will continue to be covered by private health insurance hospital treatment policies with the full 30%, 35% or 40% rebates, comprising:

- 1.6 million singles;
- 1.9 million couples (3.8 million people); and
- 2.0 million dependents.

5) Impact on people without private health insurance

Treasury estimates that the changes to the Medicare levy surcharge will affect around 130,000 higher income earners who currently do not have private health insurance (the number of people in Tiers 2 and 3 who currently pay the Medicare levy surcharge):

Table: Number of people affected by Medicare levy surcharge changes by Tier

	TIER 1	TIER 2	TIER 3
Singles Couples	$75,001–$90,000 $150,001-$180,000	$90,001-$120,000 $180,001-$240,000	$120,001 or more $240,001 or more
All ages	1.0%	1.25%	1.5%
Number of affected people without PHI	Nil (no change to current surcharge liability)	90,000	40,000

The affected 130,000 people will have to pay an increased Medicare levy surcharge, unless they purchase appropriate private health insurance. These people may decide to buy private health insurance rather than pay additional tax, which would offset any decrease in participation as a result of this measure.

6) Impact on public hospitals and dental services

The small number of people who are expected to drop out of private health insurance will not result in a significant additional burden on public hospitals. Despite having private health insurance, some people already choose to be admitted as public patients in public hospitals rather than use their insurance to alleviate pressure on public hospitals.

Ipsos *Health Care and Insurance Australia 2007* survey data indicate that around 35% of people require hospital treatment in a two year period and 11% of people with private health insurance are admitted to public hospitals as public patients. As Treasury estimates up to 25,000 people will drop out of private hospital insurance, Australian public hospitals as a whole may see a rise in demand of around 8,000 people in a two year period who may have otherwise have been privately insured patients. This increase in public patients would be around 0.1% of the usual public hospital workload (4.7 million admissions per year or more than 9 million admissions over a two year period).

At the Council of Australian Governments' (COAG) meeting in November 2008, the Commonwealth agreed to provide $64 billion over five years to the States and Territories for State health systems and national health partnerships. This included an additional $22 billion in funding largely for public hospitals, covering the costs of an additional 350,000 emergency department presentations and an additional 370,000 hospital admissions over four years.

Over a two year period when public hospitals could expect to see an extra 8,000 people who have dropped their private health insurance as a result of this measure, the additional Commonwealth funding provides for an additional 175,000 Emergency Department presentations and 185,000 public hospital admissions.

It is not expected that there will be any impact on public dental services or waiting lists associated with people dropping their general treatment (ancillary) cover, which usually provides insurance for the costs of dental services.

Public dental services are only provided to pensioners and health care concession card holders. It is very unlikely that a person earning over $75,000 a year or a member of a couple/family earning over $150,000 a year would be eligible for public dental services.

7) Impact on private health insurers

To enable people to continue to claim the rebate as an upfront premium reduction from their insurer, insurers will need to be able to adjust their rebate reduction schemes to reflect the changed rebate levels. The insurers' systems currently allow for four different rebate levels (0%, 30%, 35% and 40%).

From 1 July 2010, insurers' systems will need to be able to recognise an additional four rebate levels (10%, 15%, 20% and 25%). This may involve changes to computer systems and additional administrative staff to deal with rebate level elections by members.

In 2005, insurers implemented changes to deal with an additional two rebate levels, when the higher rebates for older Australians were introduced from 1 April 2005. At that time, no insurer sought an increase in premiums as a result of increased administrative costs or management expenses attributed to the additional rebate levels.

In fact, insurers' management expense ratios dropped from 9.9% in 2003-04 to 9.5% in 2004-05 immediately following the introduction of the additional rebate levels, and dropped again to 9.4% the following year (2005-06). On the basis of this experience, it is anticipated that significant additional administrative costs to insurers. The Government will allow insurers to decide how often they allow their members to change their rebate level elections.

The Government will assist insurers in preparing for the introduction of the new rebates, by preparing standard rebate election forms and guidance material for insurers to use, and using electronic methods for lodging and processing rebate elections as far as possible.

8) Impact on level of cover

Downgrading means buying a cheaper insurance policy than currently held. There are generally two ways to downgrade. One way is to buy a product with excluded treatments (eg hip replacements, cardiac procedures, maternity services). If people then require those treatments or services, they are not insured and must be treated as a public patient or cover the costs of private treatment themselves. The second way is to buy a product with an excess or co-payment. When people require medical treatment and opt to be treated as a private patient, they will have more to pay from their own pocket.

The Australian Bureau of Statistics *National Health Survey* includes data about the reasons that people take out private health insurance:

Main reasons for insuring	***2004-05*** ***%***	***2007-08*** ***%***
Security/protection/peace of mind	43	54
Shorter wait for treatment/concern about public hospital waiting lists	23	28

These are the two main reasons given by people for taking out private health insurance, and have significantly increased in importance over the last two surveys. The number of people who report that they insure to take advantage of the Government rebate or to avoid the MLS is much lower – both of these reasons combined in 2007-08 was 12%.

If the main reasons motivating people to purchase private health insurance are peace of mind or to access treatment with shorter waiting times, then they are less likely to purchase an exclusionary product, which will not cover them for certain illnesses or conditions.

It should be noted that in relation to higher excesses, the MLS legislation provides that a person is only exempt from the MLS if they have a hospital cover policy with an excess/co-payment of $500 or less a year for singles policies or $1000 or less a year for couples/family policies. This is to prevent people from taking out very cheap policies that they are unlikely to use, simply to avoid the surcharge.

Because the Government is providing tax cuts that will more than offset the increased costs of private health insurance premiums, people will be able to absorb the increase and maintain their current level of insurance, according to the main reasons for purchasing health insurance.

9) Other estimates of impact: Access Economics for Catholic Health Australia (CHA) and the Australian Health Insurance Association (AHIA).

9.1 Access Economics report

The Access Economics report accepts that the assumptions behind Treasury's modelling are intuitively correct, and recognises that people on higher incomes have a much higher take up rate of private health insurance. Treasury has used the average premium for the purposes of modelling as there is no way from the data available that we can work out average policy costs by income range. The ATO and the Private Health Insurance Administration Council (PHIAC) do not hold this data.

Access Economics was commissioned by Catholic Health Australia to assess the impact of the changes. Access Economics conducted its own modelling by way of a simple scenario analysis. This involved examining what various groups of private health insurance members might do when faced with cost increases of particular amounts. The groups were:

- Higher income earners who are risk averse (eg. elderly single, widowed females) - higher end higher price fully featured product
- Middle income earners who are concerned with value and affordability - lower priced product with excess and/or exclusions
- MLS avoiders – low priced product with high excess and/or exclusions

For all three scenarios, the estimated premiums for the typical products assumed to be purchased by the groups were considerably higher than the average premium assumed by the Treasury modelling. This results in a higher drop out rate. However, there is no evidence that people in those groups purchase those particular products. There are more than 20,000 possible products with different premiums from which people can select.

Access Economics has drawn conclusions about numbers that will drop out based on examples of private health insurance policies with above average costs. The Government's modelling is based on actual average costs of policies drawn from Private Health Insurance Administration Council data.

As Access Economics has used high cost policies for their modelling, this results in higher drop out rates due to price elasticity calculations. If Access Economics had used the average costs of insurance policies, then they would have reached similar conclusions to the Government.

Even if Access Economics economic assumptions were accepted, this would still result in 99% of people with private health insurance retaining their insurance.

9.2 Australian Health Insurance Association (AHIA)

The AHIA claimed in a media release (22 May 2009) that "an analysis of Federal Budget figures, industry data and research conducted by Roy Morgan Market Research and IPSOS Research revealed that 241,000 Australians would drop their hospital cover under the changes and 728,000 would downgrade their hospital cover".

The Department considers that the AHIA estimates significantly overstate the potential impact. The Department has not been provided with a detailed briefing from the AHIA about

how it modelled the estimates, but the information we do have indicates that there are significant reliability issues with the data used by the AHIA.

The Department understands that the number of people in the affected income ranges has been based on a Roy Morgan survey conducted in May 2008 about the MLS threshold changes originally proposed in the 2008 budget (which were subsequently amended by the Parliament). This means that the survey data are based on estimates of people in the income ranges $50,000 to $100,000 for singles and $100,000 to $150,000 for couples and families. This is a different population to that affected by the changes proposed in the 2009-10 Budget, including larger numbers of people on lower incomes.

Secondly, the AHIA has used data from the Ipsos *Health Care and Insurance Australia 2007* survey to estimate the number of people who would drop or downgrade their hospital insurance. Note that the Ipsos survey only included data about whether people would downgrade their hospital cover if the rebate was reduced, it did not examine whether people would downgrade their general treatment (ancillary) cover.

The Department believes that using the Ipsos survey data to estimate a cohort of people who will drop or downgrade their insurance as a result of the changes proposed in the Budget would significantly overestimate the impact because the survey did not disaggregate responses by income range. The estimate of the number of people who would downgrade their hospital cover relates to people in all income ranges.

Ipsos findings

	Scenario for Rebate Change on Hospital Cover			
Respondent's declared likely Impact of Change	Quarter removal (+10% price)	One Half removal (+20% price)	Three quarters removal (+30% price)	(Near) Full removal (+40% price)
Keep my current private hospital cover	76%	45%	43%	36%
Downgrade to cheaper cover with lower benefits	**18%**	**40%**	**42%**	**43%**
Very likely to drop private health cover	5%	11%	11%	18%
Don't know	1%	4%	4%	2%
Total	100%	100%	100%	100%

- This table appears at page 181 of the *Health Care and Insurance Australia 2007* survey.

- Ipsos discussion of the survey findings includes the following commentary: "The vast majority claim they would keep their hospital cover in some form, even with a 40% price increase (equivalent to full removal of the rebate). However, many state they would downgrade their cover under this scenario, possibly leading to some disenchantment in the future when claims are made. Note how the proportions saying they would drop their cover do not vary between 20% and 30% - again emphasising that many members are 'attached' and committed to their private hospital cover. In either case of members *downgrading* or *opting out* of hospital cover, the impact would be significant albeit in reality, probably around half would 'carry through' with their decision."

Academic research indicates that private health insurance price elasticity is different for people on higher incomes. Essentially, they have more disposable income and will absorb price increases more readily for private health insurance. The proposed means testing only affects approximately 25% of current policy holders, those on higher incomes. The Department considers that the other 75% (those on lower incomes) would be more likely to have responded to Ipsos that they would drop or downgrade cover in response to price increases.

The Ipsos survey also asked people to respond to the statement "I regard it as essential to have private health insurance" (Ipsos 2007, Table 9.1.1, p 206). The responses were disaggregated by income, indicating that those on higher incomes were much more likely to consider private health insurance as an essential purchase, see table below.

I regard it as essential to have private health insurance

Combined income	**Low – Mid** **Single up to $35K** **Family/couple up to $70K**	**Mid – High** **Single $35K - $50K** **Family/couple $70K - $100K**	**High** **Single $50K and over** **Family/couple $100K and over**
Agree a lot	31%	33%	52%
Agree a little	11%	20%	12%
Neither agree nor disagree	7%	5%	8%
Disagree a little	26%	15%	12%
Disagree a lot	25%	27%	17%
NET AGREE	42%	53%	64%
NET DISAGREE	51%	42%	29%

10) Implementation

The changes will start on 1 July 2010. People will continue to be able to receive their rebate in three ways:

- as an up-front premium deduction made by the insurer;
- by claiming the rebate as a refund at a Medicare Australia office by presenting a premium receipt; and
- by claiming the rebate through a tax return at the end of the financial year.

When claiming the rebate as a premium deduction or through a refund at Medicare, a person will need to nominate a premium rebate level that they are entitled to based on their 'adjusted taxable income'. If people over-estimate their income, they will receive a rebate 'refund' through their tax return for that year. If people under-estimate their income, they will incur a rebate 'debt' through their tax return that year. This will be recoverable as a normal tax debt.

There will be no requirement for insurers or Medicare Australia to collect information about people's income, or to check the accuracy of a person's rebate nomination. If a person claims the incorrect rebate level, this will be identified when the person completes his or her tax return for that year. People will be required to repay any rebate they claimed and were not entitled to, or will be repaid the correct rebate by the ATO if the rebate they claimed was too low.

11) Communication and Information

The Department has engaged the Consumers Health Forum (CHF) to assist with advice about the potential impact of this measure on consumers and the development of implementation strategies to avoid or minimise impact. The CHF will also assist the Department with ensuring clear communications about the measure.

The Department has established an Implementation Working Group as a consultative forum to consider, exchange information and workshop solutions to issues which might arise from the implementation of the new private health insurance rebate tiers measure. The group is chaired by the Department of Health and Ageing. The group met for the first time on Thursday 23 July 2009.

The group's members comprise of representatives from the private health insurance industry and people who have particular expertise in administering the private health insurance rebate. Invitations were sent to the following groups:

- Medicare Australia
- Australian Taxation Office
- Insurers (as represented by the Health Insurance Restricted Membership Association of Australia and the Australian Health Insurers Association)
- Institute of Actuaries of Australia
- Consumers' Health Forum
- Brokers (as represented by the Private Health Insurance Intermediaries Association)
- Rebate IT specialist
- Private Hospitals (as represented by the Australian Private Hospitals Association)
- Australian Health Service Alliance
- Private Health Insurance Ombudsman

Other people may be invited to attend the meetings as specialist advisers, as identified or required by the group. All outcomes of the group will be distributed to industry for consideration via private health insurance circulars.

Funding for a general communications campaign about the changes has been provided to the ATO through the budget. This campaign will be conducted during 2009-10 in the lead up to the changes starting on 1 July 2010.

The communications campaign will be coordinated by the Australian Taxation Office, with support from the Department of Health and Ageing. The Department will focus on assisting industry to implement the changes, through the development of information and guidance material and standard forms.

12) Interaction of private health insurance rebate tiers and changes to the Medicare Levy Surcharge with tax cuts

Treasury has provided modelling on the interactions between the Budget measure (the private health insurance rebate tiers and Medicare levy surcharge) and tax cuts across different income thresholds. This modelling clearly shows that with the tax cuts, people remain better off whether or not they experience a reduction in their private health insurance rebate or an increase in the Medicare levy surcharge.

The private health insurance budget measure impacts on two groups of people (over the income thresholds): those with private health insurance and those who pay the Medicare Levy Surcharge. These groups are mutually exclusive, as people who have complying private health insurance are exempt from the Medicare levy surcharge.

Treasury has therefore provided two tables, one relating to people with private health insurance and one relating to people without private health insurance (though many of the figures presented are common to both tables).

The following table shows the increase in income after tax cuts to individuals who purchase a private health insurance product at the estimated average premium.

Table: Tax cuts compared to premium increases for people with PHI

Income* (annual)	2008-09 Net Income Tax (incl. LITO and ML)*	Disposable income before changes to tax and PHI/ MLS	Private Health Incentive Tier	Tax cuts (annual gain in 2010-11 vs 2008-09)*	Decrease in PHI rebate **	Annual amount taxpayer better off by (10-11 vs 08-09)	% increase in income
$20,000	$1,121	$18,879	n/a	$300	$0	$300	1.60%
$40,000	$5,800	$34,200	n/a	$750	$0	$750	2.20%
$60,000	$12,900	$47,100	n/a	$750	$0	$750	1.60%
$75,000	$17,625	$57,375	n/a	$450	$0	$450	0.80%
$80,000	$19,200	$60,800	1	$450	$167	$283	0.50%
$90,000	$23,350	$66,650	1	$750	$167	$583	0.90%
$100,000	$27,500	$72,500	2	$1,050	$333	$717	1.00%
$110,000	$31,650	$78,350	2	$1,350	$333	$1,017	1.30%
$120,000	$35,800	$84,200	2	$1,650	$333	$1,317	1.60%
$130,000	$39,950	$90,050	3	$1,950	$500	$1,450	1.60%
$140,000	$44,100	$95,900	3	$2,250	$500	$1,750	1.80%
$150,000	$48,250	$101,750	3	$2,550	$500	$2,050	2.00%
$160,000	$52,400	$107,600	3	$2,850	$500	$2,350	2.20%
$170,000	$56,550	$113,450	3	$3,150	$500	$2,650	2.30%
$180,000	$60,700	$119,300	3	$3,450	$500	$2,950	2.60%
$200,000	$70,000	$130,000	3	$3,450	$500	$2,950	2.30%
$250,000	$93,250	$156,750	3	$3,450	$500	$2,950	1.90%
Notes:							
*For the purpose of calculating underlying net tax and tax cuts in these examples, taxable income has been assumed to be equivalent to income for surcharge purposes.							
**Based on average gross premiums calculated using the most recent PHIAC data available. For reasons of commercial sensitivity, projections of average premiums for 2010-11 have not been used.							

The following table shows the increase in income after tax cuts for individuals who do not purchase a private health insurance product and are therefore liable for the increased Medicare Levy Surcharge.

Table: Tax cuts compared to premium increases for people without PHI

Income* (annual)	2008-09 Net Income Tax (incl. LITO and ML)*	Disposable income before changes to tax and PHI/ MLS	Private Health Incentive Tier	Tax cuts (annual gain in 2010-11 vs 2008-09)*	Increase in MLS	Annual amount taxpayer better off by (10-11 vs 08-09)	% increase in income
$20,000	$1,121	$18,879	n/a	$300	$0	$300	1.60%
$40,000	$5,800	$34,200	n/a	$750	$0	$750	2.20%
$60,000	$12,900	$47,100	n/a	$750	$0	$750	1.60%
$75,000	$17,625	$57,375	n/a	$450	$0	$450	0.80%
$80,000	$19,200	$60,800	1	$450	$0	$450	0.70%
$90,000	$23,350	$66,650	1	$750	$0	$750	1.10%
$100,000	$27,500	$72,500	2	$1,050	$250	$800	1.10%
$110,000	$31,650	$78,350	2	$1,350	$275	$1,075	1.40%
$120,000	$35,800	$84,200	2	$1,650	$300	$1,350	1.60%
$130,000	$39,950	$90,050	3	$1,950	$650	$1,600	1.40%
$140,000	$44,100	$95,900	3	$2,250	$700	$1,550	1.60%
$150,000	$48,250	$101,750	3	$2,550	$750	$1,800	1.80%
$160,000	$52,400	$107,600	3	$2,850	$800	$2,050	1.90%
$170,000	$56,550	$113,450	3	$3,150	$850	$2,300	2.00%
$180,000	$60,700	$119,300	3	$3,450	$900	$2,550	2.10%
$200,000	$70,000	$130,000	3	$3,450	$1,000	$2,450	1.90%
$250,000	$93,250	$156,750	3	$3,450	$1,250	$2,200	1.40%
Notes:							
*For the purpose of calculating underlying net tax and tax cuts in these examples, taxable income has been assumed to be equivalent to income for surcharge purposes.							

These tables are based on a single person – in the case of couples/families with any given level of combined income, the total gains to the couple/family from tax cuts will vary, depending on how the income is distributed between the members of the couple. For example, a couple with a 70-30 income split will in many scenarios receive a different total gain from tax cuts than is a received by another couple with the same total income but a 50-50 split. It is very difficult to model all the different scenarios of couples/families, however the singles scenario reflects what would happen in principle with couples/families as well.

For the purposes of these tables, taxable income has been assumed to be equivalent to income for surcharge purposes. In practice, many singles and couples/ families will have an income for surcharge purposes that is greater than their taxable income. This is because the definition of income for surcharge purposes includes components that taxable income does not, such as reportable fringe benefits, salary sacrificed superannuation contributions, etc. As shown in the tables, people will be better off due to the tax cuts.

Treasury considers that as the annual-amount-better-off construct effectively looks to be a net dollar gain, a net disposable income base should be used for calculating the percentage increase.

The second columns in both tables set out net tax liability (including Low Income Tax Offset and 1.5% Medicare Levy impacts but not including any Medicare Levy Surcharge or private health insurance impacts, based on 2008-09 tax scales, as the 09-10 and 10-11 tax and Low Income Tax Offset changes to these scales already fall within the "Tax cuts...." column) and the third columns set out disposable income after allowing for this net tax liability.

Switching from a calculation based on percentage gains against gross income to one where gains are measured against net income leads to an increase in all of the percentage gain figures, most particularly at higher incomes, where the proportional difference between gross and net incomes is greatest.

The "Decrease in PHI rebate" in Table 1 is based on the average gross premium for a single person using the most recent data available from PHIAC. For reasons of commercial sensitivity, projected 2010-11 premiums have not been used in the presentation of these tables.

To the extent that gross premiums increase between now and 2010-11, the net gains presented in Scenario 1 will be overstated, as the PHI rebate loss will increase while the gains from tax cuts remain constant.