Chapter 2

The bill and the Medicare Levy Surcharge

2.1 The Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008 increases the Medicare Levy Surcharge (MLS) thresholds from annual taxable incomes of $50 000 to $100 000 for individuals and from $100 000 to $150 000 for families and couples. The increased thresholds will apply from the 2008–09 year of income. For 2008–09 tax returns, therefore, individuals taxpayers earning $100 000 and under will not be liable to pay the MLS.

2.2 To give effect to these changes, the bill amends subsections 6(1), 6(2) and paragraph 12(1)(a) of the *A New Tax System (Medicare Levy Surcharge—Fringe Benefits) Act 1999* and subsections 3A, 8B(2) and 8E(2) of the *Medicare Levy Act 1986*.[1]

2.3 Medicare is partially funded through the Medicare levy.[2] It is currently set at 1.5 per cent of taxable income with an exemption for low income earners adjusted regularly to account for changes in the consumer price index (CPI). The MLS is not hypothecated. In 2005–06, revenue from the Medicare levy was $6.1 billion while the surcharge raised $0.3 billion. The overall cost of Medicare in 2005–06 was $16.4 billion.[3]

2.4 Currently, the Medicare levy surcharge is an additional one per cent of taxable income imposed on those who do not have private health insurance (PHI) and who earn over $50 000 per annum (over $100 000 for couples and families). If the bill is passed, a single person without private health insurance on the average annual salary of $58 600 would therefore save $586 a year.[4]

2.5 If the MLS had been indexed to the CPI since it was introduced on 1 July 1997, the threshold would now be $67 000 per annum; if it was indexed to average weekly earnings, it would be now be set at $76 000 per annum.[5] Australian Taxation

---

1 Explanatory Memorandum

2 Part of the levy is hypothecated to fund Medicare, although it covers only a small proportion of the Commonwealth's outlays on the scheme.

3 Amanda Biggs, Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008, *Parliamentary Library*, Bills Digest, 4 June 2008, no. 121, p. 3. The Hon. Peter Costello, Treasurer, *Final Budget Outcome 2005–06*, Table B1, p. 3. Australian Taxation Office, *Taxation Statistics 2005–06*, Table 1, p. 3. Australian Tax Office data for 2006–07 has not yet been publicly released.

4 The average salary figure is based on the latest ABS data for the March Quarter 2008 (6302.0).

5 Australian Bureau of Statistics, 6401.0, March 2008 Quarter.

Office figures show that in 2005–06, 465 325 taxpayers incurred the surcharge, up from 436 490 in 2004–05 and only 167 330 in 1997–98.[6]

2.6 The policy intent of the MLS is as follows:

> The surcharge aims to encourage individuals to take out private hospital cover, and where possible, to use the private system to reduce the demand on the public system.[7]

2.7 When the MLS was introduced in 1997, it was targeted at high income earners. The then Treasurer, the Hon. Peter Costello, told the House in August 1996:

> …higher income earners who can afford to take out private health insurance will also be encouraged to do so…This is the levy which the Government hopes no-one will pay. It is entirely optional. Those who take out health insurance (with the benefits attached) will be exempt.[8]

2.8 Professor John Deeble, the principal architect of the Medicare system in the 1980s, noted in his submission to this inquiry the unusual nature of the surcharge:

> The surcharge is an income-related tax. However unlike almost any other income-based tax, it operates in a reversionary way – that is, it applies to all the taxable income of people earning above the thresholds, not just to the excess. I know of no other tax that works in this way and it is extraordinary that an Australian parliament should have approved it. The result is a very high marginal tax rate for people with incomes at or close to the thresholds.[9]

2.9 As the average income is now $58 600 per year it should be noted that an increasing number of taxpayers close to the threshold are bearing a disproportionate amount of the MLS, and that this is neither equitable nor in keeping with the original intent of the policy.

2.10 The MLS was introduced in 1997 as part of a suite of policies to encourage membership of private health funds. In 1999, the Commonwealth Government implemented a 30 per cent rebate on private health insurance premiums. For people aged between 65 and 69 years, the rebate is 35 per cent; for those aged over aged 70 years, it is 40 per cent.[10] In 2000, legislation was passed limiting any front end deductible (excess) to $500 for singles to qualify for surcharge exemption. In 2001,

---

6 Australian Taxation Office, *Taxation Statistics 2005–06*, Table 7: Personal tax, p. 3.

7 Australian Government, privatehealth.gov.au http://www.privatehealth.gov.au/information/surcharges/medicarelevy.htm (accessed 7 July 2008).

8 The Hon. Peter Costello, Appropriation Bill (No. 1) 1996–97, *Second Reading Speech*, 20 August 1996.

9 Professor John Deeble, *Submission 3*, p. 2.

10 These changes were effective as of 1 April 2005.

the Commonwealth introduced the Lifetime Health Cover scheme. The scheme imposes a two per cent annual cumulative loading (up to 70 per cent) to the cost of private health premiums for people who only take out health insurance after their 31st birthday. For example, a person who first joined a private health fund at the age of 45 will pay a 28 per cent higher premium (14 years x 2 per cent) than a person who joined at the age of 31.

2.11 The MLS threshold levels have not changed since they were introduced. The Assistant Treasurer, the Hon. Chris Bowen, noted in the Second Reading Speech that when the surcharge was introduced by the Howard government, the policy was targeted at high-income earners. He explained that the bill:

> simply increases the thresholds to an income level around which they originally applied in 1997…around 8 per cent of single taxpayers are estimated to have exceeded the Medicare levy surcharge threshold in 1997-98, when it was introduced…this proportion will be restored to around 8.5 per cent – at the end of the forward estimates – of single taxpayers likely to exceed the new singles threshold in three to four years.[11]

2.12 In explaining the rationale for the bill, Mr Swan described the current $50 000 threshold as a 'tax trap'. He added:

> I think the private health industry should have more confidence in their product. We are a supporter of private health insurance and we have supported the 30 per cent rebate and the variations to it as it runs up the scale and we will continue to do that. But you cannot support it with this sort of compulsory taxation, on a group of people who don't deserve to be hit for six, the way they were hit for six.[12]

2.13 The Medicare levy surcharge, the 30 per cent private health insurance rebate and the Lifetime Health Cover arrangements are a combination of 'carrots' and 'sticks' to encourage PHI membership. The private health insurance industry argues that these three 'pillars' are essential to maintain a 'balance' between public and private health care, and to support Australia's unique system of community rating in private health insurance.

2.14 However, these 'pillars' are expensive to maintain. Those who hold private health insurance currently receive generous tax breaks even before the exemption from the MLS. Table 2.1 shows that in 2006–07, the cost to the taxpayer of the 30 per cent private health insurance refund was higher than the tax concessions given to the total manufacturing sector.[13]

---

11 The Hon. Chris Bowen, Second Reading Speech, *House of Representatives Hansard*, 27 May 2008, p. 3349.

12 The Hon. Wayne Swan, *Address to the National Press Club*, Canberra, 14 May 2008.

13 Productivity Commission, 'Trade and Assistance Review 2006–07', *Annual Report Series*, Table 2.5b, p. 2.11.

Table 2.1: Tax concessions 2006–07 (30% PHI rebate & selected industries)

	30 per cent PHI rebate	Manufacturing	Primary production	Mining
Tax concessions 2006–07 ($ million)	980	963	192	131

Source: Tax Expenditures Statement 2007; Trade and Assistance Review 2006–07, Productivity Commission

2.15 Table 2.2 shows that the level of private health insurance increased in all states between 1996 and 2001. Membership levels have remained fairly steady since 2001. Many attribute the jump in PHI membership to the success of the 'Run for Cover' marketing campaign prior to the introduction of Lifetime Health Cover arrangements.[14]

Table 2.2: Percentage of population in private health insurance, 1996–2008

	WA	NSW	SA	Vic	Tas	Qld
March 2008	49.7	46.0	44.5	43.3	43.0	42.1
March 2001	48.2	45.8	45.7	45.1	44.3	42.4
Sept 1996	36.7	33.9	34.0	33.2	36.7	31.1

Source: Private Health Insurance Administration Council, Industry statistics.

14 See Professor John Deeble, *Submission 3*, p. 9.