

**Submission to the Senate Standing Committee on
Economics**

**Inquiry into the Tax Laws Amendment (Medicare Levy
Surcharge Thresholds Amendment) Bill, 2008**

John Deeble

Emeritus Fellow

The Australian National University

July 2008

Estimating the effects of a change in the Medicare surcharge thresholds

Background

In the 2007-2008 Budget the government announced a change in the levels of taxable income beyond which taxpayers are liable for a surcharge of 1% of taxable income in addition to the standard Medicare levy of 1.5%. However taxpayers holding an approved level of private insurance cover for hospital care may claim exemption from the surcharge. The present thresholds are \$50,000 annually for single taxpayers and \$100,000 for family units. They have not changed for over 10 years. The proposed bill would increase them to \$100,000 and \$150,000 per annum respectively. About 250,000 taxpayers currently pay the surcharge. The number claiming exemption from it is unknown (taxation statistics relate only to individual taxpayers, not families) but data from household income surveys suggest that the vast majority of people in the relevant income ranges do so. In 2005-06, nearly 1.5 million households had incomes of over \$100,000 a year.

As a preliminary, it is important to remember how the present system works. 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 of 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. For example;

- a single person with an annual income of \$50,000 pays the basic Medicare levy of \$750.(1.5%). A person earning \$60,000 – which is \$10,000 over the current surcharge threshold but not far above the current average for employed people - pays an additional surcharge of \$600 (1% of all taxable income). On the extra \$10,000, the total tax is five times the basic levy of \$150.
- a family with a combined income of \$110,000 (also \$10,000 over the current family threshold for the surcharge) pays a basic Medicare levy of \$1650, plus a surcharge of \$1,100. On the additional \$10,000 of income, the effective tax is over eight times the standard Medicare rate.

The incentive to take private insurance is therefore very strong indeed. For people who are liable for it, avoiding the surcharge is just as important as the private health insurance rebate on premiums. For higher income families, that would pay for the (subsidised) premium. The proposed changes will not alter this system. They will simply shift the incentives higher up the income scale to where fewer people are affected and the surcharged amount is greater.

For taxpayers in the relevant income ranges, the effect will be straightforward. There will be a 40% reduction in the price of public hospital treatment, from 2.5% of taxable income to 1.5%. That would be expected to have some effect on the membership of private insurance, which would flow on to both the private hospitals and the private doctors whose services the health insurance industry supports. However the size of the effect is not self-evident. It will depend on the number of people involved, their usage of hospital services and the relationship

between the benefits which the private health insurers currently pay for those members and the premiums that they receive.

There is general agreement on its broad direction. Most of the debate has been based on the assumption that any loss of membership will be concentrated amongst those relatively young and healthy contributors who rarely use hospital services and who would be the least likely to hold private insurance without the levy surcharge. Since these people subsidise the benefits to older and higher-usage members, average premiums would be expected to rise. The possible costs to governments of treating more people in the public hospital system (and the effects on access to it) have also been raised. But they are quite separate issues. The more that membership changes are concentrated on the younger and lower-use members, the greater the impact on the health insurers' results but the lower the public hospital cost to governments. A more evenly distributed shift would have less effect on the private health insurers' risk profile but the cost of providing public hospital care would then be higher.

Unfortunately, it is impossible to predict the overall result with certainty. There are two reasons for this. Firstly, while much of the necessary information exists it is in different hands and not all of it is publicly available. That means that the number of people who might be affected can only be estimated. The Commonwealth Treasury has made some estimates and these are likely to be better informed than any others. It has access to the records of taxpayers whose incomes are in the relevant ranges and who are currently claiming exemption from the surcharge by holding private insurance. And it can link the taxation data with other collections to estimate family incomes in a way that no-one else can. But the Treasury does not know what the health care usage of those people is. The health insurance funds do know and the statistics published by PHIAC are comprehensive and detailed in relation to the types of policy held, the age and sex of both the population covered and the users of services, and according to the types of services used. However the health insurers have no information on

incomes. All of the competing estimates are therefore based on partial knowledge.

The second limitation is that the debate relates only to the price effect of the proposed surcharge changes. However people hold private insurance for a variety of reasons - habit, social reasons, risk-aversion and a preference for private services over public ones. Together, they have produced a system in which private health insurance is quite sensitive to income levels (richer people are much more likely to hold it than poorer ones and changes in income have a significant effect on membership) but not particularly sensitive to price. That applies to other countries as well as Australia but in Australia it is reinforced by concerns over access to the alternative public system. Official surveys show this to be the most quoted reason for membership, by far. If doubts about the availability of public hospital care continue, reducing its price may not produce much change at all.

Estimation

Assumptions

1 That 488,000 memberships and 750,000 people will leave private insurance (8% of current coverage). These are slightly higher figures than those based on the Commonwealth Treasury estimates but they are consistent with the reported projections by Medibank Private. I am not aware of the Treasury's methodology but I presume that it was based on the same considerations as outlined above.

2 That the reduction will come from younger members. The reasoning is that, for most people, incomes are relatively low in early adult life, rise with age up to about 40- 45 years, stay relatively stable to near retiring age but decline quite rapidly from 60 years on. The extension of the Medicare surcharge

threshold would therefore have least effect on people in their peak earning period but, for different reasons, it would also have very little influence on people aged 60 years and over. Many older people would not reach the surcharge thresholds for income but they are high hospital users for whom security and access are paramount.

The figures that follow are based on two alternative assumptions. The first is that the reduction would come from all people aged up to 50 years, a relatively conservative assumption in relation to the possible effects on both the private health insurers and the public hospitals. The second is that the shift would be concentrated in people aged under 35.

3 That the utilisation data for privately insured people under 50 years of age and 35 years of age respectively, are representative of those who might be affected by a surcharge change, including their dependents. Ideally, the calculations should be based the age and family characteristics of the decision-making policy holders, but that would require a matching of the taxation data with those from private health insurance, which is impossible at present.

Data

Table 1 shows the persons covered, services used and benefits paid for the whole insured population in the year to March 2008 and the data for two age subsets, as reported by the Private Health Insurance Administrative Council (PHIAC) Sources are listed in the Appendix. The first four lines show the aggregate data, from which the ratios were then derived.

Table 1: Insured population at March 2008, with service use and benefits paid, year to March 2008

	Total	Aged under 50	Aged under 35
Coverage (mill. people)	9.476	6.192	3.904
Hospital admissions (mill)	2.762	1.004	0.497
Hospital days (mill)	7.500	2.292	1.201
Benefits (\$mill)	7,170	2,066	1,036
Admissions per person	0.292	0.162	0.127
Av. days per admission	2.71	2.28	2.41
% same day stays	61.2	67.0	65.0
Benefits per admission (\$)	2,596	2,057	2,085
Benefits per person (\$)	757	334	265

As can be seen,

- * about two thirds (65%) of the insured population were aged under 50 years of age and 41% were aged under 35.
- per person, hospital admissions for people aged under 50 were only 55% of the average for all insured people. Their average stay in hospital was shorter and they received only 79% of the average hospital benefits per admission. That is an indicator of comparative treatment costs. Per person covered, their average benefits were only 42% of the national figure.
- insured people aged under 35 years incurred very similar costs per admission, but because their admission rate was even lower than the under-50 group, the average benefit per person was only 35% of that for the insured population as a whole.

If, as seems most likely, the final result was somewhere between the two extremes, the average person leaving private health insurance would have had about 0.15 admissions per year with a benefit cost of about \$300 per head. That was very much lower than the average. If 750,000 people shifted, it would equate to a \$225 million reduction in private insurance benefits paid per year, about 3.1% of the national total in 2007-08.

Possible effect on premiums

Based on the results reported by PHIAC for 2006-07 and the average premium increases since then, the contribution income of health insurers is estimated at about \$12,000 million in 2007-08. Contributions are not allocated by function but assuming that the distribution followed that of benefits the hospital share was about \$8,800 million, of which \$7,170 million was paid out in benefits. The rest was absorbed by administrative cost (nearly 10%) and surpluses. Per person covered, the average hospital insurance premium, including the Commonwealth rebate, was about \$930.

Anecdote suggests that many of the younger, low-risk members take policies with lower than average benefits and higher deductible amounts, However the extent of that is unknown. If their average premiums were the same, a shift of 750,000 people would reduce the health insurers revenue by \$697 million (750,000 X \$930). Deducting the estimated \$225 million in benefit savings leaves a net shortfall of \$472 million. Covering that deficit would require a premium increase of only 5.1% (\$427 million over a remaining 8.37 million people) and the actual result would probably be less. Moreover, for reasons that will be discussed in relation to the public hospitals, it would not take place immediately.

It is hard to see that as any threat to the viability of private health insurance. As pointed out earlier, all of the international literature shows the demand for it to be

relatively insensitive to price. And the Australian evidence is equally clear. Private health insurance premiums have risen by about 2% more than the general inflation rate in all but one of the last seven years, a cumulative 'real' increase of over 10%, but health insurance membership has risen, not fallen. The history of the private health insurance rebate is similar. A general 30% rebate was first introduced in 1997, two years before the present structure was finalised in 1999-2000. It provided a 30% reduction in price but it had no effect on membership at all. That continued to fall. The conventional wisdom (and the interpretation of most economists) is that 'lifetime health cover' was responsible for the dramatic increase in 1999-2000, but I think that is wrong on the basis of both theory and evidence. The crucial factor was a major 'Run for Cover' publicity campaign and the message it conveyed.

Possible effects on public hospitals

Table 2 shows the estimated effect on public hospitals in 2007-08 if the private insurance patterns of service utilization and cost were to be replicated exactly in the public system. The first two lines come from Table 1. Line 4 comes from the hospital statistics published by AIHW. The other figures are derived.

Using the same admission rates and same relative cost factors as in the private sector, but applying the average cost per case in public hospitals, a shift of 750,000 people from all insured people aged under 50 years would have increased total public hospital expenditure by \$391 million annually (750,000 X 0.162 x 0.79 X \$4,079). That would equate to 2.05% of all inpatient expenditure. However because the average hospital use of people aged under 35 is much lower, a shift confined to them would raise public hospital spending by only \$311 million a year or 1.63% of current inpatient spending. If in fact the final result contained elements of both, the best estimate is an increase of about \$367 million annually or 1.92%. That is less than the figure of \$439 million in 2008-09

cited by the Australian Health Insurance Association on different and much broader parameters, but not by a different order of magnitude.

Table 2 Estimated effects on public hospitals of a shift of 750,000 people from private insurance to public cover, 2007-08, for all insured persons aged under 50 and those aged under 35 years only.

	Aged under 50	Aged under 35	Average
Additional admissions (000)	121.5	95.2	112.5
Relative cost index	.79	.80	.80
Cost weighted admissions (000)	96.0	76.2	90.0
Av. public hospital cost per admission (est. 2007-08, \$)	4,079	4,079	4,079
Additional expenditure (\$m)	391	311	367
% inpatient expenditure, 2007-08	2.05	1.63	1.92

However not all of the increase would be a new cost to governments, because the Commonwealth pays Medicare benefits for privately insured patients in hospital and gives them access to the PBS outside the private insurance system. Together these payments amounted to about \$1,200 million in 2007-08, which equated to about \$434 per insured admission on average or \$52 per person covered in the group most likely to leave private insurance. The real increase in public funding would thus be about \$325 million a year at most.

That would be a very minor addition to a system which admitted 4.66 million patients in 2006-07 and cost over \$26 billion to run. And the additional admissions, the majority of them same-day, would not significantly test the hospitals' capacity. It would certainly require some funding changes, particularly

at the Commonwealth end where significant amounts of Medicare and PBS money would be available for redirection. But the Commonwealth would also save about \$210 million on the premium rebate ($750,000 \times \$930 \times 0.3$). The net new cost to governments would thus be very small indeed.

Timing

The estimates above relate to the possible long-term effects of a pricing change. But the immediate effects (in 2008-09 for example) would be much less, for three reasons;

(1) Ignorance, apathy and uncertainty. Despite the publicity, some people will not even be aware of the change, some will defer, or forget to take, the necessary action (at least until tax return time) and others will be held in private insurance by the 'Lifetime Health Cover' rules. If they expect their income to rise in the future, not only will liability for the surcharge come back, but the cost of private insurance will be higher. The rules allow for suspension for limited periods but most contributors would not be aware of that.

(2) Flaws in the public hospital system will be widely publicised.

(3) Not all of the people who would be admitted to hospital under private health insurance would be formally admitted to the public hospitals, particularly for services like renal dialysis, chemotherapy, sleep apnea and some endoscopic procedures. The Menadue report for NSW cited a Health Department estimate that up to 30% of patients admitted to private hospitals would not have been admitted as inpatients in the public system. Some would have been treated as outpatients. Some would not have been treated in a hospital at all.

For all these reasons I would not expect the average swing over 2008-09 to be much more than half of the long-term estimates above. At only 1%, it would have

a very limited impact. However it is useful to have some indication of what the possible size might be, because it will be very difficult to isolate the effects of private health insurance changes after the event.

Summary

- the economic effect of the proposed changes will be to reduce the cost of public hospital care by 40% for single people with incomes between \$50,000 and \$100, 000 per annum, and for families with combined incomes of between \$100, 000 and \$150,000 a year
- that will have some effect on the membership of private health insurance and on the private hospitals and doctors that private insurance supports. The shift in membership is most likely to occur amongst younger people whose use of hospital services is lower than the average.
- however the effects will be quite small. Based on hospital usage in the relevant age groups, the number of people covered by private insurance is expected to fall by about 8% but benefits paid would fall by only 3%. Premiums for the remaining members would rise by just over 5%. That would not threaten the viability of private insurance.
- ultimately, public hospital admissions may rise by about 2% and expenditures may increase by a slightly lower figure. However because the Commonwealth now pays significant amounts for medical services and drugs for private patients outside the private health insurance system, and gives at least a 30% rebate on premiums, the net cost to governments will hardly rise at all.

Appendix

Data sources

Private Health Insurance Administration Council, Statistical trends in Membership and Benefits, March Quarter 2008.

Series 2, Benefits Hospital treatment coverage, episodes, hospital days and benefits, by age

Private Health Insurance Administration Council, Operations of the Private health Insurance Funds, Annual Report, 2006-07, Part C

AIHW, Australian Hospital Statistics 2006-07.

Chapter 2, Tables 2.1, 2.3 and 2.4

Chapter 4, Tables 4.1a, 4.1b and 4.1c.

Chapter 7, Tables 7.1, 7.2 and 7.4