ACCESS ECONOMICS
Pty Limited

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The impact of the changes to the income thresholds for the Medicare Levy Surcharge

Report by Access Economics Pty Limited for

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GLOSSARY

Threshold drag	Refers to the increasing number of people whose income exceeds the Medicare levy surcharge thresholds, in the context of rising nominal (and real) incomes as against fixed nominal income thresholds. It is analogous to the fiscal drag effect with income tax collections.
Surcharge dodgers	Refers to those people who choose to take out private health insurance coverage solely or primarily to avoid paying the Medicare levy surcharge. The motives for retaining PHI coverage can change over time, so it cannot be assumed that once a surcharge dodger, always a surcharge dodger.
MLS	Medicare Levy surcharge

EXECUTIVE SUMMARY

Access Economics has modelled the impact of the announced changes to the income thresholds for the Medicare Levy surcharge ('the thresholds'). The model compares expected outcomes under the policy change with alternate outcomes of no policy change.

The model identifies three distinct rounds in the impact on membership.

❑ Some existing members (mostly younger and healthier) will drop their cover.

❑ The price of health insurance will rise upon the loss of these members which will trigger further loss of existing and potential members.

❑ People who would otherwise have taken up private health insurance as their incomes moved beyond the MLS thresholds will no longer do so.

The likely effect on private health insurance (PHI) membership and coverage is substantial.

❑ First round losses (membership dropped) comprise some 202,000 policies and 359,000 persons covered.

❑ Second round losses due to an expected real price increase of 2.73% account for a further annual loss of 40,000 memberships and 83,000 persons covered.

❑ Third round effects (people who would have otherwise joined had the threshold not changed) have a large and progressive impact, rising from some 69,000 memberships (160,000 people not otherwise covered) in 2009 to nearly 302,000 memberships (nearly 709,000 people not otherwise covered) in 2012.

❑ The cumulative impact of the threshold change over the period 2008 to 2012 is some 545,000 memberships and 1.15 million people not otherwise covered.

❑ By December 2012, private health insurance coverage expressed as a percentage of the population will be 5.2% lower than under the no policy change base case.

The policy will have its largest influence on the PHI choices of younger and healthier people. The loss of these members/potential members increases the risk exposure of the private health funds as the lost contributions exceed benefits saved, a cumulative turnaround in the funds' net financial position of nearly $2.2 billion over the period. This implies the need for further real price increases beyond the initial 2.73%.

The net saving in Commonwealth outlays over the period 2008 to 2012 is estimated as approximately $113 million (compared to the Budget estimate of $300 million). The difference between the two estimates is because the Commonwealth's budget-time estimates ignore the loss of potential members in later years, as the threshold drag effect increases. It also ignores the expected price increase in health insurance from the first round losses and the consequential increase in government rebates that will need to be paid for the remaining members.

The Federal Budget saving is dwarfed by the indicated change in State and Territory government outlays, a cumulative total of $2.9 billion over the period based on conservative assumptions (that the shift in workload relates to a younger, healthier cohort cost per separation well below the average). The policy will shift an initial 82,000 episodes of care to the public hospitals in the first year of the policy but this will rise to 264,000 in 2012. In the

absence of reversal of the MLS threshold policy decision, unless the Commonwealth Government moves to mitigate the effects of the policy (by supplementing funding to the State and Territory governments), the expected outcome is increased rationing of access to public hospital services (longer waits and more people waiting).

RESULTS UNDER POLICY SCENARIO OF THRESHOLD BEING $100,000/$150,000

	2008[a]	2009	2010	2011	2012	Total
Cumulative number of policies dropped and not otherwise taken up	202,009	310,462	385,264	463,708	544,058	n.a.
Cumulative number of persons dropped and not otherwise taken up cover	359,091	602,483	779,627	963,043	1,150,999	n.a.
Episodes shifted to the public system	41,121	140,201	180,069	221,522	264,051	846,965
Annual net loss of PHI fund revenue ($m)	105.2	346.3	458.3	584.4	724.5	2,218.6
Annual net increase in government finances ($m)[b]	53.7	1.0	-1.6	20.9	38.8	112.8

Note: (a) Years refer to calendar year.(b) Refers to the net of government rebate expenditure savings, foregone MLS taxation revenue, and the additional rebate paid on remaining policies due to an expected price increase in policies. It does not include any additional funding required by the public sector to mitigate the public hospital effects of the policy.

The prior policy of leaving the thresholds at their nominal 1997 levels was not indefinitely sustainable. Against the medium term imperative to find ways to encourage more private financing, there are questions as to when a change in thresholds is appropriate, how often such changes should occur (ie, whether indexed annually or adjusted every few years) and an appropriate starting point for any recalibration. There is no prima facie reason why the real level of the threshold as at July 1997 should be the starting point for any recalibration.

If the goal of the change was to try to maintain the thresholds in terms of real incomes, then an option would be to index the thresholds based on average weekly earnings. This would be a short term measure to allow a more thorough general review of what is an appropriate level of incentivisation going forward and of the role of private health insurance in the health financing system of the future.

1. OBJECTIVES AND STRUCTURE

The aims in building the model were to scientifically analyse and quantify the potential impact of the Government decision, including:

❑ the impact of changes to the thresholds on the number of Australians with private health insurance (PHI), including an examination of how many will abandon their policies as a result and how many will not take up PHI in the future;

❑ the anticipated impact on PHI premiums and PHI products offered;

❑ the impact of the change on the cost of living and the consumer price index;

❑ the anticipated impact of changes to the threshold on:

♦ the public hospital system including waiting lists and the financial requirements of state governments;

♦ the ongoing viability of PHI given the loss of voluntary contributions; and

♦ private hospitals.

The structure of this report is as follows:

❑ Part 2 describes the immediate context (the Budget decision) but also draws attention to wider issues that are relevant to any examination of the new income thresholds;

❑ Part 3 describes the model and the data used to populate it;

❑ Part 4 summaries the results of the modelling;

❑ Part 5 gives the results of scenario and sensitivity analysis;

❑ Part 6 addresses key policy implications; and

❑ Appendix A provides a policy timeline for private health insurance in Australia.

2.   CONTEXT

The context for the model is the 2008-09 Budget decision to increase the income thresholds for the Medicare Levy surcharge (for people who do not have complying private health insurance cover) from $50,000 to $100,000 for singles and from $100,000 to $150,000 for families/couples. The surcharge was an additional 1% of taxable income on top of the base Medicare levy. For an extended period (save for a brief interlude for the gun levy) the base Medicare levy rate has been 1.5% of taxable income.

The Medicare levy surcharge was introduced in July 1997. The income thresholds, which have remained unchanged at $50,000 and $100,000 for some eleven years, are based on the total of **taxable income including total reportable fringe benefits** (so that taxpayers cannot avoid or minimise the surcharge through salary packaging).

The budget measure incited comment because the new threshold for singles in particular was set at an unusually high level, more than required to re-establish the thresholds at their 1997 real levels. Had the thresholds been indexed from their initial 1997 levels:

❑   **by the CPI**, the indicated new thresholds would have been of the order of $65,000 for singles and $130,000 for couples and families.

❑   **by average earnings** (National Accounts based), the indicated new thresholds would have been of the order of $75,000 for singles and $150,000 for couples and families.

There is, however, no presumption that the 1997 thresholds were the 'right' base from which to recalibrate the thresholds. Indeed, such policies generally are introduced at levels that have little impact in the expectation that their impact will increase gradually over time. The budget measure did not address the question of what is the appropriate share of people to capture in the threshold now and in the future, given financing sustainability considerations.

The Federal Treasury estimated that the measure would produce net savings to the Budget bottom line of some $300 million over the period 2008-09 to 2011-12, as per Table 2-1.

TABLE 2-1: BUDGET MEASURES

Year	PHI rebate savings	Loss of surcharge	Net saving
2008-09	$232m	Nil	$232m
2009-10	$237m	$195m	$42m
2010-11	$246m	$235m	$11m
2011-12	$256m	$230m	$26m
Total	**$960m**	**$660m**	**$299m**

Private health insurance has benefited from a period of relative stability in policy settings after the turbulence of the Whitlam, Fraser, Hawke and Keating eras (see Appendix A, PHI Policy Timeline). Thirty years ago there was incessant ideological debate as to the public and private sector composition of health financing. Upon its introduction some 25 years ago, Medicare reduced the role for private health insurance but, less than two years later, the then government starting shifting costs back into households and private health funds.

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Meanwhile politicians have started to realise (and in some circumstances to acknowledge) that taxpayers cannot carry all the load of future financing health care in Australia. The pressures on budgets are expected to increase substantially over the next twenty years given the high expectations and significant numbers of the 'post-war baby boomers'.

❑ Population projections point to a doubling in the proportion of the population aged 65 and over by 2050 and a quadrupling in the proportion of the population aged 85 and over in the same period.

❑ Health technologies can be expected to continue to be a major source of demand pressure as they lift expectations even further as to the quantity and quality of health care that can be provided. The inexorable rise in the prevalence and cost of chronic illness is accompanied by the very significant challenges posed by preventable lifestyle diseases.

❑ Relative success in dealing with heart disease and cancer is unmasking other costly health conditions. For example, Australia is facing epidemic-style increases in the numbers of people with diabetes and with dementia.

The Second InterGenerational Report in 2007 forecast expenditures on health to grow from 3.8% of GDP in 2006-07 to 7.3% of GDP by 2046-07. This will cause the national **fiscal balance** to fall from its current surplus of around 1% of GDP to a **deficit of around 3% of GDP**, unless there is greater reliance on private sector health financing.

PROJECTED AUSTRALIAN GOVERNMENT FISCAL BALANCE (2007-46)
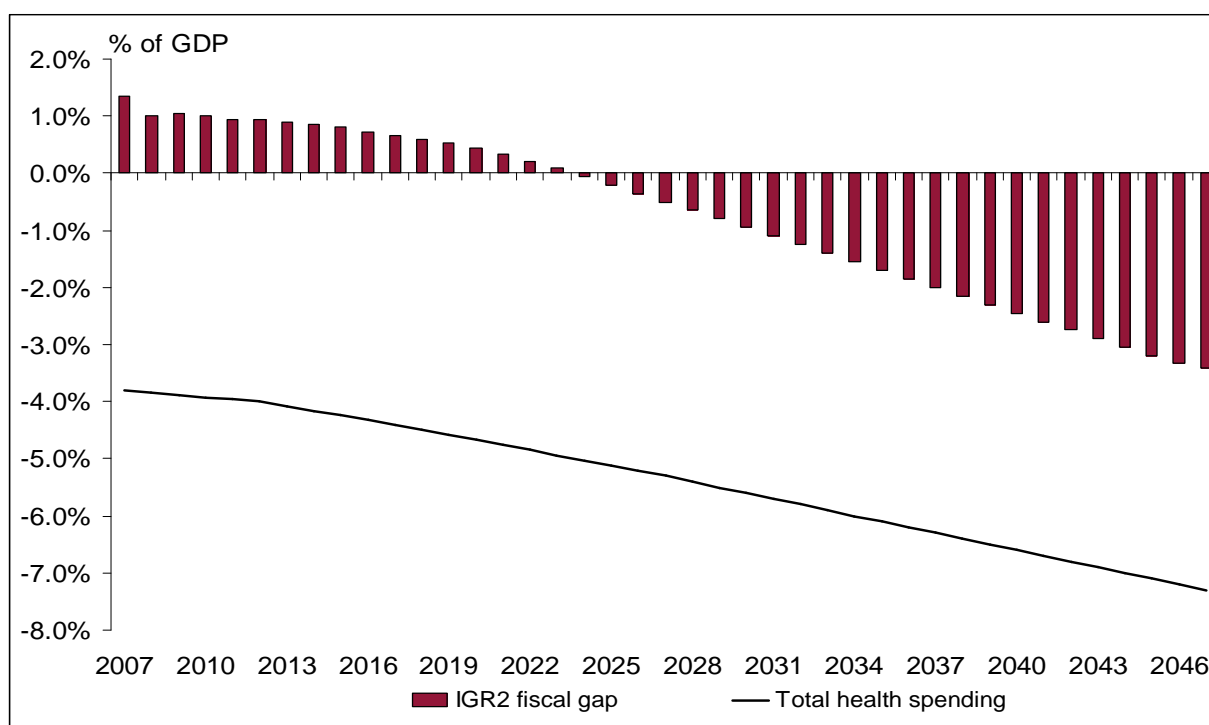
A reversion to the experience of the early 1990s (an extended period of decline in private health insurance coverage) would place an growing burden on the public health system. The quest for a robust, sustainable health financing system does not end with a viable private health insurance sector. Australia will need to explore innovative ways for private financing

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to grow in future and carry an increasing share of health costs. That may well involve new financing elements such as health savings accounts.

2.1 THE SURCHARGE IN PERSPECTIVE

It is important to retain perspective. The Medicare Levy surcharge is one element of a set of 'sticks and carrots' designed to encourage PHI membership. The tax rebate (variously 30%, 35% and 40%) assists people on the fringe of affordability. Lifetime Health Cover discourages people from 'gaming' the system, joining later in life only when they expect their health to deteriorate. Lifetime Health Cover and the surcharge together provide an effective policy framework to encourage younger members.

Those who see themselves as surcharge dodgers contemplate fund membership in a framework which can be as simple as the premium being less than the extra tax, at least in the first instance. They do not join for the expected benefits. That said, once they become members, they may start to access benefits.

For many other people, the Medicare Levy surcharge is only one of many factors that may be influencing their decision to hold, or not to hold, private cover. Factors that might deter people from dropping their cover, even though the new threshold might be below their current income, include the following.

❑ The extent of risk aversion. This can be significant for people who are widowed. The Australian population has aged and will continue to age, meaning a rising proportion of the population is in generally more risk-averse age brackets.

❑ The extent of satisfaction with the private system during their period of membership.

❑ The existence, or otherwise, of specific reasons for seeking cover (eg, a preference for private obstetric care).

❑ The perception of prospective access to—and quality of care in—the public system.

❑ The adequacy or otherwise of income and expected income. In general, those on higher incomes are less sensitive to price increases. The National Health Survey shows that one parent families in particular struggle with financial pressures and their propensity to drop PHI is the highest among the different family types.

❑ Whether or not a person expects to breach the revised threshold in the near future.

❑ The threat of higher premiums under Lifetime Health Cover if a person does rejoin at a later date.

3. DESCRIPTION OF THE MODEL

The complexity of the private health insurance market and the interaction of several different types of subsidies and regulations within health insurance and health care delivery make it a challenge for a model to capture the entire spectrum of likely impacts from a MLS threshold change. In addition, underlying changes to the economy such as income growth and population change add to the complexity.

The policy simulation model developed by Access Economics allows for membership estimates to be generated for the proposed MLS threshold change for singles and non-singles along with scenarios under alternative threshold changes. From these, impacts on the public system, PHI funds, and Federal government finances have been derived.

The underlying principle of the model is that individuals weigh up their benefits and costs when deciding to purchase (or hold if already a member) private health insurance. At any given time individuals have the option of using the public health system so in effect private health insurance provides consumers with the option of using the private health care system. Where some consumers choose to undertake care in the private system, others may choose the public system even though they own private health insurance. A change in the MLS threshold is expected to make members no longer affected by the MLS re-evaluate the additional benefits they receive from private health insurance relative to the costs of cover.

3.1 THE BASIC MODEL STRUCTURE

Broadly speaking, the model has five types of variables, including:

- Demographic and socioeconomic variables
  - Current and projected population between 2008 and 2012 by age and sex (Access Economics, 2008)
  - Personal and household income by age and sex, adjusted to 2008 dollars (ABS 2006, 2007)
- PHI variables
  - hospital cover by age, sex, and policy type (PHIAC, 2008a);
  - annual episodes of persons with hospital cover by age and sex (PHIAC, 2008b)
  - annual benefits paid to persons with hospital cover by age and sex (PHIAC, 2008b);
  - price of hospital cover by level of coverage (basic, medium, and top cover) (iSelect 2008, Cannex 2008)
  - expected increase in price of hospital cover (without threshold change) (DoHA, 2008)
  - expected private health cost inflation (AIHW, 2008)
- Policy variables (threshold change)
  - Singles - $65,000, $75,000, and $100,000
  - Non-singles - $130,000 and $150,000
- Response variables

- probability of dropping out of hospital cover due to change in threshold (NHS, 2006);

- probability of purchasing hospital cover if earning above thresholds (NHS, 2006); and

- elasticity of demand for hospital cover to measure the impact of price changes on membership (Frech et al 2003, Palangkaraya and Yong 2004)

❑ Output variables

- policy membership and persons covered by hospital insurance;

- annual episodes shifted to the public health care system;

- PHI funds benefit payments avoided and revenue lost;

- Federal government finances; and

- proportional price change in hospital insurance and hospital and general insurance.

3.2   ASSUMPTIONS IN THE MODEL

It is assumed there is a threshold change in July, 2008.

❑ Basic units in the model are persons and policies.

❑ Age is in five year cohorts , 0-4 to 95+.

❑ Household and policy types are singles and family (couple with no children, couple with children, and sole parents). Those family types classified by PHIAC as 2+ no adults and 3+ adults were incorporated into couple with children.

- Couple with no children have 2.0 members

- Couple with children have 3.99 members

- Sole parent policies have 2.75 members (PHIAC, 2008a)

❑ A person or family earning above the thresholds is exempt from the MLS if they are covered by a hospital only policy or a hospital and general policy.

❑ Income growth is projected at 4% per annum.

❑ Underlying price increase in hospital cover and hospital and general cover (without a policy change) is projected at 5% per annum.

❑ Private health cost inflation is projected at 5% per annum.

❑ Elasticity of demand is -0.335 (a one per cent increase in price will cause a 0.335 per cent decrease in membership).

❑ Singles and households that hold hospital cover and earn income close to the new threshold limits do not drop their cover as they expect their incomes to reach the new thresholds in the following years. Consequently there is no re-entry of people back into the private health insurance market from those who initially dropped out.

❑ All that drop out hold a basic hospital and general policy, which is reflected in the premiums used to calculate expected lost revenue to PHI funds.

❑ Those that drop their cover do so because they do not expect to make good use of it. Consequently, these policies are expected to be very light users of the private health care system. To account for this, benefit payments avoided are discounted by 29%

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over average benefits across age groups, derived from the ratio of basic premiums to average premiums for basic hospital and general policies (Cannex, 2008)

❑ It is noted that in the last two years hospital cover growth has been in excess of population growth, driven in part by the MLS thresholds. This has led to an increase of 1.8 percentage points in the proportion of the population with hospital cover (PHIAC, 2008). However the model conservatively assumes that the proportion of people with hospital cover under the baseline scenario of no threshold change remains constant at 44.2%.

3.3   DESCRIPTION OF THE BASELINE

The following provides a description of the private health insurance market at the end of the first quarter of 2008. This has been used as a baseline from which the model was built.

3.3.1   PERSONS WITH HOSPITAL COVER

❑ Total number of health insurance policies with hospital cover is 4,540,112
- 2,171,035 singles
- 1,020,257 couples with no children
- 1,203,001 couples with children
- 90,123 single parents
- 55,696 other

❑ Total number of people with hospital cover is 9,476,921. Of these:
- 2,171,035 covered by singles
- 5,017,386 covered by family/2+ and 3+ policies
- 247,986 covered by single parents
- 2,040,514 covered by couples

❑ Of the singles covered, 1,362,494 earn below $50,000 and 808,541 earn above $50,000
- 726,658 earn between $50,000 and $100,000

❑ Of households that are covered by non-singles policies 1,595,479 earn below $100,000 and 773,598 earn above $100,000
- 451,916 earn between $100,000 and $150,000

3.3.2   PERSONS WITHOUT HOSPITAL COVER

❑ The number of people who are not covered by hospital insurance is 11,977,516.

❑ Of these, 9,319,594 earn below $50,000 and 2,657,922 earn above $50,000:
- Of those that earn above $50,000, some are already avoiding the MLS because they are part of a household that has an income less than $100,000

❑ The total number of singles that do not have hospital cover is 2,858,785:
- The number of singles that do not have hospital cover and earn under $50,000 is 2,076,750
- The number of singles that do not have hospital cover and earn over $50,000 is 507,932

- The total number of persons that do not have hospital cover but are part of a household (couple with no children, couple with children, and sole parent) is 9,118,791. Of these:
  - 2,546,853 are couples without children, equating to 1,273,427 potential couple policies with out children
    - ◆ Of these, 950,874 earn less than $100,000 and 322,553 earn more than $100,000
  - 6,262,415 are couples with children, equating to 1,571,034 potential couple with children policies
    - ◆ Of these, 936,386 earn less than $100,000 and 634,648 earn more than $100,000
  - 309,522 are sole parents, equating to 112,486 potential sole parent policies
    - ◆ Of these, 104,127 earn less than $100,000 and 8,360 earn more than $100,000

3.4   OUTLINE OF THE MODEL

The model has been built to incorporate three sequential rounds expected to occur from a threshold change.

- The first round occurs in 2008 and is the initial impact on membership, where those who had hospital cover just to avoid the MLS drop out. These types of people are confined to the income groups between pre and post policy change thresholds ($50,000 to $100,000 for Singles members and $100,000 to $150,000 for non-Singles members).

- The second round occurs in 2009 and is the expected price increase in hospital cover due to relatively healthy individuals dropping out of the private health insurance market in the first round. The increase in price will force additional people out of the market, which is dictated by the elasticity of demand for private health insurance.

- The third round starts to occur in 2009 and continues until 2012. It is the expected number of people that would have taken up hospital cover if the thresholds had not been changed. This results from personal and household incomes increasing each year that would have pushed them across the thresholds.

3.4.1   FIRST ROUND

Hospital cover was split by policy type and across age using PHIAC data and cross-tabs from the NHS.

The total number of single policies was further split across gross personal income using NHS cross-tabs. However the NHS only has 10 personal income deciles so these were further split into 51 income groups to ensure greater sensitivity to policy change and income growth.

The NHS basic CURF (Confidentialised Unit Record File) does not provide gross household income. This meant policy type could not be split across household income using NHS data. The total number of non-single policies was split across gross household income by policy type using the distribution of household income derived from the 2006 Australian Census. As the Census does not have income distribution by insurance type, it was assumed that household income is the same for insured and non-insured households.

The number of policies affected by the policy change was calculated by aggregating the number of singles that earn gross personal income between $50,000 and $100,000 and have hospital cover (either hospital only or hospital and general) and the number of households that earn between $100,000 and $150,000 and have hospital cover.

The proportion of policies expected to drop out was estimated by multiplying the number of policies affected by the policy change by the proportion of singles and households that hold hospital cover to avoid the MLS. The latter was derived from the NHS (2004-05) which had a question that asked respondents whether they have private health insurance to 'gain government benefits/avoid extra Medicare levy' (question HEALIN_Q05). The responses are shown in Table 3-1 and Table 3-2.

The number of episodes expected to shift to the public system was derived by multiplying the expected number of persons to drop out by the episodes per person per annum derived from PHIAC. This was split by sex and age cohorts to capture the differences in risk profiles of those that drop out.

TABLE 3-1: PROPORTION OF POLICY AFFECTED SINGLES POLICIES EXPECTED TO DROP OUT

Age	Proportion
15-19	0.00
20-24	0.12
25-29	0.27
30-34	0.23
35-39	0.26
40-44	0.20
45-49	0.18
50-54	0.13
55-59	0.10
60-64	0.07
65-69	0.08
70-74	0.04
75-79	0.06
80-84	0.00
85-89	0.00
90-94	0.00
95+	0.00

Source: NHS (2006)

TABLE 3-2: PROPORTION OF POLICY AFFECTED NON-SINGLES POLICIES EXPECTED TO DROP OUT

Policy type	Proportion
Couple with no children	0.14
Couple with children	0.15
Sole parent	0.35

Source: NHS (2006)

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The savings to PHI funds from policies that drop out (the benefit payments avoided) was calculated by multiplying the expected number of episodes by the average benefit paid per episode, discounted by 29% to capture the fact that most of these people would be expected to hold a basic policy and would be relatively healthy within their age cohort.

The revenue lost to PHI funds was calculated by multiplying the number of policies expected to drop out by the average price of a basic hospital and general policy calculated across 20 PHI funds (adjusted for the Medicare rebate).

Savings to the Federal government from no longer having to pay a Medicare rebate on those policies that drop out was calculated by multiplying the expected revenue lost to PHI funds by 30% for those aged between 0-65, 35% for 65-69 year olds, and 40% for those aged 70 and over. The lost tax revenue from those not paying the MLS due to a policy change was calculated by multiplying expected Federal government savings by the ratio of Federal government savings to lost tax revenue as implied by Treasury estimates within their submission to the 'Inquiry into the Tax Laws Amendment (Medicare levy surcharge thresholds) Bill 2008 (The Treasury, 2008).

3.4.2 SECOND ROUND

Within the first round there are a significant number of policies that drop out of the market. These policies contain relatively healthy people compared to the entire risk pool, for example 51% are under the age of 35.

As the average benefits that would have been paid to those who drop out are lower than the average across all members, but through community rating the premiums for basic policies are based on the average risk profile, there is an expected net loss to PHI funds. It is assumed that PHI funds increase their premiums to capture this loss, thereby resulting in a price increase for individuals still left in the hospital cover pool.

The increase in price will lead to more people dropping out of the private health insurance market because it will reduce the net benefits of hospital cover to all. That is, those who are on a tipping point (whether to hold or not) will be tipped over to drop their cover with the price increase.

The price increase is expected to occur in 2009, once the first round impacts have occurred throughout 2008. The number of additional policies to drop out was calculated by multiplying the expected percentage increase in price by an elasticity of demand of 0.34 (Frech et al 2003, Palangkaraya and Yong 2004).

3.4.3 THIRD ROUND

Not only will policies be dropped, PHI funds will also miss out on those policies that would have been purchased between 2009 and 2012 (inclusive) if there was no change to policy. This occurs because annual income growth would have pushed an increasing proportion of singles and households over the original thresholds, thereby inducing some to pick up hospital cover to avoid the MLS.

For example, a single who earns $49,000 gross personal income in 2008 does not have a government implemented incentive to purchase hospital cover because he/she will not be hit by the MLS if not covered. However in 2009 income is expected to have increased by 4% (assumed in the model), thereby increasing gross personal income to around $51,000 and

pushing him/her into the MLS zone. The avoidance of the MLS provides an additional incentive for the person to purchase hospital cover.

Each year the number of singles and families that were expected to cross the thresholds due to income growth and population growth was calculated. However not all these people would have purchased hospital cover once they crossed the threshold, some may not be aware of the MLS or some may choose to pay the MLS.

To calculate the expected number of persons who would have otherwise purchased hospital cover, the number of singles and families that crossed each threshold was multiplied by the probability of taking up hospital cover. Probability was represented by the current proportion of singles and families who have hospital cover and earn personal and household incomes in the NHS decile closest (but above) the thresholds. Due to data limitations on household incomes in the NHS using the basic CURF, an equivalised household income decile was used.

Of course, those people who did not take up hospital cover due to the policy change must now use the public health care system or pay out-of-pocket to use the private health care system.

With each year there is a further accumulation of individuals that would have otherwise purchased hospital cover, which means there is an increasing reliance on the public health care system. This is a cumulative effect because those who did not take up hospital cover in the early years (2009 for example), will still not have hospital cover in 2010, 2011, and 2012. It is noted that some of these people may still have used the public system even though they have private hospital cover but this possibility was not captured in the model.

The expected number of episodes shifted to the public system was calculated by multiplying the expected number of persons under singles and non-singles policies that would have otherwise been purchased by the expected number of episodes per person. Once again this was done across age and sex to capture varying risk profiles.

The expected impact on benefit payments avoided, revenue lost, and government finances was calculated the same way as described in the first round but were adjusted for expected increases in underlying private health cost inflation (5% per annum) and PHI price increases (5% per annum)[1].

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[1] An increase in price from the first round may be experienced across all policies or across those policies that are relatively price inelastic. Due to the uncertainty surrounding the type of cover (basic, medium, and top) that would experience a price increase, additional rebate savings to the government due to a price increase has not been included in the model.

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4.   RESULTS OF THE MODELLING

The impact of a change in the threshold to $100,000 for singles and $150,000 for families on private health insurance membership, episodes shifted to the public system, PHI funds and Federal government finances are summarised in Table 4-1. A detailed description of the results are presented further below.

TABLE 4-1: RESULTS UNDER POLICY SCENARIO OFTHRESHOLD BEING $100,000/$150,000

	2008[a]	2009	2010	2011	2012	Total
Cumulative number of policies dropped and not otherwise taken up	202,009	310,462	385,264	463,708	544,058	n.a.
Cumulative number of persons dropped and not otherwise taken up cover	359,091	602,483	779,627	963,043	1,150,999	n.a.
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Note: (a) Years refer to calendar year.(b) Refers to the net of government rebate expenditure savings, foregone MLS taxation revenue, and the additional rebate paid on remaining policies due to an expected price increase in policies. It does not include any additional funding required by the public sector to mitigate the public hospital effects of the policy.

4.1   NO POLICY CHANGE BASELINE SCENARIO

Threshold drag has been evident for the past year in particular and explains part of the increase in private health insurance coverage that has occurred. Lifetime Health Cover is another important influence. In addition, there is anecdotal evidence of younger people responding to marketing of private health insurance products.

Assuming no change in the thresholds from the levels applying at the outset in 1997 (i.e., 50,000 for singles and $100,000 for couples/families), threshold drag would likely have exposed an additional 279,379 families and an additional 216,000 singles to the Medicare levy surcharge by 2012. This is the equivalent of nearly 1.2 million people of all ages (potential policy holders and their dependents including children).

A substantial number of people earning below average weekly earnings would be potentially subject to the surcharge by the end of the period, unless they chose to take out a private health insurance policy. Not all those subject to the surcharge seek to avoid it. In some cases, it is cheaper to pay the surcharge than to purchase insurance.

The Medicare levy surcharge is one element of a policy framework that has, over the past decade, rescued private health insurance from oblivion and, as a corollary, taken pressure

off Federal and State/Territory health budgets. The issue for policy is whether the MLS has done enough and, if the threshold drag can now be moderated, what is the appropriate policy objective.

4.2   FIRST ROUND IMPACT ON MEMBERSHIP AND COVERAGE

The model predicts that in response to the changed thresholds, there is likely to be a 'first round' effect with 202,009 policies cancelled, representing 359,091 people now covered. This is based on the stated intentions recorded in the National Health Survey (2005).

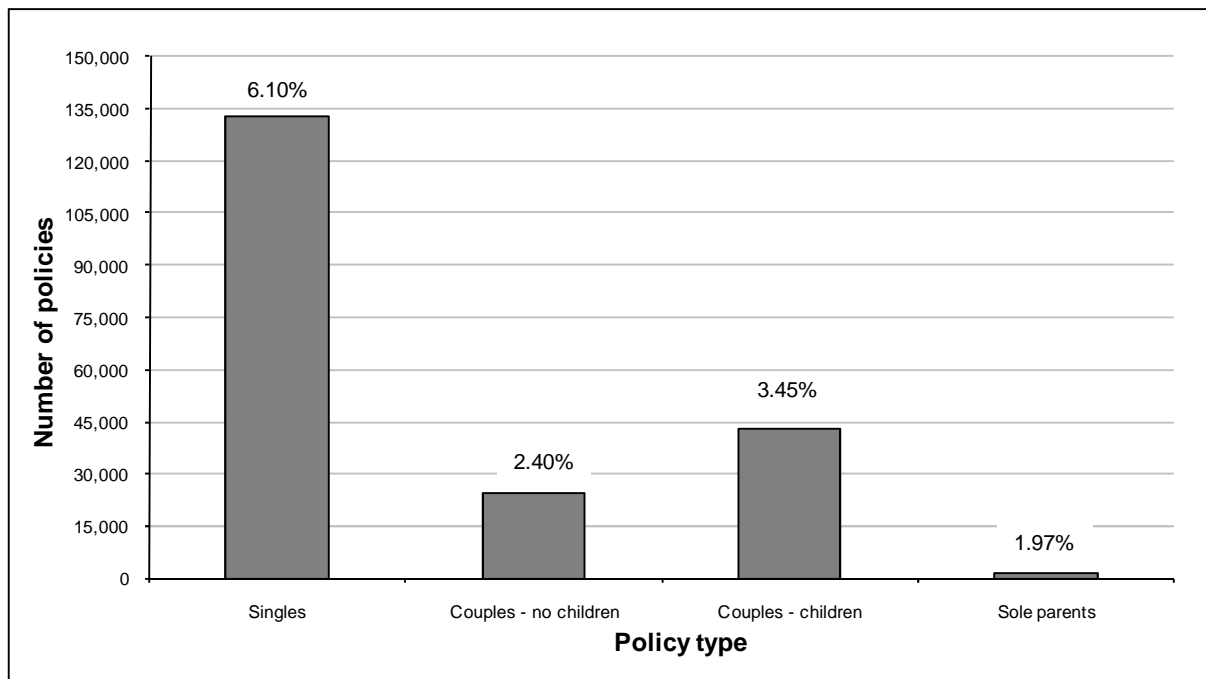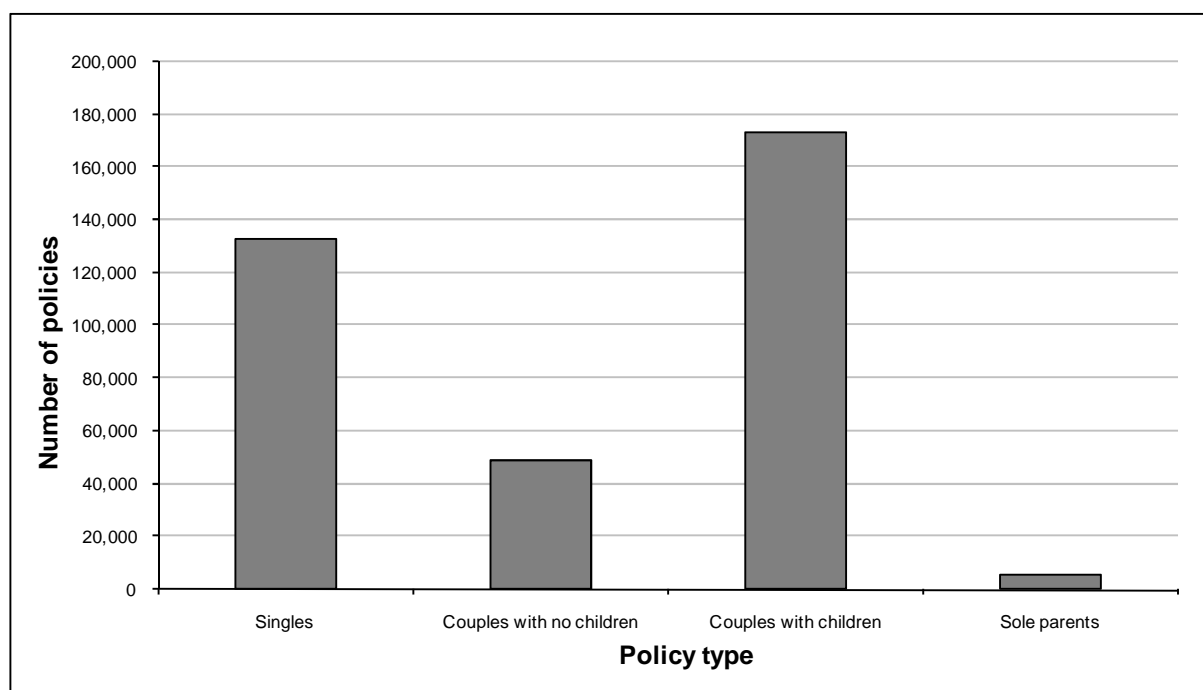**FIGURE 4-1: FIRST ROUND IMPACT ON MEMBERSHIPS (2008)**

FIGURE 4-2: FIRST ROUND IMPACT ON THE NUMBER OF PEOPLE COVERED (2008)

4.3 SECOND ROUND IMPACT ON COVERAGE

The model predicts 'second round' effects which arise because those who are most likely to drop their private health insurance coverage—or not take it up in response to the raised thresholds—are generally younger than the average for privately insured people. Their withdrawal from cover will leave the funds with a net loss of revenue that will have to be recouped from higher premiums for those who remain.

The model draws on benefits-by-age data to predict that the initial loss of some 202,000 existing policies will necessitate a real price increase of 2.73% in the first full year. This will result in a further 1% loss of membership (39,881 memberships equivalent to 83,247 people covered). As noted in part 3, this estimate is based on reputable academic estimates of the price elasticity of demand for private health insurance.

This is a conservative estimate. There have been times in the past when the fall in private health insurance coverage has been especially large when set against premium increases. Australians have shown that they have an 'affordability threshold' for private health insurance and if that threshold is breached, membership can go into a tailspin downwards.

4.4 THIRD ROUND IMPACT ON COVERAGE

The most important impact of the change in the MLS surcharge is the third round impact—those who would otherwise have taken up private health insurance in response to the threshold drag but will no longer do so. The third round effect continues throughout the period, although it is not quite as strong in 2012 as it is currently.

The model predicts that third round effects will account for an initial 68,572 policies rising to 302,168 cumulative by 2012. This is equivalent to 160,145 people covered initially to 708,661 by 2012.

4.5   COMBINED IMPACT ON COVERAGE

Figures 4-3 and 4-4 show the combined effect on coverage. By 2012 it is expected that there would have been a total of 544,058 policies and 1,150,999 people who would otherwise have had private hospital insurance.

Figure 4-5 shows the expected change in the proportion of the total population covered by hospital insurance under the base case scenario of no policy change, and under the proposed threshold change. Between 2008 and 2012 it is estimated that the proportion of people covered by hospital insurance will decrease from 44% to 39%

FIGURE 4-3: COMBINED IMPACT ON POLICIES DROPPED OR NOT TAKEN UP
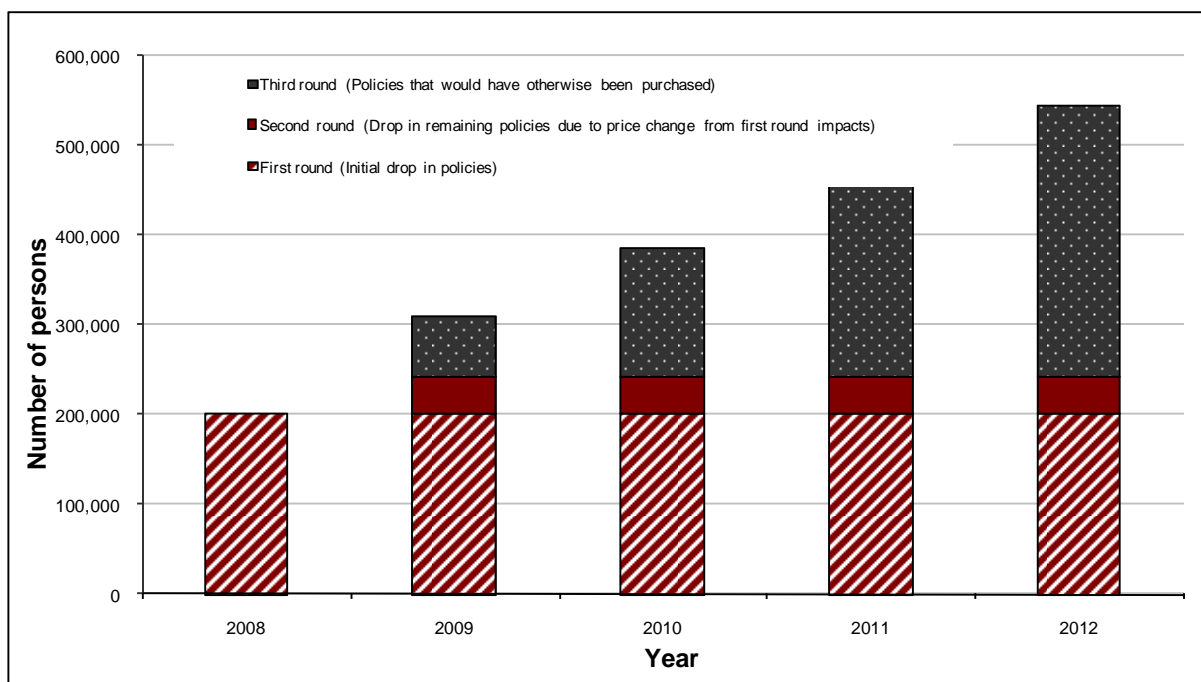
FIGURE 4-4: COMBINED EFFECT ON PEOPLE NOT OTHERWISE COVERED
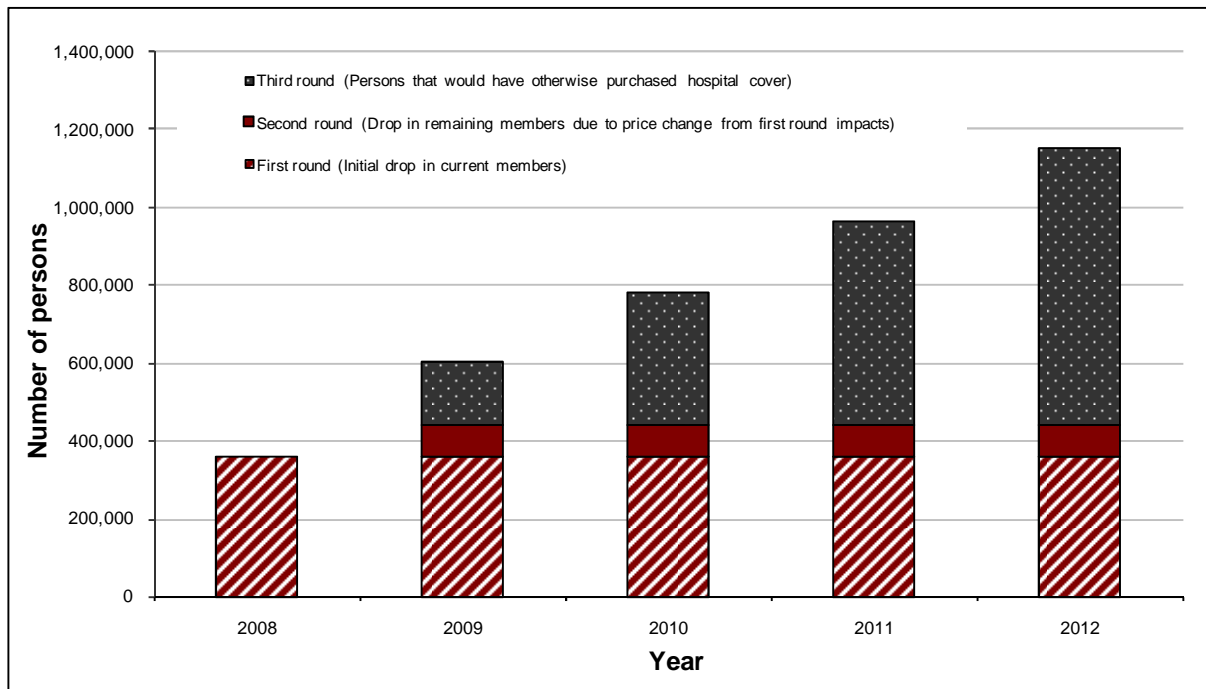
FIGURE 4-5: ESTIMATED IMPACT OF POLICY ON PROPORTION OF PEOPLE WITH HOSPITAL COVER
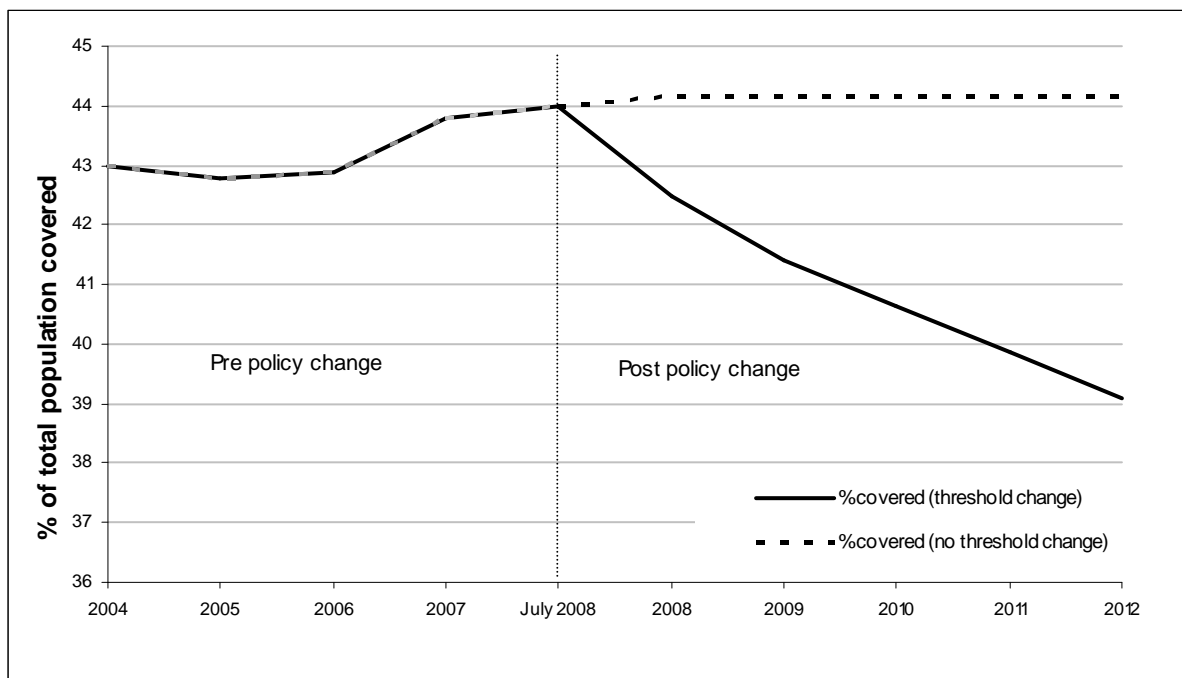
As shown in Figure 4-6, the changed MLS thresholds have their largest impact on single policies, as expected, given outsize increase in the singles threshold.

FIGURE 4-6: POLICIES DROPPED OR NOT TAKEN UP BY FAMILY TYPE (2008-12)
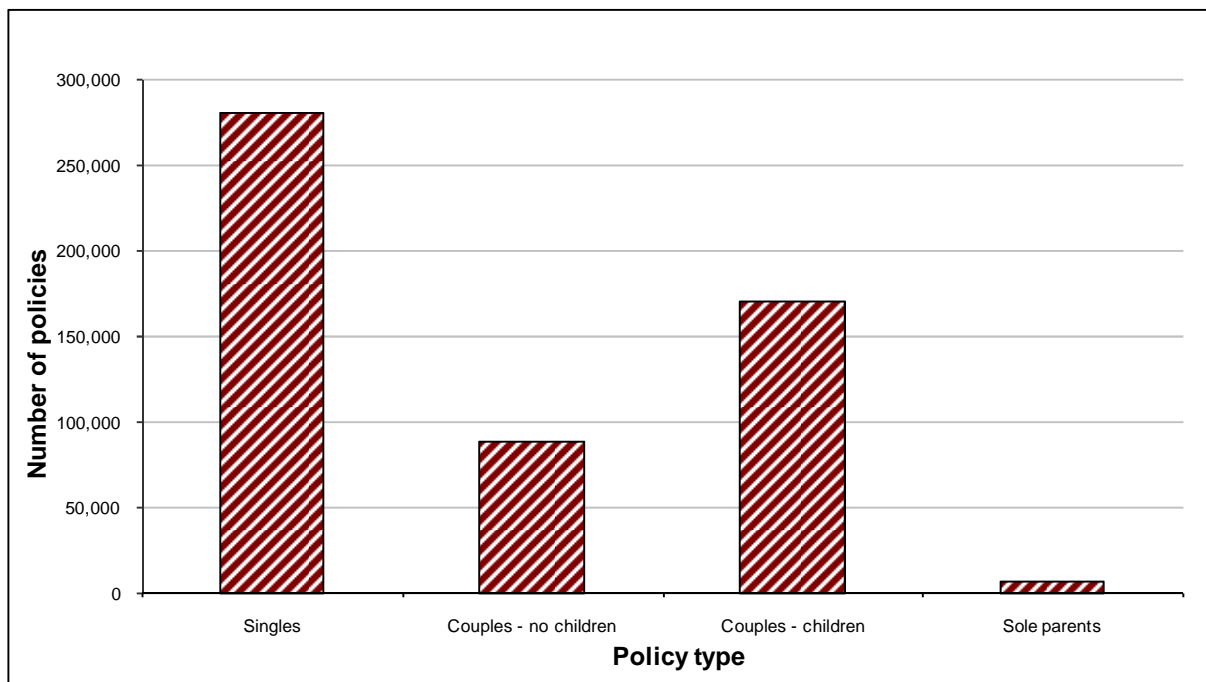
However, as shown in Figure 4-7, the largest number of people covered is in the 'families with children' category (again expected given nearly 4 people an average in each family membership).

FIGURE 4-7: PEOPLE NOT OTHERWISE COVERED BY FAMILY TYPE (2008-12)

Figure 4-8 shows the age distribution of the impact, with those aged under 30 years being significantly over-represented.

FIGURE 4-8: PERSONS NOT COVERED BY BROAD AGE GROUP (2008-12)

Total persons that are not covered due to threshold change = 1.15 million

- Under 30 years of age — 46%
- Between 30 and 59 years of age — 42%
- 60 years of age and over — 12%

4.6   IMPACT ON PUBLIC AND PRIVATE HOSPITALS

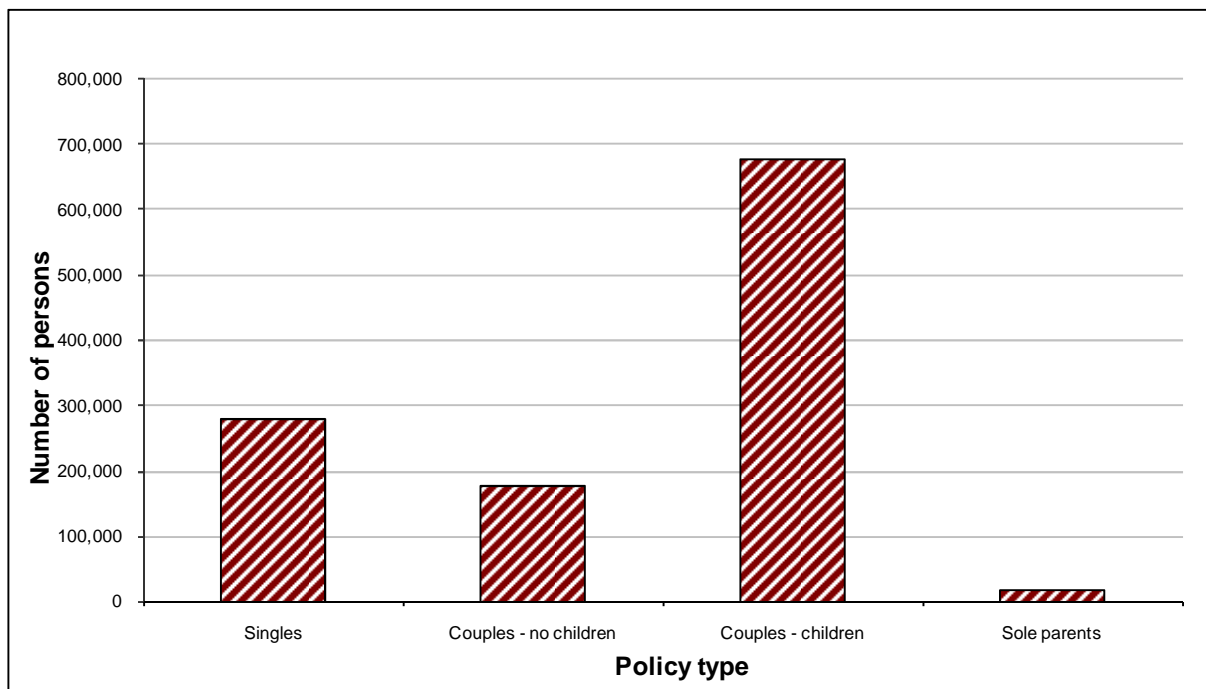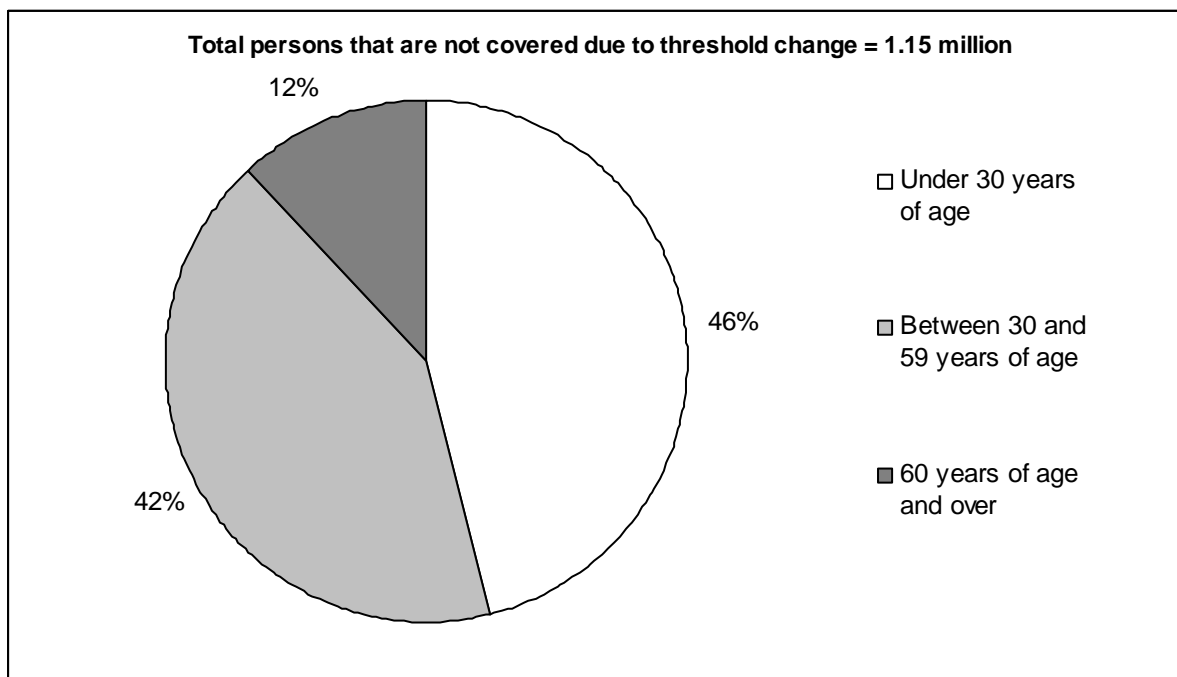It is estimated, based on age rates of claiming, that the first round effects of the changed thresholds will be to shift some 82,242 in-patient episodes of care to the public system **in the first year**. The age rates of claiming comprehend that surcharge dodgers—in addition to being younger and healthier than the average—are also more likely to exercise their rights to access public hospitals. The effect of the change is to shift their caseload only to the extent that they are now accessing private health insurance benefits.

Second round effects shift a further 21,166 annual episodes to the public health care system.

These early effects are modest compared with the third round effects which trigger a progressive shift in the workload. As shown in Figure 4-9, by the year 2012, there will be nearly 265,000 episodes of care **per year** shifted to the public system.

This has obvious implications for waiting lists and waiting times. Both will deteriorate unless there is substantial additional expenditure including capital expenditure to expand public hospital infrastructure in areas where it is already inadequate.

As the burden of shifted workload mounts, it is inevitable that State and Territory governments will press claims for compensation for the cost-shifting onto them.

The counterpart to increased workload in the public hospital sector will be reduced growth for the private hospital sector.   Viability issues for the private hospital sector could be

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exacerbated if the funds respond to their poorer risk outlook by trying to further squeeze the margins of providers.

FIGURE 4-9: ANNUAL IN-PATIENT EPISODES OF CARE SHIFTED TO THE PUBLIC SYSTEM
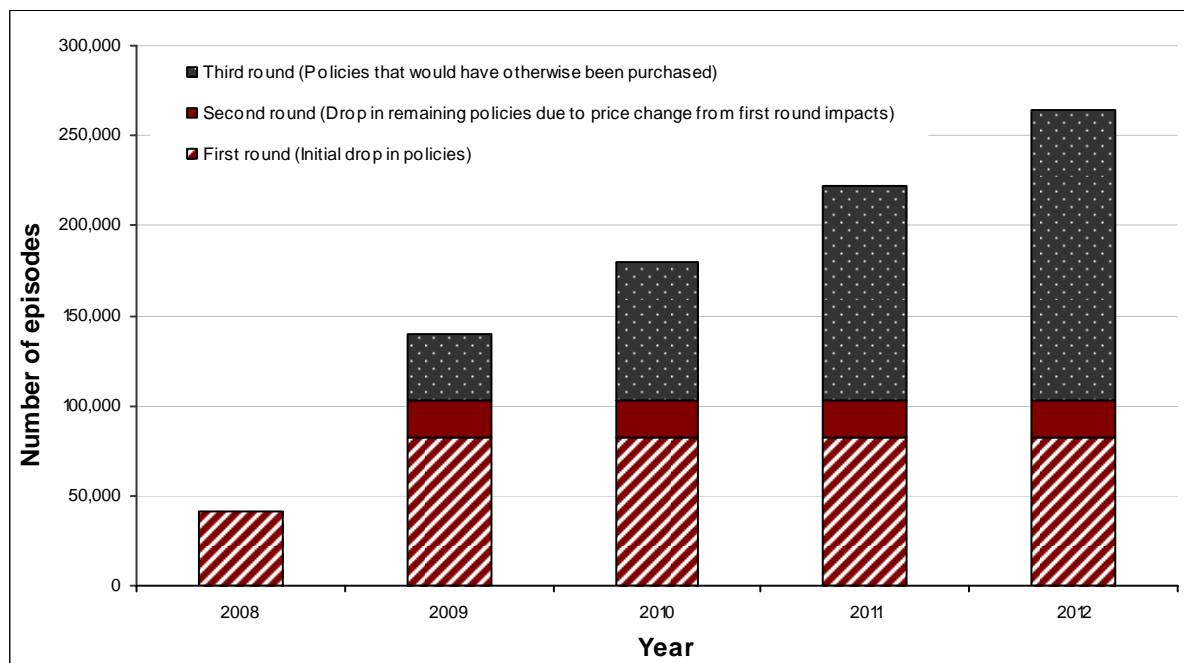
4.7   IMPACT ON PUBLIC FINANCES

There will be three direct impacts on Commonwealth finances from the threshold change for the period 2008-12. These include:

❑   savings the government is expected to make from not having to pay a rebate on dropped policies or policies that would have otherwise been taken up. This is estimated to total around $1.2 billion.

❑   tax revenue lost from those that would have otherwise paid the MLS. This has been estimated at around $693 million.

❑   additional rebate the government will have to pay on the remaining policies due to the 2.73% expected price increase in policies from the first round. This is estimated at around $388 million.

In total, the expected net savings to the Commonwealth government for the period 2008-12 is $113 million.

However, due to the expected shift of episodes to the public system there will also be an expected shift of in-patient costs to public hospitals and consequently state and territory financing. Multiplying the expected number of episodes shifted to the public system by the average cost per casemix adjusted separation (AIHW, 2008) (discounted by 29% to account

for a younger/healthier cohort[2] and adjusted for the forecasted annual health care cost inflation of 5%), the expected total health care costs to the public system due to the threshold change between 2008 and 2012 is around $2.9 billion. This figure dwarfs the expected savings the Commonwealth government is expected to make. Therefore, even if the Commonwealth government were to pass on all the savings resulting from the threshold change, the net effect is a large deficit for state and territory government finances. This is shown in Figure 4-10, which presents the public health system costs that are expected to accrue to states and territories, Commonwealth government savings, and the net public financial position.

FIGURE 4-10: ESTIMATED NET FINANCIAL POSITION OF THE PUBLIC SYSTEM
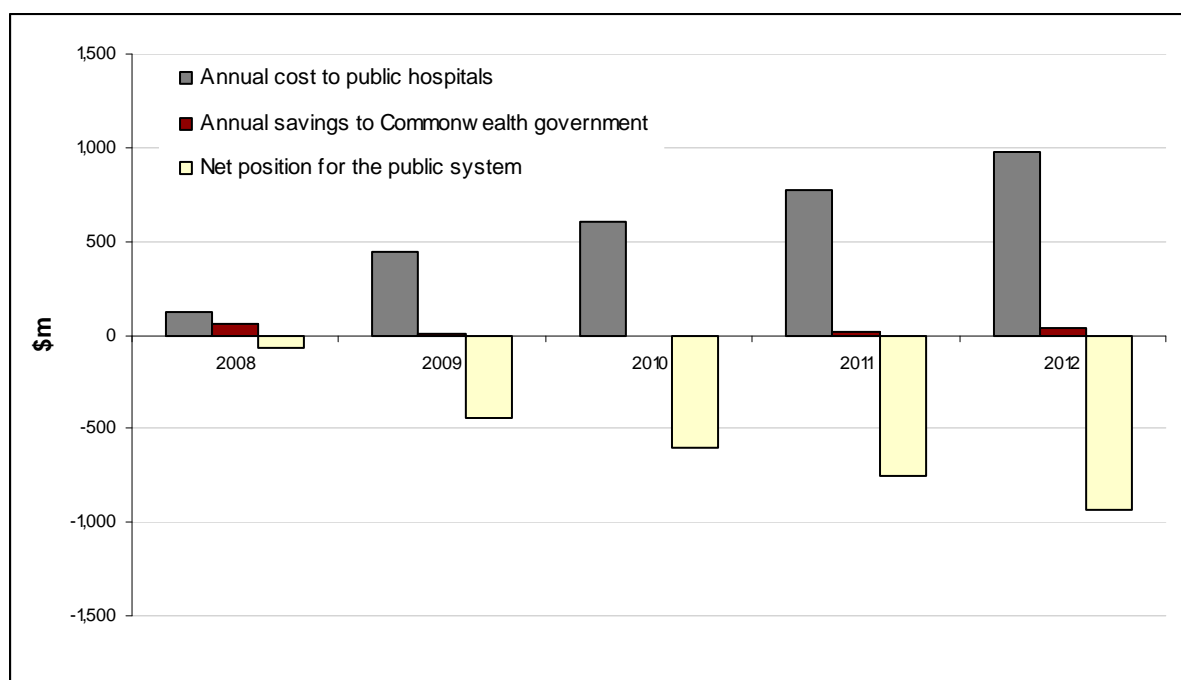
4.8   REAL PREMIUM INCREASES AND THE CPI

The CPI is a price index that measures the weighted price increase in a 'basket of goods' representing common items purchased by individuals. Weights are derived from the proportional expenditure on the items included in the basket so the greater the expenditure the higher the weight. Although expenditure on private health insurance is included in the basket, the CPI does not have a weight for private health insurance alone, instead it is included in the health group.

The health group of the CPI accounts for 4.7% of the weights in the all groups index. It has two sub-groups, health services and pharmaceuticals. The health services sub-group has three components, hospital and medical, optical, and dental. The hospital and medical services expenditure class accounts for 2.8% of the weights in the all groups index and

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[2] This discount rate has been derived from the ratio of basic premiums to average premiums for basic hospital and general policies (Cannex, 2008)

comprises health and medical insurance and out-of-pocket medical and hospital costs (ABS, 2005a)

To estimate the weight attached to health insurance within the hospital and medical services expenditure class, detailed expenditure tables were used from the household expenditure survey (ABS, 2005b).This provided a weight estimate of 60% which equates to 1.7% of the weights in the all groups index. Based on this weight estimate, an increase of 2.73% on PHI premiums is expected to push up the all groups CPI by 0.046%. Using an average inflation rate of 2.5% between 2008 and 2012 (the mid point of the RBA inflation band) this equates to an annual proportional increase in the CPI of 1.8%.

4.9   COMPARISON WITH TREASURY ESTIMATES

The Treasury estimated that 186,000 singles and 149,000 couples (equivalent to 484,000 adults) who would otherwise have held or taken out PHI cover, will not be covered under the new thresholds. Those estimates therefore comprehend ostensibly both those who drop their cover and those who do not join when the thresholds start to bite.

A major difference between the Access Economics model and the Treasury estimates relates to the timing around those who do not join in future. The Treasury estimates imply that the forecast coverage effect of 484,000 adults occurs at the outset of the implementation of the policy. Indeed, for Treasury's first year saving of $232 million to be realised, the 484,000 adults have to drop their cover (or not take up) immediately. In later years, they foresee no ongoing impact.

It is reasonable to assume that existing members who will respond to the policy change by dropping their policies will do so in the first year. In that respect, our approach is the same as that used by the Treasury. We are not able to compare the two forecasts directly because they have not separately quantified their first and second round forecasts.

The Treasury methodology ignores the second round (price driven) effects. This is the smallest of the three impacts from our modelling.

The major point of departure between the Treasury method and ours relates to the forecasting of those who do not join in future in response to the changed policy. Treasury does not allow for any threshold drag to occur after the first year (2008-09). That is entirely inconsistent with their own macroeconomic forecasts which have the economy continuing to grow in real terms. It follows that household incomes will continue to grow in nominal terms and that an increasing number of people would have seen their incomes move beyond the old thresholds.

It is difficult to compare, directly, the Treasury's budget estimates with the estimates of net revenue effects from our model. Treasury has consistently placed some of the estimated expenditure on the private health insurance rebate into the contingency reserve. The reason for non-disclosure of part of the cost is to avoid alerting the funds to the expected increases in average premiums that the Government will approve.

The model predicts that the first year savings to PHI rebate expenditure will be $107 million, in broad terms less than half the Treasury estimate. The differences are likely driven by:

❑   a smaller initial drop out;

❑   a part year effect as not all people dropping their policies do so by 1 July 2008; and

❑ evidence that surcharge dodgers tend to purchase relatively low cost policies.

While they may drift over time to higher level products, surcharge dodgers are generally more likely to favour policies that:

❑ incorporate higher front-end payments per year;

❑ incorporate co-payments on episodes of care; and

❑ exclude higher-cost services like heart surgery, hip and knee replacement, major eye surgery, in-hospital psychiatry, assisted reproductive services and pregnancy and birth-related services.

In the forward estimate years (2009 to 2012), our model produces higher estimates for both rebate savings and loss of revenue from the surcharge because the no policy change scenario is assessed as continuing to generate threshold drag. In addition, we have estimated the impact of expected price increases on the rebate paid for the remaining policies. In summary, we expect the net savings to be smaller, $113 million compared with Treasury's $300 million, without taking into account the issue of compensation to State and Territory governments.

The overall impact on the budget outcomes in the public sector is solidly negative (increased net expenditure).

4.10   PHI FUND VIABILITY

As PHI funds will experience a drop in hospital cover it is expected that annual benefits paid out will be reduced (a savings to PHI funds) but there will also be a reduction in annual revenue from lost membership premiums (a loss to PHI funds).

The net effect is an expected cumulative turnaround in the funds' net financial position of nearly $2.2 billion over the period to 2012. This consists of a net loss of premium revenues for the second half of 2008 of $105 million, escalating to $724 million per annum by 2012.

The intended thresholds also have implications for the trends in viability of the private health funds. Had the prior policy of unchanged nominal thresholds been both sustainable and sustained, the funds would have enjoyed a reduced risk outlook with an increasing number of younger members helping to cross-subsidise the older members. In other words, there would have been more effective risk sharing in the community. The community is the beneficiary of that outcome, not the funds (which serve as the messengers in the process).

Under the intended thresholds, the risk outlook for the funds can be expected to deteriorate somewhat. For example, of the 359,000 persons who drop out in the first round, 50% are expected to be below the age of 35. In addition, among the people who would have taken up hospital insurance between 2009 and 2012 had there been no policy change, around 52% are below the age of 30. Thus, the risk sharing within private health insurance will become less effective.

As time goes by, the new thresholds will again start to drag people back in to private health insurance (assuming no further change). It will be many years before the new thresholds start to draw in the relatively low risk individuals for the obvious reason that younger people generally earn a lot less than the thresholds.

This invites the conclusion that all stakeholders (the people, the public and private providers and public and private funders) would be better served by appropriate indexation of the thresholds instead of the roller-coaster, potentially disruptive, effects of infrequent and much larger adjustments.

5. SCENARIO AND SENSITIVITY ANALYSIS

5.1 ALTERNATIVE POLICY SCENARIOS

The model has been used to assess different policy scenarios for the thresholds:

❑ $65,000/$130,000 (CPI-linked); and

❑ $75,000/$150,000 (earnings linked).

Results for the alternative scenarios of $65,000/$130,000 and $75,000/$150,000 are shown in Table 5-1 and Table 5-2 respectively.

TABLE 5-1: RESULTS UNDER POLICY SCENARIO OFTHRESHOLD BEING $65,000/$130,000

	2008	2009	2010	2011	2012	Total
Cumulative number of policies dropped and not otherwise taken up	102,720	192,573	267,375	345,820	384,724	n.a.
Cumulative number of persons dropped and not otherwise taken up cover	208,667	413,233	590,377	773,792	825,126	n.a.
Episodes shifted to the public system	23,851	95,848	135,715	177,169	189,199	621,783
Annual net loss of PHI fund revenue ($m)	56.3	223.2	329.0	448.6	512.7	1,569.9
Annual net increase in government finances ($m)	29.9	22.5	25.9	45.3	20.9	144.6

TABLE 5-2: RESULTS UNDER POLICY SCENARIO OF THRESHOLD BEING $75,000/$150,000

	2008	2009	2010	2011	2012	Total
Cumulative number of policies dropped and not otherwise taken up	149,819	249,562	324,364	402,809	483,159	n.a.
Cumulative number of persons dropped and not otherwise taken up cover	306,901	532,112	709,256	892,672	1,080,628	n.a.
Episodes shifted to the public system	35,006	123,400	163,267	204,721	247,249	773,643
Annual net loss of PHI fund revenue ($m)	82.4	288.9	397.9	521.0	658.0	1,948.2
Annual net increase in government finances ($m)	43.8	11.7	11.5	32.7	50.2	149.8

5.2   SENSITIVITY ANALYSIS

The modelling results reported in Section 4 are point estimates based on uncertain inputs into the model. As such, the accuracy of the estimates cannot be determined from these results alone. In order to incorporate the uncertainty of inputs into the model, a sensitivity analysis was undertaken.

The sensitivity analysis investigated how changes in model outputs changed with different assumptions regarding inputs into the model. The inputs that were allowed to vary within the sensitivity analysis were:

❑   proportion of policies and people expected to drop out in the first round;

❑   price elasticity of demand; and

❑   proportion of people and households expected to have taken up hospital cover in the third round;

Each input was allowed to vary according to a triangular distribution. For each distribution the input employed in the model was used as the most likely estimate and a lower and upper bound were created by varying the mid point plus and minus 10%. The sensitivity analysis was undertaken using a monte carlo simulation[3], which simultaneously drew a random number for each input according to its distribution and recalculated the following model outputs:

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[3] Monte carlo simulation is a well known technique used to determine the sensitivity of model outputs from key model inputs. It iteratively replaces numbers attached to key parameters (inputs) with random numbers drawn from a specified distribution, where the type of distribution, the upper and lower bounds on the distribution, and the number of iterations are chosen by the analyst. The monte carlo simulation provides a distribution around chosen outputs from which sensitivity of outputs to inputs can be determined. The program used to undertake the monte carlo simulation was @Risk.

- ❑ cumulative total of policies not taken up;

- ❑ cumulative total of persons not otherwise covered, and

- ❑ expected number of annual episodes shifted to the public system.

Simultaneous random draws were repeated 10,000 times to provide 10,000 different estimates of each output from which output distributions can be constructed.

5.2.1   RESULTS OF THE SENSITIVITY ANALYSIS

Results from the sensitivity analysis are presented in Table 5-3. It shows a graphical representation of each output's distribution, the minimum, mean, and maximum values, and the 90% confidence intervals for each estimate. The confidence interval can be interpreted as a 90% chance that the interval contains the true value of the output.

TABLE 5-3: RESULTS FROM THE SENSITIVITY ANALYSIS

Output	Graph	Min	Mean	Max	5%	95%
Cumulative total of policies not taken up due to policy / 2008	190k 215k	191,366	201,991	212,448	197,283	206,743
Cumulative total of persons not covered due to policy / 2008	335k 385k	336,005	359,098	382,060	346,430	371,507
Total number of episodes shifted to the public system / 2008	38k 44k	38,448	41,115	43,607	39,851	42,365
Cumulative total of policies not taken up due to policy / 2009	295k 330k	296,210	310,459	327,131	303,582	317,499
Cumulative total of persons not covered due to policy / 2009	560k 640k	567,192	602,532	638,728	584,625	620,709
Total number of episodes shifted to the public system / 2009	132k 150k	132,437	140,199	148,596	136,314	144,123
Cumulative total of policies not taken up due to policy / 2010	365k 405k	367,525	385,284	404,094	376,711	394,008
Cumulative total of persons not covered due to policy / 2010	730k 840k	734,182	779,739	831,185	755,353	804,521
Total number of episodes shifted to the public system / 2010	165k 195k	169,845	180,079	191,037	174,718	185,442
Cumulative total of policies not taken up due to policy / 2011	440k 490k	442,305	463,753	487,965	452,874	474,823
Cumulative total of persons not covered due to policy / 2011	0.90m 1.04m	905,539	963,219	1,030,342	930,510	996,446
Total number of episodes shifted to the public system / 2011	205k 240k	208,621	221,547	235,137	214,373	228,775
Cumulative total of policies not taken up due to policy / 2012	510k 580k	518,555	544,128	573,862	530,645	557,973
Cumulative total of persons not covered due to policy / 2012	1.08m 1.24m	1,081,131	1,151,241	1,234,417	1,108,823	1,194,138
Total number of episodes shifted to the public system / 2012	245k 285k	248,212	264,090	280,572	254,845	273,411

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6. POLICY IMPLICATIONS

The analysis draws attention to a number of facets that are relevant to any assessment of the policy.

❑ The announced policy to significantly increase the thresholds is clearly inconsistent with other health and social policy settings in the 2008-09 Federal budget. These involved the tightening of means tests. The higher thresholds loosen the means test and, in doing so, raise the spectre of people on very comfortable incomes squeezing out the genuinely needy.

❑ As addressed in Part 2 above, the next twenty years will provide some very sturdy challenges for the health financing system (more costly health technologies stimulating demand and lifting expectations, fast growth in the number of old people, very fast growth in the number of very old people, rising expectations from the well-heeled generation of post-WW2 baby boomers). Pressures on Federal and State/Territory health budgets will become more intense. Private health financing will have to pull a larger load. Harm to the private health financing sector means collateral damage for the public hospitals in particular.

❑ The prior policy of leaving the thresholds at their nominal 1997 levels was not indefinitely sustainable. Against the medium term imperative to find ways to encourage more private financing, there are questions as to when a change in thresholds is appropriate, how often such changes should occur (ie, whether indexed annually or adjusted every few years) and an appropriate starting point for any recalibration. There is no prima facie reason why the real level of the threshold as at July 1997 should be the starting point for any recalibration.

❑ The prior policy of 'threshold drag' is not necessarily the most effective and efficient way to achieve the intended outcomes.

❑ Had the prior policy remained in place, the funds would have enjoyed an improving risk profile, whereas the new thresholds will cause a deteriorating risk profile.

❑ The increase in the threshold for singles appears to be overdone, an over-correction. A more measured adjustment is likely to achieve the Government's policy aims with less risk to the private and public systems.

❑ Large and infrequent adjustments are disruptive to all stakeholders—not just the PHI funds but also their members, the private hospitals and the public hospitals. The extra workload for the public system is problematic given that the system is already being propped up with emergency funding to deal with serious shortfalls in both A&E services and elective surgery. Other Medicare levy parameters are appropriately indexed. All stakeholders might benefit if consideration were given to a combination of more measured thresholds and their indexation in line with incomes thereafter.

❑ In the short term, if the goal of the change was to try to maintain the thresholds in terms of real incomes, then an option would be to index the thresholds based on average weekly earnings. This would be a short term measure to allow a more thorough general review of what is an appropriate level of incentivisation going forward and of the role of private health insurance in the health financing system of the future.

APPENDIX A: PHI POLICY TIMELINE

Year or month	Policy event	In term of—
1975	**Medibank** introduced (taxpayer funded medical insurance), reducing the role for voluntary private health insurance.	Whitlam Government
October 1976	**Medibank Mark II** introduced. This was an 'opt-out' model involving a **Health Insurance levy** (a tax levy) imposed on taxpayers who did not have private health insurance (for themselves and their dependents) and who did not qualify for pensioner medical or repatriation benefits. **Medibank Private** created (and operated by the Health Insurance Commission) to compete with other private health insurance funds.	Fraser Government
November 1978 to 1981	**Health Insurance Levy** discontinued. Further evolution towards to voluntary model, with full benefits restricted to the disadvantaged.	Fraser Government
July 1981	Introduction of a **PHI tax rebate** for basic medical and hospital cover only.	Fraser Government
1982-83	**State government levies** imposed on private health funds.	State governments
July 1983	Abolition of the PHI **tax rebate**, temporarily replaced by a rebate for out-of-pocket health expenses.	Hawke Government
1983-84 to 1987-88	The Federal Government's **subsidy to the private health insurance reinsurance pool** phased out over a five-year period (in 1982-83, the level of the subsidy was of the order of $100 million p.a.).	Hawke Government
February 1984	**Medicare** implemented. All medical insurance was nationalised—private health funds were not permitted to offer any insurance cover for medical services.	Hawke Government
November 1985	Private health funds **required to cover 15% of MBS fees** for private in-hospital medical services.	Hawke Government
October 1986	The Commonwealth Government's **bed-day subsidy for private hospital utilisation** discontinued. In the last full year of operation (1985-86), the expenditure on the subsidy was $135 million.	Hawke Government

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Year or month	Policy event	In term of—
November 1987	Medicare benefits payable on private in-hospital medical services **reduced from 85% of the MBS to 75%**, and the private health funds required to increase their cover from 15% of MBS fees to 25%.	Hawke Government
July 1993	New 5-year Medicare Agreements provided significant **incentives for public hospitals** to increase their throughput of public patients and reduce throughput of private patients, thus shifting workload to the private hospital system and shifting costs to the private insurance system.	Keating Government
1995	Legislative approval for private health funds to enter into **agreements** with doctors and hospitals, establishing a framework in which hospital gaps were all but eliminated and medical gap insurance permitted.	Keating Government
July 1997	**Private Health Insurance Incentives Scheme** (PHIIS) commenced.	Howard Government
July 1997	**Medicare levy surcharge** for high-income earners without private health insurance (1% of taxable income in addition to the 'standard' levy of 1.5%). The income thresholds were set at $50,000 for singles and $100,000 for families with income is defined as the total of taxable income plus reportable fringe benefits.	Howard Government
January 1999	**Private Health Insurance 30% rebate** commenced.	Howard Government
July 2000	**Lifetime Health Care** (lifetime community rating) commenced. This links the premium payable to the age of the member upon joining. Those aged under 31 when they join pay the normal premium provided they maintain continuous cover. For those joining or rejoining past the age of 31, there is a 2% loading on the premium payable for each year of age (to a maximum loading of 70%).	Howard Government
August 2000	Legislative approval for **medical gap cover schemes** that permit private health funds to offer gap insurance without needing to have agreements with medical practitioners.	Howard Government
April 2005	The **Private Health Insurance Rebate** increased from 30 percent to 35 percent for people aged from 65 to 69 years and to 40 percent for people aged 70 years and older.	Howard Government

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Year or month	Policy event	In term of—
May 2008	In the context of the 2008-09 Federal Budget, announcement of the government's intention to increase the income thresholds for the **Medicare Levy surcharge** to $100,000 for singles and $150,000 for couples/families.	Rudd Government

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