Submission to the Senate Economics Committee Inquiry on the Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008

7 July 2008

CHOICE is a not-for-profit, non-government, non-party-political organisation established in 1959. CHOICE works to improve the lives of consumers by taking on the issues that matter to them. We arm consumers with the information to make confident choices and campaign for change when markets or regulation fails consumers.

Background to changes and Senate Economics Committee inquiry

In the 2008-09 Budget, the Commonwealth Government announced an increase in the Medicare Levy Surcharge Thresholds.

The thresholds will increase to:

- $100,000 for individuals, up from $50,000; and
- $150,000 for families (with some adjustment for the number of dependents), up from $100,000.

Taxpayers with incomes over these thresholds will continue to pay an additional 1% tax if they do not have private health insurance.

The measure is estimated to achieve net savings of $232 million over four years from a reduction in the amount of Medicare Levy Surcharge revenue collected offset by a reduction in the amount the 30% Private Health Insurance Rebate paid.

The Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008, which will give effect to the changes, was referred to the Senate Economics Committee on 18 July 2008. The Economics Committee was requested to consider the Bill and the following matters:

(a) 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;

(b) the modelling underpinning the decision and the veracity of that modelling;

(c) the anticipated impact on PHI premiums and PHI products offered;

(d) the impact of the change on the cost of living and the consumer price index;

(e) including the threshold, PHI rebate and lifetime health cover on increasing PHI membership;

(f) the anticipated impact of changes to the threshold on:

(i) the public hospital system including waiting lists and the financial requirements of state governments,

(ii) the ongoing viability of PHI, and

(iii) private hospitals.

Why do people have private health insurance?

Private health insurance has a long history in Australia. In the late 1970s, before the introduction of Medicare, membership was well over 60% of the population. Membership steadily declined following the introduction of Medicare in 1984. It reached a low of 30.2% of the population in December 1998.

In the late 1990s the Federal Government introduced three initiatives to increase private health insurance membership. These are:

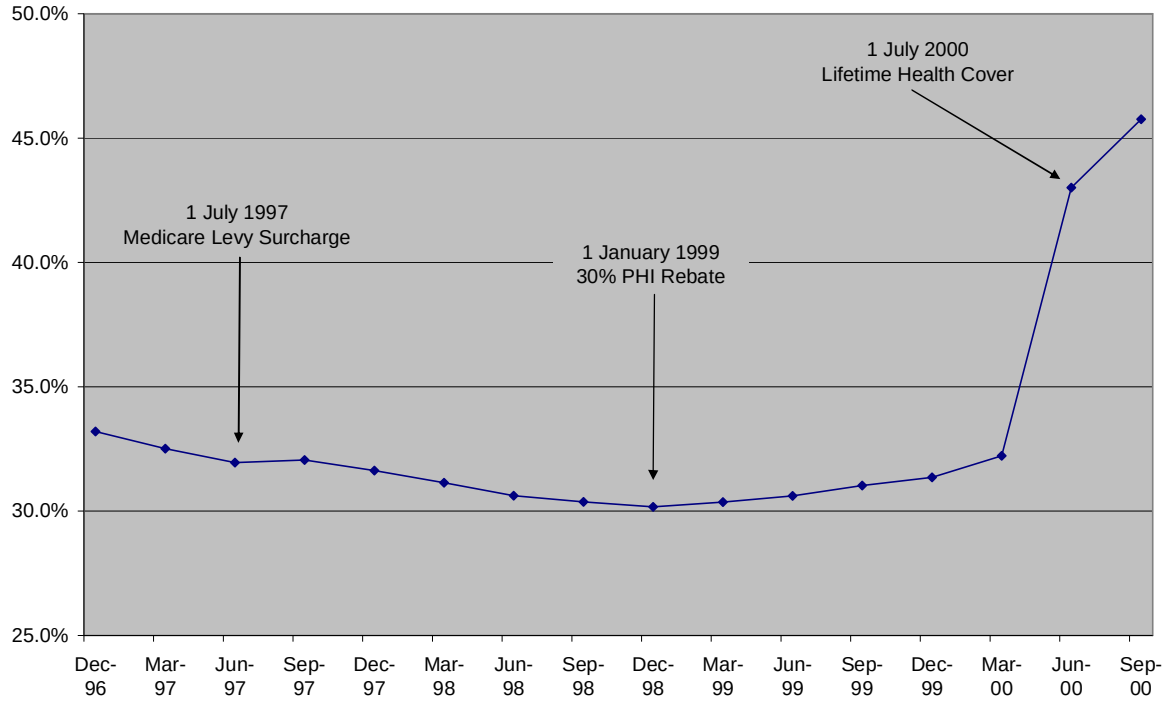
- The Medicare Levy Surcharge;
- Lifetime Health Cover: a loading which makes private health insurance more expensive for people who fail to take out private cover before they turn 31. An additional 2% is added to the premium for each year after age 30; and
- The 30% Private Health Insurance Rebate: a non-means tested rebate of 30% of total premiums for everyone with private health insurance. The member can choose to have the rebate paid directly to the fund or claim it back through the tax system. The rebate increases to 35% for people aged 65-69 and 40% for people aged 70 years and over.

The stated intention of these policies was to help the private sector and take pressure off the public hospital system.[1] There is some debate about whether the policies have been successful in achieving this outcome (and if they have, which has been the most significant). This is discussed further below.

The three policies were introduced progressively over a 3-year period and it is interesting to examine the effect that each had on private health insurance membership. Figure 1 shows the percentage of the population with private health insurance membership from December 1996, just before the introduction of the Medicare Levy Surcharge, until September 2000, just after the introduction of Lifetime Health Cover.

[1] Second reading speech for *Private Health Insurance Incentives Bill 1998* by the Hon Dr Michael Wooldridge MP, then Minister for Health and Aged Care. See House of Representatives, *Votes and proceedings*, 12 November 1998, p. 263.

Figure 1: Percentage of population with private health insurance – Dec 1996-Sep 2000



Source: Private Health Insurance Administration Council Membership Statistics

The chart shows that the Medicare Levy Surcharge had little immediate effect on private health insurance membership. There was a small increase between June and September 1997 but membership then continued to decline. The 30% Private Health Insurance Rebate was introduced in July 1999. This measure appears to have resulted in a slow increase in membership. Lifetime Health Cover was introduced in July 2000. In the lead up to its introduction the government ran a major advertising campaign under the heading 'Run for Cover'. Over 2.4 million new members joined private health insurance funds between June 1999 and June 2000.

All of these measures operate in combination to provide an incentive for people to take up private health insurance. However, from this data, it appears that Lifetime Health Cover had the most significant effect on people's decision to take up private health insurance. It continues to provide a strong incentive. Industry statistics show a sharp jump in membership at age 30 as people join to avoid the Lifetime Health Cover penalties.

In addition to government incentives, there are many other reasons why people purchase private health insurance.

These include:

- Security, protection and peace of mind;
- Choice of doctor;
- Private rooms;
- Shorter waiting lists;
- Concerns about the quality of the public health system.

Many consumers value what private health insurance offers and would purchase it in the absence of government incentives. The Medicare Levy Surcharge is just one of a range of reasons why people may take out private health insurance.

The Medicare Levy Surcharge Threshold

The Medicare Levy Surcharge is a tax on people who are over the income thresholds (currently $50,000 for individuals and $100,000 for families) and choose not to take out private health insurance. It was initially introduced as an additional incentive for high income earners to take out private cover. As discussed, it is one of a range of incentives.

CHOICE believes that people should be free to choose whether or not they take up private health insurance. However, the Medicare Levy Surcharge constrains this choice. It forces some people to purchase private health insurance who otherwise would not. They do this mainly to reduce tax. They are likely to purchase the cheapest product which will enable them to avoid the Medicare Levy Surcharge.

Income growth since the Medicare Levy Surcharge was introduced in 1997 has resulted in many people's incomes exceeding the thresholds. They are faced with little choice but to take out private health insurance if they wish to avoid the Medicare Levy Surcharge. The increase in the thresholds to $100,000 for individuals and $150,000 for families will mean more consumers will be able to exercise real choice about whether to buy private health insurance without facing the Medicare Levy Surcharge.

Policies to avoid the Medicare Levy Surcharge

As noted, some people take up private health insurance specifically to avoid paying additional tax through the Medicare Levy Surcharge. This has generated a range of private health insurance products which are designed to enable people to avoid the Medicare Levy Surcharge. Private health insurance broker iSelect specifically allows consumers to search for 'cover that avoids tax and penalties'.

Members who join only to minimise tax are likely to purchase the cheapest product they can to avoid the surcharge. The cheapest policy is likely to have a range of exclusions. Common exclusions include cardiac surgery, joint replacement surgery and eye surgery (eg cataract removal). If the member needs to use the insurance they may find they are not covered. As a result they will most likely end up in the public system. Even if they are covered they may choose to use a public hospital because of the large out of pocket costs they may face if they use the private system. If the aim is to reduce pressure on the public system, providing an

incentive for people to purchase exclusionary policies and then subsidising the premiums is a poor use of taxpayers' money.

Exclusionary policies have grown significantly in recent years but still make up a small percentage of total policies. As at 31 March 2008, there were 472,520 exclusionary policies, which was 10% of total policies.

Increasing the thresholds

The Medicare Levy Surcharge Thresholds have not been indexed since they were introduced in 1997. CHOICE believes that adjusting the threshold at this time is appropriate. If it is not done now, they will need to be adjusted at some stage. The individual threshold of $50,000 is already less than average wages. It no longer catches only high income earners. The longer the adjustment is delayed the more people are affected and the greater the impact of the change.

It has been suggested that the thresholds should be adjusted only to take account of income growth since the introduction of the Medicare Levy Surcharge. Incomes have grown by around 60% since 1997[2]. This would take the thresholds to $80,000 for individuals and $160,000 for families. We note on this basis there is support for the family threshold specified in the Bill.

There may be an argument to reduce the individual threshold to $80,000. However, this is likely to have limited effect on the outcome of the changes. There are a relatively small number of taxpayers with incomes between $80,000 and $100,000 compared to the number of taxpayers with incomes between $50,000 and $80,000. Data from the Australian Tax Office for 2005-06, show that there were 2 million individual taxpayers with incomes between $50,000 and $80,000 and 410,000 with incomes between $80,000 and $100,000.[3]

In our view, it is appropriate to adjust the thresholds to not only take account of income growth to date but also to accommodate income growth in the future. If the thresholds were indexed to take account of income growth only until 2008, then annual indexation of the thresholds should be introduced. Indexation is in our view desirable in any case.

Effect of the threshold changes

The Committee has been asked to look at the effect of the changes on a range of matters. We will address some of these below.

Effect on private health insurance membership

The exact effect of the changes on private health insurance membership is difficult to estimate. The government has assumed that approximately 485,000 taxpayers dropping their

[2] Australian Bureau of Statistics 2008, *6302.0 - Average Weekly Earnings, Australia, Feb 2008,* Australian Bureau of Statistics, Canberra, viewed at http://www.abs.gov.au/ausstats/abs@.nsf/mf/6302.0.
[3] Australian Taxation Office 2008, *Taxation Statistics 2005-06,* Australian Taxation Office, Canberra, viewed at http://www.ato.gov.au/corporate/content.asp?doc=/content/00117625.htm&pc=001/001/009/005&mnu=&mfp=&st=&cy=1.

membership. The actual number of members who drop out will be higher because this does not include dependents.

Following the announcement of the change to the Medicare Levy Surcharge thresholds, both the Australian Health Insurance Association (AHIA) and the Australian Medical Association (AMA) commissioned consultants to estimate the likely effect. Both these pieces of work were reported as showing that the decline in membership would be significantly greater than the Government's estimate. However, these calculations are based on a range of questionable and inaccurate assumptions.

The PricewaterhouseCoopers paper for the AHIA

They have both argued that the government has used an incorrect assumption about the average saving per member. Therefore, they conclude that, for the Government to achieve its estimated savings, more than 485,000 taxpayers will need to drop their cover. CHOICE believes these figures, which were widely reported, are misleading. They are not based on actual data about the number of people who will drop their cover in response to the changes to the Medicare Levy Surcharge.

However, both consultants' reports include suggestions or estimates of what they believe may actually happen. In late 2007, the AHIA commissioned focus groups to estimate the projected number of people who would cease their private health insurance in the event of a movement in the Medicare Levy Surcharge threshold. This indicated that approximately 13% of people in the relevant income bracket would leave their cover. PricewaterhouseCoopers, in its report commissioned by the AHIA, has used this finding and made estimates based on a range of population figures. These estimates suggest between 234,000 and 312,000 people will drop their cover.

Access Economics, in its report for the AMA, notes that there are many factors which keep people in private health insurance, including many of the factors we have noted above. In particular the report says, 'we do not think the $232m saving is plausible. Therefore, the impact of the measure on fund premiums will be quite modest in the first years but will build up over time.'

CHOICE's view is that the actual outcome will be somewhere in the range of the AHIA's focus groups and the Government's estimate.

Effect on premiums

It is relatively straightforward to estimate a possible effect on premiums based on assumptions about the number of members expected to drop their cover. This would assume that funds will seek to recoup all this lost revenue through premium increases. However, we believe that such a calculation fails to take into account the incentive for private health insurers to keep premiums low to remain competitive and retain members. It also ignores the fact that health funds, like other private sector entities, must take responsibility for ensuring they offer products which are attractive to consumers. They cannot merely rely on the government to force people into private health insurance to ensure their sustainability.

In response to the changes to the Medicare Levy Surcharge thresholds, some people will leave private health insurance. This is because it is a product they do not want. Forcing these members to purchase a product they do not want, and may not use, is a form of industry assistance for private health insurance. There is no requirement for health funds to account for health outcomes from the assistance provided by the government.

In its report, Access Economics says 'traditional private health insurance products may be inappropriate to meet the challenges of the future'. The health sector has changed significantly since the introduction of health insurance. Health insurance has not evolved along with the health system. In the longer term, private health funds must consider the sustainability of their current business model, with or without government incentives and assistance.

Effect on the public hospital system

It has been widely noted that the effect on the public hospital system will probably be quite small because the members who drop out are likely to be younger and healthier. We agree that the effect on the public hospital system will be minimal.

At the same time, the government has committed to additional resources to the public hospital system. An additional $1.1 billion has been committed immediately to reduce waiting lists. The Federal Government has indicated this is an initial contribution with more to come through the Australian Health Care Agreements.

Effect on the private hospital system

Given the effect on the public hospital system will be quite small, the effect on the private hospital system is also expected to be quite small. We do not expect there to be a reduction in the use of private hospital services. Combined with measures for governments to purchase additional bed days from the private hospital system, we may see an increase in utilisation in the private system.

Public incentives for private health insurance membership?

Some suggest that we need government incentives to support private health insurance because we cannot afford a public health system. While the Economics Committee is not examining the role of incentives to support private health insurance more broadly, it is worth considering the issues.

All funding for private health insurance comes from taxes or from individuals. If we can afford to support private health insurance we can afford to support a public insurance system. Furthermore, a single national health insurer has greater purchasing power and can do more to contain health costs than a number of insurers.[4]

[4] For further discussion of this see McAuley I (2008), *More than one health insurer is too many: the case for a single insurer*, Centre for Policy Development, Sydney, viewed at http://www.cpd.org.au/sites/cpd/files/u52693/CPD_Single_National_Insurer.pdf.

It's important to distinguish private health provision from private health insurance. A competitive and sustainable private health system could exist within a single public insurance system. There is no reason why the government cannot purchase services directly from the private health system rather than through an intermediary which extracts 10% in administration costs. Some states already do this and the Commonwealth Government has encouraged the approach as part of its additional funding to the States for hospital services.

Private hospitals play an important role in the health system and will continue to do so. However, it is wrong to say that private health insurance is the only way, or even the most effective way, to support an efficient private health system. It may be more efficient for the government to redirect the nearly $4 billion spent on the private health insurance rebate each year to the public system including to purchase services directly from private hospitals.

There is little evidence to support the argument that public support for private health insurance has reduced pressure on the public system. In fact it is likely that, because more services are being delivered in the private system, medical professionals have moved from the public system to the private system. This may have exacerbated the burden on the public system.

Conclusion

CHOICE believes the changes to the Medicare Levy Surcharge are fair for consumers. It will give many consumers more choice about whether or not they take up private health insurance.

Some people will drop their cover in response to the changes. They will most likely be young and/or healthy members who are holding cheap products with exclusions. They are currently likely to have little intention of using their insurance because they will want to avoid the additional out-of-pocket costs. Public hospitals are not likely to be affected significantly because young and healthy people are unlikely to required hospitalisation. Similarly, private hospitals are not likely to see a reduction in services.

Private health funds will no longer be able to rely on the Medicare Levy Surcharge to force as many people into private health insurance (although the number so forced is likely to be less than many estimates). They must take responsibility for managing the effect of the measure on their business and offer products which are attractive to consumers.

CHOICE supports the Bill in its current form. Consideration should be given to improving the Bill by indexing the thresholds.