Australian Government

Department of Health and Ageing

POST-IMPLEMENTATION REVIEW: Increase of the Income Tax Thresholds for the Medicare levy Surcharge

September 2011

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PURPOSE OF THE POST-IMPLEMENTATION REVIEW

The 2008-09 Best Practice Regulation Report issued by the Office of Best Practice Regulation (OBPR) reported that the Department of Health and Ageing did not prepare a Regulation Impact Statement (RIS) in relation to the Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008, which was tabled on 27 May 2008. This Amendment had the effect of significantly increasing the income tax thresholds when the Medicare levy surcharge (MLS) was applied. The MLS is in addition to the Medicare levy.

Under the Australian Government's best practice regulation requirements (embodied in the Best Practice Regulation Handbook) a proposal that proceeds to the decision maker without an adequate RIS, requires a Post-Implementation Review (PIR), commencing within one to two years of the regulation being implemented. This document is the PIR for the Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008.

The Department undertook an initial assessment of the policy and identified no or low regulatory burden as a result of the measure, as it related to levels of income tax on individuals and did not pose specific regulatory impacts on industry.

A PIR is similar in scale and scope to what would have been prepared in a RIS, such as identification of the:
• problem that the regulation was intended to address;
• objective of government action; and
• impacts of the regulation (whether the regulation is meeting its objectives).

EXECUTIVE SUMMARY

The MLS was introduced in 1997 to encourage high income earners to take out private hospital insurance. The MLS did this through charging individuals with an income greater than $50,000 ($100,000 for families) and who did not have private hospital insurance, a levy equal to one per cent of their taxable income. The MLS is in addition to the Medicare levy which is equal to one and a half per cent of taxable income on those that are required to pay it.

At the time the MLS was introduced it had no indexation built into its thresholds. This meant that over time more and more taxpayers would be liable to pay the MLS, due to wage inflation and increases in real-incomes.

In increasing the MLS thresholds in 2008, the Government also had the objective of providing tax relief.

In 2008 the Government amended the MLS to raise the threshold to $70,000 and introduce automatic annual indexation in order to realign the MLS threshold to focus on high income earners.

The increase in the MLS threshold to $70,000 and the introduction of indexation effectively addressed the problem that the fixed $50,000 threshold would at some stage have resulted in the MLS applying to taxpayers who would not be considered to be on a higher income.

At the time of the relevant amendments the private health insurance industry raised concerns that the changes in MLS thresholds would affect the uptake of private health, with detrimental flow on effects for the health system in general.

While the full implications of the changes to the MLS on the health system may not be known for some years, the analysis done to date shows there has been no significant impact on the uptake of private health insurance. In fact uptake in private health insurance has been growing more than population growth. However, monitoring of the effects of raising the MLS thresholds will still continue beyond this PIR under a further legislated review due in 2012.

The main findings from this review so far is that the data shows no significant adverse effects to private health insurers or the health system as a whole from the increase in the MLS threshold in 2008.

In conclusion raising the MLS thresholds were effective at refocusing the MLS to target higher-income earners. To date the uptake of private health insurance has increased more than population growth – indicating that raising the MLS thresholds did not significantly alter the incentives for people to take up private health insurance.

BACKGROUND

The MLS was introduced on 1 July 1997 to encourage those on higher incomes to take out appropriate hospital insurance. The MLS is in addition to the Medicare levy, which applies to most Australian taxpayers. Taxpayers pay 1.5 per cent of their taxable income to the Medicare levy, and the MLS is an extra tax of 1 per cent.

Along with the Private Health Insurance Rebates and Lifetime Health Cover, the MLS is a government incentive for people to take out private health insurance.

From its introduction in 1997, the MLS applied to individuals with an annual taxable income greater than $50,000 and families with an annual taxable income greater than $100,000. For each dependent child after the first, the threshold increased by $1,500.

In the 2008–09 Federal Budget, the Australian Government announced an increase in the MLS income thresholds to $100,000 for individuals and $150,000 for families. For families with dependent children, the threshold would continue to be increased by $1,500 for each dependent child after the first.

However, due to the failure of several bills attempting to do this the threshold was only increased from $50,000 to 70,000 with indexation. Table 1 shows the change in the thresholds, both due to the change in legislation and annual indexation.

Table 1: Medicare levy surcharge annual taxable income thresholds, by year

Year	Individual	Family
1997 to 2008	$50,000	$100,000
2008–09	$70,000	$140,000
2009–10	$73,000	$146,000
2010–11	$77,000	$154,000
2011-12	$80,000	$160,000

At the time some stakeholders in particular private health insurers were concerned about the regulatory impact of changing the thresholds would have on their business.

The legislative basis of the MLS is underpinned by the following Acts of Parliament:

- *Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Act (No. 2) 2008*;
- *A New Tax System (Medicare Levy Surcharge-Fringe Benefits Act) 1999*;
- *Medicare Levy Act 1986*; and
- *Private Health Insurance Act 2007*.

Appendix A provides further background on the legislation associated with the MLS. For information on the choice of indexation refer to Chapter 10 of the Productivity Commission's, 2009 Research Report: Public and Private Hospitals.

PROBLEM

When the MLS was introduced in 1997 it only applied to incomes greater than $50,000 as the intent was to target higher income earners. However, no legislative arrangements were put in place to index the applicable income thresholds. This meant that over time the number of income earners to which the MLS was applicable would expand due to wage inflation. Theoretically at some stage this would have resulted in the MLS applying to income earners who would not be considered to be on a high income. The Tax Laws Amendment (Medicare levy surcharge thresholds) (No. 2) Bill 2008 corrected this situation by raising the threshold to $70,000 and introducing annual indexation.

When the MLS was introduced in 1997, the then Government targeted the measure at higher income earners. The threshold for singles equated to the highest marginal income tax rate threshold. When he announced the measure in the 1996–97 Budget speech, the then Treasurer Peter Costello said "higher income earners who can afford to take out private health insurance will also be encouraged to do so… This is the levy which the Government hopes no-one will pay. It is entirely optional. Those who take out health insurance (with the benefits attached) will be exempt" (Costello 1996).

In 1997–98, around eight per cent of single taxpayers had taxable incomes above the MLS singles threshold. By 2007–08, the level had reached approximately 33 per cent (Productivity Commission 2009:238). MLS revenue increased from $112 million in 1997–98 to $458 million in 2007–08.

If the MLS income thresholds remained unchanged at 1997–98 levels, the proportion of taxpayers subject to the MLS would continue to increase, due to a combination of rising real incomes and wage inflation (Productivity Commission 2009). In May 1997, seasonally adjusted full-time adult ordinary time earnings were $36,150 per annum (ABS 1997). Average incomes began to exceed the singles threshold in 2005. By May 2008, seasonally adjusted full-time adult ordinary time earnings had increased to $58,833 per annum (ABS 2008).

OBJECTIVE OF GOVERNMENT ACTION

When the Government first announced its plans to increase the MLS thresholds in the May 2008 Budget, the Treasurer, Wayne Swan said that the Government was "refocus[ing] the MLS on those with higher incomes who are better able to afford the MLS" (Swan 2008). The Minister for Health and Ageing, Nicola Roxon, stated that it was not sustainable to leave the thresholds unchanged after ten years and that the private health insurance industry "should have more than a tax penalty as the main driver for taking out insurance" (Roxon 2008a).

Additionally the Government also had the objective of providing tax relief, by reducing the amount of people liable for the MLS, as well as reducing government expenditure from savings from the payment of the rebate paid to people with private health insurance.

The original MLS income thresholds of $50,000 for singles and $100,000 for couples and families were set in 1997 after extended negotiation between the then Health Minister Michael Wooldridge and then independent Senator Brian Harradine. Dr Wooldridge has said that he introduced the MLS to increase then-flagging private health insurance membership and that he would have preferred to make the income thresholds even lower at the time (Probyn and Tillett 2008).

IMPACT ANALYSIS — COSTS, BENEFITS AND RISKS

The following chapter assesses the impacts of increasing the MLS threshold relating to:

- private health insurance membership, and resulting impact on insurers;
- private health insurance premiums;
- tax relief and reduction in Government expenditure
- private hospitals;
- public hospital utilisation; and
- work for health professionals working with privately insured patients.

This impact analysis is complemented by an independent review required under the relevant legislation that raised the MLS thresholds. The review is known as the *Review of the impact of the new Medicare levy surcharge thresholds on public hospitals*. The 2010 and 2011 reports have been released and are available from the Department of Health and Ageing website. A final report is due in 2012.

The Review primarily examines the impact on public hospital activity, operating costs and elective surgery waiting lists. KPMG has been engaged to undertake this Review. The main findings from this Review so far is that the data shows no significant adverse effects to private health insurers or the health system as a whole from the increase in the MLS threshold in 2008.

The legislation enabling the increase in the MLS thresholds received Royal Assent on 31 October 2008 and the changes applied to income tax returns for the financial year ending 30 June 2009.

Private health insurance membership and impact on insurers

Key points:

- The annual increase in the number of people insured slowed from a high growth rate of 4.3 per cent in 2007-08 (+389,000 people) to an average growth rate of 2.8 per cent in 2010-11 (+282,000). The growth in the number of persons covered in 2007 and 2008 was extraordinarily high. It is not expected that this growth would have continued so strongly in the long-term.
- Information from surveys in 2007 and 2009 indicated that anywhere between 350,000 to 590,000 people may drop their insurance due to the MLS changes, however the fact that the number of people insured rose in 2009-10 indicates this scenario did not eventuate.
- More than half the respondents to a 2009 survey who had taken out insurance for the first time in the last two years of the survey indicated that the MLS had an impact of

their decision to insure. Although this may be indicative that the high growth rate at the time in people insured from 2007-08 can be attributed to the MLS threshold applying to a wider base of tax payers, caution should be exercised in the interpretation of the results.

- Overall the percentage of the population covered remains similar since the introduction of the MLS changes (43.4 per cent in at 30 June 2007 compared to 45.3 per cent at 30 June 2011).
- All large insurers and the industry remained profitable.

Impact on membership

The number of Australians taking out private health insurance continued to grow, even after the raising of the MLS thresholds, although arguably at a slower rate as seen in Figure 1. For more detailed information on hospital treatment participation by people covered by private health insurance please refer to Appendix B.

Figure 1 shows the per cent of the Australian population covered for private health insurance hospital treatment historically. Between 2006 and 2008 the per cent of the population covered for hospital treatment increased by around 1.7 percentage points. Between 2008 and 2009, however, the per cent of the population covered remained stable at 44.4 per cent.
Figure 2 shows that the absolute number of Australians covered for hospital treatment has been increasing since 2005. The number of people covered for hospital treatment reached 10,255,675 in June 2011. The number of people with hospital cover has exceeded 10.2 million for the first time since March 1982 (10,212,000 people).

Figure 1: Private hospital treatment participation, per cent of the population covered

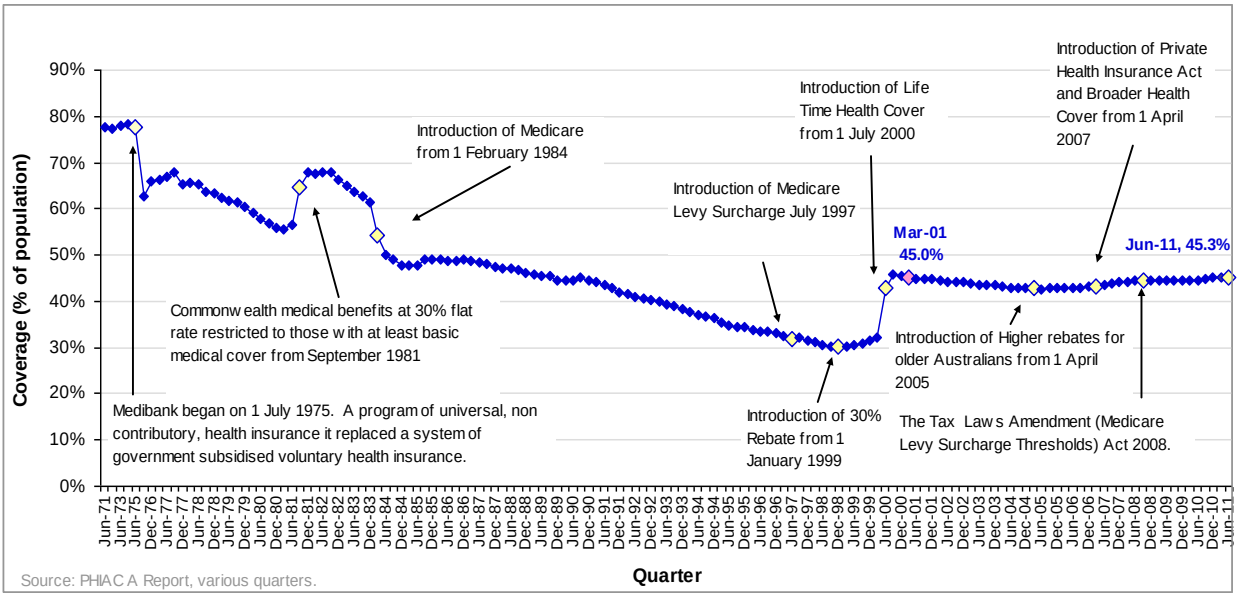

Figure 2: Private hospital treatment coverage, number of people covered

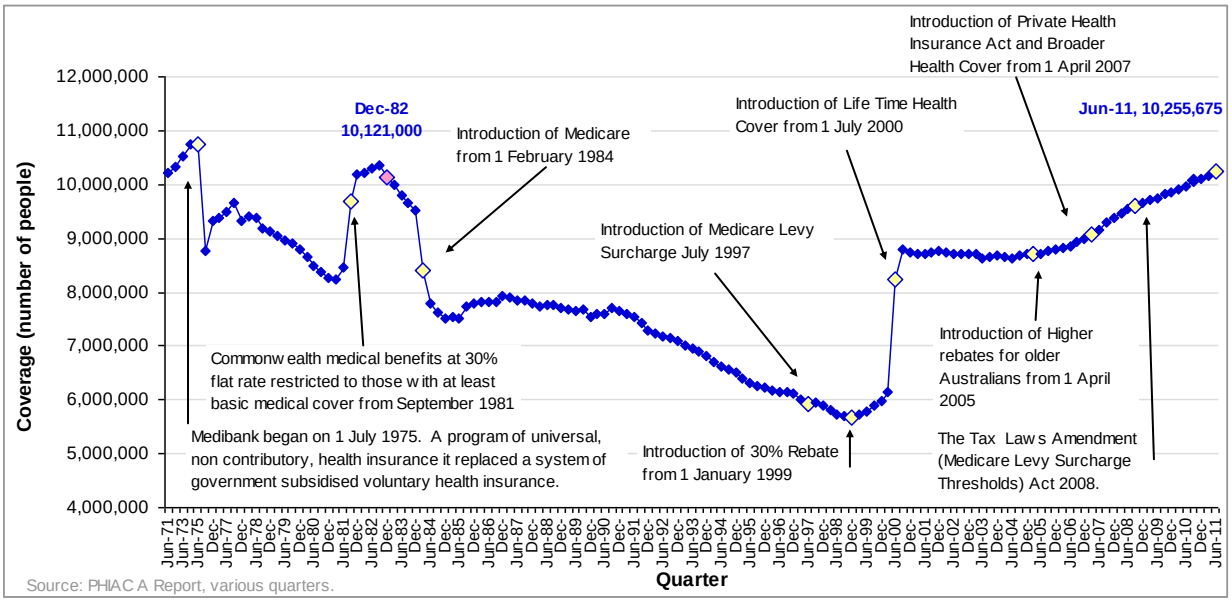

Figure 2 shows that the highest increase in the number of persons covered for hospital treatment since 2000 was between 2008 and 2009, with the per cent of the population covered during 2008 and 2009 remaining stable. The growth in the number of persons covered in 2007 and 2008 was extraordinarily high. It is not expected that this growth would have continued so strongly in the long-term. The annual growth in number of persons covered in 2010 and 2011 was 2.3 per cent and 2.8 per cent respectively. After the high growth in the number of persons covered during 2007 and 2008, these rates were the highest seen since 2001, despite the effects of the global financial crisis and comparatively low levels of consumer confidence.

Other factors at play during the period of high growth in membership in 2007 and 2008 included:

- a Government media campaign announcing changes to private health insurance in 2007 (a Government media campaign in 1999 and 2000 concerning the introduction of Lifetime Health Cover and the 30% Private Health Insurance Rebate also appeared to contribute to growth in private health insurance membership at the time); and
- the commencement of an ongoing Government mail out program in July 2007 which alerts individuals approaching their Lifetime Health Cover deadline. The program, however, appears to have had a continuing effect in contributing to growth in private health insurance membership [1].

[1] The mailout alerts a specific group of individuals that they are approaching their Lifetime Health Cover deadline and that they will incur a financial penalty if they choose to take out private health insurance hospital cover in the future after their Lifetime Health Cover deadline has passed. The individuals contacted are people who have had their 31st birthday in the preceding financial year who do not have private health insurance, and newly registered migrants. The Lifetime Health Cover mailout has had a very positive effect in supporting private hospital insurance membership, with a 10.4 per cent increase in the number of 30 to 34 year olds taking out private hospital cover since the mailout began (DoHA 2010).

In its media releases announcing premium increases in 2009 and 2010, Medibank Private indicated that it experienced a slowing in membership growth in those years (Medibank 2009b and 2010). The Managing Director of Medibank Private, Mr George Savvides, has commented that at that time, the global financial crisis had a much larger impact on slowing membership growth than changes to the MLS income thresholds (Savvides 2009).

Additionally in 2010, Mr Savvides commented that membership growth was continuing at a lower rate than prior to the global financial crisis, and that in general terms there had not been a material change in the membership age profile. He added that the changes to the MLS income thresholds would have had some influence in the slowing of membership growth, but it was difficult to disaggregate the effect, and that the dominant factor influencing the rate of membership growth has been the economy. Mr Savvides described the strong rate of growth in private health insurance membership during 2007 and 2008 as:

> …a peak in itself; it was not the average of the last five years. We have seen a sector that has come up from around two or three per cent growth into the fives in the boom economy that we saw in 2007 and it has come back to pre-boom… growth rates as we speak. Some of the impact is also from some of the regulatory changes… [but it] is very hard to determine because it is not that precise a science to be able to determine what drives growth and what drives lapse (p. 4) (Savvides 2010).

Insurer financial performance

The financial sustainability of insurers was not compromised by the MLS threshold changes. Currently, 34 private health insurers are registered in Australia (as defined by the Private Health Insurance Act 2007). Of these 21 insurers provide policies to the general public and 13 are restricted membership organisations, providing policies only to specific employment groups, professional associations or unions. The composition of the industry is highly concentrated with the largest five insurers having 84 per cent of the market share, measured in total policies (PHIAC 2010:10). Seven insurers operate for profit and 27 operate on a not-for-profit basis. There has been a trend among insurers to convert to for-profit status in the past few years.

Private health insurers received $13.1 billion in premium revenue in 2008-09 and paid $11.3 billion in benefits (PHIAC 2009). In 2009-10, insurers received $14.2 billion in premium revenue and paid $12.2 billion in benefits (PHIAC 2010). At the time of the preparation of this report, only unaudited data are available for comparison in 2010–11. Unaudited, insurers received $15.4 billion in premium revenue and paid $13.0 billion in benefits in 2010–11 (PHIAC 2011)"

Ipsos Health Care and Insurance Australia report

The Ipsos *Health Care and Insurance Australia* report is a consumer-based review of the public and private health industry in Australia. The report is based on a survey of over 5,000 interviews of Australians with and without private health cover. The 2009 report was based on interviews conducted in July/August 2009. Ipsos surveys have been undertaken every second year from 1989 onwards.

The Ipsos 2009 report includes information on people's reasons for obtaining and maintaining private health insurance, and people's knowledge and attitudes towards the three

Government private health insurance policy incentives (the rebates, the MLS and Lifetime Health Cover).

When asked "can you tell me why you have private health insurance?" in 2009, the most popular responses were "Quick attention/ avoid hospital waiting lists" (31 per cent), "Mainly for extras/ Dental etc" (18 per cent), and "May need it/ Can't afford not to have it/ Never know if need" (17 per cent). The reason "To avoid government levy/ Penalty/ Tax" was mentioned by seven per cent of respondents with private health insurance, equal tenth with three other reasons. Table 2 shows the breakdown of responses in 2009.

However, the Ipsos survey results showed that after prompting, the rebates, the MLS and Lifetime Health Cover were all important factors contributing to the maintenance of private health insurance. In 2009, the three policy incentives combined assisted in the maintenance of private cover for 83% of privately insured people (Ipsos, 2009). Of these people, 67 per cent mentioned the rebates, 54 per cent mentioned Lifetime Health Cover, and 51 per cent mentioned the MLS as factors that were encouraging their maintenance of private health insurance. The reported effect of the government policy incentives was even stronger for people that had taken out private health insurance during the two years prior to the survey, with 82 per cent mentioning the rebates, 71 per cent mentioning Lifetime Health Cover, and 76 per cent mentioning the MLS as factors that were encouraging their maintenance of private health insurance.

There had also been a statistically significant increase in the percentage of people mentioning the MLS as having an impact in maintaining private health insurance between 2007 and 2009: from 48 per cent to 51 per cent for all people with private health insurance, and from 56 per cent to 76 per cent for those who had taken out private cover in the two years prior to the survey (Ipsos 2009). However, caution should be exercised in the interpretation of these results. Ipsos notes that there was only a small sub-sample. Also, respondents could nominate multiple reasons. More than 50 per cent of people reported other reasons such as concerns about public hospital waiting lists; influence of friends, family and colleagues that it is wise to have private health insurance; and preference to be treated in the private health system.

Table 2: Why have private cover: reasons, persons with private health insurance, 2009

Why have private cover?	Per cent
Quick attention/avoid hospital waiting lists	31
Mainly for extras/Dental etc	18
May need it/Can't afford not to have it/ Never know if need	17
Choice of hospital/Use of private hospital	14
No out of pocket expenses/Cut costs	13
Choice of Doctor	12
Age factor/Getting older	9
Mainly for children	9
Medicare insufficient/Doesn't cover enough	8
Better care/Access to better facilities	7
To avoid government levy/Penalty/Tax	7
Have a particular condition	7
Lack of confidence in public system	7
Just prefer to/Secure feeling	6
Believe in private/User pays	6
May need specialist	5
30% Government rebate and similar	2
Lifetime health cover/Had to join before July 2000	1
Turning 30/Age penalty/Pay more as get older	1

Source: Ipsos 2009 Table 13.1, p. 297.
Note: Total does not add to 100. Multiple responses allowed.

In both the 2007 and 2009 Ipsos surveys, a question was included on whether or not increases in the MLS thresholds would likely cause people to drop their private health insurance. In 2007, before the thresholds were increased, the survey included two questions: firstly, would respondents drop their cover if the MLS thresholds were raised to $65,000 for individuals and $130,000 for families, and secondly, what if this rose to $75,000 for singles and $150,000 for families?

Ipsos calculated that the equivalent of three per cent of all those privately insured said that they would drop their cover if the thresholds were raised to $65,000 and $130,000, and seven per cent of all those privately insured said that they would drop their cover if the thresholds were raised to $75,000 and $150,000. Seven per cent of all those privately insured equates to approximately 590,640 people[2] (Ipsos 2007).

In 2009, four per cent of respondents within the relevant income groups said they would drop their hospital cover when the MLS thresholds were increased to $75,000 for individuals and $150,000 for families, equating to approximately 357,380 people[3] (Ipsos 2009).

Table 3 compares the Ipsos survey results—regarding people's intentions to drop their private health insurance if the MLS thresholds were increased—with the Private Health Insurance Administration Council (PHIAC) membership statistics. From the information in Table 3 it

[2] Calculated using a conversion factor of 2.14 persons per insurable unit, as described in the Ipsos 2009 report, p. 472. Calculation equal to 276,000 insurable units (Ipsos 2007:198) multiplied by 2.14. Note that this calculation is applied to data from the 2009 Ipsos report, as no conversion factor was published in the 2007 report.

[3] Calculated using a conversion factor of 2.14 persons per insurable unit, as described in the Ipsos 2009 report, p. 472. Calculation equal to 167,000 insurable units (Ipsos 2009:171) multiplied by 2.14.

can be argued that the increases to the MLS thresholds probably has had some effect on slowing the rate of annual growth in hospital treatment policies.

Table 3: Estimate of number of people dropping hospital treatment policies compared with actual annual change in number of people with hospital treatment policies, Ipsos surveys and PHIAC membership statistics, various years

Ipsos survey		PHIAC membership statistics	
Year	Estimate of number of people dropping hospital insurance	Financial year ending	Annual change in number of people with insurance for hospital treatment
2007[(a)]	590,640	30 June 2007	+299,000
		30 June 2008	+389,000
2009[(b)]	357,380	30 June 2009	+211,000
		30 June 2010	+229,000
		30 June 2011	+282,000

Sources: Ipsos 2007 and 2009; PHIAC A Report, various quarters.

(a) Total estimate when respondents were asked whether or not they would drop their hospital treatment cover *if* the MLS thresholds were raised to $75,000 for singles and $150,000 for families (emphasis added). Calculated using a conversion factor of 2.14 persons per insurable unit, as described in the Ipsos 2009 report, p. 472.

(b) Total estimate when respondents were asked whether or not they would drop their hospital treatment cover *when* the MLS thresholds were raised to $75,000 for singles and $150,000 for families (emphasis added). Calculated using a conversion factor of 2.14 persons per insurable unit, as described in the Ipsos 2009 report, p. 472.

The Ipsos survey estimates of the number of people who would no longer keep their hospital insurance if the MLS thresholds were increased is much higher than the slowing of membership growth reflected in the PHIAC statistics. A small part of this difference would be lower average wages at the time, but this does not explain such a large discrepancy. It is more likely true that more people said that they would drop their cover if the MLS income thresholds would change, than actually did.

National Health Surveys

The Australian Bureau of Statistics' (ABS) National Health Survey (NHS) is another source of information on people's reasons for having private health insurance. The NHS is an Australia-wide sample survey, and has been conducted seven times since 1977–78, with the three most recent surveys in 2001, 2004–05 and 2007–08. The 2007–08 NHS included approximately 21,000 persons. According to the NHS, in 2007–08, 52.5 per cent of Australians had either hospital cover, ancillary cover (now known as 'general treatment' cover) or both (ABS 2009a). The ABS has a caveat on the private health insurance data in the NHS, as the data reflect people's perception of their insurance cover, which may not correspond to their actual cover. As a result, the ABS qualify that data from this topic are not directly comparable with quarterly statistics reported by the PHIAC (ABS 2009b). Nevertheless, the NHS is a valuable source of information on private health insurance in Australia collected through a sample survey of the general population.

For people with private cover, "Security or protection or peace of mind" was the most common reason people gave why they had private cover in the three most recent surveys. In 2007–08, 53.5 per cent of people with private health insurance mentioned this reason. In 2007–08, "to gain government benefits or avoid extra Medicare levy" was nominated as the seventh-most popular reason for having private health insurance (nominated by 11.8 per cent

of people with private cover). The ranking for this response was similar or the same in the 2001 and 2004–05 surveys, though the per cent of people with private cover who nominated this reason showed an upward trend, increasing from 9.6 per cent in 2001 and 2004–05 to 11.8 per cent in 2007–08. The upward trend is probably related to higher proportions of people eligible to pay the MLS over time.

Both the NHS and Ipsos survey results indicate that there are a wide range of reasons people purchase private health insurance. Avoiding the MLS is a reason for purchasing private health insurance for many people, however many more people report other reasons such as security, choice of doctor, 'extras' cover, and avoidance of public hospital waiting lists.

In analysing the impact of the increases in the MLS income thresholds on private health insurers, it is difficult to disaggregate the impact of the MLS versus other factors at play. The PHIAC membership statistics show that since 2008, the number of persons with hospital insurance has continued to grow, but that in percentage terms, the annual percentage growth rate in the per cent of the population covered has slowed since 2007 and 2008. The 2009 Ipsos survey results provide an estimate that 357,380 people would no longer keep their hospital insurance when the policy-holders were no longer liable for the MLS.

Private health insurance premiums

Key points:

- Health insurance premium increases must be approved by the Minister for Health and Ageing on advice from the Department of Health and Ageing, PHIAC and where relevant, the Australian Government Actuary. In applications for premium increases taking effect in 2009 and 2010, insurers have cited the MLS changes as a minor contributing factor. However, the main factors impacting on premiums in the past few years have been increased benefits paid by insurers due to increased health care utilisation and rising costs of treatment.
- Over the last three years, annual average private health insurance premium increases have been less than the average for the five-year period 2003–2007. The main factors impacting on premiums in the past few years have been increased benefits paid by insurers due to increased health care utilisation and rising costs of treatment.

When the Government first announced its intention to increase the MLS income thresholds in May 2008, some stakeholders stated that the measure may cause people with private health insurance to drop their cover once they were no longer liable for the MLS, or not take out cover, putting upwards pressure on premiums to cover those remaining with a private health insurer.

Premium increases occur annually, and three increases have occurred since the MLS income thresholds were changed, in April 2009, 2010 and 2011.

Private health insurance premium increases are published annually by the Government, and currently take effect from 1 April each year. In 2008, prior to the introduction of the changes to the MLS income thresholds, premiums increased by an average 4.94 per cent. In 2009,

premiums increased by an average of 6.02 per cent. In 2010, premiums increased by an average of 5.78 per cent and in 2011, premiums increased by an average of 5.56 per cent. For the five-year period 2003–2007, premiums increased by an average of 6.63 per cent.

Most of the larger health insurers issue public announcements (often media releases) announcing premium increases. For the years 2009 and 2010, no public announcement regarding premium increases by insurers mentioned the change in MLS income thresholds as a contributing factor to premium increases (ahm 2010; AU 2009; BUPA/HBA 2009; HBF 2010; HCF 2009 and 2010; LaTrobe 2010; MBF 2009; Medibank 2009a and 2010; nib 2009 and 2010). Factors cited by insurers were generally rising healthcare costs, increasing utilisation and advances in medical technology. One insurer, Medibank Private, mentioned that it experienced a slowing in membership growth in the years 2009 and 2010, contributing to its premium increases.

As part of the annual premium approval process (or 'premium round'), insurers must submit applications for premium changes to the Minister for Health and Ageing. In their applications, insurers can identify factors that, they argue, influence the premium increases they seek.

For the 2009 premium round, which was the first premium round following the increases to the MLS thresholds, around two-thirds of insurers mentioned that the changes to the MLS income thresholds would have some impact on premiums. Approximately one-third of insurers cited a figure (percentage or whole number) by which they were anticipating membership to decline as a result of the MLS changes (Various health insurers, unpublished 2008). As shown in Figure 2, there was no overall membership decline, just a slowing of growth. Factors cited by insurers were generally rising healthcare costs, increasing utilisation and advances in medical technology.

For the 2010 premium round, around half of all health insurers again referred to the changes to the MLS income thresholds in their premium applications, the consensus being that they anticipated slower membership growth rather than a decrease in membership. No insurers provided numerical data to support their claims other then assumptions on future membership changes (Various health insurers, unpublished 2009). Factors cited by insurers were generally rising healthcare costs, increasing utilisation and advances in medical technology.

In the 2011 premium round, only a few insurers mentioned the changes to the MLS income thresholds in their premium applications. Again the general consensus was that insurers anticipated slower membership rather than a decrease in membership. No insurers provided numerical data to support their claims other than assumptions on future membership changes (Various health insurers, unpublished 2010). Factors cited by insurers were generally rising healthcare costs, increasing utilisation and advances in medical technology.

With more and more people being liable for the MLS since 1997 due to rising real incomes and wage inflation, it appears that some health insurers have developed products priced for and targeted at consumers wishing to avoid paying the MLS, but who do not require a product with comprehensive coverage, and may, in fact, have little intention of using their private health insurance (Macintosh, 2007). These products are generally priced at below the MLS amount that a consumer would otherwise pay, e.g. for a singles policy, currently $800

and for a couples policy, $1,600, and are therefore cheaper to buy than it is to pay the MLS. Excesses and/or exclusions usually apply to these policies to keep premiums lower. Since 2000, the Government has had regulation in place to restrict MLS excess (or 'front-end deductible') amounts to $500 per singles product per annum and $1,000 per family product per annum for hospital products that allow the consumer to avoid the MLS.

The basic hospital cover that could be purchased for such a price pays only limited benefits for all hospital treatment. The benefit paid is sufficient to cover any hospital charges for treatment as a private patient in a public hospital, but will leave the consumer with a significant amount to pay for any treatment in a private hospital. Macintosh (2007) argues that purchasers of these low-cost products have little incentive to use private health services, or nominate to use their private health insurance when using public health services.

With the increases to the MLS income thresholds, people with these types of policies and with incomes below the new thresholds may be inclined to drop their cover, or choose not to take out private health insurance, particularly if they had little intention of using their private cover. This in turn could cause private health insurers to lose premium revenue.

While many factors contribute to premium increases, in the three years since the income thresholds were increased it does not seem that the changes to the MLS income thresholds and any associated private health insurance changes in behaviour has had a significant effect on premiums. The main factors impacting on premiums in the past few years have been increased benefits paid by insurers due to increased health care utilisation and rising costs of treatment. Benefits payments, including changes in provisions, were $12,227 million in the 2009–10 financial year, an increase of $1,842 million or 17.7% from 2007–08 (PHIAC 2010).

PHIAC reported that premium revenue for 2009–10 was $14,170 million, an increase of $1,981 million or 16.2% from 2007-08, due to both growth in membership and the effect of premium increases. The increase in premiums was therefore less than the increase in benefits for the two years to 2009–10 (PHIAC 2010).

Tax relief and reduction in Government expenditure

Key points:

- Data from the ATO indicates that 2.0 million taxpayers avoided the need to pay the MLS in 2008-09, who would otherwise have been potentially liable under the previous thresholds.
- The 2008-09 Mid-Year Economic Fiscal Outlook quantified that when the policy was fully implemented the size of this tax relief component would be $130 million per annum. The total size of this tax relief is reduced significantly due to the fact many tax payers have taken out complying hospital insurance and thus would avoid paying the MLS.
- As well as providing tax relief the revised thresholds also reduced the expected expenditure by the Government on the private health insurance rebate. The 2008-09 Mid-Year Economic Fiscal Outlook estimated that when the policy was fully implemented the size of this would be $245 million per annum, providing the Government a net gain in revenue averaging $115 million per annum.

Tax relief

If the MLS income thresholds continued to remain at 1997 levels, more and more taxpayers would be subject to the MLS each year due to rising real incomes and wage inflation.

By increasing the MLS income thresholds to $70,000 per year for singles to and $140,000 per year for couples and families in 2008, the Government argued that 250,000 Australians would no longer be subject to the MLS (Roxon 2008b:9420).

When the MLS income thresholds were increased, individuals with annual taxable incomes between $50,000 and $70,000 and couples and families with annual taxable incomes between $100,000 and $140,000 either received a tax saving if they did not have hospital insurance, or were able to make a decision whether or not to keep their private health insurance, without regard to having liability for the MLS. The Government claimed that:

> …two people on average incomes of $60,000 each will get a tax cut… of $1,200… For singles earning between $50,000 and $70,000 it will be $500, $600 or $700 (p. 9420) (Roxon 2008b).

Reduction in Government expenditure

Tax cuts are a loss of taxation revenue for the Australian Government. However, as shown in Table 4, the Government expected to make a saving in expenditure on the private health insurance rebates. The Government anticipated that some people would drop their private health insurance or not take it up because of the changes to the MLS income thresholds, and the Government would thereby reduce its expenditure on the rebates.

The Government's 2008–09 Mid-Year Economic Fiscal Outlook presented the change in fiscal impact (relative to the measure published in the 2008–09 Budget) of increasing the thresholds to $70,000 per year for singles and to $140,000 for couples and families, with these thresholds to be indexed by AWOTE in future years (Commonwealth of Australia 2008b:118).

This measure was estimated to reduce the cost to revenue by $300 million (from $660 million to $360 million) and reduce the estimated savings in private health insurance rebates by $219 million (from $959.7 million to $740.6 million) over the forward estimates period. Following this amendment, the Government's forward estimates showed a net saving to the Government of approximately $380 million over the forward estimates period.

The Department of Treasury has provided Australian Taxation Office (ATO) data for the 2008–09 financial year for the express purposes of this review. However, caution should be observed in interpreting this data.

The data cannot make an allowance for any of those singles and families to have opted into hospital insurance in the event that the MLS thresholds did not increase. Indeed, the estimates will include an additional, but unquantifiable, number of singles and families who dropped their hospital cover in 2008–09 on the basis that it was no longer required in order for them to avoid paying the MLS.

Table 4 shows that up to 2.0 million taxpayers who would previously been potentially liable for the MLS were no longer liable for it in 2008–09 after the thresholds were increased (inclusive of an unquantifiable number of singles and families who dropped their hospital cover in 2008–09 on the basis that it was no longer required in order for them to avoid paying the MLS). This translates to an estimated upper bound of approximately $391 million in foregone taxation revenue for 2008–09.

The effect of change in the MLS thresholds can be seen by comparing the 748,400 individuals who were liable for the MLS in 2007-08[4] to the 201,000 liable in 2008-09, as this shows a 73% decrease or 547,400 individuals.

Table 4: Estimates of single and family taxpayers in various annual income thresholds and estimates of MLS revenue and forgone MLS revenue, 2008–09

Single taxpayers	Number	Per cent of total single taxpayers	Number who paid MLS	Total MLS revenue ($M)	Estimated foregone MLS revenue ($M)
Income $50,000–69,999	900,500	15.1	—	—	193.7
Income $70,000+	864,500	14.5	120,800	108.4	n.a.
Family taxpayers	**Number**		**Number who paid MLS**	**Total MLS revenue ($M)**	**Estimated foregone MLS revenue ($M)**
Income $100,000–139,999	1,090,500		—	—	197.7
Income $140,000+	877,100		80,200	70.5	n.a.

Source: Australian Taxation Office, unpublished as at January 2012 individual tax return data for 2008-09 income year. These data include individuals as members of couples for the entire financial year & individuals as members of couples for part of the financial year. Data on forgone MLS revenue are strictly estimates only.

Impact on private hospitals

Key points:

- Profitability of the dominant private hospital providers remains strong.
- The number of private hospital separations and the rate of private hospital separations per 1,000 population continued to grow from 2005–06 to 2009–10.

There were 573 private hospitals in Australia in 2009-10, accounting for 33 per cent of hospital beds (AIHW 2011). Private hospitals include:

- medical/surgical hospitals;
- specialist psychiatric hospitals;
- rehabilitation hospitals; and
- free-standing day hospitals.

[4] *Taxation statistics 2008-09*, personal tax detailed table 7.

Hospital financial performance

Ramsay Health Care Ltd is the largest operator of private hospitals in Australia, with 66 private hospitals. It also operates a number of hospitals in the United Kingdom, France and Indonesia (Ramsay 2011). In its 2011 annual report, Ramsay reported that in 2010–11, group core net profit after tax from continuing operations was $220.6 million, a rise of 23.6 per cent from the previous financial year, and that revenues rose by 9.4 per cent. Ramsay achieved 8.5 per cent revenue growth in its Australian hospitals for the 2010–11 financial year, and said that it was confident about the underlying strength of its business (Ramsay 2011). The managing director of the company has also recently cited PHIAC membership statistics, stating that he believes private health insurance membership in Australia is growing (Rex, 2011).

Impact on demand

The Australian Institute of Health and Welfare (AIHW) publishes an annual report on public and private hospital statistics. The most recent data available is for 2009–10 (AIHW 2011). According to the AIHW report, the number of separations[5] per 1,000 population rose by an average of 1.6 per cent per annum overall (i.e. public and private hospitals) between 2005–06 and 2009–10. The highest growth in separations per 1,000 population was at private free-standing day hospital facilities, at an average of 6.9 per cent per annum. The equivalent growth rate for other private hospitals was 1.6 per cent per annum. As shown in Table 5, the overall number of separations in all private hospitals, including free-standing day hospital facilities, grew from 2,846,000 in 2005–06 to 3,462,000 in 2009–10.

Table 5: Separations ('000), public and private hospitals, 2005–06 to 2009–10

						Change (per cent)	
	2005–06	2006–07	2007–08	2008–09	2009–10	Average since 2005–06	Since 2008–09
Public hospitals							
Public acute hospitals	4,451	4,646	4,729	4,880	5,062	3.3	3.7
Public psychiatric hospitals	16	15	15	11	11	-7.9	0.9
Total	4,466	4,661	4,744	4,891	5,073	3.2	3.7
Private hospitals							
Private free-standing day hospital facilities	547	570	668	729	783	9.4	7.4
Other private hospitals	2,298	2,371	2,462	2,528	2,678	3.9	5.9
Total	2,846	2,942	3,130	3,257	3,462	5.0	6.3
All hospitals	**7,312**	**7,603**	**7,874**	**8,148**	**8,535**	**3.9**	**4.7**

Source: AIHW 2011 Table 2.6, p. 14. Private hospitals expenditure and revenue data were sourced by the AIHW from the Australian Bureau of Statistics report *Private Hospitals Australia, 2009–10*.

[5] "Separation is the term used to refer to the episode of admitted patient care, which can be a total hospital stay… or a portion of a hospital stay beginning or ending in a change of type of care (e.g. from acute to rehabilitation). Separation also means the process by which an admitted patient completes an episode of care by being discharged, dying, transferred to another hospital or by a change of care type" (AIHW 2011:14).

Table 6 shows that between 2005-06 and 2009-10, total recurrent expenditure by private hospitals increased by an average of 2.4 per cent per annum (after adjusting for inflation).

It appears that the growth in demand for private hospitals was not impacted by the changes to the MLS thresholds. From the available data, it can be seen that the number of private hospital separations and the rate of private hospital separations per 1,000 population continued to grow from 2005–06 to 2009–10, and that the average growth rate per annum for both measures was greater for private hospitals than public hospitals.

Financial performance by the largest operator of private hospitals in Australia during 2008–09 and 2009–10 was solid, with the company returning increases in profits since the changes to the MLS thresholds. The company appears optimistic about continuing strong demand for private hospital services.

Table 6: Recurrent expenditure and revenue ($ million), public and private hospitals, 2004–05 to 2009–10

						Change (per cent)	
	2005–06	2006–07	2007–08	2008–09	2009–10	Average since 2005–06	Since 2008–09
Total recurrent expenditure, constant prices[a]							
Public hospitals[b]	26,509	27,938	29,833	31,322	32,473	5.2	3.7
Private hospitals[c]	7,148	7,182	n.a.	8,137	n.a.	2.4	n.a.
All hospitals	**33,658**	**35,120**	**n.a.**	**39,460**	**n.a.**	**n.a.**	**n.a.**
Total recurrent expenditure, current prices							
Public hospitals[b]	23,964	26,260	28,908	31,322	33,706	8.9	7.6
Private hospitals[c]	6,498	6,967	n.a.	8,137	8,946	n.a.	9.9
All hospitals	**30,462**	**33,256**	**n.a.**	**39,460**	**42,652**	**n.a.**	**8.1**
Total revenue, constant prices[a]							
Public hospitals	2,387	2,567	2,778	2,975	3,295	8.4	10.1
Private hospitals	7,702	7,773	n.a.	8,982	n.a.	n.a.	n.a.
All hospitals	**10,089**	**10,339**	**n.a.**	**11,957**	**n.a.**	**n.a.**	**n.a.**
Total revenue, current prices							
Public hospitals	2,158	2,415	2,691	2,975	3,420	12.2	15.0
Private hospitals	7,001	7,539	n.a.	8,982	9,790	n.a.	9.0
All hospitals	**9,159**	**9,955**	**n.a.**	**11,957**	**13,210**	n.a.	n.a.

Source: AIHW 2011 Table 2.3, p. 12. Private hospitals expenditure and revenue data were sourced by the AIHW from the Australian Bureau of Statistics report *Private Hospitals Australia, 2009–10*. Data limitations and methods are detailed at pp. 7–8 of Australian Hospital Statistics 2009–10, AIHW 2011.

(a) Expressed in terms of prices in the reference year 2008–09. The ABS Government Final Consumption Expenditure, State and Local — Hospitals and Nursing Homes deflator was used for public hospitals. The ABS Household Final Consumption Expenditure Hospital Services deflator was used for private hospitals.
(b) Excludes depreciation.
(c) Includes depreciation.

Impact on public hospitals

One of the concerns by stakeholders at the time of the announcement to increase the MLS threshold was that it would increase pressure on public hospitals if less people were covered by private health insurance.

Key points:

- The changes to the MLS thresholds have not affected trends in public hospital separations or mix of activity.
- The MLS changes have had no significant impact on public hospital operating costs.

There were 753 public hospitals in Australia in 2009–10, accounting for 67 per cent of all hospital beds. Public hospitals include:

- acute hospitals; and
- psychiatric hospitals.

Impact on demand

Under Section 4 of the Act, an independent review of the operation of the Act is required as soon as possible after each anniversary of the commencement of the Act, for a period of three consecutive years. The independent review is to consider the impact of the changes to the MLS thresholds on public hospitals, in particular:

- number of episodes of care;
- hospital operating costs; and
- elective surgery waiting times.

The firm KPMG was engaged to undertake the review, the second report being published in July 2011. The second year review report covers the period to June 2009 for hospital separations and to March 2010 for Elective Surgery Waiting Lists (due to data availability). Overall, the review authors concluded that there had been no substantive impact on public hospital activity nor on the relative rates of public utilisation due to the changes to the MLS thresholds (KPMG 2011)[6].

Given that the trends in these activity based drivers of operating costs showed no discernible change over the review period, it was concluded that the changes to the MLS thresholds have had no significant impact on public hospital operating costs.

These findings are based on the analysis of data to the end of June 2009, providing eight months of data following the changes to the MLS thresholds coming into effect. This impact will be better informed by the third independent legislated review, when more than 12 months of post implementation data will be available for analysis.

In its 2008–09 Budget papers, the Tasmanian government flagged that it anticipated demand for public hospitals to further increase as a result of the (then proposed) changes to the MLS thresholds (Government of Tasmania 2008). This was in particular reference to public hospital waiting lists. The 2010–11 Tasmanian budget papers have shown that the median waiting times for elective patients admitted from the waiting list remained at 38 days from 2006–07 and 2007–08. Only target (not actual) waiting times are available for subsequent financial years (Government of Tasmania 2010).

[6] As no discernible impacts on public hospital activity were found, analysis of private hospital insurance data was not undertaken for the second year review.

Another factor influencing public hospital waiting lists and the demand for public and private hospitals is the Australian Government's Elective Surgery Waiting List Reduction Plan (the Plan). Introduced in 2008, the Plan involves the Australian Government providing up to $600 million over four years to State and Territory Governments to reduce the number of people waiting longer than clinically recommended for elective surgery (Commonwealth of Australia 2010c).
The KPMG report identified the Plan as being the principal factor driving increases in elective surgery admissions and reductions in waiting times. Although the report found an increase in median waiting times for elective surgery, it concludes that this was a result of a combination of factors including supply driven demand, the ageing of the population, changing models of care, patient expectations for care and an increasing shift to the public sector for elective surgery. It is highly likely that these factors have exerted greater influence on elective surgery waiting lists than has changes to the MLS thresholds (KPMG 2011:19).

The KPMG report (2011:7) lists many other factors that influence private health insurance coverage and public hospital utilisation, including:

- consumers are potentially likely to make decisions concerning taking out or dropping private health insurance after their tax return is lodged;
- some public hospitals employ strategies to maximise rates at which privately insured patients elect to be treated as private patients in their hospital;
- people with private health insurance or contemplating taking it out may base a decision on whether or not to use a public hospital according to potential gap payments or out-of-pocket expenses for treatment as a private patient;
- declining rates of Department of Veterans' Affairs coverage in the ageing population may increase rates of treatment as public patients in those age groups;
- the impact of Lifetime Health Cover on people turning 30, prompting many people to take out private health cover;
- regular adverse publicity concerning the public hospital system potentially causing reduced consumer confidence in the public system;
- changes in public hospital waiting list policies and practices in States and Territories;
- private health insurance premium increases and consumers' perception of the value of the private health insurance product; and
- the impact of further changes to private health insurance policy generally.

It is because of this range of factors that simply observing baseline health service utilisation information before and after the changes to the MLS income thresholds is not sufficient to determine causal links between any observed changes in public hospital usage and changes to the MLS (KPMG 2010:8).

Use of public hospitals by MLS 'avoiders'

Macintosh (2007) argued that purchasers of low-cost hospital cover products have little incentive to nominate to use their private health insurance when using public health services.

People with private health insurance can elect to be a public or a private patient in a public hospital. Information from the Ipsos surveys indicates that in the last five years the majority

of people who say that they had taken out hospital insurance to avoid the MLS would use their private health insurance if they went to hospital. In 2009, 56 per cent of MLS 'avoiders' said they would use their insurance if they had to go to hospital, while 21 per cent of avoiders said they would not use their insurance, and 23 per cent said they did not know whether they would use their insurance or not. Ipsos survey report authors, however, say that there are indications that more MLS avoiders would choose to enter a public hospital as a public patient than the survey results suggest. The authors suspect that this is related to many avoiders having policies with excesses and/or co-payments, and the high percentage of 'don't know' responses may be related to avoiders with their excesses and/or co-payments in mind.

Again, situations such as these make it very difficult to determine the impact of the changes to the MLS thresholds on public hospitals.

Impact on health professionals

There are no data available that could provide information on the impact of the changes to the MLS thresholds on health professionals. Several peak bodies for health professionals were represented in the Senate inquiry, which is discussed in the consultation section of the PIR.

CONSULTATION

Stakeholders affected by increases to MLS income thresholds are:

- taxpayers;
- persons with private health insurance;
- private health insurers;
- private hospitals;
- state/territory health departments and public hospitals; and
- health professionals.

Several forms of consultation about the impact of the changes to the MLS income thresholds have been drawn upon for this PIR. These are:

- a Senate inquiry on the proposed changes held in 2008;
- consultation undertaken as part of the independent review of the impact of the changes to the MLS thresholds on public hospitals;
- private health insurance premium rounds; and
- consultation undertaken by the Consumer's Health Forum.

Table 7 summarises stakeholder views put forward in various forms of consultation about the MLS income threshold increases. Further information on consultation proceedings can be found at Appendix C.

Table 7: Stakeholders affected by increases to MLS income thresholds: Summary of stakeholder views

Stakeholder	Consultation	Views
Consumers	Senate inquiry 2008	• Concerned that if thresholds were increased to $100,000 for individuals and $150,000 this would cause some to drop out or not take up cover, causing premiums to rise. Said that a small increase in thresholds was acceptable, in line with an indexation measure such as CPI (National Seniors Australia) • Supportive of thresholds being increased to $100,000 for individuals and $150,000 for families (CHOICE; Dr G Taylor—private capacity; Mr M Cribbin—private capacity).
	Consumer's Health Forum 2010	• Nil response.
Private health insurers	Senate inquiry 2008	• Concerned that if thresholds were increased to $100,000 for individuals and $150,000 for families that people would drop out or not take up cover, causing premiums to rise. However, insurers did state that a small increase in thresholds was acceptable, in line with an indexation measure such as CPI (the Health Insurance Restricted Membership Association of Australia; nib; HBF). • Argued that increases in the thresholds would put upwards pressure on premiums, causing people to drop out or not take up cover. Opposed any threshold increases (Australian Health Insurance Association; Health Partners Limited).
	KPMG review 2009	• Said that private health insurance membership had continued to grow, but the rate of new memberships had fallen since the thresholds were increased (Australian Health Insurance Association; the Health Insurance Restricted Membership Association of Australia; Reserve Bank Health Society; Railways and Transport Health Fund; Phoenix Health Fund; CBHS Health Fund; Medibank Private; nib).
	2009 premium round	• Anticipated private health insurance membership to decline as a result of the threshold increases (various health insurers).
	2010 premium round	• Anticipated slower membership growth as a result of the threshold increases, rather than decreases in membership (various health insurers).
	2011 premium round	• Anticipated slower membership growth as a result of the threshold increases, rather than decreases in membership (various health insurers).

Stakeholder	Consultation	Views
	Additional Estimates Senate Hearings 2010	• Said that growth in private health insurance membership was continuing at a lower rate since the global financial crisis in 2009. Threshold increases would have had some effect, but broader economic conditions were the dominant factor (Medibank Private).
Private hospitals	Senate inquiry 2008	• Concerned that if thresholds were increased to $100,000 for individuals and $150,000 for families that people would drop out or not take up cover, causing premiums to rise. Said that a small increase in thresholds was acceptable, in line with an indexation measure such as CPI (Australian Private Hospitals Association, Catholic Health Australia).
	KPMG review 2009	• No views raised.
State/Territory health departments and public hospitals	Senate inquiry 2008	• Concerned that if thresholds were increased to $100,000 for individuals and $150,000 for families that people would drop out or not take up cover, causing additional demand for public hospital services (Western Australian Department of Health).
	KPMG review 2009	• Said that there had been no major changes to public hospital admissions since the thresholds were changed (State/Territory health departments).
Health professionals	Senate inquiry 2008	• Argued that increases in the thresholds would put upwards pressure on premiums, causing people to drop out or not take up cover. Opposed any threshold increases (Australian Medical Association). • Concerned that if thresholds were increased to $100,000 for individuals and $150,000 for families that people would drop out or not take up cover, causing premiums to rise. Said that a small increase in thresholds was acceptable, in line with an indexation measure such as CPI (Royal Australian College of Surgeons). • Supportive of thresholds being increased to $100,000 for individuals and $150,000 for families (Australian Nursing Federation; Doctor's Reform Society; Public Hospitals, Health and Medicare Alliance of Queensland)

CONCLUSION

In conclusion, increasing the MLS threshold achieved the government's objective to refocus its application to higher income earners. The evidence to date have shown that in meeting this objective, the number of people with private health insurance has not declined or resulted in adverse impacts to other parts of the health system.

The MLS income thresholds of $50,000 for singles and $100,000 for couples and families were originally chosen by the Government to target high income earners. The Government increased the MLS single and family income thresholds and applied ongoing indexation in 2008 to address the problem that the thresholds had remained unchanged since the policy measure was introduced in 1997, and that the measure was no longer only targeting high income earners. By 2008, around a third of single taxpayers earned more than $50,000 per annum.

In increasing the MLS income thresholds in 2008, the Government also had the objective of providing tax relief. According to estimates provided by the Department of the Treasury, the number of individuals paying the MLS decreased by approximately 73 per cent between 2007–08 and 2008–09, resulting in a tax saving for approximately 547,400 individuals.

Analysis of the impacts on various stakeholders affected by the increase in the MLS thresholds has shown that, thus far, there have been no significant adverse affects resulting from the policy. In making this conclusion, it should be noted that many factors contribute to changes in private health insurance membership, and that baseline measures in variables such as health services utilisation and number or per cent of the population insured is not sufficient to determine causal links between the policy and changes in the baseline measures.

Examination of baseline measures has shown that since the MLS thresholds were increased in 2008 and indexation was applied:

- the percentage of the Australian population with private health insurance for hospital treatment, and the number of persons with private health insurance for hospital treatment has grown at a lower rate than the growth experienced by the sector in the previous two years. However, the annual growth rate in the percentage of the population with private health insurance for hospital treatment has been at an equal or higher rate than most years since the policy was introduced in 1997, except for the peaks in 2000 and 2001;
- in 2009, private health insurance hospital treatment participation (percentage of Australians covered) fell for people aged 15 to 29 years, 45 to 59 years, and those aged 85 and over, compared with increases in participation for all other age groups. This was in-line with a relatively stable or marginally increasing proportion of the population covered over the preceding three to four years;
- in 2008 and 2009 the number of people with private health insurance for hospital treatment continued to increase across all age groups;
- several private health insurers and the largest private hospital operator in Australia have returned sound annual profits;

- annual average private health insurance premium increases since 2007 have been less than the average for the five-year period 2003–2007;
- the number of private hospital separations and the rate of private hospital separations per 1,000 population continued to grow, and the average growth rate per annum for separations and separations per 1,000 population was greater for private hospitals than public hospitals;
- total private hospital revenue has continued to increase; and
- anecdotally, State and Territory health departments have reported no major changes in admissions to public hospitals.

Consultation undertaken for the Senate inquiry into the changes in 2008 found that most stakeholders were comfortable with increasing the thresholds from the levels set in 1997, either by increasing the thresholds to an amount equal that which would have resulted if some form of indexation been in place since 1997, or increasing the thresholds to an amount above that. The 2008 legislation essentially reflected this position.

As the changes to the MLS thresholds have only been applicable to tax returns for the 2008–09 financial year onwards, the data and information available at the time of preparation of this report have been limited to observation of short-term impacts. The review of the impact of the policy on public hospitals (which also considers impacts on private health insurers and private hospitals), to be undertaken after each anniversary of the commencement of the Act for a period of three consecutive years will be able to provide a more comprehensive picture of the impacts of the policy.

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Appendix A – LEGISLATION BACKGROUND

The *Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Act (No. 2) 2008* amended the *Medicare Levy Act 1986* and *A New Tax System (Medicare Levy Surcharge-Fringe Benefits Act) 1999*.

The primary legislation authorising the introduction of the MLS was enacted as part of the 1996–97 Federal Budget: *Taxation Laws Amendment (Private Health Insurance Incentives) 1996*.

The Tax Laws Amendment (Medicare Levy Surcharge) Bill 2008 was introduced to the House of Representatives on 27 May 2008 and passed on 29 May 2008. The Bill was defeated in the Senate on 24 September 2008.

A new Bill (Tax Laws Amendment (Medicare Levy Surcharge Thresholds) (No. 2) Bill 2008) was introduced to the House of Representatives on 25 September 2008. This Bill was passed with amendments in the Senate on 16 October 2008 and received Royal Assent on 31 October 2008. The *Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Act (No. 2) 2008* (the Act) raised the MLS threshold for individuals to $70,000 per year. For couples and families, the threshold was raised to $140,000 per year. These changes applied to income tax returns for the 2008–09 financial year and continue for subsequent years. The Act also indexes the individual MLS income threshold annually against full-time adult Average Weekly Ordinary Time Earnings (AWOTE), and for the family MLS income threshold to equal double the individual surcharge threshold. For families with dependent children, the threshold would continue to be increased by $1,500 for each dependent child after the first. The definition of appropriate hospital insurance remained the same.

Transitional arrangements formed part of the Act, so that persons earning above the new income thresholds acquiring appropriate hospital insurance between the Act's date of Royal Assent and 1 January 2009 would avoid liability for the MLS for the period 1 July 2008 to 31 December 2008.

Appendix B - Hospital Treatment Participation

Table 9: Hospital treatment participation, number of persons covered and per cent of the population covered, 2000 to 2011

Financial year ending	Number of persons covered ('000)	Per cent of population covered	Number of policies ('000)	Number of persons covered: annual change	Number of persons covered: annual per cent rate of change
June 2000	8,236	43.0	3,874	n.a.	n.a.
June 2001	8,712	44.9	4,072	476,000	5.8
June 2002	8,705	44.3	4,074	-7,000	-0.1
June 2003	8,639	43.4	4,070	-66,000	-0.8
June 2004	8,627	42.9	4,074	-12,000	-0.1
June 2005	8,699	42.7	4,119	72,000	0.8
June 2006	8,846	42.7	4,200	147,000	1.7
June 2007	9,145	43.4	4,368	299,000	3.4
June 2008	9,534	44.4	4,585	389,000	4.3
June 2009	9,745	44.4	4,703	211,000	2.2
June 2010	9,974	44.7	4,822	229,000	2.3
June 2011	10,256	45.3	4,967	282,000	2.8

Source: PHIAC A Report, various quarters.

Table 10 contains a breakdown by age group of the per cent of the population covered for hospital treatment over time. The two age groups with the lowest participation between 2000 and 2010 have consistently been the 20–24 years and 25–29 years age groups. Of note is the change in percentage points over this period, with the 20–24 years age group increasing 5.6 percentage points from 25.6 per cent in 2000 to 31.2 per cent 2010, and the 25–29 years age group increasing 3.9 percentage points from 26.3 per cent to 30.2 per cent over the same period. Participation for all other age groups up to 55–59 years ranged from a 0.4 percentage point increase (30–34 years) to a 5.1 per cent percentage point decrease (45–49 years).

Between 2008 and 2009 there was a very slight decrease in the 20–24 and 25–29 years age groups, but hospital treatment participation still remained at the highest levels for these age groups seen since, and including, the year 2000.

Table 10: Hospital treatment participation, per cent of the population covered by age group, 30 June 2000 to 30 June 2010

Age group	June 2000	June 2001	June 2002	June 2003	June 2004	June 2005	June 2006	June 2007	June 2008	June 2009	June 2010
0-4	37.8	38.3	37.7	37.3	37.0	37.0	37.2	38.3	39.6	39.6	39.8
5–9	41.5	43.3	41.9	40.6	39.6	39.1	38.9	39.8	41.3	42.0	42.9
10–14	45.4	47.7	45.9	44.2	42.8	41.9	41.3	41.5	42.3	42.5	42.9
15–19	42.4	46.6	46.7	45.8	44.7	44.1	43.5	43.1	42.9	42.7	42.9
20–24	25.6	28.3	30.1	28.9	29.4	29.4	30.3	31.0	31.8	31.4	31.2
25–29	26.3	26.2	26.0	25.9	25.7	25.9	26.6	28.5	30.7	30.4	30.2
30–34	42.0	43.4	41.4	39.7	38.4	38.0	38.2	39.8	42.1	42.2	42.4
35–39	45.7	48.2	46.4	44.9	43.8	43.3	43.2	43.9	45.1	45.3	45.7
40–44	50.2	52.6	50.5	48.6	47.2	46.2	45.5	45.8	46.7	46.7	47.1
45–49	54.6	57.1	55.4	53.4	51.9	50.8	50.1	50.0	50.2	49.7	49.4
50–54	56.9	59.2	57.8	57.0	56.0	55.1	54.2	54.0	54.1	53.6	53.3
55–59	55.4	57.4	57.6	57.1	56.6	56.5	56.8	56.8	57.1	56.7	56.5
60–64	49.1	50.7	51.6	52.0	52.7	53.5	54.0	55.2	56.0	56.4	56.7
65–69	43.3	43.9	44.9	45.6	46.6	47.7	49.0	50.4	51.5	52.7	53.8
70–74	41.4	41.8	42.4	42.6	42.8	43.6	44.5	45.6	46.9	48.2	49.2
75–79	34.3	35.1	36.8	38.5	40.3	41.9	43.5	44.3	45.0	45.7	46.4
80–84	33.8	32.9	32.6	32.4	32.7	33.8	35.5	37.6	40.0	42.2	44.1
85–89	35.8	35.0	34.7	33.9	33.5	32.7	32.7	32.6	32.9	33.2	34.4
90–94	35.7	35.1	35.4	34.8	34.7	34.2	34.3	34.3	34.1	33.5	32.2
95+	36.8	33.1	33.7	32.6	33.0	33.2	34.1	33.6	33.2	32.5	31.4
Total	**43.0**	**44.9**	**44.3**	**43.4**	**42.9**	**42.7**	**42.7**	**43.4**	**44.3**	**44.4**	**44.6**

Sources: PHIAC A Report, various quarters; Australian Bureau of Statistics (ABS) 3101.0 - Australian Demographic Statistics, June 2010, released 21 December 2010

Appendix C – Summary of consultations

Senate inquiry

In June 2008 the Senate referred The Tax Laws Amendment (Medicare Levy Surcharge) Bill 2008 to the Senate Standing Committee on Economics for inquiry and report by August of that year. The Senate inquiry was in relation to the first Bill, in which the proposed MLS income thresholds were **$100,000** for singles and **$150,000** for families, with **no indexation.** The Senate Standing Committee released its report, *Tax Laws Amendment (Medicare Levy Surcharge Thresholds) Bill 2008* (Commonwealth of Australia 2008c), in August 2008.

The Senate inquiry received 22 written submissions, including from consumers and consumer groups, medical profession peak bodies, health insurers, the Australian Government Department of Treasury, the Australian Private Hospitals Association, various academics, consultants, and others. Public hearings were held in six Australian capital cities in July and August 2008. Witnesses at the hearings included individuals from many of the groups that made submissions, and State/Territory and Australian Government health departments.

Senate inquiry: stakeholders critical of the changes

Many submissions and representations to the inquiry argued that if the MLS income thresholds were raised, many young and healthy people would drop their private health insurance cover, or not take out cover, because they would no longer be liable for the MLS.

They argued that this would cause premiums to rise, leading to further dropouts from health insurance and subsequent premium increases (Commonwealth of Australia 2008c:7). However, several of these submitters reasoned that a smaller increase in the thresholds was acceptable, in line with an indexation measure such as the CPI. Among those who argued that the threshold increases announced in the May 2008 Budget would put upwards pressure on premiums but agreed that a smaller increase in the thresholds would be acceptable were:

- the health insurance advisory and comparison service iSelect (in its submission in July 2008 iSelect said that parity could be achieved with the 1997 MLS threshold levels by indexing by CPI);
- the Health Insurance Restricted Membership Association of Australia (submission July 2008);
- the Australian Private Hospitals Association (submission July 2008);
- the Private Health Insurance Intermediaries Association (submission July 2008);
- Catholic Health Australia (submission July 2008);
- Health Link Consultants Pty Ltd (submission July 2008);
- John Small Health Advisory (submission July 2008);
- National Seniors Australia (representation July 2008);
- 1805 Consulting (submission July 2008);
- the health insurer nib (submission July 2008);
- the Royal Australasian College of Surgeons (submission July 2008); and
- the health insurer HBF Health Funds Inc (representation July 2008, said that it would only support a small increase and indexation of the thresholds if analysis showed the existing balance between the public and private sectors was maintained).

A smaller selection of submissions and representations to the inquiry said that the threshold increases announced in the May 2008 Budget would put upwards pressure on premiums and that ideally the thresholds should not be changed from the 1997 levels:

- the Australian Health Insurance Association (submission July 2008; representation July 2008);
- the Australian Medical Association (AMA) (submission July 2008; representation August 2008);
- the health insurance advisory and comparison service iSelect (in its representation in August 2008 it stated that the 1997 MLS threshold levels should not be indexed and that the existing thresholds should be maintained) and;
- Health Partners Limited (representation July 2008).

The health insurance advisory and comparison service iSelect had differing views in its submission compared with its representation.

A further selection of representations to the inquiry said that the threshold increases announced in the May 2008 Budget would put upwards pressure on premiums and that ideally the thresholds should not be changed from the 1997 levels, however, the participants did not speak to indexation of the thresholds:

- the health insurer Health Insurance Fund of Western Australia (representation July 2008);
- The health insurers Teachers Union Health Fund and Queensland Teachers Union Health Fund (representation July 2008); and
- the health insurer BUPA (representation July 2008);
- the health insurer Manchester Unity (representation July 2008).

Senate inquiry: stakeholders supportive of the changes

Many submissions and representations were generally supportive of the changes to the MLS income thresholds, and/or said that there would be no significant adverse impacts. Some suggested that the changes did not go far enough and that Government incentives for private health insurance, or private health insurance itself, should be abolished:

- Dr Greg Taylor, private capacity (submission July 2008);
- Associate Professor Elizabeth Savage, University of Technology, Sydney (submission July 2008);
- Dr John Deeble, The Australian National University (submission July 2008);
- Mr Ian McAuley, Centre for Policy Development and University of Canberra (submission July 2008);
- the consumer organisation CHOICE (submission July 2008);
- the Australian Nursing Federation (submission August 2008 and representation July 2008);
- Mr Michael Cribbin, private capacity (submission July 2008);
- the Doctor's Reform Society (representations July and August 2008);
- the Public Hospitals, Health and Medicare Alliance of Queensland (representation July 2008);
- Professor Leonie Segal, Chair of Health, Economics and Policy at the University of South Australia (representation July 2008); and
- Professor Christian Gericke, Professor of Public Health Policy, and Director, Centre for Health Services Research, University of Adelaide (representation July 2008).

Senate inquiry: State Health Departments

Representatives from the Western Australian Department of Health appeared before the Senate inquiry in July 2008. The Department had undertaken modelling on the impact of the MLS changes on Western Australia's public hospital system. The modelling showed that the changes could have resulted in an additional 12,511 public patient weighted separations in 2007–08, and that a further 83 public hospital beds could have been required (Lawrence, 2008:3).

The representatives from the Western Australian Department of Health put forward two options to address the impact of the MLS changes in their State:

- for their State to seek financial compensation from the Australian Government through the Australian Health Care Agreements; or
- to implement programs that address the unique characteristics of the Western Australian health system in partnership with the Australian Government.

Senate inquiry: impact on health professionals

As there are no data on the impact of the changes to the MLS thresholds on health professionals, their submissions and representations at the Senate inquiry have been used to inform the RIS of the significant issues affecting this stakeholder group.

The AMA did not specifically mention the impact of the MLS changes on its members in its submission to the inquiry. The topic was raised by a senator during the AMA's representations in August 2008, with the AMA representative replying that "private health insurance can cover some aspects of the medical income" (Sullivan 2008:28).

The AMA's submission and representations at the inquiry mainly concerned its desire that both the public and private health systems remain strong in Australia.

The Royal Australasian College of Surgeons also did not specifically mention the impact of the MLS changes on its members in its submission to the inquiry. Its submission concerned the detrimental impact of the changes to the MLS thresholds on public hospitals, with the position that the MLS income thresholds should not be increased in 2008 beyond what they would have been if indexed with the CPI in 1997, and that annual indexation of the thresholds by the CPI would be fair, equitable, and non-partisan.

Like the AMA and the Royal Australasian College of Surgeons, the Australian Nursing Federation also did not specifically mention the impact of the MLS changes on its members in its submission to the inquiry. In its submission, it argued that the Government should be less concerned with subsidising private health insurers and more concerned with funding the public health sector.

The Doctor's Reform Society argued in its representation to the inquiry that private health services in Australia were heavily Government subsidised and very expensive. It also argued that increases in private health insurance membership do not reduce demand for public hospitals. On the topic of the impact on health professionals, its representative said:

> …health service providers go where the people are. That is what has happened. Doctors and nurses have moved towards the private system but, if people move back into the public system, the providers will then move with the patients, and having more people in the public system gives better public support.

(Schrader 2008:34).

KPMG report

As part of its first year review report, KPMG consulted with the following stakeholders:

- All State and Territory health departments;
- The Australian Private Hospitals Association;
- Catholic Health Australia;
- The Australian Health Insurance Association;
- The Health Insurance Restricted Membership Association of Australia; and
- Six private health insurers.

In consulting with State and Territory health departments about the changes to the MLS thresholds, KPMG found that anecdotally, there had been no major changes to public hospital admissions. The departments generally felt that if any changes were to occur that they would happen in the long-term (KPMG 2010:4).

KPMG held a brief workshop in October 2009 with two representatives from the two peak organisations representing private hospitals in Australia: the Australian Private Hospitals Association and Catholic Health Australia. The review report did not indicate that the private hospital representatives put forward any views on the impacts of the changes to the MLS thresholds at the workshop (KPMG 2010:13).

The workshop held in October 2009 also included a longer session with six health insurers and representatives from the two peak insurer organisations: the Australian Health Insurance Association and the Health Insurance Restricted Membership Association of Australia. The participants reported that while they were still gaining new memberships, they had found that the rates of new memberships had fallen since the introduction of the changes to the MLS thresholds (KPMG 2010:20–21).

Medibank Private: Additional Budget Estimates Senate Hearings 2009 and Additional Estimates Senate Hearings 2010

As mentioned previously, the Managing Director of Medibank Private, Mr George Savvides, spoke to the changes to the MLS thresholds at Additional Budget Estimates Senate Hearings 2009 and Additional Estimates Senate Hearings 2010. At these hearings, Mr Savvides said that Medibank Private's membership had continued to grow since the changes to the thresholds, but that the growth rate was lower than that the high rates experienced during 2007 and 2008. Mr Savvides also said that broader economic conditions had had more of an impact on membership changes than the MLS income threshold changes.

Premium round applications

Feedback from health insurers for the last three premium rounds indicated that health insurers generally anticipated slower membership growth rather than a decrease in membership. No insurers provided numerical data to support their claims other than assumptions on future membership changes (Various health insurers, unpublished 2008, 2009 and 2010).

Premium round applications

Feedback from health insurers from the 2009 premium round showed that around two-thirds anticipated that changes to the MLS income thresholds would have some impact on increasing premiums, and approximately one-third of insurers cited a figure (percentage or whole number) by which they were anticipating membership to decline as a result of the MLS changes (Various health insurers, unpublished 2008).

Feedback from the 2010 premium round showed that around half of all health insurers anticipated slower membership growth in 2010, rather than a decrease in membership (Various health insurers, unpublished 2009). Factors cited by insurers were generally rising healthcare costs, increasing utilisation and advances in medical technology.

Feedback from the 2011 premium round showed that only a few insurers mentioned the changes to the MLS income thresholds in their premium applications. Again the general consensus was that insurers anticipated slower membership, rather than a decrease in membership (Various health insurers, unpublished 2010). Factors cited by insurers were generally rising healthcare costs, increasing utilisation and advances in medical technology.

Consumer's Health Forum

In May 2010, the Consumer's Health Forum (CHF) included an article on the changes to the MLS thresholds in their newsletter *healthUPdate*. The article contained information on the changes and invited members to comment on any impacts the changes had on them. The newsletter was circulated to all of its member organisations, reaching thousands of Australian health consumers. The CHF received no responses from its members about the article.