

Private Health Insurance Consultations

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Introduction – we need a wider inquiry

We welcome the Commonwealth's initiative in consulting on private health insurance. It is evident from the regular ACCC reports on PHI that there is widespread consumer dissatisfaction with the industry, particularly around people's experience when they come to make claims on their policies.

There are also many consumers who have problems affording the cost of their health care but whose needs are not met by PHI. Inasmuch as the Commonwealth sees PHI as a major mechanism through which it supports people to afford out-of-pocket health care costs, we feel that these consumers' needs should be included in the scope of the current inquiry.

There is a view, implicit in the ACCC reports, that the problems faced by consumers (and by those who are turned off PHI) can be solved by the provision of more standardised and legible information at the time of purchase, so that consumers are well-informed on exclusions and deductibles. Also the ACCC reveals concerns about affordability of PHI, particularly in this time of tightening real incomes.

The ACCC has correctly painted a picture of "confusopoly" around the 20 000 PHI products on offer.

There is good reason to improve the quality of consumer information. And we are well aware of the affordability issue, with the real cost of PHI having risen by around five per cent a year since 2000, to be now 55 per cent higher than at the beginning of the century.¹

The question we raise, however, is whether PHI can serve a useful role in funding health care. As pointed out in the major Centre for Policy Development study "Private Health Insurance: High in cost and low in equity",² a multitude of competing insurers leads to significant market failures, most notably an incapacity to control moral hazard and an inability to act in the consumers' interest when confronted by the strong power of provider interests.

In addition to these problems is the high bureaucratic cost incurred when health funding is churned through a corporate financial intermediary: only around 85 cents in the dollar passed through PHI makes its way to fund health care, compared with around 95 cents when health care is funded through taxation and Medicare.

Our research shows clearly that among prosperous developed countries like Australia, all of which have much the same health outcomes, there is a strong and direct correlation between countries' reliance on PHI to fund health care and the total cost of health care.³ Those countries which rely on a single national insurer, generally in association with a well-structured system of consumer co-payments, manage to fund health care equitably and at low cost. (Canada and the Nordic countries are the stand-out examples).

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It is now almost a half-century since the Commonwealth has subjected PHI to scrutiny in the same way that it has examined other high-cost industries, such as clothing and motor vehicles.⁴

A 1997 Industry Commission report into PHI was about *how* to support PHI, rather than *whether* there was an economic case for supporting the industry.⁵ The strongest recommendation to emerge from that study was that there should be a broad public inquiry into Australia's health system, including financing.

The Rudd Government's National Health and Hospitals Reform Commission provided the next opportunity for a review. It was constrained, however, to ensure that "the overall balance of spending through taxation, private health insurance, and out-of-pocket contribution [should be] maintained over the next decades".⁶

More bluntly a former health minister (and future prime minister) justified support for the industry with the statement that "Private health insurance is an article of faith for the Coalition; private health insurance is in our DNA".

This permissive attitude to PHI is in spite of the annual \$11 billion and growing budgetary subsidy to the industry. (See the Appendix for a breakdown of the \$11 billion between direct outlays and taxes forgone.) As with all areas of health spending, we feel that this significant public subsidy should be assessed against other competing areas of public expenditure (or potential tax deductions) to determine whether it is delivering the best possible value for money.

Our first call on the Government, therefore, is that any policy decision that may flow from this inquiry be interim, pending a comprehensive review of the funding of health care. The threshold question should be about how Australians want to fund health care – the extent to which they want to share expenses and the extent to which they want to rely on their own financial resources.

Once this is determined, the decision about *how* funding should be shared between citizens – via public or private insurance – can be informed by empirical studies on their relative efficiency. Based on our studies we have little doubt that the most efficient and equitable way to share health care funding is through a single national insurer.

It's about funding, not delivery

We stress that our case for a single national insurer is in no way a call for an abolition of the private sector in health care delivery, or "socialised medicine", as some commentators emotionally suggest. It is about how health care is *funded*, not how it is *delivered*. There is no serious suggestion that we can or should do away with private clinics, private hospitals and private pharmaceutical firms.

We should not have to draw this distinction – the principle of differentiation between funding and delivery of services is well-established in public management. The funder-provider split is commonplace in those countries with a single insurer, where private hospitals serve a strong role in delivering services, and closer to home we have the health scheme administered by the Department of Veterans' Affairs that relies mainly on private hospitals for provision of services. Yet we often hear industry lobbies, public servants and ministers sloppily refer to the "private system", so conditioned have they become to the assumption that private hospitals can be funded only through private health insurance.

Nor are we suggesting that private insurance firms are acting in unethical ways. For the most part those employed in the industry seem to be genuinely concerned with delivering a high standard of

patient care. We find no evidence of price gouging or monopolistic behaviour in this industry. Indeed it is the very existence of competition that weakens the capacity of firms in this industry to stand up to powerful service providers: that's why a policy reliance on traditional competition measures, such as information provision, can go only so far but cannot solve systemic structural problems.

These problems have to do with the use of PHI as a means of funding health care, because there are market distortions associated with insurance of any type, public or private. Insurance is a mechanism that buys out of the discipline of markets – the presence of a price at the time a decision is made whether to purchase a service. When a service is free (or highly subsidised) at the point of delivery, that discipline is absent. Structural problems also result from the inevitable weakness of multiple funders of health care, relative to a single large purchaser.

Stop struggling with private health insurance

Ever since the Commonwealth re-introduced support for PHI in 1997 it has struggled to get the industry to function in accordance with its policy objectives – not that these objectives have ever been consistently spelled out, other than an enduring assumption that there is something “good” in having a significant proportion of the population covered by hospital insurance.

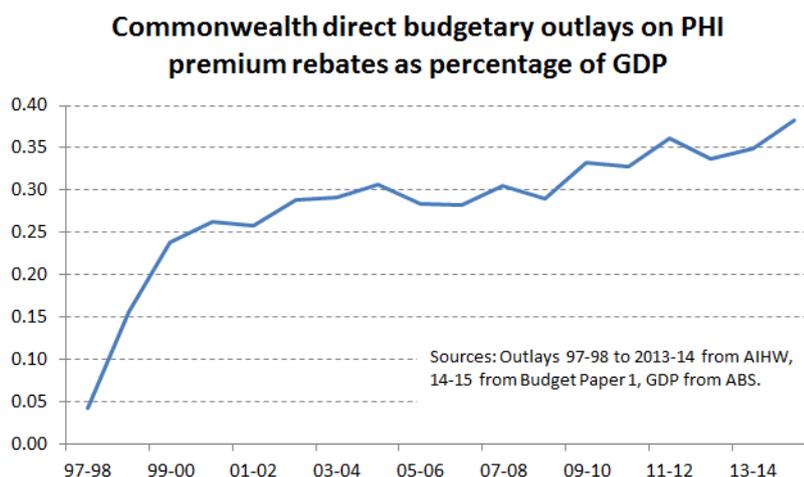
There have been many policy interventions – means tests (on, off and on again), lifetime cover, publicly-funded promotion, higher rebates for older members, the Medicare Levy Surcharge (MLS) – and still there is dissatisfaction from both consumers and policy-makers.

At least four objectives for subsidising PHI appear from time to time – containing budgetary expenditure, achieving lifetime equity (“community rating”), taking pressure off public hospitals and providing choice – as well as the idea that there is something virtuous in private insurance.

To deal with each in turn:

Containing budgetary outlays

Direct budgetary outlays to support PHI (not including revenue forgone) have continued to rise in real terms. There was a sharp rise in the early stages as people took up the incentives, but even as coverage of PHI has tended to stabilise at around 50 per cent of the population, budgetary outlays have kept growing in real terms, as shown in the graph alongside. Means testing of the rebate in 2012 had a once-off effect, but it has not reversed the trend.



The drivers of this continued rise include growing membership, more use of services per head, newer services, and price increases in established services.

On this last point it appears that prices in private hospitals, on a DRG-adjusted basis, are rising faster than prices in public hospitals as indicated by the “National Efficient Price” benchmark for public hospitals.⁷

Governments may be inclined to seek private funding mechanisms to replace budgetary outlays, but in health care this objective can be thwarted in the long run, as prices set in the private sector come to drive prices paid by governments for their remaining programs. The government loses its market power, and has to become a price taker. In the USA, for example, its Medicare and Medicaid programs, both with limited coverage, now cost the government as much (as a proportion of GDP) as comprehensive health schemes in those countries with single national insurers.

In any case it is hard to see any public benefit in shifting costs off-budget, if those same or very similar services have to be funded by private mechanisms, particularly if they are higher-cost. Australian governments have never put to the people the question whether they seek a \$1.00 decrease in taxes to be offset by a \$1.10, \$1.20 or \$1.50 increase in private outlays to fund the same services. Private health insurance, particularly when driven by the very strong incentives associated with exemption from the MLS, is essentially a privatized tax, but without the benefits of administrative efficiency, cost control, accountability and equity of official tax systems.

Governments of all persuasions are always under political pressure to keep taxes in control; insurers, by contrast, can jack up their premiums under the pretext that prices of insured services are rising strongly, even if they themselves are partly responsible for rising prices. Obtaining community views on the choice between paying more individually for health care or less via taxation is one key reason why we support a comprehensive inquiry into health funding.

Community rating

Insurance is all about spreading risk: over any period some will claim more than they pay, while others will be net payers. “Lifetime community rating” builds in a more systemic cross-subsidy, from the young to the old. (Our calculations suggest that on average those aged 30 to 55 with PHI subsidise older members.) Similarly provisions that limit discrimination on the basis of pre-existing conditions and risk factors ensure that there is a cross-subsidy from the well to the ill.

It is understandable that open-ended risk rating, particularly in Australia’s situation where there is a good public hospital system, would most probably render PHI unaffordable for the old and those with chronic conditions. Hence governments seeking to support PHI go to great effort to build in some net redistribution in PHI regulations.

But such redistributions are not always equitable by most people’s standards. PHI is expensive for young people in their 20s who are entering the workforce with high levels of education debt and also for people in their 30s and 40s, who may have reasonably high income but who also face demands from raising children, and who have high debt and little in the way of savings, in contrast to older people who may have much more capacity to deal with contingencies. Also it is important to consider the cross-subsidies in “lifetime community

rating” in the context of a taxation system that has tilted away from the young and towards benefiting older people in the form of university fees, high house prices and generous superannuation concessions.

In general, it’s a very hard task to achieve equity through fiddling with private mechanisms, which generally achieve less equitable outcomes at a higher cost. We have a tax system that is generally progressive. While no one would claim that our tax system is perfect (different people have different notions of equity), it would be hard to devise a private method of redistribution that does as well as the tax system for as low a cost.

In line with the orthodoxy of market economics, as a result of the ACCC findings the government will undoubtedly be wanting to help consumers make more informed choices. We support this idea, with the important proviso that people should be guided in the decision whether or not to hold PHI at all. The government’s “Run for cover” campaign, for example, may have left people ignorant of the universal benefits of Medicare.

Well-informed consumers, however, are not insurers’ best customers. If people who correctly assess their needs to be minor take only limited or no cover, while those who know they may have high needs take high cover, the cross-subsidies that sustain insurance are weakened. What the rational economist may see as a well-functioning market the insurer sees as a problem of “adverse selection”. Therefore there is a certain tension in the government’s desires to improve consumers’ choices and to support PHI.

The government has noted a large rise in the number of exclusionary policies over the last two years. Some may indeed be people who feel financially constrained from taking more cover, while others may simply be people exercising rational choice, particularly people with high incomes taking minimal cover to avoid the MLS. It is notable that ten years ago 59 per cent of policies were ones with co-payments and front-end-deductibles, while now 81 per cent of policies have excesses and co-payments, possibly a reflection of the government’s failure to raise the \$500 limit on front-end deductibles.⁸

One insurance product that violates most principles of equity and efficiency is ancillary insurance, which is mainly about dental care. While a few people are eligible for publicly-funded dentistry, most dental care (60 per cent) is funded by consumers’ own out-of-pocket payments.⁹ It is hard to find any justification for subsidising those who rely on PHI while relatively penalising those more self-reliant people who fund their own care.

Almost all ancillary cover, with the exception of ambulance cover, is capped, limiting the insurer’s liability and leaving the consumer subject to open-ended risk. It is hard to see how such a product can be called “insurance”.

Ideally dental care, or at least high-cost ancillary services, should be funded through Medicare, with no support from PHI. At the very least PHI ancillary subsidies should be withdrawn, saving the government around \$0.7 billion a year in subsidies.

In the context of community rating it is also important to consider the lack of equity in the current system of PHI which provides high levels of subsidies to some consumers and does not provide any benefits to others. Those who can afford the monthly premiums and co-payments associated with using their insurance when they require care receive the benefit of the tax deduction (if applicable) and the 30 per cent (or higher) rebate. However, people who are unable to afford the monthly premiums generally receive no assistance when they access private health services and pay the total cost (other than the normal MBS and PBS payments)

out of their own pocket, a situation worsened since the government has withdrawn the 20 per cent tax rebate for net medical expenses (above a threshold).

Similarly, someone with episodic health care needs who uses a range of different health services over the course of a year will receive much higher levels of benefit than someone with a chronic condition who requires regular treatment from the same provider.¹⁰ Given that Australia's health system is experiencing an increased demand for care, resulting, at least in part, from the rising rate of chronic conditions, it is vital that we find ways to fund and deliver ongoing and multi-disciplinary care equitably and efficiently. PHI, as it is currently structured, is not able to meet the needs for many people with chronic illnesses for assistance in managing their health care expenses over long periods of time.

Taking pressure off public hospitals

After fifteen years of private insurance there are still long waiting lists and waiting times for public hospitals. That is not necessarily problematic, so long as those with urgent needs are attended to promptly. A hospital with no waiting list would probably have under-used capacity, or would be providing unnecessary services.

The notion that private health insurance, through supporting private hospitals, would relieve public hospitals, was at best fanciful and at worst deceptive, because it considered only the demand side and while neglecting the supply side of health services. So long as medical specialists, nurses, operating theatres and other resources are in limited supply, resources will go to where the demand is. This point is supported by the peak body for public hospitals, the Australian Healthcare and Hospitals Association, which opposes continued subsidies to PHI on the basis that they do not benefit the public health system.

The result of subsidising PHI has simply been to re-assign queues for service, allowing some to jump the queue, thereby shuffling everyone else a little further back. Such re-assignment is not neutral, for there is no reason to believe that the person promoted has greater therapeutic needs than the people displaced – most probably it results in a worsening allocation of scarce resources (particularly in light of the fact that those with PHI tend to have better health than those without it).

Of course there are people who value an opportunity to jump the queue, but public policy that encourages such behaviour is absurd. The point was illustrated by a caller to an ABC RN talkback program, who said:

“I have heard that academic chappie (one of us who was the lead discussant) talking about private health insurance. A little while ago I had a need for some minor surgery, and with the help of private insurance I was able to get right to the front of the queue. It's a wonderful product – I think everyone should have it.”

Choice

Some people, in some situations, value choice of practitioner. But by and large people rely on expert opinion – their own GP's recommendation, or the clinicians who have been recruited to work in public hospitals. The real issue lies in sustaining high levels of professional standards so that consumers don't have to go shopping for a competent doctor.

There are, however, some situations where continuity of care is important – particularly maternity and some chronic conditions. There is no reason models cannot be developed within public hospitals and their support services that address this need. This is already being achieved to some extent in midwife-led maternity services and could easily be expanded into other areas of health care where the evidence supports the benefits of continuity of care.

Indeed, the government's *Reform of Federation Green Paper* canvasses the possibility of the Commonwealth and states developing individual care packages "for people with, or at risk of developing chronic or complex conditions".¹¹ We understand that there is some enthusiasm among state governments who are examining this possibility further.

Regarding choice of health insurer, there is little to be gained in choice in such a highly-regulated industry, where firms are constrained in their offerings. In fact, if the government does succeed in reducing the confusopoly in PHI offerings, market theory suggests that there won't even be much price dispersion among insurers.

Of course there are proposals on the table that would allow more variation in health insurers' offerings, such as the *Medicare Select* idea that emerged from the 2009 Report of the Health and Hospitals Reform Commission, essentially allowing people's taxes that they presently contribute through Medicare to be re-directed to health insurers.

Medicare Select was distinguished by its high overhead costs, involving two levels of administration, with money already taken through the taxation system being churned through the administrative layers of the health insurers.

It was not clear how those who would opt out of Medicare and into health insurers would be covered for the services presently available only in public hospitals. More basically, it was even less clear how anyone could make a sensible choice about the sort of cover they may need in the future. As has been revealed in the ACCC reports, people have enough trouble making choices involving simple monetary issues and a limited set of exclusions. When it comes to more complex contingencies, who has more than a vague (and often incorrect) idea of what their future needs will be?

The supposed virtue of private insurance

On an ABC radio interview the present Health Minister said "We support the public system for those who can't afford private health".¹² This policy view is given effect in exemption of those with high incomes (> \$90 000, or about 12 per cent above average adult full-time earnings for singles) from the MLS. The MLS exemption for people on such incomes, which many people achieve at some time over their lifetimes, has been supported by both Coalition and Labor governments. Indeed, the Rudd-Gillard government strengthened the incentives in the MLS.

The flip side of positioning "the public system" (whatever is meant by that term) as a service for the poor or the "indigent" is to ascribe some virtue to "the private system", whatever that encompasses. In the current arrangements "the private system" is almost surely about PHI and private hospitals.

Such exhortation is akin to encouraging people who are well-off to live in gated communities, to the extent of applying a 1.0 to 1.5 per cent tax surcharge on those who can afford to but do not. It is hard to conceive of a policy position that is more destructive of community values, and that is more morally offensive for those who wish to contribute to the public good

through their taxes. (Two hundred thousand Australians with incomes above the MLS threshold in fact pay the threshold, almost certainly to their personal financial detriment.¹³)

No matter how hard administrators try to maintain standards, services designed to serve only the “poor” or “indigent” inevitably deteriorate. When the well-off use the same public services as everyone else they’re bound to be kept up to high standards. The well-off inevitably have more political clout than the poor, and, because many are in professional employment themselves, they may have a more reasonable expectation of what constitutes an acceptable standard of service. When they never experience certain public services, however, the well-off have no awareness of any need to take action. (Some people attribute penal reform of the 1960s to the fact that many young people from the middle class participating in political protests found themselves imprisoned.)

We are strongly in support of retaining the MLS, but without any exemption. It would raise a little more money for Medicare (we estimate it to be in the order of \$2.5 billion a year – see the Appendix). As successive governments have learned (sometimes to their political cost) Medicare as a universal scheme is popular. The case for universality rests not only on political popularity, but also on the fact that universality gives all Australians a stake in sustaining a well-funded and high quality system of health care.

In short, in relation to all the Commonwealth’s policy objectives, there is nothing achieved by PHI that a well-funded and well-managed single insurer system could not do better – with greater technical and allocative efficiency and more equitably. Tinkering with PHI to force it to achieve these objectives is expensive and futile.

Options for reform

The *Reform of Federation Green Paper* lists a number of options for reform. We have commented above on one option (Option 3 about managed care for people complex and chronic conditions). There are two other options worthy of consideration.

Option 5 – a single national insurer

If all options for reform were on the table, we would support strongly Option 5 in the Green Paper. That is a single health purchasing agency to commission services, “including primary and acute care, from public and private providers”.

The variation of a single funder in each state, similar in respects to Canada’s system, is worthy of consideration. We note the OECD’s observation in its 2015 review of Australia’s health quality:

Adding to the Australian system’s complexity is a mix of services delivered through both the public and private sectors. To ease health system fragmentation and promote more integrated services, Australia should adopt a national approach to quality and performance through an enhanced federal government role in steering policy, funding and priority setting. The states, in turn, should take on a strengthened role as health service providers, with responsibility for primary care devolved to the states to better align it with hospital services and community care.¹⁴

Although not explicit in the Green Paper we assume that in Option 5 there would be no role for PHI, and that a reasonably well-structured system of co-payments would supplement the single insurer's funding, while providing some cost awareness.

Option 2 – a universal hospital benefit

We understand that state governments have some enthusiasm for this option. It would see Commonwealth funding applied without discrimination to public hospitals and to private hospitals on a DRG basis. The figure of 40 per cent of the “National Efficient Price” seems to have gained some traction. The balance of funding would be provided by state governments (who would be free to contract with public or private hospitals), insurers or individuals using private hospitals.

It has several economic benefits over the present arrangements. First, budgetary support for private hospitals would be direct, without being churned through the bureaucracy of PHI. Second, it would put private and public hospitals on a genuine competitive footing. Third, it would remove the present fragmentation and funding complexity in private hospitals, which sees separation of “medical”, “hospital” and “pharmaceutical” services. And fourth, it would be fairer for those who self-insure and use private hospitals. (It's ironic that health ministers from the Liberal Party, a party that stresses the virtue of self-reliance, have instituted a policy that actually penalises those who take responsibility for paying for their own health care instead of than handing over responsibility to an insurance firm.)

Insurers would be free to offer their services, but they would have to be able to offer a value proposition superior to self-insurance. Such competitive pressure may nudge them away from being mere financial intermediaries towards offering useful services to consumers.

In bringing a fairer deal for those who self-insure the proposal is fitting for a prosperous country where there is a great amount of personal wealth. Older people, the highest users of health care, are wealthier than ever before, and, thanks to superannuation, are becoming wealthier. Older couples (>64) have around \$570 000 in financial assets, while older singles have about \$200 000.¹⁵

Some suggest that a portion of people's wealth should be directed to health savings accounts, but there is no economic virtue in quarantining people's wealth. A person in good health who has a high balance in a health savings account but is otherwise having trouble making ends meet would clearly resent such paternalistic compulsion. And a health savings account, once it has a high balance, carries a “use it or lose it” moral hazard for both the holder and the service provider. Another reason for avoiding health savings accounts is that the philosophical underpinnings of this form of health funding – that people are responsible for their health status – is being increasingly challenged by research demonstrating the strong influence of both genetic and social determinants on an individual's health and life expectancy.

If Option 2 is adopted, there should be no exemption from the MLS. Otherwise PHI would be doubly subsidised – once through the 40 per cent funding to private hospitals, and again through the MLS incentive. Insurers don't need a carrot *and* a stick, and, more important, an industry with a captive clientele has little incentive to improve its product. (Even in the absence of explicit collusion, inter-firm competition is less effective than competitive pressure on a whole industry.)

In order to avoid the moral hazard of free services, private insurers should not be permitted to provide cover any more advantageous than that which is available in Medicare and in public hospitals. If, for example, public hospitals ever charge co-payments, private insurers should be prohibited from offering “no gap” policies (while being encouraged to provide “known gap” policies).

This principle also means insurers should not be permitted to subsidise ambulatory services not provided in hospitals. So long as Medicare funds medical services the product private insurers offer would be gap insurance, thus contributing to fee escalation for those without insurance and drawing resources away from those with higher therapeutic needs – a repetition of what has happened with hospitals.

Of course the best way to avoid pressure on Medicare medical charges is to raise the reimbursement for services and to consider options other than fee-for-service. The freeze on nominal payments is leading to a combination of over-pricing for some and distorted service patterns in high throughput clinics reliant on direct billing. In this regard, fixed gap payments should be on the table, but the government should do a far better job at engaging with the public before developing any firm proposals.

And the success of this option is dependent on the Commonwealth being willing to support state government finances. The states would find it hard to go on funding 60 per cent of hospital services without some better revenue base.

Appendix – present government support for private health insurance

Although a figure of \$6 billion is often cited as the level of annual government support for PHI, the actual subsidy is more in the order of \$11 billion.

There are three levels of subsidy.

First is the budgetary outlay for the 30, 35 and 40 percent rebate. In 2015-16 this is estimated at \$6 341 million (*Budget Paper 1*, Table 8.1, Page 5.23). This is the most-often used figure.

Second, and frequently overlooked, is the \$1 690 million in the Tax Expenditures Statement, (*Budget Paper 1*, Table A1, Page 4.21). This is revenue forgone, because the rebate is not counted as taxable income in the hands of the beneficiary.

Third, and even more frequently overlooked, is exemption of those whose income is above a threshold from the Medicare Levy Surcharge. This is essentially a tax expenditure, but because it does not appear in budget papers it has to be estimated separately from income tax statistics, the latest available being for 2012-13.

In that year the thresholds and rates were:

Tier	Single threshold	Family threshold	Rate
1	\$84 001	\$168 001	1.00 percent
2	\$97 001	\$194 001	1.25 percent
3	\$130 001	\$260 001	1.50 percent

While the Tax Office publishes data on the number of individual taxpayers within reasonably narrow bands, it does not reveal whether such individuals are singles or contributors to family income.

We have therefore made two estimates in the table over the page:

Assuming all are single;

Assuming all are sole earners in families.

The first gives a high estimate of the tax that would have been collected had there been no exemptions (\$3 808 million), while the second gives a low estimate (\$1 345 million). From these high and low estimates must be subtracted levies actually paid (\$249 million), presumably by high income earners without PHI.

Finally, to bring these to comparable 2015-16 figures, for consistency with budget papers, they are indexed upwards by 9 per cent, to account for nominal GDP growth.

In short, the upper estimate is \$3.9 billion, and the lower estimate is \$1.2 billion a year. Splitting the difference, for want of harder data on the singles/family mix, gives a cost of around \$2.5 billion.

That means, in round numbers, the financial subsidies to PHI in 2015-16 are:

Direct outlays	\$ 6.3 billion
Income tax forgone from subsidies	\$ 1.7 billion
Income tax forgone from MLS exemption	\$ 2.5 billion
Total	\$10.5 billion

This does not include “in kind” support for PHI, associated with promotion, such as the “Run for Cover” campaign, and political exhortation encouraging people to take PHI.

Estimate of revenue forgone from exemption from MLS

ATO income range	Mid point	Number of taxpayers	Assuming all single		Assuming all sole earners in family	
			Levy	Revenue forgone \$m	Levy	Revenue forgone \$m
84,403 to 86,148	85 276	94 780	1.00%	80 824	0.00%	0
86,149 to 88,009	87 079	94 785	1.00%	82 538	0.00%	0
88,010 to 90,014	89 012	94 740	1.00%	84 330	0.00%	0
90,015 to 92,196	91 106	94 755	1.00%	86 327	0.00%	0
92,197 to 94,587	93 392	94 810	1.00%	88 545	0.00%	0
94,588 to 97,154	95 871	94 715	1.00%	90 804	0.00%	0
97,155 to 99,939	98 547	94 795	1.25%	116 772	0.00%	0
99,940 to 102,990	101 465	94 740	1.25%	120 160	0.00%	0
102,991 to 106,393	104 692	94 780	1.25%	124 034	0.00%	0
106,394 to 110,213	108 304	94 755	1.25%	128 279	0.00%	0
110,214 to 114,527	112 371	94 760	1.25%	133 103	0.00%	0
114,528 to 119,379	116 954	94 760	1.25%	138 531	0.00%	0
119,380 to 124,876	122 128	94 760	1.25%	144 661	0.00%	0
124,877 to 131,208	128 043	94 790	1.25%	151 714	0.00%	0
131,209 to 138,699	134 954	94 760	1.50%	191 824	0.00%	0
138,700 to 147,746	143 223	94 765	1.50%	203 588	0.00%	0
147,747 to 159,256	153 502	94 760	1.50%	218 187	0.00%	0
159,257 to 174,247	166 752	94 770	1.50%	237 046	1.00%	158 031
174,248 to 191,846	183 047	94 765	1.50%	260 197	1.00%	173 464
191,847 to 228,153	210 000	94 755	1.50%	298 478	1.25%	248 732
228,154 to 312,500	270 327	94 770	1.50%	384 283	1.25%	320 236
312,501 or more	312 501	94 770	1.50%	444 236	1.50%	444 236
Total				3 808 461		1 344 699
Less levy paid				248 636		248 636
Total tax forgone				3 559 824		1 096 063
Indexed by nominal GDP growth to 2015-16*				1.09		1.09
Upper and lower estimates				3 881 348		1 195 059
Mean					2 538 203	

* National accounts and budget forecasts

Endnotes

1. A calculation based on the Government's published figures on premiums and the CPI.
2. John Meandue AO and Ian McAuley, "Private Health Insurance: High in cost and low in equity", Centre for Policy Development, 2012.
http://cpd.org.au/wp-content/uploads/2012/01/CPD_DP_Meandue_McAuley_PHI_2012.pdf
3. *Ibid*, and with later data in Ian McAuley and Miriam Lyons, *Governomics: can we afford small government?*, Melbourne University Press 2015.
4. "Report of the Committee of Enquiry into Health Insurance", (The "Nimmo Report"), Commonwealth Government Printer 1969.
5. Industry Commission, *Private Health Insurance*, Report #57, February 1997.
6. "A healthier Future for all Australians" (Interim Report of the National Health and Hospitals Reform Commission), 2008, Page 300.
7. From Departmental briefings October and November 2015.
8. PHIAC and APRA reports, September 2005 and 2015.
9. AIHW *Health Expenditure Australia 2013-14*, Table A3.
10. See, for example, Jennifer Doggett, "Out of pocket: rethinking health copayments", Centre for Policy Development, July 2009.
<http://cpd.org.au/2009/07/out-of-pocket-rethinking-health-copayments/>
11. *Reform of the Federation Discussion Paper 2015*, ("Option 3", Page 38).
12. ABC RN *Breakfast* "Fed Govt considers 'lifestyle factors' in cost of private health insurance: Sussan Ley", Audio at:
<http://www.abc.net.au/radionational/programs/breakfast/fed-govt-considers-'lifestyle-factors'-in-cost/6923078>
13. In 2012-13 199 460 Australians paid the surcharge, according to the ATO 2012-13 Taxation Statistics.
14. *OECD Reviews of Health Care Quality: Australia 2015*.
15. ABS "Household Income and Wealth, Australia, 2013-14", Cat 6523.0, Table 11.2.