

Actuarial Review of Lifetime Health Cover

Department of Health



May 2022

2 May 2022

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Dear Brian

Actuarial Review of Lifetime Health Cover

The Department of Health engaged Finity Consulting Pty Ltd to undertake actuarial studies of risk equalisation and Lifetime Health Cover (LHC). This report summarises the key findings arising from our review of Lifetime Health Cover.

Lifetime Health Cover is an important part of the incentives program supporting Australia's private health insurance system, however, it remains misunderstood by some consumers with evidence of reduced potency in recent years. We have identified opportunities to enhance communications in respect to Lifetime Health Cover which would assist in addressing consumer understanding and likely increase PHI participation. We have also identified opportunities to improve the structure of Lifetime Health Cover and the overall effectiveness of this incentive, however, assessing the impact of such changes would be premature given the current review of the Private Health Insurance Rebate and Medicare Levy Surcharge, and the complex interactions between these three consumer incentives. As we have agreed, the impact assessment and final recommendations from our actuarial review will be carried over into the Private Health Insurance Rebate and Medicare Levy Surcharge review.

We have very much enjoyed working with you and your colleagues on this project, and remain available to answer questions on this report.

Yours sincerely



Nicholas Stolk



Bronwyn Hardy

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1 Executive summary

1.1 Purpose and scope

The Australian Government Department of Health (Department) has engaged Finity to undertake comprehensive actuarial studies on risk equalisation (RE) and Lifetime Health Cover (LHC). We understand the Department's objective is to assess the performance of the current settings and identify and evaluate whether there are options to make changes to these policies which could enhance the affordability, value and attractiveness of private health insurance (PHI).

The purpose of this report is to provide the Department with a summary of the key findings and recommendations from the actuarial study into LHC. A number of interim reports, provided to the Department throughout the project, document our detailed findings. This actuarial study into LHC sets out to:

- Review the effectiveness of LHC in its current form; examining the question:
 - , Are the goals and objectives of LHC being achieved?
 - > Is LHC an effective incentive to encourage Australians to obtain PHI?
 - > Is LHC an effective incentive to encourage insured Australians to maintain PHI coverage?
- Identify and review opportunities to reform LHC by exploring the question:
 - > What LHC arrangements are possibilities to better achieve objectives?
 - > What considerations should be made in any transition?

1.2 Objective and current status of LHC

The objective of LHC is to **support community rating by providing incentives for people to obtain private hospital cover¹ earlier in life and encouraging them to maintain it**. This policy seeks to achieve this objective by charging higher premiums for private hospital cover where an individual takes out cover for the first time, or has a significant break in cover, from a certain age.

LHC effectively presents a decision point for consumers: take out PHI cover before a certain age, take out PHI cover later and pay higher premiums or don't take out PHI cover at all.

At 31 December 2021²:

- There were around 900,000 policyholders subject to an LHC loading. This represents 11% of the 8.4 million "single equivalent units" (adults covered by a hospital policy).
- For policyholders subject to an LHC loading, the average loading was between 22% and 23%.
- Multiplying these numbers together suggests LHC loadings contribute around 2.4% to industry hospital premiums. This compares to a total industry net margin (profit before investment income, tax and extra-ordinaries) of 5.1%³ of total premium income. Hospital premiums contributed 73% of total premium income in FY21.

¹ LHC loadings only apply to hospital cover. General treatment ("extras") cover, Overseas Visitors Health Cover, Overseas Students Health Cover and international forms of insurance are not considered to be hospital cover for LHC purposes.

² Finity analysis of APRA HRF601 forms.

³ <https://www.apra.gov.au/operations-of-private-health-insurers-annual-report>, 20-21

1.3 Evaluation criteria

The evaluation criteria for assessing the effectiveness of reforms were developed in consultation with the Department and representatives from insurers, consumer groups and other industry bodies and encompass access, equity, efficiency and practicality.

We have focused on two quantitative measures which were formulated through discussions with the Department and other stakeholders:

- PHI hospital cover participation (simply referred to from here as “participation” and usually expressed as a rate of the Australian population)
- The average age of insured persons

Whilst not a focus of this review, it should be noted that Government initiatives are not the only way to achieve these objectives. Initiatives by PHIs to attract and retain new and younger members should also be considered. A few options were raised in stakeholder meetings, and some insurers are working to implement these measures. It will be worth the Department continuing to work with industry to monitor which of these initiatives make it to market, and how successful they are.

In addition, PHIs and Private Health providers must work together to continue to offer products and services that are valued by consumers. If this value can be effectively demonstrated, the need for incentives is minimised.

1.4 Are the goals and objectives of LHC being achieved?

In reviewing the effectiveness of LHC in its current form, we:

- Considered how LHC works as an incentive for different segments of the Australian population
- Considered the linkages between LHC and other current Government initiatives and policies in PHI
- Estimated the impact of LHC on PHI participation and the average age of the insured population
- Noted the qualitative impacts of LHC against a range of other criteria, and
- Examined the claim frequently cited by stakeholders: “LHC is becoming less effective at encouraging younger Australians to take out private hospital cover”

1.4.1 How does LHC work as an incentive to obtain and maintain PHI?

The LHC loading impacts PHI participation and the average age of the insurance pool by creating a range of incentives and disincentives as follows:

Table 1.1 – LHC incentives

Age	Without PHI		With PHI	
	Below MLS threshold	Above MLS threshold	With LHC Loading	No LHC Loading
Under 31	Incentive to insure Particularly prior to 31	MLS should incentivise to insure		May have age based discount
Over 31	Incentive to insure earlier rather than later Disincentive for some as impacts affordability	Small group, possibly making a conscious decision, but may be unaware of MLS LHC impact superseded by MLS impact	Strongest incentive to retain for those with low loadings Higher loading means less affordable	Incentive to retain policy Exit and rejoin may have penalty

1.4.2 LHC’s linkages with other PHI policy initiatives

Given LHC seeks to incentivise Australians to obtain and maintain PHI by modifying premium rates, it is clear that its effectiveness as a policy will be impacted by other policy initiatives that influence Australians’ PHI purchase and retention decisions. Most notably the success of LHC is impacted by the Medicare Levy Surcharge (MLS) and PHI Rebate. This is investigated further in Section 5.3, and the findings of the LHC review will impact the analysis of the MLS and PHI Rebate currently being undertaken.

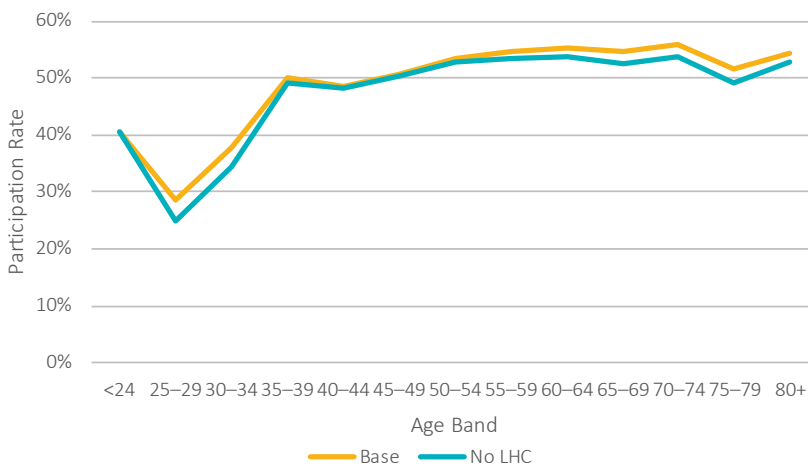
1.4.3 LHC’s impact on PHI participation and the average age of the insured population

In order to understand the overall impact of the various incentives LHC creates (see 1.4.1) we modelled the impact of the *removal* of LHC, without adjusting any other policy levers: reviewing the likely impact on PHI participation and average age profile of the insurer population five years after it was removed (as a proxy for the long-term or steady state impact). Our modelling approach is detailed in our working papers provided to the Department (“Lifetime Health Cover Modelling”), and draws on a survey of Australians with and without PHI about their price sensitivity and PHI purchase decision making.

Table 1.2 – Impact on PHI participation and average age (hospital insured persons)

	Base	No LHC	Change from Base
Participation Rate	46.1%	45.0%	-1.1%
Average Age	41.8	41.6	0.2

Figure 1.1 – Impact on PHI participation by age band



Removing LHC is projected to:

- Reduce participation from ages 25 to 34, as the incentive to participate at earlier ages is removed.
- Have an immaterial impact on participation from ages 35 to 50. While the reduced LHC loading results in higher sales at these ages, there is no longer any disincentive to lapse and so lapses are higher than otherwise. These effects are largely offsetting.
- Reduce participation at age 50 and older as the level of additional lapses projected more than offset the additional sales projected at these ages.

From this and our other analysis we conclude that LHC:

- Incentivises people to take out PHI earlier than they otherwise would have

- Incentivises people to keep their policy for longer than they otherwise would
- Reduces sales to older Australians, but not to the same extent as it encourages people to retain their policy

The overall modelled impact of LHC on PHI participation and the average age of the insured population may not appear significant (adding only 1.1% of the Australian population after five years), but removing LHC would require an industry average premium rate increase of at least 2.5%, and likely higher, to maintain the current level of financial performance and position of the PHI industry. It is important to note that this result is based on participation and average age only (replacing lost premium). While there does seem to be some selection benefits (see 1.4.4) these impacts could not be objectively sourced.

1.4.4 LHC's impact on consumer behaviour

We examined the impact of LHC on consumers in a number of key areas through both analytics and consumer surveys. In particular we examined the impact on joining behaviour, retention of PHI, claims behaviour and product selection. These are examined further in section 5.2.

The impact of LHC on consumer behaviour is complex, and highly correlated with the effects of other initiatives such as the MLS and PHI Rebate. Whilst many stakeholders focus on the impact of LHC in attracting young people, it appears that increasingly it is the retention incentive for existing policyholders that is the most significant impact of LHC. In evaluating alternatives, it is important that consideration is given to both the 'attract' and 'retain' objectives of the policy.

We also heard from a number of stakeholders about other objectives they believed LHC had, in particular, that LHC loadings serve as a deterrent to Australians joining and maintaining PHI cover only during times of healthcare need – a behaviour the 1997 Productivity Commission report⁴ noted as 'hit and run' behaviour. While LHC loadings provide some level of deterrence, they do not prevent people without PHI joining, serving waiting periods, claiming and lapsing. We saw some evidence of this behaviour in the industry dataset, and note that LHC may exacerbate affordability concerns for those joining PHI with a healthcare need, and encourage product downgrading or lapsing after their healthcare need has been met.

Surveyed consumers indicated that LHC loadings impact PHI product choice, with many stating that they would choose a lower tier product as a result of the loadings. This was supported by analysis which showed a significant proportion of customers, having served the maximum 10-year period with a loading, promptly upgrade to a higher tier hospital product.

1.4.5 LHC's impact on insurer behaviour

Our stakeholder consultation did not identify any evidence of LHC impacting insurer risk selection or sales and retention strategies. Interviews with insurers, and our own industry experience, did not identify any evidence of LHC impacting insurer risk selection or sales and retention strategies and we are not aware of any insurers who routinely analyse profitability outcomes by LHC loading.

We conclude that while LHC might be seen to generate additional revenue for the industry, in practice, all premium revenue is pooled, with LHC loading revenue allowing insurers to maintain lower premiums for those without loadings.

⁴ Industry Commission, *Private Health Insurance: Report No. 57*, Australian Government Publishing Service, 28 February 1997

1.4.6 Is LHC becoming less effective at encouraging younger Australians to obtain PHI?

During stakeholder consultation we heard that LHC was perceived to be losing effectiveness as a means of attracting younger people, as evidenced by decreasing PHI participation for under 35s (see Section 5.1.1).

In summary, we did find evidence that LHC is becoming less effective as an incentive for younger Australians to take out private hospital cover. Younger people are typically on lower incomes, and those without PHI are often earning below the MLS threshold of \$90,000. At these income levels, the threat of a future premium penalty on PHI is not significant enough to change behaviour given affordability pressures, other spending priorities including home ownership, and the presence of Medicare and the public healthcare system providing a free or low-cost alternative.

Many insurers stated that the Department's outbound LHC communication/mailout for Australians approaching their 31st birthday has significant value, and plays an important role in setting community expectations for when is an appropriate age to take out hospital cover.

A clear communication program for LHC is valuable given the complexity of the system and academic research has highlighted the favourable impacts on sales among younger Australians following changes to, and enhancement of, LHC communication. This underscores the behavioural effects the Department's communication generate and we recommend that the Department investigate running pilot programs testing the behavioural impact of different communication styles and timing with respect to LHC communications.

Importantly, while LHC may be becoming less effective as an incentive to attract young Australians to PHI, our analysis highlighted that LHC has value beyond attracting young people. In particular, LHC's incentive to encourage retention of existing policyholders assists in keeping industry premiums affordable for all. In addition, the stability provided to the market (fewer entries/exits) assists in lowering management expenses, which again flows through to the cost of purchasing cover.

1.5 Opportunities for reform

Our stakeholder workshops and interviews identified relatively few stand-alone proposals for major reforms to LHC, with more interest and thought given to changes to the MLS and PHI Rebate. Many stakeholders indicated LHC was largely working as expected, though with opportunities to reduce complexity and improve communication focused on increasing consumer understanding of LHC's purpose and impact.

Options to adjust the LHC structure to allow for income level were considered, but these were rejected due to the increased complexity and potential overlap with the existing MLS structure. The interaction between these policies will be investigated further in the ongoing MLS review.

1.5.1 Enhancing what we have

Our consultation with stakeholders indicated a number of features of LHC they would like to see retained regardless of any reform. Chief among these features was the Department's communication with young Australians to educate them about LHC and so encourage them to purchase PHI. We heard from a number of stakeholders that the Department's communication program should not be limited to a single point of contact, and that there would be value in extending this to other ages or life events.

In addition, a number of stakeholders noted opportunities for the Department to play a role in the communication to Australians about the age-based discounts, which is in effect a form of negative LHC loading. Stakeholders noted that the voluntary nature of that reform does make communication more difficult. They expressed a wish that if the Department was to consider a broader LHC communication program that thought

also be given to how tailored and timely communication about the age-based discount could assist in attracting young Australians to PHI.

Stakeholders indicated there was significant value in the communication coming from the Government as opposed to from insurers.

We note that in 2020-21, direct mail communication was sent to nearly 260,000 people, comprising nearly 37,000 recent migrants and over 222,000 residents and citizens. The cost of the mailout was just under \$330,000, which is recouped from the industry in proportion to market share (subject to regulatory limitations). The recouped funds are included in consolidated revenue and not returned directly to the Department. It must be borne in mind that introducing additional points of communication would come with associated extra costs.

1.5.2 Options for reform: alternative LHC structures

We considered a number of potential reforms, and assessed them against the evaluation criteria. We then worked with the Department to prioritise the options to model, and focussed on an examination of removing LHC loadings (see 1.4.3) and moving to tiered LHC loadings which have a step-change every decade, rather than the gradual 2% increase per year.

It was noted that there are significant interactions with other PHI incentives, in particular MLS. Reform options with significant interactions with MLS will be considered in the review of MLS and may include:

- Raising the starting age of LHC from 31 to 36 (or another identified age)
- Modifying the MLS by age to encourage earlier participation and remove the need for LHC

We have modelled one standalone reform option – tiered LHC loadings – assuming no changes in the MLS. This option was selected for modelling given stakeholder feedback and linkages to the communication opportunities identified above (1.5.1). Many stakeholders believed fewer but larger steps in the way LHC loadings are applied could enhance engagement in the PHI acquisition decision by creating fewer LHC-defined decision points. Reducing the number of LHC-triggered decision points might also assist in broadening the Department’s LHC communication program.

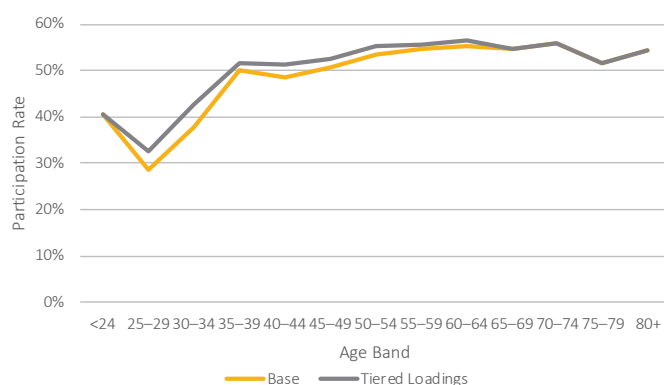
Table 1.2 shows the modelled impact of tiered loadings on the PHI participation rate and the average age of the insured population after five years of implementation.

Table 1.3 – Impacts on PHI participation and average age (hospital insured persons)

	Base	Tiered Loadings	Change from Base
Participation Rate	46.1%	47.5%	1.3%
Average Age	41.8	41.7	- 0.1

The impact on PHI participation by age band is shown below.

Figure 1.2 – Impacts on participation by age band



Implementing tiered loadings is projected to:

- Increase participation between ages 25 to 35 as the incentive to join before age 31 increases
- Increase participation between ages 35 to 60 largely due to the incentive to join before the tier increases, as the jump is sufficiently large to cause consumers to examine their options
- Have an immaterial impact on participation at older ages

Overall, tiered loadings are projected to increase participation between ages 25 to 60, which could result in a one-off premium rate reduction of up to 2.1%, however, this is unlikely to flow through immediately, as insurers are likely to adopt a prudent approach, and gradually release any savings once they have been realised.

The projected change in participation rate remains relatively small, and whilst the industry is willing to change, they only wish to do so if there are significant and tangible benefits. The costs associated with this change may not be justified by the expected outcomes, and the greatest gains, arising from the opportunity for additional communication, could be achieved without structural reforms.

1.6 Conclusion

LHC has made and continues to make a positive contribution to participation in PHI.

LHC has, historically, seemed to contribute to PHI participation outcomes in excess of that expected from a pure price or economic argument, suggesting it plays an important role in contributing to community ‘norms’ and attitudes. There is evidence that this behavioural role is weakening or becoming less relevant for younger Australians in the face of affordability challenges.

While any LHC reforms should be directed at enhancing the effectiveness of the ‘obtain’ objective, they must also be assessed against their impact on the incentive for insured Australians to maintain PHI cover.

Implications and recommendations from this study are:

- Our research and analysis did not identify an immediate imperative to change the current LHC arrangements in isolation
- We recommend the LHC policy lever be considered in conjunction with other policies such as the MLS and PHI Rebate, with a focus on simplification of the PHI customer incentives program
- Opportunities to enhance the frequency and effectiveness of communication about PHI should be investigated, including testing varied forms of communication to respond to the different needs and preferences of Australia’s heterogenous population

2 Introduction

2.1 Scope

The Department of Health (Department) has engaged Finity to undertake comprehensive actuarial studies on RE and LHC. This report is focussed on the LHC component of this engagement.

We understand the Department’s objective is to identify whether there are opportunities to reform LHC which would enhance the affordability, value and attractiveness of PHI.

Our review is comprised of:

- A review of the effectiveness of LHC in its current form
- A review of opportunities for reform to LHC

The purpose of this report is to provide the Department with the key findings arising from our review.

2.2 Previous reports, approach and supporting analysis

Throughout the engagement, we have prepared a number of reports and discussion papers which have been presented to the Department. This report relies on the thinking developed throughout these papers, and the evolution of discussion with all key stakeholders.

The approach, supporting analysis and modelling in this report reflect the learnings from a number of workstreams, which are summarised briefly below.

Table 2.1 – Summary of supporting analysis

Workstream	Activity undertaken
Stakeholder consultation	We used a number of approaches to consult broadly with stakeholders, including two large meetings with over 100 attendees, interviews, and surveys.
Literature review	Academic and industry research has guided parts of our approach and helped confirm or test some of our modelling assumptions.
Review of publicly available data and demographics	Analysis of publicly available data using APRA’s PHI statistics, data from the Australian Taxation Office and review of demographics using Finity’s proprietary data asset “Defin’d”.
Data and analysis	We collected data from 35 insurers, reflecting member and claims information for 2016-2020 (to 31 March 2020). We believe this is the most comprehensive industry dataset ever compiled on Australian PHI, and allows the Department to make data driven decisions. The data has provided a range of insights that were not apparent from the high-level data collections previously completed. As the Department has identified, ongoing data collection and analysis will assist insurers and government to improve efficiency in PHI. Our analysis was also supported by data collected from the ATO and data publicly available from APRA.
Consumer survey	We asked people the extent to which they understood LHC, as well as how changes in price and changes in LHC policy would affect their PHI purchase and retention decisions.

Workstream	Activity undertaken
Participation model	We built a model to project the impact of changes to LHC on PHI participation over time. This was aided in particular by the consumer demand survey.

2.3 Structure of this report

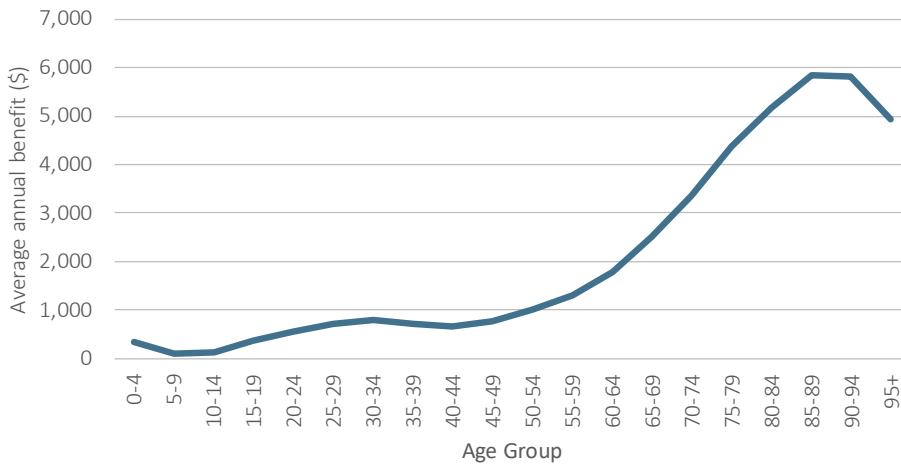
This report is structured as follows:

- Section 3 Provides important background on the current LHC policy
- Section 4 Sets out the evaluation criteria used for assessing LHC and possible reforms
- Section 5 Discusses the impacts and our assessment of the effectiveness of the current LHC scheme
- Section 6 Discusses opportunities identified for reform to LHC
- Section 7 Presents our findings and recommendations
- Section 8 Sets out Reliances and Limitations

3 LHC today: who, how and why?

Premiums under community rated health insurance do not reflect individual expected claim costs, but rather the average expected costs of everyone insured. If only people with high expected claim costs decided to insure then premiums would be unaffordable. Affordable community rated health insurance therefore requires high participation rates by people with low expected claim costs. In a voluntary PHI system, some program of incentives is required to support higher participation from this group.

Figure 3.1 – Average claim rates by age



LHC is a Commonwealth Government initiative that commenced from 15 July 2000. The objective of LHC is to **support community rating by providing incentives for people to obtain private hospital cover⁵ earlier in life and encourage them to maintain it.** The objective of LHC is achieved by charging higher premiums for private hospital cover where an individual takes out cover for the first time, or has a significant break in cover, from a certain age. The box below details how LHC is applied in practice under current legislation.

LHC

If an individual has not taken out and maintained private patient hospital cover from the year they turned 31, they will pay a 2% LHC loading on top of their hospital cover premium for every year they are aged over 30, if they decide to take out hospital cover later in life.

The maximum LHC loading that can be applied is 70%.

Once an individual has paid an LHC loading for 10 years of continuous cover, they will no longer have to pay this loading.

An LHC loading is not applied where an individual:

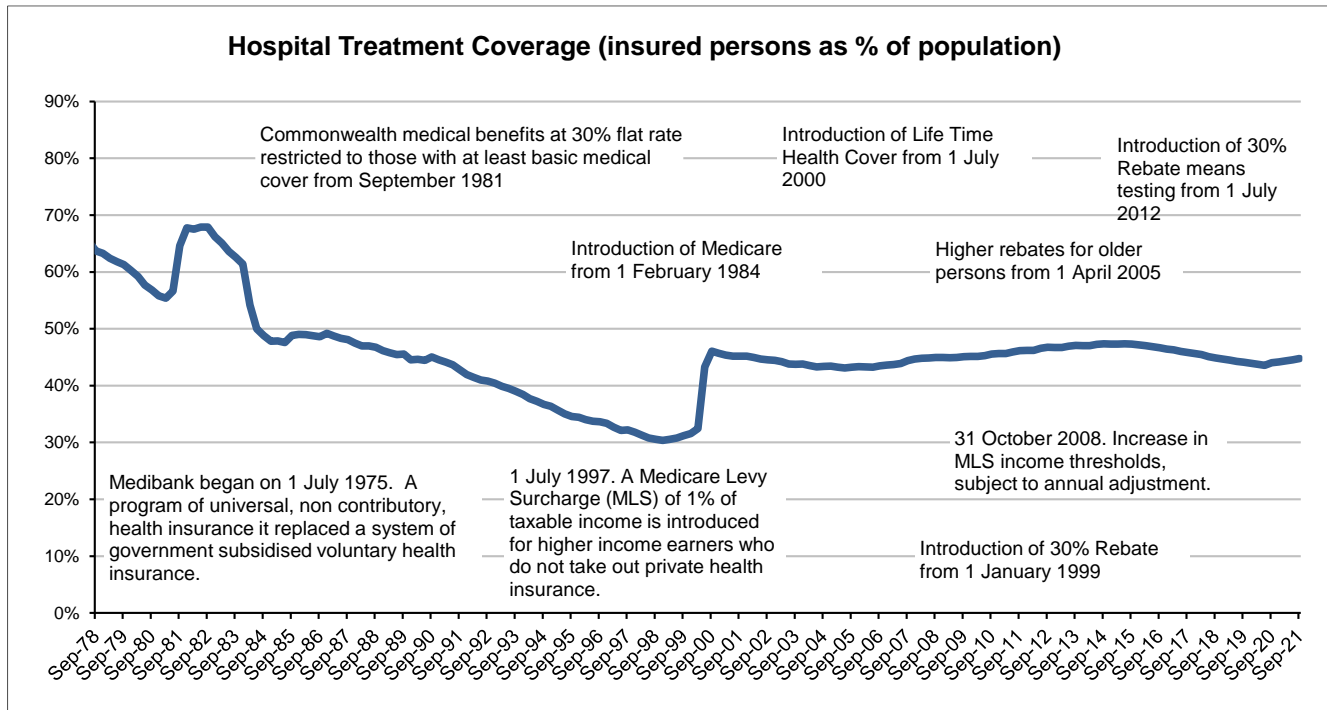
- is aged under 31 years old;
- holds an appropriate level of private patient hospital cover before they reach their LHC 'base day';
- is a new migrant to Australia, and are aged 31 or over, and had hospital cover within 12 months of being registered for full Medicare benefits;
- was born on or before 1 July 1934.

⁵ LHC loadings only apply to hospital cover. General treatment (“extras”) cover, Overseas Visitors Health Cover, Overseas Students Health Cover and international forms of insurance are not considered to be hospital cover for LHC purposes.

LHC effectively presents a decision point for consumers: take out PHI cover before a certain age, take out PHI cover later and pay higher premiums or don't take out PHI cover at all.

The introduction of LHC in 2000 followed the introduction of a number of other Government initiatives, including the Medicare Levy Surcharge (MLS) and PHI Rebate from 1997. The introduction of LHC was accompanied by a significant Government information and marketing campaign and saw the PHI participation rate increase by around 15 percentage points.

Figure 3.2 – Historical hospital participation rates with incentives



Source: APRA Quarterly report: [Quarterly Private Health Insurance Membership Trends September 2021.xlsx]HT % coverage

Many have debated the extent to which this growth in PHI participation should be attributed to any particular initiative, both at the time of introduction and on an ongoing basis. The academic research is mixed, with different methodologies ascribing different weight to each of LHC, MLS and the PHI Rebate. What can be said is that these three initiatives were collectively designed to alter consumer behaviour, and they have been successful as a package in lifting participation, and maintaining it well above pre-1997 levels.

To give a sense of scale of LHC's impact on PHI today, at 31 December 2021⁶:

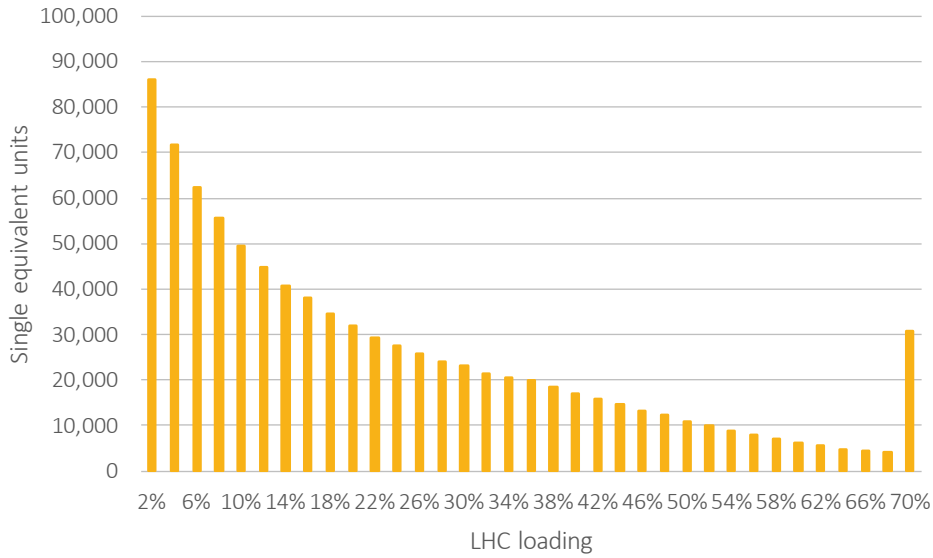
- There were around 900,000 policyholders subject to an LHC loading. This represents 11% of the 8.4 million "single equivalent units" (adults covered by a hospital policy).
- For single equivalent units subject to an LHC loading, the average loading was between 22% and 23%.
- Multiplying these numbers together suggests LHC loadings contribute around 2.4% to industry hospital premiums. This compares to a total industry net margin (profit before investment income, tax and extra-ordinaries) of 5.1%⁷ of total premium income. Hospital premiums contributed 73% of total premium income in FY21.

⁶ Finity analysis of APRA HRF601 forms.

⁷ <https://www.apra.gov.au/operations-of-private-health-insurers-annual-report>, 20-21

Figure 3.3 – Distribution of LHC loadings applied shows the count of single equivalent units by LHC loading as at 31 December 2021, for those where an LHC loading is applied. The spike at 70% reflects that this is the highest loading, and applies to all new entrants who join at age 65 or older.

Figure 3.3 – Distribution of LHC loadings applied



4 Criteria for evaluation of alternatives

4.1 Evaluation criteria for the actuarial studies into RE and LHC

The evaluation criteria for assessing the effectiveness of reforms to both RE and LHC were developed in consultation with the Department and representatives from insurers, consumer groups and other industry bodies. These are set out in Figure 4.1.

Figure 4.1 – Evaluation criteria for reforms to risk equalisation and LHC



4.2 Quantitative metrics for LHC

To assess the LHC policy in its current form and compare reform options, we have also considered two quantitative measures which were formulated through discussions with the Department and other stakeholders:

- PHI hospital cover participation (simply referred to from here as “participation” and usually expressed as a rate of the Australian population)
- The average age of insured persons

These metrics directly tie in with the objective of LHC to support community rating with incentives for people to obtain private hospital cover earlier in life and encourage them to maintain it.

4.2.1 Participation

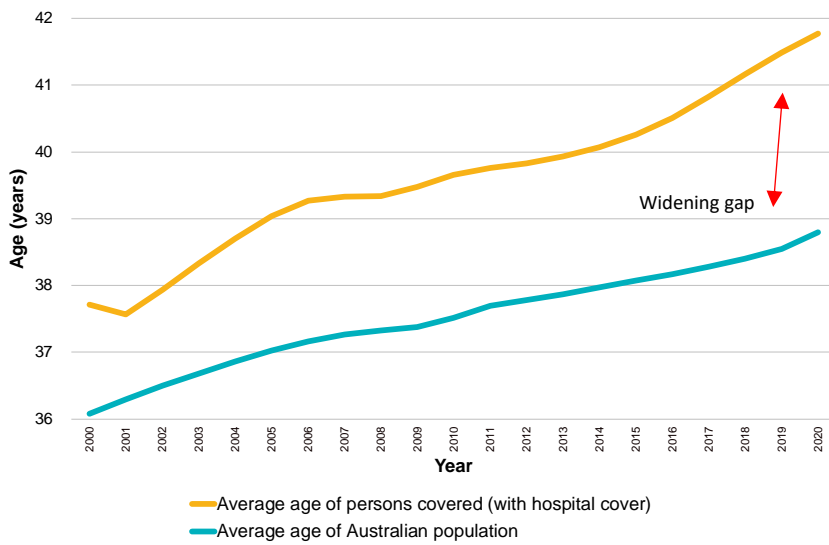
Participation is a metric widely used and understood by stakeholders. Figure 3.2 showed changes in the participation rate over time. All references to participation or the participation rate in this report refer to the proportion of Australians with hospital coverage.

The participation rate has generally been in decline since 2015, with the exception of an increase in 2021 due to the COVID-19 pandemic. A number of stakeholders stressed the importance of reversing the recent declining trend.

4.2.2 Average age of insured population

Average age (measured in years difference with population average) provides an indication of the risk profile of the insured population, as younger people typically have lower claims costs. An average age that increases faster than, or even parallel to, the population average is likely to maintain or increase cost inflation for the industry, and thus contribute to higher premium increases, impacting access to PHI. Figure 4.2 shows how the increases in the average age of people with hospital cover compares to the overall population.

Figure 4.2 – Average age of population, and of persons with hospital cover



Other criteria

Other qualitative criteria are used to assess the effectiveness of the LHC policy and any proposed reforms, namely:

- **Alignment with health policy:** This includes broader community objectives, especially regarding health outcomes and cost. It also specifically looks at consumer choice, insurer viability and provider satisfaction.
- **Practicality:** Reforms which add complexity will be deemed less appealing compared to those which reduce complexity and achieve the same outcome.

5 Impact and effectiveness of LHC in its current form

In reviewing the impact and effectiveness of LHC in its current form, we reviewed and modelled the impact of LHC on participation and average age (the quantitative metrics), while also considering impacts relevant to the other criteria set out in Section 4.

A brief summary of findings is included below, with further detail in the following sections.

Impact	Description	Relevant criteria
Participation and average age	<p>Over a 5-year time horizon, LHC is estimated to increase participation from ages 25 to 34 and from age 50.</p> <p>The overall increase in participation due to LHC is estimated to be 1.1% with a minor impact on average age.</p>	Participation and average age
Claiming behaviour	<p>We have examined the relative claiming behaviour of those with and without LHC loadings by age, product tier and duration of membership, and found some significant differences.</p> <p>In addition, we note that should LHC be removed, it is anticipated that claim experience would alter, with a higher number of people joining to claim, then exiting the system, resulting in both higher claims and administration costs.</p>	Equity
Product decision	LHC may compel some policyholders to choose a product below their preferred level of cover and delay upgrading their policies until they have served the 10-year LHC loading period.	Access
Complexity	In our surveys and interviews with stakeholders, we found that most believed LHC adds value to the industry, is generally working as expected, but that it is confusing for consumers, with opportunities to improve communication and handle exceptional cases.	Practicality; Efficiency; Alignment with health policy
Retention	While participation modelling suggests a modest change in participation at older ages should LHC be removed, there are higher rates of sales and lapses. This may increase the cost of policy administration.	Efficiency

5.1 Impacts of LHC on participation and average age

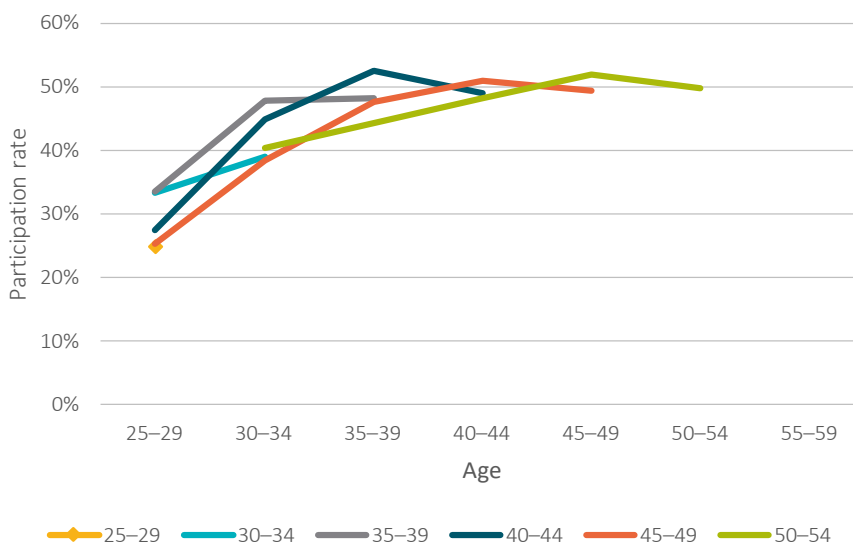
LHC impacts participation and average age by creating:

- For those aged below 31:
 - > An incentive to insure before age 31
- For those aged 31 and above:
 - > An incentive to retain a policy (or disincentive to lapse), as re-joining could result in the application of an LHC loading
 - > An incentive to insure earlier rather than later
 - > A disincentive to insure for the first time at age 31 and later, due to the higher cost created by the LHC loading

5.1.1 Incentive to insure before age 31

Figure 5.1 shows participation rates for different cohorts of people, as they age over time.

Figure 5.1 – PHI participation rates over time by cohort – 5year age band at 30 June 2020^{8,9}



How do we interpret this chart? The red line shows the participation rate for people who were aged 45-49 in 2020 as they passed through different age bands over time. In the year 2000, when they were aged 25-29, this cohort had a participation rate of 25%. The participation rate of this cohort increased to 50% in 2015 when aged 40-44 and was just below 50% in 2020. This analysis allows us to examine changes in participation rates as people reach the age at which LHC would apply, and how that impact has changed over time.

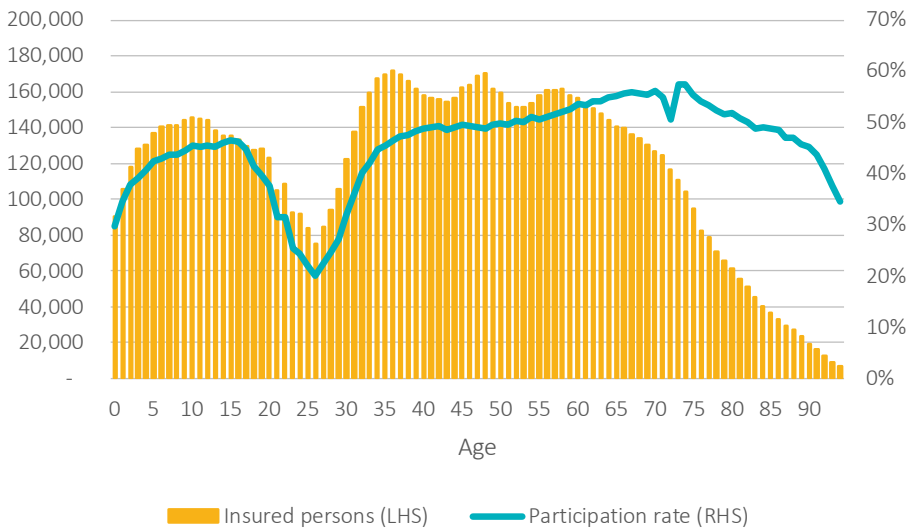
⁸ As a proportion of the Australian resident population excluding Department of Veteran Affairs Gold card holders, overseas students and overseas visitors.

⁹ Sources: Finity analysis of APRA Statistics: Private health insurance membership and coverage, December 2020 (released 23 February 2021); ABS Series 3101.0 National, state and territory population, Table 59: Estimated Resident Population by Single Year of Age; Department of Veteran Affairs Treatment Statistics; Australian Education International, Time Series - International Student Enrolments in Australia 1994–2020; Gale, Andrew P. (2019), Health, Defence and Immigration: The impact of health coverage arrangements for military, overseas visitors and students on private health insurance, Presented to the Actuaries Institute Actuaries Summit, 3-4 June 2019.

An increase in participation is seen for all cohorts as they aged from 25-29 to 30-34, although the extent of the increase appears to have reduced in the past five years (via a decrease of the slope of this line between ages 25-29 and 30-34).

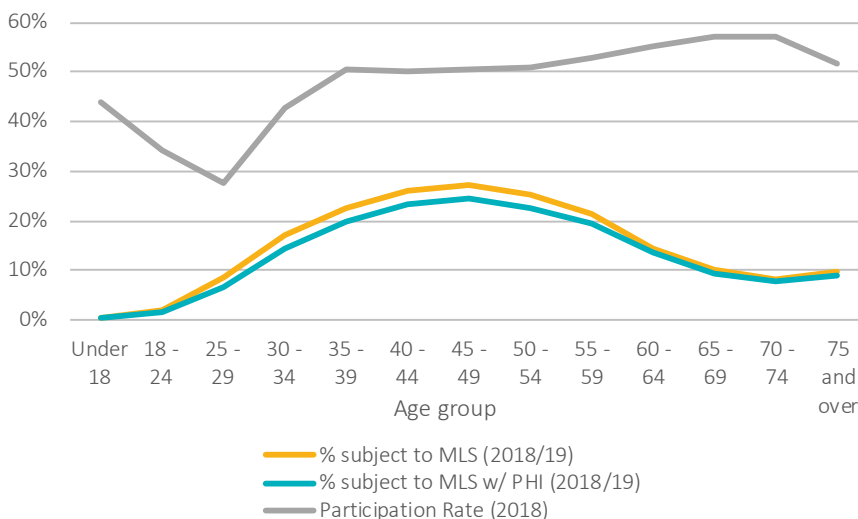
LHC has long been perceived as largely responsible for an increase in the participation rate at age 30. Analysis of participation by individual age has shown that the “jump” frequently attributed to LHC, is better described as a steady increase in participation from age 25-35 (see Figure 5.2).

Figure 5.2 – Insured persons and PHI participation rate¹⁰



The increase in participation between ages 25 and 35 is also impacted by the MLS as the proportion of Australians earning income above the MLS threshold increases significantly at these age groups, as shown in Figure 5.3.

Figure 5.3 –PHI participation rate disaggregation: participation by those subject to MLS¹¹



¹⁰ Source: As per Figure 5.1, with Finity analysis of insurer data to estimate the distribution of insured persons by integer age from insured persons by age band.

¹¹ Source: Participation rate as per Figure 5.1; Finity analysis of *Taxation Statistics 2017-18*, Table 3: Individuals, published by the Australian Taxation Office.

While participation increases around the LHC entry age, it increases consistently from age 25 to 35 and is strongly impacted by rising incomes and, in particular, the increased proportion of this group earning above the MLS threshold. Therefore, the increase in participation between the 25-29 age group and the 30-34 age group should not be attributed solely or perhaps even significantly to LHC. Kettlewell and Zhang (2021) note that previous research on the effectiveness of LHC could not isolate the LHC effect on participation from the MLS and PHI Rebates, which were policies introduced at around the same time as LHC.

LHC remains an important incentive for encouraging younger Australians to take out PHI, however, it is not the financial incentive or price signal alone that contributes to higher participation. PHI participation is likely to increase through ages 25 to 35 due to changes in earning capacity, household situation and healthcare values of this group. In this context, LHC and the associated Government initiated communication program provide a signal about community norms and individual responsibility. Many stakeholders, especially insurers, valued the Government's outbound communication program. The impact of changes in this program on the participation rate are noted in Kettlewell and Zhang (working paper, 2021)¹².

The behavioural 'norming' induced by LHC is further supported by our consumer survey which suggests limited understanding by consumers of the specific workings of LHC. This suggests that LHC, as an incentive, is not working via an economic or financial argument but via other factors. Stakeholder feedback suggests that increased understanding of how LHC works over time is contributing to a focus on financially or economically rational arguments, and there are a number of examples of consumer-focused groups highlighting the financial impact of LHC on individuals/households¹³.

Age-based discounts, introduced on a voluntary basis from 1 April 2019, provide another example of the relative strength or weakness of price signals influencing take-up of PHI. Age-based discounts allow an insurer to offer a discount to individuals who take out a policy prior to age 31. Effectively, they operate as a negative LHC loading. At the time of introduction, and to the time of writing this report, there has not been a significant uptake of young Australians accessing these discounts. Some stakeholders note the limited promotion of this reform by insurers and government, and the voluntary nature of this reform leading to a sporadic and inconsistent roll-out as reasons for the limited uptake. While it is too early to say absolutely, the limited take-up to date is not consistent with high price elasticity of demand for PHI among younger Australians.

Today's LHC loadings, and age-based discounts, do not appear to be sufficient to significantly alter many consumers' initial PHI purchase decision. Opportunities to increase the incentive for under 31s to obtain PHI are likely to lie in first and foremost improving the PHI value proposition for younger Australians, however, there may be enhancements to the LHC communication program that use learnings from behavioural economics to re-emphasise community norms. Alternatively, if the focus of LHC continues to be on financial arguments consideration could be given to increasing the LHC loadings, although this would diminish criteria directed at consumer choice.

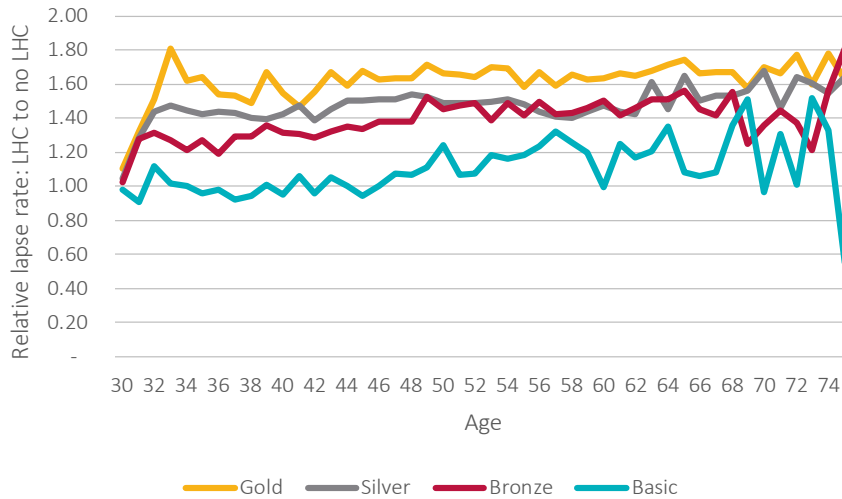
¹² Age penalties and the take-up of Private Health Insurance, Kettlewell, N and Zhang, Y, November 2021

¹³ For example, see <https://www.choice.com.au/money/insurance/health/articles/how-to-pay-the-lifetime-health-cover-loading-and-save>, accessed 25 January 2022.

5.1.2 LHC's incentive for insured persons to retain PHI

Figure 5.4 shows the relativity between exit rates (1 April 2018 to 1 April 2019) for insured persons on a policy with an LHC loading to those for insured persons on a policy without an LHC loading, by age and product tier. These lapse rates reflect the propensity to exit a given insurer, and do not allow for transfers between insurers due to the differences in data recording between companies.

Figure 5.4 – Lapse rate relativities – LHC compared to no LHC¹⁴

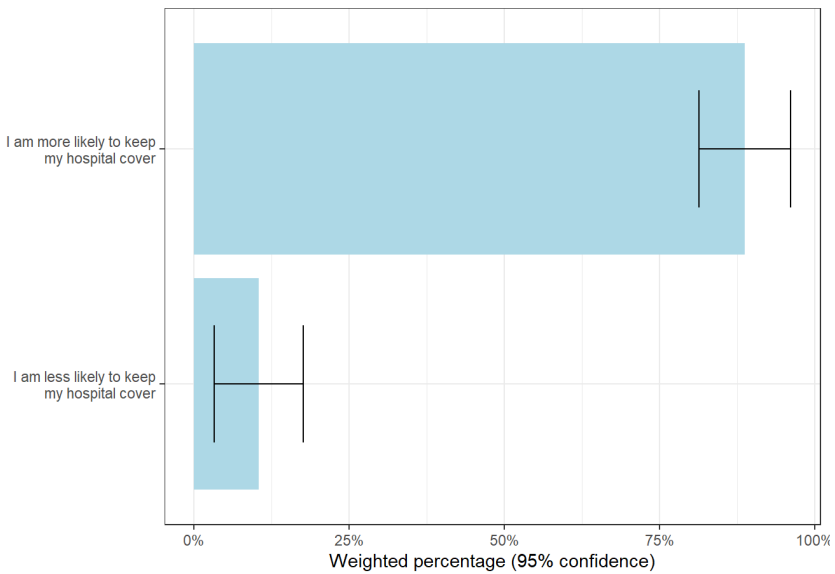


The relativity of exit rates for insured persons with LHC and insured persons without LHC ranges from 1 (i.e. comparable) for those on basic hospital policies younger than 50, to around 1.75 for those on gold hospital policies. This shows that those insured on a policy with an LHC loading are more likely to lapse their cover (with a given insurer) than those on a policy without an LHC loading.

Consumer survey results also suggest LHC encourages policyholders without a loading to retain their policy, as shown in Figure 5.5.

¹⁴ Source: Finity analysis of insurer data

Figure 5.5 – Consumer survey results: How does LHC influence your decision to keep your hospital cover?



5.1.3 Incentive for over 31s to insure earlier rather than later

LHC applies a penalty to individuals who take out insurance for the first time after the age of 30, with the penalty increasing by age. This creates an incentive to take out insurance earlier, however, the relative incentive does diminish as a person ages, and disappears from age 65 when the loading reaches the maximum level.

Figure 5.6 shows consumer survey results on how LHC affected the purchase decision for individuals with hospital cover. The majority of respondents felt that LHC encouraged them to purchase earlier than they would have otherwise.

Figure 5.6 – Consumer survey results: How did LHC influence your purchase decision?

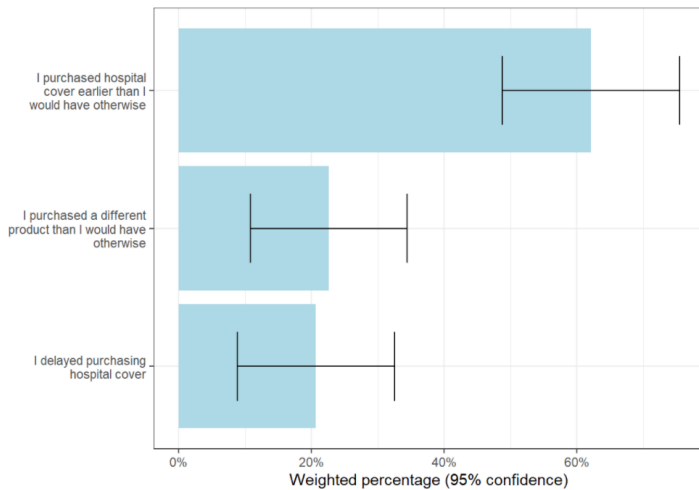
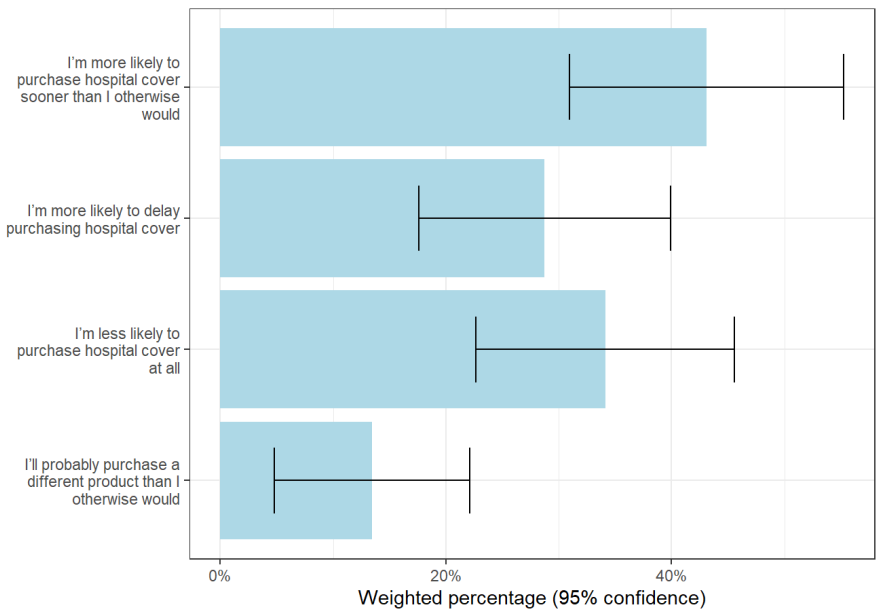


Figure 5.7 shows consumer survey results on how LHC affects the *future* purchase decision for individuals without hospital cover at the time of survey. Just over 40% of respondents stated they were more likely to purchase hospital cover earlier than they otherwise would have. Similar to those who already purchased PHI, it appears LHC may have some other impacts outside of its core objectives.

Figure 5.7 – Consumer survey results: How does LHC influence your future purchase decision?



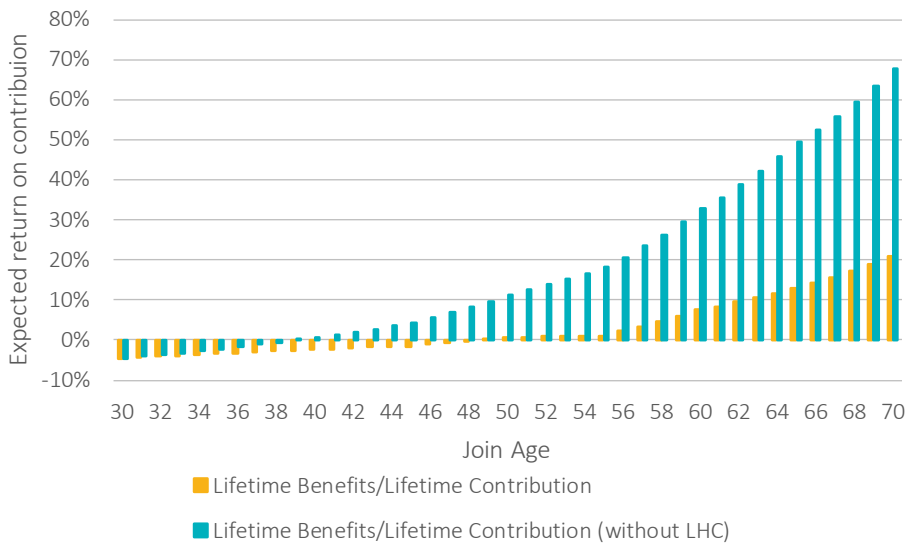
While consumer survey results indicate LHC does create an incentive to insure earlier, as we noted earlier in the discussion of the incentives for under 31s to join PHI, some individuals still do not find LHC, at current parameters, a strong enough incentive to take out insurance earlier.

To illustrate this, consider an individual who is considering at what age they should take out a PHI policy for the first time. Because insurers offer different levels of coverage at different prices, a policyholder could attempt to maximise their lifetime net benefit by taking out cheaper and more basic cover when they are younger and purchasing more comprehensive cover as they age. Therefore, in our example, we have assumed:

- If this individual holds a policy between ages 30 to 44, it will be a Bronze product
- If this individual holds a policy between ages 45 to 54, it will be a Silver product
- If this individual holds a policy between ages 55+, it will be a Gold product

The ratio of expected lifetime benefit to expected lifetime contribution for this individual is shown by age of entry in Figure 5.8 below. We have shown this metric assuming LHC in its current form and in a hypothetical scenario where LHC did not exist.

Figure 5.8 – Expected return on contribution by age of entry¹⁵



Even with the LHC in its current format, the increasing size of each bar by age of entry means that an individual would see a higher return on their lifetime contribution with each additional year of age at entry. Therefore, **LHC reduces but does not eliminate the incentive to delay entry into PHI.**

The survey responses also indicate that LHC causes some policyholders to delay purchasing hospital cover and purchase a different product than they would have otherwise. These behaviours, which are outside of the objectives of the LHC, are discussed in Section 5.2.

5.1.4 Disincentive to insure for the first time

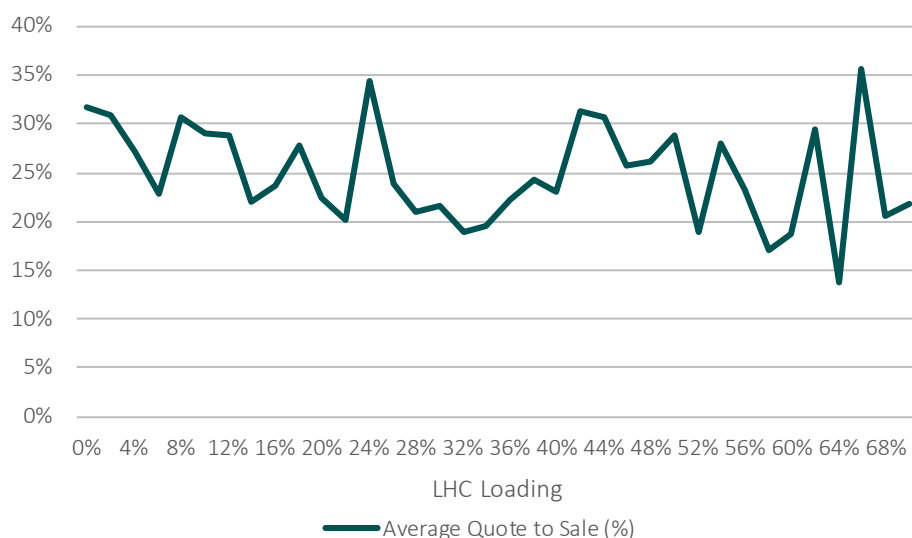
Figure 5.7 shows that more than 30% of respondents to the consumer survey indicated LHC reduces the likelihood they would purchase hospital cover at all. This reflects the disincentive created by LHC to insure for the first time.

In addition to consumer survey results, we have examined the conversion rate of sales enquiries by level of LHC loading that would apply to a converted policy¹⁶. The figure below shows the percentage of individuals who received a quote who ended up taking out a policy.

¹⁵ Sources: analysis of APRA data on average benefits by age, premium rates of large insurers and ABS life tables.

¹⁶ Data provided by the Private Health Insurance Intermediaries Association (PHIIA) and some insurers.

Figure 5.9 – Average conversion rate by LHC loading level



The average conversion rate for those enquiries where no loading would apply was 32%. The average rate for enquiries where a loading would apply was lower, at around 25%. While there is some decrease in conversion rates as the LHC loading increases, it is not as pronounced as some stakeholders had expected. Beyond a loading of 40% there is an increase in conversion rates as the loading increases.

This analysis suggests the LHC loadings are a deterrent to some, but the deterrence is not as significant as perceived by stakeholders. Some caution is required with interpreting these results, as there are a number of other factors which could explain these trends, such as:

- People enquiring about rates have already made the decision to purchase, and may already be aware of the loading.
- There are fewer quotes at higher loading levels, meaning these results may be more volatile.

5.1.5 Modelling

In order to bring the above findings together to produce a view on LHC’s overall impact on participation and average age we modelled the impact of the *removal* of LHC loadings and reviewed the impact on participation and averages after five years. Our modelling is detailed in our working paper provided to the Department previously (“Lifetime Health Cover Modelling”), and is summarised below:

- 1 Create a simulation of PHI industry membership under the status quo (the base projection). Starting with pre-LHC industry membership (30 June 2000), project PHI sales and lapses from 2001 to 2019 considering insured persons with and without LHC loadings.
- 2 Evaluate LHC:
 - a Estimate impact of changes to the sales and lapses if LHC were removed by age and LHC status, considering:
 - i Survey responses to questions about the impact of changes to LHC on future purchases and retention¹⁷.

¹⁷ This was a survey of the Australian general population asking questions about private health insurance. Questions focused on participation and LHC (this survey overlapped the RE and LHC studies). 505 respondents were sourced from a commercial panel provider and fielded between 8th and 11th October 2021.

- ii Price elasticity curve estimated from a “Gabor Granger”¹⁸ experiment.
 - iii Findings on the impact of the LHC and MLS from analysis using ATO data.
 - iv Analysis of lapse rates from the insurer dataset (see Figure 5.4).
 - v Findings of the working paper by Kettlewell and Zhang (2021).¹⁹
- b Apply estimated impacts on sales and lapse rates to determine the impact of the change in policy. We tested impacts assuming change was implemented in 2015, allowing a review of effectiveness after five years.

We have separately considered the impact of changes to the LHC on the four types of rates below.

Table 5.1 – Modelling sales and lapse rates – model point summary

	Rate	Influenced By	Denominator	Impact
1	Sales rate - under 30s	Incentive to join prior to age 31	Uninsured population in previous year	Permanent impact
2	Sales rate - over 30s	Direct price incentive and incentive to join earlier than otherwise would	Uninsured population in previous year	One-off impact with some exceptions
3	Lapse rate - No LHC applied	Disincentive of lapse and re-entry due to LHC	Insured population with no LHC loading in previous year	Permanent impact
4	Lapse rate - LHC applied	Direct price incentive and disincentive of lapse and re-entry due to LHC	Insured population with LHC loading in previous year	One-off impact with some exceptions

Changes to the LHC loading for persons who would see an LHC loading applied under current settings are expected to impact sales and lapses in the same way a change in price would impact sales and lapses. Therefore, changes to the LHC loadings are assumed to impact sales and lapses for this group in the first year of the policy change only (i.e. the market clears very quickly). For example, reducing the LHC loadings would be expected to result in a *one-off* increase in the sales of policies subject to an LHC loading.

Conversely, the impact on sales rates and lapse rates for insureds who do not currently have an LHC loading are expected to be *permanent* changes, because the LHC loadings have a behavioural impact outside of price. That is, the incentives and disincentives which influence sales and lapses of insureds with no LHC loading have changed, and the change to those incentives and disincentives has a permanent effect.

There are exceptions where changes may have both one-off and permanent impacts. For example, an increase to the LHC rates may result in a temporary increase in lapses due to the immediate price impact, but may encourage better retention from those remaining as they seek to retain their policy to avoid a higher loading should they re-join.

The tables below show the modelled impacts on sales and lapse rates if LHC were to be removed.

¹⁸ The primary result from the consumer survey for assessing price elasticity was a Gabor-Granger experiment which was administered to the respondents who had indicated they did not have private health insurance hospital cover. The Gabor-Granger method estimates price elasticity for a given product over a range of pre-specified price points. In this case we asked about a Bronze hospital only cover as this generally represents a minimum step required to move from non-participation to participation. The price points tested ranged from \$50 to \$130 a month total premium in increments of \$10.

¹⁹ Age penalties and take-up of private health insurance, Kettlewell, N & Zhang, Y, November 2021

Table 5.2 – Additive impact of removing LHC on annual sales and lapse rates

Age band	Sales rate -		Lapse rate -	
	No LHC <i>permanent</i>	Sales rate - LHC <i>one-off</i>	No LHC <i>permanent</i>	Lapse rate - LHC <i>one-off</i>
25 - 30	-2.0%	n/a	0.0%	n/a
31 - 35	0.0%	1.0%	0.1%	-8.3%
36 - 40	0.0%	1.6%	0.2%	-8.3%
41 - 45	0.0%	2.3%	0.3%	-8.3%
46 - 50	0.0%	2.7%	0.5%	-8.3%
51 - 55	0.0%	2.8%	0.6%	-8.3%
56 - 60	0.0%	2.9%	0.7%	-8.3%
61 - 65	0.0%	2.8%	0.8%	-8.3%
>65	0.0%	2.5%	0.9%	-8.3%

In summary, removing LHC loadings is expected to:

- Reduce sales at ages 30 and under as LHC provides an incentive to join prior to age 31;
- Increase sales at ages 31 and over as insuring become relatively cheaper without the LHC loading; and
- Increase lapse rates as the incentive to maintain PHI is reduced and policyholders have greater freedom to time their entries into PHI. However, this is partially offset by a one-off impact of lower lapses amongst those who currently hold a PHI policy with LHC loadings.

5.1.6 Impact on participation rate and average age of insured population

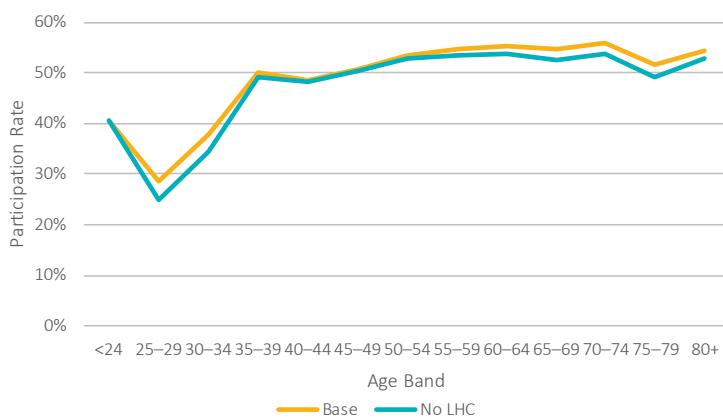
We have modelled the impact on participation and average age in 2019 assuming the policy change occurred in 2014. This allows for five years of sales and lapse impacts.

Table 5.3 – Impact on PHI participation and average age (hospital insured persons) of removing LHC

	Base	No LHC	Change from
			Base
Participation Rate	46.1%	45.0%	-1.1%
Average Age	41.8	41.6	0.2

The impact on PHI participation by age band is shown below.

Figure 5.10 – Impacts on participation by age band of removing LHC



Removing the LHC loading is projected to:

- Reduce participation from ages 25 to 34, as the incentive to participate at earlier ages is removed.

- Have an immaterial impact on participation from ages 35 to 50. While the reduced LHC loading results in higher sales at these ages, there is no longer any disincentive to lapse and so lapses are higher than otherwise. These effects are largely offsetting.
- Reduce participation at age 50 and later as additional lapses are projected to be higher than additional sales at these ages.

From this we conclude that LHC:

- Incentivises people to take out PHI earlier than they otherwise would have
- Incentivises people to keep their policy for longer than they otherwise would.
- Reduces sales at older ages, but not to the same extent as it encourages people to retain their policy

The overall impact on participation and the average age is not significant, given a 1.3% change in participation after five years, but removing LHC would require an industry premium rate rise of at least 2.5%²⁰ to maintain the current level of financial performance and position of the PHI industry.

Perhaps the impacts on participation and average age shown above are not as large as some stakeholders might expect. Impacts are smaller than expected generally because:

- MLS is a strong participation incentive for younger people who can afford PHI.
- Analysis of price elasticity, which has been used in the above modelling, suggests that significant changes in price are required to materially uplift participation. Analysis from the Gabor Granger modelling suggests a 5% price reduction would result in an absolute increase in participation of 0.2%. Further details are shown in the demand modelling paper.

Our modelling does not consider the impacts of LHC outside of participation and average age, in particular, claiming behaviour, and therefore the impact on premium increase from removing LHC could be higher.

5.2 Other impacts of LHC

5.2.1 Claiming behaviour of those with an LHC loading

Hospital policies typically have a 12-month waiting period for benefits, in order to prevent people taking out cover for the explicit purpose of claiming for a known health issue at the time cover is taken out. Without waiting periods, such claiming behaviour would be detrimental to the financial sustainability of the PHI industry.

If 12-month waiting periods do not eradicate this claiming behaviour, LHC loadings mitigate it by imposing a higher premium on people who join at age 31 and later.

To investigate the extent of this claiming behaviour, with waiting periods and LHC in their current forms, we analysed the lapse and claim behaviour of all 30-39 year old people who were *new to PHI*, purchased singles Gold cover and *paid an LHC loading* in the 2015 premium year, and compared it to the lapse and claim behaviour of 30-39 year old people who were *new to a fund*, purchased singles Gold cover and were *not paying an LHC loading* in the 2015 premium year²¹.

²⁰ Based on targeting a similar gross margin, allowing for changes in claims cost due to changes in age mix and changes in premium due to the removal of the LHC loading.

²¹ We have only relied on data from the funds which provided enough data to perform this analysis, representing approximately one third of the industry.

Figure 5.11 – Drawing rates by month of tenure

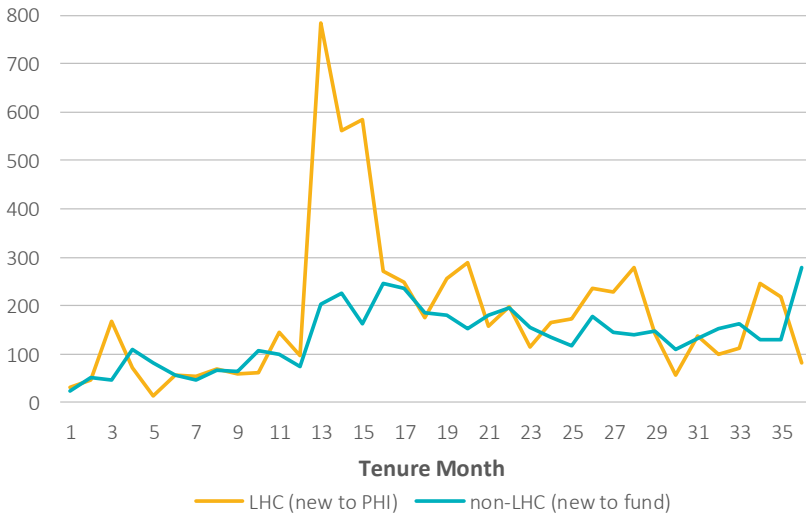
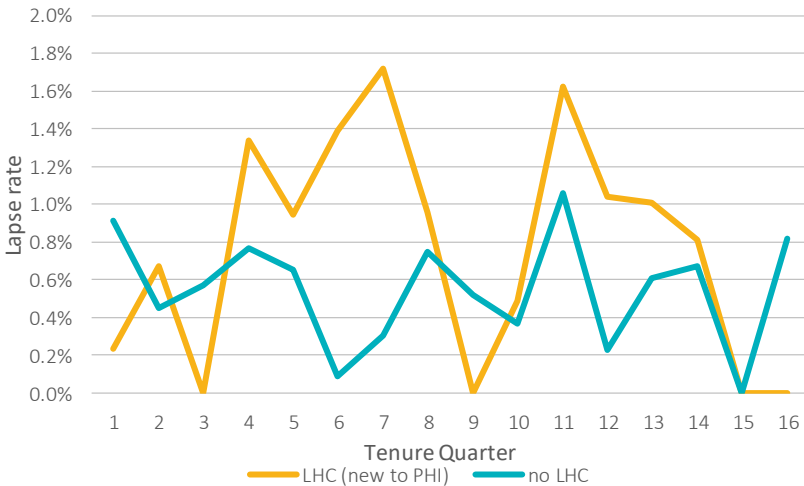


Figure 5.11 shows that LHC participants new to PHI on average have multiple times higher monthly drawing rates in the 13th to 15th months of tenure compared to non-LHC participants (who are new to a fund). This clearly exhibits that a higher proportion of LHC participants new to PHI purchase gold hospital policies for the purpose of waiting out the 12-month waiting period and then making a claim as soon as possible (i.e. they purchase with an immediate healthcare need). The same behaviour is observed at older age groups (or those with a higher LHC loading), and can also be observed for Silver, Bronze and Basic policies, but to a lesser degree.

Figure 5.12 shows the lapse rates from an existing policy, where the policyholders leaves the industry altogether, and excludes lapses to other products or funds, for a Gold singles product for a 30-39-year-old.

Figure 5.12 – Lapse rates by quarter of tenure, Gold hospital policyholders aged 30-39



The lapse rates show that LHC participants new to PHI have much higher lapse rates in the second year of tenure (quarters 5 to 8), which is consistent with concerns of some stakeholders that participants are entering the PHI system only at the time of healthcare need, and making a claim before exiting PHI. Similar experience, i.e. higher lapse rates from those with an LHC loading, are also observable on Silver hospital products.

Adverse claiming and lapsing behaviour occurs in PHI, and will always feature in a voluntary community rated system. While LHC loadings may act as a deterrent to this behaviour, the behaviour still occurs. We are not able to quantify the deterrent effect of LHC to this behaviour as we are not able to run the experiment in the absence of LHC – the PHI environment pre-LHC was different to that today, and we were not able to source individual claims and membership data prior to 2000.

While the deterrent effect of LHC on Australians exercising this option to only hold PHI at a time of healthcare need is not the primary objective of LHC, we expect it would be offering this secondary benefit (i.e. we would expect an increase in average hospital drawing rates or hospital benefits per insured person should LHC be removed). It is noted however, that this secondary impact has not been explicitly considered in the modelling above.

5.2.2 Product mix (“Access”)

Figure 5.6 and Figure 5.7 suggest that LHC influences consumers’ product choice. Analysis of insurer data confirmed an impact of LHC on product mix, with those at higher ages being more likely to hold cover at product tiers below Gold if they had an LHC loading. The data also showed that upgrades to Gold hospital cover once a policyholder had served the 10-year LHC loading period were significantly higher than expected based on age alone.

The additional cost imposed of LHC loadings compels some policyholders to choose a product below their preferred level of cover and delay upgrading their policies until they have served the 10-year LHC loading period. This is an unintended adverse impact of LHC, with the additional cost limiting access to coverage for some households below their desired level.

5.2.3 Complexity (“Practicality”; “Efficiency”; “Alignment with health policy”)

In our surveys and interviews with stakeholders, we found that most believed LHC adds value to the industry, but that it is confusing, and often not well understood. Our initial survey of industry stakeholders concluded:



Consumer advocacy groups, insurers and researchers expressed a view that when making the decision to purchase insurance, a significant portion of consumers do not understand LHC. This was supported by the consumer demand survey which indicated that less than 50% were aware of LHC prior to the survey.

As a consequence of this, insurers suggested that LHC added complexity to a product which is complex enough in the minds of consumers, and that it creates an administrative and communication cost.

5.2.4 Customer turnover or Churn (“Efficiency”)

While participation modelling suggests removing the LHC would result in a modest change in participation at older ages, there are higher rates of sales and lapses, as shown in Table 5.2.

5.3 Interaction with other incentives

As we will see in more detail in the MLS study, the MLS is very effective at incentivising Australian households who earn above the MLS income thresholds to take out PHI. In fact, it is so effective, it is logical to conclude that the LHC has little relevance for households earning above the MLS thresholds²². As a result, any change in the MLS threshold will have implications for the size of the population that LHC can be expected to be effective for, as well as, the income distribution of that population.

There are also linkages between the effectiveness of the LHC incentives and the PHI Rebate, as the PHI Rebate directly impacts the effective cost and affordability of PHI for customers. The decision to remove the PHI Rebate from the LHC loading component of the premium in 2013 significantly reduced the affordability of PHI premiums for those subject to, or potentially subject to, an LHC loading. From a customer perspective, the premium paid does not increase by 2% for each year they delay cover after age 31, but rather 2.67% for each year (assuming a 25% PHI Rebate on the standard premium). While this higher percentage further increases the incentive to obtain health insurance earlier, this increased incentive is redundant if PHI premiums are not regarded as affordable, particularly as LHC is most powerful for those earning below the MLS threshold.

It is important to note that the MLS thresholds have been held constant from 2014/15 to 2022/23. This has increased the proportion of the Australian population earning above these thresholds, but has also decreased the proportion of the population that LHC can reasonably be expected to impact. Any assessment of the effectiveness of LHC must also consider the inter-related impact of the MLS. It may be that while LHC has become less effective, this is offset by changes in the impact of the MLS.

5.4 Conclusion

The overall impact on participation and average age we have modelled is consistent with LHC's stated objective. However, the impact on these metrics is relatively small, with LHC increasing PHI participation by approximately 1.5%.

There are a number of additional positive impacts of LHC outside of participation and average age which support the efficiency and equity of PHI:

- LHC deters adverse claiming and lapse behaviour
- LHC limits "churn", or frequent entry and exits from the system, reducing administration costs

Our analysis suggests removing LHC would result in a required industry premium rate rise of over 2.5% to maintain the current level of financial performance and position of the PHI industry. It would be reasonable to assume that premium rate increases over this level would be required as policyholders' claims and retention behaviour would change in response to a new system.

There is evidence that the incentives to encourage Australians aged under 31 to obtain PHI are weakening, as affordability concerns and greater understanding of LHC are reducing the impact of some of the behavioural effects of the policy, placing greater weight on financial or economic arguments.

Our research and analysis did not identify any immediate imperative to change the current LHC arrangements. However, we have identified the positive aspects of LHC which should be retained under any reform and aspects of LHC which could be improved.

²² Although it may act as an incentive to retain cover in situations where the individuals does not expect to maintain income above the MLS thresholds.

Aspects to retain:

- Government communication to potential policyholders prior to age 31
- Additional revenue generated from the loadings

Aspects to improve:

- The complexity of rules could be reduced.
In particular, rules and exemptions around travellers and migrants, which are not well understood and confuse consumers.
Additionally, we've shown some overlap between the impacts of MLS and the impacts of LHC. Therefore, there may be an opportunity to simplify policy initiatives and achieve a similar outcome.
- Insurers expressed a desire to be given greater flexibility in applying the rules, to allow for individual circumstances. For example, waiving LHC loadings on a case-by-case basis.
- Cohesion with other policies.
For example, PHI Rebates are not applied to the LHC loading component of a premium. It's not clear if this is intended and if there are unintended consequences as a result.
- Additional communication.
Significant value is attributed to the age 30 communication, however there is no reason this could not also occur at other key milestones, ages or upon occurrence of life events.

6 Opportunities for reform

We identified opportunities for reform to LHC from a review of:

- Ideas from stakeholders
- Academic research
- International practice

This resulted in a long list of reform options, which was subsequently reduced to:

- One standalone reform option – “tiered loadings”
- Reform options to be considered alongside changes to other policy settings

In this section we present the tiered loadings reform option, discuss linkages between the LHC and other policy initiatives, uncertainties relating to reform and dismissed options.

6.1 Tiered loadings

6.1.1 Description

Tiered loadings would change the loading from 2% per year after age 30, to step-change increases over a longer period, as follows:

- 10% at ages of entry 31 to 40
- 30% at ages of entry 41 to 50
- 50% at ages of entry 51 to 60
- 70% at ages of entry 61 and older, with no other changes in scheme design

The motivation for investigating this structure is that many stakeholders believed clear triggers would complement increased communication and encourage participation. The average loadings will align with the current system and the size of the step-change loadings are sufficient to potentially impact demand decisions.

6.1.2 Modelling

We modelled this change in policy setting in line with the approach outlined in Section 5.1.5. Further details on approach and assumptions are detailed in our working paper (“Lifetime Health Cover Modelling”).

The table below shows the modelled impacts on sales and lapse rates under each policy change.

Table 6.1 – Impacts on sales and lapse rates

Age band	Sales rate - No LHC		Sales rate - LHC		Lapse rate - LHC one-off		Lapse rate - LHC permanent
	permanent	one-off	permanent	permanent	permanent	permanent	permanent
25 - 30	2.0%	n/a	n/a	-0.9%	n/a	n/a	n/a
31 - 35	0.0%	-0.5%	0.0%	-1.4%	0.0%	-3.8%	
36 - 40	0.0%	0.3%	1.0%	0.0%	-4.2%	0.0%	
41 - 45	0.0%	-0.3%	0.0%	-0.8%	0.0%	-1.1%	
46 - 50	0.0%	0.2%	1.0%	-0.1%	-1.4%	0.0%	
51 - 55	0.0%	-0.2%	0.0%	-0.3%	0.0%	-0.7%	
56 - 60	0.0%	0.1%	1.0%	0.0%	-0.6%	0.0%	
61 - 65	0.0%	-0.1%	0.0%	-0.1%	0.0%	0.1%	
>65	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	

Implementing tiered loadings is expected to:

- Increase sales at ages 30 and under as the incentive to join early is higher.
- Lower sales at ages 31-35, 41-45, 51-55, and 61-65 as the LHC loadings have increased at these ages. This is more than offset by higher sales at other ages as the LHC is relatively cheaper and there is increased incentive to insure before the next tier of loadings (this impact is assumed to be permanent as opposed to one-off).

Lapse rates are expected to be lower for those with and without LHC loadings – there is a higher incentive to keep the policy at some ages, as well as a price impact at other ages.

6.1.3 Evaluation against criteria

Participation and average age

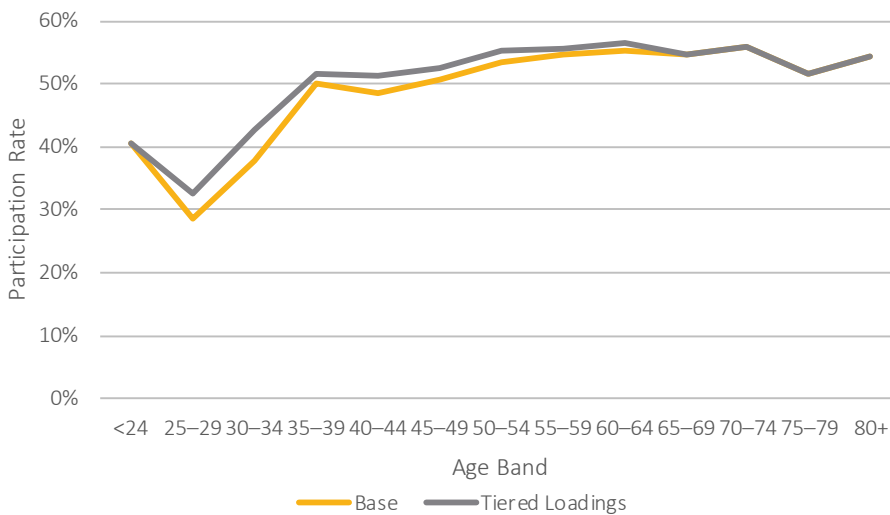
Table 6.2 shows the impact of tiered loadings on the participation rate and the average age of insureds after five years of implementation.

Table 6.2 – Impacts on PHI participation and average age (hospital insured persons)

	Base	Tiered Loadings	Change from Base
Participation Rate	46.1%	47.5%	1.3%
Average Age	41.8	41.7	- 0.1

The impact on PHI participation by age band is shown below.

Figure 6.1 – Impacts on participation by age band



Implementing tiered loadings is projected to:

- Increase participation between ages 25 to 35 as the incentive to join before age 31 increases
- Increase participation between ages 35 to 60 largely due to the incentive to join before the tier increases
- Have an immaterial impact on participation at older ages

Overall, tiered loadings are projected to increase participation between ages 25 to 60, which could, in isolation, result in premium rate reductions of up to 2.1%²³.

However, this scenario also resulted in higher sales and lapses, particularly at older ages, which could increase the overall administration costs to the industry. It is also not known what the impact on claims costs would be as a result of the change, however, as detailed above, it is expected that there would be an increase in the number of opportunistic joins, which could significantly raise the overall claims cost – and have a flow through impact on premium rates.

Stakeholder satisfaction

We received a significant amount of feedback during the stakeholder consultations that the communication from the Department to 30-year-olds regarding LHC is an important tool for increasing participation. However, it currently occurs once in an individual's lifetime, and the timing may not be right for all individuals. A step-change every 10 years would complement communication to those who have not yet purchased PHI, which may increase sales at later ages. Stakeholders may be satisfied with the additional communication that this reform would complement (noting that the impacts on participation of additional communication is estimated in the above impact on participation).

Other criteria

This approach is similar to the current system, on average over each decade, for equity, but is more favourable to those joining in the latter half of each decade. Access is also relatively consistent with current practice, however the increased awareness (prompted by more regular communications) could increase awareness and hence encourage participation. The system could be readily implemented, and so scores well on practicality.

6.1.4 Uncertainties

Our modelling of participation and average ages of this reform option relies on results of the Consumer Demand Survey. Consumers' survey responses were sometimes contradictory and consumer behaviour can be very difficult to predict as there are a number of factors beyond price change that may influence behaviour (e.g. the communication strategy accompanying any change). Therefore, the risk of model error, and that policy changes result in unintended consequences may be too high to consider any changes that are expected to have a small impact.

The projected change in participation rate remains relatively small, and whilst the industry is willing to change, they only wish to do so if there are significant and tangible benefits. The costs associated with this change may not be justified by the expected outcomes, and the greatest gains, arising from the opportunity for additional communication, could be achieved without structural reforms.

6.2 Linkages with other policy initiatives

In Section 5.1.1, we discussed some linkages between LHC and MLS, in that they both increase participation of people in the early 30s via different means. In this section we discuss further implications of the linkage between LHC and MLS as well as linkages between LHC and PHI Rebate. These linkages are important, as reforms to any one of these three policy initiatives may have implications for the others.

²³ Based on targeting a similar gross margin, allowing for changes in claims cost due to changes in age mix and projected changes in premium due to the changes in the LHC loadings.

6.2.1 LHC and MLS

MLS penalises higher income earning individuals and families who do not take out PHI cover through additional taxation. In order to determine how effective LHC continues to be in light of MLS, we have considered the impact of MLS on participation at ages 25-34.

The MLS is calculated on taxable income and varies by income and family status as shown in Table 6.3 below.

Table 6.3 – MLS thresholds²⁴

Threshold	Base tier	Tier 1	Tier 2	Tier 3
Single threshold	\$90,000 or less	\$90,001 - \$105,000	\$105,001 - \$140,000	\$140,001 or more
Family threshold*	\$180,000 or less	\$180,001 - \$210,000	\$210,001 - \$280,000	\$280,001 or more
Medicare levy surcharge	0%	1%	1.25%	1.50%

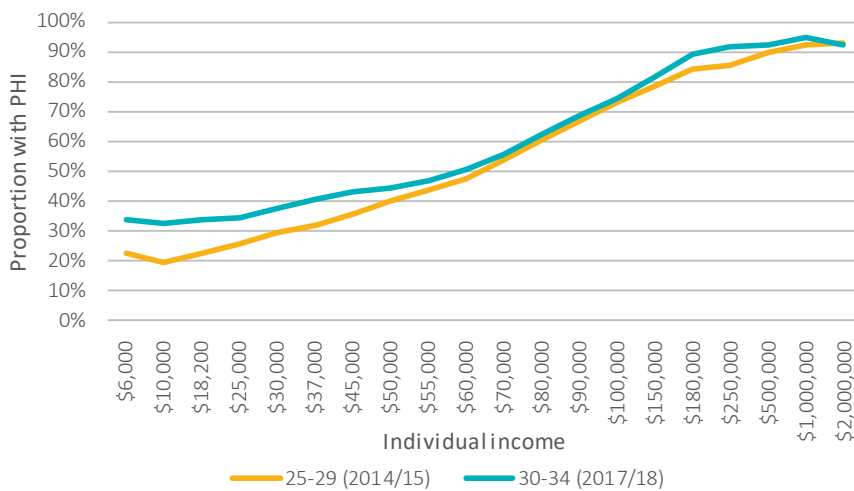
* The family income threshold is increased by \$1,500 for each MLS dependant child after the first child.

In Section 5.1.1, we noted the majority of the increase in PHI participation seen from 25-29 to 30-34 is attributable to the impact of the MLS, as people’s incomes increase as they age.

Under the current settings of the MLS and LHC, the MLS creates a stronger incentive to participate, because in most cases, it is cheaper to take out PHI than pay the MLS. Whereas, as shown in in Section 0, LHC reduced, but did not eliminate, the incentive to take out insurance at a later date.

We can therefore conclude that under the current settings, LHC will only incentivise those that are not affected by the MLS. We can observe this by comparing the proportion of taxpayers who hold PHI when they are aged 25-29 and when they are aged 30-34. We have used financial years 2014/15 and 2017/18 to try and show the impact of reaching age 30 for the one cohort.

Figure 6.2 – Proportion of taxpayers with PHI by income, age and year



The increase in participation (shown as the difference between the teal line and the yellow line) is greater for those at incomes below the MLS threshold (\$90,000) than those above.

²⁴ Source: Australian Tax Office, Income thresholds and rates for the Medicare levy surcharge, <https://www.ato.gov.au/Individuals/Medicare-and-private-health-insurance/Medicare-levy-surcharge/income-thresholds-and-rates-for-the-medicare-levy-surcharge/>.

Therefore, the standalone impacts of LHC are dependent on the MLS settings. If MLS parameters were to change, the effectiveness of LHC in its current form, and the effectiveness of reform would be different. Therefore, the following reform options with significant interactions with MLS will be considered in the review of MLS:

- Raising the starting age of the LHC from 31
- Modifying the MLS by age to encourage earlier participation and removing the LHC

6.2.2 LHC and the PHI Rebate

The PHI Rebate is primarily designed to improve the affordability of PHI for those meeting certain age / income criteria. By reducing the amount of premium paid by policyholders, the PHI Rebate counters the impact of LHC loadings. In many cases, policyholders are subject to both LHC loadings and PHI Rebates (although the rebate does not apply to the LHC loading).

Case Study

John and Margaret are both aged 70, enjoying their retirement in the ACT, living on \$130,000 per annum. As their income is below the threshold, they do not have to pay the Medicare Levy Surcharge.

They dropped out of PHI 30 years ago at age 40, but are now looking to re-enter as their preferred cardiologist works at a private hospital. They are looking at purchasing a Gold product with a low excess, as they expect to have multiple claims in coming years.

The product they select is Gold cover with a \$250 excess priced at \$6,396 per annum. They find that they have to pay an additional 60% loading as they have been out of private health for so long (30years x 2% for each year) – which equates to \$3,838.

However, due to their age and income, they are also entitled to a rebate of 32.812%, which only applies to the base premium (prior to the loading). The amount of the rebate is \$2,099.

The total amount John and Margaret end up paying is \$8,135.

Base premium	\$ 6,396
<u>LHC Loading</u>	<u>\$ 3,838 (= 30yrs x 2% x \$6,396)</u>
Premium before rebate	\$10,234
<u>Rebate (on base only)</u>	<u>-\$ 2,099 (= 32.812% * \$6,396 deduction as rebate)</u>
<u>Premium to be paid</u>	<u>\$ 8,135</u>

A number of stakeholders have raised that the interaction between the LHC and the PHI Rebate can be confusing to both staff and consumers, and a clearer alignment between policies may assist.

6.3 Other options considered

Our draft consultation paper drew together a “long list” of options which had been developed through discussion with industry and stakeholders, as well as an examination of international experience.

After reviewing stakeholder feedback, and a detailed assessment of each option with respect to both their ability to meet the objectives of LHC, and the criteria (access, equity, efficiency, practicality), we selected a number of options for further modelling.

Apart from tiered loadings and the two options to be reviewed alongside MLS, the following other options were considered but ultimately rejected for more detailed assessment for the reasons presented below.

- LHC loadings apply for lifetime:

While this option was consistent with the original design and launch of LHC, this option would impede the ability of Australians with a loading to later upgrade their cover or choose a product best suited to their healthcare needs. The introduction of the ten-year cap on LHC loadings from April 2007 noted “this measure recognises and rewards people who have made the effort to maintain their cover over time, having first joined after the age of 30. They have made the effort and they deserve the credit for their commitment and loyalty²⁵.”

- Adjust the loadings to reflect expected drawing rates of late entrants:

Analysis presented in Section 5.2 showed that those policyholders with an LHC loading claimed at a higher rate than those without a loading. This reform option sought to change the LHC loading to ensure the loading collected was sufficient to meet these higher costs.

Based on our analysis, this would result in a higher loading for Gold hospital products and lower loadings for other products. While this may reduce adverse selection of late joiners on Gold hospital products and assist in making other hospital products more affordable, there would be significant impacts on product choice, as well as increased complexity and further challenges to communication of LHC.

- Good experience bonus:

This option, with significant stakeholder support, intended to reduce the disincentive of LHC for healthier late entrants to PHI. However, this option would be accompanied by significant implementation, and the practical hurdles in maintaining claims histories as policyholders change insurer meant this option was not ultimately considered.

Further detail on these assessments were included in the October report.

6.4 Transition considerations

Should a decision be made to reform existing LHC arrangements (including closer integration with other policies), we received strong and consistent stakeholder feedback that there needs to be an appropriate transition program and consultation period.

6.4.1 Requests for consulting with stakeholders

Stakeholders requested that any consultation on proposed LHC reform should be accompanied by implementation planning which considers:

- The ongoing effectiveness of MLS and the anticipated interaction effects between the LHC and MLS
- The one-off impact on premium rate increases (to be determined in consultation with insurers, as the approach adopted could have significant impacts on the industry through product tier selection)
- The ongoing rate increase impact as a result of expected claims and retention behavioural impacts
- The treatment of policyholders currently paying an LHC loading (or the likely consumer behaviour, including lapse and product choice following reform announcement) at the point of change
- Estimates of the impact on claiming behaviour (possibly after further consumer consultation)
- Estimates of the impact on the regulatory capital requirements of insurers
- Potential impacts on non-insurer stakeholders, such as hospitals, intermediaries and care providers

²⁵ Hon. Tony Abbott, Private Health Insurance Bill 2006 Second reading speech, House of Representatives, Debates, 17 December 2006.

6.4.2 Development of transition arrangements

Stakeholders requested that in making LHC reform consideration be given to an appropriate lead time to allow insurers and other stakeholders to prepare for changes required in:

- IT systems – including customer management, claims management systems
- Marketing, communication and operational requirements (including training staff)
- Addressing regulatory requirements for product changes, capital, reporting etc

Insurers suggested the desired implementation period for implementing changes impacting customers, particularly the PHI incentives is approximately 2 years.

6.4.3 The potential for a temporary removal of LHC

A number of stakeholders requested that the Department consider temporarily removing LHC for new joiners as part of the review of LHC, and as a form of transition. Such an initiative could be considered regardless of whether any reform of LHC was made, as it could be conducted as a one-off under the current LHC arrangements.

We have not investigated the potential impact of a temporary removal at this time, given there remain a number of LHC reform options that will be modelled as part of the MLS review. However, we offer these considerations:

1. Temporarily removing LHC for new joiners could create consumer expectations of future, similar initiatives and so diminish the effect of the incentives created by LHC.
2. Therefore, it would have to be clear to consumers that the removal was one-off. It may be that the health environment created by the COVID-19 pandemic offers such an opportunity to appropriately construct and communicate a one-off amnesty, however, the window of opportunity for such an initiative is limited

7 Findings and recommendations

This actuarial study examined the impacts of LHC. Two research areas were defined:

- 1 Review current scheme effectiveness: Are the goals and objectives of LHC being achieved?
- 2 Opportunities to reform: What LHC arrangements offer possibilities to better achieve objectives?

7.1 Review effectiveness of LHC

The modelled impact of LHC on PHI participation and the average age of insured persons is in line with its stated objective, but relatively small. Our modelling is based on the surveyed responses from Australians, and we note that the reasons Australians have for purchasing PHI are complex. It is difficult to ascribe LHC as the single reason for an individual or household to obtain or maintain their PHI cover.

The value of the 'maintain' objective of LHC is significant, with better retention outcomes as a result of LHC, especially among younger Australians a powerful effect of the policy. We find that removing LHC would require industry premium rate increases of at least 2.5% to maintain the current level of financial performance and position of the PHI industry, with the likelihood of higher premium increases to combat greater incidence of adverse selection.

7.1.1 Are the goals and objectives of LHC being achieved?

Assessing the impact of LHC in isolation is difficult because the outcomes might be the result of factors that are not associated with LHC such as the PHI Rebate and the MLS. Despite its challenges, our assessment indicates that LHC has made and continues to make a positive contribution to participation.

However, with the program now mature, the ongoing positive impact of LHC is harder to detect. There is also evidence that the effectiveness of LHC's incentive to encourage Australians aged under 31 to obtain PHI is decreasing. A part of this decrease in effectiveness reflects the fact that the MLS thresholds have not changed since 2014/15 and so LHC is less relevant for the increasing proportion of Australian individuals and households earning above the MLS thresholds. For those earning less than the MLS thresholds, the increasing cost of PHI relative to household budgets means that budgetary constraints are a more dominant factor than the LHC price signal for the PHI purchasing decision.

7.1.2 Does LHC have other beneficial effects?

In encouraging Australians to obtain and maintain PHI, the LHC program reduces adverse claiming and lapse behaviour. This makes PHI more affordable, all else being equal, to all Australians.

7.1.3 Does LHC have unintended consequences?

There is evidence that LHC results in less than optimal product choices for some Australians. In particular, older Australians are electing to hold lower levels of cover while subject to LHC loadings before promptly upgrading after the ten-year loading period is served.

7.1.4 Conclusion

LHC has made and continues to make a positive contribution to participation in PHI.

LHC has, historically, seemed to contribute to PHI participation outcomes in excess of that expected from a pure price or economic argument, suggesting it plays an important role in contributing to community 'norms' and attitudes. There is evidence that this behavioural role is weakening or becoming less relevant for younger Australians in the face of affordability challenges.

While any LHC reforms should be directed at enhancing the effectiveness of the 'obtain' objective, they must also be assessed against their impact on the incentive for insured Australians to maintain PHI cover.

7.2 Opportunities to reform

LHC and other consumer incentives levers are complicated because the Australian population is heterogeneous. Stakeholders are interested in ensuring reforms increase simplicity and ease of communication to Australians, while also advancing consumer choice, increasing PHI participation and improving affordability. There are limits to what reforming a price signal like LHC can achieve, however, there are opportunities to make incremental changes and test alternative communication strategies to better meet the varied needs of Australians.

Implications and recommendations from this study are:

- Our research and analysis did not identify any immediate imperative to change the current LHC arrangements in isolation.

However, we have investigated a change to the structure of LHC loadings to a more tiered structure, creating additional points of communication to individuals who have not yet taken out a PHI policy.

It is noted that relatively small changes in price alone are not enough to change participation materially.
- We recommend the LHC policy lever be considered with other policies such as the MLS and PHI Rebate.

As the MLS and PHI Rebate are reviewed in 2022, it will be important to also include the impact of the LHC, and age-based discounts, to determine a cohesive set of policies to move forward with. As part of this analysis, we recommend reviewing the impact of increasing the starting age of LHC to age 35, whilst also considering the impact of changes to the MLS on LHC.
- Opportunities to enhance the frequency and effectiveness of communication about PHI should be investigated.

These opportunities should not be limited to LHC, but should seek to inform potential consumers of the options available, including information about the benefits offered, access to incentives and the potential impact of penalties. Any changes to communication should also consider the impacts of the associated costs.

Through our consultations, we note that stakeholders are not averse to change, however they require it to have significant tangible benefits to justify the work involved, and appropriate lead times to implement it well.

8 Reliances and limitations

8.1 Distribution and use

This report is provided for the sole use of the Department for the purpose of understanding the findings of the LHC study. It should be considered together with our previous LHC reports, which provide more detail on our findings. The report is not intended, or necessarily suitable, for any other purpose. This report should only be relied on by the Department for the purpose for which it is intended.

No other distribution of the report is allowed, unless we give our approval in writing. Any third party receiving this report should not rely on it, and this report is not a substitute for their own due diligence. We accept no liability to third parties relying on our advice.

Please read the report in full. If you only read part of the report, you may miss something important. If anything in the report is unclear, please contact us. We are always pleased to answer your questions.

8.2 Data provided

We relied on the completeness and accuracy of the information we received. This includes detailed data provided by Australian health funds.

We did not audit or verify the information provided to us, but have reviewed it for general reasonableness and consistency. If the information provided to us is inaccurate or incomplete, we may need to change our advice.

8.3 Uncertainty

Many things may change in the future. We have formed our views based on the current environment and what we know today. If future circumstances change, it is possible that our findings may not prove to be correct.

As well as difficulties caused by limitations on the historical information, outcomes remain dependent on future events, including legislative, social and economic forces. It is quite possible that one or more changes to the environment could produce an outcome materially different from that expected.

