Review of MLS, PHI Rebate and LHC

Australian Government Department of Health and Aged Care

1 Executive summary

1.1 Scope

The Australian Government Department of Health and Aged Care (Department) engaged Finity Consulting Pty Ltd (Finity) to investigate the effectiveness of the Medicare Levy Surcharge (MLS) and the PHI Rebate, including the interaction with Lifetime Health Cover (LHC). The scope of work includes identifying alternative policy settings, and modelling a shortlist of alternatives.

We understand the Department intends to use this report to develop reform options for the PHI sector. The Department's objective is to improve the affordability and value of PHI for consumers, further optimise participation in PHI and its contribution to the sustainability of the mixed delivery model of private and public healthcare.

1.2 Why does government incentivise PHI participation?

The objective for the Australian health system can be summarised as universal access to high quality care that results in the best health outcomes, at an efficient and affordable cost to individuals and the community.

Australia has a mixed delivery model of public and private healthcare. To maintain the mixed system with optionality, both the private and public health system need to be meeting consumer needs in a financially sustainable way.

Individuals can choose how they wish to engage with and pay for private healthcare, and have the option of community rated private health insurance. Premiums reflect the average claim cost of everyone insured, rather than individual expected healthcare needs. Without insurance, many people with a significant treatment need who do not have significant wealth would not be able to access private hospital treatment at an affordable cost.

Since PHI premiums reflect the average claim costs of people insured, premiums would not be affordable if only people with high expected treatment needs are insured. Policies which incentivise broad participation in PHI (including by people in good health) result in lower premium rates, which in turn makes private healthcare affordable for more Australians.

> Government incentivises PHI participation because this contributes to funding the overall sustainability of Australia's health system.

Where this report refers to the health system, we are referring to the entire Australian health system which includes both public and private healthcare.

1.3 Why review the PHI incentive policies?

It is important to ensure the incentive policies continue to benefit the objectives of the health system. Continuing effort to optimise the policy settings is necessary to ensure they provide best value to consumers and the community.

The PHI Rebate, MLS and LHC were introduced between 1997 and 2000 following many years of declining PHI participation, and the proportion of Australians with PHI has remained between 43% and 47% since this time. There have been many changes to PHI policy settings over time, for example, changes to the PHI Rebate and MLS rates for different age and income groups. More generally, the incidence of different medical conditions, as well as the nature and accessibility of public and private health services relevant to those conditions, also continue to change. Because there has been no holistic review of the incentive policies for many years, it is unlikely the policy settings have always been optimal, or are optimal now.

1.4 What do the incentive policies do?

With the objective of supporting the sustainability of the Australian health system, and in particular facilitating access to private healthcare for individuals, the incentive policies have two intended impacts:

- Those who can afford to contribute more to their healthcare are encouraged to do so through purchasing PHI.
- For others, PHI supports access to private healthcare.

The individual policies have these impacts in the following ways:

- MLS: Ensures very high participation rates for high earners, exceeding 90% for some segments. Relatively low average claim costs for this group help reduce average premiums, which makes PHI (and private healthcare) more accessible.
- PHI Rebate: Improves access to PHI by making premiums more affordable, both directly through subsidy and indirectly by making PHI more attractive to those in good health.
- LHC: Supports community rating by providing incentives for people to obtain private hospital cover earlier in life, and encouraging them to maintain it.

For each policy, this review considered who is incentivised, what are they incentivised to do, and whether the level of incentive is effective, efficient and equitable.

Policy tensions

Policy trade-offs create tensions in designing incentive policies.

- Policies which enable better access to private healthcare for people with high expected claim costs will transfer costs from the public to private health systems. Such policies will:
  - Provide value to government, where claim costs transferred to the private health system exceed the government funding provided (for example, through the PHI Rebate and private hospital Medicare benefits).
  - Make PHI less affordable, where the expected claim costs of people taking out PHI exceed the premium paid.
- Policies which incentivise people with low claim costs to insure make PHI more affordable, however, policies which aim to increase participation by people in good health should be equitable. For example, in the case of people in good health and on low incomes:
  - It is not fair to apply an income surcharge or other adverse consequence for not participating.
  - Given all Australians have access to the public health system, highly subsidised PHI may represent poor value to both government and the individual.

Policy limitations

In considering what the policies do, it is important to note that PHI incentive policies alone cannot achieve the Australian health system objectives, or address all consumer concerns. For example, the PHI policy incentives cannot wholly address issues such as out of pocket costs, or the scope of services covered by PHI. Optimising and appropriately integrating all government policies relating to PHI will assist in meeting the health system objectives.

1.5 Analysis

We highlight two pieces of analysis which have informed our findings and recommendations.

Economic experiment

We undertook an economic experiment to estimate how changes in the MLS, the PHI Rebate and LHC would affect participation in PHI. The experiment was run as an online survey, in which over 1,500 people participated.

The experiment begins by showing each consumer a scenario based on the current policy settings, and asking the respondent to choose from the available products. The prices shown reflect individual characteristics such as age, income, and LHC loadings. We then repeat the same process several times, showing the consumer the choices available under alternative policy settings. By showing multiple scenarios to a large number of respondents, we identify what policy changes would have a material impact, and which consumers they would impact.

Offset analysis

Before examining individual policy settings and the extent to which the current position can be enhanced, we examine whether the policies result in a positive overall financial contribution to the health system. We find that on balance incentive policies reduce government funding obligations. However, this does not mean the current policies are optimal.

We compared the public health system costs saved when an individual buys PHI (the "offset") to the cost to government of incentivising PHI participation. In estimating public health system costs, we assumed that if people did not obtain treatment in the private sector they would have used the public sector. Note that we do not make any distinction between Commonwealth and State government spending.

We adjusted private health claims to better reflect the public sector costs. Specifically, we adjusted for higher prosthesis costs in the private health system, and allowed for the private hospital medical benefit of 25% of MBS fee. The analysis was based on actual historical claim data, so does not allow for future changes to prosthesis pricing.

We found that the cost of the treatment funded exceeds the cost of the incentive policies, meaning that PHI is making a positive contribution to the financial sustainability of the Australian health system. On average, for each person purchasing PHI the treatment funded exceeds the cost of the PHI Rebate by over $900. This result is intuitive because, while individuals can access public sector treatment at no cost, buying PHI requires a significant individual financial contribution to the Australian health system (even after allowing for any PHI Rebate the individual is entitled to).

Comparing the cost of the treatment funded to the cost of both the PHI Rebate, and the revenue foregone because people holding PHI do not have to pay the MLS, the average net benefit of over $900 per person reduces to around $550 per person. It is debateable whether this is the more appropriate calculation, because the MLS is intended to incentivise PHI participation rather than raise government revenue.

We repeated the analysis by age group, income and policy type (single / family), and found there was a net benefit to government for each segment (public health system costs exceed cost of the PHI Rebate and MLS revenue foregone). The net benefit was highest for older people, given this group is most likely to require hospital care.

While government policy for PHI balances a range of competing factors, for hospital insurance this offset analysis provides a sound basis for testing the overall rationale for government support for each population segment. In terms of ongoing review, the arrangements should always produce a net benefit to government finances when the cost of incentivising PHI participation is compared to the cost of treatment funded.

1.6 Our findings

This section summarises the main findings of our review, based on the economic experiment, offset analysis and other investigations undertaken. These findings lead us to the recommendations set out in Section 1.8.

MLS

The MLS makes not insuring an economically irrational choice for the highest earners (tiers 2 and 3), where the surcharge amount is set well above the basic PHI premium. MLS therefore has a much more powerful impact on the individuals it targets than the other PHI incentive policies, and the key decision is when is it fair to apply such a strong incentive to individuals.

Even when the MLS is targeting the appropriate people (such as those on very high incomes), it may not be incentivising the most desirable actions because only the purchase of Basic tier hospital cover is necessary to avoid the MLS.

PHI Rebate

The PHI Rebate makes PHI more affordable, so a lower PHI Rebate results in lower participation, and a higher PHI Rebate result in higher participation. However, the impact of changes in the PHI Rebate vary depending on the size of the change, and the groups or products targeted. For example, the statistics below demonstrate the material differences by age, assuming a base tier PHI Rebate. While people can experience good or poor health at any age, the statistics refer to the average amounts for different age groups.

- For over 75s, average hospital claims are over $7,000 per person, average premium is around $3,000 per person before PHI Rebate, and average PHI Rebate is $965 per person. The PHI Rebate is small compared to the average hospital claims, which would need to be funded by the public health system if the individual decided not to insure.
- For 40-45 year olds, average hospital claims are around $850 per person, average premium is around $2,400 per person, and average PHI Rebate is $580 per person. While the difference between claim costs and PHI Rebate is lower than for over 75s, high premiums relative to claim costs support PHI affordability for older Australians.
- The above amounts are averages across all product tiers, and allow for there being no PHI Rebate on the LHC component on premiums. The average premium is higher for older people as they are more likely to purchase Gold products.

Removing the PHI Rebate entirely would result in a worse overall outcome for the sustainability of Australia's health system. We estimate the short-term impact would be a 10% reduction in the number of people covered by PHI, and a reduction in hospital claims funded by PHI of $2.3bn-$3.1bn per year. While this is lower than the annual PHI Rebate of $4.8bn for hospital products, the longer-term impacts of removing the PHI Rebate could be more significant, with the potential for a spiral of higher premiums followed by selective lapse and further premium increases, a scenario which is not consistent with a sustainable PHI industry.

The PHI Rebate has varied by household income since 2012, and has reduced as a percentage of premium since 2014 due to indexation. Our testing indicated that restoring the PHI Rebate to the levels that applied before these changes would represent poor value for money for government. With respect to the hospital component of PHI, we estimate restoring the PHI Rebate would result in a small (1%) increase in the number of people with PHI, increase the cost of the PHI Rebate by $2.2bn per year for hospital products, and increase claims funded by PHI by $0.4bn - $0.5bn.

There are opportunities to optimise and simplify the PHI Rebate. In particular:

- The PHI Rebate for tier 1 and tier 2 earners has limited impact on participation, because the MLS creates a strong participation incentive. The annual PHI Rebate paid to this group is currently around $380m.
- As shown above, PHI Rebates for older people provide value for government, given the high average claim costs of this group. We estimate that removing PHI Rebates for over 65s would reduce the claims funded by PHI by $2.3bn, which exceeds the PHI Rebate paid to the group.

LHC

LHC incentivises people to obtain private hospital cover earlier in life, and then maintain their cover. If there were no adverse consequences for taking out PHI later in life, or buying PHI only when treatment is planned, average premiums would need to be higher to cover the resulting average claim costs. It is therefore important to ensure an incentive exists that encourages people to both purchase and then continue holding their cover.

There are sound reasons for the incentive to vary according to age of entry, and to have a maximum loading, to maintain access at all ages. It is also necessary to have special rules in cases where people might reasonably take out cover at other ages, for example, due to migration. Options which remove any of these features are simpler, but test poorly against other criteria such as equity.

We have tested a range of options including changing features of the incentive such as the LHC start date, loadings and other rules, and none of the options tested represent a significant improvement on the current policy settings, or provide benefits that are sufficiently able to justify the costs of change.

In particular, the option to increase the starting age (from 30 to 35 or 40) would benefit people who take out PHI later in life, but does not result in a materially better outcome for the overall Australian health system.

Extras insurance

Our study has focused on the hospital policies, as these are more financially material than extras (general treatment) cover, and there are interactions between the PHI Rebate, MLS and LHC. In respect of the PHI Rebate, we estimate that almost 70% of the cost of the PHI Rebate is in respect of hospital, with only 30% in respect of extras. MLS and LHC do not apply to extras.

Extras funds services which are important to health, recommended by health professionals, and for which no Medicare rebate is available. Because no Medicare funding is available for most Extras services, it is not possible to demonstrate the extras PHI Rebate provides value for money in the same way as for the hospital PHI Rebate (the offset analysis).

Extras covers a wide range of treatments, however over 70% of the claim cost is in respect of dental and optical services. Services which the government identifies as inappropriate do not receive PHI Rebate funding.

While there are alternatives to PHI such as self-funding, insurance facilitates access to treatment through regular monthly premiums, access to insurer preferred provider networks, and the pooling of risk. For example, following an accident an individual may require significant dental treatment, physiotherapy, and psychology services over an extended period. Extras insurance would make a significant contribution to the treatment costs, and the premium charged does not reflect individual expected claim costs.

Our survey data indicates extras cover and PHI Rebates are valued by consumers. For people with both hospital and extras covers, the economic experiment found there was only a small impact in demand arising from a small change in price or PHI Rebate, but a much larger response to removal of the PHI Rebate.

1.7 Stakeholder perspectives

Issues raised by consumers we surveyed included PHI affordability, and perceived value given issues such as out of pocket costs and the ability to access care without PHI. While some consumers find PHI complex, cost and value are the primary concerns.

The general consensus from industry stakeholders was a preference for options which gave stability in participation, with the potential for modest improvement. Aspirations for significantly increasing participation were modest.

Many industry stakeholders identified complexity as one of the most important factors, and thought that complexity may be reducing the effectiveness of the incentive policies. While there is a preference for simplification, many stakeholders also believe changes in incentives should be focussed on particular groups, and this targeting requires a level of complexity in the policy settings.

Stakeholder engagement has not identified a consensus on the preferred options with respect to PHI Rebate, MLS or LHC. Increasing participation incentives (for example, via higher PHI Rebates or surcharges) are suggested by some stakeholders, however this needs to be balanced with other criteria such as equity and value for government.

There is greater industry stakeholder alignment regarding the longer-term direction of PHI, including the need to address issues of concern to consumers such as out of pocket costs, and the limited scope of PHI. Through detailed discussion at a stakeholder forum, it was apparent to stakeholders that achieving longer term objectives would require significant policy changes over an extended period. Changing only the incentive policies (PHI Rebate, MLS and LHC) will not achieve these objectives.

In the short term, our approach is to consider options in the context of the project objectives, and make data driven recommendations. The PHI policy incentives cannot make the longer-term policy changes required to address consumer concerns such as out of pocket costs. However, they can support other policy changes by providing space for innovation, and through ongoing optimisation.

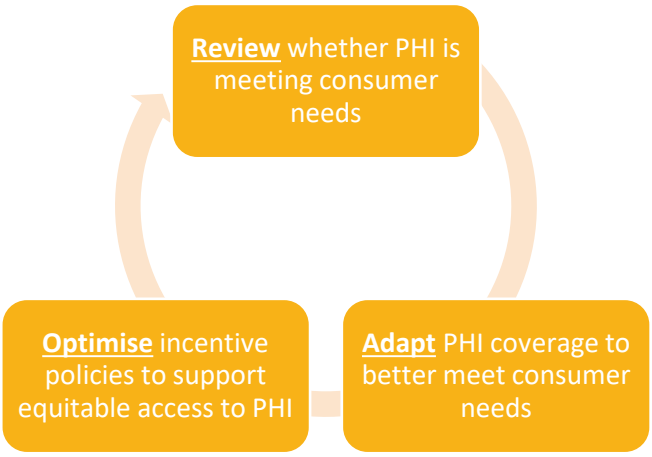
1.8 Our recommendations

Recommendation 1 – Overall recommendation

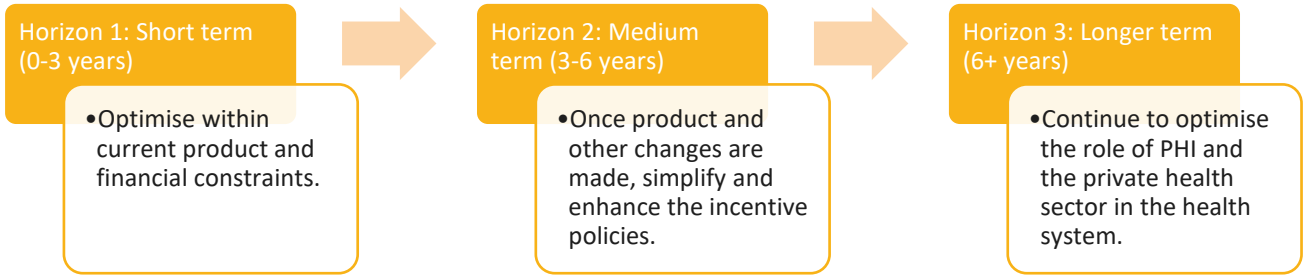
We recommend establishing a process to regularly review and adapt PHI policy settings. This will allow settings to become more optimal over time, better meeting consumer preferences and efficiently supporting health system objectives.

We have identified opportunities to enhance current policy settings. However, our overall recommendation is much broader since PHI incentive policies alone cannot achieve the health system objectives, and policies which are appropriate today will not always remain optimised.

This can be thought of as an iterative process of review of whether PHI is meeting consumer needs, adaption to better meet needs, followed by optimisation of the incentive policies, as set out below:



We propose three-time horizons for recommendations:



In more detail:

- Horizon 1 - Short term (0-3 years): The current state has many positives and the focus in this horizon should be on small changes that can be acted on quickly within the current constraints, and are consistent with longer term objectives. For example, these recommendations do not require changes to what is covered by PHI, and can be achieved in the context of the current funding commitment.
- Horizon 2 - Medium term (3-6 years): These recommendations aim to simplify and enhance private health insurance. They may require changes to other policy / regulatory settings before they can be actioned, for example, changes to what is covered by PHI, or an ability to consider wealth in setting PHI incentives.
- Horizon 3 - Longer term (6+ years): The longer-term vision to ensure PHI continues to adapt to meet both consumer preferences and Australian health system needs. In particular, simplification of PHI policy settings provides more scope for longer term innovation.

Horizon 1 - Short term recommendations (0-3 years)

Recommendation 2 – Retention and optimisation of the MLS, PHI Rebate and LHC

We recommend the MLS, PHI Rebate and LHC be retained.

- MLS should be retained because it is equitable in that high earners are incentivised to buy PHI irrespective of expected claim costs, which helps moderate premiums for others who wish to access private healthcare.
- The PHI Rebate should be retained because, by making PHI more affordable, it improves access to private healthcare and helps ensure PHI makes a meaningful contribution to Australia's health costs. This is supported by the offset analysis summarised in Section 1.5 above.

- LHC should be retained because it is necessary to have a policy to incentivise those not subject to MLS to obtain hospital cover earlier in life, and encourage them to maintain it. If people purchase PHI only when treatment is required, PHI premiums would be higher which limits access to PHI.

Our recommendations to enhance the optimisation of the MLS and PHI Rebate are set out below. We have not identified options to change LHC which result in significantly better outcomes.

MLS recommendations

We recommend the MLS be optimised as set out below:

Who should MLS incentivise?	**Recommendation 3 – incentives for the highest earners** **That MLS continue to strongly incentivise the highest percentile of earners to contribute to the Australian health system by buying PHI**. In terms of the definition of high earners, current MLS tiers 2 and 3 (corresponding to the highest 10% of earners) have the greatest capacity to pay for PHI, so should continue to be subject to the MLS. That is, the current setting is in respect of the highest 10% of earners. **Recommendation 4 – incentives for others with above average income** **That MLS not be extended to those earning less than $90k.** **That government consider removing some or all tier 1 earners from MLS**. This could be done by abolishing tier 1, or reducing the number of people in this tier over time (for example, by indexing thresholds). The arguments for applying the MLS to tier 1 earners are more finely balanced than for tiers 2 and 3. PHI represents a more material proportion of earnings for this group than for tiers 2 and 3. The low participation rate (relative to tiers 2 and 3) demonstrate the challenges with the PHI value proposition for this cohort. Recommendation 5 – indexation **That MLS thresholds be annually indexed to reflect changes in earnings** Because the purpose of MLS is to incentivise high earners to take out PHI, MLS is unlikely to be optimised if thresholds do not change over time to reflect changes in earnings. **Recommendation 6 – incentives for wealthy people** **That government investigate whether an equivalent of the MLS could be developed for high wealth households.** It is currently not practical to assess capacity to pay based on wealth. Wealthy Australians have the capacity to contribute more to their healthcare costs. However, if they are not high earners in a given tax year, wealthy people would not be subject to the MLS and would receive a PHI Rebate. As well as allowing an equivalent of the MLS to be applied, a wealth indicator would allow PHI Rebates to be retargeted away from this group.

What should MLS incentivise these groups to do?	MLS incentivises those with capacity to contribute more to the cost of their healthcare to buy PHI. It follows that MLS should incentivise a level of cover which allows this group to access private healthcare, should treatment be required. Recommendation 7 – level of cover for MLS exemption **That those on the highest incomes (current tiers 2 and 3) be required to buy Silver-tier or higher hospital cover to avoid MLS.** This ensures high earners have cover for a wide range of categories, including heart and cancer, while maintaining a level of policyholder choice. If tier 1 earners remain subject to MLS, they should not be required to buy Silver cover due to the high cost relative to income. The typical cost of a Silver tier product is currently around $2,000 per year, or $2,500 for Silver Plus (single before PHI Rebate). If tier 1 earners remain subject to the MLS, Bronze-tier cover could be required.
How should MLS incentivise these groups?	Recommendation 8 – MLS rate **For those on the highest incomes (current tiers 2 and 3), we recommend the MLS be set at 2% of income** This is a simplification of the current arrangements, where different MLS rates apply to tier 2 (1.25%) and tier 3 (1.5%). The 2% surcharge exceeds the cost of buying Silver-tier hospital cover. The level of the surcharge should be reviewed periodically to ensure it remains a strong incentive for the highest earners to contribute to funding the health system. If tier 1 earners remain subject to MLS, the MLS could also be increased to 2%. This simplifies the MLS arrangements, and incentivises the purchase of PHI. Alternatively, the MLS could remain at 1% for this group, if a higher surcharge is considered unfair.

PHI Rebate recommendations

Recommendation 9 – PHI Rebate optimisation

We recommend the optimisation of the PHI Rebate be enhanced as set out below.

- **That the PHI Rebate is removed for tier 2 earners.** This aligns with the current settings for tier 3 earners. This is the segment where the PHI Rebate provides least value for money for the community, as individuals are already strongly incentivised to buy PHI through the MLS, and have capacity to insure without the PHI Rebate.
- **That the PHI Rebate for seniors is increased**. If the objective of government is large offsets (that is, ensuring the cost of treatment funded through the private sector materially exceeds the PHI Rebate), this is the segment where the PHI Rebate provides greatest value for money for the community, due to high average claim costs.
- **That older Australians only receive a higher percentage PHI Rebate than younger Australians subject to buying Silver or higher tier hospital cover**. Paying a higher PHI Rebate assists seniors to access private healthcare if treatment is required. Incentivising Bronze or Basic cover does not meet this objective, because many treatments older people are likely to require are excluded from these policies. The age at which a higher PHI Rebate applies should align with the Age Pension Age (which is currently 67), rather than being fixed at 65.

Removing the PHI Rebate for tier 2 earners and increasing the age at which higher percentage PHI Rebates apply would reduce government spending on the PHI Rebate, and increasing the PHI Rebate for seniors would increase government spending on the PHI Rebate. The changes could be implemented in the near term (with higher PHI Rebates for seniors funded by the other two changes) or phased in over an extended period.

Horizon 2 - Medium term recommendations (3-6 years)

There recommendations cover the following areas:

- Changes to incentive policies which we have identified as desirable, but are unable to be implemented in the short term (recommendation 11, wealth indicator)
- Given changes to incentive policies are not sufficient to achieve objectives, changes to other PHI policies (recommendations 12 and 13, pricing regulation and product coverage)
- Ongoing integration and optimisation of incentive policies, consistent with recommendation 1 (including with respect to integration and communication).

Recommendation 11 – Wealthy people

That the Government implement a wealth indicator if this is found appropriate in the investigation recommended in horizon 1 (see recommendation 6).

As explained above, this would allow the incentive policies to be more appropriately targeted.

Recommendation 12 - Pricing regulation

That **the Department consider what changes should be made to pricing regulation,** given any changes made to incentive policies**.**

For example, if the incentive policies are focused on Silver-tier (or similar) policies, there is less need to regulate pricing for lower coverage products.

Recommendation 13 – Superior PHI product

That PHI policies evolve to better meet consumer needs.

As part of this work we sought to understand consumer and other stakeholder concerns regarding PHI, and attempted to address them through changes to the incentive policies. While PHI product benefits were not within our scope of work, and this recommendation reflects identified stakeholder concerns which cannot be addressed through the incentive policies.

This recommendation could involve changing the package of benefits covered by PHI with respect to the treatment cover, where treatment can be provided, prevention activity and out of pocket costs. The other PHI policy settings can then be targeted with respect to the improved PHI product, for example, requiring this product to be obtained to avoid MLS, directing PHI Rebate funding to this product, and ensuring risk equalisation settings are appropriately aligned.

Recommendation 14 – Ensure policies remain optimised and integrated

That the effectiveness of the incentive policies is regularly reviewed.

The PHI industry, health sector and population are dynamic. Reviewing and adapting incentive policies regularly enhances the potential for policies to move toward the optimal settings. Performing the offset analysis set out above will provide a sound check on the rationale of government support for each population segment.

This is important to ensure a link between changes to incentive policies and the effect on the net offset. This involves updating the break-even analysis that illustrates the factors associated with whether an increase in incentives increases/decreases the net offset. That is, how much participation needs to increase in response to a subsidy in order for the subsidy to be budget neutral. Regularly updating the expected response to subsidies based on data analysis can guide the government in terms of whether, from the standpoint of public budgets, subsidies should be increased or decreased.

We recommend that, if changes are made to one incentive policy, appropriate changes are made to the other incentive policies to ensure they remain appropriately integrated. PHI Rebate and MLS policies should remain integrated. At the present time, there is limited scope to integrate LHC with these policies, as that would increase the complexity of the PHI Rebate and MLS, with no significant gain, and possible adverse impacts. However, there may be scope to better integrate the policies in future, if there are other changes in PHI regulation.

Recommendation 15 - Communication

Once the policy settings have been determined, we recommend the Department develop a communication plan to maximise the effectiveness of the policies.

Whatever the policy settings adopted, their effectiveness will be increased if they are well communicated. Government should be involved in communication, as it benefits from the effectiveness of these policies, and information from government has high reach and credibility. However, insurers can also do more to assist people making choices about PHI. There should be regular reviews of the effectiveness of both government and insurer communication activities relating to PHI.

Horizon 3 – Longer term recommendation (6+ years)

Following the earlier recommendations, the private health insurance will have moved towards being more optimal and have had some complexities removed.

Recommendation 16

That government continue to regularly explore changes that better integrate the Australian health system, and in particular consider PHI policy levers in addition to the PHI Rebate, MLS and LHC. The context of this recommendation is that changes to the incentive policies alone are not sufficient to meet health system requirements.

Such consideration might encompass:

- Health financing, including state/federal cost shifting incentives;
- New care treatments like coordinated care;
- The potential for a standard benefits package and the role of co-payments and excesses;
- Community rating (since this is central to the need for mandates and subsidies);
- Information management in healthcare.

This may take the form of a number of specific inquiries which could be undertaken consistent with committing to a platform for change.

2 Introduction

This section provides an overview of the objectives of these policies and their history, and the indicators which would show success in future.

2.1 What are the objectives of these policies?

2.1.1 Community rating and other health system context

The principle of community rating, where premiums do not reflect an individual's health risk, enjoys broad stakeholder support and is a foundation of Australian PHI policy. Community rating improves access to private healthcare for people with significant treatment needs, however community rated premiums will far exceed expected claim costs for people in good health. This means that, if PHI participation is optional, then incentives such as the MLS, the PHI Rebate and LHC are needed to sustain the current participation rates.

Since PHI premiums reflect the average claim costs of people insured, increasing participation rates for healthy people results in lower premium rates for everyone insured. If only people with high expected treatment needs purchased PHI, premiums would not be affordable to the individuals.

Requirement for government policies to incentivise PHI participation
Policies which incentivise PHI participation by people in good health are essential to support the affordability of community rated hospital insurance.

An objective of the MLS, the PHI Rebate and LHC is to incentivise those who have capacity to contribute more to their health costs to purchase PHI. However, choice is an important feature of the private health system. It is not compulsory for any Australian to purchase PHI, and everyone has the option of treatment in a public hospital at no cost to the patient. These choices, together with community rated premiums, create a number of tensions in the policies incentivising PHI participation.

- **Value for the Commonwealth Government:** Incentivising people with higher than average claim costs (such as older people) to buy PHI transfers cost from the public to private health systems. Such policies may represent better immediate value for government than incentivising people in good health to purchase PHI, because the average claim costs for that group are low.
- **Value for people with health insurance:** Incentivising people with higher average costs to buy PHI increases the premiums for everyone insured (because community rated premiums reflect average claim costs). Incentivising people in good health to purchase PHI makes premiums more affordable.
- **Value for people in good health** (typically younger adults)**:** While incentivising this group to buy PHI ensures community rating is financially sustainable, the average benefits received by this group will be far less than premiums. It is possible to design participation incentives which make not insuring an irrational choice, for example, by applying an income surcharge which exceeds the cost of insuring. A challenge is to determine when it is equitable to apply such an incentive to groups who will claim far less than they pay in premiums.

Conflicting objectives create complex tensions in designing incentive policies.
Policies which enable better access to private healthcare for people with high expected claim costs will tend to provide good value to government but make PHI less affordable.

Policies which incentivise people with low claim costs to insure make PHI more affordable. However, policies which aim to increase participation by people in good health should be equitable, especially where they apply an income surcharge or other adverse consequence for not participating.

2.1.2 What is the history of the policies?

The history of these policies can be considered in three phases, and is summarised in the table below:

Period	Incentive policies	PHI participation (% of Australians with hospital cover)
1984 – 1997 After the introduction of Medicare, and before the introduction of the incentive policies	Various initiatives to reduce premiums, for example, by subsidising claim costs. No income surcharges or future premium loadings for people not insuring.	Reduced from 48.7% in 1984 to 32.1% in June 1997.
1997 – 2000 Package of incentive policies introduced	• July 1997: Introduction of the 1% MLS for high income earners (threshold set at $50,000 individual/$100,000 family), and the Private Health Insurance Incentive Scheme (PHIIS). PHIIS was an early form of the PHI Rebate, as it provided a fixed dollar subsidy to people on low incomes who took out PHI. • January 1999: PHIIS changed to a 30% PHI Rebate for all policyholders. • July 2000: Introduction of LHC.	Increased from 32.1% in June 1997 to 45.7% in December 2000.
2000 to present	Incentive policies have been periodically adjusted, including: • 2005: Higher PHI Rebate introduced for older Australians. • 2008: Increased MLS income thresholds (to $70,000 individual/$140,000 family) and indexed annually thereafter to average earnings. • 2012: Income testing of PHI Rebate percentage based on MLS income thresholds and increased MLS rates for higher income earners (1.25% and 1.5% for income tiers 2 and 3). • 2013: PHI Rebate no longer payable on LHC premium loadings. • 2014: PHI Rebate percentages indexed annually by a Rebate Adjustment Factor (RAF). The RAF reflects the difference between the annual increase in the consumer price index (CPI) and the average premium increase. Because premiums typically increase by more than CPI, the PHI Rebate is reducing as a percentage of premiums. • 2015: Indexation of income thresholds for MLS and PHI Rebate paused. Currently due to restart on 1 July 2023.	Over the period December 2000 to present, participation has ranged between 43.1% (June 2005) and 47.4% (June 2015). At March 2022, 45.1% of Australians had hospital cover.

Historical impacts of the policies to incentivise PHI participation

The PHI Rebate, MLS and LHC were introduced following many years of declining PHI participation, and the proportion of Australians with PHI has remained between 43% and 47% since 2000.

There have been many changes to PHI policy settings over time. As far as we are aware, there has been no holistic review of these policies for many years. It is therefore unlikely the policy settings have always been optimal.

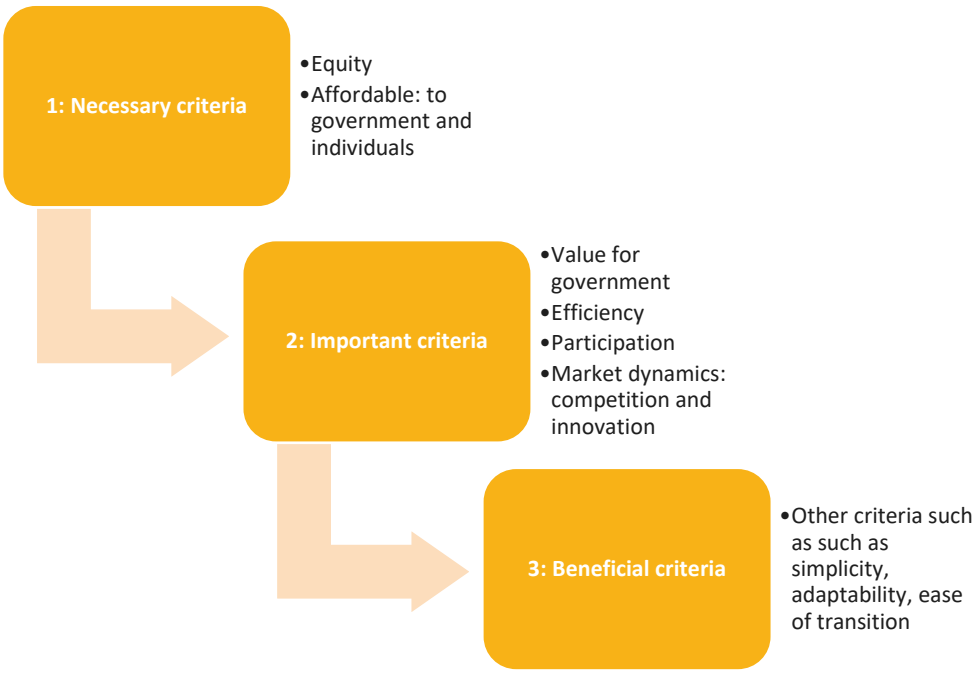
Because participation has consistently been in the range of 43% to 47% during the period which the current incentives have been in place, and is currently in the mid-point of that range, the overall effectiveness of these policies at maintaining participation does not appear to have significantly changed over time.

2.2 How can success be measured?

2.2.1 Evaluation criteria for short term impacts

Evaluation criteria allow us to measure the extent to which alternative policy options are consistent with the objectives, and are necessary because concepts such as the sustainability of private or public healthcare cannot be measured directly. Following consultation with the Department and stakeholders, we determined the following hierarchy of criteria:

Figure 2.1 – Hierarchy of criteria



The criteria have been classified as follows:

- Necessary criteria (equity, affordable to government and individuals)
  - > Options which are not considered equitable, or are not affordable to government / individuals, cannot be implemented in practice so need not be considered further.
  - > Equity is a complex area with many important dimensions to consider, including equity between groups of different age, income levels, region, health status, and people with / without PHI. Equity is linked with choice, in that the options available to consumers should be fair given their circumstances. The assessment of equity will necessarily be judgemental, however the basis for judgements should be clearly explained.
- Important criteria
  - > Value for government: It is expected that options will need to demonstrate better value for money than the status quo.

- Efficiency: Achieving the right mix of healthcare programs to maximise the health of society, using given resources to maximum advantage.
- Participation: This criterion is broader than just the number / percentage of people with PHI, and must also consider the groups participating, and whether participation provides good value to the individual and the Australian health system.
- Market dynamics (competition and innovation): This relates to the reasons why private healthcare is funded through PHI, rather than alternative options. In particular, it is important to assess whether the option supports best outcomes compared to alternative uses of economic resources, and promotes competition and innovation.

- Other beneficial criteria such as reduced complexity and ease of transition will also need to be considered, but have lower weight than the other factors.

We sought stakeholder feedback on what would represent a successful outcome. The general consensus from industry stakeholders was a preference for options which gave stability in participation, with the potential for modest improvement. Aspirations for significantly increasing participation were modest.

Many industry stakeholders identified complexity as one of the most important factors, and in particular that:

- Complexity in the PHI incentives was difficult for consumers, and may be reducing the effectiveness of these policies.
- The PHI incentives should be considered in the context of other aspects of PHI which are also complex for consumers. For example, it is complex for consumers to choose between PHI products; while differences in price are readily apparent, it can be difficult for an individual to identify a product that will cover the treatments they may need in future, and which limits out of pocket costs to a level they can afford.
- It was noted that while government is responsible for PHI policy settings, insurers make product design choices and can be well placed to explain PHI to current and potential policyholders.

Issues raised by consumers we surveyed included PHI affordability, and perceived value given issues such as out of pocket costs and the ability to access care without PHI.

Indicators of success
Options need to be considered against a large number of criteria. Individuals are concerned about the price of PHI and whether products will meet their needs. Industry stakeholders are looking to maintain or moderately increase PHI participation while reducing complexity. We expect government will consider these competing stakeholder concerns together with equity and value for government.

Conflicting stakeholder objectives make it challenging to identify options which result in better outcomes for everyone.

2.2.2 What do stakeholders see as the long-term vision for the policy direction for PHI?

The objective for the Australian health system can be summarised as universal access to high quality care that results in the best health outcomes, at an efficient and affordable cost to individuals and the community. Our research examined how PHI can make a positive contribution to this objective over the longer term. Themes identified by stakeholders include:

- A more comprehensive insurance cover, which incentivises participation by supporting access to services people want and need, and addressing issues that cause customer dissatisfaction. Specific examples include:

  - Insurance cover for a broader range of services, including preventative, and treatment outside of hospital where appropriate (including specialist and primary care).
  - Address issues of concern to policyholders, such as high out of pocket costs.
  - Improve the insurance value proposition for young people in particular.
- Appropriate market dynamics to drive better outcomes at an efficient price. This could include:
  - Policyholders, providers and insurers agreeing to share nominated data, enabling better preventative programs to be developed.
  - Insurers and providers supporting market dynamics by contracting more efficiently, to incentivise good-value, high-quality treatment.
- Reducing complexity for consumers and industry.
  - Individuals can find it difficult to navigate the health system, and the PHI incentives can be an additional source of complexity.

We observed a high level of stakeholder agreement on the broad themes, however there are different views on how these matters should be progressed. There are also tensions between some of the issues identified, for example:

- Access and affordability: Adding more benefits to PHI products would support access to treatment. Unless there are offsetting savings or additional subsidies, adding benefits makes affordability more challenging since premiums would need to rise to cover the cost of those benefits.
- Access and equity: Providing better value for young people needs to be balanced with community rating, which supports access for those with high expected claim costs (often older people).
- Efficiency and access: Insurers have a financial incentive to encourage efficiency, but there is no appetite to involve insurers in clinical decisions regarding access to healthcare.
- Complexity and equity: Targeting the PHI incentives according to age and income increases their complexity, but applying the same incentives to all would not be fair or an efficient use of resources.

Long term direction for PHI
Stakeholders envision PHI could better support Australia's health system by providing access to a broader range of services at an efficient price.

If issues which concern policyholders (such as out of pocket costs) cannot be satisfactorily addressed, over the long term this may lead to lower participation rates. PHI incentive policies alone cannot address all stakeholder concerns.

2.3 Structure of this report

We have structured this report as follows:

Table 2.1 – Structure of report

Findings and Recommendations	• Findings (Section 3), which lead to recommendations in the executive summary

Approach	• Purpose, scope and project stages (Section 4) • Stakeholder engagement undertaken (Section 5) • Guiding framework of objectives, constraints, criteria, and measures used for assessment (Section 6)
Current policy settings and alternatives	• Review of the effectiveness of the current policy settings (Section 7) • Alternative options identified and shortlisted (Section 8)
Detailed analysis	• Economic experiment (Section 9) • Policy interactions (Section 10) • Summary of our analysis for PHI Rebate (Section 11), MLS (Section 12), LHC (Section 13) and other options (Section 14)
Risks	• Risks and mitigations (Section 15)

The reliances and limitation of our work are set out in section 16, and further information is provided in a number of attachments.

This report references the following documents which we prepared for the Department:

- LHC Study: Our report "Actuarial Review of Lifetime Health Cover"
- RE Study: Our report "Risk equalisation: final report"

3 Findings

The purpose of this section is to summarise our key findings in addressing the following questions:

- How effective are Australia's PHI Incentive policies today? (Section 3.1)
- Are there alternatives which deliver better overall outcomes? (Section 3.2)

These findings lead to our recommendations, which were set out in the Executive Summary.

The findings and recommendations should be considered in the following context:

Health system objectives	The objective of Australia's health system is to provide universal and affordable access to high quality care that results in the best health outcomes at an efficient cost to the individuals and the community. The delivery is through a mixed system involving both the public and private sectors, where PHI has an important role in funding. The incentive policies are part of the health system, but their narrow focus means the policies will have limited impact on whether the overall health system objectives are achieved.
Consumer preferences	Consumers buy PHI to assist them to access private healthcare. While affordability is always an important issue in PHI, policies also need to provide good value by covering treatment consumers may need to access. What is covered by PHI should evolve to meet consumer needs, including: • Scope: support people to access treatment outside hospital, where this is the consumer's preference, clinically appropriate and provides good value. • Value: limiting out of pocket costs, which can make it difficult to access treatment and damage the PHI value proposition. • Prevention: support individuals to better manage their own health, and avoid preventable hospital admissions. • Navigation: help people to access appropriate treatment by assisting consumers to navigate the complexity of the health system. Adapting PHI to meet consumer needs is a complex ongoing process. Changing the incentive policies (PHI Rebate, MLS and LHC) alone will have limited impact on addressing the issues outlined above.

Finding 1: The role of incentive policies in Australia's health system
This study has investigated the effectiveness of the current incentive policy settings, and analysed alternatives. Our work leads to recommendations to optimise the current policy settings in the short term, and provides an analytical foundation for future reforms. However, changing the incentives policies will have limited impact on whether PHI meets consumer preferences, or PHI's overall contribution to the health system.

3.1 How effective are Australia's PHI incentives today?

We investigated whether the policies have beneficial effects, adverse side effects, and impact some recipients more than others. Our findings for each policy are as follows, with further detail in Section 7 of this report.

MLS

Description	A levy on people earning higher incomes who do not hold an appropriate level of private health insurance.
Objective	Incentivise those who can afford to contribute to the cost of their own healthcare to do so through PHI.
Features	Impact on individuals varies by income tier, household size and over time: • Higher surcharges are applied to the highest income earners, as they have greater capacity to afford PHI. • Capacity to pay is assessed at the household level, so there are different income tiers for singles/couples, and depending on the number of dependent children. • Thresholds will increase in line with average wage growth, to ensure the policies continue to target higher earners.
Main finding MLS has a powerful impact on the groups it targets	• Evidence: Over 80% of individuals aged over 30 with taxable incomes exceeding $100k have PHI. Participation is over 90% for higher incomes and older ages[1]. • Policy alternatives investigated include whether MLS targets the right people, and incentivises appropriate actions. Specific considerations include whether MLS should require people on higher incomes to make a greater contribution to health system costs, and whether some people currently paying the MLS should be exempt.
Secondary finding MLS is least effective for individuals who are under 30, or have taxable incomes below $100k	• Evidence: For example, 66% of 25-29 year olds with taxable incomes between $90k-$100k have PHI, and participation rates have declined in recent years. • Policy alternatives investigated include: Adjusting MLS settings for this group, or other opportunities relating to product design, communication and the PHI opt-in process.

[1] Source: Analysis of ATO statistics. Refer to Attachment B for further details.

PHI Rebate

Description	Government contribution to PHI premiums, depending on policyholder income and age.
Objective	Improve access to PHI by making premiums more affordable, both directly through subsidy and indirectly by making PHI more attractive to those in good health.
Features	Impact on individual varies by income, household size, age, and over time: • Varying by income (using the same household income tiers as the MLS) ensures the level of subsidy considers capacity to pay. • Higher PHI Rebates are available to older people, to provide additional support to older people wishing to access private healthcare treatment. • A PHI Rebate adjustment formula (RAF) reduces the PHI Rebate percentage when industry average price increases exceed CPI. This improves affordability of PHI Rebate spending for government, and reduces affordability for individuals.
Main finding The PHI Rebate supports PHI affordability. This review has assessed how the PHI Rebate impacts different segments and whether there are opportunities to optimise the allocation.	• Evidence: Our previous research for the LHC study indicates PHI purchasing decisions are generally price inelastic, however a focus area has been how the PHI Rebate impacts decision making by particular segments, especially those not subject to the MLS. • Policy alternatives investigated include: equitable optimisation, given government and consumer objectives. The consequences of changes in participation also need to be examined, including changes in the amounts of treatment undertaken in both the public and private health systems.

LHC

Description	Increases the premium to be paid if an individual takes out hospital cover for the first time after age 30, or has a significant break in cover.
Objective	Support community rating by providing incentives for people to obtain private hospital cover earlier in life, and encourage them to maintain it.
Features	Varies by age of entry, with an additional 2% premium loading per year after age 30, up to a maximum 70% loading. The graduated scale is intended to balance incentives to obtain cover, with ensuring everyone can access PHI at any stage of life. There are also special rules where people might reasonably take out cover at other ages, for example, migrants, Australians travelling overseas, and temporary gaps in cover.

Main finding LHC makes a positive contribution to PHI participation (through its focus on obtaining and maintaining participants), and there is no immediate imperative to change. LHC is closely linked with MLS and the PHI Rebate, so options should consider the PHI incentive policies together.	Evidence: 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. Policy alternatives investigated include: Opportunities for integration and simplification of the three PHI policy incentives (LHC, MLS, PHI Rebate). Addressing administrative issues regarding LHC. In addition, there is support for adjusting other policy levers, such as the frequency of appropriate and targeted communication.

Finding 2: Current effect of PHI policy settings, and options for change

High earners (MLS): This refers to people who are currently subject to the MLS, and in particular those in MLS tiers 2 and 3 with annual income (for families) over $210k per year. The MLS ensures very high participation rates, exceeding 90% for some high-income segments. This group has capacity to pay for PHI, and MLS means a significant surcharge is applied for not participating. However, MLS may not be incentivising the most appropriate actions, because only the purchase of Basic tier hospital cover is necessary to avoid the MLS.

Adults under 40s (all incentive policies): This cohort has lower participation rates than other groups, and the impact of the PHI incentive policies on this cohort can be complex and dynamic, changing each year as age, income and family status change. There may be a more effective combination of policy settings for this cohort.

Mid and low earners (PHI Rebate): This refers to individuals in the base tier for PHI Rebate purposes, and those in tier 1 who also receive a significant PHI Rebate. The PHI Rebate supports affordability for this group. This review has assessed how the PHI Rebate impacts different segments and whether there are opportunities to optimise the allocation.

Detailed features: Policy settings which vary by age, income or over time create complexity. The review investigated opportunities for simplification.

The options we shortlisted and analysed reflect this assessment of the effectiveness of the current policy settings.

3.2 Are there alternatives which deliver better overall outcomes?

This section comments on the types of option we tested with respect to each policy, with more detail given later in the report. The testing included modelling based on insurers' and other data sets, and an economic experiment to examine consumer impacts.

We first look at options which could be implemented in the short term, and then longer-term possibilities. This leads to our recommendations in the following section.

3.2.1 What options could be implemented in the short term?

MLS

MLS requires high earners to make an additional contribution to healthcare costs and allows the individual to choose whether to pay a surcharge or purchase private health insurance that meets the specified criteria. It

applies to singles earning more than $90k per year (tier 1), with higher surcharges applying for singles earning more than $105k (tier 2) or $140k (tier 3). The income thresholds are doubled for couples, and slightly higher still for families.

Currently less than 15% of the population is subject to the MLS. Very high participation rates for people subject to the MLS (over 90% for some age and income groups) suggest MLS has a powerful impact on the groups it targets. This is a logical outcome where it is cheaper to obtain PHI than pay the surcharge.

The table below summarises the types of short-term MLS options tested and our findings. The table also shows how each option involves trade-offs between the criteria. Detailed quantitative information is set out in Section 12 and Attachment B.

Table 3.1 – Findings for short-term MLS options

Option type (and example)	Criteria where this tests well	Criteria where this tests poorly	Comment
Abolish MLS	Choice – increased for high earners	Participation – material reduction. Affordability – loss of healthy policyholders puts upward pressure on premiums. Value for government – loss of surcharge revenue.	Retaining a strong incentive for high earners to hold PHI tests well against criteria.
Apply MLS to more people For example, reduce income threshold for singles from $90k to $80k. Under our PHI Rebate findings, we consider applying MLS to wealthy people.	We consider wealth under PHI Rebate. Extending to lower income groups does not test well against criteria. In particular, our testing suggests this is unlikely to have a material impact on participation. Assuming the surcharge remains at 1% of income, it would be cheaper to pay the surcharge than buy PHI.	Equity – using a surcharge to incentivise very high participation by people on lower incomes may not be regarded as fair, given their earnings and the benefits the individual obtains from a basic policy.	It is ultimately for government to decide the groups it is fair to apply the MLS to.
Apply MLS to fewer people For example, increase income threshold for singles from $90k to $100k (and similarly increase for families).	Equity – the thresholds have not increased since 2015, and this would ensure MLS continues to target the highest earners.	Value for government – loss of surcharge revenue. Potential increase in PHI Rebate if thresholds for both policies remain aligned, depending on participation impact.	Our economic experiment indicates limited participation impact, which may reflect other incentives (LHC, PHI Rebate) as well as capacity of this group to pay premiums.

Option type (and example)	Criteria where this tests well	Criteria where this tests poorly	Comment
Increase participation incentive, while applying MLS to the same income groups as now. For example, MLS could be simplified by applying a 1.5% surcharge to all income tiers, rather than a lower amount for some tiers.	Participation – increased for target cohort. However, the increase is not expected to be material, as MLS targets a small segment of the population (around 15%), and most already buy PHI.	Value for government – the objective of MLS is to incentivise high earners to take out PHI. However, if people do not buy PHI, the surcharge provides revenue to government.	Once government has decided a group should be subject to MLS, rates can be set to strongly incentivise participation.
Incentivise other actions, while applying MLS to the same income groups as now. For example, require people to hold at least Bronze or Silver hospital cover to avoid the MLS.	Affordability: Encouraging people in good health to buy comprehensive cover puts downward pressure on premiums, as premiums reflect average claim costs. Value for government: Compared to buying basic cover, people are better able to access private healthcare should treatment be required.	Reduces choice, and potentially increases complexity. Meets equity criteria providing the required level of cover is reasonable given income.	While this tests well against the criteria, the impact is not expected to be material because only a small number of people are impacted, and many already buy comprehensive cover.

There are a range of factors which result in higher PHI participation for Australians in MLS tier 3 (highest earners) than in MLS tier 1 (mid earners). Tier 3 is subject to a much higher surcharge than tier 1 if PHI is not purchased. PHI premiums are also relatively more affordable for tier 3 individuals and families than for those in tier 1, and those in tier 3 frequently have other characteristics which are positively correlated with PHI participation (such as those based on age profile, education and household composition).

Even if MLS settings for tier 1 earners were changed to more strongly incentivise participation, the other factors such as affordability and age limit the expected growth in PHI participation. These limiting factors also apply to options which reduce the MLS threshold to bring in lower earners. The scenarios assuming a higher MLS rate or lower income threshold therefore have a limited impact on PHI participation.

MLS does have a powerful effect on high earners who can afford PHI and would face a significant surcharge if they did not insure. The economic experiment indicates MLS would continue to have a powerful impact if it incentivised other actions, provided the cost of an individual of taking that action was less than the surcharge. Specifically, if high earners are required to hold at least a Silver tier policy to avoid MLS, then people currently buying Basic or Bronze tier cover can be expected to upgrade. This option tests well against our criteria, as it targets people who can afford more comprehensive cover, and ensures people can access private healthcare should treatment be required. Incentivising people in good health to buy comprehensive insurance will moderate price increases, as premiums reflect the average claim costs of people insured. The disadvantage of the option is that it increases complexity. The positive impacts are also limited because many high earners already buy comprehensive cover. Specifically, two thirds of tier 1 earners buy Silver or Gold products, and three quarters of tier 3 earners buy these products.

Finding 3: Short term MLS options
MLS makes not insuring an irrational choice for the highest earners (tiers 2 and 3), where the surcharge amount is set well above the basic PHI premium. MLS can have a much more powerful impact on the individuals it targets than the other PHI incentive policies. The key decision here is when is it fair to apply such a strong incentive to individuals.

As set out in the table above, our findings are:
- Removing MLS entirely would result in a worse overall outcome
- Our recommendations to optimise and simplify the MLS represent improvements to the current position, but are not expected to materially change health system outcomes. This is because MLS is a policy targeted at high earners, who are a small segment of the population and already have high PHI participation.

PHI Rebate

The PHI Rebate is integrated with the MLS, in that most people who are not subject to the MLS (base tier) receive a PHI Rebate of 24.6% of premiums. Those on higher incomes receive a lower PHI Rebate, ranging from 16.4% (tier 1) to nil (tier 3). People over 65 receive higher PHI Rebates, with a further increase after age 70 (refer to Section 7 for a summary of the percentages by income and age). The percentage PHI Rebate is reduced when annual industry average premium rate increases exceed growth in the Consumer Price Index (CPI).

The table below summarises the types of short-term PHI Rebate options tested and our findings. The table also shows how each option involves trade-offs between the criteria. Our examination has focused on the PHI Rebate for hospital policies, as these are more financially material than extras, and there are interactions with MLS and LHC. Further information is provided in Section 11, and Attachment A.

Table 3.2 – Findings for short-term PHI Rebate options (hospital policies)

Option type (and example)	Criteria where this tests well	Criteria where this tests poorly	Comment
Remove	Value for government (short term) – those in good health may be most likely to lapse, so additional public health costs are likely to be lower than PHI Rebate savings in the short term.	Participation – material reduction. Value for government (long term) – spiral of lower participation and higher premiums means PHI becomes makes a smaller contribution to health system costs.	Given the estimated participation impact indicated by the economic experiment, abolishing the PHI Rebate entirely could have significant impacts on the long-term sustainability of PHI.
Restore Increase PHI Rebate to 30%, and 35% or 40% for older people. Could be applied to only base tier, or to all.	Affordability for individuals improves Participation increases	Value for government – assessed by comparing the additional PHI Rebate spending to the additional claims funded via PHI. Restoring the PHI Rebate for high earners (who are typically younger and in good health) provides least value to government, and restoring to older people provides greatest value.	Restoring the PHI Rebate for all does not test well against the value for government criteria. Restoring the PHI Rebate for seniors may provide value for government, however high participation rates for younger people are necessary to keep premiums affordable.

Option type (and example)	Criteria where this tests well	Criteria where this tests poorly	Comment
Reduce for higher earners Potentially also simplifies if, for example, tier 2 PHI Rebate is aligned with tier 3 (nil PHI Rebate).	Value for government: less PHI Rebate spending, and limited change in other PHI outcomes.	Affordability for high earners reduces	Assuming MLS settings are unchanged (or strengthened), reducing the PHI Rebate for this cohort has minimal impact on PHI participation.
Reduce for older people Older people receive the same PHI Rebate as younger people with the same income level. This simplifies the PHI Rebate.	Affordability for younger policyholders: On average, premiums are less than claims for older people. Lower PHI Rebates will result in lapse by older people, reducing average premiums.	Affordability for older people reduces, resulting in lower participation. Value for government declines, as we estimate the additional claims in the public health system would be greater than the PHI Rebate savings.	Older people are typically not subject to MLS, so there is no penalty if they choose to drop PHI and rely on the public health system. Economic testing suggests PHI is price inelastic, so lower PHI Rebates only have a small impact on participation. However, the impact on claims is material, because older people have high average claim costs.
Reduce PHI Rebate for wealthy people This is not currently practical, as younger people do not routinely report their wealth to the government. We tested the concept for seniors, using age pension eligibility as a wealth test.	Equity: Ensures PHI Rebate spending is targeted at those with less capacity to pay.	Complexity increases.	Economic experiment indicates high and low wealth seniors have similar price elasticity, so the expected impact is similar to the above option. Combining with an MLS-type incentive for wealthy people would reduce the participation impact. May not be financially material as only applies to a small proportion of insured individuals (high wealth with low income).
Vary PHI Rebate by product tier Higher PHI Rebates for comprehensive products, offset by lower PHI Rebates for basic products	Value for government: by incentivising comprehensive cover, more treatment would be funded by PHI without additional PHI Rebate spending. Affordability for people on comprehensive products.	Affordability for people on basic products. Complexity Equity: Basic products already subsidise more comprehensive ones via risk equalisation (the average transfer per adult is over $800 per year).	
Specify PHI Rebate in dollar rather than percentage terms	Market dynamics: Stronger incentive for individuals to seek out cheaper products.	Complexity: Assuming PHI Rebate continues to vary by state, age, income and product tier.	Additional complexity does not seem to provide short term benefits against important criteria such as equity, affordability or participation.

We also tested combinations of these options, for example, reducing for some people and increasing for others. Further details are set out in Section 11, and Attachment A.

Finding 4: Short term PHI Rebate options

The PHI Rebate makes PHI more affordable, so a lower PHI Rebate results in lower participation, and a higher PHI Rebate results in higher participation. However, the impact of changes in the PHI Rebate varies depending on the size of the change, and the groups or products targeted.

Our findings are:

- Removing the PHI Rebate entirely would result in a worse overall outcome. We estimate the short-term impact would be a 10% reduction in the number of people covered by PHI, and a reduction in hospital claims funded by PHI of $2.3bn-$3.1bn per year. The longer-term impacts could be more significant, due to a spiral of increasing lapse and higher premiums.
- Restoring the PHI Rebate provides poor value for money for government, resulting in only a small (1%) increase in participation.

There are opportunities to optimise and simplify the PHI Rebate. In particular:

- PHI Rebates for tier 1 and tier 2 earners have limited impact on participation, because MLS creates a strong participation incentive. The annual PHI Rebate paid to this group is currently around $380m.
- PHI Rebates for older people provide value for government, given the high average claim costs of this group. Specifically, we estimate that removing PHI Rebates for over 65s could reduce claims funded by PHI by $2.3bn, which exceeds the PHI Rebate paid to the group.

LHC

LHC incentivises people to obtain private hospital cover earlier in life, and then maintain their cover. If there were no adverse consequences for taking out PHI later in life, or buying PHI only when treatment is planned, average premiums would need to be higher to cover the resulting average claim costs. It is therefore important to ensure an incentive exists that encourages people to both purchase and then continue holding their cover.

There are sound reasons for the incentive to vary according to age of entry, and to have a maximum loading, to maintain access at all ages. It is also necessary to have special rules in cases where people might reasonably take out cover at other ages, for example, due to migration. Options which remove any of these features are simpler, but test poorly against other criteria such as equity.

We have tested a range of options including changing features of the incentive such as the LHC start date, loadings and other rules, and none of the options tested represent a significant improvement on the current policy settings.

One option several stakeholders proposed was to increase the starting age from 30 to 40, on the basis that some people may not be ready to take out PHI at 30. Our view is that this change will not have a significant impact on PHI. Our testing indicated this would likely result in a small increase in the proportion of over 40s with PHI, as people are able to join PHI in their 30s without paying an LHC loading, or pay a smaller loading if they join in their 40s or later in life. However, the benefits of higher participation by over 40s are largely offset by fewer under 30s having PHI, and a small premium increase would be necessary to offset the lower LHC revenue and higher expected average claim cost (due to the older average membership).

Further details are set out in Section 13 and Attachment C.

Finding 5: Short term LHC options
There should be a policy similar to the current LHC policy to incentivise people to obtain hospital cover earlier in life, and encourage them to maintain it. We have not identified options to change LHC which result in significantly better outcomes. In particular, the option to increase the starting age would benefit people who take out PHI later in life, but does not result in a materially better outcome for the overall health system.

Policy integration

While we separately present analysis for each policy setting, options must be considered together as the aim is to produce integrated policies.

PHI Rebate and MLS policy settings both vary by income and household size, and are aligned through common income tiers. It is appropriate that they continue to be aligned, because if the MLS settings result in high participation for a cohort, providing a PHI Rebate will have limited additional impact on participation.

As noted above, an effective incentive for obtaining hospital cover early in life, and to maintain cover, will vary according to factors such as age of entry, periods spent uninsured, and the reasons for not being insured. Maintaining these advantageous policy features of LHC limits the scope for better integrating this policy with MLS and the PHI Rebate, as it would increase the complexity of those other policies.

Finding 6: Policy integration
PHI Rebate and MLS policies should remain integrated. There is limited scope to integrate LHC with these policies, as that would increase the complexity of the PHI Rebate and MLS, with no significant gain, and possible adverse impacts.

3.2.2 What options could be implemented in the longer term?

The Department's objectives are to:

- Improve the affordability and value of PHI
- Increase participation in PHI, and
- Secure the sustainability of the mixed delivery model of private and public healthcare.

We have identified options to optimise and simplify the PHI policy settings, which test well against a comprehensive set of criteria. While the options are consistent with the Department's objectives, their impact is expected to be limited. Bolder longer-term strategies will be necessary to make significant progress against the objectives, and better meet the needs of consumers.

Addressing issues which cause customer dissatisfaction (such as out of pocket costs, and the limited scope of PHI) is necessary to support the long-term sustainability of PHI. A challenge is that addressing these issues can increase cost, and individuals who do not benefit from the changes may not value them.

These long-term reform options cannot by implemented through changes to the PHI Rebate, MLS and LHC. However, optimising and simplifying these policies will support longer term reforms by:

- Providing space for innovation: By introducing additional features into PHI, the long-term reform options may bring a level of complexity. Stakeholders have suggested PHI is already too complex for some consumers to understand, so removing complex features from the current policy settings provides more opportunity for future change.
- Ongoing refinement to make policies more optimal: As other policy settings change, incentives can be reviewed to support those changes. For example, a product which provided additional coverage would

only be financially sustainable if it covered people in good health, as well as those who expect to use the services. MLS could be adapted to incentivise higher earners to buy the new product.

Finding 7: Supporting material longer term changes

The PHI policy incentives cannot make the longer-term policy changes required to address consumer concerns such as out of pocket costs. However, they can support other policy changes by providing space for innovation, and through ongoing optimisation.

Approach

4 Project overview

4.1 Purpose and scope

The objective of Australia's health system is to provide universal and affordable access to high quality care that results in the best health outcomes at an efficient cost to the individuals and the community. The delivery is through a mixed system involving both the public and private sectors.

To encourage a strong private health sector, there are a number of government initiatives which support private health insurance. In particular, people have the option to access private health insurance at community rated premiums, which do not reflect an individual's expected claim costs.

Community rated premiums will exceed expected claim costs for people in good health, so policies such as LHC, MLS, RE and the PHI Rebate are needed to ensure financially sustainable participation and premium rates. A challenge is to determine the optimum mix of incentives and subsidies.

The Department engaged Finity to investigate the effectiveness of the MLS and the PHI Rebate, including the interaction with the LHC loadings and RE arrangements. The scope of work includes identifying and modelling alternative policy settings. The findings of this study, in conjunction with the findings of the LHC and RE studies, will be used to develop reform options for the PHI sector. The intent of these reforms will be to improve:

- The affordability and value of PHI;
- Participation in PHI; and
- The sustainability of the mixed delivery system of private and public healthcare.

4.2 Approach

The table below lists the main work stages, together with a summary of the investigations undertaken, and a reference to further information in this report. Further information can be found in a number of appendices.

Table 4.1 – Summary of project work stages

Project stage	Description	Refer section
Guiding framework	Includes objectives, constraints, criteria, and measures which options can be assessed against.	6
Review effectiveness of current MLS / PHI Rebate regulatory settings	A stocktake of the current MLS/PHI Rebate policies, which provides a baseline against which other options can be accessed.	7
Identify alternative options, and shortlist for detailed modelling	Identify alternatives and options for subsequent evaluation. The shortlist for detailed modelling is based on the guiding framework and discussion with the Department and stakeholders.	8
Detailed modelling and impact analysis	Assessment of financial impact, stakeholder impact and other considerations.	9 to 14

5 Stakeholder engagement

We have worked closely with the Department and other stakeholders to help achieve the project objectives. We have actively sought and considered input from a wide range of stakeholders, and invited other stakeholders to engage. This section provides further information on stakeholder engagement undertaken (Section 5.1) and a summary of what we heard (Section 5.2).

5.1 How we sought stakeholder input

5.1.1 Initial engagement on project and options (December 2021 to February 2022)

We interviewed stakeholders from 20 different organisations and held 5 workshops attended by stakeholders from multiple organisations. The purpose of the meetings was to seek input regarding the effectiveness of the current MLS/PHI Rebate policy settings and any options which should be considered.

Participants included:

- Health insurers, including a range of large and small organisations
- Industry bodies, including those representing health insurers, insurance intermediaries, hospitals, and doctors
- Consumers Health Forum
- Representatives of hospitals
- A hospital contracting organisation
- Government stakeholders other than the Department, including BETA, the Ombudsman, APRA, ATO, Treasury and Services Australia
- Financial services businesses other than health insurers (a life insurer and a bank)
- Academics with expertise in health insurance
- The Institute of Actuaries Health Practice Committee
- Consulting actuaries employed by firms other than Finity.

5.1.2 Workshop (7 April 2022)

Approximately 70 people attended a professionally facilitated workshop in April 2022. In addition to providing a project update, the workshop asked for input on:

- Criteria: We provided information on the proposed assessment criteria and measures, and asked “what does success look like and how do we evaluate it?”
- We summarised the types of options which had been identified by stakeholders, and asked what further options should be considered.

5.1.3 Written consultation (April 2022)

The material presented in the workshop was subsequently provided to a much broader group of stakeholders, both via email and on the Department’s consultation portal. We requested written consultation responses, and received five submissions.

5.1.4 Stakeholder forum (July 2022)

This was a smaller meeting with around 20 stakeholders, representing a range of health insurers, hospitals and providers, doctors, consumers, intermediaries and others. Working with a small group over a half-day session, we shared findings, linked the findings to proposed options, and used the evaluation criteria to identify sensitivities and pathways for MLS, PHI Rebate and LHC policy reform that are desirable, feasible and viable. The focus group was about exploring possibilities and identifying a possible future.

5.1.5 Regular Department emails

Together with the Department, we have drafted a number of messages for the Department's weekly email to PHI industry stakeholders. The purpose of this communication is to:

- Provide project updates, including information on project timeline, copies of documents provided to other stakeholder consultations, and summaries of those meetings.
- Invite further engagement. In particular, each message has included our contact details so that stakeholders requiring further information or wishing to be more closely involved with the project can get in touch.

5.1.6 Consumer perspectives

In addition to engaging with groups such as the Consumers Health Forum, we sought direct feedback from over 1,500 people via the economic experiment. In addition to testing options, the experiment included a number of "free text" questions. In particular, there was a compulsory question asking all participants to share thoughts on PHI. We reviewed all the responses to identify themes.

We held a meeting with industry stakeholders on 29 September 2022 to summarise the findings of the economic experiment.

5.2 What we heard from stakeholders

The comments below summarise the main themes raised, noting that such a summary cannot include all stakeholder views or differences in priorities.

5.2.1 Consumer perspectives

Cost and value were the primary focus points:

- Cost: Some consumers said the cost of PHI was prohibitive given their circumstances
- Value: Concerns related to:
  - > Out of pocket cost and gap payments
  - > Scope of PHI: GP and specialist visits not covered
  - > Access of local treatment: For example, some people in regional areas noted there were limited private treatment options.

We asked whether people found PHI or the experiment confusing, with 15% agreeing. While some consumers find PHI complex, cost and value are the primary concerns.

It was also apparent that some consumers have strongly held views regarding whether or not they wish to be insured:

- Individuals supporting PHI noted peace of mind, no or lower waiting times, or specific benefits that were valued such as extras.

- Individuals with no interest in purchasing PHI noted this was due to factors such as:
  - PHI being unnecessary due to Medicare.
  - PHI being unaffordable.
  - A previous poor experience in PHI, which were often related to out of pocket costs. Some respondents also indicated they had both a poor PHI experience and a much more positive public hospital experience.

5.2.2 Industry perspectives

Most stakeholders believe PHI can do more to assist consumers and support Australia's health system. Themes identified by stakeholders include:

- A more comprehensive insurance cover, which incentivises participation by supporting access to services people want and need, and addressing issues that cause customer dissatisfaction. Specific examples include:
  - Insurance cover for a broader range of services, including preventative, and treatment outside of hospital where appropriate (specialist, primary care, and greater use of hospital at home).
  - Address issues of concern to policyholders, such as high out of pocket costs.
  - Improve the insurance value proposition for young people in particular.
- Appropriate market dynamics to drive better outcomes at an efficient price. This could include:
  - Policyholders, providers and insurers agreeing to share nominated data, enabling better preventative programs to be developed.
  - Insurers and providers supporting market dynamics by contracting more efficiently to incentivise good-value, high-quality treatment.
- Reducing complexity for consumers and industry.
  - Individuals can find it difficult to navigate the health system and the PHI incentives can be an additional source of complexity.

In the short term, most stakeholders support:

- Maintaining the PHI Rebate, MLS and LHC.
- Increasing the incentives to obtain and maintain PHI, for example, by increasing the PHI Rebate or strengthening the MLS. Stakeholders have a range of views on the segments that should be targeted.
- Simplifying the incentive policies.

While the long-term vision involves significant change, there is much more limited appetite for short term change. Industry stakeholders are looking to maintain or moderately increase PHI participation while reducing complexity.

5.2.3 Comment

Stakeholder consultation has resulted in a very large number of ideas to adjust the PHI Rebate, MLS and LHC, and we summarise the types of options identified in Section 8 below. We note that:

- While there is a preference for simplification, many stakeholders also believe changes in incentives should be focussed on particular groups, and this targeting requires a level of complexity in the policy settings.

- Increasing participation incentives (for example, via higher rebates or surcharges) are suggested to increase participation, however this needs to be balanced with other criteria such as equity and value for government.
- Stakeholder engagement has not identified a consensus on the preferred options with respect to PHI Rebate, MLS or LHC.

There is greater alignment regarding the longer-term direction of PHI, including the need to address issues of concern to consumers such as out of pocket costs, and the limited scope of PHI. Through detailed discussion at the July 2022 forum, it was apparent to stakeholders that achieving longer term objectives would require significant policy changes over an extended period.

6 Guiding framework

This section sets out the objectives, constraints, criteria, and measures we have developed in order to assess options.

6.1 System context

6.1.1 Objectives

The objective of Australia's health system is:

Universal and affordable access to high quality care that results in the best health outcomes at an efficient cost to the individuals and the community.

The intention is better health and wellbeing for all Australians, both now and for future generations.

An objective of PHI is to optimise the private contribution to funding Australia's healthcare costs. Government's PHI policy is to promote affordable, quality private health insurance and effective choice for consumers, while ensuring Australia's health system is financially sustainable.

6.1.2 Problem statement

Since PHI premiums reflect the average claim costs of people insured, high participation is necessary to ensure premiums remain affordable and to support the objectives around funding of costs in the health system by individuals and community.

Statistics on PHI participation and the average age of people insured indicate challenges in the affordability and value of PHI. Government is therefore reviewing the PHI Rebate, MLS and LHC to ensure that these initiatives are appropriately calibrated.

6.1.3 Constraints

The following are important:

- PHI premiums are community rated – this is a central policy in terms of access and equity. Deviations from "pure community" rating (such as LHC loadings) are acceptable if they appropriately balance access and equity.
- No interference with clinical delivery – government policy is for a mixed public and private healthcare delivery system. In particular, no USA style managed care – need to ensure that clinical autonomy, not funding, determines appropriate care.
- No mandate – choice is an important part of the Australian health system. The policies provide incentives to insure, however people can choose whether or not to purchase PHI.

6.2 Criteria

Evaluation criteria allow us to measure the extent to which each option is consistent with the objectives, and are necessary because concepts such as sustainability cannot be measured directly. Following consultation with the Department and stakeholders, we determined the hierarchy of criteria set out in Section 2.

6.3 Measures

We have used a range of measures to compare options with respect to these criteria. The measures vary depending on the option being tested, and include the following:

Table 6.1 – Measures

Area	Measure	Met/exceeded (look more like)	Not met (look less like)
Equity	Judgemental, considering the people impacted, what they are being incentivised to do, and the value obtained.	Option considers need and capacity to pay in a progressive way.	Not consistent with a normal view of equity.
Value for government	PHI Rebate spending MLS revenue collected Claim costs funded by PHI	More claims funded through PHI, without material additional government spending. Similar amount of claims funded through PHI, with less government spending.	Higher spending or lower revenue, without an improvement in other criteria.
Participation (% of population)	Total number of people with hospital cover Proportion of the population with hospital cover Variations in the above by income level, product tier and age	Higher participation, and/or more participation on comprehensive covers which support access to private healthcare.	Below current participation, or less demand for comprehensive cover.
Participation ($)	Total premium revenue for hospital Total hospital claims funded through PHI	More health costs covered through private sector.	Less health costs covered through private sector.
Efficiency and market dynamics	Judgemental, considering incentives for competition, innovation, and best outcomes compared to alternative uses of resources.	Mechanisms are in place to identify and offer incentives for best value for policyholders and government	The best value choices are not readily identified and propagated. Benchmark service levels are not achieved.

The other criteria such as complexity, adaptability, choice and ease of transition are also necessary to assess qualitatively.

7 Effectiveness of current policy settings

This section summarises our assessment of the effectiveness of the current policy settings. This analysis (together with stakeholder consultation) has informed the options considered (Section 8) and the modelling undertake (Sections 9 to 14).

Section 7.1 sets out the current policy settings and how they have arisen, and Sections 7.2 to 7.4 then provide more detail on each policy.

7.1 Current policy settings, and how they have arisen

7.1.1 About the PHI Rebate

The PHI Rebate is an amount the government contributes towards the cost of PHI premiums. The PHI Rebate depends on the income and age of the policyholders, and operates through personal income tax arrangements, being administered by Services Australia and the Australian Tax Office (ATO).

Objectives

The PHI Rebate is intended to support PHI access and affordability both:

- Directly – by reducing the premium payable for most people, and so increasing access.
- Indirectly – PHI Rebates encourage people in good health to purchase insurance which, through community rating, helps make PHI more affordable for all. Even people who are not eligible to receive a PHI Rebate (due to income) therefore benefit through this incentive scheme.

Policyholders can elect to receive their PHI Rebate as either a premium reduction or through the tax system. The operation through the tax system provides a practical solution, ensuring that even those who are unaware of the policy are treated equitably.

Current settings

The current policy settings are set out in the table below.

Table 7.1 – Current PHI Rebate settings: 1 April 2022 to 31 March 2023

Income for surcharge purposes		Age of oldest person on the policy		
		Under 65	65 to 69	70 or older
Singles	Families*			
$90,000 or less	$180,000 or less	24.608%	28.710%	32.812%
$90,001 - $105,000	$180,001 - $210,000	16.405%	20.507%	24.608%
$105,001 - $140,000	$210,001 - $280,000	8.202%	12.303%	16.405%
$140,001 or more	$280,001 or more	0%	0%	0%

* Note that the family income threshold is increased by $1,500 for each MLS dependent child after the first child

The PHI Rebate is calculated as a percentage of the premium and is dependent on the age, income and family type of policyholders. An additional feature is that no PHI Rebate is payable on any LHC loading to the premium.

Policyholders are able to receive the same percentage PHI Rebate on any complying health insurance product (including extras only policies).

As announced in the 2021-22 Budget, the income tiers shown above will continue to apply to 30 June 2023, while the current policy settings are reviewed. The PHI Rebate percentages may continue to reduce over that period, because the PHI Rebate is indexed to CPI rather than (generally higher) industry average price increases, effectively lowering the PHI Rebate rates applicable each year. This indexation has reduced the PHI Rebate for those in the lowest income tier and the youngest age category from 30% in 2014 to 24.608% for 2022.

7.1.2 About the MLS

The MLS is a surcharge on people who earn higher incomes and do not hold an appropriate level of private hospital cover. This policy initiative is administered through the personal taxation system by the ATO.

Objectives

The objective of the MLS is to incentivise those who can afford to contribute to the cost of their own healthcare do so. This contribution can be either directly through purchasing PHI, or indirectly through the levy. Encouraging participation in PHI improves access to healthcare for all in two ways:

- Reduces PHI premiums: If people buy PHI to avoid the MLS, rather than because they expect to claim, expected claim costs will be relatively low. Low average claim costs reduce premiums for everyone insured, encouraging greater participation.
- Reduces public healthcare costs: If people do need treatment, they have the option of private rather than public funding for their care. As a second-order effect, this can free up capacity in the public healthcare system, thereby improving access for persons who rely solely on the public system.

Current settings

The current policy settings are set out in the table below.

Table 7.2 – Current MLS settings (applying from 2014/15 to 2022/23)

Income for surcharge purposes		Medicare levy surcharge
Singles	Families*	
$90,000 or less	$180,000 or less	0.00%
$90,001 - $105,000	$180,001 - $210,000	1.00%
$105,001 - $140,000	$210,001 - $280,000	1.25%
$140,001 or more	$280,001 or more	1.50%

* Note that the family income threshold is increased by $1,500 for each MLS dependent child after the first child

As with the PHI Rebate, liability for the MLS varies according to income. For example:

- Households with lower incomes are not subject to the MLS, and receive higher PHI Rebates to support access to PHI and encourage participation.
- Households with the highest incomes receive no PHI Rebate, but are liable for a 1.5% levy if an appropriate level of private patient hospital insurance cover is not purchased.

7.1.3 About LHC

The objective of LHC is to support community rating by providing incentives for people to obtain private hospital cover 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.

If an individual has not taken out and maintained private 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.

At 31 December 2021[2]:

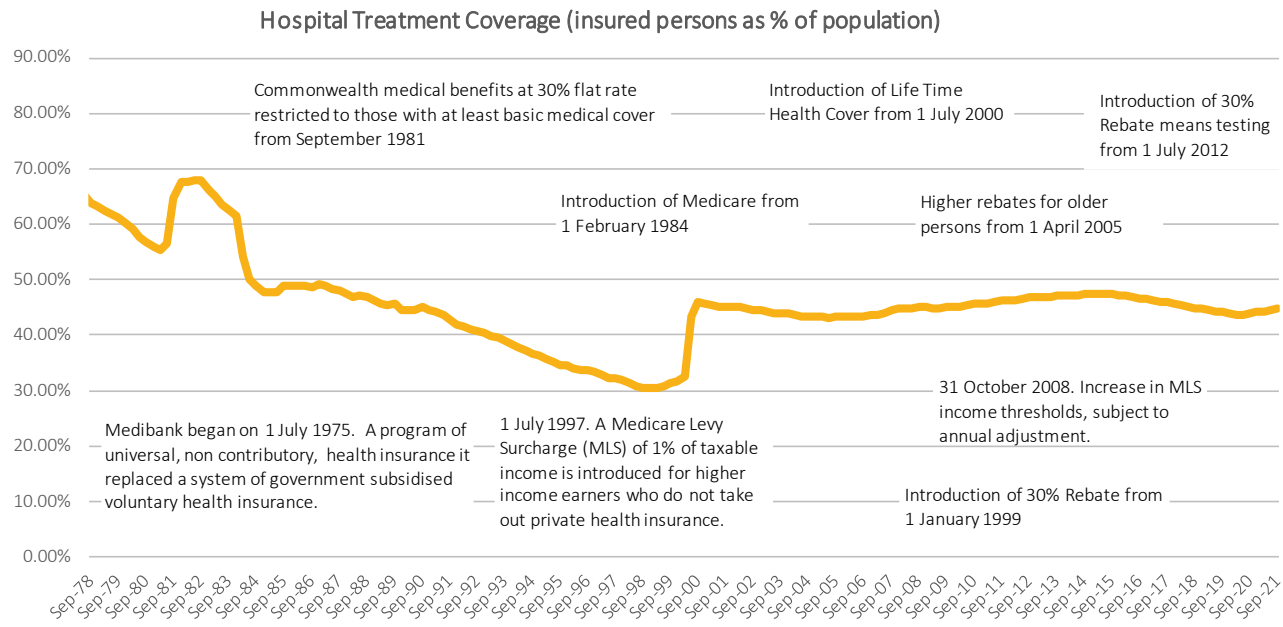
- There were around 900,000 policyholders subject to an LHC loading. This represents 11% of the 8.4 million adults covered by a hospital policy.
- For policyholders subject to an LHC loading, the average loading was between 22% and 23%.
- Multiplying these numbers together suggests LHC loadings contribute around 2.4% to industry hospital premiums.

7.1.4 History of policy settings

The charts below show how PHI participation has changed over time. Figure 7.1 shows the longer-term experience, and Figure 7.2 focuses on the most recent decade. In this report, references to participation rates refer to policies which provide hospital cover.

[2] Finity analysis of APRA HRF601 forms.

Figure 7.1 – Proportion of population with hospital cover (1978-2021)



Source: https://www.apra.gov.au/sites/default/files/2021-11/Quarterly%20Private%20Health%20Insurance%20Membership%20Trends%20September%202021.xlsx

The horizontal axis shows the time period, and the vertical axis shows the proportion of the population with hospital cover.

PHI participation fell for most of the 1990s, causing significant upward pressure on premium rates and threatening the financial sustainability of PHI. The three key PHI incentives (LHC, MLS and PHI Rebate) were initially introduced at the end of that decade, although they have been refined over time.

Specifically:

- July 1997: Introduction of the 1% MLS for high income earners (threshold set at $50,000 individual/$100,000 family), and the Private Health Insurance Incentive Scheme (PHIIS). PHIIS was an early form of the PHI Rebate, as it provided a fixed dollar subsidy to people on low incomes who took out PHI.
- January 1999: PHIIS changed to a 30% PHI Rebate for all policyholders.
- July 2000: Introduction of LHC.

PHI participation increased from 31% in June 1999 to 42% in June 2000, and has remained above that level since.

These policies have been revised periodically since their introduction, including:

- 2000: Maximum excess level ($500 single/$1000 family) required for PHI to avoid liability for MLS.
- 2005: Higher PHI Rebates introduced for older Australians.
- 2008: Increased MLS income thresholds (to $70,000 individual/$140,000 family and indexed annually thereafter to Australian Weekly Ordinary Time Earnings, AWOTE).

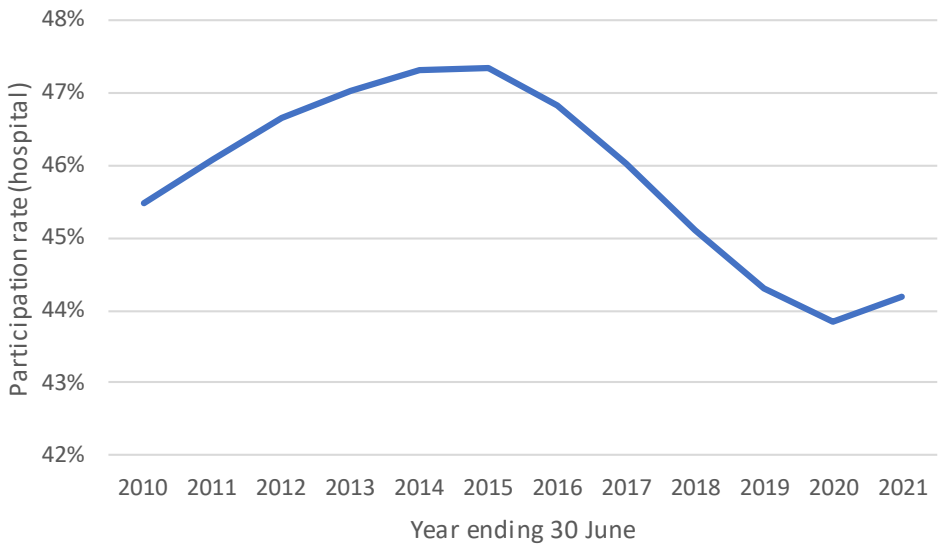
- 2012: Income testing of PHI Rebate percentage based on MLS income thresholds and increased MLS rates for higher income earners (1.25% and 1.5% for income tiers 2 and 3) – referred to as the *Fairer Private Health Insurances Incentives*.
- 2013: PHI Rebate no longer payable on LHC premium loadings.
- 2014: PHI Rebate percentages indexed annually by a Rebate Adjustment Factor (RAF) *The rebate adjustment factor is a percentage of the increase in the consumer price index (CPI) and the average annual premium price increase. It is calculated by the Department of Health*[3].
- 2015: Indexation of income thresholds for MLS and PHI Rebate paused. Currently due to restart on 1 July 2023.

The 2005 change increased PHI participation incentives, and the proportion of Australians with PHI reduced slightly during that year, which was contrary to expectations. The other changes reduced PHI participation incentives, however their implementation coincided with increases in PHI participation rates.

This experience shows estimating the impact of policy changes on PHI participation requires understanding how insurers and policyholders respond to government policy. We have investigated this through an economic experiment.

The chart below focuses on participation over the last decade.

Figure 7.2 – Proportion of population with hospital cover (2010-2021)



Source: Derived from APRA Quarterly private health insurance membership and coverage and ABS 3101.0 National, state and territory population TABLE 59. Estimated Resident Population by Single Year of Age, Australia[4]

PHI participation rates increased through to 2015, despite some reductions in participation incentives over the period. Participation rates then declined in the five years to June 2020. While the participation rate increased during the year to 30 June 2021, this is likely to be due to exceptional factors relating to the pandemic,

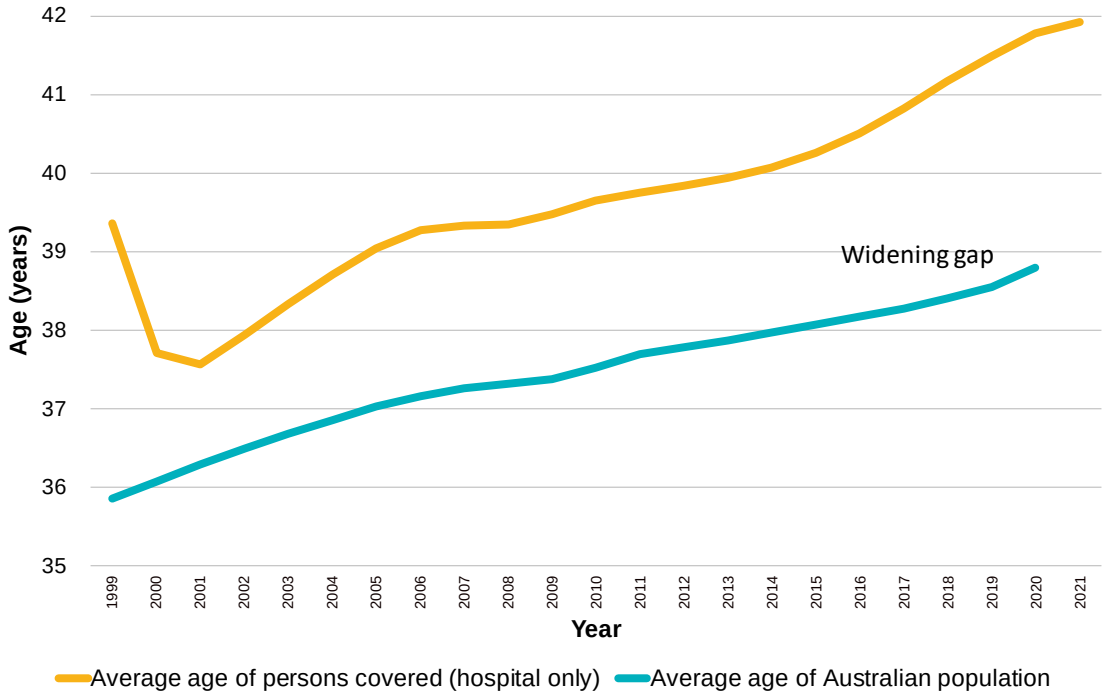
[3] https://www.ato.gov.au/Individuals/Medicare-and-private-health-insurance/Private-health-insurance-rebate/Private-health-insurance-rebate-eligibility/#:~:text=The%20rebate%20adjustment%20factor%20is,on%20or%20after%201%20April.

[4] https://www.apra.gov.au/sites/default/files/2021-11/Quarterly%20Private%20Health%20Insurance%20Membership%20Coverage%20September%202021.xlsx and https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/sep-2019

including government income support packages, insurer support packages, changes to immigration patterns and concerns regarding access to healthcare.

Increases in participation among persons with lower health costs (often younger persons, although there are low and high claimers in every age band) would be expected to be positive for the PHI industry through keeping average claim costs low; many PHI funds are therefore keen for solutions that would make the purchase of a policy more appealing to this group, through incentives or penalties. For example, before risk equalisation, average annual hospital claim costs are less than $1,000 for a policyholder aged under 55, compared to around $4,000 for a policyholder in their 70s. The figure below shows how the average age of people covered by PHI has increased in recent years, and compares this to the overall population.

Figure 7.3 – Average Age: PHI policyholders and Australian population



Source: Derived from APRA Quarterly private health insurance membership and coverage and ABS 3101.0 National, state and territory population TABLE 59. Estimated Resident Population by Single Year of Age, Australia (as per Figure 3.2)

Falling PHI participation among younger people have contributed to the age of the insured population increasing more quickly than the Australian population. The average age of people insured continued to increase through the COVID-19 pandemic, despite the increase in participation levels. Since average hospital claim costs increase with age, this trend adds to affordability concerns in PHI.

A sustainable PHI industry requires participation by people in good health, so as to ensure PHI remains affordable for all who choose to purchase it. The purpose of this review is to determine whether the current incentives, such as the PHI Rebate and MLS, are appropriately targeted to meet this objective.

7.2 Impact of current policies – PHI Rebate

7.2.1 Impact of the PHI Rebate on affordability

As shown in the previous section, the PHI Rebate level ranges from 0% for the highest income earners below age 65, to 32.81% for low income earners aged 70 or older.

This has a high impact on affordability of different policy types. We used an industry price aggregator (iSelect)[5] to find the cheapest policy available to a single person in NSW without any PHI Rebate, using the cover definitions shown below. The PHI Rebate can reduce the price of a basic hospital-only policy from $102.30 per month to only $68.74 per month, and for persons choosing the highest level of cover (Gold hospital with top extras), it reduces from almost $300 per month to just under $200.

Table 7.3 – Lowest available price in NSW for a single person, at different levels of cover and PHI Rebate

Level of cover (and typical monthly premium)	Age 70+, Income < $90,000 (32.81% PHI Rebate)	Age 65-69, Income < $90,000 (28.71% PHI Rebate)	Age under 65, Income < $90,000 (24.61% PHI Rebate)	Age under 65, Income $90,0001-$105,000 (16.41% PHI Rebate)	Age under 65, Income $105,001 - $140,000 (8.2% PHI Rebate)
Basic extras only ($22.40 per month)	$15.05	$15.97	$16.89	$18.72	$20.56
Medium extras only ($57.40 per month)	$38.57	$40.92	$43.27	$47.98	$52.69
Top extras only ($152.27 per month)	$102.31	$108.55	$114.80	$127.28	$139.78
Basic hospital ($102.30 per month - $750 excess)	$68.74	$72.93	$77.12	$85.51	$93.91
Bronze hospital ($132.10 per month - $750 excess)	$88.76	$94.17	$99.59	$110.42	$121.27
Mid hospital (Silver) ($160.50 per month - $750 excess)	$107.84	$114.42	$121.00	$134.16	$147.34
Gold hospital ($224.90 per month - $750 excess)	$151.11	$160.33	$169.55	$187.99	$206.46
Basic package (Bronze + basic extras) ($137.60 per month - $750 excess)	$92.45	$98.10	$103.74	$115.02	$126.32

[5] Aggregator websites do not necessarily cover all insurers, so this information is not intended to be exhaustive, but illustrates the impact of the rebate.

Level of cover (and typical monthly premium)	Age 70+, Income < $90,000 (32.81% PHI Rebate)	Age 65-69, Income < $90,000 (28.71% PHI Rebate)	Age under 65, Income < $90,000 (24.61% PHI Rebate)	Age under 65, Income $90,0001-$105,000 (16.41% PHI Rebate)	Age under 65, Income $105,001 - $140,000 (8.2% PHI Rebate)
Mid package (Silver + mid extras) ($199.39 per month - $750 excess)	$133.97	$142.15	$150.32	$166.67	$183.04
Top package (Gold + top extras) ($297.65 per month - $750 excess)	$199.99	$212.19	$224.40	$248.81	$273.24

It can be seen that affordability is greatly improved through the PHI Rebate, especially for older persons who do not have high incomes. In dollar terms, the highest PHI Rebate is available for those purchasing a more comprehensive policy.

Affordability – indexation of PHI Rebate: PHI premiums typically increase faster than CPI because the Australian population is ageing, utilisation of health services is increasing, and the cost of each service increases over time. CPI is currently above price increases due to high inflation in some non-healthcare related sectors of the economy, however this is unusual.

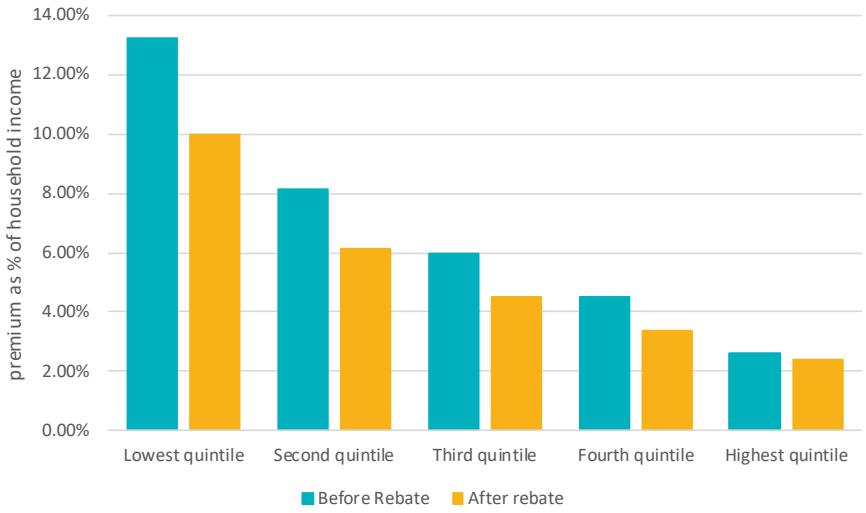
If there are no changes to the current policy, the proportion of premiums covered by the PHI Rebate will continue to reduce each year, and eventually the PHI Rebate will reduce towards nil. The PHI Rebate will provide less support to PHI participation each year (in percentage terms).

The mechanism of annual PHI Rebate reductions means each year policyholders pay both the annual price rise determined by their insurer, and an additional amount due to the reduction in the PHI Rebate rates. The policy therefore increases the impact of annual price changes as perceived by the consumer.

Affordability – as % of household income: Household income differs between states, socio-economic profile, geography and age. To ascertain the differences in affordability across the various population segments, we utilise an affordability measure. The affordability measure expresses current premium of a PHI product as percentage of mean equivalised disposable household income, which is available from the ABS for year 2017-18. We indexed the data to 2020-21 level using AWE. The premium used here is the weighted average premium by state across funds.

The graph below shows the affordability measure of a gold hospital product by income quintiles before and after the base tier PHI Rebate in Victoria:

Figure 7.4 – Affordability – Gold hospital product in VIC – by income quintile



As expected, affordability improves (i.e. the proportion of income spent on premium) as household income increases. Lower income households wishing to insure would need to spend a significant proportion of their income on health insurance, even after the PHI Rebate. This represents a significant barrier to accessing PHI.

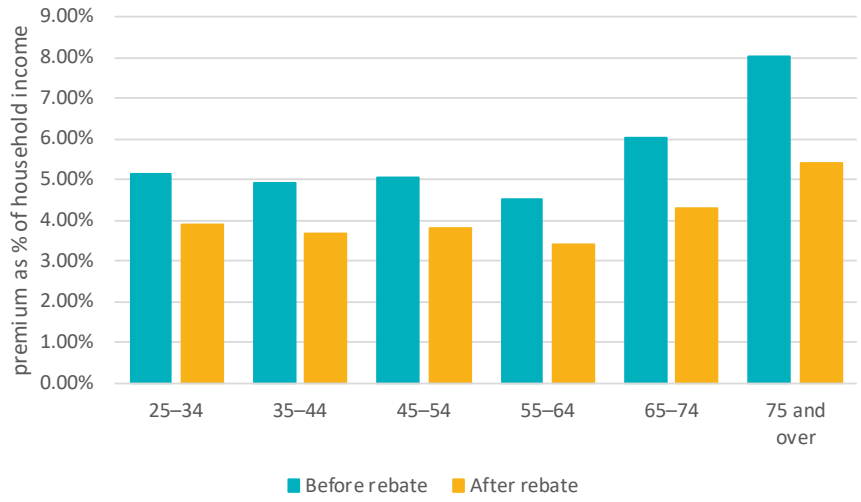
We also observe differences in affordability by geography. The ABS provide household income data by capital cities and rest of the state. The graph below contrasts the affordability measure between different geographical areas after base tier PHI Rebate, assuming a gold hospital product is purchased:

Figure 7.5 – Affordability – Gold hospital in capital city and other areas

We do not show information for ACT, as this is not split between capital city and regional in the ABS data. With the exception of the NT, regional areas tend to have lower household income than capital cities. The difference in income can be more than 25% depending on the state, which makes PHI less affordable for residents outside of capital cities. The impact may be compounded by lower access to private healthcare services outside of capital cities, especially in very remote areas.

Lastly, we analyse data to understand differences in affordability by age groups. The graph below shows the affordability measure before and after the base tier PHI Rebate in Victoria, assuming a gold hospital product is purchased:

Figure 7.6 – Affordability – Gold hospital product in VIC – by age



Before PHI Rebate, affordability is poorer amongst those who are older i.e. a higher proportion of income is spent on PHI, as they earn less income than other age groups. However, the PHI Rebate is also currently set higher for persons aged 65 and above which helps to normalise affordability, as demonstrated by the more comparable affordability measure across age groups after the PHI Rebate is applied.

However, the PHI Rebate and affordability measure does not consider the net worth of households. ABS data shows older Australians accumulate significant wealth over time. For example, the mean net worth of a 65 and over household is nearly four times that of those aged 25-34. If net worth was included in the calculation of affordability, PHI would appear more "affordable" for older Australians.

Conclusion:
The PHI Rebate provides the greatest support (in dollar terms) to older people buying high levels of both hospital and extras cover. Lower PHI Rebates are offered to younger people (under 65s), or those buying mid-levels of cover. No PHI Rebate is available to high earners.

The PHI Rebate does not consider factors other than age or income (except for a limited adjustment for number of children).

7.2.2 What is the cost of the PHI Rebate?

The estimated cost of the PHI Rebate for 2022-23 is $6,888m. In the six-year period 2019-20 to 2025-26, the PHI Rebate is expected to increase by $1,141m, equivalent to annual growth of 2.8% per year.

Table 7.4 – PHI Rebate budget and forward estimate ($m)

Budgeted expenses	2019-20 Actual	2020-21 Actual	2021-22 Actual	2022-23 Estimate	2023-24 Estimate	2024-25 Estimate	2025-26 Estimate
PHI Rebate	6,308	6,561	6,742	6,888	7,066	7,249	7,449

Source: Collated by the Department from various budget papers, includes amounts attributed to the ATO.

Of the $6,888m for 2022-23, we estimate that $4,760m (69%) is in respect of hospital claims, with the remainder payable on extras policies.

7.3 Impact of current policies – MLS

7.3.1 Impact of MLS on participation

Based on 2018-19 ATO data, approximately 2.5 million taxpayers earn more than the MLS income threshold of $90,000, and those individuals have a greater participation rate than those below the threshold as shown in the tables below:

Table 7.5 – Proportion of taxpayers by age and income tier

	Income tier			
Age band	0 (below threshold)	1	2	3
<30	18.9%	0.5%	0.4%	0.3%
30-45	21.8%	1.9%	1.9%	1.3%
45-60	19.7%	1.7%	1.8%	1.7%
60-75	17.9%	0.4%	0.4%	0.5%
75+	8.6%	0.0%	0.1%	0.1%
Total	86.9%	4.5%	4.7%	4.0%

Table 7.6 – Participation in PHI by age and income tier (LHS) and proportion of overall PHI participants (RHS)

	Income tier			
Age band	0 (below threshold)	1	2	3
<30	29.6%	62.5%	72.3%	85.7%
30-45	37.6%	76.1%	84.3%	91.3%
45-60	41.6%	76.0%	84.4%	92.4%
60-75	52.8%	89.2%	92.6%	96.1%
75+	50.6%	90.4%	91.2%	93.1%
Total	41.2%	75.7%	84.1%	92.1%

	Income tier			
Age band	0 (below threshold)	1	2	3
<30	12.0%	0.7%	0.7%	0.5%
30-45	17.5%	3.0%	3.5%	2.5%
45-60	17.5%	2.7%	3.3%	3.4%
60-75	20.2%	0.7%	0.8%	1.1%
75+	9.3%	0.1%	0.1%	0.3%
Total	76.5%	7.2%	8.4%	7.8%

Almost 87% of taxpayers are exempt from the MLS based on income. Participation for this group varies between less than 30% (for under 30s) to over 50% (for over 60s). Over 75% of people with PHI are in this base tier.

Income for MLS purposes is based on taxable income, with adjustments applied to add back (for example) investment losses and reportable super contributions. People with income which is excluded from the definition (for example, earnings on super) may not therefore be subject to MLS.

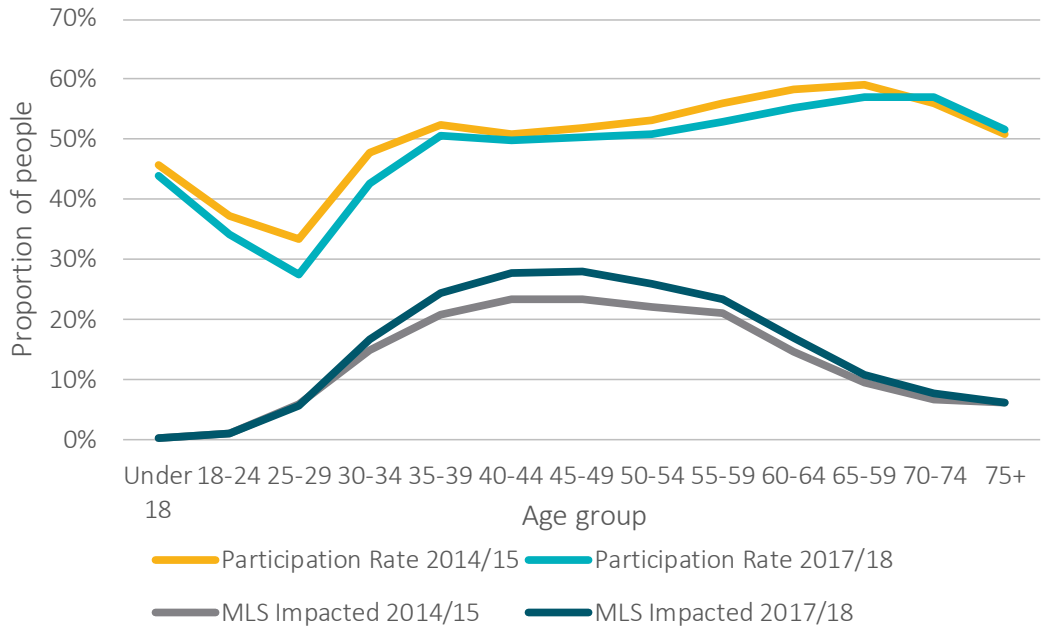
For those subject to MLS, participation rates vary from 76% for tier 1 to over 90% for tier 3. Participation varies from 63% (under 30s in tier 1) to over 95% (60-75 year olds in tier 3).

7.3.2 Participation impact on younger people – interaction with LHC

There are significant increases in PHI participation between the 25-29 and 30-34 age groups. While this increase is often attributed to the LHC, the MLS also has a significant impact on participation between these age groups, as a higher proportion of people become subject to the MLS as they transition between these age groups.

The figure below shows the proportion of tax-payers who would be subject to the MLS based on income (if they do not have PHI), as well as the participation rates for 2014/15 and 2017/18.

Figure 7.7 – Proportion of individuals subject to MLS



Source: Derived from a range of data sources including APRA statistics, ABS data, details of gold card holders, international student number and those with overseas visitors cover.

The graph can be read as follows:

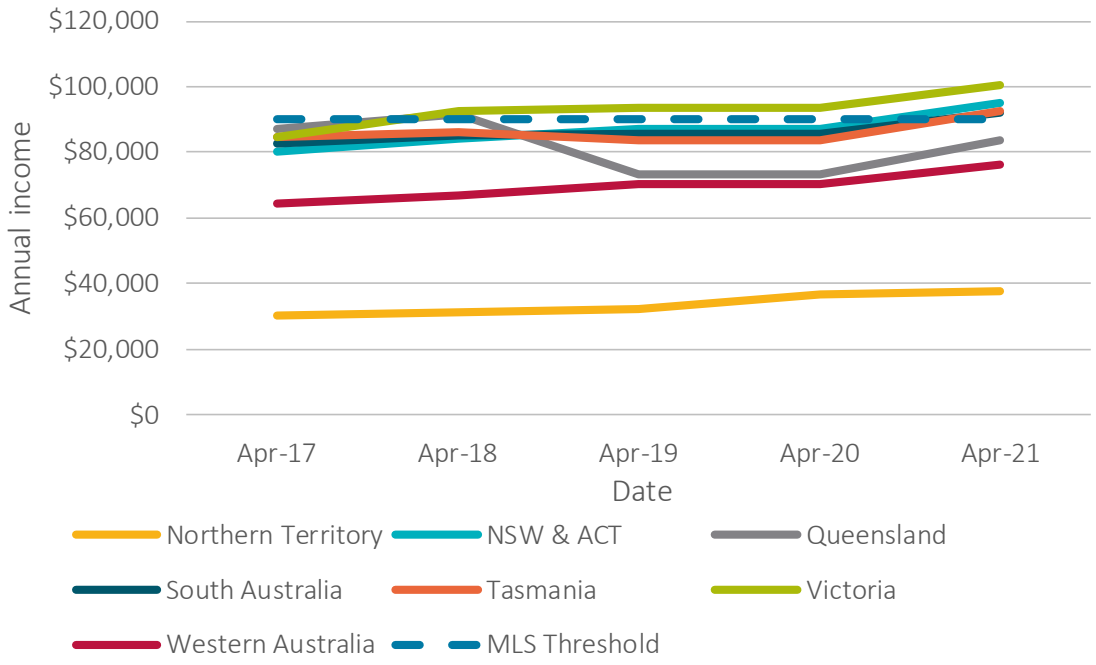
- Participation: The PHI participation rate of 30-34-year-olds is around 15 percentage points higher than for 25-29-year-olds.
- Impacted by MLS: 17% of 30-34-year-olds would need to pay the MLS (if they do not have PHI). This is around 10 percentage points higher than for 25-29-year-olds (only 6% of that group earn enough to pay the MLS).
- Therefore, up to two-thirds of the increase in participation between these age groups could be explained by MLS, rather than LHC.

While the 2014/15 and 2017/18 statistics show the same broad trends, the amount of the increase in participation between these age groups which could be explained by MLS has increased over time.

7.3.3 Impact of MLS on affordability – technical adequacy of rates

We have analysed PHI premiums at April of the last five years and identified the cheapest hospital policy by state. The figure below shows the annual income threshold at which the cheapest PHI policy in each state (after allowing for a Tier 1 PHI Rebate) becomes cheaper than paying the MLS, should it apply.

Figure 7.8 – Annual income where paying MLS (should it apply) becomes more expensive than the cheapest PHI policy



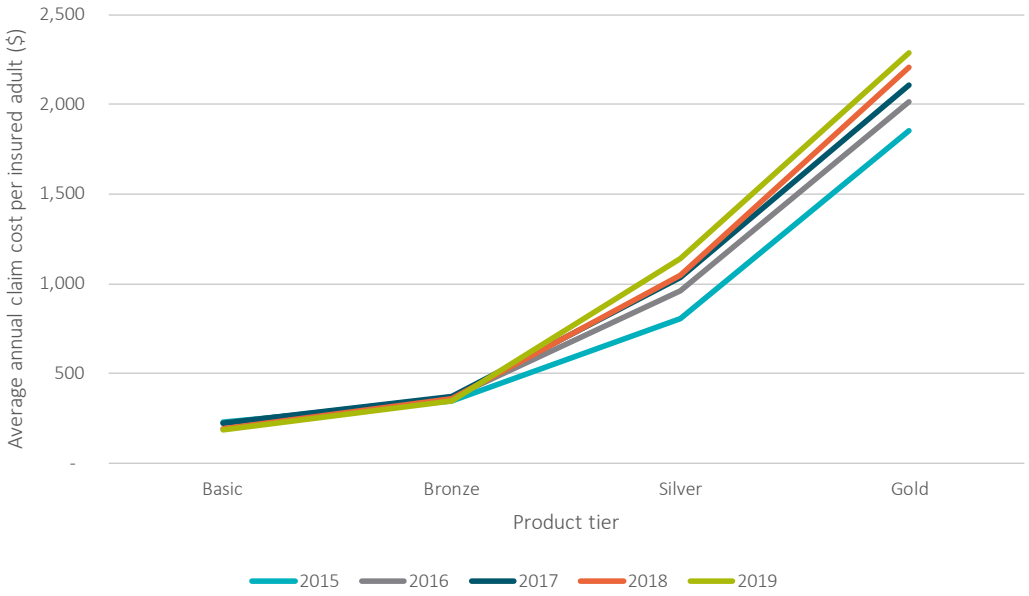
Source: Derived from calculations based on premium rates reported on privatehealth.gov.au, accessed 30/05/2021.

Note that the MLS applies for singles earning more than $90,000 (the dotted blue line on the chart), and the minimum levy is $900 (1%). In April 2017 there were basic hospital policies available for less than $900 (after tier 1 PHI Rebate) in every state. By April 2021, even the cheapest policies in Victoria, NSW/ACT and Tasmania exceed $900. In Victoria the cheapest policy is around $1,000, so for people on incomes up to $100,000 paying the MLS would cost less than buying PHI.

There are many reasons to take out PHI irrespective of income, including to access private treatment, benefits from peace of mind (which may vary depending upon the cover purchased), or avoid a future LHC loading. However, the analysis shows that over time the MLS has become less effective at encouraging participation.

It should be noted that whilst a lower tier product can be significantly cheaper, the average benefits paid are also much lower, as fewer services are covered. This could potentially lead to customer dissatisfaction should they ever need to claim.

Figure 7.9 – Average historical claim rates by product tier



Source: Derived from insurer data provided for the review of LHC and Risk Equalisation. Data shown is for those without an LHC loading.

It should also be noted that the MLS significantly reduces the effective cost of PHI to consumers. For example, if a policyholder has to pay an MLS of $1,000 if they do not insure, and so decides to purchase a $1,500 policy, the perceived marginal cost may only be $500.

7.4 Impact of current policies – LHC

Our LHC Study concluded that 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. This is based on the significant increase in PHI participation rates at around age 30, whereas for people who do not expect to claim delaying entry and paying a penalty may be a rational choice. This suggests LHC 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. One evidence point is that more of the increase in participation around age 30 can now be explained by factors such as MLS, as shown in Figure 7.75 above.

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 our LHC study were:

- Our research and analysis did not identify an immediate imperative to change the current LHC arrangements in isolation, so we recommended 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 the population.

8 Alternative options

This section explains how we identified alternative options, the types of option suggested, and how we shortlisted options for detailed analysis.

8.1 Options identified

As set out in Section 5, we have engaged with a comprehensive range of stakeholders who were asked to suggest options. We also identified options based on our industry knowledge, and input from the Department. The table below summarises the categories of options identified.

Table 8.1 – Categories of options identified

Option category	Examples
Administration	Indexation process: round result to one decimal place, index every 3 years. Dependants: remove/change complex family size adjustments to income thresholds.
Optimisation Maintain separate PHI Rebate, MLS and LHC policies, but optimise settings.	Change MLS rate or thresholds. MLS mechanics: Make PHI (rather than paying MLS) the default option, by enrolling people in insurance rather than simply collecting the surcharge. PHI Rebate: change rates, thresholds, or other aspects of the calculation (for example, how PHI Rebate varies by age or have a set PHI Rebate amount for each tier instead of %).
Incentivise more comprehensive coverage Investigate linking PHI incentives or funding to product value/ scope of coverage. Current settings are that MLS/LHC incentivises hospital participation, and PHI Rebate incentivises any PHI participation.	MLS scope: As income increases, require higher tier / comprehensive hospital coverage be held to avoid MLS. PHI Rebate scope: vary PHI Rebate by product tier, or product type (hospital / extras). Linking funding to product features, for example, where products offer benefits for particular services, or have other desirable features such as low/no out of pocket amounts.
Integrate policies by combining where possible Simpler, more understandable policies may be more effective.	For example, combine elements of PHI Rebate and LHC into a single policy. This can be further integrated with changes in what is incentivised, for example, where MLS and PHI Rebate reflect income and product tier.

Option category	Examples
Redirect PHI Rebate within PHI Government funding continues to support PHI affordability, but not necessarily solely via a PHI Rebate.	Divert some PHI Rebate funding to RE.
Alternatives or additions to PHI Rebate / MLS. For example: • New funding sources for PHI, such as employers. • Create a more valuable regulated product for the consumer, for example, remove out of pockets, greater focus on preventative healthcare, no claim discount. • Use tools other than PHI to help people access private healthcare.	Self-insurance Health savings account Adjusting FBT arrangements for PHI premiums

Maintaining current settings is also an option. The options stated above generally involve changing a single policy setting, however initiatives will be considered together as the aim is to produce integrated policies.

Our scope of work relates to MLS, the PHI Rebate and LHC. We comment on other options, however the detailed modelling has been focussed on options relating to the incentive policies.

With respect to the options which change the incentive policies, we observe that many of the options identified do not represent material changes to the current policy settings, and therefore are unlikely to significantly change current PHI participation. We raised this observation at an April 2022 stakeholder workshop, and invited participants to identify options which represent a more material change. Overall the view expressed was that the aim should be stability of participation (rather than declining participation). Aspirations for increasing participation were modest.

8.2 Shortlisted options

We identified a short list of options for detailed analysis. Limiting the number of options considered allows the shortlisted options to be assessed in the required detail. The shortlist focusses on options which either are:

- Thought likely to test well against criteria, based on initial analysis.
- Strongly promoted by stakeholders, because stakeholder engagement has been an important part of our work.

The following options were shortlisted:

- PHI Rebate
  - > Restore, reduce or remove
  - > Reduce for high wealth people
  - > Fix dollar PHI Rebate by tier, rather than percentage
  - > Redirect funding to specific initiatives (eg. mental health) via RE

- MLS
  - Link product tier to income (require Silver+ for tier 3, Bronze for tier 2)
  - For PHI Rebate and LHC change options, test with current MLS settings, and with stronger or weaker MLS settings.
- LHC
  - Move start to age 40
- Other options
  - Reduce or cap out of pocket costs
  - Youth product – PHI offers Gold-only type cover for a lower price than is currently available.
  - Data sharing – encourage patients and GPs to share information with insurers
  - Communication – increase the effectiveness of the policies by improving how they are communicated

Detailed modelling and analysis

This section briefly summarises the detailed modelling and analysis completed, and is structured as follows:

- Information on the economic experiment used to provide insight into consumer responses to options (Section 9)
- Insights into policy interactions (Section 10)
- Summary of our analysis for PHI Rebate (Section 11), MLS (Section 12), LHC (Section 13) and other options (Section 14)
- Risks identified and mitigating factors (Section 15)

Further information is also provided in a number of attachments.

9 Economic experiment

We undertook an economic experiment to estimate how changes in the MLS, PHI Rebate and LHC will affect participation in PHI. The experiment was run as an online survey with a commercial respondent panel, designed to be representative of the Australian general population, aged 18 and older. Over 1,500 people participated in the survey.

9.1 Experiment design

We designed a list of attributes for consideration in the experiment. The design reflects the shortlisted options, a review of the literature, as well as the specific features of the MLS, PHI Rebate and LHC. We have consulted with the Department and our academic partners. The design was reviewed by the behavioural economics team (BETA) of the Australian Government. The following attributed were tested.

Table 9.1 – Attributes tests in the economic experiment

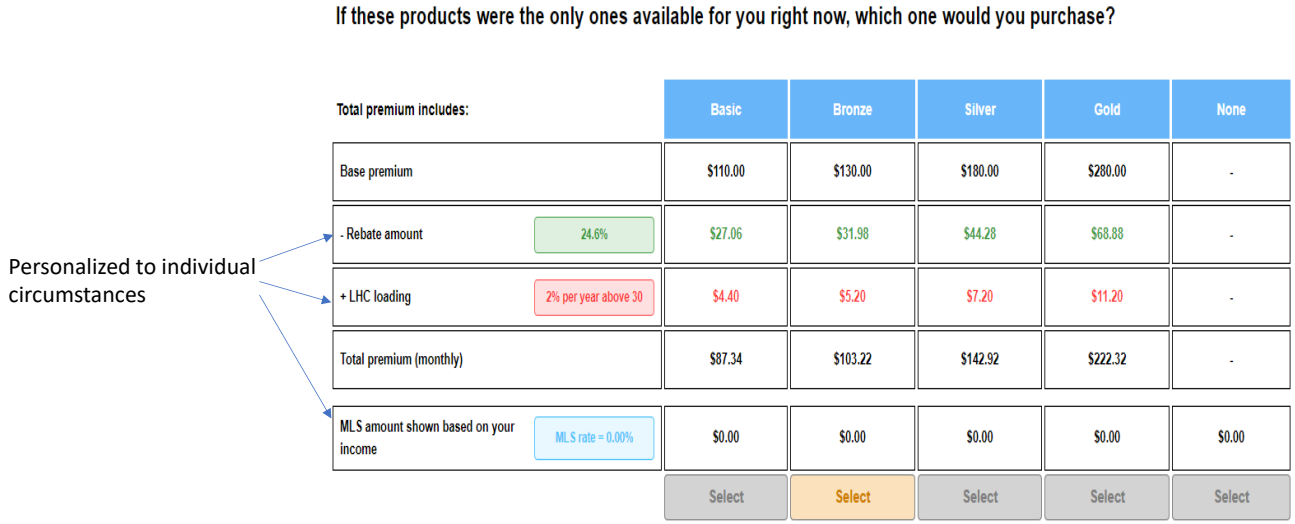
Dimensions	Level 1	Level 2	Level 3	Level 4
LHC Rate	Decrease rate to 0%	Status quo	Increase rate to 3%	
LHC threshold	Status quo	Age threshold increase to 40		
MLS Rate	Decrease by 0.5%	Status quo	Increase by 0.5%	
MLS threshold	Decrease by $10k (singles) $20k (families)	Status quo	Increase by $10k (singles) $20k (families)	
MLS exemption	Status quo (applicable for None)	Exclusion (Require Silver+ for exemption)		
PHI Rebate	Remove completely	Decrease	Status quo	Increase
OOP	Guaranteed $0	Max of $500 per treating doctor	Variable depending on treating doctor	
Public System	Longer waiting times for elective surgery	Shorter waiting times for elective surgery	Status quo	
PHI Rebate eligibility	Status quo	Restrict older brackets only for healthcare card holders		
Premium - Basic/Bronze	Decrease	Status quo	Increase	
Premium - Silver/Gold	Decrease	Status quo	Increase	

We also requested information on the respondent's current PHI product holdings and utilisation, PHI literacy, demographic information (e.g., age, income, education), risk preference, time preference, opinions on public health system and self-rated health status (poor to excellent).

The experiment entails constructing a number of hypothetical market scenarios in which the settings for the attributes identified are different from the current values and measure how respondents purchasing decisions change in response.

We begin by showing a scenario based on the current settings and ask the respondent to choose from the available products. An example is shown in the figure below for a respondent aged 35 on an income of $85,000 who has purchased PHI for the first time at age 33. The base premium values are based on typical prices observed in the market today.

Figure 9.1 – Current settings: Example choice task



We then repeat the same process several times. Each time the respondent is shown the equivalent prices under a different hypothetical market. For example, one of the hypothetical markets is where the LHC rate is increased and the age threshold is also increased to 40. Under this scenario the 35-year-old respondent from the previous example would no longer be subject to the LHC. They would see a set of options as in the following figure with slightly lower total premiums.

Each respondent sees approximately ten scenarios selected from the total set of scenarios under investigation, each with different settings and premiums and asked which product they would choose. By asking a large number of respondents we can cover the relevant scenarios and estimate the impact of changing any of the treatment variables identified.

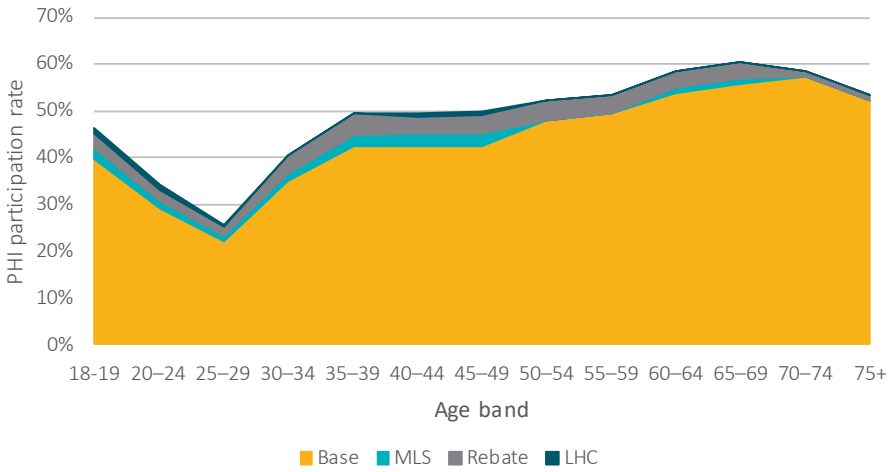
The results of the economic experiment are reflected in our modelling in the following sections.

10 Policy interactions

The figure below shows the estimated impacts of the PHI Rebate, MLS and LHC on PHI participation. Our approach to prepare these estimates was as follows:

- PHI Rebate:
  - > Determine the effective price increase that would occur if the PHI Rebate were removed.
  - > Estimate resulting cancellations using the results of the economic experiment, as well as extrapolated price elasticities estimated from the insurer dataset. The insurer data shows how consumers have responded to actual price changes historically.
- MLS:
  - > Use ATO data to review PHI participation by income, age and family status for those individuals not subject to the MLS.
  - > PHI participation rates increased by income, even for individuals who are not subject to MLS. Use regression techniques to predict PHI participation based on age band, income and family status using data on individuals not subject to the MLS. This assumes that, even if MLS were removed, high earners would be more likely to buy PHI than those on average earnings.
  - > The impact of the MLS is calculated as the difference between the predicted participation using regression, and the actual uplift in participation rates by income level.
- LHC:
  - > The estimate reflects the observed participation changes by age which are not explained by the other incentive policies.
  - > Removing LHC for older ages would reduce premium rates for older entrants, which would increase participation.

Figure 10.1 – Estimated total impact on participation of PHI Rebate, MLS and LHC



It is important to note that the above shows the *incremental* effects of each initiative, assuming the other initiatives remain in place. For example, in a scenario where the MLS is removed, the LHC would be expected to have a bigger effect than that shown above. A number of assumptions are required to estimate these impacts, and a range of other outcomes are possible.

We make the following observations on our estimates:

- If the PHI Rebate were removed, participation rates would reduce across all age groups.
- MLS has the greatest impact for under 50s, as older high earners are expected to insure even if MLS were removed.
- LHC has a smaller impact on participation than the other incentives, however it has other important roles. Specifically, it incentivises people to maintain insurance, to avoid paying an additional premium if they lapse and re-join later in life.

11 PHI Rebate options

11.1 Summary

The table below summarises the options considered. The amounts shown are annual costs. We focussed on the hospital component of the PHI Rebate, as this is more material than extras, and interacts with MLS and LHC. We comment on the extras PHI Rebate in section 11.5.

Table 11.1 – Summary of PHI Rebate options considered

Option	Description	Key findings
Remove	No PHI Rebate for hospital cover	• While small price changes may not have a material impact on participation, the experiment shows larger price changes would trigger a consumer response. We estimate this scenario results in a 10% reduction in the number of people covered. • Reduction in claims funded by PHI of $2.3bn-$3.1bn, mostly in respect of people over 65 • Community rating means average claim costs for over 65s exceed premiums. Incentives for older people can provide good value to government, as they mean treatment is more likely to be provided in the public rather than private health sector. However, high participation by people with low average claim costs (typically younger people) is necessary to ensure premiums remain affordable. • The PHI Rebate for over 65s provides good value for government. This group receives $1.7bn in PHI Rebate. If this was removed, we estimate a $1.7bn-$2.3bn reduction in claims funded by PHI. • Removing the PHI Rebate for younger people may have a positive short-term impact on government finances, because the estimated change in claim costs is less than the PHI Rebate. However, the longer-term impact could be more material, due to a spiral of increasing premiums and lapse.
Restore	Increase PHI Rebate to 30%, and 35% or 40% for older people.	• These options would make PHI more affordable for existing policyholders. For example, for individuals under 65 in base tier, premium would reduce by 7%. • However. our testing indicated only a small (1%) increase in the number of people with PHI could be expected. Restoring the PHI Rebate for everyone would increase PHI Rebate by $2.2bn, and increase claims funded by PHI by $0.4bn-$0.5bn. • Even if the increase in participation is small, restoring the PHI Rebate for seniors may still provide value for government due to the high expected claim costs of this group. We estimate restoring the PHI Rebate for over 65s would cost government $0.5bn, and increase claims funded through PHI by $0.3bn.
Reduce for high earners	Remove PHI Rebate for tier 1 and/or 2	• Assuming MLS continues to strongly incentivise participation for this group, removing the PHI Rebate has minimal impact on PHI revenue and claims. • Redistributing this PHI Rebate funding to base earners would result in some additional participation and claims funded by PHI, especially if the PHI Rebate is directed to over 65s.

Option	Description	Key findings
Reduce for older people	Older people receive the same PHI rebate as younger people with the same income level.	• Economic testing suggests PHI is price inelastic, so a lower PHI Rebate has only a small impact on participation. However, the impact on claims is material, because older people have high average claim costs. • As well as reducing PHI affordability, we expect this would have a short-term negative impact on government finances, as the PHI Rebate savings ($0.4bn) are less than the claims funded ($0.4bn-$0.5bn).
Reduce for wealthy people	PHI Rebate considers wealth as well as income	• For over 65s this can be based on existing wealth tests (eg. for age pension or concession cards). Not practical at present for under 65s as wealth information not collected by government. • Economic experiment indicates high and low wealth seniors have similar price elasticity, so impact is similar to the above option. Combining with an MLS-type incentive for high wealth people would reduce the participation impact.
Vary by product tier	Higher PHI Rebate for comprehensive products, offset by lower PHI Rebate for basic products	• Changes in PHI Rebate by tier could mean that the same PHI Rebate funding results in higher participation on comprehensive product, and more claims funded through PHI. • However, the economic experiment indicates there is not a strong consumer response to these price changes, so the overall impacts are not expected to be material.
Set in dollar rather than percentage terms		Assuming the PHI Rebate continues to vary by state, age, income and product tier, this introduces significant complexity.

11.2 Approach

Our approach to modelling the impacts of the options is as follows:

1 Estimate the number of insureds by age, PHI Rebate tier and product mix. We have considered insureds aged 25 and over based on APRA data and used ATO data to estimate the distribution by tier and age. We have used insurer data to estimate product tier mix by age and PHI Rebate tier.

2 Determine the change in PHI Rebate levels for each reform option by age, tier, and product tier.

3 Use results from the economic experiment, and our analysis of insurer data, to model the impact of changes to PHI Rebate levels on participation by product tier. This model allows for differences in elasticity by income and age.

4 Estimate total PHI industry premiums, assuming the following product pricing per single insured person based on our review of current pricing: Basic: $1,400, Bronze: $1,700, Silver: $2,600, Gold: $3,100.

5 Estimate total PHI industry claims using drawing rate relativities from insurer data. We have scaled drawing rates to calibrate to an industry hospital gross margin of 11.2% under the status quo scenario, consistent with industry FY21 results.

6 Calculate PHI Rebate spend as premiums multiplied by PHI Rebate level.

These assumptions result in total PHI Rebate for hospital products of $4,681m, which we note is close to the total estimated FY23 PHI Rebate for hospital products as shown in Section 7.2.2. The estimates do not reconcile exactly because we have made assumptions regarding average revenue. Further details on the assumptions are set out in Attachment A.

11.3 Option descriptions

The table below provides more information on the modelled options. Generally, the options are aimed at simplifying the PHI Rebate or optimising the PHI Rebate according to previously presented assessment criteria.

Table 11.2 – Option descriptions – PHI Rebate

Option	Description	Motivation	Notes
Remove	Removal of the PHI Rebate.	Test the overall impact of the PHI Rebate.	Examined separately for under and over 65s.
Restore	Restore the PHI Rebate	Test the impact of mean testing and indexation over time	PHI Rebate levels for all tiers set to 30% for under 65s, 35% for 65-70 and 40% for over 70s. Examined separately for under and over 65s.
1	Combine tier 1 and tier 2	Simplify. Given the relative inelasticity at incomes above the first threshold, and the strong MLS participation incentive, impacts are expected to be minimal.	PHI Rebate levels for tiers 1 and 2 set equal to the mid-point of current levels. E.g. for ages below 65, apply a PHI Rebate of 12% for both tiers versus 16% and 8% in the status quo.
2	Remove differential by age	Simplify.	PHI Rebate levels for over 65s brought in line with that for under 65s so that PHI Rebate by tier is the same for all ages.
3	Remove differential by age and redistribute PHI Rebate	Simplify with some optimisation. Given a higher proportion of people aged 65 and above receive the base tier PHI Rebate, there may not be a need to have different PHI Rebate levels by age.	PHI Rebate levels by tier is the same for all ages. PHI Rebate levels selected such that the overall PHI Rebate spend is unchanged from the status quo.
4	Remove the PHI Rebate for tier 2	Optimise and simplify. Given relative inelasticity at higher incomes there may be an opportunity to improve Government finances without significantly affecting participation.	PHI Rebate level at base tier and tier 1 in line with the status quo.
5	Remove the PHI Rebate for tier 1 and 2	Optimise and simplify. This is an extension of option 3 above.	PHI Rebate level at base tier in line with the status quo.

Option	Description	Motivation	Notes
6	Option 5 plus increase the PHI Rebate at the base tier	Optimise and simplify. There is an opportunity to target those most responsive to the PHI Rebate.	PHI Rebate level at base tier increased by 1.9% (under 65s) to 2.5% (over 70s) such that PHI Rebate spend unchanged from status quo.
7	Remove the PHI Rebate for tier 1 and 2 and remove the differential by age. Redistribute to base tier PHI Rebate.	Optimise and simplify.	PHI Rebate set at 29.3% at all ages for base tier. Nil PHI Rebate for tiers 1 and 2.
8	Option 7 plus vary the PHI Rebate by product tier	Optimise. There is an opportunity to target participation on products which present a greater benefit to Government finances.	Assume change in PHI Rebate of -25% for Basic, -14% for Bronze, -4% for Silver and +6% for Gold. Overall PHI Rebate spend unchanged from status quo.

For wealthy people, our modelling involved testing the elasticity of seniors, and asking whether or not they received the age pension (full or part) or held a concession card (such as the Commonwealth Seniors Health Card). This did not identify significant differences in price elasticity was similar for high and low wealth seniors, so we did not split the modelling by wealth. Modelling for wealthy people has focussed on seniors due to the availability of data, however if the option is progressed government should consider wealthy people of all ages.

For fixing PHI Rebate in dollar terms, further comments are in Attachment A.2.

11.4 Results

The results are shown in the table below, with the second half of the table showing the difference to the base scenario.

Table 11.3 – Summary of modelling – PHI Rebate

Option	Insureds	Insureds - Basic	Insureds - Gold	Premiums	Claims - base	Claims - range	Gross margin	Rebate spend
	000s	000s	000s	$m	$m	$m	%	$m
Status quo	8,083	898	3,410	21,210	18,835		11.2%	4,681
Remove	7,274	959	2,790	18,739	15,755	16,502	15.9%	0
Remove (<65 only)	7,671	957	3,121	19,965	18,033	18,220	9.7%	1,862
Remove (>65 only)	7,686	899	3,079	19,985	16,557	17,116	17.2%	2,819
Restore	8,219	876	3,531	21,646	19,307	19,308	10.8%	6,856
Restore (only base tier, only <65)	8,127	893	3,441	21,340	18,920	18,920	11.3%	5,260
Restore (only base tier, only >65)	8,129	898	3,449	21,351	19,097	19,097	10.6%	5,134
Restore (only base tier, all ages)	8,172	892	3,480	21,481	19,182	19,182	10.7%	5,713
S1: Merge tiers 1 and 2	8,084	898	3,410	21,212	18,835	18,835	11.2%	4,682
S2: Remove additional rebates for over 65s	7,993	898	3,332	20,929	18,288	18,417	12.6%	4,199
S3: Additional >65 rebate redistributed	8,066	892	3,390	21,155	18,553	18,636	12.3%	4,681
S4: No rebate for tier 2	8,074	903	3,399	21,176	18,811	18,811	11.2%	4,537
S5: No rebate for tiers and 1 and 2	8,060	913	3,383	21,123	18,775	18,775	11.1%	4,297
S6: S5 and redistribute to base tier	8,122	910	3,431	21,311	19,016	19,016	10.8%	4,681
S6 (redistribute to under 65s only)	8,114	907	3,422	21,286	18,881	18,882	11.3%	4,681
S6 (redistribute to over 65s only)	8,098	913	3,416	21,242	18,997	18,997	10.6%	4,681
S7: No rebate for tiers 1 and 2, remove higher rebates for over 65s, redistribute to base tier	8,107	904	3,412	21,260	18,727	18,769	11.9%	4,681
S8: S7 and vary rebate by product tier	8,016	839	3,439	21,184	18,977	18,992	10.4%	4,681
Change from status quo								
Remove	(810)	61	(620)	(2,471)	(3,080)	(2,333)	4.7%	(4,681)
Remove (<65 only)	(412)	59	(289)	(1,246)	(802)	(614)	(1.5%)	(2,819)
Remove (>65 only)	(397)	1	(331)	(1,226)	(2,278)	(1,718)	6.0%	(1,862)
Restore	136	(21)	122	435	473	473	(0.4%)	2,175
Restore (only base tier, only <65)	43	(5)	31	130	85	86	0.1%	579
Restore (only base tier, only >65)	45	(0)	39	141	262	262	(0.6%)	453
Restore (only base tier, all ages)	88	(5)	70	271	347	348	(0.5%)	1,032
S1: Merge tiers 1 and 2	1	0	0	1	1	1	0.0%	1
S2: Remove additional rebates for over 65s	(91)	0	(78)	(281)	(547)	(418)	1.4%	(482)
S3: Additional >65 rebate redistributed	(17)	(6)	(20)	(55)	(282)	(198)	1.1%	0
S4: No rebate for tier 2	(10)	5	(10)	(35)	(24)	(24)	(0.0%)	(144)
S5: No rebate for tiers and 1 and 2	(23)	16	(27)	(87)	(60)	(60)	(0.1%)	(384)
S6: S5 and redistribute to base tier	38	12	22	100	181	181	(0.4%)	0
S6 (redistribute to under 65s only)	31	9	12	76	47	47	0.1%	0
S6 (redistribute to over 65s only)	15	15	7	32	162	162	(0.6%)	(0)
S7: No rebate for tiers 1 and 2, remove higher rebates for over 65s, redistribute to base tier	23	7	2	50	(108)	(65)	0.7%	0
S8: S7 and vary rebate by product tier	(67)	(59)	30	(26)	142	157	(0.8%)	(0)

We show the following measures for each option:

- Participation:
  - > Total number insured
  - > Level of cover: Indicated here by the number buying Gold and Basic
  - > Some scenarios target certain age and wealth segments
- Premium revenue
- Claims
  - > Assuming treatment is clinically necessary, people would seek to access these procedures in the public sector if they did not have PHI. This is therefore a proxy for the extent to which PHI is taking pressure of the public health system.

- It is suggested that people in good health are more likely to drop PHI following a price increase, or take out PHI following a price decrease. Equivalently, people who expect to claim may be more likely to maintain PHI, even if prices rise.
- Economic testing did not identify a significant difference in price elasticity and an individual's view on their health status. This may be because other factors are important to PHI purchasing decisions (such as income), and everyone has the option to use the public health system.
- Assumed claim costs vary by product tier, age and income, and we therefore show two claim cost scenarios. The base scenario assumes people joining or leaving PHI have average claim costs. The alternative scenario assumes people joining or lapsing have claim costs which are 25% lower than average.

- Gross margin is (premiums less claims) as a proportion of premiums
  - It is assumed that changes in gross margin would result in an equivalent pricing response by insurers. For example, removing PHI Rebate for over 65s is expected to increase gross margins by 6%, because the claims of people leaving exceed the premium paid. This would allow lower premium rates for those remaining insured.
- PHI Rebate: Total cost of PHI Rebate for hospital policies. This can be compared to the claim cost funded through PHI.

Our comments on the modelling were set out in section 11.1 above, and lead to the following conclusion in Section 11.6.

11.5 Extras

Our examination has focused on the PHI Rebate for hospital policies, as these are more financially material than extras, and there are interactions with MLS and LHC. This section provides comments on the PHI Rebate for extras.

11.5.1 Benefits

Extras policies funded $5.4bn of claims in the year ending 31 March 2022, despite access to services being interrupted by the pandemic in some periods. The table below shows the types of claims funded.

Table 11.4 – Extras claims by type – year ending 31 March 2022

Service type	Claims ($m)	% of total
Dental	2,903	54%
Optical	913	17%
Physiotherapy	438	8%
Chiropractic	298	6%
Natural therapies	198	4%
Ambulance	172	3%
Podiatry	118	2%
All other services	366	7%
Total	5,405	100%

Source: APRA statistics.

Over half of claims paid are in respect of dental, and over $900m of optical is funded. In total APRA identifies a further 28 types of treatment funded, however only physiotherapy and chiropractic represent more than 5% of total ancillary costs.

11.5.2 PHI Rebate

Of the $6,888m for 2022-23, we estimate that $4,760m (69%) is in respect of hospital claims, with the remainder of $2,128m payable on extras policies.

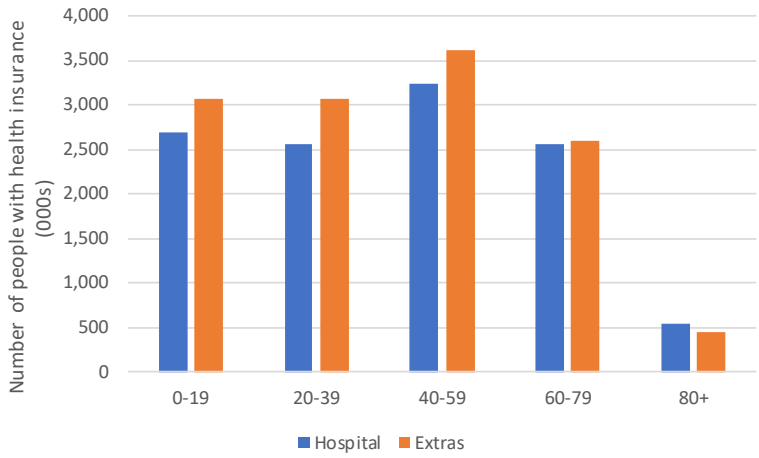
There are no other incentive policies to encourage participation in extras.

The PHI Rebate is a percentage of premium, which depends on householder income and policyholder ages. Individuals receive the same percentage PHI Rebate on any hospital or extras policy.

11.5.3 People covered

The figure below compares the number of people with hospital and extras cover at 31 March 2022, based on APRA statistics.

Figure 11.1 – Number of People with Hospital and Extras cover, by age



APRA reports that 45.1% of the population have hospital cover at 31 March 2022, compared to 55.0% with extras cover. The figure above shows extras is particularly popular with young people, with 20% more 20-39 year olds having extras compared to hospital. For 60-79 year olds, the popularity of hospital and extras are similar, and more people over 80 have hospital than extras.

11.5.4 Products

While the cheapest hospital products cost around $100 per month in some states (single, before PHI Rebate), extras products are generally much cheaper than hospital.

A wide range of products are offered by insurers (prices single before PHI Rebate):

- Basic extras policies can cost less than $25 per month, cover a limited range of services such as dental and physiotherapy, and have low annual limits and reimbursement rates.
- The most expensive extras policies can cost over $100 per month, cover a wide range of services, have high annual limits and reimbursement rates.

11.5.5 Reasons for paying the PHI Rebate on extras premiums

- Funds services which are important to health
  - > Extras funds services which are recommended by health professionals, for which no Medicare rebate is available.

- In particular PHI funds oral health, which is sometimes described as fundamental to overall health and wellbeing, and associated with chronic diseases include stroke and cardiovascular disease[6].

- Monthly premiums support access to treatment
  - The average claim size for extras claims is lower than for hospital claims, meaning some people on higher incomes can comfortably afford to pay for extras treatment whenever it is needed. Others may find it necessary or convenient to fund extras treatment through regular monthly premiums.
- Insurance model
  - There are other options to fund some extras services, for example, through dental payment plans. An advantage of the insurance model is that it facilitates access to services through pooling risk. For example, following an accident an individual may require significant dental treatment, physiotherapy, and psychology services over an extended period. Extras insurance would make a significant contribute to the treatment costs, and the premium charged does not reflect individual expected claim costs.
- Core part of insurance offering
  - Most people with health insurance buy both hospital and extras. Under the community rated model, young people pay hospital premiums which far exceed expected claim costs, in order to support affordability for older people. People of all ages regularly use extras policies, claiming almost four services per person per year according to APRA statistics. Extras provides people who do not expect to require hospital treatment a reason to obtain and maintain PHI.
- Simplicity
  - Providing the same percentage PHI Rebate for hospital and extras is simpler than having different arrangements, especially where a single combined insurance product covers both services.

11.5.6 Reasons against paying the PHI Rebate on extras premiums

- No explicit government savings
  - The hospital analysis above showed that reducing hospital PHI Rebate reduces hospital claims funded by PHI. The hospital PHI Rebate provides value to government as individuals who are not insured can seek treatment in a government-funded hospital. Because no Medicare funding is available for most Extras services, it is not possible to demonstrate the Extras PHI Rebate provides value for money in the same way.
- Alternatives to PHI
  - Subsiding Extras treatment through the PHI Rebate may be regarded as unfair by people who prefer other funding options.
- Niche services
  - Some Extras policies cover services such as acupuncture, hypnotherapy, and natural therapies, which represent a small proportion of claims. Services which the government identifies as inappropriate do not receive PHI Rebate funding.
  - The PHI Rebate on extras is sometimes criticised as subsiding services which are less important than those covered by hospital policies.

[6] https://www.aihw.gov.au/reports/dental-oral-health/oral-health-and-dental-care-in-australia/contents/introduction

11.5.7 Economic experiment

People participating in the experiment were asked what products they currently purchase, which allows us to identify people with extras only cover, hospital only, both hospital and extras, and no cover. We examined differences in price elasticity between groups.

In each case, there was only a small impact in demand arising from a small change in price or PHI Rebate. However, there was a much larger response to removal of the PHI Rebate. People who purchased only hospital cover, or only extras cover, were much more sensitive to removal of the PHI Rebate than those purchasing both hospital and extras.

While the focus of the survey was hospital covers, around 1% of the free text responses concerned extras. The themes of the responses were that extras cover is valued, and compared to hospital provides better value for money and is more affordable.

Some respondents noted that they purchase extras, but hospital cover is well beyond their means. A purpose of PHI is to assist people who can fund part of their healthcare costs to do so. The economic experiment identified people who could not afford to buy hospital, but make a small contribution to their healthcare through subsided extras.

11.6 Conclusion

The PHI Rebate makes PHI more affordable, so a lower PHI Rebate results in lower participation, and a higher PHI Rebate results in higher participation. However, the impact of changes in PHI Rebate varies depending on the size of the change, and the groups or products targeted.

As set out in the table above, our findings are:

- Removing the PHI Rebate entirely would result in a worse overall outcome, due to the material participation decline. Both hospital and extras participation would decline.
- Restoring the PHI Rebate appears to provide poor value for money for government.

There are opportunities to optimise and simplify the PHI Rebate. In particular:

- The PHI Rebate for tier 1 and tier 2 earners has limited impact on participation, because MLS creates a strong participation incentive.
- The PHI Rebate for older people provides value for government, given the high average claim costs of this group.

12 MLS options

12.1 Summary

The table below summarises the options considered.

Table 12.1 – Summary of PHI Rebate options considered

Option	Description	Key findings
Link product tier to income	Require people to hold greater than basic cover to avoid MLS	• Encouraging people in good health to buy comprehensive cover puts downward pressure on premiums, and facilitates access to private healthcare should treatment be required. • Testing indicates that people would respond to this incentive, providing the PHI premium was less than the surcharge amount. • There is some increase in complexity and, as with other MLS options, materiality is limited because MLS only targets high earners.
Target more people	For example, reduce single income threshold from $90k to $80k	• Based on both analysis of participation rates by income level, and the economic experiment, the expected participation impact is minimal (less than 0.1% increase in participation rate). • Assuming MLS remains at 1% of income for this group, most who do not currently have PHI would choose to pay the levy, which is a cheaper option than insuring. • Imposing a higher levy would result in higher participation, but does not meet equity criteria for this age group.
Target fewer people	For example, remove tier 1 from MLS	• Making people in good health (such as tier 1 earners) subject to MLS provides limited benefit to the individual, but does benefit government finances, and everyone who wishes to insure. • Ultimately it is for government to decide when it is equitable to ask individuals to contribute more to their health costs, either through buying PHI or paying MLS.
Strengthen MLS	For example, align settings for tiers 1 and 2 with tier 3	• As above, this lifts PHI participation and helps moderate premium rates. • The overall financial impacts are modest, as participation rates are already high for people subject to MLS. • This also represents a simplification of PHI policy settings.

12.2 Link product tier to income

12.2.1 Background

Participation in PHI by high income earners is well above average, however product tier choice is largely driven by age. For example, 30% of 30-34 year olds in income tier three (highest income tier) choose Basic products.

In order to avoid paying the MLS, high earners must hold at least Basic hospital cover. Imposing additional minimum hospital cover requirements on individuals with a high taxable income could shift people with lower than average claim costs to more comprehensive products would:

- Improve risk pools and overall affordability of higher coverage products.

- Transfer additional costs out of the public health system (where there was previously a gap in coverage). If people require hospital treatment, private hospital care is more likely to be an affordable option if they hold Silver/Gold, rather than Basic/Bronze.
- Make individuals pay a premium which is more in line with the MLS penalty that would be paid otherwise.

For example, if income tier three individuals (income >$140k per annum) were required to hold Gold tier, this could generate an additional ~$1,400 in premium for each individual currently holding a Basic product. The additional claims cost is likely to be small, based on their ages and product choice.

12.2.2 Results

The table below indicates the additional annual premium that could be generated, if these minimum cover levels were put in place today.

The scenarios only consider hospital products and assume that the changes will not impact participation rates. This is a reasonable assumption if cost of the required PHI product is less than the surcharge, and we also confirmed this result in the economic experiment.

Table 12.2 – Additional premium under minimum cover scenarios

Minimum product tier	Premium		Rebate
	$m	% increase	$m
Bronze			
All tiers	79	0.4%	7
Tier 2 and 3 only	50	0.3%	2
Tier 3 only	20	0.1%	0
Silver			
Tier 2 and 3 only	200	1.1%	10
Tier 3 only	82	0.4%	0
Gold			
Tier 3 only	494	2.6%	0
Increase by tier			
1- Bronze, 2- Silver, 3- Gold	641	3.4%	14

The additional premium raised is the estimated number of individuals impacted multiplied by difference in premium (before PHI Rebate) per SEU by tier, with the additional PHI Rebate cost being the premium multiplied by the base PHI Rebate percentage for that income tier[7].

For example, requiring all individuals with a taxable income above $90k (e.g. all tiers) to hold at least a Bronze level of cover, the additional hospital premium collected from those individuals moving from Basic to Bronze is estimated to be $79m or a 0.4% increase in the total hospital premium pool. Of the $79m collected, an estimated $7m would be from increased PHI Rebates (e.g. $72m paid by individuals).

Depending on the scenario applied, there could be up to a 3% increase in total hospital premiums paid, most of which will likely not be offset by higher claims[8]. This would be expected to be returned to low- and high-income policyholders through a lower premium increase (e.g. similar to historical prostheses changes). The majority of this premium income will come from high earners in younger age groups who may not consider that they require the higher level of cover.

Additional information is provided in Attachment B.1.

[7] As older age groups are predominately on Silver or Gold, we have ignored their additional rebate loading.

[8] Increase will largely be an once-off, but there could be a small level of ongoing benefits, depending on income growth and how income thresholds are revised.

12.2.3 Conclusion

This option tests well against the criteria we have identified. It has a downward impact on average premiums, an upward impact on treatment undertaken in the private rather than public sector, and no additional PHI Rebate is required. The benefits arise from additional premiums paid by higher earners, which meet equity criteria. However, the impact is not expected to be material because only a small number of people are impacted, and many already buy comprehensive cover.

12.3 Other MLS options

The table below lists other options considered. It is important that MLS and PHI Rebate be integrated, so we considered MLS changes with and without associated PHI Rebate changes.

Table 12.3 – Other MLS options considered

Scenario	Change to MLS	Change to PHI Rebate	Discussion
Removal of tier 1	Individuals in the $90k - $105k income bracket ($180k-$210k for families) are no longer subject to an MLS of 1% if they do not hold complying hospital cover No changes are made to Tier 2 or Tier 3.	Two scenarios: ◦ No change to PHI Rebate settings ◦ Restore PHI Rebate for Tier 1 to base tier level of 24.6% (from 16.4%)	In addition to simplifying the MLS structure, it quantifies the impact if individuals in that first tier are no longer considered to be 'high income' earners
Tier 2 equal to Tier 3	Individuals and families in the Tier 2 income bracket have their MLS rate increased to 1.5%. No changes are made to Tier 1 or 3.	Two scenarios: ◦ No change ◦ Tier 2 PHI Rebate of 8.2% is reduced to the Tier 3 level of 0%	Similar to Scenario 1, this simplifies and provides additional incentive for Tier 2 individuals to participate
Only 1 MLS tier	Individuals earning over $90k per annum or $180k for families, an MLS tax penalty of 1.5% (the current Tier 3 rate) applies if they do not hold a complying hospital product.	Two scenarios: ◦ No change ◦ PHI Rebate reduced to 0% (the tier 3 setting) for Tier 1 and 2	Additional simplification of the MLS policy, with increases in the MLS rate reducing incentive for lower earning individuals to not participate as relative cost of cover reduces.

These options were chosen as they simplify the MLS structure reducing complexity. Where the PHI Rebate is changed to re-align with changes in MLS, this further reduces complexity.

Where we have included a change in PHI Rebate impact these have been modelled consistently with PHI Rebate options modelled.

12.4 Approach

We adopted the following approach to determine the status quo position:

- Use ATO 2018-19 data to identify individual and family household by income tier and age group, as well as participation in PHI. This was then joined with insurer data to estimate hospital product holding by tier
- Apply premium, LHC and claims cost assumptions by age, product and income tier to estimate size of industry pool for each segment

- Multiple PHI Rebate percentages by premium to estimate cost to Government of funding the PHI Rebate. The offsetting MLS tax collected was calculated by assuming an average income by income tier and multiplying the population assumed to be uninsured.

We only considered the impact on hospital product participation, as MLS does not seek to incentivise extras participation. As such the premium and PHI Rebate expenditure do not include the contribution of general treatment products on those items.

When estimating the impact of the changes in setting, we considered:

- Current differences in participation rate by income band and MLS income tier
- Insights from the insurer data
- Findings from the economic experiment, which tested how consumers would respond to these options.

12.5 Results

The table below shows the relative impact on total insured non-dependents (those aged over 25, as individuals under aged 25 were assumed to be dependents on a family policy) by income tier.

Table 12.4 – Assumed participation changes – MLS options

MLS	Insureds	Participation rate by current MLS tier				
Scenario	000s	Below	1	2	3	Overall
Base	8,083	*42.1%*	*76.0%*	*84.2%*	*92.1%*	48.0%
Change to base						
Remove Tier 1	-107	*0.0%*	*-13.2%*	*0.0%*	*0.0%*	-0.6%
& restore rebate	-102	*0.0%*	*-12.6%*	*0.0%*	*0.0%*	-0.6%
Make Tier 2 = Tier 3	53	*0.0%*	*1.0%*	*5.2%*	*0.0%*	0.3%
& remove rebate	43	*0.0%*	*1.0%*	*4.1%*	*0.0%*	0.3%
Only have 1 MLS tier	91	*0.0%*	*5.8%*	*5.2%*	*0.0%*	0.5%
& remove rebate	68	*0.0%*	*4.1%*	*4.1%*	*0.0%*	0.4%

In the status quo (or base) position there are significant differences in PHI participation by income tier.

Removing tier 1 from MLS is expected to reduce participation, however the income level means participation is expected to remain above the current base tier levels, as even within the base tier participation was seen to increase as income did.

Applying a stronger MLS incentive to tiers 2 and 3 is expected to increase participation, however tier 3 continues to have the highest participation as this group has the highest income.

The table below summarises the results of the testing. We show the following measures:

- Participation, based on the income level assumptions shown in the previous table.
- Industry premiums and gross margins, based on the characteristics of the people assumed to be covered
  - > People subject to MLS are mostly under age 65, and therefore average claim costs are less than premiums.
  - > Because PHI premiums reflect average claim costs, increasing PHI participation due to MLS results in lower PHI premium, and vice versa.
- Government financial impacts, including:

> PHI Rebate, with only the hospital component shown.

> MLS revenue, from people who are subject to MLS and do not hold PHI for the full year.

> Change in PHI claim costs compared to the base scenario, assuming this treatment is necessary and will either be performed in the private sector or sought from the public sector.

The first part of the table shows the absolute impacts, followed by the differences to the base (status quo) scenario.

Table 12.5 – Summary of results – MLS options

MLS	Insureds		Industry $m		Government - cost $m			
Scenario	000s	Participation	Premium	Margin	Rebate	MLS	Add. Claims	Total
Base	8,083	48.0%	21,210	2,376	4,681	-585	0	4,096
Remove Tier 1	7,976	47.3%	20,952	2,227	4,640	-394	110	4,356
& restore rebate	7,981	47.3%	20,966	2,234	4,740	-394	103	4,449
Make Tier 2 = Tier 3	8,136	48.3%	21,335	2,449	4,693	-538	-52	4,103
& remove rebate	8,126	48.2%	21,310	2,439	4,541	-555	-37	3,948
Only have 1 MLS tier	8,175	48.5%	21,426	2,504	4,707	-572	-87	4,048
& remove rebate	8,151	48.4%	21,365	2,479	4,297	-610	-52	3,636

Impact	Insureds		Industry $m		Government - cost $m			
	000s	Overall	Premium	Margin	Rebate	MLS	Add. Claims	Total
Remove Tier 1	-107	-0.6%	-258	-148	-41	192	110	260
& restore rebate	-102	-0.6%	-245	-142	59	192	103	353
Make Tier 2 = Tier 3	53	0.3%	125	73	12	48	-52	8
& remove rebate	43	0.3%	100	63	-141	30	-37	-147
Only have 1 MLS tier	91	0.5%	215	129	26	13	-87	-47
& remove rebate	68	0.4%	155	103	-384	-24	-52	-460

Removing tier 1 earners from MLS is expected to result in:

- Lower PHI participation
  > Increasing the PHI Rebate for this group to base tier levels is not expected to significantly change this, as MLS has a stronger impact than the PHI Rebate for this group.
- Higher premiums for people remaining insured
  > Individuals lapsing are assumed to pay premiums which exceed their claims by $148m, so losing these members will require others insured to pay higher premiums.
- Poorer value for government, based on:
  > Lower MLS collected from people in the tier who do not insure.

  > Less claims funded through private healthcare, only partially offset by a lower PHI Rebate for this group.

These estimates demonstrate that having tier 1 earners subject to MLS contributes to both PHI and government finances. However, PHI represents poor value for some in this cohort (comparing premiums and claims), so many will not insure if MLS is removed. Ultimately it is an equity question whether MLS should apply to this group.

The other scenarios apply stronger incentives to tiers 1 and 2, resulting in higher participation, lower average premiums, and more claims funded by PHI. Removing the PHI Rebate from these tiers has minimal participation impact, if MLS creates a strong incentive to participate.

12.6 Conclusion

Based on this analysis, our suggested approach to MLS settings is:

- Who: Decide who it is reasonable to require to contribute more to their healthcare costs, by either buying PHI or paying a surcharge.
  - > MLS should be retained for the highest earners (tiers 2 and 3)
  - > Removing middle income earners (tier 1) is an equity decision. This would improve choice for this group, but it would remove healthy people from the PHI pool (higher average premiums) and reduce government MLS revenue.
  - > A form of MLS could apply to wealthy people, if the PHI Rebate were to reduce for this group.
- How: Determine the policy settings for that group
  - > The current settings for the highest earners (tier 3) are no PHI Rebate, and a high surcharge payable if people do not insure.
  - > Assuming MLS is targeted at the right people, applying these settings to everyone would simplify MLS.
- What: Decide what behaviour to incentivise
  - > If people are required to purchase higher than Basic cover, they would do so providing the cost of PHI is less than surcharge amount.

13 LHC options

We have focussed on options to increase the starting age to 40. Other options are considered in our separate LHC study.

13.1 Hypothesis

Stakeholders have suggested that as demographics have changed over time, while age 30 may have been appropriate as a starting age for Lifetime Health Cover (LHC) loadings historically, a starting age of 35 or 40 may be more appropriate now. Specifically, it has been suggested that many 30 year olds are no longer ready or able to buy PHI. For example, AMA has suggested LHC does not act as an incentive to join at age 30, but rather a barrier to people taking out PHI in their 30s, and so the start age should be raised to 40.

Delaying the start age is likely to be a better outcome if it:

- Increases participation after age 40, and overall
- The increase in participation is sufficient to offset the impact of lower participation at younger ages, and other impacts such as changes to LHC revenue.

13.2 Demographic drivers

Our experience is that, other than age, the key demographic drivers of PHI participation are income, home ownership, educational attainment and remoteness. Analysis of demographic data (refer Attachment C) does not suggest a compelling case for delaying the starting age. Home ownership is higher for 40-year-olds than 30-year-olds and housing affordability pressures may mean this is an increasingly important driver of PHI participation in future. Additionally, there is a higher proportion of the population in family households at ages 35 and 40 than at age 30. However, other important predictors of PHI take up such as household income and educational background do not change significantly between age 30 and age 40.

13.3 Methodology

As well as investigating the impact of changing the starting age to 40, we considered age 35 and changes in loadings. The methodology is summarised as follows:

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. Estimate the impact of changing the starting age of LHC:
    a. Calculate the new LHC loadings after changing the starting age and compare with the loadings under the current state
    b. Estimate impact of changes to the sales and lapses based on the change in loadings by age and LHC status, considering:
        i. Results of the economic experiment, which put these scenarios to consumers.
        ii. Price elasticity curves derived from insurer dataset.
    c. Apply estimated impacts on sales and lapse rates to determine the impact of the change in policy.
3. Test impacts assuming the change was implemented in 2015, allowing for a review of effectiveness after five years.

We assume other policy settings such as MLS remain unchanged, so young high earners are likely to insure regardless of the LHC start age.

13.4 Results

The table below summarises the impact on the number insured, claims, premiums, insurer margins and the PHI Rebate. We tested:

- Increase starting age to 40, and maintain the surcharge at 2% per year.
- Increase starting age to 40, and increase surcharge from 2% to 3% per year.
- Increase starting age to 35. While this is not shown below, it has a similar impact as increasing to age 40 except the changes in participation and financials are lower than for age 40.

Table 13.1 – LHC to age 40 – results summary

	Base	40	Diff to base	40 and 3%	Diff to base
Insureds (000s)	7,946	7,978	32	8,004	58
Claims($m)	18,436	18,723	287	18,952	516
Drawing rate ($ per person)	*2,320*	*2,347*	*27*	*2,368*	*47*
Premiums ($m)	20,761	20,718	-43	20,931	169
Average premium ($ per person)	*2,613*	*2,597*	*- 16*	*2,615*	*2*
Gross margin ($m)	2,325	1,995	-331	1,979	-346
Gross margin %	*11.2%*	*9.6%*	*-1.6%*	*9.5%*	*-1.7%*
PHI Rebate ($m)			10		35

Increasing the LHC starting age to 40 is expected to:

- Increase participation by 32k, or less than 0.5%.
  - > More over 40s have PHI, as people can join at age 40 without paying an LHC penalty. People over age 40 can join with a lower cost than is currently the case.
  - > Reduce the percentage of 30-39 year olds with PHI, as LHC no longer incentivises participation in this age group.
  - > Neither of the participation changes (fewer 30-39 year olds, more over 40s) were material. This is because LHC is only one of several considerations when people decide whether to buy PHI.
- Increase claims by $287m, or 1.6%. The increase in claims is greater than the change in membership, as there is a shift towards older members.
- Require approximately a 1.6% increase in average premiums, assuming industry gross margins are maintained. This is to offer the impact of lower LHC revenue, as well as the increase in average policyholder age.

If the loading is additionally raised to 3% per year, based on the economic experiment we expect:

- A larger increase in participation of 58k, because the incentive to join at age 40 is stronger.
- A similar 1.7% required increase in premiums, assuming industry gross margins are maintained.

    - LHC revenue is expected to be lower than under the current model (start at 30/2% loading), because the size of the loadings means fewer people will choose to join later in life and pay the loadings.
- The increase in claims reflects the higher average age of people insured than under the current model.

13.5 Conclusion

There should be a policy similar to the current LHC policy to incentivise people to obtain hospital cover earlier in life, and encourage them to maintain it. We have not identified options to change LHC which result in significantly better outcomes than the current policy settings. In particular, the option to increase the starting age would benefit people who take out PHI later in life, but does not result in a materially better overall outcome.

Refer to Attachment C for further details.

14 Other options

The table below summarises the other options considered, and notes where further information can be found in the attachments.

Table 14.1 – Other options

Option	Description	Key findings	Refer section
Out of pocket (OOP) costs	Examine the impacts of reducing or limiting OOPs	• OOPs are a significant issue for consumers, causing some people not to buy PHI. • Options explored fall into two broad categories: > Mandate what insurers must pay, and/or what doctors can charge. A challenge would be to determine a mandate which is fair to doctors and all policyholders, including those with low expected claim costs for whom premium affordability may be the major concern. > Encourage insurers and doctors to reach agreements which reduce or eliminate gaps, noting such arrangements are the norm between insurers and hospitals. Low transparency around medical charges and insurer reimbursements may be limiting progress in this area. • It is not possible to address this problem only by changing the PHI Rebate, MLS or LHC. • If product options are developed which reduce OOPs, then PHI Rebate, MLS or LHC could be used to encourage participation in these products, for example, by encouraging people with low average costs to insure (via MLS).	E.1

Option	Description	Key findings	Refer section
Youth product	PHI offers Gold-only type cover for a lower price than is currently available.	• PHI for younger adults matters because people of all ages can require hospital treatment. Young people also ensure community rated PHI remains financially sustainable due to the significant subsidies between age groups. • Current policy settings are not optimised for young adults, and this segment is frequently highlighted as one where significant change may be required. Participation rates for young adults were declining prior to the pandemic, which impacts affordability for older policyholders. Many young people who do insure buy products which are unlikely to provide them with access to comprehensive private treatment, should this be required. • If a single, standard hospital product design is available to young adults taking out PHI, low average expected treatment needs mean it is possible to provide comprehensive cover and maintain significant subsidies to older members for an affordable premium. • This foundational product would improve PHI by significantly improving value and reducing complexity of PHI for young people. The cross subsidy to older policyholders would become an explicit regulatory decision. • This tests well against criteria, and has the potential to make a material change to participation by young people. We note industry stakeholders are cautious regarding this idea, and suggest further consultation before deciding to pursue this.	E.2
Data sharing	Facilitate data sharing to allow insurers to innovate for the benefit of members	PHI funds could innovate for better patient outcomes and better value if they have access to a richer source of data. For example, insight into primary care data could assist an insurer to help a member avoid a preventable hospital admission. Such sharing would not impact clinical autonomy, that is, there should be no restriction on a member accessing services which are clinically required and covered under their policy. While data sharing is unlikely to have a material short term impact on metrics such as participation and claim costs, funds should be allowed to innovate in this area where members consent to sharing data.	E.3
Communication	Improve communication to increase the effectiveness of the policy settings	Whatever the policy settings adopted, their effectiveness will be increased if they are well communicated. Government should be involved in communication, as it benefits from the effectiveness of these policies, and information from government has high reach and credibility. However, insurers can also do more to assist people making choices about PHI	D.4

15 Risks and mitigating factors

The table below identifies a number of risks common to the options considered. We also comment on likelihood of the risk occurring, as well as mitigation options.

Table 15.1 – Risks and mitigating factors

Risk	Example	Likelihood	Mitigation
Consumer response to change in PHI Rebate, MLS or LHC is not as expected	Change in participation is not as expected (either in total, or for individual segments). Resulting change in PHI Rebate, MLS revenue, average PHI premiums, or amount of treatment funded by the private sector, are not as expected.	While the future cannot be predicted with certainty, we have: Higher confidence regarding the MLS scenarios, in particular most people will respond to the incentive, if the cost of taking this action is less than paying the surcharge. Medium confidence regarding scenarios where there are small price changes (less than 10%), which do not appear to result in a significant consumer response. Medium confidence regarding scenarios where LHC age or rate changes, providing the other incentives remain in place. Low confidence regarding scenarios were there are material changes in premium rates. These are likely to prompt people to review their cover, and there are a wide range of possible outcomes.	Further testing of preferred option prior to implementation, to test the reasonableness of our conclusions, and identify any additional risks and issues. Ensure policy settings remain well integrated. Provide sufficient notice of changes to allow all stakeholders to prepare. Effective communication of changes to consumers. Periodically review settings to ensure they remain optimised.
Changes do not significantly address consumer concerns	Examples of other concerns include out of pocket costs.	High. In particular, changes to MLS, PHI Rebate or LHC are unlikely to address issues of concern such as out of pocket costs, or progress feedback regarding the scope of PHI.	Continue to pursue other review and reform work.
Changes have a short-term impact which is not sustained over the longer term		Small changes in price unlikely to have a material long term impact on affordability, given health cost inflation generally exceeds CPI.	Periodically review policies to ensure they remain optimised. Once these settings are optimised and simplified, more scope to pursue other reforms which may increase complexity.

Risk	Example	Likelihood	Mitigation
Changes in the economy impact PHI affordability	Higher unemployment or cost of living pressures forces people to drop PHI	Possible, historical participation statistics (refer Section 1) do not show a strong correlation to the performance of the economy.	Insurers typically offer support packages in respect of localised disruption, for example, premium waiver or policy suspension following natural catastrophe. Incentives should be regularly reviewed, and can be adapted in response to exceptional economic circumstances.
Changes to the public health system impact demand for PHI	Media coverage of waiting lists increases demand for PHI	Possible, however no apparent impacts on participation in recent years.	Market dynamics. There is an expectation that the private healthcare sector innovates to appeal to consumers.
Consumers prefer alternatives to PHI to finance private sector healthcare	Self-pay, savings accounts.	Options are already available.	A unique advantage of the insurance model is that it allows pooling of risk. While people who require significant treatment may exhaust savings accounts, insurance finances access to treatment based on clinical need. Government should encourage innovation, but ensure equitable access to private healthcare is maintained.

16 Reliances and limitations

16.1 Distribution and use

This report is provided for the sole use of Department for the purpose of understanding our investigations on MLS, the PHI Rebate and LHC. 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 the analyses and conclusions of this report.

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.

16.2 Data provided

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

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.

16.3 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.

We cannot guarantee that any changes to the PHI incentive policies will be successful for government or any other stakeholder.

Appendices

A PHI Rebate – additional information

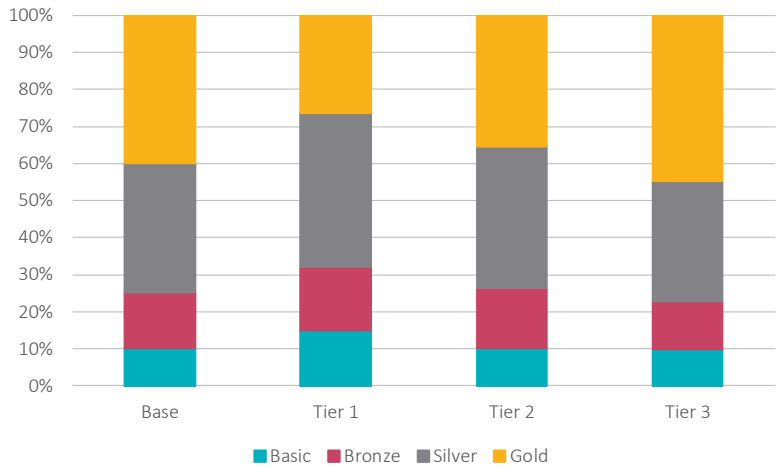
Section A.1 provides further details on the assumption supporting the modelling in Section 11. Section A.2 describes the option to fix the PHI Rebate in dollar terms.

A.1 Modelling detail

A.1.1 Product choice impacts

The figure below shows product mix by estimated PHI Rebate tier, using the insurer dataset for policies in 2019.

Figure A.1 – Product mix by PHI Rebate tier (25 year olds and older)



The proportion of Gold is lower in Tier 1 than in the Base tier, while the proportion on Basic policies is higher. This effect does not occur at higher tier levels, as the higher income people earn appears to more than offset other impacts such as the lower PHI Rebate. We have also examined hospital tier held by income and age, and found that the product held is largely determined by age rather than income.

A.1.2 Claims impacts

The figure below shows drawing rates by age, product tier and PHI Rebate level, based claims and exposure for 2019 from the insurer dataset.

Figure A.2 – Drawing rates by age, product tier and PHI Rebate level

Note: The vertical axis shows the drawing rate, which is the average claim costs per insured person per year.

Claim costs increase with age, regardless of a person's income or the level of cover held. However, we note that:

- Generally, those people receiving a high PHI Rebate have higher claiming experience than those receive low or no PHI Rebate.
- Those receiving low PHI Rebate at older ages appear to have better claiming experience than those receiving no or high PHI Rebate.

Differences in average claim cost by income are most likely driven by the effect of the MLS which incentivises people to take out PHI regardless of their expected claiming needs, whereas participants who are not subject to the MLS may be doing so because of their view of their claiming needs and therefore the value they would obtain from a PHI product.

It's not clear why drawing rates for those receiving low PHI Rebate at ages 70 and older. However, we note that the number of people in this category will be small, as over 95% of older people receive the base PHI Rebate, and most do not buy basic/bronze policies.

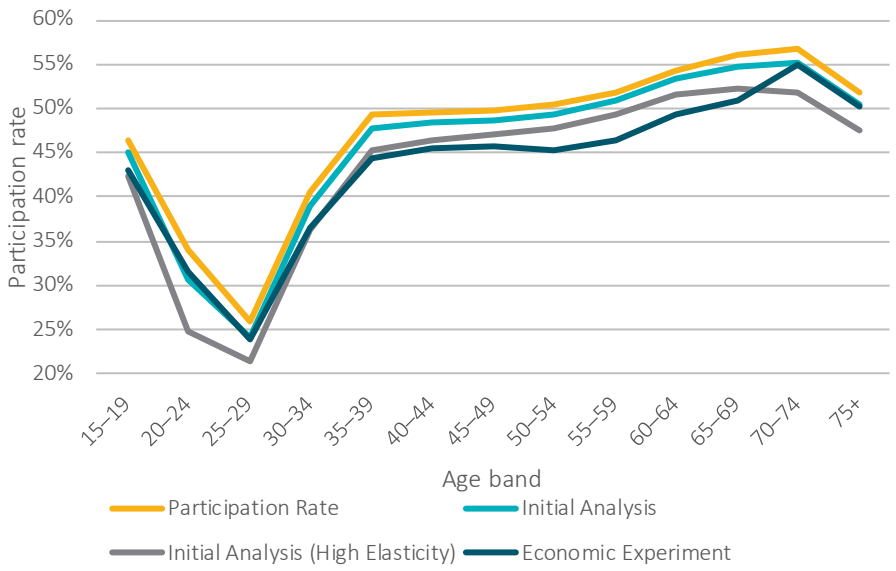
A.1.3 Economic experiment

In this section, we show the results of the economic experiment on questions regarding the PHI Rebate. Specifically, we tested the impact of PHI participation and product choice under the following scenarios:

- Status quo
- Removal of the PHI Rebate
- Decrease the PHI Rebate by 10 percentage points
- Increase the PHI Rebate by 10 percentage points

The figure below shows the impact of removal of the PHI Rebate on participation by age, as estimated by the economic experiment. Results are compared to initial analysis prepared by Finity based elasticity measured from PHI data (we show a base and high elasticity scenario).

Figure A.3 – Impact of removal of PHI Rebate on participation



The economic experiment suggests the removal of the PHI Rebate would have a greater impact on participation than our previous analysis, particularly between ages 30 to 70.

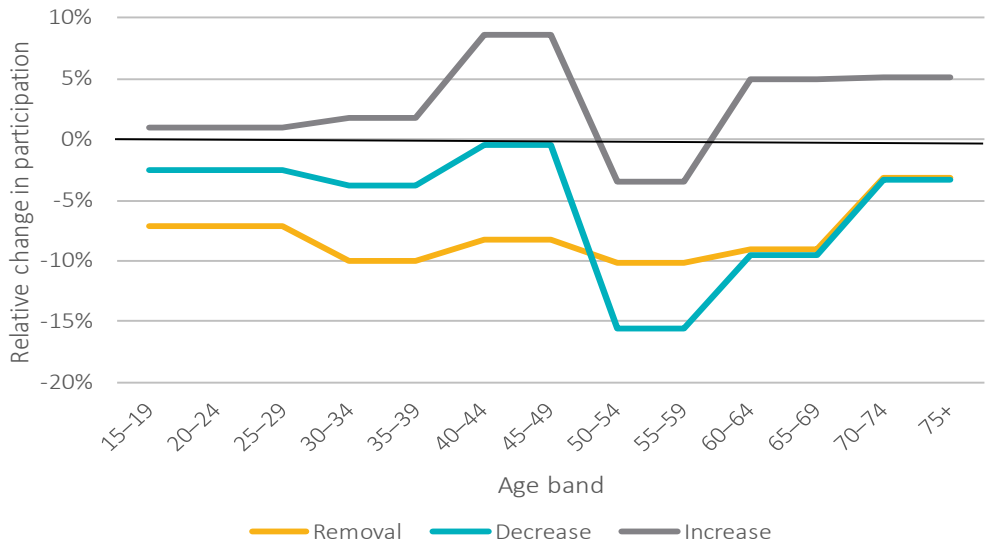
The initial analysis estimated price elasticity based on several million actual customer responses to historical PHI price changes. Limitations of this approach include:

- Because most annual PHI price changes are less than 10%, assumptions are required to extrapolate the data and estimate how people would respond to larger price changes.
- People do not always review their cover in response to annual price changes. The majority of people pay premiums by monthly direct debit, and so will remain insured if they take no action following a price increase.

The economic experiment specifically tests how individuals will respond to the removal of the PHI Rebate, and requires participants to state how they would respond. However, the number of people included in the experiment is much less than in the actual PHI data.

The figure below shows the estimated impact on participation from the economic experiment for removal, increase and decrease of the PHI Rebate.

Figure A.4 – Impact on participation of changes in PHI Rebate

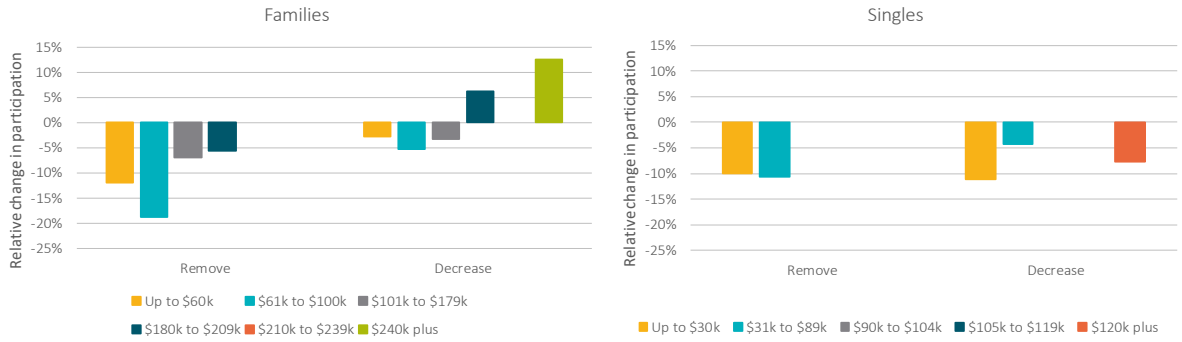


Removal of the PHI Rebate generally reduces participation by 10% (relative to status quo participation rates). The effect of decreasing the PHI Rebate are generally smaller than those for a removal (barring some volatility in responses between ages 50 and 60).

There is also asymmetry in the responses to an increase and decrease – a decrease in the PHI Rebate is expected to have a bigger impact than an increase at the same magnitude. This may reflect price elasticity, but may also reflect the impact of the LHC – the PHI Rebate does not apply to the LHC loading, therefore increases in the PHI Rebate be not a sufficient incentive for some people who will still face LHC loadings at the same amount.

The figure below shows the results of the economic experiment by family status and income[9].

Figure A.5 – Impact on participation by family status and income

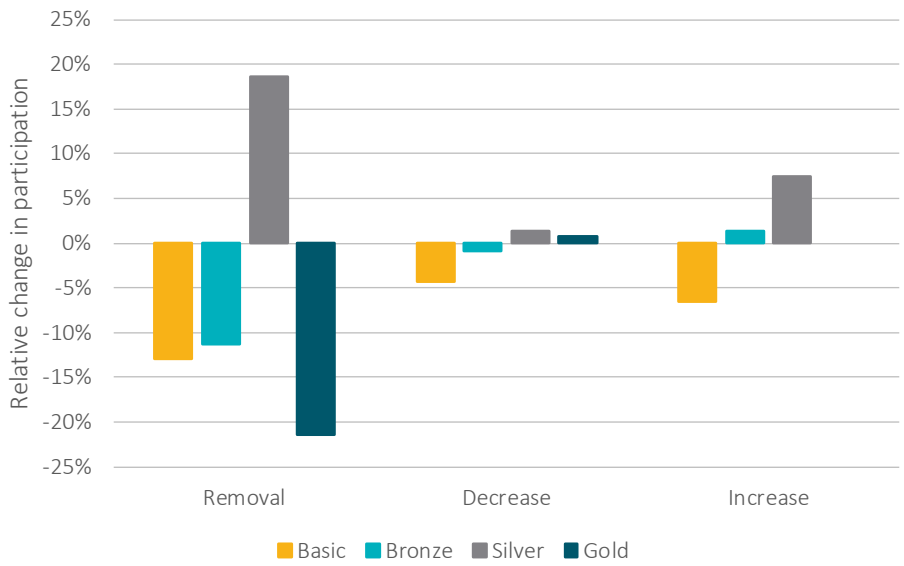


Generally, there is a stronger impact of changes to the PHI Rebate at lower income levels. We note that the experiment shows behaviour which may not be rational, for example, the reductions in participation by singles after an increase in the PHI Rebate.

[9] We have not shown results for the increase in this chart as while the experiment sample sizes are credible to determine the total response, they are not necessarily credible at each income/age/family type/product tier split.

The figure below shows the impact on product choice of changes to the PHI Rebate.

Figure A.6 – Impact of change in PHI Rebate on product choice



The economic experiment suggests removing the PHI Rebate would have a significant impact on product choice, with an estimated 20% fewer Gold participants and 20% higher Silver participants.

A.2 Fix PHI Rebate in dollar terms

This attachment summarises our evaluation of the likely impact of changing the PHI Rebate to give a fixed amount of PHI Rebate, set in $, for each product tier.

We have assumed that this would be set up so that the total amount of PHI Rebate payable remains unchanged, and hence the fixed amount of PHI Rebate would reflect the average current PHI Rebate payment per product tier. However, at an individual policy level, some policyholders will receive more PHI Rebate than previously (if their policy is cheaper than the average) and conversely others will receive less.

A.2.1 Summary of findings

While this suggested change scores well against necessary and important criteria, we expect the overall impact on private health insurance financials to be fairly small, while introducing high additional complexity or making a number of compromises which could be regarded as inequitable.

A.2.2 Comparison against criteria

The change has been evaluated against project criteria, and the findings are summarised as follows:

Necessary criteria

- No overall change to equity or Government affordability
- Minor improvement or deterioration in affordability to individuals, as some persons will receive more PHI Rebate than before and others will receive less.

Important criteria

- No change to value for government

- Slight improvement to participation, as the most affordable cover in the market will attract a higher PHI Rebate in dollar terms which could improve participation
- Slight improvement to competition and market dynamics, as lower cost products will appear even more attractive – but we expect the impact to be limited (see below).

Other criteria

- Deterioration to complexity (see below)

A.2.3 Benefits of fixed dollar rather than percentage PHI Rebate

Implementing a fixed dollar PHI Rebate could:

- Help customers understand the exact contribution that the Government makes to their health insurance premium.
- It will also be more apparent that the governments contribution to PHI premiums increases every year in dollar terms, although the PHI Rebate percentage may reduce. This could also increase the understanding of rate increases, versus the change in the actual premium paid.
- Result in a larger proportion reduction in cost for cheaper policies of the same product tier, which may increase the level of price competition in the market and allow funds operating at a lower profit margin to attract more customers. However, this impact is likely to be marginal, as the price difference already exists in the status quo.
- An additional incentive to insurers to minimise price increases, since products at a lower price will attract a higher percentage PHI Rebate.
- Make more comprehensive coverage appear more appealing, as it will be explicit that Government contributes more to such a policy. This does not change the relative value proposition, but may provide a nudge towards policyholders choosing more comprehensive coverage.
- We assume that, on implementation, a fixed dollar PHI Rebate would be set such that the average dollar PHI Rebate for each product tier is unchanged. Going forward, a dollar PHI Rebate allows for more targeted decisions regarding changes in PHI Rebate spending. For example, government could announce higher PHI Rebate increase for policies with features government wishes to promote (for example, with respect to mental health, or out of pocket costs). This could be funded by applying lower increases to products without these features.
- Decoupling PHI Rebate from insurer pricing decisions may support deregulation of PHI pricing.

A.2.4 Complexity arising from fixed dollar rather than percentage PHI Rebate

This change in methodology would significantly increase the complexity of the PHI Rebate, unless other PHI Rebate features are changed.

PHI Rebate rules

The current PHI Rebate arrangements are defined as a proportion PHI Rebate receivable based on income (in two groups – single or family), and age (in 3 groups: Under 65, 65-70, and 70+). A fixed amount of PHI Rebate per product tier will at a minimum change this structure from a single percentage for each income/age combination, to 4 $ amounts in each income/age combination. There may be arguments for varying PHI Rebate also for the plus tiers, noting the Silver category in particular includes a wide range of products. The communication of the PHI Rebate therefore becomes more complex, unless one of the other factors is removed (e.g. age, or product tier).

Additional impacts on premiums

In order to reflect a reasonable proxy to the current arrangements in $ terms, the change would have to also consider any other factors that currently impact on price. Premiums (per SEU or adult) currently vary by product scale, which may result in an amount of PHI Rebate also published separately for each scale and product tier combination (single, couple, family, and one parent and extended family product variants).

Furthermore, premiums can vary significantly by state. If the PHI Rebate amount does not vary by state, this will result in states with lower average premiums receiving a higher PHI Rebate than previous, and vice versa. This may not be considered equitable, as the intention of the PHI Rebate is not to give more support to a person who happens to live in a state with cheaper cover (for example, because the state has a younger population or fewer private hospitals).

Alternatively, the PHI Rebate could be varied by state but this adds even more complexity to the tables showing the amount of PHI Rebate each person is eligible to receive. Because the fixed dollar PHI Rebate would make differences in government premium support by state readily apparent, the reasons for those differences would need to be clearly communicated.

Can the complexity be overcome?

It is worth noting that, while the current PHI Rebate regulations would become much more complex if the PHI Rebate is fixed for each product tier (as described above), this does not negate the validity of the concept. Internationally, there are other markets where a fixed $ subsidy is available; the complexity in Australia arises from the variation that exists in the current market and the implications of implementing this change.

The table below identifies some of the sources of complexity, and assesses options to deal with these issues.

Table A.1 – Complexities with a fixed dollar PHI Rebate

Source of complexity	Alternative	Comment	Project criteria
Too many factors in the PHI Rebate calculation	Instead of fixing the PHI Rebate for each product tier, set a $ amount for Gold/Silver products, and a different one for Bronze/Basic products.	This would cut the extra factors in half and resolve some of the complexity that arises, but would produce a relative over-subsidy for persons on Silver compared to Gold, and on Basic compared to Bronze.	May not be equitable; persons on higher levels of cover may be those with more need, and reducing the PHI Rebate they receive could be considered inequitable.
Difference in pricing by State and product scale	Ignore these, and set the PHI Rebate amount as fixed regardless of State and scale	This would introduce discontinuities: Persons in States with higher PHI costs would receive a lower PHI Rebate and vice versa, reducing the effectiveness of the PHI Rebate where it may be needed more.	May not be equitable; May reduce value for Government as more money spent where affordability is less of a concern
“Plus” products	Ignore and treat as similar to base products	This reduces the PHI Rebate available to persons who choose “plus” products (as a percentage of the price) and may result in buy-downs.	As for the first point in this table: May not be equitable

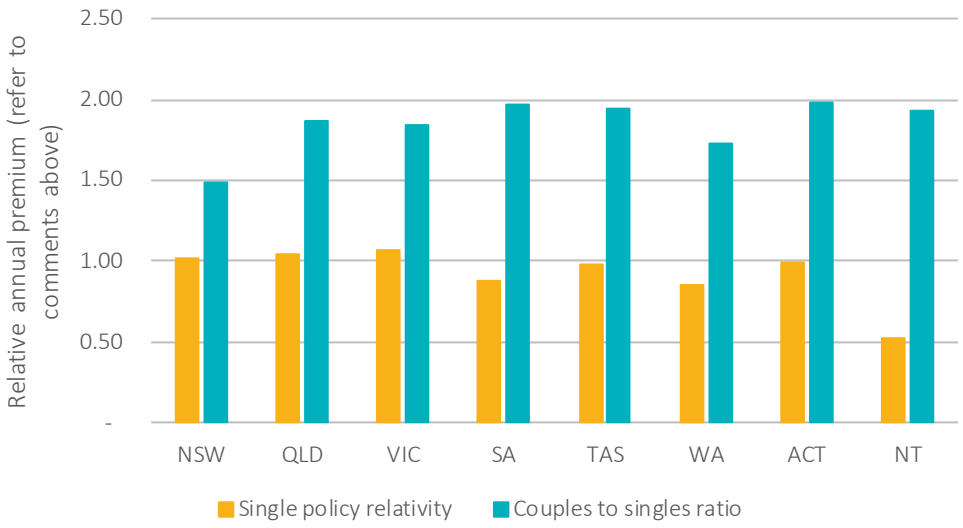
Source of complexity	Alternative	Comment	Project criteria
Differences in excess levels within a product tier	Ignore and treat as a single product	This reduces the PHI Rebate available to persons who choose low excess products (as a percentage of the price) and may result in buy-downs. This potentially increases out of pocket costs for consumers and may reduce the perceived value of PHI.	As for the first point in this table: May not be equitable May reduce value for consumers

A.2.5 Further analysis of fixed dollar PHI Rebate

Using the data provided by PHI funds for this and the RE/LHC project, we found that:

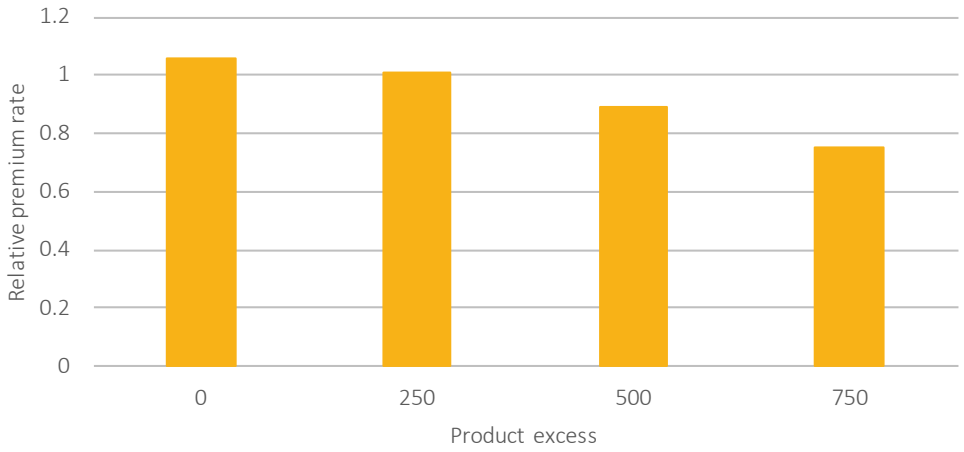
- The average cost of a singles policy with the same product tier (Gold) and the same excess level ($250) varies by State, between 53% of the "average" cost of the same product – in the Northern Territory – and 106% of the "average" – in Victoria. Ignoring State differences would therefore distort results.
  - > The calculated national average monthly premium was $233 (Gold, single, $250 excess, 2019 year). The orange bars below show the relative average premiums for each state. The figure shows the average premiums for NSW, QLD and VIC and close to but slightly higher than the national average, and the average premiums for TAS and ACT are close to but slightly below the national average. NT average premiums are 53% of the national average.
- The blue bars show the ratio of the average premium paid by couples to the average premium paid by singles for each state. The analysis is based on Gold products with a $250 excess and 2019 prices. For example, in NSW the average premium for couples was 1.49 times singles, and in SA couples paid 1.96 times the single rate. A fixed PHI Rebate amount per adult on the policy will therefore also distort pricing.

Figure A.7 – Single policy relativity and couples price as multiple of singles – by State



- The level of excess on a policy (Gold, singles policy, in NSW) impacts price: On average, no excess is 6% more expensive than the average while $750 excess is 25% cheaper than the average. A fixed PHI Rebate amount across excess levels will therefore distort results. The figure below shows the average premium rate for each excess, compared to the average premium across all the excess levels combined.

Figure A.8 – Relative premium – singles policy (Gold, NSW) by excess level



The average single in NSW with Silver hospital cover paid $200 per month in 2019. Assuming the PHI Rebate was fixed in dollar terms, the average PHI Rebate might be in the order of $50 per month (25% PHI Rebate). The PHI Rebate is equivalent to:

- 41% of the price of Medibank Silver Plus Essentials, which cost $120 at that time.
  - > This product has a $500 excess, has restricted cover for psychiatric hospital, and excludes a number of high cost clinical categories such as pregnancy and joint replacements.
- 16% of the price of nib's Top Hospital No Pregnancy Silver Plus, which cost $308 at that time.
  - > The nib product is more comprehensive than the Medibank cover, as it has a nil excess and excludes only pregnancy-type services.

This example shows how a fixed dollar PHI Rebate could disincentivise people taking more comprehensive cover. While the plus tier issue could be addressed by varying PHI Rebate according to the specific clinical categories covered, this would increase complexity.

A.2.6 Conclusion

Setting the PHI Rebate as a fixed dollar amount per product tier has advantages, but the additional complexity introduced by this change reduces the appeal of this option.

B MLS – additional information

B.1 Linking MLS to product tier

B.1.1 Hypothesis

To avoid paying the MLS, individuals with a taxable income above $90k per annum, are required to hold a complying health insurance product for hospital cover. The minimum level of cover required does not change based on income bracket, so only a basic hospital product is required for an individual with a taxable income over $90k to avoid the 1.0% levy, and similarly for an individual with a taxable income of greater than $140k to avoid the 1.5% levy.

Some high-income individuals hold only a basic or entry level hospital product despite their increased ability to insure themselves and their Medicare Levy Surcharge amount (if incurred) exceeding the cost of the most comprehensive PHI product.

Increasing the minimum level of cover required (e.g. to bronze, silver or gold tier) by income level, will improve the risk pools and sustainability of higher tier hospital products by providing people in good health (with low average claim costs) an incentive to take them out and potentially reduce some of the risk borne by the public health system. As long as the minimum cost of the hospital product remains less than the MLS that would be incurred in the absence of coverage, PHI participation is unlikely to be affected.

B.1.2 Who may be impacted?

The MLS provides high income earners a tax incentive to hold complying private hospital cover. The income thresholds at which the MLS applies, then increases, align with the levels at which the PHI Rebate level reduces. As at the start of 2022, the income thresholds were:

Table B.1 – MLS income tiers

Tier	Income threshold[1]	Rebate %[2]	MLS %	MLS $ (min)	Min premium (before rebate)[3]
1	$90k-$105k	16.40%	1%	$900	$1,077
2	$105-$140k	8.20%	1.25%	$1,313	$1,430
3	>$140k	0%	1.50%	$2,100	$2,100

1. Single threshold. Couples and families thresholds are 2x
2. For <65 yr olds, 65-69yr olds have a 4.1% higher rebate, 70+ an additional 8.2% (Tier 1 and 2 only)
3. Minimum level of MLS divided by (1 less rebate %)

For income levels just above the tier 1 threshold, an individual may choose to pay the surcharge as cover options available for between $1,100 to $1,260 are limited (particularly in the eastern states), particularly if they see limited or no value in PHI. For those on tier 3, the surcharge in dollar terms is higher meaning that a higher cover level threshold could be set without affecting participation.

From 2018-19 tax return data, we can see that participation in PHI increases with age and income level, which is likely driven (in part) by the MLS.

Table B.2 – Participation by taxable income level (2018-19)

Age band	Income tier 0 (below threshold)	1	2	3
<30	30%	63%	72%	86%
30-45	38%	76%	84%	91%
45-60	42%	76%	84%	92%
60-75	53%	89%	93%	96%
75+	51%	90%	91%	93%

For those that hold hospital cover, an indicative distribution of the product tier held based on the April 2020 Premium Round year is shown below. Income tier is derived based on the PHI Rebate level indicated to be received by the policy owner, as such income tier 3 may include those individuals who have not nominated their income tier / PHI Rebate eligibility to their insurer.

Table B.3 – Estimated hospital product holding by income tier and age group

Income tier (est)	Product tier	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 - 74	75+	Total
Below threshold	Basic	26%	27%	21%	14%	9%	5%	4%	2%	1%	1%	0%	9%
	Bronze	32%	24%	20%	18%	15%	13%	10%	8%	5%	2%	1%	12%
	Silver	23%	26%	37%	46%	48%	46%	42%	39%	35%	32%	23%	36%
	Gold	19%	23%	22%	23%	28%	36%	44%	51%	59%	65%	76%	44%
1	Basic	39%	32%	22%	15%	10%	8%	6%	4%	4%	2%	1%	16%
	Bronze	31%	27%	22%	20%	18%	14%	11%	9%	8%	5%	2%	19%
	Silver	17%	22%	36%	48%	52%	52%	48%	42%	61%	48%	44%	42%
	Gold	12%	18%	20%	17%	20%	26%	35%	45%	28%	46%	54%	24%
2	Basic	37%	31%	22%	14%	9%	7%	5%	4%	3%	2%	0%	14%
	Bronze	32%	27%	22%	18%	15%	13%	11%	8%	6%	3%	1%	17%
	Silver	18%	22%	34%	47%	53%	50%	46%	39%	32%	26%	19%	41%
	Gold	13%	20%	22%	21%	23%	30%	38%	49%	59%	69%	81%	29%
3	Basic	33%	30%	22%	13%	8%	5%	3%	2%	2%	1%	1%	10%
	Bronze	29%	25%	21%	18%	14%	11%	8%	6%	4%	2%	1%	13%
	Silver	19%	21%	29%	40%	45%	40%	33%	25%	19%	15%	14%	33%
	Gold	20%	24%	28%	29%	33%	45%	56%	67%	76%	82%	85%	43%

While there is a small shift towards higher coverage levels as income level increases (or nominated PHI Rebate level decreases), overall the product tier held is largely determined by age, not income level.

For the rest of this paper, we focus our discussion on Australian residents and what their response may be with respect to any changes in the MLS settings. We note that high-earning individuals in Australia on working visa may also be impacted by the MLS.

As a condition of their visa, overseas workers are required to hold private health insurance, however products for overseas workers do not meet the requirements of a Complying Health Insurance Product, and as such do not grant the individual exemption from the MLS.

In these cases, we are aware of overseas workers also taking out a complying Basic hospital cover to avoid the MLS, but being ineligible to use the product because they cannot access Medicare benefits. As such any changes to the minimum product requirement will exacerbate the cost to these policyholders without providing them any benefit

B.1.3 Survey responses

These are the results from the economic experiment conducted in June/July 2022. In the table below:

- Status quo is current hospital product tier holding of survey respondent

- MLS is their selected product tier after being presented with the question “Imagine if a Silver or Gold product was needed to avoid paying the MLS. So if your income was above the threshold you'd still have to pay the MLS if you only had Basic or Bronze cover” and shown the change in the relative premium of each tier and surcharge amount for their indicated income and household status

Note that the number of respondents to each question (and population segment) is different, survey respondents range from 60 to nearly 1,300.

Table B.4 – Economic experiment results

	Status quo					MLS - minimum tier of Silver					Impact				
	None	Basic	Bronze	Silver	Gold	None	Basic	Bronze	Silver	Gold	None	Basic	Bronze	Silver	Gold
All	15%	32%	19%	18%	15%	15%	26%	20%	25%	14%	0%	-6%	0%	7%	-1%
Income > $90k	6%	28%	21%	25%	19%	8%	10%	19%	39%	24%	3%	-18%	-3%	14%	5%
Age < 40	5%	42%	26%	16%	10%	9%	28%	21%	32%	11%	4%	-15%	-5%	16%	0%
Age 40+	22%	25%	15%	20%	18%	20%	25%	19%	20%	16%	-2%	0%	4%	0%	-2%
Has hospital cover	4%	23%	22%	27%	25%	6%	21%	19%	32%	22%	2%	-3%	-3%	5%	-2%
Single Household	21%	35%	20%	16%	9%	14%	35%	24%	22%	4%	-7%	0%	5%	7%	-4%
Family Household	13%	31%	19%	19%	17%	15%	23%	18%	26%	17%	2%	-8%	-1%	7%	0%

The survey results show:

- Material reduction in policyholders who choose Basic hospital cover, with a swing towards Silver tier cover, particularly for those with an Income > $90k and who are under the age of 40
- For those cohorts, also an increase in choice to not hold hospital cover, e.g. the additional premium cost exceeds the surcharge plus any perceived additional value from the higher cover. This suggests for these cohorts, that a proportion of people may see private health insurance as a ‘grudge’ purchase
- Interestingly, the Single household group sees a reduction in proportion of people who would chose not to hold hospital cover. The sample sizes were large enough to examine the overall expected impact of the policy change, but not necessarily credible when the data is split into finer groupings of product tier, age, income and family type.

C LHC – additional information

This section provides further detail on our LHC analysis, as summarised in Section 13 above.

C.1 Demographics

LHC was introduced more than twenty years ago. Since then, there have been a number of demographic shifts that may have resulted in changes in appetite for PHI by age, such that a starting age of 30 may no longer be appropriate.

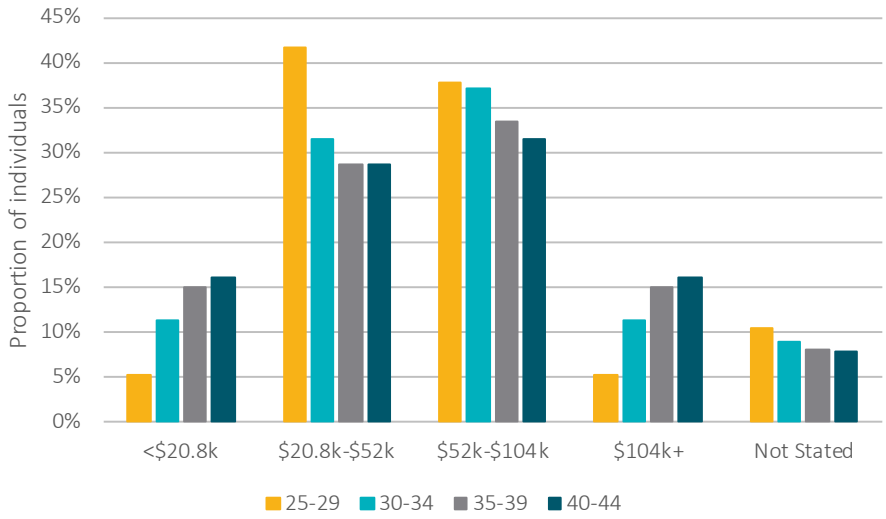
Demographic factors which are correlated to PHI participation (other than age) include:

- Income
- Home ownership
- Education
- Remoteness

In this section we compare the distributions of the above factors by age to determine what demographic evidence there may be to support increasing the starting age of the LHC. If there are significant differences, it would suggest a more significant impact of changing the starting age of LHC.

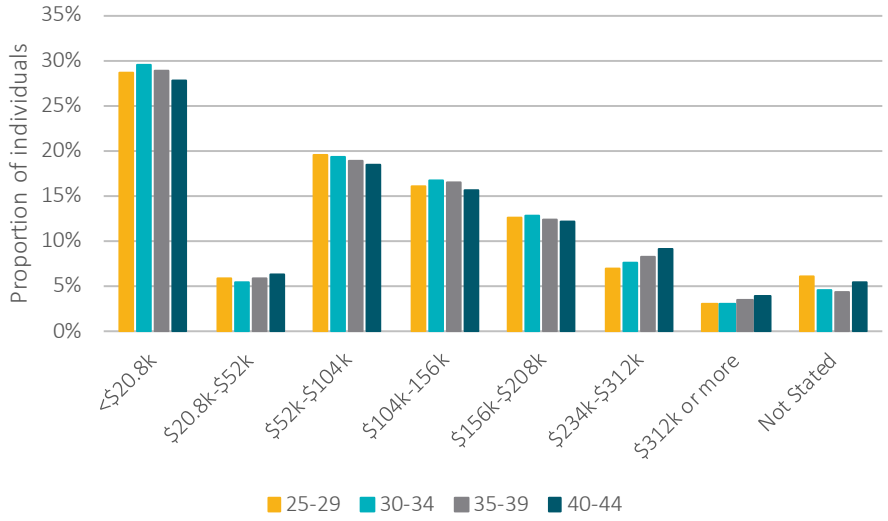
The figure below shows the distribution of individual income reported in the 2016 census by age band.

Figure C.1 – Distribution of individual income reported in the 2016 census, by age band



There appears to be a mixture of increasing incomes as people age (see $104k+) and decreasing incomes as people age (see <$20.8k). While incomes for full-time working individuals may be increasing due to career progression, there is an increase of people working part-time or not at all. Because of this, we have analysed the distribution of household income, shown in the figure below. The figure excludes adult children who live at home, because household incomes for these individuals would overstate these individuals' purchasing power.

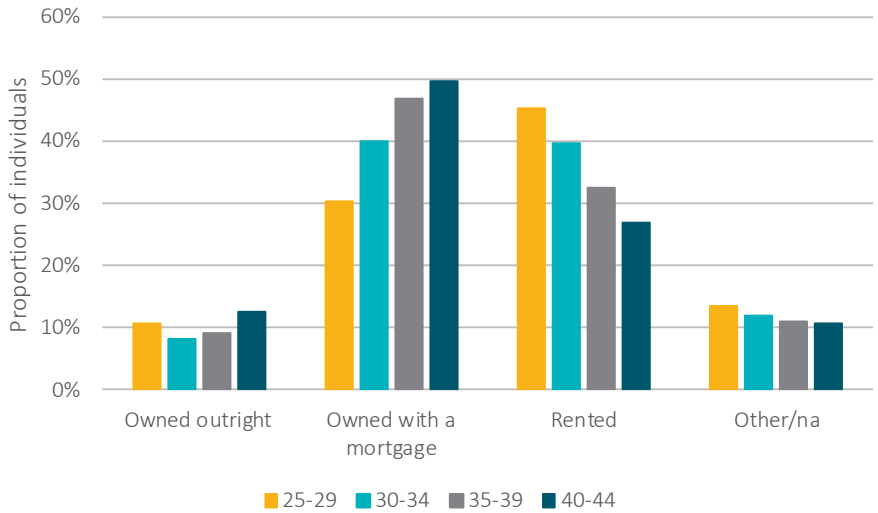
Figure C.2 – Distribution of household income reported in the 2016 census (excluding children), by age band



While there is an increase in the proportion of individuals with household incomes above $234k with age, these individuals are likely to be subject to the MLS, which applies to family households with incomes greater than $180k. The distribution at income points below $234k is generally slightly decreasing with age, indicating a shift into higher incomes where the individual would be subject to the MLS. So, while household income increases with age, the impact this could have on PHI participation is likely to be captured by the MLS in its current form anyway.

The following figure shows the distribution of home ownership reported in the 2016 census, by age band.

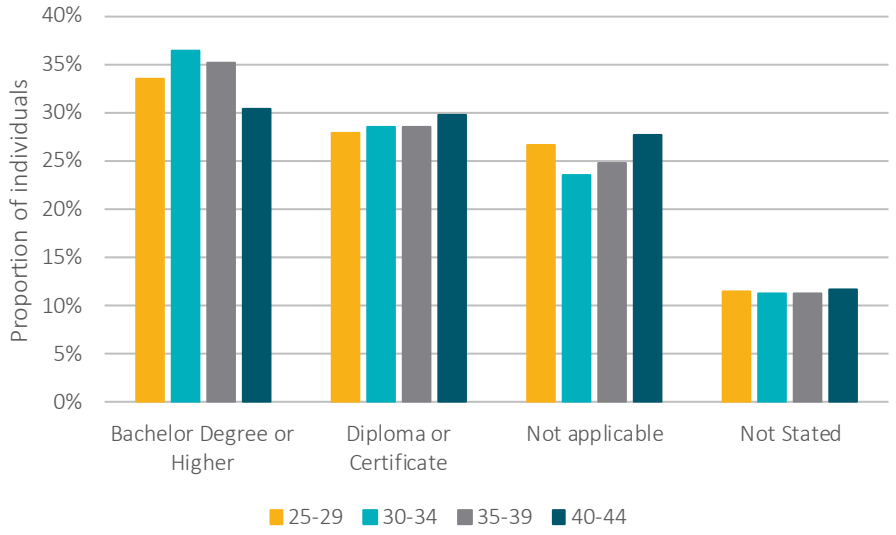
Figure C.3 – Distribution of home ownership reported in the 2016 census, by age band



There is a clear shift towards owning a home with a mortgage and away from renting as individuals age. Between ages 25-29 to 30-34, the proportion of individuals who owned their home with a mortgage increases by 10 percentage-points and the proportion of renters decreases 5 percentage-points. A previous Finity study suggested that renters would be expected to have 30% lower participation than home owners. This suggests a 1.5 percentage-point difference between age bands 25-29 and 30-34 due to home ownership status.

The figure below shows the distribution of tertiary education level reported in the 2016 census by age band.

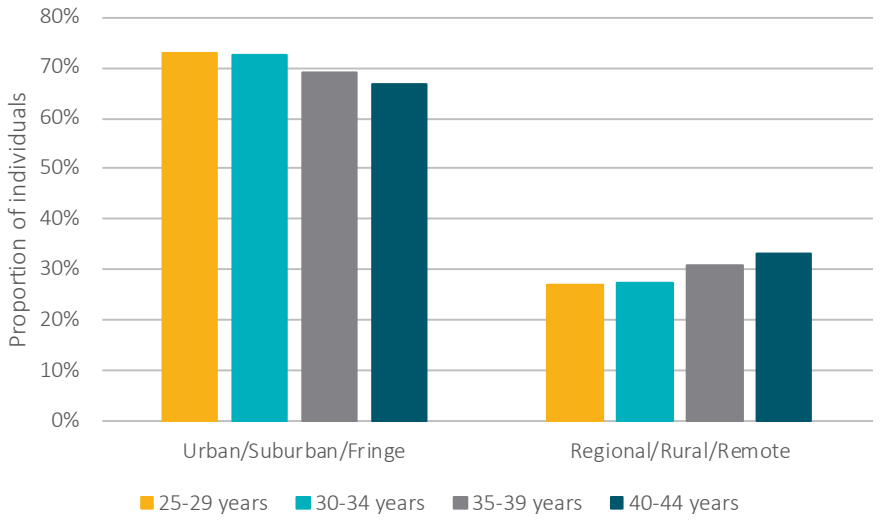
Figure C.4 – Distribution of tertiary education level reported in the 2016 census, by age band



The proportion of people with a Bachelor Degree increases from age bands 25-29 as there may still be a material number of people at this age band completing study. Tertiary education falls away for people in 40-44 age band, however this is likely a cohort effect (i.e. people who attended school more than 20 years were less likely to go on to university than people who attended school 10 years ago). Given the higher proportion of people in the 30-34 and 35-39 age brackets with some form of tertiary education compared to people aged 25-29, there is an argument for increasing the starting age based on education.

The following figure shows the geographical distribution of people by age band.

Figure C.5 – Distribution of geography by age band



An increasing portion of people live in regional or rural areas with age. This would suggest that those in the 25-29 age band are better placed to take out PHI, based on this measure alone. Further information on PHI in regional areas is provided in Attachment D.

In conclusion, differences in home ownership, household composition (observed through the relative changes in individual income and household income with age) and education by age suggests that individuals may be

slightly better placed to take out PHI in their 30s rather than their late 20s and it may be most appropriate to target them prior to age 40.

C.2 Economic experiment results & impact on modelling

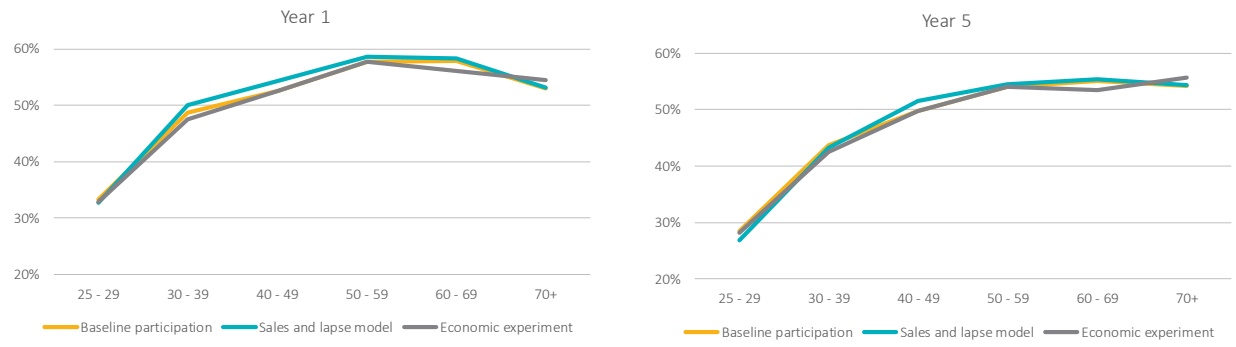
We conducted an economic experiment, surveying a wide range of current and potential PHI policyholders regarding their likely PHI choices when faced with a variety of scenarios. The outcomes of this analysis have been used to model expected future behaviour. This data has been considered with an elasticity model based largely on insurer data, which shows actual member responses to different price changes.

C.2.1 Increase LHC starting age to 40, and leave the loading at 2%

The following graphs highlight the expected impact on participation by age cohort of increasing the starting age from 30 to 40, all else being equal.

We have estimated the impact over both one- and five-year time horizons. The lines show the current (baseline) participation, and estimate based on the results of the economic experiment, and the assumptions derived from insurer data and other sources (sales and lapse model).

Figure C.6 – Impact on participation, moving LHC starting age to 40



Note: The vertical axis shows the PHI participation rate.

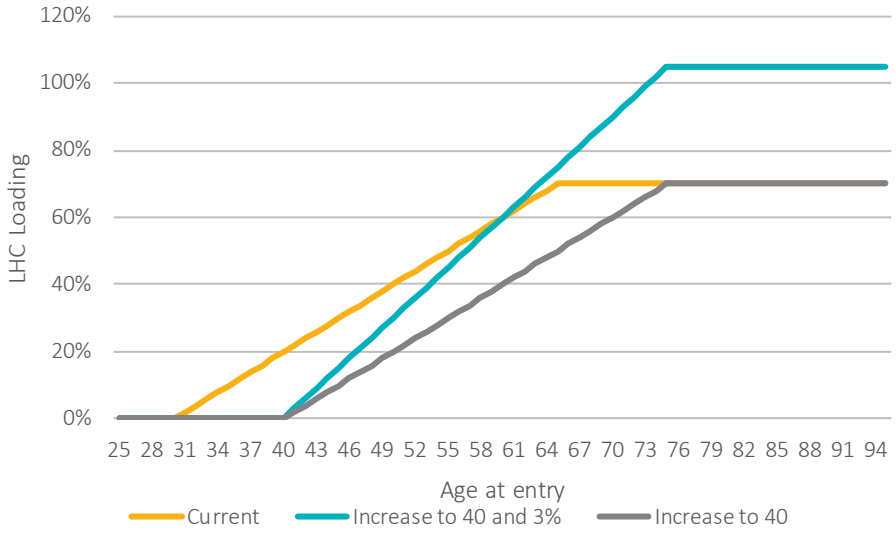
The results shown in the main report are based on the sales and lapse model. The economic experiment suggested an even smaller impact on participation.

C.2.2 Increase LHC starting age to 40, and increasing the loading to 3%

Following the previous investigation, which indicated that an additional premium rate increase of over 1% would be required to support a later LHC starting age, we investigated the impact of increasing the loading to 3%.

The following chart shows the impact on the total loading paid by age at entry under the various options considered.

Figure C.7 – LHC loading by age at entry

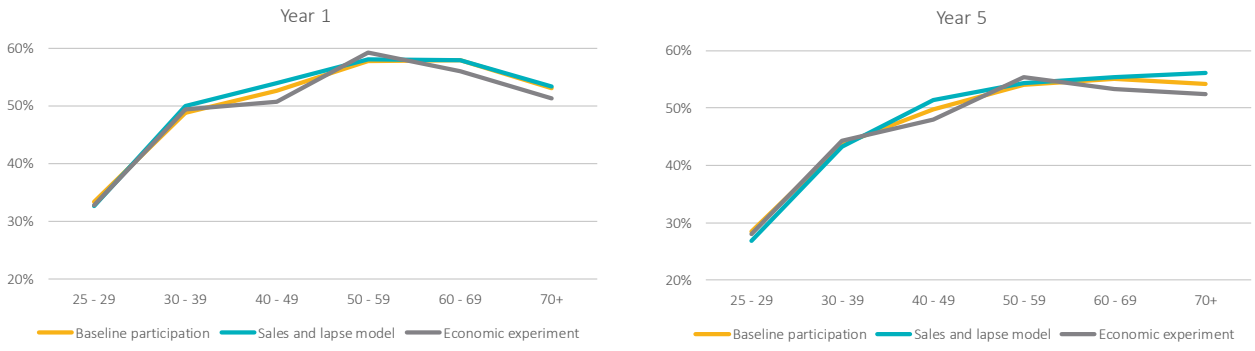


It is noted that if the loading is simply changed to 3% (and starting age is 40), those entering aged 74+ pay over double the base premium. Whilst this is more consistent with expected lifetime claiming rates, it represents a greater deviation from "pure" community rating.

Raising the starting age to 40 and increasing the loading to 3% for each year you don't participate in PHI has a number of impacts including:

- Increasing the cost of joining at a later age which is likely to decrease sales to those not intending to claim in the near future
- Increasing the consequences of lapse, as significantly higher premiums will need to be paid if a person want to re-join. This is likely to assist with retention
- Varying the LHC loading revenue received by insurers – the amount per person with a loading will increase, however the actual revenue could increase of decrease, depending upon the number, age and product choices of those who pay a loading

Figure C.8 – Impact of participation, moving LHC starting age to 40 and increasing loading to 3%



Note: The vertical axis shows the PHI participation rate.

Once again, there are slight differences by age cohort. It is worth noting that incorporating the results of the economic experiment indicates lower participation at older ages. As these groups typically have greater health

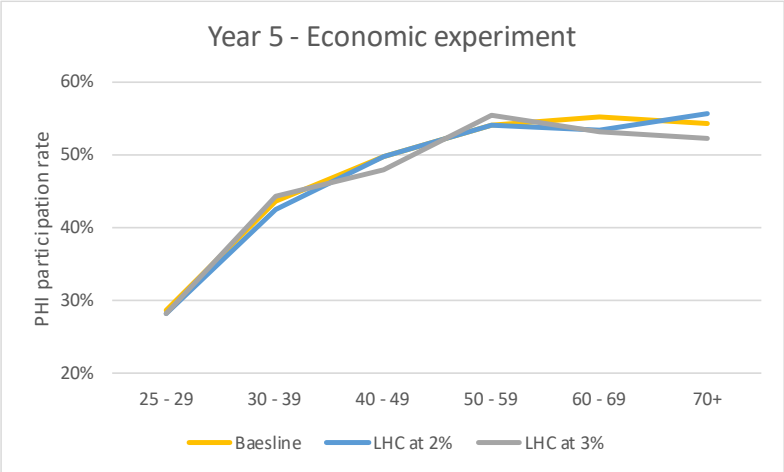
needs, this could place additional costs on the public health system (as well as moderating average PHI claim costs).

Comparison of options

We also prepared a direct comparison of the results of the economic experiment between the two proposals.

The close overlay of the participation lines indicates that the expected impact on participation alone would not warrant a change in the LHC starting age, however the options should still be assessed against the other key criteria.

Figure C.9 – Participation, comparison between options



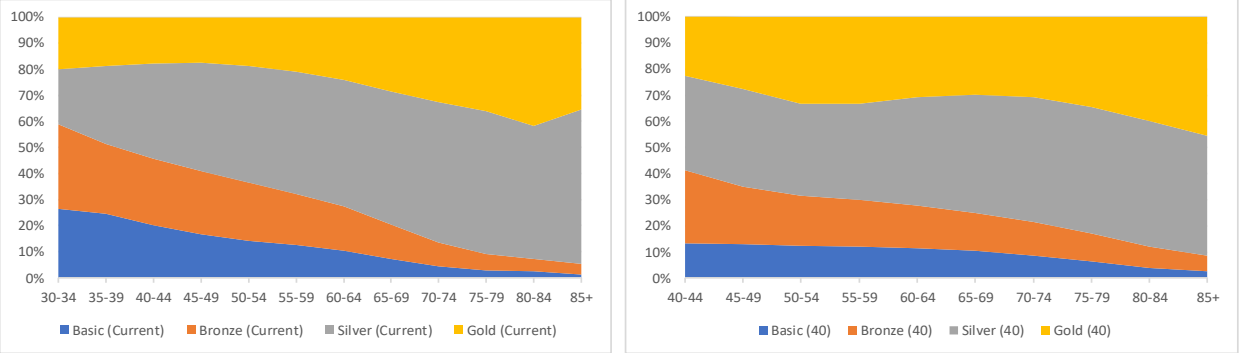
C.2.3 Impact on product choice

Participation is only one criterion for evaluating the potential success of any PHI policy change, and it has been noted by many stakeholders that the "quality" of participation is also important.

Quality is challenging to assess however product tier may be utilised as a proxy, with higher tier products (Gold and Silver) seen as preferable to the lower tiers (Bronze and Basic). It is noted however, that many argue that any participation is positive for the industry, as all hospital products contribute to the risk equalisation pool, and thereby help to reduce the costs on an individual basis.

The following charts compare the estimated distribution of product selection by age under the current policy settings (left hand chart), and if the LHC starting age was increased to age 40 (right hand chart). The assumptions have been derived by considering the impact that paying LHC loading currently has on product mix at age 30 and above, and assuming similar impacts would apply from age 40 should the LHC starting age be increased.

Figure C.10 – Product distribution by age



Once again, whilst there are some changes by age, the overall impacts include:

- An uplift in Gold participation from ages 40-65, and again at 85+
- A decline in Silver from age 40
- A shift from Basic and Bronze toward Gold for those prior to retirement, and an increase in these products thereafter.

C.3 Transition

Should these options be implemented, the transition from the existing scheme will require detailed consideration. In the modelling above we assumed that those under 40 would stop paying a loading, and those over 40 would now pay the reduced loading applicable for their age at entry.

Practical considerations:

- What will happen to those already paying loadings?
  - > Those under 40 could simply drop their cover and re-join with no loadings, but would lose loyalty benefits and limits
  - > Those over 40 have increased complexity, as they may not wish to re-join if they have already served a portion of the 10 years the loading applies for
    - – If the loadings are simply dropped to the new levels, this will result in a revenue loss to insurers (noting LHC loadings contribute around 2% of overall premium income)
    - – Careful messaging will be required to minimise the feeling of dissatisfaction if people have paid past loadings
- For those under 40 currently without PHI, there will be a window of opportunity where they avoid the existing penalty should they chose to join
- Special cases:
  - > For those who are on extended travel, consideration would need to be given to the what periods count for the LHC exemption (presumably this would be only time since the rule change, however the implications of this would need to be considered)

C.4 Assessment against criteria

We have assessed moving the starting age of LHC against a range of agreed criteria.

C.4.1 Necessary criteria

Options which are not considered equitable, or are not affordable to government and individuals, cannot be implemented in practice so need not be considered further. The table below shows our assessment against these options.

Criteria	Assessment (compared to no change scenario)	Evidence
Equity	Unclear	Increasing the starting age would reduce premiums paid by late-joiners, barring other changes to the LHC. Modelling indicates that despite initial claiming patterns (refer LHC Report), those with loadings typically have a higher gross margin indicating that a reduction in premiums may be warranted. People who joined before 40 may feel they have unjustly paid contributions for longer than necessarily.
Affordable to government	Limited impact	Under the scenarios modelled, the options are considered affordable as they do not materially shift participation, and so will have little impact on direct outlays through the PHI Rebate. Should consumers behave differently to the responses provided in the economic experiment, this could change.
Affordable to individuals	Mix of impacts	Increasing the starting age to age 40 will make PHI more affordable for those that join later than age 30. However, the mechanism by which lost LHC revenue is made up may ultimately impact affordability as prices could increase by around 1.7% on average.

These policy options to do result in a significant overall change in any of the necessary criteria.

C.4.2 Important criteria

The table below assesses the option against the importance measurable/comparable criteria.

Criteria	Assessment (compared to no change scenario)	Evidence
Value for government	Slightly improved	Changes in participation are relatively minor and have been estimated to have minimal impact on the PHI Rebate. There is an increase in the amount of claims financed by PHI, which may indicate a transfer from the public system.
Participation	Minor change	Changes estimated to be less than 1%, and could be lower if people change their expected behaviour.
Market dynamics, competition and innovation	No impact	Option does not directly impact these market features.

Criteria	Assessment (compared to no change scenario)	Evidence
Complexity	No impact (longer term) Adverse impact during transition	Overall, there is no change to the complexity of LHC under either scenario. Both should be readily managed by existing IT infrastructure, and the concepts are no more challenging to explain to consumers. During transition however, there are likely to be a number of complications, and careful thought must be given to a wide range of scenarios. These will require staff training, possible IT system changes, and a clear communication strategy.

There are expected to be small increases in participation and claims paid, however transition may be complex.

C.4.3 Other beneficial criteria

The table below considers the other criteria which, while beneficial, have lower weight than the criteria shown above.

Criteria	Assessment (compared to no change scenario)	Evidence
Adaptability	No impact	No change with this regard
Choice	Improvement	Gives people aged below 40 more choice as they are no longer penalised for taking out a policy at ages after 30 (but before 40).

This option will improve choice for 30-40 year olds.

C.4.4 Overall assessment

Our overall assessment is summarised below.

Overall assessment	Whilst increasing the average age is likely to result in a slight improvement in both participation and affordability to government (more treatment funded through PHI), premium rates may need to rise, and there is some additional complexity in transitioning to new policy settings.
Materiality	Expected changes to participation, claims and revenue are small in percentage terms.
Uncertainty	There remains moderate uncertainty as to how consumers will behave after changing the starting age of the LHC.

C.5 Conclusion

At this time, we do not believe that the LHC starting age should be moved, unless there are specific government objectives which justify the change, or it makes sense to improve integration and alignment with the other PHI incentives.

D PHI hospital costs by region

This attachment summarises our investigation of whether private health insurance hospital claim costs differ based on the insured person's region. We investigated this when considering whether the Medicare Levy Surcharge, Lifetime Health Cover or PHI Rebate should vary by region.

The investigation was based on persons with a full year of exposure in the 2019 premium year (April 2019-March 2020) and results shown reflect experience in that period.

The Modified Monash Model was used to allocate each person's location (based on postcode as provided by their PHI fund) to a healthcare region, MM1 through MM7. MM1 indicates metropolitan locations, while MM2 to MM7 are increasingly remote communities, as shown in the table below:

Table D.1 – Modified Monash categories and descriptions

Modified Monash Category (MMM 2019)	Description (including the Australian Statistical Geography Standard – Remoteness Area (2016)
MM 1	**Metropolitan areas:** Major cities accounting for 70% of Australia's population All areas categorised ASGS-RA1.
MM 2	**Regional centres:** Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are in, or within a 20km drive of a town with over 50,000 residents. For example: Ballarat, Mackay, Toowoomba, Kiama, Albury, Bunbury.
MM 3	**Large rural towns:** Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are not MM 2 and are in, or within a 15km drive of a town between 15,000 to 50,000 residents. For example: Dubbo, Lismore, Yeppoon, Busselton.
MM 4	**Medium rural towns:** Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas that are not MM 2 or MM 3, and are in, or within a 10km drive of a town with between 5,000 to 15,000 residents. For example: Port Augusta, Charters Towers, Moree.
MM 5	**Small rural towns:** All remaining Inner (ASGS-RA 2) and Outer Regional (ASGS-RA 3) areas. For example: Mount Buller, Moruya, Renmark, Condamine.
MM 6	**Remote communities:** Remote mainland areas (ASGS-RA 4) AND remote islands less than 5kms offshore. For example: Cape Tribulation, Lightning Ridge, Alice Springs, Mallacoota, Port Hedland. Additionally, islands that have an MM 5 classification with a population of less than 1,000 without bridges to the mainland will now be classified as MM 6 for example: Bruny Island.
MM 7	**Very remote communities:** Very remote areas (ASGS-RA 5). For example: Longreach, Coober Pedy, Thursday Island and all other remote island areas more than 5kms offshore.

Assumptions and methodology

The following assumptions and methods were used to derive the results shown in this report:

- Person postcodes provided to us in the dataset was assumed to be accurate for each person; no verification of this data was attempted. The postcode data is blank for 24% of persons in the dataset; they are included in the analysis and shown as "unknown".
- Postcodes were allocated to one of the MMM categories based on the mapping available online[10].
- We analysed for each setting:
  - The proportion of persons making a claim
  - The average annual cost for each person making a claim
  - The average drawing rate (which combines the previous two factors)
- Results were produced for the industry as a whole, by State, by product tier, and by 5-year age bands.

Key finding: There is no evidence that the average likelihood/cost of hospital claiming varies significantly between areas MM1 through MM5. For remote and very remote communities classified as MM6 and MM7 healthcare utilisation appears to be lower than for MM1 to MM5, however very few people in remote areas have PHI.

Healthcare utilisation comparison: Whole industry

Just over half of all industry participants live in metro areas (MM1), and just under 20% in regional and rural areas (MM2-MM5). Only 1% of people covered by PHI live in remote areas, and the location of the other 24% is unknown in our dataset. Drawing rate is the average claim costs per person insured, allowing for both likelihood of claiming and average claim cost.

Table D.2 – Comparison – industry as a whole

MMM category	Proportion of PHI members	Likelihood of claiming	Cost per claimant	Drawing rate
MM1	56%	19%	7,448	1,392
MM2	7%	20%	7,530	1,530
MM3	4%	21%	7,590	1,611
MM4	2%	21%	7,941	1,676
MM5	5%	21%	7,866	1,640
MM6	1%	17%	7,407	1,225
MM7	0%	14%	7,354	1,037
Unknown	24%	14%	7,806	1,124
Total	100%	18%	7,568	1,361

Persons living MM6 and MM7 are less likely to have a claim (17% and 14%) than the average (18%), and than persons living in MM1 through MM5 (19%-21%). When they claim, their claims are also lower cost ($7,354-$7,407) than the average ($7,568) and than those living in MM1-5 ($7,448 to $7,941). This indicates that

[10] https://data.gov.au/data/dataset/modified-monash-model-mmm-2019 Downloaded in January 2022

persons who purchase PHI cover in remote and very remote areas, where there may be lower access to health services, also use less of those services.

However, no such difference exists between the metropolitan (MM1) to small rural towns (MM5) locations; persons living in small rural towns have a higher likelihood of claiming (21% compared to 19%) and a higher cost if they claim ($7,866 compared to $7,448) compared to those living in metropolitan areas.

Persons living metropolitan areas (MM1) represent 56% of the total PHI population, but the Modified Monash Model notes that 70% of Australians live in MM1. The difference is likely to be due to the large proportion of the PHI population (24%) for whom no postcode was available. If this entire group were to be located in MM1, 80% of the PHI population would be living in MM1. While this cannot be tested given data constraints, it is not unreasonable to assume that the PHI population would skew towards metropolitan areas.

Analysis for specific subgroups

In this section we compare remote populations (MM6 to MM7) to less remote populations (MM1 to MM5), to determine whether the trends observed across the full population is also true for specific subgroups.

By State

For each state, we have considered the same factors as before. In most states, the drawing rate of persons living remotely is lower than the state average, as shown below.

Table D.3 – Comparison by state, showing difference in likelihood of claiming and cost for each person who claimed between persons from remote locations (MM6-7) and those from less remote locations (MM1-5)

State	Proportion of PHI members	Proportion in MM6-7	Likelihood of claiming		Cost per claimant	
			MM1-5	MM6-7	MM1-5	MM6-7
NSW	34%	1%	19%	20%	7,557	7,279
VIC	24%	0%	20%	23%	7,477	9,080
QLD	19%	2%	21%	17%	7,701	7,363
WA	12%	4%	18%	13%	7,457	7,477
SA	7%	3%	21%	18%	7,161	7,436
TAS	2%	5%	21%	22%	7,630	7,580
ACT	1%	0%				
NT	1%	22%	12%	9%	5,533	6,178
Total	100%	2%	19%	16%	7,507	7,389

The trend of healthcare utilisation differences between MM1-5 and MM6-7 is not uniform by State. In NSW, Victoria and Tasmania, the proportion of persons living in MM6-7 is lower than any other states (except ACT which has no remote persons); however, MM6-7 persons in those states are more likely to claim than those living closer to metropolitan areas in those States. In addition, in Victoria, the cost per claimant is also higher for MM6-7 persons, although we note the volume of these PHI members is very low.

In other States, the likelihood of claiming is lower for MM6-7 than for MM1-5. It is also worth noting that claiming patterns in the Northern Territory are lower than any of the other States, and claiming patterns for MM6-7 in the Northern Territory are exceptionally low, despite the NT having the highest proportion of remote and very remote PHI participants. We note that PHI premiums are also lower in NT than elsewhere in Australia, which reflects the relatively low claim costs in the NT.

Outside WA and NT, the statistics are generally similar for MM1-5 and MM6-7. We note again that, at a national level, the proportion of people living in MM6-7 is very low.

By product tier

A key difference in drawing rates results from differences in the benefits covered under a policy. We have repeated the above analysis for each product tier and found that persons living in remote and very remote communities (MM6-7) have lower healthcare utilisation (as indicated by likelihood to claim and cost for each claimant) than those living in less remote communities (MM1-5). However, the drawing rates for MM1 to MM5 (where almost all people with PHI live) are similar.

Table D.4 – Comparison by product tier and remoteness classification

Product tier	MMM classification	PHI members	Likelihood to claim	Cost per claimant	Drawing rate
Gold	MM1	1,863,761	26%	8,762	2,251
	MM2	269,814	25%	8,368	2,114
	MM3	169,445	27%	8,630	2,344
	MM4	88,395	27%	8,816	2,337
	MM5	204,634	26%	8,746	2,277
	MM6	32,685	21%	7,849	1,659
	MM7	15,794	18%	8,348	1,497
Gold Total		3,342,918	25%	8,797	2,231
Silver	MM1	1,824,320	17%	6,604	1,117
	MM2	209,054	19%	7,036	1,320
	MM3	130,383	19%	6,711	1,268
	MM4	66,677	19%	7,334	1,413
	MM5	151,106	19%	7,229	1,374
	MM6	18,781	15%	7,613	1,131
	MM7	9,569	13%	6,896	897
Silver Total		3,168,535	16%	6,721	1,087
Bronze	MM1	568,661	10%	3,616	375
	MM2	52,393	11%	4,160	460
	MM3	34,970	11%	3,420	381
	MM4	15,253	11%	3,963	430
	MM5	38,382	11%	3,866	410
	MM6	8,444	8%	3,793	305
	MM7	4,483	8%	3,394	274
Bronze total		1,098,756	10%	3,753	361
Basic	MM1	445,143	7%	3,027	219
	MM2	46,095	9%	3,135	283
	MM3	27,106	8%	3,157	261
	MM4	15,233	8%	2,943	236
	MM5	30,938	8%	3,051	253
	MM6	4,609	6%	3,350	211
	MM7	3,097	7%	3,405	226
Basic total		793,421	6%	3,088	177
Grand total		8,403,630	18%	7,568	1,361

By age band

Age is another strong determinant of claim costs, due to the high correlation between age and healthcare needs. We analysed the likelihood of claiming and cost per claimant for each major age group (in 20-year age bands); the conclusions are similar to previous sections. Persons living in remote or very remote communities (MM6-7) have lower likelihood of claiming and mostly lower costs when they do claim compared to those living in less remote areas (MM1-5). At younger ages the cost per claimant appears higher for persons in MM6-7, which may point to a selection effect or may simply indicate variability due to sparse data.

For MM1 to MM5 (where almost all people with PHI live), there are no significant differences in average cost by age or the different regions.

Table D.5 – Comparison by age band, showing difference in drawing rate

Age band	MMM classification	PHI members	Likelihood to claim	Cost per claimant	Drawing rate
0-20	MM1	1,219,396	8%	2,932	234
	MM2	144,159	8%	2,865	229
	MM3	84,244	8%	2,829	236
	MM4	41,103	8%	2,871	223
	MM5	95,810	8%	2,935	231
	MM6	17,235	7%	2,840	194
	MM7	9,424	6%	3,521	228
0-20 Total		2,133,341	8%	2,937	222
21-40	MM1	1,046,276	13%	5,171	673
	MM2	110,062	14%	5,201	753
	MM3	61,901	14%	4,821	659
	MM4	30,124	14%	5,042	686
	MM5	68,016	14%	5,091	697
	MM6	13,913	11%	5,426	604
	MM7	7,879	11%	5,536	631
21-40 Total		1,808,112	12%	5,288	637
41-60	MM1	1,371,636	18%	5,868	1,062
	MM2	166,721	19%	6,216	1,190
	MM3	97,841	19%	6,156	1,164
	MM4	49,633	19%	6,387	1,186
	MM5	117,043	18%	6,346	1,173
	MM6	17,874	16%	6,683	1,049
	MM7	9,556	14%	6,750	978
41-60 Total		2,427,886	17%	6,035	1,036
61-80	MM1	902,685	36%	9,569	3,425
	MM2	134,073	36%	9,276	3,317
	MM3	100,093	35%	9,197	3,230
	MM4	55,251	34%	9,544	3,265
	MM5	124,346	34%	9,504	3,209
	MM6	13,464	32%	9,198	2,968
	MM7	5,473	28%	9,616	2,732
61-80 Total		1,734,079	34%	9,558	3,229
81+	MM1	161,892	45%	13,653	6,207
	MM2	22,341	45%	12,430	5,572
	MM3	17,825	43%	11,104	4,768
	MM4	9,447	40%	11,160	4,435
	MM5	19,845	41%	11,190	4,597
	MM6	2,033	39%	10,787	4,218
	MM7	611	32%	13,909	4,485
81+ Total		66,218	39%	13,356	5,155
Grand total		8,403,630	18%	7,568	1,361

Conclusion

We conclude that persons living in remote or very remote areas have a lower likelihood of claiming than those living in less remote areas (MM1-5); this holds across State, product tier, and age group considerations. There is no evidence of significant variation between the Modified Monash categories of MM1-5, which captures the majority of Australians and the majority of PHI members.

E Other options – additional information

This attachment provides further detail on the other options considered:

- Impact of out of pocket costs
- Youth product
- Data sharing
- Communication

E.1 Impact of out of pocket costs (OOPs)

This section summarises our evaluation of the likely impact of changing PHI regulation to incentivise or require lower or known out of pocket costs for PHI members.

This was raised as an important issue given the growth in OOP and the view that consumers would value limiting OOP

E.1.1 Conclusion

- Stakeholders recognise that OOPs are a significant issue for consumers, which causes some people to choose not to buy PHI. Stakeholders identify this as a priority issue to be addressed to support the long-term sustainability of private healthcare.
- This is also a complex issue, and it is not possible to address this problem only by changing the PHI Rebate, MLS or LHC.
- We explore several options, which fall into the following two broad categories:
  - Mandate: Rules to mandate what insurers must pay, and/or what doctors can charge. A challenge would be to determine a mandate which is fair to doctors and all policyholders, including those with low expected claim costs for whom premium affordability may be the major concern.
  - Encourage insurers and doctors to reach agreements which reduce or eliminate gaps, noting such arrangements are the norm between insurers and hospitals. Low transparency around medical charges and insurer reimbursements may be limiting progress in this area.
- If product options are developed which reduce OOPs, then PHI Rebate, MLS or LHC could be used to encourage participation in these products, for example by subsidising premiums (via PHI Rebate) or encouraging people with low average costs to insure (via MLS).
  - Again, other policy levers may be better able to support these products. For example, funds assisting members to access required treatment with low gaps could be supported by RE.

E.1.2 Types of out of pocket cost

There are three key types of out-of-pocket costs for PHI members:

1. A known and pre-defined excess payable when a member claims from their PHI fund:
   a. When the member is admitted to hospital – this is typically fixed as a dollar amount and defined by product (e.g. Gold $500 excess)
   b. When the member uses Extras benefits which have a fixed proportion (e.g. 60%) paid by their Fund, or where a fixed limit applies (e.g. an amount for dental or ophthalmology care) and actual claims exceed this limit.

2. Out-of-pocket costs incurred for (usually medical) fees not covered by the PHI fund, often due to specialists charging a higher fee than the MBS
    a. This can be mitigated by so-called "gap arrangements" between funds and specialists, where the provider agrees to charge no or a known amount of out-of-pocket costs to the PHI member in return for a higher-than-MBS payment from the PHI fund. However, these arrangements are not compulsory and providers may choose not to apply the arrangement at their discretion
    b. While informed financial consent is encouraged to ensure members know the amount of out-of-pocket costs they are likely to face, this is hampered by a number of factors: Members typically do not interact with an anaesthetist prior to surgery the way that they do with the surgeon; unforeseen circumstances may lead to a change in surgical plan resulting in additional costs; and members may not know whether a gap scheme is in place or whether the provider will apply it. Furthermore, emergency care may occur without financial consent.
3. Out-of-pocket costs due to services not covered by their PHI fund:
    a. Hospital claims for clinical categories not covered by their membership (e.g. pregnancy claim in a private hospital for a person with Bronze cover)
    b. Hospital claims for clinical categories not covered by PHI at all (e.g. cosmetic surgery without a medical reason)
    c. Out-of-hospital claims for GP or specialist care above the level covered by the MBS, and not covered by a hospital substitution arrangement
    d. Out-of-hospital costs for general treatment not covered by their Extras package (e.g. specialist dental care where the member has only general dental cover, or any general treatment care where the member elected to only purchase hospital cover).

For the purpose of this paper, we have focused on the first two types only.

E.1.3 Summary of findings

There are two mechanisms that can be considered to improve the amount or uncertainty of out of pocket costs: Providing more risk equalisation support for plans with a lower excess for hospital admissions, and establishing an information sharing system or website that allows PHI members to determine which doctors are in a gap arrangement (and the details of that arrangement) in order to inform their choice of doctor and/or fund.

E.1.4 Comparison against criteria

Both mechanisms have been evaluated against project criteria, and the findings are summarised as follows:

Necessary criteria

- No overall change to equity or Government affordability
- Minor improvement or deterioration in affordability of premiums to individuals, as low excess plans may decrease slightly in price while high excess plans may become more expensive.
- Improvement in affordability of care to individuals in the out of pocket component, if patients are able to choose their doctor based on more information which includes their out of pocket outcomes.

Important criteria

- No change to value for government

- Possibly a slight improvement to participation, if the value proposition of PHI improves with a decrease in uncertainty
- Slight improvement to competition and market dynamics, as funds could create more innovative or competitive gap schemes, and doctors may be more willing to sign up to gap schemes if it brings in more business

Other criteria

- Adding another factor to RE can increase complexity
- No change to adaptability
- Improved choice as members have more information on which to base their choice of doctor

E.1.5 Results from economic experiment

We tested the impact of reducing out of pocket costs in the economic experiment, and the results were marginal: While members may be willing to consider a more expensive product tier if they know their out of pocket costs will be controlled, there is no statistically significant change to participation.

The economic experiment was designed to test how PHI participation and product choice changed if there was greater certainty regarding out of pocket costs. As part of the test, the experiment assumed only the out of pocket arrangements changed, and there was no required price increase. In practice, lowering out of pocket costs would likely require higher reimbursements for doctors, and therefore higher premiums. This could result in a decrease in PHI participation, and downgrades to lower levels of cover.

E.1.6 Mechanism

In most forms of short-term insurance, out of pocket costs form an important part of policy design to reduce frivolous or unnecessary claims at low cost and high frequency. It can be argued that in private health insurance, out of pocket fees play a role in controlling utilisation, however they may cause people to delay or avoid necessary care. Removing all out of pocket costs for PHI claimants is likely to be popular with members, but the cost to the funds may exceed any benefits of potential higher participation.

We consider separately two concepts: Reduced out of pocket costs and known out of pocket costs

Table E.1 – Potential changes that can be implemented to reduce amount or uncertainty of out of pocket costs

	Incentive or requirement	Comment
Reduce out of pocket	New rules or incentives apply	
	Member incentives: ◦ Change incentive policies to target lower excess hospital plans: Higher PHI Rebate and/or lower MLS and/or lower LHC loading if the member purchases a product with low excess	Impact is likely to be low unless a high level of support is offered (e.g. much increased PHI Rebate). The incentive already exists in the form of a lower excess payment, and yet members are moving towards higher excess plans due to affordability. The incentive will have to be large enough to exceed affordability constraints which will not meet the criteria of government affordability.

	Fund incentives: ◦ More risk equalisation support for plans where members have lower out of pocket costs	More risk equalisation support for low excess plans can incentivise funds to offer these plans, and could lower the price of these. This can result in a shift of members towards lower excess benefit options. This should be considered in the product impact investigations of the new risk equalisation scheme, together with product tier variability in payments.
	Fund requirements: ◦ Implement a maximum excess that can apply to hospital policies ◦ Require all funds to offer at least one benefit option at a specified (low) excess level	Requiring funds to cover low excess plans would be inconsistent with current regulations – for example, funds are free to choose whether they offer Gold tier products or not, and so are likely to expect to be able to decide whether or not to offer low excess products.
	Gap scheme changes: ◦ Encourage or set up an industry-wide website that can allow PHI members to search for a provider by specialty and determine whether they have a gap scheme with a specific fund. Doctors can also be encouraged to disclose their fee structure on the same website to allow members to compare fees.	This can be done at low cost to the government or industry, and allow members to include gap scheme and fee information when making the choice of doctor they wish to use. Such information sharing scores well against all criteria.

	Changes that can be used to create opportunities	
	Fund requirements: ◦ Require funds to offer a gap scheme, or in another way limit the amount of cost that a member can be liable for	This would increase fund costs and lead to an increase in premium to cover the additional claims arising; higher premiums may in turn lead to decreased participation.
	Provider requirements: ◦ Limit the amount that providers can charge above the MLS rate ◦ Limit the amount that providers can charge without obtaining informed financial consent	Any regulation that impacts on providers' ability to set their own fees is likely to be very unpopular with providers. Significant legislative changes would be required. While it may be worthwhile pursuing as a policy initiative, this is outside the scope of this project and should be considered separately

Known out of pocket	New rules or incentives	
	Fund requirements: ◦ Funds can be encouraged or required to make information available to members on the level of out of pocket fees typically associated with certain procedures. For example, this can be shared with members when a benefit entitlement check occurs. ◦ Funds can be incentivised or required to share information on the gap scheme (if any) that applies, including a way to direct members to doctors who have a gap arrangement with the fund. This can allow members to choose specialists who are more likely to charge lower and/or known out of pocket costs. While an incentive for such a change may not be easily done through the key policies under consideration for this project (MLS, PHI Rebate and LHC), it could be aligned to the RE scheme by only including gap scheme payments in retrospective arrangements if such information on the gap scheme is available to members.	It is not clear whether funds consistently receive sufficient information to help assist members with the claims data from providers – there is no requirement for the provider to bill the fund for more than the MBS fee even if the provider will then charge a co-payment from the patient. Sharing gap scheme information should enable PHI members to make informed decisions around the doctors they choose to see. This scores well against all criteria (see next section).
	Provider requirements: ◦ Providers are already encouraged to obtain financial consent prior to claims. This can be expanded to include information on whether the provider will apply any gap scheme for the particular claim and what amount the patient will be liable for.	More information is required on the proportion of claims that have a gap payment applied, and the frequency at which this information is not disclosed. We are not in a position to infer the impact that this change may have.

E.1.7 Scoring against criteria

From the assessment above, the following potential changes are worth further exploration. Each of these will be evaluated against the criteria in this section.

- Providing more risk equalisation support for benefit options where members have lower out of pocket costs. This should be investigated as part of the implementation of the potential new hybrid RE scheme, as part of the consideration of product tier impacts.
- Provide members with more information on the details of gap schemes, through the establishment of fund-specific or industry-wide website(s) with gap scheme details and the doctors signed up to that gap scheme. Once this is in place, it will help members in their choice of doctor and give improved certainty on the costs they are likely to face upon claiming.

Necessary criteria

Options which are not considered equitable, or are not affordable to government and individuals, cannot be implemented in practice so need not be considered further. The table below shows our assessment against these options.

Criteria	Risk equalisation support	Information on gap schemes
Equity	Unchanged	Unchanged
Affordable to government	Unchanged	Unchanged
Affordable to individuals	Mixed – can reduce prices of lower excess plans and increase those of higher excess plans	Improved (for the out of pocket component)

Both options score well against the critical criteria, although more investigation is required on the impact of changing risk equalisation support based on the excess level of the plan. We would not suggest changing RE for excess levels without also making an adjustment for product tier, as the impact of differences in product tier is larger than for excess levels within a product tier.

Important criteria

The table below assesses the option against the importance measurable/comparable criteria.

Criteria	Risk equalisation support	Information on gap schemes
Value for government	Unchanged	Unchanged (there could be a small cost in the initial creation of information if this is done by a government body)
Participation	Overall likely unchanged, but could shift towards lower excess plans	If value from PHI is perceived to be higher when uncertainty is decreased, it can lead to a small increase in participation
Market dynamics, competition and innovation	Improved: Funds may be incentivised to offer lower excess plans	Improved: Funds may compete for the best gap scheme; doctors may be incentivised to participate in gap schemes in order to attract more business.

These options perform well against the important criteria.

Other beneficial criteria

The table below considers the other criteria which, while beneficial, have lower weight than the criteria shown above.

Criteria	Risk equalisation support	Information on gap schemes
Complexity	The RE scheme becomes slightly more complex	Unchanged
Adaptability	Unchanged	Unchanged
Choice	Unchanged	Improved – there will be more information available to members to inform their choice of doctor and fund.

Risk equalisation support for lower excess options increases the complexity of the RE scheme, but it is a marginal increase compared to the overall change from a retrospective to a hybrid scheme.

Providing information on gap schemes improves choice for consumers.

Overall assessment

Our overall assessment is summarised below.

Overall assessment	Both options are worthy of further consideration.
Materiality	It is unlikely to have a major impact on outcomes in the industry.
Uncertainty	There is uncertainty around these options: Decisions on changes to RE have not yet been made, and so the impact of considering excess levels is not yet determined. Establishing reliable information on gap schemes may be time-consuming and funds or doctors may object to this information being made public.

E.2 Youth product

E.2.1 Background

This section outlines an idea for a “foundation” hospital product to incentivise greater participation by younger adults in a high-quality PHI product.

We have made a number of high-level assumptions to demonstrate the concept, however alternative designs and estimates should be considered.

We define younger people as those aged between 25 and 39, although a broader or narrower range could also be adopted.

E.2.2 Summary

- PHI for younger adults matters because people of all ages can require hospital treatment. Young people also ensure community rated PHI remains financially sustainable due to the significant subsidies between age groups.
- Current policy settings are not optimised for young adults, and this segment is frequently highlighted as one where significant change may be required. Participation rates for young adults were declining prior to the pandemic, which impacts affordability for older policyholders. Many young people who do insure buy products which are unlikely to provide them with access to comprehensive private treatment, should this be required.
- The primary PHI incentives such as MLS, PHI Rebate and LHC could be refined, but are unlikely to have a material impact on the issues in this segment.
    - For example, MLS already ensures high participation rates by younger adults who can comfortably afford PHI.
    - The economic experiment, elasticity analysis (and experience in risk rated jurisdictions such as New Zealand) suggests even significant price reductions may not materially increase participation by young people, and will not address other challenges in making PHI products more attractive.
    - In response to stakeholder concerns, a number of other policy responses have been introduced in this area including age-based discounts, dependent cover and mental health waivers. The number of government policies, PHI product choices and changing family circumstances makes PHI decision making especially complex for young adults.
- While anyone may need hospital treatment, the average expected hospital claim costs for young people are much lower than for older people. If a single, standard hospital product design is available to young adults taking out PHI, low average expected treatment needs mean it is possible to provide comprehensive cover and maintain significant subsidies to older members for an affordable premium.
- While most aspects of the product design would be standardised, insurers would be given significant discretion to offer appealing wellness or prevention benefits on these products. This forces insurers to innovate in this area, as this would be one of the few ways they can differentiate their product offering.
- This foundational product would improve PHI by:
    - Significantly improving the value of PHI for young people: Enhancing the cover available to younger people, reducing dissatisfaction of that group with PHI, ensuring participation is increased or at least stabilised, and allowing more young adults to access private rather than public healthcare when treatment is required.
    - Making PHI simpler for young people: Young adults no longer need to navigate complex product ranges and government policies, but instead have a single option which most should regard as superior.
    - Support the ongoing financial sustainability of community rated PHI, which would especially benefit older Australians: The cross subsidy to older policyholders would become an explicit regulatory decision, and stabilising participation by younger people means the ability to provide ongoing subsidies to older people is more secure. The current subsidy to older people may reduce on implementation, however initial modelling suggests the change would not be material, and there are options to reduce the impact on these policyholders.
- This tests well against criteria, and had the potential to make a material change to participation by young people. We note industry stakeholders are cautious regarding this idea, and suggest further consultation before deciding to pursue this.

E.2.3 Contents

We have structured this paper as follows:

- Examination of why PHI for young people is an important issue.
- Assessment of whether the current PHI policy settings are optimised, and the issues to address.
- Discussion of current PHI policy settings, and why refining these settings is not expected to address the challenges identified.
- Relevant statistics on young people and PHI, including income, product choices and claim costs.
- A policy idea for a single, superior product offer for young people in PHI.
- High level financial projections.
- Discussion of risks and alternative scenarios, and assessment against evaluation criteria.

E.2.4 Does it matter whether younger adults have PHI?

Young adults do access hospital and other healthcare, so there is a role for PHI in optimising the private contribution to healthcare funding.

While morbidity typically increases with age, people of all ages access both hospital treatment and other healthcare services. The table below shows the number of elective surgery admissions by age (noting elective surgery is an area where PHI makes a significant contribution to funding the Australian health system).

Table E.2 – Number of elective admissions involving surgery (all hospitals)

Age group	2018-19	2019-20
Younger age groups		
20 to 24	70,560	63,946
25 to 29	89,329	83,112
30 to 34	123,265	114,815
35 to 39	138,397	130,401
Older age groups (examples)		
50 to 54	142,684	133,434
70 to 74 (*)	250,108	238,169
85+	115,058	107,112

(*) 70 to 74 years olds are the group with the largest number of elective surgery admissions.

Source: AIHW

The group with the highest number of elective surgery admissions is 70-to-74-year-olds. The number of elective surgery admissions is around half that level for people in their 30s, and lower still for people in their 20s. However, there is clearly still a large amount of elective surgery undertaken for younger Australians, and indeed the number of admissions for younger age groups is similar to those for the oldest 85+ group (although we note there will be differences in the types of treatment provided by age group).

According to AIHW, the most common reasons for 25-44-year-olds to stay in hospital are as follows:

Table E.3 – Most common reasons to stay in hospital for 25-44-year-olds (ICD-10-AM diagnostic classification)

Rank	Female	Male
1	Pregnancy/child birth	Other factors influencing health*
2	Other factors influencing health*	Digestive system diseases
3	Digestive system diseases	Injury and poisoning
4	Genitourinary system diseases	Mental and behavioural disorders
5	Symptoms, signs and abnormal findings	Symptoms, signs and abnormal findings

(*) Includes examinations, investigations, observation, screening and other health management.

While pregnancy is the most common reason for females to go to hospital, there are a wide range of other reasons for admissions.

Mental and behavioural disorders are the third most common reason for 15-24-year-olds to stay in hospital (not shown above), the fourth most common reason for males 25-44, and not in the top 5 for females aged 25-44. However, the table below shows that younger people are more likely to require hospital treatment for mental healthcare than other age groups.

Table E.4 – Number of separations for mental healthcare (all hospitals)

Age group	2018-19	2019-20
Younger age groups		
20 to 24	32,527	35,438
25 to 29	32,428	32,485
30 to 34	36,248	35,521
35 to 39	36,718	36,684
Older age groups (examples)		
50 to 54	32,029	32,175
70 to 74	11,377	11,278
85+	5,249	4,626

Source: AIHW

E.2.5 Are PHI policy settings performing well for young people?

Summary

Indicators that PHI policy setting for younger people may not be optimised include:

- Participation: Lower for these age groups than for others, and (pre-pandemic) had been declining more quickly than for older age groups. This means this group is less likely to be able to access private treatment, should hospital care be required. This also impacts the sustainability of the community rated PHI model.
- Population requirements: Young people are more likely to purchase Basic or Bronze products than older people. These products may not cover the most commonly accessed treatments (as shown in the previous section). This means PHI could do more to reduce pressure on the public health system, and support those who choose to purchase cover.

- Policy choice by capacity to pay: For some people the product choice may reflect affordability, however young people on both higher and lower incomes predominantly choose the more basic policy options. Choosing basic policies may result in savings for policyholders in good health, but impacts the affordability of comprehensive covers.
- Satisfaction: Those who do buy PHI may not be satisfied because, should treatment be required, it may not be covered by the policy or there may be large out of pocket costs.
- Government incentives: Due to stakeholder concerns, there have been a number of policy responses for this group. The complexity of regulation is arguably greater for younger adults than for other groups, because:
  - The main policy settings (PHI Rebate, MLS and LHC) may impact people in a different way each year, as age, income and household size changes.
  - There are a number of secondary policies targeting this age group, including age-based discounts, policies which cover adult dependents, and the mental health waiting period exemption.
- Innovation / market dynamics: There is limited evidence of stakeholders using innovative approaches to encourage younger adults to buy hospital cover. In our stakeholder interviews several insurers said that innovation was limited by legislation, with wellness identified as an area where insurers would like to do more.

Basic products make a significant financial contribution to the affordability of PHI for older Australians, provide some cover for the policyholder, and allow the policyholder to upgrade over time based on their means and preferences. Young people on PHI products are currently contributing to funding Australia's healthcare costs, particularly through the risk equalisation scheme, however the above assessment shows that there is scope to improve the policy settings.

The challenges in more detail

We define younger people as those aged between 25 and 39, although a broader or narrower range could also be adopted. We did not consider under 25s as many people would be covered for free on family policies, however they could be included in a proposal.

We note the following challenges with the PHI market for younger people.

Table E.5 – PHI challenges for young adults

Issue	Description	Comment
Participation	These age segments have the lowest participation rates, and (prior to the pandemic) this was the segment with the most significant reductions in participation.	This segment is frequently identified by stakeholders as a priority to increase participation.

Issue	Description	Comment
Quality	When young adults do participate, they tend to buy relatively basic hospital products. This may be a financially rational choice for the individual, if they do not expect to require treatment. However, if treatment is required this may be for services such as mental health or pregnancy. Insurance for these benefits may be difficult to afford or unobtainable when the need for treatment emerges.	A policy which incentivised young people to buy higher quality PHI would help address these challenges.
Affordability	This group may have lower incomes and wealth than older people, and income may be committed to other costs which the individuals consider a higher priority (housing, student loans, etc).	If the aim is to at least maintain the current participation rates, the scope for large price increases is limited.
Value	Younger people have relatively low average claim costs. By design, community rated premiums will represent relatively poor value for this group.	Treat younger people as a separate risk pool, with an explicit subsidy to older members. The level of subsidy from young to old becomes an explicit policy choice.
Proof points	Stakeholder feedback indicates PHI can disappoint at the point of claim, with out of pockets being a key concern.	Insurers pay higher gaps in a way that does not result in higher inflation. An option would be to assist people to access low and no gap providers at point of claim.
Complexity – policy response	Policies have been introduced in response to some of the challenges set out above. This makes PHI especially complex for young adults, who may be at the intersection of LHC, PHI Rebate and MLS	A more compelling product offering would reduce the need for complex incentives.
Complexity – PHI products	The wide range of different product designs can make it difficult to choose PHI, especially when buying insurance for the first time.	A single compelling product choice would be simpler.
Cross-subsidy	Young people subsidy PHI for older people on more comprehensive policies. The subsidy averages around $900 per person per year via the RE system, and represents the majority of hospital premium for many young people. Declining PHI participation by young people reduces the subsidy available, putting pressure on PHI premiums for older people. Initiatives to address declining PHI participation by young people (such as allowing non-student dependents to age 31) also reduce the subsidy.	Could support PHI affordability for older people directly, e.g., via government contribution to RE pool, or increasing the PHI Rebate for older people. May be more efficient than supporting indirectly, which incentivises younger people to insure on products which provide poor value to the individuals but subside others.

E.2.6 Current response

There are two main challenges regarding PHI for young adults:

Community rating challenge

Community rating requires premiums for people in good health to be set well in excess of expected claim costs, so participation by people in good health will always be a challenge and government policy responses are required.

Youth challenge

New Zealand is an interesting reference point, as it offers everyone the choice of a comprehensive public health system and optional PHI. Health insurance is subject to similar regulations to other general or life insurance products, premiums are not community rated, and there are no government policies to incentivise PHI participation.

New Zealand health insurers are therefore able to offer low premiums to young adults in good health, and there are no regulatory constraints on insurers ability to innovate to attract new members. Policies typically exclude pre-existing conditions, pregnancy and mental health, but in other respects can offer higher benefits than Australian Gold PHI since out of hospital treatment can be covered, and large medical gaps are uncommon. In addition, it is more common for employers to offer PHI to their staff in New Zealand than in Australia, so some young people may obtain PHI at no cost.

The proportion of 20-30-year-olds in New Zealand with PHI is less than 25%, and therefore similar to Australian hospital PHI participation for this age group. The proportion of adults aged 30-60 with PHI is in New Zealand is around 35%. This indicates that, even in risk rated PHI markets, young adults are less likely to buy PHI than older adults.

Community rating means that incentives are required to ensure high participation by young adults and others in good health.

New Zealand experience suggests that, without incentives, participation rates may remain low even if young people are offered a low risk rated premium.

E.2.7 High level choices

At a high level, policies to increase participation are either:

- Mandates: While PHI is optional for all Australians, the impact of the MLS has some similarities to a mandate. If the surcharge exceeds the premium, it is irrational not to buy PHI.
- Incentives: Make PHI participation more attractive by lowering the price or increasing the benefits.
  - > The main PHI incentive which reduces the premium is the PHI Rebate.
  - > Other PHI incentives focussed on young adults include LHC, age-based discounts, student and non-student adult dependent policies, and the mental health waiver.

MLS

Some statistics on participation by age and income tier are shown later in this section. Options to increase participation by younger people include:

Table E.6 – Options to increase PHI participation by younger people using MLS

Option	Comment
Increase the surcharge percentage, to ensure even higher participation by those currently subject to the surcharge.	This has been considered as part of the MLS analysis. The impact is not expected to be material, as most young people who are high earners already purchase PHI.
Broaden the MLS to apply to more young people, so as to encourage them to participate.	MLS currently applies to singles earning more than $90k per year, with higher thresholds for couple and families. An individual with a taxable income of $90k would earn around $68,500 after income tax and Medicare levy. In Victoria, after 16% PHI Rebate, the cheapest PHI policy is around $1,000 (assuming no LHC loading), which is equivalent to around 1.5% of after-tax income. This is for Basic cover, which means that if the individual requires hospital treatment they may prefer to use the public health system. Extending the MLS to young people on lower incomes would increase participation, and reduce average premiums for everyone insured. However, this option may not be regarded as equitable, given premiums would represent a significant proportion of earnings.
Require people subject to MLS to purchase a higher level of cover to avoid paying the MLS.	This has also been considered as part of the MLS analysis. In summary: - For those on mid-levels of income (MLS tier 1), even a basic product costs a significant proportion of earnings. It may not be regarded as equitable to require these people to make a greater contribution to PHI. - For those on the highest incomes (MLS tiers 3 and 2) it could be regarded as fair to require people to buy a more expensive product, such as a Silver or Gold tier product. However, few young adults earn very high incomes, so this would not have a material impact on the contribution of PHI to total healthcare funding. In addition, buying these products would not address all of the challenges outlined earlier in this paper.

While there may be opportunities to fine tune MLS settings, it seems unlikely these changes will have a material impact on participation or other challenges relating to PHI for young adults.

Incentives

With the exception of the mental health waiver, the other PHI incentives attempt to increase PHI participation by lowering the price.

Increasing the price discount is unlikely to be the optimum option for participation by young people, because:

- Price elasticity: A large additional subsidy would be required to achieve a material increase in participation, and so may not be a financially sustainable option. New Zealand experience (risk rating provides low premiums for young people but participation remains low) supports the point that more than low prices are necessary to ensure high rates of participation.
- Cross subsidy: Some young adults are able to obtain free or low-cost PHI on a family policy, as no additional calculated deficit is payable. While these options can represent good value for the individuals involved, they do not support community rating.
- The large number of incentives increases complexity.

- The incentives do not address some of the **other challenges**, for example, in respect of out of pocket costs.

An alternative to an additional incentive to reduce price would be to incentivise more comprehensive PHI, which supports community rating and is less complex for consumers to understand.

Additional incentives which reduce the price of PHI may have only limited impact on participation, would not address other policyholder concerns, and may increase complexity.

E.2.8 Relevant statistics

The sources of data are:

- ABS data for population.
- APRA statistics for total participation.
- ATO data for income tier.
- Insurer data for product and claims information.

The insurer data shows people covered in the premium year commencing 1 April 2019, which was the last pre-COVID year. We have used APRA and ATO data at similar dates.

Each of the data sources have limitations. For example, ATO data only shows people who have submitted tax returns, and income tiers in the insurer data are those self-declared by policyholders.

Participation

The table below shows the number of people with hospital cover by age and income tier. We also show the number with general treatment only, and the participation rates.

Table E.7 – PHI participation statistics

Age	25 - 29	30 - 34	35 - 39
People with hospital insurance by rebate tier (000s)			
Tier			
0	329	475	522
1	42	83	86
2	40	99	117
3	23	70	115
Total: hospital	434	727	840
General treatment only			
	149	99	84
Total	583	827	924
Participation rate: hospital cover by rebate tier			
Tier			
0	19%	29%	36%
1	73%	80%	81%
2	73%	81%	83%
3	83%	89%	91%
Total: hospital	23%	38%	46%
Total: including general treatment			
	31%	43%	50%

The table shows that:

- Hospital PHI participation rates are only 23% for 25-29-year-olds, but this increases to 46% for 35-39-year-olds.
- Note that the tiers shown reflect individual income, however MLS is calculated according to household income. For example, some 25-29-year-olds with individual income in tier 1 may have a partner on a lower income, and so not be subject to MLS. Similarly, some people in tier 0 may have only purchased PHI because the family income means they are subject to MLS.
- Around 85% of 25-39-year-olds are estimated to be in tier 0 (income under $90k singles/$180k families), and only 27% of this group have PHI.
- Only 15% of 25-39-year-olds are in income tiers 1-3, and most already have PHI.
    - > Participation rates are very high for people subject to the MLS, ranging from 73% for 25-29 years only in tier 1, to over 90% for 35-39-year-olds in tier 3.
- In addition to those with hospital cover, up to 8% of the population in each age group have general treatment only cover.
    - > This would be an important target market for a new hospital product, as this extras-only group has shown some interest and capacity in using insurance to finance their healthcare needs.

A meaningful initiative for 25-39-year-olds would need to address the needs of those in income tier 0, since this represents 85% of the population in that age group, and most young people on higher incomes already have PHI. In particular, the product will need to be affordable for tier 0 earners.

Products

The table below shows the distribution of hospital products held, by age and income tier.

Table E.8 – Hospital product statistics

Income tier (est)	Product tier	25 - 29	30 - 34	35 - 39
Below threshold	Basic	26%	27%	21%
	Bronze	32%	24%	20%
	Silver	23%	26%	37%
	Gold	19%	23%	22%
1	Basic	39%	32%	22%
	Bronze	31%	27%	22%
	Silver	17%	22%	36%
	Gold	12%	18%	20%
2	Basic	37%	31%	22%
	Bronze	32%	27%	22%
	Silver	18%	22%	34%
	Gold	13%	20%	22%
3	Basic	33%	30%	22%
	Bronze	29%	25%	21%
	Silver	19%	21%	29%
	Gold	20%	24%	28%

For each tier, approximately half of people buy Basic/Bronze, and half buy more comprehensive covers.

The pattern is similar for each income tier and age group, however:

- The proportion of people in tier 0 who purchase Gold is higher than for tiers 1 and 2. This may be because Gold has been purchased to fund planned treatment needs.
- For each income tier, 35-39-year-olds tend to buy more comprehensive cover than 25-29-year-olds.

Premium rates

The table below shows typical premiums by product tier and PHI Rebate rate. Actual premiums vary depending on a wide range of factors, includes state, plus tier benefits included, individual loadings or discounts, and choice of excess. Based on these typical premiums, and the distributions of income and product tier shown above, we calculate the average premium by age.

Table E.9 – Typical single premium paid – by product and PHI Rebate tier

Tier	Before rebate	After 8% rebate	After 16% rebate	After 25% rebate
	Tier 3	Tier 2	Tier 1	Tier 0
Basic	1,400	1,285	1,170	1,055
Bronze	1,700	1,561	1,421	1,282
Silver	2,600	2,387	2,174	1,960
Gold	3,100	2,846	2,592	2,337

Average premium paid after rebate	
25-29	1,623
30-34	1,734
35-39	1,859

Offering a superior product for around $1,600 before PHI Rebate (between the current Basic and Bronze prices) could expect to be well received by those currently with PHI, as most products are currently sold at similar or higher prices.

If the product was priced well in excess of $1,600, it would need to demonstrate significant additional value to young people to maintain participation. Even if it were able to demonstrate high value, many would not be able to afford it given the income distribution shown previously.

Average claim costs

The table below show average claim costs by age and product tier.

We assume no RE recoveries, as these are rarely available for these age groups. In addition to these claim costs, each person is effectively required to contribute around $900 per year to subsidise older policyholder costs (via the calculated deficit and RE).

Table E.10 – Estimated average claims costs ($ per adult per year)

Tier	25 - 29	30 - 34	35 - 39
Basic	144	164	163
Bronze	305	310	326
Silver	739	754	638
Gold	1,760	1,778	1,475

Basic and Bronze average claim costs are very low, both in absolute terms and relative to the premiums. This is because these products are popular with those in good health, and the range of treatments covered is limited.

Silver and Gold provide more cover, and may be selected by people who expect to claim. However, in both cases the average claim costs for young adults are much less than the premiums, which also need to fund the net cost of RE.

For Silver and Gold, average claim costs lower for ages 35-39 than for 25-29. A hypothesis is that people may upgrade to Gold prior to a first pregnancy, but remain on Gold into their late 30s even once no more children are planned.

Including the 35-39-year age group in the youth product is helpful to the design, because compared to the 25-34-year group they pay higher premiums and have lower average claims.

E.2.9 Policy idea

Hypothesis

If you pool a large group of young people, average claim costs will be low. While participation of young people is lower than for other groups, we still have large numbers contributing and a significant revenue base.

Given the low average claim costs and revenue collected, it should be possible to construct a product which meets young peoples needs at an affordable price, while continuing to subside older peoples' claim costs.

Stakeholders have long acknowledged the challenges of PHI participation for younger adults, and have been sometimes been prepared to "bend" community rating rules for this segment. A simpler and higher quality PHI offer will:

- Allow some persistent problem issues to be better addressed, for example, out of pocket costs, access to wellness benefits, complex product choices.
- Reduce the need for government policy responses, for example, mental health waiver, extended family products, large numbers of exclusionary and high excess products.

Product concept

The table below sets out a possible produce design in more detail, and compares this to the current settings.

Table E.11 – Possible product design in detail

Product design	Current	Alternative – Foundation product for younger adults
Benefits	Wide choice – G/S/B/B and plus variants.	Standard product – suggest equivalent to Gold cover to ensure access to pregnancy and mental health services.
Excess	Typical choices $500/$750, but other choices / co-pay options are available. Higher excesses have been introduced to improve affordability, however they also add to out of pocket costs.	Standard product - $250 excess. A single, low excess choice reduces complexity, limits out of pockets, and avoids splitting the risk pool.

Product design	Current	Alternative – Foundation product for younger adults
Other out of pockets	Vary between insurer, provider and patient. Add to complexity. A source of dissatisfaction to many stakeholders.	A standardised, enhanced product which reduces average out of pocket costs, while preserving patient choice and clinical autonomy. This could involve: • A regulator sets schedule of medical reimbursements, which insurers factor into their pricing. Current minimum funding is that health funds pay 25% of the MBS fee, and Medicare pays 75%. A simple approach would be that insurers and Medicare together pay a higher percentage (more than 100%) of MBS. Further analysis would be needed here to examine the impacts for different treatment types, and an appropriate reimbursement rate. • There would also be standard reimbursements for other costs such as pathology, which can result in out of pockets. • If policyholders wish to access the higher medical reimbursement rates, they must contact insurers prior to receiving treatment, and ideally prior to seeing a specialist. The insurer provides a list of doctors who will provide cover with no or low out of pocket. The insurer would not be permitted to intervene in clinical decisions. • There is no restriction on patient choice. Policyholders can access any doctor or hospital as they do now, and receive an insurer reimbursement of 25% of MBS amount. Pre-claim contact with the insurer activates the higher reimbursements.
Wellness offer	Often limited or no offer.	Insurers have wide discretion to develop appealing wellness options. With other aspects of product design standardised, this is the key area for insurers to innovate in order to differentiate their product.

Product design	Current	Alternative – Foundation product for younger adults
Risk equalisation	No RE support unless claims exceed $50k in a year, which is rare. This means insurers have limited appetite to cover younger people with predictably high claim costs (for example people requiring treatment for pregnancy or mental health issues), meaning affordable cover is difficult to access.	This proposal is not contingent on changing the current RE system. However, the simple hybrid RE system represents a significant improvement on the current RE system. Over time, RE applying to the Foundation product could adapt differently to that applying to older people, due to product standardisation and a single risk pool.
Cross subsidy to older policyholders	Implicit subsidy to older (high claiming) policyholders through RE calculated deficit, averaging more than $900 per adult per year.	Under the hybrid RE model, we have recommended that cross subsidies between product tiers become an explicit regulator choice. The "community rating levy" charged on Foundation policyholders would be set annually.
PHI Rebate	Percentage PHI Rebate varies according to policyholder income and age.	Government subsidises premiums for young people, and young people then subsidise older people, so subsidising older people directly may seem a logical choice. However, retaining an income-based PHI Rebate for young people is preferred, as this allows premiums to vary based on capacity to pay. Alternative simpler PHI Rebate structures could be considered. For example, if the community charge levy could be funded through taxation, this PHI product would be significantly cheaper and a PHI Rebate may not be needed.
MLS	Ensures very high participation rates by those who would be subject to MLS.	Remains important to ensure high participation by those who can afford to pay, reducing average claim costs for all.
Other government policies	A range of other policies to incentivise participation and/or ensure access for younger people, e.g., cover for non-student dependents to age 31, mental health waiver, LHC.	To the extent these policies address shortcomings in the current PHI offer for young people, they can be changed or removed.

Other issues which could be considered include:

- Adults under 25 (and potentially up to 30 under recent changes): can already be covered on family policies up to age 21 at no charge, or to a later date if students or (for an additional premium) non-student dependants. We have focussed on people who are not currently eligible for these products, although could extend the analysis.
  - > Given many of those under 25 are covered at low or no additional premium at present, this new product is unlikely to be attractive to the group.
  - > An alternative would be that the Foundation product becomes the single product choice for all under 39s, including their children, and family premiums are adjusted accordingly.

- Families with only some members in the target age range: Would expect this could be conveniently administered by the insurers. For example, a family may currently purchase two separate products (hospital and extras), the product may provide different benefits for children, and different family members may receive a different PHI Rebate or LHC loading. This complexity could be allowed for in insurer IT systems, and a total price presented to the family.
- LHC: Whether LHC loadings apply to this policy, or whether the LHC start date should change to 40.
- RE and MLS: No changes to these policies seem necessary due to this product, however there may be options to consider.
- Community rating levy: What is the most appropriate level, and how should funding be provided?
- Product pricing: Is the indicative pricing above adequate, and what are the issues with varying premiums by age? Would higher or lower pricing (with adjustment to community rating levy or benefits) be more compelling for consumers?
- Consumer testing of shortlisted options.
- Regulator: Who would set the medical gap schedule, and how would this be done? What other regulatory changes may be required?
- Wellness spend: What the requirements or restrictions on insurers may be.

E.2.10 Financial projections

Key assumptions include:

- Pre-PHI Rebate premium similar to existing Bronze premium: Needs to be high enough to provide meaningful benefits to both the insured individual and the private health insurance system, and low enough to be affordable.
    - > Modest age rating to reflect increasing capacity to pay: The indicative estimates we have used in the projections below are $1,650 for 25-29-year-olds increasing to $1,800 for 35-39-year-olds.
- No change to PHI Rebate percentages.
- Average claim costs are 20% higher for each age group than under the current G/S/B/B range, due to additional benefits covered.
    - > The illustrative 20% loading brings average costs into line with current Silver experience. This would be a key assumption in the product financials, and further analysis would be required once the product design is finalised.
- Assumed average insurer spending on wellness and prevention initiatives of $100 per person per year.
- Calculated deficit replaced by an explicit “community rating levy” of $600 per person per year to subsidise PHI for older Australians and support community rating.

The assumptions demonstrate how a foundation PHI product could work, however there are a wide range of other possible policy settings.

Scenarios shown are:

- The current financials for this group, based on G/S/B/B products.
- Scenario 1 assumes the new product does not result in any change in participation of 25-39-year-olds
- Scenario 2 assumes the new design causes half of the members currently buying extras only products to take out hospital cover.

As part of the economic experiment, we asked young adults whether they would purchase Gold if offered at a Bronze price, and 69% agreed. A limitation is that only a small number of people were involved in the study, and people may not follow through on these intentions. While further testing would be necessary once the product design is finalised, the economic experiment suggests scenario 2 is plausible.

Table E.12 – Indicative financial projections

	Current		Scenario 1		Scenario 2	
			No change in participation 20% increase in average claims		Add 50% of extras only members 20% increase in average claims	
Insured persons (000s)		2,001		2,001		2,167
	$ / person	$m	$ / person	$m	$ / person	$m
Premium						
Individual	1,762	3,526	1,407	2,816	1,405	3,044
Rebate	417	834	333	666	333	722
Total	**2,179**	**4,360**	**1,740**	**3,482**	**1,738**	**3,766**
Claims						
Hospital and medical	665	1,330	798	1,596	797	1,726
Wellness / prevention	-	-	100	200	100	217
Calculated deficit	914	1,829	-	-	-	-
Community rating levy	-	-	600	1,201	600	1,300
Total	**1,579**	**3,159**	**1,498**	**2,997**	**1,497**	**3,243**
Claim ratio - total		72%		86%		86%
Proportion of premium returned to 25-39 year olds		31%		52%		52%

We note the following:

- 20% reduction in average premium for young adults.
- Increase in the amount of hospital and medical treatment for 25-39-year-olds which is funded through PHI. The assumed 20% increase in average costs funds $250m of additional treatment under Scenario 1, and $400m under Scenario 2.
- Around $200m of wellness and prevention initiatives provided.
- Annual subsidy for older policyholders reduces from around $1.8b to $1.2b-$1.3b.

The product provides much better value for 25-39-year-olds. Average premiums are lower, and the proportion of premium funding claims for 25-39-year-olds (rather than older members) increases from 31% to 52%.

The lower annual subsidy for older people would require a 2.5% average increase in premiums for this group. Alternatively, government may be able to fund part of the shortfall, for example, by freezing PHI Rebate indexation for three years.

Regarding the fairness of providing a lower subsidy to older people, we note:

- The new product still provides a significant cross subsidy to older members, equivalent to around one third of the total premium for the foundation product.
- PHI participation by 25-39-year-olds has been reducing. If this continues to occur, the subsidy to older members will reduce in any case.

- Other responses to lower participation by young people have included options which do not provide any subsidy to older people, for example, allowing adult dependents to remain on family products to age 31.

E.2.11 Range of outcomes

There are a wide range of possible outcomes. The table below discusses the main uncertainties, and the extent to which these are likely to represent material challenges.

Table E.13 – Initial risk assessment

Risk	Comment
Claim costs higher than expected, due to more treatment being undertaken in private rather than public sectors	For example, more people having a baby in a private hospital, or accessing treatment for mental health conditions. May be a positive outcome, if costs are shifted away from public sector, or unmet treatment needs are addressed. Possible responses to higher than expected costs include higher premiums for younger people, reducing the cross subsidy to older people, or additional government funding. There are limits on the extent to which costs can be higher than expected: • Large numbers of young adults will buy the product, because it is the only product choice for young people, and incentives such as MLS remain in place. The average claim costs are low because most young adults are in good health. • While out of pocket costs should be lower and more transparent than with standard PHI products, they are unlikely to be eliminated entirely. This means that, for example, people would still consider public treatment options rather than purchasing PHI.
Claim costs are higher than expected because the product design results in additional inflation, or inefficiency or unnecessary spending.	Higher medical gap payments may result in inflation, if providers are currently accepting lower rates. This risk can be mitigated by setting reimbursements at an appropriate rate for each procedure. This can be done more efficiently for this product than for others as there is a standard gap schedule for all insurers. On the wellness piece, this is intended to be the area of product design where insurers are allowed to innovate, however some regulatory controls may be necessary if there is waste.
Participation lower than expected	Beyond those strongly incentivised to insure through MLS, participation rates are already low. This limits the downside risk. There is no reason to expect significant reductions in participation by young adults due to launching this product, because indicative pricing is similar to current Bronze PHI however cover is superior.
Cross subsidy to older people lower than expected	This is also a risk under the current PHI system, if participation continues to reduce for young adults then premiums for older people will increase. Because the cross subsidy is explicit under the new product, there is greater transparency and regulatory control of the subsidy.

Risk	Comment
Market dynamics – insurers do not offer, or wellness offerings are not sufficiently compelling	There is a strong incentive for insurers to offer the product. Potentially offering a foundation product could be mandatory. Member growth and long-term member retention are part of most insurers' strategies. It will be difficult to execute such strategies without a competitive offer for 25-39-year-olds.
Transition to standard product range at age 40	If policyholders are satisfied with the offer for 25-39-year-olds, they may be dissatisfied at age 40 when they more to the standard product range and choose between either accepting lower cover or paying a higher premium. The example shown above includes higher premiums for 35-39-year-olds than 25-29-year-olds, which reduces the step up at age 40. Without a better offer for younger adults, some people may not take out PHI at all. MLS is a strong incentive for high earners to hold PHI at any age.
Older people consider it unfair that younger people can access Gold cover for a low premium	This assessment is subjective – some will consider lower premiums for young adults a fairer option. Maintaining high participation by young adults helps moderate premiums for older people, as there is a cross subsidy between products.

While further analysis would be required prior to launch, none of these issues appears to be insurmountable.

E.2.12 Stakeholder feedback

As noted above, limited consumer testing suggests young adults are positive regarding this option.

We presented this concept to industry stakeholders at a workshop in April 2022. A number of concerns were raised, including:

- Community rating: Stakeholders acknowledged that there are already age-related differences in average PHI premiums, eg, due to youth discounts and product choices. However, there was concern that separate products for young adults could be an unacceptably large change for current community rating practices.
- Impact on older members: While stakeholders support initiatives to encourage participation by younger people, there was concern that premiums for older people may increase.
- Participation: There was some scepticism that this idea would increase participation by young people, noting other policy changes (such as youth discounts) have not delivered the benefits some expect.
- Complexity: Concern regarding increased complexity due to new product types and benefits.

E.2.13 Assessment against evaluation criteria

While we have not undertaken detailed modelling, our initial assessment of this option is as follows:

Necessary criteria

- Equity: Transfers from younger to older policyholders reduce but remain material, and this does not seem to materially alter equity considerations.
- Affordable to government and individuals: Lower average premiums for young people, and a small increase for older people. Assuming no change in PHI Rebate policy, cost would move in line with changes in premiums.

Important criteria

- Value for government: The main impact is that more healthcare for 25-39-year-olds funded by PHI would suggest some transfer from the public system. Other impacts appear to be less material, for example, a high cost of the PHI Rebate if participation increases.
- Participation: While participation for young people in good health will always be challenging, a meaningful increase is possible. It is unlikely participation would reduce for any age group, given the improved value proposition for younger people, and the modest impact on premium of older people.
- Market dynamics: Standard product design effectively forces insurers to innovate in the wellness and prevention space, since this is the only available area for product differentiation.

Beneficial criteria

- Complexity: Significant reduction in complexity for younger adults, as there is a single level of hospital cover. Potential additional complexity for PHI, due to different product choices for young adults.
- Choice: Younger policyholders have only one PHI choice rather than many, however the available product appears to better meet their needs.

Our assessment is that this option tests well against the evaluation criteria. Unlike many other options shortlisted, it has the potential to materially increase participation by younger adults. However, it represents a major change in PHI policy settings, so further industry consultation should occur before proceeding further.

E.3 Data sharing

PHI funds in Australia act as funders of healthcare services, with little to no control over or insight into the services provided. However, some funds have expressed interest in working more closely with healthcare providers to design and deliver new care programs; for example, funding out of hospital care which reduces the likelihood of needing an expensive hospital admission. For example, if a patient has to fund their own mental health support (psychologist or psychiatrist care, and/or medication), they may hesitate to make use of such services due to financial reasons, and then require an expensive inpatient episode.

We note data sharing would not impact clinical autonomy, that is, there should be no restriction on a member accessing services which are clinically required and covered under their policy.

PHI funds' ability to innovate and design new support programs for members that need it can be hampered when they do not have appropriate data on their patients' needs. This lack of data exists on a number of levels:

- Funds may not receive detailed diagnostic or treatment data for their patients, especially where alternative reimbursement mechanisms are in place in hospital contracts. For example, a DRG-based payment mechanism can fully function based only on the DRG of the admission, without the specific information on the ICD-9-AM diagnosis, the MBS codes of the procedures performed, or the medication or other support provided to the patient.
- Funds typically do not receive information on the out-of-hospital care their patients receive from specialists, even when that care culminates in a hospital admission which the fund is liable to pay for.

- There is no mechanism to share data between primary care providers (such as GPs) and PHI funds. There are various obstacles to data sharing in this context, for example, primary care providers likely categorise members according to their Medicare number, while PHI funds may not even collect Medicare numbers and may not be able to use it even if they do collect it. Such obstacles would have to be removed before data sharing can be investigated. However, it is possible for innovative funds to create incentives for members to voluntarily share this information with them.

This attachment considers ways in which some of these gaps in information could be overcome.

E.3.1 Summary of findings

There are two mechanisms that have been considered to facilitate data sharing: Allowing funds to incentivise members to share data (or to visit providers who have signed up to share more data), or creating an independent data portal for all funds to share deidentified data for analysis. These have merit and broadly score well against criteria, but are unlikely to have a large impact metrics such as participation or claim costs in the short term.

E.3.2 Ways to incentivise data sharing

Data sharing occurs between data owners, and we can consider the data owners to be:

- Patients whose medical information is included in the data
- Doctors, hospitals and other providers who generate the data through their records of interactions with patients
- PHI funds that generate data through payments

PHI funds could innovate for better patient outcomes and better value if they have access to a richer source of data. This includes some data sources shown in the table below.

Table E.14 – Review of additional data sources

Data source	Type	Use case	Challenge
Doctors	Detailed diagnostic and treatment data for PHI patients (including those that the PHI fund may not pay for, such as out of hospital consultations)	Funds may be able to identify patients with high morbidity risk and offer them early intervention or hospital substitution.	The full dataset comes from various sources including GP or pharmacy data, and the fund may not even know who has relevant data.
Patients themselves	Previous diagnoses, family history, risk factors such as lifestyle choices (smoking etc)	Funds may be able to identify patients with high morbidity risk and offer them early intervention or hospital substitution.	Patients may not wish to share this information even if they are incentivised to do so
Other PHI funds	Previous claim history from patients who moved funds	A longitudinal investigation into claim patterns can help funds identify likely future claims for intervention and better predictions.	There is no single identifier to uniquely link a patient between health funds. Not all funds collect Medicare numbers, and there may be obstacles to using Medicare numbers in this way; using other personal information such as name and date of birth gives a good but imperfect link.

Data source	Type	Use case	Challenge
Hospitals	More detailed information on treatment such as doctors' notes	A richer understanding of the needs of patients which can be linked to better predictive modelling and used in initiatives such as discharge planning or contract negotiations	Hospitals may not want to share information which results in additional audit requests, or has an impact on contract discussions

Noting these challenges, we have considered two mechanisms which could improve data sharing:

Incentivise patients to share more data

Patients can be incentivised to share more data they hold themselves with their insurer, if the insurer is allowed to reward them for this. While some PHI funds have invested in mechanisms to do this outside the structure of the fund itself (such as through reward/loyalty schemes), they are not able to create such rewards inside the fund itself. One example could be that members could unlock additional benefits (e.g. more Extras cover) by disclosing certain aspects of their health or lifestyle.

In addition, PHI funds could set up data sharing arrangements with individual doctors or hospitals where they obtain a higher granularity of claims data – but these would be more effective if patients are encouraged to use participating providers (for example, through higher or guaranteed gap scheme payments, or a reduction in the policy excess level).

Such mechanisms can be made available without forcing any individual fund to participate, thereby allowing funds to innovate should they choose to do so. Funds that manage to successfully innovate on this basis could reduce claim costs, or provide better value to members.

Create a data sharing environment for funds and providers

Data sharing between PHI funds, or between funds and hospitals, can be difficult to achieve due to concerns from all parties. However, it is possible to create a deidentified data portal where data can be shared industry-wide to allow data analysis, with benefits for all parties:

- Hospitals can track outcomes for their methods and choices against those achieved by other groups
- PHI funds can track longitudinal claim patterns, to identify factors that indicate a high risk of future claims for early intervention
    - > This would require a way to uniquely identify a patient throughout the dataset, which may not be possible at the moment

E.3.3 Comparison against criteria

Both mechanisms have been evaluated against project criteria, and the findings are summarised as follows:

Criteria	Impact	Requirements
Participation	Likely no change	Met
Affordability	Potential for improvement if health funds develop effective prevention programs. Short term impact not expected to be material, as programs likely to be initially limited in scope, and there will be some initial cost to establish the programs.	Met
Government finances	As above, potential savings if prevention programs are successful.	Met
Equity	No change, as funds will not be allowed to discriminate against members based on the data shared.	Met
Market dynamics	Gives funds greater opportunity to innovate to support members health needs. Funds which are able to provide a better outcome to members would secure a competitive advantage.	Improvement

E.3.4 Overall assessment

The main short-term benefit is in respect of market dynamics. There is unlikely to be a material impact on metrics such as participation and claims while funds develop their programs. Any arrangements would need to be implemented in a way which retains clinical autonomy.

E.4 Communication

E.4.1 Stakeholder comments

The following areas were noted in respect with communication about private health insurance, and the related policies and incentives:

- Education is useful in reducing complexity
- There are multiple opportunities for communication
- Communication is more effective when it is pre-emptive

Education

There is confusion regarding the MLS, PHI Rebate, LHC, Age-based discounts, student dependents and other initiatives.

When the PHI Rebate and LHC were introduced, there was significant, government funded education around the changes and benefits, highlighted by an umbrella as a symbol of protection. Whilst an education campaign of such magnitude may not be required at this time, should significant changes be desired, a similar initiative may be warranted.

In the meantime, there are a number of opportunities for communication and education.

Opportunities for communication

Private health insurance is often considered around major life events: leaving home, starting work, establishing a new home with a partner, getting promoted, starting a family or a serious illness/injury.

At present, individuals may be externally prompted to consider PHI when:

Contact initiated by insurer	Contact initiated by the Government
They stop studying. Depending upon the age-dependant policy of the insurer, they may have to leave their parent's policy, or they may be able to remain covered until they are 30	**Department of Health and Aged Care**: Around age 30, individuals are contacted regarding LHC **ATO**: Assessible income exceeds $90,000 (for a single), an individual will retrospectively have to pay tax for any period of the year during which they did not have applicable hospital cover. However, the link between MLS penalty and PHI may not be highlighted.

Many stakeholders felt that there would be significant value in increasing the contact points, particularly those from government agencies. It has been suggested that individuals without PHI could be targeted:

- Around their decade birthdays – reminding them of the LHC implications of further delaying purchase and reminding them of potential MLS implications
- When their income reaches a trigger point BELOW the MLS threshold, thereby providing them with an opportunity to purchase PHI prior to incurring the surcharge

It has also been suggested that on registration of a birth or marriage, information could also be distributed reminding people of the benefits of PHI, and the support the private industry provides to the public system. It was interesting to note that in the economic experiment, some reported that they do not support PHI as they believe in the public system, showing a lack of understanding of how the two systems are intended to be complementary.

Pre-emptive communication

This was particularly raised with respect to the MLS, with many suggesting the concept of a trigger point at which individuals are contacted regarding the potential for them to have to contribute in future. This would be consistent with the approach taken by the existing government LHC communication.

E.4.2 Cohesion of policies

It has been emphasised by stakeholders that it is important the all the incentives work in a cohesive manner, to ensure understanding by all parties.

In addition, consultation with the industry indicated that PHI policy initiatives which are optional, such as age-based discounts and extended dependant cover, make it more challenging to develop consistent communications across the industry. However, this is not considered a sufficient reason to prevent such messages being developed and distributed.

E.4.3 BETA lens

There is some alignment with research conducted by the government's BETA team as detailed in the March 2020 Executive Deck entitled "Why are fewer young people participating in private health insurance?".

Amongst the recommendations and findings of the BETA report were:

- Provide targeted information about the age-based discount and the health benefits of PHI
- Send reminders at key milestones to improve effectiveness of current policies
- Improve decision tools to reduce complexity and help consumers make better-informed decisions

This consistency in findings highlights the importance of targeted and timely communication to support the ongoing role of private health insurance in the provision of Australia's health services.

E.4.4 Why should the government be involved in PHI communication?

Unlike other forms of insurance, such as car, home or even life, private health insurance plays a direct role in supporting broader government policies in respect of healthcare provision.

Communication from the government carries higher credibility than from insurers, who are often seen as simply selling their own products. In addition, feedback indicates that consumers are more likely to engage with "official" messaging.

For many other useful insurances, there is some form of mandate to support enrolment, for example:

- Automatic opt in for life insurance in superannuation
- Third party motor and workers compensation insurances are compulsory.

With no mandates in place in respect of PHI, and choice being considered important, there is a greater need for the government to take a more significant communication role. This is particularly relevant in respect of education regarding the government initiatives which support the industry, which in turn supports the overall health system.

In addition, whilst insurers can assist in targeting those who already have a link to PHI (eg through their parent's policies), many in the industry see targeted communication as an area where the government could take a more proactive role.

It is noted that the effectiveness of any government communication initiative would increase if insurers were to provide additional support through their own communication channels.

E.4.5 Conclusion

Whatever the policy settings adopted, their effectiveness will be increased if they are well communicated.

Government should be involved in communication, as it benefits from the effectiveness of these policies, and information from government has high reach and credibility. However, insurers can also do more to assist people making choices about PHI.

Once government has determined the policy settings to apply, it should develop and sustain an appropriate communication plan to maximise the effectiveness of these policy choices. There should be regular reviews of the effectiveness of both government and insurer communication activities relating to government policy.

In addition, in the current environment, we propose the following long- and short-term options be given serious consideration.

Short term options

Opportunities for additional communication with individuals include:

- When they become eligible for age-based discounts (just prior to their 25th birthday), in line with the BETA recommendation
- Around their decade birthdays (30, 40, 50 etc) – reminding them of the LHC implications of further delaying purchase and reminding them of potential MLS implications
- When their income reaches a trigger point *below* the MLS threshold, thereby providing them with an opportunity to purchase PHI prior to incurring the surcharge

Longer term considerations

In addition to the short-term communication options, there are a number of potential longer-term initiatives that could be considered.

- There is potential value in advising consumers of the PHI Rebate they receive, as many only consider the actual premium they pay. This could increase the perceived value of the product.
- We also support the BETA recommendation to provide tools to help consumers make informed decisions about the products they consider purchasing. We believe that improved education would assist in reducing consumer dissatisfaction, and raise awareness of the benefits and value of PHI.

Finally, broader education regarding the benefits of PHI, which could be targeted across the wider community at all life stages is also worth consideration in the longer term.