

Submission to the Department of Health and Aged Care

Re: Consultation Paper – Private Health Insurance (PHI) Incentives and
Hospital Default Benefits Studies

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Executive summary

We review and provide comments on documents focusing on the incentive arrangements for purchasing private health insurance (PHI) including rebates, Medicare Levy Surcharge (MLS) and Lifetime Health Cover (LHC).

In our view, several key recommendations in the report are not supported by current evidence. They should not form the input for PHI policy changes. Introducing these changes may have unintended consequences. They include:

- Rebates for seniors be increased in part because rebates are a “very good financial deal for the government” since medical claims paid by PHI is higher than rebates.
- Increase the MLS penalty to 2% of income for those with income higher than \$108K for singles and \$216K for families, and require them to buy silver or higher level hospital cover to avoid MLS (currently they only have to buy basic level cover).

Recommendations on rebates are based on results from their offset analysis, which we believe is conceptually flawed (see details in Section 2.1 Offset Analysis). Existing evidence strongly suggests that rebates are not self-financing and lead to net costs to taxpayers. An arguably more efficient and equitable approach is to support the public system directly, instead of through providing sizable public support to PHI aiming to release burden on the public system. Higher rebates are largely windfalls (or a pure income transfer) to those who would buy PHI anyway regardless of rebates and recipients are overwhelmingly financially better off.

Increasing MLS penalty and forcing people to buy more generous cover to avoid the MLS would make little difference to the take-up of PHI, but would further punish younger people, people living in regional areas who have limited access to private hospitals, and those who choose to support the public system by paying MLS (see more details in Section 2).

We advocate a cautious approach by retaining the current incentives (MLS, rebates, and LHC) in the short to medium term but longer-term policy changes should aim to gradually reduce public support for PHI. The ultimate goal of reforming PHI is to optimize the overall efficiency of healthcare system (both public and private system) and improve population health while saving taxpayer money. Merely increasing the take-up of PHI, which is the focus of the report, should not be the objective that drives policy changes. The system should also remain equitable, not increasing disparity in access, like the proposed recommendations will lead to.

To achieve this goal, we recommend:

- Further lowering income thresholds for rebates; rebates should be targeted for those with income lower than \$90K (singles) or \$180K (couples) and should not vary by age. Existing evidence shows that only very low-income earners are price sensitive and older adults are less price sensitive compared to younger adults. Providing rebates to those who would buy PHI anyway will not increase PHI take-up.

- MLS thresholds should be increased and annually indexed to reflect changes in earnings to target real high-income earners, without requirement for which level of hospital cover to waive MLS.

1. Introduction

We welcome the opportunity to provide feedback on reforms to the operations of private health insurance (PHI). Given our areas of expertise, our comments focus on the reports into the incentive arrangements for purchasing PHI.

As a short-term priority, we endorse recommendations to reduce the PHI rebate for high-income earners (1st point of recommendation 9) and raise and index the MLS threshold (recommendations 4 and 5). In the longer-term, we recommend the government gradually reduce public support for PHI. We believe the PHI rebate should be even further reduced and only targeted towards those on lower incomes and would support an increase in the MLS thresholds. We also recommend that rebates be applied to hospital cover, not general treatment (extras) cover ([Australian Taxation Office 2023](#)). We suggest that PHI settings be reviewed again within the next few years, with greater consideration given to the overall efficiency and equity of the Australian healthcare system.

We disagree with the following recommendations because they are not supported by existing evidence and may lead to unintended consequences.

R3: That MLS continue to strongly incentivise the highest percentile of earners to contribute to the Australian health system by buying PHI.

We disagree with this and believe the contribution of the MLS to overall demand for PHI is overstated in the Main Report. Our recent research shows that people only respond to tier 1 penalty modestly and do not respond to the higher penalties at tiers 2 and 3, and at these income levels most people already purchase PHI (Kettlewell & Zhang 2023). We note that our research employs a quasi-experimental design to identify the causal effect. We also note that many Australians pay the MLS rather than purchase PHI. The reasons for this are not explored in the Main report but are important. If these are mistakes, then it suggests the policy settings are punishing people for lack of knowledge. If it is because people would rather contribute more to the public system than to private insurers, then these preferences should be considered in the overall design of the healthcare system.

R7: That those on the highest incomes (current tiers 2 and 3) be required to buy Silver-tier or higher hospital cover to avoid MLS.

We do not support this recommendation. This would be especially punitive to younger people who have the least to gain from PHI, who may be satisfied with bronze level coverage, and who generally have the highest household debt. If there is a concern that people are not choosing insurance that meets their needs, the government could work with industry and academia on ways to improve policy choices.

R8: For those on the highest incomes (current tiers 2 and 3), we recommend the MLS be set at 2% of income.

We do not support this recommendation. If the goal is to simplify the policy arrangements, a single rate of 1.25% or (less desirably) 1.5% from tier 2 would be acceptable.

Our research suggests that people do not respond strongly (if at all) to the higher penalties at tiers 2 and 3, and at these income levels most people already purchase PHI (Kettlewell & Zhang 2023). The fact that there are people who already pay an MLS penalty well above the cost of PHI suggests people either make mistakes or are highly resistant to the MLS. Increasing the rate further would, in our view, make little difference to the take-up of PHI, but would further punish those who fail to insure.

R9: We recommend the PHI Rebate for seniors is increased.

We do not support increasing PHI rebates for seniors. Rather than targeting benefits based on age, we suggest that benefits be solely determined by income. The basis for this recommendation in the report is the results of the Offset Analysis, which as we argue below, **is based on flawed logic**. Moreover, this recommendation is problematic on both efficiency and equity grounds. Research suggests seniors are only moderately responsive, if at all, to the higher rebates they currently receive (Kettlewell et al 2018; Liu & Zhang 2022). So additional spending on this group is unlikely to achieve much in the way of higher PHI participation. Additionally, seniors are likely to be wealthier and less indebted than younger people, so the proposal is likely to worsen inequity.

The recommendations (R6 and R11) about developing MLS based on wealth, instead of income, may not be feasible in practice given the complexities of means testing based on wealth. We also suspect that the rate of PHI take-up amongst high-wealth low-income households is already likely to be high. We support initiating research to investigate the extent to which high-wealth low-income people not purchasing PHI. We already have access to data and can assist the government to investigate this.

The other recommendations (R12-R16) are mainly about regular reviews of pricing regulations and incentive policies, consumer needs, and role of PHI in the overall healthcare system. We support them in principle, and further suggest that high-quality empirical evaluations are built into the design of any policy changes, and that the government work with relevant academics on this. We would welcome the opportunity to work with the government and industry on ways to better support consumer choice and improve our integrated healthcare system. The Australian healthcare system is somewhat unusual in its dual public/private markets where private hospital care is largely duplicating public care, and supported by government subsidies. The performance of this system against the needs of society should be under constant review.

In Section 2, we provide a **critical review of the evidence underpinning the recommendations in the Main Report**. While we appreciate the efforts to quantify the potential effects of changes in the policy incentives, we note several flaws with the underlying analyses.

An overarching critique is the focus on a very narrow range of outcomes, namely participation in PHI and the age distribution of the insurance pool. **In our view, the justification for government support for PHI should be that it improves the overall efficiency of the health care system, while also ensuring the system remains equitable, in**

line with the preferences of society. Participation in PHI can be consistent with this aim, but should not be a goal in and of itself.

2. Review of the evidence used in the Main Report

2.1 Offset Analysis Report

Summary: *In our view, the offset analysis is logically inconsistent and conceptually flawed, it should not be relied on as an input to formulate policy responses.*

The Offset Analysis Report makes the argument that since the money saved in the public system by people with PHI using private hospitals is more than the government spends on the PHI rebate, the net cost to the government is negative and this is a “very good financial deal for the government” (p. 3).

We respectfully disagree as the arguments are based on flawed logic. According to the report, even if the PHI rebate has *no effect* on demand for PHI, it can still be a ‘good deal’ for the government. The idea is that the windfall benefit to those with PHI (who, it is worth noting, tend to be financially better off) is justified because those with PHI are taking pressure off the public hospital system in excess of the cost of the rebate.

This argument ignores the welfare costs to taxpayers from spending on the rebate, as well as the private benefits from owning PHI (i.e., shorter waiting times) received by those with PHI. To judge whether the rebate is good value for money, **we need to examine by how much demand for PHI goes up because of the rebate** – what the report describes as a dynamic analysis. This is the approach taken in French (2004) and Cheng (2014). The former study concludes that demand for PHI would need to be highly elastic for the rebate to be self-financing; the latter uses a microsimulation model and estimates that the rebate *is not* self-financing (although this analysis was prior to the introduction of means testing).

The Offset Analysis Report itself reports that a \$1 increase in the rebate would need to increase PHI demand by 0.11% to be budget neutral (p. 28). To put this in perspective, if we make the rough (lower-bound) assumption that premiums are equal to the offset amount in Table 10 (\$1,434), the elasticity of demand would need to be 1.6 (i.e., a 1% decrease in price increases demand by 1.6%) for additional spending on the rebate to be budget neutral. Average estimated elasticity in the academic literature is much lower than this at 0.2-0.6 (Ducket et al. 2019). Further, as pointed out on page 17, the fact that marginal joiners may have lower average claims than those already in the insurance pool (due to adverse selection) means an even higher elasticity might be required for higher rebates to self-finance. This demonstrates that **the rebate is unlikely to be self-financing** at the margin, and highlights a **contradiction between the results in the Offset Analysis Report and the conclusions drawn.**

We are also concerned about the report’s **failure to incorporate flow on effects for the public system in the modelling exercise.** Throughout the analysis, savings to the government through ‘offsets’ (spending on private hospital care that otherwise may have occurred in the public system) are treated as a social good. However, this ignores the **dependencies between public and private healthcare markets as well as equity issues.** It

is true that if a person chooses to receive treatment in a private hospital, that saves the government from having to fund that treatment in a public hospital. **But it does not necessarily improve the experience of people who rely on the public system.** In fact, PHI may even make it worse if additional demand for private procedures lures staff from the public to the private sector. This can happen if the healthcare labour market is tight and PHI induces additional healthcare use through moral hazard, which many studies suggest it does (e.g., Kettlewell & Dorion 2018; Eldridge et al. 2017). There is potentially a social benefit from lower taxes if public healthcare spending decreases; however, the distributional consequences of that benefit are unclear. All of this is to say that the use of welfarist language in the report (terms like ‘net social costs’) is misleading when there is no clear social welfare framework used to guide the analysis.

2.2 Economic Experiment Slides

Summary: *The economic experiment provides useful information on how consumers might react to policy changes in the PHI market. However, we note some weaknesses of this analysis that should be considered when deciding how much weight to attribute to these results.*

Both the LHC Report and Offset Analysis Report rely in part on information elicited through the stated preference experiment described in the Economic Experiment Slides.

Stated preference methods rely on asking consumers directly how they would behave under different hypothetical scenarios. This differs from **revealed preference** methods, which rely on observations of *actual* behaviour under different circumstances (e.g., observing how demand for PHI changes when market prices go up).

The drawback of stated preference methods is that there is often a **discrepancy between what people say and what they actually do, and therefore stated preferences can be unreliable, and the method is heavily dependent on framing of questions that could lead to wrong estimates.**

A pertinent example of how such approaches can be misleading is their use during debate around the 2012-13 PHI means testing reforms. Based on analysis using stated preference methods, the opposition government claimed that over five years “1.6 million Australians would drop cover and 4.3 million would downgrade their cover” (Dutton 2011 citing the Deloitte report: <https://www.privatehealthcareaustralia.org.au/means-testing-will-hurt-health-care-2/>). This number differed substantially from that of the Treasury, which estimated a negligible drop in PHI participation and based their predictions on price elasticity estimates from the (revealed preference) academic literature. In the end, there was no mass exodus from PHI and overall participation in fact slightly increased (Bilgrami et al. 2021).

In our view, **stated preference experiments like the one described in Economic Experiment Slides are not as reliable as estimates from revealed preferences data that use quasi-experimental methods to deal with confoundedness issues.**

We also have some comments about how the survey was designed and the results. **We are concerned the sample under-represents those without PHI.** We could not find a statistic on the percentage of the sample who have PHI, but according to slide 19, 85% of the sample would purchase PHI under the status quo in the experiment, much higher than the approximately 45% who have hospital cover today.

We also worry about the added salience of the policy incentives embedded into the experimental design. For each policy variation, participants appear to have been explicitly shown the policy change and then asked to select again, which may make them more salient than in the real world.

There are also some results that indicate consumers either **did not fully understand the scenarios, or made decision errors**. For example, on slide 14, when the MLS rate increases there are participants who appear to decide to upgrade their cover from basic to a higher level. Such choices do not make sense since a higher MLS rate does not provide an incentive to upgrade.

Finally, the report concludes that “changes in MLS rates or MLS removal have significant and sizeable effect on PHI uptake and PHI product choice” (slide 21). For several reasons, **we are not convinced that this conclusion is correct**. First, as discussed above we have some concerns about the reliability of the stated preference experiment. Second, this conclusion does not appear to consider what fraction of people are actually liable for the MLS. Third, **there is solid revealed preference evidence that suggests the MLS only explains a relatively modest fraction of demand for PHI**. The most recent study, Kettlewell & Zhang (2023), uses a 10% random sample of all tax-filers in Australia. We note this paper was not published online at the time the reports were released for consultation. In the study, we used a regression discontinuity approach (a quasi-experimental technique that aims to mimic an RCT) and estimated that for singles, the MLS increases probability of insuring from about 70% to 73% for singles and 90% to 91% for couples/families at the tier 1 threshold. These estimates are of a comparable magnitude to earlier studies. Importantly, because most people already purchase PHI at the income levels at which the MLS kicks in, and because only around 1 in 5 taxpayers are liable for the MLS, we concluded that its contribution to overall take-up of PHI is likely to be small (about 1%).

2.3 The LHC report

***Summary:** We have some misgivings about the empirical approach described in the LHC report, but we also think the estimates on the effect of LHC on PHI participation are of a reasonable magnitude.*

Finity simulated the possible effect of LHC by applying a variety of approaches. The essence of each is, as far as we can tell, to determine how responsive people with and without PHI are at different age groups using different sources of information including stated preferences from the Economic Experiment, observed ‘lapse rates’ from insurer data (propensity to retain cover for those with and without LHC) and revealed behaviour from estimates using ATO data from Kettlewell & Zhang (2021).

It is difficult to know the true effectiveness of LHC due to data constraints and confounding with other policies and factors affecting PHI demand. The most recent evidence, from Kettlewell & Zhang (2021), suggests the jump in take-up at age 31 in the years after LHC was introduced is relatively modest – only around 6%. Other related literature has estimated the price elasticity of demand for PHI, with estimates ranging from 0.2-0.6 (Duckett & Cowgill 2019), implying demand is relatively inelastic (i.e., people are fairly unresponsive to changes in premiums).

Together, these results imply that removing LHC would likely have a modest effect on participation in PHI. This is consistent with the findings of the LHC report, which estimates that removing LHC would decrease participation by only 1.1 percentage points (46.1% to 45%). However, the authors also note that because there are around 900,000 people paying LHC, and insurers retain this loading as revenue, **removing LHC would lower insurer's revenue and potentially lead to higher premiums.**

Our main concern with the LHC report is that it **does not pay sufficient attention to issues of equity.** For example, does LHC make it less likely that people with low lifetime incomes (who are unlikely to insure before age 31) are less likely to have PHI when they are older? Does this widen the socioeconomic health and healthcare utilization gaps? It would be helpful to have answers to these questions to better guide the direction of this policy.

3. Should PHI receive public support

Public support for PHI is a contentious topic in Australia. The rationale for this support has typically been that it helps to relieve pressure on the public hospital system. But using public money to prop up private healthcare is a round-about way of supporting the public system, while punishing people through taxes and penalties for not purchasing PHI raises issues of fairness, particularly when the policy settings are difficult to navigate.

It is important to recognise that Australia's current system of universal public insurance with duplicate PHI, supported by numerous policy incentives, is an unusual one. This system largely came about due to concerns over declining participation in PHI during the 1990s. The PHI rebate, LHC and MLS were all introduced to arrest this decline and indeed, they were successful in increasing take-up from around 30% to around 45% in the early 2000s. It has largely remained in that range since.

Australia could have gone down a different path, with limited or no public support for PHI. It is likely that participation would be much lower today, but not zero, since risk aversion and a desire to avoid waiting times for treatment would encourage some people to purchase private insurance anyway, as is the case in other similar countries. There would be increased demand for public hospital services, but this could be partly funded through savings on rebates. This alternative system would likely result in more equitable access to treatment, and possibly similar efficiency, as the current evidence shows private and public hospitals deliver care with similar efficiency and quality (PC 2009).

To decide whether we prefer this hypothetical system, or our current system, we would consider indicators like **mortality rates, average waiting times to receive healthcare, healthcare spending as a fraction of GDP, equity in access to healthcare and health outcomes, and how easy it is for consumers and stakeholders to navigate the system.**

Presently there is limited evidence available on how major reforms to PHI incentives might impact on the outcomes we ultimately care about. But as more integrated national healthcare data become available, more researchers can work with linked administrative datasets to

better understand our healthcare system. For example, one option is to add hospital data to the Multi-Agency Data Integration Project (MADIP).

Current evidence suggests that rebates are not an economically efficient way of increasing demand for PHI (Cheng 2014), that the LHC and MLS, which increase the complexity of the PHI market, only have a relatively small effect on take-up (Kettlewell & Zhang 2021; 2023) and that expanding PHI coverage only reduces waiting times by a negligible amount (Yang, Yong & Zhang 2023). In light of this, we suggest that overall public support for PHI should be gradually reduced and better targeted.

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