

Submission to the Senate Community Affairs Legislation Committee

**Inquiry into the Private Health Insurance Amendment
Modernising the Private Health Insurance Rebate Bill 2026**

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Inquiry into the Private Health Insurance Amendment Modernising the Private Health Insurance Rebate Bill 2026

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Executive summary

- We support the Bill. Removing the higher private health insurance (PHI) rebate for people aged 65 and over corrects a poorly targeted subsidy, and the evidence base for doing so is sound.
- Our paper, Liu & Zhang (2023), is cited in the Bill's Impact Analysis as the basis for expecting only a modest participation impact. A new working paper (Staub & Zhang, 2026), modelled directly on this reform, independently confirms that expectation using a different causal analysis approach and newer data.
- We pre-empt a likely objection — that reduced PHI coverage will overload public hospitals — with direct evidence (Yang, Yong & Zhang, 2024) showing any such effect would be marginal, and whose own conclusion argues rebate spending is better redirected elsewhere.
- We flag, without recommending amendment, that our evidence shows price-sensitivity is concentrated among lower-income older Australians and suggest the Government's planned monitoring track this subgroup.
- While our submission is focussed on empirical evidence on market behaviour, we note that independent of this there are good policy reasons to support the Bill. First, the Bill will improve equity; second, the economic rationale for incentivising older Australians to purchase private health insurance is unclear.
- We are available to provide further evidence or appear at a hearing.

1. Introduction

We are health economists whose peer-reviewed research on the private health insurance (PHI) rebate and Medicare Levy Surcharge (MLS) is cited in the Bill's Explanatory Memorandum and Impact Analysis. We welcome the opportunity to make this submission regarding the Bill in our capacity as researchers. Below we set out what the evidence says about it.

2. The evidence base for the Bill's key assumption

2.1 Liu & Zhang (2023)— the paper cited in the Impact Analysis

The Impact Analysis cites Liu, J., & Zhang, Y. (2023), 'Elderly responses to private health insurance incentives: Evidence from Australia', for the claim that older Australians "tend to be less sensitive to changes in insurance prices" (Section 1) and for the assumption that around 99% of the roughly 3.2 million affected older Australians will keep their cover under Option 2 (Table 16).

That paper used the 2005 age-based rebate increase — to 35% for those aged 65–69 and 40% for those 70 and over — as a natural experiment, with administrative tax data from 2001–2012. We found implied price elasticities of demand of -0.10 to -0.20 for older Australians, well below the -0.2 to -0.5 typically found for the general population. Older Australians are, on average, considerably less price-responsive than younger cohorts — the finding the Impact Analysis correctly relies on.

This finding is independently corroborated. Kettlewell, N., Stavrunova, O., & Yerokhin, O. (2018) studied the same 2005 rebate increase using a regression discontinuity design on New South Wales survey data around the age 65 and 70 thresholds. Using a different team and a different dataset to Liu & Zhang (2023), they found the higher rebate had no statistically significant effect on PHI take-up in this age group, concluding it is best interpreted as a wealth transfer to older Australians who would have held cover regardless, rather than an effective participation incentive.

2.2 Independent, contemporaneous confirmation: Staub & Zhang (2026)

Since the Bill was introduced, two of us completed Staub, K.E., & Zhang, Y. (2026) modelled directly on this reform. It is a working paper, not yet peer-reviewed, and we flag it as such.

Using linked administrative data from the Person Level Integrated Data Asset (2010–2020), it separately identifies the rebate's demand effect from the MLS's for the first time — previous studies, including our own, could only estimate their bundled effect. Applied to this Bill's proposed equalisation, it predicts PHI take-up among singles would fall by roughly 0.39 to 1.40 percentage points depending on age group. This is not directly comparable to the Impact Analysis's own -1.2% estimate for the 65+ population (Table 18), which measures a different quantity — the relative change in the total number of insured people aged 65+ (singles and families combined) — rather than an absolute percentage-point change in individual coverage probability for singles. The two figures nonetheless point in the same direction and are of a broadly similar order of magnitude, providing independent corroboration from an entirely different dataset and identification strategy. We estimated 14,821–42,498 older Australians would drop their cover, with the upper number roughly in line with the government's own modelling of about 44,000 older Australians dropping their cover. It further finds the fiscal saving is largely 'infra-marginal': the rebate is currently paid to many older Australians who would keep their cover regardless, consistent with the Impact Analysis's rationale for why the age-based uplift is poorly targeted.

2.3 Complementary evidence: Kettlewell & Zhang (2024)

Kettlewell, N., & Zhang, Y. (2024) found that high-income Australians are also largely price-inelastic to rebate and MLS changes, with little evidence of downgrading when the rebate is lower. This supports the Government's choice of Option 2 over the more aggressive Option 3 considered in the Impact Analysis, which would additionally have cut the rebate across income tiers: low price-sensitivity holds across both age and income dimensions, so the narrower, age-only change in this Bill is the proportionate one.

2.4 Real-world precedent: the 2012 rebate reform

Bilgrami, A., Cutler, H., Sinha, K., & Cheng, Z. (2021) evaluated the actual effect of the 2012 reform, which means-tested the rebate for the first time and removed it entirely for the highest income tier. That reform bundled a rebate cut with an increased tax penalty (the Medicare Levy Surcharge, or MLS) for higher earners, so its headline finding — a small net increase in PHI take-up of about 1.5 percentage points on average — partly reflects the offsetting effect of the stronger penalty.

2.5 Anticipated concern: pressure on public hospital waiting times

The Impact Analysis itself flags a risk that reduced PHI cover could increase public hospital waiting times (Section 4.3, Table 10). We expect this to be raised by opponents during the inquiry, so we address it directly.

Yang, O., Yong, J., & Zhang, Y. (2024) used linked hospital administrative data and an instrumental-variables design to estimate this relationship directly, finding that a one percentage-point increase in the PHI coverage rate reduces public elective waiting times by about 0.34 days (0.5%) on average — statistically significant but practically small. The Impact Analysis's own Table 18 estimates a 1.2% relative reduction in the number of insured people aged 65+ under this Bill; applying Yang et al.'s coefficient directly to this figure — even though it is a relative change in insured count rather than a percentage-point change in the coverage rate, which if anything makes this an upper-bound, conservative application — implies an effect of a few tenths of a day at most. This is not a material deterioration in access, and is consistent with the Impact Analysis's own assessment. Public hospital overload is not a sound basis for opposing this Bill.

That paper's own policy conclusion goes further, and is directly relevant to this Bill's rationale: it finds the waiting-time benefit of PHI subsidies is too small to justify their fiscal cost, and recommends redirecting that spending to other health priorities rather than using it to chase further PHI take-up. This is the same logic underpinning the Bill's proposal to redirect the savings from equalising the rebate toward aged care.

This fiscal logic is independently confirmed by an earlier, separate study. Cheng, T.C. (2014) modelled the effect of reducing PHI premium subsidies directly, using a simultaneous-equation microsimulation and Australian survey data. It found that because demand for PHI is price-inelastic (implied elasticities of -0.32 to -0.35) and because insured and uninsured individuals do not differ in how intensively they use hospital care, the fiscal savings from a reduced rebate consistently and substantially exceed any resulting increase in public hospital expenditure, across every reduction scenario modelled. Using different data and methods to Yang, Yong & Zhang (2024), this is an independent confirmation of the same conclusion the Bill's Impact Analysis reaches: redirecting rebate expenditure delivers a net fiscal benefit even after accounting for flow-on effects to the public system.

2.6 Other reasons to support the Bill

While our submission is focussed on empirical evidence on market behaviour, we note that independent of this there are good policy reasons to support the Bill.

First, the Bill will improve equity. If we want to target financial support to those most in need of support, income is a better basis to achieve this than age. Even after the proposed change, because of community rating, older Australians will continue to receive substantially more in benefits than they contribute in premiums.

Second, the economic rationale for incentivising older Australians to purchase private health insurance is unclear. The policy runs counter to other incentives such as Lifetime Health Cover Loading and premium discounts for people aged 18-30 years, which are designed to encourage younger people to enter the market. While encouraging older people to privately insure may help to relieve pressure on public hospitals, it also puts upward pressure on premiums, making private insurance less affordable for younger people and undermining benefits to the public sector.

3. Conclusion

We support passage of the Bill. Removing the age-based rebate uplift is well supported by peer-reviewed evidence, including our own research the Impact Analysis relies on, and independently confirmed by newer analysis modelled directly on this reform. We recommend only that post-implementation monitoring, already committed to, be disaggregated by income where possible. We are happy to provide further information or appear before the Committee.

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