

Submission to Department of Health, Disability and Ageing: Private Health Reforms - Consultation Paper 1

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Executive summary

- We have written this submission in our capacity as academic health economists with extensive past and ongoing research on the private health insurance market. Our submission addresses parts of the consultation paper that align with our research expertise. Wherever possible, our responses are underpinned by relevant empirical research.
- Overall, we support reforms that improve transparency, simplify products, and help consumers make more informed choices.
- We do not support reducing the maximum waiting period for pregnancy and birth services, or extending obstetrics to lower-tier health insurance. Both proposals are likely to increase the cost of private cover for the general population.
- More broadly, we encourage policymakers to keep sight of larger structural issues affecting the private health insurance system, including the role of the Medicare Levy Surcharge, the sustainability of community rating as the insured population ages, and the long-run balance between equity, affordability, and market viability.
- We also do not support standardising the age threshold for dependants without a disability. Our preliminary research finds that the 2021 extension of the dependant age mostly recomposed young-adult coverage rather than expanded it, and to the policy primarily benefits young people whose parents already hold private cover.
- Any policy changes should be informed by data, and subjected to rigorous post-implementation monitoring and evaluation. The availability of large linked administrative data provides new opportunities to evaluate policy settings, which we have demonstrated through recent evaluations of private health insurance incentives, as well as other ongoing work discussed in this submission. We would welcome the opportunity to work with the Department on more targeted research to inform reforms to the private health insurance system.

Introduction

We welcome the opportunity to provide feedback on the *Private Health Reforms - Consultation Paper 1* (the Report). Our commentary is informed by our backgrounds in applied health economics, and our research experience in the Australian private health insurance (PHI) sector, including current projects that are relevant to some of the proposed reforms. Further details on our backgrounds are provided below. Our feedback focuses on the questions in the report that align most closely with our research experience and expertise.

Bios

Nathan Kettlewell is an associate professor in the Department of Economics and Marketing at the University of Technology Sydney. He previously worked as a policy analyst in the Australian Treasury between 2010-12, where he was involved in the development of legislation to means test the private health insurance rebate. His research expertise is in applied and behavioural economics, and he has published many articles about the Australian private health insurance market, focussing particularly on consumer demand, evaluation of government policies, and understanding how insurance affects healthcare decisions.

Ali Yasin Vergili is an early-career researcher in the Department of Economics and Marketing at the University of Technology Sydney. His research is in applied health economics, with a focus on large-scale linked administrative data, and has been published in *Demography*. His current projects study the Australian private health insurance market, including demand for insurance around family formation and the effects of the 2021 age-of-dependants reform, using the ABS's Person-Level Integrated Data Asset (PLIDA).

Yuting Zhang is Professor at the Melbourne Institute of Applied Economic and Social Research, University of Melbourne, and Founding Director of the Health Analytics, Leadership and Economics (HALE) Hub. She is a current Australian Research Council Future Fellow (2021–2026). Her current research uses whole-of-population linked administrative data — including Medicare, hospital, tax files and the ABS's Person Level Integrated Data Asset (PLIDA) — to study private health insurance design, specialist fees and out-of-pocket costs, and Medicare policy. Her work on private health insurance incentives has directly informed government analysis, including the Parliamentary Budget Office costing that underpinned the May 2026 budget decision to remove age-based tiers from the PHI rebate.

Consultation report feedback

Section 1.2 Maternity care

Initiative 3: Shorter PHI waiting periods for privately provided pregnancy and birth

Do you agree or disagree the maximum waiting period should be reduced for the 'Pregnancy and birth' clinical category? Please specify why.

Summary response: We do not support reducing the maximum waiting period. Waiting periods play an important role in minimising 'hit-and-run' behaviour, in which consumers purchase insurance in anticipation of using it and then drop their cover afterwards. This type of behaviour is a form of 'adverse selection' and it undermines the viability of the insurance market. Our research shows that the 12-month wait disciplines the timing of birth-motivated purchases and limits enrolment timed to a single large, planned claim and dropped afterwards. Reducing the maximum would mainly ease entry for episodic purchasers, whose claims would be funded by all other policyholders through community-rated premiums, and the equity benefit is doubtful: the households best placed to exploit a shorter wait are those able to afford private obstetric care and a year of premiums at short notice. Insurers can already offer shorter waits at their discretion and generally do not, which is itself informative about where they judge the selection cost to lie.

Additional details and relevant research

Doiron and Kettlewell (2020) estimated that desire to have additional children increased demand for PHI by younger women (aged in their 20s through to early 30s) by around 2.6 percentage points, but that coverage fell with the age of the youngest child, implying a pattern of purchasing insurance as part of family building, but (for some) leaving the market after reaching the desired family size. A limitation of this study was that family aspirations were crudely measured, based on desired family size by age 35 (rather than short-term goals), which may have led to an underestimation of the true effect on demand for PHI.

We (Kettlewell and Vergili)¹ are currently building on this earlier work by using linked administrative whole-of-population data (the ABS's PLIDA asset) and actual births (rather than future aspirations) to more accurately track demand for PHI around family formation. While this research is still ongoing, given its relevance to the proposed reforms we have decided to share some early results in this submission.

In our research, we observe around 2.5 million parents with a first birth between 2013-14 and 2022-23, with private hospital cover measured annually from tax records (counts rounded under ABS output rules). Three findings bear directly on the proposal.

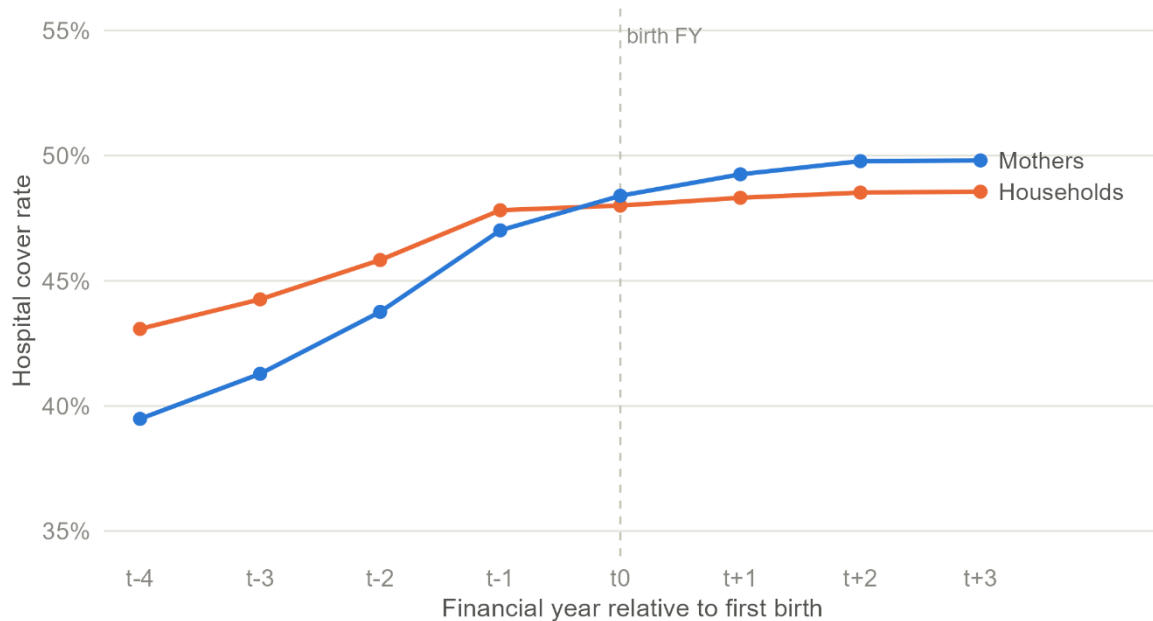
First, demand for hospital cover is strongly timed around family formation. Mothers' cover rises from 39.5% four financial years before a first birth to 47.0% the year before and 48.4% in the birth year, and stays near 50% for at least three years afterwards. Among mothers covered in the birth year, one in three first became covered in the window from two years before the birth year to the birth year itself, and their timing tracks the waiting period, with take-up tapering off in the year leading into the birth.

¹ We also acknowledge our collaborators on this research: Denzil Fiebig, Kei Liu, Vanessa Scarf and Serena Yu.

Figure 1:

Hospital cover ramps into the first birth and stays up

Share with private hospital cover, by financial year relative to the first birth



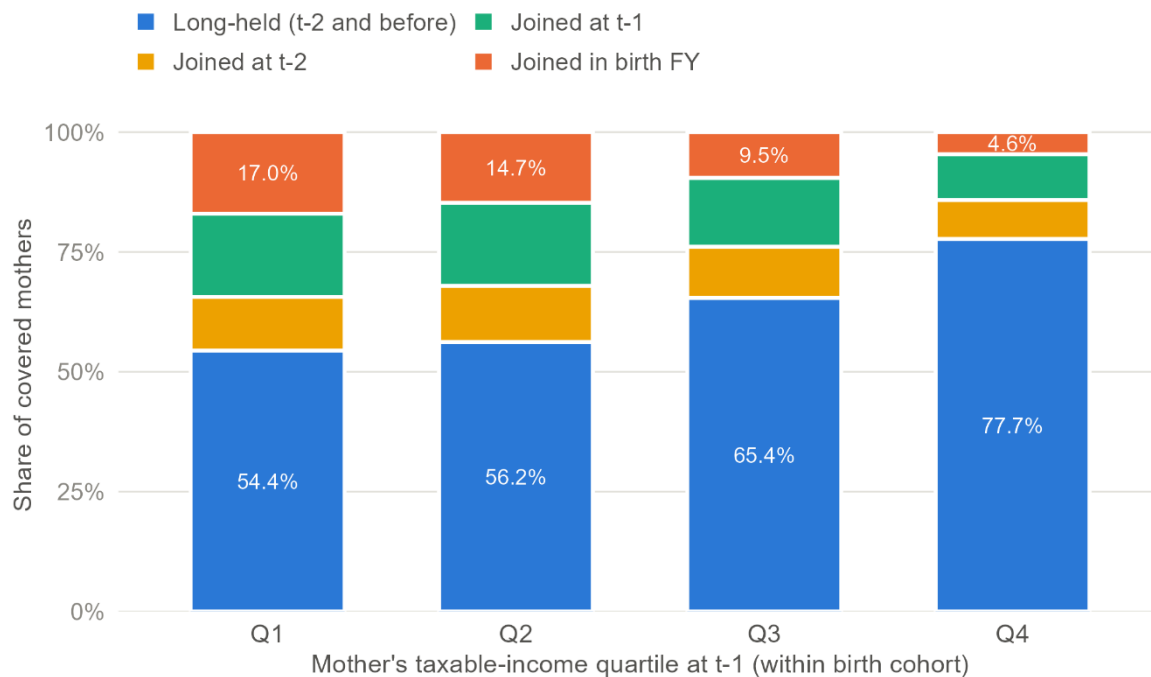
Notes: Authors' calculations from ABS PLIDA linked administrative data. Parents with a first birth in FY2013/14 to FY2022/23 (around 2.5 million parents), linked to their income tax returns. Hospital cover is the private hospital cover indicator on the tax return; t denotes the financial year relative to the birth FY. Counts rounded under ABS disclosure rules. A household is covered if either parent is.

Second, the group that insures too late to serve the waiting period is modest though skewed. One in ten covered mothers obtained cover only in the birth year itself. This is concentrated at the bottom of the income distribution: 17.0% of covered mothers in the lowest income quartile against 4.6% in the top, while 77.7% of top-quartile mothers held cover from at least two years out. This does not tell who would respond if the waiting period was reduced, but intuitively, higher-income women would have greater means to respond.

Figure 2

The income gradient in clearing the wait

Composition of covered mothers by taxable-income quartile at t-1



Notes: Authors' calculations from ABS PLIDA linked administrative data. Parents with a first birth in FY2013/14 to FY2022/23 (around 2.5 million parents), linked to their income tax returns. Hospital cover is the private hospital cover indicator on the tax return; t denotes the financial year relative to the birth FY. Counts rounded under ABS disclosure rules. Covered mothers; quartiles of the mother's taxable income at t-1, within birth cohort.

Third, birth-timed purchasing is already partly transitory even with the wait in place. Of parents who first became covered the year before the birth, 23% no longer hold cover one year after the birth year and 27% within three years, roughly double the exit rate of incumbent policyholders. Incumbent families instead upgrade: their premiums roughly double into a first birth (from around \$1,040 four years out to around \$2,420 in the birth year, nominal), and 29% of incumbent households raise their household premium by \$500 or more in the year before the birth.

Initiative 4: Review of product tier structure

e) Do you agree or disagree the 'Pregnancy and birth' clinical category should be a minimum requirement of a product tier other than Gold?

Summary response: We do not support this proposal. This change is likely to significantly increase the cost of lower-tier insurance products in the short-run and lower the overall level of coverage in the long-run.

Additional details and relevant research

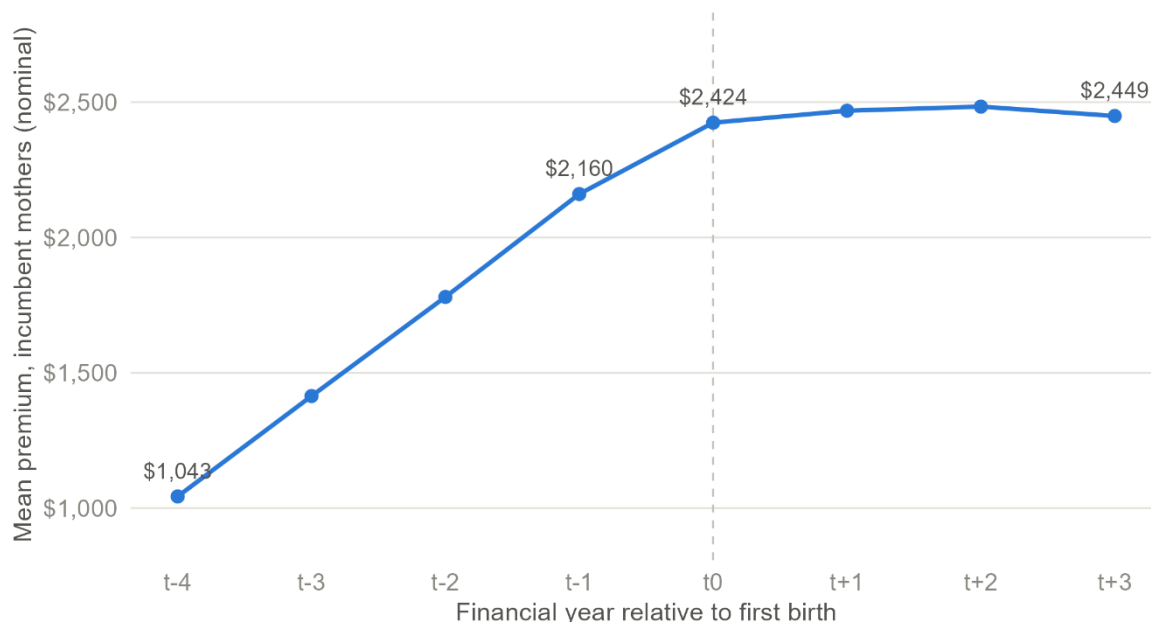
Our research discussed above shows family planning is a significant factor in the demand for PHI. At the same time, many of the services covered under Gold-level cover are unlikely to be of much value to women of child-bearing age and their spouses. For this reason, it is likely that many people would lower their level of cover, putting upward pressure on premiums for lower-level

cover, and crowding out consumers who don't need Gold coverage. The potential for this is demonstrated in our ongoing research, where we observe that average premiums rise steeply in anticipation of parenthood, more than doubling in the four years to first birth.

Figure 3

Incumbent mothers' premiums double into the birth

Mean rebate-eligible premium by event year, mothers who held cover from t-2 and before



Notes: Authors' calculations from ABS PLIDA linked administrative data. Parents with a first birth in FY2013/14 to FY2022/23 (around 2.5 million parents), linked to their income tax returns. Hospital cover is the private hospital cover indicator on the tax return; t denotes the financial year relative to the birth FY. Counts rounded under ABS disclosure rules. Premiums are nominal rebate-eligible amounts (hospital plus extras). Mothers who held cover from t-2 and earlier.

At the same time, it is not clear that the policy would do much to increase coverage levels since price elasticity for PHI is relatively low, at around 0.35-0.5 (Duckett et al. 2019).

Our ongoing research on plan switching (discussed later) also suggests a high degree of inertia (pick-and-stick plan selection), which implies that families may stay with the level of cover they select, even after they finish family building. If this is a lower level of cover, then we may see an overall drop in the percentage of people with Gold-level cover.

Section 1.3 Hospital in the home

Apply a minimum hospital benefit for HITH of \$360 per day for an initial tranche of 3 treatment services:

- *intravenous (IV) infusions*
- *complex wound care, and*
- *palliative care.*

MBS benefit for eligible medical services provided to the patient would be 75% of the Schedule item fee. Insurers would be required to pay the additional 25% of the Schedule item fee.

Summary response: While we defer commentary on the clinical aspects of this proposal, we offer principled support to the broad idea. Given the complexity of PHI plans, consumers are often uncertain about what they are covered for, and how much their insurance will cover. As the report notes, hospital in the home is sometimes an attractive alternative to hospital-based care. A minimum benefit for this would provide a degree of harmonisation across plans and thereby constitute a small step in the way of less uncertainty for consumers. At the same time, given the limited number of applicable services, this is unlikely to put meaningful cost pressure on PHI premiums.

Section 2.2 PHI product simplification

Initiative 1: simplifying PHI product structure

Summary response: We broadly support reforms that reduce the complexity of PHI noting that “this is the initial tranche of consultation on product simplification which will be used to inform independent technical expertise prior to further consultation”. Greater standardisation of products would reduce the uncertainty consumers face over what they are covered for and may improve consumer satisfaction.

Additional details and relevant research

There is considerable international evidence that people struggle to make optimal choices in health insurance markets, such that such ‘choice frictions’ (Handel and Kolstad 2015) and low comprehension (Loewenstein et al. 2013) have become somewhat stylised facts. Kettlewell (2020) used a hypothetical discrete choice experiment resembling health insurance choice in Australia and found that when private hospital cover was bundled with general treatment (‘extras’) cover, this caused people to underweight premiums, and make choices that implied they valued product features by more than they could possibly get back in benefits. The study also found that only around 35% of working-age people could correctly identify what an excess is and 38% what a co-payment is.

While there is relatively little quantitative research on the quality of plan choice in Australia, it is likely that the choice inconsistencies documented in other markets carry over (see e.g., Willis and Lewis, 2015). Australian PHI is a particularly obscure product for consumers to evaluate. Its benefits duplicate services provided for free in the public hospital system, so to make an informed choice consumers need to first have some sense of the counterfactual public system care they would receive. They then need to understand their risk across a large suite of potential hospital separations, and then understand whether a plan covers those risks, and to what extent. The actual extent of coverage is often not clear a priori; it depends on the individual doctor, hospital and negotiated contracts with insurers. This leads to so called ‘bill shock’ and large out-of-pocket costs (Ludlow et al. 2024).

It is important to recognise that improving choice architecture might not be enough to guarantee a high level of ‘optimal’ plan selection. Experiments on plan selection tools have documented somewhat modest improvements (Abaluck & Gruber 2023; Quiroga Gutierrez & Boes, 2024). One of the main ‘choice frictions’ that has been documented in the literature is so-called inertia, or ‘pick and stick’ behaviour. We (Kettlewell and Zhang) have recently started to investigate this in

Australia. Again, while this research is still ongoing, given its relevance to the proposed reforms we have decided to share some early results in this submission.

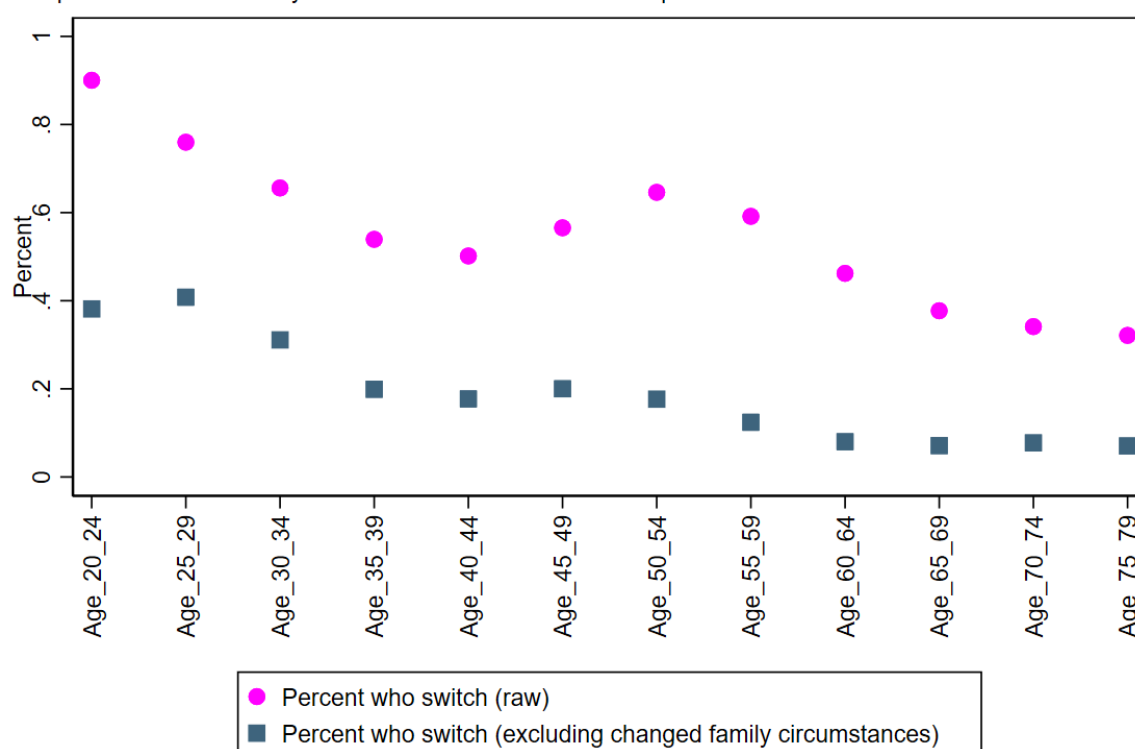
In our research we use a 10% longitudinal sample of taxfilers observed between 2012-13 to 2020-21 (ATO's ALife dataset).

Our first observation is that switching health insurance plans is fairly common – around 28% of those with insurance change their policy in a given financial year. However, this is *largely artificial and driven by mechanical updates to policies due to changes in family circumstances* from having children, coupling and decoupling.

Figure 4 plots the percentage of people continuously insured who have at least one plan switch between 2012-13 and 2020-21 by age group. The unconditional switching rate is quite high, especially for younger people. However, if we exclude switches in financial years in which the person also had a child and/or they coupled/separated, the rate is much lower; for those 50 or older more than 80% stick with the same plan over almost a decade.

Figure 4

What percent of continuously insured taxfilers had at least one plan switch between 2012-13 and 2020-21?

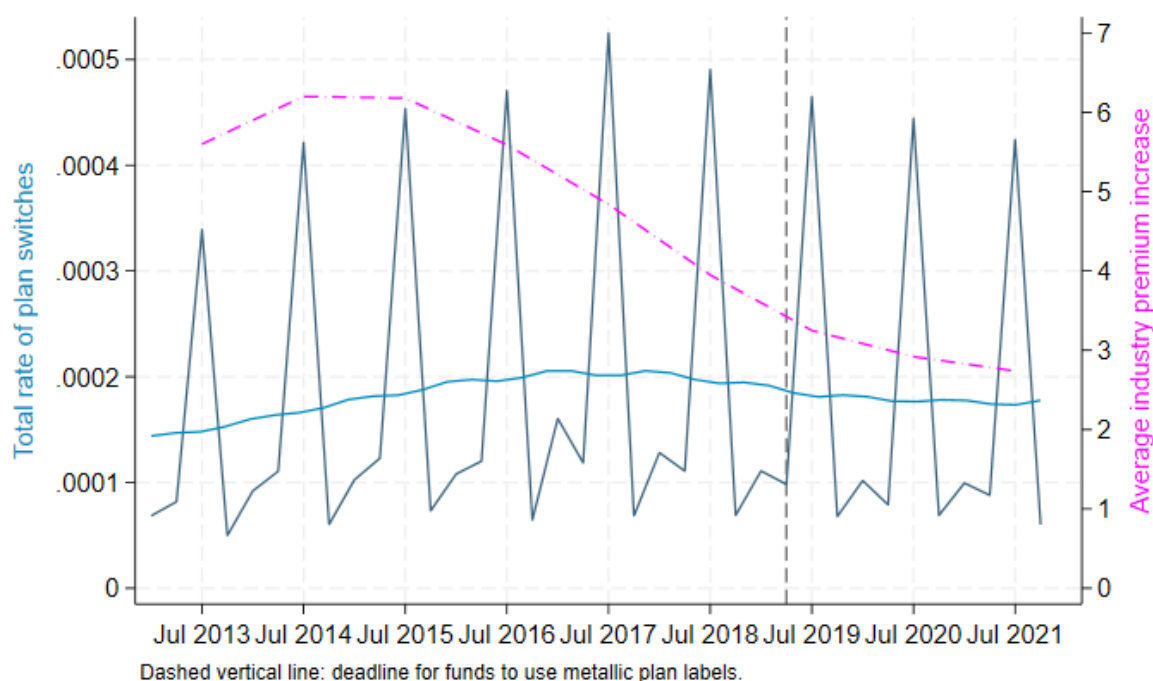


Authors calculations using ALife data (2012-13 to 2020-21)

Our research has also identified *strong seasonality to switching decisions*; switching peaks around July each year, which follows from policy incentives that encourage people to be insured at the beginning of financial years (e.g., Lifetime Health Cover Loading and Medicare Levy Surcharge). It is also slightly elevated around April which coincides with when insurers traditionally increase their premiums. *If there were targeted efforts to engage with consumers about health plan choice, these ‘switching windows’ may be optimal periods to provide information.*

The rate of plan switching has decreased since 2017. Annual premium increases were substantial between 2012-13 and 2016-17 (Figure 5), which may explain higher levels of switching during this era, although causality is unclear. We do not observe a clear change in switching behaviour at the introduction of metallic product labelling.

Figure 5



Notes: Authors' calculations using ALife data (2012-13 to 2020-21). Average industry premium increases are from the Department of Health, Disability, and Ageing. Rate of plan switching is calculated as the number of plan changes divided by the number of people insured at the day level. Dark blue line is the quarterly switching daily average; lighter blue line is smoothed local polynomial trend.

We now turn to the specific ideas to simplify PHI raised in the report.

Remove the flexibility of insurers to offer the Basic product tier or products of limited value to consumers.

Summary response: Given that Basic-tier cover is often held primarily to comply with the MLS rather than for its insurance value, we suggest it be considered in parallel with possible changes to MLS policy, rather than being changed in isolation.

Additional details and relevant research

Our research shows that both the MLS and the PHI rebate have only small-modest effects on singles' coverage decisions, and that once the two are converted to a common dollar basis, they are comparably persuasive — if anything, the rebate slightly more so (Staub and Zhang 2026). It shows that at least some current policyholders are holding cover partly because of the MLS, not purely for its insurance value. For people who only purchase PHI to avoid the MLS, Basic PHI is an attractive option. This can include people for whom PHI offers little value, including young people and those living in regional areas. Removing this class of products will potentially reduce the size of the insurance pool and increase the degree of redistribution of funds from low-risk to high-risk people.

Other research of ours suggests the overall contribution of the MLS to participation in PHI is relatively small (perhaps as low as 1 percentage point of the market) (Kettlewell and Zhang 2024). So the risk, in terms of market participation, may be small. The issue of equity raises a larger question about the MLS; should we compel people to purchase insurance they do not necessarily need or want as a way of cross-subsidising higher-risk claimants? Would a capped penalty, allowing for a more even choice between paying the tax to the Government versus paying insurers, be a fairer structure for the MLS?

Minimum coverage requirements should not be changed in isolation without considering these important questions about MLS policy.

Remove the option for insurers to offer ‘plus products’.

Summary response: We support this idea in principle. Broadly, narrowing the range of product types will reduce the uncertainty consumers face about what procedures they are covered for, and facilitate an easier comparison between competing insurance plans.

Additional details and relevant research

Although we support this idea, we note it would also reduce the flexibility for insurers to tailor policies to the needs of consumers. For savvy consumers, this flexibility may allow for choosing insurance better aligned to needs and preferences. *Regardless of whether plus products are allowed or not, the Government should also consider ways to facilitate better informed choices between health insurance plans.* This could, for example, be through the development of more transparent plan comparison tools that compare expected out-of-pocket costs, wait time, and health outcomes, for different plans given the medical needs and location of the consumer. The potential for AI to assist with this could also be explored.

Remove or consolidate some of the product tiers

Summary response: We support this idea, and refer to our response immediately above for additional details.

Ensure insurers clarify communication about whether a consumer has a hospital-only product or a combined product

Summary Response: We support this idea. We would also support choice support initiatives that make the expected benefits from purchasing general treatment insurance more transparent to consumers.

Additional details and relevant research

General treatment policies tend to operate at relatively high profit margins (around 17% in 2026 to March; APRA 2026), despite the fact that the benefits for the services they cover are generally capped. This may be due to the complexity of these products, in part because they cover multiple distinct medical services, with varying limits on insurer contributions.

Results in Kettlewell (2020) suggest that when general treatment and hospital cover are bundled into a single product, consumers may neglect certain information (including price), which supports greater transparency for consumers regarding the separate costs of each type of insurance. See also Kettlewell (2019) for evidence that people do not select into general

treatment insurance on the basis of high joint risk of using general treatment services (e.g., dental and physiotherapy), as an optimal decision maker might be expected to.

Initiative 2: standardising the age threshold and associated eligibility for dependants

Summary response: We do not support the proposal to standardise the age thresholds for dependants without a disability. This policy would benefit a narrow group of young people whose parents are PHI holders, and to date, there is little evidence extending the allowable age of dependent children has meaningfully lifted participation in PHI. Our preliminary research suggests the small increase in people covered as dependent children has been largely offset by a reduction in own-coverage.

We (Kettlewell and Vergili) and co-authors are studying the 2021 age-of-dependants reform using the ABS's PLIDA asset, where cover as a dependant can be identified from the private health insurance claim code on a person's own tax return. Because a non-student dependant aged 25-31 was not possible before the reform, the post-reform dependant share at these ages is a direct measure of take-up. It has grown steadily but remains modest: 0.5% of 25-31 year olds in 2021-22, 2.4% in 2022-23 and 3.8% in 2023-24, concentrated at the younger end of the band (6.1% at ages 25-27 against 1.0% at 28-31 post-reform).

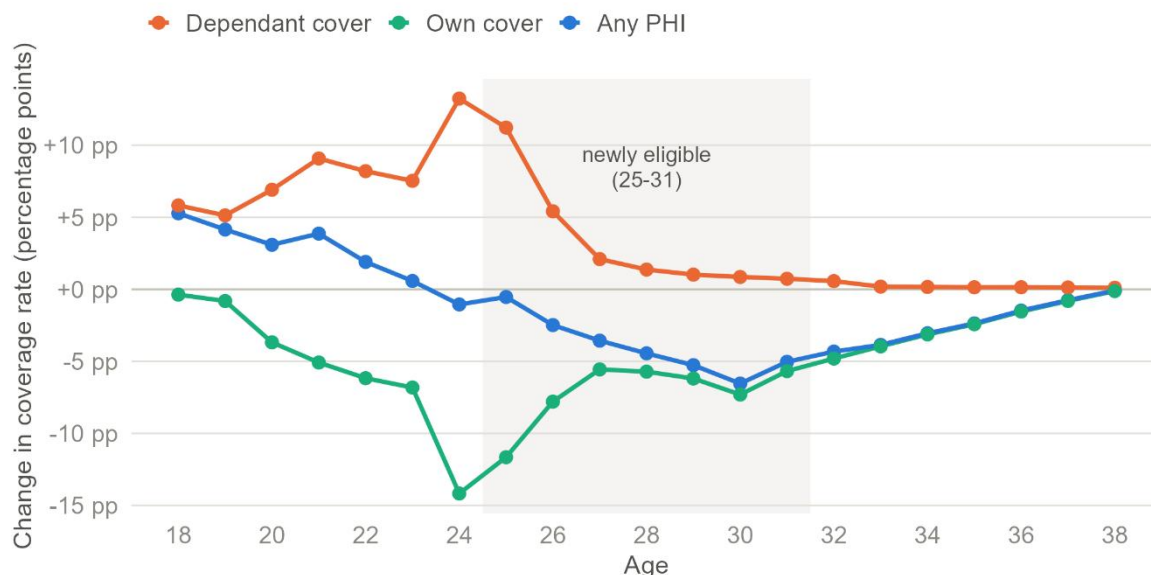
This increase has not translated into higher overall participation. Relative to an older comparison group (ages 33-35), own-policy coverage among 25-31 year olds fell by around 3.8 percentage points over the same window in pooled comparisons, while within-person estimates are close to zero. In other words, young adults who would previously have bought their own policies are instead remaining as dependants on their parents' cover, rather than existing policyholders dropping cover. The net effect on overall coverage (dependant or own) at these ages is under one percentage point in either direction across specifications, an order of magnitude smaller than the rise in dependant cover. Figure 6 illustrates this recomposition: across every young-adult age, the rise in dependant cover is mirrored by a fall in own cover, leaving overall participation little changed relative to the older comparison group.

Since dependants can generally be added to a family policy at no additional premium, this recomposition adds claims exposure without adding premium revenue, and the benefit accrues only to young people whose parents hold (and can afford) PHI. With no clear improvement in market participation and a regressive incidence, we see no case for extending the dependant age further, though we see no issue with the provisions for dependants with a disability.

Figure 6

The 2021 dependant reform recomposed young-adult cover, not expanded it

Change in coverage rate by single age: post-reform minus pre-reform, tax-filer panel



Notes: Authors' calculations from ABS PLIDA linked administrative data (tax-filer panel, FY2012/13 to FY2023/24; around 68 million person-years at ages 18 to 38). Dependant cover is identified from the private health insurance claim code on the person's own tax return; any PHI combines dependant and own cover. Pre-reform is FY2012/13 to FY2020/21, post-reform FY2022/23 to FY2023/24; the transition year FY2021/22 is excluded. Dependant cover at ages 25 and above was not permitted before the reform, so those pre-reform shares are zero by construction. Shaded band: ages 25 to 31, made newly eligible by the 2021 reform. Changes are raw post minus pre differences and include the market-wide decline in cover over the period, visible at ages 33 to 38; the estimates quoted in the text net this out against ages 33 to 35. Changes at ages 18 to 24 partly reflect post-Covid co-residence and insurers relaxing student-only rules. Counts rounded under ABS disclosure rules.

Initiative 3: excess and co-payment standardisation

Standardise the application of excesses and copayments, e.g. the maximum annual excess also includes co-payments when calculated.

Require all insurers to waive excesses in a manner consistent with community rating.

Summary response: Variation in excess levels should still be allowed, since this is a standard feature of most types of insurance that allows users to trade-off current premium for potential future out-of-pocket costs. However, we also support the idea of greater regulation around the way that excesses and co-payments are applied. For example, if plan A and plan B both have the same excess, this should mean the same thing for the consumer when they make a claim (i.e., there should be no hidden clauses that are only likely to be discovered during a claim episode).

Initiative 4: ensuring consistency across premium structures.

Review and standardise the rules governing closed and new products, including how closed products transition into new products.

Summary response: We support this idea. International evidence and our own ongoing research suggest that consumer inertia is widespread, which warrants greater protections around closed and new products.

Review and standardise the rules governing applying or waiving waiting periods.

Summary response: We support this idea. There is a risk that when insurers offer temporary benefits for products to attract consumers to that product, consumers will become locked into that product (due to inertia) even if it is not the best product for their needs. Standardisation of product features allows for a more even comparison at the point at which consumers are engaged.

Simplify the eligibility criteria for discounting.

Summary response: We support this idea for the same reasons as outlined above.

Standardise the amount of discount, including how a discount is offered or removing the flexibility for insurers to offer discounts.

Summary response: If the young-person discount is retained, we support the idea of simplifying the structure by reducing the number of rates. Our research suggests the policy has lifted participation in PHI by 20-29 years olds; however, the overall effect on the market has also been small. Since complexity can be partly addressed and the cost of the discount is borne by insurers, we do not support removing it entirely at this stage.

In the longer run, as the insurance pool ages further, it may become increasingly difficult to maintain a community-rated system. We suggest a review of the sustainability of broad community rating, and whether controlled departures to allow for age-based premium differences (which could replace the current discount policy) are worthwhile.

Additional details and relevant research

A recent working paper (not yet published in a peer-reviewed journal) (Gao & Kettlewell, 2026) estimated the effect of allowing insurers to discount premiums for people aged 18-29 years by up to 10%. Because the reform happened in April 2019, the analysis could only ‘cleanly’ estimate the effect in the short-run, since the Covid-19 pandemic distorted demand for PHI in a way that likely varied by age group. Due to this and other limitations, the analysis should perhaps be considered as suggestive. Notwithstanding, the results indicate that the discount policy did increase insurance coverage modestly for people in the target age groups (by about 1 percentage point for 20-24 year olds and 0.7 percentage points for 25-29 year olds as of December 2019).

Consider reforms to pricing rules for single parent policies to align with community rating principles.

Summary response: On equity grounds we support a greater alignment in the pricing of insurance between separated and non-separated families.

Disclaimer

The results of these studies are based, in part, on data supplied to the ABS under the Taxation Administration Act 1953, A New Tax System (Australian Business Number) Act 1999, Australian Border Force Act 2015, Social Security (Administration) Act 1999, A New Tax System (Family Assistance) (Administration) Act 1999, Paid Parental Leave Act 2010 and/or the Student Assistance Act 1973. Such data may only be used for the purpose of administering the Census and Statistics Act 1905 or performance of functions of the ABS as set out in section 6 of the Australian Bureau of Statistics Act 1975. No individual information collected under the Census and Statistics Act 1905 is provided back to custodians for administrative or regulatory purposes. Any discussion of data limitations or weaknesses is in the context of using the data for statistical purposes and is not related to the ability of the data to support the Australian Taxation Office, Australian Business Register, Department of Social Services and/or Department of Home Affairs' core operational requirements.

Legislative requirements to ensure privacy and secrecy of these data have been followed. For access to PLIDA and/or BLADE data under Section 16A of the ABS Act 1975 or enabled by section 15 of the Census and Statistics (Information Release and Access) Determination 2018, source data are de-identified and so data about specific individuals has not been viewed in conducting this analysis. In accordance with the Census and Statistics Act 1905, results have been treated where necessary to ensure that they are not likely to enable identification of a particular person or organisation.

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