Australian Government
Department of Health, Disability and Ageing

MODERNISING THE PRIVATE HEALTH INSURANCE REBATE

Impact Analysis

Prepared by Department of Health, Disability and Ageing

May 2026

Executive Summary

Private Health Insurance (PHI) is relied upon by 15.4 million people[1] in Australia to help them access healthcare. PHI in Australia operates under community rating where all policy holders pay the same premium for the same policy, regardless of their gender, age or health status. Strong PHI participation amongst the young and healthy, particularly given the increasing age of the PHI population, facilitated through targeted incentives and consumer safeguards, is critical to PHI affordability and takes pressure off the public health system.

The Government's PHI Rebate to support Australians to purchase PHI is inequitable and poorly targeted. As shown in Table 1, the Rebate subsidises older Australians more, even if they have the same income as younger Australians. However, older Australians are more likely to retain PHI and receive significantly higher average PHI benefits than younger people. This inequitable targeting does not align with the purpose of the Rebate, which is to incentivise people to take up and retain PHI[2]. This can be addressed by removing the inequitable higher Rebate received by older people compared with those aged less than 65 years earning the same income.

The objectives of Rebate reform are:

- continue to provide an incentive for people to participate in PHI through a simplified Rebate
- ensure funds are not spent on the Rebate for older people if they are generally unlikely to alter participation decisions and/or could be better directed to other priority health, disability and aged care services.
- ensure the Rebate is targeted equitably, while minimising any negative impact on participation.

Three options were considered:

- Option 1. Status Quo, with no change to the PHI Rebate.
- Option 2. Equalise Rebate rates across ages for each income tier.
- Option 3. Equalise Rebate rates across ages for low-middle incomes and remove Rebate for higher incomes (Tier 2) and reduce it for middle incomes (Tier 1).

Option 2 was considered the best option as it meets the identified objectives and has a smaller impact on insurers, policyholders and PHI participation than Option 3. Option 2 will be implemented on 1 April 2027. The additional Government funding for important aged care services would not be possible without the savings realised through the rebate changes, specifically:

[1] Source: APRA Quarterly Private Health Insurance Statistics, December 2025 quarter. Note: this includes all insured people, including dependants, while modelled participation in section 4 is for non-dependents aged 18+ years.

[2] www.privatehealth.gov.au/health_insurance/surcharges_incentives/insurance_rebate.htm

- provide targeted capital subsidies for residential aged care, providing additional funding for supported residents for newly built or refurbished homes
- increase the accommodation supplement and structural changes to introduce new tiers, and additional payment for homes with more than 60% supported residents
- deliver 20 additional Specialist Dementia Care units and expand the Hospital to Aged Care Dementia Support Program, and
- expand access to the Support at Home program and make improvements to the program so that it is fairer and more affordable for older Australians.

Background

PHI is used by 15.4 million people in Australia to help them access healthcare.[3] For the 2025 calendar year, insurer premium revenue and benefits paid were $31.9 billion and $27.2 billion, respectively.[4]

Individuals with PHI make a significant contribution to financing the cost of their own health care and to funding the Australian healthcare system. This contribution protects consumer interests, including by safeguarding their ability to exercise greater choice over their healthcare provider. In recognition of this valuable contribution, the Government provides financial incentives for people to take out PHI. Financial incentives include the Government's PHI Rebate, which is paid to eligible consumers as a percentage of premiums charged by private health insurers. People on lower incomes and older Australians receive a higher level of financial assistance from the Rebate. People on higher incomes are encouraged to take out PHI through the Medicare Levy Surcharge (MLS) which is a levy paid by Australian taxpayers who do not hold private hospital insurance[5].

For reference, the Rebate and MLS settings as at 1 July 2026 are provided below in Table 1.

Table 1: Rebate and MLS settings as at 1 July 2026

	Income Tiers			
Singles Tier threshold	< $105,000	$105,001-123,000	$123,001-164,000	>$164,001
Families Tier threshold	< $210,000	$210,001-246,000	$246,001-328,000	>$328,001
	PHI Rebate %			
	Base Tier	**Tier 1**	**Tier 2**	**Tier 3**
Age <65	24.118%	16.079%	8.038%	0%
Age 65-69	28.139%	20.098%	12.058%	0%
Age 70+	32.158%	24.118%	16.079%	0%
	MLS %			
	0.0%	1.0%	1.25%	1.5%

Income tiers presented are current for 1 July 2026 to 30 June 2027 and are subject to annual indexation on 1 July based on changes in Average Weekly Ordinary Time Earnings (AWOTE).

Rebate rates presented are current for 1 April 2026 to 31 March 2027 and are subject to annual indexation through the Rebate Adjustment Factor (RAF) based on the difference between the Consumer Price Index (CPI) and the industry weighted average premium increase.

PHI in Australia is community rated, which means everyone pays the same premium for the same cover. Insurers cannot discriminate by charging higher premiums for people likely to be paid higher benefits, for example older or sicker people. Strong PHI participation amongst the young and healthy, facilitated through targeted incentives and consumer safeguards, is critical for PHI to be affordable and take pressure off the public health system. However, PHI participation incentives

[3] APRA, Quarterly Private Health Insurance Statistics, December 2025, published 27 February 2026.
[4] Ibid.ca
[5] www.privatehealth.gov.au/health_insurance/surcharges_incentives/medicare_levy.htm

have largely remained unchanged for 20 years and are now suboptimal. In particular, the settings for the PHI Rebate are:

- complex – the Rebate includes multiple rates by both age and income criteria, and
- poorly targeted and inequitable – the Rebate subsidy is higher for older Australians even if they have the same income as younger Australians and would be likely to take out PHI even without a higher Rebate.

1. What is the policy problem you are trying to solve and what data is available?

Policy problem

Government expenditure on the PHI Rebate is estimated to be $7.9 billion in 2025-26 and a total of $32.6 billion from 2025-26 to 2028-29. The purpose of the PHI Rebate is to incentivise people to take up and retain PHI by subsidising the premiums charged by private health insurers, which contributes to the overall sustainability of Australia's health system.

However, the PHI Rebate is inequitable as it subsidises older Australians (i.e. those aged 65+ years) more, even if they have the same income as younger Australians. This creates intergenerational inequity in how the PHI Rebate is administered.

People aged 65+ years benefit more from the current Rebate settings through reduced PHI premiums (e.g. a Rebate rate of approximately 32% for those aged 70+ and 28% for 65-69 years, compared with 24% for <65 years for the Base income tier). The 65+ age group receives significantly higher average PHI benefits per person than younger people (see Figure 1). Further, health insurance is community rated, meaning all policy holders pay the same premiums for the same policy, regardless of their age or health status. If health insurance was risk-rated like other forms of insurance then health insurance would be unaffordable for many (particularly older people who have higher average claims).

Many older people are therefore likely to retain PHI even if government assistance via the PHI Rebate is reduced. They do not require a higher incentive to participate in PHI than younger people earning the same income to see the value in PHI. Therefore, targeting higher Rebates to people aged 65+ does not align with the purpose of the Rebate, which is to incentivise people to take up and retain PHI.

The PHI Rebate could be better targeted by reducing the higher Rebate rates that are currently provided to older people where it is unlikely to be incentivising uptake. Further, there are higher health, disability and aged care priorities for which the money spent on the higher Rebate for older people could be used to support.

Amending the PHI Rebate requires Government intervention to amend the *Private Health Insurance Act 2007* which provides relevant Rebate settings at Part 2-2.

Available data

The 'PHI Rebate Forward Estimates' model has been used for all PHI Rebate forward estimates and costings approved by the Department of Finance over the past 7+ years and is also used to model potential policy changes to Rebate settings. The model contains four input modules:

- demographic module – uses ABS population data to project population size, segmented by demographic characteristics relevant to PHI participation.
- economic module – projects future economic indicators e.g. CPI and AWE
- participation module – analyses data on individual PHI holders (primarily Services Australia (SA) data linked with Australian Taxation Office (ATO) data) to assess propensity to change coverage types
- premiums module – analyses premiums data on individual PHI holders to project future premiums (SA data linked with ATO data, Treasury projections of CPI, premium round rates).

These feed into a forecasting module which projects the number of insured adults, premiums and Rebates for the next 10 years. More information on the model is available in subsection 4.1 and the 'Additional Information' section.

The Australian Prudential Regulation Authority (APRA) publishes statistics on the PHI industry on a quarterly basis (and annually by insurer), covering membership, coverage, benefits paid and financial performance. These statistics can be used to track average premiums paid and benefits received by people in various age groups (as shown in Figure 1), which indicate that people aged 65+ years on average receive more in benefits than they pay in premiums. APRA data can also be used to estimate the number of policies impacted by potential changes to Rebate settings and to monitor the impact of changes to participation rates in future years.

The department procured an independent study of PHI incentives in 2022-2023[6] to review the effectiveness of the PHI Rebate and other key participation incentives. The study gathered stakeholder views[7], which included criticism of the complexity of PHI incentives and questions on the value of the Rebate and whether the funding would be more effectively spent on other healthcare priorities. The independent study was informed by data from APRA, SA, the ATO and insurers, noting that the SA and ATO datasets do not include all insured people. The department sought further stakeholder views on the final report.

Further, published reviews highlight deficiencies in the PHI Rebate settings, including that an uplift for older people targets a group already strongly incentivised to purchase PHI[8]. On average, older people tend to be less sensitive to changes in insurance prices. This may be because the value

[6] Review of MLS, PHI Rebate and LHC,

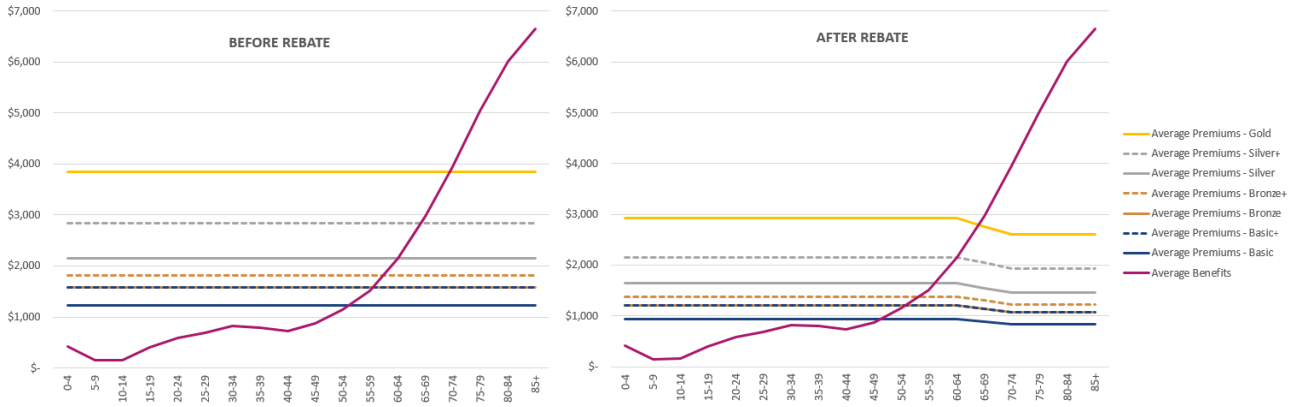
[7] Themes from Stakeholder Engagement

[8] Liu, J., & Zhang, Y. (2023). Elderly responses to private health insurance incentives: Evidence from Australia. Health Economics, 32(12), 2730–2744. https://doi.org/10.1002/hec.4751

proposition of PHI is higher for older people than younger people, they place a higher value on private treatment and/or are more risk averse than the general population.

The department did not further consult on the specific changes to the Rebate proposed in this document, due to budget confidentiality requirements and prior consultation.

Figure 1: Average PHI benefits paid per person by age compared with average premium charged for a single by product tier before and after Rebate (for Base income tier)



Source: Average benefits – APRA quarterly PHI data (benefits paid are calculated for the 12 months to December 2025 and insured persons are as at 31 December 2025.) Average premiums – private health information statements, Commonwealth Ombudsman, average premiums for Singles policy by tier after standard Rebate observed at 1 April 2026 excluding corporate policies.
Note: the after Rebate figure is presented for the Base income tier (noting that the majority of policy holders are in this tier).

2. What are the objectives, why is government intervention needed to achieve them, and how will success be measured?

Objectives

Government funding for healthcare is finite and demand across the health, disability and aged care systems continues to grow due to increasing incidence of chronic and preventable diseases and increased need for aged care services due to an ageing population.

The Australian Government is responsible for setting the PHI incentives. The government must also balance its support for privately insured patients with the funding it provides for the entire health, disability and aged care system.

In making these decisions, the government's objectives include ensuring equitable access across the community to the full range of health, disability and aged care services, not just the services within the scope of PHI products.

Depending on the policy taken out, PHI provides benefits related to hospital treatment and general treatment (certain dental and allied health services).

The objectives of the policy options are to:

- continue to provide an incentive for people to participate in PHI through a simplified Rebate
- ensure funds are not spent on the Rebate if they are generally unlikely to alter participation decisions and/or could be better directed to other priority health, disability and aged care services, and
- ensure the Rebate is equitably targeted, while minimising any negative impact on participation.

Measuring success

Table 2 outlines the factor that will make this proposed policy change a success, along with a measurable target.

Table 2: Success factor and measurable target for the policy change

Objective	Success Factor	Success Metric
Ensure the Rebate is equitably targeted, while minimising any negative impact on participation	As a result of eligibility for particular Rebate rates being determined by income only, rather than by income and age, there is minimal reduction in the proportion of the population that participates in PHI in the first two years from 1 April 2027.	Insured people as a proportion of the population in the March 2029 quarter has not reduced by more than 1 percentage point compared with the March 2027 quarter. 1 percentage point is larger than the modelled impact on participation but has been chosen to account for the possible impacts of external factors, such as higher than expected cost of living pressures that differ from the modelled assumptions. The number of insured people is expected to continue to rise, reflecting growth in the overall population. Using this participation metric allows comparison of the impact relative to the population using publicly available APRA data. A 2 year time period has been chosen because the participation impact (while expected to be minor) is likely to be most pronounced in the first 2 years. The 2 year time period will provide sufficient time for consumers to feel the impact of the change and decide whether to remain in PHI.

Limitations to implementation and barriers to success

One potential barrier to success is the possibility of significantly higher negative impacts than modelled on PHI participation as a result of the Rebate changes. While only a marginal impact on participation is expected, external factors, such as greater than anticipated increased cost of living pressures, could result in a higher than expected participation impact. This could have potential repercussions for the broader health system, including the viability of private health insurers and private hospitals and pressures on public hospitals. The department will monitor the effect of the proposed change on participation as shown in Table 2 and will communicate the results to government for consideration as appropriate.

Similarly, some affected consumers may respond to the reduced Rebate rate by choosing to reduce their level of PHI cover in line with their financial circumstances and health needs. This could include reducing their hospital product tier (such as from Gold to Silver, or Bronze to Basic, and therefore reducing the number of clinical categories they are covered for), or by increasing the excess they would need to pay for hospital treatment. This reduction in coverage could place additional pressure on public hospitals if consumers do not accurately assess their likely future health needs when choosing their level of cover. The impact on private and public hospitals is discussed in more detail in Table 10 in Section 4.3.

There may also be changes in the relationship between Government and some stakeholders, at least during an initial period in the lead up to implementation. Stakeholders, including some consumers, insurers and healthcare providers, may argue that changing Rebate settings could cause a significant change in PHI participation and flow on impacts to consumer access to privately funded health care and pressure on public hospitals. This is addressed in the consideration of options and will require effective communications with stakeholders.

Other barriers to success include the challenges associated with maintaining effective communications with concerned stakeholders. It will be important for the department to work collaboratively with insurers to ensure affected consumers understand the continuing value of PHI. The department will further address this barrier by communicating with consumers about the important aged care services which will be supported by additional Government funding as a result of the savings from the Rebate change.

Alternatives to Government intervention

One alternative to Government intervention is to maintain the current Rebate settings. A failure to adjust the existing government PHI Rebate would mean the Rebate remains inequitable, with different rates by age, as explained in more detail in the Policy Problem section. This would also result in a shortfall in funding for additional Government funding for aged care services. Therefore, Government intervention is required in order to achieve the stated objectives. As the PHI Rebate is provided in the *Private Health Insurance Act 2007*, the change will require legislative amendment.

3. What policy options are you considering?

3.1 Option 1 - Status Quo

The Rebate settings (see Table 3) include multiple rates, with eligibility determined by both age and income criteria, which creates complexity for both policyholders and insurers. The current settings are also poorly targeted and inequitable, as they subsidise older Australians more than younger Australians on the same income. This is in addition to older people's insurance claims being cross subsidised by younger members under community rating where all policy holders pay the same premium for the same policy, regardless of their gender, age or health status.

Maintaining current Rebate settings would maintain higher Rebates for people on lower incomes and older people, which is expected to cost almost $31 billion over 4 years from 2026-27. This option would mean there are no savings to government and therefore no opportunity to support additional Government funding for aged care services.

Table 3: Rebate settings as at 1 July 2026

	PHI Rebate %			
Singles Tier threshold Families Tier threshold	< $105,000 < $210,000	$105,001-123,000 $210,001-246,000	$123,001-164,000 $246,001-328,000	>$164,001 >$328,001
	Base Tier	**Tier 1**	**Tier 2**	**Tier 3**
Age <65	24.118%	16.079%	8.038%	0%
Age 65-69	28.139%	20.098%	12.058%	0%
Age 70+	32.158%	24.118%	16.079%	0%

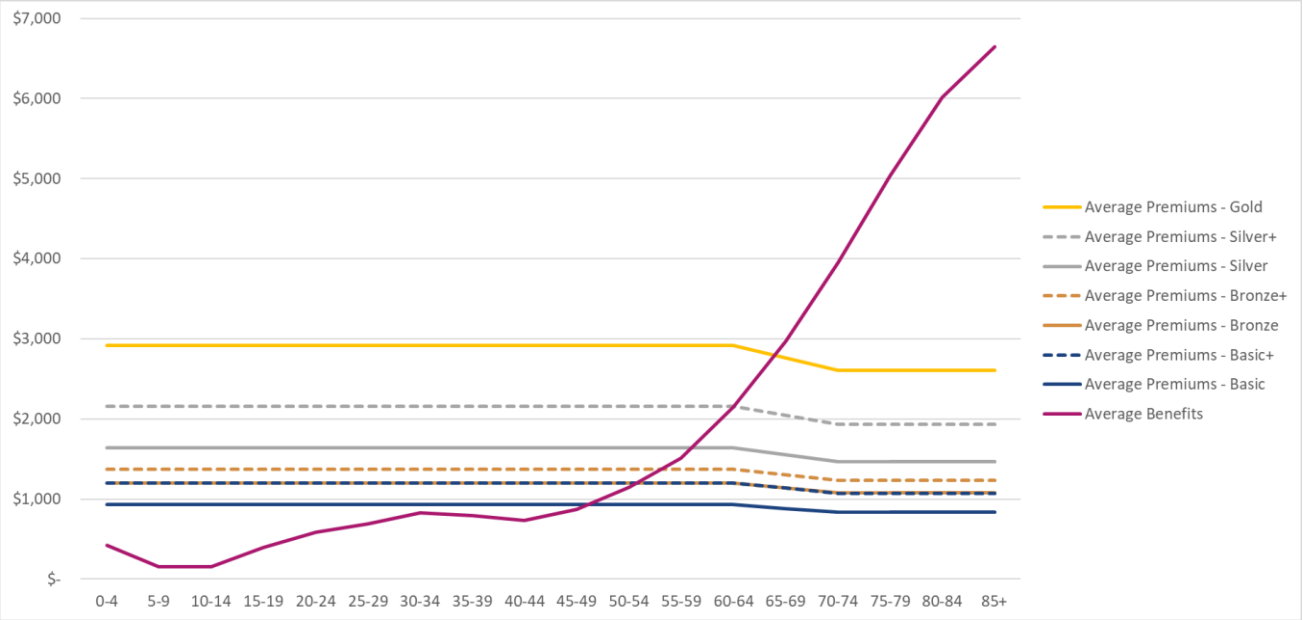
Income tiers presented are current for 1 July 2026 to 30 June 2027 and are subject to annual indexation on 1 July based on changes in AWOTE.

Rebate rates presented are current for 1 April 2026 to 31 March 2027 and are subject to annual indexation through the RAF based on the difference between the CPI and the industry weighted average premium increase.

As Rebate entitlement would continue to be determined by both income and age, this option would not address the inequity of providing higher Rebates to those aged 65+ than younger people earning the same income. It would also continue to provide Rebates to middle-higher income earners. This option does not achieve the policy objectives of ensuring the Rebate is an incentive while targeting it to where it would most likely alter a person's participation decision.

Figure 2 below shows the average PHI benefits paid per person compared with average premiums after the Rebate for the Base income Tier (noting the majority of insured people are in this tier).

Figure 2: Average PHI benefits paid per person by age compared with average premium for a single by product tier (after Rebate under Option 1 for Base income Tier)



Source: Average benefits – APRA quarterly PHI data (benefits paid are calculated for the 12 months to December 2025 and insured persons are as at 31 December 2025.) Average premiums – private health information statements, Commonwealth Ombudsman, average premiums for Singles policy by tier after standard Rebate observed at 1 April 2026 excluding corporate policies.
Note: presented as after Rebate for the Base income tier (noting that the majority of policy holders are in this tier).

3.2 Option 2 – Equalise Rebate rates across ages for each Income Tier

Based on outputs generated by the PHI Rebate model (described in subsection 4.1), this option would achieve indicative savings of $2,994.7 million over 4 years from 2026-27 (1 April 2027) compared with Option 1 (Status Quo) by moving to a model where Rebate entitlement is determined only by income, removing any age based Rebate uplifts. The Rebate would be simplified by removing the higher Rebate for older people compared to those under 65 years earning the same income.

Table 4 below shows the proposed changes (with changes from current arrangements in *italics*).

Table 4: proposed changes to PHI Rebate under Option 2

	PHI Rebate %			
Singles Tier threshold Families Tier threshold	< $105,000 < $210,000	$105,001-123,000 $210,001-246,000	$123,001-164,000 $246,001-328,000	>$164,001 >$328,001
	Base Tier	**Tier 1**	**Tier 2**	**Tier 3**
Age <65	24.118%	16.079%	8.038%	0%
Age 65-69	28.139 / *24.118%*	20.098 / *16.079%*	12.058 / *8.038%*	0%
Age 70+	32.158 / *24.118%*	24.118 / *16.079%*	16.079 / *8.038%*	0%

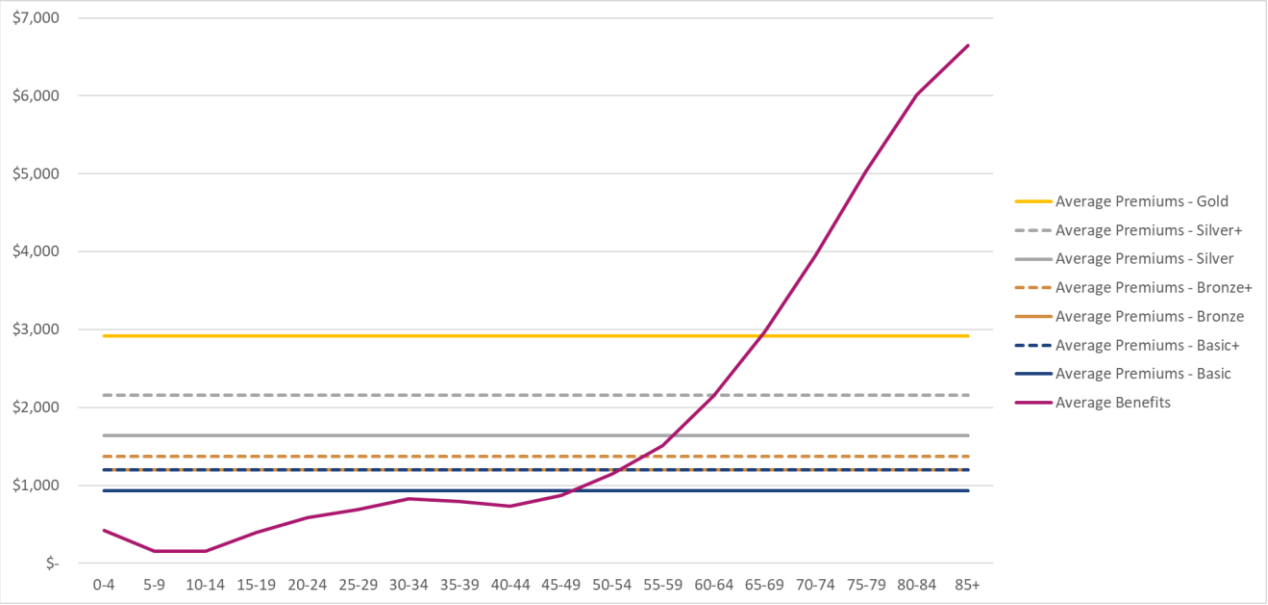
Income tiers presented are current for 1 July 2026 to 30 June 2027 and are subject to annual indexation on 1 July based on changes in AWOTE. The reset Rebate rates would be subject to annual indexation through the RAF on 1 April 2028

and subsequent years based on the difference between the CPI and the industry weighted average premium increase (however, the RAF would be set to 1 for 1 April 2027 to provide certainty of the rates to apply on 1 April 2027).

This option would address the policy objective of ensuring the Rebate is equitably targeted by ensuring the Rebate is only set with reference to income, not age. This option better targets the Rebate to cohorts where it is likely to support decisions to hold PHI, as most older Australians are likely to continue to hold PHI despite a reduction in the Rebate, given they are significant beneficiaries of the system (see Table 18).

Figure 3 below shows the average PHI benefits paid per person compared with average premiums after the Rebate for the Base income Tier (noting the majority of insured people are in this tier).

Figure 3: Average PHI benefits paid per person by age compared with average premium for a single by product tier (after Rebate under Option 2 for Base income Tier)



Source: Average benefits – APRA quarterly PHI data (benefits paid are calculated for the 12 months to December 2025 and insured persons are as at 31 December 2025.) Average premiums – private health information statements, Commonwealth Ombudsman, average premiums for Singles policy by tier after standard Rebate observed at 1 April 2026 excluding corporate policies.
Note: presented as after Rebate for the Base income tier (noting that the majority of policy holders are in this tier).

3.3 Option 3 – Equalise Rebate rates across ages for low-middle incomes and remove Rebate for higher incomes (Tier 2)

Based on outputs generated by the PHI Rebate model (described in subsection 4.1 below), this option would achieve indicative savings of $3,922.4 million over 4 years from 2026-27 (1 April 2027) by:

a) moving to a model where Rebate entitlement is determined only by income, for only Base Tier and Tier 1 earners, and removing any age based Rebate uplifts:
    a. better targeting and simplifying the Rebate for middle and lower income earners (Base tier and Tier 1) through a reset flat 25% and 10% Rebate

b. removing the higher Rebate for older people compared to those under 65 years earning the same income,
c. removing the Rebate for Tier 2 (high income earners) to align with Tier 3 earners and reduce it for middle incomes (Tier 1).

Table 5 shows the proposed changes under Option 3 (with changes from current arrangements in *italics*).

Table 5: proposed changes to PHI Rebate under Option 3

	PHI Rebate %			
Singles Tier threshold Families Tier threshold	≤ $105,000 ≤ $210,000	$105,001-123,000 $210,001-246,000	$123,001-164,000 $246,001-328,000	≥$164,001 ≥$328,001
	Base Tier	**Tier 1**	**Tier 2**	**Tier 3**
Age <65	24.118 / *25%*	16.079 / *10%*	8.038 / *0%*	0%
Age 65-69	28.139 / *25%*	20.098 / *10%*	12.058 / *0%*	0%
Age 70+	32.158 / *25%*	24.118 / *10%*	16.079 / *0%*	0%

Income tiers presented are current for 1 July 2026 to 30 June 2027 and are subject to annual indexation on 1 July based on changes in AWOTE.

The reset Rebate rates would be subject to annual indexation through the RAF on 1 April 2028 and subsequent years based on the difference between the CPI and the industry weighted average premium increase (however, the RAF would be set to 1 for 1 April 2027 to provide certainty of the rates to apply on 1 April 2027).

Removing the Rebate from Tier 2 was suggested in the 2022-2023 independent study[9]. The study also explored removing the Rebate for Tier 1 earners, and suggested that the MLS provides a sufficient incentive for Tier 1 and 2 earners to retain PHI.

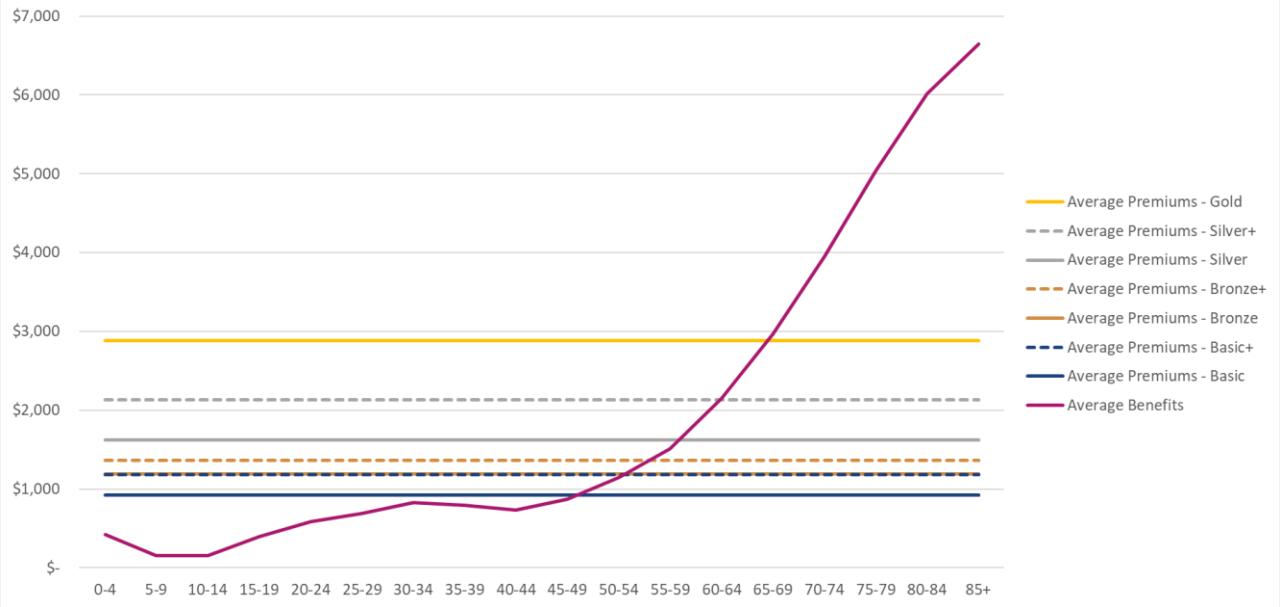
This option would address the policy objective of ensuring the Rebate is equitably targeted by ensuring the Rebate is only set with reference to income, not age. This option would also contribute to ensuring the Rebate is spent on cohorts where it is likely to influence individual decisions to hold PHI, as older Australians will continue to hold PHI despite a reduction in the Rebate (see Table 18). The reduction of the Rebate for all people in Tier 1 and removal for those on Tier 2 would target the Rebate expenditure to the lowest income earners.

Community rating would be maintained under this option, i.e. all policy holders pay the same premium for the same policy, regardless of their gender, age or health status. Older or sicker Australians would therefore continue to be protected from higher premium costs that would be associated with risk-rated insurance by their claims being cross-subsidised by the premiums paid by younger or healthier policy holders.

Figure 4 below shows the average PHI benefits paid per person compared with average premiums after the Rebate for the Base income Tier (noting the majority of insured people are in this tier).

[9] MLS and PHI Rebate Final Report, 2023.

Figure 4: Average PHI benefits paid per person by age compared with average premium for a single by product tier (after Rebate under Option 3 for Base income Tier)



Source: Average benefits – APRA quarterly PHI data (benefits paid are calculated for the 12 months to December 2025 and insured persons are as at 31 December 2025.) Average premiums – private health information statements, Commonwealth Ombudsman, average premiums for Singles policy by tier after standard Rebate observed at 1 April 2026 excluding corporate policies.
Note: presented as after Rebate for the Base income tier (noting that the majority of policy holders are in this tier).

4. What is the likely net benefit of each option?

The following analysis of the likely net benefit of each option considers both quantitative and qualitative factors:

- The estimated direct regulatory burden of each option.
- A multi-criteria analysis of each option against:
    - the objectives described in section 2
    - the impacts on stakeholders, such as consumers, private health insurers, private hospitals, public hospitals, and medical professionals.

The regulatory burden was estimated to be greatest for Option 3, followed by Option 2 and Option 1. The best option identified through the multi-criteria analysis is Option 2, followed by Option 3 and then Option 1. Option 1 is least preferred because it would not achieve the objectives.

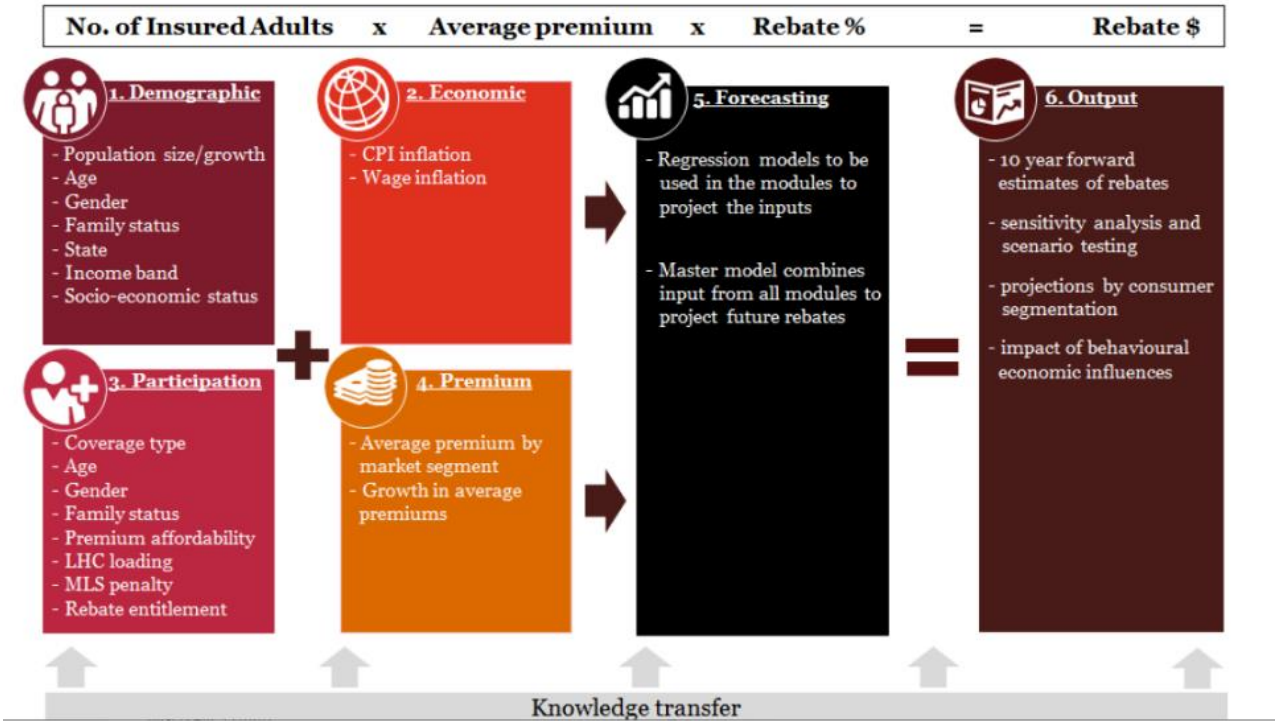
This analytical approach was taken, noting:

- the difficulty in quantifying benefits and regulatory costs
- the number of variables influencing the impact of each option
- existing and potential future Government interventions on stated or similar objectives.

4.1 Modelling

The costings for savings and the estimates of insured people and Rebate per person for all three options were estimated using the "PHI Rebate Forward Estimates Model", which has been used for all PHI Rebate forward estimates and costings approved by the Department of Finance over the past 7+ years. The PHI Rebate model uses Generalised Linear Models (GLMs) to predict whether people would buy PHI based on various different demographic characteristics like age, gender and income as well as PHI incentives like MLS and PHI Rebate. This means the PHI costings were not assumptions based, but driven by statistical regression. Further details of the model are provided in the Additional Information section.

Figure 5: Modelling module structure



4.2 Estimated regulatory burden

The estimated regulatory burden is provided in Table 6 below. Due to the confidentiality required of Budget processes, the department did not consult with industry on the expected regulatory burden associated with the proposed options.

Table 6: summary of regulatory burden estimate for each option

One-off regulatory burden				
	Individuals	Business	Community organisations	Total one-off regulatory burden
Option 1	$0	$0	$0	$0
Option 2	$0	$689,584	$0	$689,584
Option 3	$0	$1,324,140	$0	$1,324,140

There was no identified regulatory burden for individuals and community organisations. However, broader impacts on these groups have been identified in the multi-criteria analysis in subsection 4.3.

The estimated regulatory burden for businesses, specifically private health insurers, was calculated by multiplying:

- the estimated number of hours required by insurers to comply with legislative adjustments to the Rebate
- the number of insurers (28) affected by the change, where relevant
- the default labour cost, which is $85.17 per hour, as provided for in the Regulatory Burden Measurement Framework[10].

While other businesses (private and public hospitals and medical professionals) do not have a direct regulatory burden, broader impacts on these stakeholders have been identified in the multi-criteria analysis in subsection 4.3.

Table 7 demonstrates how the summary financial impact as provided in Table 6 was derived. Notably, the increased regulatory burden on business for Option 3 compared to Option 2 is solely driven by the higher the number of policyholders who are directly affected by Option 3, which would increase the number of hours likely expended by industry to handle enquiries from affected policyholders. There is no regulatory burden under Option 1, as the status quo is maintained.

[10] The Office of Impact Analysis, Regulatory Burden Measurement Framework | The Office of Impact Analysis, 6 February 2024.

Table 7: detailed regulatory burden estimate for each option

Estimated number of hours for business regulatory burden				
Category	Option 1	Option 2	Option 3	Comments
Administrative cost to implement the change				**Time taken to edit internal systems to match the new PHI Rebate percentages**
Estimated number of hours per insurer	0	0	0	Rebate changes occur on 1 April every year, therefore there is no additional administrative cost
Number of insurers affected	0	28	28	
Total estimated hours across industry	0	0	0	
Substantiative compliance cost to provide communications to all members				**Time taken to develop frontline material, centralised messaging, website updates, and other related activities**
Estimated number of hours per insurer	0	60	60	
Number of insurers affected	0	28	28	
Total estimated hours across industry	0	1,680	1,680	
Substantiative compliance cost to handle enquiries from directly affected policyholders				**Time taken to handle phone calls and web enquiries from directly affected policyholders**
Estimated total number of policies impacted	N/A	1.9 m	3.7 m	Estimated policies impacted is derived from APRA PHI quarterly data. Policies is used instead of

Estimated number of hours for business regulatory burden				
				people, as only the main contact under a multi-person policy is expected to contact the insurer. (Note: number is rounded to 1dp, but unrounded figure used for calculation)
Estimated percentage of policyholders making contact	N/A	2%	2%	Assumption information is provided below.
Estimated contact time	N/A	10 min	10 min	
Total estimated hours across industry	0	6,417	12,187	The impact will generally be concentrated on larger insurers and insurers with a greater proportion of older policyholders
Total estimated hours	**0**	**8,097**	**13,867**	
Total one-off regulatory burden	**$0**	**$689,584***	**$1,324,140***	Derived by multiplying total estimated hours and the default labour cost ($85.17 per hour)

* Figures in this table do not sum to the displayed '*total one-off regulatory burden*' due to rounding in the '*Substantiative compliance cost to handle enquiries from directly affected policyholders*' section

The department notes the following assumptions:

- 2% of policyholders making contact about the change: this is an estimate as the department has not consulted insurers on this metric given the confidentiality required of Budget processes. It is assumed that most policyholders will base their decision on the communication material provided by insurers and that some policyholders or potential policyholders already contact insurers about the Rebate and premium changes each year. The propensity of policyholders to make contact is also reduced due to the significant effort insurers put into communications and the relative difficulty for policyholders to make contact with a human responder.
- Insurers regularly prepare for PHI Rebate percentage adjustments each 1 April via the Rebate Adjustment Factor (typically announced in the February immediately prior to 1 April). Therefore, by timing implementation to 1 April, there is no expected

administrative cost. Further, insurers will have more notice of the Rebate rates to apply from 1 April 2027 than in a usual year by several months (noting the intention to set the RAF to 1 for 1 April 2027).

- Similarly, insurers prepare communications to policyholders about regular 1 April PHI Rebate changes as part of premium price change announcements. Therefore, the estimated time taken to provide communications on these Rebate changes was reduced to take this into account.

The department acknowledges there are further impacts on insurers that are not directly compliance related. Whilst these have not been modelled as they are outside the scope of the direct regulatory burden estimate, they include:

- larger financial impacts for certain insurers, based on the proportion of their policyholders who are 65 or older
- a larger relative impact on smaller insurers, noting that the transition cost (60 hours per insurer) is the same regardless of insurer size, with this being somewhat mitigated by the relatively minor nature of this transition cost, and
- insurers adjusting their business strategy in the context of reduced Rebate expenditure, which may impact on their policyholder acquisition, retention, capital and risk planning.

Given that implementation is planned for 1 April 2027, insurers will have substantial time to factor in these changes and to prepare their business and policyholders for these changes. These have been factored into the multi-criteria analysis below.

The department considers there is no direct regulatory cost on community organisations or on individuals. However, it is important to note that, if Option 2 or 3 is implemented, individuals holding PHI are more likely than usual to consider the effect of premium changes on 1 April 2027 and whether to continue to hold PHI. The impact will fall on individuals that are subject to the proposed Rebate changes as outlined for Option 2 or 3 – other PHI holders will not be directly affected. Similarly, this has been factored into the multi-criteria analysis below.

4.3 Multi-criteria analysis

A multi-criteria analysis was considered to be appropriate because the main objective relates to equity issues and there is limited information available to allow the effects to be quantified.

The multi-criteria analysis assesses each option against:

- the objectives of Rebate reform, as outlined in Section 2 i.e.:
    - continue to provide an incentive for people to participate in PHI through a simplified Rebate
    - ensure funds are not spent on the Rebate if they are generally unlikely to alter participation decisions and/or could be better directed to other priority health, disability and aged care services, and
    - ensure the Rebate is equitably targeted, while minimising any negative impact on participation;
- the impacts on stakeholders (other than government), which includes consumers, private health insurers, private hospitals, medical professionals and public hospitals.

A simple scale, ranging from -3 to +3 (with 0 representing no net change in benefit), has been chosen to illustrate and compare the relative benefits of each option. All criteria have been weighted equally for this analysis.

-3	-2	-1	0	1	2	3
Significantly adverse	Moderately adverse	Slightly adverse	Neutral	Slightly beneficial	Moderately beneficial	Significantly beneficial

Results of multi-criteria analysis

Table 8 provides the summary result of the multi-criteria analysis.

Table 8: Aggregated summary of multi-criteria analysis of each option

Score	Option 1 (Status Quo)	Option 2	Option 3
Stated objectives	-5	5	6
Stakeholders	0	-4	-7
Total	-5	1	-1

Table 9 provides results of the multi-criteria analysis on the impact of each option on the stated objectives.

Table 9: Summary of multi-criteria analysis of each option on stated objectives

Objective	Option 1 (Status Quo)	Option 2	Option 3
1. Continue to provide an incentive for people to participate in PHI through a simplified Rebate	-1	1	1
	This objective has been scored based on the relative change in participation compared to the Status Quo (Option 1), and whether the Rebate is simplified. Option 1 – no change in participation, but as the Rebate structure is unchanged, it does not achieve simplification of the Rebate. Option 2 – marginal reduction in participation through a simplified Rebate being solely based on income tiers rather than a mix of income tier and age. Option 3 – marginal impact on participation (though larger than Option 1), through a simplified Rebate being solely based on income tiers rather than a mix of income tier and age, and Rebate reduced for all people in Tier 1 and removed altogether from Tier 2.		

Objective	Option 1 (Status Quo)	Option 2	Option 3
	Further analysis on this scoring is provided below.		
2. Ensure funds are not spent on the Rebate if they are generally unlikely to alter participation decisions and/or could be better directed to other priority health, disability and aged care services.	-2	2	3
	This objective has been scored based on whether the option targets cohorts that are unlikely to drop PHI due to a reduced Rebate, and the overall savings achieved by Government that could be better directed to other priority initiatives. Option 1 takes no action to address these issues, whilst Option 2 and 3 have moderately and significantly beneficial impacts on those metrics, respectively. Further analysis on this scoring is provided below.		
3. Ensure the Rebate is targeted equitably, while minimising any negative impact on participation.	-2	2	2
	This objective has been scored based on whether each option is considered equitable. Option 1 is not considered equitable given that it would continue to provide higher Rebates for older Australians despite being on the same income. Option 2 and 3 both have beneficial impacts of removing the inequity of higher subsidy for older people.		
Total score	-5	5	6

Table 10 provides the results of the multi-criteria analysis for key stakeholders:

Table 10: Summary of multi-criteria analysis of each option against key stakeholders

Stakeholder	Option 1 (Status Quo)	Option 2	Option 3
Consumers	0	-1	-2
	Consumers will face no direct impact in relation to PHI under Option 1 which has therefore been scored to be neutral. However, in the current fiscal environment, Option 1 would reduce the funds available for Government to deliver other priority health, disability and aged care services provided to consumers. Consumers will face a slightly adverse impact under Option 2. The impact on an individual's Rebate would depend on their age, income and the cost of their policy, noting the Rebate is paid as a percentage of the premium. However, the average change in rebate per person under Option 2 in 2028-29 is -$252 for those aged 65+ years in the 3 affected income tiers (Base, 1 and 2). Some policyholders will drop or not take up PHI due to the removal of the higher Rebate for older Australians. However, the projected change is expected to be minor in the context of the total insured population. This is because older people are strongly incentivised to hold PHI even without the Rebate due to higher benefits they experience compared to the premium paid. In addition, older people who have held insurance for a longer period would have a higher cost to re-join due to the Lifetime Health Cover loading if they dropped cover and exhausted their allowable days of absence before rejoining. The lower Rebate will likely be counterbalanced by slightly lower premium increases for those remaining in PHI. This is because, whilst there is no significant impact on younger Australians, some older Australians (who generally receive more in benefits than they pay in premiums, as shown in Figure 1) will leave, putting downwards pressure on premiums. However, this impact will be moderated if those who leave PHI do so at least partly because they were less likely to make a claim than the average older Australian. Consumers will face a more adverse impact under Option 3 compared to Option 2. A greater number of policyholders will drop their insurance due to the removal of the Rebate for people in Tier 2 and the reduction of the Rebate for people in Tier 1. People with Tier 3 incomes already receive no Rebate. Unlike Option 2, there would		

Stakeholder	Option 1 (Status Quo)	Option 2	Option 3

also be no expected reduction in premium increases as more younger Australians and fewer older Australians will leave PHI compared to Option 2. The impact on an individual's Rebate would depend on their age, income and the cost of their policy, noting the Rebate is paid as a percentage of the premium. However, the average change in rebate per person under Option 3 in 2028-29 is:

- -$252 for those aged 65+ years in the 3 affected income tiers (Base, 1 and 2)
- -$203 for those aged under 65 years in the 2 income tiers (1 and 2) with a Rebate rate reduction
- +$31 for those aged under 65 years in the Base tier which had a small Rebate rate increase.

There are also some additional impacts for Options 2 and 3 factored into the above score, such as:

- the decision cost incurred by individuals who are impacted by the changes to the Rebate on 1 April 2027, who will be more likely than usual following the 1 April implementation of approved premium changes to consider whether to change or drop their cover. This is greater under Option 3 compared with Option 2 due to the higher number of people affected in Option 3.
- those who exit PHI would no longer pay PHI premiums and retain the right to be treated as a public patient in a public hospital under Medicare, noting that every Australian has the right to receive safe, high-quality healthcare that complies with national standards, as well as to receive their care in a safe setting, however, there would be impacts to access and timeliness to some services:
    - the loss of access to choice of treating specialist (unless self-funded), impacts more people for Option 3 compared to Option 2
    - longer waiting times associated with seeking treatment in the public system impacts more people under Option 3 compared to Option 2
- costs associated with paying the MLS, for those in Tier 1 and 2 ceasing to hold cover. This is greater under Option 3 compared to Option 2, as more people in Tiers 1 and 2 are expected to drop cover under Option 3 (see Tables 12 and 13).

Stakeholder	Option 1 (Status Quo)	Option 2	Option 3
Private health insurers	0	-1	-3

Private health insurers will face no impact under Option 1.

Private health insurers will face a slightly adverse impact under Option 2 and a significantly adverse impact under Option 3. Option 3 impacts a marginally larger cohort of the insured population compared to Option 2, which has consequential flow-on effects to insurers. This is mostly derived from the regulatory impact burden discussion above and considered in the context of each option as summarised here:

- larger financial impacts for insurers that have a greater proportion of policyholders affected based on the proposed changes under each Option
- adjustments to their business strategy in the context of reduced Rebate and increase in the amount of premiums paid directly by the consumer, which may impact on their policyholder acquisition and retention marketing strategies and their capital and risk planning.
- short term changes to gross margins for insurers. This is due to people aged 65+ dropping PHI (and younger people in Tiers 1 and 2 in Option 3), which would result in reduced premium revenue for insurers. People are also more likely to downgrade cover under Option 3 than Option 2, because the Rebate is being removed for Tier 2 earners who may be more likely to choose to retain a lower level of PHI at a lower premium than people in lower income tiers who may be more likely to drop cover altogether. Whether the reduced premium revenue is outweighed by the reduction in benefits paid would depend on the mix of those dropping PHI. Insurers would face reduced margins if those dropping their PHI were those members who were less likely to make a claim than those that remain. The larger number of younger people dropping cover in Option 3 could result in a bigger drop in margins than Option 2, noting that younger people are typically healthier and less likely to make a claim. The reduced younger people in Option 3 could also result in some of these people feeling locked out of PHI in future if they drop cover and would later face a Lifetime Health Cover loading if they wished to take out cover again.

Stakeholder	Option 1 (Status Quo)	Option 2	Option 3
Private hospitals	0	-1	-1

Private hospitals will face no impact under Option 1.

Private hospitals will face a slightly adverse impact under Option 2 and Option 3. Potential reduced growth in the level of privately insured patients is expected to result in a marginal reduction in demand for private hospital services compared with Option 1, while noting that the overall number of people covered by PHI is expected to continue to grow. The impact on the private hospital system will depend on the extent to which these patients would have made use of the private hospital services funded by their private health insurance.

For Option 2, the estimated impact on total insured private hospital separations, compared with Option 1, is projected to be a reduction ranging between 0.4% and 1.1% in 2028-29, depending on assumptions about the type of people who are likely to no longer take out PHI and the extent to which these people would have accessed a privately insured hospital treatment. It is possible that those who drop or reduce their PHI cover do so because their usage of PHI is below that of their peers, or because they are likely to seek treatment as a public patient regardless of whether they had PHI or not, and they don't see value in maintaining their previous cover.

This above estimates do not take into account privately insured people who decide to downgrade their cover. Some affected consumers may respond to the reduced Rebate rate by choosing to reduce their PHI cover in line with their financial circumstances and health needs. Cover reductions could include reducing their hospital product tier (such as from Gold to Silver, or Bronze to Basic, and are therefore not covered for as many clinical categories) or by increasing the excess amount they would need to pay for hospital treatment. It is possible that those who drop or reduce their PHI cover do so because their usage of PHI is below that of their peers, or because they are likely to seek treatment as a public patient regardless of whether they had PHI or not, and they do not see value in maintaining their previous cover. However, this reduction in coverage could result in a larger than estimated reduction in private hospital separations if consumers do not accurately assess their likely future health needs when choosing their level of cover.

Stakeholder	Option 1 (Status Quo)	Option 2	Option 3
	While more people drop out of PHI in Option 3, this includes some younger people and marginally fewer older people dropping than in Option 2 due to the higher (25%) Rebate rate for the Base tier in Option 3. As younger people are on average likely to be healthier and less likely to make a claim than older people, and the difference is marginal in any case, there is not expected to be a significant difference in PHI claims between Options 2 and 3. A negative score is applied to Options 2 and 3 in this case, as reduced private hospital demand is considered to be a negative outcome from the perspective of private hospitals.		
Public hospitals	0	-1	-1

	Public hospitals will face no impact under Option 1.
	
	Public hospitals may experience marginal adverse impacts under Option 2 and Option 3. Slower growth in people with PHI is expected to result in marginally higher demand for public hospital services than would occur under current settings.
	
	• For Option 2, if the decrease in private hospital separations estimated in the row above all transferred to the public hospital system, then these additional public hospital separations would represent less than 1% of projected public hospital admissions in 2028-29[11].
	• This does not take into account:
	  ○ the extent to which people who drop their PHI choose to continue to access private hospital services without insurance (i.e. self-fund) or seek alternative treatments outside of the hospital system (for example access intravitreal injections in doctors rooms or manage a joint complaint through physiotherapy etc, as opposed to surgery).
	  ○ privately insured people who decide to downgrade their cover (as discussed further above). This reduction in coverage could place additional pressure on public hospitals as a result of the change		

[11] AIHW's Admitted Patient Care, 2023-24

Stakeholder	Option 1 (Status Quo)	Option 2	Option 3
	to the Rebate if consumers do not accurately assess their likely future health needs when choosing their level of cover. It is possible that those who drop or reduce their PHI cover do so because their usage of PHI is below that of their peers, or because they are likely to seek treatment as a public patient regardless of whether they had PHI or not, and they do not see value in maintaining their previous cover. If so, this would moderate any resulting increase in public hospital admissions. • Based on the services that are more or less likely to be funded by PHI versus publicly funded, these additional admissions would be more likely to be elective rather than emergency or nursing home type stay/maintenance admissions. Most PHI funded separations in 2023-24 were elective (75%) with the remaining separations being emergency (12%) and 'not assigned' (13%)[12]. • As outlined in section 1, additional Government funding for important aged care initiatives, which may help to address delayed discharge and relieve pressure on public hospitals, would not have been possible without the savings realised through this measure. The demographic differences between the changes in the insured population between Options 2 and 3 are sufficiently marginal (similar to private hospitals above), hence the impact has been assessed as the same for both options. A negative score is applied in this case, as increased public hospital demand is considered to be a negative outcome from the perspective of public hospitals.		
Medical professionals	0	0	0
	Medical professionals will face no significant impact under any option. Medical professionals may practice in the public, private, or both systems. While some medical professionals may see a slight decrease in demand for services in a particular system under Options 2 and 3, there will be an increase		

[12] AIHW Admitted Patient Care, 2023-24.

Stakeholder	Option 1 (Status Quo)	Option 2	Option 3
	in demand in the other system. While there may be a difference in income earned depending on the relativity of working in the private and public sectors, given the marginal impact on participation this impact is expected to not be significant. Therefore, the net impact is neutral.		
Total score	**0**	**-4**	**-7**

Analysis against Objective 1: continue to provide an incentive for people to participate in PHI through a simplified Rebate

This objective has been scored based on the relative change in participation compared to the Status Quo (Option 1), and whether the Rebate is simplified.

Option 1 – no change in participation, but as the Rebate structure is unchanged, it does not achieve simplification of the Rebate.

Option 2 and Option 3 – both achieve simplification due to the Rebate being solely based on income tiers rather than a mix of income tier and age with adverse impacts on participation. Tables 11-13 analyse the differences in PHI participation under Options 1, 2, and 3, by considering:

- the projected number of people insured in 2028-29 under Option 1 (Status Quo) (Table 11)
- the projected change in the number of people insured in 2028-29 under Option 2 and Option 3 compared with Option 1 (Status Quo) (Tables 12 and 13).

All three options will result in an absolute increase in the number of people holding PHI between implementation on 1 April 2027 and 2028-29. However, the rate of increase is expected to be slower for Options 2 and 3 than Option 1 (Status Quo), resulting in fewer people insured by 2028-29 under Options 2 and 3 compared with Option 1 (see Tables 12 and 13). The net expected change in the number of non-dependent insured people under Option 2 and Option 3 (compared with Option 1) is a decrease of 42,304 and 49,204, respectively.

The figures below are the unrounded outputs of statistical regression in the PHI model described in subsection 4.1 and the Additional Information provided at the end of this document about modelling participation. The number of insured people is those aged 18+ years and does not include dependents.

Table 11: Expected number of insured people (non-dependents) in 2028-29 under Option 1 (Status Quo)

	18-64 years	65+ years
Base Tier	4,666,287	2,998,008
Tier 1	692,981	136,931
Tier 2	1,045,524	221,188
Tier 3	1,295,233	336,275

Table 12: Expected change in number of insured people (non-dependents) in 2028-29 by age and income tier for Option 2 compared to Option 1 (Status Quo)

	18-64 years	65+ years
Base Tier	1,809	-42,001
Tier 1	118	-835
Tier 2	97	-1,477
Tier 3	-4	-11

Notes: The increase in insured people aged <65 years in the Base, Tier 1 and Tier 2 incomes tiers is due to the RAF being set to 1 on 1 April 2027 (i.e. the Rebate rate for these cohorts is assumed to be slightly higher than under Status Quo). The decrease in insured people in Tier 3 is due to people in Tier 2 dropping out in 2027-28 who would have otherwise moved to Tier 3 in 2028-29 due to income tier indexation.

Table 13: Expected change in number of insured people (non-dependents) in 2028-29 by age and income tier for Option 3 compared to Option 1

	18-64 years	65+ years
Base Tier	7,885	-36,193
Tier 1	-4,419	-1,873
Tier 2	-10,388	-4,006
Tier 3	-150	-60

Note: The decrease in insured people in Tier 3 is due to a people in Tier 2 dropping out in 2027-28 who would have otherwise moved to Tier 3 in 2028-29 due to income tier indexation.

Table 14 shows the projected relative change in the number of people insured in 2028-29 under Option 2 and Option 3 compared to Option 1, in the context of:

- only the directly impacted cohort, which is:
    - Option 2 – non-dependents aged 65+ in the Base Tier, Tier 1 and Tier 2
    - Option 3 – non-dependents aged 18-64 and 65+ in the Base Tier, Tier 1 and Tier 2
- the total change in the insured population, across all age and income cohorts (as shown in Tables 12 and 13).

Table 14: expected change in the number of insured people in 2028-29 (not including dependents) compared with Option 1, as presented in Tables 12 and 13 above

Measurement	Option 2	Option 3
Expected change in number of insured people among those directly affected by the option	-44,313	-48,994
Expected change in number of insured people among total insured population	-42,304	-49,204

Under both approaches to considering the change in relative insured population between Option 1 (Status Quo) and Options 2 and 3, Option 3 would have a marginally greater impact on the insured population. Whilst Option 3 slightly boosts participation for those for those aged 18-64 years in the

Base Tier, that increase is more than offset by greater declines in other segments of the projected insured population. This is due to removal of the Rebate for people in Tier 2 and reduction for people in Tier 1 under Option 3, which is estimated to have a more significant impact on participation in PHI compared with Option 2. However, given the marginal effect on participation in both Options 2 and 3, each received the same score of 1 for this objective in the multi-criteria analysis. Option 1 received a score of -1 for this objective given the Rebate has not been simplified.

Analysis against Objective 2: ensure funds are not spent on the Rebate if they are generally unlikely to alter participation decisions and/or could be better directed to other priority health, disability and aged care services.

This objective has been scored based on whether the option targets cohorts that are generally unlikely to drop PHI due to a reduced Rebate, and the overall savings achieved by Government that could be better spent on supporting additional Government funding for important aged care services. Option 1 takes no action to address these issues. Options 2 and 3 have beneficial impacts on those metrics.

Each element has been considered based on:

a) the expected save to government for each option, which represents funds that could be used to support additional Government funding for aged care services
b) whether the cohorts impacted by each option are generally likely to alter their PHI participation decision as a result of the change.

In relation to a) above, the estimated save to Government, per the PHI model, is outlined below:

Table 15: Saving to government for each option (4 years from 2026-27)

Option	Option 1	Option 2	Option 3
Saving to government (4 years from 2026-27)	Nil	$2,994.7 million	$3,922.4 million

Both Options 2 and 3 have beneficial savings impacts, with the magnitude significantly greater for Option 3. However, the fact that the entirety of the save for option 2 is achieved through reducing the Rebate for the same cohort that is likely to benefit from increased funding for aged care services in the immediate future was factored into the scoring.

There is no saving or cost to government for Option 1. Given the fiscal challenges in delivering services across the health landscape and objective to consider better directing funds, no savings is considered negative.

In relation to b) above, an analysis of whether the cohort impacted by each option are generally unlikely to alter their PHI participation decision is provided in Table 16 below:

Table 16: Analysis of likelihood of impacted cohorts to alter PHI participation

Option	Analysis
Option 1	Option 1 would be significantly adverse in terms of the objective not to fund cohorts where the Rebate is generally unlikely to alter PHI participation. This is because the Status Quo: • would continue to provide a higher Rebate for older Australians. As discussed above, older Australians are generally less responsive to price for PHI given the value they derive from holding PHI. • would continue to provide a Rebate for Australians earning a higher income (Tier 2) and not reduce the Rebate for Tier 1 income earners. Tier 3 income earners already do not receive a Rebate. As noted in the independent study into the PHI incentives, the MLS provides a much greater incentive for higher income Australians to purchase and hold PHI than the Rebate[13].
Option 2	Option 2 would be moderately beneficial in terms of the objective not to fund cohorts where the Rebate is generally unlikely to alter PHI participation. Option 2 targets a reduction in Rebate for this segment of the population that is generally likely to continue to retain PHI despite ceasing the higher Rebate. The Rebate would be reduced for approximately 3.2 million older Australians (as per expected participation when the proposed change would be implemented on 1 April 2027). Around 99% of these affected individuals are expected to continue to participate in PHI. This is in line with research[14] that indicates the elderly tend to be less sensitive to changes in insurance prices. This may be because they place a higher value on private treatment, are more risk averse than the general population and/or because the value proposition of PHI is higher for older people than younger people. The effect of Option 2 on overall PHI participation could be monitored using publicly available APRA data, as shown in Table 2.
Option 3	Option 3 would be moderately beneficial in terms of the objective not to fund cohorts where the Rebate is generally unlikely to alter PHI participation. The proposed changes under Option 3, in addition to those under Option 2:

[13] Liu, J., & Zhang, Y. (2023). Elderly responses to private health insurance incentives: Evidence from Australia. Health Economics, 32(12), 2730–2744. https://doi.org/10.1002/hec.4751
[14] Liu, J., & Zhang, Y. (2023). Elderly responses to private health insurance incentives: Evidence from Australia. Health Economics, 32(12), 2730–2744. https://doi.org/10.1002/hec.4751

	• remove the Rebate for all Australians earning a higher income (Tier 2) and reduce the Rebate for all Australians earning a middle-high income (Tier 1) and for older Australians in the Base Tier. Noting the analysis provided for Option 1 above, Option 3 would target a segment of the population that is likely to continue to retain PHI despite the Rebate ceasing or reducing. This is based on the likely relative value placed on retaining the benefits of PHI for people in these income tiers, as well as the impact of the MLS. This was referred to in the 2022-2023 independent study of PHI incentives [15]. • provide a slightly higher Rebate for those aged 18-64 years in the Base Tier compared to Option 2. As changes in the Rebate are more likely to incentivise this cohort, this change would appropriately target a segment of the population that may be more likely to take up PHI due to the increased Rebate. Although Option 3 removes the Rebate for certain populations who may retain PHI without it, the greater participation impacts of Option 3 compared to Option 2 suggest that more of the affected individuals were relying on the PHI Rebate for their PHI participation. The Rebate would be reduced for approximately 4.9 million older Australians (as per expected participation when the proposed change would be made on 1 April 2027). Around 99% of these affected individuals are expected to continue to participate in PHI. The Rebate will also marginally increase for 1.7 million individuals aged 0 64 years in the Base tier, which is expected to increase participation in that cohort by less than half a percent (7,885 people). Although the participation impacts for Option 3 are marginally greater than for Option 2, the saving to government for Option 3 significantly outweighs that for Option 2. Therefore, on balance, Option 3 was deemed to be more beneficial for this objective than Option 2.

Therefore, based on each element described above for the objective, Option 1 overall is moderately adverse and received a score of -2, Option 2 is moderately beneficial and received a score of 2, and Option 3 is significantly beneficial and received a score of 3.

Analysis against Objective 3: ensure the Rebate is equitably targeted, while minimising any negative impact on participation

This objective has been scored based on whether each option is considered to be equitable.

[15] MLS and PHI Rebate Final Report, 2023.

Option 1 is not considered to be equitable given that it would continue to provide higher Rebates for older Australians compared to younger Australians on the same income.

Option 2 and Option 3 are considered to be more equitable than Option 1, because they remove the inequitable higher subsidy for older people compared to younger people earning the same income. Option 3 also provides a slightly higher PHI Rebate to lower income earners in the Base Tier (25%) compared to Option 2 (24.118%) and reduces the Rebate for all middle to higher income earners in Tier 1 and 2. This was considered to have a marginal impact on the overall equity of Option 3.

For Objective 3, Option 2 and Option 3 both had a score of 2, and Option 1 had a score of -2.

5. Who did you consult and how did you incorporate their feedback?

Due to the confidentiality required of Budget processes, the department did not conduct specific consultation on the proposed changes to the Rebate.

Consultation with stakeholders about PHI incentives, including Rebate settings, was undertaken in 2022 and 2023 during preparation of an independent study[16]. This included insurers, healthcare providers, hospitals, consumers and other interested parties.

The department recognises the value of consultation when considering different interventions, including identifying any unanticipated consequences, for example from adjusting the Rebate percentages. This consultation included a substantial number of one-on-one and workshop engagements to support the findings of the independent study's final report[17] and related document setting out themes from the engagement.[18] Whilst the department has not consulted on the specific proposed changes to the Rebate due to the confidentiality required for Budget processes, feedback reflected through the 2022-2023 independent study and subsequent public consultation on the final report[19] was considered in the development of the options. This feedback remains relevant because the Rebate settings have not changed since the feedback was provided, and the specific options proposed were included in the independent report.

Almost all stakeholders indicated the current Rebate settings were overly complex. Rebate reform options suggested by stakeholders typically aligned with improving their own circumstances. For example, insurers and their peak bodies asked for the Rebate to be increased, including requesting it return to the flat rate of 30% that applied when it was introduced in 1999. Consumers sought ongoing support in relation to the cost of premiums and out of pocket costs of private healthcare. They also mentioned concerns around the overall complexity of PHI in general and of the PHI incentives (including the Rebate). Healthcare providers wanted to avoid any flow-on reduction in funding potentially decreasing private hospital admissions.

Options 2 and 3 would address concerns about Rebate complexity by removing differing rates by age, with eligibility being determined only by income.

Option 2 has been designed to limit the reduction in the Rebate to minimise the anticipated increase in the cost of premiums and the cost of living pressure for people who choose to continue to participate in PHI and to remove intergenerational equity in the Rebate settings.

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[16] MLS and PHI Rebate Final Report, 2023.
[17] Ibid, pages 30-33.
[18] Themes from Stakeholder Engagement
[19] Consultation on the Private Health Insurance (PHI) Incentives and Hospital Default Benefits Studies - Australian Government Department of Health, Disability and Ageing - Citizen Space

The department acknowledges that some time has passed since the consultation process and there have been broader shifts in macroeconomic circumstances over last 3 years. However, the feedback remains relevant and current, because the Rebate and other major PHI settings remain unchanged since that time. Relevant quantitative statistics, such as changes to Rebate expenditure and insured persons, were refreshed for an up-to-date consideration of the issues via the department's Rebate Model, as described in section 4.

6. What is the best option from those you have considered and how will it be implemented?

The best option

Independent analysis of the PHI Rebate identified that government investment in the Rebate is greater than required to incentivise PHI participation[20]. Analysis of whole of health, disability and aged care system priorities and budget constraints provide a strong case for the excess Rebate funding to be directed to higher priorities like aged care. However, the private health system is under financial pressure, and reduction or removal of the Rebate without broader reforms to the private hospital and insurance system will likely result in some existing policy holders choosing to drop their cover as noted in the analysis presented in subsection 4.3.

Overall benefits and costs are summarised in Table 17.

Table 17: Overall benefits and costs per option

Overall costs per option			
	Option 1 (Status Quo)	Option 2	Option 3
Direct regulatory cost (One-off)	Nil	$689,584	$1,324,140
Estimated savings to Government / impacts to policyholders (4 years from 2026-27)	Nil	$2,994.7 million	$3,922.4 million
Expected change in the number of affected insured persons in 2028-29 for the option compared to Option 1	N/A	-44,313	-48,994
Results of multi-criteria analysis on stated objectives	-5	5	6
Results of multi-criteria analysis on affected stakeholders	0	-4	-6

The objectives of the provided options, as outlined in section 2, were to:

- continue to provide an incentive for people to participate in PHI through a simplified Rebate

[20] MLS and PHI Rebate Final Report, 2023.

- ensure funds are not spent on the Rebate if they are generally unlikely to alter participation decisions and/or could be better directed to other priority health, disability and aged care services.
- ensure the Rebate is targeted equitably, while minimising any negative impacts on participation.

As outlined in Section 3.1, maintaining the Status Quo (Option 1) would not address the objectives, as the Rebate would continue to provide a subsidy greater than required to incentivise participation, with negative consequences for other health system priorities. Maintaining the Status Quo would also not address the inherent inequity of people aged 65+ receiving a higher Rebate than younger people earning the same income.

In comparing the potential benefits of Option 2 and 3, Table 18 provides the expected change in the number of insured people in 2028-29, as a percentage change against Option 1 (Status Quo), segmented by age.

Table 18: estimated change in number of insured people in 2028-29 by age (not including dependents) compared with Option 1 (Status Quo)

Change in insured people compared to Status Quo (%)			
	18-64 years	65+ years	Whole population
Option 2	0.0%	-1.2%	-0.4%
Option 3	-0.1%	-1.1%	-0.4%

Option 2 would address each of the objectives. It would continue to provide an incentive for PHI participation through simplified Rebate rates, while ensuring some Rebate funds ($2,994.7 million over 4 years from 2026-27) were available to be spent on supporting important aged care services. Option 2 ensures the Rebate is equitably targeted by ensuring the Rebate is only set with reference to income, not age. It also ensures the Rebate is spent on cohorts where it might influence individual decisions to purchase PHI, as older Australians are likely to continue to maintain PHI even if their Rebate entitlement is reduced (see Table 9), as the benefits outweigh the reduction in Rebate (Figure 1). Overall, compared to Option 3, Option 2 has:

- a smaller regulatory burden (estimated at $689,584 and $1,324,140, respectively)
- a smaller cost to consumers ($2,994.7 and $3,922.4 million over 4 years from 2026-27, respectively), and
- a smaller participation impact (-42,304 and -49,204 in 2028-29, respectively).

Option 3 addresses the same objectives as Option 2, although the Rebate funding saved that could be used to support other priorities is higher ($3,922.4 million over 4 years from 2026-27). However, compared to Option 2, Option 3 has higher regulatory costs for insurers, a larger impact on consumers and is likely to result in more people dropping PHI (see Table 13), including younger people in Tiers 1 and 2. Younger people dropping their cover would undermine the sustainability of

the PHI system which requires participation by younger (typically healthier) individuals to cross-subsidise the older cohort.

Overall, Option 2 is preferred, as it meets the identified objectives to a greater extent overall than Options 1 and 3. It has a smaller impact on affected stakeholders than Option 3, as shown in the multi-criteria analysis in section 4.3. Overall, Option 2 received a score of 1 in the multi-criteria analysis, and Option 3 received a score of -1.

Implementation

PHI participation and performance statistics are collected and released on a quarterly basis by APRA. This regular reporting and the close prudential oversight undertaken by APRA, including on insurer governance and change management arrangements, will support government to closely monitor insurers' progress in developing and implementing sound strategies to assist their customers to adapt to the changes in Rebate levels.

The Rebate changes would be implemented through amendments to the *Private Health Insurance Act 2007,* to come into effect on 1 April 2027. Government agencies (SA and the ATO) and private health insurers will require several months' lead time following detailed communications, so they can implement relevant changes to their IT and administrative systems. Private health insurers will require time to forecast impacts to their business and develop pricing strategies to enable their businesses to transition (including through their 2027 PHI premium round applications, which would likely be due by mid-November 2026).

Implementation risks

The department is conscious of likely risks associated with implementation. Competition in the PHI market is expected to force insurers to limit the extent to which they increase premiums for some of their products, in order to maintain membership levels given the lower Rebate assistance. This may include accepting lower profit margins. Insurers are also expected to design and offer products that balance coverage with affordability, offering products with lower benefits within regulations to retain people who have had their level of Rebate assistance reduced or removed.

People who decide that PHI is no longer affordable can access necessary healthcare through Australia's universal public system. In circumstances where their level of cover was not comprehensive, or their health professional elected to charge out of pocket costs, some policy holders may be financially better off accessing care in the public system. They would lose the option for choice of service provider and may face longer waiting times for treatment. People dropping their PHI is therefore expected to lead to a marginal increase in demand on the public hospital system, as shown in section 4.3 (multi-criteria analysis).

The Private Hospital Financial Viability Health Check conducted in late 2024 found that the average profitability of the private hospital sector has declined. Several hospitals are at high risk of near-term exit and parts of the sector are not generating the returns needed for continued

investment. While some market correction is anticipated, it is expected to be limited under current PHI funding models. Potential reductions in the level of privately insured patients, compared to what would have been the case had the measure not been implemented, is expected to result in a marginal reduction in demand for private hospital services compared to Option 1, as shown in section 4.3 (multi-criteria analysis).

Potentially reduced demand for medical specialist services in the private hospital sector may result in specialists deciding to deliver more private services to non-admitted patients, delivering more services in the public sector, or competing to retain current patient numbers by reducing their fees.

Whilst the risk of the projected impacts on business, government, and consumers is relatively low, metrics will be tracked and any significant deviations will be managed through a range of reform options identified by the sector being considered by Government.

The status of the Impact Analysis at each major decision point is outlined in Table 19.

Table 19: interim and final decision points

Decision Point	Timeframe	Impact analysis status
Consideration by Government	March/April 2026	Preliminary IA undertaken March 2026 Full IA drafting process.
Preliminary announcement	22 April 2026	First Pass completed April 2026
Final announcement	12 May 2026	Second Pass completed May 2026

7. How will you evaluate your chosen option against the success metrics?

Evaluation is critical to determine whether proposed reforms efficiently achieve their objectives and is an important tool to improve policy design and implementation for future reform endeavours.

The evaluative approach will be through an internal process to consider whether the preferred option (Option 2) achieves the measures of success which were outlined in Section 2.

A proposed evaluation plan is provided below which outlines:

- Measuring and assessing
- Reporting and accountability.

7.1 Measuring and assessing

Table 20 shows the success factors and metrics needed to achieve each of the identified objectives, and the person/s responsible for the success factors/metrics.

Table 20: success factors, metrics and responsible persons needed to achieve the identified objective

Objective	Success Factor	Success Metric	Responsible person/s
• **Ensure the Rebate is equitably targeted while minimising any negative impact on participation**	• As a result of eligibility for particular Rebate rates being determined by income only, rather than by income and age, there is minimal reduction in the proportion of the population that participates in PHI in the first two years.	• Insured people as a proportion of the population in the March 2029 quarter has not reduced by more than 1 percentage point compared with the March 2027 quarter. 1 percentage point is larger than the modelled impact on participation but has been chosen to account for the possible	• Program team is responsible for interrogating APRA's Quarterly PHI Statistics to determine whether insured people (with any form of PHI) as a proportion of the population reduces by more than 1 percentage point in March

Objective	Success Factor	Success Metric	Responsible person/s
		impacts of external factors, such cost of living pressures that differ from the modelled assumptions. The number of insured people is expected to continue to rise, reflecting growth in the overall population. Using this participation metric allows comparison of the impact relative to the population using publicly available APRA data. A 2 year time period has been chosen because the participation impact (while expected to be minor) is likely to be most pronounced in the first 2 years. The 2 year time period will provide sufficient time for consumers to feel the impact of the change and decide whether to remain in PHI.	2029 quarter compared to March 2027 quarter.

7.2 Reporting and accountability

The department will conduct a formal internal evaluation of the success of meeting the third objective: *ensure the Rebate is equitably targeted while minimising any negative impact on participation*. The program team will interrogate APRA Quarterly PHI Statistics to determine whether insured people as a proportion of the population reduces by more than 1 percentage point in the March 2029 quarter compared to the March 2027 quarter. APRA data of PHI membership by age and membership by coverage type (hospital and general treatment) will also be examined to determine whether any reduction in the proportion of insured people has likely occurred due to the changes to the Rebate settings. As shown in Table 11, the greatest expected participation impacts are in people aged 65+ years in the Base Tier. Barring other significant impacts, it is anticipated this measure will have a marginal impact on participation across the whole population.

If a reduction of more than 1 percentage point occurs, this may indicate that the change has had a greater than anticipated impact on PHI participation and is potentially no longer providing an incentive for people to participate in PHI and negative impacts on participation were not sufficiently minimised. This information will be communicated to Government, as appropriate.

8. Additional Information

PHI Rebate Forward Estimates Model

A brief description of each module of the Model follows:

Demographic Module

The projection of the number of insured adults requires a projection of the population that is eligible to take up this insurance. The population size and its growth are influenced by various factors such as birth rates and mortality rates as well as rates of migration. In addition to these, the characteristics of the population also play an important role in determining the take-up of insurance. For example, an aging population will require more healthcare services, on average. Families planning for children are more likely to take up or upgrade insurance policies to include hospital cover. The incomes of individuals will determine whether insurance is affordable for them and how influential they find government incentive schemes.

The Demographic Module (built in SAS) took the most recent projection of the population of Australia from the Australian Bureau of Statistics (ABS) and updated it to reflect any deviations between the projections and the current population. It then used various other sources of information such as Census sample files and ATO sample files to disaggregate the projections. The output of this module was the projected population size, segmented by the various demographic characteristics that may be significant in determining the level of participation in PHI.

The demographic characteristics that are significant in explaining policyholder behaviour included:

- Age/age band – the older population may have a higher demand for PHI because of their increasing needs for healthcare. There may be a spike in demand for PHI at age 30 because of the operation of the Lifetime Health Cover loading (LHC).
- Gender – males may have different demand for PHI than females for various reasons.
- State/jurisdiction – PHI premiums may differ by state and affect premium affordability and therefore the demand for PHI.
- SEIFA (socio-economic indicator) – those with a higher indicator will be more able to afford PHI and may have a higher demand.
- Family status – families may have a higher demand than singles. Couples at child bearing age may have a higher demand for family cover.
- Income/income band – those with higher income may be more able to afford PHI.
- Dependent children (or number of dependent children) may increase the demand for PHI cover.

Economic Module

The Economic Module (built in Excel as part of the Forecasting Module) contains a projection of the various indicators of economic activity that will impact on the Rebate projections. These include:

- Consumer Price Index (CPI), which will directly impact on the Rebate percentage through the Rebate adjustment factor (RAF). It will also be used in the indexation of income to measure changes in real purchasing power. Similarly, it will be used in the indexation of PHI premiums to express their real rate of growth (above the cost of living).
- Average Weekly Earnings (AWE), for the purposes of inflating income over time as well as the definition of the income tier bands in the Rebate/MLS tables.

Premiums Module

The Premiums Module (built in SAS) analysed the premiums data on the individuals who have had a PHI policy in recent years. The main purpose of this analysis was to estimate premium growth rates that can be applied to current premium levels to project future premiums. The output from the analysis included:

a. the average annualised premium per insured adult in each behaviour segment;
b. the historical annual premium growth rates by state (jurisdiction), family status and coverage type;
c. the proportion of insured adults by state, family status and coverage type;
d. the average 'non-annualised' premium per insured adult in each behaviour segment (to be used for General only cover); and
e. the insured adult population in each behaviour segment per financial year.

The analysis of item a) for consecutive years allowed item b) to be calculated. Item b) formed an initial basis for the selection of future premium growth rates by state, family status and coverage type. Item c) allowed the growth rates to be summarised at an industry level (by weighting the growth rate in each segment according to the proportion of insureds in each segment). The industry growth rate was then compared against APRA figures for reasonableness. The selected growth rates were then calibrated if required.

Items a), d) and e) were used as inputs into the Forecasting Module. For General only cover, the average premiums used were the 'non-annualised' version due to the way in which the number of General only insureds were counted.

Note that the average premium growth rates from b) encapsulated multiple factors. These include the intrinsic increases due to increases the cost of providing health care over time, upgrading/downgrading within coverage types etc. In particular, it included the impact of the aging population – where progressively more insureds will be paying higher premiums that provide more comprehensive cover as they grow older. We have selected the future growth rate as the average of the growth rates observed in the latest two years. However, since our model explicitly

allows for the impact of the aging of the PHI population, before applying this growth rate, an adjustment was made to the rate to only account for the remaining sources of growth.

Participation Module

The Participation Module (built in SAS and Teradata) analysed data on all the individuals who have held a PHI policy in recent years and assessed their propensity to change coverage types depending on their behavioural characteristics (which included demographic characteristics, PHI incentive characteristics and premium characteristics). Modelling coverage type was desirable because:

- The MLS applies to those without Hospital/Combined cover and the LHC applies to those who did not purchase Hospital/Combined cover before age 31. Since these incentives are coverage type specific, it would be important to be able to project the number of insureds by coverage type, in order to be able to model their impacts.
- There may be a desire to scenario test the impact of various government policy changes that are coverage type specific. Modelling coverage type would facilitate the testing of these scenarios.

Forecasting Module

The Forecasting Module (built in SAS and Excel) brought together all the inputs from the Demographic, Economic, Premium, and Participation modules to forecast for the next ten years:

- the probabilities of transition between coverage types;
- the number of adults in each demographic segment and coverage type (General, Hospital, Combined and No Cover);
- the projected premiums paid; and
- the projected Rebate amounts.

Note that the model only projects insureds, premiums and Rebates in respect of those who claim the Rebates from a discount on the insurance premiums rather than from the ATO through their tax returns. Therefore, Rebates from the ATO need to be added to the projections from the model if total Rebates are required. Also, this model does not allow for Rebates that are paid to insureds who misdeclare their income tiers when claiming their Rebate from insurers. Therefore, to estimate the Rebates that Health pays, these amounts would also need to be added.