National Seniors AUSTRALIA

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
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Canberra ACT 2600

Private Health Insurance Amendment
(Modernising the Private Health Insurance Rebate) Bill 2026

National Seniors Australia (NSA) welcomes the opportunity to make this submission to the inquiry into the Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026.

Comprising a community of more than 300,000 individuals, NSA is the peak consumer advocacy body representing the interests of older Australians. Through our research and advocacy activities, NSA works to improve the wellbeing of all older Australians, including self-funded retirees, pensioners, part-pensioners, Veterans, and carers.

NSA does not support the Bill proceeding in its current form.

If passed, the Bill would reduce the Private Health Insurance (PHI) rebate for people aged 65 and over. Our analysis indicates the combined impact of higher premiums, lower rebates and the Rebate Adjustment Factor on 1 April 2027 could increase net premiums for people aged 70+ by almost 28%. If enacted, the bill will:

- add significantly to cost-of-living pressures facing older Australians,
- leave older people underinsured and erode the sustainability of private health,
- shift costs to state and territory hospital systems, placing the financial sustainability of the public health system at risk.

We detail the evidence to support these assertions later in this submission.

While we acknowledge savings are intended to offset the cost of additional aged care spending, it is important to note that older people reject this proposition.

Taking away supports that help older Australians maintain private health insurance to fund aged care is a false economy, especially if this results in greater demand on the public hospital system and the need for higher taxes to fund it.

Yours sincerely

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Executive summary

Currently, most people aged 65+ with Private Health Insurance (PHI) receive a higher rebate on their premiums. This was introduced to encourage older people to maintain PHI.

In the 2026 Federal Budget, it was proposed that the higher rebate end from 1 April 2027. At current rates, this would reduce the rebate from 32.158% for people 70 and over and 28.139% for people aged 65-69 down to 24.118%.

A significant number of older people have PHI:

- An estimated 3.2 million will be impacted by the proposed change.
- Recent government data estimates that 1.2 million people who receive the Age Pension have PHI.
- Approximately 55% of people aged 65 and over with PHI have Gold level coverage, or over 1.8 million people.

The government estimates that 44,000 people may drop their coverage completely due to this change in the rebate. NSA questions the modelling behind these findings and believes the impact may be greater than expected.

Little has been said about the impact on people's level of cover. Government has not included an estimate of how many people may downgrade their cover if the rebate cut proceeds, yet NSA surveys show this action is likely a response to .

Gold coverage is the highest level of cover and includes procedures relied upon by older people, such as joint replacements and cataract surgeries. The private health system performs most of these surgeries.

If people move from Gold to Silver plans, they may lose coverage for the above procedures, leaving them underinsured and facing higher out-of-pocket costs if they use the private system.

If older people drop or downgrade their cover in significant numbers, this may result in changes to cover and PHI pricing for all users, including younger people, the impact of which we won't likely understand immediately.

There is also limited understanding about the impact of the rebate cut on the public health system. The public health system already has long wait times for elective surgeries, such as knee and hip replacements, and we question if it could cope with an influx of new patients dropping or downgrading their premiums.

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On 1 April 2027, older Australians with PHI will face three interactive premium pressures:

- the annual premium increases,
- the reduction in the rebate, and
- the ongoing rebate reduction from the Rebate Adjustment Factor.

We estimate that for Gold coverage this could mean a 27.90% increase in net premiums, which could mean an increase of $2,601 in net premiums for a couple aged 70 with Gold hospital and top extras.

NSA survey data presented in this submission implies that there may be larger numbers of older people who will consider dropping or downgrading their cover to manage costs. It also shows that older people on lower incomes and savings are more likely to consider this behaviour.

NSA calls on the government to abandon the blunt change to the higher PHI rebate because of the significant uncertainties and unintended consequences in doing so.

We simply will not know the scale of impact on older people and the public and private health systems until 1 April 2027 when the cut and regular price increases take effect.

Given concerns about the impact on the viability of PHI and private hospital systems, we continue to call for a wide-ranging Productivity Commission inquiry into the private health system to identify and address the drivers of health inflation in this sector. Government must ensure that private health remains an attractive option, as this is the best way to encourage people to contribute to health costs.

It will be too late to fix this problem once the rebate reduction occurs on 1 April 2027. NSA therefore urges all parliamentarians to reject the proposed bill as it stands.

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Private Health Insurance Rebate

Since 1999, the Private Health Insurance rebate has reduced the cost of PHI premiums to encourage Australians to take up PHI and contribute to their own health care costs; and, in doing so, help reduce reliance on the public health system.

The rebate was initially 30% and later increased to 35% for people 65-69 and 40% for people 70 and over in recognition of the benefits of having older people privately insured. Subsequent changes, including the Rebate Adjustment Factor (RAF), have reduced these percentages over time.

Age of oldest person covered	Base Tier	Tier 1	Tier 2	Tier 3
Under 65 years old	24.118%	16.079%	8.038%	0.000%
65 – 69 years old	28.139%	20.098%	12.058%	0.000%
70 years old and over	32.158%	24.118%	16.079%	0.000%

Table 1: Current PHI rebate rates by age and income tier. *Source: ATO*[1]

The rebate is also income-tested. At the time of writing, the applicable income thresholds and rebate rates are set out below:

	Base Tier	Tier 1	Tier 2	Tier 3
Single	$105,000 or less	$105,001 - $123,000	$123,001 - $164,000	$164,001+
Family	$210,000 or less	$210,001 - $246,000	$246,001 - $328,000	$328,001+

Table 2: Income tiers for PHI rebate. *Source: ATO*[2]

Since April 2020, PHI hospital cover must be grouped into different categories based on the minimum inclusions offered.[3] A main concern for seniors are the differences between Silver and Gold plans, cataracts and joint replacements are a minimum requirement of Gold, but optional in Silver.[4] Some Silver-Plus plans do include these treatments, though they do come with a higher premium. The government recently consulted[5] on possible PHI reforms including removing Plus plans as an option, which we opposed in our submission as this requires more consideration.[6]

[1] Income thresholds and rates for the private health insurance rebate | ATO
[2] Income thresholds and rates for the private health insurance rebate | ATO
[3] Hospital cover and product tiers | Australian Government Department of Health, Disability and Ageing
[4] Product tiers | PrivateHealth.gov.au
[5] Private Health Reforms - Consultation Paper 1 | Department of Health, Disability and Ageing
[6] Private Health Reforms - Consultation Paper 1 | NSA

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We have estimated the number of people aged 65 and over across different levels of PHI coverage. This data suggests that approximately 64.8% of Australians aged 65+ have some level of PHI, around 52% have hospital coverage, and approximately 36% have Gold cover.

Coverage	Number of people 65+	Proportion of total
Gold	1,816,446	55.0%
Silver	746,242	22.6%
Bronze	65,295	2.0%
Basic	18,950	0.6%
Extras only	653,067	19.8%
TOTAL	3,300,000	

Table 3: Estimated number of people age 65+ by PHI coverage level.
Data source: Review of MLS, PHI Rebate and LHC[7]

What is being proposed?

The government announced in April 2026 that it would remove the higher age-based rebate for people aged 65 and over. For a person aged 70 or over in the base income tier, using current rebate rates, this would reduce the rebate from approximately 32.16% to 24.12%. This is an 8.04 percentage point reduction equivalent to a 25% reduction in rebate for someone aged 70+.

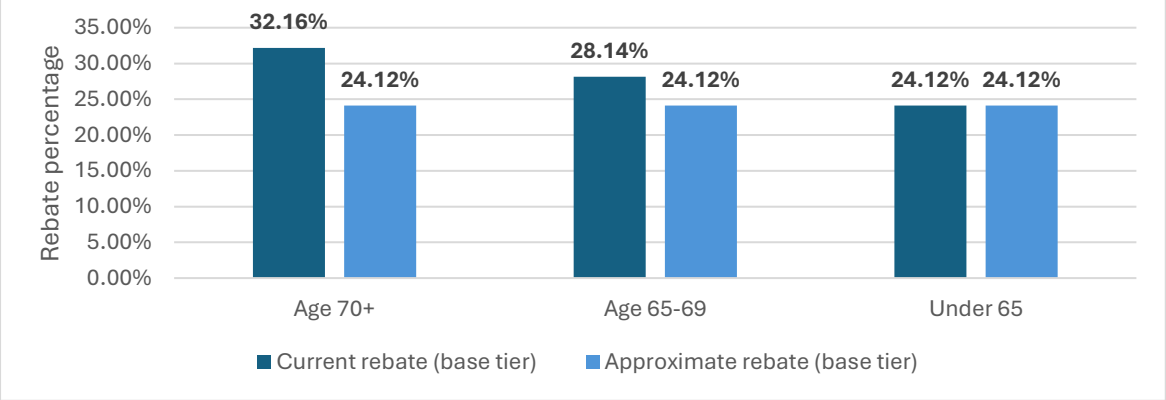

Fig. 1: Approximate change in PHI rebate, by age of oldest person covered, for base tier income. *Data source: ATO*[8]

[7] Review of MLS, PHI Rebate and LHC | Finity Consulting Pty Limited, Australian Government Department of Health and Aged Care
[8] Income thresholds and rates for the private health insurance rebate | ATO

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Impacts on the Health System

NSA considers reductions in the PHI to be a short-term saving for the federal government that risks setting off a vicious cycle:

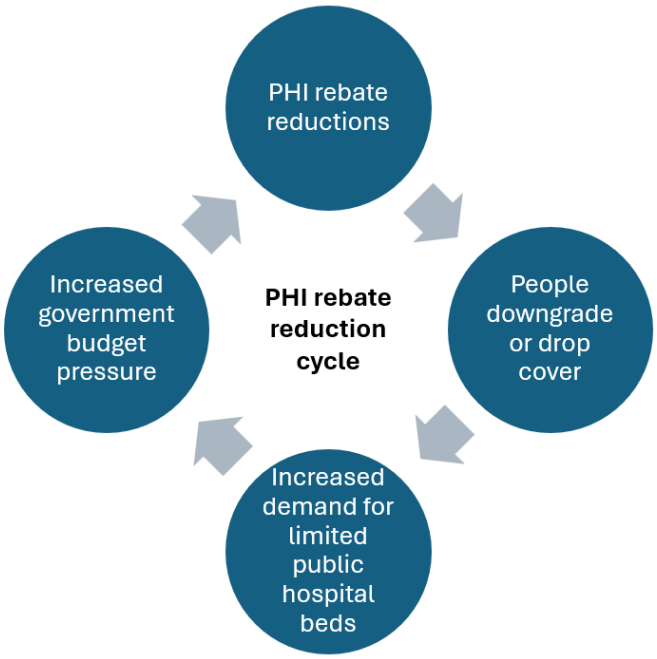

Fig. 2: Flow-on impacts from PHI reduction

NSA considers the key risks to be interconnected:

- Affordability – **PHI will become more expensive for older Australians**, with potentially disproportionate consequences for people on lower fixed incomes, especially pensioners.
- Coverage – **Some older policyholders may downgrade or discontinue hospital (and extras) cover**, including higher level cover that funds procedures heavily delivered in the private system.
- Private/public hospital capacity – **Reduced private coverage may increase demand** for public elective surgery. This may compound existing pressures associated with older people who are medically ready to be discharged but cannot access appropriate aged care or community support.
- Whole of system cost – **A measure that reduces Commonwealth expenditure on the rebate may increase health expenditure** elsewhere in the federation.

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Impact on private hospital capacity and elective surgeries

While the government has estimated the number of people likely to drop their cover (and therefore move to the public health system), the number of people who downgrade their cover is also important. This is because private hospitals undertake most joint replacements and cataract surgery, which are covered by Gold and some Silver-Plus plans. The public system is unlikely to cope with a sudden influx of such surgeries without detrimental impacts.

According to analysis by the Australian Orthopaedic Association National Joint Replacement Registry in 2022/23 (largely total replacement procedures, but some other types as well), private hospitals were responsible for almost 62.3% of the 59,510 hip replacements and almost 74.5% of the 77,099 knee replacements.[9]

According to the Australian Institute of Health and Welfare (AIHW), in 2024/25, there were 344,695 'insertion of intraocular lens prosthesis' procedures, such as for cataracts, only 27.1% of these operations were performed in public hospitals.[10]

Wait times for cataract, knee, and hip surgeries in public hospitals are still above pre-COVID-19 levels, and in the case of knee replacements trending upwards according to the latest data available from the AIHW[11]:

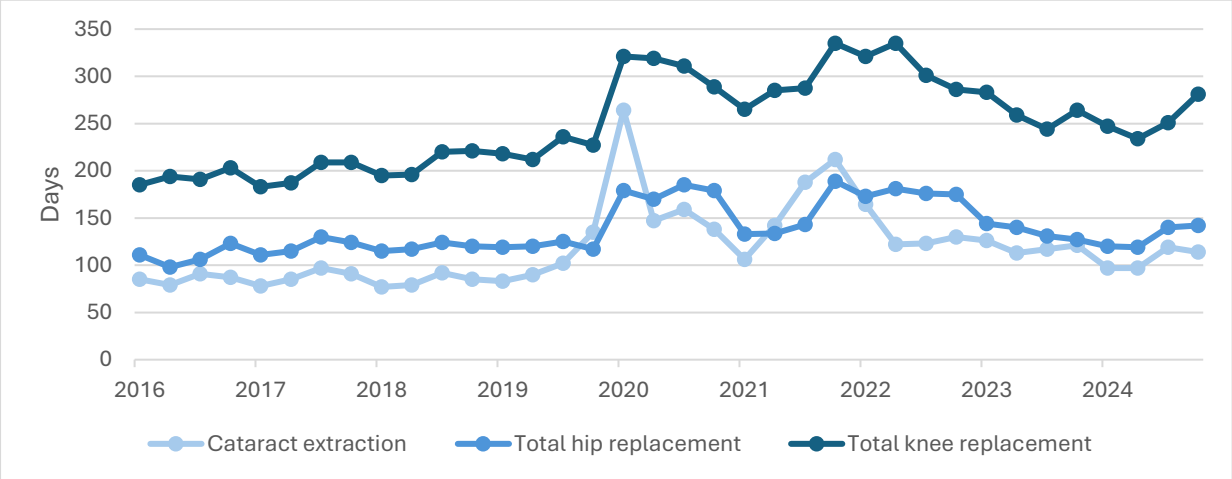

Fig 3: Median wait time for elective surgery in public hospitals.
Data source: AIHW[12]

[9] Analysis of State and Territory Health Data - 2024 Supplementary Report | Australian Orthopaedic Association National Joint Replacement Registry
[10] Admitted patient care 2024–25 6: What procedures were performed? | AIHW
[11] Elective surgery dashboard - Hospitals | AIHW
[12] Elective surgery dashboard - Hospitals | AIHW

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Impact on federal, state, and territory budgets

Modelling prepared for the government shows the PHI rebate has a positive cost-benefit to government when considered across the state and federal budgets.

The draft report by NEAA Associates[13] (unfinalised) finds a positive cost-benefit of the PHI rebate starting around age 45, and peaking at age 75+, which concluded "that the current PHI subsidy policy is a very good financial deal for the government". For people on the base income tier, having PHI offsets almost $5,000 in public health costs per person aged 75+, with the vast majority of this coming from saved hospital spending.

A report prepared for Avant Mutual in 2025 modelled four scenarios, finding a return per of $1.21 and $1.25 per dollar spent to maintain or increase the rebate levels.[14] A partial or full rebate removal scenario had a negative return of $1.57-$1.80 per dollar. Though these estimates were across the whole population.

Earlier this year, the government agreed a new five-year National Health Reform Agreement (NHRA) after much negotiation with the states and territories.[15] This is the largest new spending initiative in the federal budget, at more than $18 billion over the forward estimates. Given 'modernising private health' is the fourth largest saving measure in the budget, we question whether cutting the PHI rebate is more about clawing back some funding the states extracted in the health agreement.

Impact on delayed discharge / stranded patients

As discussed above, reduction in the PHI rebate risks a feedback loop leading to worse health outcomes. If a proportion of older policyholders move from private to public treatment that activity must be absorbed by public hospitals already managing elective surgery and bed-capacity pressures.

Public hospitals are increasingly managing older people who are medically ready for discharge but cannot leave because appropriate aged care, rehabilitation, accommodation or community supports are unavailable. Existing state data[16] indicates delayed discharge is already a material system pressure. Adding avoidable demand to public hospitals risks worsening that pressure by increasing competition for beds while existing patients wait for appropriate support outside hospital.

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[13] Offset of public hospital cost and Net cost to the government of subsidizing, Draft report: v August 29, 2022 | NEAA Associates
[14] The Value of the Australian Government Rebate on Private Health Insurance Economic Analysis and Policy Considerations for Australia's Dual Healthcare System | DeltaPearl Partners for Avant Mutual
[15] Government lands last-minute hospital funding deal with states | ABC News
[16] Statewide performance | Queensland Health; Patients waiting for residential aged care | SA Health; Hospital activity | Tasmanian Department of Health

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Impacts on premiums

If legislated, the reduction to the rebate would apply on 1 April 2027. This is the same date as the annual government-approved premium increases and the legislated annual Rebate Adjustment Factor (RAF) applied (which reduces the rebate if the premium increases are higher than inflation). This means seniors with PHI will have their premium increased by three different factors on the same day.

Public understanding about the rebate is likely low because the rebate is often applied directly to premiums. While government may hope this obscures the rebate issue, it will make little difference to consumer behaviour as policyholders will simply focus on the net premium increase when considering the value of PHI.

Unfortunately, the scale of the impact will not be apparent until the three changes take effect simultaneously on 1 April 2027. This could lead to immediate consequences for older people and the private and public health systems if older people choose to drop or downgrade their cover.

While some will be able to absorb the increase or reduce spending to maintain cover, others will take direct action to change their cover. This could undermine coverage and place significant pressure on private and public health systems over the next few years.

Our estimates suggest this could be largest premium increase since the rebate has been in place.

For example, if the premium increase for Gold in 2027 is the same as 2026 (13.3% according to an analysis by Choice[17], though PrivateHealth.gov.au data suggests this figure is sensitive to differences between states and insurers), and the same for the RAF (a 0.70% decrease in the rebate percentage), then combined with the broader rebate reduction this could result in premium increases of **27.90% for someone aged 70 and over.** While some Gold level plans did increase 25% in 2026, there is likely no previous example of such widespread premium increases and it is unclear what the consumer response will be.

For comparison, even taking the much lower 2026 government approved average of 4.41%, this would still result in a net premium increase of 17.86% in April 2027 for people aged 70 and over.

[17] Health insurance prices reach an all-time high | CHOICE

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	Gold hospital only	Gold hospital and top extras
Current premium (gross)	$9,325.20	$13,742.40
Current rebate %	32.16%	32.16%
Current rebate $	$2,998.98	$4,419.56
Net current premium	$6,326.22	$9,322.84
Premium increase (13.3%)	$1,240.25	$1,827.74
Future premium (gross)	$10,565.45	$15,570.14
Rebate at current rates $	$3,397.85	$5,007.36
Reduced rebate %	24.12%	24.12%
Reduced rebate $	$2,548.39	$3,755.52
Change from rebate reduction	**$849.46**	**$1,251.84**
RAF %	-0.70%	-0.70%
Rebate after RAF (%)	23.42%	23.42%
Rebate after RAF ($)	$2,474.43	$3,646.53
Change from RAF $	$73.96	$108.99
Future net premium	$8,091.02	$11,923.61
Total increase cost to insured	**$1,764.81**	**$2,600.77**
Increase as % of current cost	**27.90%**	**27.90%**

Table 4: Estimated combined impact on net premiums 1 April 2027

Impacts on Older Australians

NSA survey evidence

To better understand the impacts of a change in the rebate on older Australians, NSA conducted a survey of 2,500 participants, which included questions about PHI and the PHI rebate.

Coverage

- Among survey respondents, there was a high level of coverage - 84% of survey participants had PHI cover.
- PHI cover was highest among survey participants who are self-funded retirees (94.5%) and lowest among full rate pensioners (69.1%).

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Support for retention of higher rebate

Survey respondents were asked if they supported or did not support retaining the higher rebate for people aged 65 and over.

- 91.1% supported retaining the higher rebate for people aged 65 and over (83.7% strongly support / 7.4% support).
- Support to retain the higher rebate for people over 65 was highest among respondents who are part-rate pensioners (87.7%) and lowest among those who work and do not receive a pension (79.9%).

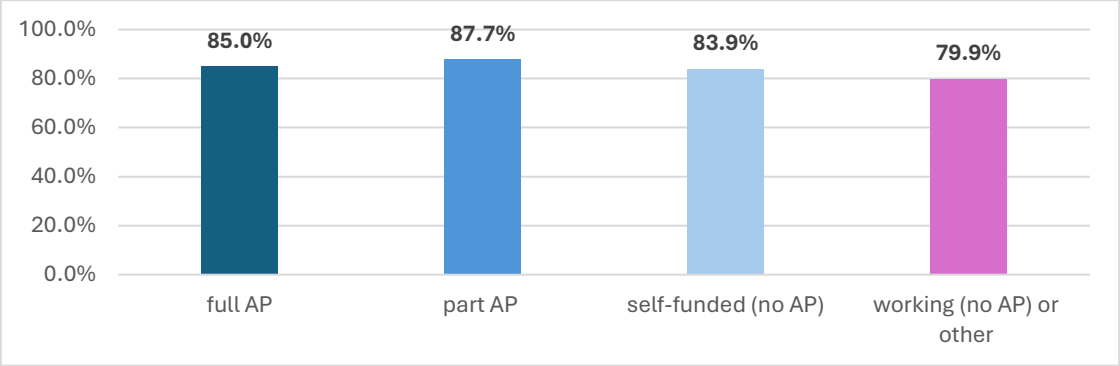

Fig 4: Support for the retention of the higher rebate for people aged 65 and over by pension status. *Source: NSA PHI Survey Results unpublished*

Support for income-based criteria for rebate

Respondents were asked if the rebate should include an income-based criteria i.e. the rebate could be higher or lower depending on a person's income.

- Support for this was higher among those with lower incomes – full rate Age Pension (61.4%) vs part rate Age Pension (59.3%) vs self-funded retiree (42.8%).
- Support for an income-based criteria for the rebate was higher among those with lower savings: <$100,000 (61.8%), $100,000-500,000 (58.3%), and $500,000+ (49.9%).

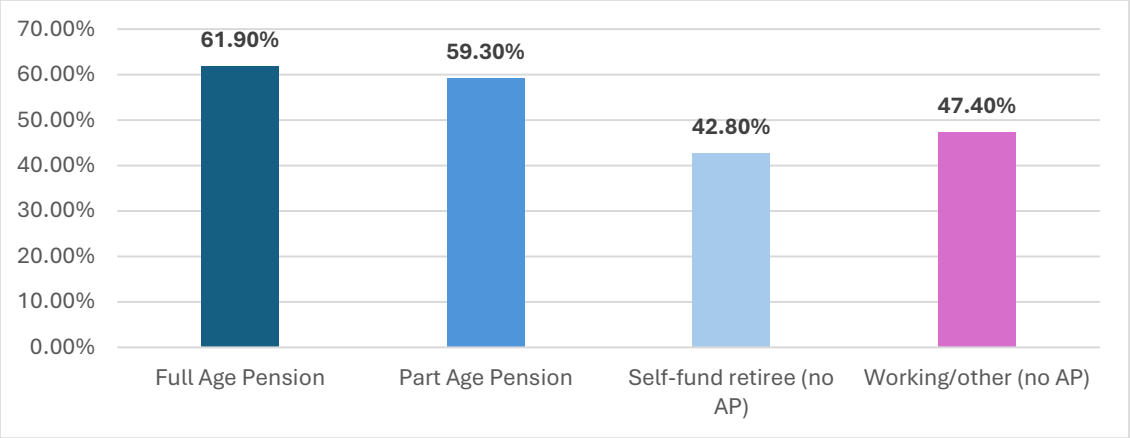

Fig 5: Support for income-based criteria for rebate by pension status.
Source: NSA PHI Survey Results unpublished

Actions to address and manage higher costs

Respondents with PHI were asked if they were considering changes to manage costs if the rebate proceeds.

- 51% of respondents with PHI said they were considering making one or more changes to manage costs from the rebate cut, to either:
    - increase their hospital excess;
    - reduce or drop their hospital or extras cover;
    - shop around for a better deal; or
    - reduce other spending.

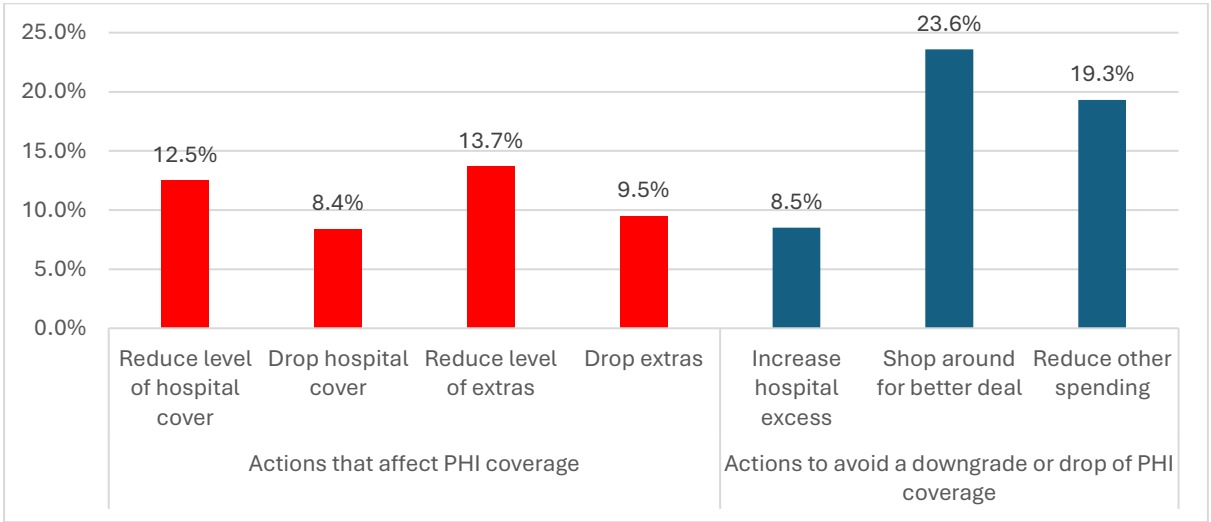

Fig 6: Proportion of respondents with PHI considering making a change to manage costs from rebate change by specific cost saving strategies. *Source: NSA PHI Survey Results unpublished*

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- While the survey sample is not representative, if the results were extrapolated to the 3.2 million Australians over 65 with cover, there could be **as many as 270,000 people who would *consider* dropping their hospital cover** in response to the change in the rebate and **400,000 who would consider downgrading** their cover.

Insights from past behaviour

The survey also asked participants if they had made any changes to their PHI in the past two years to make the cost more manageable.

- 37% indicated they had made one or more changes to make costs more manageable in the past two years – either changes affecting their coverage or changes more likely to preserve their coverage.
- While survey participants were more likely to take actions to preserve their cover in the past two years, there were still significant proportions who downgraded their hospital or extras cover or dropped their extras cover.

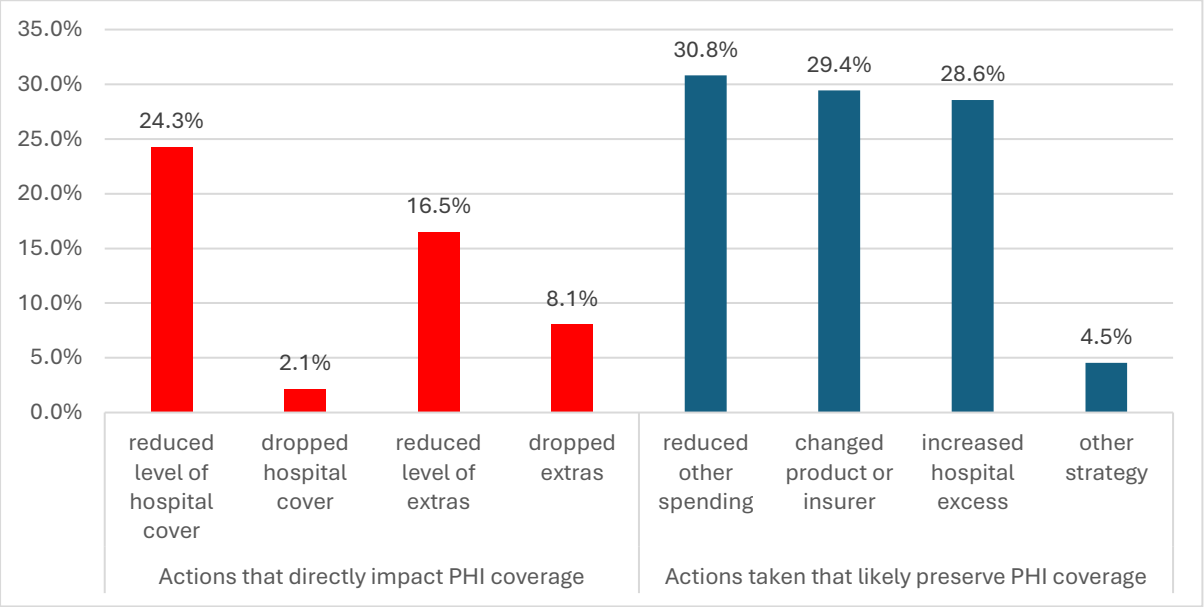

Fig 7: Proportion of respondents who took actions to manage the cost of their PHI over the past two years. *Source: NSA PHI Survey Results unpublished*

- While dropping hospital cover was the least preferable option, noting again this is not a representative sample, if this result was extrapolated to the 3.2 million affected population, it would represent about 67,000 who have dropped their hospital cover over two years (33,500 over a year) and 770,000 who have downgraded their hospital cover (385,000 over a year).

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- Combining the data on the number of survey respondents who have dropped PHI hospital cover in the past (to make costs manageable). With our estimate indicating the number who might consider dropping hospital cover to manage cost increases, this gives a significantly wide estimate of between 33,500 and 270,000 people who might actively consider dropping their hospital cover on 1 April 2027. As we argue elsewhere, there simply isn't a clear understanding of what might happen until people experience a price increase on 1 April 2027 – however, as the next section shows, we have a clearer idea of who will most likely be affected.

Sensitivity to dropping PHI cover

Our survey found that sensitivity to dropping or downgrading PHI increases as income and savings decrease.

- Respondents were asked to nominate how much premiums would need to increase before they dropped PHI or whether they would never drop PHI. The responses below show the proportion who said they would drop PHI (compared to the proportion who would never drop PHI).
- Survey respondents who were pensioners were far more likely to drop PHI than any other group. When asked if a premium increase would cause them to drop their policy (at any level of increase) – 76.2% of full pensioners said they would, compared to only 53.2% of self-funded retirees.

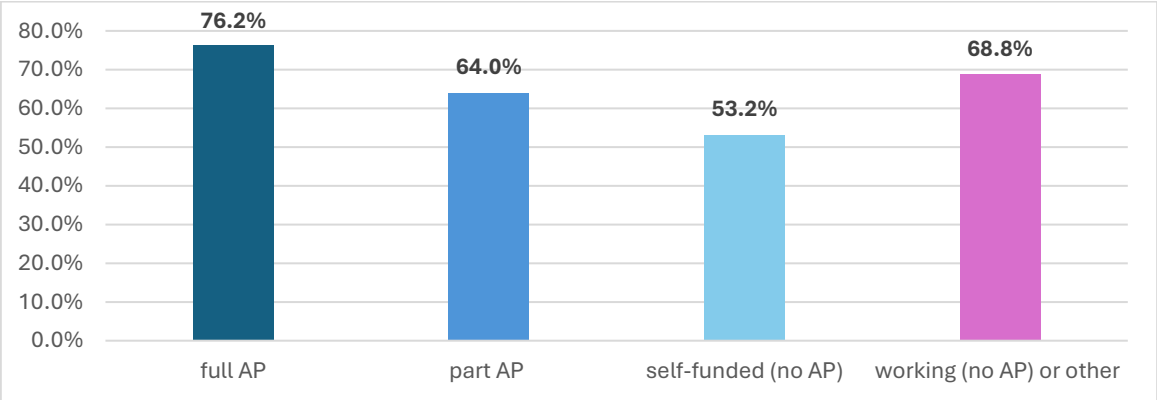

Fig 8: Survey respondents considering dropping PHI to manage cost increases by pension status. *Source: NSA PHI Survey Results Unpublished*

- Similarly, survey respondents with limited savings were much more likely to drop PHI cover as premiums increase compared to those with higher savings.

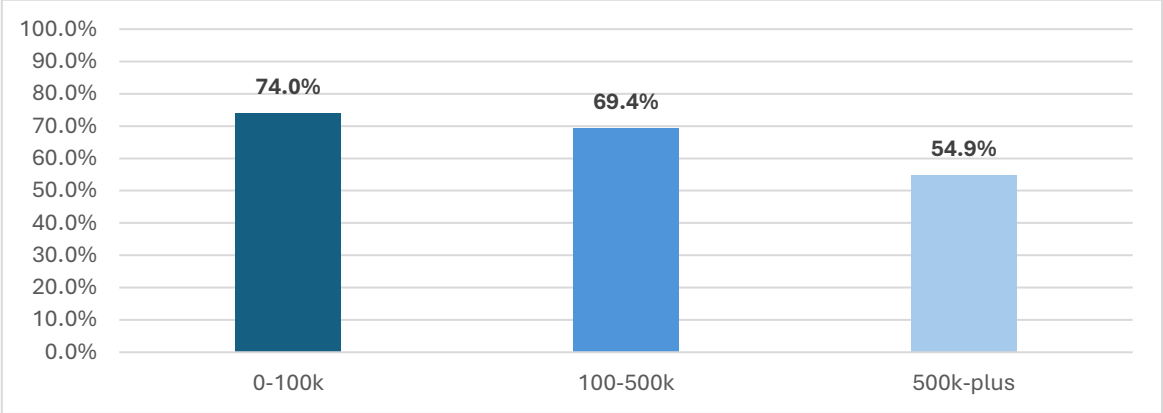

Fig 9: Survey respondents considering dropping PHI to manage cost increases by savings level. *Source: NSA Unpublished*

NSA surveys and reports on PHI show that older Australians place a high value on maintaining private health insurance, but affordability is increasingly affecting their ability to retain existing levels of cover.

While dropping hospital cover remains a last resort for many, a substantial proportion of older people are already responding to rising costs by increasing excesses, downgrading cover or reducing other household spending. Importantly, this pressure is not evenly distributed, with pensioners and those with lower savings showing greater sensitivity to premium increases.

Although the survey sample is not representative and extrapolated figures should therefore be treated with caution, the results indicate that reducing the rebate at the same time as annual premium increases risks accelerating an existing trend of older Australians reducing or relinquishing cover in response to cost pressures.

This reinforces the need for government to carefully consider both the distributional impacts of the proposed change and the potential flow-on consequences for demand on the public health system.

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Conclusion

The Federal Government's proposed reduction in the PHI is intended to deliver Budget savings but risks creating significant unintended consequences for older Australians and the broader health system. Combined with the annual premium increase, the change is likely to result in one of the largest single increases in out-of-pocket PHI costs experienced by older policyholders.

The government's modelling does not adequately capture the scale of this risk. In particular, its focus on the number of people who will drop hospital cover does not significantly account for those, who will downgrade their cover, increase their excess or make other changes to the price shock. NSA's survey findings indicate these behavioural responses could be significant, particularly among pensioners and older Australians with lower incomes and savings.

Any Commonwealth budget savings must therefore be considered against the potential transfer of costs in the health system. If older Australians drop or downgrade their private hospital cover, additional demand may ultimately fall on already constrained state and territory public hospitals, while patients may face longer waits for treatment and reduced choice in accessing care.

At a minimum, the government should undertake and publish comprehensive modelling of the impacts on coverage, downgrading behaviour, public hospital demand and costs to other levels of government before implementing any change.

NSA recommends that the proposed reduction in the PHI rebate for people aged 65 and over not proceed.

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Appendix A: Data and Modelling Limitations

In this section we address some of the data and modelling limitations used to support arguments for the removal of the higher rebate for people aged 65 and over.

The government has been using both internal and external modelling in its public defence of the proposed policy. We are concerned too much weight has been given to modelling with limited data that requires significant assumptions about future behaviour.

Changes to the rebate could dramatically impact the public health system; yet the modelling has been concerned only with people dropping cover entirely and has limited information about the response of people on low incomes and how people may respond to a significant increase in the rebate.

Given the potential impacts, we believe that more caution and modelling should be undertaken before any change to the rebate is made.

The government's Impact Analysis models a relatively small reduction in PHI participation and concludes older people are generally less sensitive to price charges because they receive greater benefits from PHI and have stronger incentives to retain cover.

The Office of Impact Analysis (OIA) – within the Department of Prime Minister and Cabinet – estimates a reduction of people with PHI of 44,313 in 2028/29 based on linked Services Australia and Australian Taxation Office data (with a reduction range of 0.4% - 1.1%).[18] The estimate did not model the number of people expected to downgrade their cover.

However, a broader concern is that there is no similar decrease in the PHI rebate to base the model on. The modelling appears to assume people will respond to a significant price increase in the reverse of how they responded to a price decrease in the past.

Similar academic research has focused on the substantial rise from 30% to 35%-40%, but this assumes responses to increases and decreases are symmetrical. They may not.

The only data involving a decline in the rebate is from the Rebate Adjustment Factor, though this is a lower decrease over time at the same time as the annual premium

[18] Modernising the Private Health Insurance Rebate | The Office of Impact Analysis

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increase. As shown in the graph below, there has been no sudden large reduction in the PHI rebate on the scale of what is proposed.

It is difficult to predict an effect when it is happening for the first time in such a blunt way. While the modelling may be correct, it simply will not be known until it happens.

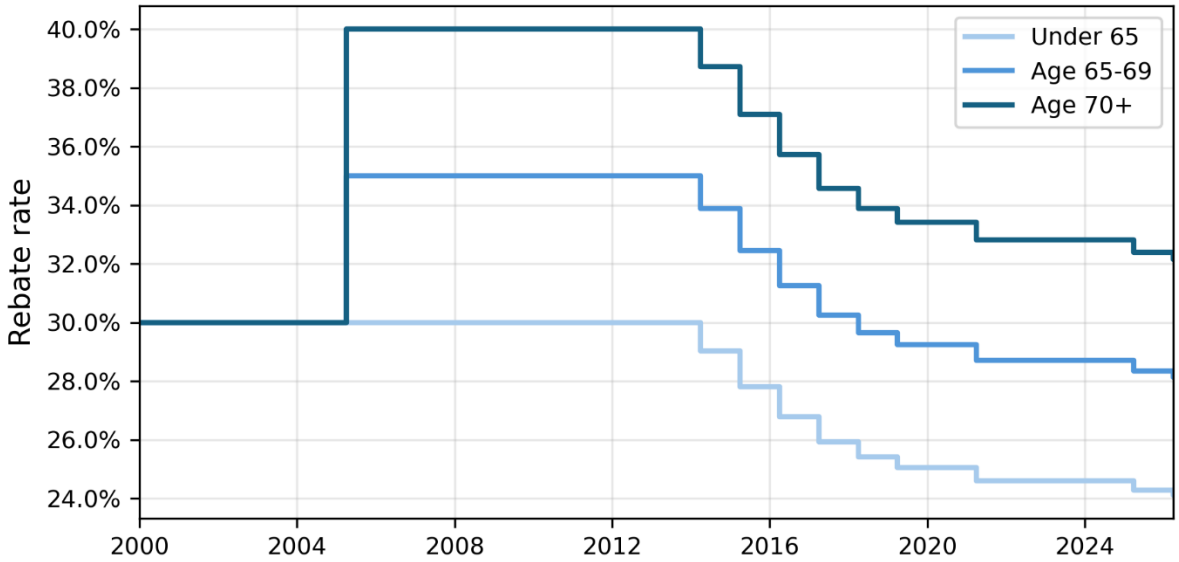

Fig. 10: PHI rebate rates by age group (base income tier). *Source: Department of Health, Disability and Ageing*[19]

Another concern with the modelling is its exclusive focus on people who will drop their cover completely, and not those who will downgrade cover. This analysis requires a consideration of both income and premiums.

The OIA did consider an alternative model (Option 3) involving equalising the rebate across age groups for low-to-middle incomes and removing the rebate for higher incomes.[20] The largest difference under the analysis between this proposal and the final proposal (Option 2 in the analysis, Option 1 was the status quo) was the 'significantly adverse' impact on insurers, in part due to the "regulatory impact burden".

Though the number of people expected to drop coverage was similar: 48,994 vs 44,313. The OIA do not split out the differential impact of these options on people on low-incomes, only people below the relatively high 'base tier'.

[19] PHI 12/26 Private health insurance rebate adjustment factor effective 1 April 2026 | Australian Government Department of Health, Disability and Ageing
[20] Modernising the Private Health Insurance Rebate | OIA

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Unfortunately, data that would allow such factors to be fully considered is limited. As the Department of Health, Ageing & Disability confirmed at Senate Estimates, the Department did not have an estimate of the number of people receiving the Age Pension who have PHI, because they "don't actually get data that supports that analysis."[21] Since then, the Department has estimated around 1.2 million people receiving the Age Pension had PHI in March 2026, or 44% of all Age Pension recipients.[22]

Liu and Zhang (Yuting Zhang, of the University of Melbourne and later joint author of *Separating the Effects of Tax Penalties and Subsidies on Private Health Insurance Demand*)[23] found that demand for PHI was more responsive to prices among older people on lower incomes and that "higher rebates led to larger increases in PHI take-up among the elderly in the bottom quartile". Indeed, they said: "Our findings suggest that directing PHI rebates toward low-income elders would be a more cost-effective approach to providing insurance coverage to those who are most in need but unable to afford it".

We note the income data for this study was the 2008 Medicare Levy Surcharge (MLS) threshold of $50,000 for singles and $100,000 for families. For reference, while the MLS thresholds have increased, the maximum single Age Pension rate from 20 September 2026 is $32,180.20 and for combined couples is $48,516[24]. This suggests the finding of higher sensitivity to pricing is still at quite a high level of income. The dataset only included people who had filed a tax return.

Despite this relatively high threshold for differentiating income – which is an issue of data limitations, not methods – the study found a statistically significant impact (at the 1% level) for both age ranges 65-69 and 70-74 in the 2006 and 2007 financial years, at the level of 1.57% for 65-69 and 2.32% for 70-74.

This suggests that even allowing for the assumption of a symmetric effect, the dropping of coverage is likely to be much higher among people on lower incomes than the 0.4% to 1.1% estimated by the OIA.

We reiterate this is only an estimate of change in any form of coverage, not within different levels of coverage.

[21] Senate Community Affairs Legislation Committee Estimates Wednesday 3 June 2026 | Commonwealth of Australia
[22] Private Health Insurance Amendment (Modernising the Private Health Insurance Rebate) Bill 2026 Submission from the Department of Health, Disability and Ageing to the Community Affairs Legislation Committee | Department of Health, Disability and Ageing
[23] Elderly responses to private health insurance incentives: Evidence from Australia | Liu, Health Economics
[24] Indexation Rates September 2026 | Department of Social Services

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This is supported by subsequent work by Kettlewell and Zhang[25] suggesting "it is reasonable to expect that for the very high income earners we study [impacted by the Medicare Levy Surcharge], price elasticity is low simply because PHI is a relatively small fraction of income, and the reductions in rebate are unlikely to cause financial stress," which raises the question of the response to a sudden increase in prices when insurance already represents a significant proportion of personal budgets.

in recent modelling[26], there appears to be little consideration given to this symmetrical assumption or different price responses at different levels of income. While *Separating the Effects of Tax Penalties and Subsidies on Private Health Insurance Demand* has access to income data, this is used as a control variable to identify the impact of the Medicare Levy Surcharge and Rebate separately from income. We hope future research identifies the interaction between income, the rebate, and holding PHI.

There are also issues with the modelling used to estimate the dollar impact on policy holders if the higher rebate for people aged 65 and over is removed. The OIA estimates the average change in per-person rebate to be $252 in 2028/29.[27] While we do not dispute this figure, this highlights a weakness of an average in showing a disparate impact.

We have recalculated what an average impact of $252 means based on level of cover, age, and rebate tier. Below we show the results for the base tier.

Coverage level	Increase in net premium, 65-69 (base tier)	Increase in net premium, 70+ (base tier)
Extras	$20.40	$40.79
Basic	$54.87	$109.72
Bronze	$63.24	$126.44
Silver	$93.22	$186.40
Gold	$181.55	$363.00
Average (all tiers)	$252.00	

Table 5: Estimated number of people 65+ with PHI by level of cover and average rebate reduction impact. *Data source: proportions derived from Finity report[28]*

[25] Financial incentives and private health insurance demand on the extensive and intensive margins - ScienceDirect
[26] Working Paper Series - Separating the Effects of Tax Penalties and Subsidies on Private Health Insurance Demand | Melbourne Institute of Applied Economic and Social Research
[27] Modernising the Private Health Insurance Rebate | OIA
[28] Review of MLS, PHI Rebate and LHC | Finity Consulting Pty Limited, Australian Government Department of Health and Aged Care

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Note that a $363 increase in net premium is per person, so $726 for a couple. This suggests a gross premium of $9,029.85 per year, roughly a current market price for gold level hospital-only cover. This implies the government average does not account for 1 April 2027 premium increases.

The government's modelling and academic work are useful contributions, but their limitations should be explicitly recognised.

Given the scale of the measure and the interaction with other PHI reforms, NSA believes the Parliament should adopt a precautionary approach and not support this change without further analysis.

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