



FINAL REPORT

Saving for one's care

Understanding how Health Savings Accounts can help fund the health of
Australians



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Summary

Existing funding arrangements for dental and allied health care are not meeting the needs of many Australians.

Out-of-pocket costs are often high, which can delay or prevent access to care. There is no assistance offered to those on low incomes without general treatment private health insurance to help them afford private dental and allied health care. Many consumers with general treatment cover still pay high out-of-pocket costs due to gaps and exclusions in policies, variation in coverage across providers, higher costs sometimes faced when selecting a provider of choice, minimal annual increases in rebates for services such as dental, and limited movement in the value of annual limits.

Health Savings Accounts (HSAs) for dental and allied health services could be used to offer positive incentives to save for one's care in a way that is consumer-centred, without barriers to consumer choice, and where consumers are rewarded for proactively managing their dental and allied health care in a way that is easily understood.

A preliminary model for HSAs in Australia has been developed to foster savings for health care across all income groups in a way that is particularly attractive to those not accessing or benefitting from general treatment cover. If available, and with modest support from government, economic modelling undertaken for this review estimates that initially around 850 000 Australians are likely to choose to adopt a HSA, increasing to up to 10 per cent of the Australian population by 2030.

The average estimated amount saved each year is \$1 225 per person, with incentives estimated to cost the Australian Government an average of \$186 per person per annum. This means that the average amount saved by individuals for dental and allied health services is close to seven times the cost of the subsidy offered to encourage those savings. Hence HSAs offer scope to encourage considerable private funding for health care at a relatively low cost to government.

These estimates are preliminary, based on a HSA model designed for the Australian context. They are provided to stimulate considered policy debate about HSAs in Australia, and their appropriate use to improve access to dental and allied health services and promote a more pro-active approach to managing one's health care.

Impetus for this review

Currently, the configuration and funding of the Australian health system presents barriers to consumers accessing private dental and allied health services that are right for them.

Like all health services, timely access to dental and allied health care is essential to population health. Currently, access to services is hampered by gaps in universal service, limits to private health insurance (PHI) uptake among consumers, and exclusions and other features of general treatment PHI policies which create cost barriers to accessing services in a way that best achieves optimal health outcomes. There has also been little change in rebates for consumers (such as for dental care) over extended periods of time, and almost no change to restrictive annual monetary limits on claimable amounts.

While data is not available for all allied health services, evidence on dental care shows that rates of avoided or delayed dental visits due to cost are more than twice as high for those without PHI, who are more likely to experience pain, discomfort or be unhappy with their dental appearance. Those without PHI are also more than three times more likely to rarely see a dentist (having only one visit every five years or longer).¹

For Indigenous Australians, only 20 per cent in non-remote areas have PHI, compared to the national average of 57 per cent for non-remote areas, with 72 per cent citing affordability as the main barrier to uptake.² Only 20 per cent of Indigenous Australians who need prescription glasses to correct near-sightedness have them compared to 56 per cent of non-indigenous Australians³ and 39 per cent of Indigenous Australians cannot see normal print due to lack of reading glasses.⁴

Even where PHI is available with general treatment cover, the number of policies with exclusions has increased over time in response to pressure on PHI affordability.⁵ Across the five major health funds, the proportion of extras covered varies from approximately 45.9 per cent to 60.4 per cent, depending on the state and fund, and on average, the out-of-pocket expenses for general treatment were \$47.73 per episode/service for covered services in 2016-17.⁶ There has also been strong growth in the proportion of Hospital and General Treatment policies with exclusions, which has increased from 26 per cent of policies in December 2013 to 42 per cent in December 2017.⁷

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- ¹ Chrisopoulos, S., Harford, J.E. & Ellershaw, A. 2015, 'Oral health and dental care in Australia — Key facts and figures 2015', prepared for *Australian Institute of Health and Welfare*, Cat. No. DEN 229.
- ² Department of Prime Minister and Cabinet. 2014, 'Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report' - 3.14; AIHW 2015, 'The Health and welfare of Aboriginal and Torres Strait Islander peoples', Cat. no. AIHW 147, p. 158.
- ³ Optometry Australia and the National Aboriginal Community Controlled Health Organisation (NACCHO). 2015, 'Closing the gap in vision through better access to prescription glasses for Aboriginal and Torres Strait Islander Australians', *Joint-submission to the Federal Budget 2015-16*.
- ⁴ Taylor, H.R., Boudville, A., Anjou, M. & McNeil, R. 2013, 'The Roadmap to Close the Gap for Vision', prepared for the Indigenous Eye Health Unit, Melbourne School of Population and Global Health, The University of Melbourne, p. 3.
- ⁵ Cheng, J. 2017. 'Policy downgrades: A closer look'. *Journal of the Consumers Health Forum of Australia*. <http://healthvoices.org.au/issues/april-2017/policy-downgrades-closer-look/>
- ⁶ APRA, 2017. Private Health Insurance Quarterly Statistics. June 2017 (released 15 August 2017). Sydney. <http://www.apra.gov.au/PHI/Publications/Documents/1708-QPHIS-20170630.pdf>
- ⁷ See <http://www.apra.gov.au/PHI/Publications/Pages/Private-Health-Insurance-Membership-and-Benefits.aspx>

There is also evidence of cyclical claiming behaviour with clustering of activity around expiration and restriction-refreshment dates,⁸ as consumers purchase services in ways that maximise their (subsidised) entitlements, often encouraged by service providers.

It is also arguable that in some cases, insurance is ill-suited to dental and allied health care. The role of insurance is to provide protection against low probability, high cost events, where the cost of an event is high but the likelihood of claim is low, supporting 'risk-pooling' across the population. This is often not the case for general treatment insurance, and in some instances savings would be more appropriate than insurance.

Moreover, as part of the insurance model within which it sits, the general treatment insurance business requires administration expenses and a return on capital to be paid. In 2013, it was estimated that the gross margin on a general treatment policy was between 23.1 per cent and 33.6 per cent, depending on the state or territory.⁹ **This means that policy fees paid by individuals plus subsidies paid by the Australian Government are necessarily higher than benefits distributed back to consumers.**

This review is an important first step in considering how an alternative (and complementary) funding model might work for dental and allied health services. The HSA model developed for this review is one where consumers are rewarded for proactively managing their dental and allied health care, and there is a mechanism for targeting low income earners that have poor access to dental and allied healthcare to receive government assistance that is specific to their individual health needs.

The key principles and objectives of an HSA model include:

- to provide incentives for low income earners not currently accessing general treatment cover to save for their own dental and allied health care
- to reduce (at least in part) the financial barrier to accessing care by developing a flexible and individual financial safety net and capacity for people to pay for their own dental and allied health care costs, and in doing so, and
- to help to deliver short and long-run benefits through better health outcomes.

Potential structure for HSAs in Australia

HSAs represent a choice for consumers, and for the health financing system in Australia, that can help meet underlying needs through savings. A carefully constructed approach to HSAs should improve, not lessen the value proposition of private spending on health care, particularly for Australians under 30, older Australians that have accumulated large deposits, and those in income sensitive brackets.

⁸ For instance, the number of optical services are 20 per cent higher in the December and March quarters than June and September quarters: See Australian Prudential Regulation Authority. 2017, "Statistics, Private Health Insurance Membership and Benefits", June 2017, released 15 August 2017.

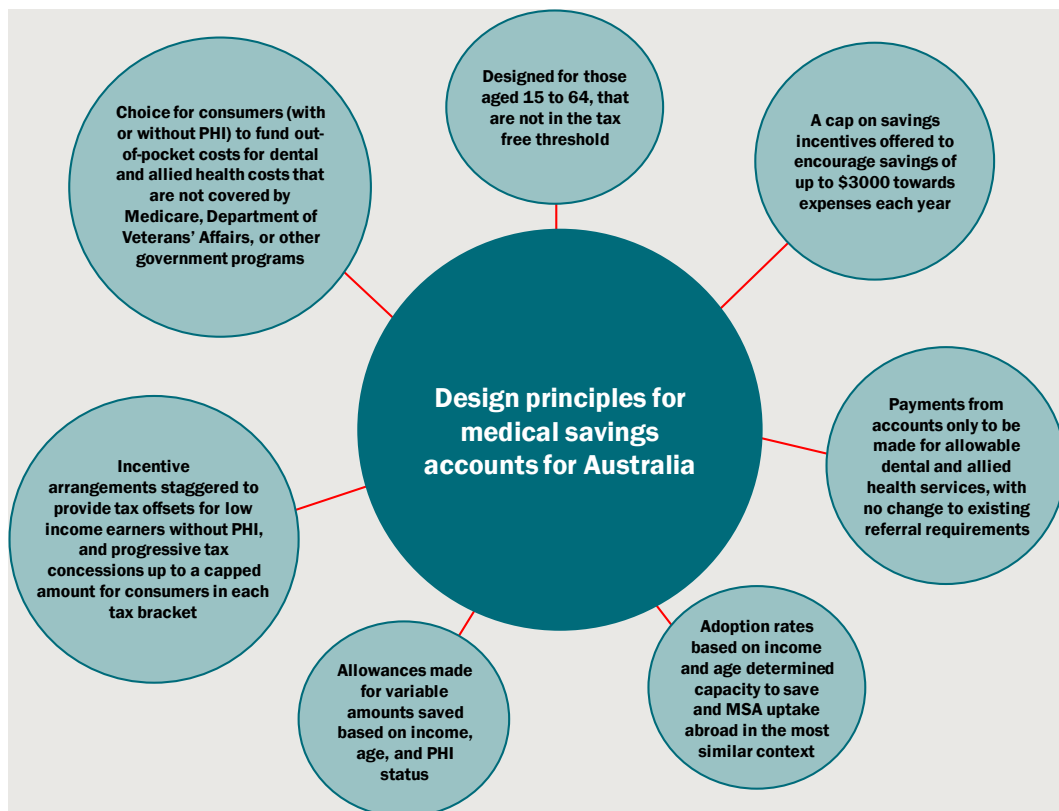
⁹ Private Health Insurance Administration Council, 2015. 'Risk sharing in the Australian private health insurance market'. Research Paper 4: June 2015.
http://www.apra.gov.au/PHI/PHIAC-Archive/Documents/Risk-Sharing_June-2015.pdf

A three-pronged approach has been developed to address gaps in access to services, and offer an attractive choice to consumers that may be able to better fund their contribution to dental and allied health services. It includes:

- a **tax offset** component, which enables those on low incomes to transfer tax-free income into a HSA up to \$3 000 per annum
- a **tax concessions** component for consumers not eligible for the tax offset to salary sacrifice into a HSA and receive a tax concession on savings up to \$3 000 per year, and
- a **market model** component, which allows consumers to save above any concessional amount, to continue to foster and reward positive saving behaviour.

Tax concessions are designed to be progressive, offering a reduced subsidy rate to those on progressively higher incomes. This approach is unique to the Australian context, as HSAs abroad are not considered readily transferable. In the Australian case, the purpose is to target savings for dental and allied health care without undermining PHI for hospital care. A summary of the design principles of HSAs for Australia is illustrated in chart 1.

1 Summary of design principles for HSAs in Australia



Data source: The CIE.

The modelling results in this review focus on those in specific age and income groups to exclude those in the tax-free threshold for whom there is no incentive offered, and those that have access to more financially attractive savings vehicles through superannuation.

Key modelling results

It is estimated that in the first year, around 850 000 Australians will be encouraged to open a HSA to contribute to their dental and allied health care, rising to 1.2 million people within 4 years, reaching a maximum adoption rate of 10 per cent of all Australians (3 million) by 2030.

It is expected that an average of \$1 226 will be saved annually by Australians because of the savings incentives on offer.

The average subsidy offered to those accessing tax offsets is found to be \$177 per person, and the average subsidy cost of those accessing tax concessions is estimated at \$198 per person, or an average of \$186 per person irrespective of the incentive offered.

This means that the average amount saved by individuals for dental and allied health services (\$1 226) is close to seven times the average cost of the subsidy offered (\$186) to encourage those savings.

The cost of incentives designed for the purposes of this review to the Australian Government is estimated to be \$157 million in the first year, rising to \$559 million once 10 per cent of the population chooses to save into a HSA.¹⁰

¹⁰ The maximum adoption rate reflects expected uptake among Australians likely to benefit from the incentives to save. This includes people in employment, excluding those in the tax-free threshold, and excluding those aged 65 years and over. Uptake rates and savings amounts within age and income groups are assumed to vary, with the overall maximum level of adoption set to be in line with international uptake rates for Medical Savings Accounts.

1 *Momentum for health funding reform in Australia*

Health financing reform has become the mainstay of the Australian Government, with strong commitment to promote financial sustainability and improve health outcomes by balancing incentives to get the best behaviours from providers, funders, and consumers.

One area of health funding yet to receive the reform limelight is dental and allied health services. While impacted by reforms to the Medicare Benefits Schedule (MBS) and private health insurance (PHI), there is no concerted effort to redress the poor and deteriorating value of general treatment cover for consumers, or the lack of incentives for low income earners to save for their dental and allied health care.

The ongoing task of health funding reform

Health funding reform is a constant on the Australian Government policy agenda. In recent decades, health expenditure has grown relatively steadily from year to year. Over the last decade, health expenditure grew faster in real terms than overall gross domestic product (GDP), with an average annual real growth of 5.0 per cent—2.2 percentage points higher than the 2.8 per cent growth in GDP. In 2015-16, total health expenditure (recurrent and capital expenditure combined) in 2015–16 was \$170.4 billion.¹¹

The large size of the health budget, and its importance to the Australian community, ensures that health funding reform and access to clinically appropriate health services receives constant attention. This includes areas of the budget that are directly, or indirectly associated with funding for allied healthcare. For instance:

- announced in 2015, the Medicare Benefits Schedule (MBS) Review Taskforce has been considering how the more than 5 700 items on the MBS can be aligned with contemporary clinical evidence and practice and improve health outcomes for patients. The MBS is one of the sources of allied health funding in Australia, and it is becoming increasingly called upon to fund allied health services. The latest available data shows that in 2013–14, for every 100 patient encounters, there were 4.9 General Practitioner referrals to allied health to help manage a patients' problems. This is an increase from 2.7 per 100 patient encounters in 2004–05,¹² and
- a series of reforms have been announced to make private health insurance (PHI) simpler and more affordable, and the Australian Government has committed to work

¹¹ Australian Institute of Health and Welfare (AIHW) 2017, *Health expenditure Australia 2015–16*, AIHW October 2017.

¹² The Bettering the Evaluation and Care of Health (BEACH) report *A decade of general practice: 2004–05 to 2013–14*.

with the medical profession on options to improve the transparency of medical out-of-pocket costs,¹³ which are widespread when PHI policy holders access dental and allied health care.

The objectives of the health funding reform were recently reiterated in the Interim Report for the MBS Review Taskforce. These include to:

- provide affordable and universal access
- support best practice health services
- provide value for the individual patient, whereby the delivery of services is appropriate to the patient's needs, provide real clinical value and do not expose the patient to unnecessary risk or expense, and to
- deliver value for the health system, including to reduce the volume of services that provide little or no clinical benefit to enable resources to be redirected to new and existing services that have proven benefit and are underused, particularly for patients who cannot readily access those services currently.¹⁴

What this review is about: developing a complementary funding option for dental and allied health

For various reasons, the configuration and funding of the Australian health system presents barriers to consumers accessing the right care for them. One area where this is evident is private dental and allied health services.

Access to dental and allied health care is currently hampered by gaps in universal service, limits to PHI uptake among consumers, and exclusions and other features of general treatment PHI policies which ultimately create cost barriers to accessing services in a way that best achieves positive health outcomes. There has also been little change in rebates for consumers (such as for dental care) over extended periods of time, and almost no change to restrictive annual monetary limits on claimable amounts.

This review is an important first step in considering how an alternative (and complementary) funding model – Health Savings Accounts – might work for dental and allied health services that can complement existing funding options to provide more choice for consumers, and better cost sharing between individuals and government.

Health Savings Accounts (HSAs) have the potential to support consumer access to general treatment cover services, and to assist those that do not have PHI to provision for their dental and allied health care.

HSAs have been used in various countries over many years, although the substantive differences in health systems internationally mean that the concept of an HSA model in

¹³ Australian Government Department of Health 2017, see <http://www.health.gov.au/internet/main/publishing.nsf/Content/private-health-insurance-reforms-fact-sheet-summary>.

¹⁴ MBS Review Taskforce 2016, Interim Report to the Minister for Health.

Australia must be unique and customised to the Australian health funding context. To achieve this, the CIE's review has included:

- a review of the Australian and international literature on health financing models and HSAs abroad to assess how an HSA model could be developed for Australia
- the development of a potential HSA model for Australia that meets the needs of the Australian population, and specifically addresses gaps or shortcomings in current arrangements
- identification of specific incentives that could be offered to encourage HSA adoption and consumer savings for dental and allied health care, that aligns with established incentive arrangements in the Australian taxation and superannuation system and health financing principles
- the development of an economic model that brings together relevant data and evidence on the population that might adopt HSAs, and the expected level of savings behaviour, and
- estimation of the potential size of the HSA savings pool, the likely cost to the Australian Government if it were to offer incentives to save, and the average cost of subsidies per person to manage any financial risk exposure.

It is acknowledged that many of the assumed parameters underpinning the HSA model developed for this review could be adjusted.

The purpose of this study is to commence an informed discussion of how an HSA model could be developed in Australia, and quantify the potential cost to the Australian Government and consumers of some of the logical and attractive options.

Disparate dental and allied health outcomes in Australia

Like all health services, timely access to dental and allied health care is essential to population health and wellbeing.

In the case of dental care, delays in accessing preventative treatments such as check-ups, or early intervention treatments such as fillings, are known to be associated with poorer long term oral health outcomes, and often require costly, complex, and uncomfortable procedures such as root canal or complete tooth removal.¹⁵ Poor oral health has ramifications for overall health, wellbeing and quality of life. People with dental disease may suffer from pain, infection and tooth loss leading to difficulty eating, swallowing and speaking, with flow-on effects for self-esteem.¹⁶

¹⁵ Harris, R.V., Pennington, A. & Whitehead, M. 2016, 'Preventative dental visiting: a critical interpretive synthesis of theory explaining how inequalities arise', *Community Dentistry and Oral Epidemiology*, doi: 10.1111/cdoe.12268.

¹⁶ Australian Government, Department of Health. 2012, 'Outcomes and Impact of Oral Disease', *Report of the National Advisory Council on Dental Health*, http://www.health.gov.au/internet/publications/publishing.nsf/Content/report_nacdh~report_nacdh_ch1~report_nacdh_out.

Good oral health has been shown to have flow on effects for overall health. For instance, oral health is an important component of diabetes management. For people with diabetes, periodontitis has a negative impact on glycaemic control. Periodontitis is a common chronic inflammatory disease that can lead to the destruction of the supporting structures of the teeth. There is a threefold increase in both the incidence of end stage renal disease and death from cardiorenal mortality in diabetics who have severe periodontitis and those who do not. Similarly, the probability of death from cardiorenal mortality is three times higher in diabetics who have severe periodontitis compared to those without.¹⁷

Further, tooth count is correlated with the probability of death from cardiovascular disease. People with less than 10 teeth are seven times more likely to die of coronary disease than someone with at least 25 teeth.¹⁸ In line with this, people who have 19 teeth or less, and suffer from difficulty eating, are 1.85 times more likely to die from respiratory disease compared with people who have at least 20 teeth.¹⁹

Barriers to accessing preventative dental

Findings from the 2013 National Dental Telephone Interview Survey indicated that affordability is a major barrier to the uptake of dental visits, and that those without any form of general treatment cover avoid and delay dental care.²⁰

Rates of avoided or delayed dental visits due to cost are found to be over twice as high in those uninsured compared to those covered by a health fund. Similarly, the proportion of people indicating that they had difficulty paying for a preventive dental visit was almost two and a half times higher in the uninsured compared to those with PHI. A higher proportion of those uninsured indicated that cost prevented them for having recommended treatment (see chart 1.1). Those without PHI are more likely to experience pain, discomfort or be unhappy with their dental appearance.²¹

Of particular concern is that the proportion of people that only attend the dentist every 5 or more years is over three times higher in those uninsured, compared to those insured, at 12.3 per cent compared to 3.7 per cent (see chart 1.2).

¹⁷ Preshaw, P.M., Alba, A.L., Herrera, D., Jepsen, S., Konstantinidis, A., Makrilakis, K. & Taylor, R. 2012, "Periodontitis and diabetes: a two-way relationship", *Diabetologia*, vol. 55, no. 1, pp. 21-31

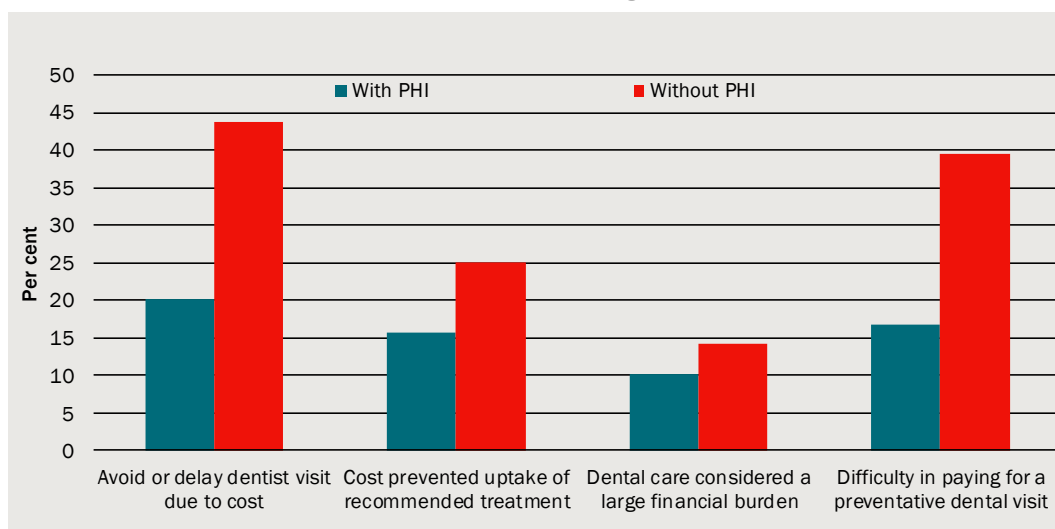
¹⁸ Holmlund, A., Holml, G. & Lind, L. 2008, 'Number of teeth as a predictor of cardiovascular mortality in a cohort of 7,571 subjects followed for 12 years', *Atherosclerosis (Supplements (Component))*, vol. 9, no. 1, pp. 79-79.

¹⁹ Aida, J., Kondo, K., Yamamoto, T., Hirai, H., Nakade, M., Osaka, K., Sheiham, A., Tsakos, G. & Watt, R.G. 2011, "Oral Health and Cancer, Cardiovascular, and Respiratory Mortality of Japanese", *Journal of Dental Research*, vol. 90, no. 9, pp. 1129-1135.

²⁰ Chrisopoulos, S., Harford, J.E. & Ellershaw, A. 2015, 'Oral health and dental care in Australia — Key facts and figures 2015', prepared for *Australian Institute of Health and Welfare*, Cat. No. DEN 229.

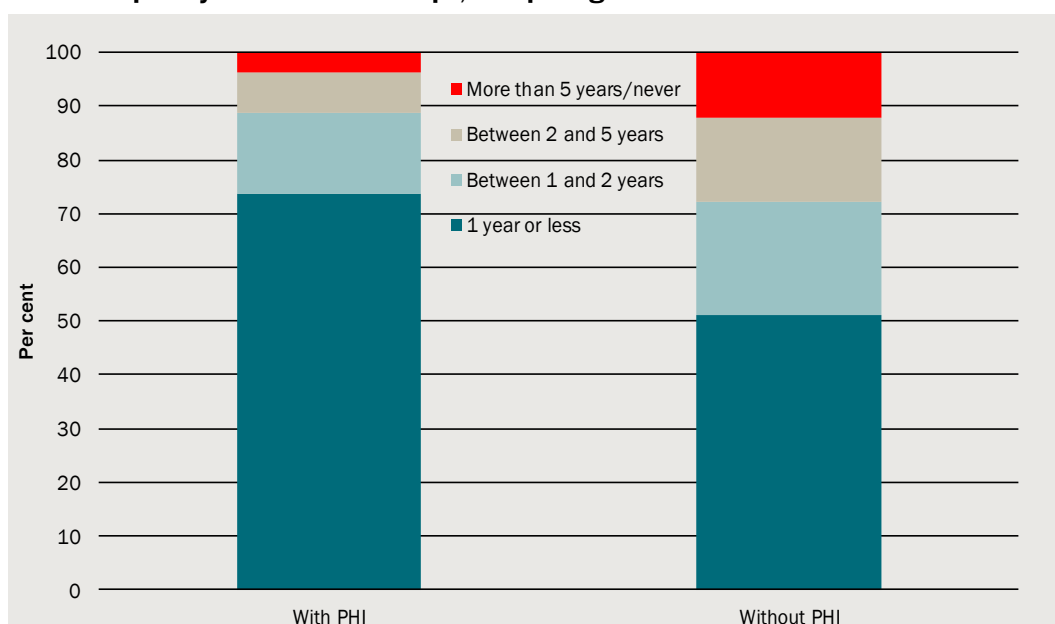
²¹ Chrisopoulos et al, 2015.

1.1 Cost as a barrier to dental access, comparing those with and without PHI



Data source: Chrisopoulos, S., Harford, J.E. & Ellershaw, A. 2015, "Oral health and dental care in Australia – Key facts and figures 2015", prepared for Australian Institute of Health and Welfare, Cat. No. DEN 229.

1.2 Frequency of dental check-ups, comparing those with and without PHI



Data source: Chrisopoulos, S., Harford, J.E. & Ellershaw, A. 2015, "Oral health and dental care in Australia – Key facts and figures 2015", prepared for Australian Institute of Health and Welfare, Cat. No. DEN 229.

For children, attending the dentist and implementing preventative measures can have lifelong benefits. Not only can visits assist in preventing dental disease, it also trains children to practice oral hygiene and develop the habit of having regular check-ups. One Australian study indicated that a child was significantly more likely to attend a 6 monthly or yearly dental check-up if they were covered by PHI.²²

²² John, J.R., Mannan, H., Nargundkar, S., DSouza, M., Do, L.G. & Arora, A. 2017, 'Predictors of dental visits among primary school children in the rural Australian community of Lithgow', *BMC Health Services Research*, vol. 17.

As presented in box 1.3, these findings resonate across other health services considered as General Treatment cover, such as Optical.

1.3 Poor access to glasses for Indigenous Australians

Refractive error occurs when the shape of the eye inhibits light from focussing on the retina. The condition commonly manifests as either near-sightedness, far-sightedness, astigmatism or presbyopia. Eye glasses and contact lenses are the simplest treatment for refractive error. However, if left untreated, vision can deteriorate.

Indigenous Australians experience 20 times the rate of blindness due to uncorrected refractive error compared to non-Indigenous Australians.²³ In 2016 the treatment rate for refractive error for Indigenous Australian's was 11 per cent lower than the treatment rate in non-Indigenous Australians.²⁴

Whilst eye tests are covered by Medicare, the provision of glasses is typically paid for using general treatment cover or at an out-of-pocket cost to the patient. Optical and dispensing accounts for 15 per cent of PHI general treatment benefits, which is predominantly for spectacle frames, lenses and contact lenses.²⁵

Indigenous Australians have lower rates of PHI uptake compared to non-Indigenous Australians, and are therefore more likely to face financial barriers to accessing prescription glasses. For instance, in 2012 and 2013 only 20 per cent of Indigenous Australians in non-remote areas were covered by PHI, compared to the national average of 57 per cent for non-remote areas. For those without PHI, 72 per cent cited affordability as the main barrier to uptake.²⁶

This results in lower access to treatments required, with 20 per cent of Indigenous Australians who need prescription glasses to correct near-sightedness having them. This compares to 56 per cent of non-indigenous Australians.²⁷ As a result, 39 per cent of Indigenous Australians cannot see normal print due to lack of reading glasses.²⁸

²³ Optometry Australia and the National Aboriginal Community Controlled Health Organisation (NACCHO). 2015, 'Closing the gap in vision through better access to prescription glasses for Aboriginal and Torres Strait Islander Australians', *Joint-submission to the Federal Budget 2015-16*.

²⁴ AIHW 2016, 'Indigenous Eye Health Measures', Cat. no. IHW 178, p. 18.

²⁵ Australian Prudential Regulation Authority. 2017, 'Private Health Insurance Quarterly Statistics', *September 2017, released 14 November 2017*, p. 6.

²⁶ Department of Prime Minister and Cabinet. 2014, 'Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report' - 3.14; AIHW 2015, 'The Health and welfare of Aboriginal and Torres Strait Islander peoples', Cat. no. AIHW 147, p. 158.

²⁷ Optometry Australia and NACCHO 2015, op. cit.

²⁸ Taylor, H.R., Boudville, A., Anjou, M. & McNeil, R. 2013, 'The Roadmap to Close the Gap for Vision', prepared for the Indigenous Eye Health Unit, Melbourne School of Population and Global Health, The University of Melbourne, p. 3.

2 *Diminishing value of general treatment cover*

While general treatment cover is available to private health insurance policy holders for a relatively low cost compared to the cost of private hospital cover, its 'value' to consumers is limited by gaps and exclusions in health services, variation in coverage across providers, and minimal change over time to rebate levels for consumers or the annual limits on claiming amounts.

Importantly, general treatment cover has evolved into an influential system of preferred suppliers that creates a barrier or penalty for the consumer to choose their preferred supplier and may interrupt continuity of care. Out-of-pocket costs are higher for those seeking to use a non-contracted or non-preferred supplier. In addition, as general treatment cover is provided as an insurance product, the policy fees paid by individuals plus subsidies paid by the Australian Government are necessarily higher than benefits distributed back to consumers.

There is concern that this system, without an alternative, may lead to less use of certain dental and allied health services, and thereby inferior health outcomes.

Overview of general treatment cover and broader trends

As at 30 June 2017, **13.5 million Australians** or 55 per cent of the population had a form of general treatment cover.²⁹ In 2016-17, PHI revenue was \$27.7 billion with approximately \$19.8 billion paid in member benefits across hospital and general treatment. Approximately one quarter of the benefits paid, \$4.9 billion, was towards general treatment cover.³⁰

General treatment cover (sometimes referred to as ancillary or 'extras') covers an individual for relatively low cost, but somewhat frequent dental and allied health services. The most significant areas of ancillary benefits paid are dental, followed by optical, physiotherapy and chiropractic. The overall rate of increase in the total benefits paid has been approximately 6 to 7 per cent each year, although this varies by category of health service and the rate of the rebate per service has not increased with premium increases.³¹

²⁹ APRA, 2017. Private Health Insurance Quarterly Statistics. June 2017.

³⁰ APRA Statistics, 2017. Private Health Insurance Membership Trends, June 2017.

³¹ Consumers Health Forum of Australia, 2017. *Senate Inquiry: Value and affordability of private health insurance and out-of-pocket medical costs*. July 2017.

In 2017, approximately 2.19 million policies (out of 13.51 million) were for general treatment only (no private hospital cover).³² By contrast, only 0.1 per cent of all policies in 2016-17 were for hospital treatment cover only.

Trend towards general treatment downgrading

Over time, the number of general treatment policies with exclusions has increased in response to pressure on PHI affordability.³³ This pressure is evidenced by a (slight) fall in the rate of hospital cover as a share of all private health insurance policies (from 87 per cent in 2009 to 84 per cent in 2017).³⁴ There is an ongoing need for PHI to be supported by Australian Government policies to encourage uptake and reduce the cost of PHI to consumers.

Some Australians with private health insurance have chosen not to take out hospital cover (approximately 16 per cent of PHI policy holders)³⁵, particularly those that are below the age of 50 years³⁶ who are arguably less likely to need it. While this may be rational for those consumers that limit their PHI exposure, it results in an increase in age and higher rates of utilisation affecting the PHI claims. The proportion of the population with PHI over the age of 50 has steadily increased from approximately 29 per cent in 2002 to 35 per cent in 2017³⁷, increasing the average age of policy holders. This has led to a higher probability of claim per member of the fund for medical claims and year-on-year increases in the total benefits paid.

Despite these broad trends in general treatment uptake, which has extended the size of the pool of benefits paid towards these expenses, Australians remain inadequately covered. This is costly, because it leads to delays in the treatment of allied (general) health, underutilisation of health care and inappropriate targeting of financial incentives.

Gaps and exclusions in dental and allied health services

As well as nearly half of all Australians being without PHI, a proportion of those that are insured are arguably 'under-using' their part-paid-for dental and allied health services.³⁸ The greater level of flexibility in the way that general treatment products are designed has

³² A small share of these is driven by General Treatment Ambulance Only.

³³ Cheng., J. 2017. 'Policy downgrades: A closer look'. *Journal of the Consumers Health Forum of Australia*. Accessed at: <http://healthvoices.org.au/issues/april-2017/policy-downgrades-closer-look/>

³⁴ Private Hospital Insurance is held by around 46.1 per cent of the population (11.3 million people). APRA Statistics, 2017. Private Health Insurance Membership Trends, June 2017.

³⁵ APRA, 2017. 'Statistics: Private Health Insurance Benefits Trends'. June 2017.

³⁶ CIE analysis of APRA data suggests a higher proportion of policies held by Australians under the age of 50 years that are for general treatment cover (excluding hospital) than for age groups above 50 years, with the exception of those under 4 years.

³⁷ CIE analysis of APRA 2017 statistics.

³⁸ This is likely to exclude consumers that access 'no-gap' dental and allied health services.

led to trade-offs between price and coverage. As stated in the recent review *Risk sharing in the Australian private health insurance market*, 'while the issue of risk sharing also arises in the general treatment products, policy makers have chosen to have less intervention in this market in terms of how general treatment products are designed'.³⁹

General treatment cover can be purchased as a package with private hospital cover, as encouraged by the PHI rebate and Lifetime Health Cover loading, or on its own which also attracts the rebate. There is a huge range of private health insurance policies. The PHIO estimated that, as of February 2017, there were 230 hospital policies, up to 157 general treatment policies and 186 packaged combinations of hospital and general treatment policies.⁴⁰ However, the ACCC has previously reported that the number of policies is significantly more, having stated in 2014 that there were 'over 20 000 private health insurance policies on offer to consumers in Australia'.⁴¹

- The largest, albeit recently declining segment of the PHI market is for combined hospital and general treatment cover. The number of people with combined cover has expanded in response to the Lifetime Health Cover loading. The trend is for those approaching 30 years of age, previously covered by extras, to expand their coverage to hospital treatment to avoid the LHC loading.
- In the 'general treatment only' cover segment (14 per cent of the market), there is significant variation in coverage. This product segment has grown as a share of the total people covered over the past five years, with consumers looking to cover themselves cheaply with the assistance of the PHI rebate, after becoming independent from their family.⁴²

Nonetheless, the specific value proposition for general treatment insurance and therefore the level of coverage varies by market segment. These can be segmented into singles, couples and families:

- families typically prioritise access to dental and allied health services that can be expensive without PHI, such as for podiatry, physiotherapy, dental and optical services
- singles generally spend more on premiums than they receive in benefit payments and as such, there has been lost ground among this group. According to a recent market report, for this reason 'young singles see little value in Private Health Insurance', and
- couples are typically concerned with avoiding the Medicare Levy Surcharge and tend to purchase more basic policies. This segment has the highest proportion of

³⁹ Private Health Insurance Administration Council, 2015. 'Risk sharing in the Australian private health insurance market'. Research Paper 4: June 2015.

http://www.apra.gov.au/PHI/PHIAC-Archive/Documents/Risk-Sharing_June-2015.pdf

⁴⁰ Commonwealth Ombudsman. 2016. *State of the Health Funds Report*. As at February 2017, the PHIO estimates

⁴¹ ACCC, 2014. *Information and informed decision-making: A report to the Senate on anti-competitive and other practices by health insurers*.

https://www.accc.gov.au/system/files/981_Private%20Health%20Report_2013-14_web%20FA.pdf

⁴² IbisWorld Industry Report K6321, Health Insurance in Australia, 2016.

individuals below 30 than any other market. As stated by IbisWorld, regaining the lost ground in this market will be difficult as 'PHI on average offers them little value'.⁴³

Across general treatment cover, there are significant out-of-pocket expenses. Across the five major health funds⁴⁴, the proportion of extras covered varies from approximately 45.9 per cent to 60.4 per cent, depending on the state and fund. It varies more widely across all funds, from 32.3 per cent (Latrobe) to 79.3 per cent (GU Corporate). On average, the out-of-pocket expenses for general treatment were \$47.73 per episode/service for covered services in 2016-17.⁴⁵ However, the benefits per service varies significantly, from an average of \$31 per chiropractic service to \$76 per optical service.⁴⁶

The extent of out-of-pocket costs depend on the health service in question. It also depends on the extent of the benefits paid to consumers which reflects their level of coverage (and therefore exclusions and caps). At one end of the spectrum are those with, so called, 'Top Cover', which generally offers fewer exclusions and higher caps but still with approximately 50 per cent of fees rebated, which accounts for approximately 15 per cent of the market.⁴⁷ At the other end is those with minimal coverage such as ambulance cover only, for which 143 503 general treatment policies are held.⁴⁸

Aside from those with 'Top Cover', all other policies represent a balance between price and risk in the form of exclusions and caps that limit savings for and use of dental and allied health services. Dental cover represents more than half of all claims payouts, but are typically limited on an annual basis by caps for general dental, major dental and endodontic. For instance, the Ombudsman suggests that the coverage of dental has ranged from 34 to 75 per cent, with major health funds typically covering around half of dental costs (in 2017).⁴⁹ Applying the share of 50 per cent of the fee being rebated to 55 per cent of the population covered by PHI might suggest that *at least 27.5 per cent* of dental costs would be borne by the insurers given that those with insurance would be more

⁴³ Ibid.

⁴⁴ These funds together held 81.7 per cent of the market in 2014. The Conversation, 2017. 'Infographic: A snapshot of private health insurance in Australia'. <https://theconversation.com/infographic-a-snapshot-of-private-health-insurance-in-australia-39237>

⁴⁵ APRA, 2017. Private Health Insurance Quarterly Statistics. June 2017 (released 15 August 2017). Sydney. <http://www.apra.gov.au/PHI/Publications/Documents/1708-QPHIS-20170630.pdf>

⁴⁶ APRA, 2017.

⁴⁷ Based on the number of people with no excess for hospital and general cover combined, as at June 2017 using APRA statistics (released 15 August 2017).

⁴⁸ Private Health Insurance Membership and Benefits, 2017.

⁴⁹ Commonwealth Ombudsman, 2017. State of the Health Funds Report 2016. Private Health Insurance Ombudsman. http://www.ombudsman.gov.au/__data/assets/pdf_file/0020/43355/2016-State-of-the-Health-Funds-Report.pdf

likely than those without to seek medical care. However, across the system, only around 18 per cent of the \$9.6 billion paid in dental costs were incurred by funds.⁵⁰

Furthermore, gaps in coverage and out-of-pocket expenses may contribute to the delay of treatment (under treatment) including for dental, contributing to cost shifts across the health care system.

Variation in coverage of services and providers

Currently, insurers establish preferred supplier arrangements with dental and allied service professionals as a mechanism for administering and limiting claims. Through this process, consumers are limited by an artificial price impost on dental and allied health care professionals without a preferred supplier arrangement with the customers' insurance company. They may also be used to as an advertising tool to entice consumers that are responsive to 'no gap' services. Insurers argue that these are used to achieve clinical efficacy of the service, meet legal requirements related to accreditation/registration, reduce administrative costs to the insurer, and manage member demand and the expected cost of claims.

Researchers at the University of Sydney recently concluded that these decisions are more of a commercial nature than in the interest of provision of best health care.⁵¹ Regardless, the effect of this practice is to restrict consumer choice because it:

- penalises consumers for going to their provider of choice, where that provider is not contracted by their fund (and adds additional complexity to the system)
- may interrupt continuity of care of the policy holder, and
- may reduce the range of independent health care providers available to consumers.⁵²

It is also noted that the choice of provider is a critical underpinning of the difference between private and public health care, for both medicine and dental. Hence, this practice effectively stifles this element of the value proposition for PHI.

Researchers have also suggested that it may lead to less use of certain dental and allied health professionals. This was highlighted by the ACCC's findings that there is significant variation between private health insurers in providing rebates for services within dental and allied health occupations same 'scope of practice'. For instance, nutritionists were more likely than dietitians to get recognised for nutrition services, among a host of other examples.⁵³

⁵⁰ See Consumers Health Forum of Australia, 2017. *Senate Inquiry: Value and affordability of private health insurance and out-of-pocket medical costs*.
https://chf.org.au/sites/default/files/chf_phi_senate_submission_final_04092017.pdf

⁵¹ Willis, K., Mackenzie, L., and Lincoln, M. 2014. 'Private health insurance rebates restrict consumer choice'. <https://theconversation.com/private-health-insurance-rebates-restrict-consumer-choice-13563>

⁵² Consumers Health Forum of Australia, 2017. *Senate Inquiry: Value and affordability of private health insurance and out-of-pocket medical costs*. July 2017.

⁵³ Willis, K., Mackenzie, L., and Lincoln, M. 2014, op. cit.

Reduced value for people in rural and regional areas

The features of general treatment cover have a greater impact in rural and regional areas. Approximately 1.3 million Australians with PHI live in rural Australia out of around 2.5 million in rural areas.⁵⁴ The value of PHI often referred to as the ability to access a 'private service' with the doctor of the patients' choice may have a limited effect across rural areas where there may be limited private hospitals and a limited choice of doctors. In addition, general treatment ('extras') cover may be 'dubious' as there could be few, if any, providers in rural areas across the broader range of ancillary health services (beyond dental care). 'General treatment only' cover might be more attractive for consumers in regional areas where there may be limited access to regionally based private hospitals to enable hospital cover to be utilised.⁵⁵

Falling consumer satisfaction

There are some indicators that consumers are less satisfied with aspects of their general treatment cover. A survey by Roy Morgan Research across 50 000 consumers per year, including detailed coverage of more than 23 000 private health insurance members suggests that satisfaction has fallen across the five largest health funds since mid-2015. Cost pressures was cited as the key driver of the falling satisfaction that has been experienced to date.⁵⁶

Potential for over-servicing

One of the realities of general treatment cover is the scope for clustering of health service activity around expiration dates, or when limits and caps are refreshed. In some cases, this activity may be perfectly appropriate, but in others it may be questionable.

The current system of general treatment cover makes it rational for health service providers to promote the uptake of services to consumers to maximise their PHI benefits, and for consumers to purchase health services to ensure that their entitlements are maximised.

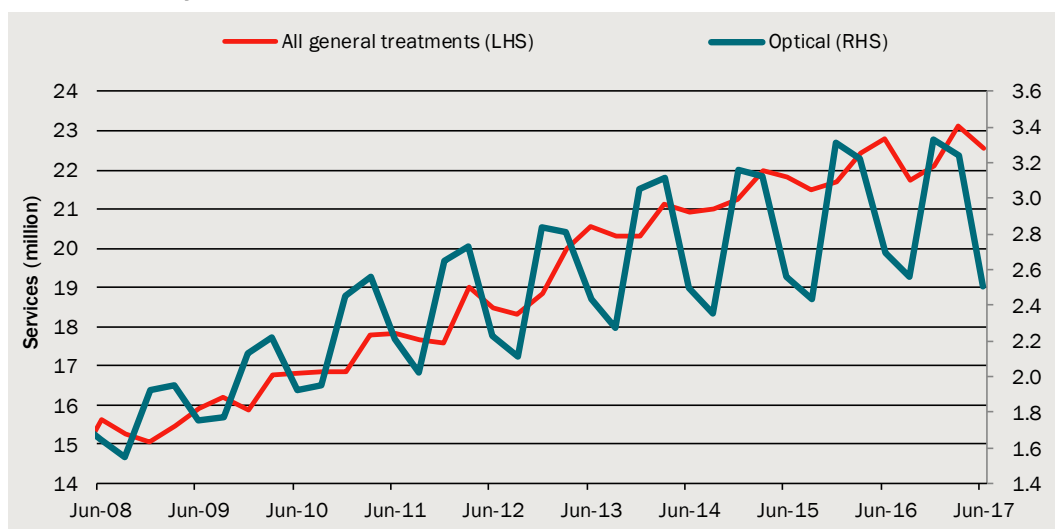
One example of this can be seen in the data for optical services, which dramatically peak in the December and March quarters every year in line with entitlement expiration at the end of the calendar year, and refreshment of entitlements from 1 January. The pattern is so dramatic, that it drives (lesser) fluctuations in total general treatment service activity (as shown in chart 2.1).

⁵⁴ Consumers Health Forum of Australia, 2017. *Senate Inquiry: Value and affordability of private health insurance and out-of-pocket medical costs*. July 2017.

⁵⁵ St Luke's Medical & Hospital Benefits Association Ltd – submission No. 20

⁵⁶ Roy Morgan Research, 2016. *Satisfaction with private health insurance declining*. November 2016. Finding No. 7044.

2.1 Quarterly fluctuations in health services



Note: All upward movements on chart represent results for the December and March quarters, and all downwards movements represent results for the June and September quarters.

Data source: APRA 2017, Private Health Insurance Membership and Benefits June 2017.

The in-principle case of 'saving' for dental and allied health

While in some cases, the insurance model may be perfectly appropriate for dental and allied health services, this might not always be the case.

The role of insurance is typically to provide protection against low probability, high cost events, where the cost of an event is high (such as for a flood or fire events) but the likelihood of claim is low, thereby supporting 'risk-pooling' across the population.

This is often not the case for general treatment insurance, and in some instances savings may be more appropriate than insurance.

General treatment cover, as is currently offered (as an insurance product), is not a savings vehicle for dental and allied health, and enables occurrence of cross-subsidisation between hospital and extras insurance.⁵⁷ While this helps fund hospital cover, it inevitably reduces the pool of funds for payment of benefits for dental and allied health.

Moreover, as part of the insurance model of which it sits within, the general treatment business needs to be managed, requiring administration expenses and a return on capital to be paid. Currently around 9 per cent of the \$23.97 billion in Health Insurance Business (HIB) and investment revenue (or \$2.15 billion) is spent on managing (all) claims. In addition, average after tax profits across both hospital and general treatment was \$1.43 billion or 6 per cent of premium revenue in 2017. Applying this proportion to general treatment, it could be assumed that the cost of 'insuring' for dental and allied health expenses is around 15 per cent of premiums. In 2013, it was estimated that the

⁵⁷ The Private Health Insurance Administration Council (PHIAC), 2013. *Competition in the Australian Private Health Insurance Market: Premiums and Competition Unit*. Research Paper 1. Canberra.

gross margin on a general treatment policy were between 23.1 per cent and 33.6 per cent, depending on the state or territory.⁵⁸

This means that policy fees paid by individuals plus subsidies paid by the Australian Government are necessarily higher than benefits distributed back to consumers.

In the 12 months to September 2017, the average benefit paid for allied health and dental care in Australia was \$403.80, compared to the average cost of a single policy, which is approximately \$606 each year⁵⁹ (table 2.2).

2.2 Indicative average cost across policies

	Single	Single parent family	Couple	Family type
NSW	622.7	1 184.4	1 233.8	1 275.8
VIC	608.0	115.5	1 203.3	1 245.3
Qld	598.5	1 137.2	1 184.4	1 226.4
SA	608.0	1 156.1	1 204.4	1 246.4
WA	579.6	1 108.8	1 147.7	1 184.4
NT	535.5	1 018.5	1 060.5	1 098.3
TAS	564.9	1 074.2	1 118.3	1 159.2
Average	588.2	970.7	1 164.6	1 205.1
Weighted average	606.1	883.0	1 200.1	1 241.5

Source: The CIE using CANSTAR, 2016. Weighted according to the residential share for the same year, the average cost of a policy was \$606 per year (before the rebate).

The private health insurance rebate improves the cost effectiveness of general treatment cover *for individuals* although it is still not widely cost effective even after the rebate.⁶⁰

⁵⁸ Private Health Insurance Administration Council, 2015. 'Risk sharing in the Australian private health insurance market'. Research Paper 4: June 2015.

http://www.apra.gov.au/PHI/PHIAC-Archive/Documents/Risk-Sharing_June-2015.pdf

⁵⁹ In aggregate, this equated to \$4.969 billion for the 12 months to September 2017. APRA, 2017. This included an average amount of \$213.56 for dental care, \$69.55 for optical, \$33.62 for physiotherapy, \$23.32 for chiropractic and \$63.72 for other ancillary expenses. *Private Health Insurance Quarterly Statistics*. September 2017 (released 14 November 2017).

<http://www.apra.gov.au/PHI/Publications/Documents/1711-QPHIS-20170930.pdf>

⁶⁰ On average, general treatment only is likely to be cost effective or cost neutral only for those in tier 1 and tier 2 income levels in the 65 years and older age category, although this does not consider the value of spreading cost risks and having the security of insurance.

3 *A new opportunity to encourage saving for one's care*

The concept of Health Savings Accounts for dental and allied health services is about offering positive incentives to save for one's care in a way that is consumer-centred, without barriers to consumer choice, and where consumers are rewarded for proactively managing their dental and allied health care.

It also offers a mechanism for targeting low income earners that have poor access to dental and allied healthcare to receive government assistance that is specific to their individual health needs.

Internationally, the use of Medical Savings Accounts has supported incentives to save and driven greater innovation in the market for insurance products, particularly through offering choices for young people less inclined or able to take out insurance coverage and less likely to claim (and benefit from their insurance).

Opportunity to use price signals to encourage people to be healthy

Despite its many virtues, the Australian health care system has limited incentives to reward people for good health. While universal access to health care is deeply embedded in the Australian health funding system and psyche, it does not extend to all services, and does not necessarily reward consumers for using health services efficiently.

For instance, Medicare offers access to many preventative and early stage services. However, consumers do not face an immediate price signal (or return) for keeping themselves well, and if they do not, then Medicare and other parts of the health system incur the costs of addressing more complex health care needs.

When used in a targeted way that is complementary to the long-established principles and systems for government funded health services, price signals can be effective in encouraging consumers to select services at a time and place that better manages their health care. To some extent, this is achieved with the current system of PHI. However, with respect to dental and allied health services, it may encourage 'use it or lose it' access patterns, where consumers are encouraged to access services to maximise their PHI entitlements.

HSA's would encourage consumers to invest in (and potentially rationalise, or at least more efficiently determine) their health service use, such as through avoiding deferral of treatment, investing in preventative health measures and accompanying healthy behaviours. Through a basic price mechanism, with the option to either spend or save, HSA's offer the potential to:

- promote those dependent on the public system to save for and invest in preventative and complementary health care, potentially

- avoiding expenses across other parts of the health system because of under investment in dental and allied health care
- reduce the financial barriers to accessing dental and allied health care for individuals that have minimal insurance coverage, with the potential to promote timely access to preventative health care use, and
- reduce the burden on public health care.

Addressing barriers to consumer choice and value for money in general treatment cover

Medical Savings Accounts (MSAs) have been used internationally to create incentives for consumers to take an interest in the cost and content of their allied health care services. In turn, this aims to provide local contestable markets for health services involving fee discounts, new competitive and innovative care packages, and other forms of non-price competition.⁶¹

Hence, for Australia, HSAs can help create a more level playing field, with treatment based on clinical need and consumer preferences, without any influence from the incentives that drive the 'consumer value' of PHI. HSAs would enable consumers to choose their provider, without facing the current level of price discrimination for suppliers that are not preferred by insurers.

For instance, the establishment of MSAs in the United States was undertaken because of 'unfair' constraints on patient choice and provider autonomy. Far from reducing the proposition for private savings and insurance, MSAs have been used to promote participation of individuals in saving for their health care, including allied health, where they would otherwise be seeing a declining value proposition of insurance coverage.⁶²

HSAs would enable consumers with both low and high general treatment cover to have less barriers to choosing their preferred supplier and allow for more competition around non-price factors. The less restrictive way in which those savings can be spent is expected to foster better non-price competition, diversity and innovation across market segments.

Hence, they could simultaneously preserve the 'choice of provider' element of PHI and promote more competition between health service providers, between whom patient servicing is not influenced by variability in out-of-pocket costs for patients.

⁶¹ Gadiel, D., and Sammut, J. 2014.

⁶² It is noted that international HSA models are not suitable to the Australian context and have not been without their critics. The HSA model developed for this review reflects the learning from international experience.

Managing long-term demand and health costs

The cost of dental and allied health receives some subsidisation through the PHI rebate that is applied to general treatment cover.⁶³

Nonetheless, the cost of dental and allied health care, including overall benefits, out-of-pocket expenses and the level of need continues to increase with an ageing and growing population. As evidenced previously, the value proposition behind general treatment cover has been falling, due to exclusions, increasing out-of-pocket costs due to rebates not being reviewed to even keep pace with inflation and preferred supplier agreements that create a price disadvantage to consumers that chose non-preferred suppliers. There has been some evidence of a trend (in consumer preferences) towards the downgrading of cover, with potentially negative impacts on consumption patterns across dental and allied health care.

To manage the cost of increasing demand, insurers generally have limited tools other than to control supply. They can exercise supply side management by restricting eligibility, coverage of services, cap the amount of services (set low annual monetary limits) and set rebate percentages. They are also able to manage the cost of administering claims and attempt to place downward price pressure on market segments of supply through preferred provider relationships. Nonetheless, controlling the underlying demand for services is particularly difficult and cost sharing mechanisms are already in place.

HSAs represent another choice for consumers, and for the system of health financing in Australia, that can help meet underlying needs through savings.

The experience of MSAs overseas, which have all provided a tax exemption on contributions and interest, has been that younger individuals were incentivised to participate in saving for their own care.⁶⁴ A carefully constructed approach to HSAs in Australia should have the potential to improve, not lessen the value proposition of private expenditure in private health care, particularly for those that are under 30, those later life for those who have accumulated large deposits, and those in income sensitive brackets.

Also, health pricing at the point of consumption encourages consideration of the value of alternative consumption preferences, including the ability to discriminate between services that are discretionary (amenable to self-care) and those that are necessary.⁶⁵ Thomson and Mossialos state that 'some studies – particularly those in settings where

⁶³ Choice, 2017. '\$6.5 billion per year spent on health insurance rebate', 20 September 2017. <https://www.choice.com.au/money/insurance/health/articles/junk-health-insurance>

⁶⁴ The details of what care was eligible varied across contexts. See appendix A for further information on each of the four schemes.

⁶⁵ Gadiel, D., and Sammut, J. 2014. 'Lessons from Singapore: Opt-out Health Savings Accounts for Australia'. *Papers in Health and Ageing* (14). Centre for Independent Studies, Australia.

people self-select into HSA plans – find that some participants increase their use of preventive services'.⁶⁶

In the international context, by design, some MSAs have aimed to improve coverage through keeping plans affordable and therefore deductibles (or out-of-pocket expenses paid by MSAs) high. In the United States, some evidence shows that those with high deductible plans may avoid, skip or delay receipt of needed health care as a result. However, careful avoidance of the use of HSAs to encourage a process of 'de-insurance' is likely to avoid this.

One way of achieving this would be to enable individuals to hold HSA accounts that are not linked to their insurance policies.

Lessons from the use of medical savings accounts abroad

The international experience with HSAs provides insight into the features of HSAs that may be relevant in an Australian context, and features that will drive potential rates of uptake. There are four countries that have adopted MSAs including Singapore, China, the United States and South Africa.

- Singapore is the most notable example where MSAs have been used as the central pillar of health system financing, with a universal, compulsory approach having been in place since 1984.
- Following this, voluntary MSAs were introduced in South Africa in 1994, and in China and the United States in the late 1990s.

Use and context of MSAs abroad

The context in which these schemes were introduced underpins their design, their effect and the extent to which these experiences may translate to the Australian context.

In the United States and South Africa, MSAs were introduced where there was no universal or comprehensive system of health coverage and there was low affordability of private health care insurance. As such, MSAs were used by the insurance market to 'de-insure', with individual protection reflecting (to an extent) their level of savings. Over time, these countries have needed to tweak their arrangements to protect 'pooling' of risk across the population.

In Singapore and China, for which savings has been 'compulsory'⁶⁷, MSAs complemented a publicly financed health care system, with a 'tight' control over health care pricing and provision. In Singapore, the consumer-centric model is coupled with the strength of a largely Government run health care system that keeps costs as low as possible by aggressively managing the supply of health services, the price of treatments

⁶⁶ Thomson, S., and Mossialos, E., The Health Policy Bulletin of the European Observatory on Health Systems and Policies.
<http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/euroObserver/obsvol10no4.pdf>

⁶⁷ Although not well enforced in China.

and the broader behavioural environment in which the system operates. This inherently reduces the ability to transfer any experiences such as with respect to *cost containment* to potential outcomes in Australia.⁶⁸

The focus of MSAs in Singapore is on inpatient hospital care, chronic disease management care, and immunisations (not the area where MSAs are being envisaged in Australia). Out-of-pocket costs paid from general savings accounts represents the dominant form of health financing.⁶⁹

An important difference to observe in all international examples is that universal access to healthcare has not been prevalent in these countries and that the cost of health insurance has been high relative to income.

The common thread with the international experience is that MSAs may address the decreasing value proposition for general treatment cover and offer a consumer centric model of funding out-of-pocket costs for health care, including dental and allied health. The United States, in particular, was motivated to introduce greater capacity for consumer led care such as in provider choice.

Characteristics of MSA's abroad

Table 3.1 presents a comparison on the design of MSA's abroad including their application, coverage and limitations (and further detailed in appendix A). Their incentives all hinge around the tax exemption provided to fund contributions and interest, with funds accumulating for the working age population.

MSAs abroad have been linked to insurance in some manner as countries seek to *reduce* public health system dependence or underinsurance, by providing a viable alternative to the public health system. In both Singapore and China, these insurance schemes are run by the public sector while in the United States and South Africa these are private insurance schemes.

Other incentives have been to allow for payment of family members' expenses, make savings accounts portable and to enable savings to be transferable to a spouse following the death of the account holder.

Uptake has also been significantly affected by the eligible inclusions. In the United States, IRS regulations have limited services that can be covered in HSA-HDHPs before meeting the plan deductible, which has made the management of chronic conditions through HSA-HDHP expensive. This is said to have reduced the affordability of and uptake of the scheme for those with chronic conditions. Although high deductibles were designed to keep premiums low, to address this 'imbalance' the US Congress introduced a bill in 2016 that would allow HSA-HDHPs to cover care for chronic conditions prior to

⁶⁸ Euro Observer, 2008. 'Medical savings accounts: can they improve health system performance in Europe?' By Thomson, S., and Mossialos, E. *Health Policy Bulletin*. Winter 2008; Volume 10, Number 4.

⁶⁹ Euro Observer, 2008.

members meeting their deductibles.⁷⁰ In addition, clarifying (and extending) the range of services that are covered as 'preventative services' that are exempt from deductibles has improved the attractiveness of the scheme.⁷¹

Typically, schemes have started out very restrictive to ensure that savings exceed expenditure, and then expand over time. All schemes overseas have included deductibles (or out-of-pocket costs) for inpatient hospital care, which is not proposed here. Schemes have varied with respect to coverage and extent of coverage of allied health care deductibles: excluded in Singapore, included minimally in China and more extensively in the United States and South Africa.

Maximum annual contributions and maximum annual withdrawal limits are common across all schemes (see table 3.1).

⁷⁰ Npr, 2016. 'Tax rule limits care for chronic ills under High-Deductible Health Plans'.
<https://www.npr.org/sections/health-shots/2016/09/20/494611994/tax-catch-limits-care-for-chronic-ills-under-high-deductible-health-plans>

⁷¹ IRS, 2013. 'Section 223 – Health Savings Accounts'.
http://learnwageworks.com/documents/IRSNotice2013-57_HSA.pdf

3.1 Comparison of drivers of uptake for MSA

	Singapore	United States	South Africa	China
Incentives for uptake				
Tax exempt contributions, interest and expenses?	√	√	√	√
Portable?	√	√	√	√
Compulsory	√	X	X	√
Rate (as a percentage of salary)	7-9.5 %			1-2 % plus ^e
Benefits drawn from spouse or family members?	√	√	√	X
Free access to public hospitals for MSA holders	X	X	√	X ^f
Uptake associated with public or private insurance	√	√	√	√
Application of incentives				
Allied health care?	X	√	√	Minimal ('preventative care')
Prescription medicines?	X	√		?
Inpatient hospital care?	√	√	√	Optional ^g
Used for the purchase of insurance (premium)?	√	√	√	√
Aspects of primary health care?	<i>Minimal</i>	√		√
Mandatory insurance to 'risk pool'	X ^a	√ ^b	√ ^c	√
Restrictions				
Maximum annual contribution	√	√	√	√
Account limits	√	√	Not explicitly ^h	Not explicitly ^h
Yearly withdrawals limits (insurance may cover amounts exceeding)	√	√	√	√

^a Insurance cover (through MediShield) is provided through an opt out manner. ^b Must be bought with a high deductible health insurance plan. ^c They have been issued by insurers so work in a similar way to the United States ^d Periodic health evaluations, immunisations, routine prenatal, obesity weight loss and screening ^e Employers also make a contribution ^f HSA funds drawn down in public hospitals until exhausted ^g Chronic disease management and immunisations ^h Can be used for all care or only outpatient health care ^h Given annual maximum contributions, a maximum account holding is not technically constrain account levels

Source: The CIE.

Table 3.2 summarises the lessons for Australia from the international experience.

3.2 Implications of the international experience for Australia

Strengths	Limits
<p>Uptake has been successful by providing tax exempt contributions, interest and withdrawals</p> <p>HSAs have encouraged some young people to stay in the PHI system. It has likely lowered the out-of-pocket burden for those reliant on private health care</p> <p>HSAs offer consumer led care, including for continuity of care with non-preferred suppliers</p> <p>They offer the potential to increase the use of preventative care, supported in contexts where individuals opt in to their health care.</p>	<p>Its impact on the price of allied health services is contested. In Singapore, for example, reported success in the pricing of health care has more likely reflected the role of the Government in funding public hospitals</p> <p>Initially, schemes are small with high restrictions and may require time to develop</p> <p>The use of HSAs is unlikely to address moral hazard in Australian health care (as was their initial purpose in theory abroad). Even when these mechanisms are mature and restrictions are broadened, as in the case of Singapore, their application is still quite restrictive to be affordable</p> <p>It does not provide an additional savings mechanism for retirees but for the population. Retirees already have available subsidised savings through their retirement savings accounts.</p>
Opportunities	Threats
<p>To increase the consumption of dental and allied health where it was below optimal. This will include from those previously under consuming health care services.</p> <p>Provide an alternative model for dental and allied health to compete on non-price factors including service, quality, continuity of care, convenience and so on. Greater contestability between providers and occupations across the health sector will benefit patients in their care</p> <p>To overcome the barriers to consumer-led care, most notably around provider choice</p> <p>To provide for greater consumer engagement in saving for and valuing their health and health care. It introduces a policy tool that may be used to cover other areas of health care at a later date, such as for chronic disease management and medicines.</p>	<p>The potential for insurers to 'de-insure' in response to HSAs with an associated reduction in risk pooling. However, a separation of accounts from insurance policies will reduce this risk and likely lead to a greater range of products</p> <p>HSAs have been used to keep PHI premiums low – this appears not to have been well received by all. By design, HSAs do not decrease amounts paid by the individual and in some contexts, out-of-pocket expenses paid by HSA holders remain high.</p> <p>Real wage growth does not typically keep pace with health care costs, and as such funds will rely on contributions or investment returns to maintain purchasing power. This is no different to normal savings mechanisms.</p>

Source: The CIE.

4 *Health savings account for dental and allied health services in Australia*

A preliminary model for HSAs in Australia has been developed to complement established funding frameworks for dental and allied health care.

The HSA concept includes dental and allied health services not covered by Medicare. Incentive arrangements have been selected to ensure consistency with government subsidies for low income earners, and where appropriate, mindful of savings incentives for superannuation.

A three-pronged approach has been developed to address gaps in access to services, and offer an attractive choice to consumers that might be able to better fund their contribution to dental and allied health services, using tax offsets, tax concessions, and a capacity to save above any incentivised amounts.

This approach is unique to the Australian context, as HSAs abroad are not considered readily transferable. In the Australian case, the purpose is to only target savings for dental and allied health care, without undermining PHI for hospital care.

Key objectives for HSAs in Australia

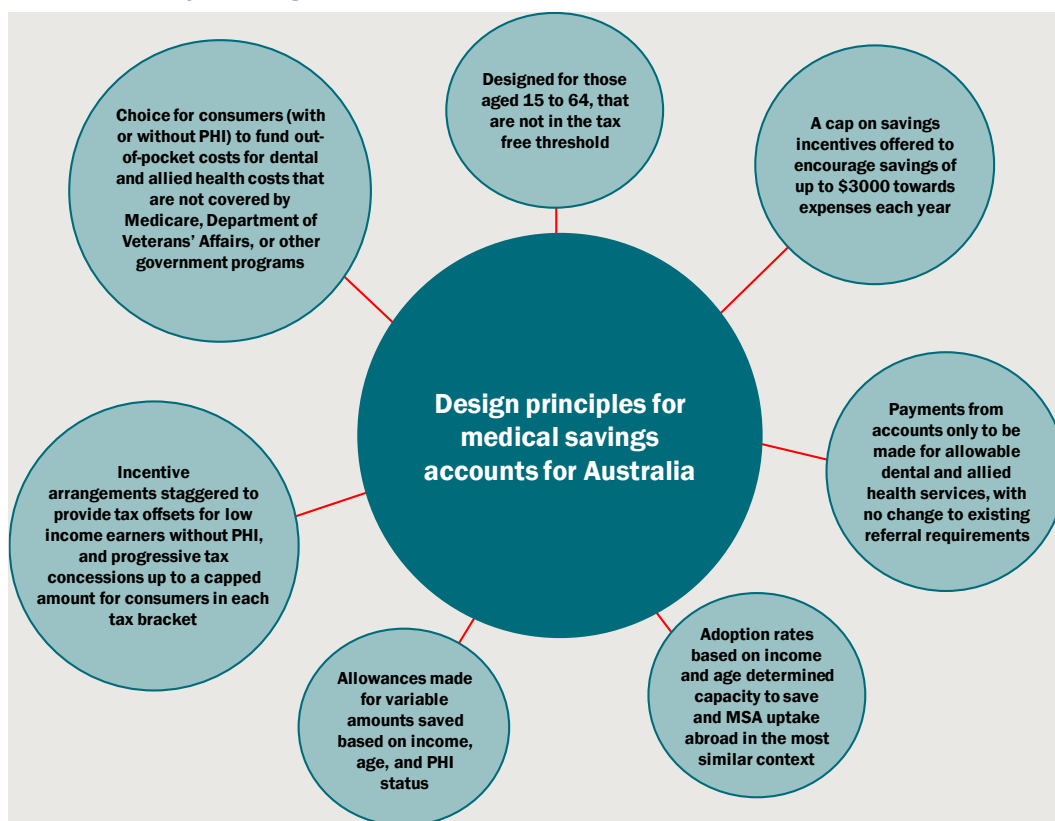
The HSA model developed for this study focuses on identified weaknesses in the existing system for funding dental and allied health, and to offer a genuine choice to consumers regarding ways to fund their dental and allied health care.

Its key objectives include:

- to provide incentives for low income earners not currently accessing general treatment cover to save for their own dental and allied health care
- to reduce (at least in part) the financial barrier to accessing care by developing a flexible and individual financial safety net and capacity for people to pay for their own dental and allied health care costs, and in doing so
- help to deliver short and long-run benefits through better health outcomes.

As shown in chart 4.1, the intention of HSAs is only to encourage co-funding from consumers for dental and allied health services that are not covered by Medicare, offering incentives that can be accessed through the Australian tax system in a way that is complementary to existing incentives for PHI and individual retirement savings.

4.1 Summary of design principles for HSAs in Australia



Note: Services not covered by Medicare include examinations for life insurance, superannuation or memberships for which someone else is responsible (for example, a compensation insurer, employer or government authority), ambulance services, most dental examinations and treatment, most physiotherapy, occupational therapy, speech therapy, eye therapy, chiropractic services, podiatry or psychology services, acupuncture (unless part of a doctor's consultation), glasses and contact lenses, hearing aids and other appliances, and home nursing.

Data source: The CIE.

Overview of the preliminary Australian HSA model

The HSA model developed for this review has three components:

- a **tax offset** component, which enables those on low incomes to transfer tax-free income into a HSA up to a specified level
- a **tax concessions** component, which enables those above the tax-free threshold to salary sacrifice into a HSA, and receive a tax concession on savings made up to a specified level, and
- a **market model** component, which allows consumers to save above any concessional amount, to continue to foster and reward positive saving behaviour.

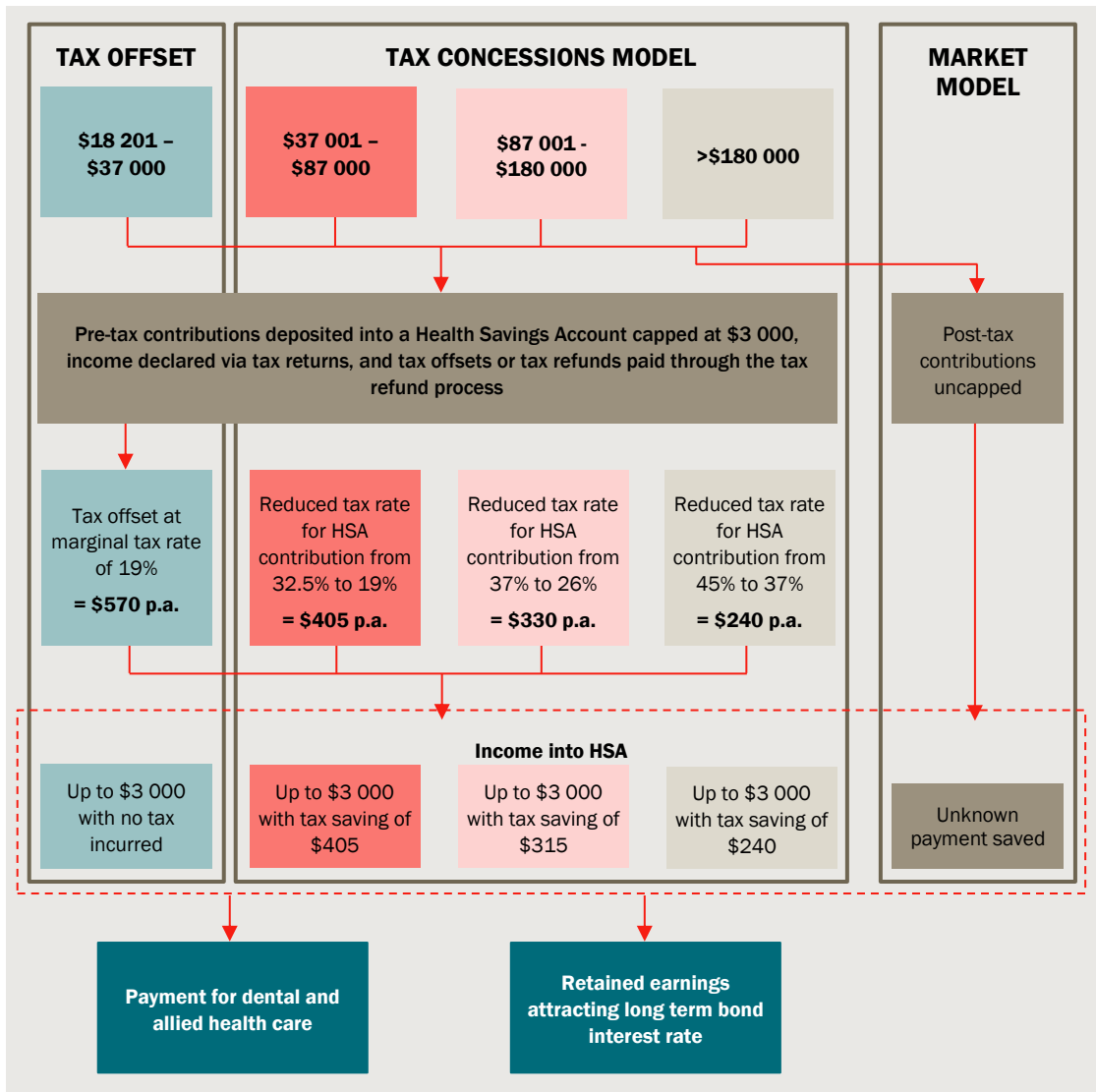
For the purposes of this review, the concessional cap is set at \$3 000 per annum per (individual) account holder.

Tax concessions are designed to be progressive, and offer a reduced rate of subsidy to those on progressively higher incomes.

A schematic of the HSA model developed for this review is shown in chart 4.2 and its consumer cohorts in chart 4.3, which shows that not all individuals that take up a HSA are expected to save to the full concessional cap.

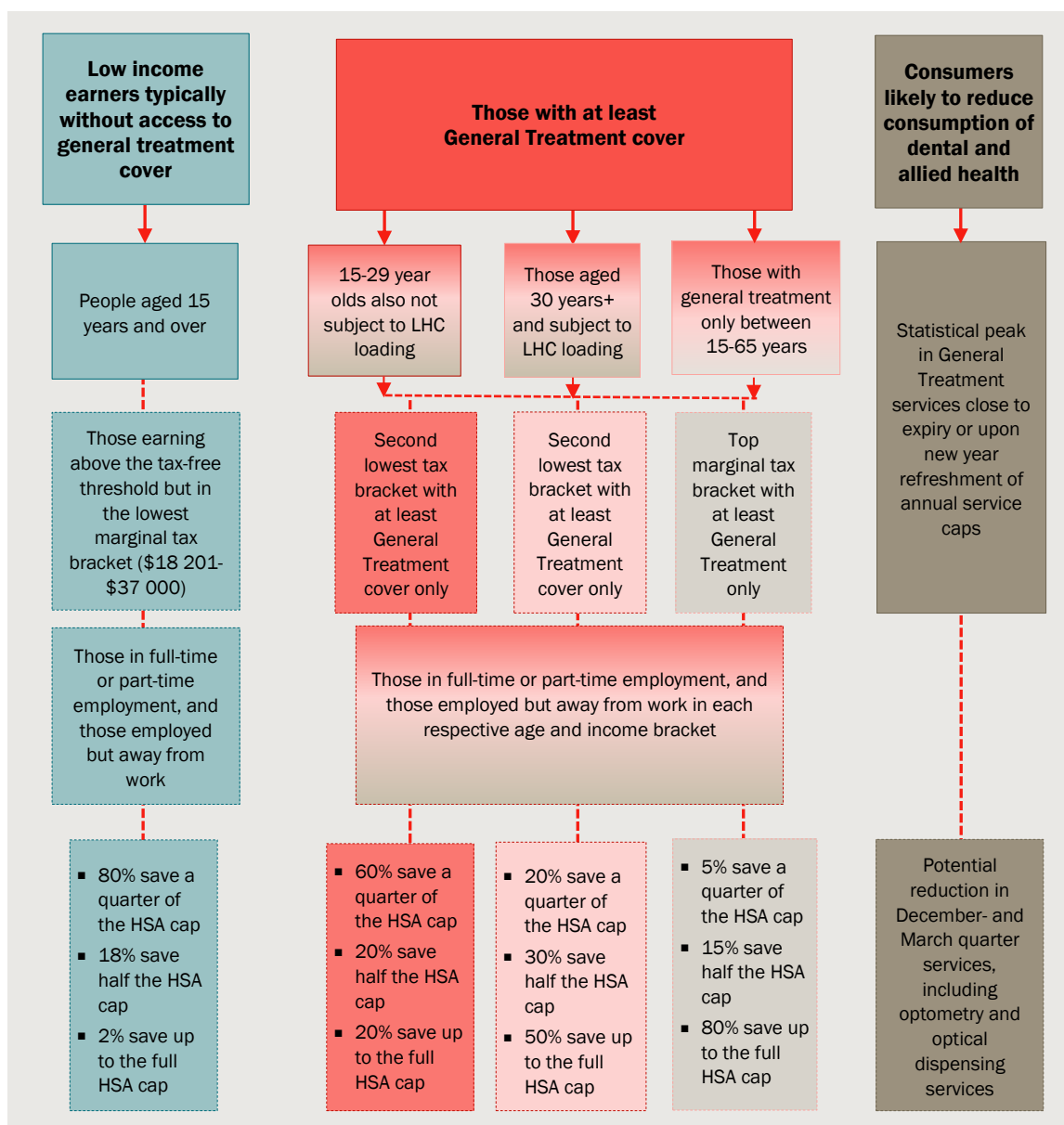
The modelling results in this review focus on those in specific age and income groups. This is because it is important to exclude those in the tax-free threshold for whom there is no incentive offered, and those that have access to more financially attractive savings vehicles.

4.2 Three-pronged HSA model for Australia



Source: The CIE.

4.3 Consumer cohorts expected to adopt HSA in Australia



Data source: CIE.

Tax offset model

The tax offset model would only be available to those aged 15 and over in the lowest marginal tax bracket. It is envisaged that consumers would be able to salary sacrifice up to \$3 000 per annum, and receive a full tax offset for any tax amounts that would otherwise accrue to these savings.

Savings that are not spent in each year would attract interest, set at the 10-year bond rate. No account fees are incurred by consumers for their HSA. The administrative costs of the accounts would be funded by account manager(s) (government or non-government), who would be able to earn a return on retained invested funds above the long-term bond rate.

The key assumptions made with respect to those able to access the tax offset component of an HSA are summarised in table 4.4.

4.4 Tax offset model

Population	PHI status	HSA savings amount	Cost to Government per person	Key assumptions
People aged 15 years and over, in employment, earning <\$37 001	None, no MLS	80% save 25% of cap	\$142.50	Subsidy cap = \$3 000 Excludes those in tax-free threshold Non-concessional savings = \$0
		18% save 50% of cap	\$285	
		2% save 100% of cap	\$570	

Source: The CIE.

Tax concessions model

The tax concessions model is progressive, with staggered tax incentives that are most generous to those on lower incomes:

- those earning between \$37 001 and \$87 000 per year receive a tax deduction of 14 per cent by taxing their HSA savings at the lowest marginal tax rate (reducing tax on contributions of up to \$3 000 per year from 32.5 per cent to 19 per cent)
- those earning between \$87 001 and \$180 000 receive a tax deduction of 11 per cent (reducing tax on contributions of up to \$3 000 per year to HSA savings from 37 per cent to 26 per cent)⁷², and
- those earning over \$180 000 per year receive a tax deduction of 8 per cent (reducing tax on amounts up to \$3 000 per year from 45 per cent to 37 per cent).

It is also designed to be in line with the principles of good tax policy for long-term, lifetime savings set out by the Australian Treasury, which includes:

- taxing such savings at a lower rate than other income or exempting it from tax income
- promoting a more consistent treatment of household savings across individuals to encourage them to seek the best pre-tax return on their savings and to invest their savings in assets that best suit their circumstances and risk-preferences, and
- broadly compensating for the effects of inflation, particularly for interest income.⁷³

While the tax concessions proposed for HSAs are purposefully less generous than those for superannuation, they are intended to be consistent with the spirit of superannuation incentive arrangements.

Individuals earning above \$37 000 that are 65 years or over are excluded from the tax concessions model, as the design of the HSA incentives offers lower incentives than they are likely to be able to access from other yielding assets (see box 4.5).

⁷² The tax concession for this income group is not directly aligned to the 2017-18 tax rates to achieve a progressive incentive across all income thresholds.

⁷³ Australian Treasury 2009, *Australia's future tax system, report to the Treasurer: Part 2 Detailed Analysis*.

4.5 Expected exclusion of individuals over 65 years from adopting HSAs

While the HSA concept embraces all Australians, it is expected that those aged 65 years and over will not be attracted by tax concessions on offer, given their access to a tax-free savings vehicle, their superannuation account, which is excluded from their assessable income for taxation purposes.⁷⁴

Those between 60 and 64 continue to be included, as they need to satisfy a condition of release, such as retiring from the workforce or starting a transition to retirement pension.⁷⁵

As with other age groups, concessional deposits into superannuation of up to \$25 000 can also be made each year at a 15 per cent rate of taxation, which are then able to be saved tax-free and withdrawn (tax free) for general expenditure. In addition, Australians aged 65 years and over may be eligible for the Seniors and Pensioners Tax Offset, which provides a higher tax-free threshold to both self-funded retirees and pensioners, not available if income exceeds a certain level.⁷⁶ Together, these incentives mean that older Australians have a low marginal tax rate and already have access to at least one zero tax savings vehicle that available for general expenses such as dental and allied health care.

It is assumed that HSA's could be rolled in to a superannuation account at the age of retirement or be kept solely for medical expenses, without additional savings being added to the account.

In Singapore, upon turning 55 an individual's Medisave account is rolled in to a retirement account (along with special and ordinary savings), subject to a minimum balance of \$32 000. However, in the United States they are required to be used for medical expenses rather than general expenses throughout retirement, but may be transferable to a spouse via health expenses or upon death.

In the context of this review, because the HSA concept for Australia has limited coverage of eligible expenses (to just dental and allied health care) and due to the modest concessions on offer, we envisage that medical savings would be rolled into a retirement saving account at 65 years.

⁷⁴ For up to \$1.6 million per person. See, for example, LGIA super, 2017. 'Tax on super in retirement'. <https://www.lgiasuper.com.au/retired-members/access-your-super/tax-on-super-in-retirement/>

⁷⁵ SuperGuide, 2017. 'Tax-free super for over-60s, except for some'. <https://www.superguide.com.au/accessing-superannuation/tax-free-super-for-over-60s>

⁷⁶ The SAPTO enables both self-funded retirees and pensioners to receive a rebate income of up to \$28 974 each or \$57 948 per couple, for 2017-18, without attracting taxation. This is in addition to any other source. The eligibility criteria is that rebate income must be less than \$50 119 or \$83 580 as a couple, with higher rates for those living apart, excluding superannuation earnings. Cited at <https://www.superguide.com.au/smsfs/no-tax-retirement-sapto>

Market model: ability to make voluntary post-tax contributions

The third proposed component of the envisaged HSA is an ability for individuals to save more than the tax concessional (or offset) amount each year. For this review, we envisage that there would not be any limit to the participation of individuals with any form of PHI including private hospital only cover. This would work by allowing the funds to accumulate according to the strength of the proposition for consumers, thereby augmenting competition and overall savings for dental and allied health care.

The extent to which individuals would add more to their HSA (above the concessional amount) would reflect the terms of those additional savings. Consistent with the concessional contributions bracket, contributions above the tax concessional amount would also only be used for spending on allied and dental health care. Over time, subject to how the mandate and policy intent of the scheme develops, there could be the option to expand the range of eligible expenses.

It is expected that the level of uptake of voluntary unsubsidised contributions would be income-dependent, based on a persons' savings capacity.

It is envisaged that voluntary non-concessional contributions will attract the long-term bond rate of interest, as would be applied to any retained earnings from savings subject to the tax offset or tax concessions.

While this makes the rate of interest relatively 'low' compared to other alternative choices for investing in yielding assets, it is assumed that HSAs will not attract administration fees. Depending on the amount saved, the attractiveness of using an HSA for health-related savings may be similar, better, or inferior to other choices.

Without any specific concession, it is difficult to assess the attractiveness of HSAs for those wishing to make post-tax contributions to their savings. With long-term bond rates at historical low levels,⁷⁷ it is likely that voluntary post-tax contributions may be limited without some form of concession.

This is indeed the very proposition of HSAs — that is, that some form of incentive is required to foster health care specific savings.

Adoption of MSAs internationally has been promoted by reducing the restrictiveness of the accounts in terms of eligible expenses. However, in Australia, the HSA proposition applies only to dental and allied health, so it is difficult to assess how successful any post tax contributions will be for this restricted set of services.

Given that no incentive is offered for post-tax contributions as part of this study, for the purposes of this report, voluntary post-tax contributions are assumed to be zero. If concessions were to be applied, one mechanism from international experience would be a concessional tax rate on interest earned in the accounts (see box 4.6).

⁷⁷ The 10-year bond yield has been around 2 to 3 per cent in 2017, see Trading Economics, 2017. 'Australia Government Bond 10Y'. <https://tradingeconomics.com/australia/government-bond-yield>

4.6 A concession that could be used to foster post-tax contributions

If individuals were to be encouraged to save from post-tax contributions, one mechanism for this based on international experience could be to apply a concessional tax rate on interest earned of 15 per cent. This would:

- increase the attractiveness of holding additional medical savings with respect to general savings or spending
- ensure consistency with the rate of taxation on interest on superannuation account savings for the working age population with incomes under \$300 000, while:
 - avoiding any competition with superannuation whose contributions receive a concessional tax rate of 15 per cent up to \$25 000
 - not changing the rate of income tax applicable to wages
- promote greater consistency with other tax concessions applied to investments (such as shares and property) held for greater than 12 months of 50 per cent
 - resulting in the same rate as applied to capital gains on investments held for over 12 months (at 50 per cent of the 30 per cent rate), and
- counteract (to an extent) the disincentive for long term savings which have restrictive terms.

Depending on the extent of post-tax savings, a cap to the contributions receiving the concession tax rate on interest could be applied to enhance fiscal management and avoid potential for misuse for tax avoidance. Time limits on spending on medical expenses could also be considered to avoid the incentive to use HSAs for savings and expenditure other than its intended purpose.⁷⁸

⁷⁸ A recent article highlighted the attractive terms for Health Savings Accounts in the United States as a vehicle for retirement savings whereby HSA accounts could potentially be “misused” by seeking reimbursement years after the medical expenses were incurred and therefore avoiding taxation that would otherwise be payable on other savings accounts, see MAD Fientist, 2017. ‘HAS – The Ultimate Retirement Account’. <https://www.madfientist.com/ultimate-retirement-account/>. This could be overcome by imposing a maximum time frame between payment and reimbursement or to require payment via the health savings account at the time of payment to the service provider.

5 *Modelling the impact of health savings accounts*

It is estimated that in the first year, around 850 000 Australians will be encouraged to open a HSA to contribute to their dental and allied health care, rising to 1.2 million people within 4 years, reaching a maximum adoption rate of 10 per cent of all Australians (3 million) by 2030.

It is expected that an average of \$1 225 will be saved annually by Australians, because of the savings incentives on offer.

Based on the tax offsets and tax concessions assumed to be made available to encourage savings, the cost of incentives to the Australian Government is estimated to be \$157 million in the first year, rising to \$559 million when the full 10 per cent adoption rate is achieved. The average subsidy offered to those accessing tax offsets is found to be \$177 per person, and the average subsidy cost of those accessing tax concessions is estimated at \$198 per person, or an average of \$186 per person irrespective of the incentive offered.

Hence, for every dollar of subsidy offered, HSAs are estimated to generate \$6.60 in private funding for dental and allied health services. This indicates that HSA offer the potential to boost the privately contributed funding pool for dental and allied health services considerably, at a relatively low cost to government.

Key modelling parameters

The HSA model developed for this review is based on a detailed population model of the Australian population, commencing in 2017 and extrapolated to 2030. For each year, the model considers PHI status, by age group, employment status and taxable income.

Data inputs for the population model were sourced from the Australian Bureau of Statistics (ABS) and the Australian Prudential Regulation Authority (APRA) (table 5.1).

Age cohorts have been determined based on capacity to contribute to an HSA. The rationale for each age cohort is presented in table 5.2. In line with this, for those of working age, the model also considers employment status.

In estimating the number of people in each age cohort, the model is driven by several assumptions. These are based on observed data reported by APRA and set out in table 5.3.

5.1 Population model parameters

Parameter	Estimation approach	Source
Australian population		
Australian population, by age	Based on Australian Bureau of Statistics forecasts	Australian Bureau of Statistics, 3222.0, Population projections, Australia, 2012 (bases) to 2101, Table B.9, "Population projections, by age and sex, Australia-Series B"
PHI		
Number of people with PHI	Linear extrapolation based on data from June 2013 to June 2017	Australian Prudential Regulation Authority. 2017, "Statistics, Private Health Insurance Membership and Benefits", June 2017, released 15 August 2017.
Number of people without PHI	Calculated based on Australian population less the number of people with PHI	CIE
General treatment		
<ul style="list-style-type: none"> ▪ Number of people with at least GT ▪ Number of people with GT only 	Linear extrapolation based on data from June 2013 to June 2017	Australian Prudential Regulation Authority. 2017, "Statistics, Private Health Insurance Membership and Benefits", June 2017, released 15 August 2017.
Top cover		
Number of people with top cover (i.e. no excess)	Linear extrapolation based on data from June 2013 to June 2017	Australian Prudential Regulation Authority. 2017, "Statistics, Private Health Insurance Membership and Benefits", June 2017, released 15 August 2017.
Personal taxable income by age group^a		
<ul style="list-style-type: none"> ▪ \$1 and \$18 200 ▪ \$18 201 and \$37 000 ▪ \$37 001 and \$87 000 ▪ \$87 001 and \$180 000 ▪ Greater than \$180 000 	Based on Australian 2016 Census	Australian Bureau of Statistics, "2016 Census- Counting persons, Total personal income (weekly) by single year age group", findings based on ABS TableBuilder data.

^a Based on Australian 2017-18 resident tax rates as specified by the Australian Taxation Office, available at: <https://www.ato.gov.au/Rates/Individual-income-tax-rates/>

Note: PHI: private health insurance; GT: general treatment

Source: CIE

5.2 Age groups and employment status

Age group and employment status	Included	Rationale
Less than 15 years	×	Not earning income ^a
15 years to 29 years, employed full time, part-time or employed but not at work	✓	Capacity to contribute to an HSA through salary sacrifice, not eligible for the Lifetime Health cover loading
15 years to 29 years, not employed	×	Not earning sufficient income
30 years to 64, employed full time, part-time or employed but not at work	✓	Capacity to contribute to an HSA through salary sacrifice, eligible for the Lifetime Health cover loading
30 years to 64, not employed	×	Not earning sufficient income
65 years+	✓	No longer working, or already have access to tax effective savings through superannuation

^a Data from the Australian 2016 Census, indicated that 0 per cent of people aged less than 15 years earn an income.

Source: Australian Bureau of Statistics, "2016 Census- Counting persons, Total personal income (weekly) by single year age group", findings based on ABS TableBuilder data.

5.3 Population model assumptions

Assumption	Estimation approach	Value
Per cent		
PHI		
Proportion of those with PHI aged less than 15 years	Based on the average proportion of those aged less than 15 years who have GT (at a minimum) and hospital cover (at a minimum) as of June 2017. That is, 18.6 per cent and 17.9 per cent respectively.	18
General treatment		
Proportion of those with GT (at a minimum), aged 15 years+	Estimate as of June 2017. Proportion unchanged since June 2003 (first year of data).	81
Proportion of those with GT (at a minimum), aged between 15 and 24	Estimate as of June 2017. Proportion unchanged since June 2003 (first year of data).	12
Proportion of those with GT (at a minimum), aged between 15 and 29	Estimate as of June 2017. Proportion unchanged since June 2003 (first year of data).	17
Top cover		
Proportion of those with no excess (i.e. top cover) aged 30 years and over	Based on the average proportion of those aged 30 years and over who have GT (at a minimum) and hospital cover (at a minimum) as of June 2017. That is, 64.6 per cent and 67.1 per cent respectively.	66

Note: PHI: private health insurance; GT: general treatment

Source: Australian Prudential Regulation Authority. 2017, "Statistics, Private Health Insurance Membership and Benefits", June 2017, released 15 August 2017.

The most relevant baseline population forecasts in the model to which HSA adoption rates are applied are set out in table 5.4.

5.4 Population forecast, by PHI status, age, employment status and income

Cohort	2018	2021	2030
	No. ('000)	No. ('000)	No. ('000)
Australian population	25 201	26 452	30 107
15 years and over	20 414	21 428	24 604
<15 years	4 787	5 024	5 503
30 years and over	15 392	16 308	18 929
65 years and over	3 929	4 319	5 587
With PHI	13 812	14 449	16 628
15 years and over	11 350	11 873	13 664
With at least general treatment cover	13 810	14 446	16 623
15 years and over	11 242	11 760	13 532
Those earning \$18,201-\$37,000	4 849	5 089	5 793
Those earning \$37,001-\$87,000	5 824	6 113	6 957
Those 15 years to 64 years of age	3 809	3 954	4 395
Those with at least GT	2 563	2 669	2 963
Those in employment	2 398	2 498	2 773
Those earning \$87,001-\$180,000	2 542	2 668	3 037
Those 15 years to 64 years of age	1 663	1 726	1 918
Those with at least GT	1 125	1 163	1 296
Those in employment	1 084	1 122	1 249
Those earning >\$180,000	321	337	384
Those 15 years to 64 years of age	210	218	242
Those with at least GT	142	147	164
Those in employment	134	139	155

Source: The CIE.

Key results

To estimate potential costs to the Australian Government and the potential size of the savings pool for dental and allied health services, it is assumed that a proportion of Australians that are employed in the nominated age and income groups are willing to save towards the cost of their dental and allied health care if they receive some form of government incentive to do so.

Depending on whether consumers are eligible for a tax offset or tax concession, the amounts saved are grouped into those that save nothing, a quarter, half, or the full amount that is subject to tax relief. Different patterns of saving across these amounts are assumed for different income and age groups. The expected pattern of adoption is estimated to occur incrementally over 10 years, with 10 per cent in the first year, 20 per cent in the second year, and so on until full adoption (10 per cent of the population) occurs over 10 years.

Hence it is assumed that, if a HSA is adopted, full time, part-time, and those employed but not currently at work, have the capacity to save either \$750, \$1 500 or \$3 000 per annum when receiving tax relief on that saving amount.⁷⁹

These results show that in the first year, around 850 000 Australians will be encouraged to open a HSA to contribute to their dental and allied health care.

This increases rapidly to 1.2 million people within 4 years, and when maximum adoption is achieved in 2030, it is expected that 10 per cent of all Australians will have at least some savings in a HSA.

The expected pool of savings for dental and allied health cover is estimated to be up to \$1 billion in the first year, rising to \$1.4 billion within 4 years, and up to \$3.7 billion once full expected adoption is reached, with an average of approximately \$1 225 saved annually by Australians.

If incentives were to be offered in line with those set out in this report, and the adoption profile gradually lifting to 10 per cent of the population, then the cost to the Australian Government is estimated to be \$157 million in the first year, rising to \$217 million within 4 years, and reaching \$559 million by 2030 when maximum expected adoption is achieved.

The average subsidy offered to those accessing tax offsets is found to be \$177 per person, and the average subsidy cost of those accessing tax concessions is estimated at \$198 per person, or an average of \$186 per person irrespective of the incentive offered.

Hence, for every dollar of subsidy offered, HSAs are estimated to generate \$6.60 in private funding for dental and allied health services.

These results presented above are considered to be conservative in terms of HSA uptake, savings, and costs to the Australian Government.

The maximum rate of HSA uptake is broadly in line with international HSA uptake rates for voluntary schemes, where their rate of uptake reflects the extent of their appeal in combination with insurance plans:

- in the United States, where HSAs are held by approximately 6 per cent of the population, there has been growth of approximately 12 per cent each year over the past six years, growing from 10 million to 20 million accounts over the period, and
- in South Africa, it is likely that around 10-11 per cent of the population hold an HSA, the rate of growth has been slowing. It is estimated that the rate of growth in HSAs is less than one per cent.

A comparison of international uptake of MSAs for compulsory and voluntary schemes is provided in table 5.5.

⁷⁹ ABS Census data by age and income sets the maximum income amount at \$156 000. To estimate those earning above and below \$180 000, a 50/50 split is used. The limitations of this approach are recognised, although it is considered reasonable for this exercise. It does have the likely effect of likely understating the number of people in the targeted age bracket earning above \$180 000.

5.5 International uptake of HSAs and the share of medical expenses covered

	Overall uptake and rate of increase	Share of total medical expenses covered
Compulsory across population or population segments		
Singapore	<p>>92 per cent of the population</p> <p>Rapid uptake, as compulsory. Scheme participation likely to increase with any growth in the working age population.</p>	<p>Medisave withdrawals were 5.4 per cent of total health care expenditure in 2006 or two decades after commencement. The largest share of health care costs is paid from household accounts, including primary care and out-patient care.</p> <p>A significant shift in costs has occurred from the 1980s when three quarters of Government spending was undertaken by the Government, to just over one third by 2003. However, while the country only <i>financed</i> 23 per cent of total inpatient care, government subsidies accounted for 51 per cent of total inpatient care (but lower in primary care).</p>
China	<p>In 2007, EUBMI covered 180.2 million urban employees and retirees, or over 13 per cent of the Chinese population. HSAs have been established for the majority of them.</p>	<p>HSAs funded around 5.7 per cent of total health expenditure in China in 2006</p>
Voluntary		
South Africa	<p>In 2016, medical schemes (which include cover of HSAs) covered 16 per cent of the population (8.8 million people). Use of Medical Savings Accounts has rapidly grown to cover 87.5 per cent of open medical scheme beneficiaries and around 50 per cent of restricted medical scheme beneficiaries.</p> <p>However, the number of principal members in Medical Schemes in 2015 grew modestly by 0.8 per cent, and by 1.1 per cent in 2014. Restricted schemes are growing faster than open schemes. There is some discussion that the market may have reached maturity.</p> <p>HSAs have encouraged some young people to stay in the PHI system. However, its uptake is concentrated to upper deciles of population (highest income quintile) and is unaffordable for most South Africans.</p>	<p>Medical scheme members paid more out-of-pocket costs compared to comparable non-scheme members. HSAs have been used to keep PHI premiums low.</p> <p>Together with out of pocket costs, medical schemes accounted for 52 per cent of total expenditure on health care in 2016. Out of pocket expenses are growing at a rate of 13.4 per cent. Out of pocket expenses paid by Medical Scheme users accounted for 60 per cent of all out-of-pocket costs paid across the health system</p>
United States	<p>HSAs held over \$37 billion in assets in 2016. Approximately 20.2 million enrollees in January 2016 or 6 per cent of the population were covered by HAS-HDHPs. There were 1 million accounts in 2005 and 10 million by 2010, and a rate of increase between 2010 and 2016 of 12.5 per cent per year.</p>	

Source: The CIE.

6 *Key findings*

- Health savings accounts present an opportunity to encourage Australians to save for their dental and allied health care, overcoming the limitations to general treatment cover and introducing a reward-based proactive approach to health care.
- Initially, around 850 000 people are expected to embrace HSAs as a tax effective way of provisioning for the cost to consumers of dental and allied health.
- The potential savings pool for dental and allied health services is estimated to initially be around \$1 billion, rising to \$3.7 billion once 10 per cent of population adoption is achieved, with Australians on average saving around \$1 225 per annum to provision for their out-of-pocket costs. Hence, HSAs offer potentially large scope to encourage sizeable private funding for healthcare.
- These estimates are preliminary and conservative. They are provided to stimulate considered policy debate about HSAs in Australia, and their appropriate use to improve access to dental and allied health services and promote a more active approach to managing one's health care.
- Based on the tax offsets and tax concessions assumed to be made available to encourage savings, the cost of incentives to the Australian Government are estimated to be around \$157 million with 850 000 adopters, rising to \$559 million once 10 per cent of Australians take up the option to save for their dental and allied health.
- The average subsidy offered to those accessing tax offsets is estimated to be \$177 per person, and the average subsidy cost of those accessing tax concessions is estimated at \$198 per person, or an average of \$186 per person irrespective of the incentive offered.
- Hence, for every dollar of subsidy offered, HSAs are estimated to generate up to \$6.60 in private funding for dental and allied health services.
- This means that HSAs offer the potential to boost the privately contributed funding pool for dental and allied health services considerably, at a relatively low cost to government.

A A summary of MSAs abroad

A.1 Key features of the HSAs in Singapore

Detail	
Context	Introduced in 1984, in a predominantly government-financed health care system, but without universally free access to public hospitals (means tested). Wages are paid in to a Central Fund and distributed to both the retirement and Medisave accounts of the employee.
Incentive for uptake	Compulsory and tax-exempt savings at 7-9.5% of the monthly salary. Contributions are made by both employers and employees in to a Central Provident Fund, from which a share of the contributions is paid to Medisave, a retirement account and an ordinary account. The share of the contribution to the CPF and the distribution share paid to each account varies by age. Savings accounts are also linked to superannuation accounts upon retirement and benefits can be drawn by the account holder and immediate family members.
Application	Its application is restrictive. Medisave may be used for the cost of inpatient hospital care, chronic disease management care, and immunisations (but generally not allied health care). It is not applicable to the cost of non-inpatient specialist care. It may be used for the purchase of an Eldershield disability insurance plan and Medishield, a state-run opt-out insurance fund, plus 'top up' private hospital cover to provide for protection against catastrophic risks.
Limits of coverage	Various limitations apply: maximum monthly contributions, account limits of \$43 500 in 2012, and caps on daily and yearly withdrawals. In 2006, Medisave formed 5.4 per cent of total health care expenditure (some two decades after commencement). The largest share of health care costs is paid from household accounts, including primary care and outpatient care.
Rate of uptake	Around 92 per cent of Singaporeans are covered under MediShield (including 95 per cent of the working age population), suggesting the same or greater rate of coverage for Medisave accounts (which have been compulsory for the working age population since 1984).
Other	There has been high rates of health expenditure growth per person in Singapore of 8.1 per cent over the decade to 2010. Gadiel and Sammut state that the evidence of impact on price of applicable services 'not overwhelming'. A significant shift in costs has occurred from the 1980s when three quarters of Government spending was undertaken by the Government, to just over one third by 2003. However, while the country only <i>financed</i> 23 per cent of total inpatient care, government subsidies accounted for 51 per cent of total inpatient care (but lower in primary care). The Singaporean Government has controlled health care expenditure through tight supply side price controls, argued to have been more important than 'consumer-driven' demand associated with Medisave. The benefit of Eldershield would be too low to meet a significant proportion of costs. In its early days, Medisave accounts were not sufficient to meet the costs intended to be covered and so there were heavy restrictions applied to its application.

Source: The Conversation, 2014. 'Creating a better health system: lessons from Singapore'. <https://theconversation.com/creating-a-better-health-system-lessons-from-singapore-30607>; Government of Singapore, 2012. 'MediShield Coverage of Population'. https://www.moh.gov.sg/content/moh_web/home/pressRoom/Parliamentary_QA/2012/medishield_coverageofpopulation.html; Vox, 2017. 'Is Singapore's "miracle" health care system the answer for America?' <https://www.vox.com/policy-and-politics/2017/4/25/15356118/singapore-health-care-system-explained>. Gadiel, D., and Sammut, J. 2014. 'Lessons from Singapore: Opt-out Health Savings Accounts for Australia'. *Papers in Health and Ageing* (14). Centre for Independent Studies, Australia. Euro Observer, 2008. *Medical savings accounts: can they improve health system performance in Europe?* By Thomson, S., and Mossialos, E., The Health Policy Bulletin of the European Observatory on Health Systems and Policies. <http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/euroObserver/obsvol10no4.pdf> 2 Key features of HSAs in the United States

Detail	
Context	Initially developed as a response to problems in the private health insurance market, with the major concern the impact of moral hazard on health care costs. But only later implemented after the development of 'managed care' (see Marcus, 2000), which was associated with 'unfair' constraints on patient choice and provider autonomy. At the time, the health insurance market provided a limited selection of plans, with plans restricting the choice of provider, subject to high levels of cost sharing, and some limitations to portability. In addition, public funded health care is limited to those aged 65 and over, some disabled people under 65, as well as low income children and other groups through Medicaid. In 2008, approximately 17 per cent of the under 65 population were uninsured (not covered).
Incentive for uptake	Voluntary, tax exempt contributions made by the employer (including payroll tax) and tax free interest on savings. It may be transferred to a spouse upon death (or another party for which the HSA becomes a taxable asset). It may be used for expenses by a spouse and dependents (claimed on tax return). HSAs have a maximum limit on the sum of the annual deductibles and out-of-pocket medical expenses paid by the plan holder (excluding premiums).
Application	It may be used for: <ul style="list-style-type: none"> ▪ 'Qualified medical expenses', which include an extensive range of allied health services ▪ Prescription medicines, OTC medicines for which a prescription is held, plus insulin ▪ Insurance premiums for long term care insurance, health care continuation coverage, health care coverage while receiving unemployment compensation, and other health care coverage for those 65 and over ▪ Additional 'preventive care' such as periodic health evaluations (primary care), routine prenatal and 'well-child care', child and adult immunisations, tobacco cessation programs, obesity weight loss programs, and screening for a wide range of conditions.
Limits of coverage	Eligibility is restricted to those with a High Deductible Health Plan and no enrolment in Medicare, and excludes those 'dependents' on other plans. The maximum contribution for 2017 is \$3 400 for single coverage and \$6 750 per family, plus an additional \$1 000 per individual aged 55 or over. HDHPs have higher annual minimum deductibles than typical health plans. They have a 'high' annual deductibles limit for network services of \$6 550 for self-only coverage or \$13 100 for family coverage. Excluded from pre-deductible coverage are clinical services to treat existing illness, injury or conditions. This is currently the subject of the "Access to Better Care Act of 2016" Bill.
Rate of uptake	HSAs held over \$37 billion in assets in 2016. Approximately 20.2 million enrollees in January 2016 or 6 per cent of the population were covered by HAS-HDHPs. There were 1 million accounts in 2005 and 10 million by 2010, and a rate of increase between 2010 and 2016 of 12.5 per cent per year. However, IRS regulations have limited what services can be covered in HSA-HDHPs before meeting the plan deductible and therefore restricted the financial advantages of a tax-free HSA for those with chronic conditions.
Other	Premiums in HSA-qualified high deductible plans are generally lower than other insurance plans, consistent with design of shifting cost from premiums to out-of-pocket payments. But the burden of out-of-pocket costs have potentially been eased by the tax exemptions for those relying on private health care.

Note: A deductible is the amount of money an individual pays for expenses before his insurance plan starts to pay. Sources: AHIP. 2016. *2016 Survey of Health Savings Account – High Deductible Health Plans*. https://www.ahip.org/wp-content/uploads/2017/02/2016_HSASurvey_Draft_2.14.17.pdf. Hsu, J., 2010. 'Medical Savings Accounts: What is at risk?' World Health Report 2010, Background Paper, 17. Euro Observer, 2008. *Medical savings accounts: can they improve health system performance in Europe?* By Thomson, S., and Mossialos, E., The Health Policy Bulletin of the European Observatory on Health Systems and Policies. <http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/euroObserver/obsvol10no4.pdf>. Marcus, D. 2000. 'Prospects for Managed Health Care in Australia'. Parliament of Australia. https://www.aph.gov.au/About_Parliament/Parliamentary_Departments/Parliamentary_Library/pubs/rp/rp9900/2000RP25

A.2 Key features of HSAs in South Africa

Detail	
Context	<p>HSAs were first included in PHI medical schemes in South Africa in 1994. They were introduced when insurers were cutting benefits and increasing cost sharing. They were introduced with minimal regulation, (under the Medical Schemes Act), which is said to account for 'high' level of innovation and experimentation across products, and 'better design' of products to needs of customers than elsewhere (such as US).</p>
Incentive for uptake	<p>Contributions, interest and withdrawals are not taxed. Contributions may be made by both individuals and employers (some employers require coverage as condition of employment). Medical schemes (including HSAs) either ring-fence employers for members or open membership to market.</p> <p>Uptake is also driven by a free overloaded public system with rationing and quality problems.</p>
Application	<p>HSAs can be used for outpatient care and out-of-pocket charges for care covered by private insurance. Medical schemes must cover a set of Prescribed Minimum Benefits (PMB) including common chronic diseases and some inpatient services. Most offer significantly more and a wider range in benefit structures than the PMBs.</p>
Limits of coverage	<p>Insurers offer HSAs, contributing to insurer-initiated process of de-insurance.</p> <p>Most members pay a flat contribution (rather than a percentage of income), increasing at 7-10 per cent above CPI per year.</p> <p>An annual contribution cap to HSAs is set at 25 per cent of annual PHI medical scheme contributions. Deductibles were initially not used, but are now used for some expensive procedures such as MRI scans or endoscopies.</p>
Rate of uptake	<p>In 2016, medical schemes (which include cover of HSAs) covered 16 per cent of the population (8.8 million people). Use of Medical Savings Accounts has rapidly grown to cover 87.5 per cent of open medical scheme beneficiaries and around 50 per cent of restricted medical scheme beneficiaries.</p> <p>However, the number of principal members in Medical Schemes in 2015 grew modestly by 0.8 per cent, and by 1.1 per cent in 2014. Restricted schemes are growing faster than open schemes. There is some discussion that the market may have reached maturity.</p> <p>HSAs have encouraged some young people to stay in the PHI system. However, its uptake is concentrated to upper deciles of population (highest income quintile) and is unaffordable for most South Africans.</p>
Other details	<p>Medical scheme members paid more out-of-pocket costs compared to comparable non-scheme members. HSAs have been used to keep PHI premiums low.</p> <p>Together with out of pocket costs, medical schemes accounted for 52 per cent of total expenditure on health care in 2016. Out of pocket expenses are growing at a rate of 13.4 per cent. Out of pocket expenses paid by Medical Scheme users accounted for 60 per cent of all out-of-pocket costs paid across the health system. It is seen as reinforcing the disparity in SA and contributing to an increase in health expenditure.</p> <p>Fragmentation has meant each scheme has had limited ability to influence rates that providers choose to charge. In addition, there is concern over the effect of HSAs of reducing 'risk-pooling'.</p>

Source: Finmark Trust, 2016. Challenges and opportunities for health finance in South Africa: A supply and regulatory perspective. <http://www.finmark.org.za/wp-content/uploads/2016/06/south-africa-health-finanince-overview.pdf>. Health24, 2016. 'The cost of healthcare in South Africa'. <http://www.health24.com/Medical-schemes/the-cost-of-healthcare-in-south-africa-20161129>. Cape Times, 2017. 'Key findings on medical schemes' activities in 2016.' <https://www.pressreader.com/south-africa/cape-times/20171027/282016147578759>. McIntyre, D., Doherty, J., and Ataguba, J. 2014. Universal health coverage assessment: South Africa. Global Network for Health Equity. December 2014. Euro Observer, 2008. *Medical savings accounts: can they improve health system performance in Europe?* By Thomson, S., and Mossialos, E., The Health Policy Bulletin of the European Observatory on Health Systems and Policies. <http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/euroObserver/obsvol10no4.pdf>, Matisonn, S. 2000. 'Medical Savings Accounts in South Africa'. National Center for Policy Analysis. <http://www.ncpa.org/pub/st234>

A.3 Key features of HSAs in China

Detail	
Context	<p>In the late 1990s, China established a system of HSAs and employment-financed health insurance for urban employees, building on an earlier pilot scheme held in several cities (in 1995 and 1996). It was conceived as a response to around half of the urban population being without health insurance and most of the rural population, such that there was a need for financing that could not be met by the immature tax system. It was determined that universal protection would not be achieved through private insurance.</p> <p>Initially, the Chinese Government allowed each city to decide the balance between HSAs and health insurance, but introduced more regulations over time to ensure greater standardization and protect risk pooling.</p> <p>The complement to HSA accounts, the Social Risk Pooling Fund is used to pay for health care expenditures above a deductible, or for inpatient care and some predefined chronic diseases.</p>
Incentive for uptake	<p>It is compulsory for urban employees, who are required to pay a percentage of employee wages to the fund. Contributions, interest and withdrawals are not taxed. The Government also makes contributions in some regions. There are relatively high deductibles of around 5-10 per cent of individual earnings or local average wages.</p> <p>Employee contributions are approximately 1 to 2 per cent of annual wages, while 30-65 per cent of total annual payroll tax from employers are paid directed in to HSAs, as well as further contributions of up to 70 per cent of payroll tax are made to the social risk pooling fund and 4 per cent of annual payroll to supplementary insurance.</p>
Application	<p>Schemes administered at the city-level. Funds can either be used to cover all health care, or to pay only for outpatient care. They may also be used for 'preventive care' and deductibles for 'social health insurance'. HSAs are used (in combination with SRPF) to fund the government-run Urban Employee Basic Medical Insurance (UEBMI) scheme.</p>
Limits of application	<p>There is no family pooling. There is mandatory drawing down on the Savings Account in the public health care system (until funds are exhausted). Contributions to the complementary SRPF are capped at 4 per cent of total annual payroll. Benefits are capped at the equivalent of four times the local average annual wage. Expenditures above the SRPF maximum reimbursement level must be paid out of pocket or through supplementary health insurance.</p>
Rate of uptake	<p>In 2006, HSAs funded around 5.7 per cent of total health expenditure in China, with the SRPF funding 7.3 per cent and the UEBMI funding 13.0 per cent. In 2007, UEBMI covered 180.2 million urban employees and retirees, or over 13 per cent of the Chinese population. HSAs have been established for most them. The extension of the UEBMI to all employees have been difficult due to lack of enforcement.</p> <p>Key issues perceived include limited risk pooling with a low level of benefits.</p>

Source: Euro Observer, 2008. *Medical savings accounts: can they improve health system performance in Europe?* By Thomson, S., and Mossialos, E., The Health Policy Bulletin of the European Observatory on Health Systems and Policies. <http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/euroObserver/obsvol10no4.pdf>

B Overview of key Australian Government PHI policies

As summarised in tables B.1 and B.2 and box B.3 there are three main government policies designed to encourage people to take-up private health insurance, these include:

- the Private Health Insurance Rebate
- the Lifetime Health Cover Loading, and
- the Medicare Levy Surcharge.

B.1 Current PHI Levy's for singles (2017)

Levy	Hospital cover	General treatment cover
	Per cent	Per cent
Lifetime Cover Loading		
All income groups	2.00 ^a	Not applicable
Medicare Levy Surcharge		
Taxable income of \$90 000 or less	0.00	Not applicable
Taxable income of \$90 001 to \$105 000	1.00	Not applicable
Taxable income of \$105 001 to \$140 000	1.25	Not applicable
Taxable income of \$140 001 +	1.50	Not applicable

^a Per year, for every year without PHI, capped at 70 per cent

Source: The Department of Health. 2017, "Private health insurance rebate frequently asked questions", available at: <http://health.gov.au/internet/main/publishing.nsf/Content/fairer-faq>

B.2 Private Health Insurance Rebate for singles (from July 1 2017)

Income group	Aged under 65	Aged 65 to 69	Aged 70+
	Per cent	Per cent	Per cent
\$90 000 or less	25.934	30.256	34.579
\$90 001 to \$105 000	17.289	21.612	25.934
\$105 001 to \$140 000	8.644	12.966	17.289
\$140 001 +	0.000	0.000	0.000

Source: The Department of Health. 2017, "Private health insurance rebate frequently asked questions", available at: <http://health.gov.au/internet/main/publishing.nsf/Content/fairer-faq>

B.3 Current Government PHI policies

Private Health Insurance Rebate

The Private Health Insurance Rebate is a subsidy provided to eligible individuals or families to assist in covering the cost of PHI premiums. The rebate is applicable to both **hospital** and **general** treatment polices individually (or combined).

The rebate is means tested and varies depending on the age of the policy holder (based on the age groups: less than 65, 65 to 69 and 70 and over). For instance, between the 1st of July 2017 and the 31st of March 2018, the largest rebate available is 34.6 per cent. Only those who are aged 70 years and over who learn less than \$90 000 are eligible for this rebate. Those aged under 65 years who earn between \$105 001 and \$140 000 receive the smallest rebate (8.6 per cent). Those earning \$140 001 or more are not eligible for the rebate (regardless of age).⁸⁰

The Lifetime Health Cover Loading

People aged 30 and over who do not have an appropriate level of PHI may have to pay the Lifetime Health cover loading. The levy is designed to incentivise people to take out PHI early in life, and to continue to take out PHI on an ongoing basis.

The loading is only applicable if the person decides to take out **hospital** cover later in life. If this is the case, they will be required to pay a 2 per cent loading (in addition to their PHI premiums), for every year they were aged over 30 and were not covered by PHI. The minimum value of the loading is 2 per cent, with a maximum loading of 70 per cent.⁸¹

The Medicare Levy Surcharge

Individuals who earn more than \$90 000 and families with a combined taxable income of \$180 000 who do not have an appropriate level of PHI are required to pay the Medicare Levy Surcharge.

The levy is designed to encourage people to use take up PHI and use the private health system, thereby taking pressure off the public health system.

To be exempt, individuals or families who earn more than \$90 000 or \$180 000, respectively must take out **hospital** cover with a maximum excess of \$500 (for individuals) or \$1 000 (for families).⁸²

⁸⁰ Australian Taxation Office. 2017, "Income thresholds and rates for the private health insurance rebate", available at: <https://www.ato.gov.au/Individuals/Medicare-levy/Private-health-insurance-rebate/Income-thresholds-and-rates-for-the-private-health-insurance-rebate/>

⁸¹ Private Health Insurance Ombudsman. 2017, "Lifetime Health Cover", available at: <https://www.privatehealth.gov.au/healthinsurance/incentivessurcharges/lifetimehealthcover.htm>

⁸² Australian Taxation Office. 2017, "Medicare levy surcharge", available at: <https://www.ato.gov.au/Individuals/Medicare-levy/Medicare-levy-surcharge/>



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