



Australian Government

Private Health Insurance Administration Council

COMPETITION IN THE AUSTRALIAN PRIVATE HEALTH INSURANCE MARKET

3 June 2013

Premiums and
Competition
Unit

Research Paper 1

About PHIAC's Premiums and Competition Unit

The Private Health Insurance Administration Council (**PHIAC**) is an independent statutory authority that regulates the private health insurance industry. Private health insurance policy is set down by the Australian Government via the Department of Health and Ageing (**DoHA**).

PHIAC's statutory objectives are described in the *Private Health Insurance Act 2007* (**PHI Act**).

Section 264-5 of the PHI Act instructs PHIAC, in performing its role, to "take all reasonable steps" to strike an "appropriate balance" between the three objectives of:

- (a) fostering an efficient and competitive health insurance industry;
- (b) protecting the interests of consumers; and
- (c) ensuring the prudential safety of individual private health insurers.

In order to promote these objectives, in the 2012-13 Budget, the Government announced that a new unit focusing on premiums and competition within the Australian private health insurance industry should be established within PHIAC. Through the Premiums and Competition Unit (**PACU**), PHIAC aims to support an improved understanding of a range of issues surrounding the Australian private health insurance industry. A particular focus of PACU's initial work will be in the area of competition.

It is important to stress that PHIAC is not a policy body. As noted above, policy responsibility for private health insurance is reposed within the DoHA as principal adviser to the Minister for Health and the Government. Accordingly, in its PACU work, PHIAC does not seek to propose or to advance any particular policy prescription or solution to the matters it examines. It does, however, aspire to provide the factual and contextual basis for a much improved discussion about the important issues that affect private health insurance in Australia. **It should not be implied that any view expressed in the paper is necessarily that of the Minister for Health or the Government.**

Preface

Private health insurance is a vital product for many Australians. It assists them to have access to Australia's private health sector with its excellent hospital resources and world-class physicians.

Most importantly, for many, it means peace of mind in times of sickness and distress. Australia's private health insurers have been a central part of our national health system for well over a hundred years. Around 11 per cent of the value of all health services provided in this country is paid for by a private health insurer.

There is a substantial market for the provision of such services. Around 47 per cent of Australians - or 10.7 million people - hold an insurance policy which covers them for hospital treatment and around 55 per cent of the population is covered for general treatment, including dental care, optical services, and many other services.

Consumer preferences and choices are at the heart of any well-functioning market. It is important that the private health insurance market be responsive to consumer needs and able to complement the broader health sector. Fostering competition within the private health insurance market is therefore a central focus for the continuing work of PHIAC.

This paper is a foundational document for PHIAC as it serves to highlight the key features of the modern Australian private health insurance market, and to identify key drivers of competition in the market today.

This paper has been prepared with the assistance of the Centre for International Economics (**CIE**) and the particular assistance of Ms Sarina Fisher and her team is gratefully acknowledged. The paper draws on PHIAC data, academic literature, a number of initial discussions that the CIE has conducted with industry stakeholders in October and November 2012, and stakeholder submissions to a Discussion Paper that was released by PHIAC in November 2012.

Use of this Paper

While PHIAC endeavours to ensure the quality of this publication, it does not accept any responsibility for the accuracy, completeness or currency of the material included in this publication and will not be liable for any loss or damage arising out of any use of, or reliance on, this publication.

This publication is available for your use under a [Creative Commons Attribution 3.0 Australia](http://creativecommons.org/licenses/by/3.0/au/legalcode) licence, with the exception of the Commonwealth Coat of Arms, photographs, images, signatures and where otherwise stated. The full licence terms are available from <http://creativecommons.org/licenses/by/3.0/au/legalcode>.



Use of PHIAC material under a [Creative Commons Attribution 3.0 Australia](http://creativecommons.org/licenses/by/3.0/au/legalcode) licence requires you to attribute the work (but not in a way that suggests that PHIAC endorses you or your use of the work).

PHIAC material used 'as supplied'

Provided you have not modified or transformed PHIAC material in any way including, for example, by changing the text; calculating percentage changes; graphing or charting data; or deriving new statistics from published PHIAC statistics — then the PHIAC prefers the following attribution:

Source: Private Health Insurance Administration Council

Derivative work

If you have modified or transformed PHIAC material, or derived new material from those of PHIAC in any way, then PHIAC prefers the following attribution:

Based on Private Health Insurance Administration Council data

Use of the Coat of Arms

The terms under which the Coat of Arms can be used are set out on the *It's an Honour* website (see www.itsanhonour.gov.au)

Disclaimer

The purpose of this paper is to provide information and background on the private health insurance market in Australia to help develop future areas of focus for PHIAC's work. It is not a position paper and the information canvassed in it does not constitute recommendations or legal advice. While PHIAC endeavours to ensure the quality of this paper, it does not accept any responsibility for the accuracy, completeness or currency of the material included in this paper, and will not be liable for any loss arising out of any use of, or reliance on, this paper. PHIAC encourages all readers to seek independent advice and to exercise care in relation to any material contained in this paper.

Table of Contents

About PHIAC’s Premiums and Competition Unit.....	i
Preface.....	ii
1. Overview and key observations.....	1
1.1 Purpose of this paper	1
1.2 The Australian private health insurance industry in 2013	3
1.3 Fostering Competition: why it matters.....	4
1.4 The nature of competition in the Australian private health insurance market.....	5
2. Structure of this paper.....	12
3. The beginnings of private health insurance in Australia	13
3.1 The origins of private health financing	13
3.2 Early market segmentation	14
3.3 The post-war years	15
3.4 Moves towards the modern mixed public/private system	18
4. Regulatory design and the impact on competition among insurers.....	21
4.1 Overview	21
4.2 Key elements of the private health insurance regulatory framework	23
4.3 Community rating and risk equalisation	25
4.4 Premium regulation	31
4.5 Demand side: membership take-up incentives.....	33
5. The contemporary Australian private health insurance market.....	36
5.1 Size of the Australian private health insurance market.....	36
5.2 Market structure and composition.....	38
5.3 Markets and submarkets for private health insurance products and services	47

5.4	Product and service categories	51
5.5	Exclusionary and excess or co-payment based policies	53
5.6	General treatment cover - fertile ground for competition between insurers	59
5.7	Consumer claims perspectives	61
6.	Market conditions that affect competition	65
6.1	Measuring competition in a market	65
6.2	Market conditions for incumbent insurers, and potential market entrants	66
6.3	Where insurers compete	69
6.4	Small insurers can compete against large insurers	70
6.5	Product diversity: driving price and non-price competition between insurers.....	72
6.6	Portability, competition and the consumer	74
6.7	Consumer behaviour: a positive or negative for competition?	75
6.8	The impact of intermediaries on competition between insurers	77
6.9	Competition issues along the health insurance supply chain	80
	Abbreviations used in this paper	89
	Submissions received	91
	References	93

1. Overview and key observations

This paper examines the Australian market for private health insurance to understand the various competitive characteristics of the market, highlighting areas where competitive tension between insurers, suppliers and consumers is robust, and where competition may not be as strong and why that might be so.

1.1 Purpose of this paper

This paper seeks to:

- **understand** the nature of competition in the Australian private health insurance market, noting that it is a product of the industry's historical development including a number of important government policy measures;
- **describe** the contemporary markets and sub-markets for private health insurance products and the main participants in those markets, noting that these markets and sub-markets can be analysed along multiple lines including by product category, by member life cycle, and by state, territory and regional areas; and
- **identify** the characteristics, drivers and barriers to competition in the market, including the impact that history, regulation and consumer behaviour have had on both the type and strength of competition in the market.

It is not within the intended scope of this research paper, or PHIAC's work on competition generally, to reach any final conclusions on the issues raised in this paper. Rather, the paper is designed to provide an accurate and reliable evidential basis for better informed discussion on the issues it raises.

Accordingly, through this paper, we have sought to engage stakeholders in an open consideration of the private health insurance market and to provide a contextual basis for future work that will be undertaken by PHIAC, and others, in this important area.

To promote better discussion, PHIAC has published the submissions it received as part of this paper on its website at www.phiac.gov.au.¹ Any person interested in pursuing a deeper consideration of the issues raised is invited to review those documents.

Evaluation method

As the national prudential regulator of the PHI industry in Australia for almost a quarter of a century, PHIAC is obviously well versed in the workings and challenges of the industry. It works with the insurers on a daily basis across a broad range of issues, going to their business, their strategic direction and the overall position of the industry. PHIAC receives and publishes a wide variety of industry data and statistics based on quarterly and annual information supplied to it by the insurers.² Unsurprisingly, the commentary that follows draws deeply upon that unique level of exposure and experience. That said, the discussion was also considerably assisted by reference to a number of external sources of information and opinion, namely:

- literature review – an extensive review of the literature on the history and development of Australia’s private health insurance market was undertaken, from the beginnings in the early 1900s, through to the more recent market and regulatory changes;³
- data analysis – utilising industry data held by PHIAC, an analysis of recent industry trends was undertaken, drawing together information on the regional diversity of insurers, market concentration of policy holdings and the diversity of product offerings;
- stakeholder consultation – a targeted round of consultations were undertaken with a cross section of stakeholders in the industry, including, insurers, hospital administrators, service providers and regulators to provide a pragmatic starting point for the competition review; and
- public consultation period – a discussion paper was released publicly and comments were sought from all interested parties, providing a wide range of viewpoints on the industry and its competitive framework.

¹ Not all submissions received by PHIAC were approved for public release. PHIAC has preserved confidentiality where it was sought both in this paper and on its website.

² See, in particular, PHIAC’s annual report on the operations of the private health insurers which is produced pursuant to section 264-15 of the PHI Act. The report (including earlier versions of the report) is available at www.phiac.gov.au.

³ Most of the items reviewed appear in the References Section at the back of this paper.

1.2 The Australian private health insurance industry in 2013

The private health insurance industry in Australia comprises 34 private health insurers registered under the *Private Health Insurance Act 2007* (**PHI Act**). The five largest private health insurers account for 83 per cent of the market and for-profit insurers account for around 70 per cent of the market. The industry's total assets were \$10.7 billion as at 31 March 2013. As at 31 March 2013, 10.8 million people in Australia (or 46.9 per cent of the population) held hospital cover and 12.6 million people in Australia (or 54.7 per cent of the population) held general cover.

Private health insurers provide consumers with two broad categories of cover, namely hospital cover and general treatment cover.

- **Hospital products** cover most of the cost of admission and accommodation in private hospitals or the costs associated with admission as a private patient in a public hospital. Medical service costs associated with hospital treatment are also covered under these products with the extent of cover varying depending on the nature of the product purchased and the medical fees relating to those services. Where there is any shortfall in cover, it is paid, predominantly, by consumers in the form of an 'out-of-pocket expense' (also known as "gap fees").⁴
- **General products** cover dental, optical, physiotherapy, chiropractic and other health services provided outside the hospital setting and services not covered by Medicare. In an aggregate sense, private health insurers cover about 50 per cent of the total cost of general treatments, with consumers contributing the other 50 per cent. The actual benefit paid to consumers will depend upon the level of cover they have purchased.

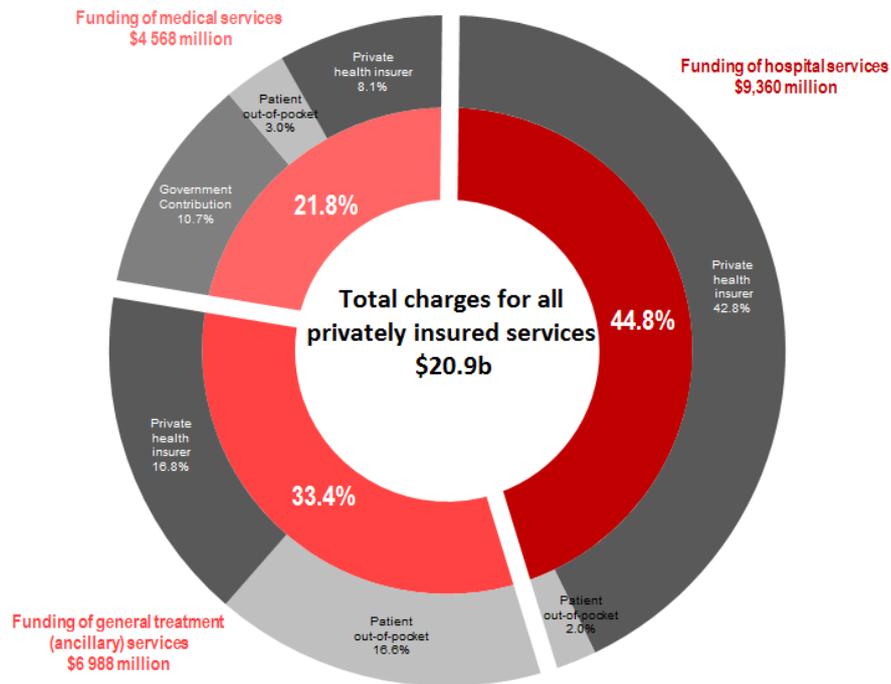
Figure 1 provides more detail on the funding of privately insured services, including the source of that funding. It shows, amongst other things, that private health insurers contributed almost 68 per cent of the total cost of privately provided health and related services in Australia in 2011-12.

In the same year, premium revenue for the industry totalled \$16.7 billion, with \$14.3 billion (or around 86 per cent) paid as benefits to policy holders. Further details of the distribution of this premium income are illustrated in **Figure 2**. From this data, it will be apparent that the private health insurance

⁴ All medical costs associated with hospital admissions, whether public or private, are also supported by government contributions. In the case of private admission, patients medical costs receive a Medicare rebate equivalent to 75 per cent of the MBS fee for that service.

industry makes a significant contribution to the financing of the Australian health care system, totalling about 11 per cent of all Australia's health expenditure in 2010–11.⁵

1: Funding source for privately insured services in 2011-12



Source: PHIAC data.

1.3 Fostering Competition: why it matters

With the costs of health care consistently growing at a faster rate than general inflation,⁶ a competitive and sustainable market for private health insurance is a vital factor in ensuring that premiums paid by consumers are contained and that the incentives promoting industry innovation are maximised.

A competitive market is generally characterised by many sellers, offering a similar product at a price of their choice, to many buyers who have their choice of suppliers, with free entry and exit of suppliers in the market. A competitive market has a number of advantages and benefits for consumers, insurers and regulators. For instance, such a market:

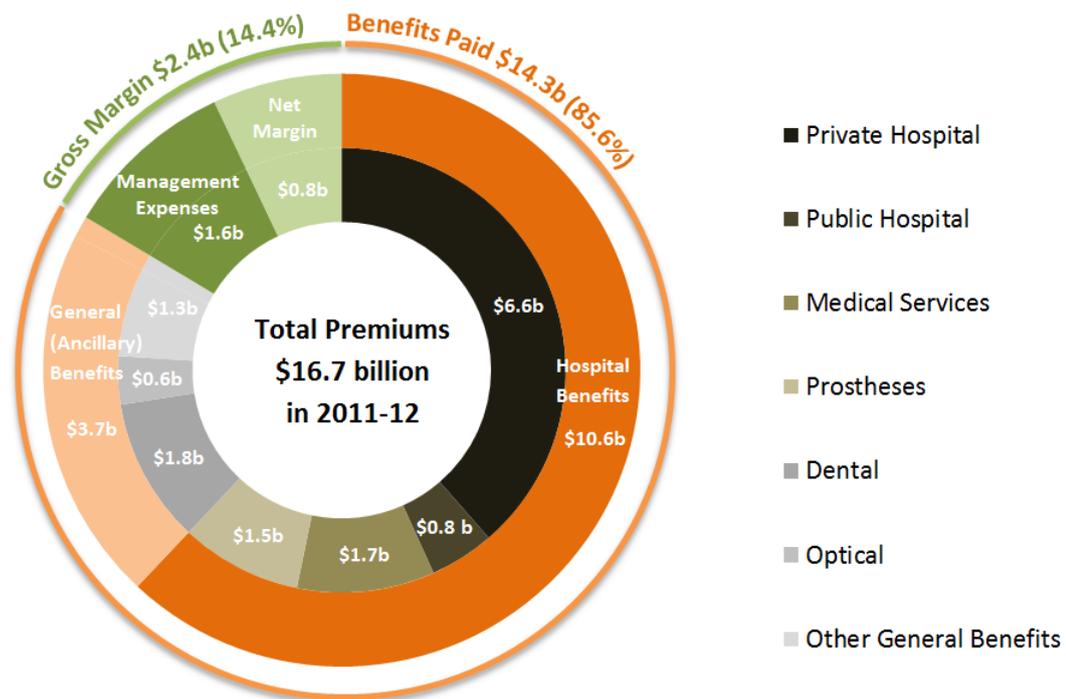
- should be able to deliver the products that consumers are seeking at the lowest price possible while also ensuring the continuing viability of suppliers;

⁵ Australian Institute of Health and Welfare, Health and welfare expenditure series No. 47. Cat No. HWE 56, Tables 3.1 and 3.12, available at www.aihw.gov.au. This includes the cost of private health insurance tax rebate paid by the Government.

⁶ Grattan Institute, *Budget Pressures on Australian Governments*, 2013, page 16.

- should be able to respond to the changing needs of consumers, allowing for adaptation in product design and delivery, as well as the flexibility to adjust to external market influences, such as cost of living pressures; and
- reduces the need for intensive regulatory oversight because competition promotes pricing and product discipline amongst market players.

2: Distribution of premium income by health insurers in 2011-12



Source: PHIAC data.

1.4 The nature of competition in the Australian private health insurance market

Some healthy signs

Healthy signs of competition include the diversity of choice of insurer and products on offer, strong incentives to minimise costs, and transferability of policies across insurers.

In a number of important respects, the private health insurance market is clearly strongly competitive, with 34 insurers vying for business in a market that — through a range of government policy measures — strongly encourages Australians to purchase, and remain covered by, private health

insurance. There are currently 12.6 million people in Australia covered by some form of private health insurance, with both the number and extent of coverage growing steadily in recent years.⁷ Because of the essentially retail nature of private health insurance in Australia, products are heavily advertised in all forms of media with the leading insurers among the country's best known commercial brands.

Supporting this diversity of providers is a large number of individual health insurance products providing considerable choice in coverage and payment options. Competition is also supported by arrangements which allow consumers to move freely between insurers without penalty in most cases, with portability rules requiring previously served waiting periods to be recognised by the new insurer.

Many insurers continue to view membership growth as an essential business strategy with constant innovation in product and service delivery being offered to consumers. As with any commercial business, health insurers are also cost conscious and are under constant pressure, through commercial arrangements, from suppliers (chiefly hospitals) to keep costs to the minimum necessary.⁸

Government policy settings also play an important role in ensuring that the pool of contributors is adequate to ensure the sustainability of the industry, that product offerings meet minimum standards and that insurers are, and remain, prudentially sound.

Despite the presence of several large insurers, scaled costs have been able to be secured at all levels of the industry, with various alliances and associations enabling smaller insurers to compete very effectively against the larger players.⁹ This has resulted in a degree of efficiency in smaller operations that keeps the market reasonably diversified and responsive to consumer needs.

Consumer demand for online information also permeates the private health insurance market, adding another dimension to the contestability and competitiveness of the market. The growth in online options and activities has provided consumers with accessible opportunities to better understand and use private health insurance. In particular, the internet provides access to comparison and evaluation services designed to promote switching to products that ostensibly better meet the consumer's

⁷ PHIAC, *Report on the Operations of the Private Health Insurers 2011-12*, page 5.

⁸ Medibank Private – submission No. 17, page 7.

⁹ Associations include Australian Health Services Alliance and Australian Regional Health Group for provider contracting, Hospital and Medical Benefits System (HAMBS) for claims processing and the Health Insurance Restricted and Regional Membership Association of Australia (HIRMAA) for member representation to Government.

particular needs. There also appears to be evidence that online reviews, chat rooms and other digital information are becoming more important sources of information for consumers.¹⁰

Other factors affecting competition

That said, it does appear that full and unbridled competition is not yet in place in the Australian PHI market. Factors such as product complexity, low levels of transfer of consumers between insurers and a relative lack of new entrants to the industry have impacted market dynamism. The regulatory framework, which seeks to deliver government policy imperatives, has also been cited by some as diminishing competition.

This paper has identified a number of issues that may appear to affect the competitiveness and efficiency of the Australian private health insurance industry today. It includes issues that have been raised by stakeholders as being important to competition that are supported by available data, as well as issues which would benefit from further research to understand their impact on the market and consumers.

At a high level, these issues group around, firstly, the behaviour of market participants and, secondly, some aspects of the regulatory framework as summarised in **Figure 3**. The following discussion examines those factors in a little more detail.

Market elements

Respondents to PHIAC's Discussion Paper broadly agreed that there were aspects of the way in which the PHI market operated which were affecting (or had the potential to affect) free and open competition. In particular, the following points were noted:

- **Issues along the service supply chain** result, it is contended, in suboptimal market outcomes.

Commonly cited examples include:

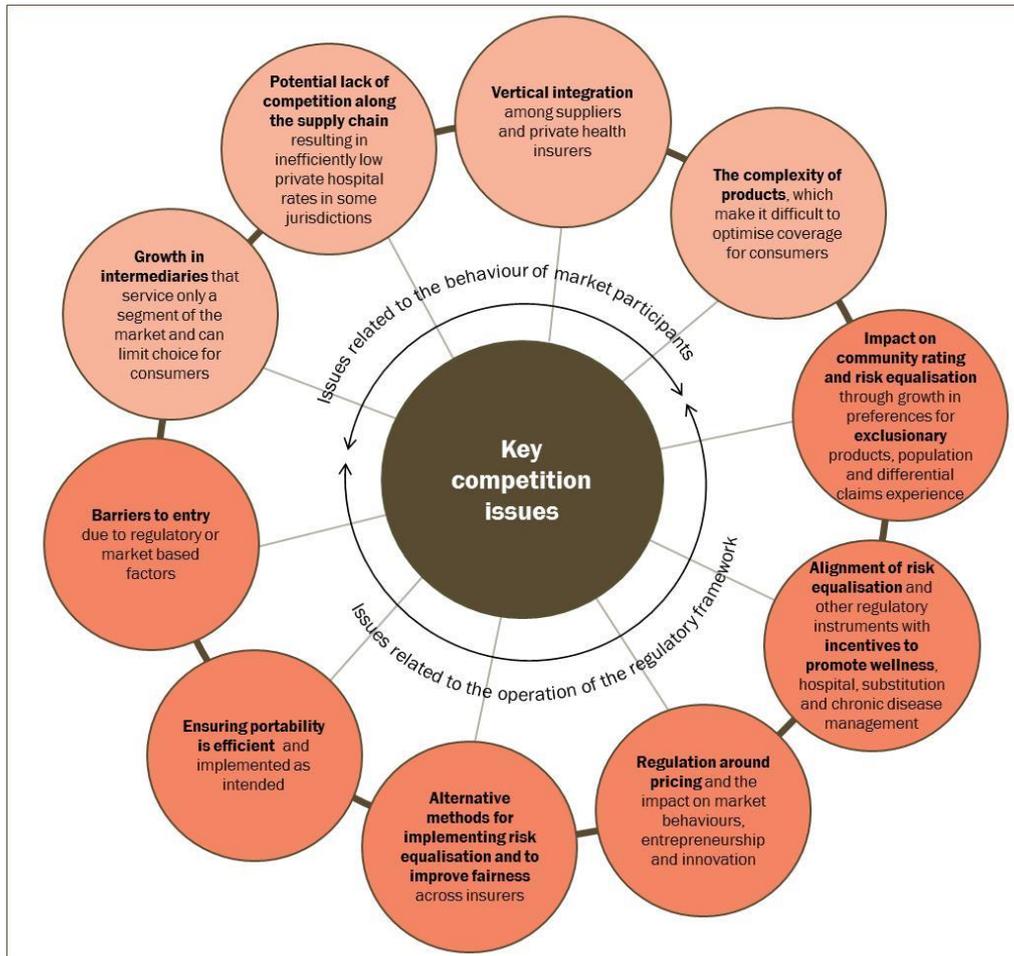
- (i) market inefficiencies (due primarily to lack of choice or inadequate consumer information) around the provision of specialist and related medical services resulting in, it is suggested, inflated or unjustifiable costs for such services;¹¹

¹⁰ IPSOS (2011), page 314 and pages 472 to 488.

¹¹ Such concerns are of long standing in the PHI industry and were at the core of the reasoning offered by the Senate for its decision to order the ACCC to prepare an annual report on anti-competitive and other practices with the potential to impact consumers of private health insurance - see *Senate Hansard*, 25 March 1999, page 3260. The fourteenth report in that series was published by the ACCC on 22 March 2013.

- (ii) pricing inequities arising in contracts between insurers and suppliers where one party or another is thought to have excessive bargaining power;¹² and
- (iii) inefficiencies in the pricing of prostheses, particularly when compared to the prices being paid for similar devices in the public health system.¹³

3. Summary of identified competition issues



Data source: The CIE.

Market processes along the supply chain of private health services are an important determinant of the level of competition between private health insurers and the delivery of efficient and effective

¹² Little Company of Mary Health Care – submission No. 16, pages 1 to 4. PHIAC notes in this context that the PHI Act anticipates this concern and vests in the PHIO a capacity to hear and assist in the resolution of contract disputes between suppliers and insurers through a process of mediation - see PHI Act, Division 247. The PHIO is also empowered to refer appropriate matters to the Australian Competition and Consumer Commission - see PHI Act, section 241-25.

¹³ Confidential submission. The benefits paid for surgically implanted prostheses, human tissue items and some other medical devices is regulated under the PHI Act.

health services to members. However, it is telling that both insurers and suppliers argue – from their respective points of view – that the market for the supply of services is not as well balanced as it might be. Further research could play a role in assessing the competitive tension and comparative bargaining strength between insurers and providers, including the areas identified above.¹⁴

- **The complexity of products.** It is suggested that consumers struggle to fully understand the range of options available in the market.¹⁵ Notwithstanding public resources such as www.privatehealth.gov.au, the large number of different private health insurance products presents a daunting challenge to consumers leading, perhaps perversely, to them becoming discouraged and withdrawing from the process of active choice and assessment and opting for the “devil they know” so to speak. Added to this, the precise nature of commercial arrangements which insurers have struck with suppliers (hospitals and doctors) can be difficult to assess at the time the contract of insurance is entered resulting in a sometimes delayed financial impact (mainly through out-of-pocket expenses).
- **Vertical integration among suppliers** to private health insurers in the non-hospital sector.¹⁶ This is a relatively new development in the private health insurance market as insurers find new ways to both expand their offering to consumers and to internalise and manage their costs. It arises with respect to expansions into broader health cover, as well as internalising various components of general treatment. The extent of vertical integration and its possible impacts on market dynamics may have competitive implications that warrant further examination.
- **The growth in the use of intermediaries** has been assisted (it is argued) by product complexity.¹⁷ Some submissions said intermediaries had had a positive impact on competition, consumer choice and the availability of easily accessible information.¹⁸ Others, however, argue that intermediaries

¹⁴ Pricing issuing relating to services provided by public hospitals is being addressed through the work of the Independent Hospital Pricing Authority. In particular, the Independent Hospital Pricing Authority is seeking to determine the annual National Efficient Price for Australian public hospital services. Further information is available at www.ihpa.gov.au.

¹⁵ Peter Carroll – submission No. 18, page 5; Defence Health Ltd – submission No. 10, page 8; Medibank Private – submission 17, pages 3, 25-26 of attached report; Australian Dental Association – submission 2, pages 5 and 11; AHSA & hirmaa – submission No. 3, pages 5 and 11; Little Company of Mary Health Care – submission No. 16, pages 5-6.

¹⁶ Australian Dental Association Inc. – submission No. 2, page 2, 3 10,11 and 15 and Australian Physiotherapy Association. – submission No. 2, pages 7 and 8.

¹⁷ Defence Health Ltd – submission No. 10, page 12.

¹⁸ AHSA & hirmaa – submission No. 3, page 25; Australian Physiotherapy Association – submission No. 5, page 7; HBF Health Ltd – submission No. 13, pages 9 and 10.

create confusion in the market, promote “moral hazard” in the industry, present a less than full range of options to consumers without full disclosure of commissions, and promote inefficient switching (or “churn”) between insurers.¹⁹

Interaction with the regulatory framework

Added to these market based factors, there is no doubt that the regulatory framework, which has been developed to protect consumers and to ensure that government policy objectives are delivered, has also played a role in restricting the level of competition in the PHI market.

- **The regulatory barriers to entry into the PHI market are considerable.** Private health insurance is a vital consumer product which is usually required at times of stress and sickness. Prudential standards developed to ensure the financial viability of the industry mean that the standards for entry into the market are necessarily demanding. But the appearance of new entrants is also an important indication of perceived commercial opportunity as well as a competitive market.²⁰ Both the appearance and threat of new market entrants’ work to encourage producers to improve efficiency, deliver value for money products and may limit the ability for above normal profits to be earned. In the last 20 years, however, there have been relatively few new entrants to Australia’s private health insurance market. Insurers have pointed to four likely reasons for this: (i) an existing high level of competition and entrenched brand loyalties, (ii) a mature and saturated market with diminishing returns on investment, (iii) demanding regulation that can be difficult to navigate and costly to comply with, and (iv) a level of sovereign risk associated with government assistance and oversight which is not present to the same degree in most other industries.
- **Some respondents viewed premium regulation as a dampener on competition and innovation.**²¹ They argue that the pricing process discourages insurers from choosing to price “aggressively” in a given year because it may preclude the opportunity to recover the (discounted) price at a later time. This leads, it is said, to conservatism in pricing when a more deregulated pricing model would produce greater pricing competition.

¹⁹ St Luke’s Medical & Hospital Benefits Association Ltd – submission No. 20, page 3; Peter Carroll – submission No. 18, page 9; Little Company of Mary Health Care – submission No. 16, pages 7 and 8.

²⁰ This is one of the Porter’s five indicators of a competitive market. For example, see Porter, M.E. *Competitive Strategy*, Free Press, New York, 1980.

²¹ Medibank Private Ltd report by Deloitte Access Economics ‘The Future of Private Health Insurance Premiums: seeking Integrated Solutions – submission No. 17, particularly pages 32 to 41; AHSA & hirmaa – submission No. 3, pages 2, 14 and 15; KPMG – submission No. 14, page 8 and 12; HBF Health Ltd – submission No. 13, pages 5 and 6.

- **The impact on community rating and risk equalisation** associated with increasing take-up of exclusionary private health insurance products.²² While the principle of consumer choice which underpins the design of types of exclusionary products is widely supported, there may be longer run issues for community rating if the use of exclusions is taken to a point where it develops into a *de facto* mechanism for risk-rating individual contributors. Population ageing may already present a challenge for risk equalisation, which will be expected to cover an even greater proportion of total benefit payments over time.
- **The approach to risk equalisation and its impacts on the evenness and fairness of the playing field** among insurers has been an important issue for many stakeholders for some time. While there are advantages and disadvantages associated with the present system and possible alternatives, there is comparatively little research or modelling assessing the competitive implications of changes to the current system.
- **The efficiency of portability** is important to maintaining the competitive tension among private health insurers. However, portability has not always worked well in practice.²³ This, in turn, may have been an impediment to attracting new private health insurers to the market. While the recent improvements to the industry's Code of Conduct²⁴ have gone some way to addressing consumer and industry concerns, the effectiveness of portability remains an area for future monitoring and research given its importance to achieving competition in the private health insurance market.²⁵

The remainder of this paper examines these, and related, issues in greater detail.

²² Defence Health Ltd – submission No. 10 page 6 and 7; Little Company of Mary Health Care – submission No. 16, page 5

²³ Confidential submission.

²⁴ The Private Health Insurance Code of Conduct is available at the Private Healthcare Australia website www.privatehealthcareaustralia.org.au.

²⁵ PHIA's published work plan for the PACU includes a report on this topic scheduled to be released in 2013.

2. Structure of this paper

The following four chapters of this paper cover the historical context of Australia's private health insurance market, the current market structure, the regulatory framework, and competitive dynamics in the market.

- **Chapter 3: The beginnings of private health insurance in Australia.** This chapter describes the development of the private health insurance market over more than a century and explains how it has influenced the market today. It has evolved from a highly segmented group of mutual funds focussed on providing hospital services to members to a modern, highly diversified, industry which serves almost half the population. This history has significantly shaped the PHI industry as it exists today.
- **Chapter 4: Regulatory design and the impact on competition among insurers.** In this chapter, the paper discusses the effect of regulation on the nature of competition for private health insurance. It shows that over many years governments of all persuasions have, through regulation and incentives, intervened in the market in order to protect consumers and ensure the viability of the industry.
- **Chapter 5: The contemporary Australian private health insurance market.** This chapter sets out how the Australian market for private health insurance is characterised by the concentration of larger insurers, but without market dominance in all regions, with smaller insurers having a stronger market presence within niche memberships (restricted) or geographic populations. The chapter shows that each level has played a role in delivering the option of private health insurance to Australians in almost every situation and location.
- **Chapter 6: Market conditions that affect competition.** This chapter explores the market driven elements which impact the competitive dynamism of the Australian private health insurance market. This includes demand side forces associated with the way that consumers behave, the impact of intermediaries and online interactions that influence consumers to join, stay or switch insurers, as well as supply side forces as insurers evolve their product offerings in an attempt to differentiate between themselves and grow their membership base.

3. The beginnings of private health insurance in Australia

The private health insurance market and its role in the funding of health care in Australia reflect its history – an original ethos of caring for the sick and a focus on equitable access to health care.

3.1 The origins of private health financing

In the 19th century, medical treatment was rudimentary and medical care was often only administered immediately before death. Hospitals were regarded as unhealthy places, to be avoided by all but the poor, with the wealthy treated by private doctors in their own homes. The role of public hospitals was to offer accommodation and personal care to the disadvantaged, rather than provide treatment that was elsewhere unavailable.²⁶

As the quality of medical care improved, so too did its value to society and its commoditisation, which increased the importance of making medical care available to those that could benefit from it even when they could not afford to pay. The expansion in the range and costs of treatments over time prompted the development of a market for sharing or subsidising health costs to make the full range of services available on affordable terms.²⁷

The establishment of a range of voluntary schemes for sharing health costs gave rise to the precursors of today's private health insurance funds. The beginnings of private health insurance in Australia trace their origins to Britain in the 19th century, with the establishment of friendly societies aimed at protecting individuals from the hazards of life, through a system of mutual self-help.²⁸ A number of these friendly societies operated in Australia during the 1800s and continued into the early part of the 20th century.

²⁶ Scotton and Macdonald 1993, *The Making of Medibank*, School of Health Services Management, Sydney, page 5.

²⁷ *ibid.*

²⁸ Gale, A. P., and Watson, D. 2007, 'Adventures in Health Risk: A History of Australian Health Insurance', presented to the Institute of Actuaries of Australia, September, Christchurch, New Zealand, page 3.

As affiliates of the English friendly societies grew, medical and hospital interest groups founded mutual organisations and commercial bodies were established to offer health cover.

3.2 Early market segmentation

Health services in 19th century Australia were available under a three-tiered structure of price discrimination:

- 'free' doctor services were provided to patients in charitable hospitals for the poor;
- friendly societies funded medical services for members, often low paid workers, under annual capitation payment arrangements with doctors; and
- uncapped fee-for-service medical care was provided in patients' homes to those who could afford to pay.

These market segments were distinctive, and entrenched a pattern that existed for many decades of separate funding arrangements for health care for the poor, the working class, and the middle/upper class.

The three-tier system came under stress in the 1930s when the depression led to widespread unemployment. The friendly societies lost members, and public hospitals struggled to cope with an increase in demand for hospital care.²⁹

Hospitals themselves began to open (means tested) private and intermediate wards for workers who were not members of friendly societies, and teaching hospitals emerged which saw a gradual improvement in hospital care quality.

At this time, too, hospital based health funds started to emerge, commencing with the Metropolitan Hospital Contributions Fund of New South Wales (HCF) in 1932, which was established to provide for the maintenance of the public hospitals within the metropolitan area, and absorb the industrial contributions scheme of the Hospital Saturday Fund.³⁰

²⁹ Ibid.

³⁰ The Metropolitan Hospital Contributions Fund was established on the 16th of June 1932 following the merger of the Hospital Saturday Fund (established 39 years prior) and the newly created Hospital Commission of New South Wales.

3.3 The post-war years

The first coordinated measures to promote health insurance began to emerge in the post-World War II period. The most significant step in this direction was the enactment of the *Hospital Benefits Act 1945*, which provided subsidies to states and territories for the costs of public and private hospital treatments. This in turn set the scene, following a referendum to change the Australian Constitution,³¹ for a more expansive system of social services, including health insurance established in the *National Health Act 1953* (NHA).

Under the Voluntary Health Insurance (VHI) scheme established by the NHA, existing insurers became agents for VHI and received subsidies for their operations through the payment of Commonwealth benefits and Commonwealth underwriting of the claims of the chronically ill.

Hospital benefit tables were used to share charges in wards of public hospitals equally between government benefits, fund benefits, and out-of-pocket patient contributions with income tax deductions available for insurance contributions and net medical expenses.³²

Funds were obliged to adhere to a policy of 'uniformity' offering identical tables, providing identical benefits and identical contribution rates to achieve equity objectives, resulting in a trading off between competition and regulation.

The scheme had a significant impact on the private health insurance industry by building coverage without competition. The established health funds were protected from external competition (from outside the VHI scheme) by subsidies that made it virtually impossible to conduct health insurance business outside the system. Registration was also restricted to not-for-profit organisations that could meet the prudential standards set by the Department of Health.³³

This evolution of private health financing in Australia is summarised in **Figure 4**.

³¹ Constitution, Section 51 xxiiiA, inserted in 1946.

³² Shamsullah A. 2011, 'Australia's private health insurance industry: structure, competition, regulation and role in a less than 'ideal world', *Australian Health Review* 2011, 35, 23-31, page 25.

³³ Scotton and Macdonald 1993 op. cit, page 15.

3.4 Moves towards the modern mixed public/private system

Eventually the high cost of the VHI scheme and its limited coverage generated momentum for a system of compulsory health insurance. Australians also became increasingly aware of alternative models of national health insurance, many of which had been operating in Europe since around the time of the end of the Second World War.

The election of the Whitlam Government in 1972 saw the first substantive steps in this direction with the establishment of the first national health insurance system after a significant policy and political contest.³⁴ The new scheme, known as “Medibank”, was a universal, compulsory, publicly-administered and funded health insurance scheme. The scheme was administered by the Health Insurance Commission (HIC), and provided for universal coverage of the population for medical expenses through a standard rebate for any medical expenses incurred.

When the Labor Government lost office in 1975, the successor Fraser Government elected to substantially restructure Medibank. The national health scheme based on universal cover was decommissioned, with a return to a system of public subsidies supporting a substantially private health insurance market.

An important feature of the new system was the establishment in October 1976 of the first significant government-owned private health insurer, known as Medibank Private, which was operated by the HIC. Medibank Private provided private medical and hospital insurance in all states in competition with existing registered health funds. Upon its establishment, Medibank Private quickly assumed a major position in the market for PHI in Australia, a position it retains to this date.

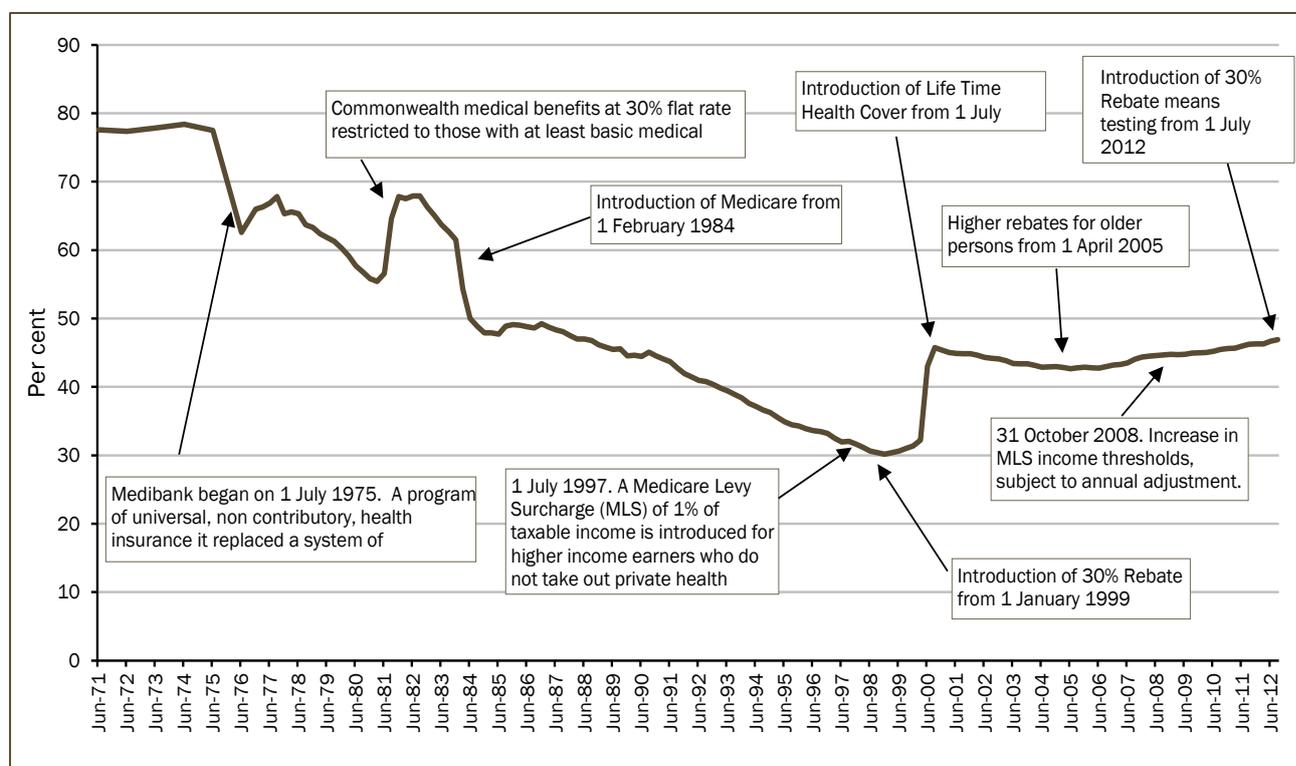
In 1984, following the election of the Hawke Labor government, a second attempt at the establishment of a universal publicly-funded health insurance scheme saw the introduction of Medicare. Medicare now continues as the major funder of the Australian health system. As shown in **Figure 5**, in the years after Medicare’s introduction, private health insurance membership fell gradually but persistently.

Over the following years, successive governments developed a number of measures to address this by introducing policies to encourage the take-up of private health insurance. These included:

³⁴ This included the only instance in Australian history where legislation (the *Health Insurance Act 1974* and the *Health Insurance Commission Act 1974*) has been passed at a joint sitting of both houses of Parliament following the double dissolution election of 18 May 1974.

- introduction of portability requirements compelling funds to recognise waiting periods for policyholders transferring from other insurers in 1988;
- adjustments to minimum solvency requirements in 1988;
- measures allowing insurers to negotiate contracts with hospitals and no gap contracts with medical specialists from 1995;
- changes to the Medicare levy, which was increased to 1.5 per cent in 1995 and a surcharge levy of an additional 1 per cent was introduced in 1997 for high income earners without private health insurance;
- introduction of the private health insurance incentive scheme in 1997 to support participation of low income earners;
- introduction of the 30 per cent rebate on private health insurance premiums in 1999 and increased for those aged over 65 in 2005;
- introduction of Lifetime Health Cover (LHC) loadings in July 2000 for those older than 30 first taking out cover; and
- commencement of the *PHI Act* in 2007.

5. Take-up of private health insurance in Australia 1971 to 2012



Source: PHIAC.

The policy environment continues to evolve with the Government's announcement on 22 October 2012 to limit the private health insurance tax rebate to the lower of the increase in premiums and the CPI, and to remove the private health insurance rebate from the LHC loading component of PHI premiums on hospital cover.³⁵

³⁵ The Deputy Prime Minister and Treasurer and the Minister for Finance and Deregulation, *Mid-Year Economic and Fiscal Outlook*, 22 October 2012, page. 237.

4. Regulatory design and the impact on competition among insurers

Private health insurance is designed to supplement and take pressure off publicly funded health services. Lifting non-risk rated private health insurance coverage has required specific incentives for consumers, with consequent impacts on insurer behaviours and rewards.

4.1 Overview

Private health insurance plays an important, supplementary role in the financing of health care in Australia today. Key financing priorities for private health insurance include:

- achieving universal access;
- achieving equity in service provision; and
- containing the cost of all health services, including services funded by Government.

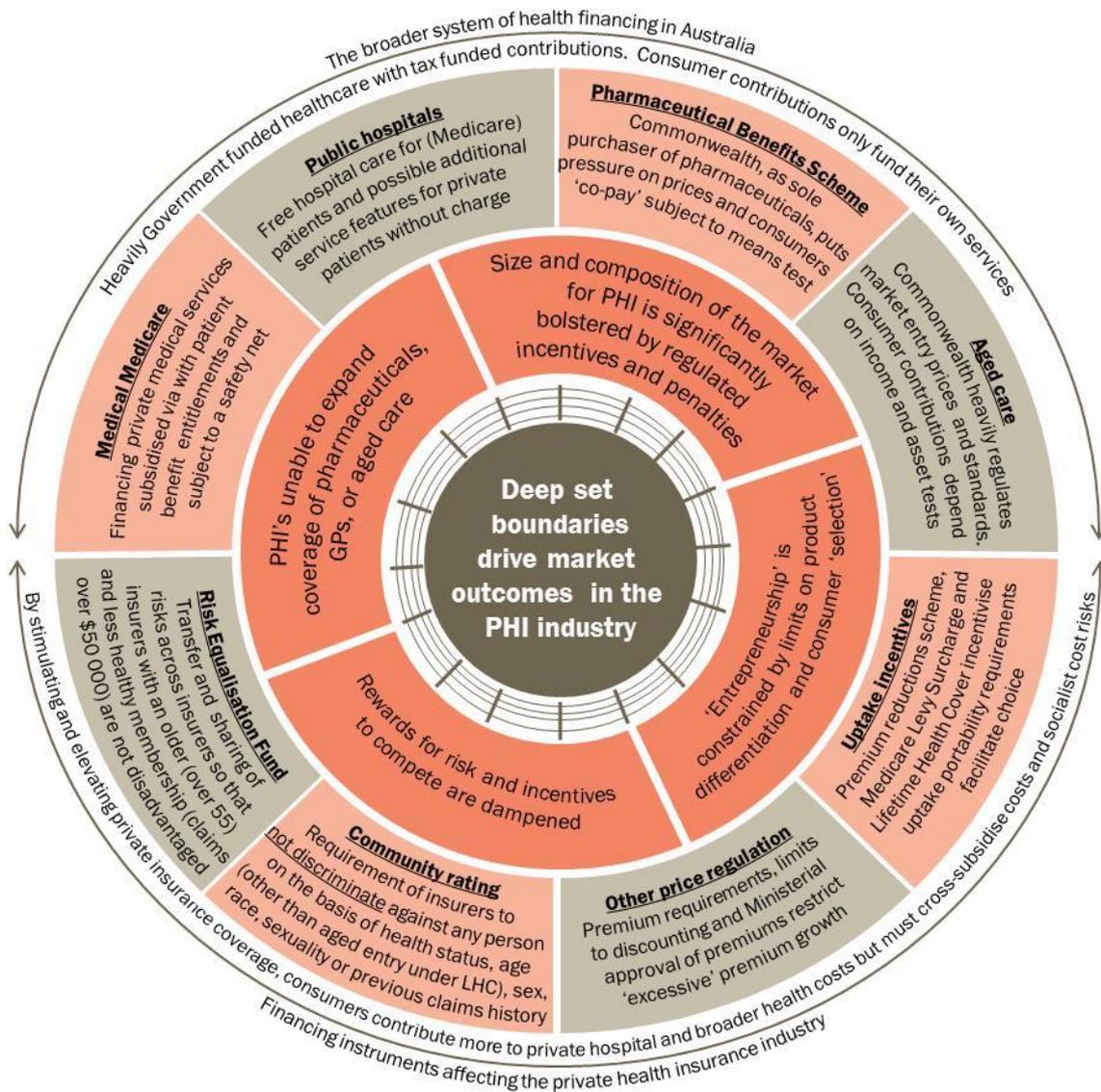
There are several policies in place that encourage early and ongoing consumer take-up of private health insurance, and to ensure that the industry is sustainable and competitive. These are important to achieve the goal of supporting the role of private health insurance in the broader system of health care financing. Indeed, the incentives and barriers facing insurers reflect the careful balancing at the policy level of the role and funding commitment of other parts of the health system.

Figure 6 highlights how PHI is nested within the health financing system and is not about duplicating Government health funding. Rather, the health services that it does fund are supported by a regulatory framework that purposefully stimulates coverage, facilitates further additional private funding of health services, and (like other health services) socialises cost risks and cross subsidises high and low cost consumers to meet the objectives of universal access to health care in Australia.

Insurers may cover the costs of treatment for private patients in private or public hospital and can include some services that Medicare does not cover (in general treatment products), such as dental and optical care, physiotherapy and chiropractic care.

Insurers cannot cover general practitioner services, pharmaceuticals listed on the Pharmaceutical Benefits Scheme, or aged care (for example, nursing home care). As a result, the private health insurance market has traditionally targeted procedure based health care (based within the “four walls” of the hospital), providing access to elective medical treatments, circumventing treatment on the basis of clinical need in the public health system via waiting lists.

6. The nesting of private health insurance within the broader systems of health financing in Australia



Source: The CIE.

This is changing, however, with the Broader Health Cover initiative implemented via the PHI Act allowing insurers to cover members for clinical services provided in 'safe, out of hospital environments' as well as preventative health services.

Today, many elements of the private health insurance framework (risk equalisation, community rating and lifetime health cover for example) are designed to level the playing field between insurers and ensure that the market is contestable. Promoting a competitive industry that provides value for money for consumers is seen as important to cost containment and the long term sustainability of the private health insurance system, and for that matter, the public health system.

4.2 Key elements of the private health insurance regulatory framework

The regulatory framework is extensive, promoting consumer uptake and shaping private health insurance products to reflect their supplementary role in the health financing system.

Balancing objectives

PHIAC's statutory objectives are set out in the *PHI Act*. Section 264-5 instructs PHIAC, in performing its role, to 'take all reasonable steps' to strike an 'appropriate balance' between three objectives:

- (a) fostering an efficient and competitive health insurance industry;
- (b) protecting the interests of consumers; and
- (c) ensuring the prudential safety of individual private health insurers.

PHIAC's central responsibility, therefore, is to protect consumers by ensuring that the private health insurance industry is competitive and prudentially sound.

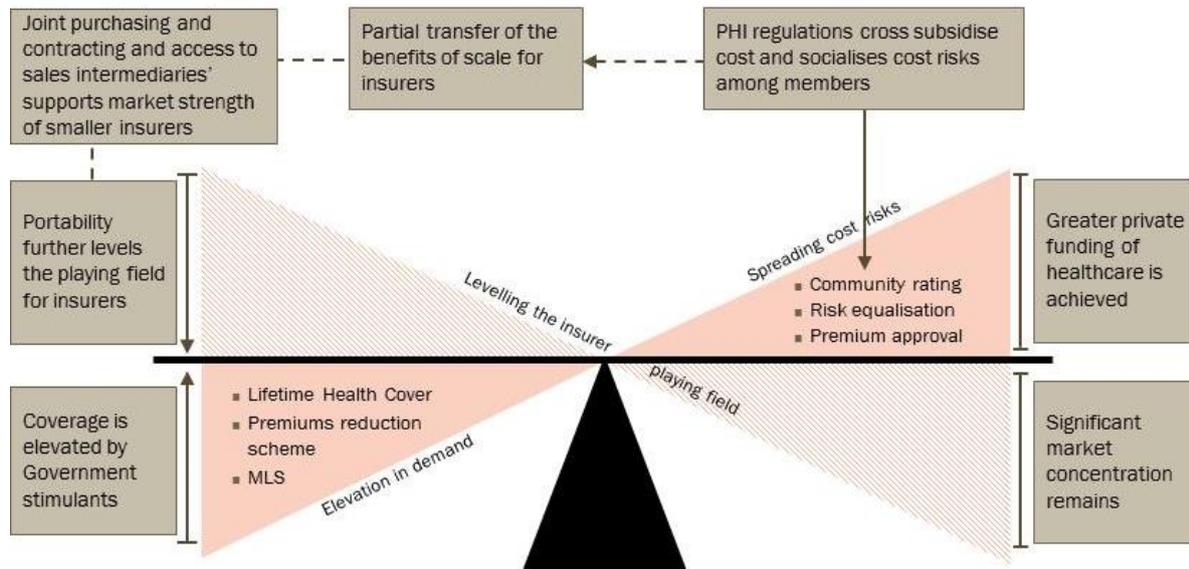
The way that the broader regulatory and policy framework operates, outside of PHIAC's remit, suggests additional objectives, including:

- increasing coverage, access and affordability to enhance consumer choice and expand consumer contributions to the costs of health care;
- sharing the case mix and case load across public and private hospitals; and
- ensuring that private health insurance plays a supplementary and positive role in the financing of health care.

As illustrated in **Figure 7** and described below, the balancing of these objectives is achieved through both demand and supply side instruments. Demand side instruments – choices about treatment, Lifetime Health Cover (LHC), premium rebates and the Medicare Levy Surcharge (MLS) over and above needs-based treatment in the public health system – lift private health insurance coverage.

At the same time, supply side instruments such as community rating and risk equalisation spread the cost of risk across consumers and allow for the cross subsidisation of high cost claims by low cost claimants, while the premium approval process constrains pricing dynamics in the industry while maintaining insurance levels.

7 A balancing act: promoting coverage and cost sharing



Source: The CIE.

This has a levelling effect on insurers as some of the advantages of scale are made accessible to all, irrespective of the size of the membership base of any individual insurer.

Portability requirements under the *PHI Act* allow consumers to shift between insurers without penalty for hospital treatment products,³⁶ providing incentives for insurers to compete, and industry led initiatives such as joint contracting and technology purchasing by smaller insurers allows a degree of economic efficiency in smaller operations.

Summary of private health insurance regulatory requirements

The regulatory requirements of insurers are extensive. These include:

- **regulations on content and benefit payments**, including specific requirements on what private health insurance can, and in some cases must cover (palliative, rehabilitative and psychiatric care) and

³⁶ It is noted that waiting periods served are not portable for general treatment products, which account for around 30 per cent of overall benefits. Consumers may often decide to move insurers based on general treatment benefits, and could be perceived as a barrier to shifting due to limits to portability.

cannot cover (outpatient and general practitioner services). There are also minimum benefit requirements that must be included in a policy;

- **the regulation of pricing** through Ministerial approval of premium changes, with the convention of a review process once a year, price increases coming into effect on the same day for all insurers, and prescribed limits to discounting (with the legislated discount set at a maximum of 12 per cent per annum which can be applied in limited circumstances);
- **the regulation of information provided to consumers** through providing consumers Standard Information Statements;
- **portability** of policies within and across insurers;
- **regulation of prudential standards** to promote market stability and ensure insurers conduct their affairs with integrity, prudence and professional skill;
- **capital adequacy and solvency standards** to ensure the prudential safety of health insurers; and
- **community rating and risk equalisation**, which prohibits insurers from 'improperly discriminating' between people who are, or wish to be, insured under a complying health insurance policy, and provides a mechanism for transferring and sharing risks across insurers so that insurers with an older or less healthy membership are not financially disadvantaged.

In aggregate, these measures are designed to achieve the dual objectives of protecting consumers of private health insurance while encouraging its take up by as many people as possible. Their impact on the market and competition is discussed further in the remainder of this chapter.

4.3 Community rating and risk equalisation

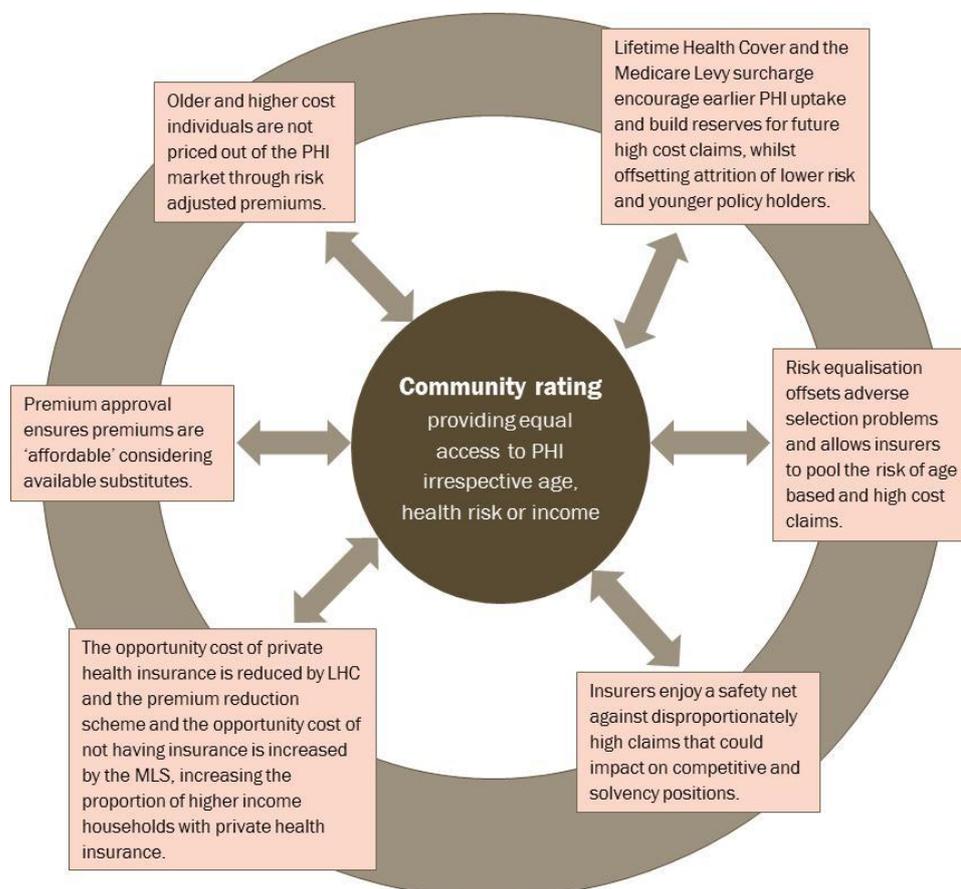
Community rating and risk equalisation is the cornerstone of universal access to private health insurance in Australia.

Community Rating

Community rating of private health insurance policies was first legislated in the *National Health Act 1953*. From that point forward, all insurance policies have been offered at the same price to any person irrespective of risk factors including age, health risk or income. The objective of community rating is to ensure that private health insurance is equitably available to all in the community who seek it – and through this, to ensure that coverage expands to enable private health insurers to play a greater role in health financing in Australia.

As shown in **Figure 8**, community rating is part of a complex and interdependent regulatory system. It sits alongside complementary tools that moderate adverse selection problems for insurers to seek out ‘attractive’ low cost members, or to resist members who are (or view themselves as) more likely to require medical treatment and claim.

8. Lifting coverage and sharing risks to sustain a community rated PHI product



Source: The CIE

While the objective of community rating is to increase the affordability and accessibility of private health insurance to all Australians, the policy does have some consequential impacts. In particular, it is suggested that by sharing risk within the entire industry, the incentives for insurers to proactively manage the welfare and health of their own members is reduced.³⁷ Further, it is argued that community rating combined with premium pricing regulation limits the ability of private health insurers to reward those members that make low or no claims.³⁸ Whether, on balance, it is desirable to encourage no (or low) claiming behaviour in that manner is, however, a matter for continuing discussion given the tendency of

³⁷ Defence Health Ltd – submission No. 10, page 4 and 5; KPMG – submission No. 14, page 11.

³⁸ HBF Health Ltd – submission No. 13, page 5.

such rewards to provide an incentive for contributors to avoid claiming altogether (possibly at risk to their own health) or to shift their treatment to the public sector.

Risk equalisation fund: pooling the risk of low and high cost policy holders

Risk equalisation is designed to spread the claim burden of individual private health insurers by pooling the claims experience of all insurers for members over 55 years and so-called 'high cost' claims. Once this is determined, a balancing transfer is made between insurers through the Risk Equalisation Trust Fund (RETF).

Risk equalisation is a long standing element of private health insurance regulation. First introduced in 1959, the scheme has evolved over the years to its current form based on:

- ex post equalisation, that is to say, based on *actual* claims experience by insurer by state/territory;
- an Age Based Pool (ABP), where claims made by all members aged over 55 years are grouped into a sliding scale of seven weighted age-based categories;³⁹
- a High Cost Claimants Pool (HCCP), which pools all claims involving more than 35 days in hospital in a 12 month period and payable benefits (net of ABP transfers) in excess of \$50,000; and
- all costs of the pool are met through industry transfers.

This process is overseen by PHIAC which manages the risk equalisation process and distributes the proceeds of the payments made into the RETF on a quarterly basis.

Unsurprisingly, insurers tend to pay into or receive transfers from the risk equalisation fund broadly in line with their market share, with 'payer' or 'receiver' status largely dependent on member age profile. **Figures 9 and 10** illustrate the transfer patterns into and out of the risk equalisation pool in value and proportional terms.

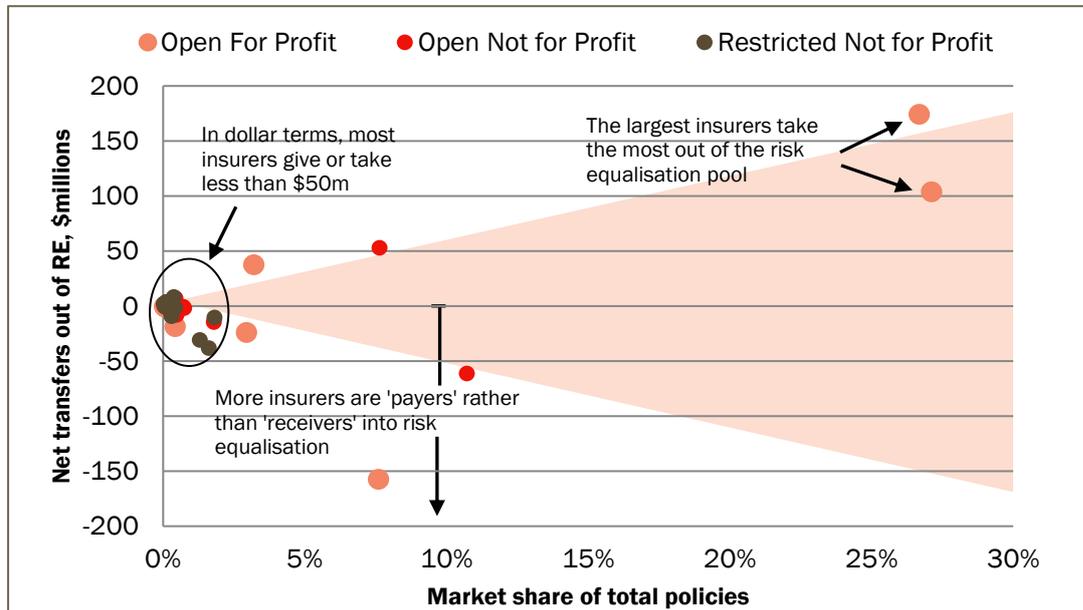
The larger insurers account for a large absolute value of risk equalisation transfers, by virtue of the large number of policies held with the six largest insurers, accounting for 75 per cent of the absolute risk equalisation transfers.⁴⁰ Large insurers that are net receivers of transfers (such as BUPA and to a lesser extent Medibank Private) have an older average profile of members, with BUPA and Medibank Private

³⁹ For example, 15 per cent of claim values for members aged 55-59 are included through to 82 per cent of claim values for members aged over 85 years.

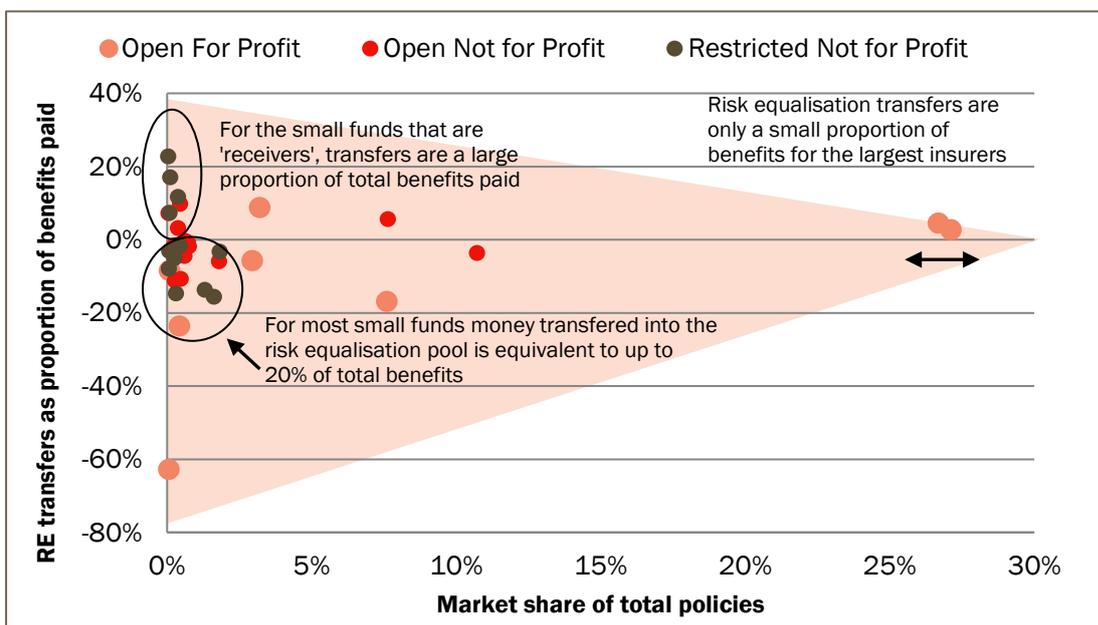
⁴⁰ PHIAC, Risk Equalisation Financial Year Results by Insurer and State available at www.phiac.gov.au.

receiving \$174 million and \$104 million respectively in 2011-12. NIB has a younger average member profile and is the single largest net payer into risk equalisation, a total of \$158 million in 2011-12.

9. Net risk equalisation transfers, by market share 2011-12



10. Net risk equalisation transfers as proportion of benefits paid, by market share 2011-12



Source: The CIE, based on PHIAC (2012) risk equalisation financial year results by insurer and state.

Smaller insurers with a relatively small number of policies account for a small value of risk equalisation transfers. There are a large number of smaller insurers, clustered around a market share of 1-3 per cent,

that also experience a low absolute value of risk equalisation transfers. The fifteen smallest insurers, by proportion of national policies held, account for around 5 per cent of the absolute transfers (**Figure 9**).

In contrast, **Figure 10** shows that when normalised by the value of benefits paid, smaller insurers with a lower market share are more likely to experience risk equalisation transfers (both in and out) that are a greater proportion of the total benefits paid out annually. Hence, smaller insurers are more deeply affected by risk equalisation relative to their benefits paid.

Furthermore, larger insurers, who are more likely to observe an internal claims experience closer to the national average claiming experience, also have a lower level of net transfers as a proportion of claims paid.

- In 2011-12, the two largest insurers, Medibank Private and BUPA received risk equalisation transfers equal to 2.7 per cent and 4.5 per cent of claims experience respectively.
- In contrast, 15 smaller insurers, accounting for on average 1 per cent of the market each, received (or made) risk equalisation transfers that were in excess of 10 per cent of their actual claims experience for 2011-12.

Risk equalisation and competition

Several competition issues associated with risk equalisation were raised in the consultation phase. The key concerns raised were that risk equalisation:

- places an effective floor price on hospital products due to expected risk transfer requirements;⁴¹ and
- may dampen incentives to use health promotion⁴² and benefit minimising strategies such as wellness and chronic disease management programs knowing that the costs of the programs are borne up front, but the returns from minimising benefit payments are likely to be shared across the industry.⁴³

As noted, risk equalisation is set up as an ex-post system, providing for transfers based on observed benefit payments. It is the ex-post nature that possibly limits the incentive for insurers to manage benefit claims that are allocated to the risk equalisation pool.

⁴¹ KPMG – submission No. 14, page 11.

⁴² Teachers Federation Health Ltd – submission No.21, page 3; Defence Health Ltd – submission No. 10, pages 4 and 5; Australian Unity Health Ltd – submission No. 8, page 3.

⁴³ AHSA & hirmaa – submission No. 3, page 8, Latrobe Health Services Ltd – submission No. 15, page 2; Defence Health Ltd – submission No. 10, page 4.

In response to this apparent limited incentive, there is a growing body of opinion which promotes the potential benefits of a so-called “ex-ante” based risk capitation system where insurers would make transfers based on actuarially expected claims calculated on the policy holder profile of the insurer. Because, under this approach, the payments from the pool are known in advance and not subject to later adjustment, it is suggested that it provides increased incentive for insurers to manage benefit payments and to provide options to assist policy holders to recover faster in lower cost environments.⁴⁴ The merits and logistics of this approach have been considered at various times in the relatively recent past, but to date no changes have been made to the current model.⁴⁵

The risk capitation model is not without its own critics. For example, the following observations have been made:

- On average, there should be no difference between an ex-post and an ex-ante based system. However, there is a risk that smaller insurers under an ex-ante system may find themselves receiving higher than expected claims in concurrent years, potentially jeopardising their long-term viability.
- The use of exclusionary and restricted policies may create some additional complications with an ex-ante risk capitation scheme as it is likely to be difficult to calculate expected claims when there is a mix of members on full cover policies and some on exclusionary and restricted policies.

The current ex-post risk equalisation scheme uses age and high cost claims as risk factors. While these present a simple and straight forward method for spreading higher risks, additional factors such as gender ratios, females of child bearing age and specific illnesses could potentially enhance the efficiency and effectiveness of the risk equalisation scheme.⁴⁶

Other suggested changes to the current risk equalisation scheme raised in submissions include:

- use of an agreed cost or benchmarks of service model, rather than actual costs;⁴⁷
- prospective risk adjustment with an expansion of risk factors beyond the current system; and
- replacement of the high costs claimants’ pool with a form of re-insurance.⁴⁸

⁴⁴ Paolucci, F. and Stoelwinder, J. (2011) *Risk-equalisation in health insurance markets: models and international experience*. Australian Centre for Health Research – ACHR submission No. 1, pages 15-16.

⁴⁵ Collins, P. (2008) *An historical perspective on risk equalization for private health insurance in Australia*. Presented to ACERH Research Forum, ANU, Canberra.

⁴⁶ Paolucci, F. and Stoelwinder, J. (2011), page 30. Australian Centre for Health Research – submission No. 1, page 16.

⁴⁷ Defence Health Ltd – submission No. 10, page 5 and 17.

The approach to risk equalisation and its impacts on the evenness and fairness of the playing field among insurers is an important yet complex issue. While there are advantages and disadvantages associated with the present system and possible alternatives, there is comparatively little research or modelling that clearly enables assessments to be made of the competitive implications of changes to the current system. This warrants further analysis.

4.4 Premium regulation

The Government regulates premium increases to protect the interests of consumers.

Objectives and process

In supporting the objectives of maintaining accessibility and affordability of private health insurance, under the PHI Act, private health insurers must apply to the Minister of Health for approval of any premium changes. The stated objectives for regulating changes in private health insurance premiums include:

- ensuring an attractive private health insurance product for consumers;
- keeping downward pressure on private health insurance premiums;
- protecting the Government's investment in private health insurance;
- transparency in the setting of private health insurance premiums;
- timeliness in the approval of private health insurance premiums; and
- the consistency in the approval of private health insurance premiums.⁴⁹

Following administrative changes announced in October 2012, PHIAC is now the primary source of advice to the Minister about premium increases. PHIAC's objectives of fostering an efficient and competitive industry align directly with the overall objectives of the premium setting process which is to protect consumers while ensuring a viable industry. The recent changes to the process were made

⁴⁸ Defence Health Ltd – submission No. 10, page 17; Australian Centre for Health Research – submission No. 1, page 9.

⁴⁹ DoHA (2011) 2011 Private Health Insurance Premium Round – Outline of premium approval process, page 2, available at www.health.gov.au/internet/main/publishing.

following extensive consultation with the industry and further changes may be considered if further benefits to all relevant stakeholders can be achieved.⁵⁰

Industry views and implications

A number of submissions have voiced concern that premium regulation limits the ability and the incentives of insurers to engage with pricing strategies designed to gain a competitive advantage.⁵¹ Taking a game theoretic perspective, as a repeated game, insurers may be reluctant to consider being more aggressive in terms of price competition over a 12 month period. This reluctance is drawn from the effective inability to adjust pricing within a 12 month period and the anticipated effects of the next round of premium regulation where there is the potential that the use of premium catch-up would not be allowed if the pricing tactics did not prove effective.

Pricing regulation also introduces an element of sovereign risk into the operations of insurers,⁵² and inadvertently directs insurers into a position of “strategizing” around pricing in order to follow the market in terms of annual premium adjustments. Approximately a third of submissions particularly noted the effect that pricing regulation has on the actions of insurers and their ability to plan and manage future risks.

Some insurers contend that, while they may be able to generate efficiency savings resulting in increased margins, the regulatory oversight associated with the pricing process would see these gains translated into lower premium increases rather than providing the insurer with options to invest in wider health programs for members. Some insurers also contend that where the approved increase in premiums is lower than what they were seeking, this may translate into lower benefits for policy holders in order to secure their profitability targets.⁵³

While the potential for unintended group movement of insurer premiums is a risk, (where insurers choose the safety of the industry average premium change rather than introducing more aggressive pricing competition), a number of insurers during the consultation process noted that the regulation of premium changes does not affect management decisions, and that the more important considerations were

⁵⁰ The Deputy Prime Minister and Treasurer and the Minister for Finance and Deregulation, *Mid-Year Economic and Fiscal Outlook*, 22 October 2012, page. 237.

⁵¹ KPMG – submission No. 14, pages 8 and 12; Medibank Private Ltd report by Deloitte Access Economics ‘The Future of Private Health Insurance Premiums: Seeking Integrative Solutions – submission No. 17, particularly pages 32 to 41; HBF Health Ltd – submission No. 13, pages 5 and 6.

⁵² KPMG – submission No. 14, pages 13 and 14; HBF Health Ltd – submission No. 13, page 7.

⁵³ Medibank Private Ltd report by Deloitte Access Economics ‘The Future of Private Health Insurance Premiums: Seeking Integrative Solutions – submission No. 17, page 34; Queensland Teachers Union Health Fund Ltd– submission No. 19, page 4.

consumer responses to ‘bumpy’ annual premium changes. That is, insurers were aware that their members were more comfortable with a steady and anticipated annual premium increase than alternating between maintaining and jumping annual premiums. In such cases where sufficient capital accumulation was reached, insurers have the option of increasing benefits rather than lowering the premium change to adjust their capital levels.

An assessment about the approach to price regulation must ultimately be made in light of the Government’s objectives for private health insurance; that is, to correctly balance the mix of private and public health care use in Australia. Private health insurers have a related but tangential objective, to maximise the benefits or returns to their members or, in the case of for-profit funds, their shareholders.

4.5 Demand side: membership take-up incentives

The Government encourages take-up of private health insurance through policy settings which provide incentives to consumers.

Apart from the inherent advantages of the PHI product itself, namely the freedom to choose the location of medical treatment, the identity of the provider and the time it is provided, from a consumer’s perspective, there are three financial factors providing the incentive to take-up private health insurance:

- the private health insurance rebate reduces the upfront premium paid;
- the MLS affects the opportunity costs associated with premium expenditure by increasing the amount of tax that is payable without private health insurance; and
- the LHC increases the incentive to take up private health insurance by making it more expensive for “late joiners”.

Other drivers of demand exist outside of the private health insurance framework, including public sector waiting lists and perceptions (whether justified or not) of the public health system.

Medicare levy surcharge

The Medicare Levy Surcharge (MLS) commenced on 1 July 1997. It was introduced in the Private Health Insurance Incentives Scheme (PHIIS) as part of wider initiative to provide incentives and penalties for private health insurance uptake or avoidance based on income thresholds. Those individuals and families that were placed in the highest of three income thresholds and did not have an acceptable level of private cover were subject to an additional 1 per cent levy on their taxable income.

Since 1997, the MLS has been adjusted a number of times and currently there are 3 rates which are added to the Medicare levy of 1.5 per cent of taxable income (1.0 per cent, 1.25 per cent and 1.5 per cent

depending on taxable income level and family status). The MLS is a regulatory instrument penalising those individuals who are considered to have adequate means to contribute to the cost of their health care and who choose not to do so.

Premium rebates

There have been at least four iterations of rebates and subsidies for private health insurance since their introduction in 1997, which originally provided those on certain incomes with a dollar denominated subsidy towards the cost of their premium. Dollar denominated rebates were originally paid to individuals and families under the given income thresholds, rebates were paid against hospital and general treatment cover separately.⁵⁴

Amendments to the PHIS in 1999 expanded the arrangements to cover all private health insurance policy holders irrespective of their income level and the subsidy was replaced with a 30 per cent rebate on the premium paid.

In 2000, amendments restricted the level of excess allowed in complying health insurance policies, and a market developed quite quickly around private health insurance products that would meet the minimum hospital criteria to avoid the MLS, but also include a sufficient level of excess that reduced the net premium paid (less the rebate). From 1 July 2000, complying hospital policies for MLS purposes were restricted to excesses below \$500 per annum for individuals and \$1 000 per annum for policies covering more than one person.

From 1 July 2012, the private health insurance rebate became means tested, reducing to zero at income levels above \$130 000 per year for individuals and \$260 000 for families. On 22 October 2012, the Government announced further changes to the rebate which would mean it is no longer applied to premium increases above CPI, or to the LHC loading component (see below). This is intended to reduce the total cost of private health insurance subsidies as well as reduce subsidies for consumers who are better able to pay for it. At the time of writing, that measure had not yet been legislated. Subject to parliamentary consideration, it is due to come into effect from 1 April 2014.

⁵⁴ Industry Commission (1997) *Private Health Insurance. Report No. 57*, February, page 2.

Lifetime health cover loading

The Lifetime Health Cover (LHC) loading came in to effect on 1 July 2000⁵⁵ as a response to the decline in participation in private health insurance, the demographics of the then diminishing pool of policy holders, and a level of adverse selection problems of community rating. Under the LHC system, individuals who take out private health insurance for the first time, or reinstate private health insurance after the age of 30, are required to pay a premium loading. This loading is 2 per cent per year for each year after they turned 30 years of age. It is removed when the individual turns 70, or has completed 10 continuous years of hospital cover.

LHC loadings introduce a consistent approach to age based risk rating for older people taking out new private health insurance policies, and attract younger individuals with a lower immediate probability of claiming to enter into the private health insurance risk pool earlier. In doing so, LHC brings a younger cohort into private health insurance each year which plays an important role in maintaining the demographic balance, particularly those with lower incomes.

The Government announced on 22 October 2012 a measure to remove the private health insurance rebate on the LHC loading component of PHI premiums. This measure addresses concerns with the Australian Government paying a proportion of the LHC loading. The LHC loading is for the public policy purpose of creating an incentive to purchase private health insurance earlier in life and maintain it. If the Australian Government continued to subsidise a proportion of the LHC loading, the incentive to take out hospital cover would be diminished. This measure is proposed to commence from 1 July 2013.⁵⁶

⁵⁵ The deadline for registering policies with insurers to avoid a Lifetime Health Cover loading was extended to 15 July 2000 due to the large numbers of people applying to take up private health insurance coverage, and the inability of insurers to process these large numbers by 1 July 2000.

⁵⁶ At the time of writing, legislation giving effect to this measure is before the Australian Parliament (see Private Health Insurance Amendment (Lifetime Health Cover Loading and Other Measures) Bill 2012).

5. The contemporary Australian private health insurance market

Private health insurers are becoming increasingly diverse and are expanding their services and role in the health sector. The financial performance of insurers is well supported by prudential requirements, although there is variation in premium increases, management expenses and margins which are not simply explained by market size or insurer status.

There are also various submarkets for private health insurance, some demand driven reflecting consumer preferences, and some supply driven due to insurers seeking to differentiate themselves and engage in price and non-price competition.

5.1 Size of the Australian private health insurance market

There are currently 12.6 million Australians covered by some form of private health insurance, that access over 25 700 private health insurance products,⁵⁷ provided across 34 registered private health insurers. This equates to an average of around 100 different (open and closed) policies per insurer in each state or territory and includes differentiated levels of both hospital and general treatment cover options.⁵⁸ Private health insurance is available to consumers alongside the public health system with contributors to private health insurance having the same rights as any Australian citizen to access the public system if they wish.

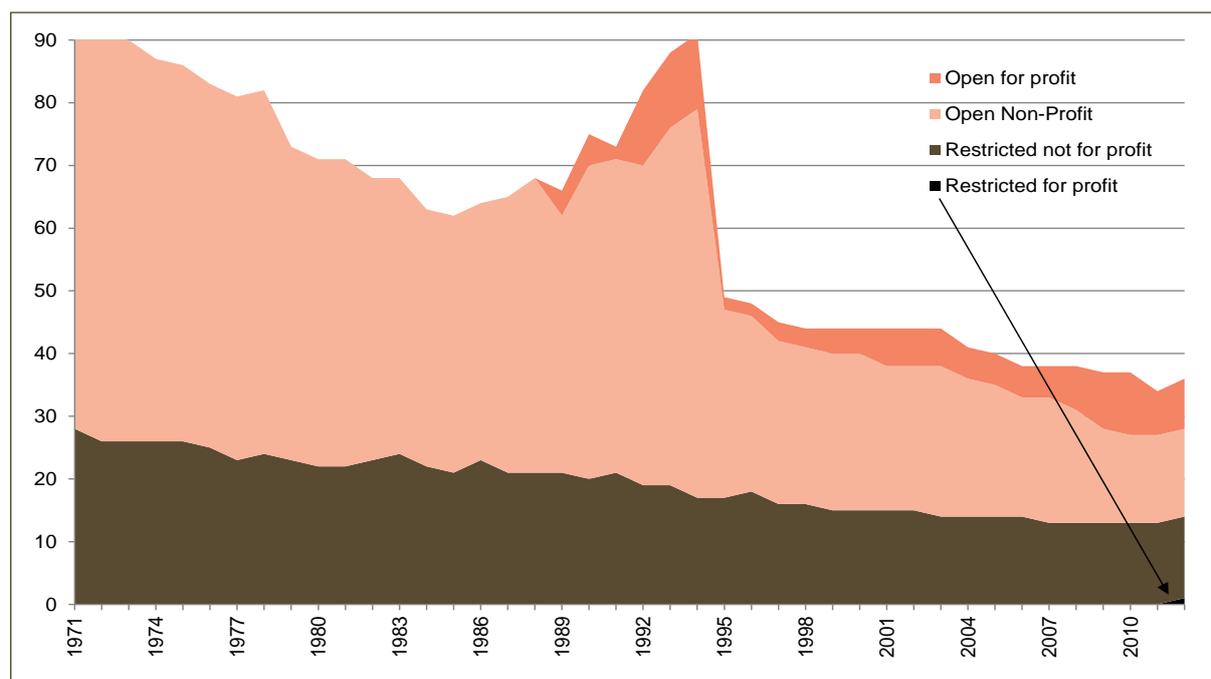
Private health insurance is embedded within the broader healthcare financing system and consumer decisions regarding coverage and use of private health insurance have a direct impact on public health services and vice-versa. Consequently, the price and quality of private health insurance plays a role in determining demand on the public health system and cost effectiveness of healthcare delivery.

⁵⁷ The state and territory based categorisation of practically identical products accounts for up to 87 per cent of this figure and many products are closed for purchase, only accessed by previous policy holders. Hence, the number of genuinely different products available in the market today is considerably less than 25 700.

⁵⁸ Identical policies offered by an insurer in different states and territories will be listed as up to eight separate policies due to state and territory variations in certain prices or conditions.

Private health insurers can be registered as an open or restricted fund, and as a for-profit⁵⁹ or not-for-profit fund. As at end-April 2013, there were 34 private health insurers, with eight for-profit (all but one are open funds) and 26 being not-for-profit (12 of which are restricted access and 14 of which are open). The two largest for-profit funds (Medibank Private and BUPA) originally operated as not-for-profits but have relatively recently changed to for-profit. **Figure 11** shows the reduction in registered funds over time and the growth in registered funds with for-profit status.

11. Number of registered health funds 1971-2012 (a)



Source: PHIAC data.

(a) Prior to 1995, the number of funds was not the same as the number of registered organisations as organisations were registered in each state or territory they were offering PHI. After national registration in 1995, the number of registered funds is equal to the number of registered organisations.

The private health insurance market is also highly diverse, beyond the distinctions between operational status, which may complicate and test the boundaries of private health insurance regulation.

For instance:

- the largest insurer in the market is a government-owned entity and has, in recent years, established a 'health solutions' company which employs a significant medical workforce and delivers a level of integrated care to policy holders;

⁵⁹ The first for-profit private health insurers began operation in 1989.

- the second largest insurer is the Australian subsidiary of a UK-based mutual, which has also recently developed integrated care delivery businesses; and
- restricted funds tend to offer a traditional range of insurance based products, and often with less restrictions and exclusions.

5.2 Market structure and composition

Not-for-profit to for-profit

Since the mid-1990s, Australia's private health insurance market has experienced a period of consolidation and an increase in the market share of for-profit providers. This combination of consolidation and demutualisation is outlined in **Table 12**.

12. Industry structure 1990 to 2012

Year (end June)	1990	1995	2000	2005	2012
Number of insurers (a)	59	49	44	40	35
Open access	39	32	29	26	22
For-profit	4	2	4	5	8
For-profit market share	0.1%	0.4%	12.5%	15.9%	68.6%

Source: PHIAC, Annual Report of the Operations of Private Health Insurers (various years).

(a) Includes AHM which merged with Medibank Private on 1 July 2012.

The increasing market share of for-profit insurers has largely come about from conversions to for-profit status in the last five years. This includes:

- the movement of NIB to for-profit status which occurred on 1 October 2007, accounting for 7.6 per cent of the market at June 2012;
- the purchase of MBF by BUPA, which occurred on 17 June 2008, with BUPA accounting for 26.7 per cent of the market at June 2012; and
- the conversion of Medibank Private to for-profit status, which occurred in October 2009, with Medibank Private accounting for 27.1 per cent of the market at June 2012.⁶⁰

There are various benefits to insurers associated with having either for-profit or not-for-profit status, although it could not, at this time, be said that either model has clearly emerged as preferable. Rather each model has its attractions and disadvantages. Not-for-profit insurers face a different tax environment,

⁶⁰ Medibank Private's market share as at March 2013 has risen to 29.6 per cent because of its acquisition of AHM with effect from July 2012.

being exempt from company tax and retaining the GST-exempt status applying within the industry as a whole, but there are much stronger restrictions on the nature and type of investments that may be made by not for profit insurers. In contrast, for-profit insurers must pay company tax, but have greater flexibility in the use of their capital.

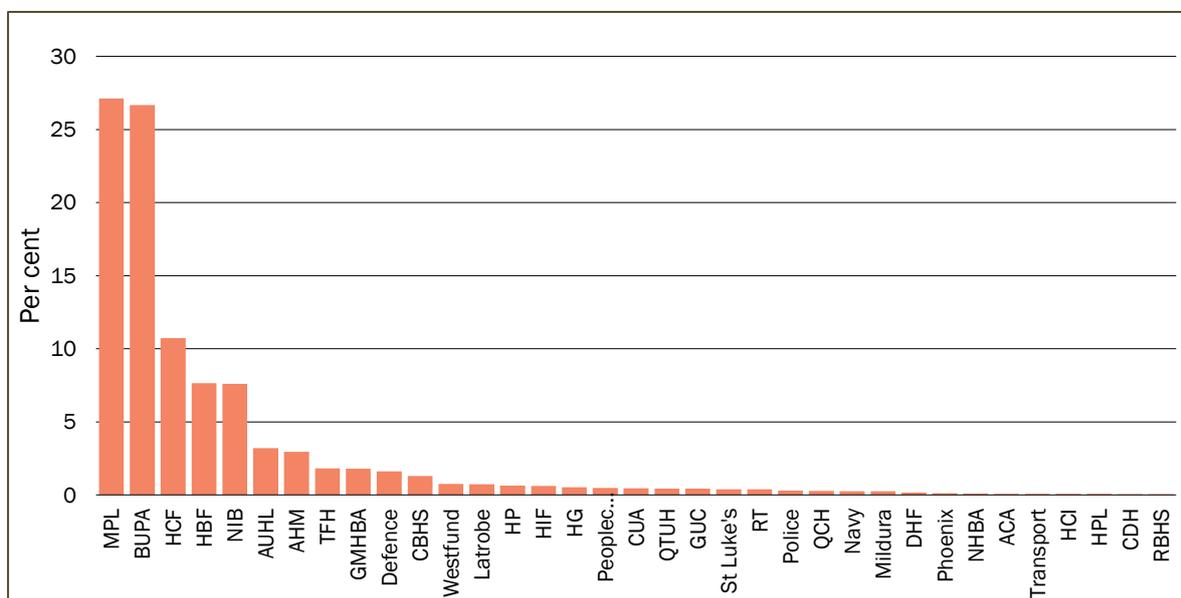
National and regional concentration and competition

Nationally, the market is significantly concentrated and pockets of concentration exist in certain geographic areas.

Australia’s private health insurance market has developed from a reasonably geographically segmented base, with individual mutual funds operating in close proximity to regional or industrial centres, or the location of medical services (hospitals). Over the years, this regionalisation has been diluted to a certain extent through growth in access to mutual funds, increasing government interaction in the private health insurance market, as well as the increasing mobility of populations.

Viewed at a national level, the market for private health insurance in Australia is significantly concentrated, despite the large number of insurers, diversity in insurance type, and a large market of over 12.6 million policy holders with some form of private health insurance.

13. Market share of individual insurers by total policies in Australia, June 2012



Source: PHIAC data.

As illustrated in **Figure 13**, the two largest insurers account for 53.8 per cent of all policies held in Australia at June 2012. However, the market does have a significant tail, with the 24 smallest insurers (each with less than 1 per cent market share) accounting for around 8 per cent of all policies in Australia.

The large number of smaller and regional insurers, able to offer a comparable level and type of service compared to larger insurers, has an important impact on competition.

Today, while the majority of private health insurers compete at a national level, with members based in most states and territories, there still remains an element of state and territory based competition, as can be seen in **Figure 14**. This more regional sub-segmentation of the national private health insurance market is mostly a legacy of historical factors associated with the development of the private health insurance market,⁶¹ and supported by state based management of health care services in Australia. It is noteworthy, in this context, that the ACCC reviews state/territory concentrations when considering the competition impacts of proposed acquisitions rather than any impacts at a national level.

Figure 14 shows a variation in market concentration across the jurisdictions. New South Wales is the least concentrated and the most heavily contested, with BUPA and Medibank Private accounting for 45 per cent of policies, and the four largest insurers (including HCF and NIB) accounting for 82 per cent of the market.

South Australia (BUPA with 54 per cent of that states' market) and Western Australia (HBF with 57 per cent) have the most heavily concentrated markets. The smaller jurisdictions provide the large national insurers, BUPA and Medibank Private, with a strong market hold, together accounting for 81 per cent of the Northern Territory market and 70 per cent of the Tasmanian market.

Participants in the industry generally agree that state/territory based competitive tensions do exist. These are most clearly seen:

- between larger incumbent insurers when new entrants are observed in a particular jurisdiction; and
- between insurers and providers where there is an increased level of insurer (or private hospital provider) concentration in a given jurisdiction.⁶²

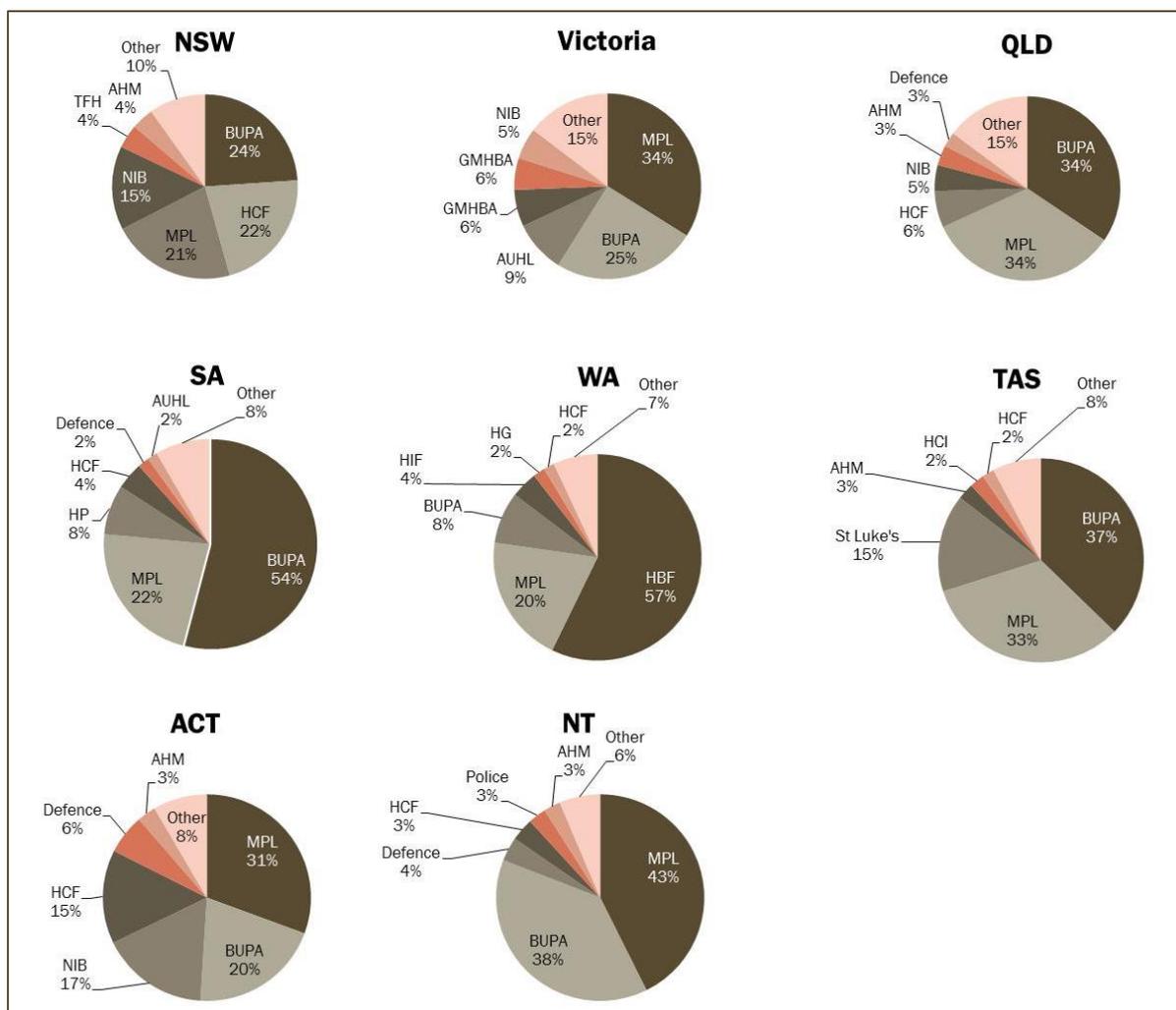
Indeed, over the past four years, the market share of the largest insurers in both Western Australia (HBF) and South Australia (BUPA) has changed with both insurers experiencing a reduction in market share since June 2008. In 2008, HBF held almost 59 per cent of the Western Australian market, and in 2012, that coverage had reduced to 57 per cent. In 2009, BUPA held 57 per cent of the South Australian market and in 2012 it held 54 per cent.⁶³ Both insurers are facing increased regional competition.

⁶¹ KPMG – submission No. 14, pages 4 and 5.

⁶² Australian Private Hospitals Association South Australia Branch – submission No. 7, page 1.

⁶³ *Ibid*, page 1.

14. State-based market share by total policies, June 2012



Source: PHIAAC data. ACT included in NSW.

The competitive tension between hospital providers and insurers is also an interesting feature of the market and can produce some striking outcomes. For example, South Australia has the highest market concentration of one of the largest national insurers, a high density of hospital facilities for the population⁶⁴ and an historical experience with low benefit payments in that sector.⁶⁵

⁶⁴ South Australia has 4.4 hospital beds per 1 000 population compared to the national average of 3.8 per 1 000 population. This is the second highest in Australia, after Tasmania (see Australian Institute of Health and Welfare 2011, Australian Hospital Statistics 2009-10, Canberra).

⁶⁵ Australian Private Hospitals Association South Australia Branch – submission 7, page 1; Little Company of Mary Health Care – submission No. 16, pages 1 and 2. The matter has attracted considerable media attention in South Australia in recent times – see “South Australia short-changed by private health funds”, *Sunday Mail*, 28 July 2012.

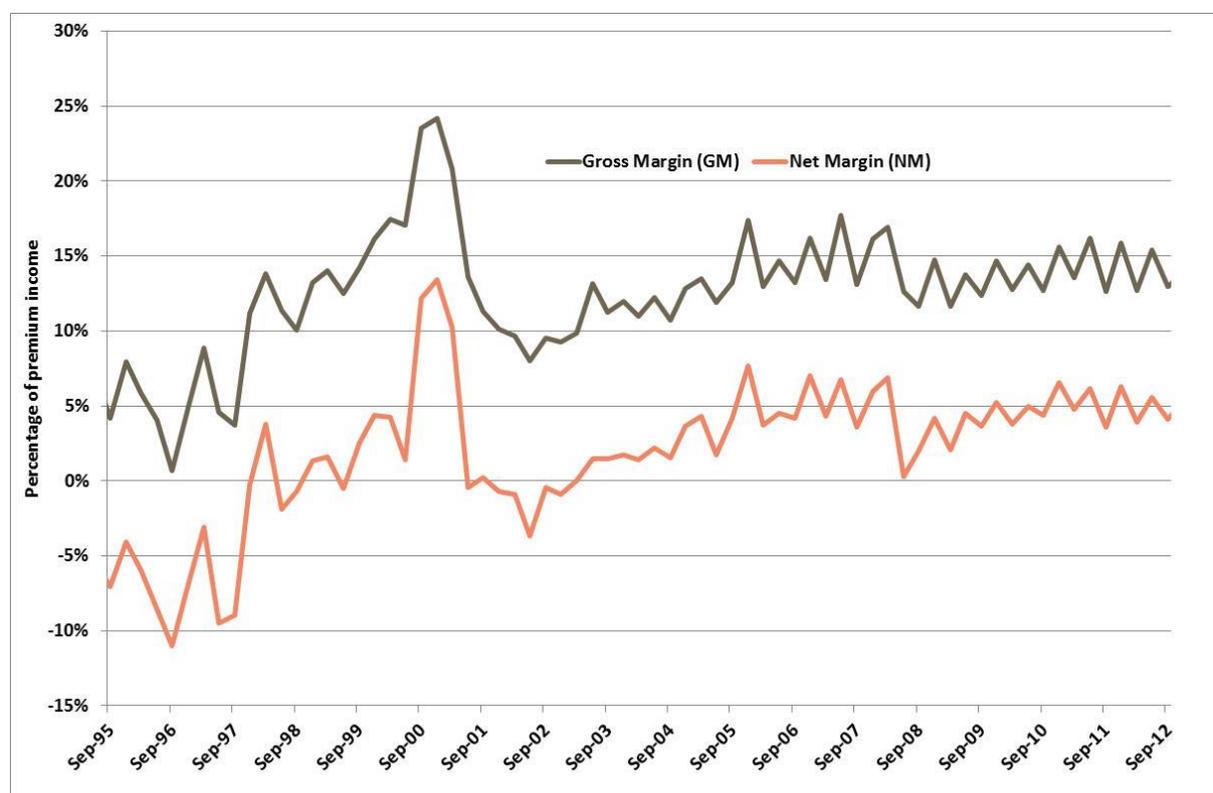
Margins and profitability

Profits have steadied in recent years and are generally strong, particularly in selected jurisdictions and for certain product types.

The profitability of the private health insurance market in recent years has been generally high by historical standards with net margins generally in the order of 3 to 6 per cent (see **Figure 15**) since 2005. The one exception was in June 2008 where the drop in net margins was the result of a large merger and a one off increase in management expenses.

While these figures can be seen to be high and more stable by historical experience, they are considered to be low compared with the wider insurance industry which realises profits in the range of 12 per cent.⁶⁶

15. Industry margins 1995 to 2012

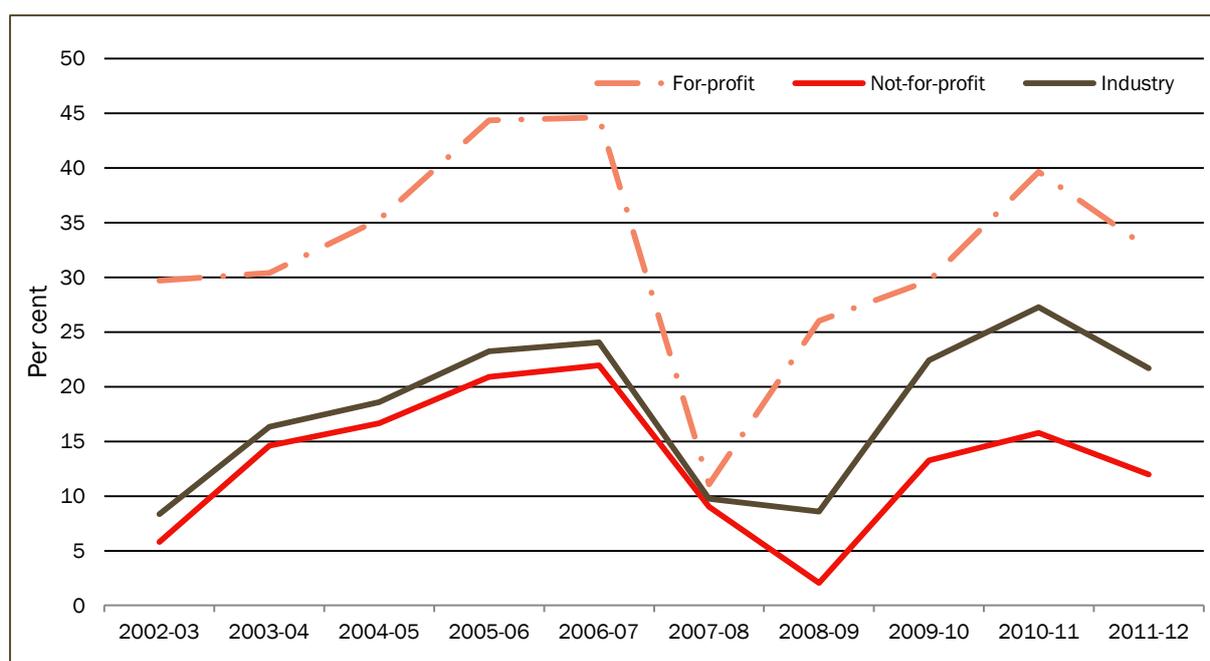


Source: PHIAC data.

Net margins at these levels have led to increases in the level of capital held by not-for-profit insurers, and to returns on capital in the order of 10 to 30 per cent across the various for-profit insurers (**Figure 16**).

⁶⁶ IBIS World (2012) *Health Insurance in Australia*, page 20.

16. Return on capital for 2002-03 to 2011-12



Source: PHIAC data.

Each year during the period from 2002 to 2005, industry premiums increased by between 6-8 per cent, which led to significant improvement in net margins in that period as premiums increased by more than benefit inflation. In the period 2006 to 2012, premiums increased between 4-6 per cent per annum. This resulted in net margins flattening out in the period since 2006.

17. Profitability of the insurers across various measures, 2011-12

	Industry-wide	Open: Not for Profit	Open: For Profit	Restricted: Not for Profit
Number of PHIs (a)	35	14	8	12
Gross Margin (b)	14.3%	11.7%	15.4%	12.3%
Management expenses (c)	9.3%	8.4%	9.9%	7.1%
Net Margin (d)	4.9%	3.3%	5.5%	5.2%

Source: PHIAC data.

(a) There is one insurer which is restricted and for-profit.

(b) Gross margin is the difference between total contribution income and the total cost of benefits. Average gross margin under each insurer category were calculated by taking the sum of gross margins across the range of private health insurers in each category and dividing by the number of insurers in that category.

(c) Management expenses are the operating expenses incurred in the course of normal insurer operations. An average of management expenses under each insurer category has been estimated.

(d) Net margin is equal to the gross margin less management expenses. The above estimates similarly refer to the average net margin under each insurer category.

Note: All averages are simple averages and have not been weighted by market share. Industry-wide estimates for each measure reflect the average across the 35 insurance providers.

However, there is considerable variability across sectors of the industry (**Table 17**) and between insurers. In 2011-12, after tax profit levels reported by for-profit insurers (excluding the new entrant health.com.au)

as a per cent of revenue ranged from 4.5 to 15.2 per cent, with management expenses as a per cent of contributions ranging from 8.6 to 16.3 per cent. In contrast, surpluses amongst not-for-profit insurers in 2011-12 ranged from 4.1 to 16.9 per cent, and management expenses ranged from 5.6 to 12.8 per cent. This shows that the variability in profitability and management expenses between for-profit and not-for-profit insurers is broadly the same.

The differentiation of margins across states and territories presents one aspect on the variability of gross margins across insurers. As shown in **Table 18**, the Northern Territory has the highest gross margin (28.0 per cent compared with a national average of 14.3 per cent), followed by South Australia (19.4 per cent) and Tasmania (18.4 per cent).

18. Gross margins by treatment type and by state/territory 2011-12

State/territory	Hospital treatment per cent	General treatment per cent	State/territory total per cent
New South Wales/ACT	12.2	23.8	12.7
South Australia	17.9	23.1	19.4
Victoria	10.9	23.9	14.0
Tasmania	15.5	27.2	18.4
Queensland	9.9	23.6	13.6
Western Australia	9.8	27.4	15.4
Northern Territory	25.0	33.6	28.0
Australia	11.7	24.3	14.3

Source: Based on PHIAC (2012) Operations of Private Health Insurers Annual Report 2011-12.

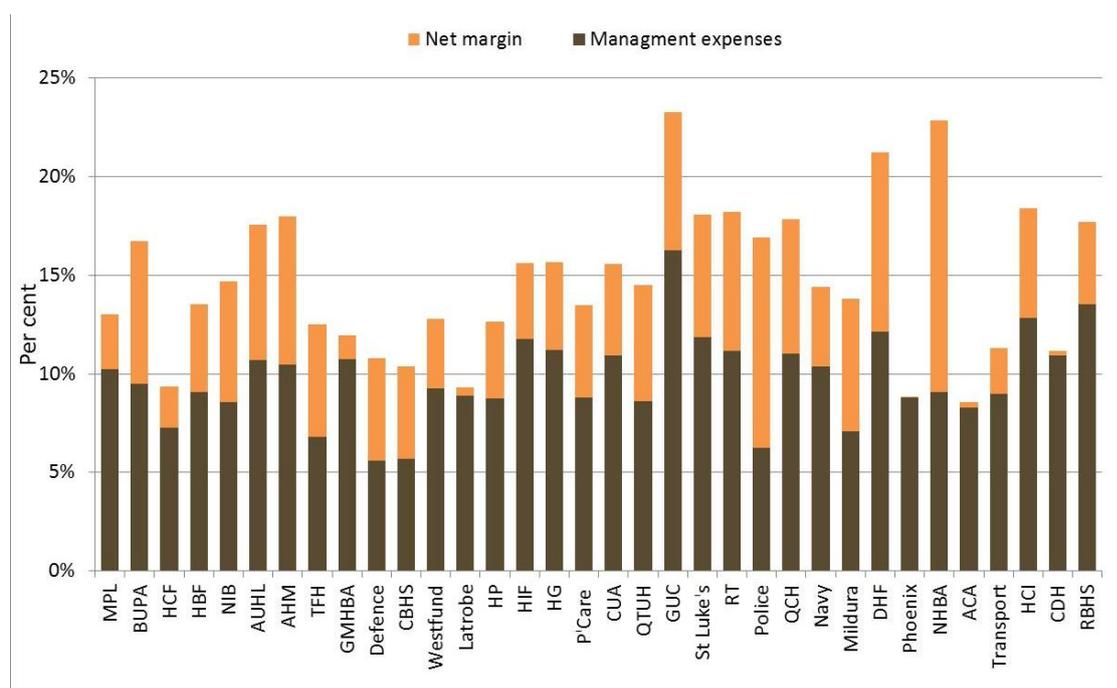
Other factors that may be affecting regional profitability include the proportion of the jurisdiction population that holds insurance policies. For example, the Northern Territory has the lowest level of coverage per head of population⁶⁷ and this contributes to a high level of profitability as the Northern Territory insured population has the lowest rate of accommodation episodes, total accommodation days and number of medical services provided.⁶⁸ Regional areas that hold a higher proportion of general treatment only policies may also observe higher margins due to the increased profitability of general treatment policies compared to hospital treatment.

Figure 19 shows variation in net and gross margins across insurers. As would be expected, there is a much higher level of variability at the insurer level (**Figure 19**) than at the state/territory (**Table 18**) or the insurer category (**Table 17**) levels.

⁶⁷ IBIS World (2012), page 18.

⁶⁸ PHIAC data.

19. Margin by insurers, 2011–12



Source: PHIAC data.

Note: HPL has been omitted due to non-representative margins for first year of operation. The sum of net margin plus management expenses represents gross margin.

These differences across insurers and insurer types may reflect different management approaches, targeting of member benefits, or shareholder returns.

While private health insurance profits as a per cent of premium revenue are relatively low by comparison with other insurance products, they are relatively high as a proportion of capital invested. In addition to the usual business drivers, like benefits paid and management expenses, private health insurance margins also reflect the regulation of annual premiums and insurer decisions and strategies to grow market share.

Industry stakeholder perspectives on the market also note that compared with other insurance industries, Australian private health insurers do not have practical access to re-insurance markets. This increases the level of risk with private health insurance which results in higher than otherwise capital levels to cover possible high claims experience in any given year. Technically, PHIs can access reinsurance markets but, in practice, this option is limited because the reinsurance provider would be required to be a registered insurer and be subject to the regulatory requirements of the industry.

Regulation of premiums and the impact on insurers' behaviour

Some insurers contend that the existing approach to price regulation dampens entrepreneurship and innovation among insurers.

Regulation of premiums set by health insurers has been a feature of the private health insurance industry in Australia for over a decade.⁶⁹ Under the PHI Act, private health insurers must apply to the Minister for Health for approval of any premium change and the Minister is required to approve this premium change unless the change is considered to be contrary to the public interest.⁷⁰ The Minister, in assessing whether a change in premiums is contrary to the public interest, will generally consider a wide range of factors including prudential and financial issues associated with a particular insurer, as well as consumer impacts and related impacts on other parts of the health system. In practice (although this is not dictated in the legislation), insurers are invited to apply for a change in premiums once a year and all insurers apply for a change at the same point in time. Any change in premiums applies on an annual basis (1 April to 31 March each year).

The annual premium regulation round is regarded by many insurers as a time-intensive task, often requiring extensive documentation and taking between 6 to 8 months or more for completion.⁷¹ The process changes introduced for the 2013 premium round have gone a long way towards addressing these concerns. A key change is that PHIAC now provides advice directly to the Minister about premium increases. The initial feedback has been that this has led to a more time efficient and transparent process.⁷²

One impact of annual premium regulation has been the narrowing in the difference between the highest and the lowest proportional annual premium changes granted since 2002 (see **Figure 20**). This is not, however, a consequence of any deliberate pricing intervention as applications for premium increases are assessed on their individual merits. The main reason appears to be that most insurers now enjoy relatively strong capital positions thereby removing the need to increase their net margin.

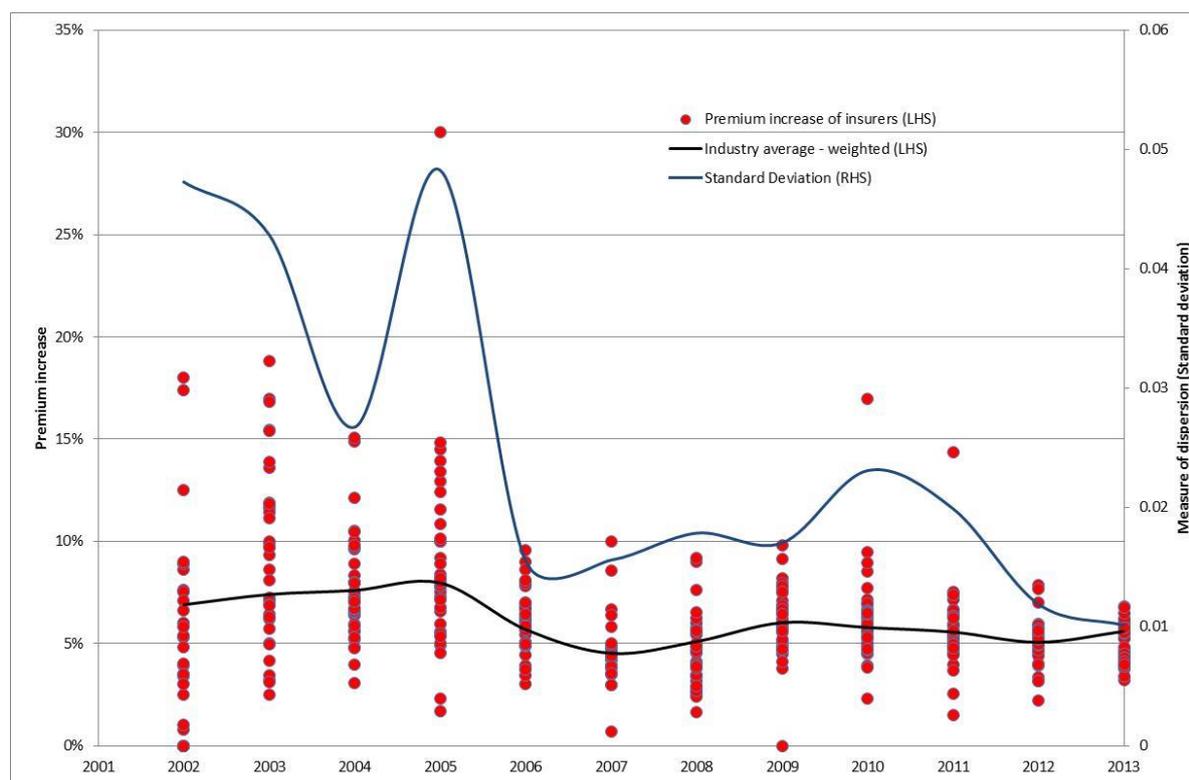
⁶⁹ For many years insurers were required to notify premium changes to the Department of Health as a form of "rule change". In the mid-1990's, a more formal process developed requiring formal application to the Minister for Health. That process has undergone a number of refinements but remains substantially in place today.

⁷⁰ PHI Act, section 66-10(3).

⁷¹ Medibank Private Ltd report by Deloitte Access Economics 'The Future of Private Health Insurance Premiums: seeking Integrated Solutions – submission No. 17, pages 44-45.

⁷² A presentation on the 2013 premium round by PHIAC's CEO is available on www.phiac.gov.au.

20. Distribution of approved premium increases



Source: PHIAC data.

5.3 Markets and submarkets for private health insurance products and services

The market for private health insurance is, in some important respects, a national market. Consumers are able to select a product from almost any registered private health insurer across the country irrespective of where that insurer is located (subject to eligible access to restricted insurers). That said, only the two largest open insurers (Medibank Private and BUPA) could properly be described as nationally-based insurers.

The private health insurance market is segmented, both from a demand and supply perspective. Many insurers target specific geographic markets and professional groups, and consumers align themselves with specific product types.

Demand side market segments

Key submarkets on the demand side include:

- **Life cycle segments.** This includes specific markets for different stage-of-life members, such as:

- young singles (below the age of 31 where the LHC measure does not have an impact, usually tailored around providing access to timely treatment to get back to work/sport);
- young people coming off family policies (largely dental and sports injury-based products);
- expecting couples;
- consumers turning 31, where the LHC measure begins to have an effect;
- older couples with children who have left home; and
- ageing Australians.

While these may be discrete market segments, they are temporary and are unlikely to characterise any one consumer for a long period of time.

- **Online only products**, with information and claims only online – this is seen as appealing to younger consumers.
- **Corporate** segments.
- **Income** segments, where basic, medium and higher cost products are offered around key price points. This is principally done through the use of varying excess levels and exclusions and restrictions.
- **Family type** segments (singles and non-singles), albeit with some overlap on lifecycle segments.
- **Country/rural versus metropolitan** segments, reflecting variable access to services. Country consumers have less ready access to private hospital services, while urban consumers have a higher preference for allied health cover and complementary medicines (naturopathy, reflexology for example).
- **Overseas visitors**, students and workers.
- **Retention markets**, with larger funds in particular developing specific products to improve member retention.

The above list demonstrates the wide variety of submarkets on the demand side. This is an indicator of insurers designing products to meet the needs of particular segments of the market, suggesting that in this respect at least, the private health insurance market is generally responsive to consumers' requirements.

Supply side submarkets

Supply side segments are equally important. As noted above, certain states are dominated by a small number of insurers, and the products on offer reflect the insurer profile, their business model, geographic cost profiles (for instance, different costs for the provision of medical services, real estate, labour costs) or membership occupation profile (for example, restricted access insurers).

State and territory based market segments are both allowed for and promoted through current regulatory arrangements. Price differentiations, which are not allowed on individual risk factors due to community rating, are permitted on a state and territory basis. This recognises differences in regional cost structures, medical systems, hospitals, claiming patterns and demographic profiles present in each state. The RETF is also operated on a state and territory basis, and is closely associated with these state and territory cost variations.

States and territories therefore constitute discrete submarkets for insurers where insurers make pricing decisions based on state and territory factors and each state and territory has a noticeably different profile of predominant insurers.

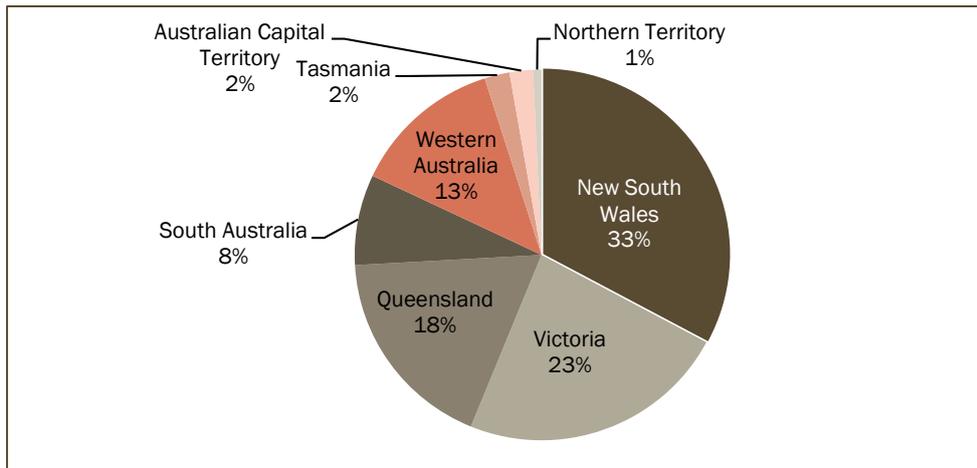
State or territory specific markets are often reinforced through the branding strategies of insurers, such as choices to use physical shopfronts to entice and service consumers (a strategy that would probably not be efficient on a national basis unless member numbers supported it). Insurers themselves will often behave as though they operate in state-specific markets.

Figure 21 shows the distribution of policies held across Australia, following closely the population distribution across states and territories. In contrast, **Figure 22** provides an overview of the distribution of policies held by insurers across the states and territories. Notably, it is only the two largest insurers that have a policy profile close to the national average, with the rest of the industry heavily targeting members in predominantly one or two jurisdictions.

There are likely to be several factors driving geographic submarkets such as:

- historical factors;
- regional consumer demands; and
- relative access to hospitals and medical services across the jurisdictions, which is largely influenced by regulation and funding of health services at the state and territory level.

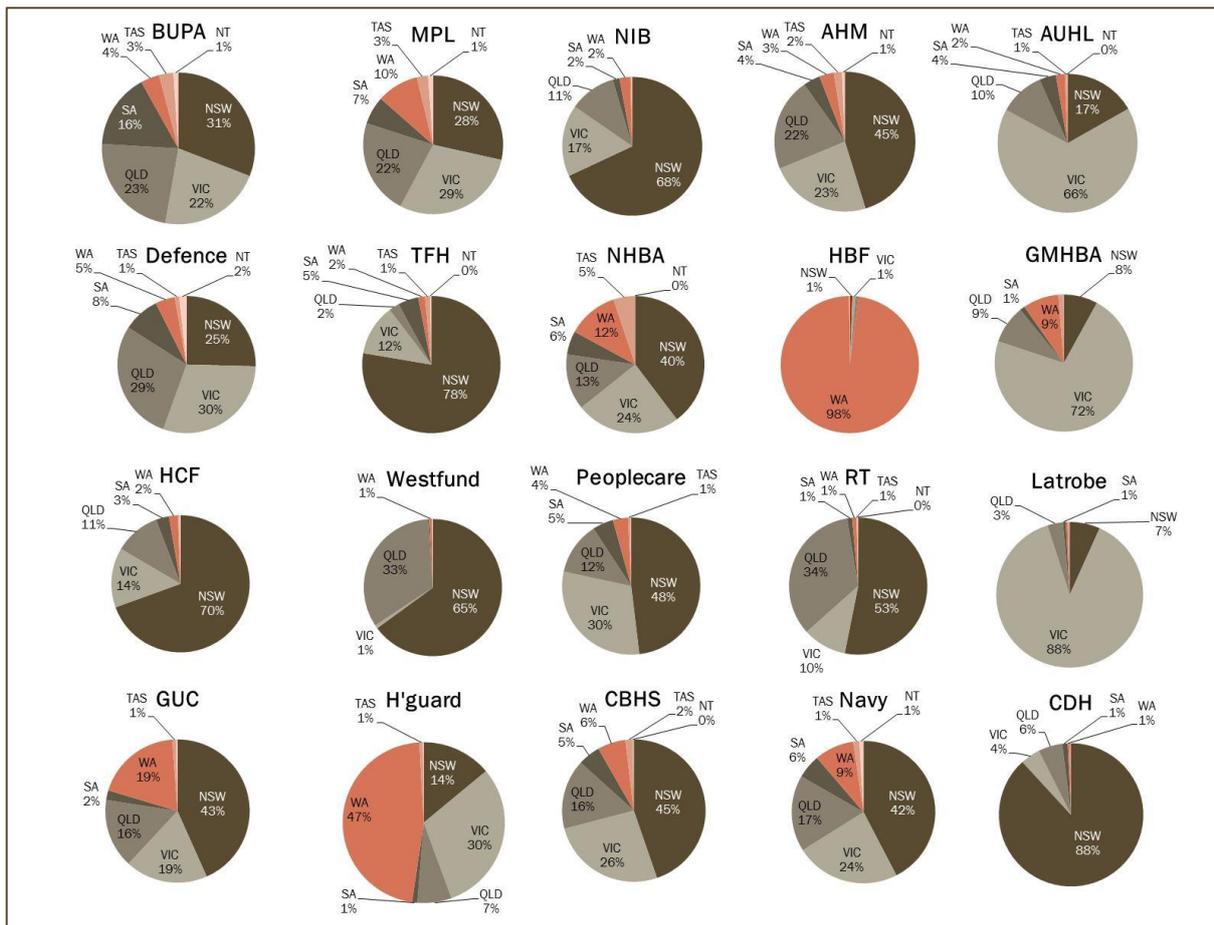
21. Distribution of policies by state and territory 2011-12



Source: PHIAAC data.

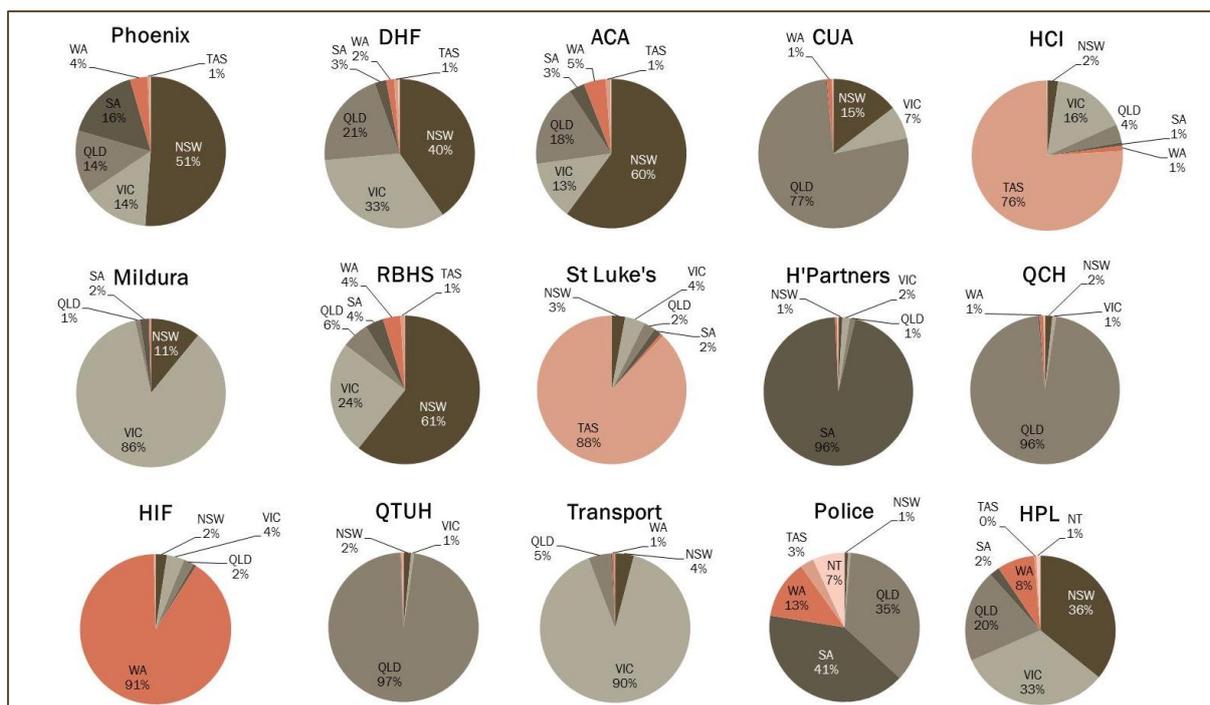
Note: NSW and ACT amalgamated.

22. Distribution of policies by state and territory 2011-12



(continued on next page)

22. Distribution of policies by state and territory 2011-12 (continued)



Source: PHIAC data.

ACT figures have been added to NSW data.

Some localised or regional markets are more narrowly defined than at the state/territory level. Generally, the membership profile of restricted, not for profit insurers in particular reflect the characteristics of their target market, indicating that more often than not these insurers are dominant in their specific market. In contrast, the market share of an open fund tends to reflect historical factors such as incumbency and dominance in particular state or geographic markets, as well as to a certain extent the level of marketing expenditure.

5.4 Product and service categories

As at October 2012, there were over 25 700 (open and closed) complying private health insurance products in Australia from 34 health insurers. Noting that state and territory based categorisation of practically identical products may account for up to 87 per cent of this figure:

- around 10 600 were hospital only products, around 4 600 general treatment only products and around 10 500 combined products; and

- around 17 700 were open for new policy holders with the remainder closed for purchase.⁷³

Aside from state and territory categorisation, private health insurance products generally fall into one of four categories including:

- **top cover hospital treatment products** that cover all services permitted to be funded by health insurers;
- **medium level cover hospital treatment products** with specific cover exclusions usually related to cardiac treatment, hip and knee replacements and maternity services;
- **low cover hospital treatment products** that typically feature exclusions, high excesses and/or co-payments and limited access to private hospitals; and
- **general treatment cover products** that typically cover dental, optical, physiotherapy and other allied services, offered either in conjunction with, or separate from, hospital cover.

From this list, there are two broad categories of submarkets that become apparent within the product ranges offered by insurers.

- The first is the use of restrictions, exclusions, excesses and co-payments, which all work to reduce upfront premium costs for members and allow members to self-select their own, perceived risk of needing to call on their private health insurance.

MANY PRODUCTS AND THEIR IMPACT ON COMPETITION

The consultation period highlighted some concern within the industry about the effect that so many different products may have on competition. Some insurers believe that the sheer number of products – and associated complexity – is inhibiting competition because consumers are unable to fully comprehend the options that are available to them.⁷⁴

The Australian Dental Association put the point succinctly when it said: *'currently it is impossible for contributors to make accurate comparisons of PHI policies and hence competition is limited'*.⁷⁵

However, this is not a universal view. Rather, the large and increasing number of different policy options is also seen by some industry stakeholders as a positive indicator of competition and innovation.⁷⁶

⁷³ Private Health Insurance Ombudsman (PHIO) data.

⁷⁴ Medibank Private Ltd report by Deloitte Access Economics 'The Future of Private Health Insurance Premiums: seeking Integrated Solutions – submission No 17, page 34-35; Little Company of Mary Health Care– submission No. 16, page 5; Consumer Health Forum – submission No. 9, page 2; Australian Dental Association Inc. – submission No. 2, page 12. It is noted that the website www.privatehealth.gov.au has been established to facilitate the comparison of different health insurance products.

⁷⁵ Australian Dental Association Inc. – submission No. 2, page 12.

⁷⁶ AHSa and hirmaa – submission No. 3, page 12; Latrobe Health Services Ltd – submission No. 15, page 3. Also see discussion below on exclusionary products.

- The second is the market for general treatment cover, both combined with and separate to hospital cover.

Each of these elements is examined in turn.

5.5 Exclusionary and excess or co-payment based policies

Recent trends

Current policy settings create incentives for consumers to take out private health insurance, particularly for higher income individuals and households. In some cases, the desire to avoid financial penalties may well be the only reason for product purchase, with the result that consumers are keen to avoid incurring premium costs for levels of cover they believe they do not require. The private health insurance industry appears to have responded to that consumer sentiment by developing a wider suite of products with important exclusions⁷⁷ and excesses, all with the aim of reducing premium costs to those consumers, preventing a loss in market share and managing the insurer's risk profile.⁷⁸

Premium regulation has also encouraged insurers to find ways to adjust their product offerings. Insurers package coverage of treatments and pricing in ways that are cost effective for them in the long run, subject to the market pressure to offer competitive policies and to retain and grow their membership base. Hence, to a certain extent, insurers facing regulated premiums with less prescriptive requirements regarding benefits can and do manage returns through adjustments to their benefit offerings within the constraints of market forces.

The result of these demand and supply side factors has been an increase in the availability of exclusionary and restricted products, as well as greater use of excess and co-payment based policies (**Figure 23**).⁷⁹

Policies with an excess and/or a co-payment requirement are more common than policies with an exclusion. Given the fact that excesses and co-payments do not limit the scope of treatment under an insurance policy, they are often considered to be a more efficient method of mitigating premium costs.

⁷⁷ A survey of policy holders identified the most common exclusions as joint replacement/orthopaedic surgery (35 per cent of surveyed), maternity/IVF programs (22 per cent) and heart/cardiovascular care (17 per cent) – see IPSOS (2011), page 209.

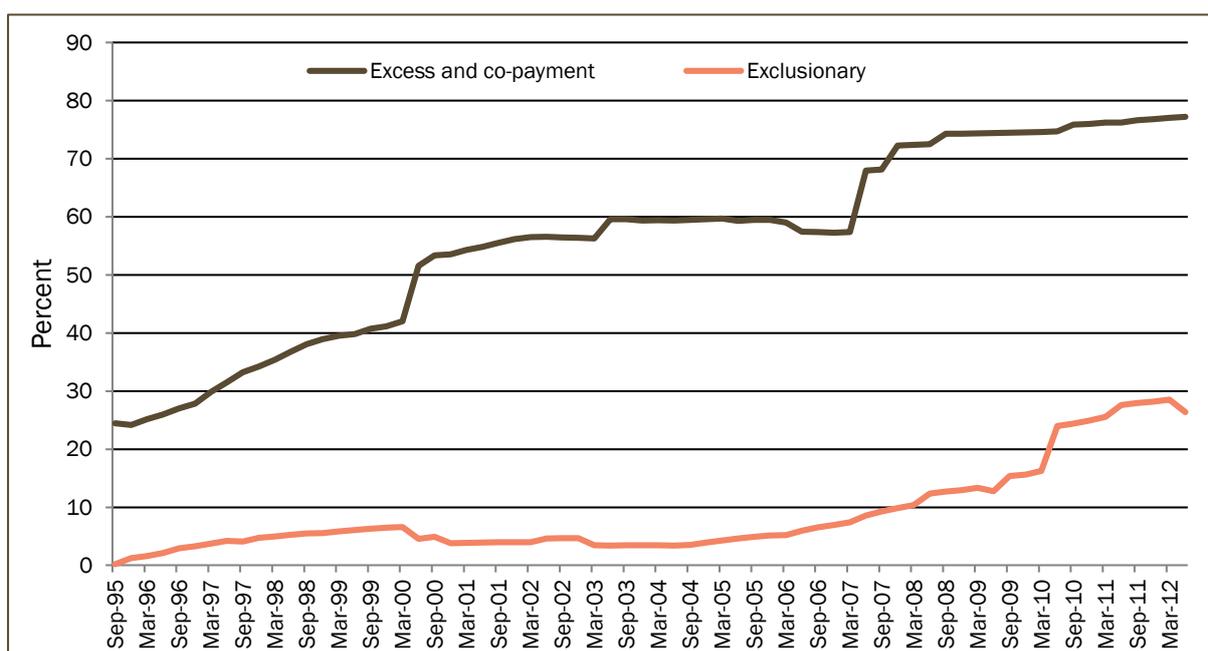
⁷⁸ Confidential submission.

⁷⁹ KPMG – submission No. 14, pages 9-10; Latrobe Health Services Ltd – submission No. 15, pages 2-3 and Queensland Teachers Union Health Fund Ltd – submission No. 19, page 3.

Approximately 77 per cent of all private health insurance hospital cover policies include either an excess and/or a co-payment requirement, irrespective of exclusions (**Figure 23**).

There is no industry level data available on the size and scope of excesses or co-payments included in policies. However, Medibank Private, for example, notes that approximately 20 per cent of members hold policies with the highest allowable level of excess for Medicare Levy Surcharge purposes (\$500 for individuals and \$1 000 for policies covering more than one person).⁸⁰

23. Percent of hospital cover policy holders with excess and co-payment or exclusionary features (a)



Source: PHIAC data.

(a) The increase in exclusionary products in June 2010 is partly due to a re-classification of policies between exclusions and restrictions by some insurers. Further, there is a break in the excess and co-payment data in June 2007 due to a change in the definition used. While the data on exclusionary products pre and post June 2010 and the data on excess and payments pre and post June 2007 is not strictly comparable, the data over the entire period can be taken as a proxy of the overall trend.

Interestingly, the increasing trend in exclusionary insurance products has not been at the expense of growth in excesses and co-payments used to mitigate premium costs, which have also been increasing

⁸⁰ Medibank Private Ltd – submission No. 17, page 12. This submission notes that the current excess limits for MLS purposes have been capped in nominal terms since July 2000. This equates to a 30 per cent real reduction since they were first introduced. With such a high proportion of policies utilising excesses, and a likely large proportion of these on the highest allowable excess, there is, it is argued, scope for these excess caps to be increased. The attendant consequences for product design and associated impacts on community ratings might need to be fully assessed before such a step is taken.

steadily over time. This indicates that exclusions are being used on top of excesses and co-payments to further mitigate premium costs.⁸¹

Impact of lower price point products on competition

Exclusionary products provide greater choice for consumers and enable better matching of premiums and consumer needs. However, this results in product complexity.

Exclusionary policies will sometimes be the most efficient and appropriate selection for a consumer who believes they will not utilise particular services, or have limited financial capacity so they limit their purchase to a product they can afford. Where policies are matched closely with an individual's risk profile, there is a limited effect on the overall provision of health services, as the individual is unlikely to require the excluded treatments in either the public or the private hospital systems. Seen in this way, the provision of well-matched exclusionary products is a rational and cost effective selection and evidence of good market behaviour where products are matching the needs of consumers.

That said, a challenge inherent with extensive exclusionary products is that a contributor's life circumstances inevitably change and levels of cover which were appropriate at one stage of life (say, mid-30s) are not so suited to another (say, mid-60s). This creates a special set of issues around the need for contributors to regularly examine their level of cover to ensure that it remains suited to their evolving personal circumstances. This need arguably sits uncomfortably, however, with the "set and forget" attitude that some consumers have where their private health insurance is concerned. Rightly or wrongly, some consumers who are in this situation become dissatisfied with their insurance when they require a treatment which is not covered.

Survey evidence suggests that about one in five consumers are unsure whether or not they are subject to restrictions or exclusions.⁸² On the other hand, the complaint rate in private health insurance is low relative to other forms of insurance.⁸³ This means that the number of complaints related to benefits and levels of cover is small compared to the number of exclusionary policies in the market.

Not all insurers support the adoption of exclusionary products preferring to offer comprehensive cover products to their members. But such insurers mostly operate in the restricted area of the industry with the

⁸¹ Consumer Health Forum – submission No. 9, page 2.

⁸² IPSOS (2011), page 208.

⁸³ KPMG – submission No. 14, page 10.

majority of open insurers now offering a full suite of products, including products with significant exclusions and/or excesses.⁸⁴

Market behaviour around excesses and exclusions

Almost 75 per cent of all non-exclusionary policies include an excess or co-payment compared to almost 85 per cent of exclusionary policies that carry an excess or co-payment requirement. That is, an exclusionary policy is more likely to have an excess or co-payment component than a policy without an exclusion (see **Table 24**).

24. Take up of exclusion, excess and co-payment policies by market segment, June 2012

Policies	Single	Family	Single parent	Couple	Total
Exclusionary policies					
Excess & co-payments	657 000	269 000	31 000	170 000	1 127 000
No excess & no co-payments	173 000	18 000	2,000	33 000	225 000
Total exclusionary policies	830 000	287 000	32,000	203 000	1 353 000
Non-exclusionary policies					
Excess & co-payments	1 226 000	862 000	75,000	670 000	2 833 000
No excess & no co-payments	413 000	216 000	23 000	292 000	944 000
Total non-exclusionary policies	1 639 000	1 078 000	98 000	962 000	3 778 000
Total policies	2 469 000	1 365 000	130 000	1 165 000	5 130 000

Source: PHIAC data.

This is more apparent in the family and single parent categories with 94 and 95 per cent of exclusionary policies respectively have excess or co-payment components compared to 75 and 78 per cent for equivalent households holding non-exclusionary policies.

PHIAC data also reveals that, while the growth in non-comprehensive cover has occurred in all market segments, the level of take up has been most prominent with singles. As shown in **Figure 25**, policies covering singles are most likely to include exclusions (representing 34 per cent of all singles policies). In contrast, the couples submarket was the least likely to hold an exclusionary policy, representing 17 per cent of policies.

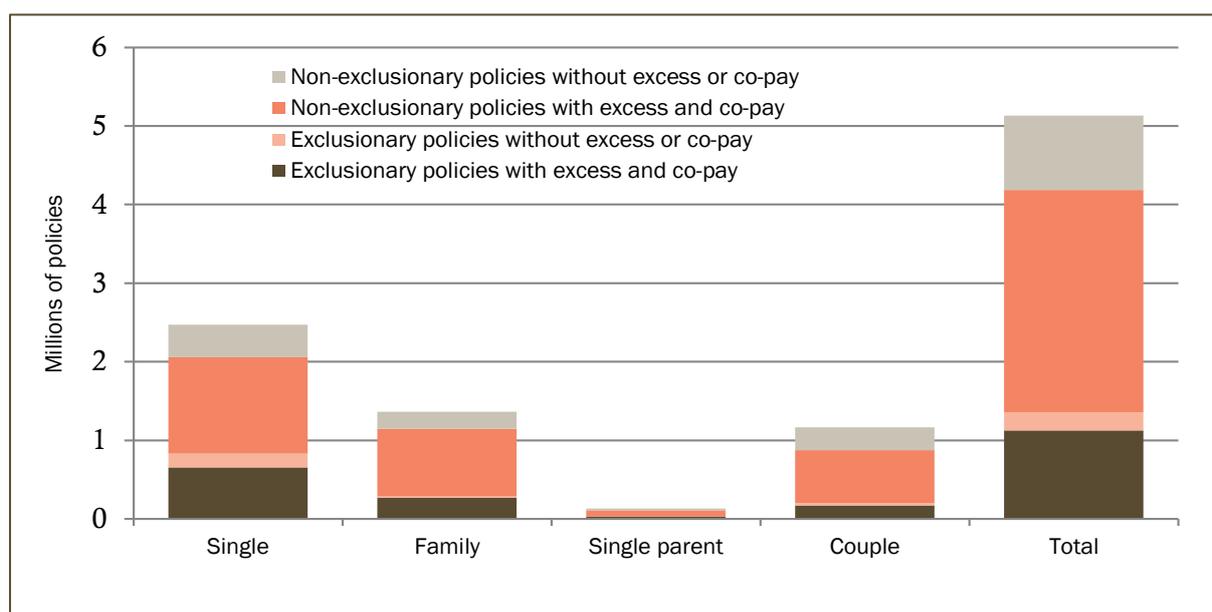
Within individual jurisdictions, states and territories with the lowest proportion of excess and co-payment-based policies are Western Australia (68 per cent) and Northern Territory (69 per cent). The anomaly

⁸⁴ HBF Health Ltd – submission No. 13, page 4; Queensland Teachers Union Health Fund Ltd – submission No.19, pages 1, 3 and 4.

appears to be singles policies issued in Western Australia, where singles are more likely to take out exclusionary policies (46 per cent) than the national average, and 18 per cent of single exclusionary policies have no excess or co-payment requirements (2.5 times greater than the national average).

Policies issued in recent years are more likely to include an exclusion or restriction than the broader population of policies already issued in the market.⁸⁵ Hence, new policy holders are more likely to take out an exclusionary policy from the outset than existing policy holders are to reduce their cover on an existing policy. This also appears to lend support to the “set-and-forget” attitude mentioned above.

25. Distribution of policy types by market segment, June 2012



Source: The CIE and PHIAC data.

Implications for risk equalisation and community rating

Exclusions are viewed by some industry stakeholders as counter-productive to community rating as they allow the healthy to reduce their premiums, leaving a greater proportion of high cost claimants in the pool for high cost services.⁸⁶ Further, some argue,⁸⁷ the increased use of exclusions may also lead to privately insured consumers choosing public hospital treatment. All Australians, of course, are entitled to public

⁸⁵ IPSOS (2011), page 208.

⁸⁶ Submissions that linked exclusionary products with adverse impacts on community rating were received from Consumer Health Forum – submission No. 9, page 2, Defence Health – submission No. 10, pages 6-8 and Little Company of Mary Health Care – submission No. 16, page 5.

⁸⁷ Latrobe Health Services Ltd – submission No. 15, page 2, while a contrary view was held by a confidential submission.

health care if they choose, but such behaviour is arguably at odds with one of the policy objectives of private health insurance which is to reduce the burden on public hospitals.⁸⁸

This ‘blurring of the lines’ between a risk rated product and a community rated product as a result of exclusionary products was noted in a number of stakeholder submissions.⁹³

Other submissions argued that, when the alternative to exclusionary products is no product at all, then exclusionary products do support community rating through risk equalisation. That is, even the most highly excluded policy makes a contribution to the risk equalisation fund which arguably may not be there if the lower cost exclusionary policy was not offered.⁹⁴

The role played by exclusionary policies is underscored by demographic considerations. With an ageing population, there is an inherent risk of increasing pressure on the public health system – especially if there is a large number of ageing members that ‘mismatch’ their policy coverage and their health condition.

STAKEHOLDER PERSPECTIVES ON EXCLUSIONARY AND RESTRICTED PRODUCTS

Stakeholder submissions to the discussion paper presented a rigorous debate around the possible market enhancements presented by exclusionary products, as well as concern for their overall effect on key pillars of Australia’s PHI market, such as community rating.

On one level, exclusionary products are viewed as examples of innovation and growth in the market, as noted by Teachers Federation Health Ltd:

‘PRIVATE HEALTH INSURERS HAVE DEVELOPED PRODUCTS WITH EXCLUSIONS AND RESTRICTIONS TO ACHIEVE A LEVEL OF PRODUCT DIFFERENTIATION... TFH CONSIDERS THAT SUCH PRODUCT DIFFERENTIATION ENABLES PRIVATE HEALTH INSURANCE CONSUMERS TO SELECT A HIGHLY TAILORED PRODUCT MOST SUITABLE TO THEIR NEEDS.’⁸⁹

Also the Australian Health Service Alliance and hirmaa indicated that:

‘INSURERS HAVE TAKEN THE OPPORTUNITY TO BE INNOVATIVE, AND DESIGN PRODUCTS WHICH CUSTOMERS WANT TO BUY... IF COMPETITION AND INNOVATION ARE OBJECTIVES OF PRIVATE HEALTH INSURANCE, FURTHER PRODUCT DESIGN REGULATIONS WOULD RUN COUNTER TO THE OBJECTIVES.’⁹⁰

Against this, St Luke’s indicated that:

EXCLUSIONARY AND RESTRICTED ‘PRODUCTS HAVE DEVALUED PRIVATE HEALTH INSURANCE; THEY FORM THE BASIS FOR SIGNIFICANT COMPLAINTS TO THE PHIO AND ARE GENERALLY TAKEN BY PRICE SENSITIVE CONSUMERS TO AVOID TAX PENALTIES SUCH AS THE MLS.’⁹¹

while the Australian Private Hospital Association South Australia Branch said:

‘THESE POLICIES ARE ANOTHER EXAMPLE OF INSURERS PASSING RISK – THIS TIME BACK TO THE POLICY HOLDER. THESE POLICIES ALSO ADD SIGNIFICANT ADMINISTRATIVE BURDEN AND RISK TO THE HOSPITALS.’⁹²

⁸⁸ Latrobe Health Services Ltd – submission No. 15, page 2; Confidential Submission(s).

⁸⁹ Teachers Federation Health – submission No. 21, page 2.

⁹⁰ Australian Health Service Alliance and hirmaa – submission No. 3, page 12.

⁹¹ St Luke’s Medical & Hospital Benefits Association Ltd – submission No. 20, page 1.

⁹² Australian Private Hospitals Association South Australia Branch – submission No. 7, page 3.

⁹³ Defence Health – submission No. 10, pages 6-8.

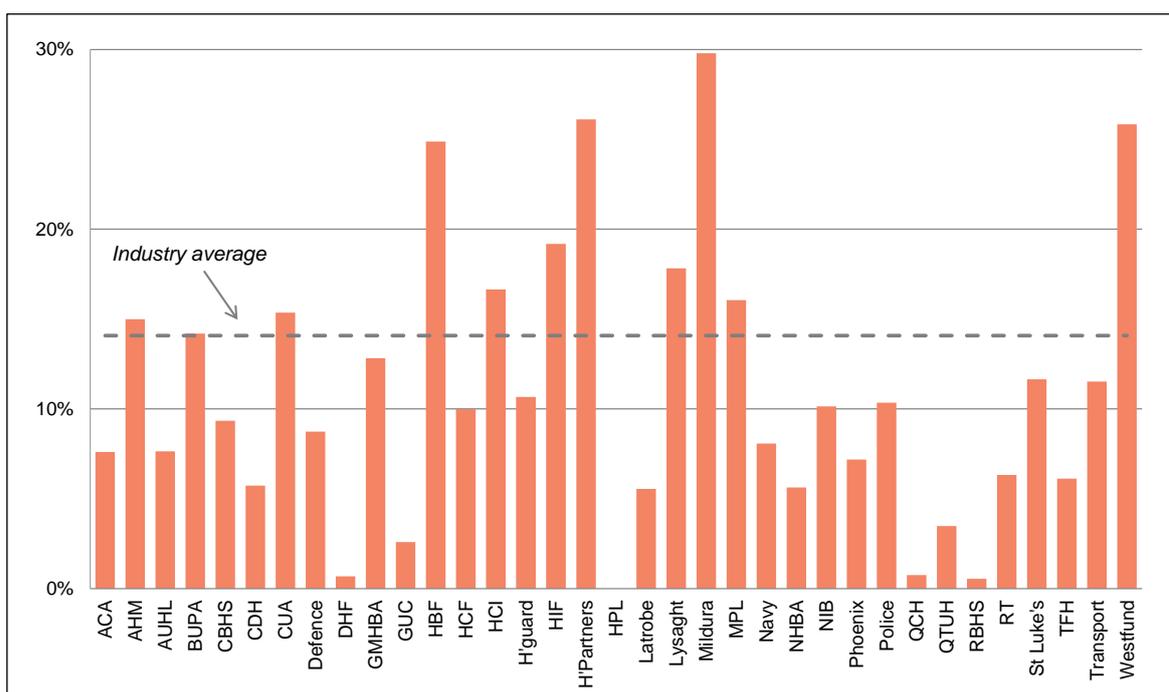
⁹⁴ AHSa and hirmaa – submission No.3, page 11.

5.6 General treatment cover - fertile ground for competition between insurers

Most funds compete on general treatment products (which provide 'instant' benefits to policy holders), in ways that appear to be attractive to health consumers.⁹⁵ General treatment products are also favoured by insurers because they are often more profitable than hospital products. As a result, insurers are increasingly differentiating themselves on the general treatment only-type products.⁹⁶ This is resulting in a small increasing trend in the take-up of general treatment only policies, from 13.0 per cent of the total market in June 2009 to 14.1 per cent in June 2012.

Figure 26 shows the insurers with more than the national average proportion of general treatment cover only policies (that is, more than 14.1 per cent) including HBF, Westfund, Health Partners, HIF, Lysaght Peoplecare, Mildura and HCI. However, reflecting their overall market shares, Medibank Private and BUPA jointly hold 57.0 per cent of all general treatment only policies in Australia, followed by HBF holding 13.0 per cent.

26. Insured persons with general treatment only cover as a proportion of total insured persons June 2012



Source: PHIAC data

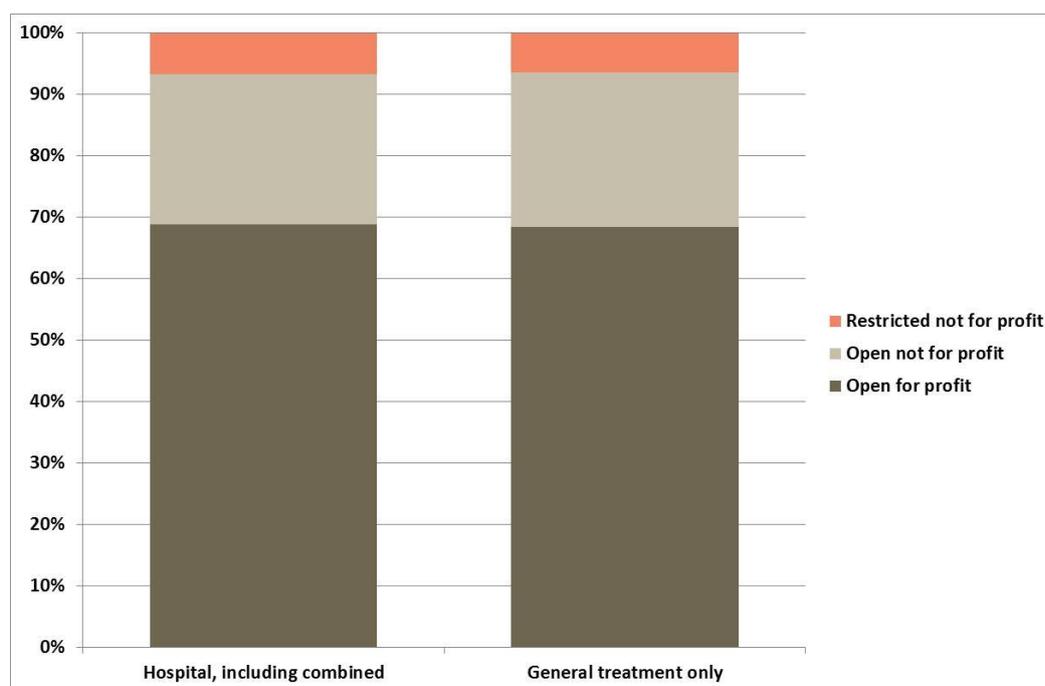
⁹⁵ Teachers Federation Health Ltd – submission No. 21, page 2; KPMG – submission No. 14, page 10.

⁹⁶ Peter Carroll – submission No. 18, page 7; Australia Physiotherapy Association – submission No. 5, page 4.

General treatment only cover might be particularly attractive for consumers in regional areas, where there may be limited access to regionally based private hospitals to enable hospital cover to be utilised.⁹⁷

Figure 27 illustrates the division of policies, by type, across insurers, by operating status. It shows that there is not a large distinction across the different types of insurers. Data is not available showing the take-up of hospital and general treatment products between the capital cities and regional areas.

27. Market share by insurer coverage type, 2011–12



Source: PHIAC data.

When surveyed, consumers note that dental and optical are, and have remained, the most important components of their general treatment cover.⁹⁸ These two key health areas have limited public health coverage, but large effects on health outcomes.

As reported in PHIAC data in ‘Membership Trends, Australia” (PHIAC), approximately 2 million people hold general treatment cover policies only, with this number growing annually. Unlike hospital cover products, general treatment cover products are not subject to a LHC loading. There has also been a slight increase in the number of policy holders surveyed that report dropping their hospital cover, but maintaining their general treatment cover.⁹⁹

⁹⁷ St Luke’s Medical & Hospital Benefits Association Ltd – submission No. 20, page 2.

⁹⁸ IPSOS (2011), pages 170 and 174.

⁹⁹ IPSOS (2011), page 217.

Extensive use of general treatment policies in Australia demonstrates their importance to insurers and members. Covering treatments that are generally not supported by Medicare, general treatment policies also have an important role in engaging primary health care services for promoting and maintaining health and wellbeing, most notably dental, optical and physiotherapy services.¹⁰⁰ However, similar to exclusionary hospital treatment policies, the use of annual and lifetime service limits have the potential to confuse or disappoint less well informed consumers at the point where costs are claimed.

5.7 Consumer claims perspectives

An industry-wide survey of private health insurance members conducted in 2011 – the IPSOS report¹⁰¹ which canvassed the views members held about their insurer and the wider private health insurance industry – confirmed that private health insurance is largely regarded by members as both important and worthwhile.¹⁰² While this finding would be a source of gratification for the industry, not all consumers have a completely satisfactory experience. To address this concern, the Private Health Insurance Ombudsman (PHIO) has been established to assist consumers to redress their concerns about private health insurance. The areas which most regularly generate complaints to PHIO are the following:

- orally received information from insurers (261 out of 2 995 complaints);
- policy benefits – hospital exclusion/restriction (215 out of 2 995 complaints); and
- waiting periods – pre-existing conditions (207 out of 2 995 complaints).

28. PHIO complaints register 2011-12

Complaint category	Number of complaints	Key issues
Benefits and level of cover	1091	Inadequate cover levels, payment delays, gaps
Service issues	573	Premium payment, customer service, delays in service
Membership issues	492	Policy cancellation, clearance certificates, suspending and resuming, continuity of benefits
Information	400	Oral advice by insurers, belief that policy change not advised
Pre-existing condition waiting period	207	Pre-existing condition waiting period
Rule changes	72	Reduction of services in hospital policies, adequate notice
Informed financial consent and hospitals	54	Unexpected gaps for hospital services

Source: Compiled from PHIO (2012) PHIO Annual Report.

¹⁰⁰ Australian Physiotherapy Association – submission No. 5, page 4.

¹⁰¹ IPSOS (2011), page i.

¹⁰² IPSOS (2011), pages 174-176.

PHIO has noted that communication issues are at the heart of most complaints received.¹⁰³ **Table 28** outlines the major complaint categories received by PHIO, the number of complaints and the key issues of concerns for members.

Common consumer concerns – recent trends

In 2010-11, there was a notable increase in the number of complaints received by PHIO compared to previous years. The increase was not uniform across the industry, and was confined to a small number of insurers that had changed policy conditions during the year. The complaints regarding hospital treatment exclusions tended to be received following ‘the imposition of exclusions to existing policies, changes to the level of excesses, changing policy restrictions to exclusions for certain services, and moving major dental treatments into the general treatment category, thereby reducing the benefit entitlements’.¹⁰⁴ Further, it was noted by PHIO, that in most of these cases, communication with members was not sufficient, to the point where many members were unaware of any changes in their policy coverage until their claims for a benefit were rejected.¹⁰⁵

In 2011-12, policy exclusions remained a main category of complaints for consumers.¹⁰⁶ Further, when surveying consumers, it was found that the issue of what is and what is not covered is one of the main issues confusing current private health insurance holders (32 per cent).¹⁰⁷

Gap payments payable by consumers have risen slightly over the years

The IPSOS survey found that approximately 44 per cent of surveyed members claiming against private hospital insurance incurred out-of-pocket expenses (known as gap payments). This proportion has been increasing over recent years – from 39 per cent in 2007.

The position varies across Australia - only 27 per cent of South Australian claimants faced a gap, while 56 per cent and 52 per cent of claimants in the Northern Territory and Australian Capital Territory faced gaps respectively.

Of those members who were admitted to a private hospital, 17 per cent were dissatisfied with gap payments they faced. However, the IPSOS survey indicated that while 67 per cent of patients are

¹⁰³ PHIO (2012) Annual Report 2011-12, page 9.

¹⁰⁴ PHIO (2012) Annual Report 2011-12, page 40.

¹⁰⁵ PHIO (2011) State of the Health Funds Report 2011, page 7.

¹⁰⁶ PHIO (2012) Annual Report 2011-12, page 9.

¹⁰⁷ IPSOS (2011), page 185.

getting some information about the gap payments they face, there is still room for improvement.

The IPSOS survey concluded that 'privately insured patients are less upset about "wearing" a gap with 74 per cent of patients reporting 'no negativity towards any person or organisation as a consequence' and only 9 per cent noting negative feelings towards their private health insurer.

The size of the gap payment required is obviously relevant to this outcome with an average private hospital gap payment of \$984 in 2011, and one in five private hospital gaps being over \$1 000.¹⁰⁸

At the more extreme end of the spectrum, the Consumer Health Forum in a recent publication has described the experience of a private hospital patient that incurred more than \$30 000 primarily in medical gaps. In the end, the patient was unable to meet the costs of their treatment and was left wondering about the value of private health insurance.¹⁰⁹

Gaps and out-of-pocket expenses were reported by surveyed consumers to be the second most confusing element of their private health insurance policy (19 per cent of respondents). This result was highest in Tasmania (35 per cent) and Northern Territory (22 per cent).¹¹⁰

HOSPITAL TREATMENT – THE CONSUMER'S FINANCIAL PERSPECTIVE

The financial impact of an episode of hospital care on a consumer will depend on the following factors:

- The excesses, exclusions, restrictions or co-payments that are applicable under the consumer's policy.
- Whether the treating medical providers have a 'no gap' or 'known gap' agreement with the consumer's insurer.
- Whether high cost non-PBS drugs were used, or if a prosthesis with a permitted gap is implanted and how these elements are covered in their policy.
- Whether there is an agreement between the insurer and the hospital. The agreement will specify the services and the amount the insurer will pay the hospital. Some non-essential in-hospital services such as private room and pay TV charges may be included as well as some post discharge services such as home nursing care and discharge medication. If these are not included in the agreement, the patient may face an additional charge. If the insurer does not have an agreement with the hospital, then extra charges may apply. The insurer will be required to make a minimum (default) payment and the patient may be required to pay the difference between that amount and the hospital charge.

Prior to any hospital treatment a patient should be informed about and agree to the financial implications (ie. informed financial consent (IFC) should be obtained). IFC requires the provision of cost information (preferably in writing) to patients, including notification of likely out of pocket expenses (gaps), by all relevant service providers.

¹⁰⁸ IPSOS (2011), pages 104 and 107.

¹⁰⁹ Health Voices – Issue 12 April 2013 "Out of pocket costs and breast cancer" Leonie Havnen, pages 9-10.

¹¹⁰ IPSOS (2011), pages 186.

Through PHIO, it was noted that where there were complaints lodged about doctors and practitioners, these were generally associated with medical gaps and/or a lack of financial consent. This is similar to complaints about hospitals which were around unexpected gaps or a lack of informed financial consent (54 complaints directed at hospitals in 2011-12). There were 44 complaints in 2011-12 regarding hospital gap payments in general.¹¹¹

¹¹¹ PHIO (2012) Annual Report 2011-12, page 40.

6. Market conditions that affect competition

There are two broad elements to private health insurance competition. The first being its interaction with the public system, Medicare, and the role played by private health services to support the public system. The second is between insurers as each competes to attract and retain policy holders.

The current regulatory framework for private health insurance has been developed in the context of a national health insurance system, namely Medicare. The availability of universal “free” cover for many forms of medical treatment, including hospital admissions, has fundamentally impacted the way the private health insurance industry has developed in Australia. Products offered in the private health sector, therefore, are designed to support and supplement cover which is otherwise available, and to offer additional “value” to consumers beyond that available through the public system. In addition, the flow of premium revenue into the private health sector provides a source of funds to deliver health care to Australians which is not primarily sourced from the public system. This reduces the strain on the public system to the advantage of all.

Accordingly, the rules governing complying health insurance products have been designed to promote private health insurance products as a viable and attractive supplement to the cover available under Medicare. Insurers are therefore able to focus their resources on competing within the private health insurance market to enhance the efficiency and quality of private health insurance services and value to policy holders. Hence, competition *between insurers*, rather than with the public health system, is the key focus of interest in understanding the competitiveness of the private health insurance sector.

6.1 Measuring competition in a market

Various measures of market competitiveness point to reasonably good competition in the private health insurance market.

Quantifying or assessing the level of competition within any given market is a complex process. This is especially so in highly-regulated markets such as the market for private health insurance. However, there are a few recognised indicators of the level of competition that have been applied to Australia’s private health insurance market.

One of these is the so-called Herfindahl-Hirschman Index (**HHI**) which is used as a measure of concentration in a market based on the distribution of market share held by participants. Australia's private health insurance industry has been estimated to have a HHI of 19. This is considered to be a moderate level of concentration as defined by the United States Department of Justice, which uses this measure to determine anti-competitive behaviour in anti-trust cases. This estimate is compared with the New South Wales and Queensland markets for compulsory third party insurance which return HHIs of 20 (borderline moderate to high concentration) and 33 (high concentration) respectively.¹¹² Given the significant market share held by the two largest insurers alone and the five largest insurers collectively, the presence of a long tail with many very small insurers heavily influences this result.

Other measures of market competition take a more qualitative view, assessing the strength of different market characteristics. For example, Harvard Business School Professor Michael Porter's Five Forces¹¹³ considers the power of suppliers, the threat of new entrants, power of customers, threat of substitute products, and level of competitor rivalry. A recent assessment based on these five factors found that competition in Australia's private health insurance market is moderate overall, with a strong level of power held by suppliers, a weak threat of new entrants and moderate influences from customers, threat of substitute products and level of competitor rivalry.¹¹⁴

In addition, an assessment based on the ACCC merger factor criteria also found that Australia's private health insurance market has a moderate level of competitiveness.¹¹⁵

6.2 Market conditions for incumbent insurers, and potential market entrants

Barriers to entry

Some barriers to entry do exist, although adverse competition impacts are less clear.

The Australian private health insurance market is characterised by many insurers that have had long tenure in the market. While there has been a trend towards industry consolidation in the market, this has generally occurred through smaller insurers being acquired by larger insurers.

¹¹² Reid, J. (2012) *Should Private Health Insurers be more competitive?* Actuaries, August 2010, page 10.

¹¹³ Porter, M.E. *Competitive Strategy*, Free Press, New York, 1980.

¹¹⁴ Medibank Private Ltd – submission No. 17, page 18.

¹¹⁵ *Ibid*, pages 19 to 21.

As KPMG's submission noted, long tenure provides benefits through the build-up of corporate and market knowledge and the accumulation of a large book of policy holders which recognise, and are often loyal to, a brand.¹¹⁶ Tenure also provides for entrenched market presence, brand recognition by new or transferring members, as well as experience and knowledge of the industry and the methods and processes for contract and provider negotiations.¹¹⁷ A further advantage of long tenure in the market is the access to intergenerational policy take-up, children growing up and joining their parent's insurer. That is, tenure provides some advantage in accessing the younger market although this traditional "channel" of new members may be weakened by the increased use and access to online information and online reviews especially by younger consumers.

Despite long standing tenure, insurers continue to evolve the products they offer, in some cases significantly, which has helped the industry to innovate and expand the boundaries of service offerings, in some ways redefining the role of private health insurance itself. This may reduce the advantage of incumbents over new entrants, as insurers are increasingly looking forward rather than backward in defining their value proposition and role in the health financing system.

The three newest market entrants have entered the market in markedly different ways. BUPA entered the Australian market through the acquisition of AXA Australia Health Insurance, which operated HBA and Mutual Community, some of the oldest private health insurance funds in Australia. NHBA obtained all of its management and operational services from an existing insurer, while health.com.au entered as a new and stand-alone entrant.

These entrants faced some similar, and some different market entry barriers. BUPA faced the costs of its acquisition while NHBA and health.com.au were required to build a holding of liquid assets required to meet solvency and capital standards.

On the surface, the profitability of the industry measured by the returns to capital appears favourable for new entrants. The return on capital for private health insurers over recent years has been between 20 and 50 per cent for for-profit insurers,¹¹⁸ which in other markets would be a very strong incentive to attract new entrants.

¹¹⁶ KPMG – submission No. 14, page 14.

¹¹⁷ HBF Health Ltd – submission No. 13, page 8.

¹¹⁸ PHIAC unpublished data.

The limited number of new entrants to the market may signal that potential new entrants face barriers to entry but may also be symptomatic of the effects of broader market conditions and perceptions that current returns may not be maintained over the long term.

The private health insurance market has also addressed economies of scale access issues through the development of industry links through claiming technology and association based negotiations for key purchases such as hospital contracts.¹¹⁹ Where ordinarily the lack of (or access to) economies of scale in negotiation and service provision for members would be a benefit for incumbents over new entrants, in the private health insurance market, new entrants have shown that it is possible to join these networks to assist in establishing a market presence.

Regulatory requirements also play a role, for example, capital and solvency standards for private health insurers and their health benefit funds requiring new entrants to hold reasonable amounts of capital in reserve prior to qualifying for registration. The accumulation and retention of the requisite capital is sometimes a challenge for insurers, but is clearly justified as a prudential measure to protect customers.

Submissions to the discussion paper identified four primary factors influencing the decision of potential new entrants to the industry:

- an existing high level of competition, entrenched brand loyalties and the relative “apathy” of many consumers making it difficult for new entrants to be attractive to consumers;¹²⁰
- a mature and saturated market, which can create diminishing marginal returns to investment;
- regulatory requirements such as minimal capital rules and pricing oversight; and¹²¹
- sovereign risk associated with the high levels of government incentives found in the industry (and the associated risk that that assistance might be reduced or withdrawn).¹²²

¹¹⁹ Associations include AHSA and ARHG for provider contracting, HAMBS for claims processing and hirmaa for member representation to Government.

¹²⁰ Little Company of Mary Health Care – submission No. 16, page 6.

¹²¹HBF Health Ltd – submission No. 13, page 7.

¹²² HBF Health Ltd – submission No. 13, page 7; KPMG – submission No. 14, page 14; St Luke's Medical & Hospital Benefits Association Ltd – submission No. 20, page 2.

6.3 Where insurers compete

Insurers compete on price and non-price factors, with the latter gaining increasing momentum over time.

The way insurers interact and compete with each other is heavily influenced by the overarching regulatory regime. The various price and non-price areas in which insurers can compete include:

- **Price:** All premium changes are regulated and must be approved and any discounting to policy premiums must meet the Complying Products Rules (for instance a maximum discount of 12 per cent is only allowable under specific circumstances, such as premiums paid in advance or electronically).
- **Scope of cover:** Restrictions and/or exclusions apply and there are minimum treatment requirements that must be included in a policy in order to be a complying health insurance product.
- **Excess and co-payments:** This includes upfront payment (irrespective of number of days in hospital) or co-payments (per day contribution to hospital costs), with maximum allowable excess requirements for MLS of not greater than \$500 per annum for individuals and \$1 000 per annum for policies with more than one person.
- **Availability of services including health related businesses and services:** This is generally developed based on the locality of the majority of members, targeting policies to the locally available services.
- **Extent of cover:** This relates to agreements with hospital and medical providers, and which may include gap free or known gap services with certain medical providers.
- **Waiting periods:** Insurers can waive or reduce prescribed maximum waiting periods.

New areas of operation for private health insurers

Whether driven by regulatory or market based factors, insurers are increasingly seeking to differentiate their member offerings beyond their core business of health insurance.¹²³ Health related businesses such as the provision of dental clinics, eye clinics, hospitals and medical clinics, coverage/indemnity for people not eligible for Medicare (international students and visitors) and chronic disease management plans have become more prevalent.

So-called “wellness services”, usually covered by general treatment policies (such as nutritionists, dieticians, and exercise physiology), are increasingly in demand by consumers and a good example of

¹²³ HBF Health Ltd – submission No. 13, page 8; Australian Unity Health Ltd – submission No. 8, pages 2 and 3.

how product offerings have been expanded while still operating within the existing regulatory framework. The development of wellness packages has been, in part, a response by insurers to compete for new and switching members. When considering the competitive effects of insurers expanding outside their core business areas, there is the potential for scale efficiencies in designing and offering wellness programs to arise. However, this has not been mentioned as a concern in the market and this form of product innovation is generally considered to have been a positive both for the industry and consumers.

The expansion of insurers vertically along the health supply chain into dental and optical clinics has been viewed with more concern.¹²⁴ Where insurers and providers often have different financial incentives there is a risk that vertical integration will require compromise on one or other side of the equation. This is an area which is still evolving and will continue to be of interest to regulators.¹²⁵

6.4 Small insurers can compete against large insurers

Small insurers can compete against the large and dominant national insurers. This keeps the market diversified and responsive to consumer needs.

As noted earlier, the private health insurance industry comprises a small number of large insurers and a large number of small insurers. The 24 smallest insurers (each with less than 1 per cent market share) account for only about 8 per cent of all policy holders in Australia but remain an important competitive element. To remain competitive, their business processes must be broadly as efficient as the processes employed by the larger firms which enjoy economies of scale commensurate with their higher transactional volumes and investment capacity. These smaller firms have sought the required efficiency levels through adopting joint negotiation and management arrangements for private hospital contracting (through the Australian Health Services Alliance (AHSA) and the Australian Regional Health Group (ARHG)) and claims processing via the Hospital and Medical Benefits System (HAMBS), which provides centralised access to software to manage their billing and more complex specific programs (such as wellness and chronic disease management programs for example).¹²⁶

The regulatory arrangements governing PHI also limit advantages that may otherwise have been available to larger businesses. In particular, the *PHI Act* requires private health insurers to operate their

¹²⁴ Australian Private Hospitals Association South Australia Branch – submission No. 7, page 4; Australian Dental Association submission No. 2, page 13.

¹²⁵ ACCC (2012) *Report to the Australian Senate on anti-competitive and other practices by health funds and provisions in relation to private health insurance*.

¹²⁶ AHSA & hirmaa – submission No. 3 page 11; KPMG – submission No. 14 page 15; Little Company of Mary Health Care – submission No. 16, page 7.

private health insurance business out of a separate health benefits fund that can only be used to conduct health insurance business and health related business. Business activities that are explicitly restricted in the *Private Health Insurance (Health Insurance Business) Rules 2010*, include accident and sickness insurance, liability insurance or any other insurance business.

It is also significant that the effects of individual private health insurer size on their membership risk profile are ameliorated by regulation, via the risk equalisation fund. This fund attempts to match all insurers with an effective (or net) claims history as though they were supporting the full Australian private health insurance market. In doing so, risk equalisation lessens the need for private health insurers to increase their size and cover a membership base with a risk profile very close to the total Australian population. Notwithstanding the risk sharing aspects of risk equalisation, economies of scale (that is, falling unit costs as output increases) still exist, largely associated with the procurement and delivery of services to members.

Other features of the market that enable smaller insurers to remain competitive include:

- regulatory safety nets, such as Second Tier hospital contracts, which stipulate a floor to prices paid to registered hospitals;
- prudential advice provided by PHIAC to support capital adequacy;
- the disconnect between the funding and provision of key cost components for private health insurers including prostheses and specialist fees; and
- the availability of intermediaries provide an additional sales channel which can substitute or reduce investment in sales and marketing.¹²⁷

Smaller insurers also typically have a restricted membership/policy holder base, which confers the benefits of selectivity in their customer/claimant pool and consumer loyalty, which further offsets the advantage of scale of larger insurers. The existence of restricted access funds is evidence that the industry is able to support a diversity of business models.¹²⁸

¹²⁷ AHSA & hirmaa – submission No. 3, page 25.

¹²⁸ Teachers Federation Health Ltd – submission No. 21, page 4.

6.5 Product diversity: driving price and non-price competition between insurers

The number of policies on offer is very high reflecting the varied circumstances and choices of consumers.

There are currently a large number of PHI products on the market available to consumers from 34 different insurers, the majority of which are from open insurers that any consumer can access. The large volume of products reflects a myriad of factors including historical evolution, product complexity, and particular marketing strategies.¹²⁹

Limits to diversification

Regulatory requirements also play an important role to ensure that insurers meet a number of “core” requirements. For example, all complying products must cover psychiatric, rehabilitative and palliative care.¹³⁰

Market dynamics can further restrict genuine product diversity. For example, where insurers are using HAMBS for their claims processing, products need to be consistent with HAMBS technology. Products also need to be interpretable by intermediaries if they are to be sold on, and be subject to actuarial analysis, which requires historical data to draw upon to ensure risks are well managed.

Despite this, insurers are increasingly seeking to differentiate themselves, drawing on various forms of price and non-price competition.

Product complexity as a factor in competition

While there is a price element to the design of private health insurance products, there is a perception that the diversity and complexity that has emerged means that consumers will often find it difficult to compare like-with-like across insurers.¹³¹ This is despite the availability of a highly regarded comparison website www.privatehealth.gov.au which provides information about all the health insurance products

¹²⁹ Because of the “multiplier effect” created by different jurisdictions and different risk equalisation pools, the degree of differentiation and substantive variation in products on offer is less than might be first thought. For example, with some insurers one product may have up to 100 “internal” variations as the product is adjusted for different household types (family, couple or single policies), different levels of excess, as well as geographic characteristics.

¹³⁰ See PHI Act, section 72(2), item 1.

¹³¹ Australian Dental Association Ltd – submission No. 2, pages 5 and 12.

available for sale.¹³² Points of differentiation such as what a product includes (or excludes), what waiting periods apply, whether there are “no gap” arrangements, all contribute to making the comparison process challenging for consumers.

Added to that, exclusionary and restricted products incorporate a number of gradations that range from fairly light through to quite heavy restrictions on the policies. For example, exclusionary policies may exclude only obstetrics treatment, or they may exclude a list of treatments such as obstetrics, cardiac surgery, joint replacement and eye surgery.

A more recent trend is for insurers to develop so-called “inclusionary” products. These are basic products that only cover 5 or 6 services such as wisdom teeth, appendectomies and knee surgery. They are usually aimed at the young, singles market and are often combined with an ancillary component. These policies exclude or restrict all services and treatments, apart from the 5 or 6 that are included. The same differentiation is also included in excess and co-payment options, two fundamental elements that may drive significant differences across products.

Seen in this light, product complexity can be viewed partly as a by-product of community rating, as insurers are not able to price premiums for specific categories of members, or to selectively offer certain products to individuals (i.e. on the basis of particular risks). Instead, insurers introduce as finely graded a mix of policies that can be administratively handled – allowing members themselves to self-select where on the sliding scale of risk they see themselves.¹³³

Whether this profusion of choice is ultimately a benefit for consumers is a contentious question and one worthy of further study. While it seems that some consumers do appreciate being able to select from a wide range of carefully designed products, the sheer size of the selection task (and the investment of time involved) may be contributing to both confusion and apathy amongst consumers.¹³⁴

¹³² www.privatehealth.gov.au is operated by the Private Health Insurance Ombudsman with financial support from the industry.

¹³³ A comparative study completed in 2000 across Australia and New Zealand found that product diversity was much greater in Australia than in New Zealand where community rating was not mandated Vaithianathan, R (2001) *An economic analysis of the private health insurance incentive Act (1998)* ANU, RISSS.

¹³⁴ For example, the 2011 IPSOS survey found that 27 per cent of respondents indicated they were either too “lazy/apathetic” or had “no time/too busy” to shop around for private health insurance - see page 313.

6.6 Portability, competition and the consumer

Portability is central to competition in the private health insurance market. In practice, it appears to be generally effective, although barriers do exist.

The portability of private health insurance is regulated as a means of increasing competition across the industry. Under the portability rules, private health insurers are provided with guidelines to facilitate the movement of policy holders from one insurer to another, including mechanisms for communication, recognition of waiting periods for hospital products already served and the continuation of access to government incentives irrespective of which insurer holds the policy.

However, the extent to which portability ‘works’ and is evidence of a competitive market has in the past been more controversial, and marketing and promotion of private health insurance by insurers tends to focus more directly on the new member market, and not the market for transferring policy holders. There appear to be two factors driving this.

- The first is that while portability is a relatively straight forward concept, in practical application this is not always the case. There is an extensive range of products that do not necessarily have an obvious like-for-like equivalent across insurers.¹³⁵ There have also been variable practices for assessing what is accepted as a ‘valid transfer request’ in terms of ‘proof’ of consumer consent and the required format of the content and delivery of the transfer form.
- Second, there are also strategic influences at play, with transfer requests often being referred by the insurer that has been requested to provide certification to so-called “retention teams” where consumers are quizzed about why they wish to transfer to another insurer, leading to delay. There is no central repository of transfer requests, making it difficult to fully understand the extent to which portability requirements fail to act as it is intended by the legislation. A small number of industry stakeholders have suggested that a central repository for transfer requests and process for enforcing legislated requirements should be established as a matter of priority.¹³⁶

Also, it is unclear whether alleged breaches of the 14 day requirement for completion of transfers are regularly reported to those charged with enforcement. Consumer complaints about transfers are relatively low, with 93 complaints placed to the PHIO in 2011-12 relating to continuity of benefits on transfer.¹³⁷

¹³⁵ Consumer Health Forum – submission No. 9, page 2.

¹³⁶ Australian Dental Association Ltd – submission No. 2, pages 13 and 14 and two confidential submissions.

¹³⁷ PHIO (2012), page 40.

Portability is likely to be less effective if consumers become disengaged, incurring duplicate fees during the transfer period, one of which later needs to be repaid, or are uncertain about which insurer is responsible for claims during the transfer period. The industry Code of Conduct for insurers now includes the use of a common transfer certificate request form, which should improve the operation of portability, although compliance with the Code still needs to be ensured.

6.7 Consumer behaviour: a positive or negative for competition?

Consumers act to both reinforce and detract from competition in the market.

As in all markets, the behaviour of consumers is a key element in driving the level of competitive tension between insurers. A particular, and enduring, feature of the Australian PHI market is the tendency for consumers to select an insurer and then remain with that insurer for an extended period – often irrespective of the efforts of competitors to win their business as transferring contributors. This tendency, often referred to as “stickiness”, is driven by:

- a ‘set and forget’ approach to private health insurance,¹³⁸ brought on by factors such as apathy,¹³⁹ perception of the difficulties of changing policies or insurers,¹⁴⁰ or loyalty to the brand;¹⁴¹
- the complexity of products and the difficulty in comparing products based on cost over value;¹⁴²
- the need to purchase private health insurance to avoid the MLS, and
- many consumers being satisfied with their current insurer and product choice.

Across the industry, consumers of restricted insurers are the most ‘sticky’. **Figure 29** shows that retention of policy holders is consistently higher for restricted insurers. The reasons for this are not entirely clear but could, in part, be due to the reduced product complexity of the restricted funds (reflecting greater homogeneity of members) and fewer exclusionary or restricted products (reflecting the reinvestment of profits into member benefits).

¹³⁸ Little Company of Mary Health Care – submission No. 16, page 5.

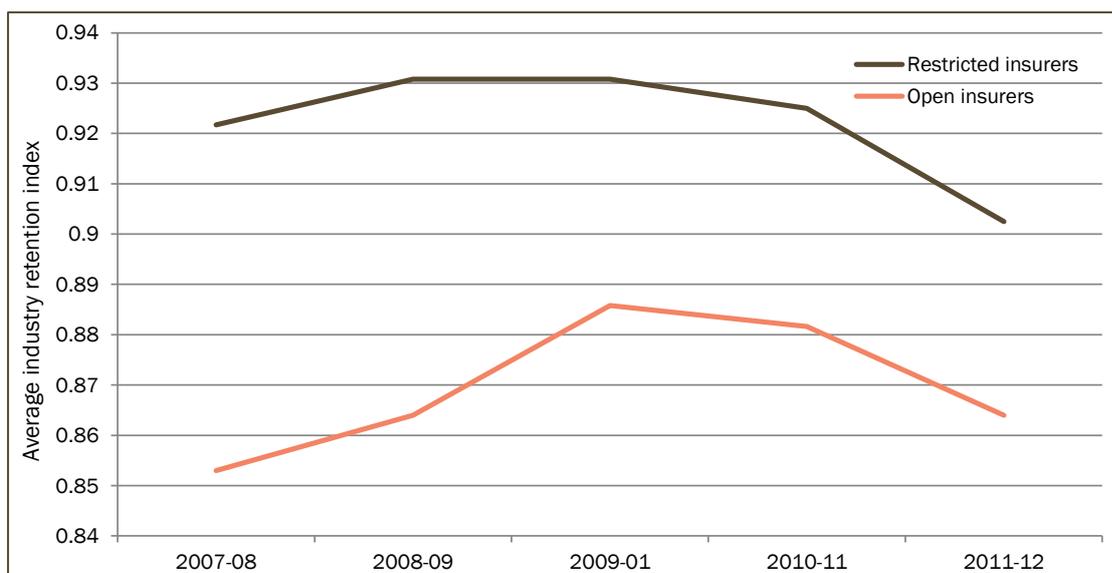
¹³⁹ For example, the 2011 IPSOS survey found that 27 per cent of respondents indicated there were either “too lazy/apathetic” or had “no time/too busy” to shop around for private health insurance - see page 313.

¹⁴⁰ For example, the ISPOS Report found that 26 per cent of respondents indicated that they may have made a switch had they known that there would be no consequences in terms of waiting periods and benefits, see page 308.

¹⁴¹ AHSA & hirmaa – submission No. 3, page 17.

¹⁴² Consumer Health Forum – submission No. 9 page 2; Australian Dental Association Inc. – submission No. 2, pages 5 and 12.

29. Retriected insurers achieve greater member retention



Source: PHIAC data.

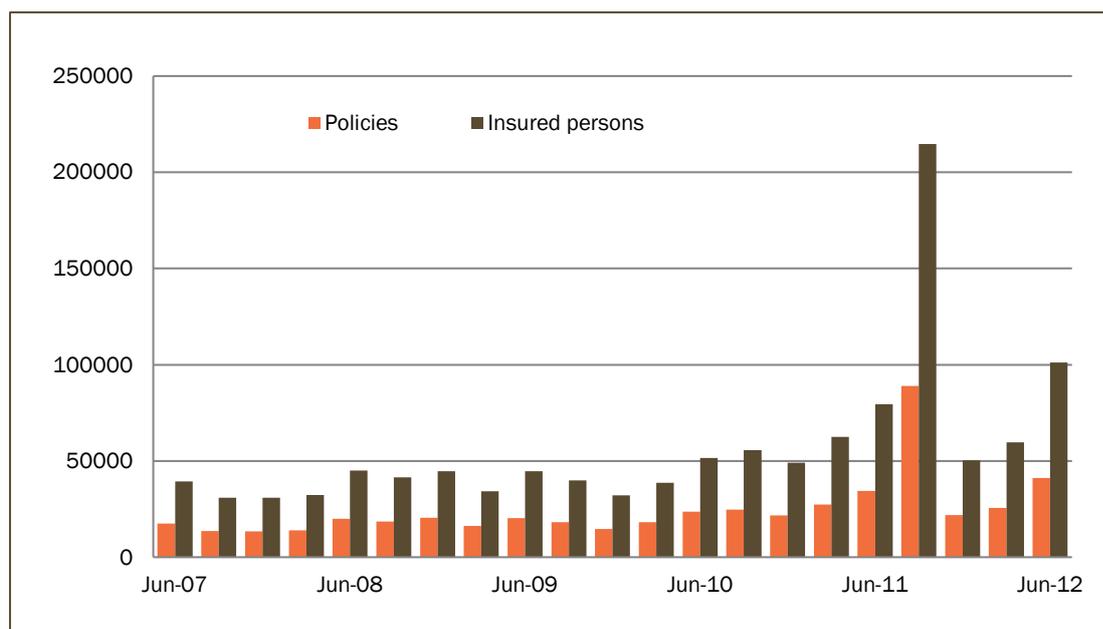
Note: The retention index is calculated based on policy holders at end of reporting quarter less policy holders joining over the previous eight quarters including the reporting quarter divided by policy holders at end of the quarter nine quarters previously.

Restricted funds also enjoy some natural selection advantages by representing (or being limited in their membership to) a segment of the community with which they have a particular affinity: consumers are more likely to have a greater sense of belonging and loyalty to that insurer. The combined effect of these factors is that despite portability, consumers only tend to move between funds if they are personally highly price driven and seek a lower cost option, or because they have had a bad experience.

Figure 30 shows the number of policies and insured people that were transferred across insurers each quarter since June 2007. In the June 2012 quarter, there were 42 000 transfers of combined cover policies, and just over 100 000 insured persons that transferred from another fund.¹⁴³ These numbers are very low when it is recalled that there are 5.3 million combined policies across Australia and that a further 140 000 new combined cover policies were issued in the June quarter 2012 alone (not graphed).

¹⁴³ There was a substantial spike in transfers for members in September 2011 due to the merger of BUPA, MBF, and MBF Alliances. From December 2011, there has been a steady increase in the quarterly level of transfers, and June 2012 reported the second highest level of transfers for the period (aside from the merger related September 2011 spike), coinciding with changes to the private health insurance tax rebate.

30. Transfers from another fund: Hospital treatment and general treatment coverage



Source: PHIAC data.

6.8 The impact of intermediaries on competition between insurers

Intermediaries can reinforce consumer-based drivers of competition, although in practice they do so in a limited way.

Intermediaries and health insurance brokers began to enter the Australian market, in a very visible way, in the early 2000's.¹⁴⁴ Intermediaries provide comparison services at a low or no up-front cost to consumers. However, the comparison only reflects differences between selected products from selected insurers based on commercial arrangements between the insurers and the relevant intermediary.

Intermediaries charge insurers for their services, usually in ways that are invisible to consumers. Commissions form part of the administrative cost base of the insurer and, ultimately, are passed through to consumers. Whether these payments are an 'efficient' use of resources is a matter which is widely debated. A key question is whether consumers receive valuable information which reduces the search costs in finding an appropriate product reflecting their particular circumstances (health, financial, etc.).

Consumers are not compelled to use an intermediary in purchasing a private health insurance product. As noted, a comprehensive resource is freely available at the industry-supported website

¹⁴⁴ There have been some brokers operating in the industry, mostly working in the corporate sector, for decades before that.

www.privatehealth.gov.au.¹⁴⁵ Nevertheless, intermediaries have greater brand recognition and offer an attractive alternative to many consumers who find the prospect of dealing with the complexity of PHI somewhat daunting.

Switching behaviour is, arguably, beneficial when it leads to a better matching of consumers with appropriate policies. It should also be a positive for competition if consumers feel they are getting better value for money, and where switching helps to ensure insurers are given an incentive to be responsive and to manage costs in an efficient way. Seen in this way, switching is welfare enhancing if consumers trade-off forms of cover that they don't require for a lower premium.

However, assessing value to the consumer can often be difficult to determine, and “churn” can create longer term inefficiencies, particularly where consumers are matched with products that provide inappropriate coverage and/or are not consistent with changes in their health care needs. Churn could also be seen as welfare reducing if the lowest priced policy was chosen to the detriment in the scope of the consumers' coverage, resulting in potentially higher total health care costs and a less appropriate sharing of costs between public and private hospitals.

A particular risk of intermediaries is the potential for a “disconnect” between the broker and the product, particularly in unregulated broking markets. This may lead to a heightened risk that unjustified or misleading claims may be made about a product in order to win business. Private health insurance broking has experienced some concerns around this issue which has led to a need for legal intervention either by regulators or, more recently, industry participants.¹⁴⁶

It is important to note that PHIO can take complaints from consumers and health insurers about brokers. Where PHIO believe a broker has provided incorrect or misleading information, a remedy such as payment of a benefit could be sought. In PHIO's experience, brokers take a collaborative approach to such complaints and would most likely implement a remedy recommended by PHIO following a complaint investigation.¹⁴⁷ In addition, the ACCC has a role in ensuring that brokers do not make misleading claims.

The activities of intermediaries are not ignored or discounted by insurers, even if they do not use them for product sales. Indeed, the use of intermediaries ultimately reflects differential investments in sales

¹⁴⁵The website www.privatehealth.gov.au was created under an initiative from DoHA in the late 2000's to help consumers make informed choices about private health insurance. Since then, the PHIO has ensured the information available is up-to-date, collated, analysed, and user-friendly.

¹⁴⁶ For example, see “BUPA, iSelect settle court battle”, *Sydney Morning Herald*, 22 March 2013.

¹⁴⁷ This point was made by PHIO during the consultation process.

infrastructure where insurers that have invested in extensive branch networks for instance are less likely to use them, compared to online businesses for which intermediaries may be the only sales outlet.

Across the industry, intermediaries are used or monitored by all insurers and have been subsumed into many business models and become part of the competitive landscape for insurers.

There is evidence that consumers are increasingly accessing online information to make decisions about private health insurance, and online businesses are increasingly shaping the competitive landscape for insurers. In particular:

- Online consumer based reviews are known to influence consumers purchasing a product for the first time as well as independent evaluations and comparisons by independent or consumer-focussed websites such as CHOICE¹⁴⁸ and Canstar.¹⁴⁹ Social media, chat rooms and wider online reviews of insurers and the market in general are also considered to be gaining prevalence.¹⁵⁰
- Private health insurance intermediaries are being used by consumers to find the cheapest product available, as well as enabling ease of comparison.
- Insurers are responding to consumer demand for online services, with many insurers limiting or completely removing walk in offices and centres, opting for online claiming services and call centres.

Growth in online options and activities is changing considerably, driven by large growth in the online activities of members. Online intermediaries are targeting members by providing access to comparison and evaluation services to promote switching to different products. In addition, online reviews, chat rooms and the growing digital presence of insurers through on-line advertising and other measures are becoming more valued by consumers. While the market behaviour of intermediaries will remain a focus of interest for the industry, consumer demand for online information continues to permeate the private health insurance market and add another dimension to the contestability and competitiveness of the market.

¹⁴⁸ See www.choice.com.au.

¹⁴⁹ See www.canstar.com.au.

¹⁵⁰ GMHBA – submission No. 12, page 1; IPSOS (2011) page 314 and pages 472 to 488.

Stakeholder submissions to the discussion paper highlighted the potential for intermediaries to have both positive and negative overall effects on the efficiency and competitiveness of the market.

Considering the ability of intermediaries to increase information flows to the market, Australian Physiotherapy Association noted that:

'INTERMEDIARIES [AND FREE SERVICES SUCH AS PRIVATEHEALTH.GOV.AU] PROVIDE AN OPPORTUNITY FOR CONSUMERS TO GAIN GREATER UNDERSTANDING OF THE COMPARATIVE LEVEL OF BENEFITS AND REBATES PER SERVICES OF DIFFERENT INSURANCE PRODUCTS... THE APA BELIEVES THAT OBJECTIVE COMPARISON OF HEALTH FUND POLICIES SHOULD ALWAYS BE ENCOURAGED.'

However, it is suggested that there are limitations to the services provided, as noted by Peter Carroll:

'[INTERMEDIARIES] GIVE AN ILLUSION OF COMPETITION, OFTEN DISINGENUOUSLY. THEIR MAIN LONG TERM EFFECT HAS BEEN TO INCREASE COSTS AND PROMOTE "MORAL HAZARD" IN THE INDUSTRY... ARGUABLY THEY ASSIST INFORMATION FLOWS IN THE MARKET, ALTHOUGH AT A HIGH PRICE.'

With respect to the ability of intermediaries to promote competition, KPMG noted that:

'OUR EXPERIENCE SUGGESTS THAT THE USE OF AN INTERMEDIARY BY A SMALL/MID-SIZED INSURER ENABLES THAT INSURER TO OFFER ITS PRODUCTS TO MARKETS THAT WITHOUT THE INTERMEDIARY IT WOULD NOT BE ABLE TO ACCESS. THIS INCREASES THE LEVEL OF COMPETITION IN THESE MARKETS.'

and HBF said:

'INTERMEDIARIES HAVE CREATED GREATER COMPETITION FOR BOTH NEW AND SWITCHING CONSUMERS. FUNDS WHICH HAVE STRUGGLED TO GAIN BRAND RECOGNITION CAN NOW USE INTERMEDIARIES TO SELL THEIR PRODUCT AND PROMOTE THEIR BRAND.'

However, there is concern that intermediaries do not grow the size of the overall market, as voiced by Latrobe:

'LOGICALLY IN A FINITE MARKET SUCH AS HEALTH INSURANCE, THE ABILITY TO RECRUIT CONSUMERS NEW TO PRIVATE HEALTH INSURANCE REDUCES THE CLOSER THE INSURED POPULATION MOVES TOWARDS SATURATION, CHURNING IS THEREFORE INTEGRAL TO THE LONG TERM VIABILITY OF AN INTERMEDIARY WITHIN AUSTRALIA'S PRIVATE HEALTH INSURANCE MARKET.'

and Little Company of Mary Health Care:

'CALVARY QUESTIONS WHETHER THEY HAVE A POSITIVE IMPACT ON THE NUMBER OF INSURED PERSONS OR WHETHER THEY SIMPLY MOVE PEOPLE FROM ONE PHI TO ANOTHER.'

6.9 Competition issues along the health insurance supply chain

There is a potential lack of competition along the supply chain possibly resulting in suboptimal outcomes in key areas.

Ensuring market interactions between insurers and providers are competitive

Competition along the supply chain of private health services is an important determinant of the level of competition between private health insurers and the delivery of efficient and effective health services to members. Where benefits account for 85 per cent of premium revenue, managing benefit payments and negotiations with service providers is an important determinant of the effectiveness of the private health

insurance market, yet the view has been expressed (both by insurers and providers) that competition in the supply of services is not as effective as it might be.¹⁵¹

While there is significant regulation and oversight of the supply and management of private health insurance policies in Australia, there is less regulation and oversight of the interactions between insurers and providers, either hospitals or medical specialists.

The competitiveness of the private health insurance industry can be enhanced or inhibited by the nature of competition along the supply chain within which private health insurance is nested. Some inputs insurers can control or influence to an extent (such as private hospital contracts), while there are other areas, such as prostheses devices¹⁵² and specialist fees, over which they have less control. Some parts of the supply chain are similarly highly concentrated and some are fragmented, which can affect the nature and efficiency of operations along the supply chain.

As noted above, given benefit payments absorb approximately 85 per cent of premium revenue, the ability of insurers to sustain their product offerings is dependent on their ability to negotiate (or cap) the prices charged to them by providers.

Given the variation in market size within the private health insurance industry itself, whether the supply chain is competitive or unbalanced and inefficient can be a matter of perspective. Some insurers have a strong market position (and could be considered as price makers), and some have a comparatively weak market position (and could be considered as price takers) in the health services supply chain. Outcomes can also be geographic specific – market power in one state may be used to extract a premium to cover market weakness elsewhere.

Competitive tensions between private health insurers and private hospitals

Private hospitals play a crucial role in delivering first rate health care to Australians. As such, they are key stakeholders in the private health insurance system.¹⁵³ Notably:

¹⁵¹ AHSA & hirmaa – submission No. 3, pages 26 and 27; Little Company of Mary Health Care – submission No. 16, page 9; Medibank Private Ltd – submission No. 17, page 7.

¹⁵² The price of prosthetics is regulated by rules issued by the Minister for Health and administered by the Department (see *Private Health Insurance (Prosthetics) Rules 2012* available at www.comlaw.gov.au).

¹⁵³ See *Private Hospitals and the Australian Health System* available at www.apha@org.au. This document provides further information on the role of private hospitals in the Australian health care system.

- private hospitals treat 40 per cent of all patients in Australia. In 2010-11, this amounted to 3.6 million patients; and
- 65 per cent of elective surgery in Australia is performed in private hospitals.

There are various safeguards in place, which tend to diffuse the scope for market power to be abused along the supply chain. These include:

- Second Tier arrangements, which provides a safety net where a contracted price is not negotiated between private health insurers and private hospitals; and
- joint purchasing arrangements through AHSA, ARHG and HAMBS, which alter the competitive position of insurers in negotiating with suppliers.

Second Tier pricing arrangements were originally introduced to provide a level of protection for the fragmented private hospital market when negotiating pricing arrangements with a more consolidated private health insurance industry. To this end, the *Private Health Insurance (Benefit Requirements) Rules 2011* require that, in the absence of a specific agreement with the hospital, private health insurers are required to pay out a minimum of 85 per cent of the average benefit for an equivalent hospital treatment episode under negotiated contracts held by the insurer with

HOSPITAL PURCHASER PROVIDER AGREEMENTS

Approximately 70 per cent of total hospital treatment benefit payments are paid to hospitals for hospital services such as accommodation and nursing, and the remaining 30 per cent are for medical services and prosthesis.

Most hospitals and insurers have negotiated agreements (known as Hospital Purchaser Provider Agreements (HPPAs)). These agreements detail the prices that the insurer pays for the treatment of their members.

The HPPA may include terms that share risk between the insurer and the hospital. For example, hospital admissions are often billed on an episodic basis meaning the hospital is paid an agreed price based on the type of case regardless of how many days the patient remains in hospital. In this way, the financial risk of the patient requiring an extended length of stay is passed from the insurer to the hospital. Consequently, the hospital has a clear incentive to reduce the length of the admission and to enhance hospital efficiency.

The HPPA can also remove or limit the additional charges that a fund member can face. For example, the insurer and the hospital can agree that the patient is not to be charged a private room fee or for discharge medication supply as the hospital agrees to provide these at no additional cost to the patient.

If the patient is treated at a hospital that does not have an agreement with their insurer, then the insurer is required to pay at least the Second Tier benefit if the hospital is appropriately registered. Lower minimum default benefits are payable if the hospital is not registered for Second Tier benefits. The patient then may be required to pay the difference between the benefit paid by the insurer and the hospital charge.

comparable hospitals in the relevant jurisdiction.¹⁵⁴

To some extent, the market determines the competitive tensions along the supply chain and generates counterbalances to equalise market forces. For instance, in recent years, there has been a broad trend of consolidation within private hospitals providing greater market strength (achieving economies of scale and scope as well as increased bargaining power), with some hospital groups now effectively ‘too big’ not to do business with.

Outside of the larger hospital groups, however, the private hospital sector remains fragmented. Smaller private hospitals are not able to rely solely on Second Tier rates, but nor can they sustainably attract co-payments from patients. They are likely to be price takers in contract negotiations.

Private hospitals differ greatly in size. In 2010-11, there were 593 private hospitals in Australia, of which 279 were acute or psychiatric hospitals and 314 were freestanding day hospitals. Of these, there are large organisations operating many hospitals (namely Ramsey Health Care Limited and Healthscope Limited in the for-profit sector and Catholic hospitals in the not-for-profit sector), as well as smaller bodies running single or only a few facilities.¹⁵⁵

Data from the ABS on private hospitals by size (excluding free standing day hospitals) shows that a significant proportion of private acute and psychiatric hospitals are relatively small, with 38 per cent having fewer than 50 beds, and less than 10 per cent having more than 200 beds (**Table 31**).

The distribution of private hospitals across metropolitan and regional areas is also quite uneven, which can have important impacts on the strength of the competitive tension between private health insurers and private hospitals in different geographic areas. For instance, approximately 75 per cent of all available private acute and psychiatric hospital beds in 2010-11 were located in capital cities, even though only 64 per cent of Australia’s population lived in these areas (**Table 32**).

¹⁵⁴ Any facility that wishes to be considered for inclusion as a Second Tier approved facility, or any facility that wishes to remain specified as an approved facility after its eligibility expires, may apply to the Second Tier Advisory Committee for approval that it satisfies the second tier eligibility criteria set out in the *Private Health Insurance (Benefit Requirements) Rules 2011*. The Committee considers each application against the eligibility criteria and compiles a complete list of Committee-approved facilities eligible for second tier benefits. The Committee may remove facilities from the list if those facilities no longer satisfy the relevant criteria. Currently, for all insurers, price negotiations with suppliers are hotly contested, which signals strong competitive pressure for all parties along the supply chain.

¹⁵⁵ Productivity Commission 2009, *Public and Private Hospitals*, Productivity Commission, Canberra, page 46.

31. Number of private hospitals by size, 2010-11 (a)

Jurisdiction	0–50 beds	51–100 beds	101–200 beds	Over 200 beds	Total
New South Wales	31	37	13	5	86
Victoria	34	21	19	5	79
Queensland	17	16	14	7	54
South Australia	np	8	5	np	30
Western Australia	8	4	np	np	21
Tas, NT and ACT(b)	np	5	np	np	9
Australia	125	87	55	22	279

Source: ABS (Private Hospitals, Cat. no. 4390.0).

(a) Acute and psychiatric hospitals (excludes freestanding day hospitals).

(b) Data for Tasmania, the Northern Territory and the ACT are aggregated to protect the confidentiality of the small number of hospitals in each of these jurisdictions

np Not published but included in totals where applicable.

32. Number of private hospitals and beds by location, 2010-11 (a)

Jurisdiction	Number of hospitals			Number of beds		
	Capital city	Rest of state/territory	Total	Capital city	Rest of state/territory	Total
New South Wales	58	28	86	4 836	1 868	6 704
Victoria	59	20	79	5 495	1 134	6 629
Queensland	22	32	54	3 266	2 734	6 000
South Australia	np	np	30	np	np	1 911
Western Australia	np	np	21	np	np	3 138
Tas, NT & ACT (b)	np	np	9	np	np	1 012
Australia	183	96	279	18 962	6 432	25 394

Source: ABS (Private Hospitals, Cat. no. 4390.0).

See footnotes to Table 31.

The differences in market power characteristics across different hospital associations, different insurer groups and state and territory delineations have raised some concerns, on both sides of the market, of the efficiency and competitiveness of pricing negotiations along the supply chain.¹⁵⁶ For example, where

¹⁵⁶ Australian Private Hospitals Association South Australia Branch – submission No. 7, page 1 to 4; Little Company of Mary Health Care – submission No. 16, page 9; HBF Health Ltd – submission No. 13, page 3.

larger hospital groups are considered by insurers as able to rely on Second Tier rates, insurers suggest that this limits and biases the amount of negotiating power brought to the table as it provides a regulated rather than market-set floor to prices.¹⁵⁷

Competitive tensions between insurers and medical providers

Another key input into the health supply chain is the provision of medical services, primarily doctors' and particularly specialists' services of various kinds. It has been suggested that the most inelastic portion of the market (where price has almost no impact on demand) is in the supply of specialist services, and for this reason, specialists have, and continue to be able to, increase prices for their services at a rate that outstrips growth in revenue from premiums.¹⁵⁸ It has also been submitted that insurers and patients bear the majority of the financial risk of diagnosis and treatment, with very little being shared with medical providers.¹⁵⁹

Insurers and specialists are able to enter into Medical Purchaser Provider Agreements (MPPAs) in respect of treatments provided to hospital patients. MPPAs allow insurers to pay medical benefits in excess of the MBS fee. This provides an opportunity to eliminate or limit out-of-pocket expenses for private patients for medical services received in hospital. Further, health insurers may offer differential benefits to members that utilise a preferred provider.¹⁶⁰ While the cost of eliminating gaps puts upward pressure on premiums, it can make private health insurance a more attractive product.¹⁶¹

In the December quarter 2012, 88 per cent of in-hospital medical services were provided with no-gap payment required. The majority of these (78 per cent of the total) were provided under no-gap agreements. A further 4 per cent of services were provided under known-gap agreements meaning that 92 per cent of services were provided to a consumer with no-gap or known-gaps.

The amount billed by the service provider for services with a known-gap was on average 184 per cent of the MBS fee. The average gap per medical service paid by the consumer under a known-gap agreement was \$87. In contrast, the average gap where there was no agreement was \$226.

¹⁵⁷ AHSA & hirmaa – submission No. 3, page 26 and 27.

¹⁵⁸ Allied to this, the capacity to regulate doctors incomes is particularly constrained by section 51(xxiiiA) of the Australian Constitution which prohibits any legislation that amounts to “civil conscription” of doctors.

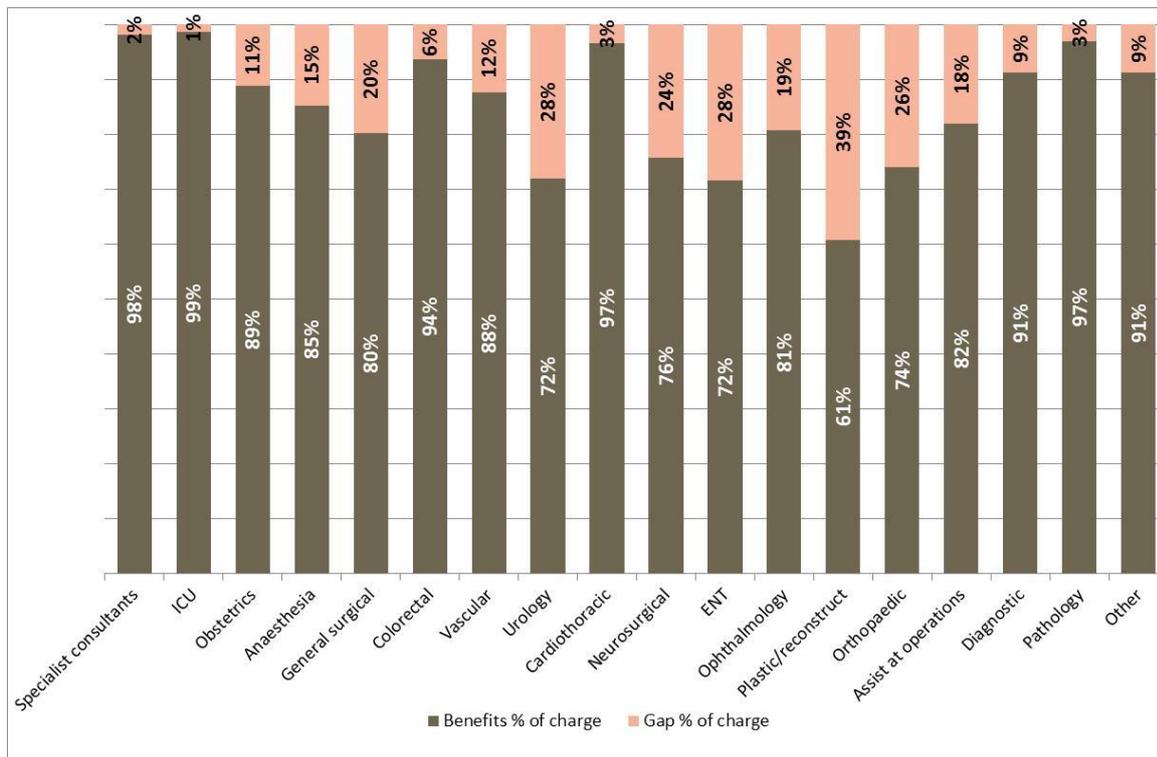
¹⁵⁹ Latrobe Health Services Ltd – submission No. 15, page 4.

¹⁶⁰ It has been argued that in the case of general treatment policies, PPAs shift negotiating power in favour of insurers and dampen consumer choices. In particular, the Australian Dental Association expressed concern about purchaser provider contracting: Australian Dental Association Inc. – submission No. 2, pages 2 and 15.

¹⁶¹ Productivity Commission 1999, *Private Hospitals in Australia*, Commission Research Paper, AusInfo, Canberra, page 86.

The data shows that on average the amount of gap for medical services varies depending on the specialty group. The specialty group with the largest out-of-pocket payment was plastic/reconstructive with an average gap of \$410, followed by orthopaedic with an average gap per service of \$335. The gap incurred for the various medical services is displayed in **Table 33**. Medical gap also varies by state and territory and these differences are shown in **Table 34**.¹⁶² Taken together, these data indicate that the market for medical services may be operating less to the benefit of consumers in some jurisdictions and in respect of some specialist groups than others.

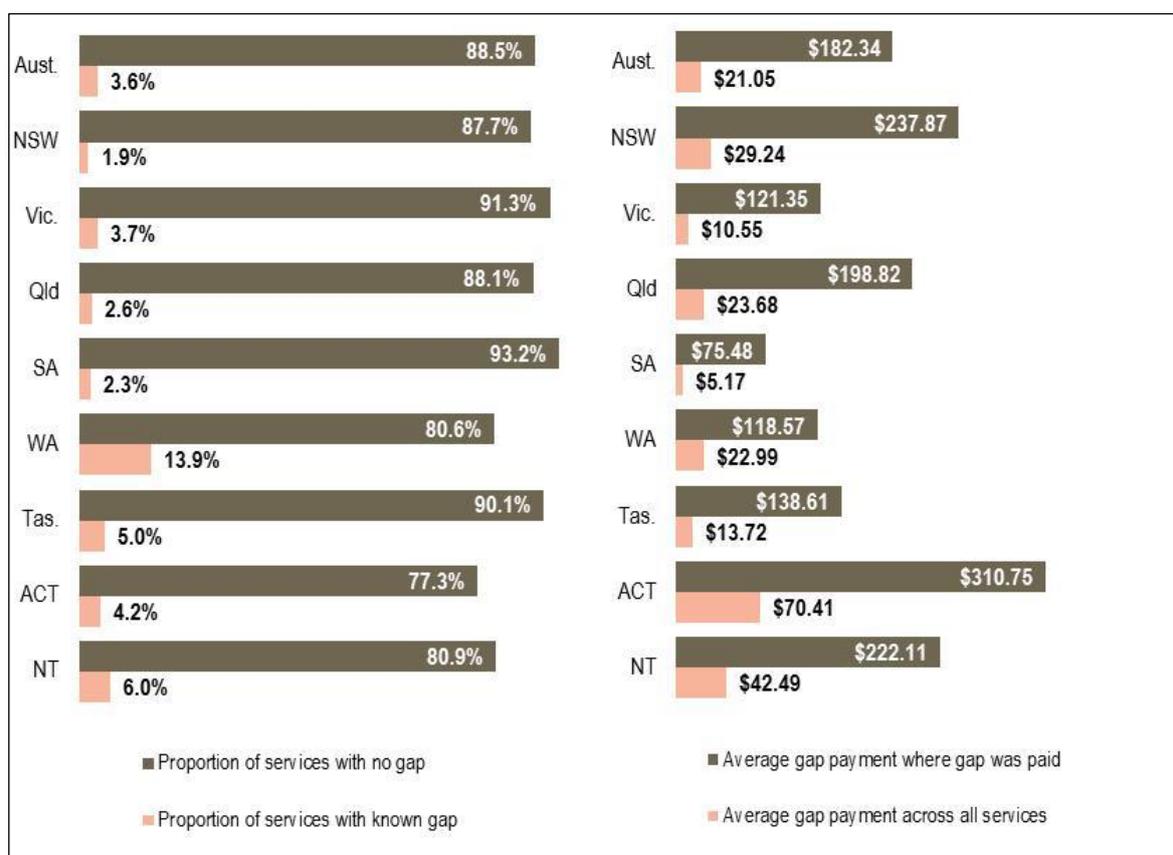
33. Medical benefits and out-of-pocket by speciality group, December quarter 2012



Source: PHIAC, Private Health Insurance Australia, Quarterly Statistics, December 2012.

¹⁶² PHIAC Quarterly Gap Payments & Medical Benefits Statistics December 2012.

34. Services with gaps and average out-of-pocket payments, December quarter 2012



Source: PHIAC, Private Health Insurance Australia, Quarterly Statistics, December 2012.

Prosthetics the most regulated element in the supply chain

The third major input into the hospital supply chain is prosthetics. In 2011-12 insurers paid out almost \$1.5 billion in benefits for prostheses which represented 14 per cent of their total hospital insurance benefit outlays. Benefit outlays on prostheses have increased by 60 per cent since 2006-07.

Under the PHI Act, private health insurers are required to pay mandatory benefits for a range of prostheses that are provided as part of an episode of hospital treatment (or hospital substitute treatment) where a Medicare benefit is payable for the associated professional service (surgery).¹⁶³ A Ministerially appointed committee, the Prostheses List Advisory Committee (**PLAC**), makes recommendations to the Minister for Health and Ageing on the prostheses that should be listed, and the benefits insurers should pay for them. Committee members have expertise in current clinical practice, health insurance, consumer health, health economics, health policy, private hospitals and the medical device industry. There are more than 9,000 products on the Prostheses List.

¹⁶³ DoHA, Private Health Insurance – Prostheses List, www.health.gov.au/internet/main/publishing.nsf/content/healthprivatehealth.

While insurers are represented on the PLAC, a number of submissions from insurers contended that they should have a more direct role in negotiating the prices paid for devices arguing that competitiveness particularly in relation to price is difficult to achieve with the consumer (or insurer) having little or no say in the selection of the product or the cost associated.¹⁶⁴

An insurer questioned the adequacy of the processes applied in the current regulatory system. In their view improvements could be made in respect of the pre-market approval process and post market surveillance (with a view to reducing unnecessary revisions).¹⁶⁵ It is also suggested that it should be made clear that the hospital or doctor, not the patient or insurer, should bear the costs of prostheses that have not been put to clinical use. In this view, the regulations should be amended so that benefits are only payable for listed prostheses which are actually implanted into the patient, as opposed to just 'provided'.¹⁶⁶

The same submission raised concern that the regulations on prostheses do not provide incentives for suppliers to put items on the prostheses list (if the item is not listed there is no guarantee that the insurer will pay a benefit but the patient may be left with a 100 per cent gap). The suggested solution is to introduce a specific requirement that insurers are only permitted to pay benefits for listed prostheses.

¹⁶⁴ Defence Health – Submission 10, page 10; AHSA & hirmaa – submission No. 3, page 27.

¹⁶⁵ Medibank Private Ltd – submission 17, pages 8 to 11.

¹⁶⁶ Confidential submission.

Abbreviations used in this paper

ABP	Age Based Pool
ACCC	Australian Competition and Consumer Commission
ADA	Australian Dental Association
AHSA	Australian Health Services Alliance
APRA	Australian Prudential Regulation Authority
ARHG	Australian Regional Health Group
ASIC	Australian Securities and Investments Commission
CIE	The Centre for International Economics
CPI	Consumer Price Index
DoHA	Department of Health and Ageing
FOI Act	<i>Freedom of Information Act 1982</i>
Fund	The health benefits fund or funds of an insurer registered under the <i>Private Health Insurance Act 2007</i>
HAMBS	Hospital and Medical Benefits System
HIC	Health Insurance Commission
HCCP	High Cost Claimants Pool
HPPA	Hospital Purchaser Provider Agreements
IFC	Informed Financial Consent
Insurer	A private health insurer registered under the <i>Private Health Insurance Act 2007</i>

LHC	Lifetime Health Cover
MBS	Medical Benefits Scheme
MLS	Medicare Levy Surcharge
MPPA	Medical Purchaser Provider Agreement
NHA Act	<i>The National Health Act 1953</i>
PACU	The Premiums and Competition Unit
PHIAC	The Private Health Insurance Administration Council
PHIS	Private Health Insurance Incentives Scheme
PHI Act	<i>The Private Health Insurance Act 2007</i>
PHIO	Private Health Insurance Ombudsman
PLAC	Prostheses List Advisory Committee
RETF	Risk Equalisation Trust Fund
VHI	Voluntary Health Insurance

Submissions received

No.	Organisation	Author	Title
1	Australian Centre for Health Research (ACHR)	Neil Batt	ACHR response to the PHIAC PACU discussion paper – Competition in the Australian PHI market
2	Australian Dental Association Inc. (ADA)	Karin Alexander	Submission to the Private Health Insurance Administration Council – Competition in the Australian Private Health Insurance Market Discussion Paper
3	Australian Health Service Alliance (AHSa) and - hirmaa	Andrew Sando Ron Wilson	Response to the PACU Discussion paper
4	Actuaries Institutes (AI)	John Newman	Discussion paper: Competition in the Australian PHI market
5	Australian Physiotherapy Association (APA)	Marcus Dripps	Feedback on the Premiums and Competition Unit Discussion Paper 1 – Competition in the Australian Private Health Insurance Market
6	Australian Private Hospitals Association (APHA)	Michael Roff	Competition in the Australian PHI market
7	Australian Private Hospitals Association South Australia Branch (APHA SA)	Nick Warden	RESPONSE SUBMISSION TO: Consultation Paper Titled – “Premiums and Competition Unit Discussion Paper 1 – Competition in the Australian Private Health Insurance Market”
8	Australian Unity Health Ltd (AUHL)	Rebecca Windsor	Response to competition in the Australian Private Health Insurance Market discussion paper
9	Consumer Health Forum (CFH)	Carol Bennett	Competition in the Australian PHI market: Discussion paper
10	Defence Health Ltd	David Lynch	Response to Competition in Australian Private Health Insurance Market – Discussion Paper Premiums and Competition Unit DP1
11	Finity	Ashish Ahluwalia and Jamie Reid	Response to PACU discussion paper

No.	Organisation	Author	Title
12	GMHBA Ltd	Mark Valena	Response to the PACU Discussion paper
13	HBF Health Ltd	Rob Bransby	Competition in the Australian Private Health Insurance Market
14	KPMG	David Torrance	Competition in the Australian Private Health Insurance Market
15	Latrobe Health Services Ltd	Bruce J Beatson	PHIAC Circular No. 12/32 - Premiums and Competition Unit Discussion Paper 1 - Competition in the Australian Private Health Insurance Market
16	Little Company of Mary Health Care Ltd (LCOMHC)	Mark Doran	Response to Consultation Questions
17	Medibank Private Ltd (MPL)	George Savvides	Competition in the Private Health Insurance Market
18	Private individual	Peter Carroll	Competition in the Australian PHI market
19	Queensland Teachers Union Health Fund Ltd (QTUH)	Rob Seljak	TUH submission to PHIAC – Competition in the PHI market
20	St Luke's Medical & Hospital Benefits Association Ltd	Ms C.M. MCGANN	Premiums and Competition Unit discussion paper
21	Teachers Federation Health Ltd (TFH)	Brad Joyce	Response to PACU Discussion Paper – Competition on the Australian Private Health Insurance Market

CONFIDENTIAL SUBMISSIONS – 8 confidential submissions received

References

ACCC (2012) *Report to the Australian Senate on anti-competitive and other practices by health funds and provisions in relation to private health insurance.*

ACCC (2007) *Public competition assessment of proposed merger of BUPA Australia Pty Limited and MBF Australia Limited.*

ACCC Notification decisions including:

- Australian Natural Brands Pty Limited T/A In Essence Aromatherapy
- Bupa Australia Pty Limited—Notification—N94896 and N94897
- ClearView Life Assurance Limited—Notification—N94901
- EFM Corporate Pty Limited—Notification—N95235 – EFM Corporate Pty Ltd (health clubs)
- Fitness First Australia Pty Limited—Notification—N95332
- Friendly Society Medical Association Limited—Notification—N95227
- GMHBA Limited—Notification—N95071- GMHBA Limited Access Economics (2005) *Regulation of Private Health Insurance Pricing*. Prepared for Challenger Financial Services Group.

ACCC Authorisation decisions including Reserve Bank Health Society Limited - Authorisation - A91264.

ANOP Research Services (2011) *Means testing the private Health Insurance Rebate: The impact on private health insurance membership in Australia*. Report on the 2011 ANOP survey for the AHIA. Accessed at <http://www.privatehealthcareaustralia.org.au/wp-content/uploads/ANOP-full-report-for-AHIA2011.pdf>

Australian Government (2012) *Mid-Year Economic and Fiscal Outlook*

Biggs, A. 2012, *Private health insurance premium increases—an overview and update*. Parliamentary Library, Background Note.

Buckmaster, I. and Davidson, J. (2006) *The proposed sale of Medibank Private: historical, legal and policy perspectives*. Parliamentary Library, Research Brief.

- Butler, J. (2002) *Policy change and private health insurance: did the cheapest policy do the trick?* Australian Health Review, Vol. 25 no 6.
- Carrington, R. et al (2008) *Regulation of private health insurance premiums: can performance assessment play a greater role?* Centre for Efficiency and Productivity Analysis, University of Queensland.
- Collins P. (2008) *An historical perspective on risk equalization for private health insurance in Australia.* Presented to ACERH Research Forum, ANU, Canberra.
- Colombo, F. and N. Tapay (2003) *Private health insurance in Australia: A case study.* OECD Health Working Papers No 8.
- Connelly, Paoluocci, Butler and Collins (2009) *Risk Equalisation in Australia.* Presentation to the 7th World Congress on Health Economics.
- Elliot, A (2003) *Regulation of private health insurance premiums.* Research note for the Department of Health and Ageing. Parliamentary Library, No 41.
- Gale, A. P. and Watson, D. (2007), *Adventures in Health Risk: A History of Australian Health Insurance,* presented to the Institute of Actuaries of Australia, September, Christchurch, New Zealand.
- Gillespie (1991), *The Price of Health: Australian Governments and Medical Politics* Cambridge University Press, Cambridge, pp.2910–60.
- Industry Commission (1997) *Private Health Insurance.* Report No. 57, February.
- Musgrove, P. (1996) *Public and private roles in health: theory and financing patterns.* World Bank Health, Nutrition and Population Discussion Paper.
- OECD (2004) *Proposal for a taxonomy of health insurance.* OECD Study on Private Health Insurance.
- Paolucci F., Butler, J. and Van de Ven, W. (2011) *Removing duplication in public/private health insurance in Australia: opting out with risk adjusted subsidies?* Agenda, Vol. 18, No 2.
- Paolucci F., and Stoelwinder, J. (2011) *Risk-equalisation in health insurance markets: models and international experience.* Australian Centre for Health Research Limited.
- Paolucci F. et al (2008), *Subsidising private health insurance in Australia: Why, how and how to proceed?* ACERH Working Paper 2.

- Parliamentary Library (2006), *The proposed sale of Medibank Private: historical, legal and policy perspectives*, Research Brief 1 September 2006, no. 2, 2006-07, ISSN 1832-2883, Parliament of Australia, Canberra.
- PHIAC, 'Operations of the Private Health Insurers', Annual Reports.
- PHIAC (2008), *Annual Report 2007-08*, Annual Reports.
- PHIAC, 'Quarterly Statistics'
- PHIAC, 'Membership Trends, Australia'
- PHIAC, 'Risk Equalisation Financial Year Results by Insurer and State'.
- PHIO (2012) *Annual Report 2012*, Commonwealth of Australia.
- PHIO (2011) *State of the Health Funds Report 2011*.
- Porter, M., Argyres, N. and McGahan, A.M. (2002) *An interview with Michael Porter*, The Academy of Management Executive (1993-2005), Vol. 16, No. 2, Theme: Achieving Competitive Advantage, May 2002, pp.43-52.
- Private Healthcare Australia, 'Annual high claims survey'.
- Private Health Insurance (Health Insurance Business) Rules 2010
- Private Health Insurance (Benefit Requirements) Rules 2011
- Private Health Insurance Act 2007
- Private Health Insurance Ombudsman, 'State of the Health Funds Report'.
- Productivity Commission (2002) *Managed Competition in Health Care*. Workshop proceedings, Canberra 23 August 2002.
- Reid, J. (2012) *Should private health insurers be more competitive*. D'finitive [private health insurance].
- Robson, A., Ergas, H. and Paolucci, F. (2011) *The analytics of the Australian private health insurance rebate and the Medicare levy surcharge*. Agenda, Vol. 18, No 2.
- SA Centre for Economic Studies (2003), *Review of lifetime health cover scheme*, prepared for the Australian Government Department of Health and Ageing.

Schnieder, R. (2002) *Health insurance: managing risk in the private sector*. Australian Health Review Vol. 25, No 6.

Scotton and Macdonald (1993) *The making of Medibank*, School of Health Services Management, Sydney.

Shamsullah, A. (2011) *Australia's private health insurance industry: structure, competition, regulation and role in a less than 'ideal world'*. Australian Health Review 35, 23-31.

Vaithianathan, R. (2001) *An economic analysis of the Private Health Insurance Incentive Act (1998)* Centre for Economic Policy Research, discussion paper No 427.