ACCC

AUSTRALIAN COMPETITION
& CONSUMER COMMISSION

Report to the Australian Senate

On anti-competitive and other practices by health insurers and providers in relation to private health insurance

For the period 1 July 2021 to 30 June 2022

Australian Competition and Consumer Commission
23 Marcus Clarke Street, Canberra, Australian Capital Territory, 2601

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Contents

Shortened terms

ABS	Australian Bureau of Statistics
ACCC	Australian Competition and Consumer Commission
ACL	Australian Consumer Law
AIA	AIA Health Insurance Pty Ltd
Allianz	Allianz Care Australia
AMA	Australian Medical Association
APRA	Australian Prudential Regulation Authority
Bupa	Bupa HI Pty Ltd
CCA	*Competition and Consumer Act 2010* (Cth)
CPI	Consumer price index
DCL	Deferred claims liability
HBF	HBF Health Limited
HCF	The Hospitals Contribution Fund of Australia Limited
HICC	Health Insurance Comparison Choosewell Pty Ltd
Medibank	Medibank Private Limited
MoU	Memorandum of Understanding
MTAA	Medical Technology Association of Australia
NAPP	National Association of Practising Psychiatrists
NIB	NIB Health Funds Limited
OSHC	Overseas student health cover
PHIO	Private Health Insurance Ombudsman
PLAC	Prostheses List Advisory Committee
RMSANZ	Rehabilitation Medicine Society of Australia and New Zealand Ltd
Tribunal	Australian Competition Tribunal

Executive Summary

This is the 24th report to the Australian Senate prepared by the Australian Competition and Consumer Commission (ACCC) on competition and consumer issues in the private health insurance industry. This report is for the period 1 July 2021 to 30 June 2022 (the reporting period).

This report analyses key competition and consumer developments and trends in the private health insurance industry during the reporting period that may have affected consumers' health cover and out-of-pocket expenses. This report is particularly focused on insurer actions taken to return profits to policyholders which were gained from fewer claims during the COVID-19 pandemic.

Increases in private health insurance participation rates continue

Ongoing lower population growth, combined with increasing health insurance membership, led to an estimated increase of 0.8% in the proportion of the population with private health insurance since June 2021. This follows an approximate 1.4% increase in 2020–21, which was the first annual increase since 2015. The private health insurance industry association has attributed this growth to consumers' desire to avoid delays in access to non-urgent surgeries.

A recent survey indicated that the most common reason why consumers do not take out private health insurance is that they feel they cannot afford it (73% of respondents), followed by consumers viewing health insurance as poor value for money (26.8% of respondents).

Average premium increases lowest since 2001, but inflationary pressures may lead to higher premium increases

Average premium increases in 2021–22 were the lowest since 2001, at 2.7%. This followed the previous low of 2.74% from 2020–21. Some insurers did not pass on premium increases to policyholders on 1 April 2022, instead deferring them, including as part of efforts to meet commitments not to profit from the COVID-19 pandemic. However, current inflationary pressures, such as labour shortages and increasing wage costs, may lead to higher premium increases in the future.

Benefit payments fall during Delta and Omicron waves, and value of deferred claims higher, as insurers continue to return COVID-19 profits

In the year to June 2022, government-imposed restrictions in response to the COVID-19 pandemic continued to limit policyholders' access to non-urgent elective surgery and non-urgent extras treatments (including most dental, optical and other health services). Significant restrictions on access to treatments were seen across Victoria, New South Wales (NSW), and to some extent Western Australia and South Australia during the Omicron wave.

This led to significant declines in policyholder claims and the amount of benefits paid out by insurers to policyholders. Insurers paid 4.5% less on average in hospital benefits per policyholder in 2021–22 than in 2020–21. The average amount paid out for extras benefits decreased by 5.4% per policyholder.

There was an 8.2% reduction in benefits paid by insurers to policyholders for hospital treatment in March 2022 (during the Omicron wave) compared to a pre-pandemic benchmark in March 2019. There was also a 12.8% decline in benefits paid for extras in September 2021 (corresponding with major NSW and Victorian restrictions) compared to pre-pandemic figures from September 2019.

The industry's net profit after tax declined overall by 28% during the reporting period, with key factors including investment incomes generating a loss, management expenses increasing and insurers' measures to fulfil their public commitments not to profit from COVID-19. However, limited growth in policyholder claims compared to before the COVID-19 pandemic appears to have tempered this drop in profitability. That is, insurers' profits could have been lower if not for the role of COVID-19 restrictions in reducing the amount of benefit claims.

The deferred claims liability (DCL) is a measure designed to make sure that insurers have adequate capital to meet the costs of services not performed due to restrictions but expected to occur later. The value of insurers' total DCL set aside for this purpose has increased to its highest level of $1.87 billion as at June 2022. This reflects the impact of further restrictions on access to services throughout 2021–22, which reversed a partial reduction of the DCL balance seen in early-to-mid 2021.

The ACCC recognises that insurers have continued to return profits from COVID-19 restrictions to policyholders by various means towards meeting their public commitments not to profit the pandemic, despite ongoing COVID-19 impacts during the reporting period. Department of Health and Aged Care data sets out insurers' 'permanent claims savings', generally defined by insurers as all missing claims due to the pandemic, less claims expected to materialise in future (the DCL). As at 30 June 2022, insurers have assessed that roughly $2.25 billion in claims will not materialise due to COVID-19 impacts.

To work towards meeting their pandemic commitments, insurers have reported returning a total of around $2.1 billion in funds to consumers up to 30 June 2022.

The figures submitted by insurers to the Department of Health and Aged Care suggest that they have largely but not entirely returned permanent claims savings to policyholders through various measures as at 30 June 2022. However, some insurers have also reported significant planned measures to return further savings to policyholders during 2022–23.

Most funds have been returned through premium relief (around $1.08 billion), especially deferral of premium increases. This is closely followed by direct payments to policyholders (around $847 million), with a smaller amount allocated to other measures (approximately $160 million).

'Other measures' encompasses a variety of insurer actions. This includes various additional COVID-19 hardship measures, and some coverage extensions for policyholders. Insurers have generally made these measures opt-in, and they might not apply to all members. For example, some policyholders may not have experienced the financial hardship others faced during COVID-19, or may not have wanted or needed a given additional extras benefit. In line with insurers' commitments not to profit from the COVID-19 pandemic, the ACCC urges insurers to ensure that any provisioning of funds for 'other measures' is utilised by policyholders, otherwise those funds should be returned through direct approaches such as payments or premium relief.

To fulfil their broader commitments, the ACCC expects insurers to continue to return funds to members until they no longer retain any financial benefits from claims that were missed due to COVID restrictions and are not expected to materialise later, including claims that insurers might have originally accounted for in their DCL.

Insurers develop new programs to collect consumer data

Insurers have continued to develop new schemes and build on existing programs which may allow them to access, use and in some cases share consumers' personal information. Private health insurers and other businesses in the health sector should be alive to the highly sensitive nature of the personal information they may be collecting and using. In this regard, private health insurers should ensure they comply with all their obligations, including those under the Australian Consumer Law (ACL).

The ACCC reiterates its concern that while Australia's community rating system for private health insurance prohibits insurers from charging different private health insurance premiums to individual consumers based on health and other factors, consumer data collected by wellbeing apps and rewards schemes could be used for various other purposes. These purposes could include targeted marketing (including from third parties), and creation of insights that could be shared with or sold to third parties.

A recent cybersecurity incident impacting Medibank also highlights the risks that arise when businesses collect large amounts of sensitive data. Insurers should weigh up these risks when considering new measures to collect consumer data, and should have sufficiently robust measures in place to protect against cybersecurity threats.

ACCC enforcement action and competition exemptions

On 6 September 2022, the ACCC announced that health insurance comparison business Health Insurance Comparison Choosewell Pty Ltd (HICC) had admitted breaching the ACL by failing to inform consumers of their termination rights, including a 10 business day cooling-off period, when entering into unsolicited consumer agreements for private health insurance. The ACCC has accepted a 3-year court-enforceable undertaking from HICC in which HICC commits to not entering into unsolicited sales contracts without giving consumers verbal and written information about their termination rights, to notify the relevant health insurance provider that the contract resulted from an unsolicited consumer agreement, and to implement a compliance program. HICC also paid an infringement notice penalty of $13,320.

On 11 November 2022, the Federal Court ordered SmileDirectClub Aus Pty Ltd and its US parent company, SmileDirectClub LLC (together, SmileDirectClub) to pay penalties of $3.5 million for making false or misleading statements, following ACCC action. SmileDirectClub's statements represented to consumers that they may be eligible for a reimbursement for SmileDirectClub aligners and associated treatment from their private health insurer. However, the vast majority (98.5% of the market) of Australian private health insurance companies did not provide coverage for the costs of SmileDirectClub's aligner treatment. The Court also ordered SmileDirectClub to compensate affected consumers, to implement a compliance program, and to pay a contribution to the ACCC's costs.

On 21 September 2021, the ACCC issued a final determination granting conditional authorisation for 5 years to Honeysuckle Health Pty Ltd and NIB Health Funds Limited to form and operate a health services buying group to collectively negotiate and administer contracts with healthcare providers on behalf of the buying group participants, largely private health insurers. In October 2021, the Rehabilitation Medicine Society of Australia and New Zealand Ltd (RMSANZ) and the National Association of Practising Psychiatrists (NAPP) applied to the Australian Competition Tribunal (the Tribunal) for review of this determination. The Tribunal raised concerns about the competitive effects of certain clauses of a settlement deed executed between the parties. The parties ultimately amended the settlement deed to address the Tribunal's concerns on this and other points. On 29 July 2022 the Tribunal subsequently gave the parties leave to withdraw their applications for review.

Prostheses List reforms lead to benefit reductions with a floor

The Prostheses List contains more than 11,000 medical devices (such as most prostheses) and lists the minimum benefits that private health insurers are required to pay (generally to a hospital) when a policyholder receives a listed device as part of hospital or substitute treatment and has the relevant insurance coverage.

Unlike prices for medical devices for public hospital systems, which are purchased centrally and are subject to formal tender processes, benefits that insurers pay for medical devices on the Prostheses List are set by the Minister for Health and Aged Care and their Department.

Reforms to the Prostheses List were initiated in the 2021–22 Federal Budget and will continue over 4 years, with a review of the effectiveness of the reforms to be conducted in 2024. The stated objective of the reforms is to reduce the cost of medical devices used in the private health sector and streamline access to new medical devices. The Department of Health and Aged Care expects that these reforms will lead to reduced premiums for policyholders.

To facilitate these reforms, on 14 March 2022 the then Minister for Health entered a Memorandum of Understanding (MoU) with the industry association representing medical device suppliers, the Medical Technology Association of Australia (MTAA). Under the MoU, most benefits paid to healthcare

providers on the Prostheses List will now be reduced in intervals, with the reductions to be calculated as a percentage of the current gap between Prostheses List benefits and the lower weighted average price paid for prostheses in the public system. Notably, the MoU sets out that reductions in Prostheses List benefits will be subject to a 'floor' for all products – meaning that prostheses benefits cannot be reduced to below 7% above the weighted average price paid in the public system. The MoU also states that no benefit reductions are to occur in year 4 of the reforms (2025–26).

The ACCC's general stance is that competition leads to lower prices, increased efficiency and innovation, better-quality products and services, and greater choice for consumers. Making the minimum benefits set in the Prostheses List more competitive could benefit consumers by reducing the costs incurred by insurers and the insurance premiums they charge. While the ACCC welcomes efforts to reduce the underlying cost of prostheses, the ACCC notes that the MoU's floor on prostheses benefit reductions is likely to have some distortionary impacts on prices for medical devices in private healthcare. Specifically, this floor will lead to some Prostheses List benefits remaining inflated when compared to prices paid for prostheses in the public system. The ACCC considers that the 2024 review of the effectiveness of the Prostheses List reform program should consider the impacts of the MoU, including whether it has had distortionary impacts on prices.

1. Introduction

For its 24th report to the Australian Senate, the Australian Competition and Consumer Commission (ACCC) provides an update on key competition and consumer developments and trends in the private health insurance industry between 1 July 2021 and 30 June 2022 (the reporting period), and some developments since the end of the reporting period.

This report is particularly focused on insurer actions taken to return profits to policyholders which were gained from fewer claims during the COVID-19 pandemic.

1.1 Senate order

This report has been prepared in compliance with a current Australian Senate order, under which the ACCC has an obligation to report annually on competition and consumer issues in the private health insurance industry.[1] The complete Senate order is extracted below.

Senate order

There be laid on the table as soon as practicable after the end of each 12 months ending on or after 30 June 2003, a report by the Australian Competition and Consumer Commission containing an assessment of any anti-competitive or other practices by health insurers or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses.

1.2 Role of the ACCC

The ACCC is an independent Commonwealth statutory agency that promotes competition, fair trading and product safety for the benefit of consumers, businesses and the Australian community. The primary responsibilities of the ACCC are to enforce compliance with the competition, consumer protection, fair trading and product safety provisions of the *Competition and Consumer Act 2010* (CCA), regulate national infrastructure and undertake market studies.

In addition to preparing this report in accordance with the Senate order, the ACCC has a broader role in the private health insurance industry of enforcing and encouraging compliance with the CCA and the Australian Consumer Law (ACL). The statutory consumer protections in the CCA apply to relationships between consumers and health insurers, hospitals, medical facilities, health providers and practitioners. Competition laws also govern relationships between industry participants and, among other things, prohibit anti-competitive arrangements and exclusionary conduct.

The ACCC's Compliance and Enforcement Policy and Priorities outlines our enforcement powers, functions, priorities and strategies.[2] The ACCC updates this document each financial year to reflect current and enduring priorities.

1 Senate procedural order no. 18 Health – Assessment reports by the Australian Competition and Consumer Commission agreed to 25 March 1999, by means of an amendment to the motion that the report of the committee on Health Legislation Amendment Bill (No. 2) 1999 be adopted. J.626, amended 18 September 2002 J.761.

2 ACCC, *ACCC's compliance & enforcement policies and priorities*, 2022–23, https://www.accc.gov.au/about-us/australian-competition-consumer-commission/compliance-enforcement-policy-priorities.

1.3 Methodology

In preparing the 2021–22 private health insurance report the ACCC has drawn on information and data from a range of sources, including desktop research and contacts data.

Key industry data used and relied upon by the ACCC includes:

- industry statistics and data collected by the Australian Prudential Regulation Authority (APRA)[3]
- private health insurance complaints data from the Private Health Insurance Ombudsman (PHIO)[4]
- reports on insurers' progress on fulfilling their commitments not to profit from COVID-19 restrictions, provided by the Department of Health and Aged Care.

3 APRA supervises private health insurers operating in Australia under a regulatory framework as set out on APRA's website.

4 The PHIO is a specialist role of the Commonwealth Ombudsman.

2. Key industry developments and trends

This chapter sets out the key competition and consumer developments and trends in the private health insurance industry in 2021–22.

Summary of key industry developments and trends in 2021–22

- As at 30 June 2022, over 14 million Australians, or approximately 55.2% of the population, had some form of private health insurance. This was an increase of 0.8% in the proportion of the population with private health insurance since June 2021. This follows an approximate 1.4% increase in 2020–21, which was the first annual increase since 2015.
- Australian consumers paid almost $26.6 billion in private health insurance premiums, an increase of over 3.5% ($910 million) from 2020–21. This reflects both premium increases and growing numbers of policyholders.
- Average premium increases were the lowest since 2001, at 2.7%. However, current inflationary pressures may lead to higher premium increases in the future.
- On average, insurers paid 4.5% less in hospital benefits per policyholder than in 2020–21. The average amount paid out by insurers to policyholders for extras benefits decreased by 5.4% per policyholder.
- COVID-19 restrictions resulted in fewer claims being made by policyholders and as a result reduced the amount of benefits paid out by insurers for both hospital and extras treatments during parts of 2021–22. There was an 8.2% reduction in benefits paid by insurers to policyholders for hospital treatment in March 2022 (during the Omicron wave) compared to a pre-pandemic benchmark in March 2019. There was also a 12.8% decline in benefits paid for extras in September 2021 (corresponding with major NSW and Victorian restrictions) compared to pre-pandemic figures from September 2019.
- Insurers' total deferred claims liability (DCL), which broadly accounts for missed claims during COVID-19 which are likely to materialise later, increased to its highest level of $1.87 billion as at June 2022. This reflects the impact of further restrictions on access to services throughout 2021–22, which reversed a partial reduction of the DCL balance seen in early-to-mid 2021.
- Insurers have continued to return profits from COVID-19 restrictions to policyholders by various means towards meeting their public commitments not to profit from the pandemic. As at 30 June 2022, insurers have assessed that roughly $2.25 billion in claims will not materialise due to COVID-19 impacts. To work towards meeting their pandemic commitments, insurers have reported returning a total of around $2.1 billion in funds to consumers up to 30 June 2022. Most funds have been returned through premium relief (around $1.08 billion). This is closely followed by direct payments to policyholders (around $847 million), with a smaller amount allocated to other measures (approximately $160 million).
- The number of exclusionary policies held during 2021–22 increased by around 154,855 (or around 4.6%) with a reduction of nearly 20,000 non-exclusionary policies (or 0.9%) during the same period.
- Over 86% of hospital policies have excesses and co-payments, an 0.8% increase during 2021–22 which continues a longer-term upward trend.
- Insurers have continued to develop new schemes and build on existing programs which may allow them to access, use and in some cases share consumers' personal information.
- Overall complaints to the PHIO decreased by 22.7% from 3,496 in 2020–21 to 2,704 complaints for 2021–22. The ACCC received 137 contacts about private health insurance issues during the reporting period, a 16.5% decrease from the previous year.

2.1 Private health insurance membership

As of 30 June 2022, over 14 million Australians, or approximately 55.2% of the population, had some form of private health insurance. The number of insured persons increased by 2.2% or 307,416 persons from July 2021 to June 2022. APRA estimates that over the same period the population grew by 153,255, or 0.6%.[5]

The annual population growth rate by March 2022 had rebounded to 0.9%[6] from a COVID-19 pandemic-influenced March 2021 low of 0.09%. However, population growth had not yet recovered to the rates seen pre-pandemic throughout the 2010s, which were generally around or slightly above 1.5%.[7]

Ongoing lower population growth, combined with increasing health insurance membership, led to an estimated increase of 0.8% in the proportion of the population with private health insurance since June 2021.[8] This follows an approximate 1.4% increase in 2020–21, which was the first annual increase since 2015.[9] Private Healthcare Australia has suggested that increases in membership have been driven by consumers' desire to avoid delays in access to non-urgent surgeries.[10]

Types of private health insurance

There are broadly 2 types of private health insurance.

Hospital treatment policies help cover the cost of in-hospital treatment by doctors and hospital costs such as accommodation and theatre fees. This report generally refers to these policies as **hospital cover** or **hospital policies**.

General treatment policies, also known as **extras** or ancillary cover, provide benefits for non-medical health services such as physiotherapy, dental and optical treatment. This report generally refers to these policies as **extras cover** or **extras policies**.

Many consumers hold combined policies that provide cover for both hospital and extras services.[11]

Table 1 shows that the proportion of the population holding hospital only or combined cover increased by 0.6% in the year to June 2022. During the same period, the proportion holding extras only policies also increased, but to a lesser degree (0.2%). The table also shows longer-term increases of 1.5% for hospital and combined cover, and 0.6% for extras cover, since June 2020.[12] Despite this growth, one analyst has suggested, based on investor feedback, that the industry may see 'an ultimate reversion to pre-COVID participation'.[13]

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5 APRA, *Statistics: Private health insurance membership trends June 2022*, 24 August 2022, viewed 30 August 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Membership%20Trends%20June%202022.xlsx.

6 The ABS annual population growth rate for June 2022 (which may differ from APRA's estimate of 0.6%) was not available at the time of publication.

7 Australian Bureau of Statistics (ABS), *National, state and territory population March 2022*, viewed 7 October 2022, https://www.abs.gov.au/statistics/people/population/national-state-and-territory-population/latest-release.

8 APRA, *Statistics: Private health insurance membership trends June 2022*, 24 August 2022, viewed 30 August 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Membership%20Trends%20June%202022.xlsx.

9 ACCC, *Private health insurance report 2020–21*, 9 December 2021, p 7, https://www.accc.gov.au/system/files/Private%20health%20insurance%20report%202020-21.pdf.

10 Kristen Jelinek, *Wait times are blowing out – How can private health insurance help?*, News.com.au, 2 June 2022, viewed 16 September 2022, https://www.news.com.au/best-of/money/waiting-lists/news-story/c855f5e5fa3398be3308b0904183f2c8.

11 Ambulance cover may be available separately, combined with other policies, or in some cases is covered by state or territory governments. See the PHIO website for more information.

12 APRA, *Statistics: Private health insurance membership trends June 2022*, 24 August 2022, viewed 30 August 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Membership%20Trends%20June%202022.xlsx.

13 Jared Lynch, *Is private health insurance worth it? More people say yes*, The Australian, 28 July 2022, viewed 19 September 2022, https://www.theaustralian.com.au/business/is-private-health-insurance-worth-it-more-people-say-yes/news-story/e1194807e4da928b0fb48c1b4df1709c.

Results from a 2021 survey indicate that the most common reason why consumers do not take out private health insurance is that they feel they cannot afford it (73% of respondents), followed by consumers viewing health insurance as poor value for money (26.8% of respondents).[14]

Table 1: Insured Australian consumers by policy type, June 2020 to June 2022

	Hospital only or combined cover	Extras cover only	Total insured persons
June 2020	**11,197,395**	**2,413,400**	**13,610,795**
% of population	*43.7%*	*9.4%*	*53.1%*
June 2021	**11,442,584**	**2,522,329**	**13,964,913**
% of population	*44.6%*	*9.8%*	*54.4%*
June 2022	**11,678,283**	**2,594,046**	**14,272,329**
% of population	*45.2%*	*10%*	*55.2%*

Note: Figures may not add up due to rounding. Population is an APRA estimate for June 2022, and is otherwise sourced from ABS data.

Source: APRA, *Statistics: Private health insurance membership trends June 2022*.

Membership by health insurer

There are a total of 33 health funds operating in Australia, including not-for-profit insurers and for-profit insurers.[15] Our previous report noted that there were 35.[16] This has changed after the Railway & Transport Health Fund Limited merged with The Hospitals Contribution Fund of Australia Limited (HCF), while Nurses and Midwives Health Pty Ltd merged with Teachers Federation Health.[17]

Medibank Private Limited (Medibank) remained Australia's largest health insurer in 2021–22, ending the financial year with around 3.76 million members (measured by individuals covered). Bupa HI Pty Ltd (Bupa) had approximately 3.64 million members.[18]

To the end of June 2022, the 5 largest health insurers in Australia provided cover to around 81% of Australian consumers with private health insurance.

Figure 1 shows that Medibank and Bupa represented just over half of the Australian private health insurance market, with market shares of 26.3% and 25.5% respectively. The next 3 largest insurers – HCF, NIB Health Funds Limited (NIB) and HBF Health Limited (HBF) – had a combined market share of around 29.1%.

14 Zurynski et. al., *The Voice of Australian Health Consumers: The 2021 Australian Health Consumer Sentiment Survey*, 2022, viewed 14 September 2022, https://healthsystemsustainability.com.au/wp-content/uploads/2022/03/PCHSS_ConsumerSentimentSurveyReport_FINAL3.pdf, p 15.

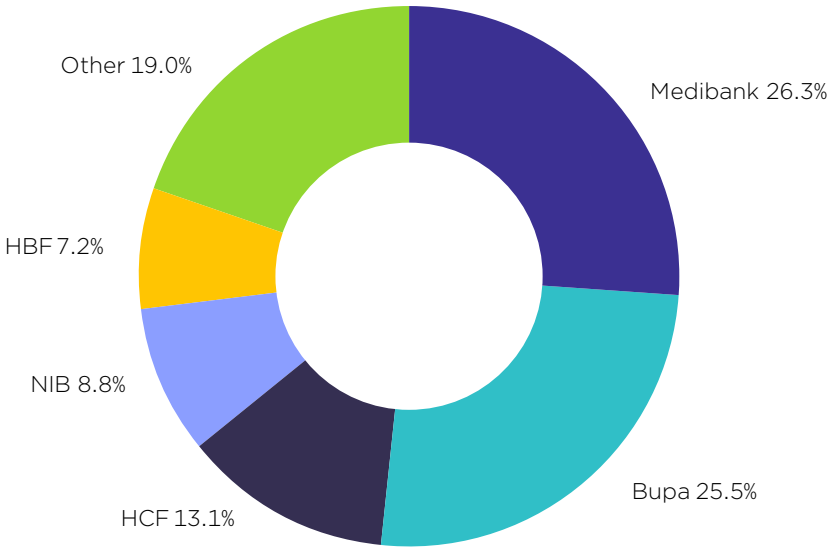
15 APRA, *Register of private health insurers*, 5 August 2022, viewed 26 October 2022, https://www.apra.gov.au/register-of-private-health-insurers.

16 ACCC, *Private health insurance report 2020–21*, 9 December 2021, https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2020–21, p 8.

17 APRA, *Operations of private health insurers annual report 2021–22*, 26 October 2022, viewed 26 October 2022, https://www.apra.gov.au/operations-of-private-health-insurers-annual-report.

18 APRA, *Operations of private health insurers annual report 2021–22*, 26 October 2022, viewed 26 October 2022, Table 3, https://www.apra.gov.au/operations-of-private-health-insurers-annual-report.

Figure 1: Insurer market share by Australians covered, 2021–22



Source data: APRA, *Operations of private health insurers annual report 2021–22*, Table 3.

The 5 largest health insurers contributed to 78% of total health fund benefits paid in 2021–22[19], with Medibank and Bupa contributing 25.4% and 24.3% respectively.[20] Benefits paid by health insurers are discussed further in section 2.3.

2.2 Premiums paid by consumers to health insurers increased

Premium increases, and growth in the number of insured persons, have led to Australian consumers paying almost $26.6 billion in private health insurance premiums in 2021–22, an increase of over $910 million (or 3.5%) compared to the previous year.[21]

Table 2: Total consumer expenditure on private health insurance, per year, by dollar and percentage change, June 2020 to June 2022

	$ paid (in '000)	$ change from previous year (in '000)	% change from previous year
June 2020	24,895,332	333,638	1.4%
June 2021	25,680,469	785,137	3.2%
June 2022	26,590,698	910,229	3.5%

Source: APRA, *Statistics: Quarterly private health insurance statistics*, June 2020, 2021 and 2022.

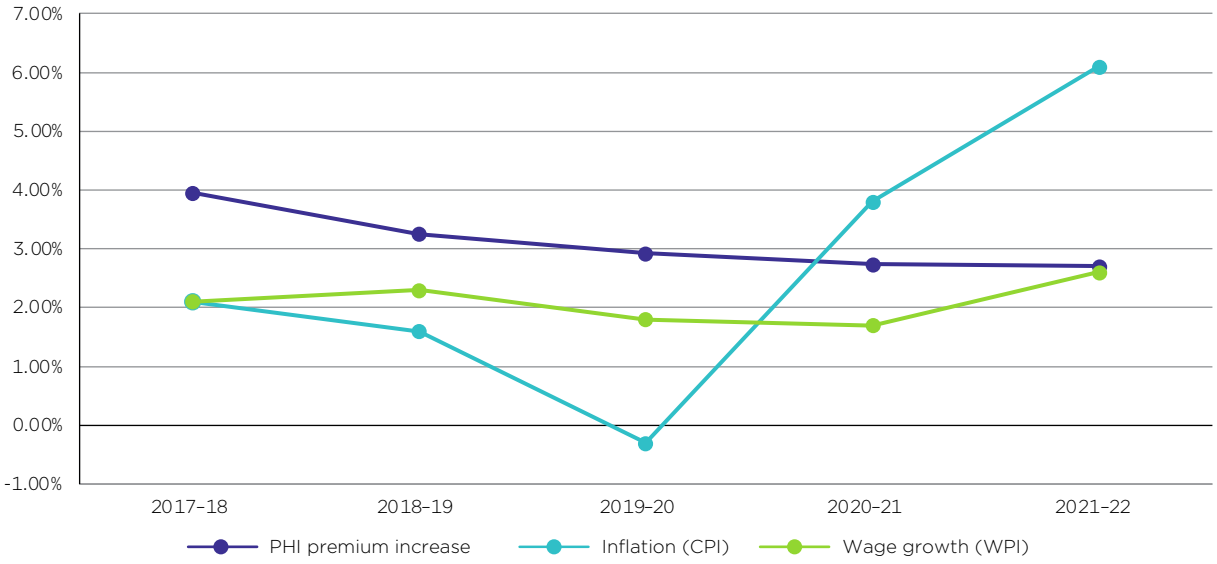
Figure 2 compares average premium increases (on an industry weighted average basis) with the inflation rate and the rate of growth in wages from 2017–18 to 2021–22.

19 The amount paid by an insurer to a policyholder to cover health care costs, inclusive of state levies.

20 APRA, *Operations of private health insurers annual report 2021–22*, 26 October 2022, viewed 26 October 2022, Table 3, https://www.apra.gov.au/operations-of-private-health-insurers-annual-report.

21 APRA, *Statistics: Quarterly private health insurance statistics June 2022*, 24 August 2022, viewed 31 August 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202022.pdf.

Figure 2: Private health insurance premium increases, inflation and wage growth, 2017–18 to 2021–22



Source data: Department of Health and Aged Care, *Average annual price changes in private health insurance premiums*; Australian Bureau of Statistics (ABS), *Consumer price index, Australia June 2022*; ABS, *Wage Price Index, Australia June 2022*, *Table 1. Total hourly rates of pay excluding bonuses: sector, original, seasonally adjusted and trend*.

Average premium increases in 2021–22 were the lowest since 2001, at 2.7%.[22] This followed the previous low of 2.74% from 2020–21. Some insurers did not pass on premium increases to policyholders on 1 April 2022, instead deferring them, including as part of efforts to meet commitments not to profit from the COVID-19 pandemic. More details on insurers' responses to COVID-19 are set out at Section 2.4.

Current inflationary pressures may lead to higher premium increases in the future. The 6.1% annual rise in consumer price index (CPI) inflation for 2021–22 was the largest rise since the introduction of the goods and services tax and was driven by higher fuel prices and dwelling construction costs.[23] More specifically, IBISWorld has suggested that the private hospital industry faces staff shortages which could drive higher wage costs.[24]

However, health inflation for 2021–22 was at 2.4%, well below the broader inflation rate of 6.1%. Health inflation is a component of the CPI, and refers to prices for health goods and services, including private health insurance premiums as well as other hospital, dental and medical services, pharmaceutical products and therapeutic equipment.[25]

Figure 3 compares the cumulative increase in average private health insurance premiums with broader health inflation, wage growth and CPI over the 5 years to 2021–22. This shows that the cumulative increase in premiums over the 5 years to June 2022 has outpaced the other metrics, particularly wage growth.

22 Private Healthcare Australia, *Health Funds are committed to easing cost of living pressures on Australian families*, media release, 23 December 2021, viewed 31 August 2022, https://www.privatehealthcareaustralia.org.au/health-funds-are-committed-to-easing-cost-of-living-pressures-on-australian-families/; Daniel Graham and Uta Mihm, *Health insurance premium increases in 2022*, CHOICE, 12 April 2022, viewed 31 August 2022, https://www.choice.com.au/money/insurance/health/articles/health-premium-hikes-on-the-horizon-131115.

23 ABS, *CPI rose 1.8% in the June 2022 quarter*, media release, 27 July 2022, viewed 5 September 2022, https://www.abs.gov.au/media-centre/media-releases/cpi-rose-18-june-2022-quarter.

24 Ama Richardson, *Private General Hospitals in Australia – Industry Outlook*, IBISWorld, October 2022, viewed 24 October 2022, https://my.ibisworld.com/au/en/industry/q8401b/industry-outlook.

25 ABS, *Consumer price index: Concepts, sources and methods Australia 2018*, 27 February 2019, viewed 31 August 2022, https://www.abs.gov.au/statistics/detailed-methodology-information/concepts-sources-methods/consumer-price-index-concepts-sources-and-methods/2018/price-collection#health.

Figure 3: Cumulative increase in average private health insurance premiums, inflation (CPI and health) and wage growth, 2017–18 to 2021–22

Source data: Department of Health and Aged Care, *Average annual price changes in private health insurance premiums*; Australian Bureau of Statistics (ABS), *Consumer price index, Australia June 2022*; ABS, *Wage Price Index, Australia June 2022*, *Table 1. Total hourly rates of pay excluding bonuses: sector, original, seasonally adjusted and trend.*

2.3 Hospital and extras benefit payments decreased

The COVID-19 pandemic substantially reduced the levels of benefits paid out by insurers. Section 2.4 describes the impacts of COVID-19 on benefit payouts, and associated impacts on insurer profitability, in more detail.

Table 3 shows that insurers paid 4.5% less on average in hospital benefits per policyholder in 2021–22 than in 2020–21. The average amount paid out by insurers to policyholders for extras benefits decreased by 5.4% per policyholder.

Table 3: Average benefits paid by health insurers to consumers, per consumer, 2020–21 to 2021–22

	2020–21	2021–22	Change
Hospital benefit per consumer ($)[26]	$1,393	$1,330	-4.5%
Extras benefit per consumer ($)[27]	$445	$421	-5.4%

Source: APRA, *Statistics*: *Quarterly private health insurance statistics*, June 2022.

26 To June 2021, the hospital benefit per consumer was precisely $1 392.86 and to June 2022 it was $1 330.45.

27 To June 2021, the extras benefit per consumer was precisely $444.60 and to June 2022 it was $420.70.

2.4 Insurer responses to COVID-19

Reduced access to treatment continued in 2021–22

In the year to June 2022, government-imposed restrictions in response to the COVID-19 pandemic continued to limit policyholders' access to non-urgent elective surgery and non-urgent extras treatments (including most dental, optical and other health services). The effects were most pronounced in NSW and Victoria, as was the case in 2020–21. Tables 4 and 5 show how services were restricted in these jurisdictions, focusing on surgery and dental treatments.

Table 4: Summary of key changes in access to private healthcare, New South Wales, 2021–22

Date	Event
12 July 2021	Due to Sydney COVID-19 restrictions, the Dental Council of NSW issue guidance recommending that dental practitioners in Greater Sydney should defer all non-essential treatment.[28]
18 August 2021	Announcement that non-urgent elective surgery would be postponed at some NSW private hospitals from 23 August 2021.[29]
5 October 2021	Announcement that Greater Sydney private hospitals would recommence some non-urgent day surgery from 5 October 2021.[30]
6 October 2021	Dental Council of NSW note a planned easing of restrictions on 11 October 2021, asking dental practitioners to deliver any care with 'correct risk-based precautions including COVID risk assessment'.[31]
20 October 2021	Announcement that restrictions on overnight elective procedures would be loosened from 25 October 2021 in Greater Sydney.[32]
12 November 2021	Announcement that elective surgery would begin returning to full capacity from 15 November 2021 in Greater Sydney.[33]
10 January 2022	Overnight non-urgent elective surgery suspended in private hospitals in NSW to ensure sufficient staffing and bed capacity to meet demand during the Omicron wave of COVID-19.[34]
1 February 2022	Announcement that overnight non-urgent elective surgery would resume in stages from 7 February 2022.[35]

28 Dental Council of NSW, *Notice from the Dental Council of NSW Update on COVID-19*, media release, 12 July 2021, viewed 8 September 2022, https://www.dentalcouncil.nsw.gov.au/notice-dental-council-nsw-update-covid-19.

29 NSW Health, *Private hospital staff join pandemic response*, media release, 18 August 2021, viewed 7 September 2022, https://www.health.nsw.gov.au/news/Pages/20210818_02.aspx.

30 NSW Health, *Non-urgent elective day surgery to recommence at private facilities in Greater Sydney*, media release, 1 October 2021, viewed 7 September 2022, https://www.health.nsw.gov.au/news/Pages/20211001_01.aspx.

31 Dental Council of NSW, *Notice from the Dental Council of NSW: Update on COVID-19*, media release, 6 October 2021, viewed 8 September 2022, https://www.dentalcouncil.nsw.gov.au/notice-dental-council-nsw-update-covid-19-3.

32 NSW Health, *Non-urgent elective surgery to resume across Greater Sydney*, media release, 20 October 2021, viewed 7 September 2022, https://www.health.nsw.gov.au/news/Pages/20211020_01.aspx.

33 NSW Health, *Elective surgery to return to full capacity for patients in Greater Sydney*, media release, 12 November 2021, viewed 7 September 2022, https://www.health.nsw.gov.au/news/Pages/20211112_01.aspx.

34 NSW Health, *Staged return of non-urgent elective surgery*, media release, 1 February 2022, viewed 7 September 2022, https://www.health.nsw.gov.au/news/Pages/20220201_00.aspx.

35 NSW Health, *Staged return of non-urgent elective surgery*, media release, 1 February 2022, viewed 7 September 2022, https://www.health.nsw.gov.au/news/Pages/20220201_00.aspx.

Table 5: Summary of key changes in access to private healthcare, Victoria, 2021–22

Date	Event
5 August 2021	Victoria enters 'lockdown'.[36] This lockdown ultimately continued in metropolitan Melbourne until late October 2021.[37] Only certain emergency and urgent surgeries were authorised. Likewise, for a time, dental services were only authorised in certain urgent cases.[38]
22 October 2021	Dental care permitted to resume in Victoria.[39]
November 2021	Elective surgery remained restricted in the private system to an extent as measures eased, with private hospitals in Melbourne and Geelong increasing their elective surgery capacity, but remaining capped, through November.[40]
5 January 2022	Announcement that elective surgery would again be restricted to urgent procedures only in private hospitals in Melbourne and major regional cities from 6 January 2022, in response to increasing case numbers.[41]
February 2022	Private hospital capacity was gradually increased throughout the month, with the Victorian Government announcing in mid-February 2022 that all elective surgery in private hospitals could resume by the end of the month.[42]

Restrictions were also in place at times in other jurisdictions. The South Australian state government restricted access to elective surgery in response to COVID-19 from January to February 2022.[43] In Western Australia, a 'scale down' of elective surgery bookings in private hospitals began in March 2022. Private hospitals were then able to 'scale up' from early May 2022.[44]

COVID-19 restrictions resulted in fewer claims being made by policyholders and as a result reduced the amount of benefits paid out by insurers for both hospital and extras treatments during parts of 2021–22. Both Figure 4 and Figure 5 show how a previously relatively stable cycle with benefits paid out gradually rising over time was disrupted by COVID-19.

Figure 4 shows that benefits paid out for hospital treatment in the March 2022 quarter were under $3.4 billion. This was a decline of 8.2% from the pre-pandemic March 2019 quarter figure of around $3.7 billion. This low corresponds with elective surgery restrictions implemented in several jurisdictions in response to the Omicron wave.

36 Premier of Victoria, *Seven Day Lockdown To Keep Victorians Safe*, media release, 5 August 2021, viewed 6 September 2022, https://www.premier.vic.gov.au/seven-day-lockdown-keep-victorians-safe.

37 Victorian Department of Health, *Coronavirus update for Victoria – 21 October 2021*, viewed 7 October 2022, https://www.health.vic.gov.au/media-releases/coronavirus-update-for-victoria-21-october-2021.

38 Premier of Victoria, *Lockdown Restrictions/Statewide Restrictions*, 5 August 2021, 21 August 2021, 2 September 2021, all viewed 6 September 2022.

39 University of Melbourne – Melbourne Dental Clinic, *COVID-19 Update*, viewed 8 September 2022, https://dental.unimelb.edu.au/dental-clinic/patients/covid-19-update.

40 Premier of Victoria, *More Elective Surgery To Resume*, media release, 11 November 2021, viewed 8 September 2022, https://www.premier.vic.gov.au/more-elective-surgery-resume; Premier of Victoria, *Elective Surgery Increases For Regional And Private Hospitals*, media release, 26 November 2021, viewed 8 September 2022, https://www.premier.vic.gov.au/elective-surgery-increases-regional-and-private-hospitals.

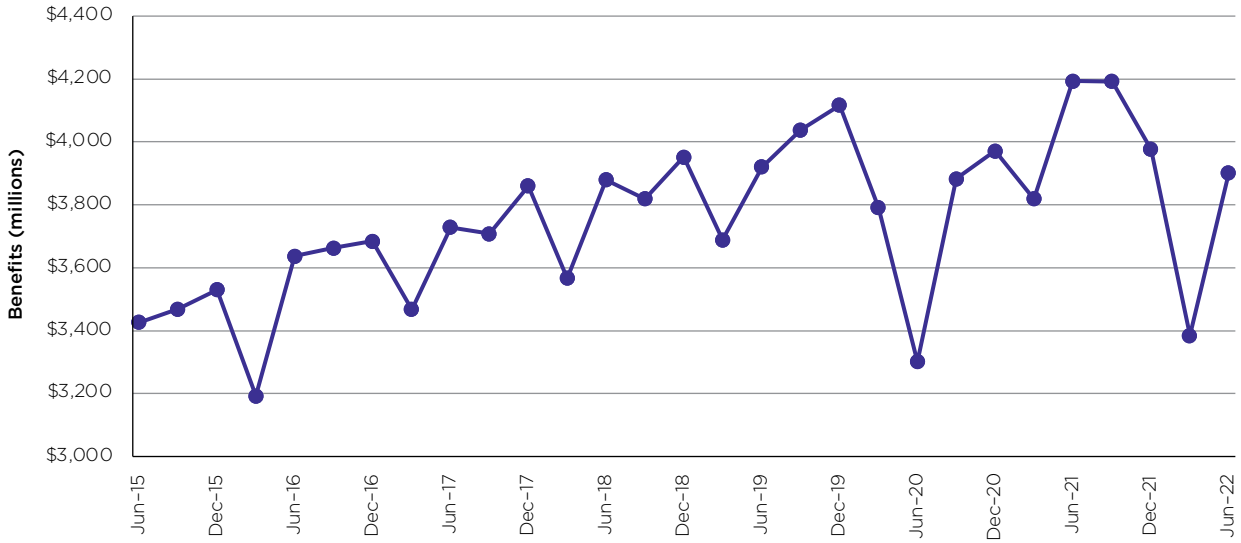
41 Victorian Department of Health, *Changes to non-urgent surgery settings helping hospitals respond to Omicron*, media release, 5 January 2022, viewed 7 September 2022, https://www.health.vic.gov.au/media-releases/changes-to-non-urgent-surgery-settings-helping-hospitals-respond-to-omicron.

42 Premier of Victoria, *Final Steps To Resume All Elective Surgery*, media release, 16 February 2022, viewed 7 September 2022, https://www.premier.vic.gov.au/final-steps-resume-all-elective-surgery.

43 SA Health, *Fact Sheet: February 2022 – Elective Surgery and Procedures*, February 2022, viewed 7 September 2022, https://www.sahealth.sa.gov.au/wps/wcm/connect/09ba531a-851d-4021-83f4-f1531f8fcbdb/Elective+Surgery+and+Elective+Procedures+FAQs+February+2022.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-09ba531a-851d-4021-83f4-f1531f8fcbdb-nXD4.Fv; see also Government of South Australia, *CEASED Appropriate Surgery Directions*, 28 February 2022, viewed 7 September 2022, https://www.legislation.sa.gov.au/legislation/CV19/appropriate-surgery-directions.

44 Government of Western Australia, *More elective surgery bookings resume at hospitals*, media release, 1 May 2022, viewed 7 September 2022, https://www.mediastatements.wa.gov.au/Pages/McGowan/2022/05/More-elective-surgery-bookings-resume-at-hospitals.aspx.

Figure 4: Total hospital benefits paid out by quarter, June 2015 to June 2022



Source data: APRA, *Quarterly Private Health Insurance Benefit Trends June 2022*.

Figure 5 illustrates that benefits paid out for extras treatment fell in the September 2021 quarter to around $1.13 billion. This was a decline of 12.8% from the pre-pandemic September 2019 quarter figure of around $1.3 billion. This fall corresponded with major lockdowns and restrictions in NSW and Victoria.

Figure 5: Total extras benefits paid out by quarter, June 2015 to June 2022

Source data: APRA, *Quarterly Private Health Insurance Benefit Trends June 2022*.

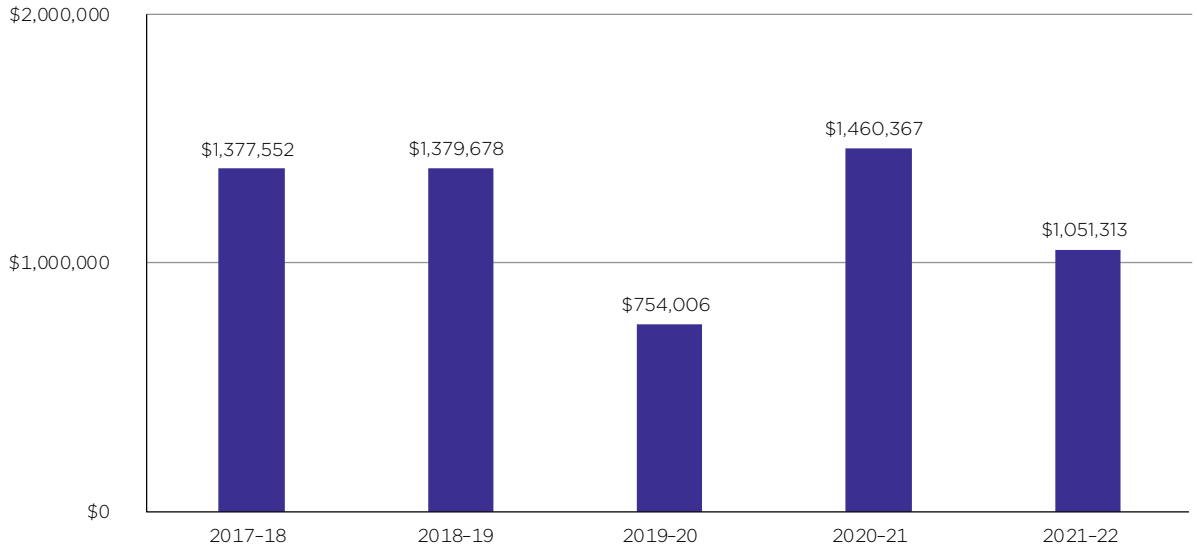
The ACCC's 2020–21 report to the Senate noted that some of these services are likely to be sought in the future, while other services are unlikely to materialise, such as missed dental 'clean and scale' appointments.[45]

APRA noted in March 2022 that techniques have evolved to estimate the types of claims that are more likely to materialise, for example:

- for hospital treatments, surgical claims are more likely to return compared to non-surgical claims
- for extras treatment, major dental claims are more likely to return compared to other extras claims.[46]

Services which are unlikely to materialise are likely to contribute to an increase in insurer profit if not offset by other policyholder returns. Figure 6 shows industry net profit after tax over 5 years.

Figure 6: Private health insurers' net profit after tax ('000s), 2017–18 – 2021–22



Source data: APRA, *Quarterly private health insurance statistics*, June 2019, June 2020, June 2021 and June 2022.

The industry's net profit after tax declined overall by 28% during the reporting period. Various factors influenced this outcome for 2021–22, including:

- investment incomes generating a loss, falling from a gain of $604 million in the previous financial year to a loss of $293 million in the year to June 2022[47]
- management expenses increased 8.3%, or by around $200 million[48]
- insurers' measures taken to fulfil their public commitments not to profit from COVID-19.[49]

However, limited growth in policyholder claims compared to before the COVID-19 pandemic appears to have tempered this drop in profitability, with only marginal growth of 0.6% overall.[50] That is, insurers'

45 ACCC, *Private health insurance report 2020–21*, 9 December 2021, https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2020-21, p 13.

46 APRA, *Application of the capital framework for COVID-19 related disruptions – frequently asked questions*, 21 March 2022, viewed 9 September 2022, https://www.apra.gov.au/application-of-capital-framework-for-covid-19-related-disruptions-frequently-asked-questions.

47 APRA, *Quarterly private health insurance statistics – highlights*, June 2022, 24 August 2022, viewed 9 September 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20Highlights%20June%202022.pdf, p 3.

48 APRA, *Quarterly private health insurance statistics June 2022*, 24 August 2022, viewed 9 September 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202022.pdf, p 10.

49 APRA, *Quarterly private health insurance statistics – highlights*, June 2022, 24 August 2022, viewed 9 September 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20Highlights%20June%202022.pdf, p 3.

50 APRA, *Quarterly private health insurance statistics – highlights*, June 2022, 24 August 2022, viewed 9 September 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20Highlights%20June%202022.pdf, p 3.

profits could have been lower if not for the role of COVID-19 restrictions in reducing the amount of benefit claims. Insurers also experienced higher premium revenue, which was attributable to both premium increases[51] and growing membership.[52]

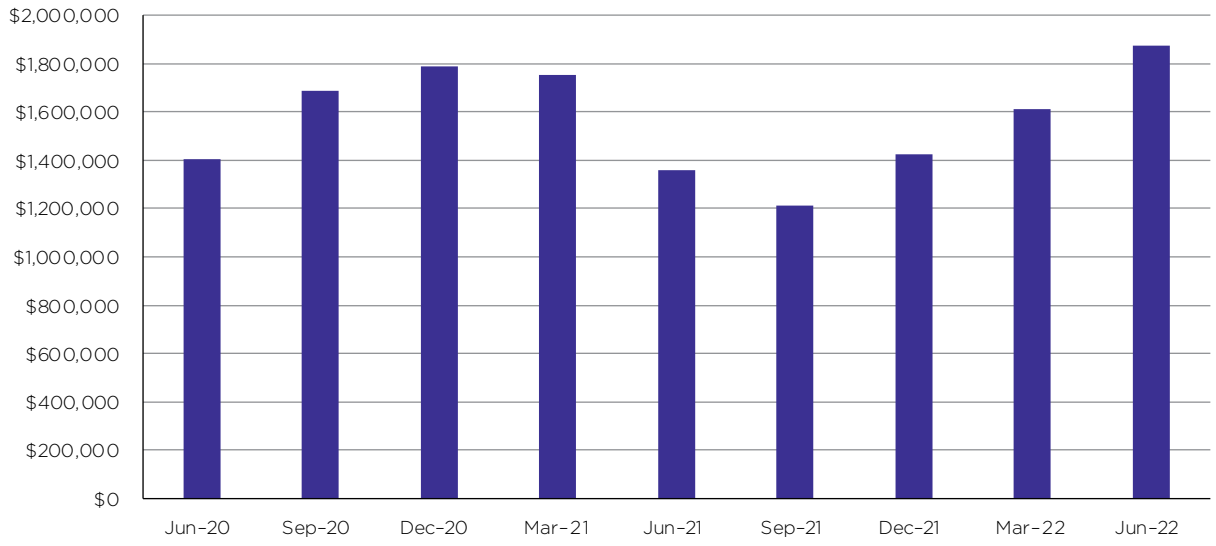
The industry held total assets of $19.8 billion as at 30 June 2022, with total assets increasing by $2.0 billion during 2021–22. Total liabilities reported by the industry increased by $1.6 billion to nearly $9.9 billion during the reporting period, of which nearly $1.9 billion is insurers' DCL (see next section).[53]

The deferred claims liability

The DCL[54] broadly accounts for private health insurance claims deferred during the pandemic that are likely to materialise later. APRA issued guidance to insurers on calculating their DCL in June 2020, which was designed to protect the interests of policyholders by making sure that insurers would have adequate capital to meet the costs of services that were not performed due to restrictions, but expected to occur later.[55] During 2022, APRA has taken a principles-based approach, allowing insurers to adopt their own methodology for calculating their DCL.[56]

Figure 7 illustrates that the total DCL across all insurers has increased to its highest level of $1.87 billion as at June 2022. This reflects the impact of further restrictions on access to services throughout 2021–22, which reversed a partial reduction of the DCL balance seen in early-to-mid 2021.

Figure 7: Private health insurers' deferred claims liability balance ('000s) by quarter, June 2020 – June 2022



Source data: APRA, *Quarterly private health insurance statistics*, June 2020, December 2020, June 2021, December 2021 and June 2022. NB DCL is recorded in financial information in these statistical reports as 'Other fund liabilities, of which: Other insurance liabilities'.

The DCL is likely to decline throughout 2022–23 if pandemic restrictions remain more limited than was seen in 2021–22. Whether deferred claims materialise will be influenced by the capacity of the health system to meet demand. A prolonged period without restrictions may lead to deferred

51 See section 2.2 of this report for further detail about premiums paid by consumers to insurers.

52 See section 2.1 of this report for further detail about private health insurance membership.

53 APRA, Quarterly private health insurance statistics June 2022, 24 August 2022, viewed 9 September 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202022.pdf, p 11.

54 A more detailed account of the history and purpose of the DCL is available in the ACCC's Private Health Insurance Report to the Senate 2020–21, pp 15–7.

55 APRA, *Application of the capital framework for COVID-19 related disruptions*, 22 June 2020, viewed 19 September 2022, https://www.apra.gov.au/application-of-capital-framework-for-covid-19-related-disruptions.

56 APRA, *Application of the capital framework for COVID-19 related disruptions – frequently asked questions*, 21 March 2022, viewed 19 September 2022, https://www.apra.gov.au/application-of-capital-framework-for-covid-19-related-disruptions-frequently-asked-questions.

claims materialising and utilisation of the DCL. Alternatively, insurers may review their valuations and determine that some claims accounted for in the DCL ultimately will not materialise. Insurers should fulfil their commitments to not profit from COVID-19, and return the value of permanently missed claims to policyholders.

Insurers' initiatives to return profits to policyholders

Restrictions and other COVID-19 impacts continued to generate deferred or permanently 'missing' claims during the reporting period. The Australian Private Hospitals Association has estimated that 'missing' admissions in private hospitals have increased to 445,000 in June 2022 since the beginning of the pandemic, with 145,000 missing episodes added over 2021–22.[57]

The ACCC recognises that insurers have continued to return profits from COVID-19 restrictions to policyholders by various means towards meeting their public commitments not to profit the pandemic, despite ongoing COVID-19 impacts during the reporting period.

Insurer data submitted to the Department of Health and Aged Care provides an industry-wide figure for 'permanent claims savings' and the total amount of money directed to 'givebacks and relief', that is, measures taken by insurers to fulfil their pandemic commitments. Insurers were able to set out their own definitions and calculation method to arrive at figures for each of these items.

Most insurers have defined 'permanent claims savings' as all missing claims due to the pandemic, less claims expected to materialise in future (the DCL). As at 30 June 2022, insurers have assessed that roughly $2.25 billion in claims will not materialise due to COVID-19 impacts.

To work towards meeting their pandemic commitments, insurers have reported returning a total of around $2.1 billion in funds to consumers up to 30 June 2022.

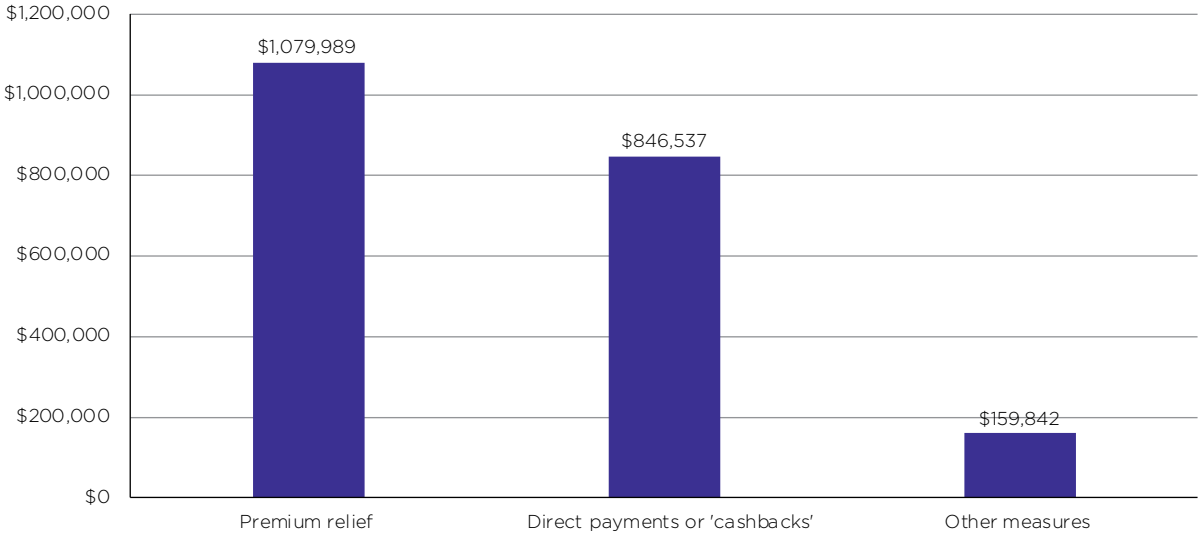
The figures submitted by insurers to the Department of Health and Aged Care suggest that they have largely but not entirely returned permanent claims savings to policyholders through various measures as at 30 June 2022. However, some insurers have reported significant planned measures to return further savings to policyholders during 2022–23. Some insurers also reported having returned all permanent claims savings as at 30 June 2022, though this does not necessarily mean that an insurer does not need to take any further steps to meet their commitments (such as if, over time, it becomes clear to the insurer that some claims accounted for in its DCL will not materialise).

Figure 8 sets out the different ways in which insurers have provided their 'givebacks and relief' to policyholders. Most funds have been returned through premium relief (around $1.08 billion), especially deferral of premium increases. Many funds deferred premium increases in 2022, meaning increases were applied in October and November, rather than April as would usually be the case.[58] This is closely followed by direct payments to policyholders (around $847 million), with a smaller amount allocated to other measures (approximately $160 million).

57 Australian Private Hospitals Association, *More Australians left with long waits for elective surgery*, media release, 24 August 2022, viewed 9 September 2022, https://apha.org.au/wp-content/uploads/2022/08/24082022_APRA_FINAL.pdf.

58 Joel Gibson, *Health insurance rates are increasing, but here's how to soften the blow*, The Age, 27 September 2022, viewed 11 October 2022, https://www.theage.com.au/money/planning-and-budgeting/health-insurance-rates-are-increasing-but-here-s-how-to-soften-the-blow-20220927-p5bla9.html.

Figure 8: Private health insurers' COVID-19 'givebacks and relief' by method of distribution ('000s), as at 30 June 2022



Source data: Department of Health and Aged Care pandemic commitment monitoring reports.

'Other measures' encompasses a variety of insurer actions. This includes various additional COVID-19 hardship measures, and some coverage extensions for policyholders. Insurers have generally made these measures opt-in, and they might not apply to all members. For example, some policyholders may not have experienced the financial hardship others faced during COVID-19, or may not have wanted or needed a given additional extras benefit. This stands in contrast to direct payments and premium relief, where wider groups of policyholders have received direct financial benefits from insurers.

In line with insurers' commitments not to profit from the COVID-19 pandemic, the ACCC urges insurers to ensure that any provisioning of funds for 'other measures' is utilised by policyholders, otherwise those funds should be returned through direct approaches such as payments or premium relief. For example, if additional extras benefits are not claimed, or the cost of hardship measures has been less than expected, insurers should take further measures to return any leftover funds.

The following summarises the 'big 5'[59] insurers' publicly stated progress in following through on their COVID-19 commitments to date:

- **Medibank** has stated that it has 'stuck by' its commitment not to profit from COVID. It has also stated that it continues 'to assess known permanent net claims savings due to COVID to return to our customers in the future'.[60] Notable recent actions include a pause on premium increases for 7 months from April to November 2022, and cash payments into members' bank accounts averaging approximately $28 for extras only policies, and $123 for combined policies.[61] As at August 2022, Medibank reported that its total 'support package' to meet its commitment to not profit from COVID-19 was around $682 million.[62]
- **Bupa** representatives have previously stated that it is not the case that health insurers have increased profit and benefited from the COVID-19 pandemic.[63] Bupa's results appear to nevertheless indicate that, like other health insurers, Bupa has received fewer claims from policyholders into 2022 and

59 The 'big 5' insurers are Medibank, Bupa, HCF, NIB and HBF. See Figure 1 for a detailed market share breakdown.

60 Medibank Private Ltd, *2022 full year results*, ASX release, 18 August 2022, viewed 12 September 2022, https://www.medibank.com.au/livebetter/newsroom/post/2022-full-year-results.

61 Medibank Private Ltd, *Medibank returning another $205m to customers bringing total COVID-19 customer give back to a record $682m*, ASX release, 22 June 2022, viewed 12 September 2022, https://www.medibank.com.au/livebetter/newsroom/post/medibank-returning-another-205m-to-customers-bringing-total-covid-19.

62 Medibank Private Ltd, *Medibank 2022 full year results*, ASX release, 18 August 2022, viewed 12 October 2022, https://yourir.info/resources/229150fa807ea4f2/announcements/mpl.asx/3A599336/MPL_FY22_Results_Media_Release.pdf?embed=1.

63 Jared Lynch, *We're not profiteering from Covid: Bupa boss*, The Australian, 21 March 2022, https://www.theaustralian.com.au/business/companies/were-not-benefiting-from-covid-says-bupa-boss-hisham-elansary-as-profit-jumps-69pc/news-story/41e08e132d3d32cc1fc86634d5deab7a.

accordingly paid a reduced amount of benefits. In the March quarter of 2022, Bupa 'saw reduced claims levels in Australian Health Insurance... as localised lockdowns persisted'.[64] It follows from this statement that pandemic impacts have financially benefitted Bupa.

Bupa announced on 13 September 2022 that it would return $315 million to eligible policyholders (or between $35 and $314 per policyholder depending on their policy and location). Bupa has said that it is honouring its commitment made at the start of the pandemic not to benefit from COVID-19.[65] Bupa stated in its 2022 half year results that it has provided $640 million in 'support to Australian insurance customers' since the pandemic started.[66]

- **HCF** announced on 3 September 2022 that it was maintaining its promise not to profit from the pandemic through an additional $130 million 'giveback' to members to be returned by December 2022. HCF stated that this was part of a total of $300 million in benefits and support for members during the pandemic, which also included deferrals of both 2020 and 2022 premium increases (for 6 and 7 months respectively).[67]
- **NIB** has previously noted its 'promise to return claims savings to members in recognition of the impact of COVID-19 restrictions on its members' ability to access some health services'.[68] In August 2022, NIB outlined its COVID-19 response and its increased profitability due to COVID-19 impacts:

  > Our higher level of profitability partially reflects deferred or foregone healthcare treatment. Members postponed or found it difficult to access hospital and other healthcare services through the COVID-19 pandemic. We have pre-emptively returned savings to members in a range of ways, and made provisions in our financial accounts for much of the deferred treatment, expecting catch-up at some future time.
  >
  > To date, we have provided premium deferrals, premium credits, expanded COVID-19 treatment cover, and additional benefits at no extra cost to members.[69]

  NIB announced a further return of $40 million to customers on 20 September 2022, through payments into its policyholders' bank accounts. NIB stated that this meant that its overall COVID-19 'support package' totalled $145 million.[70]

64 Bupa HI Pty Ltd, *The British United Provident Association Limited (Bupa): HALF YEAR STATEMENT FOR THE SIX MONTHS TO 30 JUNE 2022*, 4 August 2022, https://www.bupa.com/-/media/Files/B/Bupa/documents/financials/results-centre/2022/bupa-ltd-030822.pdf, p 6.

65 Bupa HI Pty Ltd, *Bupa customers to receive $315 million in pre-Christmas cashback*, media release, 13 September 2022, viewed 13 September 2022, https://media.bupa.com.au/bupa-customers-to-receive-315-million-in-pre-christmas-cashback/.

66 Bupa HI Pty Ltd, *The British United Provident Association Limited (Bupa): HALF YEAR STATEMENT FOR THE SIX MONTHS TO 30 JUNE 2022*, 4 August 2022, https://www.bupa.com/-/media/Files/B/Bupa/documents/financials/results-centre/2022/bupa-ltd-030822.pdf, p 9.

67 The Hospitals Contribution Fund of Australia Limited, *HCF to give back a further $130m in COVID savings to eligible members*, media release, 3 September 2022, viewed 12 September 2022, https://www.hcf.com.au/about-us/media-centre/media-releases/2022/hcf-gives-back.

68 NIB Health Funds Limited, *nib announces return of $15 million in COVID-19 claims savings to members*, media release, 23 August 2021, viewed 12 September 2022, https://www.nib.com.au/media/2021/08/media-pages-nib-covid-19-claims-savings.

69 NIB Health Funds Limited, *2022 Annual Report*, 22 August 2022, https://www.nib.com.au/docs/2022-annual-report, p 4.

70 NIB Health Funds Limited, *NIB to return $40 million in claims savings to members*, 20 September 2022, accessed 11 October 2022. https://www.nib.com.au/media/2022/09/media-pages-nib-to-return-40-million-in-claims-savings-to-members.

- **HBF** has not publicly announced any further measures following a 10 June 2021 announcement about its $42 million cashback measure (covered in the ACCC's 2020–21 report to the Senate), which it reports was taken in recognition of its commitment not to financially benefit from the COVID-19 pandemic.[71] HBF also cancelled its 2020 premium increase, which had been due to come into effect on 1 April 2020.[72]

  Due to its large WA membership, HBF faced fewer COVID impacts during WA's extended border closures in 2020–21. This changed in 2021–22 with HBF noting:

  > ...the Delta and Omicron waves and easing of border restrictions has resulted in more significant variations between expected and actual claims i.e. claims that may either be deferred or permanently avoided.[73]

  HBF has also stated that in the second half of 2021–22, it has seen a 'significant decline in claims due to COVID-19 disruptions as well as hospital capacity issues driven by staffing shortages and member hesitancy'. On this point, it has stated that 'any permanent savings are expected to be returned to members'.[74]

To fulfil their broader commitments, the ACCC expects insurers to continue to return funds until they no longer retain any financial benefits from claims that were missed due to COVID restrictions and are not expected to materialise later, including claims that insurers might have originally accounted for in their DCL.

The ACCC notes that the Minister for Health and Aged Care will have an opportunity to consider these matters, along with other factors, when they assess each health fund's application to change premiums from April 2023.

2.5 Consumer responses to private health insurance costs

As noted in section 2.1, the proportion of Australians with private health insurance started increasing in 2020–21 and has continued to do so since, with the total number of insured persons increasing by 307,416 over the reporting period.[75]

Figure 9 shows the number of hospital policies held by the working population over the last 5 years.

71 HBF Health Limited, *HBF finalises COVID-19 surplus funds to be returned to members*, media release, 10 June 2021, viewed 19 September 2022, https://www.hbf.com.au/media-releases/covid-19-surplus-funds; ACCC, *Private health insurance report 2020–21*, 9 December 2021, https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2020-21, p 17.

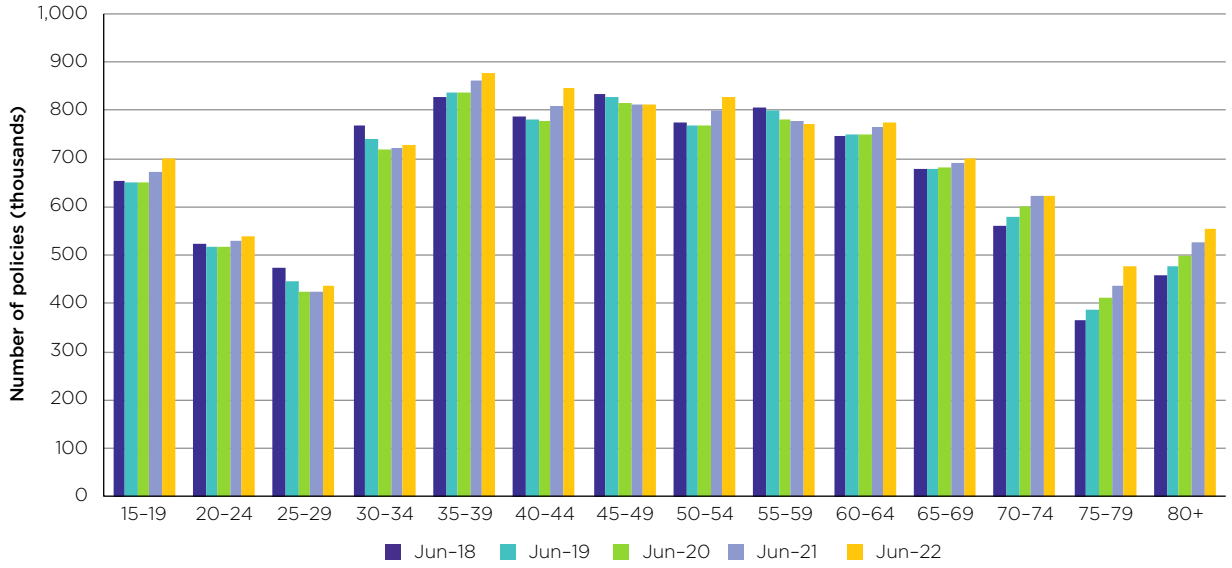
72 HBF Health Limited, *HBF cancels 2020 premium increases*, media release, 26 March 2020, viewed 12 October 2022, https://www.hbf.com.au/media-releases/hbf-cancels-2020-premium-increases.

73 HBF Health Limited, *2022 Annual Report*, 9 September 2022, https://www.hbf.com.au/-/media/files/about-us/annual-reports/hbf-annual-report-2022.pdf?&la=en&hash=E1828D956BA1656871D2EA1871CB930FFC1FF5D3, p 80.

74 HBF Health Limited, *2022 Annual Report*, 9 September 2022, https://www.hbf.com.au/-/media/files/about-us/annual-reports/hbf-annual-report-2022.pdf?&la=en&hash=E1828D956BA1656871D2EA1871CB930FFC1FF5D3, p 38.

75 APRA, *Statistics: Private health insurance membership trends June 2022*, 24 August 2022, viewed 30 August 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Membership%20Trends%20June%202022.xlsx.

Figure 9: Number of hospital policies, by age group, June 2018 to June 2022



Source data: APRA, *Statistics: Private health insurance membership trends June 2022*.

Figure 9 shows that in 2021–22, the number of hospital policies held by most age categories increased except for those aged 45–49, 55–59 and 70–74, for whom policies decreased by 0.1% (to 811,675), 0.7% (to 771,407) and 0.3% (to 622,200) respectively. Increases in the reporting period include:

- the number of hospital policies held by younger Australians in the 20–24 and 25–29 age groups growing by 1.4% (to 538,637) and 2.8% (to 437,767) respectively
- the number of hospital policies held by older Australians aged 75–79 and 80+ increased at the fastest rate of any age groups, as was the case in 2020–21, by 9.4% (to 476,622) and 5.6% (to 555,056) respectively.

In the 25–29 age bracket, increases since June 2020 have reversed several years of decline which began in June 2015.[76]

Figure 9 also reveals that over the past 5 years:

- the number of people aged 24 and under with hospital policies grew by an average of 5.1% (to 1,238,919) following growth during 2020–21 and 2021–22
- the number of hospital policies held by people aged 70 and over increased by an average of 21% (to a total of 1,653,878). Within this category, the number of policies increased by 30% for those aged 75–79.

Concerns remain about the overall trajectory of the sector, despite some increases in membership among young Australians. The Australian Medical Association (AMA) has expressed concerns in 2022, similar to past concerns expressed by the Grattan Institute[77] and APRA,[78] that the viability of the private health sector is 'in trouble' due to increasing financial pressure brought about by an aging insured population. The AMA suggests that those over the age of 60 are 'set to become the largest insured population', and that the issue remains concerning despite recent increases in health insurance membership, which they attribute in part to COVID-19.[79]

76 APRA, *Statistics: Private health insurance membership trends June 2022*, 24 August 2022, viewed 30 August 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Membership%20Trends%20June%202022.xlsx.

77 See e.g. Stephen Duckett, *Private health insurance death spiral continues*, Grattan Institute, 24 August 2021, viewed 13 September 2022, https://grattan.edu.au/news/private-health-insurance-death-spiral-continues/.

78 See e.g. John Huijsen, *Speech to the Health Insurance Summit*, speech, 23 June 2021, viewed 13 September 2022, https://www.apra.gov.au/news-and-publications/apra-general-manager-insurance-division-john-huijsen-speech-to-health.

79 Australian Medical Association, *Discussion paper: A whole of system approach to reforming private healthcare: The role of a Private Health System Authority*, June 2022, viewed 13 September 2022, https://www.ama.com.au/sites/default/files/2022-06/discussion-paper-a-whole-of-system-approach-to-reforming-private-healthcare.pdf, p 2.

One development which may increase the number of younger Australians covered by private health insurance is reforms made in 2021 to allow insurers to increase the age limit for adult dependants to remain on their parents' policies.[80] As a result, Medibank (including their ahm brand) increased their relevant age limits from 25 to 31 in August 2022[81], with Bupa[82], HCF[83] and NIB[84] also announcing similar extensions.

2.6 Policy exclusions and excesses

Exclusionary policies

Exclusions and restrictions[85]

Some health insurance policies provide full cover for the costs of most hospital admissions, apart from any applicable **excess** or **co-payment** that the policyholder is required to pay.

Other policies restrict or exclude benefits for some treatments in return for offering lower premiums.

If a policy has **exclusions** for particular conditions, the policyholder is not covered at all for treatment as a private patient in a public or private hospital for those conditions. The insurer will not pay any benefits towards a policyholder's hospital and medical costs for such treatment.

If a policy has **restrictions** for particular conditions, the policyholder will be covered for treatment for those conditions, but only to a very limited extent, and the policyholder is still likely to face considerable out-of-pocket costs for such treatment.

Table 6 shows that from June 2021 to June 2022, the proportion of hospital policies held with exclusions continued to increase. This is the fourth year in a row where exclusionary policies outnumber non-exclusionary ones.

Table 6: Hospital policies with exclusions, by percentage, June 2018 to June 2022

	June 2018	June 2019	June 2020	June 2021	June 2022
% of policies with exclusions	43.8%	56.8%	58.7%	60%	61.3%

Source: APRA, *Statistics: Private health insurance membership and benefits June 2022*.

Figure 10 shows the number of exclusionary policies held during 2021–22 increased by around 154,855 (or around 4.6%) with a reduction of nearly 20,000 non-exclusionary policies (or 0.9%) during the same period.[86] This long-term trend has seen the percentage of policies containing exclusions rise from 28.7% in June 2012 to 61.3% today, which is a 32.6% increase. This trend is likely to be influenced by many factors, but relevant consumer behaviours could include:

80 Department of Health, *Private Health Insurance – increasing the age of dependants– questions and answers*, March 2022, viewed 13 September 2022, https://www.health.gov.au/sites/default/files/documents/2022/03/private-health-insurance-age-of-dependants-measure-questions-and-answers.pdf.

81 Medibank Private Ltd, *Medibank and ahm extend age for adult dependants to 31*, media release, 12 August 2022, viewed 13 September 2022, https://www.medibank.com.au/livebetter/newsroom/post/medibank-and-ahm-extend-age-for-adult-dependants-to-31.

82 Bupa HI Pty Ltd, *Bupa lifts age of dependants up to 32 to support young Australians*, media release, 19 August 2022, viewed 13 September 2022, https://media.bupa.com.au/bupa-lifts-age-of-dependants-to-32-in-an-industry-first-to-support-young-australians/.

83 The Hospitals Contribution Fund of Australia Limited, *HCF: keeping families covered together for longer from September 1*, media release, 24 August 2022, viewed 19 September 2022, https://www.hcf.com.au/about-us/media-centre/media-releases/2022/hcf-dependant-reforms.

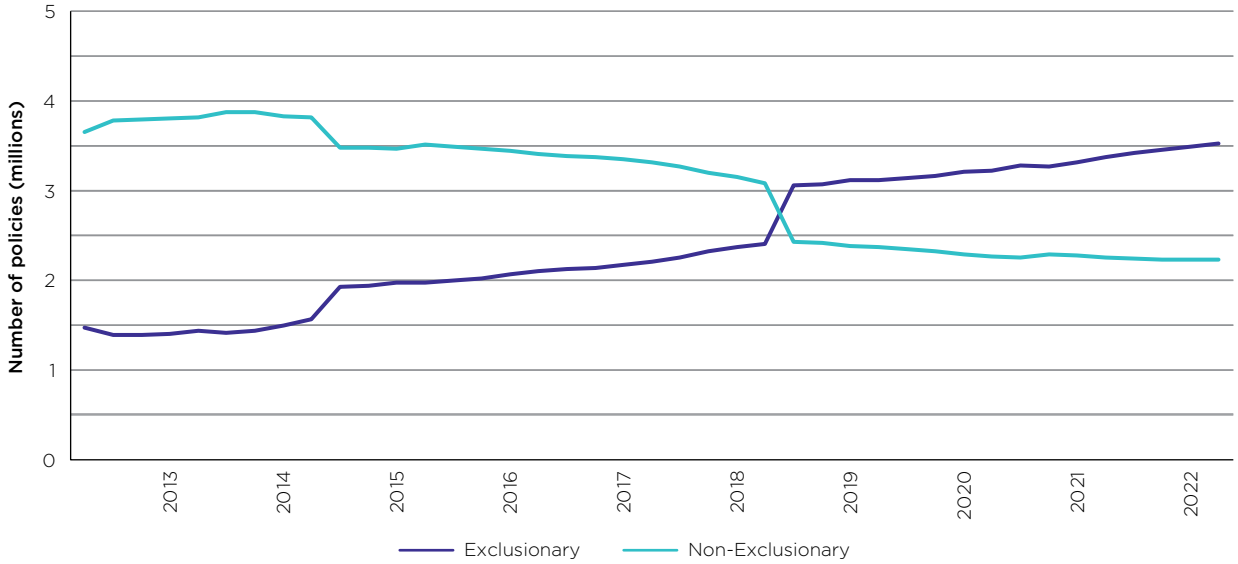
84 NIB Health Funds Limited, *nib extends the maximum age of non-student dependants to 31*, media release, 4 October 2022, viewed 11 October 2022, https://www.nib.com.au/media/2022/10/nib-extends-the-maximum-age-of-non-student-dependants-to-31.

85 Commonwealth Ombudsman, *Policy exclusions and restrictions*, viewed 13 September 2022, https://www.ombudsman.gov.au/publications/brochures-and-fact-sheets/factsheets/all-fact-sheets/phio/policy-exclusions-and-restrictions.

86 APRA, *Statistics: Private health insurance membership and benefits June 2022*, 24 August 2022, viewed 13 September 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Membership%20and%20Benefits%20June%202022_0.xlsx.

- cancelling top-level, non-exclusionary 'Gold' hospital policies—CHOICE has highlighted the high price of some of these policies[87]
- the use of low-cost 'Basic' hospital policies offering limited cover to avoid tax expenses such as the Medicare Levy Surcharge—CHOICE has also produced guidance on 'Basic' health insurance and stated that such policies may 'suit people who have health insurance for tax reasons'.[88]

Figure 10: Change in hospital exclusionary and non-exclusionary policies, June 2012 to June 2022



Source data: APRA, Statistics: *Private health insurance membership and benefits June 2022*.

Excesses

Excesses and co-payments[89]

Most insurers will offer policyholders the option of nominating an 'excess' or 'co-payment' on a hospital policy in return for reduced membership premiums.

An **excess** is a lump sum the policyholder pays towards their hospital admission before the health fund will pay its benefits.

A **co-payment** is an amount the policyholder must pay each time the health insurer pays hospital benefits for them. Normally a co-payment is payable for each day of hospitalisation up to a maximum annual amount or per admission amount.

Table 7 shows that over 86% of hospital policies have excesses and co-payments, an 0.8% increase during 2021–22 which continues a longer-term upward trend.

Table 7: Hospital policies with excesses and co-payments, by percentage, June 2018 to June 2022

	June 2018	June 2019	June 2020	June 2021	June 2022
% of policies with excesses & co-payments	83.7%	84.8%	85.8%	85.7%	86.5%

Source: APRA, *Statistics: Private health insurance membership and benefits June 2022*.

87 CHOICE, *Downgrade your top-cover health insurance and save up to $1,800 or more*, 25 October 2022, viewed 2 November 2022, https://www.choice.com.au/money/insurance/health/articles/should-you-downgrade-your-top-cover-health-insurance. See also: CHOICE, *Are you paying too much for Gold health insurance?*, 22 March 2021, viewed 14 September 2022, https://www.choice.com.au/money/insurance/health/articles/rip-off-gold-health-insurance.

88 CHOICE, *The cheapest Basic health insurance policies to save on tax*, 17 June 2022, viewed 14 September 2022, https://www.choice.com.au/money/insurance/health/articles/cheap-health-cover-to-avoid-extra-tax.

89 Commonwealth Ombudsman, *Choosing a health insurance policy*, viewed 14 September 2022, https://www.ombudsman.gov.au/publications/brochures-and-fact-sheets/factsheets/all-fact-sheets/phio/choosing-a-health-insurance-policy.

2.7 Out-of-pocket (gap) costs

An out-of-pocket or 'gap' payment is the amount a consumer pays either for medical or hospital charges, over and above what they receive from the Australian Government's Medicare scheme or their private health insurer.

Types of gap arrangements

Typically, health insurers enter contractual arrangements with selected health care service providers, in part, to minimise the out-of-pocket expenses incurred by members. Insurers negotiate set fees and other terms with those providers in exchange for the right to participate in their 'preferred provider' networks or 'no gap' and 'known gap' schemes.

In the case of a **no gap** arrangement, the participating health care service provider agrees to charge a certain amount for services and the health insurer will fully cover the cost of the relevant medical procedure performed by the participating provider.

In the case of a **known gap** arrangement, the participating provider can charge an amount beyond that which the health insurer will cover, but it is restricted to a capped maximum set by the health insurer.

Gap payments are not needed for most in-hospital services, however the proportion of services without a gap has varied in recent years, as detailed in Figure 11. The proportion of hospital services with no gap declined by 1.2% during the reporting period.

Figure 11: Proportion of in-hospital services with no gap, June 2018 to June 2022

Source data: APRA, *Statistics: Private health insurance medical gap June 2022*.

Table 8 shows that in 2021-22, the average gap expense incurred by a consumer for hospital treatment increased by 9.5% to $380.48, from $347.53 the previous year.[90] The average gap payment for extras treatments in 2021–22 increased by 2.9%, to $54.37.[91] The average gap for hospital treatment increased by around 23.2% over the last 5 years, while the average gap for extras treatment over the same period increased by approximately 14.8%. This highlights that average out-of-pocket costs for policyholders have increased substantially over time, especially for those claiming hospital benefits.

90 APRA, *Statistics: Quarterly private health insurance statistics June 2022*, 24 August 2022, viewed 14 September 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202022.pdf, p 9.

91 APRA, *Statistics: Quarterly private health insurance statistics June 2022*, 24 August 2022, viewed 14 September 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202022.pdf, p 9.

Table 8: Average gap expense incurred by consumers (hospital and extras treatments), June quarter 2018 to June quarter 2022

	Hospital treatment	Extras treatment
June 2018	$308.73	$47.38
June 2019	$314.51	$49.20
June 2020	$289.75	$50.25
June 2021	$347.53	$52.85
June 2022	$380.48	$54.37

Source: APRA, *Quarterly private health insurance statistics*, June 2018, June 2019, June 2020, June 2021 and June 2022.

2.8 Insurer collection and use of consumer data

The ACCC has previously noted its expectation that private health insurers and other businesses in the health sector should be alive to the highly sensitive nature of the personal information they may be collecting and using.[92] In this regard, private health insurers should ensure they comply with all their obligations, including those under the Australian Consumer Law (ACL).

Insurers have continued to develop new schemes and build on existing programs which may allow them to access, use and in some cases share consumers' personal information. Developments during the reporting period include:

- NIB's launch of the 'GreenPass' product in April 2022. The service (which has free and paid options) allows consumers to receive an online health check and skin check, and to track health-related information such as fitness, nutrition and mood.[93] Logging more information about health and fitness in the 'Well with nib' app as part of this program leads to customers earning more rewards.[94] NIB outlines that customers may 'choose to share additional Personal Information..through [their] interaction with the GreenPass product', and that in turn NIB may use contact details to send information 'about a particular program, program updates, new features, or to recommend programs that we think may interest you'.[95]
- Priceline Pharmacy (Priceline) and NIB jointly launched a health insurance product in April 2022.[96] This product is available to members of Priceline's Sister Club loyalty scheme. Purchasing this Priceline health insurance product, and paying premiums, gives Sister Club members more points in the loyalty scheme. Priceline's Privacy Policy notes that they may 'collect [a customer's] personal information in relation to [a customer's] interactions and transactions with us, including using our loyalty cards'. The Privacy Policy also sets out that Priceline may disclose information in some circumstances to 'an organisation that is an [sic] arrangement or alliance with us', which could include NIB.[97]
- AIA Health Insurance Pty Ltd (AIA) has offered an Extras Value Protect program since 2020.[98] This program currently allows customers to receive selected refund benefits for Extras premiums paid throughout 2022, minus any Extras claims made during the period. To receive the refund, policyholders need to join and engage with the AIA Vitality loyalty program and earn AIA Vitality

92 ACCC, *Private health insurance report to the Senate 2018–19*, 2 March 2020, https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2018-19, p 15.

93 NIB Health Funds Limited, *GreenPass*, viewed 15 September 2022, https://www.nib.com.au/health-services/greenpass/.

94 NIB Health Funds Limited, *GreenPass Rewards*, viewed 15 September 2022, https://www.nib.com.au/health-services/greenpass/rewards/.

95 NIB Health Funds Limited, *nib GreenPass Privacy Collection Notice*, 23 August 2022, viewed 15 September 2022, https://www.nib.com.au/docs/greenpass-privacy-collection-notice.

96 NIB Health Funds Limited, *nib partners with Priceline to launch new range of health covers*, media release, 14 April 2022, viewed 16 September 2022, https://www.nib.com.au/media/2022/04/media-pages-nib-partners-with-priceline-to-launch-new-range-of-health-covers.

97 Australian Pharmaceutical Industries Limited, *Priceline Policies – Privacy Policy*, May 2014, viewed 16 September 2022, https://www.priceline.com.au/priceline-policies/privacy-policy.

98 AIA Group Ltd, *Extras Value Protect*, viewed 15 September 2022, https://www.aia.com.au/en/individual/health-insurance/member-benefits/extras-value-protect.html.

Points. Consumers can earn points by conducting activities such as health reviews, nutrition assessments and dental checks.[99]

AIA explains this program with reference to the effects of the pandemic on benefit claims and the idea that this has been 'a time when getting the most out of Extras cover may have been challenging'. However, unlike many other insurer pandemic relief initiatives, AIA's program requires consumers to join and engage with their loyalty scheme (and thereby potentially share sensitive health information) to be compensated for their inability to claim extras benefits during COVID-19.

AIA Vitality's data policy allows the data to be shared with third parties in a deidentified form and to inform direct marketing emails. The policy also notes that the 'aggregated data may also be used for reporting, scientific and product research purposes'.[100]

The ACCC considers that refunds of this kind would be best applied in a way that allows all of an insurer's customers to receive the benefits, rather than applying only to customers who engage with a loyalty scheme and provide their personal information.

- Medibank announced in September 2022 that its Live Better 'health and wellbeing program' had reached 500,000 members.[101] Through its wellbeing apps, Medibank may collect sensitive information including lifestyle, diet, exercise and health related information. Medibank's privacy policy sets out a wide range of possible uses of personal information, including conducting targeted marketing, and to 'engage in analytic and research activities (inclusive of a wide range of analytics and customer behavioural research projects)'.[102]

While Australians can receive benefits from rewards and discounts offered by health insurers and other organisations that collect consumer data, the ACCC remains concerned that few consumers are fully informed of, fully understand, or can effectively control, the scope of data collected when they sign up for, or use, such services.

The ACCC reiterates its concerns raised in its 2018–19 Private Health Insurance Report[103] that while Australia's community rating system for private health insurance prohibits insurers from charging different private health insurance premiums to individual consumers based on health and other factors,[104] consumer data collected by wellbeing apps and rewards schemes could be used for various other purposes. This could include targeted marketing (including from third parties)[105], and creation of insights that could be shared with or sold to third parties.[106]

An October 2022 cybersecurity incident impacting Medibank also highlights the risks that arise when businesses collect large amounts of sensitive data. On 7 November 2022, Medibank announced following investigations that a criminal had established access to personal information of about 9.7 million current and former customers and some authorised representatives. Medibank also announced that the criminal had accessed Medicare numbers for ahm customers, passport numbers and visa details for international student customers, and health claims data for nearly

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99 AIA Group Ltd, *AIA Vitality*, viewed 19 September 2022, https://www.aia.com.au/en/individual/aia-vitality.html.

100 AIA Australia Limited, *AIA Vitality and your data*, February 2021, viewed 15 September 2022, https://www.aia.com.au/content/dam/au/en/aia-vitality/AIA-Vitality-and-Your-Data.pdf.

101 Medibank Private Ltd, *Half a million Aussies choose to Live Better*, media release, 13 September 2022, https://www.medibank.com.au/livebetter/newsroom/post/half-a-million-aussies-choose-to-live-better.

102 Medibank Private Ltd, *Terms and Conditions*, viewed 15 September 2022, https://www.medibank.com.au/livebetter/rewards/terms/.

103 ACCC, *Private health insurance report to the Senate 2018–19*, 2 March 2020, https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2018-19, pp 16–17.

104 Stephen Duckett and Matt Cowgill, *Saving private health 2: Making private health insurance viable*, 3 December 2019, https://grattan.edu.au/report/saving-private-health-2/. 'Community rating' refers to the regulatory system that requires health insurers to charge all Australian consumers the same premium for the same product, provide cover to anybody who seeks it, and not charge different premiums to individual consumers based on their past or likely future health, claims history, age, pre-existing conditions, gender, race or lifestyle.

105 See e.g. the 'Direct Marketing' section of Medibank's Privacy Policy, viewed 15 September 2022, https://www.medibank.com.au/livebetter/rewards/terms/.

106 The ACCC's *Customer loyalty schemes final report* cites the example of Qantas-owned Red Planet, which uses data insights to offer targeted digital marketing campaigns for third party clients. See section 4.2.4 of the final report for further information.

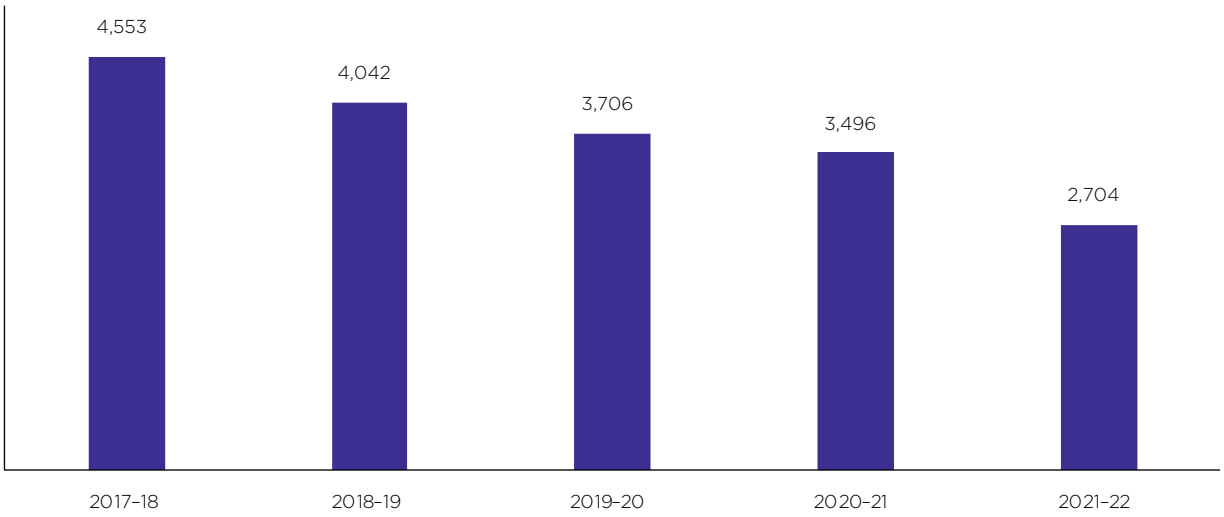
500,000 customers.[107] Insurers should weigh up these risks when considering new measures to collect consumer data, and should have sufficiently robust measures in place to protect against cybersecurity threats.

2.9 Consumer complaints about private health insurance

Complaints received by the Private Health Insurance Ombudsman

The main agency handling consumers' private health insurance complaints is the PHIO. Figure 12 shows that in 2021–22, the PHIO received 2,704 complaints about private health insurance.[108] The number of complaints decreased by 22.7% from 2020–21, where the PHIO received 3,496 complaints. This continued a downward trend from the previous year.[109] The PHIO attributed this overall reduction to the long-term positive impacts of private health insurance reforms (which came into effect from 1 April 2020 and introduced industry-standard clinical categories and product tiers), more effective servicing of customers by several insurers, and more effective complaint handling. The PHIO also notes that private health insurance activity fell during COVID-19 restrictions.[110]

Figure 12: Total complaints received by the PHIO 2017–18 to 2021–22



Source data: *Commonwealth Ombudsman annual reports* 2017–18, 2018–19, 2019–20 and 2020–21, and *Commonwealth Ombudsman Private Health Insurance Quarterly Update: 1 April to 30 June 2022*.

The PHIO reported that 2,075 complaints in 2021–22 were about health insurers, representing about 77% of total complaints.[111]

107 Medibank Private Ltd, *Medibank cybercrime update*, ASX release, 7 November 2022, viewed 8 November 2022, https://www.medibank.com.au/livebetter/newsroom/post/medibank-cybercrime-update%207%20November.

108 Commonwealth Ombudsman, *Private Health Insurance Quarterly Update: 1 April to 30 June 2022*, viewed 11 October 2022, https://www.ombudsman.gov.au/__data/assets/pdf_file/0016/115243/PHIO-QU-Apr-Jun-2022-and-Annual-Summary-v2.pdf, p 1.

109 Commonwealth Ombudsman, *Private Health Insurance Quarterly Update: 1 April to 30 June 2022*, viewed 11 October 2022, https://www.ombudsman.gov.au/__data/assets/pdf_file/0016/115243/PHIO-QU-Apr-Jun-2022-and-Annual-Summary-v2.pdf, p 1.

110 Commonwealth Ombudsman, *Private Health Insurance Quarterly Update: 1 April to 30 June 2022*, viewed 11 October 2022, https://www.ombudsman.gov.au/__data/assets/pdf_file/0016/115243/PHIO-QU-Apr-Jun-2022-and-Annual-Summary-v2.pdf, p 6.

111 Commonwealth Ombudsman, *Private Health Insurance Quarterly Update: 1 April to 30 June 2022*, viewed 11 October 2022, https://www.ombudsman.gov.au/__data/assets/pdf_file/0016/115243/PHIO-QU-Apr-Jun-2022-and-Annual-Summary-v2.pdf, p 2.

Complaints by issue

The top 5 categories for complaints to the PHIO—benefits, membership, information, service and waiting period – have remained the same for the past 5 years, as shown in Figure 13. Key issues within these complaint categories include:

- benefits: hospital exclusions and restrictions, general treatment (extras or ancillary benefits), delays in payment
- membership: cancellation, clearance certificates
- service: customer service advice, service delays, premium payment problems, general service issues
- information: verbal advice, lack of notification
- waiting period: obstetric, pre-existing conditions.

Figure 13 shows that complaints declined in 3 of these top 5 complaint categories from 2020–21 to 2021–22. Complaints about benefits decreased by around 26%, complaints about information decreased by approximately 37%, and complaints about waiting periods fell by nearly 30%.[112]

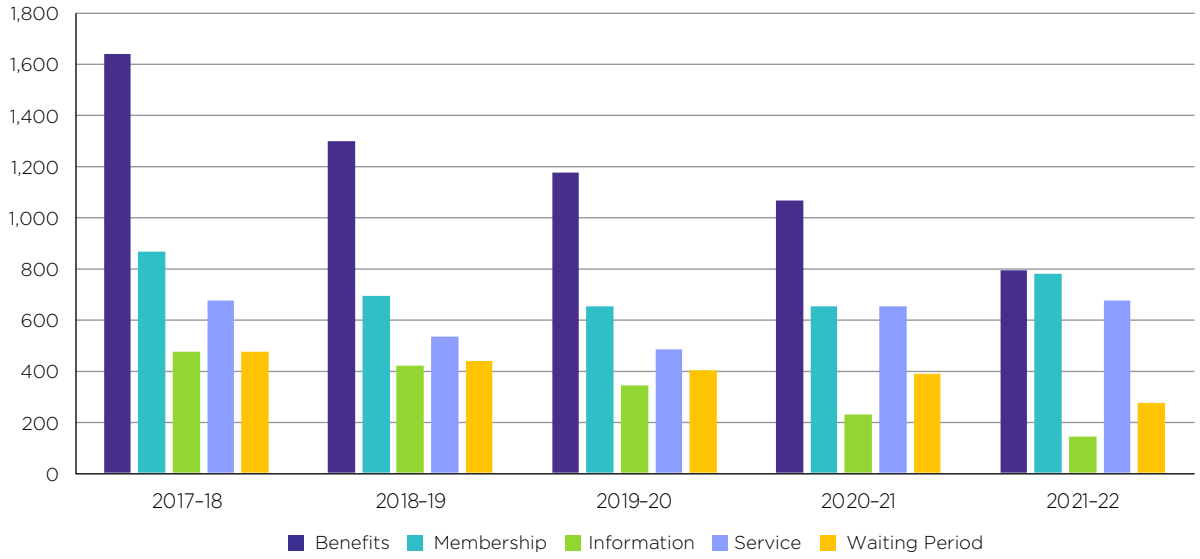
However, there was a rise in complaints about membership of around 20%. Complaints about service also rose slightly (3%).[113] This result was affected by the PHIO receiving 308 complaints in the June 2022 quarter from students experiencing problems seeking refunds in relation to Peoplecare Health Limited Overseas Student Health Cover (OSHC) policies, which are administered by Allianz Care Australia (Allianz). Most complaints related to difficulty obtaining refunds where policyholders had not used some or all of their benefits due to COVID-19-related border closures preventing or delaying their travel. Consumers sought refunds and provided the correct documents, but their refund enquiries and applications were not responded to in a timely manner, or in some instances not at all. The PHIO has been involved in Allianz's response, and Allianz has increased communication with consumers to advise of processing delays and provide realistic information about timeframes.[114] This issue increased the number of complaints about cancellations (under the membership category) and service delays (under the service category) in particular.

112 Commonwealth Ombudsman, *Private Health Insurance Quarterly Update: 1 April to 30 June 2022*, viewed 11 October 2022, https://www.ombudsman.gov.au/__data/assets/pdf_file/0016/115243/PHIO-QU-Apr-Jun-2022-and-Annual-Summary-v2.pdf, p 5.

113 Commonwealth Ombudsman, *Private Health Insurance Quarterly Update: 1 April to 30 June 2022*, viewed 11 October 2022, https://www.ombudsman.gov.au/__data/assets/pdf_file/0016/115243/PHIO-QU-Apr-Jun-2022-and-Annual-Summary-v2.pdf, p 5.

114 Commonwealth Ombudsman, *Private Health Insurance Quarterly Update: 1 April to 30 June 2022*, viewed 11 October 2022, pp 2–3, https://www.ombudsman.gov.au/__data/assets/pdf_file/0016/115243/PHIO-QU-Apr-Jun-2022-and-Annual-Summary-v2.pdf.

Figure 13: PHIO complaints, by issue, 2017–18 to 2021–22



Source data: *Commonwealth Ombudsman Private Health Insurance Quarterly Bulletins*, 87 (2017–18), 91 (2018–19), 95 (2019–20), 99 (2020–21) and 103 (2021–22).

Contacts to the ACCC about private health insurance

The ACCC and state and territory fair trading agencies also receive consumer contacts (enquiries and reports) about the private health insurance industry. However, the ACCC is not a dispute resolution body and does not generally receive many complaints about private health insurance.

In 2021–22, the ACCC received 137 contacts about private health insurance issues. This represented a 16.5% decrease from the previous financial year, when 164 contacts were received. Most private health insurance contacts related to consumer protection issues, and 46% of contacts concerned potential false representations or misleading conduct.

3. ACCC enforcement action and competition exemptions

This chapter summarises recent ACCC enforcement action and developments regarding competition exemptions.

3.1 ACCC enforcement action

Health Insurance Comparison Choosewell

On 6 September 2022, the ACCC announced[115] that health insurance comparison business Health Insurance Comparison Choosewell Pty Ltd (HICC) had admitted breaching the ACL by failing to inform consumers of their termination rights, including a 10 business day cooling-off period, when entering into unsolicited consumer agreements for private health insurance.

HICC engaged businesses as third party lead generators to initiate unsolicited contact by telephone with consumers on its behalf before negotiating agreements with those consumers for the supply of health insurance services by a partnered insurance provider.

HICC admitted that it entered into unsolicited consumer agreements without informing consumers verbally and in writing of their rights under the ACL to terminate the contract, how they could terminate the contract, and that the health insurance provider was not allowed to seek payment until after the 10 business day cooling-off period.

The ACCC has accepted a 3-year court-enforceable undertaking[116] from HICC in which HICC commits to not entering into unsolicited sales contracts without giving consumers verbal and written information about their termination rights, to notify the relevant health insurance provider that the contract resulted from an unsolicited consumer agreement, and to implement a compliance program focusing on the ACL requirements for unsolicited consumer agreements. HICC has also paid a penalty of $13,320 following the issuing of an infringement notice by the ACCC for failing to give a consumer information relating to their termination rights.

SmileDirectClub

On 11 November 2022, the Federal Court ordered SmileDirectClub Aus Pty Ltd and its US parent company, SmileDirectClub LLC (together, SmileDirectClub) to pay penalties of $3.5 million, following ACCC action. SmileDirectClub had admitted that between May 2019 and October 2020, it made false and misleading statements about private health insurance reimbursement for aligner treatment, in contravention of the ACL.[117]

SmileDirectClub's statements represented to consumers that they may be eligible for a reimbursement for SmileDirectClub aligners and associated treatment from their private health insurer. However, the vast majority (98.5% of the market) of Australian private health insurance companies did not provide coverage for the costs of SmileDirectClub's aligner treatment. SmileDirectClub conveyed this information via email, text messages, printed information cards, and on its website. In the relevant period, at least 26,300 consumers signed up for SmileDirectClub's aligner treatment, at the cost of between $2,499 and $3,155.

115 ACCC, *HICC failed to tell consumers of cooling-off period in unsolicited sales of private health insurance*, media release, 6 September 2022, https://www.accc.gov.au/media-release/hicc-failed-to-tell-consumers-of-cooling-off-period-in-unsolicited-sales-of-private-health-insurance.

116 A copy of the undertaking is available at https://www.accc.gov.au/public-registers/undertakings-registers/health-insurance-comparison-choosewell-pty-ltd.

117 ACCC, *SmileDirectClub to pay $3.5m for misleading claims about health insurance reimbursement for teeth aligners*, media release, 11 November 2022, https://www.accc.gov.au/media-release/smiledirectclub-to-pay-35m-for-misleading-claims-about-health-insurance-reimbursement-for-teeth-aligners.

The Court also ordered SmileDirectClub to compensate affected consumers, to implement a compliance program, and to pay a contribution to the ACCC's costs.

3.2 Competition exemptions

Review application withdrawn regarding authorisation for a collective buying group to negotiate with healthcare providers

On 21 September 2021, the ACCC issued a final determination granting authorisation to Honeysuckle Health Pty Ltd and NIB to form and operate a health services buying group to collectively negotiate and administer contracts with healthcare providers (including hospitals, medical specialists, general practitioners and allied health professionals) on behalf of the buying group participants, largely private health insurers.

Authorisation was granted with a condition that major insurers Medibank, Bupa, HCF and HBF in Western Australia not be allowed to join the buying group. The ACCC granted authorisation for 5 years, rather than the 10 years sought by Honeysuckle Health and NIB.[118]

On 6 and 8 October 2021, the Rehabilitation Medicine Society of Australia and New Zealand Ltd (RMSANZ)[119] and the National Association of Practising Psychiatrists (NAPP)[120] applied to the Australian Competition Tribunal (Tribunal) for a review of the ACCC's determination regarding the Honeysuckle Health/NIB buying group.

On 29 July 2022, the Tribunal gave the parties leave to withdraw their applications for review of the ACCC's determination and provided reasons.[121] This followed a settlement deed that was executed between the review applicants, the AMA (which had successfully sought leave to intervene in the review proceedings), and Honeysuckle Health.

The Tribunal identified certain clauses of the original settlement deed executed between the parties as potentially having anti-competitive effects by, on their face, preventing NIB from reducing medical specialist fees offered through its medical gap scheme, and requiring Honeysuckle Health to continue to make a gap scheme with the same terms available to the buying group participants, even if competing insurers reduced the fees offered in their schemes. The ACCC also made submissions questioning the potential competitive effects of these clauses.

The Tribunal questioned the confidentiality clause in the parties' settlement deed and considered that the terms of the original agreement should be disclosed publicly. This was so that the basis of the withdrawal, and the conditions on the authorisation set out in the agreement, could be understood.

The parties ultimately amended their agreement to address the Tribunal's concerns, leading to the Tribunal allowing the withdrawal of the applications for review.

118 ACCC, Authorisations register, https://www.accc.gov.au/public-registers/authorisations-and-notifications-registers/authorisations-register/honeysuckle-health-and-nib.

119 Australian Competition Tribunal, 'Application by Rehabilitation Medicine Society of Australia and New Zealand Ltd (RMSANZ)', viewed 14 September 2022, https://www.competitiontribunal.gov.au/current-matters/act-5-of-2021.

120 Australian Competition Tribunal, 'Application by National Association of Practising Psychiatrists (NAPP)', viewed 14 September 2022, https://www.competitiontribunal.gov.au/current-matters/act-4-of-2021.

121 Applications for review of Honeysuckle Health Buying Group authorisation determination (No 2) [2022] ACompT 4, https://www.competitiontribunal.gov.au/decisions/tribunal-decisions?sq_content src=%2BdXJsPWh0dHBzJTNBJTJGJTJGd3d3Lmp1ZGdtZW50cy5mZWRjb3VydC5nb3YuYXUlMkZqdWRnbWVudHMlMkZKdWRnbWVudHMlMkZ0cmlidW5hbHMlMkZhY29tcHQlMkYyMDIyJTJGMjAyMmFjb21wdDAwMDQmYWxsPTE%3D.

4. Policy developments in private health insurance

This chapter provides an update on policy developments relating to private health insurance during and after the reporting period.

4.1 Prostheses List reforms

The Prostheses List contains more than 11,000 medical devices (such as most prostheses) and lists the minimum benefits that private health insurers are required to pay (generally to a hospital) when a policyholder receives a listed device as part of hospital or substitute treatment and has the relevant insurance coverage.[122] Hospitals generally purchase devices from manufacturers at an amount equivalent to or lower than the Prostheses List benefit.[123]

Unlike prices for medical devices for public hospital systems, which are centrally purchased and are subject to formal tender processes,[124] benefits that insurers pay for medical devices on the Prostheses List are set by the Minister for Health and Aged Care and their Department.[125] In setting these benefits and considering which devices to include, the Minister and Department receive recommendations from the Prostheses List Advisory Committee (PLAC), which consists largely of selected medical experts.[126]

In 2021–22, prostheses benefit payments accounted for about 13% of the average total hospital benefits paid per person by insurers.[127] The total amount of prostheses benefits paid by insurers over the same period was around $2.2 billion.[128] According to the Grattan Institute, under past arrangements prosthesis prices in private hospitals were more than double public hospital prices, where the Prostheses List does not apply.[129]

Reforms to the Prostheses List were initiated in 2021–22 and will continue over 4 years, with a review of the effectiveness of the reforms to be conducted in 2024. The stated objective of the reforms is to reduce the cost of medical devices used in the private health sector and streamline access to new medical devices. The Department of Health and Aged Care expects that these reforms will lead to reduced premiums for policyholders.[130]

To facilitate these reforms, on 14 March 2022 the then Minister for Health entered a Memorandum of Understanding (MoU) with the industry association representing medical device suppliers, the Medical

122 Department of Health and Aged Care, *Prostheses cover under private health insurance*, 22 October 2020, viewed 15 November 2022, https://www.health.gov.au/health-topics/private-health-insurance/what-private-health-insurance-covers/prostheses-cover-under-private-health-insurance.

123 Department of Health, *Regulation Impact Statement (RIS): Improving the Private Health Insurance Prostheses List*, April 2021, viewed 18 November 2022, https://oia.pmc.gov.au/sites/default/files/posts/2021/06/private_health_insurance_prostheses_list_ris.docx.

124 Stephen Duckett and Greg Moran, *Stopping the death spiral: Creating a future for private health*, Grattan Institute, May 2021, viewed 15 September 2022, https://grattan.edu.au/report/stopping-the-death-spiral/, p 18.

125 Department of Health and Aged Care, *The prostheses list*, 21 April 2022, viewed 4 October 2022, https://www.health.gov.au/health-topics/private-health-insurance/the-prostheses-list.

126 Department of Health and Aged Care, *Prostheses List Advisory Committee (PLAC)*, 8 July 2022, viewed 15 September 2022, https://www.health.gov.au/committees-and-groups/prostheses-list-advisory-committee-plac.

127 APRA, *Quarterly Private Health Insurance Statistics June 2022*, 24 August 2022, viewed 15 September 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202022.pdf, p 5.

128 APRA, *Quarterly Private Health Insurance Benefit Trends June 2022*, 24 August 2022, viewed 15 September 2022, https://www.apra.gov.au/sites/default/files/2022-08/Quarterly%20Private%20Health%20Insurance%20Benefit%20Trends%20June%202022.xlsx.

129 Stephen Duckett and Greg Moran, *Stopping the death spiral: Creating a future for private health*, Grattan Institute, May 2021, viewed 15 September 2022, https://grattan.edu.au/report/stopping-the-death-spiral/, p 18.

130 Department of Health and Aged Care, *The Prostheses List reforms*, 30 August 2022, viewed 15 September 2022, https://www.health.gov.au/health-topics/private-health-insurance/the-prostheses-list/the-prostheses-list-reforms.

Technology Association of Australia (MTAA).[131] Under the MoU, most benefits paid to healthcare providers on the Prostheses List will now be reduced in intervals, with the reductions to be calculated as a percentage of the current gap between Prostheses List benefits and the lower weighted average price paid for prostheses in the public system. A 40% reduction took place from 1 July 2022[132], with further 20% reductions to occur in both July 2023 and July 2024.[133] The MoU also notes that future consultations will discuss the introduction, as part of the Prostheses List application process, of a declaration by companies that there will not be extra charges for listed and necessary ancillary products beyond the Prostheses List benefit, with penalties for false declarations, to ensure no out-of-pocket expenses for consumers.[134]

Notably, the MoU sets out that reductions in Prostheses List benefits will be subject to a 'floor' for all products – meaning that prostheses benefits cannot be reduced to below 7% above the weighted average price paid for prostheses in the public system. The MoU also states that no benefit reductions are to occur in year 4 of the reforms (2025–26), 'effectively providing a 20% private adjustment factor on the initial gap between the Weighted Average Price and the Prostheses List benefit'.

Following their negotiation of the MoU with the then Minister, the MTAA stated that:

> while these reforms will still place a significant burden on the MedTech industry, they're far better than the devastating changes the private health insurance industry had been lobbying for which would have seen doctor choice and patient access to life-saving medical devices severely restricted or even abolished.[135]

Private Healthcare Australia (PHA) has been critical of the MoU, arguing that it will 'transfer an estimated $250–$400 million from Australians with private health insurance to large international medical device companies'.[136]

The Grattan Institute has raised concerns about the Prostheses List on a number of occasions. Their stance is that competitive forces need to be brought to bear on the prostheses market 'so there are stronger incentives to reduce costs and increase quality'[137], and that there is 'no reason why the prices for medical devices at public and private hospitals should be so different'.[138]

The ACCC's general stance is that competition leads to lower prices, increased efficiency and innovation, better-quality products and services, and greater choice for consumers. Making the minimum benefits set in the Prostheses List more competitive could benefit consumers by reducing the costs incurred by insurers and the insurance premiums they charge. While the ACCC welcomes efforts to reduce the underlying cost of prostheses, the ACCC notes that the MoU's floor on prostheses benefit reductions is likely to have some distortionary impacts on prices for medical devices in private healthcare. Specifically, this floor will lead to some Prostheses List benefits remaining inflated when compared to prices paid for prostheses in the public system. The ACCC considers that the 2024 review

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131 Department of Health and Aged Care, *Memorandum of Understanding for the policy parameters of the Prostheses List Reforms*, 14 March 2022, viewed 15 September 2022, https://www.health.gov.au/sites/default/files/documents/2022/03/memorandum-of-understanding-for-the-policy-parameters-of-the-prostheses-list-reforms.pdf.

132 Explanatory Statement, *Private Health Insurance (Prostheses) Rules (No. 2) 2022* (Commonwealth), https://www.legislation.gov.au/Details/F2022L00798/Explanatory%20Statement/Text.

133 Department of Health and Aged Care, *PHI 21/22 Prostheses List Reform – Schedule of Prostheses List Price Reductions*, 8 April 2022, viewed 15 September 2022, https://www.health.gov.au/news/phi-circulars/phi-2122-prostheses-list-reform-schedule-of-prostheses-list-price-reductions.

134 Department of Health and Aged Care, *Memorandum of Understanding for the policy parameters of the Prostheses List Reforms*, 14 March 2022, viewed 15 September 2022, https://www.health.gov.au/sites/default/files/documents/2022/03/memorandum-of-understanding-for-the-policy-parameters-of-the-prostheses-list-reforms.pdf.

135 Medical Technology Association of Australia, *Agreement Reached on Funding Reforms for Medical Devices*, media release, 17 March 2022, viewed 15 September 2022, https://www.mtaa.org.au/news/agreement-reached-funding-reforms-medical-devices.

136 Private Healthcare Australia, *Medical device surcharge forcing up PHI premiums*, media release, 24 August 2022, viewed 16 September 2022, https://www.privatehealthcareaustralia.org.au/medical-device-surcharge-forcing-up-phi-premiums/.

137 Stephen Duckett and Greg Moran, *Stopping the death spiral: Creating a future for private health*, Grattan Institute, May 2021, viewed 15 September 2022, https://grattan.edu.au/report/stopping-the-death-spiral/, p 18.

138 Anthony Galloway, *Global health giants getting more subsidies from Australia than what they are paying in tax, government told*, Brisbane Times, 2 October 2022, viewed 4 October 2022. https://www.brisbanetimes.com.au/politics/federal/global-health-giants-getting-more-subsidies-from-australia-than-what-they-are-paying-in-tax-government-told-20220929-p5blze.html.

of the effectiveness of the Prostheses List reform program should consider the impacts of the MoU, including whether it has had distortionary impacts on prices.


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