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 2020 to 30 June 2021

accc.gov.au

Australian Competition and Consumer Commission
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Contents

Shortened terms

ABS	Australian Bureau of Statistics
ACCC	Australian Competition and Consumer Commission
ACL	Australian Consumer Law
AMA	Australian Medical Association
APRA	Australian Prudential Regulation Authority
ASIC	Australian Securities and Investments Commission
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
Medibank	Medibank Private Limited
NIB	NIB Health Funds Limited
PHIO	Private Health Insurance Ombudsman
WPI	Wage price index

Executive Summary

This is the 23rd 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 2020 to 30 June 2021 (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 to policyholders profits gained from fewer claims during the COVID-19 pandemic.

Increase in private health insurance participation rates for the first time since 2015

In June 2021, nearly 14 million Australians or approximately 54.3% of the population, had some form of private health insurance which was an increase of around 1.4% since June 2020. This is the first annual increase in the proportion of Australians with health insurance since 2015. People holding hospital policies increased across most age groups. Industry participants have observed that COVID 'appears to have lifted community interest in the need for protection',[1] and results from an April 2021 survey indicated that 'peace of mind' was the most common reason for purchasing private hospital insurance in Australia.[2]

Over the past five years the number of hospital policies held by those aged 25–29 decreased by 19% (to 425,685), whereas the number of such policies held by those aged 75–79 increased by 19% (to 435,623). This made 2020–21 the first year on record where people in their mid/late 70s outnumbered people in their mid/late 20s with hospital cover.

Average premium increase the lowest since 2001 but cumulative increases over the past five years continue to outpace inflation

This year's private health insurance average premium increase was the lowest since 2001 at 2.74%. However, for many policyholders the 1 April 2021 increase was the second in six months, as many insurers delayed the 1 April 2020 premium increase to 1 October 2020. Cumulative premium increases over the past five years to June 2021 continue to outpace wage growth, with average premium increases being more than double inflation (CPI) during the same period.

Australian consumers paid almost $25.7 billion in private health insurance premiums in 2020–21, an increase of just over 3.2% compared to last year. This growth in premium revenue reflects both the April 2021 premium increase and the recent growth in the proportion of Australians with private health insurance.

Changes to hospital policies and treatments

In 2020–21, average gap expense for hospital treatments increased by 19.9%, or by almost $58 (to $347.53), while the average gap expense for extras treatments increased by 5.2% to $52.85.

From June 2020 to June 2021, the proportion of hospital policies held with exclusions continued to increase, while the proportion of hospital policies with excesses and co-payments remained relatively steady.

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1 Lucas Baird, 'NIB chief confident final dividend can lift to pre-pandemic levels', *Australian Financial Review*, 22 February 2021, https://www.afr.com/companies/financial-services/nib-maintains-dividend-as-profit-takes-double-digit-hike-20210222-p574li.

2 Yuting Zhang and Kushneel Prakash, *Why do Australians buy private hospital insurance?*, Melbourne Institute, May 2021, https://melbourneinstitute.unimelb.edu.au/publications/research-insights/search/result?paper=3800758.

Insurers' initiatives to return to policyholders profits from fewer claims due to COVID-19

In the 12 months to June 2021, government-imposed restrictions in response to the COVID19 pandemic continued to limit policyholders' access to non-urgent elective surgery and non-urgent 'extras' treatments (including most dental, optical and other health services). This impact was particularly notable in Victoria, which experienced several local lockdowns during the reporting period, and to a lesser extent NSW.

Consumers were unable to access many of the services covered by their policies during periods of lockdown. This resulted in fewer medical services provided to policyholders, fewer consumers claiming against their policies and fewer claims being paid out. In response to these issues, insurers publicly committed to return profits gained from COVID-19 restrictions to policyholders, as noted in the ACCC's report for 2019–20.[3]

In mid–2020, around the time that many insurers made these public commitments, the Australian Securities and Investments Commission (ASIC), supported by the Australian Prudential Regulation Authority (APRA), directed insurers to set aside money to ensure they have adequate capital to meet the cost of the procedures that were likely to be deferred rather than cancelled, such as elective surgery.[4] This money is referred to as insurers' 'deferred claims liability' (DCL). Insurers have expended around $428 million in DCL since its peak of approximately $1.8 billion in December 2020, and still had around $1.4 billion in total liabilities in June 2021.

However, there are some procedures that are not expected to materialise later. For example, a policyholder who did not utilise dental 'clean and scale' services at their normal frequency during lockdown is unlikely to book additional appointments to compensate for those they have missed. Insurers can *exclude* the value of these claims when calculating their DCL.

For the purpose of fulfilling their broader commitments made in 2020 not to financially benefit from the pandemic,[5] the ACCC expects insurers to *include* the value of claims that were missed due to COVID restrictions and are not expected to materialise later when calculating their policyholder relief.

The ACCC recognises and supports insurers' ongoing efforts to fulfil their prior commitments to return funds gained because of COVID-19 restrictions to policyholders. Initiatives recently announced by insurers include premium credits and direct payments to policyholders. However, the ACCC is concerned that some of the statements made by insurers when announcing their promised policyholder relief may give the impression that the DCL is equivalent to their profitability from COVID restrictions. It is important to emphasise that the DCL is *not* a proxy for total profitability from COVID restrictions, and nor was this ever the intention when the DCL was created (as detailed above regarding APRA's approach). As noted above, claims that were missed due to COVID restrictions and are unlikely to materialise later, however, should be part of the overall consideration of profitability and associated policyholder relief.

The ACCC will again consider the actions taken by insurers to return profits gained from COVID-19 restrictions to policyholders in preparing the next report for the 2021–22 reporting period.

Finally, the ACCC notes that the Minister for Health will have an opportunity to consider these matters, alongside a wide range of factors, when assessing each health fund's application to change premiums from April 2022.

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3 ACCC, *Private health insurance report 2019-20*, 8 December 2020, p.1, https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2019-20.

4 ASIC, 'COVID-19 implications for financial reporting and audit: Frequently asked questions (FAQs)', viewed on 1 November 2021, https://asic.gov.au/regulatory-resources/financial-reporting-and-audit/covid-19-implications-for-financial-reporting-and-audit-frequently-asked-questions-faqs/.

5 Private Healthcare Australia, *Health funds committed to providing financial relief for members impacted by COVID 19*, 26 March 2020, https://www.privatehealthcareaustralia.org.au/health-funds-committed-to-providing-financial-relief-for-members-impacted-by-covid-19/; Members Health Fund Alliance, *COVID surpluses to benefit policyholders of not-for-profit and member owned health funds*, Media release, 15 May 2020, https://membershealth.com.au/publications/covid-surpluses-to-benefit-policyholders-of-not-for-profit-and-member-owned-health-funds/.

ACCC enforcement action and competition exemptions

On 11 May 2021, the ACCC and NIB Health Funds Limited (NIB) agreed to the ACCC's Federal Court proceedings being discontinued after NIB committed to continue to provide advance notice to its members of policy changes which are likely to result in higher out-of-pocket expenses. The proceedings related to NIB's failure to notify members in advance of its decision to remove certain eye procedures from its 'MediGap Scheme' in 2015 (NIB subsequently addressed the ACCC's concerns, and for the past four years NIB has been notifying members of changes that negatively affect their benefits ahead of the changes taking effect). Under the MediGap Scheme, members had previously been able to obtain these eye procedures without facing out-of-pocket costs when doctors participated in the scheme.

On 30 March 2021, the ACCC granted interim authorisation to Private Healthcare Australia, with a reporting condition, to enable insurers and the Members Health Fund Alliance to continue to coordinate the provision of financial relief to policyholders during the pandemic and broaden insurance coverage in certain specified ways.[6] On 8 April 2021, Private Healthcare Australia withdrew its application for reauthorisation because the ACCC did not grant interim authorisation for all the proposed conduct, and as a result the relevant parties are no longer authorised to engage in the relevant conduct.

On 21 September 2021, the ACCC authorised Honeysuckle Health Pty Ltd and NIB 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. Authorisation was granted for five years, with a condition that major insurers Medibank, Bupa, HCF and HBF in Western Australia not be allowed to join the buying group. The Honeysuckle Determination is under appeal with the matter likely to be heard before the Australian Competition Tribunal in 2022.

Policy developments in private health insurance

In May 2021, the Australian Government announced several initiatives aimed at improving the affordability and sustainability of private health insurance. These initiatives included:

- investing $22 million over four years, to improve and modernise the Prostheses List and reduce the cost of medical devices from 2021–22, with changes to be introduced progressively and in a staged manner from February 2022[7]
- the extension of the current policy settings with respect to the Medicare Levy Surcharge and private health insurance rebate income tiers for a further two years, while a study examines the effectiveness of the current regulatory settings
- an independent study to investigate private hospital default benefit arrangements, which require insurers to pay a minimum benefit towards hospital accommodation and care for hospital treatment where there is no agreement between a patient's insurer and a particular hospital
- improvements to the certification process for admitting patients to hospital for procedures normally provided out of hospital.

6 Private Healthcare Australia's 30 March 2021 application sought reauthorisation for insurers to collaborate, noting that the relevant conduct was first authorised on 17 September 2020.

7 Department of Health, *Private health insurance – Modernising and improving the private health insurance Prostheses List*, Budget 2021-22 Fact Sheet, 11 May 2021, https://www.health.gov.au/resources/publications/private-health-insurance-modernising-and-improving-the-private-health-insurance-prostheses-list.

1. Introduction

For its 23rd report to the Australian Senate, the Australian Competition and Consumer Commission (ACCC) has prepared a report which provides an update on key competition and consumer developments and trends in the private health insurance industry between 1 July 2020 and 30 June 2021 (the reporting period), and developments since the end of the reporting period.

In particular, the ACCC is monitoring the ongoing impact of the COVID-19 pandemic on the health sector, specifically regarding private health insurers' commitment not to profit from the COVID-19 pandemic when many private health insurance customers have been unable to access health services or treatments.

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.[8] 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*, 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 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, restrict anti-competitive arrangements and exclusionary conduct.

The ACCC's Compliance and Enforcement Policy and Priorities outlines our enforcement powers, functions, priorities and strategies.[9] The ACCC updates this document yearly to reflect current and enduring priorities.

8 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.

9 ACCC, *ACCC's compliance & enforcement policies and priorities,* 2021, https://www.accc.gov.au/about-us/australian-competition-consumer-commission/compliance-enforcement-policy-priorities.

1.3 Methodology in preparing this report

The ACCC has drawn on information and data from a range of sources, including desktop research and contacts data, in preparing the 2020–21 private health insurance report.

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

- industry statistics and data collected by the Australian Prudential Regulation Authority (APRA)[10]
- private health insurance complaints data from the Private Health Insurance Ombudsman (PHIO).[11]

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

11 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 that occurred in 2020–21, as summarised below.

Summary of key industry developments and trends in 2020–21

- In June 2021, nearly 14 million Australians, or approximately 54.3% of the population, had some form of private health insurance, which was an increase of 1.4% since June 2020. This is the first annual increase in the proportion of Australians with health insurance since 2015.
- In 2020–21, the number of Australians holding hospital only or combined cover increased by almost 1% from the previous year, to 44.5% of the Australian population. At the same time the number of Australians holding extras only policies increased by 0.4%, to 9.8% of the Australian population.
- Average premium increases in 2020–21 were the lowest since 2001, at 2.74%. However, the cumulative increase in premiums over the five years to June 2021 continued to outpace wage growth, with average premium increases being more than double inflation (CPI) during the same period.
- In 2020–21, Australian consumers paid almost $25.7 billion in private health insurance premiums, which was an increase of 3.2%. This reflected both the April 2021 premium increase and the growth in the proportion of Australians holding private health insurance compared to the previous year.
- As the global COVID-19 pandemic continued into a second year, access to non-urgent elective surgery and extras treatments remained limited for many policyholders. While waiting lists for private patients' non-urgent elective surgery have been reduced over the 12 months to June 2021, they are far from eliminated.
- Meanwhile, multiple private health insurers have announced various initiatives to partially return their profits gained from COVID-19 restrictions to policyholders – primarily via premium credits or direct payments to policyholders.
- The number of hospital policies held by younger Australians increased for the first time in many years, with those in the 15–19 and 20–24 age groups increasing their coverage by 3% (to 672,674) and 2% (to 531,011) respectively. However, the number of hospital policies held by older Australians, specifically those aged 75–79 and 80+, increased at the fastest rate of any age group, by 6% (to 435,623) and 5% (to 525,651) respectively.
- Over the past five years the number of hospital policies held by those aged 25–29 decreased by 19% (to 425,685), whereas the number of policies held by those aged 75–59 *increased* by 19% (to 435,623), which made 2020–21 the first year on record where people in their mid/late 70s outnumbered people in their mid/late 20s.
- The average gap expense incurred by a consumer for hospital treatment increased by 19.9%, or almost $58 (to $347.53), from the previous year. This continues a longer-term trend over at least the past five years of larger average gap expenses for consumers. The average gap payment for extras treatments increased by 5.2% in 2020–21.
- Overall complaints to the PHIO have decreased by 5.7% since June 2020, however complaints about service, including verbal advice, increased by 35%. Over the same period, the ACCC received 164 contacts about private health insurance, which was a decrease of 33% from last year.

2.1 Private Health Insurance membership

As of 30 June 2021, nearly 14 million Australians, or approximately 54.3% of the population, had some form of private health insurance.[12] While the number of insured persons increased by 354,118 between July 2020 and June 2021, the Australian population itself is estimated to have grown by approximately 3,674 people, or 0.014%.[13] This was the lowest rate of population growth in more than one hundred years, largely due to the closure of international borders in March 2020, following the outbreak of COVID-19.[14]

Due to the growth in health insurance membership and the low population growth, the proportion of Australians holding private health insurance increased by approximately 1.4% from June 2020.[15] This is the first annual increase in the proportion of Australians with private health insurance since 2015.

Types of private health insurance

There are broadly two 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.[16]

Table 1 shows the increase in the proportion of the population holding hospital only or combined cover, from 43.6 % in June 2020 to 44.5% in June 2021.[17] During the same period, the proportion of the population holding extras only policies increased from 9.4% to around 9.8 % of Australians.[18]

12 APRA, *Statistics: Private health insurance membership and coverage June 2021*, 17 August 2020, viewed 4 October 2021, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Membership%20and%20Coverage%20June%202021.xlsx.

13 APRA, *Statistics: Private health insurance membership and coverage June 2021*, 17 August 2020, viewed 4 October 2021, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Membership%20and%20Coverage%20June%202021.xlsx.

14 Australian Institute of Health and Welfare, *Profile of Australia's population*, 16 September 2021, viewed 12 October 2021, https://www.aihw.gov.au/reports/australias-welfare/profile-of-australias-population.

15 Australian Institute of Health and Welfare, *Profile of Australia's population*, 16 September 2021, viewed 12 October 2021, https://www.aihw.gov.au/reports/australias-welfare/profile-of-australias-population.

16 Ambulance cover may be available separately, combined with other policies, or in some cases is covered by state or territory governments.

17 APRA, *Statistics: Private health insurance membership trends June 2021*, 17 August 2021, viewed 4 October 2021, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Membership%20and%20Coverage%20June%202021.xlsx .

18 APRA, *Statistics: Private health insurance membership trends June 2021*, 17 August 2021, viewed 4 October 2021, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Membership%20and%20Coverage%20June%202021.xlsx.

Table 1: Insured Australian consumers by policy type, June 2019 to June 2021

	Hospital only or combined cover	Extras cover only	Total insured persons
June 2019	11,227,569	2,373,768	13,601,337
% of population	*44.3%*	*9.4%*	*53.6%*
June 2020	11,197,395	2,413,400	13,610,795
% of population	*43.6%*	*9.4%*	*53%*
June 2021	11,442,584	2,522,329	13,964,913
% of population	*44.5%*	*9.8%*	*54.4%*

Note: Figures may not add up due to rounding

Source: APRA, *Statistics: Private health insurance membership trends June 2021*.

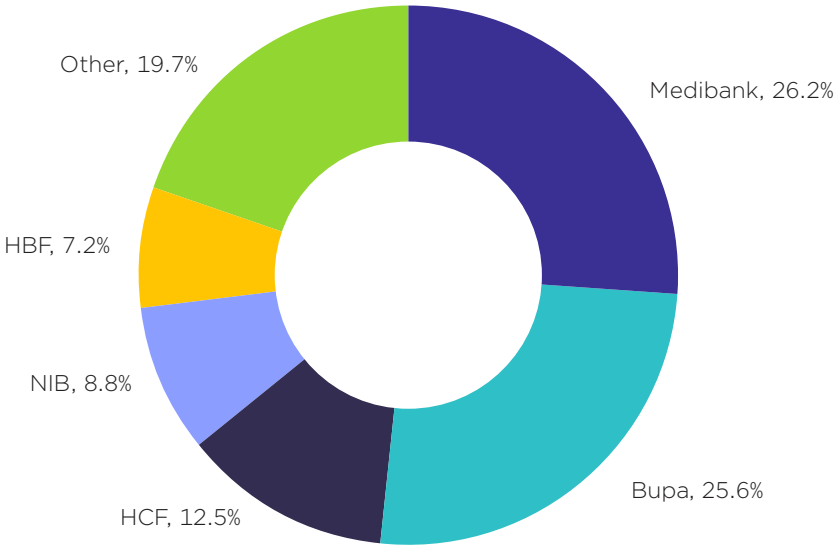
Membership by health insurer

In 2020–21, there were a total of 35 health funds operating in Australia, including not-for-profit insurers and for-profit insurers.[19] Medibank Private Limited (Medibank) became Australia's largest health insurer in 2020–21, ending the financial year with around 3.67 million members (measured by individuals covered), overtaking Bupa HI Pty Ltd (Bupa) who had approximately 3.58 million members.[20]

To the end of June 2021, the five largest health insurers in Australia provided cover to around 80.3% of Australian consumers that have private health insurance.

As shown in figure 1, Medibank and Bupa represented just over half of the Australian private health insurance market, with market shares of 26.2% and 25.6% respectively. The next three largest insurers – The Hospitals Contribution Fund of Australia Limited (HCF), NIB Health Funds Limited (NIB) and HBF Health Limited (HBF) – had a combined market share of around 28.5%.

Figure 1: Insurer market share by Australians covered, 2020–21



Source data: APRA, *Statistics: Operations of private health insurers annual report 2020–21,* Table 3.

19 APRA, *Register of private health insurers*, 2 July 2021, viewed 4 October 2021, https://www.apra.gov.au/register-of-private-health-insurers.

20 APRA, *Operations of private health insurers annual report 2020–21*, 27 October 2021, viewed 28 October 2021, table 3, https://www.apra.gov.au/operations-of-private-health-insurers-annual-report.

The five largest health insurers contributed to almost 78% of total health fund benefits paid in 2020–21[21], with Medibank and Bupa contributing 24.9% and 25.4% respectively.[22] Benefits paid by health insurers are discussed further in section 2.3.

2.2 Premiums paid by consumers to health insurers increased

Australian consumers paid almost $25.7 billion in private health insurance premiums in 2020–21, an increase of just over $785 million, or 3.2% compared to the previous year.[23] This growth in premium revenue reflects an increase in both premiums and the proportion of Australians with private health insurance (as discussed in section 2.1).

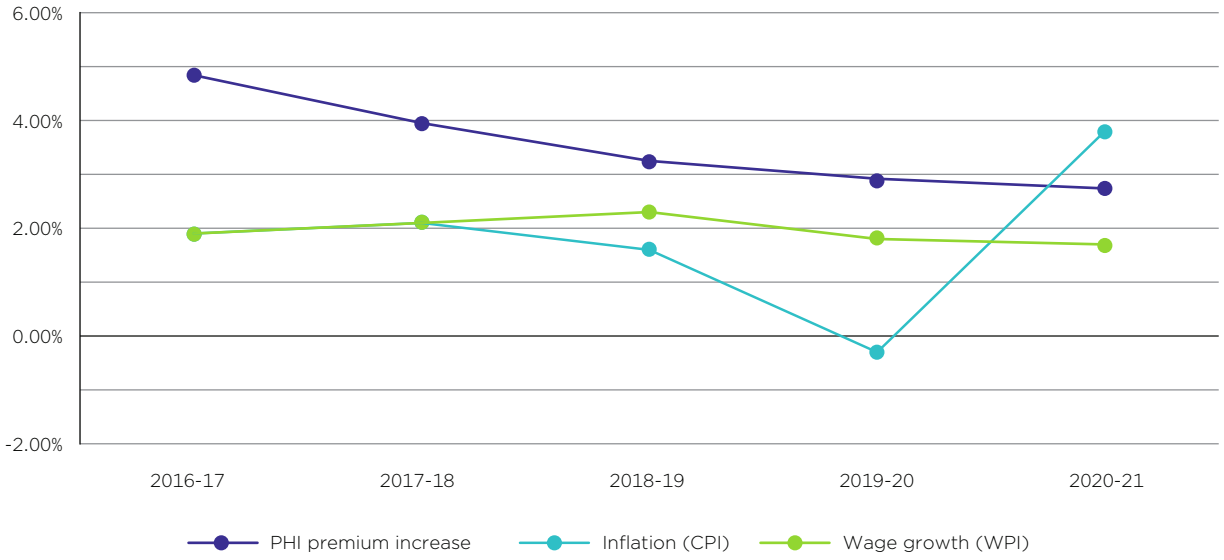
Table 2: Expenditure on private health insurance, per year, by dollar and percentage change, June 2019 to June 2021

	$ paid (in '000)	$ change from previous year (in '000)	% change from previous year
June 2019	24 561,694	662,537	2.8%
June 2020	24 895,120	333,426	1.4%
June 2021	25 680,469	785,349	3.2%

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

Figure 2 shows average premium increases (on an industry weighted average basis), the inflation rate and the rate of growth in wages from 2016–17 to 2020–21.

Figure 2: Private health insurance premium increases, inflation and wage growth, 2016–17 to 2020–21



Source data: Department of Health, Average annual premium price change by insurer; Australian Bureau of Statistics (ABS), *6401.0—Consumer price index, Australia*, Jun 2017, 2018, 2019, 2020, and 2021; ABS, *6345.0—Wage price index, Australia*, Jun 2017, 2018, 2019, 2020 and 2021.

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

22 APRA, *Operations of private health insurers annual report 2020–21*, 27 October 2021, viewed 28 October 2021, table 3, https://www.apra.gov.au/operations-of-private-health-insurers-annual-report.

23 APRA, *Statistics: Quarterly private health insurance statistics June 2021*, 17 August 2021, viewed 21 September 2021, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202021.pdf.

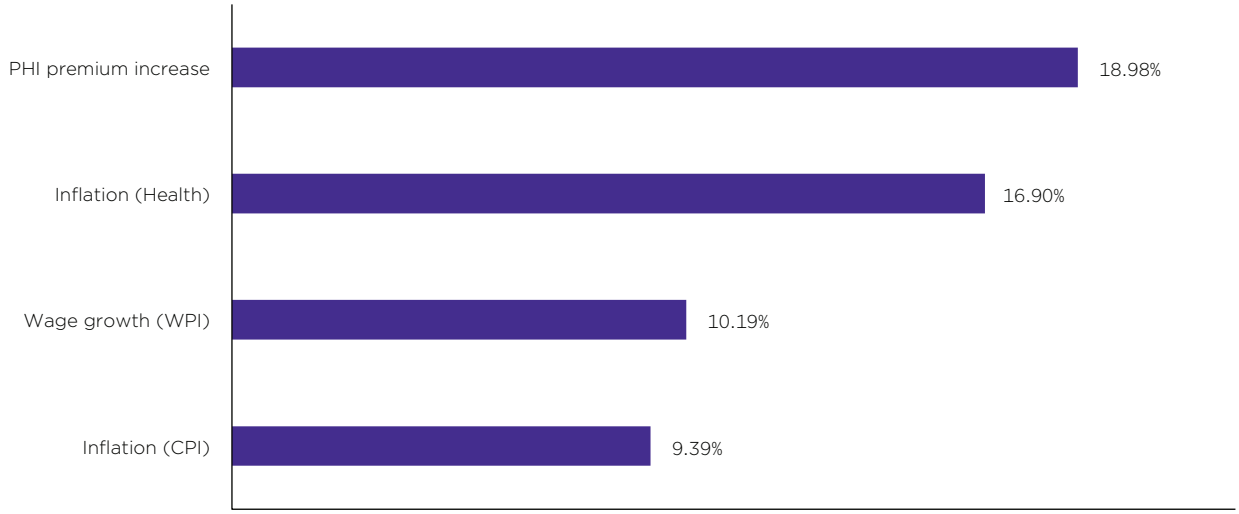
This year's private health insurance average premium increase of 2.74% was the lowest increase since 2001.[24] However, for many policyholders, this was the second increase in six months, due to many insurers delaying the 1 April 2020 premium increase to 1 October 2020.[25] Meanwhile, the Australian Government's private health insurance rebate was reduced on 31 March 2021 for all eligible income levels.[26] The rebate is adjusted every year based on a formula which considers the growth of the CPI and the industry weighted average premium increase. The private health insurance rebate was frozen at the beginning of 2020 due to the pandemic.[27] Section 2.4 of this report examines insurers' responses to the COVID-19 pandemic in further detail.

Annual inflation in 2020–21 was 3.8%, which was the highest since September 2008. This substantial rise in inflation was significantly influenced by the COVID-19 pandemic and related price changes, particularly the full unwinding of the Australian Government's free childcare package (implemented in April 2020), and a full return from the drop in fuel prices in June 2020.[28]

Figure 3 shows the cumulative increase in average private health insurance premiums, inflation in health prices, wage growth and CPI over the five years to 2020–21. The inflation in health prices figure is a component of the consumer price index, and is an all-encompassing measure, which includes healthcare prices such as private health insurance premiums, other hospital, dental and medical services, pharmaceutical products and therapeutic equipment.[29]

Figure 3 shows that the cumulative increase in premiums over the five years to June 2021 continues to outpace inflation in health prices, wage growth and CPI respectively – with average premium increases being more than double inflation (CPI) during the same period.

Figure 3: Cumulative increase in average private health insurance premiums, inflation (CPI and health) and wage growth, 2016–17 to 2020–21



Source data: Department of Health, Average annual premium price change by insurer; Australian Bureau of Statistics (ABS), *6401.0—Consumer price index, Australia*, Jun 2017, 2018, 2019, 2020, and 2021; ABS, *6345.0—Wage price index, Australia*, Jun 2017, 2018, 2019, 2020 and 2021.

24 Private Healthcare Australia, *Why is your health insurance premium going up this year?*, Media release 31 March 2021, https://www.privatehealthcareaustralia.org.au/why-is-your-health-insurance-premium-going-up-this-year/; CHOICE, *Private health premiums went up in April*, Media release 1 July 2021, https://www.choice.com.au/money/insurance/health/articles/health-premium-hikes-on-the-horizon-131115.

25 ACCC, *Private health insurance report 2019–20*, 8 December 2020, p15, https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2019-20.

26 Australian Taxation Office, *Income thresholds and rates for the private health insurance rebate*, 29 June 2021, viewed 12 October 2021, https://www.ato.gov.au/Individuals/Medicare-and-private-health-insurance/Private-health-insurance-rebate/Income-thresholds-and-rates-for-the-private-health-insurance-rebate/#Rebaterates1.

27 CHOICE, *Private health premiums went up in April*, Media release 1 July 2021, https://www.choice.com.au/money/insurance/health/articles/health-premium-hikes-on-the-horizon-131115.

28 ABS, *CPI rose 0.8% in the June 2021 quarter*, Media release 28 July 2021, https://www.abs.gov.au/media-centre/media-releases/cpi-rose-08-june-2021-quarter.

29 ABS, *Information paper: Consumer price index: Concepts, sources and methods Australia 2018*, 27 February 2019, viewed 25 October 2021, https://www.abs.gov.au/ausstats/abs@.nsf/mf/6461.0.

Review of the Prostheses List may help address the continuing pressure on premiums

In Australia, benefits paid by private health insurers for prostheses and medical devices are set by law and are known as the Prostheses List.[30] The Prostheses List contains more than 11,000 prostheses and lists the no-gap and gap-permitted prostheses and the benefits payable for them by private health insurers where a member has policy coverage. Prostheses products and benefits paid are recommended to the Minister for Health and the Department of Health by the Prostheses List Advisory Committee.[31]

Payment of prostheses benefits accounted for approximately 14% of total hospital benefits paid per person,[32] and prosthetic benefits paid by registered insurers totalled approximately $2.2 billion in 2020–21.[33] Products on the Prostheses List include devices such as cardiac implantable electronic devices, insulin infusion pumps, and hip, knee and shoulder joint replacement devices.

According to the Grattan Institute, the Prostheses List price schedule for protheses in private hospitals are more than double public hospital prices.[34] The Grattan Institute and the Australian Medical Association (AMA) both support reform to the Prostheses List to improve sector efficiencies and moderate premium increases to help make private health insurance more sustainable.[35]

Private Healthcare Australia and the Members Health Fund Alliance have also advocated for reforming the Prostheses List,[36] with both bodies arguing that Australia pays significantly more for the same devices than similar overseas markets.[37] According to Private Healthcare Australia, medical devices were the largest driver of the 1 April 2021 health insurance premium increase.[38]

The Medical Technology Association of Australia has previously argued that a reduction in the value of Prostheses List items is not likely to have a major impact on private health insurance premiums, given it accounts for approximately 14% of benefits paid by insurers and has had a low growth rate since 2010, in comparison to the growth of hospital and medical services benefits.[39]

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30 Department of Health, *Prostheses cover under private health insurance*, viewed 14 October 2021, https://www.health.gov.au/health-topics/private-health-insurance/what-private-health-insurance-covers/prostheses-cover-under-private-health-insurance.

31 Department of Health, *Prostheses List Advisory Committee*, viewed 14 October 2021, https://www.health.gov.au/committees-and-groups/prostheses-list-advisory-committee-plac.

32 APRA, *Statistics: Quarterly private health insurance statistics June 2021*, 17 August 2021, viewed 17 November 2021, p.5, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202021.pdf.

33 APRA, *Statistics: Quarterly private health insurance prostheses,* June 2021, 17 August 2021, viewed 18 October 2021, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Prostheses%20June%202021.xlsx.

34 S Duckett and G Moran, *Stopping the death spiral: Creating a future for private health*, Grattan Institute, May 2021, viewed 10 August 2021, p18, https://grattan.edu.au/report/stopping-the-death-spiral/.

35 S Duckett and G Moran, *Stopping the death spiral: Creating a future for private health*, Grattan Institute, May 2021, viewed 10 August 2021, p21, https://grattan.edu.au/report/stopping-the-death-spiral/. AMA, *AMA submission to the Department of Health consultation in relation to options for reforms and improvements to the Prostheses List,* 18 February 2021, viewed 18 October 2021, p1, https://www.ama.com.au/articles/ama-submission-department-health-consultation-relation-options-reforms-and-improvements.

36 Private Healthcare Australia, *Stop the waste: medical device claims increase out of proportion to all other health services*, Media release, 17 August 2021, https://www.privatehealthcareaustralia.org.au/stop-the-waste-medical-device-claims-increase-out-of-proportion-to-all-other-health-services/; Members Health Fund Alliance, *Private insurers say prosthesis price gouging must end: The Australian,* Media release 30 July 2021, https://membershealth.com.au/publications/private-insurers-say-prosthesis-price-gouging-must-end-the-australian/.

37 Members Health Fund Alliance, Private insurers say prosthesis price gouging must end: The Australian, Media release 30 July 2021, https://membershealth.com.au/publications/private-insurers-say-prosthesis-price-gouging-must-end-the-australian/. Private Healthcare Australia, *Private Healthcare Australia Launches Campaign to Reform Medical Device Pricing to Keep Health Insurance More Affordable*, Media release 24 June 2021, https://www.privatehealthcareaustralia.org.au/private-healthcare-australia-launches-campaign-to-reform-medical-device-pricing-to-keep-health-insurance-more-affordable/.

38 Private Healthcare Australia, *Why is your health insurance premium going up this year?*, Media release 31 March 2021, https://www.privatehealthcareaustralia.org.au/why-is-your-health-insurance-premium-going-up-this-year/.

39 Medical Technology Association of Australia, *MTAA submission to the Senate Inquiry into the Prostheses List Framework* [PDF], 17 February 2017, viewed 25 October 2021, p12, https://www.mtaa.org.au/sites/default/files/uploaded-content/field_f_content_file/mtaa_response_to_pl_senate_inquiry.pdf.

In June 2021, the Australian Government announced it would allocate $22 million over four years to improve the Prostheses List and review its scope and operations.[40] The aims of these reforms are to better align the costs of prostheses in the private system to that of the public health system, allowing private health insurers to benefit from reduced expenditure on protheses benefits paid to policyholders.[41] Private Healthcare Australia and Members Health Fund Alliance have suggested that the savings gained from protheses can then be passed on to privately insured patients through reduced premiums.[42]

2.3 Benefits paid by health insurers to consumers increased

During 2020–21, insurers' hospital benefit payout per customer increased by 1.9%, with an increase of approximately 10% for extras benefits.[43] The total amount of benefits paid for hospital treatment was over $15.9 billion, and approximately $5.6 billion for extras treatment.[44]

Table 3: Key metrics relating to the benefits paid by health insurers to consumers, June 2020 to June 2021[45]

	June 2020	June 2021	Change
Benefits: Hospital treatment ($ millions)	$15,303	$15,937	+4.1%
Benefits: General (ancillary) treatment ($ millions)[46]	$4,960	$5,606	+13%
Hospital benefit per consumer ($)[47]	$1,367	$1,393	+1.9%
Extras benefit per consumer ($)[48]	$404	$445	+10%

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

As detailed in Table 3 above, hospital benefits per consumer increased by 1.9% in the 12 months to June 2021 and 4.1% overall. Meanwhile, extras benefits paid out by insurers increased by 10% per consumer in 2020–21 and 13% overall reflecting the relaxation of many restrictions during that period in many parts of Australia.[49]

40 Department of Health, *Budget 2021-22:Modernising and Improving Private Health Insurance – Prostheses* List, Budget Fact Sheet June 2021, https://www.health.gov.au/resources/publications/private-health-insurance-modernising-and-improving-the-private-health-insurance-prostheses-list.

41 Department of Health, *Prostheses List reforms and reviews*, 30 September 2021, viewed 18 October 2021, https://www.health.gov.au/health-topics/private-health-insurance/the-prostheses-list/prostheses-list-reforms-and-reviews.

42 Private Healthcare Australia, *Stop the waste: medical device claims increase out of proportion to all other health services*, Media release, 17 August 2021, https://www.privatehealthcareaustralia.org.au/stop-the-waste-medical-device-claims-increase-out-of-proportion-to-all-other-health-services/; Members Health Fund Alliance, *Private insurers say prosthesis price gouging must end: The Australian,* Media release 30 July 2021, https://membershealth.com.au/publications/private-insurers-say-prosthesis-price-gouging-must-end-the-australian/.

43 APRA, *Statistics: Quarterly private health insurance statistics June 2021*, 17 August 2021, viewed 21 September 2021, p2, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202021.pdf.

44 APRA, *Statistics: Quarterly private health insurance statistics June 2021*, 17 August 2021, viewed 21 September 2021, p2, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202021.pdf.

45 This table presents a selection of key metrics relating to the benefits paid by private health insurers. A full outline of all benefits paid to consumers by insurers can be found in APRA's *Quarterly Private Health Insurance Statistics*.

46 Extras treatment, (General treatment - Ancillary) does not include Chronic Disease Management Plans.

47 To June 2020, the hospital benefit per consumer was precisely $1,366.88 and to June 2021 it was $1,392.81.

48 To June 2020, the extras benefit per consumer was precisely $404.29 and to June 2021 it was $444.60.

49 Noting restrictions were reintroduced in New South Wales and Victoria in August 2021.

Table 4: Hospital treatment benefits paid by health insurers to consumers, per year, by dollar and percentage change, June 2019 to June 2021

	$ paid (in '000)	$ change from previous year (in '000)	% change from previous year
June 2019	15,439	375	+ 2.5%
June 2020	15,303	-136	- 0.9%
June 2021	15,937	634	+ 4.1%

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

Table 5: Extras treatment benefits paid by health insurers to consumers, per year, by dollar and percentage change, June 2019 to June 2021

	$ paid (in '000)	$ change from previous year (in '000)	% change from previous year
June 2019	5,301	150	+ 2.9%
June 2020	4,960	-341	- 6.4%
June 2021	5,606	646	+ 13%

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

2.4 Insurer responses to the COVID-19 pandemic and the 'deferred claims liability'

Reduced access to treatment led to increased profitability for insurers

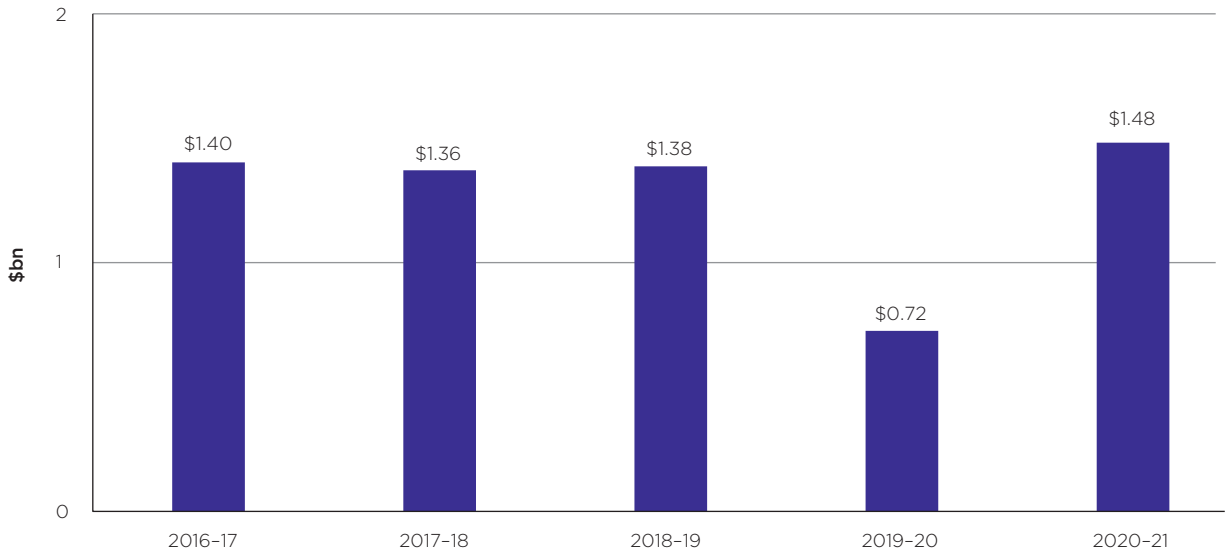
In the 12 months to June 2021, government-imposed restrictions in response to the COVID19 pandemic continued to limit policyholders' access to non-urgent elective surgery and non-urgent 'extras' treatments (including most dental, optical and other health services). This impact was particularly notable in Victoria, and to a lesser extent NSW, which experienced several local lockdowns during the reporting period.

This meant consumers were unable to access many of the services covered by their policies and insurers paid fewer claims than expected. Some of these services are likely to occur at a later date. For example, services such as surgery are still likely to be required and need to be paid for by insurers.

However, some services are unlikely to materialise in the future, such as missed appointments for a dental 'clean and scale'. The services unlikely to materialise are likely to increase insurer profit if not off-set by other policyholder returns.

After a reduction in profit in the year ending June 2020, industry net profits for the year ending June 2021 returned to a level comparable to the pre-COVID period (Figure 4).

Figure 4: Private health insurers' net profit after tax ($bn), 2016–17 – 2020–21



Source: APRA, *Statistics: Operations of private health insurers annual report*, 2016–17, 2017–18, 2018–19, 2019–20, and 2020–21

The increased profitability in the year ending June 2021, where net profits increased by almost 94% compared to the year ending June 2020, may be broadly attributed to the following factors:

- higher premium income – attributable to both premium increases[50] and a rise in memberships[51]
- relatively flat growth in benefit claims, particularly when considering the overall trend since 2018–19,[52] where the utilisation of health services was affected by COVID-19
- higher revenue from increased net investment income, up from $146 million in the previous financial year to $604 million in the year to June 2021[53] (it is estimated that around 40% of insurers' higher revenue in 2020–21 was due to increased net investment income).

The industry held total assets of $17.8 billion as at 30 June 2021, with total assets increasing by $1.2 billion in the last 12 months. Total liabilities reported by the industry increased by $340 million over the year to $8.2 billion, of which approximately $1.4 billion is deferred claims liability (DCL).[54]

As reported in the ACCC's 2019-20 report to the Senate, private health insurers and their industry associations have already committed to returning any profits gained from the pandemic to policyholders.[55] Early initiatives introduced included hardship measures (such as premium waivers or policy suspensions to policyholders financially impacted by COVID19) and the deferment of the April 2020 premium increase for at least six months (or cancellation of the April 2020 premium increase in the case of HBF and Teachers Union Health).[56]

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

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

52 See section 2.3 of this report for further detail about benefits paid by insurers to consumers; see also APRA, *Quarterly private health insurance statistics – highlights*, June 2021, at p. 3, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20private%20health%20insurance%20statistics%20highlights%20June%202021.pdf.

53 APRA, *Quarterly private health insurance statistics – highlights*, June 2021, at p. 3, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20private%20health%20insurance%20statistics%20highlights%20June%202021.pdf.

54 APRA, *Statistics: Quarterly private health insurance statistics June 2021*, 17 August 2021, viewed 21 September 2021, p11, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202021.pdf.

55 ACCC, *Private health insurance report 2019-20*, 8 December 2020, p15, https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2019-20.

56 ACCC, *Private health insurance report 2019-20*, 8 December 2020, p15, https://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2019-20.

APRA's approach to insurers' deferred claim liabilities

Following ASIC's publication of FAQs explaining COVID-19 implications for financial reporting and audit,[57] APRA issued guidance to insurers about the valuation of a DCL in June 2020. The DCL is essentially money set aside by insurers as a contingency against the likelihood that services not performed during lockdown would be carried out at a later date. APRA's guidance was issued 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 at a later date.[58]

In July 2021, the Actuaries Institute published survey results on the impact of COVID-19 on private health insurance.[59] Surveying Appointed Actuaries and other actuaries in private health insurance, it sought views on the amount of 'missing' claims that are likely to occur, potential timing and perspectives on current experience.

The survey revealed that, while it varies by geography and experience:

- participants estimated that between 45% and 75% of all *hospital* claims that did not occur during the last 18-months are expected to occur – with the most common estimate being 50%[60]
- participants estimated that between 25% and 50% of all *extras* claims that did not occur during the last 18-months are expected to occur.

The survey also highlighted the significant uncertainty of estimating the amount of claims that are just *deferred* but will still occur.

APRA initially expected that insurers' DCL would be released or expended by 30 June 2021.[61] However, as COVID-19 lockdowns and restrictions continued into 2021, it became clear the DCL would also need to extend and probably beyond 2021 – creating additional uncertainty on an appropriate valuation of that liability.[62]

Figure 5 shows insurers have expended around $428 million in deferred claims liability since its peak of approximately $1.8 billion in December 2020. It is anticipated that the industry's total deferred claim liability may again increase for the September 2021 quarter, in response to concurrent lockdowns in Victoria, NSW and the ACT.

57 ASIC, 'COVID-19 implications for financial reporting and audit: Frequently asked questions (FAQs)', viewed on 1 November 2021, https://asic.gov.au/regulatory-resources/financial-reporting-and-audit/covid-19-implications-for-financial-reporting-and-audit-frequently-asked-questions-faqs/.

58 APRA, *Application of the capital framework for COVID-19 related disruptions,* 22 June 2020, viewed 30 September 2021, https://www.apra.gov.au/application-of-capital-framework-for-covid-19-related-disruptions.

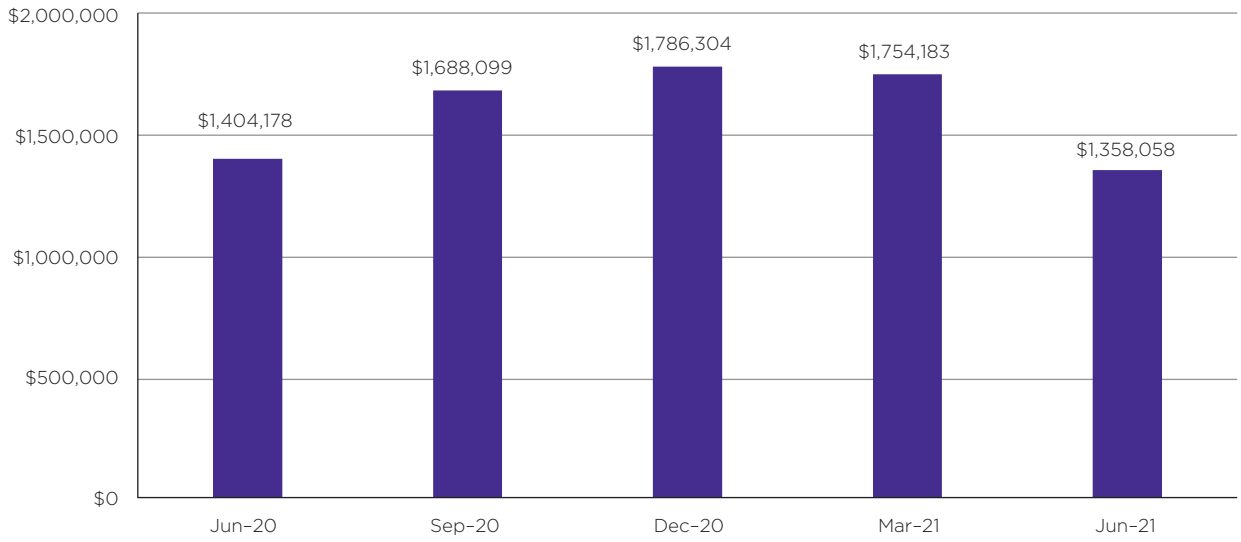
59 These estimates were in respect of the national average, noting the picture would vary by geography and experience; Stephanie Martin, 'Impacts of COVID-19 for Private Health Insurance Actuaries', *Actuaries Digital*, 4 August 2021, https://www.actuaries.digital/2021/08/04/impacts-of-covid-19-for-private-health-insurance-actuaries/.

60 This would of course vary by geography and insurer, and several survey participants also highlighted additional factors that would need to be considered in this estimate that increases its subjectivity, including the risk appetite, and the probability of adequacy.

61 APRA, *Application of the capital framework for COVID-19 related disruptions,* 22 June 2020, viewed 30 September 2021, https://www.apra.gov.au/application-of-capital-framework-for-covid-19-related-disruptions.

62 APRA, *Statistics: Quarterly private health insurance statistics June 2021*, 17 August 2021, viewed 21 September 2021, p11, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202021.pdf.

Figure 5: Private health insurers' deferred claims liability balance ('000s) June 2020 – June 2021



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

As of March 2021, APRA ceased mandating a prescriptive approach and permitted insurers to adopt their own method of calculating the DCL – though insurers could still use the prescribed method if they wished. Under the non-prescribed approach, insurers still need to demonstrate a prudent approach to calculating the DCL, including by demonstrating consideration of a list of specific factors outlined by APRA.[63]

APRA's prescriptive approach to calculating the DCL indicates that insurers do not need to make provision for claims that are considered unlikely to materialise. For example, APRA's guidance states that:

> '*For the regulatory balance sheet, insurers will have the option to:*
>
> 1. *continue to accrue the DCL if claims are below the level expected during the selected forecasts; or*
> 2. *not accrue additional DCL if they consider claims below the level expected during the selected forecasts are not likely to materialise at a later date.*'[64]

Similarly, APRA's non-prescriptive approach to calculating the DCL indicates that insurers do not need to include claims that are considered more likely to be cancelled, as opposed to deferred. For example, APRA's guidance states that:

> *'APRA expects insurers using their own valuation for the balance sheet liability will demonstrate consideration of:*
>
> - *claims that did not occur by category and an estimate of which claims are more likely to be deferred as opposed to cancelled.*'[65]

63 APRA, 'Application of the capital framework for COVID-19 related disruptions – frequently asked questions', FAQ 8: What does APRA expect to be considered when valuing the DCL?, https://www.apra.gov.au/application-of-capital-framework-for-covid-19-related-disruptions-frequently-asked-questions; It is also relevant to note that insurers unable to demonstrate these matters with an explanation acceptable to APRA may be asked to resubmit their returns, and APRA may also consider taking further action, such as applying a capital adequacy supervisory adjustment amount to that insurer.

64 APRA, 'Application of the capital framework for COVID-19 related disruptions – frequently asked questions', FAQ 5: Is there a prescriptive approach available for insurers?, https://www.apra.gov.au/application-of-capital-framework-for-covid-19-related-disruptions-frequently-asked-questions.

65 APRA, 'Application of the capital framework for COVID-19 related disruptions – frequently asked questions', FAQ 8: What does APRA expect to be considered when valuing the DCL?', https://www.apra.gov.au/application-of-capital-framework-for-covid-19-related-disruptions-frequently-asked-questions.

The DCL is intended to help ensure that insurers have adequate capital to meet future deferred claims,[66] consistent with APRA's role and purpose in providing guidance about the DCL. To meet this objective, the DCL focuses on claims that are expected to re-occur and require payment from insurers. It does not reflect all claims that did not occur due to COVID-19. Similarly, it does not reflect an insurer's expected profit due to COVID-19.

Insurers' recent initiatives to continue returning COVID-19 profits to policyholders

The ACCC recognises that ongoing restrictions has meant more claims have been deferred (or in some cases cancelled) and increased the uncertainty over the amount of the DCL and the time it may be required. This is particularly the case in NSW and Victoria, where several local and state-wide lockdowns were implemented during and after the reporting period.

The Australian Private Hospitals Association has estimated that:

> '*..there were 340,000 episodes of care "missing" from private hospitals in 2020 [due to COVID-19 restrictions]. Taking into account the six months to the end of June [2021], we now estimate that figure has fallen to 290,000, but it will still take a considerable amount of time to work through these cases.*'[67]

The AMA has argued that the ongoing backlog in private access to nonurgent elective surgery is at least partly the result of state governments prioritising public patients in private hospitals (under various COVID-19 arrangements).[68]

Despite these ongoing challenges, the ACCC is aware that many insurers have continued to return profits from COVID-19 restrictions to policyholders by way of partial premium credits or direct payments to policyholders. Recently announced initiatives to return COVID-19 profits to policyholders have included the following from the 'big five' insurers (several announcements also referred to the insurers' DCL):

- On 10 June 2021, HBF announced that 'it was following through with its commitment that it would not financially benefit from the COVID-19 pandemic', and would return around $42 million to around 470,000 policyholders (or between $20 and $140 per applicable policyholder), of its estimated total $94.3 million DCL, with payments made directly to eligible members.[69]
- On 29 June 2021, Medibank announced that it would return around $105 million to around 2 million eligible policyholders through premium relief (or an average of $25 for extras only policies and $60 for hospital/combined policies), in a partial release of its DCL for the 202021 financial year, as well as permanent claims savings since 31 December 2020.[70] Medibank's announcement noted, '[w]e said right from the start of the pandemic that we would not profit from COVID-19, and that we were committed to returning any COVID-19 savings back to our customers'.
- On 23 August 2021, NIB announced that it would return $15 million to almost 600,000 eligible policyholders through premium relief (or between $13 and $64 depending on the type of policy held), which was said to bring NIB's 'total support to date' to $60 million.[71] According to NIB's announcement:

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66 APRA, 'Application of the capital framework for COVID-19 related disruptions – frequently asked questions', https://www.apra.gov.au/application-of-capital-framework-for-covid-19-related-disruptions-frequently-asked-questions.

67 Australian Private Hospitals Association, *Elective surgery backlog 'serious',* Media release, 17 August 2021, https://apha.org.au/wp-content/uploads/2021/08/Elective-surgery-backlog-%E2%80%98serious-1.pdf.

68 Dana Daniel, 'Pandemic elective surgery bans hits value of private health cover', *The Sydney Morning Herald*, 22 October 2021, https://www.smh.com.au/politics/federal/pandemic-elective-surgery-bans-hits-value-of-private-health-cover-20211021-p5921d.html.

69 HBF, *HBF finalises COVID-19 surplus funds to be returned to members*, Media release 10 June 2021, https://www.hbf.com.au/media-releases/covid-19-surplus-funds.

70 Medibank, *Medibank to return around $105 million in COVID-19 savings to customers through premium relief*, ASX release 29 June 2021, https://www.medibank.com.au/livebetter/newsroom/post/medibank-to-return-around-usd105-million-in-covid-19-savings-to-customers.

71 NIB, *nib announces return of $15 million in COVID-19 claims savings to members*, Media release 23 August 2021, https://www.nib.com.au/media/2021/08/media-pages-nib-covid-19-claims-savings.

'nib Chief Executive - Australian Residents Health Insurance, Ed Close, said the additional support reflects nib's promise to return claims savings to members in recognition of the impact of COVID-19 restrictions on their ability to access some health services.

"In line with the requirements of our industry regulator, nib set aside funds to ensure we were able to pay for our members' future healthcare needs as there was an expectation there would be a 'catch-up' in claims once COVID-19 restrictions eased," Mr Close said.

"This anticipated claims experience has not eventuated in financial year 2021, which means we can return $15 million in claims savings to our members."

- On 6 October 2021, Bupa announced that it would return $120 million to eligible policyholders (or between $15 and $110 per policyholder, with an average payment of $71 through a direct bank payment).[72] Bupa's announcement noted,

  'We've always said we wouldn't seek to benefit from the COVID pandemic. As we haven't seen claims return to levels that we originally anticipated, we wanted our customers to share in these savings,'

- On 13 October 2021, HCF announced that it was passing on savings from COVID-19 to policyholders by freezing premiums at the current rate until 1 November 2022, which it characterised as an additional return of $66 million to policyholders.[73] HCF's announcement also noted the following:

  HCF Chief Executive Officer Sheena Jack said the additional support reflected HCF's commitment to return claims savings to members in recognition of the impact of COVID-19 restrictions on their ability to access some health services over the past 20 months.

  "The anticipated volume in claims due to the postponement of some health services has not fully eventuated, which means we're passing these savings on to all members by freezing premiums at current rates until 1 November 2022," Ms Jack said.

The ACCC supports insurers' ongoing efforts to return profits gained from COVID-19 restrictions to policyholders. However, the ACCC is concerned that some of the statements made by insurers when announcing policyholder relief may give the impression that the DCL is equivalent to their profitability from COVID restrictions. It is important to emphasise that the DCL is *not* a proxy for total profitability from COVID restrictions, and nor was this ever the intention when the DCL was created (as detailed above regarding APRA's approach).

The ACCC notes that insurers can *exclude* the value of claims that were missed due to COVID restrictions and are not expected to materialise later (e.g. dental 'clean and scale' services) when calculating their DCL.[74] However, for the purpose of fulfilling their broader commitments (made in 2020) not to financially benefit from the pandemic,[75] the ACCC expects insurers to *include* the value of these claims when calculating their policyholder relief.

72 Bupa, *Bupa customers to receive $120 million cash back in COVID savings, bringing total support to $315 million*, Media release 6 October 2021, https://media.bupa.com.au/bupa-customers-to-receive-120-million-cash-back-in-covid-savings-bringing-total-support-to-315-million/.

73 HCF, *HCF announces return of $66m in Covid-19 claims savings to members*, Media release 13 October 2021, https://www.hcf.com.au/about-us/media-centre/media-releases/2021/hcf-return-66m-to-members.

74 Consistent with the primary objective of the DCL, which is to ensure that insurers have sufficient funds to satisfy future claims for deferred procedures, such as elective surgery.

75 Private Healthcare Australia, *Health funds committed to providing financial relief for members impacted by COVID 19*, 26 March 2020, https://www.privatehealthcareaustralia.org.au/health-funds-committed-to-providing-financial-relief-for-members-impacted-by-covid-19/; Members Health Fund Alliance, *COVID surpluses to benefit policyholders of not-for-profit and member owned health funds*, Media release, 15 May 2020, https://membershealth.com.au/publications/covid-surpluses-to-benefit-policyholders-of-not-for-profit-and-member-owned-health-funds/.

These broader commitments may be particularly applicable in respect of extras treatment and geographic areas that were subject to extended lockdowns, noting:

- it has been estimated that 50–75% of all extras claims that did not occur during the last 18-months are not expected to occur in the future,[76] potentially reflecting the discretionary nature of some extras claims[77]
- the percentage of deferred claims that will be permanently lost may increase in geographic areas that have experienced extended COVID-19 lockdowns.[78]

The ACCC will continue to monitor insurers' efforts to provide policyholder relief and consider these when preparing the next report for the 2021-22 reporting period.

Finally, the ACCC notes that the Minister for Health will have an opportunity to consider these matters, alongside a wide range of factors, when assessing each health fund's application to change premiums from April 2022.

2.5 Consumer responses to private health insurance costs

The proportion of Australians with private health insurance increased in 2020–21 for the first time since 2015, with the total number of insured persons increasing by 354,118.[79]

Industry participants have observed that COVID 'appears to have lifted community interest in the need for protection'.[80] Similarly, the results from an April 2021 survey of 1,200 consumers by the Melbourne Institute indicated that 'peace of mind, which is suggestive of risk aversion' was the most common reason for purchasing private hospital insurance in Australia,[81] and the survey authors noted:

> '*This is surprising given all Australians have free access to public hospitals, so people are protected from high financial risk of catastrophic health costs. In Australia, the main benefit of having private cover is not protection from catastrophic health costs, but to reduce wait times in public hospitals. Thus, private health insurance is quite different from other insurance industries (e.g., car, property), but many people fail to understand this difference.*'[82]

Figure 6 outlines the number of hospital policies held by working population for the last five years.

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76 These estimates were in respect of the national average, noting the picture would vary by geography and experience. Several survey participants also highlighted additional factors that would need to be considered in this estimate that increases its subjectivity, including the risk appetite, and the probability of adequacy.

77 Stephanie Martin, 'Impacts of COVID-19 for Private Health Insurance Actuaries', *Actuaries Digital*, 4 August 2021, https://www.actuaries.digital/2021/08/04/impacts-of-covid-19-for-private-health-insurance-actuaries/.

78 Duffie Osental, 'Health insurers see profit bump amid COVID-19 lockdowns – S&P Global', *Insurance Business Australia*, 3 September 2021, https://www.insurancebusinessmag.com/au/news/breaking-news/health-insurers-see-profit-bump-amid-covid19-lockdowns--sandp-global-308848.aspx.

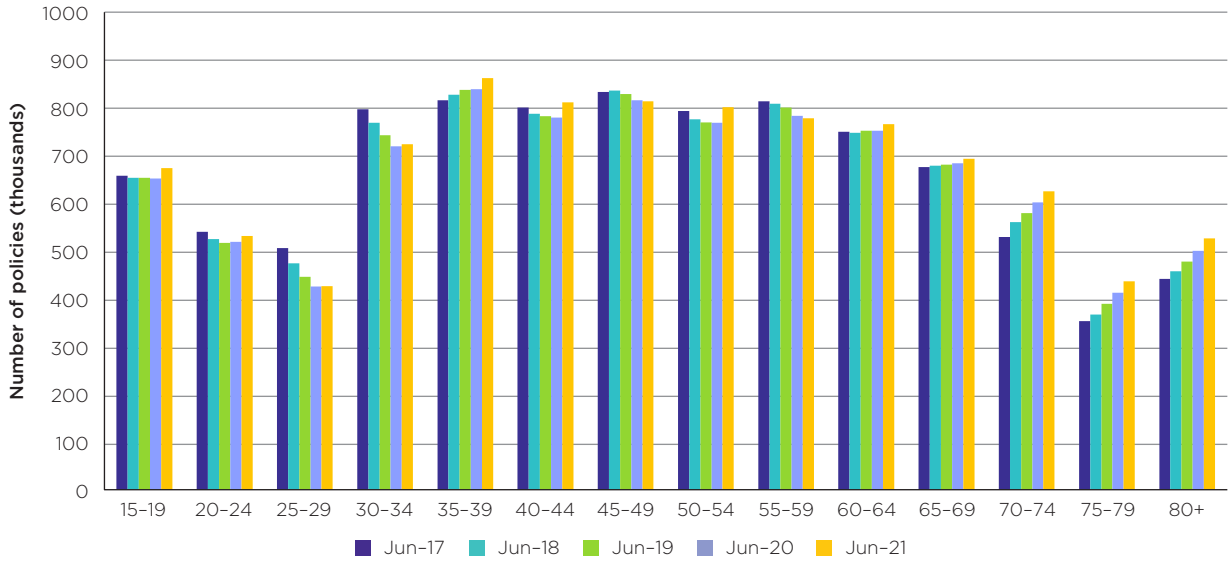
79 APRA, *Statistics: Private health insurance membership and coverage June 2021*, 17 August 2020, viewed 4 October 2021, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Membership%20and%20Coverage%20June%202021.xlsx.

80 Lucas Baird, 'NIB chief confident final dividend can lift to pre-pandemic levels', *Australian Financial Review*, 22 February 2021, https://www.afr.com/companies/financial-services/nib-maintains-dividend-as-profit-takes-double-digit-hike-20210222-p574li.

81 Yuting Zhang and Kushneel Prakash, *Why do Australians buy private hospital insurance?*, Melbourne Institute, May 2021, p. 5, https://melbourneinstitute.unimelb.edu.au/publications/research-insights/search/result?paper=3800758; see also Consumers Health Forum of Australia, *Results of Australia's Health Panel survey on the private healthcare system*, October 2021, https://chf.org.au/private-health-insurance.

82 Yuting Zhang and Kushneel Prakash, *Why do Australians buy private hospital insurance?*, Melbourne Institute, May 2021, p. 5, https://melbourneinstitute.unimelb.edu.au/publications/research-insights/search/result?paper=3800758.

Figure 6: Hospital cover, by age group, June 2017 to June 2021



Source data: APRA, *Statistics: Private health insurance membership trends June 2021*.

Figure 6 reveals that in 2020–21, the number of policies held by all age categories increased compared to the previous year, except for those aged 45-49 and 55-59, for whom policies decreased by 0.2% (to 812,758) and 1% (to 776,711) respectively. The following developments in FY2021 are also particularly notable:

- the number of hospital policies held by younger Australians increased for the first time in many years, with those in the 15-19 and 20-24 age groups increasing their coverage by 3% (to 672,674) and 2% (to 531,011) respectively
- the number of hospital policies held by older Australians, specifically those aged 75-79 and 80+, increased at the fastest rate of any age groups, by 6% (to 435,623) and 5% (to 525,651) respectively.

Figure 6 also reveals that over the past five years:

- the number of hospital policies held by those aged 25-29 decreased by 19% (to 425,685), whereas the number of policies held by those aged 75-79 *increased* by 19% (to 435,623), which made 2020–21 the first year on record where people in their mid/late 70s outnumbered people in their mid/late 20s
- the number of hospital policies held by people aged 70 and over has increased by an average of 17% (to a total of 1,585,109).

The Grattan Institute noted that these changes in membership by aged group are likely to present a problem for health insurers, because it is typically older people who draw on their insurance, while younger people (specifically those under 60), who 'generally contribute to the pool'.[83]

83 Stephen Duckett, *Private health insurance death spiral continues*, Grattan Institute, 24 August 2021, viewed 10 September 2021, https://grattan.edu.au/news/private-health-insurance-death-spiral-continues/.

2.6 Policy exclusions and excesses

Exclusionary policies

Exclusions and restrictions[84]

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 2020 to June 2021, the proportion of hospital policies held with exclusions continued to increase. This is the third year in a row where exclusionary policies outnumber non-exclusionary ones.

Table 6: Hospital policies with exclusions, by percentage, June 2017 to June 2021

	June 2017	June 2018	June 2019	June 2020	June 2021
% of policies with exclusions	39.9%	43.8%	57.6%	58.7%	60%

Source: APRA, *Statistics: Private health insurance membership and benefits June 2021*.

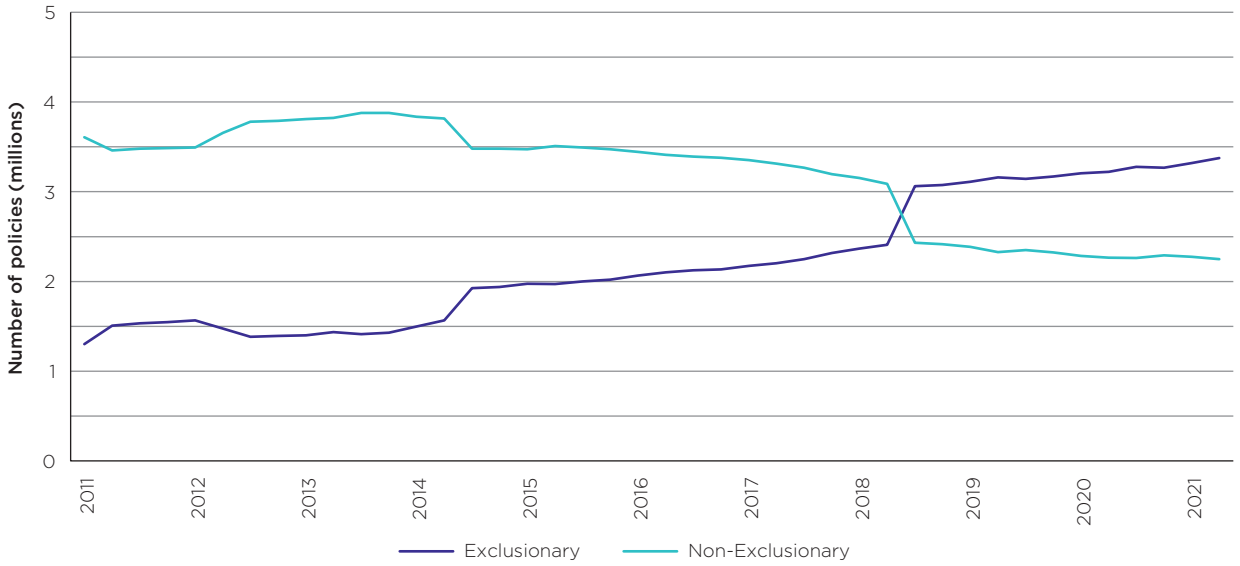
Figure 7 shows the number of exclusionary policies held during 2020–21 increased by around 152,000 (or approximately 4.7%) with a reduction of over 15,000 non-exclusionary policies (or around 0.7%) during the same period.[85] This continues a trend seen in previous years with Australians substituting non-exclusionary for exclusionary policies, as households downgrade cover to manage the costs of premiums and insurers offer more exclusionary policies. [86]

84 Commonwealth Ombudsman, *Policy exclusions and restrictions*, viewed 4 October 2021, https://www.ombudsman.gov.au/publications/brochures-and-fact-sheets/factsheets/all-fact-sheets/phio/policy-exclusions-and-restrictions.

85 APRA, *Statistics: Private health insurance membership and benefits June 2021*, 17 August 2021, viewed 5 October 2021, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Membership%20and%20Benefits%20June%202021.xlsx.

86 S Duckett and G Moran, *Stopping the death spiral: Creating a future for private health*, Grattan Institute, May 2021, viewed 10 August 2021, https://grattan.edu.au/report/stopping-the-death-spiral/.

Figure 7: Change in hospital exclusionary and non-exclusionary policies, June 2011 to June 2021



Source data: APRA, *Statistics: Private health insurance membership and benefits June 2021*.

Excesses

Excesses and co-payments[87]

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 almost 86% of hospital policies have excesses and co-payments, similar to last year's proportion of policies with excesses and co-payments.

Table 7: Hospital policies with excesses and co-payments, by percentage, June 2017 to June 2021

	June 2017	June 2018	June 2019	June 2020	June 2021
% of policies with excesses & co-payments	82.9%	83.7%	84.8%	85.8%	85.7%

Source: APRA, *Statistics: Private health insurance membership and benefits June 2021*.

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.

87 Commonwealth Ombudsman, *Choosing a health insurance policy*, viewed 4 October 2021, https://www.ombudsman.gov.au/publications/brochures-and-fact-sheets/factsheets/all-fact-sheets/phio/choosing-a-health-insurance-policy.

Types of gap arrangements

Typically, health insurers enter into 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.

Most in-hospital services are delivered with no gap payments required from patients, as detailed below in Figure 8. During the last five years, the proportion of in-hospital services delivered with no-gap payments has varied between a low of 86.8% in June 2019 to a high of 91% in June 2020.

Figure 8: Proportion of in-hospital services with no gap, June 2017 to June 2021

Source data: APRA, *Statistics: Private health insurance medical gap June 2021*.

Table 8 reveals that in 2020–21, the average gap expense incurred by a consumer for hospital treatment increased by 19.9% to $347.53, from $289.75 the previous year.[88] Meanwhile, the average gap payment for extras treatments in FY21 increased by 5.2%, to $52.85.[89] Across the five years from June 2017 to June 2021, the average gap for hospital treatment has increased by around 16.3% and the average gap for extras treatment has increased by approximately 14.4%.

88 APRA, *Statistics: Quarterly private health insurance statistics June 2021*, 17 August 2021, viewed 21 September 2021, p. 9, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202021.pdf.

89 APRA, *Statistics: Quarterly private health insurance statistics June 2021*, 17 August 2021, viewed 21 September 2021, p. 9, https://www.apra.gov.au/sites/default/files/2021-08/Quarterly%20Private%20Health%20Insurance%20Statistics%20June%202021.pdf.

Table 8: Average gap expense incurred by consumers (hospital and extras treatments), June quarter 2017 to June quarter 2021

	Hospital treatment	Extras treatment
June 2017	$298.92	$46.19
June 2018	$308.73	$47.38
June 2019	$314.51	$49.20
June 2020	$289.75	$50.25
June 2021	$347.53	$52.85

Source: APRA, *Statistics: Quarterly private health insurance statistics*, June 2017, 2018, 2019, 2020 and 2021.

A recent report by the Commonwealth Fund of New York comparing health care in 11 high income countries found Australia ranked as the third performing country overall, however was ranked eighth in the 'Access to Care' measure.[90] This measure assesses affordability and timeliness, including high out-of-pocket expenses, facing insurance shortfalls, or having problems paying medical bills.[91] Australia's lower ranking in 'access to care' reflects increasing out-of-pocket costs that consumers face when utilising private health insurance. The Consumers Health Forum stated:

> "*The gap costs, sometimes resulting in what has been called "bill shock" when a patient receives an unexpected bill for hundreds of dollars after surgery, has become a significant downside for those with private health insurance. It has also meant that many people, insured or not, must think twice about seeing a specialist as recommended by the GP because a large part of the specialist's fee is not covered by Medicare*." [92]

The Grattan Institute also reported that some medical specialists charge more than twice the Medicare Schedule fee, and this pattern has not changed during the COVID-19 pandemic – on average, 6% of services continued to be billed at more than twice the Medicare fee during 2020.[93]

2.8 Consumer complaints about private health insurance

Complaints received by the Private Health Insurance Ombudsman

The main complaints agency for consumers about their private health insurance is the PHIO. Figure 9 shows that in 2020–21, the PHIO received 3,496 complaints about private health insurance.[94] The number of complaints decreased by 5.7% from 2019-20 where the PHIO received 3,706 complaints.[95]

90 Consumers Health Forum of Australia, *Our health system nearly world-beating*, Media release, 13 August 2021, https://chf.org.au/blog/our-health-system-nearly-world-beating.

91 E C Schneider et al, , *Mirror, Mirror 2021: Reflecting Poorly, Health Care in the U.S. Compared to Other High-Income Countries*, Commonwealth Fund Report, 4 August 2021, https://www.commonwealthfund.org/publications/fund-reports/2021/aug/mirror-mirror-2021-reflecting-poorly.

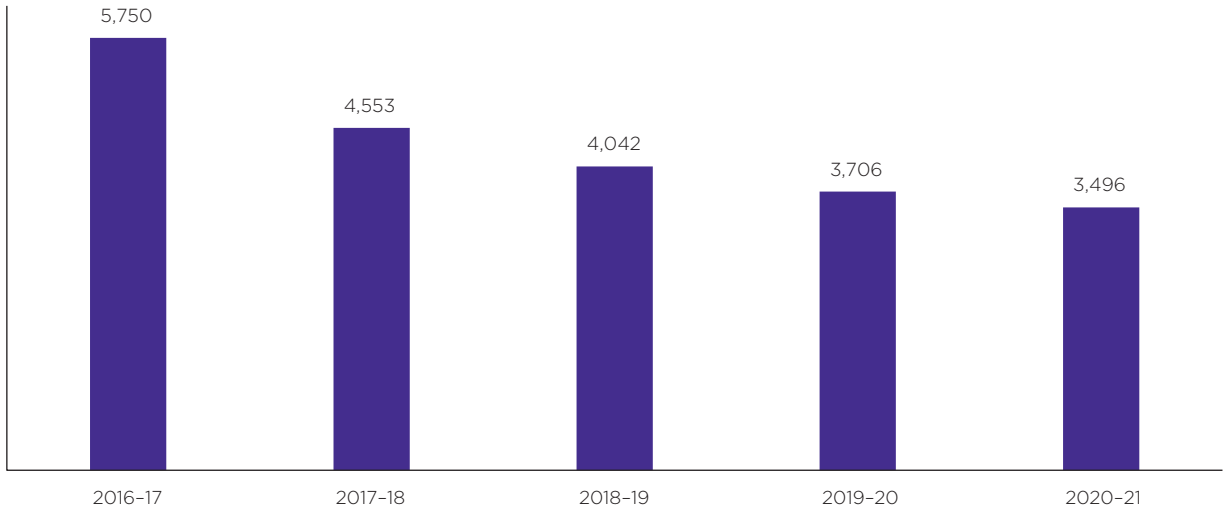
92 Consumers Health Forum of Australia, *Our health system nearly world-beating*, Media release, 13 August 2021, https://chf.org.au/blog/our-health-system-nearly-world-beating.

93 S Duckett and G Moran, *Stopping the death spiral: Creating a future for private health*, Grattan Institute, May 2021, viewed 10 August 2021, p.16, https://grattan.edu.au/report/stopping-the-death-spiral/.

94 Commonwealth Ombudsman, *Commonwealth Ombudsman Annual Report 2020–21,* October 2021, viewed 25 October 2021, p. 51, https://www.ombudsman.gov.au/publications/reports/annual/all-reports/docs/commonwealth-ombudsman-annual-report-2020–21.

95 Commonwealth Ombudsman, *Commonwealth Ombudsman Annual Report 2020–21,* October 2021, viewed 25 October 2021, p. 51, https://www.ombudsman.gov.au/publications/reports/annual/all-reports/docs/commonwealth-ombudsman-annual-report-2020–21.

Figure 9: Total complaints received by the PHIO 2016-17 to 2020–21



Source data: *Commonwealth Ombudsman annual reports* 2016-17, 2017-18, 2018-19, 2019-20 and 2020–21

The PHIO reported that 3,021 complaints in 2020–21 were about health insurers, which represents approximately 86% of complaints to the PHIO in 2020–21.[96] During 2020–21, the PHIO received 192 complaints about issues related to the COVID-19 pandemic, mostly about requests to suspend a private health insurance policy, costs of premiums and being unable to access hospital and general treatment services as planned.[97]

Complaints by issue

The top five categories for complaints to the PHIO — benefits, membership, service, waiting period and information— have remained the same for the past five years, as shown in Figure 10. The key issues within these complaint categories are as follows:

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

Figure 10 shows that complaints declined in four of the top five complaint categories from 2019–20 to 2020–21, the service category being the only increase of approximately 35%.[98] Complaints about information decreased by around 33% and benefits complaints decreased by approximately 9%, with complaints about memberships and waiting periods being relatively stable.[99]

96 Commonwealth Ombudsman, *Commonwealth Ombudsman Private Health Insurance quarterly bulletin 99: 1 April–30 June 2021*, viewed 25 October 2021, p. 6, https://www.ombudsman.gov.au/__data/assets/pdf_file/0025/112696/PHI-QB-99_1-April-to-30-June-2021.pdf.

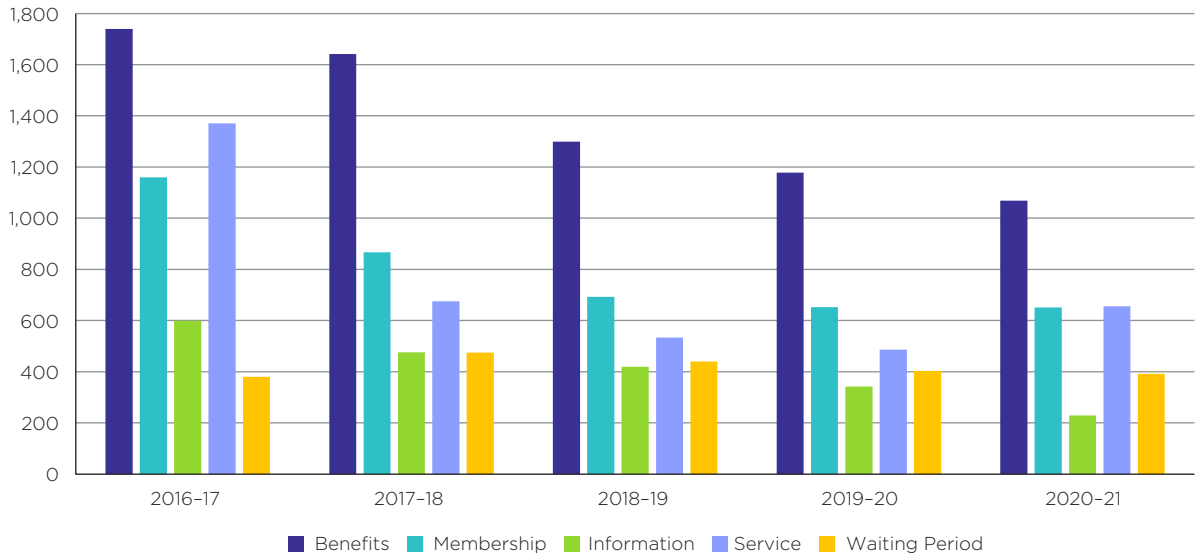
97 Commonwealth Ombudsman, *Commonwealth Ombudsman Private Health Insurance quarterly bulletin 99: 1 April–30 June 2021*, viewed 25 October 2021, p. 9, https://www.ombudsman.gov.au/__data/assets/pdf_file/0025/112696/PHI-QB-99_1-April-to-30-June-2021.pdf.

98 Commonwealth Ombudsman, *Commonwealth Ombudsman Private Health Insurance quarterly bulletin 99: 1 April–30 June 2021*, viewed 25 October 2021, p. 8, https://www.ombudsman.gov.au/__data/assets/pdf_file/0025/112696/PHI-QB-99_1-April-to-30-June-2021.pdf.

99 Commonwealth Ombudsman, *Commonwealth Ombudsman Private Health Insurance quarterly bulletin 99: 1 April–30 June 2021*, viewed 25 October 2021, p. 8, https://www.ombudsman.gov.au/__data/assets/pdf_file/0025/112696/PHI-QB-99_1-April-to-30-June-2021.pdf; Complaints about membership decreased by approximately 0.1 % and waiting period complaints decreased almost 3%.

Figure 10 also illustrates that issues regarding the benefits paid by insurers to consumers continued to account for the highest level of overall complaints. Key issues of concern with the benefits category in 2020–21 included hospital policies with unexpected exclusions and restrictions, extras treatments and delay in payment of benefits.[100] The issue that generated the most complaints was cancellation of memberships. [101]

Figure 10: PHIO complaints, by issue, 2016–17 to 2020–21



Source data: *Commonwealth Ombudsman Quarterly Bulletins* 2016–17, 2017–18, 2018–19, 2019–20 and 2020–21.

ACCC contacts received about private health insurance

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

In 2020–21, the ACCC received 164 contacts about private health insurance issues. This represented a 33% decrease from the previous financial year, when 246 contacts were received. The majority of private health insurance contacts related to consumer protection issues, and 39% of contacts concerned potentially misleading or deceptive conduct, or potentially false representations.

100 Commonwealth Ombudsman, *Commonwealth Ombudsman Private Health Insurance quarterly bulletin 99: 1 April–30 June 2021*, viewed 25 October 2021, p. 8, https://www.ombudsman.gov.au/__data/assets/pdf_file/0025/112696/PHI-QB-99_1-April-to-30-June-2021.pdf.

101 Commonwealth Ombudsman, *Commonwealth Ombudsman Private Health Insurance quarterly bulletin 99: 1 April–30 June 2021*, viewed 25 October 2021, p. 8, https://www.ombudsman.gov.au/__data/assets/pdf_file/0025/112696/PHI-QB-99_1-April-to-30-June-2021.pdf.

3. ACCC enforcement action and competition exemptions

This chapter summarises recent ACCC enforcement action and applications for authorisation of insurer collaboration.

3.1 ACCC enforcement action

NIB matter concluded

On 11 May 2021, the ACCC and NIB agreed to the ACCC's Federal Court proceedings being discontinued after NIB committed to continue to provide advance notice to its members of policy changes which are likely to result in higher out-of-pocket expenses.[102]

The ACCC instituted proceedings in the Federal Court in May 2017 against NIB regarding alleged misleading or deceptive conduct, unconscionable conduct and false representations.[103]

The proceedings related to NIB's failure to notify members in advance of its decision to remove certain eye procedures from its 'MediGap Scheme' in 2015. Under the MediGap Scheme, members had previously been able to obtain these eye procedures without facing out-of-pocket costs when doctors participated in the scheme.

NIB has since addressed the ACCC's concerns and, for the past four years, has been notifying members of changes that negatively affect their benefits ahead of the changes taking affect. NIB also provided compensation to a number of consumers affected by the conduct who had to pay out-of-pocket expenses when receiving eye treatments they had previously undergone with no gap fees.

3.2 Competition exemptions

Authorisation for private health insurers to coordinate during COVID-19

On 17 September 2020, the ACCC granted authorisation, with conditions, to Private Healthcare Australia until 31 March 2021, to enable private health insurers and the Members Health Fund Alliance (together, the Participating Parties) to coordinate on providing financial relief to policyholders during the COVID-19 pandemic, and broadening insurance coverage to include COVID-19 treatment, tele-health and medical treatment provided at home. The conditions of authorisation required Private Healthcare Australia to provide the ACCC details of proposed measures formulated by participants, provide fortnightly reports regarding any meetings, discussions and decisions, agreements to increase premiums were prohibited, and any agreements reached must terminate when authorisation ceases.

On 3 March 2021, Private Healthcare Australia applied for re-authorisation to enable the Participating Parties to continue to engage in the authorised conduct and to expand the conduct to include coordination on broadening the category of dependents that can remain on an adult's policy, utilising unreleased DCL and coordination on measures in relation to the economic and social effects of COVID-19.

On 30 March 2021, the ACCC granted interim authorisation to Private Healthcare Australia, with a reporting condition, to enable private health insurers to continue to engage in the conduct authorised on 17 September 2020, while the ACCC continued to assess the substantive application

102 ACCC, *NIB to continue to notify consumers of health insurance changes which increase out-of-pocket expenses*, Media release, 11 May 2021, https://www.accc.gov.au/media-release/nib-to-continue-to-notify-consumers-of-health-insurance-changes-which-increase-out-of-pocket-expenses .

103 ACCC, *ACCC takes action against NIB*, Media release, 30 May 2017, https://www.accc.gov.au/media-release/accc-takes-action-against-nib.

for re-authorisation. The ACCC decided not to grant interim authorisation for the expanded conduct, noting that it would continue to assess the proposed conduct, including the expanded conduct.

On 8 April 2021, Private Healthcare Australia withdrew its application for re-authorisation because the ACCC did not grant interim authorisation for all the proposed conduct. As a result, the ACCC ceased its assessment of the application, the interim authorisation granted on 30 March 2021 ended and the Participating Parties are no longer authorised to coordinate in relation to providing financial relief to policy holders and broadening insurance coverage.

Authorisation for a collective buying group to negotiate with healthcare providers

On 21 September 2021, the ACCC authorised 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 has also only granted authorisation for five years, rather than the 10 years sought by Honeysuckle Health and NIB, to facilitate a review of the effects of the authorisation at an earlier time, if reauthorisation is sought.[104]

In October 2021, the Rehabilitation Medicine Society of Australia and New Zealand Ltd[105] and the National Association of Practising Psychiatrists[106] applied to the Australian Competition Tribunal to review the ACCC's determination regarding the Honeysuckle Health/NIB buying group. The Australian Competition Tribunal is expected to consider these applications in 2022.

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

105 Australian Competition Tribunal, 'Application by Rehabilitation Medicine Society of Australia and New Zealand Ltd (RMSANZ)', viewed 19 November 2021, https://www.competitiontribunal.gov.au/current-matters/act-5-of-2021.

106 Australian Competition Tribunal, 'Application by National Association of Practising Psychiatrists (NAPP)', viewed 19 November 2021, https://www.competitiontribunal.gov.au/current-matters/act-4-of-2021.

4. Policy developments in private health insurance

The observations in this report are made in the context of recent and ongoing reforms to the sector. This chapter provides an update on policy developments relating to private health insurance during and after the reporting period.

4.1 Medical costs finder website

In December 2019, the Department of Health launched the Medical costs finder website,[107] to help address increasing out-of-pocket costs and complexity for consumers when considering medical specialists and services. The website shows typical out-of-pocket costs for common treatments and procedures in the private system, based on a person's location.[108] The website currently shows general information on typical costs for common services both in and out of hospital.

An expansion of the website is scheduled to rollout in 2022 to include fees and information about individual medical specialists' fees for common medical services, which will be able to be searched by consumers and other interested parties such as referring doctors. The Department of Health expects these changes will increase transparency and raise awareness about potential costs for treatments and procedures in Australia and help consumers choose the right specialist for their needs.

4.2 Initiatives announced in the 2021–22 Federal Budget

In May 2021, the Australian Government announced initiatives aimed at improving the affordability and sustainability of private health insurance, including:

- investing $22 million over four years, to improve and modernise the Prostheses List and reduce the cost of medical devices from 2021–22, with changes to be introduced progressively and in a staged manner from February 2022 [109]
- the extension of the current policy settings with respect to the Medicare Levy Surcharge and private health insurance rebate income tiers for a further two years, while a study examines the effectiveness of the current regulatory settings
- a review of the private health insurance rebate model by specialist modelling and data analytics experts
- an independent study to investigate private hospital default benefit arrangements, which require insurers to pay a minimum benefit towards hospital accommodation and care for hospital treatment where there is no agreement between a patient's insurer and a particular hospital
- improvements to the certification process for admitting patients to hospital for procedures normally provided out of hospital.[110]

107 Department of Health, 'Medical Costs Finder', viewed 1 November 2021, https://www.health.gov.au/resources/apps-and-tools/medical-costs-finder.

108 The Hon. Greg Hunt MP, Minister for Health and Aged Care, *New website to improve consumer understanding of medical costs,* Media release 30 December 2019, https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/new-website-to-improve-consumer-understanding-of-medical-costs.

109 Department of Health, *Private health insurance – Modernising and improving the private health insurance Prostheses List*, Budget 2021–22 Fact Sheet, 11 May 2021, https://www.health.gov.au/resources/publications/private-health-insurance-modernising-and-improving-the-private-health-insurance-prostheses-list.

110 Department of Health, *Private health insurance – Improving affordability and sustainability of private health insurance*, Budget 2021–22 Fact Sheet, 11 May 2021, https://www.health.gov.au/resources/publications/private-health-insurance-improving-affordability-and-sustainability-of-private-health-insurance.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