



Australian Government
Private Health Insurance
Administration Council

The Operations of Private Health Insurers

ANNUAL REPORT

2010–11

Report required by section 264–15 of the *Private Health Insurance Act 2007*

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18 November 2011

The Hon. Nicola Roxon MP
Minister for Health and Ageing
Parliament House
CANBERRA ACT 2600

Dear Minister

PHIAC submits to you for presentation to Parliament the *Operations of Private Health Insurers Annual Report 2010–11*, for the period 1 July 2010 to 30 June 2011 as required under section 264–15 of the *Private Health Insurance Act 2007*.

The report has been prepared in accordance with the Commonwealth printing standards for documents tabled in Parliament.

Section 34C of the *Acts Interpretation Act 1901* requires that you lay the report before each House of the Parliament within 15 sitting days after it is received.

Yours sincerely

Lynn Ralph
Commissioner

Shaun Gath
Chief Executive Officer

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■ Abbreviations

BHC	Broader Health Cover
CDMP	Chronic Disease Management Program
GFC	Global Financial Crisis
HRB	Health-related Business
Insurer	private health insurer
LHC	Lifetime Health Cover
Minister, the	Minister for Health and Ageing
OVC	Overseas Visitor Cover
PHI Act	<i>Private Health Insurance Act 2007</i>
PHIAC	Private Health Insurance Administration Council
PHIO	Private Health Insurance Ombudsman
RETF	Risk Equalisation Trust Fund
SIS	Standard Information Statement

■ Symbols

-	nil or rounded to zero
%	Per cent
...	not available
'000	thousands
\$'000	thousands of dollars

Note: most monetary amounts shown in tables and figures have been rounded to the nearer thousand dollars. Where numbers have been rounded, discrepancies may occur between sums of component items and totals. However, actual figures have been used in respect of the membership statistics reported.

■ About the Private Health Insurance Administration Council

The Private Health Insurance Administration Council (PHIAC) was established in 1989 under section 82B of the *National Health Act 1953* as the prudential regulator for Australia's private health insurance industry. PHIAC continues its existence under section 264–1 of the *Private Health Insurance Act 2007* (the PHI Act) which came into effect from 1 April 2007.

PHIAC is an independent statutory authority that reports to the Minister for Health and Ageing (the Minister). It works closely with other regulatory bodies including the Private Health Insurance Ombudsman (PHIO) to ensure that consumers have access to a well-run and competitive private health insurance industry.

In carrying out its regulatory and supervisory functions, PHIAC is required by the PHI Act (section 264–5) to achieve an appropriate balance between three objectives:

- fostering an efficient and competitive private health insurance industry
- protecting the interests of consumers
- ensuring the prudential safety of individual private health insurers.

Full details concerning the operations of PHIAC are contained in a separate report, the *Private Health Insurance Administration Council Annual Report 2010–11*. This report is required under section 9 of the *Commonwealth Authorities and Companies Act 1997* and can be obtained from PHIAC's office and is also available at PHIAC's website www.phiac.gov.au.

■ About this report

This report is prepared pursuant to section 264–15 of the PHI Act. The report details the operations of private health insurers including details about:

- premiums payable to the fund
- fund benefits payable out of the fund
- management expenses
- the balance of the fund as at the end of that year
- how the reserves of the fund have been invested.

The report is based on statistics and other information collected by PHIAC, provided mostly by insurers in the course of PHIAC's regulation of the industry. Most statistics referenced in this report are derived from PHIAC's quarterly statistics publications, with the exception of the funds' financial details which are based on the annual audited returns.

The report mainly comprises summary statistics for the industry. The full range of statistics previously published in this report is available on PHIAC's website, along with information published in previous reports.

■ Commissioner's Report



It is a pleasure to present this report on the operations of the private health insurance industry, my first since assuming the position of Commissioner.

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

Most importantly, for many, it means peace of mind in times of sickness and distress.

Australia's private health insurers have been a central part of our national health system for well over a hundred years. Around 11 per cent of the value of all health services provided in this country are paid for by a private health insurer. This contribution plays a key role in ensuring an effective health system and, in particular, a vibrant private hospital sector and a viable dental profession.

Given this, the role PHIAC plays in ensuring that the private health funds are well run and remain prudentially sound cannot be overstated.

Prudential snapshot

In that light, it is pleasing to report that, at the time of this report, the Australian private health insurance industry is in very sound condition.

As this report notes, all the registered private insurers were profitable during the year with an average net margin of 5.6%. Investments, too, have been a steady source of income for the insurers thereby ensuring that their overall financial position has remained solid throughout the year.

As a result of this, and strong results in prior years, the industry has \$3.7 billion in excess of the statutory capital requirement.

The outlook for the industry continues to be positive with growing numbers of contributors ensuring that the industry will continue to grow for the foreseeable future. During the year, the number of persons covered by private health insurance exceeded 10 million and, by the end of the year, had attained the highest number since the introduction of Medibank in the 1970s.

These results mean that the industry is well positioned to address the many challenges it is facing including an ageing population, ever increasing benefits costs, investment uncertainty and attracting new membership. Australia's private health insurers will need to find innovative and cost effective ways to respond to these changes.

PHIAC's work

During the year, PHIAC has focused on advancing the work set out in its Corporate Plan.

This has included extending the suite of standards and other measures which set out the requirements for best practice within the private health insurance sector. Work is continuing within PHIAC to complete standards dealing with outsourcing, capital adequacy and solvency and, in the near future, PHIAC will be initiating its work on a prudential standard dealing with risk management.

At the same time, we continue our ongoing regular reviews of the operations of the insurers.

This year, PHIAC has worked closely with the actuarial profession to improve and broaden the role played by actuaries in the affairs of insurers. An important milestone in this project was the adoption by the Actuaries Institute of a new professional standard, PS 600, dealing with the compilation of annual Financial Condition Reports by actuaries. The standard came into force on 1 July 2011. PHIAC remains strongly committed to promoting the role of actuaries in identifying and describing business risk within insurers. I want to take this opportunity to thank the leadership of the Actuaries Institute for their contribution towards achieving this outcome.

Premiums

PHIAC continued its important role as an adviser to the Minister for Health and Ageing in the annual setting of premiums. This is a key role for PHIAC given the complex interaction between consumers' interests, pricing and prudential safety. We are pleased that the Minister has continued to demonstrate strong confidence in PHIAC's judgment in this crucial area.

A further welcome development was the decision, by the Minister, to make PHIAC's pricing advice available to the insurers. The disclosure of this information and the important assessments they contain, has resulted in a vigorous—but informed—discussion about the issues surrounding capital adequacy and sustainable profitability in the industry. This contribution to transparency has been an important step forward in demystifying what is sometimes a complex process.

Acknowledgment

I want to acknowledge the fine work done by my fellow board member, Ms Rebecca Davies who will be retiring from Council in December 2011 after almost 10 years' service to PHIAC and the private health insurance industry. Rebecca has been the finest of colleagues—intelligent, clear headed, hard-working and, above all, committed to ensuring the objectives of PHIAC are fulfilled.

Comment and feedback

I commend this report to a wide community of readers both in Australia and abroad. Australia has a successful story to tell about the role private health insurance plays in the delivery of health care. This report ensures that people who wish to understand more about that role have excellent and reliable information.

Any person wishing to comment on the contents of the report is invited to do so by contacting PHIAC at phiac@phiac.gov.au.

The report is available to be downloaded at www.phiic.gov.au

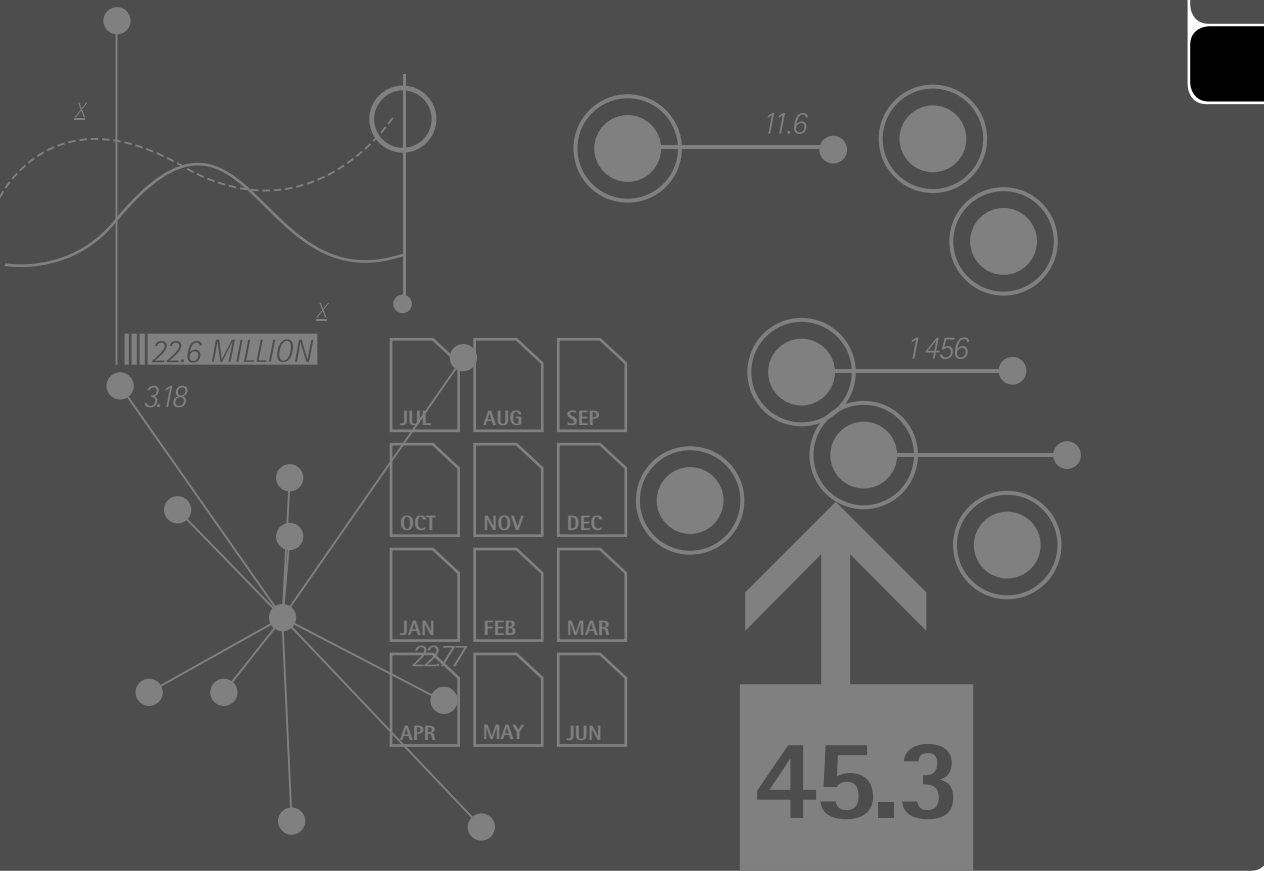
Lynn Ralph

Commissioner

18 November 2011



REVIEW OF THE INDUSTRY



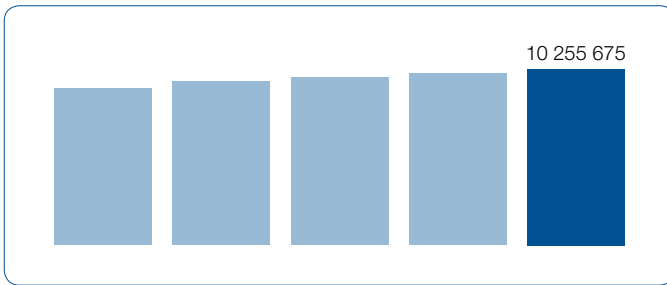
Private Health Insurance Industry at 30 June 2011		
Open access or Restricted access, For-profit or Not-for-profit Market Share: Based on total policies nationally ¹ In alphabetical order		
ACA Health Benefits Fund Ltd "ACA"	Australian Health Management Group Pty Ltd "AHM"	Australian Unity Health Ltd "AUHL"
Restricted Not-for-profit Market Share: 0.08% www.acahealth.com.au	Open For-profit Market Share: 2.92% www.ahm.com.au	Open For-profit Market Share: 3.13% www.australianunity.com.au/health-insurance
BUPA Australia Pty Ltd "BUPA"	CBHS Health Fund Ltd "CBHS"	Cessnock District Health Benefits Fund Ltd "CDH"
Open For-profit Market Share: 26.86% www.bupa.com.au	Restricted Not-for-profit Market Share: 1.29% www.cbhs.com.au	Open Not-for-profit Market Share: 0.05% www.cdhbf.com.au
CUA Health Ltd "CUA"	Defence Health Ltd "Defence"	The Doctors' Health Fund Ltd "DHF"
Open Not-for-profit Market Share: 0.43% www.cuahealth.com.au	Restricted Not-for-profit Market Share: 1.57% www.defencehealth.com.au	Restricted Not-for-profit Market Share: 0.13% www.doctorshealthfund.com.au
GMHBA Ltd "GMHBA"	Grand United Corporate Health Ltd "GUC"	HBF Health Ltd "HBF"
Open Not-for-profit Market Share: 1.71% www.gmhba.com.au	Open For-profit Market Share: 0.38% www.guhealth.com.au	Open Not-for-profit Market Share: 7.70% www.hbf.com.au
Health Care Insurance Ltd "HCI"	Health Insurance Fund of Australia Ltd "HIF"	Healthguard Health Benefits Fund Ltd "H'guard"
Restricted Not-for-profit Market Share: 0.07% www.hcilt.com.au	Open Not-for-profit Market Share: 0.55% www.hif.com.au	Open Not-for-profit Market Share: 0.52% www.centralwesthealth.com.au www.gmfhealth.com.au
Health Partners Ltd "H'Partners"	The Hospitals Contribution Fund of Australia Ltd "HCF"	Latrobe Health Services Ltd "Latrobe"
Open Not-for-profit Market Share: 0.65% www.healthpartners.com.au	Open Not-for-profit Market Share: 10.46% www.hcf.com.au	Open Not-for-profit Market Share: 0.72% www.latrobehealth.com.au

¹ For group holdings, parent market share excludes subsidiaries

Lysaght Peoplecare Ltd "Peoplecare"	Medibank Private Ltd "MPL"			Mildura District Hospital Fund Ltd "Mildura"
Open Not-for-profit Market Share: 0.43% www.peoplecare.com.au	Open For-profit Market Share: 27.70% www.medibank.com.au			Open Not-for-profit Market Share: 0.25%
National Health Benefits Australia Pty Ltd "NHBA"	NIB Health Funds Ltd "NIB"			Navy Health Ltd "Navy"
Open For-profit Market Share: 0.08% www.onemedifund.com.au	Open For-profit Market Share: 7.53% www.nib.com.au			Restricted Not-for-profit Market Share: 0.25% www.navyhealth.com.au
Phoenix Health Fund Ltd "Phoenix"	Police Health Ltd "Police Health"			Queensland Country Health Fund Ltd "QCH"
Restricted Not-for-profit Market Share: 0.11% www.phoenixhealthfund.com.au	Restricted Not-for-profit Market Share: 0.30% www.policehealth.com.au			Open Not-for-profit Market Share: 0.25% www.qldcountryhealth.com.au
Queensland Teachers' Union Health Fund Ltd "QTUH"	Railway & Transport Health Fund Ltd "RT"			Reserve Bank Health Society Ltd "RBHS"
Restricted Not-for-profit Market Share: 0.43% www.tuh.com.au	Restricted Not-for-profit Market Share: 0.40% www.rthealthfund.com.au			Restricted Not-for-profit Market Share: 0.04%
St Luke's Medical & Hospital Benefits Association Ltd "St Luke's"	Teachers Federation Health Ltd "TFH"			Transport Health Pty Ltd "Transport"
Open Not-for-profit Market Share: 0.39% www.stlukes.com.au	Restricted Not-for-profit Market Share: 1.78% www.teachershealth.com.au			Restricted Not-for-profit Market Share: 0.07% www.transporthealth.com.au
Westfund Ltd "Westfund"	<i>Insurers</i>	<i>For-profit</i>	<i>Not-for-profit</i>	<i>For-profit insurers make up around 70% of the industry based on market share</i>
Open Not-for-profit Market Share: 0.78% www.westfund.com.au	<i>Open</i>	7	14	
	<i>Restricted</i>	0	13	

■ Snapshot of the industry

People with hospital treatment cover, 2007-11



As at 30 June 2011

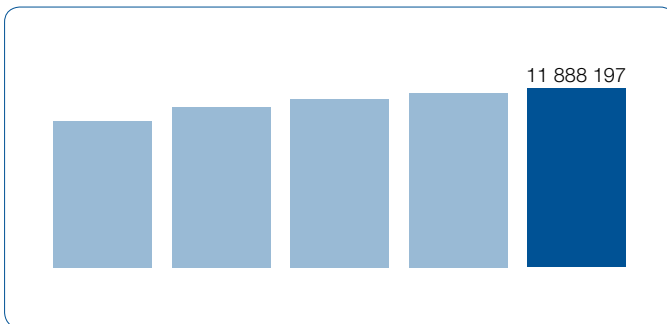
45.3%

of Australians were covered by hospital treatment insurance,

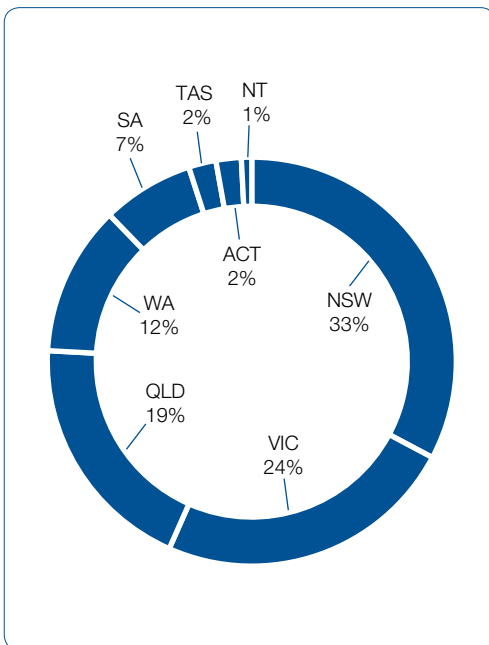
52.5%

by general treatment insurance.

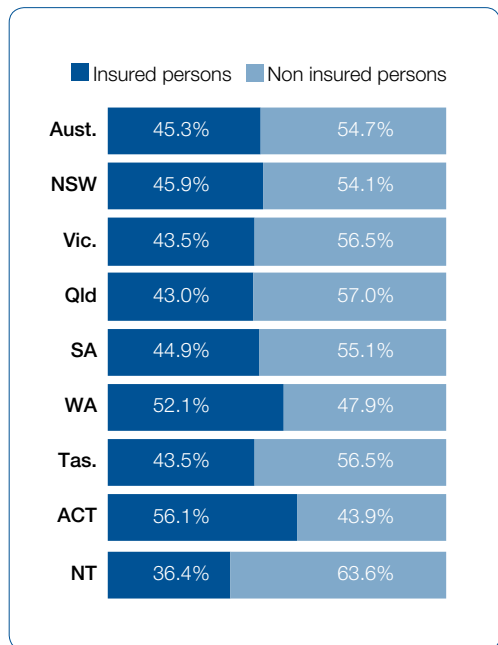
People with general treatment cover, 2007-11



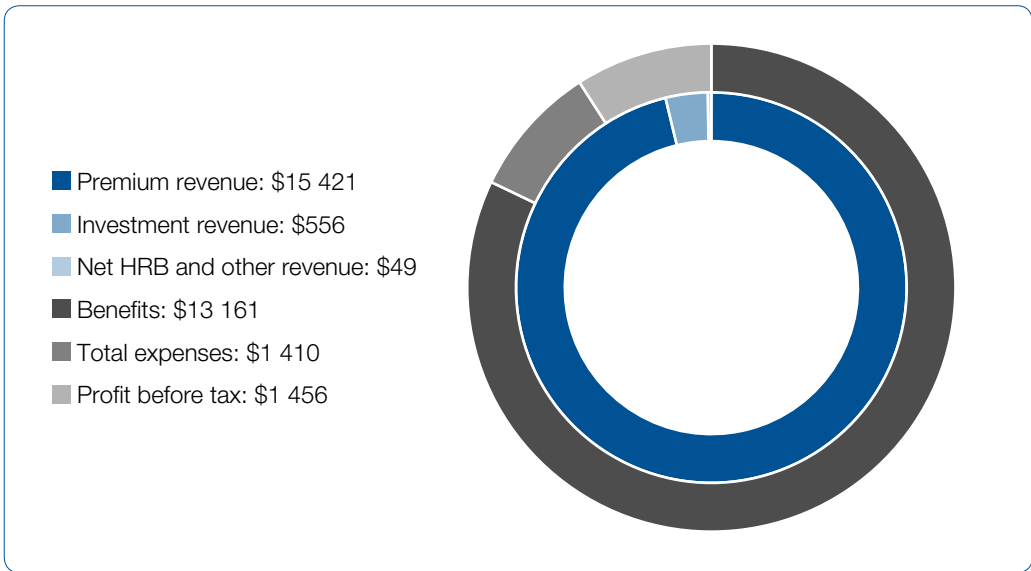
Hospital treatment membership, national breakdown by state, 30 June 2011



Hospital treatment membership, state coverage, 30 June 2011

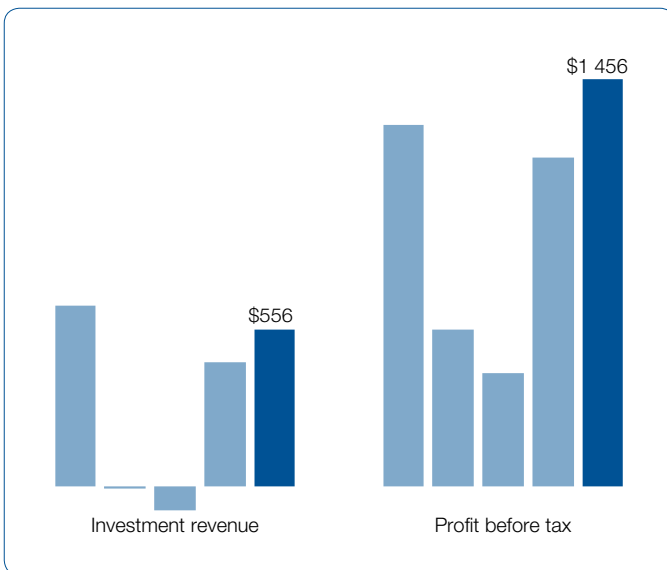


Revenue, expenses and profit (millions), 2010-11



Since 2000, membership has grown by **24.5%**, and as at 30 June 2011, the total number of hospital treatment policies was 4.97 million, covering **10.26 million** people—a 2.8 per cent increase when compared to 30 June 2010

Investment revenue and profit (millions), 2007-11



During 2010–11,
 Investment revenue
↑ \$112 million
 Pre-tax profit
↑ \$281 million

■ The private health insurance industry in Australia

Over the past two years, insurers have recorded strong levels of performance in all aspects of the private health insurance business—in underwriting performance, in investment revenue and in membership growth. Insurers' balance sheets have strengthened since the global financial crisis (GFC) and the level of capital in the industry is now at historically high levels. The industry's financial position is very sound and it is well-placed to deal with the current uncertainty surrounding financial markets and the general world economy as a whole.

While growth assets only make up a small proportion of the industry's total investments, the industry retains some exposure to falls in financial markets. That said, the strong Australian economy, together with the largely conservative investment portfolios of insurers, has left the industry relatively unaffected in the current period of global financial market uncertainty and volatility. PHIAC will continue its regular monitoring of the investment activity of the industry, but maintains the view that the industry is capable of absorbing substantial market declines before minimum regulatory requirements would come under pressure.

PHIAC's supervision of the industry continues to focus on a number of key areas of risk for insurers, including maintenance of the strength of the core underwriting business, management of their capital position, and the potential risks of rapid membership growth on long term stability.

While as a percentage of Australia's total population, membership has been stable over the last few years, for some insurers, rapid growth of membership has impacted on performance and capital position. This has resulted in significant implications for their policyholders such as large premium increases.

“ THE INDUSTRY IS CAPABLE OF ABSORBING SUBSTANTIAL MARKET DECLINES BEFORE MINIMUM REGULATORY REQUIREMENTS WOULD COME UNDER PRESSURE. ”

In the past decade, poorly-managed membership growth has been associated with a number of stressed insurers and the need for regulatory intervention. In carrying out its regulatory functions, PHIAC emphasises the importance for insurers to appropriately plan for growth, to carefully consider the implications of its achievement, and to closely monitor performance during, and beyond, any growth phase. PHIAC's recent experience has shown that this is one area that requires closer supervision, and will continue to be so in the foreseeable future.

A short history of private health insurance in Australia

The beginnings of private health insurance can be dated back to England in the 19th century with the establishment of friendly societies as a way for people to mutually protect themselves against adverse events. A number of these friendly societies operated in Australia during the 1800s, but it was not until after 1901 that private health insurance in Australia thrived—affiliates of the English friendly societies grew, medical and hospital interest groups founded mutual organisations and commercial bodies were established to offer health cover.

The *Hospital Benefits Act 1945* introduced an approach to commonwealth funded health care by providing subsidies to States for the costs of public and private hospital treatment. Following this, it was the *National Health Act 1953* which

formed a basis for the growth and progression of private health insurance in Australia, incorporating the fundamental principles of community rating and voluntary membership. Health care was subsidised by the government with consideration to a patient's income and circumstance.

Those with private health cover were refunded for additional treatment costs subject to their fund's rules. The scheme was enormously successful with over 80% of the population holding private health insurance through to the 1970s.

A 1968 Commonwealth enquiry raised concerns with rising health care costs, increasing out-of-pocket expenses and the complexity of the private health insurance system. The recommendations arising from this inquiry led to changes and restrictions to insurers operations in the early 1970s.

The *Health Insurance Act 1973* was key to the establishment of Medibank in 1975—the purpose of which was to administer an equitable universal health insurance scheme for Australians. The scheme provided for subsidised health treatment with private health insurers covering further costs to private patients.

The original Medibank scheme operated for only a short period before a change in government led to the 1976 Medibank review. The result of this review was an introduction of a 2.5% levy on income, with the option provided to take out private health insurance to avoid the levy. In addition, Medibank Private was established to promote competition in the private health insurance industry.

In 1976 a reinsurance pool (Hospital Benefits Reinsurance Trust Fund) was established to ease the cost to insurers of the chronically ill and to support the principal of community rating. This pool was a precursor to the current risk equalisation scheme.

In 1978, the 2.5% levy and the Medibank scheme were abolished, medical benefits were reduced and tax rebates were introduced for those with private health insurance.

Medicare was then implemented in 1984, which was essentially similar to the original Medibank scheme but with different financing arrangements. After Medicare's introduction, private health insurance membership dropped significantly. In order to combat this fall and encourage the take-up of private health insurance, the government introduced a series of reforms which included:

- introduction of portability requirements obligating funds to recognise lapsed waiting periods for policyholders transferring from other insurers in 1988
- adjustments to legislated solvency requirements in 1988
- changes to industry regulation including the establishment of PHIAC in 1989
- ability to negotiate contract with hospitals and no gap contracts with medical specialists from 1995
- changes to the Medicare levy, which was settled at 1.5% in 1995 with a surcharge levy of 1% introduced in 1997 for high income earners without private insurance
- introduction of the private health insurance incentive scheme in 1997 to support participation of low income earners
- introduction of the 30% rebate on private health insurance premiums in 1999 and increased for those aged over 65 in 2005
- Lifetime health cover (LHC) loadings for those older than 30 first taking out cover introduced in 2000
- introduction of the PHI Act in 2007.

Figures 1 and 2 plot hospital treatment coverage as a percentage of the population as well as by persons covered since 1971. Both figures include key events that have had a significant impact on the industry and show the significant increase in the number of people covered by private health insurance over the last five years.

Figure 1 – Hospital treatment coverage (insured persons as a % of the population)

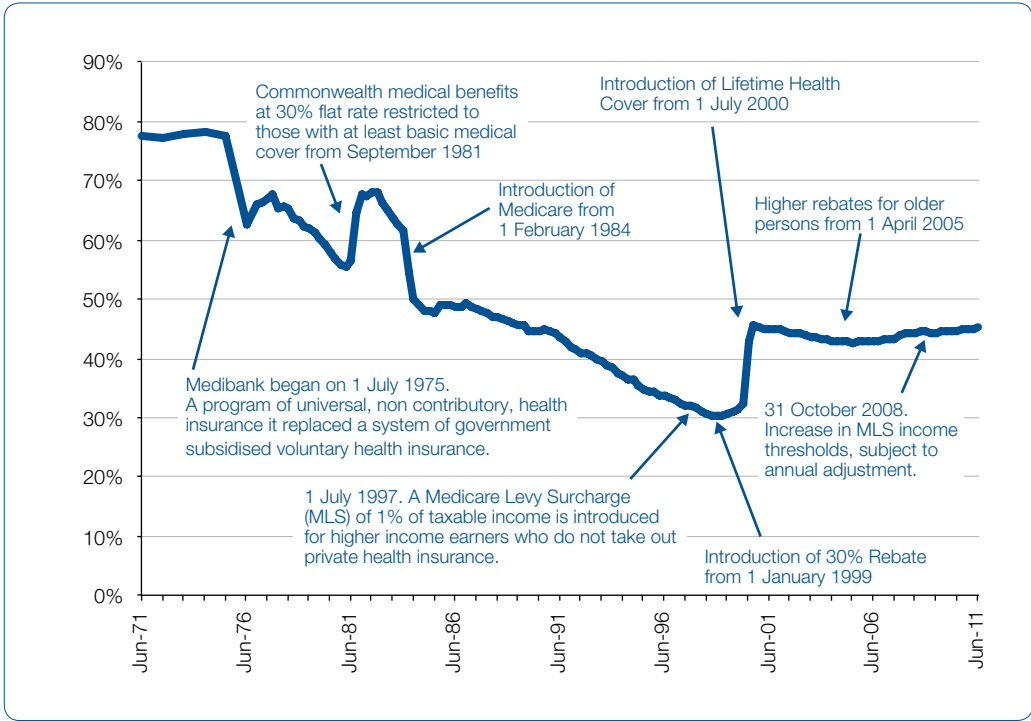
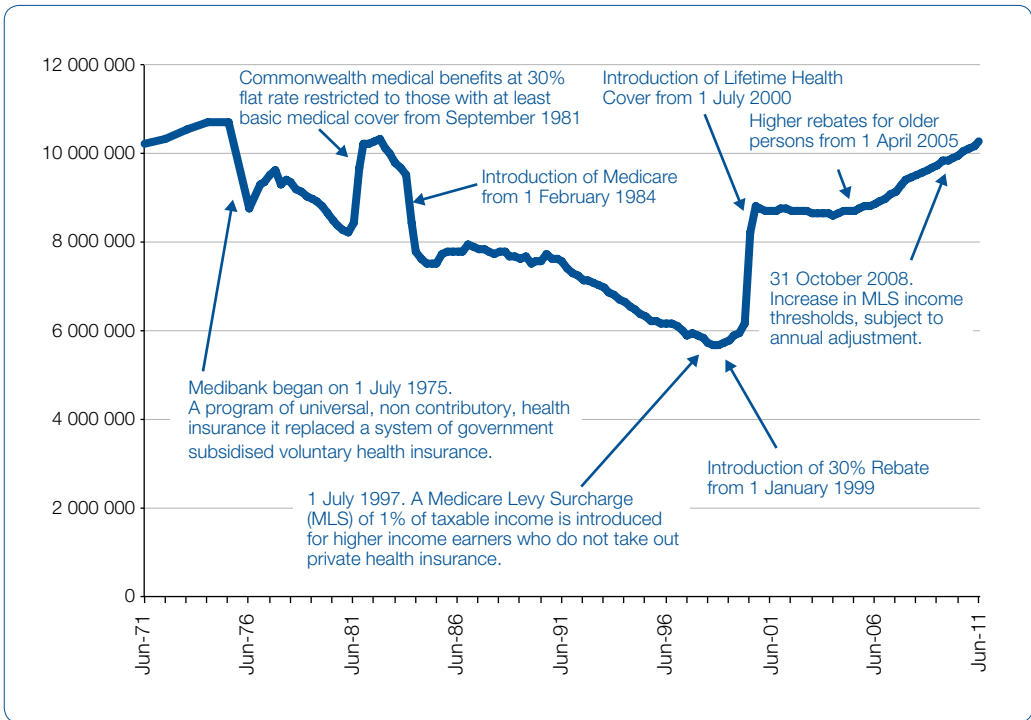


Figure 2 – Hospital treatment coverage (insured persons)



A decade of change

The private health insurance industry has changed substantially over the last decade as a result of the introduction of the government initiatives, the new framework and legislation governing insurers (via the PHI Act) and, more recently, uncertainty in the economic environment. Significantly, the traditional emphasis on not-for-profit operations and strong mutual ethos shifted as the number of for-profit insurers has increased from four to seven—68.6% of policyholders are now covered by a for-profit health insurer.

At the same time consumers of private health insurance have become more informed about their health insurance options. The introduction of the website www.privatehealth.gov.au has played an important role in ensuring consumers have reliable and timely information about the industry and the full range of health insurance products which are available for purchase by consumers. The website is maintained by PHIO.

The change in the make-up of the industry can be seen in the Table 1 below which shows the industry structure at different points over the last 10 years. The data also clearly shows the growth that has occurred in the financial scale of the industry, seen through changes in contribution income, benefits paid and total assets, which all show three-fold increases.

In addition to the increase in for-profit insurers, Table 1 also shows the significant industry consolidation that has occurred since 2000—from 44 insurers to 34 insurers. Consolidation during 2010–11 included the merger of the three insurers that operated within the BUPA Australia group—BUPA Australia Health Pty Ltd, BUPA Australia Pty Ltd and MBF Alliances Pty Ltd. In addition, the merger of the HCF and MU funds occurred at the end of the financial year. PHIAc expects that further consolidation of the industry will occur in the future.

Many commentators expected that the rapid conversion of much of the industry to for-profit and consolidation to fewer insurers would sharpen competition in the sector, though the sustained margin outcome and profitability of the industry suggests that this has yet to occur, at least insofar as premiums are concerned.

Private health insurance today

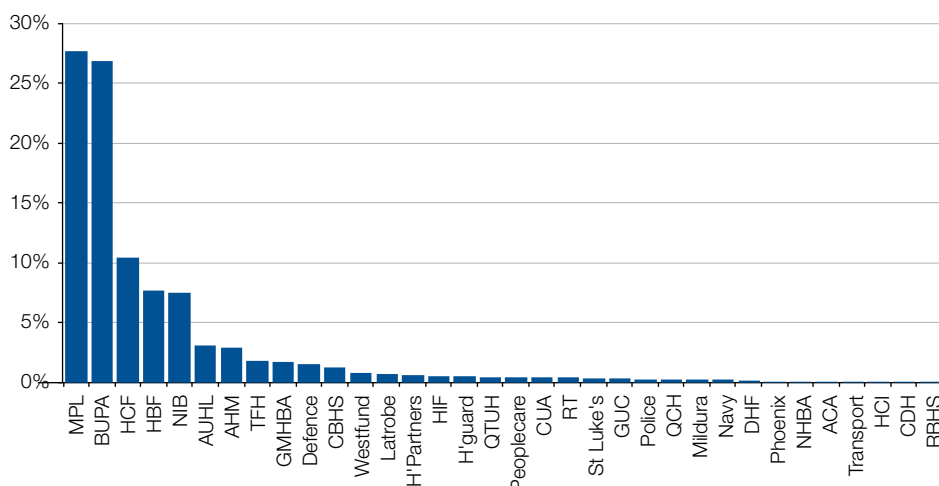
Today, the private health insurance industry continues to be an important component of Australia's health care system, assisting insured people with the costs associated with treatment in the hospital setting, treatment outside hospitals that serve as alternatives to hospital treatment, and for general treatment—services

Table 1 – Industry Structure 2000–2011

Year	2000	2005	2011
No. of insurers	44	40	34*
Open access	29	26	21
For-profit	4	5	7
For-profit market share	12.5%	15.9%	68.6%
Total premium revenue	\$5.46b	\$9.38b	\$15.42b
Total benefits paid	\$4.51b	\$8.24b	\$13.16b
Total assets	\$3.26b	\$5.87b	\$9.49b

* As at 30 June 2011 there were 34 insurers, however the statistical tables list 35 insurers as they include Manchester Unity Australia Ltd (MU) data applicable to 2010–11.

Figure 3 – Market share as at 30 June 2011



predominately known as “ancillary”—covering healthcare needs such as dental treatment, eye care and physiotherapy, but also including chronic disease management programs (CDMP).

The importance of private health insurance is illustrated by the increasing levels of participation. Since 2000, membership in terms of people covered for hospital treatment has grown by 24.5%, and as at 30 June 2011, the total number of hospital treatment policies was 4.97 million, covering 10.26 million people—a 2.8 per cent increase when compared to 30 June 2010.

Over the same period, the Australian population grew by 1.4 per cent thus the take-up of private health insurance has exceeded the rate of growth in the population. The percentage of the population with hospital treatment policies increased from 44.7% to 45.3% in the 12 months to 30 June 2011.

Private health insurance can provide for all, or part, of the costs associated with hospital and ancillary treatments, but often involves the sharing of some costs with the Commonwealth Government (through Medicare) and some with patients/policyholders in out-of-pocket costs.

Private health insurance may only be offered by registered insurers, registered by PHIAC under the PHI Act. Registered private health insurers are regulated by PHIAC. PHIAC’s strategic vision in regulating the industry is to protect consumers of private health insurance by ensuring an industry which is competitive, efficient and financially sound.

The skewed distribution in market share remains—the five largest insurers, or insurer groups, account for 83.7% of the market:

- MPL/AHM 30.6%
- BUPA² 26.9%
- HCF³ 10.5%
- NIB 7.5%
- HBF/H’guard 8.2%

27 insurers share the remaining 16.3% of the market. Figure 3 shows the market share of all insurers demonstrating the dominance of the above five insurers.

² The health benefits funds conducted by the three BUPA Australia group insurers were merged on 1 July 2010.

³ The health benefit funds conducted by HCF and MU were merged on 30 June 2011.

“ CURRENT CAPITAL POSITIONS AND MARGIN OUTCOMES FOR THE INDUSTRY SUGGEST THAT PRICE COMPETITION IS NOT AS SHARP AS IT COULD BE ”

Although insurers can operate in the national market, not all insurers are active in all states. Smaller and restricted access⁴ insurers often focus on a particular market niche. There are also regional insurers that focus on specific areas and regions in Australia.

Insurers' efforts to attract and retain members, particularly those who are young and healthy, have been intense in recent years. While price is often a driver of competition for younger members, insurers also seek to attract members through the services available to policyholders from product offerings, service quality, branding and broader value recognition of their products. Current capital positions and margin outcomes for the industry suggest that price competition is not as sharp as it could be.

Although there is a significant degree of market concentration in the largest five insurers, smaller insurers can provide effective competition in regional and discrete, professional and trade based markets, competing for members through price, cover and service.

As an industry, insurers also in effect compete with the public health system, Medicare.

⁴ Whereas open access insurers are available to anyone, restricted access insurers are only available through specific employment, professional or union groups.

Membership and coverage

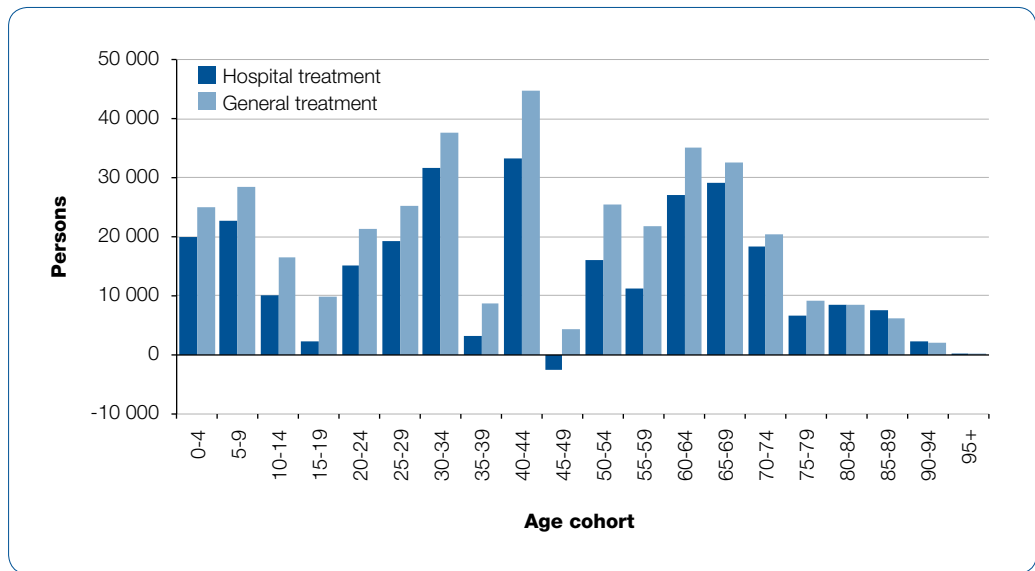
Private health insurance membership continued to increase throughout 2010–11, with hospital and general treatment coverage growing by 2.8% and 3.0% respectively. Growth occurred in almost all age groups for both hospital and general treatment cover, the exception being hospital membership for those aged 45 to 49, which suffered a slight decrease. These growth rates represent 281 811 additional people covered for hospital treatment and 346 496 additional people for general treatment.

People aged over 60 represented a third of all growth in hospital treatment cover. Much of this growth occurred in the 60 to 69 age groups which contributed 19.9% of the total growth in hospital treatment cover and 17.7% in general treatment cover. People joining in these age categories add pressure on benefits through higher demographic risk, although this is offset to varying degrees by LHC loadings applied to their premiums.

Another aspect of the increase in membership is that the take-up for general treatment has been increasing at a marginally faster rate than hospital treatment. As at 30 June 2011, 11.89 million people, or 52.5% of the population, held some form of general treatment cover, compared to 45.3% with hospital treatment cover.

The take-up of hospital treatment and general treatment products differs substantially by age group. Figure 4 shows that the overall annual take-up of general treatment policies is higher than hospital treatment policies across most age groups, and that the 30–34 and 40–44 age groups had the highest growth of new members for both types of products during the year to June 2011. This contrasts to the previous year when the 60–70 age group had the highest number of new members for both types of products.

Figure 4 – Net annual change in persons covered by hospital treatment and general treatment cover by age cohort, 2010–11



Comparing the number of people with hospital treatment cover to the total population of Australia also provides some further insight into participation as shown in Figure 5.

Figure 5 shows that people in the oldest age groups, 90 and older, had the lowest participation rates (averaging 31.3%). Low participation rates are also common for people aged between 20 and 29 years (averaging 31.0%).

Participation continues to be higher for females than for males in most age groups, with 46.5% of the total female population holding hospital insurance at 30 June 2011, compared to 44.1% for males.

People affected by the LHC loading

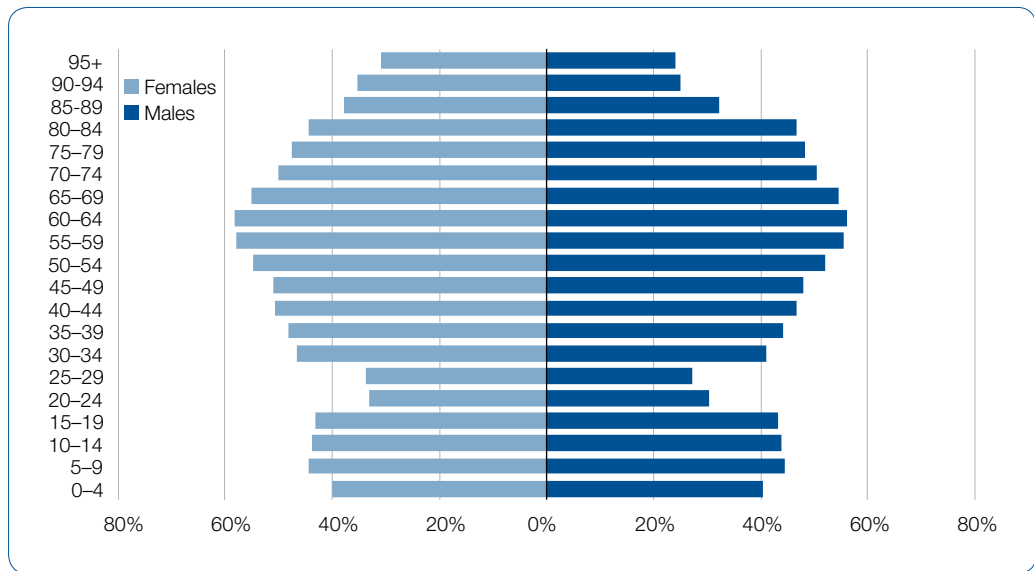
Most people with hospital cover (87.2%) have a certified age of entry of 30 and attract no LHC loading. The number of people with a certified age of entry of 30 grew by 109,406 and the number of people with a certified age of entry of more than 30 and subject to an LHC loading grew by 95,861 over the year. At the end of 2010–11, there were a total of 949,491 people subject to an LHC loading.

LHC imposes a 2% loading on top of the normal premium for each year over the age of 30 that a person was not previously insured, to a maximum loading of 70%⁵. For example, a person taking up private health insurance for the first time at the age of 35 would have to pay a LHC premium loading of 10%. LHC premium loadings cease if the person has had hospital cover for a continuous period of ten years.

Ten years had passed since the introduction of LHC loadings on 1 July 2010. This meant the 2010–11 year saw 28 059 people have their loading completely removed.

PHIO provides an online calculator at www.privatehealth.gov.au which allows consumers to calculate the LHC loading applicable to them.

⁵ Division 37 of the PHI Act details exceptions to the general rules about LHC.

Figure 5 – Percentage of people with hospital treatment cover, by age and sex, 30 June 2011

Products and services

The minimum range of services that must be covered by private health insurers is determined by legislation. Strict rules determine whether a product offered by an insurer is a ‘complying health insurance product’.

On request, an insurer must provide a Standard Information Statement (SIS) on any of its products, regardless of whether the person is a policyholder or not. The SIS can also be viewed at www.privatehealth.gov.au. The SIS for a product must include information on:

- which services are covered
- exclusions or services that are not covered
- restrictions or benefit limitation periods, services that have limited cover, and the length of time restrictions are in place
- out-of-pocket expenses, waiting periods, excess, co-payment and gap details.

Most insurers’ product offerings and prices are state-based to reflect the varied risk factors, cost structures, medical systems, hospitals, and demographic profiles that exist in each state.

Insurers also offer products with excesses and co-payments, as well as products with exclusions. A co-payment is the agreed amount a policyholder pays when they receive hospital treatment, while an excess is the amount a policyholder must pay before health insurance benefits are payable. A policyholder may have a policy that requires an excess, or co-payment, or both being payable.

Exclusionary products offer members lower premiums as a trade-off for excluding cover for certain conditions or procedures such as maternity, cardiac surgery or hip replacements.

The increasing availability of information about private health insurance products—through the media, brokers, consumer groups, the internet and SISs—has improved the quality of information available to assist policyholders to understanding health insurance. This, together with the increasing number of products with co-payments, excesses, and exclusions, has resulted in a steady uptake of these products.

Table 2 – Episodes/services by type for hospital treatment, 2010–11

	2010–11	% change from 2009–10
Acute hospital episodes	3 376 636	↑ 4.4%
Hospital days	9 121 375	↑ 6.8%
Medical services	27 770 770	↑ 8.7%
Prostheses items	1 761 093	↑ 8.5%
<i>Cardiac</i>	37 992	↑ 0.1%
<i>Hip</i>	74 136	↑ 7.2%
<i>Knee</i>	92 951	↑ 9.9%
<i>Lens</i>	48 623	↓ 48.2%

Hospital treatment

Hospital treatment products cover those services provided in or with the direct involvement of a hospital. Levels of cover available are:

- Comprehensive or top products: which cover virtually all services permitted to be funded by health insurers and cover all services where Medicare pays a benefit
- Medium cover products: are those that identify certain exclusions but include all basic cover. Exclusions typically relate to surgical eye procedures, joint replacements, dialysis, assisted reproductive services and obstetrics
- Basic or low cover products: typically feature exclusions and limited access to private hospitals. Exclusions are typically cardiac related services, joint replacements, pregnancy related services and hospital treatment for which Medicare pays no benefit.

Hospital treatment services

During 2010–11, private health insurers provided financial support for 3.4 million hospital based episodes of care, an increase of 4.4% from 2009–10. In total, private health insurers covered more than 9.1 million patient days in hospital, which was an increase of 6.8% from 2009–10.

PRIVATE HEALTH INSURERS PROVIDED FINANCIAL SUPPORT FOR 3.4 MILLION HOSPITAL BASED EPISODES OF CARE

Table 2 compares services and items involved in hospital treatment between 2009–10 and 2010–11.

The number of hospital episodes increased in all four hospital setting categories over 2010–11. The number of episodes for 2010–11 were:

- 2 319 400 private hospital ↑1.5%
- 494 819 public hospital ↑6.0%
- 490 774 day hospital ↑4.4%
- 71 643 hospital-substitute treatment ↑422.2%

Growth in the utilisation of hospital-substitute treatment was very high in 2010–11 with insurers rolling-out more specific and tailored services for this treatment—hospital-substitute treatment is administered at home, or in a

Figure 6 – Hospital-substitute episodes by age, 2009–11

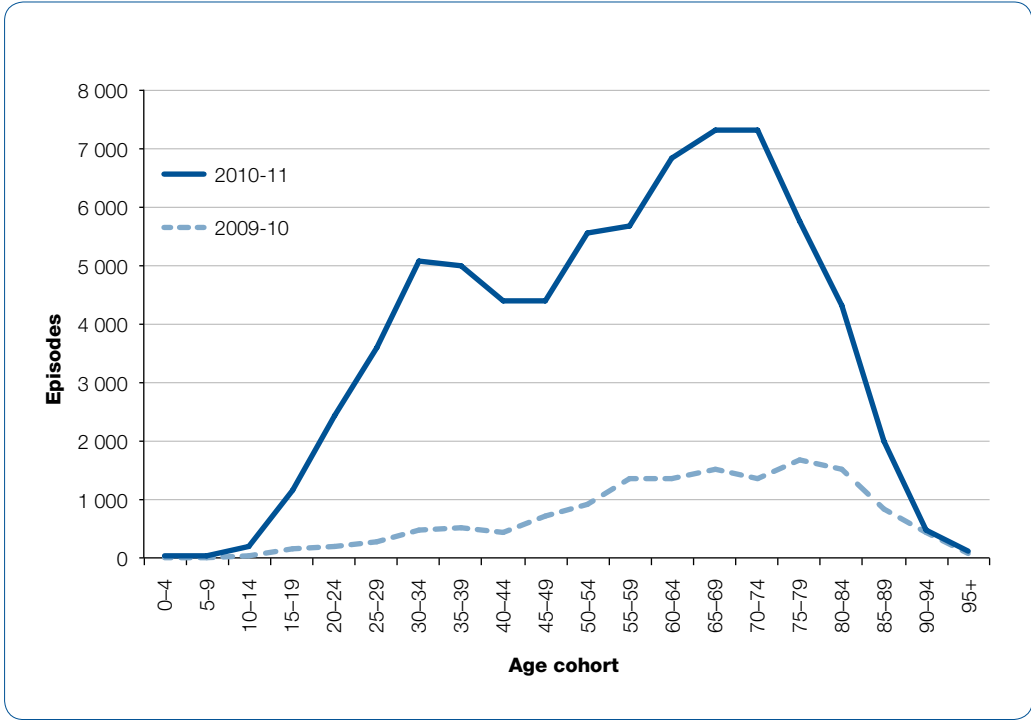


Figure 7 – Length of stay (hospital days) by age, 2010–11

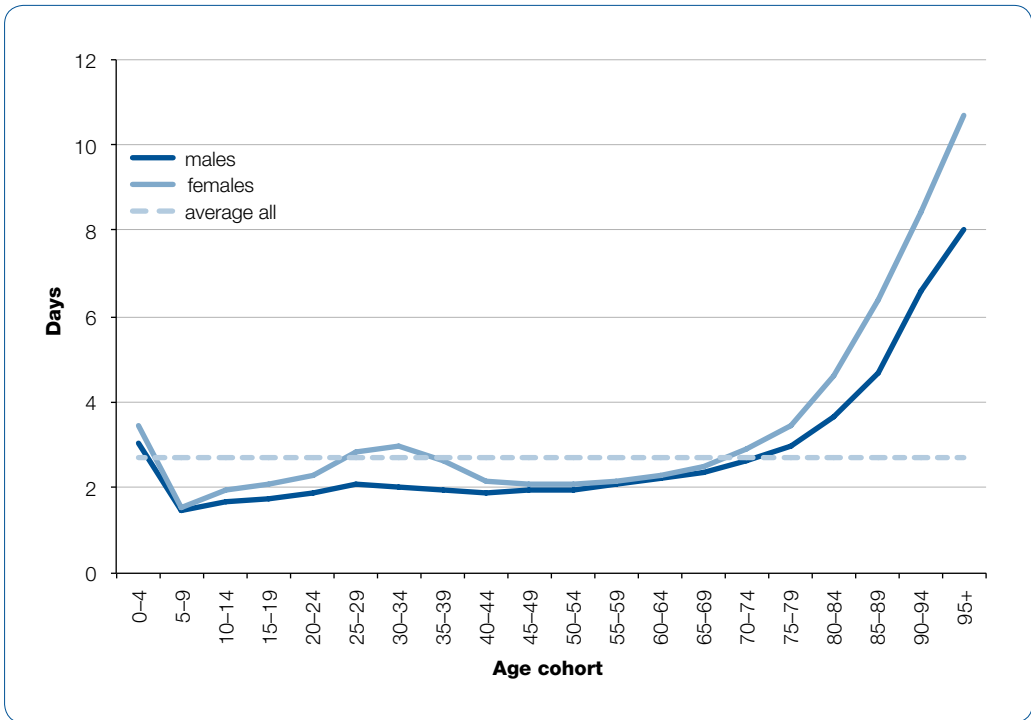
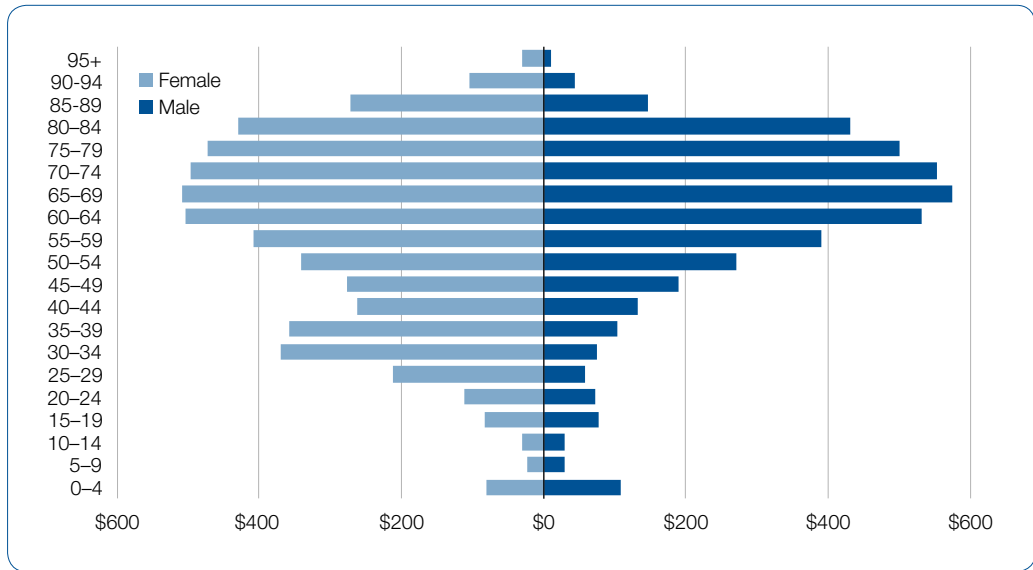


Figure 8 – Hospital treatment benefits paid by age (millions), 2010–11

non-hospital setting, rather than at hospital and examples of this treatment include the administration of acute wound management, diabetes medication management and palliative care. Figure 6 shows the number of hospital-substitute episodes by age cohort for 2009–10 and 2010–11.

Usage of day-only services

During 2010–11 there was an increase in day-only stays of 4.6% from 2009–10, to a total of 2 131 066 days. A day-only service occurs when an insured person is accommodated as a patient in a public or private hospital for day treatment. A same-day patient is a patient who is admitted and discharged on the same date, having had same-day surgical or diagnostic treatment⁶. The number of same day services is expected to continue to grow strongly, reflecting changing medical techniques and the wide and growing range of services performed as same-day treatments.

⁶ Same-day patients also include patients who were intended as overnight patients but who left of their own accord on the same day as their admission, or patients who died or were transferred on their first day in hospital.

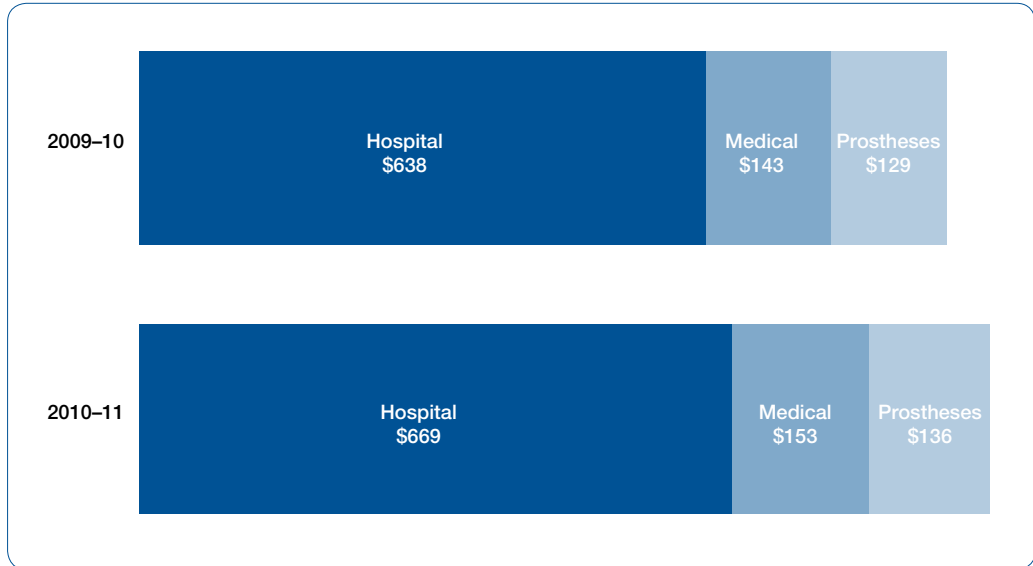
Most day-only stays of people covered by private health insurance—63.4%—occurred in private hospitals, with 23.0% in day hospital facilities, 10.3% in public hospitals and 3.3% as hospital-substitute treatment in non-hospital settings.

The length of hospital stays

The average length of a hospital stay for privately insured patients increased by 2.3% to 2.70 days. The length of stay for females is greater than males across all age groups. While males in the older age groups typically incur more hospital episodes than females, the average length of stay is shorter. The length of stay trends upward for older people, increasing significantly from the age of 75, as shown in Figure 7.

Hospital treatment benefits

The effect of membership growth, growing utilisation rates and increasing treatment costs resulted in strong growth in benefits paid by insurers for hospital treatment. Insurers paid \$9 701 million in hospital treatment benefits during 2010–11, an increase of 8.1% from 2009–10.

Figure 9 – Hospital treatment benefits per person, 2009–11

INSURERS PAID \$9 701 MILLION IN HOSPITAL TREATMENT BENEFITS DURING 2010–11, AN INCREASE OF 8.1% FROM 2009–10.

All major categories of hospital treatment benefits increased in 2010–11:

- \$6 772 million for hospital services ↑ 7.6%
 - i. \$5 765 million for private hospital ↑ 7.0%
 - ii. \$682 million for public hospital ↑ 10.4%
 - iii. \$307 million for day hospital ↑ 6.9%
 - iv. \$19 million for hospital-substitute treatment ↑ 388.5%
- \$1 548 million for medical services ↑ 10.0%
- \$1 380 million for prostheses items ↑ 8.6%

The age groups for which most hospital benefits are paid are between 60 and 79 years. Older age groups draw significantly higher amount of benefits per person than younger groups. For example, those aged between 60 and 79 claim \$2 572 in average benefits per year, whereas those aged between 20 and 39 only claim \$543 in average benefits per year. Figure 8 shows hospital treatment benefits by age for 2010–11.

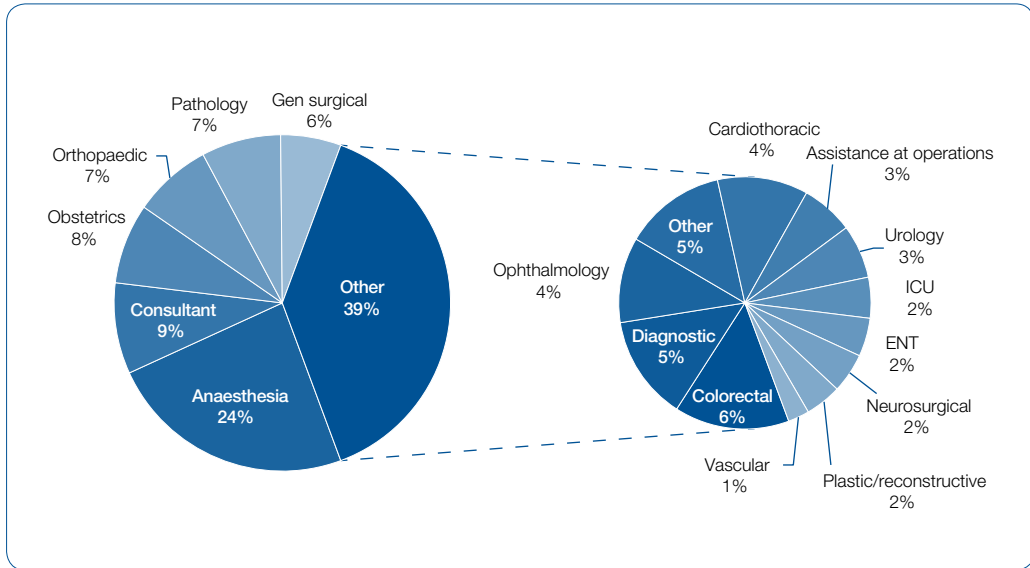
The relatively large amount of benefits paid to the 20–39 female age groups is a normal occurrence in claiming patterns, and is associated with obstetric care.

When averaged across the total population with private health insurance, the benefits per person for hospital treatment increased from \$910 in 2009–10 to \$959 in 2010–11. The break-up of these benefits into treatment categories, of hospital, medical services and prostheses is shown in Figure 9.

Medical services and benefits

Insurers pay medical benefits for in-hospital services provided by medical specialists. The amount that insurers pay toward these costs will depend on the Government contribution for the

Figure 10 – Medical benefits by speciality group, 2010–11



service (75% of the Medical Benefits Schedule fee) and the agreement the insurer has with the specialist provider. If the agreement between the insurer and specialist provider does not cover all costs, an out-of-pocket contribution (gap payment) toward the cost of the service will need to be made by the patient.

The number of medical services increased 8.7% in 2010–11, totalling 27.8 million services and drawing \$1 548 million in medical benefits paid by insurers over the year—an increase of 10.0%. Figure 10 shows the break-up of medical benefits, as a percentage, by specialist group.

Prostheses services and benefits

Under the PHI Act, private health insurers are required to pay benefits for a range of prostheses, that are listed on the Prostheses List⁷, provided as part of an episode of hospital treatment or hospital-substitute treatment for which a patient has cover and for which a Medicare benefit is payable for the associated professional service. The type of products on the Prostheses List include cardiac pacemakers

and defibrillators, cardiac stents, hip and knee replacements and intraocular lenses, as well as human tissues such as human heart valves, corneas, bones (part and whole) and muscle tissue. The list does not include external breast prostheses, wigs or other external devices (some of which may be covered by Medicare).

Use of prosthetic items has shown a considerable increase in recent years because of a rise in utilisation due to the ageing population, advancements in technology and membership growth. The number of prosthetic items paid for through private health insurance increased 8.5% in 2010–11 to 1.8 million, and related benefits totalled \$1 380 million, an increase of 8.6%. Since 2004–05, prostheses benefits have increased by 77.7%, driven primarily by utilisation that has increased by 56.2%.

In addition to increased use of prosthetics, the cost of particular items continues to rise due to factors such as advancing technology and more complex manufacturing processes.

Figure 11 displays the benefits paid by the categories of prostheses reported to PHIAC.

⁷ Contained in *Private Health Insurance Rules (Prostheses) Rules 2009 (No.2)*

Figure 11 – Benefits paid for prostheses (millions), 2010–11

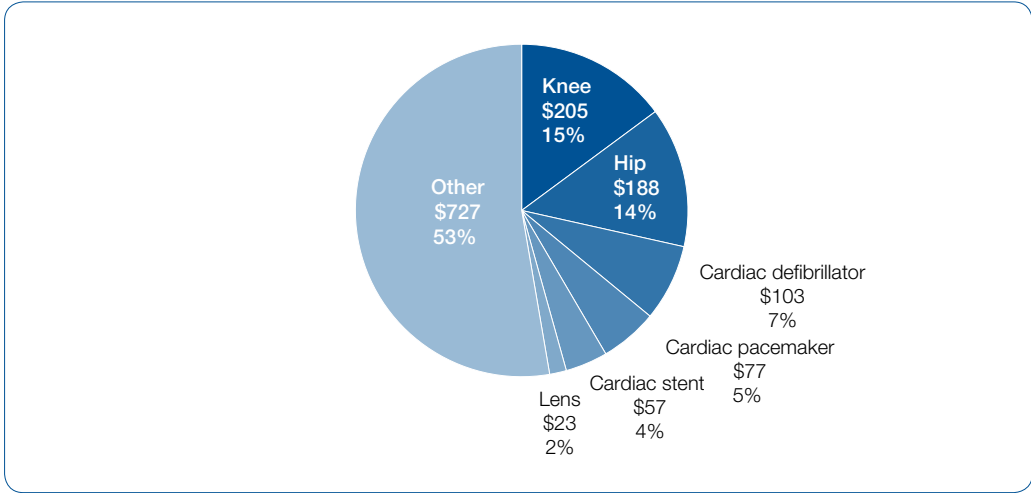
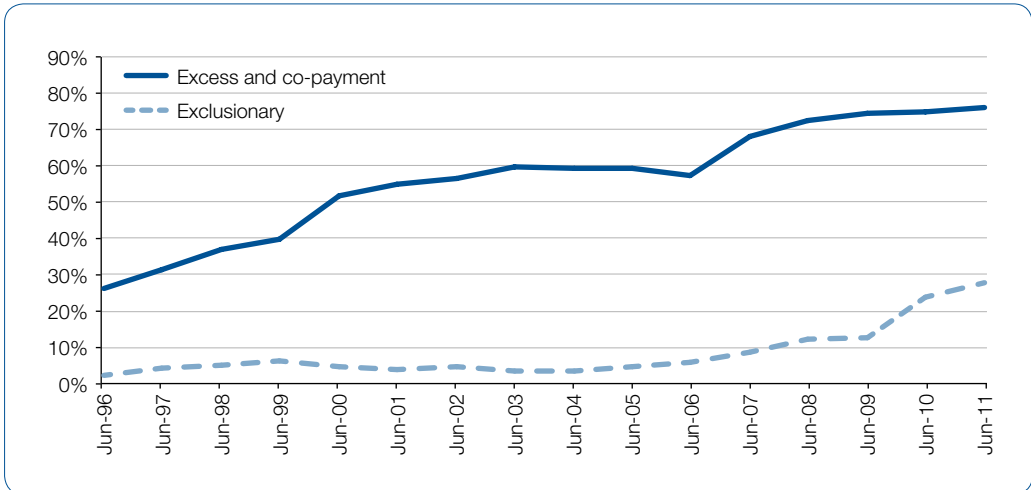


Figure 12 – Per cent of policies with excess and co-payment or exclusionary features



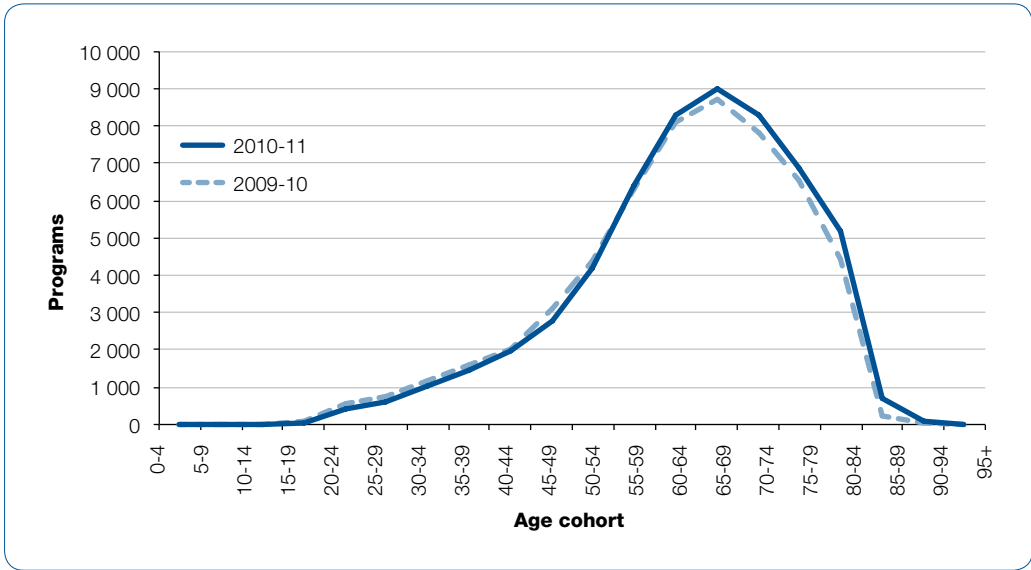
Preference for excess, co-payments and exclusionary products

At 30 June 2011, 76.2% of privately insured people were covered by a policy that required either an excess or co-payment for hospital treatment, an increase of 1.5 percentage points over the year. The proportion of policies that have exclusions has also risen in recent years and during 2010–11, the proportion rose 3.6 percentage points to 27.6%.

At the same time, the percentage of hospital policies with full cover—that is, with no exclusion or restrictions—has decreased. During 2010–11, the percentage of insured people that had full hospital cover decreased 2.4 percentage points to 55.0%. Conversely, policies with exclusionary features have increased by 3.6% over the same period⁸. Figure 12 shows the growth trend in policies with excess, co-payment or exclusionary features.

⁸ The sharp increase between 2008–09 and 2009–10, shown in Figure 12, in products with exclusionary features is partly due to a reclassification of policies by some insurers.

Figure 13 – CDMP utilisation by age, 2009–11



As can be seen from Figure 12, insurers are increasingly competing with a range of different coverage options that exclude certain treatments or have a co-payment or excess.

General treatment (ancillary)

General treatment products are designed to prevent or minimise the impact of health concerns by covering services delivered by ancillary health providers. General treatment products are classified into:

- Comprehensive products: include cover for dental, optical, pharmaceuticals, physiotherapy, podiatry and psychology
- Medium level products: provide similar cover to comprehensive products, however, there are allowances for a minimum number of additional exclusions
- Basic products: cover at least one of general dental, optical, physiotherapy or chiropractic services.

Ambulance cover can also be obtained from private health insurers in states where costs are not covered by state governments.

Cover for general treatment is an important element in maintaining the attractiveness of the private health insurance product as general treatment cover is routinely utilised by privately insured people across all age groups. People taking up general treatment cover are able to access benefits shortly after purchasing a policy due to shorter waiting periods for general treatment services. In some cases, waiting periods are waived by the insurer allowing the policyholder to make claims immediately.

On average, the benefits paid to a person for general treatment during 2010–11 increased from \$300 to \$308.

During 2010–11, policyholders received 69.6 million general treatment services. Table 3 shows the increases in usage for the major general treatment ancillary service categories. These categories collectively accounted for 84.0% of the benefits paid for general treatment services (excluding hospital-substitute and CDMPs).

Table 3 – General treatment services covered in 2010–11

	2010–11	Change from 2009–10
General treatment services	69 580 311	↑ 5.5%
Dental	29 408 010	↑ 3.7%
Optical	9 162 731	↑ 13.9%
Chiropractic	9 034 881	↑ 2.7%
Physiotherapy	8 962 540	↑ 4.7%

Insurers paid \$3 224 million in benefits for all general treatment services—an increase of 6.5% from 2009–10. Benefits paid for the major ancillary services of general treatment were:

- dental \$1 650 million
- optical \$574 million
- physiotherapy \$258 million
- chiropractic \$225 million

Broader health cover

Broader health cover (BHC) refers to services that prevent, are part of, or substitute for traditional hospital-based services and include hospital-substitute treatment services and CDMPs. The services that insurers were permitted to offer in their products were extended with the introduction of the PHI Act in 2007 to include BHC services.

Under BHC, insurers are able to offer consumers a wider range of out-of-hospital treatment options involving clinical services. Some out-of-hospital services such as general practice services and accommodation costs of residential aged care facilities are not covered by BHC.

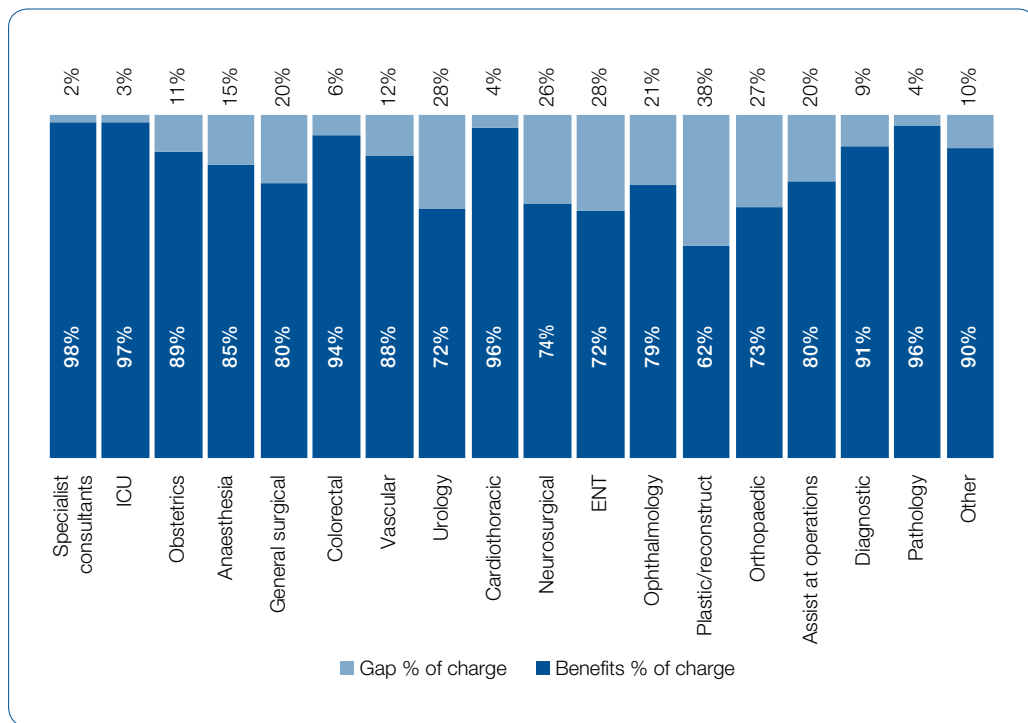
Preventive type treatments

Preventive programs such as CDMPs are intended to reduce complications associated with diagnosed chronic disease, or to prevent/delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease. CDMPs were mostly used by people who were in the age groups that are more likely to use hospital services. Figure 13 shows CDMP utilisation for 2010–11 compared to 2009–10.

The roll-out and take-up of CDMPs was initially slow, followed by rapid growth in the number during 2009–10. Growth in CDMPs flattened during 2010–11, with only 2% growth in programs over the year. The number of insurers offering cover for CDMPs increased from 14 to 30 in 2009–10, and remained at 30 during 2010–11. Of these 30 insurers, 26 incurred claims (the same as the previous year, but compares to nine in 2008–09). Benefit outlays for CDMPs is small by comparison to acute treatment cover payments and totalled \$39.6 million in 2010–11 (\$24.7 million in 2009–10 and \$9.0 million in 2008–09). Participation in CDMPs is expected to continue to grow as more programs become available and the benefits of such individual programs become more widely marketed and accepted.

Insurers see BHC initiatives as important in assisting members to better manage their health, to reduce the frequency and severity of medical interventions associated with their condition, and to minimise the costs associated with those interventions, especially in-hospital episodes. However, some insurers acknowledge that their investment in BHC may be lost to the wider industry, with the future savings stemming from an expected reduction in benefit payments from healthier members being shared amongst other insurers through risk equalisation. As such, BHC programs are currently strategically targeted at high risk, high cost health areas where insurers have a greater confidence in achieving a return on their investment.

Figure 14 – Medical benefits and out-of-pocket expenses by speciality group, 2010–11



Health-related business

Under the PHI Act, insurers can conduct health-related business (HRB) within the health benefits fund. The key HRB activities include:

- the provision of health insurance to people who are ineligible for Medicare such as overseas students health cover and overseas visitors cover (OVC)
- agency arrangements for other service providers such as general insurers
- direct provision of services (such as dental and optical).

In 2010–11 one insurer operated a private hospital and medical centre, five insurers provided dental services and six insurers provided optical services. Total HRB revenue was \$367 million, approximately 7% higher than 2009–10. The main growth area in HRB was in OVC which saw revenue increase by 22% over the year to \$170 million.

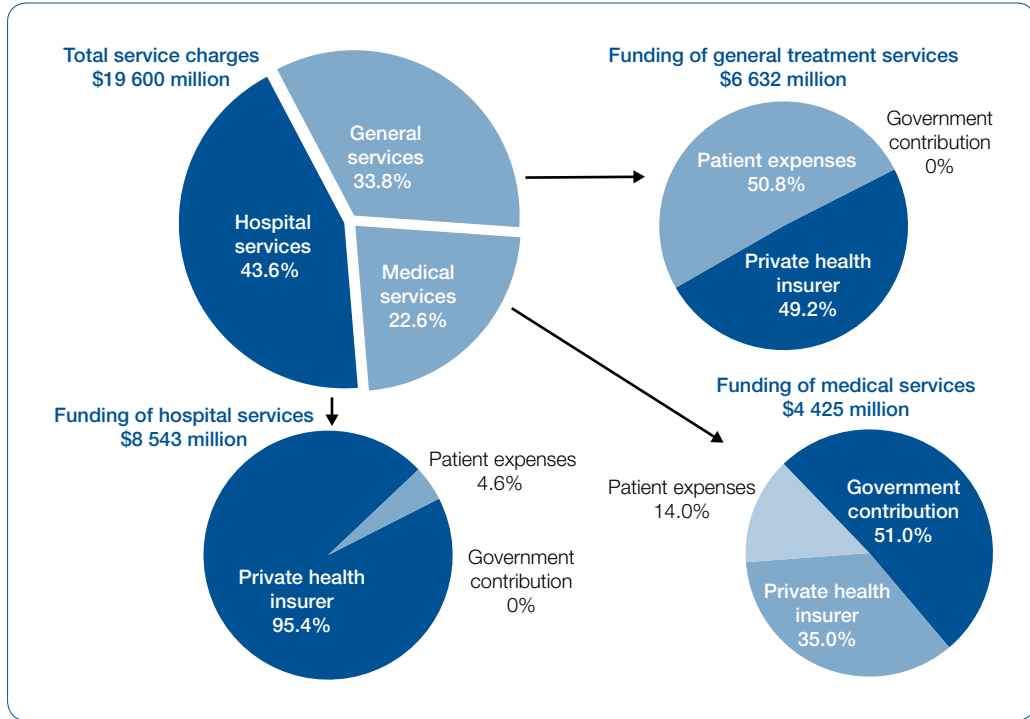
Who pays for treatment?

The cost of privately insured health treatment is shared between insurers, the Government and patients. During 2010–11, there were 3.4 million privately insured hospital episodes, 69.6 million general treatment ancillary services, and 57 thousand CDMPs, that were wholly or partly funded by private health insurance. The total cost of these services was \$19 511 million, which was met from:

- benefits provided by private health insurance \$12 964 million
- benefits provided by Medicare \$ 2 257 million
- out-of-pocket costs of patients \$ 4 379 million

The benefits paid in respect of health services received by policyholders in 2010–11 increased by 7.7% from 2009–10; much more than membership growth alone could account for.

Figure 15 – Funding for privately insured services, 2010–11



Patient contributions (out-of-pocket costs, or gaps)

The gap is the amount paid by an insured person after any Medicare benefit and benefit paid by an insurer have been deducted from the amount charged.

In 2010–11, policyholders contributed \$1 010 million in out-of-pocket payments (including excesses and co-payments) towards the \$12 878 million in fees charged for hospital treatment (including hospital-substitute and hospital related medical services) and \$3 369 million of the \$6 632 million in fees charged for general treatment.

The occurrence of out-of-pocket costs, or gaps, is a common cause of complaints and disputes between the insurers and policyholders.

Out-of-pocket costs, or gaps for medical services

In 2010–11, 88% of all medical services did not require a gap payment to be made by the patient. On average, the out-of-pocket payment for the 12% of medical services where a gap payment was required to be made was \$183.86⁹.

The extent of the gap for medical services varies depending on the specialty group and is shown in Figure 14.

Government contributions

The Australian Government makes contributions to the cost of medical services provided to privately insured patients in the form of Medicare benefits for medical services related to a hospital or hospital-substitute episode of care. For privately funded services, the Government provides a rebate of 75% of the Medical Benefits Schedule fee. Of the \$4 425 million in privately

⁹ On a hospital per episode basis the average out-of-pocket cost was \$305.22.

Table 4 – Privately insured separations, 2006–10

	2005–06	2006–07	2007–08	2008–09	2009–10
Privately insured separation in public hospitals as % of total separations in public hospitals	7.9%	8.2%	8.8%	9.2%	9.9%
Privately insured separations in total as % of total separations in all hospitals	34.8%	35.9%	37.0%	37.2%	38.3%

* Source: *Separations and patient days, by patient election status, funding source, hospital sector and year, Australia from Australian Institute of Health and Welfare, Australian Hospital Statistics (various years)*

insured, hospital related, medical costs incurred in 2010–11, \$2 257 million were funded by Medicare benefits.

Figure 15 shows the break-up of total costs for privately insured services.

Contribution to total hospital funding

Data on separations—which is when an episode of care comes to an end—shows that privately insured separations have been growing as a proportion of all separations.

Table 4 shows that privately insured separations in public hospitals have been growing as a proportion of public hospital separations. The table also shows the increase in privately insured separations as a proportion of total separations in all hospitals.

Not only does the data imply that private health insurers are funding an increasing amount of total hospital funding, it also indicates that more people with private health insurance choose to be treated as a private patient in a public hospital.

Financial outcomes for 2010–11

The 2010–11 financial year saw further strengthening of the industry—margins and investment returns were higher—further bolstering balance sheets and the capital strength of funds. The industry also experienced

slightly higher growth in new participants than in the previous year, slowing the ageing of the overall membership and reducing to a degree the burden from an ageing population.

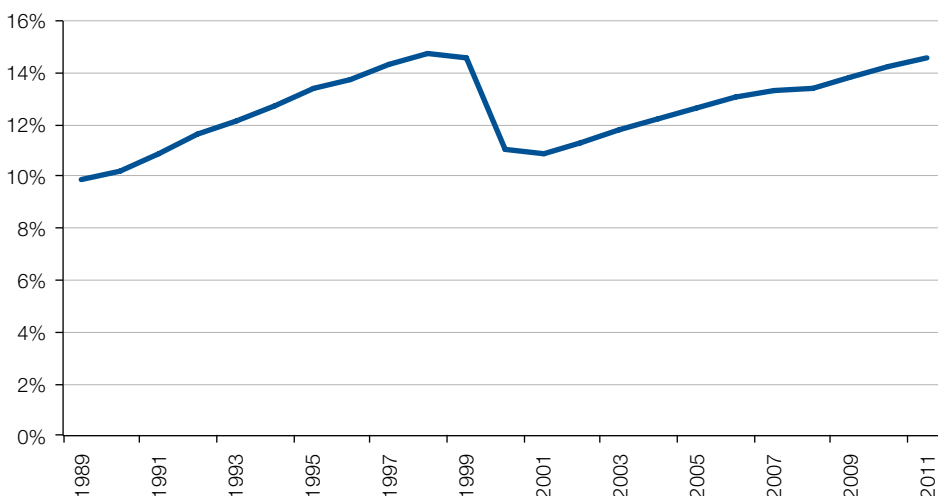
The combination of membership growth and the 5.78% weighted average premium increase that took effect from 1 April 2010 saw premium revenue increase by \$1 251 million or 8.8% from 2009–10, growing to total \$15 421 million for 2010–11.

The 2010–11 year also saw an increase in privately insured services for both hospital and general treatment. Membership growth and higher levels of private health insurance usage, together with continued underlying costs growth, led to a significant increase in the quantum of benefits paid by private health insurers.

Insurers paid benefits totalling \$13 161 million, an increase of \$934 million or 7.6% from 2009–10. Included in this amount was:

- \$9 749 million in hospital treatment benefits
- \$3 251 million in general treatment benefits
- \$157 million in state levies (a decrease of \$2 million) which entitle privately insured patients in some states and territories to emergency ambulance transport within Australia.

There are several factors which will continue to influence the rate of growth of benefits outlays. Membership is a primary driver, but within the broader membership of the industry other factors too are at play. An important factor is

Figure 16 – Per cent of insured persons aged over 65

the ageing of the insured population, estimated to add between one and two per cent per annum to benefits payments. The ageing trend of the insured population is clearly shown in Figure 16 which shows the percentage of insured persons over the age of 65.

One upside of this driver is that as more pressure is exerted from ageing, insurers have greater incentive to find new ways to manage the health risks of their membership and associated increasing costs, while continuing to offer attractive products in terms of features, cover and price.

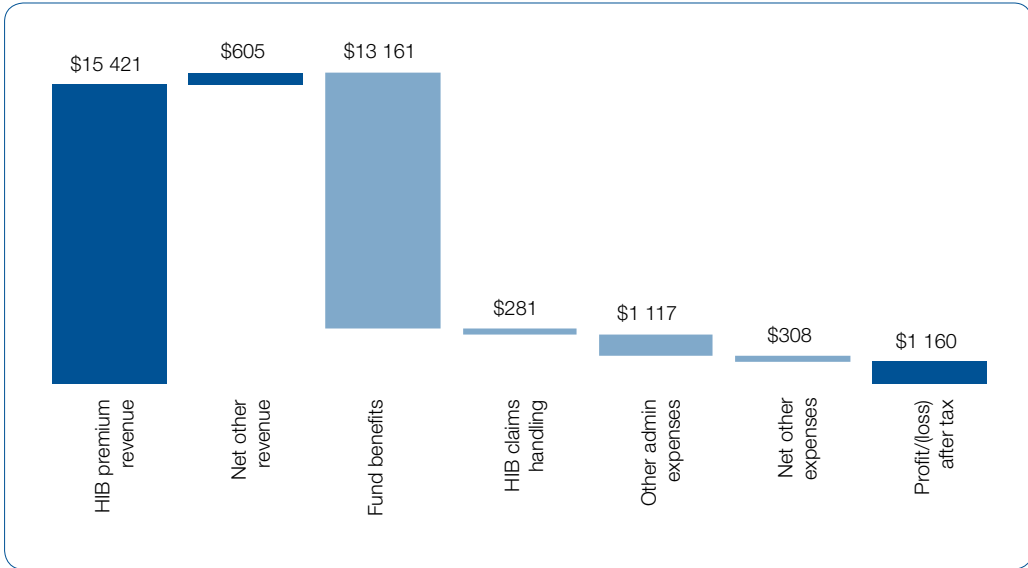
Figure 16 also illustrates the dramatic impact that the government initiatives introduced in 2000 had on the age profile of the industry—the proportion of older people dropped significantly as a result of increased take-up rates in private health insurance in all age groups, but particularly to younger age groups. Since that time, the proportion of members over 65 has returned to the levels seen prior to the introduction of the government’s initiatives. Statistics show that the ageing of the insured population generally reflects the ageing of Australia’s population.

There are other factors contributing to the increase in benefits payments, and growing service utilisation and underlying cost growth are key drivers among them. The 2010–11 financial year included:

- a 6.8% increase in hospital days
- a 4.4% increase in hospital admissions
- an 8.7% increase in number of medical services provided
- a 4.1% increase in acute bed days per person
- a 10.0% increase in medical benefits
- an 8.6% increase in benefits paid for prostheses.

The drawing rate, or benefits paid per person, increased by 5.4% for hospital treatment and 2.3% for general treatment across 2010–11. Cost growth within the industry is consistently in excess of the consumer price index, but is also consistent with the rate of cost growth across the broader health system, and together with rising service usage is a key driver of premium increases.

Figure 17 – Health benefits fund profit after tax (millions), 2010–11



The industry's gross margin result of 14.7% is considered strong, and after allowing for management costs of 9.1% of premium revenue (\$1,398 million), the industry recorded a net margin result of 5.6%, up from 4.5% in 2009–10. In addition to the improved margin performance, the industry earned investment revenue of \$556 million for 2010–11, improving from the strong post GFC turnaround reported in 2009–10 of \$444 million.

Overall, the industry recorded a profit after tax of \$1,160 million for 2010–11 compared with

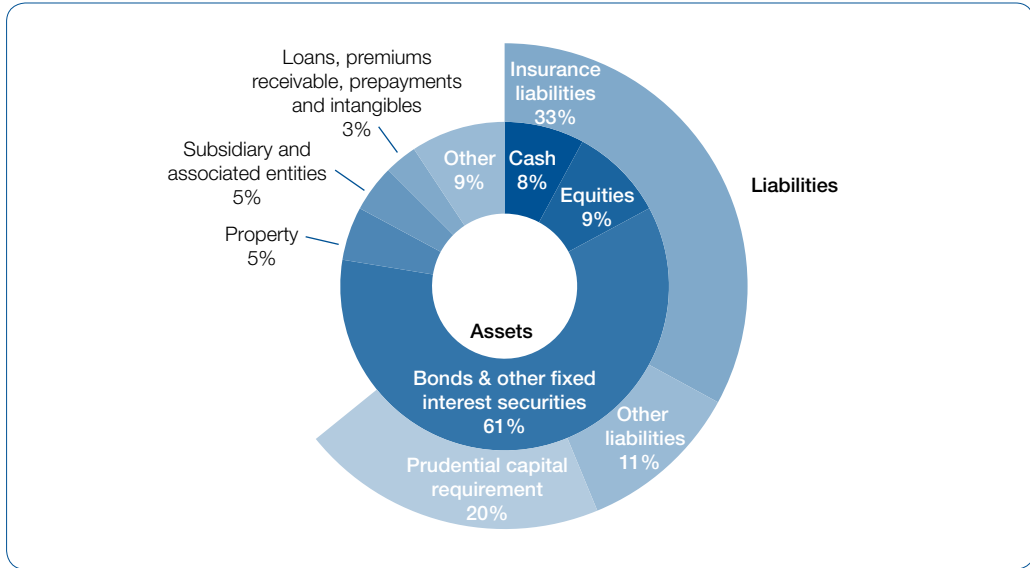
\$953 million in 2009–10. Figure 17 shows the financial performance of the industry over the last 12 months.

Historical figures show that the core business performance of the industry—that is, the provision of private health insurance measured by the net margin—has consistently been in the range of 3–6%. This range has proven to be more than sufficient to meet the ongoing growth in costs and minimum capital requirements of the industry. Table 5 shows the performance of the industry over the previous five years. The underwriting

Table 5 – Industry profitability

Year	Average weighted premium increase on 1 April	Premium revenue (\$'000)	Benefits payments (\$'000)	Management expenses (\$'000)	Gross margin	Net margin	Profit before tax (\$'000)	Profit margin
2010–11	5.56%	15,421,372	13,160,592	1,398,001	14.7%	5.6%	1,455,586	9.4%
2009–10	5.78%	14,170,292	12,226,721	1,299,774	13.7%	4.5%	1,174,946	8.3%
2008–09	6.02%	13,078,133	11,349,113	1,311,053	13.2%	3.2%	404,632	3.1%
2007–08	4.99%	12,188,820	10,385,181	1,282,300	14.8%	4.3%	562,433	4.6%
2006–07	4.52%	11,127,365	9,432,110	1,067,787	15.2%	5.6%	1,288,165	11.6%

Figure 18 – Health benefits fund assets and liabilities, 2010–11



margins achieved by private health insurers are a key area of risk for the industry, demanding significant focus and careful management.

The profit margin, which takes into account investment revenue, has shown much more volatility than underwriting margins ranging between 3–12%, a reflection of the variation in investment returns and the relative contribution of investment returns to overall profitability.

Capital strength of the industry

The strong financial performance in 2010–11 added significant strength to the industry’s capital position. As a whole, the industry held assets totalling \$9 526 million—with assets of \$3 461 million in excess of the capital adequacy requirements (an increase of 5.6% from 2009–10), and \$3 720 million in excess of the solvency requirements (an increase of 3.6% from 2009–10).

The PHI Act permits for-profit insurers to make distributions by way of dividends or to apply assets for purposes other than the health insurance business provided they maintain sufficient capital to satisfy minimum capital

“ THE INDUSTRY HELD ASSETS TOTALLING \$9 526 MILLION ”

requirements. Capital distributions in 2010–11 included dividend payments totalling \$777 million (\$409 million in 2009–10) and a further \$685 million withdrawn for non-health benefits fund purposes (\$528 million in 2009–10).

At the end of 2010–11, all private health insurers were compliant with their prudential requirements for solvency and capital adequacy.

Figure 18 compares health benefit fund assets and liabilities as at 30 June 2011.

■ Outlook for the industry

The strong margin and capital position of the industry and the funds within it means that it is well placed to meet the needs of policyholders into the future. While there is little in the short term that would seem capable of causing major disruption to the industry, its future is not issue free, and future success will largely be determined by how the industry responds and adapts to the challenges facing it in the near to mid-term.

Affordability

Affordability will continue as a critical challenge for the industry. As the insured population ages and the demand for costly services grows, the proportion of younger people is expected to shrink, undermining one of the principle benefits of community rating, demographic risk sharing. Each year there is concern about the extent to which premiums rise to cover costs and as the industry and overall population ages, funding pressures will continue to mount.

In addition to premiums, private health insurance policyholders directly fund 23% of the cost of all privately insured services through excesses, co-payments and gaps. In 2010–11 the Commonwealth Government introduced a Bill to the Parliament containing measures to reduce the extent and growth of premium rebates and improve the public cost of the rebate scheme into the longer term. At the time that this report was prepared, the legislation was yet to be debated by the Parliament.

At the same time there has been a continuation in the strong uptake of exclusionary policies. In exchange for lower premiums these policies usually exclude certain high cost treatments. While there are clear benefits to be gained for both policyholder and insurer from rational choice of these products, selection of them limits choice for the insured and transfers the financial burden of treatment for excluded services to the public health system.

A continued increase in the burden on policyholders and the public system to fund services would risk diminution of policyholder and community sentiment and a lessening of the contribution that private health insurance makes to the overall health system.

Changing industry

In response to both rising costs and an ageing future the industry has embraced the opportunity to change from being a service funder to also provide services and assistance

“ THE AMOUNT OF CAPITAL HELD BY INSURERS IN EXCESS OF MINIMUM CAPITAL REQUIREMENTS HAS GROWN STEADILY OVER THE LAST DECADE. ”

to policyholders to help manage chronic disease burden and improve health risk. Continuation and expansion of these activities is seen by many industry players as critical to the longevity and sustainability of their health insurance businesses, and the sector as a whole, assisting in managing future health costs, as well as providing new and fertile ground for product expansion and competition for consumers.

So too will technology continue to change the nature of the health insurance business. Already a very short tailed insurance industry, the ongoing development of technology supporting business to business transactions will make transactions between providers and insurers highly efficient and further compress the time and effort involved. For health insurers, risk will be concentrated in their ability to forecast and manage future experience.

Managing capital

The amount of capital held by insurers in excess of minimum capital requirements has grown steadily over the last decade. A decade ago the industry could ill afford narrow margins as the industry dealt with the rapid growth of the early 2000s and capital was relatively thin. After a decade of sustained positive margins and capital accretion, a focus for many insurers is the achievement and maintenance of balance between the risk in the health insurance business they conduct, and cost of maintaining higher capital levels which must be met either from investment returns or through policyholders' premiums.

This issue is particularly acute for not-for-profit insurers which are more constrained in the use of their capital than for-profit insurers, but all industry participants will need to determine an appropriate balance between capital security and consumer interests.

Competition in the broader health system

Private health insurance contributes significantly to overall health outcomes for all Australians. As well as complementing the operation of the public system, there is also competition between the sectors. The governments of the States and Commonwealth have agreed to significant reform of the public health system which, when implemented, will see greater competition between the two sectors for service provision. The changes agreed could see erosion of a key plank in product value perception for private health insurance—timely access to services. The attractiveness of the private health insurance product relates to more than access however, and while some pressure on value perception is expected, the broader implications for the industry are not yet clear.

■ Legislation and supervision of the industry

Private Health Insurance Act 2007

The PHI Act is the principal legislation governing the private health insurance industry in Australia. It provides incentives to encourage consumers to take out private health insurance, sets rules governing private health insurance products and imposes requirements on private health insurers regarding how they conduct their business. The PHI Act also contains a range of enforcement options for monitoring and ensuring insurer compliance with the legislation, and protecting the interests of consumers.

PHIAC's own administrative arrangements are governed by the PHI Act as well as the

Commonwealth Authorities and Companies Act 1997.

Private Health Insurance Rules

The PHI Act allows the Minister and PHIAC to make rules which provide greater flexibility in establishing legislative requirements that support the operation of the PHI Act.

A summary of the Rules made by the Minister and the Council in relation to the PHI Act is set out in the legislation index.

Community rating and risk equalisation

Registration as a private health insurer imposes restrictions on insurers that are important features of the Australian private health insurance system. The most important of these is preventing improper discrimination, which is achieved through the mechanism of community rating¹⁰ and prohibits insurers from discriminating against any person on the basis of:

- health status
- age (other than age at entry under Lifetime Health Cover)
- race, gender or sexual orientation or religious belief
- where a person lives (except to the extent allowed under the PHI Act)
- use of hospital treatment, medical or general treatment services, or general claiming history.

These anti-discrimination requirements are designed to ensure that private health insurance products are available to all residents irrespective of risk factors which might ordinarily impact upon their insurability. Limited exceptions to these requirements exist in LHC and state-based pricing.

Registration also requires that insurers participate in Risk Equalisation—a key mechanism supporting

¹⁰ *Private Health Insurance Act 2007, Division 55.*

the principle of community rating. The Risk Equalisation Trust Fund (RETF)¹¹ transfers and shares certain claims costs across all insurers, so that insurers with an older and less healthy membership, and therefore riskier profile, are not disadvantaged. PHIAC is responsible for administering the RETF.

Levies

Private health insurers directly support the operational costs of PHIAC and PHIO. Insurers may also bear the cost of supporting other insurers in the industry that have collapsed or have experienced greater than average claims due to having an older age profile. These costs can be levied through specific purpose legislation. There are four private health insurance levies:

- the Council Administration Levy¹² which finances the administrative costs of PHIAC
- the Complaints Levy¹³ which finances the administrative costs of PHIO
- the Risk Equalisation Levy¹⁴ which transfers and shares risk across the industry so that insurers with a membership demographic that is older or less healthy are not disadvantaged. In support of community rating, this levy enables insurers to charge the same premium to everyone for the same product, regardless of their individual risk profile
- the Collapsed Insurer Levy¹⁵ which empowers the Council to raise a levy from the industry to help meet a collapsed insurer's liabilities to the people insured under its policies that the insurer is unable to meet itself. To date, this levy has not been imposed on the industry.

¹¹ *Private Health Insurance Act 2007, Division 318*

¹² *Private Health Insurance (Council Administration Levy) Rules 2007*

¹³ *Private Health Insurance (Complaints Levy) Rules 2007*

¹⁴ *Private Health Insurance (Risk Equalisation Levy) Rules 2007*

¹⁵ *Private Health Insurance (Collapsed Insurer Levy) Act 2003*

A private health insurer must pay any levy and any late payment penalty in respect of any unpaid amount of each levy. The PHI Act and the *Private Health Insurance (Levy Administration) Rules 2007* detail when to pay, how the levy and late payment penalties are recovered, when a levy may be waived and the records required to be maintained by each private health insurer.

Prudential standards

PHIAC has in place these standards:

- Capital Adequacy Standard
- Solvency Standard
- Appointed Actuaries Standard
- Governance Standard
- Disclosure Standard (1 January 2011).

Solvency and Capital Adequacy Standards¹⁶

The Solvency and Capital Adequacy Standards are key tools that assist PHIAC in achieving its objectives of ensuring the prudential safety of individual private health insurers and protecting the interests of consumers.

The Solvency Standard prescribes the minimum capital requirement of a health benefits fund conducted by a private health insurer. This is to ensure that, under a wide range of potential circumstances, the private health insurer will be in a position to meet all of its obligations to policyholders and creditors.

The Capital Adequacy Standard defines the minimum level of capital required to ensure a private health insurer will meet the liabilities of existing and new policyholders, as well as creditors, on an ongoing basis.

¹⁶ *Contained in the Private Health Insurance (Health Benefits Fund Administration) Rules 2007*

Risks in the industry

Under the PHI Act 2007, health benefits funds are required to hold capital where the minimum level is determined by the solvency and capital adequacy standards.

Insurers must consider a range of factors, including the minimum regulatory requirements, when determining the capital needs of the fund. These factors include a range of key risks as well as the ability to manage those risks. Broadly speaking, these include:

- **Strategy and planning:** risks associated with the insurer's choices about the future direction for the business and the pursuit of initiatives to achieve those goals. A key risk area is the planning and forward management of growth
- **Insurance risks:** such as the insurer's product range and prices as well as distribution channels
- **Governance risks:** include all risks associated with the insurer's board, policies, and decision making processes
- **Operational risks:** the inherent risks in the structure, processes and operating systems and the insurer's ability to manage and minimise losses and respond to adverse events. Key areas include outsourcing arrangements, IT, claims management and human resources
- **Financial risks:** relate to investment, market and liquidity risks
- **Environmental risks:** are generally outside of the insurers' control and include sovereign risks such as changes in government policy and occurrences in the wider environment such as pandemics, legal issues or supplier changes.

While the impact and likelihood of these risks eventuating largely depends on the size and nature of an insurer's operations, it does not reduce the importance for insurers to have a robust risk management framework. PHIAC regularly liaises with insurers in relation to the

risk management processes and frameworks they have in place to ensure that the framework and internal controls are sufficiently robust to manage the insurer's risks.

Appointed Actuaries, Governance and Disclosure Standards¹⁷

Appointed actuaries are an important part of the essential prudential structure which sustains the financial and governance standing of the private health insurance industry. The full discharge of responsibilities for this role necessitates that the advice given by an appointed actuary is direct, unambiguous and fearless.

The Appointed Actuaries Standard supports the appointed actuaries in the performance of their role. The Standard establishes eligibility and duty requirements of appointed actuaries, the reporting and notification requirements for both the appointed actuaries and insurers, and confers specific powers upon appointed actuaries to access information and to attend and speak at meetings. The standard also requires that appointed actuaries report to PHIAC any occurrence of a significant breach of the PHI Act or Rules.

The reporting of instances of breaches and other concerns held by appointed actuaries to PHIAC is a necessary and fundamental element in the fulfilment of their obligations.

PHIAC worked closely with the appointed actuaries and their professional body—the Institute of Actuaries of Australia (now the Actuaries Institute)—promoting, through education and professional practice improvements, the strengthening of both understanding and performance of the appointed actuary's role.

In June 2011, the Actuaries Institute released the *Professional Standard 600: Financial Condition Reports for Private Health Insurers*. PHIAC welcomed the new professional requirements strengthening the role of

¹⁷ Contained in the *Private Health Insurance (Insurer Obligations) Rules 2009*.

appointed actuaries and establishing practice requirements intended to ensure the quality of advice provided to insurers.

To strengthen and maintain the overall governance of insurers and minimise the risk of future regulatory and market failures, the *Private Health Insurance (Insurer Obligations) Rules 2009* now include a Governance Standard which includes number of requirements for insurers—one of which is the need to have independent directors. A review of industry practice conducted in 2010–11 showed that the industry continues to strengthen governance policy and compliance with the requirements of the Standard.

These Rules also include a Disclosure Standard, which requires insurers to report and notify PHIAC of certain events and was established to provide additional information to assist PHIAC in its ongoing oversight of insurers and to facilitate early detection of prudential risk. Whilst the emphasis of this standard is on more comprehensive communication with PHIAC, its application will increase the protection provided to consumers and beneficiaries of private health insurance policies, through more timely prudential supervision of private health insurance.

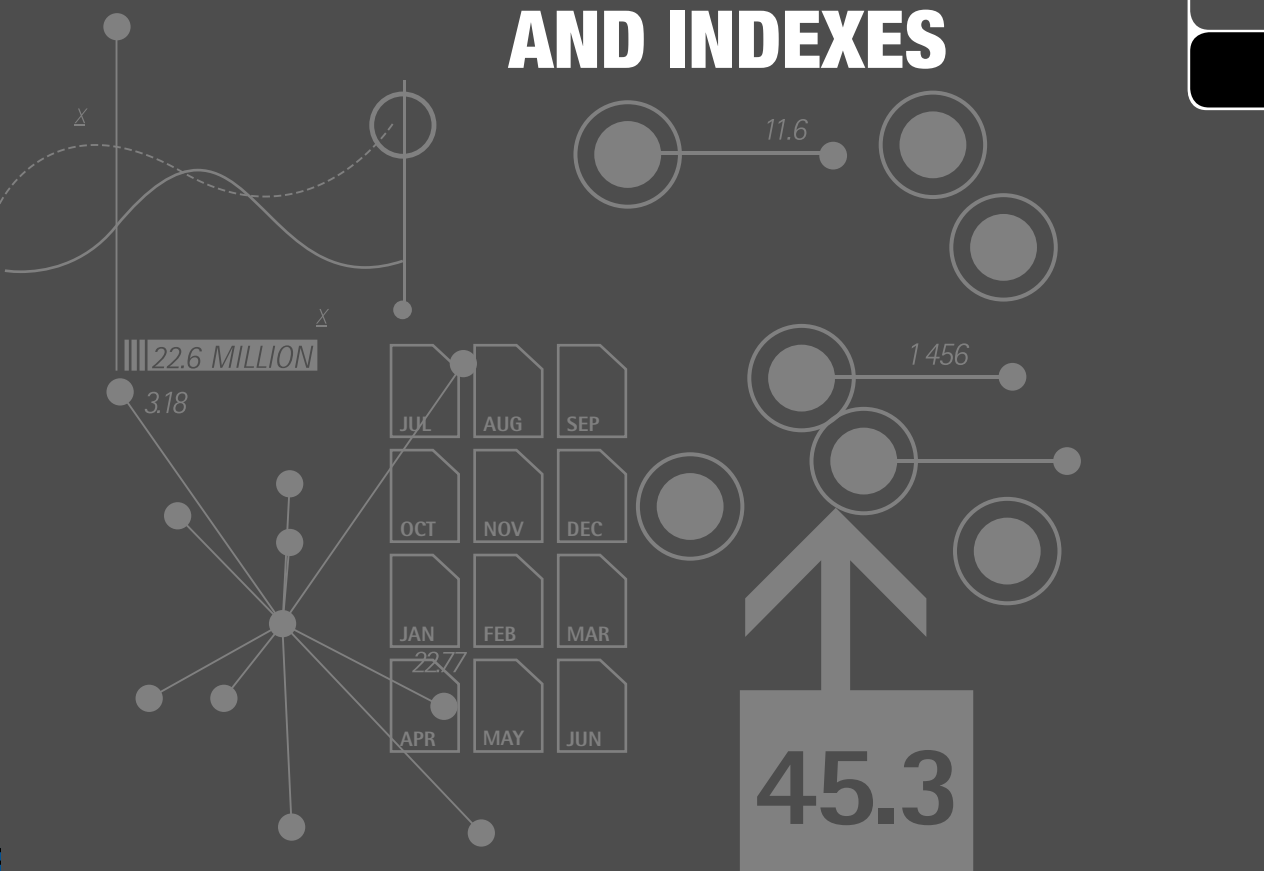
Outsourcing Standard

On 9 August 2011, PHIAC initiated the first of two planned rounds of industry consultation on a planned Outsourcing Standard for private health insurers. PHIAC's proposed standard will require insurers to have in place an effective control framework in relation to implementing and managing the outsourcing arrangements of material business activities.

When made, the Outsourcing Standard will be a prudential standard made under Division 163 of the PHI Act and will appear as a new schedule to the *Private Health Insurance (Insurer Obligations) Rules 2009*.



STATISTICAL TABLES AND INDEXES



Statement of financial performance

All figures \$'000	Revenue				Benefits			Expenses	
	HIB premium revenue	Investment revenue	Net HRB and other revenue	Total revenue	Fund benefits	State ambulance levies	Total fund benefits	HIB expenses	HIB claims handling
Industry	15,421,372	556,332	48,744	16,026,448	13,003,364	157,228	13,160,592	1,116,713	281,288
ACA	17,848	768	8	18,623	15,784	231	16,015	633	624
AHM	479,651	16,938	121	496,711	386,888	6,880	393,768	46,514	4,116
AUHL	463,903	6,903	1,050	471,856	375,318	1,997	377,315	44,972	8,343
BUPA	4,360,516	78,488	20,697	4,459,701	3,607,973	33,587	3,641,560	305,027	100,625
CBHS	227,983	8,227	-	236,210	207,268	3,044	210,312	7,394	4,951
CDH	7,894	456	-	8,350	6,810	173	6,983	851	57
CUA	73,132	2,356	-	75,488	62,203	201	62,404	6,374	1,283
Defence	248,110	13,849	6	261,965	213,977	2,278	216,255	9,474	5,187
DHF	25,044	1,762	26	26,832	20,179	290	20,469	2,520	756
GMHBA	247,747	8,419	70	256,236	216,168	524	216,692	24,006	2,142
GUC	86,901	1,593	123	88,617	64,151	939	65,090	11,430	1,475
HBF	1,008,157	102,583	1,620	1,112,361	881,607	116	881,722	86,437	8,391
HCF	1,454,059	65,146	3,264	1,522,469	1,296,007	33,509	1,329,516	74,001	26,395
HCI	11,539	651	9	12,199	9,792	7	9,799	1,111	353
H'guard	84,826	6,408	102	91,336	66,782	287	67,069	8,320	1,025
HIF	72,703	3,727	457	76,887	61,785	-	61,785	6,562	1,229
H'Partners	105,093	4,887	2,650	112,631	92,903	-	92,903	7,590	1,324
Latrobe	105,541	7,064	355	112,959	92,331	227	92,558	6,166	3,835
Mildura	29,406	3,292	286	32,984	24,712	114	24,826	784	1,389
MPL	4,112,912	155,149	17,033	4,285,094	3,472,570	33,555	3,506,125	314,717	64,470
MU	225,356	5,384	2,163	232,904	182,221	4,074	186,295	13,642	6,540
Navy	44,525	3,847	9	48,380	37,299	648	37,947	2,550	1,581
NHBA	16,803	504	-	17,307	12,667	168	12,835	986	626
NIB	991,306	21,310	163	1,012,779	818,037	22,874	840,911	75,328	14,922
Peoplecare	73,100	2,888	276	76,265	62,083	1,005	63,088	5,095	1,644
Phoenix	21,910	864	9	22,783	19,662	214	19,876	1,077	861
Police	69,655	981	76	70,712	57,837	11	57,848	3,445	875
QCH	51,581	2,731	-	54,312	41,803	25	41,828	2,829	2,626
QTUH	92,014	3,888	(1,383)	94,519	77,371	33	77,404	7,234	1,297
RBHS	9,408	402	4	9,815	6,910	122	7,032	1,537	-
RT	80,126	(343)	62	79,845	66,124	939	67,063	8,886	765
St Luke's	66,868	3,267	-	70,135	53,766	57	53,823	4,707	2,483
TFH	329,746	15,283	(967)	344,062	283,309	7,555	290,864	17,839	4,798
Transport	11,888	570	-	12,458	10,674	20	10,694	183	768
Westfund	114,119	6,088	456	120,663	98,392	1,525	99,917	6,491	3,530

			Profitability							
Other expenses*	Total expenses	Surplus/(deficit) before tax	Taxation expense	Surplus/(deficit) after tax	Non HBF related surplus/(deficit)	Surplus/(deficit) of the insurer	Gross margin	Management expenses	Net margin	
12,270	1,410,271	1,455,586	295,521	1,160,064	11,719	1,171,783	14.7%	9.1%	5.6%	
-	1,257	1,351	-	1,351	-	1,351	10.3%	7.0%	3.2%	
-	50,631	52,312	16,964	35,348	-	35,348	17.9%	10.6%	7.3%	
2,999	56,314	38,228	11,335	26,893	-	26,893	18.7%	11.5%	7.2%	
-	405,651	412,490	122,510	289,980	11,408	301,388	16.5%	9.3%	7.2%	
120	12,465	13,433	-	13,433	-	13,433	7.8%	5.4%	2.3%	
-	908	459	-	459	-	459	11.5%	11.5%	0.0%	
-	7,657	5,427	-	5,427	-	5,427	14.7%	10.5%	4.2%	
500	15,161	30,549	-	30,549	1,195	31,744	12.8%	5.9%	6.9%	
-	3,276	3,087	-	3,087	-	3,087	18.3%	13.1%	5.2%	
-	26,148	13,395	-	13,395	-	13,395	12.5%	10.6%	2.0%	
139	13,044	10,484	3,126	7,358	-	7,358	25.1%	14.9%	10.2%	
-	94,828	135,810	-	135,810	-	135,810	12.5%	9.4%	3.1%	
3,917	104,313	88,640	-	88,640	-	88,640	8.6%	6.9%	1.7%	
-	1,464	936	-	936	-	936	15.1%	12.7%	2.4%	
-	9,345	14,922	-	14,922	-	14,922	20.9%	11.0%	9.9%	
-	7,791	7,311	-	7,311	-	7,311	15.0%	10.7%	4.3%	
-	8,915	10,813	-	10,813	-	10,813	11.6%	8.5%	3.1%	
59	10,060	10,341	-	10,341	-	10,341	12.3%	9.5%	2.8%	
-	2,173	5,985	-	5,985	-	5,985	15.6%	7.4%	8.2%	
-	379,187	399,782	110,206	289,576	(617)	288,960	14.8%	9.2%	5.5%	
4,506	24,688	21,920	6,694	15,227	-	15,227	17.3%	9.0%	8.4%	
-	4,131	6,302	-	6,302	61	6,363	14.8%	9.3%	5.5%	
-	1,612	2,860	858	2,002	13	2,015	23.6%	9.6%	14.0%	
-	90,250	81,618	23,829	57,789	-	57,789	15.2%	9.1%	6.1%	
-	6,739	6,438	-	6,438	(341)	6,096	13.7%	9.2%	4.5%	
-	1,938	969	-	969	-	969	9.3%	8.8%	0.4%	
-	4,320	8,544	-	8,544	-	8,544	17.0%	6.2%	10.7%	
-	5,455	7,029	-	7,029	-	7,029	18.9%	10.6%	8.3%	
18	8,549	8,565	-	8,565	-	8,565	15.9%	9.3%	6.6%	
-	1,537	1,245	-	1,245	-	1,245	25.3%	16.3%	8.9%	
-	9,651	3,131	-	3,131	-	3,131	16.3%	12.0%	4.3%	
-	7,190	9,122	-	9,122	-	9,122	19.5%	10.8%	8.8%	
-	22,637	30,561	-	30,561	-	30,561	11.8%	6.9%	4.9%	
13	964	801	-	801	-	801	10.0%	8.0%	2.0%	
-	10,021	10,725	-	10,725	-	10,725	12.4%	8.8%	3.7%	

* Other expenses includes borrowing costs and all other costs paid/payable from the fund

Statement of financial position

All figures \$'000	Health Benefits Fund Assets											Unearned premium liabilities
	Financial assets	Investments									Total assets	
	Cash	Equities	Bonds & other fixed interest	Property	Subsidiary & associated entities	Loans	Premiums receivable	Intangibles DAC & FITBS	Prepayments	Other		
Industry	746,539	879,890	5,735,827	500,824	439,949	35,570	62,965	190,974	16,057	882,151	9,490,745	1,745,308
ACA	328	-	15,253	-	-	-	155	-	11	842	16,589	949
AHM	11,355	-	307,413	33,950	-	-	2,640	6,971	716	26,843	389,888	45,602
AUHL	92,620	27,885	65,907	27,998	-	-	710	11,066	248	42,159	268,593	85,001
BUPA	260,245	-	1,296,351	-	2,660	32,291	5,447	18,872	1,156	199,361	1,816,383	492,587
CBHS	3,791	16,418	114,364	3,000	-	-	377	-	240	10,423	148,614	12,302
CDH	1,948	-	5,923	483	-	-	64	-	-	258	8,676	863
CUA	4,186	-	38,240	-	-	-	-	-	16	3,947	46,388	2,329
Defence	7,165	28,886	182,199	-	-	-	1,415	-	139	8,507	228,311	21,058
DHF	556	99	26,800	-	-	-	491	-	-	2,663	30,609	8,064
GMHBA	5,181	-	152,433	4,875	-	-	2,465	1,256	-	12,979	179,189	32,782
GUC	25,070	5,468	10,458	4,139	-	-	4,665	2,364	44	3,279	55,487	7,433
HBF	98,267	127,720	590,633	29,765	-	2,334	7,031	1,436	952	91,566	949,704	199,375
HCF	87,803	128,667	560,427	110,693	67,531	100	9,056	108,570	4,192	72,689	1,149,728	198,681
HCI	12	-	11,800	-	-	-	58	-	21	540	12,431	1,250
H'guard	4,776	7,278	72,915	3,587	-	-	867	452	10	4,695	94,580	12,078
HIF	4,975	2,387	52,134	6,670	-	-	314	460	162	3,279	70,381	8,428
H'Partners	7,415	21,638	39,353	7,102	-	-	349	-	346	8,902	85,106	5,856
Latrobe	1,726	-	117,998	8,453	1,935	-	757	-	145	6,304	137,320	12,682
Mildura	3,150	-	51,339	4,788	-	-	413	-	143	5,263	65,096	4,267
MPL	11,447	432,897	1,235,939	146,093	367,823	-	9,503	26,340	5,082	247,828	2,482,952	431,783
MU	-	-	-	-	-	-	-	-	-	-	-	-
Navy	2,993	10,086	37,398	4,441	-	-	63	-	95	3,171	58,247	6,514
NHBA	474	-	8,400	-	-	-	18	-	12	874	9,778	961
NIB	62,375	35,785	204,905	38,582	-	-	4,302	12,331	1,620	71,991	431,891	65,202
Peoplecare	1,677	4,629	34,992	5,249	-	-	684	-	114	3,113	50,458	4,561
Phoenix	4,265	-	12,450	-	-	-	252	-	-	1,977	18,944	3,158
Police	13,473	1,320	7,853	3,596	-	-	760	-	-	2,156	29,158	1,851
QCH	7,518	2,471	44,000	4,229	-	-	198	-	-	2,488	60,904	7,862
QTUH	6,414	12,604	45,471	20,280	-	-	105	329	140	3,828	89,171	7,232
RBHS	632	-	7,176	-	-	-	8	-	14	814	8,644	230
RT	3,352	938	22,104	16,352	-	-	1,329	-	97	5,865	50,037	8,990
St Luke's	58	2,639	50,623	6,691	-	845	3,400	-	148	8,802	73,206	8,094
TFH	10,409	10,075	200,408	6,100	-	-	4,262	-	127	15,498	246,878	26,721
Transport	842	-	8,971	-	-	-	337	-	-	964	11,114	1,910
Westfund	40	-	103,195	3,708	-	-	470	527	67	8,285	116,292	18,653

Health Benefits Fund Liabilities					Private Health Insurer Capital							Prudential Reserves		
Unpresented & outstanding claims	Other fund liabilities	Interest bearing liabilities	Payables provisions & other liabilities	Total liabilities	Health benefits fund capital	Non health fund assets	Non health fund liabilities	Equity			Total equity	Solvency capital/risk multiple	Solvency reserve	
								Contributed equity	Reserves	Retained profits				
1,380,184	126,140	30,230	871,963	4,153,825	5,336,921	684,758	124,031	2,623,086	(2,166,543)	5,441,104	5,897,647	3.22	1,677,397	
1,244	-	136	202	2,530	14,059	-	-	-	-	14,059	14,059	8.35	1,684	
35,857	5,376	-	48,306	135,140	254,748	-	-	367,000	(362,159)	249,907	254,748	3.77	67,577	
37,108	-	25,000	20,902	168,011	100,582	-	1	100	-	100,480	100,580	2.64	47,553	
487,307	20,000	-	196,356	1,196,250	620,133	365,104	-	2,112,627	(1,910,000)	782,609	985,236	2.85	217,446	
26,728	7,700	-	2,767	49,497	99,117	-	-	-	312	98,805	99,117	8.63	11,480	
511	-	-	938	2,312	6,364	-	-	-	621	5,743	6,364	4.10	1,552	
4,060	-	-	99	6,488	39,900	-	-	-	-	39,900	39,900	8.05	4,954	
28,466	9,436	-	4,146	63,106	165,205	4,196	74	43,346	-	125,981	169,327	10.82	15,270	
2,159	-	-	497	10,720	19,889	-	-	-	-	19,889	19,889	5.92	3,360	
16,847	14,521	-	5,422	69,572	109,617	-	-	-	97	109,520	109,617	5.69	19,253	
7,700	4,047	-	6,120	25,300	30,187	-	-	11,715	-	18,470	30,185	2.03	14,853	
93,445	-	-	26,819	319,638	630,066	-	-	-	-	630,066	630,066	5.05	124,808	
125,679	14,791	-	105,591	444,742	704,986	-	-	-	61,912	643,074	704,986	2.61	284,003	
934	105	-	189	2,478	9,953	-	-	-	-	9,953	9,953	5.11	1,946	
8,127	-	-	1,535	21,740	72,840	-	-	-	-	72,840	72,840	7.58	9,614	
5,365	62	-	1,380	15,235	55,146	-	-	-	3,699	51,447	55,146	7.07	7,801	
5,387	-	-	5,680	16,924	68,182	-	-	-	1,046	67,136	68,182	7.98	8,546	
9,255	-	-	2,282	24,219	113,101	-	-	-	1,242	111,859	113,100	9.63	11,750	
2,187	-	-	1,467	7,921	57,175	-	-	-	3,848	53,327	57,175	14.83	3,856	
331,011	5,941	-	356,824	1,125,558	1,357,394	314,846	123,657	85,000	17,819	1,445,764	1,548,583	2.12	640,627	
-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
3,000	340	-	2,214	12,068	46,179	273	-	-	1,027	45,425	46,452	9.95	4,643	
1,029	407	-	483	2,880	6,897	34	10	2,130	-	4,792	6,922	3.85	1,793	
65,883	34,501	3,603	59,923	229,111	202,780	-	-	1,168	1,386	200,226	202,780	2.46	82,266	
4,374	1,609	-	2,141	12,685	37,773	304	288	-	-	37,789	37,789	5.51	6,856	
1,457	-	-	431	5,046	13,898	-	-	-	-	13,898	13,898	6.18	2,248	
4,061	2,178	-	527	8,617	20,541	-	-	-	341	20,200	20,541	5.71	3,598	
2,885	1,184	-	561	12,492	48,412	-	-	-	-	48,412	48,412	11.00	4,400	
6,955	640	-	3,053	17,880	71,292	-	-	-	8,372	62,921	71,293	7.78	9,161	
478	-	-	212	919	7,725	-	-	-	-	7,725	7,725	4.35	1,775	
9,866	-	-	2,305	21,161	28,876	-	-	-	767	28,109	28,876	1.56	18,476	
3,385	-	1,491	2,044	15,014	58,192	-	-	-	658	57,534	58,192	5.92	9,831	
35,085	2,589	-	8,086	72,480	174,398	-	-	-	1,725	172,673	174,398	7.74	22,545	
1,072	90	-	(4)	3,068	8,046	-	-	-	-	8,046	8,046	4.97	1,619	
11,280	624	-	2,466	33,023	83,269	-	-	-	743	82,526	83,269	8.12	10,252	

Membership, revenue and expenses by insurer

	Policies			People			Average Policies			Average People		
	Hospital treatment	General treatment only	Whole fund	Hospital treatment	General treatment only	Whole fund	Hospital treatment	General treatment only	Whole fund	Hospital treatment	General treatment only	Whole fund
Industry	4,967,392	760,174	5,727,566	10,255,675	1,646,240	11,901,915	4,820,326	731,890	5,552,216	9,972,186	1,595,241	11,567,427
ACA	4,284	350	4,634	9,860	784	10,644	4,272	356	4,628	9,807	801	10,608
AHM	148,687	18,422	167,109	305,039	36,623	341,662	149,343	17,034	166,377	305,913	33,792	339,705
AUHL	167,683	11,478	179,161	285,060	23,271	308,331	160,429	11,036	171,465	274,014	22,442	296,456
BUPA	1,329,460	208,687	1,538,147	2,778,074	451,830	3,229,904	1,243,904	193,887	1,437,791	2,608,574	419,676	3,028,250
CBHS	66,723	6,942	73,665	158,215	15,380	173,595	65,401	6,663	72,064	156,028	14,788	170,816
CDH	2,572	160	2,732	5,551	337	5,888	2,519	162	2,680	5,460	343	5,803
CUA	21,163	3,219	24,382	42,049	6,835	48,884	20,416	3,016	23,433	41,051	6,453	47,504
Defence	78,090	11,776	89,866	183,696	17,679	201,375	75,691	11,296	86,987	179,337	17,357	196,694
DHF	7,425	67	7,492	15,031	104	15,135	6,895	51	6,946	14,128	69	14,197
GMHBA	86,536	11,656	98,192	182,242	27,859	210,101	82,816	11,565	94,381	174,910	28,131	203,041
GUC	21,073	652	21,725	55,530	1,458	56,988	19,253	606	19,860	50,449	1,362	51,811
HBF	331,384	109,595	440,979	671,445	217,998	889,443	327,291	105,909	433,200	668,581	213,529	882,110
HCF	477,103	57,488	534,591	1,096,151	136,854	1,233,005	460,595	56,203	516,798	1,056,780	134,472	1,191,252
HCI	3,138	674	3,812	7,439	1,566	9,005	3,130	679	3,809	7,409	1,590	8,999
H'guard	26,477	3,201	29,678	59,549	6,860	66,409	24,929	2,560	27,489	56,952	5,620	62,572
HIF	25,686	6,010	31,696	53,690	11,651	65,341	24,289	5,320	29,609	50,620	10,432	61,052
H'Partners	27,268	9,941	37,209	57,778	20,906	78,684	26,782	9,923	36,706	56,851	21,014	77,865
Latrobe	38,817	2,166	40,983	78,140	5,007	83,147	38,068	2,195	40,262	77,159	5,146	82,305
Mildura	10,811	3,685	14,496	19,676	8,329	28,005	10,816	3,716	14,532	19,684	8,348	28,032
MPL	1,368,623	217,856	1,586,479	2,677,594	492,142	3,169,736	1,363,504	215,910	1,579,414	2,668,930	490,681	3,159,611
MU	62,200	2,566	64,766	153,183	5,610	158,793	64,665	2,631	67,296	159,145	5,775	164,920
Navy	12,720	1,743	14,463	28,330	2,502	30,832	12,516	1,677	14,193	28,025	2,411	30,436
NHBA	4,368	336	4,704	10,555	766	11,321	4,141	336	4,476	10,178	777	10,955
NIB	390,461	40,712	431,173	752,137	87,145	839,282	379,233	39,355	418,588	732,834	85,603	818,437
Peoplecare	20,293	4,116	24,409	47,959	8,803	56,762	19,068	3,407	22,475	45,135	7,199	52,334
Phoenix	5,961	439	6,400	12,617	992	13,609	5,888	437	6,325	12,558	986	13,544
Police	15,274	1,698	16,972	41,044	4,400	45,444	14,909	1,587	16,496	40,080	4,149	44,229
QCH	14,394	119	14,513	34,592	307	34,899	13,936	126	14,062	33,561	333	33,894
QTUH	23,599	1,010	24,609	51,261	1,894	53,155	22,908	963	23,870	50,064	1,862	51,926
RBHS	2,058	12	2,070	3,906	21	3,927	2,038	11	2,049	3,858	20	3,878
RT	21,996	1,186	23,182	47,810	2,982	50,792	22,454	1,152	23,606	48,751	2,912	51,663
St Luke's	19,641	2,501	22,142	40,381	5,438	45,819	19,481	2,444	21,925	40,143	5,338	45,481
TFH	95,609	6,428	102,037	206,415	13,369	219,784	93,538	6,293	99,831	202,465	12,970	215,435
Transport	3,766	435	4,201	7,922	1,015	8,937	3,613	417	4,030	7,564	970	8,534
Westfund	32,049	12,848	44,897	75,754	27,523	103,277	31,595	12,969	44,564	75,189	27,894	103,083

		Premium Revenue (\$'000)				Fund Benefits (\$'000)					Management Expenses Per	
	Whole fund	Hospital treatment	General treatment	General treatment ambulance only	Total	Hospital treatment	General treatment	General treatment ambulance only	State levies	Total	Average policy	Average people
	11,567,426	11,095,135	4,309,168	17,069	15,421,372	9,769,293	3,209,104	24,966	157,228	13,160,592	\$252	\$121
	10,607	11,671	6,176	-	17,848	10,239	5,545	-	231	16,015	\$272	\$119
	339,704	336,660	142,719	273	479,651	292,468	94,420	-	6,880	393,768	\$304	\$149
	296,456	347,472	116,431	-	463,903	294,599	80,719	-	1,997	377,315	\$311	\$180
	3,028,250	3,185,327	1,172,753	2,437	4,360,516	2,797,295	809,326	1,352	33,587	3,641,560	\$282	\$134
	170,816	152,617	75,233	132	227,983	143,941	63,327	-	3,044	210,312	\$171	\$72
	5,803	6,484	1,406	4	7,894	5,739	1,070	1	173	6,983	\$339	\$156
	47,503	53,125	20,007	-	73,132	44,859	17,344	-	201	62,404	\$327	\$161
	196,695	183,017	65,093	-	248,110	161,020	52,957	-	2,278	216,255	\$169	\$75
	14,197	18,808	6,235	-	25,044	15,666	4,514	-	290	20,469	\$472	\$231
	203,041	185,332	62,415	-	247,747	164,985	51,183	-	524	216,692	\$277	\$129
	51,812	48,457	38,444	-	86,901	38,910	25,241	-	939	65,090	\$650	\$249
	882,110	664,753	339,647	3,757	1,008,157	639,729	223,577	18,300	116	881,722	\$219	\$108
	1,191,252	1,091,553	359,394	3,112	1,454,059	967,397	327,255	1,355	33,509	1,329,516	\$194	\$84
	9,000	8,257	3,282	-	11,539	7,078	2,714	-	7	9,799	\$384	\$163
	62,572	64,368	20,458	-	84,826	53,197	13,585	-	287	67,069	\$340	\$149
	61,052	46,558	26,145	-	72,703	41,342	20,443	-	-	61,785	\$263	\$128
	77,864	66,354	38,739	-	105,093	58,596	34,307	-	-	92,903	\$243	\$114
	82,305	89,735	15,807	-	105,541	83,132	9,199	-	227	92,558	\$248	\$122
	28,032	20,365	9,041	-	29,406	17,846	6,866	-	114	24,826	\$150	\$78
	3,159,610	2,991,314	1,118,123	3,475	4,112,912	2,608,389	862,210	1,971	33,555	3,506,125	\$240	\$120
	164,919	160,772	63,388	1,195	225,356	135,570	46,032	619	4,074	186,295	\$300	\$122
	30,436	31,469	13,056	-	44,525	27,480	9,819	-	648	37,947	\$291	\$136
	10,954	11,667	5,136	-	16,803	8,821	3,846	-	168	12,835	\$360	\$147
	818,436	669,129	320,356	1,822	991,306	595,163	221,887	987	22,874	840,911	\$216	\$110
	52,333	51,063	22,014	24	73,100	42,244	19,834	5	1,005	63,088	\$300	\$129
	13,545	15,894	6,016	-	21,910	13,999	5,663	-	214	19,876	\$306	\$143
	44,229	44,859	24,796	-	69,655	36,321	21,516	-	11	57,848	\$262	\$98
	33,894	37,765	13,816	-	51,581	31,341	10,462	-	25	41,828	\$388	\$161
	51,926	60,529	31,485	-	92,014	53,785	23,586	-	33	77,404	\$357	\$164
	3,878	5,428	3,981	-	9,408	3,793	3,116	-	122	7,032	\$750	\$396
	51,663	59,359	20,722	45	80,126	50,648	15,476	-	939	67,063	\$409	\$187
	45,481	49,585	17,283	-	66,868	41,991	11,775	-	57	53,823	\$328	\$158
	215,435	232,701	96,928	117	329,746	198,448	84,839	23	7,555	290,864	\$227	\$105
	8,534	8,315	3,573	-	11,888	7,703	2,971	-	20	10,694	\$236	\$111
	103,083	84,370	29,071	678	114,119	75,560	22,479	353	1,525	99,917	\$225	\$97

Health-related business

All figures \$'000	Revenue				Expenses			
	Overseas students health cover	Overseas visitors cover	Other health- related activities	Total revenue	Overseas students health cover	Overseas visitors cover	Other health- related activities	Total Expenses
Industry	70,756	169,864	126,045	366,665	82,721	125,213	122,169	330,103
ACA	-	-	-	-	-	-	-	-
AHM	10,934	-	37,120	48,054	12,830	-	36,082	48,911
AUHL	-	6,365	-	6,365	-	5,315	-	5,315
BUPA	4,200	47,491	-	51,691	3,596	27,399	-	30,995
CBHS	-	-	-	-	-	-	-	-
CDH	-	-	-	-	-	-	-	-
CUA	-	-	-	-	-	-	-	-
Defence	-	-	-	-	-	-	-	-
DHF	-	-	-	-	-	-	-	-
GMHBA	-	-	-	-	-	-	-	-
GUC	-	13,327	-	13,327	-	13,204	-	13,204
HBF	-	4,031	-	4,031	-	2,526	-	2,526
HCF	-	1,525	40,049	41,574	-	652	40,049	40,701
HCI	-	-	-	-	-	-	-	-
H'guard	-	-	374	374	-	-	272	272
HIF	-	756	-	756	-	385	-	385
H'Partners	-	-	21,539	21,539	-	-	18,962	18,962
Latrobe	-	-	-	-	-	-	-	-
Mildura	-	-	6,825	6,825	-	-	6,539	6,539
MPL	54,772	79,523	-	134,295	64,561	59,260	-	123,821
MU	-	854	-	854	-	531	-	531
Navy	-	-	84	84	-	-	75	75
NHBA	-	-	-	-	-	-	-	-
NIB	550	15,992	415	16,957	1,600	15,940	-	17,541
Peoplecare	300	-	-	300	133	-	-	133
Phoenix	-	-	-	-	-	-	-	-
Police	-	-	-	-	-	-	-	-
QCH	-	-	-	-	-	-	-	-
QTUH	-	-	7,838	7,838	-	-	8,888	8,888
RBHS	-	-	-	-	-	-	-	-
RT	-	-	-	-	-	-	-	-
St Luke's	-	-	-	-	-	-	-	-
TFH	-	-	6,031	6,031	-	-	5,989	5,989
Transport	-	-	-	-	-	-	-	-
Westfund	-	-	5,769	5,769	-	-	5,313	5,313

Legislation index

The legislation index provides details of Acts and Rules that govern the private health insurance industry or the practices of private health insurers. It includes legislation relevant to private health insurers, policyholders of health benefit funds and health insurance related government agencies. Full versions of most Commonwealth Legislation are available at www.comlaw.gov.au.

This index was updated at the time of writing. Rules are subject to unincorporated amendments; for the most up-to-date version/s check the home page for each Rule on the comlaw website. The start dates refer to the date on which the current compilation became effective.

Commonwealth Acts

Corporations Act 2001

Act compilation (current): C2011C00910
Administering department: AG, Treasury

Start date: 1 July 2011

An Act to make provision in relation to corporations and financial products and services, and for other purposes.

Health Insurance Act 1973

Act compilation (current): C2011C00618
Administering department: Health

Start date: 27 July 2011

An Act providing for payments by way of medical benefits and payments for hospital services and for other purposes.

Health Legislation Amendment Act 2007

Act compilation (current): C2007A00180
Administering department: Health

Date of assent: 28 September 2007

An Act to amend the law in relation to health and private health insurance, and for related purposes.

Medicare Levy Act 1986

Act compilation (current): C2011C00451
Administering department: Treasury

Start date: 27 June 2011

An Act to impose a Medicare Levy upon certain incomes.

Privacy Act 1988

Act compilation (current): C2011C00503
Administering department: AG, PMC

Start date: 28 June 2011

An Act to make provision to protect the privacy of individuals, and for related purposes.

Private Health Insurance Act 2007

Act compilation (current): C2011C00703
Administering department: Health

Start date: 1 July 2011

An Act to regulate private health insurance, and for related purposes.

Private Health Insurance (Collapsed Insurer Levy) Act 2003

Act compilation (current): C2007C00197
Administering department: Health

Start date: 1 April 2007

An Act to impose a levy to be known as the collapsed insurer levy on private health insurers.

Private Health Insurance (Complaints Levy) Act 1995

Act compilation (current): C2007C00198
Administering department: Health

Start date: 1 April 2007

An Act to impose a levy on health insurance business conducted by private health insurers.

Private Health Insurance (Council Administration Levy) Act 2003

Act compilation (current): C2007C00189
Administering department: Health

Start date: 1 April 2007

An Act to impose a levy to be known as the Council administration levy on private health insurers.

Private Health Insurance (Risk Equalisation Levy) Act 2003

Act compilation (current): C2007C00193
Administering department: Health

Start date: 1 April 2007

An Act to impose a levy to be known as the Risk equalisation levy on private health insurers.

Private Health Insurance (Transitional Provisions and Consequential Amendments) Act 2007

Act compilation (current): C2011C00456
Administering department: Health

Date of assent: 1 July 2011

An Act to provide for transitional matters, and make consequential amendments, relating to the enactment of the PHI Act.

Taxation Laws Amendment (Private Health Insurance) Act 1998

Act compilation (current): C2004C01243
Administering department: Treasury

Start date: 3 July 2002

An Act to amend the law relating to income tax in respect of private health insurance.

Trade Practices Act 1974

Act compilation (current): C2011C00894
Administering department: DBCDE,
Infrastructure, DIISR, Treasury

Start date: 19 April 2011

An Act relating to certain trade practices.

Commonwealth Rules

Private Health Insurance (Accreditation) Rules 2008

Legislative instrument: F2008L02106
Administering department: Health

Date of making: 12 June 2008

These Rules provide for matters required or permitted by section 81-1 of the PHI Act or necessary or convenient to be provided in order to carry out or give effect to that section of the Act.

Private Health Insurance (Benefit Requirements) Rules 2011

Legislative instrument: F2011L02160
Administering department: Health

Date of making: 26 October 2011

These Rules provide for the minimum benefit requirements for psychiatric, rehabilitation and palliative care and other hospital treatment.

Private Health Insurance (Council Administration Levy) Rules 2007

Legislative instrument: F2011C00383

Administering department: Health

Start date: 1 July 2011

These Rules specify the rate of Council Administration Levy, and also specify Council Administration Levy days, and the census day.

Private Health Insurance (Council) Rules 2007

Legislative instrument: F2007L00899

Administering department: Health

Date of making: 30 March 2007

These Rules specify matters relating to the public information functions of PHIAC and the periods of appointment for the Commissioner of PHIAC, Deputy Commissioner and members of the council.

Private Health Insurance (Complaints Levy) Rules 2007

Legislative instrument: F2011C00143

Administering department: Health

Start date: 18 December 2010

These Rules specify the rate of Complaints Levy and also specify Complaints Levy days and the census day.

Private Health Insurance (Complying Product) Amendment Rules 2008 (No. 2)

Legislative instrument: F2009L00433

Administering department: Health

Date of making: 6 February 2009

These Rules amend the *Private Health Insurance (Complying Product) Rules 2008 (No. 2)* to alter the Nursing Home Type Patient contribution at public hospitals in Western Australia.

Private Health Insurance (Data Provision) Rules 2011

Legislative instrument: F2011L01079

Administering department: Health

Date of making: 214 June 2011

These Rules specify the kinds of information relating to the treatment of insured persons that private health insurers are to give to the Secretary of the Department of Health and Ageing.

Private Health Insurance (Health Benefits Fund Administration) Rules 2007

Legislative instrument: F2008C00605

Administering department: Health

Start date: 15 November 2008

These Rules are made by PHIAC under item 1 of the table in section 333–25 for the purposes of part 4–4 of the PHI Act. These Rules specify requirements for the administration and operation of health benefits funds, including requirements about the expenditure and application of fund assets, restructure of health benefits funds and merger and acquisition of health benefits funds. These Rules specify risk equalisation jurisdictions for the purposes of the Act and establish Solvency and Capital Adequacy Standards for the conduct of health benefits funds.

Private Health Insurance (Health Benefits Fund Enforcement) Rules 2007

Legislative instrument: F2007L00901

Administering department: Health

Date of making: 30 March 2007

These Rules deal with the external management of health benefits funds.

Private Health Insurance (Health Benefits Fund Policy) Rules 2007 (No. 3)

Legislative instrument: F2007L04453

Administering department: Health

Date of making: 22 November 2007

These Rules provide limitations on the amount of brokerage and commission that can be paid in respect of health insurance premiums. These Rules revoke and replace the *Private Health Insurance (Health Benefits Fund Policy) Rules 2007 (No. 2)*.

Private Health Insurance (Health Insurance Business) Rules 2010

Legislative Instrument: F201100585

Administering department: Health

Start date: 21 July 2011

These Rules revoke and replace the *Private Health Insurance (Health Insurance Business) Rules 2009* and provide for private health insurers to expand hospital products to cover a broader range of services that substitute for or prevent hospitalisation, and categorise privately insured services as being hospital or general treatment.

Private Health Insurance (Incentives) Rules 2007

Legislative Instrument: F2007L00903

Administering department: Health

Date of making: 30 March 2007

These Rules provide for matters relating to the premiums reductions scheme and the incentive payments which give effect to the private health insurance rebate.

Private Health Insurance (Insurer Obligations) Rules 2009

Legislative instrument: F2011C00703

Administering department: Health

Start date: 24 August 2011

These Rules revoke the *Private Health Insurance (Insurer Obligations) Rules 2007* and establish prudential standards for private health insurers that set minimum requirements for the governance arrangements of private health insurers, specify appointed actuary requirements of private health insurers and detail reporting and notification requirements for private health insurers.

Private Health Insurance (Levy Administration) Rules 2010

Legislative instrument: F2010L00144

Administering department: Health

Date of making: 14 January 2010

These Rules revoke the *Private Health Insurance (Levy Administration) Rules 2007* and make a new set of rules with the addition of a new rule 8.

Private Health Insurance (Lifetime Health Cover) Rules 2007

Legislative instrument: F2007L00906

Administering department: Health

Date of making: 30 March 2007

These Rules set out administrative matters relating to Lifetime Health Cover.

Private Health Insurance (Ombudsman) Rules 2007

Legislative instrument: F2007L00907

Administering department: Health

Date of making: 30 March 2007

These Rules deal with requirements in relation to the appointment of the PHIO and with requirements relating to mediation.

Private Health Insurance (Prostheses Application and Listing Fee) Rules 2008 (No. 1)

Legislative instrument: F2009C00276

Administering department: Health

Start date: 15 January 2009

These Rules provide for the fees for human tissue prosthesis and other prosthesis, and revoke *Private Health Insurance (Prostheses Application and Listing Fee) Rules 2007* (No. 2).

Private Health Insurance (Prostheses) Rules 2011 (No. 2)

Legislative instrument: F2011C00765

Administering department: Health

Start date: 05 September 2011

These Rules list the kinds of prostheses that attract benefits, and specify circumstances and conditions which must be satisfied in order for a benefit to be payable for the provision of those kinds of prostheses.

Private Health Insurance (Registration) Rules 2009 (No. 2)

Legislative instrument: F2009L02701

Administering department: Health

Date of making: 3 July 2009

These Rules revoke and replace the *Private Health Insurance (Registration) Rules 2009* to provide for changes following the change of name of a listed entity.

Private Health Insurance (Risk Equalisation Administration) Rules 2007

Legislative instrument: F2011C00173

Administering department: Health

Start date: 30 March 2011

These Rules are made by PHIAC under item 3 of the table in section 333-25, for the purposes of Part 6-7 of the *PHI Act*.

Private Health Insurance (Risk Equalisation Levy) Rules 2007

Legislative instrument: F2007L00911

Administering department: Health

Date of making: 30 March 2007

These Rules specify the 21st day of the second month of each quarter as a Risk Equalisation Levy day for a financial year.

Private Health Insurance (Risk Equalisation Policy) Rules 2007

Legislative instrument: F2007L00912

Administering department: Health

Date of making: 30 March 2007

These Rules specify what the 'eligible benefits' are to be paid for by a private health insurer.

Private Health Insurance (Transition) Rules 2007

Legislative instrument: F2008C00163

Administering department: Health

Start date: 8 March 2008

The purpose of the Rules is to deal with transitional matters not otherwise provided for in the *Transitional Provisions Act*.

Private Patients' Hospital Charter

Legislative instrument: F2006L01224

Administering department: Health

Date of making: 14 April 2006

Rights and responsibilities as a private patient in hospital. This statement revokes all previous statements issued under section 73F of the *National Health Act 1953*.

State Legislation

Australian Capital Territory

Full versions of territory legislation are available at www.legislation.act.gov.au.

Emergencies Act 2004

Act number: A2011-28 R17 (current)
Effective: 21 September 2011

Fair Trading Act 1992

Act number: A2011-49 R26 (current)
Effective: 23 November 2011

New South Wales

Full versions of state legislation are available at www.legislation.nsw.gov.au.

Health Insurance Levies Act 1982 No 159

Act number: 159
Current version for: 28 June 2010

Fair Trading Act 1987 No 68

Act number: 68
Current version for: 8 July 2011

Victoria

Full versions of state legislation are available at www.legislation.vic.gov.au.

Fair Trading Act 1999

Act no. 16/1999, version 047
Effective date: 1 November 2010

Queensland

Full versions of state legislation are available at www.legislation.qld.gov.au.

Fair Trading Act 1989

Reprint No. 7G
Reprinted: 1 January 2011

Subordinate legislation: Fair Trading Regulation 2001

South Australia

Full versions of state legislation are available at www.legislation.sa.gov.au.

Fair Trading Act 1987

Version: 1.1.2011
Gazette 14.12.1993 p2965

Subordinate legislation: Fair Trading (General) Regulations 1999

Western Australia

Full versions of state legislation are available at www.slp.wa.gov.au.

Fair Trading Act 1987

Act No. 108 of 1987
Currency Start: 26 October 2011

Tasmania

Full versions of state legislation are available at www.thelaw.tas.gov.au.

Fair Trading Act 1990

Royal Assent: 29 November 1990
Current view: 1 August 2004

An Act to make provision with respect to certain unfair or undesirable trade practices and with respect to incidental matters.

Northern Territory

Full versions of territory legislation are available at www.nt.gov.au

Consumer Affairs and Fair Trading Act

In force: 21 September 2011
Reprint number: REPC062

Glossary

Acute accommodation/patient

An episode of acute care for an admitted patient where the principal clinical intent is to:

- manage labour (obstetric)
- cure illness or provide definitive treatment of injury
- perform surgery
- relieve symptoms of illness or injury (excluding palliative care)
- reduce severity of illness or injury
- protect against exacerbation or complication of an illness or injury which could threaten life or normal functions
- perform diagnostic or therapeutic procedures.

This does not include nursing home type patients.

Age based pool (ABP)

Age cohorts	Age % of eligible benefits included in pool
0–54	0.0%
55–59	15.0%
60–64	42.5%
65–69	60.0%
70–74	70.0%
75–79	76.0%
80–84	78.0%
85+	82.0%

The age based pool equalises benefits for the Risk Equalisation Levy. Pooling is based on adding a proportion of applicable benefits, 55 and above, in a sliding scale. Applicable benefits include benefits paid for hospital and hospital-substitute, and medical benefits associated with those hospital services, as well

as eligible benefits paid for chronic disease management programs. The amount to be notionally allocated to the ABP in a quarter is to be calculated in accordance with the formula pC , where:

- p is the percentage of the eligible benefit paid having regard to the age cohort, as specified in the ABP table, into which the insured person falls on the day or days on which the insured person receives the treatment to which the eligible benefit relates, and
- C is the gross benefit in the current quarter for the age cohort.

Agreement

An agreement entered into between a medical practitioner, within the meaning of that term in subsection 3 (1) of the Health Insurance Act 1973, and an insurer under which the practitioner agrees to accept payment by the insurer in satisfaction of the amount that would, apart from the agreement, be owed to the practitioner in relation to the treatment provided to the insured person.

Benefits

The financial section of this report refers to benefits reported in financial statements which are determined by application of accounting standards and are accrual based. These include claims incurred but not reported and claims that are processed but not yet paid. All other benefit statistics refer to benefits paid for hospital treatment and general treatment services and differ as they are derived on a cash basis.

Broader Health Cover Services

Services covers services that prevent, are part of, or substitute for hospitalisation. General practice services and accommodation costs of residential aged care facilities are not covered by BHC.

Calculated deficit

Each organisation's share of the state risk equalisation pool. The figure is calculated by multiplying the organisation's average SEUs by the average gross deficit (per SEU) for the state.

Chronic disease management program

A CDMP is intended to reduce complications in a person with a diagnosed chronic disease and prevent or delay the onset of chronic disease for a person with identified multiple risk factors for chronic disease.

Community rating

Means that health funds cannot charge members different premiums for the same level of cover because of their age (other than age at entry), claims history, gender, health or place of residence.

Complying health insurance policy

A complying health insurance policy is an insurance policy that meets:

- a) the community rating requirements
- b) the coverage requirements
- c) if the policy covers hospital treatment – the benefit requirements
- d) the waiting period requirements
- e) the portability requirements
- f) the quality assurance requirements
- g) any requirements set out in the Private Health Insurance (Complying Product) Rules for the purposes of this paragraph.

Complying health insurance product

A complying health insurance product is a product made up of complying health insurance policies.

Eligible benefits for risk equalisation

Benefits paid by an insurer for any of the following:

- hospital treatment
- hospital-substitute treatment
- planning and coordination services for CDMP
- allied health services which are provided as part of a CDMP.

Episode

The period of admitted patient care between a formal or statistical admission and a formal or statistical separation (for example, discharge, death) characterised by only one care type.

Excess and co-payments

Are an amount of money a policyholder agrees to pay before private health insurance benefits are payable.

For-profit organisation

An insurer that is registered, or taken to be registered, under part 4–3 of the PHI Act as a for-profit insurer. For-profit insurers are subject to different requirements regarding the assets contained in its health benefits fund/s (see division 137 of the PHI Act) and are subject to income tax (also see not-for-profit organisation).

General treatment

Treatment (including the provision of goods and services) that is intended to manage or prevent a disease, injury or condition and is not hospital treatment.

General treatment ambulance only

Means policies that cover ambulance services but do not cover any other hospital or general treatment.

Gross margin

The difference between total contribution income and total cost of benefits, which include state levies, expressed as a percentage or in dollar terms.

Health insurance business

The business of undertaking liability, by way of insurance or an employee health benefits scheme, that relates to hospital treatment and general treatment.

Health-related business

Any one or more of the following:

- a) a business of providing goods or services (or both) to manage or prevent diseases, injuries or conditions
- b) a business of undertaking liability, by way of insurance, to indemnify people who are ineligible for Medicare for costs associated with providing treatment, goods or services that are provided to:
 - i. those people in Australia
 - ii. manage or prevent diseases, injuries or conditions.
- c) a business of providing a financial service to assist people insured under complying health insurance products to meet the costs associated with treatment, goods or services that are provided to manage or prevent diseases, injuries or conditions
- d) any other business, or business included in a class of businesses, specified in the Private Health Insurance (Health Benefits Fund Policy) Rules for the purposes of this paragraph.

Hospital treatment

Treatment (including the provision of goods and services) that is:

- a) intended to manage a disease, injury or condition
- b) provided to a person:
 - i. by a person who is authorised by a hospital to provide the treatment
 - ii. under the management or control of such a person.
- c) either:
 - i. provided at a hospital
 - ii. provided or arranged with the direct involvement of a hospital.

Hospital treatment memberships are categorised by family type: single, family, single parent, couple, 2+ persons no adults, and 3+ adults. Hospital treatment membership is further classified by whether the product has exclusions and whether the product is subject to an excess or co-payment.

Hospital-substitute treatment

Means general treatment that:

- a) substitutes for an episode of hospital treatment
- b) is any of, or any combination of nursing, medical, surgical, podiatric surgical, diagnostic, therapeutic, prosthetic, pharmacological, pathology or other services or goods intended to manage a disease, injury or condition
- c) is not specified in the Private Health Insurance (Complying Product) Rules as a treatment that is excluded from this definition
- d) must be part of a hospital treatment policy.

Ineligible Benefits

Includes other benefits paid by an insurer that are not eligible. (see eligible benefits)

Insured person

All persons covered by health insurance policies.

Joint policy

For the purpose of the Council Administration Levy, means a policy under which two or more persons are insured.

Known gap agreement

An agreement where the medical practitioner agrees to accept a payment by the insurer in part satisfaction of the amount owed and the patient has provided informed financial consent so that the gap or out-of-pocket expenses to be paid by the insured person are known in advance.

Length of stay

The time a patient stays in hospital treatment for an episode of care, measured in patient days. A same-day patient is allocated a length of stay of one patient day. The length of stay of an overnight stay patient is calculated by subtracting the date the patient is admitted from the date of separation.

Lifetime Health Cover

A private health insurer must increase the amount of premiums payable for hospital cover in respect of an adult if the adult did not have hospital cover on his or her Lifetime Health Cover base day (generally the 1 July following the adult's 31st birthday). The penalty is 2% above the base rate for each year over 30 at the time of joining. Exceptions to this are:

- people born on or before 1 July 1934
- people over 31 and overseas on 1 July 2000
- persons yet to turn 31.

The maximum loading a person can be required to pay is 70%, payable by people who first take out hospital treatment cover at age 65 or older. A private health insurer must stop charging premiums above the base rate for hospital cover in respect of an adult, if the adult has had hospital cover for a continuous period of 10 years (commencing from 1 April 2007).

Management expenses

The operating expenses incurred in the course of normal fund operations (i.e. salaries, commission, rent). The percentage relationship between management expenses and contribution income will be influenced by such factors as the structure of an organisation, the level of contribution rates, assistance from employers in the case of some restricted access insurers, and establishment costs for new organisations.

Market Share

The proportion of policyholders that each insurer holds in comparison with total policies, expressed as a percentage.

Medicare Benefits Schedule

A fee set by the Australian Government for services provided by medical professionals for which a rebate is payable.

Medicare Benefits Schedule Fee rebate

The government provides a rebate on some medical fees as listed in the Medicare Benefits Schedule (MBS). This rebate is currently 75% of the MBS fee for part of an episode of hospital treatment or hospital-substitute treatment, and 85% of the MBS fee for medical fees incurred out-of-hospital.

Medicare Levy Surcharge

An Australian Government private health insurance initiative to encourage high-income earners to take out private health insurance. The surcharge imposes an additional 1% on top of the Medicare levy for high-income earners who are not policyholders of private hospital treatment cover offered by an insurer, or to high-income earners with a maximum excess of \$500 a year for single policies, or more than \$1,000 for all other policies.

The income thresholds that applied in 2009–10 were \$73,000 for a single person with no dependents and \$146,000 for couples and families. The threshold increases by \$1,500 for each child in excess of one (for example, a couple with two children would have a threshold of \$147,500). For the 2010–11 financial year, the MLS income thresholds will be \$77,000 for a single person and \$154,000 for families, plus \$1,500 for each dependent child after the first.

Membership statistics

Refer to an insurer's number of policies and the number of insured persons covered under those policies (coverage).

Net margin

Gross margin less management expenses, expressed as a percentage of contribution income.

No gap agreement

An agreement where the medical practitioner agrees to accept a payment by the insurer in full satisfaction of the amount owed so that there is no gap, or no out-of-pocket expenses to be paid by the insured patient.

Not-for-profit

An insurer that is registered, or taken to be registered, under part 4–3 of the PHI Act as a not-for-profit insurer. Not-for-profit insurers are exempt from income tax under section 50–30 of the Income Tax Assessment Act 1997.

Nursing home type patient

Means a patient in the hospital who has been provided with accommodation and nursing care, as an end in itself, for a continuous period exceeding 35 days.

Open access insurer

Open health benefits funds have no restrictions on who may join.

Outstanding claims

Claims that have been:

- reported and have not yet been settled
- incurred but not yet reported (incurred but not reported)
- incurred but not yet fully settled (incurred but not enough reported)
- administratively finalised but which may be reopened.

Payments to or from RETF

The net amount paid or payable to or from the RETF in respect of the financial year. A negative figure denotes a payment to the pool.

Percentage point

A unit expressing the difference between two percentages. A fall from 10% to 9% would be a fall of one percentage point.

Policyholder

A holder of a policy that is referable to a health benefits fund.

Private health insurance policy

An insurance policy that covers hospital treatment or general treatment or both (whether or not it also covers any other treatment or provides a benefit for anything else).

Private Health Insurance Rebate

Applies to all people, provided that they are eligible for Medicare and have purchased a complying health insurance product that provides hospital treatment cover, general treatment cover or both. The rebate is usually applied at a rate of 30% of the total premium. It increases to 35% for policyholders aged between 65 and 69 years, and 40% for policyholders aged 70 years and over.

Prudential standards

The standards currently in force are:

- Solvency standard – schedule 2 of the *Private Health Insurance (Health Benefits Fund Administration) Rules 2007*
- Capital adequacy standard – schedule 3 of the *Private Health Insurance (Health Benefits Fund Administration) Rules 2007*
- Appointed actuary standard – schedule 2 of the *Private Health Insurance (Insurer Obligations) Rules 2009*
- Governance standard – schedule 1 of the *Private Health Insurance (Insurer Obligations) Rules 2009*.

Restricted access group

A group of people who all belong to a particular group, based on whether they:

- are or were employed in a particular profession, trade, industry or calling
- are or were employed by a particular employer or by an employer who belongs to a particular class of employees
- are or were members of a particular profession, professional association or union

- are or were members of the defence force or part of the defence force
- are or were part of any group described in the Private Health Insurance (Registration) Rules.

The partners and dependent children of people who belong to such a group are also taken to belong to that group.

Restricted access insurer

Insurers that are registered to offer complying health insurance products to a restricted access group, as per the insurer's constitution. Restricted access insurers are prohibited from issuing a complying health insurance product to a person who does not belong to the restricted access group.

Risk equalisation

A system for sharing the hospital treatment costs of high-risk groups and high cost claims between insurers that commenced on 1 April 2007. It is comprised of three elements:

- an age based pool—that shares the costs of treatment for people aged 55 and above
- a high cost claimants pool—that shares the costs of claims greater than \$50,000
- the transfer of money between insurers and the RETF, based on the experience and relative risk of their health benefits fund membership base.

Risk equalisation is an iteration of the previous arrangement known as reinsurance, and is a fundamental component of the system of community rating in the private health insurance industry. The operation of risk equalisation is governed by the *Private Health Insurance (Risk Equalisation Policy) Rules 2007* and the *Private Health Insurance (Risk Equalisation Administration) Rules 2007*.

Risk Equalisation Trust Fund

The pool of monies established on 1 April 2007 that is used for the risk equalisation arrangements that underpin community rating in private health insurance.

Rounding

Most monetary amounts shown in tables and figures have been rounded to the nearest \$1,000. Where numbers have been rounded, discrepancies may occur between sums of component items and totals. However, actual figures have been used in respect of the membership statistics reported. Most percentage amounts shown are rounded to one decimal place.

Separation

The process by which an episode of care for an admitted patient ceases. The mode of separation may be statistical, discharge, transfer or death.

Single equivalent unit (SEU)

SEUs are used as a standard measure, as the number of persons covered under a policy may vary. Single, 2+ persons no adults and single parent policies are counted as one SEU. Couple, family and 3+ adults are counted as two SEUs.

From 1 April 2007 the definition of SEUs changed. For example, single parent policies were previously counted as two SEUs. To keep a consistent data series, PHIAC has applied the new definition of SEUs to the historical calculation of SEUs.

Single policy

For the purpose of the Council Administration Levy, means a policy under which only one person is insured.

Solvency risk multiple

A measure of a health benefits fund's compliance with the Solvency Standard. The solvency risk multiple is calculated by dividing the capital of the health benefits fund by the solvency reserve (as calculated and defined in schedule 2 of the *Private Health Insurance (Health Benefits Fund Administration) Rules 2007*).

State levies

Amounts payable to the New South Wales and Australian Capital Territory governments in respect of levies on policyholders of insurers for ambulance cover.

Unearned premium liabilities

The liability determined in respect of premiums paid in advance, being premiums paid for policies prior to the date of valuation which provide cover in respect of some period beyond the valuation date.

Waiting periods

The waiting period that applies to a person for a benefit under an insurance policy.

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PROTECTING CONSUMERS OF PRIVATE HEALTH INSURANCE
BY ENSURING A WELL-RUN AND COMPETITIVE INDUSTRY