



Australian Government

Private Health Insurance Administration Council

Quarterly Statistics

June 2009

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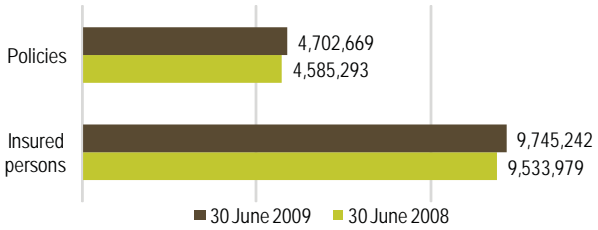
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Snapshot of the industry

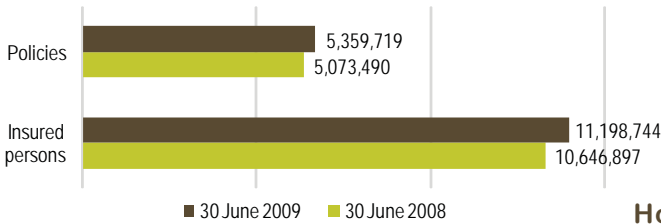
Hospital treatment membership



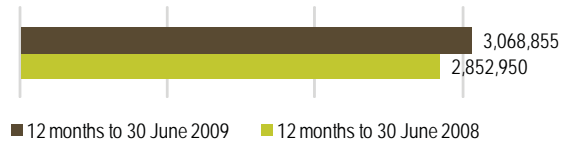
Hospital treatment membership
44.6% at 30 June 2009
no per cent change over the quarter
↑ 43,125 insured persons over the quarter

General treatment membership
51.3% at 30 June 2009
no per cent change over the quarter
↑ 58,091 insured persons over the quarter

General treatment membership



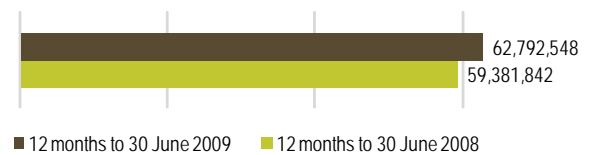
Hospital treatment episodes



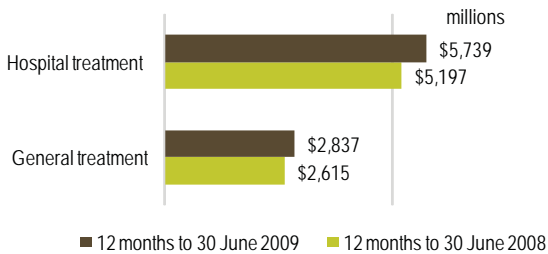
Hospital treatment episodes
↑ 7.6% over the 12 months to June 2009
↑ 0.7% over the quarter

General treatment services (ancillary)
↑ 5.7% over the 12 months to June 2009
↑ 1.9% over the quarter

General treatment services (ancillary)



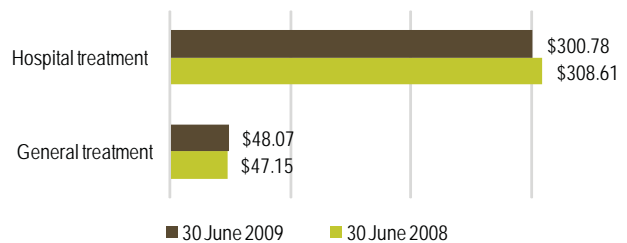
Benefits



Hospital treatment benefits
↑ 10.4% over the 12 months to June 2009
↑ 4.9% over the quarter

General treatment benefits
↑ 8.5% over the 12 months to June 2009
↑ 4.0% over the quarter

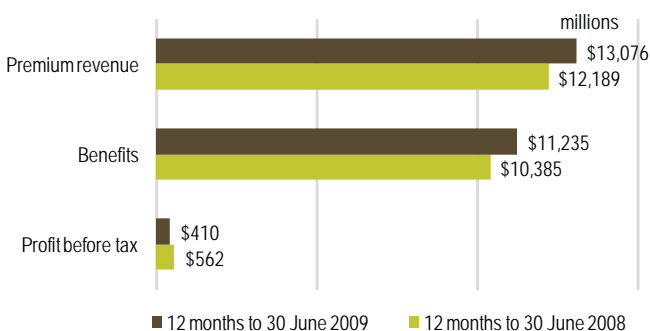
Out-of-pocket per episode/service



Hospital treatment out-of-pocket
\$300.78

General treatment out-of-pocket
\$48.07

Financial



Premium revenue
↑ 7.3%

Profit before tax
↓ 27.1%

Hospital treatment

At 30 June 2009, 9,745,242 persons, or 44.6% of the population, were covered by Hospital Treatment cover. There was no change in the percentage of the population covered, compared to the March 2009 quarter.

There was an increase in coverage of 43,125 insured persons in the June 2009 quarter. There was an increase of 16,893 single policies and an increase of 15,810 family policies during the quarter. There was a net increase of 32,703 hospital policies. Over the year, from 30 June 2008, the number of insured persons with hospital treatment cover has increased by 211,263 persons and 117,376 policies.

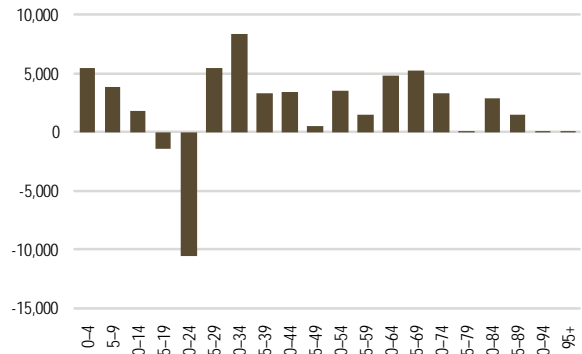
There was a notable decrease in coverage during the quarter of 10,570 persons for people aged 20 to 24. The largest increase was 8,345 for people aged 30 to 34. The increases in the older age groups are partly due to ageing of the insured population with people moving from younger to older age cohorts.

Lifetime health cover

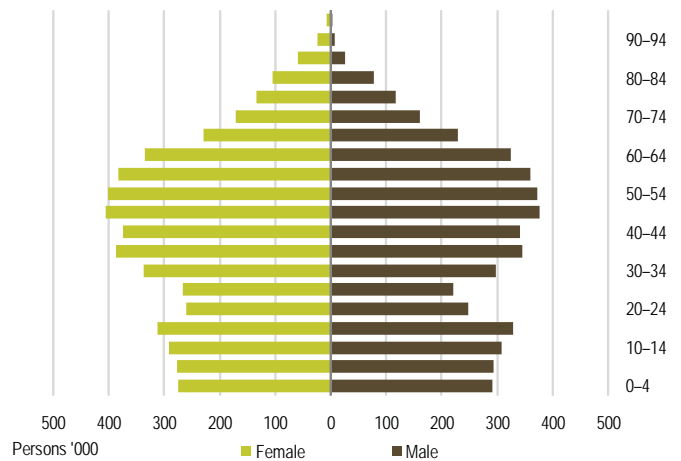
The majority of adults with hospital cover (89.2%) have a certified age of entry of 30, with no penalty loading. However, the proportion of adults with hospital cover paying a loading has increased every quarter since the introduction of Lifetime Health Cover.

At the end of the June 2009 quarter, there were 756,204 persons with a certified age of entry of more than 30 and subject to Lifetime Health Cover loading; a net increase in persons paying a penalty over the year of 86,898. There was a net increase in persons with a certified age of entry of 30 (with no penalty) over the year of 71,329.

Net quarterly change in insured persons



Number of insured persons by age



Hospital treatment tables

State/Territory	Insured persons (%)	Non insured persons (%)	Total insured persons	Male	Female	Single policies (%)	Family policies (%)
Aust.	44.6%	55.4%	4,717,652	5,027,590	48.1%	51.9%	
NSW	45.8%	54.2%	1,651,611	1,753,114	47.9%	52.1%	
Vic.	43.1%	56.9%	1,122,738	1,210,322	51.8%	48.2%	
Qld	42.4%	57.6%	901,569	965,157	45.5%	54.5%	
SA	44.7%	55.3%	347,992	376,392	48.6%	51.4%	
WA	50.2%	49.8%	552,149	569,894	45.1%	54.9%	
Tas.	43.1%	56.9%	103,654	113,154	48.9%	51.1%	
NT	34.6%	65.4%	37,939	39,557	45.1%	54.9%	

General treatment

At 30 June 2009, 11,198,744 persons or 51.3% of the population had some form of General Treatment cover. There was no change in the percentage of the population covered, compared to the March 2009 quarter.

There was an increase in coverage of 58,091 insured persons in the June 2009 quarter. There was an increase of 23,005 single policies and an increase of 19,988 family policies during the quarter. There was a net increase of 42,993 general treatment policies.

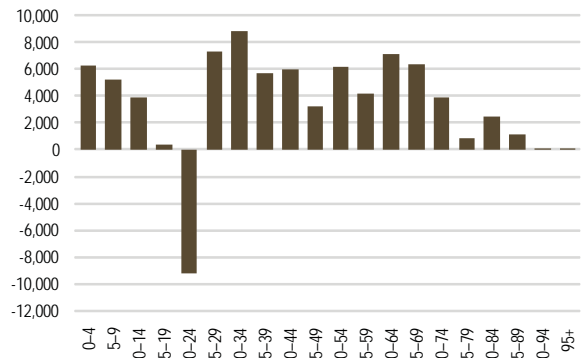
Over the year, to 30 June 2009, the number of insured persons with general treatment cover has increased by 551,847 persons and 286,229 policies.

The General Treatment (ancillary) by age charts and data in this reports show persons that have general treatment policies that cover ancillary services such as dental treatment, and excludes those General Treatment policies that do not cover ancillary treatment. The March 2009 quarter is the first quarter since March 2007 in which data is collected according to this definition. The aim of this change is to map the trend in ancillary coverage prior to 1 April 2007 to the current period.

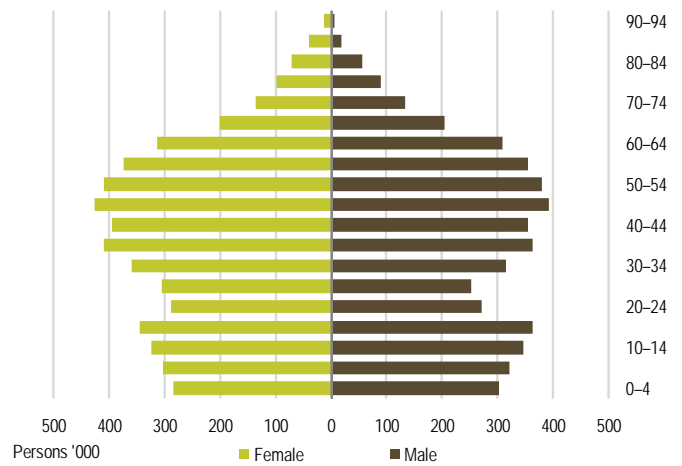
There was an increase in coverage of 70,219 persons with General Treatment ancillary coverage in the June 2009 quarter. The largest increases in coverage of 8,845 persons, was for people in the 30–34 age cohort.

The 20 to 29 age group historically has a lower proportion of persons with general treatment insurance compared to other age groups. There was a decrease in coverage of 9,201 for persons with ancillary coverage in the 20–24 age cohort in the June 2009 quarter.

Net quarterly change in insured persons (ancillary)



Number of insured persons by age (ancillary)



General treatment tables

State/Territory	Insured persons (%)	Not insured persons (%)	Total Insured Persons	Total Not Insured Persons	Single policies (%)	Family policies (%)
Aust.	51.3%	48.7%	4,815,629	5,116,967	48.0%	52.0%
NSW	53.9%	46.1%	1,745,695	1,840,275	47.3%	52.7%
Vic.	47.4%	52.6%	975,880	1,044,081	51.4%	48.6%
Qld	45.8%	54.2%	886,472	951,717	46.1%	53.9%
SA	55.0%	45.0%	398,954	432,974	48.5%	51.5%
WA	62.2%	37.8%	662,241	688,675	45.8%	54.2%
Tas.	47.9%	52.1%	108,637	119,382	49.4%	50.6%
NT	36.9%	63.1%	37,750	39,863	45.5%	54.5%

■ Insured persons ■ Not insured persons
Includes all general treatment persons

■ Male ■ Female
Includes only general treatment persons with ancillary coverage

■ Single policies ■ Family policies
Includes all general treatment persons

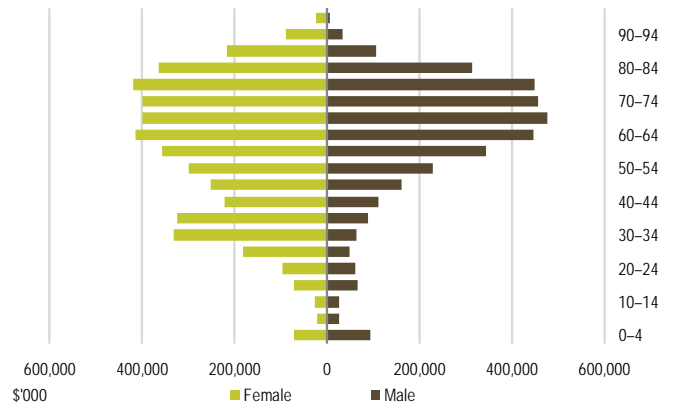
Benefits paid

Hospital treatment

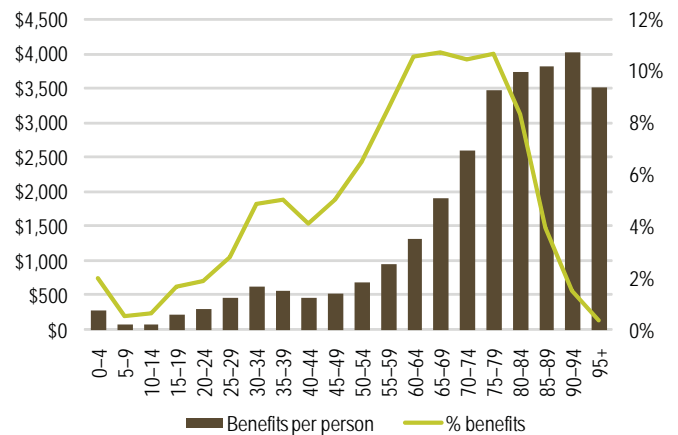
Benefits per episode/service

	June 2009	Change from March 2009
Hospital Treatment		
Acute	\$1,887.98	-1.7%
Medical	\$54.32	1.8%
Prostheses	\$775.71	-0.8%
Cardiac	\$5,808.67	-3.7%
Hips	\$2,628.35	0.6%
Knees	\$2,224.19	-1.3%
Lens	\$424.62	1.4%
Total benefits		
Hospital	\$2,100,707,656	2.2%
General	\$735,604,123	0.6%

Hospital treatment benefits paid by age 12 months to 30 June 2009



Hospital treatment benefits per person and percentage of benefits paid by age cohort



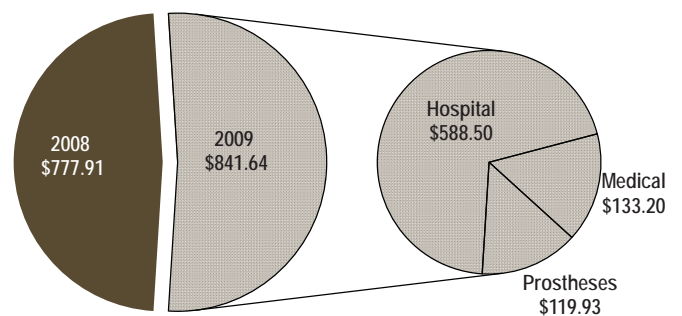
During the June 2009 quarter, insurers paid \$2,101 million in hospital treatment benefits. This was an increase of 2.2% compared to the March 2009 quarter. Hospital treatment benefits were comprised of:

- ◇ \$1,461 million for hospital services such as accommodation and nursing
- ◇ \$334 million for medical services
- ◇ \$304 million for prostheses items.

Benefits paid for hospital treatment by age and gender (top chart) show the total benefits paid in each age group. The age group for which most hospital benefits are paid is between 60 and 79. The benefits per person (middle chart) are affected by the age of the person and the number of persons in each age group. The older age groups have a higher claiming rate. The rise in benefits in 20–39 age cohorts is due to increases in female benefits associated with child bearing.

Hospital treatment benefits per person during the year increased from \$777.91 to \$841.64. The largest amount of benefits per person was spent on hospital accommodation and nursing, followed by medical and prostheses benefits.

Hospital treatment benefits per person

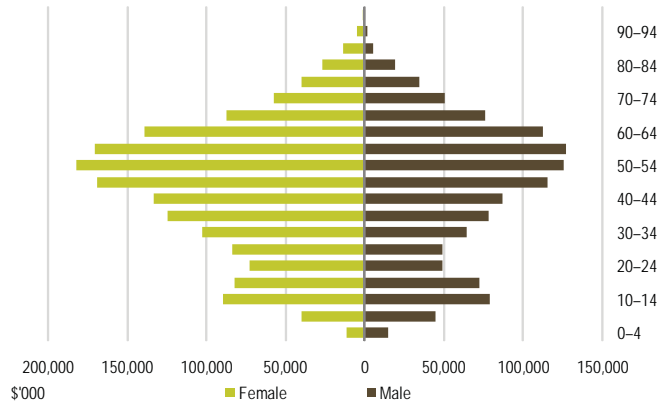


General treatment

Benefits per episode/service

	June 2009	Change from March 2009
General Treatment		
Dental	\$54.26	-1.1%
Chiropractic	\$24.36	-1.8%
Physiotherapy	\$27.99	-1.7%
Optical	\$65.24	-0.6%

General treatment benefits paid by age 12 months to 30 June 2009 (ancillary)

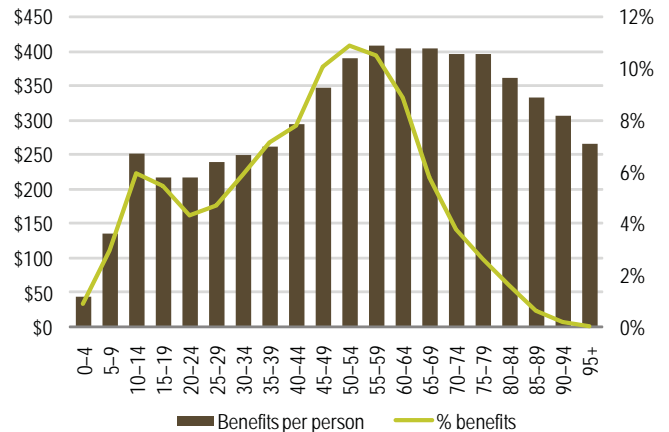


During the June 2009 quarter, insurers paid \$736 million in general treatment (ancillary) benefits. This was an increase of 0.6% compared to the March 2009 quarter. Ancillary benefits for the June quarter included the major categories of:

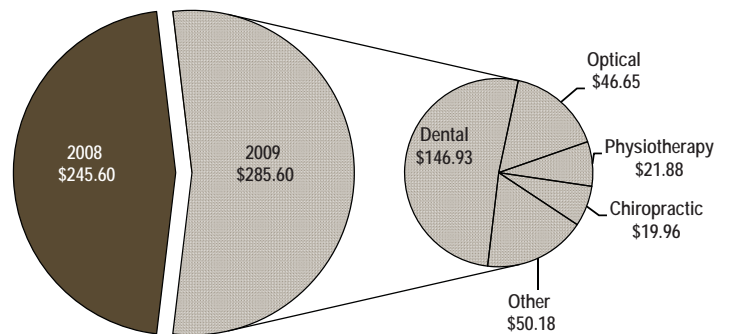
- ◇ Dental \$379 million
- ◇ Optical \$115 million
- ◇ Physiotherapy \$59 million
- ◇ Chiropractic \$54 million.

There is a marked difference between the distribution of benefits over age groups between hospital benefits and ancillary benefits. The major difference is the higher claiming rate in older age groups for hospital benefits while benefits per person for ancillary benefits are more evenly spread over the age groups.

General treatment benefits per person and percentage of benefits paid by age cohort (ancillary)



General treatment benefits per person (ancillary)



General treatment ancillary benefits per person during the year to June 2009 were \$285.60, increasing from \$245.60 in the year to June 2008. The largest component of ancillary benefits is dental for which \$146.93 was paid per person during the year to June 2009.

Medical benefits

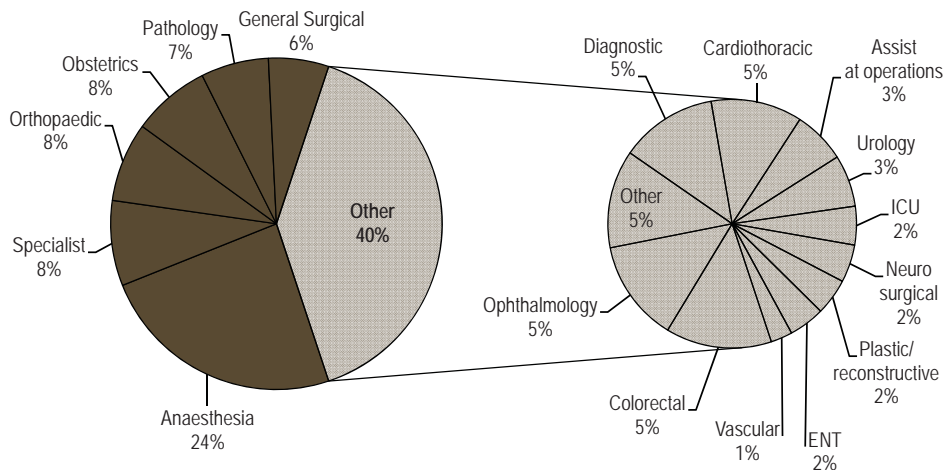
Total benefits for medical services increased 5.7% during the quarter and the number of medical services in the quarter increased by 3.8%. Benefits paid on average for the medical services increased 1.8% per service during the quarter.

The increase in medical benefits per service was calculated over a range of medical services and does not mean medical services overall increased in cost. The increase in benefits paid may reflect a change in the type of medical services utilised, or a change in the overall utilisation of medical services. The medical service for which the greatest amount of benefits was paid was anaesthetics, comprising 24% of all medical benefits and totalling \$80.364 million.

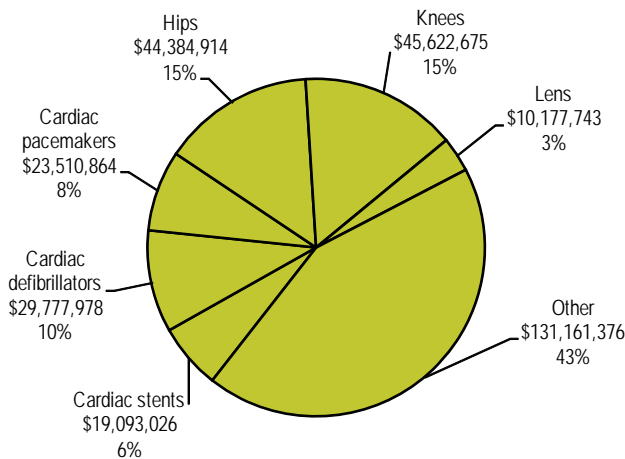
Prostheses benefits

Benefits paid for prostheses decreased 0.8% per prosthetic item during the quarter. Similar to medical services, the increase in benefits paid for prostheses was calculated over a range of prosthetics (see chart) and does not mean prostheses overall increased in cost. The increase in benefits paid may reflect a change in the type of prosthetics utilized, or a change in the overall utilisation of prosthetics. The prosthetic groups for which the greatest amount of benefits were paid were "hips" and "knees", comprising 15% each of all prosthetics and totalling close to \$45 million each. The combined cardiac group comprised 24% of all prosthetics and totalled \$72 million over the quarter.

Medical benefits paid by speciality group



Benefits paid for prostheses



Service utilisation

Episodes/Services by type

By Type	June 2009	Change from March 2009
Hospital Episodes	773,704	3.1%
Hospital Days	2,054,111	-1.1%
Medical Services	6,151,724	3.8%
Prostheses Items	391,560	3.7%
Cardiac	12,461	0.4%
Hips	16,887	7.3%
Knees	20,512	12.7%
Lens	23,969	24.5%
General Treatment Services	16,208,576	2.9%
Dental	6,975,521	3.5%
Chiropractic	2,199,026	4.7%
Physiotherapy	2,103,946	9.2%
Optical	1,756,368	-10.1%

Hospital utilisation is distributed over four categories of hospital: public, private, day only facilities and hospital substitute. During the June 2009 quarter hospital episodes were distributed as follows:

- ◇ public hospitals 110,931 episodes
- ◇ private hospitals 549,837 episodes
- ◇ day hospital facilities 108,913 episodes
- ◇ hospital-substitute 4,023 episodes.

Between the March 2009 and June 2009 quarters hospital utilisation increased in all categories of hospital. These increases continue the trend with increases in utilisation in all categories over the year from June 2008 to June 2009.

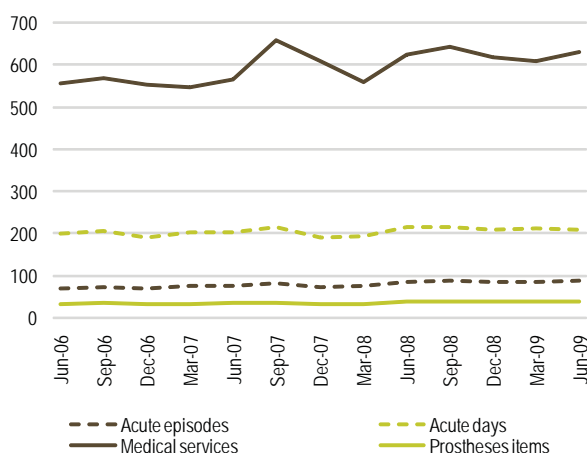
During the June 2009 quarter, insurers paid benefits for 2.054 million days in hospital, arising from 773,704 hospital episodes of care.

The average length of stay was 2.65 days; a decrease of 4.1% compared to the March 2009 quarter. The utilisation rates for hospital episodes, medical services and prostheses services increased during the quarter, continuing the general trend.

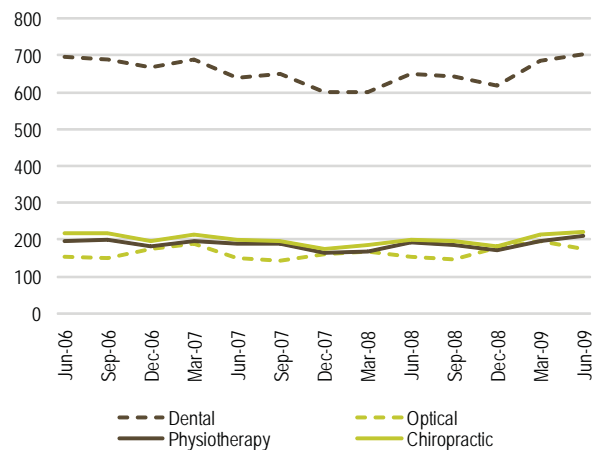
	Quarter change %	Year change %
◇ public hospitals	↑ 1.3	↑ 7.7
◇ private hospitals	↑ 2.6	↑ 7.5
◇ day hospital facilities	↑ 6.7	↑ 8.2
◇ hospital-substitute	↑ 43.4	↑ 0.4

Day-only episodes in the four categories of hospital totaled 482,343, an increase of 5.8% compared with the March 2009 quarter.

Hospital treatment services per 1,000 insured persons



General treatment services per 1,000 insured persons



Out-of-pocket payments

Average out-of-pocket per episode/service

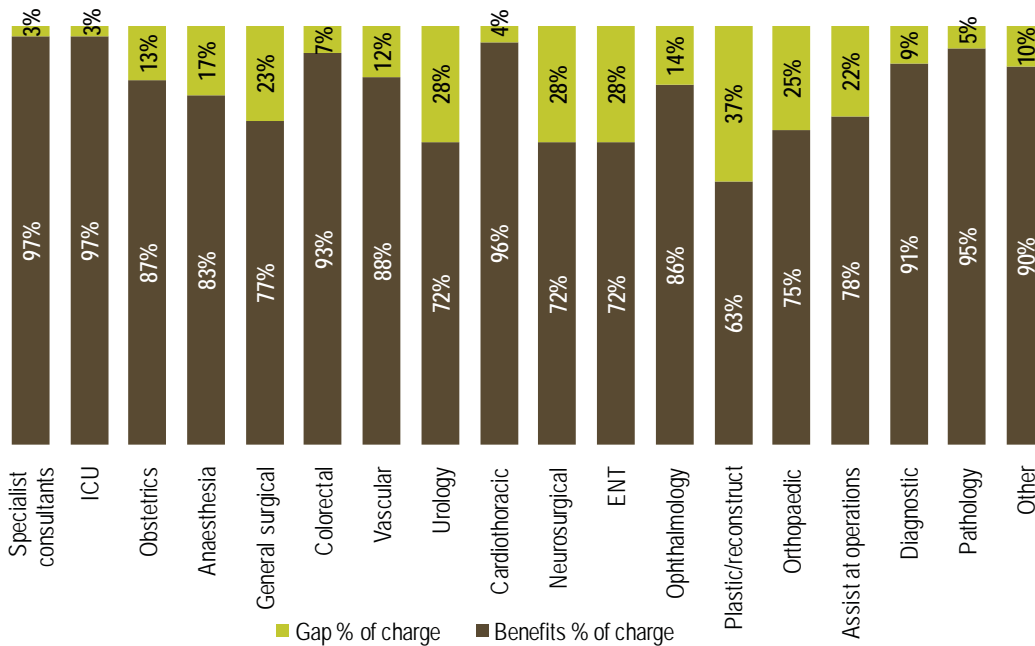
	June 2009	Change from March 2009	Change from June 2008
Hospital treatment	\$300.78	-2.1%	-2.5%
Hospital-substitute treatment	\$1.28	-49.7%	-63.1%
General treatment	\$48.07	-0.6%	1.9%
Prostheses where gap was paid	\$29.41	24.7%	-26.9%
Medical gap where gap was paid	\$145.44	1.6%	2.8%

The average out of pocket (gap) payment for a hospital episode was \$300.78 in the June 2009 quarter and included out-of-pocket payments for medical services and some prostheses as well as any excess or

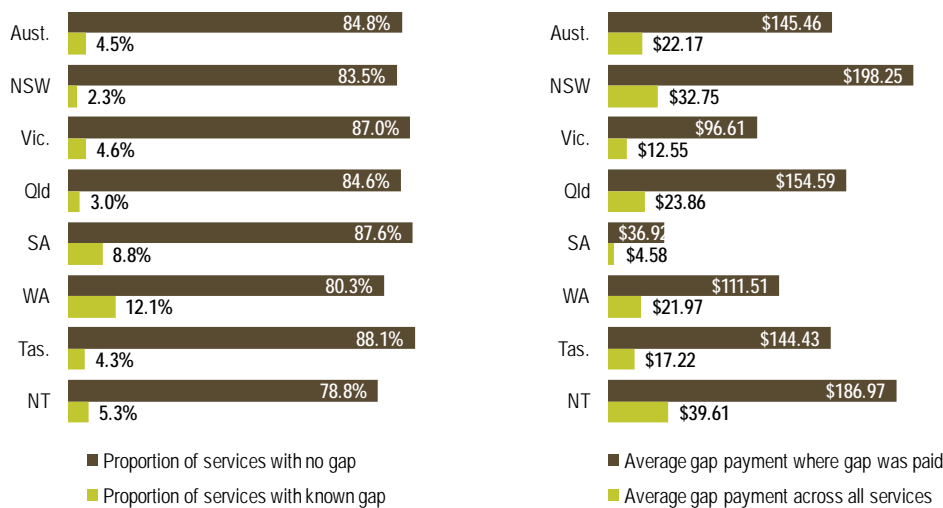
co-payment amounts relating to hospital accommodation. The out of pocket payments for hospital episodes decreased by 2.5% compared to the same quarter of the previous year.

Out of pocket payments for medical services were \$145.44 where an out of pocket payment was payable. The amount of gap for medical services varies depending on the specialty group. The specialty group with the largest out of pocket payment was plastic/reconstructive with an average gap of \$326.37, followed by orthopaedic with an average gap per service of \$267.15, followed by neurosurgical and then urology. Plastic/reconstructive medical services incurred the largest gap as a percent of the fee followed by "ear, nose and throat", neurosurgical and urology. The state with the highest amount of gap payment where gap was paid was New South Wales.

Medical benefits and out-of-pocket by speciality group



Proportion of services and average out-of-pocket payments



Financial information

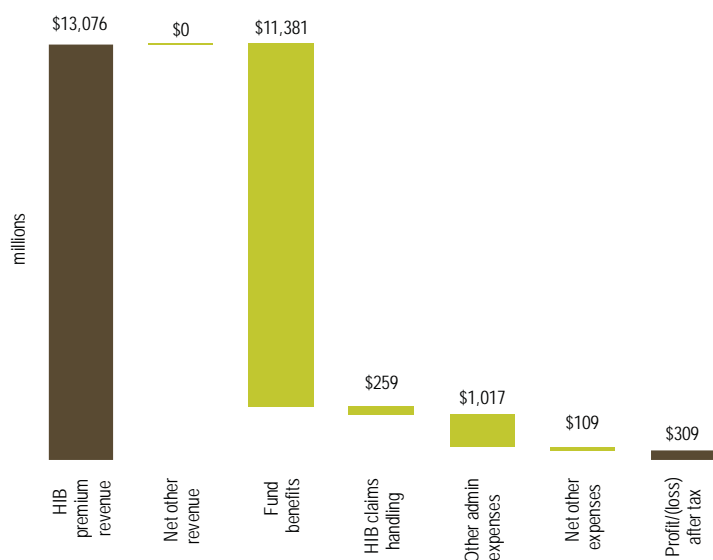
Financial performance

All Figures \$'000	12 months to June 2009 [†]	12 months to June 2008
Revenue		
HIB premium revenue	13,075,859	12,188,820
Net HRB and other revenue	(308)	48,949
Total revenue	13,075,551	12,237,769
Benefits		
Fund benefits	11,235,251	10,248,174
State ambulance levies	146,032	137,008
Total fund benefits	11,381,283	10,385,181
Expenses		
HIB expenses	1,017,055	1,032,323
HIB claims handling	258,909	249,977
Other expenses	8,457	7,855
Total expenses	1,284,420	1,290,154
Profit		
Profit/(loss) before tax	409,847	562,433
Taxation expense	100,461	68,666
Profit/(loss) after tax	309,386	493,767
Non HBF related profit/(loss)	4,058	3,937
Profit/(loss) of the insurer	313,444	497,704
Margins		
Gross margin	12.96%	14.80%
HIB expenses	9.76%	10.52%
Net margin	3.20%	4.28%

[†]June 2009 figures are unaudited

Data relating to the industry's performance for the 12 months to 30 June 2009 have been compiled by aggregating the last four quarters of unaudited data submitted by private health insurers.

Health Benefits Fund Profit After Tax Breakdown for 12 months to 30 June 2009



For comparative purposes, the figures for the 12 months to 30 June 2008 contain audited data for that financial year.

Total benefits paid including state ambulance levies over the 12 months to June 2009 increased by \$996 million from the previous 12 months. However, premium revenue had increased by only \$887 million. With benefits increasing at a faster rate than premium revenue, the gross margin was weaker—down from 14.8% to 13.0%.

Management expenses of \$1,276 million was almost identical to the preceding 12 months. Overall, a net margin of 3.2% and profit after tax of \$313 million were recorded by the industry for the 12 months to June 2009, down from 4.3% and \$498 million when compared to the 2008 financial year.

The impact of the global financial crisis has negatively affected investment revenue with a loss of \$85 million from investment activities. However, of significance is that investment revenue has returned to positive territory. The reallocation of assets into more conservative investment types by insurers over the past few quarters, coupled with greater stability in asset value and improvements in economic conditions, have resulted in investment revenue of \$121 million for the quarter. In the March and December quarters the industry recorded investment losses of \$7 million and \$201 million respectively.

Whilst there has been some recovery in revenues from investments, PHIAC remains cautious about future economic circumstances affecting asset values and returns.

With ongoing increases in utilisation and costs in the industry and considering a number of policy changes in train or mooted, PHIAC emphasizes the importance of prudent investment management and continued sound underwriting performance.

Prudential position

All Figures \$'000	As at June 2009 [†]	As at June 2008
Health benefits fund financial assets		
Cash	1,435,407	1,383,188
Investments		
Equities	1,110,114	1,084,692
Bonds & other fixed interest securities	3,896,045	4,506,459
Property	396,989	483,021
Subsidiary and associated entities	1,113,542	394,168
Loans	141,533	266,510
Premiums receivable	88,468	74,732
Intangibles DAC and FITBS	64,483	65,666
Prepayments	15,403	20,763
Other*	453,396	868,138
Total assets	8,715,380	9,147,336
Health Insurance Liabilities		
Unearned premium liabilities	1,539,788	1,429,614
Unpresented & outstanding claims	1,439,131	1,308,940
Other fund liabilities	120,504	116,504
Interest bearing liabilities	25,439	29,417
Payables, provisions & other liabilities	551,664	504,412
Total liabilities	3,676,526	3,388,888
Health benefits fund capital	5,063,854	5,758,448
Solvency Requirement	5,723,525	5,203,114
Capital Adequacy Requirement	5,991,195	5,495,734

Total assets reduced by \$432 million over the 12 months to June 2009. An increase of \$719 million was reported for subsidiary and associated entities, and was primarily related to mergers and acquisitions within the industry. This was partially offset by a decrease of \$610 million in bonds and other fixed interests securities. Property was impacted by current market conditions and lost \$86 million.

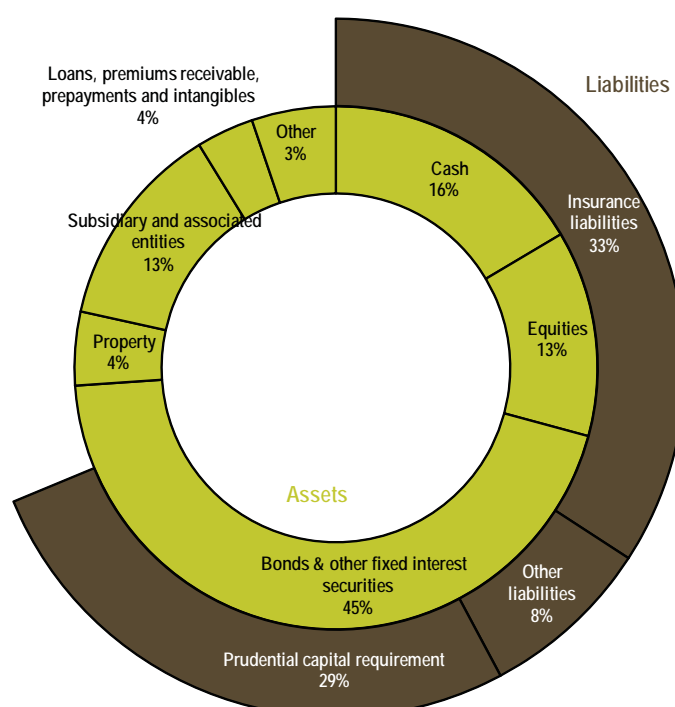
By contrast, liabilities rose over the same period by \$288 million, the majority of which was caused by an increase in unearned premium liabilities, as well as unrepresented and outstanding claims liabilities.

The industry as a whole remains in a sound capital position with excess assets for solvency purposes of \$3,026 million against a requirement of \$5,723 million.

[†]June 2009 figures are unaudited

*includes health insurance equipment and other assets

Health Benefits Fund Assets vs Liabilities as at 30 June 2009



The population figures used to calculate coverage are derived from:

Australian Bureau of Statistics, Australian Demographic Statistics, ABS cat no. 3101.0, ABS, Canberra, 2009.

Figures for NSW include ACT

Lifetime Health Cover is a financial loading (LHC loading) that can be payable in addition to the premium for your private health insurance hospital cover (hospital cover). LHC loadings apply only to hospital cover. The loading is 2% above the base rate for each year over the age of 30 in which the policy holder did not have private health insurance hospital cover.

Starting from 1 April 2007 general treatment policies replaced ancillary policies. General treatment policies cover treatment similar to that previously known as ancillary (eg. dental) but can also cover hospital-substitute treatment and Chronic Disease Management Programs.

Definitions and abbreviations

<i>DAC</i>	Deferred Acquisition Costs
<i>Episode</i>	The period of admitted patient care between an admission and separation (eg. discharge) characterised by only one care type.
<i>Family policy</i>	A policy under which more than one person is insured including: two parents and children; single parent and children; two or more children and no adults; three or more adults.
<i>FITBS</i>	Future Income Tax Benefits
<i>General treatment</i>	Treatment that is intended to manage or prevent a disease, injury or condition and is not hospital treatment.*
<i>General treatment services</i>	Ancillary services such as dental and optical.
<i>Gross margin</i>	The difference between total premium revenue and total cost of benefits (inclusive of state levies) expressed as a percentage of premium revenue.
<i>HIB</i>	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.*
<i>Hospital treatment</i>	Treatment that is intended to manage a disease, injury or condition provided to a person at a hospital or arranged with the direct involvement of a hospital.*
<i>Hospital-substitute treatment</i>	General treatment that substitutes for an episode of hospital treatment.*
<i>HRB</i>	Health Related Business* includes one or more of: <ul style="list-style-type: none">• Providing goods and/or services to manage or prevent disease, injuries or conditions (may include dental or optical centres)• Undertaking liability, by way of insurance, to indemnify people who are ineligible for Medicare• Providing a financial service to assist people meet the costs associated with treatment, goods or services that are provided to manage or prevent diseases, injuries or conditions.
<i>Medical service</i>	Medical specialist services such as the anaesthetist or obstetrician. A hospital episode may involve several medical services.
<i>Net margin</i>	Gross margin less management expenses expressed as a percentage of premium revenue.
<i>Out-of-pocket</i>	Refers to the amount paid by the policy holder for a service after private health insurance benefits and medicare benefits are paid. Out-of-pocket includes medical gap, excess or co-payments for hospital or hospital-substitute episodes, and co-payments for ancillary services.
<i>Persons</i>	Refer to the number of persons covered by private health insurance policies.
<i>Policies</i>	Refer to the number of private health insurance policies referable to private health insurance funds. Each policy may cover one or more persons.*
<i>Single policy</i>	A policy under which only one person is insured.
<i>State ambulance levy</i>	Amounts payable to the New South Wales and Australian Capital Territory governments in respect of levies on policy holders of insurers with hospital treatment cover, for ambulance cover.

Related publications

Data Tables

PHIAC produces a number of statistical data tables that are available from

www.phiac.gov.au/for-industry/industry-statistics/. These include:

Membership and Coverage Statistics

Provides the number of insured persons, by state, for hospital treatment and general treatment and the proportion of the population these persons represent. The tables are shown on both a quarterly and an annual basis and include hospital treatment by age cohort.

Medical Gap Information

Provides data on in-hospital medical services. The proportion of services for which there was no gap or known gap and the average gap payment are shown for each state.

PHIAC A Report

Provides the membership and benefits paid by private health insurers for the period by state. These state reports are available both in PDF format and Excel.

PHIAC 3 Report

Provides data on prosthetic benefits paid by private health insurers by major prosthetic category

PHIAC 4 Report

Provides data on services, benefits paid and gap payments by MBS Speciality Block Groupings for medical services paid by private health insurers.

Statistical Trends - Quarterly Statistics

These are two separate tables detailing trends since September 1997 in the number of insured persons and benefits paid for hospital and general treatment.

Annual publications

PHIAC is also required to produce a Annual Report on the Operations of the Private Health Insurance Industry. This report contains an industry overview and tables of statistics by individual fund. Current and historical versions are available at www.phiac.gov.au/for-industry/industry-statistics/

About PHIAC

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 in existence by force of section 264–1 of the *Private Health Insurance Act 2007*, subject to the provisions of the Act.

PHIAC is an independent statutory authority that reports to 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 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 the *Private Health Insurance Administration Council Annual Reports*. These reports are required under section 9 of the *Commonwealth Authorities and Companies Act 1997* and can be obtained from the PHIAC office or are available at <www.phiac.gov.au>.
