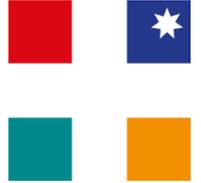


Australian
Private Hospitals
Association



What is driving health insurance premiums?

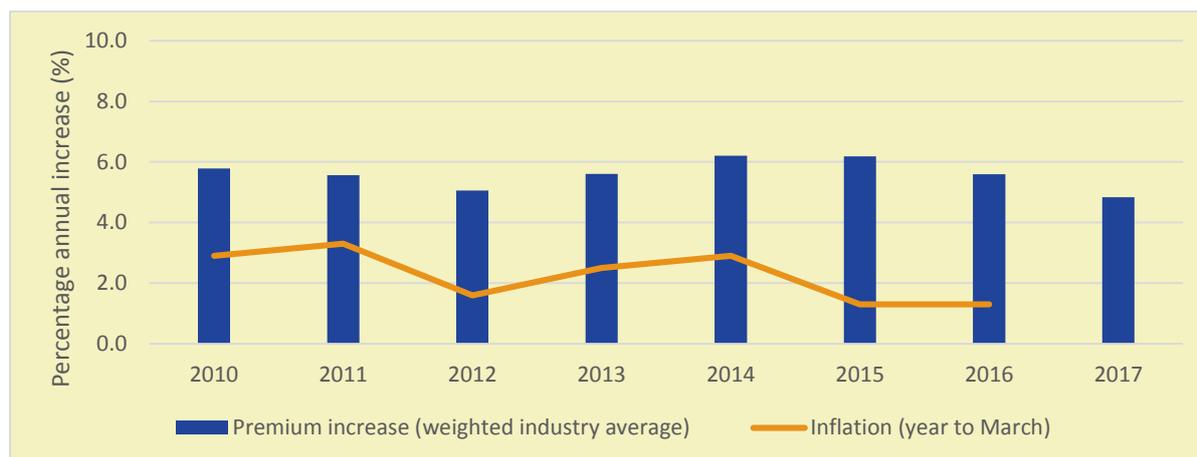
March 2017

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What is happening to premiums?

Over the past eight years, premiums have increased by 4.8%–6.2% per annum (Figure 1) (Department of Health 2016; Department of Health 2017). This rate of increase has been well in excess of inflation (1.3%–3.3% per annum) and wage inflation (2.1%–3.9% per annum) (ABS 2016a; ABS 2016b). These premium increases are prompting growing concerns about the affordability of private health insurance.



Source: Department of Health 2016; Department of Health 2017.

Figure 1: Annual weighted industry average increase in health insurance premiums and inflation, 2010–2017

This paper will seek to unpack some of the cost drivers to premiums to better understand what is happening. This paper has used annualised data from March 2010 to March 2016, to keep the data as comparable as possible with premium increases, which happen as of 1 April. Data for the year to 31 March 2017 is not yet available. Where possible, the time period has been kept as 2010–2016. If data were not available for this period, it is highlighted in the analysis.

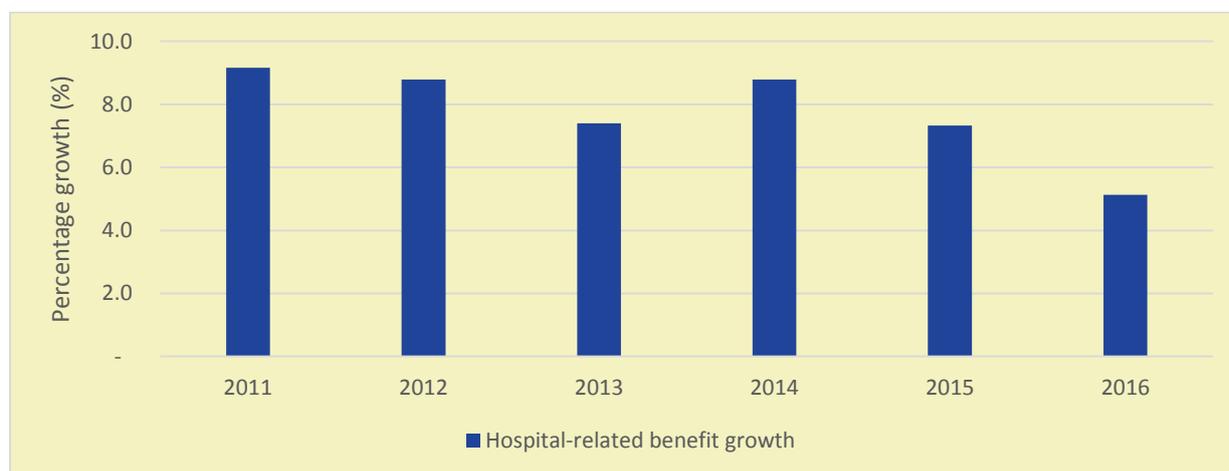
Why are premiums going up?

Private health insurers set premiums to ensure they will be able to meet requirements for benefits payouts (claims from their members for services accessed) while also covering business costs, meeting prudential requirements and delivering an acceptable return to stakeholders.

Private health insurers pay benefits to help cover the costs for two types of health services:

- hospital-related services provided to patients with health insurance in private and day hospitals, public hospitals as well as hospital substitutes
- specified 'ancillary services' (or 'general treatment' services) not involving hospitalisation (e.g. dental, physiotherapy, etc.).

Since 2011, growth in annualised total hospital-related benefits¹ (year to 31 March) has slowed from 9.2% to 5.1% in 2016 (Figure 2).



Note: Data to March 2017 not yet available. Source: APRA.

Figure 2: Annual change in total benefits paid out, year to 31 March, 2011–2016

So if the growth in benefits paid out has been slowing, why are premiums continuing to rise? Rising health benefits paid out is one driver for premium increases, but it is not the only one.

Australians are downgrading their level of cover

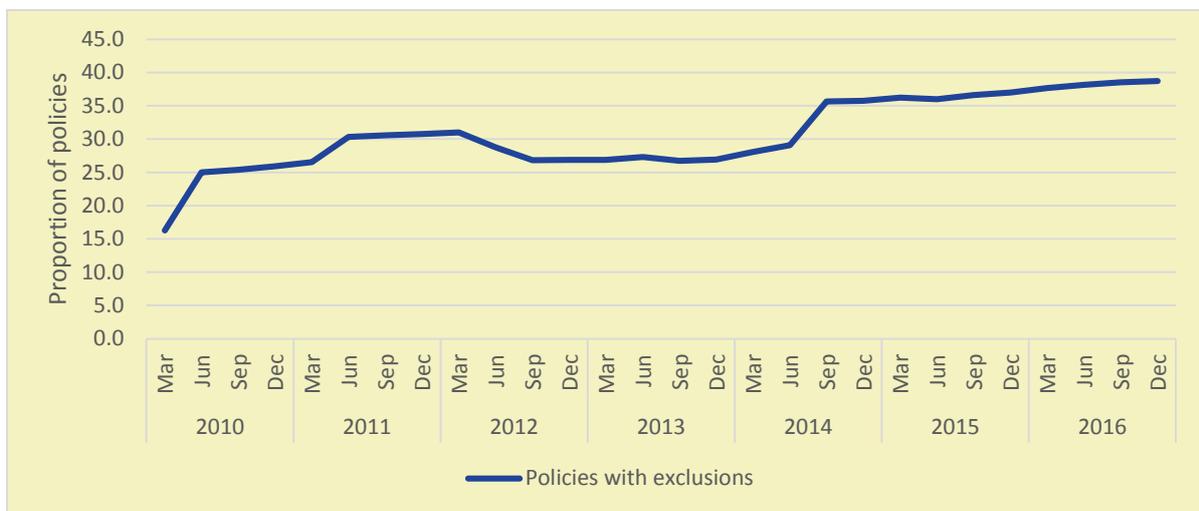
The higher proportion of exclusionary policies (which are cheaper than full cover policies) the smaller the premium pool available to cover claims, putting upward pressure on all premiums.

¹ Hospital-related benefits include hospital services such as accommodation and nursing, medical services, prostheses items and nursing home-type patients.

There are currently several disincentives for consumers dropping their health insurance:

- Australians earning more than a certain amount and who do not take out private health insurance are liable to pay the Medicare Levy Surcharge, an additional tax (up to 1.5%). The Medicare Levy Surcharge is designed to encourage individuals to take out private hospital cover, and where possible, to use the private hospital system to reduce demand on the public Medicare system.
- Discontinuing insurance after the age of 30 means a much higher cost to repurchase it at a later stage due to the Lifetime Health Cover loading.

One option for consumers who wish to reduce their annual cost is to downgrade their cover. The proportion of policies held that have exclusions (i.e. do not cover the full range of health services) has been steadily increasing (Figure 3).



Source: APRA.

Figure 3: Proportion of private health insurance policies with exclusions, 2010–2016

Australians are opting out of private health insurance

Health insurers are less able to use revenue from healthy patients to meet the costs of those who require health services, pushing premiums up.

Despite not being the preferred option for most consumers, there is increasing evidence more Australians are now dropping their insurance. Some decide not take out health insurance at all. The proportion of Australians with private health insurance had been slowly increasing from 2010 until mid-2015. In 2015, however, this trend started reversing. From its recent peak of 47.4% in June 2015, the participation rate is now 46.6% (Figure 4).



Source: APRA.

Figure 4: Proportion of Australians with private health insurance, 2010–2016

Growth in numbers of people insured was fairly steady until mid-2015 when it slowed drastically. Historically, June is a quarter with high growth due to tax returns as well as the incentives for young people to sign up before they turn 31. Despite this, the June quarter 2016 saw the first decrease in the number of Australians covered for hospital care since June 2005, and this was repeated for December 2016, when the total number went down by almost 8,000 (Figure 5).



Source: APRA.

Figure 5: Quarterly change in number of Australians with private health insurance, 2010–2016

Those most likely to reduce their level of cover or drop health insurance are those who perceive they are less likely to make a claim.

The insured population is ageing

As people age, they are more likely to need health interventions and an ageing population will be a highly serviced population when it comes to health care and health insurance. This will also put upward pressure on premiums.

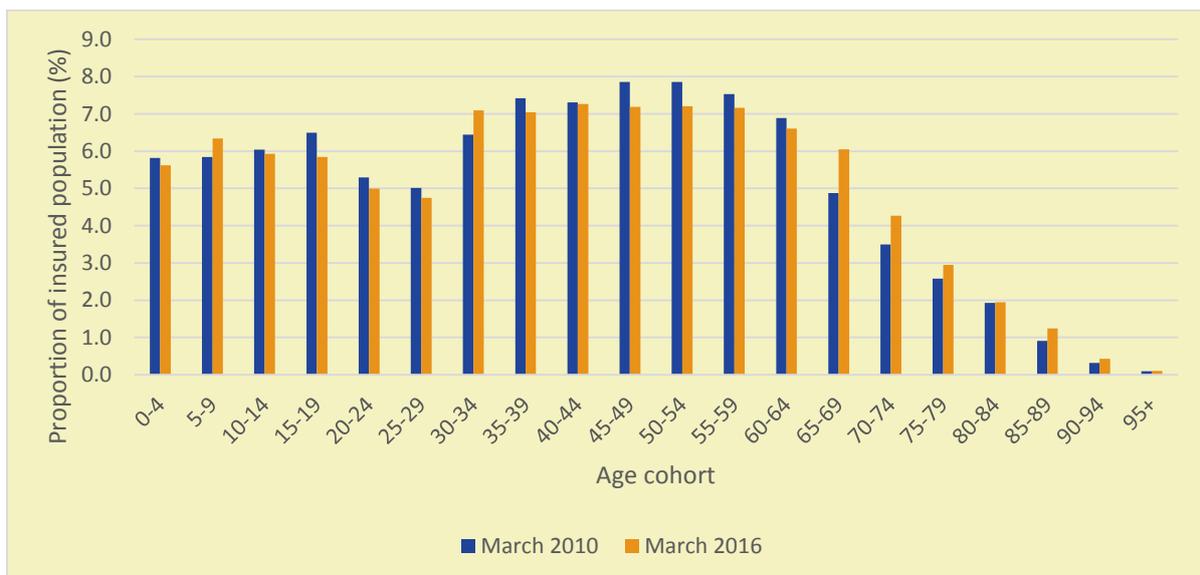
The insured population is ageing faster than the Australian population as a whole:

- in 2010, the average age in Australia was 38.0 years. In 2016, it was 38.7, or an increase of 0.7 years (ABS 2016c)
- in the December quarter 2010, the weighted average age of a person with hospital treatment insurance was 40.2 years. By December 2016, this had increased to 41.2 years, or an increase of 1.0 year (APRA statistics).

The participation rate of people 65 and over is increasing while for younger cohorts it is decreasing (Figure 6). Children and dependent students have relatively high participation rates because they are usually covered by family policies.

The ageing of the privately insured population is due to several factors:

- the population in general is ageing
- young people no longer covered by policies held by their parents/guardians, are either not taking up private health insurance or delaying take up
- the role of the Department of Veteran Affairs in funding older age cohorts is diminishing as the number of veterans and their dependents in these age groups declines – so the proportion of elderly who would have previously been covered by DVA is now turning to or maintaining private health insurance
- the baby-boomer generation is wealthier than previous generations, and can afford to take up and maintain private health insurance
- older people know they are more likely to require care, and will hang on to their health insurance to help cover these costs and to access care without waiting on public waiting lists
- government policy (including the policy that persons 65 and older are entitled to a higher government rebate on premiums) has provided additional incentives for older people to invest in private health insurance.



Source: APRA.

Figure 6: Age distribution of insured persons, as at 31 March, 2010 and 2016

As at 30 September 2016, 17.2% of insured persons were aged 65 or over, up from 14.3% seven years ago. This same cohort accounted for 52.2% of benefits paid out in the year ending 30 September 2016.

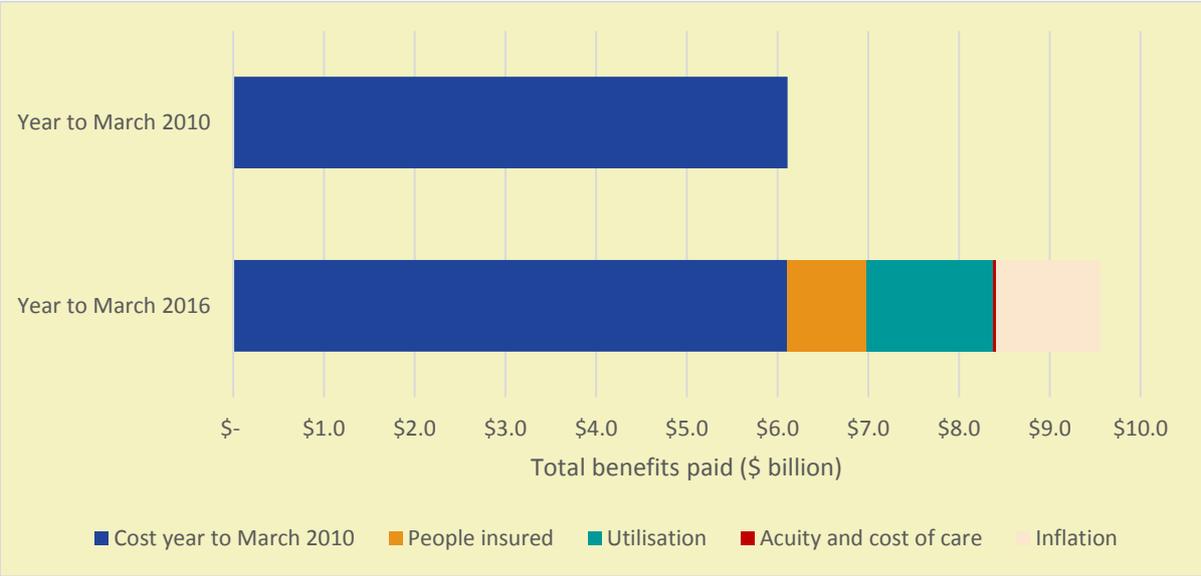
The increased participation of older people in private health insurance benefits those individuals and reduces pressure on the public hospital system. However, Australia’s community-rated insurance system needs a balance of low-risk consumers (generally younger ones) to pay for high-risk consumers. As the low-risk consumers reduce their level of cover, opt out or fail to take up health insurance at all, this places added pressure on premiums.

Are hospital costs out of control?

The growth in total benefits paid for hospital care has slowed, but it is still rising at 5% per annum. The total benefits paid for hospital care is driven by four factors:

- number of people insured
- utilisation of hospital services
- inflation
- increased acuity and cost of care.

When splitting these cost drivers out, an interesting picture emerges. In fact, after accounting for inflation, the increase in number of people insured and increased utilisation of hospital services, increased cost of care accounts for only 1.1% of the growth in benefits paid. This 1.1% is entirely due to increased patient acuity. (Figure 7). The following chart compares total hospital benefits paid for the year to 31 March 2010 (\$6.1 billion) to those paid for the year to 31 March 2016 (\$9.6 billion).



Source: APRA.

Figure 7: Cost drivers for the increases in benefits paid to hospitals, change 2010 and 2016

Growth in number of people insured

In the March quarter 2010, there were 9,912, 887 people who were covered by private health insurance in Australia. By March 2016, this had increased to 11,331,535 people. This

was an increase of 1.4 million people over six years. This increase in participation accounted for just over a quarter (25.4%) of the increase in benefits paid out over that period (Figure 7).

Increased utilisation of hospital services

People with private health insurance are increasing the rate at which they access hospital services. In the year to 31 March 2010, there were 321.0 privately insured hospital episodes (in any setting) per 1,000 people insured, whereas in the year to 31 March 2016, this had increased to 384.8 episodes per 1,000. This was an increase of 63.8 episodes per 1,000 people insured, or 19.9% (Table 1).

The increase in use accounted for forty percent (40.2%) of the growth in benefits paid out over 2010–2016 (Figure 7).

Table 1: Annual ratio of episodes per 1,000 persons insured, 2010–2016

Year	2010	2011	2012	2013	2014	2015	2016	Change 2010-2016
Utilisation ratio	321.0	328.9	337.4	347.1	365.7	374.8	384.8	63.8

Source: APHA, based on APRA data.

One reason for this increase in use is the ageing of the insured population. Growth in some services delivered through a planned sequence of episodes – chemotherapy, dialysis, day-programs in mental health and day programs for rehabilitation – may also be contributory. These reasons for growth reflect increased value for health fund members as services are provided in response to consumer health needs.

One area of growth less easy to justify is the increase in privately insured patients treated in public hospitals. Private patient episodes in public hospitals have been growing more quickly than private patient episodes overall. The total share of private patients treated in public hospitals has increased from 14.4% (year to 31 March 2010) to 17.4% (year to 31 March 2016). This level of growth is a direct result of deliberate strategies to persuade patients presenting to public hospitals and emergency departments to “elect” for private patient admission. The impact of this activity on private health insurance is more than \$1 billion annually.

Acuity and cost of care

During the period March 2010 to March 2016, inflation increased by 13.7%. After inflation, increases in cost of care accounted for just 1.1% of the increase in private health insurance outlays for hospital care over these five years (Figure 7). This increase is less than would have been expected due to the increasing age and acuity of patients treated in the private sector.

The average cost weight – a guide to expected resource use per separation and an indicator of casemix complexity – increased from 0.77 in 2010–11 to 0.81 in 2014–15 (latest data available), an average increase of about 1.5% annually (AIHW 2016).

Additionally, APRA data shows people over the age of 65 account for 17.2% of privately insured episodes of hospital care (year to 31 December 2016), and this has been steadily increasing over time. Older patients are more likely to have more complex health needs as a result of age related health risks and an increased incidence of comorbidity.

There has been a marked shift in the age of privately insured patients treated between 2010 and 2016 (Figure 8). In the year to 31 March 2010, 38.1% of private patients were aged 65 or over. In the year to March 2016, this had increased to 45.9%.



Source: APRA.

Figure 8: Age distribution of privately insured episodes, year to 31 March 2010 and 2016

As acuity of care directly impacts on the cost of care, the low increases in cost paired with the increases in acuity actually points to increasing efficiencies on the part of private hospitals.

These efficiencies have been achieved by the private hospital sector through:

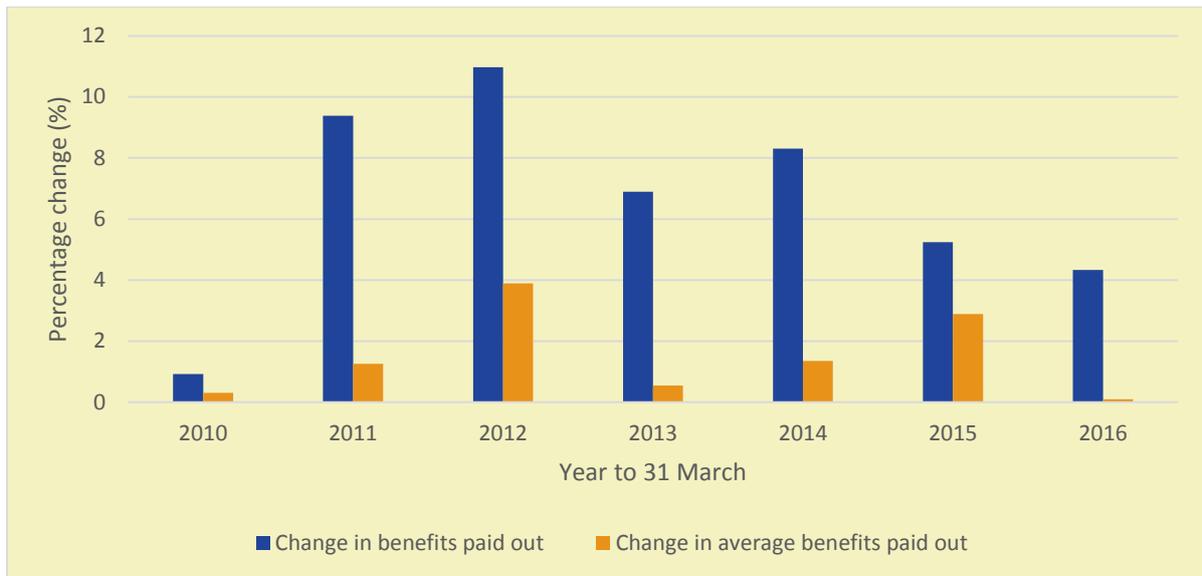
- innovation in models of care – making best use of the clinical staff employed by private hospitals
- maintenance of a low length of stay (2.4 days per episode).
- use of same day episodes (length of stay < 1 day) – in the year to March 2016, 68.4% (2.3 million) episodes were same day.

What about other costs?

Medical benefits

Medical benefits are fees paid to medical practitioners treating patients while they are in hospital. Fees are paid per service provided. Multiple services may be provided during one episode of care. For the year ending 31 March 2016, these benefits totalled \$2.1 billion.

Benefits paid out for all medical services have increased by 0.9%–11.0% annually between 2010 and 2016 (years to 31 March). Average benefits for all medical services increased by 0.1%–3.9% annually over that time (Figure 9).



Source: APRA.

Figure 9: Percentage change in total and average medical benefits paid out, year to 31 March, 2010–2016

Prostheses benefits

In the December quarter of 2011, there was a significant change in how benefits paid for prostheses were categorised. For this reason, it was only possible to compare data for years ending 31 March 2013 and 2016.

In the year to March 2013, the number of claims paid for prostheses was 2.0 million, and the benefits paid out for these was \$1.5 billion. In the year to 2016, this had increased to 2.5 million claims, and nearly \$2.0 billion.

Between 2013 and 2016, most of the increase (87%) in outlays for prostheses was attributable to utilisation and just 13% to increased benefits. The increase in the average benefit was just 2.8% in three years, well below inflation of 5.5%.

Health insurer profits

Since hospitals are in fact driving efficiencies while caring for patients of growing acuity and age, can private health insurers be more efficient?

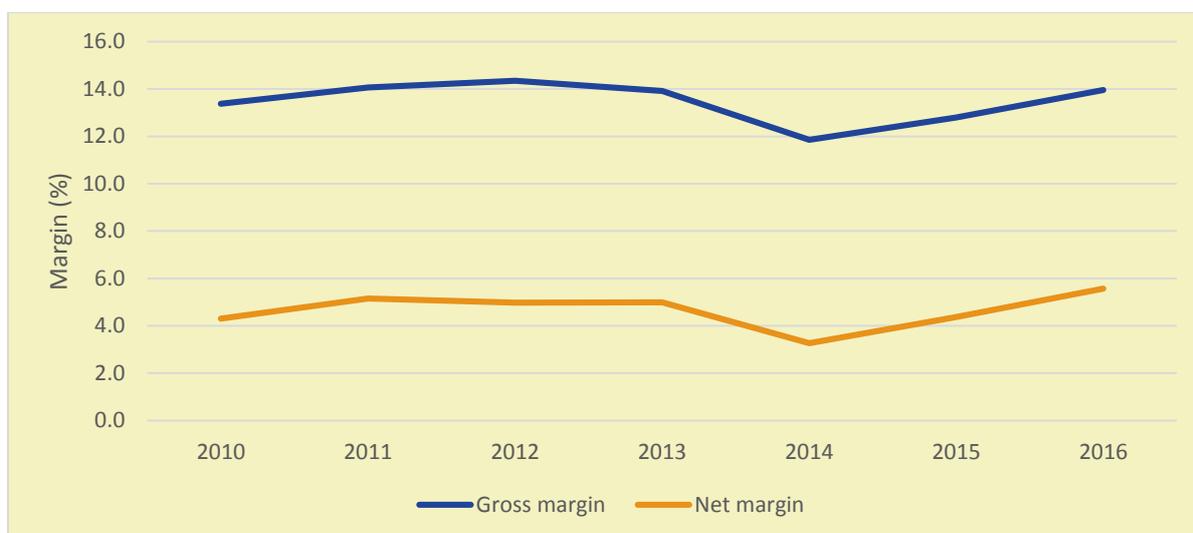
Government data shows between the years to 31 March 2010 and 31 March 2016, the private health insurance sector as a whole saw an increase in profits before tax (up 17.8%, from \$1.3 billion to \$1.5 billion) as well as profits after tax (up 8.0%, from \$1.06 billion to \$1.14 billion) (Figure 10).



Source: APRA.

Figure 10: Private health insurance profits before and after tax, year to March, 2010–2016.

It is also worth noting the margins for the private health insurance sector have increased between the years ending 31 March 2010 and 31 March 2016; gross margins went up from 13.38% to 13.96%, whilst net margins went up from 4.31% to 5.57%. Despite a notable dip in both gross and net margins in 2014, they both recovered well by 2016 (Figure 11).



Source: APRA.

Figure 11: Private health insurance margins, gross and net, year to March, 2010–2016.

Bibliography

Australian Bureau of Statistics (ABS), 2016a, *Consumer price index, Australia*, September 2016. Cat. no. 6401.0. Canberra: ABS.

Australian Bureau of Statistics (ABS), 2016b. *Wage price index, Australia*, September 2016: 'original' data. Cat. no. 6345.0. Canberra: ABS.

Australian Bureau of Statistics (ABS), 2016c. *Australian demographic statistics*, Jun 2016. Cat. no. 3101.0. Canberra: ABS.

Australian Institute of Health and Welfare (AIHW) 2012. *Australian hospital statistics 2010–11*. Health services series no. 43. Cat. no. HSE 117. Canberra: AIHW.

Australian Institute of Health and Welfare (AIHW) 2016. *Admitted patient care: 2014–15: Australian hospital statistics*. Health services series no. 68. Cat. no. HSE 172. Canberra: AIHW.

Australian Prudential Regulation Authority (APRA), various years, Private health Insurance Statistics <http://www.apra.gov.au/PHI/Publications/Pages/Industry-Statistics.aspx>

Department of Health (2016). 2016 premium round individual private health insurer average premium increases. Accessed on 19 Jan 2017. Available online at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/privatehealth-average-premium-round>.