

A close-up photograph of a silver stethoscope and a dark fountain pen resting on a document. The document contains financial data, including dollar amounts and category names. The stethoscope is positioned in the upper left, and the fountain pen is in the lower right. The background is a blurred grid of numbers and text.

Why is health insurance getting more expensive?

Quantifying the drivers of premium rate increases

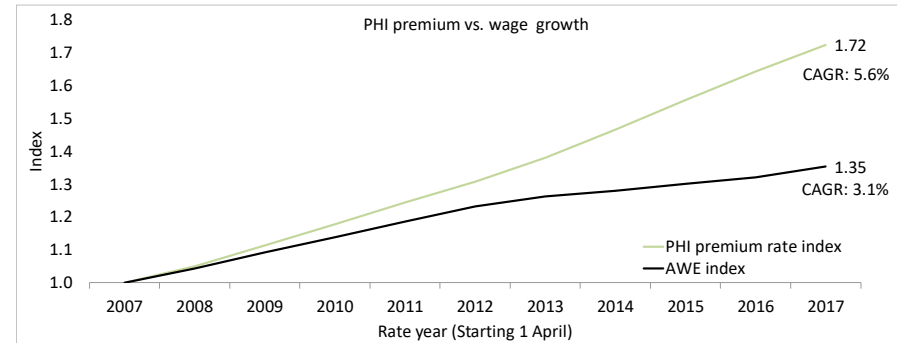
15th February 2018
Simon Lim

1 Executive Summary

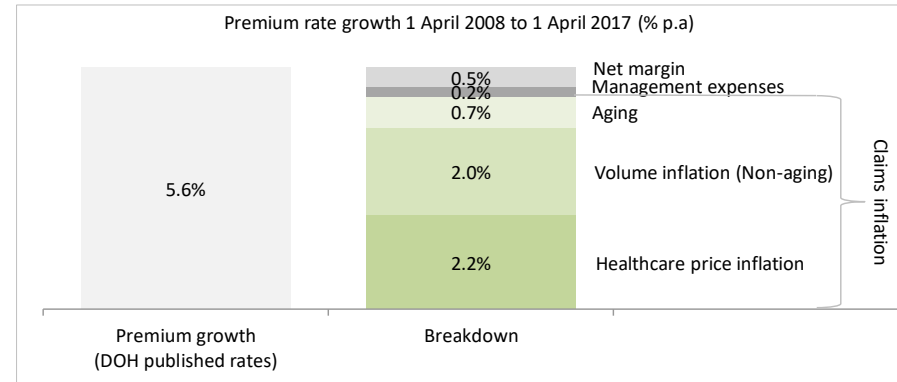
1. This paper investigates the drivers of health insurance premium rate increases over the 10 years to June 2017 by attributing the drivers of historical premium rate rises to a number of factors.
2. The affordability of premiums has been decreasing, as evident by premium rates increasing at 2.0 times wages over the 10 years to June 2017. The indexation of the Australian Government Private Health Insurance Rebate over this period has further affected affordability.
3. Over the 10 years to 1 April 2017, premium rates have increased by 5.6% p.a.¹ Claims inflation has contributed 4.9% p.a. of this inflation. Insurers' operating costs and profit margins have contributed to 0.7% p.a. of the remaining increase, a rate of growth less than the CPI.
4. Three forces drive the growth in claim costs and therefore premium rates. In decreasing order of magnitude:
 - a. Healthcare price inflation: Inflation in the price of healthcare services
 - b. Volume inflation: Growth in the utilisation of healthcare services in excess of what is explained by aging, with new technologies and treatments, as well as changes in provider and consumer expectations being contributing factors
 - c. Aging population – The population is getting older, resulting in higher per capita consumption of healthcare.
5. The methodology involves attributing historical health insurance industry premium revenue growth to the underlying drivers and scaling the results to Department of Health (DOH) published average premium growth. The complexities of the methodology are described in the Appendix.
6. The results of the analysis are generally consistent with AIHW and ABS studies on the drivers of healthcare cost inflation in the wider health system, as shown in Sections 5.1 and 7.
7. Attributing premium rate rises provides a framework in which to evaluate reform or the value offered to consumers from the underlying drivers. Efforts to optimise future premium rate inflation should therefore focus on addressing these underlying drivers.

¹ Department of Health industry average rate rises

Figure 1: Summary of results



Source: DOH industry weighted average premium increase with rate protection, ABS Australia Persons AWE index (interpolated and extrapolated past November 2016 based on past experience), Author's analysis



Notes: Management expenses refers to the non-claim expenses incurred by the insurer relating to the health insurance business. Net margin refers to premiums less claims net of risk equalisation less management expenses. Excludes investment income.

2 Introduction

Health is important to Australians, and by extension healthcare and health insurance. It is therefore expected that the affordability of health insurance is also a topical issue that draws extensive public commentary and proposed solutions.

Constructive discussion of this issue and of possible reform for the benefit of all Australians is only possible if participants understand the root causes of premium inflation and their relative magnitude. Due to the nature of healthcare and health insurance, an industry involving a heterogeneous mix of services, funders and providers the quantification of root causes is complex, as described in the Appendix. Nevertheless, this paper's goal is to explain and quantify the drivers of premium rate rises.

2.1 Premium affordability has been declining

Over the 10 years to June 2017, health insurance premium growth outpaced earnings, resulting in households contributing an increasing proportion of their budget towards premiums. During this period the growth in earnings was lower than the premium rate rises by a significant margin, particularly during the last five years where earnings growth was relatively low.

In an individual year, a gap of a few percent is less significant. However, the affordability issue arises as this gap accumulates over the long term, such that cumulatively, over this period, health insurance premiums have grown at 2.0 times wages.

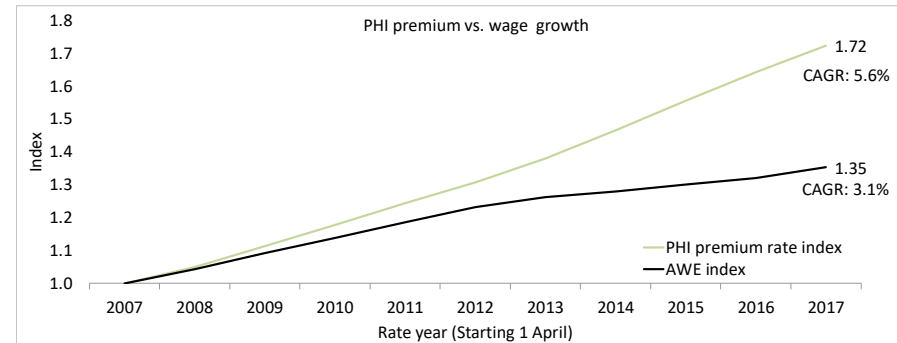
The impact of this compounding effect is illustrated by the increasing proportion of premiums relative to household income, which has grown from 2.4% to 3.0% between FY2008 and FY2016². Premiums now account for 1.6 weeks of pre-tax household income, up from 1.2 weeks 10 years ago. In other words, average households now work on average an additional 2.8 days just to cover the cost of health insurance relative to FY2008³.

² FY2016 data was the latest available at the time the analysis was performed

³ $(3.0\% - 2.4\%) / (1 - 18\%) * 52 * 7$, where 18% is the proportion of pre-tax HH income paid as income tax (ABS)

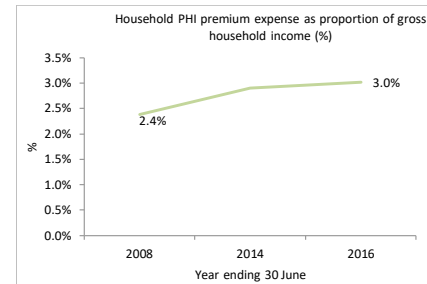
For further discussion on health insurance affordability, the reader can refer to Leung 2017⁴.

Figure 2: Premiums and wage growth



Source: DOH industry weighted average premium increase with rate protection, ABS Australia Persons AWE index (interpolated and extrapolated past November 2016 based on past experience), Author's analysis

Figure 3: Premium rates relative to household income



Source: APRA Operations of Private Health Insurer data, ABS, Author's analysis

Notes: ABS gross household income data to FY2014, forecasted to FY2016 using historical rates of growth. ABS defines gross household income as "the sum of income from all sources before income tax and the Medicare levy have been deducted". ABS household income data produced every two years with linear interpolation in between. PHI premium rates defined as annual premium revenue per average policyholder.

⁴ Is Private Health Insurance Affordable in Australia?, Barry Leung, 2017, Institute of Actuaries of Australia

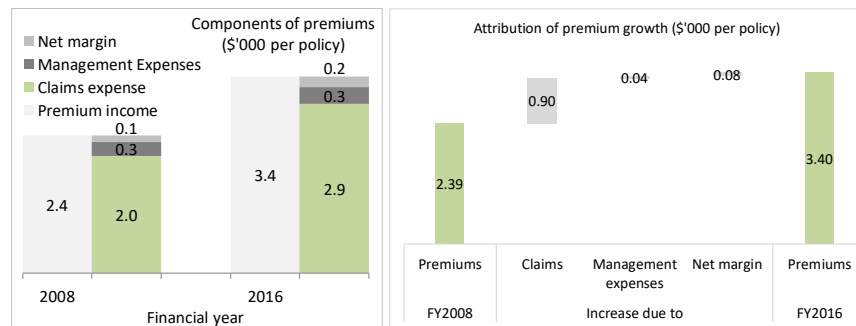
3 Components of health insurance premiums

The price of health insurance is made up of three components:

- The cost of claims paid by the insurer, which is the largest component of premiums (“claims expense”)⁵
- The operating costs of the insurer for policy administration, claims handling and overheads (“management expenses”)
- The insurers’ profit margin before tax (“net margin”), which excludes investment and non-health insurance income.

As shown by Figure 4, claims are the largest component of premiums and have been the largest driver of the premium increase during this period.

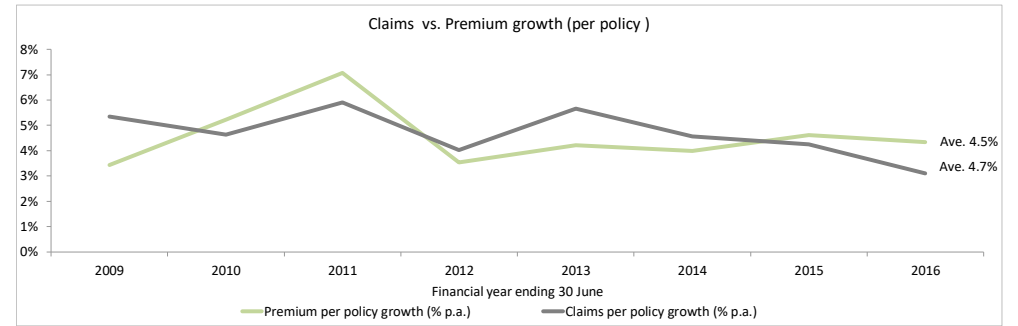
Figure 4: Components of health insurance premiums historically



Source: APRA statistics
 Note: HRB and other income and other expenses are excluded to better reflect insurers’ health insurance business. Net margin shown before tax. Average policies as shown in the APRA annual statistics used.

As a result, premium rate inflation over the last eight years was highly correlated with claims inflation, as shown in shown in Figure 5.

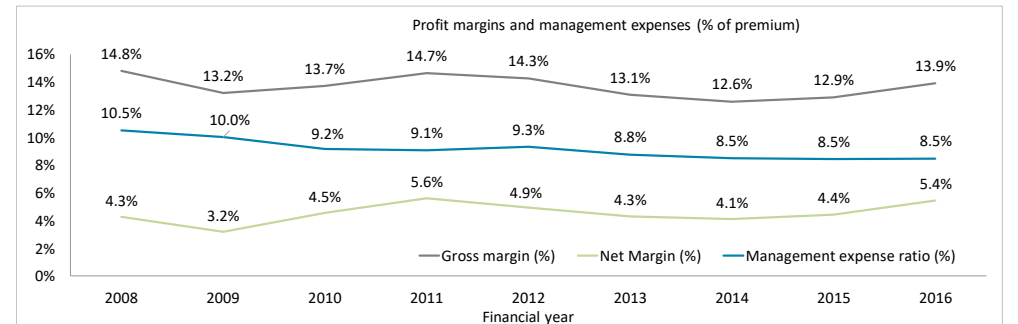
Figure 5: Claims vs. premium growth per policy



Source: APRA statistics. Note: Claims and premiums per policy using average policies over the financial year

Management expenses and insurers’ profit contribute to premium rate rises to a lesser extent than claims. As outlined in Figure 6, while insurers’ net margins have increased by 1.1%, this has been as a result of efficiency savings, as evident by the reduction in management expense ratios. In fact, part of the efficiency savings have been allocated to paying more claims, as evident by the reduction in the gross margin.

Figure 6: Operating and profit margins



Source: APRA statistics
 Notes: The gross margin refers to the proportion of premium remaining after claim costs (including ambulance levies) are paid. The operating expense refers to the operating, or non-claim costs of the insurer (excluding other non-health insurance business expenses). The net margin refers to the proportion of premium remaining after claims and operating costs have been paid. This represents the insurers’ profit from insurance activities before tax and investment income.

⁵ The risk equalisation pool nets to zero when whole of industry claims costs are combined

The following table provides additional commentary on the trends in these metrics.

Gross margin	Despite all the premium increases over the last 10 years, insurers have been paying back a greater proportion of that revenue to policyholders (see the reduced gross margin line) – i.e. premium increases have not been keeping pace with claims growth.
Management expense ratio	Decreases in gross margins have been offset by decreases in the management expense ratio, i.e. insurers are also spending less on non-claim expenses as a proportion of premiums. This is not unexpected since management expenses are generally driven by wage or CPI inflation, which have been lower than claims inflation.
Net margin	While insurers’ net margins have increased in absolute dollar terms (Figure 4), as a proportion of premium they have generally remained within the range between 4.5% and 5.5%. This indicates that the growth in health insurance premium rates is not driven by insurers’ increasing their profit margins.

3.1 Actual premium revenue growth has been lower than the DOH headline due to downgrading

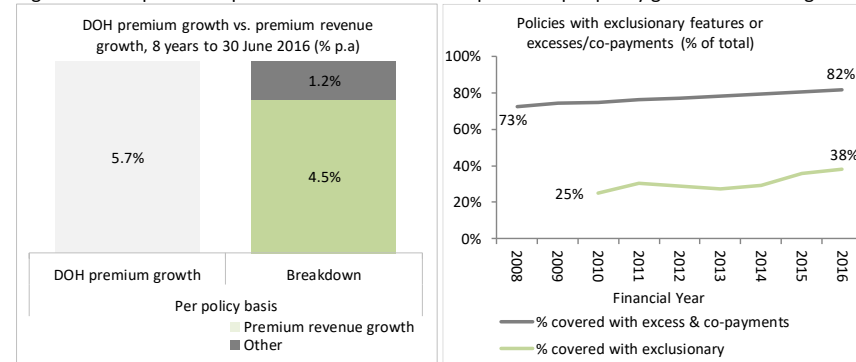
The Department of Health (DOH) also publishes average industry rate rises. Over the last 10 years, the DOH’s measure has been 1.2% higher than actual growth in premium revenue per policy. This is because, among other factors, the DOH’s measure does not take into account membership changes⁶ — its ‘headline’ figure is partially offset by policyholders downgrading or opting for lower priced cover with less benefits, i.e. consumers are responding to higher prices by purchasing or downgrading to less coverage. This increase in mix towards lower coverage is illustrated by the increase in mix of products with exclusionary features and/or excesses as shown in Figure 7⁷.

Downgrading is not a sustainable solution to premium affordability because there is a limit to it and consumers lose coverage in the process. Furthermore, it has only partially negated the financial pressures on households, as evident by the rising proportion of household budgets allocated to premiums (Figure 3).

⁶ Other factors include rate protection being applied annually to the DOH published average rate rise, although in practice this only has the effect of deferring the rate rise, and other factors such as one-off discounts.

⁷ APRA defines exclusionary policies as “where the private health insurance policy features an

Figure 7: DOH published premium rate rise vs. actual premium per policy growth and downgrading



Source: APRA statistics

Notes:

- % covered with exclusionary data in FY2008 and FY2009 are stated on a different basis and therefore not shown for comparison.
- DOH published premium growth of 5.7% differs slightly to the 5.6% figure quoted in Figure 1 due to a slight difference in period and the required interpolation between the rate years (ending 31 March) and financial years

3.2 Section conclusion

The three components of premiums are claims, management expenses and profit. Claims are the main driver of premium rate inflation, rather than management expenses and profitability. The sections below assess the three drivers of claims growth:

- Aging population
- Healthcare price inflation
- Volume drivers

exclusion for a particular condition and there is no coverage at all for medical treatment as a private patient in a public or private hospital or any other setting for that condition”. This implies that downgrades from mid to basic covers are excluded from this statistic. It is likely that downgrading will become more apparent if this type of product movement was included.

4 Aging population (0.8% p.a)

4.1 Australia is aging

The term “aging population” refers to the change in the population age distribution over time, whereby there are increasing numbers and proportion of older people, i.e. the average age of Australians is increasing. Reflecting Australia’s aging population, the proportion of the population with private health insurance has also been aging, as illustrated in Figure 8, which show that over the analysis period:

- Chart 1: The average age of hospital insured persons has increased from 39.8 to 40.9 years
- Chart 2: The proportion of the insured population aged 55 and above has grown from 27.7% to 30.8%
- Chart 3: The general population has also been aging, with the fastest population growth occurring in the older ages.

A further contributor to aging, as explained by Gale (2017)⁸ is that recent growth in older insured persons had been due to reduced access to veteran’s medical benefits of new cohorts within these age groups.

4.2 Older people’s healthcare costs more

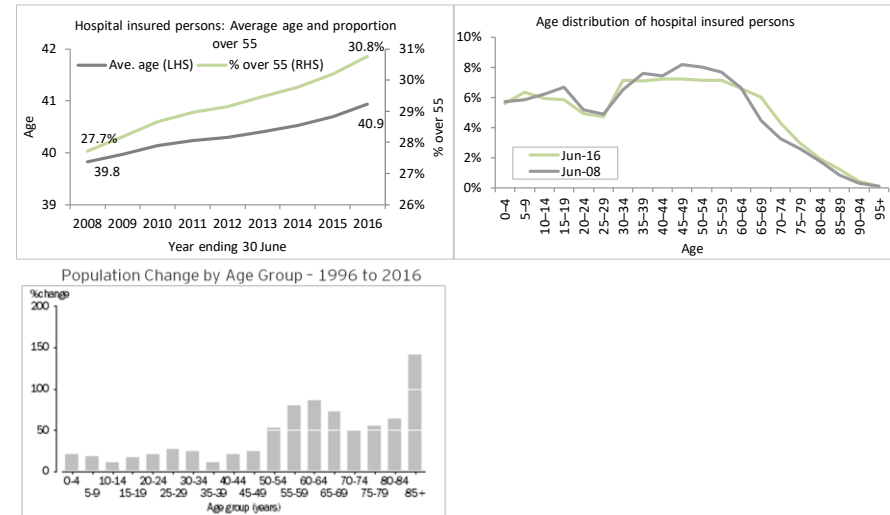
As shown in Figure 9, health insurance claim costs are higher for the older ages. This is due to higher utilisation and higher cost per service. Higher utilisation refers to the increasing number of healthcare services required by people as they age, for example in the form of more frequent medical services, hospital visits or pharmaceutical purchases. Furthermore, as Australians are living longer, there is a longer period in which they utilise healthcare services.

In general, the healthcare services required for older people are also more expensive, for example, due to more extensive treatment required. This is referred to as the higher cost per service effect (refer to Figure 11 and Figure 13).

⁸ Gale, War and Peace - The impact of veterans’ health care on Private Health Insurance, 2017, Actuaries Institute

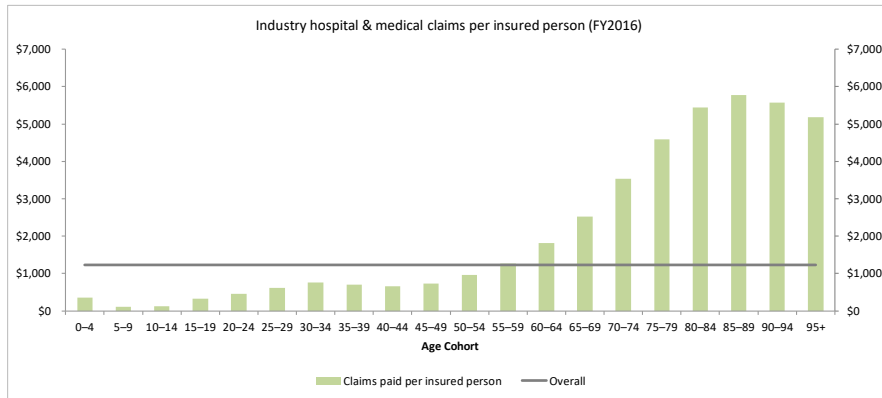
These two effects result in the population consuming additional and more expensive healthcare services as it ages, which results in higher claim costs and ultimately higher health insurance premiums.

Figure 8: Average age and age distribution



Source: APRA Statistics, ABS Australian Demographic Statistics June 2016, Population by Age and Sex, Australia, States and Territories

Figure 9: Hospital and medical claims per insured person by age



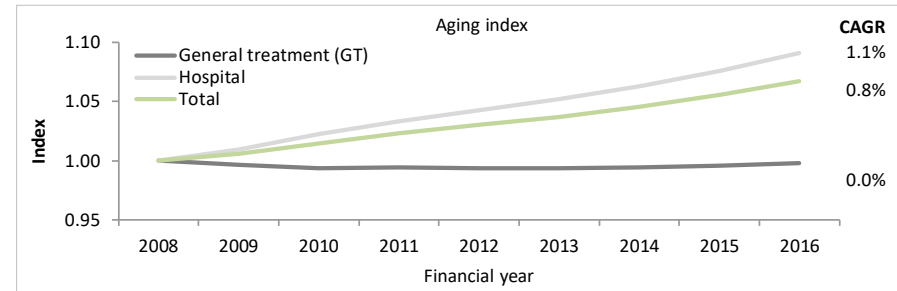
Source: APRA industry statistics FY2016, hospital and medical benefits

4.3 Aging is estimated to contribute 0.8% p.a. to premium rate increase

During the period of analysis, aging is estimated to have contributed to approximately 0.8% of the annual premium price rise. This conclusion was derived using an aging index represents the increase in overall claim cost per person while standardising for healthcare price and volume inflation. The aging index was constructed by re-calculating the average claim cost per person at each point in time using cost per person by age factors prevalent at FY2008.

Growth in the aging index indicates that even if price and utilisation levels remain at FY2008 levels, overall claim cost per person is increasing due to the aging population. In other words, even if there are no other drivers, the aging population alone will result in premium price rises of approximately 0.8% p.a.

Figure 10: Aging index



Source: APRA Statistics

Notes:

- The aging index is the ratio of overall claim cost per person (all ages) at each point in time to that in June 2008, weighted using June 2008 claim cost per person by age and the age distribution at each point in time.
- GT CAGR of 0.0% is due to the decline in the mix of older ages during FY2008 and FY2009. The reasons for this has not been investigated, however this is less material given the smaller variations in cost per person by age for general treatment. CAGR from FY2010 is 0.1%.
- Total aging index is weighted by hospital and general treatment benefits at each FY
- The figure above uses hospital claims only. The analysis was re-performed including medical and prosthesis benefits and the CAGR is consistent with the hospital only results.

5 Healthcare price inflation (2.5% p.a)

Healthcare price inflation refers to the inflation of the price of healthcare, such as hospital and medical fees. Inflation in these prices arise from general economic inflation in addition to the availability of improved and higher cost treatments. Inflation in the price of these services flow through to higher cost of claims and therefore premium rates.

Over the analysis period, the healthcare price inflation was found to be 2.5% p.a. based on health insurance data. Figure 11 and the following describe the methodology used to derive this result:

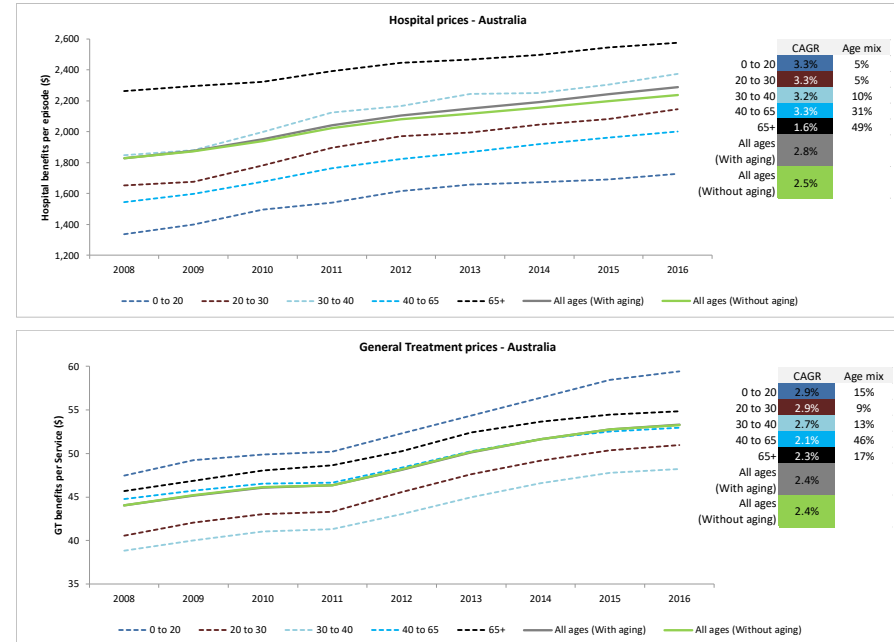
1. Determine the compound annual growth rate of hospital claims per hospital episode and claims per general treatment (GT) service separately by age. These metrics are used as a proxy for healthcare prices
2. For hospital and general treatment separately, determine the average price inflation over all ages, by using each age's CAGR weighted by its the claims mix over the analysis period
3. Determine the average price inflation for the combined hospital and GT group as each group's CAGR weighted by its claims mix.

I note the following limitations in using the hospital claims cost per hospital episode and per GT claims cost per GT service as a proxy for price inflation:

- Ideally, such an analysis should standardise for the type of episode or service. Available industry health insurance data is not granular enough to assess price inflation standardising for the types of services incurred for each age band. However, I believe that due to the high expected correlation between age and type of service, only standardising for age is a reasonable approach
- GT claim costs per service metrics are affected by the application of per service and aggregate limits, which potentially understates the underlying changes in price. However, as insurers' generally increase limits in response to increases in service fees this is a reasonable proxy for healthcare "price"
- Only direct hospital costs are included in the cost per hospital episode analysis. Associated medical and prosthesis costs are excluded due to the lack of volume data by age. Furthermore, as with GT, varying out of pocket

expenses incurred may result in under-estimating price inflation. However, this is a reasonable approximation given the correlation between medical and hospital costs.

Figure 11: Healthcare prices per service (Hospital, medical and general treatment)



Source: APRA statistics

Notes:

- The age-adjusted (without aging) prices are the weighted average price using the average benefit mix by age over the analysis period
- The aging adjustment is relatively modest for hospital because the second oldest age bracket (40 to 65) have lower prices than the younger 30 to 40 age range (likely due to life stage related services such as obstetrics). This results in the price inflation due to aging being partially offset by deflation as policyholders age from 30-40 to the 40-65 brackets.

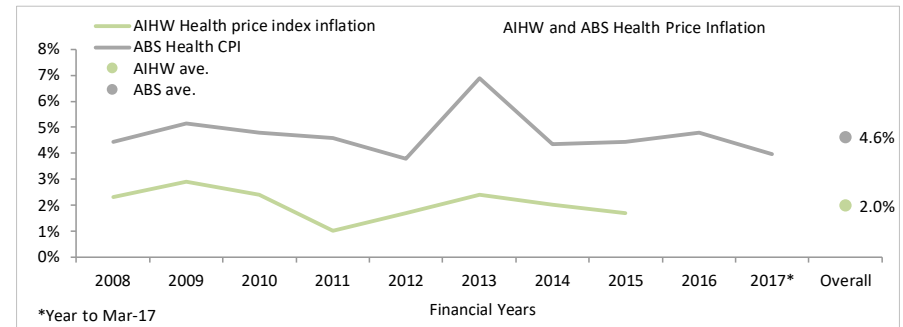
5.1 Comparison with AIHW and ABS data

This rate of price inflation is consistent with the experience of the Australian healthcare industry in general. Since FY2008, healthcare price inflation has averaged between 2.0% p.a. to 4.6% p.a. as reported by the AIHW and ABS as shown in Figure 12. While these statistics refer to general healthcare price inflation including services funded by non-health insurers (government and individuals), they provide an additional source illustrating the price inflation that is inherent in the services covered by private health insurance.

The AIHW statistic is more appropriate for the purposes of assessing pure healthcare price inflation. The ABS health CPI includes the price of health insurance premiums and therefore partially includes inflation due to aging and volume. This has the effect of overstating the true inflation in the price of healthcare services.

My analysis suggests that the healthcare price inflation is 2.5%, which is 0.5% higher than the AIHW figure. On one hand, there is the possibility that the AIHW statistic is more accurate due to the lack of standardisation by service type in my analysis. On the other hand, my analysis focuses on health insurance data whereas the AIHW figure relates to healthcare in general. Overall, a 0.5% difference is within a reasonable range relative to the variability of insurance claims, and furthermore this difference relates only to the allocation of inflation between the components of claims, i.e. if the 0.5% is not allocated to price inflation, then it must be allocated to volume or aging.

Figure 12: AIHW and ABS healthcare price inflation



Source: ABS Health CPI (6401.02) to March 2017, AIHW Health Expenditure FY2015

Notes:

- ABS Health CPI inflation is the annual non-overlapping moving average
- ABS FY2017 inflation is represented by the annual inflation for the year to March 2017
- Key differences between the AIHW and ABS statistic as quoted in AIHW are "the consumer price index only measures movements in the prices that households face. The overall consumer price index and its components do not, for example, include government subsidies, benefit payments and non-marketed services that governments provide."

6 Healthcare volume inflation (2.3%)

Healthcare volume inflation refers to the increasing utilisation of healthcare services per person in excess of what can be explained by aging, i.e. people at all ages are utilising more healthcare services than people at the same age in the past.

Over the analysis period, this was found to be 2.3% p.a. based on health insurance data.

As with the price inflation, Figure 13 and the following describes the methodology used to derive volume inflation:

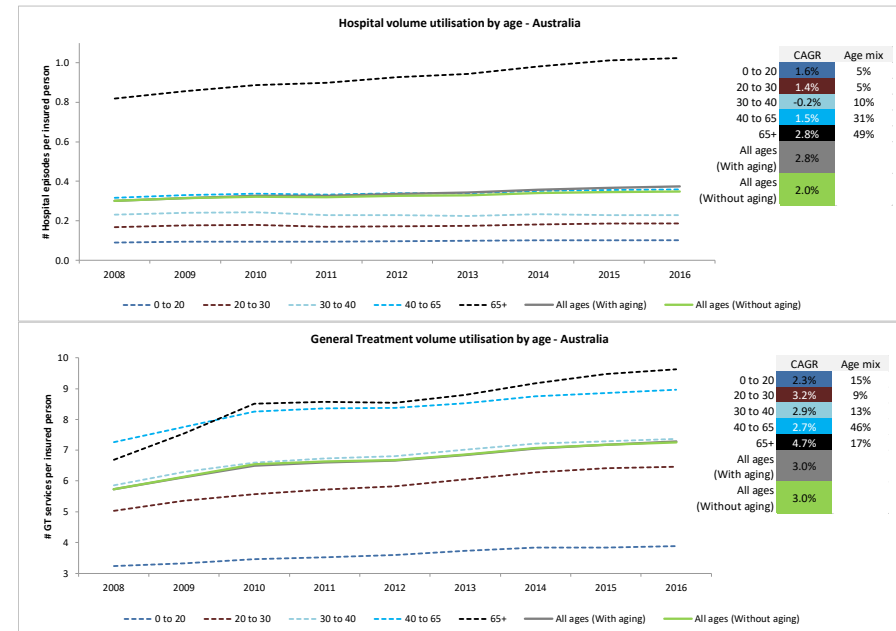
1. Determine the compound annual growth rate of hospital episodes per person and GT services per person by age. These metrics are used as a proxy for the healthcare volume inflation
2. For each portfolio, determine the average volume inflation over all ages, by weighting each age's CAGR by its claims mix over the analysis period
3. Determine the average volume inflation for the combined hospital and GT portfolio as each portfolio's CAGR weighted by its claims mix.

While this analysis excludes medical services due to data constraints, given the high correlation between hospital and medical costs, it is likely that there is also volume growth in medical services.

Other key observations include:

- Older age ranges typically experience higher utilisation of services in addition to higher inflation of utilisation
- The increase in utilisation by age, particularly for the 65+ age range is especially large for hospital volumes. This was not investigated, although this is likely to be correlated with worsening health with age. On the other hand, GT volumes are driven by allied health services, which typically treat less serious health conditions, and as a result exhibit less of an aging effect.

Figure 13: Volume inflation



Source: APRA statistics

Note:

- Hospital substitute and chronic disease service utilisation were not included in these charts as this is less material (less than 1.0% of annual industry hospital and medical benefits for the year ending March 2017)

7 Comparison with AIHW results

In 2008, Goss, as part of an AIHW study⁹ used broader healthcare data to forecast the growth in Australian healthcare expenditure attributed to underlying drivers including aging, population growth, changes in disease rates, treatment proportion¹⁰ and price.

Overall, the results of this paper are generally consistent with the findings in the AIHW report, as summarised by the table below.

	AIHW	This paper
Volume inflation	1.8%	2.3%
Price inflation	0.2% (real), 2.8% (nominal)*	2.5%
Aging	0.8%	0.8%

*: Nominal inflation not stated in the AIHW report. This table adopts 2.6% p.a., representing the CPI inflation over the 10 years to FY2003, the starting point of the AIHW projection. Note that this AIHW statistic is from a different time period to the version referenced in Figure 12.

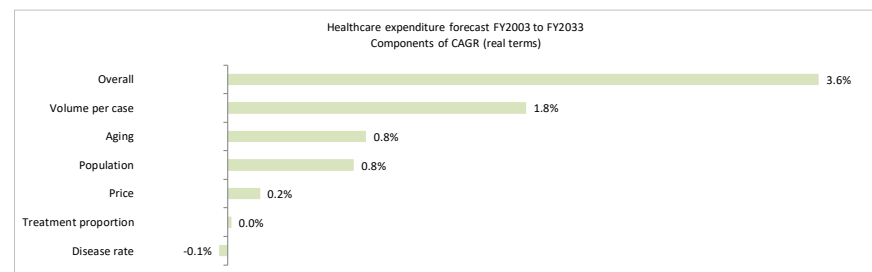
7.1 Volume inflation

It is clear that the volume of healthcare services demanded by Australians within and outside health insurance has been growing significantly, even allowing for the aging population. The AIHW report states that the *“introduction of new technologies and changes in treatment practices have been the main contributors to changes in volume per case in the past and this is expected to continue”*. Examples of changes in treatment practices provided by the AIHW include increases in the proportion of the population with disease who are treated (although their results indicate this to be not material), changes in the pattern of treatment and changes in the pattern of service delivery.

Regardless of the underlying drivers, volumes of healthcare services demanded has been growing at a rate higher than can be explained by aging, which in turn flows to higher health insurance costs and therefore higher health insurance premium rates.

⁹ Goss J 2008. Projection of Australian health care expenditure by disease, 2003 to 2033. Cat. no. HWE 43. Canberra: AIHW.

Figure 14: AIHW projected drivers of healthcare expenditure



Source: Projection of Australian health care expenditure by disease, FY2003 to FY2033, John Goss, AIHW
Note:

- CAGR allocation determined via the author’s analysis on AIHW results. Overall healthcare expenditure CAGR was allocated to each driver in proportion to their contribution to overall cost increases
- AIHW scope includes “total health and residential aged care expenditure as at 2004–05 funded by the Australian government, state and territory governments and the private sector”

¹⁰ Defined by AIHW as *“The proportion of cases that receive treatment”*

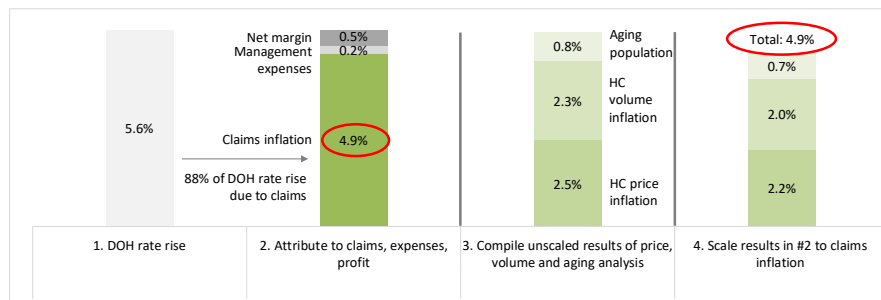
8 Results

The sections above attribute premium rate inflation into claims, management expenses and net margin, and then subsequently breakdown the drivers of the claims inflation.

For the purpose of presenting the drivers of premium rate inflation in the context of the DOH published rate rises, the results were scaled to the average industry rate rises as published by the DOH, as outlined in Figure 15 below and as described by the following:

1. The reference point being the DOH industry average rate rise for the 10 years to 1 April 2017
2. Based on analysis in Section 3, 88%, 4% and 8% of the increase in premiums per policy was due to claims, management expenses and net margin respectively. These figures were then used to apportion the DOH headline rate rise
3. Analysis in Sections 4, 5, 6 indicated that healthcare (HC) price inflation, volume inflation and the aging population inflated claims per person by 2.5%, 2.3% and 0.8% p.a. respectively
4. Results were then scaled to the claims inflation derived in Step 2 accordingly. Scaling is necessary due to the differences in per policy and per person metrics and the complexities described in the Appendix.

Figure 15: Compilation of results (% p.a. contribution to premium growth)



Notes: Arithmetic scaling was performed to allow the sum of the individual component CAGRs to reconcile to its component totals.

9 Conclusion

The purpose of this paper is to quantify the drivers of health insurance premium rate rises over the 10 years to June 2017. Premium rate inflation over this period has been primarily driven by healthcare price inflation, volume inflation, the aging population and to a lesser extent insurers' management expenses and profit.

Attributing premium rate rises provides a framework in which to evaluate reform or the value offered to consumers from the underlying drivers. Efforts to optimise future premium rate inflation should therefore focus on addressing these underlying drivers.

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10 Appendix

Complexities in the analysis

The nature of healthcare, health insurance and associated data introduces a number of complexities in conducting attribution analysis of this nature, necessitating the use of scaling and assumptions. These include:

- | | |
|---|--|
| <ul style="list-style-type: none"> • The APRA data is split over two versions, each with different variations of metrics at different levels of detail • The overlapping nature of Hospital and GT, i.e. policyholders can hold a hospital, GT or combined policy or two policies individually, either with the same or different insurer. These have implications for the way insured persons and policies are recorded • The hospital category includes both hospital and medical costs, each with different volume measures | <ul style="list-style-type: none"> • Chronic disease and hospital substitute persons have different treatments within GT over time. These people measures are themselves not mutually exclusive relative to hospital or GT persons. • The non-linear relationship between price and volume. For example, decreasing lengths of stays result in decreasing cost per episodes being reflected as price deflation, even if the price per day charged does not change. |
|---|--|

Detailed results table

	Contribution to claims growth Unscaled (% p.a.)			Mix – Ave. benefits	
	Overall	Hos	GT	Hos	GT
Aging	0.8%				
Price	2.5%	2.5%	2.4%	75%	25%
Volume	2.3%	2.0%	3.0%	75%	25%
Overall	5.5%				

The reader may question why the unscaled sum of 5.5% does not reconcile to the claims per policy inflation of 4.7% in Figure 5. This is because of inflation differences between the per policy and per person metric and the differential treatment of hospital substitute/chronic disease management programs/hospital-linked ambulance (HS/CDMP) across time and between the analysis and the overall inflation. The table below provides a more detailed comparison between these metrics.

These differences are unlikely to materially affect the results because the key insights relate to the relativity of each driver and are reasonably small relative to the inherent variability of an insurance portfolio.

Comparison of per policy and per person metrics across the three PHI datasets utilised

#	% p.a. 8 yrs to FY2016	Annual	Quarterly	DOH	Notes
	Description of data				<ul style="list-style-type: none"> Annual: Operations of PHI report, released annually, publicly available Quarterly: Data released by the regulator, industry section is publicly available DOH: Average industry rate rise including rate protection released by the DOH¹¹
1	Premium per policy growth – DOH	4.5%	N/A	5.7%	<ul style="list-style-type: none"> Interpolated from year ending 31 March to FY. Calculation performed on average policies over the year for the annual data. Quarterly data does not include premiums Difference between the annual and DOH data is due to downgrading and other revenue impacts. Refer to Section 3.
2	Claims inflation per average policy	4.7%	N/A	N/A	Calculation possible using the quarterly data but for this exercise it was not used or performed
3	Claims inflation per person – Overall	5.0%	5.1%	N/A	<ul style="list-style-type: none"> Inflation appears low relative to #4 and #5 because the overall metric includes CMDP/HS persons, and at some stage during the analysis period the insured persons by age data used in #5 changed from including CMDP/HS to excluding it Overall inflation using the quarterly data excluding medical and prosthesis claims included for comparison
4	Claims inflation per person – Hospital	5.6%	5.7%	N/A	<ul style="list-style-type: none"> Annual data includes all non-GT claims expenses including CDMP/HS Quarterly data includes Hospital, medical and prosthesis only for simplicity and materiality reasons. The same inflation was derived if medical and prosthesis claims are excluded
5	Claims inflation per person - GT	N/A	5.5%	N/A	<ul style="list-style-type: none"> Not possible using the annual data which does not include GT persons

¹¹ <http://health.gov.au/internet/main/publishing.nsf/content/privatehealth-average-premium-round>