



Australian
Competition &
Consumer
Commission

ACCC Report

Communicating changes to private health insurance benefits

A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance

For the period 1 July 2014 to 30 June 2015



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Shortened terms

ACCC	Australian Competition and Consumer Commission
ACL	Australian Consumer Law
ACPS	Australasian College of Podiatric Surgeons
ADA	Australian Dental Association
ADHA	Australian Day Hospital Association
AMA	Australian Medical Association
AOPA	Australian Orthotic Prosthetic Association
APA	Australian Physiotherapy Association
APRA	Australian Prudential Regulation Authority
ASA	Australian Society of Anaesthetists
ASO	Australian Society of Orthodontists
CBHS	Commonwealth Bank Health Society
CCA	<i>Competition and Consumer Act 2010</i> (Cth)
CCC	Code Compliance Committee
HBF	Metropolitan Hospitals Benefit Fund of Western Australia
HCSP	health care service provider
HIRMAA	Health Insurance Restricted Membership Association of Australia
IFC	informed financial consent
IVF	In Vitro Fertilisation
LASA	Leading Age Services Australia
MBS	Medicare Benefits Schedule
MTAA	Medical Technology Association of Australia
nib	Newcastle Industrial Benefits Hospital Fund
OA	Optometry Australia
PAA	Pedorthic Association of Australia
PDS	Product Disclosure Statement
PHA	Private Healthcare Australia
PHI	private health insurance
PHI Act	<i>Private Health Insurance Act 2007</i> (Cth)
PHI Code	Private Health Insurance Code of Conduct
PHIAC	Private Health Insurance Administration Council
PHIO	Private Health Insurance Ombudsman
PHMAC	Private Health Ministerial Advisory Committee
RANZCO	Royal Australian and New Zealand College of Ophthalmologists
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SIS	Standard Information Statement
SMS	Short Message Service

Executive summary

This is the 17th report to the Australian Senate prepared by the Australian Competition and Consumer Commission (ACCC) on competition and consumer issues in the private health insurance industry. The report is for the period 1 July 2014 to 30 June 2015.

A key issue identified in last year's report was the way in which changes to private health insurance are communicated to consumers. ACCC research revealed examples of changes to the benefits provided by health insurers that might breach consumer laws.¹ The ACCC decided to further examine this issue in this year's report by focusing on how consumers are notified of changes to their private health insurance benefits, and the impact these changes can have on consumers (for example, by increasing out of pocket expenses or limiting access to health care).

While the report addresses issues specific to the reporting period, it also gives broader consideration to the enduring impact of these issues on consumers. This approach aligns with the ACCC's 2016 Compliance and Enforcement Policy, which identifies competition and consumer issues in the health and medical sectors as a priority.²

Over 11 million people in Australia hold combined hospital and extras cover while another 2 million hold extras cover only.³ Private health insurance represents a significant financial commitment for many consumers and changes to the benefits available through these policies can have serious impacts on consumers.

During 2014–15, the Private Health Insurance Ombudsman (PHIO) received a total of 4265 complaints relating to private health insurance—a 24 per cent increase on the number of complaints received in 2013–14 and the second consecutive year of a significant increase. During the same period, the PHIO received 281 complaints specifically related to changes to insurers' rules, representing a dramatic increase of 290 per cent on 2013–14.

Notifying consumers of changes to their private health insurance benefits

This year's report finds that the private health insurance industry continues to be characterised by imperfect information and complexity, particularly around how the industry communicates with consumers about changes to their private health insurance benefits.

Consumers can experience a change to benefits in a number of ways, including through a change to an insurer's rules or a change to an insurer's arrangements with health care service providers (HCSPs).⁴ Available evidence suggests that benefit changes are widespread and increasing over time, and that inadequate notification can have a significant impact on consumers.

1 Changes to private health insurance can be described in various ways, including by referring to changes to private health insurance policies, products, insurer rules and benefits. This report considers changes from the consumer perspective and so focuses on changes to the benefits consumers can access through their private health insurance. This can result from variations to private health insurers' rules, product design, and/or the contracting arrangements between insurers and health care service providers.

2 See ACCC Compliance & Enforcement Policy: <https://www.accc.gov.au/about-us/australian-competition-consumer-commission/compliance-enforcement-policy>.

3 See Private Health Insurance Statistical Trends: <http://www.apra.gov.au/PHI/Publications/Pages/Statistical-Trends.aspx>.

4 HCSPs include hospitals, specialists, and providers of 'extras' services such as dental, optical, physiotherapy and chiropractic care. An example of contractual arrangements between insurers and HCSPs include 'preferred provider arrangements' where an insurer negotiates reduced fees from HCSPs in exchange for the right to participate in the insurer's preferred provider network. Consumers who use a HCSP within these networks typically face lower out of pocket expenses. Consumers may choose to go to a HCSP outside the insurer's network but they may face higher out of pocket expenses.

Providing imperfect information about a benefit change can limit consumers' ability to manage their private health insurance by limiting their ability to maintain their level of cover through upgrading their policy or switching to another insurer, or by selecting an alternative health care provider before they incur out-of-pocket expenses.

Submissions and complaints data have revealed a range of good and poor industry practices for communicating benefit changes to consumers. Practices of particular concern include:

- insurers choosing, in some circumstances, to not notify consumers of changes (typically occurring when changes are made to insurer-HCSP arrangements)
- insurers using unclear and unhelpful communication methods to notify consumers of changes, such as through the use of:
 - low prominence, low profile messaging
 - unclear and misleading terms and language
 - single notifications without any follow up
 - email as a default communication channel without informed 'opt in' by consumers or clear signalling of message content in subject lines
 - communication that mixes benefit change notifications with marketing information
 - passive messaging on websites to communicate changes.

Submissions noted a range of unnecessary and negative impacts on consumers that can occur when they are not properly advised of a change to their benefits, including:

- bill shock or unexpected out-of-pocket expenses post-treatment
- losing the opportunity to port to another insurer to maintain the level of cover held before the change was imposed—this loss of opportunity to port can mean consumers re-serve waiting periods to obtain their previous level of cover
- cancelled and delayed medical procedures where consumers learn of a benefit reduction prior to medical treatment
- long waiting periods for treatment in the public health system where a consumer cannot afford to pay for a no-longer-covered service out of their own pocket
- inadequate health insurance coverage given consumers' health needs.

Research and submissions indicate that some groups of consumers, particularly younger people, non-English speaking people, the elderly, those with chronic illnesses and those undergoing ongoing treatment, can have a greater exposure to these negative impacts.

Key observations

Our analysis has led to two primary observations:

- First, although not universal, there are a range of poor practices adopted by some insurers around how they notify consumers of changes to their private health insurance benefits, and these practices negatively impact consumers through bill shock, inadequate insurance coverage, lost switching/porting opportunities, and by limiting access to health care. These poor practices include:
 - No notification being given to consumers in some circumstances where benefits are changed (such as where consumers are not notified of changes to insurer-HCSP arrangements). This industry practice appears to be driven, in part, by a narrow view of compliance with notification requirements under the *Private Health Insurance Act 2007* (PHI Act), and an overly restrictive view of compliance with the Private Health Insurance Code of Conduct (PHI Code), without due consideration to general obligations arising under the *Competition and Consumer Act 2010* (CCA) and Australian Consumer Law (ACL).
 - Poor communication practices being used to inform consumers of changes to their benefits resulting in consumers sometimes missing the notifications, or reporting that the information provided is poorly presented, overwhelming, ambiguous as to its impact or

misleading. Related to this point is a lack of consumer awareness in general that insurers include terms in their policies which purport to allow insurers to make unilateral changes to their insurance benefits. While insurers are required to notify consumers of these changes, some insurers' methods of notification as described in this report are ineffective. Furthermore, consumers may lack awareness of their portability rights which allow them to maintain their cover by switching or upgrading policies without penalty. In some circumstances, these practices are also at risk of contravening the ACL.

- Second, as also noted in last year's PHI Senate Report, the Australian private health insurance industry continues to increase in complexity, driven in part by a greater number of policies, changes to available benefits, and the rise of non-comprehensive policies (in particular those with exclusions, restrictions and excesses). This landscape makes it harder for consumers to understand and react when insurers change their benefits, and makes reform to consumer notification processes in this industry even more important.

The ACCC acknowledges that the findings in this report are being made in the context of ongoing government consideration of reforms to the private health insurance sector.

The role of the ACCC

The ACCC is committed to increasing awareness among consumers about the protections offered by Australia's consumer laws. It is in the interests of both consumers and insurers to be as clear and transparent as possible so that consumers can make informed decisions about the level of insurance cover they want and respond effectively when changes to their benefits are made. Importantly, insurers should not assume that compliance with specific private health insurance laws and regulations alone will satisfy obligations that arise under the CCA and ACL.

As observed in last year's report, current trends in the private health insurance industry warrant a closer examination of the conduct of private health insurers and HCSPs. It also warrants that policy makers consider these issues to ensure that insurers adopt better practices around the information provided to consumers when changes to benefits are made. While the ACCC has an overarching consumer protection role that encompasses the private health insurance sector, we do not have policy responsibility for many of the issues raised in this report.

In accordance with the ACCC's Compliance and Enforcement Policy, the ACCC has dedicated resources to investigating certain conduct by private health insurers. In particular, the ACCC has focused its resources on matters which contribute to improving the ability of consumers to make informed decisions regarding private health insurance products.

An example of the ACCC's enforcement and compliance activities include the proceedings instituted against Medibank Private Ltd in June 2016 for allegedly engaging in misleading conduct, making false or misleading representations and engaging in unconscionable conduct (section 2.1). Specifically, the ACCC alleges that Medibank failed to notify its members and members of its subsidiary brand, ahm, regarding its decision to limit benefits paid to members for in-hospital pathology and radiology services. We are currently investigating the conduct of other health insurers arising from ACL concerns associated with changes in benefits or application of policies. This may result in further action in 2016-17.

While some effort has been made by industry and government over recent years to address these issues, as this report makes clear, further work to improve the information available to consumers is needed. Suggestions for change are included at the conclusion of this report (section 4).

1. Introduction

The ACCC's 16th report to the Australian Senate (released in October 2015) undertook a detailed review of the private health insurance industry with a focus on information provision, including the transparency, accuracy, and consistency of information provided to consumers about health insurance policies and the impact this has on consumers and competition more broadly.

A key issue identified in last year's report related to the way in which changes to private health insurance are communicated to consumers. ACCC research revealed examples of changes to the benefits provided by health insurers that could be at risk of breaching consumer laws.⁵

For its 17th report to the Australian Senate, the ACCC decided to further examine this issue by focusing its report on how consumers are notified of changes to their benefits, and the impact these changes can have on consumers. Specifically, this year's report examines:

- whether these changes are appropriately communicated to consumers, and
- the possible impacts where changes are not appropriately communicated, including the extent to which this may:
 - deprive a consumer of the opportunity to choose an alternative private health insurer or to select an alternative health care provider
 - lead to 'bill shock'
 - limit consumer access to, or choices of health care.

Although definitions among submissions varied, 'bill shock' is generally defined as 'the situation where a consumer receives a bill for goods received or services already provided that is higher than expected'.⁶ In line with the Senate reporting obligation to consider practices that 'increase their [consumers] out-of-pocket medical and other expenses', this report defines bill shock more generally as the situation where a consumer learns (before or after treatment) that they will be subject to an unexpected out-of-pocket expense.

1.1 Senate Order

The ACCC has an obligation to provide an annual report on competition and consumer issues within the private health insurance industry under an Australian Senate order. The complete order is:

Senate order

There be laid on the table as soon as practicable after the end of each 12 months ending on or after 30 June 2003, a report by the Australian Competition and Consumer Commission containing an assessment of any anti-competitive or other practices by health insurers or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses.

⁵ Changes to private health insurance can be described in various ways, including by referring to changes to private health insurance policies, products, insurer rules and benefits. This report considers changes to private health insurance from the consumer perspective and so focuses on changes to the benefits consumers can access through their private health insurance. This can include benefit changes that result from variations to private health insurers' rules, product design, and/or the contracting arrangements between insurers and health care service providers.

⁶ PHA, p. 6; nib, p. 4.

1.2 Role of the ACCC

The ACCC is an independent Commonwealth statutory authority whose role is to enforce the CCA, including the ACL, which is a single national law that provides uniform consumer protection and fair trading laws across Australia. The ACL is enforced by the ACCC and all state and territory fair trading agencies. The object of the CCA is to enhance the welfare of Australians by promoting fair trading and competition, and through the provision of consumer protections.

All relationships within the private health insurance industry are governed by the statutory protections offered to consumers by the CCA, including the ACL.⁷ These include relationships between consumers and health insurers, hospitals, medical facilities, health providers and practitioners. Competition laws also govern relationships between industry players and, among other things, restrict anti-competitive arrangements and exclusionary conduct.

The ACCC's role in the private health insurance industry includes satisfying the terms of the Senate order and enforcing and encouraging compliance with the CCA and ACL. The ACCC's Compliance and Enforcement Policy outlines our enforcement powers, functions and priorities.⁸ This policy is updated yearly to reflect current and enduring priorities. In 2016, competition and consumer issues in the health and medical sectors continue to be a priority area for the ACCC.

Consequently, the ACCC seeks to increase transparency and awareness within the health sector generally about consumer rights under the CCA and ACL and the obligations on industry participants, with a view to:

- reducing barriers to entry, and improving competition
- protecting consumers from unlawful behaviour by medical and health providers
- empowering consumers and patients with knowledge of their consumer rights and how they can assert those rights
- encouraging improved competition in the industry by taking targeted compliance and enforcement action in accordance with our Compliance and Enforcement Policy, where potential breaches of the law are identified.

1.3 Methodology in preparing this report

The ACCC 2013–14 PHI report identified various market failures in the private health insurance industry (related to asymmetric and imperfect information) and some of the policy interventions that are designed, in part, to address these failures.⁹ The topic of this year's report—communicating changes to benefits—focuses again on a subset of these market failures and policy interventions. Specifically, to what extent insurers and HCSPs giving imperfect information about changes to benefits may lead to negative outcomes for consumers, such as bill shock, inadequate coverage or limits on access to health care (box 1).

7 In addition, the 34 private health insurers presently operating in Australia are regulated by the Australian Prudential Regulation Authority (APRA) under a legislative framework set out at—<http://www.apra.gov.au/PHI/Pages/Private-Health-Insurance-Legislation.aspx>

8 See Compliance & Enforcement Policy: <https://www.accc.gov.au/about-us/australian-competition-consumer-commission/compliance-enforcement-policy>

9 'Information and Informed Decision Making', ACCC PHI Senate Report 2015, p. 10.

Box 1: Imperfect information and the rationale for intervention in private health insurance markets

Economics can help us better understand how private health insurance markets operate and the rationale behind government policies implemented in these markets.

As a starting point, competition should be relied upon to drive efficient outcomes wherever possible. The role consumers play is to drive competition by buying from those suppliers who deliver the goods and services that best meet their needs. However, where there is a market or regulatory failure, competition may not work to deliver those efficient outcomes.

Private health insurance markets may fail to operate efficiently and competitively if consumers face imperfect information about insurance coverage which limits their ability to make informed comparisons and choices about insurance products. Consumers may lack important information for various reasons, including where:

- information is not made available (for example, some insurers may not inform their customers of detrimental changes to benefits out of fear they may lose customers to competitors)
- information provided is unclear or unhelpful (for example, some insurers may provide unclear or misleading information about benefit changes to lessen the chance of losing customers to a competitor).

Provision of relatively clear and complete information can still be imperfect from the point of view of consumer capacity to understand and analyse the information. This can be particularly true where consumers are required to make complex assessments about their own health needs and are trying to understand the benefits and restrictions of health insurance policies and the consequences when their benefits are changed.

In Australia, a mixture of legislation (such as the PHI Act and the ACL), voluntary industry codes (such as the PHI Code) and government guidance notes (such as the PHIO's Quarterly Bulletins) require and guide insurers and HCSPs to provide information to consumers about changes to their health insurance with the aim of helping consumers understand their cover and reduce harm that can result from imperfect information and complexity.

In preparing this report, the ACCC has drawn on information and data from a range of sources including public consultation processes, desktop research, commissioned research and complaints data.

Public consultations included written submissions and a roundtable forum of key stakeholders from the industry, consumer groups and government. The ACCC encourages public submissions to promote transparency and accountability in its reporting processes. Information used in this report from public submissions is identified by footnoted references. Information provided in confidential submissions has been included in a de-identified form.

Data from ACCC commissioned consumer research, undertaken by Colmar Brunton in 2015 as part of last year's PHI Report, has also been included.¹⁰

The ACCC also sought complaint data on private health insurance from the Private Health Insurance Ombudsman (PHIO). During the reporting period (2014–15), the PHIO was the statutory government agency tasked under the PHI Act with protecting the interests of people covered by private health insurance. From 1 July 2015, the PHIO's functions were merged with the Commonwealth Ombudsman.

More detailed information regarding written submissions, the roundtable forum, commissioned research and complaint data is provided at appendix A.

¹⁰ ACCC Consumer Survey—Private Health Insurance Full Report, Colmar Brunton April 2015.

In preparing this report, the ACCC has considered the broader health system reviews being undertaken by the Australian Government. In October 2015 the Australian Government announced the Private Health Insurance Consultations 2015–16 with a stated focus on the value of private health insurance for consumers and its long term sustainability.¹¹ The consultations included an online consumer survey open from 8 November to 7 December 2015 with over 40 000 respondents and roundtable discussions with industry and consumer representatives.¹² Following on from this initiative, in September 2016, the government further announced the establishment of the Private Health Ministerial Advisory Committee (PHMAC) ‘to examine all aspects of private health insurance and provide government with advice on reforms including:

- developing easy-to-understand categories of health insurance
- developing standard definitions for medical procedures across all insurers for greater transparency and simplifying billing; and
- ensuring private health insurance meets the specific needs of Australians living in rural and remote Australia’.¹³

At the time of publication, the PHMAC had not completed its review.

11 See ‘Minister for Health Sussan Ley’s address to the National Press Club on 28 October 2015’. 28 October 2015. Available at: <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2015-ley151028.htm?OpenDocument&yr=2015&mth=10>

12 At the time of printing, the results of the Private Health Insurance Consultations 2015–16 had not been made public and so could not be used in this report.

13 See ‘Private Health Ministerial Advisory Committee’, 8 September 2016. Available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac>

2. Changes to benefits provided to consumers by private health insurers

For the purposes of this report, a benefit change refers to a situation where a private health insurer varies payments relevant to medical procedures, equipment or services to members or service providers pursuant to existing private health insurance policies. A benefit change can include where an insurer adjusts coverage by varying the insurers' fund rules (i.e. through the introduction of exclusions, restrictions, excesses or co-payments).¹⁴ It can also include changes to the contracting arrangements between insurers and HCSPs providing services to an insurer's customers. Both these type of changes can negatively impact a consumers' access to health care benefits as well as cause a consumer to incur out-of-pocket expenses.

The ACCC recognises that insurers sometimes make changes that are beneficial to their customers (such as when insurers expand cover to include a new service). However, as the Senate Order requires an assessment of practices 'which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses', this report focuses on detrimental changes.

As changes to benefits are typically made by insurers and information provision requirements about these changes apply to insurers, this report focuses primarily on the practices of insurers. However, the conduct of HCSPs as it relates to benefit changes is also considered through their role in providing informed financial consent (IFC) to their patients.

This section describes how consumers experience changes to their private health insurance benefits, including consumer complaints related to benefit changes, the regulatory framework that applies to those changes and why insurers make changes to available benefits. Drawing on research and submissions to this study, the section also identifies existing good and poor industry practices in communicating benefit changes to consumers and the impacts that inadequate change notifications can have on consumers.

2.1 The consumer perspective of changes to benefits

How consumers experience changes to benefits provided by private health insurers and the types of complaints they make about this experience can inform policy makers about potential issues in the sector.

Consumers' experience private health insurance differently to other types of insurance

Information obtained in the process of compiling this report suggested that consumers were often surprised when they discovered that private health insurance companies include terms in health insurance policies that purport to allow an insurer to unilaterally make changes to the benefits available through an existing policy (section 2.5).

This reaction may be explained by consumers' experience with other types of insurance (such as car or home and contents insurance) and an expectation that private health insurance should operate in a similar way to fixed term insurance products. In addition, where private health insurers provide notice of changes, the method and timing of communication can mean that the notices about changes are not effective. Ineffective notice provided to these consumers can mean that they are also prevented from being able to make informed decisions about their level of cover and choice of service provider before undergoing treatment.

The legal framework applying to insurer-initiated benefit changes is outlined in section 2.2.

¹⁴ Risk sharing in the Australian private health insurance market, Research Paper 4 June 2015, PHIAC.

Changes to benefits can affect many consumers

As of June 2016, 11.3 million people in Australia (or 47 per cent of the population) held combined hospital and extras cover and around another 2 million people had extras cover only.¹⁵ The likely impact of changes to benefits on consumers is widespread and increasing over time.

ACCC commissioned research found that nearly two thirds (61 per cent) of all respondents with private health insurance reported a ‘policy’ change since taking out their insurance.¹⁶ Respondents with combined hospital and extras cover were more likely to report experiencing a change (66 per cent) compared to respondents with hospital cover only (46 per cent).

One insurer noted that over half a million of its members were affected by benefit changes in the calendar year of 2014 while another stakeholder stated that over the same period one insurer removed over 200 medical benefit items from its schedules. The PHIO has observed an increasing trend in the number of changes to private health insurance benefits in recent years.¹⁷

Consumer complaints, particularly about benefit changes, continued to increase in 2014–15

During 2014–15, the PHIO received a total of 4265 complaints relating to private health insurance, representing an increase of 24 per cent on the 3427 complaints received in 2013–14.¹⁸ This was the second consecutive year of a significant increase in the total number of complaints following a 16 per cent rise in 2013–14—and a trend that continued into 2015–16.¹⁹ The breakdown of the PHIO complaint data is shown in figure 1.

In 2014–15, the PHIO received 281 complaints specifically relating to changes to insurers’ rules, an increase of 290 per cent on the 72 complaints made in 2013–14. Rule change complaints typically involved consumers reporting that they did not receive or did not understand the notification of a change to insurer rules, and as a result, missed the opportunity to maintain continuity of cover by switching policies. While rule change complaints made up a small proportion of total complaints overall in 2014–15 (at around 7 per cent), they have risen sharply in recent years from 41 in 2012–13 to 281 in 2014–15 making up around a quarter of the overall increase in all complaints in 2014–15 (table 1).²⁰

The PHIO also received over 60 complaints in 2014–15 relating to a change by an insurer to its insurer-HCSP arrangements which resulted in a reduction in medical gap benefits for in-patient diagnostic and pathology services. The majority of these complaints related to the insurer not advising consumers in advance of the change and the consumer experiencing unexpected out-of-pocket expenses when discharged from hospital (section 2.5).

In June 2016, the ACCC instituted proceedings in the Federal Court against Medibank Private Limited (Medibank) alleging that in this case Medibank contravened the ACL by engaging in misleading conduct, making false or misleading representations and engaging in unconscionable conduct (see below).

15 See Private Health Insurance Statistical Trends: <http://www.apra.gov.au/PHI/Publications/Pages/Statistical-Trends.aspx>.

16 Question 26 included premiums, coverage and level of benefits in the definition of a ‘policy change’ and is likely to overestimate the incidence of non-premium related changes (ACCC Consumer Survey—Private Health Insurance Full Report, Colmar Brunton 2015).

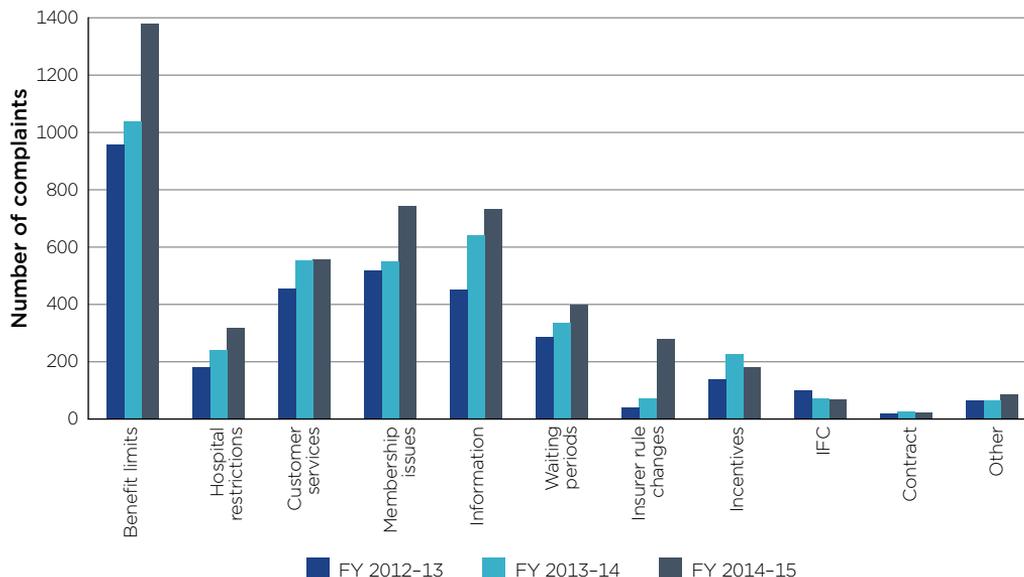
17 PHIO, p. 8.

18 In 2014–15, the ACCC received 253 contacts regarding insurers or in relation to private health insurance issues. This represented a 95 per cent increase from the previous year where it received 130 contacts.

19 In 2015–16, total complaints to the PHIO increased a further 5 per cent to 4506 (PHIO Supplementary, p. 10).

20 In 2015–16, consumer complaints to the PHIO about rule changes fell to 157.

Figure 1: PHIO private health insurance complaints, FY 2012-13 to 2014-15



Source: PHIO supplementary p. 10. Notes: In 2015-16, the PHIO received 1359 benefit complaints, 276 hospital restrictions complaints, 599 information complaints and 157 rule change complaints. Hospital restriction complaints represent a subset of benefit complaints.

ACCC action against Medibank

The ACCC alleges that Medibank failed to notify its members and members of its subsidiary brand, ahm, regarding its decision to make a detrimental change to its contractual arrangements with some HCSPs that resulted in it ceasing to cover gap payments for charges above the Medicare Benefits Schedule for in-hospital diagnostic services, including pathology and radiology which is commonly required.

The ACCC alleges that Medibank did not provide members with any advance notice of the change despite previously representing that it would do so and that Medibank adopted a strategy of keeping communications about this change contained and reactive. The ACCC alleges that Medibank's conduct was misleading and, in all circumstances, unconscionable.

The ACCC also alleges that Medibank represented to members and potential members that a number of its policies covered in-hospital pathology and radiology services, such that members would not pay any out-of-pocket expenses for these services, unless Medibank provided them with prior notice otherwise. The ACCC alleges that these representations were false or misleading from 1 September 2014, since from that time members incurred out-of-pocket expenses for such services and were not notified by Medibank in advance of the change.

This case is before the courts and the ACCC is seeking declarations, injunctions, compensation orders, pecuniary penalties, findings of fact, implementation of a trade practices compliance program, corrective notices and costs.²¹

Medibank is defending these allegations.

21 See Media Release 'ACCC takes action against Medibank for alleged misleading and unconscionable conduct': <http://www.accc.gov.au/media-release/accc-takes-action-against-medibank-for-alleged-misleading-and-unconscionable-conduct>.

The PHIO reports that the significant increase in complaints about benefit changes in 2014–15 is attributable to the larger numbers of people affected by detrimental changes (particularly from the removal of hospital benefits, changed excess structures and reduced extras benefits) and the financial impact on consumers of the changes (table 1).²²

It is likely that the complaint data understates the incidence and impact of insurers inadequately notifying consumers of benefit changes. Customers typically lodge a complaint with the PHIO after becoming aware that their benefits have changed through the experience of bill shock or after being informed by the service provider that a scheduled treatment is no longer covered. Those customers who remain unaware that their benefits have changed (because of inadequate notification) are not counted in this type of data. In addition, many consumers who become aware that they have not been informed of a benefit change do not lodge complaints.

Changes of benefits to consumers typically involve increasing exclusions of cover

The PHIO has indicated that in recent years, detrimental changes typically involve the exclusion or reduction of services from existing hospital cover to restricted/default/minimum benefits, while a smaller number of changes were to insurer rules, provider arrangements, and lowering of general treatment and dental benefits.²³ For 2014–15, most change complaints related to the exclusion of IVF, gastric banding, psychiatric and spinal treatments (table 1).

Exclusions made by an insurer in any given year can result in ongoing consumer harm and generate complaints over several years (for example, the exclusion of IVF services in 2013–14 by one insurer generated ongoing complaints over three years to 2015–16) (table 1).

Table 1: PHIO complaints relating to insurer rule changes, 2012–13 to 2015–16

Year	Rule change complaints	% of total complaints that year	Number of complaints against a given insurer (de-identified) relating to listed changes
2012–13	41	1.3	9—restricted services downgraded to exclusions
2013–14	72	2.1	38—exclusion of IVF
2014–15*	281	6.6	46—exclusion of IVF, gastric banding 78—exclusion of gastric banding, psychiatric, excess changes 33—exclusion of gastric banding, spinal surgery 106—forced extra cover migration
2015–16	157	3.7	20—exclusion of IVF, gastric banding 15—forced migration, significant hospital downgrade 48—exclusion of gastric banding, spinal surgery

Source: PHIO p. 9 and PHIO supplementary pp. 2–6. Notes: *In 2014–15, the PHIO also received over 60 complaints relating to an insurer not notifying its customers of changes to insurer-HCSP arrangements which resulted in a reduction in gap benefits paid for in-patient diagnostic and pathology services (section 2.1). Data for the 2014–15 reporting period for this report is shaded grey.

22 PHIO p. 10.

23 PHIO Supplementary, p. 11.

The impact on consumers from the 281 rule change complaints received in 2014-15 by PHIO primarily related to:

- limits on coverage for certain health services (in particular IVF, gastric banding, psychiatric treatment and types of spinal surgery)
- unexpected out-of-pocket expenses for these services, and
- consumers cancelling or delaying planned medical procedures to avoid unexpected expenses.²⁴

Complaints about private health insurance information continued to increase in 2014-15

The PHIO reports that consumer complaints about private health insurance information provided by insurers increased from 454 in 2012-13 to 645 in 2013-14 and 736 in 2014-15 (up 62 per cent over two years). Complaints related to consumers not being notified of changes to their benefits increased from 55 in 2012-13 to 96 in 2013-14 and 91 in 2014-15 (up 65 per cent over two years) (table 2).²⁵

Table 2: PHIO complaints relating to information provision, 2012-13 to 2015-16

Information sub-issue	2012-13	2013-14	2014-15	2015-16
Oral advice	289	410	522	430
No change notification given	55	96	91	90
Written advice	45	66	64	38
Brochures and websites	53	65	47	34
Standard Information Statements	11	5	8	6
Radio and television	1	2	4	1
Total on information provision	454	645	736	599

Source: PHIO Supplementary p. 10. Notes: Information complaints typically related to consumers reporting that they were misinformed or misunderstood information provided by an insurer in relation to available benefit and changes to benefits. Data for the 2014-15 reporting period for this report is shaded grey.

Changes to benefits may be occurring more often throughout the year

The PHIO has submitted that health insurers generally impose one round of major changes a year with notifications to members typically sent by letter in March with a premium increase notice. Those changes usually take effect from the beginning of the following financial year.²⁶ However, while changes tend to coincide with the yearly premium increases in July, a shift to changes happening at other times of the year was noted by the Ombudsman and in submissions.²⁷ While the changes may take effect on a financial year basis, the yearly limits on coverage provided in policies operate on a calendar year basis. The different bases may contribute to further confusion about what benefits are available at any given time.

²⁴ PHIO p. 7.

²⁵ In 2015-16, total information provision complaints decreased by 19 per cent to 599 while consumer complaints related to not receiving notification of a rule change remained approximately steady at 90 (PHIO Supplementary, p. 10).

²⁶ PHIO Supplementary, pp. 11-12.

²⁷ Ibid, p.11.

2.2 The regulatory framework applying to changes to benefits

Insurers have a key role in ensuring that their customers are kept informed about their private health insurance policies in general as well as changes to benefits when they occur. HCSPs also play a role in ensuring customers are informed of the cost of a medical service prior to undergoing treatment. Requirements for communicating changes to consumers arise from the PHI Act, the PHI Code, the ACL and other agreements and protocols referred to below.

The Private Health Insurance Act

The PHI Act establishes some minimum requirements for health insurers to communicate changes to affected customers.²⁸

Under the PHI Act, insurers are required to provide notification of proposed changes to insurers' rules that are or might be detrimental to the interests of an insured person.²⁹ Notably, this provision is entitled 'Keeping insured people up to date'. The notification must occur within a reasonable time before the change takes effect.³⁰ The rationale behind notification is to allow consumers time to exercise their right to transfer to another policy to maintain cover without serving waiting periods again.³¹ In some cases, prior notice would also allow consumers to select a different service provider to avoid certain out-of-pocket expenses. The PHI Act defines 'rules' of a private health insurer as the body of rules established by the insurer that relate to the day-to-day operation of the insurer's health insurance business and (if any) health related business.³²

In addition, once every 12 months, the insurers must provide their members with an updated Standard Information Statement (SIS) applicable to the product subgroup of the policy they have purchased from the insurer.³³

The Private Health Insurance Code of Conduct

The PHI Code is a self-regulated and voluntary industry code that aims to 'maintain and enhance the regulatory compliance and service standard of private health insurers', and to 'promote information sharing between insurers, consumers and intermediaries'.³⁴ Signatories to the PHI Code cover over 99 per cent of people with private health insurance.³⁵

A Code Committee, comprising representatives from Private Healthcare Australia, the Health Insurance Restricted Membership Association of Australia (HIRMAA), and two independent members, oversee the PHI Code. This Committee is responsible for monitoring, investigating and reviewing insurers' compliance with the PHI Code.³⁶

Amongst other practices, signatories to the PHI Code commit to providing clear and complete information on PHI policies generally, including by:

- providing policy documentation in plain language and ensuring it is full and complete
- providing effective verbal explanations by appropriately trained staff

28 Key private health insurance regulatory instruments include: the PHI Act and its subordinate legislative instruments; the *Private Health Insurance (Prudential Supervision) Act 2015*, its subordinate legislative instruments and related APRA administered prudential standards; and the *Health Insurance Act 1973*.

29 *Private Health Insurance Act 2007* (Cth) ss. 93–20 (2).

30 Ibid.

31 See: Private Health Insurance Ombudsman Quarterly Bulletin 76 (1 July–30 September 2015) p. 3.

32 *Private Health Insurance Act 2007* (Cth) Dictionary comprising Schedule 1.

33 *Private Health Insurance Act 2007* (Cth) ss. 93–20 (1).

34 See: <https://www.privatehealthcareaustralia.org.au/codeofconduct/> p. 4.

35 See: <http://www.privatehealthcareaustralia.org.au/codeofconduct/participatingfunds/>.

36 The Committee has the responsibility to ensure that the PHI Code is fully complied with by health funds and does this by: admitting funds to participate in the PHI Code; monitoring and enforcing compliance by participants by conducting random and other audits; receiving complaints about any alleged breach of the PHI Code; imposing sanctions for breaches of the PHI Code and reporting annually to the PHA Board (while maintaining its independence).

- designing and presenting documentation that assists consumer comprehension, and
- providing information to new members on benefits, including waiting periods, pre-existing conditions, exclusions, restrictions, benefit limitation periods and co-payments and/or excesses.³⁷

The PHI Code requires private health insurers which are signatories to:

‘...provide in a timely manner to consumers specific information on any changes to their policy, being made in plain language and in a format aimed to assist comprehension by consumers...’.³⁸

Further, the PHI Code defines the levels of ‘detrimental’ change to hospital and ancillary benefits that is required to trigger minimum time periods for insurers to notify customers of the change before it takes effect (box 2).

Box 2: PHI Code standards for notification of changes to hospital and ancillary benefits (as at 1 July 2015)

Detrimental changes to hospital policy benefits

A ‘significant detrimental’ change to hospital policy benefits includes:

- removal of material benefits or restriction to default benefits for any identified condition
- addition of material excesses/co-payments, or
- increases in excesses/co-payments greater than 50 per cent.

Where there is a detrimental change to hospital benefits insurers will:

- for significant detrimental changes provide affected consumers with details of the change giving at least 60 days’ written notice
- for all other detrimental changes provide the affected consumer with details of the change giving at least of the change (and for all other detrimental changes provide at least 30 days written notice)
- not apply the changes to pre-booked admissions, and
- put in place transitional measures for patients in a course of treatment for a reasonable time period, for example, up to six months.

Ancillary (extras) benefits

A ‘significant detrimental’ change to ancillary policy benefits includes:

- introduction of a new limit or sub-limit; or
- a greater than 50 per cent reduction in any limit.

For significant detrimental changes to ancillary benefits, insurers will:

- provide the affected consumer with at least 30 days’ written notice; and
- put in place transitional measures for rollover type benefits accumulated in a previous year.

Source: <https://www.privatehealthcareaustralia.org.au/codeofconduct/> p. 9. Note: Version 6 of the PHI Code released in August 2016 includes the same notification requirements except for the omission of the words ‘for significant detrimental changes’ from the second paragraph of part E, 2.1.

³⁷ See: <https://www.privatehealthcareaustralia.org.au/codeofconduct/>.

³⁸ Part E(g) of the August 2016 Version 6 of the PHI Code. The word ‘specific’ was added to Part E(g) in 2016 with the intent of requiring signatories to provide more ‘specific’ information to consumers about changes to their insurance.

The PHI Code however provides limited guidance or is silent on certain matters concerning changes to private health insurance which may lead to impacts on consumers. For example the PHI Code does not stipulate how changes to insurers' rules should be communicated (beyond references to it being made in plain language and in a format aimed to assist comprehension by consumers).

In addition, the PHI Code, as with other voluntary, self-regulatory industry codes, does not have the same force as regulations or legislation such as the PHI Act or ACL.

Other agreements and guidance on change notifications

The Code of Conduct for Health Fund and Hospital Negotiations³⁹ and the PHIO Hospital Agreements: Transition and Communication Protocols⁴⁰ both require insurers and hospitals who are signatories to keep their customers/patients informed of changes to contracted insurer-hospital arrangements (appendix B).

There is a range of other industry guidance from the PHIO relating to when and how customers should be notified of changes to their private health insurance benefits (appendix B).⁴¹

The Australian Consumer Law

The relationship between health insurers and consumers is also subject to the general statutory protections under the CCA and the ACL. The ACL contains general prohibitions against particular categories of harmful conduct in trade or commerce, including misleading or deceptive conduct, false or misleading representations (including by omission) and unconscionable conduct. These legal requirements apply to private health insurers in addition to those imposed by the PHI Act and the PHI Code.

As noted above, under the ACL, private health insurers are prohibited from engaging in conduct that is likely to mislead or deceive consumers. When considering complaints about misleading and deceptive conduct, the ACCC considers the overall impression created for consumers by the conduct. Examples of conduct the ACCC considers may be misleading or deceptive in some circumstances include:

- failing to notify customers of changes to their benefits which may be detrimental to members' interests in circumstances where the insurer created an impression among members that they would be notified of such changes
- marketing or advertising that uses language which may exaggerate or overstate the level of 'cover' for certain medical procedures, when in fact the insurer only partially covers the cost of the procedure
- marketing or advertising that uses attention grabbing headlines which are qualified by fine print disclaimers that lack prominence or are unlikely to correct the overall impression of the headline
- representations that certain services would be offered over a particular period of time when, in fact, the insurance policy terms and conditions provide that changes can be made by the insurer at any time and those terms and conditions were not adequately disclosed to consumers at the time of purchasing the cover
- representations that paying premiums in advance would 'lock-in' all benefits for the period of the advance payment when, in fact, the policy terms and conditions provided that all benefits could be changed at any time by the insurer and these terms and conditions are not adequately disclosed to consumers at the time of purchase.

39 The Code (applying to signatory hospitals and health insurers) is a self-regulated voluntary industry code that aims to encourage best practice in contracting between private hospitals and health insurers.

40 The Protocols are arrangements agreed between the PHIO and the private health industry to ensure adequate consumer protection and minimise undue disruption and risk to the industry when contractual agreements between insurers and hospitals are terminated.

41 See: PHIO Quarterly Bulletins 45, 52, 69 and 76

Under the ACL, private health insurers are prohibited from engaging in conduct that is unconscionable in all the circumstances. To be considered unconscionable, the conduct must be against conscience as judged against the norms of society. The ACCC considers that factors which may be relevant in determining whether a private health insurer's failure to disclose detrimental changes was unconscionable may include:

- whether the insurer adopted a communication strategy to intentionally minimise the number of members who would become aware of the change either before it took effect or at all
- whether the insurer sought to exploit its members' reliance on the insurer to provide information about benefit changes by deciding to remain silent on detrimental changes when it was in a position to inform its members of changes in advance
- whether the insurer decided not to inform members of changes on the basis that members would likely consider changing policies in response to the changes
- whether the health insurer complied with the applicable industry code, or
- whether the health insurer put its commercial interests ahead of its members' welfare to the significant detriment of its members.

Finally, under the ACL, any unfair terms in standard form consumer contracts are void. A term may be unfair if:

- it would cause a significant imbalance between the rights and obligations of the consumer and the business arising under the contract
- the term is not reasonably necessary to protect the legitimate interests of the business who would be advantaged by the term, and
- the term will cause detriment (financial or non-financial) to the consumer if the business tries to apply or rely on it.⁴²

The ACL applies in addition to the minimum requirements under the PHI Act and Code

Private health insurance policies and the ACL's 'unfair contract term' provisions

Private health insurance products are generally provided pursuant to standard form consumer contracts.⁴³ Accordingly, the unfair contracts term regime under the ACL can be relevant.

For example, private health insurers commonly include a term which they purport allows them to unilaterally vary a consumer's insurance policy. This means that even where a consumer spends considerable effort in understanding the policies on offer in order to make an informed choice, that effort may become redundant if an insurer subsequently decreases the cover provided. In some circumstances, such terms may be unfair, particularly where the term:

- is not transparent
- allows the health insurer to make significant changes which reduce consumers' benefits without informing consumers
- allows the health insurer to make changes which significantly disadvantage consumers and does not provide consumers with any recourse.

The ACCC is continuing to investigate potential breaches of the CCA and ACL by private health insurers. Ultimately, these matters will be subject to judicial consideration in the Federal Court of Australia.

⁴² Part 2–3 of Chapter 2 (ss. 23–28) of the ACL defines unfair contract terms and the circumstances and consequences of the existence of such terms in standard form contracts.

⁴³ See 'Unfair contract terms': <https://www.accc.gov.au/consumers/contracts-agreements/unfair-contract-terms>.

Changes to insurer-HCSP arrangements can require a notification

Some industry representatives submit that under the PHI Act insurers are not required to notify customers of changes to contracting arrangements with HCSPs as notification requirements only apply to changes to insurers' rules.⁴⁴

However, changes to contractual arrangements between private health insurers and HCSPs can have a significant detrimental impact on consumers. The ACL provisions may apply in these circumstances. Consumers may be misled by a failure to adequately disclose changes to benefits provided to consumers. A failure to disclose in some circumstances could be also unconscionable under the ACL. Private health insurers also need to ensure that any statements or conduct used in the marketing of different products align with the benefits that are delivered after a consumer purchases a policy. Any misalignment between what is marketed and what is provided may also contravene the ACL.

The level of detriment from a change can affect the notification requirement

The level of detrimental change needed to trigger the notification requirement under the PHI Act is not defined in the Act. The PHI Code defines 'significant detrimental change' for changes to hospital and ancillary benefits. The more significant a detrimental change, the more important that an insurer communicate and disclose the change to its members at the earliest opportunity, and the more likely that the ACL provisions will be triggered in the event such disclosure is not made.

For example, a customer with a chronic illness who has in the past received benefits from their private health insurer for ongoing treatment from the only specialist in their area, may suffer significant expense from a change to an insurer-HCSP arrangement that removes coverage for that specialist (if the insurer does not notify the customer of the change in advance). The higher level of detriment will influence consideration as to whether the insurer may have engaged in unconscionable conduct by not notifying the customer of the change, especially in cases where the insurer is aware of the potential harm, and was in a position to notify the customer but chose not to.

Change notifications should be prominent and appropriately targeted

The PHI Act has no specific requirements regarding the form or content of a change notification other than that it be written. The PHI Code sets some general standards for policy documentation (i.e. that it be in plain language and in a format aimed to assist comprehension).

Bearing in mind the general prohibitions under the ACL, it is advisable practice for private health insurers to ensure that any notification to consumers of changes to benefits provided by them is done in a way that is sufficiently prominent and appropriately targeted towards the affected class of consumers.

2.3 Why do insurers change the benefits they provide to consumers?

Insurers have argued strongly that the industry practice of making unilateral changes to the benefits they provide to consumers at any time is necessary as it gives them the ability to manage increases in business costs (typically caused, they submit, by a range of unpredictable regulatory and external factors) and to limit premium rises for customers. The PHA submitted that:

'Advancements in medical technology, new research on the effectiveness of treatments, changes in government reimbursements (MBS), and changes in population health and claiming profiles are all factors that contribute to insurers

⁴⁴ PHA, p. 6.

needing to make adjustments from time to time to continue meeting the needs of policy holders at an affordable price.⁴⁵

One insurer explained that increases in the uptake of certain 'high cost' procedures can drive up the cost of a policy for an insurer and premiums for all policy holders, the majority of whom may not need those procedures. This insurer submitted that removing those services from the policy can reduce the insurer's costs and keep premiums lower for customers generally, while the policy holders who need the newly excluded service are free to move to a higher (and more expensive) level of cover.

The PHIO submitted that insurers are increasingly introducing exclusions on existing policies to manage increases in claims from specific 'higher risk' groups of people by excluding certain high-cost services used by those groups.⁴⁶

PHIO case studies: Using benefit changes to manage increases in high cost services

- a. Private psychiatric treatment is 'high cost' compared to many other covered services. In recent years a number of insurers have restricted benefits for private psychiatric treatment as costs of these claims increased. One insurer restricted psychiatric benefits on all of its policies.
- b. In recent years there has been a sharp increase in claims for bariatric (gastric banding) surgery associated with higher cost claimants suffering from obesity. A number of insurers have changed policies to exclude bariatric (gastric banding) surgery from existing policies and the service is now typically only covered by top hospital policies.

The PHA contend that the industry practice of making unilateral changes is balanced by notification requirements and the concept of portability, which allows policyholders to change their level of cover or switch to another insurer without the need to re-serve waiting periods provided they switch to an equivalent or lower level of cover. The PHA contend that these requirements give consumers time to react to a change by either maintaining their coverage without a waiting period (by paying to upgrade) or accepting the new lower level of cover.⁴⁷

The regular use of benefit changes to manage increases in high cost procedures can moderate premium rises for policy holders not immediately affected by the changes. The APA, for example, acknowledged that restrictions and exclusions on policies can assist to keep premiums low and may be suitable for some groups of consumers.⁴⁸

However, this approach also creates a number of problems for consumers. It shifts costs from the insurer to the consumer and increases the chances that existing policy holders may suffer bill shock or inadequate coverage in the future where they are not made aware of or do not understand the change or that their portability rights allow them to switch without reserving waiting periods. It also adds further complexity to the private health insurance industry which could degrade the level of effective competition between providers. It can also undermine the community rating approach⁴⁹ used in the Australian private health insurance industry as it increasingly allows healthier consumers to reduce their premiums while leaving a greater proportion of higher cost claimants in the pool for higher cost services.⁵⁰

The legislative requirements regarding portability are also only applicable to hospitals cover and do not apply to extras cover.

45 Ibid.

46 PHIO Supplementary, p.11.

47 PHA p. 8.

48 APA p.4.

49 The Community Rating of private health insurance policies in Australia (first legislated in the *National Health Act 1953*) requires that all insurance policies be offered to any person at the same price irrespective of risk factors including age (apart from the LHC loading), health risk or income.

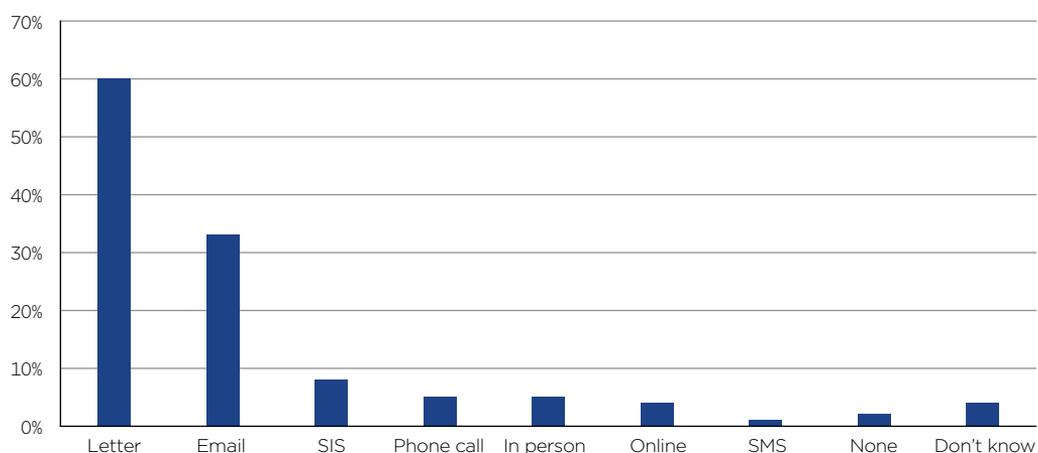
50 Competition in the Australian Private Health Insurance Market, Research Paper 1 June 2015, PHIAC 2015, pp. 43-47.

The degree to which the notification and portability requirements under the PHI Act effectively balance the practice whereby insurers unilaterally change their customers' benefits will depend to a significant degree on the effectiveness of the notification of the change and consumer knowledge about portability.

2.4 How are changes to benefits communicated to consumers?

The ACCC's commissioned research indicates that while insurers use various media for providing notifications, most consumers reported receiving written notice of changes by letter or email (figure 2).⁵¹ The research found that around 60 per cent of consumers who reported experiencing a change to their insurance received notification by letter and about one third (33 per cent) by email. A small number of consumers reported receiving notifications through the SIS (8 per cent), a phone call or in person (5 per cent) or by SMS (1 per cent).

Figure 2: Proportion of respondents receiving information, by medium, 2015



Source: ACCC Consumer Survey—Private Health Insurance Full Report, Colmar Brunton 2015.
Note: Some respondents reported receiving a change notification by more than one medium.

Further analysis found that older respondents were more likely to report receiving a change notification by letter while younger respondents were more likely to report receiving emails (table 3).⁵²

51 Question 27 asked, 'How did the fund communicate the policy change to you?' (ACCC Consumer Survey—Private Health Insurance Full Report, Colmar Brunton 2015).

52 SIS communication was more commonly reported in older age groups (at 10.1 per cent for those aged 45–59 years and only 5.2 per cent for respondents aged 18–29 years), phone and online communication was more commonly reported amongst younger age groups (8.6 per cent of 18–29 year old reported phone communication versus 4 per cent of 60+years, while 8.6 per cent of 18–29 year olds reported online communication versus 1.3 per cent of 60+year olds) (ACCC Consumer Survey—Private Health Insurance Full Report, Colmar Brunton 2015).

Table 3: Proportion of respondents receiving notification by letter/email, by age, 2015

Age groups (years)	By letter (%)	By email (%)
18–29	41.4	44.8
30–44	55.1	36.1
45–59	58.0	32.5
60+	70.4	29.1
All	60.2	33.4

Source: ACCC Consumer Survey—Private Health Insurance Full Report, Colmar Brunton 2015.

The PHIO notes that benefit change notification processes vary significantly by insurer. Typical notification methods involve sending a personalised letter or email (according to the member's preferred contact method) with a follow-up reminder closer to the date that the change is to take effect. Alternately, some insurers (such as 'health.com.au' which was established as an online only insurer) primarily uses online communications to notify customers of changes. Health insurers may also complement notifications by including benefit change information in member publications and on websites.⁵³

HCSOs made submissions that they routinely communicate with patients about changes to coverage, typically explaining to their patients any changes that have already occurred. The Australian Society of Ophthalmologists noted that their members talk to patients on a daily basis about their health insurance as part of the informed financial consent process and are often asked to assist patients in interpreting their cover and treatment options.⁵⁴ These comments highlight the difficulties consumers are having in this area.

2.5 Good and poor practices for communicating benefit changes to consumers

Submissions and complaint data have identified a range of good and poor practices in the private health insurance sector for communicating benefit changes to consumers. These are outlined below.

Good practices around change notifications

The following are examples of good practices identified in submissions around benefit change notification processes.

Good general information improves consumers' understanding of changes

A number of submissions noted that providing good general information on health insurance makes it easier for consumers to understand any subsequent change notifications they may receive. The AMA, for example, emphasised that, 'Most consumers can only understand the policy changes communicated to them if they have a full understanding of what their current policy covers'.⁵⁵

In submissions, insurers identified a range of practices they argued improved information provision generally. These included:

- sending information through multiple channels (including letters, emails, website, video, pamphlets, retail centres and broker partners)

⁵³ PHIO Supplementary, p.11.

⁵⁴ ASO p. 1.

⁵⁵ AMA p. 1

- regularly inviting customers to review their cover (especially during the annual premium change process)
- providing statements that detail services lost and gained whenever customers change their cover
- making pricing agreements with HCSPs easily accessible and understandable so customers can easily check cost prior to any hospital stay or service, and
- providing members with guidance on seeking IFC before receiving treatment.⁵⁶

Although it is best practice to provide consumers with clear and simple messages, health insurers should also be alert to the possibility that oversimplified messages may themselves mislead consumers by providing incomplete information.

Trialling notification processes that exceed the minimum standards

Some insurers reported that they were testing the effectiveness of change notification processes that went beyond the current minimum standards under the PHI Act and PHI Code.

One example involved an insurer trialling processes whereby customers were notified four times (instead of once) and provided with 100 days written notice (instead of the 60 days required under the PHI Code for changes resulting in ‘significant detriment’). The insurer reported that the targeted customers had responded positively to the trialled approaches.

Use of multiple channels for communicating change information

Some insurers highlighted the importance of using a range of channels to communicate change information as a means of increasing the likelihood that consumers would notice and engage with the information.⁵⁷

Stakeholder example: Using multiple channels

One insurer reported using ‘easy to understand’ product material, making change messages as engaging as possible through use of visual stimulus to draw consumers’ attention, text to articulate the change, and multiple channels for communicating the message such as letters, flyers, special inserts, and alerts on their online portal.⁵⁸

Using data to target change notifications to high-risk customers

Some insurers highlighted the benefits of using data (for example, on hospital admissions and ancillary service use) to proactively identify consumers at risk of experiencing bill shock from a given change to benefits and then targeting those customers with information.⁵⁹

Stakeholder example: Using data to identify and target high-risk customers

An insurer reported using its own data (including information on previous claims, benefit quotes and customer catchment zones) to identify and target benefit change information to members it identifies as being most likely to attend hospital and/or use the services affected by the change. By better understanding the impact of the change on its customers it can target its customers with information tailored to the members’ situation.⁶⁰

56 CBHS, p. 3; nib, pp. 5–6.

57 HBF, p. 2.

58 Ibid.

59 Ibid, p. 1.

60 Ibid.

Informed financial consent by HCSPs

The PHA argued that the IFC requirement was an important part of the regulatory mechanism to safeguard members from bill shock (especially where they are uncertain of their coverage).⁶¹ One insurer noted that while IFC relied on the participation of the health service provider, they assisted in the process by providing various pathways a provider could use to check a patient's coverage.

There are costs and benefits from information provision

While there are clear benefits for consumers and the efficient operation of private health insurance industry from practices that improve the availability of clear and useful information on insurance products, there are also costs from supplying this information which are predominantly born by insurers. Actions to encourage or require better information provision by the industry should take into account the relative benefits and costs of different approaches and ensure those with the greatest net benefit are considered first.

Technological change, the availability of data and shifting consumer behaviour and communication preferences are also creating opportunities to better inform consumers about the goods and services they use at lower cost. In private health insurance markets, for example, insurers can use data to identify which consumers are at higher risk of experiencing negative impacts from a given benefit change, while text messaging and social media platforms (with informed consumer opt-in mechanisms) offer potentially more effective and lower cost channels for communicating benefit change notifications to consumers. Any steps to improve consumer access to information on their private health insurance should examine these new opportunities and the appropriate complementary safeguards.

Poor practices in change notifications

Submissions also identified a range of poor practices around change notifications which were said to reduce consumers' ability to understand the changes and increased the likelihood of unexpected out-of-pocket expenses and inadequate coverage for consumers. These are outlined below.

Many consumers do not realise insurers may change their coverage at any time

While the PHIO provides material advising consumers that insurers make changes to health insurance policy at any time⁶², the PHIO noted that 'there does not seem to be any information that is clearly provided to consumers [at the point of purchase] advising them that the insurer might remove important benefits at a later stage'.⁶³

As a result, many consumers do not realise that insurers include terms and conditions in their policies which insurers purport allows them to make changes to benefits at any time. The PHIO noted in their submission 'Most consumers who contact our office are surprised to find that this is the case as they assume that they have 'locked in' the policy as it was at the time of purchase'.⁶⁴

61 PHA, p. 9.

62 See: PHIO Health Insurance Insider Issue #1—April 2012.

63 PHIO, p. 4.

64 Ibid.

PHIO case study: Consumers unaware that policies can change

In October 2014, an insurer sent letters or emails to affected members advising that there would be a forced migration from one policy to another with lower benefits and higher premium. Customers generally reported that the notification process and letters and emails were adequate and communicated the change clearly.

However, many customers were surprised that the insurer could force or unilaterally change policy terms and felt this was unfair. In particular, customers who had pre-paid their premiums felt this should have locked in the product at the level they had purchased.

As stated above, in some circumstances, such changes and the way such changes are communicated will still be subject to general obligations that arise from the ACL.

Use of unclear language and the low prominence of the change message

A number of submissions noted that change notifications were being missed or misunderstood by consumers due to the medium, format and language used.⁶⁵

The ADHA, for example, noted that consumers' understanding of their health insurance policy can be reduced by the use of unclear or ill-defined terminology around policy exclusions and restrictions. For example, ADHA noted confusion about what is considered 'major eye' surgery.⁶⁶ This, in itself, may mislead some consumers.

The PHIO (drawing on analysis of past complaints) identified key features of the language and presentation of benefit change information provided that they believed contributed to customers missing or not understanding notifications. These features include:

- the inclusion of marketing information with change notifications (customers overlooked the information because the message was not given prominence and was down the page or on a second page)
- the inclusion of change notifications in an accompanying booklet/pamphlet (customers missed the information because they did not see it)
- ambiguous headings that do not make it clear that the change is a negative one (customers missed change notifications)
- use of unclear or ambiguous language and terms in the notification (customers misunderstood the impact of the change); and
- limited or no follow up notifications.⁶⁷

PHIO case study: Unclear notification by letter or email

In 2014 an insurer sent letters or emails to affected members advising that gastric banding and obesity related surgery would be removed. Members were given a grace period for upgrading cover without incurring new waiting periods. Follow up by the PHIO identified a number of factors that contributed to poor notifications in this case:

- Unclear notification. Some customers reported not seeing information in letters and emails as these communications were not specifically about gastric banding and included promotional material and information on several updates and changes.
- One off notification. No additional notifications or follow-ups were given to affected members after the original letter or email was sent.

65 LASA, p. 2; ASO, pp. 5–6; ADA, p. 7, ASA, p. 2; PAA, p. 4.

66 ADHA, p. 3.

67 PHIO, p. 2 and PHIO Supplementary, pp. 3–9.

Many submissions to this year's report from HCSPs also noted that their patients report that information provided to them on their policies tended to be unclear, confusing and difficult to use. In particular, it was stated that:

- information can be difficult to understand due to the heavy use of jargon⁶⁸
- patients report confusion and that policies are not well understood⁶⁹
- documents are not written or structured in an easily understood manner⁷⁰
- some information provided (terms and wording) is misleading.⁷¹

Single notifications are less effective

While the PHI Act provides for the minimum requirement of one written notification of a change, some insurers have provided additional notice to their customers through follow up/reminder letters, phone calls and emails while additional information on changes may also be included on insurers' websites and in pamphlets and brochures.⁷²

Based on review of complaint data, the PHIO has identified single notifications as a cause of consumers missing change notifications (especially when sent by email only). The PHIO has also noted a trend amongst some health insurers toward less communication, moving from multiple notices to a single notification.⁷³

Email used as the default channel for change notifications

In 2015, the PHIO reported that a small number of insurers had begun using email as the default communication channel for delivering change information. The insurers had sent notifications to customer email addresses stored on their computer systems in cases where no previous email notification or communication had been sent for that policy holder and, in some cases, without seeking agreement or notifying customers of the approach.⁷⁴ Letters were only sent where the insurer's database did not contain an email or where emails bounced back.⁷⁵

The PHIO found that consumers missed the notification message as emails were sent to an incorrect or outdated email address, were diverted to a spam folders, or consumers had not checked their emails as they were unaware the address was being used by their insurer.

Email subject lines not referencing the change

The PHIO also reported that email subject lines did not clearly inform the customer that the email contained information about a detrimental change to benefits. The Ombudsman argued that an email subject line is an important signal to customers to open the email and read on, noting that consumers cannot easily scan over an email to locate the important news as receivers of letters are able to.⁷⁶

Mixing change notifications with marketing material

The PHIO also noted that the common practice of sending marketing material and change notifications to the same email address can increase the likelihood that customers will overlook important change information, or result in emails being treated as spam and diverted to Junk folders or blocked.⁷⁷

68 LASA, p. 4.

69 ASO, p. 5.

70 ADA, p. 7.

71 ASA, p. 2.

72 nib, pp. 2-3; hbf, pp.1-2.

73 PHIO Supplementary, p. 12.

74 PHIO Quarterly Bulletin 76 (1 July-30 September 2015).

75 PHIO Supplementary, pp. 1-2.

76 PHIO Quarterly Bulletin 76 (1 July-30 September 2015).

77 PHIO Quarterly Bulletin 76 (1 July-30 September 2015) and PHIO Supplementary, pp. 1-2.

The PHIO Annual Report for 2014-15 highlighted the importance of insurers communicating detrimental benefit changes in clear and unambiguous language, and without diluting the message by interspersing unrelated promotional material.⁷⁸

Over-reliance on websites to communicate changes

Some stakeholders expressed concerns about insurers using their websites as the primary method of communication for changes. The Australian Physiotherapy Association (APA) submitted that they often hear from consumers that some insurers advertise changes on their website without directly communicating the change to individual members who may be affected by the change.⁷⁹

An ACCC review of 34 insurers' websites (undertaken over 2014-15) identified a general lack of transparency and availability of information on insurers' websites, suggesting that using a website as the primary or only means of communicating a change may be problematic for consumers, as navigating the insurer's website to locate the change notification may not be easy.⁸⁰

Consumers not being notified of changes at all

Submissions raised concerns that some insurers were not providing customers with notification of changes in some circumstances.⁸¹ The APA, for example, stated that patients have raised concerns with their members about private health funds increasingly varying existing policies and restricting the level of cover without warning.⁸²

As mentioned earlier, for 2014-15 the PHIO received 281 complaints from policy holders specifically relating to changes to insurers' rules, an increase of 290 per cent on 2013-14, with many of these complaints related to consumers reporting that they had not been notified of a change (table 1).

PHIO case study: Not being notified

A couple called their insurer and upgraded their membership to include IVF on 1 May 2014. However, IVF was being removed from their selected policy on 1 June 2014. The fund did not advise them of the upcoming change either verbally or in writing. As there was no evidence to show the couple had been advised of the change, the fund agreed to backdate a change to include IVF.

Not notifying customers of changes to insurer-HCSP arrangements

The PHIO has noted that some health insurers typically only notify consumers of changes to benefits where they involve changes to insurer rules and do not notify their customers of other detrimental changes, such as where changes are made to insurer-HCSP arrangements.⁸³

The PHA contended that insurer-HCSP arrangements do not necessarily involve a change to insurer rules and so may not be subject to the notification requirements under the PHI Act.⁸⁴

78 PHIO Annual Report 2014-15, p. 29.

79 APA, p. 5.

80 'Information and Informed Decision Making', ACCC PHI Senate Report 2015, p. 24.

81 PHIO Supplementary pp. 1, 10; APA, p. 5.

82 APA, p. 5.

83 PHIO, pp. 5-6.

84 PHA, p. 5.

However, changes to these arrangements can lead to significant consumer detriment by impacting on the benefits a consumer receives from their policy (for example, by leading to unexpected out-of-pocket cost or the loss of coverage of treatment by local HCSPs). Failure to notify consumers of changes to these arrangements may, in some circumstances, contravene the ACL.

As noted earlier, in 2014–15 the PHIO received over 60 complaints specifically related to an insurer not advising consumers of changes to its insurer-HCSP arrangements (section 2.1).

In June 2016, the ACCC instituted proceedings in the Federal Court against Medibank alleging that it contravened the ACL by engaging in misleading conduct, making false or misleading representations and engaging in unconscionable conduct. Specifically, the ACCC alleges that Medibank failed to notify its members and members of its subsidiary brand, ahm, regarding a change to insurer-HCSP arrangements involving limits on benefits paid to members for in-hospital pathology and radiology services (section 2.1). Medibank is defending these allegations.

PHIO case study: No communication of changes to insurer arrangements with HCSPs

The PHIO received a complaint that an insurer chose not to notify its policy holders that it would no longer offer ‘gap cover’ with particular health service providers. The PHIO noted that whilst there is a ‘technical argument’ that this is not a change to an individual policy because other medical services are still payable under the insurer’s gap scheme, it resulted in consumers no longer being covered for previous ‘no gap’ in hospital health services. In investigating the issue, the PHIO reached the conclusion that the definition of a ‘rule change’ adopted by the health insurer was too narrow.

2.6 What impacts can benefit changes have on consumers?

The PHIO notes that the requirement to notify customers of detrimental benefit changes is particularly important as it gives customers:

‘...an opportunity to change to a different policy to ensure they maintain continuous cover for that benefit.’⁸⁵

It also gives policy holders time to choose to accept the less comprehensive policy and plan ways to manage or avoid the new out-of-pocket expenses, switch to a different insurer or choose an alternative health service provider with a reduced fee structure.

Where customers are not adequately informed of a change or not informed at all, they can suffer a range of negative impacts. Some of these experiences (drawn from consumer research data, complaint data and submissions) are outlined below.

Younger and non-English speaking people are more likely to experience bill shock

An ACCC commissioned consumer survey revealed that 32 per cent of respondents who reported that their private health insurance had been changed also reported that they had incurred unexpected expenses as a result of the change.⁸⁶ Younger respondents reported substantially higher rates of unexpected expenses with the incidence decreasing with age, falling from 43 per cent of 18–29 year olds to 25 per cent of people 60 years and older (table 4). Respondents who identified as speaking a language other than English at home were also more likely to report unexpected expenses from a change compared with English language only respondents (39 per cent compared with 31 per cent).

85 PHIO Quarterly Bulletin 69 1 October–31 December 2013, p. 2.

86 ACCC Consumer Survey—Private Health Insurance Full Report, Colmar Brunton 2015, p. 54.

Table 4: Respondents reporting unexpected expenses as a result of a change, by age, 2015

Age (years)	18-29	30-44	45-59	60 plus	All
%	43	42	23	25	32

Source: ACCC Consumer Survey—Private Health Insurance Full Report, Colmar Brunton 2015.

Bill shock at pre-admission

The PHIO reported that a significant number of rule change complaints result from patients discovering during their pre-admission process that their policies had changed. In 2014-15, the PHIO received 91 complaints of this type (table 2).

Hospitals and other health service providers are required to perform a check of a person's health insurance policy during pre-admission, as part of the IFC process. Patients who find out just before being admitted for treatment that their insurer has changed their policy and the planned treatment is not covered, or is subject to reduced coverage, can suffer significant emotional distress. They may also be forced into making a quick decision to proceed with the planned treatment and incur potentially substantial out-of-pocket costs, or delay or cancel the procedure.

PHIO case study: Bill shock at pre-admission

A consumer commenced multi-staged dental treatment and received a quote on fund benefits in April. In September, the consumer called the fund again to check benefits for final stage of treatment and found that due to a change their annual dental limit had been reduced and instead of the expected \$1000 refund on the final treatment the consumer learned that they would receive no benefit.

Failure to provide a change notification and IFC can impose large costs

The combination of a consumer being unaware of a change made by their insurer, and a HCSP not adequately following the IFC process can result in patients experiencing large unexpected out-of-pocket expenses after undergoing treatment.

ACCC case study: No notification of a benefit change and failure to undertake IFC

Ms A attended hospital to undergo a procedure for which she believed to be fully covered. The hospital failed to properly undertake the IFC. Following the procedure, Ms A received an invoice from the hospital notifying her that her insurer no longer covered the full cost of service. Ms A incurred out-of-pocket costs as a result. She complained to her insurer and was advised that due to escalating costs, they no longer covered the procedure in full due to changed contracting arrangements with the HCSP. The insurer advised Ms A that they did not consider this a change to a policy and did not advise members.

Cancelled and delayed medical procedures and new waiting periods

The AMA submitted that their members have reported that medical procedures are typically cancelled where patients become aware that they are not covered for treatment they believed they were. AMA members reported that patients are often unaware that changes affecting their cover have been made.⁸⁷

87 AMA p.3.

Stakeholder example: Cancelled and delayed medical procedures

'In my own speciality of neurosurgery I have had many patients for whom I have had to change their treatment in these circumstances. ... a patient with a 20 year history of spinal complaints and who now requires spinal fusion was shocked to find her policy no longer covered that treatment. She is adamant that she did not receive advice from her insurer that her cover had changed'.⁸⁸

In some cases where a consumer finds that their policy has been changed and a procedure is not covered, the privately insured patient can attempt to access the services in the public system. The RANZCO reported that depending on the procedure and location, these customers can experience long waiting times and significant welfare impacts.⁸⁹

Stakeholder example: Waiting for treatment in the public system

A HCSP representative noted that 'in many cases mental health consumers with PHI are surprised to learn their insurance does not cover psychiatric admission while attending private mental health services and [that these people] are then referred to the public system [for treatment]'.⁹⁰

Inadequate coverage for a customer's risk profile

Some submissions highlighted that benefit changes are increasingly resulting in customers holding policies that are not risk-appropriate for their circumstances (such as their age) and that this can lead to bill shock and reduced access to private health care.⁹¹ Where a change removes or reduces coverage for a given service and policy holders are unaware of the change, customers are unable to make an informed assessment of the need to upgrade and maintain coverage or accept the loss.

Submissions noted that some recent benefit changes which introduced exclusions for age-related services (such as the removal of certain eye surgery) potentially leave elderly policy holders in particular with insurance that is not appropriate to their expected needs.⁹²

Stakeholder example: Changes that potentially lead to inadequate coverage

A HCSP representative noted that: 'We know that diseases such as cataract, glaucoma, and macular degeneration all occur in much higher rates in older population demographics. Any of these diseases left untreated will result in vision impairment or complete vision loss. Despite these known risks, health insurance funds appear to be increasingly amending a majority of policies to exclude eye surgery or other ophthalmic treatment'.⁹³

Conclusion

Drawing on consumer research, complaint data and submissions to this report, this section has identified a range of existing good and poor industry practices for communicating benefit changes to consumers and the impacts inadequate notifications can have on consumers. The

88 AMA, p.3.

89 RANZCO, p. 2.

90 RANZCP, p. 2.

91 RANZCP, p. 1; RANZCO, p. 2; ASO, pp. 7-8.

92 RANZCO, p. 2.

93 ASO, pp. 7-8.

next section examines how the poor notification practices identified in section 2.5, as well as other factors such as increased complexity in private health insurance markets, may be leading to the negative impacts described above (section 2.6).

3. Causes of the detrimental impacts of changes

Many factors can contribute to consumers experiencing negative impacts when insurers change insurance coverage and benefits. Submissions to this year's report from all stakeholder groups highlighted the ongoing complexity consumers face in private health insurance markets, with many noting it can contribute to negative impacts for consumers when benefit changes are made.⁹⁴ Insurer submissions tended to argue that the main causes of detrimental consumer impacts were factors such as consumers failing to read and understand the information they provided, the failure of HCSPs to properly undertake IFC, and a lack of transparency for consumers around specialist and hospital pricing. Other submissions tended to highlight a range of poor communication practices used by insurers when they notify consumers of benefit changes.

3.1 Poor change notification practices

Consumer research data, PHIO complaints data and submissions to this report have identified a number of poor change notification practices (section 2.5). How these practices may contribute to consumer harm is considered below.

Some consumers are unaware that insurers may change their benefits at any time

As noted in section 2.5, some stakeholders have argued that consumers' lack of awareness of terms in their insurance policies which purport to allow insurers to make unilateral changes to insurance benefits is contributing to bill shock and inadequate coverage.⁹⁵ The APA, for example, argued that 'many consumers view private health cover as a long-term purchase and expect that product offerings will remain consistent throughout the life of the policy'.⁹⁶

The PHIO noted that consumers who have lodged change complaints frequently express surprise that an insurer can alter the terms of their insurance contract without their consent and argued that this lack of awareness means that consumers are also unaware of the need to review correspondence from their health insurer for possible changes.⁹⁷ As noted in section 2.3, current industry practice is for insurers to remove or decrease policy coverage to manage unexpected increases in the uptake of high cost medical services.

These factors, combined with a lack of awareness by consumers of their portability rights, which allows consumers to maintain their cover by switching or upgrading policies without penalty, are likely to be contributing to bill shock and other reported consumer harm.

Not notifying consumers of changes to their benefits

When insurers fail to notify existing policy holders of changes to the coverage and level of benefit of their private health insurance, it clearly contributes to policy holder detriment. This harm is likely to be greater for particularly vulnerable groups, for example, patients undergoing ongoing treatment, those with chronic conditions, the elderly, and people living in remote areas with limited access to HCSPs.

94 PHA, p. 7; CBHS, p. 2; Choice, p.5; ADA, pp. 3, 8; MTAA, p. 7; Heart4Hearts, p. 1; Medtronic, p. 2; ASA, p. 1; RANZCP, p. 2.

95 PHIO p. 3-4.

96 APA, p. 5.

97 PHIO, pp. 3-4

The PHI Act and PHI Code establish some minimum requirements for health insurers when communicating changes to insurer rules (section 2.2). There is little data on the level of noncompliance with these minimum requirements. While non-notification of changes to insurers' rules has been noted by the PHIO in some complaints (table 2), overall insurers recognise the minimum standard under the PHI Act and in some cases exceed it (section 2.5).

However, in certain circumstances private health insurers do not appear to take into account other obligations that may arise under the ACL which are greater than the minimum requirements set out in the PHI Act and PHI Code (section 2.2). Not doing so may be contributing to the reported consumer harm, particularly where an insurer has decided not to notify their customers of change because it considers that:

- the level of detriment from the change to an insurers' rule is deemed to not meet the 'significance' triggers set out in the PHI Code, or
- the changes are made to insurer-HCSP rules.

The greatest source of potential consumer detriment is likely to arise from insurers failing to notify consumer when significant changes are made to insurer-HCSP arrangements.

Some consumers report finding information provided by insurers to be difficult to understand

A number of submissions from HCSPs noted that their patients report that information provided by insurers about policies can be unclear, confusing and difficult to understand.⁹⁸ Submissions also provide examples of poor industry practices in providing information to policy holders (section 2.5). Recent consumer research confirms some of these stakeholders' views. For example, a survey of consumers with private health insurance commissioned by the ACCC in 2015, found that while a majority of survey respondents (57-64 per cent) reported feeling 'informed' by information available about their private health insurance, significant numbers reported that the information was 'overwhelming' (36-40 per cent), 'confusing' (29 per cent) and should be 'easier to understand' (46 per cent).⁹⁹

Qualitative research undertaken as part of the same survey also found that consumers reported being provided with 'overwhelming and/or confusing' information by their insurers and comparator websites. Consumers in focus groups stated that the information provided by insurers was not 'straight-forward' or 'easily accessible' and that too little information was provided before purchase and too much after purchase. Participants also noted that the information provided after purchase was presented in a way that made it difficult to locate relevant content, and used unfamiliar terminology and legal jargon making it ambiguous and difficult to interpret.¹⁰⁰

Younger and non-English speaking respondents report greater dissatisfaction with benefit change information provided by insurers

The ACCC research commissioned also sought consumers' views on the information provided by insurers on benefit changes.¹⁰¹ While a majority of respondents felt 'informed' about the changes (60 per cent) and agreed that the information was 'easy to understand' (61 per cent), a quarter (25 per cent) felt that the information 'should have been more visible and upfront',

98 LASA, p. 2; ASO, pp. 5-6; ADA, p. 7; ASA, p. 2; PAA, p. 4.

99 ACCC Consumer Survey—Private Health Insurance Full Report, Colmar Brunton 2015, pp. 37, 38, 45 and 50.

100 ACCC Consumer Survey—Private Health Insurance Full Report, Colmar Brunton 2015, pp. 77-79.

101 Question 28 asked, 'On a scale of 0 to 10, where 0 means 'strongly disagree' and 10 means 'strongly agree', please rate your level of agreement with the following statements regarding the information you received from the fund in relation to the policy change:' (ACCC Consumer Survey—Private Health Insurance Full Report, Colmar Brunton 2015).

or ‘was overwhelming’, while one fifth (20 per cent) felt it ‘was not clear about the impact of the change’.¹⁰² It is possible that those in the ‘informed’ cohort had yet to require calling on a significant benefit.

The survey also found that younger respondents were more dissatisfied with the information provided by insurers about a change compared with older groups. Younger respondents (18–29 and 30–45 years) were more inclined to agree that the information:

- was not clear about the impact of the change (26 and 34 per cent compared to 14 and 15 per cent for those aged 45–64 and 65 years and older)
- was not relevant at the time (21 and 24 per cent compared to 5 and 7 per cent for those aged 45–64 and 65 years and older)
- should have been more visible and upfront (36 and 37 per cent compared to 19 per cent for those aged 45–64 and 65 years and older)
- was overwhelming (24 and 35 per cent, compared to 18 and 22 per cent for those aged 45–64 and 65 years and older).¹⁰³

Similarly, speakers of a language other than English also reported more negative views about change information compared with English only speakers.

The ASO in its submission agreed with the direction of these findings, noting that certain consumers (such as those from non-English speaking backgrounds, those with poor vision or reduced cognitive awareness) have difficulty reading and understanding health fund communication.¹⁰⁴

People who report poor understanding of change information are more likely to experience bill shock

The ACCC commissioned research also found a direct connection between consumers reporting negative feelings about the change information and experiencing higher rates of bill shock. While a majority of respondents who reported bill shock had read the information provided to them, they were significantly less likely to agree that the information was easy to understand or informed them about the changes, compared with those who had reported positive feelings about the information and had not incurred unexpected expenses.¹⁰⁵

Engaging with private health insurance can be challenging for consumers

A number of submissions noted that consumer disengagement with the information provided to them could contribute to consumers not understanding benefit changes and suffering bill shock or inadequate coverage as a result.¹⁰⁶

Hbf, for example, submitted that even where they make their best effort to communicate a change to members, not all would read everything they send. They also argued that government incentives that ‘force unwilling consumers to purchase the cheapest possible cover’ may mean consumers do not take the time to understand their policies causing bill shock.¹⁰⁷ Another insurer attributed disengagement to a range of factors, including:

- the complexity of PHI regulation and related concepts
- some customers not wanting to commit the time and effort needed to understanding their policy
- the regulated nature of mandatory communications (such as the SIS) not assisting consumers with their personal circumstances.

102 ACCC Consumer Survey—Private Health Insurance Full Report, Colmar Brunton 2015, pp. 54–57.

103 Ibid, p. 46.

104 ASO, p. 5.

105 ACCC Consumer Survey—Private Health Insurance Full Report, Colmar Brunton 2015, p. 55.

106 ADA, pp. 3–4; MTAA, p. 8; Hearts4Hearts, p. 1; Medtronic, p.2; ASA, p. 1; HBF, p. 1.

107 HBF, pp. 1–2.

Last year's PHI Report observed the information asymmetry and complexity in the private health insurance industry can make it difficult for consumers to engage in informed decisionmaking.¹⁰⁸

In addition, some consumers can have difficulty understanding and effectively using relatively clear and complete information on benefit changes for various reasons.

- Policies designed by insurers are increasingly complex (with differing levels of exclusions, restrictions, waiting periods, excesses, co-payments) and use technical, medical and legal language. The limits on coverage and the language used are often not consistent across policies or insurers and differ by treatment and hospital.
- Different treatments have different costs, outcomes and consequences making it hard for people to predict what treatments they might seek or be recommended in the event of a specific health issue.
- Much medical decision-making is based on highly technical information. The underlying medical information is difficult to gather and difficult to understand.¹⁰⁹

Combined with uncertainty over present and future health needs, these factors increase the effort needed for consumers to understand change information and react appropriately by accepting the lower coverage, upgrading to maintain coverage or switching to a different insurer.

Industry is working on improving information provision

Submissions have identified a range of attempts to improve consumer engagement with, and understanding of change information (section 2.5). The PHI Code has recently been amended with the intent of providing more specific information to consumers about changes (section 2.2). Also, as noted earlier, there has been some trialling of potentially more effective communication approaches by insurers.

- One insurer reported that it was testing the effectiveness of communication processes that went beyond the minimum standards for communicating changes including by increasing the number of notifications, the use of multiple channels and follow up calls.
- One insurer highlighted the benefits of using data (for example, on policy usage and hospital admissions) to proactively identify customers at risk of experiencing bill shock from a given change and then target those customers with information (section 2.5).¹¹⁰

However, in spite of this work by industry, the complaints data, consumer research and stakeholder comments on poor practices (sections 2.1, 2.5 and 3.1) indicate that a significant proportion of policy holders, particularly younger and non-English speaking ones, continue to be dissatisfied with the change information provided by insurers, and that poor information provision is contributing to consumer harm. The research supports action to provide consumers with change information that is better focused, clearer about the impact of changes, more relevant to their situation, easier to understand and more visible in how it is presented.

The SIS is of limited effectiveness in informing consumers of benefit changes

Insurers must provide their members with an up-to-date copy of the SIS every 12 months and an updated copy, if necessary, when changes to insurers' rules are made.¹¹¹ Submissions have argued that the SIS is of limited use for informing consumers about their private health insurance policies (and consequently of changes to their benefits) as the document provides incomplete

108 'Information and Informed Decision Making', ACCC PHI Senate Report 2015, p. 10.

109 Henderson 2015, Health Economics and Policy, p. 182.

110 HBF, p. 1.

111 PHI Act 2007 (Cth) s93-20 (2d).

information for consumers.¹¹² Various stakeholders have advocated that the SIS be reviewed and improved.¹¹³ Research indicates that around 9 per cent of policy holders reported receiving a policy change notification through the document.¹¹⁴

The SIS forms part of the change notification requirements under the PHI Act. However, the stated purpose of the SIS is to give consumers “..a summary of the key product features” and to see whether their “..broad needs are covered and where products differ in both price and features”.¹¹⁵ As such, it may be of limited use to inform consumers of benefits changes.

The effectiveness of informed financial consent

While it is the responsibility of the insurer to provide advanced notification to consumers of detrimental changes to their benefits, IFC can be an important opportunity for consumers to be made aware of likely out-of-pocket expenses that they may face (including from previously made benefit changes).

However, as noted in section 2.6, the combination of a consumer being unaware of a change made by an insurer and a HCSP not adequately following the IFC process, can result in patients incurring unexpected out-of-pocket expenses after undergoing treatment. The PHA, for example, reported that commissioned research (Ipsos 2015 Health Care and Insurance Australia) found that the majority of patients who report out-of-pocket hospital costs were not informed about these costs prior to their treatment.¹¹⁶

One insurer observed that while IFC compliance is high among private hospitals, individual specialists, some stand-alone day hospitals and public hospitals are less reliable in fulfilling this requirement. The PHA submitted that although some insurers have developed materials with the aim of assisting policyholders to ask questions of HCSPs relevant to IFC, many policy holders are either unwilling or unable to obtain this information from their HCSP.¹¹⁷ Improved IFC processes would likely be an effective means of reducing post-procedure bill shock. However, it should be noted that undertaking IFC alone does not necessarily give consumers complete notice of all the out-of-pocket expenses they will face for a given treatment (for example, a HCSP may not know which medical services will be required until after a treatment has commenced). In addition, there are situations in which it is not practical to perform IFC such as for emergency treatment or where a patient is too unwell to effectively receive the information.

The PHI Act requires HCSPs to provide their patients with IFC information before undertaking medical procedures. HCSPs should ensure they meet these legislative requirements. However, health insurers should note that the HCSP carrying out IFC is not a substitute for effective and timely change notifications and will not cure any misleading or unconscionable conduct by the insurer prior to obtaining IFC.

112 PHA, p. 7; nib, p. 5; Choice, p. 5; CCC, p. 5; ADA, p. 6.

113 Ibid.

114 ACCC Consumer Survey – Private Health Insurance Full Report, Colmar Brunton 2015, p.56..

115 See ‘Standard Information Statement’: <http://www.privatehealth.gov.au/faq/sisguide.htm>.

116 PHA, p. 9.

117 Ibid.

3.2 The market for insurance is becoming more complex

The ACCC's 16th report to the Senate (2015) noted that the failure of insurers to provide appropriate information and the complexity of the private health insurance industry make it difficult for consumers to understand their private health insurance policies (and benefit changes), and make informed decisions, including purchasing appropriate coverage and managing out-of-pocket costs.¹¹⁸ The report identified various factors that increase complexity, including:

- the number and variety of policies
- policy exclusions, excesses, co-payments and waivers
- the regulatory settings, including incentives and government rebates to holding insurance
- benefit changes themselves.¹¹⁹

This section further explores factors that may be contributing to increased industry complexity and how this can contribute to consumer harm when insurers change benefits.

There is a large number of insurance products in the market

Consumers continue to be confronted with a large number of private health insurance policies to choose from when purchasing a new policy or considering changing existing coverage. As at June 2015, there were around 46 500 (open and closed) private health insurance products in Australia offered by 34 health insurers.¹²⁰ Of these:

- around 18 535 were hospital only products, around 9646 general treatment only products and around 18 273 combined products
- around 25 219 were open for new policy holders with the remainder closed for purchase.¹²¹

The share of non-comprehensive policies continues to grow

Insurers have noted that they are using reduced coverage and increased costs sharing (through the increased use of exclusions, restrictions, excesses, co-payments etc.) as a means of managing their costs and risks (section 2.3). This can be done either by designing new policies with exclusions or by imposing exclusions on existing customers.¹²²

This reduction in the level of comprehensive policy coverage allows insurers to shift risks and costs onto their customers and can be used as a mechanism for managing the insurers' operating costs, profits and premium rises.

In recent years, there has been a steady decrease in the proportion of hospital policies with full cover (falling from around 68 per cent of all policies in 2006 to 47 per cent in 2015).¹²³ There has been a corresponding increase in the proportion of hospital policies with exclusions, restrictions, excesses and co-payments (figure 3). Overall trends include a steady increase in the proportion of:

- hospital policies with an excess and/or copayment from around 58 per cent in 2006 to 82 per cent in 2016¹²⁴

118 Information and Informed Decision Making ACCC PHI Senate Report 2015, pp. 10 and 17.

119 Ibid, p. 17.

120 State and territory based categorisation of practically identical products may account for up to 86 per cent of this figure, (see Competition in the Australian Private Health Insurance Market, Research Paper 1 June 2015, PHIAC 2015, p.72).

121 Ibid, p.72.

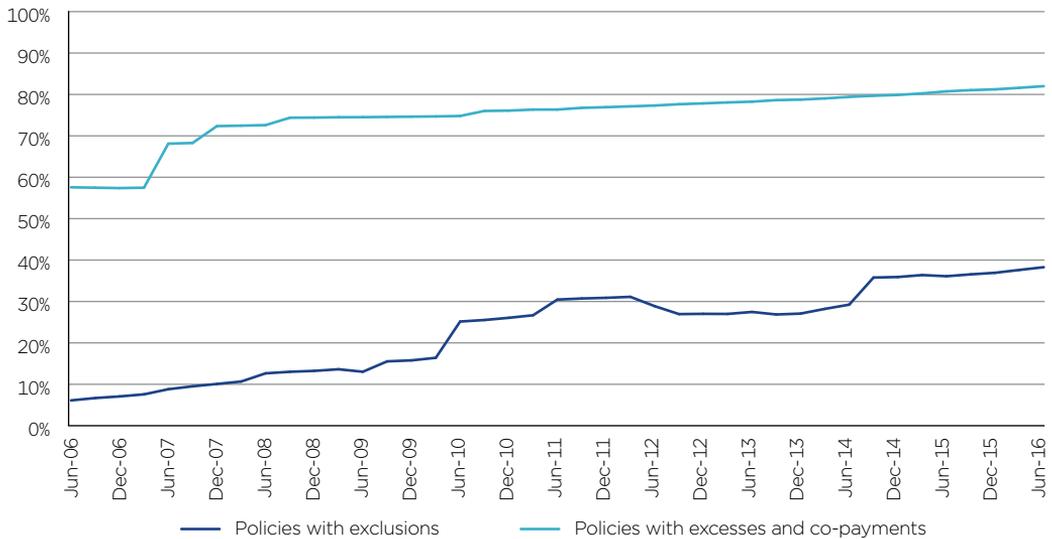
122 PHA p. 7.

123 Risk sharing in the Australian private health insurance market, Research Paper 4 June 2015, PHIAC 2015, p. 13.

124 See: <http://www.apra.gov.au/PHI/Publications/Pages/Statistical-Trends.aspx>.

- hospital cover policies with one or more exclusions from 6 per cent in 2006 to 38 per cent in 2015¹²⁵
- hospital cover policies with one or more restrictions from Just over 30 per cent in 2006 to around 45 per cent in 2015.¹²⁶

Figure 3: Change in the proportion of private health insurance policies with exclusions, or excesses and co-payments, 2006 to 2016



Source: APRA data¹²⁷. Notes: Part of the increase in exclusionary policies in the Sep-14 quarter was due to an insurer reclassifying its policies from non-exclusionary to exclusionary.

This change in the Australian private health insurance market has some benefits. An exclusionary policy can be the most efficient and rational choice for consumers who do not need the excluded services, and may be the most cost effective approach where a consumer cannot afford to pay higher premiums to secure wider coverage.

However, this approach also creates problem for consumers. The RANZCO submission, for example, noted that while ‘multiple coverage options may be beneficial for different patients with varying needs, the lack of clarity regarding the differences between different policies may increase the risk that patients may purchase a policy that is not the most appropriate for their needs.’¹²⁸

PHIAC has noted that as long as consumers can accurately match their risk profile with the right policy, there is limited opportunity for bill shock or inadequate coverage.¹²⁹ However, the increase in non-comprehensive policies may increase the possibility of existing policy holders experiencing bill shock or inadequate coverage where consumers have difficulty in matching their health needs with the right policy.

125 Ibid.

126 Risk sharing in the Australian private health insurance market, Research Paper 4 June 2015, PHIAC 2015, p. 12.

127 Ibid, p. 12.

128 RANZCO, pp. 1-2.

129 Competition in the Australian Private Health Insurance Market Research Paper 1 June 2015, PHIAC 2015, p. 44.

Affordability is driving growth in non-comprehensive policies

Last year's Senate report observed that existing regulatory settings can change consumers' incentives in purchasing health insurance, and as insurers respond to market demands for affordable policies, consumers can face an increased likelihood of unexpected out-of-pocket costs for consumers.¹³⁰

A number of submissions to this year's report also drew connections between existing regulatory settings, the rise of non-comprehensive policies and increased exposure to bill shock and inadequate coverage.¹³¹

It is likely that the continued rise of non-comprehensive policies is driven, in part, by insurers' attempts to attract price sensitive consumers who are enticed into the private health insurance market by current federal government policy settings and who want to avoid tax penalties at minimum premium cost.¹³² One HCSP also suggested that increasingly price conscious policy holders may be choosing to downgrade their existing cover to more exclusionary policies as a way of minimising their premium costs. In both cases, insurers have an incentive to offer lower-premium, higher-exclusion policies to stay competitive. Insurers also have a commercial incentive to downgrade cover or benefits on existing policies as a means of managing their costs to maintain or increase profitability.

This continued trend toward greater complexity in the Australian private health insurance market (driven in significant part by a rise in the number of policies, benefit changes, and the number of noncomprehensive policies on offer) is further reducing consumers' ability to understand health insurance products and accurately self-assess and match their health risk profile with the right policy. Together, these changes are also likely to be contributing to increased consumer harm, such as unexpected out-of-pocket expenses and the rise of inadequate coverage.

Conclusion

Drawing on consumer research, the PHIO complaints data and public consultations, this report has identified various poor industry practices that are likely to be contributing to the consumer harm identified in section 2.6, including:

- approaches to product disclosure that result in low awareness among consumers that their private health insurance policies may be unilaterally changed by insurers at any time
- poor practices by some industry participants resulting in consumers not being informed of changes to coverage and level of benefits (such as when consumers are not informed of changes to insurer-HCSP arrangements)
- poor practices by some industry participants in communicating benefit changes to consumers (including the provision of information that is poorly presented, overwhelming, not clear about the impact of the change or misleading)
- the failure, in some cases, to provide effective IFC.

In addition, increased complexity in the private health insurance market due, in part, to the increasing number of policies, changes to benefits, and the increase in non-comprehensive policies, is making it harder for consumers to understand and respond effectively when insurers change their benefits. This is also likely to be contributing to bill shock and inadequate coverage.

The next section outlines this report's key findings and suggestions for improving industry practices around benefit change notifications.

130 Information and Informed Decision Making ACCC PHI Senate Report 2015, p. 2.

131 HBF p. 2; Choice p. 4; PHA p. 7; APA p.4; AMA p.4; ASA p. 1.

132 Competition in the Australian Private Health Insurance Market, Research Paper 1, June 2015, PHIAC 2015, p. 47.

4. Findings and suggestions for change

The ACCC considers there to be two key concerns arising from its research into how consumers are being informed of changes to their private health insurance benefits and the impacts these changes can have.

- First, although not universal, there are a range of poor practices around how some insurers notify consumers of changes to their private health insurance benefits, and these practices are contributing to consumer harm such as increased bill shock, inadequate insurance coverage, lost switching/porting opportunities and limited access to health care. These poor practices include:
 - No notification being given to consumers in some circumstances when benefits are changed (such as where consumers are not notified of changes to insurer-HCSP arrangements). This industry practice appears to be driven, in part, by a narrow view of compliance with notification requirements under the PHI Act, or an overly restrictive view of compliance with the PHI Code, without due consideration to obligations arising under the CCA and ACL.
 - Poor communication practices to inform consumers of changes to their benefits resulting in consumers sometimes missing the notifications, or reporting that the information provided is poorly presented, overwhelming, not clear about the impact of the change or misleading.¹³³ Related to this point is a lack of consumer awareness in general that insurers include terms in their policies which purport to allow insurers to make unilateral changes to insurance benefits. While insurers are required to notify consumers of these changes, some insurers' methods of notification as described in this report are ineffective. Furthermore, consumers lack awareness of their portability rights which allow them to maintain their cover by switching or upgrading policies without penalty. In some circumstances, these practices are also at risk of contravening the ACL.
- Second, as also noted in last year's PHI Senate Report, complexity in the Australian private health insurance industry continues to increase, driven in part by the increasing number of policies on offer, changes to available benefits, and the continued rise of non-comprehensive policies (in particular those with exclusions, restrictions, and excesses). This complexity makes it harder for consumers to understand and respond effectively when insurers change their benefits, and makes consideration of reforms to improve benefit change notifications in this industry even more important.

Research and submissions indicate that some consumers, particularly younger people, non-English speaking people, the elderly, those with chronic illnesses and those undergoing ongoing treatment, are more likely to suffer the negative impacts of poor practices around benefit change notifications.

In making these findings, the ACCC recognises that the Australian Government is formulating reforms to private health insurance following, among other actions, the Department of Health's Private Health Consultations 2015-2016 and the establishment of the Private Health Ministerial Advisory Committee.

However, the ACCC, as Australia's national competition and consumer protection regulator, will take action where it considers intervention is warranted. The ACCC will also continue to engage with industry on improving compliance with the ACL.

¹³³ Key poor communication practices identified in this report include the use of: low prominence messaging, unclear and misleading terms and language, single notifications without any follow up, email as default communication channel without informed 'opt in' by consumers or clear signalling in email subject lines of the email's content, and communication that mixes a benefit change notification with marketing information (section 2.5).

In addition, the ACCC highlights recommendations, some of which were provided by stakeholders, on how insurers could improve how they inform consumers of changes to their private health insurance benefits. These include:

- Improved upfront disclosure to consumers (at the point of purchase and whenever a change notification is made) about how their private health insurance works, with the aim of raising consumers' awareness of their rights and responsibilities and improving consumers' ability to respond to changes effectively. Improved disclosure could highlight that if insurers make changes to insurance benefits:
 - consumers should expect advanced notification of these changes and be given an opportunity to specify (or 'opt in' to) a preferred communication channel for receiving these notifications
 - consumers can act to maintain their level of cover by exercising their portability rights (at a minimum, in relation to hospital cover) allowing them to switch or upgrade their policies without incurring further waiting periods.
- Improved industry practices around when benefit change notifications are triggered with the aim of reducing the incidence of consumers not being notified of changes. Improvements could include:
 - providing clarity about the triggers for requiring insurers to notify consumers of changes to their benefits to ensure that any consumers who face significant detriment are appropriately notified, including by confirming that insurers are required to notify their customers of significant changes to insurer-HCSP arrangements
 - improving industry understanding of and compliance with their general obligations arising under the ACL around benefit change notifications.
- Improved industry practices around how benefit change notifications are communicated to consumers with the aim of increasing the likelihood that consumers see and understand notifications and are able to respond to the information effectively. Any improvements in this area should consider:
 - research and complaint data showing that consumers want information that is better focused, clearer about the impact of changes, more relevant, easier to understand and more prominent in the form of presentation
 - submissions to this report which have suggested a variety of good communication strategies that could improve how change notifications are communicated, including current good industry practices (section 2.5), the existing PHIO guidelines (appendix B) and suggested stakeholder reforms (appendix C)
 - consumer testing of the benefit change notification strategies used by insurers to demonstrate that they are effective at informing consumers of changes to their benefits
 - limiting the frequency of benefit changes and standardising the time of year when consumers are notified of changes (for example, by requiring that benefit changes coincide with the private health insurance premium round process to enable consumers to consider any changes at the same time as being notified of their premiums).

5. Other issues identified by stakeholders and ACCC actions

The Senate Order requires the ACCC to report on anti-competitive or other practices which increase consumers' out-of-pocket medical and other expenses or reduces the extent of consumer health cover.

The ACCC asked that submissions to this year's report focus on the issue of changes to insurance following on from an extensive review undertaken as part of the ACCC's 16th report to the Senate (appendix A). A number of submissions raised additional issues in relation to competition and other matters in the health insurance industry. Since 2015, as part of the ACCC's continuing focus on health under its 2015 and 2016 Compliance and Enforcement Policy, the ACCC has instituted a range of investigations and actions related to consumer health cover—some of which relate to issues raised by stakeholder submissions. This section summarises these issues.

The ACCC continues to monitor these matters and will take action where warranted.

5.1 Issues identified by stakeholders

Practices around preferred provider arrangements

A number of submissions raised concerns about the perceived misuse of market power by some insurers in their dealings with HCSPs, especially where an insurer has a large market share. The alleged practices relate to some insurers 'pressuring' HCSPs into agreements that result in detriment to healthcare providers and limit consumer choice of provider.¹³⁴

One submission argued that the practice under preferred provider arrangements, whereby some insurers offer differential rebates, is anti-competitive in that the rebates are used to direct consumers to providers who are contracted to private health insurers or to insurer owned clinics, and away from those non-contracted providers. Another submission argued that some insurers use preferred provider arrangements with hospitals to 'coerce' visiting doctors into performing 'no gap' treatment at rates below the doctor's normal fees. The submission argued that the practice involves the insurer offering the hospital a beneficial fee to induce the hospital to require the visiting doctor to charge a 'no gap' fee.

Information provided by insurers on preferred provider arrangements

Submissions raised concerns about the provision of potentially misleading and/or inaccurate information by some health funds to consumers on preferred provider arrangements.¹³⁵

Examples of these practices include:

- underestimating the coverage for scheduled treatments at hospitals outside the insurer's network
- underestimating the level of benefits payable to consumers attending HCSPs outside the insurer's network
- misrepresenting the recognition/certification of certain health professional groups (for example, by stating that otherwise accredited HCSPs are 'not recognised' for certain procedures).

¹³⁴ APA, pp. 12–15; ASO, p. 2.

¹³⁵ ADHA, p. 2; ACPS, pp. 1–2; OA, p. 2.

Non-recognition of certain HCSPs

Some submissions raised concerns that some insurers do not recognise certain HCSPs as 'equal' for the purposes of performing certain clinical services for which HCSPs are otherwise recognised as qualified.¹³⁶

One stakeholder noted an example whereby some insurers do not recognise Orthotists as equivalent to other HCSPs for the purposes of providing clinical services or prescribing orthoses, despite Orthotists being recognised as being able to perform these functions by state disability schemes, motor accident insurance schemes and the National Disability Insurance Scheme.¹³⁷ Another submission alleged that some insurers were refusing to accept specific dentists into their contracted provider network, arguing that this was anti-competitive, particularly where there were no apparent criteria or process for assessing applications to join an insurer's networks.

Insurers requiring pre-approvals by HCSPs

Some stakeholders raised concerns about pre-approval processes being imposed on HCSPs by some insurers which could result in a consumer's claim being denied if preapproval was not obtained.¹³⁸

One submission described an example where surgeons were required to complete pre-approval or eligibility forms for some plastic and ophthalmic procedures. The insurer informed the HCSP that if the fund's pre-approval was not completed by the surgeon the hospital's account claim made on the consumer's behalf would be rejected. Another stakeholder noted that some insurers had begun requiring doctors to sign pre-approval forms for Medicare Benefits Schedule listed surgeries before agreeing to uphold a member's cover. The stakeholder argued that this process interfered with the doctor-patient relationship and appeared to contravene the PHI Act.

Private patients in public hospitals

Some submissions expressed concern about public hospitals increasingly asking patients to use their private health insurance in a public hospital.¹³⁹

One submission noted research (Ipsos—Health Care and Insurance Australia 2015) that found that around one in five private patients treated in public hospitals end up being liable for out-of-pocket expenses. Other submissions were concerned that public hospitals were pressuring patients to use their private health insurance, or were billing private health funds without the consent of patients.

Online comparator websites

Some stakeholders, including providers and insurers, expressed concern about the operations of online comparator websites, in particular, that such sites should not be considered independent as they accept commissions from insurance companies and that these commissions should be declared to consumers.¹⁴⁰

136 ACPS, pp. 1-2; AOPA, p. 5; ADA, p. 16.

137 AOPA, p. 5.

138 ADHA, p. 3; ASO, p. 3.

139 PHA, p. 2; CCC, p. 5.

140 PHA, p. 9; ADA, p. 8; Choice, pp. 5-6; RANZCP, p. 1.

5.2 The ACCC's Health Project

Competition and consumer issues in the health area are a priority under the ACCC's 2016 Compliance and Enforcement Policy.

The ACCC has dedicated resources to investigating certain conduct by private health insurers which raises concerns about the lack of transparency to consumers of changes that have been made to private health insurance products and the marketing and promotion of those products.

In particular, the ACCC has focused its resources to matters which contribute to improving the ability for consumers to make informed decisions regarding private health insurance products. The ACCC continues to investigate matters which involve misleading and deceptive advertising and failures to properly disclose important fine print disclaimers.

Enforcement and Compliance Work

The Medibank matter

Proceedings were instituted against Medibank Private Ltd in June 2016 for alleged contraventions under the ACL (see section 2.1).

The 'Save on Tax' matter

On 2 June 2016, the ACCC published a media release to warn consumers against the potentially misleading claims about the tax benefits of private health insurance. In particular, the ACCC noted its concern that some private health insurance providers and comparator websites were misrepresenting the circumstances in which a consumer could reduce their tax burden by avoiding the Medicare Levy Surcharge through the purchase of private health insurance, when in fact this would only apply to individuals with a taxable income above \$90 000 and couples with a taxable income above \$180 000. The ACCC has worked with a number of private health insurers, comparator websites and the peak industry body representing insurers, the PHA, to ensure that all future advertising with regard to such claims are accurate and not misleading or deceptive.

Competition Health Work

The objectives of the ACCC's examination of competition issues in the health sector are to improve access to medical professionals and products and services. The ACCC will meet these aims through targeted investigations, actions that educate industry stakeholders in relation to their CCA obligations and, where appropriate, assisting with information sharing and referral of complaints.

The investigation and education aims to reduce barriers and improve competition. The areas of investigation, where such allegations arise, include:

- Private health insurance providers imposing conditions on health providers within their preferred providers network that may adversely affect competition.
- Health providers in a position of market power imposing conditions on private health insurance funds entering into provider agreements, where such conditions may substantially lessen competition.
- Medical practitioners being subject to restrictions or excluded from practicing in a particular facility or geographic location, where such restrictions or exclusions may substantially lessen competition.
- Accreditation decisions in relation to medical practitioners being made by their competitors, or potential competitors.
- Exclusive referral arrangements, where such arrangements may substantially lessen competition.
- Exclusive or conditional arrangements for the supply of medical or health-related goods or services, where such arrangements may substantially lessen competition.

- Alleged misuse of market power to prevent the entry of participants in, or deter competitive conduct in, particular medical or health-related markets.
- Alleged anti-competitive conduct in the emerging e-Health industry.
- Potential cartel behaviour in the medical and health industry.

Consumer Health Work

Over 2016, the ACCC has also focused enforcement activities on action designed to protect consumers in health markets, particularly vulnerable patients and large groups of Australians affected by conduct of health practitioners or corporations which may raise ACL concerns.

The ACCC has targeted areas where consumers may be harmed through:

- misleading conduct and/or unconscionable conduct in relation to the supply of health services, treatments or products by corporations or large businesses, with a particular focus where patient care is compromised
- claims about the efficacy of new technology or emerging areas of medicine that are not supported by evidence, in particular where the potential for consumer detriment is widespread
- claims about health treatments or services which are not supported by scientific evidence, when they have the likelihood of deterring or delaying consumers from pursuing effective treatments.

The ACCC is also engaging with health sector regulators to assist information sharing and referral of matters, as well as raising awareness of consumers and patients of their consumer rights, and industry participants about their ACL obligations.

Appendix A: Consultations

The ACCC consulted with a wide range of stakeholders. An invitation to make a submission to the report was also available on our website. The invitation letter is provided below.

We received a total of 39 submissions to the report. A list of public submissions is provided below and links to each submission are available on our website at www.accc.gov.au/phireport. We would like to thank stakeholders for their time in making a submission to the report.

The ACCC also conducted a stakeholder forum which discussed the focus issues for this year's report. The roundtable was attended by 28 stakeholders, including representatives from industry associations, insurers, intermediaries, providers, consumer groups and government agencies. The invitation letter is provided below.

This report uses data and information from consumer research commissioned by the ACCC and undertaken by Colmar Brunton as part of last year's PHI Senate Report. The research explored the relationship between consumers, information provision and the PHI industry. The full report of this research is available on our website.

List of publicly available submissions

ACT Endoscopy

Australasian College of Podiatric Surgeons

Australian Day Hospital Association

Australian Dental Association

Australian Medical Association

Australian Medical Association (SA)

Australian Orthotic Prosthetic Association

Australian Physiotherapy Association

Australian Society of Anaesthetists

Australian Society of Ophthalmologists

CBHS Health Fund

CHOICE

Code Compliance Committee

Commonwealth Ombudsman (formerly PHIO)

HBF

HCF

Health Insurance Restricted Membership Association of Australia

hearts4heart

Leading Age Services Australia

Medical Technology Association of Australia

Medtronic Australasia

nib

Optometry Australia

Pedorthic Association of Australia

Private Healthcare Australia

Public Health Association of Australia

Royal Australian and New Zealand College of Ophthalmologists

Royal Australian and New Zealand College of Psychiatrists

Unspun Solutions



Australian
Competition &
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Dear Stakeholder

Re: ACCC Report to the Senate on Private Health Insurance

The Australian Competition and Consumer Commission (ACCC) is commencing the preparation of its annual report to the Senate on 'any anti-competitive or other practices by health funds or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical or other expenses'. The report will cover the period 1 July 2014 to 30 June 2015.

The ACCC welcomes stakeholders' input into this report.

Focus issue for 2014–15 report

The 2013–14 report examined a range of issues relating to the level of transparency, accuracy and consistency of information about private health insurance and the impact it may have on consumers and competition more broadly. The ACCC undertook considerable research and consultation in the preparation of this report.

This year, the ACCC proposes to report on one key issue identified in the 2013–14 report, namely policy changes that are inappropriately communicated to consumers and which lead to unexpected costs ('bill shock') and inadequate coverage. As noted in the 2013–14 report, market failures due to asymmetric and imperfect information can significantly reduce consumers' ability to compare policies and make informed choices.

Specifically, the ACCC is interested in examining this year:

- whether changes to policies are sufficiently clear, transparent and consistent and are appropriately communicated to consumers when they occur; and
- the impact policy changes that are not appropriately communicated to consumers may have, including the extent to which they may:
 - lead to 'bill shock'
 - limit consumer access to, or choices of health care
 - cause other potential consumer harm or detriment.

The ACCC will be seeking to inform itself on this issue using available data and the input of stakeholders. This approach also takes into account the Department of Health's Private Health Consultations 2015–16 (further information is available at <http://www.health.gov.au/internet/main/publishing.nsf/Content/PHIconsultations2015-16>).

Submissions

In order to help us prepare our report, we invite you to provide your views on the following:

- In addition to complying with the legislative requirements, are you aware of or do you undertake any additional steps to inform consumers of policy changes?
- Do you think there are any problems with the way in which policy changes are communicated to consumers e.g. are they being communicated effectively?
- Are you aware of specific examples where policy changes have not been communicated to consumers in a clear and transparent way? Please provide details.
- Are you aware of practices where policy changes have not been communicated to consumers at all? Please provide details.

- Are you aware of practices where the information provided by insurers relating to policy changes has resulted in consumers experiencing 'bill shock'? Please provide details.
- Are you aware of practices where the information provided by insurers relating to policy changes has resulted in inadequate policy coverage for consumers?
- Are you aware of any common practices or methods for communicating policy changes to consumers that you consider 'poor practice,' or that insurers should not be doing?
- Do you have any suggestions for how the provision of policy change information can be simplified or made more accessible to assist consumers to understand any changes to the terms and conditions of their policies?
- What do you consider to be 'best practice' principles for communicating policy changes to consumers, and when should this communication occur? Are there other industries which may provide an example of a 'best practice' approach?

Data

- If you are a health insurer provider or consumer organisation, could you provide us with information about complaints and/or concerns you receive relating to the communication of policy changes to consumers, including:
 - the number or frequency of such complaints
 - the main causes of these complaints
 - how you address these complaints.
- Are these complaints changing over time and if so, how?

Lodgement

Submissions are welcome by Friday 29 April 2016 and can be made in the following ways:

- Online at <https://consultation.accc.gov.au/ipil/phireport-2015/>
- Send your submission to Joelle Leggett, GPO Box 520, Melbourne Vic 3001.

We would be grateful if you could provide your responses online and in PDF format. Submissions will be published on-line in accordance with the ACCC Information Policy.¹⁴¹ Information which is of a confidential nature or which is submitted in confidence can be treated as such by the ACCC, provided the cause for such treatment is shown.

Stakeholder forum

The ACCC will be inviting a range of stakeholders to a face-to-face stakeholder consultation forum following the written submission process. The ACCC anticipates that this forum will be held in May/June 2016. Invited stakeholders will be further notified about this process via email.

For more information on the ACCC report to the Senate and to see previous reports and past submissions, please go to www.accc.gov.au/phireport.

Any questions or queries can be directed to phireport@accc.gov.au.

Yours sincerely



David Salisbury
Acting General Manager
Consumer & Small Business Strategies Branch
Australian Competition & Consumer Commission

¹⁴¹ <https://www.accc.gov.au/system/files/ACCC-AER%20Information%20Policy.pdf>.



22 April 2016

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Dear Stakeholder

Re: Invitation to attend Private Health Insurance forum—1 June 2016

The Australian Competition and Consumer Commission (ACCC) would like to invite your organisation to attend a stakeholder forum it will be conducting on Wednesday 1 June 2016 in Canberra.

The purpose of this forum is to inform this year's report by the ACCC to the Australian Senate on the private health insurance industry. Details of the report and the forum are outlined further.

ACCC's 2014–15 Private Health Insurance report

The ACCC has commenced the preparation of its 17th annual report to the Senate on 'any anti-competitive or other practices by health funds or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical or other expenses'. The report will cover the period 1 July 2014 to 30 June 2015.

On 24 March 2016, a letter was sent to your organisation announcing the commencement of this year's report process, outlining the range of issues the ACCC is initially seeking comment on, and inviting your organisation to provide a written submission on these and related issues of interest to you. Written submissions are welcome by Friday 29 April 2016.¹⁴²

As noted in our letter to your organisation, this year, the ACCC proposes to report on one key issue identified in the ACCC's 2013–14 report, namely issues related to policy changes that are not adequately communicated to consumers and which lead to unexpected costs ('bill shock') and inadequate coverage. As noted in the 2013–14 report, market failures due to asymmetric and imperfect information can significantly reduce consumers' ability to compare policies and make informed choices.

Specifically, the ACCC is interested in examining this year:

- whether changes to policies are sufficiently clear, transparent and consistent, and are adequately communicated to consumers when they occur, and
- the impact policy changes that are not adequately communicated to consumers may have, including the extent to which they may:
 - lead to 'bill shock'
 - limit consumer access to, or choices of health care
 - cause other potential consumer harm or detriment.

The ACCC will be seeking to inform itself on this issue using available data and the input of stakeholders. This approach also takes into account the Department of Health's Private Health Consultations 2015–16.

¹⁴² A copy of the letter and information about the submission process is available on the ACCC's Consultations Hub https://consultation.accc.gov.au/jpil/phireport-2015/consult_view.

Details of the stakeholder forum**Date:** Wednesday 1st June 2016**Time:** 1:30 pm to 5:30 pm**Location:** Commission Room Level 4, 23 Marcus Clarke Street, Canberra ACT 2601

The purpose of the forum will be to discuss, in a roundtable environment, the focus issue for this year's report with key stakeholders in the private health insurance industry. The ACCC is inviting a range of stakeholders to attend, including industry associations, insurers, intermediaries, providers, consumer groups and government agencies. ACCC Commissioners will be chairing the forum.

Issues for discussion will include, but not be limited to:

- common issues and themes arising in the submissions
- suggestions on how the provision of policy change information can be simplified or made more accessible to assist consumers to understand any changes to the terms and conditions of their policies
- 'best practice' principles for communicating policy changes to consumers and when this communication should occur.

A final agenda will be sent to confirmed attendees at least two weeks prior to the forum.

To confirm your organisation's attendance at the forum, please respond via email to phireport@acc.gov.au by Friday 6 May 2016. To note, due to the range of stakeholders to be represented, participation in the roundtable discussions will be restricted to one representative per organisation. However, additional representatives can also attend to provide support where needed. If you can please provide the name and contact details of the person who will be representing your organisation at the roundtable (and any other support staff) it would be appreciated.

For more information on the ACCC report to the Senate and to see previous reports and past submissions, please go to www.accc.gov.au/phireport.

Any questions or queries about the forum should be directed to phireport@acc.gov.au.

Yours sincerely



David Salisbury

Acting General Manager

Consumer & Small Business Strategies Branch

Australian Competition & Consumer Commission

Appendix B: Other guidance on benefit change notifications

The Code of Conduct for Health Fund and Hospital Negotiations

The Code is a self-regulatory, voluntary industry code that aims to encourage best practice in contracting between private hospitals and health insurers. The Code applies to signatory hospitals and health insurers.

The Code primarily deals with procedural issues relating to the negotiation of contracts between private hospitals and health funds. The Code requires insurers to keep their members informed of changes to contracted hospital arrangements and of any changes to benefit levels in a reasonably timely manner in accordance with the insurer's normal communication systems. It also requires hospitals to inform patients of changes in a fair and reasonable manner.¹⁴³

PHIO Hospital Agreements: Transition and Communication Protocols

The protocols are arrangements agreed between the PHIO and the private health industry to ensure adequate consumer protection and minimise undue disruption and risk to the industry when contractual agreements between insurers and hospitals are terminated.¹⁴⁴

The protocols require health insurers to notify customers of changes to contractual arrangements with hospitals, including by advising their members on:

- which hospitals have agreements with the health insurer
- which hospitals will no longer have agreements with the insurer
- potential for out-of-pocket expenses for treatment at a non-contracted hospital
- how to avoid out-of-pocket expenses
- transitional arrangements.¹⁴⁵

PHIO guidance on how to notify consumers of rule changes

The PHIO has provided detrimental rule change notification guidelines to insurers in response to questions about how best to inform consumers of detrimental rule changes (Box 3 and 4).¹⁴⁶

The PHIO notes that 'the guidelines are helpful because the legislative requirements in the *Private Health Insurance Act 2007* (Cth) to notify consumers of a detrimental change to a policy in 'reasonable time before the change takes effect (section 93–25)' ... 'leaves open to interpretation what is considered a policy change, the level of detriment, how far in advance of a change notice needs to be provided, and what is considered an acceptable method of notification'.¹⁴⁷

While not binding on insurers, the PHIO notes that complying with the guidelines will assist insurers reduce the likelihood of complaints. However, an insurer is advised to obtain its own legal advice with any change notification it makes.

143 See: <https://www.privatehealthcareaustralia.org.au/resources/provider-resources/hospital-code-of-conduct/>.

144 The protocols have been developed by the Private Health Insurance Ombudsman, in consultation with the Australian Health Insurance Association, the Health Insurance Restricted Membership Association of Australia, the Australian Health Services Alliance, the Australian Private Hospitals Association and the Department of Health.

145 See: http://www.ombudsman.gov.au/__data/assets/pdf_file/0012/30351/transitionandcommunicationprotocolsdec2009.pdf.

146 See: PHIO Quarterly Bulletins 45, 52, 69 and 76.

147 PHIO, p. 1.

Box 3 PHIO guidelines for informing consumers of rule changes

How to provide rule change information

PHIO Quarterly Bulletins 45 and 69 provide the following advice to insurers about what constitutes a reasonable notice period for detrimental rule changes, definitions for levels of detriment, and good practices for offering upgrade information and protecting patients that are 'pre-booked' and in 'a course of treatment':

1. Significant detrimental changes to hospital benefits

- Removal of benefits or restriction to default benefits for a condition or treatment
- Addition of excesses or co-payments
- Increases in excess or co-payment >50 per cent
- At least 50 days' notice to affected contributors
- Information about 'upgrade' options in and outside the fund
- Pre- booked admissions (prior to notification) unaffected
- Patients currently in a 'course of treatment' to be unaffected (for up to six months).

2. Other detrimental changes to hospital benefits

- At least 30 days' notice to affected contributors
- Information about 'upgrade' options in and outside the fund
- Pre- booked admissions (prior to notification) unaffected
- Patients in a 'course of treatment' (at time of notification) to be unaffected (for up to three months).

3. Detrimental changes to ancillary benefits

- At least 30 days' notice to affected contributors
- Changes to annual limits and withdrawal of benefits subject to annual limits to take effect from beginning of next annual period.

4. For all detrimental changes:

- Flexibility to deal with special or unusual circumstances on a case by case basis.

PHIO Quarterly Bulletins 45 noted specifically for product closures and forced migrations involving detrimental change (i.e. where customers are forcibly migrated to a different policy with a lower level of cover such as with excesses and restrictions), customers should be:

- alerted to the specific detrimental changes in a letter
- be advised of appropriate levels of cover if they do not want a cover with restrictions
- have waiting periods waived where they change cover.

Source: PHIO Quarterly Bulletins 45 and 69.

Box 4: PHIO guidelines for informing consumers of rule changes

How and what rule change information to provide

PHIO Quarterly Bulletin 52 provides guidance on 'how to provide information' and 'what type of information to provide' to improve customer understanding of rule changes and reduce complaints. This includes that:

- a comprehensive and well planned communications campaign should be used
- written communication (a letter or email) should be written in such a way that notice of the change in cover cannot be missed amongst information about rate changes or other initiatives
- the relevant information needs to be high on the first page of the letter, under a bold heading along the lines of 'Important changes to your cover—removal of maternity services'—or similar
- the letter or email need to highlight the action required by the member if they do not wish to accept the reduction in their cover and options for upgrading cover, as well as the date by which an upgrade needs to occur
- follow up communication should be used either by a specific second letter or an outbound call or email campaign to members who have not chosen to upgrade their cover
- the information can be highlighted in the fund's newsletter.

PHIO Quarterly Bulletins 69 provides further guidance, including that information provided to members about detrimental rule changes should be clear and unambiguous and be given prominence on the first page of a letter. The PHIO noted this was to address complaints where customers overlooked, missed or misunderstood change notifications because messages were not being given sufficient prominence, had ambiguous headings, and used unclear and ambiguous language.

Sending rule change notifications by email

PHIO Quarterly Bulletin 76 provides guidance on sending rule change notifications by email, noting that the below guidelines should be followed to ensure customers know where to expect the communications. Guidance includes that:

- there is a record of the policy holder opting in to receive all communications by email and an understanding that the email address needs to be kept up to date, or
- there is an established record of the policy holder receiving all communications by email, and
- the communications can be reproduced in a suitable format and given to a consumer who makes a complaint about not receiving the notification.

The PHIO noted the guidelines for email notifications were designed to address complaints where customers overlooked or missed change notifications by email because the email was used as the default method of communication without an 'opt in' by the customer, email subject headings were not clear and did not reference a change, and where change notifications and marketing material were sent to the same email address.

Source: PHIO Quarterly Bulletins 52 and 76.

Appendix C: Stakeholder suggestions for improvement

Submissions to this report described a range of actions underway or which could be taken to improve consumer understanding of benefit change notifications and their impacts.

Suggestions to help consumers better understand their benefits generally

- undertake an independent review of consumer communications to identify ways to harmonise terminology and interpretation across all insurers (PHA p. 7)
- make consumers aware when purchasing policies of coverage and limitations (such as exclusions, qualifying periods, annual limits etc.) (ASA p. 2, ADA pp. 7–8, APA p. 4)
- clearer and transparent explanations provided to consumers of what their proposed policy covers (ADHA p. 3, RANZCP p. 3)
- make comparative information (such as pricing, caps on rebates and exclusions) available in one place (APA p. 2)
- define common terms such as ‘premium’, ‘exclusion’ and ‘cap’ (APA p. 2)
- use plain English in all written communication (ASO pp. 6–7, ADA pp. 7–8)
- introduce clear, simple and consistent language
- improve the content of the SIS (PHA p. 7, Choice p. 5, CCC p. 5)
- publish charges levied by HCSPs (PHA p. 7)
- create model PHI policies with model clauses that provide a uniform set of terms and conditions (ADA p. 7)
- standardise benefits, terminology and payment for hospital cover (industry-agreed definition of a minimum coverage product with no restricted services, no contract based co-payments and higher excess limits)
- improve product design and usability of content (such as brochures, product sheets, and web content) to make information easier to find, understand and navigate
- provide policy documents with large easy to read print (ASO pp. 6–7)
- continue to fund PrivateHealth.gov.au and require participation of all private health insurers in comparison websites (APA p. 2)
- improve verbal advice from customer service staff (APA p. 5).

Suggestions to help improve benefit change notifications specifically

- better upfront disclosure to consumers that benefits can change (PHIO pp. 3–4)
- further reform the PHI Code of Conduct (for example, by requiring information tailored to consumer needs, or limiting detrimental changes to once annually) (APA p. 6)
- consumer test change communication approaches to determine which are more effective
- ensure that change information is clear, unambiguous and is given prominence on the first page of the letter (PHIO p. 2)
- provide information in a manner that people can understand and that is easily available (LASA p.4)
- avoid the use of industry jargon and use plain English (LASA p. 4)
- clearly communicate the implications of a change for consumer access to health services and out-of-pocket costs (ADA p. 6)
- mandate simple to read policy update notifications and require the reissuing of PDS/SIS to consumers in a timely manner whenever changes are made (ADA p. 6)

- provide consumers with options for receiving change notifications (such as traditional mail, email, SMS, and other social media) (ADA p. 5).

The PHIO's standardised language and communication protocols

In addition to the PHIO's best practice benefit change notification processes (Appendix B), the Ombudsman has proposed a 'standardised language and communication protocol' to simplify how information is provided to consumers with the aim of ensuring that the communication is clear and unambiguous, and is not mixed up with other communication such as marketing materials. The protocol would require the clear statement of key messages, including:

- the change to the policy, including dollar/percentage figures of benefits before and after the change
- the details of any policy a consumer may change to to maintain a particular benefit
- the date of the change
- the contact details for further advice from the insurer (the PHIO suggests a help line and/or website link) (PHIO p. 8).

