ACCC Report

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 2015 to 30 June 2016

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Contents

Shortened terms

ACCC	Australian Competition and Consumer Commission
ACL	Australian Consumer Law
ADA	Australian Dental Association
AMA	Australian Medical Association
APRA	Australian Prudential Regulation Authority
ASA	Australian Society of Anaesthetists
CCA	*Competition and Consumer Act 2010* (Cth)
CCC	Code Compliance Committee
CHF	Consumer Health Forum of Australia
CMA	Complementary Medicines Australia
CPI	Consumer Price Index
DHA	Day Hospitals Australia
DOH	Department of Health
HCSP	health care service provider
hirmaa	Health Insurance Restricted Membership Association of Australia
IFC	informed financial consent
MBS	Medicare Benefits Schedule
PHA	Private Healthcare Australia
PHI	private health insurance
PHI Act	*Private Health Insurance Act 2007* (Cth)
PHI Code	Private Health Insurance Code of Conduct
PHIIA	Private Health Insurance Intermediaries Association
PHIO	Private Health Insurance Ombudsman
PHMAC	Private Health Ministerial Advisory Committee
PDS	product disclosure statement
PLAC	Prostheses List Advisory Committee
RANZCOG	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RDAA	Rural Doctors Association of Australia
SIS	Standard Information Statement
STAC	Second Tier Advisory Committee

Executive summary

This is the 18th 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 2015 to 30 June 2016.

This report analyses key competition and consumer developments and trends in the private health insurance industry during the reporting period that impacted on consumers' health cover and out-of-pocket expenses, while also noting significant developments that have occurred following the conclusion of the reporting period.

The ACCC's two previous reports to the Senate contained a range of observations relating to the adequacy of information provided by health insurers to consumers. This report outlines some of the changes health insurers have made to their information provision practices since the publication of those reports.

Consumer concerns about the affordability and value of private health insurance

In 2015–16, there was a small reduction in the percentage of Australians holding private health insurance. Recent consumer surveys suggest that this is, in part, a result of concerns regarding the affordability of private health insurance and the value that can be derived from policies.

Further research has confirmed that real household expenditure of consumers on their private health insurance policies has risen steadily over the last decade. Among all households with insurance, mean annual expenditure on premiums rose by nearly 20 per cent between 2006 and 2014. There has been a continuation of this trend with average industry weighted premium increases being above inflation for the past three years.

Households over time have shifted to lower cost premiums in response to increases in the cost of private health insurance. Between June 2014 and June 2016 there was a 400 000 reduction in hospital policies with no exclusions (which can be equated with 'top cover'), while an additional 600 000 hospital policies with exclusions were taken out.

Data was mixed in 2015–16 in relation to the benefits paid by insurers and the out-of-pocket (gap) expenses incurred by consumers. Although hospital benefits paid by health insurers per person increased (by 4.2 per cent, along with a 2.9 per cent increase in general (or 'extras') benefits), the average out-of-pocket expense incurred by a consumer from a hospital episode increased further by 6.9 per cent. In addition, while most in-hospital services are still delivered with no gap payments required from patients, this rate has been in decline over the past three years.

Consumer complaints continue to rise

In 2015–16, complaints about private health insurers to the Private Health Insurance Ombudsman (PHIO) rose for the third consecutive year, although at a slower rate than the previous two years. Over 30 per cent of these complaints related to the benefits paid by insurers to consumers.

The PHIO has reported that the main issue of consumer concern relating to benefits was hospital policies with unexpected exclusions and restrictions. In particular, the PHIO notes that some basic and budget levels of hospital cover exclude or restrict services that many consumers assume are routine treatment or standardised items.

In previous reports the ACCC has observed that it is in the interests of both consumers and health insurers for insurers to be clear and transparent in relation to their policy offerings. This will assist consumers to make informed decisions about the level of insurance cover they want and can afford and respond effectively when changes to their benefits are made.[1] The ACCC maintains this view.

ACCC continues to pursue enforcement activity in health and medical sectors

In 2015–16, the ACCC advanced a number of investigations and proceedings relating to competition and consumers matters in the health and medical sectors. Section 3 outlines recent matters the ACCC has pursued in the Federal Court of Australia, including:

- against Medibank, alleging it contravened the Australian Consumer Law (ACL) by failing to notify Medibank members and members of its subsidiary brand, ahm, regarding its decision to limit benefits paid to members for in-hospital pathology and radiology services
- against NIB, alleging it contravened the ACL by failing to notify members in advance of its decision to remove certain eye procedures from its 'MediGap Scheme', and
- against Ramsay Health Care Australia for alleged anti-competitive conduct involving misuse of market power and exclusive dealing in the Coffs Harbour region.

The ACCC continues to focus on consumer issues in private health insurance as one of its priority areas in the 2017 Compliance and Enforcement policy.[2] As part of this focus, the ACCC currently chairs the Consumer Health Regulators Group[3], which meets on a quarterly basis (or as otherwise needed), to exchange information, including about emerging issues of interest or concern, and to ensure responsibilities and functions of each regulator within the consumer health industry are understood and consistently applied.

Recent changes to health insurers' information practices

For this report, the ACCC requested specific input from stakeholders regarding any recent changes health insurers have made to their information provision practices. This follows the ACCC's findings in its 2014–15 report that the industry was characterised by imperfect information and complexity, particularly around how insurers communicated with consumers about changes to their private health insurance benefits.[4]

In response, a number of stakeholders submitted that there remain challenges for consumers in understanding and using information provided by health insurers relating to their policies, particularly in relation to the terminology insurers use and the implications of this for consumers when they are seeking to claim from their policy.

Positively, there are some recent examples of initiatives which insurers report they have implemented, or are in the process of implementing, to assist consumers to better understand the information they receive. These initiatives are outlined in section 4. The ACCC recognises

1 ACCC, *Communicating changes to private health insurance benefits—A report to the Australian Senate on anti-competitive and other practices by health insurers and other providers in relation to private health insurance*, October 2016, p. 3.

2 See ACCC Compliance and Enforcement Policy: https://www.accc.gov.au/about-us/australian-competition-consumer-commission/compliance-enforcement-policy (accessed June 2017).

3 In addition to the ACCC, other members include the Australian Health Practitioner Regulation Agency (who work in partnership with 14 National Boards in the National Registration and Accreditation Scheme), the Private Health Insurance Ombudsman, the Therapeutic Goods Administration and the NSW Health Consumer Complaints Commission (as the current chair of the state Health Consumer Complaints Commission). The Department of Health participates in the Group as an observer.

4 ACCC, *Communicating changes to private health insurance benefits*, October 2016, p. 1.

these efforts and encourages insurers to monitor and measure their effectiveness to ensure that the intended consumer benefits are realised. However, the ACCC notes that it received submissions from only five[5] of the 33 insurers it corresponded with on this issue, making it difficult to assess whether the industry more broadly is actively responding to the concerns expressed by the ACCC in previous reports.

Other matters raised by stakeholders

Stakeholders raised a number of additional matters in submissions. The key issues identified by the ACCC are discussed in section 5 of the report, relating to:

- contracting between health insurers and hospitals
- preferred provider arrangements
- rebates and coverage for medical services
- the Prostheses List framework
- administration of online directories, and
- intermediaries' role in the consumer switching process.

These issues may be considered by the ACCC in a subsequent report.

Policy developments relating to private health insurance

In preparing this report, the ACCC has been mindful of the broader policy developments that are occurring in relation to private health insurance, which are outlined in section 6.

Over the past 12 months, industry stakeholders have contributed to the Private Health Ministerial Advisory Committee's (PHMAC) consideration of all aspects of private health insurance. PHMAC will continue to meet in the second half of 2017 to refine its advice to the Australian Government on potential reforms.[6]

Many of the competition and consumer issues the ACCC has addressed in previous reports to the Senate are under active consideration by the PHMAC and Australian Government. The ACCC will continue to closely monitor developments relating to this policy process and consider the competition and consumer aspects of any reforms in future reports.

The ACCC notes that the operation of the Prostheses List has also been the subject of recent consideration and action by the Australian Government. Most categories of prostheses and their benefits have not undergone major review since they were established in 2005–06. The Prostheses List Advisory Committee (PLAC) reports that it will address this by conducting targeted category (device grouping) and benefit (pricing) reviews following consultation with stakeholders on its proposed review process in May and June 2017.[7] The ACCC recommends that competition law principles be considered in these reviews to ensure that the industry is operating efficiently and effectively.

5 The five insurers are Bupa, CBHS Health Fund, HBF, HCF and NIB, who have a combined coverage of approximately 55 per cent of Australian private health insurance members.

6 See PHMAC Work Plan at: http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac-committee-workplan (accessed July 2017).

7 See: http://www.health.gov.au/internet/main/publishing.nsf/content/health-privatehealth-plac (accessed June 2017).

1. Introduction

This report analyses key competition and consumer developments and trends in the private health insurance industry for 2015–16, while acknowledging significant developments that have occurred since the conclusion of the reporting period.

1.1 Senate Order

The ACCC has an obligation to provide an annual report 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.

1.2 Role of the ACCC

The ACCC is an independent Commonwealth statutory authority whose role is to enforce the *Competition and Consumer Act 2010* (Cth) (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.[8] 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 its enforcement powers, functions and priorities.[9] This policy is updated yearly to reflect current and enduring priorities. In 2017, consumer issues in private health insurance continue to be a priority area for the ACCC.

8 In addition, the 33 private health insurers presently operating in Australia are regulated by the Australian Prudential Regulation Authority under a legislative framework set out at http://www.apra.gov.au/PHI/Pages/Private-Health-Insurance-Legislation.aspx (accessed June 2017).

9 See ACCC Compliance & Enforcement Policy: https://www.accc.gov.au/about-us/australian-competition-consumer-commission/compliance-enforcement-policy (accessed June 2017).

1.3 Methodology in preparing this report

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

Consultation with industry stakeholders has been conducted through a written submissions process, with the ACCC receiving 29 public submissions and one confidential submission. The ACCC encourages public submissions to promote transparency and accountability in its reporting processes. More detailed information regarding the consultation is provided at appendix A.

The ACCC has also used and relied on:

- industry statistics and data collected by the Australian Prudential Regulation Authority (APRA)
- complaints data on private health insurance from the PHIO (from 1 July 2015 the PHIO's functions were merged with the Commonwealth Ombudsman), and
- the results of a number of consumer surveys recently undertaken by stakeholders including CHOICE and the Consumer Health Forum of Australia (CHF).

2. Key industry developments and trends

This section of the report sets out key competition and consumer developments and trends in the private health insurance industry that occurred in 2015–16, as summarised below.

Summary of key industry developments and trends in 2015–16

- The affordability of insurance remains a significant concern for consumers, which is supported by research confirming real household expenditure on private health insurance premiums has increased steadily over the past decade.
- There was a small decline in the percentage of Australian consumers holding hospital or combined cover (0.42 per cent), compared to a small increase in the number holding general ('extras') cover (0.26 per cent).
- Consumers are shifting towards lower-cost policies with lower benefits. Between June 2014 and June 2016 there was a 400 000 reduction in hospital policies with no exclusions (which can be equated with 'top cover'), while an additional 600 000 hospital policies with exclusions were taken out.
- The amount of hospital benefits paid by health insurers per person increased by 4.2 per cent, along with a 2.9 per cent increase in general benefits per person.
- Average out-of-pocket expenses incurred by consumers from hospital episodes increased by 6.9 per cent, compared to only 0.7 per cent for general treatments.
- Overall consumer complaints to the PHIO rose for the third consecutive financial year, although the year-on-year increase of 3.5 per cent followed much larger increases of nearly 16 per cent in 2013–14 and 24.5 per cent in 2014–15.
- The PHIO continued to receive the highest level of complaints regarding the benefits paid by insurers to consumers (over 30 per cent of total complaints in 2015–16). The main issue of consumer concern relating to benefits was hospital policies with unexpected exclusions and restrictions.
- Consumers increasingly rely on information provided by commercial comparison websites when making decisions about their private health insurance. Around 40 per cent of consumers who made comparisons between insurers prior to selecting their current policy utilised a commercial comparison website, such as iSelect and Compare the Market, to assist their decision-making.[10]

2.1 Private health insurance membership

As at 30 June 2016, 13.43 million Australian consumers, or over 55 per cent of the population, had some form of private health insurance.[11]

There are two types of private health insurance cover. Hospital policies help cover the cost of in-hospital treatment by doctors and other costs such as accommodation and theatre fees. General treatment policies, also known as 'extras' cover, provide benefits for services such as physiotherapy, dental and optical treatment.

Many consumers hold combined policies that provide packaged cover for both hospital and general treatment services.

10 Market research conducted by ACCC and CHOICE about consumers' use of commercial comparison websites is discussed at section 4.1.

11 See APRA Private Health Insurance Statistical Trends—Membership Trends (December 2016): HT & GT pol inspers tab—'Insured persons by type of treatment': http://www.apra.gov.au/PHI/Publications/Pages/Statistical-Trends.aspx (accessed June 2017).

Table 1 demonstrates that there was a reduction of 0.42 per cent of the population holding hospital only or combined cover from June 2015 to June 2016. In contrast, the proportion of the population holding general treatment only policies increased by 0.26 per cent during the same period.[12]

Table 1: Insured Australian consumers by policy type, June 2015 and June 2016

	June 2015	% of population	June 2016	% of population
Hospital only or combined cover	11 267 413	**47.37%**	11 325 253	**46.95%**
General only	2 009 579	**8.45%**	2 101 444	**8.71%**

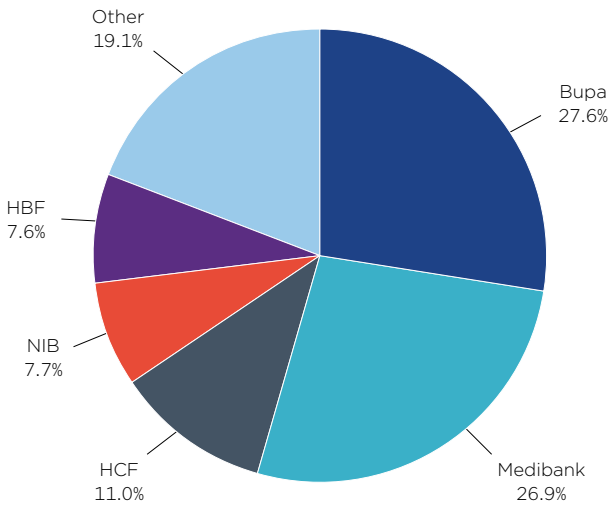
Source: APRA, Private Health Insurance Statistical Trends—Microsoft Excel data cube—Membership Trends (December 2016).

Membership by health insurer

The top five health insurers provide cover to over 80 per cent of Australian consumers with private health insurance. As demonstrated in figure 1, Medibank and Bupa account for over half of the market, with similar market shares around 27 per cent.[13] The next three largest insurers—HCF, NIB and HBF—have a combined market share equivalent to one of the market leaders.

In 2015–16, Bupa overtook Medibank as Australia's largest insurer, as measured by people covered. Bupa ended the financial year with just over 3.7 million members, compared to Medibank's 3.61 million members. This was a result of Bupa gaining 78 315 members, while Medibank lost 96 661 members across the 12 months. However, Medibank still held nearly 37 000 more policies than Bupa at the end of the financial year.[14] On average, Bupa's policies covered more people.

Figure 1: Insurer market share by number of Australian consumers covered, 2015–16



Source: APRA, *The Operations of Private Health Insurers Annual Report—2015–2016*, November 2016.

12 op. cit., APRA Private Health Insurance Statistical Trends—Membership Trends (December 2016): HT & GT pol inspers tab—'Insured persons by type of treatment': http://www.apra.gov.au/PHI/Publications/Pages/Statistical-Trends.aspx.

13 See APRA Operations of Private Health Insurers—Table 3: Membership, revenue and expenses: http://www.apra.gov.au/PHI/Publications/Pages/Operations-of-Private-Health-Insurers-Annual-Report.aspx (accessed June 2017).

14 ibid.

2.2 Private health insurance expenditure by consumers

In June 2016, the Melbourne Institute of Applied Economic and Social Research (Melbourne Institute) released the most recent findings of the Household, Income and Labour Dynamics in Australia (HILDA) Survey, a household-based study following more than 17 000 Australians each year. The report included an analysis of changes in household expenditure on private health insurance premiums[15] from 2006 to 2014.[16]

The report found that among households with private health insurance, real expenditure on health insurance premiums increased considerably between 2006 and 2014. Among all households with insurance, mean annual expenditure on premiums rose from $1869 (at December 2014 prices) in 2006 to $2237 in 2014, a 19.7 per cent increase.[17]

Further findings are not available for the period since 2014; however it is noted that the industry weighted average premium increases[18] for the past three years—6.18 per cent (2015), 5.59 per cent (2016) and 4.84 per cent (2017)—have been above the Consumer Price Index (CPI) measure of inflation.[19]

The Melbourne Institute observed a trend from 2009 (when the Australian Government began reporting industry weighted average premium increases) to 2014 that despite these premium increases, real increases in household expenditure on premiums (11.6 per cent) during this period were below real increases in average premiums (15.5 per cent).[20] The Melbourne Institute concluded that the cause of this was that the composition of policies held by households had shifted towards lower-cost policies with lower benefits during this period.[21]

This conclusion appears consistent with the ACCC's prior observations in relation to the upward trend of consumers having lower cost private health insurance policies with exclusions/excess payments (correlated with a decline in the proportion of consumers' hospital policies with full cover).[22] Data published by APRA confirms these trends with APRA noting that between

15 In reflection of the HILDA survey and its use in the Melbourne Institute Report referred to in this Report, 'private health insurance premium expenditure' refers to the premiums paid by consumers to private health insurers, and does not include the out-of-pocket costs consumers incur for medical treatment. The 'HILDA Living in Australia' questionnaire (which was used to inform the Melbourne Institute Report), distributed by Roy Morgan Research, asked respondents to identify their annual expenses for a number of categories, including 'private health insurance'. The questionnaire also asked respondents to separately identify their annual expenses for 'Fees paid to doctors, dentists, opticians, physiotherapists, chiropractors and any other health practitioner' and 'Medicines, prescriptions and pharmaceuticals (Include alternative medicines)'. However, the latter two categories were not included in the Melbourne Institute Report cited. See questionnaire at: http://melbourneinstitute.unimelb.edu.au/assets/documents/hilda-questionnaires/SelfCompletionQuestionnaireW14.pdf (accessed June 2017).

16 Melbourne Institute of Applied Economic and Social Research, *The Household, Income and Labour Dynamics in Australia Survey: Selected Findings from Waves 1 to 14*, July 2016, pp. 95–100 available at: http://melbourneinstitute.unimelb.edu.au/__data/assets/pdf_file/0007/2155507/hilda-statreport-2016.pdf (accessed June 2017).

17 ibid., p. 97.

18 The industry weighted average premium increase is calculated by weighting each insurer's average increase by its market share. The market share is measured according to the number of people covered. Further details regarding the private health insurance premium round process are available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/privatehealth-summary-premiumincreases (accessed June 2017).

19 See Department of Health website—'Average premium increases by insurer by year': http://www.health.gov.au/internet/main/publishing.nsf/content/privatehealth-average-premium-round (accessed June 2017); Table—'Inflation rates and health insurance premiums' in Dan Conifer and Stephanie Anderson, 'Health insurance premiums to see almost 5 per cent hike after green light from Government', 10 February 2017, available on the ABC News website at: http://www.abc.net.au/news/2017-02-10/health-insurance-premiums-set-to-rise-by-nearly-5-percent/8258014 (accessed June 2017).

20 Melbourne Institute of Applied Economic and Social Research, *The Household, Income and Labour Dynamics in Australia Survey: Selected Findings from Waves 1 to 14*, July 2016, p. 98

21 ibid.

22 ACCC, *Communicating changes to private health insurance benefits*, October 2016, pp. 35–6.

June 2014 and June 2016 there was a 400 000 reduction in hospital policies without exclusions (which can be equated with 'top cover'), while an additional 600 000 hospital policies with exclusions were taken out.[23]

Consumer perspectives on affordability and value of private health insurance

There have been a number of recent consumer surveys conducted about private health insurance. This research focus reflects the significance of issues relating to private healthcare for a large proportion of Australian consumers. The surveys discussed below support the observation that as real household expenditure on private health insurance has increased, affordability has become a significant consumer concern.

It is important to note that the surveys discussed below have different methodologies and emphases, so caution needs to be taken in reviewing and comparing the results. In particular, consumer perspectives on the 'value' of private health insurance vary depending on the specific aspects of policies that are tested in individual surveys.

The 2015 *Ipsos Healthcare and Insurance survey*[24] asked the main health decision maker in a household to rate the value of private health insurance, based on the protections and benefits it provides. The majority of respondents (63 per cent) with private health insurance considered it represented 'fairly good value', while 22 per cent considered it represented 'very good value'. Only 11 per cent of respondents considered the value to be 'not too good', with 2 per cent considering it 'not good at all'.[25] Of those respondents who had allowed their insurance to lapse, 61 per cent reported the reason as being the cost of premiums. Private Healthcare Australia (PHA) considers this demonstrates consumers' primary concern with health insurance is affordability.[26]

Consumer concern regarding the affordability of accessing medical services was prominent in a nationally representative consumer pulse survey CHOICE conducted in 2015–16.[27] Health and medical costs, including health insurance, was the second biggest cost of living concern for respondents, after electricity prices.[28] When asked how concerned they were about the current costs of health or medical expenses, 37 per cent of respondents were 'quite concerned' and another 36 per cent of respondents were 'very concerned'.[29]

CHOICE commissioned the Online Research Unit (ORU) to conduct a further national survey of over 1000 private health insurance policy holders in April 2017.[30] The sample was supplied by ORU. The survey was aimed at identifying the main sources of information used by consumers when making decisions about private health insurance.

The survey found that 21 per cent of respondents were planning to relinquish or reduce their cover in the following 12 months. The main reason given by respondents was affordability, with 66 per cent considering their current policy was too expensive. A further 39 per cent of respondents did not consider they were using their current policy enough to get value for money.[31]

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23 See APRA Private Health Insurance Statistical Trends—Membership Trends (December 2016): HT Membership tab—'Insured persons by type of treatment': http://www.apra.gov.au/PHI/Publications/Pages/Statistical-Trends.aspx (accessed June 2017).

24 This is a biennial survey of over 5000 respondents. See: http://ipsos.com.au/ipsos-public-affairs/specialist-business-areas/healthcare-and-insurance/ (accessed June 2017).

25 These results were provided directly to the ACCC by Ipsos. The survey report is not released publicly.

26 Private Healthcare Australia (PHA), Submission: ACCC Report to the Senate 2015–16, 17 March 2017, p. 3.

27 Report available at: https://www.choice.com.au/money/budget/consumer-pulse/articles/electricity-costs-biggest-concern-july-2016 (accessed June 2017). In 2014, CHOICE established a quarterly survey that maps the key cost of living concerns of Australian households and how they are responding to cost pressures.

28 CHOICE, *Consumer Pulse: Australians' attitudes to cost of living 2015–16*, July 2016, p. 7.

29 ibid., p. 5.

30 CHOICE, *Information provision in private health insurance—Results from CHOICE's national survey*, April 2017, p. 15.

31 ibid., p. 16.

The CHOICE survey found that older Australians (56+) were more likely to leave their cover level unchanged (61 per cent), while only 36 per cent of 31–40 year olds planned to keep their cover the same.[32]

Further results from CHOICE's 2017 survey relating specifically to information provision by health insurers are discussed in section 4.

In addition, the CHF conducted an online survey of 573 consumers in 2015–16, seeking perspectives on private health insurance policies.[33] CHF promoted the survey through its member organisations, publications and social media platforms.[34]

The survey revealed that only 38 per cent of respondents with health insurance were satisfied with their policies.[35] Some of the results that appeared to be driving respondents' overall dissatisfaction included:

- only 30 per cent of respondents were satisfied that their policies kept the costs of health care manageable
- only 43 per cent of respondents were satisfied that their policies adequately covered their health needs, and
- only 52 per cent of respondents considered that they understood what their policy covered well.[36]

Respondents did express higher levels of satisfaction in relation to their insurance providing them with better access to hospitals for elective procedures (64 per cent) and offering them control over the providers they wish to see (60 per cent).[37]

2.3 Benefits and payments made to consumers

This section presents data on the overall amount of benefits paid out to consumers by health insurers in 2015–16, while also reporting on the average out-of pocket costs incurred by consumers when accessing medical services.

Health insurers set the rebate amounts they pay for medical services. The rebate amounts they set have an impact on the out-of-pocket expenses (if any) that consumers incur when using their insurance. However, it is important to note that the amounts charged by different health care service providers (HCSPs)[38] for the same medical service can vary, which is a significant determinant of the final costs incurred by consumers. Some insurers use contracting arrangements with HCSPs to provide certainty around these charges, as discussed below.

Benefits paid by health insurers to consumers

During 2015–16, the amount of hospital benefits paid by health insurers per consumer increased by 4.2 per cent, along with a 2.9 per cent increase in general benefits per consumer.[39] This was consistent with increases in the total dollar value of benefits paid by insurers to consumers, as outlined in table 2.

32 op. cit., p.15.

33 Consumers Health Forum of Australia (CHF), *Private Health Insurance Consumer Survey—Results and Discussion*, January 2016, available at: https://chf.org.au/sites/default/files/chf_survey_report_-_private_health_insurance.pdf (accessed June 2017).

34 It is noted that this approach is likely to have attracted respondents that are more engaged with healthcare issues than a nationally representative sample of the population.

35 ibid., p. 7.

36 ibid., p. 4 and p. 7.

37 ibid., p. 6.

38 HCSPs include hospitals, specialists, and providers of 'extras' services, such as dental, optical and physiotherapy and chiropractic care.

39 See: Australian Prudential Regulation Authority, Private Health Insurance Quarterly Statistics, June 2016 at http://www.apra.gov.au/PHI/Publications/Documents/1608-QSR-20160630.pdf (accessed June 2017).

Table 2: Key metrics relating to the benefits paid by health insurers to consumers[40]

	June 2015	June 2016	Change
Benefits—hospital treatment ($ millions)	$13 281	$13 905	**+4.7%**
Benefits—general treatment ($ millions)	$4 552	$4 730	**+3.9%**
Hospital benefits per consumer ($)	$1 178	$1 227	**+4.2%**
General benefits per consumer ($)	$376	$387	**+2.9%**

Source: APRA, Private Health Insurance Quarterly Statistics, June 2016.

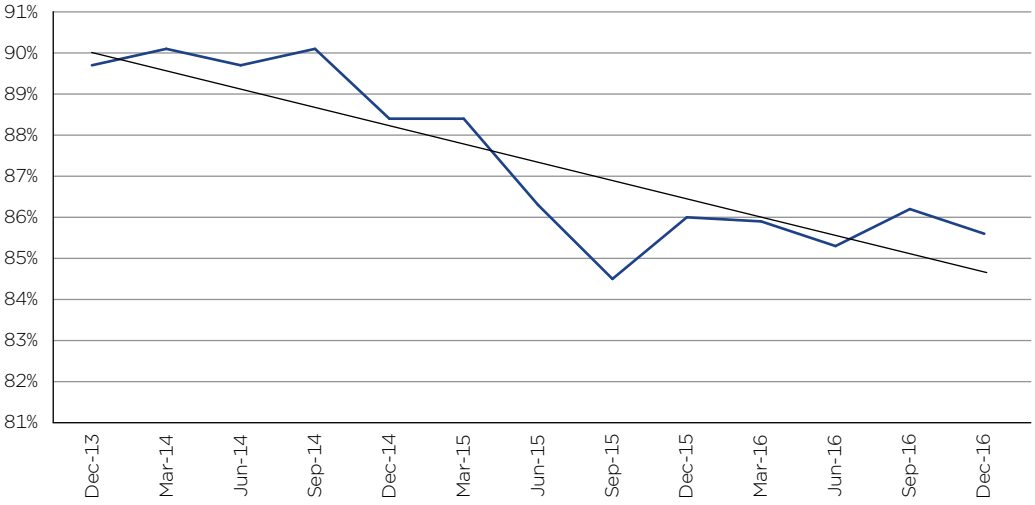
Out-of-pocket payments

An out-of-pocket or 'gap' payment is the amount a consumer pays either for medical or hospital charges, over and above what they receive from the Australian Government's Medicare scheme or their private health insurer.

Typically, health insurers enter into contractual arrangements with selected HCSPs, in part, to minimise the out-of-pocket expenses incurred by members. Insurers negotiate set fees and other terms with HCSPs in exchange for the right to participate in their 'preferred provider' networks or 'no gap' and 'known gap' schemes.

While most in-hospital services are still delivered with no gap payments required from patients, this rate has been in decline over the past three years from nearly 90 per cent of services to closer to 85 per cent of services, as demonstrated in figure 2.[41]

Figure 2: Percentage of in-hospital services with no gaps, Dec 2013 to Dec 2016



Source: APRA, Medical Gap publication, December 2016.

40 This table presents a selection of key metrics relating to the benefits paid by private health insurers. A full outline of all benefits paid to consumers by insurers can be found in APRA's Private Health Insurance Quarterly Statistics.

41 See Medical Gap—Table A: 'In hospital services with no gaps Dec 2013 to Dec 2016 and percentage point changes': http://www.apra.gov.au/PHI/Publications/Pages/Medical-Gap.aspx (accessed June 2017).

In 2015–16, the average out-of-pocket (gap) expense incurred by a consumer from a hospital episode increased by 6.9 per cent (from $282.25 to $301.22). A much smaller increase of 0.7 per cent in out-of-pocket expenses was recorded for general treatments (from $46.43 to $46.77).[42]

This means that members of private health funds are facing both increased expenditure in real terms on their premiums, and increased out-of-pocket expenses, particularly in relation to in-hospital services.

Some HCSPs have suggested that increasing out-of-pocket expenses for consumers is the result of insurers reducing cover for specific medical services (such as psychiatric services), or providing inadequate increases in, or freezing, rebates for services.[43] These views are outlined in detail in section 5.

Insurer representative bodies PHA and the Health Insurance Restricted Membership Association of Australia (hirmaa) submit that a lack of transparency relating to HCSPs' fees is a contributing factor to out-of-pocket expenses for consumers. PHA notes that insurers generally enter into contracts with major hospitals to ensure certainty over the cost of hospital admissions. However, PHA submits that estimating medical costs is more difficult because, with some exceptions such as preferred provider arrangements, doctors do not enter into contracts with insurers and set their own fees which can vary from patient to patient.[44] hirmaa submits that HCSPs should be required to reveal standardised cost estimates, including Medicare Benefit Scheme (MBS) item numbers, for each part of a procedure, and whether they will accept the benefits offered by a consumer's insurer or charge out-of-pocket fees. hirmaa considers this would ensure that patients are better able to avoid 'bill shock'.[45]

As discussed further in section 5, some health insurers report that they are seeking to provide greater transparency and informed choice for their members regarding medical costs through supplying information to online directories regarding HCSPs' charging practices.

2.4 Consumer complaints about private health insurance

Presented below is an analysis of consumer complaints to the PHIO and ACCC relating to private health insurance. This data provides a good indication of the specific aspects of health insurance that consumers are most frequently concerned about.

Complaints received by PHIO

The main complaints agency for consumers about their private health cover is the PHIO. During 2015–16, the PHIO received a total of 4416 complaints relating to private health insurance, representing an increase of 3.5 per cent from 2014–15. This increase in complaints followed larger increases of nearly 16 per cent in 2013–14 and 24.5 per cent in 2014–15, as demonstrated in figure 3.[46]

42 op. cit.

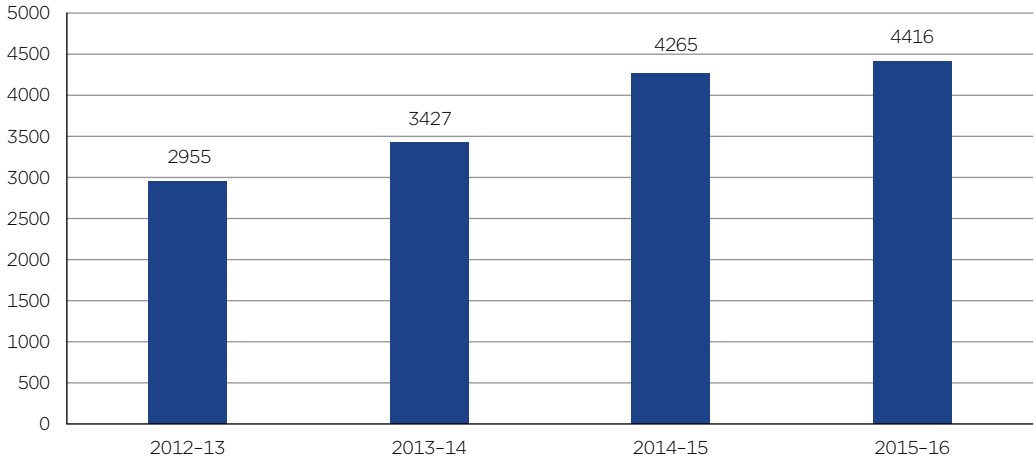
43 See submissions from Royal Australian and New Zealand College of Psychiatrists, Private Mental Health Consumer Carer Network, Complementary Medicines Australia, Australian Dental Association, Australian Society of Anaesthetists.

44 PHA, p. 4.

45 hirmaa, *Re: ACCC Report to the Senate on Private Health Insurance*, March 2017, p. 10.

46 Commonwealth Ombudsman, *Annual Report 2015–16*, September 2016, p. 55 available at: http://www.ombudsman.gov.au/__data/assets/pdf_file/0022/41584/ombudsman-annual-report15-16.pdf (accessed June 2017).

Figure 3: Total complaints received by PHIO, 2012–13 to 2015–16



Source: Commonwealth Ombudsman's Annual Report 2015–16 (PHIO section, p. 55).

Most complaints made to the PHIO are about health insurers (88 per cent in 2015–16).[47] However, complaints can also be made about HCSPs and health insurance brokers.

PHA submits that variations in the number of complaints lodged with the PHIO are not a fair or accurate representation of consumer attitudes towards private health insurance. PHA notes that for every complaint lodged with the PHIO, more than 3000 people have held PHI cover without complaint.[48]

While the ACCC acknowledges the number of complaints may be comparatively low relative to the overall size of the market, it is clear that there has been a substantial increase in complaints over the past three years. The PHIO considers that trends in complaints provide a meaningful reflection of the major issues and specific insurers which are causing concern for consumers.[49]

HCF has noted that the PHIO's current reporting methodology highlights the total number of disputes received, but not the outcome following investigation. HCF submits that this means consumers are not given the opportunity to fairly appraise the complaints handling of a health insurer to determine the legitimacy of these complaints. HCF suggests that the PHIO consider a reporting approach similar to the Financial Ombudsman Service Australia (FOS), which makes available a breakdown of dispute outcomes.[50]

However, the PHIO submits that assigning fault to one of the parties in a complaint would be counterproductive to its role in protecting the interests of consumers.[51] The PHIO notes that its legislated powers authorise investigation and recommendation only, whereas non-government, industry ombudsman bodies have the authority and industry agreement to impose penalties, fines, and abide by set complaint handling processes.[52] The PHIO considers its role is focused more on negotiating outcomes and providing explanations for all parties involved in a dispute, rather than assigning fault and applying a penalty or fine to one party.[53]

47 op. cit., p. 63.

48 PHA, p. 6.

49 Commonwealth Ombudsman (PHIO), *ACCC Report to the Senate on Private Health Insurance 2015–16—PHIO's Role as Independent Dispute Resolution Organisation*, April 2017, p. 1.

50 HCF, *Re: ACCC Report to the Senate on Private Health Insurance*, March 2017, p. 5.

51 PHIO, p. 1.

52 ibid.

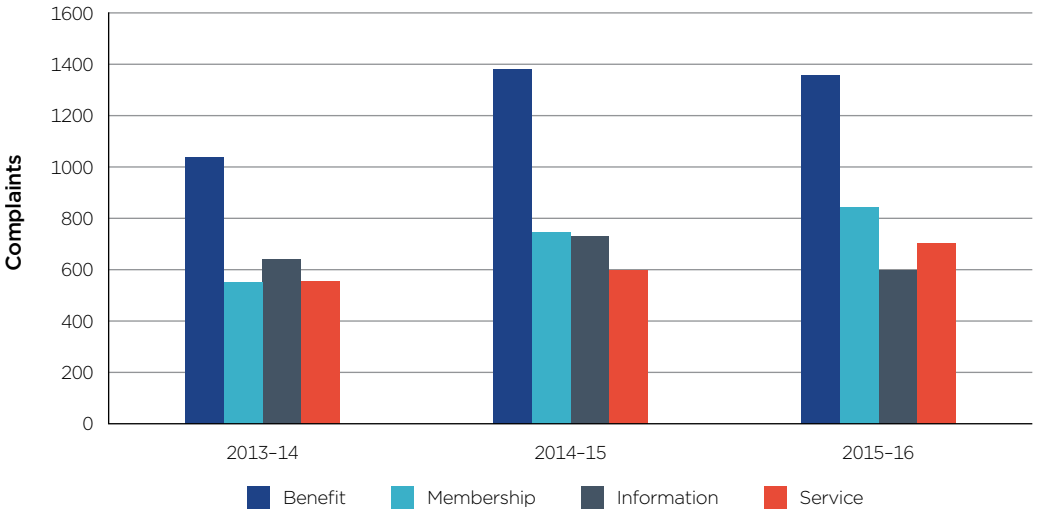
53 ibid.

PHIO complaints by issue

The PHIO categorises complaints by issue. The top four complaint issues—benefits, membership, information and service—have remained the same for the past three years, as demonstrated in figure 4. Of these issues, the benefits paid by insurers to consumers continued to receive the highest level of complaints (over 30 per cent of total complaints in 2015–16).[54]

The ACCC notes that complaints in relation to the provision of information to consumers, a recent focus of ACCC reporting, is the only category of complaints that has decreased (by 19 per cent) over the reporting period. The PHIO reports that this is attributable to reductions in complaints about insurers' oral advice (18 per cent), the largest complaint sub-issue, and written advice (41 per cent).[55] However, consumer complaints about insurers' lack of notification of rule changes remained steady.[56]

Figure 4: PHIO complaint issues, 2013–14 to 2015–16



Source: Commonwealth Ombudsman's Annual Report 2015–16, Private Health Insurance Ombudsman Annual Report 2014–15 and 2013–14.

The PHIO has reported that the main issue of consumer concern relating to benefits in 2015–16 was hospital policies with unexpected exclusions and restrictions. In particular, the PHIO notes that some basic and budget levels of hospital cover exclude or restrict services that many consumers assume are routine treatment or standardised items.[57]

54 Commonwealth Ombudsman, *Annual Report 2015–16*, pp. 58–62.

55 PHIO, *Private Health Insurance Ombudsman Supplementary Information* (to 2016 ACCC PHI consultation), September 2016, p. 10.

56 ibid.

57 ibid., p. 58.

PHIO case study: Hospital exclusions and restrictions

The consumer held a basic hospital policy with her health insurer which she bought because it included accident cover. She had an accident at home and fell. Initially she thought she did not need further treatment, but after a few days she experienced pain in her nose. She consulted a GP and was referred to a specialist who recommended surgery.

She thought she would be covered for this surgery as her policy covered 'accidents'. However, on contacting her insurer, she found she was not covered because she did not meet the 'accident' definition for her policy.

According to the insurer's definition, an 'accident' is an injury which requires hospital emergency department attendance within 24 hours of the accident occurring. Her accident did not meet this criterion.

The insurer declined to pay the claim because she did not seek treatment within 24 hours. In this case, the PHIO determined that the information about the accident clause was sufficiently clear in the policy documents that had been provided to the complainant.

The PHIO has observed that the most significant increases in complaints from 2014–15 to 2015–16 related to membership (administration) issues and service problems. The PHIO saw an increase in requests for assistance from consumers waiting for refunds from cancelled memberships and those waiting for transfer/clearance certificates to establish their private health insurance history when moving from one insurer to another.[58]

The Private Health Insurance Intermediaries Association (PHIIA), which represents independent intermediaries, agents and brokers selling health insurance, submits that when it comes to insurers' relinquishing members there are instances where the procedure for issuing clearance certificates becomes unnecessarily bogged down and delayed.[59]

PHA notes that insurers are addressing issues relating to customer switching through the Transfer Certificates Working Group, a joint project with the Department of Health (DOH), Health Direct Australia (HDA), the National Health Service Directory (NHSD) and the PHIO. The project is designed to improve the timeliness and reliability of customer switching between insurers through the creation of a fully electronic solution. It is expected that all funds will have adopted the new electronic system by the end of 2017.[60]

ACCC contacts received relating to private health insurance

The ACCC and state and territory fair trading agencies also receive consumer complaints relevant to the private health insurance industry. However the ACCC is not a dispute resolution body and does not generally receive a large number of complaints in relation to private health insurance.

In 2015–16, the ACCC received 169 contacts (enquiries and complaints) from the public regarding insurers or in relation to private health insurance issues. This represented a 33 per cent decrease from the previous year, when 253 contacts were received.

The majority of private health insurance contacts related to consumer protection issues, with 85 per cent of these contacts concerning potentially misleading or deceptive conduct, or false representations.

Section 3 of this report provides a summary of the enforcement actions undertaken by the ACCC in relation to the health and medical sectors during 2015–16.

58 Commonwealth Ombudsman, *Private Health Insurance Ombudsman State of the Health Funds Report 2016*, March 2017, p. 5.

59 Private Health Insurance Intermediaries Association (PHIIA), *Submission to the ACCC report to the Senate on private health insurance 2015/2016*, March 2017, p. 3.

60 PHA, p. 6.

3. Health and medical sector enforcement activity

In 2015–16, the ACCC advanced a number of enforcement matters relating to the health and medical sectors. Matters subject to court proceedings and ACCC compliance activities during the reporting period, and since, are outlined below.

The ACCC continues to focus on consumer issues in private health insurance as one of its priority areas in the 2017 Compliance and Enforcement policy.[61] As part of this focus, the ACCC currently chairs the Consumer Health Regulators Group[62] , which meets on a quarterly basis (or as otherwise needed), to exchange information, including about emerging issues of interest or concern, and to ensure responsibilities and functions of each regulator within the consumer health industry are understood and consistently applied.

3.1 ACCC action against Medibank

On 16 June 2016, the ACCC instituted proceedings in the Federal Court against Medibank alleging it contravened the ACL by engaging in misleading conduct, making false or misleading representations and engaging in unconscionable conduct.[63]

The proceedings arise from Medibank's failure to notify Medibank members and members of its subsidiary brand, ahm, regarding its decision to limit benefits paid to members for in-hospital pathology and radiology services.

The matter was heard during March and April 2017. Judgment has been reserved.

3.2 ACCC action against NIB

On 30 May 2017, the ACCC instituted proceedings in the Federal Court against NIB alleging it contravened the ACL by engaging in misleading or deceptive conduct, unconscionable conduct and making false or misleading representations.[64]

The proceedings arise from NIB's failure to notify members in advance of its decision to remove certain eye procedures from its 'MediGap Scheme' in 2015. Under the MediGap Scheme, members had previously been able to obtain these eye procedures without facing out-of-pocket costs when doctors participated in the scheme.

61 See ACCC Compliance & Enforcement policy: https://www.accc.gov.au/about-us/australian-competition-consumer-commission/compliance-enforcement-policy (accessed June 2017).

62 In addition to the ACCC, other members include the Australian Health Practitioner Regulation Agency (who work in partnership with 14 National Boards in the National Registration and Accreditation Scheme), the Private Health Insurance Ombudsman, the Therapeutic Goods Administration and the NSW Health Consumer Complaints Commission (as the current chair of the state Health Consumer Complaints Commission). The Department of Health participates in the Group as an observer.

63 ACCC, 'ACCC takes action against Medibank for alleged misleading and unconscionable conduct', 16 June 2016 available on ACCC website at: https://www.accc.gov.au/media-release/accc-takes-action-against-medibank-for-alleged-misleading-and-unconscionable-conduct (accessed June 2017).

64 ACCC, 'ACCC takes action against NIB', 31 May 2017 available on ACCC website at: https://www.accc.gov.au/media-release/accc-takes-action-against-nib (accessed June 2017).

3.3 ACCC action against Ramsay Health Care Australia

On 1 May 2017, the ACCC instituted proceedings in the Federal Court against Ramsay Health Care Australia (Ramsay) for alleged anti-competitive conduct involving misuse of market power and exclusive dealing in the Coffs Harbour region.[65]

Ramsay operates Baringa Private Hospital and the Coffs Harbour Day Surgery, the only private hospital and private day surgery facilities in the Coffs Harbour region. Coffs Harbour surgeons use operating theatres at Ramsay's facilities to perform surgical procedures on private patients.

The ACCC alleges Ramsay became aware that a group of Coffs Harbour surgeons were planning to establish a competing private day surgery facility in Coffs Harbour. In response to this competitive threat, the ACCC alleges senior Ramsay executives told these surgeons that if they were involved with the proposed new day surgery they would have their access to operating theatre time at Baringa Hospital substantially reduced or withdrawn.

The ACCC alleges that Ramsay engaged in this conduct for the purpose of deterring or preventing a new entrant in the day surgery market in Coffs Harbour, or substantially lessening competition in that market.

3.4 The 'Save on Tax' matter

On 2 June 2016, the ACCC published a media release to warn consumers against potentially misleading claims about the tax benefits of private health insurance.[66] In particular, the ACCC noted its concern that some private health insurers 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 industry bodies representing insurers, PHA and hirmaa, to ensure that all future advertising with regard to such claims is accurate and not misleading or deceptive.

The ACCC continues to monitor industry representations about the tax benefits of private health insurance.

65 ACCC, 'ACCC takes action against Ramsay Health Care for alleged anti-competitive conduct', 1 May 2017 available on the ACCC website at: https://www.accc.gov.au/media-release/accc-takes-action-against-ramsay-health-care-for-alleged-anti-competitive-conduct (accessed June 2017).

66 ACCC, 'ACCC warns against potentially misleading claims about the tax benefits of health insurance', 2 June 2016 available on the ACCC website at: https://www.accc.gov.au/media-release/accc-warns-against-potentially-misleading-claims-about-the-tax-benefits-of-health-insurance (accessed June 2017).

4. Developments relating to insurers' information practices

The ACCC's two previous reports to the Senate, which covered the 2013–14 and 2014–15 reporting periods, contained a range of observations relating to the adequacy of information provided by health insurers to consumers. Both reports emphasised that the private health insurance industry is characterised by imperfect information and complexity.

The 2014–15 report had a particular focus on the way in which changes to private health insurance are communicated to consumers, finding that:

> … 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.[67]

In preparing this report, the ACCC requested specific input from stakeholders regarding the changes health insurers have made to their information provision practices since the publication of the previous two reports.

This section outlines the following:

- survey results relating to how consumers interact with available information regarding private health insurance
- continuing challenges that stakeholders have identified with how health insurers provide information to consumers, and
- a summary of the recent initiatives insurers have reported using to improve their information practices.

4.1 Consumer interaction with information

As noted in section 2, CHOICE conducted a survey of over 1000 policy holders in April 2017. The key findings are discussed below. The ACCC has also drawn on consumer research it commissioned Colmar Brunton to undertake in 2015, where relevant to the analysis ('ACCC 2015 research').[68]

Accessing information about private health insurance

The CHOICE survey asked consumers to identify the sources of information they used to obtain information about private health insurance. Most commonly, respondents sourced information from friends, family or colleagues (29 per cent), health insurers (25 per cent) or comparison website iSelect (25 per cent). A further 16 per cent used another comparison website Compare the Market.[69]

67 ACCC, *Communicating changes to private health insurance benefits*, October 2016, p. 2.

68 Colmar Brunton, *Australian Competition and Consumer Commission—Consumer Survey—Private Health Insurance—Full Report*, May 2015, available at: http://www.accc.gov.au/system/files/ACCC%20Consumer%20Survey%20Private%20Health%20Insurance%20Final%20Report.pdf (accessed June 2017). Note: some caution should be taken in comparing the results of the CHOICE and Colmar Brunton surveys, as the surveys collected data from differing samples of the population and had other methodological differences.

69 CHOICE, *Information provision in private health insurance—Results from CHOICE's national survey*, April 2017, p. 8.

Previous ACCC finding

The ACCC's 2015 research found that 70 per cent of respondents compared different insurers prior to signing up with their current provider. Of those who did compare insurers, 60 per cent made their own comparisons, while 40 per cent used a comparison website.[70]

CHOICE considers its survey results demonstrate a significant reliance by consumers on commercial comparison services as a source of information on private health insurance. Therefore, CHOICE suggests that any regulatory or policy interventions that target the marketing materials provided by insurers, or information through privatehealth.gov.au, may fall short of addressing issues with complexity unless they are also directed at information provided by commercial insurance comparator websites.[71]

Further issues raised by stakeholders in relation to the operation of intermediaries, such as commercial comparison websites and broker services, are discussed in section 5.

Comparing health insurance policies

CHOICE's survey results revealed that 44 per cent of respondents found it difficult to compare private health insurance policies. Specifically, respondents were much more likely to find hospital policies difficult to compare (48 per cent) than 'extras' policies (25 per cent).[72]

Previous ACCC finding

The ACCC's 2015 research found that respondents with hospital cover had lower levels of agreement that information accessed prior to policy purchase was easy to find (46 per cent), accurate (57 per cent), and left them feeling sufficiently informed (56 per cent), compared to those with combined cover (responses ranging from 58–68 per cent) and those with extras only (responses ranging from 57–75 per cent).[73]

The CHOICE survey asked respondents to identify the specific elements they found difficult when comparing different health insurance policies. Table 3 summarises the results. Over two-thirds of consumers found it difficult to compare policies 'side-by-side', specifically in relation to comparing likely out-of-pocket expenses for hospital treatment and levels of 'extras' rebates.

70 Colmar Brunton, *Australian Competition and Consumer Commission—Consumer Survey—Private Health Insurance—Full Report*, pp. 32–33.

71 CHOICE, *Information provision in private health insurance—Results from CHOICE's national survey*, April 2017, p. 8.

72 ibid., p. 12.

73 Colmar Brunton, *Australian Competition and Consumer Commission—Consumer Survey—Private Health Insurance—Full Report*, p. 9.

Table 3: Key difficulties in comparing health insurance policies

Difficulty	% of respondents
Difficulties comparing policies side by side	69%
Difficulties comparing out-of-pocket costs if I were to go to hospital	54%
Information from insurers not set out consistently	53%
Difficulties comparing extras rebates	53%
Not all policies available for comparison	45%
Confusing terminology and language	43%
Unable to compare cover for specific health problems I'm worried about	39%
Unable to find independent information I could trust	36%
Too much information from insurers	25%
Difficulties comparing what I would save on tax or get from rebate	21%

Source: CHOICE survey: Q16A. Please select what you found difficult when comparing different health insurance policies (N=325).

Utility of the standard information statement

Health insurers are required by law to provide standard information statements (SIS) so that policy holders can review their existing policy or compare private health insurance products. The SIS provides a standardised summary of key product features.

The CHOICE survey reported that a majority of respondents recalled receiving the SIS (58 per cent overall). Of those policy holders who recalled receiving the SIS, 92 per cent considered it useful.[74]

The CHOICE survey found that consumers who recalled receiving their SIS were more likely to understand what exactly was covered by their policy (42 per cent), compared to those who did not recall receiving their SIS (30 per cent).[75]

CHOICE considers this indicates that improving the SIS through consumer testing and ensuring it is proactively and regularly provided to all consumers will assist in reducing complexity.[76]

Previous ACCC finding

The ACCC has previously concluded that the SIS alone does not provide sufficient information for consumers to understand the key benefits and limitations of their policies and the ACCC suggested a complete review of the role of the SIS.[77]

74 CHOICE, *Information provision in private health insurance—Results from CHOICE's national survey*, April 2017, p. 11.

75 ibid.

76 ibid., p. 4.

77 ACCC, *Information and informed decision-making: 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 of 1 July 2013 to 30 June 2014*, October 2015, p. 31.

The ACCC notes that the PHMAC Information Provision for Consumers Working Group considered the utility of the SIS in early 2017. Most members were of the view that the SIS in its current format was not ideal, but there was agreement that a minimum data set was essential for comparing products. Members agreed that a revised design of the SIS would be helpful to enhance consumer understanding.[78]

4.2 Continuing challenges with how information is provided

Previous ACCC finding

The ACCC has previously concluded that private health insurance policies are increasingly complex (with differing levels of exclusions, restrictions, waiting periods, excesses and 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.[79]

A number of stakeholders submitted that there remain challenges for consumers in understanding and using information provided by health insurers relating to their policies.

The PHIO has noted that the overriding themes of most of the complaints it receives relate to confusion over understanding the terminology used by health insurers and the implications of this for individual consumers seeking to claim from their policy.[80]

Similarly, the CHF submits that the terminology used to describe the out-of-pocket payments that consumers may or may not have to pay is laden with jargon. The CHF observes that the term 'no gap' can be used to mean a range of benefits and entitlements or lack thereof.[81]

The CHF also considers that the contracting arrangements that insurers enter into with providers are consistently poorly publicised, with insufficient details of how consumers can access these 'preferred provider' networks. The CHF observes that in reviewing insurers' websites, it is necessary to go through a number of search steps to find if a hospital, or other health provider, has a relationship with an insurer.[82]

The Rural Doctors Association of Australia (RDAA) submits that the plethora of health insurance policies available, the range of variations and exclusions and the lack of plain English explanations hamper the ability of rural people to assess the adequacy and appropriateness of health insurance products against their requirements.[83]

hirmaa, the industry body representing 21 not-for-profit, member owned and community based health insurers, considers there are notable differences in the communications practices of for-profit and not-for-profit insurers, which are reflected in its member satisfaction levels. hirmaa reports that its most recent independent, annual customer satisfaction survey found that 96 per cent of members were satisfied with the level of communication they received regarding their membership.[84] hirmaa also draws attention to the underrepresentation by market share of its members as a proportion of total PHIO complaints.[85]

78 See PHMAC Information Provision for Consumers Working Group—31 March 2017 meeting summary at: http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac-provision-meeting-3 (accessed June 2017).

79 ACCC, *Communicating changes to private health insurance*, October 2016 p. 33.

80 Commonwealth Ombudsman, *Private Health Insurance Ombudsman State of the Health Funds Report 2016*, p. 7.

81 Consumer Health Forum of Australia (CHF), *Submission: ACCC Report to the Senate on Private Health Insurance*, March 2017, p. 5.

82 ibid.

83 Rural Doctors Association of Australia, *Private Health Insurance: Submission to the Australian Competition and Consumer Commission*, March 2017, p. 3.

84 hirmaa, p. 6.

85 ibid., p. 7.

The ACCC notes that the PHMAC Clinical Definitions Working Group met in the first half of 2017 to focus on possible reforms to standardise the clinical definitions used by insurers in the information they provide about their products. Members considered the clinical definitions currently listed in the SIS and worked to develop a new list of definitions. Members identified the need for consumer testing of any changes and agreed that this is an important step in the reform process.[86]

4.3 Industry changes to information practices

Revisions to Private Health Insurance Code of Conduct

Nearly all health insurers are signatories to the Private Health Insurance Code of Conduct (the PHI Code), which was established in 2001 as a voluntary and self-regulated industry code.[87] It is important to note that the PHI Code does not have the same force as legislation such as the ACL.

The PHI Code is overseen by the Code Compliance Committee (CCC), which comprises representatives from PHA, hirmaa and two independent members.

Previous ACCC finding

The ACCC has previously noted that the PHI Code provides limited guidance or is silent on certain matters concerning changes to private health insurance which impact 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).[88]

In 2015, the CCC conducted a biennial review of the PHI Code which resulted in some changes. The new version was published in August 2016.[89] The CCC notes that the changes are related to:

- requirements for welcome letters to consumers to contain more details regarding consumers' entitlements, benefits and product inclusions/exclusions
- tailored communication on product changes
- provision of clearer product information and links to product disclosure statements (PDS)
- clarification of preferred provider relationships and consumer options outside of these (i.e. the consumer is free to select their provider of choice)
- clarifying requirements on transfer certificates from one fund to another, and
- amended dispute resolution provisions.[90]

These changes have been reflected in some of the recent initiatives reported by insurers to the ACCC, which are outlined below. It is too early to assess the impact of the changes to the PHI Code on industry practices and outcomes for consumers.

86 See 'Summary of the second meeting of the Private Health Ministerial Advisory Committee—Clinical Definitions Working Group, 19 April 2017' at: http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac-clinical-meeting-2 (accessed June 2017).

87 A list of participating health insurers is available at: http://www.privatehealthcareaustralia.org.au/codeofconduct/participatingfunds/ (accessed June 2017). These insurers represent over 99 per cent of people who are covered by private health insurance in Australia.

88 ACCC, *Communicating changes to private health insurance benefits*, October 2016, p. 15.

89 See PHI Code: http://www.privatehealthcareaustralia.org.au/wp-content/uploads/Code-of-Conduct-2016.pdf (accessed June 2017).

90 Private Health Insurance Code of Conduct Code Compliance Committee (CCC), *Re: ACCC Report to the Senate on Private Health Insurance*, March 2017, p. 4.

These changes do not directly address the ACCC's previously held concerns regarding the PHI Code's limited guidance on the circumstances in which insurers should communicate changes to benefits to consumers. The ACCC has observed that poor industry practices appear to be driven, in part, by a narrow view of compliance with notification requirements under the PHI Code, without due consideration to general obligations arising under the CCA and ACL.[91]

Insurer initiatives to improve information practices

A small number of insurers have provided information for the purposes of this report regarding their recent efforts to improve the manner in which they communicate information to consumers. These insurers (Bupa, CBHS Health Fund, HBF, HCF and NIB) have a combined coverage of approximately 55 per cent of Australian private health insurance members.

Simplified and consistent language

Previous ACCC finding

The ACCC's 2015 research revealed that many consumers found the information provided to them by insurers was overwhelming (40 per cent) and would have preferred the information to have been easier to understand (46 per cent).[92]

As noted above, the complexity associated with industry terminology remains a concern for a number of stakeholders. Responding to these concerns, NIB reports that it has revised its written and online communications to try to explain industry terminology in layman's terms and without jargon.[93] Bupa also reports that it has introduced a *Customer Friendly Language* program with the aim of improving overall simplicity, clarity and consistency of language in customer-facing content.[94]

Making website content more user-friendly and informative

Previous ACCC finding

The ACCC has previously observed that insurers commonly do not provide clear information on their websites about the extent of coverage, such as whether treatment at a particular hospital or by a particular specialist will be covered, or provide clear information about the gap that the consumer can expect to pay.[95]

Insurers' websites are an increasingly important channel for communicating information to consumers. Some insurers report that they have made recent investments to improve the usability and information on their websites. These include:

- HBF introducing a new section on its website which aims to explain health insurance in a simplified way[96]
- HCF launching a specific webpage which they report provides consumers with a cost indicator tool to understand what an average out-of-pocket cost might be for a particular procedure depending on the provider they choose[97]

91 ACCC, *Communicating changes to private health insurance*, October 2016, p. 2.

92 ACCC, *Information and informed decision-making*, October 2015, p. 15.

93 NIB, *Re: ACCC Report to the Senate in relation to Private Health Insurance*, March 2017, p. 1.

94 Bupa, *Untitled submission*, March 2017, p. 1.

95 ACCC, *Information and informed decision-making*, October 2015, p. 16.

96 See: https://www.hbf.com.au/health-insurance/explained/private-health-insurance-explained?intcmp=hi:explained_overview (accessed June 2017).

97 HCF, p. 2. See: https://www.hcf.com.au/preparing-for-hospital (accessed June 2017).

- Bupa indicating it is undertaking a review of web content and information architecture to make web content easier for customers to understand[98], and
- Medibank and HCF providing data regarding HCSPs who participate in their 'no gap' and 'known gap' schemes to online directories, such as Healthshare and Whitecoat.[99] Insurers report that these directories allow consumers to better understand the likely costs they will incur for medical procedures with particular practioners (see further discussion in section 5).[100]

Clearer explanations of what is included and excluded in a policy

Previous ACCC finding

The ACCC's 2015 research revealed that consumers frequently misunderstand the extent of their private health insurance cover and the nature of exclusions.[101] Where insurers provide information that is overwhelming, incomplete or complex, it is less likely that consumers will be able to exercise informed choices to purchase cover that is appropriate to their needs and circumstances. In turn, these consumers are more likely to face unknown or hidden costs of private services that are not covered in full by their insurance.[102]

NIB reports that it has introduced a personalised policy statement for each policyholder with its premium notification correspondence to provide greater transparency and to remind them what they are actually covered for.[103] In addition, NIB has introduced a losses and gains statement for any customer who switches hospital health cover policies.[104]

In relation to the information provided to prospective customers, CBHS reports that its sales process is now based on a needs analysis to identify a prospective member's health needs and life stage, which should assist to avoid 'post sale surprises' for members.[105] NIB reports that it is rolling out a new online quoting function that allows prospective customers to undertake a more in-depth comparison of products. During the final confirmation step in the quote process NIB reports that it now reiterates in detail the inclusions and exclusions of a customer's selected product.[106]

Once customers have been acquired, HBF reports that it is developing an 'on boarding' process that will allow for the provision of 'bite size' pieces of information to members over a longer period of time. HBF views that this will allow it to reinforce key messages to its members, for example, how to submit claims or find registered providers.[107]

98 Bupa, p, 1.

99 See: Healthshare website at: https://www.healthshare.com.au/ (accessed June 2017); Whitecoat website at: https://www.whitecoat.com.au/ (accessed June 2017).

100 HCF, p. 4. See also: Sean Parnell, 'Medibank software deal to keep experts honest on big gap fees', *The Australian,* 17 February 2017.

101 ACCC, *Information and informed decision-making*, October 2015, p. 12.

102 ibid., p. 17.

103 NIB, p. 3.

104 ibid., p. 2.

105 CBHS Health Fund, *Submission to the ACCC Report to the Senate on Private Health Insurance*, March 2017, p. 2

106 NIB. p. 1.

107 HBF, p. 1.

Communicating changes to benefits

Previous ACCC finding

The ACCC has previously identified various poor industry practices relating to change notification that likely contribute to consumer harm, including:

- approaches to product disclosure that result in low awareness among consumers that their 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
- poor practices by some industry participants in communicating benefit changes to consumers, and
- the failure, in some cases, to provide effective informed financial consent (IFC).[108]

The ACCC received one submission from an insurer outlining enhancements to their benefit review and change notification processes. CBHS reports that it has strictly tested and followed a benefit review process to ensure:

- any communication is separate to marketing campaigns to avoid the message being lost or deleted
- it occurs annually and at the same time each year
- it is deliberately separate to and distinct from the annual pricing review to ensure the benefit review message is not overshadowed
- it is fully compliant with the *Private Health Insurance Act 2007* (Cth) (PHI Act) and the PHI Code, and
- members receive communication via email or letter. In addition, the benefits communication is referenced in the annual pricing adjustment message, and is also highlighted in CBHS' monthly magazine sent to members.[109]

4.4 Conclusions

The ACCC notes that some stakeholders have drawn attention to the continuing challenges for consumers associated with how insurers provide information to them, particularly in relation to the terminology used within the industry.

Positively, there are some recent examples of initiatives which insurers report they have implemented, or are in the process of implementing, to assist consumers to better understand the information they receive about their private health insurance. The ACCC recognises these efforts and encourages insurers to monitor and measure the effectiveness of these initiatives to ensure that the intended consumer benefits are realised. However, as the ACCC received only five submissions from insurers (who only cover around half of private health insurance consumers) outlining these types of initiatives, it is difficult to assess whether the industry more broadly is actively responding to the concerns expressed by the ACCC in previous reports.

The different perspectives of stakeholders on the adequacy of current information practices suggest that this issue will require continued attention from insurers. As stated in previous reports, the ACCC considers it to be in the interests of both consumers and health insurers for insurers to be clear and transparent about their policy offerings so that consumers can make informed decisions about the level of insurance cover they want and respond effectively when

108 ACCC, *Communicating changes to private health insurance benefits*, October 2016, p. 37.

109 CBHS Health Fund, p. 2.

changes to their benefits are made.[110] Insurers need to ensure they satisfy their obligations under the CCA and ACL in relation to the information they provide to consumers, in addition to compliance with specific private health insurance laws and regulations.

The ACCC notes that the PHMAC Information Provision for Consumers Working Group met on a number of occasions in early 2017 to consider potential reforms to how insurers provide information to consumers.[111] The PHMAC Clinical Definitions Working Group also met to consider the terminology used by insurers in the information they provide to consumers about their products, which continues to be raised as an area of concern by some stakeholders. The ACCC will continue to monitor the outcomes of the PHMAC process, which may lead to further improvements in these areas.

110 ACCC, *Communicating changes to private health insurance benefits*, October 2016, p. 3.

111 See further details and meeting summaries for each PHMAC Working Group at: http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac (accessed June 2017).

5. Other matters raised in submissions

The ACCC received submissions on a range of matters relating to competition and consumer issues in private health insurance. The key issues and themes are discussed below, including references to the views expressed by the ACCC in previous reports where they remain relevant.

5.1 Contracting between health insurers and hospitals

Some stakeholders have provided submissions to the ACCC outlining concerns relating to the manner in which health insurers contract with private hospitals.

Day Hospitals Australia (DHA) submits that in 2015–16 there was a continuation of the trend by the major health insurers not to contract with new private day hospitals and smaller private hospitals.[112] The Australian Medical Association (AMA) submits that this ability to selectively contract means that insurers will not provide coverage for facilities if these facilities do not meet the insurer's business needs.[113]

DHA notes that uncontracted private hospitals have to rely on the Second-Tier Default Benefit[114] in order to provide services to privately insured consumers. DHA observes that this may result in the consumer being charged an out-of-pocket expense in the form of a gap payment, which allows the hospital to cover the cost of the patient's treatment or procedure.[115]

The AMA considers it is important that the Second-Tier Default Benefits and basic default benefits regulation continue to operate to protect providers who do not have enough market power to negotiate on equal terms with the private health insurers.[116]

In contrast, hirmaa submits that private health insurers should not be forced to, in effect, contract with every single private hospital as a passive payer, and that the Second-Tier Default Benefit legislation in its current form urgently requires review.[117] hirmaa considers that only regional and rural hospitals, where there is limited competition and choice, should have access to the minimum default benefits safety net such as Second-Tier Default Benefits.[118]

112 Day Hospitals Australia (DHA), *ACCC report to the Senate on private health insurance*, March 2017, p. 4.

113 Australian Medical Association (AMA), *AMA submission—ACCC report to the Senate on private health insurance*, March 2017, p. 8

114 Second-tier default benefits, which are regulated under the *Private Health Insurance (Benefit Requirement) Rules*, enable certain hospitals that do not have a Hospital Purchaser Provider Agreement (HPPA) with a particular insurer to receive a default benefit of no less than 85 per cent of the average scheduled benefit payable by that insurer to comparable hospitals. The second–tier default benefit rates are state-based and also vary according to seven different categories of facility based on size, services and complexity. The Second Tier Advisory Committee (STAC) meets every three months to consider applications for eligibility. The STAC comprises three nominees of private hospitals and three nominees of health insurers. For further details see: http://www.apha.org.au/wp-content/uploads/2015/08/Second-Tier-Default-Benefits-QA-1.pdf (accessed June 2017).

115 DHA, p. 4.

116 AMA, p. 8.

117 hirmaa, p. 13

118 ibid.

Previous ACCC finding

The ACCC has previously noted that if a health insurer has sound commercial reasons for the selection of contracted providers, and no proscribed anti-competitive purpose, the behaviour is not likely to be caught by the CCA.[119]

Further, the ACCC has previously noted that it sees the Second-Tier Default Benefits regime as predominantly a government policy initiative set outside the boundaries of the CCA.[120]

The ACCC notes that a PHMAC Contracting and Default Benefits Working Group, constituted by a cross-section of industry stakeholders, met a number of times in the first quarter of 2017 to consider these arrangements and provided advice to the PHMAC on potential reforms.[121] The working group reviewed data that revealed that the vast majority of hospital separations—the process by which an episode of care for an admitted patient ceases—are paid under contracts.[122]

5.2 Preferred provider arrangements

As noted earlier, some health insurers have entered into preferred provider arrangements with HCSPs to minimise gap payments for their members. The Australian Dental Association (ADA) and some individual dentists have expressed concerns regarding health insurers' administration of these arrangements and the associated competitive impacts.[123]

Previous ACCC finding

The ACCC has noted that preferred provider arrangements can deliver benefits to health fund members, most commonly in the form of a greater rebate, when they choose to have treatment at one of their health insurer's preferred providers. Members remain able to seek treatment elsewhere but may receive a lower rebate.[124]

While the ACCC has recognised the benefits that consumers can receive from preferred provider arrangements, it has also noted that the existence of these arrangements further complicates the range of matters a consumer must consider when purchasing and using private health insurance.[125]

The ADA submits that health insurers are leveraging contracted provider arrangements and discriminatory rebate practices to steer consumers to their contracted providers. The ADA suggests this largely occurs through insurers' call centre staff, who may, for example, make assertions that a non-contracted dentist is 'too expensive'.[126]

The ADA considers that there is a further risk that insurers who own clinics will withdraw support from other contracted providers as they continue to steer consumers to their own clinics.[127]

119 ACCC, *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance—For the period 1 July 2010 to 30 June 2011*, June 2012, p. 27.

120 ibid., p. 28.

121 Meeting summaries for the PHMAC Contracting and Default Benefits Working Group are available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac (accessed June 2017).

122 PHMAC Contracting and Default Benefits Working Group meeting summary, 2 February 2017: http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac-working-group-meeting-1 (accessed June 2017).

123 ADA, pp. 1–2.

124 ACCC, *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance—For the period 1 July 2010 to 30 June 2011*, June 2012, pp. 31–2.

125 ACCC, *Information and informed decision-making*, October 2015, p. 21.

126 ADA, pp. 1–2.

127 ibid., p. 7.

In addition, the ADA submits that during the 2015–16 reporting period, one insurer wrote to dentists/dental practice owners/principals in its preferred provider network noting that their contracted provider status would be removed if they did not ensure all non-contracted dentists at that practice were also contracted.[128] The ADA submits that this conduct constitutes third line forcing under the CCA.[129]

The ACCC recognises the concerns raised by industry associations about the potential impact of preferred provider arrangements and has previously considered similar issues.[130] The ACCC's current assessment is that these matters are unlikely to raise competition issues under the CCA. However, the ACCC will continue to monitor and assess these issues on a case by case basis as they arise.

ACCC finding

The ACCC notes the concerns expressed by some stakeholders regarding the manner in which health insurers explain and promote their preferred provider arrangements. In particular, the ACCC notes the allegation that call centre staff employed by an insurer have told members that non-contracting dentists are 'too expensive'. While such conduct does not necessarily breach provisions of the CCA or ACL, it does not represent best practice and in some circumstances may be misleading.

The ACCC encourages all businesses, including insurers, to follow a best practice approach with a compliance program in place that includes training call centre staff about their obligations under the ACL, particularly regarding the prohibition against misleading or deceptive conduct and false or misleading representations, and monitoring of calls.[131]

5.3 The Prostheses List framework

Both Medibank and hirmaa consider there are significant problems associated with the operation of the Prostheses List framework[132], leading to unnecessary costs being incurred by health insurers, which are subsequently passed on to consumers.

Medibank submits that the current framework has had the unintended consequence of setting an artificially inflated price for surgically implantable devices for private patients.[133] Similarly, hirmaa considers costs associated with prostheses are underpinned by poor government regulation and oversight, and the result is that prostheses prices in Australian private hospital settings are amongst the highest in the world.[134]

Medibank has assessed that the current governance mechanisms for prostheses have led to benefit levels that are often two to five times higher than prices in comparable systems, both domestically and abroad.[135] hirmaa estimates that the effect of the Prostheses List is such that

128 op. cit.

129 ibid.

130 ACCC, *Report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to private health insurance—For the period 1 July 2010 to 30 June 2011*, June 2012, p. 33.

131 ACCC, *Comparator websites: A guide for comparator website operators and suppliers*, August 2015, p. 7.

132 The Prostheses List is a list of surgically implanted prostheses, human tissue items and other medical devices that private health insurers must pay benefits for when they are provided to a patient with appropriate health insurance cover as part of hospital treatment or hospital substitute treatment, and there is a Medicare benefit payable for the professional service.

133 Medibank, *ACCC Report to the Senate on Private Health Insurance*, March 2017, p. 1.

134 hirmaa, p. 12.

135 Medibank, *Price regulation associated with the Prostheses List Framework—Medibank submission to Senate Community Affairs References Committee*, January 2017, p. 3.

the difference between projected benefits that will be paid for prostheses for privately insured patients in 2016–17, and what would be the case if public sector rates were utilised, is nearly $883 million.[136]

The ACCC notes that industry concerns regarding the operation of the Prostheses List led to a 2016 review of the framework and subsequent action by the Australian Government. The Senate Community Affairs References Committee also conducted an inquiry on the price regulation associated with the Prostheses List, which reported in May 2017. A chronology of these policy developments is outlined in section 6.

ACCC finding

The ACCC encourages a robust competitive framework that allows businesses to set competitive prices for prostheses products covered by the framework.

In September 2016 the Australian Government reconstituted an expanded Prostheses List Advisory Committee (PLAC) which has begun implementing a reform work plan to improve affordability and access to medical devices for consumers.[137] The ACCC notes that most categories of prostheses and their benefits have not undergone major review since they were established in 2005–06. The PLAC reports that it will address this by conducting targeted category (device grouping) and benefit (pricing) reviews following consultation with stakeholders on its proposed review process in May and June 2017.[138]

The ACCC welcomes this development, and recommends that competition law principles be considered as part of these reviews to ensure that the industry is operating efficiently and effectively.

5.4 Administration of online directories

A number of stakeholders have expressed reservations regarding the administration of online directories that disclose HCSPs' details, particularly in relation to their charging practices.

The AMA submits that one of the common terms and conditions set by insurers for HCSPs participating in 'gap' schemes is that the practitioner agrees to certain information about them being published, including gap agreement usage and participation rate, and average gap charges.[139] The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) has confirmed this practice and submitted that under these arrangements, HCSPs must agree to terms, conditions and business rules without the opportunity to 'opt-out' of publishing such information.[140] RANZCOG considers these requirements have been mandated by insurers without the opportunity to negotiate contract terms and may raise potential issues under the CCA.[141]

The AMA has also raised concerns regarding Medibank's announcement that it will be providing information to referrals database Healthshare that will allow general practioners to identify which specialists participate in its 'no gap' or 'known gap' schemes. The AMA is concerned that these

136 hirmaa, p. 12.

137 See: http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2016-ley057.htm (accessed June 2017).

138 See: http://www.health.gov.au/internet/main/publishing.nsf/content/health-privatehealth-plac (accessed June 2017).

139 AMA, p. 5.

140 The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG), *Re: RANZCOG feedback for contribution to ACCC Senate Report*, March 2017, p. 1.

141 ibid.

developments could have a detrimental impact upon the referrals received by practioners who are not part of these schemes, as patients are increasingly weighing up gap charges into their decision on which specialist to choose.[142]

Medibank has noted that this initiative is responding to consumers' 'very high desire to use the schemes so they have certainty over their out-of-pocket costs.'[143] HCF submits that it also maintains a partnership with Healthshare to enable a discussion at the point of referral between the patient and GP around not just clinical information but also charge information.[144]

The ADA has expressed concerns regarding the incentives for insurers to favour certain providers on websites they own/administer. The ADA suggests that the website Whitecoat is inadequately transparent about declaring its conflicts of interest; being partly owned by NIB, Bupa and HBF. The ADA believes that such ownership puts the website in a position to be more favourable towards practitioners or practices contracted and owned by these respective insurers.[145]

ACCC finding

The ACCC has previously noted that some consumers find it difficult to understand the extent of their cover, the costs they are likely to incur if they use a health service and determine who to seek information from (insurer or health provider).[146] The Healthshare database, along with other similar online databases and services, has the potential to empower consumers to better deal with some of these challenges in their broader consideration of medical options.

Stakeholders have not presented any specific examples of conduct by insurers in relation to online directories that they consider to be misleading or deceptive to consumers. Therefore, the ACCC's general guidance to website operators applies, which is to be open and transparent about commercial relationships and not allow these relationships to affect the presentation of results to consumers.[147]

5.5 Intermediaries' role in the consumer switching process

As noted in section 4, consumers are increasingly using commercial comparison websites and other broker services to assist in making purchasing decisions about private health insurance. These service providers can play an important role in assisting consumers to navigate the switching process between health insurers. The PHIO has observed that a significant proportion of the membership complaints it receives typically arise in relation to the processing of cancellations and provision of clearance certificates by health insurers.[148] The addition of third party intermediaries to the process has the potential to add further complexity to the process, particularly if the interactions between parties are not managed well.

The PHIO recorded an increase in complaints about verbal advice and incorrect information provided by health insurance brokers from 34 in 2014–15 to 75 in 2015–16.[149] The below case study is reflective of the type of administration issues the PHIO can be asked to assist with when an intermediary is involved in the switching process between health insurers.

142 AMA, p. 6.

143 Sean Parnell, 'Medibank software deal to keep experts honest on big gap fees', *The Australian,* 17 February 2017.

144 HCF, p. 4.

145 ADA, p. 9.

146 ACCC, *Information and informed decision-making*, October 2015, p. 2.

147 ACCC, *Comparator websites: A guide for comparator website operators and suppliers*, August 2015, p. 3.

148 Commonwealth Ombudsman, *Annual Report 2015–16*, p. 58.

149 ibid., p. 63.

PHIO case study: Administrative error when switching insurers

The consumer held health insurance with Insurer ABC. He used a broker service to switch to Insurer XYZ. The broker told him that his old policy would be cancelled automatically once his new policy began. The consumer agreed and commenced a new policy with Insurer XYZ.

Thirteen months later, the consumer realised his policy with Insurer ABC had never been cancelled. He had been double-paying premiums for the entire period and Insurer ABC had never sent his clearance certificate to Insurer XYZ.

On investigation, it was found that the broker had failed to record details for the consumer's Insurer ABC policy when they were making the sale. As a result, Insurer XYZ was never informed about the previous policy and therefore did not contact Insurer ABC to cancel the old policy and obtain the clearance certificate.

The broker had advertised that as part of its service, it would contact and cancel a previous policy if authority had been granted. Records reflected that the consumer had authorised the request to cancel the previous policy, and so the PHIO asked the broker to provide a response to remedy the error it had made.

The broker and Insurer ABC discussed the issue and arranged to correct the error and refund the consumer for 13 months of premiums.

The PHIIA, who represent independent intermediaries, agents and brokers selling health insurance, submits that its members face challenges with some health insurers who fail to promptly act on a request to end debits and provide membership history to a new fund. Further, PHIIA suggests that health insurers can use these delays as a 'prompt to offer' inducements and encouragement for members to remain, exhausting that process before following through on members' clear instructions.[150] The PHIIA notes that the anecdotal evidence it receives from its members is that consumers often blame the new fund for the delays, which can lead to cancellations or cooling offs.[151]

ACCC finding

The ACCC notes that it is in consumers' interests to be able to select and switch health insurance providers in a timely and efficient fashion. In most cases, this is what already occurs. Health insurers and intermediaries should continue to ensure they are transparent with consumers and each other about the actions they are taking and likely timelines for switching, which should assist to minimise consumer confusion or frustration.

5.6 Rebates and coverage for specific medical services

Some HCSPs have suggested that the main cause of out-of-pocket expenses is inadequate insurer rebates or coverage for the services they provide.

The Australian Society of Anaesthetists (ASA) submits Medicare and PHI rebates have not kept pace with the rising costs of medical practice, with a number of insurers freezing rebates, while others have provided small indexations that remain well below inflation.[152]

Similarly, the ADA submits that the industry has failed to ensure policy holders' rebates for dental services are increased to reflect the annual premium increases paid by consumers.[153]

150 PHIIA, p. 3.

151 ibid., p.5.

152 Australian Society of Anaesthetists (ASA), *Reference: ACCC report to the Senate on Private Health Insurance*, March 2017, p. 4)

153 ADA, pp. 2–3

Complementary Medicines Australia (CMA) considers that the use of bundling in the insurance sector appears to be a technique to hide the true value of a product. CMA notes that not all natural therapies are treated the same within the sector and that an 'extras' package may have various sub-limits, cap growth and rebate amounts between the natural therapies offered.[154]

The Royal Australian and New Zealand College of Psychiatrists (RANZCP) submits that there is currently a lack of transparency about which psychiatric services are covered by private health insurance, which is detrimental to health outcomes.[155] Further, the Private Mental Health Consumer Carer Network considers there is intent from the larger insurers to remove psychiatric cover from their products.[156]

ACCC finding

The ACCC notes that the rebate levels and annual limits set by insurers for specific medical services are commercial decisions. However, the ACCC encourages insurers to provide clear information to consumers regarding these policy settings to promote informed decision making. This may help to avoid some cases of 'bill shock' when consumers need to use medical services.

154 Complementary Medicines Australia (CMA), *ACCC Report to the Senate on Private Health Insurance—CMA submission*, March 2017, p. 2.

155 Royal Australian and New Zealand College of Psychiatrists (RANZCP), *Re: ACCC Report to the Senate on Private Health Insurance 2015–16*, March 2017, p. 1.

156 Private Mental Health Consumer Carer Network, *Increasingly discriminatory practices by health insurance funds to psychiatry cover*, March 2017, p. 1.

6. Policy developments relating to private health insurance

6.1 Private Health Ministerial Advisory Committee

In September 2016, the Australian Government announced the establishment of the PHMAC to examine all aspects of private health insurance and provide it 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.[157]

The PHMAC has met regularly since September 2016 to progress its work plan.[158] In addition, the following three working groups were established to provide specialist advice to the PHMAC:

- Contracting and Default Benefits Working Group
- Information Provision for Consumers Working Group, and
- Clinical Definitions Working Group.[159]

The PHMAC will continue to meet in the second half of 2017 to refine its advice to the Australian Government.[160] The ACCC will closely monitor developments relating to this policy process and consider the competition and consumer aspects of any reforms in future reports.

6.2 Prostheses List framework

An Industry Working Group on Private Health Insurance Prostheses Reform reported to the Minister for Health in April 2016.[161] The report provided a range of recommendations to improve the Prostheses List framework. In response, the Government announced:

- a reduction in the cost of medical devices as set by the Prostheses List by 10 per cent for cardiac devices and intraocular lenses and 7.5 per cent for hip and knee replacements from 20 February 2017
- that it would be revamping the PLAC—the PLAC subsequently released a reform work plan to address the recommendations of the industry working group, and
- investigation of a move towards applying a more robust and transparent price disclosure model of ongoing, sustainable reductions to the cost of medical devices through the new PLAC.[162]

157 See 'Private Health Ministerial Advisory Committee', 8 September 2016. Available at: http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac (accessed June 2017).

158 See PHMAC work plan: http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac-committee-workplan (accessed June 2017).

159 Meeting summaries are provided at: http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac (accessed June 2017).

160 See PHMAC Work Plan at: http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac-committee-workplan (accessed July 2017).

161 See: http://www.health.gov.au/internet/main/publishing.nsf/content/iwg-phi-pros-ref (accessed June 2017).

162 See: http://www.health.gov.au/internet/main/publishing.nsf/Content/health-privatehealth-PLAC (accessed June 2017).

In May 2017, the PLAC set out in its draft *Approach for Targeted Prostheses Reviews* a process for conducting targeted category (device grouping) and benefit (pricing) reviews.[163] The PLAC will utilise this approach to conduct reviews of the hip, knee, cardiac and spinal categories.[164]

The price regulation associated with the Prostheses List framework was also the subject of an inquiry by the Senate Community Affairs References Committee, which reported in May 2017.[165] The committee made 16 recommendations intended to enhance:

- the administration of the PLAC
- data collection
- transparency in benefits setting process, and
- transparency in pricing.[166]

The ACCC notes that the Australian Government continues to stress the importance of reforming the Prostheses List framework to put downward pressure on private health insurance premiums.[167]

6.3 Senate Committee inquiry into value and affordability of private health insurance and out-of-pocket medical costs

On 1 June 2017, the Senate Community Affairs References Committee commenced an inquiry into the value and affordability of private health insurance and out-of-pocket medical costs.[168] The Committee is due to report in November 2017 and will hold public hearings and accept written submissions. The ACCC will monitor this inquiry as relevant to competition and consumer matters.

163 op. cit.

164 Minister for Health and Sport, the Hon. Greg Hunt MP, *Prostheses reforms to deliver better value for private health insurance* (Media release), 4 May 2017 available at: http://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediarel-yr2017-hunt043.htm?OpenDocument&yr=2017&mth=05 (accessed June 2017).

165 Senate Community Affairs References Committee, *Price regulation associated with the Prostheses List Framework*, May 2017 available at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/ProsthesesListFramework/Report (accessed June 2017).

166 ibid., pp. 59–63.

167 op. cit., Minister for Health and Sport, the Hon. Greg Hunt MP, *Prostheses reforms to deliver better value for private health insurance* (Media release), 4 May 2017.

168 The terms of reference for the inquiry are available at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Privatehealthinsurance (accessed July 2017).

Appendix A: Consultations

In February 2017, the ACCC sent a letter to a wide range of industry stakeholders inviting submissions to inform the report. The invitation letter is provided below. An open invitation was also available on our website.

We received a total of 29 public submissions and one confidential submission to the report. A list of public submissions is provided below and each submission is 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.

List of publicly available submissions

Australasian College of Podiatric Surgeons

Australian Dental Association

Australian Medical Association

Australian Orthopaedic Association

Australian Society of Anaesthetists

Bupa

Catholic Health Australia

CBHS Health Fund

CHOICE

Chris Walker

Commonwealth Ombudsman (Private Health Insurance Ombudsman)

Complementary Medicines Australia

Consumer Health Forum of Australia

Day Hospitals Australia

Dr Serge Diklitch

HBF

HCF

hirmaa

Matthew Cohen

Medibank

NIB

PHI CoC Code Compliance Committee

Private Health Insurance Intermediaries Association

Private Healthcare Australia

Private Mental Health Consumer Carer Network

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Royal Australian and New Zealand College of Psychiatrists

Rural Doctors Association of Australia

Australian Competition & Consumer Commission

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Melbourne Vic 3000

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www.accc.gov.au

16 February 2017

Dear Stakeholder

Re: ACCC Report to the Senate on Private Health Insurance

The Australian Competition and Consumer Commission (ACCC) is commencing the preparation of our 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 2015 to 30 June 2016.

Key consumer and competition developments and trends

This year, the ACCC will produce a focussed report that provides an update to the Senate on key consumer and competition developments and trends for 2015–16.

The ACCC's two previous reports have contained a range of observations relating to the adequacy of information provided by health insurers to consumers. The ACCC intends to report on the changes health insurers have made to their information provision practices since the publication of these reports.

The ACCC will utilise publicly available data and information where possible in preparing the report, but is also interested in examining complementary sources of data and information that stakeholders consider will assist the ACCC's understanding of the key consumer and competition developments that occurred during 2015–16. The ACCC would also welcome any additional information relating to developments that have occurred since 2015–16 that stakeholders consider pertinent.

Submissions

The ACCC welcomes stakeholders' input into this report, but is also conscious that industry has been asked to contribute to a number of consultation processes over the last 18 months. The ACCC does not wish to unnecessarily add to this burden. The ACCC is able to access a wide range of industry data and information, so would encourage stakeholders to consider whether making a submission will provide additional insight to what is already publicly available.

The ACCC is also mindful that the Private Health Ministerial Advisory Committee, established by the Australian Government in September 2016, is currently considering all aspects of private health insurance and will provide advice to Government on potential reforms this year. This is a separate policy process, which has a broader focus than the ACCC's report. Further information is available at http://www.health.gov.au/internet/main/publishing.nsf/Content/phmac.

If your organisation would like to provide a submission, we invite your organisation to provide the following types of data and information:

- case studies that can illuminate market issues and trends
- details of any changes health insurers have made to information provision practices
- findings of consumer surveys or testing (which might assist to understand customer behaviour, preferences and concerns relating to their private healthcare), and
- consumer complaints/enquiries data (preferably year-on-year data that can demonstrate relevant changes/trends).

Lodgement

Submissions should be provided by **COB Friday 17 March 2017**. The ACCC's preference is to receive electronic copies of submissions, either in PDF or Microsoft Word format, at phireport@accc.gov.au.

Alternatively, submissions can be sent by mail to:

Simon Haslock
ACCC
GPO Box 520
MELBOURNE VIC 3001

Confidentiality claims

To foster an informed and consultative process for this year's report, all submissions will be considered public and will be posted on the ACCC website at https://consultation.accc.gov.au/. Interested parties wishing to submit commercialin-confidence material to the ACCC should submit both a public and a commercial-in-confidence version of their submission. The public version of the submission should clearly identify the commercial-in-confidence material by replacing the confidential material with an appropriate symbol or 'c-i-c'.

The fewer confidentiality restrictions placed on submissions, the more easily we can use information provided to inform our report. We therefore ask that information you claim confidentiality over be genuinely of a confidential nature and not otherwise publicly available. We request that you provide reasons in support of your claim, to assist us to better understand your claim and assess the information you provide. We also remind you that the accuracy of submissions (including public) is the responsibility of submitting organisations.

For further information on the ACCC's treatment of confidential information, please refer to the ACCC/AER Information Policy.

Any queries relating to the submissions process can be directed to phireport@accc.gov.au.

Yours sincerely

David Salisbury
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