ACCC

AUSTRALIAN COMPETITION
& CONSUMER COMMISSION

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 2016 to 30 June 2017

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Contents

Shortened terms

ACCC	Australian Competition and Consumer Commission
ACL	Australian Consumer Law
APRA	Australian Prudential Regulation Authority
CCA	*Competition and Consumer Act 2010* (Cth)
CPI	Consumer Price Index
HCF	Hospitals Contribution Fund of Australia Limited
Medibank	Medibank Private Limited
NIB	NIB Health Funds Limited
PHI Act	*Private Health Insurance Act 2007* (Cth)
PHIO	Private Health Insurance Ombudsman
SIS	Standard Information Statement

Executive summary

This is the 19th 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. This report is for the period 1 July 2016 to 30 June 2017 (the reporting period).

This report analyses key competition and consumer developments and trends in the private health insurance industry during the reporting period that have affected consumers' health cover and out-of-pocket expenses.

A major focus in recent reports has been on whether health insurers and other participants' practices may be affecting the ability of consumers to make informed decisions when purchasing and comparing private health insurance, or accessing particular products or services under their existing policies.

Consumers remain concerned about the affordability of private health insurance

The affordability of private health insurance continues to be an area of significant consumer concern. A consumer survey conducted in 2016–17 found that the affordability of private health insurance is the second biggest cost of living concern for Australian households, after electricity prices.

Premium increases have been greater than inflation and wage growth in recent years. In response to higher prices, consumers are switching to more affordable policies with greater exclusions and restrictions. In response to higher prices, some consumers appear to be exiting the private health insurance market. There was a small reduction in the proportion of Australians holding private health insurance during 2016–17.

Consumer complaints continue to rise

In 2016–17, complaints about private health insurance to the Private Health Insurance Ombudsman (PHIO) increased by 30 per cent, continuing a trend of increasing complaints which have risen for the fourth consecutive year.

The PHIO reported that 88 per cent of complaints in 2016–17 were about health insurers. The benefits paid by insurers to consumers continued to receive the highest level of complaints—over 30 per cent of total complaints—the main issue of concern being hospital policies with unexpected exclusions and restrictions.

The ACCC continues to pursue enforcement activity in the health sector

Private health insurers and other health industry participants have been the subject of a number of recent ACCC enforcement matters. These include ACCC actions and investigations in relation to NIB, Australian Unity, and Ramsay Health Care Australia. The ACCC has also granted authorisation to health insurer HCF and participating dentists to agree on a maximum price for some dental services, and is awaiting the outcome of an appeal against Medibank.

Further information about recent ACCC action, including matters subject to court proceedings, are detailed in section 3.

Policy developments relating to private health insurance

The observations in this report are made in the context of ongoing government consideration of a series of reforms to the sector, with the aim of making private health insurance simpler and more affordable. Many of the consumer issues identified by the ACCC, including in previous private health insurance reports, are under active consideration.

The ACCC welcomes the reforms announced by the Australian Government in October 2017 to the private health insurance industry and recommends that competition and consumer law principles be considered as part of the implementation of these reforms.

The ACCC has previously identified that there are continuing challenges in how information is provided to consumers of private health insurance. The ACCC has found that the existing standard information statement—a broad summary of key policy features all health insurers are required to provide to consumers—does not provide sufficient information for consumers to understand the key benefits and limitations of their policies.

The Australian Government has announced that the standard information statement will be replaced with a new minimum data set. The ACCC recognises this significant reform and considers it to be important that the new minimum data set is effective in informing consumers about their private health insurance policies and of changes to the benefits available under those policies. The ACCC considers that the new minimum data set should:

- provide consumers with more reliable and transparent information in relation to the extent of each policy's coverage
- provide consumers with sufficient information to make informed choices when comparing and selecting policies
- enable consumers to understand the extent of their financial exposure to additional health costs
- include clear and prominent disclosures with respect to applicable out-of-pocket costs in hospital for all items listed.

The ACCC also considers that private health insurers are capable of providing consumers with significantly more detail on their gap arrangements. The new minimum data set should include a clear description of the gap arrangements for each insurer. The proper disclosure of an insurer's gap arrangements is fundamental to providing consumers with an informed choice when selecting a policy, as gap arrangements may be a key differentiating factor when comparing hospital insurance policies.

The ACCC will closely monitor developments relating to these and other policy processes and consider the competition and consumer aspects of any reforms.

1. Introduction

This report analyses key competition and consumer developments and trends in the private health insurance industry between 1 July 2016 and 30 June 2017 (the reporting period), while acknowledging significant developments that have occurred since the end of the reporting period.

1.1 Senate order

This report has been prepared in compliance with an Australian Senate order, under which the ACCC has an obligation to report annually on competition and consumer issues in the private health insurance industry.[1] 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 Australian Consumer Law (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 protection.

All relationships within the private health insurance industry are governed by the statutory protections offered to consumers by the CCA, including the ACL.[2] These include relationships between consumers and health insurers, hospitals, medical facilities, health providers and practitioners. Competition laws also govern relationships between industry players and, among other things, restrict anti-competitive arrangements and exclusionary conduct.

The ACCC's role in the private health insurance industry includes satisfying the terms of the Senate order and enforcing and encouraging compliance with the CCA and ACL. The ACCC's Compliance and Enforcement Policy outlines our enforcement powers, functions and priorities.[3] This policy is updated yearly to reflect current and enduring priorities.

1 Senate procedural order no. 17 Health—Assessment reports by the Australian Competition and Consumer Commission agreed to 25 March 1999, by means of an amendment to the motion that the report of the committee on Health Legislation Amendment Bill (No. 2) 1999 be adopted. J.626, amended 18 September 2002 J.761.

2 In addition, private health insurers operating in Australia are regulated by the Australian Prudential Regulation Authority under a legislative framework set out on their website.

3 See ACCC Compliance & Enforcement Policy (accessed June 2018).

1.3 Methodology in preparing this report

In recent private health insurance reports, the ACCC has made a range of observations relating to the adequacy of information provided by health insurers to consumers, including the way in which changes to the benefits available under policies are communicated to customers.

In October 2017, the Government announced a series of reforms with the aim of making private health insurance simpler and more affordable. Certain reforms are aimed at addressing issues such as the complexity of private health insurance products and difficulties in comparing different policies. These issues have been the subject of previous ACCC reports. The implementation of these reforms is ongoing.

In preparing this year's private health insurance report, the ACCC has not conducted a consultation process inviting written submissions from industry stakeholders as has occurred in previous years.

The ACCC has drawn on information and data from a range of sources, including desktop research and complaints data. Key industry data used and relied upon by the ACCC includes:

- industry statistics and data collected by the Australian Prudential Regulation Authority (APRA)
- private health insurance complaints data from the Private Health Insurance Ombudsman (PHIO).[4]

4 The PHIO is a specialist role of the Commonwealth Ombudsman.

2. Key industry developments and trends

This section sets out key competition and consumer developments and trends in the private health insurance industry that occurred in 2016–17, as summarised below.

Summary of key industry developments and trends in 2016–17

- The affordability of private health insurance continues to be an area of significant consumer concern.
- Australian consumers paid private health insurance premiums of around $23.1 billion in 2016–17, an increase of $1 billion from 2015–16. Premium increases have been greater than inflation and wage growth in recent years.
- In June 2017, 54.9 per cent of the Australian population held hospital or general health insurance cover. This was a decrease of 0.6 percentage points from June 2016, when 55.5 per cent of the population had some form of private health insurance. Hospital policies cover the cost of in-hospital treatment. General treatment policies, also known as 'extras' cover, provide benefits for services such as physiotherapy, dental and optical treatment.
- The amount of hospital benefits paid by health insurers per person increased by 5.2 per cent, along with a 3.4 per cent increase in general or extras benefits per person.
- Average out-of-pocket expenses incurred by consumers from hospital episodes decreased by 0.8 per cent, but increased by 2 per cent for general or extras treatments.
- Consumers are shifting towards lower-cost policies with greater exclusions and restrictions. In June 2017, 40 per cent of hospital policies held had exclusions, compared with 38 per cent in June 2016. There was also an increase in hospital policies with an excess or co-payment from 82 per cent to 83 per cent over the same period.
- Complaints to the PHIO increased by 30 per cent, continuing a trend of increasing complaints, which have risen for the fourth consecutive year. The benefits paid by insurers to consumers continued to receive the highest level of complaints—over 30 per cent of total complaints – the main issue of concern being hospital policies with unexpected exclusions and restrictions.

2.1 Private health insurance membership

There are two broad 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.

Table 1 shows that as at 30 June 2017, 13.51 million Australian consumers, or 54.9 per cent of the population at the time, had some form of private health insurance. This represents a small reduction in coverage from June 2016, when 55.5 per cent of the population had some form of private health insurance.

Table 1 also shows a reduction in the proportion of the population holding hospital only or combined cover, from 46.8 per cent in June 2016 to 46.0 per cent in June 2017. In contrast, the proportion of the population holding general treatment only policies increased from 8.7 per cent to 8.9 per cent during the same period.

Table 1: Insured Australian consumers by policy type, June 2016 and June 2017

	June 2016	% of population	June 2017	% of population
Hospital only or combined cover	11 328 577	**46.8%**	11 318 742	**46.0%**
General only	2 101 444	**8.7%**	2 194 435	**8.9%**
Total insured persons	13 430 021	**55.5%**	13 513 177	**54.9%**

Source: APRA, Private Health Insurance Statistical Trends, Membership Trends – March 2018.

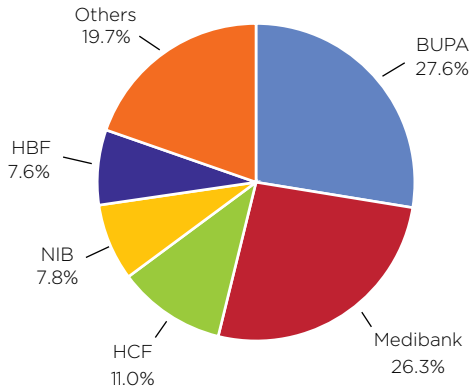
Membership by health insurer

In 2016–17, there were a total of 37 health funds operating in Australia, including both not-for-profit insurers and for-profit insurers. Bupa remained Australia's largest insurer ahead of Medibank, ending the 2016–17 financial year with just over 3.73 million members (as measured by individuals covered), compared to Medibank's 3.55 million members.[5]

As at June 2017, the top five health insurers in Australia provided cover to over 80 per cent of Australian consumers holding some form of private health insurance. As shown in figure 1, Medibank and Bupa represent over half of the Australian private health insurance market, with market shares of over 26 per cent each. The next three largest insurers—HCF, NIB and HBF—have a combined market share slightly larger than that of Medibank.

However, despite their combined market share of over 80 per cent, the top five health insurers contributed to only 78.7 per cent of total health fund benefits paid in 2016–17,[6] with Bupa and Medibank contributing 27.4 per cent and 25.7 per cent respectively.[7] Benefits paid by health funds are discussed further in section 2.3.

Figure 1: Insurer market share by number of Australian consumers covered, 2016–17



Source: APRA, Operations of Private Health Insurers Annual Report 2016–17, released 8 November 2017.

5 APRA, Operations of Private Health Insurers Annual Report 2016–17—Table 3, 8 November 2017.

6 The amount paid by an insurer to a policy holder to cover health care costs.

7 APRA, Operations of Private Health Insurers Annual Report 2016–17—Table 3, 8 November 2017.

2.2 Private health insurance expenditure by consumers

The affordability of medical services and private health insurance has been an area of significant consumer concern in recent years. The CHOICE consumer pulse survey conducted in 2016–17 found that health and medical costs, including the cost of private health insurance, were the second biggest cost of living concern for Australian households, after electricity prices.[8]

In 2016–17, Australian consumers paid about $23.1 billion in private health insurance premiums, an increase of $1 billion or 4.6 per cent from 2015–16.[9] Figure 2 shows private health insurance premium increases (on an industry weighted average basis) as well as the inflation rate and growth in wages, between 2013 and 2017. During this period, private health insurance premiums increased by an average of 5.6 per cent per year. This was significantly greater than the average annual growth in the wage price index (2.3 per cent) and the consumer price index (1.9 per cent) between 2013 and 2017.

Figure 2: Private health insurance premium increases, inflation and wage growth, 2013 to 2017

Source: Department of Health, Average premium increases by insurer by year, available at http://www.health.gov.au/internet/main/publishing.nsf/Content/privatehealth-average-premium-round; Australian Bureau of Statistics, 6401.0—Consumer Price Index, Australia, Mar 2018, Tables 1 and 2. CPI: All Groups, Index Numbers and Percentage Changes; Australian Bureau of Statistics, 6345.0—Wage Price Index, Australia, Mar 2018, Table 1. Total Hourly Rates of Pay Excluding Bonuses: Sector, Original, Seasonally Adjusted and Trend.

Consumer responses to private health insurance premium increases

Average consumer expenditure on private health insurance premiums tends to grow at a slower rate than the industry weighted average premium increases shown in figure 2. This is likely due to consumers switching to more affordable policies in response to higher prices. This conclusion appears to be consistent with the trend observed in table 2, which shows that the increases in private health insurance premiums have coincided with an increase in

8 CHOICE, Consumer Pulse: Australians' Attitude to Cost of Living 2014–2017, August 2017, p. 5.

9 APRA, Private Health Insurance Quarterly Statistics, June 2017 (released August 2017), p. 11.

the proportion of hospital insurance policies with exclusions,[10] excess payments,[11] or co-payments.[12]

In addition to switching to more affordable policies, some consumers appear to be exiting the private health insurance market. As shown in table 1 (above), between June 2016 and June 2017 there was a decrease of 9835 in the number of consumers with hospital policies. Data from APRA indicates that the 25–29 age group experienced the largest drop in hospital policy membership (5.4 per cent fewer policy holders), while the 70–74 age group had the largest increase in hospital cover (8.6 per cent).[13]

Table 2: Hospital policies with exclusions or excess, June 2013 to June 2017

	June 2013	June 2014	June 2015	June 2016	June 2017
% with exclusionary policies	27%	29%	36%	38%	40%
% with excess & co-payments	78%	79%	81%	82%	83%

Source: APRA, Operations of Private Health Insurers Annual Report data 2016–17 (Tables and Figures), Policies by type, released 8 November 2017.

2.3 Benefits paid to consumers and out-of-pocket costs

This section presents data on the overall amount of benefits paid out to consumers by health insurers in 2016–17, 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 for the same medical service can vary,[14] which is a significant determinant of the final costs incurred by consumers. Some insurers use contracting arrangements with health care service providers to provide certainty around these charges.

Benefits paid by health insurers to consumers

During 2016–17, the amount of hospital benefits paid by health insurers per consumer increased by 5.2 per cent, along with a 3.4 per cent increase in general benefits per consumer. This was broadly consistent with increases in the total dollar value of benefits paid by insurers to consumers, as outlined in table 3.

10 Conditions or services not covered under a health insurance policy, a private health insurer will not pay benefits towards hospital or medical costs for these items.

11 An amount of money that a policy holder agrees to pay towards the cost of hospital treatment, this is paid before private hospital insurance benefits are payable.

12 For a hospital policy a co-payment is a set amount a policy holder agrees to pay for each day they are in hospital, most have a limit on the number of days they apply per stay.

13 APRA, Private Health Insurance Membership and Coverage, May 2018.

14 Health care service providers include hospitals, specialists, and providers of 'extras' services, such as dental, optical and physiotherapy and chiropractic care.

Table 3: Key metrics relating to the benefits paid by health insurers to consumers, June 2016 to June 2017[15]

	June 2016	June 2017	Change
Benefits—hospital treatment ($ millions)	$13 874	$14 592	**+5.2%**
Benefits—general treatment ($ millions)	$4 730	$4 923	**+4.1%**
Hospital benefits per consumer ($)	$1 225	$1 289	**+5.2%**
General benefits per consumer ($)	$387	$400	**+3.4%**

Source: APRA, Private Health Insurance Quarterly Statistics, June 2017 (released 15 August 2017).

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 health care service providers, in part, to minimise the out-of-pocket expenses incurred by members. Insurers negotiate set fees and other terms with those providers in exchange for the right to participate in their 'preferred provider' networks or 'no gap' and 'known gap' schemes. In the case of a 'no gap' arrangement, the participating health care service provider agrees to charge a certain amount for services and the health insurer will fully cover the cost of the relevant medical procedure performed by the participating provider. In the case of a 'known gap' arrangement, the participating provider can charge an amount beyond that which the health insurer will cover, but it is restricted to a capped maximum set by the health insurer.

In June 2017, the average out-of-pocket (gap) expense incurred by a consumer for hospital treatment was $299, which represents a decrease of 0.8 per cent compared to the average gap in June 2016 ($301). However, there was a 2 per cent increase in out-of-pocket expenses for general treatments over the same period (from $46.77 to $47.73).[16]

While most in-hospital services are delivered with no gap payments required from patients, this rate has been in decline in recent years, falling from nearly 90 per cent of services not requiring a gap payment in June 2013 to closer to 85 per cent of services at the end of 2016, as demonstrated in figure 3. However, the proportion of services requiring no gap increased to over 88 per cent in the June quarter 2017.

15 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.

16 APRA, Private Health Insurance Quarterly Statistics, June 2017 (released 15 August 2017), p. 10.

Figure 3: Proportion of in-hospital services with no gap, June 2013 to June 2017

Source: APRA, Private Health Insurance Medical Gap, March 2018.

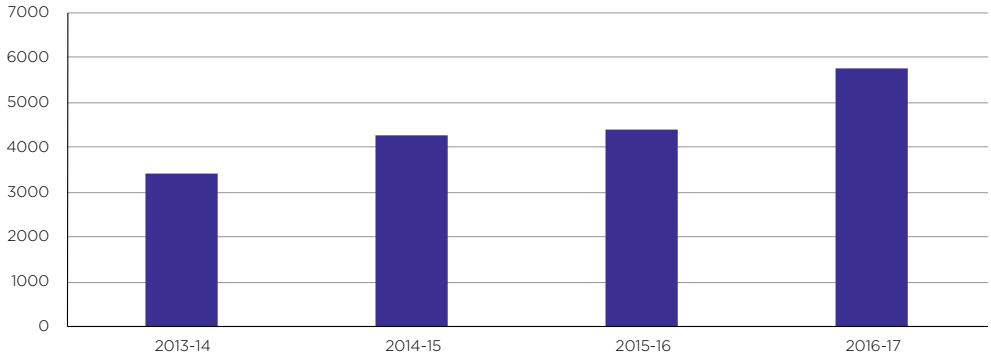
2.4 Consumer complaints about private health insurance

This section presents an analysis of consumer complaints to the PHIO and contacts to the 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 with.

Complaints received by the PHIO

The main complaints agency for consumers about their private health insurance is the PHIO. During 2016–17, the PHIO received a total of 5750 complaints relating to private health insurance, representing an increase of 30.2 per cent from 2015–16. This increase in complaints followed increases of 3.5 per cent in 2015–16 and 24.5 per cent in 2014–15, as demonstrated in figure 4.

Figure 4: Total complaints received by the PHIO, 2013–14 to 2016–2017



Source: Commonwealth Ombudsman's Annual Report 2016–17 (PHIO section, p. 81)

The PHIO reported that 88 per cent of complaints in 2016–17 were about health insurers. However, complaints were also made about providers including hospitals, health care service providers, health insurance brokers and other practitioners.[17]

After several years where private health insurance complaint levels remained steady, there has been a substantial increase in complaints over the past four years. The PHIO considers there is no single cause for the increase in complaints made by health insurance consumers at this time, and noted there was an increase in complaints across a wide range of issues.

Anticipated reduction in future complaints

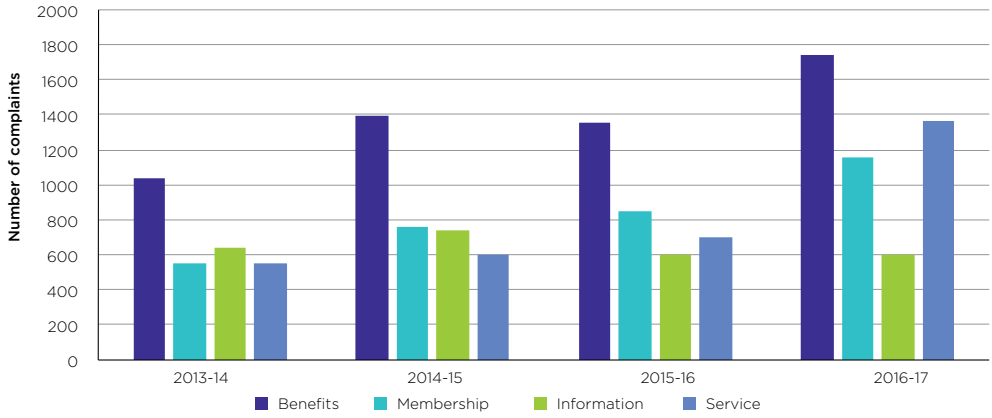
The PHIO notes that between 1 July and 31 December 2017, there was a 28 per cent reduction in the number of complaints received by the PHIO, compared to the same period in 2016–17.[18] The PHIO attributes this reduction in complaints to a range of factors, including that the PHIO identified health insurers who were the subject of the increase in complaints in 2016–17 and assisted them with strategies to reduce complaints, and also the efforts by health insurers to better address consumer complaints.

PHIO complaints by issue

The top four categories for complaints to the PHIO – benefits, membership, information and service – have remained the same for the past four years, as shown in figure 5. The key issues within these complaint categories are as follows:

- Benefits: hospital exclusions and restrictions
- Membership: cancellation, clearance certificates
- Information: verbal advice, lack of notification
- Service: service delays, premium payment problems, general service issues.

Figure 5: PHIO complaint issues, 2013–14 to 2016–17



Source: Commonwealth Ombudsman's Annual Report 2016–17 (PHIO section, pp. 87–89), PHIO Annual Report 2013–14.

17 Commonwealth Ombudsman's Annual Report 2016–17 (PHIO section, p. 90).

18 Commonwealth Ombudsman, Private Health Insurance Ombudsman State of the Health Funds Report 2017, March 2018, p. 9.

As shown in figure 5, the benefits paid by insurers to consumers continued to receive the highest level of complaints (over 30 per cent of total complaints in 2016–17). With respect to complaints about benefits, the main issues of concern were hospital policies with unexpected exclusions and restrictions and delays in payment.

The PHIO stated that part of the increase in complaints may be attributed to consumers experiencing problems obtaining timely responses from health insurer complaint officers—particularly during peak months including March 2017, when there was an increase in complaints about delays in benefits and service issues.[19]

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 about private health insurance.

In 2016–17, the ACCC received 248 contacts (enquiries and complaints) from the public regarding insurers or in relation to private health insurance issues. This represented a 32 per cent increase from the previous year, when 169 contacts were received, and about the same number as 2014–15, when 253 contacts were received.

The majority of private health insurance contacts related to consumer protection issues, with 50 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 the health sector during 2016–17.

19 Commonwealth Ombudsman, *ibid.*

3. Health sector enforcement and other action

Consumer issues in private health insurance were a priority area during the reporting period, as outlined in the ACCC's 2017 Compliance and Enforcement policy. Private health insurers and other health industry participants have been the subject of a number of recent ACCC enforcement matters relating to the health sector. This section outlines recent ACCC action, including matters subject to court proceedings.[20]

3.1 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.[21]

Ramsay is Australia's largest private hospital operator with about 70 hospitals and day surgeries nationwide. At the relevant time, Ramsay operated Baringa Private Hospital and the Coffs Harbour Day Surgery, the only private hospital and private day surgery facilities in the Coffs Harbour region. The Coffs Harbour Day Surgery closed in mid-2017, and Baringa Hospital remains the only private hospital in the region. Coffs Harbour surgeons used 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. The matter is set down for hearing in the Federal Court in Sydney for three weeks commencing 25 February 2019.

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.[22]

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.

20 Some of the enforcement and other actions detailed in this section have occurred since the end of the reporting period.

21 ACCC media release, 'ACCC takes action against Ramsay Health Care for alleged anti-competitive conduct', 1 May 2017.

22 ACCC media release, 'ACCC takes action against NIB', 30 May 2017.

3.3 ACCC appeal against Medibank

On 20 September 2017, the ACCC lodged a Notice of Appeal from the Federal Court's decision on 30 August 2017 dismissing the ACCC's proceedings against Medibank.[23]

The ACCC had alleged that Medibank engaged in misleading or deceptive conduct, made false or misleading representations to consumers, and engaged in unconscionable conduct, in relation to its failure to notify Medibank members and members of its subsidiary brand, ahm, of its decision to limit benefits paid to members for in-hospital pathology and radiology services, despite representing across a number of its communications and marketing materials that it would.

The appeal was heard by the Full Federal Court in May 2018 and the matter is awaiting judgment.

3.4 Australian Unity compensates members over dental benefits

On 3 November 2017, following an ACCC investigation, Australian Unity agreed to pay compensation to members who held couples and family policies in 2015 that were likely to have been misled about the dental benefits they could claim from their policy.[24]

Australian Unity provided a court-enforceable undertaking to the ACCC, under which it has agreed, amongst other things, to improve the information it provides to consumers and to provide compensation to affected members, including reimbursement for out-of-pocket costs for dental services. The compensation is expected to be at least $620 000.

3.5 HCF authorised to set capped prices for dental services

On 11 May 2018, the ACCC granted authorisation to health insurer HCF and dentists who voluntarily participate in HCF's "More for Teeth" program, to allow them to agree on a maximum price for some dental services provided to HCF members.[25]

HCF intends to open its own dental clinics in locations where it already runs its "More for Teeth" program. Under the program, participating dentists cap fees for HCF members for a limited number of basic preventative and diagnostic dental services, enabling HCF to offer "no gap" arrangements at participating dentists. The authorisation allows HCF to agree with participating dentists to set the same fees at its new clinics as members are charged by dentists in the "More for Teeth" program.

The ACCC invited submissions from several interested parties on HCF's application for authorisation and considered the broader concerns raised by interested parties about the role of health insurers in the provision of dental services. The ACCC concluded that capping prices for the limited number of preventative and diagnostic dental procedures offered under the "More for Teeth" program was likely to result in a net public benefit. The ACCC considered that public benefits would take the form of lower costs and improved quality of preventative dental services for HCF members. The ACCC considered that these benefits would outweigh the likely minimal public detriment, including any detriment caused by any

23 ACCC media release, 'ACCC appeals Medibank decision', 21 September 2017.

24 ACCC media release, 'Australian Unity to compensate some members over dental benefits', 3 November 2017.

25 ACCC media release, 'HCF authorised to set capped prices for dental services', 11 May 2018.

lessening of competition between dentists or between health insurers, since HCF and its clinics would remain subject to competitive pressure from other health insurers and providers of dental services.

Authorisation was granted for five years rather than the ten-year period sought. HCF may seek reauthorisation in 2023. A five-year authorisation period provides an opportunity for the ACCC to assess any changes to the program as HCF proposes to vary the items covered from time to time. It will also allow the ACCC to consider whether the public benefits continue to outweigh any detriments in deciding whether to grant a further authorisation.

3.6 Consumer Health Regulators Group

Noting the potential for the ACCC's consumer law work to intersect with other health sector regulators, the ACCC is a member of the Consumer Health Regulators Group.[26] The Consumer Health Regulators Group 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.

26 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 PHIO, the Therapeutic Goods Administration and the NSW Health Consumer Complaints Commission (as the current chair of the state Health Consumer Complaints Commissions). The Department of Health participates in the Group as an observer.

4. Recent policy developments relating to private health insurance

This section addresses policy developments relating to private health insurance during and after the reporting period. As outlined below, significant policy developments have occurred since the end of the reporting period.

The observations in this report are made in the context of ongoing government consideration of a series of reforms to the sector. Many of the consumer issues previously raised by the ACCC, including in previous private health insurance reports, are under active consideration. The ACCC will closely monitor developments relating to these policy processes and consider the competition and consumer aspects of any reforms in future reports.

4.1 Private health insurance reforms announced in October 2017

In October 2017, the Australian Government announced a series of reforms with the aim of making private health insurance simpler and more affordable.[27] These proposed reforms include:

- replacing the existing Standard Information Statement (SIS) with a new technology neutral minimum data set
- upgrading the privatehealth.gov.au website to make it easier to compare insurance products
- requiring insurers to categorise products as gold/silver/bronze/basic, and use standardised clinical definitions for treatments across their documentation and platforms to make clear what is and is not covered in their policies.

The ACCC welcomes the Australian Government's reforms to the private health insurance industry. The ACCC recommends that competition and consumer law principles be considered as part of the implementation of these reforms.

Better information provision

A key interest of the ACCC is the ability of consumers to understand and compare policies. The ACCC has previously identified continuing challenges in how information is provided to consumers.[28] The ACCC has also expressed concern about how some private health insurers notify consumers of changes to the benefits available under their private health insurance policies.[29]

Further, the ACCC has previously concluded that the private health insurance industry can be complex for consumers to navigate. Policies are complex, with varying exclusions, restrictions, waiting periods, excesses and co-payments expressed using technical, medical

27 Department of Health, 'Private health insurance reforms: Summary' and 'Information Provision', 16 October 2017.

28 ACCC, 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, pp. 21–22.

29 ACCC, *ibid*, pp. 25–26.

and legal language.[30] The limits on coverage and the language used often vary across policies or insurers, and differ by treatment and hospital.

Replacing the SIS

Private health insurers are required under the PHI Act to provide consumers with a summary of key product features for their policy. This is known as a Standard Information Statement, which forms part of the change notification requirements under the PHI Act. The ACCC has found that the existing SIS does not provide sufficient information for consumers to understand the key benefits and limitations of their policies.[31]

In replacing the SIS, the ACCC considers it to be important that the new minimum data set is effective in informing consumers about their private health insurance policies and of changes to the benefits available under those policies. The ACCC considers that the new minimum data set should:

- provide consumers with more reliable and transparent information in relation to the extent of each policy's coverage
- provide consumers with sufficient information to make informed choices when comparing and selecting policies and enable consumers to understand the extent of their financial exposure to additional health costs
- include clear and prominent disclosures with respect to applicable out-of-pocket costs in hospital for all items listed.

The ACCC also considers that private health insurers are capable of providing consumers with significantly more detail on their gap arrangements. The new minimum data set should include a clear description of the gap arrangements for each insurer. The proper disclosure of an insurer's gap arrangements is fundamental to providing consumers with informed choice when selecting a policy, as gap arrangements may be a key differentiating factor when comparing hospital insurance policies.

Upgrading and promoting *privatehealth.gov.au*

The ACCC supports the additional funding announced for the PHIO to enable it to widely promote its website and comparison service to consumers. The ACCC also considers it to be important that the PHIO website is upgraded to make it easier for consumers to compare insurance products and for the upgraded website to be widely promoted.

The ACCC considers that an investment in improved functionality of the privatehealth.gov.au website to help to enable consumers to compare factors beyond price would be beneficial. Active promotion of the website is necessary to improve consumer awareness of this independent service for comparing and selecting private health insurance policies.

30 ACCC, *ibid,* pp. 21–22.

31 ACCC, *ibid*, pp. 20–21 and 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.

4.2 Senate Committee inquiry into private health insurance

On 19 December 2017 the Senate Committee inquiry into the value and affordability of private health insurance and out-of-pocket medical costs published its final report.[32] The Senate Committee made a number of recommendations, including in relation to:

- adequate written notifications of changes to the benefits available under policies
- funding the Private Health Insurance Ombudsman to enable it to widely promote its upgraded website and comparison service to consumers
- preferred provider arrangements
- intermediaries disclosing commissions received from private health insurers
- reporting on whether the benefits from the Prostheses List reforms are being passed on to consumers.

During this inquiry, the ACCC appeared at a Senate Committee hearing to provide evidence on a range of issues, including preferred provider arrangements and adequate written notifications of changes to the benefits available under policies.[33] The ACCC notes that several of the Government's announced reforms may address some of the concerns raised by the Senate Committee. The ACCC understands the Government is considering the recommendations contained in the Senate Committee's report and the Government's response will be tabled in the Senate and made publicly available.

The ACCC supports the Senate Committee's recommendation that legislative amendments occur to require private health insurers to provide adequate written notice of changes to the benefits available under their policies. The ACCC considers that inadequate notification of detrimental changes to benefits available under policies can have a significant impact on consumers. Any legislative amendment should require insurers to provide advance notice for any changes that affect consumers' hospital, medical and ancillary benefits, including material changes to contractual arrangements with service providers.

4.3 Ministerial advisory committees

In January 2018, the Ministerial Advisory Committee on Out-of-Pocket Costs (MACOPC) was established to provide advice to the Minister on possible reforms covering:[34]

- best practice models for the transparency of in-hospital medical out-of-pocket costs, and associated medical services in the community
- regulatory barriers to consumer transparency of out-of-pocket medical costs
- the implementation of best practice models
- other related issues as directed by the Minister.

The MACOPC has met twice since January 2018 to progress its functions. The MACOPC has stated that increased transparency of out-of-pocket medical costs is a priority issue. The committee has discussed ways to address the lack of transparency around out-of-pocket

32 Senate Community Affairs References Committee, Parliament of Australia, Value and affordability of private health insurance and out-of-pocket medical costs, December 2017.

33 Australian Senate, Transcript of Community Affairs References Committee, Inquiry into the value and affordability of private health insurance and out-of-pocket medical costs, 31 October 2017.

34 Department of Health, 'Expert committee to consider out-of-pocket medical costs', 2 January 2018.

costs, including the type of information that consumers require to easily understand the financial implications of their health care choices.[35]

The MACOPC has agreed that consumers should be educated about their rights, the billing practices of health care providers, and to correct misapprehensions that higher medical fees do not necessarily have a relationship to higher quality care.[36] In addition, the MACOPC agreed that consumers should be educated about the referral process and about providing informed financial consent.[37]

The ACCC also understands that, under the Government's announced reforms, the Private Health Ministerial Advisory Committee will move from providing advice on the design of policy changes to assuming an implementation oversight role.[38] The Private Health Ministerial Advisory Committee was established in September 2016 to provide recommendations on private health insurance reform.[39]

35 Department of Health, 'Ministerial Advisory Committee on Out-of-Pocket Costs Communique', 12 February 2018; Ministerial Advisory Committee on Out-of-Pocket Costs Communique', 4 April 2018.

36 Department of Health, *ibid.*

37 Department of Health, 'Ministerial Advisory Committee on Out-of-Pocket Costs Communique', 4 April 2018.

38 Department of Health, Summary of the twelfth meeting of the Private Health Ministerial Advisory Committee, 13 February 2018, Department of Health offices (Scarborough House), Canberra.

39 Department of Health, 'New Committee to provide recommendations on private health insurance reform', 8 September 2016.

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