



Australian
Competition &
Consumer
Commission

ACCC Report

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



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For the period of 1 July 2013 to 30 June 2014

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Executive summary

This is the 16th 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 for the period 1 July 2013 to 30 June 2014.

The ACCC has approached this year's report by undertaking a detailed review of the industry, with a particular focus on information provision, including the transparency, accuracy and consistency of information about policies and the impact this has on consumer behaviour.

While the report addresses issues specific to the reporting period, it also gives broader consideration to the enduring impact of these issues on consumers. This approach aligns with the ACCC's 2015 *Compliance and Enforcement Policy*, which identifies competition and consumer issues in the health and medical sectors as a priority.

Almost one in two Australians hold a private health insurance policy for all or part of their hospital treatment costs.¹ It represents a significant financial investment for many consumers and their families. The ACCC has previously found that the industry is characterised by information asymmetry and complexity. These findings have been replicated in this report.

Competition, complexity and consumer engagement

In general, competition delivers efficient market outcomes where consumers engage with the market and reward suppliers who deliver goods and services that meet their needs. This drives lower prices, better quality products, greater innovation and increased efficiency. However, where there is market failure, competition may not deliver the most efficient outcomes.

It appears there are a number of market failures in the private health insurance industry. In particular, imperfect and asymmetric information impede consumers' ability to make choices that are likely in their best interests. These problems mean that consumers experience difficulty in determining the effectiveness of various policies given their uncertain future health needs, which makes it difficult for consumers to choose the appropriate level of cover. This in turn affects competition in the industry.

The complexity of the private health insurance system, and its impact on consumers, was a frequent theme of submissions to the ACCC from both consumer and industry bodies. A range of factors contribute to this complexity, including regulatory settings, the sheer number of policies available, the range of potential policy benefits and exclusions, preferred provider arrangements, policy variations and differing terminology between funds which makes comparison difficult.

When faced with such complexity consumer decision-making is affected and consumers are less inclined to review and change policies; that is, consumers become less engaged market participants. Reduced consumer engagement impacts competition, as the incentives for suppliers to offer better policies are reduced, and increases the likelihood of decreasing confidence in the perceived value of policies.

Stakeholders raised a number of concerns about industry practices that impact consumer decision-making, including:

- a lack of sufficient and comparable information before purchase
- information or terminology that is ambiguous or difficult to interpret
- inconsistent information
- difficulty locating relevant information
- consumer uncertainty about what questions to ask.

¹ PHIAC, *Operations of the Private Health Insurers Annual Report 2013-14*, p .30.

As a result, 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 determining who to seek information from (insurer or health provider), which can exacerbate the problem of information asymmetry.

This may be leading to disengaged consumers. The ACCC's research indicates that consumers are engaged at the commencement of the purchasing process. However, significant numbers of consumers who contemplate changing their insurance arrangements fail to do so. The reasons for this are varied, but the research suggests that one significant reason is the complexity faced by consumers when undertaking a meaningful comparison process.

Price is a critical factor in many consumers' decision-making, particularly as premiums are increasing with rising health care costs. The regulatory incentives alongside uncertainties about future health care needs, as well as policy complexities may drive consumers towards lower priced policies than they would otherwise prefer. While price is a legitimate means for consumer decision-making, there are concerns that some consumers are not fully considering the trade-offs between the costs and benefits of the various policies on offer. This is leading to some consumers facing detriment when they come to subsequently claim under the policy and find their procedure is not covered. This is of concern given recent reports that suggest that insurers are encouraging consumers more broadly to downgrade their cover to secure cheaper premiums. As a result, consumers are finding themselves more often without the cover they expected.²

The majority of consumers surveyed as part of the quantitative research commissioned by the ACCC indicated general satisfaction with their private health insurance. However, the research highlighted that most consumers do not frequently access their private health insurance and consumer satisfaction is often based on the overall cost of the policy. For some consumers this may mean that their understanding of the relevant inclusions and exclusions of their policy will only be tested when the time comes to make a claim. This is of particular concern given our research indicates that insurers can often change the coverage of their policies or make other changes that impact the benefits available and do not always communicate changes effectively to consumers.

The submissions identified a significant disconnect between consumers' expectations of the services and rebates they are entitled to receive under their policy, and the reality of the benefits their policy provides. Complaints to regulatory and complaint bodies about unexpected out-of-pocket expenses and 'bill shock' are also rising.³ The ACCC has also received submissions about certain conduct by insurers that may potentially breach the Australian Consumer Law (ACL). For example, some of the conduct may be at risk of misleading consumers. Such conduct has the ability to harm consumers and also competition.

Key observations

Our findings have led to three primary observations:

- First, there are market failures in the private health insurance industry due to asymmetric and imperfect information. This, and its effect on competition, leads to complexities in private health insurance policies, which reduce consumers' ability to compare policies and make informed choices about their future medical needs.
- Second, existing regulatory settings can change consumers' incentives in purchasing private health insurance and drive insurers to offer products to primarily reduce consumers' tax liabilities. As funds respond to market demand for affordable policies, there are increasing policy limitations and exclusions leading to an increased risk of unexpected out-of-pocket expenses and general dissatisfaction with the system.

2 The World Today, Jessica Kidd, ABC News, 'Buyer beware: Private Health Insurance complaints rise significantly', 26 June 2015, www.abc.net.au/worldtoday/content/2015/s4262363.htm.

3 The PHIO, *Quarterly Bulletin for the period 1 January-31 March 2015*, reported receiving 1088 complaints, a 10 per cent increase on the previous quarter of 981 complaints and 23 per cent on the same quarter in 2014, which recorded 883 complaints.

- Third, the research has revealed examples where representations by insurers to consumers, including when entwined with policy changes, may be at risk of breaching consumer laws.

The role of the ACCC

The ACCC is committed to increasing awareness among consumers about the protections offered by Australia's consumer laws. We consider it is in the interests of both consumers and insurers to be as clear and transparent as possible so that consumers purchasing insurance can make informed decisions about their level of cover. It is also important that insurers do not assume that compliance with specific private health laws and regulations alone will satisfy obligations that arise under the ACL.

Current trends in the private health insurance industry warrant a closer examination of the conduct of private health insurers and health providers/practitioners. It also warrants consideration of these issues by policy makers to ensure greater transparency and decreased information asymmetry. While the ACCC has an overarching consumer protection role that encompasses the private health insurance sector, we do not have policy responsibility for many of the issues raised in this report.

In line with the ACCC's current focus on the health and medical sector, we will be closely reviewing some practices in the health insurance industry. The ACCC will consider any issues identified in accordance with the ACCC's *Compliance and Enforcement Policy*.⁴

Some of the issues that we are currently considering include:

- bold headline claims that are heavily qualified in fine print, for example: 'no gap' or '100% cover', when significant qualifications apply
- misleading conduct through the use of industry terms or phrases that are inconsistent with plain language or consumers' understanding of commonly used words
- the provision of incomplete information that creates the representation that there is broader insurance cover than the consumer has
- use of complicated terms and conditions, exclusions and practices that inhibit a consumer's capacity to make appropriate comparisons and which risk misleading consumers or exposing them to unfair claims assessments.

The ACCC recognises that a number of efforts have been made by industry and government over recent years to address these issues. However, as this report makes clear, further work to enhance consumer engagement is needed. Suggestions for change are included at the conclusion of this report.

⁴ ACCC, *2015 ACCC Compliance and Enforcement Policy*, February 2015, www.accc.gov.au/publications/compliance-and-enforcement-policy.

1. Introduction

This year the ACCC examined the information provided by the private health insurance industry and the impact it has on consumers. Informed consumers facilitate competitive outcomes by purchasing products that offer the best value for their circumstances. This in turn drives lower prices, higher quality products, greater innovation and an overall increase in efficiency. When consumers are not provided with adequate or accessible information to guide their decisions, these potential benefits are unlikely to be realised.

In previous Senate reports the ACCC has noted the complex environment within which consumer decision-making occurs and has found that the private health insurance industry is characterised by information asymmetry and complexity. We remain concerned that the complexity of the private health insurance offer can affect consumers' ability to make informed decisions about the policy that best suits their health care needs. This report considers the underlying causes of the information asymmetry in the private health insurance industry, and the impact it has on consumers.

The ACCC examined the role of insurers, health providers/practitioners, intermediaries and government in providing information to consumers about private health insurance policies. We also conducted research and sought public submissions in order to better inform our understanding of consumers' experiences in comparing and choosing private health insurance policies and in accessing health care. Our findings are set out in sections 3-8 of this report.

1.1 Senate order

The ACCC has an obligation to provide an annual report on competition and consumer issues within the private health insurance industry under an Australian Senate order.⁵ 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 (**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.

⁵ 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.

All relationships within the private health insurance industry are governed by the statutory protections offered to consumers by the consumer laws. These include relationships between consumers and health insurers, hospitals, 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. The ACCC's *Compliance and Enforcement Policy* outlines our enforcement powers, functions and priorities. This is updated yearly to reflect current and enduring priorities. In 2015 competition and consumer issues in the health and medical sectors is a priority area. Consequently, we are seeking to increase awareness within the health sector generally about consumer rights under the CCA and the obligations on industry participants, with a view to:

- reducing barriers to entry, and improving competition
- protecting consumers from unlawful behaviour by medical and health providers
- empowering consumers and patients with knowledge of their consumer rights.

In considering the private health insurance industry, the ACCC's objective is to increase transparency and decrease information asymmetry, including by taking targeted enforcement action in accordance with our *Compliance and Enforcement Policy*, where potential breaches of the law are identified.

1.3 Methodology in preparing this report

While this report considers a wide range of issues, it has focused on the provision of information to consumers. Specifically, the report examines the transparency, accuracy and consistency of information, and how this contributes to information asymmetry between insurers, health providers/practitioners and consumers.

In preparing this report the ACCC sought submissions, consulted with a wide range of stakeholders and engaged Colmar Brunton to undertake quantitative and qualitative research of consumers' experiences. More detailed information regarding the submissions, consultation and research is provided at appendix A.

2. Operation of the private health insurance industry

2.1 Industry overview

The private health insurance industry is an important component of the Australian health care system. The number of people with private health insurance has been growing steadily, with year on year average increases of 2.5 per cent over the last 10 years.⁶ At the end of 2013-14, 47.2 per cent of the population was covered for hospital treatment and 55.2 per cent was covered by general treatment policies⁷, commonly referred to as ‘extras’ cover. Health insurers generate revenue from the sale of health insurance policies as well as through the investment of premium reserves. Currently there are over 20 000 private health insurance policies on offer to consumers in Australia.⁸ The table below provides a brief statistical snapshot of the industry forecast for 2014-15.

Table 1: Industry snapshot⁹

\$21.1 bn	5.4%	6.4%	\$1.5 bn	\$970.7 m	34
Estimated total annual revenue generated by the private health insurance industry	Estimated annual growth rate of the private health insurance between 2010-15	Estimated annual growth rate of the private health insurance between 2015-20	Estimated total annual profit generated by the private health insurance industry	Amount the private health insurance spends on wages each year	Total number of businesses providing private health insurance policies in Australia

Over the next five years, industry revenue and profit are forecast to grow at a compound annual rate of 6.4 per cent to reach \$28.8 billion.¹⁰

The industry is concentrated—while there are a large number of insurers overall¹¹, the top five insurers issued 81.8 per cent of policies nationally. The two biggest insurers, BUPA Australian Holdings (**Bupa**) and Medibank Private (**Medibank**), are estimated to account for 26.74 per cent and 29.11 per cent of the policies issued nationally.¹² The industry is also expected to consolidate further over the next five years.

The table below indicates the current major players within the industry and their respective shares, based on total numbers of policies nationally.

Table 2: Top five industry players¹³

Medibank	Bupa	HCF	NIB	HBF Health Limited
29.11%	26.74%	10.76%	7.74%	7.4%

6 PHIA, *Operations of the Private Health Insurers Annual Report 2013-14*, p. 28.

7 Ibid.

8 PHIO, *Annual Report 2013-14*, p. 43.

9 IBISWorld, (Chia, S), *Industry Report K6321: Health Insurance in Australia*, May 2015. Comparably, in the IBISWorld industry report of March 2014, the estimated annual revenue for 2013-14 was \$19.7 bn, the estimated annual growth rate between 2009-14 was 6.5 per cent, the estimated annual growth rate between 2014-19 was 4.2 per cent, the estimated total annual profit was \$1.3 bn, the wages spend was \$932.2 and the total number of insurers was 35.

10 Ibid.

11 There are currently 34 insurers.

12 PHIA, *Operations of the Private Health Insurers Annual Report 2013-14*, p. 28.

13 Ibid, pp. 8-9.

Competition within the industry is based on price, product design, marketing and service. Product design is vital in attracting members and insurers tend to tailor their policies to specific consumer segments to maximise membership numbers.

Barriers to entry are high. Capital requirements constitute one of the highest barriers, as industry regulations (the Private Health Insurance Rules) require participants to meet certain capital adequacy and solvency standards. As established players account for a large proportion of an industry that is becoming increasingly concentrated, this can also deter new players from entering the industry.¹⁴

There are two types of membership funds that operate within the industry. 'Open' membership funds provide policies to the general public and 'restricted' health funds are accessible only to employees of certain companies, occupations or members of particular organisations. Both fund types offer private health insurance to a range of consumer groups, including families, couples and singles. Families generate the most revenue, followed by singles (which have the highest policy numbers). Couples account for the third-largest proportion of premium revenue and policy numbers for insurers.

2.2 Private health cover options

Insurers sell policies using a variety of methods, including websites, over the phone, or face-to-face at shop fronts. Consumers may use any one, or a combination of these methods to seek information from insurers.

The different types of insurance policies that a consumer can choose from are outlined in the table below.

Table 3: Types of private health insurance

Type of health insurance	Description
Extras cover	Provides benefits to cover the costs of services not covered by Medicare (e.g. dental and optical). There is a large variation in the services covered and the benefits provided by different health insurers.
Hospital cover	Provides benefits to cover some or all of the costs associated with being treated as a private patient in public or private hospitals. Coverage levels vary depending on the policy, but generally provide some form of benefit to meet the cost of shared-ward accommodation in public hospitals, private hospital accommodation and medical costs incurred above the Medicare rebate.
Combined cover	Provides combined cover for both general and hospital treatment.
Excess and co-payments	These are options within the above types of insurance. They offer incentives for members to minimise claims as opposed to the no excess and no co-payment policies. Co-payments require members to contribute to the cost of each incremental service. Excess policies require an up-front excess to be paid when a hospital stay is claimed.

¹⁴ IBISWorld, (Chia, S), *Industry Report K6321: Health Insurance in Australia*, May 2015.

Once a consumer decides on a type of cover and insurer, they will formally enter into a contract, which involves paying a regular premium in return for insurance cover. Consumers purchasing cover for the first time or upgrading their policy may need to serve a waiting period before they can claim any benefits. During this period, consumers may not receive any benefits for particular treatments, or may receive a lower benefit than they would otherwise be entitled.

2.3 The regulatory framework of the private health insurance industry in Australia

The private health insurance industry in Australia is primarily governed by the *Private Health Insurance Act 2007* (Cth) (**Private Health Insurance Act**). This legislation is supported by a number of subordinate rules. Appendix B provides a brief overview of the relevant laws that apply to the industry.

The Private Health Insurance Act

Under the Private Health Insurance Act, insurers cannot price discriminate on the basis of age, sex, sexuality, health status or claims history. However, restricted funds can confine membership by reference to employment, profession, professional association or union.

The Private Health Insurance Act regulates premium charges and allows premium variances in relation to Lifetime Health Cover (**LHC**) loading, where a 2 per cent loading on the price of a premium is added for every year in which an adult over 30 does not have the relevant level of cover. The LHC loading is removed once a consumer has 10 years of appropriate cover.

The Private Health Insurance Act provides that the responsible Minister must approve premium price increases.

All health insurers are required by the Private Health Insurance Act to maintain and provide up-to-date standard information statements (**SIS**). These statements provide a broad summary of key policy features designed to allow consumers to review existing policies or compare policies.

Regulatory bodies

Note: The below information is accurate for the 2013-14 financial year.

There are a number of government agencies involved in the administration and regulation of private health insurance and each has a specific role and function within the industry.

The Commonwealth Department of Health (**DoH**) is responsible for administering the Private Health Insurance Act. The Private Health Insurance Act also provides for the Minister for Health to make Private Health Insurance Rules. The Private Health Insurance Administration Council (**PHIAC**) (functions now transferred to the Australian Prudential Regulation Authority and the DoH) was an independent statutory authority that reported to the Minister for Health. PHIAC aimed to protect the interests of consumers through prudential and administrative regulation of the private health insurance industry. It also had a role in advising the government on competition policy within the industry.

The Private Health Insurance Ombudsman (**PHIO**) (functions now transferred to the Commonwealth Ombudsman) also played a role in protecting the interests of consumers by managing consumer complaints relating to private health insurance. During the reporting period it identified underlying problems in the practices of insurers or health providers in relation to the administration of private health insurance, and provided advice to government and industry about issues affecting consumers within the industry. PHIO also managed the government comparator website PrivateHealth.gov.au.

Private Health Insurance Code of Conduct

The private health insurance industry also has a voluntary code that applies to health insurers. The Private Health Insurance Code of Conduct (**Private Health Insurance Code**) is a self-regulated voluntary code that aims to maintain and enhance the regulatory compliance and service standards of private health insurers across the industry, and promote information sharing between insurers, consumers and intermediaries. Currently, only three funds¹⁵ are not signatories to the Code.

The Code aims to cover four main areas of insurers' conduct by ensuring:

- consumers receive correct information on private health insurance from appropriately trained staff
- consumers are aware of internal and external dispute resolution procedures available in the event of a dispute with an insurer
- policy documents are provided in plain language
- communications are conducted in a way that ensures the appropriate information flows between consumers and insurers
- consumers' personal information is protected in accordance with privacy principles.

A Code Committee made up of representatives from Private Healthcare Australia, the Health Insurance Restricted Membership Association of Australia (**hirmaa**), and two independent members oversees the Code. This Committee is responsible for monitoring, investigating and reviewing insurers' compliance with the Code.

2.4 Why do consumers purchase private health insurance?

The likelihood that an individual will purchase private health insurance is affected by a number of factors, and has been found to increase with factors such as income, age, marital status (higher for married people), country of birth (higher for those born in Australia), employment status (higher for full-time employees), type of employment (higher for professionals), level of education and chronic health issues.¹⁶

Regulatory settings also encourage consumers to obtain private health insurance. These include:

- the private health insurance rebate—tax payers earning less than specified thresholds get rebates on their premiums
- LHC loading—people that have not taken out private health insurance by the time they are 31 years old pay a 2 per cent per year loading on their premium (which increases with the age at which they first take out cover)
- Medicare levy—people earning above a certain income threshold that do not have private hospital cover pay an additional levy as part of their tax
- insurers may only increase premiums with approval from the Commonwealth Minister for Health.¹⁷

In Australia, private health cover is also taken up by consumers for reasons including:

- to take advantage of specific features, particularly extras such as dental, optometry and physiotherapy
- in anticipation of specific surgery or procedures (such as childbirth) or if consumers wish to avoid long public hospital wait times

¹⁵ As at the date of writing of this report the following three funds were not signatories: CDH Benefits Fund, health.com.au and Mildura District Hospital Fund representing a market share of less than 0.6 per cent.

¹⁶ Randall P. Ellis and Elizabeth Savage, 'Run for Cover Now or Later? The Impact of Premiums, Threats and Deadlines on Private Health Insurance in Australia', *International Journal of Health Care Finance and Economics*, Vol. 8, No. 4 (Dec., 2008), p. 260.

¹⁷ Section 66-10 Private Health Insurance Act.

- to have more control over their health care, choice of services they use, choice of health providers/practitioners and timing of appointments
- perceived better quality of care and security or 'peace of mind'
- for those that are risk averse, to insure against any future eventualities.

Consumers are likely to have different requirements for coverage over their lifetime. For example, the findings of the quantitative survey undertaken by Colmar Brunton highlighted that more older consumers take out hospital and extras cover (73 per cent), while hospital cover only is popular with younger consumers (39 per cent of those aged 18-29).

The rationale for government intervention

Economics can help us understand the rationale behind some of the policies that have been implemented in the private health insurance industry.

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

Private health insurance is subject to two well-known market failures related to information asymmetry that affect all insurance markets: moral hazard and adverse selection.

Moral hazard in the private health insurance context refers to a consumer changing behaviour to the detriment of an insurer after a private health insurance policy has been entered into. To manage this effect, insurers seek to manage their exposure to claims through, for example, exclusions in policies.

In the private health insurance context, adverse selection means that a consumer has more information than the insurer about their health and likelihood of making a claim. Therefore, in the absence of other incentives, those consumers who most need private health insurance will purchase it while consumers who perceive a low risk won't buy insurance.

In Australia, the regulatory system provides financial incentives for consumers to purchase private health insurance to overcome the effects of adverse selection and ensure a sufficient pool of insurance funds and support for broader health policy.

The responses to both moral hazard and adverse selection mean there is an underlying complexity to private health insurance. This complexity is further exacerbated by imperfect information and the tendency of consumers to disproportionately favour immediate benefits above those available in the future.

Further, suppliers that service markets that have a few large suppliers may have an incentive to engender information that is complex and confusing because, faced with this, consumers will tend not to change suppliers.

All these factors in the private health insurance industry can result in consumers being less engaged, which can lessen competition among insurers.

In these circumstances, a case for regulation can be made with the objective of better informed consumers and better functioning markets.

2.5 Complaint bodies

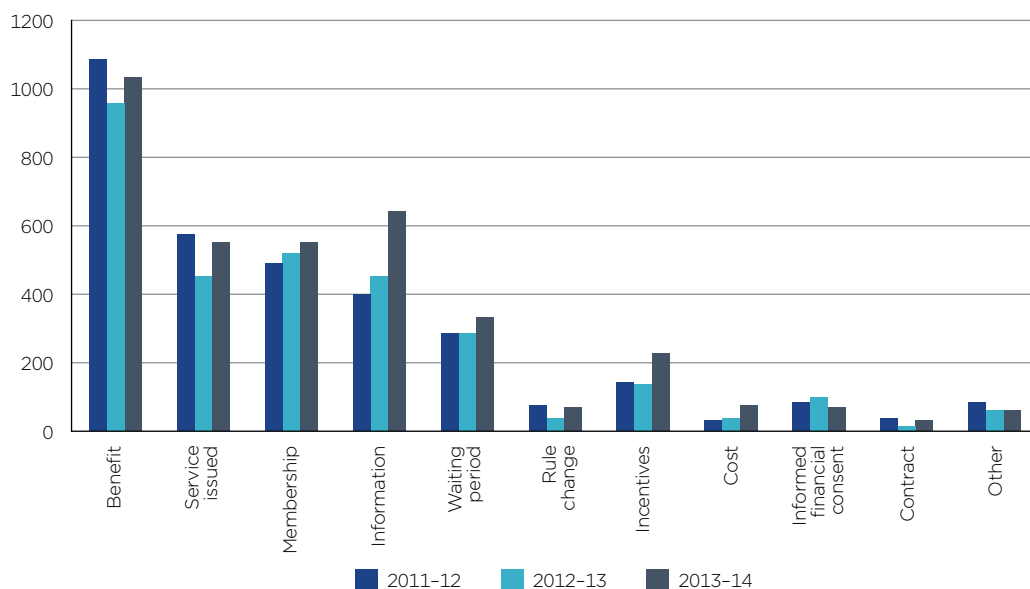
In 2013-14 the main complaints agency for consumers with concerns about their private health cover was the PHIO. During this period, the PHIO received a total of 3427 complaints representing a 16 per cent increase on complaints the previous year.¹⁸ After several years where complaint levels had remained steady, this was a significant increase—a trend that continued in 2014-15.

PHIO categorised the main consumer issues as complaints about:

- *oral information*—provided by private health insurer staff over the telephone or in branches
- *hospital exclusions and restrictions*—members who found out when they needed treatment that the treatment was partially covered or excluded under their policy
- *the pre-existing condition waiting period*—benefits excluded during a pre-existing waiting period or as a result of a pre-existing condition
- *cancellation and general service issues*.

A common theme resulting in increased complaints was the quality of information provided to consumers about health insurance policies and claiming benefits. This is reflected in the graph below:

Figure 1: PHIO complaint issues 2011-14



Of particular relevance to this report, trends in complaints relating to information provision are outlined below.¹⁹

¹⁸ PHIO, *Annual Report 2013-14*, p. 6.

¹⁹ PHIO, *Annual Report 2013-14* p. 28.

Table 4: PHIO Information complaints 2012-14

Information	2012-13	2013-14	Change
Oral advice	289	410	↑121
Lack of notification	55	96	↑41
Written advice	45	66	↑21
Brochures and websites	53	65	↑12
Standard Information Statement	11	5	↓6
Radio and television	1	2	↑1

The ACCC and state and territory fair trading agencies also receive consumer complaints relevant to the private health insurance sector. However, we are not a dispute resolution body and therefore not the key complaint agency for private health insurance. As such, we do not generally receive a large number of complaints regarding private health insurance.²⁰

Some examples of recent complaints received by the ACCC are below:

Mr A complained about representations made by his private health insurer. Prior to purchasing his policy, Mr A had reviewed the insurer’s website which included a representation that members would receive 100 per cent back on specified benefits. After taking out the policy, Mr A made a claim and was informed that the 100 per cent offer was only available to him if he used the specified services with particular providers. This exclusion was not disclosed to Mr A and he was significantly out-of-pocket as a result.

Ms B took out private health insurance and subsequently had dental work carried out. She understood that the dental work fell within the dollar value listed as the limit for dental work in her annual extras cover. However, the insurer advised Ms B that she was only covered to a lesser amount. Ms B complained that this information was not listed on any information that the insurer provided on its website including the consumer’s personalised ‘what you’re covered for’ section.

Ms C’s health insurer covered her for day surgery and private hospitals. Ms C required gynaecological surgery which she understood was covered under the policy. However, after the surgery Ms C discovered that her insurer defined her surgery as ‘obstetrics’, which was excluded from her policy. Ms C sought information from Medicare which confirmed the item numbers claimed for were not obstetrics related. However, Ms C has been unable to resolve this with her insurer.

The ACCC’s research and stakeholder submissions have indicated that examples such as these, where consumers misunderstand the extent of their private health insurance coverage and the nature of exclusions, can arise frequently in the private health insurance area. The reasons for this are discussed in more detail below.

²⁰ During 2013-14 the ACCC received 130 contacts regarding insurers or in relation to private health insurance issues. This represented a 30 per cent increase from the previous year where we received 100 contacts.

3. Purchasing private health insurance and accessing health care services—the consumer experience

Whether a consumer is purchasing health insurance for the first time, or reviewing and/or renewing an existing policy, there are a range of complexities through which a consumer has to navigate to exercise informed choice.

These complexities include:

- regulatory settings
- policy benefits and exclusions
- excesses, co-payments and waivers
- preferred provider arrangements
- inaccurate information
- variations to policies or variations to third party arrangements that impact the availability or amount of benefit provided.

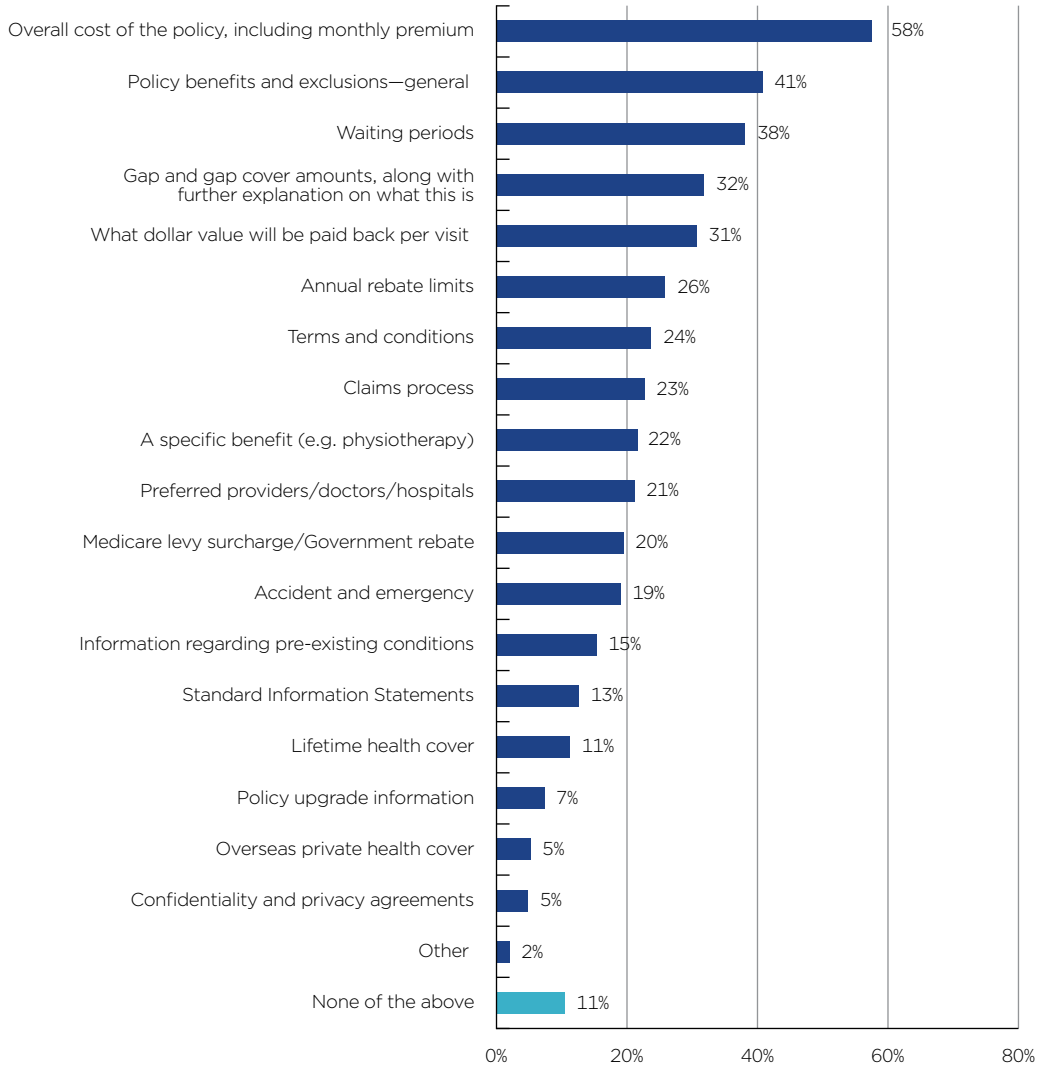
Private health cover is also a significant cost for many families, and is further complicated by the nature of the advance purchase in circumstances where consumers cannot predict the kind of cover or exclusions that may impact them in future years. For example, the decision to purchase cover that excludes certain conditions may have a significant financial impact by way of out-of-pocket expenses if that condition unexpectedly arises in the future. In these circumstances it is critical that information made available to consumers to inform these complex choices is clear, accessible, readily understandable and provides guidance as to important features to consider.

3.1 What information is sought by consumers?

The ACCC engaged Colmar Brunton to conduct a survey exploring the relationship between consumers, information provision and the private health insurance industry. For more information about the survey methodology see appendix A. This research revealed that the most common action undertaken by consumers prior to purchasing private health insurance was to compare different funds (70 per cent), followed by contacting the insurer (64 per cent). Section 4 provides more information on how consumers compare funds. Of the 64 per cent of consumers who contacted an insurer prior to purchasing a premium, the most common methods were by telephone (47 per cent), website (31 per cent) or visiting the shop front (30 per cent). Fifty five per cent of consumers searched for individual funds on the internet.

The type of information sought by consumers prior to purchasing a policy varied, however the most common was the overall cost of the policy, including the monthly premium (58 per cent). Consumers also often sought information about general policy benefits and exclusions (41 per cent). See below for a detailed list of information sought.

Figure 2: Information specifically sought



3.2 Is this information easy to find?

The quantitative research indicated that the majority (80 per cent) of survey respondents reported being able to find the information they were looking for, with about half (55 per cent) reporting that the information was easy to find. At the time they were searching for a policy, most consumers (67 per cent) thought the information was accurate.

These quantitative results appear at the outset reasonably positive. However, the results of the qualitative research presented a somewhat different picture. Participants reported that information was not straightforward or easily accessible despite some being self-reported avid researchers with a high level of engagement with their private health insurance policies. This feedback was echoed in many of the public submissions (see further below).

Participants identified that confusion was caused by:

- a lack of information before purchase
- difficulties locating relevant information

- unfamiliar terminology and legal jargon that was ambiguous and difficult to interpret
- the need to consult the fine print and attend to clauses marked with an asterisk
- incorrect and inconsistent information.

Comments from participants included:

- ‘Too much information and jargon in all these documents and we as laymen might interpret them wrongly.’
- ‘The terminology is a problem, but each fund uses different terminology and groups different covers together.’
- ‘How many other people are also given wrong information and don’t know?’

Participants called for more transparency and simplicity of information provided by insurers, especially when conducting initial information searches and comparing funds. Many felt that they did not know the questions to ask to get the information they needed. Comments about the challenges faced by consumers included:

- ‘The info is there but it’s not set out very clearly or explained well.’
- ‘I found the info, I hope. How can you really know until you claim?’
- ‘How do you know all the right questions to ask for something that you don’t know you might need?’

There is some support for these statements in the quantitative consumer survey results, which 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).

3.3 The importance of price

The quantitative research revealed that the most popular reason for policy selection is cost related, and it appears that consumers are increasingly selecting policies based solely or largely on price. There are a number of potential causes for this, including:

- a perception that ‘value for money’ is difficult to determine
- tax incentives, which drive consumers to focus on the cheapest option
- price (particularly premiums) is the only readily comparable factor between policies
- a natural tendency by consumers to discount future costs and benefits when compared to immediate costs and benefits—that is, consumers often focus more on immediate savings than potential long-term benefits
- the complexity and presentation of information, which impacts informed decision-making on non-price terms.

The influence of regulatory settings and price on consumers was evidenced in the qualitative research where some consumers reported having private health insurance primarily to avoid having to pay the Medicare levy surcharge and LHC loading. Some industry participants also claim that insurers present information to consumers in a way that encourages consumers to focus on price. The Australian Dental Association (**ADA**), in its submission to the draft report of the Harper Competition Policy Review noted:

[Health insurers] deliberately pitch advertising and various levels of cover to make it difficult for policy holders to compare the levels of cover on offer. It is not possible to make direct comparison of levels of cover on offer by the 34 private health insurance funds in Australia. The larger private health insurance funds engage in massive advertising campaigns using minor aspects of their business such as gym memberships or ‘join now claim now’ campaigns to make them attractive but give sparse details about the fine

print of eligible services or full cost of premiums. Rather the cheap option is used as 'bait advertising' with the aim of having the consumer make direct contact in order to 'up sell' the level of cover.²¹

Price is an important consideration for most consumers in making any purchase. Given the existing regulatory settings, purchasing a private health insurance policy with a low premium may be the best choice for consumers that are primarily trying to avoid paying higher taxes or being subject to the LHC loading. However, these consumers are entitled to expect a level of cover from their policies. Further, some consumers may be seeking to be covered for a range of procedures as well reducing their tax liabilities. If these consumers focus too heavily on price due to difficulties in assessing the coverage of the alternative policies, this may lead them to unintentionally underinsure, which would cause consumer detriment. In addition, this may lessen competition on quality of cover between insurers.

Determining the value of cover

Participants in the qualitative research identified that value for money is important in their decision-making and stated that they understood the cost-benefit equation. However, many also felt that value for money is becoming more difficult to achieve, and that it is difficult to know if a policy is 'good value for money' before using it.

In conducting website research the ACCC identified a number of barriers for consumers in determining the true value of a policy. In most instances, we found that consumers would be unable to determine or accurately estimate their likely out-of-pocket expenses for a particular procedure by using the insurer's website. To determine this, a consumer would need to separately consult at least their treating practitioner(s), the hospital and their insurer.

The ACCC recognises that insurers often have limited control over out-of-pocket costs imposed by hospitals or practitioners. It also accepts that for some benefits it is not possible to provide a complete explanation of potential cost as it is dependent on a case-by-case assessment (for example which hospital, doctor, benefits already used, billing method) and can only be determined at the time of treatment.

However, we found 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.²² All of these factors limit the ability of consumers to determine the value of their policy, and also undermine consumers' ability to compare policies.

Most insurers provide an online search tool for consumers to determine whether the insurer has an arrangement with a particular hospital or specialist. However, these online tools frequently lack important information. For example, few insurers provide easily accessible or simple information about the nature of the relationship between the insurer and the hospital or specialist, and how this will impact the costs a consumer is likely to incur. Most insurers provide information on the amount of an excess, however, in most instances it is less clear when the customer should expect to pay the excess. For example, liability to pay an excess may depend on timing, which for some insurers is determined on a 'membership' year from policy commencement. This is different from the 'calendar' year that applies for annual limits, which could confuse consumers.

21 ADA, *Submission to the Competition Policy Review*, 13 June 2014, <http://competitionpolicyreview.gov.au/files/2014/06/ADA.pdf>.

22 Consumers who are treated as private patients in a hospital (public or private), will be covered by Medicare for 75 per cent of the MBS fee for medical costs. The remaining hospital and medical costs will be charged to the consumer and some or all of these costs may be covered by the insurer depending on the consumer's policy. For hospital and theatre costs, if the insurer and hospital do not have an agreement in place, the hospital is able to set their own charges and the insurer will only be required to pay the minimum benefit as set out in the Private Health Insurance (Benefit Requirements) Rules 2011, resulting in higher out-of-pocket expenses for the consumer.

3.4 Complexity and consumer behaviour

Consumers' understanding of policy benefits and exclusions will vary depending on the complexity of the information provided and their familiarity with the health system and their health needs. 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.²³

As previously noted, there are a range of factors in the private health sector that increase complexity for consumers, including:

- regulatory settings, providing participation incentives and government rebates that vary depending on age and income
- policy exclusions, excesses, co-payments and waivers
- preferred provider arrangements
- the rewards and benefits being offered by larger insurers if certain conditions are met.²⁴

Adding to the complexity is the sheer number of options available²⁵, and that each insurer has different terminology and ways of presenting information, which makes comparisons difficult. Policies can contain a mix of levies, surcharges and rebates. Sometimes the specific details are hidden or obscured in lengthy and complex policy documents that are not easily accessible to consumers.

In addition, private health insurance contracts allow for the insurer to unilaterally vary a consumer's policy terms, conditions and exclusions (subject to private health insurance legislation). This means that even where a consumer spends considerable effort in understanding the policies on offer in order to make an informed choice, that effort may become redundant if an insurer subsequently decreases the cover provided. Under the ACL, provisions that allow such unilateral variations may constitute unfair contract terms (subject to a number of exemptions), particularly if the term is not transparent and causes consumer detriment.

The mix of levies, combined with a tendency by funds to change their policies over time, make it difficult for even astute consumers to judge the true cost and value of their private health insurance.²⁶

The issue of the complexity of private health insurance cover featured in many of the submissions, from industry bodies and consumers alike. For example, the Consumers' Health Forum (**CHF**) submitted that consumer confusion and the complexity of the private health insurance industry contributes to the problem of 'set and forget' behaviour by consumers. Similarly, the Australian Society of Anaesthetists (**ASA**) claims that the complexity and variability of policies, and the reluctance of insurers to fully educate their customers, has resulted in a system lacking both transparency and consistency. The Royal Australian and New Zealand College of Ophthalmologists claims that it is increasingly difficult for consumers to compare health insurance policies due to their complexity, resulting in an effective loss of competition.

Submissions also pointed to a significant level of consumer confusion about private health insurance.

23 Sophie Lewis, Karen Willis, Marika Franklin, The Conversation, 'Explainer: why do Australians have private health insurance?' March 30 2015, <https://theconversation.com/explainer-why-do-australians-have-private-health-insurance-38788>.

24 See Medibank offers of Fitbit and sports vouchers, viewed 10 June 2015, www.medibank.com.au/health-insurance/compare-medibank-health-cover/.

25 PHIO, *Annual Report 2013-14*, indicates there are over 20 000 policies on offer.

26 Lesley Russell, the Conversation, 'The debate we are yet to have about private health insurance', 2 April 2015, <https://theconversation.com/the-debate-were-yet-to-have-about-private-health-insurance-39249>.

Bupa advised that their customer research confirmed that various practices of the health insurance industry were confusing so they have specifically designed their online sales pathway to cater for the varying needs of prospective customers and reduce the confusion. Bupa also advised that consumers are confused by the 'basic, medium and top' classifications used by insurers.

The Dental Hygienists' Association of Australia identified a number of issues with the main ways in which insurers communicate with consumers. This includes complex websites and printed materials, inadequate generic correspondence and call centres with long and frustrating waiting times.

Although the Colmar Brunton quantitative research found generally low levels of self-reported confusion, several submissions advised that consumers are often unaware of the ways in which complex business rules may affect them, and warned that the impact of consumers' purchasing choice may not be apparent until they come to make a claim.

Other submissions noted the difficulty for consumers of accessing simple information. hirmaa submitted that member-owned and community based insurers place value on clear communication and member understanding. hirmaa submitted that its member funds have a strong understanding of the importance of effective information communication but that attaining this level of consumer understanding requires considerable effort and expertise, given the complexity of Government regulation in the industry.

The ADA advised that it found insurer websites do not provide easy access to important documents such as product disclosure statements (**PDS**). Considering the work required to locate all the details of the fine print for one particular policy, it submitted that it is highly unlikely that consumers would perform the same exercise repeatedly across other policies of insurers in order to make an informed choice and often proceed with a purchase in the hope that what is being purchased meets their needs.

Several submissions also highlighted that consumers find it difficult to locate information about specific rebates, annual limits and details of exclusions.

Decision-making in the face of complexity

Where consumers are faced with complexity and confusion, and unable to easily access relevant information, it affects their decision-making. This is particularly so in circumstances where consumers also face the uncertainty of how to accurately assess their potential future needs in choosing appropriate cover.

In addition, consumers tend to discount future benefits (for example, broader cover) when compared to immediate benefits (for example, lower premiums), even if the future benefits may ultimately be worthwhile.²⁷

The complexity of decision-making about private health insurance also stems from the sheer number of options available. While there are benefits for consumers having multiple options, there is a point at which too much complexity will reduce the ability of consumers to make decisions²⁸:

... as the choice set grows there are increasing costs to an individual of processing information. This happens if individuals continue to consider all alternatives as the choice set expands. Even if short cuts are used (elimination of the worst alternative) information processing costs grow with the choice set. This leads to the hypothesis that consumers can be overwhelmed by 'too much' choice...²⁹

27 Jeffrey Liebman and Richard Zeckhauser, 'Simple Humans, Complex Insurance, Subtle Subsidies', National Bureau of Economic Research, Working Paper 14330, www.nber.org/papers/w14330.pdf.

28 This is called the 'information overload' or 'choice overload', for example, Dimitri Kuksov and J. Miguel Villas-Boas, 'When More Alternatives Lead to Less Choice', *Marketing Science*, Vol. 29, No. 3, May-June 2010, pp. 507-524.

29 Richard Frank and Karine Lamiraud, 'Choice, Price Competition and Complexity in Markets for Health Insurance', National Bureau of Economic Research, Working Paper 1381, www.nber.org/papers/w13817, p. 11.

Further, concerns about making the wrong decision may hinder decision-making:

In situations where decisions are complex, consequential and uncertain there is often fear of making the wrong decision and later suffering regrets. One set of responses to such decision-making circumstances that have been observed in both experimental and observational studies is a tendency towards decision avoidance by either opting for the status quo or walking away from the decision entirely...³⁰

This decision paralysis is evidenced in the quantitative research, where 40 per cent of respondents said they had seriously considered changing insurers but did not proceed with the transaction. The implications for competition are clear: if consumers do not switch in response to poor or confusing information or dissatisfaction with their cover, the incentives for insurers to offer competitive prices and high quality cover to pre-existing consumers are weakened.

3.5 The contributors to complexity

Regulatory settings

Our consultation also revealed that the complexity encountered by consumers is exacerbated by the organisational and regulatory structure of the Australian healthcare system. Regulatory settings aim to encourage consumer take up of private health insurance to reduce the number of consumers relying on the public health system, and to address issues of adverse selection and moral hazard as noted in section 2.4 of this report.

Medibank submitted that consumers often find policies to be complex but argued that the structure of the health care system itself, can increase complexity. Although Medibank acknowledged the benefits of regulation, it noted that it can dampen innovation and entrench complexity.

The growth in benefits, restrictions and exclusions

The submissions highlight concerns that there is a growing trend toward policies with more exclusions, as well as increasing variations to existing policies that decrease the level of cover. Complaints about exclusions have also been increasing.

This growth in policy exclusions is reflected in recent PHIAC reports, which highlight that a part of the industry's response to rising premiums has been the emergence of a greater array of policies with exclusions and excesses. PHIAC data found that around 30 per cent of policies now have important exclusions, for example regarding joint replacement costs and cardiac treatments.³¹

PHIO also reported in its 2012–13 Annual Report that the number of people holding policies that restrict or exclude a range of hospital services has gradually increased. As at June 2014, approximately 52 per cent of policies held included one or more exclusions or restrictions, a jump from 45 per cent on the previous year.³²

Research by the Australian Private Hospitals Association (**APHA**) shows that 40 per cent of Australians with private health insurance are unsure if their policies have any exclusions. Further, of the 33 per cent who state that their policies are exclusionary, 37 per cent do not know what they are covered for. This means that over half (52 per cent) of private health insurance customers do not know what, if any, exclusions are contained in their policy.³³

³⁰ Richard Frank and Karine Lamiraud, 'Choice, Price Competition and Complexity in Markets for Health Insurance', National Bureau of Economic Research, Working Paper 13817, www.nber.org/papers/w13817, p. 11.

³¹ PHIAC, *Operations of the Private Health Insurers Report 2013–14*, p. 5.

³² PHIO, *Annual Report 2012–13*, p. 26.

³³ APHA, Submission to the ACCC 2013–14 Senate report on private health insurance, 13 February 2015.

Under the Private Health Insurance Act there is no limit on the number of services that can be restricted or excluded provided minimum benefits are provided for psychiatric, rehabilitation and palliative care services.³⁴

The Australian Medical Association (**AMA**) submitted that the most common complaints from its members relate to policies with exclusions. They also advised that the policies most commonly cited by their members as impacting on the care of their patients are policies with exclusions or minimum benefits and policies that are for treatment in public hospitals only. These are details which are often only fully explained in the 'fine print' of hospital cover policies.

The AMA suggested that the minimum coverage requirements should be extended to cover procedures for which people expect to be covered such as heart surgery, knee and hip replacements, eye surgery, psychiatric care, rehabilitation and palliative care. Other submissions suggested that minimum policy features are inadequate and need to be reviewed to ensure consumers can be confident they will be covered for important procedures.

The submissions also highlighted two areas where significant consumer detriment may arise—limitations on psychiatric services and ambulance cover.

The Royal Australian and New Zealand College of Psychiatrists (**RANZCP**) submitted that there is insufficient transparency and consistency regarding the features of policies to allow consumers to make informed decisions about their health care. RANZCP noted this to be the case specifically for psychiatric care, and noted that there is no single source available for consumers to compare the different kinds of psychiatric policies that might be available.

RANZCP stated that this problem is exacerbated by the fact that less than half of all policies of the major insurers cover the cost of admission to private psychiatric hospitals. This means that consumers requiring admission are transferred to the public system, which is already overstretched. Some insurers have recently moved psychiatric treatment from full benefits to restricted benefits in some of their policies. RANZCP provided examples of cases where consumers did not realise that their psychiatric cover is capped resulting in the potential for detrimental health and treatment outcomes. One example provided is outlined below.

RANZCP case study—surpassing number of psychiatric admission days

A 30 year old man with severe obsessive compulsive disorder and obsessive compulsive personality disorder was denied admission to hospital at a critical time because he had surpassed the number of psychiatric admission days his policy permitted per annum. While the patient was eventually admitted with the support of the relevant fund, his admission process was delayed by many days, taking up a great deal of unnecessary administrative time and causing the patient concerned undue stress.

RANZCP advised that this demonstrates a clear need for better information and communication by insurers to consumers about whether they are covered for psychiatric care and the extent of inclusions and exclusions on their policies.

Submissions also advised that in other instances, consumers may find that the number of days or number of admissions for which full cover is provided is limited not by a term of the policy they have selected, but by the insurer's contract with the hospital. In such instances, the consumer has no option but to seek admission at another hospital, thus losing the advantages of clinical appropriateness, quality of care, continuity of care, location, trust, familiarity and access to particular health professionals that led them to select that hospital in the first place.

The Australian Society of Plastic Surgeons (**ASPS**) submitted that many insurers offer policies that exclude, or provide reduced benefits for, plastic and reconstructive surgery. In their experience, when insurance sales staff are asked about these exclusions, they are not aware of what is, or is not, intended to be excluded.

³⁴ Section 72-1 Private Health Insurance Act.

ASPS also submitted that due to exclusions for ‘cosmetic’ surgery, on some occasions insurers deny cover for procedures they describe as ‘cosmetic’ but which are not. Examples include the treatment of burns, breast reconstruction after cancer treatment and reconstructive procedures after bodily injury.

APHA also submitted an example of problems arising where benefit terms are misunderstood:

APHA case study—ambulance cover

Consumers are often advised that hospital policies provide ‘comprehensive cover for ambulance (see insurer for details)’. In practice there is significant variation in the interpretation of ‘comprehensive cover’. This term may mean:

- emergency transport to a hospital but not between hospitals
- emergency transport to a hospital but not for a callout that does not result in transport to hospital
- emergency transport to hospital but not between public hospitals and/or only between a private hospital and another hospital if written medical advice is provided.

The ACCC also received a complaint about confusion regarding ambulance cover:

ACCC case study

The ACCC received a complaint from Ms H who switched health insurers in April 2012.

Ms H received a disclosure document from her new insurer which represented that Ms H would receive ‘partial ambulance cover’ (*see insurer for details). Ms H called the insurer and was advised that this meant Ms H was covered for part of the bill where an ambulance was required for emergency response. In April 2013, the insurer sent Ms H an amended disclosure document. The insurer had made changes to the terms which now referred to ‘comprehensive ambulance cover’* (*see insurer for details). Upon calling the insurer Ms H was advised that ‘comprehensive’ referred to full ambulance cover and not just for emergencies. Subsequently Ms H’s husband required ambulance transport, and Ms H received a bill for \$2500. Ms H’s insurer did not cover the cost on the basis that it claimed she did not have ‘emergency’ cover. The bill did not state that it was required for an ‘emergency’. Ms H had recordings of her conversations and was ultimately successful in resolving the complaint with the insurer.*

Preferred provider arrangements—the relationship between practitioners and insurers

The existence of preferred provider arrangements between insurers and hospitals or practitioners, while offering some benefits, further complicates the range of matters a consumer must consider when purchasing and using private health insurance. For instance, a consumer must consider whether their insurer has a particular agreement with their practitioner/doctor or hospital, and the associated gap and charging arrangement.

Since 1995, insurers and health providers/practitioners have been able to contract with each other for the provision of hospital services to members. These arrangements were introduced in order to enhance competition, with the aim of better managing costs within the industry.³⁵ The agreements allow for members to access a range of private hospitals with no or minimal gaps for theatre fees and accommodation. These are commercial arrangements and the agreement is negotiated on the basis of the amount the insurer is willing to pay for services across the term of the contract and the amount the provider is willing to accept.³⁶ Different insurers have

³⁵ PHIO, *Annual Report 2013-14*, p. 9.

³⁶ *Ibid.*

arrangements with different hospitals which will fully or partially cover a consumer's costs. If consumers are treated at a hospital that does not have an agreement with their insurer, they may face significant out-of-pocket expenses.

Insurers also have arrangements with particular doctors/practitioners that cover all or some of the doctor's fees for a consumer's hospital treatment. These agreements will determine the consumer's [out-of-pocket expenses](#). These are the expenses incurred by the consumer for their medical treatment during their stay in hospital, reflecting the difference between the total fee charged by the doctor and any Medicare rebate plus the benefit paid by the insurer. Unless an insurer has a gap cover arrangement in place with the treating doctor/practitioner which will cover all of the charge, the consumer will have to contribute towards the doctor's bill out of their own pocket.

The same arrangements apply with extras cover providers. Many funds establish 'preferred provider' or 'participating provider' arrangements with some suppliers of extras cover services such as dentists or optometrists. Those providers offer an agreed charge for fund members, with the intention of lowering out-of-pocket costs for members after fund benefits are taken into account.

Consumers often look to medical and other practitioners for advice about fees and potential out-of-pocket medical costs. The AMA submitted that some of its members spend a considerable amount of time assisting patients to understand their private health insurance policies, and liaising with insurers on their patients' behalf to determine the extent of their cover.

Consumers can encounter significant difficulty in determining what a procedure will cost and how the relationship between their insurer and the relevant provider or hospital will affect this cost. Submissions also raised concerns about the inability of consumers to readily access Medicare Benefits Schedule (MBS) item numbers to enable them to inquire about coverage for specific procedures or benefits, and determine the associated out-of-pocket expenses. Stakeholders suggested a need for access to this information to enable a smoother and more transparent process of determining whether a procedure is covered by a consumer's policy, what it may cost and any associated out-of-pocket expenses.

In practical terms, in order to ascertain out-of-pocket costs, once a consumer knows the relevant MBS item numbers the onus is on them, before they go to hospital, to contact:

- the hospital to determine the fees payable and whether they have specific contractual arrangements with their insurer that would result in lower out-of-pocket expenses
- their health provider/practitioner (and any assisting providers) to determine the fees payable and method of billing, including breakdown of costs and relevant MBS item numbers to provide to their insurer and inquire whether they are a preferred provider of their insurer
- the insurer, to discuss estimated out-of-pocket costs based on the chosen hospital, practitioner/doctor and relevant MBS item numbers provided by their practitioner for the procedure.

Navigating this process is not easy. Stakeholders advised the ACCC that in some cases practitioners are not providing consumers with sufficient information to allow them to seek information from their insurer about coverage for particular treatments and out-of-pocket expenses, and several submissions identified that comprehensive information on fees is not always given to consumers before a procedure or there is not sufficient time to do so. This means consumers may not be well informed to determine the out-of-pocket expenses they will incur.

The ASA provided an example:

ASA case study—anaesthetist fees

An anaesthetist may at times not receive information about a patient’s procedure early enough to provide a fee estimate. It is not uncommon for a patient to have elective surgery booked only a few days in advance. As a result:

- the anaesthetist is unable to provide a sufficient estimate to the patient well in advance of the procedure, or
- the anaesthetist may not have enough time to contact the consumer prior to the procedure.

This issue can also create difficulty for insurers. Insurers may not be able to provide sufficient information to consumers as they will not know exactly what the consumer will be claiming until the consumer has seen the practitioner/doctor or undergone a procedure.

The relationship and communication between practitioners and insurers can also contribute to consumer misunderstanding about their private health insurance. The case studies below provide examples of this:

ASA case study—anaesthetist requirements for above MBS-rebates

All health insurers provide above-MBS rebates for the in-hospital services of anaesthetists and other doctors. However, the terms and conditions applying to such payments vary from insurer to insurer and in some cases are complex. They may require that the doctor ‘registers’ with the health insurer, or that accounts are presented in a specific format. If a doctor is not fully compliant with the terms and conditions, the patient will receive only the MBS fee as the rebate, and their out-of-pocket expenses may be substantially increased. The ASA has been made aware of numerous instances where patients have been subject to unnecessary expense because of this situation, and it appears that the number of consumers who are aware of these facts prior to treatment, is close to zero.

Australian Orthotic Prosthetic Association (AOPA) case study—referral requirements

Ms M has been wearing foot orthoses for a number of years and receiving treatment from an orthotist. She selected a health cover policy in order to claim some of the costs of her orthoses. She enquired regarding the coverage of foot orthoses and was assured that her policy was appropriate. Upon submitting the paperwork for her rebate, Ms M was advised that unless there was a referral from a podiatrist or an orthopaedic surgeon, then she was unable to claim a rebate. The reason given was that an ‘orthotist is only eligible to “supply” on behalf of a Podiatrist following a biomechanical examination, gait analysis, negative cast or 3D digitised impression taken of the feet’.

Excesses, co-payments and waiting periods

The AMA and other stakeholders submitted that problems also arise from limited consumer awareness and understanding about whether their policy has an excess, co-payment and waiting period provision. Many policies contain waiting periods for particular procedures such as maternity cover. Other policies contain excesses or co-payments for hospital admissions, such as paying \$500 upon admission. This information is sometimes buried in the information provided to consumers, forgotten or not explained clearly.

Several other submissions advised that many consumers misunderstand excesses and co-payments, which by their inclusion lower consumers’ annual premiums. Consumers often need this information clarified when they go to claim, particularly as it can lead to ‘bill shock’.

Accuracy of information

In other submissions, it was argued that private health insurance policy brochures can be vague about the benefits of a policy. These perceived benefits may be inconsistent with the detailed information provided in longer policy documents, which often contain legal and industry jargon that results in consumers failing to read or understand the restrictions.

AOPA submitted that telephone conversations between consumers and insurers are a key source of misinformation. AOPA believes it is not uncommon for consumers to be incorrectly advised regarding their coverage or to receive variations in the advice depending on which health insurer representative they speak to. AOPA points to the use of complex terminology and the lack of a schedule for the services of orthotists as primary drivers of this problem.

Optometry Australia (**OA**) also submitted that some health funds provide inconsistent or inaccurate information about the rebates that consumers can claim. OA notes that consumers are frequently under the misapprehension that preferred provider schemes provide 'no-gap' or 'known-gap' optical policies, when this is often not the case. These situations increase the risk of unexpected costs and 'bill shock' for the consumer, and place pressure on optometrists to cover the 'gap' to retain the consumer's business.

The ASA submitted there are numerous examples of patients who have been led to believe that because they have 'top cover' and an insurer with a 'gap cover' or a 'no gap' policy, that all of their medical expenses will be covered when this is not the case. This only serves to worsen the problem of unexpected out-of-pocket expenses.

3.6 Insurers' websites—adding to complexity

Taking into account the number of consumers who access insurers' websites (over half in the quantitative research) and the issues raised in submissions, the ACCC conducted a review of information available on insurer websites and the online quote process.

We reviewed 34 insurers' websites and identified a lack of transparency and availability of information in the three key areas below.

Determining out-of-pocket costs and preferred providers

There were significant challenges in finding information which enabled an informed estimate of the gap a consumer could expect to pay, in particular where preferred provider arrangements could impact the level of benefit available.

Many insurers did not provide transparent information about the nature of the relationship between the insurer and particular hospitals and specialists, and the impact of this for coverage and benefits. For example, the implications of a 'no gap' arrangement or a 'limited gap' arrangement were unclear. There were also vague explanations that the benefit payable would be determined on a 'case by case' basis.

Many insurers also did not provide information about the benefits payable if a consumer was admitted as a private patient in a public hospital.

Waiting periods and pre-existing conditions

Information about any applicable waiting periods or limitations relating to pre-existing conditions was not always transparent or provided during the online quote process. In some cases it could only be found in the product guide/pdf link containing complete policy information.

Extras cover

Many insurers failed to provide clear information about the rebate and annual limits for some extras, such as general dental. Some insurers failed to provide further information about the rebate amounts for specific extras services and instead asked consumers to ring the insurer for details.

Some insurers also failed to provide clear links to their PDS or easy access to the further information contained in these documents. These findings were consistent with that of the ADA's noted previously (see page 18), highlighting the difficulty consumers can have in accessing important information.

Online quote processes

The review indicated that most online quote processes begin by asking consumers for basic details such as age, location and status (single, couple, family), as the applicable rebate, premium cost and or policy options may vary depending on these factors. Better quote processes explain the government rebate and request information about income up front (or require selection of the appropriate tier for their income) making it easier for consumers to compare the price of similar policies.

Some websites enable better tailoring of policy options, such as including specific items the consumer is seeking to be covered for, e.g. cataract surgery, osteopathy or remedial massage. However, there are some challenges with this approach, including that:

- consumers may not be aware of the limitations on the particular category without having to find and read extensive fine print
- there is inconsistent terminology and a lack of agreed definitions about terms such as 'major dental'
- there is no standardised approach about what is included in cover for specific conditions, for example 'cardiac' cover may include different items with different insurers.

As a result consumers may have particular expectations which may not be compatible with the terms of the insurers' offer. The more effective websites provide prominent disclosure early in the search and quote process to make it clear what is and is not included in cover for that selected item and include links to further information.

3.7 When consumers access health care and claim benefits

Most consumers with private health insurance will access some of their benefits at some point. The quantitative research found that while 30 per cent of consumers rarely access their benefits, 43 per cent sometimes do and 18 per cent do so frequently. Eight per cent had not yet accessed their private health insurance.

The quantitative research also indicates that consumers who regularly use their private health insurance are more likely to feel informed about their health insurance, and confident they have received all they expected in terms of their rebate or claim. However, the data further discloses that one quarter of consumers who have accessed their benefits have experienced at least one occasion where their expectations were not met, largely because they were dissatisfied with the claim amount or believed they were covered for something that they were not.

The AMA highlighted in its submission that there is a significant disconnect between some consumers' understanding, and therefore expectations, of the services and rebates they are entitled to under their policy, and the reality of what their policy provides.

PHIO's 2014 *State of the Health Funds Report* also discusses complaints that arise where consumer expectations are not met. The report outlined that PHIO received 242 complaints concerning hospital exclusions and restrictions affecting benefits to consumers during 2013-14. This was an increase of 34 per cent on the previous year. These complaints mostly resulted from a lack of knowledge that a particular benefit was not covered on their policy, or a belief that a particular hospital treatment was incorrectly defined as a restricted or excluded service.³⁷ This last point is illustrated in the case study below:

PHIO case study—complaint regarding restrictions

PHIO received a complaint from a consumer who was contesting a health fund's view as to whether a treatment to a lumbar joint in their back should be considered restricted. The restriction was worded as 'Joint Replacements, i.e. shoulder, knee, hip and elbow, including revisions', which the fund claimed indicated that lumbar joint treatments were restricted. The consumer was of the view that because a joint was not replaced and because the procedure was a minor lumbar procedure, it should not be considered as restricted under the 'Joint Replacement' restriction.

Several submissions identified 'bill shock' as a common consequence of consumers not fully understanding policy exclusions, excesses and gaps when making a claim. For example, CHF outlined that it often hears of consumers suffering 'bill shock' when they get final accounts and realise the size of the gap payments, which they had not been adequately prepared for.

³⁷ PHIO, *State of the Health Funds Report 2014*, p. 5.

4. Comparing and choosing policies

Well-functioning markets require engaged consumers who are prepared to switch insurers. It is therefore critical that consumers have sufficient information, and appropriate tools, to compare policies and make informed choices.

4.1 How do consumers compare policies?

As noted above, the quantitative research indicated that most consumers (70 per cent) conduct comparisons across funds before selecting a policy. The qualitative research found that consumers generally undertake more than one activity in an effort to determine the best cover for them. Activities include:

- searching for information online including on funds' individual websites
- reading reviews on review sites (e.g. Whirlpool, blog sites)
- making phone call/s to individual funds
- visiting individual fund shop front/s
- setting up their own comprehensive spreadsheets to compare policies
- asking family/friends/colleagues.

Comparator websites

The Colmar Brunton quantitative research found that:

- forty per cent of respondents who compared funds used comparator websites
- the primary websites used were iselect.com.au (58 per cent) and comparethemarket.com.au (29 per cent).

The qualitative research indicated that for many consumers comparator websites are a starting point, but more in-depth individual research is required. Examples of comments were:

- 'comparison websites are a good starting point but I wouldn't limit my search to just this to make a decision'
- 'comparison websites are a useful first line look to compare at a high level but you need to look and talk to individual companies'
- 'comparison tools are generic and everybody's requirements are different.'

In November 2014 the ACCC released *The comparator website industry in Australia* report (**the comparator report**), which examines how the comparator website industry operates, and identifies challenges and benefits for both consumers and businesses.³⁸

The comparator report found that comparator websites can assist consumers to make more informed purchasing decisions when comparing complex policies, and can promote healthy competition by assisting small or new service providers to compete more effectively. The report also identified issues around many comparator websites including statements that the service is unbiased, impartial or independent and undisclosed commercial relationships affecting recommendations to consumers. This raised concerns that some statements on comparator websites may be false or misleading in circumstances where there is inadequate disclosure that:

- a comparator website operator earns some or all of its revenue from leads or sales under commercial relationships with service providers whose policies it compares
- the nature and extent of the comparison service is entirely or largely based on which service providers a comparator website operator has commercial relationships with.

³⁸ See www.accc.gov.au/publications/the-comparator-website-industry-in-australia.

Stakeholders consulted by the ACCC in preparation of the comparator report argued that comparator websites provide consumers with both the tools and ability to analyse their needs to help them choose the right policy. Some stakeholders highlighted the benefits of comparator websites including that information is presented consistently, which supports clear comparison and simplifies purchasing decisions. However, it was also noted that the simplification of information to provide consistency can decrease the transparency of important differences between policies. Comparators may not provide adequate 'like for like' comparisons particularly when consumers focus primarily on price.

Many of the issues identified by the ACCC in the comparator report were also raised in submissions to this review.

For example, the CHF conducted an online survey across its membership to ascertain consumers' views on how they find out about private health insurance policies. The results indicated that of the 55.6 per cent of respondents who used non-government comparator websites to research insurance policies, over one-third (40 per cent) did not know that most non-government insurance websites did not cover all possible policies.³⁹

It was also submitted that consumers who use comparator websites, as opposed to informational sites or single insurer sites, receive accurate quotes based on their specific needs. Further, it was acknowledged that transparency around coverage is paramount for consumers' trust in comparator services.

Several submissions received by the ACCC indicated concerns with the commission-based model for intermediaries such as comparator websites. They argued that the commission-based structure means comparator website operators have incentives to entice switching in instances where it is not necessarily in the best interests of the consumer. Concerns were also raised that consumers do not understand the commission-based model and structure of price comparators which may lead to an incorrect assumption that services are unbiased, independent or impartial.

Concerns were also raised that comparators can unnecessarily focus on price rather than health needs.

The Private Health Insurance Code Committee submitted that the expansion of third party intermediaries has added to consumer confusion, and as consumers are increasingly attracted to lower cost policies, there is a greater likelihood of a diminished consumer experience.

Against this, the Private Health Insurance Intermediaries Association (PHIIA) submitted that intermediaries exist to facilitate and improve consumer understanding. The PHIIA claims that most member companies boast highly developed web-enabled comparison platforms, all designed to enhance consumer understanding through product transparency. Critically, these platforms are supported by trained employees who are able to explain the differences between policies over the phone, and investments that ensure the customer experience, underscored by comparison, transparency and choice, is at its optimum. PHIIA also advised that insurers in isolation have no interest in, nor capability to, compare health cover policies of different funds. This is because any insurer is, understandably, only interested in offering and selling the product they have to offer.

PrivateHealth.gov.au

PrivateHealth.gov.au is an Australian Government initiative, managed by the Commonwealth Ombudsman.⁴⁰ This website provides the SIS for every health insurance policy available from every registered health fund, allowing consumers to search all health insurance policies and compare what is covered through the SIS.

³⁹ CHF, Submission to the ACCC 2013-14 Senate report on private health insurance, February 2015, https://consultation.accc.gov.au/ipil/phireport-2014/consultation/view_respondent?uuld=307615016.

⁴⁰ Prior to 1 July 2015 this website was managed by the PHIO whose functions were transferred to the Commonwealth Ombudsman.

A number of submissions noted that consumer awareness of the website is low. The CHF advised that in its 2015 consumer survey, none of the 61 respondents used information from PHIAC or PHIO in researching private health insurance, and fewer than one in six consumers (15 per cent) used PrivateHealth.gov.au.⁴¹ The CHF states that there is a need for this website to be promoted more actively as it could be useful for consumers if they knew about it and how to access it.

The Colmar Brunton quantitative research found that only 26 per cent of consumers were aware of the website.

Some submissions noted that specific details of policies were unable to be compared; this is largely because the SIS lacks information about important aspects such as rebate amounts.

Submissions also advised that PrivateHealth.gov.au is only an information site and not as helpful as non-government comparator sites. It does not allow for the purchase of policies or the ability to conduct a search based on specific needs, for example comparing particular treatments/conditions.

4.2 Changing insurers

The quantitative research found that just under two thirds of all respondents have had private health insurance for 10 or more years. However, only 14 per cent of respondents had changed insurers, despite 48 per cent having thought about changing insurer and some taking steps to do so without completing the transaction.

For respondents who have changed insurer or contemplated it, the most reported reason was that the premium was too expensive (57 per cent), followed by dissatisfaction with claim amount and policy benefits and exclusions (both 6 per cent).

Respondents who have thought about changing private health insurers but have not done so, reported that their main reason for not changing was that they have not found an insurer that meets their needs (21 per cent), whilst 12 per cent considered that the process of changing is too difficult.

The tools and information available to facilitate policy comparison and choice can influence consumer switching. It appears that even when consumers may be dissatisfied with their current insurer and have thought about changing insurers, few actually do. The research and submissions indicated that this could be due to a number of reasons, including:

- a perception that there are no satisfactory policies available
- difficulty assessing and comparing the benefits and limitations of policies
- concerns that the process of switching is too difficult
- concerns that by switching, consumers will be denied benefits they may currently be entitled to and forego any loyalties accrued.

As the ACCC has previously noted, where 'choice can appear too difficult, consumers remain with their current provider [insurer] leading to sub-optimal results for competition and Australian economic welfare'.⁴²

41 CHF, Submission to the ACCC 2013–14 Senate report on private health insurance, February 2015, https://consultation.accc.gov.au/ipil/phireport-2014/consultation/view_respondent?uuld=307615016.

42 ACCC, Submission to the Competition Policy Review—Response to the Draft Report, 26 November 2014, p .27, <https://www.accc.gov.au/system/files/Competition-Policy-Review-ACCC-submission-to-Draft-Report-26-November-2014.pdf>.

4.3 Standard Information Statements

Submissions highlighted the important role insurers play in ensuring consumers have access to the information they need to make informed decisions and to understand the terms and conditions, costs, benefits and limitations associated with a policy. Terminology (particularly medical terms and procedures) in policies is not standardised across the industry, posing particular challenges for consumers when comparing policies.

All insurers are required by the Private Health Insurance Act to provide an up to date SIS, so consumers can review their existing policy or compare policies. The SIS provides a summary of the key policy features enabling comparison of both price and features. Insurers are required to provide a SIS for each policy they offer and these are also available on the government comparator website PrivateHealth.gov.au.⁴³ The SIS requirement and website were introduced in 2007. The SIS has been subject to several changes since its introduction.

The SIS was designed to provide consumers with a tool to compare policies and make informed choices, but there is general agreement among stakeholders that the SIS lacks important policy details. There is also concern that the premium payable is dependent on personal circumstances which is not reflected in the SIS. Benefits are also dependent on the terms of the policy, the treatments required, the hospital and the treating practitioner/doctor.

Many submissions argued that the SIS does not include sufficient detail to enable consumers to effectively compare policies and be adequately informed about the relevant costs. Consumer reliance on the SIS, it was submitted, may lead to claim shock.

Medibank submitted that the SIS is restrictive, particularly where the same template is required regardless of whether insurers are describing inclusions or exclusions. The SIS is a one size fits all approach, which means that insurers cannot always easily describe their policy accurately, particularly as product innovation sees new types of products released.

Bupa made a similar submission, and noted further that the benefits to consumers of an insurer's strong preferred provider network cannot be reflected in the SIS. Bupa also noted that to address the information shortfall in the SIS, insurers often provide short form brochures that more accurately represent the policy. Bupa also noted that however, this is another piece of information for consumers to read and can sometimes appear inconsistent with the SIS, leading to further confusion.

The ADA agreed that information regarding exclusions, limits and categories is poorly outlined in the SIS.

APHA also raised concerns, that while the SIS is required to provide details about which services are restricted or limited, the nature of any limitations is not disclosed. Instead, consumers must seek further information from the relevant fund and restrictions can vary significantly. In one case the 'restriction' may mean that cover in a private hospital for that particular service is only provided for a set number of days in any one year. In another case the 'restriction' may mean that the fund will only pay the minimum default hospital benefit and the consumer will need to pay any additional cost out of their own pocket.

The Private Health Insurance Code Committee submitted that in its view, the SIS compounds the problem of inaccurate and incomplete information provided to consumers, and is of diminished value to consumers because of the information it does not contain. The Committee submitted that the SIS is in need of review and should be replaced with a new version which is compatible with current practices, including full and accurate disclosure of essential facts.

⁴³ See www.privatehealth.gov.au/faq/sisguide.htm for a detailed explanation of what SIS entail and relevant brochures demonstrating what SIS look like and how information is presented.

A number of stakeholders also submitted that the legal requirement to provide a copy of the SIS to policy holders annually was confusing for consumers and not of any real value. It was argued that this requirement should be replaced with a more tailored or innovative form of communication.

The Colmar Brunton quantitative research showed that 76 per cent of consumers read at least one piece of information about their private health insurance. However, while most consumers read website summaries, few read the SIS.⁴⁴

Future of the SIS

Based on the research and submissions outlined above, it appears that the SIS alone does not provide sufficient information for consumers to understand the key benefits and limitations of their policies. The concerns highlighted in submissions suggest a need for a complete review of the role of the SIS. This should include exploring incentives to encourage consumers to read the document and use it to compare private health insurance products.

While a number of stakeholders suggested the current SIS was not adequately flexible to reflect current policies, any review needs to balance the requirements of clear comparable disclosure with flexibility. Where the presentation of information is highly flexible and not sufficiently standardised, consumers may be unable to make meaningful comparisons.

There is a need to work towards a consistent level of information and terminology to assist consumer understanding and awareness of conditions associated with their private health insurance policy.

44 81 per cent of consumers surveyed did not read the SIS after purchase, 6 per cent read the SIS but did not understand it and 13 per cent read and understood the SIS.

5. Communicating policy changes

5.1 Requirements to communicate policy changes

Insurers often vary their policies to change the procedures and benefits that are included and excluded. Insurers also change the arrangements that they have in place with third parties. Many of these changes have the potential to cause detriment to policy-holders.

Under the Private Health Insurance Act any proposed change to an insurer's rules that is or might be detrimental to the interests of an insured consumer must be communicated in a reasonable time before the change takes effect. In addition, insurers have an obligation to provide their members with an updated SIS where policy changes are made as well as to provide a copy of the current SIS once every 12 months.

The Private Health Insurance Act does not stipulate how changes to insurer rules are to be communicated, what amounts to detriment or what is a reasonable time. However, the Private Health Insurance Code provides a definition of significant detrimental changes to hospital policy benefits.

The Private Health Insurance Code stipulates that consumers should be provided with 30 or 60 days written notice depending on the nature of the change. While the Code acknowledges that changes to fund/hospital contracting arrangements can affect a consumer, the Code does not include any requirement for notification in these circumstances.

Stakeholders raised some concerns with the way in which policy changes are communicated. The Australian Diabetes Educators Association submitted that consumers only receive written communication; the information does not cater for all literacy levels and that consumers do not understand how the changes affect their current policy.

Similarly, the Obesity Surgery Society of Australia and New Zealand (**OSSANZ**) submitted that in 2014, a number of insurers made changes to policies relating to bariatric surgery, as well as orthopaedic, cardiac and reconstructive plastic surgery procedures. This forced members to pay additional premiums for the highest level of cover or else to join extensive public hospital waiting lists to undergo potentially life-saving surgery, including bariatric procedures. OSSANZ advised that their surgeons reported that patients were surprised and aggrieved by these policy changes and felt that these changes were not adequately communicated.

The PHIO has also noted that consumers are not always aware that changes, such as removing coverage for procedures, can be made to their policy as consumers do not always carefully read policy documents that are sent to them by their insurer. Although the onus is on the consumer to read important information, insurers also have an obligation to ensure they communicate clearly to consumers. This will encourage consumers not to overlook important information and aid their understanding.

PHIO received 72 complaints about rule changes in the relevant period, up from 41 rule change complaints in 2012-13.⁴⁵ The most common complaints concerned changes to hospital policies, where the number of services covered by a policy was reduced by one or more services.

The PHIO noted that giving adequate notice to consumers is an important obligation for insurers, as it provides an opportunity for consumers to transfer to a different policy if he or she wants to maintain cover for a benefit that would otherwise be reduced or removed.⁴⁶

The ACCC's engagement with stakeholders identified that there is some obscurity about whether the obligation to notify of changes cover instances where an insurer changes its arrangement with service providers such as hospitals and specialists, but there is no consequential change in the terms and conditions of the policy. Stakeholders suggested that

⁴⁵ PHIO, *Annual Report 2013-14*, p. 34.

⁴⁶ *Ibid.*

since a change in the arrangements does not necessarily cause a change in the terms and conditions of the policy (namely the insurer's rules), such information may not necessarily need to be communicated under the Private Health Insurance Act. There were concerns raised that some practices that are distinct from changes to rules, terms and conditions, may nevertheless lead to out-of-pocket costs and be detrimental to consumers, and therefore ought to be communicated.

Example

The ACCC has been made aware that a particular insurer has recently made a change to its contractual arrangements with particular providers. This meant that it would no longer cover the full cost of a range of services provided by the provider and as a result consumers would receive a reduced benefit. This change was not communicated to policy holders.

5.2 Policy changes and consumer protection laws

Insurers have a key role in ensuring that consumers are informed about changes that impact their insurance policies. There are concerns about the adequacy of the current requirements and the practices of some industry participants who take a minimal approach to compliance. It appears that many insurers do not notify consumers of changes that fall outside the Private Health Insurance Act or Code, even though these changes may negatively impact consumers. This includes changes to contracts between insurers and health providers that may result in higher out-of-pocket costs for consumers.

Compliance with the Private Health Insurance Act and/or the Code does not, of itself, necessarily result in compliance with the ACL. In some circumstances, failing to inform consumers about policy changes can amount to false, misleading or deceptive conduct.

5.3 Methods of communicating policy changes

Given the absence of any mandated method of communicating policy changes to customers under the Private Health Insurance Act, the method is generally at the discretion of the insurer. Insurers currently have a range of processes for providing such information.

The quantitative research found that 60 per cent of respondents received information about policy changes by letter and 33 per cent by email. A small number of customers recalled receiving this information through their SIS, a phone call or SMS.

While the law requires communication of changes to policy terms, it is best practice for insurers to also communicate changes to insurer practices or arrangements to clearly inform consumers of matters that may impact their out-of-pocket costs or choices of health care.

As noted by the PHIO in its 2013-14 Annual Report, it is also important for insurers to communicate any reduction in coverage in clear and unambiguous language, without diluting the message by interspersing unrelated promotional material.

6. Resolving problems with private health insurance

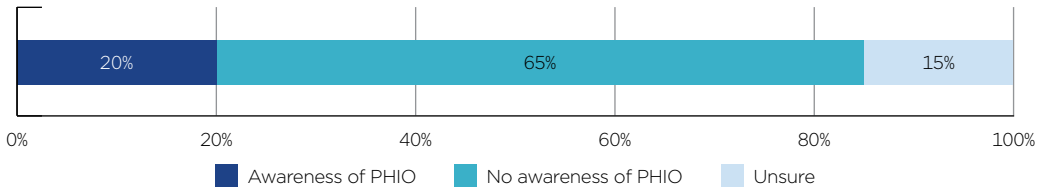
It is clear from stakeholder consultation that some consumers experience problems with their private health insurers and make complaints. Generally consumers will not be aware of a problem until they seek to make a claim, and many consumers do not frequently access health care and make claims.

When consumers do experience problems, some of the most commonly experienced relate to claim amounts, processes and inaccurate information.

When these types of problems arise, resolving them can be difficult and time consuming. For example, as outlined in the Australian Hand Therapy Association’s (AHTA) submission, insurers’ PDS may advise consumers to contact their insurer to determine if a particular device is approved or eligible for a rebate. When consumers contact their insurer to seek a determination on this issue, the process is often time consuming and does not always immediately resolve their enquiry. Similarly, the APHA advised that if a patient’s admission to hospital is lengthy and complex, it may take a long time for insurers to get the claim sorted for the consumer.

The quantitative research indicated that while PHIO was the key complaints organisation, most consumers had no awareness of that agency. The ADA also expressed the view that it is likely a large proportion of complaints are not lodged with PHIO, and this may be because consumers are pessimistic about how adequately their problem will be addressed and resolved.

Figure 3: Awareness of PHIO



From July 2015, the role of the PHIO was transferred to the Commonwealth Ombudsman.

7. Other concerns identified by stakeholders

The Senate order requires the ACCC to report on anti-competitive or other practices which increase consumers' out-of-pocket medical and other expenses and reduce the extent of consumers' health cover. This section summaries other issues identified by industry, not directly related to this year's focus on information provided to consumers. We are carefully reviewing these concerns in line with our *Compliance and Enforcement Policy*.

7.1 Preferred providers

Concerns were raised by a number of industry associations that the quality of service provided to consumers is being compromised. This is as a direct result of:

- consumers being led to believe that preferred providers offer a better service or an exclusive product when this is not necessarily the case
- consumers being directed to preferred providers because the service may be cheaper but the practitioner may not be as qualified or offer the appropriate quality of service that the consumer requires.

Questions were raised about whether the preferred provider scheme impacts freedom of choice for consumers.

Several dentists expressed concern about being forced to become preferred providers in order to retain their patient base. They also advised that in some situations where they may be interested in becoming preferred providers, some insurers were not accepting any more providers and had 'closed their doors'.

Concerns were also expressed about preferred provider schemes having the potential to disadvantage policy holders from rural/remote areas who pay the same premiums but may receive lower benefits for comparable services because they have less choice, resulting in greater out-of-pocket expenses.

7.2 Fund owned clinics

The ACCC was advised of concerns about clinics which are owned and run by the health fund. This was especially concerning where the health fund redirects customers to these clinics. Allegations were made that this could restrict consumers' freedom of choice, compromise the quality of service being provided and result in anti-competitive conduct.

7.3 Limited coverage of services

There are several service providers who believe the lack of recognition of their profession by insurers is unwarranted and in some cases anti-competitive. The increasing trend of exclusionary policies by insurers further adds to this concern. Specific concerns include:

- The lack of recognition of counsellors and psychotherapists. The majority of psychology consultations for which rebates are paid are consultations for counselling/psychotherapy provided by psychologists.
- Private health insurance rebates for psychology are usually available only through premium health insurance policies. This limits access to rebates for psychological treatments to those with the means to purchase these premium policies.
- The intention of the Podiatric Surgery and Other Matters Bill 2004 was to ensure that admitted private patients being treated by an accredited podiatrist are able to access

benefits, under an applicable benefits arrangement, for the hospital treatment costs as they would if a medical practitioner provided a professional service. The intention of the bill has not been followed by the majority of health insurers' and it is alleged that the refusal of insurers' to follow this represents anti-competitive behaviour. This results in a large discrepancy of out-of-pocket expenses between services provided by podiatric surgeons as compared to orthopaedic surgeons.

- In 2014, a number of insurers began forcing their higher-risk members to pay additional premiums for the highest level of cover to undergo potentially life-saving surgery, including bariatric procedures.
- The clinical services of orthotists are often unrecognised by health funds whilst the same services by other types of providers are extensively supported. It is alleged that this distinction is unjustified, places orthotists at a competitive disadvantage, and negatively impacts on consumers who are denied the right to select their preferred health care provider. This concern also extends to assessment and reviews.
- Concerns were expressed about the two different models of perfusionists—clinical and medical. This has historically created a two tiered, anti-competitive system, which allows medical perfusionists (doctors) to collect a rebate from the MBS for the service of 'cardiopulmonary bypass' but not clinical perfusionists who routinely undertake the same service.
- Concerns about poor coverage for preventative dental care, specifically dietary advice and oral hygiene instruction, which are a vital service that educates people in the skills necessary to maintain oral health.
- Only a small number of private health insurers officially recognise and provide rebates for credentialed diabetes educator services, which is an essential service for many consumers—more and more people are turning to the public health system for this service.
- Some insurers do not pay psychiatrists for Medicare items regarding case conferencing, which is essential to the safe and effective discharge of complex patients.

7.4 Prostheses

Several submissions have advised that there should be an urgent review of the supply of prostheses in the private health system. Several allegations were made of anti-competitive and ethically questionable 'rebating' arrangements reached between prostheses manufacturers and private hospitals.

7.5 Cost of private health insurance

Concerns have been expressed about the continued increase in premiums, coupled with an increase in policy exclusions and no relief from a change in eligible rebates. Consumers are concerned about the rising cost making private health insurance less affordable. As a result some consumers are either opting out of private health insurance altogether or reducing their policy coverage and increasing the risk of out-of-pocket expenses.

The strict rules around the LHC loading are creating considerable expense for consumers and imposing a disincentive to take out private health insurance later in life. This is particularly the case for people who become unemployed, are self-employed, and those with casual jobs who may have to lapse private health insurance during hard times because they just cannot afford it.

As a result more people may be relying on the public health care system for their procedures, even if they have private hospital cover, because it is cheaper and/or their policy excludes their procedure.

This issue has also been covered in the report from the perspective that it affects consumer choice and can ultimately lead to unexpected out-of-pocket expenses.

7.6 Insurer behaviour toward providers' level of service

The ACCC was advised that health providers feel pressured by insurers to limit the level of service accessible to patients through the use of 'take it or leave it' contracts, preferred provider schemes and audits. It is alleged that insurers have been marketing increased annual benefit limits but then implementing processes to pressure providers into not providing 'too many' services, or more costly services, regardless of patient need.

7.7 Second-tier default benefit system

Considerable concern has been expressed about the second tier default legislation in its current form. It is alleged that the system is burdensome on insurers and distorts normal market dynamics, ultimately affecting service and pushing up the price of premiums for consumers purchasing private health insurance.

The ACCC has been advised that there has been a trend not to negotiate contracts with new day hospitals which is increasing gaps payable by consumers.

7.8 Private patients in public hospitals

It has been alleged that public hospitals are becoming increasingly active in pressuring patients to use their insurance in a public hospital. What apparently originated as an issue confined to a small number of hospitals is now evolving into standard practice across public hospitals. There are many incentives in place for public hospitals to persuade patients to elect to be treated as private patients.

7.9 Funding model for inpatient admissions and interstate coverage

The submissions expressed concerns about funding models between insurers and health providers that result in restrictions on private health insurance usage across different states. This can force consumers to remain without care or default to the public system. Under this model insurers provide a specific amount of funding to health providers for particular care, such as private psychiatric care, based on their members' previous use over a given period. The health care provider can utilise the funding for whatever purpose so long as it does not ask for additional funding. As a result of this arrangement, if a consumer living in that particular state, where this funding agreement has taken place, wishes to access specialist interstate services, the consumer is informed that they cannot do so and coverage is only provided in the state they reside in.

7.10 Frustration of the transfer process from one insurer to another

The ACCC has been advised that there are a select number of insurers who appear to be deliberately frustrating the transfer process for consumers who elect to change insurers. This involves the insurer not providing the certificate within the legislated 14 days, if at all. It was alleged in many cases the consumer will cancel the new policy and remain with the old insurer, simply because 'it's easier'. This results in the consumer remaining on a policy that is not ideally suited to their needs and/or budget.

It was also alleged, that due to the lack of appropriately enforced laws governing the transfer of consumers between health funds, the current transfer process can be lengthy, confusing and costly for consumers and serve as a significant barrier to transfer between insurers. It was further alleged that this dynamic is artificially constraining healthy competitive market behaviour.

Concerns have also been expressed about the use of customer retention teams by some insurers to try to convince consumers not to switch insurers and remain with their current insurer.

8. Findings and stakeholder suggestions for change

The ACCC considers there to be three key concerns arising from its research on the private health insurance industry:

- First, there are market failures due to asymmetric and imperfect information. This leads to complexity in private health insurance policies, which reduce consumers' ability to compare policies and make informed choices. Further, consumers have limited information about their likely future health needs, which may lead to consumers underestimating their future medical needs and instead focusing on the immediate costs and benefits of private health insurance.
- Second, existing regulatory settings can change consumers' incentives in purchasing private health insurance and drive insurers to offer products to primarily reduce consumers' tax liabilities, rather than also focussing on consumers' current and future medical needs (which are difficult to predict). As funds respond to market demand for affordable policies, there are increasing policy limitations and exclusions leading to higher numbers of consumers having policies with less cover than they expected. This leads to an increased risk of consumers facing unexpected out-of-pocket expenses and general dissatisfaction with the system. We accept that some consumers in purchasing private health insurance may only be seeking to reduce their tax burden and/or the risk of the LHC loading. However, they still expect basic cover from their purchase.
- Third, while health insurers may be strictly compliant with the requirements of the Private Health Insurance Act and the Code, the research has revealed examples where representations by insurers to consumers, including when entwined with policy variations, may be at risk of breaching the consumer laws.

The ACCC enforces competition and consumer law; it is for others to ensure that the regulatory settings are fit for purpose. This report shows though, that there is a market failure in the private health insurance sector and, while many attempts have been made to address this in the past, more is needed if consumers are to have the information they need to make informed choices and allow for effective competition between health insurers.

As is clear from the report, the regulation of the private health insurance sector involves a complex array of legislation and co- and self-regulation. This report has aimed to highlight consumer and stakeholder concerns with the current system; it does not provide a road map for reform (which could be approached by industry driven changes, such as through the Private Health Insurance Code⁴⁷ or by changes to private health insurance legislation). Nevertheless, stakeholders repeatedly made a number of suggestions that should be highlighted. They include:

- Review of the SIS requirements to ensure they serve their purpose as an effective information and comparison tool, with a focus on balancing comparability and thoroughness without overwhelming consumers. Modern technology may help here.
- If reform of the SIS is to occur the ACCC would recommend that any proposed reforms be consumer tested through a pilot study before being finalised. Such a review should also look at the best means of providing the SIS to encourage consumers to read it.
- Standardisation of terminology used in promoting policies and describing levels of coverage and specific procedures. For example, standardisation around terms such as 'known gap' and 'no gap' policies, top, medium or low cover and a consistent definition of procedures such as 'plastic and reconstructive surgery' so it is clear what the inclusions and exclusions of policies are.

⁴⁷ The ACCC notes that the Private Health Insurance Code is currently up for review with a proposed implementation date in July 2016. As a 'living code' this is the sixth version since its introduction in 2005 and will aim to include input from industry as well as various government agencies that are impacted by the Code.

- Review of the requirements for minimum policy coverage given the growth of restrictions and exclusions.
- The functionality and promotion of www.privatehealth.gov.au. This is a valuable and independent site and the one place where all private health insurance policies can be compared. With the Commonwealth Ombudsman recently taking over responsibility for the site, an investment in improving its functionality to enable consumers to compare on factors beyond price would be beneficial. Benefits would also flow from better promotion of the site to consumers.
- Review of the triggers for requiring insurers to inform consumers about any changes that may affect their out-of-pocket expenses or choice of hospital or practitioner and how these changes are communicated. As with any changes to the SIS, the ACCC would recommend that any review should also look at the most effective ways of communicating this information and run a pilot to test effectiveness prior to making formal changes.
- Considering how consumers can more easily calculate their likely out-of-pocket expenses before committing to a policy and/or procedure. Intelligent, interactive tools should be considered to assist with this. Stakeholder submissions⁴⁸ raised suggestions that could be explored to advance this goal, including:
 - health providers/practitioners providing standardised cost estimates to consumers that include specific information such as MBS item numbers for each part of the procedure
 - health providers/practitioners providing average or maximum rates for all procedures for the MBS item numbers covered
 - insurers providing a detailed and easily searchable schedule of benefits and services they cover, including specific details about MBS item numbers, eligible aids/appliance, inclusions and exclusions, health practitioners eligible to provide services and referral requirements and item limits.

Role of the ACCC

Insurers and health providers/practitioners are subject to the CCA and need to understand their obligations to avoid breaching the law. The ACCC has identified competition and consumer issues in the health and medical sector as a priority area for 2015 in its *Compliance and Enforcement Policy*. We will consider conduct by health insurers that may contravene the CCA in line with this policy.

The ACCC will also consider preparing appropriate information to empower consumers and increase awareness within the private health insurance industry.

Industry participants, consumers or representative groups may wish to draw our attention to claims or practices that they consider particularly problematic.

⁴⁸ See appendix A for a list of publically available submissions or visit <https://consultation.accc.gov.au/ipil/phireport-2014>.

Appendix A—Research and submissions

Consultation and research

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

We received a total of 50 submissions to the report. A list of public submissions is provided below and links to each submission are available on our website at www.accc.gov.au/phireport. We would like to thank stakeholders for their time in making a submission to the report.

The ACCC also conducted research, including its own review of insurers' websites and engaged Colmar Brunton to conduct a survey exploring the relationship between consumers, information provision and the PHI industry.

The research consisted of:

- A quantitative online survey with people who have PHI
From 25 March to 7 April 2015, a 10 minute online survey was conducted with members of the general public who currently have PHI. 1909 people were surveyed and 1004 surveys qualified for completion. The survey consisted of a series of questions, broken up into nine parts reflecting the consumer journey when purchasing and using PHI.
- Qualitative online focus groups
Following the quantitative online survey of consumers with PHI, two online focus groups were undertaken with participants, recruited on the basis of their responses to the online survey. The groups were as follows:
 - those who have experienced occasions where their expectations were not met after accessing their PHI
 - those who compared policies (including both those who were satisfied and those who experienced challenges) either via a comparison website, or did their own comparisons.

Groups were mixed where possible in terms of participants' length of time with PHI, type of PHI, age and gender. Fieldwork was conducted on the evening of Thursday, 7 May 2015, at 5.30 pm and 7 pm AEST.

The full report of this research is available on our website.

Invitation letter

3 December 2014



**Australian
Competition &
Consumer
Commission**

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Dear Stakeholder

Re: ACCC Report to the Senate on PHI

The Australian Competition and Consumer Commission (ACCC) is commencing preparation of its annual report to the Australian Senate on anti-competitive and other practices by health funds and providers in relation to PHI for the period 1 July 2013 to 30 June 2014.

The Senate requires the ACCC to provide an annual assessment of '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 ACCC is inviting stakeholders to provide input into any current or emerging anti-competitive or other practices observed in this industry.

The ACCC has already identified that it will examine issues relating to the level of transparency, accuracy and consistency of information about PHI and the impact it may have on consumers and competition more broadly. It is considered that the complexity of PHI products may impact consumers' ability to make informed decisions about PHI and health care.

While recognising that there are some legislative requirements around information provision, such as standard information statements, the ACCC is interested in understanding whether there are particular problems relating to information provision in this industry. This includes examining the role of insurers, health providers and intermediaries in assisting consumers to understand their policies and make informed decisions about accessing health services that best suits their needs.

Consumers may seek (or be provided with) advice or information relating to PHI at several stages, for example, when:

- comparing, choosing and signing up to a PHI policy
- seeking to transfer, or switch, to another insurer
- choosing and accessing health care and utilising benefits they expect to be available under a policy
- determining the cost, gaps or rebates that may be applicable or have been paid under a policy
- being informed of policy changes and how these may impact the policy and their future or existing health care needs
- making a complaint about an aspect of their insurance policy or health care options.

It is intended that the report will consider whether insurers and other participants' practices may be impacting the ability of consumers to make informed decisions when purchasing and comparing PHI, or accessing particular products or services under their existing policies. This includes examining whether current practices may lead to unexpected costs for consumers or limit their access to, or choices of, health care.

Specifically, the ACCC is interested in determining:

- whether consumers are able to clearly understand:
 - the extent of coverage under their own or different policies, and
 - the impact of exclusions, excesses and gaps that apply to policies
- whether the provision of information is sufficiently clear, transparent and consistent to minimise the risk of unexpected costs, or reduce barriers to accessing health care.

In order to help us prepare this year's report, we would appreciate your views on the following issues:

Private health insurers and policies

- What do you think are consumers' experiences in relation to accessing accurate and complete information about their existing policy or new policies? Please provide details.
- Do you think consumers are experiencing difficulty understanding their policies, products and services? For example, understanding the extent and impact of inclusions and exclusions. If so, what steps are being taken or could be taken to improve consumer understanding?
- Is there sufficient transparency and/or consistency regarding the features of PHI policies to enable consumers to make informed decisions and choices about their health care and be able to compare policies?
- Are you aware of situations where as a result of advice or information provided, consumers have:
 - experienced difficulty choosing the right cover for their circumstances?
 - been misled about the benefits and inclusions of their policy, e.g. the preferred providers included, which procedures are covered or the expected cost?
 - experienced bill shock?
 - been discouraged from switching providers?

Please provide details.

- Do you have any suggestions for how information could be simplified or made more accessible to assist consumers to better understand the terms and conditions of policies?

Third parties, intermediaries and technology

- Are there any problems arising from advice or information provided by health providers or intermediaries, particularly in relation to access to services, coverage, costs or gaps?
- What is the role of new technologies in information provision in this industry?

Policy changes

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

Complaints/concerns

- If you are a health insurer or consumer organisation could you provide us with information about complaints and/or concerns you receive relating to information provision and advice, for example:
 - number or frequency of such complaints
 - main causes of these complaints, and
- how you address these complaints.
- Are these complaints changing over time and if so, how?

Other issues

- Any other issues you wish to raise.

Making a submission

This year submissions can be made in the following ways:

- Online at <https://consultation.accc.gov.au/ipil/phireport-2014>, or
- Send your submission to Jayde Richmond, GPO Box 520, Melbourne Vic 3001.

Submissions are welcome by **Friday 30 January 2015**.

Similar to last year, we strongly encourage you to provide your responses online. This will also ensure that you can manage the submission process in relation to privacy and confidentiality, and will ensure that you receive an acknowledgement that your submission has been received.

The ACCC will table the final report in the Senate and communicate its findings to stakeholders and the general community as soon as practicable after submissions close.

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

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

Yours sincerely



Kim Parker

General Manager

Australian Competition and Consumer Commission

List of publicly available submissions

Australasian College of Podiatric Surgeons
 Australian Dental Association
 Australian Diabetes Educators Association
 Australian Hand Therapy Association Inc.
 Australian Holistic Healers Counsellors Association
 Australian Medical Association
 Australian Orthotic Prosthetic Association
 Australian Society of Anaesthetists
 Australian Society of Plastic Surgeons Inc.
 Christina Louise Morris—Cottesloe Dental
 Consumers Health Forum of Australia
 Dental Hygienist's Association
 Dr Guy Wright-Smith
 Help Me Choose
 Medibank
 Newcastle Division Australian Dental Association
 Obesity Surgery Society of Australia and New Zealand
 Optometry Australia
 Optometry Australia, Australian Dental Association and Australian Physiotherapy Association
 joint submission
 Private Health Insurance Code of Conduct Committee
 Private Health Insurance Intermediaries Association
 Psychotherapy and Counselling Federation of Australia
 Royal Australian and New Zealand College of Ophthalmologists
 Royal Australian and New Zealand College of Psychiatrists
 Serge—self-employed dentist

Appendix B—Overview of private health insurance industry regulatory framework

Legislation	Purpose
Private Health Insurance	
<i>Private Health Insurance Act 2007</i>	<p>This is the primary legislation governing the private health insurance industry and has the following functions:</p> <ul style="list-style-type: none"> • sets out the rules governing private health insurance policies • imposes requirements about the conduct of health insurance business • provides incentives for people to have private health insurance • details the powers and functions of the regulators in the private health insurance sector.
Insurer Obligations	
Private Health Insurance (Health Benefits Fund Administration) Rules 2007	<p>Specifies requirements for the operation of health benefits funds, including asset usage, restructures, and mergers and acquisitions. The rules also establish risk equalisation jurisdictions and establish solvency and capital adequacy standards.</p>
Private Health Insurance (Insurer Obligations) Rules 2009	<p>These Rules establish prudential standards for private health insurers including: governance, appointed actuary requirements, reporting, disclosure and outsourcing requirements. A breach of a prudential standard is a breach of a Council-supervised obligation. This may trigger the Council's enforcement powers.</p>
Private Health Insurance Administration Council	
Private Health Insurance (Council) Rules 2007	<p>These rules relate to the public information functions of the PHIAC and the periods of appointment for the Commissioner of Private Health Insurance Administration, Deputy Commissioner and members of the Council.</p>
<i>Private Health Insurance (Council Administration Levy) Act 2003</i>	<p>This Act provides for the Minister to make rules to specify the rate of the Council Administration Levy. This levy is imposed on insurers to meet the general administration costs of the Council.</p>
<i>Private Health Insurance (Collapsed Insurer Levy) Act 2003</i>	<p>This levy may be imposed to meet a collapsed insurer's liabilities to policy holders that it is unable to meet itself.</p>
Private Health Insurance (Levy Administration) Rules 2010	<p>Deals with the administration of private health insurance levies.</p>
Private Health Insurance (Council Administration Levy) Rules 2007	<p>Deals with the calculation and collection of the Council Administration Levy.</p>

List of acronyms and definitions

ACCC	Australian Competition and Consumer Commission
ACL	Australian Consumer Law, Schedule 2 to the CCA
ADA	Australian Dental Association
AMA	Australian Medical Association
AOPA	Australian Orthotic Prosthetic Association
APHA	Australian Private Hospitals Association
ASA	Australian Society of Anaesthetists
ASPS	Australian Society of Plastic Surgeons
Bupa	BUPA Australian Holdings
CCA	<i>Competition and Consumer Act 2010</i> (Cth)
CHF	Consumer Health Forum
DoH	Department of Health
hirmaa	Health Insurance Restricted and Regional Membership Association of Australia
LHC	Lifetime Health Cover
MBS	Medicare Benefits Schedule
Medibank	Medibank Private
OA	Optometry Australia
OSSANZ	Obesity Surgery Society of Australia and New Zealand
PDS	Product Disclosure Statement
Private Health Insurance Act	<i>Private Health Insurance Act 2007</i> (Cth)
PHIAC	Private Health Insurance Administration Council
Private Health Insurance Code	Private Health Insurance Code of Conduct
PHIA	Private Health Insurance Intermediaries Association
PHIO	Private Health Insurance Ombudsman
RANZCP	Royal Australian and New Zealand College of Psychiatrists
SIS	Standard Information Statement
Comparator report	The comparator website industry in Australia: An ACCC report
Submissions	Submissions received in relation to this report
Quantitative research	Consumer survey conducted by Colmar Brunton for the ACCC
Qualitative research	Consumer focus groups conducted by Colmar Brunton for the ACCC

ACCC contacts

ACCC Infocentre: business and consumer inquiries: 1300 302 502

Website: www.accc.gov.au

Translating and Interpreting Service: call 13 1450 and ask for 1300 302 502

TTY users phone: 1300 303 609

Speak and Listen users phone 1300 555 727 and ask for 1300 302 502

Internet relay users connect to the NRS (see www.relayservice.com.au and ask for 1300 302 502)

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