choice

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PRIVATE HEALTH INSURANCE

Submission to the ACCC on its report to the Senate on private health insurance

ABOUT US

Set up by consumers for consumers, CHOICE is the consumer advocate that provides Australians with information and advice, free from commercial bias. By mobilising Australia's largest and loudest consumer movement, CHOICE fights to hold industry and government accountable and achieve real change on the issues that matter most.

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CONTENTS

INTRODUCTION 3
Junk health insurance policies 3
Early release of health insurance data and publishing premium increases 5
Comparing and understanding policies 5

INTRODUCTION

CHOICE appreciates the opportunity to provide the following comments to the ACCC, to help inform its report to the Senate on private health insurance.

CHOICE is concerned about several trends in the private health insurance market:

- The 48.3% cumulative rise in premiums since 2009, including the 5.59% increase in 2016-17;
- The emergence of 'junk' policies, such as accident-only cover, covering less than 1% of services available in hospitals, yet eligible for the Private Health Insurance Rebate and exempting policy holders from the Medicare Levy Surcharge; and
- The growing information asymmetry between consumers and industry, including in relation to the actual fees charged by doctors and benefits provided by insurers, the size of annual premium increases, and the capacity for consumers to make easy and meaningful comparisons between products.

  In this submission, CHOICE outlines issues we have identified when examining the health insurance market that the ACCC should take into consideration when preparing reporting to the Senate.

Junk health insurance policies

Several funds offer policies with restrictions and even exclusions for the vast majority of treatments with little benefit above what is already provided through Medicare. In many cases junk policies cover less than 1% of the services available in hospital, and exclude treatment for the most common serious illnesses. The benefits they do provide are in many cases questionable, for example emergency surgery that would almost always be carried out in a public hospital, accident cover that expires before treatments are finished and the surgical removal of wisdom teeth that could be cheaper if performed by a dentist.

CHOICE has found a number of hospital policies that provide bad value for consumers, including policies that only provide cover for a very small number of procedures such as accidents, wisdom teeth removal, appendix surgery, knee investigations and reconstructions, but exclude all other services and illnesses. Examples include[1]:

[1] Note that premiums vary between states – the lowest premium usually applies to NT, the highest normally to VIC, NSW or QLD.

- Australian Unity Basic Hospital, from $1500 to $2260
- Defence Health Essentials Hospital, from $1475 to $2210
- HIF Gold Vital, from $1090 to $1700
- Medibank Young Hospital, from $1235 to $2410
- NIB Basic Hospital, from $1540 to $2060.

It's important to note that there are more comprehensive and more affordable policies in the market than the 'junk' options identified above. I.e. consumers are able to get more coverage for a lot less.

CHOICE has also found some policies that offer cover for accident and ambulance only, with all other services and illnesses excluded. These include:

- HCF Accident Hospital Only Cover, from $770 to $2140
- Medibank Accident Cover, from $1190 to $2310

The benefits these health policies provide consumers with are in many cases questionable. For example, emergency appendix surgery that would in the great majority of cases be carried out in a public hospital, accident cover that can expire before treatments are finished and the surgical removal of wisdom teeth that might be cheaper if performed by a dentist.

These policies have emerged in response to a market distortion caused by the Medicare Levy Surcharge and Lifetime Health Cover, leading consumers to purchase products that offer negligible benefits to their own health care, to the public health system and to the community more broadly, in order to achieve some tax benefits. In many cases, these policies are not even the cheapest available, and are marketed in ways that would lead consumers to expect they have greater coverage than is the case.

Expenditure through the Private Health Insurance Rebate is inefficient, because consumers with these policies will almost always be dependent on the publicly funded system for hospital treatment despite the fact that they receive the rebate. The only beneficiaries of this situation are the private health funds that market these junk policies.

There is a case for excluding junk policies from the Private Health Insurance Rebate and/or applying the Medicare Levy Surcharge to consumers who hold them. This should not be approached as simply a savings measure, but as a means of increasing the value of private health insurance, and making quality health care more accessible and affordable for all Australians.

Early release of health insurance data and publishing premium increases

Health insurance premium increases are approved between December and March each year but new policy information is not available to consumers until 1 April, the day the premium increases take effect. If privatehealth.gov.au released data on the day after the announcement of the increase in premiums, consumers would have a reasonable window to compare policies and find a better deal before the premium increases take effect. This would also increase competition between health insurers and could in turn put downward pressure on premium increases.

Individual insurers are also not required to clearly communicate the effect of premium increases to consumers. Insurers should be required to publish the size of annual premium increases on any renewal or premium change letters sent to consumers, stating the increase as both a percentage and in dollar terms. This would encourage more consumers to actively seek out a better deal.

Comparing and understanding policies

Health insurance policies have become far more complex than when the Standard Information Statement (SIS) was first developed. For this reason, a review of the SIS, including consumer testing, should be undertaken to ensure the value of policies is better communicated through these documents. For example, the SIS should clearly indicate to a consumer whether a policy excludes nearly all treatments. The SIS should also be displayed prominently on every health fund's website. At present, not all insurers make it easy to find - if it can be found at all.

CHOICE's research shows that Australian consumers perceive the health insurance market to be extremely complex, while also believing there are significant potential benefits from switching. Despite this, switching rates among existing policy holders are very low. The only site where consumers are able to compare all available policies is privatehealth.gov.au. However, consumer use of this site appears to be limited, either because of a lack of awareness or ease of use.

Other sites such as iSelect.com.au and CompareTheMarket.com.au compare only a fraction of policies and cannot be considered independent due to the influence of commission arrangements. Consumers need greater independent assistance to understand and select the best policy for their requirements; to easily assess the value for money of their existing policy

compared to other policies; and switch to a better value deal if one exists. We recommend building these enhancements into privatehealth.gov.au or facilitating a new site that can achieve this.

As part of this, consumers need a one-stop-shop where they can access information about the actual fees charged by doctors and hospitals, and the benefit paid by insurers above the Medicare Schedule Fee. It's often very difficult for policyholders to anticipate their out-of-pocket costs, which are comparably high by international standards.

In addition to providing a better comparison website, other reforms need to be pursued to facilitate switching. Many consumers consider switching health insurance but get stuck in the process due to the complexity of policies and the difficulty of switching. Consumers need to get a number of documents from their old fund – a clearing certificate and claims statement - and forward them to the new fund.