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SUBMISSION TO SENATE INQUIRY INTO THE VALUE AND AFFORDABILITY OF PRIVATE HEALTH INSURANCE AND OUT-OF-POCKET MEDICAL COSTS

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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

CONTENTS

INTRODUCTION

"I am an anaesthetist in private practice. I know a fair bit about private health insurance. I tried to shop around for new health insurance for me and my family and I don't have a clue! If I can't tell then how can anyone else?"

Private health insurance has become a perfect storm for Australian consumers. Premiums have increased an average of 54.6% since 2009, well ahead of CPI. According to CHOICE's national Consumer Pulse survey, it is one of the hardest markets for people to find the product that best suits them.[1] This toxic combination of surging prices and complexity is leading many Australians to downgrade or drop their cover completely.

With rising premiums and out of pocket costs, consumers are increasingly questioning the value of their cover. Consumers are downgrading cover to manage these rising costs and are at risk of taking out very low value 'junk' policies that don't deliver good value to individuals or the Australian community. Some consumers are dropping cover altogether, leaving them at risk of never being able to afford private health insurance again if they are slugged with the lifetime health cover loading.

Those consumers who can afford private health insurance often find themselves saddled with unpredictable and high out of pocket costs when accessing the private healthcare system. Unexpected costs from surgeons and anaesthetists can total hundreds or thousands of dollars.

CHOICE believes there are steps that government can take to improve the experience of private health insurance for Australians. Some reforms are structural, touching on the blurry boundaries between public and private provision of healthcare, and radically simplifying the more-than-48,000 policies currently in the market.

Other changes are about providing significantly better information, learning from experiences in other 'perfect storm' markets like energy and banking, testing solutions, engaging in open data

[1] CHOICE's quarterly Consumer Pulse survey tracks cost of living concerns with a representative sample of Australian consumers.

discussions, and giving consumers easy access to their own data to help navigate complex choices in the purchase and switching journey.

Greater transparency of policy coverage and the cost of treatment and procedures in the private system will help reduce 'bill shock' and create a more competitive market. The confusion and complexity of the market has created poor demand-side competition and measures to address this will be crucial to creating a successful private health insurance market. This includes removing subsidies for products that provide little or no value to consumers and society as a whole, providing greater transparency on out of pocket costs, and helping consumers to understand their cover, compare it side-by-side and switch, upgrade or downgrade as needed.

While these measures to improve information and transparency in the private health insurance market may help drive competition and create a better market for consumers, there are problems in the private health insurance market that are best addressed structurally. Consumers seeking treatment, by their very nature of being in the healthcare system, are in a vulnerable position. They may be unable, despite best intentions, to 'shop around' and to fully understand the costs they may incur. Only structural changes to the way our system works, whether it is through changes to the lifetime health cover loading or by reining in the sometimes excessive out of pocket costs of medical procedures, will protect vulnerable consumers.

This submission draws on CHOICE's nationally representative survey data, user insights from CHOICE product testing for our online health insurance finder and over 1000 consumer submissions detailing real-life problems with the private healthcare market. The consumer submissions are attached as appendices to this submission, and illuminate the economic and emotional strain felt by consumers in this sector.

RECOMMENDATIONS

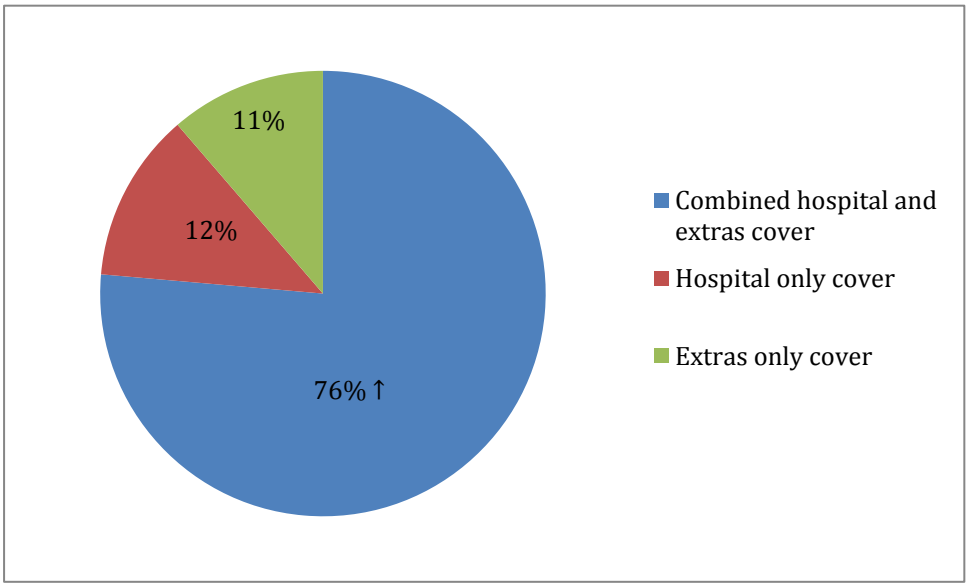
1. The Federal Government and Department of Health should take steps to promote greater transparency and comprehensiveness in third-party options for consumers to compare PHI. This could be progressed by:
    1.1. Making information about PHI policies more openly available so that third parties with new approaches and non-commission based business models can create solutions.
    1.2. Requiring third-party comparators to inform consumers in the transaction process how much of the market they cover and whether they receive commissions or other payments from funds.
2. More broadly, we encourage the Committee to consider the effect of different kinds of remuneration practices for third party comparison sites selling health insurance on consumer outcomes, noting the conflicts that can arise when staff are paid to sell certain kinds of policies or are paid to sell by volume.
3. The Federal Government encourages an open data approach in the private health insurance market.
4. To achieve this, consumer representatives, industry and government work together on a standard for data access and security requirements to ensure that sensitive data is protected but also able to be used by consumers for better comparison services.
5. Policy information continues to be proactively provided to consumers in a standardised, concise 'Standard Information Statement'
6. The current Standard Information Statement is improved through consumer testing.
7. Data on premium increases should be released publicly prior to premium increases taking effect, with enough time for consumers to compare and switch policies before April 1.
8. The Federal Government conducts economic analysis on the efficacy of Lifetime Health Cover loading as an incentive to take up private health insurance.
9. The Federal Government assess whether incentivising consumers to purchase low-value health insurance products which they are unlikely to use, and then making it more expensive to purchase useful policies in later life, is the most effective way to improve health outcomes for the community as a whole.
10. 'Junk' policies should not attract the Private Health Insurance rebate or exempt high income earning consumers from paying the Medicare Levy Surcharge.

11. 'Junk' policies that only cover treatment as a private patient in a public hospital should not attract the Private Health Insurance rebate or exempt high income earners consumers from paying the Medicare Levy Surcharge.
12. Insurers and general practitioners encourage competition in the market by empowering consumers to 'shop around' to reduce out of pocket costs for treatment in the private system, through better information. This would be enhanced through an open data approach where cost information was provided by specialists and insurers, directly to GPs.
13. Specialist average pricing is more transparent, and average prices for common procedures are publicly available online and over the phone to consumers requiring treatment.
14. Other measures to improve competition, such as bulk billing, are investigated in the inquiry.
15. The committee considers a range of measures to curb out of pocket costs, such as capping procedure costs.
16. A best practice 'informed financial consent' model is developed for specialists and hospitals to ensure private health insurance patients are fully informed of out of pocket costs in advance.
17. Ongoing support is provided for the ACCC and Private Health Insurance Ombudsman to continue undertaking enforcement work and dispute resolution.
18. Insurers must make sure their customers have received, acknowledged and understood any changes to their policy with adequate time.
19. Consumers are provided with this information for any policy or gap scheme changes in in formats that maximise their understanding (e.g. whether in writing, over the phone, website, via sms or a combination of channels, the outcome should be consumer acknowledgement and understanding of the changes).
20. Policy holders who have ongoing treatment in the private system through their private health insurance policy should be exempt from any changes to their policy until their treatment has ended.
21. This inquiry should review the value and options available in extras cover to better meet consumer demand and expectations of value.
22. Item limits should be clearly stated in insurers advertising and marketing materials.
23. Funds should make a full list of benefits for covered items available on their websites for prospective members.
24. The inquiry and the ACCC should investigate competition in preferred provider networks and fund-owned clinics

WHO HAS HEALTH INSURANCE AND WHY DO THEY HAVE IT?

More than 55% of Australians have some kind of private health cover.[2] Overwhelmingly, Australians with private health insurance have both combined hospital and extras cover, with smaller numbers of consumers having only hospital or extras cover.[3]

Graph: Types of health insurance held by Australian consumers



Consumers take out private health insurance for a variety of reasons, with the top two reasons being "cover for extras" (57%) and "peace of mind/as a security 'just in case'" (56%). Cover for pregnancy and birth related services were the least popular reason for taking out private health insurance.

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[2] As at June 2015, http://www.privatehealthcareaustralia.org.au/have-you-got-private-healthcare/why-private-health-insurance/

[3] CHOICE conducted a national survey of 1,027 Australian private health insurance policyholders in April 2017. The sample and online data collection was provided by an independent, accredited third party, The ORU. Quotas and weighting has been applied, ensuring the sample is reflective of the 2011 Census results by age and geographic location. Fieldwork was conducted from the 7th to the 12th of April 2017. All tables presented in this submission are of the sample N=1027 unless otherwise indicated.

Table: What are the key reasons consumers take out private health insurance?

Reason	%
Cover for extras	57%
Peace of mind/ as a security 'just in case'	56%
Avoid public hospital waiting lists	43%
Caring for my own wellbeing (and, if applicable, that of my family)	40%
Avoid paying extra tax (Medicare Levy Surcharge)	34%
Have a private room in a private hospital	32%
Have my choice of doctor	30%
Cover for specialists' treatments	28%
Avoid paying higher premiums after turning 31 (Lifetime Health Cover Loading)	24%
Cover for pregnancy and birth-related services	10%

Females were more likely to cite extras cover as the reason for taking out private health insurance. More than half of older Australians (56+) listed extras, peace of mind, avoiding waiting lists, caring for their wellbeing, private room, choice of doctor and cover for specialists' treatment. They were less likely to want health insurance to avoid paying extra tax, to avoid paying lifetime health cover loading, and, unsurprisingly, cover for pregnancy and birth-related services (0%). 55% of private health insurance holding households earning $150,000+ cited avoiding paying extra tax as their reason for taking out health insurance.

Table: What are the key reasons why you have taken our private health insurance? Results by individual and demographic.

	Row %	Cover for extras	Peace of mind/ as a security 'just in case'	Avoid public hospital waiting lists	Caring for my own wellbeing (and, if applicable, that of my family)	Have a private room in a private hospital	Have my choice of doctor	Avoid paying extra tax (Medicare Levy Surcharge)	Cover for specialists' treatments	Avoid paying higher premiums after turning 31 (Lifetime Health Cover Loading)	Cover for pregnancy and birth-related services
Gender	**Male**	51%	55%	42%	39%	34%	31%	36%	30%	23%	7%
	Female	61%	56%	43%	41%	31%	29%	33%	27%	25%	12%
Age	**18-30**	57%	49%	31%	39%	22%	21%	31%	17%	17%	14%
	31 - 40	46%	47%	30%	30%	22%	16%	42%	21%	32%	17%
	41 - 55	62%	61%	47%	42%	37%	32%	42%	28%	32%	6%
	56 +	66%	70%	67%	51%	50%	55%	20%	50%	12%	0%
PHI decision role	**Main / sole**	55%	54%	41%	38%	31%	28%	35%	28%	25%	9%
	Joint	61%	59%	46%	44%	35%	33%	34%	28%	24%	12%
Type of cover	**Combined hospital & extras**	62%	61%	48%	44%	37%	33%	38%	32%	27%	12%
	Hospital only	6%	46%	43%	26%	33%	35%	35%	19%	20%	7%
Household income	**Extras only**	77%	30%	8%	28%	3%	4%	12%	13%	9%	1%
	Under $50K	60%	61%	42%	44%	32%	36%	21%	33%	19%	4%
	$50-$150K	58%	53%	43%	39%	30%	27%	34%	27%	25%	11%
	$150K+	57%	57%	40%	37%	42%	33%	55%	25%	29%	20%

INFORMATION PROVISION IN PRIVATE HEALTH CARE

Consumers find their information on private health insurance from a variety of sources. Most commonly, consumers reported sourcing information on private health insurance from friends, family or colleagues (29%); this was followed by materials from their own health insurers (25%) and comparison website iSelect (25%).[4]

Table: Where do consumers get information about private heath insurance?[5]

	%
Family, friends or colleagues	29%
Material from your health insurer incl. print, online or over the phone information	25%
iSelect (iselect.com.au)	25%
Material from other health insurers incl. print, online or over the phone information	18%
Compare the Market (comparethemarket.com.au)	16%
The one page key factsheet (also referred to as regulated 'standard information sheet') from your health insurer	16%
Health insurer's store / shop	14%
The government's website (privatehealth.gov.au)	11%
Health Insurance Comparison (healthinsurancecomparison.com.au)	8%
CHOICE (choice.com.au)	7%
Choosi (choosi.com.au)	6%
Canstar, including the CANSTAR Star Ratings (canstar.com.au)	6%
Finder (finder.com.au)	3%
Private Health Insurance Ombudsman service	3%
Choosewell (choosewell.com.au)	1%
Other (please specify)	1%
Didn't seek out any information at all	18%

[4] CHOICE national survey on private health insurance
[5] CHOICE national survey on private health insurance

Consumer confusion: choosing a policy

The thousands of variations in health insurance products on the market make it difficult for consumers to judge and understand the value of the product they are purchasing. Complex jargon makes it challenging for consumers when reading, comparing and understanding their policies[6] and consumers lack the ability to efficiently compare across policies, because terminology used across insurers is not standardised.

> *"My wife is a doctor and we have two children. After having decided recently that we would not be having any more children we thought we would investigate if we could obtain a better rate from another fund as the Doctors fund does not let you separate maternity cover. We spent a few weeks doing so but we ended up very confused. Trying to find which [policy] is the best for the consumer is very difficult and the government needs to act."*

When consumers are unable to access relevant, consistent information between providers and policies, the task of comparing policies is made unnecessarily difficult and consumers cannot make informed decisions. Consumers are also purchasing policies that do not meet their needs, such as 'junk' insurance policies, which can lead to complications when a health problem arises and the policyholder is unable to receive and claim benefits for treatment.

Comparing policies

Consumers find it difficult to compare private health insurance policies at the point of purchase. CHOICE research into information provision in health insurance found that 44% of private health insurance policyholders said they found it difficult to compare policies, compared to only 28% of policyholders who said it was easy.[7]

Extras cover was the easiest policy type to compare, with 43% of individuals finding it easy to compare policies. It was significantly harder for individuals to compare hospital policies, with

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6 Consumer Health Forum of Australia, 2017. Media Release: Time for public listing for specialist fees: https://chf.org.au/sites/default/files/docs/20170306_time_for_public_listing_of_specialist_fees_final.pdf
7 CHOICE national survey on private health insurance

only 20% finding it easy. More people with combined hospital and extras (46%) and hospital cover (48%) found it difficult to compare policies compared to people who only held extras cover (25%).

Of those who found it hard to compare policies, the biggest issues were difficulties comparing policies side-by-side (69%), comparing out of pocket costs (54%), inconsistency of information from insurers (53%) and difficulty comparing extras rebates (53%).

Table: What consumers found difficult when comparing different health insurance policies.[8]

	%
Difficulties comparing policies side by side	69%
Difficulties comparing out-of-pocket costs if I were to go to hospital	54%
Information from insurers not set out consistently	53%
Difficulties comparing extras rebates	53%
Not all policies available for comparison	45%
Confusing terminology and language	43%
Unable to compare cover for specific health problems I'm worried about	39%
Unable to find independent information I could trust	36%
Too much information from insurers	25%
Difficulties comparing what I would save on tax or get from rebate	21%
None of the above	0%

These findings suggest that maintaining and improving a consistent layout of information will be critical for effective comparison for consumers wanting to switch cover, including consumers wanting to compare out of pocket costs, coverage and other benefits. They also point to an overarching need for transparency about the out of pocket costs consumers will face when going to hospital, as this submission discusses in greater detail.

[8] CHOICE national survey on private health insurance, n=325

"I had a wisdom tooth extraction and I had to pay most of the cost myself... This was my first private health insurance policy and I didn't have much experience buying and analysing healthcare policies."
Choice Community Member 19th May 2017[9]

Using commercial comparison services

There is a significant reliance on commercial comparison services as a source of information on private health insurance. 42% of people with private health insurance sought information about their cover from commercial comparisons. This suggests that any interventions that simply target the marketing materials provided by insurers, or information through privatehealth.gov.au, may fall short of addressing issues with complexity.

Table: What sources do consumers use to get information about private heath insurance?[10]

	%
All commercial comparators: iSelect , Compare the Market, Choosi, Health Insurance Comparison, Canstar (including the CANSTAR Star Ratings)	42%
Family, friends or colleagues	29%
Material from your health insurer incl. print, online or over the phone information	25%
Material from other health insurers incl. print, online or over the phone information	18%
The one page key factsheet (also referred to as regulated 'standard information sheet') from your health insurer	16%
Health insurer's store / shop	14%
The government's website (privatehealth.gov.au)	11%
CHOICE (choice.com.au)	7%
OTHER	8%
Didn't seek out any information at all	18%

[9] A CHOICE Community thread asked consumers about their experiences with private health insurance: https://choice.community/t/out-of-pocket-costs-and-your-private-health-insurance/13869/19
[10] CHOICE national survey on private health insurance

CHOICE believes that, on the whole, current commercial comparison sites are not transparent or comprehensive. They commonly use their websites as funnels into call centres, where 'comparison' gives way to sales. At the same time, it is not in the interest of insurers to provide unbiased comparison of their own products with the rest of the market.

"These other places that consumers ring to get quotes (e.g. Compare the Market) they are really biased and I have found them to be a pain and are so rude and pushy and therefore doesn't help with making my decision as they seem to have their preference for me and not what I want. Compare the Market and iSelect are both biased and are only interested in making a sale. I find rather than actually helping me I find them hopeless and useless." Confidential consumer submission

"I'd been thinking of changing funds for some time and this email was the finally needed catalyst. So I contacted iSelect; or, rather they contacted me after I'd had a look at their site. I settled on NIB and though the chap at iSelect was really starting to push to sign up there and then, I wanted to contact NIB directly. And I'm glad I did as they were able to offer a - slightly - better deal than what I was offered by iSelect. It wasn't much but enough to sway the deal." Jeff Pohlmann, consumer submission

Better standards for commercial comparator websites would also reduce instances of confusing information being provided to consumers, or in some cases misleading information being provided.

"I went to iSelect online to do a comparison and they contacted me to discuss my needs. On going through what NIB covered as compared to RT Health I was assured that NIB could offer the same cover for a $30/month reduced premium. I found out later that this wasn't the case and I was angry with myself for trusting the iSelect Admin Officer and should have checked the policy for myself." Linda Vella, consumer submission

Given this mix of conflicts and barriers, a priority should be creating more transparency and comprehensiveness in third-party options for consumers to compare PHI. This could be progressed by making information about PHI policies more openly available so that third parties with new approaches and non-commission based business models can create solutions.

RECOMMENDATIONS

1. The Federal Government and Department of Health should take steps to promote greater transparency and comprehensiveness in third-party options for consumers to compare PHI. This could be progressed by:
   1.1. Making information about PHI policies more openly available so that third parties with new approaches and non-commission based business models can create solutions.
   1.2. Requiring third-party comparators to inform consumers in the transaction process how much of the market they cover and whether they receive commissions or other payments from funds.
2. More broadly, we encourage the Committee to consider the effect of different kinds of remuneration practices for third party comparison sites selling health insurance on consumer outcomes, noting the conflicts that can arise when staff are paid to sell certain kinds of policies or are paid to sell by volume.

Cutting confusion with better information and data

The task of cutting confusion in private health insurance should start with considering the sources, format and timing of how consumers receive information in the healthcare sector. There is little evidence to suggest consumers want even more information or engagement with highly complex products. Rather the focus should be on increasing the quality of engagement, delivering simpler, more transparent information at the times and in the formats that are most useful.

This process should recognise the fact there is no 'one size fits all' approach to providing better consumer information, and that multiple sources and formats – some consistent, some personalised – are worth testing and refining. We should also recognise that healthcare professionals and intermediaries (e.g. non-government comparison services and platforms) are key sources of information for consumers in the sector.

> *"I am not an unintelligent person and yet, I have an extremely tough time trying to compare plans and determine whether I actually need any extras."* Confidential consumer submission

There are some areas where accurate or up to date information is simply not available. This would be addressed by creating better databases for and between hospitals, insurers,

healthcare professionals and the Private Health Insurance Ombudsman. Customer service agents at insurers would be able to provide more accurate information on treatments and procedures covered, and the likelihood of any gap payment. Comparator websites would be able to access the most up to date information on policy inclusions and exclusions from the Private Health Insurance Ombudsman. Currently, information can be out-of-date and consumers are not notified immediately of policy changes.

Adopting a consumer data-led approach would very likely give rise to new products and services for reviewing, switching and comparing policies. The Productivity Commission's findings established that there are significant potential benefits where data is shared and released back to consumers:

> "Improved data access and use can enable new products and services that transform everyday life, drive efficiency and safety, create productivity gains and allow better decision making."[11]

The Productivity Commission refers to the health sector as an exemplary industry where confusion could be cut by better use of available health data, and that Australia's health data is an underutilised resource:

> "At the individual level, patients are required in many cases to act as information conduits between the various health care providers they see… At the system level, inefficient collection and sharing leads to data gaps and unnecessary expenditure"[12]

We should not assume the majority of consumers want to spend additional time and effort engaging with private health insurance. However, there is a strong case for making it much simpler and faster for consumers to regularly test their products against the market, re-evaluate their needs, and if they choose to, switch providers. The more consumers are willing to shop around, the greater the benefits for genuine demand-side competition.

One way to facilitate this is through the provision of further information to consumers about the use of their policy over time. For example, consumers would benefit from being able to view data that insurers and the public health system hold about them within secure comparison sites to find the best products based on their past, immediate and possibly even future needs.

[11] Productivity Commission, Data Availability and Use: Overview and Recommendations, p. 2
[12] Productivity Commission, Data Availability and Use: Overview and Recommendations, p. 6

This future-state can only be achieved through the Federal Government implementing the findings of the Productivity Commissions report into Data Availability and Use, which are currently being considered.

Data that is already being collected separately by hospitals, health insurers and medical practitioners in their local area could provide consumers with information on costs and waiting times for a procedure they may require or wish to be covered for. Presented in the right format, for example personalised, online tools, this data could help consumers assess if they are best covered by the public or private system and switch policies to options that better suit their needs.

"I do not understand exactly what our policy covers, and have been confused what we can and cannot claim, confused when being admitted into hospital, and confused when being billed. My husband has been booked in for procedures and tests by his doctor, only to have to cancel them, as they are not covered when he and his doctor expected they would be in the basic cover. It is also very difficult to determine whether the policy is good value or not." Confidential consumer submission.

RECOMMENDATIONS

3. The Federal Government encourages an open data approach in the private health insurance market.
4. To achieve this, consumer representatives, industry and government work together on a standard for data access and security requirements to ensure that sensitive data is protected but also able to be used by consumers for better comparison services.

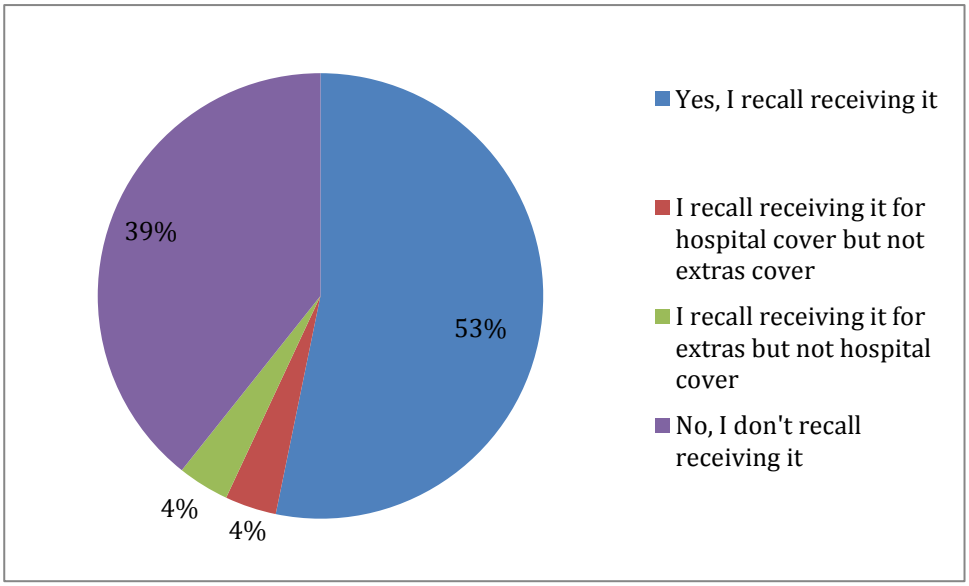
Cutting confusion with the standard information statement

One way that consumers find it easier to compare policies is by using the Standard Information Statement (SIS). CHOICE's survey of private health insurance holders asked respondents whether they recalled receiving their SIS. Policy holders were shown one example each of statement for hospital and extras cover in the following context:

> "Once a year private health insurance customers are sent a key factsheet by their insurer about their health insurance. This is known as the **'standard information statement'**. It describes what your health

insurance policy includes and what you're covered for. (Examples shown)"

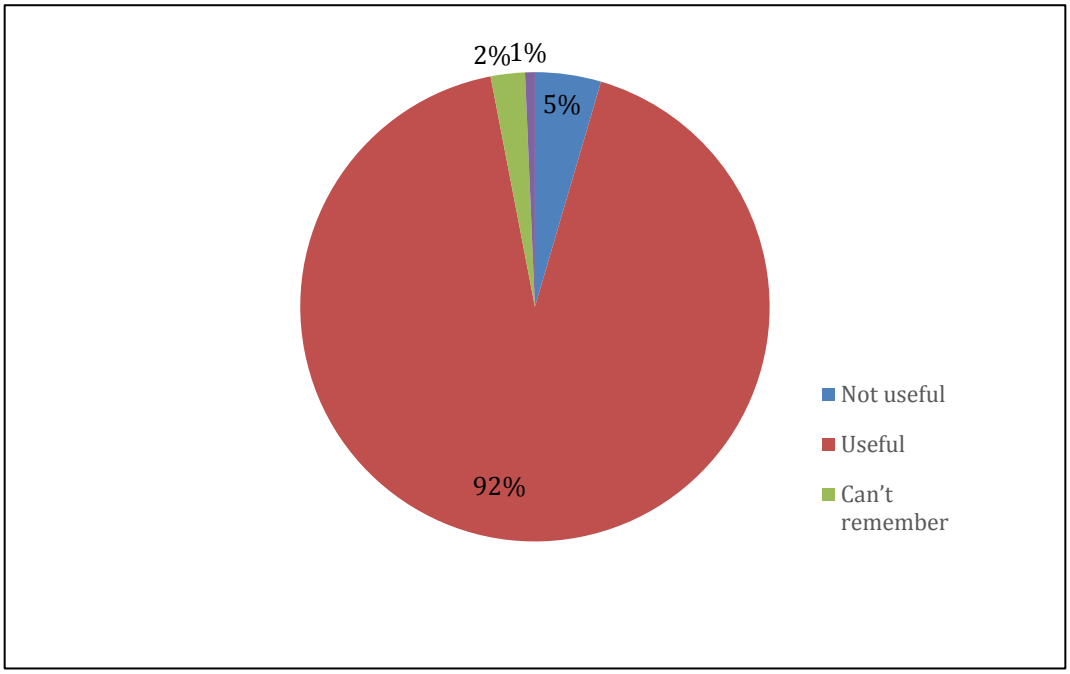
Graph: Consumer recall of the key factsheet for current health insurance.[13]



The majority of policyholders recalling receiving this document (58% overall; 61% of those with combined policies). Of those policyholders who recalled receiving the SIS, 92% said they found it useful.

[13] CHOICE national survey on private health insurance

Graph: Usefulness of the key factsheet in explaining cover.[14]



Importantly, consumers who recalled receiving their SIS were significantly more likely to understand what their private health insurance covered them for. Of those that recalled receiving the SIS, 42% found it easy to understand what exactly was covered for by their health insurance, compared to only 30% of those who did not recall receiving their SIS.

Table: Ease of understanding coverage by whether respondents recalled receiving their SIS[15]

	Difficult	Neither	Easy
Yes, I recall receiving it	32%	25%	42%
No, I don't recall receiving it	38%	32%	30%

These results indicate that the SIS is an important tool to make private health insurance easier to understand. Given its usefulness, there should be no move away from standardised information provision in private health insurance.

[14] CHOICE national survey on private health insurance
[15] CHOICE national survey on private health insurance

"I'd like to see a consistent format for showing what policies offer. They are so confusing that even with a uni degree I have difficulty comparing. People with poor education or little English must really be in the dark completely." Anne Mackay, consumer submission

Some people choose not to take out cover at all because it is too confusing and simplifying and making information comparable will cut confusion and increase the pool of people looking to take up cover.

"I do not have private health insurance as I find it too difficult to understand and all the different premiums etc. Would be great if they used user friendly English and descriptions." Lyn Eyles, consumer submission

Improving the SIS through consumer testing and ensuring it is proactively and regularly provided to all consumers will help policyholders better understand their coverage. This would make consumers more informed during the purchase stage, ensuring they purchase cover that meets their needs and will cover costs, and minimise out of pocket costs.

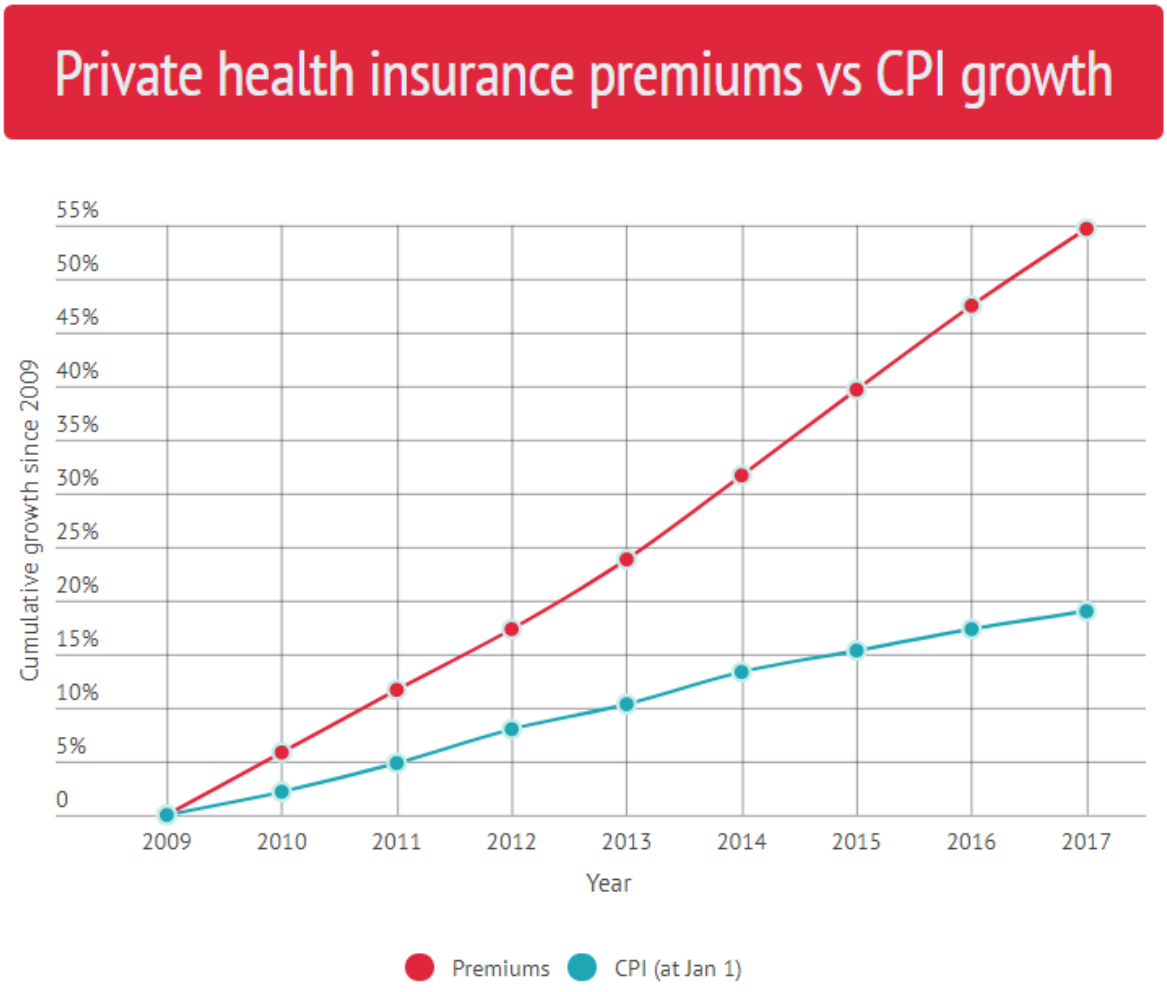
RECOMMENDATIONS

5. Policy information continues to be proactively provided to consumers in a standardised, concise 'Standard Information Statement'
6. The current Standard Information Statement is improved through consumer testing.

THE COST OF HEALTHCARE

The cost of healthcare is a significant concern for Australians, including for consumers who hold private health insurance are worried about the cost of policy premiums. Premiums have increased an average of 54.6% since 2009, well ahead of CPI.[16]

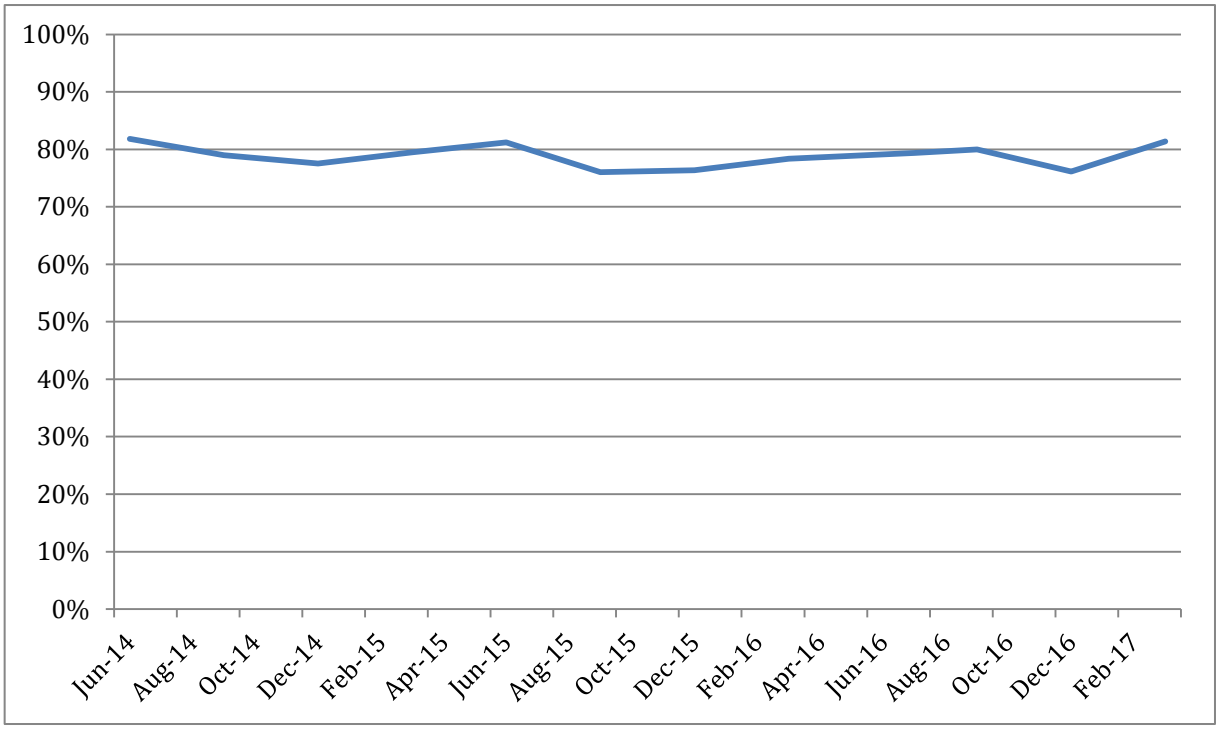
Graph: Private health insurance premiums vs CPI growth, 2009-2017



[16] CHOICE, Private health insurance premium increases announced: https://www.choice.com.au/money/insurance/health/articles/health-premium-hikes-on-the-horizon-131115

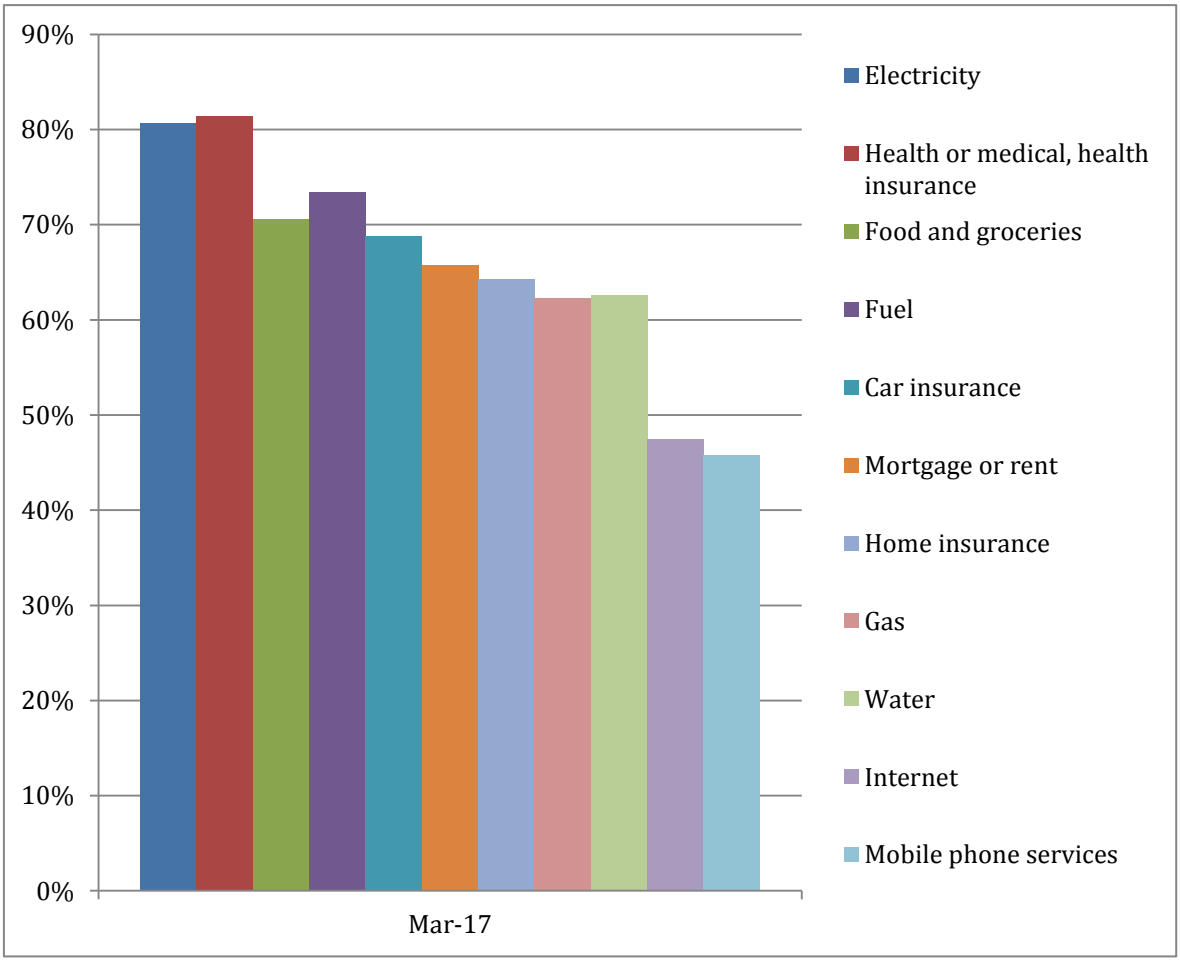
CHOICE's quarterly Consumer Pulse survey tracks household cost of living concerns, with health costs, including private health insurance, consistently a top issue. The percentage of consumers concerned about health issues has sat between 82% and 76% since the Consumer Pulse survey commenced in 2014.[17]

Graph: consumer concern of health or medical costs, including health insurance 2014-2017



[17] The CHOICE Consumer Pulse survey is conducted quarterly with a nationally representative sample of n=1000 based on the 2011 census.

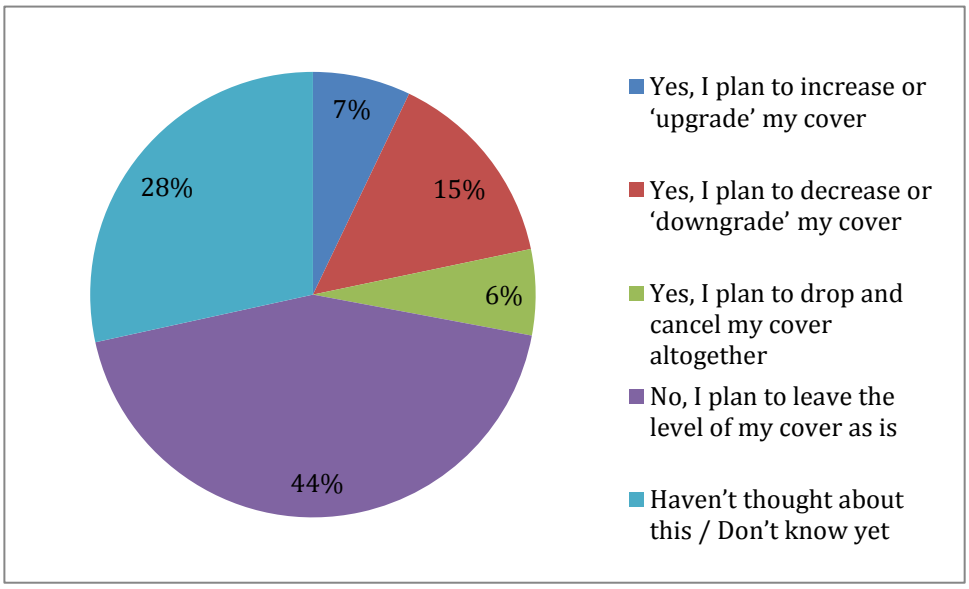
Graph: consumer cost of living concerns, March 2017[18]



Rising premiums is one of the main reasons consumers decided to drop or downgrade cover. 6% of consumers planned to drop or cancel cover altogether, and 15% planned to 'downgrade' their cover.

[18] CHOICE Consumer Pulse March 2017 is based on a survey of 1,006 Australian households. Quotas were applied for representations in each age group as well as genders and location to ensure coverage in each state and territory across metropolitan and regional areas. Fieldwork was conducted from the 1st to the 10th of March, 2017.

Graph: Consumers considering changing their health insurance cover[19]



The main reasons given for dropping or downgrading cover is cost concerns ("my current policy is too expensive", 66%) and lack of value ("I'm not using my current policy enough to get value for money", 39%).

Table: Reasons for changing the level of health insurance[20]

Reason for changing cover	%
My current policy is too expensive	66%
I'm not using my current policy enough to get value for money	39%
My current policy is too complicated	8%
My health circumstances have changed	20%
I had a negative experience with my current health insurance provider (please briefly specify what happened)	2%
I had unexpected or high out-of-pocket costs	12%
I would prefer to use the public system, Medicare	9%

[19] CHOICE survey footnote here
[20] CHOICE survey footnote here

Rising premiums and low income Australians

"I am a pensioner in my early sixties and have paid for private health cover since my late teens. I now find that I cannot afford a level of cover appropriate to my age. In recent years, conditions that we covered on my policy have been removed and I am paying for a 'junk policy'. Private health insurance is an unaffordable mine field that is impossible to navigate!" Confidential consumer submission

As a direct result of rising premiums, many people can no longer afford to stay insured when they reach an age when they will need it most. When CHOICE asked for comments from consumers for this submission, we received many complaints from pensioners and low-income Australians who felt that the cost of private health insurance was almost crippling, but that they were too nervous to drop cover as they had reached a stage in their life where they were more likely to use it.[21] After many years of paying into the private health insurance 'pool', they are being forced out by rising premiums and are unable to use the system they have spent many years contributing to.

"I'm concerned I may not be able to afford health insurance when I retire as the premiums are rising so quickly. I've been insured for over 30 years and just when I may actually need to use it, it may be unaffordable." Lisa Levine, consumer submission

"The cost are going up far to much for an 81 year old and I may have to cancel it if it goes any higher, it's all very well to put them up higher but in the long run you will have a lot fewer clients because you have priced them out of the market and we will all fall back on Medicare, which in return will overload them." Brian Austin, consumer submission

Rising premiums were also very concerning for low income Australians, especially those on disability pensions who have high healthcare needs. High premiums can be particularly difficult for Australians needing cover for mental health treatment, which is chronically underfunded in the public system and often only available on expensive medium or top cover policies.[22] Consumers reported that while wanting to maintain a certain level of cover, they found this increasingly difficult to manage in their day-to-day budgeting. In such circumstances, the best outcome may be a strengthening of Australia's public healthcare system to ensure vulnerable

[21] CHOICE called for comments from consumers about public health insurance from June-July 2017 to collect public submissions to this inquiry. 1051 submissions were received, coded and analysed. Consumer submissions have been edited for clarity. Excerpts from submissions are presented throughout this report. The complete list of submissions is attached to this report in Appendix A.

[22] Rosenberg, S. Mental health funding in the 2017 budget is too little, unfair and lacks a coherent strategy. The Conversation, accessed: https://theconversation.com/mental-health-funding-in-the-2017-budget-is-too-little-unfair-and-lacks-a-coherent-strategy-77470

consumers have affordable access to quality healthcare, particularly those in need of specialised care. The alternative is forcing the costs of private health cover onto those who can least afford it.

"As a disability pensioner who suffers from a mental illness and diabetes I need to keep my cover in case I need to be hospitalised again but as you can imagine paying the expense of approximately $130 per fortnight out of my pension is crippling to say the least. On top of that I have a $500 excess which is a further expense. After my bills I am left with $300 per fortnight to pay for food, clothing, petrol, registration, car servicing and any unforeseen bills. As a result I cannot afford to pay the gap for extras like dental and optical so I attend the University of Queensland Dental Service where there is no fee." Peter Turner, consumer submission

Timely release of premium data

One way of addressing consumer concerns with the cost of private health insurance would be to release premium increase data earlier so consumers are encouraged to switch, upgrade or downgrade cover as needed. While premium increases are approved between December and March each year, new policy information is not available to consumers until 1 April, the day premium increases take effect.

As noted in other parts of this submission, private health insurance is highly complex and many consumers are understandably reluctant to engage with it. The annual premium announcement is a critical window of opportunity when many policyholders focus on the value of their cover, their health needs and potentially try and test the market. For many consumers, the best value option would be to identify a policy that meets their needs and pay a full 12 months of premiums in advance. Yet the gap between the announcement of premium increases and the availability of updated product information makes this almost impossible.

"I changed to NIB because of their dental cover and on 01/04/2016 they dropped the Major Dental Annual Limit to $1000 per person per year. Not happy! If it wasn't so complicated & time consuming I would look for a better cover." Terance Brittain, consumer submission

Announcements from the Federal Government, and subsequently, private health insurers notification letters regarding premium prices for the new financial year should give consumers, at minimum, a month to assess costs and compare policies between insurers. Pricing data on all policies should be easy available and publicly accessible by March 1 on www.privatehealth.gov.au, for individual consumers to search and for third-party organisations that can distribute the data in meaningful ways to consumers.

If the Private Health Insurance Ombudsman released data on the day after the announcement of the increase in premiums consumers would have a window to compare policies and find a better deal before the premium increases take effect, which they are currently unable to do.

RECOMMENDATION

7. Data on premium increases should be released publicly prior to premium increases taking effect, with enough time for consumers to compare and switch policies before April 1.

Tax incentives and the lifetime health cover loading

Tax incentives are designed to increase the pool of people with private health insurance, distributing the risk by encouraging young people (who may be less likely to use private cover) to take out private cover. Both the Medicare Levy Surcharge (MLS) and the Lifetime Health Cover (LHC) loading act as incentives to move young individuals into the private health insurance pool.

On average, younger policy holders receive less in payments for hospital treatments than older policy holders.[23] Because of the low benefits paid out to younger policy holders many consumers expressed that their policies weren't good value for money. This leads consumers to react to the private health insurance system in a number of ways:

- They reluctantly took out cheap cover (often junk), which they didn't use
- They preferred to pay the MLS instead of funding a product they didn't see providing them with a personal benefit

Many consumers contacted CHOICE expressing an ideological opposition to private health care, but felt forced to take out cover for financial reasons.

"I found that the private health insurance is only worth having for tax reasons (significantly reduced Medicare levy obligations). Which is an anti-incentive to contribute to public health. I would rather my money go to public health than private health insurance." Michelle Ganzer, Consumer submission

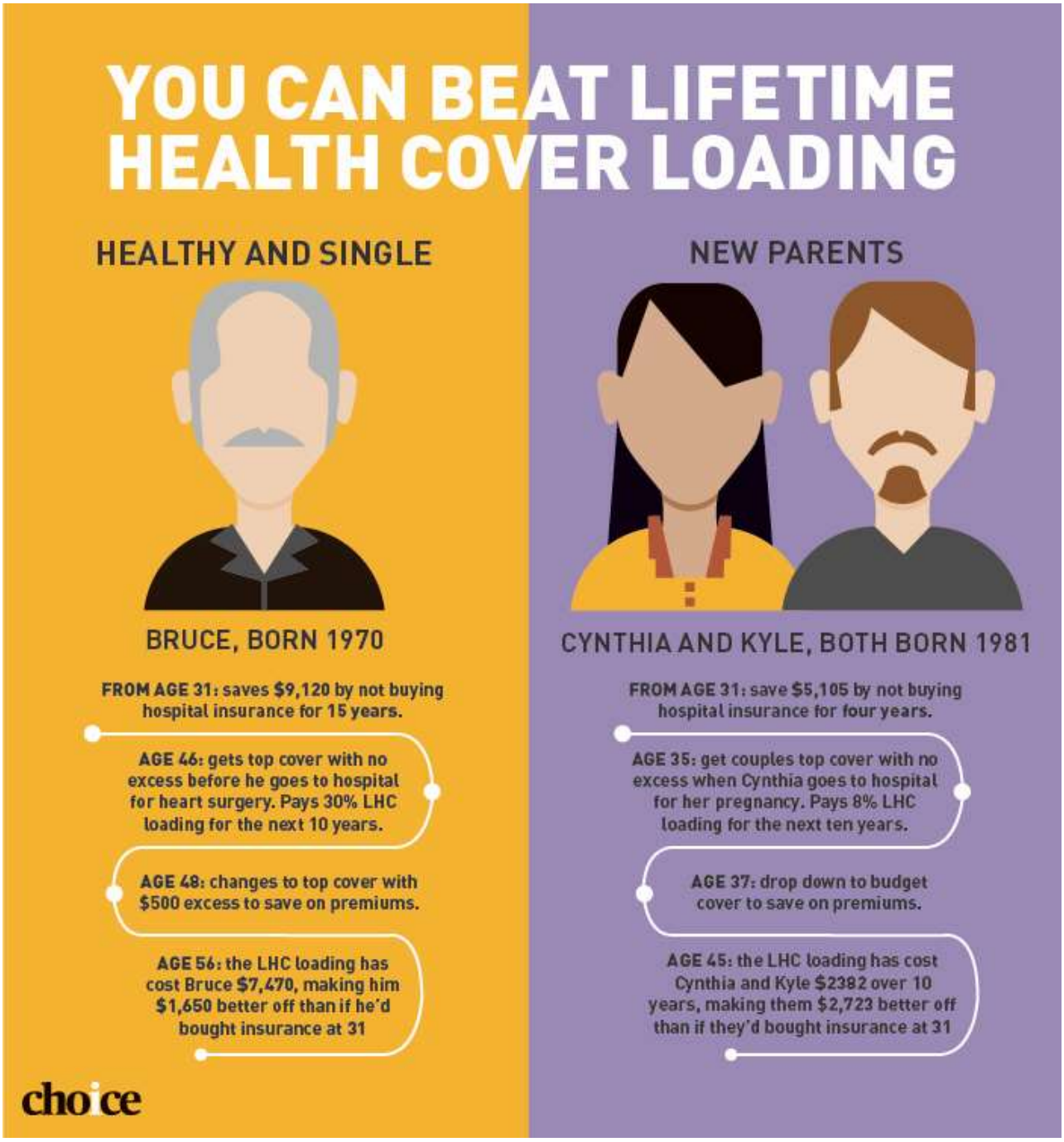
[23] PHIAC, Private Health Insurance Quarterly Statistics, March 2017: http://www.apra.gov.au/PHI/Publications/Documents/1705-QPHIS-20170331.pdf

"Hardly used and extremely expensive for a family of 3. Yet we are made to have it for 'tax purposes' and life loading of Medicare if we do not hold continuous health cover." Lisa Harrison, Consumer submission

Managing the lifetime health cover loading

CHOICE analysis found that consumers could avoid the financial strain of the LHC loading without taking out health insurance at the age of 31. Consumers could benefit financially by saving money equivalent to a premium, and using it to take out health insurance later in life, when they need it for a particular medical reason.

Image: CHOICE comparison, LHC calculations for two individuals[24]



[24] CHOICE, How to pay the lifetime health cover loading and still be better off, available at https://www.choice.com.au/money/insurance/health/articles/how-to-pay-the-lifetime-health-cover-More loading-and-save

Even with the deterrents such as the LHC and Medicare Levy Surcharge, consumers continue to drop their cover. There are also consumers who cannot afford health insurance at 31, yet may wish to take it out later in life. These consumers are then either heavily financially penalised when they decide to take out private health insurance with the LHC, or pay out of pocket for health care because they cannot afford insurance with the LHC.

"It is unfair that I must pay 10% extra in premiums because I was a low wager earner when I was 30 and the LHC policy was introduced. Once I was on a decent income, this created a disincentive for me to take out private health insurance until I was over 40 and had children that needed cover. There was no way I could have paid health insurance at 30 on the wage I was on at the time and still paid rent and ate food. The LHC policy seems to advantage the wealthy or those with high incomes post graduation (finance or law?)." Emma Groube, Consumer submission

"When I became a carer and out of the workforce for a while, I could not afford private health care. Now when I want to return, I have the lifetime penalty - this means I will never be able to afford private health insurance again." Confidential consumer submission
"I do not have private hospital cover as the cost is prohibitive. For most of my adult life - I am now in my mid 50's I have been a sole parent raising a large family. I have spent large periods of time out of the paid workforce. Paying for hospital cover on the pension was not even a consideration. Now that I have employment, and could consider hospital cover, the Lifetime Health Cover loading prevents me from doing so. This government policy means me and no doubt many other people in a similar situation are denied the opportunity for private cover. When any of my family has required a procedure in a private hospital, I have paid for it myself. Sometimes I have taken out a personal loan, other times the credit card has been used and the debt paid off over time." Confidential consumer submission

The government should review how the LHC affects young low-income earners who take up insurance later in life, and how the LHC and rising premiums will affect future take-up rates of private health insurance. As consumers continue to drop cover because of rising premiums, a sub-class of Australians is created who are less likely to be able to afford private health care even if they wish to take out this cover in the future. In its current form, the LHC loading places low and middle income Australians in a difficult financial position later in life, and does not cater to changing lifestyles. With a growing concern about cost of living in our major cities, particularly stress around the costs of housing and energy, many younger Australians will find it harder to take out private health insurance at the arbitrary age of 31.

It would be useful for the Federal Government to assess the impact of tax incentives on private health insurance take-up rates, and on the healthcare system generally, for example the costs and benefits of providing even greater subsidies to a dwindling pool of insured Australians versus providing additional funding to the public healthcare system. It is not clear that incentivising younger Australians to take up insurance products which they may not want, understand or in fact need is the best way of improving health outcomes for the community as a whole. For example, there may be a case for the government to support risk equalisation directly, rather than using health insurers as a form of privatised tax collectors, churning customers through low-value products and clipping the ticket on the way through.

RECOMMENDATION

8. The Federal Government conducts economic analysis on the efficacy of Lifetime Health Cover loading as an incentive to take up private health insurance.
9. The Federal Government assess whether incentivising consumers to purchase low-value health insurance products which they are unlikely to use, and then making it more expensive to purchase useful policies in later life, is the most effective way to improve health outcomes for the community as a whole.

Junk insurance

The rise of 'no-frills' junk policies marketed at younger consumers has led to an increase of insurance holders who are not getting value for money. Unlike private health insurance policy holders (who may still face hefty 'gap' payments for procedures), junk policy holders can face significant 'bill shock' when needing treatment as they discover treatment is not available under their policy. Consequently, if someone with a junk policy needs a procedure they must either pay out of their own pocket, rely on the public system or delay or not seek treatment.

Junk policies cover less than 1% of hospital treatments and services, with little value being delivered to the consumer beyond the Medicare rebate incentive. The policies typically cover a very small number of procedures such as accidents, wisdom teeth, appendix surgery, knee investigations and reconstructions, but exclude all other services and illnesses. In 2016, couple premiums ranged from $1200 to $2200 per annum.[25]

[25] Premiums for a couple without Private health insurance rebate. CHOICE media release 2016, 'Time to trash 'junk' health insurance policies', https://www.choice.com.au/about-us/media-releases/2016/march/junk-health-insurance-policies

Junk insurance policies are very popular. Consumers are attracted to the affordability of these policies, and they take out these policies for one of two reasons:

- The consumer knows the policy is junk and does not intend to use it, but takes it out solely for tax purposes.
- The consumer wants the cheapest policy possible, but doesn't realise the policy is junk and delivers very low value.

With a growing number of consumers concerned by the cost of healthcare, it reasonable that consumers would seek out the lowest cost coverage possible.26 While not all consumers can afford top level cover, 'junk' policies are not always the cheapest policies available on the market, and it can be difficult for a consumer to identify if the policy provides real value. For example, in Queensland, popular junk policy 'Medibank Hospital Essentials' charges a monthly premium for a couple of $146, however a couple can obtain basic coverage (covering thousands of treatments) for $144 per month with CUA's 'Basic Hospital'.[27]

These policies are not only poor value for consumers, but are poor value for the Australian community, who subsidise junk policies that do not reduce the strain on the public health care system. Given their low value to both policy holders and the broader community, these policies should not attract a rebate or exempt consumers from the Medicare Levy Surcharge. Further, if these policies did not attract the rebate, consumers would not inadvertently sign up to these policies and incur significant costs for medical treatment after taking out the policy.

RECOMMENDATION

10. 'Junk' policies should not attract the Private Health Insurance rebate or exempt high income earning consumers from paying the Medicare Levy Surcharge.

Private patients in public hospitals

CHOICE is concerned about 'public hospital' private health insurance policies leaving the Australian community worse off. One of the core reasons behind the creation of the two tired, private-public healthcare system in Australia is to allow private health insurance to relieve the strain on the public system. Therefore, Australians should expect that products receiving the

[26] CHOICE article: "Consumer Pulse reveals Aussies' economic gloom" CHOICE. October 22. https://www.choice.com.au/money/budget/consumer-pulse/articles/consumer-pulse-shows-economic-pessimism-211015

[27] Analysis from CHOICE' health insurance comparisons collated and compared data on the costs of thousands of policies in the market.

Government's Private Health Insurance Rebate and subsidised through the tax system should efficiently reduce pressure on the public healthcare system.

Specific policies that restrict treatment to public hospitals, allowing the policy holder to choose their own doctor but use the facilities of a public hospital, attract a tax rebate even though they do not reduce the strain on the public system.

RECOMMENDATION

11. 'Junk' policies that only cover treatment as a private patient in a public hospital should not attract the Private Health Insurance rebate or exempt high income earners consumers from paying the Medicare Levy Surcharge.

OUT OF POCKET COSTS IN PRIVATE HEALTH CARE

"It's definitely not value for money. I also find it all very confusing about what is covered and what isn't, and why is there a gap? Why, if I go to hospital and have a procedure, do I still have to fork out thousands of dollars because the insurance doesn't cover it all? Why doesn't it cover all expenses? I can write off a $50,000 car and pay an excess of a $1000. Go to hospital, have an operation that costs $4000 and the insurance covered $300 of that. Absolutely disgusting. Out of pocket costs can be financially damaging to consumers who feel under pressure to accept the price set by their medical practitioner. Consumers who are ill and need serious and/or urgent treatment may not feel that they are in a position to negotiate costs or shop around for a cheaper alternative." Confidential consumer submission

Understanding specialists' costs

Consumers have to consult a variety of entities and individuals in order to get an accurate estimate of the out of pocket costs associated with a procedure or treatment. Out of pocket costs are typically not provided in a simple format and a consumer must be proactive to fully understand them.

This can be a difficult process, as many people do not have the information or capacity to properly understand the quality or function of each specialist or hospital, the difference between individual item numbers, or the timeliness within which a procedure must be performed. Consumers are heavily reliant on the advice given to them by their specialist or general practitioner, and rarely question the costs (including those out of pocket costs) of treatment. This is also a time when some people are extremely vulnerable, understandably focused on health outcomes and not necessarily motivated to undertake a shopping around exercise. This has created a market that does not see sufficient competition, and prices are not transparent or competitive. 'Value for money' tends to be a perception problem, with consumers not understanding how they are getting value for money when faced with high specialists costs under private treatment:

"I have always felt well served by my health fund, until I had surgery on my cervical spine eighteen months ago. I was seen by a neurosurgeon who told me that the pain in my right arm was caused by a nerve being compressed in my neck. I agreed to the surgery and when asking the neurosurgeon about any gap was told that his practice manager would go through the

details with me. I went into her office where she sat me down and passed me a sheet of paper with some figures on it. When I looked at the bottom line I thought that it was the amount my health fund would pay. When I looked more closely it was the amount left after my health fund had paid. The gap was $2000. I was devastated, we are on the aged pension and that $2000 bit into our small savings account very badly. We had been trying to save for a holiday. I rang my health fund and they said that unfortunately there was nothing they could do. I did ask the practice manager if there was any chance of the doctor reducing his fee but there was none. I was in pain, needed the surgery, so reluctantly bit the bullet." Lyn Whiteway, consumer submission

"We are forced to have private insurance due to our income level. I have had two major operations in last 6 years (both craniotomies for a brain tumour - so not elective). First time around we were over $10,000 out of pocket, despite having top hospital cover. Plus add cost of Medicare levy and Medibank premium. Second time it was about $7,000 out of pocket. If I had gone public, it would have cost nothing. Not sure why we have to pay high premiums for private insurance and then are still out of pocket." Confidential consumer submission

These costs can be unpredictable ranging from a few hundred dollars to thousands of dollars, including variations in:

- Specialists' fees, including between hospitals
- Room charges (overnight or day) between hospitals
- Anaesthetists' costs that are difficult to predict
- Other specialists involved in the procedure such as assistant surgeon
- Pathology and other tests
- Changes can occur during a procedure, changing or adding additional item numbers charged
- Fees for follow up visits with specialists or ongoing allied health services

"The general problem is discovering who is involved, potentially involved, and in or not in your plan, who has no-gap arrangements. You can pick your surgeon, but not the anaesthesiologist, any assisting surgeon, the lab processing, radiologists, and the sometimes long line of supporting medicos involved." Choice Community member, May 2017

Consumers need to collect the relevant information from their specialist, insurer and hospital to determine how these variables might affect total costs. Should a consumer take a proactive approach and attempt to establish the costs of a procedure prior to treatment, they will need to contact a range of stakeholders, including their insurer and hospital. In the case of surgery,

a consumer would need to establish costs with their surgeon, anaesthetist, surgery assistants, hospital and their insurer. To be fully informed and to minimise costs a consumer would need to ask questions about the possibility of an alternate anaesthetist, surgery assistants and an alternate hospital (if there is a cheaper option available at an agreement hospital) and post-surgery costs.

"I had to undergo surgery last year. I thought I had top cover. However I found that I was not covered by surgeons/anaesthetists who charged more that the scheduled fee. I also found that the Epworth hospital issues 3 separate bills, one for hospital which was covered, and others for pathology and radiology, which is only covered for the basic scheduled fee. I ended up about $8000 out of pocket." Tom Dutkowski, Consumer submission

Consumers may also wish to 'shop around' with specialists to get the best possible price, however this is both cost and time prohibitive, as advice would need to be sought from the patient's general practitioner on local, available specialists. Each visit to a specialist to be assessed and to receive a quote for surgery will result in additional costs directly payable by the consumer (i.e. additional costs for multiple appointments). Where this is prohibitive, there is a role for General Practitioners to play, assisting patients in the referral process. GPs should have access to databases that allow them to refer patients to 'no-gap' specialists to reduce any potential for out-of-pocket costs. Currently, the referral system from GP to specialist is haphazard and can be dependent on the professional network of a patient's GP. Better databases would make the referral process more competitive and better tailored to consumers' financial circumstances.

However, there are some instances where encouraging competition amongst specialists may not be possible when surgery is required within weeks or months, where a private health insurance patient would have a limited ability to 'shop around' because of the time taken to do so. It is also unreasonable to expect consumers to test the market in the same way they would with other significant expenses given that many people facing surgery are understandably focused on health outcomes and not necessarily motivated to undertake a shopping around exercise.

Encouraging competition in private health care

Policy solutions that drive competition in the private health care market need to be investigated. Encouraging competition would drive down out of pocket costs and empower consumers to have a choice of practitioner, which is not currently normal consumer behaviour in this sector. This inquiry should consider measures to:

- Enable ‘shopping around’, where consumers can easily and affordably seek quotes from multiple specialists.
- Encourage greater transparency of specialist pricing for common procedures.
- Empower general practitioners to understand the private health care market and help consumers make the best decisions about their health care based on their health needs and ability to absorb out of pocket costs.

The Productivity Commission report into competition in human services aimed to identify reforms that would “introduce greater competition, contestability or user choice.”28 In their review of public hospital services, they noted that competition and better coordination of healthcare services would ensure services would be more efficiently delivered. User choice needs to be encouraged, and consumers should be empowered to:

- Seek out best or better performing providers (best outcomes and lowest waiting times)
- Enable choice between providers (hospitals) to increase competitions (in locations with multiple hospitals)

Proactive consumers who reported negotiating on costs were able to reduce costs, but were also confused by the wide variety of prices for services in the market:

“We always ask for the cost of the service whether it is just a consultation or a service. Then check with Medicare and Health fund what the rebates are, if the "out of pocket" expenses are too great, we will contact the doctor and ask if there is a possibility of a reduction in the cost. Most times we get a better price, if we do not, then we move on. We even had one surgeon ring us back after we cancelled and give us a fairer price. We have found there can be as much as $7500 difference (out of pocket) between the same procedures. Even for a consultation (of 10 -15 min) cost can be a outrageous "out of pocket" I had one gastroenterologist quote a price of $350 dollars for my first consultation, of which Medicare would refund $75, and the charge for the surgical procedure would be $3000. I then rang another gastroenterologist and his cost was $150 and would bulk bill for the surgical procedure. I decided to go with this surgeon and I am delighted with the end result. But I would like to make a point in regards to the auxiliary services e.g. anaesthetist, assistant surgeons etc., they can end up more expensive then the surgeon. It is also worthwhile checking into these costs before proceeding, as this could add as much as $2000 ‘out of pocket’.” CHOICE Community member, May 2017

[28] Productivity Commission, 2016. *Identifying Reform in Human Services:* http://www.pc.gov.au/inquiries/current/human-services/identifying-reform/report/human-services-identifying-reform-overview.pdf

The Productivity Commission also suggests that better "user-oriented information" would empower patients to make more efficient and better choices in their use of the public system, and transparency of data would improve the performance of hospitals.[29]

Similarly, the private system may benefit from an open data approach. If consumers had more support to shop around through better access to information and services they may be able to reduce their out of pocket costs. If a consumer was empowered to obtain multiple quotes from surgeons or specialists overall costs would be reduced and there would be greater competition in the market. Consumers would have the ability to shop around and compare prices if:

- First consultations with specialists were bulk-billed so consumers could visit multiple specialists without significant financial penalties.
- There was more clarity about the item numbers or specific procedures required and specialists were more willing to provide quotes by phone.
- Specialists had to disclose their standard pricing for item numbers online and over the phone when requested by a potential patient.
- Better information was provided to general practitioners on specialists (including costs and waiting times) so they can provide a patient with several options

Transparency in pricing for common procedures would also allow consumers to compare the cost of their surgeon or specialist and encourage 'shopping around'. Consumers could then consult their first specialist of choice, and compare that price against a listed average treatment cost, or the treatment costs of alternative specialists provided to them by their general practitioner. These costs could be provided by either requiring the doctor to make average prices available online (through a professional body) or over the telephone. This would then reduce costs for the consumer, who would not need to see multiple specialists (and pay for each separate consultation).

While greater transparency and reduced transaction costs is important, it is far from a complete solution to out of pocket costs. It is not realistic or in fact reasonable to expect consumer with acute health needs, many of them vulnerable, to spend additional time engaging with the market. Therefore CHOICE believes there is a case for considering measures to curb unexpected or excessive costs for consumers. For example, a cap on specialists' costs for procedures may give consumers confidence that their final out of pocket

[29] Productivity Commission, Data Availability and Use: http://www.pc.gov.au/inquiries/completed/data-access/report/data-access-overview.pdf

costs will be manageable and in some ways, predictable. While this would be a significant reform and require economic analysis, we believe it is worth further consideration.

"The idea that I can shop around for a surgeon is a joke. Each visit to a specialist means a visit to the GP to get a referral, then a 6 week wait to see the specialist. If you are in need of treatment these additional waiting times and costs are just too much to bear." Greg Rostron, Consumer submission

RECOMMENDATIONS

12. Insurers and general practitioners encourage competition in the market by empowering consumers to 'shop around' to reduce out of pocket costs for treatment in the private system, through better information. This would be enhanced through an open data approach where cost information was provided by specialists and insurers, directly to GPs.
13. Specialist average pricing is more transparent, and average prices for common procedures are publicly available online and over the phone to consumers requiring treatment.
14. Other measures to improve competition, such as bulk billing, are investigated in the inquiry.
15. The committee considers a range of measures to curb out of pocket costs, such as capping procedure costs.

Disclosure and informed financial consent

Given the increasingly worrying problem of out of pocket costs in private health care, there should be more emphasis on informed financial consent for medical procedures. Understanding the costs of a procedure is one of the most confusing elements of private health insurance for consumers, with 54% of private health insurance policy holders stating they had difficulty comparing out of pocket costs if they were to go to hospital. 12% of consumers dropped or downgraded their policy because they had unexpected or high out-of-pocket costs.[30]

[30] CHOICE survey information in private health insurance.

When consumers are sick, they are particularly vulnerable and may not be able to make informed, financial decisions about their care in the private healthcare system.

"I would like to provide a perspective as a doctor. I have seen patients consented for a procedure to use their private health insurance by surgeons and anaesthetists when patients were too unwell and/or receiving strong medications, and were obviously not able to provide informed financial consent." Confidential consumer submission

Consumers reported being confused about the amount and nature of fees for procedures, in particular for anaesthetists' fees. While consumers often have the opportunity to negotiate with their specialist in an initial or follow-up consultation, often the patient meets the anaesthetist at the time of the procedure and has very little opportunity (or does not know) to choose their anaesthetist.

"Seem to be out of pocket more each year. Doctors & anaesthetists charging over the scheduled fee. Recently my wife was charged $1287.00 over the scheduled fee by the anaesthetist. Too much for pensioners after paying for private health care. How can they charge so much over the scheduled fee?" Confidential consumer submission

Consumers are also confused about the financial arrangements of specialists, hospitals, Medicare and insurers. While they sign paperwork for their procedure, it is highly unlikely that this would constitute 'informed financial consent'.

"I recently had a baby and while my private hospital fees were covered, the obstetrician, anaesthetists and paediatrician fees were not. In total I paid an additional $6500 in specialist fees ($1200 for anaesthetists, $300 for paediatrician and the rest in obstetrician fees). When I tried to get some money back for the anaesthetist fees (which should be covered by my policy), they kept on using jargon and terms that I'm not familiar with to explain what I would get back. In fact, they couldn't even tell me what I would get back - they just said I would have to wait and see what Medicare would give back to me." Rachel Maiden, consumer submission

Much clearer information should be provided to consumers about the cost of a treatment, the cost covered by their fund, the cost covered by Medicare and the out-of-pocket costs. If a consumer were fully informed of their financial obligations well in advance of a procedure, it would also empower them to negotiate costs or shop around, increasing competition and lowering costs for all consumers.

"When one goes into private hospital (I am unaware of what happens in a public hospital) there should be a requirement, well before the event if at all possible, to know all costs including anaesthetist charges which are often separate. Surely this could be mandated." Confidential consumer submission

RECOMMENDATION

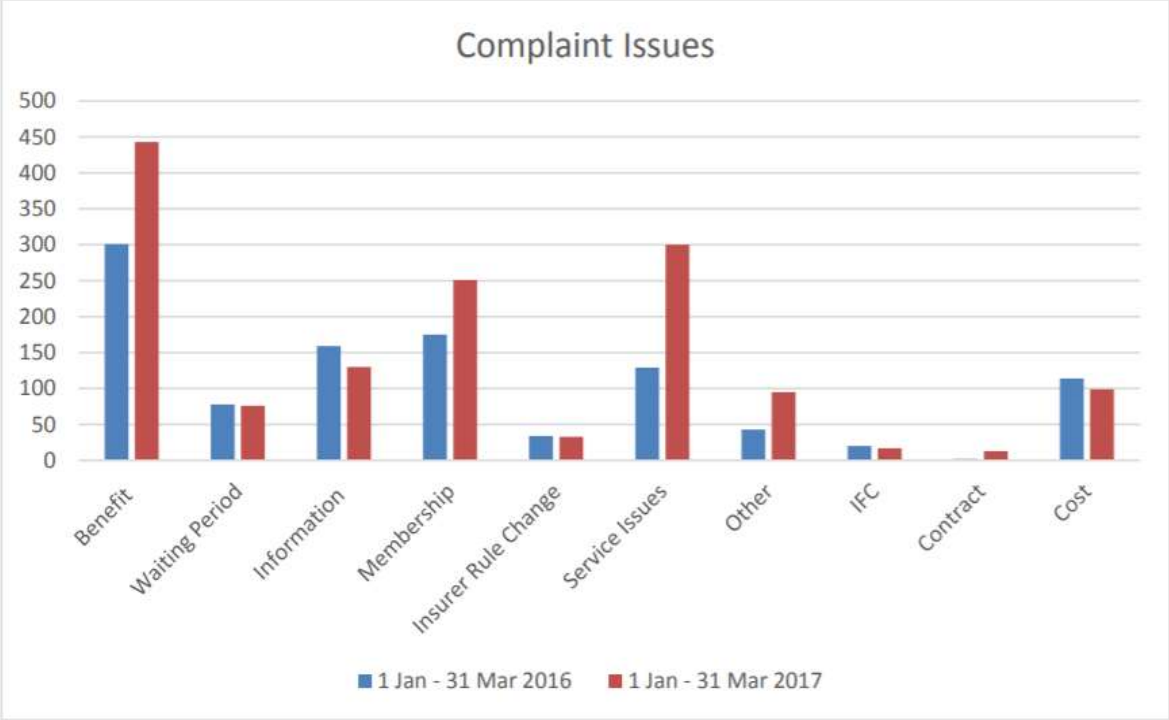
16. A best practice 'informed financial consent' model is developed for specialists and hospitals to ensure private health insurance patients are fully informed of out of pocket costs in advance.

Complaints about misleading information

Consumers can often feel uninformed about their PHI policy, misled by their insurer, or not made aware of specialists' costs in a clear and transparent manner. A significant increase in complaints made to the Private Health Insurance Ombudsman (PHIO) in relation to consumer confusion highlights the complexity of the private health insurance system.[31] A lack of information available to consumers and poor communication of policies (including changes to policies) impacts a consumer's ability to understand their coverage inclusions and exclusions.[32]

[31] Australian Competition & Consumer Commission, 2016. *Communicating changes to private health insurance benefits: A report to the Australian Senate on anti-competitive and other practices by health insures and providers in relation to private health insurance,* https://www.accc.gov.au/system/files/1109_Private%20Health%20Report%202014-15_FA1_web.pdf
[32] Australian Competition & Consumer Commission, 2015. *Information and informed decision-making: a report to the Australian Senate on anti-competive and other practices by health insurers and providers in relation to private health insurance.* https://www.accc.gov.au/system/files/981_Private%20Health%20Report_2013-14_web%20FA.pdf

Graph: The top ten consumer complaints made to the PHIO between January and March in 2016 and 2017[33]



Data from the Private Health Insurance Ombudsman complaints in 2016-17 found that many consumers found it difficult to either switch insurers or cancel their insurance altogether and most hospital exclusions and restrictions complaints were from consumers who found their policy no longer included coverage for a procedure they required. Up to 40% of PHI consumers do not even know if their PHI policy had policy exclusions and over 50% of PHI consumers were aware of coverage exclusions but were either unable to name these exclusions or did not know what their coverage included.[34]

[33] Private Health Insurance Ombudsman, 2017. *Quarterly Bulletin 82.* http://www.ombudsman.gov.au/__data/assets/pdf_file/0018/47205/PHIO-QB82.pdf

[34] Australian Competition & Consumer Commission, 2015. Information and informed decision-making: a report to the Australian Senate on anti-competive and other practices by health insurers and providers in relation to private health insurance.

Cases where insurers have changed gap scheme agreements without notifying consumers have been brought to light in recent legal proceedings initiated by the ACCC, highlighting the out of pocket costs incurred by these consumers.

Case study: Legal proceedings against NIB

"From not later than May 2015 NIB knew or ought to have known that consumers, or a significant proportion of consumers, of private health insurance were a particularly vulnerable class of consumers, and at a significant disadvantage relative to nib because they:

a) had low levels of understanding about medical costs, private health insurance and the risks of Out-of-pocket Expenses;
b) relied on nib to inform them about their entitlements to benefits and about potentials Out-of-pocket Expenses and Included Services under the Policies;
c) relied on nib to inform them of any changes to the Policies that would have a detrimental impact on them:
d) were unlikely to receive, from sources other than nib, up-to-date and timely information about the risks of Out-of-pocket Expenses prior to hospital admission; and
e) were unlikely to seek (either from nib, or their treating medical practitioner) up-to-date information about the risks of Out-of-pocket Expenses prior to hospital admission, because of their characteristics in (a) above or because they were distracted or anxious by the medical condition requiring their hospital admission."[35]

While consumers were still covered for their procedure, NIB (and Medibank, in a separate case) changed its gap scheme which is alleged to have resulted in significant financial harm to consumers. As consumers were not informed of these changes, they were unable able to search for better value products that met their needs. Insurers should always fully disclose any changes to the policy in formats that maximise consumer understanding (e.g. whether in writing, website, over the phone, via sms or a combination of channels, the outcome should be consumer acknowledgement and understanding of the changes).

Consumers reported not being warned about significant changes in payments for ongoing treatment:

[35] Court proceedings, obtained by personal communication. Media release accessible at https://www.accc.gov.au/media-release/accc-takes-action-against-nib

"Prior to 2015 we had top cover with Medibank Private. Following a lengthy emergency admission for me, we were stunned to receive accounts of almost $4,000 for radiology & pathology services. On querying these accounts with both providers we were informed that Medibank Private had recently discontinued cover on all radiology & pathology services. We had not received any notice of these changes from Medibank, & checking with family & friends revealed that they had also not received any notices & were unaware of the changes. Direct negotiation with Medibank & threats of referral to the Ombudsman resulted in partial refunds of costs from Medibank." Confidential consumer submission

CHOICE is supportive of recent enforcement undertaken by the ACCC. A strong enforcement regime against insurers that do not adhere to regulation and/or the Australian Consumer Law is necessary to ensure the private health insurance market is functioning in the interests of consumers. Given the complexity of this market, it is necessary for the regulators to continue to monitor the industry for bad practice.

RECOMMENDATIONS

17. Ongoing support is provided for the ACCC and Private Health Insurance Ombudsman to continue undertaking enforcement work and dispute resolution.
18. Insurers must make sure their customers have received, acknowledged and understood any changes to their policy with adequate time.
19. Consumers are provided with this information for any policy or gap scheme changes in in formats that maximise their understanding (e.g. whether in writing, over the phone, website, via sms or a combination of channels, the outcome should be consumer acknowledgement and understanding of the changes).
20. Policy holders who have ongoing treatment in the private system through their private health insurance policy should be exempt from any changes to their policy until their treatment has ended.

UNDERSTANDING EXTRAS

Confusion between extras coverage and hospital coverage

Extras coverage is the most common reason consumers purchase PHI (57% cited cover for extras as a key reason for taking out private health insurance)[36]. However, CHOICE's user testing indicates there is some confusion between the two.[37] We believe affordability and complexity could be addressed by helping consumers to better understand the difference between hospital and extras coverage, and to assess the value of their extras based on data about how they use their policy. For example:

- Some consumers may believe extras coverage is required for tax benefits, when it is not;
- Many consumers are unaware that it is possible to purchase hospital and extras policies from separate insurers, rather than as combined policies;
- Extras cover is essentially a budgeting tool. Perceptions of value would be enhanced if consumers could quickly assess the benefits of their extras policies against the costs, and use this data to explore the potential savings of other policies, from their own and other insurers. There is a role for government in enabling easier access and use of this information through open data initiatives.

The value of extras cover

While hospital insurance covers you for unexpected events that may otherwise cost thousands of dollars, extras health insurance acts like a budgeting tool assisting consumers with smaller ongoing costs. In many cases, this insurance is not good value for consumers because of the low dollar amount allocations for 'set benefits'.[38]

[36] CHOICE conducted a national survey of 1,027 Australian private health insurance policyholders in April 2017. The sample and online data collection was provided by an independent, accredited third party, The ORU. Quotas and weighting has been applied, ensuring the sample is reflective of the 2011 Census results by age and geographic location. Fieldwork was conducted from the 7th to the 12th of April 2017. All tables presented in this submission are of the sample N=1027 unless otherwise indicated.

[37] In the development of CHOICE's heath insurance finder user tests were conducted while consumers from diverse backgrounds to understand their health insurance information needs.

[38] CHOICE, Extras health insurance buying guide: https://www.choice.com.au/money/insurance/health/buying-guides/extras-insurance

Table: Benefits in extras insurance

Type of benefit	Definition	Example
Set benefit	Set benefits payout of a specific dollar amount for each item.	$40 is paid for each physiotherapy appointment (up to the annual limit).
Percentage benefit	A fixed percentage is paid out for each item.	80% of a physiotherapy appointment is covered, regardless of the cost of the appointment (up to the annual limit).
Combined set and percentage benefit	The two benefits are combined.	80% of a physiotherapy appointment is paid, up to $40.
Annual limits	Total amount that can be claimed for the entire year. Usually applies per person.	$250 for optical in a year.
Lifetime limits	Total amount that can be claimed over a long-term period. Usually applies per person.	Up to $2500 over a three-year course of orthodontic treatment.

CHOICE research has found that percentage benefits provide better value to consumers over the long term.[39] CHOICE research also found that advertising for extras coverage can attempt to overstate the benefits a consumer may receive back on their policy. For example, an insurer may advertise the top-line benefit (e.g. $400 for physiotherapy), but the policy holder will be restricted to item limits on individual claims. This means in some cases it would be extremely difficult for consumers to claim the full benefit on their policy unless they have ongoing treatment for a condition, which may be prohibitive because of the out of pocket expenses involved. Items limits are found in every service covered under extras insurance.

Some funds offer little clarity about the benefits they offer for particular items. In their marketing materials some only mention a "fixed benefit" for some items, without detailing the value of this benefit. Others list a benefit range for individual treatments without making it clear when the member will receive the higher benefit or the lower benefit.

[39] CHOICE, Extras health insurance buying guide: https://www.choice.com.au/money/insurance/health/buying-guides/extras-insurance

In order to find out what rebate they might receive from a dentist visit, prospective members often have to provide the fund's customer service with specific item numbers. This can make comparison a lengthy process, especially if dealing with several funds. Funds also regularly omit benefits for many medical appliances covered under extras, opting to list only benefits paid for consultations.

Information about item limits should be clear to consumers. A consumer would have to be very proactive to receive the full value back on their extras policy.

"The rebates we get on extras are like a lottery - you never know what you're going to get. On my first chiropractic visit after the change I got back 100% of the cost - $71. On the next visit, I got $62 back, out of pocket $9. My husband went - his first visit since the change and his first visit to the chiropractor (so charged as a long appointment). He got back $16.50, out of pocket $66.50." Paula Bown, Consumer Submission

Some policy holders argued that better benefits should be provided for extras cover as it was largely funding preventative measures, which made the overall population healthier. Better value for money in extras, and encouraging policy holders to use extras on proven therapies could reduce the strain on the hospital system.

"Our private health insurance is very expensive and the physiotherapy limit of $450 per annum only makes for 4 visits; there is no incentive to keep fit or healthy. As I need physio and a lot of exercise to help prevent surgery this is a short-sighted, total money making attitude by nib." Caroline Kades, Consumer submission

"I believe health care should be preventative and not 'after the fact'. The more we take care of our health now by following health diets, moderate exercise, stress reduction in all its forms the less we need extreme interventions later. Basically we build a healthy population and that's why the 'extras' are so important in health funds. AHM is quite fair in the way it distributes benefits for extra services. Other Health funds I've been in (Australian Unity, HCF) you can struggle to regain any benefit for the amount you pay for extras - you have to outlay so much money to get a measly few dollars back." Confidential consumer submission

Poor value leads people to either drop extras cover, or to not claim on this cover. Encouraging better information in extras cover would be beneficial to consumers accessing preventative health measures and would increase consumer confidence in the extras insurance product. Funds should make information on benefits for item numbers publicly available for all its

policies. Public listing of this information would help consumers shop around to find the best value policy for their needs.

> *"Extras are very poor value and don't seem to be worth having."*
> *Confidential consumer submission*

RECOMMENDATIONS

21. This inquiry should review the value and options available in extras cover to better meet consumer demand and expectations of value.
22. Item limits should be clearly stated in insurers advertising and marketing materials.
23. Funds should make a full list of benefits for covered items available on their websites for prospective members.

Unproven treatments in extras coverage

"When we looked into our options as we reached the end of the tax year, policies were confusing and opaque. Treatments and therapies actually covered through PHI seemed minimal: they either covered only a tiny portion of a treatment or did not cover it at all. Every policy is slightly different so you cannot compare like for like. Many policies were also clearly not informed by evidence-based healthcare (e.g. covering "complementary therapies"): not only does this give these 'therapies' credibility to those less-informed but they could also be harmful at worst." Confidential consumer submission

Consumers have complained to CHOICE about the inclusion of unproven medical treatments in 'extras' policies, including heath funds subsidies for:

- Chiropractic
- Naturopathy
- Homeopathy
- Aromatherapy

In some cases, there is strong evidence that these medical treatments are not effective, as is the case with homeopathy, naturopathy and chiropractic treatments offered beyond assistance

with muscle issues (e.g. treatment for irritable bowel syndrome or chiropractic services for infants).[40]

CHOICE strongly supports an evidence-based approach to 'extras' insurance. Currently, consumers are unable to opt out of subsidising unproven treatments in order to receive insurance for medically proven treatments such as optometry, physiotherapy and dental. The Australian taxpayer also subsidises these treatments, through the private health insurance rebate. There was a strong sentiment from consumers that they should also be provided with the option to purchase a product that only covers these proven medical treatments.

"I would like to see more rigour applied to the sort of extras cover offered. There is no evidence that a number of the therapies that are regularly covered have any value at all. I think it is dishonest to cover these as extra's and, at the very least, we should be allowed to opt out of these unproven therapies (e.g. acupuncture, chiropractic, naturopathy, homeopathy) and replace them with evidence based therapy such as physiotherapy and remedial massage." Confidential consumer submission

"Apart from the ever escalating cost, I find the bundling of extras complex and unfair. I require a medically prescribed CPAP machine. The extras rebate on such units themselves is nugatory. Each machine comes with essential ancillaries such as masks, tubes, filters and so on. All these wear out with usage and must be replaced or the equipment doesn't function. There is no rebate paid by Medibank on any of these things, some of which cost up to $300. At the same time I can make a claim for rebate of costs incurred for pseudo-therapies such as chiropractic, aromatherapy, naturopathy, homeopathy and so on which are all of dubious benefit to anyone. Also, I cannot opt out for contributing to these unwanted therapies." Gerald Lynch, Consumer submission

Preferred providers

CHOICE is concerned that a growing trend of preferred provider networks and fund-owned clinics is raising potential issues for competition consumer choice.

Where fund-owned clinics provide no-gap services, and preferred provider networks provide known-gap or lower gap services, consumers are steered to using these services. The growth

[40] CHOICE, Natural therapies likely to be stripped of benefits: https://www.choice.com.au/money/insurance/health/articles/natural-therapies-likely-to-be-stripped-of-benefits-070115

of these agreements has meant insurers are quasi-dictating where a policy holder can receive a service.

A consumer might want to see a provider over several years for continuity of care (either for their general health or for treatment for a specific, ongoing health issue). While a policy holder might receive benefits from their insurer for visiting their provider, they may not receive this benefit if they were to change health insurers.

"We can not understand why there should be a difference between preferred providers. For example the dentist we prefer is in walking distance but, if we want the maximum rebate, we have to drive a 40km round trip. The same applies to optometrists if we go to our local optometrist we get less rebate then if we go to their preferred provider who is a 40km round trip." Anneke Vanderkolk, Consumer submission

For example, a policy holder's dentist may have an agreement with their insurer BUPA, but no agreement with Medibank. If the consumer wanted to exercise their choice to have continuity in their treatment, it would be prohibitive for them to change funds to an alternate provider.

Clearer benefits and fewer restrictions on consumers would increase competition between providers and open up consumer choice. Increased competition would also allow consumers to select providers that best meet their healthcare and other personal needs. While there are consumers who see the direct benefits of preferred provider networks, the growth of these networks and its impact on consumer choice should be carefully monitored.

RECOMMENDATION

24. The inquiry and the ACCC should investigate competition in preferred provider networks and fund-owned clinics