Private Health Insurance Consumer Survey

Results and Discussion

January 2016

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Introduction

Australia has a public-private health system. Private health insurance (PHI) is a critical component of the Australian health care system: it is intended to assist with the costs of care in the private system, to support choice of private provider and to help take the pressure off public hospitals.

As just over half of all Australians are covered by some form of private health insurance[1], it is timely to consider whether consumers have the confidence that their policies are robust and will afford them access to critical treatments should the need arise. And as all taxpayers contribute to the Rebate, even though they may not be insured themselves, it is important to ask whether their contributions are being used to the greatest benefit of the health system at large.

The Government announced a review into private health insurance on 28 October 2015. In order to help inform the government's review into private health insurance, the Consumers Health Forum of Australia (CHF) launched the online survey on 6 November 2015, and it ran until 27 November 2015. CHF promoted the survey through its member organisations, publications and social media platforms. It was also highlighted in a number of other stakeholder newsletters and subscription media outlets.

CHF made its formal submission to the government's review on 14 December 2015. The full submission can be accessed from CHF's website[2]. The findings, discussion, and recommendations in this report should be viewed as a companion to the full submission, which discusses CHF's views in detail. While some of the recommendations in this report mirror those in our submission, we have limited them to the results of the survey.

The survey received 573 responses. The profile of survey respondents is discussed in detail in the report, but in general, respondents tended to be older than the general population and with higher incomes. The survey respondents were also overwhelmingly holders of private health insurance, thus making it impossible to draw meaningful comparisons to the experiences and opinions of non-insurance holders. Survey respondents were also slightly higher users of the health system than the general population.

The government also conducted a consumer survey as part of the review from 8 November 2015 to 7 December 2015 and received over 40,000 responses[3]. However, at the time of this report's publication, the government had not detailed the survey's results in order for CHF to draw comparisons.

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[1] According to the Australian Prudential Regulation Authority's preliminary data for the quarter ending September 2015, 47.3 per cent of Australians are covered by hospital treatment plans, and 55.8 per cent by general treatment plans – 50.9 per cent if ambulance only plans are excluded. *Private Health Insurance Membership and Coverage*, November 2015.

[2] *CHF Submission to the Review on Private Health Insurance: December 2015*. https://www.chf.org.au/pdfs/chf/CHF-PHI-Review-Submission-FINAL.pdf

[3] According to the Department of Health's page for the "Private Health Insurance Consultation 2015-16." http://www.health.gov.au/internet/main/publishing.nsf/Content/phiconsultations2015-16, updated 5 December 2015.

The survey

The key findings of the survey are:

- Most respondents were driven to take out private health insurance because of a lack of confidence in the public system's ability to provide timely, coordinated care.
- The leading reasons why respondents had private health insurance were to have better access to elective procedures, have control over their choice of provider, and avoid out of pocket costs.
- While holders of private health insurance were satisfied that their policies provided them with control over their providers (60 per cent) and having timely access to elective procedures (64 per cent), they were less satisfied that their policies adequately covered their health needs (43 per cent) and kept their out-of-pocket costs low (30 per cent).
- Only a slim majority of policy holders (51 per cent) were confident that they understood what their policy covers, even though almost half (48 per cent) have had their policies for 11 years or longer. More than one-in-five respondents (24 per cent) reported having had a claim denied by their health insurer.
- Overall satisfaction of respondents with insurance of their policies was 38 per cent.

The key takeaway from the survey is that while people are choosing to take out private health insurance for apparently practical reasons, they do not appear to be receiving overall value for having insurance in the absence of a medical need. Even then, their coverage for necessary procedures was not always comprehensive, resulting in higher consumer costs. This lack of overall value appeared to be a significant burden on households.

On the whole, respondents reported the average annual cost of their policies was $3,377 per year, varying between $1,938 for individual policies and $4,337 for family policies. Considered on top of other out-of-pocket expenses, for respondents with insurance who also reported out-of-pocket expenses, the average cost of their policies was $3,294 with an additional, average, annual out-of-pocket expenditure of $2,035. Among these persons, 46 per cent reported a combined expenditure above the national average of medical care and health expenses, as reported by the Australian Bureau of Statistics (ABS)[4], with almost one-in-five (18 per cent) having a combined expenditure of 10 per cent or higher.

The implications of the lack of value of private health insurance for consumers are far reaching. Consumers desire having private health insurance as a way to avoid increasing wait times in the public system – which is also a key government interest – and having control over their choice of care provider, but are not happy about the lack of cost controls. Although respondents were supportive of the Rebate (65 per cent), many felt it was too low to cover the cost of health insurance (35 per cent).

[4] According to the "Household Expenditure Survey, Australia: Summary of Results, 2009-10," its most recent survey, "Medical care and health expenses" made up 5.3 per cent of Australians' household expenditures.

Results and Discussion

Utilisation of Private Health Insurance

The survey respondents were overwhelmingly currently covered by health insurance (87 per cent, ***Table 1***) – much higher than the general population – or previously had insurance (6 per cent). The proportion of respondents without private health insurance and who did not previously have private health insurance (7 per cent) was too small to make significant extrapolations about the opinions of non-insured Australians. As such, our analysis of the survey is confined to those respondents who reported currently having or being covered by private health insurance, unless otherwise indicated.

Table 1

Do you have private health insurance?

Yes - Policy Holder	76%
Yes - Covered by Insurance	10%
No - Previously Insured	6%
No	7%
Don't Know	*

Based on 540 responses

Overwhelmingly, respondents with private health insurance had a Combined Cover policy (85 per cent), with 11 percent having Hospital Cover only, and the remainder General Cover. The policies were almost evenly distributed across individual plans (34 per cent), families (33 per cent) and couples (32 per cent).

Almost three-fourths of respondents with insurance reported having had some form of insurance coverage for 16 or more years, with another 10 per cent having coverage for 11 to 15 years (***Table 2***). Overall, just less than half (48 per cent) of respondents with private health insurance reported having their current policies for 11 years or more, with almost one-in-three (29 per cent) having had their existing policies for more than 20 years (*Appendix, **Charts 1 and 2***).

Table 2

How long have you had any form of private health insurance?

More than 20 years	63%
16-20 years	11%
11-15 years	10%
6-10 years	9%
2-5 years	5%
Less than 2 years	2%

Based on 457 responses

These statistics strongly suggest that persons with private health insurance fall victim to a "set and forget" frame of mind, despite possible changes to their life circumstances that may affect the value of their coverage. While a high percentage of respondents indicated they understood what their policies did and did not cover (42 per cent responding to either "4" or "5" on a Likert scale), the degree of confidence varied based on how long the respondent had been an insurance holder (***Table 3***).

Respondents who have had some form of health insurance for more than 20 years were more than twice as likely to say they knew what their insurance covered (58 per cent) than respondents with some form of health insurance for 5 years or less (24 per cent). This may be a reflection that the more direct experience consumers have with the insurance system, the better able they are to understand their coverage.

Table 3

How well would you say you understand what your insurance does and does not cover?

	Not well at all 1	2	3	4	*Very well* 5	Don't know
All respondents	7%	15%	25%	29%	23%	1%
Respondents having insurance for…						
More than 20 years	7%	11%	22%	32%	26%	1%
11-20 years	5%	31%	23%	23%	17%	0%
6-10 years	8%	21%	36%	21%	15%	0%
5 years or less	7%	34%	28%	14%	10%	7%

Based on 456 responses

As nearly three-fourths of respondents (73 per cent) indicated that they had needed to lodge a claim with their provider at some point in the last year, and more than one-in-five (24 per cent) said they'd ever had a claim denied, consumers with insurance appear to have ample opportunity to learn the ins-and-outs of their policies over time.

The reasons most commonly cited by respondents for taking out private health insurance (*Appendix*, ***Chart 3***) were to:

- Have quicker access to elective procedures (77 per cent)
- Have more control over the providers they could see (69 per cent)
- Avoid possible financial costs in the absence of insurance (68 per cent)
- Avoiding over-reliance on the public system (64 per cent).

Regarding the point about reliance on the public system, the survey revealed strong concerns among all respondents – those with and without private health insurance – about the ability of the public system to meet demand. A majority (54 per cent responding to either "4" or "5" on a Likert scale) disagreed that the public system is able to offer timely access for health care. Just less (48 per cent) disagreed that it has sufficient medical professionals to meet demand, with an equal proportion disagreeing that it is able to coordinate services for chronic or complex needs. The only apparent support for the public system among respondents was in its ability to provide affordable health care, a position which 47 per cent of respondents agreed with.

Value of private health insurance

As the government pays billions of dollars each year through the Rebate to support the insurance industry, it is vital that the products are viewed by consumers as having value in the delivery of health care for the expense of insurance.

Among all respondents with insurance, they reported an average, annual cost of their policies at $3,377 per year. The costs varied by policies, with individual plans costing an average $1,936, couples plans costing $3,955, and family plans $4,337.

For respondents who reported both the annual costs of their insurance and out-of-pocket expenses, the averages were $3,294 and $2,035, respectively. The average Australian, however, pays $1,075 per year in out-of-pocket health costs[5], meaning persons with private health insurance are paying significantly more than those who do not. This is consistent with previous research undertaken by CHF which found that persons with private health insurance are more likely to pay more in out of pocket expenses than those without[6].

These figures come despite the fact, as discussed in the previous section, that more than two-thirds of people sought private health insurance in order to avoid a financial burden.

Of the respondents who reported the costs of their insurance, out-of-pocket expenses, and gross household income, three-in-five (40 per cent) reported that the combination of their insurance and out-of-pocket expenses were six per cent or more of their household income. Almost one-in-five (19 per cent) reported that their combined health costs represented 10 per cent or more of their household income (***Table 4***).

Table 4

Combined insurance premiums and out-of-pocket expenses as a percentage of household income

10% or more	"Very High"	19%
8.0-9.9%	"High"	8%
6.0-7.9%	"Above Average"	13%
4.0-5.9%	"Average"	19%
2.0-3.9%	"Below Average"	25%
Less than 2.0%	"Low"	16%

Based on 407 responses

The survey responses do not appear to indicate that the higher out of pocket costs for persons with private health insurance are due to greater use of the health system.

Table 5

What's your best guess as to how many times you visited a GP in the last year?

NHPA Category	Respondents	Australians	Difference
Very High (20+)	8.6%	3.8%	4.8%
Frequent (12-19)	9.5%	8.7%	0.8%
Above Average (6-11)	22.2%	22.8%	-0.6%
Occasional (4-5)	22.9%	15.8%	7.1%
Low (1-3)	34.1%	33.6%	0.5%
Zero	2.6%	15.3%	-12.7%

Based on 552 responses

On the whole, the survey respondents were more frequent users of the health system than the general population, with 97 per cent of respondents having seen a GP in the last year versus 85 per cent of Australians[7]. However, the frequency of visits still hovered around the national average, with only 40 per cent of respondents seeing a GP six or more times in the last year versus 35 per cent of the general population (***Table 5***).

[5] The Senate Community Affairs References Committee Report, *Out-of-pocket costs in Australian healthcare*. August 2014.

[6] In our report on our survey into out-of-pocket costs, *Health Consumer Out-of-Pocket Costs Survey: Results and Analysis*, 38 per cent of respondents without private health insurance had annual out-of-pocket costs in excess of $1,000. For respondents with insurance, that percentage rose to 56 per cent.

[7] According to a report by the National Health Performance Authority, *Healthy Communities: Frequent GP attenders and their use of health services in 2012–13*. March 2015.

While the government offers a tax Rebate to assist with the affordability of health insurance, it does not appear that this is providing any meaningful assistance to consumers who are struggling with health affordability. In their comments on the survey, many respondents indicated that a major financial burden was the gap in specialist fees that their insurance does not cover.

Although a large majority of respondents support the government's Rebate policy (65 per cent overall, 71 per cent of policy-holders) only one-third (32 per cent) believed the level of Rebate to be adequate, with 36 per cent believing it's too low. Among respondents whose combined health costs were 10 per cent or more of their gross household income, a majority (54 per cent) believed the Rebate level to be too low (***Table 6***).

Table 6

In general, how do you feel about the levels of rebates offered by the government?

	Too low	About right	Too high	Don't know
All respondents	36%	32%	17%	15%
Respondents with household health expenses of…				
10% or more	54%	35%	5%	6%
8.0-9.9%	29%	44%	9%	18%
6.0-7.9%	32%	40%	17%	11%
4.0-5.9%	34%	39%	12%	14%
2.0-3.9%	41%	29%	20%	10%
Less than 2.0%	24%	36%	27%	12%

Based on 540 responses

Yet while the government offers the Rebate to assist with insurance affordability, it also penalises Australians who don't have health insurance through two mechanisms – the Lifetime Health Cover rating and the Medicare Levy Surcharge. Those measures were introduced by the government at a time when overall uptake of health insurance in Australia was at historic lows in order to compel uptake of policies.

While 49 per cent of respondents with health insurance said they wanted to avoid a higher Lifetime Health Cover, only 35 per cent were worried about being penalised by the Medicare Levy Surcharge.

When asked about their satisfaction with their insurance policies' ability to keep costs manageable, less than one-in-three indicated satisfaction (30 per cent responding to either "4" or "5" on a Likert scale), with 43 per cent indicating dissatisfaction (***Table 7***).

While majorities indicated satisfaction that their insurance provided them with better access to hospitals for elective procedures (64 per cent) and offered them control over the providers they wished to see (60 per cent), just over two-in-five (43 per cent) said they were satisfied that their insurance covered treatments for their specific health conditions.

The combination of high costs of coverage and lower satisfaction in insurers' ability to meet consumers' needs appeared to be the key factors behind respondents' overall satisfaction with their insurance. Despite the previously mentioned satisfaction with access to care, only 38 per cent of respondents with health insurance indicated overall satisfaction with their policies, despite the otherwise high marks for access to hospitals and providers. Moreover, it did not appear that respondents were satisfied that their insurance was keeping up with their health needs.

Table 7

How satisfied are you that your current policy…

	Not at all 1	2	3	4	*Very* 5	Don't know
Gives you control over the providers you see?	8%	11%	16%	28%	32%	5%
Provides you with better access to hospitals?	6%	7%	15%	32%	31%	8%
Adequately covers treatments your health conditions?	13%	18%	22%	26%	17%	4%
Keeps the costs of your health care manageable?	19%	24%	25%	19%	11%	2%
Based on 456 responses						
Overall	7%	21%	31%	26%	12%	3%
Based on 454 responses						

Policy Considerations and Recommendations

The Government has a responsibility to ensure that the public health system is sustainable. Yet in recent years, more attention has been given to whether the health insurance market is solvent.

As the government is involved in the health insurance market by way of the Rebate and regulation of premium increases, it has the responsibility to ensure that taxpayer dollars are not going towards a system that both lacks transparency and places an undue burden on consumers to purchase a health plan that meets essential health needs.

The proliferation of insurance policies has made it increasingly difficult for consumers to shop for an appropriate insurance policy and understand just what their policies cover. Given the scope of the market, it is incumbent on Government to be an active regulator by identifying and eliminating policies that do not provide value to consumers.

It also has the responsibility to set the policy frameworks to ensure that consumers are able to have timely access to information about the costs of insurance – not just the premiums on the face of the policies, but what other fees and relevant performance information might be applicable by specialists and other health practitioners in order for consumers, in consultation with their GPs, to make informed choices.

In light of the issues revealed by our survey, CHF makes the following recommendations for the future of the Australian health insurance market. As mentioned previously, we discuss these and other recommendations in greater detail in our full submission to the review, which is available from our website.

Nationally standard health insurance product (myCover)

CHF believes that there ought to be a legislated, national standard for basic or default hospital coverage (*myCover*) that would be required by all health funds to offer to consumers. The suite of myCover packages should be tailored to accommodate different stages of the life course. The services covered under this basic package ought to be evidence-based and in relatively widespread use by the medical community. It should have minimal exclusions, standard excess arrangements and be fit for purpose.

Having such a standard package would prevent Australians from falling victim to "junk policies" that fail to meet essential health needs. It would allow Australians shopping for health insurance to have a basic standard against which they could compare the financial costs and potential value of other policies and services and so make it easier to use comparator websites when making the decision.

Rebate reform

CHF calls for the Rebate to be redesigned to only apply to hospital products that meet as a minimum the myCover standard for hospital cover as recommended above. Furthermore, the Rebate ought to be indexed to the costs of providing care under the package.

Regarding General Cover policies, CHF believes that, if a rebate continues to apply, it should be tied to treatments and procedures with an evidence base and shown to have clinical benefits. CHF also believes that the Government could consider other innovative policy options such as moving away from offering Rebate incentives and, instead, encourage people to self-insure for the costs of private allied health and dental services, such as a health savings account.

In place of offering the Rebate broadly for General Cover policies, the Government could offer matching contributions or provide flexible reimbursements for certain, evidence-based procedures and preventive measures. Additionally, there may be incentives to support to consumers and insurers that participate in preventive health and hospital avoidance programs. These could also include certain, targeted chronic disease prevention and management programs.

Insurers ought to be permitted to develop and market policies that can compete with the health savings account, and consumers would be free to select such policies based on their own needs and preferences. However, such policies should exist in a purely competitive environment and not be supported by Government rebates or other subsidies.

Transparency of premiums

Survey respondents repeatedly made comments about the impact of premium increases against the overall value of their insurance. Many cited ever-rising premiums as a possible reason for eventually dropping their insurance coverage. CHF calls for amendments to the *Private Health Insurance Act of 2007* to require health insurers to make more transparent and explicit their rationales for increasing premiums when notifying their customers. Additionally, insurers should be transparent about the reasons why some customers' premiums have increased at a higher rate than the health fund and national averages. Moreover, we call for a cap on the rate that premiums may rise on health insurance packages in a given year while retaining eligibility for the Rebate.

Consumer information and decision-making

When shopping for private health insurance, most respondents (51 per cent) reported turning to insurer-provided information, whether printed or electronic. This was followed closely by the use of insurance comparison sites (40 per cent) and then recommendations by family and friends (35 per cent). Other respondents reported "going with the flow" and using the providers of their parents and employers, and several indicated that they had held their policies for so long that they could not remember which sources of information had been available.

One constant among the sources of information, however, was that few found the process easy. Only 27 per cent of respondents indicated that the process of shopping for health insurance was easy, versus 42 per cent who found it difficult (with 24 per cent indicating the highest level of difficulty).

Overcoming the chronic information asymmetry in the marketplace is a critical area of reform that must be addressed in this Review. The current health insurance marketplace is a morass of confusion for consumers, repeatedly reinforced through several surveys, reports, and complaints to agencies such as the Australian Competition and Consumer Commission and ourselves. The proliferation of policies and the manner in which they may change can leave many consumers unsure of what they are and are not covered for until they present at hospital.

CHF calls for legislated reforms to improve informed financial consent at the time a consumer purchases health insurance, and at any stage that their premiums may change. Such reforms ought to include a mandate for the use of plain language in explaining the policy's coverage and costs. Similarly, there should be regulatory requirements for funds to publicise information held about specialists' fees, performance and waiting times. Many health funds have already taken it on themselves to provide information to their customers in this manner, CHF believes that legislating such requirements would not provide an undue administrative burden for compliance and is the only way to ensure consistent, industry-wide information and disclosure practices.

Appendix

Chart 1

Percent of Repondents with PHI and Time Under Current Policy

Time with any Insurance (Years) \ Time Under Current Policy (Years)	20+	16-20	11-15	6-10	2-5	< 2
20+	29%	4%	4%	9%	10%	8%
16-20		4%	1%	2%	2%	2%
11-15			6%	1%	1%	2%
6-10				4%	2%	2%
2-5					4%	1%
< 2						2%

Based on 457 Responses

Chart 2

Repondents' Time Under Current Policy vs. Lifetime of Coverage

Time Under Current Policy (Years) \ Length of all Insurance Coverage (Years)	20+	16-20	11-15	6-10	2-5	< 2
20+	46%	6%	6%	14%	16%	12%
16-20		35%	8%	14%	22%	22%
11-15			60%	6%	13%	21%
6-10				46%	26%	28%
2-5					87%	13%
< 2						100%

Based on 457 Responses

Appendix

Chart 3

How strong were these factors for you in choosing to purchase private health insurance?

	Not at all 1	2	3	4	*Very* 5	Don't know	1 & 2	4 & 5	Diff.
I wanted to have quicker access to elective procedures	7%	5%	7%	19%	58%	4%	12%	77%	65%
I wanted more control over the providers I see	9%	7%	11%	21%	48%	3%	16%	69%	53%
I was concerned about financial costs of care without insurance	8%	10%	11%	18%	50%	3%	18%	68%	50%
I was concerned about relying on the public hospital system	11%	11%	12%	20%	43%	3%	22%	64%	42%
I wanted to avoid paying a high Lifetime Health Cover later	22%	11%	12%	15%	34%	6%	33%	49%	16%
I wanted better coverage for existing health conditions	26%	13%	13%	14%	30%	4%	39%	44%	5%
I wanted to avoid the Medicare Levy Surcharge	34%	13%	14%	10%	25%	4%	47%	35%	-12%

Based on 466 responses

Background information

The Consumers Health Forum of Australia (CHF) is the national peak body representing the interests of Australian healthcare consumers. CHF works to achieve safe, quality, timely healthcare for all Australians, supported by accessible health information and systems.

CHF does this by:

1. advocating for appropriate and equitable healthcare
2. undertaking consumer-based research and developing a strong consumer knowledge base
3. identifying key issues in safety and quality of health services for consumers
4. raising the health literacy of consumers, health professionals and stakeholders
5. providing a strong national voice for health consumers and supporting consumer participation in health policy and program decision making

CHF values:

- our members' knowledge, experience and involvement
- development of an integrated healthcare system that values the consumer experience
- prevention and early intervention
- collaborative integrated healthcare
- working in partnership

CHF member organisations reach thousands of Australian health consumers across a wide range of health interests and health system experiences. CHF policy is developed through consultation with members, ensuring that CHF maintains a broad, representative, health consumer perspective.

CHF is committed to being an active advocate in the ongoing development of Australian health policy and practice.