Consumers Health Forum of Australia

SUBMISSION

ACCC Report to the Senate on Private Health Insurance

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Overview

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

CHF has consistently called for improved information provision to consumers as way of ensuring they understand their private health insurance policies and can make informed decisions. We regard the ACCC's continued interest in this issue and the fact that the last two reports have been focused on information provision as critically important. We made a submission on this issue to the 2015 report and were a participant at the stakeholder roundtable on information provision that the ACCC held in 2016. We welcome the opportunity to contribute to the latest ACCC report to the Senate on Private Health Insurance. Concurrently to this process we are participating in the Private Health Ministerial Advisory Committee and are represented on the Information Provision Working Group of that Committee.

CHF launched a campaign in February 2017 to encourage consumers to look into their current private health insurance cover and to see if they may be able to get a better deal elsewhere. The 'HealthyCover' campaign consists of a five question checklist which consumers can use as a starting point for evaluating their cover (see final section). Following their engagement with this checklist they were encouraged to participate in a short survey about their experiences of doing so, including a free text comment section. The following submission draws on the results of that survey which are relevant to information provision practices.

General comments

It is becoming increasingly evident that there are disparities between what consumers are told verbally and what is written in PDS or information on insurer's websites. These disparities are highly concerning, as they reflect an inequality in how insurance is being offered. Consumers who have the time and ability to call their insurer, or to read more detail, may have access to different or better benefits than those who don't. We suggest that attention to this area is warranted to ensure that all consumers are able to access the same set of benefits at the same price.

The contracting arrangements that insurers enter into with providers are consistently poorly publicised. The existence of these schemes is promoted using inconsistent wording between insurers, and the details of how consumers are to access them are unclear. While CHF does not oppose the existence of contracting arrangements, and we acknowledge that they may be beneficial to consumers, consumers are disadvantaged if these schemes are not well publicised. In preparing for this submission we attempted to access the list of hospitals that a number of insurers contract with through their websites. All of the insurers we examined required consumers to go through a number of search steps to find if a hospital, or other health provider, had a relationship with the insurer. In all instances consumers were strongly recommended to call the insurer to confirm their benefit entitlement prior to receiving treatment.

In a number of cases the caveats associated with these arrangements (e.g. that providers can apply the no-gap arrangements on a case-by-case basis) were presented in text that was lighter than the other text on the page or displayed at the end of a page which had a lot of other information on it.

CHF strongly believes that these arrangements disadvantage consumers through the imposition of overly onerous requirements. In the majority of cases where consumers require even elective hospital treatment they are in a position and time of stress. Requiring consumers to call the insurer, often on a number which is only answered during business hours, compounds this stress. Insurers could prevent this by making the lists of hospitals and providers that they have contracts with clearer and through guaranteeing the fidelity and accuracy of their websites.

There are a range of terms used by insurers which have minimal use outside of the private health insurance industry and are not intuitive to consumers. We have selected and discussed a number of these below. However, we intend this list to be indicative of the problem, not comprehensive.

The terms used to describe the out of pocket payments that consumers may or may not have to pay are described in terminology which is laden with jargon. The frequently accepted terms in the industry of 'gap' or 'no gap' are not intuitive to consumers without prior experience in private health insurance. Further to this, 'no gap' can be used to mean a range of benefits and entitlements or lack thereof.

The meaning of 'pre-existing conditions' and the implications of having said conditions is another term which had varied meaning across the industry. Recent estimates of the prevalence of chronic disease in the Australian population are that half of all Australians have one or more chronic disease[1]. Given this, we believe that the meaning and implications of this idea need to be clarified for consumers. Encouragement or regulation to clearly explain these terms on insurers websites or by providing a glossary in PDS brochures are ways that this could be clarified.

A final area of confusion is the practice of how insurers notify consumers about increases to their premiums. The practice of reporting the average increase across an insurer's policies in the media and on insurer's websites, while simple, is unhelpful to consumers. Further to this, the methods by which insurers notify consumers of the increase to their premiums could be made clearer. We have observed that insurers adhere to the letter, not the spirit, of the regulation in many instances. The information provided to consumers is detailed and convoluted, particularly when their premium is increased concurrently to a reduction in the benefits offered. We are supportive of the efforts made by insurers in the development of the Code of Conduct, however we believe that the requirements for information provision in this code need to be further strengthened in favour of consumers.

Findings from CHF's Healthy Cover survey

The responses to our Healthy Cover survey to date and which is currently still open, show that overall consumers use a range of ways to find information about their health insurance but the majority of consumers only use one source of information. While the depth of understanding that can be drawn from these survey responses is limited due to the small number of respondents to date (63 at time of submission). However, these comments are broadly indicative of the results of our wider consultations and as such we believe the conclusions to be trustworthy.

Approximately one third of respondents used each of the government website, a specific insurer's website, and a comparator website. This finding shows the importance of each of these sources being accurate, up to date and honest about the limitations of the information they display. While we do not

[1] Australian Institute of Health and Welfare (2015). 1 in 5 Australians affected by multiple chronic diseases: http://www.aihw.gov.au/media-release-detail/?id=60129552034

believe that each of these sources need to be, or should, be completely comprehensive as they serve different purposes and target different audiences, we strongly believe that they should acknowledge their limitations.

In particular we are concerned about the lack of regulation around comparator websites. We support the work of the ACCC to date on comparator websites, in particular the consumer information provided on your website. However, none of our survey respondents indicated they had accessed these publications. We suggest that greater efforts are put into disseminating these information sources and would be happy to work with you to do so.

A positive finding from our survey was that over half of respondents were able to complete the actions they wished to do using available information whether that be to review and affirm the value of their current policy, or make the decision and take the step to switch, downgrade or drop. This suggests that consumers are able to access the information they need when they choose to search for it. However, this finding stands in contrast to the other reports we've heard from other sources and there could be an element of over confidence in these responses as reported in the Insurance Council of Australia's report *Too Long; Didn't Read* which looked at effective disclosure for general insurance. We believe that this positive findings is worthy of further investigation in future.

A majority of consumers chose to leave comments to the survey. The comments relevant to information provision are summarised below.

A strong theme arising from the comments was that complexity of policies makes comparing and moving between policies a significant challenge. Consumers found the process of comparing policies extremely time consuming and difficult. When they were able devote sufficient time and effort to compare policies they often found that they could make considerable savings on the amount they were paying in premiums. One consumer told us:

> *I did this a few months ago and appear to have saved up to around $1700 / year although refunds could be a little less on some items. It was a very complicated process especially for older people who have a relationship with the old insurer and pre-existing conditions*

Another consumer concisely captured the implications of misleading information being conveyed. This report is concerning and we would suggest that the ACCC consider this disparity for further investigation in future. Our data cannot determine whether or not these practices are deliberately misleading or merely accidental, however in either case this practice is problematic.

> *Health insurance websites are so complicated it is difficult to work out often what the benefit will be. For 2 things recently I called first and then later found the advice they provided was not consistent with the benefit they would pay - that is to say no benefit.*

A final area raised by consumers in our survey was their difficultly understanding the practice of insurers paying differential amounts for different medical item numbers, particularly for extras insurance. For example, when going to the dentist consumers don't differentiate between each of the steps or actions taken by their dentist which are then charged as separate items. Despite this, insurers are in the practice of limiting the amount they will rebate per item in a given year, not the overall amount paid for a dental service. As above, while CHF does not necessarily disagree with this practice we feel that insurers are not adequately explaining how and why the rebates paid are limited

per item. Both insurers and practitioners could work to change this practice by equipping consumers with tools to better understand the range of items included in a consultation or service and how they are differentially charged. This would empower consumers to get better value from their insurance and to better be able to compare insurance policies when they wish to change insurance coverage.

Consumer issues arising from Private Health Insurance Ombudsman reports

CHF acknowledges the work done by the Private Health Insurance Ombudsman (PHIO) around clarifying consumer concerns around private health insurance. The following section draws on the PHIO's recent state of the health funds report and their reports of the complaints received.

The 24% increase in complaints to the PHIO in the year 2014-15 are concerning. The key areas of complaints: hospital restrictions and exclusions and a lack of understanding of detrimental rule changes are areas which could be changed, in part, by improved communication by insurers. We suggest that the ACCC and the PHIO can help change this through examining the regulation around how and when information needs to be conveyed to consumers.

Complaints to the Ombudsman about insurers paying a lower benefit than expected reveals another area of insufficient and low quality information being provided to insurers. Insurance product brochures don't clearly articulate how much a consumer can expect to receive back from their insurer. The amounts stated as rebates are not stated with relation to the standard or average costs charged for a service. E.g. an insurer pays '$X' back for the initial use of a service in any one year. That $X is virtually meaningless if it is not stated in relation to the average cost of a service.

Text of CHF's 'Healthy cover' survey

Where did consumers go for information?

- A specific insurer's website
- Government website
- Comparator website (e.g. iselect, choosi, CHOICE)

Did they make a change?

- Yes
- No
- Dropped their insurance

If they made a change, they:

- Switched to another insurer and kept the same level of cover
- Switched to another insurer and increased the level of cover
- Switched to another insurer and reduced the level of cover
- Paid their premiums in advance

What stopped them when looking for information?

- Nothing, they were able to do what they needed to do
- The information from their insurer was too complex
- The information from the government was too complex
- Switching to another insurer was too hard

Consumers were also able to add comments to their survey response. A majority of respondents did so, these comments are summarised below.