



AUSTRALIAN COMPETITION
& CONSUMER COMMISSION

Report to the Australian Senate

**On anti-competitive and other practices by health
insurers and providers in relation to private health
insurance**

For the period 1 July 2017 to 30 June 2018

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Australian Competition and Consumer Commission
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Shortened terms

ABC	Australian Broadcasting Corporation
ABS	Australian Bureau of Statistics
ACCC	Australian Competition and Consumer Commission
ACL	Australian Consumer Law
APRA	Australian Prudential Regulation Authority
Bupa	Bupa HI Pty Ltd
CCA	<i>Competition and Consumer Act 2010 (Cth)</i>
CPI	Consumer price index
HBF	HBF Health Limited
HCF	The Hospitals Contribution Fund of Australia Limited
MACOPC	Ministerial Advisory Committee on Out-of-Pocket Costs
Medibank	Medibank Private Limited
NIB	NIB Health Funds Limited
PHIO	Private Health Insurance Ombudsman
Ramsay	Ramsay Health Care Australia Pty Ltd
SIS	Standard Information Statement

Executive summary

This is the 20th report to the Australian Senate prepared by the Australian Competition and Consumer Commission (ACCC) on competition and consumer issues in the private health insurance industry. This report is for the period 1 July 2017 to 30 June 2018 (the reporting period).

This report analyses key competition and consumer developments and trends in the private health insurance industry during the reporting period that have affected consumers' health cover and out-of-pocket expenses. This report also focuses on how private health insurers should communicate detrimental policy changes to consumers.

Premiums, out-of-pocket costs and participation rates are of concern

The costs of private health insurance continue to be of concern to consumers. In 2017–18, private health insurance participation rates continued to decline, while gap payments for in-hospital treatment increased. Further, recent premium increases have been greater than inflation and wage growth. Cumulative premium increases have been higher than wage growth over the past five years indicating that households with private health insurance are contributing an increasing proportion of their budgets to paying premiums.

Out-of-pocket costs are also of concern for consumers, with gap payments for in-hospital treatment having increased when they are payable. While the percentage of in-hospital services delivered without a gap payment remained relatively stable, and most in-hospital treatments are delivered with no gap payments required from patients, there has been concern around some patients paying significant out-of-pocket costs and being charged hidden administrative and booking fees.

There was a reduction in the proportion of Australians holding private health insurance during 2017–18, as occurred during the previous year. In response to higher prices, some consumers are switching to more affordable policies with greater exclusions or excess payments while others appear to be exiting the private health insurance market. The Australian Government is currently implementing reforms with the aim of making private health insurance simpler and more affordable.

Complaints to the Private Health Insurance Ombudsman decreased last year

In 2017–18, complaints about private health insurance to the Private Health Insurance Ombudsman (PHIO) decreased by 21 per cent, following their historic high in 2016–17. The PHIO reported that last year's decrease was partly attributable to its work in assisting insurers to improve their complaint handling processes, improvements in the complaint handling processes of the larger insurers, and smaller premium increases in 2018 compared to recent years. Despite this decrease, the number of complaints received by the PHIO in 2017–18 is the second highest level recorded over the past five years.

The PHIO reported that 82 per cent of complaints in 2017–18 were about health insurers. The benefits paid by insurers to consumers continued to receive the highest level of complaints—around 36 per cent of total complaints—the main issue of concern being hospital policies with unexpected exclusions and restrictions.

The ACCC seeks clear, prominent and timely communications from insurers notifying consumers of detrimental changes to their benefits

The ACCC has recently engaged with private health insurers and has put the industry on notice about communicating detrimental policy changes to consumers and complying with their obligations under the Australian Consumer Law.

The ACCC strongly recommends that private health insurers conduct a thorough review of all future communications with consumers to ensure any information about detrimental policy changes is clear, prominent and timely. This is particularly relevant in the context of changes to premiums and health insurance policies likely to take place ahead of private health insurance reforms coming into effect on 1 April 2019. In these circumstances, consumers must be given sufficient time ahead of any changes to consider the impact and make informed decisions about their health insurance cover.

ACCC enforcement actions

Private health insurers and other health industry participants have been the subject of a number of recent ACCC enforcement matters. In November 2017, following an ACCC investigation, Australian Unity agreed to pay at least \$620 000 in compensation to affected customers that were likely to have been misled about dental benefits they could claim from their policy. In finalising this matter, Australian Unity has provided a court-enforceable undertaking to the ACCC which includes commitments to improve the information it provides to consumers. ACCC enforcement matters involving NIB and Ramsay Health Care Australia are ongoing, and the ACCC's appeal in the Medibank matter is awaiting judgment.

Policy developments in private health insurance

The observations in this report are made in the context of ongoing implementation of a series of reforms to the sector, with the aim of making private health insurance simpler and more affordable. Reforms that did not require legislative amendment have been implemented from October 2017 onwards. In September 2018, a package of legislation implementing further reforms was passed by Parliament and given Royal Assent.

The reforms include:

- replacing the existing Standard Information Statement (SIS) with a new technology neutral minimum data set
- strengthening the powers of the PHIO and upgrading the privatehealth.gov.au website to make it easier to compare insurance products
- requiring insurers to categorise products as gold/silver/bronze/basic, and use standardised clinical definitions for treatments across their documentation and platforms to make clear what is and is not covered in their policies.

The last of the reforms, relating to increased maximum excesses, age-based discounts, travel and accommodation benefits, and the replacement to the SIS, will come into force on 1 April 2019.

The ACCC notes that some of the reforms are aimed at addressing issues which have been the subject of previous ACCC reports, such as the complexity of private health insurance products, difficulties in comparing different policies, improving information provision practices, and clarifying defined terms.

1. Introduction

This report analyses key competition and consumer developments and trends in the private health insurance industry between 1 July 2017 and 30 June 2018 (the reporting period), while acknowledging developments since the end of the reporting period.

In recent reports, the Australian Competition and Consumer Commission (ACCC) has made a range of observations relating to the adequacy of information provided by health insurers to consumers, including the way in which changes to the benefits available under policies are communicated to customers. The ACCC has recently written to private health insurers about these issues.

For its 20th report to the Australian Senate, the ACCC has prepared a concise report which provides an update on relevant consumer and competition developments during the reporting period. The ACCC has taken this approach having regard to a series of policy reforms that are currently being implemented addressing issues which have been the subject of previous reports.

The ACCC outlines in this report its expectation that private health insurers accurately inform consumers about any detrimental changes to policies in a clear, prominent and timely manner. This is particularly relevant in the context of changes to premiums and health insurance policies likely to take place ahead of private health insurance reforms coming into effect on 1 April 2019.

The ACCC notes that it will be actively monitoring complaints during this period to identify any issues arising from how private health insurers are communicating detrimental policy changes to consumers. For instance, the ACCC also understands that under the new reforms, a number of defined natural therapies will no longer receive the private health insurance rebate as part of an extras cover policy. In communicating detrimental policy changes to consumers, insurers should ensure that disclosures are accurately conveyed.

1.1 Senate order

This report has been prepared in compliance with an Australian Senate order, under which the ACCC has an obligation to report annually on competition and consumer issues in the private health insurance industry.¹ The complete Senate order is extracted below.

Senate order

There be laid on the table as soon as practicable after the end of each 12 months ending on or after 30 June 2003, a report by the Australian Competition and Consumer Commission containing an assessment of any anti-competitive or other practices by health insurers or providers which reduce the extent of health cover for consumers and increase their out-of-pocket medical and other expenses.

1.2 Role of the ACCC

The ACCC is an independent Commonwealth statutory authority whose role is to enforce the *Competition and Consumer Act 2010* (Cth) (CCA), including the Australian Consumer Law (ACL), which is a single national law providing uniform consumer protection and fair-trading laws across Australia. The ACL is enforced by the ACCC and all state and territory fair trading agencies. The object of the CCA is to enhance the welfare of Australians by promoting fair trading and competition, and through the provision of consumer protection.

¹ Senate procedural order no. 17 Health—Assessment reports by the Australian Competition and Consumer Commission agreed to 25 March 1999, by means of an amendment to the motion that the report of the committee on Health Legislation Amendment Bill (No. 2) 1999 be adopted. J.626, amended 18 September 2002 J.761.

All relationships within the private health insurance industry are governed by the statutory consumer protections in the CCA, including the ACL.² These include relationships between consumers and health insurers, hospitals, medical facilities, health providers and practitioners. Competition laws also govern relationships between industry players and, among other things, restrict anti-competitive arrangements and exclusionary conduct.

The ACCC's role in the private health insurance industry includes satisfying the terms of the Senate order, and enforcing and encouraging compliance with the CCA and ACL. The ACCC's Compliance and Enforcement Policy and Priorities outlines our enforcement powers, functions, priorities and strategies.³ The ACCC updates this document yearly to reflect current and enduring priorities.

1.3 Methodology in preparing this report

In preparing this year's private health insurance report the ACCC has not conducted a consultation process inviting written submissions from industry stakeholders as has occurred in previous years.

The ACCC has drawn on information and data from a range of sources, including desktop research and contacts data. Key industry data used and relied upon by the ACCC includes:

- industry statistics and data collected by the Australian Prudential Regulation Authority (APRA)
- private health insurance complaints data from the Private Health Insurance Ombudsman (PHIO).⁴

² The Australian Prudential Regulation Authority (APRA) supervises private health insurers operating in Australia under a regulatory framework as is set out on APRA's [website](#).

³ See [ACCC Compliance & Enforcement Policy & Priorities 2018](#).

⁴ The PHIO is a specialist role of the Commonwealth Ombudsman.

2. Key industry developments and trends

This chapter sets out key competition and consumer developments and trends in the private health insurance industry that occurred in 2017–18, as summarised below.

Summary of key industry developments and trends in 2017–18

- The costs of private health insurance continue to be of concern to consumers. In 2017–18, private health insurance participation rates continued to decline, while gap payments for in-hospital treatment increased. Further, recent premium increases have been greater than inflation and wage growth.
- Some consumers are allowing their policies to lapse, while others are not participating in the private health insurance market. The Australian Government is currently implementing reforms in an effort to make private health insurance more affordable.
- In 2017–18, consumers paid about \$23.9 billion in private health insurance premiums, an increase of almost \$834 million or 3.6 per cent from 2016–17. The amount of hospital benefits paid by health insurers was \$15.1 billion and the amount of extras treatment benefits paid was \$5.2 billion.
- Cumulative premium increases have been higher than wage growth in the past five years indicating that households with private health insurance are contributing an increasing proportion of their budgets to paying premiums.
- In June 2018, 45.1 per cent of the Australian population held hospital only or combined health insurance cover. This was a decrease of 0.9 percentage points from June 2017. Meanwhile, the proportion of the population holding extras treatment only policies increased from 8.9 per cent in June 2017 to 9.2 per cent in June 2018.
- While the percentage of in-hospital services delivered without a gap payment remained relatively stable over the past year, there has been an increase in gap payments when it is payable. About 88 per cent of in-hospital treatments were delivered with no gap payments required from patients. However, the average out-of-pocket expenses incurred by consumers from hospital episodes increased by 3.3 per cent. Extras treatment recorded a slight decline of 0.7 per cent.
- Consumers are also continuing to shift towards lower cost policies with exclusions, or excess and co-payments. In June 2018, 44 per cent of hospital policies held had exclusions, compared with 40 per cent in June 2017. There was also an increase in hospital policies with an excess or co-payment from 83 per cent to 84 per cent.
- Complaints to the PHIO have decreased by 21 per cent since June 2017. The PHIO attributes this decrease to their work in assisting insurers to improve complaint handling processes, the improved complaint handling processes of larger insurers, and the smaller premium increases in 2018 compared to recent years. Despite this decrease, the number of complaints received by the PHIO in 2017–18 is the second highest level recorded over the past five years. Over the same period, contacts to the ACCC declined by 17 per cent from 248 to 205.

2.1 Private health insurance membership

As at 30 June 2018, 13.55 million Australians, or 54.3 per cent of the population, had some form of private health insurance. This represents a reduction in coverage of 0.6 percentage points from June 2017, when 54.9 per cent of the population had some form of private health insurance. The Australian population grew by 365 244, or about 1.5 per cent, during this period.

This decrease in private health insurance continues the trend between June 2016 and June 2017, when the total number of insured persons decreased by 0.6 percentage points and the Australian population grew by almost 1.7 per cent.

Types of private health insurance

There are broadly two types of private health insurance. Hospital policies help cover the cost of in-hospital treatment by doctors and hospital costs such as accommodation and theatre fees. General treatment policies, also known as extras or ancillary cover, provide benefits for non-medical health services, such as physiotherapy, dental and optical treatment. Many consumers hold combined policies that provide cover for both hospital and extras services.⁵

Table 1 shows a reduction in the proportion of the population holding hospital only or combined cover, from 46.0 per cent in June 2017 to 45.1 per cent in June 2018. Meanwhile, the proportion of the population holding extras only policies has continued to increase, from 8.9 per cent in 2017 to 9.2 per cent in 2018.

Table 1: Insured Australian consumers by policy type, June 2016 to June 2018

	Hospital only or combined cover	Extras cover only	Total insured persons
June 2016	11 328 577	2 101 444	13 430 021
<i>% of population</i>	46.8%	8.7%	55.5%
June 2017	11 318 742	2 194 435	13 513 177
<i>% of population</i>	46.0%	8.9%	54.9%
June 2018	11 259 263	2 287 859	13 547 122
<i>% of population</i>	45.1%	9.2%	54.3%

Source: APRA, Private Health Insurance Statistical Trends, Membership Trends—June 2018.

Membership by health insurer

In 2017–18, there were a total of 37 health funds operating in Australia, including both not-for-profit insurers and for-profit insurers. Bupa HI Pty Ltd (Bupa) remained Australia's largest insurer ahead of Medibank Private Limited (Medibank), ending the 2017–18 financial year with just over 3.65 million members (as measured by individuals covered), compared to Medibank's 3.53 million members.⁶

As at June 2018, the top five health insurers in Australia provided cover to over 79.8 per cent of Australian consumers holding some form of private health insurance. As shown in figure 1, Medibank and Bupa represented over half of the Australian private health insurance market, with market shares of over 26 per cent each. The next three largest insurers—the Hospitals Contribution Fund of Australia Limited (HCF), NIB Health Funds Limited (NIB) and HBF Health Limited (HBF)—had a combined market share of around 26.8 per cent.

The top five health insurers have a combined market share of almost 80 per cent and contributed to 78 per cent of total health fund benefits paid in 2017–18,⁷ with Bupa and Medibank contributing

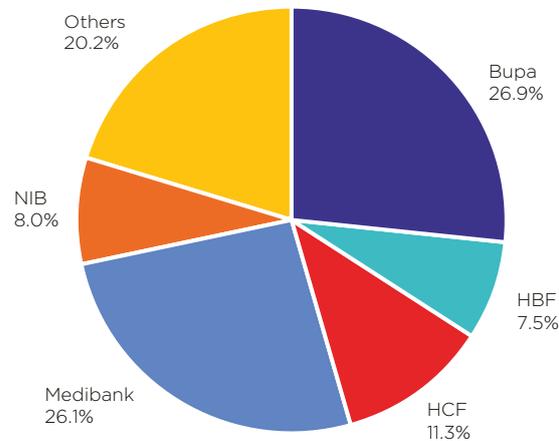
⁵ Ambulance cover may be available separately, combined with other policies, or in some cases is covered by state or territory governments.

⁶ APRA, [Operations of Private Health Insurers Annual Report 2017–18](#)—Table 3, 6 November 2018.

⁷ The amount paid by an insurer to a policy holder to cover health care costs.

27.2 per cent and 25.1 per cent respectively.⁸ Benefits paid by health funds are discussed further in section 2.3.

Figure 1: Insurer market share by Australians covered, 2017-18



Source: APRA, Operations of Private Health Insurers Annual Report 2017-18—Table 3, 6 November 2018.

2.2 Private health insurance expenditure by consumers

In 2017-18, Australian consumers paid about \$23.9 billion in private health insurance premiums, an increase of almost \$834 million or 3.6 per cent from 2016-17.⁹ As table 2 shows, this increase is less than in 2016-17.

Table 2: Expenditure on private health insurance, per year, by dollar and percentage change, June 2016 to June 2018

	\$ paid (in '000)	\$ change (in '000)	% change
June 2016	22 060 756	-	-
June 2017	23 066 402	1 005 646	4.6%
June 2018	23 900 108	833 706	3.6%

Source: APRA, Private Health Insurance Quarterly Statistics, June 2016 to June 2018.

Figure 2 shows average premium increases (on an industry weighted average basis), the inflation rate and the rate of growth in wages from 2013-14 to 2017-18.

During this period, premiums increased by an average of 5.4 per cent per year. The increase in private health insurance premiums has been significantly higher than the average annual growth in the wage price index (2.2 per cent) and the consumer price index (1.9 per cent) over the past five years. However, the rate of the average yearly increases in premiums has been decreasing each year over the past five years, and was 3.95 per cent in 2017-18.

Figure 3 shows the cumulative average increases in private health insurance premiums, the consumer price index, inflation in healthcare prices and wage growth over the five year period from 2013-14 to

⁸ APRA, [Operations of Private Health Insurers Annual Report 2017-18](#)—Table 3, 6 November 2018.

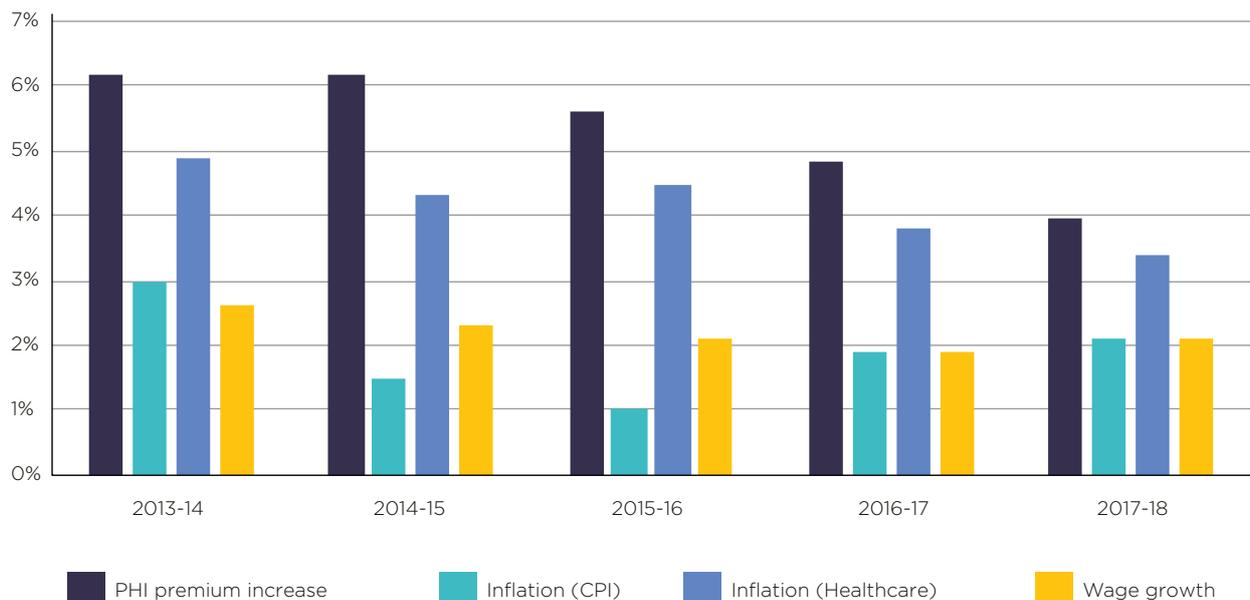
⁹ APRA, [Private Health Insurance Quarterly Statistics](#), June 2018, p. 10.

2017-18. Healthcare price inflation refers to the increase in the price of healthcare, including hospital, dental and medical fees, pharmaceutical products and therapeutic equipment,¹⁰ over time.¹¹

Figure 3 shows that private health insurance premium increases have outpaced wage growth and inflation in both the consumer price index and healthcare prices. Over the past five years cumulative average increases in inflation and wages were approximately 9.5 and 11 per cent respectively, while healthcare price inflation was nearly 21 per cent and premium increases were almost 27 per cent. The cumulative higher than wage growth increases in premiums indicates that those households with private health insurance are contributing an increasing proportion of their budgets to paying premiums.

The affordability of private health insurance and consumer responses to premium increases are discussed in section 2.4.

Figure 2: Private health insurance premium increases, inflation and wage growth, 2013-14 to 2017-18

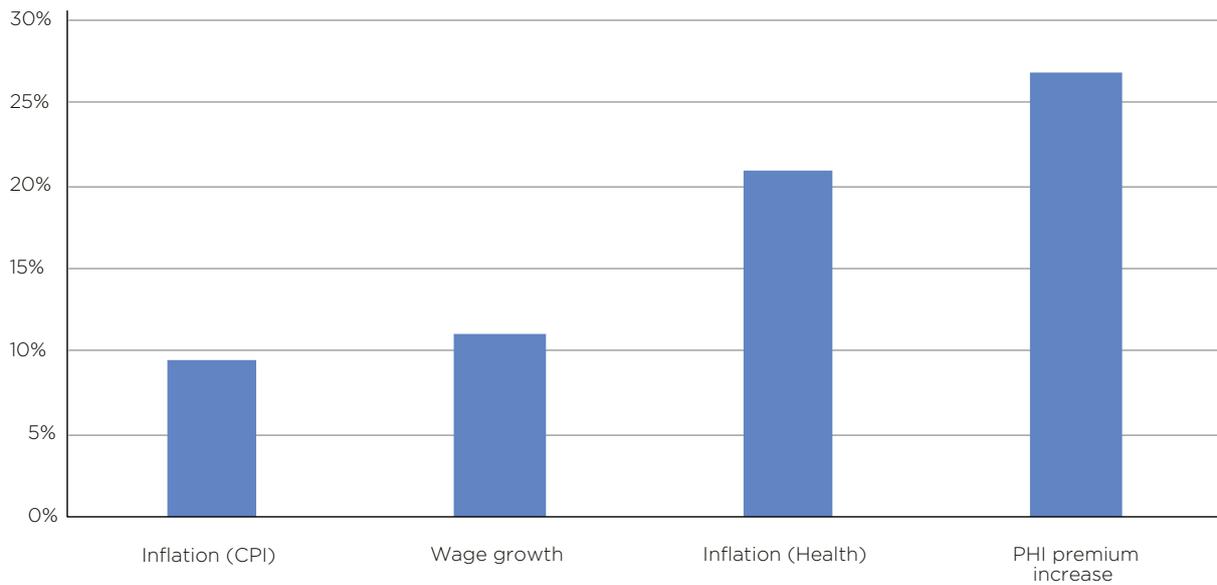


Source: Department of Health, Average premium increases by insurer by year, available at <http://www.health.gov.au/internet/main/publishing.nsf/Content/privatehealth-average-premium-round>; Australian Bureau of Statistics (ABS), 6401.0—Consumer Price Index, Australia, Jun 2018, Tables 1 and 2 - CPI: All Groups, Index Numbers and Percentage Changes and Tables 3 and 4 - CPI: Groups, Weighted Average of Eight Capital Cities, Index Numbers and Percentage Changes; ABS, 6345.0—Wage Price Index, Australia, Jun 2018, Table 1. Total Hourly Rates of Pay Excluding Bonuses: Sector, Original, Seasonally Adjusted and Trend.

¹⁰ ABS, [Information Paper—Consumer Price Index: Concepts, Sources and Methods](#), Australia, February 2018.

¹¹ One component of healthcare price inflation includes increases in the price of private health insurance premiums. Healthcare is a component of the consumer price index, accounting for 5.4 per cent of household expenditure.

Figure 3: Cumulative average increase in private health insurance premiums, inflation (CPI and healthcare) and wage growth, 2013-14 to 2017-18



Source: Department of Health, Average premium increases by insurer by year, available at <http://www.health.gov.au/internet/main/publishing.nsf/Content/privatehealth-average-premium-round>; ABS, 6401.0—Consumer Price Index, Australia, Jun 2018, Tables 1 and 2 - CPI: All Groups, Index Numbers and Percentage Changes and Tables 3 and 4 - CPI: Groups, Weighted Average of Eight Capital Cities, Index Numbers and Percentage Changes; ABS, 6345.0—Wage Price Index, Australia, Jun 2018, Table 1. Total Hourly Rates of Pay Excluding Bonuses: Sector, Original, Seasonally Adjusted and Trend.

2.3 Benefits paid by health insurers to consumers

During 2017-18, the amount of hospital benefits paid by private health insurers per consumer increased by 3.2 per cent, along with a 4.6 per cent increase in extras benefits per consumer. The total amount of benefits for hospital treatment paid was \$15.1 billion, and \$5.2 billion for extras treatment.

Table 4: Key metrics relating to the benefits paid by health insurers to consumers, June 2017 to June 2018¹²

	June 2017	June 2018	Change
Benefits-hospital treatment (\$ millions)	\$14 594	\$15 064	+ 3.2%
Benefits-extras treatment (\$ millions)	\$4 923	\$5 151	+ 4.6%
Hospital benefit per consumer (\$)	\$1 289	\$ 1 338	+ 3.8%
Extras benefit per consumer (\$)	\$400	\$419	+ 4.8%

Source: APRA, Private Health Insurance Quarterly Statistics, June 2018.

¹² This table presents a selection of key metrics relating to the benefits paid by private health insurers. A full outline of all benefits paid to consumers by insurers can be found in APRA's Private Health Insurance Quarterly Statistics.

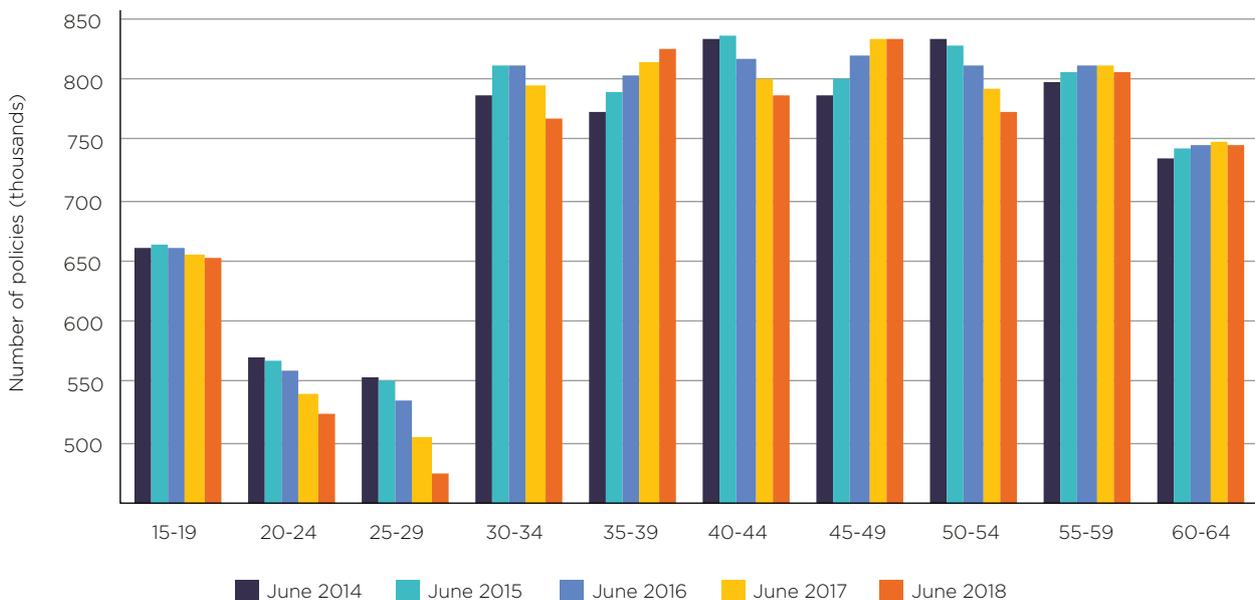
2.4 Consumer responses to private health insurance premium increases

Consumers continue to be concerned about the affordability of private health insurance. The CHOICE consumer pulse survey conducted in 2016-17 found that health and medical costs, including the cost of private health insurance, were the second biggest cost of living concern for Australian households, after electricity prices.¹³

It has also been found that the expense of private health insurance is the predominant reason why consumers allow their policies to lapse or do not buy private health insurance.¹⁴ A Roy Morgan survey conducted in 2017 found that about 50 per cent of respondents who allowed their private health insurance to lapse did so because of its expense.¹⁵ The survey also found that participation rates tended to be lower among poorer and younger Australians, noting that younger Australians, students not in employment, and those with low incomes tended to have never had private health insurance.¹⁶

These findings are consistent with data from APRA. Figure 4 shows the change in the number of people with hospital treatment policies by age group (working age population, aged 15 to 64) over the past five years. In particular, it shows the decline in the number of policies held by the 20-24 and 25-29 age groups. Over the past five years, the number of policies held by 20-24 year olds has declined by 46 580 and for 25-29 year olds by 82 017. While the number of policies held by 30-34 year olds is significantly more than for 25-29 year olds, which likely reflects consumers taking up private health insurance to avoid incurring the lifetime health cover loading, the number of policies held by this cohort has declined by 19 069 in the past five years.

Figure 4: Hospital cover, by age group (working age population, 15 to 64 year olds), June 2014 to June 2018



APRA, Private Health Insurance Statistical Trends, Membership Trends, June 2018.

While some consumers fail to renew their policies or do not buy private health insurance at all, others are switching to more affordable policies, with exclusions or excess payments, in response to higher prices.

¹³ CHOICE, [Consumer Pulse: Australians' Attitude to Cost of Living 2014-2017](#), August 2017, p. 5.

¹⁴ Private Healthcare Australia, [Submission No 18 to the Australian Senate, Value and affordability of private health insurance and out-of-pocket medical costs](#), July 2017; Roy Morgan, [Private Health Insurance Report](#), March 2018.

¹⁵ Roy Morgan, [Private Health Insurance Report](#), March 2018, p. 12.

¹⁶ Ibid.

Yearly increases in private health insurance premiums (see figure 2) have coincided with an increase in the proportion of hospital insurance policies with exclusions,¹⁷ excess payments,¹⁸ or co-payments.¹⁹ Table 3 shows a significant increase in exclusionary policies being held, increasing by 4 per cent from June 2017 to June 2018, and an increase of 1 per cent in policies with excess and co-payments being held over the same period.

The Australian Government has noted that growing insurance costs have partly caused a decline in membership, particularly among younger Australians, and is currently implementing reforms in an effort to address these issues (see below at section 4.1).²⁰

Table 3: Hospital policies with exclusions or excess, by percentage, June 2014 to June 2018

	June 2014	June 2015	June 2016	June 2017	June 2018
% with exclusionary policies	29%	36%	38%	40%	44%
% with excess & co-payments	79%	81%	82%	83%	84%

Source: APRA, Private Health Insurance Membership and Coverage, June 2018.

2.5 Out-of-pocket (gap) costs

Out-of-pocket costs continue to be a concern for consumers. An out-of-pocket or ‘gap’ payment is the amount a consumer pays either for medical or hospital charges, over and above what they receive from the Australian Government’s Medicare scheme or their private health insurer.

Types of gap arrangements

Typically, health insurers enter into contractual arrangements with selected health care service providers, in part, to minimise the out-of-pocket expenses incurred by members. Insurers negotiate set fees and other terms with those providers in exchange for the right to participate in their ‘preferred provider’ networks or ‘no gap’ and ‘known gap’ schemes.

In the case of a ‘no gap’ arrangement, the participating health care service provider agrees to charge a certain amount for services and the health insurer will fully cover the cost of the relevant medical procedure performed by the participating provider.

In the case of a ‘known gap’ arrangement, the participating provider can charge an amount beyond that which the health insurer will cover, but it is restricted to a capped maximum set by the health insurer.

While most in-hospital services are delivered with no gap payments required from patients, this rate has varied in recent years, falling from nearly 90 per cent of services not requiring a gap payment in June 2014 to less than 85 per cent of services in September 2015, as demonstrated in figure 5. However, the proportion of services requiring no gap has been level at about 88 per cent since June 2017.

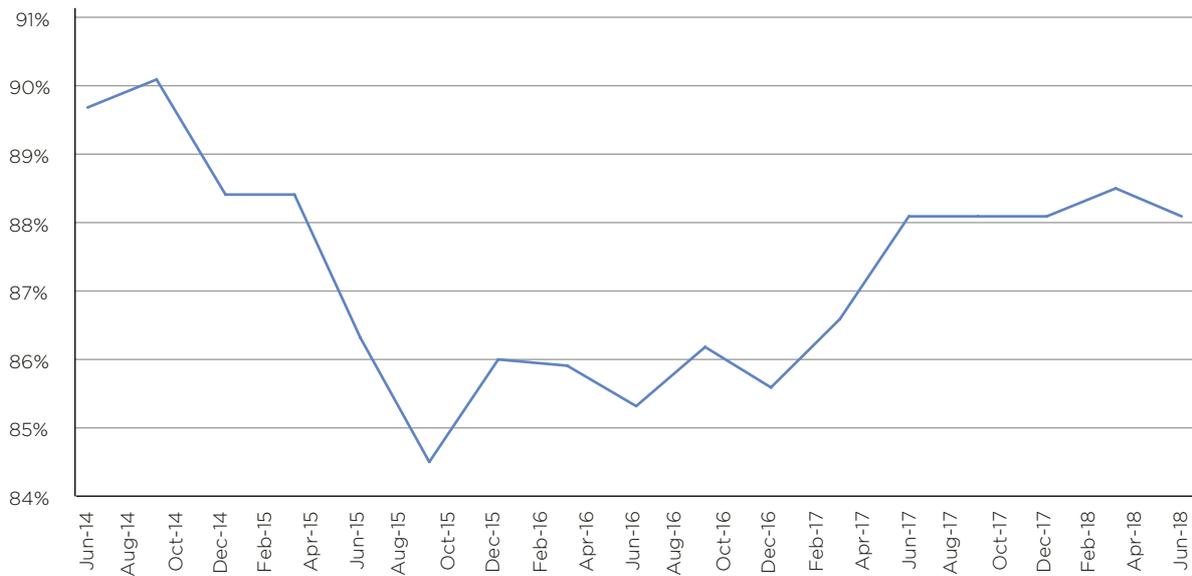
17 Where conditions or services are not covered under a health insurance policy, a private health insurer will not pay benefits towards hospital or medical costs for these items.

18 An amount of money that a policy holder agrees to pay towards the cost of hospital treatment, this is paid before private hospital insurance benefits are payable.

19 For a hospital policy a co-payment is a set amount a policy holder agrees to pay for each day they are in hospital, most have a limit on the number of days they apply per stay.

20 Explanatory Memorandum, [Private Health Insurance Amendment Bill 2018](#), pp. 5-6.

Figure 5: Proportion of in-hospital services with no gap, June 2014 to June 2018



Source: APRA, Private Health Insurance Medical Gap, June 2018.

From June 2017 to June 2018, the average gap expense incurred by a consumer for hospital treatment was \$309, an increase of 3.3 per cent from the previous year, as shown in table 5. Average gap payments for extras treatment remained relatively steady, with a slight decline of 0.7 per cent to \$47.38 over the same period.²¹

The average gap expense incurred by consumers for either hospital or extras treatment has remained relatively stable over the past five years. From June 2014 to June 2018, the average gap expense for hospital treatment increased by 5.4 per cent, and by 2.4 per cent for extras treatments. This is below the cumulative increase in the rate of inflation over the period (around 10 per cent), as shown in figure 3.

Table 5: Average gap expense incurred by consumers (hospital and extras treatments) June quarter 2014 to June quarter 2018

	Hospital treatment	Extras treatment
June 2014	\$292.92	\$46.27
June 2015	\$282.25	\$46.43
June 2016	\$301.22	\$46.77
June 2017	\$298.92	\$47.73
June 2018	\$308.73	\$47.38

Source: APRA, Private Health Insurance Quarterly Statistics, June 2014 to June 2018.

²¹ APRA, [Private Health Insurance Quarterly Statistics](#), June 2018, p. 9.

Recent media reports

There has also been recent media interest in out-of-pocket fees. This included an investigation by the Australian Broadcasting Corporation's (ABC) Four Corners in May 2018.²² As part of the investigation, the ABC reviewed 700 patients' medical bills. The investigation revealed that many patients were paying significant out-of-pocket costs, despite having private health cover. It also reported that some patients were charged hidden fees, such as booking and administration fees. The Four Corners report suggested that in many cases, significant out-of-pocket costs are due to excessive fees charged by medical specialists. It is possible that these so-called hidden fees are not captured in the data above.

Issues regarding out-of-pocket costs are under active consideration by the Australian Government. In January 2018, the Government established the Ministerial Advisory Committee on Out-of-Pocket Costs (MACOPC) to provide advice to the Minister on possible reforms covering best practice models for the transparency of in-hospital medical out-of-pocket costs and to help consumers with private health insurance better understand out-of-pocket costs. Recent activities of the committee are outlined at section 4.2.

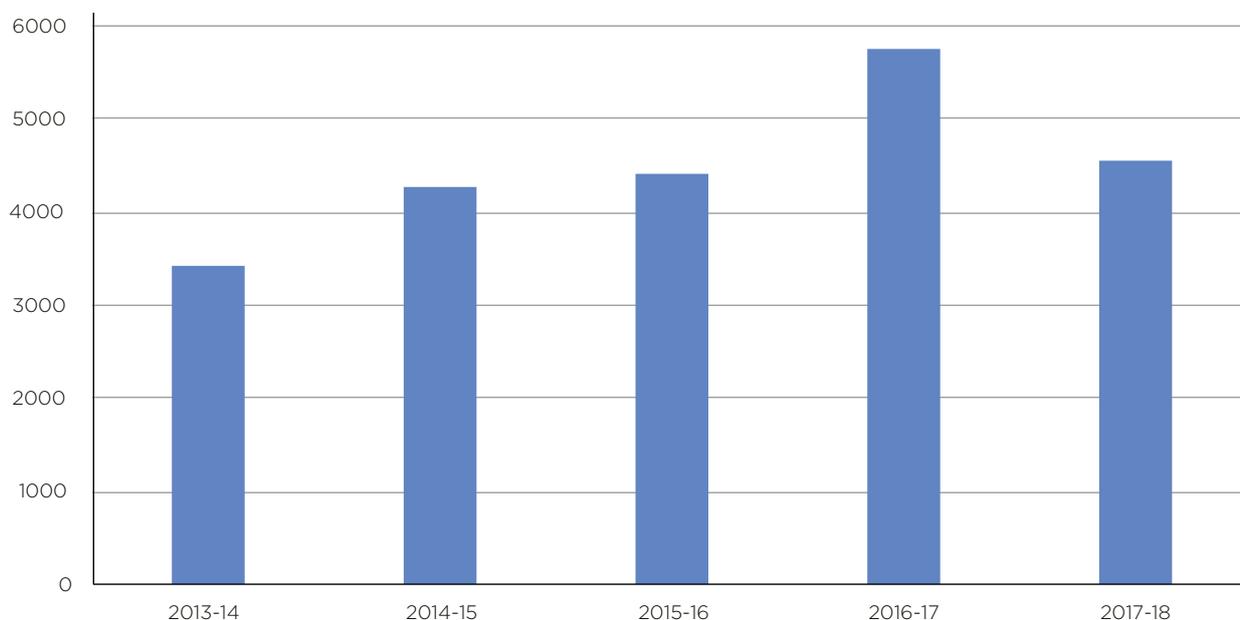
2.6 Consumer complaints about private health insurance

This section presents an analysis of consumer complaints to the PHIO and contacts to the ACCC relating to private health insurance. This data provides a good indication of the specific aspects of health insurance that consumers are most frequently concerned about.

Complaints received by the PHIO

The main complaints agency for consumers about their private health insurance is the PHIO. Figure 6 shows that in 2017-18 complaints to the PHIO declined by 21 per cent to 4 553.²³ This was a significant reduction compared to the 5 750 complaints received in 2016-17.

Figure 6: Total complaints received by the PHIO, 2013-14 to 2017-18



Source: Commonwealth Ombudsman, Annual Report 2017-18 (PHIO section, p. 89).

²² ABC, Four Corners, [Mind the Gap](#), 28 May 2018.

²³ Commonwealth Ombudsman, [Annual Report 2017-18](#) (PHIO section, p. 89).

The PHIO stated that the decrease was partly because 2016–17 was an outlier in terms of a significant increase from previous years and partly attributable to PHIO’s work in assisting insurers to improve their complaint handling processes and as a result of improved complaint handling processes being implemented by the larger insurers during 2017–18. The PHIO noted there was no single cause for the increase in complaints in 2016–17, and that complaints increased across several categories of issues including benefits, service, written information, verbal advice and health insurance membership administration.²⁴

In 2017, the PHIO identified health insurers that were the subject of the increase in complaints in 2016–17 and assisted them with strategies to reduce complaints.²⁵ One issue was that consumers were experiencing problems obtaining timely responses from health insurer complaint officers. The PHIO stated that between 1 July and 31 December 2017, its assistance and the efforts by health insurers to better address complaints contributed to a 28 per cent reduction compared to the same period in 2016–17. The PHIO also stated that the slower rate of premium increases played a role in the lower level of complaints received between 1 January and 31 March 2018.²⁶

Despite the decrease in complaints received by the PHIO in 2017–18, this was the second highest level recorded over the past five years. The PHIO noted that although complaints have moderated, there remains a steady increase in trend terms.

The PHIO reported that 82 per cent of complaints in 2017–18 were about health insurers. However, complaints were also made about service providers including hospitals, health care service providers, health insurance brokers and other practitioners.²⁷

Complaints by issue

The top four categories for complaints to the PHIO—benefits, membership, service and information—have remained the same for the past five years, as shown in figure 7.

The key issues within these complaint categories are as follows:

- Benefits: hospital exclusions and restrictions, general treatment (extras or ancillary benefits), delay in payment
- Membership: cancellation, clearance certificates
- Information: verbal advice, lack of notification
- Service: service delays, premium payment problems, general service issues.

Figure 7 shows that complaints declined in the top four complaint categories from 2016–17. Complaints about membership declined by 25.2 per cent, service by 50 per cent and information by 20.5 per cent. Complaints about benefits declined by about 5.7 per cent.

Figure 7 also shows that the benefits paid by insurers to consumers continued to account for the highest level of complaints, comprising about 36 per cent of complaints to the PHIO. The main issue of concern was hospital policies with unexpected exclusions and restrictions. Some basic and budget levels of hospital cover exclude or restrict services that many consumers assume are routine treatments or standard items. Delays in benefit payments and complaints about insurer rules that limited benefits also represented a significant proportion of complaints received.²⁸

24 Commonwealth Ombudsman, [Private Health Insurance Ombudsman State of the Health Funds Report 2017](#), March 2018, p. 9.

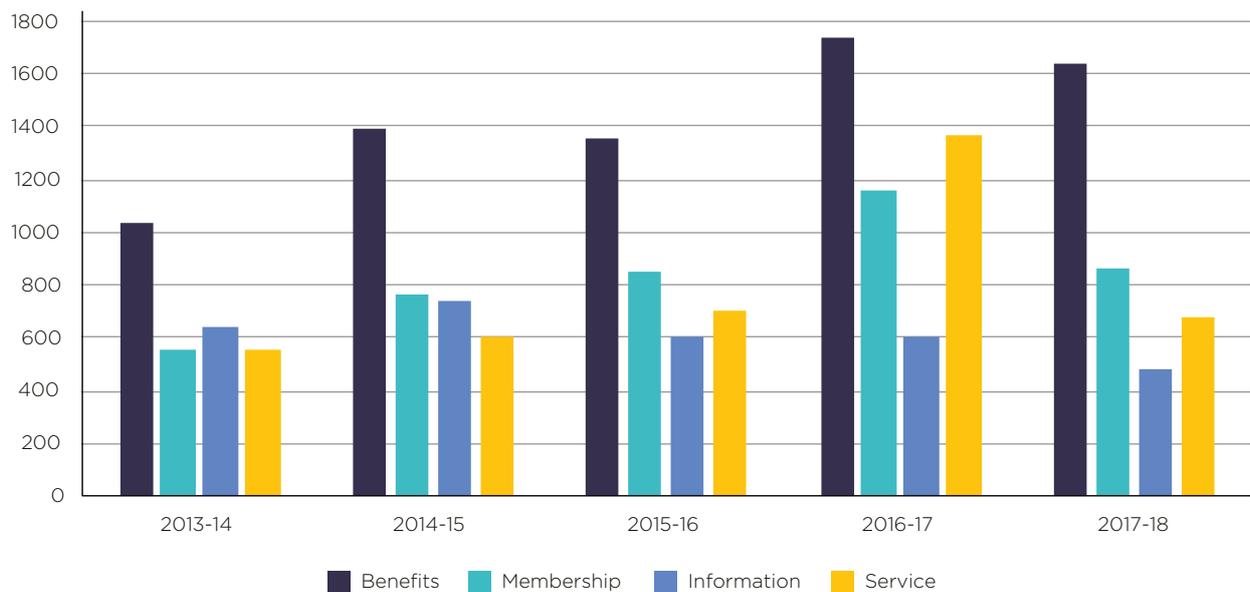
25 Ibid.

26 Commonwealth Ombudsman, [Private Health Insurance Quarterly Bulletin 86](#) (1 January –31 March 2018), p. 1.

27 Commonwealth Ombudsman, Annual Report 2017–18 (PHIO section, p. 99).

28 Ibid, p. 91.

Figure 7: PHIO complaints, by issue, 2013-14 to 2017-18



Source: Commonwealth Ombudsman, Annual Report 2017-18 (PHIO section, pp. 96-98), PHIO Annual Report 2013-14.

ACCC contacts received relating to private health insurance

The ACCC and state and territory fair trading agencies also receive consumer complaints relevant to the private health insurance industry. However, the ACCC is not a dispute resolution body and does not generally receive a large number of complaints about private health insurance.

In 2017-18, the ACCC received 205 contacts (enquiries and complaints) in relation to private health insurance issues. This represented a 17 per cent decrease from the previous year, when 248 contacts were received. The majority of private health insurance contacts related to consumer protection issues, with 50 per cent of contacts concerning potentially misleading or deceptive conduct, or false representations.

Chapter 3 of this report provides a summary of the enforcement actions undertaken by the ACCC in the private health sector during 2017-18.

3. Industry developments

The ACCC, as well as the PHIO, continues to have concerns about the private health insurance industry, including about how private health insurers notify consumers of detrimental changes to their benefits. This is particularly relevant due to current reforms being implemented by the Australian Government to the private health insurance framework. These reforms, among other things, require insurers to categorise products as gold/silver/bronze/basic and use standardised clinical definitions, as well as allow insurers to offer increased maximum excesses and age-based discounts.

The ACCC notes that many insurers will be informing consumers of changes to their policies, including possible detrimental changes, in the lead up to many of these reforms coming into effect on 1 April 2019. In these circumstances, consumers must be given sufficient time ahead of any changes to consider the impact and make informed decisions about their health insurance cover.

This chapter also provides an update on the recent ACCC actions, including matters subject to court proceedings.²⁹

3.1 The PHIO's report into Bupa's hospital policy changes

In June 2018, the PHIO released a report into hospital policy changes announced by Bupa in February 2018.³⁰ The PHIO investigated two issues:

- that Bupa was changing policy restrictions to become exclusions in its basic and mid-level hospital policies
- that Bupa would no longer pay above the Medicare Benefit Schedule, referred to as the 'medical gap' benefit, for all Bupa policyholders electing to be private patients in public hospitals or attending non-contracted facilities.

Some changes affected consumers holding basic and mid-level hospital policies from 1 July 2018, while changes to its medical gap scheme affected all Bupa hospital policyholders from 1 August 2018.

The report discussed the detrimental impacts of these changes on consumers, particularly those in regional Australia. It also considered the appropriateness of communications that Bupa provided to policyholders about the changes, and referred to the ACCC's previous guidance on this issue contained in its 2014-15 private health insurance report to the Australian Senate.³¹ The PHIO made three key findings, namely, that:

- 'it is imperative that if a fund is to make significant changes to its policies which may have a detrimental impact on consumers that the changes are explained in plain English and in a way that prominently communicates their potential impact'³²
- 'it is important that health insurers advise policyholders that their policy is being reduced as it provides consumers with the opportunity to upgrade their health insurance policy ... to ensure they maintain their level of cover for the services affected'³³
- 'detrimental changes to the policy are the second most important change [after premium increases] and should be included at the top of the communication under a heading that correctly identifies it as a reduction in benefits ...'³⁴

29 Some of the enforcement and other actions detailed in this section have occurred outside the reporting period.

30 PHIO, [Bupa Health Insurance Hospital Policy Changes](#), June 2018.

31 ACCC, [Communicating changes to private health insurance benefits: A report to the Australian Senate on anti-competitive and other practices by health insurers and providers in relation to private health insurance \(for the period 1 July 2014 to 30 June 2015\)](#), October 2016.

32 PHIO, [Bupa Health Insurance Hospital Policy Changes](#), June 2018, p. 1.

33 Ibid, p. 7.

34 Ibid, p. 8.

Bupa accepted these findings from the PHIO and changed its communication practices accordingly.³⁵ Bupa also extended the period for policyholders affected by the changes to upgrade their policy without having to re-serve waiting periods.

3.2 ACCC industry engagement concerning detrimental policy changes

In August 2018, the ACCC wrote to private health insurers about communicating detrimental policy changes to consumers. The purpose of this industry engagement was to draw attention to the findings in the PHIO's report into Bupa and to put the industry on notice that the ACCC is continuing to monitor the private health insurance industry in relation to its ACL obligations and will consider enforcement action where insurers do not comply with the ACL.

The ACCC strongly recommended that private health insurers conduct a thorough review of all future communications with consumers to ensure any detrimental policy changes are clear, prominent and timely. This is particularly relevant in the context of changes to premiums and health insurance policies likely to take place ahead of the private health insurance reforms coming into effect on 1 April 2019. In these circumstances, consumers must be given sufficient time ahead of any changes to consider the impact and make informed decisions about their health insurance cover.

The ACCC noted to private health insurers that it recognises there may be circumstances where it may be appropriate for insurers to align the timing of communications to consumers regarding multiple policy changes and would take these circumstances into account in any consideration of whether particular notifications were timely. However, consumers will still need to be given sufficient time ahead of any changes to consider the impact of such changes and make informed decisions about their health insurance cover.

3.3 ACCC enforcement actions

At the time of publication, the ACCC had finalised or instituted proceedings against the following participants in the private health insurance sector. It is also awaiting the outcome of its appeal in the Medibank matter.

Matters finalised

Australian Unity compensates members over dental benefits

On 3 November 2017, following an ACCC investigation, Australian Unity agreed to pay compensation to members who held couples and family policies in 2015 that were likely to have been misled about the dental benefits they could claim from their policy.³⁶

Australian Unity provided a court-enforceable undertaking to the ACCC, under which it has agreed, among other things, to improve the information it provides to consumers and to provide compensation to affected members, including reimbursement for out-of-pocket costs for dental services. The compensation is expected to be at least \$620 000.

Matters awaiting outcome

Ramsay Health Care Australia

On 1 May 2017, the ACCC instituted proceedings in the Federal Court against Ramsay Health Care Australia (Ramsay) for alleged anti-competitive conduct involving misuse of market power and exclusive dealing in the Coffs Harbour region.³⁷

³⁵ PHIO, [Commonwealth Ombudsman releases Bupa Health Insurance Hospital Policy Changes report](#), 7 June 2018.

³⁶ ACCC media release, [Australian Unity to compensate some members over dental benefits](#), 3 November 2017.

³⁷ ACCC media release, [ACCC takes action against Ramsay Health Care for alleged anti-competitive conduct](#), 1 May 2017.

Ramsay is Australia's largest private hospital operator with about 70 hospitals and day surgeries nationwide. At the relevant time, Ramsay operated Baringa Private Hospital and the Coffs Harbour Day Surgery, the only private hospital and private day surgery facilities in the Coffs Harbour region. The Coffs Harbour Day Surgery closed in mid-2017, and Baringa Hospital remains the only private hospital in the region. Coffs Harbour surgeons used operating theatres at Ramsay's facilities to perform surgical procedures on private patients.

The ACCC alleges Ramsay became aware that a group of Coffs Harbour surgeons were planning to establish a competing private day surgery facility in Coffs Harbour. In response to this competitive threat, the ACCC alleges senior Ramsay executives told these surgeons that if they were involved with the proposed new day surgery they would have their access to operating theatre time at Baringa Hospital substantially reduced or withdrawn.

The ACCC alleges that Ramsay engaged in this conduct for the purpose of deterring or preventing a new entrant in the day surgery market in Coffs Harbour, or substantially lessening competition in that market. The matter is set down for hearing in the Federal Court in Sydney for three weeks commencing 25 February 2019.

NIB

On 30 May 2017, the ACCC instituted proceedings in the Federal Court against NIB alleging it contravened the ACL by engaging in misleading or deceptive conduct, unconscionable conduct and making false or misleading representations.³⁸

The proceedings arise from NIB's failure to notify members in advance of its decision to remove certain eye procedures from its 'MediGap Scheme' in 2015. Under the MediGap Scheme, members had previously been able to obtain these eye procedures without facing out-of-pocket costs when doctors participated in the scheme. A date for the hearing has yet to be fixed.

Medibank

On 20 September 2017, the ACCC lodged a Notice of Appeal from the Federal Court's decision on 30 August 2017 dismissing the ACCC's proceedings against Medibank.³⁹

The ACCC had alleged that Medibank engaged in misleading or deceptive conduct, made false or misleading representations to consumers, and engaged in unconscionable conduct, in relation to its failure to notify Medibank members and members of its subsidiary brand, ahm, of its decision to limit benefits paid to members for in-hospital pathology and radiology services, despite representing across a number of its communications and marketing materials that it would. The appeal was heard by the Full Federal Court in May 2018 and the matter is awaiting judgment.

3.4 Consumer Health Regulators Group

Noting the potential for the ACCC's consumer law work to intersect with other health sector regulators, the ACCC is a member of the Consumer Health Regulators Group.⁴⁰ The group meets on a quarterly basis (or as otherwise needed), to exchange information, including about emerging issues of interest or concern, and to ensure responsibilities and functions of each regulator within the consumer health industry are understood and consistently applied.

³⁸ ACCC media release, [ACCC takes action against NIB](#), 30 May 2017.

³⁹ ACCC media release, [ACCC appeals Medibank decision](#), 21 September 2017.

⁴⁰ In addition to the ACCC, other members include the Australian Health Practitioner Regulation Agency (who work in partnership with 14 National Boards in the National Registration and Accreditation Scheme), the PHIO, the Therapeutic Goods Administration, the NSW Health Consumer Complaints Commission and the Victorian Health Complaints Commissioner. The Department of Health (Cth), the NSW Fair Trading Commissioner and Consumer Affairs Victoria participate in the group as observers.

4. Policy developments in private health insurance

This chapter provides an update on policy developments relating to private health insurance during and after the reporting period.

The observations in this report are made in the context of ongoing implementation of a series of reforms to the sector. At the time of publication, the ACCC understands that the Australian Government is considering recommendations contained in the report of the Senate Committee inquiry into the value and affordability of private health insurance and out-of-pocket medical costs and that its response will be tabled in the Senate and made publicly available.⁴¹

The ACCC will closely monitor developments relating to these policy processes and consider the competition and consumer aspects of any reforms in future reports.

4.1 Implementation of private health insurance reforms

In October 2017, the Australian Government announced a series of reforms with the aim of making private health insurance simpler and more affordable.⁴² These reforms include:

- replacing the existing Standard Information Statement (SIS) with a new technology neutral minimum data set
- strengthening the powers of the PHIO and upgrading the privatehealth.gov.au website to make it easier to compare insurance products
- requiring insurers to categorise products as gold/silver/bronze/basic, and use standardised clinical definitions for treatments across their documentation and platforms to make clear what is and is not covered in their policies.

The ACCC notes that some of the reforms are aimed at addressing issues which have been the subject of previous ACCC reports, such as the complexity of private health insurance products, difficulties in comparing different policies, improving information provision practices, and clarifying defined terms.

Reforms not requiring legislative amendment have been implemented from October 2017 onwards, with consultation undertaken by the Department of Health. In September 2018, a package of legislation implementing those reforms requiring legislative amendment was passed by Parliament and given Royal Assent.⁴³ The last of the reforms, relating to increased maximum excesses, age-based discounts, travel and accommodation benefits, and the replacement to the SIS, will come into force on 1 April 2019.

4.2 Ministerial committees

In January 2018, the Ministerial Advisory Committee on Out-of-Pocket Costs (MACOPC) was established to provide advice to the Minister on possible reforms covering:⁴⁴

- best practice models for the transparency of in-hospital medical out-of-pocket costs, and associated medical services in the community
- regulatory barriers to consumer transparency of out-of-pocket medical costs
- the implementation of best practice models
- other related issues as directed by the Minister.

41 Senate Community Affairs References Committee, Parliament of Australia, [Value and affordability of private health insurance and out-of-pocket medical costs](#), December 2017.

42 Department of Health, [Private health insurance reforms: Summary](#) and [Information Provision](#), 16 October 2017.

43 Australian Parliament, [Private Health Insurance Legislation Amendment Bill 2018](#).

44 Department of Health, [Expert committee to consider out-of-pocket medical costs](#), 2 January 2018.

The MACOPC has had four meetings since January 2018 to progress its functions.⁴⁵ The MACOPC has stated that increased transparency of out-of-pocket medical costs is a priority issue. The committee has discussed ways to address the lack of transparency around out-of-pocket costs, including the type of information that consumers require to easily understand the financial implications of their health care choices, and its presentation.

The MACOPC has agreed that consumers should be educated about their rights, the billing practices of health care providers, and to correct misapprehensions that higher medical fees do not necessarily have a relationship to higher quality care. The MACOPC also agreed that consumers should be educated about the referral process and about providing informed financial consent, and noted the importance of educating general practitioners and specialists.

In August 2018, Federal, State and Territory Health Ministers at the Council of Australian Governments Health Council noted the work being undertaken by the MACOPC. They agreed that the Australian Government will release a detailed report of the activity of the MACOPC before the next Health Council meeting, including specific fee transparency options, so that they can agree on the next steps.⁴⁶ The MACOPC intends to provide advice on the issues considered and options to improve the transparency of out-of-pocket costs to the Minister by the end of 2018.⁴⁷

In addition to the work of the MACOPC, the Private Health Ministerial Advisory Committee brings together key stakeholders in the private health sector to work in partnership on the development and implementation of possible reforms to private health insurance.⁴⁸ These include product design, consumer information provision, regulation affecting affordability and transparency, providing better value for rural and remote consumers, alternative funding models for general treatment and other issues as directed by the Minister. The committee is currently working on issues associated with the implementation of the current private health insurance reforms, including in relation to standardising clinical definitions, product categorisation, and consumer testing of information provision components of the reforms.⁴⁹

45 Department of Health, Ministerial Advisory Committee on Out-of-Pocket Costs Communiques, dated [12 February 2018](#) (Meeting 1), [4 April 2018](#) (Meeting 2) and [21 September 2018](#) (Meetings 3 and 4).

46 COAG Health Council, [Communiqué, 2 August 2018](#), p. 5.

47 Department of Health, Ministerial Advisory Committee on Out-of-Pocket Costs Communiqué, dated [21 September 2018](#) (Meetings 3 and 4).

48 Department of Health, [Private Health Ministerial Advisory Committee - Terms of Reference](#), 7 October 2016.

49 Department of Health, [Summary of the 14th meeting of the Private Health Ministerial Advisory Committee](#), 19 June 2018.



AUSTRALIAN COMPETITION
& CONSUMER COMMISSION

