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AMA submission – ACCC report to the Senate on private health insurance

The AMA welcomes the opportunity to inform the ACCC about anti-competitive and other practices impacting on consumers and their medical practitioners.

We note that the ACCC has chosen to focus in depth on the appropriate communication of policy changes to consumers and the impact that this has on competition within the industry on a broader level after identifying this issue in its 2013-14 report. The AMA remains concerned that patients are not understanding their health insurance policies and, as a result, do not receive treatment when they need it.

The AMA believes that poor communication of changes to private health insurance policies held by consumers is symptomatic of a system designed to confuse customers to the advantage of the insurers. Noticeably, the health insurance industry has been slow to respond to changing consumer preferences hiding behind the complexity of health insurance to protect profit[1]. The Government's own expert Graeme Samuel likened the private health insurance industry to superannuation, "shrouded in obfuscation and obscurity"[2].

This problem commences with the lack of transparency, accuracy and consistency of information provided by private health insurers and this impacts on consumers' ability to make informed decisions about their insurance choices. Most consumers can only understand the policy changes communicated to them if they have a full understanding of what their current policy covers. It is usually only at the time when people need to have medical treatment in a hospital that they first comprehend that their insurance policy is deficient.

What people expect from their insurance

Private health cover is a significant cost for many families, and, therefore, the affordability of private health insurance is important to consumers. The ever increasing premiums have obviously impacted upon the type of products that people are choosing to purchase. However, policy holders should be able to expect a reasonable level of cover for their premiums. Information collected by CHOICE (Are you covered August 2010) found that most people expect their private health insurance to cover them for heart surgery, hips and knee replacements, eye

[1] Australian Financial Review Wednesday 30/3/2016 Page: 40
[2] Australian Financial Review Wednesday 6/4/2016 Page: 1

surgery, psychiatric care, rehabilitation and palliative care. This misplaced expectation is supported by the misleading names for some policies, implying that they will provide a very high standard of benefits such as 'top cover' or 'gold standard'. However, some of these policies fall into what the Private Health Insurance Ombudsman would classify as 'basic' and only provide a basic amount of benefits, excluding one or more of the above items of care that people expect.

It is increasingly difficult for consumers to ensure that they have the correct level of coverage, especially as it often changes after purchase. AMA members report their patients do not fully understand how excesses, co-payments and waiting periods apply and according to the Australian Private Hospitals Association, 40% of policy holders do not know if they have any exclusions and of those who know, 33% do not know what the exclusions are[3].

The private health insurance products most commonly cited by our members as impacting on the care of their patients are products with exclusions or minimum benefits, and policies that are for treatment in public hospitals only. Public hospital only products do not provide the choice that people expect and use resources in public hospitals that would otherwise be made available to public patients. These are the details which are often only fully explained in the 'fine print' of hospital cover products.

This problem will grow as the proportion of exclusionary policies does. The number of policies with some form of exclusion has increased from 9.8% in June 2009 to 35% in June 2015[4,5]. The quantum of covered and excluded services are not included in Government data. It is not clear therefore precisely what treatments are excluded.

It is this high rate of "insured" people who find that the exclusions have "changed" after purchase. Insurers are creating a de facto risk rating system. By increasing exclusions and creating products that are less likely to require them to pay benefits, they effectively reduce their exposure. For example, some insurers removed support for life saving weight loss surgery such as gastric banding from policies in 2015[6] causing numerous complaints to the Private Health Insurance Ombudsman (PHIO).

Issues regarding communication of changes to policies are more likely to occur in the environment of constant churn and change. This behaviour by the insurers has largely been left unchecked by the Government.

[3] SMH, '*Private health insurers may be breaking the law by varying customers' policies: ACCC'*, 20 Oct 2015
[4] Private Health Insurance Administration Council: *Operations of the Private Health Insurers – Operations Report 2013-14 Data*, Table: Policies by type
[5] Private Health Insurance Administration Council: *Private Health Insurance Membership and Benefits – June 2015*, Table: Australia
[6] Commonwealth Ombudsman, 2016. *Private Health Insurance Ombudsman Quarterly Bulletin 77*, page: 3

Further contributors to complexity

The 'gap/known gap' arrangements for medical services and contracts with hospitals is not well understood by consumers. Consumers do not understand that unless the doctor accepts the insurer's schedule of medical benefit as their fee, or the hospital has a contract with the insurer, that the insurer is only required to pay a minimum benefit amount. Again, this information changes regularly and is not easily accessible or comparable leading to significant inequities between patients claiming for the same procedure.

Consumers are also unaware that each private health insurer has its own schedule of benefits that it will pay for medical services and that the benefits paid to members for the same procedure varies significantly between health insurers. These benefits change when the insurer changes its benefits schedule.

In 2014, Medibank reduced the benefits it will pay for pathology and diagnostic imaging services to the level only of the Medicare schedule fee. Last year nib removed over 225 items from its schedule of medical benefits, three of which are for treatment of macular degeneration. It is unclear how nib advised its policy holders of this change.

The impact on the provision of care

The obfuscation from constant changes to policies and poor communication results in patients not receiving treatment when they need it. Too often, AMA members report that they need to cancel booked procedures when it becomes apparent that the patient is not covered for treatment they believed they were covered for. Commonly, patients believe they purchased cover and cannot recall being advised by their insurer that their policy had changed.

Even more concerning is patients with ongoing conditions finding that treatments for their particular condition are suddenly not covered. These policy holders have a vested and current interest in ensuring that their policies continue to cover their conditions, but are inexplicably unaware of policy changes.

One neurosurgeon stated that "In my own speciality of neurosurgery I have had many patients for whom I have had to change their treatment in these circumstances. As recently as last week, a patient with a 20 year history of spinal complaint and who now requires spinal fusion was shocked to find her nib policy no longer covered that treatment. She is adamant that she did not receive advice from her insurer that her cover had changed. She is now serving a 12 month waiting period with another insurer and in substantial pain".

This continued with "Four years ago I placed a shunt in a child for hydrocephalus. His mother understood that there is a 50% revision rate due to shunt blockage, and therefore the importance of maintaining private cover. This child required revision surgery last week, but as you can now guess, the family policy no longer covered neurosurgical procedures. Fortunately,

I was able to treat this child as a public patient, an opportunity which is not often available to adult patients".

It is hard to imagine that in both these cases the patients and their families were completely ignorant of advice from their health insurer about changes to their cover and failed to "upgrade" their policy when their existing policy became inadequate for their needs.

These changing exclusions have a considerable impact on the businesses of medical practitioners and private hospitals and through this implications for patient care and treatment. Practitioners need to commit considerable time to help patients understand their policy, check with their insurer about the level and extent of their cover, and assist patients to challenge incorrect information provided by insurance staff. Hospitals carry a similar burden.

Increasing complaints to the Private Health Insurance Ombudsman

The most telling finding from last year's ACCC report is that complaints about private health insurers are continuing to rise and that the main concerns of complainants are the unpleasant surprises patients get (exclusions, co-payments, restrictions on choice of providers) when they make a claim on a policy.

Our members were universal in condemning the practice of selling policies with exclusions for procedures that are commonly required and the lack of clear explanation of the terms used. For example, selling inappropriate policies, such as cover for obstetrics but not arthroplasty to older people, or cover for obstetrics and neonatal care but not if it is for the special care nursery (e.g. cardiac or respiratory issues).

Not surprisingly, there is a steady increase in the number of complaints to the Private Health Insurance Ombudsman (PHIO) with a 16 % increase in the last report year (2013-14)[7]. Even more concerning is the higher number of complaints requiring intervention, increasing by 28% in that year.

Consistent with the theme of poor communication, PHIO received 20 complaints stating that the notification about the changes was insufficient for the three months 1 July to 30 September 2015. The majority of which were from a person advising PHIO that they were not told of the removal of a benefit.

In investigating these complaints, PHIO identified an issue with insurers choosing to use email for notifying their policy holders. PHIO was concerned to learn that some notifications for the removal of individual hospital benefits were sent to affected policy holders by email only, when some of those policy holders had not previously "opted in" to receive communications by that method[8].

[7] Private Health Insurance Ombudsman, 2014. *State of the Health Funds Report 2013-14*, p4
[8] Commonwealth Ombudsman, 2015. *Private Health Insurance Ombudsman Quarterly Bulletin* 76, page: 3

In addition, the AMA hears frequent reports of insurers cold calling policy holders encouraging them to downgrade their cover to reduce their premiums, and without a clear explanation of the exclusions.

Insurers should ensure that their communications are consistent with both the legislation and community expectations.

Summary

Ongoing consumer confusion and the increases in complaints to the PHIO demonstrate that people expect to be covered for the most common procedures and often don't understand that, because of the changes to the policy they hold, they are not. It is reasonable for consumers to expect that their product continues to provide the same cover as it did at the time of purchase.

If policy changes are essential, private health insurers should take more responsibility for providing clear and accurate information so that consumers understand what their policy does cover. Private health insurers should be required to publish their schedules of medical benefits in a way that is easily accessible to consumers and comparable with each other. As pointed out in previous submissions to the ACCC, this information is either not published or difficult to find on health insurers' websites.

Further, the majority of confusion and disappointment, and in some cases hardship, could be prevented by eliminating policies that exclude the very procedures for which patients expect to be covered, or that provide cover only for treatment in public hospitals.

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