COMMONWEALTH OMBUDSMAN

Submission by the Commonwealth Ombudsman

Ernst & Young Consultation Paper on Private Health Insurance Default Benefit Arrangements

Submission by the Commonwealth Ombudsman, Iain Anderson

September 2022

Background

The purpose of the Office of the Commonwealth Ombudsman (the Office) is to:

- Provide assurance that the organisations we oversight act with integrity and treat people fairly
- Influence systemic improvement in public administration in Australia and the region.

We seek to achieve our purpose through:

- investigating complaints about Australian Government administrative action, identifying deficiencies, and making recommendations and suggestions on how to improve administrative practices
- fostering good public administration that is accountable, lawful, fair, transparent and responsive
- assisting people to resolve complaints about government administrative action; and
- providing assurance that Commonwealth, State and Territory law enforcement, integrity and regulatory agencies are complying with statutory requirements and have sound administrative practices in relation to certain covert, intrusive and coercive powers.

In our capacity as the Private Health Insurance Ombudsman (PHIO), the Office protects the interests of consumers in relation to private health insurance matters. The Office handles complaints about private health insurers, overseas visitors and overseas student insurers, brokers, hospitals, and other medical and health practitioners.

Overview of complaints

Complaint volumes

A small number of complaints received by the Office each year relate directly to second tier and default benefits as shown in **Table 1**, totalling 18 complaints since 2015-16. However, the Office receives a larger volume of complaints about hospital contracts and hospital gap fees, both aspects of insurance which may be indirectly affected by default and second tier benefit arrangements. It would be reasonable to assume any change to second tier and default benefit arrangements would have a negative impact on private health insurance consumers and cause an increase to the Office's complaint numbers.

Table 1: Complaints received per year

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22
Second tier default benefits	2	4	1	5	0	4	2
Hospital contracts	18	23	22	20	15	4	14
Hospital gap fees	53	75	69	83	81	59	62
All complaints received by Private Health Insurance Ombudsman	4416	5750	4553	4042	3708	3496	2704

Complaint themes

Of the 18 complaints received specifically about second tier default benefits:

Consumer complaints: 9 complaints

Some consumers choose a non-contracted facility understanding that they will be required to pay a portion of their costs, but are unhappy with the amount they are required to pay or explanation of why the benefit from their insurer was lower than they anticipated.

Hospital provider complaints: 9 complaints

Complaints from hospitals about the calculation of second tier rates, classification of facilities or treatments and delays.

Access to and Choice of Services

Q13. Are you aware of examples where hospitals go from in contract to out of contract (and thus have to rely on default benefits)?

Q15. Option for Change | What mechanisms could be introduced to impact the predictability of and reduce hospital and medical out-of-pocket costs for consumers?

One of the requirements for second tier eligibility is that the hospital makes provisions for patients to provide informed financial consent (IFC).

The Office has observed in some cases where Hospital Purchaser Provider Agreements (HPPAs) are terminated, an insurer will not disclose the second tier rates to the hospital until very close to the date that it comes into effect - in some cases the day before they take effect. This may limit the ability of the hospital to prepare their IFC processes and may disadvantage both the hospital and consumers.

The Office has issued voluntary *Termination and Transition Guidelines for Hospitals and Insurers* which recommend that insurers provide second tier default rates to hospitals as soon as practical after the notice of termination is issued. For example, if a notice is issued 60 days before termination and the insurer issues the rates to them a week later, this provides 53 days for the hospital to adjust its processes.

In addition to the voluntary Guidelines, the Department could consider a review of the rules in relation to second tier default benefits or introduce a more mandatory approach to managing insurer-hospital relationships. The Department might consider a change to allow for more certainty when HPPAs end by introducing a timeframe in which insurers are obliged to provide hospitals advice about the second tier rates which apply.

Potential future options

Q38. Option for Change | What are the other key considerations associated with these potential changes to default benefit arrangements, including:

a. the impacts for consumers

Any potential change to existing arrangements could reduce consumer entitlements. Option 1 "*to abolish default benefit arrangements"* in particular would be a significant reduction in consumer protections by exposing consumers to higher potential costs. This may especially be the case for consumers who choose or are required to attend an out-of-contract hospital due to their

personal circumstances. The Department of Health and Aged Care should consider undertaking further research into the potential long-term impact of these changes and whether it should consult further with consumers about potential impacts to their insurance.