Submission by the Commonwealth Ombudsman

Value and affordability of private health insurance and out-of-pocket medical costs

Private Health Insurance Ombudsman (PHIO) Complaints and Consumer Perspectives

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http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Privatehealthinsurance

Introduction and summary

This submission is based on our analysis of the complaints received by the Office. The Ombudsman considers that the insights we have gained from handling consumer complaints and enquiries provides important information which will assist in understanding the real world problems faced by the Australian public holding private health insurance policies. Complaint and consumer information also helps to place the requests from different stakeholders in the private health insurance industry into the proper context of understanding what is in the interest of the Australian public.

Background

The Private Health Insurance Ombudsman (PHIO) is one of the roles held by the Commonwealth Ombudsman. The Ombudsman's role is to protect the interests of consumers in relation to private health insurance. The Ombudsman is an independent body that resolves complaints about private health insurance. Complaints can be about health insurers, hospitals, doctors, dentists, other practitioners and brokers. The Office also receives some complaints between different stakeholders in the industry, for example, by mediating in contracting disputes between hospitals and health insurers. The Ombudsman regularly reports and provides advice to industry and government about these issues.

The Ombudsman has a significant consumer information and advice role regarding private health insurance and handled 3,749 consumer enquiries last year in addition to its complaint work. In support of this role, we produce and publish a range of tools for consumers, including the consumer website PrivateHealth.gov.au, the annual State of the Health Funds Report, consumer e-bulletin Health Insurance Insider, Quarterly Bulletin and a range of brochures and factsheets. The quarterly bulletin, which had over 900 subscribers at July 2017, was expanded in early 2017 to provide additional statistics on private health insurance consumer complaints quarterly rather than only reporting annually.

Increase in complaints to the PHIO & Comparison to Other Industries

After several years where private health insurance complaint levels remained steady, the past three years have seen a significant increase. In 2016–17, we received 5,750 (30 per cent increase) private health insurance complaints, compared to 4,416 in 2015–16 and 4,265 in 2014–15.

This is a small number of complaints when compared to the total number of interactions that occur in an industry covering over 11 million Australians and suggests that the health insurance industry handles many consumer complaints relatively well when compared to other industries such as telecommunications where complaints have reached 100,000 each year. Telecommunications may not however be a suitable industry to compare health insurance to because complaints in that industry are often concerned with failures to provide a technological service; whereas the actual "service" that is provided in the health industry is provided by hospitals, doctors and other providers and the insurer has a more limited role.

Comparison can also be made by comparing health insurers to Medicare which performs a similar function in assessing and paying medical claims. The Ombudsman received 200 complaints about Medicare in 2015-16 which was significantly fewer than the 4,416 received for the health insurance industry overall in the same year. This is despite Medicare covering 100% of Australians compared to health insurers which cover approximately 46 per cent.

Affordability and Value from Health Insurance

An important role for the Ombudsman is to monitor complaint issues and the causes of complaints from health insurance consumers. The Office has used a consistent methodology for recording and tracking complaint issues for over a decade. We analyse trends in consumer problems over time and whether particular issues are significant.

We analysed complaint information to provide some insight into the value and affordability of health insurance and out-of-pocket medical expenses experienced by consumers.

We received only 138 complaints about premium increases in 2016-17, which is low compared to other problems experienced by consumers and reported to our Office. Part of the reason for this low incidence may be because health insurance consumers are advised that premiums are approved by government and so consumers don't see the benefit of complaining to a government appointed Ombudsman to make a complaint.

The other side of affordability which is perhaps given less attention than premium increases is reductions in benefits and particularly problems experienced by consumers when benefits are reduced by what is commonly referred to in the industry as a "rule change". We registered 93 complaints about insurer rule changes in 2016-17 and 308 complaints about hospital exclusions and restrictions.

Hospital exclusion and restriction complaints are generally made by consumers who don't believe that a benefit is being paid in accordance with what the policy offered. Some of these complaints include policyholders whose policies were reduced in previous years without the consumer noticing.

The impact on an individual consumer who finds that they are no longer covered for a hospital treatment and needs to either pay for treatment themselves or opt for the public system is far more significant than a premium increase.

Insurer obligations to notify consumers of policy changes

The Ombudsman has noted several instances where insurers demonstrated poor communication practices when informing private health insurance consumers about changes to their policies and as reductions in benefits.

During 2015–16, the Australian Competition and Consumer Commission (ACCC) released a report to the Australian Senate titled *Communicating changes to private health insurance benefits*[1]. The report highlights that although health insurers may be complying with health insurance regulations and the Private Health Industry Code of Conduct when notifying their members of detrimental changes to policies, they still have broader obligations under the Australian Consumer Law to consider. We encourage all insurers to carefully consider the recommendations made in the report and to improve on and learn from past experiences.

Many consumers are not aware that health insurance products can change over time at the discretion of their insurer. It would be preferable for health insurers to provide this advice clearly at the point of sale or upgrade, rather than providing it in fine print at the end of membership guides. If consumers understand that from time to time the insurer may write to them and change

[1] http://www.accc.gov.au/publications/private-health-insurance-reports/private-health-insurance-report-2014-15

their policy, then they are less likely to overlook important correspondence and be aware of how policy changes affect them.

Problems are also caused when a consumer has spent time and effort selecting a policy, only to have it changed shortly after purchase. In instances where it is identified that a consumer was not made aware of an impending change to a policy, our view is that the consumer has a special case to remain under the old policy conditions for an extended period of time, or that some other measure should be taken to address the consumer's complaint.

When we investigate cases where the complainants allege their insurer did not properly notify them of a reduction in benefits, we consider the following key questions:

1. Did the communication unambiguously state that the change was a negative one? Was this message mixed up with positive marketing material?
2. Did the insurer use the address or email address at which the policyholder expected to receive important communications?
3. Was the consumer notified of their options to upgrade or transfer with continuity to a policy to maintain a benefit?
4. Had the policyholder commenced the policy shortly before the change and were they notified at commencement of the policy that it was about to change?

Other Key Consumer Issues

The key issues for consumers that the Ombudsman typically records involve issues about service, information, administration and benefits. By extension, these indicate where consumers are finding the value of their health insurance premiums not meeting their expectations for a variety of reasons.

The following table shows the sub-issues causing the highest number of complaints in 2016-17, compared to the preceding two years:

Issue	**Sub-issue**	**2014-15**	**2015-16**	**2016-17**
Service	Premium payment problems	184	211	494
Service	Service delays	155	153	441
Information	Verbal advice	522	430	408
Membership	Cancellation	299	315	399
Membership	Clearance certificates	108	196	310
Benefit	Hospital exclusion/restriction	320	276	308
Service	General service issues	184	234	298
Waiting Period	Pre-existing conditions	283	268	293
Benefit	Delay in payment	154	142	237
Incentives	Lifetime Health Cover	156	121	222

Service

There was a significant increase in the number of service-related complaints in 2016–17, with very high increases in complaints about premium payment problems (494 complaints) and service delays (441).

This was mainly the result of Information Technology (IT) problems at Medibank Private, which caused significant delays in the issuing of tax certificates and various problems associated with premium payments and policy administration.

Information

Information-related complaints usually arise because of disputes or misunderstandings about verbal or written information provided by an insurer. In most years, verbal advice is the cause of more complaints than any other sub-issue (408 complaints in 2016-17). These complaints can be particularly complex if the insurer has not kept a clear record or call recording of its interaction with the member.

Membership

Complaints about cancellation (399 complaints) and clearance certificates (310) increased this year, again mostly due to IT problems at Medibank. These delays meant that members were waiting long periods to cancel and obtain refunds on their policies, or to obtain the documentation required to transfer to other insurers with continuity of waiting periods and Lifetime Health Cover loadings.

Conclusion

The Ombudsman welcomes the current consideration being made to ways that the health insurance system can be improved in the interests of health insurance consumers. We note that there has been significant public discussion about improving comparison tools to assist consumers in finding new health insurance products that meet their individual needs. New comparison tools will not address the overall problems for consumers as little evidence has been presented to our Office through complaints that consumers find it difficult to switch from one insurer or policy to another. APRA reported average retention of health insurers of 84% in 2015-16, at the same time as the Industry reported a growth of 1.35%, which indicates that a large number of consumers are switching from one insurer to another quite readily.

The overall affordability issue with health insurance is a formidable problem to solve because health insurance premium increases and benefit outlays are mostly the result of rising costs and usage in the hospital system. The solution to the problem of rising health costs overall is something that is outside the scope of this Office to comment on.

Instead, the Office would like to summarise the two key concerns being expressed by the complainants who contact our Office, as follow:

- Health insurance is too complex and it is difficult to understand the terms used by different insurers. Health insurance policies can change over time, which increases the difficulty for consumers in understanding what they are covered for.
- The information provided by health insurers causes a number of problems for some consumers who consider the policy they received does not match their expectations. This information is both written, online and provided by staff at health insurers via telephone calls centres and retail offices.

Improvements to these key areas would go some way to addressing the concerns of consumers who have found the value of their health insurance policy to be less than they expected.