COMMONWEALTH OMBUDSMAN

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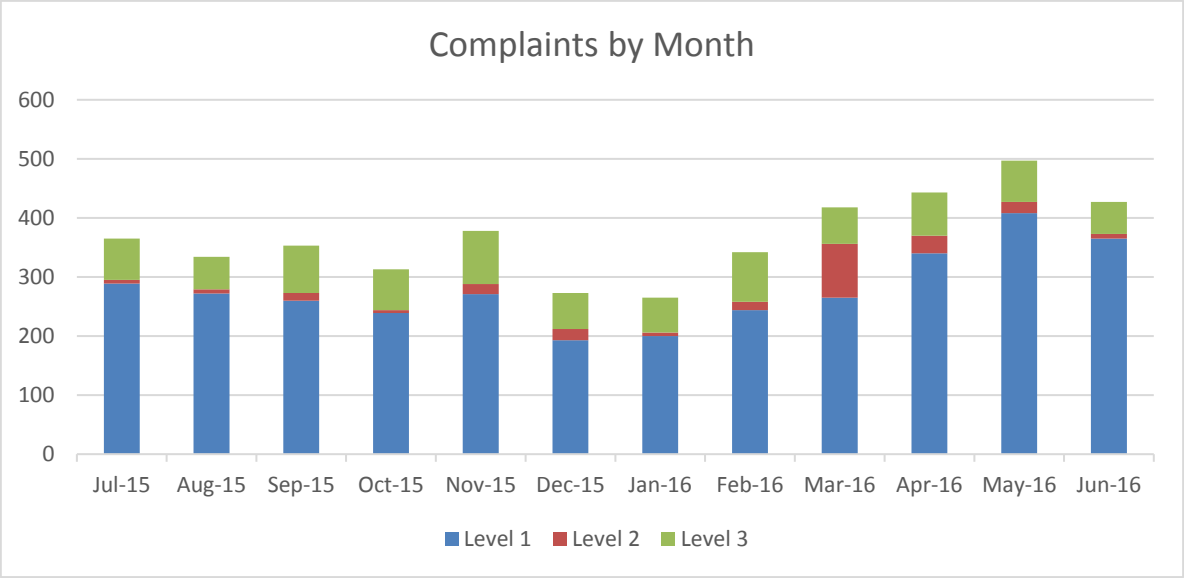
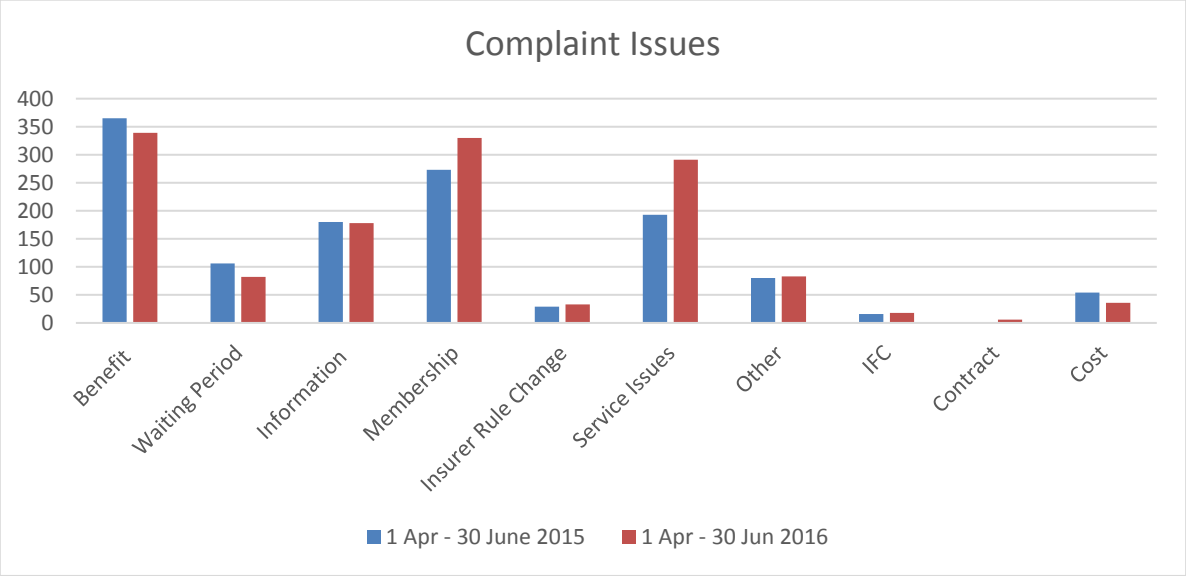
Private Health Insurance Ombudsman Quarterly Bulletin 79
(1 April – 30 June 2016)

Complaint Statistics and Workload

The June quarter is usually a busy one, with health insurance 'top of mind' for consumers due to the approaching Lifetime Health Cover deadline and the end of the financial year. However, this June quarter was particularly busy - the Ombudsman received 1367 complaints, a significant increase on the 1025 complaints received in the previous quarter and the 1219 complaints in the same quarter in 2015.





Top 5 Consumer Complaint Issues This Quarter

There was a notable increase in complaints about health insurance administration, membership and service this year compared to previous years. The increase was associated with health insurer administration systems experiencing problems handling a higher number of requests from consumers wishing to change or make enquiries about their health insurance policies when insurers increased premiums on 1 April.

1. **Oral Advice: 136 Complaints** – Most oral advice complaints concern consumers misunderstanding their benefits during telephone calls and retail branch visits, particularly where records are not adequately maintained.

2. **Membership Cancellation: 122 Complaints** – These complaints mostly concern refunds and administrative issues for those cancelling or transferring health insurance policies. Although it is expected that will be a higher number consumers shopping around for new polices at this time of year and that there will be service problems associated with this activity, the 122 complaints this quarter was a significant increase on the 67 complaints received in the same period last year.

3. **Clearance Certificates: 121 Complaints** – These complaints are caused by problems and delays associated with transferring a person's health insurance history information from their previous health insurer to a new insurer. The incidence of complaints was significantly higher this quarter compared to the same period last year when 50 complaints were received.

4. **Premium Payment Problems: 105 Complaints** – Complaints predominantly concerning direct debits from bank accounts and credit cards. These were higher than normal this quarter, similar to other service type complaints.

5. **General Service Issue Complaints: 94 Complaints** – Most complaints concern delays or inaction from health insurer's customer service staff.

Pre-Existing Condition Assessments

Health insurers are permitted to apply a 12 month waiting period to claims deemed to be the result of pre-existing conditions (PECs). Complaints that reach PHIO about PECs are often associated with poor processes and communication with policy holders about how a health insurer's medical adviser has reached a decision about a claim.

The number of complaints that PHIO receives about PEC assessments made by insurers is relatively constant as shown in the table below.

Complaints Per Quarter	
Jul-Sep 2014	72
Oct-Dec 2014	78
Jan-Mar 2015	65
Apr-Jun 2015	68
Jul-Sep 2015	55
Oct-Dec 2015	82
Jan-Mar 2016	57
Apr-Jun 2016	61

PHIO can provide an independent opinion for complainants about whether a health insurer's PEC decision is valid. In some instances this will result in a decision being overturned, but in the majority of cases the decision remains unchanged. However, the review from PHIO provides reassurance to the complainant that they have had a fair hearing, and often provides them with additional reasons and information about the decision.

PHIO has identified what we see as the major issues with PEC decisions that complainants have brought to us for a second opinion. This forms the basis of our advice to insurers about the steps they can take to minimise complaints and

to provide information to consumers so they can understand why a benefit hasn't been paid to them.

Insurers should clearly identify the following to the person about whom they have made a claims assessment:

- The condition relating to the proposed procedure or hospitalisation;
- The signs and symptoms linked to that condition;
- The date that the health insurer medical adviser believes signs and symptoms started; and
- The date that the health insurer medical adviser made that decision.

In many cases, the complainant is confused because they cannot see the link between the signs and symptoms they are aware of themselves, and the reason for which they require treatment. The insurer's medical adviser has the expertise and judgement to identify the signs and symptoms which are linked to the condition in question; but the problem is the outcomes of that judgement are not always clearly explained to the individual in the communications they receive from the insurer.

In some cases, PHIO has seen that there is difficulty in making a determination because a patient's medical practitioner or specialist has not clearly stated when signs or symptoms developed, or has provided an ambiguous time period such as "months". This is a common cause of complaints that reach PHIO and it seems that more could be done by insurers to explain the problem to the policy holder who may be left confused.

In these situations, if the insurer's medical adviser believes that the patient developed signs or symptoms at a different time than the time stated by the GP or specialist, it is best to state this clearly so that the policyholder understands the basis of the decision. By giving this information to the individual, he or she can ask their own doctor to find out why the information that was provided to the insurer was unclear or incomplete.

There are many further considerations for insurers making claims assessments and communicating with policyholders which are discussed in the Pre-Existing Condition Best Practice Guidelines. We recommend all insurance officers handling enquiries about PEC decisions familiarise themselves with these guidelines.

- Best Practice Guidelines for Health Insurers (PDF)
- Best Practice Guidelines for Hospitals (PDF)

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Complaints by Health Insurer Market Share

1 April to 30 June 2016

Name of Insurer	Complaints(1)	Percentage of Complaints	Level 3 Complaints(2)	Percentage of Level 3 Complaints	Market Share(3)
ACA Health Benefits	0	0.0%	0	0.0%	0.1%
Australian Unity	52	4.3%	2	1.2%	3.1%
BUPA	201	16.6%	38	23.5%	26.8%
CBHS	15	1.2%	3	1.9%	1.4%
CDH (Cessnock District Health)	1	0.1%	0	0.0%	<0.1%
CUA Health	25	2.1%	10	6.2%	0.6%
Defence Health	6	0.5%	0	0.0%	1.8%
Doctors' Health Fund	4	0.3%	0	0.0%	0.2%
GMHBA	23	1.9%	3	1.9%	2.0%
Grand United Corporate Health	8	0.7%	3	1.9%	0.4%
HBF Health	39	3.2%	6	3.7%	7.4%
HCF (Hospitals Cont. Fund)	119	9.8%	16	9.9%	10.5%
Health.com.au	15	1.2%	1	0.6%	0.6%
Health Care Insurance	0	0.0%	0	0.0%	0.1%
Healthguard (GMF)	0	0.0%	0	0.0%	0.5%
Health-Partners	5	0.4%	0	0.0%	0.6%
HIF (Health Insurance Fund of Aus.)	7	0.6%	0	0.0%	0.9%
Latrobe Health	6	0.5%	0	0.0%	0.7%
Medibank Private & AHM	586	48.5%	66	40.7%	28.6%
Mildura District Hospital Fund	1	0.1%	1	0.6%	0.2%
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
Navy Health	1	0.1%	0	0.0%	0.3%
NIB Health	78	6.5%	10	6.2%	7.9%
Peoplecare	2	0.2%	1	0.6%	0.5%
Phoenix Health Fund	0	0.0%	0	0.0%	0.1%
Police Health	0	0.0%	0	0.0%	0.3%
QLD Country Health Fund	0	0.0%	0	0.0%	0.3%
Railway & Transport Health	2	0.2%	0	0.0%	0.4%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Lukes Health	2	0.2%	0	0.0%	0.4%
Teachers Federation Health	8	0.7%	1	0.6%	2.1%
Teachers Union Health	2	0.2%	1	0.6%	0.5%
Transport Health	1	0.1%	0	0.0%	0.1%
Westfund	0	0.0%	0	0.0%	0.7%
Total for Health Insurers	**1209**	**100%**	**162**	**100%**	**100%**

1) Number of Complaints (Levels 1, 2 & 3) from those holding registered health fund policies.

2.) Level 3 Complaints required the intervention of the Ombudsman and the health fund.

3.) Source: APRA, Market Share, All Policies, 30 June 2015.