COMMONWEALTH OMBUDSMAN

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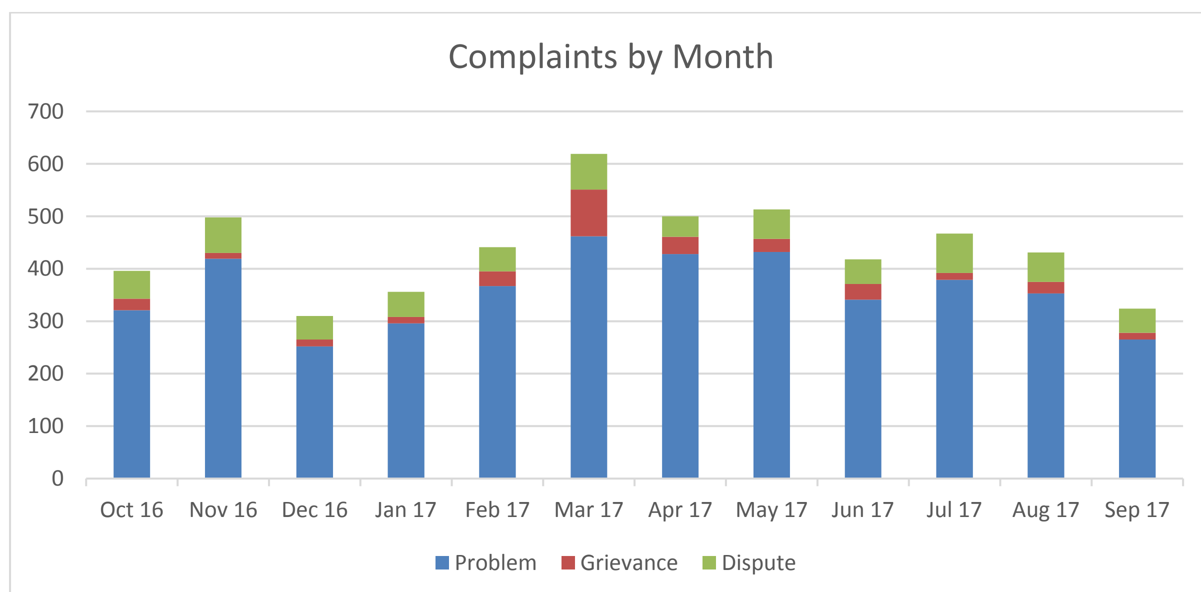
Private Health Insurance Quarterly Bulletin 84 (1 July – 30 September 2017)

Complaint statistics this quarter

This quarter, the Office of the Commonwealth Ombudsman (the Office) received 1,222 private health insurance complaints. Compared to the same period in 2016, the Office received 1,683 complaints, which represents a decline of 28 per cent. In the previous quarter ending June 2017, the Office received 1,431 complaints – this represents a decline of 15 per cent.

It is pleasing to see that the industry has worked to address the higher than average consumer complaints made in 2016, and this has resulted in a significant reduction in complaints reaching the Office.



Pre-Existing Condition (PEC) waiting period

The Pre-Existing Condition (PEC) Best Practice Guidelines (the Guidelines) for both private health insurers and hospitals for dealing with PEC claims and patient/consumer enquiries were developed by the Department of Health in 2001. Our Office has reviewed the guidelines and considers that the advice it provides to health insurers and hospitals is still relevant and a good basis upon which an organisation can ensure compliance with s 75–15 of the *Private Health Insurance Act 2007* (Cth) and the Australian Consumer Law, in assessing claims and informing patients of fees.

Complaints about PEC matters have remained constant with between 59 to 93 complaints each quarter over the last four quarters. It seems that a significant number of these complaints are the result of consumers switching between health insurers and attempting to claim during the 12 month waiting period that insurers are able to apply. However, there seems to be a significant proportion of complaints that could have been prevented through improving practices in assessing PEC claims and importantly, explaining decisions to policyholders better.

The majority of the complaints that our Office investigates about PEC do not result in a change in the decision made by the insurer's medical practitioner and a claim becoming payable. Only 16 per cent of PEC complaints we investigated in 2016–17 resulted in an additional payment to the complainant. The remaining 84 per cent of PEC matters in 2016–17 resulted in the original decision being confirmed when individually assessed, but importantly a better explanation was provided to the complainant.

Health insurers who are seeking to reduce complaints and dissatisfaction with their organisations should consider whether their current claims assessment processes for PEC are providing adequate explanations to people whose claims are being assessed as pre-existing. In our view, insurers do not always provide a clear statement of reason, and we would like to remind health insurers that the Guidelines provide all the information that is required to guide claims staff and medical practitioners in informing policyholders of PEC decisions.

In the Guidelines at Attachment C, there is a template which specifies the information that needs to be stated by a health insurer's medical practitioner in making a decision. We note that the following fields are the ones that are most often missing in the decisions provided to consumers that result in complaints to our Office:

- name of general practitioner and specialist
- date of presentation to doctor
- signs and symptoms appearing in the patient's history
- a medical opinion/explanation of why the signs and symptoms are those which lead to the need for treatment
- if there is a difference of opinion between the treating practitioner and health insurer medical practitioner about signs and symptoms, the insurer practitioner must justify with appropriate references why the opinion of the treating practitioner should be disregarded.

If this information is clearly stated to the person whose claim has been assessed as a PEC they will be less likely to misunderstand the decision or to believe the insurer has made an assessment without recognising their medical history or the opinions of their treating practitioner.

Top five consumer complaint issues this quarter

1. **Hospital exclusions and restrictions: 120 complaints** – usually caused when complainants find they are not covered for a service or treatment that they had assumed was included in their cover.

2. **Membership cancellation: 97 complaints** – complaints caused by problems and delays associated with processing requests to cancel memberships and handling payments or refunds. It's important to note that in most cases these membership cancellations are caused by consumers transferring from one insurer to another and not the result of people leaving health insurance altogether.

3. **Pre-existing conditions waiting period: 93 complaints** – these complaints are usually caused by the health insurer or the insurer's medical practitioner failing to clearly state which signs and symptoms were relied upon in assessing a claim and the complainant misunderstanding how a pre-existing condition is defined.

4. **Verbal advice: 91 complaints** – most verbal advice complaints concern consumers misunderstanding their benefits during telephone calls and retail branch visits with their insurer, particularly where records are not adequately maintained. In many cases our case officers will access the recording of advice provided to a consumer and provide an independent assessment of the quality of the information provided.

5. **General treatment benefits: 58 complaints** – these complaints usually concern disputes over the amount payable under 'extras' policies, such as dental, optical, physiotherapy, and pharmaceuticals, or the insurer's rules for benefit payments (such as certain minimum claim criteria).

Complaints by provider or organisation type

Provider or organisation type	Dec 2016 QTR	Mar 2017 QTR	Jun 2017 QTR	Sep 2017 QTR
Health insurers	1,067	1,245	1,237	1,020
Overseas visitor & overseas student health Insurers	95	108	114	141
Brokers and comparison services	15	19	25	26
Doctors, dentists, other medical providers	5	6	13	4
Hospitals and area health services	4	15	17	13
Other (e.g. legislation, ambulance services, industry peak bodies, etc.)	17	19	25	18

Updates to privatehealth.gov.au

The Office looks forward to working constructively with the health insurance industry over the coming months to implement an update to the **privatehealth.gov.au** website. The existing Consumer Website Reference Group (the group) will assist in developing the website and ensuring it meets the requirements of health insurers in meeting their obligations to maintain up-to-date information on the site. The group consists of representatives from Private Health Care Australia and the Health Insurance Restricted Membership Association (HIRMAA). We appreciate the continuing support of these associations in ensuring that all health insurers are able to take part in the process.

To keep up-to-date with developments on the website, insurers should ensure their contact information entered into the interface is up-to-date.

New Deputy Ombudsman

The Commonwealth Ombudsman is pleased to welcome Ms Jaala Hinchcliffe who has been appointed as our new Deputy Ombudsman. Jaala joins us from the Department of Parliamentary Services where she was the head of People and Governance Branch. In that role she had responsibility for a variety of corporate functions and prior to this, Jaala was a legal officer, principal legal officer and has six years' experience as a senior executive in the Office of the Commonwealth Director of Public Prosecutions.

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Complaints by Health Insurer Market Share
1 July to 30 September 2017

Name of Insurer	Complaints(1)	Percentage of Complaints	Disputes(2)	Percentage of Disputes	Market Share(3)
ACA Health Benefits	0	0.0%	0	0.0%	0.1%
Australian Unity	58	5.7%	4	3.1%	3.1%
BUPA	247	24.2%	45	35.2%	27.0%
CBHS Corporate Health	0	0.0%	0	0.0%	n/a
CBHS	12	1.2%	1	0.8%	1.4%
CDH (Cessnock District Health)	1	0.1%	0	0.0%	<0.1%
CUA Health	8	0.8%	2	1.6%	0.6%
Defence Health	13	1.3%	1	0.8%	1.9%
Doctors' Health Fund	3	0.3%	0	0.0%	0.2%
Emergency Services Health	0	0.0%	0	0.0%	n/a
GMHBA	22	2.2%	4	3.1%	2.1%
Grand United Corporate Health	12	1.2%	2	1.6%	0.4%
HBF Health & GMF/Healthguard	70	6.9%	5	3.9%	8.0%
HCF (Hospitals Contribution Fund)	137	13.4%	18	14.1%	10.3%
Health.com.au	10	1.0%	3	2.3%	0.6%
Health Care Insurance	0	0.0%	0	0.0%	0.1%
Health-Partners	5	0.5%	1	0.8%	0.6%
HIF (Health Insurance Fund of Aus.)	8	0.8%	1	0.8%	0.9%
Latrobe Health	2	0.2%	0	0.0%	0.7%
Medibank Private & AHM	266	26.1%	15	11.7%	27.6%
Mildura District Hospital Fund	0	0.0%	0	0.0%	0.2%
MO Health Pty Ltd	0	0.0%	0	0.0%	n/a
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
Navy Health	2	0.2%	1	0.8%	0.3%
NIB Health	89	8.7%	16	12.5%	8.1%
Nurses and Midwives Pty Ltd	1	0.1%	0	0.0%	n/a
Peoplecare	5	0.5%	0	0.0%	0.5%
Phoenix Health Fund	3	0.3%	1	0.8%	0.1%
Police Health	3	0.3%	0	0.0%	0.3%
QLD Country Health Fund	0	0.0%	0	0.0%	0.3%
Railway & Transport Health	6	0.6%	1	0.8%	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	22	2.2%	6	4.7%	2.1%
Teachers Union Health	6	0.6%	1	0.8%	0.6%
Transport Health	5	0.5%	0	0.0%	0.1%
Westfund	2	0.2%	0	0.0%	0.7%
Total for Health Insurers	**1020**	**100%**	**128**	**100%**	**100%**

1) Total number of Complaints (Problems, Grievances & Disputes) regarding Australian registered health insurers. This table excludes complaints regarding OVHC and OSHC insurers, and other bodies.

2) Disputes required the intervention of the Ombudsman and the health insurer.

3) Source: Australian Prudential Regulation Authority, Market Share, All Policies, 30 June 2016. Insurers which commenced business after 30 June 2016 have no reportable market share.

Issues and sub-issues: complaints received in previous four quarters

ISSUE Sub-issue	Dec 16	Mar 17	Jun 17	Sep 17
BENEFIT				
Accident and emergency	14	10	10	20
Accrued benefits	0	2	3	1
Ambulance	23	17	21	16
Amount	41	51	54	32
Delay in payment	47	54	70	43
Excess	13	22	16	17
Gap - Hospital	16	22	23	13
Gap - Medical	33	33	29	25
General treatment (extras/ancillary)	67	52	36	59
High cost drugs	4	4	2	1
Hospital exclusion/restriction	68	73	90	120
Insurer rule	33	38	30	27
Limit reached	5	6	4	14
New baby	8	6	6	8
Non-health insurance	0	5	1	0
Non-health insurance - overseas benefits	0	0	0	0
Non-recognised other practitioner	10	6	9	4
Non-recognised podiatry	3	4	5	1
Other compensation	4	3	6	7
Out of pocket not elsewhere covered	6	9	5	5
Out of time	4	5	3	4
Preferred provider schemes	12	19	15	11
Prostheses	0	1	5	0
Workers compensation	0	1	2	1
CONTRACT				
Hospitals	3	10	4	8
Preferred provider schemes	6	2	8	6
Second tier default benefit	1	1	1	0
COST				
Dual charging	3	4	0	0
Rate increase	6	95	32	8
INCENTIVES				
Lifetime Health Cover	49	46	63	55
Medicare Levy Surcharge	4	1	2	4
Rebate	11	9	11	4
Rebate tiers and surcharge changes	0	2	0	0
INFORMATION				
Brochures and websites	11	16	15	12
Lack of notification	19	11	15	15
Oral advice	101	80	87	91
Radio and television	0	1	0	0
Standard Information Statement	3	1	1	3
Written advice	11	21	8	9

ISSUE Sub-issue	Dec 16	Mar 17	Jun 17	Sep 17
INFORMED FINANCIAL CONSENT				
Doctors	4	7	7	1
Hospitals	2	10	17	9
Other	2	0	3	2
MEMBERSHIP				
Adult dependents	6	5	9	7
Arrears	38	31	14	23
Authority over membership	8	3	3	3
Cancellation	79	97	111	97
Clearance certificates	62	41	57	50
Continuity	40	47	44	31
Rate and benefit protection	2	4	9	1
Suspension	17	23	22	26
SERVICE				
Customer service advice	27	32	53	41
General service issues	51	81	65	55
Premium payment problems	102	127	163	57
Service delays	53	60	45	21
WAITING PERIOD				
Benefit limitation period	5	0	0	1
General	11	6	6	10
Obstetric	4	7	11	9
Other	5	4	6	6
Pre-existing conditions	61	59	88	93
OTHER				
Access	1	1	0	0
Acute care certificates	2	1	3	1
Community rating	0	0	0	1
Complaint not elsewhere covered	18	24	24	14
Confidentiality and privacy	5	4	2	4
Demutualisation/sale of health insurers	0	1	0	0
Discrimination	0	0	0	0
Medibank sale	0	1	0	1
Non-English speaking background	0	0	0	0
Non-Medicare patient	2	2	3	3
Private patient election	0	3	2	1
Rule change	23	33	14	6

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