Private Health Insurance Ombudsman

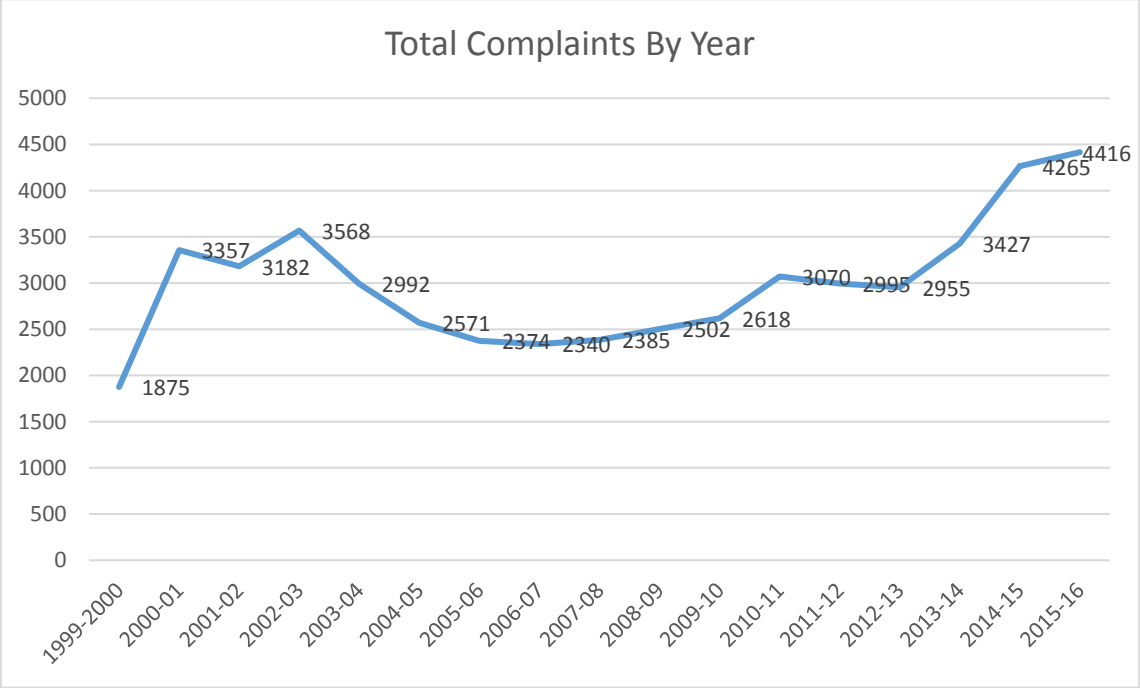
Additional Information for 2015-16

This document supplements the Private Health Insurance Ombudsman section in the Commonwealth Ombudsman Annual Report 2015-16 *available on www.ombudsman.gov.au. For further information or queries please contact phio.info@ombudsman.gov.au or 1300 362 072.*

Annual Complaint Figures

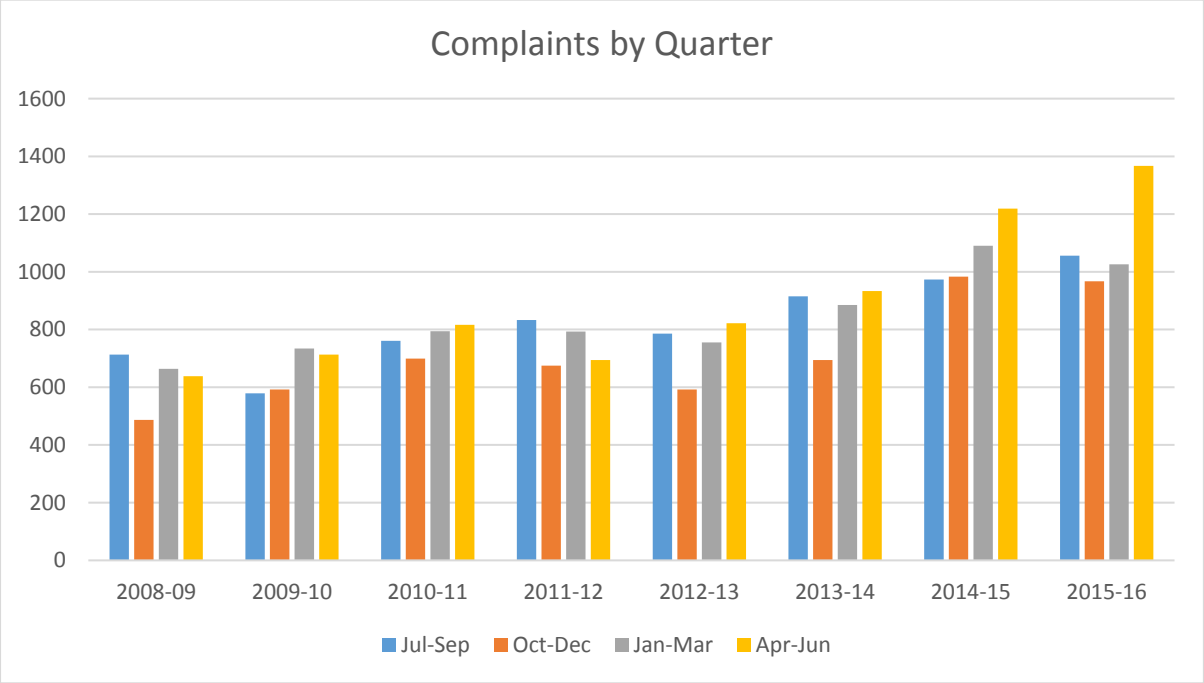
After several years where PHIO complaint levels remained steady, the past two years have seen an increase in approaches. In 2015–16, the PHIO received 4416 complaints, slightly higher than 2014–15's total of 4265 complaints and a considerable increase on the 3427 complaints received in 2013–14. The graph below shows the total number of complaints received per year since 1999–2000.

The increase in the number of complaints in the 2000–01 year was associated with a large increase in the number of Australians covered by private health insurance following the introduction of the Government Rebate and Lifetime Health Cover.



Complaints by Quarter

The following graph shows the distribution of complaints over the four quarters of the 2015–16 financial year. The January-March and April-June quarters have historically been the period with the highest complaints due to the 1 April premium increases, Medicare Levy Surcharge and Lifetime Health Cover deadlines which keep private health insurance 'top of mind' for consumers. This was especially apparent in the past two years.



Complaints by Level

Approaches to the Ombudsman's office were recorded as complaints if they met the relevant criteria - a complaint must be an expression of dissatisfaction with a matter arising out of or connected with a private health insurance arrangement. Complaints can be made by, and be concerned with: a member of a health insurer, a hospital, a doctor or other practitioner, a health insurer, or a health insurance broker.

Complaints dealt with by the Ombudsman range from simple contacts that do not require investigation and can be referred to the service provider for resolution, through to matters requiring mediation or a formal recommendation under the Act. The Ombudsman's complaints categorisation takes account of the following factors:

- Type of approach;
- Degree of effort required by Ombudsman staff to resolve the matter; and
- Any potential sensitivity.

In 2015-16, complaints were categorised as follows:

1. **Problems: Moderate level of complaint**

These complaints are dealt with by referring the complainant back to the health insurer, health care provider or health insurance broker which is the object of complaint. This occurs where, in the view of the Ombudsman, the complainant has not made an adequate attempt to resolve the problem or the Ombudsman is able to suggest to the complainant other ways of approaching the problem.

The majority of these are resolved as "Assisted Referrals" where the Dispute Resolution Officer referred a complaint directly to a specifically arranged representative in the insurer or service provider on behalf of the complainant. Complainants are always advised that if they are not satisfied after their health insurer or health care provider contacts them, the Ombudsman can then contact the other party and ask for a report in order to review the complaint. When this occurs, the complaint is reclassified as a Dispute.

2. **Grievances: Moderate level of complaint resolved without requiring a report from the object of the complaint**

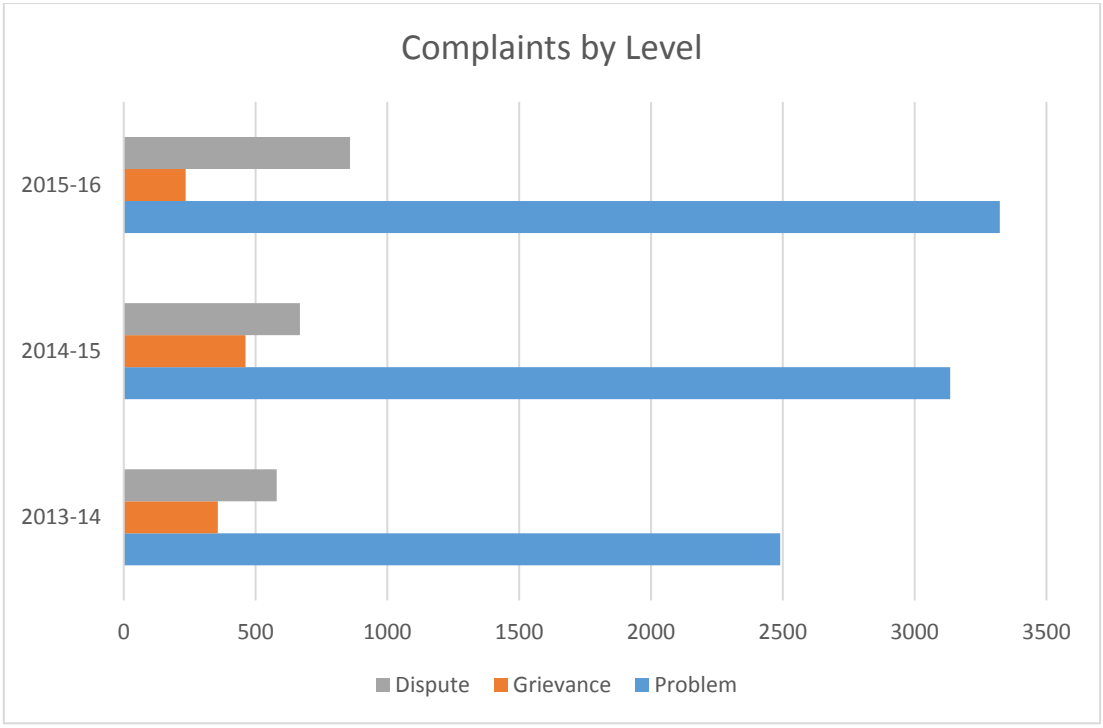
Grievances are dealt with by staff investigating issues of grievance and providing additional information or a clearer explanation directly to the complainant. Complaints within this category generally result from a misunderstanding by consumers of their rights under the policy they have purchased, including concerns about service levels provided by the insurer or provider, price increases, benefit limitations and waiting periods. The provision of an explanation by the Ombudsman as an independent third party is generally sufficient to conclude the complaint.

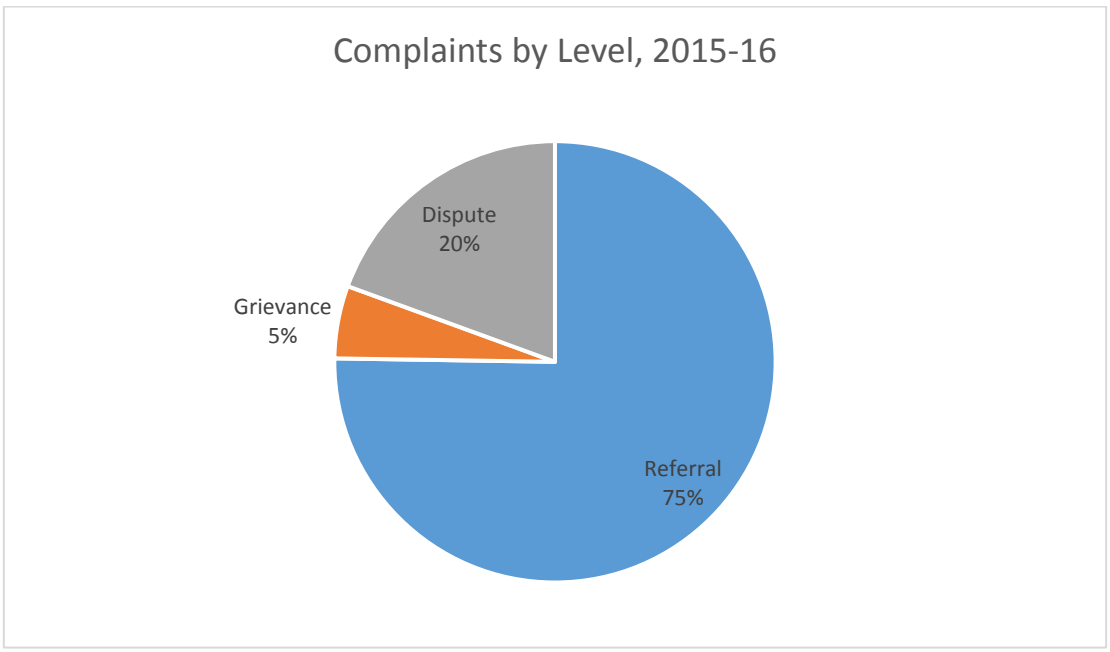
3. **Disputes: High level of complaint where significant intervention is required**

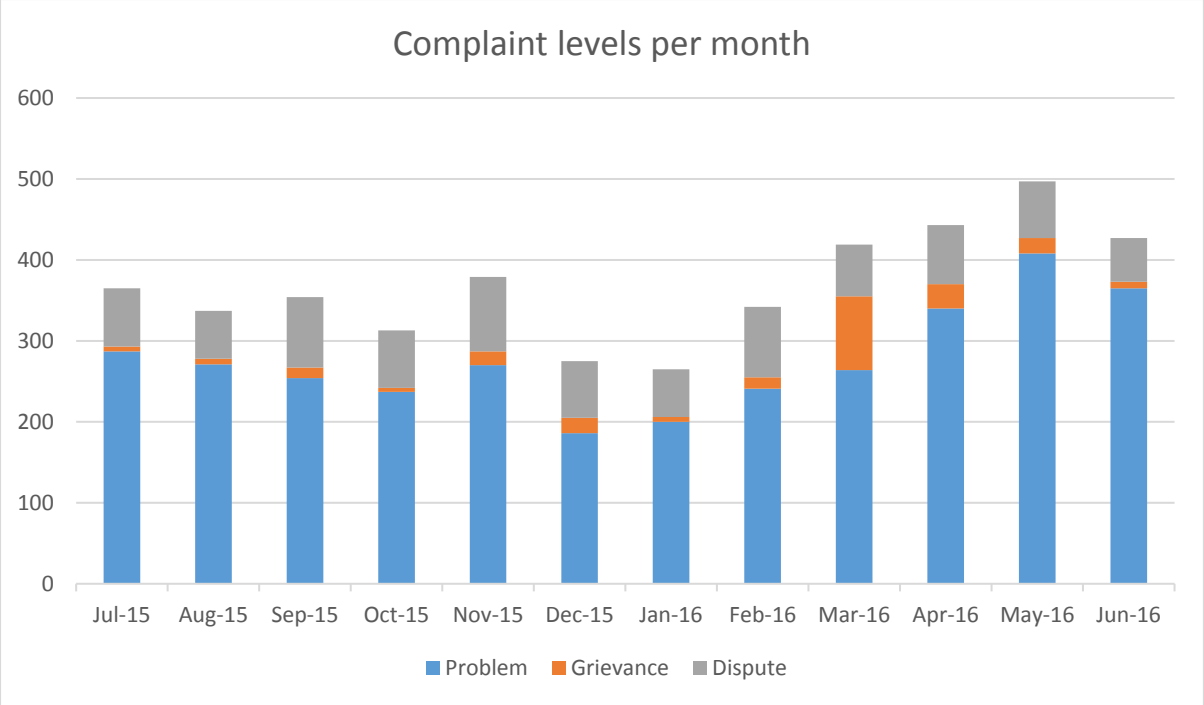
Level 3 complaints are dealt with by Ombudsman staff contacting the health insurer, health care provider or health insurance broker about the matter and requesting a formal report. Issues in this category will have previously been the subject of dispute between the complainant and the insurer or service provider and not have been resolved. The Ombudsman attempts resolution through conciliation by telephone or in writing. Common complaints in this category include pre-existing

ailments, lack of informed financial consent, benefits available on transfer of membership, benefits not in accordance with brochure descriptions and contribution errors.

While the overall numbers of complaints rose in 2015–16, the proportion of complaints in each level remained steady from previous years. There was a slight decrease in Grievances (5% down from 11%) and a slight increase in Disputes (20% up from 16%).

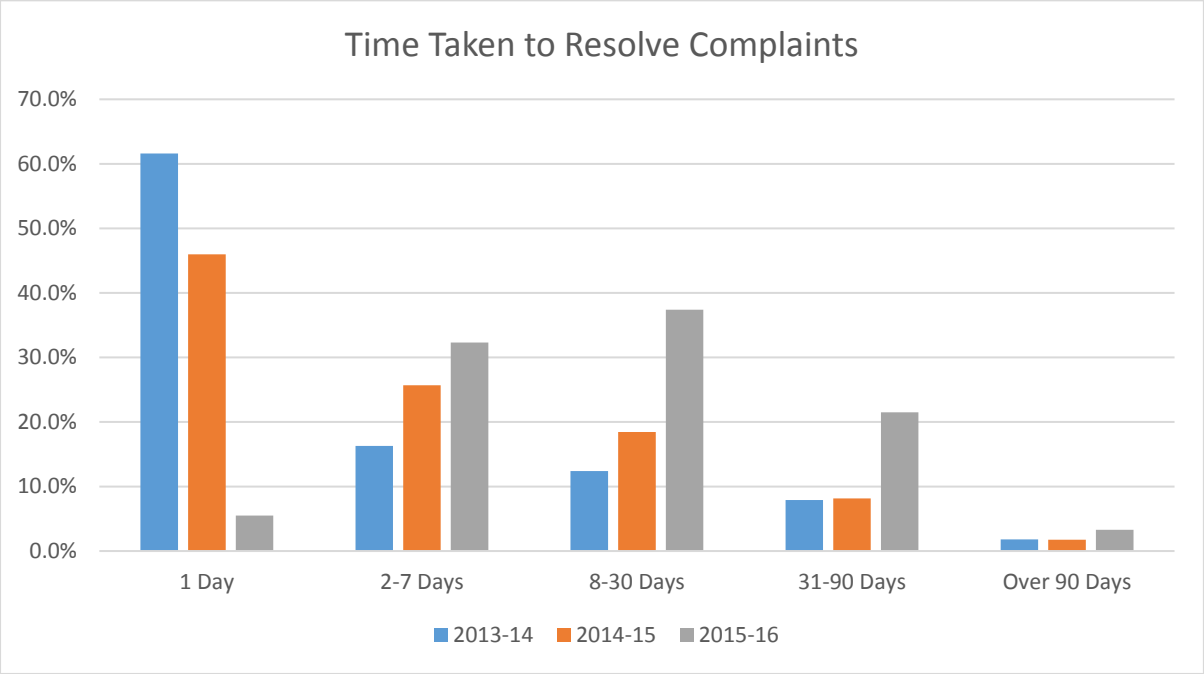


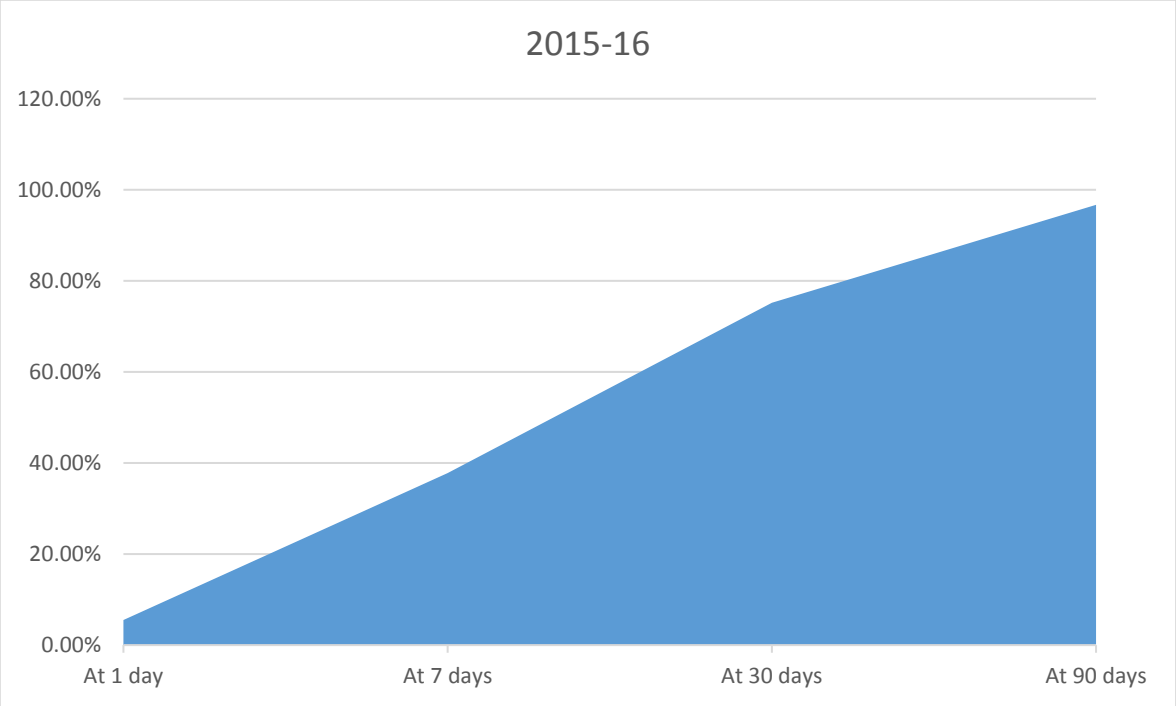



Complaint levels per month
600
500
400
300
200
100
0
Jul-15
Aug-15
Sep-15
Oct-15
Nov-15
Dec-15
Jan-16
Feb-16
Mar-16
Apr-16
May-16
Jun-16
Problem
Grievance
Dispute

Time Taken to Resolve Complaints

The majority of cases (75.2%) continue to be finalised within 30 days and almost all cases (96.7%) are finalised within 90 days. However, this is a change from previous years - in 2014-15, 90.1% of cases were finalised in 30 days. The change is partially attributable to a change in case recording processes as PHIO transitioned from the previous complaint recording system to the current Commonwealth Ombudsman system. Complaint handling time is an issue the PHIO will continue to monitor and review in the year ahead.





Who was Complained About

As in previous years, most complaints were made about health insurers (88%), followed by overseas visitors insurers (7%), health insurance brokers (2%), hospitals (1%) and practitioners (1% including doctors, dentists and other health care providers). These figures remain steady from previous years.

Hospitals

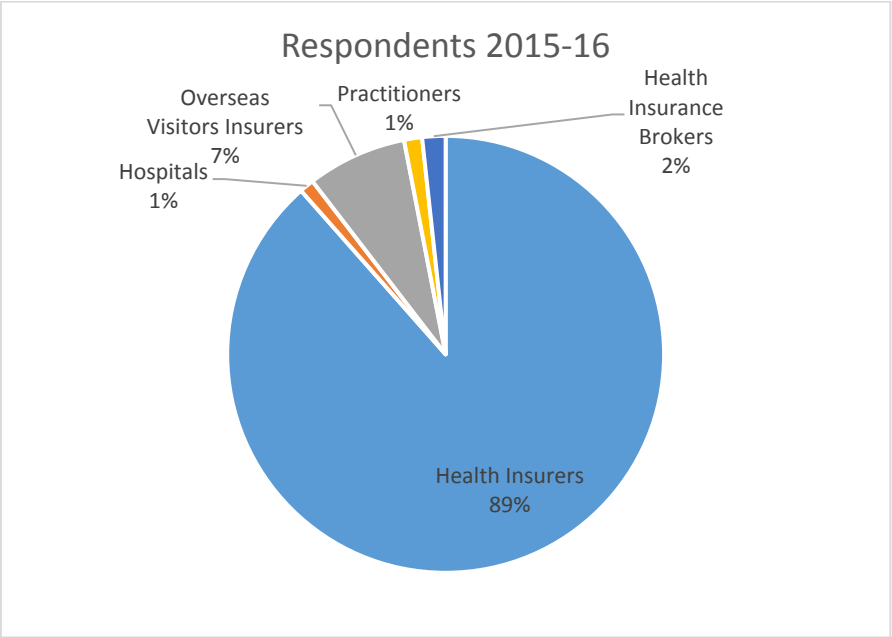
Of the 47 complaints about hospitals, the majority relate to Informed Financial Consent (IFC) issues. The PHIO received 36 complaints about IFC in relation to hospital fees. Complaints about hospitals and hospital-related bills usually occur when patients experience unexpected gaps for a hospital admission – usually occurring when the patient has unexpected restrictions or exclusion on their policy, or is within waiting periods, or if their insurer does not have a contractual agreement with their hospital. In most cases, there are adequate processes in place in private hospitals to ensure the provision of Informed Financial Consent (IFC) to patients, so the number of complaints about unexpected gaps is low compared with the number of hospitalisations taking place each year.

Doctors and Practitioners

Most complaints about doctors and practitioners concerned medical gap issues and/or a lack of IFC, and in some cases pathology and radiology providers in hospital. PHIO received 58 complaints about practitioners, an increase on the 30 complaints in the previous year. Again, however, the number of complaints about unexpected gaps is low compared with the number of services being provided each year.

Health Insurance Brokers

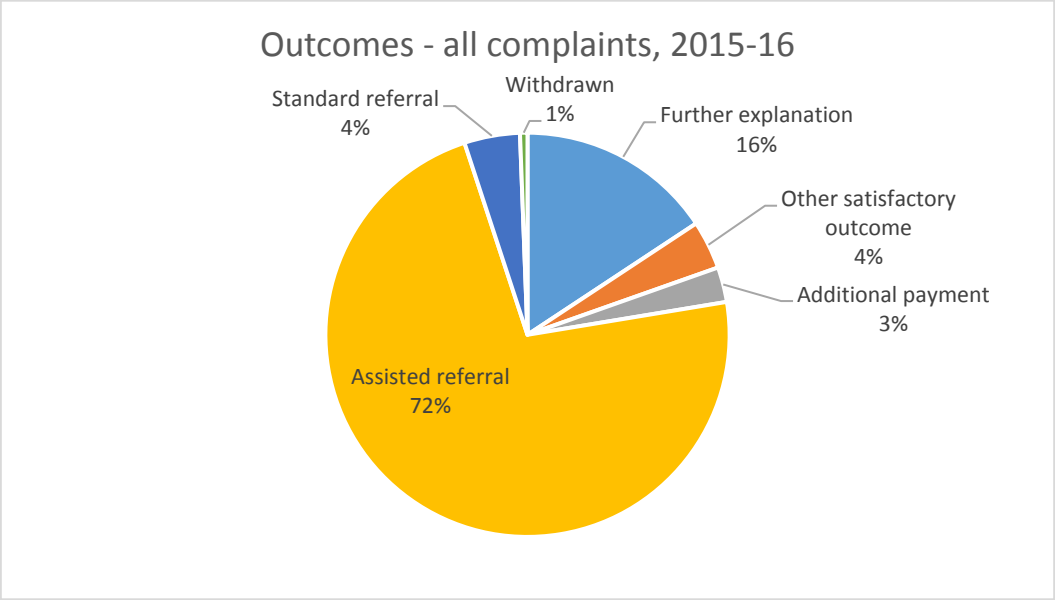
There were 75 complaints received about brokers, steady from the previous year. The major cause of complaint against brokers was the provision of oral advice to people joining or transferring between health insurers. After switching between funds or joining for the first time, these consumers later found that brokers had supplied incorrect or incomplete details about their new policies, leaving them with unexpected exclusions and restrictions or waiting periods to complete. Administrative delays and service issues for members trying to cancel existing or new policies was also a significant cause of complaint against brokers.



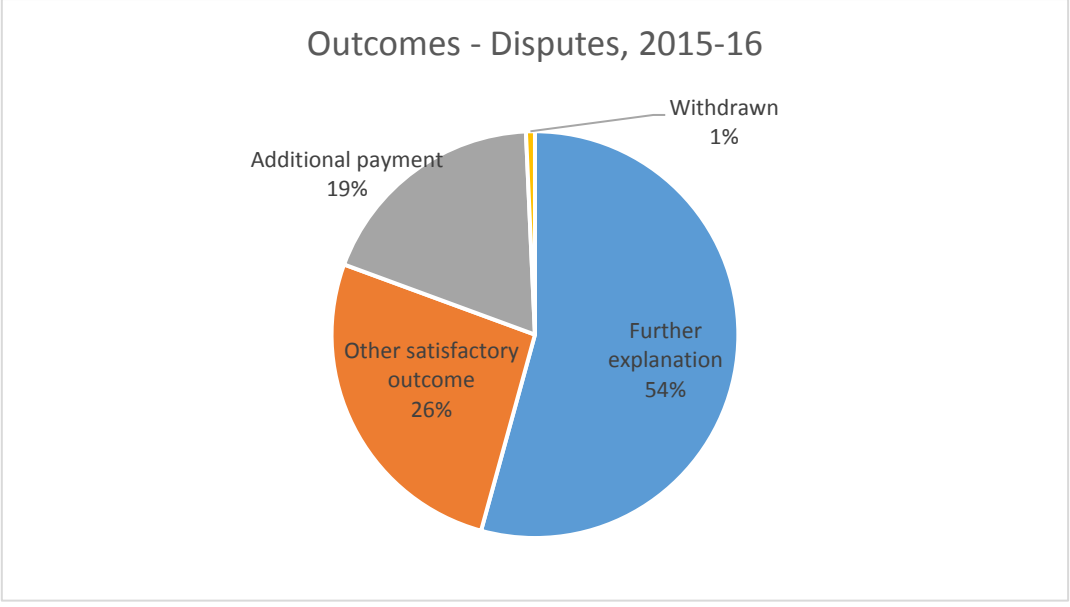
Resolving Complaints

The following figure shows 16% of all complaints were resolved by the Ombudsman's office providing an additional and independent explanation of the member's complaint. A further 72% of all complaints were referred directly to health insurers with the assistance of the Ombudsman's staff, on the understanding that the complainant could request a review of the complaint by the Ombudsman if they remained unsatisfied.

Four per cent of complaints were resolved by standard referral — that is, the complainant obtained advice from the Ombudsman's office and then referred their complaint to the appropriate body themselves. In 3% of cases, the health insurer resolved the issue by making a payment, and 4% were resolved by another satisfactory outcome.

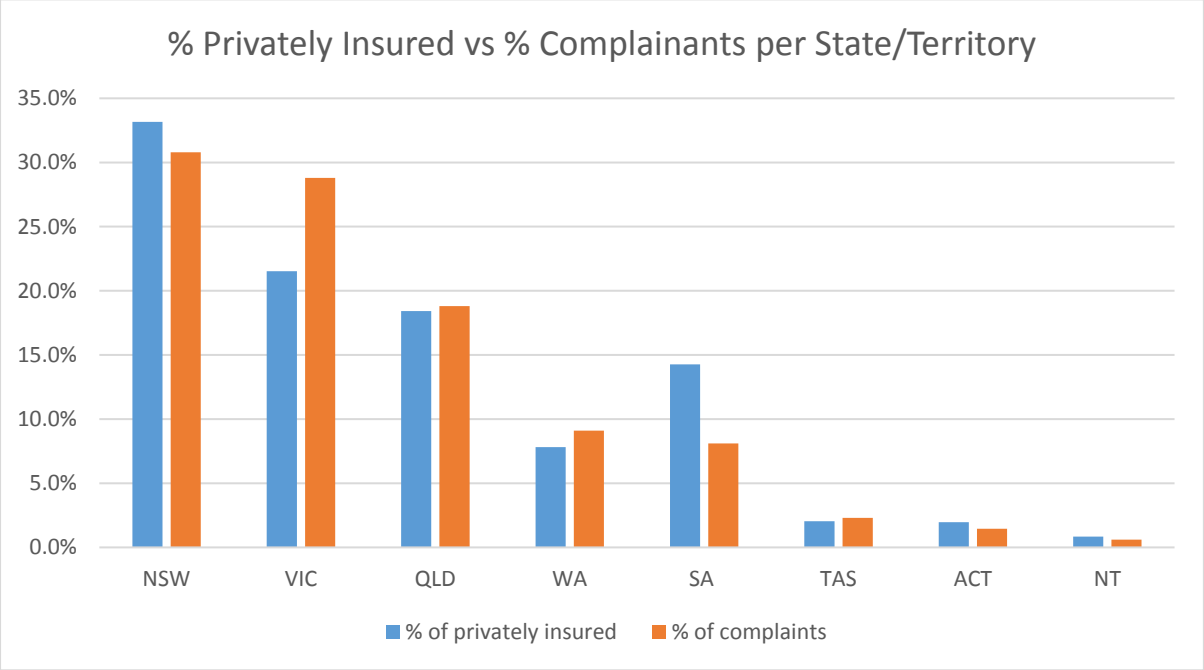


In relation to higher Disputes investigated by the Ombudsman, the following figure shows 54% were resolved by giving a more detailed explanation to the member; 1% were withdrawn by the complainant; 19% were resolved by a payment and 26% by another satisfactory outcome (for example, backdating a change to a policy).



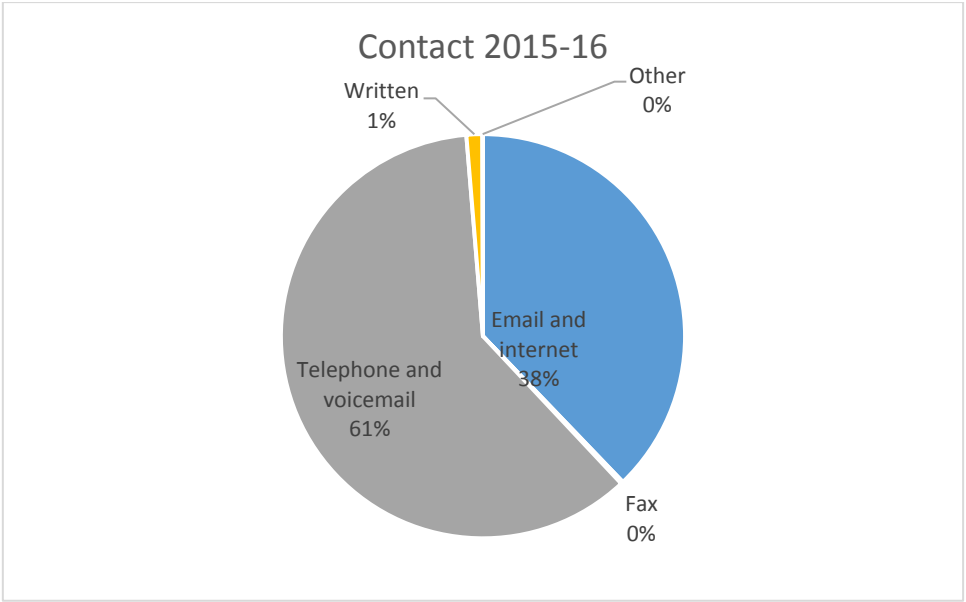
Complaints by State or Territory

This data is shown by state and territory, against the percentage of people who have private health insurance coverage. The figures show that, proportionally, Victorians were more likely to have a health insurance complaint than other states.



How Complaints Were Made

Although the majority of complaints continue to be lodged by telephone, the proportion of complaints received online by internet or e-mail has risen steadily in recent years. In 2015–16, 61% of complaints were initially made by phone and 38% by internet or e-mail, very similar to the previous year. Other methods of complaint continued to be very low. Only 1% of complaints were received by letter; and the remainder of other complaint mediums — including fax, personal visit, and parliamentary representation — comprised less than 0.2%.



Overseas Visitors Health Cover: Sub-Issues

The complaints investigated by PHIO in relation to OVHC are usually similar to those received about Australian residents' policies, except for a higher proportion of complaints about waiting periods and other restrictions on the policy.

Cancellation complaints and delays in benefit payment continued to be significant issues. Complainants have reported that they find it difficult to have claims paid or to have cancellations processed, either due to onerous paperwork requirements from the insurer or simply a lack of timely responses to service requests. These complaints are usually not complex and could be resolved by insurers implementing more rapid response times and processing efficiencies – this can be seen by comparison to Australian residents' policy holders, who experience a proportionally much lower rate of complaint about these issues.

Complaints about Pre-Existing Conditions also continued to be relatively high. Unlike Australian residents' policies, which have strict regulations about maximum waiting periods and how pre-existing conditions are defined, many OVHC policies are not subject to the same rules. They may impose harsher definitions or lengthier waiting periods. The financial impact of having a condition found to be PEC has the potential to be much larger for visitors than they are for Australian residents who can access Medicare.

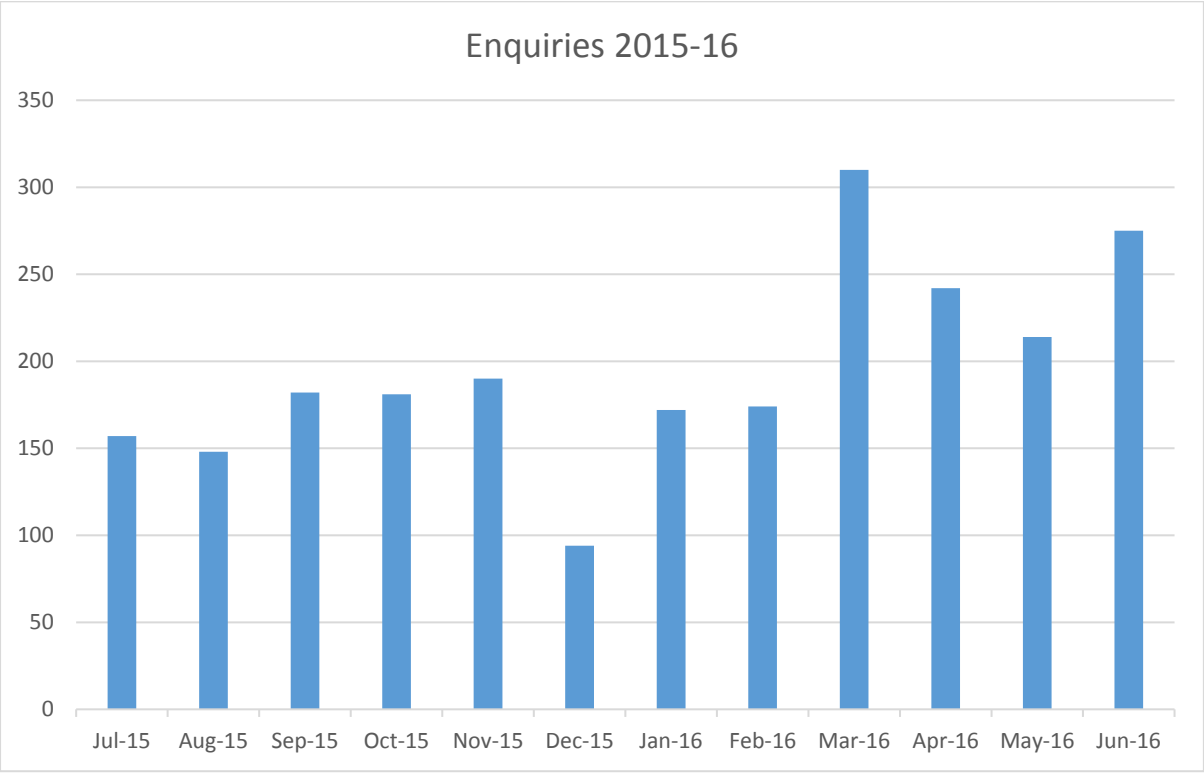
Issue	Sub Issue	2013-14	2014-15	2015-16
Benefit	Accident and emergency	5	9	11
Benefit	Ambulance	1	8	7
Benefit	Amount	6	6	4
Benefit	Delay in payment	33	37	38
Benefit	Gap - Hospital	2	5	7
Benefit	Gap - Medical	2	5	9
Benefit	General treatment (extras/ancillary)	1	1	3
Benefit	High Cost Drugs	3	1	0
Benefit	Hospital exclusion/restriction	11	16	12
Benefit	Insurer rule	11	13	8
Benefit	Limit reached	1	0	0
Benefit	New baby	3	3	0
Benefit	Non health insurance - overseas benefits	0	1	2
Benefit	Non-recognised other practitioner	0	0	2
Benefit	Other compensation	0	3	1
Benefit	Out of pocket not elsewhere covered	1	0	2
Benefit	Out of time	0	0	1
Contract	Hospitals	1	0	0
Cost	Rate increase	0	17	9
Incentives	Lifetime Health Cover	0	0	3
Incentives	Medicare Levy Surcharge	4	2	5
Information	Brochures and websites	0	1	3
Information	Lack of notification	4	1	0
Information	Oral advice	19	32	17
Information	Written advice	0	2	1

Informed Financial Consent	Doctors	0	1	0
Informed Financial Consent	Hospitals	8	5	3
Membership	Adult dependents	0	0	1
Membership	Arrears	2	3	3
Membership	Authority over membership	0	2	2
Membership	Cancellation	28	69	74
Membership	Clearance certificates	0	4	1
Membership	Continuity	4	6	7
Membership	Suspension	0	3	5
Other	Access	0	0	3
Other	Confidentiality and privacy	1	1	0
Other	Discrimination	0	0	1
Other	Non Medicare patient	1	2	2
Other	Not elsewhere covered	1	4	4
Other	Rule change	0	3	0
Service	Customer service advice	4	6	13
Service	General service issues	5	15	8
Service	Premium payment problems	6	7	8
Service	Service delays	16	21	8
Waiting Period	General	7	8	2
Waiting Period	Obstetric	5	10	3
Waiting Period	Other	1	1	0
Waiting Period	Pre-existing condition	25	48	40

Consumer Website Privatehealth.gov.au - Enquiries

The office responded to 2339 consumer enquiries received via the consumer website Privatehealth.gov.au. Approximately 58% of the enquiries received by the office were received via the consumer website, either by e-mail or telephone. The most frequently raised questions are about the following topics:

- Lifetime Health Cover, especially regarding how this affects new migrants to Australia and Australians returning from overseas. The LHC rules determine how much a person pays for hospital insurance;
- The Medicare Levy Surcharge for high income earners and how to avoid the Surcharge by purchasing appropriate private hospital insurance;
- The Australian Government Private Health Insurance Rebate, an income-tested and age-dependent incentive to help cover the cost of premiums;
- Waiting periods for people who are currently uninsured or upgrading existing cover;
- How to use the website, locate information and compare policies;
- How to choose a health insurance policy; and
- Overseas Visitors Health Cover, especially for Subclass 457 visa holders and overseas student visa holders.



Consumer Website Privatehealth.gov.au – Survey Results

During the year, 764 users completed a survey about the website. The key ratings for the site are summarised below. Survey results are used to highlight areas where improvements can be made to the website, to track satisfaction with the site and whether changes have been successful.