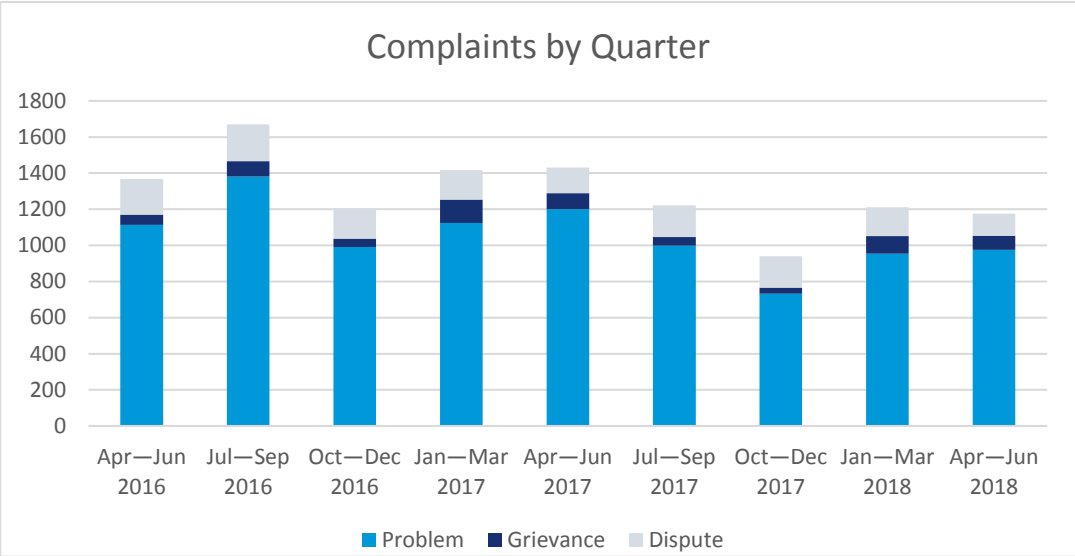
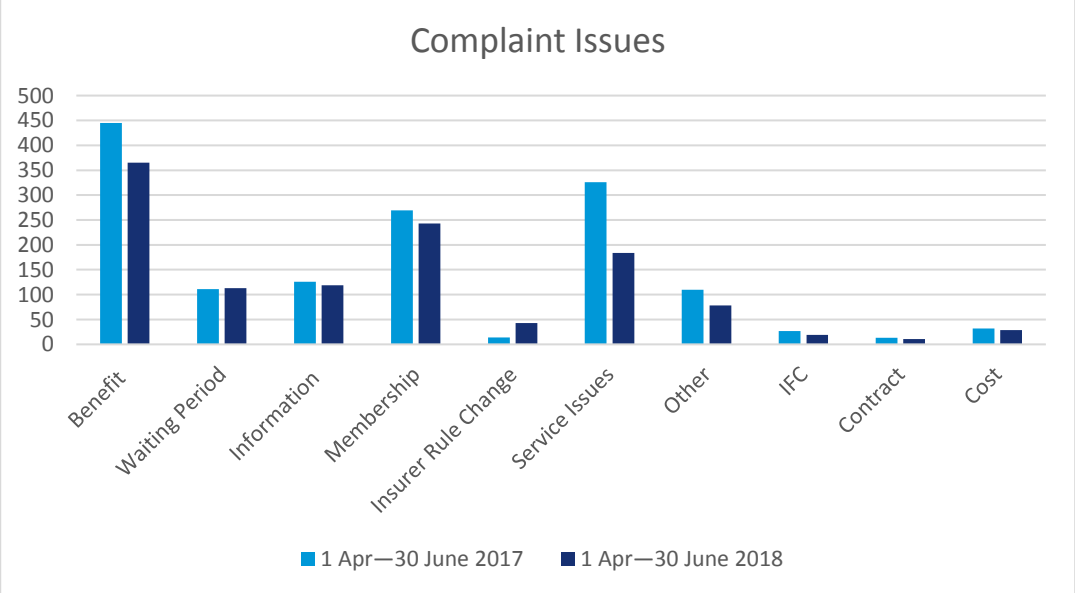
Quarterly Bulletin 87: 1 April to 30 June 2018

Complaint statistics

The Office of the Commonwealth Ombudsman (the Office) received 1,175 private health insurance complaints this quarter, down slightly from the 1,211 complaints received in the March quarter. However, this represented an 18 per cent reduction compared to the 1,431 complaints received in the same period last year.

In the June quarter, health insurance is usually 'top of mind' for consumers as the end of the financial year approaches there is usually significant media attention and advertising regarding the Medicare Levy Surcharge (MLS) and Lifetime Health Cover (LHC). This makes the reduction in complaints this quarter notable compared to the same quarter in 2017.

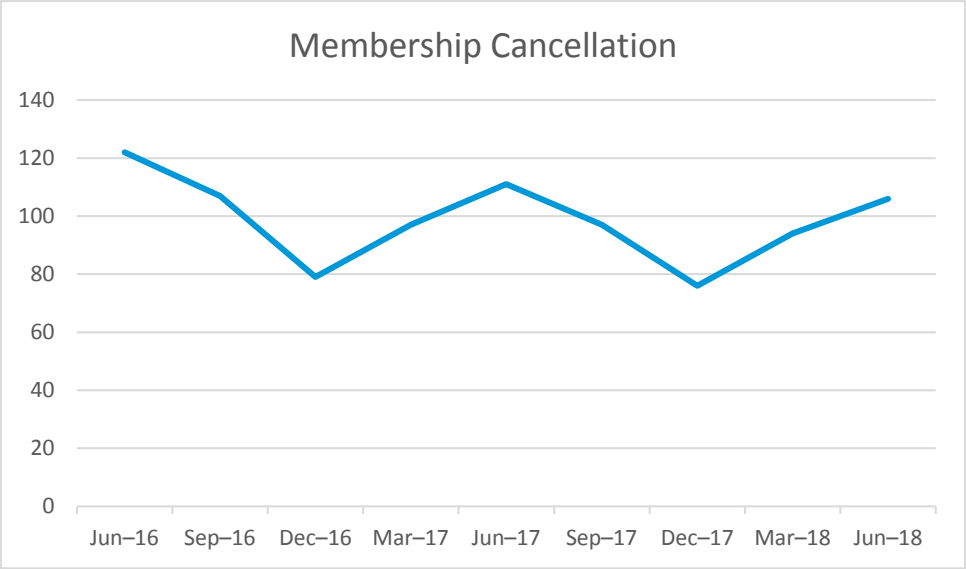




Membership cancellation complaints

Over the last few quarters there has been an increasing number of complaints from policyholders experiencing difficulties cancelling memberships with insurers. During the June 2018 quarter the Office received 106 complaints about membership cancellation issues, which was one of the highest number received—the highest was 122 in the June 2016 quarter—and at a time when other complaint numbers have moderated.

Membership cancellation complaints are not an indicator that health insurance consumers are abandoning health insurance. The vast majority of these complaints concern the problems experienced by consumers seeking refunds and the closure of health insurance policies after they have commenced transferring to a new insurer. These complaints point to consumers switching health insurance policies and to competition in the market.



It is understandable that mistakes will sometimes occur amongst the thousands of transactions that health insurers administer each day. However, the higher incidence of complaints about membership cancellation indicates that more work could be done by health insurers to expedite membership refunds and/or cancellation of direct debits once a consumer has alerted them to a problem.

In many of the cases that our Office handles, we are able to refer a matter to an insurer to issue a refund within two to three days, or to provide a detailed explanation of why a refund is not owing. The rise in the number of membership cancellation complaints points to a problem within some health insurers in responding to complaints sufficiently quickly. It is understandable that if a consumer is waiting on a sum of money they might seek the services of an Ombudsman if they are advised that the refund will take longer than anticipated or if the insurer doesn't respond quickly enough.

A small number of complaints about membership cancellation involve problems with insurers questioning whether a person requesting a cancellation is authorised to do so. Health insurers are right to be cautious regarding cancelling a policy without appropriate authority, but in some instances the service provided to an individual experiencing a problem could have been better. For example, where an individual adult wishes to remove themselves from a family policy, the insurer should allow the individual to do so as it doesn't affect the entitlements of the remaining policyholders. In cases where a person who isn't authorised on the policy—such as an ex-partner—wishes to rescind direct debit authority from their own (not joint) bank account, the insurer needs to recognise their request and then contact the authorised policy holder to make new payment arrangements.

Our Office requests health insurers review their processes in handling complaints about membership cancellation and refunds. It is recommended that insurers have in place clear processes that will expedite refunds for those consumers who complain to frontline staff members about delays in processing refunds.

Checking correspondence from insurers

We always advise consumers to check letters and emails from their insurer carefully, as these contain important information about their level of cover and changes to their policy. We also advise consumers to check their direct debits regularly to make sure their payments are being correctly deducted.

If a private health insurance consumer requires assistance with understanding an insurer's letters or emails, or if they believe there is an error with their policy or payments, then they should contact their insurer as soon as possible. The sooner an error is detected, the easier it is to resolve.

If a consumer receives a request for payment from their insurer and they do not understand why such a request has been sent, they should speak to their insurer in the first instance. If they require further assistance, they can contact our Office for advice.

Case study

Raj was admitted to a private hospital for an investigative procedure. He had commenced his policy relatively recently and was still within his 12 month waiting period for pre-existing conditions. Raj proceeded with the admission knowing that the insurer might not cover his hospitalisation and paid for the hospital fee upfront.

The insurer's medical advisor later determined that the condition being treated was pre-existing and that the insurer would not cover Raj's admission. Raj accepted the insurer's decision.

However, in the meantime, Raj's doctors at the hospital had sent their fees to his insurer under the insurer's "no gap benefit" scheme. The insurer's automated claims processing system paid for the claims in error and sent the benefits directly to Raj's doctors.

On review, the insurer realised it had paid the doctors' fees in error and would require the claims to be repaid.

The insurer then wrote to Raj, asking him to repay the claims. Raj was confused by this request—he had not received any benefit from the insurer, as the insurer had paid the benefits directly to the doctors. The insurer suggested that Raj should pay back the benefits to the insurer, then seek a refund from the doctors. Raj was not satisfied with this response and approached our Office for assistance.

We asked the insurer to review the case and retract their request for Raj to repay the claims. The claims had been processed in error due to a fault in the insurer's automated claims payment scheme and it was not fair that Raj should be held liable for the insurer's mistake. As the benefit had been paid directly to the doctors, the insurer should ask the doctors to repay the claims without involving Raj in the transaction.

Following the Office's investigation, the insurer agreed to write to the doctors and ask for the refund directly. The doctors subsequently repaid the benefits to the insurer, without any need for Raj to become involved in the transaction.

Report into Bupa Health Insurance Hospital Policy Changes

In June 2018, the Ombudsman released a report—Bupa Health Insurance Hospital Policy Changes. In late February 2018, Bupa Health Insurance (Bupa) announced significant changes to policies affecting consumers with basic and mid-level hospital policies and to its medical gap scheme on all hospital policies, in conjunction with its 3.99 per cent average premium increase announcement. The report investigated the impact of these changes on consumers, particularly those in regional Australia. The report made two recommendations, which Bupa accepted.

The first recommendation was that Bupa review its communications to affected policyholders in February 2018. The insurer advised that it would review its communications for future notifications and ensure that they are in accordance with recommendations about notifying detrimental policy changes made to all insurers by both this Office and the ACCC.

The second recommendation was that Bupa send a clear message to consumers affected by the detrimental changes before the changes took effect on 1 July 2018. In response, Bupa sent a second communication to all affected policyholders. The insurer also extended the period in which customers could upgrade to a higher policy to maintain cover without waiting period from 1 July 2018 to 1 September.

Affected Bupa Policyholders received letters in late July 2018 and they have until 1 September to accept the waiver offer.

The Report is available at Ombudsman.gov.au.

Top five consumer complaint issues this quarter

1. Membership cancellation: 106 complaints—see above for discussion.

2. 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.

3. Premium payment problems: 88 complaints—predominantly concerning direct debits from bank accounts and credit cards, such as incorrect direct debit amounts or irregular direct debits, or the accidental cessation of direct debit arrangements.

4. Pre-existing conditions waiting period: 79 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.

5. General treatment benefits: 73 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	Sep 2017 QTR	Dec 2017 QTR	Mar 2018 QTR	Jun 2018 QTR
Health insurers	1,020	780	1,055	1,019
Overseas visitor and overseas student health insurers	141	114	91	95
Brokers and comparison services	26	17	15	25
Doctors, dentists, other medical providers	4	3	9	10
Hospitals and area health services	13	15	16	10
Other (e.g. legislation, ambulance services, industry peak bodies, etc.)	18	11	25	16

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Complaints by Health Insurer Market Share: 1 April–30 June 2018

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	37	3.6%	2	2.3%	3.0%
BUPA	199	19.5%	20	23.0%	27.0%
CBHS Corporate Health	0	0.0%	0	0.0%	<0.1%
CBHS	14	1.4%	1	1.1%	1.5%
CDH (Cessnock District Health)	0	0.0%	0	0.0%	<0.1%
CUA Health	4	0.4%	0	0.0%	0.6%
Defence Health	16	1.6%	0	0.0%	2.0%
Doctors' Health Fund	2	0.2%	1	1.1%	0.3%
Emergency Services Health	0	0.0%	0	0.0%	<0.1%
GMHBA	41	4.0%	4	4.6%	2.3%
Grand United Corporate Health	11	1.1%	0	0.0%	0.4%
HBF Health & GMF/Healthguard	82	8.0%	6	6.9%	8.0%
HCF (Hospitals Contribution Fund)	150	14.7%	16	18.4%	10.4%
HCI (Health Care Insurance)	4	0.4%	0	0.0%	0.1%
Health.com.au	12	1.2%	5	5.7%	0.6%
Health-Partners	5	0.5%	1	1.1%	0.6%
HIF (Health Insurance Fund of Aus.)	7	0.7%	0	0.0%	0.9%
Latrobe Health	8	0.8%	0	0.0%	0.7%
Medibank Private & AHM	257	25.2%	13	14.9%	26.9%
Mildura District Hospital Fund	1	0.1%	0	0.0%	0.2%
MO Health Pty Ltd	0	0.0%	0	0.0%	<0.1%
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
Navy Health	2	0.2%	0	0.0%	0.3%
NIB Health	115	11.3%	14	16.1%	8.3%
Nurses and Midwives Pty Ltd	0	0.0%	0	0.0%	<0.1%
Peoplecare	3	0.3%	1	1.1%	0.5%
Phoenix Health Fund	4	0.4%	1	1.1%	0.1%
Police Health	1	0.1%	0	0.0%	0.3%
QLD Country Health Fund	1	0.1%	0	0.0%	0.4%
Railway & Transport Health	3	0.3%	0	0.0%	0.4%
Reserve Bank Health	1	0.1%	0	0.0%	<0.1%
St Lukes Health	4	0.4%	0	0.0%	0.5%
Teachers Federation Health	21	2.1%	1	1.1%	2.3%
Teachers Union Health	2	0.2%	0	0.0%	0.6%
Transport Health	7	0.7%	1	1.1%	0.1%
Westfund	5	0.5%	0	0.0%	0.7%
Total for Health Insurers	**1,019**	**100%**	**87**	**100%**	**100%**

[1] Total number of complaints (Problems, Grievances and 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 2017.

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

ISSUE Sub-issue	Sep 17	Dec 17	Mar 18	Jun 18
BENEFIT				
Accident and emergency	20	16	17	14
Accrued benefits	1	2	5	5
Ambulance	16	21	17	20
Amount	32	17	25	15
Delay in payment	43	28	35	27
Excess	17	21	11	16
Gap – Hospital	13	25	17	11
Gap – Medical	25	33	23	47
General treatment (extras/ancillary)	59	77	61	73
High cost drugs	1	3	1	1
Hospital exclusion/restriction	120	105	92	71
Insurer rule	27	24	38	28
Limit reached	14	3	8	0
New baby	8	3	3	3
Non-health insurance	0	2	2	2
Non-health insurance – overseas benefits	0	0	0	0
Non-recognised other practitioner	4	2	1	4
Non-recognised podiatry	1	1	1	5
Other compensation	7	3	3	3
Out of pocket not elsewhere covered	5	6	3	2
Out of time	4	10	1	6
Preferred provider schemes	11	9	9	7
Prostheses	0	2	2	3
Workers compensation	1	0	1	2
CONTRACT				
Hospitals	8	2	5	6
Preferred provider schemes	6	5	3	5
Second tier default benefit	0	0	1	0
COST				
Dual charging	0	0	1	2
Rate increase	8	4	69	27
INCENTIVES				
Lifetime Health Cover	55	27	52	57
Medicare Levy Surcharge	4	2	2	6
Rebate	4	3	7	4
Rebate tiers and surcharge changes	0	1	1	1
INFORMATION				
Brochures and websites	12	6	13	10
Lack of notification	15	19	5	9
Oral advice	91	64	89	91
Radio and television	0	0	1	0
Standard Information Statement	3	0	0	1
Written advice	9	6	7	8

ISSUE Sub-issue	Sep 17	Dec 17	Mar 18	Jun 18
INFORMED FINANCIAL CONSENT				
Doctors	1	0	6	7
Hospitals	9	12	13	12
Other	2	1	1	0
MEMBERSHIP				
Adult dependents	7	1	12	13
Arrears	23	14	12	16
Authority over membership	3	8	5	9
Cancellation	97	76	94	106
Clearance certificates	50	18	40	47
Continuity	31	18	28	22
Rate and benefit protection	1	0	5	4
Suspension	26	15	22	26
SERVICE				
Customer service advice	41	19	24	28
General service issues	55	42	61	56
Premium payment problems	57	36	85	88
Service delays	21	18	21	12
WAITING PERIOD				
Benefit limitation period	1	0	0	0
General	10	9	9	18
Obstetric	9	9	8	8
Other	6	3	6	8
Pre-existing conditions	93	75	100	79
OTHER				
Access	0	0	0	0
Acute care certificates	1	2	6	2
Community rating	1	0	1	0
Complaint not elsewhere covered	14	10	4	2
Confidentiality and privacy	4	2	4	3
Demutualisation/sale of health insurers	0	1	0	0
Discrimination	0	0	0	1
Medibank sale	1	0	0	0
Non-English speaking background	0	0	0	0
Non-Medicare patient	3	0	1	1
Private patient election	1	0	0	1
Rule change	6	0	40	43