Commonwealth OMBUDSMAN

*Issues in this bulletin*



# Private Health Insurance Ombudsman Quarterly Bulletin 76

**(1 July – 30 September 2015)**

## New Home for the Private Health Insurance Ombudsman (PHIO) and 2014-15 Annual Report

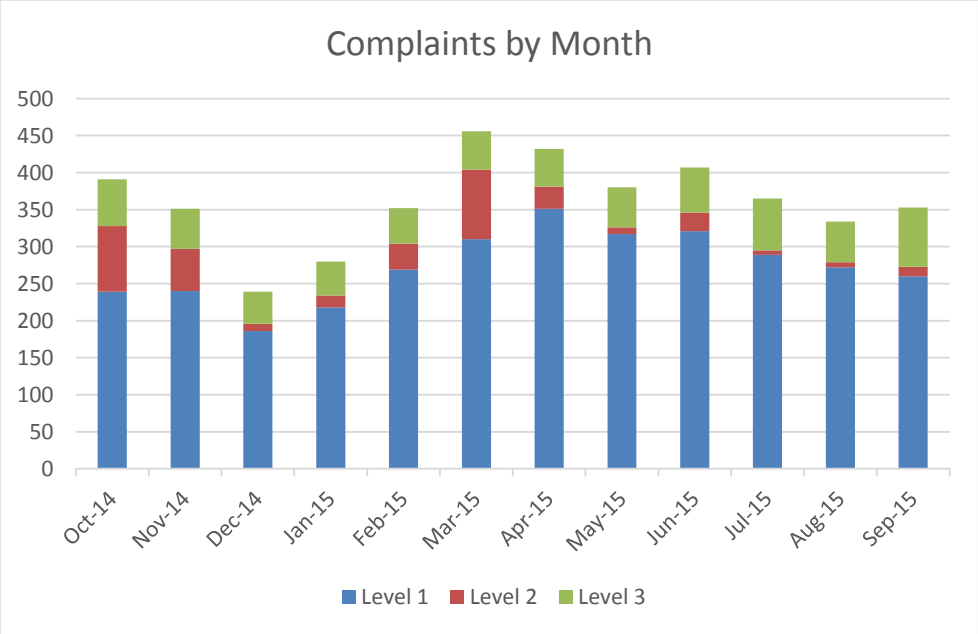
From 1 July 2015 the PHIO was included among the functions performed by the Commonwealth Ombudsman. We are pleased to report that the transition has been smooth and dispute resolution services provided to private health insurance consumers were not affected.

The PHIO Annual Report for the period 1 July 2014 – 30 June 2015 was tabled before Parliament on 27 October 2015 and the report is now available online. The report discusses why more health insurance complaints were received by the PHIO last year than in any previous year, and the steps that insurers and the industry can take to address the causes of consumer dissatisfaction.

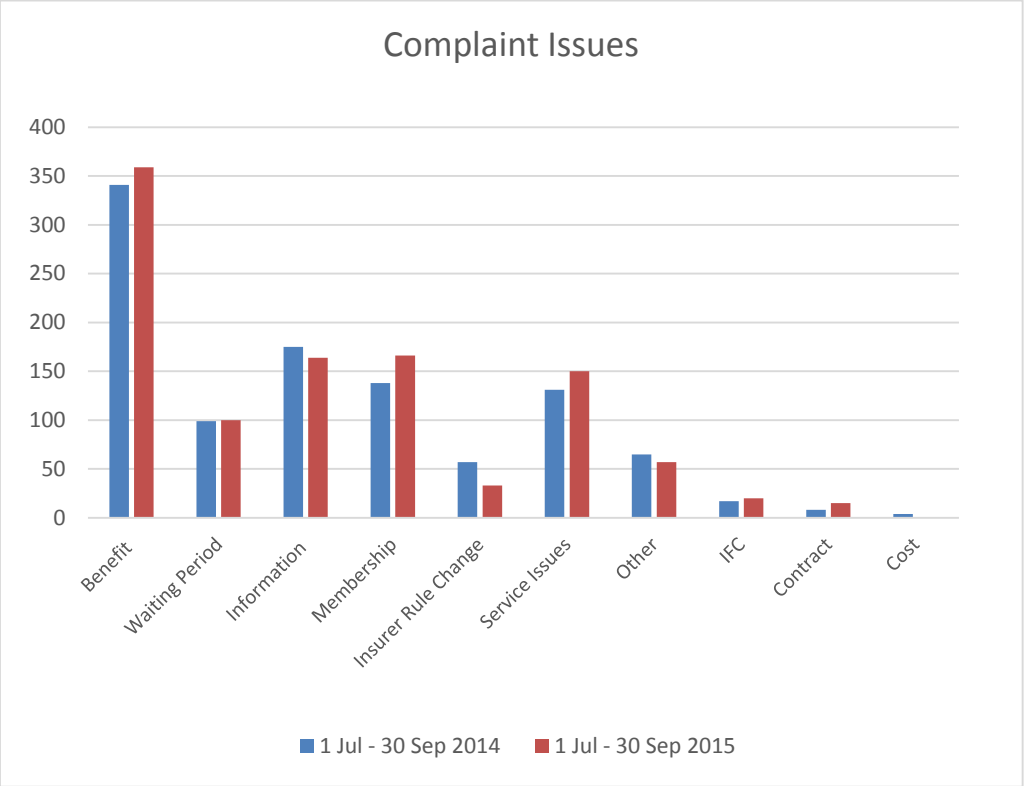
The Commonwealth Ombudsman will be updating websites and phone numbers for PHIO over the next few months. We will be contacting all current stakeholders before making any changes but if you would like to stay up to date we recommend subscribing to our mailing list. You can subscribe by emailing phio.info@ombudsman.gov.au.

## Complaint Statistics and Workload

The Private Health Insurance Ombudsman (PHIO) received 1052 complaints this quarter, compared to 1219 in the previous quarter. Health insurance complaints are best compared to similar periods in the previous year, because the figures tend to increase and decrease each quarter due to seasonal factors such as annual premium increase announcements. Compared to the July to September quarter last year, health insurance consumer complaints have increased by 8%.



Complaint issues were largely similar to those in the same quarter in the previous year, with Benefit issues continuing to be the most common cause of complaint. Membership and Service complaints increased slightly, while Insurer Rule Change complaints decreased slightly.




## Health Insurance Broker Complaints

During the quarter, the office received 18 complaints about brokers, which represents a low number of complaints compared to the number of customers who use private health insurance brokers each year. However, a number of new brokers have entered the market recently, so this is a good opportunity for a reminder about how complaints concerning brokers are handled by the PHIO.

As a health insurance policy can only be provided by a registered health insurer, a broker that is paid a commission by a health insurer is, in effect, acting as an agent for the insurer. The arrangement is one where the insurer is seen as outsourcing the sales process of its business.

When PHIO receives a complaint from a health insurance consumer about a broker service, we will raise the matter with the broker concerned and they are required to respond to us, as an insurer would with a similar case. We will normally also need to contact the insurer to investigate what information was provided to a policy holder after the broker service was completed, in order to understand the context of the broker's advice.

When PHIO recommends a remedy for the complainant involving the payment of a claim, backdate of a policy, or other financial resolution, it is a matter for the registered insurer and the broker to decide which organisation is responsible for the payment of the claim. However, when a broker and an insurer have formed an agreement, the health insurer is ultimately responsible for the actions of the broker to which it is paying a commission. Health insurers who use brokers as part of their sales process need to ensure that the consumer who purchased a policy through a broker is not treated differently to the consumer who purchased from the insurer directly.

## Giving Information to Consumers by Email

Health Insurers are obliged under Section 93 of the *Private Health Insurance Act 2007* to send a number of documents to consumers. These include:

- (93-15) a Standard Information Statement (SIS) to new policy holders, including those changing policies;
- (93-20) an annual Standard Information Statement to existing policy holders, designed to remind them of their cover details
- (93-25) a notice of any detrimental changes to a policy issued in sufficient time before the change comes into effect. This is so the consumer has time to exercise their right to transfer to another policy to maintain cover without serving waiting periods again.

During the quarter PHIO received 33 complaints from consumers about detrimental rule changes. 20 of those complainants stated that the notification about the changes was insufficient.

As health insurers are currently organising their premium and policies for the next year, it would be valuable if insurers could ensure that their communications are consistent with both the legislation and community expectations. Most complaints about this issue concern a person advising PHIO that they were not advised of the removal of a benefit. In investigating these complaints, we have identified an issue with insurers choosing to use email for notifying their policy holders.

PHIO was concerned to learn that some notifications for the removal of individual hospital benefits were sent to affected policy holders by email only, when some of those policy holders had not previously "opted in" to receive communications by that method. Complaints were caused because people had not been checking the email address or did not have any expectation of receiving important correspondence at that address, which they had only provided as part of the initial sales process. In some cases, insurers did not advise that if the person provided an email address on the phone then the insurer might start using that address some years later, even if all prior notifications had been provided by post up to that time. This change of communication method also caused a problem for people whose notifications had been sent to their work email address when they had left an employer and could not access the account anymore.

Sending some communications by email and others such as rate increase letters by post is confusing for the consumer and increases the likelihood of important notices being missed.

In the examples that PHIO investigated where the insurer had sent notifications by email and the message wasn't received, we could not agree that sufficient notice of the change had been provided. We requested the insurers assist the individuals affected, usually by allowing them to backdate a change to a higher policy, as they would have done had they understood they were losing a benefit they still required.

It is the responsibility of each health insurer to seek its own legal opinion on whether its communication methods are complaint with legislation, including the *Private Health Insurance Act 2007* and Australian Consumer Law. From PHIO's perspective we consider the use of email to communicate with consumers is acceptable so long as the following conditions are met to ensure the policy holder knows where to expect communications:

1. There is a record of the policy holder opting in to receive all communications by email and an understanding that the email address needs to be kept up to date; or
2. There is an established record of the policy holder receiving all communications by email; and
3. The communications can be reproduced in a suitable format and given to a consumer who makes a complaint about not receiving the notification. PHIO understands that this can be provided as an extract from the insurer's computer system which is acceptable.

## Top 5 Consumer Complaint Issues This Quarter

1. **Oral Advice: 116 Complaints**
   Complaints about oral advice continue to be a leading cause of consumer dissatisfaction with health insurers. Most complaints concern a consumer misunderstanding the benefits payable under their cover, or relying on advice and choosing a level of cover they are later dissatisfied with.

2. **Hospital Policy Exclusions and Restrictions: 76 Complaints**
   Most complaints concern consumers misunderstanding the limits of their health insurance policies and finding they are not covered sufficiently for private hospital treatment.

3. **Pre-Existing Conditions Waiting Period: 69 Complaints**
   As noted previously, PHIO is seeking to update the Pre-Existing Condition Best Practice Guidelines as they are now almost fifteen years old. Until then, PHIO is working with individual insurers to provide for better processes for assessing these matters. We have found that many complaints about this waiting period would be avoided if insurers more effectively communicated their reasons for finding a condition to be pre-existing.

4. **Membership Cancellation: 67 Complaints**
   Common complaints concern delays in sending clearance certificates and issuing refunds.

5. **General Service Issues: 55 Complaints**
   Most complaints concern delays or inaction from health insurer's customer service staff such as taking too long to respond to correspondence.

## Complaints by Health Insurer Market Share

### 1 July - 30 September 2015

| 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 | 45 | 4.9% | 8 | 4.9% | 3.2% |
| BUPA | 229 | 24.8% | 48 | 29.4% | 26.7% |
| CBHS | 9 | 1.0% | 4 | 2.5% | 1.3% |
| CDH (Cessnock District Health) | 0 | 0.0% | 0 | 0.0% | <0.1% |
| CUA Health | 13 | 1.4% | 2 | 1.2% | 0.5% |
| Defence Health | 10 | 1.1% | 4 | 2.5% | 1.7% |
| Doctors' Health Fund | 1 | 0.1% | 1 | 0.6% | 0.2% |
| GMHBA | 11 | 1.2% | 1 | 0.6% | 1.9% |
| Grand United Corporate Health | 1 | 0.1% | 0 | 0.0% | 0.4% |
| HBF Health | 30 | 3.2% | 3 | 1.8% | 7.4% |
| HCF (Hospitals Cont. Fund) | 116 | 12.6% | 16 | 9.8% | 10.8% |
| Health.com.au | 14 | 1.5% | 5 | 3.1% | 0.5% |
| Health Care Insurance | 0 | 0.0% | 0 | 0.0% | 0.1% |
| Healthguard (GMF/Central West) | 4 | 0.4% | 0 | 0.0% | 0.5% |
| Health-Partners | 4 | 0.4% | 1 | 0.6% | 0.6% |
| HIF (Health Insurance Fund of Aus.) | 7 | 0.8% | 2 | 1.2% | 0.7% |
| Latrobe Health | 3 | 0.3% | 1 | 0.6% | 0.7% |
| Medibank Private & AHM | 326 | 35.3% | 49 | 30.1% | 29.1% |
| Mildura District Hospital Fund | 0 | 0.0% | 0 | 0.0% | 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 | 74 | 8.0% | 14 | 8.6% | 7.7% |
| Peoplecare | 1 | 0.1% | 0 | 0.0% | 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 | 3 | 0.3% | 0 | 0.0% | 0.4% |
| Reserve Bank Health | 0 | 0.0% | 0 | 0.0% | <0.1% |
| St Lukes Health | 1 | 0.1% | 0 | 0.0% | 0.4% |
| Teachers Federation Health | 17 | 1.8% | 2 | 1.2% | 2.0% |
| Teachers Union Health | 1 | 0.1% | 0 | 0.0% | 0.5% |
| Transport Health | 1 | 0.1% | 1 | 0.6% | 0.1% |
| Westfund | 2 | 0.2% | 1 | 0.6% | 0.7% |
| **Total for Health Insurers** | **924** | **100%** | **163** | **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: PHIAC, Market Share, All Policies, 30 June 2014.