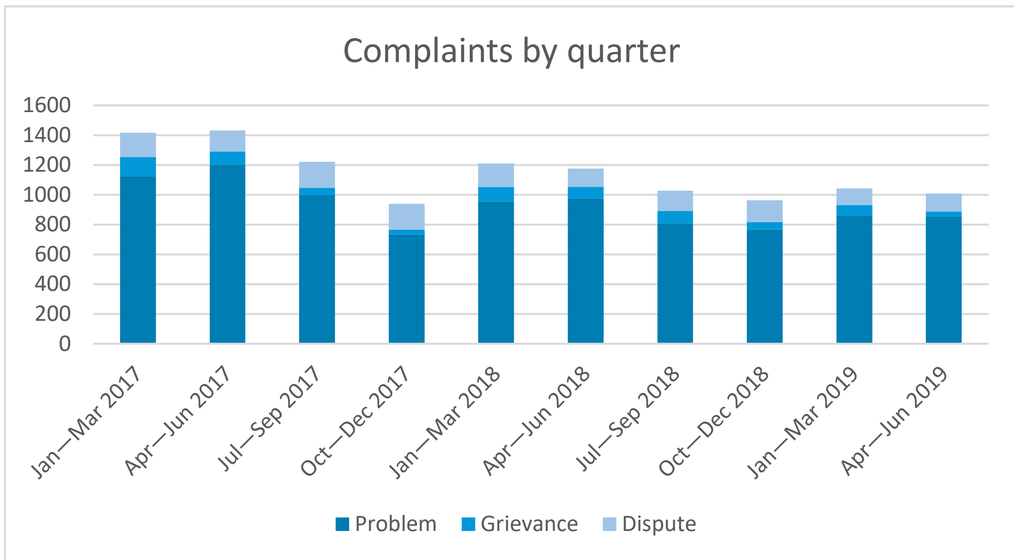
COMMONWEALTH OMBUDSMAN
PRIVATE HEALTH INSURANCE

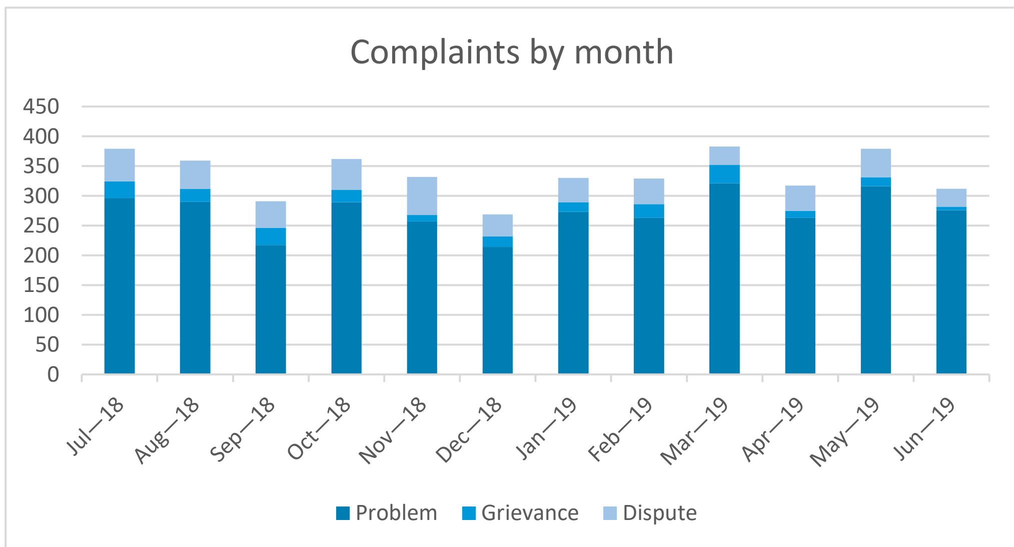
Quarterly Bulletin 91: 1 April–30 June 2019

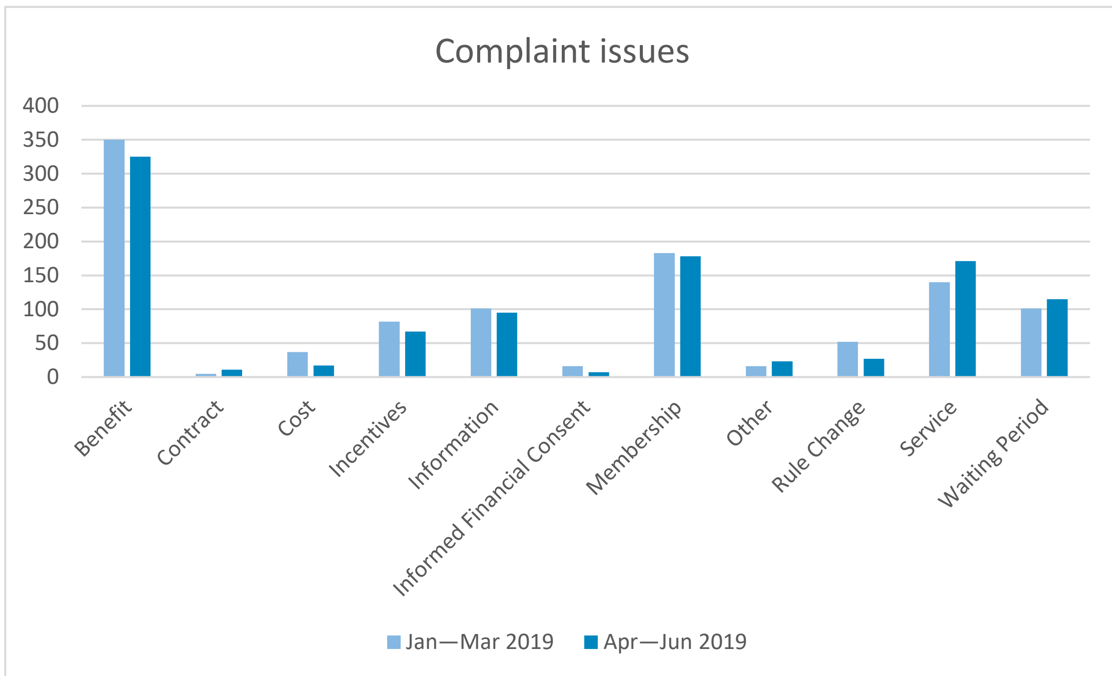
Complaint statistics

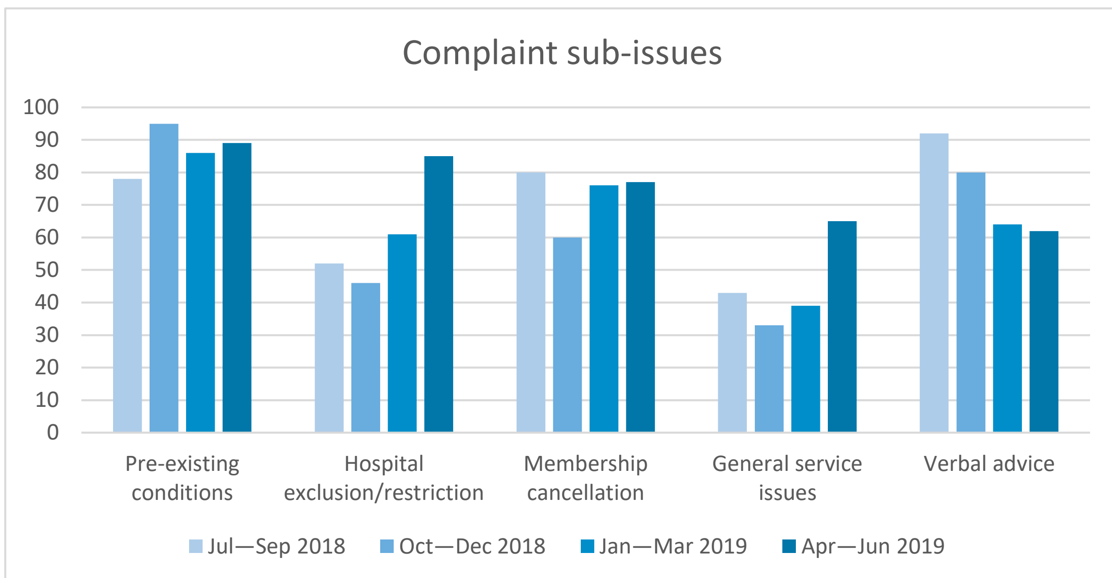
The Office of the Commonwealth Ombudsman (the Office) received 1,008 private health insurance complaints this quarter. This represented a decrease of 3 per cent compared to the previous quarter (Jan–Mar 2019) and 15 per cent compared to the June quarter last year.

On 1 April 2019, signficant reforms to private health insurance came into effect, including the introduction of hospital product tiers (Gold, Silver, Bronze and Basic) and standard clinical categories. During the quarter a number of health insurers transferred policyholders onto new policies and this process will continue until 1 April 2020 when the transition period ends. Despite the significant changes to policies and the volume of communications to policyholders, there was no resulting increase in complaints to the Office.









Top five consumer complaint sub-issues this quarter

1. **Pre-existing conditions waiting period: 89 complaints**—these complaints are typically caused by the health insurer or the insurer's medical practitioner not clearly stating which signs and symptoms were relied upon in assessing a claim, or the complainant misunderstanding how a pre-existing condition is defined. The Office is able to seek a better explanation of the insurer's medical practitioner's decision as well as provide an impartial review based on the medical evidence.

2. **Hospital exclusions and restrictions: 85 complaints**—these complaints usually arise when complainants find they are not covered for a service or treatment that they had assumed was included in their cover, leaving them unable to access or incurring large expenses to access the hospital treatment they need.

3. **Membership cancellation: 77 complaints**—these complaints are caused by problems and delays associated with processing requests to cancel memberships and handling payments or refunds. It is 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 private health insurance altogether. This issue has remained consistently high for several quarters and we are monitoring this issue for industry trends.

4. **General service issues: 65 complaints**—service issues are not usually the sole reason for complaints. A combination of unsatisfactory customer service, untimely responses to simple issues and poor internal escalation processes can cause policy-holders to grow increasingly aggrieved and dissatisfied with their dealings with an insurer, until the service itself becomes a cause of complaint as well as the original issue.

5. **Verbal advice: 62 complaints**—most verbal advice complaints concern poorly communicated advice to people over the phone or at a retail centre, 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.

Complaints by provider or organisation type

The majority of cases handled by the Office are about Australian private health insurers. However, we also handle complaints about other providers, so long as it is relevant to a health insurance arrangements.

A comparison of the previous four quarters shows complaints about different provider and organisation types remains generally steady. Notably, complaints against brokers and comparison services continue to be down by approximately 50 per cent, compared to the September 2018 quarter.

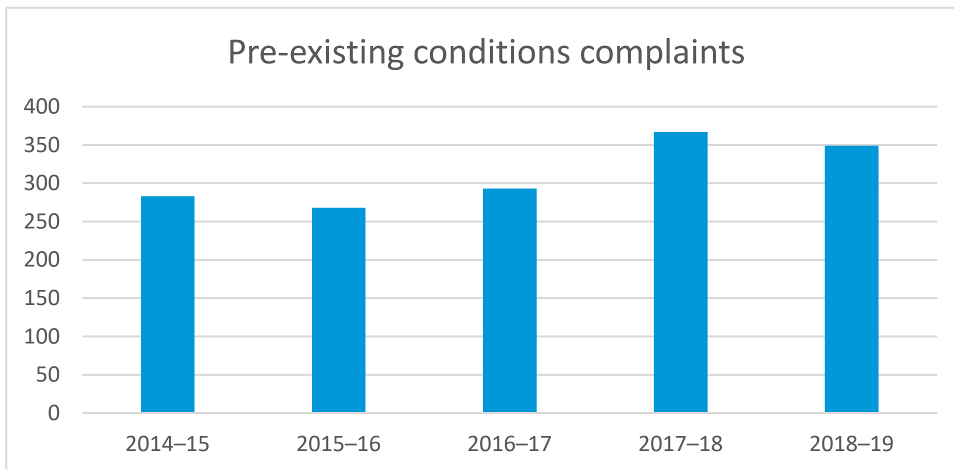
Provider or organisation type	Sep 2018 quarter	Dec 2018 quarter	Mar 2019 quarter	Jun 2019 quarter
Health insurers	854	816	904	846
Overseas visitor and overseas student health insurers	111	98	81	111
Brokers and comparison services	26	13	12	16
Doctors, dentists, other medical providers	6	5	5	2
Hospitals and area health services	17	3	10	10
Other (e.g. legislation, ambulance services, industry peak bodies, etc.)	14	16	30	23

Issue in focus: pre-existing condition complaints

As part of our role, we investigate complaints from consumers about PEC decisions and ensure the PEC rules have been correctly applied by the insurer. The Office acts as an independent third party when dealing with complaints about PEC waiting periods.

PHIO investigates 4,000 private health insurance matters a year, and on average 300 of which involve PEC decisions by insurers. The number of PEC complaints received by the Office has risen slightly over the past five years.

The Office regularly publishes information about complaint issues for the industry and consumers. Insurer responsibilities in making PEC determinations have been regularly covered in the Private Health Insurance Ombudsman Quarterly Bulletins (QB) including: QB 84, QB 80, and QB 79.



In making determinations about complaints about the PEC waiting period, the Office ensures the waiting period has been applied correctly and that the insurer and hospital have complied with the Pre-Existing Condition Best Practice Guidelines. In circumstances where individual complaints highlight systemic issues with the application of the private health insurance regulatory framework, the Office may provide feedback to the insurer in our complaint finalisation correspondence, or the Ombudsman may initiate an own motion investigation or refer the matter to the regulator – for PEC matters this would be the Department of Health.

The Office recommends that all health insurers should examine their internal claims assessment processes to ensure that they are complying with their obligations to assess PEC claims using a medical practitioner as required by s75-15 of the *Private Health Insurance Act 2007* (Cth).

Although this Office investigates PEC matters and will raise compliance issues with a health insurer if we are aware of them, it is the obligation of each health insurer to ensure compliance with the legislation. If there is any doubt about compliance, it is contingent on a health insurer to seek its own legal opinion to provide reassurance of compliance.

For more information about the Ombudsman's role in PEC cases, please read our factsheet.

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Complaints by health insurer market share

Name of insurer	Complaints[1]	Percentage of complaints	Disputes[2]	Percentage of disputes	Market share[3]
ACA Health Benefits	1	0.1%	0	0.0%	0.1%
Australian Unity	52	6.1%	1	1.3%	2.9%
BUPA	174	20.6%	23	29.9%	26.3%
CBHS Corporate Health	0	0.0%	0	0.0%	<0.1%
CBHS	16	1.9%	2	2.6%	1.5%
CDH (Cessnock District Health)	0	0.0%	0	0.0%	<0.1%
CUA Health	5	0.6%	1	1.3%	0.6%
Defence Health	6	0.7%	0	0.0%	2.1%
Doctors' Health Fund	3	0.4%	0	0.0%	0.3%
Emergency Services Health	1	0.1%	0	0.0%	<0.1%
GMHBA	42	5.0%	2	2.6%	2.4%
Grand United Corporate Health	9	1.1%	2	2.6%	0.4%
HBF Health & GMF/Healthguard	44	5.2%	2	2.6%	7.8%
HCF (Hospitals Contribution Fund)	142	16.8%	14	18.2%	10.7%
HCI (Health Care Insurance)	1	0.1%	0	0.0%	0.1%
Health Partners	5	0.6%	1	1.3%	0.6%
Health.com.au	12	1.4%	3	3.9%	0.6%
HIF (Health Insurance Fund of Aus.)	15	1.8%	1	1.3%	0.8%
Latrobe Health	7	0.8%	1	1.3%	0.7%
Medibank Private & AHM	185	21.9%	12	15.6%	26.9%
Mildura District Hospital Fund	1	0.1%	0	0.0%	0.2%
MO Health Pty Ltd	3	0.4%	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	68	8.0%	10	13.0%	8.5%
Nurses and Midwives Pty Ltd	0	0.0%	0	0.0%	<0.1%
Peoplecare	8	0.9%	1	1.3%	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%	0.4%
Railway & Transport Health	5	0.6%	1	1.3%	0.4%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Lukes Health	3	0.4%	0	0.0%	0.5%
Teachers Federation Health	20	2.4%	0	0.0%	2.4%
Transport Health	4	0.5%	0	0.0%	0.1%
TUH	2	0.2%	0	0.0%	0.6%
Westfund	10	1.2%	0	0.0%	0.7%
Total for Health Insurers	846	100%	77	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 2018.

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

ISSUE Sub-issue	Sep 18	Dec 18	Mar 19	Jun 19
BENEFIT				
Accident and emergency	13	20	15	14
Accrued benefits	0	1	1	4
Ambulance	10	12	16	17
Amount	16	22	10	11
Delay in payment	45	43	27	28
Excess	17	8	17	14
Gap — Hospital	0	14	27	18
Gap — Medical	42	17	25	25
General treatment (extras/ancillary)	74	63	81	51
High cost drugs	1	2	2	0
Hospital exclusion/restriction	52	46	61	85
Insurer rule	8	18	13	17
Limit reached	1	2	6	4
New baby	1	3	5	1
Non-health insurance	1	1	0	1
Non-health insurance — overseas benefits	0	0	0	0
Non-recognised other practitioner	2	1	7	0
Non-recognised podiatry	4	0	2	0
Other compensation	2	2	5	0
Out of pocket not elsewhere covered	6	10	5	8
Out of time	5	6	4	3
Preferred provider schemes	2	8	11	15
Prostheses	8	11	8	7
Workers compensation	1	0	2	2
CONTRACT				
Hospitals	5	9	2	4
Preferred provider schemes	3	0	2	5
Second tier default benefit	1	1	1	2
COST				
Dual charging	5	4	5	3
Rate increase	5	2	32	14
INCENTIVES				
Lifetime Health Cover	60	37	42	42
Medicare Levy Surcharge	6	3	1	1
Private health insurance reforms[4]	-	4	37	20
Rebate	5	1	2	4
Rebate tiers and surcharge changes	3	0	0	0
INFORMATION				
Brochures and websites	5	4	7	10
Lack of notification	9	16	10	9
Radio and television	0	0	0	0
Standard Information Statement	4	1	4	3
Verbal advice	92	80	64	62
Written advice	7	5	16	11

ISSUE Sub-issue	Sep 18	Dec 18	Mar 19	Jun 19
INFORMED FINANCIAL CONSENT				
Doctors	2	6	2	1
Hospitals	8	3	10	6
Other	2	6	4	0
MEMBERSHIP				
Adult dependents	4	3	10	3
Arrears	12	16	19	14
Authority over membership	7	5	9	10
Cancellation	80	60	76	77
Clearance certificates	33	31	31	31
Continuity	28	13	13	22
Rate and benefit protection	4	1	2	5
Suspension	23	12	23	16
SERVICE				
Customer service advice	15	22	15	17
General service issues	43	33	39	65
Premium payment problems	32	42	68	58
Service delays	16	20	18	31
WAITING PERIOD				
Benefit limitation period	0	0	0	0
General	16	7	5	12
Obstetric	9	8	7	9
Other	3	7	3	5
Pre-existing conditions	78	95	86	89
OTHER				
Access	1	2	0	0
Acute care and type C certificates	6	2	2	7
Community rating	1	0	0	0
Complaint not elsewhere covered	14	13	8	6
Confidentiality and privacy	7	5	3	3
Demutualisation/sale of health insurers	1	0	0	1
Discrimination	1	2	1	1
Medibank sale	0	0	0	0
Non-English speaking background	0	0	0	0
Non-Medicare patient	1	0	0	2
Private patient election	1	2	2	3
Rule change	68	76	52	27

[4] New sub-issue as of 1 October 2018