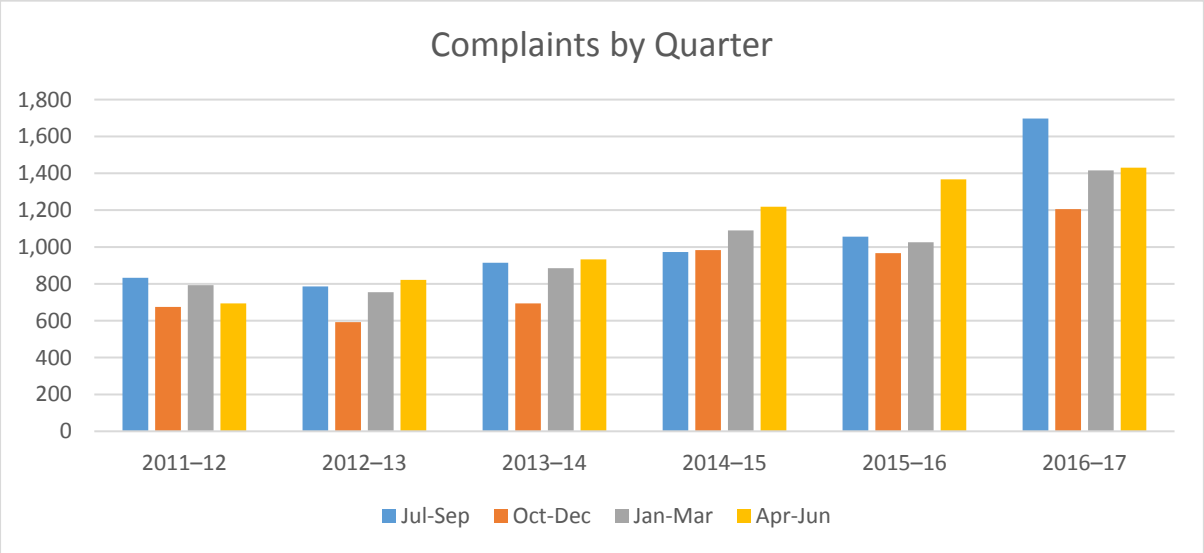
Private Health Insurance Ombudsman

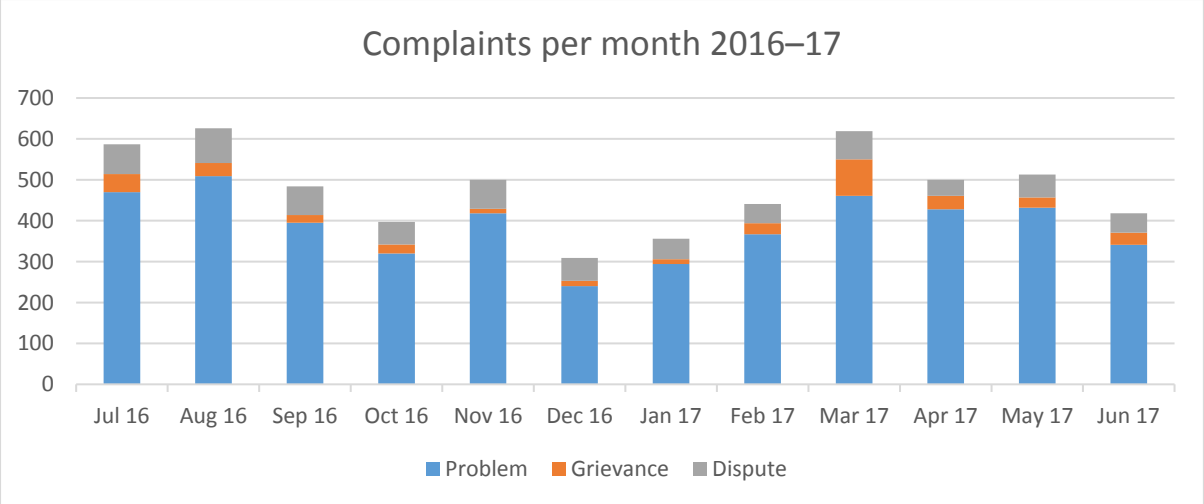
Additional information for 2016–17

This document supplements the Private Health Insurance Ombudsman section (pp 81–91) in the *Commonwealth Ombudsman Annual Report 2016–17* available at **ombudsman.gov.au**. For further information or queries, please contact **phio.info@ombudsman.gov.au** or call **1300 362 072**.

Complaints by quarter and month

The following graphs detail the distribution of complaints by quarters and by months for 2016–17. 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 year, the peak period was the July–September period, mainly due to Information Communication Technology (ICT) problems at Medibank Private. These complaints were addressed by the insurer and subsequently reduced by the end of 2016–17.





Complaints by level

Approaches about private health insurance to the Office of the Commonwealth Ombudsman (the 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 our Office 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 *Private Health Insurance Act 2007*. The Office's complaints categorisation takes account of the following factors:

- type of approach
- degree of effort required by our staff to resolve the matter, and
- any potential sensitivity.

In 2016–17, complaints were categorised as follows:

1. Problem: Moderate level complaint

These complaints are dealt with by referring the complainant back to the health insurer, health care provider or health insurance broker that is the object of complaint. This occurs where, in the view of the Office, the complainant has not made an adequate attempt to resolve the problem or we are 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 of the insurer or service provider on behalf of the complainant. Complainants are always advised that, if they are not satisfied after their insurer or health care provider contacts them, our Office 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.

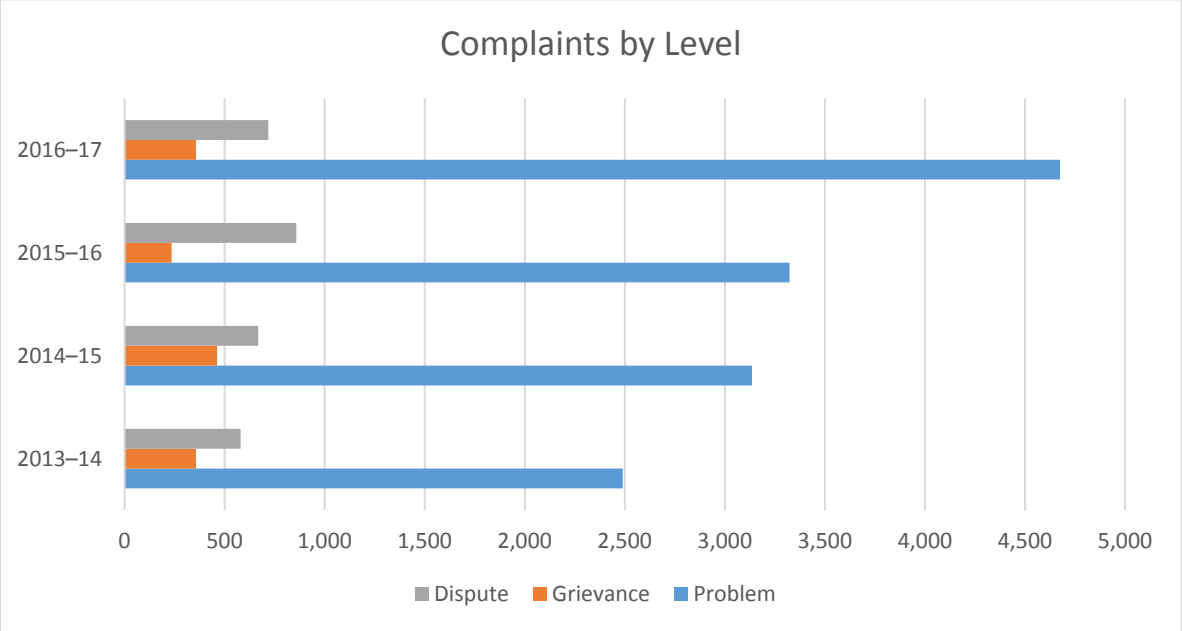
2. Grievance: Moderate level complaint resolved without requiring a report from the object of the complaint

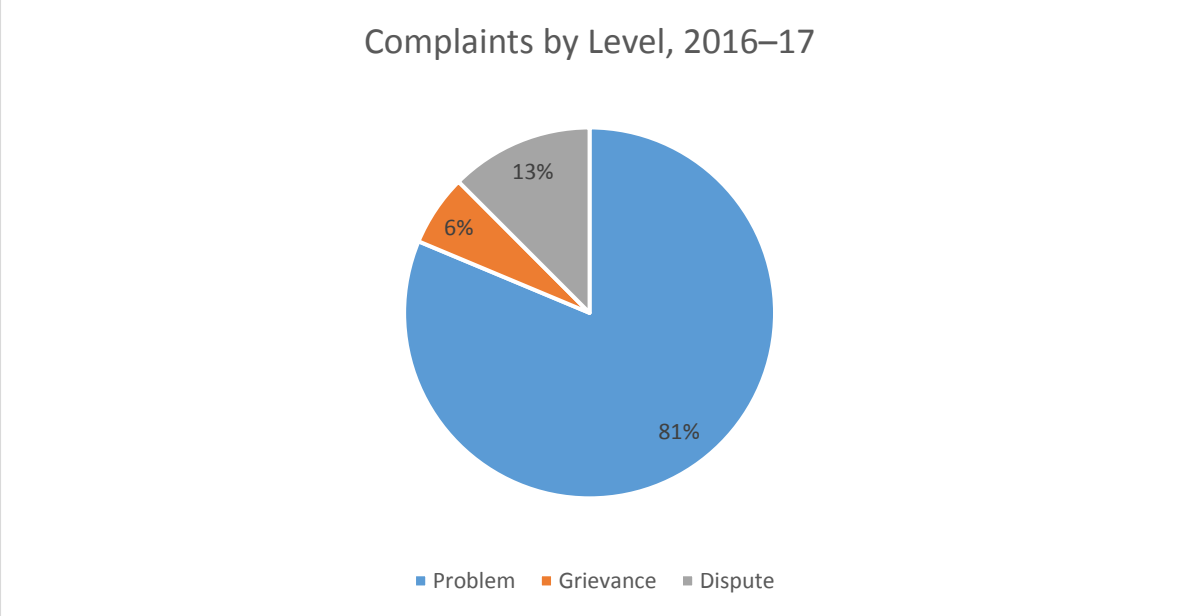
A grievance is dealt with by the dispute resolution officer investigating issues of grievance and providing additional information or a clearer explanation directly to the complainant. Complaints within this category generally result from a misunderstanding by consumers of their rights under the policy 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 our Office, as an independent third party, is generally sufficient to conclude the complaint.

3. Dispute: High level complaint where significant intervention is required

A dispute is dealt with by the dispute resolution officer contacting the health insurer, health care provider or health insurance broker about the matter and requesting a formal report. Complaints 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. Our Office attempts resolution through conciliation by telephone or in writing. Common complaints in this category include pre-existing conditions, lack of informed financial consent, benefits available on transfer of membership, benefits not in accordance with brochure descriptions and contribution errors.

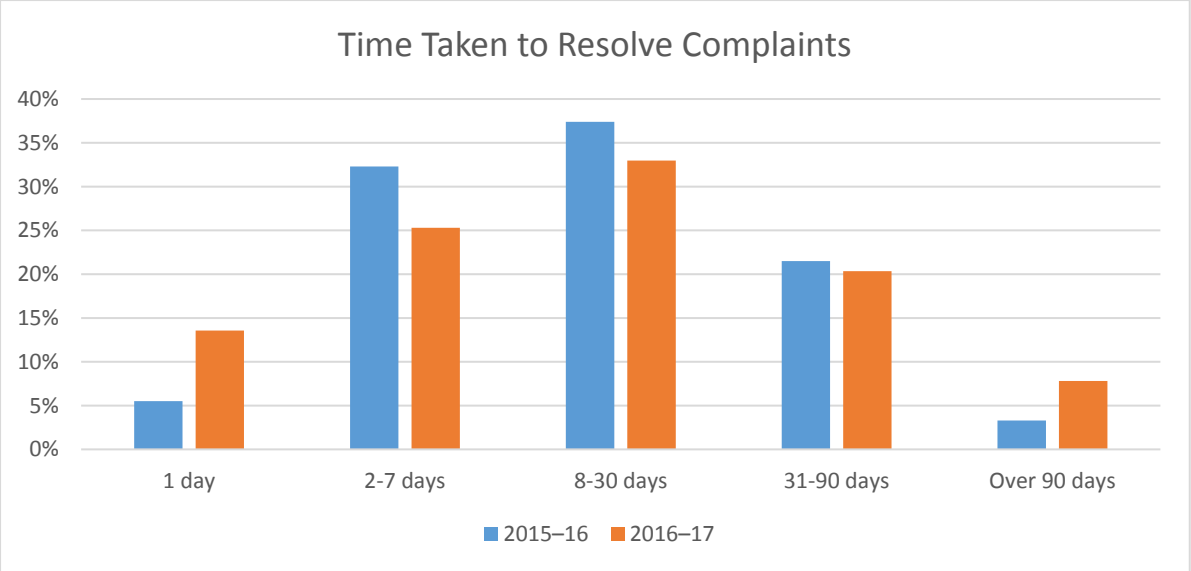
While the overall numbers of complaints rose in 2016–17, there was a decrease in Disputes from 19 per cent to 13 per cent whereas Assisted Referrals increased from 75 per cent to 81 per cent. Grievances remained steady at six per cent compared to five per cent in the previous year.

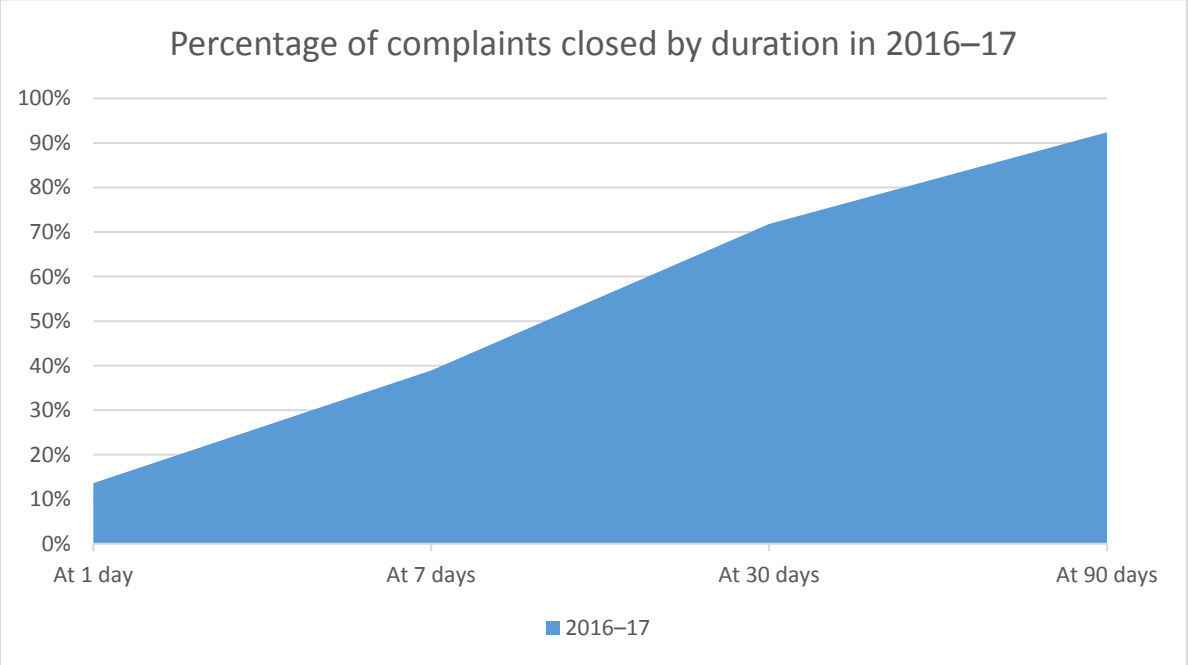




Time taken to resolve complaints

Complaint-handling time increased as there was a significant increase in complaints received. However, the majority of cases (71.8 per cent) continue to be finalised within 30 days and almost all cases (92.4 per cent) were finalised within 90 days.



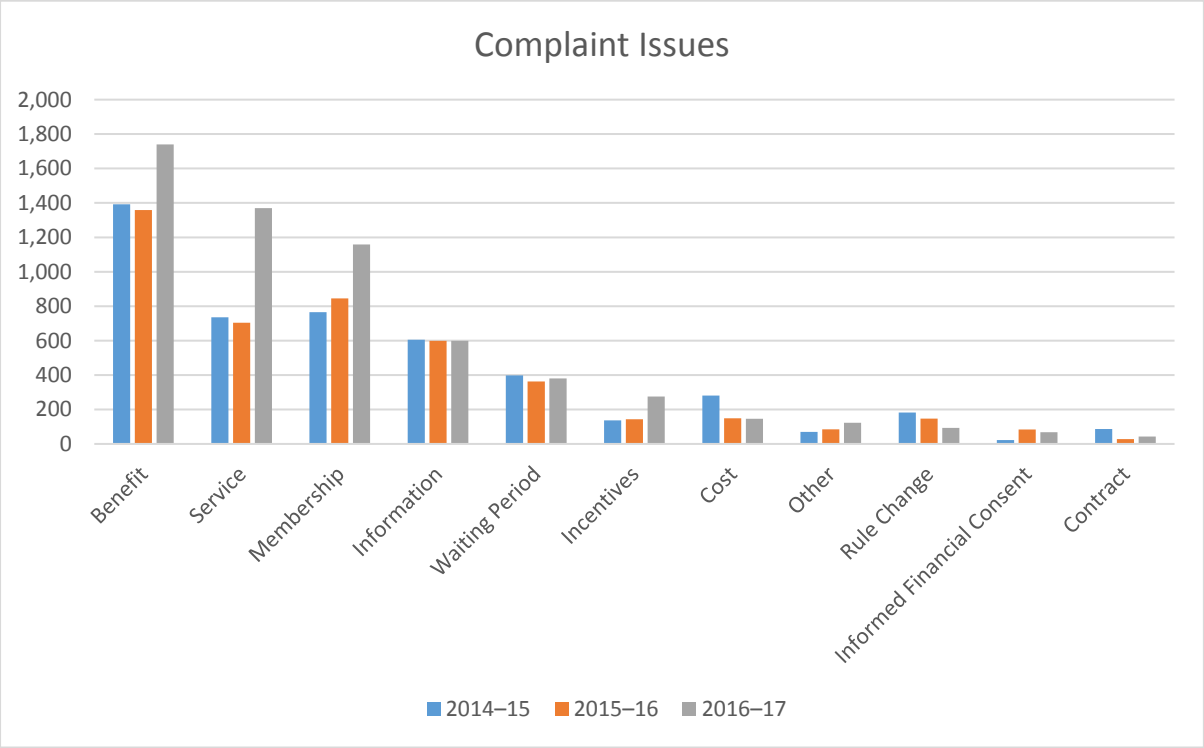


Complaint issues

The following graph shows complaint issues for the previous three years. This year, Benefit, Service and Membership complaints all increased.

The major issue with Benefits complaints were hospital policies with unexpected exclusions and restrictions with 308 complaints. Some basic and budget levels of hospital cover exclude or restrict services that many consumers assume are routine treatments or standard items. Delays in benefit payments and complaints about insurer rules that limited benefits also represented a significant proportion of complaint.

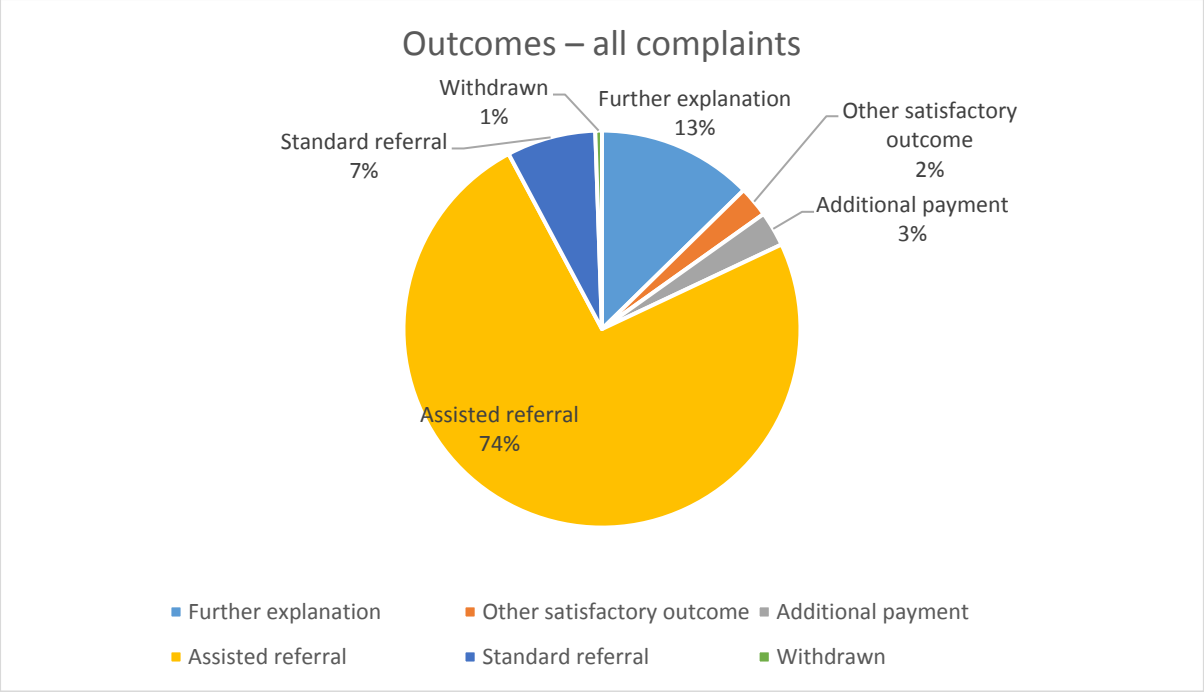
The increase in Service and Membership complaints this financial year was largely caused by ICT problems at Medibank.



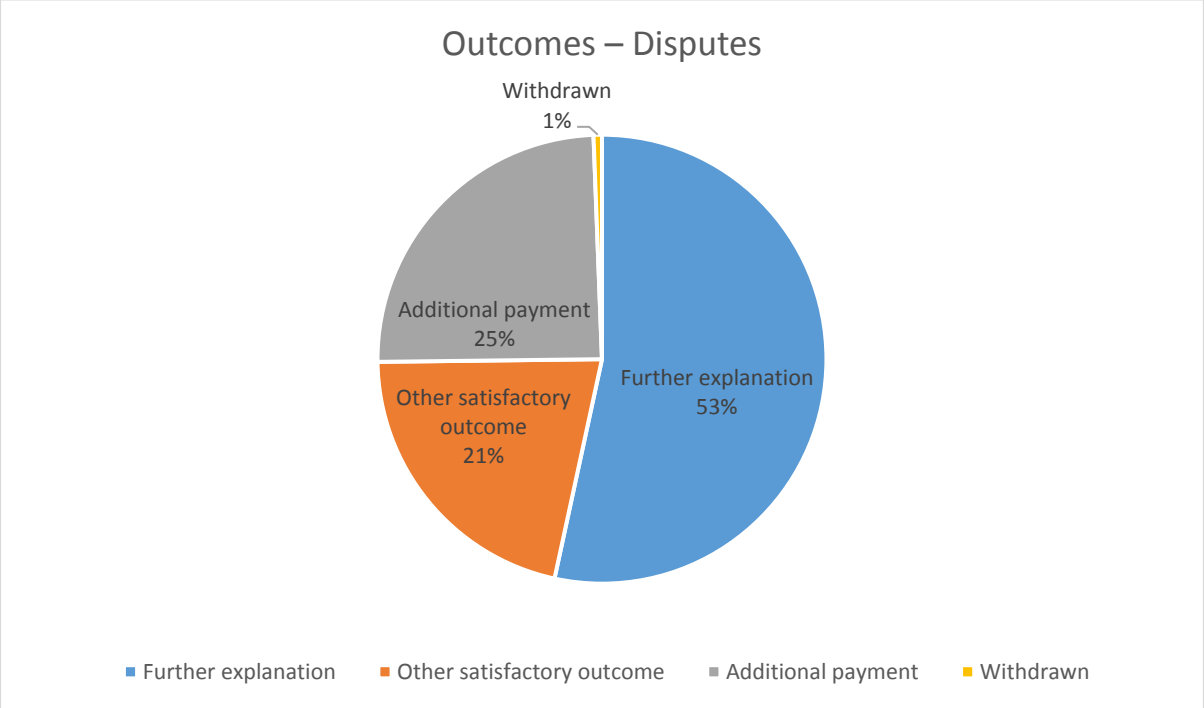
Resolving complaints

The following figure shows that 74 per cent of all complaints were referred directly to health insurers with the assistance of our staff. This was done on the understanding that the complainant could request a review of the complaint by our Office, if they remained unsatisfied. We resolved a further 13 per cent of all complaints by providing an additional and independent explanation of the member's complaint.

Seven per cent of complaints were resolved by standard referral—that is, the complainant obtained advice from our Office and then referred their complaint to the appropriate body themselves. In three per cent of cases, the health insurer resolved the issue by making a payment, and two per cent were resolved by another satisfactory outcome.

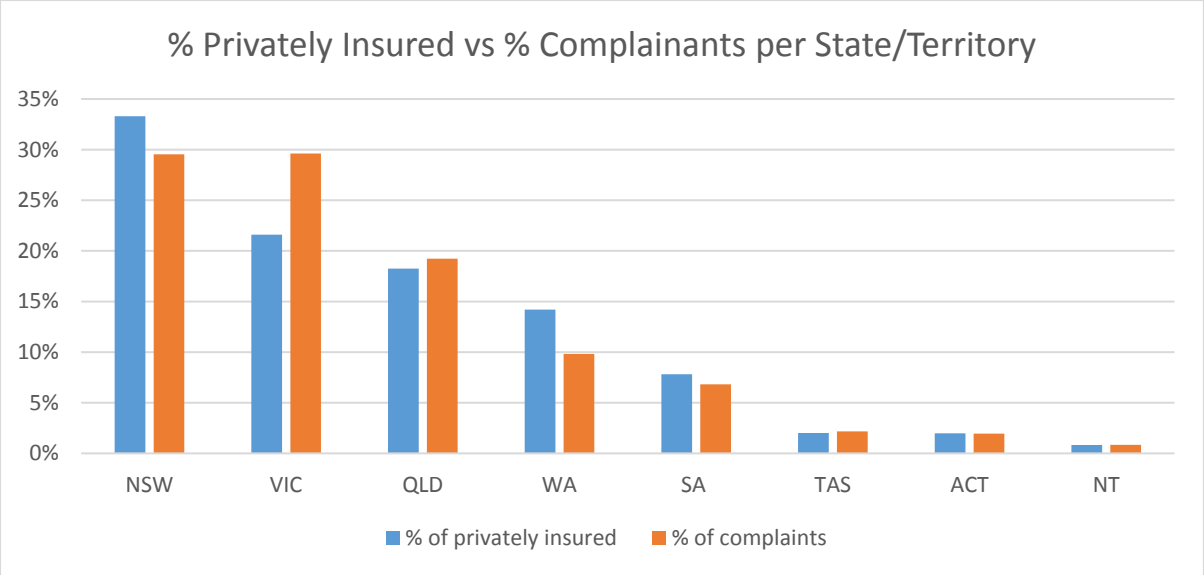


The following chart details Dispute outcomes and shows that 53 per cent were resolved by giving a more detailed explanation to the complainant, 25 per cent were resolved by a payment, 21 per cent by another satisfactory outcome (for example, backdating a change to a policy) and one per cent were withdrawn by the complainant.



Complaints by state or territory

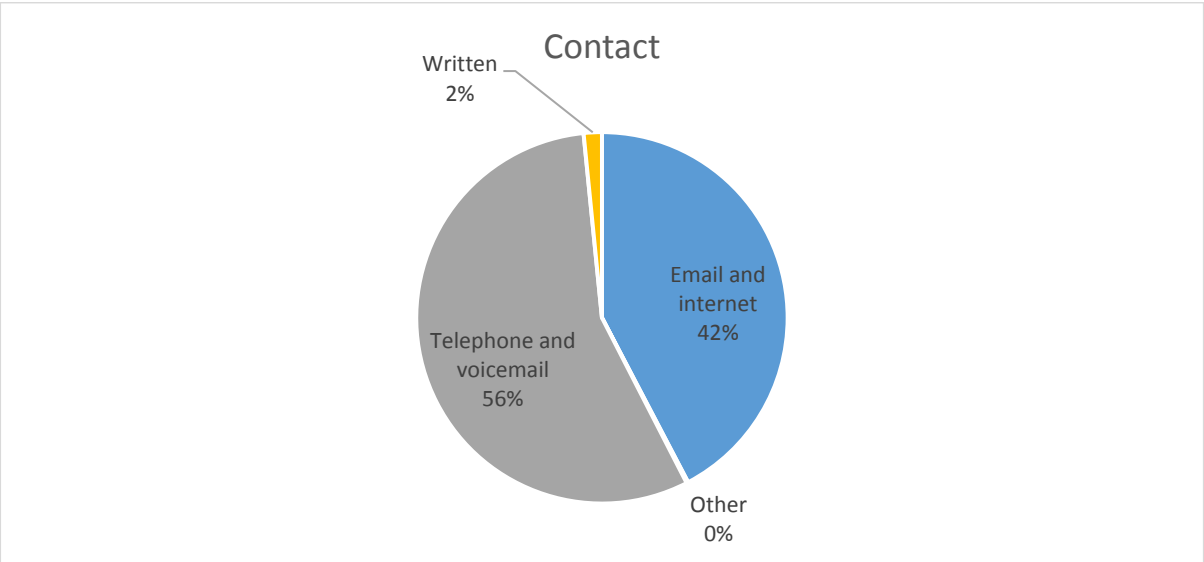
This data is shown by state and territory against the percentage of people who have private health insurance coverage. The figures show that, proportionally, Victorians were more likely to have a health insurance complaint than other states.



How complaints were made

Although the majority of complaints continue to be lodged by telephone, the proportion of complaints received online by internet or email has risen steadily in recent years. In 2016–17, 56 per cent of complaints were initiated by phone and 42 per cent by email and internet, with email and internet approaches rising slightly from 38 per cent in the previous year.

Other methods of contact continued to be very low. Only two per cent of complaints were received by letter and the remainder of other complaint mediums—including fax, personal visit and parliamentary representation—comprised less than one per cent.



Overseas Visitors Health Cover: Sub-issues

The complaints investigated by our Office in relation to Overseas Visitors Health Cover (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.

As in previous years, 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. Complaints about Pre-Existing Conditions also continued to be relatively high.

The financial impact on visitors who have hospital claims refused by health insurers are usually much greater than they are for Australian residents who can access Medicare.

	2014–15	2015–16	2016–17
ISSUE: BENEFIT			
Accident and emergency	9	11	19
Ambulance	8	7	7
Amount	6	4	19
Delay in payment	37	38	49
Gap – Hospital	5	7	23
Gap – Medical	5	9	11
General treatment (extras/ancillary)	1	3	7
High Cost Drugs	1	0	0
Hospital exclusion/restriction	16	12	15
Insurer rule	13	8	16
Limit reached	0	0	0
New baby	3	0	1
Non health insurance – overseas benefits	1	2	2
Non-recognised other practitioner	0	2	2
Other compensation	3	1	0
Out of pocket not elsewhere covered	0	2	4
Out of time	0	1	1
ISSUE: COST			
Dual charging	0	0	1
Rate increase	17	9	11
ISSUE: INCENTIVES			
Lifetime Health Cover	0	3	5
Medicare Levy Surcharge	2	5	1
Brochures and websites	1	3	6
Lack of notification	1	0	4
Oral advice	32	17	25
Written advice	2	1	2
ISSUE: INFORMED FINANCIAL CONSENT			
Doctors	1	0	0
Hospitals	5	3	1

	2014-15	2015-16	2016-17
ISSUE: MEMBERSHIP			
Adult dependents	0	1	0
Arrears	3	3	1
Authority over membership	2	2	3
Cancellation	69	74	87
Clearance certificates	4	1	3
Continuity	6	7	16
Rate and benefit Protection	0	0	1
Suspension	3	5	7
ISSUE: OTHER			
Access	0	3	0
Complaint not elsewhere covered	4	4	7
Confidentiality and privacy	1	0	2
Discrimination	0	1	0
Non Medicare patient	2	2	3
Private patient election	0	0	2
Rule change	3	0	1
ISSUE: SERVICE			
Customer service advice	6	13	16
General service issues	15	8	12
Premium payment problems	7	8	18
Service delays	21	8	12
ISSUE: WAITING PERIODS			
Benefit limitation period	0	0	1
General	8	2	4
Obstetric	10	3	4
Other	1	0	1
Pre-existing condition	48	40	55

Health policy: liaison with other bodies

Our Office has a role in assisting with the broader issues associated with health policy. During the year, we provided information and assistance to various bodies involved in the formulation of health and consumer policy and compliance with established rules and laws.

Some significant activities during 2016–17include:

- submission to the ACCC's Report to the Senate on Anti-Competitive and Other Practices by Health Funds and Providers in relation to private health insurance
- attendance at the ACCC Health Regulators Group
- attendance in Private Health Ministerial Advisory Committees – Information Provision and Clinical Definitions Working Groups
- consultation with the Overseas Students Ombudsman and private health insurers regarding issues relating to private health insurance for overseas students
- submission to the NSW Government regarding amendments to the NSW *Health Insurance Levies Act 1982* and *Health Services Amendment (Ambulance Services) Act 2015*, and

- contribution to Consumers Health Forum Journal *Health Voices*.

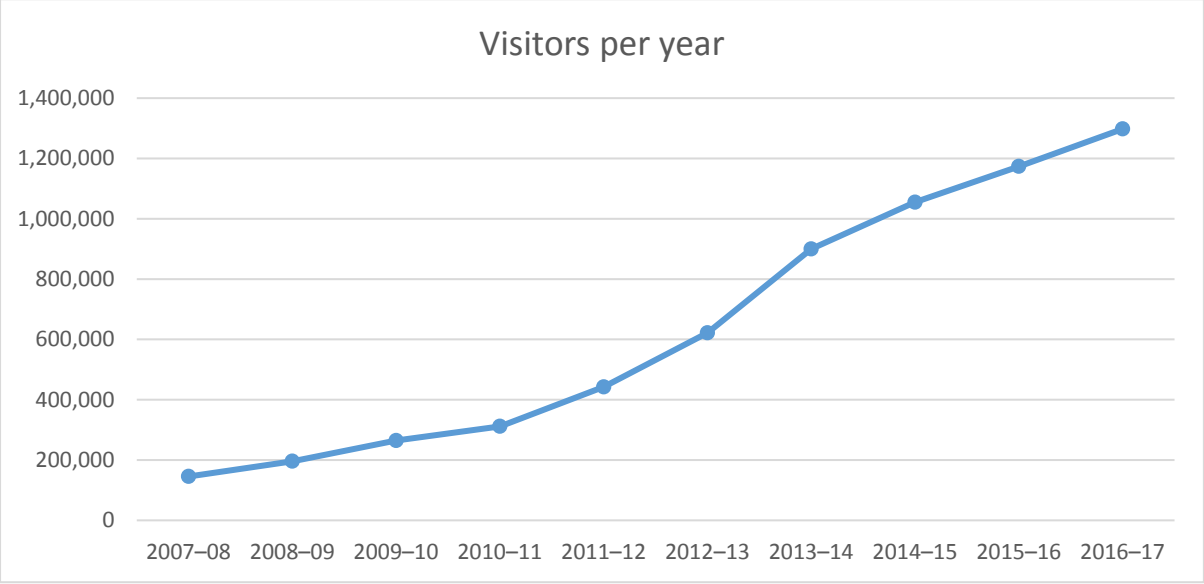
Consumer website privatehealth.gov.au

Privatehealth.gov.au is Australia's leading source of independent information about health insurance for consumers. Website usage has continued to grow annually since the website's launch in 2007, with 1,297,851 visits in 2016–17.

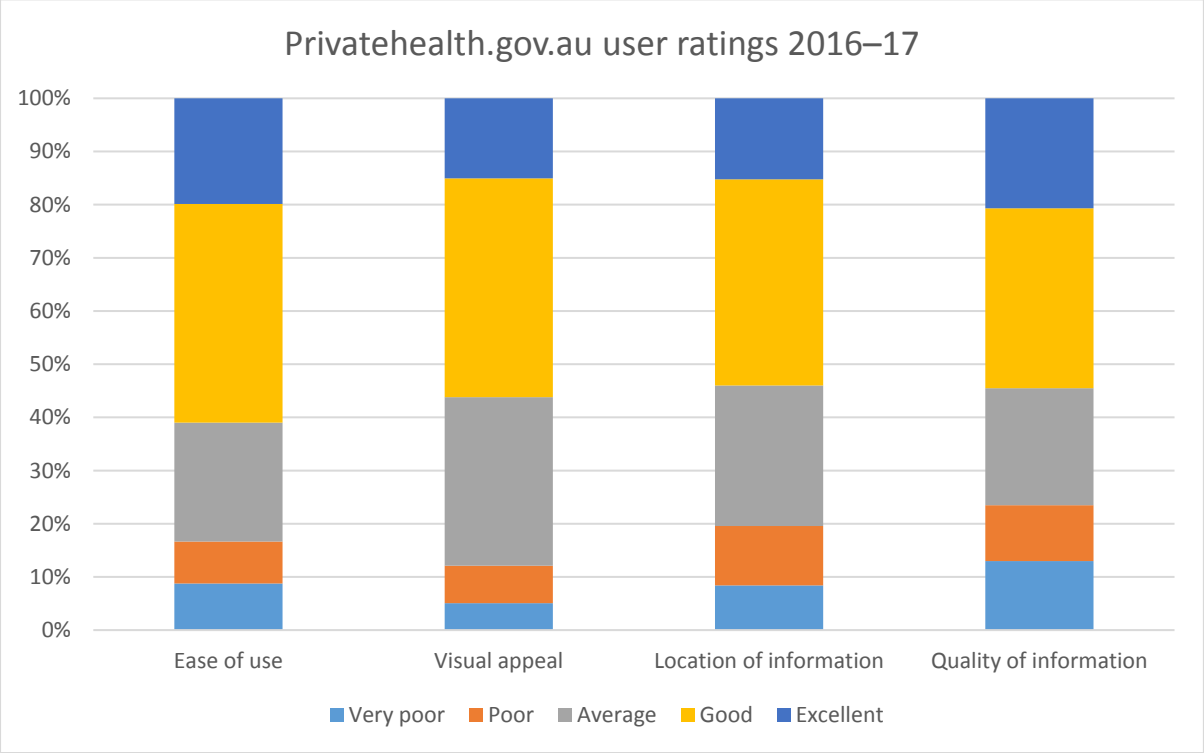
Our Office responded to 2,503 consumer enquiries received via the consumer website privatehealth.gov.au. Approximately 67 per cent of the enquiries we received were via the consumer website, either by e-mail or telephone.

The most frequently raised questions are about the following topics:

- Lifetime Health Cover (LHC), 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.



During the year, 810 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 and to track satisfaction with the site and whether changes have been successful.



The website's major features include:

1. *Compare Policies* – consumers can use the Compare Policies feature to easily compare all health insurance policies provided in Australia.

2. *'Ask a Question' web form and phone number* – we responded to 2,503 people using the website for advice on details of the health insurance system.

3. *Standard Information Statements* – health insurers are required to maintain up-to-date Standard Information Statements (SISs) for each of their policies and use the website's industry interface to manage this process.

4. *'Health Insurance Explained'* – comprehensive and independent information on private health insurance including government surcharges and incentives.

5. *Lifetime Health Cover Calculator* – consumers can calculate how much Lifetime Health Cover (LHC) loading applies to their hospital policy premiums. If they already have a loading they can calculate whether they qualify to have the loading removed.

6. *Agreement Hospitals Locator* – check which insurers and hospitals have agreements, meaning out-of-pocket expenses for consumers are minimised.

7. *Average Dental Charges* – the website publishes information on the average cost of the most common dental procedures.