Quarterly Bulletin 92: 1 July–30 September 2019

Complaint statistics

The Office of the Commonwealth Ombudsman (the Office) received 1,029 private health insurance complaints this quarter. This represented a 2 per cent increase compared to the previous quarter (April–June 2019) and no change compared to the September quarter last year.

Figure 1—Complaints by quarter

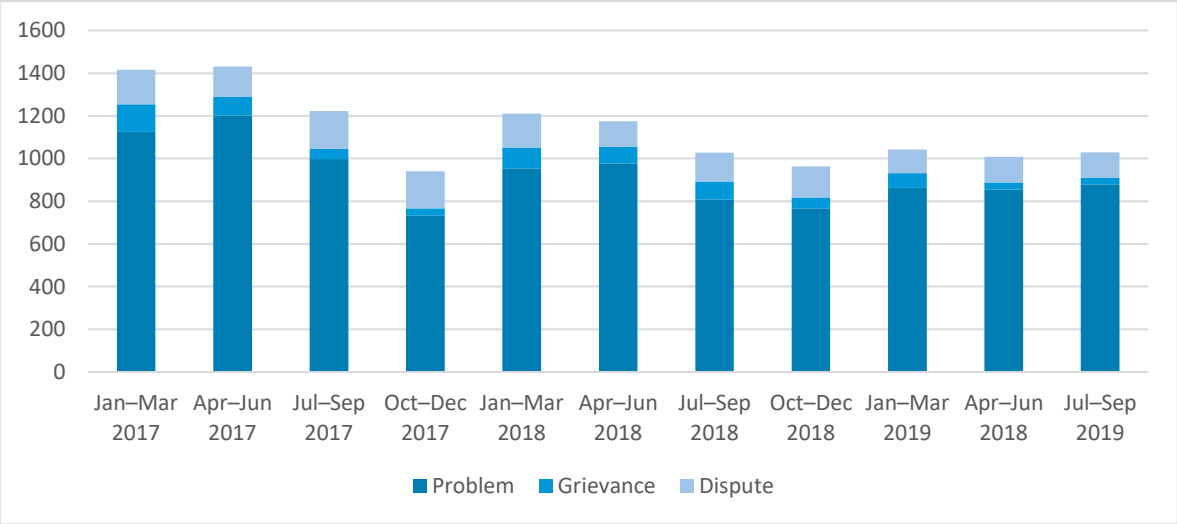


Figure 2—Complaints by month

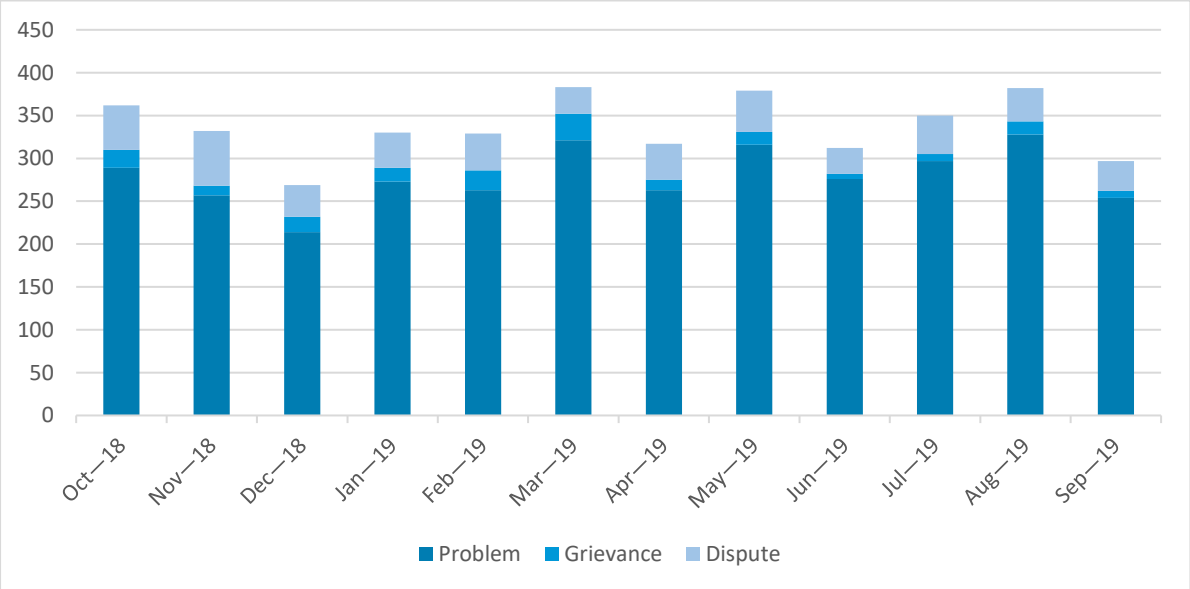


Figure 3—Complaint issues

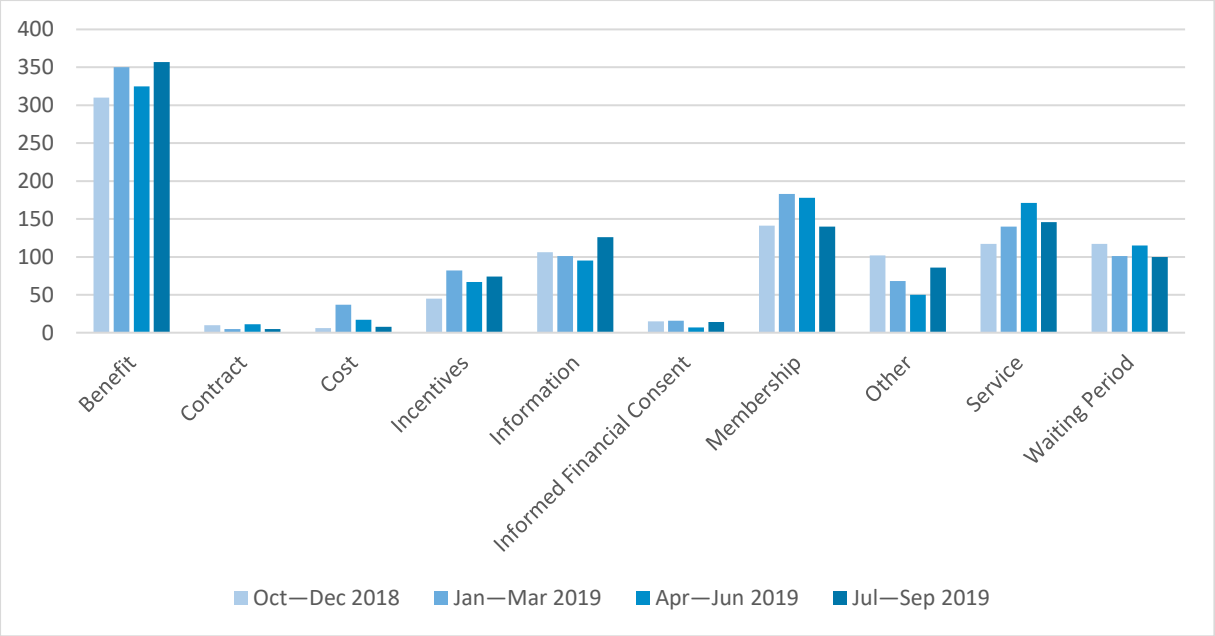
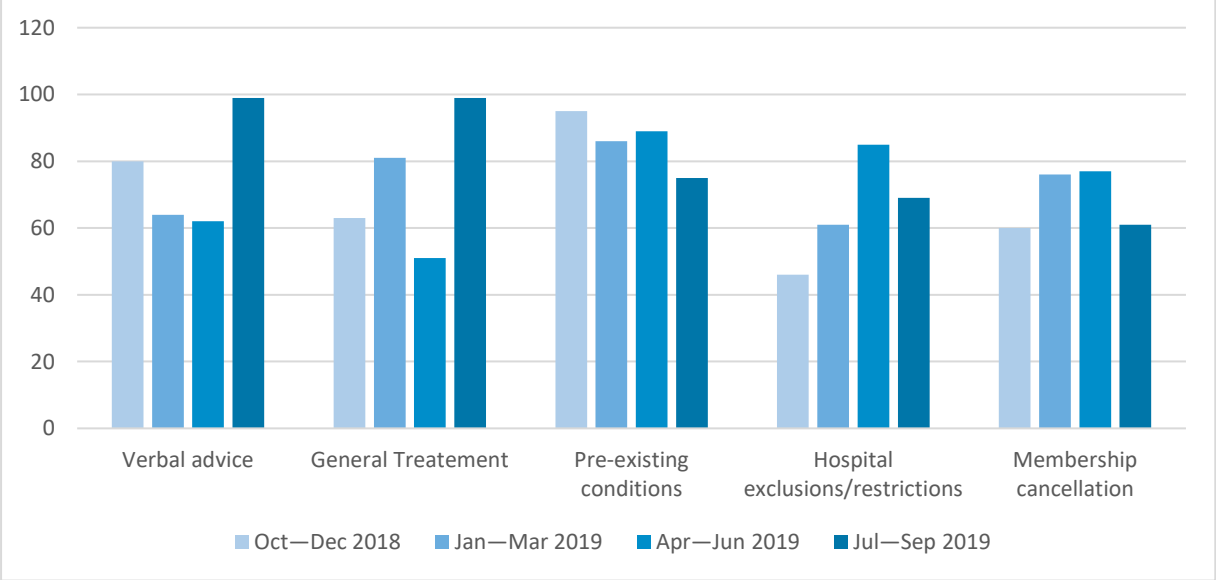


Figure 4—Complaint sub-issues



Top five consumer complaint sub-issues this quarter

1. **Verbal advice: 99 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. For many complaints 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.

2. **General treatment: 99 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).

3. **Pre-existing conditions waiting period: 75 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.

4. **Hospital exclusions and restrictions: 69 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.

5. **Membership cancellation: 61 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 for industry trends.

Complaints by provider or organisation type

The majority of complaints 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 health insurance arrangements.

A comparison of the previous four quarters shows complaints about different provider and organisation types remains generally steady. Complaints about overseas visitors and overseas student insurers continue to increase, with 132 complaints this quarter compared to 111 complaints in the same period last year—an increase of 19 per cent.

Provider or organisation type	Dec 2018 quarter	Mar 2019 quarter	Jun 2019 quarter	Sep 2019 quarter
Health insurers	816	904	846	851
Overseas visitor and overseas student health insurers	98	81	111	132
Brokers and comparison services	13	12	16	12
Doctors, dentists, other medical providers	5	5	2	3
Hospitals and area health services	3	10	10	12
Other (e.g. legislation, ambulance services, industry peak bodies, etc.)	16	30	23	19

Bundled products, rewards programs, and consumer transparency

It is quite common for registered private health insurers to also operate as general insurers or partner with companies that offer other types of products.

For example, an insurer may offer to bundle its private health insurance products with an income protection product or travel insurance product at a discounted rate. Some insurers may suggest that consumers add a non-insurance product such as a health rewards program.

Consumers often find bundled offers to be useful and appealing. However, in some cases they may not be aware that these add-ons are optional and that it is possible to de-couple their private health insurance from these additional products. This is especially the case where the additional product is presented as an 'automatic' add-on in the join process.

The Office's view is that in the interests of consumer transparency, insurers should make it clear at the point of sale and in product documentation that the consumer is purchasing two types of product, and that they may choose to opt-out of the additional product. Ideally, the consumer is provided with a break-down of the premium prior to purchase so they can understand the cost of the additional product.

In situations where complaints do arise, we expect insurers to exercise flexibility where a consumer may not have been aware that they were purchasing several products, and not simply their private health insurance product.

Consultation on Mediation Guidelines and Transition and Termination Guidelines

The Office has legislative power to require health insurers and healthcare providers to attend formal mediation in order to resolve disputes that may affect consumers' rights and entitlements under their private health insurance cover. These disputes usually occur when there is disagreement between a health insurer and a hospital provider about the renewal of a hospital agreement. The Office also has a role in providing advice and informal mediation for stakeholders and we note that many disputes are resolved through informal counselling and advice, without the need for formal mediation.

The Office recently published consultation drafts of our Mediation Guidelines and Transition and Termination Guidelines for Hospital and Insurers.

The current guidelines[1] were developed in consultation with industry stakeholders several years ago. Although the processes have not changed significantly, the guidelines have been updated to reflect the current private health insurance environment and that the Private Health Insurance Ombudsman is now a function of the Commonwealth Ombudsman.

The updated guidelines are available at: http://www.ombudsman.gov.au/How-we-can-help/private-health-insurance/private-health-insurance and are summarised below.

- Mediation Guidelines and FAQs—this document assists stakeholders in assessing whether mediation of a complaint is required and the process for facilitating this process.
- Termination and Transition Guidelines for Hospitals and Insurers—this document provides guidance on appropriate transitional arrangements and communication with health insurer members and patients in the event of a hospital contract cessation or dispute.

[1] PHIO Mediation Guidelines (September 2012), PHIO Mediation Role—FAQs (September 2012) and Hospital Agreements: Transition and Communication Protocols (December 2009).

We are seeking feedback on the updated guidelines, which can submitted to phi@ombudsman.gov.au. The consultation period will close on 20 December 2019.

Pre-existing condition complaints

As discussed in Quarterly Bulletin 91, the Office acts as an independent third party when dealing with complaints about pre-existing condition (PEC) waiting periods.

In making determinations about complaints about the PEC waiting period, the Office considers whether 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, the Office may provide feedback to the insurer, initiate an own motion investigation, or refer the matter to the regulator.

The Office recommends that all health insurers 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*.

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.

Commonwealth Ombudsman Annual Report and Additional Information

The Commonwealth Ombudsman Annual Report 2018–19 was published on Monday 21 October 2019, providing an overview of the Office's work in the last financial year. The report is available on the Office website.

Additional information relating to the activities of the Private Health Insurance Ombudsman has also been published on the Ombudsman's website and is available at the link above.

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Complaints by health insurer market share

Name of insurer	Complaints[2]	Percentage of complaints	Disputes[3]	Percentage of disputes	Market share[4]
ACA Health Benefits	0	0.0%	0	0.0%	0.1%
Australian Unity	43	5.1%	2	2.7%	2.9%
BUPA	181	21.3%	25	33.3%	26.3%
CBHS Corporate Health	1	0.1%	0	0.0%	<0.1%
CBHS	19	2.2%	5	6.7%	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	11	1.3%	1	1.3%	2.1%
Doctors' Health Fund	3	0.4%	0	0.0%	0.3%
Emergency Services Health	0	0.0%	0	0.0%	<0.1%
GMHBA	30	3.5%	3	4.0%	2.4%
Grand United Corporate Health	5	0.6%	0	0.0%	0.4%
HBF Health & GMF/Healthguard	27	3.2%	0	0.0%	7.8%
HCF (Hospitals Contribution Fund)	129	15.2%	10	13.3%	10.7%
HCI (Health Care Insurance)	2	0.2%	0	0.0%	0.1%
Health Partners	7	0.8%	0	0.0%	0.6%
Health.com.au	8	0.9%	3	4.0%	0.6%
HIF (Health Insurance Fund of Aus.)	15	1.8%	3	4.0%	0.8%
Latrobe Health	4	0.5%	1	1.3%	0.7%
Medibank Private & AHM	207	24.3%	9	12.0%	26.9%
Mildura District Hospital Fund	0	0.0%	0	0.0%	0.2%
MO Health Pty Ltd (myOwn)	15	1.8%	1	1.3%	<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	84	9.9%	7	9.3%	8.5%
Nurses and Midwives Pty Ltd	1	0.1%	0	0.0%	<0.1%
Peoplecare	5	0.6%	2	2.7%	0.5%
Phoenix Health Fund	0	0.0%	0	0.0%	0.1%
Police Health	4	0.5%	0	0.0%	0.3%
QLD Country Health Fund	1	0.1%	0	0.0%	0.4%
Railway & Transport Health	3	0.4%	0	0.0%	0.4%
Reserve Bank Health	1	0.1%	0	0.0%	<0.1%
St Lukes Health	3	0.4%	0	0.0%	0.5%
Teachers Federation Health	19	2.2%	1	1.3%	2.4%
Transport Health	7	0.8%	1	1.3%	0.1%
TUH	3	0.4%	0	0.0%	0.6%
Westfund	6	0.7%	0	0.0%	0.7%
Total for Health Insurers	**851**	**100%**	**75**	**100%**	**100%**

[2] Total number of complaints (Problems, Grievances & Disputes) regarding Australian registered health insurers. This table excludes complaints regarding OVHC and OSHC insurers, and other bodies.

[3] Disputes required the intervention of the Ombudsman and the health insurer.

[4] 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	Dec 18	Mar 19	Jun 19	Sep 19
BENEFIT				
Accident and emergency	20	15	14	12
Accrued benefits	1	1	4	4
Ambulance	12	16	17	12
Amount	22	10	11	10
Delay in payment	43	27	28	28
Excess	8	17	14	14
Gap — Hospital	14	27	18	30
Gap — Medical	17	25	25	21
General treatment (extras/ancillary)	63	81	51	99
High cost drugs	2	2	0	3
Hospital exclusion/restriction	46	61	85	69
Insurer rule	18	13	17	23
Limit reached	2	6	4	5
New baby	3	5	1	1
Non-health insurance	1	0	1	0
Non-health insurance—overseas benefits	0	0	0	0
Non-recognised other practitioner	1	7	0	0
Non-recognised podiatry	0	2	0	2
Other compensation	2	5	0	3
Out of pocket not elsewhere covered	10	5	8	10
Out of time	6	4	3	1
Preferred provider schemes	8	11	15	5
Prostheses	11	8	7	4
Workers compensation	0	2	2	1
CONTRACT				
Hospitals	9	2	4	3
Preferred provider schemes	0	2	5	2
Second tier default benefit	1	1	2	0
COST				
Dual charging	4	5	3	2
Rate increase	2	32	14	6
INCENTIVES				
Lifetime Health Cover	37	42	42	51
Medicare Levy Surcharge	3	1	1	9
Private health insurance reforms	4	37	20	8
Rebate	1	2	4	6
Rebate tiers and surcharge changes	0	0	0	0
INFORMATION				
Brochures and websites	4	7	10	1
Lack of notification	16	10	9	16
Radio and television	0	0	0	0
Standard Information Statement	1	4	3	1
Verbal advice	80	64	62	99
Written advice	5	16	11	9

ISSUE Sub-issue	Dec 18	Mar 19	Jun 19	Sep 19
INFORMED FINANCIAL CONSENT				
Doctors	6	2	1	4
Hospitals	3	10	6	8
Other	6	4	0	2
MEMBERSHIP				
Adult dependents	3	10	3	6
Arrears	16	19	14	5
Authority over membership	5	9	10	4
Cancellation	60	76	77	61
Clearance certificates	31	31	31	28
Continuity	13	13	22	20
Rate and benefit protection	1	2	5	2
Suspension	12	23	16	14
SERVICE				
Customer service advice	22	15	17	22
General service issues	33	39	65	44
Premium payment problems	42	68	58	60
Service delays	20	18	31	20
WAITING PERIOD				
Benefit limitation period	0	0	0	3
General	7	5	12	12
Obstetric	8	7	9	9
Other	7	3	5	1
Pre-existing conditions	95	86	89	75
OTHER				
Access	2	0	0	1
Acute care and type C certificates	2	2	7	8
Community rating	0	0	0	0
Complaint not elsewhere covered	13	8	6	11
Confidentiality and privacy	5	3	3	7
Demutualisation/sale of health insurers	0	0	1	0
Discrimination	2	1	1	2
Medibank sale	0	0	0	0
Non-English speaking background	0	0	0	0
Non-Medicare patient	0	0	2	0
Private patient election	2	2	3	1
Rule change	76	52	27	56