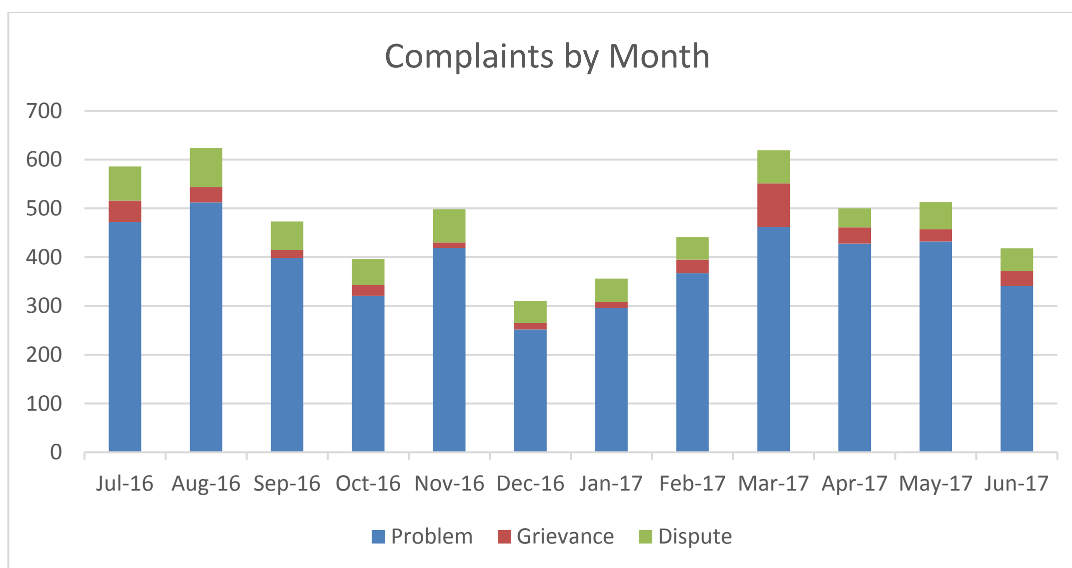
COMMONWEALTH OMBUDSMAN

Issues in this bulletin
- Complaint statistics
- Increase in benefit complaints
- Top 5 consumer complaint issues this quarter

Private Health Insurance Ombudsman Quarterly Bulletin 83 (1 April – 30 June 2017)

Complaint statistics this quarter

This quarter we received 1,431 private health insurance complaints. Compared to the same period in 2016, when the office received 1,367 complaints, this quarter was five percent higher. Health insurance complaints are generally more prevalent in the middle of the year due to premium increases in April and Lifetime Health Cover and other end of financial year deadlines. These industry-wide events tend to cause an increased awareness of private health insurance with the issue 'top of mind' for many consumers. However, the issues that are raised with the Office of the Commonwealth Ombudsman (the Office) about private health insurance predominantly concern benefits, membership administration and information.



Increase in Complaints about Benefits

Comparing this quarter to the same quarter in 2016, there was a 31 percent increase in complaints about benefits. Analysing the complaints data shows that the increase in these complaints was largely caused by the following consumer concerns:

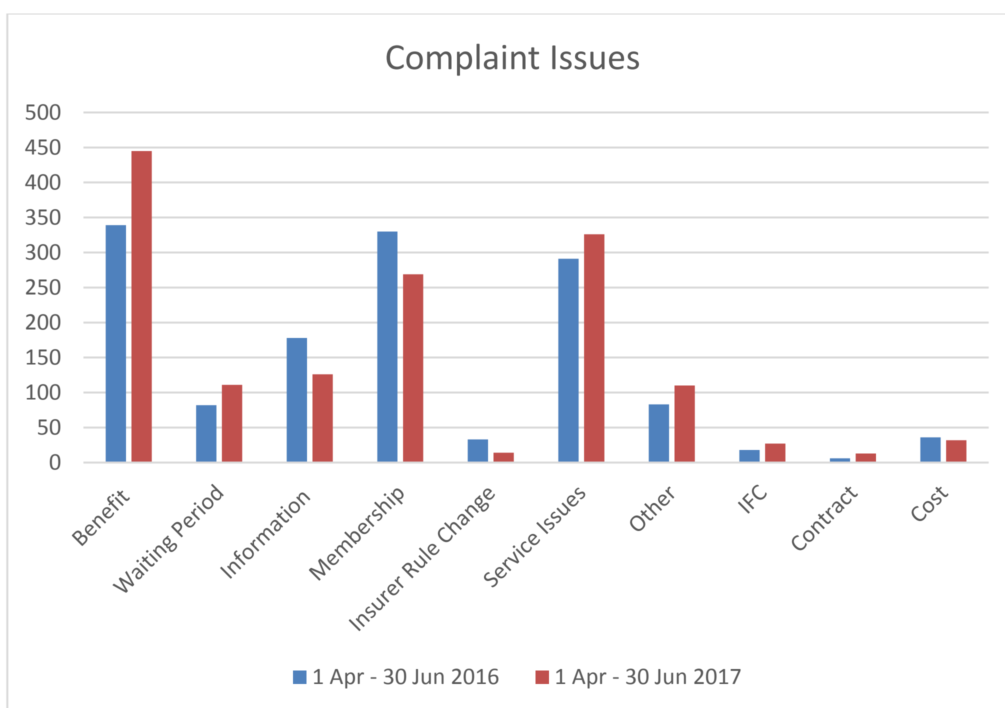
Benefit Amounts – Where a consumer complains that they received less than they anticipated for a treatment. Most of these complaints concerned benefits received for dental, optical, physiotherapy and other treatments outside hospital.

Delays in Payment – These are complaints where the Office is contacted because an insurer is taking too long to respond to a complaint that a benefit has not been paid.

Hospital Exclusions and Restrictions – Where a consumer feels that a hospital benefit has been restricted or excluded incorrectly. These complaints often involve a misunderstanding or disagreement over the wording of a policy document and whether the treatment a person needs fits inside or outside that definition.

For example, where a policy states that benefits for “minor eye procedures” are paid at a higher level than “major eye procedures” which are considered “restricted” - a complaint can come about because the insurer has a list of what it considers minor and major eye procedures which differs from the definitions used by a patient’s ophthalmologist. Furthermore a consumer’s reading of the policy documents and understanding of what constitutes a minor or major eye procedure could also differ from that of an insurer.

Gap-Hospital and Gap-Medical – Where consumers complain that the additional amounts they were asked to pay for treatment were higher than they expected. Gap complaints usually concern health insurance coverage and the arrangements insurers make, or don’t make, to cover hospital and medical gaps. It’s important to differentiate these from complaints about the lack of provision of ‘informed financial consent’ by the service provider, which are not a significant complaint issue.



Complaints by provider or organisation type

Provider or organisation type	Sept 2016 QTR	Dec 2016 QTR	Mar 2017 QTR	Jun 2017 QTR
Health Insurers	1,504	1,067	1,245	1,237
Overseas Visitor & Overseas Student Health Insurers	143	95	108	114
Brokers and comparison services	16	15	19	25
Doctors, dentists, other medical providers	3	5	6	13
Hospitals and area health services	12	4	15	17
Other (e.g. legislation, ambulance services, industry peak bodies, etc)	11	17	19	25

Top 5 consumer complaint issues this quarter

1. **Premium payment problems: 163 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. Premium payment complaints have increased significantly in the last three quarters - 127 in the previous quarter and 102 in the September 2016 quarter.

2. **Membership cancellation: 111 complaints** – Complaints caused by problems and delays associated with processing requests to cancel memberships and handling payments or refunds. It's 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 health insurance altogether. Many health insurance consumers request and authorise a new health insurer to cancel their previous policy and transfer their health insurance details across. If an administrative step isn't taken by one of the insurers causing a refund or cancellation not to occur, it can sometimes be difficult for a consumer to understand which insurer they need to complain to and if they can seek the assistance of the Ombudsman.

3. **Hospital exclusion or restriction: 90 complaints** – Usually caused when complainants find they are not covered for a service or treatment that they had assumed was included on their cover.

4. **Pre-existing conditions waiting period: 88 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. **Verbal/Oral advice: 87 complaints** – Most oral 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.

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Complaints by Health Insurer Market Share
1 April to 30 June 2017

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	76	6.1%	10	9.3%	3.1%
BUPA	260	21.0%	34	31.8%	27.0%
CBHS Corporate Health	1	0.1%	1	0.9%	n/a
CBHS	10	0.8%	1	0.9%	1.4%
CDH (Cessnock District Health)	0	0.0%	0	0.0%	<0.1%
CUA Health	16	1.3%	4	3.7%	0.6%
Defence Health	14	1.1%	0	0.0%	1.9%
Doctors' Health Fund	2	0.2%	0	0.0%	0.2%
Emergency Services Health	0	0.0%	0	0.0%	n/a
GMHBA	31	2.5%	0	0.0%	2.1%
Grand United Corporate Health	7	0.6%	2	1.9%	0.4%
HBF Health & GMF/Healthguard	82	6.6%	2	1.9%	8.0%
HCF (Hospitals Contribution Fund)	146	11.8%	12	11.2%	10.3%
Health.com.au	13	1.1%	4	3.7%	0.6%
Health Care Insurance	1	0.1%	0	0.0%	0.1%
Health-Partners	6	0.5%	0	0.0%	0.6%
HIF (Health Insurance Fund of Aus.)	10	0.8%	0	0.0%	0.9%
Latrobe Health	3	0.2%	0	0.0%	0.7%
Medibank Private & AHM	440	35.6%	18	16.8%	27.6%
Mildura District Hospital Fund	0	0.0%	0	0.0%	0.2%
MO Health Pty Ltd	0	0.0%	0	0.0%	n/a
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
Navy Health	0	0.0%	0	0.0%	0.3%
NIB Health	78	6.3%	14	13.1%	8.1%
Nurses and Midwives Pty Ltd	0	0.0%	0	0.0%	n/a
Peoplecare	3	0.2%	0	0.0%	0.5%
Phoenix Health Fund	1	0.1%	0	0.0%	0.1%
Police Health	2	0.2%	0	0.0%	0.3%
QLD Country Health Fund	0	0.0%	0	0.0%	0.3%
Railway & Transport Health	7	0.6%	1	0.9%	0.4%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Lukes Health	4	0.3%	0	0.0%	0.4%
Teachers Federation Health	17	1.4%	3	2.8%	2.1%
Teachers Union Health	3	0.2%	0	0.0%	0.6%
Transport Health	2	0.2%	0	0.0%	0.1%
Westfund	2	0.2%	1	0.9%	0.7%
Total for Health Insurers	**1,237**	**100%**	**107**	**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 2016. Insurers which commenced business after 30 June 2016 have no reportable market share.

Issues and sub-issues: complaints received in previous 4 quarters

ISSUE Sub-issue	Sep 2016	Dec 2016	Mar 2017	Jun 2017
BENEFIT				
Accident and emergency	10	14	10	10
Accrued benefits	0	0	2	3
Ambulance	23	23	17	21
Amount	20	41	51	54
Delay in payment	66	47	54	70
Excess	16	13	22	16
Gap - Hospital	14	16	22	23
Gap - Medical	55	33	33	29
General treatment (extras/ancillary)	58	67	52	36
High cost drugs	2	4	4	2
Hospital exclusion/restriction	74	68	73	90
Insurer rule	50	33	38	30
Limit reached	3	5	6	4
New baby	2	8	6	6
Non-health insurance	3	0	5	1
Non-health insurance - overseas benefits	2	0	0	0
Non-recognised other practitioner	9	10	6	9
Non-recognised podiatry	1	3	4	5
Other compensation	1	4	3	6
Out of pocket not elsewhere covered	5	6	9	5
Out of time	6	4	5	3
Preferred provider schemes	7	12	19	15
Prostheses	2	0	1	5
Workers compensation	0	0	1	2
CONTRACT				
Hospitals	6	3	10	4
Preferred provider schemes	1	6	2	8
Second tier default benefit	0	1	1	1
COST				
Dual charging	1	3	4	0
Rate increase	5	6	95	32
INCENTIVES				
Lifetime Health Cover	63	49	46	63
Medicare Levy Surcharge	3	4	1	2
Rebate	10	11	9	11
Rebate tiers and surcharge changes	0	0	2	0
INFORMATION				
Brochures and websites	12	11	16	15
Lack of notification	24	19	11	15
Oral advice	139	101	80	87
Radio and television	0	0	1	0
Standard Information Statement	4	3	1	1
Written advice	16	11	21	8

ISSUE Sub-issue	Sep 2016	Dec 2016	Mar 2017	Jun 2017
BENEFIT				
Doctors	6	4	7	7
Hospitals	2	2	10	17
Other	2	2	0	3
MEMBERSHIP				
Adult dependents	5	6	5	9
Arrears	31	38	31	14
Authority over membership	7	8	3	3
Cancellation	107	79	97	111
Clearance certificates	148	62	41	57
Continuity	57	40	47	44
Rate and benefit protection	2	2	4	9
Suspension	20	17	23	22
SERVICE				
Customer service advice	25	27	32	53
General service issues	101	51	81	65
Premium payment problems	103	102	127	163
Service delays	281	53	60	45
WAITING PERIOD				
Benefit limitation period	0	5	0	0
General	5	11	6	6
Obstetric	9	4	7	11
Other	8	5	4	6
Pre-existing conditions	82	61	59	88
OTHER				
Access	0	1	1	0
Acute care certificates	1	2	1	3
Community rating	0	0	0	0
Complaint not elsewhere covered	9	18	24	24
Confidentiality and privacy	10	5	4	2
Demutualisation/sale of health insurers	0	0	1	0
Discrimination	0	0	0	0
Medibank sale	0	0	1	0
Non-English speaking background	0	0	0	0
Non-Medicare patient	0	2	2	3
Private patient election	2	0	3	2
Rule change	22	23	33	14