Data and glossary summary Private Health Insurance Ombudsman quarterly bulletins

The Commonwealth Ombudsman is also the Private Health Insurance Ombudsman. This document explains the data and terms we use in our quarterly bulletins.

For information about our complaint handling processes, please refer to our Private Health Insurance Complaint Checklist and Information for Insurers factsheet.

Summary of terms

Complaint issue descriptions

Issue	Description
Delay in benefit payment	These complaints mostly relate to delays in health insurers processing a claim and the time taken for a consumer to receive their benefit payment.
General service issues	Service issues are not usually the sole reason for complaints. Other issues, when combined with poor customer service, inadequate or delayed responses to simple issues and poor internal escalation processes, can cause policy holders to grow increasingly aggrieved and dissatisfied with the insurer until the service itself becomes a cause of complaint in addition to the original problem.
General treatment (extras) benefits	These complaints usually concern disputes about 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).
Hospital exclusions and restrictions	These complaints arise where a complainant finds their policy does not cover a particular service or treatment, which means they cannot access the treatment or must incur expenses they did not anticipate.
Insurer rule change	These complaints often concern disputes about reduced services in health insurance policies. Health insurers can change the terms of health insurance policies provided the changes comply with the requirements of the *Private Health Insurance Act 2007* and they give consumers adequate notice.

Membership Cancellation	These complaints are caused by problems and delays in processing requests to cancel memberships and handling payments or refunds. In most cases these membership cancellations are due to consumers transferring from one insurer to another and not the result of people leaving private health insurance altogether.
Membership Suspension	Insurers may allow consumers to suspend their coverage for reasons such as travelling overseas or financial hardship. During suspension, premiums are not paid, and benefits are not payable, but the person's membership remains continuous.
Pre-existing conditions waiting period	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 • the complainant misunderstanding how a pre-existing condition is defined. The Office can seek a better explanation of the insurer's medical practitioner's decision and/or complete an impartial review based on the medical evidence.
Premium payment problems	Premium payment issues can include higher than expected or irregular debit amounts, debits occurring on an unexpected date or not occurring at all, issues with receiving or sending requests for payment, or payroll deduction issues.
Rate increase	Insurers are permitted to increase their rates once per year, following an application to and approval by the Minister of Health. The rate increase usually applies from 1 April each year, so the March quarter is typically the period when we receive a higher volume of complaints about this issue.
Service delays	These complaints are typically received from consumers having trouble contacting their insurer or concerned about delays or inaction from the health insurer's customer service staff.
Verbal advice	Most verbal advice complaints concern poorly communicated advice to people over the phone or at a retail centre, and often we identify there are no clear records of the advice given. Our officers can access the recording or advice provided to a consumer and provide an independent assessment of the quality of the information the insurer gave them.

Actions taken to finalise complaints

Action	Description
Assisted referral	In many cases, we refer the complaint to the insurer so it can consider the matter. Once we refer a complaint, the insurer will contact the complainant within 3 business days and, once the complaint is finalised, report the outcome to our Office. The insurer may reconsider the complaint, expedite an action or provide the complainant with a better explanation. If the assisted referral process does not resolve the complaint, the complainant can return to us for further assistance. Our client survey results indicate that consumers generally report higher rates of satisfaction when their complaint is resolved through an assisted referral, rather than through an investigation by the Office.
Standard referral	In some cases, we may provide advice to the complainant to support them to lodge a complaint directly with their insurer or service provider. This provides the other party an opportunity to resolve the matter first. If the complaint is not resolved through the standard referral process, the complainant can return to us for further assistance.
Further explanation	This means we listen to the complainant's concerns and provide them with advice about what we consider would be an appropriate response from the insurer or service provider in the circumstances. We then finalise the matter, either because the complainant accepts our explanation, or they otherwise decide not to continue with the complaint. Providing members of the public with assurance that the insurer's decision was consistent with their processes or the rules can be a very helpful outcome.
Withdrawn	In some cases, complainants make complaints to our Office but later withdraw their complaint or fail to respond to our contacts seeking further information.
Other	Other satisfactory outcomes can include reconsideration of the matter by the insurer, backdating a change in cover or expedited action.

More information is available at **ombudsman.gov.au**.