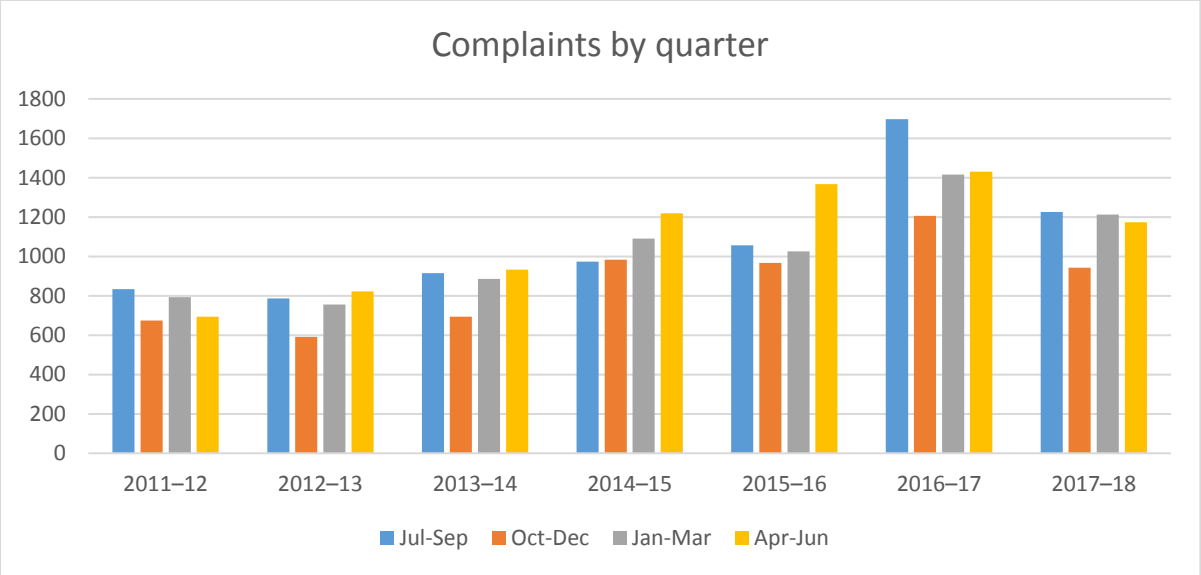
Private Health Insurance Ombudsman

Additional information for 2017–18

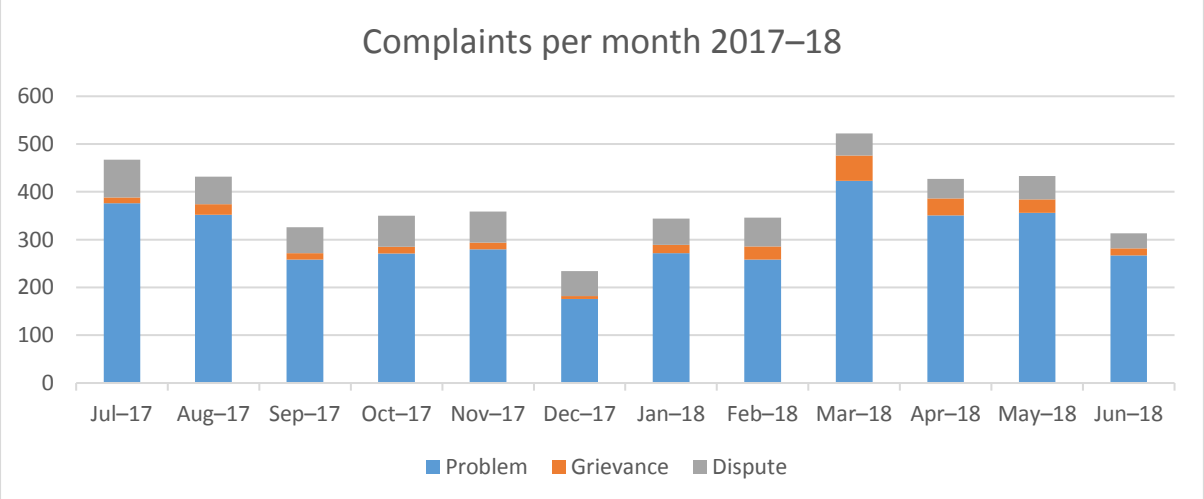
This document supplements the Private Health Insurance Ombudsman section (pp89–101) of the *Commonwealth Ombudsman Annual Report 2017–18* available at **ombudsman.gov.au**. For further information or queries, please contact **phio.info@ombudsman.gov.au** or call **1300 362 072**.

Complaints by quarter and month

The following graphs detail the distribution of complaints by quarters and by months for 2017–18.



The time between March and July has 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. In 2017–18 complaints moderated compared to the previous year, particularly in the period from July to September.



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 *Ombudsman Act 1976*. 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
- any potential sensitivity.

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.

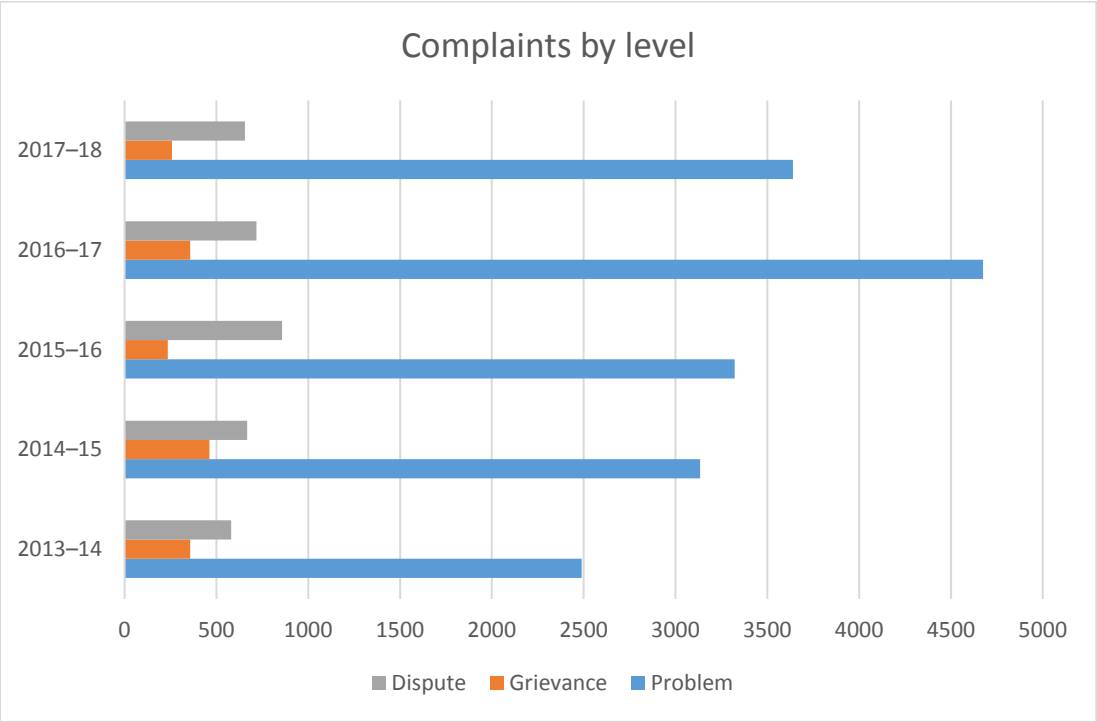
2. Grievance: Moderate level complaint resolved without requiring a report from the object of the complaint

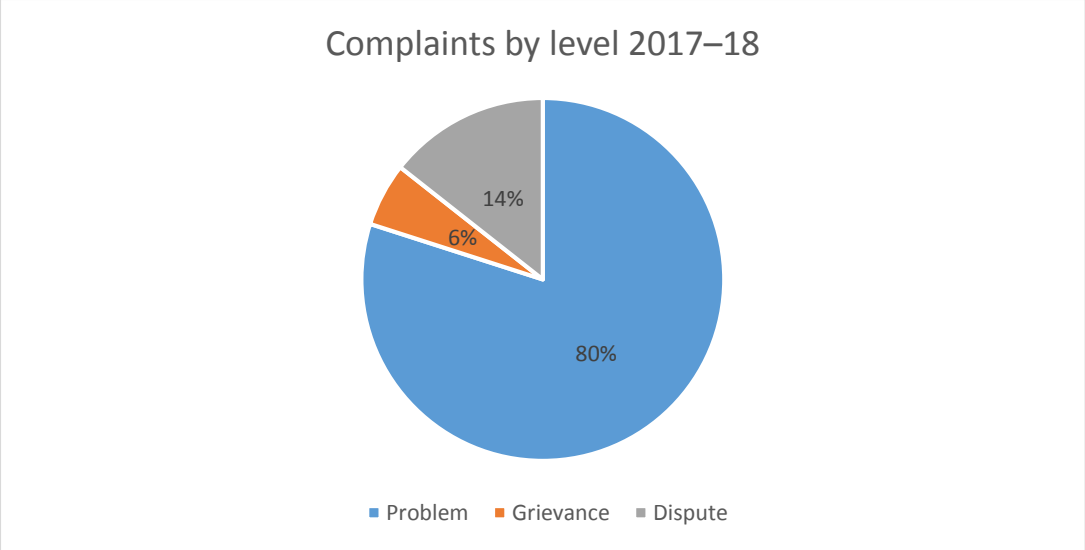
A grievance is dealt with by the dispute resolution officer investigating issues of grievance and providing additional information or a clearer explanation directly to the complainant. Complaints within this category generally result from a misunderstanding by consumers of their rights under the policy 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 have not 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.

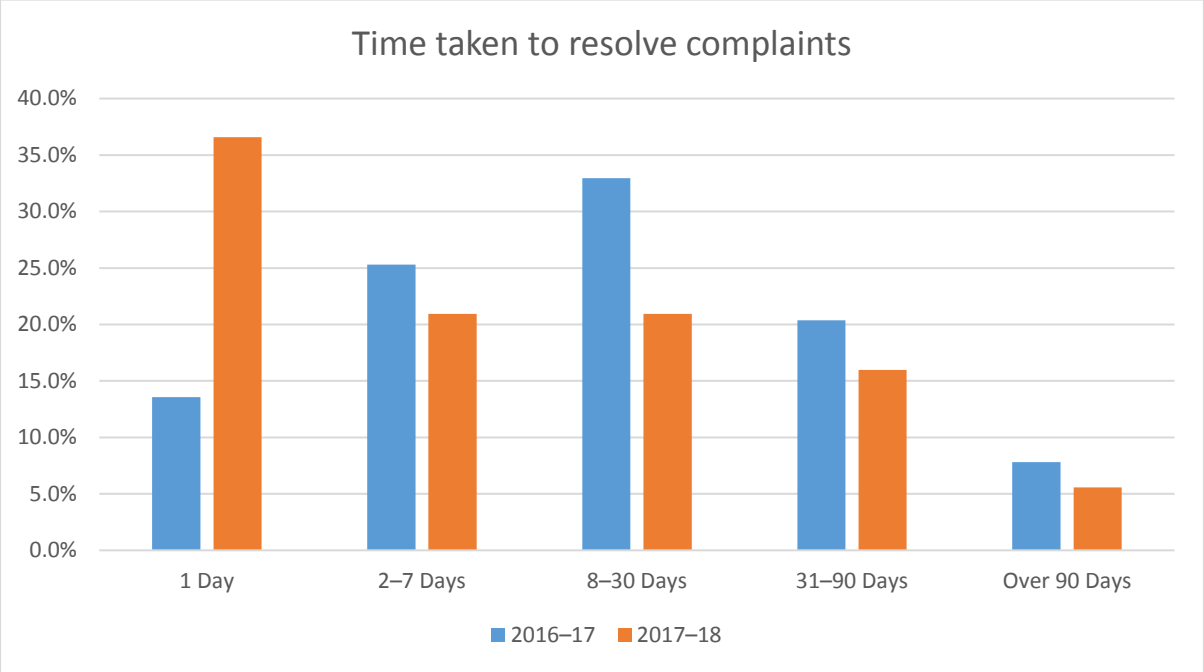
The overall numbers of complaints received in 2017–18 (4,553) were significantly lower than complaints received in 2016–17 (5,750). This represented a 1,197 (21 per cent) decrease in complaints compared to the previous year. There was a slight increase in the proportion of complaints handled as disputes from 12 per cent to 14 per cent, whereas assisted referrals remained steady at 80 per cent compared 81 per cent in the previous year. Grievances remained steady at six per cent this financial year.

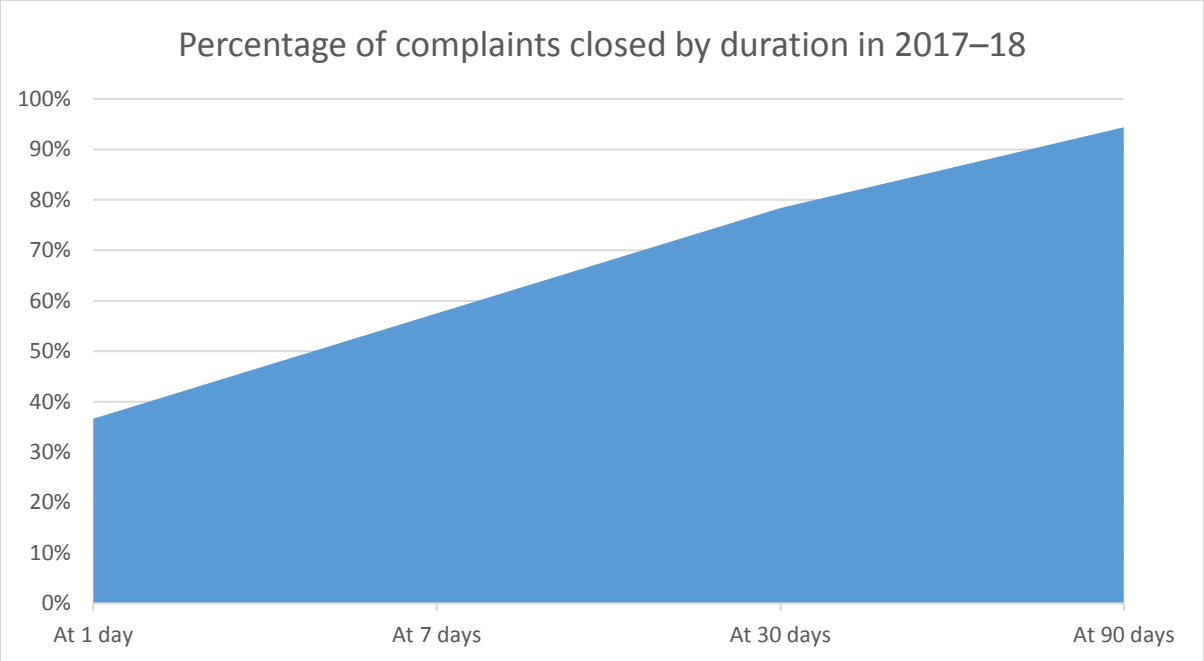




Time taken to resolve complaints

The majority of cases (78 per cent) were finalised within 30 days and almost all cases (94 per cent) were finalised within 90 days.

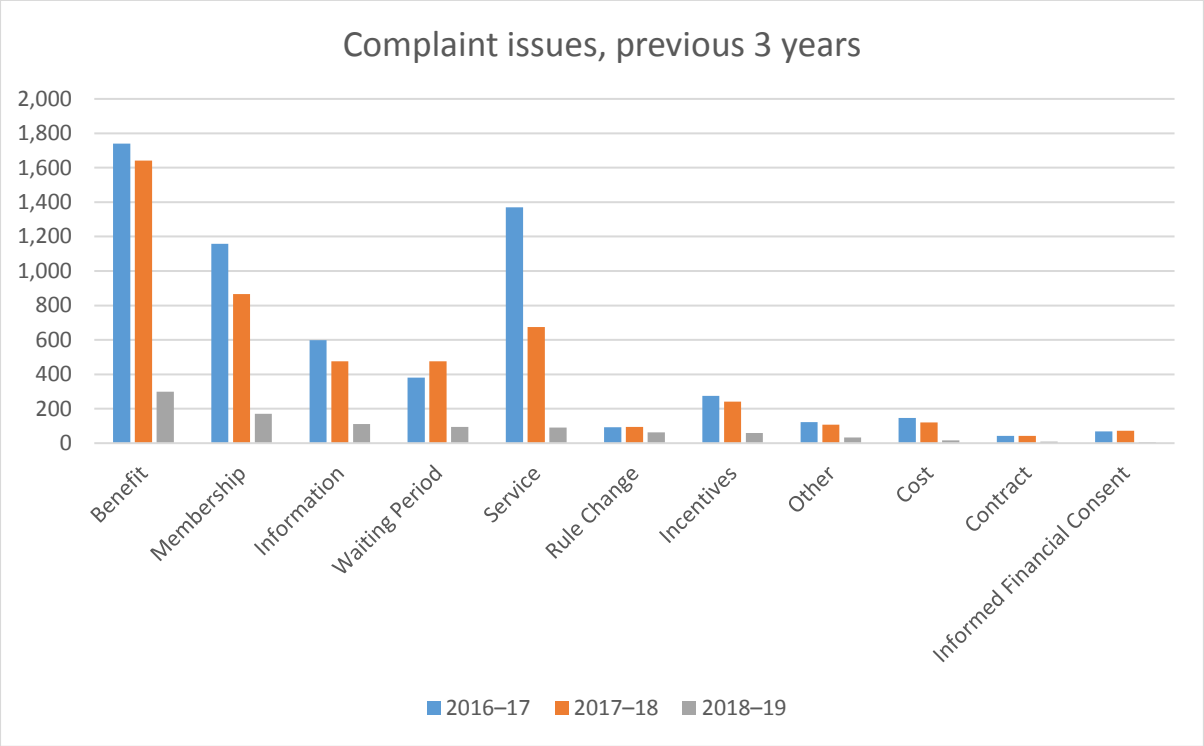




Complaint issues

The following graph shows complaint issues for the past three years. Almost all complaint issues reduced compared to the previous year, showing a general improvement across the industry. Health insurers improved most in the handling of service complaints compared to the previous year.

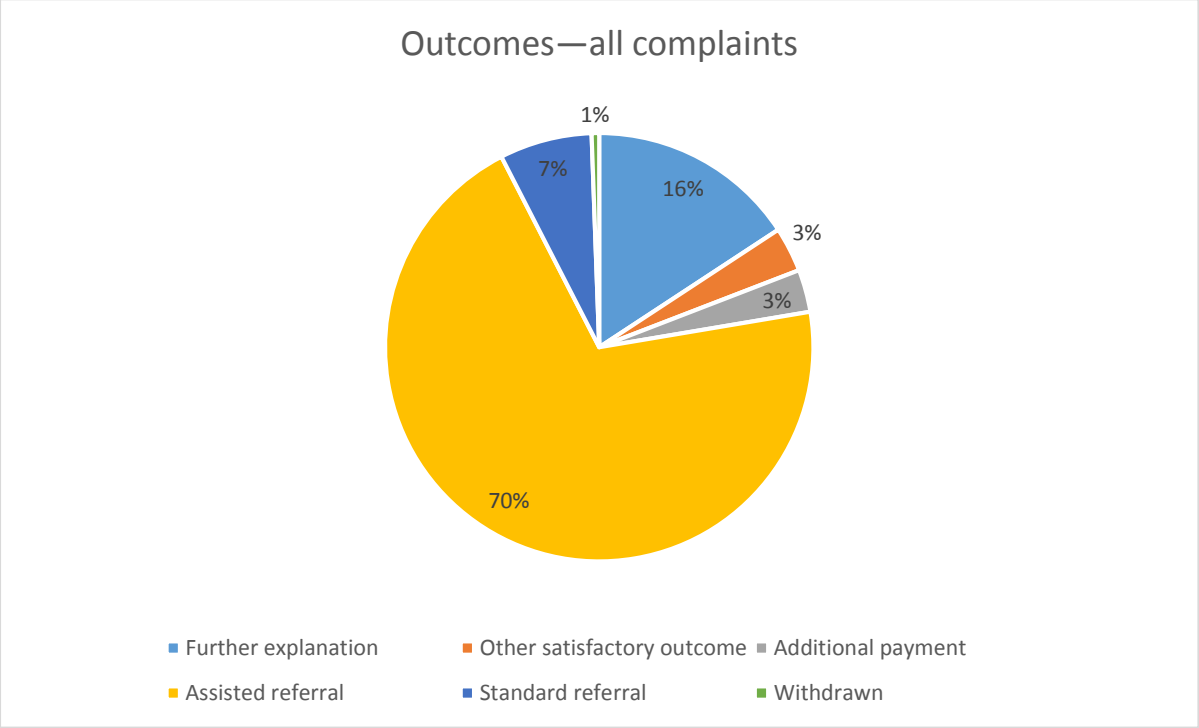
The major issue with benefits complaints were hospital policies with unexpected exclusions and restrictions—397 complaints compared to the previous year's 308 complaints.



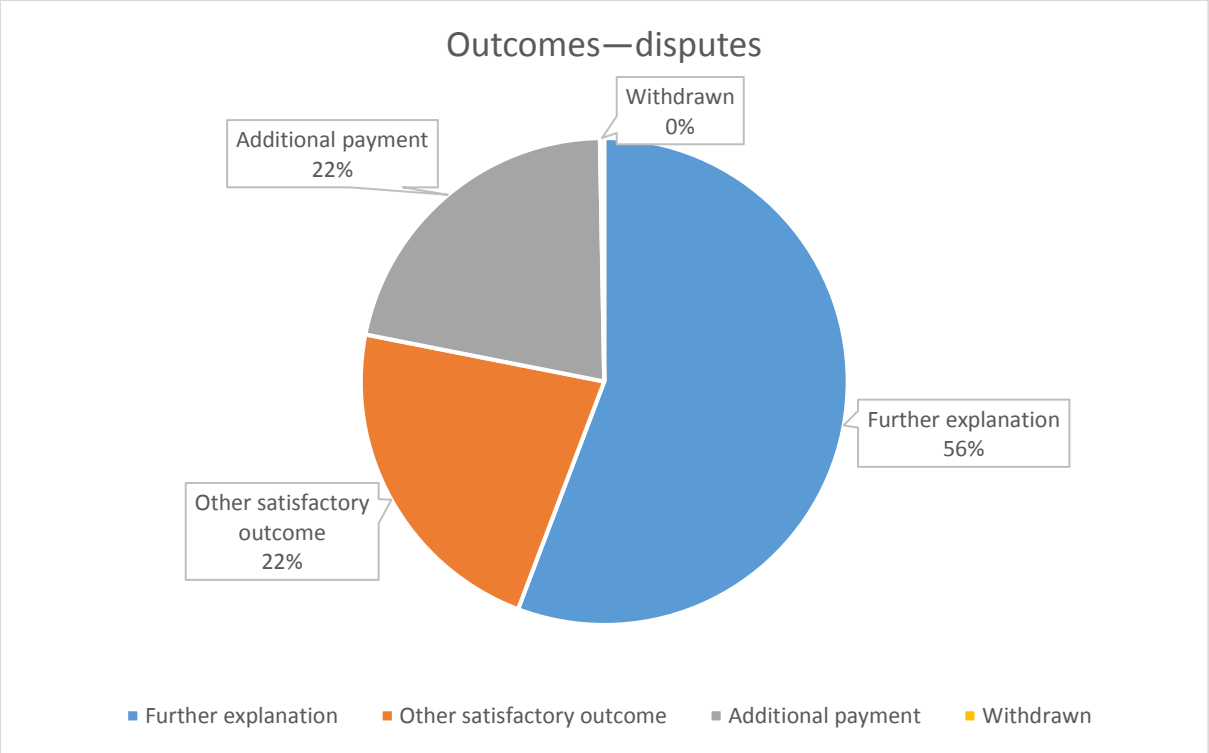
Resolving complaints

The following figure shows that 70 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 16 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 three per cent were resolved by another satisfactory outcome.

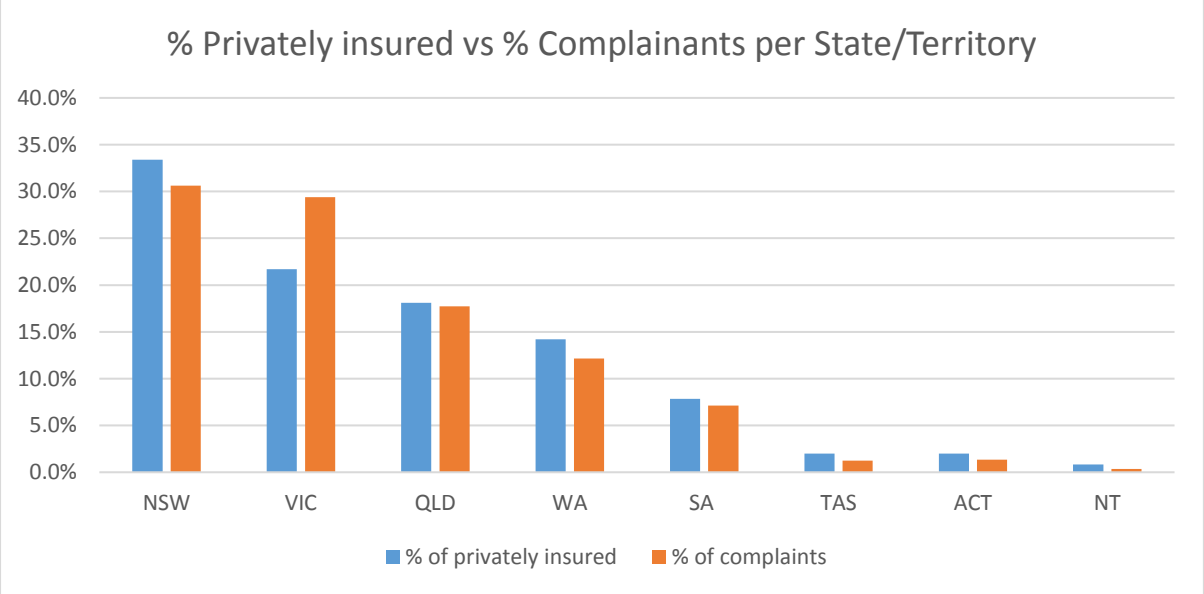


The following chart details dispute outcomes and shows that 56 per cent were resolved by giving a more detailed explanation to the complainant, 22 per cent were resolved by a payment and 22 per cent by another satisfactory outcome (for example, backdating a change to a policy).



Complaints by state or territory

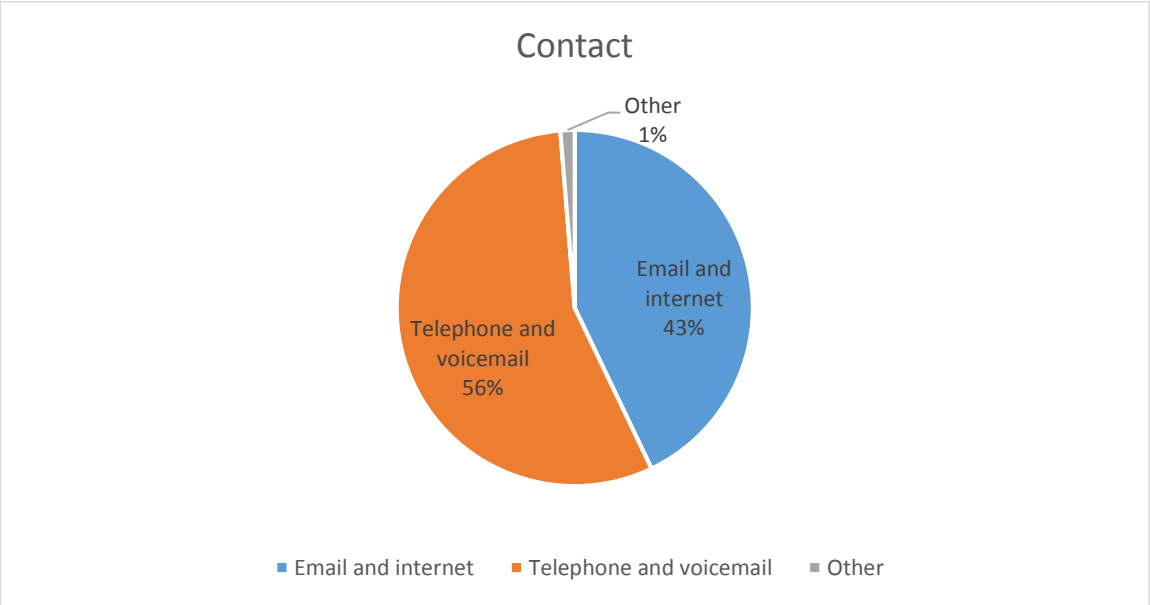
The following table contains a breakdown of the complaints we received by state and territory compared to the percentage of people who have private health insurance coverage. This data shows that those in Victoria are most likely to contact us to make a complaint about their health insurer and those in New South Wales were comparatively less likely to.



How complaints were made

In 2017–18, 55 per cent of complaints were initiated by phone, and 44 per cent by email and internet, with email and internet approaches rising slightly from 42 per cent in the previous year. The ratio of complainants using the telephone compared to using the internet has remained the same for a number of years.

Other contacts making up one per cent of complaints were letters, representation from members of parliament and personal visits to our offices which are located in Sydney, Melbourne, Brisbane, Perth and Canberra.



Overseas Visitors Health Cover: Sub-issues

In 2017–18 the Office received 441 complaints concerning Overseas Visitors Health Cover (OVHC), a 6.2 per cent reduction from 2016–17 when the Office received 470 complaints.

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.

	2015–16	2016–17	2017–18
ISSUE: BENEFIT			
Accident and emergency	11	19	21
Ambulance	7	7	6
Amount	4	19	10
Delay in payment	38	49	28
Gap – Hospital	7	23	15
Gap – Medical	9	11	13
General treatment (extras/ancillary)	3	7	6
High cost drugs	0	0	2
Hospital exclusion/restriction	12	15	23
Insurer rule	8	16	8
Limit reached	0	0	2
New baby	0	1	7
Non-health insurance – overseas benefits	2	2	2
Non-recognised other practitioner	2	2	0
Other compensation	1	0	0
Out-of-pocket not elsewhere covered	2	4	4
Out of time	1	1	2
Total	**107**	**176**	**149**
ISSUE: COST			
Dual charging	0	1	0
Rate increase	9	11	4
Total	9	12	4
ISSUE: INCENTIVES			
Lifetime Health Cover	3	5	0
Medicare Levy Surcharge	5	1	3
Total	**8**	**6**	**3**
ISSUE: INFORMATION			
Brochures and websites	3	6	4
Lack of notification	0	4	1
Verbal advice	17	25	19
Written advice	1	2	2

	2015–16	2016–17	2017–18
Total	**21**	**37**	**26**
ISSUE: INFORMED FINANCIAL CONSENT			
Doctors	0	0	0
Hospitals	3	1	4
Total	**3**	**1**	**4**
ISSUE: MEMBERSHIP			
Adult dependents	1	0	1
Arrears	3	1	2
Authority over membership	2	3	1
Cancellation	74	87	90
Clearance certificates	1	3	0
Continuity	7	16	6
Rate and benefit protection	0	1	0
Suspension	5	7	8
Total	**93**	**118**	**108**
ISSUE: OTHER			
Access	3	0	0
Complaint not elsewhere covered	4	7	1
Confidentiality and privacy	0	2	0
Discrimination	1	0	0
Non-Medicare patient	2	3	1
Private patient election	0	2	0
Rule change	0	1	0
Total	**10**	**15**	**3**
ISSUE: SERVICE			
Customer service advice	13	16	8
General service issues	8	12	14
Premium payment problems	8	18	15
Service delays	8	12	12
Total	**37**	**58**	**49**
ISSUE: WAITING PERIODS			
Benefit limitation period	0	1	0
General	2	4	4
Obstetric	3	4	5
Other	0	1	2
Pre-existing condition	40	55	92
Total	**45**	**65**	**103**

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 2017–18 included:

- Private Health Insurance Reform Bills.
- Working towards the redevelopment of the **privatehealth.gov.au** website to make it easier to compare insurance products and allowing insurers to provide personalised information to consumers on their products.
- Report into Bupa Health Insurance Hospital Policy Changes.
- 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.
- Consultation with the Department of Home Affairs regarding policies for overseas visitors health cover.

Consumer website privatehealth.gov.au

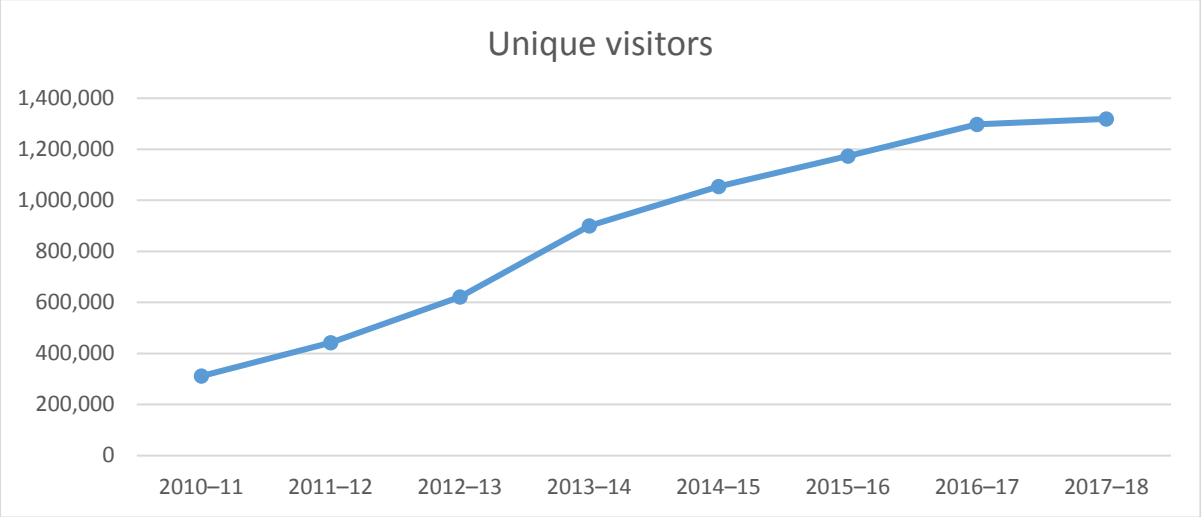
Privatehealth.gov.au is Australia's leading source of independent information about health insurance for consumers. Website usage has continued to grow annually since the website's launch in 2007, with 1,319,130 visits in 2017–18.

The Office is working with the industry to redevelop the website as part of the health insurance reforms and will be launching a newly designed website expected to be available from April 2019.

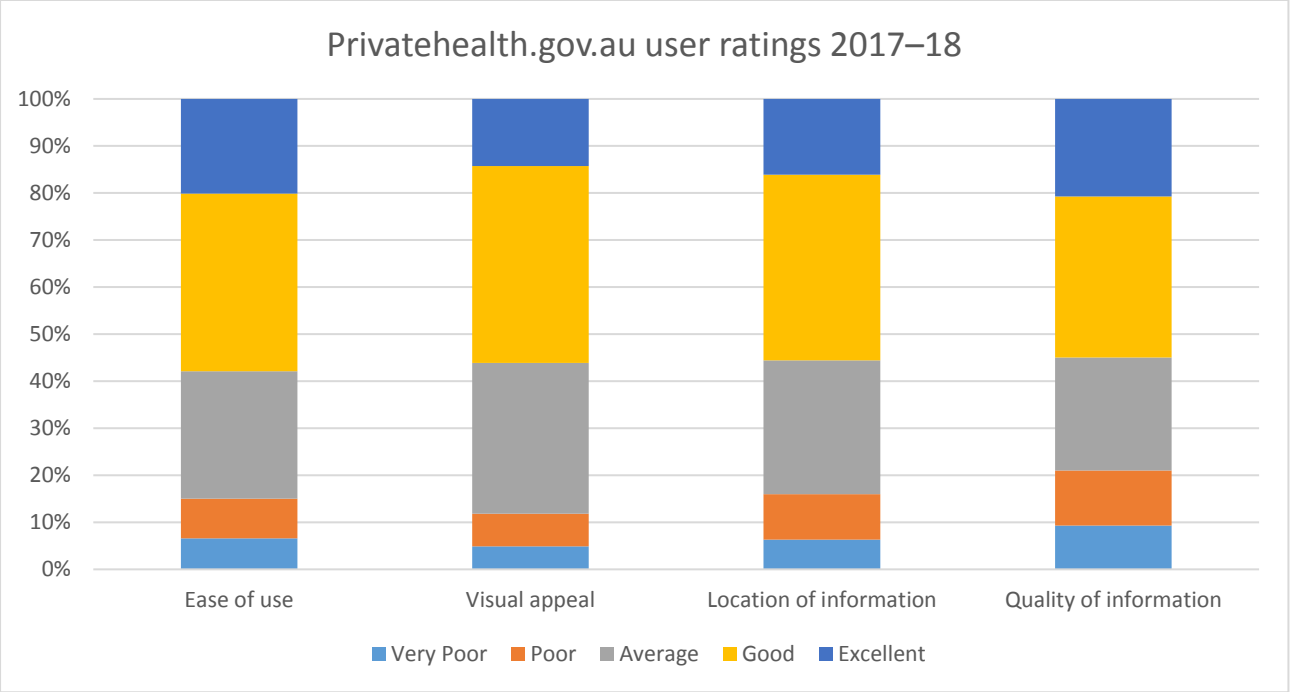
Our Office responded to 1,924 consumer enquiries received via the consumer website **privatehealth.gov.au**. Approximately 65 per cent of the enquiries we received were via the consumer website, either by email, web form, or the dedicated website telephone line.

The most frequently raised questions were 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.
- Overseas Visitors Health Cover, especially for Short Term Temporary 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 to the website can be made 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 1,924 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.