Private Health Insurance Ombudsman issues paper

Lessons learned following a major system transformation

Introduction

This issues paper provides a case study on the lessons learned from a private health insurer's major system transformation. Incidents occurring simultaneously to the transformation impacted the insurer's ability to deliver services and resulted in a subsequent increase in complaints.

Although this case focuses on a private health insurer, it is by no means unique to the private health insurance industry. Any customer service organisation, including other insurers, can consider the lessons learned before planning major system transformations.

Change management includes planning for unexpected events that could interact with the proposed change. Some ways of preparing for this include additional training for staff, ensuring communication channels are resourced to support customers through the change, and reviewing complaint handling processes to ensure they will be effective. In addition, active monitoring of anticipated and unanticipated impacts arising at the time of the change supports continuous improvement to the process.The 'Best practice guidance' section of the paper (page 6 onwards) provides high level considerations for customer service organisations to have in mind when preparing for, managing and monitoring the impacts of large scale change on their organisation and customers.

The role of the Office of the Commonwealth Ombudsman

The Office of the Commonwealth Ombudsman (the Office), as the Private Health Insurance Ombudsman, protects the interests of private health insurance consumers. We do this in many ways, including:

- assisting health insurance consumers to resolve complaints through our independent complaint-handling service
- identifying underlying problems with private health insurers or health care providers
- reporting and providing advice and recommendations to industry and government about private health insurance, including the performance of the sector and the nature of complaints
- managing PrivateHealth.gov.au, a comprehensive source of independent information about private health insurance for consumers.

Background

For some years, the Office has received a higher rate of complaints about a private health insurer than expected based on its market share.[1]

During this period, the insurer undertook a major system transformation which included delivery of multiple new core systems including its customer relationship, customer communications management system and a claims and member health portal. At the same time, the insurer had a scheduled premium increase, which had been deferred earlier in the year.

Also at the same time but unrelated to the system transformation, the insurer experienced problems with its phone system which impacted customers attempting to contact the insurer. Although the insurer moved within 2 hours to implement its Business Continuity Plan and seek to mitigate the problem, the external provider of the insurer's phone system was unable to fully correct the issue for three months.

Impact on complaints

The problems resulting from the system transformation and the simultaneous telephony issues, combined with service issues related to either or both, meant that complaints to our Office about the insurer increased even further, peaking at over one third of all private health insurance complaints received by this Office one month after the transformation, which was well above the insurer's market share.

Although complaints gradually reduced since that spike, the number continues to be above what we would expect, based on its market share.

Our analysis of complaints to the Office shows the effect of the major system transformation was not concentrated in one area but impacted many aspects of the insurer's customer and complaint resolution service. This included issues with premium payments, membership cancellations, issuing transfer of membership (clearance/transfer) certificates, and claims processing. When the insurer was unable to adequately resolve the issues or respond in a reasonable timeframe, this prompted complainants to contact our Office.

The case studies below highlight some of the common issues the insurers' customers reported to us following the major system transformation.

[1] There are many reasons one insurer may be the focus of a greater rate of complaints to our Office than another, ranging from problems with an insurer's service to an insurer actively encouraging complainants to contact our Office if they remain dissatisfied. However, in most instances, we expect that complaints to us about an insurer, as a percentage of complaints about all insurers, will be roughly equivalent to its share of the total market.

Case study: Premium payment problems

The complainant advised us that they downgraded their level of cover in January 2021. However, the insurer continued to deduct their previous fortnightly premium via direct debit, leaving their bank account overdrawn and causing them financial hardship. The person complained that they spent two months pursuing a fix and spoke to numerous staff. The person requested that the insurer cease debiting the higher premium and provide a refund of the amount they overpaid.

The Office referred the person's complaint to the insurer via our assisted referral process. The insurer confirmed that the person had requested a change in cover but due to the system error, it deducted the wrong premium amount on four occasions. The insurer advised it had already rectified the issue and refunded the person the amount they overpaid.

The insurer advised us that it apologised to the person and, to make up for the system error, offered them additional credit on their policy.

Case study: Membership card issue

The complainant contacted the Office in May 2021, stating that they upgraded their cover with the insurer in early March 2021, but had not received their new membership cards.

The person told us they contacted the insurer repeatedly and its staff informed them the cards had already been issued twice. The person asked if they could collect the cards from a branch or have the cards sent via registered post, but customer service staff told them this was not possible.

The person advised that the insurer sent the matter to an escalation manager in late April 2021, but the issue remained unresolved.

Our Office referred this complaint to the insurer via the assisted referral process. In response, the insurer advised that it issued the cards twice already and then sent a further set of cards. It advised its system reflected the correct address, so it was not clear why the cards were not received.

The insurer also contacted the person to apologise for the delays. During this conversation, the person informed staff that they moved to a different health insurer due to the issues they experienced.

The insurer advised the Office that it would provide feedback to relevant business areas about the membership card issues.

Best practice guidance

When we queried how the insurer prepared for the major systems upgrade, it advised that it applied existing governance processes and executive oversight arrangements prior to and throughout the change process. It also advised that it undertook various independent reviews in the lead up to the system change to ensure that the project was on track.

Although the insurer stated that its project plan considered the effect on consumers, there appeared to be little specific detail in their response to our Office about how the insurer would respond to potential risks that might arise during and after the major system transformation, for example, the concurrent problems with the phone system or other risks to the insurer's business continuity.

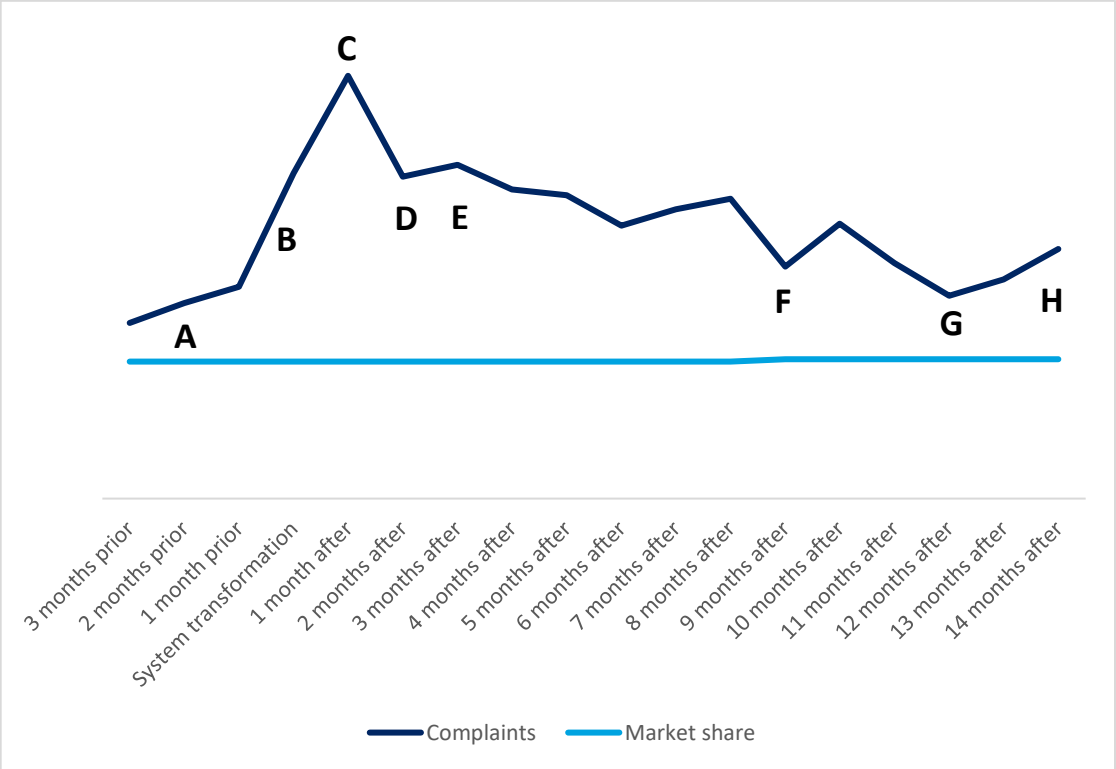
Best practice models for change management show that projects of significant size and complexity should be supported by a structured approach to project planning and implementation. To succeed, projects should have a clear, consistent change vision and strong sponsorship within the insurer and be prioritised to ensure they can be resourced appropriately.[2]

Insurer's remedial actions

Over recent years the Office engaged regularly with the insurer to understand the reasons for increased complaints to the Office from its members, as well as the steps it was taking to address the underlying causes.

Figure 1 below shows the insurers' complaints (as a percentage of all complaints to the Office about insurers) received per quarter since the system upgrade, compared to its market share, along with the key remedial actions it took at the time.[3]

Figure 1: Timeline of insurers' actions and complaints



[2] For example, John P. Kotter's 'Leading Change Project Cycle' tool provides a pathway for project management and more complex change events, setting out a change management process with eight stages. See: "Leading Change" (1995) and "The Heart of Change" (2002) by J.P. Kotter.
[3] We recognise that the effect of system and process changes may not be seen in data until some time after the changes are made.

Key actions:

A	**Pre-system transformation**	Communication sent to customers and other stakeholders (including the Private Health Insurance Ombudsman) of upcoming major system transformation and temporary service restrictions. New staff recruited to assist with expected increase in contacts arising from system transformation and upcoming rate change.
B	**Month of system transformation**	Major systems transformation takes systems offline for 3 days. Insurer expected there would be some bugs and defects with the new system, which is what the insurer experienced and led to service issues and backlogs. Telephony issue began, leading to longer wait times for customers – both for general contacts and those related to problems arising from the system transformation. Premium increase took effect. Many of the insurer's frontline and back office support areas worked overtime (after hours and on weekends) during the system transformation. Complaints increased significantly.
C	**One month post system transformation**	Communication sent to customers to provide a system transformation update and services update including an apology for call wait times. Piloted a centralised complaints system. Complaints peaked.
D	**Two months post system transformation**	More new staff recruited. The insurer informed the Office it was proactively managing the backlog in customer requests and complaints following the system transformation and telephony issues, and it expected that complaint numbers would return to normal levels over the coming months.
E	**Three months post system transformation**	Telephony issues fully resolved.
F	**Seven months post system transformation**	External company engaged by insurer to develop additional training tools for frontline staff
G	**Nine months post system transformation**	Centralised complaints team was made permanent.
H	**Thirteen months post system transformation**	The insurer advised that residual issues arising from the system transformation had been resolved.

		Further remedial activities undertaken, e.g. apology communications to customers impacted by service issues.
I	**Fourteen months post system transformation onwards**	Continuous improvement to improve internal complaint reporting and responsiveness and address member "pain points" as well as improve products and processes.

Best practice guidance for insurers making major changes

In our view, this insurer's experience provides a valuable case study that other insurers and customer service organisations can learn from when planning a major system change.

We developed the following best practice guidance for insurers to consider when planning similar changes.

1. Expecting and planning for unexpected events

Prior to undertaking any major change, insurers should employ a risk management methodology which incorporates a broad range of contingencies into project plans. This will ensure consideration is given to and responses are contemplated for unexpected events.

- Insurers should consider possible events that could arise during the change process, their likelihood, and the impact they could have on customers. These might include ICT, network or telephony failures, workforce gaps, increased complaints, a confluence of events and other emergencies.
- Insurers should develop strategies to address, or at least mitigate the impact of unexpected events. This may include backup systems or business accommodation, extra staff and formal emergency response plans which can be deployed in the event of service interruptions.
- Insurers should consider whether there are other known changes or upcoming events they will be managing at the same time that might impact on customers and/or affect their ability to successfully deliver one or more projects or respond to unexpected events.
- Insurers should also consider and document what success (or, alternatively, failure) will 'look' like for the project, in terms of the customer experience, noting this may vary depending on the stage of the project. These goals should be specific and measurable, communicated to frontline and complaints staff, and be accompanied by information about the timeframes in which results will be measured and how the insurer will respond to 'failures.'

Insurer's experience

The insurer advised that it had planned extensively for the major system transformation and it had a robust governance structure with internal and external monitoring oversight. This included project teams, steering committees, program governance and external independent assurances. Complaints and problems arising from the system transformation were monitored throughout by relevant teams as well as the Executive Team and Board, as

part of regular governance processes implemented prior to and during the system transformation.

The insurer advised that as part of the major system transformation project, it also established a triage system to enable daily tracking of complaints and remediation activities across all areas impacted by the upgrade.

In our view, the insurer did not fully anticipate some problems before they occurred. The insurer explained that its system transformation took place during a period of unique circumstances, including:

- Due to staff working from home during the COVID-19 pandemic, the insurer had to adapt staff training and associated support structures so they could be delivered remotely. Both were new approaches for the insurer.
- The insurer employed new staff shortly before the system upgrade to handle an expected increase in customer service requests. It explained that training was done at this time to ensure simplicity for new staff in training in one set of core systems. It then employed more staff two months later. The insurer acknowledged that the inexperience of some of these staff played a role in member dissatisfaction and increased complaints.
- A technical problem with its telephony system which was not connected to the system transformation. This issue was managed through the insurer's Major Incident Management Standard Operating Procedure and communicated to the insurer's Executives and Board. The insurer moved within 2 hours to implement its Business Continuity Plan which mitigated the problem and allowed the insurer to continue operating its Contact Centre although not as effectively. It took time for the telephony provider to resolve the root cause which caused major delays for members trying to reach the insurer after the implementation of its new system. It led to member dissatisfaction and increased complaints as members were unable to get resolutions with long wait times and backlogs across the insurer.
- The insurer proceeded with a scheduled premium increase at the same time as the system transformation. The insurer had earlier postponed its premium increase to recognise the impact of COVID-19 on members. However, the additional call volumes and backlogs associated with the rate increase placed additional pressure on the insurer.

We acknowledge there were several factors arising from the major system transformation that impacted on the insurer's ability to respond to and address the service disruptions that followed. We also acknowledge that the insurer employed additional resources to manage the process, both prior to and after the system transformation.

In our view, the insurer's experience highlights the importance of building contingencies into project plans to ensure that planned responses are contemplated for likely and unlikely events.

2. Having an effective and efficient complaint handling process

Prior to undergoing any major change, insurers should ensure that they have well established complaint handling processes and have built in sufficient redundancy to manage

associated surges in complaint numbers. This will ensure insurers have the necessary resources and capability to quickly identify, respond to and resolve service issues that arise, and prevent further complaints about their handling of the issues.

- The insurer should have a centralised complaints system and a documented complaint policy/procedure.
- The insurer should ensure clear information about its complaints process is readily accessible to customers, and its process for lodging a complaint is simple and user friendly.
- The insurer's frontline staff should be familiar with its complaints processes and receive appropriate training prior to any change, to ensure they are confident in identifying complaints, explaining the complaint process, and knowing how and when to escalate issues. Wherever possible, they should also have appropriate delegation to resolve simple complaints to avoid the need for escalation and double handling.
- The insurer should have processes in place to guide frontline staff and managers to identify and report customer problems to the project team and management.
- The insurer should ensure complaint handling staff are appropriately trained and skilled to manage complaints in line with its complaint handling policy.
- The insurer should have records management processes and systems in place to record meaningful information about the reasons for complaints and how they are resolved and produce and report on reliable data about complaint trends and issues to the Executive.
- The insurer should have robust quality assurance and review processes to identify and address systemic issues, weakness areas and opportunities for improvement.
- The insurer's senior leadership should have oversight of performance indicators and how the insurer is tracking against these to identify issues early.
- The insurer should ensure it directs adequate resources to its complaint handling and has capacity to bolster this workforce to respond to unexpected events, if required.

For further information on improving complaint handling, see the Commonwealth Ombudsman's Better Practice Complaint Handling Guide.[4]

Insurer's experience

For some time prior to the systems transformation, the insurer had worked to improve its complaints handling processes and resourcing, including trialling the centralisation of its complaint handling functions into a single specialised team. Previously, the insurer allocated complaints to different teams and retail offices to handle, each of which likely used slightly different approaches to engage with and resolve complaints.

A centralised (but not necessarily geographically co-located) complaints team is preferable to a dispersed model because it provides the insurer with opportunities to standardise, monitor and influence improvement in its complaint handling approach. It enables the

[4] https://www.ombudsman.gov.au/publications/better-practice-guides/Better-practice-complaint-handling-guide

insurer to more effectively identify systemic complaints issues so that it can address underlying problems and more usefully respond to customers.

We acknowledge the insurer's commitment to improving its complaint handling and note that it *commenced* improvements prior to the system upgrade. However, in our view, if new processes had been *fully embedded* ahead of the major system change, the insurer may have been in a better position to respond to the issues arising from the change and avoid the escalation of complaints.

A well-established, centralised complaints team and effective internal reporting would likely have put the insurer in a better position to respond to the service issues that arose during the major system transformation. Problems for customers would have been identified earlier and the scale of the problems would have been apparent if better tracking and reporting of complaints were in place.

3. Communicating with stakeholders

As part of any major change, insurers should provide advance notice of the change to customers to enable them to prepare for any potential impacts or actions required of them.

Insurers should also ensure that relevant stakeholders such as health care providers and regulatory and oversight bodies are given prior notice of the changes, the potential impacts of these, and any change in processes applicable to them.

Insurer's experience

A month before it occurred, the insurer notified the Office that its online services would be unavailable for a period of three days while it undertook a major system transformation. It advised that during this time, members would be unable to access regular services, such as on the spot claiming, online member services and its membership app.

The insurer told the Office it notified its members of the service disruptions via email, mail, on hold messages and its online member portal. It provided us with samples of communication it sent members before and after the system transformation. The insurer also provided us with an example of an apology letter it sent to members who were impacted by a system issue which prevented payment reminders being sent and caused members' policies to lapse.

We acknowledge the insurer took steps to keep stakeholders informed throughout the change process. We also recognise that it undertook various remediation activities. For example, the insurer provided apology letters to members impacted by specific system errors.

4. Monitoring the impact of the change

Insurers should have processes in place to monitor and assess the impacts of the change. This helps to identify relevant learnings from the project and maximise opportunities for improvement.

- Insurers' review and reporting processes for any major change should include an assessment of the impact on customer satisfaction and complaints.
- Insurers should have transparent feedback and reporting processes to ensure complaints information is communicated to senior leadership and the Board early.
- Insurers should complete a post-implementation review, which includes analysis of:

- customer complaints and enquiries before, during and after the change was made
- lessons learned during the project to assist in formulating better project plans for future changes, and
- any further opportunities for improvement that became apparent during the project and the areas responsible for their implementation.

Insurer's experience

To understand the lessons the insurer itself learned from implementing the major system transformation, we invited it to share any assessments or review reports it completed or commissioned on the topic.

The insurer advised various reviews and assessments occurred throughout the transformation project and after it was completed. We are not aware whether the insurer has completed a formal post implementation review. In our view such a review should include analysis of the problems that arose during the project and the impact these had on policy holders and should not be confined to whether the intended benefits of the system transformation had been realised. We also expect the review would identify any learnings to improve processes for future projects.

Conclusion

This is not the first time the Office has observed an increase in complaints about an insurer following a system upgrade or other ICT issues. For insurers planning major changes, the Office can share its experience in complaint handling and provide practical advice on steps for reducing complaints. This includes providing advice on the lessons learned outlined in this paper. That is, expecting and planning for unexpected events, having an effective and efficient complaint handling process in place, communicating with stakeholders in a clear and timely manner, and monitoring the impact of change.

By applying the learnings from these lessons, and strong project management and change management processes, insurers can mitigate the risks associated with large systems changes and reduce the incidence of consumer complaints.

Appendix A: Checklist for insurers contemplating major system changes

1. Has the insurer considered possible unexpected events?

- ☐ The insurer should consider possible unexpected events that could arise during the change process and the impact these may have on customers.
- ☐ The insurer should prepare contingencies for potential unexpected issues. This may include extra resourcing, staffing and contingency funding in place before the change.
- ☐ The insurer should consider whether there are other known changes or upcoming events the insurer will be going through concurrently that might also impact on customers, along with how it will manage these.

2. Does the insurer have an effective and efficient complaint handling process?

- ☐ The insurer should have a centralised complaints system and a documented complaint policy/procedure. It should also have appropriate records management procedures for recording complaints.
- ☐ Clear information about the insurer's complaints process should be readily accessible to customers, and the process to lodge a complaint should be simple and user friendly.
- ☐ Frontline staff should be familiar with the insurer's complaints processes and receive appropriate training prior to any change, to ensure they are confident in being able to identify complaints, explain the complaint process and know when to escalate issues. They should also have appropriate delegation to resolve simple complaints.
- ☐ Complaint handling staff should be appropriately trained, including in best practice complaints handling.
- ☐ The insurer should have a process in place to review the quality of its complaint handling, and a means of identifying systemic problems affecting customers.
- ☐ The insurer should ensure it has directed adequate resources to its complaint handling.

3. Does the insurer have an appropriate approach to alert and update stakeholders about the impacts of the change?

- ☐ Insurers should provide advance notice to customers affected by the change as early as possible. Customers should also be kept updated throughout the process.
- ☐ Insurers should ensure that relevant stakeholders (for example, health care providers and regulatory and oversight bodies) are given prior notice of the changes, the potential impacts of these, and any change in processes applicable to them.

4. Does the insurer have an appropriate process to monitor and assess the impacts of the change?

- ☐ The review and reporting process for any major change should include an assessment of the impact on customer satisfaction and complaints.
- ☐ Transparent feedback and reporting processes to ensure senior leadership and the Board is made aware of complaints early.