PRIVATE HEALTH INSURANCE OMBUDSMAN

Readers of previous PHIO annual reports: please refer to **www.ombudsman.gov.au/about/private-health-insurance** for more detailed complaint statistics on the private health insurance industry. From 2016–17, PHIO will be providing additional quarterly updates of complaint statistics online.

Context

The role of the Private Health Insurance Ombudsman (PHIO) is to protect the interests of consumers in relation to private health insurance. The Ombudsman is an independent body that resolves complaints about private health insurance and acts as the umpire in dispute resolution at all levels within the private health industry. The Ombudsman also reports and provides advice to industry and government about these issues. The office has a significant consumer information and advice role including managing the consumer website PrivateHealth.gov.au

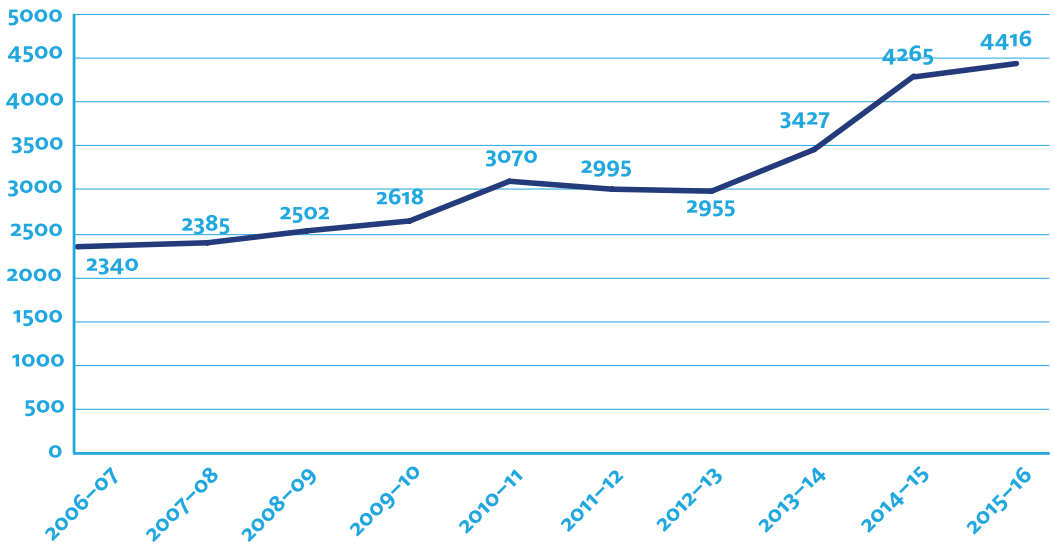
Overview of 2015–16

The office of PHIO merged successfully with the Commonwealth Ombudsman on 1 July 2015. It is pleasing that the standard of service provided to complainants was maintained, and in some areas improved, as measured by audit and survey data. The level of overall satisfaction as reported by complainants to PHIO increased from 84 per cent in 2014–15 to 85 per cent in 2015–16 (see page 65).

After several years where PHIO complaint levels remained steady, the past two years have seen an increase. In 2015–16, PHIO received 4416 complaints, compared with 4265, in 2014–15 and 3427 in 2013–14.

In our consumer information and advice role, the office received 3999 consumer information enquiries in 2015–16, of which 59 per cent were received through consumer website PrivateHealth.gov.au

Figure 9: Total complaints by year received by Private Health Insurance Ombudsman



Complaints about Private Health Insurers

Table 5 shows the number of complaints and disputes[6] received about registered private health insurers, and compares these to their market share. A high ratio of complaints or disputes compared to market share usually indicates either a less-than-adequate internal dispute-resolution process, especially for complex issues, or an underlying systemic or policy issue.

Table 5: **Complaints by registered private health insurer, by market share 2015–16**

	2015–16				
	Complaints	Percentage of Complaints	Disputes	Percentage of Disputes	Market Share
ACA	0	0.0%	0	0.0%	0.1%
Australian Unity	195	5.1%	33	4.8%	3.1%
BUPA	834	21.7%	196	28.6%	26.8%
CBHS	35	0.9%	9	1.3%	1.4%
CDH (Cessnock)	2	0.1%	0	0.0%	<0.1%
CUA	70	1.8%	17	2.5%	0.6%
Defence	26	0.7%	6	0.9%	1.8%
Doctors	11	0.3%	2	0.3%	0.2%
GMHBA	55	1.4%	6	0.9%	2.0%
Grand United Corporate	17	0.4%	5	0.7%	0.4%
HBF	125	3.3%	21	3.1%	7.4%
HCI	1	0.0%	0	0.0%	0.1%
Health.com.au	53	1.4%	13	1.9%	0.6%
Health Insurance Fund of Australia	22	0.6%	3	0.4%	0.9%
HealthGuard (GMF/ Central West)	10	0.3%	0	0.0%	0.5%
Health-Partners	13	0.3%	1	0.1%	0.6%
Hospitals Contribution Fund (HCF)	406	10.6%	66	9.6%	10.5%
Latrobe	16	0.4%	1	0.1%	0.7%
Medibank (AHM)	1544	40.2%	252	36.8%	28.6%
Mildura	1	0.0%	1	0.1%	0.2%

6 A Dispute is a high level complaint where significant intervention is required.

	2015–16				
	Complaints	Percentage of Complaints	Disputes	Percentage of Disputes	Market Share
National Health Benefits (Onemedifund)	1	0.0%	0	0.0%	0.1%
Navy	2	0.1%	0	0.0%	0.3%
NIB	301	7.8%	42	6.1%	7.9%
Peoplecare	6	0.2%	1	0.1%	0.5%
Phoenix	0	0.0%	0	0.0%	0.1%
Police	1	0.0%	0	0.0%	0.3%
Queensland Country Health	2	0.1%	0	0.0%	0.3%
Railway and Transport	15	0.4%	1	0.1%	0.4%
Reserve	0	0.0%	0	0.0%	<0.1%
St Lukes	4	0.1%	0	0.0%	0.4%
Teachers Health	47	1.2%	6	0.9%	2.1%
Teachers Union	6	0.2%	1	0.1%	0.5%
Transport	8	0.2%	1	0.1%	0.1%
Westfund	10	0.3%	1	0.1%	0.7%
Total	3839		685		

Complaint issues

BENEFITS

Complaints: 1359

Key issues:

- *Hospital exclusions and restrictions*
- *General treatment (extras or ancillary benefits)*
- *Medical gaps*

This was the largest area of complaint. The main issues of concern were hospital policies with unexpected exclusions and restrictions. Some basic and budget levels of hospital cover exclude or restrict services that many consumers assume are routine treatments or standard items. Delays in benefit payments and complaints about insurer rules that limited benefits were the other large areas of complaint.

CASE STUDY—Benefit: Hospital exclusion or restriction

Ayesha required surgery to her hand. The surgery was defined in the Medicare Benefits Schedule, under the 'Hand Operations' sub-group, as a '*carpal bone replacement or resection arthroplasty using adjacent tendon or other soft tissue including associated tendon transfer or realignment when performed*'.

Initially, her health fund refused to cover the surgery because it considered the surgery to be 'joint replacement' which was an excluded service on her cover. However, this type of surgery does not involve the replacement of bone, but rather the removal of it.

On reviewing the information available to consumers about Ayesha's policy, the office noticed there was little guidance on what the insurer includes in the 'joint replacement' exclusion. However, it is a term used outside of its use by the health insurer; and our view is that the insurer should only use a definition of that term that is commonly understood in the community.

The office concluded that the surgery should be included in Ayesha's policy as it is not a joint replacement under any definition the office could find. After reviewing the case, the health fund agreed that the surgery was not 'joint replacement' and paid an appropriate benefit.

MEMBERSHIP

Complaints: 845

Key Issues:

- *Policy/Membership Cancellation*
- *Clearance certificates*
- *Continuity of cover*

Membership complaints typically involve policy administration issues, such as processing cancellations or payment of premium arrears. Delays in the provision of clearance certificates when transferring between health insurers is also a major cause of complaint.

CASE STUDY—Membership: arrears and cancellation

Kim joined his health fund in 2012 and had paid premiums by direct debit every month afterwards. In 2015 he required a hospital admission, but his booking was refused by the hospital as his membership appeared to have been cancelled.

On contacting the fund, Kim found that due to an administrative error, he had been undercharged for his premiums ever since joining in 2012. The fund had recently discovered this and corrected its records. But this had the effect of putting his policy into arrears and cancelling it.

The office concluded that Kim should not be adversely affected for an error the fund had made. The fund agreed to write off the arrears, bringing Kim's policy back up to date and allowing him to be covered for his hospital admission. However in future, Kim would need to pay the correct higher premium.

INFORMATION

Complaints: 599

Key issues:

- *Verbal advice*
- *Lack of notification*

Information complaints usually arise because of disputes or misunderstandings about verbal or written information provided by an insurer. Verbal advice is the cause of more complaints than any other sub-issue, and these can be particularly complex if the insurer has not kept a clear record or call recording of its interaction with the member.

CASE STUDY—Information: verbal advice

Adam realised he needed surgery which was not covered on his basic hospital policy. He called his health insurer to upgrade his policy, explaining he wanted to book a hospital admission within the next few months. The insurer told him that only a two month waiting period would apply, so Adam proceeded with the upgrade and booked a hospital admission in four months' time.

However, Adam was later advised that his treatment was actually subject to a 12 month waiting period for pre-existing conditions. This meant he was not covered for the surgery and he was asked to pay the full cost of the hospitalisation as he was about to be admitted.

On investigation, phone records confirmed that the health insurer had given incorrect advice about waiting periods when Adam upgraded his cover. The insurer had also encouraged Adam to upgrade to a more expensive policy to better cover hospital services.

Although Adam was made aware of the correct waiting periods for his cover before he was admitted, the office asked the insurer to consider a response to his complaint which accounted for the costs and inconvenience he had already incurred. The insurer instead decided to compensate Adam more than this and offered to honour the information it had provided him by paying the full hospital costs.

SERVICE

Complaints: 704

Key issues:

- *General service issues*
- *Premium payment problems*

Service issues are usually not the sole reason for complaints. The combination of unsatisfactory customer service, untimely responses to simple issues, and poor internal escalation processes can cause members to become more aggrieved and dissatisfied in their dealings with the insurer, until the service itself becomes a cause of complaint as well as the original issue.

WAITING PERIODS

Complaints: 363

Key Issues:

- *Pre-existing condition disputes*
- *Compliance with PEC Best Practice Guidelines*

Health insurers are able to apply a 12 month waiting period to new members if treatment is for a Pre-Existing Condition (PEC). Details about how the PEC waiting period is applied can be obtained by referring to our brochure 'Waiting Periods' and our factsheet on Pre-Existing Conditions, which are available at **ombudsman.gov.au.** PHIO's role in investigating complaints about the PEC waiting period is to ensure that the insurer has applied the waiting period correctly, and that the insurer and hospital have complied with the PEC Best Practice Guidelines.

RULE CHANGE

Complaints: 147

Key Issues:

- *Detrimental changes to policies*
- *Adequate notice to consumers*

Health insurers are permitted to make detrimental changes to their policies provided they give suitable advance warning to the affected members so they can change their cover or make other plans. In our view,

a significant detrimental change to a hospital policy includes the exclusion or restriction of a previously included benefit, or the addition or increase of an excess or co-payment. It is important for insurers to communicate detrimental policy changes in clear and unambiguous language, without diluting the message by interspersing unrelated promotional material. Insurers should honour any pre-booked hospital admissions and ensure that benefits for patients currently in a 'course of treatment' continue for up to six months.

Figure 10: Complaint issues, previous three years

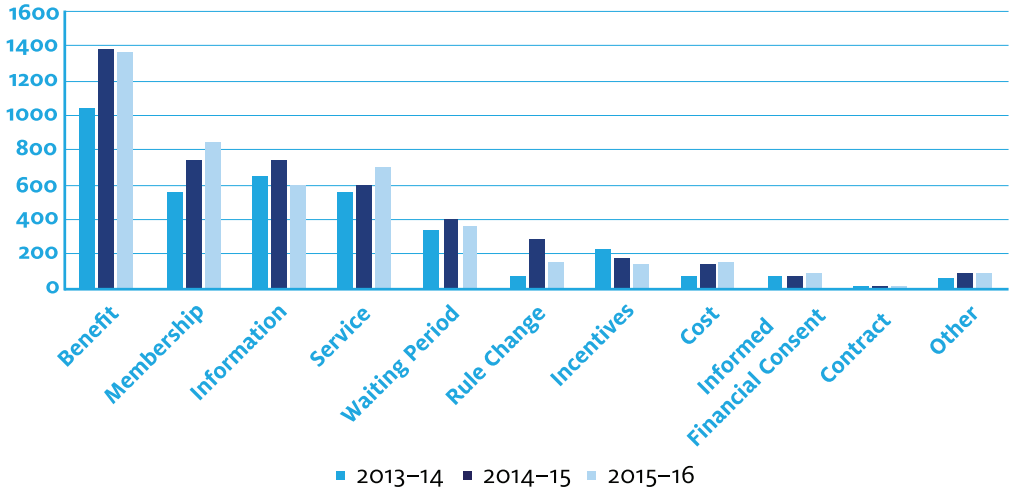


Table 6: Complaint issues

Issue	Sub-issue	2013–14	2014–15	2015–16
Benefit	Accident and emergency	23	40	49
Benefit	Accrued benefits	4	9	3
Benefit	Ambulance	36	51	66
Benefit	Amount	58	63	67
Benefit	Delay in payment	147	154	142
Benefit	Excess	48	56	56
Benefit	Gap—Hospital	23	50	53
Benefit	Gap—Medical	38	131	151
Benefit	General treatment (extras/ancillary)	78	105	194
Benefit	High cost drugs	11	13	13
Benefit	Hospital exclusion/restriction	242	320	276
Benefit	Insurer rule	152	192	131
Benefit	Limit reached	28	24	14
Benefit	New baby	11	22	6

Issue	Sub-issue	2013–14	2014–15	2015–16
Benefit	Non-health insurance	19	8	9
Benefit	Non-health insurance - overseas benefits	8	8	3
Benefit	Non-recognised other practitioner	16	29	22
Benefit	Non-recognised podiatry	15	12	15
Benefit	Other compensation	10	16	14
Benefit	Out of pocket not elsewhere covered	12	9	15
Benefit	Out of time	15	19	15
Benefit	Preferred provider schemes	44	50	32
Benefit	Prostheses	10	9	11
Benefit	Workers compensation	1	2	2
Contract	Hospitals	15	10	18
Contract	Preferred provider schemes	9	9	8
Contract	Second tier default benefit	4	3	2
Cost	Dual charging	2	5	2
Cost	Rate increase	78	132	147
Incentives	Lifetime Health Cover	163	156	121
Incentives	Medicare Levy Surcharge	21	12	11
Incentives	Rebate	39	13	9
Incentives	Rebate tiers and surcharge changes	5	1	2
Information	Brochures and websites	65	47	34
Information	Lack of notification	96	91	90
Information	Oral advice	410	522	430
Information	Radio and television	2	4	1
Information	Standard Information Statement	5	8	6
Information	Written advice	66	64	38
Informed Financial Consent	Doctors	25	19	35
Informed Financial Consent	Hospitals	40	50	36
Informed Financial Consent	Other	7	1	13

Issue	Sub-issue	2013–14	2014–15	2015–16
Membership	Adult dependants	15	25	15
Membership	Arrears	93	144	106
Membership	Authority over membership	16	20	16
Membership	Cancellation	218	299	315
Membership	Clearance certificates	106	108	196
Membership	Continuity	72	100	114
Membership	Rate and benefit protection	5	19	32
Membership	Suspension	41	50	51
Service	Customer service advice	52	82	106
Service	General service issues	207	184	234
Service	Premium payment problems	141	184	211
Service	Service delays	164	155	153
Waiting Period	Benefit limitation period	5	6	1
Waiting Period	General	34	41	29
Waiting Period	Obstetric	47	49	51
Waiting Period	Other	22	19	14
Waiting Period	Pre-existing conditions	229	283	268
Other	Access	0	0	3
Other	Acute care certificates	1	4	2
Other	Community rating	1	0	1
Other	Complaint not elsewhere covered	33	56	54
Other	Confidentiality and privacy	12	12	11
Other	Demutualisation/sale of health insurers	2	1	1
Other	Discrimination	1	3	4
Other	Medibank sale	1	0	1
Other	Non-English speaking background	0	0	0
Other	Non-Medicare patient	3	8	2
Other	Private patient election	10	3	6
Other	Rule change	72	281	147

Complaints about hospitals, doctors, brokers and others

Most complaints (88 per cent in 2015–16) are made about health insurers. However, complaints can also be made about providers including hospitals, doctors, health insurance brokers and other practitioners (such as dentists). There was an increase in complaints about verbal advice and incorrect information provided by health insurance brokers in 2015–16, which accounts for the increase in complaints from 34 to 75 complaints.

Table 7: Complaints about hospitals, doctors, brokers and others

	2013–14	2014–15	2015–16
Hospitals	40	38	47
Health Practitioners	53	29	58
Health Insurance Brokers	42	34	75

Overseas Visitors Health Cover

Each year, the Ombudsman helps consumers with complaints about Overseas Visitors Health Cover (OVHC) and Overseas Student Health Cover (OSHC) policies for visitors to Australia. These complaints are counted separately from complaints made against domestic health insurance policies.

Unlike Australians, who have the option of using the public Medicare system at no cost if they are not covered for a hospital treatment under their private health insurance policy, most visitors to Australia have no choice about whether they are treated at private patient rates.

The most common issue for overseas visitors included 74 complaints about policy cancellation and refunds, 40 complaints about the pre-existing condition waiting period and 38 complaints about delays in paying benefit payments.

Table 8: Complaints received from overseas visitors in 2015–16

Insurer	2013–14	2014–15	2015–16
Allianz (Lysaght Peoplecare)	32	63	69
Australian Unity	11	25	12
BUPA	84	160	119
HBF	1	1	1
HCF	1	1	1
HIF	2	7	3
Medibank Private (AHM)	44	62	73
NIB	25	28	43
Total	200	347	321

NOTE: Figures for providers of cover for overseas visitors are not directly comparable, as market share data is not available. These figures show the number of complaints over time and it can be assumed market share numbers are relatively similar to those for domestic providers (see Table 5 on page 56) and do not greatly change from year to year.

Complaint–handling procedures and categories

PHIO has three levels of complaint:

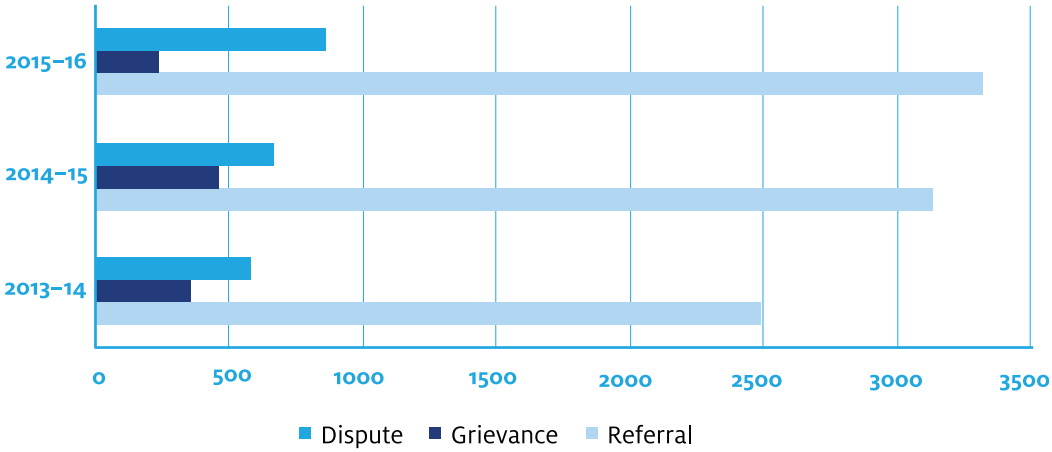
- Assisted Referrals for moderate complaints
- Grievances for moderate complaints that do not require a report or further investigation, and
- Disputes for high-level complaints where significant intervention is required.

In 2015–16, 75 per cent of complaints were resolved as Assisted Referrals. In these instances, the Dispute Resolution Officer refers a complaint directly to a nominated representative of the insurer or service provider, on behalf of the complainant. This approach ensures a quicker turnaround time and our client satisfaction survey confirms that complainants have a high satisfaction rate with this method of resolution.

Grievances are a moderate level of complaint. They are dealt with by investigating the issues of grievance and providing additional information or a clearer explanation directly to the complainant, without the need for a report from the health insurer or health care provider. Approximately five per cent of complaints were registered as Grievances.

Approximately 20 per cent of complaints were classified as Disputes, slightly higher than last year's 16 per cent (858 complaints compared to 668 complaints). In these cases, a member of the Ombudsman's Dispute Resolution Office requests a detailed report from a health insurer or other object of a complaint. The report is then reviewed and a decision is made as to whether the initial response was satisfactory or whether a further investigation is warranted.

Figure 11: Private health insurance complaints by level



Complaint outcomes

Most cases (72 per cent) were resolved as Assisted Referrals, with complaints referred directly to health insurers with our assistance, on the understanding that the complainant may ask us to review the complaint if he or she remains unsatisfied. A further 16 per cent of cases were resolved by our providing an additional and independent explanation of the issues.

These ratios change for high-level disputes. Most of these cases are resolved with the provision of a further explanation (54 per cent), but 45 per cent received additional payments or some other satisfactory outcome.

Client survey

PHIO regularly carries out a postal survey of randomly selected complainants. Each fortnight, the office sends survey forms to a sample of complainants whose cases have been closed during the previous period. In 2015–16, the office received 128 responses (23 per cent)—a reasonable participation rate for a postal survey of this kind.

Overall, 85 per cent of clients who responded were satisfied or very satisfied with the handling of their complaint, compared to 84 per cent the previous year.

Table 9: Client survey feedback results

	2014–15	2015–16
Overall satisfaction	84%	85%
Agreed that staff listened adequately	88%	93%
Satisfied with staff manner	87%	90%
Resolved complaint or provided adequate explanation	85%	81%
Thought PHIO acted independently	86%	86%
Would recommend PHIO to others	85%	86%
Happy with time taken to resolve complaint	86%	79%

Health policy: Liaison with other bodies

PHIO has a role in assisting with the broader issues associated with health policy. During the year, the office provided information and assistance to various bodies involved in the formulation of health policy and compliance with established rules and laws.

This included:

- Submission to the ACCC's Report to the Senate on Anti-Competitive and Other Practices by Health Funds and Providers in relation to private health insurance.
- Advice to the Private Health Insurance Industry Code Compliance Committee in relation to the voluntary industry code.
- Consultation with state health departments, public hospitals and health insurers in relation to acute care certification processes for long-stay private patients in public hospitals.
- Consultation with the Overseas Students Ombudsman and private health insurers regarding issues relating to private health insurance for overseas students.

Consumer website: PrivateHealth.gov.au

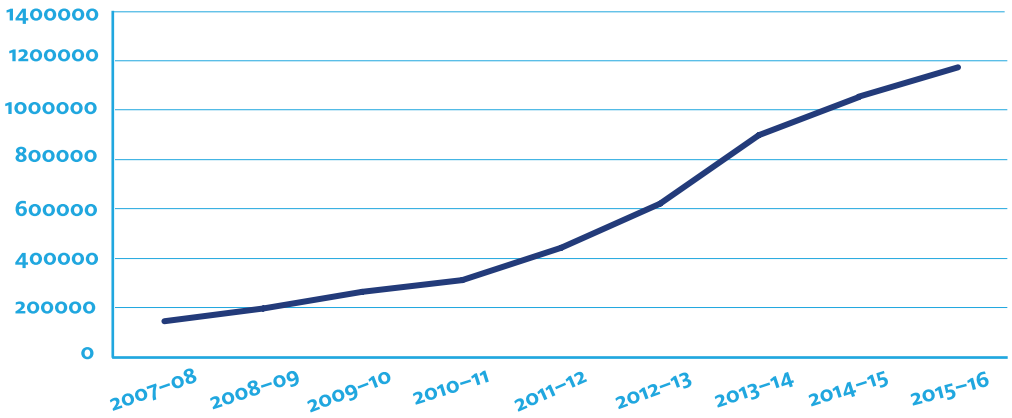
In 2015–16 the office responded to 3999 individual enquiries, providing written consumer information and advice and managing the consumer website **PrivateHealth.gov.au.** This is Australia's leading source of independent information about health insurance for consumers. Its major features include:

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: the office responded to over 2300 people using the website for advice on details of the health insurance system, particularly people seeking help understanding lifetime health cover, health cover for visitors and overseas students in Australia and advice on how to use the website and choose a policy.

3. Health insurers are required to maintain up-to-date Standard Information Statements (SISs) 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 funds 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.

Website usage has continued to grow annually since the website's launch in 2007, with over 1,173,644 visits in 2015–16.

Figure 12: Website visitors per year to PrivateHealth.gov.au



During 2015–16 PHIO has worked with industry representatives on improving the search feature for consumers using the website. One difficulty, which has been reported in consumer surveys, is that too much information and too many results are presented when searching for policies. This is a difficult issue because the website must impartially list all policies available in the marketplace. On the other hand, the office wants to make the search process as simple as possible. The office expects to make changes to the website early in 2016–17.