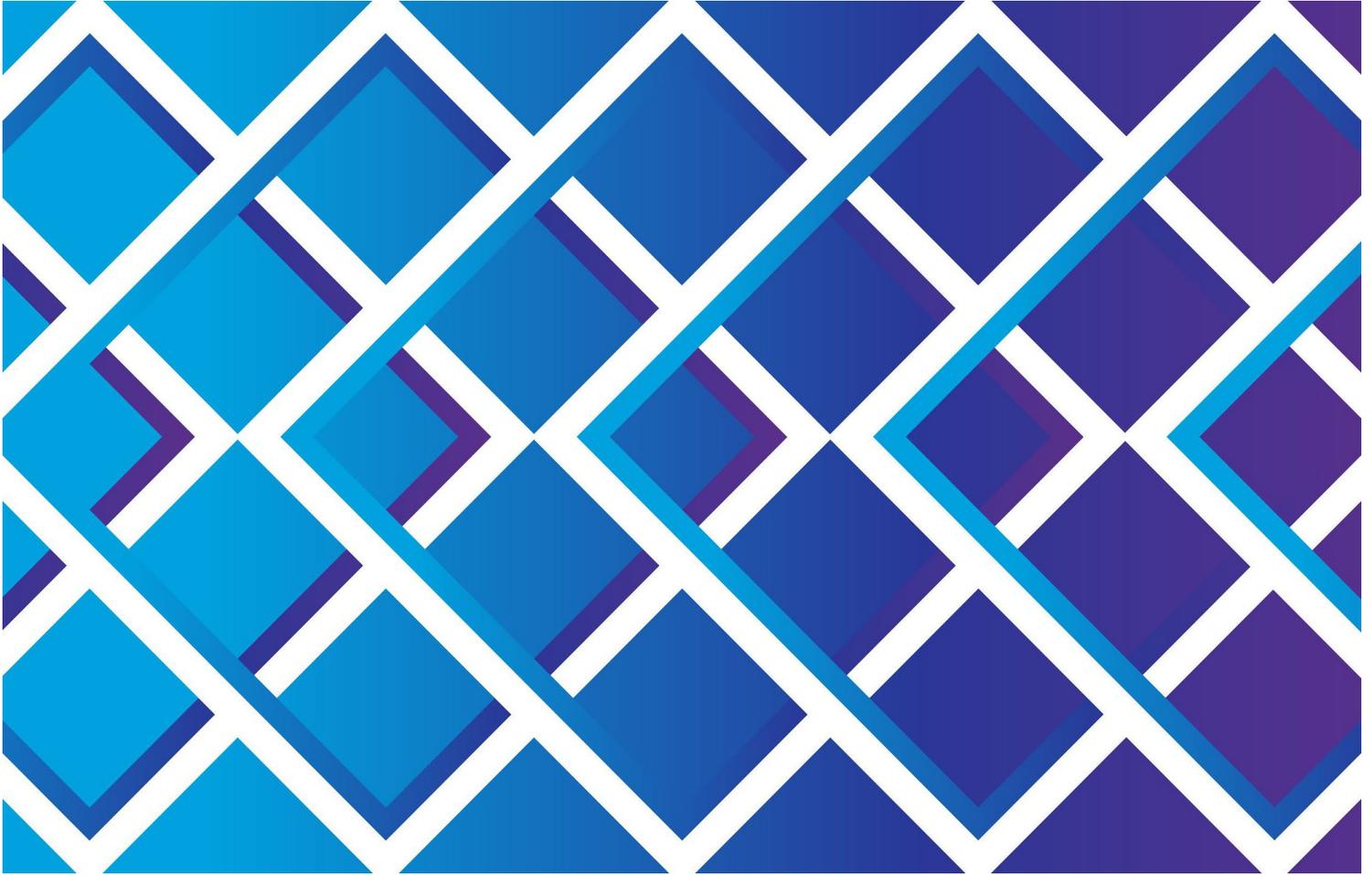


Private Health Insurance Code of Conduct

Annual Report 2024-2025



Private Healthcare Australia
Better Cover. Better Access. Better Care.



Code of Conduct Compliance Committee Annual Report

14 October 2025

Code of Conduct Compliance Committee

The Code of Conduct Compliance Committee (**Committee**) comprises of Byron Gregory (Independent Chair), Sharon Waterhouse, Samantha Gavel and Rebecca Harwood.

The Committee has held 4 meetings during July 2024-June 2025.

Private Health Insurance Code of Conduct submissions

As at 30 June 2025, twenty three submissions and two desktop audits were considered and approved by the Committee. (Noting that due to timing, not all submissions fell within the 12-month timeframe.)

Committee activities

The Committee carried out its duties in accordance with the Terms of Reference.

The Committee also carried out a review of these Terms of Reference, to ensure it reflects the current Code.

Sanctions and issues of non-compliance

During the period June 2024 – June 2025 no sanctions were issued by the Committee for any of the following actions set out in the Compliance Policy:

- Refusing or failing to cooperate with a request of the Committee in response to an alleged or suspected breach of the Code;
- Failing or refusing to comply with any recommendation by the Committee;
- Failing to adopt or comply with amendments to the Code within the timeframe required, and without an extension of time being granted by the Committee;
- Failing to implement procedures to prevent a reoccurrence of breaches identified by the Committee.

The Committee is cognisant of the media reports surrounding the Australian Competition & Consumer Commission's (ACCC) action against Bupa HI Pty Ltd. However, the issues occurred outside of the current reporting period and did not form part of the submission lodged for the most recent submission period. Notwithstanding this, Hall Advisory have taken substantial steps to query the issue and understand the actions that led to the issues.

Bupa HI Pty Ltd

As part of the regular submission cycle, Bupa Health Insurance submitted their self-audit to Hall Advisory for assessment. Two weeks prior to the Committee considering Bupa's submission, the ACCC announced it was taking action against Bupa. The Committee considered the issues and agreed to delay considering Bupa's compliance against the Code and instead, undertook an investigation through Hall Advisory.

The Committee considered the findings of the investigation by Hall Advisory in October 2025 and determined that, given the issues (which were raised in the public domain) occurred between 2018 and 2023 and are not currently in effect, the health fund was deemed at that time to be compliant with the Code. Further to this, a recent review undertaken by the Independent Auditors did not identify any current issues or gaps in the framework.

It should be noted that Bupa Health Insurance, were for a period of time, prohibited from discussing matters under investigation with Hall Advisory while the review by the Australian Competition and Consumer Commission was taking place.

Defence Health Limited

The Committee considered the compliance of Defence Health Limited and undertook an investigation through Hall Advisory. Given that the issues appear to be significantly resolved, a determination regarding the compliance status of Defence Health was finalised at the November 2024 Committee meeting and Defence Health was deemed at that time to be compliant with the Code.

The Committee continues to monitor consumer complaints and Defence Health's compliance with the Code.

The Committee notes that Defence Health is undertaking significant steps to address the issues it continues to face and the Committee will continue to monitor as part of its review process.

Private Health Insurance Code of Conduct review

The next review of the Private Health Insurance Code of Conduct will be undertaken in June 2026.

Private Health Insurance Ombudsman State of the Health Funds Report 2023

In the 2023 Private Health Insurance Ombudsman State of the Health Funds Report the Ombudsman outlined that *Complaints about benefits include those about general treatment (extras/ancillary) benefits and unexpected hospital policy exclusions and restrictions, typically about the amount the insurer paid for the service or the time it took to process a claim.*

Noting the requirement for health funds to issue Private Health Insurance Statements, the Committee sought guidance from the Commonwealth Ombudsman regarding what

constituted unexpected hospital policy exclusions and restrictions and queried if there is separation between the general complaints and those which were due to unclear information provided by the insurer.

The Committee was of the opinion that if the complaint was due to unclear information provided by the insurer, the complaint should fall under one category rather than, for example, fall under both the service-related complaints about customer service advice and benefit complaints.

Similarly, if the complaint is related to the consumer's lack of understanding regarding the limitations of their policy, the Committee is of the opinion that this type of complaint should not be included in benefits nor any category except the 'other' category.

The Committee is waiting on a detailed response from the Commonwealth Ombudsman and would welcome feedback from its signatories regarding if this is an issue they wish to see pursued.

Private Health Insurance Ombudsman State of the Health Funds Report 2024

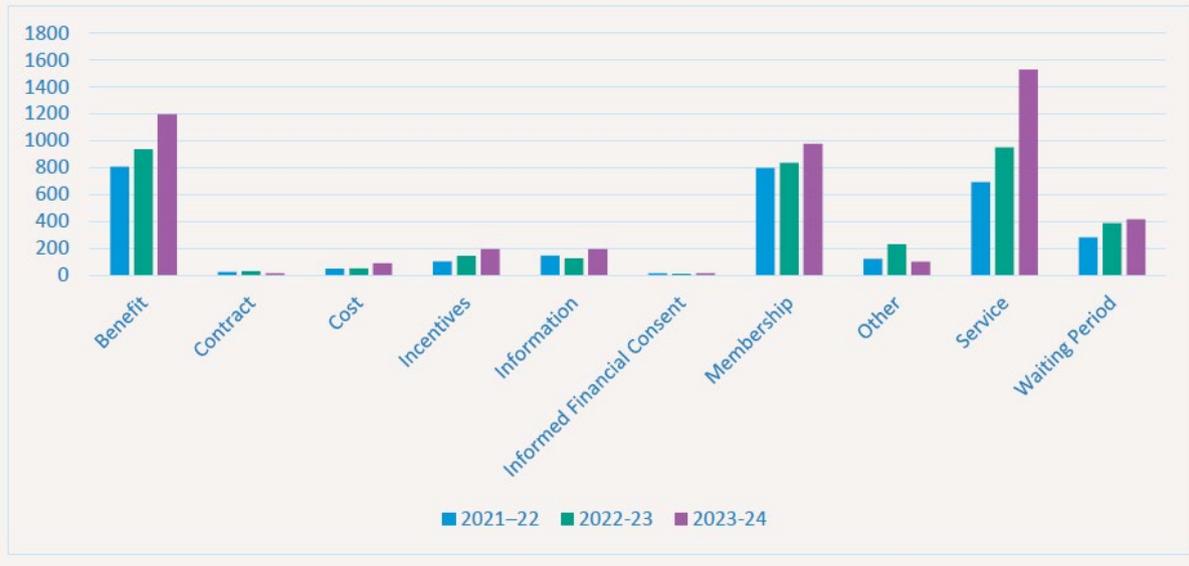
The Committee notes the importance and relevance of the 2024 State of the Health Funds Report (dated March 2025) particularly regarding the guidance it provides to health funds to assist in mitigating a number of ongoing issues.

In 2023-2024, the Office of the Commonwealth Ombudsman received 4,241 complaints about private health insurance, representing a 23.7% per cent increase in complaints received compared to 2022-2023.¹ The Office of the Commonwealth Ombudsman received 3,429 complaints in 2022-2023, 2,704 complaints in 2021-2022, 3,496 complaints in 2020-2021, 3,706 complaints in 2019-2020 and 4,553 in 2018-19.

A breakdown of the complaint issues received by the Office of the Commonwealth Ombudsman is provided below.

¹ 2024 State of the Health Funds Report https://www.ombudsman.gov.au/data/assets/pdf_file/0019/317440/state-of-the-health-funds-annual-report-2023-24.pdf

Figure 2: Complaint issues over past 3 years



Issues related to service, benefits, and membership were the dominant complaint categories received by the Office of the Commonwealth Ombudsman.

Enquires related to how private health insurance works and Lifetime Health Cover (LHC) were the dominant queries received by the Office of the Commonwealth Ombudsman, followed by enquires regarding Overseas Visitors Health Cover.

Membership complaints continue to mainly be related to membership cancellations.

The Committee again notes this is an ongoing issue and is examining this more closely.

Complaints and issues

Defence Health, BUPA and Medibank had the highest number of complaints (31.6%, 18% and 17.9% respectively) for July 2023 - June 2024 which reflects the internal issues experienced and being actively addressed by the funds.

As part of their report to the Committee, Hall Advisory identifies funds that have a large number of complaints in comparison to their market share. The Committee considers the severity of the complaints and determines if further investigation is required. Funds with high complaint ratios are usually subject to a desk audit by Hall Advisory.

Enquiries received via the code@pha.org.au email

For the period July 2024 – June 2025, queries were received and responded to:

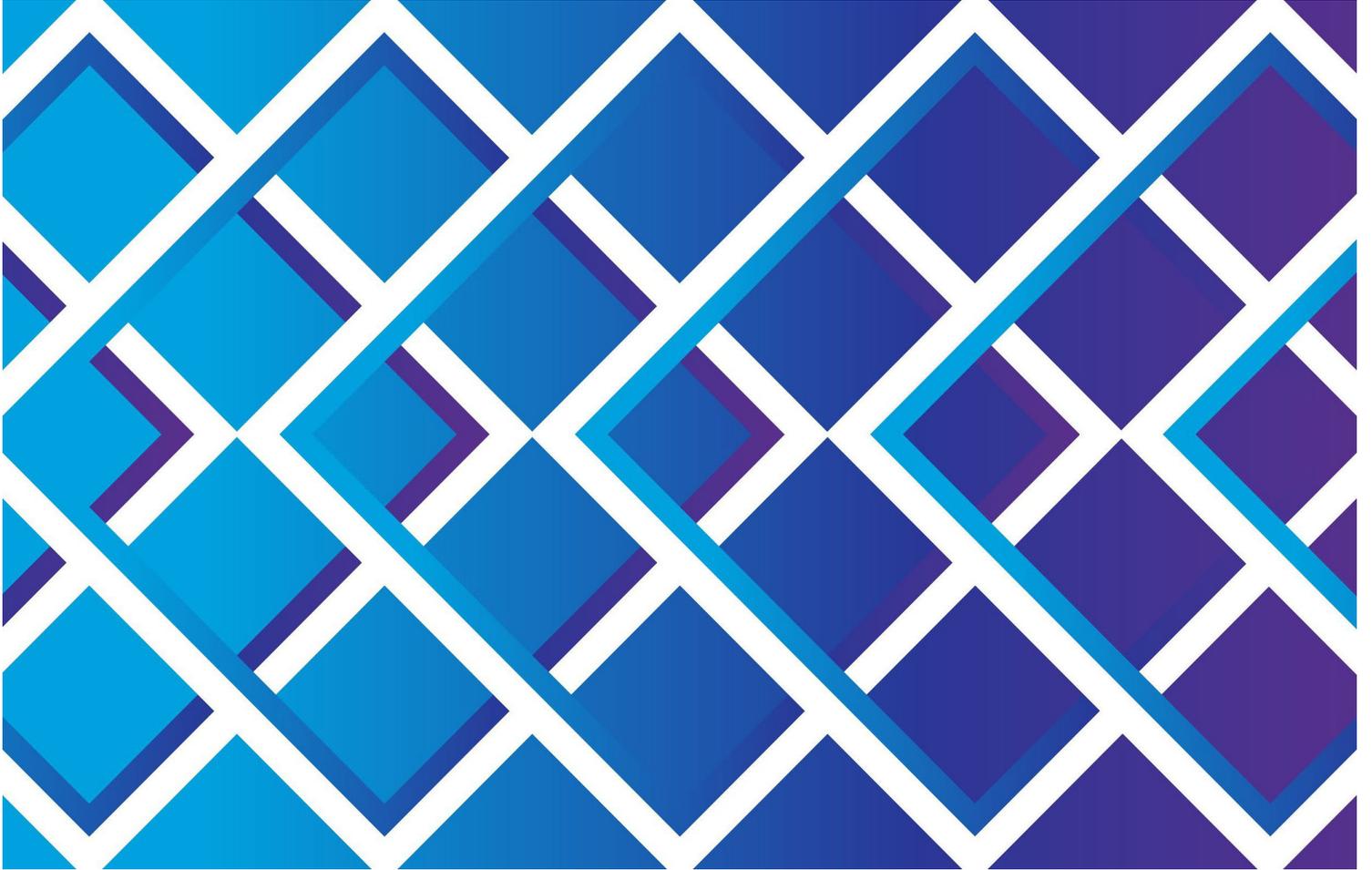
1. from a signatory regarding “vulnerable consumers” and the sector’s appetite for future alignment with the Insurance Council of Australia’s Code of Conduct;

2. from a signatory seeking guidance for communications regarding waiting periods;
3. from a consumer seeking the Committee's guidance regarding divorced parents who have two separate family policies and as such, are both paying premiums but only one family is receiving a benefit.

An additional communication was received but was ineligible.



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