COMMONWEALTH OMBUDSMAN
PRIVATE HEALTH INSURANCE

Quarterly Bulletin 94: 1 January–31 March 2020

Executive Summary

This is the 94th quarterly bulletin for the Office of the Commonwealth Ombudsman's (the Office) Private Health Insurance Ombudsman function. Our role is to protect the interests of consumers in relation to private health insurance. The Office is an independent body that acts to resolve disputes about private health insurance at all levels within the private health industry. We also report and provide advice to industry and government about these issues.

This update covers the quarter 1 January–31 March 2020 and:

- provides statistical data on complaints received, finalised and key consumer issues
- compares complaint data against previous quarters
- outlines the action we took to finalise the complaints we received.

Changes to Commonwealth Ombudsman services due to COVID-19

As part of our commitment to the health and safety of our staff, many of whom are working remotely or who have been redeployed to other public service agencies so that government resources are focused on the delivery of essential services to the Australian public, it may take longer than usual for the Office to respond to complaints. Our complaint service is continuing within this new environment but we needed to make some changes in order to respond to the demands on our services.

Our phone service has been temporarily limited to 9am to 12 noon Australian Eastern Standard Time, Monday to Friday. During this time we are encouraging complainants to lodge complaints through our online complaint form.

Private Health Insurance industry complaints in a time of COVID-19 disruption

The Office has observed significant and rapid changes within the industry, which has led to uncertainty in the community and changes in the nature of complaints we have received. Between February and April, the Office received more than 120 contacts related to COVID-19. The majority of these contacts raised issues related to suspension requests, premium costs and the inability to access hospital and general treatment services as planned. We will provide a more holistic data on the COVID-19 related complaints in our next quarterly update.

The Office's expectation is that insurers should provide flexibility and transparency to their members, and ensure that consumers are not being treated unfairly.

The majority of insurers have postponed their 1 April 2020 premium increases for at least six months.

The majority of insurers are also providing financial relief to people who have lost their jobs, are underemployed or have contracted the virus and most insurers will cover COVID-19 treatment for existing policyholders.

The Office encourages consumers to contact their insurer in the first instance if they have any questions or concerns regarding their membership.

Overseas Student Health Cover updates

Overseas Student Health Cover (OSHC) policies assist in covering the costs of hospital and medical treatment as well as ambulance services. The minimum requirements of an OSHC policy are set out in the OSHC Deed.

The Department of Health has recently published two documents which help to explain how OSHC works. The Explanatory Guidelines for the Deed and a one-page Factsheet are now available on the Department's website. For further information, check with your OSHC insurer.

OSHC and COVID-19

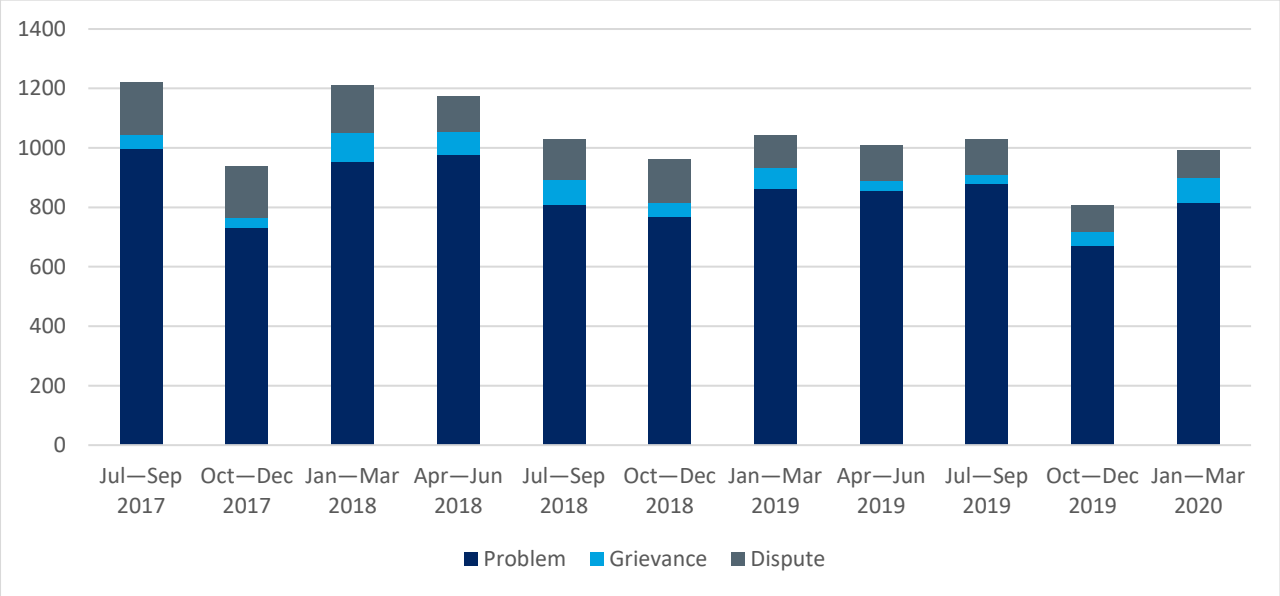
OSHC includes cover for COVID-19 related illnesses, principally "lung and chest", "kidney and bladder" and "dialysis for chronic kidney failure" clinical categories. International students who are stranded in Australia, due to mandated travel restrictions put in place by the Australian Government in response to the pandemic, are encouraged to contact their private health insurer for further assistance to ensure continuity of cover during this time. For more information see the Department of Health website.

Complaints received

The Office received 991 private health insurance complaints this quarter. This represented a decrease of 4.9 per cent compared to the same period last year, but a 23.1 per cent increase compared to the previous quarter. Complaints are typically lower in the December quarter, due to the holiday period, and higher in the March quarter due to increased consumer attention on private health insurance due to the rate increase. This year, there was additional attention on the sector as a result of the COVID-19 pandemic, with consumers requesting a delay in the rate increases and consideration of premium suspension, due to reduced access to services or financial hardship.

Complaints received by quarter

Figure 1—Complaints received by quarter



Complaints and enquiries finalised

Timeframes to finalise complaints in the quarter

This quarter we received 991 complaints and finalised 1,041 complaints. A complaint is finalised when no further action is being taken in response to the complaint.

During 1 January–31 March 2020 the Office met its private health insurance complaints service standards.

Table 1—Complaint handling service standards

Complaints finalised	Timeframe	Service Standard
78.1%	Within 2 business days	70%
86.9%	Within 7 days	85%
92.3%	Within 30 days	90%
96.8%	Within 90 days	95%
99.9%	Within 12 months	99%

This quarter we received 706 private health insurance enquiries and finalised 700. All enquiries received in the quarter were finalised within our service standards.

Table 2—Enquiries service standards

Enquiries finalised	Timeframe	Service Standard
100%	Within 2 business days	95%
100%	Within 7 days	99%

Actions taken to finalise complaints in the quarter

Assisted referral

Almost 70 per cent of complaints were finalised through an assisted referral, where we refer the case to the insurer for reconsideration. Once a complaint has been referred, we have an agreed standard with insurers where they will make initial contact with the complainant within three business days. They also report the outcome to our Office once the complaint is finalised.

If the complaint is not resolved through the assisted referral process, the complainant can return to the Office for further assistance. Our client survey results indicate that consumers generally have higher satisfaction when their complaint is resolved through an assisted referral, rather than complaints that require us to investigate. When we refer a complaint to an insurer, some of the common outcomes include: the insurer reconsiders the person's complaint, expedites an action for the complainant or provides the complainant with a better explanation.

Standard referral

In some cases, we may provide advice to the complainant, enabling them to lodge their 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 the Office for further assistance.

Further explanation

We listen to the concerns of the complainant and provide advice on what we would consider an appropriate response from the insurer or service provider. The complaint is then either finalised because the complainant accepts the explanation we provide or they decide not to continue with the complaint.

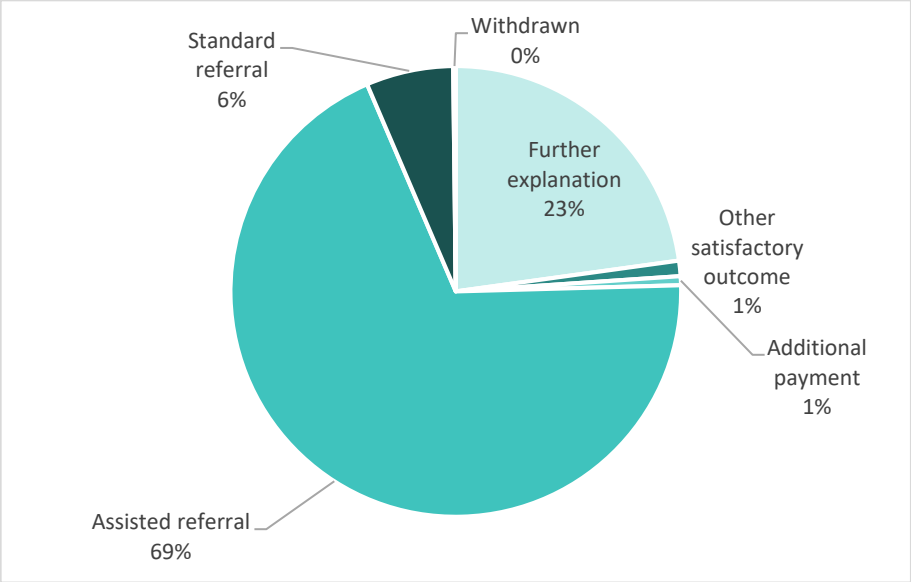
Withdrawn

In some cases, complainants make complaints to our Office but later withdraw their complaint, or fail to respond to requests for further information.

Other

Other satisfactory outcomes can include reconsideration of the matter by the insurer, backdating a change in cover, or expedited action.

Figure 2—All complaints finalised January–March 2020



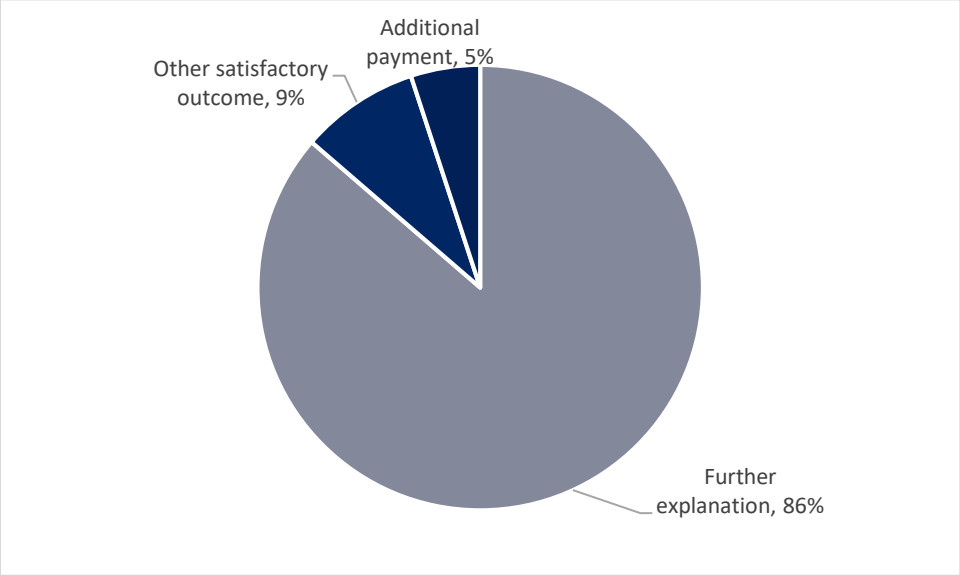
Disputes

During the quarter we finalised 129 disputes. Disputes are a higher level complaint where the Office investigates the matter further. As part of our investigation process we request detailed information from the health insurer (or other organisation) and then consider whether the initial response was satisfactory or if further investigation is warranted.

In this quarter:

- 86 per cent of disputes were finalised by providing the complainants with further explanation.
- Nine per cent of complaints were resolved through other satisfactory outcomes, which include: reconsideration of the matter by the insurer, backdating a change in cover, or expedited action.
- Five per cent of disputes in this quarter were finalised through a further payment to the complainant.

Figure 3—Disputes finalised January–March 2020



Complaint issues

The top consumer complaint issues this quarter included:

1. General treatment: 101 complaints—these complaints usually concern disputes over 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).

2. Pre-existing conditions waiting period: 78 complaints—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, or the complainant misunderstanding how a pre-existing condition is defined. The Office is able to seek a better explanation of the insurer's medical practitioner's decision as well as provide an impartial review based on the medical evidence.

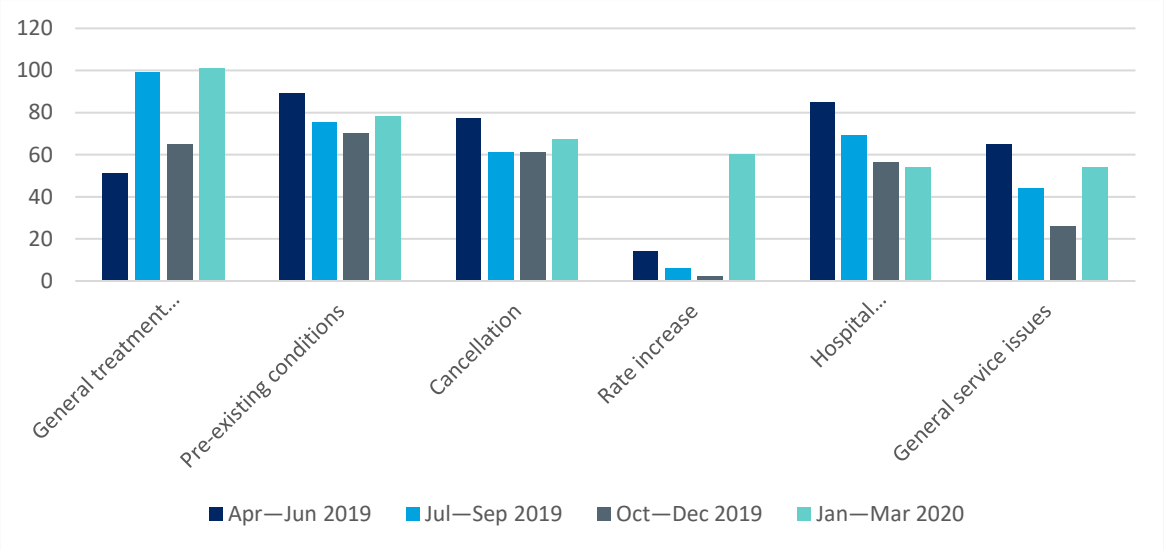
3. Membership cancellation: 67 complaints—these complaints are caused by problems and delays associated with processing requests to cancel memberships and handling payments or refunds. It is important to note that in most cases these membership cancellations are caused by consumers transferring from one insurer to another and not the result of people leaving private health insurance altogether.

4. Rate increase: 60 complaints—insurers are permitted to increase their rates once per year, following an application to and approval from the Minister of Health. The rate increase usually applies on 1 April of each year, so the March quarter is typically the period in which we receive a high volume of complaints on this issue. This year, a number of rate increase complaints were related to the COVID-19 pandemic, with consumers requesting a cancellation or delay of the rate increase due to financial hardship or lack of access to services. The majority of insurers decided to delay the 1 April rate increase for a period of 6 months.

5. Hospital exclusions and restrictions: 54 complaints—these complaints usually arise when complainants find they are not covered for a service or treatment that they had assumed was included in their cover, leaving them unable to access or incurring large expenses to access the hospital treatment they need.

6. **General service issues: 54 complaints**—service issues are not usually the sole reason for complaints. A combination of unsatisfactory customer service, untimely responses to simple issues, and poor internal escalation processes can cause policy-holders to grow increasingly aggrieved and dissatisfied with their dealings with the insurer, until the service itself becomes a cause of complaint as well as the original issue.

Figure 4—Top complaint issues



Complaints by provider or organisation type

The majority of complaints handled by the Office are about Australian private health insurers. However, we also handle complaints about other providers, so long as it relates to private health insurance arrangements.

Table 3—Complaints by provider or organisation type

Provider or organisation type	Jun 2019 quarter	Sep 2019 quarter	Dec 2019 quarter	Mar 2020 quarter
Health insurers	846	851	706	852
Overseas visitors and overseas student health insurers	111	132	70	80
Brokers and comparison services	16	12	6	10
Doctors, dentists and other medical providers	2	3	2	8
Hospitals and area health services	10	12	4	6
Other (e.g. legislation, ambulance services, industry peak bodies)	23	19	17	35

Table 4—Complaints and disputes compared to health insurer market share

Name of insurer	Complaints[1]	Percentage of complaints	Disputes[2]	Percentage of disputes	Market share[3]
ACA Health Benefits	0	0.0%	0	0.0%	0.1%
Australian Unity	31	3.6%	0	0.0%	2.7%
BUPA	190	22.3%	10	16.4%	25.8%
CBHS Corporate Health	0	0.0%	0	0.0%	<0.1%
CBHS	21	2.5%	3	4.9%	1.5%
CDH (Cessnock District Health)	2	0.2%	0	0.0%	<0.1%
CUA Health	7	0.8%	1	1.6%	0.6%
Defence Health	17	2.0%	1	1.6%	2.1%
Doctors' Health Fund	4	0.5%	0	0.0%	0.3%
Emergency Services Health	1	0.1%	0	0.0%	<0.1%
GMHBA	32	3.8%	1	1.6%	2.3%
Grand United Corporate Health	15	1.8%	3	4.9%	0.5%
HBF Health & GMF/Healthguard	35	4.1%	3	4.9%	7.5%
HCF (Hospitals Contribution Fund)	136	16.0%	12	19.7%	11.1%
HCI (Health Care Insurance)	1	0.1%	0	0.0%	0.1%
Health Partners	9	1.1%	1	1.6%	0.7%
Health.com.au	8	0.9%	2	3.3%	0.6%
HIF (Health Insurance Fund of Aus.)	18	2.1%	3	4.9%	0.8%
Latrobe Health	9	1.1%	0	0.0%	0.7%
Medibank Private & AHM	184	21.6%	12	19.7%	26.9%
Mildura District Hospital Fund	0	0.0%	0	0.0%	0.2%
MO Health Pty Ltd (myOwn)	13	1.5%	5	8.2%	0.2%
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
Navy Health	2	0.2%	0	0.0%	0.3%
NIB Health	69	8.1%	1	1.6%	8.6%
Nurses and Midwives Pty Ltd	2	0.2%	0	0.0%	0.1%
Peoplecare	2	0.2%	0	0.0%	0.5%
Phoenix Health Fund	2	0.2%	0	0.0%	0.1%
Police Health	1	0.1%	0	0.0%	0.3%
QLD Country Health Fund	0	0.0%	0	0.0%	0.4%
Railway & Transport Health	3	0.4%	1	1.6%	0.4%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Lukes Health	3	0.4%	0	0.0%	0.5%
Teachers Federation Health	17	2.0%	1	1.6%	2.4%
Transport Health	6	0.7%	0	0.0%	0.1%
TUH	1	0.1%	0	0.0%	0.6%
Westfund	11	1.3%	1	1.6%	0.7%
Total for Health Insurers	**852**	**100%**	**61**	**100%**	**100%**

[1] Total number of complaints (Problems, Grievances & Disputes) regarding Australian registered health insurers. This table excludes complaints regarding OVHC and OSHC insurers, and other bodies.
[2] Disputes required the intervention of the Ombudsman and the health insurer.
[3] Source: Australian Prudential Regulation Authority, Market Share, All Policies, 30 June 2019.

Table 5—Complaint issues and sub-issues

ISSUE Sub issue	Jun 19	Sep 19	Dec 19	Mar 20
BENEFIT				
Accident and emergency	14	12	9	15
Accrued benefits	4	4	0	1
Ambulance	17	12	18	8
Amount	11	10	4	5
Delay in payment	28	28	12	18
Excess	14	14	14	9
Gap — Hospital	18	30	9	27
Gap — Medical	25	21	20	27
General treatment (extras/ancillary)	51	99	65	101
High cost drugs	0	3	5	1
Hospital exclusion/restriction	85	69	56	54
Insurer rule	17	23	27	27
Limit reached	4	5	3	2
New baby	1	1	2	1
Non-health insurance	1	0	0	1
Non-health insurance — overseas benefits	0	0	0	0
Non-recognised other practitioner	0	0	0	6
Non-recognised podiatry	0	2	1	2
Other compensation	0	3	2	1
Out of pocket not elsewhere covered	8	10	1	9
Out of time	3	1	2	0
Preferred provider schemes	15	5	5	7
Prostheses	7	4	4	4
Workers compensation	2	1	2	4
CONTRACT				
Hospitals	4	3	1	0
Preferred provider schemes	5	2	6	3
Second tier default benefit	2	0	0	0
COST				
Dual charging	3	2	4	4
Rate increase	14	6	2	60
INCENTIVES				
Lifetime Health Cover	42	51	34	42
Medicare Levy Surcharge	1	9	7	3
Private health insurance reforms	20	8	21	9
Rebate	4	6	1	1
Rebate tiers and surcharge changes	0	0	0	0
INFORMATION				
Brochures and websites	10	1	6	7
Lack of notification	9	16	16	16
Radio and television	0	0	0	0
Standard Information Statement	3	1	0	3
Verbal advice	62	99	60	46
Written advice	11	9	7	10

ISSUE Sub issue	Jun 19	Sep 19	Dec 19	Mar 20
INFORMED FINANCIAL CONSENT				
Doctors	1	4	2	6
Hospitals	6	8	2	2
Other	0	2	0	2
MEMBERSHIP				
Adult dependents	3	6	1	6
Arrears	14	5	10	12
Authority over membership	10	4	4	4
Cancellation	77	61	61	67
Clearance certificates	31	28	18	24
Continuity	22	20	14	27
Rate and benefit protection	5	2	2	6
Suspension	16	14	12	21
SERVICE				
Customer service advice	17	22	12	21
General service issues	65	44	26	54
Premium payment problems	58	60	35	45
Service delays	31	20	31	23
WAITING PERIOD				
Benefit limitation period	0	3	0	0
General	12	12	7	13
Obstetric	9	9	11	7
Other	5	1	6	2
Pre-existing conditions	89	75	70	78
OTHER				
Access	0	1	1	4
Acute care and type C certificates	7	8	3	2
Community rating	0	0	0	1
Complaint not elsewhere covered	6	11	3	8
Confidentiality and privacy	3	7	3	7
Demutualisation/sale of health insurers	1	0	0	0
Discrimination	1	2	1	0
Medibank sale	0	0	0	0
Non-English speaking background	0	0	0	0
Non-Medicare patient	2	0	0	1
Private patient election	3	1	2	3
Rule change	27	56	51	26

Data

The data in this update is for the period 1 January—31 March 2020. Our data is dynamic and regularly updated as new information comes to light. For this reason, there may be minor differences in data when compared to what was reported in the last quarterly update. Previous quarterly updates are available on the Ombudsman's website.

More information is available at https://www.ombudsman.gov.au/How-we-can-help/private-health-insurance