COMMONWEALTH OMBUDSMAN
PRIVATE HEALTH INSURANCE

Quarterly Bulletin 95: 1 April–30 June 2020

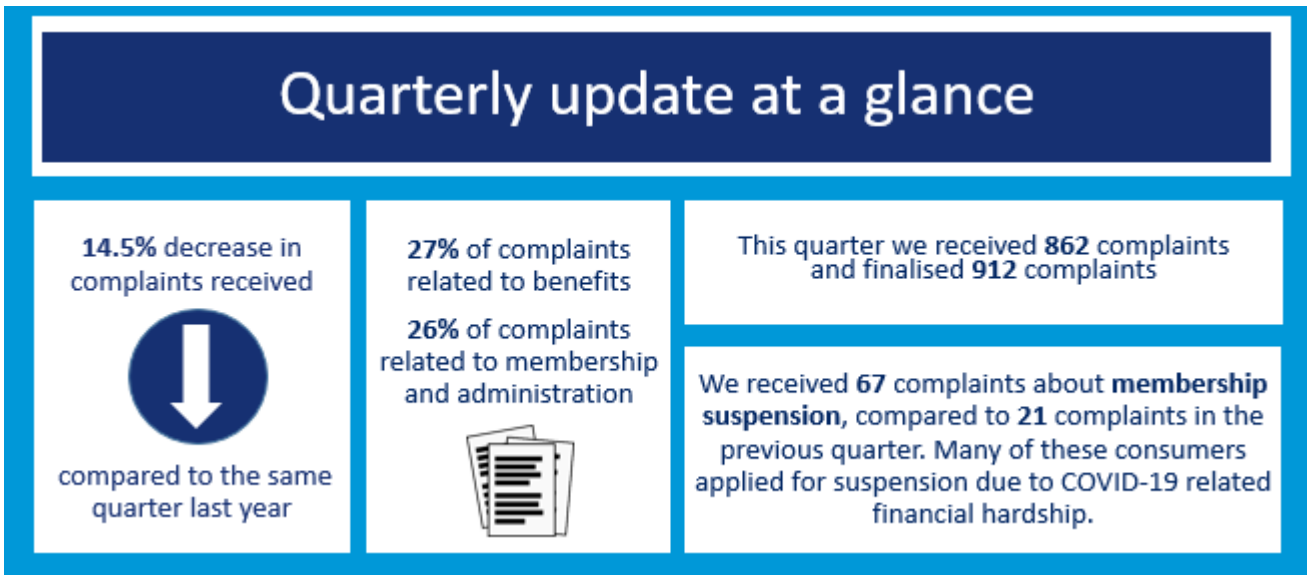
Executive Summary

This is the 95th 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 report and provide advice to industry and government about these issues.

The impact of COVID-19 on the private health insurance industry is reflected in the complaints received by the Office this quarter. We observed significant and rapid changes within the industry over this period due to consumers experiencing financial hardship and being unable to access planned hospital treatments and routine general treatment services. Almost all insurers postponed their 1 April 2020 premium increases for at least six months, and the majority also introduced provisions to provide financial relief to impacted members. There was a decrease in the overall number of complaints but an increase in specific complaint issues - the number of complaints about suspension of membership tripled compared to the previous quarter. The Office continued to provide its services in this period, with many staff transitioning to work from home arrangements.

This update covers the quarter 1 April–30 June 2020 and:

- provides an overview of the Office's complaint handling activities and stakeholder engagement work throughout 2019–20
- 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.



COVID-19

Complaints

In the February to June 2020 period, the Office received 212 complaints and 43 enquiries 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. The top five issues were:

1. Membership suspension: 62 complaints—consumers seeking temporary suspensions of membership due to financial hardship as a result of COVID-19.
2. Rate increase: 39 complaints—almost all insurers postponed their 1 April 2020 premium increases for at least six months. Many of these complaints were received prior to the postponement announcement in late March. However, a number of complainants have stated their view that insurers should be reducing premiums or not charge at all for a period when access to services is limited.
3. Access: 24 complaints—these complaints related to difficulty in accessing services such as elective surgery and extras benefits due to COVID-19 restrictions.
4. Membership cancellation: 13 complaints—8 out of 13 complaints about cancellation related to Overseas Visitors and Overseas Students, typically because they have been unable to continue or commence their studies due to COVID-19 restrictions.
5. General treatment benefits: 10 complaints—these complaints related specifically to difficulties in accessing extras benefits due to COVID-19 restrictions.

Reasonable notice of changes

The majority of insurers postponed their 1 April 2020 premium increases for at least six months. The majority of insurers provided financial relief to people who have lost their jobs, are underemployed or contracted COVID-19 and most insurers will cover COVID-19 treatment for existing policyholders.

Some insurers have asked what kind of notification is required when reversing these measures or unfreezing of premiums.

The Office recommends that insurers provide advance notice to customers when any benefits are removed or when premiums increase. Consumers should be afforded an opportunity to consider their options in advance. The Office suggests at least one—and preferably two—month's notice should be provided for a change in premiums so consumers can make any necessary financial arrangements. Insurers should take whatever reasonable action they can to notify consumers accordingly via the member's preferred contact method.

2019–20 in focus

During 2019–20, we continued to deliver services to the public with minimal disruptions from bushfires and COVID-19. The effects of COVID-19 on our complaint numbers can be seen in this quarter.

The following summarises the work that the Office undertook relating to private health insurance this financial year:

- In 2019–20, the Office received 3,706 complaints about private health insurance, representing an 8.3 per cent decrease in complaints received compared to 2018–19. In the same period we also received 2,049 private health insurance enquiries.[1]

- Consumers used privatehealth.gov.au to view and compare every policy available in Australia, with each product summarised in a simplified Private Health Information Statement (PHIS) format. In 2019–20, the website had over 1 million visitors and more than 2.2 million PHIS downloads. We also implemented changes following the conclusion of the Private Health Insurance Reforms transition period on 1 April 2020. Under the reforms, all

[1] The methodology for counting private health insurance enquiries changed during 2019–20 so this figure is not directly comparable to the previous year.

private hospital insurance policies are categorised into Gold, Silver, Bronze and Basic tiers, and standardised Clinical Categories make it clearer as to what services are covered.

- We published *A Quick Guide to the Private Health Insurance Ombudsman's New Inspection Powers*, following consultation with private health insurance stakeholders. This document summarises the Office's powers to conduct inspections of private health insurers and health insurance brokers. This document is available online at: ombudsman.gov.au/How-we-can-help/private-health-insurance/private-health-insurance

- We updated the Office's *Mediation Guidelines* and the *Termination and Transition Guidelines for Hospitals and Insurers*. These documents were finalised after taking into account the feedback provided from our private health insurance stakeholders. We would like to acknowledge the stakeholders that provided comments and suggestions. These guidelines are available online at: ombudsman.gov.au/How-we-can-help/private-health-insurance/private-health-insurance.

- In May 2020 the Office provided voluntary mediation for a contract dispute between a group of insurers and a group of hospitals. Since then the two parties came to an agreement. This is a positive outcome for the close to 2 million consumers potentially impacted by contract arrangements between the two parties.

- The *State of the Health Funds Report 2019* was published in February 2020. The report gives comparative information on the performance and service delivery of all health insurers and provides consumers with information to help them make decisions about private health insurance. The report is available online at: ombudsman.gov.au/publications/reports/state-of-the-health-funds. We will publish our next annual State of the Health Funds report in 2020–21.

Medical gaps and out of pocket costs

The Office recently updated our online information about out of pocket costs. The Out of Pockets Costs page on **privatehealth.gov.au** and the Informed Financial Consent factsheet on **ombudsman.gov.au** have been revised to include more information for consumers about what to expect from medical fees as a private patient, how to avoid unexpected out of pocket costs and what steps they can take if their bill is much higher than expected.

Generally, we suggest that consumers should first contact their doctor's or health care provider's office to check whether they agreed to these charges before treatment and discuss the reasons for the various charges. If they still consider the charge to be unfair or more than they were advised, we suggest they pay at least the part of the bill they expected and write a letter to their doctor explaining their circumstances.

If they can't resolve their issue directly with their doctor or health care provider, consumers can seek assistance from other organisations including our Office. A full list of complaint bodies that can assist with this type of complaint can be found on the Out of Pockets Costs page.

2019–20 client satisfaction survey

The Office carries out a regular survey of people who have accessed our services. In 2019–20, we used a mix of online and postal surveys, but in 2020–21, we intend to transition to a primarily online survey process.

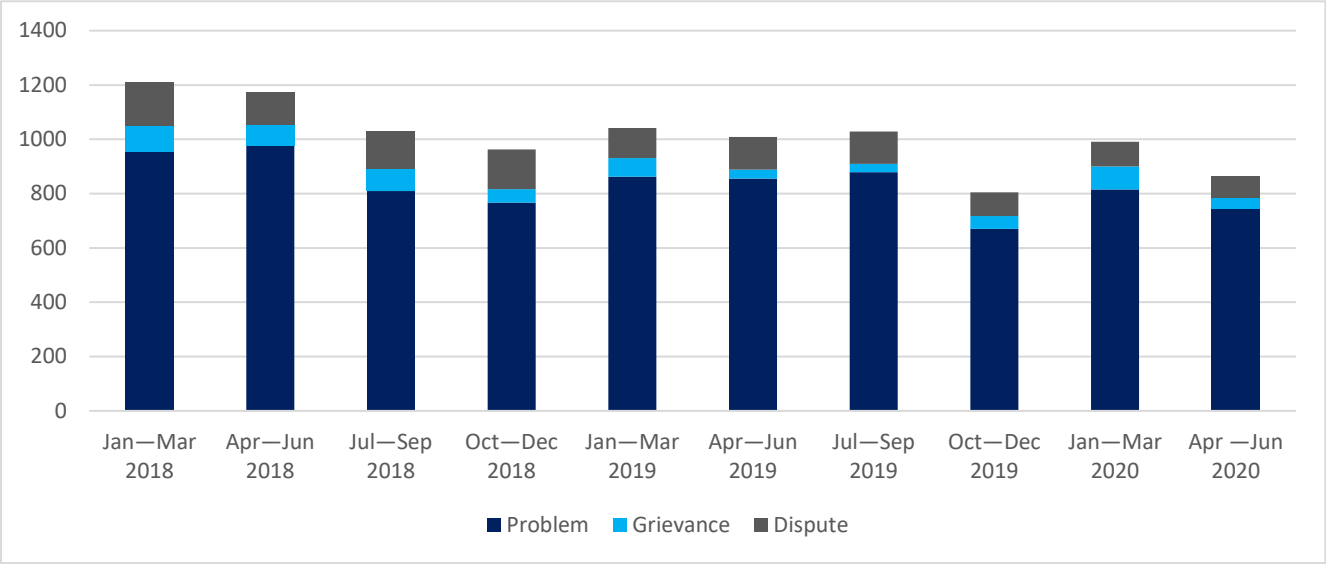
We received an overall satisfaction rating of 81 per cent from 138 responses, and 81 per cent of respondents also stated they would recommend the Ombudsman's services to friends and family. While these are pleasing results, we note these are lower than the previous year's ratings of 89 per cent on both metrics. We will continue to monitor our survey results and look for ways to improve the consumer experience with our Office.

Complaints and enquiries received

The Office received 862 private health insurance complaints this quarter. This represented a decrease of 14.5 per cent compared to the same period last year. We anticipate that COVID-19 may have impacted complaint numbers as consumers weren't accessing their benefits during this quarter, leading to less complaints. We will continue to watch the trends as the COVID-19 environment continues to change.

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 862 and finalised 912 complaints. A complaint is finalised when we determine that no further action will be taken. This is usually because the issue raised has been resolved, we have referred the issue to the private health insurer for a resolution or we are assured that the private health insurer has made the right decision.

During this period we met three of our five service standards, and were within 3 per cent of the remaining two service standards.

Table 1—Complaint handling service standards 1 April–30 June 2020

Timeframe	Service Standard	Complaints finalised
Within 2 business days	70%	77.8%
Within 7 days	85%	82.4%
Within 30 days	90%	87.3%
Within 90 days	95%	95.3%
Within 12 months	99%	99.7%

This quarter we received 579 and finalised 582 enquiries. All enquiries received in the quarter were finalised within our service standards.

Table 2—Enquiries service standards 1 April–30 June 2020

Timeframe	Service Standard	Enquiries finalised
Within 2 business days	95%	96.3%
Within 7 days	99%	99.4%

Actions taken to finalise complaints in the quarter

Assisted referral

73 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, insurers will make initial contact with the complainant within three business days. They will 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 us 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, the insurer may reconsider the complaint, expedite an action or provide 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 again return to us 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. Providing assurance to the public that the decision of an insurer was made according to their processes or the rules, can be very helpful.

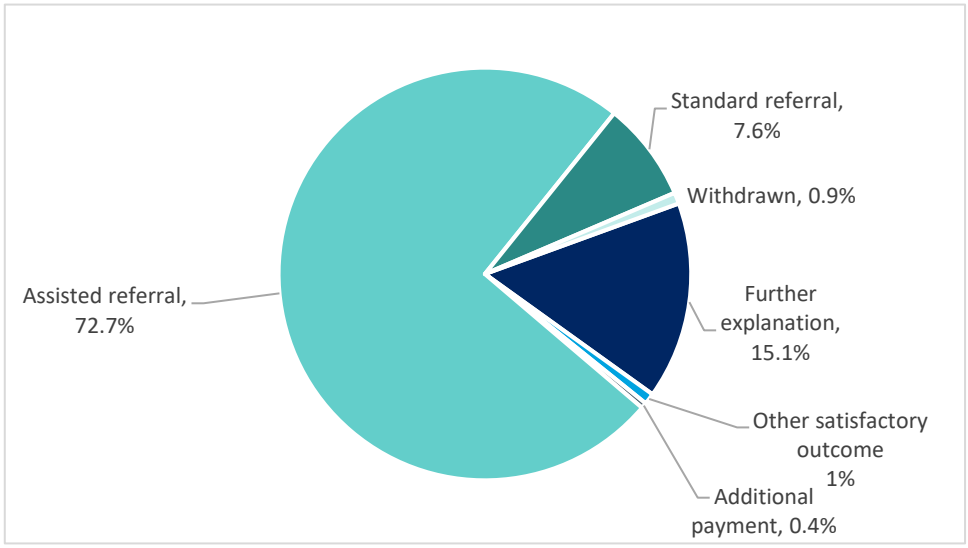
Withdrawn

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 April–June 2020



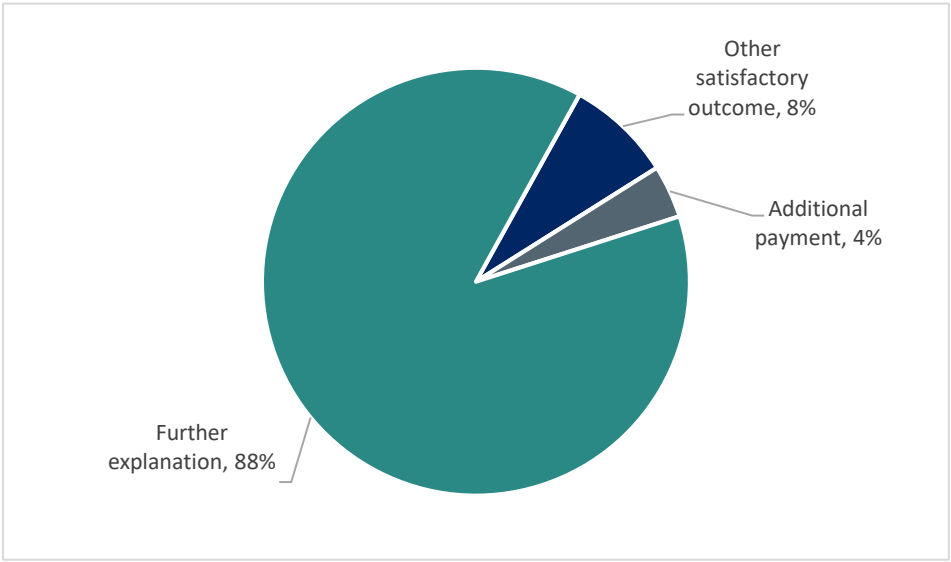
Disputes

During the quarter we finalised 78 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:

- 89 per cent of disputes were finalised by providing complainants with further explanation
- 8 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
- 4 per cent of disputes in this quarter were finalised through a further payment to the complainant.

Figure 3—Disputes finalised April–June 2020

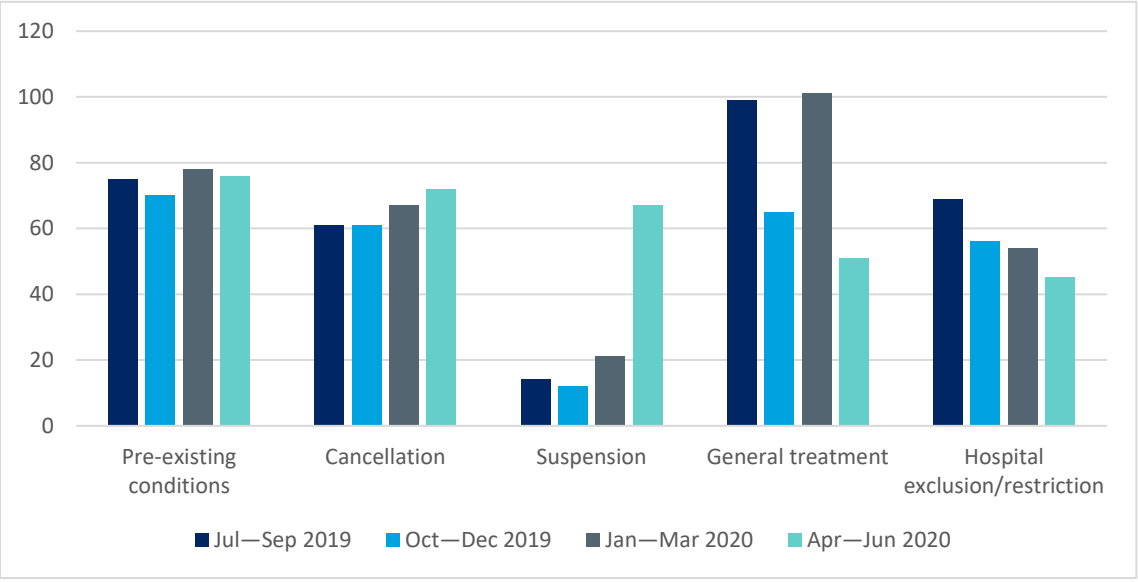


Complaint issues

The top five consumer complaint issues this quarter were:

1. **Pre-existing conditions waiting period: 76 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.
2. **Membership cancellation: 72 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.
3. **Membership suspension: 67 complaints**–insurers may allow consumers to suspend their coverage for reasons such as travelling overseas or financial hardship. During suspension, no premiums are paid and no benefits are payable, but the person's membership remains continuous. This quarter there was a significant increase in suspension requests due to more consumers experiencing financial hardship as a result of COVID-19. The majority of these complaints to the Office were resolved directly by the relevant insurer, following an assisted referral.
4. **General treatment benefits: 51 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).
5. **Hospital exclusions and restrictions: 45 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.

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	Sep 2019 quarter	Dec 2019 quarter	Mar 2020 quarter	Jun 2020 quarter
Health insurers	851	706	852	741
Overseas visitors and overseas student health insurers	132	70	80	81
Brokers and comparison services	12	6	10	5
Doctors, dentists and other medical providers	3	2	8	3
Hospitals and area health services	12	4	6	7
Other (e.g. legislation, ambulance services, industry peak bodies)	19	17	35	25

Table 4—Complaints and disputes compared to health insurer market share 1 April–30 June 2020

Name of insurer	Complaints[2]	Percentage of complaints	Disputes[3]	Percentage of disputes	Market share[4]
ACA Health Benefits	0	0.0%	0	0.0%	0.1%
Australian Unity	44	5.9%	2	3.6%	2.7%
BUPA	164	22.1%	16	29.1%	25.8%
CBHS Corporate Health	0	0.0%	0	0.0%	<0.1%
CBHS	19	2.6%	0	0.0%	1.5%
CDH (Cessnock District Health)	0	0.0%	0	0.0%	<0.1%
CUA Health	4	0.5%	0	0.0%	0.6%
Defence Health	18	2.4%	0	0.0%	2.1%
Doctors' Health Fund	2	0.3%	0	0.0%	0.3%
Emergency Services Health	1	0.1%	0	0.0%	<0.1%
GMHBA	16	2.2%	2	3.6%	2.3%
Grand United Corporate Health	8	1.1%	0	0.0%	0.5%
HBF Health & GMF/Healthguard	23	3.1%	0	0.0%	7.5%
HCF (Hospitals Contribution Fund)	144	19.4%	8	14.5%	11.1%
HCI (Health Care Insurance)	0	0.0%	0	0.0%	0.1%
Health Partners	3	0.4%	0	0.0%	0.7%
Health.com.au	13	1.8%	3	5.5%	0.6%
HIF (Health Insurance Fund of Aus.)	14	1.9%	2	3.6%	0.8%
Latrobe Health	5	0.7%	0	0.0%	0.7%
Medibank Private & AHM	158	21.3%	10	18.2%	26.9%
Mildura District Hospital Fund	0	0.0%	0	0.0%	0.2%
MO Health Pty Ltd (myOwn/AIA)[5]	3	0.4%	2	3.6%	0.2%
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
Navy Health	5	0.7%	1	1.8%	0.3%
NIB Health	39	5.3%	1	1.8%	8.6%
Nurses and Midwives Pty Ltd	0	0.0%	0	0.0%	0.1%
Peoplecare	3	0.4%	0	0.0%	0.5%
Phoenix Health Fund	2	0.3%	0	0.0%	0.1%
Police Health	4	0.5%	0	0.0%	0.3%
QLD Country Health Fund	1	0.1%	0	0.0%	0.4%
Railway & Transport Health	5	0.7%	2	3.6%	0.4%
Reserve Bank Health	1	0.1%	0	0.0%	<0.1%
St Lukes Health	6	0.8%	3	5.5%	0.5%
Teachers Federation Health	26	3.5%	1	1.8%	2.4%
Transport Health	3	0.4%	0	0.0%	0.1%
TUH	0	0.0%	0	0.0%	0.6%
Westfund	7	0.9%	2	3.6%	0.7%
Total for Health Insurers	**741**	**100%**	**55**	**100%**	**100%**

[2] Total number of complaints (Problems, Grievances & Disputes) regarding Australian registered health insurers. This table excludes complaints regarding OVHC and OSHC insurers and other bodies.
[3] Disputes required the intervention of the Ombudsman and the health insurer.
[4] Source: Australian Prudential Regulation Authority, Market Share, All Policies, 30 June 2019.
[5] MyOwn was renamed AIA Health as of 30 July 2020.

Table 5—Complaint issues and sub-issues 1 April–30 June 2020

ISSUE Sub issue	Sep 19	Dec 19	Mar 20	Jun 20
BENEFIT				
Accident and emergency	12	9	15	7
Accrued benefits	4	0	1	1
Ambulance	12	18	8	10
Amount	10	4	5	4
Delay in payment	28	12	18	20
Excess	14	14	9	10
Gap — Hospital	30	9	27	16
Gap — Medical	21	20	27	19
General treatment (extras/ancillary)	99	65	101	51
High cost drugs	3	5	1	1
Hospital exclusion/restriction	69	56	54	45
Insurer rule	23	27	27	21
Limit reached	5	3	2	1
New baby	1	2	1	4
Non-health insurance	0	0	1	1
Non-health insurance — overseas benefits	0	0	0	1
Non-recognised other practitioner	0	0	6	4
Non-recognised podiatry	2	1	2	3
Other compensation	3	2	1	3
Out of pocket not elsewhere covered	10	1	9	0
Out of time	1	2	0	2
Preferred provider schemes	5	5	7	5
Prostheses	4	4	4	1
Workers compensation	1	2	4	0
CONTRACT				
Hospitals	3	1	0	11
Preferred provider schemes	2	6	3	3
Second tier default benefit	0	0	0	0
COST				
Dual charging	2	4	4	6
Rate increase	6	2	60	28
INCENTIVES				
Lifetime Health Cover	51	34	42	43
Medicare Levy Surcharge	9	7	3	0
Private health insurance reforms	8	21	9	3
Rebate	6	1	1	3
Rebate tiers and surcharge changes	0	0	0	0
INFORMATION				
Brochures and websites	1	6	7	1
Lack of notification	16	16	16	14
Radio and television	0	0	0	1
Standard Information Statement	1	0	3	5
Verbal advice	99	60	46	22
Written advice	9	7	10	2

ISSUE Sub issue	Sep 19	Dec 19	Mar 20	Jun 20
INFORMED FINANCIAL CONSENT				
Doctors	4	2	6	2
Hospitals	8	2	2	1
Other	2	0	2	3
MEMBERSHIP				
Adult dependents	6	1	6	6
Arrears	5	10	12	6
Authority over membership	4	4	4	12
Cancellation	61	61	67	72
Clearance certificates	28	18	24	39
Continuity	20	14	27	21
Rate and benefit protection	2	2	6	0
Suspension	14	12	21	67
SERVICE				
Customer service advice	22	12	21	12
General service issues	44	26	54	23
Premium payment problems	60	35	45	37
Service delays	20	31	23	21
WAITING PERIOD				
Benefit limitation period	3	0	0	0
General	12	7	13	13
Obstetric	9	11	7	17
Other	1	6	2	3
Pre-existing conditions	75	70	78	76
OTHER				
Access	1	1	4	25
Acute care and type C certificates	8	3	2	4
Community rating	0	0	1	0
Complaint not elsewhere covered	11	3	8	6
Confidentiality and privacy	7	3	7	0
Demutualisation/sale of health insurers	0	0	0	0
Discrimination	2	1	0	0
Medibank sale	0	0	0	0
Non-English speaking background	0	0	0	0
Non-Medicare patient	0	0	1	0
Private patient election	1	2	3	0
Rule change	56	51	26	26

Data

The data in this update is for the period 1 April—30 June 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 **ombudsman.gov.au**.