COMMONWEALTH OMBUDSMAN
PRIVATE HEALTH INSURANCE

Quarterly Bulletin 96: 1 July–30 September 2020

Executive Summary

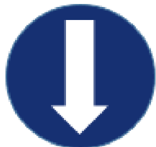
This is the 96th quarterly bulletin for the Office of the Commonwealth Ombudsman's (the Office) Private Health Insurance Ombudsman function. Our role is to protect the interests of consumers in relation to private health insurance. The Office is an independent body that acts to resolve disputes about private health insurance at all levels within the private health industry. We report and provide advice to industry and government about these issues.

This update covers the quarter 1 July–30 September 2020 and:

- summarises COVID-19 related complaints received in this period
- 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.

Quarterly update at a glance

10.1% decrease in complaints received



compared to the same quarter last year

28% of complaints related to benefits

20% of complaints related to membership and administration

This quarter we received **925** complaints and finalised **935** complaints

We received **91** complaints and **26** enquiries related to **COVID-19**. Many of these complaints were about membership suspension requests due to COVID-19 related financial hardship.

COVID-19

Complaints

In the July to September 2020 period, the Office received 91 complaints and 26 enquiries related to COVID-19. In the previous financial year from February to June 2020, the Office received a total of 212 complaints and 43 enquiries.

The majority of complaints in this quarter raised issues related to suspension requests, the inability to access hospital and general treatment services as planned, and cancellation:

1. **Membership suspension: 21 complaints**—consumers seeking temporary suspensions of membership due to financial hardship as a result of COVID-19.
2. **Access: 10 complaints**—these complaints related to difficulty in accessing services such as elective surgery and extras benefits due to COVID-19 restrictions.
3. **Membership cancellation: 10 complaints**—5 out of 10 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.

We also received complaints about rate increase, rule changes and general service issues, with five complaints about each of these issues.

October rate increase

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 lost their jobs, were underemployed or contracted COVID-19 and most insurers will cover COVID-19 treatment for existing policyholders.

As of 1 October 2020, most insurers have applied the delayed 1 April 2020 premium increase and many insurers have adjusted or ceased their COVID-19 measures. At this stage, we have not seen a significant impact on complaint numbers due to these changes. We will continue to monitor complaints received by the Office and any trends in consumer approaches.

Pre-existing conditions

The Office acts as an independent third party when dealing with complaints about pre-existing condition (PEC) waiting periods. In making determinations about complaints about the PEC waiting period, the Office considers whether the waiting period has been applied correctly and that the insurer and hospital have complied with the Pre-Existing Condition Best Practice Guidelines. In circumstances where individual complaints highlight systemic issues, the Office may provide feedback to the insurer, initiate an own motion investigation, or refer the matter to the regulator.

Following a number of instances of non-compliance across the industry, the Office wrote to all health insurers in 2019 and 2020, asking that they confirm their internal claims assessment processes comply with their obligations to assess PEC claims using a medical practitioner as required by s75-15 of the *Private Health Insurance Act 2007*. We have received affirmative responses from all insurers.

We remind health insurers that it is their obligation to ensure compliance with the legislation. If there is any doubt regarding compliance, it is the responsibility of the health insurer to seek its own legal opinion to remove that doubt.

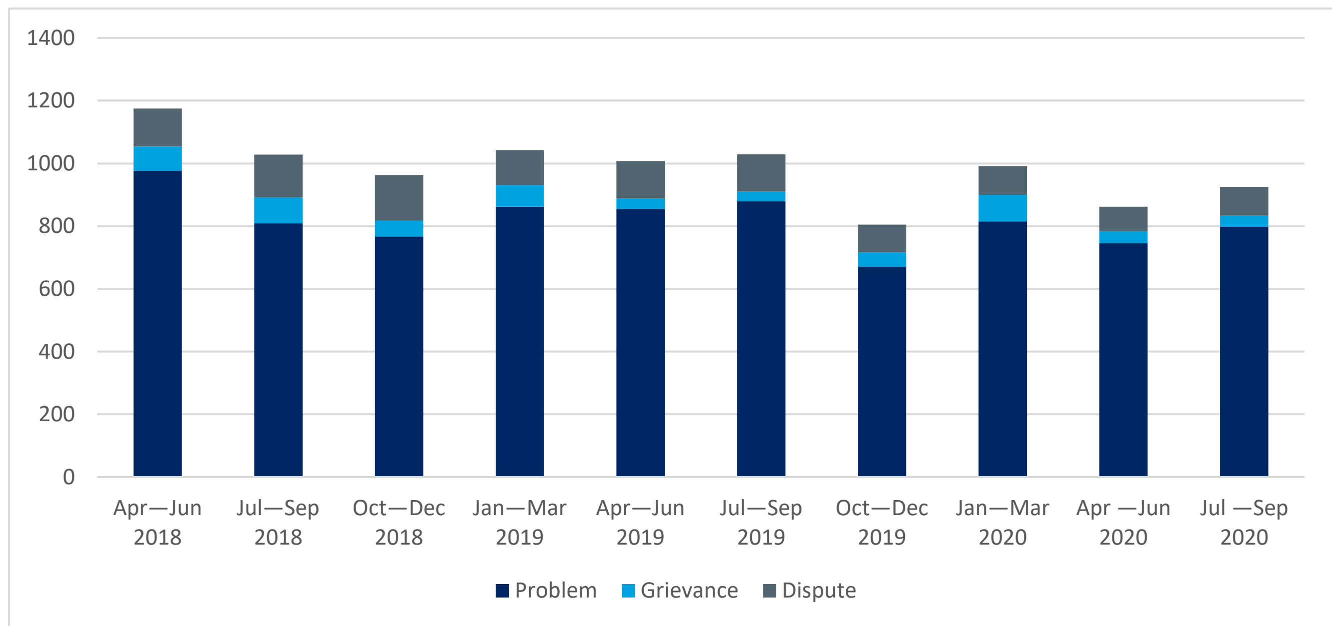
For more information about the Ombudsman's role in PEC cases, please read our factsheet.

Complaints and enquiries received

The Office received 925 private health insurance complaints this quarter. This represented a decrease of 10.1 per cent compared to the same period last year. We received more complaints in September than the previous two months, partly due to insurers applying the delayed 2020 rate increase from 1 October which kept private health insurance top of mind for some consumers.

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 925 and finalised 935 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 successfully met all of our five service standards.

Table 1—Complaint handling service standards 1 July–30 September 2020

Timeframe	Service Standard	Complaints finalised
Within 2 business days	70%	83.8%
Within 7 days	85%	87.0%
Within 30 days	90%	92.4%
Within 90 days	95%	99.6%
Within 12 months	99%	100.0%

This quarter we received 398 and finalised 396 enquiries. All enquiries received in the quarter were finalised within our service standards.

Table 2—Enquiries service standards 1 July–30 September 2020

Timeframe	Service Standard	Enquiries finalised
Within 2 business days	95%	97.5%
Within 7 days	99%	100.0%

Actions taken to finalise complaints in the quarter

Assisted referral

In this quarter, 72 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. In this quarter, nine per cent of cases were finalised as standard referrals.

Further explanation

These are cases where 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. We resolved 17 per cent of complaints this quarter by providing further information.

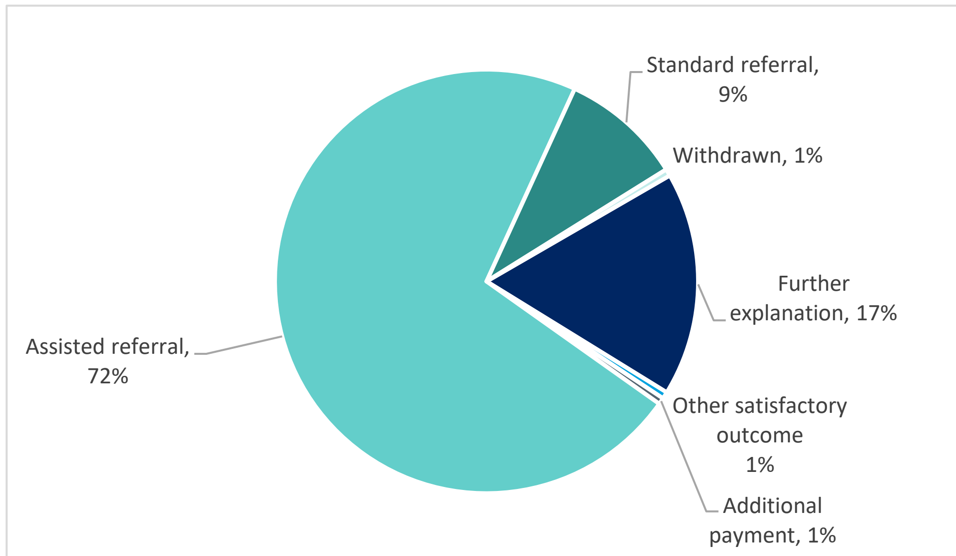
Withdrawn

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 July–September 2020



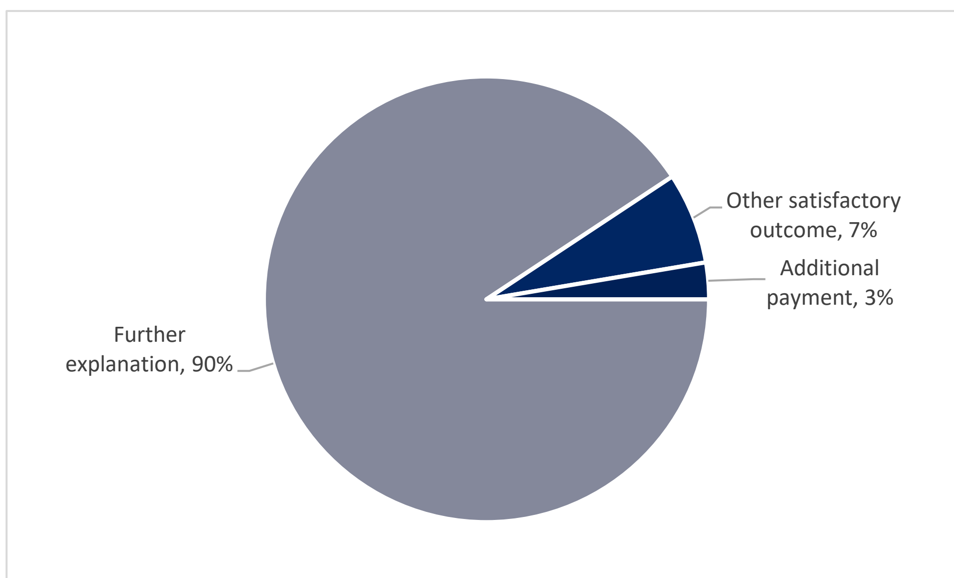
Disputes

During the quarter we finalised 76 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:

- 90 per cent of disputes were finalised by providing complainants with a further explanation
- seven 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
- three per cent of disputes in this quarter were finalised through a further payment to the complainant.

Figure 3—Disputes finalised July–September 2020

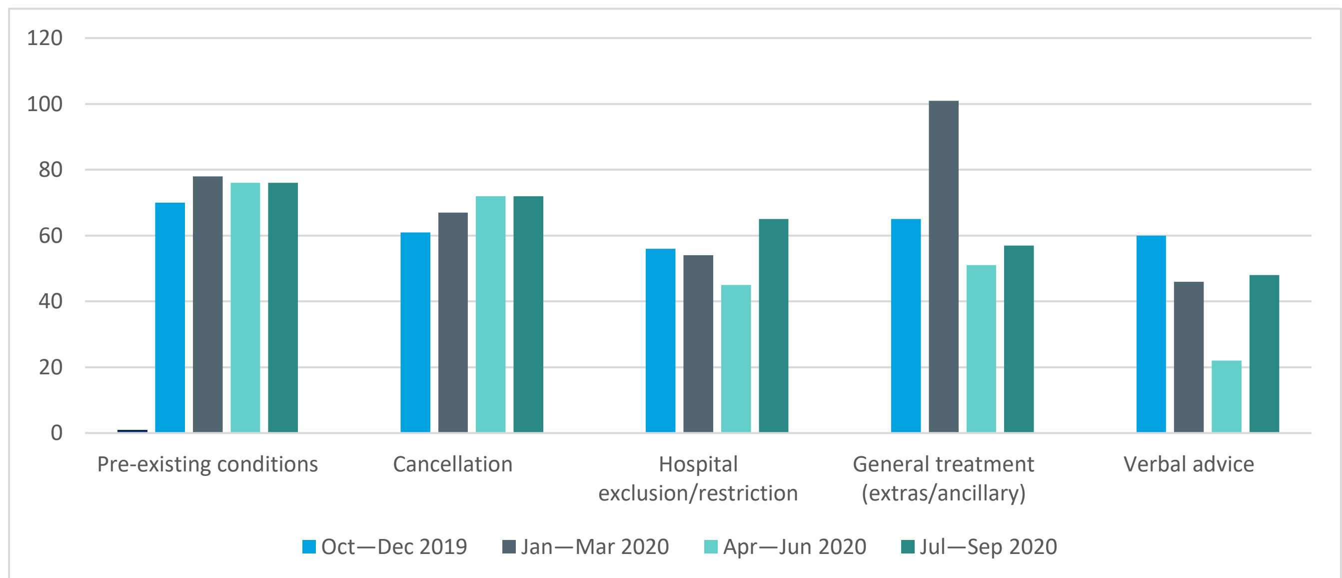


Complaint issues

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. **Hospital exclusions and restrictions: 65 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.
4. **General treatment benefits: 57 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. **Verbal Advice: 48 complaints**—most verbal advice complaints concern poorly communicated advice to people over the phone or at a retail centre, particularly where records are not adequately maintained. For many complaints our case officers will access the recording of advice provided to a consumer and provide an independent assessment of the quality of the information provided.

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	Dec 2019 quarter	Mar 2020 quarter	Jun 2020 quarter	Sept 2020 quarter
Health insurers	706	852	741	793
Overseas visitors and overseas student health insurers	70	80	81	93
Brokers and comparison services	6	10	5	8
Doctors, dentists and other medical providers	2	8	3	2
Hospitals and area health services	4	6	7	5
Other (e.g. legislation, ambulance services, industry peak bodies)	17	35	25	24

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

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%
AIA Health (myOwn)	3	0.0%	0	0.0%	0.2%
Australian Unity	34	4.3%	0	0.0%	2.6%
BUPA	232	29.4%	16	26.7%	25.4%
CBHS	12	1.5%	1	1.7%	1.5%
CBHS Corporate Health	0	0.0%	0	0.0%	<0.1%
CDH (Cessnock District Health)	0	0.0%	0	0.0%	<0.1%
CUA Health	4	0.5%	0	0.0%	0.6%
Defence Health	17	2.2%	4	6.7%	2.1%
Doctors' Health Fund	3	0.4%	1	1.7%	0.4%
GMHBA	17	2.2%	1	1.7%	2.1%
HBF Health & GMF/Healthguard	25	3.2%	4	6.7%	7.3%
HCF (Hospitals Contribution Fund)	132	16.7%	13	21.7%	11.7%
HCI (Health Care Insurance)	1	0.1%	0	0.0%	0.1%
Health Partners	4	0.5%	0	0.0%	0.7%
Health.com.au	2	0.3%	0	0.0%	0.5%
HIF (Health Insurance Fund of Aus.)	5	0.6%	0	0.0%	0.7%
Latrobe Health	4	0.5%	1	1.7%	0.6%
Medibank Private & AHM	169	21.4%	10	16.7%	26.9%
Mildura District Hospital Fund	0	0.0%	0	0.0%	0.3%
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
Navy Health	7	0.9%	0	0.0%	0.3%
NIB Health & GU Corporate Health	76	8.9%	4	5.0%	9.2%
Nurses and Midwives Pty Ltd	1	0.1%	0	0.0%	0.1%
Peoplecare	3	0.4%	0	0.0%	0.5%
Phoenix Health Fund	1	0.1%	0	0.0%	0.1%
Police Health[4]	3	0.4%	0	0.0%	0.4%
QLD Country Health Fund	1	0.1%	0	0.0%	0.4%
Railway & Transport Health	7	0.9%	1	1.7%	0.4%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Lukes Health	5	0.6%	1	1.7%	0.5%
Teachers Federation Health	16	2.0%	1	1.7%	2.5%
Transport Health	3	0.4%	1	1.7%	0.1%
TUH	0	0.0%	0	0.0%	0.6%
Westfund	6	0.8%	1	1.7%	0.9%
Total for Health Insurers	**793**	**100.0%**	**60**	**100.0%**	**100.0%**

[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 2020.
[4] Emergency Services ceased trading as of 20 June and merged with Police Health.

Table 5—Complaint issues and sub-issues 1 July–30 September 2020

ISSUE Sub-issue	Dec 19	Mar 20	Jun 20	Sep 20
BENEFIT				
Accident and emergency	9	15	7	12
Accrued benefits	0	1	1	1
Ambulance	18	8	10	8
Amount	4	5	4	5
Delay in payment	12	18	20	26
Excess	14	9	10	7
Gap—Hospital	9	27	16	17
Gap—Medical	20	27	19	8
General treatment (extras/ancillary)	65	101	51	57
High cost drugs	5	1	1	3
Hospital exclusion/restriction	56	54	45	65
Insurer rule	27	27	21	24
Limit reached	3	2	1	3
New baby	2	1	4	1
Non-health insurance	0	1	1	2
Non-health insurance—overseas benefits	0	0	1	0
Non-recognised other practitioner	0	6	4	1
Non-recognised podiatry	1	2	3	2
Other compensation	2	1	3	0
Out of pocket not elsewhere covered	1	9	0	1
Out of time	2	0	2	4
Preferred provider schemes	5	7	5	11
Prostheses	4	4	1	3
Workers compensation	2	4	0	1
CONTRACT				
Hospitals	1	0	11	2
Preferred provider schemes	6	3	3	5
Second tier default benefit	0	0	0	1
COST				
Dual charging	4	4	6	7
Rate increase	2	60	28	24
INCENTIVES				
Lifetime Health Cover	34	42	43	31
Medicare Levy Surcharge	7	3	0	3
Private health insurance reforms	21	9	3	1
Rebate	1	1	3	2
Rebate tiers and surcharge changes	0	0	0	0
INFORMATION				
Brochures and websites	6	7	1	4
Lack of notification	16	16	14	17
Radio and television	0	0	1	0
Standard Information Statement	0	3	5	2
Verbal advice	60	46	22	48
Written advice	7	10	2	1

ISSUE Sub-issue	Dec 19	Mar 20	Jun 20	Sep 20
INFORMED FINANCIAL CONSENT				
Doctors	2	6	2	2
Hospitals	2	2	1	4
Other	0	2	3	0
MEMBERSHIP				
Adult dependents	1	6	6	8
Arrears	10	12	6	3
Authority over membership	4	4	12	6
Cancellation	61	67	72	72
Clearance certificates	18	24	39	40
Continuity	14	27	21	23
Rate and benefit protection	2	6	0	0
Suspension	12	21	67	32
SERVICE				
Customer service advice	12	21	12	34
General service issues	26	54	23	41
Premium payment problems	35	45	37	34
Service delays	31	23	21	25
WAITING PERIOD				
Benefit limitation period	0	0	0	1
General	7	13	13	19
Obstetric	11	7	17	19
Other	6	2	3	7
Pre-existing conditions	70	78	76	76
OTHER				
Access	1	4	25	16
Acute care and type C certificates	3	2	4	2
Community rating	0	1	0	1
Complaint not elsewhere covered	3	8	6	5
Confidentiality and privacy	3	7	0	4
Demutualisation/sale of health insurers	0	0	0	1
Discrimination	1	0	0	0
Medibank sale	0	0	0	0
Non-English speaking background	0	0	0	0
Non-Medicare patient	0	1	0	0
Private patient election	2	3	0	2
Rule change	51	26	26	47

Data

The data in this update is for the period 1 July–30 September 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**.