COMMONWEALTH OMBUDSMAN
PRIVATE HEALTH INSURANCE

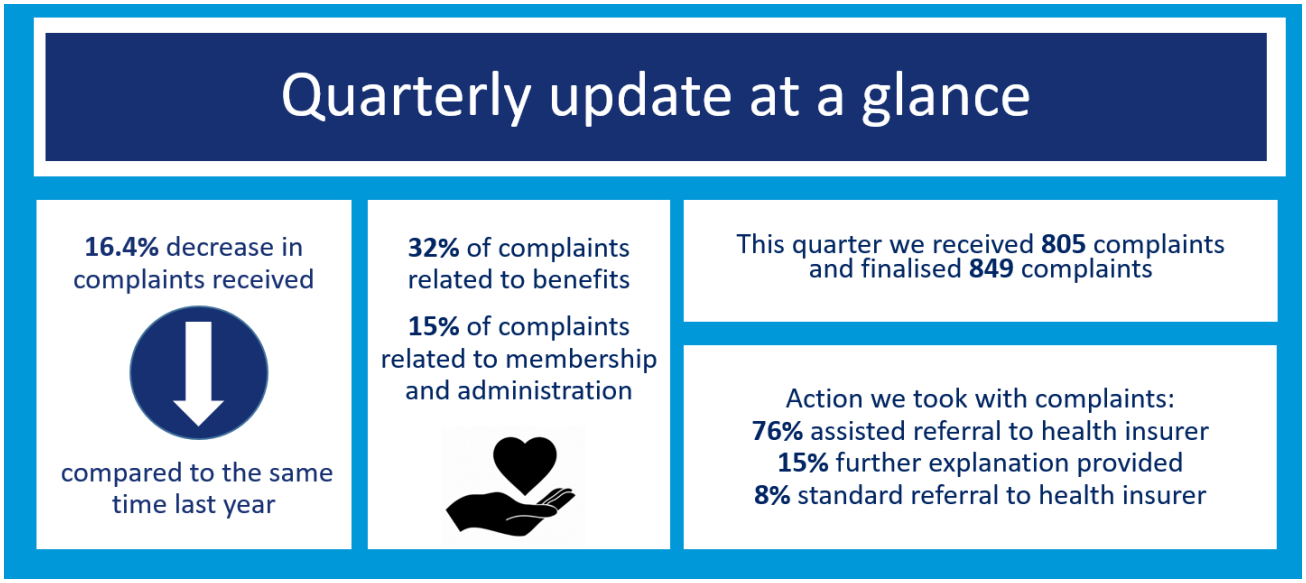
Quarterly Bulletin 93: 1 October–31 December 2019

Executive Summary

This is the 93rd 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 October–31 December 2019 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.

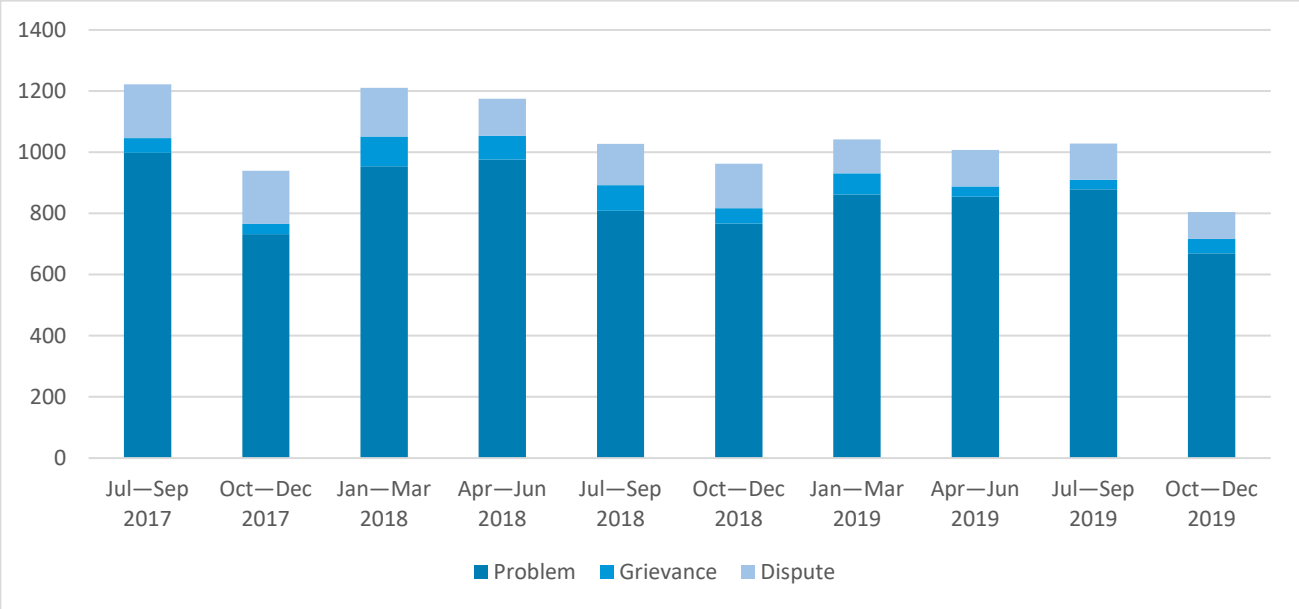


Complaints received

The Office received 805 private health insurance complaints this quarter. This represented a decrease of 16.4 per cent compared to the same period last year and a 21.8 per cent decrease compared to the previous quarter. Complaints are typically lower in the December quarter. The reduction also reflects the downward trend in private health insurance complaints over the past year.

Complaints received by quarter

Figure 1: Complaints received by quarter



Complaints finalised

Timeframes to finalise complaints in the quarter

This quarter we received 805 complaints and finalised 849 complaints. A complaint is finalised when no further action is being taken in response to the complaint.

During 1 October–31 December 2019 the Office met the majority of private health insurance complaints service standards.

Table 1: Complaints handling service standards

Complaints finalised	Timeframe	Service Standard
71.4%	Within 2 business days	70%
83.2%	Within 7 days	85%
88.6%	Within 30 days	90%
95.1%	Within 90 days	95%
100.0%	Within 12 months	99%

All private health insurance enquiries received in this 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

Over three-quarters of complaints are 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.

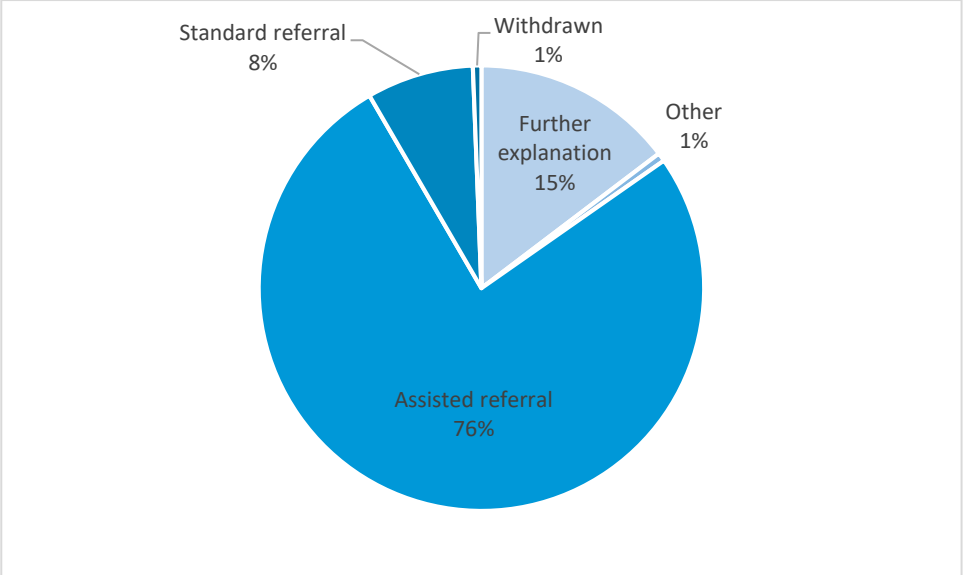
Withdrawn

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 October–December 2019

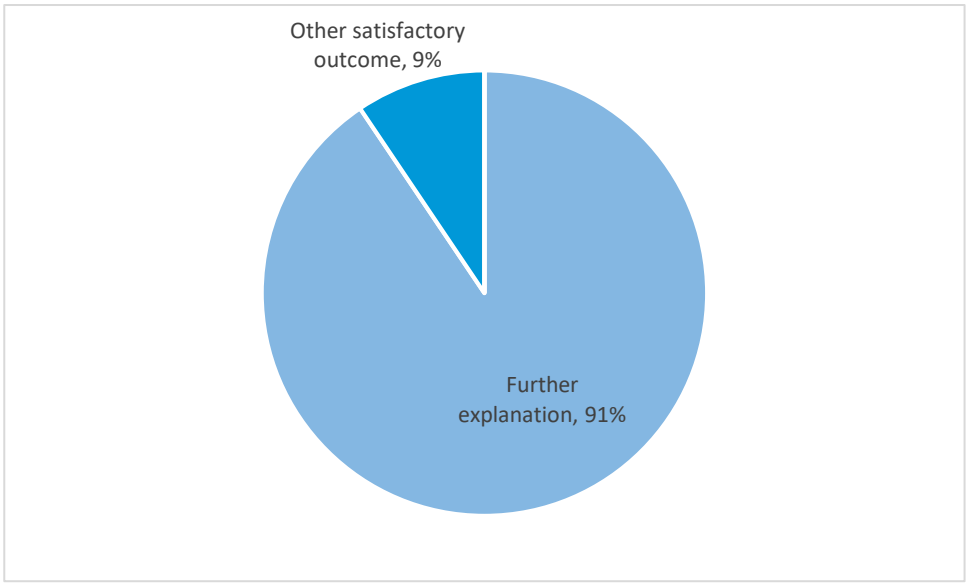


Disputes

During the quarter we finalised 53 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, 91 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. No disputes in this quarter were finalised through a further payment to the complainant.

Figure 3: Disputes finalised October–December 2019



Complaint issues

The top five consumer complaint issues this quarter included:

1. **Pre-existing conditions waiting period: 70 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.

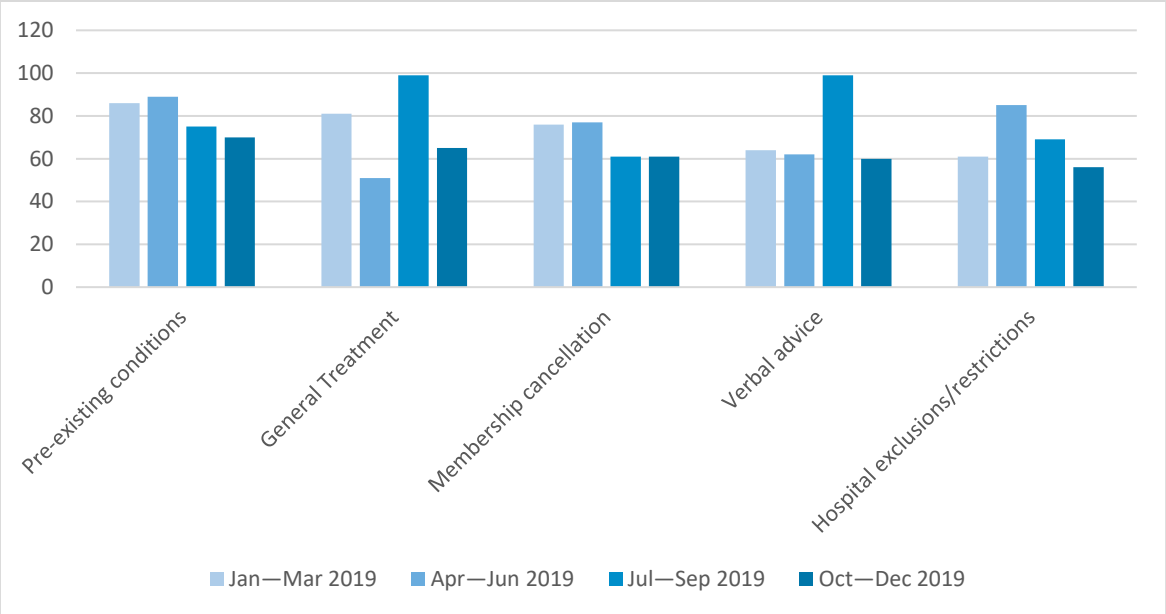
2. **General treatment: 65 complaints**—these complaints usually concern disputes over the amount payable under 'extras' policies such as dental, optical, physiotherapy and pharmaceuticals, or the insurer's rules for benefit payments (such as certain minimum claim criteria).

3. **Membership cancellation: 61 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. **Verbal advice: 60 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.

5. **Hospital exclusions and restrictions: 56 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 five 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	Mar 2019 quarter	Jun 2019 quarter	Sep 2019 quarter	Dec 2019 quarter
Health insurers	904	846	851	706
Overseas visitors and overseas student health insurers	81	111	132	70
Brokers and comparison services	12	16	12	6
Doctors, dentists and other medical providers	5	2	3	2
Hospitals and area health services	10	10	12	4
Other (e.g. legislation, ambulance services, industry peak bodies)	30	23	19	17

Inspection guidelines

In this quarter we published *A Quick Guide to the Private Health Insurance Ombudsman's New Inspection Powers*. This document summarises the Office's new powers to conduct inspections of private health insurers and health insurance brokers. The document was finalised after taking into account feedback provided from our stakeholders through a consultation process—we would like to acknowledge the stakeholders that provided comments and suggestions. The final version of the Quick Guide is available online at: ombudsman.gov.au/How-we-can-help/private-health-insurance/private-health-insurance

Covering two or more procedures where one is excluded from the policy

The Office has received a number of complaints from consumers who are planning admissions for more than one type of procedure, where one of the procedures is an excluded service under their policy.

In the past, insurers were not required to pay hospital benefits if the admission comprised of an excluded service. This would sometimes result in the insurer not paying any benefit toward the admission even though some of the services would have otherwise been covered.

Under the new Gold, Silver, Bronze and Basic hospital policy tiers, insurers will now be required to pay a benefit toward the procedure covered by the policy even if the admission includes planned surgery for an excluded procedure. Insurers do not have to cover any planned surgeries that are excluded under the policy.

This means that if a person is admitted to hospital for multiple procedures and at least one of the procedures is covered, the insurer will be required to pay a benefit toward the eligible service.

A small number of current hospital policies do not yet fall under the new Gold, Silver, Bronze or Basic hospital tiers. The Office advises consumers under old-style policies to contact their insurer in the first instance to check their cover. If they require further assistance, they can contact our Office for more information. All hospital policies will be required to be compliant with the new tiers by 1 April 2020.

Case study:

Chris* required a hernia operation and a weight loss surgery. Both procedures could be done in the same admission.

However, his policy (which fell under the new hospital tiers) only covered the hernia procedure and not the weight loss surgery.

Chris's insurer advised him that if both surgeries took place during the same admission, he would not be covered. The insurer stated if he only had the hernia procedure, he would be covered. Chris approached our Office for assistance.

The Office asked the insurer to consider the rule for multiple procedures under the new hospital policy tiers.

The insurer reconsidered the case and agreed they should pay for Chris's hernia operation, even if he had the weight loss surgery at the same time. They agreed to cover the hernia operation costs and Chris would be responsible for the weight loss surgery costs.

**Identifying details have been changed for privacy reasons*

Bushfire relief

A number of health insurers have implemented a range of bushfire relief arrangements to support their members affected by the devastating and widespread national bushfires. Consumers should contact their insurers for more information about bushfire relief arrangements.

New features on privatehealth.gov.au

In January 2020, an updated *Compare Policies* tool was launched on **privatehealth.gov.au**, allowing consumers to search for policies according to Gold, Silver, Bronze and Basic hospital tiers. It will be mandatory for all hospital policies to fall under the tier system from 1 April 2020.

See the updated feature at: privatehealth.gov.au/dynamic/search/start

Consumers can also evaluate their policy using the new *Does My Policy Cover* feature, which includes a tool that checks whether specific Medicare Benefits Schedule (MBS) item numbers are covered on each policy.

See the new feature at: privatehealth.gov.au/dynamic/mbsitems/findmypolicy

Overseas Student Health Cover (OSHC) and maintaining cover for duration of visa

Students from overseas who are living in Australia on temporary student visas are required to maintain adequate health insurance in the form of OSHC for the duration of their visa (some exceptions may apply to students from Sweden, Norway, or Belgium).

All overseas students should ensure that they maintain their cover at all times, because holding OSHC is a visa requirement.

If a student's visa status or Medicare eligibility changes at any time they need to inform their insurer as soon as possible to find out whether their level of cover is still suitable. For example, if a student visa expires, they are no longer eligible to hold OSHC. However, they could change to a residents' cover or to an Overseas Visitors Health Cover policy.

OSHC is offered by certain insurers under a Deed of Agreement with the Department of Health to provide adequate health insurance to students at a reasonable cost. Only a small number of registered health insurers offer OSHC. Our Office advises insurers to check their processes to ensure students are being advised of the correct information about the duration of their coverage.

For more information, see: privatehealth.gov.au/health_insurance/overseas/

Table 4: Complaints, disputes and compared 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	24	3.4%	1	1.4%	2.7%
BUPA	144	20.4%	20	29.0%	25.8%
CBHS Corporate Health	0	0.0%	0	0.0%	<0.1%
CBHS	11	1.6%	0	0.0%	1.5%
CDH (Cessnock District Health)	0	0.0%	0	0.0%	<0.1%
CUA Health	8	1.1%	2	2.9%	0.6%
Defence Health	10	1.4%	1	1.4%	2.1%
Doctors' Health Fund	1	0.1%	0	0.0%	0.3%
Emergency Services Health	0	0.0%	0	0.0%	<0.1%
GMHBA	25	3.5%	2	2.9%	2.3%
Grand United Corporate Health	11	1.6%	0	0.0%	0.5%
HBF Health & GMF/Healthguard	41	5.8%	3	4.3%	7.5%
HCF (Hospitals Contribution Fund)	107	15.2%	18	26.1%	11.1%
HCI (Health Care Insurance)	1	0.1%	0	0.0%	0.1%
Health Partners	4	0.6%	0	0.0%	0.7%
Health.com.au	7	1.0%	1	1.4%	0.6%
HIF (Health Insurance Fund of Aus.)	11	1.6%	0	0.0%	0.8%
Latrobe Health	5	0.7%	0	0.0%	0.7%
Medibank Private & AHM	171	24.2%	11	15.9%	26.9%
Mildura District Hospital Fund	0	0.0%	0	0.0%	0.2%
MO Health Pty Ltd (myOwn)	18	2.5%	4	5.8%	0.2%
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
Navy Health	1	0.1%	0	0.0%	0.3%
NIB Health	61	8.6%	4	5.8%	8.6%
Nurses and Midwives Pty Ltd	5	0.7%	0	0.0%	0.1%
Peoplecare	7	1.0%	0	0.0%	0.5%
Phoenix Health Fund	1	0.1%	0	0.0%	0.1%
Police Health	1	0.1%	0	0.0%	0.3%
QLD Country Health Fund	1	0.1%	0	0.0%	0.4%
Railway & Transport Health	2	0.3%	0	0.0%	0.4%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Lukes Health	2	0.3%	0	0.0%	0.5%
Teachers Federation Health	14	2.0%	1	1.4%	2.4%
Transport Health	6	0.8%	0	0.0%	0.1%
TUH	1	0.1%	0	0.0%	0.6%
Westfund	5	0.7%	1	1.4%	0.7%
Total for Health Insurers	**706**	**100%**	**69**	**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] 3) Source: Australian Prudential Regulation Authority, Market Share, All Policies, 30 June 2019.

Table 5: Complaint issues and sub-issues

ISSUE Sub-issue	Mar 19	Jun 19	Sep 19	Dec 19
BENEFIT				
Accident and emergency	15	14	12	9
Accrued benefits	1	4	4	0
Ambulance	16	17	12	18
Amount	10	11	10	4
Delay in payment	27	28	28	12
Excess	17	14	14	14
Gap—Hospital	27	18	30	9
Gap—Medical	25	25	21	20
General treatment (extras/ancillary)	81	51	99	65
High cost drugs	2	0	3	5
Hospital exclusion/restriction	61	85	69	56
Insurer rule	13	17	23	27
Limit reached	6	4	5	3
New baby	5	1	1	2
Non-health insurance	0	1	0	0
Non-health insurance—overseas benefits	0	0	0	0
Non-recognised other practitioner	7	0	0	0
Non-recognised podiatry	2	0	2	1
Other compensation	5	0	3	2
Out of pocket not elsewhere covered	5	8	10	1
Out of time	4	3	1	2
Preferred provider schemes	11	15	5	5
Prostheses	8	7	4	4
Workers compensation	2	2	1	2
CONTRACT				
Hospitals	2	4	3	1
Preferred provider schemes	2	5	2	6
Second tier default benefit	1	2	0	0
COST				
Dual charging	5	3	2	4
Rate increase	32	14	6	2
INCENTIVES				
Lifetime Health Cover	42	42	51	34
Medicare Levy Surcharge	1	1	9	7
Private health insurance reforms	37	20	8	21
Rebate	2	4	6	1
Rebate tiers and surcharge changes	0	0	0	0
INFORMATION				
Brochures and websites	7	10	1	6
Lack of notification	10	9	16	16
Radio and television	0	0	0	0
Standard Information Statement	4	3	1	0
Verbal advice	64	62	99	60
Written advice	16	11	9	7

ISSUE Sub-issue	Mar 19	Jun 19	Sep 19	Dec 19
INFORMED FINANCIAL CONSENT				
Doctors	2	1	4	2
Hospitals	10	6	8	2
Other	4	0	2	0
MEMBERSHIP				
Adult dependents	10	3	6	1
Arrears	19	14	5	10
Authority over membership	9	10	4	4
Cancellation	76	77	61	61
Clearance certificates	31	31	28	18
Continuity	13	22	20	14
Rate and benefit protection	2	5	2	2
Suspension	23	16	14	12
SERVICE				
Customer service advice	15	17	22	12
General service issues	39	65	44	26
Premium payment problems	68	58	60	35
Service delays	18	31	20	31
WAITING PERIOD				
Benefit limitation period	0	0	3	0
General	5	12	12	7
Obstetric	7	9	9	11
Other	3	5	1	6
Pre-existing conditions	86	89	75	70
OTHER				
Access	0	0	1	1
Acute care and type C certificates	2	7	8	3
Community rating	0	0	0	0
Complaint not elsewhere covered	8	6	11	3
Confidentiality and privacy	3	3	7	3
Demutualisation/sale of health insurers	0	1	0	0
Discrimination	1	1	2	1
Medibank sale	0	0	0	0
Non-English speaking background	0	0	0	0
Non-Medicare patient	0	2	0	0
Private patient election	2	3	1	2
Rule change	52	27	56	51

Data

The data in this update is for the period 1 October–31 December 2019. 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