COMMONWEALTH OMBUDSMAN
PRIVATE HEALTH INSURANCE

Quarterly Update: 1 October–31 December 2021

During this quarter, the Office of the Commonwealth Ombudsman (the Office) received 567 complaints in its capacity as the Private Health Insurance Ombudsman.[1] This was a decrease of 35 per cent compared to the same period last year, continuing the existing downward trend. During the previous 2 quarters, the Office received the lowest numbers of private health insurance complaints in any quarter since 2012.

Some of this decrease may be explained by many consumers not using their health insurance due to restrictions associated with COVID-19, which reduced access to planned hospital treatments and routine general treatment services.

Figure 1: Complaints received by quarter

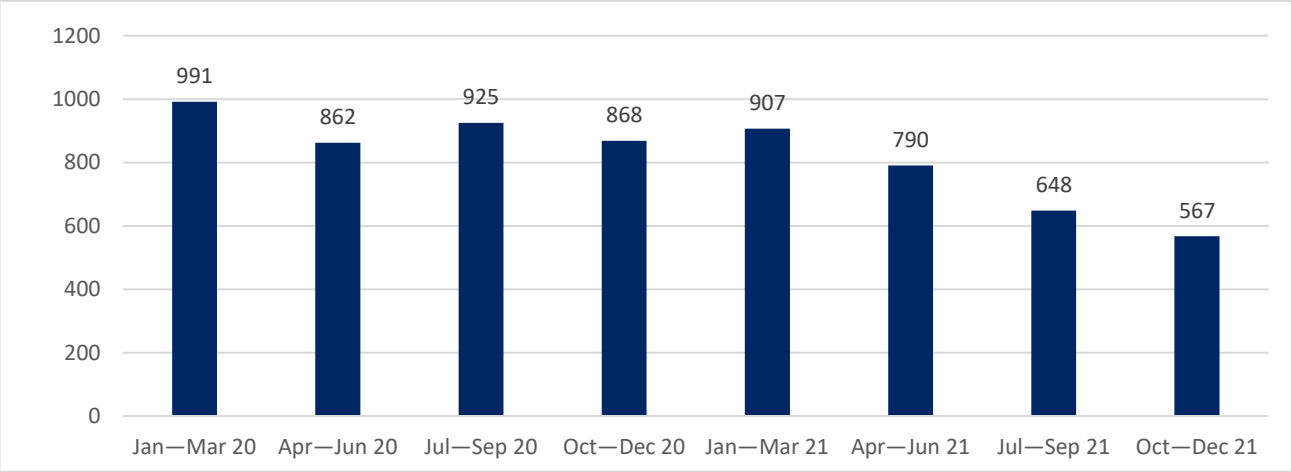
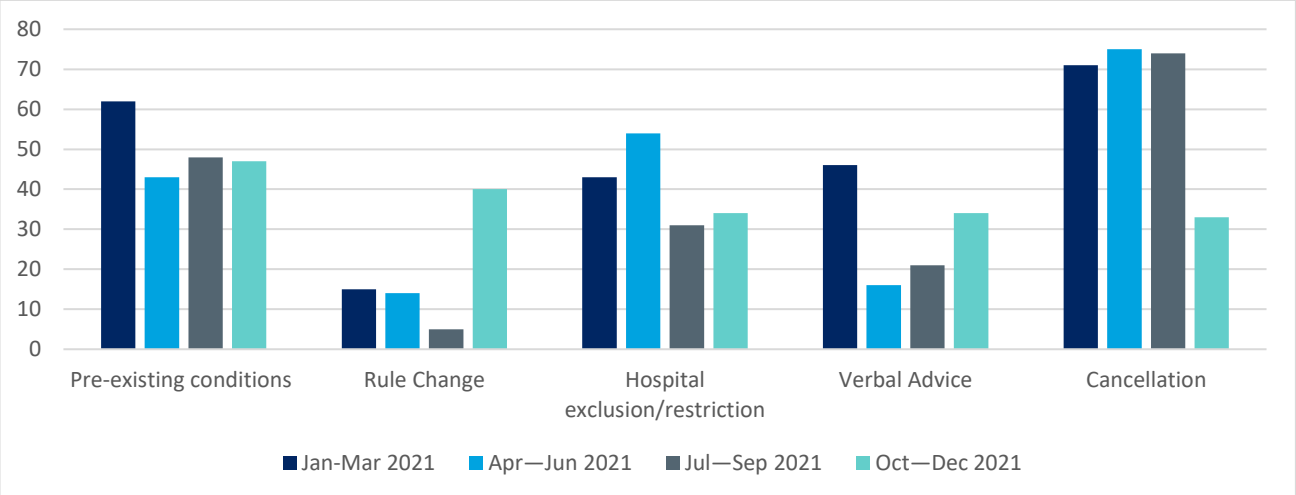


Figure 2: Top complaint issues, October 2020 to September 2021



[1] Includes complaints about private health insurers, hospitals, practitioners and brokers. Refer to Private Health Insurance - Commonwealth Ombudsman for definitions of complaints, issues and other terms. Our data is dynamic and regularly updated. This means there may be minor differences when compared to the last quarterly update. Previous quarterly updates are available on the Ombudsman's website.

Insurer rule changes

During this quarter, complaints about changes to insurer rules increased significantly. In most quarters, the Office receives 10–20 complaints about insurer rule changes, but between October and December 2021 we received 40 complaints. This was due to 2 insurers migrating large numbers of policyholders onto new policies.

Health insurers are permitted to change the terms of health insurance policies provided adequate notice is given and the changes comply with the *Private Health Insurance Act 2007,* Australian Consumer Law and other legislation. By providing consumers with advance notice of a change, insurers ensure consumers have appropriate information to decide whether to accept the change or switch to a new policy or new insurer.

The Office advises consumers to carefully read letters or email updates from their insurers to ensure they understand any policy changes that may affect them. We also have a guide to transferring health insurance entitlements between health insurers, called The Right to Change.

Case Study

A person complained to the Office after their insurer notified them that their existing policy would be removed from sale and they would be transferred to a new policy. The person felt it was unfair to make changes to their existing policy given they paid premiums in advance of the date the existing policy would close. They were also unhappy with the new policy offered by the insurer because it provided lower benefit amounts for some services. The person wanted the insurer to consider allowing them to stay on their existing policy during the period for which they had pre-paid their premium.

After we referred the complaint to the insurer, it contacted the person to discuss the policy changes. The insurer explained its decision to the complainant in more detail but did not agree to make an exception.

After receiving the insurer's response, the complainant considered their option to switch health insurers, in which case the premiums paid in advance would be refunded.

Going to hospital

The Office advises anyone planning a hospital admission to contact the doctor, hospital, and health insurer in advance to find out what costs they might need to pay. The person's doctor and hospital should obtain their Informed Financial Consent (IFC) by providing them with a quote of their charges and any out-of-pocket expenses. If the person receives advice over the phone or at a retail centre, we encourage them to keep a record of the advice and the date it was provided, and if possible, ask for the advice to be confirmed in writing.

Case Study

A complainant was advised by their doctor their child would need surgery. After speaking with their doctor, the complainant called their insurer to check their cover. The insurer advised them their child was covered for the surgery, so they booked the surgery in a month's time. However, 2 days before the planned admission, the complainant was told the previous advice was incorrect and, as their child was added to the policy within the last 12 months, a waiting period still applied. This meant the insurer could refuse to pay the claim if the surgery was found to be for a pre-existing condition (see our guide on waiting periods and pre-existing conditions for more information).

The person complained to the Office and we referred the matter to the insurer for review. The insurer checked its records and found that, in their initial call, the person was incorrectly advised their child would be covered for the surgery. The staff member who provided this advice did not check the child's waiting periods. Although the child's condition was found to be pre-existing, the insurer agreed to cover the child's hospital admission because it provided incorrect advice and the person relied on this advice to book the surgery.

Table 1: Complaints by health insurer market share, 1 October–31 December 2021

Name of insurer	No further action[2]	Percentage of no further action	Referrals	Percentage of referrals	Investigations[3]	Percentage of investigations	Market share[4]
ACA Health Benefits	0	0.0%	0	0.0%	0	0.0%	<0.1%
AIA Health (myOwn)	1	3.7%	7	1.6%	2	5.8%	0.3%
Australian Unity	1	3.7%	25	5.6%	1	2.9%	2.5%
BUPA	5	18.5%	102	22.9%	4	11.8%	24.8%
CBHS	1	3.7%	11	2.5%	1	2.9%	1.5%
CBHS Corporate Health	0	0.0%	0	0.0%	0	0.0%	<0.1%
CDH (Hunter Health Insurance)	0	0.0%	0	0.0%	0	0.0%	<0.1%
CUA Health	0	0.0%	1	0.2%	0	0.0%	0.6%
Defence Health	0	0.0%	5	1.1%	0	0.0%	2.1%
Doctors' Health Fund	0	0.0%	3	0.7%	0	0.0%	0.4%
GMHBA	1	3.7%	14	3.1%	1	2.9%	2.1%
HBF Health & GMF/Healthguard	4	14.8%	35	7.9%	1	2.9%	7.3%
HCF (Hospitals Contribution Fund)	2	7.4%	89	20.0%	6	17.6%	11.9%
HCI (Health Care Insurance)	0	0.0%	0	0.0%	0	0.0%	<0.1%
Health Partners	0	0.0%	3	0.7%	1	2.9%	0.7%
Health.com.au	0	0.0%	0	0.0%	0	0.0%	0.4%
HIF (Health Insurance Fund of Aus.)	0	0.0%	3	0.7%	2	5.9%	0.7%
Latrobe Health	0	0.0%	3	0.7%	1	2.9%	0.7%
Medibank Private & AHM	5	18.5%	84	18.9%	9	26.5%	27.3%
Mildura District Hospital Fund	0	0.0%	0	0.0%	0	0.0%	0.3%
National Health Benefits Aust.	0	0.0%	0	0.0%	0	0.0%	<0.1%
Navy Health	0	0.0%	2	0.4%	0	0.0%	0.4%
NIB Health & GU Corporate Health	3	11.1%	39	8.8%	2	5.9%	9.3%
Nurses and Midwives Pty Ltd	0	0.0%	0	0.0%	0	0.0%	<0.1%
Peoplecare	0	0.0%	0	0.0%	0	0.0%	0.5%
Phoenix Health Fund	0	0.0%	0	0.0%	0	0.0%	0.2%
Police Health	0	0.0%	0	0.0%	0	0.0%	0.4%
QLD Country Health Fund	1	3.7%	1	0.2%	0	0.0%	0.4%
Railway & Transport Health	0	0.0%	2	0.4%	0	0.0%	0.3%
Reserve Bank Health	0	0.0%	0	0.0%	0	0.0%	<0.1%
St Lukes Health	0	0.0%	5	1.1%	0	0.0%	0.6%
Teachers Health	1	3.7%	7	1.6%	2	5.9%	2.5%
Transport Health	0	0.0%	0	0.0%	0	0.0%	<0.1%
TUH	0	0.0%	2	0.4%	0	0.0%	0.6%
Westfund	2	7.4%	2	0.4%	1	2.9%	0.9%
Total for Health Insurers	**27**	**100%**	**445**	**100%**	**34**	**100.0%**	

[2] This table shows complaints regarding Australian registered health insurers. This table excludes complaints regarding Overseas Visitors Health Cover and Overseas Student Health Cover insurers, and other bodies.
[3] Investigations required the intervention of the Ombudsman and the health insurer.
[4] Source: Australian Prudential Regulation Authority, Market Share, All Policies, 30 June 2021.

Table 2: Complaint issues and sub-issues, received 1 October–31 December 2021

ISSUE Sub-issue	Mar 21	Jun 21	Sep 21	Dec 21
BENEFIT				
Accident and emergency	8	3	2	8
Accrued benefits	2	1	0	0
Ambulance	8	10	11	3
Amount	12	12	6	15
Delay in payment	60	51	37	24
Excess	11	7	8	12
Gap—Hospital	13	22	15	14
Gap—Medical	22	15	12	15
General treatment (extras/ancillary)	50	39	34	32
High cost drugs	1	0	1	2
Hospital exclusion/restriction	43	54	31	34
Insurer rule	32	24	27	27
Limit reached	1	1	5	5
New baby	0	4	0	1
Non-health insurance	2	2	0	1
Non-health insurance—overseas benefits	0	0	0	0
Non-recognised other practitioner	0	0	1	1
Non-recognised podiatry	2	2	1	2
Other compensation	0	2	2	4
Out of pocket not elsewhere covered	2	4	0	1
Out of time	2	2	2	0
Preferred provider schemes	5	5	2	2
Prostheses	1	3	3	2
Workers compensation	0	0	0	0
CONTRACT				
Hospitals	1	0	3	0
Preferred provider schemes	0	1	1	4
Second tier default benefit	0	0	1	1
COST				
Dual charging	4	9	0	6
Rate increase	36	16	5	4
INCENTIVES				
Lifetime Health Cover	40	39	28	20
Medicare Levy Surcharge	1	0	1	0
Private health insurance reforms	1	1	0	0
Rebate	1	5	4	2
Rebate tiers and surcharge changes	2	0	1	0
INFORMATION				
Brochures and websites	3	8	2	7
Lack of notification	7	9	13	10
Radio and television	0	0	0	0
Standard Information Statement	1	0	1	1
Verbal advice	46	16	21	34
Written advice	1	3	2	3

ISSUE Sub-issue	Mar 21	Jun 21	Sep 21	Dec 21
INFORMED FINANCIAL CONSENT				
Doctors	0	2	0	2
Hospitals	1	4	1	1
Other	1	0	1	0
MEMBERSHIP				
Adult dependents	5	11	13	10
Arrears	6	2	3	1
Authority over membership	4	3	2	2
Cancellation	71	75	74	33
Clearance certificates	34	33	34	10
Continuity	19	13	9	12
Rate and benefit protection	0	9	1	1
Suspension	17	10	15	8
SERVICE				
Customer service advice	52	39	43	24
General service issues	65	43	36	29
Premium payment problems	31	45	23	18
Service delays	57	21	25	20
WAITING PERIOD				
Benefit limitation period	0	0	0	0
General	17	21	14	11
Obstetric	7	10	3	4
Other	3	8	7	1
Pre-existing conditions	62	43	48	47
OTHER				
Access	5	2	14	15
Acute care and type C certificates	2	1	1	1
Community rating	0	1	1	0
Complaint not elsewhere covered	5	3	1	5
Confidentiality and privacy	2	1	0	2
Demutualisation/sale of health insurers	0	1	0	0
Discrimination	0	1	0	0
Medibank sale	0	0	0	0
Non-English speaking background	0	0	0	0
Non-Medicare patient	1	1	0	0
Private patient election	1	0	0	0
Rule change	15	14	5	40