COMMONWEALTH OMBUDSMAN
PRIVATE HEALTH INSURANCE

Quarterly Bulletin: 1 April–30 June 2021

Executive Summary

The role of the Office of the Commonwealth Ombudsman's (the Office) Private Health Insurance Ombudsman function 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 period from 1 April to 30 June 2021 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.

It also includes a summary of the Office's complaint data for the 2020–21 financial year and information about the impacts of the COVID-19 pandemic on private health insurance.

Quarterly update at a glance

8.4% decrease in complaints received

compared to the same quarter last year

33% of complaints related to benefits

19% of complaints related to membership and administration

This quarter we received **790** complaints and finalised **824** complaints

We received **10** complaints and **3** enquiries related to **COVID-19**. Several were about requests to suspend membership due to financial hardship caused by the COVID-19 pandemic.

Private Health Insurance Legislation Amendment (Age of Dependents) Bill 2021

In October 2020 the Australian Government announced it would increase the maximum age of dependents covered under family private health insurance policies from 24 to 31 years (inclusive) and remove the age limit for dependents with a disability. These changes were passed by Parliament on 22 June 2021.

It may take time for insurers to reflect these changes in their policies. New or updated policies will be included on the privatehealth.gov.au website as they become available.

Managing persistent complainants

In April 2021 the Office published the second edition of *Commonwealth Ombudsman Insights*, focusing on good practices for managing persistent complainants.

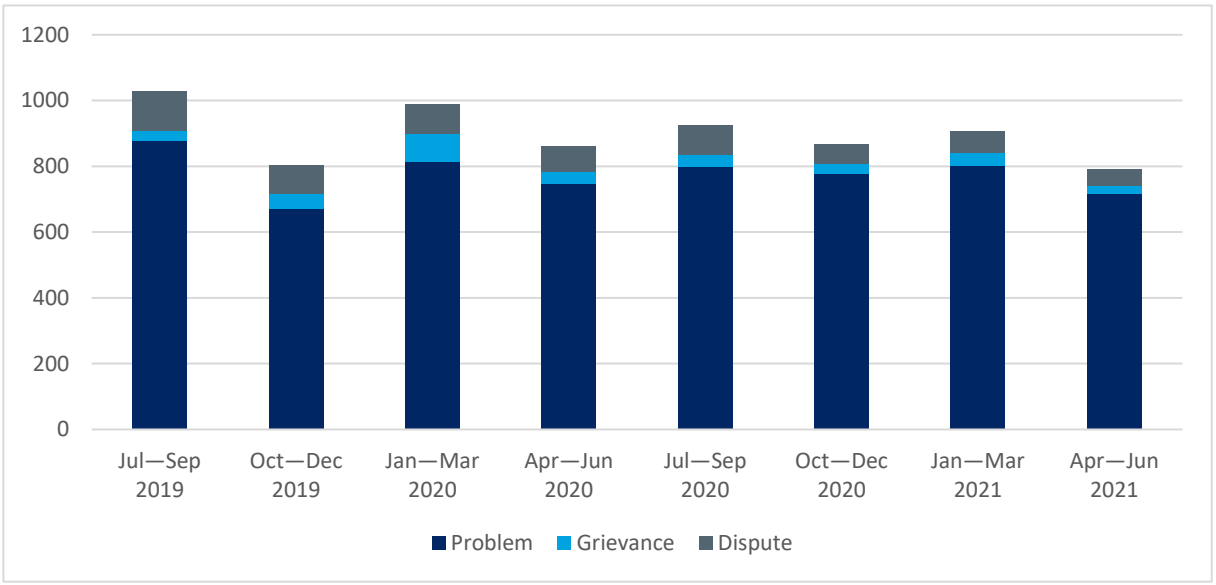
This guidance might be useful for complaint handlers responsible for reviewing decisions made by health insurers and hospitals.

Complaints and enquiries received

Between 1 April and 30 June 2021 the Office received 790 complaints about private health insurance. This represents a decrease of 8.4 per cent compared to the same period last year and a 12.9 per cent decrease compared to the previous quarter.

Complaints received by quarter

Figure 1: Complaints received by quarter



We categorise complaints in 3 ways:

- **Problem:** a complaint that is resolved by the Office transferring the complaint to the respondent (assisted referral) or by the complainant directly raising the matter with the respondent (standard referral).
- **Grievance:** a complaint that is noted and closed without further action, on the basis that investigation is not warranted.
- **Dispute:** a complaint that warrants investigation.

Complaints and enquiries finalised

Between 1 April and 30 June 2021 we received 790 complaints and finalised 824 complaints. We treat a complaint as finalised when we inform the complainant of the outcome of an investigation and/or that we have decided not to take further action.

During this period, we met all 5 service standards for complaints.

Table 1: Performance against complaint handling service standards between 1 April and 30 June 2021

Finalisation timeframe	Service Standard	Complaints finalised
Within 2 business days	70%	77.8%
Within 7 days	85%	86.2%
Within 30 days	90%	91.9%
Within 90 days	95%	98.2%
Within 12 months	99%	100.0%

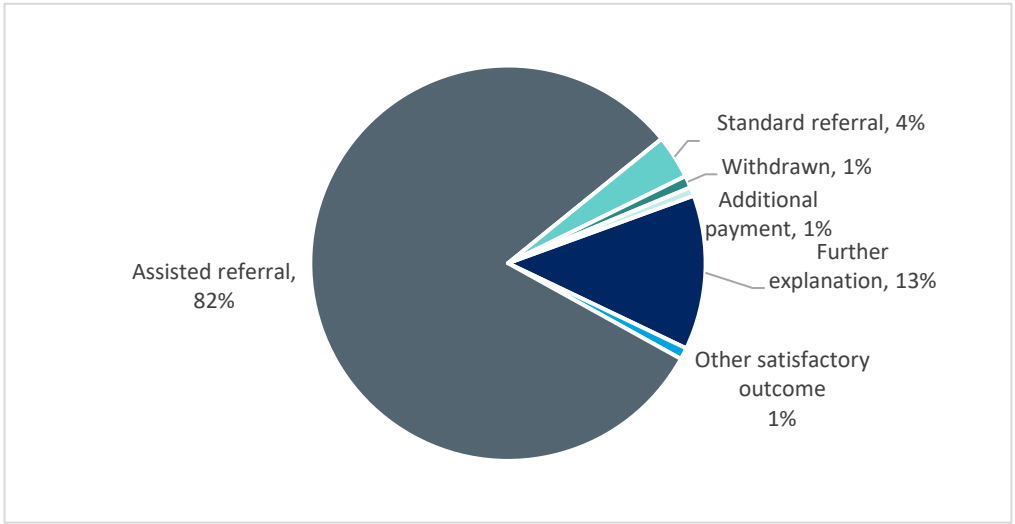
This quarter we received 527 enquiries and finalised 531 enquiries. We finalised almost all these enquiries within our service standards. We treat an enquiry as finalised when we provide the person with relevant advice or information.

Table 2: Enquiries service standards 1 April–30 June 2021

Finalisation timeframe	Service Standard	Enquiries finalised
Within 2 business days	95%	94.2%
Within 7 days	99%	97.9%

Actions taken to finalise complaints in the quarter

Figure 2: All complaints finalised 1 April–30 June 2021



For the complaints we finalised as 'disputes':

- 12 per cent were finalised through an additional payment
- 12 per cent were resolved through other satisfactory outcomes such as reconsideration of the matter by the insurer, backdating a change in cover, or expedited action
- 76 per cent were finalised by providing a further explanation to the complainant.

We finalised the complaints categorised as 'problems' in one of 3 ways:

Assisted referral

During this quarter, we finalised 87 per cent of complaints through an assisted referral. This occurs when we refer a matter to the insurer to resolve. The insurer makes initial contact with the complainant within 3 business days and reports the outcome to our Office once the complaint is finalised. If the complainant considers their complaint is not resolved by the assisted referral process, they can return to us for further assistance.

Standard referral

In some cases, we provide information to a complainant to support them to lodge a 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 this process, the complainant can contact us again.

In this quarter, 4 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 information about what we consider would be 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 9 per cent of complaints this quarter by providing further information.

Withdrawn

In some cases, people make complaints to our Office but later withdraw their complaint or fail to respond to requests for further information. One per cent of complaints were withdrawn this quarter.

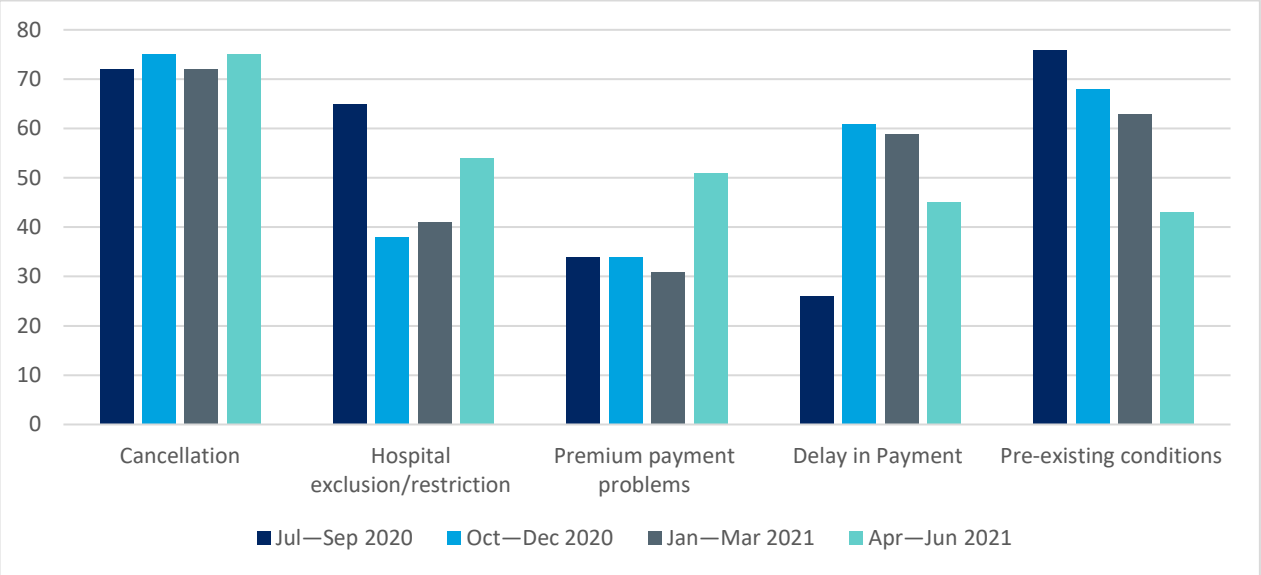
Complaint issues

During this quarter, the 5 most common issues in the complaints we received were:

1. Membership cancellation: 75 complaints – these complaints relate to problems or delays in insurers processing requests to cancel memberships and managing associated payments or refunds. Most membership cancellations are the result of consumers transferring from one insurer to another, rather than leaving private health insurance altogether.
2. Hospital exclusions and restrictions: 54 complaints – these complaints usually arise when complainants find their policy does not cover a particular service or treatment, which means they are not able to access the treatment or must incur expenses they did not anticipate.
3. Premium payment problems: 51 complaints – premium payment issues can include higher than expected or irregular debit amounts, debits occurring on an unexpected date or not being taken, issues with receiving or sending requests for payment, or payroll deduction issues.
4. Delay in benefit payment: 45 complaints – most complaints relate to delays caused by health insurers in processing a claim and the time taken for a consumer to receive their benefit payment.

5. **Pre-existing conditions waiting period: 43 complaints** – these complaints are often 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. In these cases, the Office can seek a better explanation of the insurer's medical practitioner's decision and also provide an impartial review based on the medical evidence.

Figure 3: Top complaint issues, this quarter compared to 3 previous quarters



Case study – advice on a detrimental change

A person complained to our Office after their health insurer advised it intended to remove the excess waiver for same-day surgery from their cover. This meant they would be required to pay a $500 excess for same-day procedures.

A few days before the change took effect the person contacted the insurer to express their dissatisfaction that the excess waiver was being removed. They advised they had paid their premiums in full 18 months in advance and did not believe the change should be reflected immediately on their policy. The insurer explained the change was within its rules and offered to have a customer service officer speak with them about other policies that may suit their needs.

In subsequent correspondence, sent shortly after the change had taken effect, the insurer advised the person that if they did not wish to pay an excess for day surgery they could upgrade to a policy without an excess and complete a waiting period. The insurer explained waiting periods would apply as it would be considered a pre-existing condition.

After considering the complaint, our investigation officer concluded the insurer should have provided the person with better information about how to avoid losing the benefits of zero excess for same-day admissions before the change came into effect. In particular, the insurer should have explained they had an opportunity to transfer to another policy, either with the insurer or with another insurer, to maintain their zero-excess same-day surgery entitlement without having to serve a waiting period. This information was time sensitive and should have been provided before the policy change.

In response to the Office's views, the insurer agreed to upgrade the person to a policy with no excess and backdate their cover so that they could maintain continuity for the nil excess.

Case Study – incorrect clearance certificate

A person complained to our Office about an incorrect clearance certificate their previous health insurer provided.

The person explained they had contacted their current insurer to advise they were pregnant and to enquire about pregnancy and childbirth (obstetrics) services. Their current insurer informed them they were not eligible for pregnancy-related benefits as they had not yet served their full 12 month waiting period.

The person advised they had already served a waiting period with their previous insurer, so their current insurer suggested they obtain a clearance certificate from their previous insurer to verify this information.

After receiving the clearance certificate, their current insurer advised there was a gap of one day between the end date of their previous policy and the start date of their current policy. The insurer advised it was therefore unable to waive the waiting period because the person had not held continuous cover.

The person explained that they had made sure to take out a new policy before cancelling their earlier policy and that earlier correspondence from their previous insurer included the correct date.

Our Office contacted the person's previous insurer via our Assisted Referral process. In response, the previous insurer amended the incorrect date on the clearance certificate and provided the new certificate to the person's current insurer. This meant that the current insurer was able to recognise their previously served waiting period for obstetric services and the person was covered for their upcoming hospital admission.

Complaints by provider or organisation type

Most complaints handled by the Office are about Australian private health insurers. However, we also handle complaints about other providers if they relate to private health insurance arrangements.

Table 3: Complaints by provider or organisation type, this quarter compared to 3 previous quarters

Provider or organisation type	Sept 2020 quarter	Dec 2020 quarter	Mar 2021 quarter	Jun 2021 quarter
Health insurers	793	754	772	702
Overseas visitors and overseas student health insurers	93	89	105	53
Brokers and comparison services	8	6	8	4
Doctors, dentists and other medical providers	2	0	0	2
Hospitals and area health services	5	2	2	4
Other (e.g. legislation, ambulance services, industry peak bodies)	24	18	23	25
Total	*925*	*869*	*910*	*790*

Table 4: Complaints and disputes received, compared to health insurer market share, 1 April–30 June 2021

Name of insurer	Complaints[1]	Percentage of complaints	Disputes[2]	Percentage of disputes	Market share[3]
ACA Health Benefits	1	0.1%	0	0.0%	0.1%
AIA Health (myOwn)	2	0.3%	0	0.0%	0.2%
Australian Unity	39	5.6%	1	2.3%	2.6%
BUPA	148	21.1%	8	18.2%	25.4%
CBHS	9	1.3%	2	4.5%	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	0.6%	1	2.3%	0.6%
Defence Health	14	2.0%	1	2.3%	2.1%
Doctors' Health Fund	1	0.1%	0	0.0%	0.4%
GMHBA	8	1.1%	0	0.0%	2.1%
HBF Health & GMF/Healthguard	35	5.0%	3	6.8%	7.3%
HCF (Hospitals Contribution Fund)	172	24.5%	6	13.6%	11.7%
HCI (Health Care Insurance)	1	0.1%	0	0.0%	0.1%
Health Partners	3	0.4%	0	0.0%	0.7%
Health.com.au	8	1.1%	1	2.3%	0.5%
HIF (Health Insurance Fund of Aus.)	11	1.6%	1	2.3%	0.7%
Latrobe Health	7	1.0%	0	0.0%	0.6%
Medibank Private & AHM	122	17.4%	9	20.5%	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	1	0.1%	0	0.0%	0.3%
NIB Health & GU Corporate Health	76	10.8%	6	13.6%	9.2%
Nurses and Midwives Pty Ltd	2	0.3%	0	0.0%	0.1%
Peoplecare	1	0.1%	0	0.0%	0.5%
Phoenix Health Fund	1	0.1%	0	0.0%	0.1%
Police Health	1	0.1%	0	0.0%	0.4%
QLD Country Health Fund	1	0.1%	0	0.0%	0.4%
Railway & Transport Health	2	0.3%	1	2.3%	0.4%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Luke's Health	5	0.7%	2	4.5%	0.5%
Teachers Federation Health	15	2.1%	0	0.0%	2.5%
Transport Health	3	0.4%	0	0.0%	0.1%
TUH	2	0.3%	1	2.3%	0.6%
Westfund	7	1.0%	1	2.3%	0.9%
Total for Health Insurers	**702**	**100.0%**	**44**	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.

Table 5: Complaint issues and sub-issues 1 April–30 June 2021

ISSUE Sub issue	Sep 20	Dec 20	Mar 21	Jun 21
BENEFIT				
Accident and emergency	12	6	8	3
Accrued benefits	1	0	2	1
Ambulance	8	6	8	10
Amount	5	5	12	12
Delay in payment	26	61	60	51
Excess	7	10	11	7
Gap—Hospital	17	6	13	22
Gap—Medical	8	12	22	15
General treatment (extras/ancillary)	57	54	50	39
High cost drugs	3	4	1	0
Hospital exclusion/restriction	65	38	43	54
Insurer rule	24	23	32	24
Limit reached	3	5	1	1
New baby	1	2	0	4
Non-health insurance	2	1	2	2
Non-health insurance—overseas benefits	0	0	0	0
Non-recognised other practitioner	1	5	0	0
Non-recognised podiatry	2	5	2	2
Other compensation	0	1	0	2
Out of pocket not elsewhere covered	1	3	2	4
Out of time	4	3	2	2
Preferred provider schemes	11	11	5	5
Prostheses	3	4	1	3
Workers compensation	1	1	0	0
CONTRACT				
Hospitals	2	1	1	0
Preferred provider schemes	5	5	0	1
Second tier default benefit	1	3	0	0
COST				
Dual charging	7	5	4	9
Rate increase	24	14	36	16
INCENTIVES				
Lifetime Health Cover	31	31	40	39
Medicare Levy Surcharge	3	2	1	0
Private health insurance reforms	1	1	1	1
Rebate	2	5	1	5
Rebate tiers and surcharge changes	0	0	2	0
INFORMATION				
Brochures and websites	4	4	3	8
Lack of notification	17	12	7	9
Radio and television	0	0	0	0
Standard Information Statement	2	1	1	0
Verbal advice	48	43	46	16
Written advice	1	3	1	3

ISSUE Sub issue	Sep 20	Dec 20	Mar 21	Jun 21
INFORMED FINANCIAL CONSENT				
Doctors	2	4	0	2
Hospitals	4	0	1	4
Other	0	0	1	0
MEMBERSHIP				
Adult dependents	8	6	5	11
Arrears	3	7	6	2
Authority over membership	6	2	4	3
Cancellation	72	74	71	75
Clearance certificates	40	25	34	33
Continuity	23	23	19	13
Rate and benefit protection	0	1	0	9
Suspension	32	17	17	10
SERVICE				
Customer service advice	34	28	52	39
General service issues	41	46	65	43
Premium payment problems	34	34	31	45
Service delays	25	60	57	21
WAITING PERIOD				
Benefit limitation period	1	0	0	0
General	19	12	17	21
Obstetric	19	16	7	10
Other	7	3	3	8
Pre-existing conditions	76	67	62	43
OTHER				
Access	16	8	5	2
Acute care and type C certificates	2	4	2	1
Community rating	1	1	0	1
Complaint not elsewhere covered	5	2	5	3
Confidentiality and privacy	4	2	2	1
Demutualisation/sale of health insurers	1	0	0	1
Discrimination	0	0	0	1
Medibank sale	0	0	0	0
Non-English speaking background	0	0	0	0
Non-Medicare patient	0	0	1	1
Private patient election	2	2	1	0
Rule change	47	29	15	14

2020–21 in focus

During 2020–21, despite the COVID-19 pandemic, we were able to deliver services to the public with minimal disruption.

Some highlights include:

- We received 3,496 complaints. This represents a 5.7 per cent decrease compared to 2019–20, when we received 3,706 complaints. In the same period, we also received 1,705 enquiries about private health insurance.[4]
- The Office maintains the privatehealth.gov.au website which consumers can use to view and compare every policy available in Australia, with each product summarised in a simplified Private Health Information Statement (PHIS) format. In 2020–21, over 1 million visitors accessed the website and downloaded more than 2.7 million PHIS.
- In consultation with private health insurance stakeholders, we produced a new guide Private Health Insurance Ombudsman: How we deal with complaints (information for insurers). This summarises the Office's approach to handling and reporting on complaints.
- We published the *State of the Health Funds Report 2020* on 1 March 2021. The report provides comparative information about the performance and service delivery of all health insurers. We will publish our next annual State of the Health Funds report by 1 April 2021–22.

COVID-19 impacts

Complaints related to the COVID-19 pandemic

During 2020–21 the Office received 192 complaints and 41 enquiries about issues related to the COVID-19 pandemic. Most of these complaints were about requests to suspend a policy, the cost of premiums and being unable to access hospital and general treatment services as planned.

The issue that prompted the most COVID-related complaints was membership suspension (41 complaints), where consumers requested temporary suspensions of their membership due to financial hardship. Although many health insurers decided to assist policy holders experiencing financial hardship, some consumers needed assistance from our Office to make an application.

Almost all insurers postponed their 1 April 2020 premium increases for at least 6 months to 1 October 2020. Many insurers also introduced arrangements to provide financial relief to people who lose their jobs, are underemployed, in hardship or contract the virus. Most insurers covered COVID-related treatment for existing policyholders.

Deferred liability claims pool

During the 2020–21 pandemic when consumers had limited access to services, insurers retained a deferred liability claims pool to cover potential future costs. For example, some or most of the people who deferred a hospital admission due to the pandemic may still have the surgery later. It was important that insurers retained sufficient funds to cover these claims when or if they eventuated.

Where the cost of deferred claims was not as high as anticipated, some insurers are now returning, or considering returning, excess funds retained in the pool to their policy holders.

[4] As we revised our methodology for counting private health insurance enquiries during 2019–20, it is not possible to directly compare this figure to the number of enquiries we received during the previous year.

Data

The data in this bulletin is for the period 1 April–30 June 2021. 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 bulletin. Previous quarterly bulletins are available on the Ombudsman's website.