COMMONWEALTH OMBUDSMAN
PRIVATE HEALTH INSURANCE

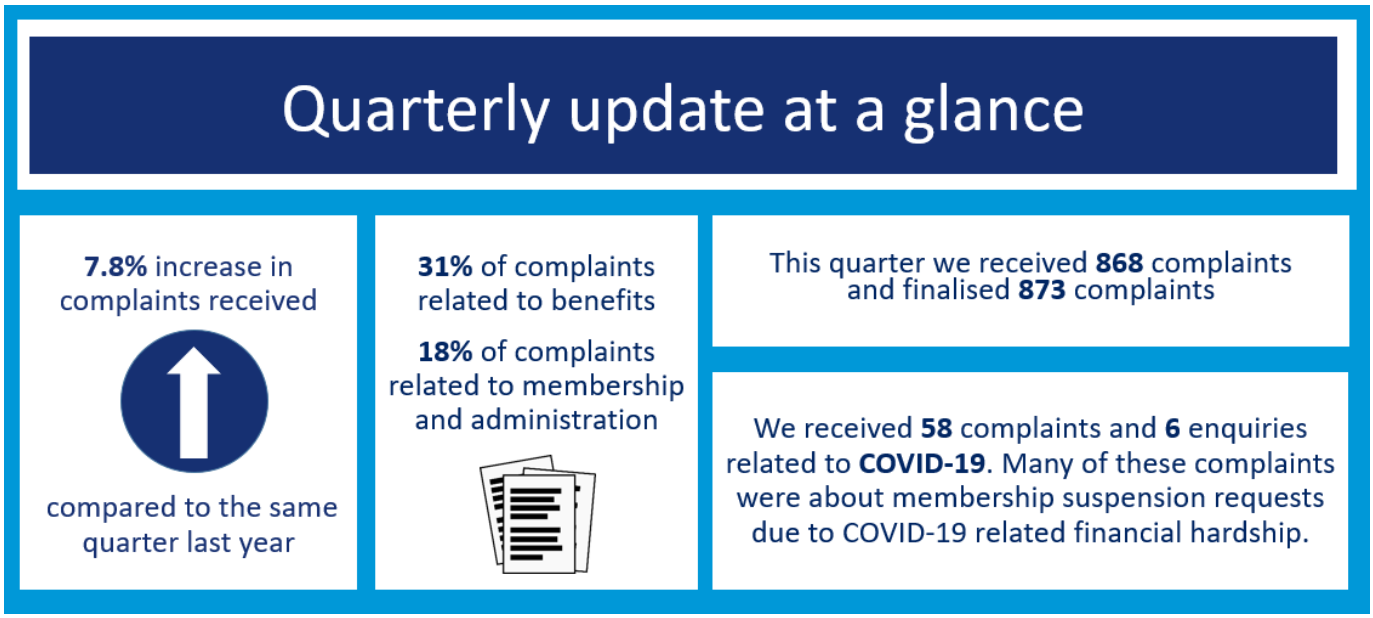
# Quarterly Bulletin 97: 1 October–31 December 2020

## Executive Summary

This is the 97th 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 October–31 December 2020 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.



## COVID-19

### Complaints

In the October to December 2020 period, the Office received 58 complaints and six enquiries related to COVID-19. The reduction in the number of complaints related to COVID-19 is likely due to the easing of restrictions and consumers being able to access health services and claim health insurer benefits.

The issues which received the most complaints in this quarter were related to suspension requests, cancellation, and the inability to access hospital and general treatment services as planned:

1. membership suspension: eight complaints—consumers seeking temporary suspensions of membership due to financial hardship as a result of COVID-19
2. membership cancellation: nine complaints—consumers experiencing delays in cancelling their cover or obtaining a refund
3. access: seven complaints—these complaints related to difficulty in accessing services such as elective surgery and extras benefits due to COVID-19 restrictions.

### Premium increase 1 April 2021

On 21 December 2020, the Minister for Health announced private health insurance premiums would increase on average by 2.74 per cent from 1 April 2021.[1]

In the previous year, most insurers delayed their 1 April 2020 premium increase to 1 October 2020 due to the impacts of COVID-19.

We suggest that consumers who have queries about their premium increase or any changes to their policy should first contact their insurer. If they are not satisfied with their policy or their new premium, their current health insurer or another insurer may be able to offer an alternative private health insurance policy that meets their needs.

We advise consumers to take care to understand the range of benefits and any conditions or restrictions before choosing a lower cost cover. In general, we suggest giving priority to maintaining cover for a broad range of conditions in hospital cover, to protect against the risk of unanticipated medical conditions in future years.

For more information, please see the Office's factsheet on Health insurance premium increases or visit our website privatehealth.gov.au where consumers can review product information from every insurer in Australia.

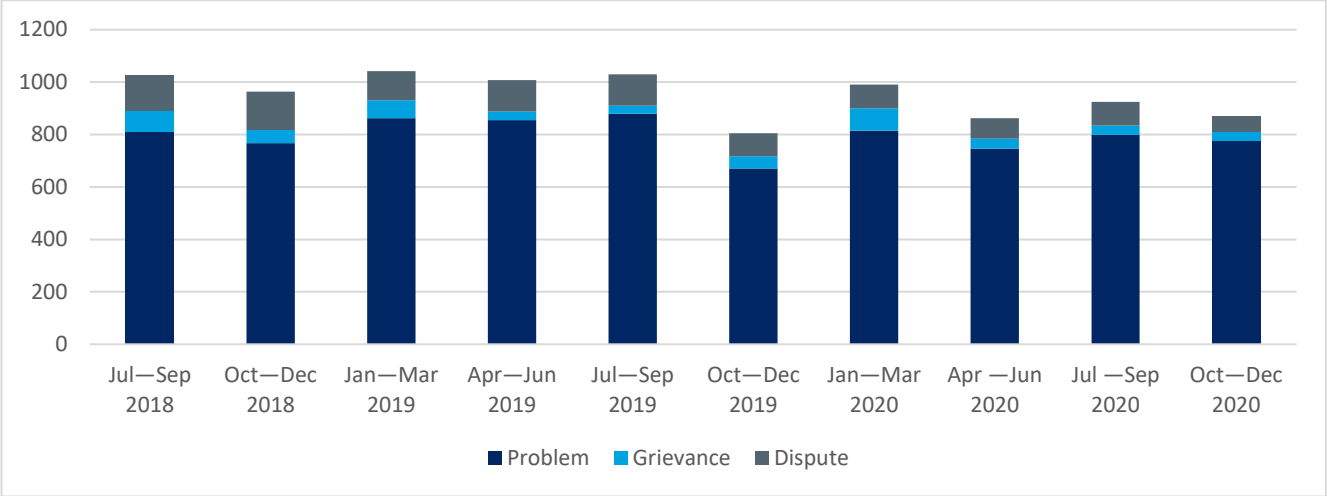
## Complaints and enquiries received

The Office received 868 private health insurance complaints this quarter. This represented an increase of 7.8 per cent compared to the same period last year, but a 6.5 per cent decrease compared to the previous quarter. Complaints are typically lower in the December quarter, due to the holiday period.

[1] Department of Health Circular 88/20: https://www.health.gov.au/phi-8820-2021-private-health-insurance-premium-round-announcement

### 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 868 and finalised 873 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 referred the issue to the private health insurer for a resolution or we are assured that the private health insurer made the right decision.

During this period we met our five service standards.

Table 1—Complaint handling service standards 1 October–31 December 2020

| Timeframe | Service Standard | Complaints finalised |
|---|---|---|
| Within 2 business days | 70% | 84.2% |
| Within 7 days | 85% | 87.7% |
| Within 30 days | 90% | 92.8% |
| Within 90 days | 95% | 98.9% |
| Within 12 months | 99% | 100.0% |

This quarter we received 318 and finalised 333 enquiries. All enquiries received in the quarter were finalised within our service standards.

Table 2—Enquiries service standards 1 October–31 December 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, 78 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 and 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 15 per cent of complaints this quarter by providing further information.

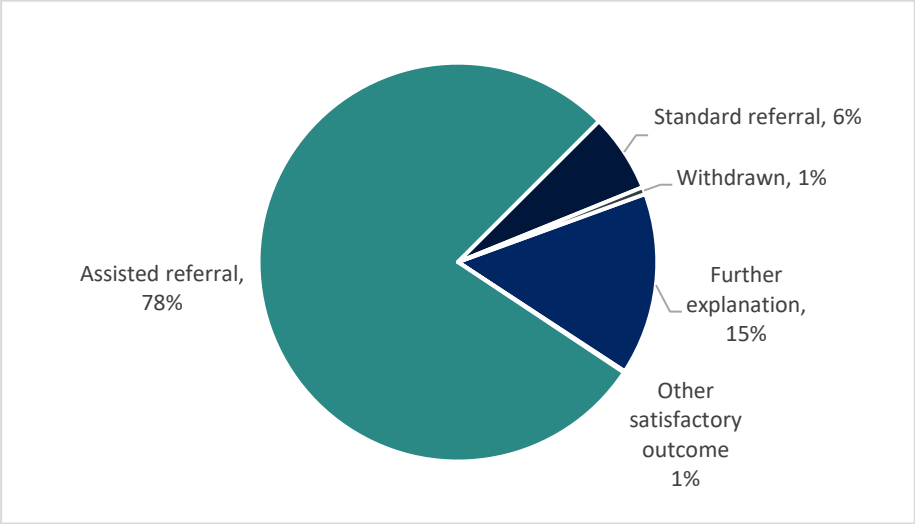
### Withdrawn

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 October–December 2020



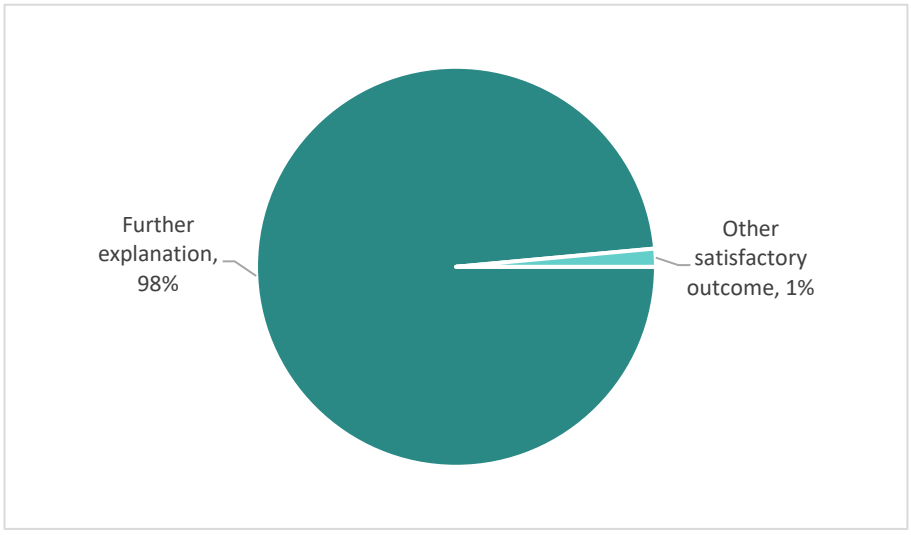
### Disputes

During the quarter we finalised 50 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:

- 98 per cent of disputes were finalised by providing complainants with a further explanation
- one 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.

**Figure 3—Disputes finalised October–December 2020**

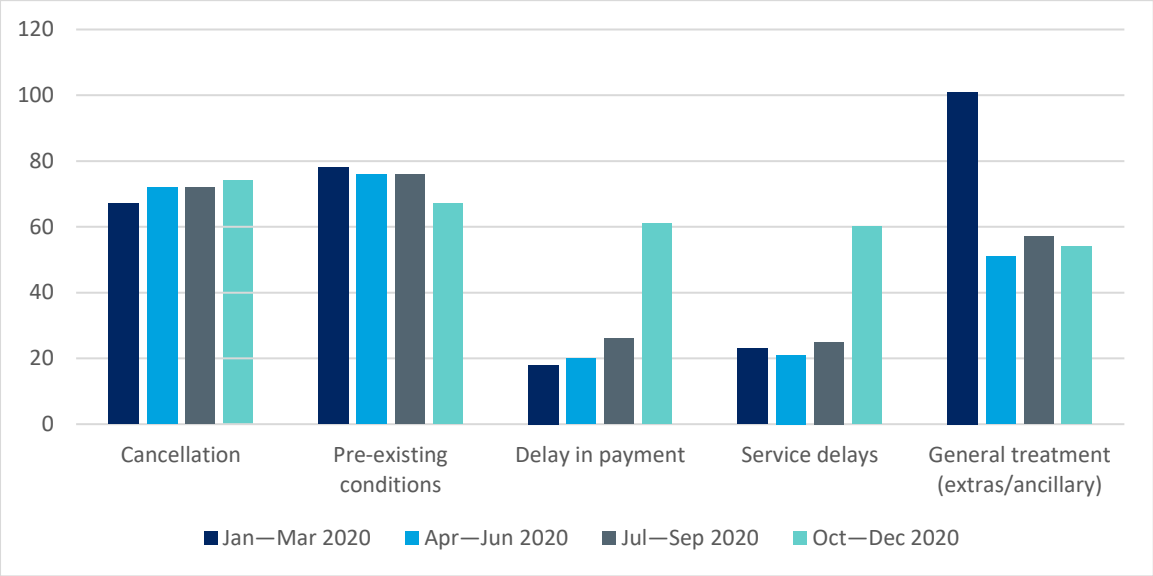



## Complaint issues

The top five consumer complaint issues this quarter were:

1. **Membership cancellation: 74 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.
2. **Pre-existing conditions waiting period: 67 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.
3. **Delay in benefit payment: 64 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. In this quarter, these complaints were higher than usual due to HCF undertaking a major system upgrade which caused claim delays.
4. **Service delays**: **60 complaints** —these complaints are typically received from consumers experiencing difficulty in contacting their insurer or concerned about delays or inaction from health insurer's customer service staff. The increase in service delays was also linked to HCF's system upgrade which caused a backlog of consumer contacts.
5. **General treatment benefits: 54 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).

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 | Mar 2020 quarter | Jun 2020 quarter | Sept 2020 quarter | Dec 2020 quarter |
|---|---|---|---|---|
| Health insurers | 852 | 741 | 793 | 754 |
| Overseas visitors and overseas student health insurers | 80 | 81 | 93 | 89 |
| Brokers and comparison services | 10 | 5 | 8 | 6 |
| Doctors, dentists and other medical providers | 8 | 3 | 2 | 0 |
| Hospitals and area health services | 6 | 7 | 5 | 2 |
| Other (e.g. legislation, ambulance services, industry peak bodies) | 35 | 25 | 24 | 18 |

Table 4—Complaints and disputes compared to health insurer market share 1 October–31 December 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% |
| AIA Health (myOwn) | 6 | 0.8% | 0 | 0.0% | 0.2% |
| Australian Unity | 34 | 4.5% | 3 | 6.5% | 2.6% |
| BUPA | 174 | 23.1% | 11 | 23.9% | 25.4% |
| CBHS | 14 | 1.9% | 4 | 8.7% | 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 | 11 | 1.5% | 1 | 2.2% | 2.1% |
| Doctors' Health Fund | 2 | 0.3% | 1 | 2.2% | 0.4% |
| GMHBA | 19 | 2.5% | 0 | 0.0% | 2.1% |
| HBF Health & GMF/Healthguard | 32 | 4.2% | 2 | 4.3% | 7.3% |
| HCF (Hospitals Contribution Fund) | 230 | 30.5% | 10 | 21.7% | 11.7% |
| 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 | 6 | 0.8% | 1 | 2.2% | 0.5% |
| HIF (Health Insurance Fund of Aus.) | 7 | 0.9% | 0 | 0.0% | 0.7% |
| Latrobe Health | 5 | 0.7% | 0 | 0.0% | 0.6% |
| Medibank Private & AHM | 119 | 15.8% | 4 | 8.7% | 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 | 1 | 0.1% | 0 | 0.0% | 0.3% |
| NIB Health & GU Corporate Health | 49 | 6.5% | 5 | 10.9% | 9.2% |
| Nurses and Midwives Pty Ltd | 2 | 0.3% | 1 | 2.2% | 0.1% |
| Peoplecare | 3 | 0.4% | 0 | 0.0% | 0.5% |
| Phoenix Health Fund | 0 | 0.0% | 0 | 0.0% | 0.1% |
| Police Health | 0 | 0.0% | 0 | 0.0% | 0.4% |
| QLD Country Health Fund | 0 | 0.0% | 0 | 0.0% | 0.4% |
| Railway & Transport Health | 3 | 0.4% | 0 | 0.0% | 0.4% |
| Reserve Bank Health | 0 | 0.0% | 0 | 0.0% | <0.1% |
| St Lukes Health | 7 | 0.9% | 0 | 0.0% | 0.5% |
| Teachers Federation Health | 12 | 1.6% | 1 | 2.2% | 2.5% |
| Transport Health | 4 | 0.5% | 0 | 0.0% | 0.1% |
| TUH | 3 | 0.4% | 2 | 4.3% | 0.6% |
| Westfund | 4 | 0.5% | 0 | 0.0% | 0.9% |
| **Total for Health Insurers** | **754** | **100.0%** | **46** | **100.0%** | |

[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 2020.

Table 5—Complaint issues and sub-issues 1 October–31 December 2020

| ISSUE<br>Sub-issue | Mar 20 | Jun 20 | Sep 20 | Dec 20 |
|---|---|---|---|---|
| **BENEFIT** | | | | |
| Accident and emergency | 15 | 7 | 12 | 6 |
| Accrued benefits | 1 | 1 | 1 | 0 |
| Ambulance | 8 | 10 | 8 | 6 |
| Amount | 5 | 4 | 5 | 5 |
| Delay in payment | 18 | 20 | 26 | 61 |
| Excess | 9 | 10 | 7 | 10 |
| Gap—Hospital | 27 | 16 | 17 | 6 |
| Gap—Medical | 27 | 19 | 8 | 12 |
| General treatment (extras/ancillary) | 101 | 51 | 57 | 54 |
| High cost drugs | 1 | 1 | 3 | 4 |
| Hospital exclusion/restriction | 54 | 45 | 65 | 38 |
| Insurer rule | 27 | 21 | 24 | 23 |
| Limit reached | 2 | 1 | 3 | 5 |
| New baby | 1 | 4 | 1 | 2 |
| Non-health insurance | 1 | 1 | 2 | 1 |
| Non-health insurance—overseas benefits | 0 | 1 | 0 | 0 |
| Non-recognised other practitioner | 6 | 4 | 1 | 5 |
| Non-recognised podiatry | 2 | 3 | 2 | 5 |
| Other compensation | 1 | 3 | 0 | 1 |
| Out of pocket not elsewhere covered | 9 | 0 | 1 | 3 |
| Out of time | 0 | 2 | 4 | 3 |
| Preferred provider schemes | 7 | 5 | 11 | 11 |
| Prostheses | 4 | 1 | 3 | 4 |
| Workers compensation | 4 | 0 | 1 | 1 |
| **CONTRACT** | | | | |
| Hospitals | 0 | 11 | 2 | 1 |
| Preferred provider schemes | 3 | 3 | 5 | 5 |
| Second tier default benefit | 0 | 0 | 1 | 3 |
| **COST** | | | | |
| Dual charging | 4 | 6 | 7 | 5 |
| Rate increase | 60 | 28 | 24 | 14 |
| **INCENTIVES** | | | | |
| Lifetime Health Cover | 42 | 43 | 31 | 31 |
| Medicare Levy Surcharge | 3 | 0 | 3 | 2 |
| Private health insurance reforms | 9 | 3 | 1 | 1 |
| Rebate | 1 | 3 | 2 | 5 |
| Rebate tiers and surcharge changes | 0 | 0 | 0 | 0 |
| **INFORMATION** | | | | |
| Brochures and websites | 7 | 1 | 4 | 4 |
| Lack of notification | 16 | 14 | 17 | 12 |
| Radio and television | 0 | 1 | 0 | 0 |
| Standard Information Statement | 3 | 5 | 2 | 1 |
| Verbal advice | 46 | 22 | 48 | 43 |
| Written advice | 10 | 2 | 1 | 3 |

| ISSUE<br>Sub-issue | Mar 20 | Jun 20 | Sep 20 | Dec 20 |
|---|---|---|---|---|
| **INFORMED FINANCIAL CONSENT** | | | | |
| Doctors | 6 | 2 | 2 | 4 |
| Hospitals | 2 | 1 | 4 | 0 |
| Other | 2 | 3 | 0 | 0 |
| **MEMBERSHIP** | | | | |
| Adult dependents | 6 | 6 | 8 | 6 |
| Arrears | 12 | 6 | 3 | 7 |
| Authority over membership | 4 | 12 | 6 | 2 |
| Cancellation | 67 | 72 | 72 | 74 |
| Clearance certificates | 24 | 39 | 40 | 25 |
| Continuity | 27 | 21 | 23 | 23 |
| Rate and benefit protection | 6 | 0 | 0 | 1 |
| Suspension | 21 | 67 | 32 | 17 |
| **SERVICE** | | | | |
| Customer service advice | 21 | 12 | 34 | 28 |
| General service issues | 54 | 23 | 41 | 46 |
| Premium payment problems | 45 | 37 | 34 | 34 |
| Service delays | 23 | 21 | 25 | 60 |
| **WAITING PERIOD** | | | | |
| Benefit limitation period | 0 | 0 | 1 | 0 |
| General | 13 | 13 | 19 | 12 |
| Obstetric | 7 | 17 | 19 | 16 |
| Other | 2 | 3 | 7 | 3 |
| Pre-existing conditions | 78 | 76 | 76 | 67 |
| **OTHER** | | | | |
| Access | 4 | 25 | 16 | 8 |
| Acute care and type C certificates | 2 | 4 | 2 | 4 |
| Community rating | 1 | 0 | 1 | 1 |
| Complaint not elsewhere covered | 8 | 6 | 5 | 2 |
| Confidentiality and privacy | 7 | 0 | 4 | 2 |
| Demutualisation/sale of health insurers | 0 | 0 | 1 | 0 |
| Discrimination | 0 | 0 | 0 | 0 |
| Medibank sale | 0 | 0 | 0 | 0 |
| Non-English speaking background | 0 | 0 | 0 | 0 |
| Non-Medicare patient | 1 | 0 | 0 | 0 |
| Private patient election | 3 | 0 | 2 | 2 |
| Rule change | 26 | 26 | 47 | 29 |

## Data

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