COMMONWEALTH OMBUDSMAN
PRIVATE HEALTH INSURANCE

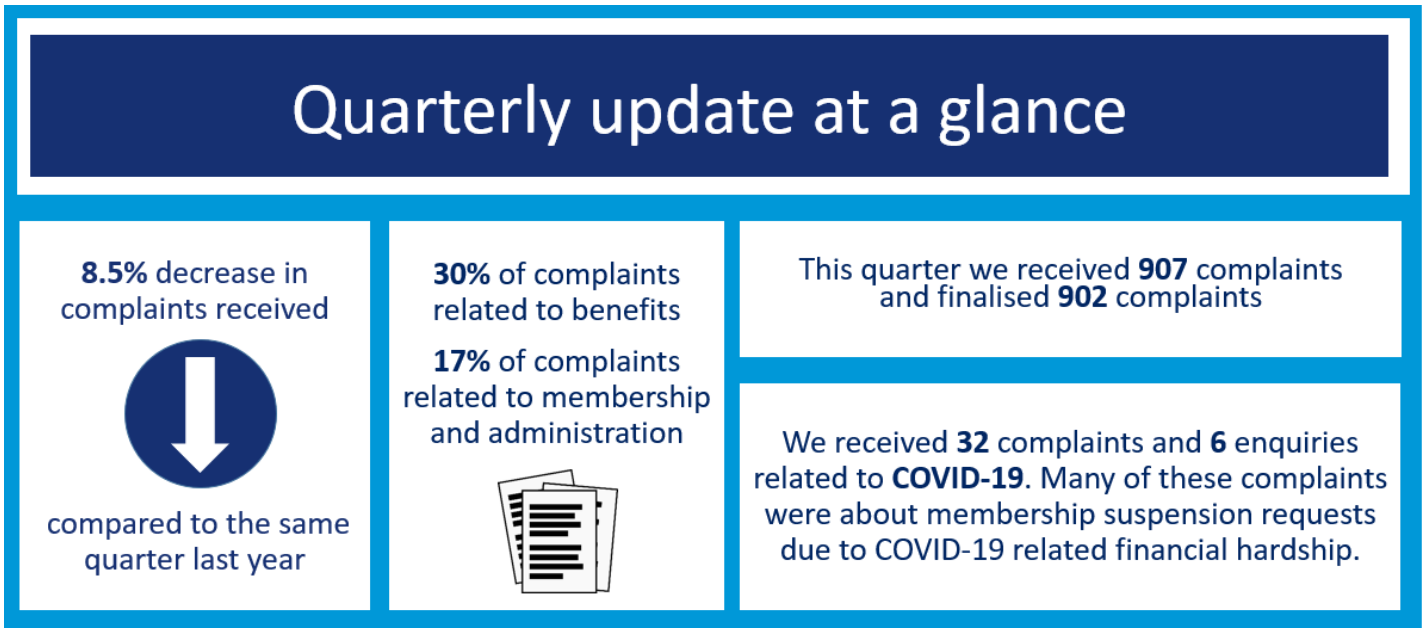
Quarterly Bulletin 98: 1 January–31 March 2021

Executive Summary

This is the 98th 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 January–31 March 2021 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.



COVID-19

In the January to March 2021 period, the Office received 32 complaints and six enquiries related to COVID-19, compared to 58 complaints and six enquiries in the previous quarter. The continued 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 insurance benefits.

The most common complaints in this quarter were related to temporary suspension requests, cancellation and the inability to access general treatment (extras) benefits:

1. membership suspension: seven complaints – consumers seeking temporary suspension of membership due to financial hardship as a result of COVID-19
2. membership cancellation: six complaints – consumers experiencing delays in cancelling their cover or obtaining a refund
3. general treatment (extras) benefit: five complaints – consumers unable to access general treatment services and claim health insurer benefits due to COVID-19 restrictions.

Lifetime Health Cover mailing

Each year the Department of Health sends letters to Australian citizens and permanent residents who have recently turned 31 or registered for full Medicare benefits to inform them about the Lifetime Health Cover (LHC) rules. This year the mailing will commence in late May.

The deadline for the 31-year-old cohort to apply for private hospital cover and avoid paying a LHC loading is 30 June 2021. For new migrants, the deadline is one year from the date they registered for full Medicare (usually a blue or green card).

Please visit privatehealth.gov.au for further information about LHC.

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

The Government previously announced that it will increase the maximum age of dependents for private health insurance policies from 24 to 31 years and remove the age limit for dependents with a disability. These changes are currently before Parliament. If the changes are passed, insurers will be able to introduce policies under these two dependent categories.

We understand insurers will need time to review and implement these changes to their policies. Consumers will be able to search the privatehealth.gov.au website for the new policies as they become available.

Commonwealth Ombudsman general advice to stakeholders

Insurers and industry stakeholders often contact our Office for general advice on policy and membership issues, which we provide on the basis that we are stating a view about impacts on consumers and complaints.

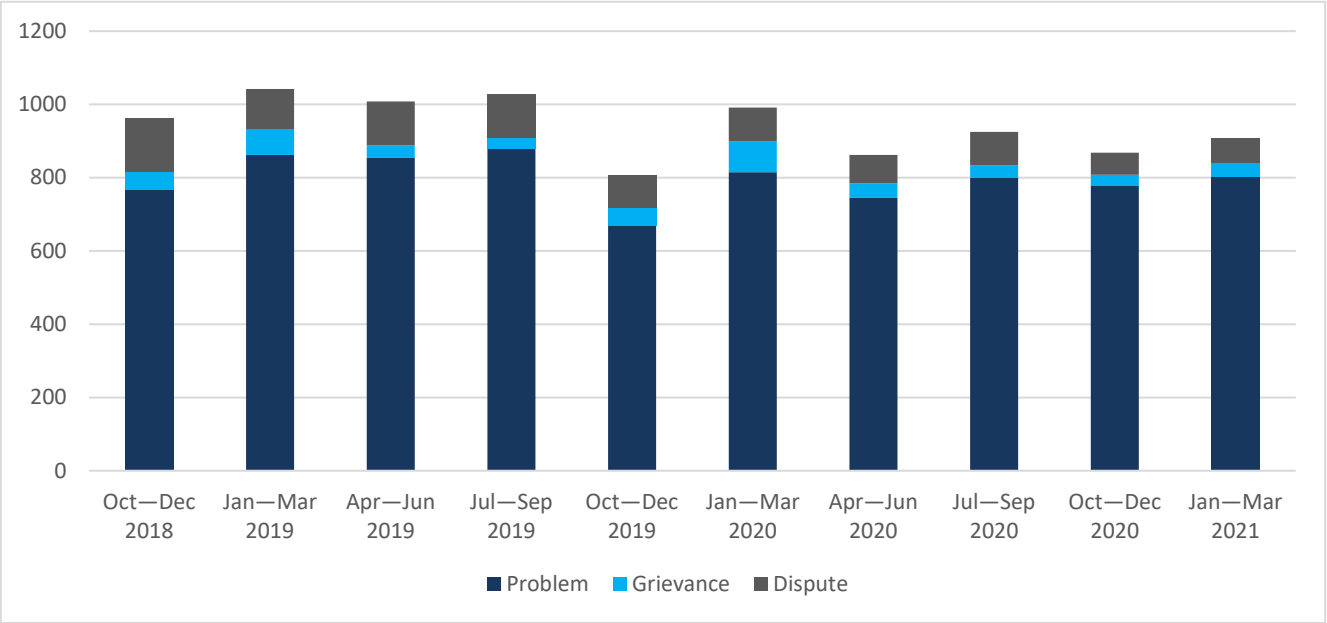
The Office does not provide legal advice, and stakeholders should seek their own independent legal advice on matters of legislative compliance. Likewise, advice provided in Ombudsman publications such as previous quarterly bulletins cannot be taken as legal advice on compliance with private health insurance regulations.

Complaints and enquiries received

The Office received 907 private health insurance complaints this quarter. This represents a decrease of 8.5 per cent compared to the same period last year, but a 4.5 per cent increase compared to the previous quarter. The Office typically receives more complaints in the March quarter leading up to insurers implementing the 1 April rate increase.

Complaints received by quarter

Figure 1—Complaints received by quarter



Complaints are categorised as follows:

- **Problem:** complaint 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:** complaint noted and closed with no further action warranted
- **Dispute:** complaint requiring further investigation.

Complaints and enquiries finalised

Timeframes to finalise complaints in the quarter

This quarter we received 907 and finalised 902 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 January–31 March 2021

Timeframe	Service Standard	Complaints finalised
Within 2 business days	70%	80.9%
Within 7 days	85%	87.9%
Within 30 days	90%	92.8%
Within 90 days	95%	97.9%
Within 12 months	99%	99.8%

This quarter we received 449 and finalised 442 enquiries. All enquiries received in the quarter were finalised within our service standards. Enquiries are finalised by the provision of general advice or information.

Table 2—Enquiries service standards 1 January–31 March 2021

Timeframe	Service Standard	Enquiries finalised
Within 2 business days	95%	95.9%
Within 7 days	99%	99.1%

Actions taken to finalise complaints in the quarter

Assisted referral

In this quarter, 84 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, eight 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 eight per cent of complaints this quarter by providing further information.

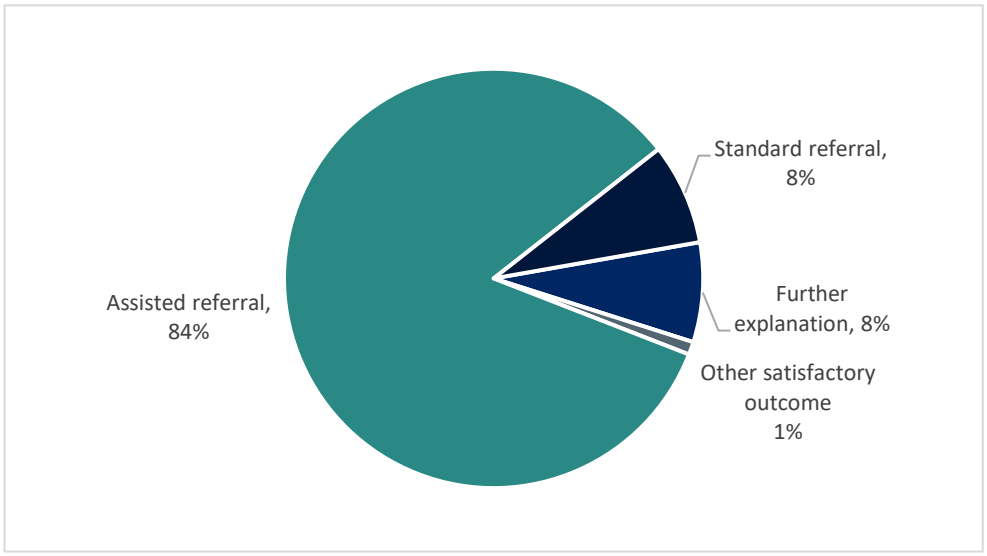
Withdrawn

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 1 January–31 March 2021



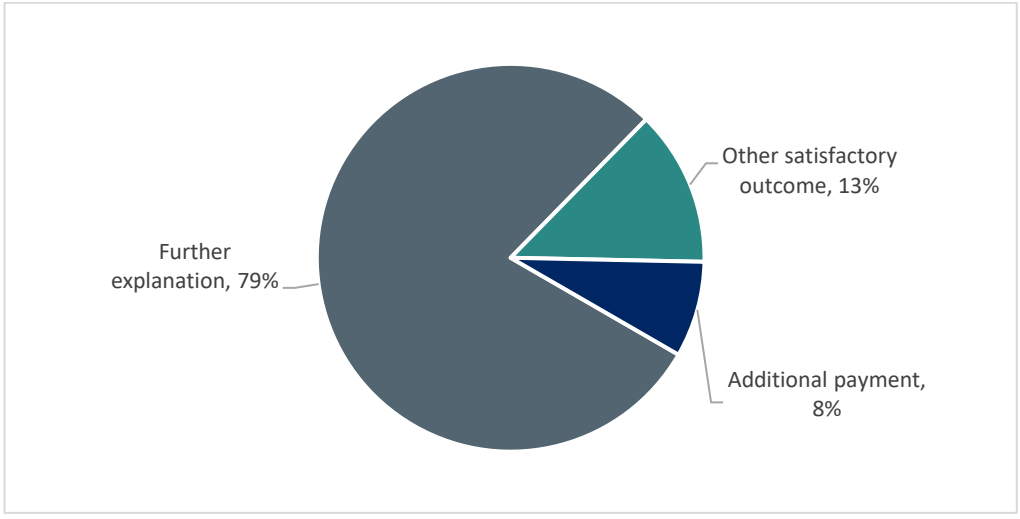
Disputes

During the quarter we finalised 39 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:

- 79 per cent of disputes were finalised by providing complainants with a further explanation
- 13 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 1 January–31 March 2021

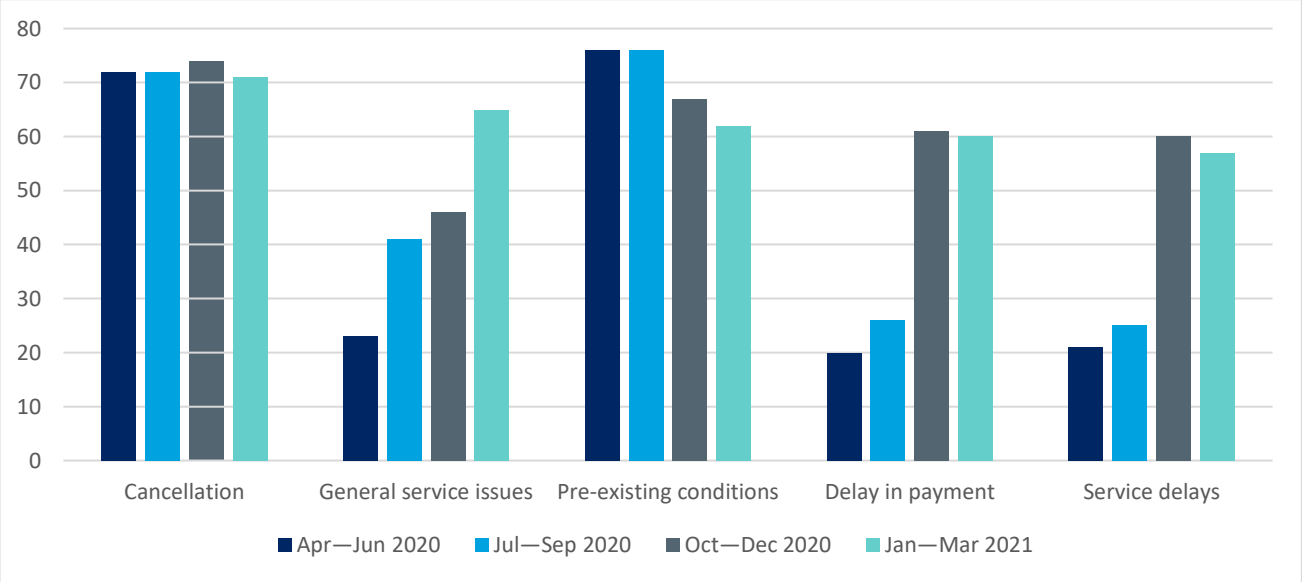


Complaint issues

The top five consumer complaint issues this quarter were:

1. **Membership cancellation: 71 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. **General service issues: 65 complaints**—service issues are not usually the sole reason for complaints. A combination of unsatisfactory customer service, untimely responses to simple issues, and poor internal escalation processes can cause policy-holders to grow increasingly aggrieved and dissatisfied with their dealings with the insurer, until the service itself becomes a cause of complaint as well as the original issue.
3. **Pre-existing conditions waiting period: 62 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 can seek a better explanation of the insurer's medical practitioner's decision as well as provide an impartial review based on the medical evidence.
4. **Delay in benefit payment: 60 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.
5. **Service delays**: **57 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.

Figure 4—Top complaint issues, this quarter compared to three previous quarters



Case study – delay in payment of benefit

A person submitted a claim for hospital treatment with their health insurer. The person understood they were covered for the full cost of treatment, however, they received only a partial refund from their insurer. When they queried this, the insurer acknowledged it had paid the incorrect amount and that a further payment would be made within three weeks to cover the full claim.

After waiting three weeks, the person contacted the insurer again and was told a cheque had been sent but had not been received. The person was then told the refund would be paid into their bank account within a few business days. Two months later, the person eventually contacted our Office to complain that after several attempts at following up, the payment had still not been received.

The Office referred the complaint to the insurer through our Assisted Referral process. The insurer investigated the matter and advised that it had initially issued the refund to the person via cheque, however, it failed to reissue the payment via EFT after the cheque had been cancelled. The insurer confirmed that the refund had been paid and it provided an apology to the person.

Case Study – incorrect advice

A person contacted their insurer by telephone to seek advice about the pregnancy-related benefits they were entitled to access under their policy. They quoted item numbers that had been provided to them by their obstetrician and the insurer confirmed the amount that would be covered for each service.

When the person later attempted to claim an outpatient (out of hospital) "pregnancy management fee" of $5,000, the insurer advised that this service was not included under their level of cover. This was inconsistent with earlier advice that the insurer would cover the full amount of fees for the delivery of the person's baby, less an excess of $500.

The person complained to their health insurer about the advice they received, but the insurer maintained it had not provided wrong advice because it had a record made by the agent who spoke to them stating they were told outpatient services were not covered. The insurer declined to reimburse the person the $5,000 fee on the basis that they were not entitled to any benefit.

The person then contacted our Office, stating they would never have accessed this service had they known they were not covered for it. The Office contacted the insurer on the person's behalf. In responding to our enquiries, the insurer advised it had reviewed historical calls that had not been considered during its initial investigation of the complaint. Based on the call recordings, and not the written record, the insurer agreed that the person had been left with the impression that the pregnancy management fee would be included in the hospital account. On that basis, the insurer decided to approve an ex gratia benefit of $5000 to the person.

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, as long as it relates to private health insurance arrangements.

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

Provider or organisation type	Jun 2020 quarter	Sept 2020 quarter	Dec 2020 quarter	Mar 2021 quarter
Health insurers	741	793	754	772
Overseas visitors and overseas student health insurers	81	93	89	105
Brokers and comparison services	5	8	6	8
Doctors, dentists and other medical providers	3	2	0	0
Hospitals and area health services	7	5	2	2
Other (e.g. legislation, ambulance services, industry peak bodies)	25	24	18	23

Table 4—Complaints and disputes compared to health insurer market share 1 January–31 March 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)	9	1.2%	0	0.0%	0.2%
Australian Unity	37	4.8%	1	2.2%	2.6%
BUPA	158	20.5%	6	13.0%	25.4%
CBHS	8	1.0%	0	0.0%	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	12	1.6%	1	2.2%	2.1%
Doctors' Health Fund	2	0.3%	1	2.2%	0.4%
GMHBA	15	1.9%	1	2.2%	2.1%
HBF Health & GMF/Healthguard	26	3.3%	2	4.3%	7.3%
HCF (Hospitals Contribution Fund)	207	26.8%	7	15.2%	11.7%
HCI (Health Care Insurance)	0	0.0%	0	0.0%	0.1%
Health Partners	5	0.6%	0	0.0%	0.7%
Health.com.au	9	1.2%	2	4.3%	0.5%
HIF (Health Insurance Fund of Aus.)	3	0.4%	0	0.0%	0.7%
Latrobe Health	9	1.2%	1	2.2%	0.6%
Medibank Private & AHM	147	19.0%	13	28.3%	26.9%
Mildura District Hospital Fund	1	0.1%	1	2.2%	0.3%
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
Navy Health	4	0.5%	1	2.2%	0.3%
NIB Health & GU Corporate Health	73	9.5%	4	8.7%	9.2%
Nurses and Midwives Pty Ltd	0	0.0%	0	0.0%	0.1%
Peoplecare	2	0.3%	0	0.0%	0.5%
Phoenix Health Fund	1	0.1%	0	0.0%	0.1%
Police Health	0	0.0%	0	0.0%	0.4%
QLD Country Health Fund	3	0.4%	0	0.0%	0.4%
Railway & Transport Health	4	0.5%	0	0.0%	0.4%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Lukes Health	4	0.5%	0	0.0%	0.5%
Teachers Federation Health	22	2.8%	2	4.3%	2.5%
Transport Health	2	0.3%	0	0.0%	0.1%
TUH	2	0.3%	2	4.3%	0.6%
Westfund	2	0.3%	1	2.2%	0.9%
Total for Health Insurers	**772**	**100.0%**	**46**	**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 January–31 March 2021

ISSUE Sub issue	Jun 20	Sep 20	Dec 20	Mar 21
BENEFIT				
Accident and emergency	7	12	6	8
Accrued benefits	1	1	0	2
Ambulance	10	8	6	8
Amount	4	5	5	12
Delay in payment	20	26	61	60
Excess	10	7	10	11
Gap—Hospital	16	17	6	13
Gap—Medical	19	8	12	22
General treatment (extras/ancillary)	51	57	54	50
High cost drugs	1	3	4	1
Hospital exclusion/restriction	45	65	38	43
Insurer rule	21	24	23	32
Limit reached	1	3	5	1
New baby	4	1	2	0
Non-health insurance	1	2	1	2
Non-health insurance—overseas benefits	1	0	0	0
Non-recognised other practitioner	4	1	5	0
Non-recognised podiatry	3	2	5	2
Other compensation	3	0	1	0
Out of pocket not elsewhere covered	0	1	3	2
Out of time	2	4	3	2
Preferred provider schemes	5	11	11	5
Prostheses	1	3	4	1
Workers compensation	0	1	1	0
CONTRACT				
Hospitals	11	2	1	1
Preferred provider schemes	3	5	5	0
Second tier default benefit	0	1	3	0
COST				
Dual charging	6	7	5	4
Rate increase	28	24	14	36
INCENTIVES				
Lifetime Health Cover	43	31	31	40
Medicare Levy Surcharge	0	3	2	1
Private health insurance reforms	3	1	1	1
Rebate	3	2	5	1
Rebate tiers and surcharge changes	0	0	0	2
INFORMATION				
Brochures and websites	1	4	4	3
Lack of notification	14	17	12	7
Radio and television	1	0	0	0
Standard Information Statement	5	2	1	1
Verbal advice	22	48	43	46
Written advice	2	1	3	1

ISSUE Sub issue	Jun 20	Sep 20	Dec 20	Mar 21
INFORMED FINANCIAL CONSENT				
Doctors	2	2	4	0
Hospitals	1	4	0	1
Other	3	0	0	1
MEMBERSHIP				
Adult dependents	6	8	6	5
Arrears	6	3	7	6
Authority over membership	12	6	2	4
Cancellation	72	72	74	71
Clearance certificates	39	40	25	34
Continuity	21	23	23	19
Rate and benefit protection	0	0	1	0
Suspension	67	32	17	17
SERVICE				
Customer service advice	12	34	28	52
General service issues	23	41	46	65
Premium payment problems	37	34	34	31
Service delays	21	25	60	57
WAITING PERIOD				
Benefit limitation period	0	1	0	0
General	13	19	12	17
Obstetric	17	19	16	7
Other	3	7	3	3
Pre-existing conditions	76	76	67	62
OTHER				
Access	25	16	8	5
Acute care and type C certificates	4	2	4	2
Community rating	0	1	1	0
Complaint not elsewhere covered	6	5	2	5
Confidentiality and privacy	0	4	2	2
Demutualisation/sale of health insurers	0	1	0	0
Discrimination	0	0	0	0
Medibank sale	0	0	0	0
Non-English speaking background	0	0	0	0
Non-Medicare patient	0	0	0	1
Private patient election	0	2	2	1
Rule change	26	47	29	15

Data

The data in this bulletin is for the period 1 January–31 March 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.

More information is available at **ombudsman.gov.au**.