COMMONWEALTH OMBUDSMAN
PRIVATE HEALTH INSURANCE

Quarterly Update: 1 January–31 March 2022

During this quarter, the Office of the Commonwealth Ombudsman (the Office) received 532 complaints in its capacity as the Private Health Insurance Ombudsman.[1] This was a decrease of 41 per cent compared to the same period last year, continuing the existing downward trend. During the previous 3 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 some consumers not using their health insurance due to restrictions associated with COVID-19, and a reduction in planned hospital treatments and routine general treatment services. The Office continues to analyse complaint data to identify trends or themes that may also be associated with this decrease.

Figure 1: Complaints received by quarter

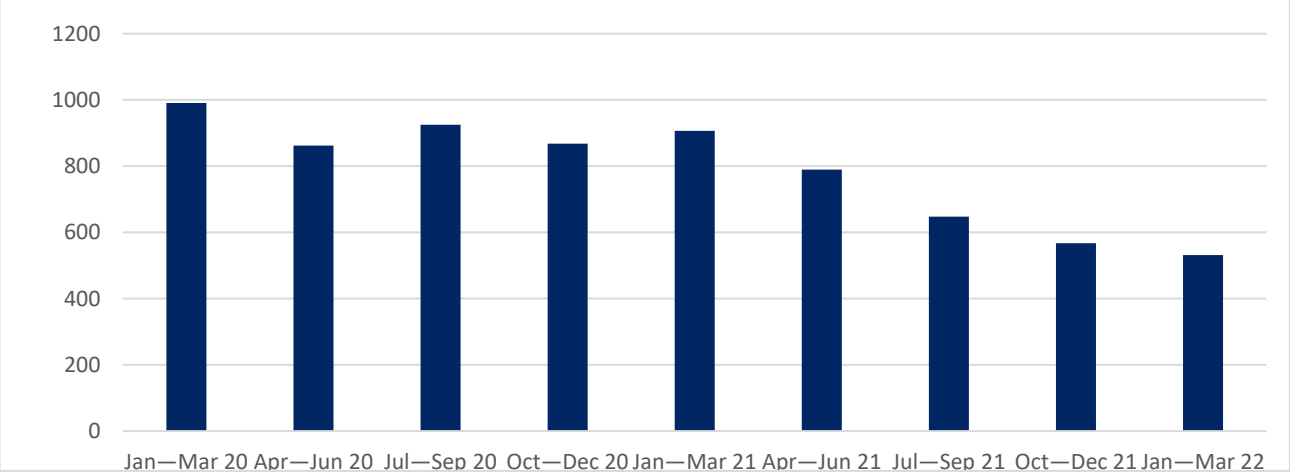
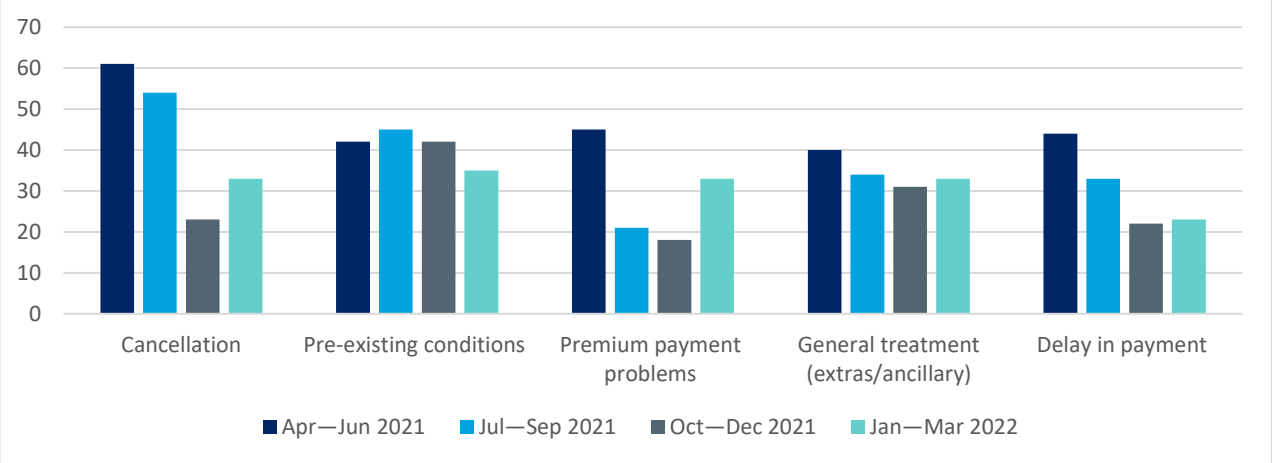


Figure 2: Top complaint issues, April 2021 to March 2022



[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.

Payment of claims for Type C procedures

Type C procedures normally do not require in-patient hospital treatment and do not attract accommodation benefits. An example includes surgical removal of a tooth. In cases where a medical practitioner certifies that the patient requires hospital admission for a Type C procedure, a health insurer can pay benefits in accordance with the Private Health Insurance (Benefit Requirements) Rules 2011. Generally, a hospital or medical practitioner will submit a claim to the insurer along with a Type C certificate. The insurer is responsible for liaising directly with the hospital or medical practitioner if there are administrative matters to confirm benefits.

During the previous 6 months, the Office received approximately 10 complaints where insurers did not pay benefits for Type C procedures as they believe the claims do not meet the Type C certification requirements. In some cases, insurers did not actually reject claims but instead requested patients provide more documents, such as proof they provided informed financial consent, before assessing further. In the examples the Office has seen, the insurers concerned have not provided sufficiently clear reasons why individual claims could not be assessed and paid in accordance with the existing documents provided. We are considering this matter further.

We remind insurers that as per the *Private Health Insurance Circular 37/17*, it is the role of the insurer to check the validity of Type C certification documentation to ensure these meet the minimum requirements set out in the Private Health Insurance (Benefit Requirements) Rules 2011. If there is insufficient information for the insurer to assess the claim, the insurer should '*in the first instance, work with the hospital or medical practitioner providing the certification documents to seek further information'*.

We expect where there are matters to discuss between hospitals and insurers regarding Type C claims, the parties will actively ensure patients are not inconvenienced with requests for additional information that can be obtained from the other party.

It is important to understand that from a patient's perspective, when a medical practitioner certifies their claim as Type C, the medical practitioner has advised their patient the procedure needs to take place in a hospital environment. If an insurer reviews a claim and decides it has adequate reasons to reject a Type C claim, we expect insurers to provide clear reasoning to the patient.

Lifetime Health Cover

Each year, the Department of Health sends letters to Australian citizens and permanent residents who recently turned 31 or registered for full Medicare benefits with information 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 2022. For new migrants, the deadline is 1 year from the date they registered for full Medicare (usually a blue or green card).

Between 1 July 2021 and 31 March 2022, the Office received 67 complaints about LHC matters. Issues from these complaints included correcting mistakes with LHC loading by correcting health insurance records and obtaining refunds for overpaid LHC amounts.

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

Guidance for complaint handlers dealing with risks of harm

Do complaint handlers in your organisation sometimes need to handle callers who are at risk of harming themselves or others? The Commonwealth Ombudsman has published a short, practical guide with step-by-step instructions and advice on caring for staff involved in speaking with distressed or threatening complainants. Download the document from our website.

Table 1: **Complaints by health insurer market share, 1 January–31 March 2022**[2]

Name of insurer	No further action	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)	0	0.0%	4	0.9%	0	0.0%	0.3%
Australian Unity	0	0.0%	22	5.2%	0	0.0%	2.5%
BUPA	4	20.0%	97	22.9%	3	16.7%	24.8%
CBHS	0	0.0%	10	2.4%	1	5.6%	1.5%
CBHS Corporate Health	0	0.0%	1	0.2%	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%	0	0.0%	0	0.0%	0.6%
Defence Health	1	5.0%	6	1.4%	2	11.1%	2.1%
Doctors' Health Fund	0	0.0%	1	0.2%	0	0.0%	0.4%
GMHBA	0	0.0%	15	3.5%	0	0.0%	2.5%
HBF Health & GMF/Healthguard	0	0.0%	29	6.9%	1	5.6%	7.3%
HCF (Hospitals Contribution Fund)	3	15.0%	62	14.7%	4	22.2%	11.9%
HCI (Health Care Insurance)	0	0.0%	0	0.0%	0	0.0%	<0.1%
Health Partners	0	0.0%	7	1.7%	0	0.0%	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%	5	1.2%	1	5.6%	0.7%
Latrobe Health	0	0.0%	2	0.5%	0	0.0%	0.7%
Medibank Private & AHM	7	35.0%	89	21.0%	1	5.6%	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	0.5%	0	0.0%	0.4%
NIB Health & GU Corporate Health	2	10.0%	41	9.7%	2	11.1%	9.3%
Nurses and Midwives Pty Ltd	0	0.0%	1	0.2%	1	5.6%	<0.1%
Peoplecare	0	0.0%	1	0.2%	0	0.0%	0.5%
Phoenix Health Fund	0	0.0%	3	0.7%	0	0.0%	0.2%
Police Health	0	0.0%	2	0.5%	0	0.0%	0.4%
QLD Country Health Fund	1	5.0%	2	0.5%	0	0.0%	0.4%
Railway & Transport Health	1	5.0%	0	0.0%	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%	2	0.5%	0	0.0%	0.6%
Teachers Health	0	0.0%	14	3.3%	1	5.6%	2.5%
Transport Health	0	0.0%	0	0.0%	0	0.0%	<0.1%
TUH	1	5.0%	0	0.0%	0	0.0%	0.6%
Westfund	0	0.0%	5	1.2%	1	5.6%	0.9%
Total for Health Insurers	**20**	**100%**	**423**	**100.0%**	**18**	**100%**	

[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 January–31 March 2022

ISSUE Sub-issue	Jun 21	Sep 21	Dec 21	Mar 22
BENEFIT				
Accident and emergency	3	2	8	13
Accrued benefits	1	0	0	2
Ambulance	10	11	3	3
Amount	12	6	15	17
Delay in payment	51	37	24	23
Excess	7	8	12	8
Gap—Hospital	22	15	14	11
Gap—Medical	15	12	15	14
General treatment (extras/ancillary)	39	34	32	33
High cost drugs	0	1	2	1
Hospital exclusion/restriction	54	31	34	22
Insurer rule	24	27	27	16
Limit reached	1	5	5	2
New baby	4	0	1	0
Non-health insurance	2	0	1	0
Non-health insurance—overseas benefits	0	0	0	0
Non-recognised other practitioner	0	1	1	1
Non-recognised podiatry	2	1	2	1
Other compensation	2	2	4	1
Out of pocket not elsewhere covered	4	0	1	6
Out of time	2	2	0	4
Preferred provider schemes	5	2	2	0
Prostheses	3	3	2	1
Workers compensation	0	0	0	0
CONTRACT				
Hospitals	0	3	0	6
Preferred provider schemes	1	1	4	0
Second tier default benefit	0	1	1	0
COST				
Dual charging	9	0	6	2
Rate increase	16	5	4	7
INCENTIVES				
Lifetime Health Cover	39	28	20	19
Medicare Levy Surcharge	0	1	0	0
Private health insurance reforms	1	0	0	0
Rebate	5	4	2	1
Rebate tiers and surcharge changes	0	1	0	0
INFORMATION				
Brochures and websites	8	2	7	2
Lack of notification	9	13	10	3
Radio and television	0	0	0	0
Standard Information Statement	0	1	1	1
Verbal advice	16	21	34	9
Written advice	3	2	3	2

ISSUE Sub-issue	Jun 21	Sep 21	Dec 21	Mar 22
INFORMED FINANCIAL CONSENT				
Doctors	2	0	2	3
Hospitals	4	1	1	1
Other	0	1	0	1
MEMBERSHIP				
Adult dependents	11	13	10	4
Arrears	2	3	1	7
Authority over membership	3	2	2	1
Cancellation	75	74	33	33
Clearance certificates	33	34	10	14
Continuity	13	9	12	15
Rate and benefit protection	9	1	1	4
Suspension	10	15	8	9
SERVICE				
Customer service advice	39	43	24	15
General service issues	43	36	29	23
Premium payment problems	45	23	18	33
Service delays	21	25	20	10
WAITING PERIOD				
Benefit limitation period	0	0	0	0
General	21	14	11	7
Obstetric	10	3	4	9
Other	8	7	1	4
Pre-existing conditions	43	48	47	35
OTHER				
Access	2	14	15	8
Acute care and type C certificates	1	1	1	0
Community rating	1	1	0	2
Complaint not elsewhere covered	3	1	5	8
Confidentiality and privacy	1	0	2	0
Demutualisation/sale of health insurers	1	0	0	0
Discrimination	1	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	0	0	0	0
Rule change	14	5	40	2