



Australian Government
Private Health Insurance Ombudsman

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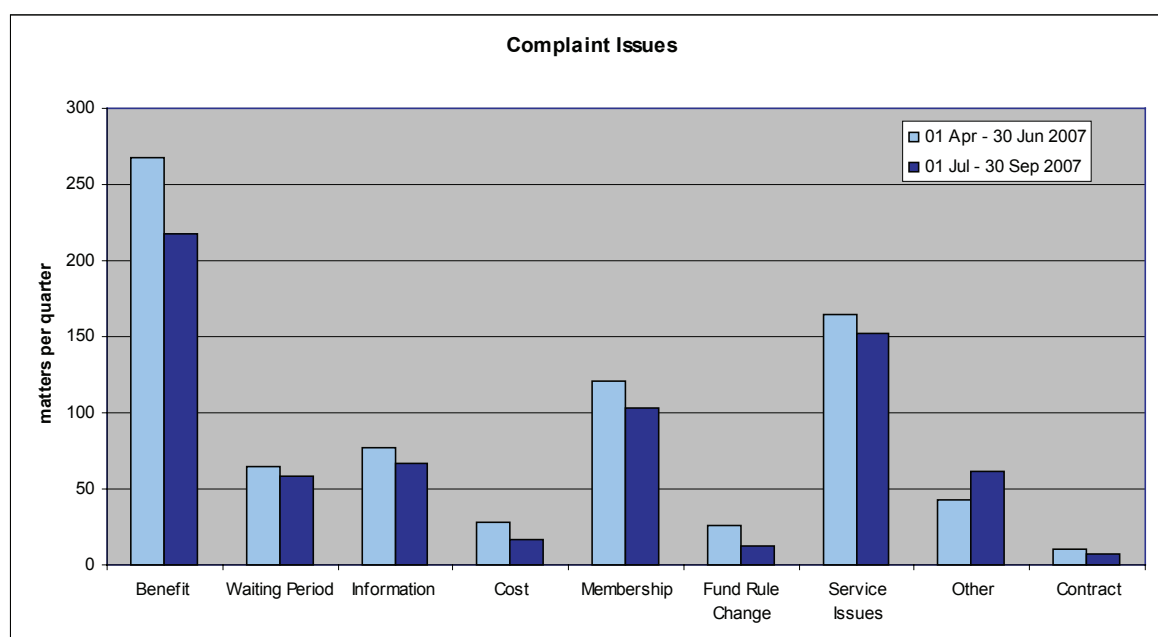
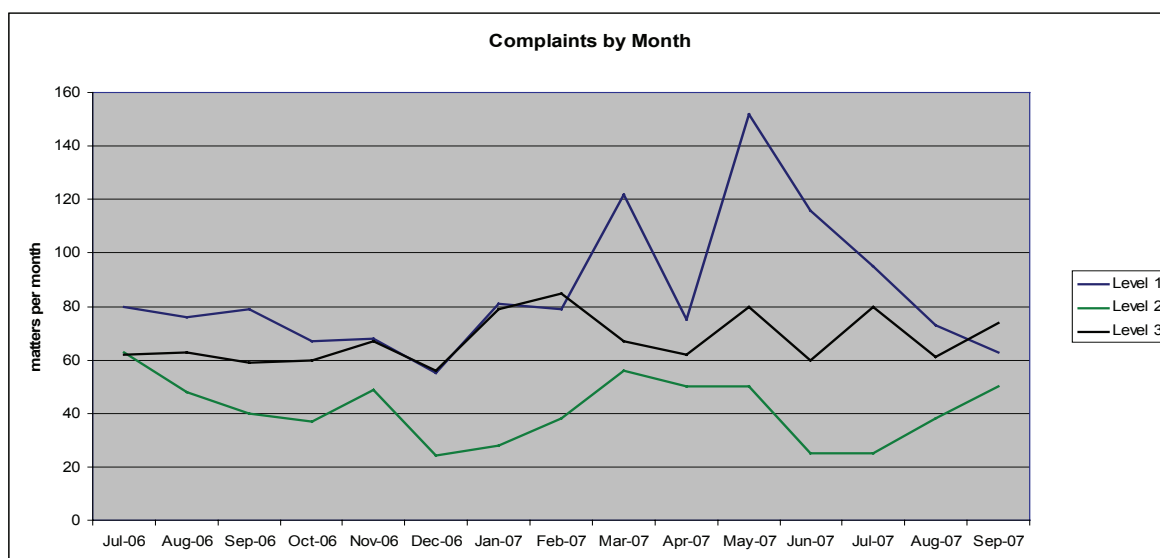
Quarterly Bulletin 44

(1 July to 30 September 2007)

Complaint Statistics

PHIO received 543 complaints about health insurers during the quarter. This was a decrease of 13% on the previous quarter but an increase of 3% on the same period last year.

The office received 209 Level-3 complaints about health insurers, representing an increase of 11% on the previous quarter and an increase of 26% on the same period in 2006.



PrivateHealth.gov.au Website

Human Solutions is upgrading the interface used by insurers to update policies on the website. The intention of the change is to more easily manage the process of updating policies for next year's rate increase.

Human Solutions will be conducting short training sessions on the new interface in Sydney on 27th November and Melbourne on the 28th November. Please contact PHIO if you haven't received information about the sessions and wish to attend.

We are currently working on improving the search facility on the website. At this stage PHIO expects that the new look search facility will be ready to go live by April 2008. At the same time, the site design will also be improved based on feedback from users of the site.

PHIO Referral Process

From time to time, particularly when new health insurance staff members become responsible for complaints, people ask PHIO how we deal with and categorise complaints. In common with the majority of complaint handling bodies, when a complainant first contacts our office, we check whether he or she has given the insurer the opportunity to resolve the complaint.

In cases where this has not occurred, we will contact the insurer and provide the member's contact details and a brief description of the complaint. We give the insurer 3 business days to contact the complainant to acknowledge receipt of the complaint and advise a timeframe for a response. We then request the insurer to let us know when the complaint has been dealt with and a brief explanation of the outcome. We will then close the complaint and categorise it as a Level-1 "assisted referral" complaint.

If the member has given the insurer the opportunity to resolve the matter; or if the member isn't satisfied with the resolution; or where the matter has been sent to the insurer as an assisted referral and they have not contacted the member within the timeframe, we will formally take on the complaint as a Level-3 complaint or "dispute" and request a report from the insurer.

Complaints are audited by senior PHIO staff on a quarterly basis, prior to the production of the Quarterly Bulletin complaints figures. Complaint categorisation is not static. Complaints may be escalated or downgraded over the course of time, depending on a number of factors such as complainants withdrawing a complaint, or coming back to PHIO at a later date because they are dissatisfied.

PHIO has an internal review process for complaints and if complainants aren't satisfied with the outcome of their complaint, they can request a review by a more senior staff member. Where a complaint is reviewed at a senior level, PHIO staff members will request escalation within the insurer to a more senior staff member. When PHIO requests an insurer review an escalated complaint, we request that the matter is not sent back to the same staff member who originally dealt with it. This is not intended to reflect negatively on the staff member, but to ensure an independent view of the complaint.

Ultimately, PHIO's escalation process allows for complaints to be reviewed by the Ombudsman and raised at a senior level with the insurer's CEO.

Oral Advice

A number of insurers have introduced recording of customer calls. Call recording is an added protection for health insurance consumers and staff. PHIO has found that where insurers have a recording of a call which is related to a complaint, it is much easier to resolve the complaint. It is pleasing to note that in most cases, insurers will resolve the complaint in the consumer's favour as soon as they become aware via a call recording that incorrect or misleading advice has been given.

Call recordings show that while fund staff members usually provide accurate advice, there are a few occasions where better advice could be provided to consumers. In a recent example, a member who held a cover that restricted a large range of hospital services phoned his insurer for advice because he was going into hospital. The fund staff member told him that he didn't need this information because the hospital would check his health insurance on admission. It was only when the member pressed for more information that the staff member revealed he was not covered for the procedure. It would have been greatly inconvenient for this member to find this out on admission to the hospital.

Regardless of membership eligibility checking by the hospital, PHIO and indeed most insurers advise all members to ring their insurer prior to going to hospital. Members are in a much better position to make decisions about their treatment options before they arrive at the hospital. By the time they've arrived at the hospital they have already booked a surgeon, arranged for someone to collect them from the hospital and usually, they've arranged for time off work as well.

State of the Health Funds Report

PHIO is aiming to produce this year's report by the end of January. Work will commence once data from PHIAC is available, which should be in December.

All health insurers will receive a copy of the report prior to publication so that any errors can be corrected. This will also enable insurers to update their contact/branch/etc information without needing to fill in a survey. Insurers can expect to receive a copy of the draft report in early January.

The format of the State of the Health Funds Report will be similar to last year's report with a few minor changes. A couple of health insurers have expressed an interest in providing input into various parts of the report. If funds wish to provide input into the structure of the report, please do so by the end of November by contacting David McGregor at david@phio.org.au

Complaints by Health Fund Market Share

01 July - 30 September 2007

Name of Fund	Complaints ¹	Percentage of Complaints	Level-3 Complaints ²	Percentage of Level-3 Complaints	Market Share ³
				Complaints	
ACA Health Benefits	1	0.2	0	0	0.1
AHM	23	4.2	12	5.7	2.4
Australian Unity	39	7.2	21	10.0	3.6
BUPA (HBA)	40	7.4	12	5.7	9.9
CBHS	2	0.4	0	0	1.1
CDH (Cessnock District Health)	2	0.4	1	0.5	<0.1
Credicare	0	0	0	0	0.4
Defence Health	6	1.1	2	1.0	1.4
Doctors' Health Fund	0	0	0	0	0.1
Druids Victoria	1	0.2	0	0	0.1
GMHBA	5	0.9	2	1.0	1.5
Grand United Corporate Health	0	0	0	0	0.3
HBF Health	12	2.2	4	1.9	7.9
HCF (Hospitals Cont. Fund)	35	6.4	13	6.2	8.8
Health Care Insurance	2	0.4	1	0.5	0.1
Health Insurance Fund of W.A.	5	0.9	1	0.5	0.4
Healthguard	1	0.2	0	0	0.6
Health-Partners	1	0.2	0	0	0.7
Latrobe Health	1	0.2	0	0	0.6
Manchester Unity	16	2.9	8	3.8	1.4
MBF Alliances	18	3.3	8	3.8	2.2
MBF Australia Limited	129	23.8	49	23.4	16.7
Medibank Private	139	25.6	46	22.0	28.7
Mildura District Hospital Fund	0	0	0	0	0.3
N.I.B. Health	42	7.7	16	7.7	6.2
Navy Health	0	0.0	0	0	0.3
Peoplecare	1	0.2	0	0	0.3
Phoenix Health Fund	0	0	0	0	0.1
Police Health	2	0.4	1	0.5	0.2
Queensland Country Health	2	0.4	2	1.0	0.2
Railway & Transport Health	4	0.7	4	1.9	0.3
Reserve Bank Health	0	0	0	0	<0.1
St Lukes Health	3	0.6	1	0.5	0.4
Teacher Federation Health	4	0.7	2	1.0	1.6
Teachers Union Health	1	0.2	0	0	0.4
Transport Health	0	0	0	0	0.1
Westfund	6	1.1	3	1.4	0.7
Total for Registered Funds	543	100	209	100	100

1. Number of Complaints (Levels 1, 2 & 3) from those holding registered health fund policies.
2. Level 3 Complaints required the intervention of the Ombudsman and the health fund.
3. Market share data provided by PHIAC as at 30 June 2006.