Australian Government
Private Health Insurance Ombudsman

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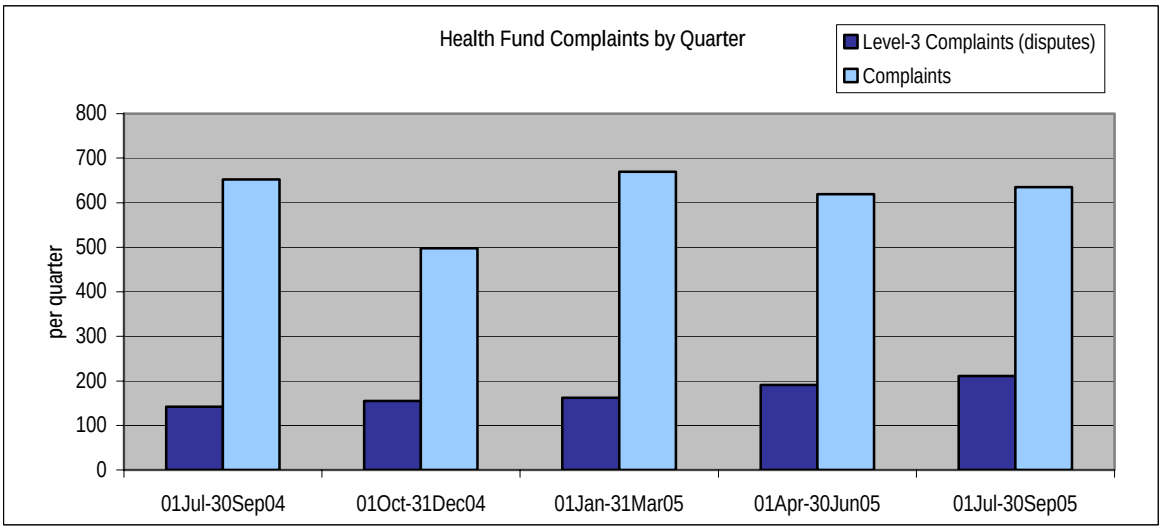
Quarterly Bulletin 36
(1 July to 30 September 2005)

COMPLAINT STATISTICS

My office received 635 health fund complaints in the September quarter 2005. This was an increase of 3% over the June quarter but 3% less than the number of health fund complaints received in the quarter to September 2004. The two largest funds experienced notable changes in complaint numbers.

The number of level-3 complaints (disputes) about health funds continued to rise, with 211 new level-3 complaints registered in the quarter. This is the highest level of disputes recorded in any quarter in the last four years.



COMPLAINT ISSUES

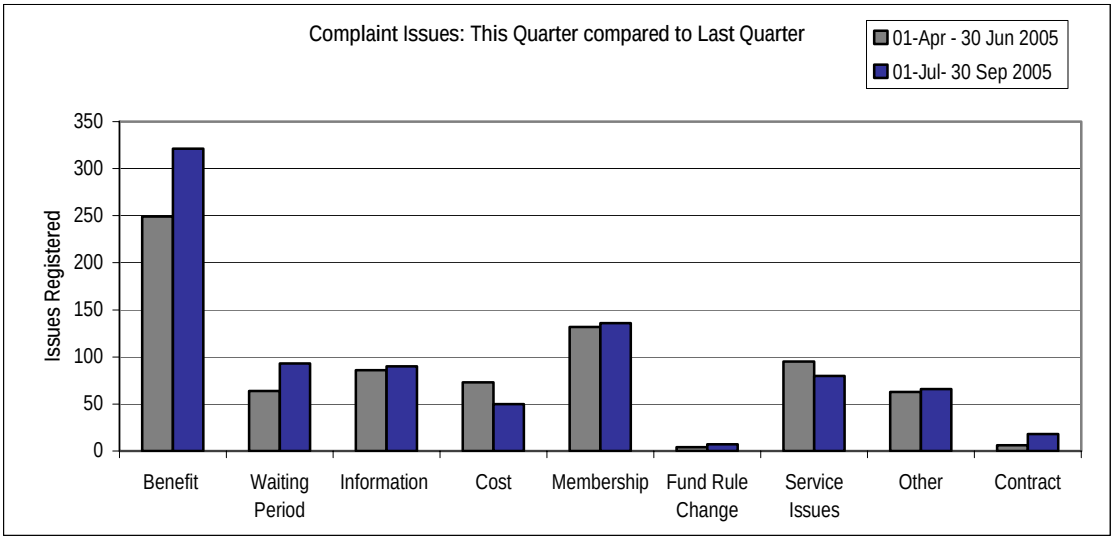
The two broad issues that accounted for most of the increase in complaints last quarter were health fund benefits and waiting periods.

Podiatric Surgery Benefits

Last quarter we received 30 complaints about fund benefits for podiatric surgery. This is the most we have received on this issue in any quarter and more than twice as many as we received last quarter. This increase appears to be associated with actions by podiatric surgeons to better inform patients of the availability of the Ombudsman's services.

Until recently, virtually all funds paid only minimal benefits for hospital costs associated with podiatric surgery. Recent changes to legislation were aimed at removing any regulatory barriers to paying higher benefits and, as a result, some funds have significantly improved the benefits payable for such treatments.

However, many funds continue to pay only the minimum benefits permissible under the legislation. This has resulted in substantial differences in the costs of such treatments for contributors; depending on which health fund they are with. It is this inconsistency between funds that has given rise to complaints both from contributors and providers of podiatric surgery.



Pre-existing Ailment Waiting Period

The increase in complaints about the pre-existing ailment waiting period has continued. In quarterly bulletin 33 I suggested that both funds and hospitals should familiarise themselves with the "Pre Existing Ailments – Best Practice Guidelines".

The Pre Existing Ailment (PEA) guidelines include the following recommendations on the administration of the pre–existing ailment waiting period.

For health funds:

A PEA assessment should be able to be completed within 5 working days.
If the fund is notified less than 5 days before a planned admission, a contributor subject to a pre-existing waiting period should be advised that the assessment may not be completed prior to admission, that the fund will carry out the assessment as quickly as possible; together with advice on the implications of the waiting period. This should apply whether the advice of a pending admission comes from the contributor or a hospital (as part of an eligibility check).

Funds should provide written advice to a treating hospital about the requirement for a PEA assessment and an explanation of the process as soon as it is known that a PEA assessment is necessary. This requirement for written advice to the hospital is additional to the basic information provided through the fund eligibility checking processes.

For hospitals:

When the hospital becomes aware that the fund will be undertaking a PEA assessment, the hospital should immediately contact the patient to explain the situation. (Suggestions on what should be covered in this explanation are included in the guidelines.) Hospitals should also alert the treating doctor. All hospitals should ensure that prior to and after the outcome of a PEA assessment, the patient receives clear advice about the hospital's charges and their potential or actual liability.

The PEA Best Practice Guidelines also contain a recommendation that funds and hospitals include in their agreements an acceptable cost sharing arrangement to cover unplanned admissions where it is not possible for the hospital to confirm basic hospital details in advance. Many of the complaints received about the PEA waiting period would not occur if these recommendations were being followed.

Arrangements for checking payment of hospital excesses

PHIO has received a small number of complaints recently that suggest that some funds' processes for checking the amount of excess payable for a particular hospital admission may be exposing members to the risk of paying more than the correct amount. A recent case illustrates the potential problem:

Our complainant required urgent surgery at a private hospital when away from home on business. After checking with his fund the hospital advised him correctly that he was liable to pay an (annual) excess of $1000. He paid this amount to the hospital on admission. The surgery was performed. He was discharged and returned home.

The hospital subsequently submitted a claim to the health fund for the remaining hospital costs but incorrectly coded the item numbers, resulting in the claim not being processed and returned to the hospital. Around that time our complainant was admitted for a follow up procedure at a local day hospital. He was not charged an excess by the day hospital because he advised them he had recently paid his annual excess. However, when the day hospital submitted their claim to the fund, fund records had not recorded that the excess had already been paid (because the previous hospital claim was not yet processed). The day hospital bill was less than $1000 so the fund paid no benefits and advised the day hospital, which then billed our complainant.

Only after the complainant was able to convince the day hospital to take the matter up further with the fund was the matter resolved. PHIO's investigation of the complaint, which also involved several other issues, suggested that the fund processes may not have picked up the dual payment of the excess had the member and the day hospital not brought the matter to the fund's attention.

There have been a small number of other cases over the last year that suggest that other funds may not have adequate systems in place to guard against (or at least identify retrospectively) duplicate payment of excesses by members. It is not acceptable to simply rely on the member drawing this to the fund's attention.

PHIO Levy increase

In last year's budget the government approved an increase in ongoing funding for PHIO of $200,000 per annum in recognition of extra functions allocated to the PHIO in the *Health Legislation Amendment (Private Health Insurance Reform) Act 2004.* (This was the first increase in PHIO funding since 1999/2000.)

The government also authorised an increase in the PHIO levy on health funds to collect an equivalent amount. The increase in the levy is expected to be included in the accounts the department will send to the funds in December.

Ombudsman Reappointed

The Hon Tony Abbott, Minister for Health and Ageing, recently announced the appointment of Mr John Powlay as the Private Health Insurance Ombudsman for a further three years from 19 November 2005.

Complaints by Health Fund Market Share

1 July - 30 September 2005

Name of Fund	Complaints (1)	Percentage of Complaints	Level-3 Complaints (2)	Percentage of Level-3 Complaints	Market Share (3)
ACA Health Benefits	0	0	0	0	0.1
AMA Health Fund	1	0.2	0	0	0.1
AHMG	24	3.8	9	4.3	2.4
Australian Unity	24	3.8	7	3.3	3.2
BUPA (HBA)	69	10.9	19	9.0	9.9
CBHS	5	0.8	2	0.9	1.1
CDH (Cessnock District Health)	0	0	0	0	<0.1
Credicare	5	0.8	1	0.5	0.4
Defence Health	18	2.8	7	3.3	1.4
Druids NSW	0	0	0	0	<0.1
Druids Victoria	1	0.2	0	0	0.1
Federation Health	2	0.3	0	0	0.2
GMHBA	11	1.7	5	2.4	1.5
Grand United Corporate Health	5	0.8	2	0.9	0.3
Grand United Health	9	1.4	2	0.9	0.4
HBF Health	27	4.3	8	3.8	7.9
HCF (Hospitals Cont. Fund)	41	6.5	16	7.6	8.8
Health Care Insurance	0	0	0	0	0.1
Health Insurance Fund of W.A.	1	0.2	1	0.5	0.4
Healthguard	7	1.1	1	0.5	0.6
Health-Partners	3	0.5	1	0.5	0.7
Latrobe Health	2	0.3	1	0.5	0.4
Lysaght Peoplecare	1	0.2	0	0	0.3
Manchester Unity	19	3.0	8	3.8	1.4
MBF Australia Limited	119	18.7	46	21.8	16.7
MBF Alliances[4]	20	3.1	5	2.4	2.2
Medibank Private	156	24.6	44	20.9	28.7
Mildura District Hospital Fund	0	0	0	0	0.3
N.I.B. Health	40	6.3	20	9.5	6.2
Navy Health	1	0.2	0	0	0.3
Phoenix Health Fund	0	0	0	0	0.1
Police Health	0	0	0	0	0.2
Queensland Country Health	3	0.5	1	0.5	0.2
Railway & Transport Health	2	0.3	0	0	0.3
Reserve Bank Health	0	0	0	0	<0.1
St Lukes Health	4	0.6	2	0.9	0.4
Teacher Federation Health	6	0.9	1	0.5	1.6
Teachers Union Health	4	0.6	1	0.5	0.4
Transport Health	0	0	0	0	0.1
Westfund	5	0.8	1	0.5	0.7
Total for Registered Funds	635	100	211	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 2005.
4. Previously called "MBF Health (NRMA, SGIO)"