Commonwealth OMBUDSMAN

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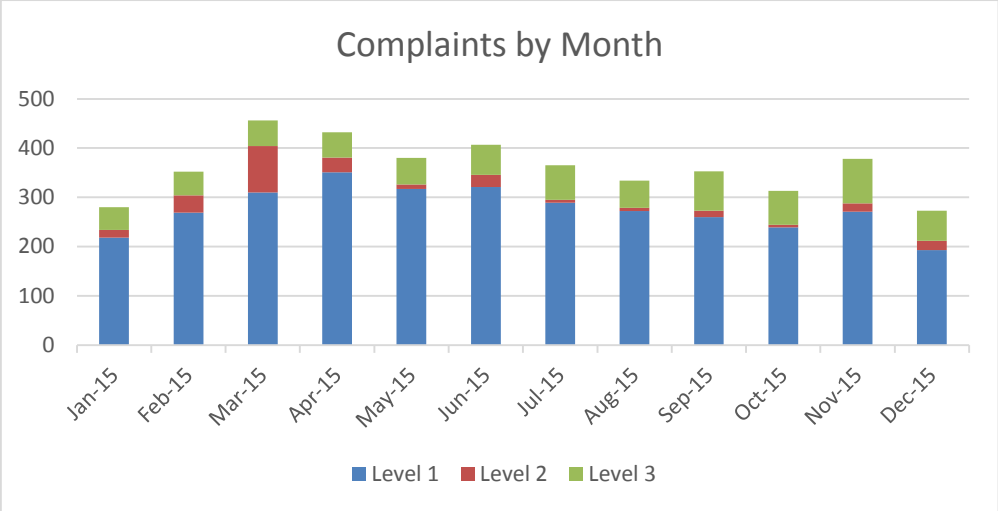
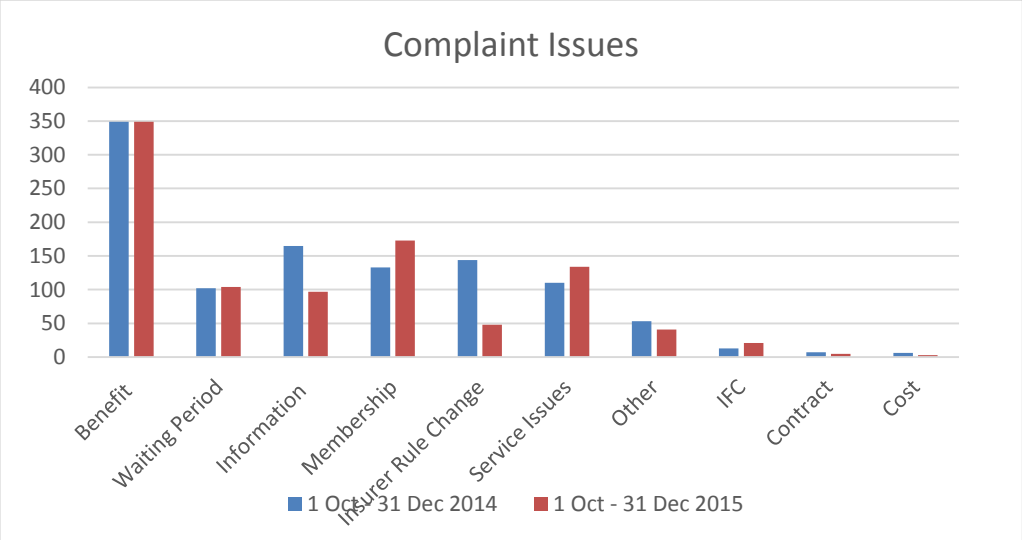
Private Health Insurance Ombudsman Quarterly Bulletin 77
(1 October – 31 December 2015)

Complaint Statistics and Workload

The Private Health Insurance Ombudsman (PHIO) received 964 complaints this quarter, compared to 1052 in the previous quarter; the December quarter is usually the lowest quarter in the year. In the same period last year, PHIO received a similar number of complaints at 981. Health insurance complaints are best compared to similar periods in the previous year, due to seasonal factors such as annual premium increases.

Complaint issues were largely similar to those in the same quarter in the previous year, with Benefit issues continuing to be the most common cause of complaint. Membership complaints increased slightly, while Information and Insurer Rule Change complaints decreased.





Overseas Visitors Health Cover and Overseas Student Health Cover complaints

In addition to complaints against registered Australian health insurers, the Ombudsman assists a number of consumers with complaints about Overseas Visitors Health Cover (OVHC) and Overseas Student Health Cover (OSHC) policies for visitors to Australia. These policies are not domestic 'complying health insurance policies' under the Act and these complaints are therefore not included in the table in this report, which lists complaints against each registered health insurer.

In the 2014-15 financial year, the Ombudsman assisted 351 consumers with complaints about OVHC and OSHC, up from the 207 complaints received in 2013–14. Of those complaints, 58 were investigated as Level 3 Disputes, compared to 44 in the previous year. In the 2015-16 year to date, the Ombudsman has received 144 complaints about OVHC and OSHC, of which 30 are Level 3 Disputes.

The complaints investigated by PHIO in relation to OVHC are usually similar to those received about domestic policies, except for a higher proportion of complaints about waiting periods and other restrictions on the policy. A full list of the complaint issues and sub-issues for 2014-15 is included in the PHIO's Annual Report 2015. Some notable complaint issues in 2014-15 included:

Service Issues and Delays: Complainants have reported that they find it difficult to have claims paid or to have cancellations processed, either due to onerous paperwork requirements from the insurer or simply a lack of timely responses to service requests. These complaints are usually not complex and could be resolved by insurers implementing more rapid response times and processing efficiencies – this can be seen by comparison to Australian residents' policy holders, who experience a proportionally much lower rate of complaint about these issues.

Rate Increase: In the past year a number of OVHC and OSHC providers imposed very high premium increases. Generally premium increases are necessary to balance the outlays made by the insurer in paying benefits to members and administrative costs, but such high premium increases cause a significant impact, especially for OVHC and OSHC members with limited incomes (e.g. holders of student visas or working holiday visas, who usually have restricted employment conditions, and holders of retiree visas, who are relying on their savings).

Pre-Existing Conditions: Unlike Australian residents' policies, OVHC policies may impose harsher definitions or lengthier waiting periods for PECs. Also unlike Australian residents, who have the option of going to a public hospital as a public patient to be treated at no cost under Medicare, most overseas visitors have no such recourse if they require hospital treatment and they are not covered by their health insurer. The impact of having a condition found to be PEC has the potential to be much larger for visitors, who often have no choice but to pay for the full private patient cost.

Switching from Visitors' Cover to Australian Residents' Cover: PHIO continues to receive complaints from overseas visitors and new permanent residents who have found they have either stayed for too long on their visitors' cover, or taken a residents' policy too early. Holding the wrong type of cover can have adverse impacts on the individual's hospital benefits, Medicare Levy Surcharge obligations, Lifetime Health Cover loading, and visa status. It's important for health insurer and insurance brokers to ask appropriate questions at the time the person first purchases the policy, and then to prompt them throughout the course of their membership to contact the insurer as soon as their situation changes. Generally, the person's level of Medicare benefits should be the primary guiding factor for which policy type suits their situation. For further information please see the Annual Report, or Quarterly Bulletin #65.

Clearance Certificates and Lifetime Health Cover

PHIO has been contacted by a number of complainants whose health insurers have conducted an audit of their membership record and found no Clearance Certificate on file from their previous insurer. On finally sourcing a Certificate, in some instances it has become apparent that the person should have been paying a Lifetime Health Cover loading for some months or years. This causes problems if their current insurer decides to retrospectively apply the LHC loading, as it can place the membership several months into arrears and result in a large and unexpected request for payment.

While PHIO considers it appropriate for the LHC loading to be applied going forward, as it is the correct price for the policy, our view is that the health insurer should be considering the retrospective application of full LHC loading on a case by case basis. Abruptly placing a person into arrears and asking for an immediate lump sum payment of several thousand dollars to continue their coverage is unfair to the member when they have paid what they believe to be the correct premium in good faith for many months or years. It also puts the person into a very difficult position if they are expecting treatment or have ongoing treatment.

In cases where LHC has been underpaid for long periods of time, we expect that insurers should give consideration to waiving the arrears and only charge the LHC loading going forward. To prevent the occurrence of these situations in the first place, health insurers should audit for missing Clearance Certificates as soon as possible in a person's membership, rather than months or years later. We also note that the *Private Health Insurance Act 2007* states that the onus of requesting the Certificate from the old insurer within 7 days falls on the new insurer. If the new insurer has omitted to take an action, then the impact of that failure should not fall upon the member.

Top 5 Consumer Complaint Issues This Quarter

1. **Pre-Existing Conditions Waiting Period: 82 complaints**
   The number of PEC complaints has been increasing for some time. These complaints are usually caused by the health insurer or the insurer's medical practitioner failing to clearly state which signs and symptoms were relied upon in assessing a claim: there are many instances where information about signs and symptoms is left blank, or the date of onset of symptoms is not stated. This problem seems to be most frequent at two health insurers, so PHIO will be discussing this with those insurers individually.

   It should be noted that there will always be a level of complaint about this issue because of the large number of health insurance consumers changing their hospital cover each year, some of whom will require treatment in the first twelve months of their new policy. Applying the waiting period appropriately is fair to existing contributors who have already served the waiting period themselves.

2. **Hospital Policy Exclusions and Restrictions: 75 Complaints** - Many of these complaints concerned exclusions on weight loss surgery such as gastric banding, which were removed by some insurers from basic policies in 2015.

3. **Oral Advice: 72 Complaints** - Most oral advice complaints concerned consumers misunderstanding their benefits during telephone calls and retail branch visits, particularly where records are not maintained.

4. **Membership Cancellation: 59 Complaints** - Issuing refunds and clearance certificates in a timely manner are the main cause of complaints.

5. **Gap – Medical fees: 50 Complaints** - A common cause of complaints concerned pathology bills received after being admitted to hospital. Medical gap fee complaints are counted separately from informed financial consent (medical bills) complaints, which accounted for 10 complaints.

Complaints by Health Insurer Market Share

1 October - 31 December 2015

Name of Insurer	Complaints(1)	Percentage of Complaints	Level-3 Complaints(2)	Percentage of Level-3 Complaints	Market Share(3)
ACA Health Benefits	0	0.0%	0	0.0%	0.1%
Australian Unity	52	6.3%	14	7.8%	3.1%
BUPA	196	23.9%	53	29.4%	26.8%
CBHS	4	0.5%	0	0.0%	1.4%
CDH (Cessnock District Health)	0	0.0%	0	0.0%	<0.1%
CUA Health	7	0.9%	0	0.0%	0.6%
Defence Health	4	0.5%	0	0.0%	1.8%
Doctors' Health Fund	5	0.6%	1	0.6%	0.2%
GMHBA	13	1.6%	2	1.1%	2.0%
Grand United Corporate Health	2	0.2%	1	0.6%	0.4%
HBF Health	39	4.8%	9	5.0%	7.4%
HCF (Hospitals Cont. Fund)	92	11.2%	18	10.0%	10.5%
Health.com.au	13	1.6%	4	2.2%	0.6%
Health Care Insurance	0	0.0%	0	0.0%	0.1%
Healthguard (GMF)	1	0.1%	0	0.0%	0.5%
Health-Partners	2	0.2%	0	0.0%	0.6%
HIF (Health Insurance Fund of Aus.)	5	0.6%	0	0.0%	0.9%
Latrobe Health	3	0.4%	0	0.0%	0.7%
Medibank Private & AHM	283	34.6%	70	38.9%	28.6%
Mildura District Hospital Fund	0	0.0%	0	0.0%	0.2%
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
Navy Health	0	0.0%	0	0.0%	0.3%
NIB Health	77	9.4%	6	3.3%	7.9%
Peoplecare	1	0.1%	0	0.0%	0.5%
Phoenix Health Fund	0	0.0%	0	0.0%	0.1%
Police Health	1	0.1%	0	0.0%	0.3%
QLD Country Health Fund	1	0.1%	0	0.0%	0.3%
Railway & Transport Health	5	0.6%	1	0.6%	0.4%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Lukes Health	1	0.1%	0	0.0%	0.4%
Teachers Federation Health	8	1.0%	1	0.6%	2.1%
Teachers Union Health	2	0.2%	0	0.0%	0.5%
Transport Health	0	0.0%	0	0.0%	0.1%
Westfund	2	0.2%	0	0.0%	0.7%
Total for Health Insurers	**819**	**100%**	**180**	**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. Source: PHIAC, Market Share, All Policies, 30 June 2015.