Australian Government
Private Health Insurance Ombudsman

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Quarterly Bulletin 38
(1 January to 31 March 2006)

COMPLAINT STATISTICS

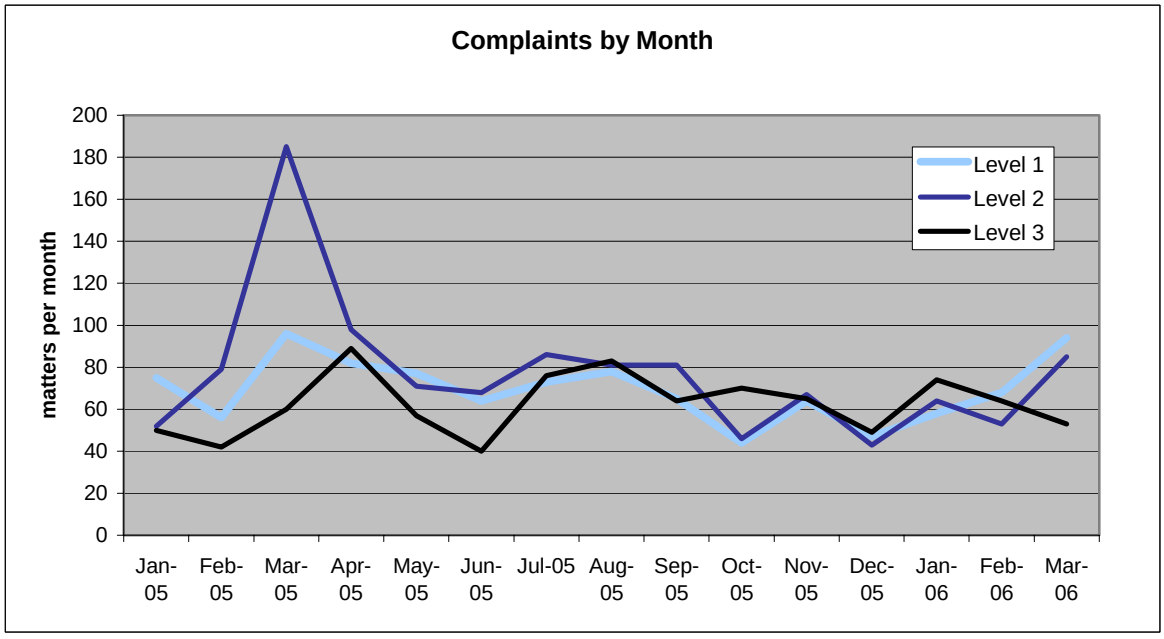
In the first quarter of 2006 PHIO received 576 complaints about health funds. This represents an increase of 25% over the previous quarter. The increase is explained by seasonal factors, some reaction to the announcement of premium increases in early March and advice of some detrimental rules changes by a couple of funds.

However, as detailed below, complaints about premium rises were substantially lower than last year and overall complaints about health funds were 14% below the number received for the first quarter of last year (669).

The number of level-3 (investigated) health fund complaints registered during the quarter (183) was slightly higher than last quarter (171) but, as shown in the graph of *Complaints by Month* below, has been declining over the three month period.

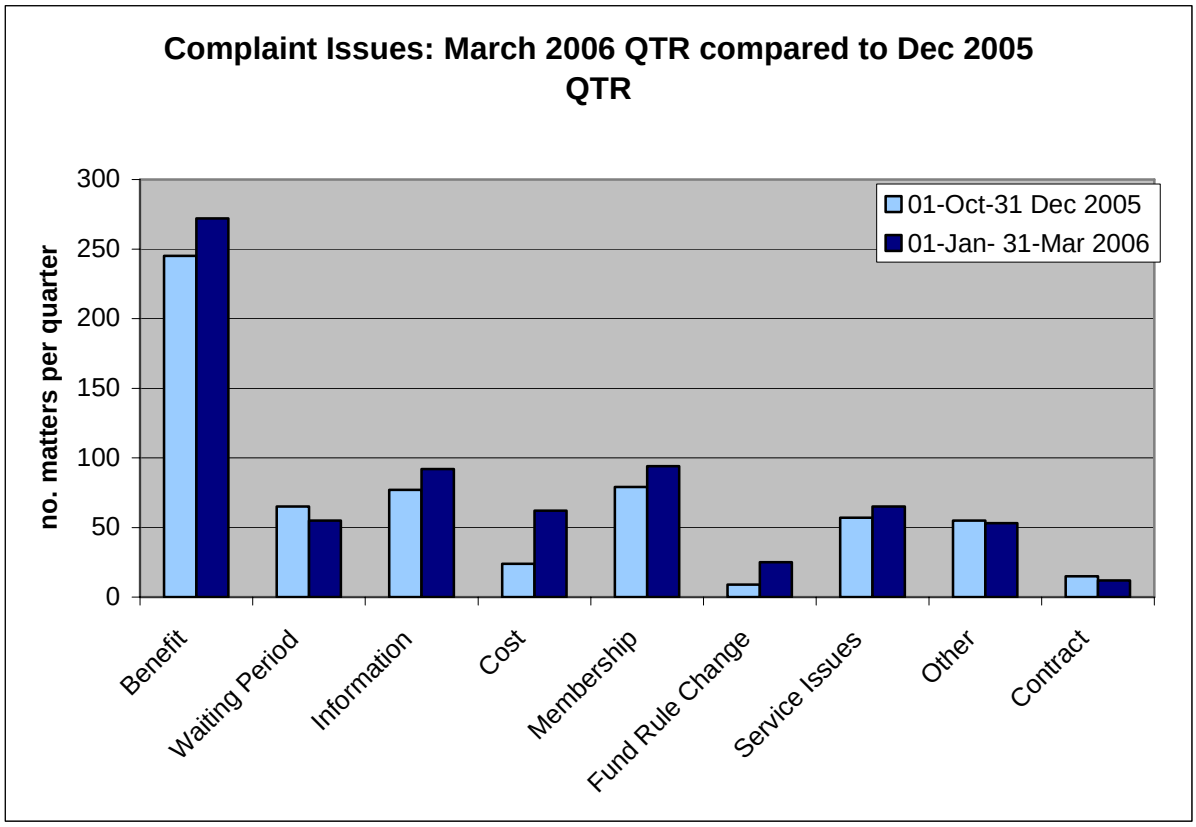
Complaints Related to Premium Increases

Compared to previous years the number of complaints about premium increases is very low. Only 44-premium increase complaints had been received up to the end of the March quarter this year, compared to 147 in the same period last year. The lower average premium increase this year has obviously been a key factor in this drop in premium increase complaints. (Premium increase complaints are mainly classified as level-2 complaints and the significantly lower level of these complaints, this year, can be seen in the *Complaints by Month* graph below).



COMPLAINT STATISTICS

The most significant change in the range of issues being complained about this quarter is the complaints associated with premium increases. These complaints are categorised under the issue of “cost” in the graph below. The rise in complaints about “fund rule change” and “information” is also associated with the premium increase process. A small number of funds introduced (or announced) detrimental rule changes in conjunction with the advice to consumers about premium increases.



Changes to Loyalty Schemes

The rule changes that led to the most complaints were those that involved changes to loyalty schemes. In the case of two funds, loyalty entitlements built up over a number of years were scrapped and/or replaced by other arrangements. While there may have been sound business reasons for the funds to make those changes, they certainly sent a mixed message to some consumers about the concept of “loyalty”.

Restricted Cover Products (yet again)

PHIO again received a significant number of complaints about consumers being unaware of the effect of restricted cover products. A couple of examples highlight the problems of marketing these products as suitable for younger contributors. This quarter we received complaints from a 27-year old needing a hip replacement, a 34-year old women requiring major heart surgery and a 23-year old requiring major abdominal surgery. In all cases the complainants claimed not to be aware of the restrictions on their cover that meant they faced thousands of dollars in out-of-pocket costs.

Ancillary Claims Over 2-Years Old

We have recently received a number of complaints related to funds' refusal to process (and pay) claims relating to services provided more than two years ago. There are good reasons for funds to adopt this two-year rule and it is allowed under the legislation. Most funds will also be flexible enough to have regard to reasonable exceptional or special circumstances. But our complaints do indicate ignorance of the two-year requirement among contributors. Funds may need to consider additional strategies to alert and remind members of this requirement.

WHAT'S ON THE APPLICATION FORM

Recently a number of complaints and enquiries have drawn our attention to significant differences between funds in the range of information sought and collected through application forms. These variations were noted in relation to two issues; Medicare eligibility/residence status and pre-existing ailments. Given that funds are generally subject to the same legislation and requirements on these issues and all are subject to the same privacy rules governing the collection of personal information, it is difficult to understand why there should be such significant differences. The collection of information relating to pre-existing ailments in this way is, in my view, inappropriate and a possible breach of privacy principles.

1. **Medicare eligibility/ residence status**

We regularly receive complaints from people who are not permanent residents (nor fully covered by Medicare) but who have nonetheless joined a residential cover. In many cases the problem is not detected until they receive hospital treatment and are left with large out-of-pocket costs because Medicare does not pay benefits. In some cases health fund benefits may not be paid because, on discovering the person's Medicare/resident status, the fund takes the view that they are actually ineligible for membership. In other cases the fund may refuse to pay gap cover benefits or the 25% MBS benefit in relation to doctors' charges for in-hospital treatment, on the grounds that such benefits cannot be paid where no Medicare benefit can be paid. Effective resolution of such complaints can be extremely difficult.

Through our investigation of such cases we have noted that fund rules relating to the membership eligibility of persons who are not residents vary significantly. In many cases the fund's rules do specifically require that a member (for residential cover) must be a permanent resident and eligible for full Medicare benefits. In some cases the funds do not specify any residence or Medicare related eligibility requirement. Our understanding is that, where it is not specified in the fund rules, there is no basis for refusing membership to persons on the basis of their resident or Medicare status.

As noted above, there is also considerable variation in how (or whether) funds obtain information at the point of application on the resident and Medicare status of potential contributors (and other people to be covered by the membership). All funds collect Medicare information about the contributor as part of an application for deduction of the rebate. In some cases this forms part of the membership application form, in some cases it's a separate document and in all cases it requires a separate declaration and signature. Some funds also include specific questions about residence and Medicare status of persons to be covered, as part of the general application form (not necessarily all those funds who have specific

requirements in their rules). Some funds do not include specific questions but include a statement as to permanent residence and Medicare eligibility in the (fine print) declaration above the signature line on the application form.

My view is that all funds should include specific questions about residence and Medicare status of all person to be covered in the general application form (in addition to the rebate application section). Even where the fund rules do not include a permanent resident/ full Medicare eligibility requirement this information should be obtained so that the member can be advised of the implications. I would be happy to advise funds on the appropriate wording.

Funds should also review their rules on membership eligibility on this issue.

2. Questions about Pre-Existing Ailments

Most funds do not include questions about pre-existing ailments on their application forms. In my view this is the correct approach.

However, around a third of funds do request the applicant to supply some information about pre-existing ailments or illnesses. In many cases the questions asked go beyond the proper definition of a pre-existing ailment in seeking details about past or possible future treatment. In one extreme case, there is a full page of questions purporting to relate to pre-existing ailments included in the application form.

I cannot envisage what proper use can be made of this information because only a fund medical adviser can determine whether or not a particular ailment is pre-existing. This assessment can only be made when a particular treatment is proposed. There is a risk that seeking pre-existing ailment information on an application form could deter someone who thinks they may have a pre-existing ailment from applying for membership; or it could mislead an applicant as to the scope of the pre-existing ailment rules. Privacy principles require that personal information should only be sought and obtained when it is required for a legitimate purpose. This applies particularly to information about a person's medical history, illnesses, etc. Such information is regarded as particularly sensitive information under privacy provisions.

Where I have identified such questions about pre-existing ailments on fund application forms I will be writing to public officers to request that the form be reviewed immediately, in light of my concerns.

PHIO BROCHURE ON WAITING PERIODS

This new brochure has been finalised and will be available for download from www.phio.org.au. Bulk stocks are being printed and can be ordered from PHIO by email to info@phio.org.au or by telephoning PHIO Admin on **02 8235 8711**.

Please note the new waiting period brochure replaces the pink "Pre-Existing Ailments" brochure that was previously available from the Department of Health & Ageing.

Complaints by Health Fund Market Share

01 January to 31 March 2006

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
AHM	15	2.6	3	1.6	2.4
Australian Unity	41	7.1	18	9.8	3.6
BUPA (HBA)	49	8.5	18	9.8	9.9
CBHS	5	0.9	3	1.6	1.1
CDH (Cessnock District Health)	0	0	0	0	<0.1
Credicare	6	1.0	4	2.2	0.4
Defence Health	13	2.3	6	3.3	1.4
Druids NSW	0	0	0	0	<0.1
Druids Victoria	2	0.3	0	0	0.1
Doctors' Health Fund	0	0	0	0	0.1
GMHBA	11	1.9	1	0.5	1.5
Grand United Corporate Health	4	0.7	1	0.5	0.3
HBF Health	26	4.5	4	2.2	7.9
HCF (Hospitals Cont. Fund)	43	7.5	12	6.6	8.8
Health Care Insurance	0	0	0	0	0.1
Health Insurance Fund of W.A.	2	0.3	1	0.5	0.4
Healthguard	7	1.2	2	1.1	0.6
Health-Partners	5	0.9	0	0	0.7
Latrobe Health	2	0.3	0	0	0.6
Lysaght Peoplecare	1	0.2	0	0	0.3
Manchester Unity	14	2.4	7	4.1	1.4
MBF Australia Limited	94	16.3	23	12.6	16.7
MBF Alliances	27	4.7	12	6.6	2.2
Medibank Private	157	27.3	48	26.2	28.7
Mildura District Hospital Fund	0	0	0	0	0.3
N.I.B. Health	40	6.9	16	8.7	6.2
Navy Health	0	0	0	0	0.3
Phoenix Health Fund	0	0	0	0	0.1
Police Health	2	0.3	0	0	0.2
Queensland Country Health	2	0.3	1	0.5	0.2
Railway & Transport Health	3	0.5	1	0.5	0.3
Reserve Bank Health	0	0	0	0	<0.1
St Lukes Health	0	0	0	0	0.4
Teacher Federation Health	2	0.3	1	0.5	1.6
Teachers Union Health	1	0.2	0	0	0.4
Transport Health	1	0.2	0	0	0.1
Westfund	0	0	0	0	0.7
Total for Registered Funds	575	100	182	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.