Australian Government

Private Health Insurance Ombudsman

Quarterly Bulletin 50

(1 January to 31 March 2009)

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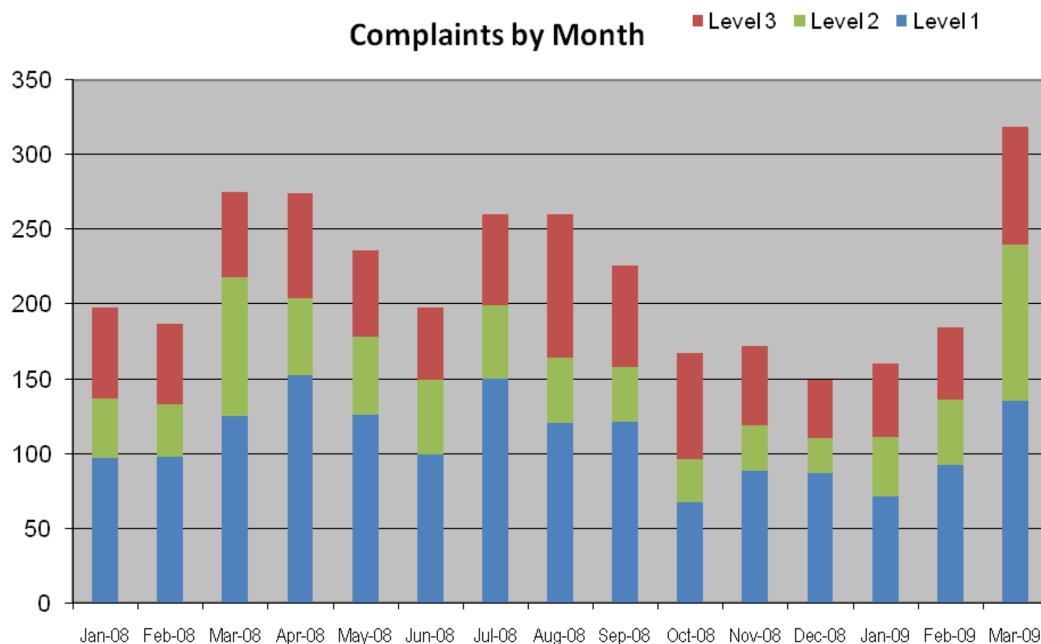
Complaint Statistics

The office received 610 complaints about health insurers during the March quarter, which was 12 fewer than the same period last year. Of the 610 complaints received, 157 were Level 3 complaints, 4 less than the same quarter last year.



Premium Increases and www.privatehealth.gov.au

The office received 67 complaints about premium increases during the quarter, which is 5 more than the 62 complaints recorded about this issue in the March quarter 2008. This continues the trend of significantly lower numbers of complaints about premium increases in recent years. Most of these complaints were made by individuals holding policies where the rate increase was above the 6.02% industry average. PHIO staff handled these complaints by explaining the process for the scrutiny and approval of premium increases and the need for higher than average increases on some policies to ensure that premium income covers the cost of the benefits paid out.

Usage of the consumer website, www.privatehealth.gov.au, increased at the time the premium increases were announced, which indicates that consumers were using the website to check their policies and compare prices and benefits between covers.

Health insurers are required to keep all policies updated on the website, so the upload of new Standard Information Statements to reflect 2009 premiums was a considerable task for insurers and their staff, as well as PHIO's website contractor.

The upload proceeded smoothly and was completed by midday on 1st April. The number of policies listed on the website has increased by 24% on the previous year and there are now 20 282 Standard Information Statements on the site. Given the very large number of policies now on the website, PHIO encourages insurers to review their policies and consider whether any reductions are possible. The size of an insurer does not necessarily equate to the number of policies available and there would be administrative savings to be made by insurers in reducing the number of different policies being maintained.

2008 State of the Health Funds Report

The 2008 "*State of the Health Funds Report*" was released on 31st March 2009. The release of the report generated some media interest and PHIO took the opportunity to promote the report and the www.privatehealth.gov.au website in the media as sources of independent information for consumers to use when making decisions or seeking information about private health insurance. This resulted in a significant increase in the number of consumers visiting the website. The report can be downloaded from the www.phio.org.au website and printed copies can be obtained by e-mailing richard@phio.org.au.

PHIO Complaint Review and Escalation Process

There have been some staff changes to PHIO's senior contacts within a number of insurers, which has resulted in inquiries to the office regarding our review and escalation processes for complaints. It therefore seems timely to remind all insurers about PHIO's complaint escalation and review process.

Best practice complaint handling requires the ability to review or escalate a matter where the complainant or the PHIO is unsatisfied with the resolution proposed by the insurer or service provider. If a member expresses dissatisfaction with the outcome of their complaint, PHIO has an internal process for escalation and review of the matter by a more senior staff member.

Initially when a complaint is received, the PHIO Dispute Resolution Officer (DRO) will refer the complaint to the insurer as either an assisted referral (Level 1 complaint) or a dispute (Level 3 complaint). (Level 2 complaints are closed with an explanation to the member, without the need for referral to the insurer.) In the case of Level 3 complaints, the DRO will work with the insurer to obtain a resolution. If the complainant is not satisfied with the resolution of their complaint, the DRO will bring it to the weekly PHIO case meeting where the issues are discussed and input is received from peers, senior staff and the Ombudsman. As this stage, a decision is made to undertake further investigation or negotiation with the insurer, or to close the complaint with an explanation to the complainant.

If a satisfactory resolution cannot be agreed at this point, the complaint is escalated to PHIO's Director of Policy and Client Services. The Director of Policy and Client Services will contact the nominated senior contact at the insurer, and put a case to them for review of the complaint. If the resolution as requested cannot be agreed upon, the case is escalated to the Ombudsman for further review.

At this stage, the Ombudsman may decide to make a formal recommendation to the insurer under the powers available under Subdivision 241 – E of the *Private Health*

Insurance Act 2007. Once a formal recommendation is made to the insurer, the insurer is required to respond to the recommendation within the nominated time frame. The recommendation and outcome may be reported by the Ombudsman to the Minister for Health and Ageing and in our reporting mechanisms including the Annual Report.

The PHIO encourages insurers to have their own internal review and escalation processes as well, in line with best practice customer service and complaints handling practices.

Fund Response Time for Level 3 Complaints (disputes)

Since its establishment, the PHIO has allowed 21 days for insurers to respond to Level 3 complaints (disputes). Most insurers provide responses to the majority of disputes in well under 21 days. However, feedback from complainants indicates dissatisfaction with the possible length of time before the PHIO receives a response from the insurer in relation to their complaint. Given that communication via the internet is now common, consumers expect a faster service. PHIO now has internet communication processes in place with insurers, which makes faster response times more achievable.

The Ombudsman has written to all health fund CEOs to request the implementation of 14 days as the standard response time for Level 3 complaints, with effect from 1st June 2009. The response from CEOs to this initiative has so far been positive, as CEOs recognise that in most cases, their staff members are already providing responses within this timeframe. Of course there will always be matters that are more complex where insurers require more time to respond. These can be notified to the PHIO Case Officer as needed.

Membership Suspension Due To Financial Hardship

Current economic conditions mean that some members may have difficulty affording their premiums if they become unemployed. There are, however, significant disadvantages to members if they cancel their hospital policy, as they may become liable for the Lifetime Health Cover penalty loading and will be subject to waiting periods if they re-join at a later date. It is therefore important that these are drawn to the member's attention, either when they contact the fund to cancel their membership, or by letter if the membership lapses or is cancelled without contact with the fund.

A flexible membership suspension policy is one way insurers can assist members experiencing financial hardship in the current economic climate. If the policy is suspended in accordance with the fund rules, the member doesn't lose their Lifetime Health Cover status, which is an important benefit in this situation.

The PHIO's advice to members who are concerned about premium costs and considering downgrading or cancelling their hospital or extras cover is to consider retaining their hospital cover, even if they need to take a higher excess or cease their extras cover. This is because the disadvantages of cancelling hospital cover are more significant and private hospital treatment is generally much more costly to self-fund than out of hospital services.

Complaints by Health Insurer Market Share

01 January - 31 March 2009

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	0.0%	0.1%
AHM	40	6.6%	7	4.5%	3.0%
Australian Unity	23	3.8%	7	4.5%	3.2%
BUPA (HBA)	65	10.7%	18	11.5%	9.8%
CBHS	7	1.1%	2	1.3%	1.2%
CDH (Cessnock District Health)	0	0.0%	0	0.0%	<0.1%
CUA Health	3	0.5%	0	0.0%	0.4%
Defence Health	8	1.3%	2	1.3%	1.4%
Doctors' Health Fund	2	0.3%	0	0.0%	0.1%
GMHBA	6	1.0%	2	1.3%	1.5%
Grand United Corporate Health	2	0.3%	0	0.0%	0.3%
HBF Health	15	2.5%	3	1.9%	7.5%
HCF (Hospitals Cont. Fund)	47	7.7%	4	2.5%	8.9%
Health Care Insurance	0	0.0%	0	0.0%	0.1%
Health Insurance Fund of W.A.	6	1.0%	1	0.6%	0.4%
Healthguard	6	1.0%	2	1.3%	0.5%
Health-Partners	1	0.2%	0	0.0%	0.6%
Latrobe Health	5	0.8%	2	1.3%	0.6%
Manchester Unity	21	3.4%	9	5.7%	1.5%
MBF Alliances	35	5.7%	6	3.8%	2.0%
MBF Australia Limited	104	17.0%	30	19.1%	15.7%
Medibank Private	130	21.3%	36	22.9%	28.7%
Mildura District Hospital Fund	0	0.0%	0	0.0%	0.3%
National Health Benefits Aust.	0	0.0%	0	0.0%	<0.1%
N.I.B. Health	61	10.0%	22	14.0%	7.0%
Navy Health	1	0.2%	0	0.0%	0.2%
Peoplecare	2	0.3%	0	0.0%	0.3%
Phoenix Health Fund	1	0.2%	0	0.0%	0.1%
Police Health	0	0.0%	0	0.0%	0.3%
QLD Country Health Fund	2	0.3%	0	0.0%	0.2%
Railway & Transport Health	2	0.3%	0	0.0%	0.3%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Lukes Health	0	0.0%	0	0.0%	0.4%
Teacher Federation Health	8	1.3%	1	0.6%	1.7%
Teachers Union Health	1	0.2%	0	0.0%	0.4%
Transport Health	0	0.0%	0	0.0%	0.1%
Westfund	6	1.0%	3	1.9%	0.7%
Total for Health Insurers	**610**	**100%**	**157**	**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 2008