COMMONWEALTH OMBUDSMAN

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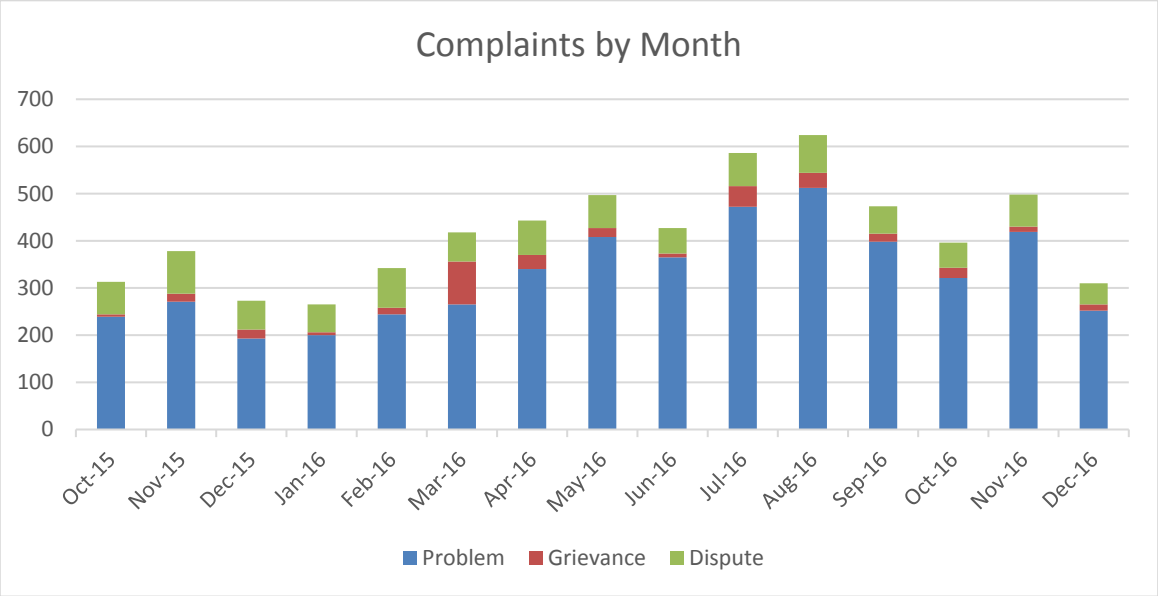
Private Health Insurance Ombudsman Quarterly Bulletin 81
(1 October – 31 December 2016)

Complaint Statistics and Workload

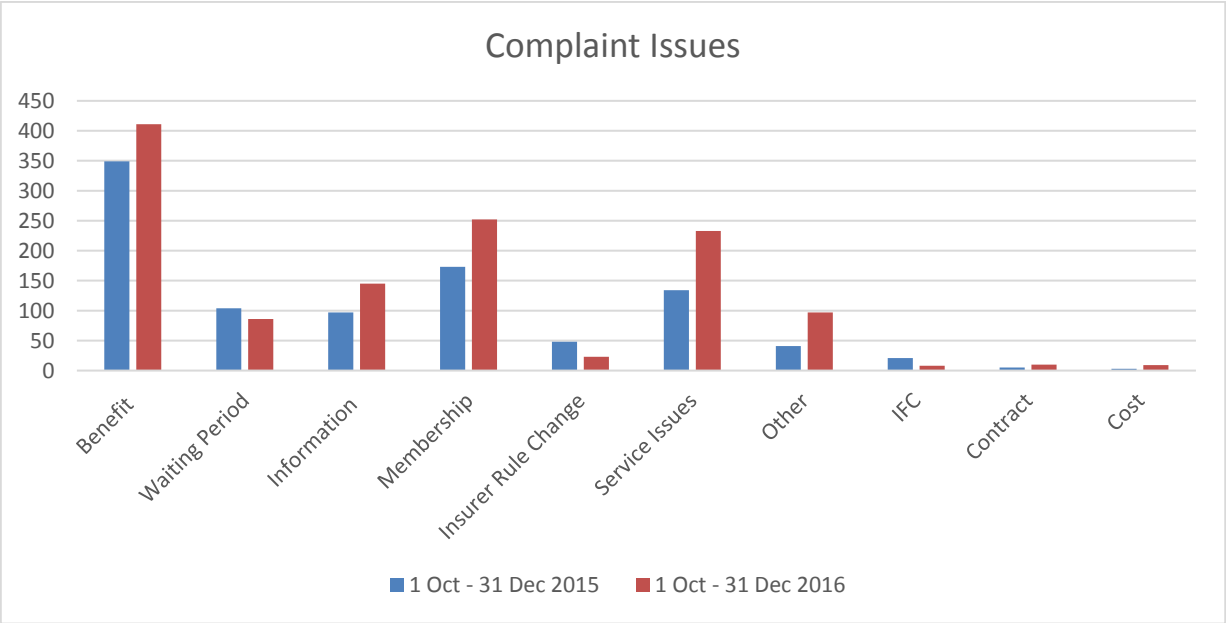
The December quarter is usually a 'quieter' period in private health insurance. However, after receiving a historically high 1683 complaints in the July to September 2016 quarter, the Private Health Insurance Ombudsman (PHIO) received 1203 complaints in the October to December 2016 quarter. While this was a reduction on the previous quarter, it was still a 25% increase on the 964 complaints received in the same quarter in 2015.

The Complaint Issues graph below shows the increase in complaints about Service and Membership.



Complaints by Provider or Organisation Type

Provider or Organisation Type	Sept 2016 QTR	Dec 2016 QTR
Health Insurers	1504	1067
Overseas Visitor & Overseas Student Health Insurers	143	95
Brokers and Comparison Services	16	15
Doctors, dentists, other medical providers	3	5
Hospitals and area health services	12	4
Other (e.g. legislation, ambulance services, industry peak bodies, etc)	11	17



Top 5 Consumer Complaint Issues This Quarter

1. **Premium Payment Problems: 102 complaints** – Predominantly concerning direct debits from bank accounts and credit cards, such as incorrect debit amounts or irregular debits, or the accidental cessation of direct debit arrangements. The majority of these complaints were caused by IT problems at one insurer.

2. **Oral Advice: 101 complaints** – Most oral advice complaints concern consumers misunderstanding their benefits during telephone calls and retail branch visits, particularly where records are not adequately maintained.

3. **Membership Cancellation: 79 complaints** – Complaints caused by problems and delays associated with processing requests to cancel memberships and handling payments or refunds.

4. **Hospital exclusion/restriction: 68 complaints** – Usually caused when complainants find they are not covered for a service or treatment that they had assumed was included on their cover.

5. **General treatment (extras/ancillary): 67 complaints** – These complaints are often caused by complainants receiving a lower benefit than they expected.

For further information on consumer complaint issues, please see the 'Issues and Sub-issues: Complaints Received in Past 4 Quarters' table attached to this bulletin.

Australian Dental Association Campaign

During the quarter, PHIO received complaints as a result of a campaign conducted by the Australian Dental Association (ADA). The ADA provided an online complaint form which automatically sent complaints to PHIO's email address and contacted its members to encourage them to complete the form.

PHIO received 2505* complaints from dental providers and 637* from health insurance consumers during the quarter. A copy of the two complaint forms are attached to the end of this bulletin.

The complaints concerned:

- The level of dental benefits provided by health insurance policies and concern that benefits have not increased at the same level as health insurance premiums
- The existence of health insurer preferred provider schemes and dental centres
- The complexity of health insurance dental benefits and difficulty for consumers in obtaining clear information about benefits and limits.

Health insurance for dental services in Australia are not specially regulated by the government. Therefore the level of benefits and provision of dental centres and preferred provider schemes are the result of market forces and the decisions of consumers to choose policies with such benefits. PHIO recognises that some consumers have chosen policies that include dental centres and preferred provider schemes.

For those consumers who would like to choose policies that do not operate preferred provider schemes or dental centres, they have the option to choose health insurers that are suited their needs. There are also tools available for consumers wishing to choose a health insurance policy based on the level of dental benefits provided. The PHIO website Privatehealth.gov.au provides a policy comparison feature which includes an indication of whether the insurer pays above or below average benefits for dental and other services. The Ombudsman also publishes an annual State of the Health Funds Report on health insurers (available on Ombudsman.gov.au) which reports on how much insurers pay the cost of treatment for a range of services.

* *Note about complaint recording:* The complaints that PHIO has received as a result of the ADA campaign are recorded separately to the individually initiated complaints by health insurer (meaning they are not included in the table in this bulletin). These complaints are valid expressions of dissatisfaction and the Ombudsman fully supports the right of consumers and providers to complain; however, they are different from matters PHIO considers in its normal complaint handling, where we consider an individual complaint and raise it with an insurer for a response.

Policies that Provide Benefits for "Minor" Knee Procedures

PHIO is aware that there are a number of hospital policies in the market that provide benefits for what is described to the consumer as "minor" knee procedures. To the consumer this would appear to mean procedures such as arthroscopies performed as a day procedure. Problems occur, however, when the insurer's the definition of what is a minor procedure is narrower than a consumer, or their doctors, would appreciate. It is also difficult for a consumer to understand exactly what they are covered for because the definition of "minor" knee procedures is not standardised, with each insurer determining its own definition.

Recently PHIO investigated a case where a policy holder was seeking to obtain a benefit quote from his insurer after he was advised by his surgeon that he required a knee arthroscopy. He was told that the surgeon might use one of three or four possible item numbers. In these type of cases, it is common that the surgeon cannot confirm the exact item number until the patient is present, as the extent of the condition is only determined after the investigative treatment commences. Having made an assessment, the surgeon then decides on and provides the treatment during the procedure.

On querying the insurer, as was later confirmed by PHIO, it became apparent that the insurer only paid benefits for one knee arthroscopy item number, and not others that would be considered minor knee procedures by other health insurers or a surgeon. Furthermore, if this policy holder proceeded with his treatment on the basis that the covered item number would be performed, but then a different item number was required for medically necessary reasons, he would end up receiving no benefit from the insurer.

This type of restrictive policy presents a practical problem for consumers because it is impossible to know for sure whether benefits will be paid for a minor knee procedure until after it has occurred. It is common for surgeons to change item numbers used once a patient is present in theatres and they are responsible for providing medical treatment that is appropriate. It is not practical to perform an investigative arthroscopy, then close the patient up and check their cover to see if they are covered for a further treatment if required.

In this case, after presenting the problem to the insurer they offered to pay a benefit towards the policy holder and give consideration to how the policy was described.

However, in PHIO's view the key issue in cases such as these, where a consumer finds it difficult to confirm their benefits before the hospital procedure takes place, is the policy design itself. Although poor information can present further problems to the consumer, the cause of the problem is the policy.

PHIO has also received complaints concerning definitions of "minor gynaecological procedures", "minor eye surgery", and "minor joint investigations". These policies can present difficulties if an individual's procedure is considered minor by their surgeon, but is not considered minor by the insurer. When this occurs the consumer may be aggrieved that the insurer's definition of a "minor" procedure does not match their doctor's view on the nature of their treatment. Presenting a complainant with a list of item numbers which are and are not covered after they wish to make a claim raises the question why this information could not have been made available to the consumer earlier.

Whilst PHIO does not consider providing a list of all included item numbers to a consumer would be useful due to the amount of information it would involve, it is preferable in a small number of policies where only one or two item numbers are covered under a policy inclusion. For example, instead of indicating that "minor knee procedures" are covered, indicate that "diagnostic arthroscopy item 49557" is covered – by stating the inclusion clearly at the point of purchase, this is less likely to cause problems for the consumer.

Clarification on the Number of Policies Available to Consumers

There have recently been reports stating that over 40,000 policies are available to consumers in the Australian health insurance market. PHIO believes this number is incorrect and a misunderstanding of the 40,000+ number of Standard Information Statements (SISs) shown on the Privatehealth.gov.au website.

The real number of policies available to a consumer seeking a policy for themselves, or as a couple or family, in their home state/territory, will be significantly lower than the total number of SISs.

Firstly, removing policies that are no longer available for purchase, the total number of SISs for policies available for purchase on the websites was 27,281 as at 5 January 2017.

However, this number does not take into account that one product available for purchase will generate several SISs, as a new SIS must be generated for each premium variation: e.g. different excess options, 7 state/territories (noting ACT-NSW is counted as one state), 4 main scales (single, couple, family, single parent family, plus single/young adults, couple/young adults and children only) and 3 types of policy (Hospital, General treatment, Combined).

This figure also includes all restricted funds and corporate policies, which are not available for purchase to all members of the public.

Eliminating closed policies, those from restricted funds and corporate policies, but counting different excess levels & co-payments, the number of policies available to a consumer are closer to the following:

Please note these are two examples estimating the number of "for sale" policies available to a consumer; other states and single/family/couple/etc options display similar results.

Single Person, Victoria

- Number of hospital policies available: 185
- Number of general treatment policies available: 119
- Number of combined (packaged by insurer) policies available: 117

Family in Western Australia

- Number of hospital policies available: 230
- Number of general treatment policies available: 157
- Number of combined (packaged by insurer) policies available: 186

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Complaints by Health Insurer Market Share
1 October to 31 December 2016

Name of Insurer	Complaints(1)	Percentage of Complaints	Disputes(2)	Percentage of Disputes	Market Share(3)
ACA Health Benefits	0	0.0%	0	0.0%	0.1%
Australian Unity	40	3.7%	6	4.4%	3.1%
BUPA	180	16.9%	35	25.9%	27.0%
CBHS Corporate Health	0	0.0%	0	0.0%	n/a
CBHS	4	0.4%	0	0.0%	1.4%
CDH (Cessnock District Health)	0	0.0%	0	0.0%	<0.1%
CUA Health	16	1.5%	7	5.2%	0.6%
Defence Health	7	0.7%	0	0.0%	1.9%
Doctors' Health Fund	1	0.1%	1	0.7%	0.2%
Emergency Services Health	0	0.0%	0	0.0%	n/a
GMHBA	23	2.2%	4	3.0%	2.1%
Grand United Corporate Health	7	0.7%	2	1.5%	0.4%
HBF Health & GMF/Healthguard	47	4.4%	6	4.4%	8.0%
HCF (Hospitals Contribution Fund)	100	9.4%	21	15.6%	10.3%
Health.com.au	10	0.9%	3	2.2%	0.6%
Health Care Insurance	0	0.0%	0	0.0%	0.1%
Health-Partners	4	0.4%	2	1.5%	0.6%
HIF (Health Insurance Fund of Aus.)	8	0.7%	1	0.7%	0.9%
Latrobe Health	3	0.3%	0	0.0%	0.7%
Medibank Private & AHM	516	48.4%	30	22.2%	27.6%
Mildura District Hospital Fund	1	0.1%	0	0.0%	0.2%
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
Navy Health	1	0.1%	1	0.7%	0.3%
NIB Health	62	5.8%	9	6.7%	8.1%
Nurses and Midwives Pty Ltd	0	0.0%	0	0.0%	n/a
Peoplecare	2	0.2%	0	0.0%	0.5%
Phoenix Health Fund	2	0.2%	0	0.0%	0.1%
Police Health	0	0.0%	0	0.0%	0.3%
QLD Country Health Fund	0	0.0%	0	0.0%	0.3%
Railway & Transport Health	3	0.3%	0	0.0%	0.4%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Lukes Health	2	0.2%	0	0.0%	0.4%
Teachers Federation Health	17	1.6%	4	3.0%	2.1%
Teachers Union Health	7	0.7%	1	0.7%	0.6%
Transport Health	2	0.2%	0	0.0%	0.1%
Westfund	2	0.2%	2	1.5%	0.7%
Total for Health Insurers	**1067**	**100%**	**135**	**100%**	**100%**

1) Total number of Complaints (Problems, Grievances & Disputes) regarding Australian registered health insurers. This table excludes complaints regarding OVHC and OSHC insurers, and other bodies.

2) Disputes required the intervention of the Ombudsman and the health insurer.

3) Source: Australian Prudential Regulation Authority, Market Share, All Policies, 30 June 2016. Insurers which commenced business after 30 June 2016 have no reportable market share.

Issues and Sub-issues: Complaints Received in Past 4 Quarters

ISSUE Sub-issue	Mar 2016	June 2016	Sep 2016	Dec 2016
BENEFIT				
Accident and emergency	10	12	10	14
Accrued benefits	2	0	0	0
Ambulance	11	21	23	23
Amount	14	16	20	41
Delay in payment	33	49	66	47
Excess	16	8	16	13
Gap - Hospital	13	9	14	16
Gap - Medical	27	19	55	33
General treatment (extras/ancillary)	56	50	58	67
High cost drugs	0	6	2	4
Hospital exclusion/restriction	50	74	74	68
Insurer rule	34	32	50	33
Limit reached	6	3	3	5
New baby	2	1	2	8
Non-health insurance	1	3	3	0
Non-health insurance - overseas benefits	0	0	2	0
Non-recognised other practitioner	4	6	9	10
Non-recognised podiatry	5	5	1	3
Other compensation	3	5	1	4
Out of pocket not elsewhere covered	6	5	5	6
Out of time	4	5	6	4
Preferred provider schemes	3	7	7	12
Prostheses	1	3	2	0
Workers compensation	0	0	0	0
CONTRACT				
Hospitals	1	4	6	3
Preferred provider schemes	1	2	1	6
Second tier default benefit	0	0	0	1
COST				
Dual charging	2	4	1	3
Rate increase	114	32	5	6
INCENTIVES				
Lifetime Health Cover	22	40	63	49
Medicare Levy Surcharge	1	5	3	4
Rebate	0	7	10	11
Rebate tiers and surcharge changes	0	1	0	0
INFORMATION				
Brochures and websites	10	6	12	11
Lack of notification	36	26	24	19
Oral advice	104	136	139	101
Radio and television	1	0	0	0
Standard Information Statement	1	3	4	3
Written advice	7	7	16	11

ISSUE Sub-issue	Mar 2016	June 2016	Sep 2016	Dec 2016
INFORMED FINANCIAL CONSENT				
Doctors	6	8	6	4
Hospitals	12	6	2	2
Other	2	4	2	2
MEMBERSHIP				
Adult dependents	2	4	5	6
Arrears	30	26	31	38
Authority over membership	7	5	7	8
Cancellation	66	122	107	79
Clearance certificates	22	121	148	62
Continuity	30	26	57	40
Rate and benefit protection	8	10	2	2
Suspension	10	16	20	17
SERVICE				
Customer service advice	25	20	25	27
General service issues	42	94	101	51
Premium payment problems	31	105	103	102
Service delays	31	72	281	53
WAITING PERIOD				
Benefit limitation period	1	0	0	5
General	4	6	5	11
Obstetric	14	13	9	4
Other	2	2	8	5
Pre-existing conditions	57	61	82	61
OTHER				
Access	1	1	0	1
Acute care certificates	2	0	1	2
Community rating	0	0	0	18
Complaint not elsewhere covered	11	24	9	5
Confidentiality and privacy	3	2	10	5
Demutualisation/sale of health insurers	0	0	0	0
Discrimination	1	2	0	0
Medibank sale	0	0	0	0
Non-English speaking background	0	0	0	0
Non-Medicare patient	0	1	0	2
Private patient election	2	0	2	0
Rule change	34	33	22	23

Australian Dental Association Campaign

Form letter from dental professional:

To the Commonwealth Ombudsman

As a dental professional dealing with a range of private health insurers on a daily basis, I am deeply unhappy about the way in which their behaviour is affecting the oral health of my patients.

It is increasingly apparent to me that the funds are playing a far more proscriptive role in the healthcare system than before, increasingly positioning themselves as the final decision makers on what is best for my patient's oral health. This excessive grab for decision-making power by a non-health provider should be of concern to the government, and anyone focused on the overall wellbeing of patients.

This trend is being accelerated by the growth of the insurers' own clinics. This increasingly means patients are being lured away from their long-term dentists, a development which disrupts the very valuable continuity of care that is integral to effective ongoing oral health care.

My patients are also being forced to shoulder a greater share of their treatment costs due to stagnant or decreasing rebates, despite consistent and significant increases to their premiums. Along with impractical annual limits and claiming restrictions, this is prompting many of my patients to put off vitally important treatment. The focus must always be on health over profit but the funds' policies and behaviour indicate that improvement to their bottom line is their prevailing motive.

Finally, while I appreciate that the federal government has undertaken a review of private health insurance, I am worried that it has underestimated the scope of the problem by narrowly focusing only on the lack of transparency in the private health insurance industry.

Unlike general medical services, which receive a significant amount of public funding via Medicare, dentistry is largely privately funded with patients bearing the major portion of treatment costs. I am not convinced the government is taking all the necessary steps to ensure that patients receive the assistance they need nor that dental care is properly funded.

I do not require any response to this complaint but I would like you to officially lodge and record it.

Form letter from consumer:

To the Commonwealth Ombudsman

I wish to make a complaint about my private health fund, [name].

I have been unhappy with their service for quite some time but recently it's become quite obvious that the rebates I am given for dental services are far too low, leaving me with increasingly unaffordable out of pocket expenses.

I appreciate that I was provided a product disclosure statement when I signed up to my policy; however, it didn't fully outline the claiming restrictions of my policy and also failed to prepare me for the considerable out of pocket expenses I'd incur.

I initially thought the problem lay with the fees charged by my dentist, but after finding out that their fees have pretty much stayed the same for years, I don't think my dentist is the problem. It's looking more and more like the health insurers are the ones at fault with my insurance premiums going through the roof while the amount I get back as a rebate hasn't budged.

And frankly, they don’t make it easy to work out exactly what I am getting for my money:

1. There are too many policies and they’re too hard to understand. How am I supposed to figure out which policy is right for me?

2. Their ads don’t help much either – they gloss over all the important stuff, and leave me none the wiser about what their policies are actually offering.

3. My health fund does not make it easy to work out how much my rebate will be. There is no list of how much I will get back even though my dentist provided me with a detailed list of services I'll be receiving. I should be able to work out my out-of-pocket expenses ahead of seeing my dentist, just like I am able to with any other form of insurance.

4. I'm paying the same premiums for the same policy as my friend but they get higher rebates than I do because they go to see a dentist contracted to their fund while I'd prefer to keep seeing my own dentist. One of the main reasons I took out this policy was so I'd have a choice in which dentist treated me but now I am being financially disadvantaged for seeing the dentist of my choice.

I appreciate that you’ll likely advise me to contact my health fund directly and consider a different policy, but I have no confidence in their ability to address these issues and feel that the government needs to intervene.

I do not require any response to this complaint but I would like you to officially lodge and record it.