Australian Government
Private Health Insurance Ombudsman

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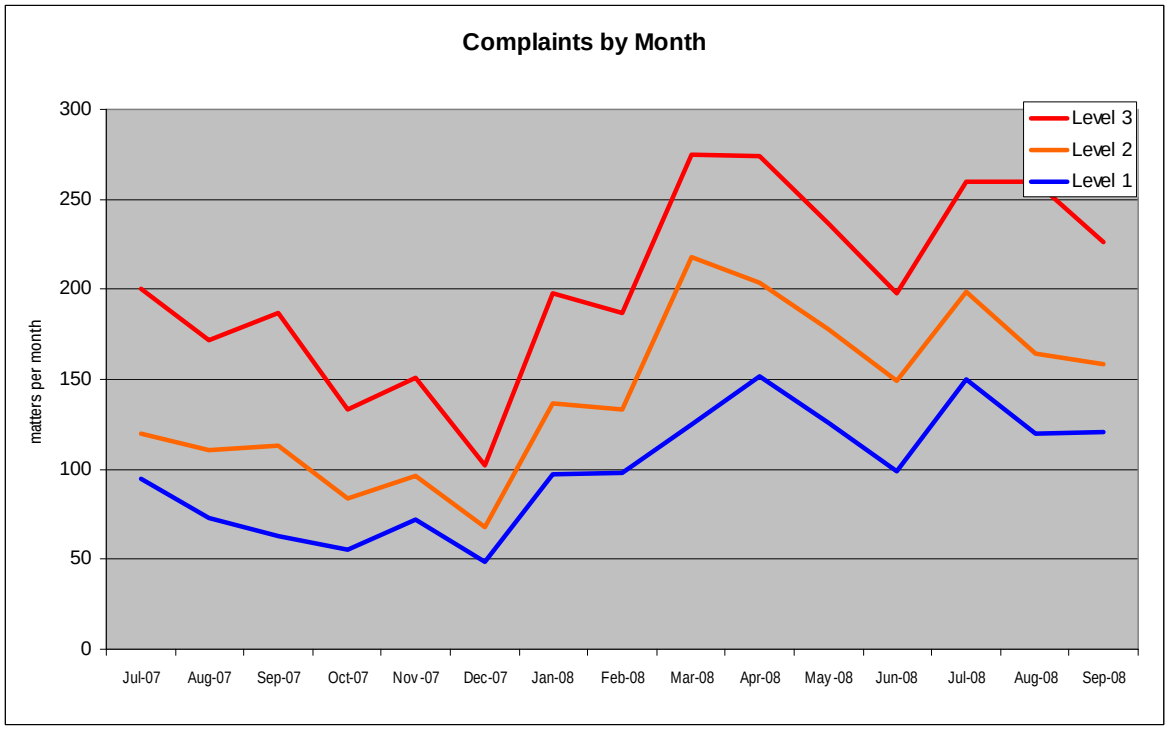
Quarterly Bulletin 48

(1 July to 30 September 2008)

Complaint Statistics

This quarter we received 675 complaints about health insurers, which was a similar number of complaints to the June quarter. Normally the office receives fewer complaints in the September quarter than the June quarter, but this year we received 132 more (24%) health insurer complaints than the same quarter in 2007.

Of the 675 complaints received, 171 were Level-3 complaints, which was 5% more than the previous quarter, but 18% fewer than the same period last year.



Complaint Issues

PHIO has analysed the possible causes for the higher level of complaints during this quarter compared with the previous year. It is worth noting that the increase is not attributable to premium increases as the office received only 9 complaints about premium increases in the September 2008 quarter.

The increase in complaints seems to be attributable to two areas of complaint:

1. General Service and Payment issues. The office received 108 complaints where consumers sought the assistance of the PHIO because their health insurer hadn't responded to their complaint. The office received 69 complaints regarding premium payment problems and 37 complaints regarding delays in benefit payments.

2. Demutualisation of Health Insurers. The office received 60 complaints from consumers regarding issues related to the sale of their health insurer. The most common type of complaints were from long term members of health funds who believed that their full membership history was incorrectly recorded and they were being offered a lower payment as a result.

Pre-Existing Condition Rule Determinations

Australia's system of *Community Rating* means that all consumers pay the same premiums as others on the same policy, regardless of their age or health status. The twelve month waiting period for pre-existing conditions exists to keep Community Rating sustainable and to protect the interests of existing health fund members who have contributed to the pool of funds available to pay health insurance claims.

The Pre-Existing Condition (PEC) rule[1] allows health insurers to apply a 12-month waiting period to conditions where, in the opinion of the insurer's medical practitioner, signs or symptoms of the ailment, illness or condition existed at any time in the 6-months before the policy commenced.

The PHIO receives a regular number of complaints regarding the application of the rule, which isn't surprising, given the number of people joining or upgrading their health insurance policy every year. It is important for insurers to ensure that the rule is correctly applied and that the people who are subject to the 12-month waiting period are correctly advised of their options.

Some years ago, *Best Practice Guidelines* were developed in consultation with industry for assessing and communicating information and decisions about pre-existing conditions. Analysis of the PHIO's complaints data reveals that where insurers follow these guidelines, there is a lower incidence of complainants feeling aggrieved about the application of the PEC rule and contacting the PHIO for assistance.

At PHIO's seminar in August this year, Dr Geoff Dreher, who was a member of the original Review Committee that recommended the development of the *Best Practice Guidelines*, provided an update on how insurers are complying with the requirements to assess PEC correctly and issues that are still persisting.

The key issues that Dr Dreher and the PHIO believe that some insurers need to address are:

- Using the appropriate Pre-Existing Condition certificates. The guidelines include a recommended certificate that ensures that the patient's medical practitioner understands the PEC rule. It would appear that some funds do not include a definition of the rule on their certificates. PHIO recommends that all insurers review their medical certificates and include the definition if it isn't already included.

- Asking inappropriate questions on the certificate. The clinical facts relating to length of time signs and symptoms were present are required on the certificate; asking for the opinion of the treating doctor on whether the

[1] Section 75-15 of the *Private Health Insurance Act 2007* defines the meaning of a pre-existing condition.

condition is a PEC is not necessary, as the Act states that it is the insurer's medical adviser who forms an opinion about whether the condition is a PEC.

- Sending the certificate to only one practitioner. The guidelines recommend sending the certificate to both the patient's general practitioner and specialist. Sending one certificate means that full information is often not obtained, leading to further requests for information from patient and doctor which unnecessarily prolongs the decision making process.

- Not providing a "Statement of Reason". When an insurer's medical adviser determines that a person's condition was pre-existing, the fund needs to provide a statement of reason to the member. A template for the statement of reason is attached to the Best Practice Guidelines.

The PHIO recommends that health insurers review their processes and documentation for assessing Pre-Existing Conditions in light of Dr Dreher's comments. Copies of the guidelines are available on our website at www.phio.org.au. Insurers are welcome to contact Alison Leung on 02 8235 8708 if they require advice on the guidelines or if they would like us to review their process.

Consumer Website Survey Results

A survey was added to the www.privatehealth.gov.au website recently. Results and comments from the survey are being used by PHIO to guide changes to the site. Here are some initial results from the survey:

- Quality of Information: 82.9% found the quality of the information on the site was acceptable, 63.1% reported it was good or excellent.
- Ease of Use: 86% reported ease of use was acceptable, 63.6% reported ease of use as good or excellent.
- Visual Appeal: 90.4% reported the visual appeal as acceptable, 57.4% reported visual appeal as excellent or good.
- Location of Information, 79.1% said that information was located in an acceptable way, 53.9% reported location of information as excellent or good.

State of the Health Funds Report 2008

The *State of the Health Funds Report* has evolved since the first report in 2004, based on a considerable amount of feedback from consumers, industry participants and others. The current format of the report is designed to use the best data available, without requiring insurers to re-send data that is already available to PHIO. Decisions as to what is included in the report have been based on managing different opinions from stakeholders and consumers; opinions which sometimes vary widely between stakeholders.

PHIO intends for the 2008 report to be in a similar format to the previous year as this will ensure that the views of all stakeholders that have previously contributed to the report are taken into account. Draft versions of the report will be sent to each insurer for fact checking and comments and suggestions can be sent to David McGregor at david@phio.org.au or 02 8235 8788.

Complaints by Health Insurer Market Share

01 July - 30 September 2008

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	35	5.2	17	9.9	2.7
Australian Unity	32	4.7	8	4.7	3.4
BUPA (HBA)	47	7.0	11	6.4	9.8
CBHS	7	1.0	2	1.2	1.2
CDH (Cessnock District Health)	0	0.0	0	0.0	<0.1
CUA Health	0	0.0	0	0.0	0.4
Defence Health	4	0.6	0	0.0	1.4
Doctors' Health Fund	0	0.0	0	0.0	0.1
Druids Victoria	8	1.2	3	1.8	0.1
GMHBA	4	0.6	1	0.6	1.5
Grand United Corporate Health	4	0.6	2	1.2	0.3
HBF Health	19	2.8	6	3.5	7.6
HCF (Hospitals Cont. Fund)	42	6.2	5	2.9	8.8
Health Care Insurance	0	0.0	0	0.0	0.1
Health Insurance Fund of W.A.	6	0.9	1	0.6	0.4
Healthguard	1	0.1	0	0.0	0.5
Health-Partners	4	0.6	0	0.0	1.1
Latrobe Health	2	0.3	0	0.0	0.6
Manchester Unity	22	3.3	6	3.5	1.6
MBF Alliances	31	4.6	8	4.7	2.1
MBF Australia Limited	213	31.6	36	21.1	15.9
Medibank Private	133	19.7	40	23.4	28.6
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	42	6.2	19	11.1	6.6
Navy Health	0	0.0	0	0.0	0.3
Peoplecare	3	0.4	0	0.0	0.3
Phoenix Health Fund	0	0.0	0	0.0	0.1
Police Health	0	0.0	0	0.0	0.2
Queensland Country Health	0	0.0	0	0.0	0.2
Railway & Transport Health	1	0.1	1	0.6	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	4	0.6	2	1.2	1.7
Teachers Union Health	4	0.6	1	0.6	0.4
Transport Health	1	0.1	1	0.6	0.1
Westfund	3	0.4	1	0.6	0.7
Total for Health Insurers	672	100	171	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 2007