



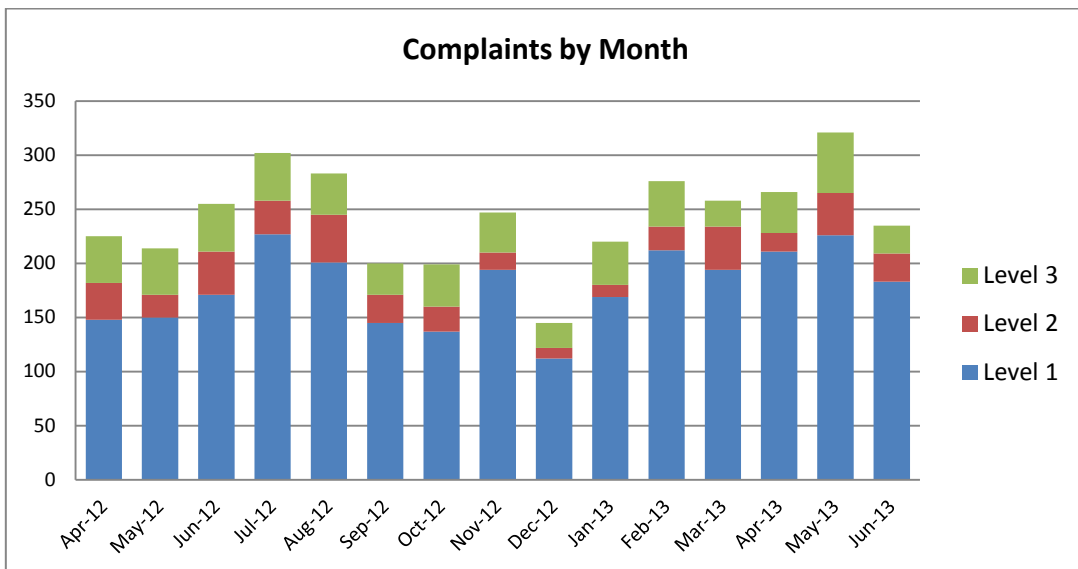
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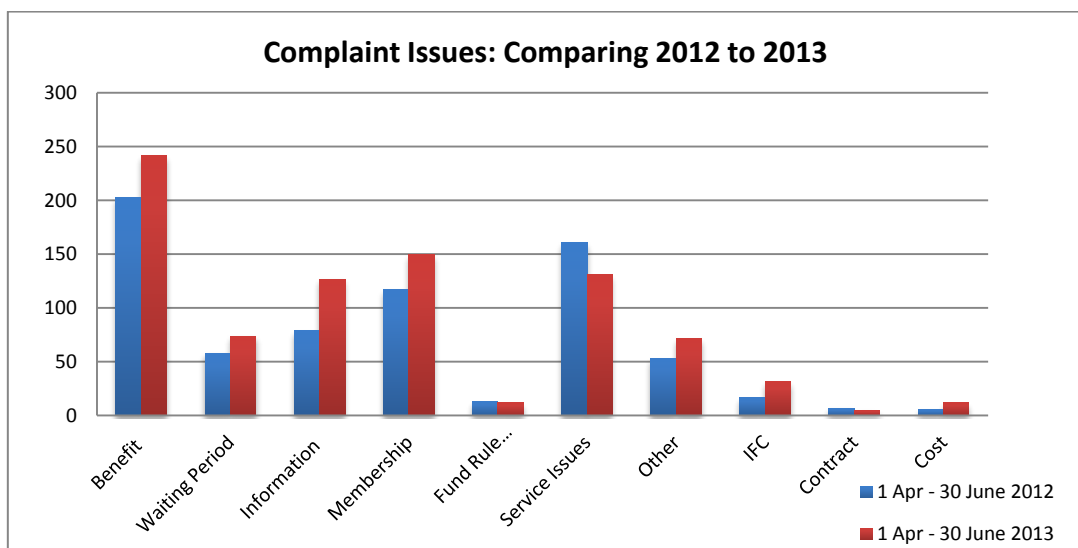
Quarterly Bulletin 67
(01 April – 30 June 2013)

Complaint Statistics & Workload

The Ombudsman received 822 complaints during the June quarter, compared with 754 last quarter. This represented an increase of 18% on the 694 complaints received in the same quarter last year. May in particular was a busy period for the office, with an increased level of consumer dissatisfaction across a broad range of areas. PHIO will report further on these complaint issues in its 2013 Annual Report due later this year. Preliminary figures suggest that the total number of complaints for 2012-13 will be similar to 2011-12, because the busy period in May is balanced by a relatively quiet period in December 2012.

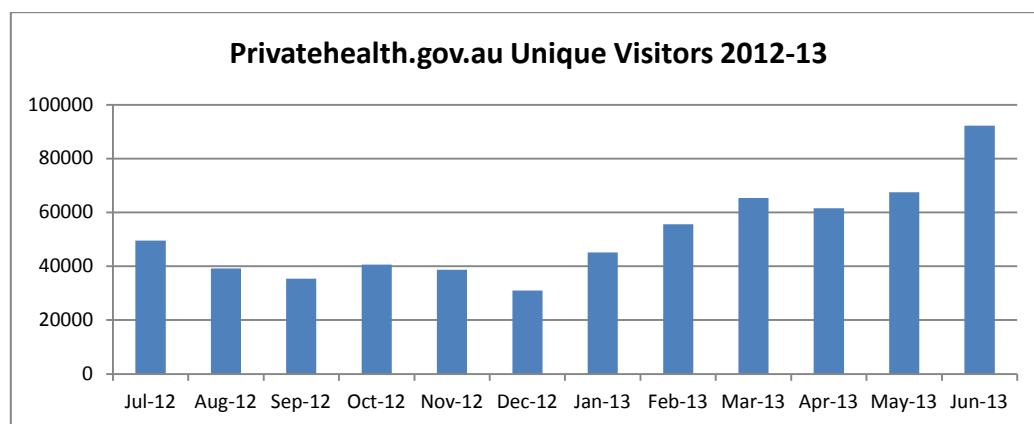


The complaint issues graph below shows which complaint areas have contributed to the overall number of complaints. The most significant changes in the June quarter were that Benefit complaints increased from 203 to 242, Information complaints from 79 to 127 and Membership complaints from 117 to 150.

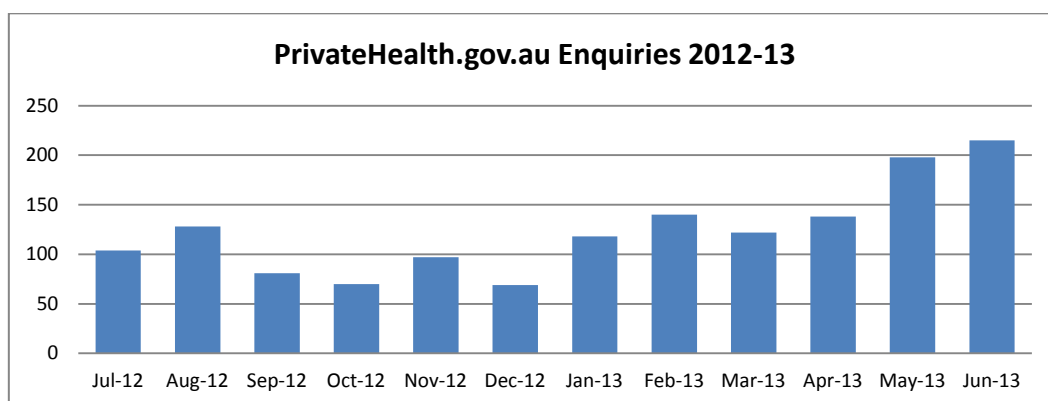


Privatehealth.gov.au Visits and Enquiries

There continues to be a steady increase in unique visits each month to the consumer website, Privatehealth.gov.au. This year, visits peaked in June 2013, with over 92,000 unique visitors. June tends to be a busy period due to the Department of Health & Ageing's Lifetime Health Cover mailing to 31-year-olds and new migrants and general industry focus on the Lifetime Health Cover deadline and Medicare Levy Surcharge.



Due to the increased number of website visits, PHIO also received an increased number of consumer enquiries. During the June quarter, 551 consumer enquiries were received through Privatehealth.gov.au; a significant increase on the 380 enquiries received in the previous quarter. In the June 2012 quarter, the office received 463 queries. While the majority of enquiries are general questions about private health insurance, a significant portion (between 15 to 20% each quarter) relate to Lifetime Health Cover.



Providing Information to Consumers about Medical Costs

In dealing with complaints, PHIO dispute resolution officers listen to a significant number of recorded calls between insurers and policyholders. In most cases, fund customer service officers deliver health insurance information well. For example, if a member calls to enquire about whether an upcoming hospital admission will be covered, and is able to provide the medical item number for the procedure, they will usually receive correct advice about whether the hospital admission will be covered.

PHIO staff members have noticed, however, that insurer staff members could expand their advice to cover issues that are very important for the caller to understand when planning a hospital admission, but which aren't asked about during the call. The most common example of this is the question of how benefits are paid for medical bills. Many consumers are not aware that hospital accounts and medical accounts are billed separately, and that different rules apply to the benefits paid by the insurer.

If the member is attending a hospital that has a contract with their insurer and holds an appropriate level of hospital cover, they will incur few out-of-pocket costs for their hospital admission, apart from the excess or co-payment on their policy.

This is not necessarily the case with medical accounts. If the member's treating doctor agrees to use the insurer's gap scheme, the member will have no gap or a known gap to pay for the treatment. If the treating doctor chooses not to use the insurer's gap scheme, the member will receive a portion of the cost from

Medicare and a portion from the fund, but they may also incur a significant out-of-pocket cost for the gap portion not covered by the fund or Medicare.

When members call their insurer to ask whether they will be covered for a hospital admission, what they really want to know is whether there are costs they will have to cover themselves. In the case of doctors' bills, some of these can be significant, depending on a range of factors. Insurers should assist their members by advising them to query their treating doctors about whether they will charge under the insurer's gap scheme and whether there are any gap costs the member will need to pay themselves. This is information any private patient has a right to understand when considering the financial implications of a hospital admission and choice of surgeon and other doctors.

Doctors are responsible for seeking Informed Financial Consent from their patients. People often assume, however, that their insurer will cover any out-of-pocket medical costs. Where members are given advice such as "you are fully covered" or "you will receive 100% of the Medicare Schedule fee", they are more likely to infer that the insurer will cover all of their medical costs. The more information the member has, the better informed they are and the less likely to complain after the event when they discover their insurer pays only a small portion of their medical gap.

New Health Insurance Requirements for the Temporary Graduate (Sub Class 485 visa)

PHIO has received advice from the Department of Immigration and Citizenship (DIAC) regarding new health insurance requirements for the Temporary Graduate (Subclass 485) visa. The new arrangements mean that Subclass visa 485 applicants can meet the health insurance requirement of their visa by taking out a health insurance policy that has the same level of cover that is required for the 457 visa.

Insurers that sell either Overseas Visitor Cover or Overseas Student Cover need to ensure their sales staff members are aware of this new requirement and able to advise applicants for the Subclass 485 visa appropriately.

On 23 March 2013, the Skilled Graduate (Subclass 485) visa was renamed the Temporary Graduate (Subclass 485) visa and amended to include new post-study work arrangements. The amendments also included new health insurance requirements for Subclass 485 visa applicants and their accompanying family members.

The regulations now require applicants to have evidence of adequate arrangements for health insurance in Australia from the time they lodge their application until the time a decision is made on the application.

- If the applicant holds a valid Student visa at the time they apply for the Subclass 485 visa, their existing Overseas Student Health Cover (OSHC) is acceptable.
- However, OSHC is not acceptable if their Student visa expires during the processing period. It is also not acceptable at the time DIAC makes a decision on the visa application. The applicant must make arrangements for non-OSHC cover in both of these circumstances.

The regulations also introduce a mandatory requirement that Subclass 485 visa holders hold health insurance for the duration of their stay in Australia after the visa has been granted.

Details on the minimum level of health insurance coverage that Subclass 485 visa holders must hold is available on a template letter on the DIAC website. See Attachment A to the [health insurance standard template letter](#). This letter contains the same level of health insurance cover that is required for the Temporary Work (Skilled) (Subclass 457) visa. Subclass 485 visa applicants can be granted the same level of cover as Subclass 457 visa applicants.

More information on the Subclass 485 visa health insurance requirements is available on DIAC's website. See: [Who can apply](#) – section on 'Health Insurance'.

PHIO Complaint Handling Workshops

PHIO recently conducted workshops for health insurer complaints staff members in Perth, Sydney and Melbourne. We intend to hold a complaint workshop in Adelaide in early October.

PHIO would like to thank all participants for attending and for the contributions made to discussions and feedback provided to PHIO. We believe that these forums, where the office is able to update complaint staff members with our latest information on the causes of complaints and how to address them, contribute to reducing the level of complaints that the health insurance industry in Australia receives.

Complaints by Health Insurer Market Share

1 April - 30 June 2013

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	58	8.2%	9	9.3%	3.0%
Australian Unity	33	4.6%	4	4.1%	3.2%
BUPA (includes MBF)	205	28.8%	23	23.7%	26.7%
CBHS	10	1.4%	0	0.0%	1.3%
CDH (Cessnock District Health)	0	0.0%	0	0.0%	<0.1%
CUA Health	2	0.3%	0	0.0%	0.4%
Defence Health	9	1.3%	0	0.0%	1.6%
Doctors' Health Fund	2	0.3%	1	1.0%	0.2%
GMHBA	15	2.1%	1	1.0%	1.8%
Grand United Corporate Health	0	0.0%	0	0.0%	0.4%
HBF Health	23	3.2%	1	1.0%	7.6%
HCF (Hospitals Cont. Fund)	79	11.1%	16	16.5%	10.7%
Health.com.au	6	0.8%	2	2.1%	<0.1%
Health Care Insurance	0	0.0%	0	0.0%	0.1%
HIF (Health Insurance Fund of Aus.)	8	1.1%	1	1.0%	0.6%
Healthguard (GMF/Central West)	1	0.1%	0	0.0%	0.5%
Health-Partners	1	0.1%	0	0.0%	0.6%
Latrobe Health	3	0.4%	2	2.1%	0.7%
Medibank Private	157	22.1%	25	25.8%	27.1%
Mildura District Hospital Fund	0	0.0%	0	0.0%	0.2%
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
NIB Health	74	10.4%	8	8.2%	7.6%
Navy Health	2	0.3%	0	0.0%	0.3%
Peoplecare	1	0.1%	0	0.0%	0.5%
Phoenix Health Fund	0	0.0%	0	0.0%	0.1%
Police Health	2	0.3%	0	0.0%	0.3%
QLD Country Health Fund	0	0.0%	0	0.0%	0.3%
Railway & Transport Health	2	0.3%	0	0.0%	0.4%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Lukes Health	0	0.0%	0	0.0%	0.4%
Teachers Federation Health	9	1.3%	0	0.0%	1.8%
Teachers Union Health	3	0.4%	1	1.0%	0.4%
Transport Health	0	0.0%	0	0.0%	0.1%
Westfund	6	0.8%	3	3.1%	0.8%
Total for Health Insurers	711	100%	97	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 2012