Australian Government
Private Health Insurance Ombudsman

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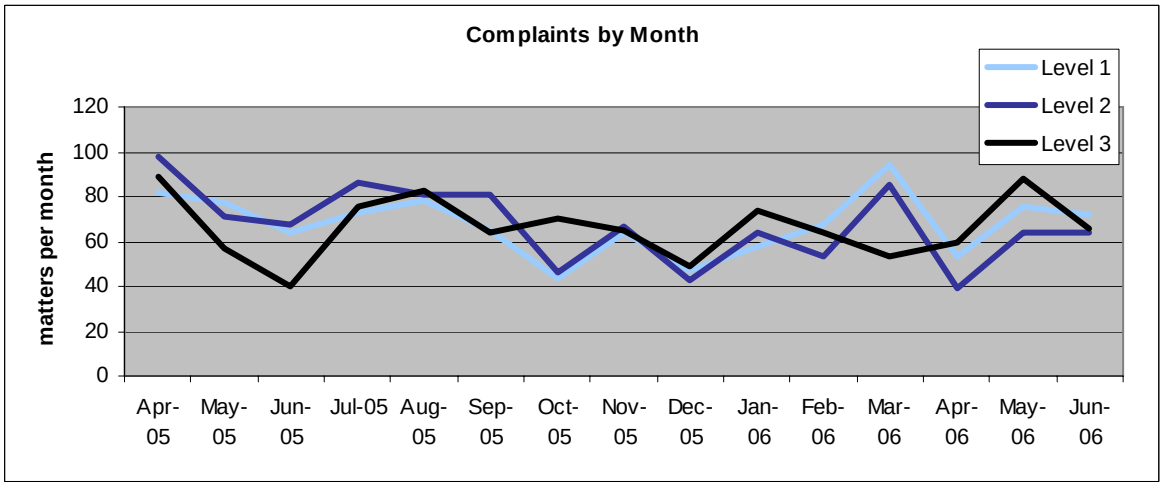
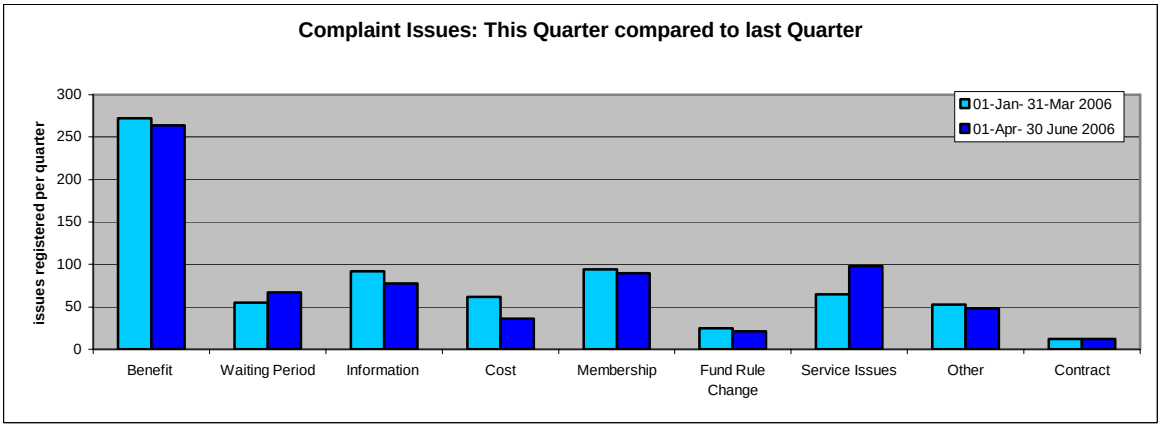
Quarterly Bulletin 39
(1 April to 30 June 2006)

Complaint Statistics

In the second quarter of 2006 PHIO received 534 Complaints about health funds. This was a 7% reduction on the previous quarter. Despite the general decrease in complaints, the number of level-3 (investigated) health fund complaints registered during the quarter increased by 16% to 213.



There has been a general increase in the proportion of level-3 complaints over time. This quarter, almost 40% of all complaints were level-3 complaints (that required the intervention by the Ombudsman and the health fund).



Compared to the last quarter, PHIO received a lower number of complaints about health funds premiums and membership related problems but a higher number of complaints were received about waiting periods and service issues.

Pre- existing Ailment Waiting Period
Complaints about the pre-existing ailment waiting period have continued to increase this quarter. I commented in Quarterly Bulletin 36 on the need for health funds and hospitals to familiarise themselves with the "Pre-existing Ailments - Best Practice Guidelines". The Guidelines were released as HBF Circular 736 by the Department of Health & Ageing in September 2001 and can be accessed via the departmental website at www.health.gov.au.

My office continues to receive complaints from people who have been admitted to hospital and incurred large out-of-pocket expenses because their claim has later been denied by their fund on PEA grounds. The majority of these cases could be prevented if funds and hospitals followed the Best Practice Guidelines.

Page twelve of the Guidelines for Health Funds lists the information that should be sent to members who contact their fund to inquire about an upcoming hospital admission. In particular, the Guidelines require the fund to send the member a formal letter explaining the requirements of the PEA rule. The letter should also advise that the fund medical adviser (and not the member's doctor) makes the decision about whether the PEA rule should apply. Most importantly, the letter should advise that if the member proceeds with their hospitalisation before their PEA assessment is finalised, benefits will not be payable if the fund medical adviser subsequently determines their condition is a PEA.

Two PEA medical certificates should be included with the letter, as well as a copy of the PEA Consumer brochure. As indicated in my last Quarterly Bulletin, this brochure has recently been updated. The new brochure provides information on all health fund waiting periods, including pre-existing ailments. Bulk stocks of the waiting period brochure can be ordered online at www.phio.org.au.

The Guidelines also require funds to take a number of steps when a hospital contacts them for an eligibility check for a member who is within the PEA waiting period. These include a requirement for the fund to advise the hospital that a PEA assessment will be required; that the fund will send the necessary forms to the member for completion by their treating doctors and that the fund will need up to five working days to complete the assessment.

The fund should also advise the hospital that if the member proceeds with treatment prior to the assessment being finalised, benefits will not be payable if it is subsequently determined to be for a pre-existing aliment.

It is not enough for the fund to advise the hospital that the member is within the waiting period and leave it to the hospital alone to organise the PEA assessment and ensure the member is aware of the possible financial consequences of proceeding with the admission before the medical assessment is completed.

Complaints about Withdrawal of Ex-gratia Benefits
Several complaints received this quarter have concerned the issue of funds withdrawing ex-gratia benefits for treatment. In these cases, the fund has authorised on-going ex-gratia payments for items of equipment or drugs. Usually, a doctor or supplier has requested the funding through the fund's formal process and the request has been granted.

In such cases, the doctor, hospital and fund are often aware of the ex-gratia payment, but the member is not. Problems arise when the funding is withdrawn at

a later date and the member then discovers the treatment was only covered on an ex-gratia basis and was not an entitlement under their cover.

In one case, a member had been receiving intra-venous medication on an ex-gratia basis for some five years. The member was unaware that her treatment was not an entitlement under her level of cover. Her doctor recently submitted a request for the next round of treatment and was advised that the fund would no longer be paying for it. It was only at this point that the member became aware of the situation. When she complained to the fund, they agreed to pay the previous account and one more. This did not give the member time to explore other treatment options.

My view is that in these cases, funds should ensure their members are made aware when treatment is being provided on an ex-gratia basis. They should also be advised of the basis for the funding, the duration of the funding, the nature of any review process and that funding may be withdrawn in future. Most importantly, where a fund decides to withdraw funding, there needs to be a reasonable transition period to enable the member to explore other treatment options. The length of the transition period will depend on the circumstances, but in the case outlined above, I do not consider two months' additional funding to be adequate notice after five years of paying for the treatment without question.

Complaints About Hospital Agreements

Most health funds require a patient to attend an "agreement" or "preferred" hospital in order to be fully covered (less any excess/restriction a member agrees to). PHIO has recently received a few complaints where patients have been charged up-front at the time of admission, because (as hospitals have explained) the health fund no longer has an agreement with the hospital. Although the number of complaints about this issue is not large, the impact on individuals is considerable.

A few patients have paid for their hospital admission (on the understanding that most of the money can be claimed on their health fund) only to find that a large amount of their bill is not claimable because the fund only pays a default benefit for attending a non-agreement hospital. In cases like these, there is a responsibility on both the health fund and hospital to ensure that these problems don't occur.

Health funds should advise, wherever possible, that they are no longer covering a local hospital. Also, in instances where a health fund is selling policies in areas where they don't cover all local hospitals; they should make an extra effort to ensure members understand their choices of hospitals in the local area in which they live (and where their doctors are most likely to refer them to). This is particularly the case where a health fund does not have agreements with the largest hospitals in each state they operate branches.

Hospitals should accurately seek a patient's informed financial consent; whether or not they have asked for an upfront payment. Advising a patient that he or she can claim an unspecified portion of their hospital bill; when the hospital has the ability to advise the exact cost; is not sufficient.

Updated PHIO Website

In June, PHIO re-launched its website with a clearer format.

PHIO's website address: **www.phio.org.au**

Complaints by Health Fund Market Share

01 April - 30 June 2006

Name of Fund	Complaints[1]	Percentage of Complaints	Level-3 Complaints[2]	Percentage of Level-3 Complaints	Market Share[3]
ACA Health Benefits	1	0.2	0	0	0.1
AHM	21	3.9	7	3.3	2.4
Australian Unity	37	6.9	17	8.0	3.6
BUPA (HBA)	48	9.0	26	12.2	9.9
CBHS	5	0.9	2	0.9	1.1
CDH (Cessnock District Health)	0	0	0	0	<0.1
Credicare	2	0.4	0	0	0.4
Defence Health	11	2.1	4	1.9	1.4
Doctors' Health Fund	0	0	0	0	0.1
Druids Victoria	1	0.2	1	0.5	0.1
GMHBA	4	0.7	0	0	1.5
Grand United Corporate Health	5	0.9	1	0.5	0.3
HBF Health	19	3.6	7	3.3	7.9
HCF (Hospitals Cont. Fund)	29	5.4	11	5.2	8.8
Health Care Insurance	0	0	0	0	0.1
Health Insurance Fund of W.A.	4	0.7	3	1.4	0.4
Healthguard	3	0.6	1	0.5	0.6
Health-Partners	3	0.6	1	0.5	0.7
Latrobe Health	2	0.4	1	0.5	0.6
Lysaght Peoplecare	0	0	0	0	0.3
Manchester Unity	14	2.6	3	1.4	1.4
MBF Australia Limited	96	18.0	34	16.0	16.7
MBF Alliances	25	4.7	7	3.3	2.2
Medibank Private	144	27.0	59	27.7	28.7
Mildura District Hospital Fund	0	0	0	0	0.3
N.I.B. Health	46	8.6	21	9.9	6.2
Navy Health	1	0.2	0	0	0.3
Phoenix Health Fund	0	0	0	0	0.1
Police Health	0	0	0	0	0.2
Queensland Country Health	1	0.2	1	0.5	0.2
Railway & Transport Health	2	0.4	1	0.5	0.3
Reserve Bank Health	0	0.0	0	0	<0.1
St Lukes Health	1	0.2	0	0	0.4
Teacher Federation Health	2	0.4	0	0	1.6
Teachers Union Health	0	0	0	0	0.4
Transport Health	0	0	0	0	0.1
Westfund	7	1.3	5	2.3	0.7
Total for Registered Funds	534	100	213	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.