Australian Government
Private Health Insurance Ombudsman

Issues in this bulletin

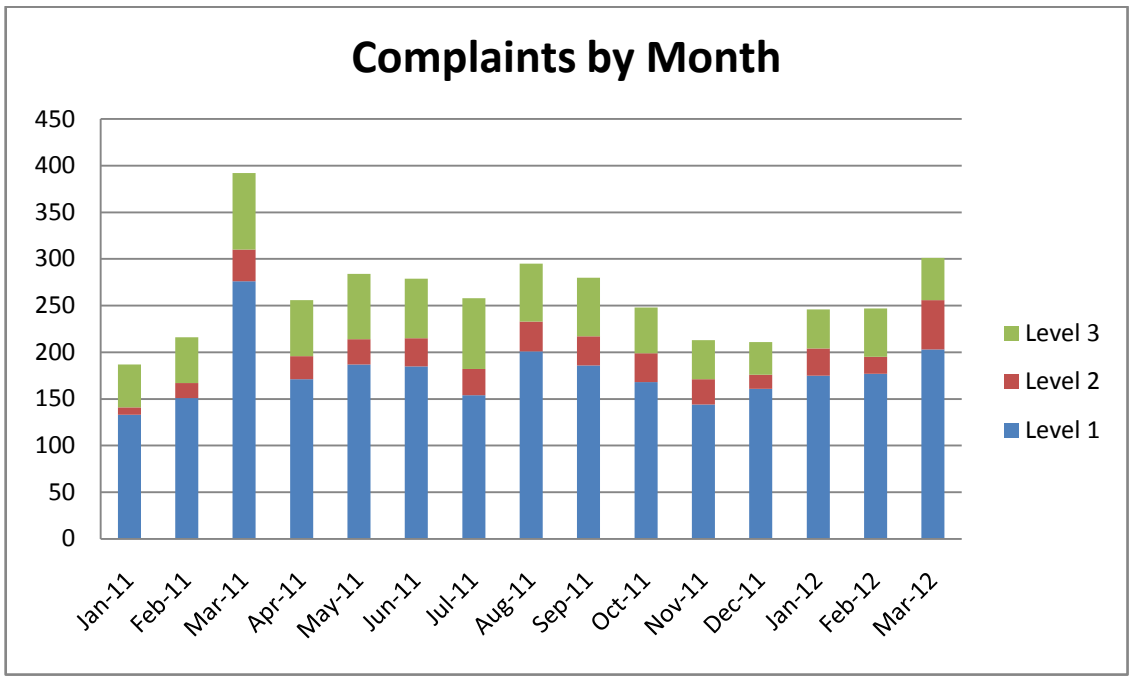
-Complaint statistics
-April premium increases
-Information gathering
-Freedom of Information
-Direct debit mistakes

Quarterly Bulletin 62

(01 January to 31 March 2012)

Complaint Statistics & Workload

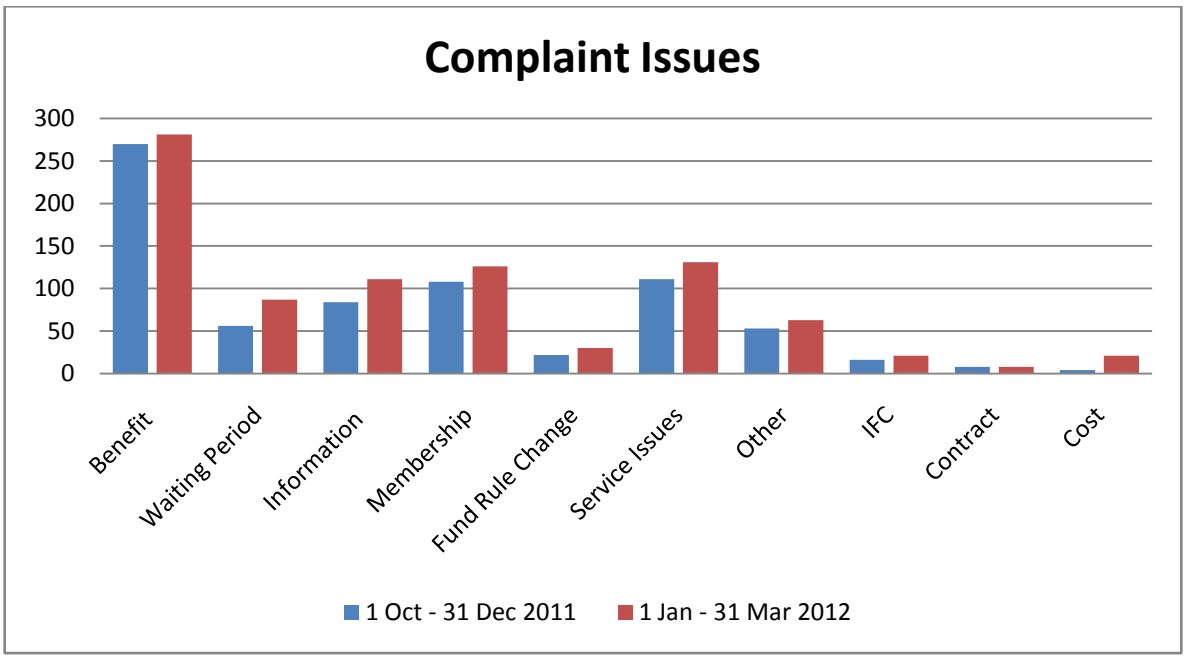
The office received 794 complaints during the March 2012 quarter, a similar figure to the 795 complaints received in the same quarter the previous year. As expected, this is an increase on the 672 complaints received in the December quarter, because there are typically less complaints in the lead up to the holiday season during the December quarter, and more in the March quarter as consumer awareness of private health insurance issues rises with the annual premium round.



2012 Premium Increases

The office received 18 complaints about premium increases during the March quarter. This was 12 less than the same period last year and significantly less than complaints about most other issues during the quarter.

For the 2012 premium round, the industry weighted average premium increase was 5.06%. This was lower than in recent years, which assisted in further reducing complaints about this issue. In addition, insurers have improved their explanations to members about why increases are necessary, which has also assisted in reducing complaints about this issue in recent years.



PHIO Information Gathering and Disclosure

The office receives questions from time to time about whether insurers and providers are required to provide information to PHIO and whether information provided to PHIO can be released to a third party.

If the office receives a complaint, it is able to obtain information, including records, from an insurer or other body under section 250 of the *Private Health Insurance Act 2007* (the Act). PHIO is able to determine what is considered relevant to a complaint and to specify which records should be provided. The office usually requests this information informally from the insurer and also requests that where possible, the information is provided within 14 days.

Information provided to the office for the purposes of investigating a complaint is considered *protected information,* as it is obtained by the office in the course of performing a function under the Act. Section 323-1 of the Act strictly prohibits a person from disclosing protected information unless it is authorised under the Act.

PHIO will therefore seek authorisation from any third party who has provided information to the office before releasing it to another party. The information will not be released unless such authorisation is provided. Of course, in many cases, an insurer or provider will authorise the release of information to a complainant, to assist the complainant to better understand the issues relating to their complaint. In addition, complainants can also seek access to information that relates to them from their insurer under the *Privacy Act 1988*.

Freedom of Information

As a Commonwealth Government statutory agency, PHIO is subject to the provisions of the *Freedom of Information Act 1977*. PHIO has always had a policy of openness, where appropriate, with the information it holds and complainants can have access to material held on the complaints register that relates to them.

We also recognise, however, our obligation to treat information and documents supplied under the *Private Health Insurance Act* as confidential, unless their release has been authorised. This means that we will consult with any third party before releasing information or documents they have provided to the office to any other party and these documents will only be released if authorisation is given. This is an important protection to ensure that any third party (complainant, insurer or provider) can provide information to the office without being concerned that it might be released to another party without their consent.

Information about PHIO's Freedom Information Policy is on our website at http://www.phio.org.au/about-phio/freedom-of-information.aspx

Clear Policies for Dealing with Direct Debit Problems

PHIO received 25 complaints about direct debit arrangements and 23 complaints about membership arrears during the quarter.

Most complaints about problems with direct debit arrangements result from a misunderstanding about how direct debit payments work and what process an insurer follows if payments are not deducted when they fall due.

Complaints to the office show that failure of direct debit deductions can result from a number of causes, including problems with the insurer's computer system, problems with the bank's computer system and problems which result from the member providing an incorrect account number or having insufficient funds in their account.

Some members believe that if they sign up for a direct debit to pay their health insurance and there is a problem with payments being deducted, they should not be asked to back pay premiums. PHIO doesn't support this view and believes that if a mistake has occurred, then the reasonable approach in most cases is to put the complainant back into the same position they would have been in had the mistake not occurred. This means the complainant is required to pay a portion or all of the outstanding arrears, but is given sufficient time to do so.

As this is a common complaint to PHIO, we have reviewed the information that is provided to consumers at the time they set up a direct debit arrangement. In the cases we have looked at, there is a clear warning that the consumer is responsible for ensuring deductions are occurring; however, there seems to be no specific warning of the insurer's process should the deduction fail to occur. PHIO would like to suggest to insurers that receive complaints about this issue that they review the information that is provided when a direct debit arrangement is set up and include a clear statement that advises the member that they will be responsible for paying any arrears that arise on the membership due to a direct debit payment not being deducted.

This would assist members to better understand their responsibility to ensure their direct debits are occurring and to back pay any arrears that may arise if there is a problem with the direct debit.

Complaints by Health Insurer Market Share

1 January - 31 March 2012

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	25	3.6%	4	3.5%	2.9%
Australian Unity	40	5.8%	4	3.5%	3.1%
BUPA (includes MBF)	156	22.4%	24	20.9%	26.9%
CBHS	7	1.0%	1	0.9%	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	6	0.9%	1	0.9%	1.6%
Doctors' Health Fund	1	0.1%	1	0.9%	0.1%
GMHBA	12	1.7%	2	1.7%	1.7%
Grand United Corporate Health	7	1.0%	1	0.9%	0.4%
HBF Health	23	3.3%	3	2.6%	7.7%
HCF (Hospitals Cont. Fund)	81	11.7%	8	7.0%	10.5%
Health Care Insurance	0	0.0%	0	0.0%	0.1%
HIF (Health Insurance Fund of Aus.)	2	0.3%	0	0.0%	0.6%
Healthguard	3	0.4%	0	0.0%	0.5%
Health-Partners	3	0.4%	1	0.9%	0.7%
Latrobe Health	8	1.2%	2	1.7%	0.7%
Medibank Private	223	32.1%	50	43.5%	27.7%
Mildura District Hospital Fund	1	0.1%	0	0.0%	0.3%
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
N.I.B. Health	53	7.6%	6	5.2%	7.5%
Navy Health	0	0.0%	0	0.0%	0.2%
Peoplecare	3	0.4%	1	0.9%	0.4%
Phoenix Health Fund	0	0.0%	0	0.0%	0.1%
Police Health	1	0.1%	0	0.0%	0.3%
QLD Country Health Fund	2	0.3%	0	0.0%	0.3%
Railway & Transport Health	4	0.6%	2	1.7%	0.4%
Reserve Bank Health	1	0.1%	0	0.0%	<0.1%
St Lukes Health	1	0.1%	0	0.0%	0.4%
Teacher Federation Health	21	3.0%	3	2.6%	1.8%
Teachers Union Health	4	0.6%	0	0.0%	0.4%
Transport Health	0	0.0%	0	0.0%	0.1%
Westfund	5	0.7%	1	0.9%	0.8%
Total for Health Insurers	**695**	**100%**	**115**	**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 2011