Australian Government

Private Health Insurance Ombudsman

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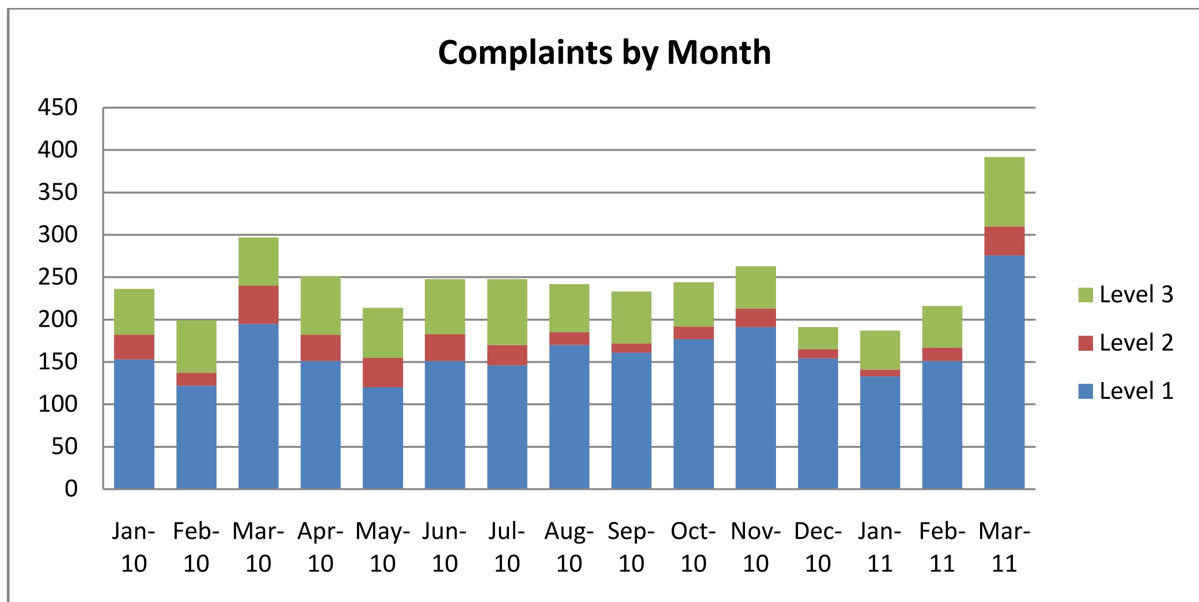
Quarterly Bulletin 58

(01 January – 31 March 2011)

Complaint Statistics & Workload

The office received 736 complaints about registered health insurers during the March 2011 quarter, which was 13% more than the previous quarter and 10% more than the same period last year. The office received a relatively low number of complaints in January, but a significantly higher number of complaints in March.



Of the 736 complaints received, 157 were Level-3 complaints. This was similar to the number received in the same period last year, and an increase of 39% on the relatively quiet December 2010 quarter.

Similar to the previous quarter, the most significant area of complaint to PHIO related to benefits. 128 complaints related to insufficient levels of cover, 33 complaints were about detrimental rule changes to policies, 10 concerned benefit amounts and 52 were about delays in payments. The office received 14 complaints about hospital gaps and 15 complaints about medical gaps.

Service issue complaints have increased over the last two quarters. During the quarter, the office received 70 general service issue complaints and 48 complaints about premium payment problems. Complaints about information issues have decreased, with 57 complaints about oral and written information from health insurers. The office received 24 complaints about clearance certificates, 30 about membership cancellation, and 23 about continuity.

Premium Increases 2011

During the quarter, health insurers announced their premium increases for the year and individual letters were sent to affected policy holders advising of new premium rates. The average increase across the industry was 5.56%. The Department of Health and Ageing provided detailed information on its website about the premium increase approval process, including the scrutiny of health insurers' applications for premium increases by the Minister, Department of Health and Ageing and the Private Health Insurance Administration Council.

PHIO received only 30 complaints about premium increases during the quarter, which is similar to the previous year, where 32 complaints were recorded. Complaints about premium increases have continued to decline over a number of years. PHIO analysis of complaints data suggests that there has been a sustained improvement in two key areas that has assisted in reducing complaints about this issue. Firstly, the incidence of exceptional premium increases above the industry average has decreased. People are more likely to complain if their increase is more than a few points above the industry average, so this has helped to reduce complaints. Secondly, insurers have been providing better explanations to members about the reasons for their premium increases, which has also assisted in reducing complaints.

Consumers' Understanding of Exclusions & Restrictions

PHIO regularly investigates cases where policy holders have incurred out-of-pocket expenses for treatment in a private hospital that is not payable by their insurer due to a restriction or exclusion on their policy. Investigation of these complaints reveals that consumers are increasingly reporting that they knew they had a restriction or exclusion on their policy, but believed that this would apply only to the surgeon's charges and not to the hospital charges.

Most consumers are unaware of how much an admission to a private hospital could cost them if they are not fully covered for the procedure. In addition, many consumers, particularly those who have not been to hospital recently, do not appear to understand that doctors and hospitals raise separate charges.

In a recent case that was investigated by PHIO, a member was admitted to a private hospital for a gastric banding procedure. She had discussed the financial details with her surgeon and borrowed money to pay her out-of-pocket medical costs.

When she contacted her health fund to check her hospital cover, she was told that she had no cover for gastric banding procedures. She understood this to mean that she wasn't covered for the amount she had paid the surgeon, which is what she had already been advised. It is unclear from the records that she was told that she would not be covered for the procedure and the hospitalisation.

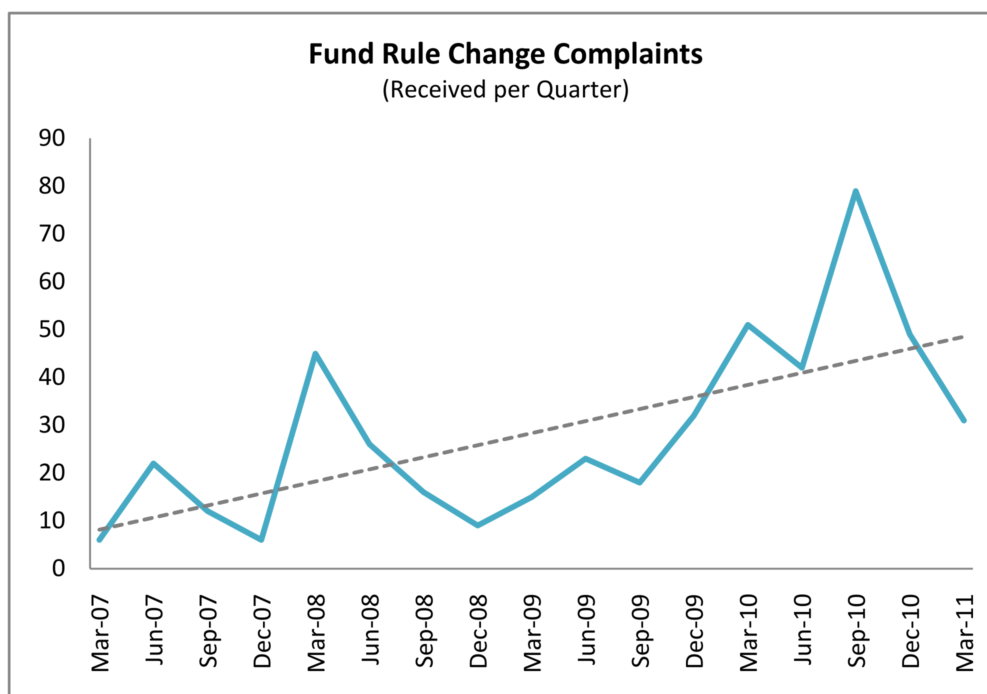
At the conclusion of the call, the complainant was left with the impression that she would not have to pay anything towards the hospital charges except for her excess. On admission to the hospital, the hospital staff member received membership eligibility information from the fund indicating she was not entitled to benefits for her hospitalisation, but this information was not provided to the complainant. Since informed financial consent was not sought from the complainant, and due to some other aspects of this case, the hospital offered to write off the entire account.

This case illustrates the need for fund and hospital staff to ensure that members understand what benefits they will receive for an admission, as well as the services they will not be covered for. It is particularly important to remember that consumers may not be aware of information that fund and hospital staff may assume they understand, such as the fact that doctors and hospitals will raise separate charges for an admission and that if a service is excluded, there will be no benefits payable for medical or hospital charges.

Fund Rule Changes

There has been a small but increasing number of complaints received by PHIO about fund rule changes. These complaints occur when a health insurer reduces benefits or enacts a detrimental rule change, or when the member has a claim rejected and questions whether they were properly notified of the change.

Notifying policy holders of a rule change in a timely manner is an important obligation for insurers because members are entitled to maintain coverage for a benefit that is being removed or reduced by their insurer if they transfer to a new policy, either with the same insurer or a new one, before the change comes into effect. Consumers, not surprisingly, feel more aggrieved if they have missed an opportunity to maintain cover for a benefit because they have missed this deadline.



PHIO regularly reviews how insurers notify members about fund rule changes and in general, letters advising of such changes are acceptable. Where this is not the case, PHIO will take the matter up with the individual insurer and request that additional information be sent to affected members. It seems the problem for some consumers is that they don't fully read the information sent by their insurer. One reason for this is that consumers receive large amounts of promotional and other material through the post and important information can on occasion be missed.

For major detrimental changes, such as removing obstetric benefits from a hospital policy, PHIO recommends that additional measures be taken to ensure the message gets through. Some insurers run a phone campaign to follow up with policy holders to ensure they received their letter and have given consideration to upgrading their policy to maintain benefits. Other insurers will send a follow-up letter to affected policy holders without any additional information in the envelope, which reduces the chances of the message being overlooked.

Incidental Fees at Private Hospitals

PHIO has received a number of complaints about patients being charged for incidental services such as Foxtel Television and Wireless Internet access while staying at hospitals run by a large hospital provider. In particular, complaints have been raised by patients who were charged for services they did not wish to or could not use, but were required to pay for regardless. PHIO is currently in discussion with the hospital provider and other stakeholders concerning this issue and will report the outcome in due course.

Complaints by Health Insurer Market Share

01 January - 31 March 2011

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	22	3.0%	4	2.5%	3.0%
Australian Unity	28	3.8%	11	7.0%	3.2%
BUPA (HBA/Mutual Community)	72	9.8%	11	7.0%	9.8%
CBHS	6	0.8%	2	1.3%	1.2%
CDH (Cessnock District Health)	0	0.0%	0	0.0%	<0.1%
CUA Health	1	0.1%	0	0.0%	0.4%
Defence Health	4	0.5%	1	0.6%	1.4%
Doctors' Health Fund	0	0.0%	0	0.0%	0.1%
GMHBA	13	1.8%	0	0.0%	1.5%
Grand United Corporate Health	5	0.7%	1	0.6%	0.3%
HBF Health	20	2.7%	5	3.2%	7.6%
HCF (Hospitals Cont. Fund)	42	5.7%	3	1.9%	8.9%
Health Care Insurance	0	0.0%	0	0.0%	0.1%
HIF (Health Insurance Fund of Aus.)	1	0.1%	0	0.0%	0.4%
Healthguard	4	0.5%	0	0.0%	0.5%
Health-Partners	2	0.3%	2	1.3%	0.6%
Latrobe Health	5	0.7%	1	0.6%	0.6%
Manchester Unity	14	1.9%	3	1.9%	1.5%
MBF Alliances	13	1.8%	0	0.0%	1.9%
MBF Australia Limited	145	19.7%	39	24.8%	15.7%
Medibank Private	247	33.6%	56	35.7%	28.6%
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	57	7.7%	9	5.7%	7.1%
Navy Health	0	0.0%	0	0.0%	0.2%
Peoplecare	1	0.1%	0	0.0%	0.3%
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	1	0.1%	0	0.0%	0.2%
Railway & Transport Health	8	1.1%	1	0.6%	0.3%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Lukes Health	1	0.1%	0	0.0%	0.4%
Teacher Federation Health	14	1.9%	4	2.5%	1.7%
Teachers Union Health	1	0.1%	0	0.0%	0.4%
Transport Health	1	0.1%	0	0.0%	0.1%
Westfund	5	0.7%	4	2.5%	0.8%
Total for Health Insurers	**736**	**100%**	**157**	**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 2010