Australian Government
Private Health Insurance Ombudsman

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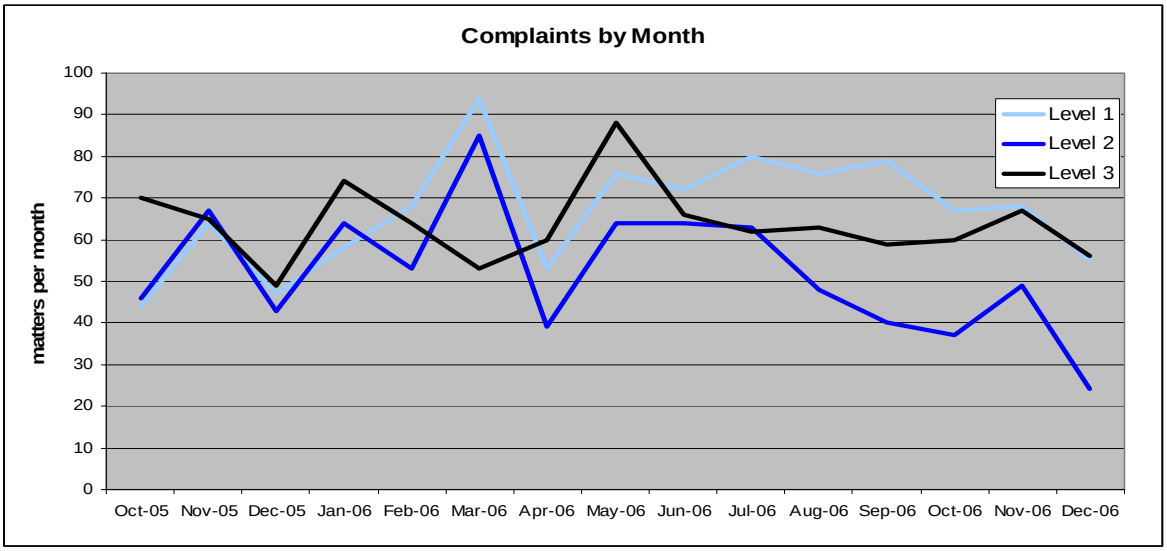
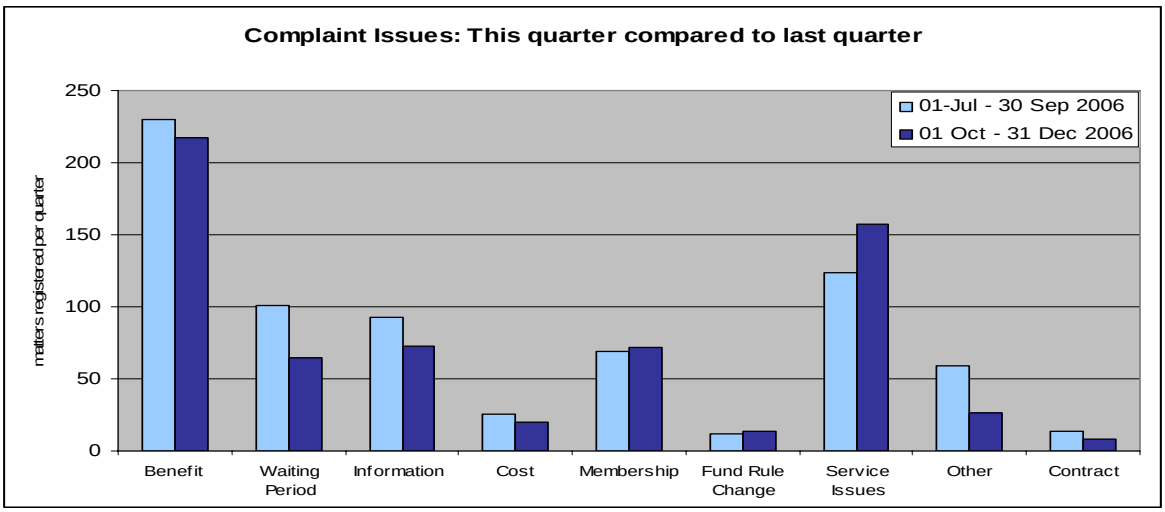
Quarterly Bulletin 41
(1 October to 31 December 2006)

Complaint Statistics

In the last quarter of 2006, PHIO received 458 complaints about health funds. This was a 13% decrease on the previous quarter, which is consistent with normal seasonal trends. PHIO received approximately the same level of complaints in the same period last year. The number of level-3 complaints increased from 161 to 175 (8.5%) compared with last quarter.



Although PHIO received fewer complaints about most issues, complaints about service issues, particularly those related to premium payment problems, increased during the quarter. These were mostly related to a computer system problem with one particular fund.



Direct Debits of Membership Payments

In most cases, direct debit arrangements for premium payments work without any problems. PHIO regularly receives a small number of complaints about direct debit problems, which usually concern only one or two premium payments. Most of these complaints relate to incorrect bank account numbers, lack of sufficient funds and other administrative matters. Recently, however, we have received a number of complaints from one health fund's members about instances where computer system errors have resulted in very large amounts of money being deducted from member's bank accounts.

PHIO expects that when an obvious error has resulted in mistaken direct debits being taken from a person's bank account, a health fund will fix the problem immediately and ensure a refund is given to the member as soon as possible. With electronic banking, it should be possible to refund money into someone's account within 24 hours.

It was pleasing to see that this health fund took immediate steps to correct these problems and arranged, on a case-by-case basis, to refund affected members immediately. In one instance, the health fund even took the step of directly handing one refund to a member at the airport before he left for an overseas trip.

Given that these mistakes occur very rarely, but can have a significant negative impact on the individuals concerned, it is hoped that other health funds will take a similar approach in providing refunds for mistaken direct debits *as soon as possible* and not under the same timeframes for a normal membership refund payment.

Verification of Ancillary Claims

Most health funds regularly monitor ancillary claims to ensure that payment of inappropriate claims is kept to a minimum. PHIO believes that such monitoring is necessary and in the interests of members, as benefits are paid directly from members' contributions. Without such controls in place, there is a risk of escalation in the costs of claims, which could have a significant impact on members' premiums.

When PHIO receives complaints from providers and members about health funds' monitoring of claims, we generally seek to ensure that a proper process is followed and that delays in paying valid claims are kept to a minimum. Sometimes, a complaint is settled simply by ensuring that everyone is aware of why claims are being audited and that once the process is completed they will be paid. In other instances, cases can be more complex because there is disagreement about the details of individual billing and other practices.

PHIO believes that health funds should ensure that members are kept informed of issues that affect their future claims. This is especially important when a health fund decides, for whatever reason, to no longer recognise a provider for benefits. In such a case, PHIO is unable to insist (on behalf of the provider or a member) that a provider be registered by a health fund. However, PHIO can investigate the process that was followed to ensure it was reasonable and in line with the fund's policy on provider registration.

PHIO also believes that when health funds take the rare step of no longer recognising a provider, they should inform any members who have made a claim for treatment by that provider in the last 12-months of that change.

Privatehealth.gov.au Website

The website project is progressing on schedule and we are confident that the website will be operational on 1 April as planned.

The technical "backend" design of the website has been completed and the format of the *standard information statements* have been finalised. The project team is busy building and testing the system that will run the website and writing (in conjunction with the assistance of industry experts) the comprehensive guide to health insurance that will be included on the site.

The project now requires considerable input from health funds to enter all of the information into the system. PHIO conducted workshops on 15th and 16th of February to acquaint health fund staff with the spreadsheet for uploading their health fund's policies into the system. The aim of these workshops was to ensure that the wide variety of policy features will be able to be displayed on the system and that any problems can be addressed well ahead of the 1 April deadline for the site to go live.

PHIO requests that health funds ensure that the staff responsible for entering their health fund's information receive all possible assistance, as we appreciate the timeframes for inputting and checking all of the policy information for each health fund's range of products are short.

Mr John Powlay

It is with regret that we advise that Mr John Powlay, the Private Health Insurance Ombudsman, passed away on 16th January 2007. Mr Powlay had held the position of Private Health Insurance Ombudsman since November 2002. Mr Powlay will be sadly missed by the staff of the Ombudsman's office and by his colleagues in government and the private health insurance industry.

Mr Powlay was a passionate consumer advocate for people with private health insurance and a great believer in the importance of accessible and impartial information to help consumers understand the complexities surrounding private health insurance, as well as their own health insurance product and how it compares with others available in the marketplace.

The staff of the PHIO would like to thank all the people in health funds, government and the industry for their kind wishes and assistance during what has been a difficult time.

Complaints by Health Fund Market Share

01 October - 31 December 2006

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	0.1
AHM	13	2.8	2	1.1	2.4
Australian Unity	25	5.5	9	5.1	3.6
BUPA (HBA)	34	7.4	14	8.0	9.9
CBHS	4	0.9	2	1.1	1.1
CDH (Cessnock District Health)	0	0	0	0	<0.1
Credicare	2	0.4	1	0.6	0.4
Defence Health	3	0.7	3	1.7	1.4
Doctors' Health Fund	0	0	0	0	0.1
Druids Victoria	1	0.2	0	0	0.1
GMHBA	5	1.1	1	0.6	1.5
Grand United Corporate Health	4	0.9	2	1.1	0.3
HBF Health	9	2.0	3	1.7	7.9
HCF (Hospitals Cont. Fund)	30	6.6	10	5.7	8.8
Health Care Insurance	0	0	0	0	0.1
Health Insurance Fund of W.A.	2	0.4	1	0.6	0.4
Healthguard	1	0.2	0	0	0.6
Health-Partners	3	0.7	1	0.6	0.7
Latrobe Health	2	0.4	0	0	0.6
Manchester Unity	12	2.6	2	1.1	1.4
MBF Alliances	13	2.8	3	1.7	2.2
MBF Australia Limited	139	30.3	61	34.9	16.7
Medibank Private	124	27.1	46	26.3	28.7
Mildura District Hospital Fund	0	0	0	0	0.3
N.I.B. Health	19	4.1	8	4.6	6.2
Navy Health	0	0	0	0	0.3
Peoplecare	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	2	0.4	1	0.6	0.2
Railway & Transport Health	1	0.2	0	0	0.3
Reserve Bank Health	1	0.2	1	0.6	<0.1
St Lukes Health	1	0.2	1	0.6	0.4
Teacher Federation Health	2	0.4	0	0	1.6
Teachers Union Health	1	0.2	1	0.6	0.4
Transport Health	1	0.2	1	0.6	0.1
Westfund	3	0.7	1	0.6	0.7
Total for Registered Funds	458	100	175	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 2006.