Australian Government
Private Health Insurance Ombudsman

Quarterly Bulletin 49

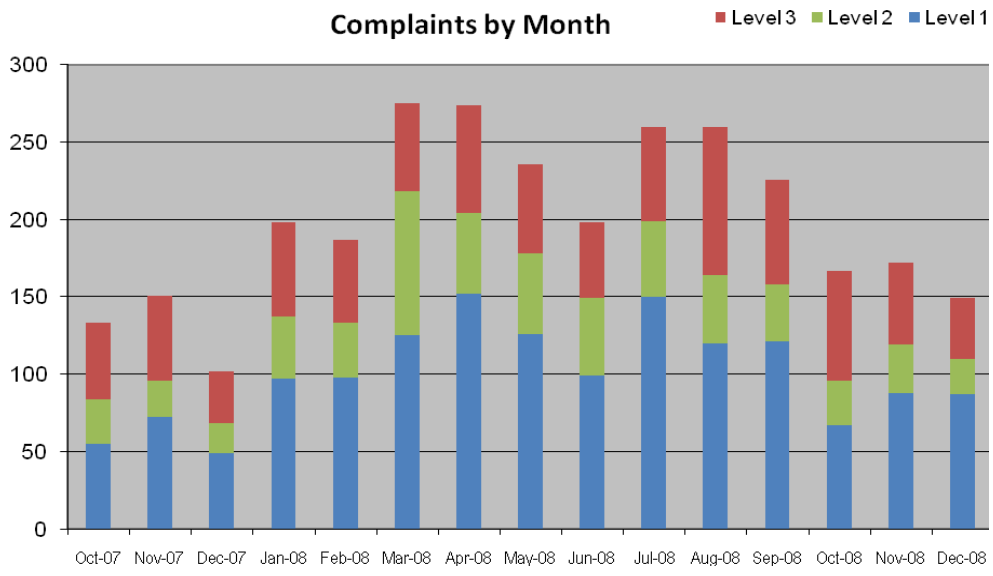
(1 October to 31 December 2008)

Issues in this bulletin

Complaint Statistics

The PHIO usually receives a lower number of complaints in the lead up to Christmas. During this quarter the PHIO received 453 complaints about health insurers, which was a reduction of 222 (33%) from the previous quarter. The office received 28 (7%) more complaints compared with the same period last year.

Of the 453 complaints received, 147 were level-3 complaints. This was 24 (14%) fewer than the previous quarter and only 3 more than the same period last year.



Giving SIS Information to Consumers: Timing and Method

The PHIO would like to clarify when insurers are required to send out new Standard Information Statements (SISs) as a result of premium or rule changes. Under Section 93-20 of the *Private Health Insurance Act 2007,* updated statements need to be sent to insured people if the change affects an item that appears on the SIS *and* if a change is made to the insurer's rules.

This means that SISs do not need to be sent at the same time as premiums are updated, as a premium change isn't considered a rule change. Section 93-20 only requires that the health insurer must give a standard information statement once every 12-months and the timing is not stated.

The PHIO would also like to clarify that under Section 93-20, it is not sufficient for health insurers to refer a consumer to view the statement on a website. The Act specifies that insurers must ensure the statement "is given" to the insured person and referring a person to look for the statement on a third party's website is not considered "giving" the statement to them. The Act specifies a penalty for an insurer that doesn't comply with this part of the Act.

The aim of giving the statement to the member each year is to encourage them to review the features of their health insurance policy, including any limitations such as an excess or restrictions and consider whether the policy is still suitable for their needs. The member is also able to use the statement to compare the features and the indicative monthly premium of their own policy with other policies available for purchase, so they can check their policy still provides the most appropriate cover and the best value for them.

Relationship Breakdown

From time to time, insurers and the PHIO receive complaints about membership issues arising out of relationship breakdown. Although the number of complaints about this issue is not large, the complaints that arise can be difficult for the fund to resolve in a way that is fair to all parties, and doesn't result in the fund being drawn into the dispute. The then-Ombudsman provided advice about this issue in Quarterly Bulletin 19 (April-June 2001), which is still a useful reference and is available from the PHIO website at www.phio.org.au.

The most common issues that arise following a relationship breakdown are: dependents wishing to remove themselves and/or their children from the membership; contributors wishing to remove dependents from the membership and dependents losing continuity of cover because they have been removed from the policy by the contributor. In particular, QB 19 made the following points:

- Adult dependents should be able to remove themselves from the membership even if not the contributor;
- An insurer should allow dependent children to be covered under both parents' (separate) memberships, if there are disputes over which parent has the children on the membership;
- Funds should have a set of administrative guidelines for dealing with relationship breakdowns to give guidance to staff on these issues.

The contributor has the right to remove dependents from the membership, but problems can arise if the dependent is not made aware that they are no longer covered. PHIO expects that insurers will attempt to advise the dependent of their removal, but understands that in many cases, the insurer will not have the dependent's current address. PHIO therefore recommends that insurers take a flexible approach to providing continuity to adult dependents who have been unknowingly removed from the membership by the contributor.

Joining over the internet

During the quarter, PHIO received several complaints from members who had joined over the internet, about the quality of the information they were given in relation to waiting periods and limitations on their policy. In PHIO's view, it should be relatively easy to give

members clear information about restrictions and waiting periods online. Information about the statutory waiting periods (i.e. 12 months for Pre- Existing Conditions and Maternity Services and 2 months for all other services) should be clearly provided in a box which the member can click early in the process to show they have read the information. The member should not have to read through a lengthy disclaimer or scroll down to see the relevant information. PHIO will be monitoring this issue, which is becoming more important as more people choose to take out or upgrade their policy via the internet.

Application of Excess to Prosthesis Benefits

PHIO has sought advice on the issue of whether an insurer can apply an excess to the prosthesis component of a hospital stay. This issue generally arises in relation to hospitalisation as a private patient in a public hospital. The Department of Health and Ageing has provided the following advice:

- *An insurer cannot apply an excess to prostheses benefits. Section 72-1, Item 4 specifies that the minimum benefit must be paid. Under the Private Health Insurance (Benefit Requirements) Rules 2008, Part 2, Rules 4 and 5, the insurer can apply the excess to hospital accommodation benefits.*

Clearance Certificates

A number of insurers have (again) raised concerns about the difficulties some members and insurers have in obtaining clearance certificates in a timely manner. The *Private Health Insurance Act 2007* Section 99-1 and *Private Health Insurance (Complying Product) Amendment Rules 2008 (No. 2) Rule 9*, specify that a health insurer must provide a clearance certificate to the new insurer within 14 days of request by the new insurer. The new insurer is also required to follow up with the old insurer if the transferring member doesn't give them a clearance certificate within 7 days of transfer. The legislation provides a penalty for an insurer that doesn't comply with this part of the Act. Problems tend to arise over concerns about exchanging information between insurers. Possible solutions could include:

- a standard clearance certificate request or authority form for insurers to use if they wish, or to speed up the process if a form has gone astray, which can be downloaded from the internet;
- a set of industry agreed protocols or guidelines for the provision of clearance certificates.

PHIO would appreciate any feedback on this issue and these suggestions, which can be e-mailed to Alison Leung at alison@phio.org.au.

2009 Rate and Benefit Changes

The PHIO would appreciate advance notice from insurers about any planned detrimental rule changes. Information about premium increases, particularly if they are higher than the average for a specific policy, would also be appreciated when available. This information assists PHIO staff in dealing with complaints about rate and benefit changes.

Complaints by Health Insurer Market Share

1 October - 31 December 2008

Name of Fund	Complaints1	Percentage of Complaints	Level-3 Complaints2	Percentage of Level-3 Complaints	Market Share3
ACA Health Benefits	0	0.0%	0	0.0%	0.1%
AHM	41	9.1%	15	10.2%	3.0%
Australian Unity	15	3.3%	5	3.4%	3.2%
BUPA (HBA)	32	7.1%	6	4.1%	9.8%
CBHS	5	1.1%	0	0.0%	1.2%
CDH (Cessnock District Health)	1	0.2%	0	0.0%	<0.1%
CUA Health	1	0.2%	0	0.0%	0.4%
Defence Health	2	0.4%	0	0.0%	1.4%
Doctors' Health Fund	0	0.0%	0	0.0%	0.1%
Druids Victoria	0	0.0%	0	0.0%	0.1%
GMHBA	9	2.0%	1	0.7%	1.5%
Grand United Corporate Health	3	0.7%	1	0.7%	0.3%
HBF Health	9	2.0%	4	2.7%	7.5%
HCF (Hospitals Cont. Fund)	30	6.6%	9	6.1%	8.9%
Health Care Insurance	0	0.0%	0	0.0%	0.1%
Health Insurance Fund of W.A.	0	0.0%	0	0.0%	0.4%
Healthguard	1	0.2%	0	0.0%	0.5%
Health-Partners	1	0.2%	0	0.0%	0.6%
Latrobe Health	3	0.7%	1	0.7%	0.6%
Manchester Unity	22	4.9%	11	7.5%	1.5%
MBF Alliances	19	4.2%	6	4.1%	2.0%
MBF Australia Limited	109	24.1%	30	20.4%	15.7%
Medibank Private	90	19.9%	32	21.8%	28.7%
Mildura District Hospital Fund	0	0.0%	0	0.0%	0.3%
National Health Benefits Aust.	0	0.0%	0	0.0%	<0.1%
N.I.B. Health	46	10.2%	22	15.0%	7.0%
Navy Health	1	0.2%	0	0.0%	0.2%
Peoplecare	1	0.2%	0	0.0%	0.3%
Phoenix Health Fund	0	0.0%	0	0.0%	0.1%
Police Health	0	0.0%	0	0.0%	0.3%
QLD Country Health Fund	1	0.2%	0	0.0%	0.2%
Railway & Transport Health	2	0.4%	1	0.7%	0.3%
Reserve Bank Health	1	0.2%	0	0.0%	<0.1%
St Lukes Health	0	0.0%	0	0.0%	0.4%
Teacher Federation Health	5	1.1%	3	2.0%	1.7%
Teachers Union Health	2	0.4%	0	0.0%	0.4%
Transport Health	0	0.0%	0	0.0%	0.1%
Westfund	1	0.2%	0	0.0%	0.7%
Total for Health Insurers	**453**	**100%**	**147**	**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 2008