Commonwealth OMBUDSMAN

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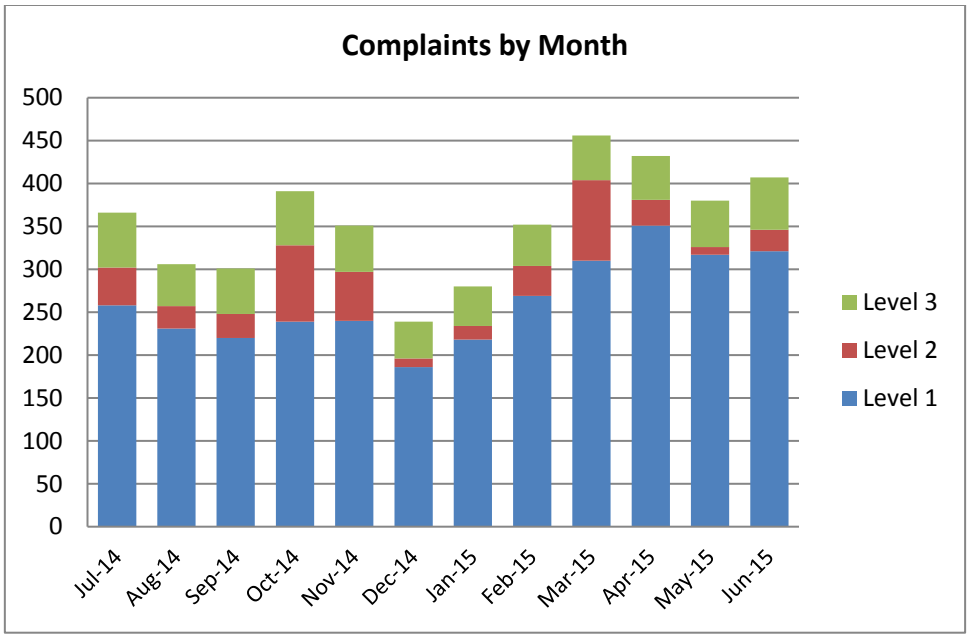
Private Health Insurance Ombudsman Quarterly Bulletin 75 (1 April – 30 June 2015)

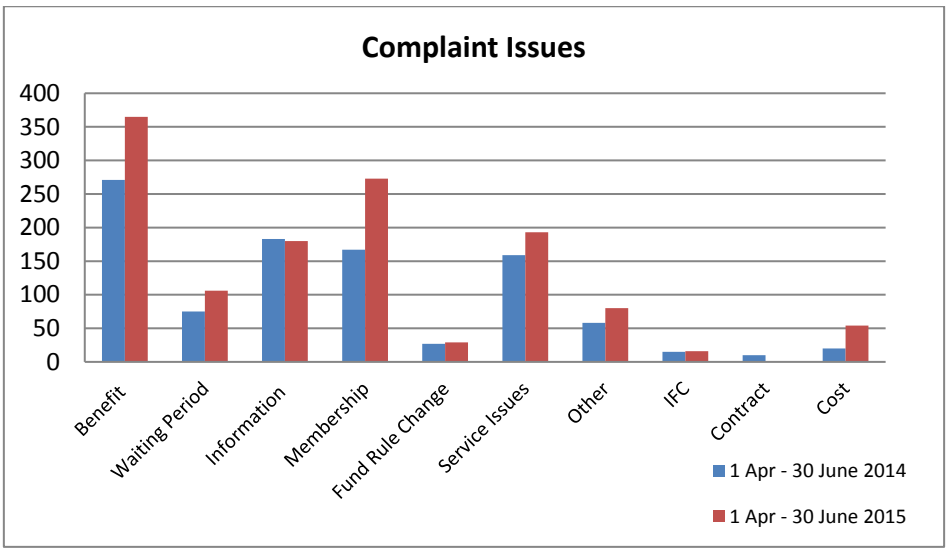
Complaint Statistics and Workload

The Private Health Insurance Ombudsman (PHIO) received 1219 complaints this quarter, which is the highest number of complaints received in a quarter since 2003. The number of complaints increased 12% compared to the previous quarter (1088 complaints) and increased 30% compared to the same period last year (933 complaints).

This is usually the busiest quarter in the private health insurance year as it coincides with health insurer premium increases and the end of the financial year deadlines for some consumers to join health insurance before paying a levy. However, this quarter's increase was related to other areas of concern for consumers as detailed in this bulletin.



The most significant complaint issues that contributed to the increase in complaints were benefits and membership issues. To a lesser extent waiting periods, service issues and cost also contributed to the higher number of complaints in the quarter.



Public Hospital Cover and Waiting Times

The PHIO received some complaints from consumers who have purchased public hospital cover with the misunderstanding that it will assist them in avoiding the public hospital waiting list.

Private health insurers need to be careful in describing the benefits of a public hospital-only cover and not give the impression that it provides any advantage over being a public patient, other than choice of your own physician in a public hospital.

Importantly, consumers should understand that accessing treatment in a public hospital is controlled by state or territory health arrangements, and these arrangements do not place privately admitted Australians ahead of other Australians on public hospital waiting lists. Area health services control the waiting lists based on a number of criteria, which do not include whether someone is privately insured.

In explaining the situation to consumers, this office advises that public hospital insurance policies cover a 'default benefit' for private treatment in a public hospital. However, the default benefit only represents a portion of the true cost of public hospital fees, with the remainder of the cost still being met by the public system. As such, both public and private patients at public hospitals are treated on a needs basis, rather on the basis of whether they have insurance.

Looking at some examples of how public hospital cover policies are described, it seems that private health insurers could improve their information to consumers about this type of cover. This office considers that the single most important message about these policies is that they do not help avoid a public hospital waiting list, and this is one of the main differences between these policies and more expensive ones that provide for treatment in a private hospital.

In sales calls or retail visits, our office's expectation is that private health insurers' staff should explain these policies accurately, describe how public hospital cover is different to private hospital cover, and keep a record of the advice.

This office has received a number of complaints where policy holders tell us they have been advised they can avoid the public hospital waiting list by purchasing public hospital cover and then complained that they have in fact been required to wait on the list. Sometimes this has occurred after the consumer has purchased the policy and served a 12-month waiting period for pre-existing conditions, and only then are advised that their policy doesn't avoid the public hospital waiting list.

They feel particularly aggrieved because they could have been waiting on the public hospital waiting list for those 12 months and instead are faced with at least another 12-month wait.

In such cases where the evidence shows the consumers were clearly misadvised, this office has arranged for the private health insurer to pay for private hospital treatment and to correct the advice provided.

Upgrading to Avoid Benefit Limitation Periods

A Benefit Limitation Period (BLP) occurs during and after a waiting period has been completed, during which the health fund pays only a restricted benefit sufficient to cover the default hospital benefit only, rather than a full benefit to cover a private hospital admission.

For example, Policy X might have a 24-month BLP on knee replacements. This means, combined with the standard 12-month waiting period on pre-existing conditions, a member would have to wait up to 24 months to be fully covered in a private hospital for a knee replacement.

While BLPs were more common in the early 2000s, they have recently begun to be re-introduced in new products offered by health funds today. As such it's timely to note that BLPs cannot be applied to upgrading or transferring members. In other words, health fund members transferring their cover within their current fund or to a new fund will not be subject to a BLP, provided they have completed at least the standard waiting period.

In the previous example of Policy X, health fund member Greg finds he needs a knee replacement. Greg has completed 12 months of membership on a policy which includes knee replacements, but is still within the 24-month BLP. In order to avoid the BLP, Greg upgrades within the same fund to Policy Y, which also includes knee replacements.

The BLP cannot be imposed on transferring members and he has already completed his 12-month waiting period for knee replacements, so Greg has continuity of benefits and can be covered for the knee replacement on Policy Y immediately. This applies even if Policy Y also has a BLP on knee replacements.

Top 5 Consumer Complaint Issues This Quarter

The following are the top five complaint issues for the quarter:

1. Oral Advice: 128 Complaints
The number of consumers dissatisfied with oral advice has increased and remained high for some time. Most complaints about oral advice concern an allegation that a health insurer's staff member misadvised a consumer and caused them to hold an incorrect level of cover.

As part of the office's role in addressing areas of systemic complaint we have assisted some insurers to improve their processes and, in particular, their responses to allegations of incorrect oral advice. In addition, we have recommended that after a policy is commenced over the phone or at a retail office, a special emphasis be put on the importance of checking the written policy information and that it matches what was asked for.

Under the private health insurance Code of Conduct, to which most health insurers are signatories, a consumer has 30 days after commencing a policy to make any changes. Unfortunately, many of the individuals who have contacted this office after finding that their policy isn't the one they wanted have done so well after the 30 days have passed.

2. Membership Cancellation: 128 Complaints
An increase in complaints about membership cancellations during this quarter is to be expected as it is the busiest time of year for consumers switching health insurers. Most complaints about membership cancellation concern requests for clearance certificates and refunds not being responded to quickly enough.

It is in the interests of all insurers to make the process of leaving a health insurer as quick as possible as it reflects badly on all health insurers if portability isn't easy.

3. Hospital Policy Exclusions and Restrictions: 77 Complaints
Most insurers offer a range of hospital policies with exclusions and restrictions, some of which are very complex for consumers to understand. Some policies only cover a very limited number of services, while others may exclude or restrict items that consumers believe they won't need or don't understand. As a result, a number of consumers can be unpleasantly surprised to find they are not covered for treatments that they now require.

4. Premium Payment Problems: 72 Complaints
Complaints about this issue mostly relate to direct debits from credit cards and bank accounts and problems occurring with changes to premiums on 1 April.

5. Pre-Existing Conditions Waiting Period: 68 Complaints
The Pre-Existing Conditions Best Practice Guidelines, which insurers use to assist them in determining pre-existing condition cases, were introduced in 2001. Since that time a number of technological developments have occurred that have led to uncertainty in making determinations and led to some complex investigations by the PHIO office. We would like to see an update to the guidelines, in consultation with the industry and stakeholders, to address this issue and other causes of complaint that we see coming from policy holders whose claims have been determined as pre-existing but receive insufficient explanations.

Update to Contact Details

From 1 July 2015 the PHIO became part of the Office of the Commonwealth Ombudsman. As a result the following contact details have changed (note the previous addresses are still being forwarded):

Complaints and enquiries: phio.info@ombudsman.gov.au
Staff: firstname.secondname@ombudsman.gov.au
Media enquiries: 02 6276 3759 during business hours
Fax number: 02 6276 0123

Postal address:
Private Health Insurance Ombudsman
Office of the Commonwealth Ombudsman
GPO Box 442
CANBERRA ACT 2601

Complaints by Health Insurer Market Share

1 April - 30 June 2015

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%
Australian Unity	66	6.3%	8	5.3%	3.2%
BUPA	316	29.9%	40	26.5%	26.7%
CBHS	10	0.9%	1	0.7%	1.3%
CDH (Cessnock District Health)	0	0.0%	0	0.0%	<0.1%
CUA Health	4	0.4%	0	0.0%	0.5%
Defence Health	5	0.5%	0	0.0%	1.7%
Doctors' Health Fund	0	0.0%	0	0.0%	0.2%
GMHBA	14	1.3%	2	1.3%	1.9%
Grand United Corporate Health	6	0.6%	1	0.7%	0.4%
HBF Health	33	3.1%	6	4.0%	7.4%
HCF (Hospitals Cont. Fund)	126	11.9%	21	13.9%	10.8%
Health.com.au	20	1.9%	7	4.6%	0.5%
Health Care Insurance	0	0.0%	0	0.0%	0.1%
Healthguard (GMF/Central West)	5	0.5%	1	0.7%	0.5%
Health-Partners	1	0.1%	0	0.0%	0.6%
HIF (Health Insurance Fund of Aus.)	12	1.1%	1	0.7%	0.7%
Latrobe Health	4	0.4%	0	0.0%	0.7%
Medibank Private & AHM	312	29.5%	41	27.2%	29.1%
Mildura District Hospital Fund	0	0.0%	0	0.0%	0.2%
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
Navy Health	0	0.0%	0	0.0%	0.3%
NIB Health	93	8.8%	18	11.9%	7.7%
Peoplecare	6	0.6%	1	0.7%	0.5%
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	0.1%	1	0.7%	0.3%
Railway & Transport Health	1	0.1%	0	0.0%	0.4%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Lukes Health	1	0.1%	0	0.0%	0.4%
Teachers Federation Health	12	1.1%	1	0.7%	2.0%
Teachers Union Health	3	0.3%	1	0.7%	0.5%
Transport Health	2	0.2%	0	0.0%	0.1%
Westfund	3	0.3%	0	0.0%	0.7%
Total for Health Insurers	**1056**	**100%**	**151**	**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 2014