Australian Government
Private Health Insurance Ombudsman

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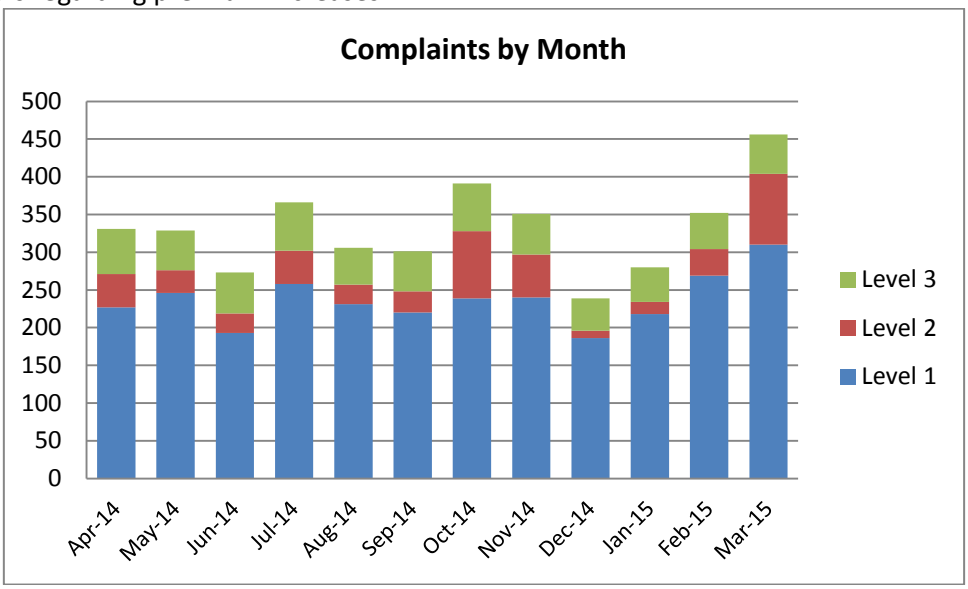
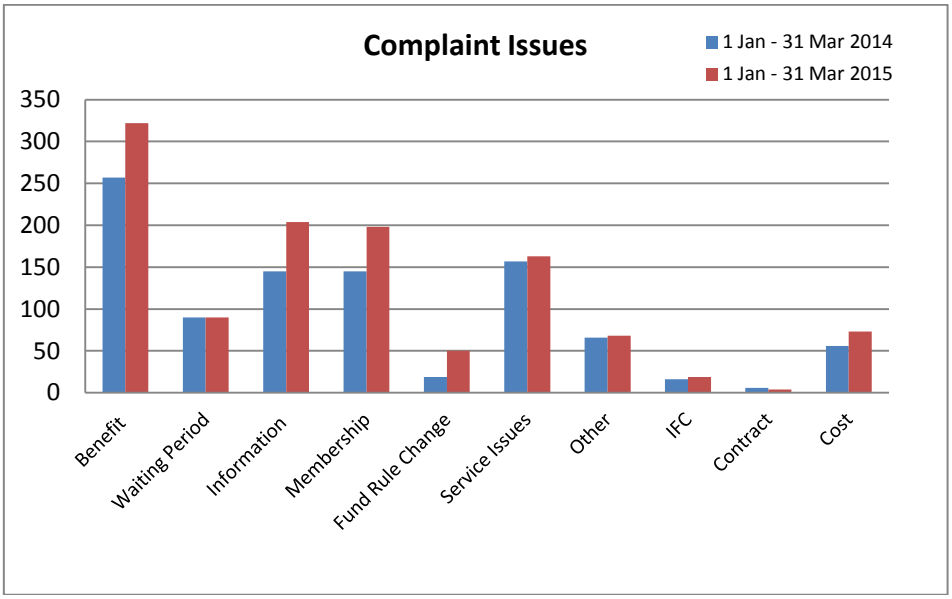
Quarterly Bulletin 74
(1 January – 31 March 2015)

Complaint Statistics & Workload

The office received 1,088 complaints this quarter. This is a 10% increase on the previous quarter (981 complaints) and a 23% increase on the same quarter last year (883 complaints). This is usually the busiest quarter in the private health insurance year with health insurers contacting consumers regarding premium increases.



With rate increases taking effect on 1 April 2015, there was an increase in complaints about cost this quarter. With health insurance at front of mind for consumers at this time of the year, however, we also recorded significant increases in complaints about benefits, information and membership issues.



How the 1st April Premium Increases Affected Complaints

Firstly, it must be remembered that PHIO does not play a part in any of the processes involved in reviewing and making changes to premiums levels.

The whole issue about premium levels is one of striking the right balance – consumer affordability against the need to have a financially vibrant health funds.

There are increasing costs in health care due in part to the cost of utilising technology and an ageing population. The challenge in managing premium levels lies in balancing the need for affordable health care against the need for health funds to remain solvent.

Complaints about premium increases have remained low in recent years for a number of reasons. These include: better communication to members about rate increases; an annual rate increase at a pre-determined time and government measures that support private health insurance, including the Private Health Insurance Rebate; Lifetime Health Cover penalty loading; and Medicare Levy Surcharge.

Since the introduction of the *Private Health Insurance Act 2007 (Cth),* health insurers require the approval of the Minister for Health before they can raise their premiums. This ensures there is appropriate scrutiny of all premium increase applications each year.

Health funds have to go through an approval process before any price increase is permitted. Under legislation, each fund must provide detailed financial information, including cost and benefit projections, to the Minister for Health. The information must be certified by an accredited professional actuary, and undergoes review by the industry's financial regulator, the Private Health Insurance Administration Council (PHIAC).

The Minister assesses premium applications to ensure requested increases are kept to the minimum necessary. This takes into consideration fund solvency requirements, forecast benefit payments and prudential requirements, while also ensuring the affordability and value of private health insurance as a product.

If the Minister is not satisfied that a premium increase requested by a fund is the minimum necessary, the Minister can ask the fund to consider re-submitting their application by seeking a lower premium increase. Alternatively, the fund can choose to provide further justification as to why the increase requested is the minimum necessary.

This process ensures consumers can be confident that any rate increase has received significant scrutiny and can be justified as necessary to cover their fund's on-going costs.

Consumers should remember that the Minister will not sign off on any premium increase unless she is satisfied that the increase is justified.

The overall increase in complaints this quarter is not directly attributable to the number of complaints about premium increases - PHIO received only 72 complaints about premium increases, typically from consumers expressing dissatisfaction with their particular health insurance policy increasing more than the average for their insurer or the industry. This was an increase on the 56 premium increase complaints last year, but it is clearly not the cause of the 23% increase in overall complaints comparing this quarter to 2014.

In discussing this matter with the dispute resolution staff at the PHIO, it seems that the correlation between the general increase in complaints and the health insurance premiums increase is caused

by a number of factors. Although a number of complainants in this quarter indicated that they are aware of the premium increase, their actual complaint concerns other issues. These typically include:

- Insurers making changes to benefits and notifying members of the change at the same time they are notified of the rate increase;
- Consumers shopping around for insurance and encountering administrative problems switching from one insurer or policy to another. This is reflected in the increased number of "membership" complaints, which include issues like cancellation and transfers;
- Problems caused by bank account and credit card direct debits, due to a large number of consumers experiencing changes in premiums at one time; and
- Service problems because insurers experience a very high level of customer activity with people enquiring and changing policies before the 1 April deadline.

So the increased number of complaints during this quarter is due to a number of factors, many of which are only indirectly related to the scale of the premium increase itself.

The increased number of complaints could also be the result of more consumers shopping around and choosing to switch insurers and policies. Anecdotal reports from insurers indicate this is a likely cause of complaint; however, it will take some time before the figures on member change and retention will be available to confirm if this is the case.

Top 5 Consumer Complaint Issues This Quarter

1. Oral Advice: 129 Complaints
This issue has been raised regularly in these quarterly bulletins as a leading cause of consumer complaints. In the recently released *State of the Health Funds Report 2014*, PHIO provided some recommendations to insurers to address these complaints, based on PHIO's handling of a large number of oral advice complaints across all insurers in the industry over a number of years and what we believe could reduce these types of complaint – see page 5 of the Report. We also note that the insurers who have actively sought to reduce their number of oral advice complaints are the ones that have fewer overall complaints compared to their market share, as shown on page 4 of these quarterly bulletins.

2. Membership Cancellation: 84 Complaints
The higher number of consumers experiencing a problem with cancelling their policy correlates with reports of a high number of policyholders shopping around and switching during the quarter.

Many membership cancellation complaints occur when a member wishes to cancel a policy, but the insurer does not action the cancellation within the expected time frame or delays the refund of excess premiums. (It should be noted that complaints about transferring policies and being recognised for continuity of waiting periods and Lifetime Health Cover is counted separately and caused 26 complaints.)

3. Premium Increases: 72 Complaints
Complaints about premium increases were mostly lodged by consumers whose premiums increased more than the reported average for their insurer or the industry overall. PHIO's dispute resolution officers record these complaints and provide further explanation of the premium increase process, as well as advice on their right to change if the consumer expresses interest in changing to a different policy with a lower premium.

4. Pre-Existing Condition Waiting Period: 64 Complaints
This was a small reduction from the 77 complaints received the last quarter.

5. Hospital Policy Exclusions & Restrictions: 70 Complaints
Most of these complaints related to changes made to health insurance policies in 2014, from consumers who find they are no longer covered for a procedure that they now require. The effect of any changes made during this year's 2015 premium increase round will show in the coming quarters.

Complaint Response Times by Health Insurers from 1 July 2015

PHIO has previously negotiated with insurers to agree on standard response times to complaint referrals. This enables PHIO's dispute resolution officers to inform complainants of the expected resolution time of their complaints. Timeliness of complaint handing is a major reason why satisfaction levels with PHIO's complaints handling service have been maintained at a high level for a number of years.

In particular, consumers have expressed satisfaction with our "Assisted Referral" process - PHIO refers a matter to an insurer's complaints team and the insurer contacts the complainant within three working days with a response. When PHIO does this, the dispute officer will explain the process to the consumer and explain that if the matter is not resolved within the specified time frame or if they dispute the fund's response, they should come back to PHIO to follow up the complaint and see if the matter warrants further investigation.

This is a very efficient way to handle complaints because simple matters are dealt with rapidly, and dispute officers at PHIO can concentrate their time on more complex level of complaints that require more intervention. Consumers also seem to accept giving insurers a further chance to respond to a complaint, provided they can be assured that the process has a short turnaround time and that they will not need to explain the matter for a second time if they need to come back for assistance.

With the merger of the PHIO into the Commonwealth Ombudsman on 1 July 2015 it is anticipated that there will be no change to these arrangements. To summarise the expected response times:

Level 1 Complaints (Assisted Referrals)	3 business days for an insurer to respond to complainant
Level 2 Complaints (Grievances)	Complaint registered by PHIO for reporting purposes, no response required from insurer
Level 3 Complaints (Disputes)	14 standard days for an insurer to respond to PHIO and 7 standard days for any follow-up requests for additional information.

For further details on current arrangements with insurers for responding to complaints and how matters are classified as level 1 and 3 complaints please refer to the PHIO Referral to Fund Guidelines, available on the PHIO website:
http://www.phio.org.au/downloads/file/complaints/PHIOReferraltofundGuidelines.pdf

Complaints by Health Insurer Market Share

1 January - 31 March 2015

Name of Fund	Complaints(1)	Percentage of Complaints	Level-3 Complaints(2)	Percentage of Level-3 Complaints	Market Share(3)
ACA Health Benefits	1	0.1%	0	0.0%	0.1%
Australian Unity	45	4.8%	3	2.4%	3.2%
BUPA	254	27.1%	33	26.6%	26.7%
CBHS	8	0.9%	1	0.8%	1.3%
CDH (Cessnock District Health)	0	0.0%	0	0.0%	<0.1%
CUA Health	6	0.6%	0	0.0%	0.5%
Defence Health	2	0.2%	1	0.8%	1.7%
Doctors' Health Fund	0	0.0%	0	0.0%	0.2%
GMHBA	13	1.4%	1	0.8%	1.9%
Grand United Corporate Health	7	0.7%	1	0.8%	0.4%
HBF Health	28	3.0%	5	4.0%	7.4%
HCF (Hospitals Cont. Fund)	147	15.7%	28	22.6%	10.8%
Health.com.au	19	2.0%	7	5.6%	0.5%
Health Care Insurance	2	0.2%	0	0.0%	0.1%
Healthguard (GMF/Central West)	4	0.4%	1	0.8%	0.5%
Health-Partners	0	0.0%	0	0.0%	0.6%
HIF (Health Insurance Fund of Aus.)	4	0.4%	0	0.0%	0.7%
Latrobe Health	5	0.5%	0	0.0%	0.7%
Medibank Private & AHM	303	32.3%	35	28.2%	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	1	0.1%	0	0.0%	0.3%
NIB Health	69	7.4%	6	4.8%	7.7%
Peoplecare	2	0.2%	0	0.0%	0.5%
Phoenix Health Fund	0	0.0%	0	0.0%	0.1%
Police Health	3	0.3%	1	0.8%	0.3%
QLD Country Health Fund	2	0.2%	0	0.0%	0.3%
Railway & Transport Health	1	0.1%	0	0.0%	0.4%
Reserve Bank Health	1	0.1%	0	0.0%	<0.1%
St Lukes Health	1	0.1%	0	0.0%	0.4%
Teachers Federation Health	8	0.9%	0	0.0%	2.0%
Teachers Union Health	1	0.1%	1	0.8%	0.5%
Transport Health	1	0.1%	0	0.0%	0.1%
Westfund	0	0.0%	0	0.0%	0.7%
Total for Health Insurers	**938**	**100%**	**124**	**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