Australian Government
Private Health Insurance Ombudsman

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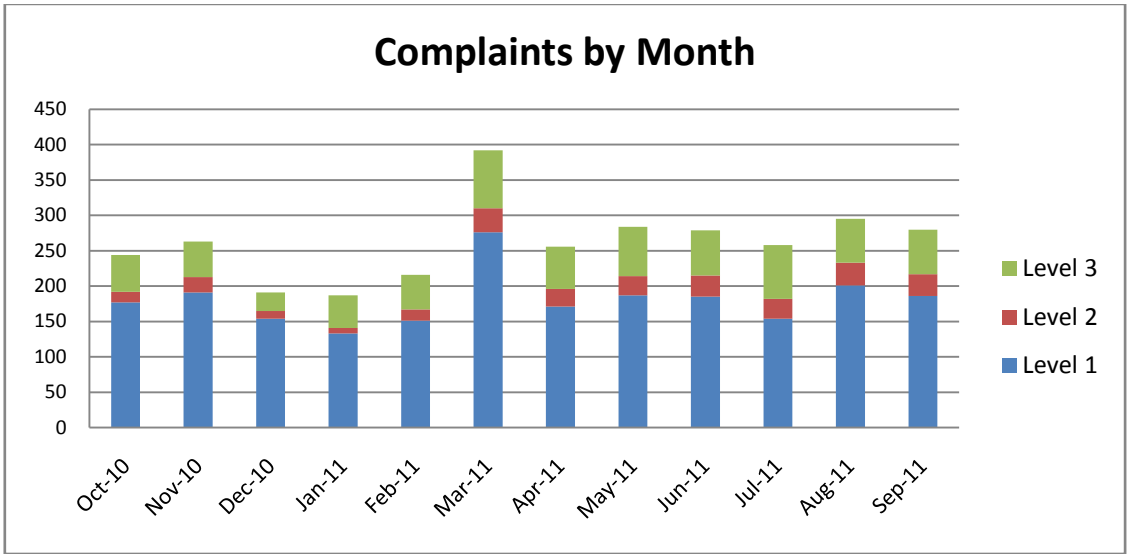
Quarterly Bulletin 60

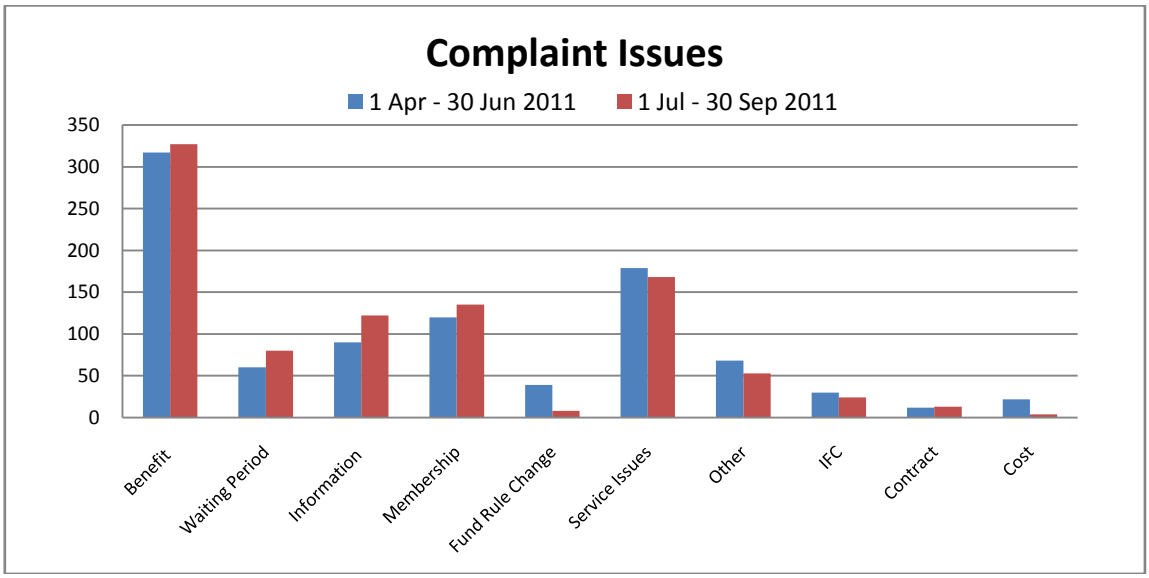
(01 July – 30 September 2011)

Complaint Statistics & Workload

The office received 833 complaints in total during the September 2011 quarter. This was 1.7% more than the previous quarter, and 15% more than the same period last year, continuing the upward trend of complaints made to the office in 2011. Of the 729 complaints about health insurers, 157 were Level 3 complaints.



Compared to the previous quarter, overall complaint numbers are steady. However, there has been an increase in complaints about Waiting Periods, Information and Membership. Information complaints include fund brochures and websites, lack of notification, and oral or written advice. Membership complaints include arrears, cancellation, suspension, and transfers between funds.



Informing Members about Problems with Continuity

During the quarter, the office received 37 complaints from people experiencing difficulties with transferring their membership to another insurer.

When a member wishes to transfer to a new insurer, a transfer certificate needs to be produced by their previous insurer, then sent to the new insurer and processed. Until the previous membership is recognised by the new insurer, the member is not automatically entitled to benefits without the application of a waiting period. In addition, the premiums charged might be provisional until the member's Lifetime Health Cover status can be confirmed.

Issues raised with PHIO by members complaining about continuity issues include:

- patients being advised by a hospital that their eligibility for benefits cannot be confirmed by their insurer because of delays in receiving and/or processing their transfer certificate;
- members who pay their membership by direct debit experiencing a large increase in premiums because a Lifetime Health Cover loading has been retrospectively applied to their membership.

In most cases, after PHIO has contacted both the previous and the new insurer, these complaints are resolved by addressing the administrative problems and confirming the member's entitlement to benefits. In some cases, however, processing the transfer certificate confirms that the member has had a gap in their membership, or has previously held a restricted or lower level of hospital cover, which means that a Lifetime Health Cover loading or waiting periods apply to their new policy.

It is therefore important for insurers to ensure they have good processes for notifying new members who have transferred from another insurer that their transfer certificate has been processed and advising, where necessary, of any waiting periods or Lifetime Health Cover loading that apply to their new membership. It is not good practice to leave a member to find out about a problem with their membership when they are arranging a hospital admission and it is not surprising that such practices usually lead to complaints from members to PHIO.

Effective Rule Change Notifications

Health Insurers are permitted to alter the terms of a health insurance policy so long as affected consumers are given sufficient notice of any detrimental changes to their policy. This allows a consumer to decide whether to accept the change, or to look for a new policy and transfer without waiting periods if they are not happy with the change to their policy.

PHIO has raised the need for proper advance notice to members of detrimental changes with insurers on a regular basis, but unfortunately, we continue to receive complaints from members who have attempted to make a claim on their policy, only to discover that benefits have been reduced from their previous entitlement. In investigating these complaints, PHIO requests the insurer to provide a copy of the letter that was sent to members to notify them of the change. PHIO staff will then assess whether this information provided sufficient notice or whether there were other reasons why the consumer misunderstood the information. From our perspective, a letter that attempts to gloss over the changes and mix negative news up with promotional messages is more likely to fail in its obligation to provide clear information about a detrimental change to benefits.

In some cases, insurers have made what they consider minor changes to a policy and therefore decided not to send a letter to notify members of a reduction in benefits. In these cases, after reviewing the consumers' concerns, PHIO has asked that the insurer pay claims under the terms of the previous policy rules until such time as correct notification is provided to members.

The following problems with previous rule change letters have been identified by PHIO and consumers:

1. Not stating the dollar difference between the previous benefit and the new, reduced benefit.
2. Overloading the letter with positive promotional messages that obscure the message that benefits have been reduced.
3. Poor setting out of letters. Organising the messages in the letter and providing appropriate headings assists members to understand the changes and focus on the important information

about changes to their cover. Some letters appear to hide negative news at the end of the letter, or in a separate booklet that is more likely to be overlooked by members.

4. Not advising members that they can choose a new policy and maintain continuity if they are not happy with the change to their policy.

PHIO encourages insurers who are considering making rule changes in 2012 to provide draft copies of letters to PHIO for comment. This enables us to highlight any information that may be unclear or identify issues that may lead to complaints, based on our experience in dealing with complaints about fund rule changes and information issues.

Waiting Period Waivers – Ensuring Consumers Understand which Waiting Periods Apply

PHIO continues to receive complaints from newly insured people who have signed up for promotional offers waiving the 2 and 6 month waiting periods and have misunderstood the terms of the waiver, believing that it applies to all hospital waiting periods including the 12 month waiting period for Pre-Existing Conditions.

When an insurer is waiving waiting periods as part of a promotion, it is important that the wording of the special offer is clear and that it specifies in unambiguous terms which waiting periods are waived and which waiting periods still apply. If a member joins during a waiver of waiting periods, it is not sufficient to provide them with a generic brochure and expect them to understand which waiting periods have been waived and which still apply to their membership.

This information should be provided separately in writing, either before or immediately after the policy commences (i.e. during the 30 day cooling off period).

New Features at www.privatehealth.gov.au

A series of new features will shortly be added to the www.privatehealth.gov.au consumer information website.

The new update takes the form of:

- Three online video tutorials covering the key consumer topics of:
  1. “An Introduction to the Privatehealth.gov.au website”
  2. “Your Health Choices” and
  3. “How to Compare Policies”

- A revamped agreement Hospitals Locator with a user-friendly map based interface (using Google Maps) that allows consumers to check which hospitals in their local area have agreements with their health fund.

- New health fund information pages with tabbed sections and additional information about insurer performance (extracted from the State of the Health Funds Report).

Complaints by Health Insurer Market Share

1 July - 30 September 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	32	4.4%	11	7.0%	3.0%
Australian Unity	32	4.4%	9	5.7%	3.2%
BUPA (HBA/Mutual Community)	83	11.4%	18	11.5%	9.8%
BUPA (MBF/MBF Alliances)	102	14.0%	19	12.1%	17.6%
CBHS	5	0.7%	1	0.6%	1.2%
CDH (Cessnock District Health)	1	0.1%	0	0.0%	<0.1%
CUA Health	4	0.5%	2	1.3%	0.4%
Defence Health	6	0.8%	0	0.0%	1.4%
Doctors' Health Fund	0	0.0%	0	0.0%	0.1%
GMHBA	12	1.6%	3	1.9%	1.5%
Grand United Corporate Health	6	0.8%	1	0.6%	0.3%
HBF Health	25	3.4%	2	1.3%	7.6%
HCF (Hospitals Cont. Fund)	83	11.4%	14	8.9%	10.4%
Health Care Insurance	0	0.0%	0	0.0%	0.1%
HIF (Health Insurance Fund of Aus.)	4	0.5%	1	0.6%	0.4%
Healthguard	2	0.3%	1	0.6%	0.5%
Health-Partners	10	1.4%	1	0.6%	0.6%
Latrobe Health	2	0.3%	0	0.0%	0.6%
Medibank Private	242	33.2%	55	35.0%	28.6%
Mildura District Hospital Fund	2	0.3%	0	0.0%	0.3%
National Health Benefits Aust.	0	0.0%	0	0.0%	0.1%
N.I.B. Health	45	6.2%	13	8.3%	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	1	0.1%	0	0.0%	0.3%
QLD Country Health Fund	0	0.0%	0	0.0%	0.2%
Railway & Transport Health	2	0.3%	0	0.0%	0.3%
Reserve Bank Health	0	0.0%	0	0.0%	<0.1%
St Lukes Health	0	0.0%	0	0.0%	0.4%
Teacher Federation Health	15	2.1%	4	2.5%	1.7%
Teachers Union Health	3	0.4%	1	0.6%	0.4%
Transport Health	0	0.0%	0	0.0%	0.1%
Westfund	9	1.2%	1	0.6%	0.8%
Total for Health Insurers	**729**	**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