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**Australian Government****Private Health Insurance Ombudsman**

HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING
INQUIRY INTO HEALTH FUNDING

PHIO CASE STUDIES

The following case studies have been prepared for the committee to illustrate the types of complaints received by the Ombudsman on issues that have been raised with the committee.

It should be noted that complaints to the Ombudsman are not representative of the experience of the majority of private health insurance contributors.

Case studies are de-identified (to the extent possible) and have been chosen to illustrate particular issues and implications of health insurance administration.

CASE STUDY A - Portability (administration)**CASE STUDY B - Portability (administration)****CASE STUDY C - Australian Unity Benefit Limitation Periods****CASE STUDY D - Portability (gap cover schemes)****CASE STUDY E - Informed Financial Consent (Private Hospital charges)****CASE STUDY F - Informed Financial Consent (Doctor's fees)**

Additional case studies can be found in the Private Health Insurance Ombudsman's Annual Reports and Quarterly Bulletins, which are available on the PHIO website at www.phio.org.au.

PRIVATE HEALTH INSURANCE OMBUDSMAN - CASE STUDY A

PORTABILITY:

CONTEXT: While changing health funds is a reasonably straightforward matter for most people, the Private Health Insurance Ombudsman receives between 150 and 200 complaints each year about problems experienced in transferring from one fund to another. Most of these complaints arise from administrative delays or errors.

ISSUES IN THIS CASE: Quality of information provided to new/transferring members, application of 30% rebate and Lifetime Health Cover rules to transferring members, requirements for "clearance certificates" when transferring, Cooling Off period.

CASE SUMMARY

Mrs A's monthly health insurance premiums increased by about 10%. She was finding it difficult to meet this cost. She telephoned another fund and was advised they offered a similar product at a much lower cost. She was advised that changing funds would be simple and the new fund would contact her existing fund to obtain all the information to arrange the transfer.

Six weeks later, when she got her credit card statement, she noticed that the deduction for three months premiums for the new fund had been made but the amount deducted was much higher than expected (in fact more than she had been paying at her old fund). She also noted that the deduction for her premium for the old fund had also been taken from her account.

When she contacted her new fund, staff were unable to provide her with a clear explanation of why the premium was so much higher than she had been quoted but assured her the amount deducted was correct.

When she contacted her old fund she was advised that her membership remained current and they had received no instructions to cancel her policy. As her old policy was cheaper she decided it was better to keep that membership and wrote to the new fund asking them to cancel their policy and refund the contributions she had paid.

The new fund agreed to cancel the policy from the day she asked them to but refused to refund contributions paid up to that date (approximately two months worth of premiums).

INVESTIGATION

PHIO's investigation revealed that:

- The new fund's records showed they had sent a request for a "clearance certificate" to the old fund immediately it was authorised to do so by Mrs A but had not received a response from the old fund.
- Because this information was not received the new fund included a 20% Lifetime Health Cover Loading on Mrs A's premium. (This is why the premium amount deducted was higher than quoted.)
- The old fund had received the request for cancellation and clearance certificate but administrative delays held up the processing of that request.
- Both the new fund and the old fund had rules that precluded a person contributing to two different funds for the same service at the same time. Both funds argued that the other fund was at fault.

OUTCOME

After being advised of PHIO's findings Mrs A decided that she wanted to stay with her original fund (even though the new fund would in fact be cheaper) because of the poor service she had received from the new fund. The Ombudsman recommended that the new fund refund all contributions paid by Mrs A. That fund offered to payback the contributions less a small administration charge. This offer was accepted by Mrs A.

COMMENT

Delay in response to requests for clearance certificates is a factor in the majority of such complaints. This is despite a requirement under the Lifetime Health Cover legislation that such information should be provided within 7 days of the request. If that timeframe had been met in this case the problems for Mrs A would not have arisen. The new fund should also have followed up on the delay before imposing the Lifetime Health Cover loading. Given Mrs A's experience, the fund's insistence on deducting even a small administration charge was inappropriate and petty.

PRIVATE HEALTH INSURANCE OMBUDSMAN - CASE STUDY B

PORTABILITY:

CONTEXT: While changing health funds is a reasonably straightforward matter for most people, the Private Health Insurance Ombudsman receives between 150 and 200 complaints each year about problems experienced in transferring from one fund to another. Most of these complaints arise from administrative delays or errors. Sometimes the consumer's own actions or inaction can contribute to the problem.

ISSUES IN THIS CASE: Arrangements for cancellation of previous policy, Lifetime Health Cover Loading, the importance of reading health fund correspondence, making a record of advice provided by telephone.

CASE SUMMARY

Mrs B arranged to transfer to a new fund, over the telephone in 2002. The new fund explained that they would arrange to cancel her policy with her old fund and obtain the transfer details if she completed and signed the relevant request on the application it sent to her. She received and completed the application form but forgot to complete the relevant "transfer request" section.

When the application form was received by the new fund it was processed as a completely new application. (The fund had not recorded any notes about the previous telephone discussion of the transfer arrangements.) As a result the new fund imposed a 50% Lifetime Health Cover loading.

Two and a half years later Mrs B's bank contacted her to advise that a direct debit payment to her old fund had been dishonoured because her savings account now had insufficient funds. After some further inquiries Mrs B discovered that she had been paying premiums to two health funds for nearly three years and had been paying the 54% extra loading to one of the funds.

INVESTIGATION

PHIO's investigation revealed:

- Mrs B had been receiving correspondence from her old fund throughout the two and a half year period but because she thought she was no longer a member, assumed it was marketing material and she threw it out without reading it.
- Mrs B had made some claims for benefit from her new fund but no claims against her old fund during the period.
- Mrs B's new fund had sent her three annual Lifetime Health Cover statements that showed she was being charged a 54% loading but these failed to alert Mrs B to the problem.
- Both the new fund and the old fund had rules that precluded a person contributing to two different funds for the same service at the same time. Both funds initially argued that, as Mrs B was at fault, they should not have to give her a refund.

OUTCOME

The Ombudsman was able to negotiate a resolution with the two funds that involved some refund of contributions and crediting of extra contributions against her membership. The result was that Mrs B was not out of pocket and Mrs B accepted the resolution.

COMMENT

The Ombudsman concluded that Mrs B had contributed significantly to the problem by not reading her Lifetime Health Cover statements and other correspondence from her old fund and not checking her bank statements. Nonetheless the Ombudsman did not believe that it was reasonable for her to be liable for two health fund memberships.

PRIVATE HEALTH INSURANCE OMBUDSMAN - CASE STUDY C

PORTABILITY – BENEFITS LIMITATION PERIODS (Australian Unity):

CONTEXT: In April 2004, Australian Unity (AU) introduced 12 month Benefit Limitation Periods on all of its products for psychiatric and rehabilitation treatments. The effect of this change is that any person joining AU (including transfers from another fund) will only receive the minimum, default benefits if they are admitted for psychiatric or rehabilitation treatment in the first 12 months of their AU membership. These AU rules have been criticised because they undermine consumer portability rights and because they appear to discriminate against people with mental illness.

The Private Health Insurance Ombudsman has only received three (3) complaints from consumers about the AU rules and only one where the person had actually joined AU. This is a description of that complaint.

ISSUES IN THIS CASE: Portability of hospital cover, effect of benefit Limitation Periods, explanation of conditions on joining.

CASE SUMMARY

Mr C has a psychiatric illness for which he has been treated (both in and out of hospital) over a period of 5 years. Mr C's mother had initially arranged and paid for Mr C's private health cover with Medibank Private. In late 2004, after seeing AU advertising a cheaper hospital product, and reading reports of plans by Medibank Private to cut back on its hospital contracts, Mr C decided to transfer the hospital cover from Medibank Private to AU.

About two months later Mrs C became aware (via a newsletter from a psychiatric support group) that AU had restricted the benefits paid for in-hospital psychiatric treatment. After checking with AU she was advised that AU would have explained the benefit limitation to Mr C when he contacted them to join and provided a full disclosure of these rules in the written information sent to Mr C on joining. Mrs C considered that the AU rule was unfair. She also considered that the written information sent to her son was misleading because it indicated that waiting periods would not apply again for new members transferring from an equivalent cover with another fund. She complained to the PHIO, on behalf of her son.

INVESTIGATION

PHIO's investigation revealed:

- AU computer records of the initial contact with Mr C did include a notation that the benefit limitation periods were explained.
- Mr C said that, when he initially contacted AU, he simply confirmed the premium amount applicable to him and asked for an application to be sent to him. He said there was some explanation of "waiting periods" and other aspects but he did not recall any discussion of the benefit limitation period rule for psychiatric treatment. However, he could not definitely say that it wasn't covered.
- Mr C had received a welcoming letter and brochure, on joining AU, which included an explanation of the 12-month benefit limitation period for psychiatric treatment. PHIO did not agree that the explanation provided in the brochure was misleading. The explanation in the brochure made it clear that benefit limitation periods would apply, even though waiting periods might not.
- Mr C had not required in-hospital psychiatric treatment since joining AU.

OUTCOME

Mrs C contacted Medibank Private, who allowed Mr C to reactivate his previous membership with them, providing full cover for in-hospital psychiatric treatment. He cancelled his AU membership.

COMMENT

The Ombudsman considers that the application of benefit limitation periods on transfers undermines the portability rights of some transferring members. Notwithstanding that it was found that the AU explanation was not misleading, it is understandable that consumers are confused by the distinctions drawn between waiting periods and benefit limitation periods in transfer situations.

The very small number of complaints received on this issue suggests that the AU benefit limitation periods are having the (intended) effect of discouraging members with mental illness from transferring to that fund, rather than resulting in reduced benefits for individual consumers.

PRIVATE HEALTH INSURANCE OMBUDSMAN - CASE STUDY D

PORTABILITY – GAP COVER SCHEMES:

CONTEXT: Portability provisions allow health fund members to transfer between “broadly comparable” products without having to re-serve waiting periods for equivalent benefits but a transferring member is required to serve a waiting period for any additional benefit that was not available on their old product.

The legislation includes a provision that differences in hospital agreement arrangements (whether or not a fund does or doesn't have an agreement with a particular hospital) should be disregarded when deciding if products are broadly comparable and whether benefits are equivalent. Although there is no similar provision requiring funds to ignore differences between gap cover schemes, funds have adopted this approach as a matter of policy. (ie. A transferring member does not have to wait to gain the full benefits of their new fund's gap cover scheme.) This policy is supported by the Ombudsman and the Department.

ISSUES IN THIS CASE: Portability of hospital cover, access to gap cover scheme benefits, Doctors advocating change of health funds.

CASE SUMMARY

Mrs D lived in a medium sized regional city and was expecting her first child. She had been a member of MBF health fund for five years. On a visit to her obstetrician, several weeks before the expected date of birth of her child, the doctor's receptionist explained the obstetrician's fees for assisting at the birth in the local private hospital. It was explained that the doctor did not use the MBF no-gap scheme and therefore if she stayed with that fund her out-of-pocket costs for the obstetrician's bill would be approximately \$1500. However, she was advised that the doctor suggested to all patients that they join another fund (a small, locally based regional fund). That fund offered a Known Gap scheme that the doctor was prepared to use. If Mrs D transferred to that fund her out-of-pocket cost would only be \$500. It was also noted that the local fund's op cover was quite reasonably priced.

Mrs D decided that she should try to check on the advice she had been given. A friend suggested that she could check with the Ombudsman's office about her transfer entitlements.

INVESTIGATION

PHIO was able to confirm that Mrs D would gain immediate access to the local fund's gap cover scheme should she transfer. However PHIO also explained the range other issues that may need to be taken into account when changing funds.

The Ombudsman was concerned about the implications of the doctor's actions in this case. He contacted the local fund to ensure that they understood the application of portability policy in such cases and to discuss the issues (without identifying the member and doctor involved).

The local fund advised that they had over recent months experienced an influx of new members transferring from other funds and, very soon after, claiming significant benefit amounts for hospital costs and obstetric charges. Although the number of transfers was relatively small, for a small fund, the additional benefit costs involved were significant and well beyond what the fund had budgeted for. The fund had identified that most of the claims for gap scheme benefits had come from specialist doctors associated with a particular practice group (which included Mrs D's obstetrician).

The CEO of the local fund decided to seek a meeting with the doctors to explain the impact their actions were having on the fund.

OUTCOME

It is not known whether Mrs D transferred her health fund membership to the local fund.

Following discussions with the health fund, the doctors involved agreed they would no longer advocate to patients that they transfer to the local fund.

Due in part to higher than expected benefit costs, the local fund increased its premiums, for all members by around 30% in the next year.

COMMENT

The Ombudsman considers that it is not appropriate for doctors to advocate or recommend that patients transfer to a particular health fund, simply to take advantage of gap scheme arrangements for a particular episode of treatment. A doctor's choice to use or not use any scheme will have implications for the gap the patient has to pay but the doctor's choice will normally be based on other considerations, including the total amount that the doctor will receive. As noted above, there can be other implications and disadvantages for any patient in changing funds.

PRIVATE HEALTH INSURANCE OMBUDSMAN - CASE STUDY E

INFORMED FINANCIAL CONSENT – PRIVATE HOSPITAL CHARGES:

CONTEXT: The National Health Act 1953 requires health funds to include in their agreements with private hospitals a provision requiring the hospital to advise any member being admitted of any costs that will not be covered by the health fund and the patient will need to pay out of their own pocket. The patient signs an acknowledgement of those costs. To facilitate this hospitals check with the fund to obtain details of the person's benefit entitlements prior to the patients admission wherever possible.

ISSUES IN THIS CASE: Informed Financial Consent, restricted benefits for cardiac surgery.

CASE SUMMARY

Mr E, a man aged 60 years, was admitted to a local small private hospital for an angiogram on the recommendation of his doctor. The tests revealed major blockages and it assessed that he was at imminent risk of a heart attack and required surgery urgently. He was booked into a larger private hospital for the operation but remained at the small hospital for a further two days until a bed became available at the larger hospital. Mr E was transferred to the larger private hospital on a Thursday night and had heart surgery on Sunday. Two days later, when Mr E was still in intensive care, Mrs E was contacted by the hospital to advise that their health fund would not fully cover the bill and Mr E would be liable for an amount of \$7000. Mrs E asked about her options and hospital staff said they would get back to her. There were several further conversations with hospital staff regarding the account but the matter was not resolved by the time of Mr E's discharge. When she later contacted her health fund she was told that as the hospital had not advised her of the charge to Mr E in advance the hospital would be expected to waive the additional charges. Two months later Mr E received an account from the larger hospital for \$7000 with a demand to pay within 7 days or legal action may be taken. At about the same time he received a bill from the small hospital for \$600.

INVESTIGATION

PHIO's investigation revealed:

- Mr and Mrs E joined their current health fund two years before his surgery, when Mr E changed jobs and was no longer covered by a corporate policy. The product they joined provided only restricted benefits for cardiac procedures and a range of other items such as joint replacement and cataract surgery. This meant the fund paid only the ministerial default benefit for those treatments. This is sufficient to cover the cost of treatment as a private patient in a public hospital but normally covers only about a third of the cost of treatment in a private hospital.
- The health fund records showed that the restrictions on the product had been explained to Mrs E on joining and were explained in a number of brochures and letters to Mr and Mrs E subsequently.
- Nonetheless it was clear that neither Mr nor Mrs E understood that their health insurance would not fully cover cardiac treatment in a private hospital. Mrs E acknowledged that this might have been explained to her on joining but she did not take sufficient notice. She said that at the time she was more concerned to clarify what dental and orthodontic benefits would be available through the extras cover for her children.
- The small hospital did request an eligibility check from Mr E's health fund on the day he was admitted. The health fund confirmed the next day that only minimum benefits would be paid for the procedure (angiogram). The hospital was aware that there would be a charge of \$600 for Mr E but did not advise either Mr or Mrs E prior to Mr E's discharge and did not pass on the relevant information to the larger hospital.
- The larger hospital did not request an eligibility check from Mr E's health fund until two days after his admission. The health fund again confirmed that only minimum benefits would be paid. Hospital staff waited a further day before contacting Mrs E.
- Mrs E advised that if they had known Mr E's treatment would not have been fully covered they could have arranged for him to be treated at a nearby public hospital.

OUTCOME

The Ombudsman recommended that both hospitals waive their accounts because neither had complied properly with their obligation to obtain informed financial consent from Mr or Mrs E prior to or as soon as possible after admission. Both hospitals responded that they considered they should not have to waive any of the account because either the fund was deficient in its explanation to Mr and Mrs E about what their policy covered or Mr and Mrs E would have realised the limitations of their cover and not proceeded with the admission. Mr and Mrs E have authorised the Ombudsman to undertake further negotiations with the hospitals on their behalf.

COMMENT

The process of informed financial consent and fund eligibility checking is an essential safeguard for health insurance consumers. Regardless of how well products are explained some consumers will not recognise the implications at the time of treatment particularly in serious, life threatening situations.

PRIVATE HEALTH INSURANCE OMBUDSMAN - CASE STUDY F

INFORMED FINANCIAL CONSENT – DOCTOR'S BILL:

CONTEXT: PHIO receives about 150 complaints per year about the actions of doctors. Most of these complaints are about the failure of doctors to advise patients in advance of the cost of treatment in hospital or to obtain the patients acknowledgement of those costs. (Informed Financial Consent). The complaints involve all specialties but anaesthetists are the most frequently complained of specialty on this issue.

ISSUES IN THIS CASE: Informed financial consent. Health fund advice.

CASE SUMMARY

Mr F had major orthopaedic surgery in December 2004.

Prior to his hospitalisation he discussed the costs of the hospitalisation with his health fund and doctor. The surgeon advised that he would use Mr F's health fund gap cover scheme and he would have a known gap of \$250. The fund confirmed that his surgeon used their gap scheme and that a \$250 gap was allowable under that scheme. The fund also advised that the hospital proposed was an agreement hospital and all the hospital charges would be covered. Mr F's surgery was completed and he was discharged by the hospital after being advised there were no outstanding hospital charges (his fund covered all costs). He paid the surgeon's gap bill of \$250. One month later he received a bill from an anaesthetist Dr A for \$1080. On enquiring about the bill Mr F was advised that Dr A did not use any fund's gap scheme and that about \$400 should be covered by Medicare and health fund rebates. He wrote to the doctor complaining about the bill and the failure of the doctor to advise him in advance of these costs, noting that neither the surgeon nor his health fund had advised him either. Dr A responded saying the actions of the surgeon and the fund were not his concern, explaining the importance of anaesthesia and outlining his qualifications, extensive training and credentials. He enclosed a further copy of the bill for \$1080.

INVESTIGATION

PHIO's investigation revealed:

- Mr F did see Dr A the day before his operation. Dr A checked some information with him and left him with some printed information about anaesthesia. He did not mention anything about fees and Mr F assumed he was one of the hospital staff.
- PHIO wrote to Dr A asking why he had not provided any advice to Mr F about his charges, advising of the difficulty that Mr F would have in paying the account asking if, in the circumstances it would be possible for him to discount his bill.
- Dr A replied that he was not prepared to discount his bill noting that the \$1080 included a 10% discount for payment within 30 days. He also indicated that it was not his policy to discuss his fee with patients in the pre-surgery consultation because most private patients were not unduly concerned about such matters, it may not be good for them to be discussing such matters at that time and anyway it would mostly be too late for them to do anything else. He said that Mr F's surgeon should have advised him that he could expect a bill from an anaesthetist.

OUTCOME

The Ombudsman wrote to Dr A formally recommending that he discount his bill to the MBS schedule amount of approximately \$400. Dr A did not reply to the recommendation but sent Mr F an account for \$1200 (because the original account had not been paid within 30 days).

After some further discussion with the Ombudsman, Dr A agreed that the account would remain at \$1080 and that Mr F could contact the doctor's office to arrange suitable payment terms.

The Ombudsman also wrote to Mr F's health fund, suggesting that enquiry staff alert members to possibility of doctors and anaesthetist bills when members enquire about an impending hospitalisation.

COMMENT

The Ombudsman recognises the practical difficulties for anaesthetists obtaining informed financial consent from patients and has worked with the Society of Anaesthetists to develop an appropriate policy and form for this purpose. However the Ombudsman's view is that significant problems will remain unless surgeons can be authorised and encouraged to provide advice of anaesthetist's fees.