Commonwealth OMBUDSMAN

PRIVATE HEALTH INSURANCE OMBUDSMAN

ANNUAL REPORT 2014-15

Protecting the interests of people covered by private health insurance

The Private Health Insurance Ombudsman can be contacted in the following ways:

Postal address

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

Telephone, fax and email

Private Health Insurance enquiries and complaints
1800 640 695
(free call from landline, higher cost from mobile)
9am to 5pm Sydney time, Monday to Friday.

Website and general enquiries
1300 737 299 (normal call cost)
9am to 5pm Sydney time, Monday to Friday.

Other

Email phio.info@ombudsman.gov.au
Website http://www.phio.gov.au/
General administration 1300 362 072
Facsimile (02) 6276 0123

Consumers requiring translators 13 14 50
(Translating and Interpreting Service)

Deaf, or hearing or speech impaired 13 36 77
(National Relay Service)

Readers with enquiries about the Ombudsman or this report should contact the Administration Officer at the above address. Information for senators and members of parliament is available from the Private Health Insurance Ombudsman at the above telephone and facsimile numbers.

LETTER OF TRANSMITTAL

Commonwealth OMBUDSMAN

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9 October 2015

The Hon Malcolm Turnbull MP
Prime Minister
Parliament House
CANBERRA ACT 2600

Dear Prime Minister

I have pleasure in submitting the Private Health Insurance Ombudsman Annual Report for the period 1 July 2014 to 30 June 2015 as required by section 20ZG of the *Ombudsman Act 1976*.

I certify that this report has been prepared in accordance with the Requirements for Annual Reports for 2014–15 as approved by the Joint Committee of Public Accounts and Audit under sections 6.3(2) and 70(2) of the *Public Service Act 1999*.

Section 20ZG(4) of the *Ombudsman Act 1976* requires that you place a copy of the report before each House of Parliament within 15 sitting days after it is received.

A copy of this report has also been sent to The Hon Sussan Ley MP, Minister for Health.

Yours sincerely

Colin Neave
Commonwealth Ombudsman

Defence Force Ombudsman ▪ Immigration Ombudsman ▪ Law Enforcement Ombudsman ▪ Overseas Students Ombudsman
Postal Industry Ombudsman ▪ Taxation Ombudsman

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FOREWORD

I assumed the responsibility for the role of the Private Health Insurance Ombudsman (PHIO) from 1 July 2015.

I am aware of the Private Health Insurance Ombudsman's deserved reputation for excellent service and strong relationships with consumers and insurers, and I intend to work to maintain that reputation now that the Ombudsman's functions have become the responsibility of my office.

The role of the Private Health Insurance Ombudsman is to protect the interests of private health insurance consumers by:

- assisting health insurer members to resolve disputes through an independent complaint-handling service
- identifying underlying problems in the practices of private health insurers or health care providers in relation to the administration of private health insurance
- providing advice to government and industry about issues affecting consumers in relation to private health insurance
- providing advice and recommendations to government and industry about private health insurance, specifically the performance of the sector and the nature of complaints.

PHIO also has an important consumer information and advice role regarding private health insurance, including publishing the consumer website, PrivateHealth.gov.au.

I would like to acknowledge the previous Private Health Insurance Ombudsman, Samantha Gavel, for her important role in the success of the office during her time as Ombudsman from 2008 to 31 December 2014.

I would also like to thank the staff at both the Private Health Insurance Ombudsman's office and my own office for their professionalism in ensuring the seamless transfer of the function into the Office of the Commonwealth Ombudsman.

Colin Neave AM
Commonwealth Ombudsman

OMBUDSMAN'S OVERVIEW

During 2014–15 PHIO received 4265 complaints, which represented an increase of 24% on the 3427 complaints received the previous year. The increase in complaints correlated with an increase in the number of higher level complaints requiring an investigation by PHIO.

In 2014–15 we received 668 higher level complaints, which represented a 15% increase on the 580 received the previous year.

That we managed this increased workload while maintaining good response times and a high level of client satisfaction is a result of the excellent work of the dispute resolution team and the assistance of all the health insurer officers who responded to referred complaints.

The increase in health insurance complaints

The causes for the increase in complaints are outlined in further detail in the 'Complaint issues and case studies' section of this report. It is important to note that the increase in complaints was not even across the industry; some insurers contributed more to the increase in complaints than others, as shown in Figure 10: Complaints by health insurer market share 2014–15.

There are no easy answers about how to address the rise in complaints about health insurance, as many are related to decisions made by health insurers in attempting to keep health insurance premiums lower by making changes to health insurance policies; and by consumers choosing health insurance policies with restrictions and exclusions, in return for paying a lower premium.

Health insurer restrictions and exclusion complaints

The number of complaints about hospital restrictions and exclusions has increased significantly over the past two years, from 180 in 2012-13 to 242 in 2013–14, and then 320 in 2014–15. Most of these complaints occur when a policy holder does not consider that a particular service should fall under the list of services restricted or excluded on their policy.

The cause of such complaints could be that the policy was described poorly to the member either at the point of sale or during the course of the membership, or that the insurer has ambiguously or unfairly determined whether a treatment falls into an excluded or restricted category.

We have noticed that when a consumer expresses dissatisfaction about a premium increase, a common response from the insurer is to offer them a lower hospital policy. If a health insurer chooses to recommend a lower policy, it needs to ensure the range of restrictions and exclusions is understood and no assumptions are made about a person's health needs, either by the consumer or the sales officer.

If a person lowers their level of hospital cover, it is a requirement for the health insurer to provide them with a Standard Information Statement. Our view is that the insurer should explicitly point this out to the member and explain that the statement will list all or most of the exclusions and restrictions on their policy.

The consumer should be made aware that they need to review this document and other membership documents, and then contact the insurer if they want to change their decision within their 30-day cooling-off period.

Health insurer detrimental rule changes

Health insurers are permitted to reduce the range and amount of benefits for most services in a health insurance policy, provided sufficient notice is given to existing policy holders. The consumer is then able to decide whether to accept the reduced benefit or switch to another health insurance policy and maintain continuity of their cover.

Complaints occur when the consumer does not understand the change to their policy and therefore they miss the opportunity to maintain continuity of cover for a particular service they require. A common complaint raised by consumers is that the notification was not received or was not understood.

PHIO's investigations in such cases centre on whether the notification was made and whether a reasonable member of the public would understand the wording of the notification.

During 2014–15 there were 281 complaints concerning health insurer rule changes, compared to 72 the previous year. The most common changes complained about were a small number of insurers restricting or removing benefits for gastric banding, obesity-related surgery and reduced benefits for general treatment policies.

In addition to the 281 complaints about insurer rule changes, we received over 60 complaints relating to a reduction in medical gap benefits paid by Medibank towards in-patient diagnostic and pathology services, due to the insurer ceasing its gap cover agreements with service providers.

The majority of these complaints were caused because consumers were not advised in advance that they were no longer covered for gap services in hospital, and encountered unexpected bills on discharge.

We assisted these consumers with their complaints by seeking one-time ex gratia benefits for medical fees incurred in the period soon after the insurer-provider agreements ceased in September 2014.

Oral advice complaints and lack of understanding of the 30-day cooling-off period.

It is disappointing that the number of oral advice complaints addressed to us has increased so significantly over the past few years. In 2012-13, 289 complaints were received, increasing to 410 in 2013–14 and 522 in 2014–15.

These complaints are most prevalent where the insurer has not kept a good record of advice provided to their member. This in turn means the insurer is unable to prove to the complainant that they were given the right advice, or for us to confirm whether the insurer did provide satisfactory advice. However, in most instances there are records of the conversations in question and our role is to determine whether the advice was of acceptable quality.

As the number of complaints about oral advice has increased so significantly, we can only conclude that work needs to be done by insurers to better train health insurer telephone and retail office staff to provide clear and helpful advice to consumers.

We would particularly like to address the lack of understanding among consumers about the 30-day cooling-off period, which applies upon commencement or a change to a health insurance policy.

After providing oral advice to a consumer – for example, changing a policy over the phone or in a retail centre –the insurer is required to send written documents about the policy so the consumer can check their cover and address any discrepancies between the oral advice they received and the change documented by the insurer.

If insurer staff could highlight the importance of checking the policy after a sales call and tell consumers to contact them if any mistake or misunderstanding has been made, it would go a long way towards addressing oral advice complaints.

Membership service complaints

A further cause of the increase in complaints in 2014–15 were membership cancellations, continuity, and arrears. These complaints concern the administrative efficiency of health insurers and their response to policy holders.

Anecdotal reports to PHIO indicated health insurers experienced a high number of service requests and requests to switch health insurance policies during 2014–15, and some health insurers found it difficult to meet requests in a timely fashion.

Premium increases

The number of premium increase complaints increased from 78 to 132. These complaints are caused by individuals experiencing higher than average increases in the cost of their insurance, or by untimely notification or lack of notification about increases.

Far more significant, however, were the overall increase in the number of complaints we received in March and April. With premium increases at front of mind, many consumers are reviewing their cover and seeking to transfer to new insurers during this period, which in turn causes complaints about service and administrative problems.

PHIO's mediation role in 2014–15

Health insurers and healthcare providers contract with each other for the provision of hospital services to ensure policy holders can access treatment with no or minimal gaps for hospital accommodation and theatre fees. Most agreements are renewed every few years, and in almost all cases the two organisations can reach agreement on the amounts to be paid for treatment and other conditions.

When health insurers and health care providers can't reach an agreement, PHIO has the legislative power to require disputing parties to attend compulsory mediation to assist in resolving contractual disputes. Our mediation role does not extend to determining the outcome of the commercial dispute by setting the rates that health insurer's pay, or other conditions as occurs in arbitration.

PHIO was given the mediation function in order to protect the interests of health insurance consumers, who may be disadvantaged in the event of a contract dispute affecting the hospitals they want to attend.

Should their existing insurer no longer have an agreement with a consumer's preferred hospital, the consumer is also protected under portability rules – consumers are able to switch their policy to another health insurer that still covers a preferred hospital[1].

While this is an important protection, in almost all cases a public dispute between a health care provider group and a health insurer is resolved by the parties before any consumers are affected.

This means that a key aim of our mediation role is to ensure the parties do not cause unnecessary worry to consumers, or cause them to switch health insurers only to see their previous insurer and preferred hospital form an agreement after all.

Our mediation guidelines aim to:

- ensure that parties keep discussion of negotiations to themselves and don't provide negative comment to the media
- ensure that pre-booked patients and those with ongoing treatment are not affected by the dispute as they can't easily change health care providers or insurers
- pause the termination date of the previous agreement to allow the parties time to consider the other side's argument and reconsider their position with the best chance of reaching agreement.

Our mediation guidelines are not mandatory and there have been instances of unnecessary comment in the media. Such instances are unfortunate as they worry patients unnecessarily, and have a negative impact on the perception of the whole health insurance and private hospital industry in the eyes of consumers.

During 2014–15 we assisted a number of health care providers and health insurers with advice on how to proceed with their negotiations and what steps they could take on their own without seeking our assistance in mediation.

Voluntary mediation occurred on three occasions during the year: Epworth HealthCare and Medibank Private Ltd in August 2014; St Vincent's Health Australia Ltd and Medibank Private Ltd in October 2014; and Little Company of Mary Health Care Ltd (Calvary Health Care) and Australian Health Service Alliance Ltd in October-November 2014.

In all these cases the parties reached an agreement, usually after the formal mediation day conducted by PHIO. Our mediation aims were achieved so that there was a minimal negative impact on the private health insurance consumers affected, and in particular for those expecting treatment at the time contracts were being negotiated.

1 Section 78-1(5) *Private Health Insurance Act 2007* requires insurers to disregard the existence or otherwise of a health insurer's contracts with health care providers in working out whether portability of benefits applies.

Consumer information website

Our website, Privatehealth.gov.au, continues to be the leading independent source of private health insurance information for Australian consumers. It publishes information on every health insurance policy from every health insurer in Australia, comparing over 20,000 policies in a Standard Information Statement format that makes it easy for consumers to compare their own policy with others available for purchase.

Website usage has continued to grow annually since the site's launch in 2007, with 1,054,858 unique visitors throughout 2014–15, an increase of 17% on the previous year. Over 54% of the enquiries received in 2014–15 were via the website, either by email or telephone.

The most commonly discussed topics include government surcharges and incentives, how health insurance works, waiting periods and how to use the website to compare policies.

ROLE AND FUNCTIONS

Introduction

The role of the Ombudsman is to protect the interests of consumers in relation to private health insurance.

During the 2014–15 financial year the Private Health Insurance Ombudsman was a statutory agency established under the *Private Health Insurance Act 2007*. This report will summarise the Ombudsman's activities under that Act for 2014–15 unless otherwise indicated.

On 1 July 2015 the functions of PHIO were assumed by the Commonwealth Ombudsman under the *Ombudsman Act 1976*.

Functions

The Ombudsman is an independent body that resolves complaints about private health insurance and acts as the umpire in dispute resolution at all levels within the private health industry. The Ombudsman also reports and provides advice to industry and government about issues affecting consumers in relation to private health insurance, and has an important consumer information and advice role.

The functions of the Ombudsman were outlined in section 238-5 of the *Private Health Insurance Act 2007* as follows:

- Deal with complaints and conduct investigations
- Publish aggregate data about complaints
- Publish the *State of the Health Funds Report*
- Make recommendations to the Minister or Department of Health
- Report to the Minister or the department about the practices of particular private health insurers, private health providers and private health insurance brokers or other related parties
- Collect and publish information about complying health insurance products (that is, manage the consumer website PrivateHealth.gov.au)
- Promote a knowledge and understanding of the Ombudsman's functions
- Undertake any other functions that are incidental to the performance of any of the preceding functions.

Who can make a complaint?

Anyone can make a complaint, as long as it is relevant to private health insurance. The objective of PHIO is to 'protect the interests of people covered by private health insurance'. The Ombudsman will look into complaints that concern private health insurance consumers, but the office may not investigate complaints of a purely commercial nature that do not have significant impact on the rights of consumers.

Objects of complaint

Complaints may be made against private health insurers, health care providers and private health insurance brokers.

What can the Ombudsman do with a complaint?

The Private Health Insurance Ombudsman is able to deal with complaints by:

- referring the complaint to the health insurer, broker, hospital or provider, with a request to report to the Ombudsman with its findings and any action it proposes to take. If the Ombudsman is not satisfied with the explanation or proposed action, the Ombudsman may further investigate the complaint and make a formal recommendation
- mediating between the complainant and the subject of the complaint
- referring the complaint to the Australian Competition and Consumer Commission
- referring the complaint to any other appropriate body.

The Ombudsman is also able to investigate the practices and procedures of health insurers, health care providers and health insurance brokers. Under the Act, the Minister was able to request the Ombudsman to undertake such an investigation.

What happens at the end of a complaint or investigation?

At the end of a complaint or investigation the Ombudsman is able to recommend that:

- health insurers, health care providers and health insurance brokers take a specific course of action in relation to a complaint
- a health insurer changes its rules or practices.

In certain circumstances the Ombudsman may request that a health insurer, health care provider or health insurance broker provide a report on any action taken as a result of the Ombudsman's recommendations.

Section 241-35 of the *Private Health Insurance Act 2007* provided various grounds for the Ombudsman to decide not to deal with a complaint. These include if the:

- complainant has not taken reasonable steps to negotiate a settlement
- complainant is capable of assisting the Ombudsman in dealing with the complaint but does not do so on request
- subject of the complaint has dealt, or is dealing, adequately with the complaint or has not yet had an adequate opportunity to do so
- complainant does not have a sufficient interest in the subject matter of the complaint
- matter is trivial, vexatious or frivolous; or the complaint was not made in good faith
- Ombudsman or another organisation has already been dealing with, or has dealt with, the complaint adequately
- complaint is mainly about commercial negotiations and it is not appropriate to deal with the complaint.

How the Ombudsman's staff resolve complaints

The Ombudsman deals with most complaints by telephone, email and fax. Where complainants have not made a sufficient attempt to resolve their complaint with their health insurer or provider, staff will usually refer complainants back to these parties in the first instance. Staff will refer the complaint themselves in order to provide a faster and more convenient service.

Where complaints are complex, or where formal contact with the health insurer has been unable to resolve the problem, the Ombudsman will write to the insurer or provider seeking further information.

Staff members regularly keep complainants informed of developments about complaints, usually by telephone. The Ombudsman will advise complainants of the outcome of a complaint.

Complainants may seek a review of their case if they are not satisfied with the response, or seek further clarification of the reasons for a decision.

PERFORMANCE

Performance indicators

The 2014–15 Portfolio Budget Statements (PBS) indicate that the Private Health Insurance Ombudsman contributed to the Commonwealth Department of Health and Aged Care PBS Outcome Number 6, Private Health: 'Improved choice in health services by supporting affordable, quality private health care, including through private health insurance rebates and a regulatory framework'.

We contributed to this outcome by protecting the interests of private health insurance consumers. We promoted consumer confidence through an accessible, effective and timely complaint-handling service that is objective and non-judgemental.

We mediated between insurers and health care providers to resolve issues and complaints. We also worked to identify administrative problems that underlie the practices of private health insurers or health care providers, and encouraged health insurers to continuously improve their own complaints handling practices.

We provided consumer and education services to enhance awareness of health insurance options. In order to provide consumers with accurate and relevant guidance and advice, we investigated the practices and procedures of insurers and health care providers.

We also provided advice and recommendations to government and industry about private health insurance, specifically the performance of the sector and the nature of complaints. To protect the interests of private health insurance consumers, PHIO reported and made recommendations to government about industry practices.

The PBS outlined the Ombudsman's program to promote public confidence in private health insurance in 2014–15:

- Closure of PHIO, including wind-up and transfer of its functions, assets and liabilities to the Office of the Commonwealth Ombudsman by 1 July 2015
- Protect the interests of private health consumers
- Improve the quality and accessibility of private health insurance information
- Provide an efficient and effective complaint-handling service.

The following is a summary of performance outcomes against the program's formal performance indicators in 2014–15.

Deliverables

Qualitative deliverables

Closure of the entity, including wind-up and transfer of its functions, assets and liabilities to the Office of the Commonwealth Ombudsman by 1 July 2015

QUALITATIVE DELIVERABLES	2014–15 REFERENCE POINT OR TARGET	2014–15 RESULT
PHIO programs and activities are transferred to the Office of the Commonwealth Ombudsman	Information and support is provided to the Office of the Commonwealth Ombudsman to assist in the smooth transfer of programs and activities	PHIO and OCO managed the change process through regular meetings and teleconferences, successfully transferring PHIO programs and activities by 1 July 2015
PHIO assets and liabilities are identified and transferred to the Office of the Commonwealth Ombudsman	Due diligence completed to identify all assets and liabilities Support provided to transfer assets and liabilities to the Office of the Commonwealth Ombudsman	PHIO assets and liabilities transferred to OCO following due diligence and change management process
Final annual report prepared	Information is provided to allow the final annual requirements for PHIO to be discharged	PHIO completed final annual report for 2014–15 according to requirements of the *Private Health Insurance Act 2007*

Protect the interests of private health insurance consumers

QUALITATIVE DELIVERABLE	2014–15 REFERENCE POINT OR TARGET	2014–15 RESULT
Investigate the practices and procedures of health insurers	Timely investigation and mediation of complaints as required	PHIO staff worked closely with industry stakeholders to identify and address systemic issues causing complaints against specific insurers or across the industry as a whole. PHIO staff were involved in mediating complaints between health insurers and healthcare providers

Improve the quality and accessibility of private health insurance information

QUALITATIVE DELIVERABLE	2014–15 REFERENCE POINT OR TARGET	2014–15 RESULT
Provide consumers with accurate and up-to-date information	Regular and timely updates of the private health insurance consumer website www.privatehealth.gov.au and production of private health insurance fact sheets	Website updated regularly in response to industry changes and feedback from consumers. 83% of surveyed website clients rated information as easy to find and 81% rated the information as very good or of satisfactory quality

Quantitative deliverables

Protect the interests of private health insurance consumers

QUANTITATIVE DELIVERABLE	2014–15 BUDGET TARGET	2014–15 RESULT
Number of high-quality and timely advisory services, policy advice, submissions and reports	>12	>12

Key performance indicators

Qualitative key performance indicators

Protect the interests of private health insurance consumers

QUALITATIVE INDICATOR	2014–15 REFERENCE POINT OR TARGET	2014–15 RESULT
Production of high-quality and timely advisory services, policy advice, submissions and reports	Positive stakeholder feedback on the information products	Consumer brochures were sent directly to consumers, accessed online, and distributed by health insurers, hospitals and providers. Over 72,000 brochures were distributed throughout the year. The consumer website received 1,054,858 unique visitors, an increase of 17% on the previous year

Improve the quality and accessibility of private health insurance information

QUALITATIVE INDICATOR	2014–15 REFERENCE POINT OR TARGET	2014–15 RESULT
Provide independent and reliable information to consumers via the private health insurance consumer website www.privatehealth.gov.au	Measured by website survey and feedback and consumer focus testing, which indicates the information provided is viewed as independent and reliable	83% of surveyed website clients rated information as easy to find. 81% rated the information as very good or of satisfactory quality

Quantitative key performance indicators

Protect the interests of private health insurance consumers

QUANTITATIVE INDICATOR	2014–15 BUDGET TARGET	2014–15 RESULT
Percentage of recommendations to private health insurers that have resulted in changes to insurer or industry practices	75%	Not applicable as no formal recommendations regarding industry practices were made in 2014–15

Provide an efficient and effective complaint-handling service

QUANTITATIVE INDICATOR	2014–15 BUDGET TARGET	2014–15 RESULT
Percentage of clients satisfied with complaint-handling service	85%	84% The slight decrease in satisfaction is attributable to a higher number of complex disputes this year. Although PHIO continued to handle complaints in a similar way, satisfaction rates are lower when complainants do not achieve a payment or similar favourable outcome

Complaints

The Ombudsman received 4265 complaints during 2014–15, a 24% increase on the 3427 complaints received in 2013–14. After several years where complaint levels remained steady, this is the second consecutive year with a significant increase in the total number of complaints.

Of those complaints, 16% (668) were classified as level 3 disputes, a similar proportion to last year's 17% (580). Level 3 complaints are those where a member of the Ombudsman's dispute resolution staff requests a detailed report from a health insurer or other subject of a complaint. The report is then reviewed and a decision made as to whether the initial response was satisfactory or whether a further investigation is warranted.

Figure 1 shows the distribution of complaints over the four quarters of the 2014–15 financial year. Figure 2 shows the total number of complaints received per year since 1999–2000.

The increase in the number of complaints in the 2000–01 year was associated with a large increase in the number of Australians covered by private health insurance following the introduction of the Government Rebate and Lifetime Health Cover.

The reduction in complaints after 2002–03 is mostly attributable to a decline in complaints about premium increases and improvements to complaint-handling processes within the health insurance industry.

Figure 1 Complaints by Quarter

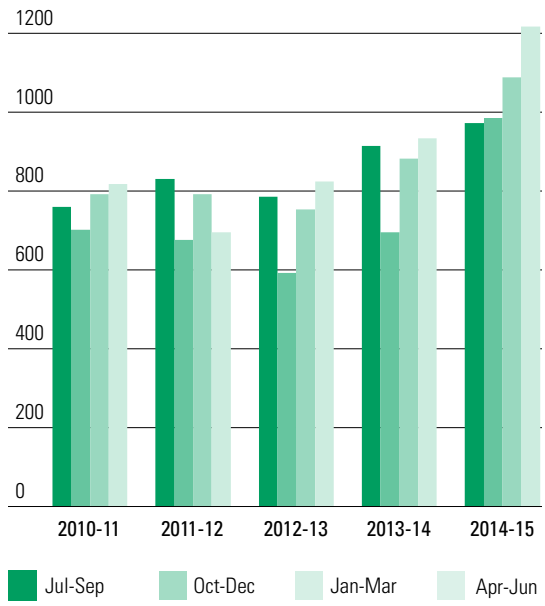
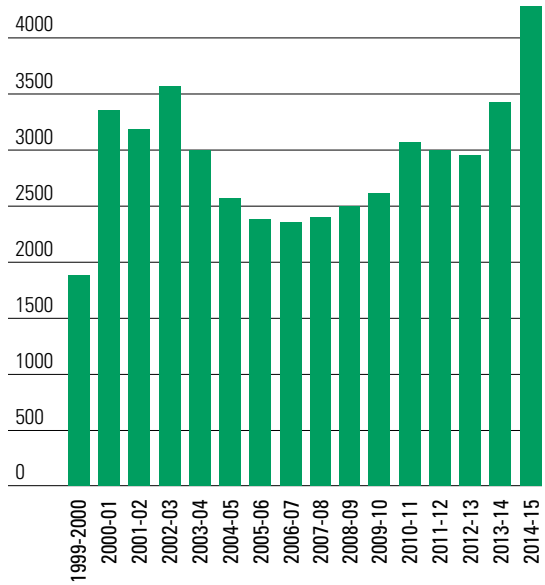


Figure 2 Complaints by Year



Consumer enquiries: the Ombudsman's consumer education function

Enquiries are instances where Ombudsman staff provide advice or information where the matter does not meet the definition of a complaint. We recorded 2415 consumer enquiries in 2014–15, compared to 2623 in 2013–14.

More than 53% of enquiries were received via our consumer website PrivateHealth.gov.au. Using the 'Ask a question' feature on the website, consumers can contact us by completing a form, and generally receive a response within one to two working days.

Enquiry levels tend to be seasonal, with spikes in activity in March 2015, when health insurers sent out their rate increase letters to members and changes to the Australian Government Private Health Insurance Rebate took effect, and in June 2015, with the commencement of the Department of Health's annual Lifetime Health Cover mailing. These factors caused heightened consumer awareness of private health insurance in those periods. (See the consumer website section for more information.)

Recording and categorisation of complaints

Approaches to the Ombudsman's office were recorded as complaints when they met the criteria contained in the *Private Health Insurance Act 2007*. A complaint must be an expression of dissatisfaction with a matter arising out of or connected with a private health insurance arrangement. Complaints can be made by, and be concerned with:

- private health insurance members
- a hospital, a doctor or other practitioner
- a health insurer
- a health insurance broker.

Complaints dealt with by the Ombudsman range from simple contacts that do not require investigation and can be referred to the service provider for resolution, through to matters requiring mediation or a formal recommendation under the Act. The Ombudsman's complaints categorisation takes account of the following factors:

- Type of approach
- Degree of effort required by Ombudsman staff to resolve the matter
- Any potential sensitivity.

In 2014–15 complaints were categorised as follows:

COMPLAINT LEVEL 1 (PROBLEMS): MODERATE LEVEL OF COMPLAINT

Level 1 complaints are dealt with by referring the complainant back to the subject of the complaint. This occurs where, in the view of the Ombudsman, the complainant has not made an adequate attempt to resolve the problem or the Ombudsman is able to suggest to the complainant other ways of approaching the problem. Issues within this category may fall anywhere across the complaint spectrum including product description, benefits paid, informed financial consent, pre-existing ailments and service quality.

In 2014–15, 79% of level 1 complaints were resolved as 'assisted referrals' (similar to the 77% resolved as assisted referrals in the previous year) where the Dispute Resolution Officer referred a complaint directly to a specifically arranged representative in the insurer or service provider.

When this occurs the officer will counsel the complainant, advise them of the complaint process and timeframes, ensure the complaint is responded to by the other party, and offer to investigate the complaint at a later date if the matter is not resolved.

This approach ensures a quicker turnaround time and enables the appropriate person within an organisation to assist the complainant. The Ombudsman's client satisfaction survey indicates that complainants are more often satisfied with the office if assistance is provided by staff members in this way.

Complainants are always advised that if they are not satisfied after their health insurer or health care provider contacts them, the Ombudsman can then contact the other party and ask for a report in order to review the complaint. When this occurs, the complaint is reclassified as a level 3 complaint.

COMPLAINT LEVEL 2 (GRIEVANCES): MODERATE LEVEL OF COMPLAINT RESOLVED WITHOUT REQUIRING A REPORT FROM THE SUBJECT OF THE COMPLAINT

Level 2 complaints are dealt with by staff investigating issues of grievance and providing additional information or a clearer explanation directly to the complainant.

Complaints within this category generally result from a misunderstanding by consumers of their rights under the policy they have purchased, including concerns about service levels provided by the insurer or provider, price increases, benefit limitations and waiting periods. The provision of an explanation by the Ombudsman as an independent third party is generally sufficient to conclude the complaint.

COMPLAINT LEVEL 3 (DISPUTES): HIGHEST LEVEL OF COMPLAINT WHERE SIGNIFICANT INTERVENTION IS REQUIRED

Level 3 complaints are dealt with by Ombudsman staff contacting the subject of the complaint and requesting a formal report. Issues in this category will have previously been the subject of dispute between the complainant and the insurer or service provider and not have been resolved.

The Ombudsman attempts resolution through conciliation by telephone or in writing. Common complaints in this category include pre-existing ailments, lack of informed financial consent, benefits available on transfer of membership, benefits not in accordance with brochure descriptions and contribution errors.

Figure 3 and Figure 4 show the ratio of complaints by level. This year, 3135 (73%) complaints were classified as level 1, 462 (11%) as level 2 and 668 (16%) as level 3. While the overall numbers of complaints rose in 2014–15, the proportion of complaints in each level remained steady from previous years. Level 3 complaint numbers have remained relatively low in recent years, as most cases are resolved by direct referral to the insurer.

Figure 3 Complaints by Level

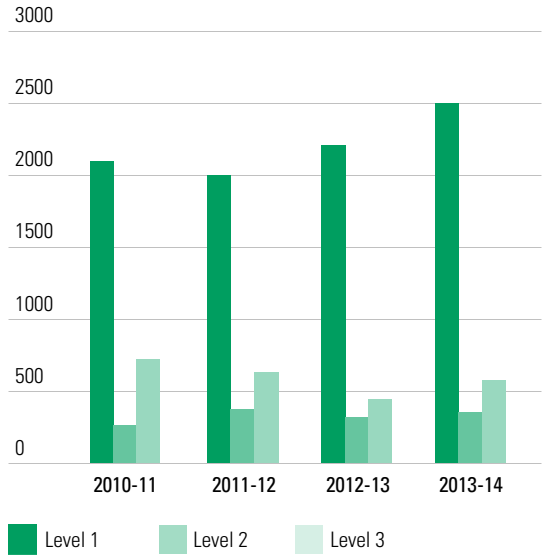
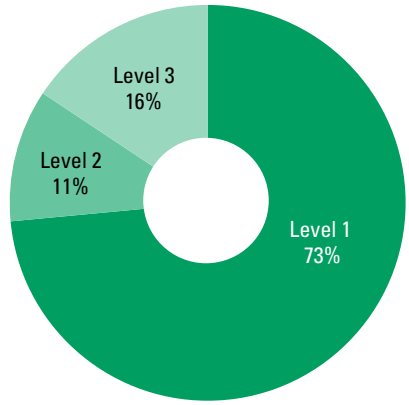


Figure 4 Complaints by Level, 2014–15



Complaint audit and escalation

During the reporting period about one-quarter of the level 3 complaints reported were initially recorded as level 1 complaints. These were upgraded either because the complainant was not satisfied with the insurer's initial response or further investigation of the matter was required.

A complaint's categorisation may be changed during our continuous audit process. Complaints are audited by a senior member of staff, who reviews details of the complaint to ensure the complainant's concerns have been addressed and that the categorisation of complaints is accurate and consistent. If the audit shows, for example, that a complaint initially thought to be a simple (assisted referral) complaint turned out to be a more complex matter requiring further investigation, it is reclassified as a level 3 complaint.

Complaint-handling procedures

The process and timeframes for the different complaint categories are shown in Figure 5. The majority of complaints are from members of health insurers about their own insurer. However, there are instances where a complaint needs to be recorded against both the health insurer and a health care provider.

This occurs, for example, where the complaint involves contradictory advice from an insurer and a hospital about how much of a hospital bill will be paid by the insurer.

Health insurer members can also lodge complaints about health care providers, including:

- hospitals (generally about inadequate information to enable informed financial consent)
- doctors (almost always about lack of informed financial consent or the gap between charges and benefits paid through Medicare and the insurer)
- other practitioners (generally about the gap between the charges and the benefit paid on general treatment policies)
- health insurance brokers (usually related to information provided when joining an insurer).

Overall, complaints against provider groups are small in number when compared with complaints against health insurers. Health care providers can also lodge complaints against health insurers.

These are numerically small but generally of a complex nature. Issues relating to selective contracting and difficulties in arriving at a satisfactory conclusion to a contract or arrangement constitute the majority of complaints from this group.

Figure 5 Steps In Handling Approaches To The Ombudsman

	LEVEL 1 (PROBLEM)	LEVEL 2 (GRIEVANCE)	LEVEL 3 (DISPUTE)
Timeframe	Immediate.	Usually within 24 hours.	Depends on the nature and complexity of matter and responses from health insurer and provider.
Actions	If complainant has made insufficient effort to resolve the matter with insurer or provider, refer complaint to insurer on behalf of complaint or empower the complainant to take the matter up directly.	Complainant provided with explanation or information to resolve matter, or explanation if there is no avenue for the Ombudsman to take up the matter.	PHIO contacts health insurer or provider to obtain a report, then mediates the dispute between the parties or investigates the matter further.
Outcomes	Referral to health insurer or provider. Complainant may also contact PHIO and request a review; these matters may then be upgraded to a Level 3 complaint (Dispute).	Detailed information provided which appropriately resolves the issue.	Explanation of health insurer or provider's action; mediated resolution including payment of benefits; or formal recommendation by Ombudsman.

Workload

The office received 4265 complaints in 2014–15. This was an average of 355 complaints per month, a significant increase compared to 286 complaints per month in the previous year. Of those complaints, 668 were level 3, compared to 580 in the previous year.

The office closed 4170 complaints in 2014–15, or 347 per month, of which 627 were level 3. In 2013–14 we closed 3047 complaints, or 253 per month, of which 570 were level 3.

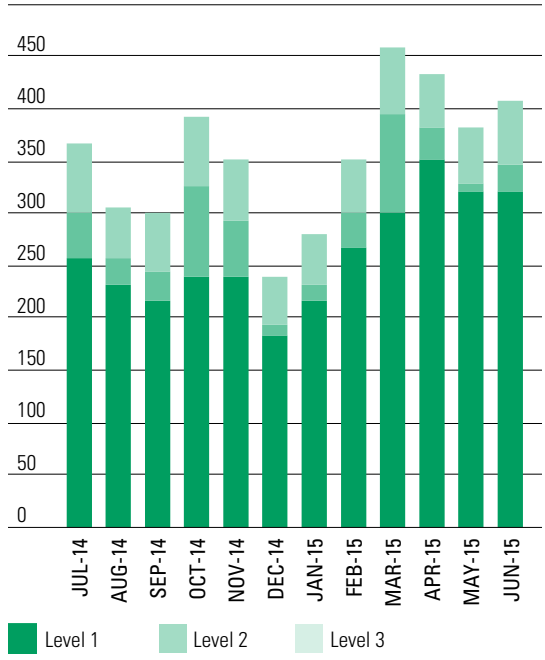
We recorded 2415 consumer enquiries in 2014–15, compared to 2623 in 2013–14.

Figure 6 shows the number of complaints by month and level. As mentioned earlier, we tend to receive a high number of contacts during the March to June period each year, due to the annual premium increase mailings by all health insurers, and the Lifetime Health Cover and Medicare Levy Surcharge deadlines at the end of the financial year.

However, it is important to note that most complaints concern other issues unrelated to the premium increase. It seems the annual mailings remind consumers to contact their insurer regarding existing matters.

This year there was also a significantly higher level of complaints in October and November. This was mainly due to changes made by one insurer to reduce benefits for one of its popular general treatment (extras) policies.

Figure 6 Complaint level by month



Time taken to resolve complaints

Figure 7 and Figure 8 provide information on the time taken to resolve complaints this year compared to last year. The office continues to handle the majority of complaints within one month, with 90.1% finalised within 30 days, a similar figure to the 90.3% in the previous year.

There was a slight decrease in the number of complaints resolved within one day and a proportionate increase in those resolved within two to seven days and eight to 30 days. This change is attributable to a change in case recording processes.

Figure 7 Time taken to resolve complaints (%)

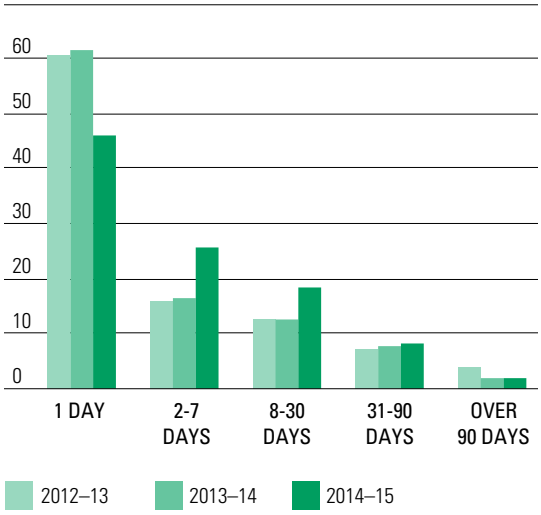
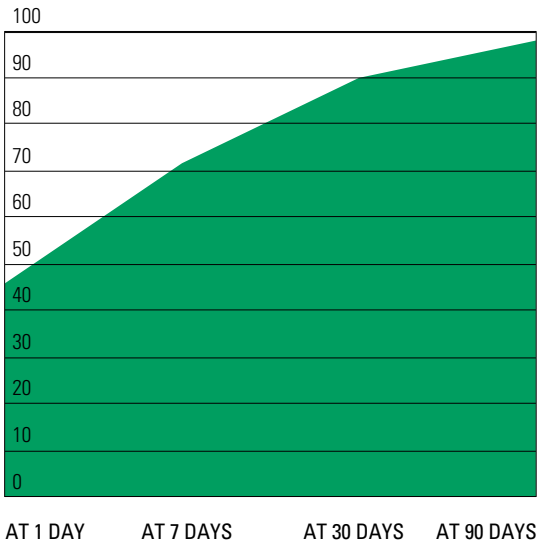


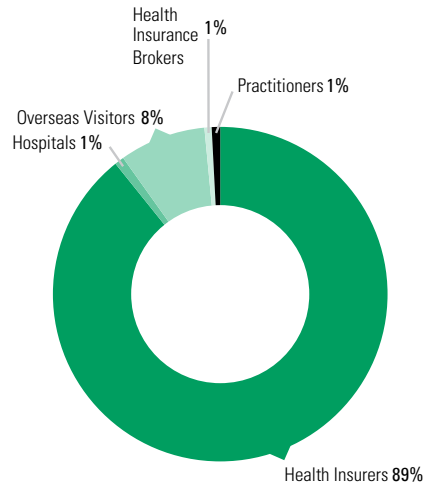
Figure 8 Complaints closed since day of lodgement 2014–15 (%)



Who was complained about

Figure 9 shows most complaints (89%) were made about registered health insurers, followed by overseas visitors insurers (8%), practitioners (1% including doctors, dentists and other health care providers), hospitals (1%) and health insurance brokers (1%). These figures remain steady from previous years.

Figure 9 Complaint Objects, 2014–15



Complaints about registered health insurers

Figure 10 provides a summary of all complaints for individual health insurers compared with their market share. This data is also presented for the higher-category level 3 complaints. Analysing the information at this further level of detail provides a more realistic picture of the way insurers respond to their members' complaints. A high ratio of level 3 complaints compared to market share points to a less-than-adequate internal dispute resolution process for complex issues within the insurer.

Figure 10 Complaints by Health Insurer Market Share (2014–15)

	COMPLAINTS	PERCENTAGE OF COMPLAINTS	DISPUTES	PERCENTAGE OF DISPUTES	MARKET SHARE
ACA	1	0.0%	0	0.0%	0.1%
Australian Unity	214	5.8%	20	3.4%	3.2%
BUPA	1022	27.6%	151	25.9%	26.7%
CBHS	36	1.0%	5	0.9%	1.3%
CDH (Cessnock)	1	0.0%	0	0.0%	<0.1%
CUA	19	0.5%	4	0.7%	0.5%
Defence	23	0.6%	2	0.3%	1.7%
Doctors	5	0.1%	0	0.0%	0.2%
GMHBA	43	1.2%	6	1.0%	1.9%
Grand United Corporate	20	0.5%	4	0.7%	0.4%
HBF	99	2.7%	14	2.4%	7.4%
HCI	3	0.1%	0	0.0%	0.1%
Health.com.au	73	2.0%	24	4.1%	0.5%
Health Insurance Fund of Australia	26	0.7%	3	0.5%	0.7%
HealthGuard (GMF/Central West)	14	0.4%	2	0.3%	0.5%
Health-Partners	5	0.1%	2	0.3%	0.6%
HCF (Hospitals Contribution Fund)	551	14.9%	110	18.9%	10.8%
Latrobe	17	0.5%	0	0.0%	0.7%
Medibank (AHM)	1028	27.8%	162	27.8%	29.1%
Mildura	0	0.0%	0	0.0%	0.2%
National Health Benefits (Onemedifund)	0	0.0%	0	0.0%	0.1%
Navy	1	0.0%	0	0.0%	0.3%
NIB	399	10.8%	55	9.5%	7.7%
Peoplecare	10	0.3%	1	0.2%	0.5%
Phoenix	2	0.1%	0	0.0%	0.1%
Police	5	0.1%	3	0.5%	0.3%
Queensland Country Health	3	0.1%	1	0.2%	0.3%
Railway and Transport	9	0.2%	4	0.7%	0.4%
Reserve	1	0.0%	0	0.0%	<0.1%
St Lukes	4	0.1%	0	0.0%	0.4%
Teachers Health	45	1.2%	3	0.5%	2.0%
Teachers Union	9	0.2%	4	0.7%	0.5%
Transport	5	0.1%	1	0.2%	0.1%
Westfund	10	0.3%	1	0.2%	0.7%
TOTAL	**3703**		**582**		

Complaints about hospitals

We received 38 complaints about hospitals, steady from the 40 complaints received in the previous year. The office recorded 50 informed financial consent (IFC) complaints relating to hospital bills, compared to 40 complaints in the previous year.

Complaints about hospitals and hospital-related bills usually occur when patients experience unexpected gaps for a hospital admission. In most cases there are adequate processes in place in private hospitals to ensure the provision of IFC to patients, so the number of complaints about unexpected gaps is low compared with the number of hospitalisations taking place each year.

Most consumers who face hospital gap charges are those who hold policies with restrictions or exclusions on certain treatments, or who were admitted to hospital within their waiting periods. The office also assisted a small number of consumers who were asked to pay unexpected hospital gaps because their health insurer did not have a contractual agreement with the hospital they were intending to visit.

Complaints about practitioners

Most complaints about doctors and practitioners concerned medical gap issues and/or a lack of IFC.

It was pleasing to see that IFC complaints against practitioners (including doctors, dentists and other practitioners) decreased to 19 this year, compared to 25 in the previous year.

Complaints about health insurance brokers

Complaints about brokers concern issues relating to the information provided on joining and the level of cover chosen. There were 34 complaints about brokers in 2014–15, compared to 42 the previous year.

The major cause of complaints against brokers was the provision of oral advice to people joining or transferring between health insurers. After switching between insurers or joining for the first time, these consumers later found that brokers had supplied incorrect or incomplete details about their new policies, leaving them with unexpected exclusions and restrictions or waiting periods to complete.

Administrative delays and service issues for members trying to cancel existing or new policies was also a significant cause of complaints against brokers.

Resolving complaints

Figure 11 shows 25% of all complaints were resolved by the Ombudsman's office providing an additional and independent explanation of the member's complaint. A further 59% of all complaints were referred directly to health insurers with the assistance of Ombudsman staff, on the understanding that the complainant could request an Ombudsman's review of the complaint if they remained unsatisfied. These figures are similar to the previous year.

Our arrangements for assisted referrals are designed to allow complainants and insurers to quickly resolve the majority of complaints using an informal approach, where we may suggest ways for the complaint to be resolved. Complainants are made aware that if they remain dissatisfied with the response they receive via the informal referral process, they are able to approach us again for a review of their case.

Seven per cent of complaints were resolved by standard referral; that is, the complainant obtained advice from the Ombudsman's office and then referred their complaint to the appropriate body themselves. In 3% of cases the health insurer resolved the issue by making a payment, and 3% were resolved by another satisfactory outcome.

Figure 11 Outcomes – All complaints

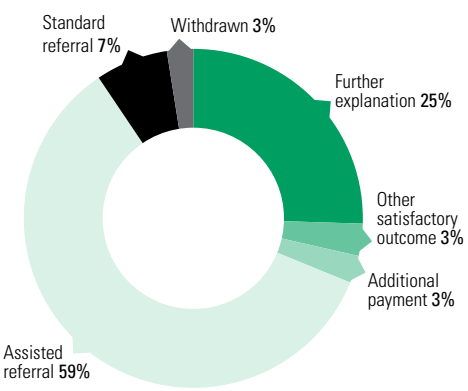
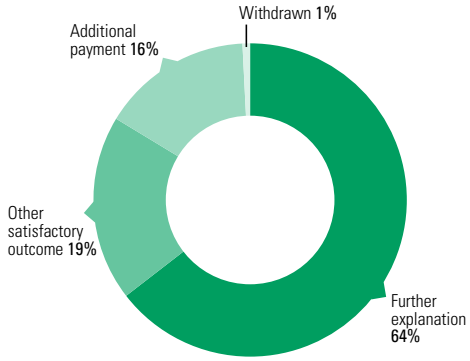


Figure 12 Outcomes – Level 3 Disputes



Resolving level 3 complaints

Figure 12 shows that 64% of level 3 complaints were resolved by giving a more detailed explanation to the member, 1% were withdrawn by the complainant, and the remaining 35% were resolved by a payment or other satisfactory outcome.

These payments usually followed an investigation by the Ombudsman where the health insurer agreed that a member was entitled to a benefit payment or some other payment. In some cases payment was made by health insurers on an ex gratia basis; for instance, where the insurer paid a benefit the member was not entitled to under their policy.

Some complaints were resolved by a hospital agreeing to reduce an account because IFC to out-of-pocket gaps had not been obtained from the member.

Who complained

The *Private Health Insurance Act 2007* allows private health insurance members, health care providers, health insurance brokers or persons acting on their behalf to lodge complaints. The overwhelming majority of complaints were made by health insurance members (4222 or 99%). A further 29 complaints were made by practitioners, 11 by hospitals and one from a health insurer.

How complaints were made

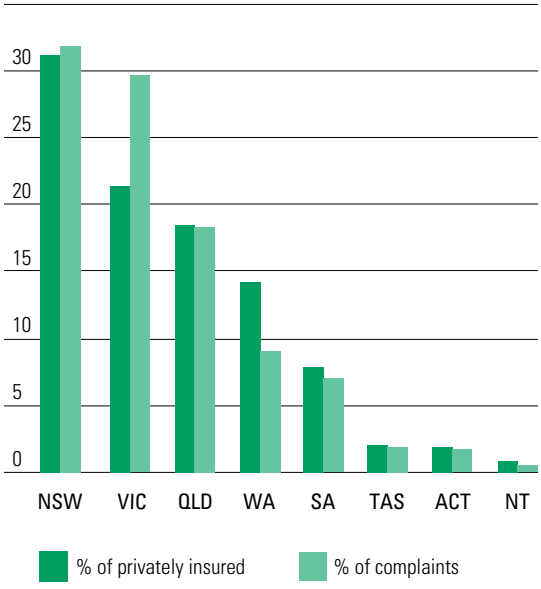
Although the majority of complaints continue to be lodged by telephone, the proportion of complaints received by internet or email has risen steadily. In 2014–15, 55% of complaints were initially made by phone (59% in the previous year) and 43% by internet or email (40%).

Other methods of complaint continued to be very low. Only 1.2% of complaints were received by letter, up slightly from 0.85% in the previous year; and the remainder of other complaint mediums — including fax, personal visit and parliamentary representation — comprised less than 0.2%.

Complaints by state or territory

Figure 13 identifies where complaints originate on a state-by-state basis. This data is shown by state and territory, against the percentage of people who have private health insurance coverage. The figures show that, proportionally, Victorians were more likely to have a health insurance complaint than other states.

Figure 13 Complaints by Population covered by State or Territory



Investigations

From 1 July 2014 to 30 June 2015 there were no formal investigations under section 244 of the *Private Health Insurance Act 2007*.

COMPLAINT ISSUES AND CASE STUDIES

Introduction

Section 241-10 of the *Private Health Insurance Act 2007* states that complaints to the Ombudsman were to concern a health insurance arrangement. For reporting purposes, complaints are classified in terms of broad issues and sub-issues.

Most complaints are about benefits, followed by information, service issues, membership issues and waiting periods. Figure 14 and Figure 15 illustrate the proportion of complaints corresponding to each issue type.

Figure 16 shows the number of complaints received for each sub-issue this year compared to the previous year. A key function of the Ombudsman's office is to monitor the levels of complaints over time and investigate the causes of consumer dissatisfaction.

Figure 14 Complaint Issues 2014–15

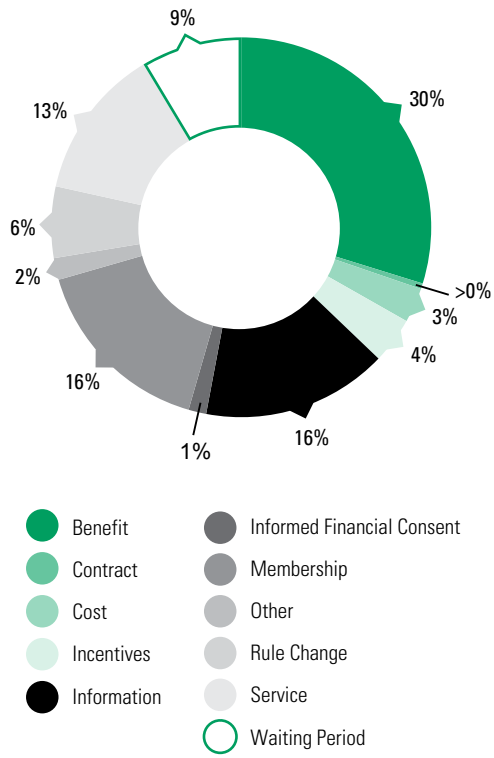


Figure 15 Complaint Issues 2012-13 to 2014–15

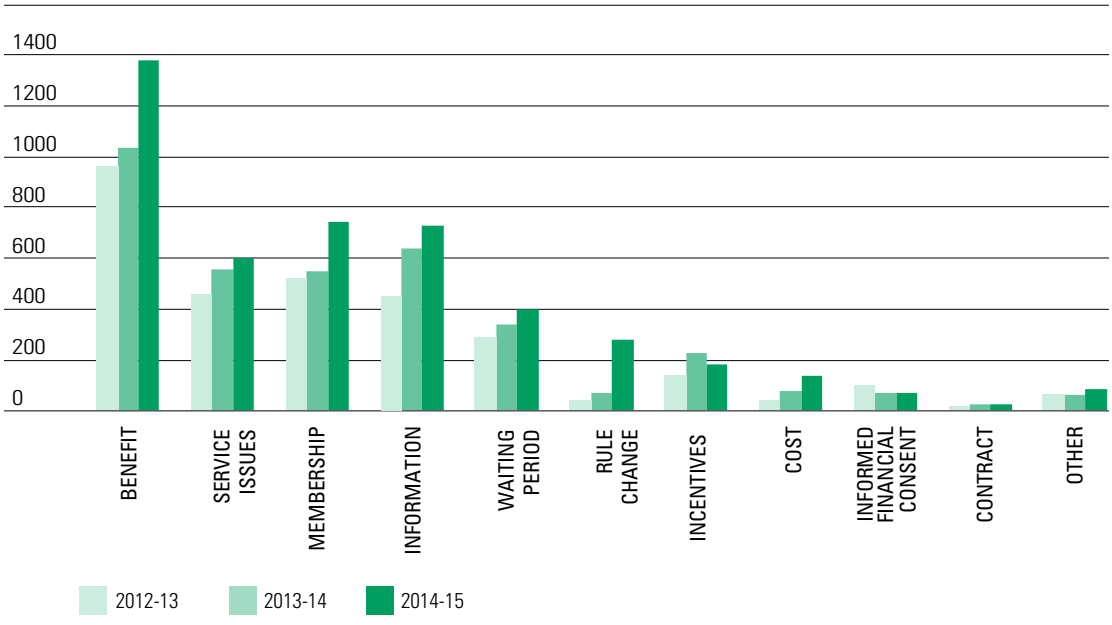


Figure 16 Complaint sub-issues

ISSUE	SUB-ISSUE	2012–13	2013–14	2014–15
Benefit	Accident and emergency	15	23	40
Benefit	Accrued benefits	7	4	9
Benefit	Ambulance	37	36	51
Benefit	Amount	32	58	63
Benefit	Delay in payment	157	147	154
Benefit	Excess	40	48	56
Benefit	Gap - Hospital	32	23	50
Benefit	Gap - Medical	56	38	131
Benefit	General treatment (extras/ancillary)	69	78	105
Benefit	High cost drugs	15	11	13
Benefit	Hospital exclusion/restriction	180	242	320
Benefit	Insurer rule	140	152	192
Benefit	Limit reached	22	28	24
Benefit	New baby	7	11	22
Benefit	Non-health insurance	15	19	8
Benefit	Non-health insurance - overseas benefits	9	8	8
Benefit	Non-recognised other practitioner	26	16	29
Benefit	Non-recognised podiatry	19	15	12
Benefit	Other compensation	6	10	16
Benefit	Out of pocket not elsewhere covered	16	12	9
Benefit	Out of time	15	15	19
Benefit	Preferred provider schemes	36	44	50
Benefit	Prostheses	12	10	9
Benefit	Workers compensation	2	1	2
Contract	Hospitals	13	15	10
Contract	Preferred provider schemes	3	9	9
Contract	Second tier default benefit	2	4	3
Cost	Dual charging	3	2	5
Cost	Rate increase	38	78	132
Informed Financial Consent	Doctors	41	25	19
Informed Financial Consent	Hospitals	54	40	50
Informed Financial Consent	Other	5	7	1
Incentives	Lifetime Health Cover	106	163	156
Incentives	Medicare Levy Surcharge	12	21	12
Incentives	Rebate	10	39	13
Incentives	Rebate tiers and surcharge changes	13	5	1

ISSUE	SUB-ISSUE	2012–13	2013–14	2014–15
Information	Brochures and websites	53	65	47
Information	Lack of notification	55	96	91
Information	Oral advice	289	410	522
Information	Radio and television	1	2	4
Information	Standard Information Statement	11	5	8
Information	Written advice	45	66	64
Membership	Adult dependents	7	15	25
Membership	Arrears	43	93	144
Membership	Authority over membership	14	16	20
Membership	Cancellation	192	218	299
Membership	Clearance certificates	152	106	108
Membership	Continuity	56	72	100
Membership	Rate and benefit protection	8	5	19
Membership	Suspension	55	41	50
Service	Customer service advice	63	52	82
Service	General service issues	111	207	184
Service	Premium payment problems	144	141	184
Service	Service delays	151	164	155
Waiting Period	Benefit limitation period	2	5	6
Waiting Period	General	28	34	41
Waiting Period	Obstetric	35	47	49
Waiting Period	Other	16	22	19
Waiting Period	Pre-existing conditions	207	229	283
Other	Access	0	0	0
Other	Acute care certificates	1	1	4
Other	Community rating	0	1	0
Other	Complaint not elsewhere covered	37	33	56
Other	Confidentiality and privacy	9	12	12
Other	Demutualisation/sale of health insurers	1	2	1
Other	Discrimination	3	1	3
Other	Medibank sale	0	1	0
Other	Non-English speaking background	0	0	0
Other	Non-Medicare patient	7	3	8
Other	Private patient election	6	10	3
Other	Rule change	41	72	281

How case studies are chosen

The following case studies highlight some of the regular complaints received by PHIO, rather than the most difficult or unusual cases. They have been chosen to illustrate the lessons that can be learned from complaints by both health insurers and consumers. The names, references and some details have been changed as needed to protect the privacy of individuals.

Benefits and level of cover

Complaints: 1379

Key issues:

- Hospital policy exclusions and restrictions
- Delays in payment
- Insurer rules that limit benefits

The most significant area of complaint to our office was benefits, with a total of 1379 complaints, compared to 1039 complaints in 2013–14. The main issues of concern for consumers were hospital policies with unexpected exclusions and restrictions. Some basic and budget levels of hospital cover, in particular, exclude or restrict services that many consumers assume are routine treatments or standard items.

Delays in benefit payments and complaints about insurer rules that limited benefits were the other significant areas of complaint. A complete list of the issues classified as benefit complaints is provided in Figure 16.

CASE STUDY

Medical procedures and cosmetic procedures

Noni had booked into hospital for an operation that would lift her drooping eyelids. When she called her health insurer with the Medicare Benefits Schedule (MBS) item numbers for the procedure, she was told she would need to provide more information from her doctor to prove she had a relevant medical condition. The health insurer told Noni this was part of their pre-approval process for all claims they considered to be potentially cosmetic.

Noni was not happy with this reply, as she had already checked with her doctor that the procedure was medical and not cosmetic, so she approached us for assistance.

On contacting the insurer, we were advised that the insurer required more information from Noni's doctor before they would decide if the claim could be paid. The insurer said that if Noni chose not to proceed with the pre-approval process, she could go ahead with the procedure but that the insurer would audit her claim after the fact.

If the insurer's audit procedure found that the MBS item number confirmed by Medicare did not match the procedure actually performed, the insurer would deny benefits for the claim, meaning Noni would be left with the entire hospital bill.

In other words, the insurer was asserting that even if the doctor considered that the procedure was required to treat a medical condition, and even if Medicare confirmed this by paying a benefit and assigning an MBS item number, the insurer still reserved the right to override the doctor and Medicare to deem the procedure to be cosmetic.

Our response to the insurer was that if Noni's eye surgery procedure was eligible for MBS benefits by Medicare, the insurer had to pay for her procedure according to the terms of her policy. The insurer had no authority to deny benefits on the basis that the insurer considered the procedure to be cosmetic.

In Australia, the role of the insurer in a hospitalisation is to provide benefits to members as appropriate under their chosen policies. It is not their role to decide which services are cosmetic or to require that their members request pre-approval for potentially cosmetic procedures. Only the doctor and their patient can decide which medical treatments they choose to undertake, and only Medicare has the authority to decide which treatments are considered cosmetic rather than medical.

The insurer agreed to pay for Noni's surgery, on the basis that her doctor had provided valid MBS item numbers and Medicare would be paying a benefit for the service as a medically necessary procedure.

Information complaints

Complaints: 732

Key issues:

- Oral advice provided by health insurer staff members
- Records or sales and benefit quote advice not being kept
- Brochures, websites and health insurer notification letters

Information complaints are usually brought to the office by consumers because they have misunderstood oral advice or written information provided by an insurer in relation to benefit amounts, or the inclusions and exclusions on a policy. A total of 732 information complaints were received this year, an increase on the 641 complaints in the previous year. Oral advice made up the majority (71%) of these complaints.

The issue of oral advice can be particularly complex if the insurer has not kept a clear record or call recording of their interaction with the member. Generally, record keeping in relation to call centre interactions is much improved in recent years across the industry, due to the introduction of voice recording technology.

Where there is a recording of a telephone interaction regarding the advice given to a member, it is much easier for the insurer or for PHIO to resolve the complaint. However, maintaining good record keeping practices by staff members working in the branch network, where call recording is not possible, remains a challenge.

CASE STUDY

Oral advice and call recordings

Due to a change in financial circumstances, Walter decided to change his hospital policy to a lower level of cover. When he called his insurer to make the change, the insurer staff member told him that if he needed to upgrade at later time, no waiting period would apply for in-hospital psychiatric treatment. Based on this incorrect advice, Walter chose to downgrade to a hospital policy which did not cover psychiatric benefits.

One year later Walter required hospitalisation to treat a psychiatric condition. When he called his insurer to upgrade his cover he was advised that a two-month waiting period applied to psychiatric benefits. (Unlike other pre-existing conditions which have a 12-month waiting period, hospital treatment for psychiatric treatment, rehabilitation and palliative care has only a two-month waiting period.)

Initially the insurer refused to allow Walter to backdate a change to the higher cover or waive the waiting period, causing Walter to approach us for assistance.

We escalated the case to a higher level at the insurer. On reviewing the recording of the downgrade call, the insurer was able to confirm that incorrect advice about waiting periods had been provided to Walter. Based on the misinformation, the insurer agreed to waive Walter's waiting period so his hospital admission could be covered.

While this case was favourably resolved for Walter, ideally the insurer should have retrieved the call recording when the complaint was first raised, so that Walter's case was resolved in his initial contact.

Had the insurer staff member also made an accurate written note to supplement the call recording, it could also have assisted the insurer to determine what advice had been given to Walter and allowed them to resolve his issue without the need for him to contact PHIO.

CASE STUDY

Defining medical terms in brochures and phone calls

Genevieve required an abdominoplasty procedure to restore abdominal muscular functions, improve her posture and relieve back pain. She called the insurer and was told that gastric banding and obesity-related surgeries were not covered on her policy; however, if it didn't fall into these categories and was medically necessary, the surgery would be covered.

On this advice Genevieve proceeded with her hospital booking. It was only when her hospital performed an eligibility check on her policy that Genevieve was advised that the surgery was only covered to a restricted level, leaving her out of pocket for the majority of the hospital fee. When she called the insurer she was told that her surgery was considered obesity-related and therefore only a restricted benefit applied.

As Genevieve's surgery was not obesity-related, she approached us for assistance.

We reviewed the insurer's brochures and the oral advice Genevieve had received. The policy brochures and statements only indicated that gastric banding and obesity-related surgery would receive a restricted benefit; while the verbal advice Genevieve had received indicated she would be covered if the surgery was not obesity-related.

We also sought advice from an independent medical advisor. They confirmed that although abdominoplasty surgery could be performed for obesity reasons, in this case Genevieve's surgery was for medical reasons unrelated to obesity.

On the basis of the advice provided to Genevieve, which led her to reasonably assume that her surgery would be covered, the insurer agreed to pay benefits for her surgery.

Membership issues

Complaints: 744

Key issues:

- Cancellation of policies and refunds
- Premium arrears
- Obtaining clearance certificates

Issues with membership and policy administration increased to 744, compared to 552 in the previous year. Forty percent of these complaints were related to problems experienced by people in processing the cancellation of their health insurance policies, and a further 19% about membership arrears.

If a membership falls behind in payments, it may be automatically cancelled, meaning that the member needs to rejoin and complete waiting periods again. However, health insurers also have the discretion to allow members to backpay arrears and continue their membership without needing to rejoin.

Health insurers should take into account that some members are in vulnerable or difficult positions, and make certain allowances where there are extenuating circumstances.

CASE STUDY

Arrears and special circumstances

Terry was admitted to a private hospital for psychiatric treatment and remained in hospital for two months. After he was discharged he found that his hospital insurance policy had been cancelled because his payments had fallen behind while he was in treatment.

When he contacted his insurer he was told that his membership had been cancelled and he would not be allowed to back pay the arrears. This meant not only would he have to re-join as a new member and complete all waiting periods again, but that he would not be covered for the hospitalisation – leaving him with a bill of $21,000. Terry then approached us for assistance.

The insurer's view was that they had provided sufficient notification to Terry and that they had permitted considerable discretion for Terry in the past. The insurer cited the fact that they had sent Terry two letters and two text messages advising him that his policy was about to lapse; and that over the course of his membership, Terry had been in arrears over a dozen times and they had allowed him to back pay on each of the previous occasions.

However, our view was that the notifications sent to Terry about the most recent lapse had all occurred while he was actually in hospital and therefore unable to receive normal correspondence, and there was no indication in these notifications that there was a specific deadline or action that Terry needed to take.

Records showed that the insurer was aware that Terry had been hospitalised, yet no indication was made to Terry that if he did not attend to the arrears issue as soon as possible, no benefits would be payable for his hospitalisation.

The previous occasions that the insurer had accepted his arrears without question had created an expectation that the insurer would always be flexible about such issues. There had been no previous indication from the insurer that such discretion would be withdrawn on the next occasion and he would need to re-join as a new member.

Furthermore, Terry's specific circumstances were highly mitigating. He had suffered a significant trauma which resulted in a lengthy hospitalisation. On discharge from hospital he was in financial difficulty due to having been without income for two months and was seeking the assistance of a social worker to get his life back on track.

Given that there were no deadlines on the notifications sent to him by the insurer, it was not unreasonable for him to take a short period of time after his discharge from hospital to attend to other aspects of his life. Indeed, by the time he contacted the insurer his membership was only three to four weeks past the usual point at which the insurer would have accepted arrears without question.

Based on the circumstances, our view was that the insurer should exercise its discretion and allow flexibility for Terry, as had been permitted on previous occasions.

The insurer agreed to settle the account with the hospital so that Terry would not incur a bill for his hospital stay. The insurer did not accept the full arrears on his policy, but did agree to backdate Terry's re-join so that he would have completed at least some of his waiting periods rather than having to start his membership from scratch.

Service issues

Complaints: 599

Key issues:

- Customer service issues and administrative delays
- Problems associated with direct debit systems

We received 599 complaints about service and payment administration, steady from 554 the previous year. Of these, 30% were premium payment problems, usually associated with direct debit systems. The remainder were general service issues such as customer service issues or delays in service.

Service issues are not usually the sole reason for members' complaints. The combination of unsatisfactory customer service, untimely responses to simple issues and poor internal escalation processes can cause a member to become more aggrieved and dissatisfied in their dealings with the insurer, until the service itself also becomes a cause of complaint.

CASE STUDY

Failing to give appropriate advice

Sharon had been a member of her health insurer for several years. In January she upgraded from a basic hospital cover to a top hospital cover. As Sharon was expecting a hospital admission for a reconstructive procedure, she called the insurer to check she was covered.

Sharon was advised that she would be covered provided her surgery was medically required and had MBS item numbers. Sharon followed up with her doctor for the item numbers and called back to the insurer twice more to supply this information. The insurer's staff told Sharon her procedure would be covered because it was medically required, so she booked in her hospital procedure for July.

It was only on the fourth contact, when Sharon called to check on benefit claiming processes, that she was advised she was still within the 12-month waiting period for pre-existing conditions as she had only upgraded to top hospital cover in January of that year.

As Sharon and her doctor confirmed that signs and symptoms of her medical condition existed before her hospital policy upgrade in January, the procedure was deemed pre-existing and the insurer declined to cover her admission in July. Sharon then contacted us for assistance.

Our investigation found that the insurer had had three opportunities to advise Sharon that she was within waiting periods and had failed to do so. The insurer should have told Sharon on the first contact in January that she was within the 12-month waiting period, in addition to asking her for Medicare item numbers.

Based on the three instances of misinformation and the poor phone service provided to Sharon, the insurer agreed to backdate her hospital cover at the higher level so that her waiting period would be completed before her planned hospital admission in July. Sharon was then able to proceed with her hospital procedure as planned.

Waiting periods

Complaints: 398

Key issues:

- Pre-existing condition disputes
- Compliance with pre-existing condition best-practice guidelines

Health insurers are able to apply a 12-month waiting period to new members if treatment is for a pre-existing condition. Details about how the waiting period is applied can be obtained by referring to our brochure 'Waiting periods' and our factsheet on pre-existing conditions, which are available at Phio.gov.au or by contacting the PHIO office.

We received 283 complaints about the pre-existing condition waiting period during the year, up slightly from 229 complaints in the previous year. Our role in investigating complaints about this waiting period is to ensure that the insurer has applied the waiting period correctly, and that the insurer and hospital have complied with the pre-existing condition best-practice guidelines. A copy of the guidelines is available from the PHIO website.

Informed financial consent

Complaints: 70

Key issues:

- Unexpected costs for hospital admission
- Gaps for medical and doctors' fees

Complaints about hospitals usually occur when patients experience unexpected costs for a hospital admission, or 'hospital gaps'. In most cases private hospitals have good processes in place to ensure the provision of informed financial consent to patients, so the number of complaints about unexpected gaps is low compared with the number of hospitalisations taking place each year. The office recorded 50 IFC complaints about hospital bills, up from 40 in the previous year.

In Australia, doctors are free to decide how much to charge for their services. Fees vary because doctors have to take into account their particular costs in delivering services and may have differing views about what represents a reasonable return for their time and skill.

If a doctor charges more than the health insurer and Medicare cover, the remainder is the patient's own cost. This is known as the gap.

Complaints about medical gaps have remained low in recent years, reflecting efforts made by doctors and medical service providers to inform patients about potential gaps whenever practicable, and health insurer 'gap cover' schemes, which can help to minimise out-of-pocket expenses for patients. We received 19 complaints about medical gaps compared to 25 in the previous year.

Rule changes

Complaints: 281

Key issues:

- Detrimental changes to policies
- Adequate notice to consumers

We received 281 complaints about rule changes, a large increase from the 72 in 2014–15. This jump in complaints is largely attributable to changes made by two health insurers – one which removed certain hospital benefits and changed excess structures on some of their products, and a second which reduced general treatment (extras) benefits on a popular policy.

Under the *Private Health Insurance Act 2007*, health insurers are permitted to make detrimental changes to their policies provided they give suitable advance warning to the affected members so they can change their cover or make other plans. In our view, a significant detrimental change to a hospital policy includes the exclusion or restriction of a previously included benefit, or the addition or increase of an excess or co-payments.

Insurers are required to give reasonable notice to affected members. Where a significant detrimental change has occurred, we recommend insurers provide at least 50 days' notice to affected members in a clear and simply worded letter that includes information about upgrade options.

It is important for insurers to communicate detrimental policy changes in clear and unambiguous language, and without diluting the message by interspersing unrelated promotional material. Insurers should honour any pre-booked hospital admissions and ensure that benefits for patients currently in a course of treatment continue for up to six months.

CASE STUDY 03

Removal of hospital benefits

Rashida received a letter from her insurer stating gastric banding was being removed from her policy from 1 July and she would need to upgrade if she wanted continued coverage for this procedure. Rashida visited her local branch in early June to discuss her policy because she knew she would need a gastric banding procedure in the coming months.

The health insurer staff member told her she would be covered for the upcoming surgeries and no changes needed to be made. On this advice, Rashida planned her surgery for September.

However, in September, as she was preparing for the second admission, Rashida was advised by her hospital that she was no longer covered for gastric banding as of July. She called the insurer and was told she would need to upgrade and complete a 12-month waiting period again. Rashida then contacted us for assistance.

Our investigation included a review of the system notes on Rashida's policy and the correspondence from the insurer about her policy changes.

The insurer was able to show it had sent appropriate notification to Rashida about the detrimental policy change in writing on at least two occasions in advance of the 1 July change.

Had this been the only interaction between Rashida and the insurer, the complaint would have been unlikely to proceed any further as the insurer was able to demonstrate it had met its obligations to provide 50 days' notice of the removal of gastric banding benefits.

However, Rashida had also visited the insurer in June to discuss the change. While no notes had been made to verify what had been discussed between Rashida and the health insurer staff member, the insurer's computer system had automatically recorded that an eligibility check was made during that visit.

An eligibility check is an electronic test that indicates whether or not a hospital admission will be covered on the basis of the individual's policy, the nature of the surgery, date of admission and the hospital facility.

The eligibility check made by the staff member for Rashida's planned surgery in September returned an eligible result; that is, even though gastric banding was being removed from the cover from 1 July, the computer system failed to return an error message to indicate she would no longer be covered in September.

Although the health insurer was able to demonstrate that correct written advice had been provided, the eligibility checks from Rashida's branch visit in June indicated it was highly likely she had been incorrectly advised that she would be covered for the gastric banding operation in September, and there were no other records from her visit to contradict this.

On this basis the health insurer agreed to allow Rashida to retrospectively upgrade her insurance so she could be covered for gastric banding without waiting periods and proceed with the operation.

Health insurer premium increases

Complaints: 132

Key issue:

- Premium increases

We receive a relatively low number of premium-increase complaints each year. This year we received 132 complaints about premium increases, an increase on the 78 in the previous year, possibly due to higher than average premium increases by several insurers. The proportion of complaints about premiums remained low, however, comprising only about 3% of all complaints.

OVERSEAS VISITORS HEALTH COVER

Each year we assist a number of consumers with complaints about overseas visitors health cover (OVHC) and overseas student health cover (OSHC) policies for visitors to Australia. These policies are not domestic complying health insurance policies under the Act and these complaints are therefore not included in Figure 10, which lists complaints against each registered health insurer.

This year we assisted 351 consumers with complaints about OVHC and OSHC, up from the 207 received in 2013–14. Of those complaints, 58 were investigated as level 3 disputes, compared to 44 last year.

Most overseas visitors to Australia have no access to Medicare. Some have limited access, if they are from a country with which Australia has a reciprocal health care agreement. For visitors with no or limited Medicare access, purchasing OVHC or an international health plan from an Australian or international provider is the only way they can be insured for services that Australians have covered under Medicare (for example, medical services received outside of hospital and the Pharmaceutical Benefits Scheme) and private patient hospital admissions.

Unlike Australians, who have the option of using the public Medicare system if they are not covered for a treatment under their private health insurance policy, most visitors to Australia have no choice about whether they are treated at private patient rates.

A public hospital admission for an uninsured, non-Medicare patient can cost over $1500 a day for the accommodation alone, in addition to which they will incur medical fees for the doctors. Sometimes it is actually more cost-effective for an uninsured overseas visitor to attend a private hospital than a public hospital, since public hospital fees are extremely high for non-Medicare-eligible patients.

Pharmaceutical items also cost far more for visitors than they do for Medicare-eligible Australian residents, who can usually benefit from subsidised prices under the Pharmaceutical Benefits Scheme.

For this reason we always recommend that visitors to Australia should consider purchasing OVHC or an international health plan. Benefits, waiting periods, membership costs and eligibility can vary greatly between insurers, so we recommend that anyone looking to take out OVHC should take care to ensure the policy they select is suitable for their needs. Information to assist overseas visitors with selecting health insurance is available at PrivateHealth.gov.au.

Overseas student health cover

Overseas student health cover was introduced in March 1989 to provide self-insured medical and hospital cover for overseas students and their dependents. Five insurers hold deeds of agreement with the Department of Health to offer OSHC, including Australian Health Management, BUPA Australia, Lysaght Peoplecare (subcontracting to Allianz Global Assistance), Medibank Private and NIB.

The OSHC deed sets minimum coverage requirements which OSHC insurers are required to meet for all types of OSHC policies. It is government policy that overseas students should be insured at no or minimal cost to the Australian taxpayer, so that the potential for unpaid accounts to Australian hospitals, doctors and other health professionals is minimised, while ensuring that the costs of health insurance does not serve as a disincentive to prospective overseas students.

In 2011–12 changes to the deed of agreement required students to take out cover for the length of their overseas student visa at the time of visa application, to ensure students are appropriately covered by health insurance while they are in Australia.

Who was complained about?

Some complaints were made against hospitals and providers, but the majority of complaints were registered against a small number of insurers who offer these policies. The number of complaints made for each insurer over the past three years can be seen in Figure 17.

As market share information for overseas visitor cover is unavailable, the number of complaints against each insurer should be treated as indicative only, as the proportion of complaint numbers cannot be compared against the number of policies held. It is reasonable to expect that insurers with a higher number of policies will be the object of a higher number of complaints.

Figure 17 Overseas Visitors cover complaints by fund[1]

INSURER	2013–14	2014–15
Australian Unity	11	25
BUPA	84	160
HBF	1	1
HCF	1	1
HIF	2	7
Medibank Private (AHM)	44	62
NIB	25	28
Worldcare/Allianz (Lysaght Peoplecare)	32	63
Total	200	347

1. Complaint figures for different overseas visitors cover providers are not directly comparable to each other as market share data is not available. These figures show the number of complaints over time and it can be assumed market share numbers are relatively similar to registered domestic providers and do not greatly change from year to year.

Complaint issues

The complaints investigated by PHIO in relation to OVHC are usually similar to those received about domestic policies, except for a higher proportion of complaints about waiting periods and other restrictions on the policy. A full list of the complaint issues and sub-issues is included in Figure 18. Some notable complaint issues this year included:

Service issues and delays

There was a significant rise in cancellation complaints (from 28 last year to 69 this year), while delays in benefit payments continued to be a significant issue (37 complaints compared to 33 in the previous year).

Complainants have reported that they find it difficult to have claims paid or to have cancellations processed, either due to onerous paperwork requirements from the insurer or simply a lack of timely responses to service requests.

These complaints are usually not complex and could be resolved by insurers implementing more rapid response times and processing efficiencies. This can be seen by comparison to Australian resident policy holders, who experience a proportionally much lower rate of complaint about these issues. However, these continue to cause a higher proportion of complaint from OVHC and OSHC policy holders, despite being relatively simple issues.

Rate increase

It is notable that we received 17 complaints about rate increases, compared to zero in the previous year. While premium increases have in the past been roughly commensurate to those experienced by Australian resident policy holders, in the past year a number of OVHC and OSHC providers imposed very high premium increases.

While, generally, premium increases are necessary to balance the outlays made by the insurer in paying benefits to members and administrative costs, such high premium increases cause a significant impact, especially for OVHC and OSHC members with limited incomes. These can include holders of student visas or working holiday

visas, who usually have restricted employment conditions, and holders of retiree visas, who are relying on their savings.

Pre-existing conditions

Complaints about pre-existing conditions rose from 25 in the previous year to 48 in 2014–15. Unlike Australian residents' policies, which have strict regulations about maximum waiting periods and how pre-existing conditions are defined, many OVHC policies are not subject to the same rules. They may impose harsher definitions or lengthier waiting periods.

Unlike Australian residents, who have the option of going to a public hospital as a public patient to be treated at no cost under Medicare, most overseas visitors have no such recourse if they require hospital treatment and they are not covered by their health insurer.

The impact of having a condition found to be pre-existing has the potential to be much larger for visitors, who often have no choice but to pay for the full cost of being a private patient.

Switching from visitors' cover to Australian residents' cover

The office continues to receive complaints from overseas visitors and new permanent residents who have found they have either stayed for too long on their visitors' cover, or taken a residents' policy too early.

Holding the wrong type of cover can have adverse effects on the individual's hospital benefits, Medicare Levy Surcharge obligations, Lifetime Health Cover loading and visa status.

It is important for health insurers and insurance brokers to ask appropriate questions at the time the person purchases the policy, and then to prompt them throughout the course of their membership to contact the insurer as soon as their situation changes.

Generally, the person's level of Medicare benefits should be the primary guiding factor for which policy type suits their situation.

If the person has no Medicare eligibility: For health purposes, visitors' cover is appropriate as it is designed for people who do not have Medicare entitlements. Depending on their visa type, they may also be required to hold specific types of visitors' cover (for example, student visa holders must purchase OSHC) or visitors' cover that meets certain requirements (for example, minimum health insurance requirements for 457 and 485 visa holders). People with no Medicare benefits are unaffected by Lifetime Health Cover and the Medicare Levy Surcharge.

If the person has reciprocal Medicare eligibility: For health purposes, visitors' cover is appropriate as it is designed for people who have reciprocal Medicare entitlements and, depending on their visa type, they may also be required to hold specific types of visitors' cover (as above) or request exemption from this requirement from the Department of Immigration and Border Protection.

However, if the person also earns over the Medicare Levy Surcharge threshold, they may also wish to purchase a resident's private hospital policy for the sole purpose of avoiding the Medicare Levy Surcharge.

If the person has interim Medicare eligibility: From a health insurance perspective, an interim Medicare card should be considered equivalent to a full Medicare card. For health purposes, the holder of an interim card can purchase an Australian resident's hospital policy or choose not to have private health insurance at all.

It is no longer appropriate or necessary for them to hold OVHC or OSHC and they should be encouraged to discuss their change in Medicare status with their insurer as soon as possible. If they delay in switching from visitors' cover to a residents' cover, they may be adversely affected by Lifetime Health Cover loading or the Medicare Levy Surcharge.

Figure 18 Overseas Visitors cover complaints by sub-issues

ISSUE	SUB ISSUE	2012–13	2013–14	2014–15
Benefit	Accident and emergency	1	5	9
Benefit	Ambulance	1	1	8
Benefit	Amount	2	6	6
Benefit	Delay in payment	15	33	37
Benefit	Gap - Hospital	5	2	5
Benefit	Gap - Medical	1	2	5
Benefit	General treatment (extras/ancillary)	2	1	1
Benefit	High Cost Drugs	0	3	1
Benefit	Hospital exclusion/restriction	9	11	16
Benefit	Insurer rule	10	11	13
Benefit	Limit reached	0	1	0
Benefit	New baby	1	3	3
Benefit	Non health insurance - overseas benefits	0	0	1
Benefit	Non-recognised other practitioner	1	0	0
Benefit	Out of pocket not elsewhere covered	0	1	0
Benefit	Other compensation	0	0	3
Contract	Hospitals	0	1	0
Cost	Rate increase	1	0	17
Incentives	Medicare Levy Surcharge	3	4	2
Information	Brochures and websites	4	0	1
Information	Lack of notification	6	4	1
Information	Oral advice	13	19	32
Information	Written advice	4	0	2
Informed Financial Consent	Doctors	3	0	1
Informed Financial Consent	Hospitals	7	8	5
Membership	Arrears	1	2	3
Membership	Authority over membership	0	0	2
Membership	Cancellation	10	28	69
Membership	Clearance certificates	0	0	4
Membership	Continuity	4	4	6
Membership	Suspension	1	0	3
Other	Confidentiality and privacy	1	1	1
Other	Non Medicare patient	0	1	2
Other	Not elsewhere covered	0	1	4
Other	Rule change	1	0	3
Service	Customer service advice	2	4	6
Service	General service issues	9	5	15
Service	Premium payment problems	4	6	7
Service	Service delays	4	16	21
Waiting Period	General	1	7	8
Waiting Period	Obstetric	4	5	10
Waiting Period	Other	0	1	1
Waiting Period	Pre-existing condition	14	25	48

GENERAL ISSUES

Access and public awareness

The Private Health Insurance Ombudsman was established primarily for the benefit of health insurance members. It is therefore important that they know about their right to approach the Ombudsman for assistance and for all members to be able to access the office's services.

We provide a speedy and informal complaints and enquiry service which is free of charge. Complaints and enquiries can be made from anywhere in Australia on a freecall hotline, 1800 640 695. They can also be lodged by telephone, fax, email or by post.

People who are deaf or hearing or speech impaired can contact the office through the National Relay Service by telephoning 133 677.

People who are non-English speakers can contact the office through the Translating and Interpreting Service by telephoning 131 450.

To raise public awareness of the services provided by PHIO, the following strategies were employed during 2014–15:

- Details of PHIO's services were referenced in various government publications and in publications produced by other agencies and consumer bodies
- Health insurers provided information about the availability of PHIO's services and contact details in brochures, publications and in some correspondence to their members. These details were also included on health insurers' websites
- We contributed to or reviewed information on private health insurance for inclusion in press articles, periodicals and public websites
- We published a regular quarterly report which was distributed in printed format and on the PHIO website
- We hosted an internet site where consumers could access a range of brochures, consumer bulletins, quarterly bulletins, annual reports and factsheets. The site enabled consumers to make enquiries, lodge complaints and request printed copies of brochures. Website users could also subscribe to updates via an email newsletter or through RSS feeds. The website also linked to other useful sites. The website is located at Phio.gov.au
- We conducted a number of media interviews and spoke at several health industry conferences during the year.

Client survey

We regularly carry out a postal survey of randomly selected complainants. Each fortnight, surveys are posted to a sample of complainants whose cases have been closed during the previous period. The office received 138 responses (27%), a good participation rate for a postal survey of this kind. Figure 19 summarises these results.

The aim of the survey is to gauge how well we meet our clients' needs and to identify any areas where improvements could be made. Overall, 84% of clients were satisfied or very satisfied with the handling of their complaints, compared to 86% the previous year.

Analysis of the results has shown that for complainants who obtain a payment or other outcome from a health insurer, satisfaction levels with the office were at 93%. This indicates there is a strong correlation between the ratings of our service to the financial or other outcome that the office is able to achieve for the complainant.

The challenge for the office is to improve satisfaction levels for the complainants who did not obtain the outcome they wanted. This involves ensuring complainants feel their concerns were addressed, and a good and fair explanation was provided to them.

This year, 86% of respondents were happy with the time taken to resolve complaints, up slightly from the 84% of respondents in the previous year.

Figure 19 Client survey

	2012–13	2013–14	2014–15
Overall Satisfaction	85%	86%	84%
Agreed that staff listened adequately	94%	89%	88%
Satisfied with Staff Manner	88%	88%	87%
Resolved complaint or provided adequate explanation	88%	88%	85%
Thought PHIO acted independently	89%	86%	86%
Would recommend PHIO to others	90%	89%	85%
Happy with time taken to resolve complaint	83%	84%	86%

Health policy: liaison with other bodies

We have a role in assisting with the broader issues associated with health policy. During the year the office provided information and assistance to various bodies involved in the formulation of health policy and compliance with established rules and laws.

Some significant activities included:

- submission to the ACCC's report to the Senate on Anti-Competitive and Other Practices by Health Funds and Providers in relation to private health insurance
- the provision of advice to the Private Health Insurance Industry Code Compliance Committee in relation to the voluntary industry code
- consultation with state health departments, public hospitals and health insurers in relation to acute care certification processes for long-stay private patients in public hospitals
- consultation with the Overseas Students Ombudsman and private health insurers regarding issues relating to private health insurance for overseas students.

Relations with stakeholders

We seek to work in a collaborative way with its stakeholders in order to achieve the best outcome for consumers, and maintains regular contact with health insurer, hospital and consumer organisations. During the past year the Ombudsman gave regular presentations to industry conferences and meetings of industry, consumer and other stakeholder associations; and held several informal meetings with insurers to provide feedback on specific complaint issues.

We produce a *Quarterly Bulletin* containing general information about current issues and health insurance complaint statistics that is published at Phio.gov.au.

Health Insurance Insider is our consumer e-bulletin, which is published at Phio.gov.au every six months. Recent topics have included what consumers need to know about government surcharges and regulations, such as the Government Rebate, Lifetime Health Cover and the Medicare Levy Surcharge; and information on the health insurer premium increase process.

The website's Facts and Advice section provides factsheets about topics that are regularly raised by consumers, such as why and how health premiums are increased, and how to plan to be covered for pregnancy and obstetrics services. This area will continue to be reviewed and updated in response to consumer needs.

Each year we produce a *State of the Health Funds Report* to assist consumers to compare insurers and make decisions about their health insurance. The report and individual health insurer report cards can be viewed at Phio.gov.au and PrivateHealth.gov.au.

The Ombudsman chairs a Website Reference Group, which meets quarterly and comprises representatives of health insurers, the Department of Health and the Consumers' Health Forum. The group provides advice to the Ombudsman about issues relating to the consumer website, PrivateHealth.gov.au.

CONSUMER WEBSITE PRIVATEHEALTH.GOV.AU

The consumer website, PrivateHealth.gov.au, is Australia's leading source of independent information about health insurance for consumers. The website lets consumers view a Standard Information Statement (SIS) for their own policy and compare it with other policies available for purchase.

It is regularly reviewed in response to feedback from consumers' contacts with the Ombudsman's office through enquiries and complaints, and to take account of industry changes.

The website's major features include:

- Compare policies: consumers can use the feature to easily compare SISs. This is the only independent website that has information on every health insurance policy available from any health insurance insurer in Australia, comparing over 20,000 policies
- Health insurance explained: comprehensive and independent information on all aspects of private health insurance including government surcharges and incentives
- Lifetime Health Cover calculator: consumers can calculate how much Lifetime Health Cover loading applies to their hospital policy premiums; or if they already have a loading they can calculate if they have completed enough time to have the loading removed
- Agreement hospitals locator: check which insurers and hospitals have agreements, meaning out-of-pocket expenses for consumers are minimised
- Average dental charges: the website publishes information on the average cost of the most common dental procedures.

We continued to develop and improve the website and the behind-the-scenes system insurers use to keep their policy information accurate, in response to changes in the private health insurance industry and feedback from consumers and stakeholders.

Developments in 2014–15 included improvements to the content management system to improve SIS accuracy, and less manual input and checking by insurer staff; and adjustments to the policy search feature to provide more accurate search results.

Usage

The website received 1,054,858 unique visitors throughout the year, an increase of 17% on the previous year. In March and June 2015, the website experienced a higher level of traffic as seen in Figure 20.

An increase in enquiries is typical in March each year, as this is the period when health insurers send out their rate increase letters to members. This year, changes to the Australian Government Private Health Insurance Rebate also increased enquiries at this time.

In June 2015, the commencement of the Department of Health's annual Lifetime Health Cover mailing, as well as heightened consumer awareness due to the impending close of the financial year and potential Medicare Levy Surcharge implications, caused a similar spike in visitors.

Figure 21 shows that website usage has continued to grow annually since the website's launch in 2007. Analysis of the available data suggests that general growth of the site's usage can be attributed to the site becoming better known via recommendations and search results, our own initiatives to promote the website to consumers, and regular reminders of the site's existence in annual mailings of SISs and LHC letters.

Figure 20 Privatehealth.gov.au Unique Visitors 2014–15

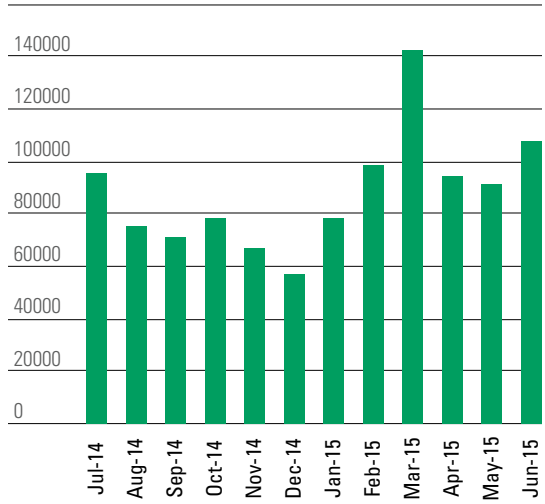
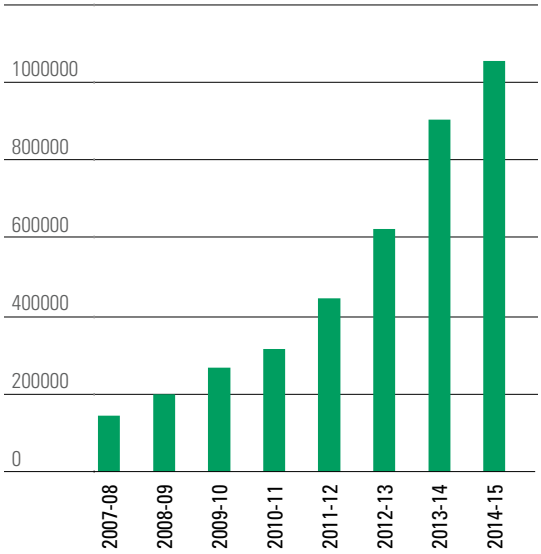


Figure 21 **Privatehealth.gov.au Visitors by Year**



Website enquiries

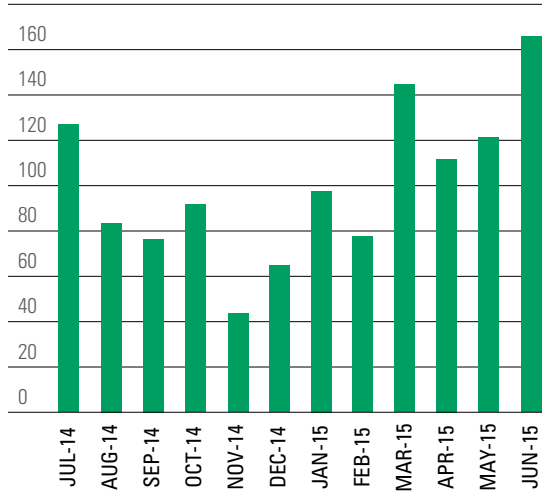
The 'Ask a question' feature allows consumers to ask quick questions by completing a web form. Consumers can also call for an answer on the enquiries line 1300 737 299. This service is used by consumers who are seeking answers for general health insurance questions beyond what they can find elsewhere on the website or from contacting individual health insurers.

As seen in Figure 23, the office responded to 1292 consumer enquiries through the website, compared to 1584 in the previous year. Approximately 54% of the enquiries received by the office were received via the consumer website, either by email or telephone.

The most frequently raised questions are about the following topics:

- Lifetime Health Cover, especially regarding how this affects new migrants to Australia and Australians returning from overseas. The LHC rules determine how much a person pays for hospital insurance
- The Medicare Levy Surcharge for high income earners and how to avoid the surcharge by purchasing appropriate private hospital insurance
- The Australian Government Private Health Insurance Rebate, an income-tested and age-dependent incentive to help cover the cost of premiums
- Waiting periods for people who are currently uninsured or upgrading existing cover
- How to use the website, locate information and compare policies
- How to choose a health insurance policy
- Overseas Visitors Health Cover, especially for Subclass 457 visa holders and overseas student visa holders.

Figure 22 **Privatehealth.gov.au Consumer Enquiries 2014–15**

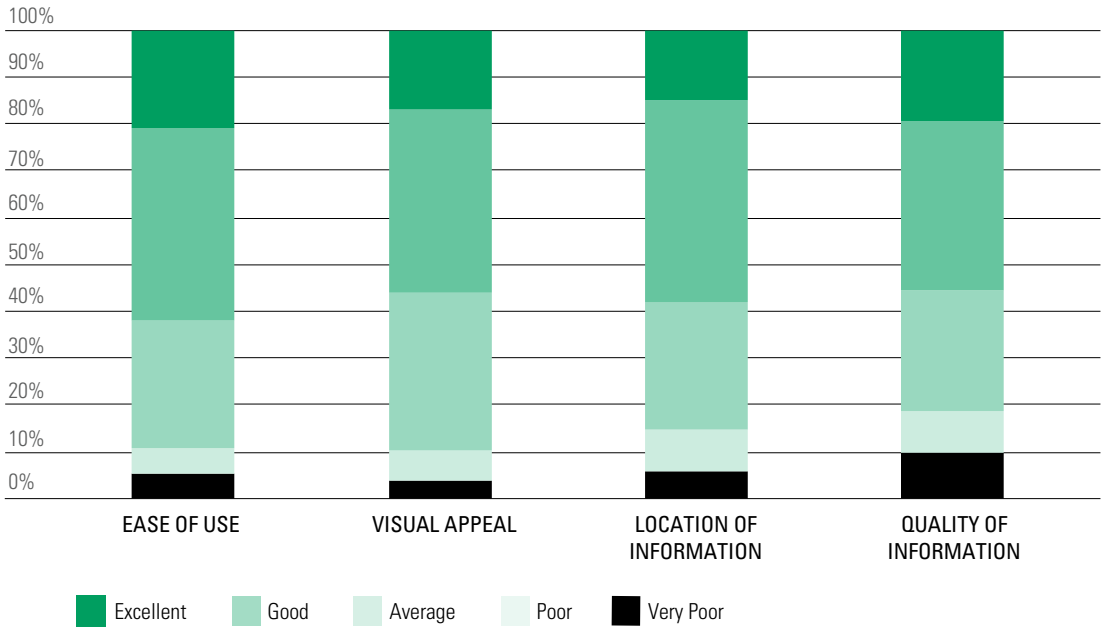


Survey results

During the year 671 users completed a survey about the website. The key ratings for the site are summarised in Figure 23. Survey results are used to highlight areas where improvements can be made to the website, to track satisfaction with the site and whether changes have been successful.

Since July 2010, when the website was relaunched in its current form, consumer satisfaction for major rating criteria has remained consistently high, especially for visual appeal. We will continue to monitor user feedback and work on improving survey results.

Figure 23 Privatehealth.gov.au User Survey 2014–15



APPENDIX: STATUTORY REPORTING INFORMATION

Management of human resources and organisational structure

The core function of the office is to resolve complaints from consumers, practitioners, hospitals and health insurers with respect to health insurance arrangements. This involves the resolution of individual complaints, and development of strategies to assist in identifying and resolving the underlying issues which lead to complaints.

The office is also responsible for regular reporting to government and industry, and the provision of advice and information about private health insurance to consumers. The ability to accomplish these tasks within a small team places a significant reliance on all staff to work collectively and to fully understand the fundamentals associated with the private health insurance industry.

The core business of complaint handling and dispute resolution was managed by the Dispute Resolution team. Dispute Resolution staff are responsible for the day-to-day management of individual complaints and for bringing potential and actual issues that require broader investigation to the attention of the Ombudsman and the Director of Policy and Client Services.

The Project and Policy team managed consumer and website enquiries, website updates, and PHIO reports and publications. This team also reported to the Director of Policy and Client Services.

The Director of Policy and Client Services, Principal Policy Officer and Director of Programmes and Education comprised the management level of the organisation, which handled complex disputes and mediations, industry liaison, policy development, staff training, and compliance issues. These positions reported directly to the Ombudsman.

Administrative matters and corporate services were handled by the Office Manager and Financial Controller, also reporting directly to the Ombudsman.

Table 1 shows the permanent staff employed by the Private Health Insurance Ombudsman in 2014–15 as compared to 2013–14.

Table 1 Permanent staff

FULL-TIME AND PART-TIME EMPLOYEES	AT 30 JUNE 2015			AT 30 JUNE 2014		
	FEMALE	MALE	EFT	FEMALE	MALE	EFT
SES 2		1	1.0	1	-	1.0
Executive Level 2	1	-	0.4	1	1	1.4
Executive Level 1	3	-	2.4	3	-	2.4
APS 6	2	-	2.0	2	-	2.0
APS 5	3	1	3.6	4	1	4.2
APS 4	1	-	0.7	1	-	0.7
APS 3	-	-	-	-	-	-

EFT: equivalent full-time employee

Table 2 Statutory positions

OFFICER	POSITION	TERM	EXPIRY DATE
Ms Samantha Gavel	Ombudsman	6 months	31 December 2014
Mr David McGregor	A/g Ombudsman	6 months	30 June 2015

Statutory positions

The Private Health Insurance Ombudsman comprised one statutory office holder in 2014–15 (see Table 2).

Staff employment status

All Ombudsman staff are employed under the provisions of the *Public Service Act 1999* and are required to adhere to the Public Service Values and Code of Conduct. All staff, other than Senior Executive Service staff, were covered under an Enterprise Agreement in accordance with the *Fair Work Act 2009* and in compliance with Australian Public Service Commission recommendations. The PHIO Enterprise Agreement came into effect on 21 September 2011, following a staff ballot.

Table 3 shows rates of pay under the Enterprise Agreement.

The Ombudsman is committed to providing a safe working environment that supports the rights, responsibilities and legitimate needs of all staff. The Ombudsman is also committed to best practice in selection, recruitment and promotion of staff in line with the merit principle.

Workplace structures, systems and procedures are in place to assist employees in balancing their work and family responsibilities effectively. This includes flexible working arrangements (Flextime) and work-from-home arrangements.

As a result we have a high retention rate and low staff turnover, with total staff members remaining almost unchanged over the past three years.

Table 4 shows the numbers and status of staff who were employed on 30 June 2015.

Staff development and training

During the 2014–14 financial year, $19,374was spent directly on the Ombudsman's staff attending training and development courses, conferences and seminars. This included the continuation of the Ombudsman's internal staff development and training program for dispute resolution staff.

Staff training and development ensures staff members have the appropriate skills and knowledge to provide high-level advice and services to consumers, as well as providing for staff career development, satisfaction and retention.

Attendance at conferences and seminars allows staff to keep up to date with industry changes and to engage with their peers across the private health insurance, health services and government sectors.

Training and development courses enable staff to develop skills that empower them to more effectively manage their work in areas that include leadership in the workplace, managing and working within teams, and best practice in customer complaints handling.

Table 3 Rates of pay

CLASSIFICATION	JULY 2013	JULY 2014
Executive Level 2	108,742 – 127,109	108,742 – 127,109
Executive Level 1	92,945 – 101,810	92,945 – 101,810
APS 6	75,633 – 85,324	75,633 – 85,324
APS 5	68,560 – 72,364	68,560 – 72,364
APS 4	63,035 – 66,603	63,035 – 66,603
APS 3	55,636 – 61,668	55,636 – 61,668
APS 2	47,676 – 52,027	47,676 – 52,027
APS 1	40,794 – 45,813	40,794 – 45,813

Table 4 Numbers and status

OCCUPATIONAL GROUP	WOMEN	MEN	TOTAL	NESB1
SES	0	1	1	0
Other	10	1	11	3
Total	10	2	12*	3

SES Senior Executive Service, Ombudsman
Other All other staff – temporary and permanent
NESB1 Non-English speaking background, first generation
* Includes part-time employees and those on maternity leave. Actual EFT = 10.1

Performance appraisal

The Ombudsman's Performance Development Program measured staff performance and provided a basis for staff training and development. The program was used to assist the Ombudsman with general staff management and annual salary reviews.

All staff members were subject to a half-yearly and an annual performance appraisal. Salary and promotion advancement were based on performance and productivity. A total of $98,934 in performance bonuses was paid in 2014–15. This figure has been aggregated to preserve employees' privacy.

In accordance with the *Private Health Insurance Act 2007*, the Ombudsman's remuneration was determined by the Remuneration Tribunal, an independent statutory body that handles the remuneration of key Commonwealth offices. For more information, refer to the note regarding Senior Executive remuneration in the financial statements of this report.

Industrial democracy

Staff members are involved in all decisions that affect their working lives and the Ombudsman's functions through regular staff meetings and dissemination of relevant written material.

Corporate governance

As a small office with duties specified by the *Private Health Insurance Act 2007*, the business of the Ombudsman's office and the role of the Private Health Insurance Ombudsman was well defined. In accomplishing the tasks envisaged under the Act, the office implemented procedures to monitor staff performance and process, together with the appropriate management and staff policies.

External review and scrutiny

The office regularly reviewed its performance by conducting a survey of complainants. Detail of the review for this year is provided in the body of this report (see Client survey).

During this year there were no judicial decisions, decisions of administrative tribunals or decisions by the Australian Information Commissioner which had a significant impact on the operations of PHIO. There were no reports on the operations of the office by the Auditor-General, a Parliamentary committee, the Commonwealth Ombudsman or agency capability reviews.

There were no other reviews conducted of PHIO.

Fraud Control

Staff members are trained in fraud awareness and procedures, which are in place to notify the Australian Federal Police and/or the Director of Public Prosecutions if loss occurs as a result of fraud. A formal fraud procedure manual has been produced and all staff made aware of their obligations and responsibilities.

No cases of fraud were detected during the year. The Ombudsman has reported the office's fraud data to the Australian Institute of Criminology in accordance with the Commonwealth Fraud Control Guidelines.

Accounting and audit

The office utilised the MYOB suite of accounting programs internally and contracted BuildSmart Bookkeeping for day-to-day administration of general accounting functions. The Ombudsman had an Audit Committee, chaired by an independent Chair, Mr Neill Buck, which held regular meetings to ensure appropriate oversight of the office's compliance with the requirements of the *Public Governance, Performance and Accountability Act 2013*.

PHIO's financial statements were audited by the Australian National Audit Office in line with government requirements.

Consultancy services

The office engaged consultants where it lacked specialist expertise or when independent research, review or assessment was required. Consultants were typically engaged to investigate or diagnose a defined issue or problem; carry out defined reviews or evaluations; or provide independent advice, information or creative solutions to assist in PHIO's decision-making.

Before engaging consultants, PHIO took into account the skills and resources required for the task, the skills available internally and the cost-effectiveness of engaging external expertise. Decisions to engage consultants were made in accordance with the *Public Governance, Performance and Accountability Act 2013* and related regulations including the Commonwealth Procurement Rules and PHIO's procurement policies.

Annual reports contain information about actual expenditure on contracts for consultancies. Information on the value of contacts and consultancies is available on the AusTender website Tenders.gov.au.

During 2014–15, PHIO did not engage any consultancy services of $10,000 or more.

Consultants engaged by PHIO:

- BuildSmart Bookkeeping provided financial, accounting and reporting assistance to the office
- PT&A Health provided services on an ad hoc basis as medical referees on cases requiring a medical opinion
- Human Solutions was awarded a one-year contract for the provision of maintenance, support and hosting services for the consumer website (PrivateHealth.gov.au) after an open tender process in 2014. The contract commenced on 1 June 2014 and expired on 31 May 2015. The contract was extended for a further one year and will expire on 31 May 2016.

Information systems

The Ombudsman's information system was based on a Windows 2008 Network Server and the Microsoft Office suite. For accounting, the office used MYOB Accounting and Asset Manager. For core business, the Ombudsman used a purpose-built complaints management and reporting system.

Payroll services

The Ombudsman engaged Australian Payroll Management Services to provide a payroll processing service.

Service charter

In line with requirements for all Australian Government agencies, the office had a service charter which was last reviewed in 2010–11. The charter covered all of the Ombudsman's clients and set out the service-delivery standards they could expect from the office.

It was developed in consultation with staff and clients; copies of the charter were routinely sent out to people who contacted the office (in the brochure 'About our service'). The key performance standards listed in the service charter are accessibility, timeliness, courtesy and sensitivity, and high-quality advice.

The charter included a number of service standards and provided a tiered system for handling complaints specifically about our service (as distinct from our work as a complaints body). The Ombudsman had a system in place for recording complaints, compliments and feedback about our service.

PHIO staff attended a weekly case meeting, which enabled Dispute Resolution Officers to seek input from peers and senior staff on their cases. Dispute Resolution Officers were encouraged to discuss their cases with peers and senior staff on a more informal basis, to ensure the best approach was used for each matter.

If a complainant requested that their call to PHIO be escalated, they could be referred to the Senior Dispute Resolution Officer or other delegated person. If a complainant was not happy with how their case had been handled, they could request a review by the Senior Dispute Resolution Officer or the Manager, Dispute Resolutions.

Client survey results showed that in 2014–15, 88% of consumers found PHIO staff listened to their concerns adequately and 87% were satisfied with the manner in which PHIO staff handled their cases. Overall, 85% of clients were happy to recommend PHIO's services to others. These results are generally consistent with the previous two years of survey results.

Work health and safety

The Ombudsman complied with all provisions of the *Work Health and Safety Act 2011*. The staff included an Occupational Health and Safety Officer and two Fire Wardens. No reportable incidents occurred and no investigations were conducted during the year.

Equal employment opportunity

The Ombudsman is committed to the principles outlined in the *Disability Discrimination Act 1992* and the *Equal Employment Opportunity (Commonwealth Authorities) Act 1987*.

Advertising and market research

PHIO did not conduct any advertising or market research in 2014–15.

Ecologically sustainable development and environmental performance

The Ombudsman is committed to the ecologically sustainable development goals of the *Environment Protection and Biodiversity Conservation Act 1999*. The Ombudsman promoted reduction in use of resources through the provision of recycling bins, ecologically mindful purchasing guidelines, and implementation of office processes that reduce the unnecessary consumption of electricity and water.

Our office is located in a building that has achieved 3.5 stars under the National Australian Built Environment Rating: Water and 5 stars under the National Environment Building Rating: Energy.

Grant programs

We did not administer any grant programs during the 2014–15 financial year.

Changes to disability reporting

Since 1994, Commonwealth departments and agencies have reported on their performance as policy adviser, purchaser, employer, regulator and provider under the Commonwealth Disability Strategy.

In 2007–08, reporting on the employer role was transferred to the Australian Public Service Commission's *State of the Service Report* and the APS *Statistical Bulletin*. These reports are available at apsc.gov.au. From 2010–11, departments and agencies have no longer been required to report on these functions.

Procurement initiatives to support small business

We support small business participation in the Commonwealth Government procurement market. Small and medium-sized enterprises (SME) and small enterprise participation statistics are available on the Department of Finance's website:

www.finance.gov.au/procurement/statistics-on-commonwealth-purchasing-contracts/

Freedom of information and Information Publication Scheme

Agencies subject to the *Freedom of Information Act 1982* are required to publish information to the public as part of the Information Publication Scheme (IPS). This requirement is in Part II of the FOI Act and has replaced the former requirement to publish a section 8 statement in an annual report.

Each agency must display on its website a plan showing what information it publishes in accordance with the IPS requirements. The Ombudsman's IPS and FOI requests — Disclosure Log can be found at Ombudsman.gov.au.

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INDEPENDENT AUDITOR'S REPORT

To the Minister for Health

I have audited the accompanying annual financial statements of the Private Health Insurance Ombudsman for the year ended 30 June 2015, which comprise:

- Statement by the Commonwealth Ombudsman and Chief Financial Officer of the Office of the Commonwealth Ombudsman;
- Statement of Comprehensive Income;
- Statement of Financial Position;
- Statement of Changes in Equity;
- Cash Flow Statement;
- Schedule of Commitments; and
- Notes comprising a Summary of Significant Accounting Policies and other explanatory information.

Accountable Authority's Responsibility for the Financial Statements

The Accountable Authority of the Private Health Insurance Ombudsman is responsible under the *Public Governance, Performance and Accountability Act 2013* for the preparation and fair presentation of annual financial statements that comply with Australian Accounting Standards and the rules made under that Act. The Accountable Authority is also responsible for such internal control as is necessary to enable the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

My responsibility is to express an opinion on the financial statements based on my audit. I have conducted my audit in accordance with the Australian National Audit Office Auditing Standards, which incorporate the Australian Auditing Standards. These auditing standards require that I comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial

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statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of the accounting policies used and the reasonableness of accounting estimates made by the Accountable Authority of the entity, as well as evaluating the overall presentation of the financial statements.

I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my audit opinion.

Independence

In conducting my audit, I have followed the independence requirements of the Australian National Audit Office, which incorporate the requirements of the Australian accounting profession.

Opinion

In my opinion, the financial statements of the Private Health Insurance Ombudsman:

(a) comply with Australian Accounting Standards and the *Public Governance, Performance and Accountability (Financial Reporting) Rule 2015*; and

(b) present fairly the financial position of the Private Health Insurance Ombudsman as at 30 June 2015 and its financial performance and cash flows for the year then ended.

Australian National Audit Office

Brandon Jarrett

Executive Director

Delegate of the Auditor-General

Canberra

23 September 2015

Australian Government
Private Health Insurance Ombudsman

STATEMENT BY THE COMMONWEALTH OMBUDSMAN AND CHIEF FINANCIAL OFFICER OF THE OFFICE OF THE COMMONWEALTH OMBUDSMAN

These are the final statements of Private Health Insurance Ombudsman. The *Private Health Insurance Amendment Act 2015* provides for the merger of Commonwealth Ombudsman and Private Health Insurance Ombudsman on 1 July 2015. All obligations for the Private Health Insurance Ombudsman (PHIO) have passed to the Office of the Commonwealth Ombudsman.

Pursuant to section 17A of the *Public Governance, Performance and Accountability Rule 2014*, the Department of Finance has nominated the Commonwealth Ombudsman to produce the annual financial statements for PHIO.

In our opinion, the attached financial statements for the year ended 30 June 2015 comply with subsection 42(2) of the *Public Governance, Performance and Accountability Act 2013* (PGPA Act), and are based on properly maintained financial records as per subsection 41(2) of the PGPA Act.

In our opinion, at the date of this statement, there are reasonable grounds to believe that the Office of the Commonwealth Ombudsman will be able to pay the debts of PHIO as and when they fall due.

Signed

Richard Glenn
a/g Commonwealth Ombudsman

23 September 2015

Signed

Dermot Walsh
Chief Financial Officer

23 September 2015

STATEMENT OF COMPREHENSIVE INCOME

for the period ended 30 June 2015

	NOTES	2015 $	2014 $
NET COST OF SERVICES			
Expenses			
Employee benefits	4A	**1,433,936**	1,384,226
Suppliers	4B	**887,463**	766,937
Depreciation and amortisation	4C	**281,001**	292,789
Finance costs	4D	**1,605**	1,644
Total expenses		**2,624,005**	2,445,596
Own-Source Income			
Own-source revenue			
Other revenue	5A	**18,277**	19,682
Total own-source revenue		**18,277**	19,682
Net cost of services		**2,605,728**	2,425,914
Revenue from Government	5B	**2,632,000**	2,203,000
Surplus/(Deficit) on continuing operations		**26,272**	(222,914)
OTHER COMPREHENSIVE INCOME			
Other comprehensive income		-	-
Total other comprehensive income		-	-
Total comprehensive profit/(loss)		**26,272**	(222,914)

The above statement should be read in conjunction with the accompanying notes.

STATEMENT OF FINANCIAL POSITION

as at 30 June 2015

	NOTES	2015 $	2014 $
ASSETS			
Financial assets			
Cash and cash equivalents	7A	**18,411**	90,023
Trade and other receivables	7B	**777,473**	55,161
Total financial assets		**795,884**	145,184
Non-financial assets			
Leasehold improvements	8A,C	**34,910**	94,755
Property, plant and equipment	8B,C	**31,724**	43,241
Intangibles	8D,E	**427,251**	509,890
Other non-financial assets	8F	**25,822**	26,486
Total non-financial assets		**519,707**	674,372
Total assets		**1,315,591**	819,556
LIABILITIES			
Payables			
Suppliers	9A	**162,101**	106,078
Other payables	9B	**50,367**	52,694
Total payables		**212,468**	158,772
Provisions			
Employee provisions	10A	**229,406**	358,944
Other provisions	10B	**43,237**	41,632
Total provisions		**272,643**	400,576
Total liabilities		**485,110**	559,348
Net assets		**830,480**	260,208
EQUITY			
Contributed equity		**1,223,321**	679,321
Reserves		**99,981**	99,981
Accumulated deficit		**(492,822)**	(519,094)
Total equity		**830,480**	260,208

The above statement should be read in conjunction with the accompanying notes.

STATEMENT OF CHANGES IN EQUITY

for the period ended 30 June 2015

	Retained earnings		Asset revaluation surplus		Contributed equity/capital		Total equity	
	2015	2014	**2015**	2014	**2015**	2014	**2015**	2014
	$	$	**$**	$	**$**	$	**$**	$
Opening balance								
Balance carried forward from previous period	**(519,094)**	(296,180)	**99,981**	99,981	**679,321**	2,382,041	**260,208**	2,185,842
Adjusted opening balance	**(519,094)**	(296,180)	**99,981**	99,981	**679,321**	2,382,041	**260,208**	2,185,842
Comprehensive income								
Surplus/(Deficit) for the period	**26,272**	(222,914)	-	-	-	-	**26,272**	(222,914)
Total comprehensive income	**26,272**	(222,914)	-	-	-	-	**26,272**	(222,914)
Transactions with owners								
Contributions to/by owners								
Contributions repealed by Statute Stocktake	-	-	-	-	-	(1,762,720)	-	(1,762,720)
Departmental capital budget	-	-	-	-	**544,000**	60,000	**544,000**	60,000
Sub-total transactions with owners	-	-	-	-	**544,000**	(1,702,720)	**544,000**	(1,702,720)
Closing balance as at 30 June	**(492,822)**	(519,094)	**99,981**	99,981	**1,223,321**	679,321	**830,480**	260,208

The above statement should be read in conjunction with the accompanying notes.

CASH FLOW STATEMENT

for the period ended 30 June 2015

	NOTES	2015 $	2014 $
OPERATING ACTIVITIES			
Cash received			
Appropriations		**2,465,000**	2,203,000
Sales of goods and rendering of services		**687**	2,390
Net GST received		**63,759**	16,575
Total cash received		**2,529,446**	2,221,965
Cash used			
Employees		**1,583,473**	1,451,838
Suppliers		**890,585**	714,983
Other		**-**	(34,236)
Total cash used		**2,474,058**	2,132,585
Net cash from operating activities	11	**55,388**	89,380
INVESTING ACTIVITIES			
Cash used			
Purchase of property, plant and equipment		**-**	5,763
Purchase of intangibles		**127,000**	102,610
Total cash used		**127,000**	108,373
Net cash used by investing activities		**(127,000)**	(108,373)
FINANCING ACTIVITIES			
Cash received			
Contributed equity		**-**	30,000
Total cash received		**-**	30,000
Net cash from financing activities		**-**	30,000
Net increase (decrease) in cash held		**(71,612)**	11,007
Cash and cash equivalents at the beginning of the reporting period		**90,023**	79,016
Cash and cash equivalents at the end of the reporting period	7A	**18,411**	90,023

The above statement should be read in conjunction with the accompanying notes.

SCHEDULE OF COMMITMENTS

as at 30 June 2015

	2015 $	2014 $
BY TYPE		
Commitments receivable		
Net GST recoverable on commitments	**38,996**	66,950
Total commitments receivable	**38,996**	66,950
Commitments payable		
Other commitments		
Operating leases	**183,990**	491,477
Other	**244,972**	244,972
Total other commitments	**428,962**	736,449
Net commitments by type	**389,966**	669,499
BY MATURITY		
Commitments receivable		
Operating lease income		
Within 1 year	**38,996**	50,224
Between 1 to 5 years	**-**	16,726
Total operating lease income	**38,996**	66,950
Commitments payable		
Operating lease commitments		
Within 1 year	**183,990**	307,487
Between 1 to 5 years	**-**	183,990
Total operating lease commitments	**183,990**	491,477
Other Commitments		
Within 1 year	**244,972**	244,972
Between 1 to 5 years	**-**	-
Total other commitments	**244,972**	244,972
Net commitments by maturity	**389,966**	669,499

Note: Commitments are GST inclusive where relevant.

Operating leases comprise of a lease for office accommodation. Lease payments are subject to a fixed increase of 4.5% per annum as per the lease agreement. The lease will terminate on 31 January 2016.

Other commitments comprise of a contract for maintenance and development of the www.privatehealth.gov.au website. Payments are per the contract agreement. The contract will expire after 31 May 2016.

This schedule should be read in conjunction with the accompanying notes.

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Note 1: Summary of Significant Accounting Policies

1.1 Objectives of the Entity

The entity is an Australian Government controlled entity. It is a not-for-profit entity. The objective of the entity is to be an independent body which resolves complaints about private health insurance, and act as the umpire in dispute resolution at all levels within the private health industry.

The entity is structured to meet the following outcome:

> Outcome 1: Public confidence in private health insurance, including through consumer and provider complaint and enquiry investigations, and performance monitoring and reporting.

The *Private Health Insurance Amendment Act 2015* provided for the merger of Commonwealth Ombudsman and Private Health Insurance Ombudsman on 1 July 2015.

As a consequence of this, Private Health Insurance Ombudsman ceased as an entity on 30 June 2015.

1.2 Basis of Preparation of the Financial Statements

As noted in 1.1, Private Health Insurance Ombudsman ceased to exist on 30 June 2015 and its functions, assets and liabilities transferred to the Commonwealth Ombudsman. The financial statements have been prepared on this basis.

The financial statements are general purpose financial statements and are required by section 42 of the *Public Governance, Performance and Accountability Act 2013*.

The financial statements have been prepared in accordance with:

a) Financial Reporting Rule (FRR) for reporting periods ending on or after 1 July 2014; and
b) Australian Accounting Standards and Interpretations issued by the Australian Accounting Standards Board (AASB) that apply for the reporting period.

The financial statements have been prepared on an accrual basis and in accordance with the historical cost convention, except for certain assets and liabilities at fair value.

The financial statements are presented in Australian dollars and values are rounded to the nearest dollar unless otherwise specified.

Assets and liabilities are recognised in the statement of financial position when and only when it is probable that future economic benefits will flow to the entity or a future sacrifice of economic benefits will be required and the amounts of the assets or liabilities can be reliably measured. However, assets and liabilities arising under executory contracts are not recognised unless required by an accounting standard. Liabilities and assets that are unrecognised are reported in the schedule of commitments or the contingencies note.

Income and expenses are recognised in the statement of comprehensive income when and only when the flow, consumption or loss of economic benefits has occurred and can be reliably measured.

Note 1: Summary of Significant Accounting Policies (continued)

1.3 Significant Accounting Judgements and Estimates

The assets and liabilities of Private Health Insurance Ombudsman have been transferred to the Commonwealth Ombudsman on the basis that the functions and responsibilities will continue and that assets will continue to produce future economic benefits over the useful life used in these financial statements.

1.4 New Australian Accounting Standards

Adoption of New Australian Accounting Standard Requirements

No accounting standard has been adopted earlier than the application date as stated in the standard.

The following standard was issued prior to the signing of the statement by the Commonwealth Ombudsman and chief financial officer, was applicable to the current reporting period and had a material effect on the agency's financial statements:

AASB 1055 Budgetary Reporting (March 2013) (operative from 1 July 2014). The disclosure requires the inclusion of the budgeted figures from the Portfolio Budget Statements (PBS) to be disclosed with material variances against actuals explained. This disclosure will provide users with information relevant to assessing the performance of an entity, including accountability for resources entrusted to it.

All other new/revised/amending standards issued prior to the sign-off date and applicable to the current reporting period did not have a material effect on the entity's financial statements.

1.5 Revenue

Revenue from Government

Amounts appropriated for departmental activities for the year are recognised as Revenue from Government when the entity gains control of the appropriation. Appropriations receivable are recognised at their nominal amounts.

1.6 Gains

Resources Received Free of Charge

Resources received free of charge are recognised as gains when, and only when, a fair value can be reliably determined and the services would have been purchased if they had not been donated. Use of those resources is recognised as an expense.

1.7 Transactions with the Government as Owner

Equity Injections

Amounts appropriated which are designated as 'equity injections' for a year (less any formal reductions) and Departmental Capital Budgets (DCBs) are recognised directly in contributed equity.

1.8 Employee Benefits

Liabilities for 'short-term employee benefits' (as defined in AASB 119 *Employee Benefits*) and termination benefits due within twelve months of the end of reporting period are measured at their nominal amounts.

The nominal amount is calculated with regard to the rates expected to be paid on settlement of the liability.

Other long-term employee benefits are measured as of the present value of the obligation at the end of the reporting period.

Note 1: Summary of Significant Accounting Policies (continued)

Leave

The liability for employee benefits includes provision for annual leave and long service leave. No provision has been made for sick leave as all sick leave is non-vesting and the average sick leave taken in future years by employees of the entity is estimated to be less than the annual entitlement for sick leave.

The leave liabilities are calculated on the basis of employees' remuneration at the estimated salary rates that will be applied at the time the leave is taken, including the entity's employer superannuation contribution rates to the extent that the leave is likely to be taken during service rather than paid out on termination.

The estimate of the present value of the liability takes into account attrition rates and pay increases through promotion and inflation.

Superannuation

The entity's staff are members of the Public Sector Superannuation Scheme (PSS) or the PSS accumulation plan (PSSap).

The PSS is a defined benefit scheme for the Australian Government. The PSSap is a defined contribution scheme.

The liability for defined benefits is recognised in the financial statements of the Australian Government and is settled by the Australian Government in due course. This liability is reported in the Department of Finance's administered schedules and notes.

The entity makes employer contributions to the employees' superannuation scheme at rates determined by an actuary to be sufficient to meet the current cost to the Government. The entity accounts for the contributions as if they were contributions to defined contribution plans.

The liability for superannuation recognised as at 30 June represents outstanding contributions for the final fortnight of the year.

1.9 Leases

Operating lease payments are expensed on a straight-line basis which is representative of the pattern of benefits derived from the leased assets.

1.10 Cash

Cash is recognised at its nominal amount.

1.11 Financial Assets

The entity classifies its financial assets as 'trade and other receivables' which comprises of appropriations receivable and GST receivable from the ATO.

1.12 Acquisition of Assets

Assets are recorded at cost on acquisition. The cost of acquisition includes the fair value of assets transferred in exchange and liabilities undertaken.

Note 1: Summary of Significant Accounting Policies (continued)

1.13 Property, Plant and Equipment

Asset Recognition Threshold

Purchases of property, plant and equipment are recognised initially at cost in the Statement of Financial Position, except for purchases costing less than $1,000, which are expensed in the year of acquisition (other than where they form part of a group of similar items which are significant in total).

The initial cost of an asset includes an estimate of the cost of dismantling and removing the item and restoring the site on which it is located. This is particularly relevant to 'make good' provisions in office premises taken up by the entity where there exists an obligation to restore the premises to its original state. These costs are included in the value of the entity's Leasehold Improvements asset with a corresponding provision for the 'make good' recognised.

Revaluations

Following initial recognition at cost, property, plant and equipment were carried at fair value less subsequent accumulated depreciation and accumulated impairment losses. Valuations were conducted with sufficient frequency to ensure that the carrying amounts of assets did not differ materially from the assets' fair values as at the reporting date. The regularity of independent valuations depended upon the volatility of movements in market values for the relevant assets.

There were no revaluations conducted in 2014–15.

Depreciation

Depreciable property, plant and equipment assets are written-off to their estimated residual values over their estimated useful lives to the entity using, in all cases, the straight-line method of depreciation.

Depreciation rates (useful lives), residual values and methods are reviewed at each reporting date and necessary adjustments are recognised in the current, or current and future reporting periods, as appropriate.

Depreciation rates applying to each class of depreciable asset are based on the following useful lives:

	2015	2014
Leasehold improvements	Lease term	Lease term
Property, plant and equipment	4 to 10 years	4 to 10 years

Lease agreements with PHIO have been transferred to the Office of the Commonwealth Ombudsman who will continue to use the premises. Property, plant and equipment, mainly furniture and equipment, will also continue to be used.

Impairment

All assets were assessed for impairment at 30 June 2015. No assets were found to be impaired.

1.14 Intangibles

The entity's intangibles comprise purchased software for internal use and the website. These assets are carried at cost less accumulated amortisation and accumulated impairment losses.

Software is amortised on a straight-line basis over its anticipated useful life. The useful lives of the entity's software are 5 to 7 years (2013–14: 5 to 7 years) and will continue to be used by the Office of the Commonwealth Ombudsman.

All software assets were assessed for indications of impairment as at 30 June 2015.

Note 1: Summary of Significant Accounting Policies (continued)

1.15 Contingent Liabilities and Contingent Assets

Contingent liabilities and contingent assets are not recognised in the Statement of Financial Position. They may arise from uncertainty as to the existence of a liability or asset or represent an asset or liability in respect of which the amount cannot be reliably measured. Contingent assets are disclosed when settlement is probable but not virtually certain and contingent liabilities are disclosed when settlement is greater than remote.

A potential overpayment to employees of the Private Health Insurance Ombudsman (PHIO) of approximately $60,000 was identified late in the financial statement process. While the recovery of this overpayment is probable, it is not virtually certain based on the information available at the time of finalising the financial statements and is therefore considered a contingent asset. The Office of the Commonwealth Ombudsman is currently seeking legal advice on the potential overpayment to PHIO employees (2014: nil).

1.16 Taxation

The entity is exempt from all forms of taxation except Fringe Benefits Tax (FBT) and the Goods and Services Tax (GST).

Revenues, expenses, assets and liabilities are recognised net of GST except:

a) where the amount of GST incurred is not recoverable from the Australian Taxation Office; and
b) for receivables and payables.

Note 2: Events After the Reporting Period

The *Private Health Insurance Ombudsman Amendment Act 2015* (the Act) provides for the merger of the Private Health Insurance Ombudsman (PHIO) functions with the Office of the Commonwealth Ombudsman (the Office) on 1 July 2015.

PHIO ceased as a separate entity and its assets, liabilities, funding, policy and programme responsibilities transferred to the Office on 1 July 2015.

There were no other subsequent events.

Note 3: Net Cash Appropriation Arrangements

	2015 $	2014 $
Total comprehensive income (loss) less depreciation/amortisation expenses previously funded through revenue appropriations [1]	**307,273**	69,875
Plus: depreciation/amortisation expenses previously funded through revenue appropriation	**(281,001)**	(292,789)
Total comprehensive profit/(loss) - as per the Statement of Comprehensive Income	**26,272**	(222,914)

1. From 2010-11, the Government introduced net cash appropriation arrangements, where revenue appropriations for depreciation/amortisation expenses ceased. Entities now receive a separate capital budget provided through equity appropriations. Capital budgets are to be appropriated in the period when cash payment for capital expenditure is required.

Note 4: Expenses

	2015 $	2014 $
Note 4A: Employee Benefits		
Wages and salaries	1,231,399	1,216,295
Superannuation:		
Defined contribution plans	70,655	58,640
Defined benefit plans	105,503	131,929
Leave expense and other entitlements	38,741	(29,413)
Other employee expenses	7,638	6,775
Total employee benefits	1,453,936	1,384,226
Note 4B: Suppliers		
Goods and services supplied or rendered		
Accounting and audit	25,739	31,853
Brochures and printing	49,782	58,315
Consultants	4,737	1,403
Insurance	3,673	8,514
Media and non campaign advertising	46,386	41,148
Mediation	14,049	3,500
Recruitment	211	4,545
Staff development	19,374	21,688
Subscriptions and memberships	40,654	35,588
Telephone and internet	20,555	20,606
Transition costs for merger	102,000	-
Travel and accommodation	37,077	48,359
Website	185,458	139,183
Other	44,021	75,136
Total goods and services supplied or rendered	593,716	489,838
Goods and services supplied or rendered in connection with:		
Related parties	102,000	-
External parties	491,716	489,838
Total goods and services supplied or rendered	593,716	489,838
Other suppliers		
Operating lease rentals – external parties:		
Minimum lease payments	284,380	269,269
Workers compensation expenses	9,367	7,830
Total other suppliers	293,747	277,099
Total suppliers	887,463	766,937
Note 4C: Depreciation and Amortisation		
Depreciation:		
Property, plant and equipment	11,517	17,407
Leasehold improvements	59,845	31,924
Total depreciation	71,362	49,331
Amortisation:		
Web development	202,113	235,934
Intangibles	7,526	7,524
Total amortisation	209,639	243,458
Total depreciation and amortisation	281,001	292,789
Note 4D: Finance Costs		
Unwinding of discount	1,605	1,644
Total finance costs	1,605	1,644

Note 5: Own-Source Income

	2015 $	2014 $
OWN-SOURCE REVENUE		
Note 5A: Other Revenue		
Resources received free of charge – remuneration of auditors	**17,800**	17,800
Other income	**477**	1,882
Total other revenue	**18,277**	19,682
REVENUE FROM GOVERNMENT		
Note 5B: Revenue from Government		
Appropriations:		
Departmental appropriation	**2,632,000**	2,203,000
Total revenue from Government	**2,632,000**	2,203,000

Note 6: Fair Value Measurements

The following table provide an analysis of assets and liabilities that are measured at fair value.

The different levels of the fair value hierarchy are defined below.

Level 1: Quoted prices (unadjusted) in active markets for identical assets or liabilities that the entity can access at measurement date.
Level 2: Inputs other than quoted prices included within Level 1 that are observable for the asset and liability, either directly or indirectly.
Level 3: Unobservable inputs for the asset or liability.

Note 6A: Fair Value Measurements, Valuation Techniques and Inputs Used

Fair value measurements at the end of the reporting period by hierarchy for assets and liabilities in 2015

	Fair value measurements at the end of the reporting period using			
	2015	2014		
	$	$	Category	Valuation technique
Non-financial assets				
Leasehold improvements	**34,910**	94,755	3	Market approach
Property, plant and equipment	**31,724**	43,241	3	Market approach
Total non-financial assets	**66,634**	137,996		
Total fair value measurements of assets in the statement of financial position	**66,634**	137,996		

Note 6B: Reconciliation for Recurring Level 3 Fair Value Measurements

	Leasehold improvements		Property, plant and equipment		Total	
	2015	2014	**2015**	2014	**2015**	2014
	$	$	**$**	$	**$**	$
Opening balance	94,755	126,679	**43,241**	54,885	**137,996**	181,564
Purchases	-	-	-	5,763	-	5,763
Depreciation/amortisation	**(59,845)**	(31,924)	**(11,517)**	(17,407)	**(71,362)**	(49,331)
Closing balance	**34,910**	94,755	**31,724**	43,241	**66,634**	137,996

Note 7: Financial Assets

	2015 $	2014 $
Note 7A: Cash and Cash Equivalents		
Cash on hand or on deposit	18,411	90,023
Total cash and cash equivalents	18,411	90,023
Note 7B: Trade and Other Receivables		
Goods and Services in connection with		
External parties	-	138
Total goods and services receivables	-	138
Appropriations receivables		
Existing programs	741,000	30,000
Total appropriations receivables	741,000	30,000
Other receivables		
GST receivable from the Australian Taxation Office	36,473	25,023
Total other receivables	36,473	25,023
Total trade and other receivables (net)	777,473	55,161
Trade and other receivables (net) expected to be recovered		
No more than 12 months	777,473	55,161
Total trade and other receivables (net)	777,473	55,161
Trade and other receivables (gross) aged as follows		
Not overdue	777,473	55,161
Total trade and other receivables (gross)	777,473	55,161

Goods and services receivable was with entities external to the Australian Government. Credit terms are net 30 days (2014: 30 days). No trade and other receivables were impaired.

Note 8: Non-Financial Assets

	2015	2014
	$	$
Note 8A: Leasehold Improvements		
Leasehold improvements:		
Fair value	207,041	207,041
Accumulated depreciation	(172,131)	(112,286)
Total leasehold improvements	34,910	94,755

No indicators of impairment were found for leasehold improvements.
No leasehold improvements are expected to be sold or disposed of within the next 12 months.

Note 8B: Property, Plant and Equipment		
Property, plant and equipment:		
Fair value	83,093	83,093
Accumulated depreciation	(51,369)	(39,852)
Total property, plant and equipment	31,724	43,241

No indicators of impairment were found for leasehold improvements.
No leasehold improvements are expected to be sold or disposed of within the next 12 months.

Revaluations of non-financial assets
All revaluations were conducted in accordance with the revaluation policy stated at Note 1.
The last revaluation was conducted on 30 June 2011 by the Australian Valuation Office.

Note 8C: Reconciliation of the Opening and Closing Balances of Property, Plant and Equipment (2014–15)

	LEASEHOLD IMPROVEMENTS	PROPERTY, PLANT & EQUIPMENT	TOTAL
	$	$	$
As at 1 July 2014			
Gross book value	207,041	83,093	290,134
Accumulated depreciation and impairment	(112,286)	(39,852)	(152,138)
Net book value 1 July 2014	94,755	43,241	137,996
Additions	-	-	-
Depreciation expense	(59,845)	(11,517)	(71,362)
Net book value 30 June 2015	34,910	31,724	66,634
Net book value as of 30 June 2015 represented by:			
Gross book value	207,041	83,093	290,134
Accumulated depreciation and impairment	(172,131)	(51,369)	(223,500)
	34,910	31,724	66,634

Note 8C: Reconciliation of the Opening and Closing Balances of Property, Plant and Equipment (2013–14)

	LEASEHOLD IMPROVEMENTS	PROPERTY, PLANT & EQUIPMENT	TOTAL
	$	$	$
As at 1 July 2013			
Gross book value	207,041	123,248	330,289
Accumulated depreciation and impairment	(80,362)	(68,363)	(148,725)
Net book value 1 July 2013	126,679	54,885	181,564
Additions	-	5,763	5,763
Depreciation expense	(31,924)	(17,407)	(49,331)
Net book value 30 June 2014	94,755	43,241	137,996
Net book value as of 30 June 2014 represented by:			
Gross book value	207,041	83,093	290,134
Accumulated depreciation and impairment	(112,286)	(39,852)	(152,138)
	94,755	43,241	137,996

	2015	2014
	$	$
Note 8D: Intangibles		
Computer software:		
Purchased	**1,175,771**	1,048,771
Accumulated amortisation	**(784,584)**	(582,471)
Total computer software	**391,187**	466,300
Other intangibles:		
Purchased	**75,262**	75,262
Accumulated amortisation	**(39,198)**	(31,672)
Total other intangibles	**36,064**	43,590
Total intangibles	**427,251**	509,890

No indicators of impairment were found for intangible assets.
No intangibles are expected to be sold or disposed of within the next 12 months.

Note 8E: Reconciliation of the Opening and Closing Balances of Intangibles

Reconciliation of the Opening and Closing Balances of Intangibles for 2015

	COMPUTER SOFTWARE PURCHASED $	OTHER INTANGIBLES PURCHASED $	TOTAL $
As at 1 July 2014			
Gross book value	**1,048,771**	**75,262**	**1,124,033**
Accumulated amortisation	**(582,471)**	**(31,672)**	**(614,143)**
Net book value 1 July 2014	**466,300**	**43,590**	**509,890**
Additions	**127,000**	**-**	**127,000**
Amortisation	**(202,113)**	**(7,526)**	**(209,639)**
Net book value 30 June 2015	**391,187**	**36,064**	**427,251**
Net book value as of 30 June 2015 represented by:			
Gross book value	**1,175,771**	**75,262**	**1,251,033**
Accumulated amortisation	(784,584)	(39,198)	(823,782)
	391,187	**36,064**	**427,251**

Reconciliation of the Opening and Closing Balances of Intangibles for 2014

	COMPUTER SOFTWARE PURCHASED $	OTHER INTANGIBLES PURCHASED $	TOTAL $
As at 1 July 2013			
Gross book value	1,989,547	75,262	2,064,809
Accumulated amortisation	(1,389,923)	(24,148)	(1,414,071)
Net book value 1 July 2013	599,624	51,114	650,738
Additions	102,610	-	102,610
Amortisation	(235,934)	(7,524)	(243,458)
Net book value 30 June 2014	466,300	43,590	509,890
Net book value as of 30 June 2014 represented by:			
Gross book value	2,092,157	75,262	2,167,419
Accumulated amortisation	1,625,857	(31,672)	(1,657,529)
	466,300	**43,590**	**509,890**

	2015 $	2014 $
Note 8F: Other Non-Financial Assets		
Prepayments	**25,822**	26,486
Total other non-financial assets	**25,822**	26,486
Other non-financial assets expected to be recovered in:		
No more than 12 months	**25,822**	26,486
Total other non-financial assets	**25,822**	26,486

No indicators of impairment were found for other non-financial assets.

Note 9: Payables

	2015 $	2014 $
Note 9A: Suppliers		
Trade creditors and accruals	**162,101**	106,078
Total supplier payables	**162,101**	106,078
Suppliers expected to be settled within 12 months:		
External parties	**162,101**	106,078
Total	**162,101**	106,078
Total supplier payables	**162,101**	106,078
Settlement is usually made within 30 days.		
Note 9B: Other Payables		
GST payable to Australian Taxation Office	**11**	(36)
Lease liabilities	**11,186**	30,361
PAYG liabilities	**39,170**	22,369
Total other payables	**50,367**	52,694

Other payables are expected to be settled within 12 months.

Note 10: Provisions

	2015 $	2014 $
Note 10A: Employee Provisions		
Leave	**229,406**	358,944
Total employee provisions	**229,406**	358,944
Employee provisions are expected to be settled in:		
No more than 12 months	**138,382**	221,580
More than 12 months	**91,024**	137,364
Total employee provisions	**229,406**	358,944
Note 10B: Other Provisions		
Provision for restoration	**43,237**	41,632
Total other provisions	**43,237**	41,632
Other provisions are expected to be settled in:		
More than 12 months	**43,237**	41,632
Total other provisions	**43,237**	41,632

	PROVISION FOR RESTORATION $	TOTAL $
Carrying amount 1 July 2014	**41,632**	41,632
Unwinding of discount	**1,605**	1,605
Closing balance 2015	**43,237**	43,237

The entity currently has one agreement for the leasing of premises which have provisions requiring the entity to restore the premises to their original condition at the conclusion of the lease. The entity has made a provision to reflect the present value of this obligation.

Note 11: Cash Flow Reconciliation

	2015 $	2014 $
Reconciliation of net cost of services to net cash from operating activities:		
Net cost of services	**(2,605,728)**	(2,425,914)
Revenue from Government	**2,632,000**	2,203,000
Adjustments for non-cash items		
Depreciation / amortisation	**281,001**	**292,789**
Finance cost	**1,605**	**1,644**
Changes in assets / liabilities		
(Increase) / decrease in net receivables	**(178,312)**	17,283
Decrease in prepayments	**664**	10,032
Decrease in employee provisions	**(129,538)**	(29,413)
Increase in supplier payables	**72,918**	40,547
Decrease in other payables	**(19,222)**	(20,588)
Net cash from operating activities	**55,388**	89,380

Note 12: Senior Management Personnel Remuneration

	2015 $	2014 $
Short-term employee benefits:		
Salary	**221,102**	249,942
Total short-term employee benefits	**221,102**	249,942
Post-employment benefits:		
Superannuation	**39,491**	39,491
Total post-employment benefits	**39,491**	39,491
Other long-term employee benefits:		
Annual leave	**22,264**	22,264
Long-service leave	**7,236**	7,236
Total other long-term employee benefits	**29,500**	29,500
Total senior executive remuneration expenses	**290,093**	318,933

The total number of senior management personnel that are included in the above table is 2 (2014: 1). Note that the Ombudsman resigned on 3 December 2014 and an acting Ombudsman was appointed from 1 January 2015 to 30 June 2015.

Note 13: Financial Instruments

	2015 $	2014 $
Note 13A: Categories of Financial Instruments		
Financial Assets		
Cash and cash equivalents	**18,411**	90,023
Trade and other receivables	**-**	138
Total financial assets	**18,411**	90,161
Financial Liabilities		
Trade creditors	**162,101**	106,078
Total financial liabilities	**162,101**	106,078

Note 13B: Liquidity Risk

The exposure to liquidity risk is based on the notion that the entity will encounter difficulty in meeting its obligations associated with financial liabilities. PHIO's obligations will be met by the Office of the Commonwealth Ombudsman.

Note 14: Appropriations

Note 14A: Annual Appropriations ('Recoverable GST exclusive')

Annual Appropriations for 2015

	Appropriation Act	*PGPA Act*				
	Annual Appropriation	Section 74	Section 75	Total appropriation	Appropriation applied in 2015 (current and prior years)	Variance[1]
	$	$	$	$	$	$
Departmental						
Ordinary annual services	**3,176,000**	**477**		**3,176,477**	**2,416,589**	**759,888**
Equity	-	-	-	-	-	
Total departmental	**3,176,000**	**477**	-	**3,176,477**	**2,416,589**	**759,888**

Annual Appropriations for 2014

	Appropriation Act	*FMA Act*			
	Annual Appropriation	Section 31	Total appropriation	Appropriation applied in 2015 (current and prior years)	Variance[1]
	$	$	$	$	$
Departmental					
Ordinary annual services	2,263,000	1,882	2,264,882	2,172,977	91,905
Equity	-	-	-	-	
Total departmental	2,263,000	1,882	2,264,882	2,172,977	91,905

Notes:

1. Supplier expenses in relation to the merge was less than anticipated hence not all appropriation revenue required.

Note 14B: Departmental and Administered Capital Budgets ('Recoverable GST exclusive')

	2015 Capital Budget Appropriations			Capital Budget Appropriations applied in 2015 (current and prior years)			
	Appropriation Act	*PGPA Act*	Total Capital Budget Appropriations	Payments for non-financial assets [2]	Payments for other purposes	Total payments	Variance[1]
	Annual Capital Budget	Section 75					
	$	$	$	$	$		$
Departmental							
Ordinary annual services - Departmental Capital Budget[1]	**544,000**	-	**544,000**	**102,610**	-	**102,610**	**441,390**

	2014 Capital Budget Appropriations			Capital Budget Appropriations applied in 2014 (current and prior years)			
	Appropriation Act	*FMA Act*	Total Capital Budget Appropriations	Payments for non-financial assets [2]	Payments for other purposes	Total payments	Variance[1]
	Annual Capital Budget	Section 32					
	$	$	$	$	$		$
Departmental							
Ordinary annual services - Departmental Capital Budget[1]	60,000	-	60,000	30,000	-	30,000	30,000

Notes:

1. Departmental Capital Budgets are appropriated through Appropriation Acts (No.1,3,5). They form part of ordinary annual services, and are not separately identified in the Appropriation Acts. For more information on ordinary annual services appropriations, please see Note 14A: Annual appropriations.
2. Payments made on non-financial assets include purchases of assets, expenditure on assets which has been capitalised, costs incurred to make good an asset to its original condition, and the capital repayment component of finance leases.
3. Planned major upgrades to consumer website did not occur.

Note 14C: Unspent Annual Appropriations ('Recoverable GST exclusive')

	2015	2014
	$	$
Departmental		
2014-2015 Appropriation Act 1	**70,000**	-
2014-2015 Appropriation Act 3	**97,000**	-
2014-2015 Appropriation Act 1 - DCB	**544,000**	-
2013-2014 Appropriation Act 1 - DCB	**30,000**	30,000
Cash on hand or on deposit	**18,411**	90,023
Total	**759,411**	120,023

Note 15: Reporting of Outcomes

The Private Health Insurance Ombudsman is structured to meet one outcome, namely public confidence in private health insurance, including through consumer and provider complaint and enquiry investigations, and performance monitoring and reporting. Major classes of revenue and expenses are shown in the Statement of Comprehensive Income and assets and liabilities in the Statement of Financial Position.

Note 16: Budgetary Reports and Explanations of Major Variances

The following tables provide a comparison of the original budget as presented in the 2014–15 Portfolio Budget Statements (PBS) to the 2014–15 final outcome. The Budget is not audited.

Note 16A: Departmental Budgetary Reports

Statement of Comprehensive Income *for the period ended 30 June 2015*

	ACTUAL	BUDGET ESTIMATE	
		ORIGINAL[1]	VARIANCE[2]
	2015	2015	2015
	$	$	$
NET COST OF SERVICES			
Expenses			
Employee benefits	**1,453,936**	**1,296,000**	157,936
Suppliers	**887,463**	**949,000**	(61,537)
Depreciation and amortisation	**281,001**	**309,000**	(27,999)
Finance costs	**1,605**	-	1,605
Total expenses	**2,624,005**	**2,554,000**	70,005
Own-Source Income			
Own-source revenue			
Other revenue	**18,277**	**10,000**	8,277
Total own-source revenue	**18,277**	**10,000**	8,277
Net cost of services	**2,605,728**	**2,544,000**	61,729
Revenue from Government	**2,632,000**	**2,535,000**	97,000
Deficit on continuing operations	**26,272**	**(9,000)**	35,271
OTHER COMPREHENSIVE INCOME			
Other comprehensive income	-	-	-
Total other comprehensive income	-	-	-
Total comprehensive loss	**26,272**	**(9,000)**	35,271

1. The entity's original budgeted financial statement that was first presented to parliament in respect of the reporting period.

2. Between the actual and original budgeted amounts for 2015. Explanations of major variances are provided further below.

Statement of Financial Position *as at 30 June 2015*

	ACTUAL	BUDGET ESTIMATE	
		ORIGINAL[1]	VARIANCE[2]
	2015	2015	2015
	$	$	$
ASSETS			
Financial assets			
Cash and cash equivalents	18,411	153,000	(134,589)
Trade and other receivables	777,473	342,000	435,473
Total financial assets	795,884	495,000	300,884
Non-financial assets			
Leasehold improvements	34,910	56,000	(21,090)
Property, plant and equipment	31,724	44,000	(12,276)
Intangibles	427,251	718,000	(290,749)
Other non-financial assets	25,822	37,000	(11,178)
Total non-financial assets	519,707	855,000	(335,293)
Total assets	1,315,591	1,350,000	(34,409)
LIABILITIES			
Payables			
Suppliers	162,101	139,000	23,101
Other payables	50,367	-	50,367
Total payables	212,468	139,000	73,468
Provisions			
Employee provisions	229,406	388,000	(158,594)
Other provisions	43,237	40,000	3,237
Total provisions	272,643	428,000	(155,357)
Total liabilities	485,110	567,000	(81,890)
Net assets	830,480	783,000	47,480
EQUITY			
Contributed equity	1,223,321	1,297,000	(73,679)
Reserves	99,981	100,000	(19)
Accumulated deficit	(492,822)	(614,000)	121,178
Total equity	830,480	783,000	47,480

1. The entity's original budgeted financial statement that was first presented to parliament in respect of the reporting period.
2. Between the actual and original budgeted amounts for 2015. Explanations of major variances are provided further below.

Cash Flow Statement *for the period ended 30 June 2015*

	ACTUAL	BUDGET ESTIMATE	
		ORIGINAL[1]	VARIANCE[2]
	2015	2015	2015
	$	$	$
OPERATING ACTIVITIES			
Cash received			
Appropriations	**2,465,000**	**2,235,000**	230,000
Sales of goods and rendering of services	**687**	**10,000**	(9,313)
Net GST received	**63,759**	**96,000**	(32,241)
Total cash received	**2,529,446**	**2,341,000**	188,446
Cash used			
Employees	**1,583,473**	**1,296,000**	287,473
Suppliers	**890,585**	**949,000**	(58,415)
Net GST paid	**-**	**96,000**	(96,000)
Total cash used	**2,474,058**	**2,341,000**	133,058
Net cash from operating activities	**55,388**	**-**	55,388
INVESTING ACTIVITIES			
Cash used			
Purchase of intangibles	**127,000**	**544,000**	(417,000)
Total cash used	**127,000**	**544,000**	(417,000)
Net cash used by investing activities	**(127,000)**	**(544,000)**	417,000
FINANCING ACTIVITIES			
Cash received			
Contributed equity	**-**	**544,000**	(544,000)
Total cash received	**-**	**544,000**	(544,000)
Net cash from financing activities	**-**	**544,000**	(544,000)
Net increase (decrease) in cash held	**(71,612)**	**-**	(71,612)
Cash and cash equivalents at the beginning of the reporting period	**90,023**	**153,000**	(62,977)
Cash and cash equivalents at the end of the reporting period	**18,411**	**153,000**	134,589

1. The entity's original budgeted financial statement that was first presented to parliament in respect of the reporting period.
2. Between the actual and original budgeted amounts for 2015. Explanations of major variances are provided further below.

Note 16B: Departmental Major Budget Variances for 2015

EXPLANATIONS OF MAJOR VARIANCES	AFFECTED LINE ITEMS (AND STATEMENT)
Employee expenses were higher than the original budget due increased payments of higher duties allowances and unplanned payments to staff in accordance with the Enterprise Agreement. This is also reflected in cash appropriations being higher than the original budget.	Employee benefits (Statement of Comprehensive Income) Employees (Cash Flow Statement) Appropriations (Cash Flow Statement)
Supplier expenses relating to the merger were less than anticipated in the original budget.	Suppliers (Statement of Comprehensive Income) Suppliers (Cash Flow Statement)
Appropriations receivable includes $544,000 of unspent departmental capital budget. Planned major upgrades to the consumer website did not occur in 2014–15.	Trade and other receivables (Statement of Financial Position) Intangibles (Statement of Financial Position) Purchase of intangibles (Cash Flow Statement) Contributed equity (Cash Flow Statement)
PAYG liabilities are higher than budget due to higher employee expenses.	Other payables (Statement of Financial Position)
Employee provisions decreased due to employee cessations.	Employee provisions (Statement of Financial Position)
Cash and cash equivalents were lower than the original budget due to the higher employee expenses noted above, and cash outflows associated with employee cessations.	Cash and Cash equivalents (Statement of Financial Position)
GST grossed up in actuals.	Net GST paid (Cash Flow Statement)

GLOSSARY

Agreement hospital: Private hospital or day surgery contracted with a health insurer to provide services at low or no out-of-pocket costs.

Broker: A person or organisation which sells private health insurance on behalf of a health insurer.

Combined policy: Health insurance that covers both hospital and general treatment services. See General treatment policy and Hospital policy.

Commonwealth Ombudsman: The Commonwealth Ombudsman safeguards the community in its dealings with Australian Government agencies. The Ombudsman's office handles complaints, conducts investigations, performs audits and inspections, encourages good administration, and carries out specialist oversight tasks. Effective from 1 July 2015, the Private Health Insurance Ombudsman (PHIO) function was transferred to the Commonwealth Ombudsman.

Exclusions: Conditions or services which are not covered by a hospital insurance policy.

Health fund: see *Health insurer*.

Health insurer: Organisation which provides private health insurance, also known as a 'health fund'.

Department of Health: The Commonwealth Government department responsible for policy development and maintaining the regulatory framework for private health insurance.

Gap fee: The amount you pay out of your own pocket for medical treatment in hospital, over and above what you get back from Medicare or your private health insurer. Health insurers have gap cover arrangements to insure against some or all of these additional payments.

General treatment policy: Health insurance to cover non-hospital medical services that are not covered by Medicare, such as dental, optical, and ambulance. Also known as 'extras' or 'ancillary' cover.

Hospital policy: Health insurance to cover your costs as a private patient in hospital.

Hospital agreement: The contract between a health insurer and a private hospital to provide services at low or no out-of-pocket costs.

Informed financial consent: The provision of cost information to patients, including notification of likely out-of-pocket expenses (gap fees) by all relevant service providers, preferably in writing, before admission to hospital.

Lifetime Health Cover: A government initiative introduced from 1 July 2000 that determines how much you pay for private hospital insurance, primarily based on your age.

Medicare: Australia's universal public health care system.

Medicare Benefits Schedule: The schedule of fees set by the government for standard medical services.

Medicare Levy Surcharge: An income tax levy that applies to Australian taxpayers who earn above a certain income and do not have private hospital cover.

Overseas student health cover: A type of health cover designed for overseas student visa holders which can be purchased from some Australian private health insurers.

Overseas visitors health cover: A type of health cover designed for people without Medicare benefits or with only reciprocal (partial) Medicare benefits.

Pharmaceutical Benefits Scheme: A government subsidy which reduces the price of some prescription medicines. The scheme is available to all Australian residents who hold a current Medicare card.

PHIO: Private Health Insurance Ombudsman.

Private Health Insurance Administration Council: An independent statutory authority which was responsible for the prudential regulation of private health insurers. From 1 July 2015 the responsibility for the prudential supervision of private health insurers transferred to the Australian Prudential Regulation Authority (APRA).

Private Health Insurance Rebate: Most Australians with private health insurance currently receive a rebate from the government to help cover the cost of their premiums. The rebate is income tested and varies depending on your age.

Restrictions: Treatment or services which a hospital insurance policy covers to a limited extent and which are eligible for only reduced benefits on hospital admissions. Where a policy has a restriction, the benefit paid is only sufficient to cover the cost of admission as a private patient in a shared room in a public hospital; it is not sufficient to cover the cost of a private room in a public hospital or any room in a private hospital.

Waiting period: How long you need to be a member of a policy before you are eligible for benefits.

LIST OF REQUIREMENTS

	PART OF REPORT	DESCRIPTION	REQUIREMENT	PAGE
8(3) & A.4		Letter of transmittal	Mandatory	V
A.5		Table of contents	Mandatory	VI
A.5		Index	Mandatory	89
A.5		Glossary	Mandatory	83
A.5		Contact officer(s)	Mandatory	inside front cover
A.5		Internet home page address and Internet address for report	Mandatory	inside front cover
9	Review by Secretary			
9(1)		Review by departmental secretary	Mandatory	2
9(2)		Summary of significant issues and developments	Suggested	2
9(2)		Overview of department's performance and financial results	Suggested	2
9(2)		Outlook for following year	Suggested	n/a
9(3)		Significant issues and developments – portfolio	Portfolio departments – suggested	1, 2
10	Departmental Overview			
10(1)		Role and functions	Mandatory	6
10(1)		Organisational structure	Mandatory	40
10(1)		Outcome and programme structure	Mandatory	8
10(2)		Where outcome and programme structures differ from PB Statements/PAES or other portfolio statements accompanying any other additional appropriation bills (other portfolio statements), details of variation and reasons for change	Mandatory	n/a
10(3)		Portfolio structure	Portfolio departments - mandatory	n/a
11	Report on Performance			
11(1)		Review of performance during the year in relation to programmes and contribution to outcomes	Mandatory	8
11(2)		Actual performance in relation to deliverables and KPIs set out in PB Statements/PAES or other portfolio statements	Mandatory	9-10
11(2)		Where performance targets differ from the PBS/PAES, details of both former and new targets, and reasons for the change	Mandatory	n/a
11(2)		Narrative discussion and analysis of performance	Mandatory	11-20
11(2)		Trend information	Mandatory	11-20
11(3)		Significant changes in nature of principal functions/ services	Suggested	n/a
11(3)		Performance of purchaser/provider arrangements	If applicable, suggested	n/a

	PART OF REPORT	DESCRIPTION	REQUIREMENT	PAGE
11(3)		Factors, events or trends influencing departmental performance	Suggested	1-5
11(3)		Contribution of risk management in achieving objectives	Suggested	n/a
11(4)		Performance against service charter customer service standards, complaints data, and the department's response to complaints	If applicable, mandatory	35, 43
11(5)		Discussion and analysis of the department's financial performance	Mandatory	45
11(6)		Discussion of any significant changes in financial results from the prior year, from budget or anticipated to have a significant impact on future operations.	Mandatory	45
11(7)		Agency resource statement and summary resource tables by outcomes	Mandatory	45
12	Management and Accountability			
	Corporate Governance			
12(1)		Agency heads are required to certify their agency's actions in dealing with fraud.	Mandatory	42
12(2)		Statement of the main corporate governance practices in place	Mandatory	42
12(3)		Names of the senior executive and their responsibilities	Suggested	40
12(3)		Senior management committees and their roles	Suggested	n/a
12(3)		Corporate and operational plans and associated performance reporting and review	Suggested	n/a
12(3)		Internal audit arrangements including approach adopted to identifying areas of significant financial or operational risk and arrangements to manage those risks	Suggested	n/a
12(3)		Policy and practices on the establishment and maintenance of appropriate ethical standards	Suggested	n/a
12(3)		How nature and amount of remuneration for SES officers is determined	Suggested	41
	External Scrutiny			
12(4)		Significant developments in external scrutiny	Mandatory	42
12(4)		Judicial decisions and decisions of administrative tribunals and by the Australian Information Commissioner	Mandatory	42
12(4)		Reports by the Auditor-General, a Parliamentary Committee, the Commonwealth Ombudsman or an agency capability review	Mandatory	42
	Management of Human Resources			
12(5)		Assessment of effectiveness in managing and developing human resources to achieve departmental objectives	Mandatory	40
12(6)		Workforce planning, staff retention and turnover	Suggested	40-42

	PART OF REPORT	DESCRIPTION	REQUIREMENT	PAGE
12(6)		Impact and features of enterprise or collective agreements, individual flexibility arrangements (IFAs), determinations, common law contracts and Australian Workplace Agreements (AWAs)	Suggested	41
12(6)		Training and development undertaken and its impact	Suggested	41
12(6)		Work health and safety performance	Suggested	44
12(6)		Productivity gains	Suggested	n/a
12(7)		Statistics on staffing	Mandatory	41
12(8)		Statistics on employees who identify as Indigenous	Mandatory	41
12(9)		Enterprise or collective agreements, IFAs, determinations, common law contracts and AWAs	Mandatory	41
12(10) & B		Performance pay	Mandatory	41
12(11)-(12)	Assets management	Assessment of effectiveness of assets management	If applicable, mandatory	n/a
12(13)	Purchasing	Assessment of purchasing against core policies and principles	Mandatory	n/a
12(14)-(23)	Consultants	The annual report must include a summary statement detailing the number of new consultancy services contracts let during the year; the total actual expenditure on all new consultancy contracts let during the year (inclusive of GST); the number of ongoing consultancy contracts that were active in the reporting year; and the total actual expenditure in the reporting year on the ongoing consultancy contracts (inclusive of GST). The annual report must include a statement noting that information on contracts and consultancies is available through the AusTender website.	Mandatory	42
12(24)	Australian National Audit Office Access Clauses	Absence of provisions in contracts allowing access by the Auditor-General	Mandatory	n/a
12(25)	Exempt contracts	Contracts exempted from publication in AusTender	Mandatory	n/a
12(26)-(28)	Small business	Procurement initiatives to support small business	Mandatory	44
13	Financial Statements	Financial Statements	Mandatory	45
	Other Mandatory Information			
14(1) & C.1		Work health and safety (Schedule 2, Part 4 of the *Work Health and Safety Act 2011)*	Mandatory	44
14(1) & C.2		Advertising and Market Research (Section 311A of the *Commonwealth Electoral Act 1918)* and statement on advertising campaigns	Mandatory	44
14(1) & C.3		Ecologically sustainable development and environmental performance (Section 516A of the *Environment Protection and Biodiversity Conservation Act 1999)*	Mandatory	44

PART OF REPORT	DESCRIPTION	REQUIREMENT	PAGE
14(1)	Compliance with the agency's obligations under the *Carer Recognition Act 2010*	If applicable, mandatory	n/a
14(2) & D.1	Grant programmes	Mandatory	44
14(3) & D.2	Disability reporting – explicit and transparent reference to agency level information available through other reporting mechanisms	Mandatory	44
14(4) & D.3	Information Publication Scheme statement	Mandatory	44
14(5)	Correction of material errors in previous annual report	If applicable, mandatory	n/a
E	Agency Resource Statements and Resources for Outcomes	Mandatory	n/a
F	List of Requirements	Mandatory	85

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