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QUARTERLY BULLETIN NO 16
(1 July to 30 September 2000)

INTRODUCTION

This main focus of this quarter's bulletin will be the aftermath of the Lifetime Healthcover success, but it is also necessary to bring to the industry's attention two other issues, which are causing concern, firstly, the waiting periods for obstetrics and secondly the growing number of funds disadvantaging their members by imposing the first tier default benefit.

WAITING PERIODS FOR OBSTETRICS

There is still some confusion with respect to waiting periods for obstetrics and what related procedures are included in the twelve month waiting period. Some funds consider the detailing of ***pregnancy related procedures*** in their brochures to be sufficient justification for denying benefits for the full twelve months.

This office sought clarification from the Department on the interpretation to be placed on HBF Circular 623, and received the following advice from Dr Robert Wooding:

"*Your interpretation of the Circular is correct. The clear intention of Schedule 1 of the National Health Act 1953 (the act) and National Health Regulation 53 is that the 12 month waiting period only be applied to obstetric conditions listed under the Medicare Benefits Schedule (MBS). It is not to apply to procedures listed under gynecological item numbers such as the evacuation of the uterine contents following miscarriage and the removal of ectopic pregnancy. For these conditions, a two month waiting period is to apply."*

It is obvious from the above that item numbers in the MBS from 16,500 to 16,636 are covered in the twelve month waiting period, but items in the 35,500 to 35,756 range are gynecological and unless they are pre existing, only attract a two month general waiting period. These latter items include the evacuation of uterine contents following miscarriage and the removal of ectopic pregnancy which are items 35,643, 35,639, and 35,640.

NON CONTRACT HOSPITALS –WHICH DEFAULT-WHEN IT SHOULD BE APPLIED

A number of complaints recently have brought to light a practice that is significantly disadvantaging consumers. It is apparent that when some funds and hospitals cannot agree on contractual arrangements, the fund, either as part of the negotiation strategy or a punishment to the hospital, provide only first tier default benefits to members attending that hospital. This is even occurring with hospitals that have quality accreditation and indeed had previously held contracts with the particular fund.

This practice not only disadvantages the hospital but it also reduces the consumer to a position within the system where they are completely disempowered. The hospital for which a week before they would have received a benefit of around $500 per day now becomes a $300 per day patient moiety option.

The consumer should not be disadvantaged to this extent. They have generally paid for top cover and are due more for their contributions than to be treated in this way. Second tier default, although ostensibly brought in to help the hospital, is a very significant consumer safeguard that is being overlooked in this practice.

LIFETIME HEALTHCOVER

The Lifetime Healthcover campaign has concluded. The membership coverage has increased by an impressive 36.4%. The complaint numbers to the office of the Ombudsman, by contrast have increased 141%, from 354 for the July - September quarter last year to 856 for the corresponding quarter this year. These numbers exclude entirely any enquiry workload.

An increase of this magnitude is almost impossible to handle in an organisation of only 6.6 staff. Additional Disputes Resolution Officers have been recruited and should soon begin to make an impact on the backlog of complaints.

In the process of examining the extent and impact on our office of the influx of newly insured members, some useful information emerged. This information can assist those in the private health industry who have a responsibility for the provision of both service and finance for the consumer. We have commenced some analysis of the data and our preliminary results and recommendations are detailed for the benefit of providers and insurers.

Waiting Periods and Pre Existing Ailments

There were 197 complaints relating to waiting periods associated with pre existing ailments (PEA), contrasting with 71 for the corresponding period last year. This is an **increase** of 177%. We dissected this statistic further, into the higher level category of Dispute (where this office commences a detailed investigation of the initial decision) and Grievance, (where the complainant is informed that the initial decision, on the information available appears correct).

In the 1999 quarter, the percentage of PEA type complaint which were Grievances was 30%. In the 2000 quarter this has risen to 43%. On the surface you could say this is getting better, we got 43% correct rather than 30%. But how did these 85 grievances (as compared with 22 the last year) arise at all? Generally, it is because of inadequate information from participants.

- The fund had not been explicit enough when advertising. This was an all too common complaint. Waivers of waiting periods without properly distinguishing between the general waiting periods and pre existing ailments was the main cause of grievance. Members actually proceeded with treatments before the detailed brochures arrived.
- Information provided by both call centers and front counters was not correctly conveyed.
- Some practitioners encouraged new members to go ahead now they had private cover, sure in their own belief the member had not presented with this problem before joining and therefore it was not pre existing. Practitioners were ignorant of the specifics of the Act with respect to signs and symptoms and that the medical practitioner appointed by the fund was the arbiter.

The number of complaints about PEAs that fall into the Dispute category rose from 49 in the 1999 quarter to 112 in the corresponding 2000 quarter. The difficulty here is that almost all of these complainants have already had the procedure performed before they became aware they were not covered. The cost to some reaches the tens of thousands of dollars. It is difficult to imagine anyone entering into this sort of arrangement and possible financial hardship if they have any

thought that they are not covered. There are just too many of them for this statistic to appear by chance. A high proportion of these people were led to believe by "the system" they were covered.

"The system" referred to here is the combination of events leading up to the hardship that now faces a large number of these people. It comes about because of misinformation and lack of care in procedures.

- Many practitioners are not sufficiently aware of the implications of the present National Health Act as it refers to signs or symptoms and routinely tell patients they will be covered.
- Some health funds deny all claims that fall into certain categories of ailment or condition and do not rely on the signs or symptoms of the individual.
- Hospitals have not in some circumstances even carried out the most rudimentary checks to see if a patient is covered. In other circumstances they have failed to follow up on an indication by the fund that the member has not served the 12 month PEA waiting period.
- Funds have advertised waivers without making **absolutely** sure that the new member knew the difference between general waiting times and pre existing ailments.
- Many fund staff or call center operators did not really understand what signs or symptoms meant and routinely told new members "if your doctor is sure you didn't have it when you joined you will probably be OK".
- Hospitals and practitioners operate 365 days a year 24 hours a day and yet the health funds still offer (in the main) Monday to Friday 9 to 5 answers to questions on possible PEAs.

The Department, in conjunction with this office, the insurers and hospitals have set in train processes that should dramatically reduce the number of consumers being placed in the position where they face financial liabilities of which they were not informed. For the system to work it needs commitment and cooperation from all industry participants.

Cost

In our last quarterly bulletin, it was reported that aggressive marketing associated with introductory prices of products had created problems. This related mainly to a small number of funds that made generous offers in the local and national media. Unfortunately as predicted the number of such complaints reaching this office has remained steady at about one per working day, where a contributor feels they were not accurately informed as to the length of time the offer referred. This is particularly the case when it was accompanied by information that strongly suggested the fund was not going to increase its prices for the next twelve months. Again the numbers are too high for the "excuse" that the person just didn't understand the conditions, which to everybody else were quite obvious. Consumer protection laws are there to ensure that companies marketing products conduct their business and advertising in such a way as not to mislead any consumer. It is insufficient to rely on the fact that only a very small number of purchasers incorrectly interpret the information.

Advertising and Marketing

Complaints received from various quarters pointed to a degree of laxity on the part of those responsible for approving advertising and marketing campaigns. Very early in the life of this office, the ACCC and PHIO combined to produce advertising and marketing guidelines for health insurance, it is perhaps time some fund CEOs brought the copy out of the bottom drawer and loaned it to the marketing department.

Complaints (Problems, Grievances & Disputes) by health fund
1 July 2000 to 30 September 2000

Name of Fund	Total number of complaints (1)	% of total complaints	Total number of disputes (2)	% of total disputes	Health fund Market share (3)
ACA Health Benefits Fund	1	0.12	1	0.33	0.10
AMA Health Fund Ltd	0	0.00	0	0.00	0.10
Australian Health Management	20	2.34	5	1.67	2.40
Australian Unity Health Fund	33	3.86	10	3.33	2.70
AXA Australia Health Insurance	83	9.70	34	11.33	10.60
CBHS Friendly Society	3	0.35	2	0.67	1.00
CDH Benefits Fund	0	0.00	0	0.00	0.10
Credicare Health Fund	2	0.23	0	0.00	0.50
Defence Health Benefits Society	14	1.64	7	2.33	1.30
Geelong Medical & Hospital Benefits Ass.	4	0.47	0	0.00	1.00
Goldfields Medical Fund Inc	3	0.35	0	0.00	0.20
Grand United Corporate Health Ltd	2	0.23	0	0.00	0.30
Grand United Friendly Society	7	0.82	3	1.00	0.50
Health Care Insurance Ltd	0	0.00	0	0.00	0.10
Health Insurance Fund of WA	4	0.47	0	0.00	0.30
Health-Partners	2	0.23	1	0.33	0.60
Healthguard Health Benefits Fund Ltd	1	0.12	0	0.00	0.10
Hospital Benefit Fund of WA (Inc)	14	1.64	5	1.67	11.00
Hospital Contribution Fund of Australia Ltd	36	4.21	16	5.33	8.50
IOOF Friendly Society of Victoria	8	0.93	4	1.33	0.20
IOR Australia Pty Ltd	14	1.64	6	2.00	0.70
Latrobe Health Services (VIC)	3	0.35	2	0.67	0.40
Lysaght Hospital and Medical Club	0	0.00	0	0.00	0.20
Manchester Unity Friendly Society In NSW	21	2.45	8	2.67	1.00
Medibank Private	288	33.64	89	29.67	26.90
Medical Benefits Fund of Australia Ltd	229	26.75	85	28.33	18.10
Mildura District Hospital Fund	0	0.00	0	0.00	0.30
Navy Health	0	0.00	0	0.00	0.30
NIB Health Funds Ltd	33	3.86	15	5.00	4.70
NRMA Health Pty Ltd	9	1.05	1	0.33	1.30
NSW Teachers Federation Health Society	5	0.58	0	0.00	1.50
Phoenix Welfare Association Ltd	0	0.00	0	0.00	0.20
Queensland Country Health Ltd	3	0.35	0	0.00	0.20
Railway & Transport Emp'ees Friendly Soc.	1	0.12	0	0.00	0.40
Reserve Bank Health Fund Friendly Soc.	0	0.00	0	0.00	0.10
SA Police Employees Health Fund Inc	0	0.00	0	0.00	0.10
St Lukes Medical & Hospital Benefits Ass.	3	0.35	2	0.67	0.50
Transition Benefits Fund	0	0.00	0	0.00	0.20
Teachers Union Health	3	0.35	1	0.33	0.40
Transport Friendly Society	1	0.12	0	0.00	0.10
United Ancient Order of Druids Victoria	0	0.00	0	0.00	0.10
United Ancient Order of Druids G/L NSW	0	0.00	0	0.00	0.10
Western District Health Fund Ltd	5	0.58	3	1.00	0.50
Federation Health	1	0.12	0	0.00	0.10
Total for Registered Funds	**856**	**100.00**	**300**	**100.00**	**100.00**

1 Complaints = problems, grievances and disputes
2 Disputes require intervention by the Ombudsman and the fund
3 Proportion of people covered by health fund as at 30 June 1999 as reported in the PHIAC Annual Report - These figures could now be somewhat different due to the yet unreported changes which occurred through Lifetime Health Cover.