PRIVATE HEALTH INSURANCE
COMPLAINTS COMMISSIONER

Quarterly Bulletin Issue 7
1 January – 31 March 1998

Welcome to the third Quarterly Bulletin for 1997/98, summarising the Complaints Commissioner's operations between 1 January and 31 March 1998.

Highlights this quarter

- 370 *complaints* were received (a decrease of 24% on the 488 complaints received in the previous quarter)

- most complaints were about benefits (29%), which is up significantly on the previous quarter's proportion of 22%. 'Benefits' displaced 'cost' as the main issue complained about in the March quarter

- 51% percent of complaints were resolved within a week, which is slightly down on the 57% on the previous quarter

- 258 *inquiries* were recorded during the March quarter (down by about 28% from the December quarter)

- Overwhelmingly, it is health fund members that lodge complaints.

Distribution and suggestions

- Quarterly Bulletins are provided to the Minister for Health and Family Services, members of the Senate Community Affairs Legislation Committee, health funds, the Australian Health Insurance Association (AHIA), Health Insurance Restricted Membership Association of Australian (HIRMAA) and officers of the Department of Health and Family Services.

- Please direct any questions or concerns you may have about this Bulletin to Samantha Gavel, Policy and Project Officer on (02) 9261 5855. Samantha welcomes suggestions for future issues of the Bulletin.

- To be included on our mailing list, please telephone Nicole Castaldi on the same number, or e-mail us at info@phicc.org.au.

Mary Perrett
COMPLAINTS COMMISSIONER
May 1998

Background

Who we are
The Complaints Commissioner provides consumers and other key stakeholders with an independent means of resolving their health insurance problems. The Commissioner aims to provide a world class complaints and advice service that:

- is accessible to the privately insured
- is effective at resolving disputes
- is driven by the needs of its customers
- is independent of health funds, private & public hospitals and government
- works co-operatively with interested parties to resolve problems
- provides high quality information and advice to people with, or who are seeking to take out, private health insurance.

Contacting the Commissioner
A national freecall Complaints Hotline (1800 640 695) is staffed between 8.30 am and 5.00 pm (Sydney time), Monday through Friday. The Commissioner does not require complaints to be in writing before they are investigated. Complaints may also be lodged from our internet site.

Some callers do not want to make a complaint but want further information about private health insurance generally or about their own health insurance fund. These calls are regarded as “inquiries”. Callers with complaints about private health insurance regulatory or policy issues are also recorded as inquiries.

Complaints can be made by health fund members, hospitals, doctors, some dentists, health funds and people acting on behalf of any of the above.

The Complaints Commissioner does not have the power to enforce any recommendations and relies on health funds, hospitals, day surgery centres, doctors and dentists to implement the remedies that are proposed.

Further information
Further printed information about the Complaints Commissioner is available by telephoning Nicole Castaldi on (02) 9261 5855. Available brochures include:

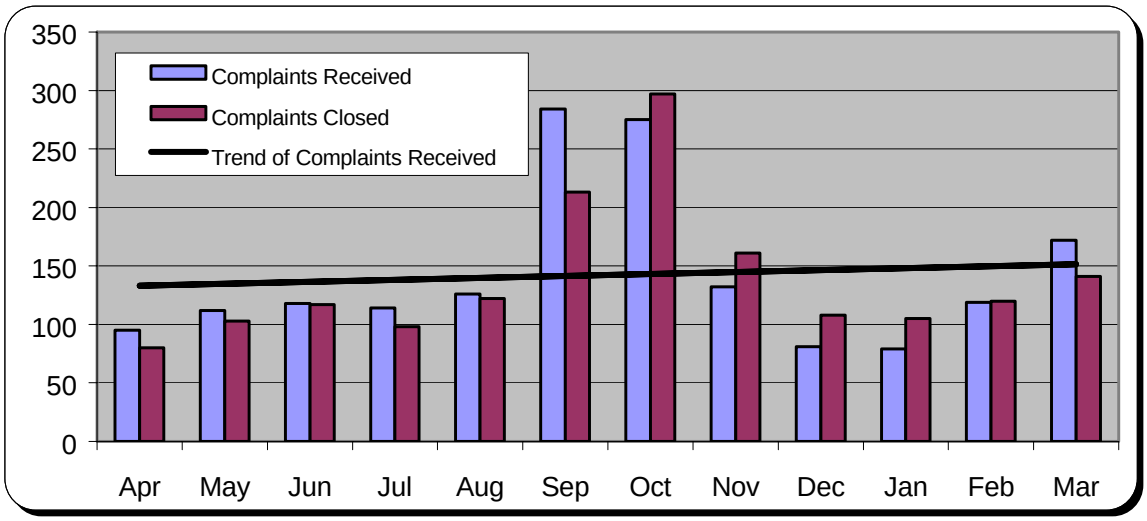
- The 10 Golden Rules of private health insurance
- Can we help with your health insurance complaint? (available in a variety of community languages)
- Our Mission
- Service Charter
- Insure? Not Sure? Your quick guide to private health insurance
- When the Doctor’s bill makes you ill.

World Wide Web
We are also on the internet at http://www.phicc.org.au. Copies of our brochures and the 1996/97 Annual Report are available on the site.

Complaints

Complaints received
There was a large decrease in the number of complaints received in the March quarter (370 complaints compared with 488 in the December quarter). The large number of complaints received in the September and December quarters reflected complaints about premium increases by two funds, including a major product restructure by one. The trendline for the number of complaints received by the Commissioner remains upwards.

Figure 1: Complaints received and closed by month – April '97 to March '98



Who Complains?
During the March quarter, the overwhelming majority of complaints were made by members of health funds. There was one complaint made by a hospital and one complaint made by a health fund. Two complaints were made by doctors.

What issues are complained about?
The 370 complaints received were about 406 different issues. The most complained about issue was benefits (118 or 29%), which is up from 22% in the previous quarter.

Complaints about waiting periods were the second most complained about issue (79 or 20%). Most concerned application of the pre existing ailment rule.

Complaints about membership problems were the third most complained about issue during the March quarter (70 or 17%). Membership complaints include problems with fund transfers and membership continuity, payment of arrears, and membership cancellation and suspension. There were 7 complaints about the membership rights of dependents.

Concerns about information were recorded in 45 instances (11%). Most of these were about oral information provided about benefit entitlements. Many of the 'Complaints NEC' (52) in Figure 2 were about health fund rule changes.

Figure 2: Issues complained about

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How do people complain?
Most complaints in the March quarter were initially made by telephone (89%, down slightly from previous quarters at 91% and 92% respectively).

Other complaint vehicles included letter (10%, up slightly from 8% and 6% respectively in the previous quarters) and fax (constant at 1%). There was one Parliamentary representation and no personal visits in the March quarter.

The Complaints Commissioner encourages people to telephone with details of their complaint. It is not necessary to lodge a complaint in writing. Complaints may also be lodged from the World Wide Web site or by e-mail.

Who is complained about?
Complaints received by the Commissioner can involve one or more of: a health fund, hospital, doctor or dentist. During the March quarter, as in previous quarters, the majority of complaints were about health funds, with almost half the complaints received referred to the relevant fund for investigation and report.

What action is taken about complaints?
Where a complainant has not attempted to resolve their problem with the health fund, hospital, doctor or dentist, the complainant is usually referred back to the service provider on the spot over the telephone, so that the service provider has an opportunity to resolve the problem before the intervention of the Complaints Commissioner. These are recorded as ‘complainant directed back to fund’.

Some complaints can be resolved by staff of the Commissioner without the need to directly contact the health fund, hospital, doctor or dentist concerned. These are shown in Figure 3 as ‘complainant dealt with in-house’.

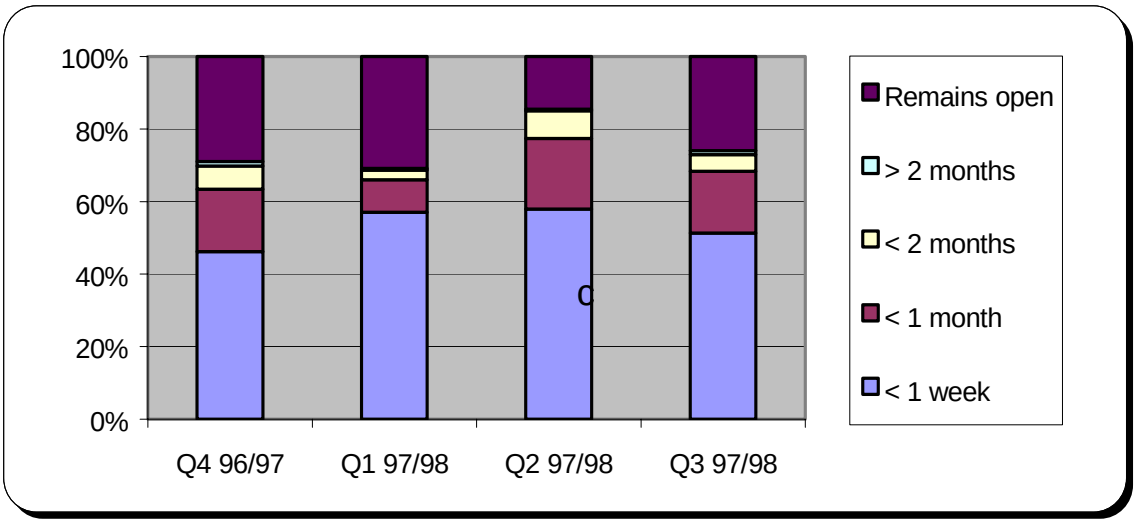
Other complaints are referred to the health fund, hospital, doctor or dentist for investigation and/or comment. This may be done in writing or by telephone.
Figure 3: Actions taken by the Complaints Commissioner

Action by Complaints Commissioner	1997/98 Jan No.	Jan %	Feb No.	Feb %	Mar No.	Mar %
Complainant directed back to fund	13	17%	16	14%	13	8%
Complainant dealt with in house	20	26%	44	39%	59	36%
Complaint referred to fund	44	57%	53	47%	90	56%
Total complaints about funds	77	100%	113	100%	162	100%
Complainant directed back to hospital	0	0%	0	0%	0	0%
Complainant dealt with in house	1	100%	2	67%	5	45%
Complaint referred to hospital for comment	0	0%	1	33%	6	55%
Total complaints about hospitals	1	100%	3	100%	11	100%
Complainant directed back to doctor	2	100%	5	63%	4	36%
Complainant dealt with in house	0	0%	3	38%	7	64%
Complaint referred to doctor for comment	0	0%	0	0%	0	0%
Total complaints about doctors/dentists	2	100%	8	100%	11	100%

Time taken to resolve complaints

Around 51% of complaints received in the March quarter were resolved within a week, which is down slightly from the 57% in the previous quarter. More complaints remained open at the end of the quarter, possibly reflecting a trend of the Commissioner's office dealing with more difficult complaints that take longer to resolve.

Figure 4: Time taken to resolve complaints



Where do complainants live?

During the March quarter, most complaints were lodged from NSW (114), followed by Victoria (98) and Queensland (80). All State and Territories recorded falls. The accompanying graph compares the distribution of complaints received by State with the distribution of private health insurance (for all open funds only).

Figure 5: Complaints received by State

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What were the outcomes?

Of the complaints closed during the quarter, only 10% were referred directly back to the object of complaint, usually because there had been no attempt by the complainant to resolve the problem. This compares with 34% in the previous quarter, and is due to most complaints about cost in the previous quarter being directed back to the member's fund. The remainder of the complaints that were closed were resolved in the following way:

- providing complainants with additional information or an explanation of their problem, including confirmation of advice originally provided by a health fund (64% of complaint issues were dealt with this way in the March quarter, compared with 47% in the previous quarter)

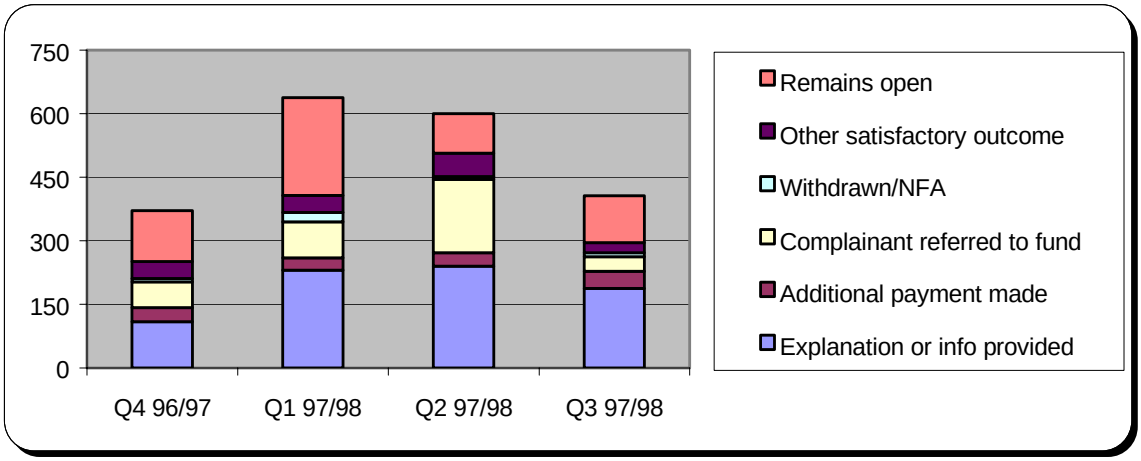
- the fund providing an additional payment or the hospital, doctor or dentist writing off all or part of an account (14% of complaint issues, double the proportion in the previous quarter)

- the fund reversing its previous decision, for example, to deny continuity of membership (8% of complaint issues compared with 11% previously)

- the Complaints Commissioner referring a matter to another more appropriate agency, such as the ACCC (1%).

In a small number of cases (3%) the complaint was withdrawn at the request of the complainant, or closed by the Complaints Commissioner where the complainant failed to provide additional information requested by the Commissioner.

Figure 6: Outcomes for complaints received



Inquiries

The Complaints Commissioner received 258 inquiries in the March quarter, a decrease of about 28% on the December quarter. Most inquiries were about general health service and health insurance issues.

The majority of inquiries came from NSW, with half as many from each of Victoria and Queensland. Callers in 21% of cases did not identify the State/Territory of their residence.

Most inquiries are dealt with by providing additional information or an explanation, including providing a brochure. Some callers were referred to a health fund or other appropriate agency. Some calls and letters do not require action on the part of the Complaints Commissioner – the complainant is provided with information only, or callers simply seek confirmation that the Commissioner may be able to assist them in the future should they have difficulties with their private health insurance.

Case Studies

Pre existing ailments and access to Medicare records
The Complaints Commissioner receives many calls and letters about application of the pre existing ailment rule. Often the member is unaware of the specific reason for the fund rejecting a claim for benefits. In many cases the fund writes to the member in very general terms, saying that information provided by the member's doctors supports application of the pre existing ailment rule.

In a few instances raised with the Complaints Commissioner, the fund's decision to apply the pre existing ailment rule has been made by a clerical staff member, rather than the fund's medical adviser, as required by law. In some of these instances, a closer inspection by the Commissioner of the information used by the fund does not support application of the pre existing ailment rule, as shown in the following case example.

A fund's claims manager applied the pre existing ailment rule to proposed knee surgery based on information supplied by the member's doctor that the member had previously had surgery on the knee about 20 years ago. When the Complaints Commissioner queried this with the fund, the Commissioner was advised that the need to seek advice from the fund's medical adviser was only a "technical" requirement. The Commissioner was concerned that the fund had not demonstrated that "signs and symptoms" were present in the six months before joining the fund as the member had advised that he had not suffered any problems with his knee for many years.

The member went ahead with the surgery and the surgeon provided a report to the fund. On the basis of the report the fund paid benefits.

In some instances, information used by the fund to support application of the rule is flimsy, although the information may be strongly suggestive of an ailment or illness. In some of these situations, the medical evidence needed to form a view about whether an ailment is pre existing is unavailable; sometimes this is because the member has not visited the attending doctor previously or the member has not visited a doctor for many months.

In these situations, the Complaints Commissioner asks the member to approach the Health Insurance Commission to obtain a copy of the member's Statement of Benefits. If the member has visited another doctor or doctors, the Complaints Commissioner approaches each of the doctors and, if necessary, asks for copies of the member's medical record. If it can be established that the member did not seek medical treatment for an ailment, and there is no record of any signs and symptoms during the relevant period, the Commissioner recommends that the fund pay benefits.

Oral advice

Advice obtained from funds by telephone or at a branch continues to cause difficulties as shown by the following case example.

A fund member was advised by his doctor that he needed an angiogram. He was not sure about his health insurance cover and asked the doctor's secretary to contact his fund, with his membership number and details of the procedure, to confirm if he was covered. The secretary telephoned the fund and was advised that the member was covered. The member was admitted to hospital for the angiogram.

The angiogram showed a need for angioplasty. The member and doctor's secretary assumed that the member was covered, and the doctor's secretary again booked him into hospital. Some months after the angioplasty, the hospital sent the member an account because his fund refused to pay benefits. About the time when the Complaints Commissioner began to investigate the matter, the fund realised it had mistakenly paid for the first operation and asked the hospital for repayment. The member was then sent another account from the hospital for the first operation.

In the end, the fund paid both accounts after the hospital wrote off a small amount. The involvement of the doctor's rooms and the fact that the secretary had made notes of her dealings with the fund was the crucial factor in the outcome. The fund's mistaken payment for the first hospitalisation appeared to support the complainant's account of the incident.

Compensation

Some health funds will pay benefits for treatment where a right to claim compensation may exist. These funds may require the member to sign an undertaking to repay any benefits should subsequent legal or other action be successful. Other health funds refuse to pay any benefits for treatment associated with compensation injuries, even where the "compo" insurer does not cover the treatment in question as shown in the next case example.

A nineteen-year-old who sustained spinal injuries in a work related accident was treated at a private hospital. The state based workers compensation agency refused to pay the hospital account because it had not given prior approval for treatment in a private hospital as required by law – and under the relevant regulations there is no discretion to pay. The fund has refused to pay benefits for treatment and has refused to consider doing so. The Complaints Commissioner believes that the fund's stance is contrary to its rules and is waiting for the fund's response on this point.

Health fund promotional material

Many fund members would be surprised that their health fund does not pay benefits in compensation matters.

Some funds entice previous members to rejoin, or existing members to upgrade, with offers of waiting period waivers. The Complaints Commissioner has dealt with some complaints where there appeared, on the basis of the fund's letter, no reason to deny the waiver offer to the member.

A fund member rejoined on a 'cheapo' cover after letting his family cover lapse. When he re-joined, he advised the fund about a pre existing ailment that his wife was suffering from. As they had been previous members, the fund reduced the pre-existing ailment waiting period from 12 to 6 months.

Subsequently, the member upgraded his cover. On the day that his wife was due to be admitted to hospital, he received a letter from the fund advising a waiting period waiver. The offer applied to members who joined the 'cheapo' health cover between certain dates and who upgraded or had already upgraded. As the member had rejoined during the relevant dates, and had already upgraded, he contacted the fund to ensure that his wife's hospitalisation would be covered by the waiver. However, the fund advised that as it had already reduced the pre-existing ailment waiting period when he took out the 'cheapo' cover, a further waiver as outlined in the letter was not available to him.

Following discussions between the Complaints Commissioner, the member and the fund, the fund agreed that the offer applied to the member and paid benefits for the member's wife at the upgraded level.

A recent publication by the Australian Competition and Consumer Commission and the Private Health Insurance Complaints Commissioner, the ‘Guide to the Trade Practices Act for the promotion of private health insurance’ outlines problems that can arise in offering waiting period waivers. On page 13, the Guide states that: ‘promotional material should clearly set out the circumstances in which waiting periods apply for pre existing ailments’. In the example above, the fund was attempting to rely on an exclusion that was not referred to in the offer letter.

Notes of complaint statistics

Information contained in each Quarterly Bulletin is subject to revision. Registered Health Benefits Organisations receive a summary of the number of complaints made by their members only, with this Bulletin.

Figure 7: Complaint Issues

	Dec Qtr 1997/98				Mar Qtr 1997/98			
Issue	***No.***	***%***	***No.***	***%***	***No.***	***%***	***No.***	***%***
Benefits								
Extent of cover			67	51.5%			38	32.2%
Amount			13	10.0%			23	19.5%
Delay			5	3.8%			5	4.2%
Excess			7	5.4%			11	9.3%
Limit reached			6	4.6%			5	4.2%
Gap payment			17	13.1%			17	14.4%
Out of State			0	0.0%			0	0.0%
Other			15	11.5%			19	16.1%
Subtotal Benefits	***130***	***21.7%***		*100.0%*	***118***	***29.1%***		*100.0%*
Information								
Oral			31	56.4%			24	53.3%
Printed			10	18.2%			13	28.9%
Radio/TV			2	3.6%			0	0.0%
Written			2	3.6%			2	4.4%
Lack of notification			10	18.2%			6	13.3%
Subtotal Information	***55***	***9.2%***		*100.0%*	***45***	***11.1%***		*100.0%*
Waiting Periods								
General			9	15.5%			14	17.7%
Obstetrics			8	13.8%			16	20.3%
Pre existing ailment			41	70.7%			49	62.0%
Subtotal Waiting Periods	***58***	***9.7%***		*100.0%*	***79***	***19.5%***		*100.0%*
Membership issues								
Who is the contributor?			4	6.8%			10	14.3%
Arrears			8	13.6%			19	27.1%
Cancellation/suspension			23	39.0%			24	34.3%
Transfer/continuity			24	40.7%			17	24.3%
Subtotal Membership	***59***	***9.8%***		*100.0%*	***70***	***17.2%***		*100.0%*
Costs								
Premiums			134	93.1%			23	67.6%
Fees and services			9	6.3%			11	32.4%
Dual charging			1	0.7%			0	0.0%
Subtotal Costs	***144***	***24.0%***		*100.0%*	***34***	***8.4%***		*100.0%*
Subtotal Incentives	***8***	***1.3%***			***6***	***1.5%***		
Subtotal Contracts	***12***	***2.0%***			***2***	***0.5%***		
Other specific issues								
Acute Care Certificates			3	2.2%			1	1.9%
Confidentiality			1	0.7%			0	0.0%
Discrimination			2	1.5%			1	1.9%
Language & culture			0	0.0%			1	1.9%
Quality of service			24	17.9%			8	15.4%
Private patient election			1	0.7%			3	5.8%
Premium payments			12	9.0%			5	9.6%
Other complaint NEC			11	8.2%			6	11.5%
Fund rule change NEC			80	59.7%			27	51.9%
Subtotal Other	***134***	***22.3%***		*100.0%*	***52***	***12.8%***		*100.0%*
TOTAL	600	100%			406	100%		