Private Health Insurance
OMBUDSMAN

Quarterly Bulletin Issue 8
1 April – 30 June 1998

Welcome to the final Quarterly Bulletin for 1997/98 summarising the Complaints Commissioner's (now Ombudsman's) operations between 1 April and 30 June 1998.

Highlights this quarter

- 578 *complaints* were received.
- Most complaints were about cost (28%) and "cost" replaced "benefits" as the main issue complained about in the June quarter.
- 63% of complaints were resolved within a week, which is a significant increase on the 51% in the March quarter.
- 174 *inquiries* were recorded during the June quarter, a significnt under-reporting due to ….
- Overwhelmingly, it is health fund members who 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 Australia (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, or e-mail sgavel@phicc.org.au. Samantha welcomes suggestions for future issues of the Bulletin.
- If you would like to be included on our mailing list, please telephone Jillian O'Shea on the same number, or e-mail us at info@phicc.org.au.

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ACTING OMBUDSMAN

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Complaints Line 1800 640 695

Background

Who we are

The Ombudsman provides consumers and other key stakeholders with an independent means of resolving their health insurance problems. The Ombudsman 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 Ombudsman
A national freecall Complaints Hotline (1800 640 695) is staffed between 8.30 am and 5.00 pm (Sydney time), Monday through Friday. The Ombudsman 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 Ombudsman does not have the power to enforce any recommendations and relies on the health funds, hospitals, day surgery centres, doctors and dentists to implement the remedies that are proposed.

Further Information
Further printed information about the Ombudsman is available by telephoning Jillian O’shea on (02) 9261 5855. Available brochures include:

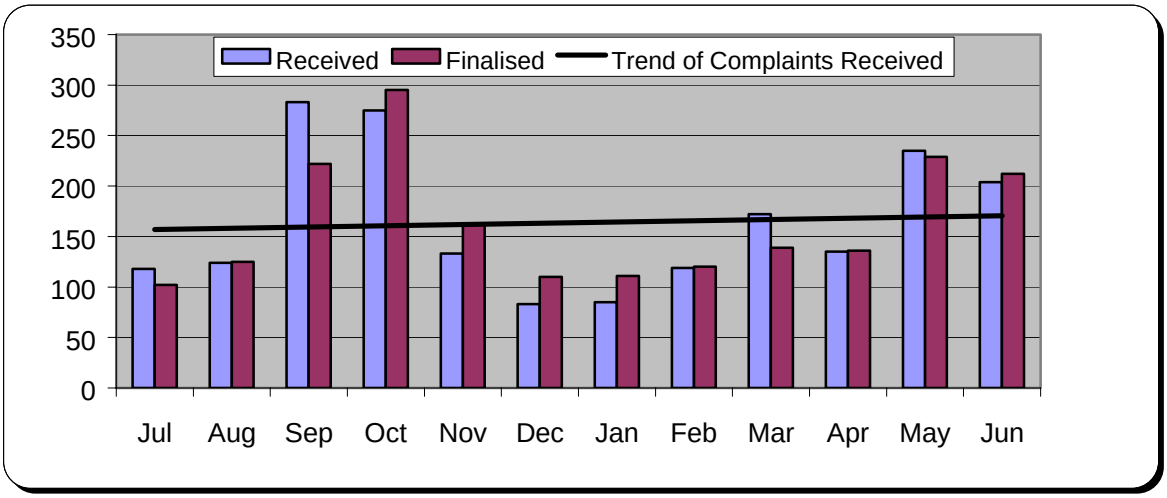
- The 10 Golden Rules of private health insurance
- Can we help with your health insurance complaint? (available in a variety of community languages)
- Service Charter
- Insure? Not Sure? Your quick guide to private health insurance
- Private Patients’ Hospital Charter
- When the Doctor’s bill makes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

We also have an internet site. The address is http://www.phicc.org.au. Complaints may be lodged from our internet site.

Complaints

Complaints received
There was a significant increase in the number of complaints received in the June quarter compared with the previous quarter (578 complaints compared with 370 in the March quarter).

Figure 1: Complaints received and closed by month



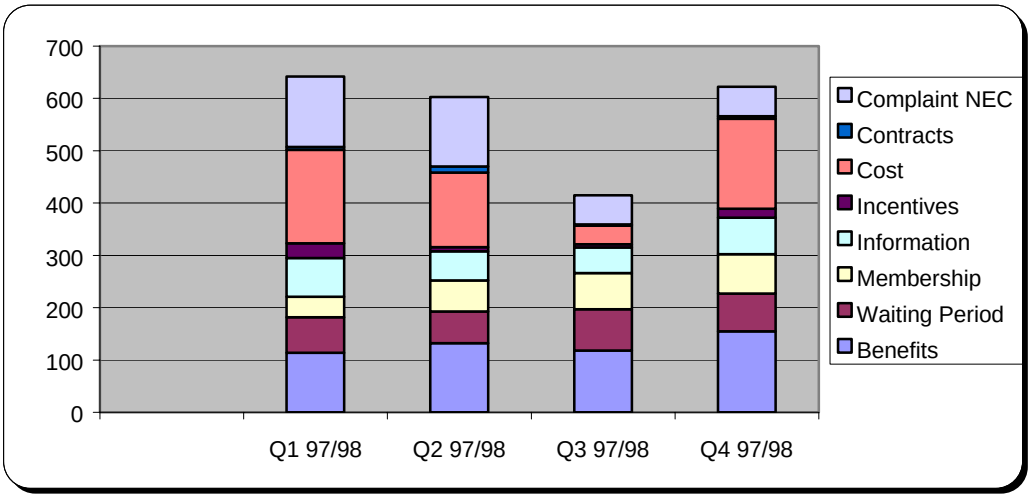
Who Complains?
During the June quarter, the overwhelming majority of complaints were again made by members of health funds. There was one complaint made by a hospital and two complaints made by health funds. Two complaints were made by doctors in the June quarter.

What issues are complained about?
The 578 complaints received were about 622 different issues.

The most complained about issue was cost (172 issues or 28%), compared with the March quarter when benefits was the most complained about issue (29% of issues).

Complaints about benefits were the second most complained about issue during the June quarter (155 issues, or 25%). This was followed by membership (75 issues or 12%) and waiting periods (72 issues, or 12%).

Figure 2: Complaint issues



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

How do people complain?
The majority of complaints in the June quarter were made by telephone (89%, which is the same as the March quarter).

Other complaint vehicles included letter (9%, compared with 10% in the previous quarter), fax (1% in the June quarter, which is the same as the previous quarter), and personal visit (0.7%, compared with 0.3% in the previous quarter). There were no complaints by Ministerial letter in the June quarter, which is the same as the previous quarter.

The Ombudsman encourages people to telephone with details of their complaint. It is not necessary to lodge a complaint in writing.

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 Ombudsman. These are recorded as complainant directed back to fund in Figure 3.

Some problems can be resolved by staff of the Ombudsman 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.

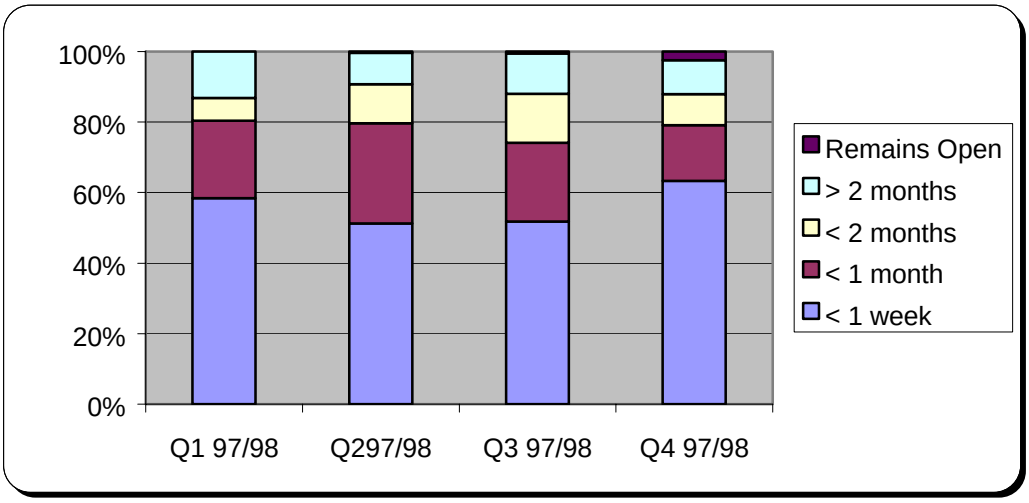
Figure 3: Object of complaint & type of action taken - 1998

	1997/98					
	April		*May*		*June*	
Action by Ombudsman	*No.*	*%*	*No.*	*%*	*No.*	*%*
Complainant directed back to fund	18	15%	87	38%	24	12%
Complainant dealt with in house	36	29%	114	50%	106	54%
Complainant referred to fund for investigation	69	56%	29	13%	68	34%
Total complaints about funds	**123**	100%	**230**	100%	**198**	100%
Complainant directed back to hospital	1	20%	2	67%	1	17%
Complainant dealt with in house	0	0%	1	33%	2	33%
Complainant referred to hospital for comment	4	80%	0	0%	3	50%
Total complaints about hospitals	**5**	100%	**3**	100%	**6**	100%
Complainant directed back to doctor	2	22%	2	22%	3	60%
Complainant dealt with in house	7	78%	5	56%	2	40%
Complainant referred to doctor for comment	0	0%	2	22%	0	0%
Total complaints about doctors/dentists	**9**	100%	**9**	100%	**5**	100%

Time taken to resolve complaints

Around 64% of complaints received in the June quarter were resolved within a week, compared with 51% last quarter.

Figure 4: Time taken to resolve complaints

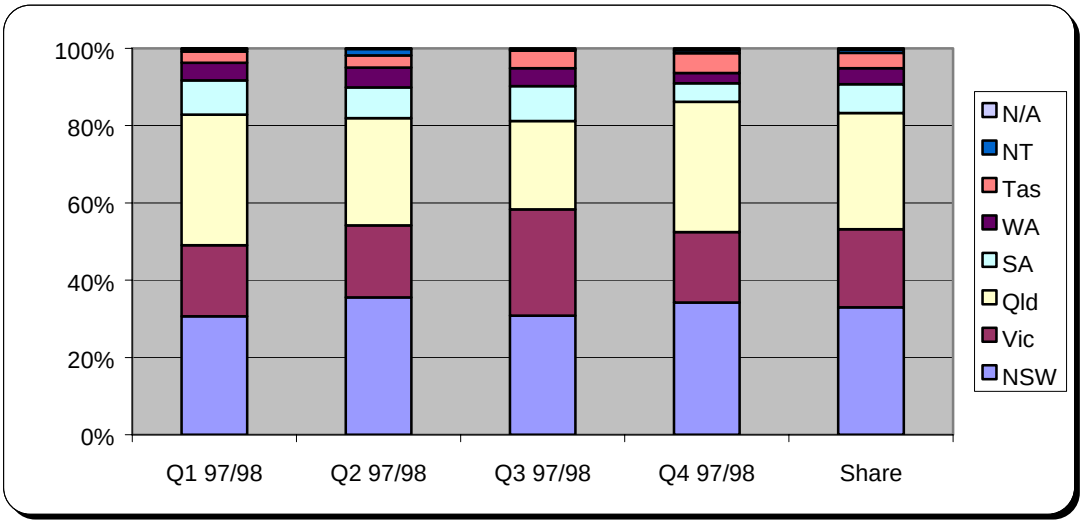


Where do complainants live?

During the June quarter, NSW recorded the most complaints, followed closely by Queensland and Victoria. NSW received slightly more complaints than Queensland, with 193 complaints, compared with 190 complaints from Queensland members. Last quarter, 114 complaints were received from NSW and 80 from Queensland.

Victoria received 103 complaints, Tasmania received 29, South Australia received 27, WA received 15, the ACT received 14 and the Northern Territory received 4.

Figure 5: Complaints by State

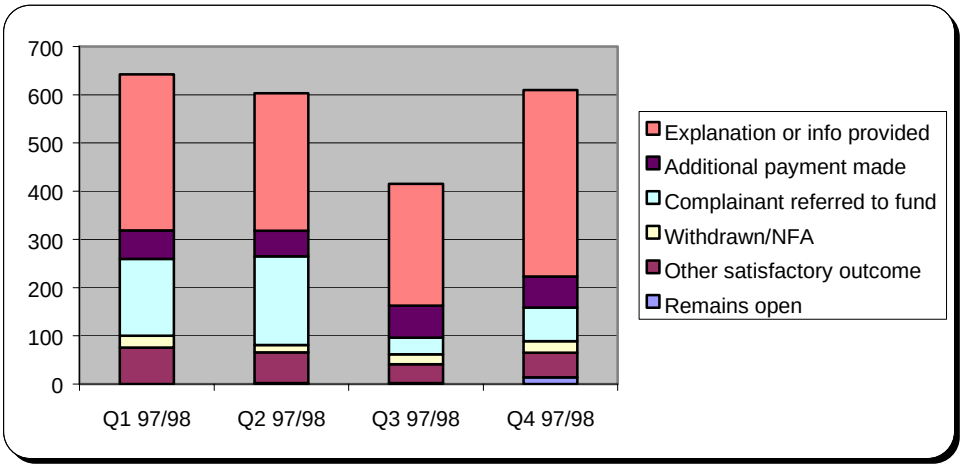


What were the outcomes?
Of the complaints closed, 12% were referred directly back to the object of complaint, because there had been no attempt to resolve the problem with the fund, hospital, doctor or dentist. This compares with 10% last quarter. The rest of the complaints that were closed were dealt with 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 (62% of complaint issues were dealt with this way in the December quarter, compared with 64% in the previous quarter);
- the fund providing an additional payment or the hospital, doctor or dentist writing off all or part of an account (10% of complaint issues);
- the fund reversing its previous decision eg. to deny continuity of membership, or where a hospital or medical account is written off (8% of complaint issues).

In a small number of cases the complaint was withdrawn by the complainant or closed by the Ombudsman where the complainant failed to provide additional information requested by the Ombudsman.

Figure 6: Outcomes for complaints received



Inquiries

The Ombudsman received 174 inquiries about issues in the June quarter, a decrease on the 258 inquiries received in the March quarter.

Most inquiries were about general health service and health insurance issues.

The majority of inquiries came from NSW, followed by Queensland and Victoria. Callers in 8% of cases did not identify the State/Territory of their residence.

Most inquiries were resolved by providing additional information or an explanation, including providing a brochure (68% of inquiries). 11% of inquiries were referred to another agency and 11% were referred to a health fund. The remaining 10% of inquiries required no action on the part of the Ombudsman or were withdrawn before the inquiry could be dealt with.

Case Studies

Problems with transferring between funds – loyalty bonuses
The Ombudsman has received a number of complaints from people who have transferred to another fund and found their benefits on some items are lower than expected, because their membership of the first fund does not qualify them for “loyalty bonuses” offered by their new fund.

In theory, under the portability provisions of the National Health Act, consumers are able to transfer between funds without penalty, providing they have served their waiting periods and transfer to a comparable level of cover. Some funds, however, have put in place a system of “loyalty bonuses”, whereby members receive higher benefits depending on the number of years they have been in the fund. Such loyalty bonuses are often associated with dental benefits and other ancillary products.

As loyalty bonuses increase in popularity as a means of encouraging members to stay with their existing fund, more consumers are getting caught by loyalty bonuses when they transfer between funds, as the following case study shows.

A member who had been with his health fund for over 40 years decided to transfer to another fund. He obtained a copy of the new fund's brochure and read it carefully. He paid particular attention to the section on transferring from another fund, which indicated that no waiting or benefit limitation periods would apply to comparable or lower benefits. After satisfying himself that he would not be disadvantaged by the transfer, the member transferred to the new fund.

Some months later, the member needed a set of dentures, which cost him about $1200. He submitted a claim for benefits to the new fund and was surprised to receive only $360 back. He checked his brochure, which stated that the limit for dentures was $360, rising to around $800 after 5 years of membership. The member felt that as a health fund member for over 40 years, he should receive the higher benefit, even though his previous 40 years of membership had been with another fund.

After querying the amount with the fund, the member wrote to the Ombudsman. The Ombudsman examined the fund brochure and membership guide. She found that the loyalty bonus applying to dental benefits was explained in the guide, although it was not mentioned in the section on transferring from another fund in the brochure. The Ombudsman advised the member that the increase in benefits for dental procedures was one of the ways in which the fund encourages its members to stay with them for a long period of time. As such, it is designed to reward members' loyalty to that fund and is distinct from a waiting or benefit limitation period.

Although loyalty bonuses are a legitimate way of encouraging members to remain with their fund, the Ombudsman would encourage funds to ensure that their staff advise members who are thinking of transferring from other funds about their eligibility for loyalty bonuses when they transfer.

Overpayment

Many months ago, Mrs Jones purchased a pair of spectacles. Before she proceeded, she telephoned the fund and was advised that she would be covered.

10 months later the fund advised her that she should not have been advised she was covered as she had previously used her optical entitlement during the year. The fund wanted Mrs Jones to refund $100, and after some discussions with the fund, she and the fund agreed to offset the $100 against future optical claims.

Some months later, Ms Brown cancelled her ancillary cover, retaining only her hospital cover. Ms Brown complained that the fund has written wanting payment of the $100 as it can no longer offset the amount.

Staff of the Ombudsman contacted the fund and was advised that the fund's rules are clear about the recovery of overpayments. However, it was possible that wrong advice was provided to the complainant on this occasion. The fund and optical dispenser, as part of their preferred supplier arrangement, have in place a system where the optical dispenser contacts the fund to confirm the eligibility for benefits before providing the spectacles, and the dispenser subsequently bills the fund directly.

It is likely that the this system did not operate correctly for Ms Brown; due to this and the length of time since the spectacles were purchased (18 months) the fund agreed to write off the outstanding amount.

Premium arrears

Mr Smith called to complain about his health fund not notifying his paymaster about premium increases. Mr Brown said that he had received a letter in May 1998 from his fund advising that there was a premium increase in September 1997 and enclosing an account for the overdue amount, being the difference between the old and new premium for 9 months.

Mr Smith was particularly insulted that as a long standing fund member, he was also advised that he would be unable to make any claims until the outstanding money is paid. Mr Smith says that problem is with his health fund for not notifying the paymaster

The fund advised that it had written to Mr Smith about the premium increase on a number of occasions about the matter. However, the fund acknowledged that its had not handled the matter well, and in view of the members length of membership (16 years), it was prepared to write off the overdue account and send a detailed letter to the member.

Private Patient Election

Mrs Brown called to complain about her husband's admission to a public hospital some months earlier. Mr Brown was admitted to hospital for an acute illness through the hospital's Accident and Emergency Department. During the admission, Mrs Brown was asked whether they had private insurance - she replied that they did. Mrs Brown admits to signing a lot of forms at the hospital without reading them as she was concerned with her husband's medical condition.

Mrs Brown was subsequently sent an account for approximately $200 by the hopsital for her private health fund "excess". Mr and Mrs Brown are on low fixed incomes and are unable to pay the account. The hospital has placed the mater I the hands of debt collectors.

The hospital was approached for its views about Mrs Brown's complaint. The hospital advised that admissions staff are instructed to give patients the choice of being admitted as a private or public patient. The hospital also advised that some patients elect to be private patients, but do not realise the full implications of this, and subsequently complain that they were not given the choice.

Complaints made to the Private Health Insurance Ombudsman about this issue arise in the following ways:

- There may be lack of documentation on the private patient election form about the choices available to patients with private insurance and the implications of the choice (doctors fees, payment of health insurance excess, etc)

- Hospital staff may ask the patient a the time of admission whether they are "public or private", which may be interpreted by the patient as a question about whether they have private health insurance

- Some patients mistakenly believe that if they have private health insurance that they must use it.

In one case dealt with by the Ombudsman, the hospital implied that patients with private insurance should not have the option to be treated publicly in a private hospital.

After further discussions with the hospital, it agreed to write off the outstanding account.