PRIVATE HEALTH INSURANCE
COMPLAINTS COMMISSIONER

Quarterly Bulletin Issue 4
1 April - 30 June 1997

Welcome to the final issue of our Quarterly Bulletin for 1996/97. As well as providing a statistical overview of the Complaints Commissioner's operations for the period 1 April 1997 to 30 June 1997, comparisons with previous quarters are included.

This issue of the Quarterly Bulletin is being distributed as soon as practicable after publication and tabling of the Annual Report in Parliament. As some issues mentioned in the Quarterly Bulletin are covered in greater detail in the Annual Report, I have chosen case studies for this Quarterly Bulletin that illustrate the *processes* we use to deal with complaints rather than the issues dealt with.

The number of *complaints* received in the June quarter was 325, compared with 359 in the previous quarter. This represents a decrease of 10% from the previous quarter, although the trendline for complaints remains upward. Forty-six percent of complaints were resolved within a week, down from 60% previously.

The number of *inquiries* rose slightly to 349, up from 340 in the March quarter.

During the June quarter, the vast majority of complaints and inquiries were again from health fund members. The main issues complained about were benefits (112 out of 377 issues or 30%). Waiting periods were the second most complained about issue (69 or 18%); most of these complaints were specifically about the application of the pre-existing ailment rule.

Problems with membership were the third most complained about issue (51 or 14%). Most of these complaints concerned cancellation or suspension of membership. Complaints about the cost of premiums, which was the largest single specific area of complaint in the March quarter, decreased considerably in the June quarter.

Quarterly Bulletins are provided to the Minister for Health and Family Services, members of the Senate Community Affairs Legislation Committee, health funds, the AHIA, HIRMAA, and the Department of Health and Family Services.

Please call Samantha Gavel, Policy and Projects Officer on (02) 9261 5855 if you have any questions about this Bulletin or suggestions for future issues.

Matthew Blackmore
ACTING COMPLAINTS COMMISSIONER
14 November 1997

Background

The Complaints Commissioner provides consumers with an independent means of resolving problems with health insurance. The Complaints Commissioner's key features include:

- being easily accessible to those who are privately insured
- being driven by the needs of its customers
- being independent of Government and health funds, but working co-operatively with both
- providing high quality information and advice to people with, or who are seeking to take out, private health insurance
- being effective at resolving disputes.

A Complaints Hotline (1800 640 695) has been established and is staffed between 8.30 am and 5.00pm (Sydney time). The Commissioner does not require a complaint to be in writing before it is investigated.

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 the health funds, hospitals, day surgery centres, doctors and dentists to implement the remedies that are proposed.

Further printed information about the Complaints Commissioner is available by telephoning Kathryn Gilhooley 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.

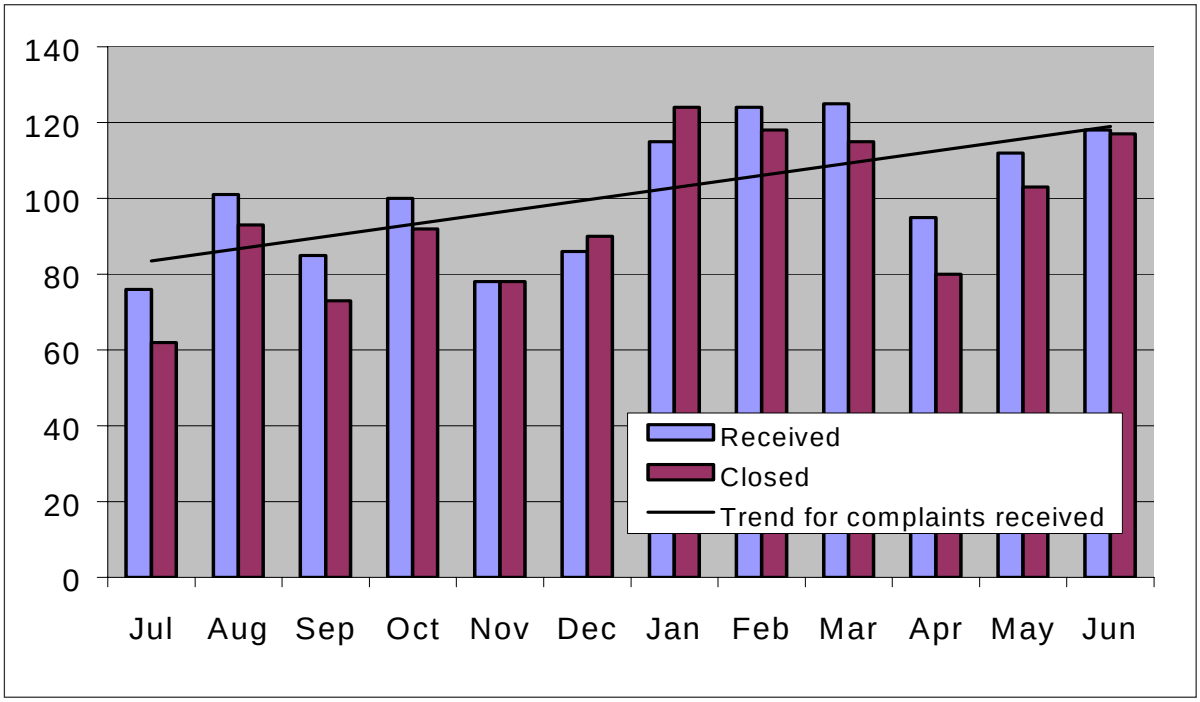
We have also recently launched our internet site. The address is http://www.phicc.org.au. Complaints may be lodged from our internet site.

If you would like your fund hotlinked to our site, please telephone Sasha Andrews on (02) 9261 5855.

Complaints

The Commissioner received 325 complaints in the June quarter compared with 359 previously. The trendline for complaints remains upward. Two hundred and ninety-nine complaints were finalised.

Figure 1: Complaints received and closed by month



Who Complains?

Most complaints in the June quarter were made by members of health funds (99%, compared with 98% in the March quarter). Complaints were also made by hospitals (1% in the June quarter which is the same as the March quarter). No complaints were received from doctors (1% previously).

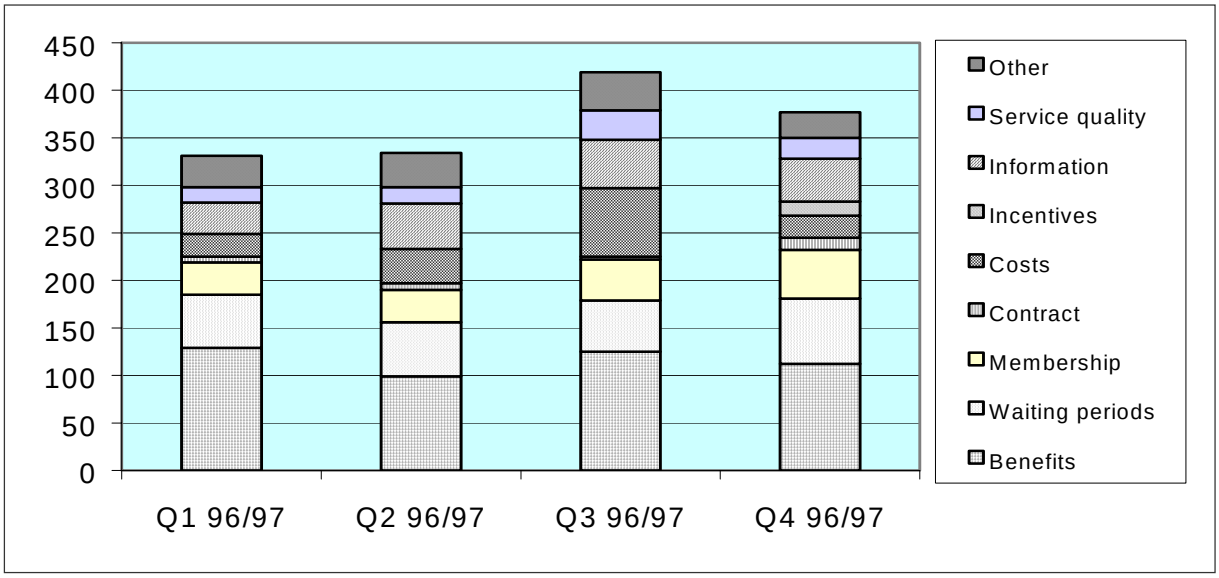
What issues are complained about?

The 325 complaints received in the June quarter concerned 377 different issues. Most complaints concerned disputes about benefits (112 issues). This included concerns about the amount of benefit or confusion about whether a service is included under the complainant's level of cover.

During the June quarter, waiting periods were the second most complained about issue (69 issues); most of these complaints were specifically about the application of the pre-existing ailment rule (52 issues).

Problems with membership were the third most complained about issue (51 issues) – most were about the cancellation or suspension of a membership (28 issues), transfer of membership to another fund (10 issues) or disputes about who the contributor is (5 issues).

Figure 2: Issues complained about



Who is complained about?

Complaints 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 and report to the Commissioner.

How do people complain?

The majority of complaints in the June quarter were made by telephone (90%, compared with 91% in the March quarter and 86% in the December quarter).

Other complaint vehicles included letter (7%, compared with 8% previously), fax (2% in the June quarter, compared with 1% previously) and Ministerial letter (1%, compared with 1 only in the previous quarter). There was also 1 complaint made as a result of a personal visit.

The Complaints Commissioner 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 Complaints Commissioner. These are recorded as “complainant directed back to fund” below.

Some problems can be resolved by staff of the Complaints 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 their investigation and report or comment. This may be done in writing or by telephone.

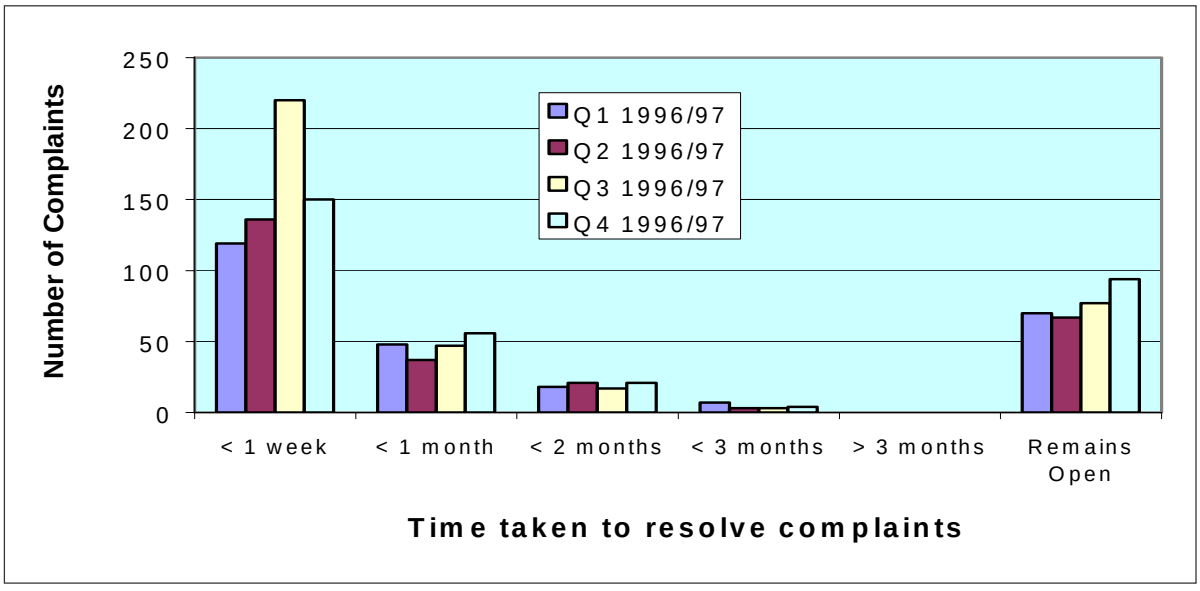
Figure 3: Object of complaint & type of action taken – Jan 1997 to Jun 1997

	Month 1997					
Action taken by Complaints Commissioner	Jan	Feb	Mar	Apr	May	Jun
Complainant directed back to fund	22	35	32	18	21	26
Complainant dealt with in house	33	42	28	18	21	25
Complaint referred to fund for investigation	56	38	59	54	64	63
Total complaints about health funds	*111*	*115*	*119*	*90*	*106*	*114*
Complainant directed back to hospital	1	1	3	0	2	1
Complainant dealt with in house	0	1	1	1	3	3
Complaint referred to hospital for comment	10	5	2	3	4	6
Total complaints about hospitals	*11*	*7*	*6*	*4*	*9*	*10*
Complainant directed back to doctor/dentist	0	4	2	0	0	1
Complainant dealt with in house	0	3	1	1	3	0
Complaint referred to doctor /dentist for comment	1	0	1	4	1	1
Total complaints about doctors	*1*	*7*	*4*	*5*	*4*	*2*

Time taken to resolve complaints

Around 46% of complaints received in the June quarter were resolved within a week, compared with 60% and 45% respectively in the previous two quarters.

Figure 4: Time taken to resolve complaints



Where do complainants live?

During the June quarter, most complaints were received from NSW, followed by Victoria and Queensland. In NSW, the number of complaints remained about the same (114 compared with 117 in the March quarter).

Complaints increased in Victoria and South Australia, with 70 complaints and 46 complaints respectively (up from 49 and 34 in the previous quarter). Complaints also increased in Tasmania (up to 16 compared with 10 in the previous quarter) and in the Northern Territory (complaints rose to 5 compared with one in the March quarter).

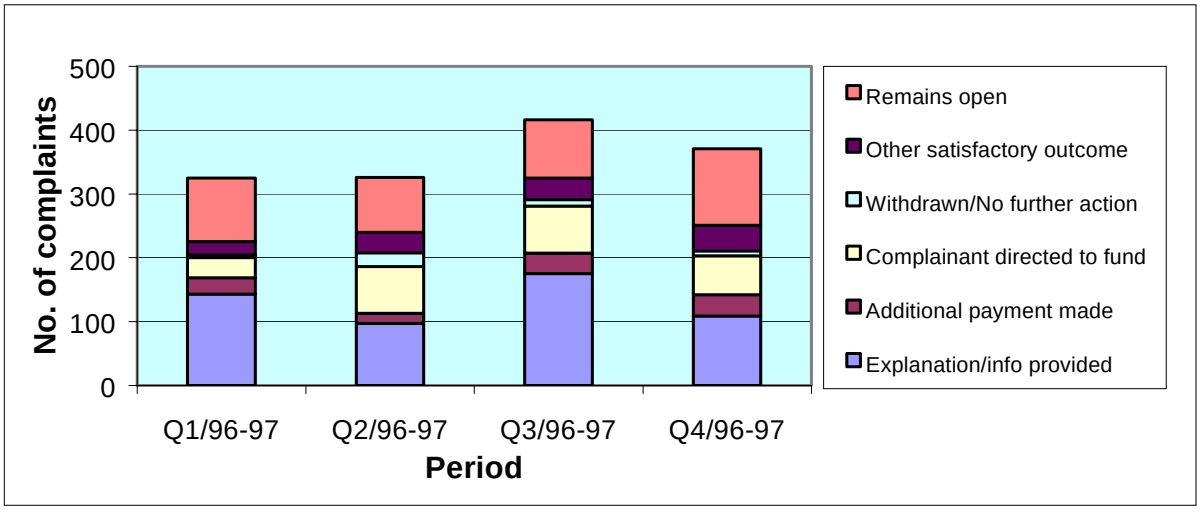
The number of complaints from Queensland decreased (48 complaints, compared with 66 in the March quarter) as did the complaints from WA (19 compared with 30) and the ACT (5 compared with 14).

What were the outcomes?

26% of matters were referred directly back to the service provider, because there had been no attempt to resolve the problem with the fund, hospital, doctor or dentist. The remaining 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 (43% of complaint issues were dealt with this way in the June quarter)
- the fund providing an additional payment or the hospital, doctor or dentist writing off all or part of an account (15% of complaint issues)
- the fund reversing its previous decision (eg. to deny continuity of membership) or resolving a premium payment problem (12% of complaint issues)
- 4% of complaint issues were withdrawn by the complainant or closed by the Complaints Commissioner (eg. where the complainant failed to provide additional information requested by the Commissioner), were out of jurisdiction or where no further action was warranted.

Figure 5: Outcomes for complaints received



Inquiries

The Complaints Commissioner received 349 inquiries in the June quarter, a slight rise on the 340 inquiries received in the March quarter. The majority of inquiries came from NSW, which recorded 59 inquiries, followed by Queensland and Victoria with 32 each. There were 23 inquiries from South Australia, 20 from WA, 8 from Tasmania, 3 from the NT and 4 from the ACT 4. In nearly half of the inquiries, callers did not identify the State/Territory of their residence.

Most inquiries were resolved by providing additional information or an explanation, including providing a brochure (74% of inquiries). 23% of inquiries were referred to another agency or health fund. The remaining inquiries required no action - they were mainly letters about health insurance issues requesting no further action.

Case Studies

As the recently released Complaints Commissioner's Annual Report contains many case examples, this Bulletin includes case examples that illustrate the steps taken by staff of the Complaints Commissioner in dealing and resolving complaints.

Benefits

As in previous quarters, most complaints from health fund members in the June quarter concerned benefits (112 issues). This includes concerns about the amount of benefit, confusion about whether the service is included under the complainant's level of cover and disputes about the way benefits are calculated.

Case example

A long time fund member relocated interstate and believed that he would be best served by transferring his health fund membership to another fund in his new state of residence. This occurred part-way through expensive and time consuming orthodontic work. His previous fund paid benefits one way - 50% at the beginning of the treatment and 50% at the end of the treatment; the new fund paid benefits another way - 100% at the beginning of the treatment.

When the fund member went to claim the remaining 50% benefit from his new fund, he was advised that no benefits would be paid, as all benefits are paid at the beginning of the treatment. On receiving this advice, and contacting his previous fund that also refused to pay further benefits, the member contacted the Complaints Commissioner.

The member said that he had asked the new fund about orthodontic benefits when he transferred his membership, and said that he was advised he would be eligible for "full" benefits. The fund brochure made no reference to the way benefits are paid for orthodontic treatment, and he did not think to ask about this. He had no idea that there would be different ways to calculate such things.

Staff from the Complaints Commissioner contacted each fund by telephone advising that this type of dispute is best resolved between the two funds and asked that they jointly solve this health fund member's problem. The Commissioner said that the member had held private health insurance for many years, and through no fault of his own, the member had been disadvantaged by transferring between funds. Although the fund rules may have been followed, this type of problem did not help people remain in private health insurance.

Each fund replied that it was unable to assist. The Complaints Commissioner was disappointed that the funds did not assist their member and subsequently wrote formally to the two funds suggesting that they each contribute half the remaining benefit. After further dialogue with the funds, they each agreed to pay half the outstanding benefit.

Case history

A fund member was admitted to hospital and on discharge, the hospital requested that he pay $79 to cover the out of pocket expenses for his stay. Nearly six months later, he received a bill from the hospital for another $331, which was the difference between the hospital's accommodation charge and the benefit paid by his fund. The member was surprised to receive a second bill for out of pocket expenses on top of the $79 he had paid. As the bill arrived so long after his hospitalisation, and the hospital and fund were unable to give him a satisfactory explanation for either bill, he contacted the Commissioner.

The Complaints Commissioner asked the fund member whether the hospital had advised him about any out of pocket expenses when he was admitted. The member replied that his admission was an emergency and he did not recall the hospital confirming his cover with the fund or advising him of any out of pocket expenses.

The Complaints Commissioner rang the hospital to ask about its admission procedures. The hospital advised that the normal procedure was to check with a member's fund and advise of any out of pocket expenses, but that in an emergency admission, the normal procedures may not have been followed. The hospital later confirmed that it had checked with the fund and been advised to charge the member the extra $79 on discharge. However, the member was originally admitted for a lesser procedure than the one that was eventually carried out, which explained the extra $331 charge.

The Commissioner advised the hospital that she was particularly concerned about the length of time it had taken for them to send out the second account. The hospital eventually agreed to write off the outstanding amount, because of this factor.

Pre-existing ailments

Complaints about pre-existing ailments (PEA) remained a significant area of concern for health fund members during the June quarter (14% of issues complained about). The following case history provides a good illustration of the processes used by staff of the Complaints Commissioner in investigating complaints of this nature and deciding whether the PEA rule has been correctly applied.

Case history

Two weeks before joining a fund, a health fund member suffered a viral infection and experienced symptoms which caused his doctor to refer him to a heart specialist. The specialist recommended an angiogram, which revealed a blocked artery. The fund refused to pay benefits for the subsequent hospitalisation on the grounds that the hospitalisation was for a PEA. The member then contacted the Complaints Commissioner, because he believed his symptoms were due to the viral infection and not the blocked artery, and therefore the fund should pay benefits.

Staff of the Complaints Commissioner explained the PEA rule to the member, and agreed to check with the fund to clarify the member's concerns.
The Commissioner obtained the member's consent in writing to access his medical records, then approached the cardiologist for further information. The cardiologist explained that signs or symptoms of the member's blocked artery would have been present "for some time", but could not be more specific.

Staff of the Complaints Commissioner then requested access to the cardiologist's notes and those of the referring doctor, and these were provided. The notes of the referring doctor indicated that recent symptoms were strongly suggestive of angina. The member had also been prescribed heart medication before joining the fund. In view of this information, the Commissioner took the view that the PEA rule had been correctly applied by the fund.

Commonwealth Government Incentives Scheme

The Commissioner has jurisdiction for dealing with complaints about the health funds' administration of the Private Health Insurance Incentives Scheme (PHIIS) which came into effect on 1 July 1997. Although the scheme was not in operation during the June quarter, the Commissioner received inquiries and complaints from people about it. Most were inquiries and were referred to the toll free incentives Hotline.