Quarterly Bulletin Issue 2
1 October - 31 December 1996

Welcome to the second issue of our Quarterly Bulletin which I hope will keep you informed of our activities and highlight trends and important developments within the private health insurance industry.

As well as providing a statistical overview of the Complaints Commissioner's operations for the period 1 October 1996 to 31 December 1996 we also include comparisons for the previous quarter and for the previous reporting year.

In the December quarter, the majority of complaints and inquiries were from health fund members. The largest single specific type of complaint continued to be pre-existing ailments.

The feedback from consumers this quarter suggests that we (health insurance funds, Department of Health, hospitals, professional health associations and consumer organisations) still need to do more to inform and educate consumers about Private Health Insurance.

The Complaints Commissioner will shortly have a brochure available for consumers which promotes what we call the 10 Golden Rules for private health insurance. They include reading the fine print before selecting a health fund and regularly reviewing your private health insurance cover.

This Bulletin has been redesigned to include the suggested changes from many of our readers. We are happy to take on-board your thoughts and ideas for future issues. Comments can be directed to Matthew Blackmore, Director, Policy and Customer Service on (02) 9261 5855.

To be included on our mailing list or receive a copy of the 1996 Annual Report please telephone Kathryn Murray on the same number.

Mary Perrett
COMPLAINTS COMMISSIONER

February 1997

Executive Summary

The number of complaints received in the December Quarter remained constant with 264 complaints received compared with 262 previously. More than half of the complaints were resolved within a week, compared with 45.4% in the previous quarter and 39% in 1995-96.

Most complaints in the December quarter were from members of health funds and the telephone was the preferred vehicle for making a complaint.

Most complaints concerned disputes in the general area of benefits and involved either the amount of benefit or confusion about whether the service was included under a particular level of cover. Other areas of complaint related to the calculation of excesses and delays in payment and benefits for services received in other states.

Waiting periods were the second most complained about issue with concerns lodged about application of the pre existing ailment rule and the waiting period for obstetric benefits.

There was a small reduction in the number of inquiries handled by the Complaints Commissioner in the December quarter. There were 242 inquiry issues recorded for the 232 inquiries received.

It is anticipated that there will be an increase in inquiries during 1997 with health funds now required to include reference to the Complaints Commissioner in their brochures.

In the December quarter the majority of inquiries related to specific health insurance problems such as waiting periods, costs, membership and benefits (60%).

Introduction

The Complaints Commissioner was established in 1995.

For the first time, consumers have an independent means of resolving problems with their health funds, and there is an accountability mechanism for health funds.

PHICC'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 insurance or who are seeking to take out private health insurance
- being effective at resolving disputes.

Complaints can be made by contributors to health funds, hospitals and day hospital facilities, medical and some dental practitioners and people acting on behalf of any of the above.

The Complaints Commissioner does not have the power to enforce its recommendations and relies on the health funds, hospitals, day surgery centres, doctors and some dentists to implement the remedies it proposes.

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".

A Complaints Hotline (1800 640 695) has been set up to resolve complaints as efficiently and effectively as possible. Further information about the Complaints Commissioner is available in a variety of community languages.

Complaints

The number of complaints received this quarter has remained constant (264 complaints received compared with 262 previously) despite some variations by State.

New South Wales (NSW) experienced a 6% decline in the number of complaints while Victoria and Queensland recorded no change. Complaints rose in Western Australia (from 4.2% to 10.6%), South Australia (11.3% up from 6.1%) and Tasmania (4.2% up from 0.4%). The table below shows that the distribution of complaints more generally reflects the break-up of private health insurance by state and territory.

Figure 1: Complaints received by State/Territory

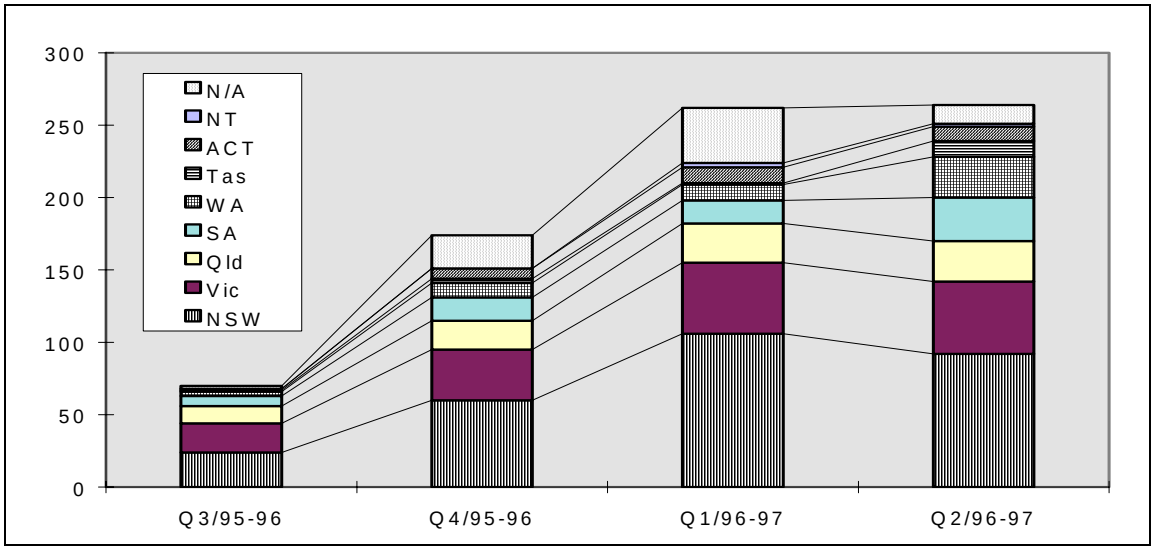
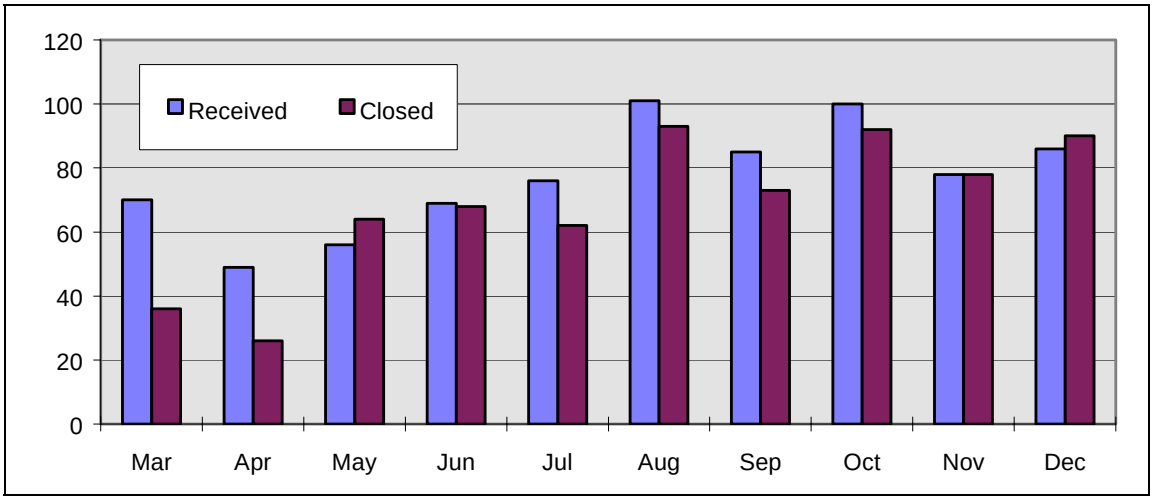


Figure 1 reflects the increasing awareness of the existence of the office of the Complaints Commissioner in the various states and territories.

Figure 2: Complaints received and closed by month



As can be seen, August and October were the busiest months for receiving and handling complaints.

Who is complained about?

Complaints received by the Complaints Commissioner often involve one or more of the following: a health fund, hospital, doctor or some dentists.

The table below provides information about who was complained about and how the complaints were dealt with. Most complaints involved health funds (250 out of 264 complaints received) with almost half of all complaints received being referred to the relevant health fund for investigation. The busiest month in the December quarter for complaints received against health funds was October.

Figure 3: Object of complaint & type of action taken - July-December 1996

	Month 1996-97					
Action taken by Complaints Commisisoner	Jul	Aug	Sep	Oct	Nov	Dec
Complainant directed back to fund	9	8	5	13	12	19
Complaint dealt with in house	22	43	20	38	18	18
Complaint referred to fund for investigation	41	44	56	44	47	41
Total complaints about funds	*72*	*95*	*81*	*95*	*77*	*78*
Complainant directed back to hospital	0	1	1	1	0	1
Complaint dealt with in house	2	2	1	2	3	3
Complaint referred to hospital for comment	7	5	2	1	2	4
Total complaints about hospitals	*9*	*8*	*4*	*4*	*5*	*8*
Complainant directed back to doctor/dentist	0	0	2	1	1	0
Complaint dealt with in house	1	4	1	0	0	3
Complaint referred to doctor /dentist for comment	1	0	0	0	0	0
Total complaints about doctors	*2*	*4*	*3*	*1*	*1*	*3*

What action is taken?

Where a complainant has not attempted to resolve their problem with the health fund, doctor or some dentists, the complainant is 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.

Some complaints 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 the table as dealt with in-house.

Examples of this type of complaint are complaints about health fund premium increases where the complainant has previously approached the fund and not

been satisfied with the response. Other examples are complaints about service providers charging above the relevant Medicare Benefit Schedule fee.

Where the complaint is complex or where the facts are in dispute, the Complaints Commissioner will refer the complaint to the health fund, hospital, doctor or dentist for investigation and/or comment. This may be done in writing or by telephone.

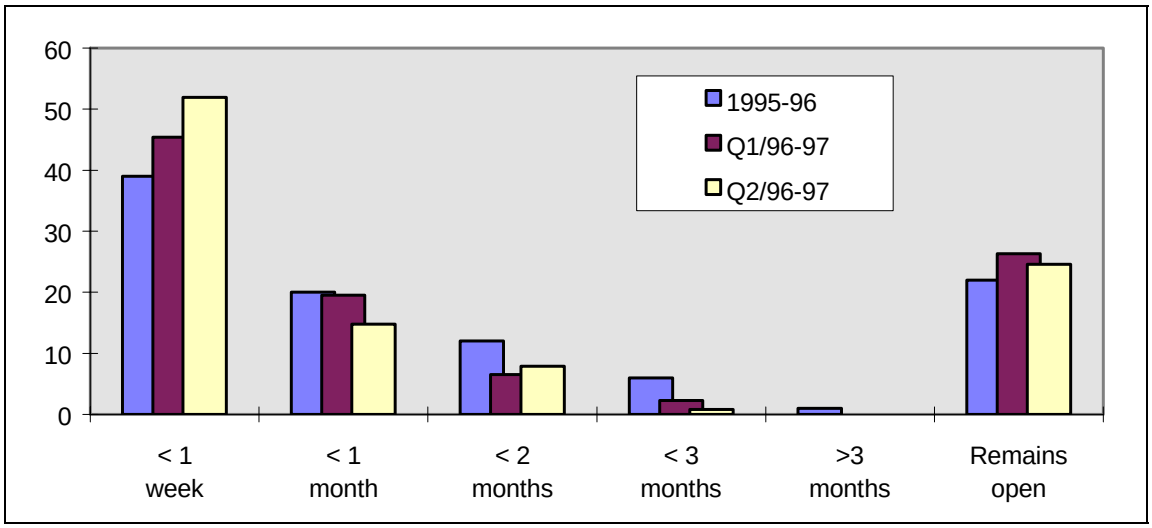
Time taken to resolve complaints

More than half the complaints received in this quarter were resolved within a week compared with 45.4% in the previous quarter and 39% in 1995-96.

No complaints closed in the first two quarters of 1996-97 have taken longer than 3 months to resolve (there were two complaints in 1995-96 which took 101 and 108 days to resolve). 24.6% of complaints received in the quarter remain open compared with 26.3% in the previous quarter and 22% in 1995-96.

Many health funds respond to informal telephone requests for information by the Complaints Commissioner's staff so that complaints may be resolved quickly. This accounts for many complaints being resolved in less than one week.

Figure 4: Time taken to resolve complaints



Who complains?

Most complaints in the December quarter were made by members of health funds (98.5% in the December quarter compared with 98.9% in the September quarter). Complaints were also made by hospitals (1.5% in December compared with 1.1% previously).

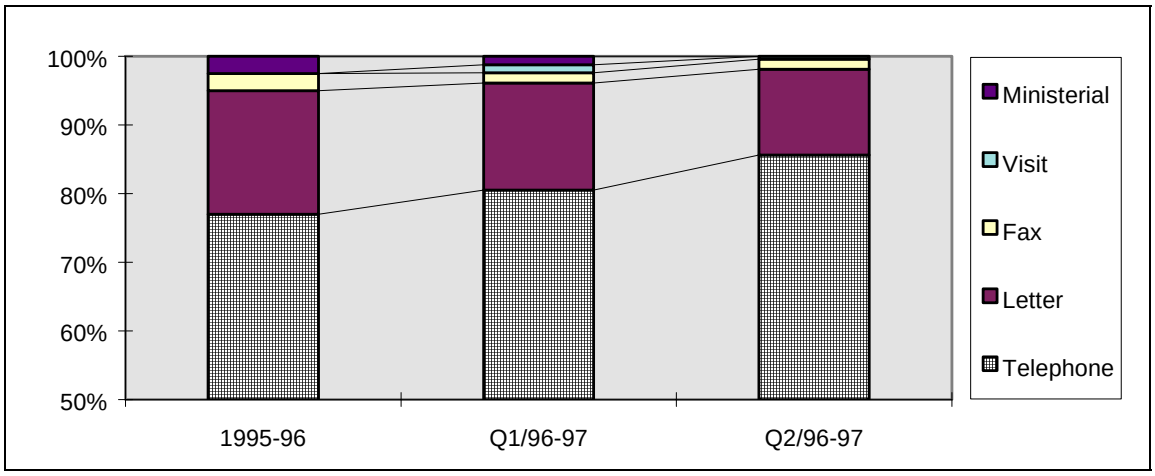
How do people complain?

The majority of complaints in the December quarter were made by telephone (85.8%, with 81% in the previous quarter and 77% in 1995-96).

Other complaint vehicles included letter (12.4%, with 16% in the previous quarter and 18% in 1995-96), fax (1.5% for both quarters in 1996-97) and Ministerial letter and visit (0.3%, with 2.2% in the previous quarter).

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

Figure 5: How do people complain?



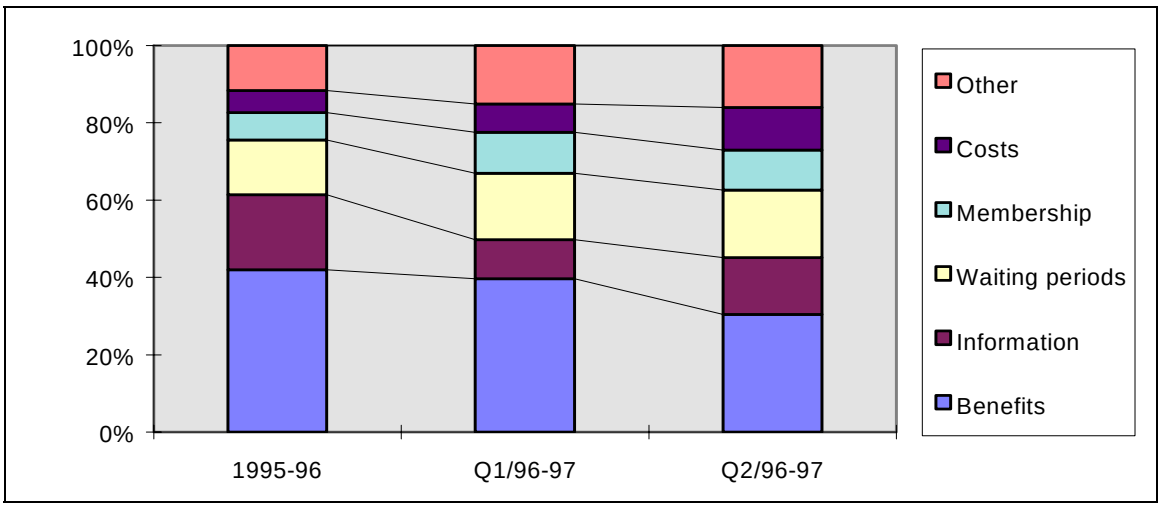
Types of complaints?

Most complaints concern disputes about benefits. These include concerns about the amount of benefit or confusion about whether the service is included under their level of cover. Other areas of complaint relate to the calculation of excesses, delays in payment and benefits for services received in other states.

Waiting periods are the second most complained about general issue. Most of these complaints are about application of the pre existing ailment rule and the waiting period for obstetric benefits.

The 264 complaints received in the December quarter were about 327 complaint issues. A detailed table of the issues concerning the complaints received follows.

Figure 6: What issues are complained about?



Complaints received by issue												
	1995/96				Sept Qtr 1996/97				Dec Qtr 1996/97			
Issue	***No.***	***%***	***No.***	***%***	***No.***	***%***	***No.***	***%***	***No.***	***%***	***No.***	***%***
Benefits												
Extent of cover			64	44.1%			54	41.9%			50	50.5%
Amount			26	17.9%			16	12.4%			11	11.1%
Delay			9	6.2%			10	7.8%			1	1.0%
Excess			7	4.8%			8	6.2%			7	7.1%
Limit reached			6	4.1%			9	7.0%			5	5.1%
Gap payment			13	9.0%			17	13.2%			15	15.2%
Out of State			4	2.8%			1	0.8%			1	1.0%
Other			16	11.0%			14	10.9%			9	9.1%
Subtotal Benefits	***145***	***42.0%***		*100.0%*	***129***	***39.7%***		*100.0%*	***99***	***30.3%***		*100.0%*
Information												
Oral			32	47.8%			15	45.5%			30	62.5%
Printed			15	22.4%			10	30.3%			11	22.9%
Radio/TV			2	3.0%			3	9.1%			1	2.1%
Written			4	6.0%			2	6.1%			3	6.3%
Lack of notification			14	20.9%			3	9.1%			3	6.3%
Subtotal Information	***67***	***19.4%***		*100.0%*	***33***	***10.2%***		*100.0%*	***48***	***14.7%***		*100.0%*
Waiting Periods												
General			4	8.2%			7	12.5%			2	3.5%
Obstetrics			4	8.2%			9	16.1%			9	15.8%
Pre existing ailment			41	83.7%			40	71.4%			46	80.7%
Subtotal Waiting Periods	***49***	***14.2%***		*100.0%*	***56***	***17.2%***		*100.0%*	***57***	***17.4%***		*100.0%*
Membership issues												
Who is the contributor?			3	12.5%			8	23.5%			6	17.6%
Arrears			3	12.5%			3	8.8%			3	8.8%
Cancellation/suspension			18	75.0%			22	64.7%			20	58.8%
Transfer/continuity			0	0.0%			1	2.9%			5	14.7%
Subtotal Membership	***24***	***7.0%***		*100.0%*	***34***	***10.5%***		*100.0%*	***34***	***10.4%***		*100.0%*
Costs												
Premiums			19	95.0%			17	70.8%			30	83.3%
Fees and services			1	5.0%			7	29.2%			6	16.7%
Subtotal Costs	***20***	***5.8%***		*100.0%*	***24***	***7.4%***		*100.0%*	***36***	***11.0%***		*100.0%*
Other specific issues												
Acute Care Certificates			3	12.5%			1	2.2%			1	2.2%
Discrimination			2	8.3%			3	6.5%			1	2.2%
Language & culture			3	12.5%			1	2.2%			0	0.0%
Quality of service			6	25.0%			16	34.8%			17	37.0%
Private patient election			2	8.3%			2	4.3%			2	4.3%
Contracts			1	4.2%			6	13.0%			7	15.2%
Confidentiality			1	4.2%			3	6.5%			1	2.2%
Premium payments			0	0.0%			5	10.9%			10	21.7%
Other specific complaint NEC			6	25.0%			9	19.6%			7	15.2%
Subtotal Other	***24***	***7.0%***		*100.0%*	***46***	***14.2%***		*100.0%*	***46***	***14.1%***		*100.0%*
Fund Rule Changes	***16***	***4.6%***			***3***	***0.9%***			***7***	***2.1%***		
TOTAL	345	100%			325	100%			327	100%		

How are complaints resolved?

Most complaints are resolved:

- by providing complainants with additional information or an explanation of the problem, including confirmation of advice originally provided by a health fund (29.8% of complaint issues were dealt with this way in the December quarter)

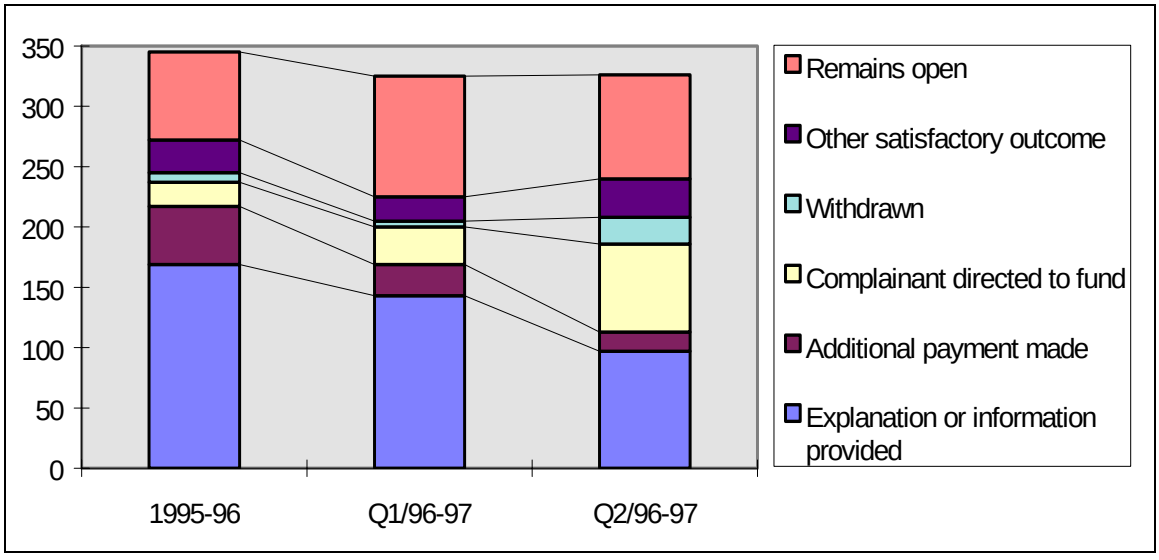
- to the complainant's satisfaction by the fund. For example, the fund agreeing to accept a student dependent on a membership (previously denied) or where a membership has been reinstated (after falling into arrears due to problems with payroll premium payments or bank direct debits). 9.8% of complaint issues were resolved this way in the December quarter.

- by the fund providing an additional payment or where a hospital or medical account is written off (4.9% of complaint issues were resolved in this way).

- by the complainant being referred directly back to the fund, where there has been no attempt to resolve the problem (22%).

Some 7% of complaint issues are withdrawn by complainants or are closed by the Complaints Commissioner where the complainant fails to provide additional information requested by the Commissioner.

Figure 7: How complaints are resolved?



Case Studies

Pre existing ailments

Complaints about pre-existing ailments continue to be the largest single specific type of complaint from health fund members. Complaints of this type can be compounded if advice is being given by health fund agents who may not be as familiar with health fund rules and policies as fund branch office staff.

A family, who had previously held private health insurance, sought advice from a local chemist who was the agent for a health fund. The prospective members explained that further additions to the family were being planned and as previous pregnancies had been premature, they wanted information about the pregnancy waiting periods. Although this fund has a 9 month waiting period for pregnancy related benefits with no explicit discretion to pay benefits for premature births, the chemist advised that he "did not think that the fund would reject a claim just because the member missed out on the 9 month waiting period by 2 weeks due to a premature birth totally outside their control".

The fund initially refused to pay benefits on the basis of the 9 month waiting period. The fund agreed that the member may have genuinely believed that the fund would not apply the waiting period to premature births, but added that the chemist's advice conveyed a sense of uncertainty, and in this context, the fund would have expected the member to contact it directly. After discussions with the chemist and staff of the Complaints Commissioner, the fund agreed to pay for half the hospital costs because of the uncertainty of the chemist's advice.

Although the complainant was not satisfied with this offer, the Complaints Commissioner advised that after taking all the relevant factors into account, the fund offer was fair and reasonable.

Exclusionary products

Some health fund members who complain are confused about their health insurance cover and it is likely that complaints of this nature will increase as health funds develop new products targeted at different markets.

A health fund member was unsure, after reading the brochure, if a proposed knee replacement at a local hospital would be covered by his level of health insurance. He was aware that he had an exclusionary cover, but after reading the brochure, was not sure of the extent of the exclusion and whether he would be covered, so he visited a fund branch office to clarify the situation.

He was advised that the fund did not have a Purchaser-Provider agreement with the hospital of his choice. The fund advised that he would have to pay only his $300 excess if the knee replacement was undertaken in another hospital.

A few days before his planned admission, the member checked with the fund again, this time by telephone, and was advised that he would be fully covered. On admission, the hospital also advised it had confirmed his cover with the fund.

When the hospital account was rejected by the fund, the member approached the fund which advised that knee replacements are excluded under his level of cover. The member contacted the Complaints Commissioner who approached the fund. The fund agreed it may have given insufficient or incorrect advice to the member and the hospital about the member's level of health insurance cover. The fund agreed to pay for the hospitalisation.

Most exclusionary products are based on "item number" exclusions. Complaints Commissioner staff recommend that fund members contact their fund before being admitted to hospital providing them with details of item numbers wherever possible. Item numbers are available from your local GP or medical specialist.

Recent premium increases

Many health fund members were faced with an increase in premiums in the December quarter.

Although the Complaints Commissioner received complaints and inquiries about the extent of the rises, many members were annoyed at the short notice they were given about their rise (many members received letters about their premium rise after the date of effect).

Members in funds without rate protection also complained that their "paid to" date had been brought forward, in some cases by many months. Customer service staff of the Complaints Commissioner explained the broad reasons for premium increases (from information contained in the Productivity Commission draft report) especially where members were unable to contact their fund directly (usually due to busy telephone lines).

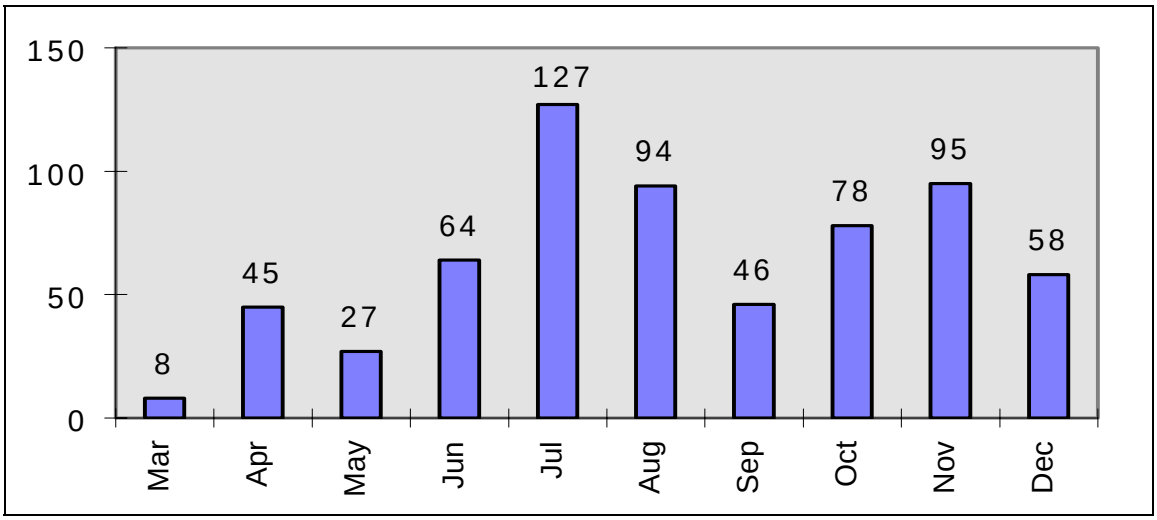
Where members were advised of changes to the levels of cover and the fund provided a limited time to upgrade without members having to serve waiting periods, the Complaints Commissioner was able to assist members, who were not advised in time, to take advantage of the upgrade offer.

Inquiries

There was a small reduction in the number of inquiries handled by the Complaints Commissioner in the December quarter. It is anticipated, however, that there will be an increase in inquiries during 1997 with health funds now required to include reference to the Complaints Commissioner in their brochures.

As the graph below shows, the peak activity was in July 1996 following the official launch of the office. August and November were also busy periods for inquiries.

Figure 8: Inquiries received by month



Time taken to respond to an inquiry

The Complaints Commissioner deals with most inquiries on the day they are received (97.4% in the December quarter compared with 86.9% in the September quarter).

Inquiries which are complex may take longer to deal with and often involve customer service staff seeking further advice from, for example, health funds or the Department of Health and Family Services. Figure 9 compares the duration of inquiries received in 1995-96 with the first two quarters of 1996-97.

How are inquiries resolved?

In most instances, customer service staff provide information about some aspect of private health insurance or explain the terminology used by health fund staff (52% in the December quarter compared with 69% in the September quarter).

Figure 9: Duration of inquiry resolution

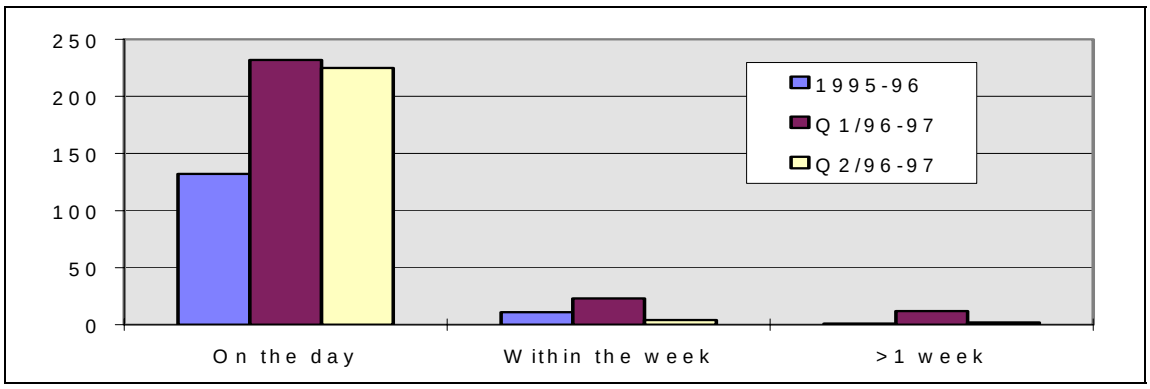
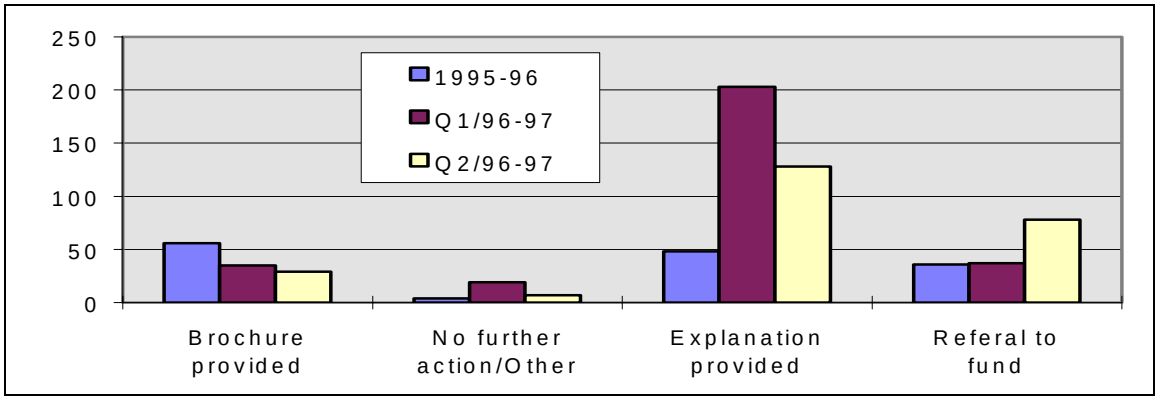


Figure 10: Method of resolving inquiries



What are the inquiries about?

In the December quarter the majority of inquiries related to specific health insurance problems such as waiting periods, costs, membership and benefits (60%). The rest of the inquiries related to general health insurance issues (30%) and other health and/or insurance related issues (10%) which are usually referred to State or Territory health complaints' units, Departments of Fair Trading and insurance disputes resolution services.

Figure 11: Inquiries received by issue