We are hirmaa

21 January, 2015

Ms Jayde Richmond
Acting Director, Industry Compliance
Australian Competition and Consumer Commission
GPO Box 520
Melbourne VIC 3001

Dear Ms Richmond

hirmaa welcomes the opportunity to make a submission to the Australian Competition and Consumer Commission (ACCC) regarding the practices by health funds and providers in relation to private health insurance (PHI) for the period 1 July 2013 to 30 June 2014.

By way of introduction, hirmaa is a peak industry body representing ten (10) restricted access insurers and seven (7) open access regional private health insurers. hirmaa funds are member-owned an community based insurers which collectively provide health insurance to over one million Australians across the country.

Since its formation in 1978, hirmaa has advocated for the preservation of competition, believing it to be fundamental to Australians having access to the best value health care services. hirmaa has done this by:

- promoting legislation, regulations, policies and practices which increase the capacity of its member organisations to deliver best value health care services; and,
- advocating for the preservation of a competitive market, which we see as essential to the integrity and viability of the PHI industry.

A number of characteristics distinguish the hirmaa member funds. They:

- are value-based as opposed to being profit-based;
- continue to offer various levels of insurance at highly competitive premiums;
- optimise benefit entitlements and premiums;
- continue to tangibly grow their membership numbers, in recent years above the industry average;
- in terms of the restricted insurers, have their unique nature acknowledged in the Private Health Insurance Act 2007.

At the outset, we note the ACCC's focus on issues relating to the level of transparency, accuracy and consistency of information about private health insurance. As a peak representative body for seventeen health insurers, hirmaa is not intimately aware of all aspects of information communication undertaken by insurers, however we are certainly aware of the of practices of insurers and other stakeholders at a collective level and as such, we will respond to the consultation questions where we are appropriately placed to do so.

As a peak representative body for seventeen insurers, we are also well aware of the various competition issues experienced by our member funds. Accordingly, we will dedicate a section of this submission to

such matters. We are of the opinion that there are a number of competition issues that warrant examination and we welcome the ACCC's invitation to provide input to any current or emerging anti-competitive or other practices in the industry.

hirmaa welcomes the engagement of stakeholders by the ACCC in preparing its annual report to the Senate on PHI. The engagement of stakeholders gives organisations such as hirmaa the ability to comment on contemporary issues impacting upon the industry.

Thank you for the opportunity to provide a submission on these important issues.

Yours sincerely

MATTHEW KOCE
Chief Executive Officer

A. Issues relating to information provision in the private health insurance industry

What do you think are consumers' experiences in relation to accessing accurate and complete information about their existing policy or new policies? Please provide details.

As stated, hirmaa is not ideally placed to comment on individual insurers' dealings with individual consumers. However, at a collective level, hirmaa facilitates the surveying of consumers to test a number of key service areas, including hirmaa-fund policy-holder perspectives on the quality of information provision and also the policy-holder's understanding of their cover and how it works.

This research is conducted annually by independent research group *Discovery Research*. In 2014, eleven hirmaa funds participated (list of participants attached) and 13,016 policy-holders were surveyed in total.

The results, summarised below, quite clearly demonstrate that hirmaa funds do an excellent job at communicating information to members, which results in very high levels of satisfaction. While we do not suggest that such results would be exactly replicated industry-wide, these findings provide a good indication that member-owned and community based insurers place value on clear communication and member understanding.

It is also important to note that 2014 marked the ninth consecutive year of member satisfaction surveying for most hirmaa funds. hirmaa funds understand the importance of accurate, transparent and complete communication of information and are committed to analysing and improving their service delivery through research such as this.

Key questions and results pertaining to the communication of information:[1]

How satisfied are you with the amount of communication that you receive regarding your membership?

	2006	2007	2008	2009	2010	2011	2012	2013	2014
Satisfied	93%	94%	94%	95%	96%	96%	96%	97%	97%
Dissatisfied	8%	6%	6%	5%	5%	4%	4%	4%	3%

How satisfied are you that the information you receive regarding your membership is easily understood, easy to read and written in plain language?

	2006	2007	2008	2009	2010	2011	2012	2013	2014
Satisfied	96%	97%	96%	97%	97%	97%	97%	97%	98%
Dissatisfied	4%	3%	3%	2%	2%	2%	2%	3%	3%

[1] Note: Rounding of percentages may produce totals not equal to 100

How satisfied are you with our telephone responsiveness?

	2006	2007	2008	2009	2010	2011	2012	2013	2014
Satisfied	96%	97%	96%	97%	97%	97%	98%	97%	98%
Dissatisfied	4%	3%	4%	3%	3%	3%	3%	3%	3%

How satisfied have you been with the quality of the service that you have received over the telephone, i.e. in terms of your problem being solved, the advice that you have been given, etc?

	2006	2007	2008	2009	2010	2011	2012	2013	2014
Satisfied	96%	96%	95%	97%	97%	97%	97%	96%	97%
Dissatisfied	4%	4%	4%	4%	3%	3%	3%	3%	3%

How satisfied are you with the service offered by mail, fax or email?
i.e. the response to your written enquiries.

	2006	2007	2008	2009	2010	2011	2012	2013	2014
Satisfied	95%	95%	95%	95%	96%	94%	93%	95%	95%
Dissatisfied	5%	5%	6%	4%	4%	6%	7%	6%	6%

Having tested members' satisfaction with communications received, the research looks at the member's understanding of their cover:

I have a good understanding of my cover and how it works

	2006	2007	2008	2009	2010	2011	2012	2013	2014
Agree	83%	85%	83%	86%	86%	86%	87%	86%	88%
Neither agree nor disagree	10%	9%	10%	8%	8%	9%	8%	9%	8%
Disagree	7%	6%	7%	6%	6%	5%	5%	5%	4%

Overall, how satisfied are you with your health fund membership?

	2006	2007	2008	2009	2010	2011	2012	2013	2014
Satisfied	97%	98%	97%	98%	98%	98%	97%	97%	98%
Dissatisfied	3%	2%	3%	2%	2%	2%	2%	2%	2%

Do you think consumers are experiencing difficulty understanding their policies, products and services? For example, understanding the extent and impact of inclusions and exclusions. If so, what steps are being taken or could be taken to improve consumer understanding?

hirmaa funds attain high levels of satisfaction among their policy-holders. With respect to their understanding of cover, only 4% surveyed indicate a poor understanding. It is important to note however, that attaining this level of consumer understanding requires considerable effort and expertise, given the complexity of Government regulation in the industry.

We note the ACCC's questions: ***Do the complexity of private health insurance products impact consumers' ability to make informed decisions about PHI and healthcare?***

Also, ***Is there sufficient transparency and/or consistency regarding the features of private health insurance policies to enable consumers to make informed decisions and choices about their health care and be able to compare policies?***

hirmaa suggests that regulations and Government policies do impact on the complexity of PHI products, but we believe insurers, generally, do a good job of distilling this complexity.

Policy changes have resulted in greater complexity for consumers, with the Australian Government Rebate (the Rebate) being means-tested, the Rebate being taken off the Lifetime Health Cover loading and the indexation of the Rebate to the Consumer Price Index. All of these changes require careful communication to policy-holders in order to build an understanding of how the changes function.

The other impact of these policy-changes has been to decrease the affordability of PHI and therefore accelerate movement toward lower-cover, lower-cost policies. Policies inevitably become more difficult to understand the more exclusions and restrictions they contain and hirmaa is strongly of the opinion that were full rebate support to be restored to PHI, such a dynamic would be alleviated.

This is not to say that hirmaa is strictly against exclusionary policies, rather, we believe that innovative product designs reflect competition in action as insurers work to meet differing consumer needs. Our main point of contention is that affordability issues may be pushing consumers away from products that are best suited to their needs.

As a side note, it is worth stating that while insurers do their best to match policies with the needs of consumers, they are working on the basis of limited (demographic) information. We note that the focus of this consultation is largely on the communication of information to consumers, but hirmaa suggests that the report should also be prepared to look at the communication of information to insurers, to assist them in providing policies and programs more suited to the consumer's needs. In particular, hirmaa suggests it would be in the interests of consumers to allow insurers better access to information with respect to health records. Giving consumers the option to grant their insurer access to their Personally Controlled Electronic Health Record would be an excellent starting point to allow more targeted and effective Chronic Disease Management Programs and insurance policies.

The Private Health Insurance Code of Conduct

The importance insurers place on informed relationships between parties is evidenced by the industry Code of Conduct (the Code), which is described as a "*self-regulatory code to promote informed relationships between Private Health Insurers, consumers and intermediaries*."[2]

hirmaa has long been a strong supporter of the Code and a strong contributor, with each Code of Compliance Committee Chairperson being from a hirmaa-fund.

Since the introduction of the Private Health Insurance Code of Conduct in 2005, nearly all health funds have been admitted to the Code. The admitted funds represent over 99% of people who are covered by private health insurance in Australia.

The Code of Compliance website advises that insurers which are signatories to the code will:[3]

- work towards improving the standards of practice and service in the private health insurance industry;

- provide information to consumers in plain language;

- promote better informed decisions about their private health insurance products and services by:
  - ensuring that policy documentation is full and complete
  - providing clear explanations of the contents of the policy documentation when asked by consumers
  - ensuring that persons providing information on health insurance are appropriately trained

- ensure information exchanged between the consumer and the fund is protected in accordance with privacy principles;

- provide information to the consumer on their rights and obligations under their relationship with their health fund, including information on this PHI Code of Conduct;

- provide the consumer with easy access to the insurer's internal dispute resolution procedures, which will be undertaken in a fair and reasonable manner and advise the consumer of his/her rights to take an issue to an external body such as the Private Health Insurance Ombudsman ("PHIO").

In the interests of building these informed relationships, the Code is regularly reviewed to maintain relevance and the input of consumers is also sought from time to time, including through consulting with the Private Health Insurance Ombudsman.[4]

---

[2] Private Health Insurance Code of Conduct, Part A: General; p. 1

[3] http://www.privatehealthcareaustralia.org.au/codeofconduct/codepromise/

[4] Ibid., p.1

The Code deals directly with many conditions that impact on the consumer's ability to understand policies, products and services. In particular, the Code considers the importance of the following:

- Employee quality and training and the importance of clear and accurate communication to consumers. This applies to both the insurer's staff, as well as staff at intermediaries (who make representations to consumers on behalf of the insurer).

- Policy documentation being accurate, complete and communicated in plain language. Also that such documentation be communicated in a timely manner upon appropriate request

- That detrimental policy changes be communicated to members in an appropriate and reasonable time-frame (at least 60 days for significant detrimental changes, at least 30 days for other detrimental changes

In considering these above, the Code details specific processes that signatories must adhere to. Because of the importance and relevance of these processes to the consultation questions posed by the ACCC, we have deemed it appropriate to attach excerpts of the Code that are directly relevant (see below).

It is also vitally important to note that there are strict processes in place to ensure compliance with the Code, including provisions for enforcement and for sanctions to be placed on non-compliance by the Code Compliance Committee.

This Committee employs the services of an independent auditor and is tasked with the following:

> *"Admitting funds to participate in the code, monitoring and enforcing compliance by participants by conducting random and other audits; receiving complaints about any alleged breach of the Code; imposing sanctions for breaches of the Code and publicising an annual report on compliance and operation of the Code."*[5]

Participating health insurers also have distinct responsibilities under the Code:

> *"Health Funds who are signatories to the Code must, in addition to complying with the Code, ensure they: implement appropriate systems and document procedures to comply with the Code; report to the Committee on the operation and compliance with the Code in accordance with the requirements of the Code and any guidelines issued by the Committee; cooperate with any compliance audits by or on behalf of the Committee and comply with any sanctions or requests made or imposed by the Committee. Health Funds must further satisfy the Code Compliance Committee that they continue to comply with all requirements of this Code by certifying their compliance with the Code in accordance with any guidelines or requests made by the Committee."*

It is also important to note that the effectiveness of the Code of Compliance has not gone unnoticed across stakeholders, most recently and significantly, the Private Health Insurance Ombudsman who we note is tasked specifically with "*protecting the interests of private health insurance consumers"*[6]*.*

---

[5] Ibid., p.1

[6] http://www.phio.org.au/about-phio/about-phio.aspx

In its 2014 Annual Report, with regard to the provision of clearance certificate information, the PHIO specifically notes the "*significant work to improve clearance certificate processes across all insurers, led by the industry's Code Compliance Committee*".[7]

Code of Conduct excerpts pertaining to informing consumers and improving consumer understanding:

PART C: EMPLOYEES

1. TRAINING OF EMPLOYEES
We will ensure that:

(a) employees involved in:
- arranging PHI,
- providing PHI services directly to consumers, including claims processing,
- developing Policy documentation or product sales material,
- developing marketing services, or
- dispute resolution,

are familiar with the provisions of this Code, and that they possess the necessary skills, appropriate to their responsibilities;

(b) we provide adequate on-going training in relation to PHI and Code requirements to employees having regard to the employee's role and responsibility and the PHI contracts for and the insurance services to consumers that the employee is authorised to arrange or provide;

(c) we measure the effectiveness of this training by monitoring the performance of individual employees in relation to their obligations under the Code;

(d) we require employees to undergo any necessary additional or remedial training to address any identified deficiencies identified by our monitoring; and

(e) we keep appropriate records of the training provided to individual employees.

PART D: INTERMEDIARIES
1. RESPONSIBILITIES IN RESPECT OF INTERMEDIARIES

If an intermediary is required or authorised under an agreement to provide information about our private health insurance products to consumers, we will ensure that the agreement requires the intermediary to:

(m) only provide to the consumer copies of product sales material and Policy documentation that complies with the requirements of this Code; and

(n) explain the consumer's options clearly using plain language and provide such information as the consumer requires to make an informed choice as to their private health insurance

[7] http://www.phio.org.au/downloads/file/PublicationItems/PHIOAR2014.pdf

purchase; and

(o) keep appropriate records of their advice to consumers.

2. TRAINING

We will require our intermediaries to possess the necessary skills appropriate to the private health insurance products they are promoting or selling or activities they are undertaking.
To this end, we will require our intermediaries to receive adequate on-going and documented training or instruction to competently provide the services to consumers that they are authorised to provide. The obligation to provide training or instruction is ongoing during the term of the agreement.

PART E: POLICY DOCUMENTATION

1. CLEAR AND COMPLETE POLICY DOCUMENTATION

We will:

(a) provide information to consumers in plain language;

(b) express Policy documentation in plain language and design and present Policy documentation, with the aim of assisting comprehension by consumers;

(c) ensure each new consumer to our fund is advised of or has presented to them prior to joining Policy documentation, information or advice detailing the consumer's entitlement to benefits, including any waiting periods and pre-existing conditions, exclusions, restrictions, benefit limitation periods and co-payments and/or excesses, and we will confirm this cover following acceptance by our fund;

(d) ensure all forms of Policy documentation accurately reflect the cover offered, will highlight information at (i) to (vi) below and contain accurate information at a minimum on:

(i) waiting periods and pre-existing conditions;
(ii) an explanation of the scope and implications of exclusions;
(iii) an explanation of the scope and implications of restriction on benefits;
(iv) an explanation of the scope and implications of benefit limitation periods;
(v) co-payments and/or excesses;
(vi) annual limits (individual and membership);
(vii) an explanation of pre-existing conditions;
(viii) how to find agreement hospital details;
(ix) how to find no gap or known gap doctors for our fund;
(x) how to find out if an ancillary provider is recognised by our fund;
(xi) how to find out about our fund's privacy policy;
(xii) how to access our fund's complaints handling procedures;
(xiii) information about the existence of the Code including the Code logo; and
(xiv) advice that the documentation should be read carefully and retained

(e) ensure all forms of product sales material including in any digital or electronic media, will accurately reflect the cover offered.

(f) at the request of any existing consumer, provide the consumer with the details of the consumer's entitlements to benefits;

(g) provide in a timely manner to consumers information on any changes to their policy, being made in plain language and in a format aimed to assist comprehension by consumers;

(h) on a State-by-State basis (where applicable), produce and maintain, in both written and electronic format, material detailing all tables of benefits or products that are available to consumers and ensure that the material:

(i) is freely available to any person; and
(ii) includes advice as to the existence of, and contact details for,the PHIO; and
(iii) indicates the date at which it is correct; and
(iv) is available in its written format at all of our organisation's offices; and
(v) can be accessed reasonably in its electronic format;

(i) at the request of another Private Health Insurer holding an authority (whether written, electronic or as a sound recording) from a transferring member, provide direct to that
Private Health Insurer in a timely manner, but within 14 days, a Transfer Certificate on behalf of a member or former member of our fund.

2.1 DETRIMENTAL CHANGES TO HOSPITAL POLICY BENEFITS

A significant detrimental change to hospital policy benefits includes:

(a) removal of material benefits or restriction to default benefits for any identified condition;

(b) addition of material excesses/co-payments; or

(c) increases in excesses/co-payments greater than 50%.

Where there is a detrimental change to hospital benefits we will:

(a) or significant detrimental changes provide the affected consumer with details of the change giving at least 60 days' written notice;

(b) for all other detrimental changes provide the affected consumer with details of the change giving at least 30 days' written notice; and

(c) not apply the changes to pre-booked admissions; and

(d) put in place transitional measures for patients in a course of treatment for a reasonable time period, for example, up to six months.

2.2 SIGNIFICANT DETRIMENTAL CHANGES TO ANCILLARY BENEFITS

A significant detrimental change to ancillary policy benefits includes:

(a) introduction of a new limit or sub-limit; or

(b) a greater than 50% reduction in any limit.

For significant detrimental changes to ancillary benefits we will:

(a) provide the affected consumer with at least 30 days' written notice; and

(b) put in place transitional measures for rollover type benefits accumulated in a previous year.

2.3 GENERAL PRINCIPLE IN RELATION TO
DETRIMENTAL CHANGES TO BENEFITS

We acknowledge and agree that although the above principles should be adhered to in the majority of cases, there is the flexibility to deal with special or unusual circumstances on a caseby-case basis. For example, the rules would not apply to changes imposed outside our reasonable control.

3. CHANGES TO HOSPITAL CONTRACTING ARRANGEMENTS

We recognise that while not constituting a change to hospital benefits for the purpose of Section 2 above, changes to hospital contracting arrangements between a fund and a hospital can affect a consumer. We understand that requirements for notification of consumers of such changes and transition arrangements are included in the relevant agreements and the Code of Conduct for Health Fund and Hospital Negotiations. We acknowledge that additional guidance can be found in DoHA circulars and in PHIO's Transition and Communication Protocols.

4. GUIDELINES FOR PRE-EXISTING CONDITIONS

We recognise that while not part of hospital contracting arrangements referred to in Section 3 above, we will ensure that the 'Best Practice Guidelines for Pre-existing Ailments' or any subsequent review are implemented as appropriate throughout our fund, including in the specific areas of:

- our medical practitioner; and
- in our dealings with hospitals including emergency admissions and other medical providers if appropriate and if applying to them.

5. "COOLING OFF" PERIOD

We will allow any consumer who has not yet made a claim, to cancel their private health insurance policy and receive a full refund of any premiums paid within a period of 30 days from the commencement date of their policy.

Do you have any suggestions for how information could be simplified or made more accessible to assist consumers to better understand the terms and conditions of policies?

As the peak-body for seventeen insurers Australia-wide, hirmaa regularly consults with our members to ascertain issues of relevance. With respect to information provision, the general opinion held across our membership is that the amount of legislation mandating information provision is excessive. The feedback from our membership is that the highly regulated implementation of information requirements are often highly prescriptive, costly and have little, if any, positive effect. Indeed, this can result in an over-supply of information for consumers that has an adverse impact on their understanding of their cover.

hirmaa is a strong supporter of the deregulation of information provision requirements as a way to reduce confusion amongst consumers. The following paragraphs contain some suggestions on how information provision could be simplified:

i. Standard Information Sheet (SIS)

The SIS contains generic information that is not inclusive of rebates, loadings or insurer discounts. Therefore it often causes confusion amongst policy holders and generates a high volume of customer enquiries (e.g. the member's premium may be different to the one disclosed on the SIS due to Lifetime Health Cover loadings or means-testing of the PHI rebate. Additionally, the SIS does not report on the waiving of waiting periods).

Inconsistencies between the SIS and Product Disclosure Documents provided by funds, means that it is of no practical value to the policy holder and in fact, can be detrimental.

At present, insurers are required to physically mail SIS' annually. hirmaa suggests that this should be modified, such that insurers only have to make SIS available to policyholders through their website, or upon request. Physically mailing these statements every year causes confusion for the consumer each year.

ii. Annual Lifetime Health Cover (LHC) statements

Industry experience is that the annual LHC Statement is costly to produce & distribute and of no value to policy holders.

This document provides a summary of the policy-holder's lifetime Health Cover status with respect to the loading applicable to them.

If deemed necessary, the information pertaining to LHC should be incorporated into premium change letters – which must also be sent annually to policyholders.

Are you aware of situations where as a result of advice or information provided, consumers have:

- ***Experienced difficulty choosing the right cover for their circumstances?***
- ***Been misled about the benefits and inclusions of their policy e.g. the preferred providers included, which procedures are covered or the expected cost?***
- ***Experienced bill shock?***
- ***Been discouraged from switching providers?***

Are there any problems arising from advice or information provided by health providers or intermediaries, particularly in relation to access to services, coverage, costs or gaps?

As communicated earlier in this submission, hirmaa is not intimately aware of the dealings of individual insurers with individual consumers, however we are able to make general comments relating to the activities of certain parties.

In particular, it is important to note that the role of intermediaries has grown in importance greatly over the last five years and they are now a major aspect of the competitive environment. Insurers - through structures such as the Code of Compliance - work to ensure, as best they can, that intermediaries represent their products accurately to consumers.

We suggest that the ACCC should place a significant focus on the activities of intermediaries with respect to their communication of information. The commission-based model for intermediaries means they have incentives to entice switching and downgrading in instances where it is not necessarily in the best interests of the consumer. This is certainly a dynamic that warrants focus in the report.

As a broader issue, hirmaa believes informed financial consent to be a crucial principle for all parties to adhere to, be they insurers, intermediaries or providers. Many hirmaa funds however, are concerned that their members are not always in receipt of informed financial consent. In particular, with respect to the charging practices of specialist medical practitioners. While insurers work hard to sign 'no-gap' and 'known-gap' agreements with providers, there can still be a lot of ambiguity with specialist medical practitioners which can result in significant 'bill-shock' for members. hirmaa suggests the ACCC investigates this issue with reference to the principles of informed financial consent and transparency in information provision.

We are also concerned that this principle is not being adhered to in the treatment of privately insured patients in public hospitals. Indeed, public hospitals are becoming increasingly active in pressuring patients to use their insurance in a public hospital. What originated as an issue confined to a small number of hospitals is now evolving into standard practice across public hospitals, where they outwardly publicise the supposed benefits of electing to be treated privately in a public hospital.

There are many incentives in place for public hospitals to persuade patients to elect to be treated as private patients. Not only can public hospitals obtain additional revenue from health insurers, but also from the Commonwealth directly, bypassing the states. Once a patient elects to be private, 75 per cent of all scheduled medical fees can be billed to the Commonwealth.[8]

[8] Private Patients in Public Hospitals – ACHR / AHSA; retrieved: http://www.achr.com.au/pdfs/Paper-Private-Patients-in-Public-Hospitals-April-2013.pdf

Unfortunately, patients who are admitted to public hospitals are often in a vulnerable position and not always able to make rational decisions over their treatment. Putting undue pressure on these patients to use PHI can be completely at odds with the principle of informed financial consent.

hirmaa suggests the ACCC investigates this issue with reference to the principles of informed financial consent and transparency in information provision.

Are you aware of specific examples where policy changes have not been communicated to consumers in a clear and transparent way? Please provide details.

During the 2013-14 period, the Private Health Insurance Ombudsman reported a significant increase in complaints, up 16% by comparison to 2012-13.

The complaint category that experienced the largest increase over the period was *'questions about oral information provided by customer service staff in fund call centres and branches'*, up from 229 complaints, to 410.

These results however, were not reflective of industry-level issues, rather, the performance of one large health fund in isolation. Ombudsman Samantha Gavel stressed this, noting in the PHIO Annual Report that the increase in complaints *"was largely attributable to a number of significant product and policy changes made by a large health insurer, which impacted on its members and resulted in higher numbers of complaints to the PHIO".*[9]

The Ombudsman notes further:

"In 2013-14, the PHIO received 580 higher level complaints, which was a 28% increase on the 450 received the previous year. Again, this increase was not industry wide, but due to higher numbers of complaints from members of a large insurer in response to a number of policy and product changes made during the year."

Bupa was responsible for 1,040 complaints over the 2013-14 financial year and was involved in 231 disputes, 46.6% of all disputes across the industry.

These figures demonstrate that customers are sensitive to, information provision in the industry. hirmaa funds consistently out-perform the larger funds by measure of complaints statistics and this reflects a strong understanding of the importance of effective information communication amongst the hirmaa group.

In addition to complying with the legislative requirements, are you aware of or do you undertake any additional steps to inform consumers of policy changes?

In addition to the legislative provisions and additional provisions as set out in the Code of Compliance, a number of hirmaa funds have internal processes for informing members of policy changes.

[9] PHIO Annual report 2013-14; retreieved: http://www.phio.org.au/downloads/file/PublicationItems/PHIOAR2014.pdf

We are aware that a number of hirmaa funds follow processes whereby they ask members to review their cover each year and provide incentives for them to increase their cover, without waiting periods. hirmaa funds want to make sure their members get the most appropriate cover and work to ensure members are aware of the implications of any exclusions and restrictions.

B. Other current, or emerging anti-competitive practices in the industry

Medibank and the Independent Practitioner Network

hirmaa believes that some cases of private health insurance involvement in primary-care threaten competition in the industry.

hirmaa acknowledges that a large portion of this involvement is currently concentrated to a small number of insurers, but as the activities of a few become increasingly rooted in the competitive landscape, the broader industry will be increasingly obliged to respond in kind. As such, it is important that the impact on competition and consumers is examined.

Whilst hirmaa recognises that activities in primary care certainly are not limited to those undertaken by Medibank Private, we suggest that the insurer's 'GP Access' trial provides the best example of a new venture that could be detrimental to competition.

Medibank Private's GP Access trial

hirmaa suggests that GP Access has the potential to be anti-competitive - due to its scale and exclusivity.

Under the arrangement, Medibank members are exclusively provided with preferential access to care from participating GPs practising at nominated Independent Practitioner Network (IPN) clinics. Through the GP Access pilot, participating GPs have agreed to bulk-bill Medibank Private customers, offer same day appointments if Medibank Private customers call before 10am and provide access to an after-hours bulk-billed GP service with a maximum three hour waiting period.

According to Medibank Private, GP Access is currently operating in South East Queensland where 26 medical clinics are involved with about 145 doctors participating, with more than 20,000 consultations having already taken place.

hirmaa notes that IPN is owned by one of Australia's largest healthcare companies, the ASX listed Sonic Healthcare Limited. The IPN network includes over 220 medical centres located around Australia which facilitate over 10 million consultations per year. Furthermore, it is the trusted business partner of over 1,700 dedicated General Practitioners and it employs over 3,000 healthcare professionals.

hirmaa is concerned that the exclusivity of the relationship between Australia's largest private health insurer (Medibank Private) and Australia's largest GP Network (IPN) is anti-competitive, threatens competition and is a potential misuse of market power.

If the intention of GP Access is to function as a pilot, as opposed to a marketing activity, we question why the GP Access pilot is being undertaken on such a grand scale, with Medibank Private recently indicating that it could further expand the pilot by rolling it out nationally:

"(GP Access) now has been rolled out across the whole of Queensland with participating GP practices. As that absorbs into volume, we will monitor and evaluate that program before we take it out nationally"[10]

Given the exclusive arrangement between Medibank Private and IPN in the provision of primary care and the fact that in terms of its national size and scale IPN is unique, there presents very limited scope for private health insurers to compete with GP Access.

Recent feedback from hirmaa member funds operating in South East Queensland is that the GP Access trial has created a public perception that Medibank Private is covering the cost of the GP co-payment. An observation initially supported by the Managing Director of Medibank Private, who inadvertently said that Medibank Private:

"Would provide a guaranteed booking for a GP service for them and also cover the cost of the co-payment"

For all intents and purposes, the Medibank Private GP Access pilot, creates a public perception that it covers the cost of GP copayments. This is reinforced by Medibank Private choosing to promote GP Access as 'Fee-free GP consultations' avoiding reference to the scheme being a pilot (see appendix 1).

While hirmaa recognises that there are opportunities for PHI to complement Medicare and contribute to a more sustainable health system, hirmaa also strongly believes that it should be done within an open and transparent regulatory framework that facilitates and encourages competition.

As noted, this trial is only one example of insurer activity in primary care – either already commenced, or in the planning stages. However, hirmaa suggests the issue warrants the attention of the ACCC report.

<u>Anti-competitive behaviour in the market for prostheses</u>

hirmaa advocates an urgent review of the market for prostheses in the private health system. We suggest the current regulatory structure is highly inefficient and directly contributes to anti-competitive market activities and significant waste in the system.

[10] Finance and Public Administration Legislation Committee – 29/05/2014 – Estimates – FINANCE PORTFOLIO – Medibank Private, retrieved: http://parlinfo.aph.gov.au/parlinfo/search/display/display.w3p;orderBy=date-eFirst;page=0;query=George%20Savvides%pilot;rec=1;resCount=Default

hirmaa has long held this position and has consistently advocated for reform in this area. Given that in 2012-13, $1.57 billion in benefits were paid for prostheses[11], this is an issue of significant importance for all insurers and representative bodies across the industry.

We are aware of conservative estimates that indicate around $600 million is wasted every year as a consequence of the current regulatory structure which artificially inflates prices for devices. We are also aware of anti-competitive and ethically questionable 'rebating' arrangements reached between prostheses manufacturers and private hospitals that also stem from this regulatory structure.

The effects of ineffective regulatory settings in the market for prostheses

1. Benefits paid by insurers do not reflect net prices paid for prostheses by hospitals

2. Lower cost and innovative competitors are restricted in their ability to compete with incumbent suppliers, due to the current method of determining group benefits for prostheses items

3. Benefits paid by insurers for prostheses items are substantially higher than benefits paid for identical items in international markets and the Australian public system

The problems inherent to the current regulatory settings are evident and competition is simply not functioning freely in the market for prostheses. hirmaa suggests that a review of competition issues is necessary and hirmaa is strongly of the view that significant cost-savings can be achieved to reduce premiums and benefit consumers.

<u>Second-tier default benefit legislation</u>

Second tier default benefit legislation obliges private health insurers to pay any accredited health facility (be it a private hospital or day surgery) who have met some basic criteria, at least 85% of the average charge for the equivalent episode of hospital treatment under that health insurer's negotiated agreements with comparable facilities in the State. Payment must be made irrespective of whether an insurer believes a health facility is delivering services of an acceptable standard to support sending its members there or at a fair and reasonable price.

Second tier default benefits are a significant issue in that health funds are compelled to pay a minimum level of benefits to a hospital with which they have been unable to agree on a contract or with which they do not have (or need to have) a contract. This is clearly an anachronistic and inappropriate arrangement that is completely unnecessary and runs counter to letting normal market dynamics prevail to the benefit of the consumer.

The fact that second tier default benefits restricts competition at the expense of innovation, choice, improved service and efficiency, by distorting normal market dynamics, is a major concern to the health insurance industry.

[11] *The Operations of Private Health* Insurers, Annual Report 2012-13, Private Health Insurance Administration Council

Indeed, health facilities that meet higher standards, are innovative and deliver better health outcomes deserve to be compensated commensurately, but perversely, when insurers pay more for higher performing facilities, they inadvertently reward low performing facilities as a direct result of second tier default benefits.

It is hirmaa's strong view that second tier default legislation in its current form is burdensome on insurers and distorts normal market dynamics, ultimately affecting service and pushing up the price of premiums for the consumer purchasing private health insurance.

With approximately 50% of the population covered by PHI, second tier default rates are now an outdated legacy which is unnecessary and only serves to increase costs, drive innovation away from health insurers and hospitals and creates complex and unnecessary "red tape".

The Second Tier Default Benefits regulation has the following consequences:

It obstructs innovation:

- It is difficult for insurers to negotiate agreements on quality, patient comfort or other non-price factors. Increasing rates for high-performing hospitals will also increase rates for second tier hospitals
- It stifles competition and price tension amongst private hospitals/day surgeries- since they all know that they will have some kind of arrangement with each insurer – so why innovate or try to control prices

It makes it more difficult to control inflation:

- Regulations strengthen the position of hospitals when negotiating with insurers, since without an agreement they still receive 85% of average rates and avoid the various non-price requirements in agreements

It results in an inefficient use of health funding:

- Access to insurer funding through second tier rates allows new facilities to open in areas which are already well-serviced

It distorts normal market dynamics:

- The artificial floor price drives up cost, impacting both consumers and the Government (via the premium rebate)

Attachment A – Participating hirmaa funds in 2014 customer satisfaction survey

ACA Health Benefits Fund Ltd

Defence Health Ltd

Doctors' Health Fund Ltd

Lysaght Peoplecare Ltd*

Mildura Health Fund Ltd*

Navy Health Ltd

Phoenix Health Fund Ltd

Police Health Ltd

Queensland Country Health Ltd*

Railway and Transport Health Fund Ltd

Reserve Bank Health Society Ltd

* denotes regional open fund. All other funds are restricted insurers