We are hirmaa

29 April, 2016

David Salisbury
Acting General Manager
Consumer & Small Business Strategies Branch
Australian Competition and Consumer Commission
GPO Box 520 Melbourne VIC 3001

Dear Mr Salisbury,

hirmaa is pleased to provide a submission to the Australian Competition and Consumer Commission (ACCC) on the topic of health fund practices that either result in 'bill shock', reduce the extent of health cover or result in general detriment to the consumer for the period 1 July 2014 to 30 June 2015.

hirmaa is the peak industry body for 19 not-for-profit, member-owned and community-based private health insurers comprising both restricted and open access funds.

hirmaa funds collectively provide health insurance to more than one million Australians, including vital segments of society including the police and armed forces, teachers, medical practitioners, key industries such as transport, steel and mining, and regional and rural communities.

As background, hirmaa's core mission is to;

- Advocate to all levels of Government, relevant departments and regulators to ensure that the hirmaa membership is equipped with optimal policy and regulatory settings to provide the best-quality private health insurance and customer services to their policy holders.
- Promote the values and benefits of the mutual, member-owned and not-for-profit business model and ethos.

Since its establishment in 1978, hirmaa has been a strong supporter of preserving competition in Australia's private health insurance industry. The Association firmly believes that maintaining a diverse mix of health insurance products and providers encourages innovation, value and organisational integrity.

Further to that, hirmaa believes that the mutual and member-owned business model ensures that organisations remain inherently focused on providing the best outcomes for their membership.

hirmaa funds have developed a reputation for integrity among their policyholders through a number of unique and vital characteristics, including;

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

hirmaa acknowledges the ACCC's specific questions regarding individual instances of communications practices by health insurers that have either led to 'bill shock' or out-of-pocket expenses, limited access to healthcare services or caused general detriment to the consumer.

As detailed in its submission, hirmaa suggests that a lack of transparency and accountability around performance and pricing by health service providers, (in particular medical practitioners, hospitals and prostheses suppliers) is impeding competition and choice to the detriment of consumers.

As the peak representative body for nineteen health insurers, hirmaa is not aware of all aspects of information communication undertaken by insurers. However, we are aware of the collective practices of insurers and as such, hirmaa is pleased to provide broad responses where appropriately placed to do so.

Again, hirmaa welcomes the ACCC's engagement with industry stakeholders in preparation of its Annual Report to the Senate on Private Health Insurance. Consultation between the ACCC and industry ensures that all stakeholders continue to be critically engaged with issues presently impacting the sector.

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

Yours sincerely,

Matthew Koce

Chief Executive Officer

Overview of performance and transparency in private health insurance

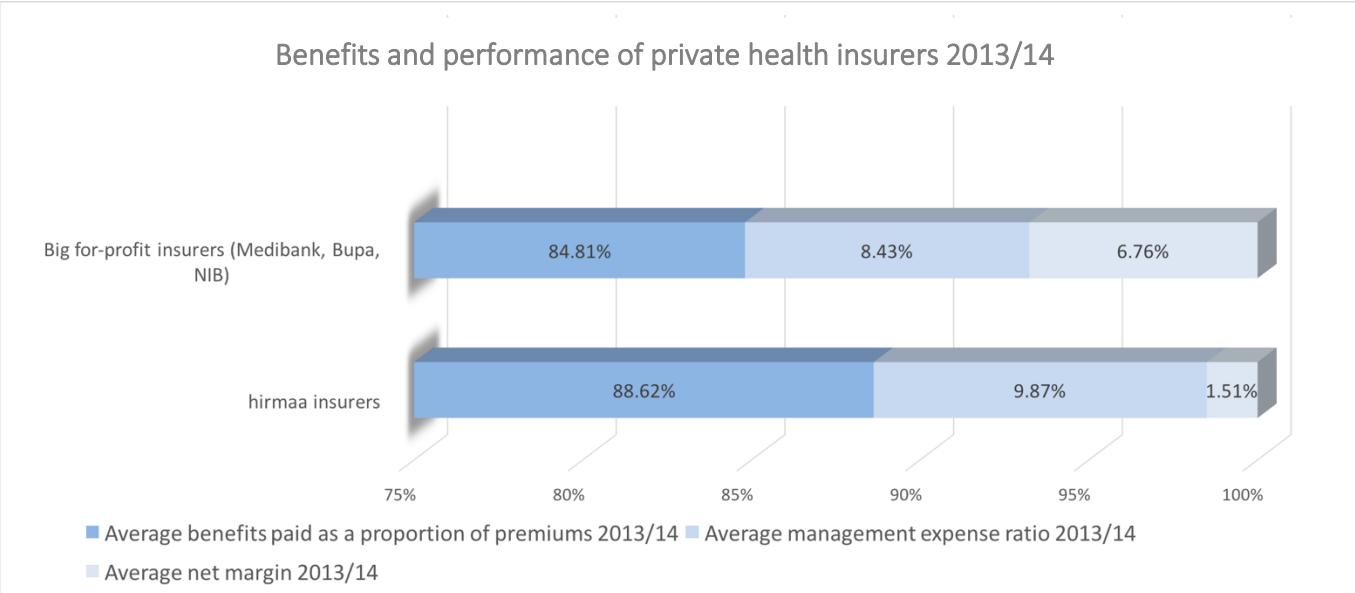
From the outset, hirmaa believes it is important to highlight that within the private health insurance industry there is a notable difference between Australia's for-profit and not-for-profit insurers.

Not-for-profit, member-owned and community-based health funds make up 27 of the 33 private health insurers and contribute more than $6 billion to the economy in health care services annually.

hirmaa funds are respected and valued by their members and by the industry as part of a diverse and highly competitive marketplace. Their year-on-year, extremely high levels of customer satisfaction, member retention and growth makes them a key driver of competition and choice in the industry.

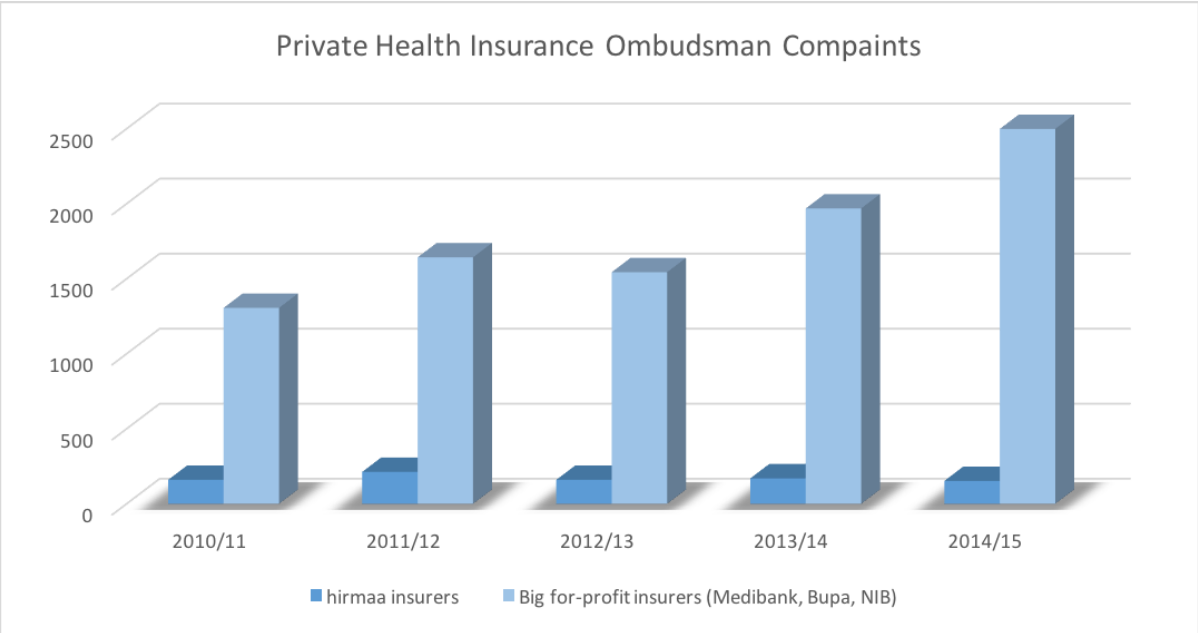
The not-for-profit, member owned and community based business model ensures that the consumer is the primary focus of all hirmaa funds' operations.

hirmaa funds re-invest around 90 per cent of all premiums paid, back to policyholders, as benefits. This is in contrast to the country's for-profit insurers, which operate primarily for the benefit of shareholders and return only around 84 per cent.



Source: Private Health Insurance Ombudsman State of the Health Funds Report 2013/14

The Commonwealth Ombudsman's annual statistics further highlight the value proposition of the not-for-profit, member-owned and community based insurers. While hirmaa funds represent around 10 per cent of the private health insurance marketplace, they account for just 4 per cent of all complaints received in 2014/15 by the Commonwealth Ombudsman relating to health insurance products and service. The big for-profit insurers meanwhile account for more than two thirds of all complaints.

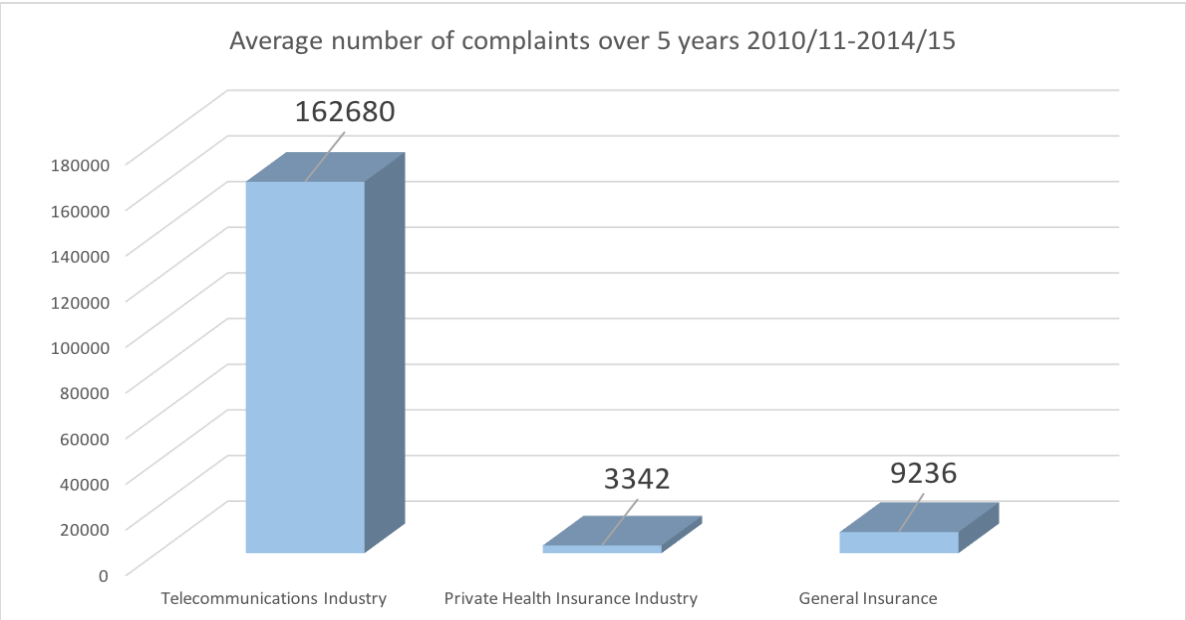


Source: Private Health Insurance Ombudsman Annual Report 2010/11 – 2014/15

With the above in mind, hirmaa submits that this difference between the for-profit and not-for-profit, member-owned business models appears to have a direct correlation with the quality of customer service and perfomance.

More broadly, it is also worth highlighting that among the country's largest service industries, private health insurance performs significantly better with regards to lower numbers of recorded complaints.

An average of 3342 compaints were received by the Private Health Insurance Ombudsman annually between 2010/11 and 2014/15 – that's less than 0.03 per cent of the 13.5 million Australians that currently have some form of private health insurance – either hospital cover



Source: Private Health Insurance Ombudsman Annual Report 2010/11 – 2014/15; Telecommunications Industry Ombudsman Annual Report 2010/11 – 2014/15; Financial Services Ombudsman Annual Report 2010/11 – 2014/15

or general treatment/ancillary cover, or a combination of both. In contrast, this figure falls well below the number of complaints received by both the Telecommunications Ombudsman or the Financial Services Ombudsman relating to general insurance.

With such a strong reputation for quality customer service and effective communications, hirmaa welcomes the ACCC's ongoing scrutiny around competition within private health insurance. In particular, hirmaa encourages the ACCC to take an increased interest in the health service supply chain, especially barriers to competition and pricing and performance of hospitals, medical practitioners and prostheses suppliers.

hirmaa believes it is critical to acknowledge that private health insurance is already subjected to numerous transparency and accountability measures including the Private Health Insurance Act 2007, which impose very strict requirements on health insurers.

Further to the Act and prudential oversight from the Australian Prudential Regulation Authority (APRA), the private health insurance industry also imposes its own form of performance and compliance monitoring through the Code of Conduct.

"hirmaa's not-for-profit, member-owned and community-based health funds communicate effectiveley to policyholders resulting in significantly fewer complaints."

Most aspects of a private health insurers operations are also made publically available through the annual 'State of the health funds report' published by the Commonwealth Ombudsman. This report details the financial and operational performance of health insurers, including their Management Expense Ratio. APRA also provides quarterly comprehensive statistical updates on the operations and performance of all health insurers, most of which are published on the agency's website.

hirmaa acknowledges that the level of scrutiny placed on Australia's health funds provides an important understanding of the costs and pressures that influence premiums each year. Given the important role that insurers play in peoples' lives, hirmaa also appreciates the level of transparency and accountability applied to the industry.

It is unfortunate however, that the same level of transparency and accountability around performance and pricing does not extend to all service providers in the health sector including hospitals, medical practitioners and medical device manufacturers, which are the core drivers of health inflation.

In the interests of ensuring effective competition, choice, transparency and consumer empowerment, it is vital to achieve a wider understanding of all aspects of the health supply chain. Considering the vast majority of each premium dollar paid by policyholders goes towards benefits, it is imperative that health provider costs and performance metrics be much more closely scrutinised by the ACCC and the Government in order to provide assurances around affordability and value for Australian consumers.

hirmaa fund communication standards

As the peak body for 19 not-for-profit, member-owned and community-based health insurers,

hirmaa is not ideally positioned to provide comment on each specific insurers' communications practices with individual consumers. However, on a broader level, hirmaa is pleased to provide comment on the aggregate performance of its member-funds in relation to customer service, communication and support.

Each year hirmaa facilitates a customer satisfaction survey of the policyholders of participating hirmaa member-insurers'. The survey assesses policyholder perspectives on the quality of information provision and their understanding of their cover and how it works.

The survey has been conducted annually for the past 11 years by independent research group Discovery Research (see appendix 1). In 2016, 13 hirmaa funds participated and more than 21,800 policy-holders provided responses.

hirmaa Member Satisfaction Survey Results 2016: Questions and results pertaining to the communication of information to customers by hirmaa member funds[1]

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

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Satisfied	97%	98%	97%	98%	98%	98%	97%	97%	98%	98%	97%
Dissatisfied	3%	2%	3%	2%	2%	2%	2%	2%	2%	2%	2%

Is your fund a member-service focused company?

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Agree	90%	91%	89%	91%	91%	92%	91%	91%	92%	91%	91%
Neither agree nor disagree	8%	7%	9%	7%	7%	7%	7%	7%	7%	7%	8%
Disagree	2%	2%	2%	1%	1%	1%	1%	1%	1%	1%	1%

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	2015	2016
Satisfied	96%	97%	96%	97%	97%	97%	97%	97%	98%	97%	97%
Dissatisfied	4%	3%	3%	2%	2%	2%	2%	3%	3%	2%	3%

How satisfied are you with how quickly we answer your telephone calls?

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Satisfied	96%	97%	96%	97%	97%	97%	98%	97%	98%	97%	99%
Dissatisfied	4%	3%	4%	3%	3%	3%	3%	3%	3%	3%	1%

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

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	2015	2016
Satisfied	96%	96%	95%	97%	97%	97%	97%	96%	97%	97%	97%
Dissatisfied	4%	4%	4%	4%	3%	3%	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	2015	2016
Satisfied	95%	95%	95%	95%	96%	94%	93%	95%	95%	95%	95%
Dissatisfied	5%	5%	6%	4%	4%	6%	7%	6%	6%	5%	5%

Following on from the line of questioning on communication practices, participants were asked about overall understanding of their policy and coverage.

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

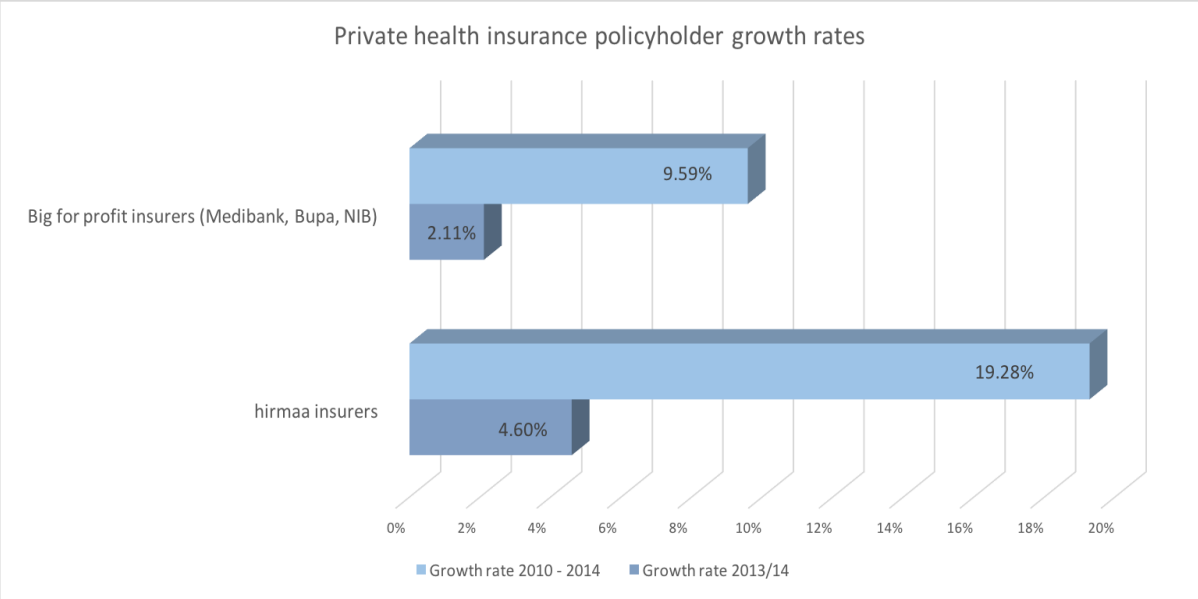
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Agree	83%	85%	83%	86%	86%	86%	87%	86%	88%	87%	87%
Neither agree nor disagree	10%	9%	10%	8%	8%	9%	8%	9%	8%	8%	9%
Disagree	7%	6%	7%	6%	6%	5%	5%	5%	4%	4%	5%

Further Reading: Appendix 1 - hirmaa Member Satisfaction Survey Results 2016

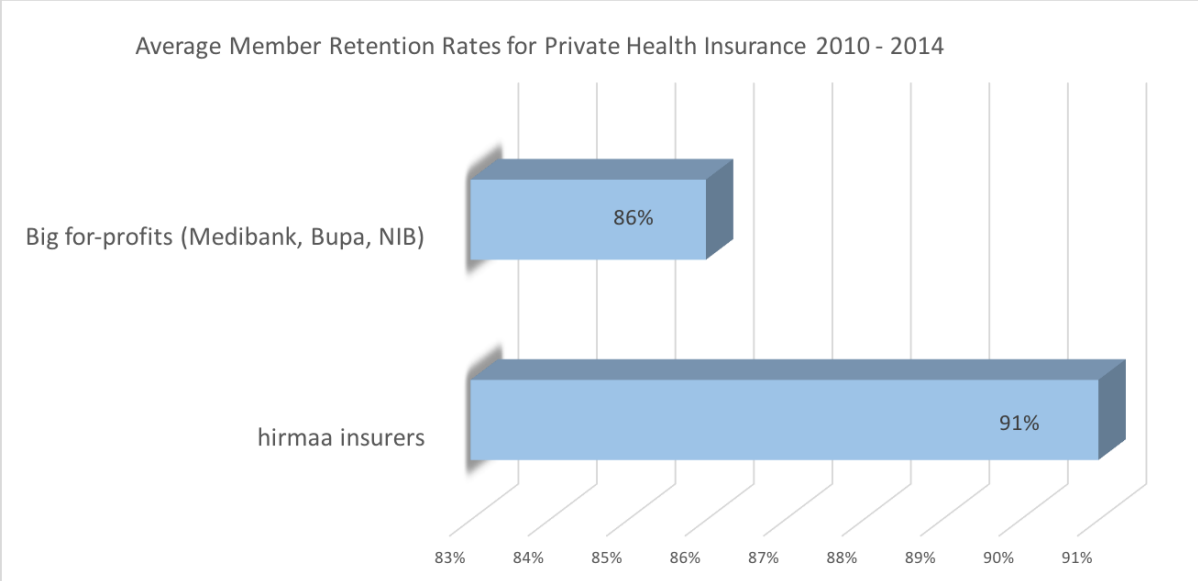
The Member Satisfaction Survey results clearly demonstrate the unwavering effort that hirmaa funds go to inform consumers of policy changes and their ongoing commitment to meeting the value and service demands of their membership.

As stated in the survey findings, the funds' commitment to the research and to effective consumer communications is further evidenced by the fact that many of them now have teams that develop member-focused improvements. A number of funds have also developed KPIs that are tightly focused on achieving improved customer satisfaction levels.

Figures supplied by APRA and the Commonwealth Ombudsman highlight that policyholder growth and member retention figures for hirmaa insurers are well above the industry average, further reinforcing the survey's findings that hirmaa insurers meet the very highest standards for customer service.



Source: Operations of PHI Annual Report 2009/10 -2013/14, PHIAC



Source: State of the Health Funds Report 2010/11 – 2013/14, PHIO

Specifically on retention rates, hirmaa commissioned a study into private health insurance policy switching. Ten hirmaa funds participated in a one month study during late 2015. Participating funds provided de-identified details of members either changing products within their fund or new members joining from another insurer.

A key finding of the study was the extent to which policyholders review their cover. Some commentators have argued that policyholders don't review their cover often enough, suggesting a lack of competition in the industry, or that policyholders don't understand their health insurance or engage with their insurer. However these statements are based on public statistics, which just consider the proportion of members leaving each fund. hirmaa's research suggests that the true level of policy changes are much higher, because **for every policyholder changing funds, around two change policies but remain with the same insurer.**

Barriers to communications in private health insurance

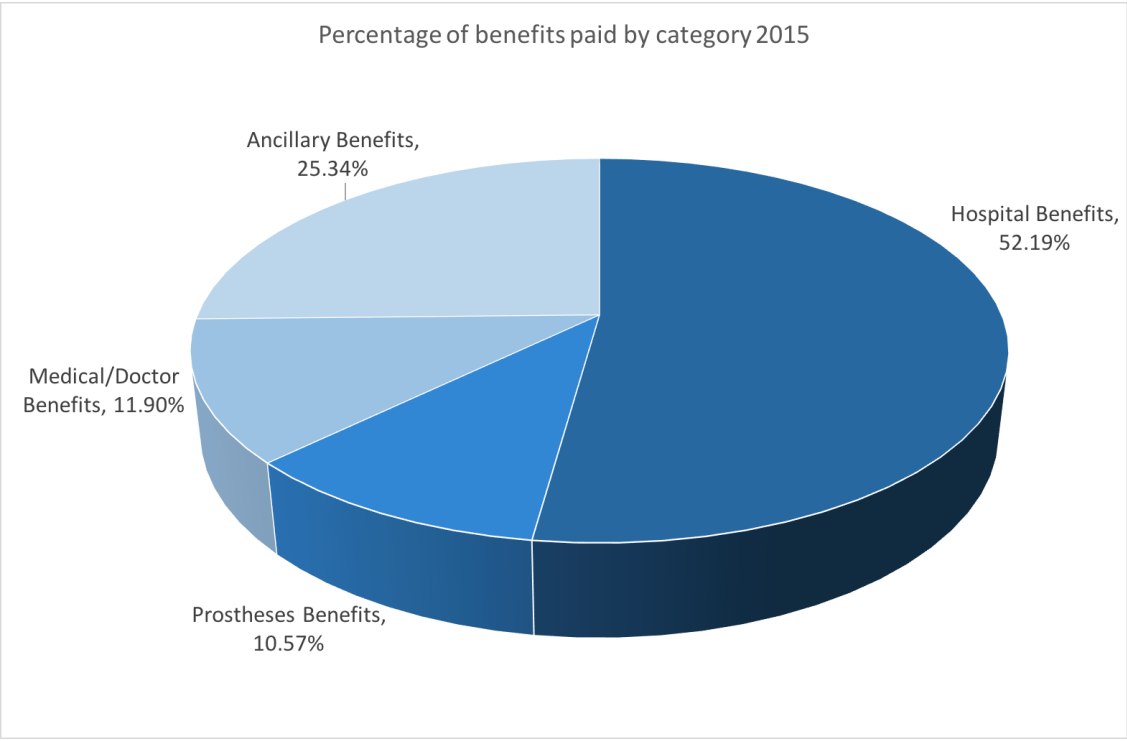
hirmaa notes the ACCC's questions relating to specific examples of policy changes that have not been communicated to consumers in a clear and transparent way or have not been communicated to consumers at all. hirmaa also notes the ACCC's queries regarding communications that may have resulted in consumers experiencing 'bill shock' or resulted in inadequate policy coverage for consumers.

The results of the 2016 hirmaa Customer Satisfaction Survey show that just three per cent of the 21,800 respondents believed that the information provided by their health fund was not easily understandable. Only five per cent believed that they did not have a good understanding of how their cover worked. Extremely low levels of consumer dissatisfaction among hirmaa-fund policyholders have been consistently recorded for the past 11 years – since the Member Satisfaction Survey's establishment.

Very low rates of consumer dissatisfaction corresponding with very high rates of consumer satisfaction, illustrates the longstanding commitment that hirmaa funds have to effective communication with their membership base.

Transparency and accountability across the entire health supply chain

All the evidence suggests that the core issue driving 'bill shock' in private health insurance is market failure around health service providers. The lack of transparency around the pricing and performance of medical practitioners, prostheses and hospitals has disempowered consumers and resulted in a lack of competition and choice. With the majority of premiums paid to health funds spent on medical practitioners, prostheses and hospital benefits, it is in the interest of the Australian consumer that the Government address transparency at all stages of the health supply chain in order to combat 'bill shock' or out-of-pockets.



Source: APRA Private Health Insurance Membership and Benefits Report, December 2015

Consumers face substantial barriers to pre-determining the cost of a procedure. The full cost of a procedure is commonly not disclosed to a patient until after they have paid for a specialist consultation. Additionally, neither the consumer nor their General Practitioner have access to timely data on the performance of specialists such as post infection rates.

Surgeons, anesthetists, specialist physicians and other medical practitioners all rank consistently among the highest paid occupations in Australia with annual salaries increasing steadily.

In 2013-14, Surgeons were listed as the highest paid profession with an average taxable salary of $375,094, up from an average of $361,200 in 2012-13. Compared with five years ago, surgeons are earning $77,342 more (a 25.98 per cent increase), anesthetists $75,068 more (29.23 per cent increase) and specialist physicians $63,582 more (a 29.51 per cent increase).

With that evidence in mind, hirmaa supports increased transparency, consumer engagement and the highest possible standards for informed financial consent (IFC) being provided to patients. IFC is crucial to empowering consumers and allowing them to participate fully in their healthcare decisions whether that be by exercising choice over their medical specialist, hospital or medical device.

We suggest that intelligent use of existing MBS data could provide an immediate element of transparency and accountability in the area of medical consultations and treatments. Making MBS data pertaining to practitioner billing and out-of-pocket costs and performance publicly available on an internet portal would substantially improve communications with consumers and empower them in their health care decision making.

All health providers and practitioners should publicly reveal standardised cost estimates to consumers that include MBS item numbers for each part of the procedure and whether they will accept the benefits offered by a consumer's insurer. We note progress is being made in the area of service provider transparency and accountability in the United Kingdom with the establishment of MyNHS and in the United States through online government portals for consumers such as HealthCare.gov and Medicare.gov/hospital compare.

The recent findings of '*The Surgical Variance Report for General Surgery'*, prepared by Medibank Private with the Royal Australasian College of Surgeons and released on 29 April 2016, provides some tangible insight into the impact that a lack of genuine competition is having on the consumer. The research points to some surgeons working in private hospitals charging 15 times what their peers charge for the same procedure, and many have wildly different complication rates.

The Report identified significant variation in fees charged by doctors for eight common operations including hernia repairs, colonoscopies (bowel investigations) and gastroscopies (investigation of the oesophagus, stomach and duodenum). Surgeons performing gastric sleeve operations for weight loss charged average private fees ranging from $231 in South Australia to $3593 in Queensland. The average fee in NSW was $3160 and in Victoria it was $1874.

Private fees charged for gall bladder removals (over and above what Medibank Private and Medicare covered) also ranged from $369 in Tasmania to $1166 in NSW. In Victoria, the average fee was $387.

Professor Watters, President of the Royal Australasian College of Surgeons responded to the publication of the Report by publically encouraging patients to question surgeons, including about how many times they had done an operation and what their rate of complications was.

For many patients, questioning a surgeon about their competency is daunting, as it is complex. Therefore hirmaa strongly suggests that the only way to ensure patients and their General Practitioners are fully informed to make an empowered choice around the selection of a surgeon based on value for money, is to provide the necessary tools and information on a publically available consumer website portal run by government.

On the issue of transparency around prostheses prices, hirmaa supports the Australian Government's recent establishment of the Industry Working Group on Prostheses, which investigated the prices of medical devices in Australia's private health system, compared with prices in the public system and worldwide.

Research shows that the price for common prostheses items, such as pacemakers and hip-joint replacement parts, in the Australia private hospital setting can attract a 300 per cent premium compared to the public hospital system or overseas jurisdictions, such as France. Furthermore, for many prostheses there is a lack of credible independent comparative data on performance and quality, the exception being the National Joint Replacement Registry (NJRR).

"Consumers do not have timely access to the information they need to participate constructively in their healthcare decisions."

The exorbitant cost of prostheses in the private hospital system appears to be driven in large part by regulatory failure by the Government that has resulted in widespread 'discounting' or 'rebating' between the large prostheses manufacturers and private hospital networks, giving rise to the appearance of profiteering at the expense of consumers.

In the interests of enhancing competition, performance and reducing costs, hirmaa strongly advocates for mandatory price disclosure, consistent with Pharmaceutical Benefits Scheme (PBS), and the expansion of registries based on the highly successful NJRR.

Finally, transparency and accountability by hospitals is equally as important to ensure consumers have access to the best-quality health care.

Australia's not-for-profit, member-owned and community-based insurers' ability to remain competitive and provide affordable, high quality cover is reliant on contracting with hospitals on a level playing field.

At present, information around hospital performance is highly limited and as such, consumers do not have timely access to the information they need to participate constructively in their healthcare decisions.

hirmaa therefore supports greater transparency around the performance of hospitals, with regard to key performance indicators such as infection rates, hospital errors and waiting times at an individual hospital level.

hirmaa is currently seeking confirmation from the Coalition Government on increasing transparency across the entire health system; recognising that transparent and accessible information relating to the cost, performance and quality of medical specialists, hospitals and prostheses companies, as well as in private health insurance, will truly empower consumers, put downward pressure on health inflation, reduce communication complexity and reduce out-of-pockets.

hirmaa supports Government establishing a digital gateway to provide consumers access to all of the above information.

Second-tier default legislation stifling competition

Second-tier default benefit legislation compels private health insurers to pay any accredited health facility (private hospital or day surgery) at least 85 per cent of the state average for a similar facility type. Insurers are obliged to pay these facilities irrespective of whether that facility is required or whether the insurer believes the services provided are of sufficient quality to warrant paying for members being treated there.

The second-tier default benefit legislation disrupts competition through the following adverse impacts:

- Innovations in quality and efficiency of service is obstructed
- It is difficult for insurers to negotiate purchaser-provider agreements on quality, patient comfort or other non-price factors. Increasing rates for high-performing hospitals will increase the average and therefore 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 is more difficult to control cost inflation: Regulations strengthen the position of hospitals when negotiating with insurers by granting them 85 per cent of average rates without agreements, and by allowing them to 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 that are already well-serviced, and effectively subsidised poor commercial, entrepreneurial and investor judgments.
- It distorts normal market dynamics: the artificial floor price drives up contract costs, impacting both consumers and the Government (via the premium rebate)

It is hirmaa's strong view that private health insurers should not be forced to in effect contract with every single private hospital and that the second-tier default benefit legislation in its current form urgently requires review. Removing the second tier default benefit would result in:

- Lower premium rises for consumers with the restoration of normal market dynamics
- Higher quality and more innovative facilities would be rewarded whereas service deficient facilities would be required to lift their performance
- Unnecessary administrative costs to insurers and the Department of Health of managing these schemes being removed

At a minimum, hirmaa suggests that only stand-alone regional and rural hospitals – where there is limited competition and choice - should have access to a minimum default benefits safety net.

Means-testing the Rebate causing unnecessary complexity

Effective communication between health insurers and consumers is complicated by the fact

that the private health insurance industry is subject to many complexities brought on by government policy and regulation.

The most obvious example of the over-complication of the private health insurance industry can be seen in the Government's decision to means-test the Australian Government Rebate (the Rebate), take the Rebate off Lifetime Health Cover Loading and index it to CPI. These changes impact the cost of all policies and add complexity to the task of accurately communicating the price of health insurance premiums.

hirmaa suggests that changes should not be made to the rebate that increase its complexity or diminish its value. Ideally, the Rebate should be applied without means tests and should be set at a fixed percentage with indexation to CPI removed. This is administratively much simpler and easier to understand for governments, insurers and, most importantly, consumers. Keeping the Rebate as simple as possible would assist consumers to understand any changes to the terms and conditions of their policies and simplify communications between the insurer and member.

Other factors impeding communications between health insurers and consumers

Another visible example of over complexity in the private health insurance industry, which impacts communications between insurers and members and can cause unexpected costs and changes in coverage, is the fragmented nature of ambulance services across the country.

At present, complexity and inconsistency in the models for funding and delivery of ambulance services across different States and Territories is imposing an unfair and costly financial and administrative burden on patients and their health insurers. It is clear that the current arrangements are unnecessarily complex and that leadership through COAG is required to achieve harmonisation.

States and Territories manage their own ambulance services in Australia and there are a range of different models of funding. The range of different funding and administrative arrangements contribute to a highly complex national ambulance picture, the consequences of which can be significant for health insurers and their members.

In many cases, patients are not sure what they are covered for in different States and equally, insurers are not sure what their liability will be, especially if travel across two separate jurisdictions is required. Requiring overly complex messages to be communicated between insurer and member, this fragmented system often results in limited understanding of cover or even out-of-pocket costs for patients.

The highly fragmented nature of the ambulance scheme should be addressed through reforms that give effect to a nationally-coordinated scheme including reciprocal arrangements across the States and Territories.

hirmaa notes that at the April, 2016, meeting of COAG Health Ministers, the issue of ambulance services across state lines was referred to the Australian Health Ministers Advisory Council for further consideration.

Further Reading: Appendix 2 - hirmaa Ambulance Position Paper and Research

Self monitoring, policing and scrutiny: The Private Health Insurance Code of Conduct

One of the most effective forms of regulation and monitoring the communications and practices of private health insurers has been through the establishment of the Private Health Insurance Code of Conduct (the Code).

The Code was formed in 2005 by hirmaa and fellow industry peak body, Private Healthcare Australia. The Code presently includes the majority of funds, which cover 99 per cent of people with health insurance in Australia. The Code is charged with being a "self-regulatory code to promote informed relationships between Private Health Insurers, consumers and intermediaries."[2]

hirmaa is a strong supporter and contributor to the Code. The Association is confident that the Code promotes best practice in information communications and provision, which consequently results in better customer services and lower instances of detriment to the consumer as proven in the figures provided earlier relating to Private Health Insurance Ombudsman complaints compared to other industries such as telecommunications and general insurance.

Further to that, the successful collaboration between the Code and the Commonwealth Ombudsman is well documented. The Commonwealth Ombudsman specifically notes in its 2015 Annual Report as one of the agency's "significant activities", its engagement and provision of advice to the Private Health Insurance Industry Code Compliance Committee.[3] Furthermore, the immediate past Private Health Insurance Ombudsman, Samantha Gavel, is a current member of the Code of Conduct committee.

The Code explicitly states that all signatories must provide easy access to the insurer's internal dispute resolution procedures and advise the consumer of his/her rights to take an issue to an external body such as the Private Health Insurance Ombudsman. The Code is regularly reviewed to maintain relevance and input is also sought from consumers and from the Private Health Insurance Ombudsman.

Among other requirements, the Code of Compliance dictates that signatories continuously work toward improving the standards of practice and service in the private health insurance industry; provide information to consumers in plain language and promote better informed decisions about their private health insurance products and services.

Simple measures such as ensuring that all policy documentation is easily understood and communicated, and health fund employees are well-trained to provide that information, are both clearly stated as requirements in the Code.

The Code additionally commands high standards from participating funds specifically relating to practices that impact on the consumer's ability to understand policies, products and services. Health fund employees and intermediaries must be trained to provide clear and accurate communication to consumers, all policy documentation must be accurate and communicated in plain language and any detrimental policy changes must 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).

Furthermore, the Code has effective processes in place to ensure that each participating funds comply with the conditions set. Provisions for monitoring, certifying, enforcement and for sanctions have also been developed for cases of non-compliance by the Code Compliance Committee.

[2] Private Health Insurance Code of Conduct, Part A: General; p. 1
[3] Private Health Insurance Ombudsman Annual Report 2015, p.40

The Code Compliance Committee employs the services of an independent auditor who is charged with 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.[4]

hirmaa suggests that the Code provides sound evidence of the private health insurance industry's strong commitment to providing consumers with clear, transparent and consistent communications and information provision, including but not limited to policy and changes.

Further Reading: Appendix 3: PHI Code of Conduct

[4] Ibid., p.1

Appendix 1: Discovery Research Member Satisfaction Survey 2016

Research Metrics

Total Respondents:	21,875
hirmaa Funds Involved: [13]	ACA Health Benefits Fund Defence Health Doctors' Health Fund Mildura Health Fund Navy Health Peoplecare Health Insurance Phoenix Health Fund Police Health Queensland Country Health Fund RBHS rt health fund St Lukes Health TUH
Research Conducted:	February 2016
Service Areas Tested:	Member Communication Telephone Service Written Service Payment of Claims
Values Tested:	Value for Money, Price Competitiveness, Benefits Positioning, Premium Affordability, Reliability, Integrity, Personal Service, Friendliness, Member Service Focus, Ease of Dealing With, Staff Problem Solving, Understanding of Cover and Website Information

Overview of the Member Satisfaction Research Work

The commitment of the hirmaa Funds to the research

- 2016 marked the eleventh consecutive year of the Member Satisfaction Research for most of the hirmaa Funds. The hirmaa Funds remain committed to closely examining how their value and service offer meets the demands of their membership base.

Satisfaction improvements are steady and incremental by nature

- A very pleasing aspect of the Member Satisfaction program is the improvement in satisfaction scores noted by all hirmaa Funds that have committed to the process. An element of "healthy competition" exists between the Funds that has seen them all striving for improvement in member satisfaction; having obvious benefits for the Funds in terms of member retention, but ultimately being for the benefit of each individual Fund member through receiving improved products and/or services.

Improvement through member focused initiatives coming via team based workgroups

- The commitment to the research has been reinforced by action within the hirmaa Funds; many of the funds having teams that meet regularly to develop member focused improvements, and a number of funds having developed KPIs that are tightly focused on achieving improved satisfaction levels.

Depth of customer understanding

- Each year of the research the hirmaa funds have been able to build upon their knowledge regarding the needs and motivations of specific segments within their membership base. This knowledge has enabled the funds to remain in touch with changing expectations of their membership; enabling them to renew and reinvigorate their products, service offer and marketing strategies to best meet the needs of their members – for now and into the future.

Still managing to achieve their best results over the years of the research work

- As mentioned, many of the Funds have been conducting the Member Satisfaction Research for a number of consecutive years. It is remarkable that for many of the key service and value areas that the research tests, that very high satisfaction levels have been maintained, and in some cases this year the Funds have achieved their highest ratings of any of the years of the research, i.e. improving on their previous best results.

Overwhelmingly positive feedback in the thousands of members' comments

- Many thousands of verbatim comments are collected each year from members of the hirmaa Funds. These comments are overwhelmingly positive in nature and reflect on the strength of the service and the value proposition offered by the hirmaa Funds. What comes through as a regular theme is the deep care for the individual member and their circumstances.

Overview of Results

Overall Member Satisfaction Overall, how satisfied are you with your health fund membership?	**2016: 97% satisfied**	2015: 98% satisfied 2014: 98% satisfied 2013: 97% satisfied 2012: 98% satisfied 2011: 98% satisfied	2010: 98% satisfied 2009: 98% satisfied 2008: 97% satisfied 2007: 98% satisfied 2006: 97% satisfied
Member Communication How satisfied are you with the amount of communication that you receive regarding your membership?	**2016: 96% satisfied**	2015: 96% satisfied 2014: 97% satisfied 2013: 97% satisfied 2012: 96% satisfied 2011: 96% satisfied	2010: 96% satisfied 2009: 95% satisfied 2008: 94% satisfied 2007: 94% satisfied 2006: 93% satisfied
Telephone Service 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?	**2016: 97% satisfied**	2015: 97% satisfied 2014: 97% satisfied 2013: 96% satisfied 2012: 97% satisfied 2011: 97% satisfied	2010: 97% satisfied 2009: 97% satisfied 2008: 95% satisfied 2007: 96% satisfied 2006: 96% satisfied
Written Service How satisfied are you with the service offered by mail, fax or email?	**2016: 95% satisfied**	2015: 95% satisfied 2014: 95% satisfied 2013: 95% satisfied 2012: 94% satisfied 2011: 94% satisfied	2010: 96% satisfied 2009: 95% satisfied 2008: 95% satisfied 2007: 95% satisfied 2006: 95% satisfied

Overview of Results

Payment of Claims How satisfied are you with the speed of the payment of your claim(s)?	**2016: 98% satisfied**	2015: 98% satisfied 2014: 98% satisfied 2013: 98% satisfied 2012: 97% satisfied 2011: 98% satisfied	2010: 98% satisfied 2009: 97% satisfied 2008: 95% satisfied 2007: 95% satisfied 2006: 97% satisfied
Value for Money Offers good value for money to its members	**2016: 84% agree**	2015: 85% agree 2014: 86% agree 2013: 86% agree 2012: 86% agree 2011: 86% agree	2010: 86% agree 2009: 87% agree 2008: 84% agree 2007: 85% agree 2006: 84% agree
Price Competitiveness Is competitively priced with other health funds	**2016: 77% agree**	2015: 78% agree 2014: 79% agree 2013: 78% agree 2012: 79% agree 2011: 80% agree	2010: 80% agree 2009: 81% agree 2008: 79% agree 2007: n/a 2006: n/a

Appendix 2: hirmaa Ambulance Service Provision Research

Reform of ambulance service provision across Australia

Position and Research Paper

November, 2015

By way of introduction, hirmaa is a peak-industry organisation representing 18 community-based private health insurers, comprising both industry, or employer focused 'restricted access' insurers and 'open' insurers serving particular regions. Collectively, hirmaa funds provide health insurance to over one million Australians across the country.

Being community-based and not-for-profit, hirmaa funds exist solely to benefit their members.

Summary of findings

At present, complexity and inconsistency in the models for funding and delivery of ambulance services across different States and Territories is imposing an unfair and costly financial and administrative burden on patients and their health insurers. It is clear that the current arrangements are unnecessarily complex and that leadership through COAG is urgently required to achieve harmonisation.

States and territories manage their own ambulance services in Australia and there are a range of different models of funding. These models range from universal coverage (as is the case in Queensland and Tasmania), voluntary subscription schemes (as is the case in Victoria, South Australia and the Northern Territory), and fee-for-service models where the charges differ significantly across States and Territories. Private health insurance is a funding source across most States and Territories.

In addition, some States and Territories offer subsidies and safety-net arrangements for low-income earners and pension-card holders.

The range of different funding and administrative arrangements contribute to a highly complex national ambulance picture, the consequences of which can be significant for health insurers and their members.

In many cases, patients are not sure what they are covered for in which State and equally, insurers are not sure what their liability will be, especially if travel across two separate jurisdictions is required. This often results in significant out-of-pocket costs for patients.

hirmaa has attempted to draw together information from each of the States' and Territories' ambulance providers (attached as appendices) to build a picture of the respective systems and their interactions. Reflective of the complexity of the ambulance system, the process of gathering information has proved complex, with inconsistent information often provided by customer service staff and on their websites.

Recommendations

The highly fragmented nature of the ambulance scheme should be addressed through reforms that give effect to a nationally-coordinated scheme, and we note that a number of other industry associations, including the Heart Foundation have previously made submissions to this effect.[1]

While hirmaa sees a nationally-coordinated scheme as the ultimate long-term solution, in the short-term, hirmaa suggests COAG work to enhance reciprocal arrangements across the States and Territories.

Noting appendix 1 – *Ambulance service provision across Australia* and in particular, the column *Cover for residents outside their home state*, it is clear that there is substantial variation across States and Territories as to the liability for funding. When patients are transported in their State or Territory of residence, the funding of ambulance services is generally* straightforward. However, as appendix 1 demonstrates, this breaks down entirely when interstate transport or patient repatriation is required.

In cases where States and Territories have signed reciprocal agreements, clarity over liability for funding and potential out-of-pocket costs is greatly improved. Unfortunately, as Appendix 1 demonstrates, reciprocal arrangements are severely lacking in many instances and historically, these arrangements have been subject to change, often without forewarning.

hirmaa suggests COAG considers reform to ensure reciprocal arrangements are in place across all States and Territories.

Some of the benefits of reform in this area would be:

- Improved clarity for patients over the liability for funding

- Reduced out-of-pocket expenses for patients

- Reduced red-tape and administrative costs for private health insurers:

  Keeping and recording up to date information relating to ambulance arrangements within each State and Territory is a major issue for Customer Service Officers (CSOs) who provide information to consumers and members.

  Health funds are often not kept informed by State and Territory health authorities when changes are made, so there is a difficulty in training CSOs to ensure the provision of information is correct and up-to-date. This has implications for health fund's compliance with

*NSW for example, has a particularly complex system. For non-privately insured residents, a 49% subsidy is provided for emergency and clinically necessary non-emergency patient transport (NEPT). For the privately insured, a State ambulance levy is paid by private health funds to cover the costs of ambulance services. However, a recent directive from the NSW Government, allowing Local Health District and Specialty network vehicles to provide ambulance services for fee or reward, has made the system more complex, as transport by these vehicles is not covered by the State ambulance levy. Patients who assume they are covered by private health insurance are therefore often left with significant out-of-pocket costs.

[1] National Heart Foundation of Australia, *Submission to the Senate inquiry into out-of-pocket costs in Australian healthcare*, May 2014, retrieved: http://www.aph.gov.au/DocumentStore.ashx?id=9398968a-97d8-49fa-a8eb-9e739262646b&subId=252545

the Private Health Insurance Code of Conduct.

- Enhanced simplicity and transparency for insurers in communicating with their members:

  Different arrangements between States and Territories means that health funds are required to develop multiple member correspondence scenarios that are tailored to where members reside, where they obtain an ambulance service or what they are trying to claim. This is both confusing for the consumer and arduous for health funds.

- Enhanced capacity for insurers to design appropriate products for their members:

  At present, developing a consistent level of benefits for ambulance cover is problematic. If an insurer does make an attempt to have a single benefit regime so that consumers can more easily understand what they are covered for, some members are disadvantaged over others. Enhancing reciprocity across States and Territories would make a significant, positive impact on ease of product design.

hirmaa believes ensuring reciprocity in ambulance service funding is a crucial first step to improving financial and health outcomes for Australian citizens. We would be happy to discuss the content of this submission in greater detail. Please do not hesitate to be in touch with our offices.

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Appendix 1 – Ambulance service provision across Australia.

State	Type of coverage	Reciprocal agreements	Cover for Residents outside of their home state	Repatriation - NEPT	Concessions
NSW	Partly State funded for NSW services - 49% subsidy for NSW residents. Applies to both emergency and clinically necessary non-emergency patient transport (NEPT). A State ambulance levy is paid by private health funds to cover the costs of ambulance services used by their members.* * Recently, the Health Secretary in NSW has issued consent to Local Health District and Specialty network vehicles to provide ambulance services for fee or reward. Services provided by these vehicles is not covered by the State ambulance levy. Insurers can cover members for these services, or treat them as exclusions.	• Residents of ACT, VIC, NT, WA, TAS that use the NSW services are provided a 49% subsidy. • Residents of QLD & SA are charged 100% of cost (no reciprocal agreement). Liability may fall with the individual, a State (i.e. QLD Government), a State-based insurer (i.e. Ambulance Victoria), or a private health insurer, depending on the patient's coverage and State of residence.	• NSW residents are subject to fees as set by other States. • NSW residents holding appropriate PHI cover will have emergency transport in ACT, VIC, NT, WA and TAS covered by the State ambulance levy. This cover does not extend to SA or QLD (no reciprocal arrangements).	• The repatriation of NSW residents is free in the case of public-to-public, clinically necessary transport. • Repatriation to a private hospital is subsidised 49% by the NSW Government. • The above does not apply in the case of repatriation from SA or QLD, where no subsidy or coverage is provided by the NSW Government. • If the patient holds private health insurance, the expense of repatriation is covered through the insurer's State ambulance levy.	• Health Care Concession Card, Pensioner Concession Card, Commonwealth Seniors Health Card holders are entitled to free ambulance transport services
VIC	Full cover in VIC available through Ambulance Victoria membership. This covers emergency transport and clinically necessary NEPT. Victorians without Ambulance Victoria cover will be charged full fees. Victorians may also be able to obtain ambulance cover through PHI.	• Residents of other States are charged for Victorian ambulance services. Liability may fall with the individual, a State (i.e QLD Government), a State-based insurer (i.e. Ambulance Victoria), or a private health insurer, depending on the patient's coverage and State of residence.	• Ambulance Victoria members are fully covered for emergency transport and clinically necessary NEPT anywhere in Australia. • Non-members are not covered and will be charged according to the relevant State's fee schedule.	• Ambulance Victoria membership provides cover for all clinically necessary repatriation.	• Pensioner Concession Card and Health Care Concession Card holders are entitled to free ambulance transport services.
TAS	Full cover in TAS for all TAS residents through the State tax system.	• Residents of other States are charged for Tasmanian ambulance services. • Liability may fall with the individual, a State (i.e QLD Government), a State-based insurer (i.e. Ambulance Victoria), or a private health insurer, depending on the patient's coverage and State of residence.	• TAS residents are fully covered in all states and territories expect in SA and QLD. • For transport in SA and QLD, liability may fall with the individual, or a private health insurer, depending on the patient's insurance cover.	• Concession Card holders are covered for air ambulance in VIC; and this extends to clinically necessary repatriation to TAS. • Tasmanian residents are covered for air ambulance transport to and from Public Hospitals between mainland states only where the medical procedure is not available in TAS. • Cover is not provided for repatriation to TAS	• Full cover for all TAS residents through the State tax system.

WA	No cover available for metropolitan residents. Residents may be may be able to obtain cover through PHI. Full cover in WA available for emergency and clinically necessary NEPT for regional residents through St John Country Ambulance membership.	• Residents of other States are charged for WA ambulance services. Liability may fall with the individual, a State (i.e QLD Government), a State-based insurer (i.e. Ambulance Victoria), or a private health insurer, depending on the patient's coverage and State of residence.	• WA residents with St John Country Ambulance membership are covered for all other States' principal providers of ambulance services. • Non-members and metropolitan residents are not covered and will be charged according to the relevant State's fee schedules. Liability may fall with the individual, or a private health insurer, depending on the patient's insurance cover.	• WA residents are not covered for repatriation. Liability may fall with the individual, or a private health insurer, depending on the patient's insurance cover.	• Pensioner Concession Card holders are entitled to free ambulance transport services. • Up to 31 December, 2015 all senior citizens aged 65 years and over receive a 50 per cent subsidy on the normal fee. ***Note: From 1 January, 2016, all senior citizens aged 65 years and over with Private Health Insurance will no longer receive a 50 per cent subsidy on the normal fee.** • Inter-hospital transfers, where one or both hospitals are a private hospital, are not covered.
QLD	Full cover in QLD for all QLD residents through the State tax system.	• Residents of other States are charged full rates for QLD ambulance services. Liability may fall with the individual, a State-based insurer (i.e. Ambulance Victoria), or a private health insurer, depending on the patient's coverage and State of residence.	• QLD residents are fully covered for emergency transport and clinically necessary NEPT anywhere in Australia.	• QLD residents are covered for clinically necessary repatriation.	• Full cover for all QLD residents through the State tax system
SA	Cover for emergency transport in SA available through membership with the South Australia Ambulance Service. Cover for NEPT in SA also available through the SA Ambulance service.	• Residents of other States are charged full rates for South Australian ambulance services. Liability may fall with the individual, a State (i.e QLD Government), a State-based insurer (i.e. Ambulance Victoria), or a private health insurer, depending on the patient's coverage and State of residence.	• SA Ambulance Service members are fully covered for emergency transport anywhere in Australia. If NEPT extras have been purchased, members are fully covered for clinically necessary NEPT anywhere in Australia. • Non-members are not covered and will be charged according to the relevant State's fee schedule. Liability may fall with the individual, or a private health insurer, depending on the patient's insurance cover.	• SA Ambulance Service members with NEPT cover are covered for repatriation provided by a recognised interstate ambulance service. • Non-members and members without NEPT cover, are not covered. Liability may fall with the individual, or a private health insurer, depending on the patient's insurance cover.	• Pensioner Ambulance Cover is provided to pensioners at a discount. • Health Care Concession Card holders may also be eligible for discounted cover. • Pensioners who are not members of SA Ambulance service may be entitled to a 50% reduction in ambulance fees when ambulance transport is medically justified.

NT	Full cover available for emergency transport in NT through St John Ambulance membership. Cover for NEPT not provided, except where the treating doctor deems an ambulance to be the most appropriate means of transport.	• Emergency transport Holiday cover is available for interstate visitors for a maximum of 30 days, through St John Ambulance. • Those without holiday cover will be charged. Liability may fall with the individual, the State (i.e QLD Government), a State-based • insurer (i.e. Ambulance Victoria), or a private health insurer, depending on the patient's coverage and State of residence.	• St John members are fully covered for emergency transport (but not NEPT) in any State or Territory in Australia. • Non-members are not covered and will be charged according to the relevant State's fee schedule. Liability may fall with the individual, or a private health insurer, depending on the patient's insurance cover.	• Neither St John members, nor non-members are covered for NEPT repatriation. Liability may fall with the individual, or a private health insurer, depending on the patient's insurance cover.	• Holders of a Pensioner Concession Card, a Health Care Concession Card or Commonwealth Seniors Health Card are entitled to free ambulance transport services.
ACT	No cover available for ACT residents. Residents must purchase ambulance cover through PHI.	• Residents of other States are charged for ACT ambulance services. Liability may fall with the individual, the State (i.e QLD Government), a State-based insurer (i.e. Ambulance Victoria), or a private health insurer, depending on the patient's coverage and State of residence.	• Health Care Concession Card and Pensioner Concession Card holders are entitled to free emergency ambulance services from approved ambulance providers in VIC, NSW**, NT and TAS (no reciprocal arrangements with QLD, SA & WA). • All other residents are not covered. Liability may fall with the individual, or their insurer, depending on coverage. Fees are determined by the State in which transport is received.	• ACT residents are not covered for repatriation. Liability may fall with the individual, or a private health insurer, depending on the patient's insurance cover.	• Health Care Concession Card and Pensioner Concession Card holders are entitled to free emergency ambulance services.

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Appendix 2 – Examples; liability for Ambulance services

New South Wales residents.

1. A NSW resident, without ambulance cover through PHI, requires an ambulance service in NSW.	Patient receives 49% subsidy on emergency and non-emergency transport. Liability falls with the individual.
2. A NSW resident, holding ambulance cover through PHI, requires an ambulance service in NSW. *NSW ambulance service vehicle is used.	Patient receives 49% subsidy on emergency and non-emergency transport. Fees covered by insurer, through State ambulance levy.
3. A NSW resident, holding ambulance cover through PHI, requires an ambulance service in NSW. *Local Health District, or Speciality network vehicle used.	Patient receives 49% subsidy on emergency and non-emergency transport. State ambulance levy does not cover LHD / Specialty network vehicle services. Insurer's discretion to cover or to have patient cover cost.
4. A NSW resident, without ambulance cover through PHI, requires an ambulance service outside of NSW.	Patient is charged full fees as set respectively by Ambulance Victoria, Ambulance Tasmania, St John WA, the Queensland Ambulance service, the SA Ambulance service, St John NT (unless Holiday cover is obtained), and the ACT Ambulance service.

5. A NSW resident, with ambulance cover through PHI, requires an ambulance service outside of NSW.	If the insurance policy provides cover for ambulance services in these States, the insurer is required to pay the invoice.
6. A NSW resident, without ambulance cover through PHI, requires clinically necessary repatriation from VIC, TAS, WA, NT or ACT.	Public to public hospital repatriation, where clinically necessary, is free. Clinically necessary repatriation to a private hospital is subsidised 49% by the NSW Government. The patient is liable for the remainder.
7. A NSW resident, with ambulance cover through PHI, requires clinically necessary repatriation from VIC, TAS, WA, NT or ACT.	Public to public hospital repatriation, where clinically necessary, is free. Clinically necessary repatriation to a private hospital is subsidised 49% by the NSW Government. Remaining fees covered by the insurer through the State ambulance levy.
8. A NSW resident, without ambulance cover through PHI, requires clinically necessary repatriation from QLD or SA.	No subsidy is provided by the NSW Government and the patient is liable for the full cost.
9. A NSW resident, with ambulance cover through PHI, requires clinically necessary repatriation from QLD or SA.	No subsidy is provided by the NSW Government. Fees are not covered through the State ambulance levy (?). The insurer will cover the cost of repatriation, if this is covered in the insurance policy.

Victorian residents.

1. A VIC resident, without ambulance cover through Ambulance Victoria or PHI, requires an ambulance service in VIC.	The patient is charged full fees as determined by Ambulance Victoria.
2. A VIC resident, holding Ambulance Victoria cover, requires an ambulance service in VIC.	Ambulance Victoria covers the cost of emergency and clinically necessary NEPT.
3. A VIC resident, holding ambulance cover through PHI, requires an ambulance service in VIC.	The insurer will cover the cost of emergency and clinically necessary NEPT, to the extent that this is covered in the insurance policy.
4. A VIC resident, without ambulance cover through Ambulance Victoria or PHI, requires an ambulance service in NSW.	The patient receives a 49% subsidy by the NSW Government. The remaining cost is incurred by the patient.
5. A VIC resident, with ambulance cover through Ambulance Victoria, requires an ambulance service in NSW.	The patient receives a 49% subsidy by the NSW Government. The remaining cost is covered by Ambulance Victoria.
6. A VIC resident, with ambulance cover through PHI, requires an ambulance service in NSW.	The patient receives a 49% subsidy by the NSW Government. The remaining cost is covered by the insurer, to the extent that this is covered in the insurance policy.

7. A VIC resident, without ambulance cover through Ambulance Victoria or PHI, requires an ambulance service in TAS / WA / QLD / SA / NT / ACT.	Patient is charged full fees as set respectively by the Ambulance Tasmania, St John WA, the Queensland Ambulance service, the SA Ambulance service, St John NT (unless Holiday cover is obtained), and the ACT Ambulance service.
8. A VIC resident, holding Ambulance Victoria cover, requires an ambulance service in TAS / WA / QLD / SA / NT / ACT.	Ambulance Victoria covers the cost of emergency and clinically necessary NEPT.
9. A VIC resident, holding Ambulance cover through PHI, requires an ambulance service in TAS / WA / QLD / SA / NT / ACT.	The insurer will cover the cost of emergency and clinically necessary NEPT, to the extent that this is covered in the insurance policy.
10. A VIC resident, without ambulance cover through Ambulance Victoria or PHI, requires clinically necessary repatriation from outside of VIC.	The patient is liable for the full cost.
11. A VIC resident, with ambulance cover through Ambulance Victoria, requires clinically necessary repatriation from outside of VIC.	Ambulance Victoria covers the cost.
12. A VIC resident, with ambulance cover through PHI, requires clinically necessary repatriation outside of VIC.	The insurer will cover the cost of repatriation, to the extent that this is covered in the insurance policy.

Tasmanian residents.

1. A TAS resident, either with or without ambulance cover through PHI, requires an ambulance service in TAS.	Fully covered by the State of Tasmania.
2. A TAS resident, either with or without ambulance cover through PHI, requires an ambulance service in VIC / NSW / WA / NT / ACT.	Fully covered by the State of Tasmania.
3. A TAS resident, without ambulance cover through PHI, requires an ambulance service in QLD / SA.	Patient is charged full fees as set respectively by the Queensland Ambulance service and the SA Ambulance service.
4. A TAS resident, holding Ambulance cover through PHI, requires an ambulance service in QLD / SA.	The insurer will cover the cost of emergency and clinically necessary NEPT, to the extent that this is covered in the insurance policy.
5. A TAS resident, without ambulance cover through PHI, requires clinically necessary repatriation from outside of TAS.	The patient is liable for the full cost
6. A TAS resident, with ambulance cover through PHI, requires clinically necessary repatriation from outside of TAS.	The insurer will cover the cost of clinically necessary repatriation, to the extent that this is covered in the insurance policy.

Western Australia residents.

1. A WA resident, without ambulance cover through PHI, requires an ambulance service in WA.	The patient is liable for the full cost
2. A WA resident, holding ambulance cover through PHI, requires an ambulance service in WA.	The insurer will cover the cost of emergency and clinically necessary NEPT, to the extent that this is covered in the insurance policy. If a regional WA resident holds St John Country ambulance cover, St John will cover the full cost.
3. A WA resident, without ambulance cover through PHI, requires an ambulance service in NSW.	The patient receives a 49% subsidy by the NSW Government. The remaining cost is incurred by the patient.
4. A WA resident, with ambulance cover through PHI, requires an ambulance service in NSW.	The patient receives a 49% subsidy by the NSW Government. The remaining cost is incurred by the insurer, to the extent that this is covered in their insurance policy. Note, regional WA residents with St John Country ambulance cover are covered for ambulance services outside of WA.
5. A WA resident, without ambulance cover through PHI, requires an ambulance service in VIC / TAS / QLD / SA / NT / ACT.	The patient is liable for the full cost.

6. A WA resident, with ambulance cover through PHI, requires an ambulance service in VIC / TAS / QLD / SA / NT / ACT.	**The insurer is liable for the cost, to the extent that this is covered in the patient's insurance policy.** **Note, regional WA residents with St John Country ambulance cover are covered for services outside of WA.**
7. A WA resident, without ambulance cover through PHI, requires clinically necessary repatriation from outside of WA.	**The patient is liable for the full cost.**
8. A WA resident, with ambulance cover through PHI, requires clinically necessary repatriation from outside of WA.	**The insurer is liable for the cost, to the extent that this is covered in the patient's insurance policy.** **Note, regional WA residents with St John Country ambulance cover are not covered for repatriation to WA.**

Queensland residents.

1. A QLD resident, without ambulance cover through PHI, requires an ambulance service in QLD.	Fully covered by the State of Queensland.
2. A QLD resident, with ambulance cover through PHI, requires an ambulance service in QLD.	Fully covered by the State of Queensland.
3. A QLD resident, without ambulance cover through PHI, requires an ambulance service outside of QLD.	Fully covered by the State of Queensland.
4. A QLD resident, without ambulance cover through PHI, requires an ambulance service outside of QLD.	Fully covered by the State of Queensland.
5. A QLD resident, without ambulance cover through PHI, requires clinically necessary repatriation from outside of QLD.	Fully covered by the State of Queensland.
6. A QLD resident, with ambulance cover through PHI, requires clinically necessary repatriation from outside of QLD.	Fully covered by the State of Queensland.

South Australian residents.

1. A SA resident, without ambulance cover through SA Ambulance or PHI, requires an ambulance service in SA.	The patient is charged full fees as determined by the SA Ambulance service.
2. A SA resident, with SA Ambulance service cover, requires an ambulance service in SA.	SA Ambulance service covers the cost of emergency transport. If NEPT extras has been purchased, SA Ambulance service covers the cost of clinically necessary NEPT.
3. A SA resident, with ambulance cover through PHI, requires an ambulance service in SA.	The insurer will cover the cost of emergency and clinically necessary NEPT, to the extent that this is covered in the insurance policy.
4. A SA resident, without ambulance cover through SA Ambulance service or PHI, requires an ambulance service in outside of SA.	Patient is charged full fees as set respectively by the NSW Ambulance service, Ambulance Victoria, Ambulance Tasmania, St John WA, the Queensland Ambulance service, St John NT (unless Holiday cover is obtained), and the ACT Ambulance service.
5. A SA resident, holding SA Ambulance service cover, requires an ambulance service outside of SA.	SA Ambulance service covers the cost of emergency transport. If NEPT extras has been purchased, SA Ambulance service covers the cost of clinically necessary NEPT.
6. A SA resident, holding Ambulance cover through PHI, requires an ambulance service outside of SA.	The insurer will cover the cost of emergency and clinically necessary NEPT, to the extent that this is covered in the insurance policy.

7. A SA resident, without ambulance cover through SA Ambulance service or PHI, requires clinically necessary repatriation from outside of SA.	**The patient is liable for the full cost.**
8. A SA resident, with ambulance cover through the SA Ambulance service, requires clinically necessary repatriation from outside of SA.	**If the patient holds NEPT extras, the SA Ambulance service covers the cost.**
9. A SA resident, with ambulance cover through PHI, requires clinically necessary repatriation outside of SA.	**The insurer will cover the cost of repatriation, to the extent that this is covered in the insurance policy.**

Northern Territory residents.

1. A NT resident, without ambulance cover through St John or PHI, requires an ambulance service in NT.	The patient is charged full fees as determined by St John NT.
2. A NT resident, with St John ambulance cover, requires an ambulance service in NT.	St John covers the cost of emergency transport, but not NEPT.
3. A NT resident, with ambulance cover through PHI, requires an ambulance service in NT.	The insurer will cover the cost of emergency and clinically necessary NEPT, to the extent that this is covered in the insurance policy.
4. A NT resident, without ambulance cover through St John or PHI, requires an ambulance service in NSW.	The patient receives a 49% subsidy by the NSW Government. The remaining cost is incurred by the patient.
5. A NT resident, with St John cover, requires an ambulance service in NSW.	The patient receives a 49% subsidy by the NSW Government. The remaining cost is incurred by St John (for emergency transport only).
6. A NT resident, with Ambulance cover through PHI, requires an ambulance service in NSW.	The patient receives a 49% subsidy by the NSW Government. The remaining cost is incurred by the insurer, to the extent that this is covered in the insurance policy.

7. A NT resident, without ambulance cover through St John or PHI, requires an ambulance service in VIC / TAS / WA / QLD / SA / ACT.	Patient is charged full fees as set respectively by Ambulance Victoria, Ambulance Tasmania, St John WA, the Queensland Ambulance service, the SA Ambulance service and the ACT Ambulance service.
8. A NT resident, with ambulance cover through St John, requires an ambulance service in VIC / TAS / WA / QLD / SA / ACT.	St John covers the full cost of emergency transport (not NEPT).
9. A NT resident, with ambulance cover through PHI, requires an ambulance service in VIC / TAS / WA / QLD / SA / ACT.	The insurer will cover the cost of emergency and clinically necessary NEPT, to the extent that this is covered in the insurance policy.
10. A NT resident, without ambulance cover through St John or PHI, requires clinically necessary repatriation from outside of NT.	The patient is liable for the full cost.
11. A NT resident, with ambulance cover through St John, requires clinically necessary repatriation from outside of NT.	The patient is liable for the full cost. St John does not cover for repatriation.
12. A NT resident, with ambulance cover through PHI, requires clinically necessary repatriation outside of NT.	The insurer will cover the cost of repatriation, to the extent that this is covered in the insurance policy.

ACT residents.

1. An ACT resident, without ambulance cover through PHI, requires an ambulance service in ACT.	The patient is charged full fees as determined by the ACT ambulance service.
2. An ACT resident, with ambulance cover through PHI, requires an ambulance service in ACT.	The insurer will cover the cost of emergency and clinically necessary NEPT, to the extent that this is covered in the insurance policy.
3. An ACT resident, without ambulance cover through PHI, requires an ambulance service in NSW.	The patient receives a 49% subsidy by the NSW Government. The remaining cost is incurred by the patient.
4. An ACT resident, with Ambulance cover through PHI, requires an ambulance service in NSW.	The patient receives a 49% subsidy by the NSW Government. The remaining cost is incurred by the insurer, to the extent that this is covered in the insurance policy.
5. An ACT resident, without ambulance cover through PHI, requires an ambulance service in VIC / TAS / WA / QLD / SA / NT.	Patient is charged full fees as set respectively by Ambulance Victoria, Ambulance Tasmania, St John WA, the Queensland Ambulance service, the SA Ambulance service and St John NT.
6. An ACT resident, with ambulance cover through PHI, requires an ambulance service in VIC / TAS / WA / QLD / SA / NT.	The insurer will cover the cost of emergency and clinically necessary NEPT, to the extent that this is covered in the insurance policy.

7. An ACT resident, without ambulance cover through PHI, requires clinically necessary repatriation from outside of ACT.	**The patient is liable for the full cost.**
8. An ACT resident, with ambulance cover through PHI, requires clinically necessary repatriation outside of ACT.	**The insurer will cover the cost of repatriation, to the extent that this is covered in the insurance policy.**

Private Health Insurance Code of Conduct

July 2014:
Version 5

CONTENTS

PART A: GENERAL

1. INTRODUCTION

1.1 Introduction

The Private Health Insurance Code of Conduct (**"Code"**) is a self-regulatory code to promote informed relationships between Private Health Insurers, consumers, and intermediaries.

The PHI industry's objective is that the Code will maintain and enhance regulatory compliance and service standards of PHI policies across the private health insurance industry.

For this purpose the Code is to be a "living Code" which will be progressively reviewed from time to time. The PHI industry, through Private Healthcare Australia (**"PHA"**), welcomes the input of consumers into the Code and its operation. The PHI industry may also seek the input of consumers from time to time, including through consulting with the Private Health Insurance Ombudsman (**"PHIO"**).

1.2 Compliance

Code Compliance Committee

The PHA has formed an independent Code Compliance Committee (**Committee**). The Committee has the responsibility to ensure the Code is fully complied with by Health Funds and does this by: 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.

Responsibilities of Health Funds

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.

Full details of the process of compliance with the Code of Conduct are contained in the document *Private Health Insurance Practice Codes*.

2. OUR COMMITMENT UNDER THE CODE

As a signatory under the Code, as a private health insurer, we will:

(a) continuously work towards improving the standards of practice and service in the private health insurance industry;

(b) provide information to consumers in plain language;

(c) promote better informed decisions about our private health insurance products and services:

(i) by ensuring that our Policy documentation is full and complete;

(ii) when asked by a consumer, by providing an effective verbal explanation of the contents of the Policy documentation;

(iii) by ensuring that our staff and other persons providing information on our behalf are appropriately trained;

(d) provide information to consumers on their rights and obligations under their relationship with their Private Health Insurer, including information on this Code;

(e) provide consumers with easy access to our internal dispute resolution procedures, which will be undertaken in a fair and reasonable manner; and

(f) where internal dispute resolution procedures do not reach a satisfactory outcome for the consumer, or if a consumer wishes to deal directly with an external body, advise the consumer of the right to take the issue to an external body, such as the PHIO;

but apart from the provisions for enforcement and sanctions in the Private Health Insurance Codes of Practice, a breach of the Code shall not give rise to any legal right or liability.

3. PRIVATE HEALTH INSURANCE ENVIRONMENT

In meeting our commitments, we will have regard to:

(a) the provisions of the *Private Health Insurance Act 2007* which govern private health insurance policies and arrangements between consumers, Private Health Insurers and government, including the requirement to meet prudential standards;

(b) our requirement to comply with the provisions of the *Competition and Consumer Act 2010*;

(c) the need for effective competition and cost efficiency being promoted in the private health insurance industry, and the need for ensuring flexibility in the development and enhancement of products and services for consumers.

PART B: DISPUTE RESOLUTION PROCEDURES IN RELATION TO THE CODE

1. INTERNAL DISPUTE RESOLUTION

1.1 INTERNAL DISPUTE RESOLUTION

We have a fully documented internal process for resolving a dispute between the consumer and us.

This process shall be readily accessible by consumers, without charge.

The internal process shall comply with the appropriate Australian Standard or equivalent and provide a fair and timely method of handling disputes, together with procedures for monitoring the efficient resolution of disputes.

1.2 RESOLUTION REQUESTS

Where we receive from a consumer a request, whether written or oral, for the resolution of a dispute or a request for a response in writing in relation to the dispute, we will promptly reply to the consumer. If the dispute is not resolved in a manner acceptable to the consumer, we will provide:

(a) where appropriate, the general reasons for that outcome; and

(b) information on the further action that the consumer can take such as the process for resolution of disputes referred to in Section 2 below.

2. EXTERNAL DISPUTE RESOLUTION

2.1 EXTERNAL DISPUTE RESOLUTION

In the event that a dispute is considered by the consumer to be unresolved internally, we will advise the consumer of the available external dispute resolution procedures in which we participate.

This includes providing information regarding the Private Health Insurance Ombudsman.

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.

2. IMPLEMENTATION FOR EMPLOYEES

In implementing these requirements, we will have regard to whether the employee would ordinarily make representations on PHI products to consumers and, if this is not the case, we will provide such employees with information as to how consumers may be able to obtain product information.

We will instruct and remind our employees not to make representations in relation to any PHI product in respect of which they have not been trained to provide information.

We will instruct our employees to explain the consumer's options clearly and provide, in addition to the Policy documentation, the information that the consumer requires to make an informed choice as to their private health insurance purchase. We will ensure the necessary systems and procedures are in place for the appropriate recording of advice given to consumers and we will instruct employees to keep appropriate records of their advice to consumers.

PART D: INTERMEDIARIES

1. RESPONSIBILITIES IN RESPECT OF INTERMEDIARIES

We acknowledge that there are many different types of arrangements we may enter into with intermediaries to provide a range of services or act on our behalf in dealing with consumers. We also acknowledge that some intermediaries have obligations under their own industry self-regulatory code of conduct, namely the Private Health Insurance Intermediaries Code of Conduct ("Intermediary Code"). We will satisfy our obligations under this code in relation to intermediaries if the intermediary is a signatory to the Intermediary Code. However, if the intermediary is not a signatory to the Intermediary Code we will comply with the following principles.

We will ensure that all arrangements with any intermediary clearly and unambiguously set out the obligations of each party and are able to be verified, if required, by an audit.

We will ensure that any agreement that we have with an intermediary to provide PHI services on our behalf and who is not a signatory to the Intermediary Code that is entered into or renewed any time after the implementation of version 4 of this Code will include provisions that will require the intermediary or its employees to:

(a) discharge their responsibilities and duties competently and with integrity and honesty and in compliance with the law;

(b) exercise reasonable care and skill in the discharge of their duties;

(c) comply with the provisions of the *Private Health Insurance Act 2007*, the *Competition and Consumer Act 2010*, and any other relevant laws;

(d) maintain records required by law and comply with legal requirements for production of, access to, or copying of, such records;

(e) provide such information as may be legally required by any regulatory or other authority;

(f) maintain confidentiality of any confidential information in relation to consumers or our business, and comply with relevant privacy laws;

(g) have the necessary skills to represent our health insurance business, and its products, having regard to the nature of representation required and the areas of activity undertaken or required to be undertaken by the intermediary;

(h) not provide advice, make representations or otherwise act outside the areas of activity or private health insurance products authorised under our agreement, arrangement or understanding;

(i) make clear disclosure to all consumers who deal with the intermediary in relation to our health insurance business the nature of their relationship with our health insurance business;

(j) make clear disclosure to all consumers who deal with the intermediary in relation to our health insurance business whether any fees, commissions or other benefits are paid or payable by us to the intermediary in respect of any health insurance business entered into by the consumer through or as a result of the services of the intermediary;

(k) have an effective alternative dispute resolution procedure for resolving a dispute between a consumer and the intermediary;

(l) comply with any applicable industry Code where relevant,

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 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; and

(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. DETRIMENTAL CHANGES TO POLICIES

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 case-by-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.

PART F: PRIVACY

AUSTRALIAN PRIVACY PRINCIPLES

We will:

(a) embrace the Australian Privacy Principles under the *Privacy Act 1988* as amended and the provisions of relevant State privacy legislation or requirements; and

(b) formulate and publish our own Privacy Policy, by which we will abide.

PART G: DEFINITIONS

1. DEFINED WORDS

In this Code, the following terms mean:

"consumer" means an individual, where that individual, whether alone or jointly with another individual, enters or proposes to enter into a PHI contract;

"DoHA" means the Australian Government Department of Health and Ageing, or such other name given to such body from time to time;

"dispute" means an unresolved complaint about a product or service of a Private Health Insurer and for this purpose a complaint is an expression of dissatisfaction conveyed to a Private Health Insurer together with a request that the complaint be remedied by the Private Health Insurer;

"health insurance business" is as defined in Division 121 of the *Private Health Insurance Act 2007*;

"HIRMAA" means the Health Insurance Restricted & Regional Membership Association of Australia, an industry body that Private Health Insurers may join if they wish;

"intermediary" means a third party (including a related body corporate) who, pursuant to an agreement with a Private Health Insurer or another person, has responsibility to perform, whether on a continuous, intermittent or ad hoc basis and whether for a specified limited period or an ongoing period of time, a business activity that is part of the Private Health Insurer's health insurance business, or could be, undertaken by the Private Health Insurer itself.

"Minister" means the Federal Minister or his or her delegate with the powers vested in the Minister under the *Private Health Insurance Act 2007*;

"PHA" means Private Healthcare Australia (formerly the Australian Health Insurance Association), the national PHI industry organisation, which Private Health Insurers may join if they wish;

"PHI" means private health insurance;

"PHI contract" or **"PHI policy"** means each PHI contract arising out of or in connection with health insurance business between a Private Health Insurer and a consumer;

"PHIO" means the Private Health Insurance Ombudsman as appointed by the Minister from time to time;

"Policy documentation" means private health insurance product policy wording, fund rules or similar PHI policy information in any printed or electronic form;

"product sales material" means material that markets or promotes a PHI fund, PHI policy or PHI product of a Private Health Insurer that is not Policy documentation, whether in printed or electronic form;

"Private Health Insurance" means health insurance business;

"Private Health Insurer" means a private health insurer registered under the *Private Health Insurance Act 2007*;

"Transfer Certificate" means a certificate issued pursuant to section 99 of the *Private Health Insurance Act 2007*.

NOTES

Private Healthcare Australia

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