We are hirmaa

24 March 2017

Simon Haslock
ACCC
GPO Box 520
MELBOURNE VIC 3001

Dear Mr Haslock

Re: ACCC Report to the Senate on Private Health Insurance

hirmaa welcomes the opportunity to make a submission to the Australian Competition and Consumer Commission (ACCC) regarding the practices by health funds and providers in relation to private health insurance (PHI) for the period 1 July 2015 to 30 June 2016.

By way of introduction, hirmaa is a peak industry body representing 21 not-for-profit, member owned and community based private health insurers which collectively provide health insurance to over one million Australians across the country.

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

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

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

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

At the outset, we note the ACCC's focus on issues relating to communication and consumer engagement.

As detailed in this submission, hirmaa suggests that a lack of transparency and accountability around performance pricing across the health service provider chain is impeding consumer choice and competition.

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Further, the submission describes how existing arrangements in the areas of prostheses benefits setting and Second-Tier Default Benefits are further limiting competition and choice, while also noting concern regarding the significant growth of private health benefits in public hospitals.

Again, hirmaa welcomes the active engagement of the ACCC with industry stakeholders in the preparation of its Annual Report to the Senate on Private Health Insurance.

Thank you for the opportunity if provide a submission on these importance issues.

Yours sincerely

Matthew Koce
Chief Executive Officer

We are hirmaa

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rt health FUND

stlukeshealth

Phoenix Health Fund

Defence Health

Latrobe HEALTH SERVICES

doctors health fund an Avant company

healthcare insurance

TUH It's my health fund

Mildura HEALTH Fund

WESTFUND HEALTH Insurance

Teachers Health Fund

Queensland COUNTRY HEALTH FUND

Health Partners

ACA HEALTH BENEFITS FUND

Peoplecare

Police Health

rbhs reserve bank health society simply better benefits

CDH

Transport Health

NAVY HEALTH

NURSES MIDWIVES HEALTH

Caring for the carers

We are hirmaa

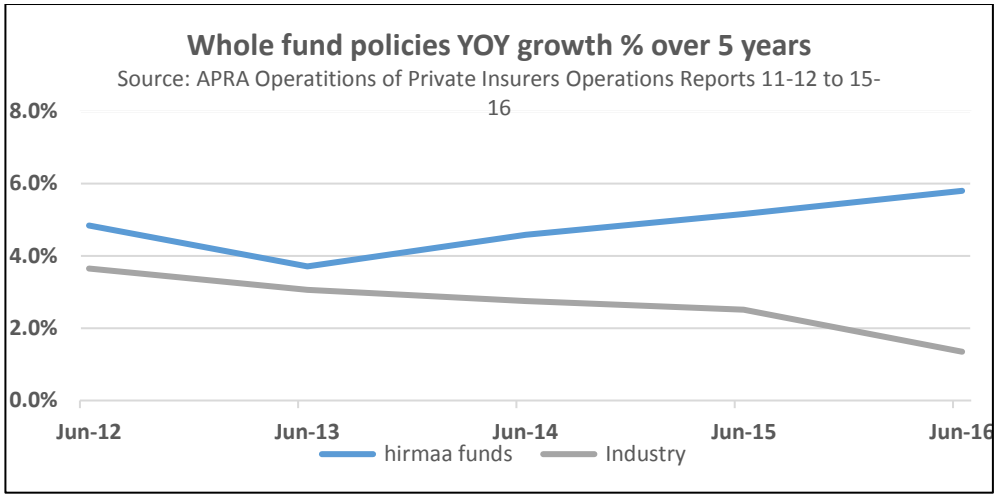
Overview, customer satisfaction and policy holder growth among the hirmaa funds

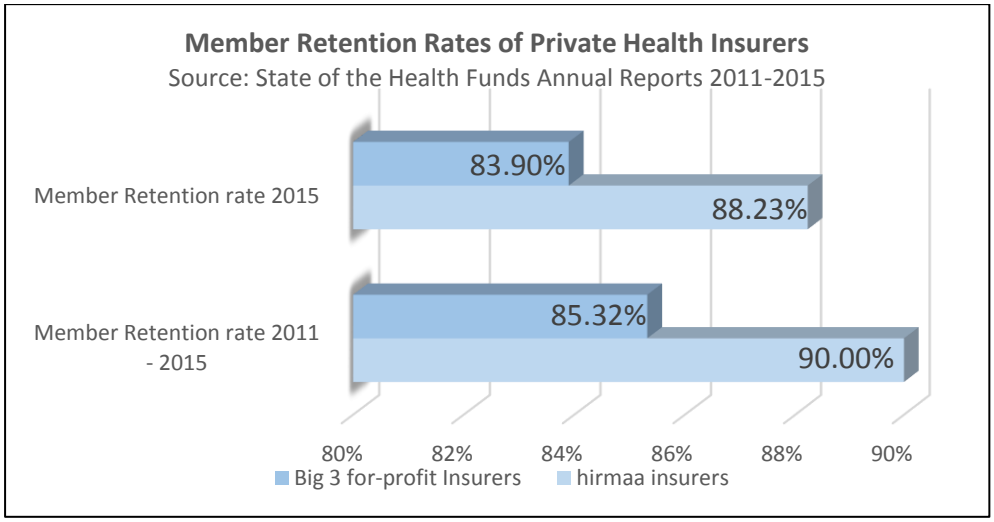
It is important to highlight that within Australia's private health insurance industry there is a notable difference between for-profit and not-for-profit, member owned health insurers.

hirmaa funds make up 21 of the 38 private health insurers and contribute more than $2.1 billion to the economy in health care services annually[1].

hirmaa funds are respected and valued by their members and ensure a diverse and highly competitive marketplace.

Extremely high levels of customer satisfaction is reflected in official policyholder growth and member retention figures, which are well above the industry average.

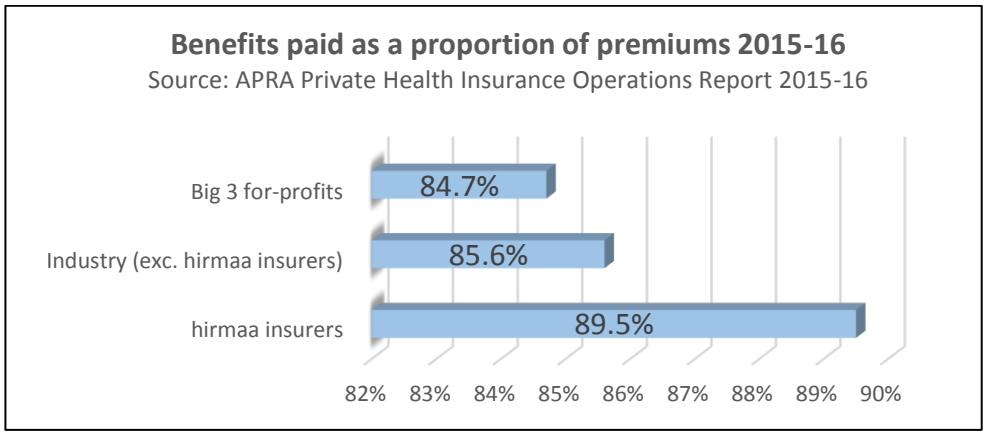




[1] APRA Private Health Insurance Operations Report 2015-16

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 85 per cent.



High levels of consumer satisfaction with hirmaa funds

Each year hirmaa facilitates an independent customer satisfaction survey of the policyholders of participating hirmaa member-insurers.

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

Overall, the research report found:

- Of the 21,673 responses received from policy holders, 97% were satisfied with their membership.

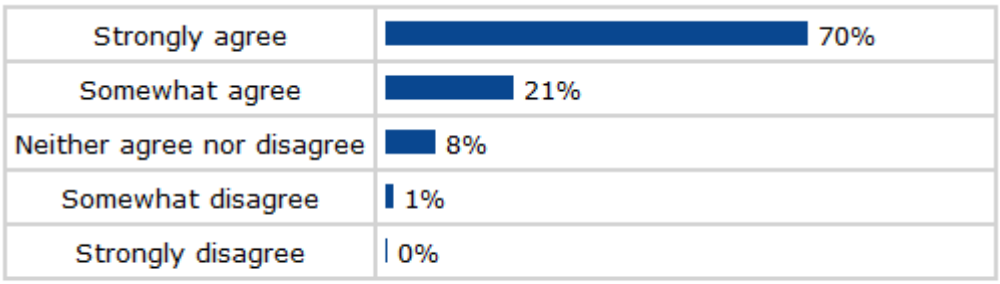
Overall, how satisfied are you with your health fund membership?

Very satisfied	71%
Somewhat satisfied	26%
Somewhat dissatisfied	2%
Very dissatisfied	0%

Total responses: 21673

- Of the 21,436 responses received, 91% agreed with the proposition that their fund was a member-service focused company.

A member-service focused company



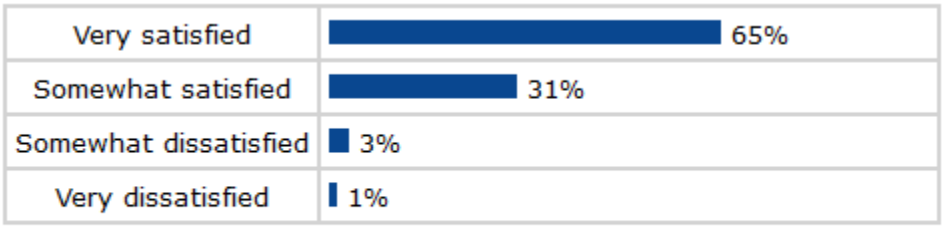
Total responses: 21436

Communication and Understanding Cover

hirmaa member funds actively work to ensure the highest level of communication and information is provided to policyholders in order to ensure that they have a high level of understanding about their policy.

With regard to communication, policyholders were asked "How satisfied are you with the amount of communication that you received regarding your membership?" The latest report found that of the 21,706 responses received, 96% were satisfied with the level of communication they received.

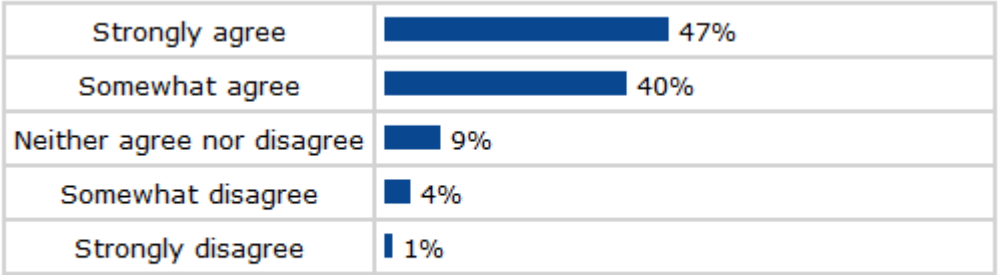
How satisfied are you with the amount of communication that you received regarding your membership?



Total responses: 21706

With regard to understanding their cover, policyholders were asked their level of agreement with the statement "I have a good understanding of my cover and how it works". The latest report found that of the 21,353 responses received, 87% agreed, a very strong result, especially given the complexity of private health insurance.

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



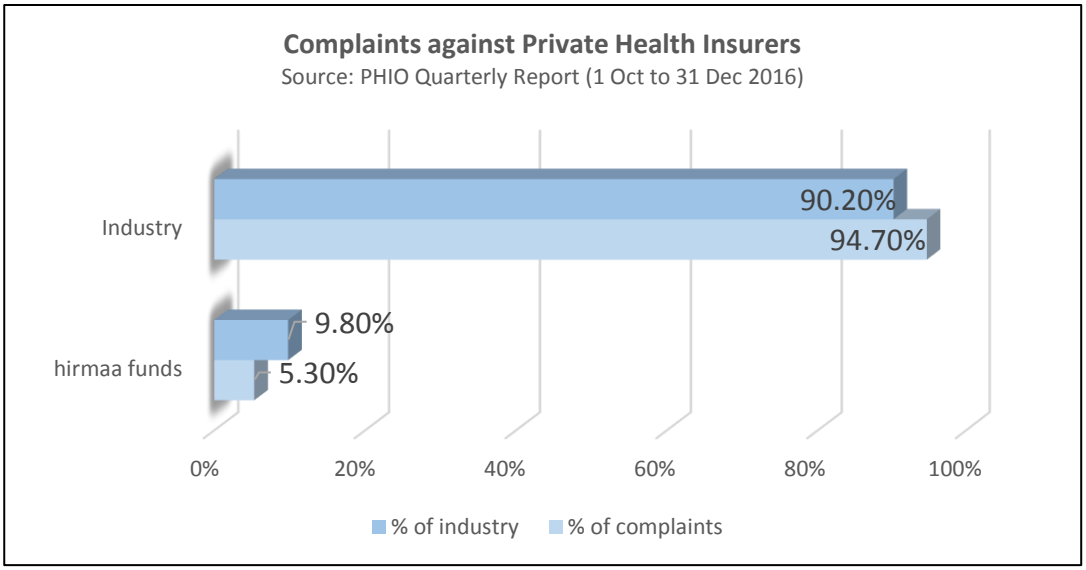
Total responses: 21353

The overall results from the independent research clearly demonstrate the unwavering effort that hirmaa funds make to inform consumers about their health and their ongoing commitment to meeting the highest possible standards for service. Consistently strong results over the least eleven years during which this survey has been run also shows the depth of commitment of hirmaa member funds to continual improvement.

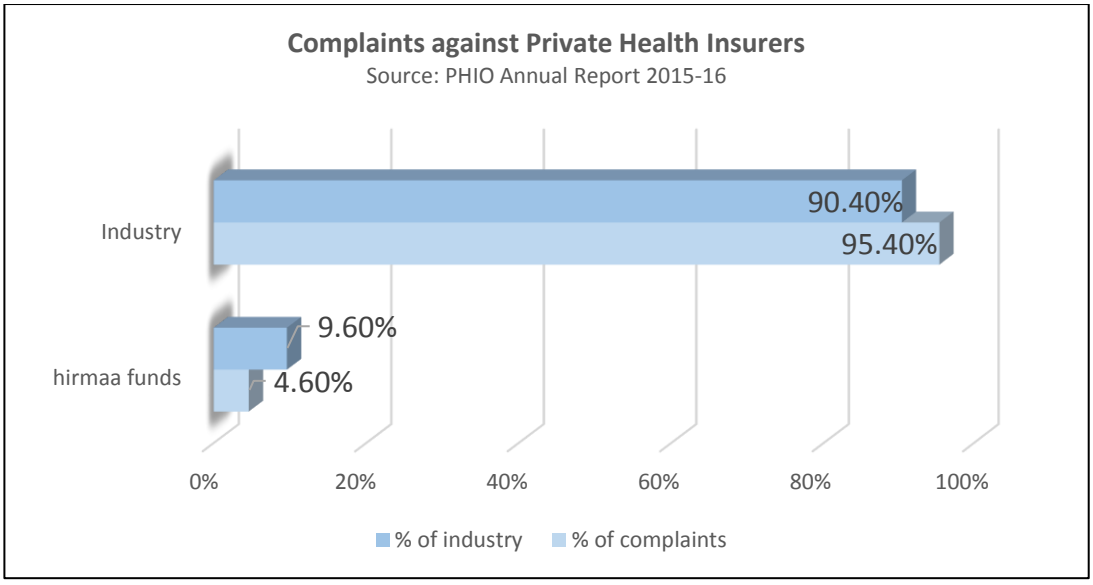
Underrepresentation of hirmaa funds in official complaint statistics

Statistics from the Commonwealth Private Health Insurance Ombudsman's (PHIO) clearly highlight the value proposition of the not-for-profit, member-owned and community based insurers, with the hirmaa group of insurers significantly underrepresented in the area of complaints.

In the latest Private Health Insurance Ombudsman (PHIO) Quarterly Bulletin (number 81) hirmaa member funds, comprising approximately 9.8% of the private health insurance industry, attracted just 5.3% of all complaints.



The strong results outlined within the latest quarterly report are strongly reflected within the previous Private Health Insurance Ombudsman 2015-16 Annual Report which shows that hirmaa member funds attracted just 4.6% of all complaints for the year.



Significantly, the latest PHIO Annual Report found a 0.9% decrease in the number of disputes for hirmaa member funds, compared to a significant 17.7% increase for the industry as a whole.

This difference between the for-profit and not-for-profit, member-owned and community based business models of hirmaa member funds appears to have a direct correlation with the quality of customer service and performance.

With the very high levels of success achieved by hirmaa funds in the area of communication, policy awareness and overall satisfaction, hirmaa welcomes the ACCC's ongoing scrutiny around competition within private health insurance.

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 (the Act), which impose very strict requirements on health insurers.

The private health industry is also subject to strict governance requirements with the existing Governance Standard (Schedule 1 of the Private Health Insurance (Insurers Obligations) Rules 2009 setting clear obligations with respect to Boards and Directors.

Further to the Act and prudential oversight from APRA, the private health insurance industry also imposes its own form of performance and compliance monitoring through the Code of Conduct (discussed later in this submission).

Further, most aspects of a private health insurers operations are 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.

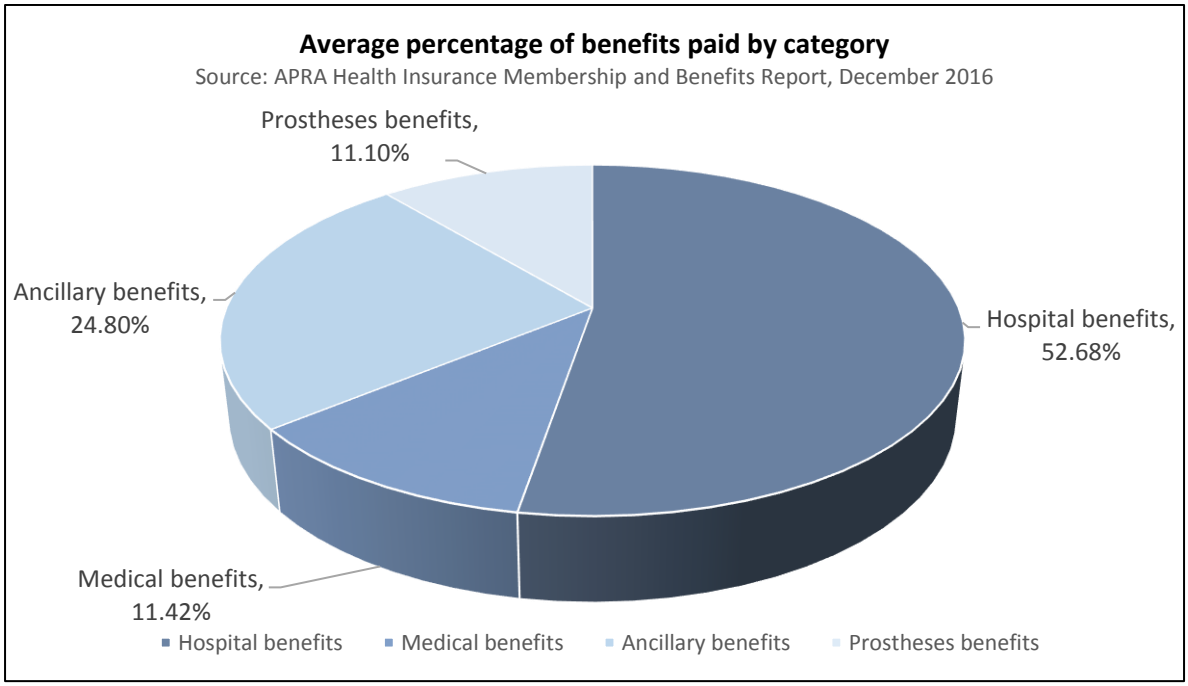
This transparency allows the consumer to have a high level of information of private health insurers that is unavailable in other areas of the health supply chain.

It is unfortunate that the transparency and accountability standards applied to private health insurers do 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 and premium increases, and are central to patient care and treatment.

In the interests of ensuring effective competition, choice, transparency and consumer empowerment, it is vital that a much wider understanding of all aspects of the health supply chain be achieved through the adoption of reporting and publishing standards that meet worlds best practice.

Considering that 90 cents in the dollar paid by a hirmaa fund policyholder goes towards benefits, combined with significant government investment in health (such as through the MBS), 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, performance and value for Australian consumers.



Affordability and value

Affordably remains a key issue for holders of private health insurance. Official data released in 2016 showed that the percentage of Australian with private health insurance has fallen[2] for the first time in 15 years.

As noted earlier in this submission, hirmaa facilitates an annual survey of policy holders from member funds on across a range of areas.

Asked to state a level of agreement with the statement, “The cost of my health insurance premiums is affordable”, the latest research report found that of the 21,296 responses received, 63% either strongly agreed or somewhat agreed.

This represented a significant drop of 3% from the previous year and an 8% drop from 2010.

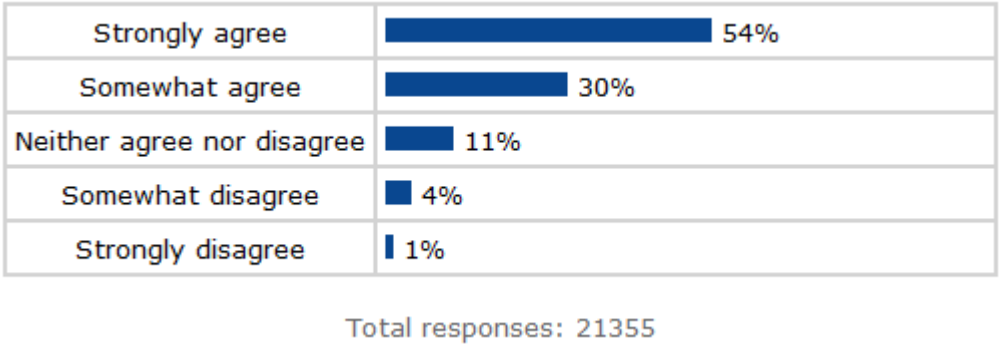
[2] APRA, Private Health Insurance Operations reports 2014-15 and 2015-16

Responses to the statement 'The cost of my health insurance premiums is affordable" over time

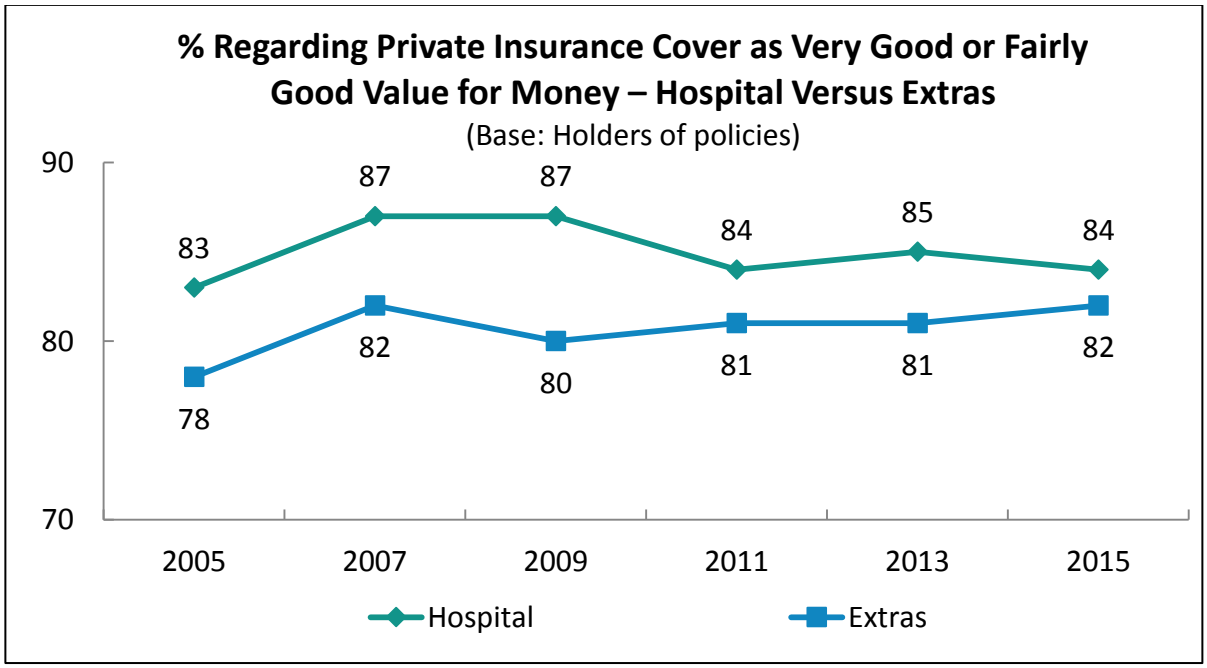
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Agree	n/a	n/a	n/a	n/a	71%	70%	69%	66%	66%	66%	63%
Neither agree nor disagree	n/a	n/a	n/a	n/a	17%	18%	17%	19%	18%	17%	18%
Disagree	n/a	n/a	n/a	n/a	12%	12%	13%	15%	16%	16%	18%

Importantly, while affordability pressure are growing the value that policy holder see in their private health cover remains very high. Asked to state a level of agreement to the statement "offers good value for money to its members" the research report found that of the 21,355 responses received, 84% agreed.

Offers good value for money to its members



The fact that private health insurance is seen by policyholders as offering good value was also clearly demonstrated in the 2015 IPSOS health survey results.



Source: IPSOS survey of private health policy holders 2015

It is clear that despite affordability concerns, private health insurance policyholders continue to see private health insurance as being of high value. While hirmaa funds will continue to offer services of excellent value, costs throughout the health service provider chain require attention if the growing impact of affordability is to be addressed.

Need for transparency and accountability across the entire health supply chain

Medical and specialists

Australian consumers face substantial barriers when attempting to pre-determine the value of a medical procedure. The full cost of a procedure is commonly not disclosed to a patient until after they have paid for a specialist consultation, and there is limited visibility of a specialist's track record to both patients and their General Practitioner, such as post infection rates or even basic information such as the number of procedures performed.

Surgeons, anesthetists and physicians and other medical practitioners consistently rank among the highest paid occupations in Australia, with the latest Tax Office data showing that 18 of the top 20 highest paying jobs for men and 17 of the top 20 highest paying jobs for woman being in medical practitioner field[3].

With this in mind, hirmaa believes that consumers are entitled to increased transparency, improved engagement and the highest possible standards for informed medical and financial consent. Only significant improvements across these areas will empower consumers and allow them the high level of control over their healthcare decisions.

In order to ensure that consumers have the level of medical and financial information they deserve, there are a number of options that should be explored as a priority. Existing data associated with the Medicare Benefit Scheme (MBS) could be utilized in a considered manner that would facilitate transparency in the areas of medical consultations and treatments. This transparency would allow consumers to consider data pertaining to practitioner billing and performance and greatly improve communications with consumers and empower them in their decision making.

Health providers and practitioners should also be required to reveal standardized cost estimates, including MBD item numbers, for each part of a procedure, and whether they will accept the benefits offered by a consumer's insurer or charge any out of pocket fees. This will ensure that a patients are better able to avoid 'bill shock.'

The recent findings of 'The Surgical Variance Report for General Surgery[4]', prepared by Medibank Private with the Royal Australasian College of Surgeons provides some tangible insight into the impact that a lack of genuine transparency 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.

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[3] McCauley, Dana, news.com.au, Australia's 50 highest paid jobs revealed in Tax Office Data, Dec 2016
[4] Report, The Surgical Variance Report for General Surgery

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 at the time of the documents release, 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. However, for many patients, questioning a surgeon about their competency is daunting, and there is no way to be certain that consumers will be recipients of clear and honest answers.

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.

Prostheses

A hirmaa has thoroughly outlined within recent submission to the Department of Health[5] and the Australian Senate[6], that there is a clear lack of transparency prostheses pricing arrangements.

Costs associated with prostheses are underpinned by poor government regulation and oversight, and the result is that prostheses prices in Australian private hospital settings are amongst the highest in the world.

This pricing framework mandates fixed benefits for prostheses in the private hospital system that are not systematically assessed, nor set on value based principles or the principles of supply competition.

Pricing norms in the Australian public sector and internationally do not appear to have any correlation to the benefit level set for prostheses in the Australian private hospital setting under the current regulatory system. This is consistent with established evidence which shows that Australian consumers are being charged up to 300% more for some items than would be paid in comparable health jurisdictions overseas.

The effect of the Prostheses List is such that the difference between projected benefits that will be paid for prostheses for privately insured patients in 2016-17, and what would have been the case if public sector rates had of been utilized, is estimated at $882,743,381. For holders of the 5,512,365 hospital treatment health policies across Australia, this represents an average difference in cost of $160.

Cost difference between prostheses in private vs. public settings	Total difference	Impact on hospital policy premium*
2013-14 (*publicly available data*)	$718,256,536	$130
2015-16 (projected)	$824,338,607	$149.50

[5] hirmaa submission to Commonwealth Department of Health on Prostheses Reform
[6] hirmaa submission to Senate Inquiry into price regulation associated with the Prostheses List Framework

2016-17 (projected)	$882,743,381	$160
2017-18 (projected)	$945,286,159	$171.50
2018-19 (projected)	$1,012,260,123	$181

*based on the current number of hospital cover policies

The existing model has been described by one large device company seeking to enter the Australian market as cartel like given the way they it artificially fixes process for prostheses devices[7].

Of particular concern is the fact that the current arrangements provide strong incentives for device sponsors to engage in activities directly with private hospitals to influence decision making, such as offering secretive volume discounts and under the table rebates with none of the savings disclosed or passed on to the consumer.

During his verbal presentation to the Senate Inquiry into Price Regulation associated with the Prostheses List Framework the CEO of Australian Private Hospitals Association (APHA) confirmed the systematic practice of rebating between private hospitals and medical device manufacturers.

> *…a large proportion of my members report that they do not get any rebates from suppliers. These are typically the smaller standalone, independent hospitals and other smaller groups like day surgeries — that sort of segment of the industry.*
>
> *Those who are a bit larger and in a stronger negotiating position have arrangements, I am advised, that there are typically on two bases. There is a volume basis. So, if you hit a particular target for a whole - of - business spend, for example, you spend X million dollars or X hundred million dollars a year — and that is not necessarily just on prostheses but also on consumables, theatre equipment or whatever that particular company supplies — **then a rebate regime will kick in.***
>
> *The other way it works is on a growth target. So if you exceed what you spent the previous year by X per cent, then a certain level of rebate might kick in and that might even be tiered, so **the higher your growth the greater the rebate you get.***[8]

The fact that there is no accountability with respect to these secretive arrangements is a point of significant concern to the private health insurance sector and should be to the ACCC and we strongly encourage the ACCC to refer this matter to their enforcement and policy divisions for urgent and serious action.

Second-Tier Default Benefit

Since the "Lawrence legislation" of 1995, Second-Tier Default Benefit legislation has compelled private health insurers to pay any accredited health facility (private hospital or day surgery) at least 85 per cent of the state average.

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.

[7] Applied Medical submission to Senate Inquiry into Prostheses Price Regulation associated with the Prostheses List Framework.
[8] Roff, Michael, Senate Inquiry into Price Regulation associated with the Prostheses List Framework, 16 March 2017

The Second-Tier Default Benefit legislation disrupts competition in the following consequences:

- 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.
- 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).
- The inability to set a price signal for consumers makes it impossible for insurers to drive volume to higher performing hospitals that would reduce costs and improve patient outcomes.

It is hirmaa's strong view that private health insurers should not be forced to in effect contract with every single private hospital as a passive payer, 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, only regional and rural hospitals, where there is limited competition and choice, should have access to the minimum default benefits safety net such as Second-Tier Default Benefits.

Thorough investigation into the impact of second tier default arrangements on innovation, competition and the consumer by the ACCC would be a highly beneficial exercise.

Private Patients in Public Hospitals

The significant growth in the number of patients using their private health insurance in public hospital setting is of significant concern to himaa. Particularly concerning is anecdotal evidence that there are many incentives in place for public hospitals to persuade patients to elect to be treated as private patients, including patients being led to believe that they will not receive the same urgency of care if they don't opt to use their private health insurance.

What originated as an issue confined to a small number of public hospitals has now evolved into widespread practice with benefit growth in public hospitals increasing dramatically from $295.6 million in 2002[9] to $1,062 billion in 2016[10], an average growth of 9.56% per annum.

[9] PHIAC A data (2002)
[10] APRA Private Health Insurance Membership and Benefits data (2016)

Those methods being used by public hospitals to drive the growth of benefit use in public hospitals are highly opaque. Any active encouragement by hospital staff and/ or representatives for a patient to use their private health cover at a time what a patient is extremely vulnerable to pressure is of concern to private health insurers and warrants the attention of the ACCC.

There is a real risk that the systematic practice of encouraging patients to elect to be treated as private patients will create a two tier public health system while shifting costs from State health budgets to the Commonwealth and to private health insurers, and putting upward pressure on premiums via the following:

- Accommodation fees

In the case of private rooms for private patients, State Governments publish recommended rates. While insurers are only obliged to pay the lower, Commonwealth Default rate, they are under immense pressure to pay the higher amount charged through the State Government published recommended rate, otherwise their policy-holders could face significant out-of-pocket costs. Often public hospitals offer inducements to patents for a private election, including guarantees of no out of pocket costs and excesses. While expensive to their budgets, such inducements are often cheaper for public hospitals than bearing the full episodic cost as a public admission.

- Diagnostic Imaging and Pathology

If an individual agrees to elect to be a private patient, the public hospital can invoice Medicare for 75 per cent of the schedule fee for these services. In addition, the public hospital can bill the insurer for the remaining 25 per cent of the schedule fee.

- Revenue from (and for) Medical Practitioners

Once an individual has elected to be treated as a private patient, bills can be raised against Medicare, transferring costs from the State to the Commonwealth. In addition to the payments made by Medicare, there are also payments made to the doctors by the private health funds themselves. Once a patient has elected to be treated as a private patient the doctor has the right to charge the patient fees as he/she deems appropriate. Medical specialists welcome the private election of patients in public hospital settings as a way to effectively supplement their normal public hospital income.

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 (see Appendix 2) 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".[11]

The successful collaboration between the Code and the Commonwealth Ombudsman is well documented. The Commonwealth Ombudsman specifically notes in its 2016 Annual Report that "the office provided information and assistance to various bodies involved in the formulation of health policy and compliance with established rules and laws. This included… advice to the Private Health Insurance Industry Code Compliance Committee in relation to the

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

voluntary industry code". 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.

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: PHI Code of Contuct

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

ABN 35 008 621 994

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