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26 September 2018

The Hon. Michael Keenan MP
Minister for Human Services and Digital Transformation
PO Box 6022
House of Representatives
Parliament House
Canberra ACT 2600

E: Michael.Keenan.mp@aph.gov.au

Dear Minister

Re: Addressing excessive red tape on the Government Rebate for PHI

The Alliance of Members Health Funds and HAMBS write to you regarding issues and excessive red tape surrounding the registration process for the Australian Government Rebate on Private Health Insurance.

As the peak body for 23 not-for-profit, member owned and community based health insurers, Members Health advocates for a successful and vibrant private health insurance industry supported by robust and fit-for-purpose policy frameworks and efficient processes.

Since 1978, Members Health Funds have endeavoured to be leaders in customer service and satisfaction. Yearly independent surveys of thousands of Members Health fund policyholders consistently reflect our Funds' customer-first credo, with extremely high satisfaction rates.

Established in 1991, HAMBS supplies and supports the HAMBS (Hospital and Medical Benefits System) Application. A sophisticated and user-friendly software and information technology solution for the private health insurance industry in Australia.

In a rapidly changing industry with increased regulation, technological advances and in an increased competitive environment, HAMBS continues to grow and expand on the services available to our customers. Today, HAMBS has over 80 professional staff servicing 25 mostly not-for-profit Health Funds nationwide.

Our approach, based on co-operation, quality and integrity, is backed by superior applications and services specifically designed to meet today's health insurance information technology needs.

Part of the success of Members Health Fund Alliance and HAMBS is our member Funds' constant aim to provide new policyholders with an uncomplicated and hassle-free joining process with the best value health cover possible.

Reducing complexity and consumer confusion in private health insurance is also a key objective of the Australian Government's current reform agenda for the industry, and one that the Australian Competition and Consumer Commission raises as an area requiring ongoing consideration.

However, we suggest the current registration and management process for the Rebate on private health insurance contradicts these efforts.

The application form for the Rebate and the relative auditing process have been in place since 1999 and the current Private Health Insurance Rebate (PHIR) processing guidelines date back to 2003, with minor amendments, including legislative changes. During this period, the proportion of the Australian population with hospital cover has risen from 30 per cent of the country or 5.79 million in June 1999[1], to 11.2 million or 45 per cent of the nation in June 2018[2], with 41 per cent of all procedures taking place in private hospitals.

Despite this increase, and with exception to legislative changes, there has been minimal effort to streamline the Rebate registration process for consumers. There has not been a holistic, end-to-end review of the Rebate registration process, from a consumer's perspective since 1999.

Meanwhile, numerous audits conducted by the Australian National Audit Office have focused only on the administration of the Rebate between the ATO, the Department of Health and Medicare. The impact on consumers has not been considered.

With membership numbers growing, exacerbating Funds' staffing requirements to meet exacting customer service standards, Members Health and HAMBS see the current situation for Rebate registration and management as outdated and unsustainable – further compounded by the increased consumer savviness and expectations with digital advancements.

Following an extensive survey of our Health Funds, a handful of Rebate-related issues have surfaced as key concerns for insurers and consumers alike.

Most prominently among them is that the Rebate registration process – and the involvement of aggregator websites – sets health insurers up for a raft of consumer complaints relating to unexpectedly high policy prices, questions and doubts over the application of the Government Rebate.

In addition, the form itself requires simplified wording in plain English; there needs to be concerted effort to modernise the process and migrate users off paper onto online forms to ensure accurate and timely completion; and the process of having to recapture information or chase down forms is inefficient.

Members Health and HAMBS submit the following issues for the Department's consideration:

> **Issue 1:** DHS enforcing Health Funds to undertake the practice of not applying a reduced premium for a new policy until they receive a signed Rebate form from the member. Implementing this would be detrimental to the Health Funds and have a negative impact on consumers.
>
> **Issue 2:** Inability for an aggregator to collect the Rebate information from a person joining a new Health Fund at the time of joining.
>
> **Issue 3:** The rigor and guidelines applied to the Rebate registration form is not fit for purpose in today's current market and technological advancement.

[1] Private Health Insurance Administrative Council – Operations of the Registered Health Benefits Organisations Annual Report 1998-1999
[2] APRA – Private Health Insurance Membership and Benefits Statistics June 2018

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Issue 4: DHS requirement for a new rebate application form each time a member transfers between health funds.

Issue 5: Processing overhead when a person's details change and these details must be re-registered with Medicare.

Issue 6: Pre-population of data in the Rebate form can only occur if it is in the same session that the member is joining. The member is forced to manually enter in all their data again if it is in a different session, which leads to a negative consumer experience.

Issue 7: Absence of industry consultation with the annual review of the approved form, particularly to gain an understanding of the impact on the industry with any proposed change. The burden and overhead to the industry to implement changes, even a minor word change, is not understood by DHS.

Issue 8: Insufficient lead times to implement software changes to support a new Approved form.

Issue 9: Insufficient approval times for DHS to review, provide feedback and approve when DHS impose Funds change information included in the PHI rebate application.

Issue 10: Seven-day Rebate notification timeframe does not reflect the reality of many registration and withdrawal circumstances.

Ideally, Members Health and HAMBS believe the Rebate registration process should be consolidated into a single, efficient process that is easily transferrable across Health Funds and managed via modern technological means, not paper forms.

Members Health and HAMBS look forward to working with the Department on improving this process for the benefit of the consumer and the insurer.

Attached is a summary of the concerns and recommendations submitted by Members Health Funds on the Rebate process.

Yours sincerely

MATTHEW KOCE
CEO, Members Health

ROB SELJAK
Chairperson, HAMBS

cc: *The Hon. Greg Hunt MP, Minister for Health*
Randall Brugeaud, CEO, Digital Transformation Agency

Members Health FUND ALLIANCE

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Members Health and HAMBS summary of Funds survey responses

Issue 1: DHS enforcing Health Funds to undertake the practice of not applying a reduced premium for a new policy until they receive a signed Rebate form from the member. Implementing this would be detrimental to the Health Funds and have a negative impact on consumers.

Guidelines enforced by the Department of Human Services on Rebate registration cause double handling of members' policies and makes the customer experience of joining a Health fund unnecessarily complex, costly and laborious.

Health Funds cannot apply the Rebate to memberships unless the registration form has been received completed and signed (manually or electronically). This triggers a raft of issues, particularly when new members want to be debited for the policy with the reduced premium on the same day or when the document is incorrectly filled out.

New members often request to be debited on the day of joining, but often do not have all the information required for the Rebate form at the time. Consequently, they elect to complete the form later.

The rules dictate, however, that 100% of the total cost of the policy must be charged until the Health Fund receives the completed Rebate form back. Only then can Health Funds update the policy and apply the reduced premium from the policy join date.

Not only does this stymie the joining process, but it adds unnecessary confusion over the price of the policy into the process. Making matters worse, a typical consumer is not aware of the impact of completing the Rebate form incorrectly, hence it is often sent back to members more than once, causing frustration that is directed at the Health Fund not the Department.

Chasing the Rebate forms causes a significant resourcing overhead, with some Health Funds having to hire personnel dedicated only to administering the Rebate. Indeed, Health Funds can collect Rebate information through voice recognition systems, but not all insurers have the capacity to adopt such systems.

Currently the Department only allow voice transactions via a Voice Recognition and IVR workflow which is costly and cumbersome to implement. Health Funds explored this option and found the cost would be $60,000-$100,000 to initially implement. There would be ongoing costs each time the guidelines changed.

At a time when Health Funds are under enormous scrutiny to keep costs down and make the joining process as simple as possible, Members Health and HAMBS suggest the guidelines around Rebate registration waste vital resources that could be better spent on providing improved benefits or lower premiums.

It is also worth noting that members who claim the Rebate through their tax return are not required to sign, fill or complete a separate Rebate form other than their tax return.

Our Health Funds have suggested that taking Rebate information over the phone, without a voice recognition system, should be treated no differently than joining a member on a policy. They also look forward to a day when members complete a Rebate form only once, when they first enter into private health insurance. That information would follow the person and potentially be included in transfer certificates between Funds, or stored by Medicare.

Health Funds noted that the Rebate registration form is not simple to fill out, it includes a lot of irrelevant information and needs simplifying to plain English language to eliminate the chances of customers filling it out incorrectly, which just causes further angst between the Health Fund and member.

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A few details in the Rebate form that Health Funds raised as problematic:

- Two check boxes (top and bottom) required to be filled in order for the form to be processed – common error is the member not ticking both
- Tiers are confusing – clarity is required around this (often choosing the incorrect tier) from a consumer perspective
- Clear instructions for spouses completing forms where it needs to be completed by the member on the policy – this is a common error and frustrating
- Collection of membership signatures can also be a burden to the customer. Typically paper membership applications from the Health Fund may need to include a number of signature panels. When a PHI Rebate form is included in a membership application, a tick box declaration should be considered acceptable.

Issue 2: Inability for an aggregator to collect the Rebate information from a person joining a new Health Fund at the time of joining.

Inefficiencies in the Rebate registration process are further exacerbated by the practices of aggregator websites/call centers, which can quote a policy with a prospective member's Rebate entitlement included but do not require a completed Rebate form.

With aggregators quoting new members inclusive of Rebate entitlements i.e. the reduced premium, but having no official Rebate approved form to pass on, insurers are left with the following options;

- To go against the aggregator website's quotation and instead charge 100% of the policy amount without the rebate; or,
- Apply the rebate to the policy and charge the reduced premium amount, as was quoted by the aggregator website, and urge the new member to return the completed Rebate form on the same day or as quickly as possible.

This sets health insurers up for consumer complaints relating to unexpectedly high policy prices, questions and doubts over the application of the Rebate.

As per the points raised in Issue 1, this also increases the burden on consumers and insurers to complete, return and process a Rebate registration form as soon as possible.

Our Health Funds suggest that allowing aggregators to collect Rebate forms on behalf of members and provide that to the health insurers may alleviate the confusion and frustration in this process.

Issue 3: The rigor and guidelines applied to the Rebate registration form is not fit for purpose in today's current market and technological advancement.

Everything today is done online, through an app or over the phone.

Health insurers nowadays have the ability to debit money out of a members account or credit card simply after a conversation, as most banks do not require direct debit terms and conditions to be read by a pre-recorded message.

However, the guidelines for the Rebate do not allow such simplicity and are not designed to support the multitude of information collection technologies available, such as chatbot's or chat sessions, or electronic signature services via a third party, which are commonly used for legal contracts and have a built-in audit trail.

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Our Health Funds suggest the Rebate information should be treated with the same level of rigor as payment requests. Health Funds would also be open to the Department providing scripting for terms and conditions to make this a possibility.

Like all modern businesses, Health Funds are constantly seeking ways to streamline information gathering processes and alleviate staffing overheads to improve management expense ratios. Allowing them to explore the many new technologies to improve the Rebate registration process, which affects the majority of customer interactions, is a natural progression in today's business environment.

Issue 4: DHS requirement for a new rebate application form each time a member transfers between health funds.

Given the propensity for members to now switch Health Funds and the ease with which it can be done, this again seems like a process that delivers no benefit but requires considerable effort from all parties.

It is reasonable to ask a person to update their details when circumstances change, however, the process needs to change.

Health Funds suggest that members should be able to update their details digitally, as they can with other financial institutions. While it is agreed that guidelines should be in place, pre-approval from the Department is an unnecessary requirement when the policy and relative Rebate is already registered.

Having members nominating to receive the Rebate once at the time of entering private health insurance and allowing portability of the Rebate across policies and Health Funds would rid the system of unnecessary paperwork.

Issue 5: Processing overhead when a person's details change and these details must be re-registered with Medicare.

Again, it is reasonable to ask a person to update their details when circumstances change however the process needs to change to allow members to do so via digital means. As in Issue 4, while guidelines should be in place, pre-approval from DHS is an unnecessary requirement.

Health Funds spend considerable time and resources on the completion of Rebate forms. Members Health and HAMBS suggest the more time spent on this excessive process, the less time and resources invested into the customer experience.

One of the metrics that Health Funds are continually measured by is their management expense ratios. The Private Health Insurance Ombudsman describes it as "a key measure of Funds' efficiency"[3].

Members Health Funds consider this measure a reflection of their customer-first credo, and consistently record the lowest management expense ratios in the industry while reinvesting 90% of premium dollars paid back into benefits for members.

Streamlining the Rebate process would allow all Health Funds to improve further on this key measure for the benefit of the consumer, the Health Fund and their staff.

[3] Private Health Insurance Ombudsman – 2017 State of the Health Funds Report

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Issue 6: Pre-population of data in the Rebate form can only occur if it is in the same session that the member is joining. The member is forced to manually enter in all their data again if it is in a different session, which leads to a negative consumer experience.

The current process that the Department dictates is not fit for purpose in this technologically advanced day and age. Only allowing pre-population of the data in the Rebate form in the initial joining session is laborious for the consumer and makes little sense practically.

Health Funds suggest it does not provide a positive customer experience for new members to provide their personal details to insurers, then have to complete an entirely blank Rebate form if it cannot be completed in the initial session.

It is understood by Health Funds that this restriction was in place to reduce the risk of potential breaches of the member's privacy if the pre-populated form is sent to an incorrect email address. However, this is easily mitigated by password protecting the Rebate form.

Health Funds suggested that allowing data to remain stored in the document and changeable by the consumer prior to submission would vastly improve this process. It would make for a better customer experience, allowing Health Funds and customers to pick up from where they left off.

Issue 7: Absence of industry consultation with the annual review of the approved form, particularly to gain an understanding of the impact on the industry with any proposed change. The burden and overhead to the industry to implement changes, even a minor word change, is not understood by DHS.

The following were direct responses from Health Funds:

> *"We have experienced how long it takes the DHS to approve forms when starting the process for April 1, 2018 on December 1, 2017 and not receiving the final approval until April 3, 2018. This approval included our hard copy versions, soft copy versions and our online versions. It seemed like when DHS were checking the form it was returned on each individual issue rather than having the issues collated so we could resolve the all at once. Consequently, this caused a great deal of 'back and forth' with the forms."*
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> *"This is evident in the fact the DHS no longer undertake the audit process themselves, also they do not provide any training or attend industry events like they did in the past.*
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> *"DHS seem to be very inward looking and have no real understanding of what happens in the industry in terms of fund or member impact in time or cost."*
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> --
>
> *"The Department held a consultation process approximately two years ago where submissions were provided from the industry on how to streamline the rebate application process. To date, no outcomes of this industry consultation have been made public."*

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Issue 8: Insufficient lead times to implement software changes to support a new Approved form.

Each time the PHI Guidelines are released, it is DHS expectation that the health insurers must implement the new form when it is released that particular year, and if this is not and the health insurer is audited then they are deemed to have been non-compliant.

Each time the guidelines are released, these are not distributed to the vendors that have the Vendor Agreement with DHS for implementation, the guidelines are not dated nor versioned, so it is difficult to ascertain which guidelines are current.

For an industry wide guideline this is inadequate.

In addition, some insurers require a software change in order to implement changes to the form, even if it is a minor word change. The software release cycle for a Health Funds is often planned 12 months in advance, so in order to schedule an implement a change at such short notice is challenging and not easily achievable.

Vendors that offer a shared software solution are now restricted from contacting DHS direct for approval which exacerbates the delay in implementation of the new form by its member Health Funds.

Issue 9: Insufficient approval times for DHS to review, provide feedback and approve when DHS impose Health Funds change information included in the PHI rebate application.

The following were direct responses from Health Funds:

> *"We have experience inconsistency in the process of getting new forms created by the fund approved. One 'delegate' will approve all but one thing on the new form, but when corrected and returned, another 'delegate' will approve the amendment but find something else the first 'delegate' overlooked (arguably). Another minimum two-week delay is then incurred. We have seen this go through four delegates in one scenario, all finding something another one did not with each new submission we were hoping was finally correct."*
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> *"This year DHS released two guidelines, one of which was in error and a correction made. This required Funds to modify the application form and resupply for approvals which typically takes four to eight weeks. Changes to the guidelines also have cost implications, such as the scrapping of pre-printed material (membership forms), and changes to electronic membership systems to support the new requirements. Reducing and simplifying the DHS required information would be more appropriate if it reduced the number of changes to content and possibly the requirement for annual changes."*

Issue 10: Seven-day Rebate notification timeframe does not reflect the reality of many registration and withdrawal circumstances.

The Department allows Health Funds seven days from the commencement of memberships, or cancellation of membership, to notify of a new Rebate registration or withdrawal.

But memberships can be joined or withdrawn from a past or a future date, which means the Department will receive the Rebate form outside of the seven-day timeframe.

Examples of when Health Funds may fail to comply with the seven-day time frame:

- Registrations:
  - Change of membership commencement date ie. due to a change of join date for a member transferred from another Health Fund; or,
  - Backdating of membership commencement dates ie. student dependents joining their own membership; or,
  - Commencement of membership from the date the application was received in the mail – these can take more than a week to be received.
- Withdrawals:
  - Termination of Deceased members ie. notification to the Health Fund is usually not within seven days; or,
  - Termination of un-financial members ie. un-financial members are not terminated until they are more than two months in arrears.

Our Health Funds suggest these rules need to be more flexible to accommodate the above.