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Private Health Insurance Intermediaries Association

Response to

ACCC Report to the Senate

on the

Private Health Insurance industry.

PHIIA was formed to establish and implement standards for independent intermediaries, agents and brokers selling health insurance on behalf of registered health insurance organisations, and to represent the industry in the development of that standard.

The following is a response provided on behalf of the Private Health Insurance Intermediaries Association (PHIIA), a Not for Profit organisation guided by a **Code of Conduct** which members are signatory to and are assessed against.

PHIIA membership includes the vast majority of Health Insurance Retail Brokers, Corporate Brokers, and other Intermediaries.

Private health insurers & policies

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

Given the growth of our sector and the ever growing volume of customer numbers and health cover transactions we as an "industry" are responsible for, there can be little doubt that the role of intermediaries and brokers has brought about far greater accessibility to and understanding of health cover for consumers generally.

That consumers can access an ever growing cross section of information regarding new or alternative health cover policies has only served to drive competitiveness in private health insurance and to better inform the choice which consumers have today. We believe the choice which the health insurance intermediary sector facilitates should be encouraged and supported in the interests of consumers.

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

There is little doubting that consumers experience difficulty in understanding health cover and the anecdotal evidence of all our member companies supports this, regardless of age, socio-economic circumstances and demographics.

Indeed much of what constitutes customer loyalty in relation to private health insurance we believe is more a function of customers believing that it is too difficult to review their cover and attempt to understand a new policy as well as not understanding the Portability rules. It is a complex and often times bewildering space for the consumer and one where product composition is seldom easily understood. This results in consumers often being on sub-optimal policies. They may be underinsured, such as people who don't upgrade their hospital cover as they get older. Alternatively there are consumers who are obviously over insured, such as single males of any age who are paying for obstetrics cover.

Whilst we believe that Registered Health Funds (RHFs) are making meaningful inroads to overcome this, the need remains to simplify product and product composition and how it is articulated.

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

We, as an industry sector, exist to facilitate and improve consumer understanding. Indeed that could accurately be described as our greatest focus, as most member companies boast highly developed web-enabled comparison platforms, all designed to achieve precisely that understanding through product transparency. Critically these are supported by fully trained employees that are able to explain the differences between policies over the phone.

As an industry we are continually investing millions of dollars to ensure that the customer experience, underscored by comparison, transparency and choice, is at its optimum and market fundamentals will ensure that we continue to do so or risk losing the credibility that we enjoy with consumers.

RHFs in isolation have no interest in, nor capability to compare health cover policies of different funds. Any RHF is, understandably, only interested in offering and selling the product they have to offer, so to suggest there is any transparency in that sense is flawed as there is no comparison to begin with.

The value and benefit PHIIA member companies achieve for consumers is that of transparent comparison and choice. Each has a metaphorical shelf of health cover to compare in response to a consumer's stated needs. However, just as no supermarket can be expected to stock every possible product item in any given range, no intermediary can, nor does offer every insurer's products.

The quality of comparison and transparency, and the greater the inroads that can be achieved in doing so with health insurance, the greater the participation rate we believe will ultimately be the result.

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

- *Experienced difficulty choosing the right cover for their circumstances?*

In the vast majority of cases we believe that the ability of consumers to choose the right cover through a PHIIA member has only been greatly enhanced due to a) the existence of our sector and b) the competition which we foster because we exist to compare for the benefit of consumers.

- *Been misled about the benefits and inclusions of their policy e.g. the preferred providers included, which procedures are covered or the expected cost?*

All PHIIA members are required to disclose the providers which they offer health cover from. Every PHIIA member website is required to showcase those RHFs on their landing page and to specifically declare and disclose that throughout the website.

Whilst there have no doubt been cases of inappropriate conduct of personnel acting on behalf of a PHIIA member companies, in dealing with consumers, based on the statistics available from the Health Insurance Ombudsman we know that their number is limited if not miniscule and represent only a tiny percentage of the overall consumer complaints made to the Ombudsman.

PHIIA has spent some years, considerable effort and expense in developing a Code of Conduct, in collaboration with Private Healthcare Australia and their member health funds, by which the intermediary industry is self-regulated. With the support of the RHFs we are at a point where the RHFs will no longer engage with intermediaries which are not signatories to that Code and we intend to pursue that mandate across the industry by continuing to equip our organisation's Audit and QA resources.

- *Experienced bill shock?*

'Bill shock' can be understood in two ways. The first relates to bills from providers. Our industry receives feedback from consumers that they are shocked by medical gaps particularly for services provided by surgeons.

Of more direct relevance is "bill shock" as it relates to the health insurance bill (premium charged). This type of bill shock occurs frequently for transferring members. It occurs because the old fund takes too long to process the request to transfer. As a consequence members are subject to double payments (sometimes 2 or 3 times for weekly or fortnightly payers). They are also subject to higher payment as the absence of transfer documentation can trigger the charging of Lifetime Health Cover loadings, which are later reversed.

- *Been discouraged from switching providers?*

Notwithstanding the protections provided in the Act that allow for portability between funds, there are in practice actual and perceived impediments that discourage consumers from switching to products that better meets their individual needs. This is well known within the industry and has been a point of discussion amongst the health funds for several years.

Whilst there are no definitive published figures, the generally accepted figure for the churn rate (switch rate) in private health insurance is in the order of 2%. With the contribution of intermediaries no more than 50% of this rate, i.e. 1% of total.

There are several factors which come into play here.

1. **The practice by RHFs to call customers who have decided to change providers to encourage them not to switch is common. This is particularly potent when the caller talks down the new fund and product (in our view**

often without having appropriate training and information) and plays on members' insecurities in relation to portability and re-serving waiting periods.

2. **This becomes a greater challenge when funds delay the issuance of clearance certificates to an incoming fund resulting in multiple payments (or bills) and an inability to use the new cover.**
   The 14 day time-frame to act upon a request to cancel a cover is unreasonably long. It typically involves customer distress as a result of double payments, and prevents customers from using their new cover. Other industries don't allow the withholding of information for the purpose of providing an opportunity to retain a client. There would be outrage if a bank said that it would take 14 days to close an account or transfer $ to another institution. The Interfund Transfer process was never designed as a tool to facilitate customer retention. Rather it is a process to require the old RHF to pass on the member's insurance and claiming history to the new RHF. The 14 day limit was set because RHFs were not complying (or taking an extra-ordinary amount of time). At the time RHFs argued they couldn't do it any quicker. Technology has moved on.

   Issuing a transfer certificate is largely an automated function, confirming cover and maintenance of cover and transferring the customer's claim history and so it is maintained system to system. We believe that 14 days is not only un-necessary but it is frankly anti-competitive. We think that the optimal outcome here is an industry wide electronic exchange that would see the immediate issuance of transfer certificates. We note that this is well recognised within the industry and the insurers have been discussing (at a committee level) for years. In the absence of such a system a reduction of the allowable time to 5 days would improve outcomes for consumers.

   3. As mentioned above, notification of a "former" customer's intentions to leave triggers a how-do-we-retain-the-customer process. We recognise the right to attempt to retain customers, but would recommend that anyone involved in such an activity is fully trained in the competitor policy to which they are comparing and is subject to the same standards of compliance with the industry Code of Conduct as the sales teams. If they are going to downgrade covers, they should clearly explain to customers what they will lose. If they are offering corporate products, they should state the criteria by which the member is eligible.

The issue of churn or switching exists is not so much a measure of the role of the intermediary as it is a function of competition in the market place. It should not be condemned but expected. A robust and competitive market must have customers switch providers otherwise it won't operate efficiently.

At the heart of every PHIIA member company's operations is the objective of ensuring that their customer gets the best possible health cover at the best possible cost, which in itself is very simply the lifeblood of informed choice for consumers and the very essence of the spirit of healthy competition.

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

Third parties, intermediaries & technology

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

As stated earlier, in relation to the customers of intermediaries (being health cover consumers generally), the Ombudsman's own data confirms that these instances are few and far between. That they occur at all is clearly regrettable and unacceptable from PHIIA's perspective but, when measured against the volume of customer health cover comparisons which PHIIA member companies facilitate, it is miniscule.

There would also no doubt be occasions where "problems" arise due to technology flaws, system bugs, etc. Although indirectly related and no doubt infrequent, these can and do occur from time to time and as such can innocently contribute to customer outcomes and satisfaction.

What is the role of new technologies in information provision in this industry?

Put simply, this is absolutely crucial.

The development of ever more robust comparison platforms is fundamental to driving competition and delivering consumer outcomes. In the longer term at PHIIA we believe that the more comparison technology evolves to draw from medical and health statistics (consistent with Privacy law) the more purposeful our role can become. How that manifests remains to be seen but we know a number of our member companies have initiatives in development with the aim in mind being to see consumer needs shape the product composition of the health cover being offered by the RHFs.

Policy changes

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

This is not an issue which PHIIA members can directly assist with.

Do you think there are any problems with the way in which policy changes are communicated to consumers, e.g. are they being communicated effectively? If so, how do you think communication could be improved?

This is not an issue which PHIIA members can directly assist with.

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

This is not an issue which PHIIA members can directly assist with.

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