PHIIA

PRIVATE HEALTH INSURANCE
INTERMEDIARIES ASSOCIATION

SUBMISSION TO THE ACCC REPORT TO THE SENATE ON PRIVATE HEALTH INSURANCE 2015/2016

Level 40, 140 Williams Street Melbourne VIC 3000
03 9229 3896, www.phiia.com.au

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INTERMEDIARIES ASSOCIATION

About us

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 association enforces a code of conduct. PHIIA is a not-for-profit guided by a code of conduct which members are signatory to and are assessed against.

PHIIA membership includes the vast majority of comparison services, health insurance retail brokers, corporate brokers and other intermediaries.

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Opening statement

There are two main areas where members of PHIIA believe there are anti-competitive practices and measures which reduce the beneficial impact of competition to consumers.

The first involves the switching process and delays above and beyond what a reasonable consumer might expect. There are also issues in terms of behaviour and statements of so-called 'save teams' that aim to retain customers who have elected to change provider.

The second revolves around access to data and the inability of PHIIA members to get up-to-date, detailed information of all policies including those no longer being marketed.

Given the fast-moving technological developments it's also incumbent for regulations to insist this data is available in portable and readable electronic formats that facilitate comparison.

The comparison services, agents and brokers PHIIA represents have the experience, expertise and equipment to deal with and explain (usually on the phone or in person) the complexities and technicalities of private health insurance. Unlike the individual consumer the more data they get, the better matched the advice they can give.

Ironically in the very area where an open data policy would help competition and consumers the most, it is only available on the government-sponsored website privatehealth.gov.au

To quote from the Department of Prime Minister and Cabinet website: "All Australian Government agencies are encouraged to make their data available (using an appropriate open license) on the data.gov.au website. Since 2013, over 7,000 additional data sets have been published on data.gov.au"[1]

Point 1: The delay and play around issuing clearance certificates

Members of PHIIA work with the funds as a key channel providing them with new members. However when it comes to the relinquishing of members there are instances where the procedure of issuing clearance certificates – which should be clean, clear and prompt – becomes unnecessarily bogged down and delayed.

The basis of the private health insurance system is that consumers are free to exercise choice and find the best plans and providers to suit their needs. The portability provisions were designed to oil the wheels of competition by ensuring there were no new waiting periods or exclusions for those switching.

PHIIA members report that funds can fail to promptly act on a request to end debits and provide membership history to the new fund. Whilst in most circumstances they will issue the clearance certificate in the 14 days as is legislated, it can be at the 11th hour, and with the knowledge that they may well have unnecessarily debited the customer.

They use delay as a 'prompt to offer' inducements and encouragement for the consumer to stay put and exhaust that process before following through on the members' clear instructions.

This intentionally, or otherwise, inconveniences the consumer by exposing them to double and triple payments and extending the apparent waiting periods.

According to the Private Health Insurance Act 2007 health funds have 14 days in which to issue a clearance certificate but it doesn't always happen.

The practice is noted in official reports: "Delays in the provision of clearance certificates when transferring between health insurers is also a major cause of complaint."[2]

The problem also shows up in the top five issues of complaint in the Ombudsman's quarterly bulletins. The latest for the final quarter 2016 records 79 complaints for membership cancellations. It is ranked number three in the list, not far below the number one issue around

[1]www.dpmc.gov.au/public-data/open-data
[2]Complaints about Private Health Insurers, Annual Report 2015-16, Commonwealth Ombudsman, www.ombudsman.gov.au/__data/assets/pdf_file/0022/41584/ombudsman-annual-report15-16.pdf

premium payment problems. It is described in the bulletin thus: “Complaints caused by problems and delays associated with processing requests to cancel memberships and handling payments or refunds.”[3]

Health funds are required to process transfers and produce clearance certificates within a certain number of days. But in practice, some funds don’t abide by the timelines so they can try to ‘save’ the customer.

The ACCC may be able to determine if the failure to comply with the industry standard is deliberate or, given the amount of work for the relinquishing fund, unavoidable.

It’s also fair to ask if given the degree of digitisation even the 14-day period would be considered a ‘reasonable’ time period by most consumers given the greater speed of other switching processes.

Even if the funds require 14 days to produce the clearance certificate they should have the will and process to stop taking direct debits from their departing customers’ account much faster.

PHIIA wants action on the issue as an increasing number of consumers are using our members’ services and the delays, although nothing to do with members, reflect poorly on their operations.

It’s not just a ‘poor experience’ that reflects badly on PHIAA members and the new fund rather it causes genuine grief and hardship for members such as being being double and triple debited. This frequently results in people being overdrawn on their account and facing extra fees and problems.

With respect to the save teams, people can be given incorrect and misleading information about the health fund they are moving to. We recommend that the audit procedures in place under the health funds code of conduct that are effectively applied to their sales teams are equally applied to their ‘save teams’ if this isn’t the case already.

We are aware of a project, which has been going for some years, and facilitated by one of the government agencies to build a type of clearing-house for policy switches which would accelerate the time required to process clearance certificates. However given the time taken so far we believe there should be faster ways to drive change.

[3]www.ombudsman.gov.au/__data/assets/pdf_file/0022/42916/PHIO_QB_81.pdf

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In summary

The 14-day standard set by the industry to produce a clearance certificate and stop debiting the account of a departing customer, is out-of-line with the reasonable expectations of consumers and is not reflective of the minimal amount of work required by the departing fund.

Interestingly, funds have improved their ability to establish direct debit payments for new customers from 7-10 working days to within 24 hours.

They have done this because it is in their interests, and it is a reasonable customer expectation that funds will take immediate action to close their memberships once instructed.

The fact that facilitating the wishes of a departing consumer might not be so closely aligned with their interests is no excuse to drag the chain.

Anecdotal evidence from businesses is that consumers often blame the new fund for the delay, which is not a great first experience/impression and can lead to cancellations or cooling offs

We respect the right of funds to attempt to retain customers, however they need to prioritise actioning the explicit instructions of clients. Therefore an instruction from a customer to ‘stop debits’ and ‘pass my history to another fund’ should be complied with immediately and in the first instance.

If a ‘save team’ is able to convince a customer to change his/her mind then that is part of the competitive process so long as the inducements to stay are transparent and deliverable.

One PHIIA members reports: “Some of the feedback we get from consumers who are either outraged or confused by the tactics used/claims made/misinformation provided by these save teams is extremely poor and doesn’t help the overall perception of private health insurance.”

An accountable compliance regime, as per the fund’s code of practice, should be applied to both the ‘save teams’ as well as those who sell health insurance to new customers. ie: Save team staff should not talk down other funds or products unless they are qualified to talk about the fund or products and can provide an accurate comparison

Also if someone verbally agrees to return to their fund, then particularly when changing products, the new product should be explained in full and a proper cancel/join process should occur.

Point 2: Low level of complaints to PHIO

Re: request for consumer complaints/enquiries data

The table below from the private health insurance Ombudsman's latest quarterly report shows the level of complaints around brokers and comparison services remains low, especially considering the number of consumers they assist. Industry figures suggest comparators helped some 200,000 consumers find a new policy in 2016.

While all complaints are taken seriously, we believe the quality of advice provided by the members of PHIIA and supported by our code of conduct is of a high standard and well regarded by consumers.

Complaints by Provider or Organisation Type

Provider or Organisation Type	Sept 2016 QTR	Dec 2016 QTR
Health Insurers	1504	1067
Overseas Visitor & Overseas Student Health Insurers	143	95
Brokers and Comparison Services	16	15
Doctors, dentists, other medical providers	3	5
Hospitals and area health services	12	4
Other (e.g. legislation, ambulance services, industry peak bodies, etc)	11	17

Source: www.ombudsman.gov.au/__data/assets/pdf_file/0022/42916/PHIO_QB_81.pdf

Point 3: Access to policy/product data

Comparison services, such as those represented by PHIIA, use the best people and data to match consumers with the health cover that best suits their needs.

But an impediment is access to timely, accurate, machine-readable and highly detailed data about the complete range of policies in the market.

The government's site privatehealth.gov.au provides much-needed transparency as to this data but not in a form or format which permits PHIIA members to add as much value to the customer's experience as should be possible.

In fact regulation prevents the site from 'sharing' data from even basic standard information sheets more broadly. On legal advice the private health insurance Ombudsman was unable to fulfil a FOI request to release just some of this data.

Comparators have to seek written permission from the funds to access information that, in an open market, should be free.

Comprehensive product information is central to the consumer making more informed choices and using whatever tools or services they see fit to help them in this decision.

Privatehealth.gov.au is a repository for all policy information for the purpose of helping consumers compare their private health insurance cover but the consumer benefit of this information won't be fully realised until it electronically available to comparators, without the present need for written consent, from each relevant health fund.

In the words of one member there's a conflict of interest for funds controlling access by requiring consent as 'opening up the vault' to encourage switching might take away more customers than it brings.

"PHI funds are conflicted in giving this consent as it is used to inform the consumer in a decision to switch away. Given the high and increasing volume of consumers looking for advice through our services, it is important that electronic access to this information (and the ability to reproduce it on our websites and consumer documentation) is provided."

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Any questions about PHIIA or this submission should be directed to the PHIIA chief executive Christopher Zinn

Email: chriszinn@phiia.org

Phone: 0425 296 442