

Our Code

ISSUE 2 JUNE 2013 CODE COMPLIANCE COMMITTEE - PRIVATE HEALTHCARE AUSTRALIA



Welcome letter by Chairman

Thank you to the many funds and other organisations that took the time to comment on the first edition of "Our Code" newsletter.

There was unanimous support for more information to assist funds improve their dealings with consumers. It is also pleasing to have the PHI Ombudsman's support for both the newsletter and the Code of Conduct.

In the recently released State of the Health Funds Report 2012, the Ombudsman acknowledges that complaints to her office are relatively small compared to other industry Ombudsman schemes, but also makes the point that these complaints are representative of the much larger number of complaints that funds receive from their members.

So it is great to see that health funds continue to engage with the PHI Code of Conduct process to improve their members' experience. In fact 87% of health funds that are signatory to the Code are more than 90% compliant with all Code measures (read more about these below), and more than a third are 100% compliant.

This issue includes a couple of compliance issues and interesting questions raised by health funds over the last couple of months. We welcome any feedback or suggestions for "Our Code".

Rob Seljak, Chair
Code Compliance Committee

For further information, questions or suggestions please email: code@pha.org.au

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A growth in funds 100% compliant with the Code

The Code Compliance Committee has requested the independent auditor to report on four main measures to gauge a health fund's compliance with the Code:

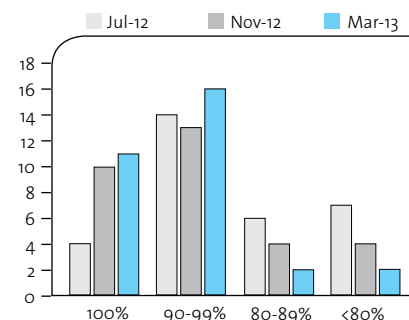
1. The health fund's self audit;
2. Results of Desk Audit (including websites, brochures, dispute resolution process and joining process);
3. Results of any Full Audit and
4. Any breaches of the Code reported to the Committee for investigation.

Over the last year, the Code Compliance Committee has been tracking the number of funds who are 100% compliant with the Code based on a total score over these four measures.

The following chart indicates that the number of health funds that score 100% has increased steadily each quarter,

from 4 funds in July 2012 up to 11 funds in March 2013. The number of funds that score 90% or more on these measures has increase from 18 to 27. Only 4 health funds scored below 90% as of March 2013.

This is a great result and shows the hard work and commitment health funds are making in improving services to consumers.



Compliance Issues

Does size matter?

A question raised by a number of health funds: Are the Self Audit questions designed for large health funds? The answer is that the Self Audit questions are written to accommodate funds of all sizes.

The Full Audit program has been applied to processes and procedures of funds of all sizes. While a larger fund may clearly understand the need for documented policies and procedures, and establishing clear links to training material, a small fund managed by a team of 10 or so employees may see this as unnecessary work.

The experience we have gained from the audit process allows us to consider a variety of documentation that has ensured compliance. Most often we find extremely effective and efficient methods that are used by small funds that satisfy compliance without unnecessary administrative expense.

Documenting various processes, such as the training undertaken by a team (when the team members hardly ever change),

or keeping records of member complaints and disputes (when there are so few), is often questioned. One fund found they already had a simple solution. The staff suggested that formal minutes of their weekly meetings, covering a wide range of matters from training to complaints, be kept so they had a record of training and complaints as well as other matters covered by the Code. Because the minutes were identified as the documentation supporting answers to the Self-Audit the fund was considered compliant.

If any fund has questions concerning their compliance or are concerned about documentation supporting a Self-Audit question they should contact the independent auditor for a review of your specific processes in relation to the questions.

Regardless of a fund's size we are also happy to review any proposed changes and comment on them from the perspective of complying with the Code. Please phone Wayne Cooper on 0407 276 023.

Transfer Certificates

Funds would be aware of the recent work undertaken by Private Healthcare Australia under the leadership of Greg Kovacs to finalise an industry standard process for the request and issue of Transfer Certificates.

The new process includes agreement on the types of authority held by a fund and a standard format for a fund to use when requesting a Transfer Certificate on behalf of a member. Funds can find the process and forms on the Private Healthcare Australia web site: www.privatehealthcareaustralia.org.au/for-fund-members/transfer-certificate/

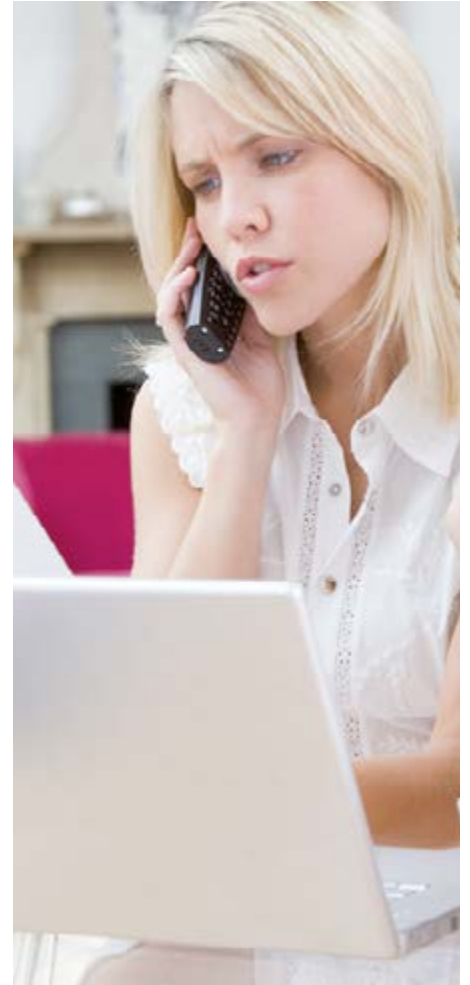
Despite this agreement to improve the consumer experience with private health insurance, the Ombudsman continues to receive regular complaints from consumers about delays in the issue of Certificates. To ensure consumers enjoy a positive experience in dealing with their health cover, it is essential that we, as an industry, make this experience as easy as possible. Consumers are increasingly making decisions online and expect quick turnarounds for services they are entitled to. The Government also expects a seamless process and has established a legislative 14-day framework to ensure portability between health funds.

When a fund receives a request for a Transfer Certificate, regardless of who makes the request, a Certificate must be issued within 14 days of receiving the request and must

be sent to whoever made the request, whether this be a former member or a new health fund.

A health fund receiving a request for a Transfer Certificate may make an attempt to contact and retain the member. However, there is no link between attempts to retain and the issue of the Certificate. The Code Compliance Committee recommends that the person who issues the transfer certificate is separate to the person who attempts to retain the member, and they both have their own performance target. The person issuing the transfer certificate has 14 days to issue the certificate to the member or the new health fund. The person attempting to retain the member can make as many calls as they like to the member and take as long as they like, but the issue of the Transfer Certificate by law should not be delayed while these attempts are made. Consumers should not be put in the situation of having to re-justify or re-confirm their intention to transfer funds and have the transfer process delayed or aborted because of the actions of a health fund trying to retain a member.

From the perspective of the PHI Code of Conduct and the audit process, we will be focusing on auditing questions E15 and E16 and testing if Certificates are in fact issued within the 14-day timeframe. If funds have any questions on this process please contact Wayne Cooper on 0407 276 023.



Interesting Questions

In the last issue of *Our Code*, which we suggest you keep handy, we answered some questions about intermediaries. This information concerned the Private Health Insurance Intermediaries Code of Conduct (Intermediaries Code) managed by their industry association the Private Health Insurance Intermediaries Association (PHIIA). Details of those intermediaries who are accredited under the Intermediaries Code can be found at this location: <http://phiia.com.au/about>



Another question has arisen on this subject:

If we deal with an intermediary who is accredited under the Intermediaries Code why are we considered not compliant because they are not doing the right thing with our product on their website?

Regardless of any accreditation an intermediary has, if our audit found incorrect information being presented by an intermediary we would still report this to the fund concerned, as we would be unaware of the arrangements a fund might have or the status of any particular intermediary's accreditation. A fund is free to also take whatever action is needed with the intermediary from their point of view including reporting this to PHIIA. A second consideration is online intermediaries such as iSelect and InfoChoice are presenting funds' Policy Documentation, which of course is audited under the PHI Code as documentation of the fund not of the intermediary.

The changes to the PHI Code last year mean that funds no longer have to answer questions on the Self Audit Guide relating to intermediaries accredited under the Intermediaries Code. These intermediaries however have obligations to present information as required by a fund and in accordance with that fund's obligations under the PHI Code. The information required under the Intermediaries Code is almost identical to the PHI Code (hence the acceptance of the Intermediaries Code by our industry).

Why is it necessary to point out waiting periods, exclusions, restrictions, benefit limitations periods, excesses and co-payment when we put all these in our letter to new members?

We can probably all agree that we would like to think all of our members would join fully understanding what they are covered for...utopia you would say. While this is a goal we need to think about how to get close to it.

Health insurance is complicated to anyone but a trained person and we know how much training is required. What consumers want, but they realise they may not be able to afford, is to be fully covered. And any research will tell you they also want to keep it simple. Therefore, starting from what they want (full cover) and keeping it simple, what we really need to do is to alert them what they are NOT covered for and point them to the detail... both before and after joining. This needs to be undertaken at all touch points of taking out membership with your fund.

Remember, any good health insurance sales person knows that the simplest way to ensure a sale is to clearly point out what is not covered and ensure the person is happy with this information. This is the easiest way to explain health insurance products and cost regardless of their complexity.

The tables below illustrate two ways to describe the same health insurance product with exclusions, a product typically sold to the "fit and healthy" person. Which explanation in your opinion best conveys cover that will lead to understanding and the lowest level of complaint over time – 'Show them the ticks' OR 'Give them the facts'?

'Show them the ticks'	
Cover for fit & healthy people who don't think they need full cover at this stage of their busy lives	
Accidents	✓
Ambulance (emergency)	✓
Back surgery	✓
Brain surgery	✓
Cancer treatment	✓
Dental surgery	✓
Genealogical	✓
Hernia surgery	✓
Appendectomy	✓
Stroke	✓
Rehabilitation	✓
Grommets in Ears	✓
Tonsils removal	✓
Adenoids	✓
Colonoscopies	✓

'Give them the facts'	
Limited Cover for the fit & healthy	
Accidents	✓
Ambulance	✓
All hospital treatment other than the following <i>excluded treatments</i> :	✓
Heart conditions	✗
Joint replacement	✗
Reconstructive surgery	✗
Eye conditions	✗
Cosmetic surgery	✗
Infertility treatment	✗
Obesity surgery	✗
Pregnancy and birth related	✗
Psychiatric illness	✗
Renal dialysis	✗
<i>When can I claim? Once waiting periods have been served – details are on our website or in our brochure.</i>	



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