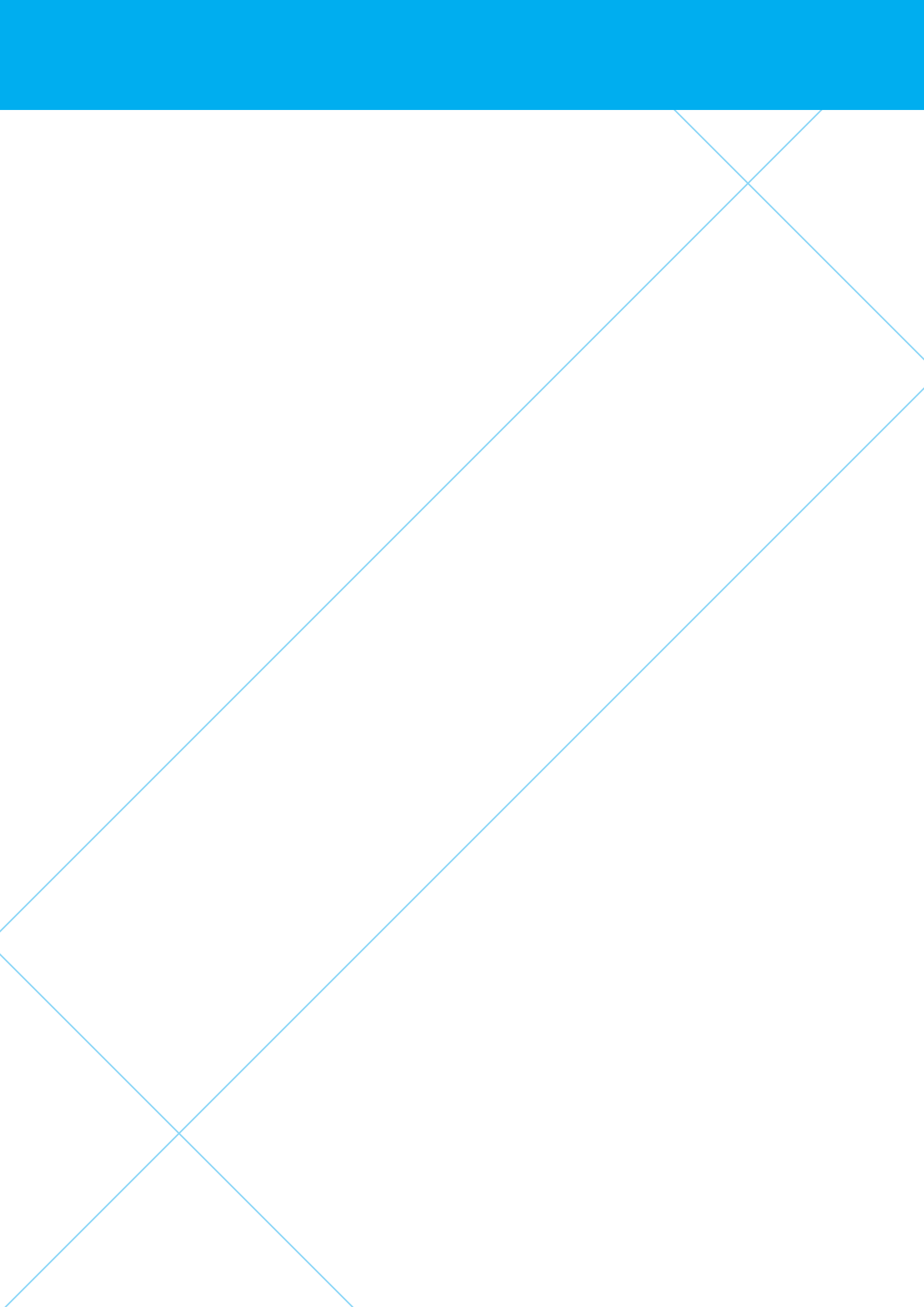




Private Health Insurance Code of Conduct

October 2009



CONTENTS

PRIVATE HEALTH INSURANCE CODE OF CONDUCT

PART A: GENERAL

- 1. Introduction 1
- 2. Our Commitment under the Code 1
- 3. Private Health Insurance Environment 2

PART B: DISPUTE RESOLUTION PROCEDURES IN RELATION TO THE CODE

- 1. Internal Dispute Resolution 2
 - 1.1 Internal Dispute Resolution 2
 - 1.2 Resolution Requests 2
- 2. External Dispute Resolution 3
 - 2.1 External Dispute Resolution 3

PART C: EMPLOYEES

- 1. Training of Employees 3
- 2. Implementation for Employees 3

PART D: AGENTS

- 1. Responsibilities of Agents 4
- 2. Training 4
 - 2.1 Training of Agents 4
 - 2.2 Implementation for Agents 5
- 3. Disclosure 5
 - 3.1 Disclosure Requirements 5

PART E: BROKERS

- 1. Recommendatory Provisions 6
- 2. Obligations 6
 - 2.1 Training and Accreditation Requirements 6
 - 2.2 Responsibilities of Insurance Broker Acting as Agent of Insured 6
 - 2.3 Responsibilities of Corporate Broker Acting as Agent of an Organisation 7
- 3. Disclosure 7
 - 3.1 Disclosure Requirements 7

PART F: POLICY DOCUMENTATION

- 1. Clear and Complete Policy Documentation 8
- 2. Detrimental Changes to Policies 9
 - 2.1 Significant Detrimental Changes to Hospital Policy Benefits 9
 - 2.2 Other Detrimental Changes to Hospital Policy Benefits 9
 - 2.3 Significant Detrimental Changes to Ancillary Benefits 9
 - 2.4 General Principle in Relation to Detrimental Changes to Benefits 10
- 3. Changes to Hospital Contracting Arrangements 10
- 4. "Cooling Off" Period 10

PART G: PRIVACY

- 1. National Privacy Principles 10

PART H: DEFINITIONS

- 1. Defined Words 11

PART A: GENERAL

1. INTRODUCTION

The Private Health Insurance Code of Conduct (“Code”) is a self-regulatory code to promote informed relationships between Private Health Insurers, consumers, agents and brokers.

Our objective is that the Code will maintain and enhance regulatory compliance and service standards across the private health insurance industry. The provisions in this Code are for the purpose of clarification or are in addition to the existing regulatory obligations on Private Health Insurers.

For this purpose the Code is to be a “living Code” which will be progressively reviewed from time to time. We welcome the input of consumers into the Code and its operation. We may also seek the input of consumers from time to time, including through consulting with the Private Health Insurance Ombudsman (“PHIO”).

2. OUR COMMITMENT UNDER THE CODE

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 health fund, including information on this PHI Code of Conduct;
- (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 *Trade Practices Act 1974* and the state *Fair Trading Acts*;
- (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 shall have a fully documented internal process for resolving a dispute between the consumer and us and the consumer and any of our agents.

This process shall be readily accessible by consumers, without charge.

The internal process shall 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 consumers 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 insurance and in dispute resolution are familiar with the provisions of this Code and that they possess the necessary skills appropriate to their responsibilities; and
- (b) we provide adequate on-going training to employees having regard to the employee's role and responsibility and the PHI contracts for and the insurance services to consumers that he/she is authorised to arrange or provide; and
- (c) 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 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 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 health insurance purchase. We will instruct employees to keep appropriate records of their advice to consumers.

PART D: AGENTS

1. RESPONSIBILITIES OF AGENTS

We will ensure that agents engaging in health insurance business will:

- (a) discharge their responsibilities and duties competently and with integrity and honesty;
- (b) exercise reasonable care and skill;
- (c) comply with the provisions of the *Private Health Insurance Act 2007*, the *Trade Practices Act 1974* and the *State Fair Trading Acts*;
- (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) comply with the Code where relevant;
- (g) provide to the consumer copies of policy wordings, insurance documentation and certificates;
- (h) explain the consumer's options clearly and provide such information as the consumer requires to make an informed choice as to their health insurance purchase;
- (i) promptly convey to the consumer, relevant information and documents being sent by us to the consumer; and
- (j) not engage in any non-disclosure or misrepresentation.

2. TRAINING

2.1 TRAINING OF AGENTS

We will require our agents to possess the necessary skills appropriate to the private health insurance product they are arranging and the insurance services they are providing.

To this end, we will require our agents to receive adequate on-going and documented training or instructions, and documentation to competently arrange PHI contracts for and provide the insurance services to consumers that they are authorised to arrange or provide. This training will allow sufficient information for the consumer to make an informed choice as to their health insurance purchase.

The obligation to provide training or instruction, and documentation shall be ongoing and will include training or instruction and documentation in the areas of:

- (a) principles of health insurance and any relevant consumer protection law;
- (b) product knowledge;
- (c) what to do in the event of a claim; and
- (d) the requirements of this Code;

as may be appropriate in relation to the authority and responsibility of the agent.

2.2 IMPLEMENTATION FOR AGENTS

In implementing these requirements, we will have regard to whether the agent would ordinarily make representations on products to consumers.

If the agent makes no representations to consumers and merely has brochures in its premises or receives claims from members, we will provide such agents with information as to how consumers may be able to obtain further product information and assistance.

We will instruct and periodically remind agents not to make representations in relation to any product in respect of which they have not been trained to provide information. We will instruct agents to keep appropriate records of their advice to consumers.

3. DISCLOSURE

3.1 DISCLOSURE REQUIREMENTS

We will require agents to inform consumers; of their status, the fact that they are acting for us and the nature of our association.

PART E: BROKERS

1. RECOMMENDATORY PROVISIONS

The following provisions set out the desired minimum principles for Brokers or Corporate Brokers with whom we deal. They are outlined on a recommended basis only and we are free to deal with any Brokers or Corporate Brokers we wish. We will, however, request all Brokers with whom we deal to comply with the provisions of this section of the Code.

2. OBLIGATIONS

2.1 TRAINING AND ACCREDITATION REQUIREMENTS

All Brokers or Corporate Brokers who wish to act in the private health insurance industry should meet appropriate training and accreditation requirements.

This training will allow for sufficient information to be provided to the consumer to make an informed choice as to their health insurance purchase.

2.2 RESPONSIBILITIES OF INSURANCE BROKER ACTING AS AGENT OF INSURED

As a minimum, a Broker when acting as the agent of a consumer in relation to a PHI contract offered by us will be required by us to:

General

- (a) discharge its responsibilities and duties competently and with integrity and honesty;
- (b) act in the best interest of its principal (the company it is representing);
- (c) exercise reasonable care and skill;
- (d) ensure consumers are able to make an informed decision about their health insurance purchase by clearly explaining all options and providing all relevant information;

- (e) develop and maintain an internal complaints handling procedure including information on external processes available to the consumer such as the PHIO;
- (f) comply with its fiduciary obligations to its principal, including:
 - (i) avoiding conflicts of interest;
 - (ii) if a conflict of interest occurs, disclosing that conflict as soon as is reasonably practicable;
 - (iii) disclose fees, commissions or other remuneration or benefits to the consumer;
 - (iv) maintain the confidentiality of its principal's records and other information;
- (g) comply with the provisions of all relevant laws, including the *Private Health Insurance Act 2007*, the *Trade Practices Act 1974* and the *State Fair Trading Acts*;
- (h) maintain all records required by law and comply with all requirements for the production of, access to, or copying of, such records;
 - (i) provide such information as may be legally required by any regulatory or other authority;
 - (j) comply where relevant with the Code;

Policy arrangements/renewal/cancellation

- (k) assist the consumer in all ways to comply with the Private Health Insurer's requirements of the consumer;
- (l) promptly provide the consumer's proposal information to the Private Health Insurer;
- (m) not engage in any non-disclosure or misrepresentation; and

Drafting proposal forms

- (n) when drafting proposal forms, ensure that they:
 - (i) identify the usual information the Private Health Insurer ordinarily requires to be disclosed; and
 - (ii) are in plain language and provide instruction where necessary on how the questions should be answered.

2.3 RESPONSIBILITIES OF CORPORATE BROKER ACTING AS AGENT OF AN ORGANISATION

As a minimum, a Corporate Broker when acting as the agent of an organisation wishing to offer health insurance products provided by us will be required to:

- (a) discharge its responsibilities and duties competently and with integrity and honesty;
- (b) act in the best interest of its principal (the company it is representing);
- (c) exercise reasonable care and skill;
- (d) ensure organisations are able to make an informed decision about our health insurance products and services by clearly explaining all options;
- (e) comply with its fiduciary obligations to its principal, including:

- (i) avoiding conflicts of interest;
 - (ii) if a conflict of interest occurs, disclosing that conflict as soon as is reasonably practicable;
 - (iii) disclose fees, commissions or other remuneration or benefits to the organisation; and
 - (iv) maintain the confidentiality of its principal's records and other information;
- (f) comply with the provisions of all relevant laws, including the *Private Health Insurance Act 2007*, the *Trade Practices Act 1974* and the *State Fair Trading Acts*;
 - (g) maintain all records required by law and comply with all requirements for the production of, access to, or copying of, such records;
 - (h) provide such information as may be legally required by any regulatory or other authority; and
 - (i) comply where relevant with the Code.

3. DISCLOSURE

3.1 DISCLOSURE REQUIREMENTS

Brokers or Corporate Brokers with whom we deal will be required by us to inform consumers of their status, the company they are representing and the identity of any other Private Health Insurers whose products they are presenting to the company or to consumers.

Brokers or Corporate Brokers with whom we deal will be required by us to also inform consumers and the corporate entity for whom they are acting of any associations between the Broker or Corporate Broker and Private Health Insurers.

PART F: POLICY DOCUMENTATION

1. CLEAR AND COMPLETE POLICY DOCUMENTATION

We will:

- (a) express policy documentation in plain language and design and present policy documentation, with the aim of assisting comprehension by consumers;
- (b) ensure each new consumer to our fund is advised of or has presented to them prior to joining policy documentation detailing the consumers entitlement to benefit, including any waiting periods, exclusions, restrictions and benefit limitation periods, and we will confirm this cover following acceptance by our fund;
- (c) ensure the various forms of policy documentation, including our website, will accurately reflect the cover offered, will highlight any waiting periods, exclusions, restrictions and benefit limitation periods and will contain at a minimum:
 - (i) waiting periods;
 - (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) annual limits (individual and membership);
 - (vi) co-payments and/or excesses;
 - (vii) how to find agreement hospital details;
 - (viii) how to find no gap or known gap doctors for our fund;
 - (ix) how to find out if an ancillary provider is recognised by our fund;
 - (x) how to find out about our fund's privacy policy;
 - (xi) how to access our fund's complaints handling procedures;
 - (xii) information about the existence of the Code including the Code logo; and
 - (xiii) advice that the documentation should be read carefully and retained;
- (d) at the request of any existing consumer, provide the consumer with the details of the consumer's entitlements to benefits;
- (e) 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; and
- (f) 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 outlets; and
- (v) can be accessed in its electronic format.

2. DETRIMENTAL CHANGES TO POLICIES

2.1 SIGNIFICANT 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; and
- (c) increases in excesses/co-payments greater than 50%.

Where there is a significant detrimental change to hospital benefits we will:

- (a) provide the affected consumer with details of the change giving at least 60 days' notice;
- (b) not apply the changes to pre-booked admissions; and
- (c) 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 OTHER DETRIMENTAL CHANGES TO HOSPITAL POLICY BENEFITS

For detrimental changes to hospital policy benefits other than significant detrimental changes we will:

- (a) provide the affected consumer with at least 30 days' notice;
- (b) not apply the changes to pre-booked admissions;
- (c) put in place transitional measures for patients in a course of treatment for a reasonable time period, for example, up to three months.

2.3 SIGNIFICANT DETRIMENTAL CHANGES TO ANCILLARY BENEFITS

A significant detrimental change to ancillary policy benefits includes:

- (a) introduction of a new limit or sub-limit; and
- (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' notice; and
- (b) put in place transitional measures for rollover type benefits accumulated in a previous year.

2.4 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 the control of the Private Health Insurer.

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. "COOLING OFF" PERIOD

We will allow any consumer who has not yet made a claim, to cancel their policy and receive a full refund of any premiums paid within a period of 30 days from the commencement date of their policy.

PART G: PRIVACY

1. NATIONAL PRIVACY PRINCIPLES

We will:

- (a) embrace the National Privacy Principles under the *Privacy Act 1988* and the provisions of relevant State privacy legislation; and
- (b) formulate and publish our own Privacy Policy, by which we will abide.

PART H: DEFINITIONS

1. DEFINED WORDS

In this Code, the following terms mean:

“**agent**” means an insurance intermediary who is an agent for a Private Health Insurer and who acts on behalf of the Private Health Insurer;

“**AHIA**” means the Australian Health Insurance Association, the national PHI industry organisation, which Private Health Insurers may join if they wish;

“**broker**” means an insurance intermediary who is an agent for a consumer and who acts on behalf of the consumer;

“**consumer**” means an individual, where that individual, whether alone or jointly with another individual, enters or proposes to enter into a PHI contract;

“**corporate broker**” means an insurance intermediary who is an agent for an organisation wishing to offer health insurance products, provided by a Private Health Insurer, to their employees and acts on behalf of that organisation;

“**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;

“**Minister**” means the Federal Minister or his or her delegate with the powers vested in the Minister under the *Private Health Insurance Act 2007*;

“**PHI**” means private health insurance;

“**PHI contract**” or “**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 policy information in brochures, websites or other printed or electronic form;

“**Private Health Insurer**” means a registered health benefits fund under the *Private Health Insurance Act 2007*.



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