Submission on discussion document: Insurance contract law review

Your name and organisation

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Organisation	Ophthalmology New Zealand - ONZ

Regarding consumers' disclosure obligations

Were you aware of your general duty to disclose all material information when applying for insurance, and that the duty goes beyond the specific questions you are asked in your application for insurance?
No Comment
If you were aware of your duty to disclose material information, who informed you of this duty?
No Comment
When applying for insurance, do you understand what material information you need to give the insurer so they can assess the risk of providing you with insurance?
No Comment
Do consumers understand the potential consequences of breaching their duty of disclosure?
No Comment
Have you ever breached your duty of disclosure? What consequences were there for you in terms of the insurance cover you were able to obtain under the policy following the breach?
No Comment

Regarding conduct of insurers

What do you think fair treatment looks like from both an insurer's and consumer's perspective? What behaviours and obligations should each party have during the lifecycle of an insurance contract that would constitute fair treatment?

Introduction

We are a member body and work on behalf of New Zealand Ophthalmologists (www.ophthalmologynz.co.nz). Our mission is to represent our members and their patients' interests.

ONZ feels the current legislative framework and approach to contracting private health insurance in New Zealand leads to asymmetry of information for the consumer, and allows health insurers to exhibit unfair behaviour in their contracting with providers. These practices can result in the consumer being unaware of what procedures their health insurance is covering them for and of the service they are to experience.

Health insurance in New Zealand is a free market, with no specific health insurance regulations or restrictions, a lack of incentives for individuals to attain health insurance, a limitation on the ability to design and price competitor insurance products and an information imbalance between the insurer and the insured.

Health care is, by its nature, complex and eventualities for treatment are not always known initially. But a lack of regulation in the health insurance market has led to a lack of knowledge and transparency in what consumers are being insured for and the options of service that they can contract for. Specifically, we are seeing what could be the start of a trend towards what is known in other insurance markets as "managed care" meaning that an insured has limited choice as to:

- *which health care provider he or she can choose; or*
- *the nature and types of the procedures covered by his or her insurance.*

Reform in health insurance would address a marketplace that would ensure transparency in services that consumers are insured for, increase competition in health insurance, allow consumers to have more information on their service, and educate themselves on the latest treatments and technology with an awareness and ability to choose their options.

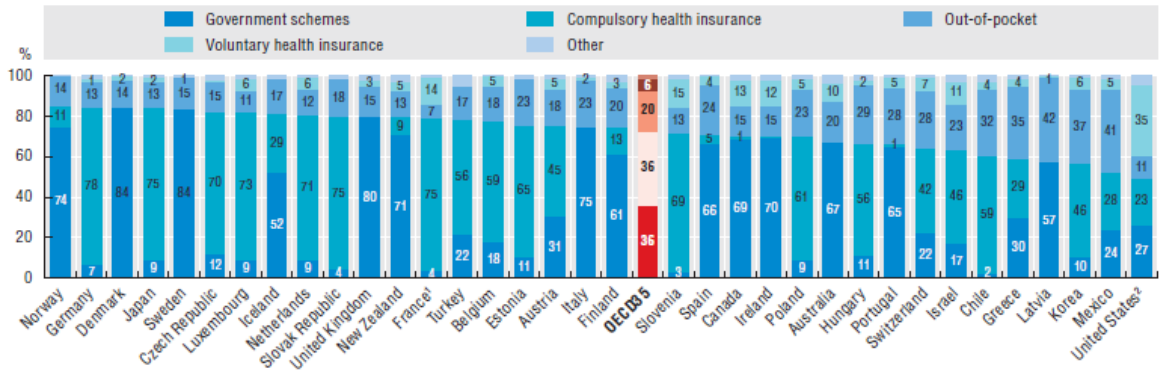
**Please see comments on Community Rating below*

Background

Like many OECD countries New Zealand's health care is funded by public and private sources, mainly public, with approximately 5% funded by voluntary health insurance. This rate of funding by health insurance is under the OECD average for voluntary health insurance which is 6% (Health at a Glance, 2017, OECD).

Health insurance providers operating in this marketplace are few, compared to other countries, with a near monopoly health insurance entity, which anecdotally estimates its market share at 62% of the market. Its closest competitor estimates its market share at over 15%.

Table 1: Health Insurance rates in the OECD



1. France does not include out-of-pocket payments for inpatient LTC thus resulting in an underestimation of the out-of-pocket share.
2. Spending by private health insurance companies in the United States is reported under voluntary health insurance.

Source: OECD Health Statistics 2017.

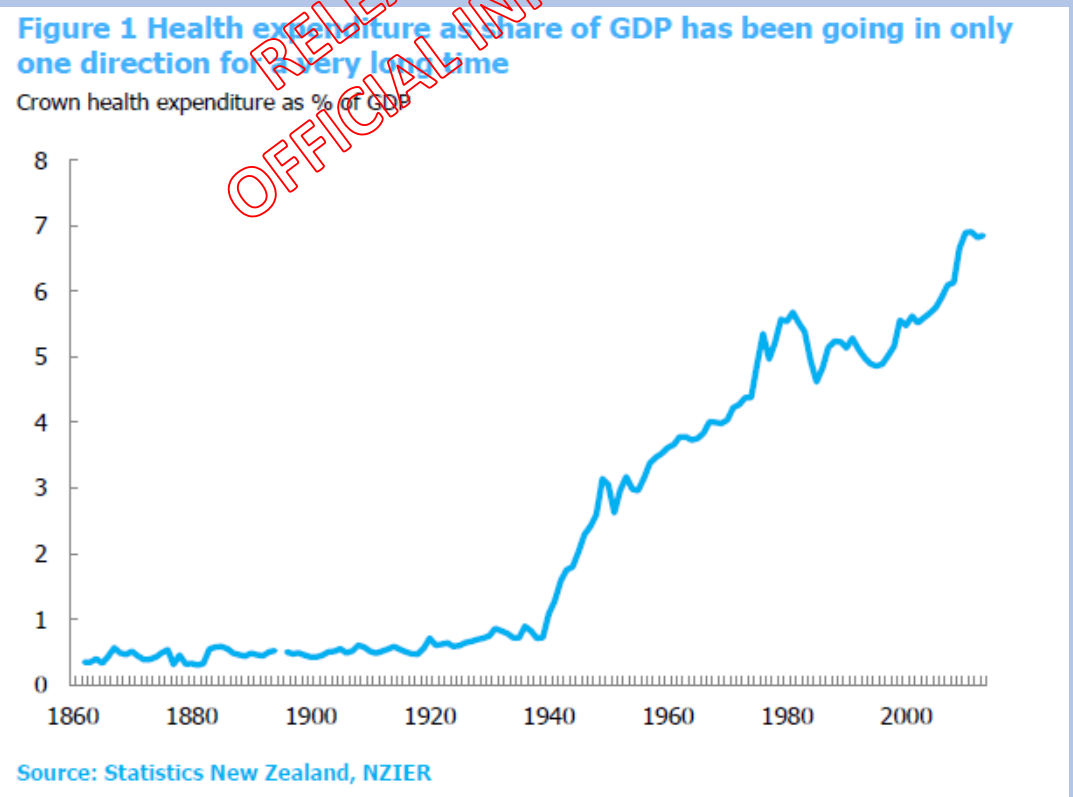
StatLink http://dx.doi.org/10.1787/888933604286

Rising Health Care Costs

It is necessary at this point to discuss the health care crisis in cost that is facing many nations, this is due to the following factors:

- *An aging demographic needing more care*
- *Increasing life expectancies*
- *Rising costs in technology and aids, and*
- *Rising costs in pharmaceuticals*

Table 2: Rising Costs



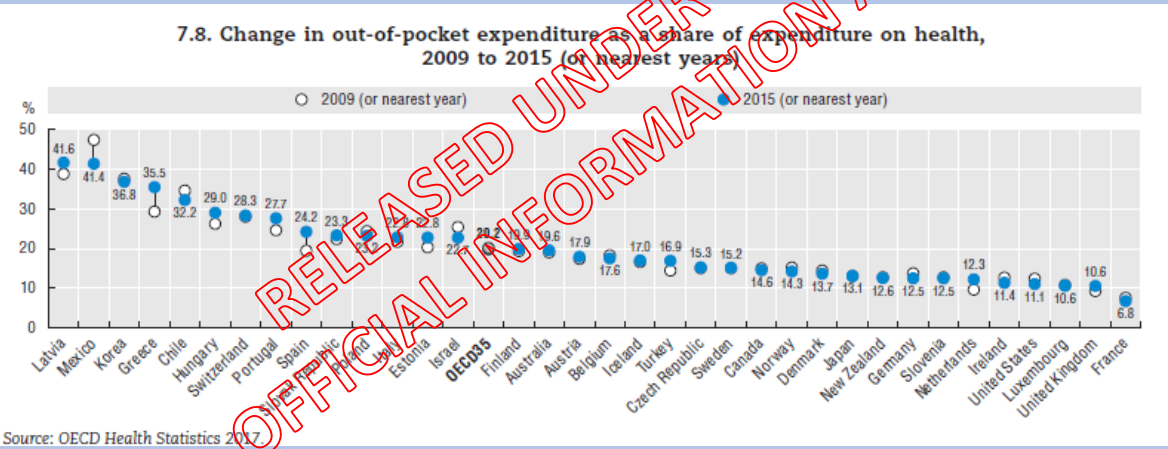
This rise in costs is well documented, and although New Zealand's health system rates highly by international standards, the impact of rising costs are felt on both public and private health care consumers in most developed countries. ***https://theconversation.com/new-zealands-health-service-performs-well-but-inequities-remain-high-82648****. In the public system there are varying attempts to address the rising costs, but the concern of a lack equity for less advantaged is still salient. (****http://www.who.int/bulletin/volumes/88/10/10-021010/en/****).*

Part of the funding for health care in New Zealand comes from out of pocket expenditure which has changed very little in the recent past compared to other OECD countries, where rising costs have been passed on to the consumer, but so too has choice in their care. Health insurance rates of membership themselves are rising, with insurance numbers up by 20,100 (1.5%) taking cover for the year ending in March 2018 (Health Funds Association, August 2017).

What the comparison to OECD figures tells us is that health care costs are rising in most countries, with subsequent rises in costs in "out of pocket costs" (costs to the consumer outside of insurance) to consumers. However, these increases in costs have not been fully passed on to New Zealanders with "out of pocket costs" changing very little over the years 2009 – 2015 (Health at a Glance, 2017).

That these costs have not been passed on speaks well of the New Zealand system, but there are hidden costs to the patient in maintaining this status quo.

Table 3: Out of pocket costs



Health Insurance Strategies to contain out of pocket costs to members.

In New Zealand the monopoly insurer has highlighted concerns with rising health care costs to all its providers but has a dual dilemma with ensuring these costs are not passed on to its members, as to do so may result in loss of members and this would impact on this insurer itself. It has become abundantly clear to health care providers that in order to keep premiums down this insurer has sought to pass increasing costs on to health care providers.

In order to constrain rising costs, the insurer concerned has developed an affiliated provider scheme, which is not unlike schemes used elsewhere. The intent of which is to contract providers at an agreed price, and give a no "out of pocket service" to the member. Such a service is admirable and attractive for insureds but comes at the cost of restricted choice.

The affiliated provider scheme has been in operation for some time in a voluntary nature. Initially when this scheme was introduced it was seen as an effective tool to manage costs and services from an administration and quality measurement perspective. Services on this programme were constrained with two mechanisms, one being the use of eligibility criteria for certain procedures,

and another being the policy of not insuring for pre-existing illnesses (see below).
Much has been said about the potential negative impacts on consumers where these mechanisms are utilised and their limitation on clinical autonomy. In a review of the impact of changing roles of health insurers on clinical autonomy commissioned by the Royal Australian College of Surgeons (November 2015) it was found that, at that time, New Zealand's largest insurer had eligibility criteria for some 37 groups of procedures, with minimal transparency on how the criteria are developed or on the evidence base utilised. The authors found, at that time only two of the 37 sets included external referencing (i.e. recommended medical guidelines).
The affiliated provider agreement changed with the introduction of Affiliated Provider Only services, an approach that was gradually utilised in approximately 2014, whereby certain more expensive services (such as cataracts) were negotiated on a one to one basis with affiliated providers only and (ONZ members report) price appears to be the main criteria that was negotiated. This meant that a provider had no choice but to agree to a lower price if it wanted to perform the procedure for its patients who were members of this insurer.

Interventions such as the use of eligibility criteria and pre-existing conditions rules have (according to the above review) led to a number of negative impacts:

- *Denial of access to some hospitals for private patients*
- *Denial of access to some treatments for patients*
- *Delays in access to treatments for patients*
- *Non-payment or reduced benefits to hospitals for some services*
- *Non-payment or reduced benefits to medical practitioners for some services*
- *Non-payment or reduced benefits to patients for some services*

(Impact of the Changing Role of Private Health Insurers on Clinical Autonomy.p25)

Providers have agreed to terms such as the eligibility criteria, and in many cases been forced to reduce prices, and absorb costs themselves as they do not see a choice. However cost shifting to the providers themselves can only be tolerated to a certain level before their business models become unable to be supported and it becomes an economical risk to offer private services.

Another strategy that insurers have adhered to is limiting new technology. There is a non-transparent process by which some insurers have reviewed and assessed new technology, resulting in very few new ophthalmic (and other) treatments and technologies being approved in the private sector regardless of their perceived efficacy by the clinicians themselves. An example is the use of MIGS (Minimally invasive glaucoma surgery). This is funded in many DHBs. Clinical trails indicate its efficacy and insurers still have not approved any devices for use privately in NZ. Another example is intracameral antibiotics.

With price being constrained, and new technology being limited the resultant service to members is limited compared to the same service as performed in other nearby nations such as Australia. This may leave New Zealand behind in the provision of private health care and choice for consumers.

This limitation is non-transparent to the consumer, and the attraction of an affiliated provider no out of pocket scheme misleads the consumer in that the service on offer is limited mostly by price. In other countries insurers work with providers to offer products which set a price per service and offer no out of pocket providers, but due to competitive forces, there are other providers who offer services which state that if this price does not cover the costs of the treatment available with the latest technology, and the patient is able to pay for a surcharge for the treatment to cover the cost, then they are able to pay an out of pocket cost. Insurers do not limit the provider and demand that no out of pockets are charged as they do in New Zealand. Therefore, the overall marketplace is not hindered from developing and utilising new technology. The market demands that providers and insurers keep up with technology.

We believe the current environment that encourages health insurance contracts which limit service by price, are unfair to the consumer. We also believe an environment that bullies providers into offering cheaper services may lead to cost cutting that could impact on the consumer.

Current example

As an example of this behaviour ONZ would like to cite the current situation with cataract surgery. For one major health insurer, cataract surgery is only available on the Affiliated provider agreement. Therefore if a provider wishes to offer cataract surgery to its patients who are insured with this health insurer it must agree to the price. With an aging demographic cataract surgery will become more and more common and necessary.

This health insurer is aiming to constrain the cost of this increase, limiting costs and providers of this service, whilst keeping its premium costs to members low.

A more worrying situation has developed. Our members report the current approach is that this particular health insurer is negotiating agreements for cataract procedure whilst refusing to pay for anaesthesia in cataract surgery. The insurer is intimating that use of anaesthetist for this surgery is a choice by the clinician, and that the costs should be borne by the clinician.

Patients are unaware that their providers are unable to be compensated for the use of an anaesthetist when they pay their insurance premiums. Affiliated provider contracts are negotiated in an air of secrecy and providers are unable to discuss these services and agreements with other parties. If consumers were able to be informed of the full service and chose to pay for an anaesthetist outside of the scheme they would not be able to within an Affiliated Provider agreement. Providers are unable to request even part payment according to such agreements.

ONZ believes this approach is unfair to both the consumer and the provider.

Lack of Transparency

The current environment of agreements being conducted in secrecy means the health insurance company is shifting the costs of these services, without the consumer being aware.

We do not condone shifting the costs to the consumer via the premium cost, as this may imperil our private health insurance sector, which would lead to a burden on the public sector. But we do believe in a regulatory approach that encourages a more open and transparent accounting of costs where private patients can choose their providers and services, and gauge performance on criteria other than just cost.

New Zealanders may be reluctant to accept that within our highly successful health system there are areas where they need to be ready to consider out of pocket costs. But this idea of raising consciousness in responsibility to constrain costs was explored in a paper commissioned by Health Funds Association of New Zealand (December 2014) by the New Zealand Institute of Economic Research (NZIER). In this paper NZIER looked at different mechanisms to constrain cost and found the most effective to be raised consciousness:

Table 4: Efficacy of methods of constraining costs.

Table 1 Option evaluation framework

Option	Effectiveness	Efficiency	Equity of access	Administrative simplicity
Nudging towards personal responsibility	Weak	High	High	Simple
KiwiSaver style approach	High	High	Moderate	Complex
Purchase of elective surgery	Weak	High	High	Moderately complex
General subsidy	Weak	Weak	Moderate	Simple
Targeted subsidy for the over 65s	Weak	Weak	Moderate	Simple
Targeted subsidy for accelerating the return to work	High	Moderate	High	Complex
Partial removal of FBT on PHI	Moderate	Weak	Moderate	Complex
Surcharge on high income earners who do not have health insurance	High	Moderate	Moderate	Complex

Source: NZIER

[3] Vaithianathan (2002) argues subsidising private care, rather than subsidising insurance would be more effective in reducing demand for public care; however, the objective of this paper is to look at options enabling people to manage increased cost-sharing. https://ideas.repec.org/a/bla/ecorec/v78y2002i242p277-83.html

Conclusion

New Zealand needs to develop a regulatory approach that addresses the rising costs of health care within both public and private health systems. Such an approach would utilise all mechanisms available to (a) contain cost, (b) ensure within that containment the consumers of health care are able to have up to date treatment and technology, whether they are public or private, and (c) highlight the costs and share responsibility with all parties including consumers.

New Zealand clinicians are concerned that the current private insurance environment encourages an approach to surgery based on price not comfort or evidence based clinical care. This is not in the best interests of the consumers of care. It is also unrealistic to presume that clinicians can continue to absorb the increasing costs of health care, as the outcome will be a reduction in services available in the private sector, and an increased burden on the public sector. We also believe that transparency of services and costs is crucial to consumers being aware of the costs of these services to providers and to consumers, and in allowing them to make choices in their own care.

We believe a regulatory framework that allows for more transparency around what is provided within health insurance agreements with providers, more transparency and clinical accountability for insurers when exercising eligibility criteria, and a more even balance of information to both providers and consumers would result in consumers being able to exercise choice in insurance provision.

What has your experience been of the claims handling process? Please comment particularly on:
• information from the claims handler about:
  ○ timeframes and updates on timeframes
  ○ reasons for declining the claim (if relevant)
  ○ how you can complain if declined
• The handling of complaints (if relevant)

No Comment
Have you ever been sold an insurance product that was inappropriate for your circumstances? Or are you aware of this happening to others?
No Comment
Have you ever felt undue pressure from an insurer or insurance intermediary (such as an insurance broker or salesperson) to buy or renew an insurance policy?
No Comment

Regarding difficulties comparing and changing providers and policies

When considering the purchase of insurance, what sources of information do you draw upon to make your decision? (e.g. comparison websites, talking directly to different insurance providers, talking to an insurance broker or financial adviser)

[Insert response here]

How long do you think you typically spend reading an insurance policy before you purchase it?

[Insert response here]

Do you think you have a good understanding of the insurance policies you currently hold?

[Insert response here]

If not, what is the main barrier to you understanding your insurance policy?

See above regarding lack of transparency.

Have you ever been in a situation where you thought you had a certain level of cover under your policy, but when you went to make a claim found you were not covered? If so, please provide us with a description of the situation.

[Insert response here]

Would you like to switch insurance providers? If so, what is your main barrier to switching?

Please see above submission regarding Conduct for background factors.

Currently in New Zealand if you wish to switch health insurers and you have a pre-existing condition, you may have to wait up to 3 years for your new health insurer to cover your condition if at all. This means that the dominant health insurer's position in the market is very secure and there is limited scope for competitors to increase market share. The risk to members in switching policies and not being covered is too great.

Please see the potential negative effects of interventions such as pre-existing condition rules above.

In other markets, such as Australia, legislation ensures that the health insurer has to offer a reasonable time frame for pre-existing illnesses. This time frame ranges from 2 – 12 months depending on the treatment required. With increased competition in the marketplace providers are dropping even that period.

ONZ believes the current lack of regulations within the health insurance sector contributes to a lack of healthy competition in that market place which may reduce pre-existing waiting times for consumers. Regulatory approaches such as community rating, incentivisation to join health insurance and penalties with the taxation system are utilised in other countries to maintain health insurance and shoulder the burden of increased costs.

In New Zealand health insurance premiums are weighted on risks, therefore as our population ages, staying insured becomes an expensive proposition. The prospect of health insurance membership consisting of high risk individuals also is daunting to health funds.

Community rating of health insurance is a concept, which requires health insurance providers to offer health insurance policies within a given territory at the same price to all persons without medical underwriting, regardless of their health status. As just one measure of health insurance reform, a regulatory approach that ensures community rating would share the burden of risk, resulting in less drop out of members as they age, less of a burden on the public sector and a healthy private insurance sector.

References

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3. Health Policy Solutions (2015); Impact of the Changing Role of Private Health Insurers on Clinical Autonomy. *https://www.surgeons.org/media/22316534/HPS-Report-Health-Insurance-and-Clinical-Autonomy-Nov-2015.pdf*
4. OECD (2017), *Health at a Glance 2017: OECD Indicators*, OECD Publishing, Paris,https://doi.org/10.1787/health_glance-2017-en.
5. NZIER Report to Health Funds Association of New Zealand (2014) : Private Health Insurance an Expanding role to the future of Health Care in New Zealand. ***https://nzier.org.nz/***
6. *https://theconversation.com/new-zealands-health-service-performs-well-but-inequities-remain-high-82648.*
7. *http://www.who.int/bulletin/volumes/88/10/10-021010/en/*

What, if anything, should the government do to make it easier for consumers to compare and change insurance providers and policies?

[Insert response here]

Regarding exceptions from the Fair Trading Act's unfair contract terms provisions

Are you aware of instances where the current exceptions for insurance contracts from the unfair contract terms provisions under the Fair Trading Act are causing problems for consumers? If so, please give examples.

More generally, are there terms in insurance contracts that you consider to be unfair? If so, why do you consider them to be unfair?

As per above

Other comments

We welcome any other comments that you may have.

[Insert response here]