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Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
By email: community.affairs.sen@aph.gov.au

Dear Senators,

ASA Submission to the Senate Inquiry into the Value and affordability of private health insurance and out-of-pocket medical costs

Our reference: 1.2.10.7.3

The Australian Society of Anaesthetists (ASA) notes that the Senate Community Affairs References Committee (the Committee) is holding an inquiry into the value and affordability of private health insurance (PHI) and out-of-pocket (OOP) medical costs. The ASA is grateful for the opportunity to make a submission to the Committee, and acknowledges the contributions made by Dr Mark Sinclair, Chair of the ASA Economics Advisory Committee, and other senior ASA members whom have assisted.

The value and affordability of PHI, and OOP medical costs, are to a large extent separate issues, and the ASA will deal with each in turn.

PHI and Healthcare in the Private Sector

The Australian healthcare system relies strongly on an appropriate balance between publicly-funded healthcare, and privately-funded healthcare. It is essential that the Australian community support the private healthcare sector. The public sector does not have the capacity or the resources to cope with any increased workload which would result from consumers dropping their PHI and relying on the public system instead.

Of course, the vast majority of healthcare consumers receiving services in private hospitals are covered by PHI; hospital costs would be unaffordable to individual consumers otherwise. However, there is a huge range of different PHI products available, with different inclusions and exclusions, and the range of different insurance options has been on the increase. The Committee's terms of reference for this inquiry include (point c):

"Private health insurance product design including product exclusions and benefit levels, including rebate consistency and public disclosure requirements"

In recent years, there has been an increasing number of reports of consumers not being aware of the extent of their insurance cover, resulting in problems such as unexpected OOP expenses for hospital costs, or even last-minute cancellation of hospital admissions for surgery. Clearly, many Australians with PHI cover are not fully aware of what their product covers and what it does not. Considering the growth in exclusionary products in recent years (see Table 1, below), this issue is becoming increasingly important.

Table 1. Number of consumers with exclusionary/non-exclusionary PHI products, 2009-15[1]

Type of Cover	June 2009	June 2010	June 2011	June 2012	June 2013	June 2014	June 2015
Exclusionary (millions)	0.95	2.2	2.8	2.7	2.7	3.0	3.9
No exclusions (millions)	8.8	7.8	7.4	7.9	8.2	8.1	7.3
% exclusionary	9.8%	21.6%	27.1%	25.5%	24.6%	26.8%	35.0%

The continuing rise in premiums for PHI is the reason for the increase in the range of different products available, and the resulting complexity. This allows consumers to maintain their PHI cover, at an affordable cost. However, while the resultant changes may make PHI affordable, it does not necessarily make it more valuable – in fact, the value for money becomes less. It is essential that healthcare consumers are fully aware of the limitations of their cover, should they opt for exclusionary products. At the same time, it is essential that PHI companies offering such products make their customers aware of exactly what services are and are not covered.

To date, the provision of such information by PHI companies has been sorely lacking. In October 2016, the Australian Competition and Consumer Commission (ACCC) released its report "Communicating Changes to Private Health Insurance Benefits" to the Australian Senate[2]. This report covered the period July 2014 -June 2015, and statements in the report include:

- *"This year's report finds that the private health insurance industry continues to be characterised by imperfect information and complexity, particularly around how the industry communicates with consumers about changes to their private health insurance benefits" (p1)*

- *"…there are a range of poor practices around how some insurers notify consumers of changes to their private health insurance benefits, and these practices are contributing to consumer harm such as increased bill shock, inadequate insurance coverage, lost switching/porting opportunities and limited access to health care" (p38)*

Of even greater concern, the ACCC has launched legal proceedings against Medibank Private, alleging the company breached Australian Consumer Law by "engaging in misleading conduct, making false or misleading representations and engaging in unconscionable conduct". The insurer NIB has also had legal proceedings launched against it, with the ACCC making similar allegations.

The ASA acknowledges that the Private Health Ministerial Advisory Committee (PHMAC) is investigating methods by which health insurance products could be made simpler, and looks forward to the output of this Committee.

Out-of-Pocket Medical Costs

All Australians are eligible for a Medicare benefit for medical services provided in the private sector. The federal government sets a Medicare Benefits Schedule (MBS) Fee for the Medicare item(s) relevant to the service. For services provided on an outpatient basis, Medicare provides a rebate of 85% of the MBS Fee for that item. For services provided on a hospital inpatient basis, the figure is 75% of the MBS Fee. If the patient has PHI with hospital cover, the insurer pays the remaining 25% of the MBS Fee as a minimum.

All PHI companies provide rebates at above-MBS Fee levels. The actual above-MBS component varies from insurer to insurer, from specialty to specialty, and in the case of many insurers, from state to state. The above-MBS component is also subject to certain terms and conditions, which again vary from insurer to insurer.

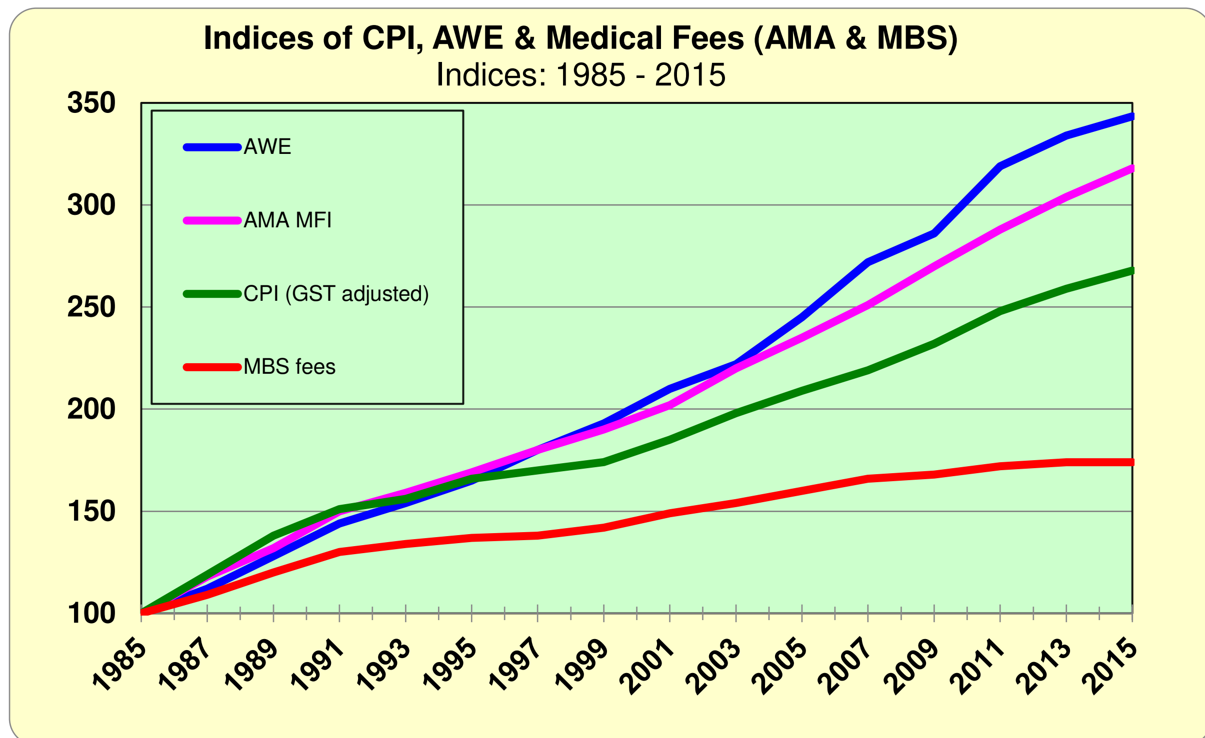
Some insurers will not provide their above-MBS component if the doctor does not accept the combined Medicare-PHI rebate as the full fee. The patient will receive only 100% of the MBS Fee as their rebate, and their OOP expense will be higher as a result. NIB is the only remaining insurer which applies this policy universally. Other insurers will decrease the rebate to 100% MBS if the OOP exceeds a certain amount, or if the account for the service is not presented in the way the insurer requires. All of this creates a large amount of needless complexity, and uncertainty regarding the rebates to which patients are entitled. It also serves to increase OOP expenses to patients, often on the basis of nothing more than an administrative matter.

The ASA strongly submits that all insurers should provide their above-MBS rebates to all patients, regardless of the fee charged by the doctor, and regardless of the method of billing. This would be a significant step forward in creating certainty for both patient and doctors, and in improving informed financial consent (IFC) processes. Insurers cannot criticise the medical profession on the issue of IFC, and the level of OOP expenses, if they continue to place detailed but highly variable terms and conditions on their above-MBS rebate schedules.

The ASA, as well as other medical bodies, has for many years repeatedly pointed out to governments, consumer groups, the media, and other bodies, the primary reason for the existence of OOP expenses for doctors' fees. The problem lies with Medicare and PHI rebates, and their pattern of inadequate and failed indexation, over many years.

For over 30 years now, MBS rebates for medical fees have been inadequately indexed, year after year. They have also been frozen since 2012, and indexation (even at the inadequate levels of the past) will not be fully reinstated until 2019. Figure 2 demonstrates the result of these three decades of poor/frozen indexation. It is essential to note that the costs of running a medical practice have certainly not been subject to low indexation or freezes. They have continued to rise, year after year, and the method of indexation of the AMA fee schedule does in fact takes this into account, as well as indices such as Average Weekly Earnings and the Consumer Price Index. Originally, the MBS Fee and the AMA fees were the same. The ASA continues to support the AMA fee as a reasonable maximum to be charged. The fact that the vast majority of doctors discount their fees to far less than this level for many patients, in order to protect them from OOP expenses, must be acknowledged.

Figure 2. AMA Indices Chart



(Source: Australian Medical Association)

PHI rebates have also been subject to repeated inadequate indexation, and many insurers have followed the MBS freeze. At the same time, the majority of Australian PHI customers are now covered by "for-profit" insurers, and the PHI industry is enjoying profits of over $1.6 billion per annum.

The ASA has no doubt that these facts are well known by the key stakeholders who are responsible for this situation, but levelling the blame at the medical profession is clearly much easier than accepting the facts. The ongoing "blame game" also conveniently serves to distract public attention from the agendas of those responsible.

Insurers, politicians, the media, and other groups regularly criticise the medical profession for its supposedly poor IFC processes. The ASA submits that, given the criticisms levelled at PHI companies by the ACCC (above) and the fact that two major companies are facing legal action by the ACCC, PHI companies and their lobbyists should examine their own practices before criticising others.

However, it is also essential to examine the evidence regarding OOP medical expenses.

According to APRA data[3], for the quarter ended March 2017, 86.6% of in-hospital medical services were provided at no OOP expense to the patients. With a further 5-6% provided according to a "known gap" arrangement, where IFC is compulsory, this only leaves approximately 7% of services where there may have been an OOP expense to the patient, and where IFC may not have occurred. Genuine IFC failure where there is an OOP is clearly uncommon.

This is not to say that these patients are not deserving of best possible IFC practices. They clearly are. The ASA has, for many years, strongly urged and assisted anaesthetists to adopt

best practices here. The improvements in anaesthetists' IFC practices have been acknowledged by independent parties such as the Private Health Insurance Ombudsman.

Insurers and consumer groups, among others, have also called for greater "transparency" regarding doctors' fees. It has been suggested that online publication of doctors' fees would be of value. However, it is important to note that doctors do take patients' individual circumstances into account when deciding on an appropriate fee. Publication of the fees charged could therefore be quite misleading. Just because one patient is charged a certain OOP fee for a service, does not mean that the next patient will be charged the same fee – they may well pay less, or nothing at all. Publication of fees could also discourage doctors from accepting more difficult or complex cases, where unexpected extra services may be needed, involving more than one doctor. The best approach is to encourage patients to ask for information on fees, and to continue to encourage doctors to adopt best possible IFC practices.

If information on individual doctors' fees and OOP expenses are to be presented, consumers should be given all relevant information, including the AMA graph of Medicare rebates vs. indices of inflation.

"Transparency" regarding financial information goes both ways. The ASA notes that insurers' rebate schedules can be difficult to find, and that again, insurers could examine their own practices rather than criticising others. Furthermore, given the massive profits being enjoyed by the industry, it would be reasonable for consumers to receive information on the salary packages of insurance company executives, in order for consumers to see where their premiums are being spent. Expenditure of consumers' health insurance premiums on medical services is certainly not a major issue. For some years now, expenditure on rebates for doctors' services has been steady, at a rate of only 16-17% of total PHI company expenditure.

<u>Summary</u>

The ASA welcomes this inquiry by the Senate Community Affairs References Committee. Australian health consumers must be encouraged to purchase private health insurance, in order to relieve pressure on the public healthcare system. As such, the affordability of health insurance is an essential issue. However, at the same time, it is extremely important that consumers are fully aware of the extent of their insurance coverage, and in particular, any services which may be excluded. At present, this is simply not the case.

In a system in which Medicare and private health insurance rebates for medical services have been inadequately indexed for decades, and are now subject to a prolonged freeze of indexation, out-of-pocket expenses are inevitable. That they continue to apply only to a minority of services is testament to the generosity of the medical profession, in that patients' fees are being discounted to well below their true worth, in order to protect patients from even higher expenses, and to ensure treatment is received. The Medicare system has been treated poorly by governments of all political persuasions for many years, and there is a lack of transparency regarding health insurance products. Attempts by non-medical stakeholders to distract from their own poor performance and from their own agendas for financial or political gain, via repeated criticism of transparency regarding doctors' fees, are entirely inappropriate when the real facts are considered.

References

1. Private Health Insurance Administration Council/Australian Prudential Regulation Authority. Available online: https://www.apra.gov.au/PHI/Publications/Pages/Industry-Statistics.aspx
2. Australian Competition and Consumer Commission "Communicating Changes to Private Health Insurance Benefits for the period 1 July 2014 to 30 June 2015" Report, 31 October 2016.
3. Australian Prudential Regulation Authority "Private Health Insurance Quarterly Statistics March 2017", 16 May 2017.

Yours sincerely

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