Private Healthcare Australia
Better Cover. Better Access. Better Care.

MSAC Consultation Survey – Application 1799

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About Private Healthcare Australia

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have 21 registered health funds throughout Australia as members and collectively represent 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for over 14.4 million Australians.

1. What is your organisation's experience with the proposed health service or technology. Or with the related health condition?

Private Healthcare Australia (PHA) is the peak body for private health insurance (PHI) funds who represent more than 15 million Australians. For members with hospital cover, PHI covers hospital procedures that have valid MBS item codes. Although TTVR is currently not funded by PHI (due to no MBS and evidence assessment), PHI currently funds other surgical interventions for members with this condition, including open heart surgery and rehabilitation. Current diuretics delivered through optimal medical treatment are not funded by PHI. While the detail is always lacking in MSAC applications, the expectations with this request will come with a significant medical device cost for a replacement valve. While this device component is not mentioned beyond a brief note in the PICO, PHA has little doubt that, irrespective of clinical risks, the total cost of this device makes it not cost-effective.

2. Is the proposed population(s) for the health service or technology appropriate?

Were the procedure to be approved for funding the proposed population would be appropriate.

3. Is the proposed approach to delivery of the health service or technology appropriate?

Information provided in the MSAC and PICO is substantially understated regarding the true cost of providing the proposed treatment to the greater health system. The '$1,800' quoted for the new MBS item is only a minor component of the true cost of this surgery. While the full costs are not provided, we note that in an overseas review, Tricuspid valve replacement surgery is listed as the 9th most expensive surgical intervention in the USA, with an average cost of US$82,631 (A$133K) per patient. We would, therefore, anticipate the cost in Australia to be comparable (i.e. 74 times the rate of the MBS itself). As a significant contributor to PHI through the PHI Levy, the actual contribution of taxpayers for this intervention is substantially higher than what is quoted in the PICO.

The outcomes differences provided between the EVOQUE Edwards product and the current effectively "no cost" optimal medical therapy within PHI also appear limited. Although there appear to be marginal gains in heart failure hospitalisation reduction, quality of life scores etc, these are offset by the higher early mortality risk and substantial increase in cost. Table 3 (p16

of the PICO) also shows the number of other MBS items incurred in addition to the new MBS item proposed (these costs must also be considered in this review, as none of these are incurred if current standard of care in optimised medical treatment - OMT is continued).

PHA has noticed an increasing number of high-cost devices being presented in recent years, particularly in cardiac, for often late or end stage treatment. This is making it increasingly harder to keep PHI affordable for the vast majority of members, especially under the current cost-of-living crisis. While PHA and member funds are always empathetic to those suffering advanced disease, all participants in our health system, including MSAC, have a duty of care to provide clinical and cost-effective treatment. Yet there is limited evidence that the EVOQUE device is clinically effective and no evidence it is cost effective.

In recent years health insurers have been required to fund AF on the Prescribed List (PL) along with TAVI. In both cases, the predicted burden of volumes based on "access of qualified sites" as covered in PICO and HTA reviews has been far exceeded in actual surgery observed (with the first 3-5 years). A PL listing and a valid MBS creates a very low burden on device suppliers and providers to ensure treatment is restricted to patients where a potential HTA outcomes is achieved. With this device, and the impact cohort/reported outcomes, it is likely that no surgeries performed would be considered clinically and cost effective should this MBS application be approved.

While PHA and member funds are always empathetic to health conditions of the privately insured, the outcomes presented from the TRISCEND/TRISCEND II trials and the substantial cost of multiple surgeries cannot justify funding this procedure given the implications it will have on premium costs for all insured Australians.

The PICO identifies a potential 25,500 eligible patients for this MBS and procedure if funded. Using a conservative base of $125,000 for total hospital and device cost then the potential exposure of this is $3.2bn to PHI against a current annual spend as reported by APRA of $18.7bn for ALL procedures (5.1m procedures). While it is clear not all eligible patients would elect or could have the surgery delivered in the first year, the impact of even a small percentage of members in such a high-cost disease state would substantially add to the cost of premiums for all Australians. There are already over 4,000 TAVI cases being performed annually, which is well above the original claimed intervention rate projected by MSAC and HTA experts employed by MSAC, just a few years post MBS approval.

4. Does the comparator(s) set out in the application accurately reflect Australian clinical practice?

Yes.

5. Does the organisation agree with the outcomes as set out in the PICO?

Outcomes should be reported consistent to the TRISCEND and TRISCEND II data. PHA accepts there are modest improved outcomes across a number of measures, but notes there was also an increase in immediate post-surgery mortality (this is a membership group that are almost

exclusively in the later year of life, many of whom will spend much of that time in a hospital post this surgery, if approved).

What this PICO does not address is the cost to achieve these modest clinical outcomes. The PICO set on p.11 also claims 'Subgroup analysis suggests patients with better baseline functional capacity derived greater benefit'. Again, PHIs have observed in separations that following approval for narrow indications such as with TAVI and Mitraclip, the sponsors routinely come back seeking to open conditions further (usually 2 years later) to maximise their revenue, increasing the cost to the health system. This results in substantial increases in premiums for all health insurance members. High value procedures for older members need to be covered under our community rated system by all insured members. This procedure does not deliver value to the system when assessing the outcomes vs the costs.

6. Where the application is for an item on the Medicare Benefits Schedule, does the organisation want to comment on the proposed item descriptor(s)?

PHA supports clinicians making the required descriptor where an MBS item is approved. But we note that the descriptor covers metrics that are not going to be visible to insured members or health funds so would largely be based on trust. Experience suggests certain providers and clinicians are likely to perform these surgeries at a higher rate that their colleagues, driven by economic rather than clinical benefit.

7. Where the application is for an item on the Medicare Benefits Schedule (MBS), does the organisation support the proposed fee for the health service or technology?

No. The evidence, while it may be assessed as value for an MBS of $1,800, it is not a cost-effective procedure. In reality, it is estimated to cost more than $125,000 for the intervention, compared with the outcomes achieved with effectively zero-cost diuretics under optimal medical therapy.

8. If MSAC supported the proposed health service or technology, would the organisation want to see it implemented? If yes, what would have to happen for this to occur? If no, why not?

No. As above, the outcomes from the reported study are not consistent with HTA value against the high cost that would be funded by the greater health system, private health insurance in particular.

With a requested MSAC rate of $1,800 against a likely cost of more than $125,000 for the procedure, the surgeon's fee is a comparatively small amount of real intervention cost. The cohort of members requiring this surgery are both aged and have other comorbidities that influence any long-term outcomes from the interjection of this surgery.

The small number of members who may benefit from this surgery based on the clinical outcome, are massively overrepresented by the remainder of PHI members who would potentially incur a substantial increase in annual premiums to fund this low value care.

The Department of Health and the Health Minister are well aware of the balancing act of facilitating access to high-cost debatable value procedures against the number of members likely to exit PHI should premiums rise by more than 4 or 5% because of health inflation.

This reality is consistent with all payers (PHI and government) being forced to make HTA decisions based on value against the risk of losing members from high premium rises during the ongoing cost of living crisis Australians are living through.

9. Does the organisation support public funding for the proposed health service or technology, as it is proposed to be delivered?

We do not support.