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# Assignment of Benefits for Simplified Billing – Regulations and System Changes

## PHA Submission

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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 more than 20 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 15 million Australians.

# Introduction

PHA appreciates the opportunity to provide feedback on proposed amendments to the *Health Insurance Act 1973* (HI Act) to enable regulation and system changes to facilitate the new assignment of Medicare benefit requirements for simplified billing services.

Any significant system changes take time for health funds to implement, so we request that the Department continue consulting with stakeholders ahead of the *Health Insurance Legislation Amendment (Assignment of Benefits) Act 2024* (AOB Act) coming into effect in January 2026.

# Responses to guidance questions

## Online Eligibility Check Web Services

*• Are the current information inputs and outputs in the Online Eligibility Check web service sufficient for a hospital or medical practitioner to determine whether the patient has a complying private health insurance policy (CHIP) that provides coverage for the service, enable good informed financial consent (IFC) discussions to be conducted, and to facilitate a valid assignment of the Medicare benefits?*

The online eligibility checking is insufficient for obtaining informed financial consent (IFC) and, therefore, facilitating a valid assignment of the Medicare benefits. This is because the OEC is not a quoting system. It provides basic patient verification information only, such as:

- whether the individual is a member of a health fund
- if the member is financial with the health insurer
- any applicable waiting periods
- any excess that applies, and
- if the item number or clinical category code used to conduct the eligibility check is valid.

Most providers do not even have access to comprehensive fund check capabilities that enable them to confirm whether a particular service is covered under the patient's policy. The lack of access to accurate, contemporaneous fund check and eligibility data through existing vendor systems means the proposed amendment to the regulations for the simplified billing assignment process may present significant challenges for hospitals, medical providers and patients.

OEC provides information to support a hospital or medical provider obtaining IFC (i.e. the development of a quote) and, as part of this process, a valid assignment of Medicare benefits. But obtaining IFC requires additional information, such as:

- the hospital or medical charges
- whether the doctor or hospital has an agreement with the private health insurer, and
- whether the doctor will charge in accordance with a Medical Purchaser Provider Agreement (MPPA), or under a 'no gap' or 'known gap' scheme.

Even though patients and providers might believe they are following the correct procedures, they may be operating with incomplete data. As a result, the integrity of the IFC process is undermined, which could lead to billing discrepancies that do not align with patient expectations. This, in turn, may diminish the effectiveness of the proposed accountability mechanisms within the simplified billing assignment process.

In addition, for certain medical services (e.g. pathology), the assignment of benefits cannot be completed before the service is provided. These services are often dependent on the dynamic needs of the patient, particularly during hospital admissions, where tests may be repeated on multiple occasions. In such cases, patients may not be aware of the specific MBS items to be used in advance, or they may not be fully aware of the services being rendered, which could further complicate the assignment of benefits process.

Solutions will need to be found for these challenges before the AOB Act and proposed regulations and system changes take effect, to ensure the integrity of both the IFC and assignment of benefits processes, thereby maintaining transparency and accuracy in billing practices.

*• Should the list of presenting illness codes include all legislated clinical categories?*

Yes, MBS-based illness codes should be available for eligibility checking, except Common and Support items, which can apply to multiple clinical categories.

Clinical categories such as "Lung and chest" should be available to conduct eligibility checks for those services where there is not a principal MBS item number e.g. pneumonia.

*• Which request and insurer response fields in OEC should be amended, introduced, or removed?*

PHA acknowledges that assignment of benefits should be part of the admission process. But, as noted above, OEC is the process of the hospital determining the eligibility of the service provided to be covered by the member's product. Health fund members may or may not proceed to admission or make a private patient election.

## Assignment Declaration in Claim

*• What is the impact of the mandatory assignment of benefit declaration on the organisation and billing or claims processing software?*

The impact of the mandatory assignment of benefit declaration for funds on claims involving Implied Assignment should be low. The record of consent should be captured in a new ECLIPSE field within the medical claim for which the Medicare benefit is being assigned.

It is likely to be more difficult to manage when the assignment is via Request Pathway. In that situation, the hospital is attesting "as part of the claim that they have satisfied the requirements of legislation as it relates to the assignment of benefit". A record of this attestation would need to be received by the health fund so they could cross-reference it with the associated medical claims. But the ECLIPSE hospital claims messages references the MBS only as they relate to the hospital services and the hospital claim. This is a separate transaction to the medical claims, which are received independently of the HCL transaction. Many common medical services are provided during the hospital stay but do not form part of the hospital claim transmission. A solution will need to be found for this ahead of the commencement of the AOB Act.

## S20AAA(1) 'Implied' Assignment Pathway

*• Are practitioners providing services in public hospitals to private patients eligible for medical gap cover arrangements, purchaser provider agreements, or any other insurer arrangements?*

Yes, practitioners in public hospitals have access to 'no gap' or 'known gap' schemes or Medical Purchaser Provider Agreement (MPPA) arrangements.

## Regulations for s20AAA(3) 'Requested' Assignment Pathway

*• Medical practitioners (surgeons, assistant surgeons, anaesthetists, pathologists, and radiologists, etc.), hospitals, and organisations are invited to provide examples of how and when IFC discussions are facilitated. If IFC is not provided to the patient or assignor, stakeholders should also advise under which circumstances these apply.*

The Department has noted a requirement for 'Improving eligibility checking and informed financial consent processes to support assignment of benefit requirements'. This is particularly important for public hospital admissions, as there are significant deficiencies in many public hospitals' current processes for obtaining IFC in relation to private patient elections.

Health fund members are routinely urged by public hospital staff to sign forms when the patient's ability to properly understand the ramifications is compromised. In these circumstances, many patients are unable to appreciate that they are signing a legal contract while they are still in the emergency department in significant pain or duress, and/or under the influence of strong medication.

Private patient election forms are also routinely completed by hospital staff, or they are signed by the patient before IFC has been obtained, and/or the medical services have been outlined in the forms. For example, the correspondence below was recently received by a policy holder of a PHA member fund, which demonstrates how the current process is being abused by public hospitals:

15 February 2025

To. [redacted] CLAIMS ASSESSMENT.
Attention Health Claims Assessor.

Subject: Irregularities involving RAH Patient Election Form Dear

I refer to your letter of 25 January 2025 containing a copy of the Patient Election Form and your Hospital Questionnaire. I have included this letter with the questionnaire to advise you of my experience with **RAH** practices which, in my view, appear questionable and may impact on your own policies.

On 29 [redacted] I was admitted to the **RAH** through the Emergency Department (ED) following a heart attack. After being stabilized I was transferred to a Cardiac ward. Following further tests I was informed I needed open heart surgery to occur on [redacted], to be performed by **RAH** Cardiac surgeons.

On 31 [redacted], I was approached by a **RAH** representative who asked if I was electing to be a private patient. I informed him I was admitted through the ED as a public patient. He appeared to agree but added as I had private insurance that RAH goes through this process in order that private insurance companies may make a so called "contribution" to the public health system. I was more worried about my upcoming surgery and not really focused on this. However, I did sign the form but only because I accepted his "altruistic" explanation. I did note the form was mainly a blank with just my name etc on the top.

On receiving a copy of the form from you, I observed several items had been filled out after my signature and not in my presence. These included:

- That I requested to be treated by a Dr [redacted] (who I don't know or even met)
- That I chose not to be treated by the doctor on duty. and requested a private room.

These items are false and I am not really sure as to the ethics of this process Could you provide clarification of these practices please

Yours faithfully,

In addition, forms are often signed by other people who have no legal authority to sign on behalf of the patient.

Staff at many public hospitals also encourage – and often pressure – privately insured patients to elect to use their health insurance, demonstrating scant regard for the rights of the patient to make an informed choice about the funding for their care. This is usually without explaining to the patient that patient election form is a legally binding contract.

For these reasons, a more formal process should be implemented for private patients in public hospitals to ensure the integrity of the assignment of Medicare benefits.

*• Feedback is sought on the assignment particulars and the standardised wording proposed to facilitate the assignor's request to assign their Medicare benefit to the insurer or billing agent via the medical practitioner, hospital, or organisation.*

Nil comment.

*• How do practitioners and hospitals manage post-service IFC processes in instances where there is a complication, unplanned treatment, or modification to the service originally planned?*

Nil comment.

*• For the description of treatment and services part of the request, feedback is sought on the level of specificity that accurately conveys what the service or treatments are and reasonable accommodations (i.e., descriptions of a technical nature may require modifications to the original assignment request or multiple assignment requests).*

Nil comment.

## Record-keeping

*• Stakeholder feedback is requested on the list of documents that the relevant stakeholder should keep. These documents provide the basis for an 'implied' or 'automatic' assignment under s20AAA(1) or a 'requested' assignment under s20AAA(3) and is proposed to be included in the HI Regulations 2018.*

Nil comment

*• Stakeholders should consider records that are already being kept or are required to be kept in providing feedback on the proposed list of records set out in pages 14 and 15.*

Nil comment

## Claims Payment

*• For insurers, are there timeframes for claims processing and claims payment to the provider after they have submitted the claim to the insurer or after the insurer has received the ECLIPSE claim?*

There are timeframes for claims processing and claims payment to the provider after they have submitted the claim to the insurer, or after the insurer has received the ECLIPSE claim, but these are minimal.

*• In which circumstances are claims paid later than 6 months from the day the insurer receives it?*

It is rare for claims to be paid later than six months of receipt. However, payments may be delayed beyond this timeframe in specific circumstances, such as if:

- the claim has been submitted late by the provider(s)
- the fund is waiting for an associated hospital claim to be submitted to support the claim
- it is submitted with an incorrect service date, and
- it has been rejected due to missing or insufficient clinical notes.

*• Do insurers provide notification if there is a delay in the claims processing or benefit payment?*

Yes, insurers usually provide notification of a delay in the claims processing or benefit payment. And providers will generally chase up any delay in payment.

## Notification

*• Stakeholders are invited to provide feedback on:*

*o billing agent and insurer timeframes for notification to patients*

Health insurers only send the statement of benefit to the provider rather than to the patient, largely due to the high risk of misinterpretation and the lack of knowledge and understanding members have of the services they may have received and the claims process.

Patients may not be aware of certain services provided, such as pathology, assistant surgeons, or ICU consultants. This lack of awareness can lead to confusion, concerns about billing and even complaints. In some cases, members may question the validity of services they have legitimately received, potentially resulting in Governance, Risk, and Compliance (GRC) incidents related to billing.

*o confirmation if their organisation conducts this notification process, and*

*o the method this notification is provided to the assignor (e.g., physical letter or electronic means, etc.).*

*• For insurers and billing agents, is the statement of benefits generally sent to the patient, the assignor or another individual related to the patient?*

Nil comment.

## IFC and Financial Disclosures

*• Do stakeholders provide patients with a copy of informed financial consent documentation at each instance of IFC or only if requested?*

Nil comment.

*• Stakeholders are invited to provide the department with copies or templates relating to the assignment of a benefit, benefit statements, or similar documentation that they provide patients.*

Nil comment.