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

Private Healthcare Australia Federal Budget submission

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Introduction

This will be a tough Budget, with tough choices facing the government. Australia's economic position has deteriorated over recent years. Debt and expenditure are higher, worldwide inflation is at the highest rate in a generation, and real wages are falling. The foundations of the Budget are not sound, with structural issues predating the pandemic. The Government has inherited a Budget position that is very different than was known at the time of the election just twelve months ago.

There are two key issues in health that the government must address urgently:

- Cost of living pressures on families, and
- Relieving pressure on the health system.

Both objectives can be met by government addressing areas where consumers are paying too much for health care and redistributing those savings to other areas of need within the health system.

Summary of recommendations

PHA recommends that the government:

- introduce a standing committee to combat fraud, miscoding and low value care
- reduce the over-pricing of medical devices to the same as the public sector, then commission the ACCC to review a better way forward to prioritise consumer interests
- abolish second tier default benefits
- allow private health insurance to support specified primary care programs approved and monitored by general practitioners
- legislate to hold consumers not liable for costs not disclosed beforehand
- allow Services Australia to inform other payors of fraud and overpayments
- increase the Medicare Levy Surcharge, and
- increase the Private Health Insurance Rebate for people on very low incomes.

Context

Over 14 million Australians hold private health insurance, with over $25 billion paid in premiums. The Australian Government supports these customers with over $6 billion paid through the Private Health Insurance Rebate (PHIR). As described when Medicare was designed by the Hawke Government to incorporate private health, Australia relies on a strong private sector to provide choice and access, and importantly, reduce pressure on Medicare.

Medicare is almost 40 years old. The principles of Medicare are sound, but the system is old and clunky. PHA calls on the Australian Government to recommit to a more modern Medicare system, building on the values articulated by the Labor Government in 1983 and applying those values to current consumer needs.

Those values include:

- Simplicity
- A progressive redistribution of funding to support those in need
- Ensuring fairness and access for all
- Supporting general practice as the cornerstone of health care
- Using a balance of public and private funding

Changes to Medicare over the last few years have not taken account of the original values. Rebates have been frozen. Support has shifted from supporting general practice to supporting specialist care. This has damaged the progressive nature of the system, as specialist care is more accessible by the wealthy due to geography and cost. This has also damaged access and fairness.

When introducing Medicare in 1983, then Health Minister Neal Blewett noted, "The more complex a health scheme, the more likely it is to favour the well -off, the articulate and those capable of manipulating a complex system."[1]

In recent years, provider interests have been prioritised over consumer interests. Multinational device companies, hospital groups and some specialist groups have benefited from regulatory constraints entrenching the status quo. The benefits of innovation and convenient community-based care have been compromised, as have general practice and allied health care. Some large commercial interests have profited enormously, while small medical practices struggle, and consumers pay more out of pocket.

Medicare originally emphasised fairness and equality, designed to "make health insurance fairer and affordable to every Australian because everyone will contribute towards the nation's health costs according to his or her ability to pay."[2] This objective has been compromised by increased income inequality and a declining proportion of health funding covered by the Medicare Levy. While noting that people on higher incomes pay more tax, the progressive nature of Medicare has been eroded over time.

For the most part people with private health insurance are not rich - 42% have a taxable income of $50,000 per year or less and 10% of these are on the aged pension as their only income.[3] They are all however trying to do the right thing by making a direct contribution to the cost of their health care. Without this contribution our world-class health system would fall over.

It is well recognised a strong private system supports the public health system – inequity is often greater in entirely public systems. Pressure on the primary care sector affects hospitals. Pressure on the private system affects the public system, and vice versa.

Australian consumer research shows clearly consumers want lower premiums, access to high quality care, and lower out of pocket costs. These objectives are consistent with system improvement, addressing access and quality for people with private health insurance and those relying wholly on the public system.

[1] Hansard, 6 September 1983
[2] Hansard, 6 September 1983
[3] Australian Tax Office figures, 2022

When considering health financing reform, the Government needs to ensure that public value is paramount by imposing discipline and rigour. It will take courage to take on the vested provider interests in healthcare, but the nation can no longer afford to allow so much wastage in our health system.

While there will be arguments about the scale of the problem, there is fraud, systematic inappropriate claiming and many areas of low value care in Australia's health system. No level of fraud is acceptable, and we must collectively focus on eliminating miscoding and low value care.

As the private health industry is currently overregulated and therefore inefficient, cost and value objectives can be addressed without reducing quality care. The Federal Budget can reduce direct costs to consumers, increase the value of private health care, and improve the targeting of subsidies supporting care.

Addressing waste

PHA recommends that the government introduce a standing committee to combat fraud, miscoding and low value care.

Estimates of the prevalence of low value care in Australia indicate a significant issue for consumers, funders and governments. Braithwaite et al (2020) notes, "While change is everywhere, performance has flatlined: 60% of care on average is in line with evidence- or consensus-based guidelines, 30% is some form of waste or of low value, and 10% is harm."[4]

PHA identifies three key aspects of low value care:

- **Fraud**, where monies are claimed for a service that did not occur. We consider fraud to be rare in Australia. PHA recommends that payors, governments and consumers adopt a zero-tolerance policy to fraud.
- **Miscoding**, where a provider chooses the more favourable description of a service where the descriptors are open to interpretation. In a fee for service model such as Australia, miscoding is endemic among some providers.
- **Low value care**, where there is low benefit (or risk of harm) which do not outweigh the costs of the procedure. Importantly, dollars spent on low value care are not productive.

The definitions of low value care are contestable and estimates of the prevalence vary significantly. Regardless of the scale of the problem, fraud, miscoding and low value care should be eliminated to maximise public benefit.

Private health insurance is particularly prone to miscoding and low value care. There can be a culture from some providers that views private health insurance as a cash cow to be exploited. More widely there has been a culture in the private health sector which is defined by moral hazard, and views private health funds as 'passive payors' whose funding is an entitlement for providers and not fund members.

Private health insurance funding is also highly contested compared with other funding models in health, with powerful vested interest groups like medical specialists, multinational device companies and hospital companies all vying for their share of the pie. In an inflationary environment it is critical

[4] At https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-020-01563-4

that every dollar spent in this sector is productive and adds measurable value. Too often historical funding models under the health portfolio compel expenditure in ways that are wasteful and even harmful.

While the use and misuse of Medicare is a central component of low value care, the associated expenditure (including hospital rebates and medical device rebates) are often higher and can show greater variance. The issues extend beyond Medicare – they include a range of harmful regulatory protections that lead to care which is expensive, wasteful and drives up costs for consumers.

In many of the examples identified by PHA, there are a small number of providers who use the funding system imposed by government in ways that are different to their peers, in order to maximise their personal benefit. This is not confined to the private system; de Oliveira Costa et al (2021) identified a handful of public hospitals in NSW that provide higher rates of low value care to private patients (although differences were not significant overall).[5] Most providers follow the evidence; a small number are disproportionately influenced by the funding available.

There are several studies available highlighting low value care, including several in the Australian context. The work of Choosing Wisely and the Australian Council for Quality and Safety in Healthcare (ACQSHC) highlights areas of low value care, and Australia has a strong academic and professional capacity to identify and anticipate loopholes in Medicare and regulated PHI funding which are vulnerable to exploitation.

Reducing low value care is important across the health sector. For the 14 million Australians with private health insurance, some of the key areas of low value care are highlighted in the appendix.

An expert committee tasked with addressing fraud, miscoding and low value care should be established. The terms of reference would include:

- Providing advice to the ongoing Medicare Services Review
- Identifying regulatory barriers to best practice care
- Promoting minimally disruptive medicine
- Providing advice on common coding errors to ensure best practice
- Reducing patient harm, including financial injury, and
- Decommissioning low value care

One underutilised tool at the government's disposal is the HCP1 database, which tracks all expenditure for an intervention in the private sector (Medicare, out of pocket costs, hospital rebates and device rebates). Utilising these data to determine outliners and issues of concern should be a priority for the proposed standing committee.

It often takes many years or decades to reduce or eliminate low value care. However, it can be done. For example, knee arthroscopies used to be very common in Australia, but hard work from academics, strong clinical leadership and government action has reduced the incidence of this essentially useless procedure dramatically in recent years – saving consumers millions of dollars and much pain and suffering.

[5] At https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786996

If best practice care was enforced for the examples in the appendix, consumers would save more than $330 million per annum, with the Federal Government saving at least $80 million each year.

These changes would address cost of living pressures and meet the Government's election commitment to reduce waste and rorts.

Reduce costs

The simplest way for government to reduce pressure on health insurance premiums is to remove government legislation that keep costs high.

Prostheses List

PHA recommends that the government immediately reduce the over-pricing of medical devices to the same as the public sector, then commission the ACCC to review a better way forward to prioritise consumer interests.

Australians pay 30%-100% more than people in other countries for commonly used generic medical devices.

The previous government's policy was that Australians should pay more for medical devices than people in other countries.

The unilateral deal signed by the previous health minister with multinational device companies requires Australians with private health insurance to pay higher prices for medical devices than Australians without private health insurance. The previous government introduced a 7-20% surcharge for private patients over the public price of medical devices. No economic justification for this has been provided.

The Albanese Government has the opportunity to scrap the unilateral deal made by the previous minister in the last days of government with medical device companies, which transfers $250-$400 million from health fund members to multinational device companies. This will reverse policy settings that see Australians paying higher prices than any other country for medical devices, costs the budget and locks in higher premiums for 14 million policy holders.

Dropping this deal would reduce private health insurance premiums by around 50 basis points and save the Federal Budget around $80-100 million over the next four years.

If the government continues with previous government's deal with the multinational device companies for the term of the agreement, it should immediately begin work on ensuring consumers are better protected from 2026.

A review of the program should be commissioned which is truly independent, objective and not subject to lobbying or capture by those who stand to benefit financially from maintaining the status quo.

The review should be conducted at arms-length by the ACCC under Part VIIA of the *Competition and Consumer Act 2010*. This will allow the Government to make an informed assessment of the program and how it operates, based on evidence, data and facts alone. Further, conducting an inquiry under Part VIIA will empower the ACCC to exercise its extensive statutory powers to obtain information or documents, and to compel potentially reluctant witnesses to answer questions on oath.

This inquiry should examine the following issues caused by the over-pricing of generic medical technology:

1. The impact on consumers of adding to the cost of surgery flowing through to premiums
2. Pricing of generic medical devices compared with those same devices in other countries
3. The distortion of markets caused by poor controls on the activities of sales representatives and the undisclosed rebates, secret commissions and other benefits paid to doctors and hospitals
4. Additional costs of unnecessary devices that are being 'push-sold' by medical technology sales representatives being present in operating theatres, resulting in inflated overall costs to consumers of surgical procedures
5. Enabling multinationals to pay close to zero tax in Australia through transfer pricing against Protheses List benefits
6. The anti-competitive effect on Australian manufacturing of generic medical technology as the multinationals have secured lucrative supply chains (through payment of benefits to doctors and hospitals) such that local businesses can no longer compete
7. The inflationary impact on public hospital procurement and costs of the floor price set by the Federal Government, and
8. The economic and health risks created by inflated Prostheses List benefits, and the effects this has on the quality of care – noting, for example, the lives of Australians ruined by the upselling of pelvic mesh for an inappropriate indication and other examples.

A truly independent review by the ACCC, which sits outside the usual health sector interests and lobbyists, will be able to provide the Government with reliable data and economic analysis as to why the present Prostheses List program must change. That will then enable health funds to direct savings — running into billions of dollars — back to consumers or to high-value healthcare.

Reforms would mean cheaper private health premiums for consumers, a positive impact on the budget bottom line and a more transparent system.

These changes would address cost of living pressures and meet the Government's election commitment to reduce waste and rorts.

Out of hospital care

PHA recommends that the government abolish second tier default benefits.

Australia has very lengthy hospital stays for common conditions, relative to comparable economies and much more care is delivered in hospitals rather than in community-based alternatives. Part of the reason for these additional costs is outdated Commonwealth legislation that encourages in-hospital care and longer stays with minimum hospital benefits.

Removing, or at least reforming, minimum and default benefits paid for hospital care would reduce length of stay, improving efficiency and patient outcomes at a lower cost to consumers.

Depending on the reforms agreed, consumers could save up to $225 million per annum. This translates to around 75 basis points' reduction in premiums, and over $200 million in savings for the Federal Budget over four years.

Reducing perverse financial incentives for in-hospital care would address cost of living pressures.

Investing in primary care

PHA recommends that the government allow private health insurance to support specified primary care programs approved and monitored by general practitioners.

Bizarrely, the Australian Government prohibits private health insurance working with primary care. It is basic health economics that coordinating care is better for patients, and earlier intervention saves lives and health costs. Yet private health insurers are unable to fund primary care to help coordinate care or provide early intervention.

Private health insurers, patient groups and medical organisations are wary of allowing private health insurance to 'top up' common Medicare services, and medical groups warn of dangers if health insurers direct referrals to chosen providers. However, there are many other areas where private health insurers can and should work with primary care.

Insurers would like to work with primary care to improve access to a range of chronic health conditions, such as mental health and alcohol and drug treatment, joint health support, weight loss support, and heart health.

PHA recommends that, in the first instance, the government remove the prohibition on utilising primary care workers, mental health nurses and peer support workers by removing the approved provider list for chronic disease management programs.

Second, PHA recommends that the government allow health funds to directly support patients in primary care with programs approved by medical experts. These programs could cover treatment areas of concern to general practice, including mental health care, alcohol and drug treatment, and weight control and joint protection.

This initiative would increase income for primary care, better support patients, and in the longer term, reduce the need for hospitalisations.

Increase value

Good value health care involves the best possible information serving the consumer, and financial rewards reflecting best practice.

Eliminate surprising billing

PHA recommends that the government legislate to hold consumers not liable for costs not disclosed beforehand.

Out of pocket costs for consumers have been increasing over the last two years, partially attributable to the Morrison Government freezing Medicare rebates. Our data show that the vast majority of doctors describe out of pocket costs to their patients (informed financial consent).

Unknown out of pocket costs are one of the greatest concerns of people with private health insurance. While the vast majority of doctors and hospitals provide no-gap (or known-gap) services, some consumers experience very high out of pocket costs — and some patients are not told of the costs beforehand.

The United States has recently introduced surprise billing legislation, and Australia could learn from these consumer protections. PHA has released a detailed policy paper recommending surprise billing legislation in Australia (attached).

The key elements of the proposal are that patients should not be held liable for above-MBS schedule costs if they are not informed beforehand, and that doctors and hospitals should face civil or criminal penalties if they deceive patients, insurers or governments about their charges.

These changes would address cost of living pressures and meet the Government's election commitment to reduce waste and rorts.

Sharing information about fraud

PHA recommends that the government allow Services Australia to inform other payors of fraud and overpayments.

Private health insurers are vulnerable to fraud, and the Australian Government does little to assist. When health insurers inform Services Australia about billing mistakes and suspected fraud, Services Australia may determine Medicare payments were incorrectly paid and require the practitioner to repay the Australian Government. However, the current legislation prohibits Services Australia from informing the notifying health fund when it has taken action.

When this occurs, Services Australia is aware a provider has incorrectly billed a health fund but does nothing about it. This costs the fund, and thus the consumer as it leads to higher premiums. The Australian Government (and taxpayer) also lose out as they rebate almost a quarter of health insurance premiums, via the means-tested PHI rebate.

It is not known how much each year Services Australia reclaims from providers who bill incorrectly. On average, doctors who bill privately receive about 80% of the MBS rebate from the health insurer. Thus, for every $1 million that Services Australia reclaims for in-hospital care, consumers could benefit by more than $800,000 if Services Australia was permitted to inform the health fund. The Australian Government would also save $200,000 through the rebate.

These changes would address cost of living pressures and meet the Government's election commitment to reduce waste and rorts.

Improve subsidies

The Australian Government supports private health insurance through a range of incentives, as promoting private health insurance brings more funding into the health system and avoids overloading the public health system. Current subsidies are flawed, as many high income earners do not take out insurance, and the Private Health Insurance Rebate has steadily eroded over the last nine years.

Increase the Medicare Levy Surcharge

PHA recommends that the government increase the Medicare Levy Surcharge.

It is not fair that some very high income earners rely exclusively on the public system when they could afford to use the private system. High income earners crowd out others, meaning longer

waiting times. As the Medicare levy only covers a fraction of the costs of healthcare, the Australian Government encourages high income earners to take out private health insurance with a Medicare levy surcharge (MLS).

Over 300,000 high income earners pay the MLS – it is not high enough to influence behaviour. Research shows that very few of these people are true conscientious objectors to private health, most are simply unaware of this obligation.

Increasing the MLS by 100 basis points would encourage many more high income earners to take out private health insurance and Budget would save a net $170 million pa.[6] State and territory health systems would also benefit from a proportion of people seeking care in the private system rather than the public system.

Increasing the MLS surcharge would improve the Budget position and decrease pressure on the public health system.

Increase the private health insurance rebate for very low income Australians

PHA recommends that the government increase the Private Health Insurance Rebate for people on very low incomes.

Over 40% of Australians with private health insurance have incomes under $50,000 per annum. Cost of living pressures are biting hard amongst this group, and more support is needed for them to maintain their private health insurance.

Increasing the PHI rebate for singles earning under $50,000 and families under $100,000 by one percentage point would cost the Budget around $70 million directly (with lower net costs), saving families with a Silver policy an average $27 on their premiums each year.

Second order savings to Commonwealth and States and Territories Budgets from increasing the PHI rebate have a combined positive Return on Investment[7], as low-income earners leaving private health insurance will then create greater pressure on the public system.

Supporting private health insurance is the best way to ensure more access to elective surgery - elective surgery through the Private Health Insurance Rebate costs less than 30c in the dollar, while elective surgery funded through state-run public hospitals costs 45c in the dollar.

Restoring the rebate will address cost of living pressures and decrease pressure on the public health system.

Conclusion

During a long period of trending economic growth, Australian governments have rarely taken on the hard reforms. As the world become more unstable, this Budget provides and opportunity for the

[6] This net figure includes increased premium revenue and increased PHI rebate costs to government, with lower proportions of MLS collection at a higher rate. PHA has done extensive modelling on this policy proposal.
[7] The RoI for the Commonwealth alone is marginal, with assumptions on savings on additional payments to states under the NHRA probably not achievable in the current environment. There are significant savings to state and territory governments with a transfer of activity to the private sector.

Labor Government to take some of the hard decisions that have been squibbed over the previous decade.

There is a burning platform – high inflation, international conflicts affecting supply chains, and the changing climate affecting how and where we live. In health care, these issues are exacerbated by workforce pressures and the effects of previous decisions that did not emphasise public value. Taking on the vested interests in health is hard, but necessary if Medicare and our world class health system is to survive into the next decade.

Attachments

- Low value care
- Combatting Surprise Billing in Australia
- Improving default benefits in private care

Appendix one: Low value care in private health insurance

Over 14 million Australians hold private health insurance, with over $25 billion paid in premiums. The Australian Government supports these customers with over $6 million paid through the Private Health Insurance Rebate (PHIR). As described when Medicare was designed by the Hawke Government to incorporate private health, Australia relies on a strong private sector to provide choice and access, and importantly, reduce pressure on the public system.

There are two key streams of private health insurance – hospital cover (over $19 billion) and extras cover (over $5 billion), the latter covering dental and allied health services. The most significant factors contributing to premium increases are, in order, medical device prices, hospital costs, medical rebates and extras costs. This ordering reflects the regulatory environment, with higher levels of regulation strongly correlated with the impact on premiums.

Estimates of the prevalence of low value care in Australia indicate a significant issue for consumers, funders and governments. Braithwaite et al (2020) notes, "While change is everywhere, performance has flatlined: 60% of care on average is in line with evidence- or consensus-based guidelines, 30% is some form of waste or of low value, and 10% is harm."[8]

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The definitions of low value care are contestable and estimates of the prevalence vary significantly. Regardless of the scale of the problem, fraud, miscoding and low value care should be eliminated to maximise public benefit.

Private health insurance is particularly prone to miscoding and low value care. There can be a culture from some providers that views private health insurance as a cash cow to be exploited. More widely there has been a culture in the private health sector which is defined by moral hazard, and views private health funds as 'passive payors' whose funding is an entitlement for providers and not fund members.

Private health insurance funding is also highly contested compared with other funding models in health, with powerful vested interest groups like medical specialists, multinational device companies and hospital companies all vying for their share of the pie. In an inflationary environment it is critical that every dollar spent in this sector is productive and adds measurable value. Too often historical funding models under the health portfolio compel expenditure in ways that are wasteful and even harmful.

[8] At https://bmcmedicine.biomedcentral.com/articles/10.1186/s12916-020-01563-4

In many of the examples below, there are a small number of providers who use the funding system imposed by government in ways that are different to their peers, in order to maximise their personal benefit. This is not confined to the private system; de Oliveira Costa et al (2021) identified a handful of public hospitals in NSW that provide higher rates of low value care to private patients (although differences were not significant overall).[9] Most providers follow the evidence; a small number are disproportionately influenced by the funding available.

There are several studies available highlighting low value care, including several in the Australian context. The work of Choosing Wisely and the Australian Council for Quality and Safety in Healthcare (ACQSHC) highlights areas of low value care, and Australia has a strong academic and professional capacity to identify and anticipate loopholes in Medicare and regulated PHI funding which are vulnerable to exploitation.

Reducing low value care is important across the health sector. For the 14 million Australians with private health insurance, some of the key areas of low value care are highlighted below.

Paying too much for medical devices

Low value care includes paying too much for goods and services when lower prices are available. The Australian Government has signed a unilateral Memorandum of Understanding (MoU) with the Medical Technology Association (representing the multinational medical device suppliers) which locks in high prices over the next four years. The Government's decision to grant high prices to medical device companies through the Prostheses List means consumers will be paying between $563-700 million more for the same medical devices in the private sector than they would in the public sector over the next four years.

In its annual report to the Federal Parliament on private health insurance tabled in the Senate in November 2022 the ACCC expressed concern about the inflationary impact on consumer prices oof the MoU.

Outside of the MoU, there are several initiatives that the Government is considering, or should be considering. The first is conditions on listing similar to the PBS and MBS, where rebates are available only when the medical device is used for the intended purpose (or when a medical practitioner deems it reasonable and necessary). This initiative would save consumers around $20-50 million per annum. Errors on the Prostheses List favouring manufacturers are also rife, and identified errors take months or years to fix.

Other areas which should be explored include better control of sales representatives' conduct through an ACCC enforceable code (similar to pharmaceuticals), implementing the Unique Patient Identifier proposed by the Therapeutic Goods Administration and requiring reporting of adverse events.

In addition, several categories of medical devices are strongly associated with low value care. The Department of Health and Aged Care is currently reviewing surgical guides and biomodels, neurostimulation devices, knee replacement components receiving a premium for revisions when used for primary procedures, human tissues products and several others. The evidence is building

[9] At https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2786996

for removal or significant restrictions replaced on the use of these products. Once the reviews are concluded, this should be undertaken without further delay.

Intravitreal injections in hospitals

Intravitreal eye injections are an outpatient procedure, that only rarely requires admission to hospital. The MBS Review found that at most 3% of patients requiring this procedure should have it done in hospital. At present the figure is 18% and growing. Unnecessary hospital admission appears integral to the business model of a small number of doctor-owned ophthalmology clinics (ten facilities account for more than half of in-hospital services). The Royal Australian and New Zealand College of Ophthalmologists (RANZCO) supports greater use of out of hospital settings.[10] Savings to PHI will be $75 million per annum and $15 million to the government (through the PHI Rebate).

This is an existing MBS review recommendation which was not implemented by the previous government.

Varicose veins

The MBS review made two recommendations on varicose veins which have been overturned. First, the MBS Review recommended that cosmetic procedures be prohibited. However, the previous government rejected this recommendation, allowing "discomfort" to be a clinical indicator for MBS funding. Second, the MBS Review recommended that the MBS items not allow co-claiming with venography services when required during varicose vein interventions – this recommendation was overturned in November 2022. This is likely to lead to more outpatient type procedures being performed in hospital and hence being funded by insurers.

Surgeons have written to PHA suggesting this will increase low value care. The data appear to back up these claims, with costs per procedure increasing by over 12% in five years. Reducing the average cost by 10% and reducing the number of services by 10% would save consumers almost $8 million per annum, with over $1 million saved by the Commonwealth.

Spinal fusion

Spinal fusion (excluding for congenital spinal deformities) is a controversial area of medicine, with several commentators describing it as low value care. The procedure is now rare in public hospitals, and the ACQSHC has highlighted inappropriate variations in practice in the private sector.[11]

In 2018 the government announced plans to stop surgeons billing Medicare for spinal fusions to treat uncomplicated chronic low back pain, only to reverse the decision in 2019.[12]

The original decision was based on the MBS Review (which is no longer from the MBS Review website), the ACQSHC report, and a Choosing Wisely recommendation – "Do not refer axial lower lumbar back pain for spinal fusion surgery."[13]

In Australia, rates of spinal fusion surgery increased by 167% in the private sector between 1997 and 2006, despite almost no increase in the public sector. Spinal fusion rates differ

[10] See https://www.choosingwisely.org.au/recommendations/ranzco4
[11] See https://www.safetyandquality.gov.au/sites/default/files/migrated/4.3-Lumbar-spinal-fusion-1.pdf
[12] See https://www.theage.com.au/national/the-government-tried-to-stop-this-surgery-then-surgeons-got-involved-20191220-p53ltv.html
[13] See https://www.choosingwisely.org.au/recommendations/fpm5

significantly between regions of Australia, with the highest being in Tasmania and the lowest in South Australia: a seven-fold variation.[14]

Spinal surgery is also a strong contributor to medical device spending, with significant increases in expenditure per procedure over recent years. Further, spinal surgeries often need to be repeated, with many patients requiring multiple procedures as the initial surgeries do not improve quality of life.

A 2018 review, conducted by spine surgeon Dr Roy Carey, of about 1200 private health insurance claims for spinal fusion revealed more than 85 per cent were inappropriately billed.[15] The miscoding in spinal surgeries has been partially addressed by the MBS review but needs monitoring and review.

The average cost of a spinal fusion operation is over $40,000. Reducing the incidence of spinal fusion (excluding spinal fusion for congenital deformity) by 20 per cent would save consumers more than $30 million per annum.

Type C certificates for consultations

There are a handful of hospitals (out of more than 900) that appear to have built a business model out of using Type C certificates, which certify that a patient needs to be hospitalised for a particular issue when it is generally not required. Fewer than 2% of hospitalisations use Type C certificates, yet one provider uses Type C certificates for over 90% of their services – all of which are consultations, not procedures. This is a type of fraud which is specific to private health insurance, but which also creates an incentive to overbill the MBS.

This hospital also hospitalises people for group consultation items (and appear to be the only hospital in the country to do so). For this hospital, health fund customers pay over $200,000 per annum extra for identical services.

The previous government promised action on this issue in the 2020 Budget but failed to implement any changes. PHA recommends that the government limit the use of Type C certificates to procedural MBS items in the first instance.

Rehabilitation in hospital

There is growing evidence that the best outcomes from rehabilitation for a range of procedures is done in home rather than in hospital. In Australia, financial incentives meant that prior to the COVID 19 pandemic in-hospital rehabilitation increased sharply with the creation of a number of standalone facilities. This meant patients were getting lower quality care at a higher price. During COVID, most of this shifted to at-home care with no change in patient outcomes. It is currently unclear whether the trend for in-patient rehabilitation will re-emerge as under normal circumstances there is a perverse incentive in private health regulation encouraging this, but there is no benefit in allowing this to happen.

[14] See www.safetyandquality.gov.au/sites/default/files/migrated/4.3-Lumbar-spinal-fusion.pdf
[15] See https://www.smh.com.au/healthcare/dracula-in-the-blood-bank-years-of-inappropriate-billing-for-spine-surgery-revealed-20221020-p5brbp.html

Furthermore, standards of care for inpatient rehab had been allowed to slip in uncontracted hospitals (receiving default benefits from health funds) with some patients receiving as little as 15 minutes of supervised physio per day.

Prior to the pandemic, 45% of private patients spent an average 15 days of hospital care for uncomplicated primary surgery such as a knee or hip replacement, while the standard in the public system and in other countries for these procedures is 5-6 days. If the length of stay was the same in the public and private systems, around $205 million would be saved from health insurance premiums.

PHA has provided detailed recommendations to the Department of Health and Aged Care, as has the Australian Faculty of Rehabilitation Medicine. These include ensuring a minimum standard of clinical care requirements for hospitalised patients before private health insurance benefits are payable.

Alcohol and drug treatment in hospital

Runciman et al (2012) suggested that only one in eight interventions for alcohol and drug treatment in Australia were evidence-based.[16] Recent guidelines published by the MJA in 2021 note, "In most cases, alcohol withdrawal can be safely completed in the patient's home (ambulatory withdrawal) if they have sufficient support," and "while there is evidence showing that residential rehabilitation reduces substance use during the residential program, its long term effectiveness is unknown."[17]

Despite the evidence promoting care in place, private health insurers must fund residential programs and are prohibited from funding many evidence-based community programs.

The Australian Government should remove barriers to out of hospital care by removing the list of prescribed practitioners allowed to provide services under a chronic disease management program, remove default benefits for hospital-based alcohol and drug services, which would allow funds to provide out of hospital services using trained GPs, allied health professionals and peer support workers.

Public hospitals harvesting private patients

Cost-shifting in the health sector is rife, and it gets worse when the sector is under economic pressure. While many informed consumers intentionally decide to be private patients in a public hospital, some providers establish procedures and business models to divert patients presenting to public sector emergency departments and outpatients to private funding options.

Some hospitals ask about private health insurance at emergency triage, which may lead some to believe that their care is conditional on providing private health insurance information. As many people attending ED are in distress, this is not a suitable environment for people to provide informed financial consent.

In patient surveys undertaken by PHA and its member funds a significant number of patients feel coerced into using their private health insurance in public hospitals, and many were charged co-payments as a result (an average of $400 per patient). There has been at least one very significant case of fraud, in which a large public hospital incentivised staff to meet private patient quotas and a number of signatures were forged.

[16] At https://pubmed.ncbi.nlm.nih.gov/22794056/
[17] At https://www.mja.com.au/system/files/2021-09/Sup_215_7_4%20Oct.pdf

The previous government acted through the National Health Reform Agreements to dampen the incentives to harvest private patients in public hospitals, but this may have perversely encouraged some hospitals to harvest private patients at a greater rate to protect existing revenue streams.

The funding from private health insurance to public hospitals is significant $1.213 billion in 2017-18 (an 84% increase over the past decade).

We recommend prohibiting hospitals from checking private health insurance eligibility in an emergency department, to alleviate distress and any suggestion that care is conditional on payment; ensuring patients are not liable for any additional out of pocket costs if electing to be treated as a private patient in a public hospital (with the liability being with the hospital); and ensuring that staff providing informed financial consent identify themselves on the form to provide accountability.

While patients and private health insurers may generate savings through this approach, the Commonwealth would also save on MBS expenditure and the Private Health Insurance Rebate.

Public hospitals will bill the MBS for services provided to private patients, including diagnostics. The funding they derive for this is rarely spent on patient care, but is parked in 'Medical Education' funds for use by doctors, and on occasion this money is not spent and large balances accumulate in these accounts.

Colonoscopy

Colonoscopies have been overused in Australia, leading to a Choosing Wisely recommendation[18] and significant changes in 2020 following the MBS Review. Funds report that the MBS changes may not have had the desired effect of reducing inappropriate care. The Department has announced a review of the changes and we look forward to contributing to this review.

Other areas to explore

There are many areas where low value care is likely occurring in Australia. We recommend the Australian Government implement a Standing Committee to eliminate low value care in Australia, translating the existing expertise available to provide government implementation strategies to decommission identified areas of low value care. The objective should be to improve the quality, equity and sustainability of the health system as well as making savings.

In addition to the areas above, the following are worthy of consideration:

- Australia has very high rates of dental procedures with anaesthetics compared to other countries.
- Some dentists may be claiming inappropriate MBS items so they can use the Prostheses List for dental implants (which are not payable for standard dental procedures). For example, ridge augmentation for repair after cancer have grown at a much greater rate than incidence of cancer would indicate, but can trigger Prostheses List benefits for dental implants.
- Some hospitals have very high use of Intensive Care Units for procedures that often do not require ICU use, and then discharge patients directly from ICU. It is possible some hospitals may be miscoding to ensure that their most expensive services are always being utilised.

[18] See https://www.choosingwisely.org.au/recommendations/gesa1

- Choosing Wisely states that inguinal hernia repair should not occur …without careful consideration, particularly in patients who have significant co-morbidities, [19] yet rates in Australia are still very high. Reducing these procedures by 10% would save consumers over $8 million per annum.
- There are a number of procedures that are rarely performed in the public sector that may have cosmetic benefits (eg breast reduction, and rhinoplasty) where some providers may be undertaking clinically unnecessary procedures. For example, it is commonplace for some surgeons to facilitate a claim for a cosmetic rhinoplasty on the MBS by claiming the patient has fractured their nose in the past and has difficulty breathing. This kind of claim should be accompanied by imaging to show there has been a previous fracture before it is paid.
- Recent evidence that stents are overused in Australia with low effectiveness. [20] This is particularly galling as stents are among the most overpriced items on the Prostheses List. Even after price cuts, private patients are paying twice as much for drug-eluting stents as public patients, at a total cost of $14 million per annum.
- Adenoidectomy, tonsillectomy or grommets show significant variation and are the subject of new UK guidelines which are yet to be implemented in Australia.

Focusing on low value care can work

It often takes many years or decades to reduce or eliminate low value care. However, it can be done. For example, knee arthroscopies used to be very common in Australia, but hard work from academics, strong clinical leadership and government action has reduced the incidence of this essentially useless procedure dramatically in recent years – saving consumers millions of dollars and much pain and suffering.

[19] See https://www.choosingwisely.org.au/recommendations/racs1

[20] See https://www.theage.com.au/politics/federal/outrageous-overservicing-public-pays-for-unnecessary-stents-20221212-p5c5ny.html

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Reforming default hospital benefits

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Second-tier default benefits

Second-tier default benefits provide patients treated in an eligible hospital, that does not have a negotiated agreement with the patient's insurer, access to higher benefits than those that would otherwise be payable.[1]

The second-tier default benefit was introduced in 1998 as a market intervention to assist with direct negotiations between health funds and hospital providers. At the time, individual health funds had a larger average market share than operators in a fragmented private hospital market. By placing an effective floor under provider payments, the benefit would even up negotiations for 'second-tier' smaller hospitals.

By 2003, private hospital ownership was concentrating and negotiating power was levelling. After five years' negotiations, the health fund-provider contracting environment had matured. As well, health funds wanted to enter contracts with private hospital networks so that their members could access those services. A government proposal to remove the second-tier default provision was defeated by industry group argument that its removal may reduce consumer choice of hospital providers.

However, the current operation of second-tier default benefits is simply a hospital subsidy program, and a poor one. It does little to ensure consumers have access to hospital care where they live. It also can support very poor care, such as some cosmetic surgery clinics.

Second-tier default benefits are the major barrier to promoting out of hospital care in Australia. While funds are required to pay minimum benefits for non-contracted hospitals, innovation is stifled and the market mechanisms that should promote out of hospital care are retarded.

In a post-COVID environment, Australians cannot afford to be propping up old models of care. We also cannot afford a poorly targeted hospital subsidy program which in many cases reduces consumers' access to health care.

Consumer impacts

Reforming second tier default benefits as recommended will:

- Reduce out of pocket costs for consumers
- Remove a major barrier to out of hospital care
- Reduce pressure on premiums, and
- Improve the distribution of services over time by removing disincentives for rural services

Current winners and losers

The second-tier default benefit is a regulatory price control. When governments control prices, "serious welfare loss results because not enough of the good is sold. The wasted chance to create both producer and consumer surplus from those sales is known as 'deadweight loss' because it is income that is lost forever. In addition to creating deadweight loss, an artificially high price transfers profits from consumers to producers." [2]

The second-tier default benefit is a partial price control, because it allows for sensible contractual arrangements between most providers and health funds while providing a safety net for providers who do not have contractual agreements. Thus, the second-tier default benefit transfers gains towards:

- **Low quality provider hospitals**. Hospitals that provide low quality services that cannot attract a contract from health funds due to quality issues are able to attract 85% of the average price regardless of quality.
- **Providers in oversupplied areas.** Hospitals in areas of high competition, such as inner urban areas, can attract 85% of the average price regardless of the level of competition.

Second-tier default benefits mean gains are transferred away from:

- **Consumers (and health funds).** Consumers pay more than the market price for services that are not valued enough by their representative health funds to attract a contractual arrangement.
- **High quality provider hospitals.** As the health funds must account for paying benefits for lesser-value services through the second-tier default benefits, they are unable to offer higher (deserved) benefits to quality providers.
- **Providers in undersupplied areas.** As the health funds must account for paying benefits for lesser-value services in oversupplied markets through the second-tier default benefits, they are unable to offer higher benefits to providers in undersupplied areas.
- **Providers in higher-cost locations**. Some areas have higher costs of labour, transport or other inputs. Remote locations, even large urban centres, can often have higher supply costs. As the health funds must account for paying benefits for lesser-value services in oversupplied markets through the second-tier default benefits, they are unable to offer higher benefits to providers in undersupplied areas.
- **Providers offering innovative services, such as hospital in the home**. Innovative services generally require greater risk tolerance from both the provider and the funder. As the health funds must account for paying benefits for lesser-value services in oversupplied markets through the second-tier default benefits, their risk tolerance is reduced and more innovative services need to demonstrate a higher return ratio.
- **Taxpayers**. The administrative load in the current system is significant and, in most cases, unnecessary. This produces a burden on taxpayers for no net community gain.

There are strong incentives under the current system to provide a low-cost service in an oversupplied area, as receiving a large percentage of the average fee with no need to improve quality or service levels is a very attractive business proposition. The information asymmetry often observed in health care (where consumers may not be in a position to judge the quality of the

product) aids such providers.[3] Supplier-induced demand, where consumers are supplied more health care than may be optimal, has been observed in a number of studies in Australia and overseas. [4] [5]

In addition, capital investment decisions are distorted, meaning that construction and capital maintenance is wrongly favoured in oversupplied urban locations, and capital is transferred from undersupplied areas such as rural and regional Australia.

Evidence

Second-tier default benefits are predominantly used by day hospitals in urban areas.

In 2018-19, there were 249,607 insured patients treated in hospitals without an agreement. Around 72% of these separations without an agreement occur in day hospitals.[6]

Very few day hospitals are located in rural and remote areas. An examination of the list of the 345 day hospitals eligible for second-tier default benefits in January 2020 suggests that only around 10% are outside major cities. [7]

There has been a decline in patients with private health insurance treated in hospitals without an agreement over recent years.[8] Generally, hospitals have entered agreements with health funds to reduce out of pocket costs for their customers. However, day hospitals are not (on average) moving with this trend. Day hospitals charge patients significantly higher out of pocket hospital fees than other private hospitals. In 2018-19, the average hospital gap payment across all separations per day in day hospitals was $134, [9] compared to $63 per day for other private hospitals.[10] This gap has increased over the last five years by $24 for day hospitals and by $9 for other hospitals. [11]

Private Healthcare Australia data for 2018-19 (based on 64% completeness) suggests that around 2.2% of second-tier default benefits are paid in rural areas, and a further 11% in large regional centres.[12]

Policy proposal

Second-tier default benefits are not meeting their intended purpose of supporting smaller hospitals and hospitals in underserviced areas. PHA recommends the Australian Government modernise second-tier default benefits and realign the policy to the original intent.

- Reduce out of pocket costs
    - Require hospitals using default benefits to sign a common form of undertaking to prohibit charging more than 100% of the defined benefits, should a hospital fall out of contract.
- Change the benefits
    - Option one: abolish second-tier default benefits
    - Option two: abolish second-tier default benefits in urban areas
    - Option three: decrease second-tier default benefits in urban areas and increase second-tier default benefits in rural areas
- For options two and three, replace the current formula with defined benefits

Reduce out of pocket costs: a common form of undertaking

The existing second-tier default benefit is a floor price, but there is no ceiling. With most services now contracted between insurers and hospitals, services attracting second-tier default benefits have some of the largest out of pocket costs in the nation. It is unfair to consumers, health funds and contracting hospitals that non-contracting hospitals have a high floor price with no limits on what they are able to charge the consumer.

Private Healthcare Australia recommends that to access second-tier default benefits, providers be required to sign a common form of undertaking which stipulates that services receiving default benefits be prohibited from charging more than 100% of the reference price. There is a precedent; prior to 2015, Medicare only paid benefits for services provided by 'participating' optometrists who have signed a Common Form of Undertaking for Participating Optometrists with the Australian Government. The optometry Common Form of Undertaking required that optometrists charge no more than the Medicare Benefits Schedule standard fee.

Change the benefits

Second-tier default benefits were originally designed to assist smaller and regional services. The current policy settings do not achieve these goals. There are four options to be considered.

Option one: abolish second-tier default benefits

Second-tier default benefits are a dated, poor policy prescription that is not meeting the policy objectives. The best option would be to abolish them.

Option two: restrict second-tier default benefits to rural and remote area hospitals and increase the rate

Should option one be rejected, PHA recommends the second-tier default benefit be abolished for all services in Rural, Remote and Metropolitan Area (RRMA) classifications 1-3 (urban areas).

PHA recommends that any default benefit rate for country hospitals be increased to 90% for services in RRMA 4-7 (rural and remote areas), unless the service was part of a larger entity with more than 3% national market share.

This would return the policy to the original intent, to protect and preserve private hospital services in rural and remote areas of Australia. Only having the benefit available in rural areas would promote greater levels of service in country Australia, as country-based services would be able to afford higher wages to attract better staff.

There is also a case for specialised hospitals in urban areas to attract default benefit rates if they can demonstrate to the Department of Health that they are providing a service otherwise unavailable in the location. Any default benefits should only be attracted for the new services, which may be a proportion of the new hospitals' services.

Option three: rebalance the benefits to promote rural and remote area hospitals.

Should options one and two be rejected, PHA recommends that the second-tier default benefit rate be set at 60% for all existing services in Rural, Remote and Metropolitan Area (RRMA) classifications 1-3 (urban areas) from 2021, and reduce by 10 percentage points each year until being abolished in 2026. No new services would be eligible for second tier default benefits.

Under this option, PHA recommends that the second-tier default benefit rate reference price be increased to 90% for services in RRMA 4-7 (rural and remote areas), unless the service was part of a larger entity with more than 3% national market share.

This would partially return the policy to the original intent, to protect and preserve private hospital services in rural and remote areas of Australia. The different rates between city and country services would also partially promote greater levels of service in country Australia, as country-based services would be able to afford higher wages to attract better staff.

Replace the benefit formula with defined benefits

The second-tier default benefit for hospital treatment is set at 85% of the average charge for the equivalent treatment, under that insurer's negotiated agreements for comparable private hospitals (those in the same state and in the same second-tier hospital category).

This approach increases incentives for hospitals to rely on default benefits, as they know that if hospitals and hospital groups increase the value of their contracts, the uncontracted hospital also receives a benefit. Freeloading on others' hard work reduces incentives to seek contracts that may suit consumers' needs.

The formula also allows for a farcical situation where uncontracted hospitals may receive higher benefits than contracted hospitals, depending on the changes to contracts elsewhere, the hospital location, and what stage of the contract cycle other hospitals are in.

A more sensible approach should default benefits be retained is a simple dollar rate. The defined benefit reference rate should be the same rate as for private patients in public hospitals, with default benefits being a proportion of the reference rate.

Implementation

The legislative framework underpinning second-tier arrangements is:

- The *Private Health Insurance Act 2007- Sections 121-8A to 121-8D*
- The *Private Health Insurance (Benefit Requirements) Rules 2011- Schedule 5*
- The *Private Health Insurance (Health Insurance Business) Rules 2018 - Part 2A.*

PHA's initial assessment suggests that changes to the Act are not necessary to implement the policy proposal. There would need to be changes to the *Private Health Insurance (Benefit Requirements) Rules 2011* at schedule 5(3) to:

- Option one
    - remove the clauses to abolish the second-tier default benefit, or
- Options two and three
    - nominate the new rates at clause 3(4) based on RRMA postcode on the location of service delivery
- insert a new clause based on the previous s23A of the *Health Insurance Act 1973* to provide for the common form of undertaking with providers

PHA's preliminary assessment suggests that the only change necessary to the *Private Health Insurance (Health Insurance Business) Rules 2018 - Part 2A* would be to reference the common form of undertaking as a requirement for the assessment criteria at clause 7C.

There would be a net reduction in legislation, consistent with government policy objectives to remove red tape.

Conclusion

Australians want private health to be high quality and accessible, with minimal out of pocket costs and low insurance premiums. The previous government began a series of reform initiatives to address these aims, and reforming default benefits is a key step identified in the program.

Removing or reforming second-tier default benefits will increase access to care by removing incentives to provide care in already overserviced areas with old-fashioned inpatient models. Without the regulatory crutches, hospitals and other health providers are more likely to promote modern community-based models of care, in areas where services are most needed.

The current practice of some providers in charging very high out of pocket costs, while collecting the second-tier default benefits, will be reduced with the proposal that in exchange for the right to receive default benefits comes the responsibility not to profiteer.

Choice will be protected by other elements of the system, in particular the ability of consumers to switch funds with minimal fuss. More importantly, health funds want to provide choice and care to their customers, because that is what consumers demand.

Endnotes

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Combatting surprise billing in Australia

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What is surprise billing?

Surprise billing is any charge that is not expected by the payer.

Large, unexpected costs are a major concern for the community, and they hurt the perception of private health insurance being value for money.[1]

In Australia, a medical practitioner may charge whatever fees they choose in the private system, including when practising as a private provider in a public hospital. The government is not able to regulate fees due to a clause in the Australian Constitution prohibiting civil conscription of doctors[2] (noting the limits of this provision have not been fully tested in the High Court).

As consumers and their agents, health funds, seek to reduce out of pocket costs, insurers and doctors have worked together to negotiate contracts that pay well in excess of MBS schedule fees. Contracted providers agree to provide services with no gap or a known gap, and in return they may receive long-term contract certainty, reduced administrative costs, and may get access to a larger volume of patients. Doctors who provide medical services without a contract get none of these benefits but can charge higher prices for their services.

In the March 2021 quarter, more than 97% of medical services covered by private health insurance had no gap (89.9%) or a known gap (7.7%).[3] The Grattan Institute has pointed out that just 7% of medical services account for 89% of medical gaps.[4]

Professional medical bodies, led by the Australian Medical Association, have been very strong in recent years about the need for informed financial consent, with their most recent policy document, *Informed Financial Consent: a collaboration between doctors and patients*, released September 2020.[5]

The previous Minister's Committee on out of pocket costs noted, "a minority of medical specialists have been charging very large fees, including to patients on low incomes. The Committee expressed serious concerns about such egregious charging."[6]

Egregious billing is practiced by fewer doctors than ever before. However, thousands of people still pay significant gap payments each week. Many of these consumers are surprised, shocked and disappointed by receiving large bills that they were not expecting.

All major advocacy groups in Australia support informed financial consent, where "doctors, hospitals and health insurers work together to provide information to patients about the costs associated with treatment, and the private health insurance benefits payable, prior to admission to hospital." [7]

Bills for private health services can come from a range of providers – medical practitioners and hospitals are the most common, but other bills may be levied by allied health services, diagnostic services or ancillary services.

Forms of surprise billing

There are four major types of surprise billing:

- High out of pocket charges not disclosed beforehand
- Split billing, where the full cost of the service is not disclosed to various payers
- Charges that are related to the service, but not described as part of the service (for example, 'administrative fees')
- Where the scope of service changed during the service (for example, where a complication in surgery required an unexpected intervention)

Charges not disclosed beforehand

This form of surprise billing occurs where a patient is charged an out of pocket cost that is not disclosed beforehand. In some cases, the patient may not even be aware of the service provided (for example, assistance at operations or pathology charges), let alone that they would receive a bill for it.

The major cost of this practice is borne by the consumer, who is unprepared for the bill and may lack the capacity to pay. Other costs are borne by the health funds and government, as providers may blame the gap payment on low rebates.

Split billing

This is where a provider does not disclose the full extent of their fees to payers.

For example, a doctor may charge a total of $2000 for a service where the MBS fee is $1000 and they don't have a contract with the insurer. That doctor may then bill the government $750 (the rebate amount for the service), bill the insurer $250 (the private health insurance rebate based on the MBS fee and no contract) and bill the patient $1000 directly. None of the payers know what the other has been billed, and the doctor is not being transparent about the full extent of their fees.

This practice is different to allowing or requiring payment of the bill at different times. For example, it is common and reasonable for doctors to ask for a proportion of the fee prior to the service being provided, where the full cost of the procedure is clear and apparent on all invoices. Further, consumers may prefer to make two or more payments to smooth out the financial burden if out of pocket costs are significant.

Transparency is key. All payers bear the costs where there is a lack of transparency on fees. There is no public value in split billing where the full fees are not disclosed.

Administrative or other fees

This is where a provider seeks to increase their income by charging a "booking" or an "administration" fee in addition to the medical fee by artificially claiming a fee is a different service to avoid meeting contractual obligations with no-gap or known-gap arrangements.

The AMA states, "If a medical practitioner has signed a contract with a private health insurer, the billing requirements must be adhered to. Circumventing contractual arrangements by issuing a second, separate bill for a single course of treatment is inappropriate."[8]

Costs for this practice are predominantly borne by the consumer, although health funds and governments are also affected. In particular, insurers and government may erroneously believe that a service has been provided without charge to the patient.

Changes to the scope of service

Medicine is an inexact undertaking. Occasionally planned outcomes go awry, and additional costs will be incurred. For example, if there are complications that require an unanticipated stay in the Intensive Care Unit, that will incur significant costs. The surprise in this instance is less about the billing and more about the scope of services needed. Complication rates for surgery in Australia are very low indeed (approximately 2%),[9] with much lower rates of complications in private hospitals compared to public hospitals.[10]

Our experience is most patients understand the need for flexibility if an upfront quote for services is provided. Part of the informed financial consent process is to explain that if certain things go wrong, additional claims and charge may be incurred.

Evidence

Unexpected high bills

Research commissioned by the Department of Health and PHA by IPSOS in 2018 found, “Medical out of pocket expenses were a significant driver of discontent with the private system, particularly in the context of rising cost of living and increasing private health insurance premiums.”[11]

Out-of-pocket medical costs alone are not the major cause of discontent with private health insurance among consumers, as some consumers recognise the need to contribute to costs. However, consumers are very unhappy when they do not expect or understand an out of pocket fee.

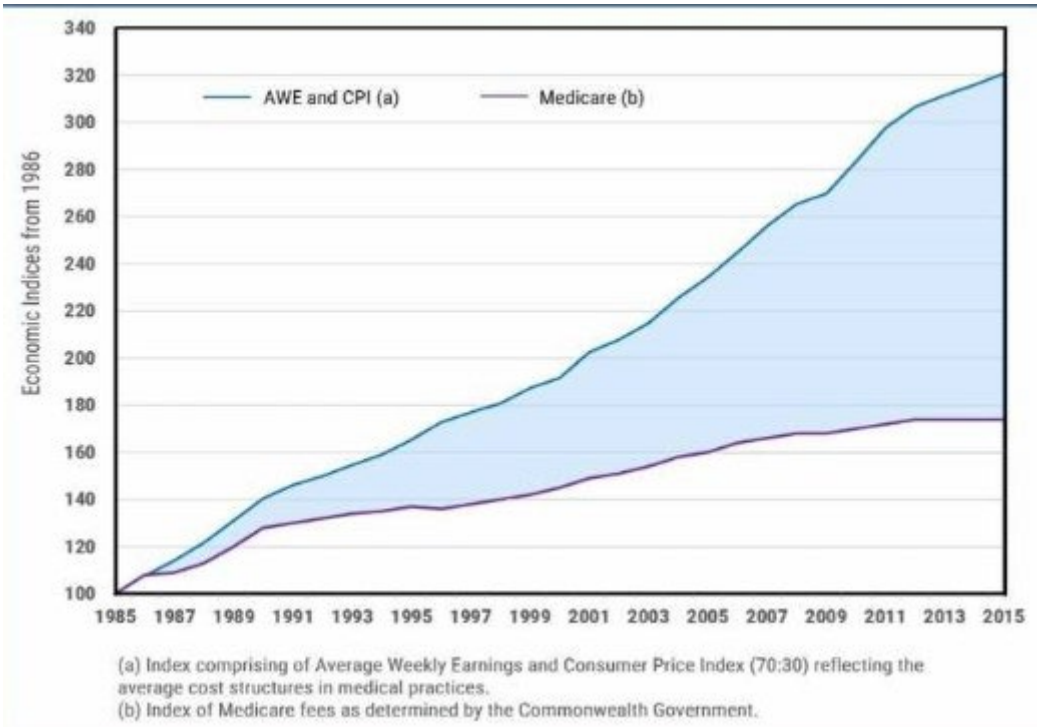
IPSOS found that there was considerable confusion about what constitutes a gap payment, an excess payment, or other charge that left the patient out of pocket. However, it was clear that, “Attitudes towards out of pocket expenses vary according to whether patients are fully informed of costs in advance. Discontent was particularly intense among those not fully informed.” [12]

One in three respondents (32%) were surprised by their gap – the majority knew of their gap in advance of their hospitalisation (68%).[13]

The higher the gap, the greater the negativity. Those surprised by their gap had more than double the negativity than those with a known gap. [14]

Medical fees

There has been a steady rise in the difference between fees charges for medical services and the MBS rebates for services since the introduction of Medicare in 1984.[15] The AMA and others point out that the increase in MBS fees has not kept up with inflation,[16] as indicated in the graph below from the AMA poster on gap fees.[17] As a result of government actions, above-MBS fees have increased significantly over the last ten years for specialist attendances, operations and anaesthetics.[18]



With the growing gap between the fees charged by doctors and the MBS rebate, health funds have increased rebates to doctors. In the September 2019 quarter alone, funds paid over $373 million additional to doctors above the MBS fee they are required to pay by law.[19] The AMA also argues that health fund rebates have not kept pace with costs, and "this is why patients may have out-of-pocket costs for medical services."[20] However, health fund rebates for medical fees have increased at a much higher rate than the MBS Schedule fee, and there is variation between funds' schedules.

The Grattan Institute notes that there are "a handful of specialists who bill their patients at more than twice the official Medicare Benefit Schedule fee. Only about 7 per cent of all in-hospital medical services are billed at this rate, yet these bills account for almost 90 per cent of all out-of-pocket medical costs for private hospital patients." [21] The data from the Australian Prudential Regulatory Authority suggests many of these high fees will actually be covered by no-gap or known-gap agreements between doctors and funds. [22]

Consumers are willing to change providers (or even go without care) to avoid medical gaps. The IPSOS survey found that possible gaps influence use of health care providers for 70% of those surveyed. [23] However, many consumers do not get this choice. The Consumers' Health Forum has found that, with respect to anaesthetists, many consumers "reported feeling disempowered and that they had no choice over the practitioner that they used." [24]

Hospital fees

Most hospitals have entered agreements with health funds to reduce out of pocket costs for their customers. There has been a decline in patients with private health insurance treated in hospitals without an agreement over recent years.[25] However, day hospitals are not (on average) moving with this trend. Day hospitals charge patients significantly higher out of pocket hospital fees than other private hospitals. In 2018-19, the average hospital gap payment across all separations per day in day hospitals was $134, [26] compared to $63 per day for other private hospitals.[27] This gap has increased over the last five years by $24 for day hospitals and by $9 for other hospitals.[28]

Split billing and 'administrative' fees

There are no data available on the practice on splitting billing between patients, health funds and government, where the full cost of the service is not disclosed. (Asking for payment at different times does not constitute split billing in this context.) The lack of data is not surprising given the nature of the practice is to deceive. Health funds report that the practice is known to occur and is deemed to be rare but significant. The IPSOS survey noted that just under one in twenty (4%) of respondents indicated a fee for a single service was split across two or more invoices for one person/organisation. [29] This may be an indication of a provider seeking to avoid disclosure of the full fee.

The survey by IPSOS in 2018 suggested booking and administration fees are charged in about 11% of hospital admissions and other 'hidden' fees in about 5% of admissions.[30] Just fewer than one in ten (8%) of those who had claimed against their private hospital insurance said they had been charged a booking fee. Of those, 13% claim to be charged multiple booking, admission or other types of administration charges.[31] Common types of booking, admission or other administration charges as detailed by respondents included:

- Hospital admission fees/charges, hospital stays, and hospital services and consumables
- Emergency hospital administration charges

- Booking fees/hospital booking fees, and/or
- fees to confirm the surgeon or room. [32]

Seven percent (7%) of respondents reported that they were charged a 'deposit' to lock in their surgery on their most recent hospital admission. [33]

The Consumers' Health Forum undertook a self-selected survey in 2018, which found, "An unexpected and highly concerning finding was that some surgeons are asking consumers to pay upfront before surgery. Consumers described experiences of being told that they would not be able to proceed with their appointment or with surgery unless they were able to pay up front."[34]

The Australian Competition and Consumer Commission (ACCC) does not explicitly address split billing or balance billing, but does state, "If you promote a price that is only **part of the total price**, the total price must also be displayed at least as prominently as the partial price" and "It is illegal for a business to make claims to customers about its goods or services — including claims about price — that are incorrect or likely to create a false impression."[35]

The Minister's Committee on out of pocket costs "expressed strong concerns about the practice, by an unknown number of medical specialists, of charging 'hidden' administrative or booking fees, which are not disclosed to Medicare or private health insurers and circumvent the requirements of the 'no' or 'known' gap private health insurance arrangements. The Committee was of the view that all charges from a given provider, for an admitted clinical episode, should be provided on a single bill."[36]

The Australian Medical Association has also clearly stated, "A single episode of care or medical service should not be subject to a booking fee or a split bill."[37]

The experience from the United States

Surprise billing has been a policy focus of consumer groups and governments in the United States for a number of years. 33 States have enacted legislation to address surprise billing as at February 2021,[38] and bipartisan legislation, the *No Surprises Act*, was agreed by Congress in December 2020.[39] [40]

The legislation follows action by the previous US President, Donald Trump, who announced principles to address surprise billing in May 2019[41], followed by an Executive Order in June 2019 with a range of policy proposals to eliminate unnecessary barriers to price and quality transparency; to increase the availability of meaningful price and quality information for patients; to enhance patients' control over their own healthcare resources, ... and to protect patients from surprise medical bills. [42]

The Biden Administration has continued this work, with the President making a commitment earlier this year that "Millions of hardworking Americans will no longer have to worry about unexpected medical bills."[43] Details of the American Federal legislation, including fact sheets, are available at https://www.cms.gov/nosurprises.

The Commonwealth Fund, a world-renowned policy think tank, describes a comprehensive approach to surprise billing legislation as including, among other things, protecting consumers both by "holding them harmless from" extra provider charges (meaning they don't have to pay) and prohibiting providers from balance billing. In states that have adopted both approaches, out-of-network (uncontracted) providers are directly prohibited from balance billing consumers for additional charges beyond what the health plan pays.[44]

In the Australian context, the health plan equivalent is Medicare plus health insurance rebates. The Australian equivalent to a hold harmless provision would be that the patient would not be liable for more than the MBS fee or fund contracted amount without an explicit agreement beforehand.

Policy proposal

Unlike most parts of the economy, "in health care, normal market forces have failed to prevent surprise medical bills."[45]

Surprise billing does not serve the interests of payers (individuals, governments and health funds). There is a strong public value argument for transparency, as it is only with transparency on pricing that we can make informed decisions and ensure efficient allocation of resources.

As surprise billing is only enabled by the strict regulatory environments around health care markets, the options are to deregulate all pricing (including abolishing Medicare) or to introduce a proper regulatory framework for transparent pricing.

Private Healthcare Australia (PHA) recommends:

- Legislation change to ensure consumers not held liable for costs not disclosed beforehand, and
- Civil and criminal offences be introduced for split billing where the full cost of the service is not disclosed to payors.

No liability for excess costs not disclosed beforehand

For non-emergency admissions, doctors, hospitals and health funds should be able to disclose costs beforehand.

PHA recommends legislation be introduced to protect consumers by ensuring that consumers are not liable for out of pocket costs that have not be disclosed at least seven days in advance of a non-emergency procedure, or two days after booking the procedure in cases where the procedure is booked within the seven day period.

Health funds must disclose all fees and excess amounts under existing legislation.

Hospitals will need to provide information about fees through the booking medical practitioner or directly to the consumer. Should hospitals fail to do so, they will still receive either the amount contracted by the health fund, or if there is no contract with the fund in place, the default benefit.

All medical practitioners involved in the consumer's care will need to disclose fees to the patient for the expected services. This may be coordinated through the admitting doctor, the hospital or individually. Should a doctor fail to provide a written quote prior to service, they will receive any fee contracted under a no-gap arrangement with the health fund, or where no agreement exists, they will receive the MBS Schedule fee.

Offence to not disclose costs

PHA recommends that legislation be introduced to protect consumers by making it an offence to fail to detail the full cost of a service covered by Medicare or by private health insurance to payers.

One mechanism would be to amend the *Private Health Insurance Act 2007* to introduce an offense if any tax invoice for a service under a private health insurance arrangement (as defined in schedule one) does not include the full cost of the service, referring to the principles of the *Australian Consumer Law 2010*. An explicit clause may be required to prevent split billing or balance billing.

Constitutional issues

The Australian Constitution prohibits the "civil conscription" of doctors,[46] which has been widely interpreted as prohibiting the government regulating medical fees. The limits of this provision have not been fully tested in the High Court, although civil conscription has been debated in other contexts.[47]

PHA contends that our recommendations do not prohibit doctors from setting their own fees in a private contract with the patient but concede the enforcement of such contracting would be made conditional on providing informed financial consent.

Third party positions

PHA's recommendations provide a lesser standard than recommended by Minister's Committee on out of pocket costs, which "was strongly of the view that patients need better fee information before [the] first consultation, noting that such information is complex and has limitations when provided outside of a formal clinical consultation." [48]

The Consumers' Health Forum is "urging the Government and the medical profession to introduce a national standard for informed financial consent requiring patients to be given a single quote covering all components of care, including procedure and diagnostic costs, before operations."[49]

The Australian Medical Association (AMA) "opposes the introduction of any legislation that prescribes or restricts the fees that medical practitioners must charge."[50] However, the recommended position is entirely consistent with the AMA's position statement *Setting Medical Fees and Billing Practices 2017*[51] and *Informed Financial Consent: a collaboration between doctors and patients 2020*.[52]

The Australian Private Hospitals Association "unequivocally endorses transparency in relation to medical fees and out-of-pocket charges including the provision of written information to consumers prior to treatment."[53]

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