Private Healthcare Australia
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Modernising the 'Assignment of Benefit' process for simplified billing

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About Private Healthcare Australia (PHA)

Private Healthcare Australia (PHA) is the Australian private health insurance industry's peak representative body. We have 21 registered health funds throughout Australia as members and collectively represent 98% of people covered by private health insurance. PHA member funds provide healthcare benefits for 14.7 million Australians.

Introduction

The assignment of a Medicare benefit through a private health fund – known as simplified billing – has been a significant boon for consumers since it was introduced in May 1995.

Simplified billing reduces the number of accounts a private patient receives after being in hospital by streamlining the claims procedures by removing the need for patients to submit claims to Medicare and their private health fund themselves. This reduces transaction costs, particularly for consumers; promotes lower out of pocket costs by increasing the attraction of contracting; and reduces the burden of care for consumers.

As highlighted in the discussion paper, these arrangements are used comprehensively across the industry to protect consumers from having to deal with complex billing procedures and out of pocket costs. Practitioner agreements covered 92.5% of in hospital services paid for by private health insurance in June 2023 and significantly reduced, or eliminated, out of pocket costs for patients where charges are above the Medicare benefit. This resulting in one month alone in health funds coordinating over $600 million in benefits across over 9 million services.

Any changes to the assignment of benefits legislation must protect the existing consumer advantages, and not add significantly to administrative costs as these would be passed on to the consumer.

The assignment of a Medicare benefit to a health fund under Section 20A (2A) of the *Health Insurance Act 1973* ("the Act") is fundamentally different to an assignment under s20A(1). The latter is an assignment of benefit to the provider, who keeps the money. The former is a simplified billing arrangement where the assignee is not the final beneficiary. Further, the s20A(1) assignment is a single service paid to a single provider, while s20A(2A) is designed to consolidate a range of invoices from a number of providers as part of an episode of care. Any legislative changes should recognise the differences between the two types of assignment of benefits.

Private Healthcare Australia recommends:

- *The assignment of benefit Section be split into two parts, with the current s20A(2A) be moved to a new Section 20AA, titled "Simplified Billing" or "Assignment of Medicare Benefit – Simplified Billing."*

The assignment of benefits to a health fund under simplified billing arrangements is not an isolated event and needs to be considered in the context of patient care and other consumer protection mechanisms, including informed financial consent, contracting arrangements, and the National Health Reform Agreements for public hospitals.

The natural fit for consumer approval for the assignment of benefit process is when the provider(s) seek informed financial consent. This combines the processes of the consumer understanding what charges are likely to be incurred with how those charges will be collected, collated and delivered.

The process of documenting informed financial consent along with the assignment of benefits for simplified billing should minimise the impact on providers. Asking providers to both ensure financial consent prior to service(s), and then seek assignment of benefits following the service(s), would impose unnecessary administrative costs.

Unlike direct benefit assignments, the simplified billing arrangements have additional accountability mechanisms where the health fund will have line of sight between the consumer and the final beneficiary and may audit providers. In most cases, there are existing contractual arrangements which provide further consumer protection.

Private Healthcare Australia recommends:

- *The new Section 20AA, titled "Simplified Billing" or "Assignment of Medicare Benefit – Simplified Billing" allow for the assignment of benefits to occur prior to service where informed financial consent is obtained for the episode of care.*

Health funds recognise the importance of payment integrity, as preventing fraud, waste, miscoding and low value care. Funds have a vested interest in promoting compliance with accurate assignment of benefits.

Where consumers are most vulnerable is when informed financial consent fails to occur or is not clearly understood by the consumer. Reforming the assignment of benefits provides an opportunity for the government to address these weaknesses.

PHA have proposed to government a package of legislative amendment to remove surprise billing from private healthcare (a copy is at appendix one). This legislation would provide penalties for misleading charges, and hold that where informed financial consent is not provided, consumers would only be liable to pay the Medicare scheduled fee for medical services.

This would address one of the most irritating issues for consumers – unexpected charges. It would also bring health care into line with other industries where consumers are better protected from egregious and unexpected billing.

Private Healthcare Australia recommends:

- *The Australian Government introduce surprise billing provisions in conjunction with assignment of benefits legislative changes (detailed in appendix one).*

The second area where health funds observe consumer vulnerability is where the informed financial consent process is incomplete or lacks accountability. This is a greater problem in the public hospital system than the private system, as processes for informed financial consent for a patient to elect to be treated as a private patient in a public hospital can often be described as misleading. One key issue is that consumers are routinely told by public hospitals that they will not have out of pocket

costs for a range of services, without the public hospital disclosing that other services (in particular, medical services) may or will incur out of pocket costs.

This issue was called out in the recent Mid-term review of the National Healthcare Reform Agreement Addendum (October 2023, pp62-3). The review found addressing the challenges requires greater transparency in the patient election process such as:

- More stringent requirements, principles and criteria to ensure informed financial consent when making a private patient election.
- Curbing the ability to make multiple changes of election during a hospital episode.
- An audit of patient election processes/forms, to ensure there is consistency and compliance with minimum requirements for admitted patient election, to ensure all patients are consistently informed of their choices, in accordance with Clause G30 of the NHRA.
- Ensuring that staff gathering informed financial consent identify themselves on the form to provide accountability.

PHA supports the review recommendation and highlights the importance of this issue for the assignment of benefits through simplified billing processes. PHA will urgently review our HC21 form to ensure it is compliant with the review recommendations, and work with consumer groups and stakeholders to ensure all hospitals, including public hospitals, have a clear, standard framework for ensuring informed financial consent is obtained and understood.

Private Healthcare Australia recommends:

- *The Australian Government support processes led by PHA to redesign forms and frameworks to ensure improved informed financial consent when patients elect to be treated as a private patient in a public hospital.*

PHA offers additional comments on the consultation questions below.

Response

1. What does your ideal assignment of benefit process look like?

The medical provider should obtain consent for assignment of Medicare benefit(s), including consent by the patient for the benefit to be transmitted to the provider via the patient's private health insurer, as part of the informed financial consent process.

It is very important that this process is as easy as possible for providers, as even a small increase in administrative costs per transaction would result in consumers paying more for health care. Even an extra minute of doctors' time per transaction would add up to over $100 million in additional annual expenditure for little consumer benefit (noting most episodes of care will cover many transactions and assignment can be done simultaneously).

Standardised forms may assist providers in ensuring consumers understand the process. PHA would be happy to work with stakeholders, including other consumer representatives, the Australian Government, and medical bodies, to develop a suitable standard.

This process should be labelled as 'simplified billing' for consumers rather be labelled as 'assignment of benefits.' Consumers are likely to be confused by the need to assign a benefit to a private health insurer when insurers are simply transmitting the benefit – it is counterintuitive. It is important that consumers understand who will be paid with their rebate entitlements from Medicare and their health fund, and/or other payors.

PHA submits that utilising the existing Eclipse framework would minimise additional administrative costs.

Most medical claims are submitted to health funds using the Eclipse system. There is an Eclipse field called the "IFC Issue Code". This field can currently be populated with "N" (Not issued), "V" (Verbal), "W" (Written), "S" (Signed) or "X" (Not obtained). The rules for use of this coding could be expanded so that certain ones of these (e.g. "S") could only be used if the informed financial consent form signed included an assignment of benefit for the episode of care, or a new value could be created to signify the assignment. Using this existing field may facilitate a relatively simple solution requiring minimal system change.

2. What are the current main workflow 'pain points' for assignment of benefit?

Health funds' role would be to check that assignment has been done, either by the doctor or the hospital (if that were allowed as part of the declaration on the hospital certificate). Funds would then need some direction on what to do if they do not receive a valid assignment, which could be to simply reject the claim.

Health funds may need to update their processes depending on the changes proposed.

3. What barriers hinder the use of digital assignment by providers and patients, and how could these be overcome (for practices/practice managers/service providers/hospitals/patients)?

Health funds are not expected to obtain the assignment, so nil comment. However, it will be important to be able to audit any non-digital method of assignment.

4. What technologies are already in practices/hospitals that could support electronic assignment of benefit? What is missing?

PHA asks that the government consider using the MyHealthRecord (MHR) platform. As more Australians sign up for the MHR app, a feature to upload the assignment of benefit form and allow consumers to use their own devices to approve informed financial consent and assignment of benefits would address many of the concerns around fraud and compliance.

5. Are there populations for whom electronic assignment of benefit is likely to be more challenging? Is there any population for which is it not considered feasible?

Any Australian who lacks access to a smartphone and/or internet connection is likely to be disadvantaged and will need assistance. Further, informed financial consent requires information to be provided in a manner accessible to the consumer. Many government services through Services Australia share these challenges.

6. Would pre-payment validation help reduce providers' concerns about their risk of post payment audits?

As per the above, PHA recommends the assignment of benefits occur prior to service where informed financial consent is obtained for the episode of care.

Health funds must always retain the right to audit to protect member funds.

7. What kind of prompt for electronic signature is most likely to get a timely response from patients?

o Does the requester (e.g., practice, Government, or a third-party such as a hospital) matter?

o How might patient-targeting scams be mitigated?

Health funds are not expected to obtain the assignment, so nil comment.

Health funds must always retain the right to audit to protect member funds.

8. How should patients' delayed or non-responses be managed?

Where a patient does not elect to use simplified billing arrangements, the benefit should default to the patient after a period of time.

9. What information should be collected to document an assignment, in addition to information provided for claiming purposes?

The five key elements of consent are:

- The individual gives consent voluntarily.
- The individual is adequately informed before giving consent.
- The consent is specific.
- The consent is current.
- The individual has the capacity to understand and communicate their consent.

PHA will work with stakeholders to redesign the existing forms commonly used across the industry (including the HC21 form). PHA expects that this form will include, among other things:

- To whom the assignment is being made, and under what conditions/understanding.
    - This should include a clear description of what services are included in the assignment, and what services (if any) are excluded.
- Clearly understand who will be the final beneficiaries, where simplified billing arrangements are utilised.
- Whether any out of pocket costs are anticipated in connection with the benefits being assigned.
- Clear communication with the medical practitioner so they know the patient is being billed in their name.
- The name and position of the person providing the information for the assignment.

10. Who should be included as a 'responsible person', in what situations and why?

The patient or their legal guardian should be the responsible person. In some cases, this may not be possible at any stage during the admission (for example, where there is an emergency admission resulting in death or severe disability). It is not appropriate to nominate a next of kin where that person does not have legal decision-making powers for financial matters. Particularly where out of pocket costs are possible, it is not appropriate for public hospitals to ask next of kin to make a declaration for assignment of benefits.

The process should also be reversible for private patient election in a public hospital, which it is not currently. Patients are hopefully more likely to be in a position to make better decisions after a course of treatment rather than being asked while acutely unwell, under stress and under pressure.

11. Should providers, hospitals or insurers be required to retain copies of assignment of benefit forms?

The person who obtains the assignment (providers and hospitals) should be required to retain copies of assignment of benefit forms. These should be available to funders (including Services Australia and health funds) on request for auditing purposes.

12. Should patients be required to receive copies of completed assignment of benefit forms, or are there alternative and preferable ways to maintain a record of their decisions?

PHA recommends that the government build capability for assignment of benefit forms to be captured in MyHealthRecord.

Appendix one

Private Healthcare Australia
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Combatting surprise billing in Australia

September 2022

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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.[i]

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[ii] (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%).[iii] The Grattan Institute has pointed out that just 7% of medical services account for 89% of medical gaps.[iv]

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.[v]

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."[vi]

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." [vii]

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."[viii]

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%),[ix] with much lower rates of complications in private hospitals compared to public hospitals.[x]

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."[xi]

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.

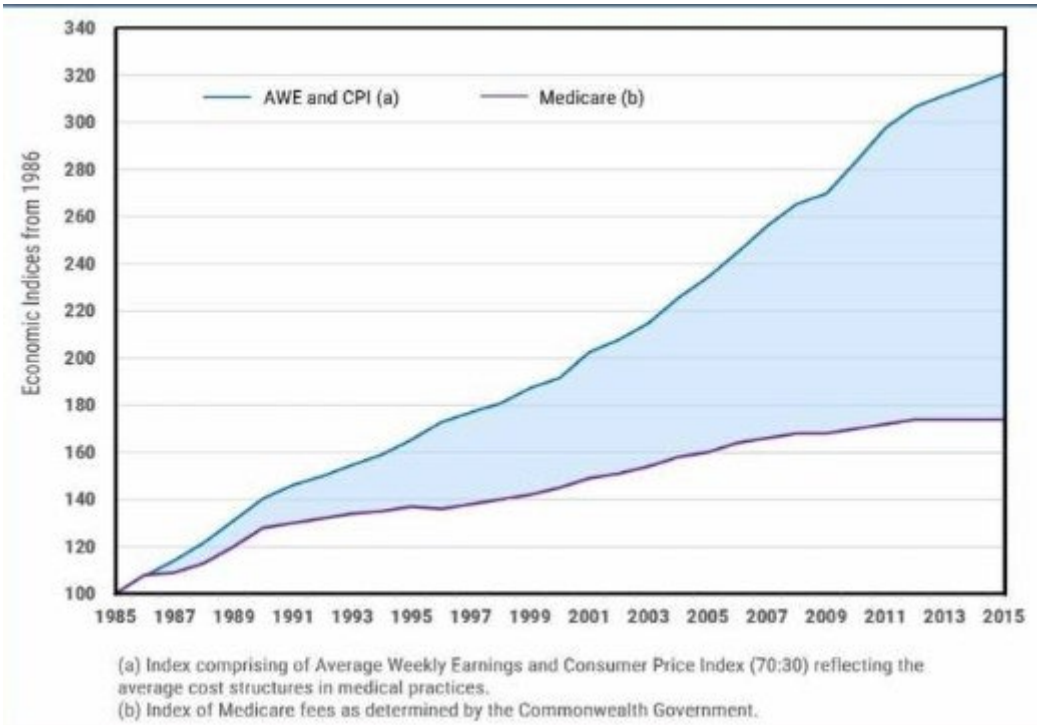
IPSOS found that there was considerable confusion about what constitutes a gap payment, an excess payment, or other charge that left the patient out of pocket. However, it was clear that, "Attitudes towards out of pocket expenses vary according to whether patients are fully informed of costs in advance.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

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

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. [xiv]

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.[xv] The AMA and others point out that the increase in MBS fees has not kept up with inflation,[xvi] as indicated in the graph below from the AMA poster on gap fees.[xvii] As a result of government actions, above-MBS fees have increased significantly over the last ten years for specialist attendances, operations and anaesthetics.[xviii]



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.[xix] 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."[xx] 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." [xxi] 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. [xxii]

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. [xxiii] 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." [xxiv]

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.[xxv] 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, [xxvi] compared to $63 per day for other private hospitals.[xxvii] This gap has increased over the last five years by $24 for day hospitals and by $9 for other hospitals.[xxviii]

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. [xxix] 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.[xxx] 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.[xxxi] 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. [xxxii]

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

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."[xxxiv]

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."[xxxv]

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."[xxxvi]

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."[xxxvii]

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,[xxxviii] and bipartisan legislation, the *No Surprises Act*, was agreed by Congress in December 2020.[xxxix] [xl]

The legislation follows action by the previous US President, Donald Trump, who announced principles to address surprise billing in May 2019[xli], 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. [xlii]

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."[xliii] 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.[xliv]

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."[xlv]

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,[xlvi] 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.[xlvii]

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." [xlviii]

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."[xlix]

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

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."[liii]

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[viii] AMA 2017, 'Setting Medical Fees and Billing Practices 2017' Position statement. Available at https://ama.com.au/position-statement/setting-medical-fees-and-billing-practices-2017.

[ix] Australian Institute of Health and Welfare 2019. *Admitted patient care 2017–18: Australian hospital statistics*. Health services series no. 90. Cat. no. HSE 225. Canberra: AIHW.

[x] Australian Institute of Health and Welfare 2019. *Admitted patient care 2017–18: Australian hospital statistics*. Health services series no. 90. Cat. no. HSE 225. Canberra: AIHW. For example, see table 8.6 (onset during care); tables 4.9, 4.10, 4.12, 6.11 (complications) and table 8.9 (falls).

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