AMA Submission to the Senate Community Affairs Legislation Committee Inquiry into the *Private Health Insurance Legislation Amendment Bill 2018 and related Bills* July 2018

Private Health Insurance Legislation Amendment Bill 2018 and related Bills

Australia needs a strong and viable private health sector to maintain the reputation of the Australian health system as one of the world's best. The AMA advocates that improving the value of private health insurance for consumers is vital for the continuation of private health care in Australia.

The AMA understands that purchasing private health insurance is a significant financial commitment for many consumers and achieving value for money is extremely important. Ideally, private health insurance should offer Australians greater choice in their doctors and location of their treatment and should deliver shorter waiting times for services.

However, private health insurance is one of the most complex forms of insurance and the current complexity of product offerings has led many consumers to report that they do not understand what they are covered for. This complexity reduces the value of private health insurance to patients, through reducing transparency of benefit coverage, and choice of practitioner and timing of treatment.

This becomes very apparent when patients require treatment only to find out that they are not covered by their insurance product. Patients either face long wait times to upgrade their policies or need to revert to the public system, losing their choice of doctor. This undermines confidence in the private health system and the insurance that underpins it.

The AMA has made several submissions to recent inquiries into private health insurance[1][2]. In these we have discussed how there has been a marked change in the last decade. Private health insurance firms have moved from primarily not-for-profit organisations, to the current situation where 70 per cent of the insured population are now covered by for-profit funds. This has been accompanied by a shift from funds acting as passive payers to 'active funders' – extracting sizable profits from the sector for shareholders and executive remuneration.

[1] AMA submission to the Inquiry into the value of private health insurance | Australian Medical Association

[2] AMA Submission - ACCC report to the Senate on private health insurance | Australian Medical Association

With the market power shifting in favour of the private health insurers, they are deciding who can provide what treatment and where it can be provided. The AMA believes that private health insurers (often being driven to make a profit for their shareholders) should not determine the provision of treatment in Australia. Health insurers should not interfere with the clinical judgement of medical practitioners (this includes interfering in the medical advice about which provider of medical and ancilliary services - imaging, pathology, anaesthetics, physiotherapy etc - a medical practitioner requests, as often they can contribute particular expertise in a clinical area).

Government reforms of private health insurance

The AMA believes that the range of private health insurance reforms, announced by Government, provide a long overdue opportunity to bring much-needed transparency, clarity, and affordability back to the private health sector.

The AMA welcomes the decision of the Government to introduce the Gold, Silver, and Bronze categories for private health insurance policies, and the application of the concept of standard clinical definitions across these groups. The AMA has advocated strongly for standard clinical definitions on behalf of patients for some time – these now need to be translated into meaningful and consistent levels of cover in each insurance category.

On Monday 16 July Minister Hunt announced further details about the new system. He stated that the new system will:

- Categorise all of the existing 70,000 private health insurance policies into a four-tier system – Gold, Silver, Bronze and Basic;
- Allow consumers to determine exactly what is covered in a policy in one clear page of information – with no surprises; and
- Not result in increased prices for consumers[3].

However, the AMA notes that the Minister did not yet address in the announcement a number of areas of uncertainty, including:

- The issue of funds having highly variable payment rates for the same items;
- How the new system will address an episode of trauma covering a range of body parts;
- What the new system will mean for patients with cancer where the surgery to remove a cancer may be at a higher insurance level than the chemotherapy or radiotherapy required to treat the cancer; and
- The recent move by some private health insurers to limit access to no or known gap arrangements to those private hospitals with which they are willing to contract.

[3] Making private health insurance simpler and boosting coverage for women > Greg Hunt MP, Federal Member for Flinders | Minister for Health | Minister for Sport

The AMA also notes with interest that the Minister has stated that the new system will ensure that consumers will be able to determine what they are (and are not) covered for, on one page, and that there will be 'no surprises'. The AMA believes that these new private insurance categories will not satisfy the consumers' need for increased health insurance transparency, unless all treatments 'included' in each category are fully insured. No carve outs, no restrictions and no exclusions. Australians want reasonable and simple things from their insurance. They need transparency.

They want to know if a treatment is 'insured' on their policy – all costs (hospital accommodation, nursing, diagnostics and imaging, PBS listed and ward drugs, prostheses, theatre and ICU) are fully insured. They want to choose their treating doctor and have a choice of hospital. The AMA is hopeful that the new system will deliver a 'no surprises' approach for consumers – including that this announcement means that all restrictions and carve outs will be removed (outside rehabilitation, psychiatric and palliative care services) from all private health insurance policies from April 2019. We fully support this move - the AMA has been very clear that the proposed new insurance categories – Gold, Silver and Bronze – will not boost consumer confidence or trust in the private health insurance products, unless insurers remove the caveats, carve-outs, and exclusions; inconsistent and tricky product definitions; and unexpected or high out-of-pocket costs.

In regard to out-of-pocket costs, it should be made clear that doctors' fees are not the problem – 95 per cent of services in Australia are currently provided at a no-gap or a known-gap of less than $500. Accordingly, the AMA has called on the expert committee considering out-of-pocket costs to broaden its review beyond doctors' fees to look at the real determinants of these costs.

The AMA has repeatedly called for the banning of so-called junk policies that do not clearly show consumers the limited level of cover offered and which are simply designed to avoid the Medicare Levy Surcharge. The AMA also notes that the system announced on Monday 16 July, will retain a 'Basic' level of cover that provides only restricted cover for every clinical category of treatment where it is a minimum requirement. We will watch closely to ensure that with the roll out of this restricted 'Basic' level policy, it remains clear to consumers that this provides very limited coverage – both in terms of the range of conditions and the level to which they are covered.

The AMA supports the increased coverage for mental health services and access to travel and accommodation benefits for rural and regional Australians included in the reform package. We note with disappointment that pregnancy care remains restricted to the top level of cover – making private maternity care unaffordable and inaccessible for the majority of Australian women.

The AMA continues to call for pregnancy cover to be included from Bronze policies upwards – matching it alongside coverage for female reproductive policies. It's a natural part of life. Half

of all pregnancies are unplanned[4]. The AMA believes it should be covered properly, the cost spread appropriately, making it affordable for more people.

Product design - Gold, Silver, Bronze, Basic.

The ability for funds to change coverage through differing benefit schedules, co-payments, excesses, limitation periods, and procedures covered has created a system where there are 70,000 policy variations around the country. Without reform, consumers will continue to leave private health insurance, undermining the viability of the private health system, and increasing pressure on the public health system.

The AMA has argued for minimum standards that simplify the offerings for consumers:

- *Gold*: products must cover all hospital services, with insurers precluded from charging excesses or co-payments. No restrictions or exclusions allowed.
- *Silver*: products must cover all hospital services but insurers may impose any combination of excesses or co-payments (up to a limit). No restrictions or exclusions allowed.
- *Bronze*: products may include exclusions, excesses or co-payments. No restrictions allowed, and accidents should be covered.

The AMA is gratified that the Government appears to have heeded this advice in the design of the new categories with regard to the removal of restrictions.

The AMA acknowledges the requirement to legislate for the transfer of currently insured people to the new Gold, Silver, Bronze and Basic products. However, beyond this limited circumstance, the AMA has reservations about the private health insurers being given the ongoing ability to terminate a product and transfer all the people insured under that product to new policies.

This legislative change may enable insurers to offer products with incentives added in addition to the base level of product, (ie., Silver "plus") but after a period of time move them to a new product without the incentives (ie., Silver). For example, an insurer could promote a Silver product but add a Gold level service to attract customers. However, after a period of time they could move the consumer to the basic Silver product by simply informing the customer of this move.

The capacity of private health insurers to chop and change their policies can only reduce transparency and certainty for consumers, and as such we would ask that the Private Health Insurance Ombudsman be tasked with monitoring this specific issue, once the new categories are implemented.

[4] https://www.mja.com.au/journal/2012/197/2/current-contraceptive-management-australian-general-practice-analysis-beach-data#0_i1149769

Standard clinical definitions for private health insurance hospital treatment policies

The biggest challenge to implementing the new private health insurance categories is to clearly define and describe the insurance products on offer so that families and individuals – many of whom are facing considerable cost of living and housing affordability pressures – have the confidence that their investment in private health delivers the cover they are promised and expect when they are sick or injured. Also that they can compare insurance products with a greater level of certainty – knowing that they will be properly covered by the different insurers.

To do this the Government has been working with a range of industry and health sector representatives to develop standard clinical definitions. The AMA strongly supports this approach but will reserve judgement until there has been strong and considered consultation on the rules with the full medical community, and we see Government implement the rules as a result of that consultation. In our submission to the Health Department regarding draft standard clinical definitions for private health insurance hospital treatment policies[5] the AMA has outlined concerns that the definitions may not reflect clinical pathways, with potential errors in the mapping of MBS items to the proposed Gold, Silver, Bronze and Basic product categories, and further consultation with the specialist groups was needed.

Standard clinical definitions are a critical underpinning of the reformed system and require thorough mapping to ensure that changes to private health insurance categorisation do not result in consumers experiencing an unexpected lack of coverage and out-of-pocket costs. The AMA was very disappointed that the allowed timeframe for the initial consultation was less than three weeks which limited the amount of discussion to inform appropriate allocation of clinical services under the proposed insurance categories and definitions. The AMA notes that the Government released the draft Rules for public consultation on 16 July. But again the timeframe for this consultation, which required detailed and rigorous analysis, is woefully inadequate with just 15 working days to carry out this complex work.

The importance of second-tier default benefit in a changing private health insurance sector

The AMA supports the proposed administrative amendments, given the main quality criterion (the National Safety and Quality Health Service Standards) is now a requirement of all hospital accreditation. It is sensible for the Health Department to assess second-tier eligibility as part of the Commonwealth hospital declaration process with appropriate review processes.

[5] AMA Submission: Department of Health Consultation on the draft standard clinical definitions for private health insurance hospital treatment policies | Australian Medical Association

There has been a noticeable shift in private health insurers from funds acting as passive payers to 'active funders'. The AMA is concerned that if this shift is allowed to flourish, it has the ability to undermine both the private and public systems. Increasingly, private health insurers are determining who is able to provide services and how they are to be provided under their contracts[6]. Australians do not support a US style managed care health system and the AMA asserts that recent actions from some private health insurers are taking Australia closer to such a system.

The terms and conditions between the private health insurers and providers now arrange for the publication of practitioner details, allow for the establishment of closed shop referral databases and have no-pay clauses for adverse events. The health insurance funds now have the ability to selectively contract, meaning that insurers will not provide coverage for facilities if these facilities do not meet the insurer's business needs. The AMA believes that any further consideration of the second-tier benefit must be about protecting consumers' choice and protecting them from high out-of-pocket costs.

The AMA strongly opposes any dilution of the second-tier benefit rate itself, or its current application to facilities that do not have a contract with a health fund. The second-tier rate ensures that consumers, who have duly paid their insurance premium, have access to the hospital and doctor of their choice – regardless of whether that doctor or hospital has been successful in securing a contract from a health fund.

The AMA believes that provision of second-tier benefits means that private health insurance funds cannot dictate the health landscape. Without second-tier rates, organisations that cannot contract likely will not be able to survive, as insurers will essentially be able to direct traffic to their contracted facilities. This will see Australia heading down a path of managed care and closed provider networks, limiting choice of doctor and facility (and therefore reducing the value proposition of private health insurance), as well as impacting on clinical referral/decision making. Private health insurers should not determine who provides services in Australia.

[6] AMA Submission - ACCC report to the Senate on private health insurance | Australian Medical Association

2018 - Bupa Health Insurance Hospital Policy Changes

In late February 2018 Bupa announced significant changes to policies affecting consumers with basic and mid-level hospital policies, and to its medical gap scheme on all hospital policies, in conjunction with its average premium increase announcement.

Following the intervention of the Private Health Insurance Ombudsman (PHIO), Bupa announced that it would restore future access to 'no-gap' schedules for private patients in public hospital emergency departments. While the AMA is pleased the decision has been made to retain the second-tier arrangements, BUPA policy holders will not be able to use their 'no-gap' or 'known-gap' cover in non-contracted private facilities. Patients will be required to ascertain whether their surgeon and their hospital have a contract with BUPA.

This new insurer led arrangement means that the no or known-gap rate, will only be paid when a medical service is carried out in a private facility that has a contract with the specific insurer. When it is not carried out in a contracted facility the insurer will only pay the 25 per cent of MBS item rate towards the doctor's fee – the minimum amount they are required by law to pay. The patient, while still free to choose a non-contracted facility, will now suffer a new, and potentially significant out-of-pocket cost – even when the medical practitioner charges at the no gap rate.

This change will have significant consequences for doctors and for the hospital where they treat their patients and may make it difficult for the patient to choose the hospital that best suits them. Not only does the patient need to confirm if their preferred doctor has a no or known-gap arrangement - they will now need to confirm if their doctor has admitting rights to a private hospital that has a contract with their insurer.

In the AMA's opinion it creates a new complexity – it increases the likelihood of patients being caught with an unexpected out-of-pocket cost, and ultimately it undermines the intent behind second-tier – that is, maintaining choice of doctor and choice of facility.

This situation is something the AMA has spoken strongly against, and will continue to do so, as it potentially exposes patients to greater out-of-pocket costs.

Further information regarding this issues can be found in the AMA's 2018 Private Health Insurance Report Card here: AMA Private Health Insurance Report Card 2018 | Australian Medical Association

Improve information provision for consumers

Private health insurance products need to clearly state whether the consumer will or won't be covered for a particular service. This should not be difficult for any consumer to understand or work out. Accordingly, the AMA strongly supports the proposed increased information provisions and agrees that, when combined with the application of standard clinical definitions across all private health insurance products, this should reduce confusion for consumers.

Currently the full information for private health insurance products is often segmented into multiple documents. This requires the consumer to go searching for the full scope of information and have to analytically pull together the piecemeal advice in various documents to develop an accurate understanding of their entitlements.

The AMA supports the better provision of information for consumers. The AMA believes that insurers should be required to use standard consistent definitions across all their products - all their documents that explain benefit entitlements. Insurers should include all definitions in consumer documentation in which the term is used. Additionally, insurers should be required to provide up to date Fund Rules on their websites (not all insurers do this - some insurers only provide access to Fund Rules if requested in writing).

Example: Ambulance Coverage

When purchasing private health cover – the headline advice in the product summary will tell you that you are covered for air and road ambulance, but it will refer you to somewhere else for more information.

In this different document, located elsewhere on website (eg., an important information guide) the insurer reveals ambulance cover is insured only when provided by the insurers preferred provider. Perhaps these preferred providers are listed – but consumers are not given explicit information about the type of ambulance travel each is contracted to provide.

For example, it may be that Provider A is listed as the preferred provider. But since Provider A only do road transport in that jurisdiction, the headline statement in the product summary 'air ambulance insured' becomes misleading.

The AMA believes that insurers need to summarise ambulance insurance accurately the first-time ambulance insurance is mentioned in the product summary to ensure that the consumer understands exactly what services they are purchasing in their product.

Improved access to travel and accommodation benefits for regional and rural areas

The AMA supports the legislative change to provide rural and regional patients with the ability to be covered for travel and accommodation benefits under hospital cover, instead of only under general treatment policies.

Age-based premium discounts for hospital cover - discounts for 18 to 29-year olds

The AMA acknowledges that private health insurance margins are under stress and there are real upward pressures on health insurance premiums from costs associated with an ageing insured population, the changing burden of disease and new health technologies. However, in an effort to make insurance more affordable for younger Australians, community rating must also be protected to maintain equity of access to private health treatment. When the policy objective is to support a strong private health sector to take pressure off the public sector – it makes no sense to financially discourage patients most likely to need access to private health. The AMA views community rating as essential in maintaining the delicate balance between the public and private hospital sectors in the Australian healthcare system.

Charging premiums according to "risk" undermines the central tenet that supports the community rating system for private health insurance. The community rating system ensures that private health insurance is equitably available to all in the community who seek it (and can afford it). It is important that any regulatory adjustment does not move from a community rating system, to one based upon risk where different premiums are charged based on a combination of age, gender, and other factors. Undermining community rating could lead to the development of a true risk rating system which will leave insurer deemed 'high risk' people uninsurable.

Increasing permitted excess levels.

The AMA accepts the logic of lifting the excess thresholds given that they have not been reviewed for many years. An increase to the excess eases some pressure on premiums and provides consumers with choices about how they pay for their private health insurance. However, the AMA believes that information about the excess levels must be provided to consumers up front and clearly. The result to the consumer needs to be a better-quality product with a clear excess, and no additional out-of-pocket costs based on caveats, carve-outs, exclusions or hidden conditions.

Regulation of Private Health Insurers

The AMA supports the expansion of the powers of the PHIO to be able to conduct inspections and audits of private health insurers to ensure they meet their obligations in relation to private health consumers.

The AMA acknowledges that the role of PHIO is to protect the interests of private health insurance consumers by:

- Assisting health fund members to resolve disputes;
- Identifying underlying problems in the practices of private health funds or health care providers in relation to the administration of private health insurance;
- Providing advice to Government and industry about issues affecting consumers in relation to private health insurance; and
- Providing advice and recommendations to government and industry about private health insurance, specifically the performance of the sector and the nature of complaints.

PHIO has seen increases of 92 per cent for complaints (over the last five years with an increase of 30 per cent in the last year) and 72 per cent for enquiries in the same period[7]. The ombudsman acknowledges that "In most years, verbal advice is the cause of more complaints than any other sub-issue". In 2016/17 54 per cent of complaints related to unsatisfactory customer service and unexpected exclusions and restrictions.

However, it needs to be clearly understood that the Commonwealth Minister for Health and the Australian Prudential Regulatory Authority (APRA) carry the ultimate responsibility for regulating the private health insurers and ensuring compliance with the provisions of the *Private Health Insurance Act 2007*. Whilst the powers and resources for PHIO have been increased recently, the AMA has increasing concerns regarding the capacity of the Health Department to manage its regulatory obligations with effectively decreasing resources. While not directly addressed in these legislative amendments, the AMA believes that ensuring an adequate regulatory system underpinning private health insurance is critical to the provision of an effective private health system.

[7] Commonwealth Ombudsman Annual Report 2016-17 - Commonwealth Ombudsman

Case Study - Delays in Regulatory Action

As part of the Government's 2016 Budget repair plans, the Health Department used the outcomes of a recent Skin Services review to implement a number of changes to the MBS, including deleting 48 skin service items and replacing them with 28 new items recommended by the Medical Services Advisory Committee.

Separate to this, an internal decision was made by the Health Department, without consultation, to reclassify a number of items into a new private health insurance "banding". These changes affect the clinical setting in which services can be delivered in order to still be eligible for private health insurance rebates.

Though the development of new MBS skin item numbers arose from constructive engagement between the Health Department and medical profession stakeholders, there was no discussion of the banding of items under the *Private Health Insurance Act*.

It is not surprising then that, in absence of advice from the medical profession, the changes to banding classification had a deleterious effect on patient care.

The banding classification disadvantages patients, in particular children and patients with complex medical needs, who may require these procedures to be carried out in the hospital setting. Under the new banding classifications, these items are no longer indicated for hospital stay unless a written certification is provided. Even when supplied with a clinically relevant written certificate, the AMA was made aware of incidences where the private health insurers denied the claim, disagreeing with the clinical assessment of the managing medical practitioner.

The AMA brought this issue to the Government's attention in December 2016 – it took the Health Department a further eight months to issue a Private Health Insurance circular (PHI 37/17) acknowledging that they had been made aware of systemic issues, including the rejection of the medical conditions or special circumstances outlined in the certification documentation based on medical assessment by insurers. The circular outlined that any insurer that rejects certification for any reason other than that they fail to meet the requirements prescribed by the Rules (or that the proposed procedure is not covered by the patient's health insurance policy) is in breach of the Rules.

Considering the anxiety and financial stress placed on patients in the intervening period – this response time is not adequate.

Future work required

In the private health insurance announcement of 16 July 2018 it was stated that the reforms will not increase prices for consumers [8] :

> *What this means is that we take the existing policies, no change in price, no change in coverage, but we make it simpler so as everybody can see in one page exactly what is in place[9].*

The AMA is yet to be certain that this is how the new system will operate for everyone. The AMA believes that a number of consumers may need to change their policies, or level of cover, to ensure that they have coverage of their existing conditions. There may be consumers whose current policy may cover them – albeit partially – for a particular condition, which under the new system may be covered in full, but only in higher level policies. For example, there will be a premium impact for consumers if they move from a current mid-tier policy to a gold policy in the future, based on the above scenario. In the absence of information, it is difficult to say how large this group is likely to be or the level of financial impact.

In the AMA's submission to the Health Department's consultation on the draft standard clinical definitions for private health insurance hospital treatment policies (May 2018)[10] – we stated that:

> *The AMA also considers a full and thorough mapping exercise is needed to compare the proposed coverage by product category/tier with the existing health insurance product offering. Mapping the current product offering against the proposed new Gold, Silver, Bronze, Basic categories will assist PHMAC in understanding where consumers will lose coverage of items which they currently have, and where they can expect to see an improvement in their level of coverage. As far as AMA can see, this mapping work has not yet been done.*

The AMA has carried out a quick 'desktop' search of a number of private health insurance policies and their associated levels of coverage, contrasted with the proposed new tiers of insurance. Whilst incomplete, even this short exercise highlighted that for some policies, their equivalent in the new schemes will result in a reduction of policy coverage for a range of conditions.

The AMA has called for and continues to call for much better transition mapping to show what areas of coverage people are likely to gain or lose as they move from their current policy to the new Basic, Bronze, Silver and Gold policies. Only with this information can the consumer make a fully informed choice about the appropriate level of cover that will suit their health needs.

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[8] Making private health insurance simpler and boosting coverage for women > Greg Hunt MP, Federal Member for Flinders | Minister for Health | Minister for Sport

[9] Doorstop - Melbourne > Greg Hunt MP, Federal Member for Flinders | Minister for Health | Minister for Sport

[10] AMA Submission: Department of Health Consultation on the draft standard clinical definitions for private health insurance hospital treatment policies | Australian Medical Association

The AMA position is supported by the Office of Best Practice Regulation, which assessed the Regulation Impact Statement prepared by the Health Department as compliant, but not best practice and went on to say:

> *The RIS was assessed as falling short of best practice because it did not present a range of feasible options and the level of analysis did not clearly demonstrate how the preferred option would result in a net benefit for consumers, private health insurers and the community*[11].

Rules Development

The AMA is disappointed with the recent consultation process, in particular, that the category mapping has not been undertaken via wider consultation with key stakeholders directly involved with administration of, or reform to the MBS, or with the Colleges and Specialist groups.

Alignment of MBS item numbers with clinical definitions for the purpose of private health insurance benefit coverage must be informed by consultation with clinical experts familiar with the MBS and its application. Transparency is critical to any large reform process. To limit the timeframe for consultation at this stage threatens the entire body of work to date and poses a significant risk of unforeseen and unintended consequences.

Finalising this major piece of health reform work is a complex exercise. To ensure that we produce a quality product, to ensure that we have a strong and viable private health sector, to ensure that we maintain the reputation of the Australian health system as one of the world's best, will require our best efforts. For this next phase of work on the private health insurance reforms, the AMA calls on the Government to:

- Properly engage with the full range of stakeholders and clinical experts;
- Underpin the development of clinical definitions and rules with quality evidence and modelling; and
- Provide adequate time for meaningful consultation and consideration.

Only then will we ensure that the final result delivers the change Australian health consumers are expecting.

[11] Private Health Insurance Reform | Regulation Impact Statement Updates