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HOUSE OF REPRESENTATIVES STANDING COMMITTEE ON HEALTH AND AGEING

INQUIRY INTO HEALTH FUNDING

Roundtable Notes

MBF Australia Limited

Tuesday 23 August 2005

Theme One – Contracting arrangements between private hospitals and private health insurance funds

- The key submission MBF wishes to make in relation to hospital contracting is that there is a need for enhanced competition with hospitals

- The requirement for health funds to pay second tier default benefit rates to non-agreement hospitals that meet certain quality criteria greatly inhibits competition and appropriate negotiation with hospitals. Second tier is often used as a negotiating fall back by hospitals. This makes it difficult for health funds to negotiate pay for performance criteria, both for quality and financial performance. **Removal of second tier default benefits** would enable funds to contract more effectively in the interests of members as a whole.

- Allied to this is that there is little **mandatory reporting of information** by hospitals; if hospitals were required to publish financial and clinical data, health funds would have a basis on which to negotiate contracts and to provide essential information to consumers about the hospitals to which they are being admitted.

- The combined removal or second tier and mandatory reporting of information would enable funds to better contract on the grounds of quality and performance, ensuring optimal use of scarce health resources and appropriate consumer information.

Theme Two – Portability and Informed Financial Consent

1) Portability

- This has become a key industry issue in circumstances where one fund falls out of an agreement with a hospital so members move from that fund to another fund ("**gaining fund**"). This can be financially onerous on the gaining fund, especially where there is a significant amount of publicity about the fact that the hospital has gone out of agreement with a fund.

- Currently MBF's HPPAs, and those of many other funds, have provisions for "protected members". In MBF's case, this means that those with pre-booked admissions in the two months following expiry, nine months for obstetrics and 12 for certain chronic conditions are still to be treated under current HPPA terms.

- Our submission is that in addition to the above transitional provisions the hospital/fund code of conduct should include a requirement that the hospital continues to accept the contracted rate of the fund for a period of 90 days following termination of the contract for **all** members approaching the hospital, whether or not they have a booking. This will allow funds to write to members to explain the position and the members' options going forward.

- Other options for addressing issues have included:

    1) **Imposing additional waiting periods if you transfer after the contract with the losing fund has expired.** The issue with this approach is that this would lead to increased cost for the consumers and may devalue PHI. However, if appropriate transitional periods are in place as detailed above, this will minimise the impact on members.

    2) **Risk sharing arrangements.** There have been recommendations for the gaining fund and losing fund to share the benefit cost. MBF's view is that this would be overly complex (especially if reinsurance arrangements were to be impacted) and administratively unworkable. It could also create perverse incentives in fund/hospital negotiations.

- MBF considers that instead of making substantive changes to the way that health insurance benefits work, the Hospital Code of Conduct should be reviewed and provisions included to:

    1) Require that all hospitals and funds provide services for all pre-booked admissions and bookings to the hospital for a period of 90 days following the end of the agreement at the former contracted rate.

    2) Further regulations in relation to the conduct if funds and hospitals when negotiating or going out of agreement, particularly around how members should be communicated with.

2) Informed Financial Consent

Publication of gap doctors

- A requirement should be placed on health funds to publish lists of their no and/or known gap doctors, together with an analysis of the percentage of times that the doctor has opted into the gap arrangements for that fund's members. This will educate members about which doctors are using gap cover and give consumers the ability to choose a doctor who is more likely to use the arrangements.

IFC by treating doctor

- The onus should also squarely be placed on the treating doctor to obtain informed financial consent to the costs of all the doctors involved in the patient's care, otherwise no doctor should not be able to charge above CMBS for the treatment.

Theme three – Scope of private health insurance cover

- In relation to the scope of private health insurance cover, the following broad principles apply:

  1) There is a need for a continuum of care in health funding to ensure optimum health outcomes.
  2) There should be appropriate incentives to providing disease management services. The current reinsurance arrangements and the NHA need to be reviewed as a matter of urgency to remove obstacles to this.
  3) Care should be provided in the appropriate care setting, both in terms of optimum health outcomes and the most cost-effective manner of providing care.

- Expanding into outpatient services should be at the discretion of a fund, ie, there should not be any mandatory requirement to provide any services.

- The issue is how health funds engage stakeholders and GPs to determine appropriate care. If funds were able to help GPs to be adequately reimbursed for case management, GPs would have the resources and incentive to provide this case management.

- Services provided should only be eligible for reinsurance where they meet one of the following criteria:

  1) Preventable to an inpatient admission
  2) Case management/staffing
  3) Early discharge
  4) Substitutional care

- There should be an evaluation as to whether it meets the above tests.