SENATE COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Consideration of Legislation Referred to the Committee

HEALTH LEGISLATION AMENDMENT (GAP COVER SCHEMES) BILL 2000

MAY 2000

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ISSN 1440-2572

Senate Community Affairs Legislation Committee Secretariat

Mr Elton Humphery
Secretary

The Senate
Parliament House
Canberra ACT 2600

Phone: 02 6277 3515
Fax: 02 6277 5829
E-mail: community.affairs.sen@aph.gov.au
Internet: http://www.aph.gov.au/senate_ca

This document was produced from camera-ready copy prepared by the
Senate Community Affairs Legislation Committee Secretariat
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REPORT

HEALTH LEGISLATION AMENDMENT (GAP COVER SCHEMES) BILL 2000

1. THE INQUIRY

1.1 The Health Legislation Amendment (Gap Cover Schemes) Bill 2000 (the Bill) was introduced into the House of Representatives on 17 February 2000 and into the Senate on 12 April 2000. On 6 April 2000, the Senate, on the recommendation of the Selection of Bills Committee (Report No. 5 of 2000), referred the Bill to the Committee for report by 9 May 2000.

1.2 The Committee considered the Bill at a public hearing on 8 May 2000. Details of the public hearing are referred to in Appendix 2. The Committee received 15 submissions relating to the Bill and these are listed at Appendix 1. Copies of submissions may be accessed through the Committee's web site at: www.aph.gov.au/senate_ca.

2. THE BILL

2.1 The Bill amends the National Health Act and the Health Insurance Act to provide for gap cover schemes to enable registered health benefits organisations to provide no gap and/or known gap private health insurance without the need for contracts.

2.2 The 'gap' is the difference, paid by the health fund member, between fees charged by doctors for in-hospital medical services and the combined health insurance benefit and Medicare benefit. Data for 1997-98 shows that the cost of medical gaps for in-hospital medical services provided to people with private health insurance was around $200 million. The average medical gap for an episode for a private patient in a private hospital was $151 and for a private patient in public hospital was $69, though for some procedures the gap payment can be much higher.[1]

2.3 Research has regularly shown that the gap is a major contributor to consumer perception that private health insurance does not offer value for money. It remains a major cause of consumer complaint about private health insurance.[2]

2.4 Current legislation allows the gap to be covered in circumstances where the service is rendered by, or on behalf of, a medical practitioner:

- with whom the registered health fund has a medical purchaser-provider agreement (MPPA); or
- who has a practitioner agreement (PA) that applies to the professional service provided, with the hospital where treatment occurred, and that hospital has a hospital purchaser-provider agreement (HPPA) with the registered fund.

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1 Submission No.4, p.8 (DHAC) quoting Hospital Casemix Protocol Data.

2 Submission No.7, p.1 (PHIO).

2.5 While many health insurance funds have successfully negotiated HPPAs with hospitals, most medical practitioners have been implacably opposed to the agreements as a means of limiting out-of-pocket costs for health fund members. Their opposition is based on a perception that the system would permit health insurance funds to interfere in the doctor-patient relationship, thereby leading to 'US-style managed care'. As a result, very few MPPAs have been negotiated. The gap cover schemes proposed in the Bill are entirely voluntary and provide an alternative mechanism through which the medical gap may be covered by funds, without the need for formal contracts between doctors and funds.

2.6 The Bill establishes the framework that allows health insurance funds to develop gap cover schemes, subject to ministerial approval and review, to provide no gap and/or known gap private health insurance cover. The machinery provisions relating to gap cover schemes such as the form and content of applications; the ministerial approval process, including the criteria for approval; the ministerial power to impose and vary conditions on the operation of the schemes; annual reports and periodic reviews; and revocation and variation of schemes will be contained in regulations.

2.7 The criteria for approval of schemes by the minister as specified in the draft regulations (which will be the subject of further consultation with the industry) are:

- the scheme must be a genuine scheme that would reduce or eliminate gaps;
- the scheme contains proposals under which patients are offered informed financial consent, that is, a contributor to a fund is informed of any amounts that they can reasonably be expected to pay in respect of the professional service, including the amount of any Medicare benefit, health insurance benefit and the amount (if any) that the contributor may be liable to pay for the professional service;
- where appropriate, the scheme provides for simplified billing arrangements;
- the fund must demonstrate the scheme will not have an inflationary impact;
- arrangements made by the fund to ensure that contributors will not be disadvantaged by revocation of the scheme;
- the scheme requires all parties to maintain the professional freedom of medical practitioners involved in the scheme, within the scope of accepted clinical practice, to identify appropriate treatments in the rendering of professional services to which the scheme applies.[3]

3. ISSUES

3.1 The Department has stated that this legislation addresses the demands of consumers, the concerns of the medical profession and the needs of the health funds. The views of all relevant stakeholders were canvassed, with health funds and their representative bodies, peak medical bodies and consumer groups all supporting the proposed model.[4] This broad level of support for, or non-opposition to, the Bill was confirmed in submissions to the Committee.[5]

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3 Explanatory memorandum, p.5 which summarises proposed ss 37C (4) in the draft regulations. These criteria were strongly supported by the AHIA – Submission No.6, p.3.

4 Submission No.4, p.6 (DHAC); explanatory memorandum, p.10.

5 Submissions No.9, p.5 (AMA); No.6, p.2 (AHIA); No.13, p.1 (MBF); No.3, p.2 (ACA); No.14, p.1 (CHF); No. 7, p.1 (PHIO); No.10, p.1 (APHA).

3.2 It is important to note that the legislation provides a framework and is not intended to be prescriptive. The intention is to provide flexibility for the various parties in reaching agreement over schemes. However, there was discussion in a number of submissions that some aspects were not clearly defined. Because the legislation effectively relies on the goodwill of all parties in the formulation and success of schemes, some groups suggested that the legislation should be reviewed in a few years time to insure that it is meeting its stated objectives.[6] The AHIA suggested that a time limit be placed on the legislation's operation in the form of a sunset clause 'to ensure that the market behaviour anticipated by its supporters does not change in ways contrary to the interests of contributors'.[7]

3.3 While there was general agreement with the intended scope of the Bill, the Committee was asked to examine a number of specific issues. These are discussed below.

The practicality of the proposed 'gap cover schemes' and the likely acceptance of these schemes by medical service providers

3.4 Indications to the Committee were that there was broad, but not necessarily universal, acceptance of these schemes.

3.5 The AMA referred to a survey of its members that found near unanimous support for gap insurance but overwhelming opposition to products based on the agreements. The AMA concluded that the proposed gap cover schemes were likely to be at least as practical and have far greater acceptance by medical providers than the existing schemes based on agreements. APHA believed that the proposed schemes are generally practical and should be attractive to medical practitioners as they gave them a choice.[8]

3.6 The flexibility of the proposals was emphasised by the Department, stating that 'it is up to the funds and the medical profession to develop schemes that meet the needs of consumers and the expectations of practitioners'.[9] Success seems probable with the Minister saying in the second reading speech that this is the first time health funds and doctors have been able to agree on strategies for dealing with gaps. These sentiments were shared in submissions with the AHSA saying 'health funds cannot provide true value for money without the cooperation of the medical profession – the legislation…will promote this cooperation to the benefit of all' and the AMA saying 'our talks have lead us to believe the funds will now launch products under this legislation that, for the first time, could be endorsed by the AMA'.[10]

The effectiveness of measures proposed to cover gaps without inflation of health insurance premiums or total costs to patients

3.7 The Committee received differing views on the issue of inflation. The ACA expressed concern that the absence of clear contract between health funds and providers has a very real possibility of leading to inflation on medical fees, though their concern was moderated by the

6 Submission No.12, p.8 (CHA); *Committee Hansard,* 8.5.00, p.28 (CHF).

7 Submission No.6, p.3 (AHIA).

8 Submissions No.9, p.5 (AMA) and No.10 p.3 (APHA).

9 Submission No.4, p.17 (DHAC).

10 Submissions No.2, p.3 (AHSA) and No.9, p.5 (AMA).

protective features in the Bill.[11] Dr Woollard, however, argued that due to an exaggerated price signal, gap insurance 'is likely to have a deflationary effect on medical fees rather than the much touted medical fee inflation'.[12]

3.8 The AMA argued that all existing gap cover products based on agreements have the potential to be inflationary on both medical fees and insurance premiums and that any solution to medical fee inflation must be a market-based solution with the key being informed financial consent.[13] The AHA commented that the proposed schemes should bring market forces into play, stating that 'finding the pricing level for the no-gaps fees schedule which encourages a critical mass of medical practitioners to use it, yet keeps the premium price down will be the key to its uptake by medical practitioners, and ultimately the attractiveness of the product to consumers'.[14]

3.9 The criteria for a scheme's approval requires health insurance funds to demonstrate that the operation of the scheme will not have an inflationary impact. The Minister has acknowledged that this is not an absolute standard. He has stated that:

> In exercising powers of approval, I would ensure the gap cover schemes would not have an inflationary impact over and above those associated with gap product already developed under existing arrangements. But in doing this, I am trying to send a clear message that we simply will not allow any open-ended scheme and we will not allow a scheme that allows medical fee inflation.[15]

3.10 In order to ensure the schemes do not produce adverse impacts, safeguards have been built into the legislation. The Minister is permitted to approve a scheme subject to conditions. In addition, funds will have to report annually on the operation of the scheme and the Minister can periodically review the schemes. The proposed legislation also provides for revocation of a scheme if it is not meeting the required criteria as set out in the regulations.

The best method to measure inflation and the process for revocation of schemes which fail to meet this criteria

3.11 While the approval process provides that schemes should not have an inflationary impact over and above gap cover products already developed under existing arrangements, the Committee received a number of views on measuring inflation. The impact of inflation was seen as most significant when viewed from the perspective of the consumer. To assist the protection of the consumer it would be necessary to measure the known gap over a period of time, including the amount of benefits for medical fees paid by health funds and the total amount charged by doctors, especially additional fees such as booking charges.

3.12 The criteria for ministerial approval of a scheme provide for the scheme to be revoked if criteria are not met. To gain approval there must also be a demonstration that members would not be disadvantaged should the scheme be revoked. Arguments were put that there should be further specification as to how the minister would exercise this discretion,

11 Submission No.3, p.2 (ACA).

12 Submission No.1, p.1 (Dr Woollard).

13 Submission No.9, p.6 (AMA).

14 Submission No.8, p.4 (AHA).

15 Minister's second reading speech.

including assessing the inflationary effect prior to ministerial intervention and allowing funds a period of grace to remedy any unforseen impact. The criteria on members disadvantage was also seen as possibly being open-ended in its requirement on health funds.[16]

3.13 The Department advised that the provision for revocation of schemes is provided as a last resort. Revocation of a scheme would only occur if the scheme no longer met the essential criteria, and the fund was not complying with a previously imposed condition. The Department emphasised that contributors should not be disadvantaged if a scheme is revoked, giving by way of example that funds may provide that contributors will be able to transfer to an alternative product without additional cost.[17]

The definition of 'informed financial consent' and 'known gaps'

3.14 As noted earlier informed financial consent is seen as central to the successful operation and uptake of gap cover schemes. It was this issue which raised the most debate and concern in submissions and evidence. The concerns related to questions of clarity and certainty. Due to the framework nature of the legislation there is no precise definition of informed financial consent, with it ultimately being an arrangement between the funds, doctors and patients.

3.15 The Private Health Insurance Ombudsman proposed a formal definition in his submission that included all the elements necessary to ensure the consumer had sufficient information on which to judge the cost of the procedure to be undertaken. However, he conceded that 'actually it is the administration of the information rather than the definition that is important'.[18]

3.16 The operation of informed financial consent was questioned in evidence including issues such as the detail of cost information to be provided, what would be an acceptable level of cost variation, cost escalations resulting from clinical complications or other unforeseen events, the timing of advice to consumers, information problems in emergency situations, should doctors and/or funds provide information, and should information be coordinated by the medical team leader.

3.17 The Department confirmed that informed financial consent is an integral part of gap cover schemes. They recognised that many doctors already have their own systems of providing informed financial consent in place that work well for their patients. The wording in the regulations requiring informed financial consent reflects that in the existing agreement legislation. This requires the practitioner to inform the contributor of any amounts they can reasonably be expected to pay, where practicable, at any time before treatment, or otherwise as soon after treatment as the circumstances permit. The Department advised that:

> The Government does not seek to make the requirement any more or less prescriptive than this. It would not be appropriate to impose a standard informed financial consent system when individual practitioners and funds are in the best

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16 Submissions No.10, p.3 (APHA); No.13, p.4 (MBF).

17 Submission No.4, p.22 (DHAC).

18 Submission No.7, p.3 (PHIO).

> position to determine the ways of communicating information about costs that will best suit their patients.[19]

3.18 The provision of information in relation to a 'known gap' was seen as crucial for consumers within this legislation. With the rhetoric surrounding this subject and the perceived high costs associated with private health insurance, consumer expectations are for no gaps in either the hospital or medical component of their treatment. The existence of such expectations places considerable pressure on the practitioners and funds in the development of gap schemes and the provision of information to and outcomes for consumers.

3.19 The Department noted that the Government had not indicated a preference for either no or known gap policies as both would be an improvement on the current situation. It stated that 'if consumers are provided with known gap cover, this is acceptable in the short term, as this addresses what is currently one of the most often reported complaints about the gap – the element of surprise'.[20]

The form of disclosure of costs to patients and the enforceability of bills when there has been no disclosure

3.20 There was widespread agreement of the need for a written form for the disclosure of costs. A number of groups have been working on the development of a standard form and some models were submitted to the Committee. The AMA felt strongly that there should be an industry-wide standard form.[21]

3.21 The Department was relaxed over the exact format such disclosure should take saying that in the final analysis it is between the fund and the doctor as to what type of informed financial consent arrangement they would like to use. However, the Department's expectation was that all would have a certain basic form 'based on the principle of some sort of quote, some sort of concept of what the procedure is to be, how much you would be expected to be charged and how much out of pocket you would need to pay'.[22]

3.22 There was also general agreement that informed financial consent should apply to all consumers and not just those with gap or known gap policies. Discussion about enforceability was not restricted to just those cases where there had been no disclosure, but also to where there was a failure to met an agreed fee or where additional unexpected services were required by a patient for proper clinical care. Many groups believed that the practitioners should be bound by their quotes, while acknowledging that this needed to be balanced by clinical considerations. The ACA argued that 'where a patient either is not properly informed of a fee or where they are misinformed, they should not have to pay any more than the Schedule fee amount'.[23] Some felt that market forces would come into play with practitioners who do not adequately advise their patients of anticipated costs or adhere to their quoted fee being avoided by patients and possibly excluded from participation in approved schemes.

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19 Submission No.4, p.23 (DHAC). This view was supported by the AMA - Submission No.9, p.7.

20 Submission No.4, p.24 (DHAC).

21 Submission No.9, p.7 and Attachment (AMA). See also Submission No.4, Attachment D (DHAC).

22 *Committee Hansard,* 8.5.00, p.34.

23 Submission No.3, p.3 (ACA).

3.23 The legal situation applying to the enforcement of fees through the courts where there is no prior agreement on the fee may not support the consumer. The Private Health Insurance Ombudsman advised that:

> Although a South Australian magistrates court case held that in the absence of fee discussion, the consumer had a right to rely on the MBS fee as a reasonable fee, it is doubtful if this would be upheld in all jurisdictions.
>
> This office has informally received advice that indicates to us, that we should not rely too heavily on the South Australian case as it may not always apply. The circumstances of this advice make it all the more important for the practitioners to engage in proper advice to patients to enable them to make an informed decision.[24]

The impact of the schemes on existing medical purchaser-provider agreements

3.24 The intention of the legislation is to provide an alternative approach additional to the existing arrangements. There should be no impact on the operability of the existing provisions. The AHIA emphasised that member funds have no desire to abolish or alter existing arrangements that have been implemented for the elimination or reduction of the gap problem.[25] The AMA noted that it is not proposed that the agreement provisions of the existing legislation be removed, nor does the AMA seek their removal although it hopes they become redundant. The AMA believes that 'the ultimate test for the profession is to have these schemes work or face a return to contracts and the threat of managed care'.[26]

3.25 Some submissions hinted at a possible move to redundancy of agreements by suggesting that the introduction of fair and reasonable gap cover schemes would be likely to decrease the uptake of MPPAs. In particular, MBF thought that 'where MPPAs are currently being utilised by doctors on an opt in/opt out basis, an approved gap cover scheme is likely to replace the use of or be used as an alternative to MPPAs on an episode of care basis'.[27]

3.26 While there are few MPPAs in place, the Department expects that those doctors already participating in agreements would continue to do so under the current framework. However, the APHA 'expects that health funds with existing MPPA arrangements and existing no or known gap insurance products will modify existing products to comply with the requirements of the legislation'.[28] The AHSA suggested that there is a possibility that some doctors will choose to move from an existing MPPA to an approved scheme and, if so, that this should not present any problems to member funds.[29]

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24 Submission No.7, p.4 (PHIO). See also Submissions No.1, p.2 (Dr Woollard) and No.6, p.5 and Attachment (AHIA).

25 Submission No.6, p.7 (AHIA).

26 Submission No.9, p.7 (AMA).

27 Submission No.13, p.4 (MBF). Also Submission No.11, p.4 (Mr John Buntine).

28 Submission No.10, p.5 (APHA).

29 Submission No.2, p.7 (AHSA).

The effectiveness of the reporting and review provisions

3.27 The Committee received little comment on this issue, though the AHSA noted that 'in our view, the reporting provisions appear more than adequate. In an industry that is already highly regulated, a balance is needed to ensure that consumer rights are adequately safeguarded without imposing undue requirements (and costs) on insurers.'[30]

3.28 The AMA offered a cautionary word that 'if the reporting arrangements become too onerous, the Gap Cover Schemes will not be successful' and suggested that 'targeted and small audits would be a more successful strategy than whole of industry reporting arrangements'.[31]

3.29 The Department noted that the legislation aims to provide reporting and review mechanisms that are not overly bureaucratic, but are still able to protect consumers by allowing the minister to monitor whether schemes continue to meet the essential criteria and to take action if problems arise.

The need for any additional consumer safeguards

3.30 The proposed legislation provides many additional consumer safeguards over those contained in the current agreement framework. The CHF commented that 'known gap' products should provide for simplified billing arrangements wherever possible and argued that the wording of the regulations providing for simplified billing 'where appropriate' should be strengthened to ensure that the criteria cannot be abused.[32]

3.31 The ACA observed that the legislation in dealing only with gap cover schemes implies that only consumers with a 'known gap policy' will be properly informed of their medical fees. The ACA believes that it is the right of all consumers to be clearly informed about the nature of their medical expenses and argued that this legislation 'presents an opportunity to require all medical providers to inform consumers of out-of-pocket expenses and, where this does not occur for consumers to have some recourse'.[33]

4. RECOMMENDATION

4.1 The Committee reports to the Senate that it has considered the Health Legislation Amendment (Gap Cover Schemes) Bill 2000 and **recommends** that the Bill proceed.

Senator Sue Knowles
Chairman
May 2000

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30 Submission No.2, p.7 (AHSA).

31 Submission No.9, p.8 (AMA).

32 Submission No.14, p.4 (CHF).

33 Submission No.3, p.3 (ACA).

MINORITY REPORT

AUSTRALIAN LABOR PARTY

HEALTH LEGISLATION AMENDMENT (GAP COVER SCHEMES) BILL 2000

MINORITY REPORT

Overview

The Opposition agrees that gap charges are a major problem for private health insurance. Patients are quite rightly upset about large additional costs being incurred above the costs paid by Medicare and their private health insurance.

The Department estimated that privately insured patients paid around $215 million in gap charges for in-hospital, medical services in calendar year 1999. The AMA used a higher figure of $249 million for all gap charges in 1997/8. The average amount paid is difficult to calculate because of uncertainty about how many patients receive gap charges. However the evidence suggests the average is between $120 and $200 per private patient and that some patients pay gap charges ranging up to thousands of dollars.

Some patients with private insurance still find themselves facing a bewildering pile of bills that can amount to thousands of dollars in out of pocket expenses, which are covered by neither Medicare nor their private health fund. This situation is unsustainable.

In recent years, a number of successful gap cover schemes have been introduced under the 1996 amendments allowing “medical purchaser-provider agreements”. These schemes should continue as they have a demonstrated record of dealing with the problem without causing fee inflation or costs feeding back into increased premiums.

Doctors have argued for a different kind of agreement being allowed, subject to Ministerial approval. This Bill is intended to deliver such an alternative.

However there are a number of major concerns which should be addressed if this legislation is to have the desired effect.

The Opposition will move amendments to improve the legislation to deal with these issues when it is debated.

Lack of Objectives

The Bill takes the form of general enabling legislation with the specifics of the scheme contained in regulations. It is not possible to get a clear idea of what the intent of the legislation is from just reading the Bill.

The Department emphasised the degree of discretion being left to the funds and stated it would not produce any Guidelines on the form of the Gaps cover schemes and would only discuss the Schemes if approached by the Funds.[1]

This is an unsatisfactory situation because the nature of the issue requires the legislation to be more specific about how Gap cover schemes are intended to work. It is also a concern that the Department has advised that the legislation gives no certainty that a person who purchases a "no gaps" policy will in fact have no gap charged if they are treated by a doctor who is a member of that scheme. The best that the legislation can offer is apparently "an increased likelihood" that they will be charged no gap.[2]

There is a need for the legislation to broadly describe the objectives of the legislation and contain the key elements of the process for approval and revocation of a Scheme. If this were not the case the powers given to the Minister could be used very broadly indeed to authorise schemes which lie well beyond the scope of what the doctors advocating these amendments would have had in mind.

Inflation in medical fees

There was a common recognition – even amongst the scheme's proponents – that success of gap cover schemes depends on them not resulting in doctors simply increasing their fees.

The AMA recognised that there was an onus on doctors to make the scheme work in a non-inflationary way. Dr Brand summarised his views as follows:

> "If all it does is inflate fees and instead of putting money in patients pockets it puts money in doctor's pockets then the Minister, I am sure, will exercise the right that the Minister has to withdraw the schemes and put them back on the basis of a Lawrence style contract."[3]

Unfortunately, past experience suggests there is a serious risk of fee inflation and the measures proposed do not sufficiently come to grips with inflation.

Several submissions highlighted the two kinds of inflation that contribute to the total cost for patients. Increases in total medical fees due to doctors increasing their charges in response to the higher rebates received and the flow on costs of increased rebates being recovered by increases in health insurance premiums. Both of these problems need to be solved.

It would be too easy for doctors to rationalise that because they were now obtaining higher rebates from health insurers (significantly above the Schedule fee) then they could still extract as a "known gap" a substantial direct contribution from their patient. Some have even tried to argue that both the doctor and the patient could be better off.

This is a nonsense. The health system, the contributors to health funds and other doctors would all be worse off if such action was condoned. Any rapid escalation of medical fees would be a serious threat to the access and affordability of health services.

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[1] Dr Wooding DHAC CA 35

[2] Dr Wooding, DHAC CA 36

[3] Dr Brand, AMA CA 21

If the “gap cover schemes” established under this Bill are predominantly used to offer “known gap” products where the total medical fees are significantly increased then they will have failed both the short term and long term objectives.

The Minister should be required to ensure that the proposed scheme will not have an inflationary impact on fees or total medical costs before deciding on the approval of the scheme. The current wording is very vague on this point and there is a need for a specific provision in relation to inflation in the legislation.

Inflation in insurance premiums

The Department advised that if all existing gaps were covered by health funds the estimated premium increase would be 6.2%. [4] The Department also noted the AMA findings from a survey that 80% of their members would be interested in such a scheme.

It is important therefore that the schemes not simply transfer existing charges onto the total bill or there will be a sizeable increase in the cost of health insurance and a flow on cost to the Government through the 30% rebate. A 6% increase in hospital benefits by the funds would add around $200 m to the expenditure by the funds and $60 million to the Government’s own costs.

The major funds have indicated in their submissions that they have so far been able to extend their no gap contracts without any impact on their premiums.

It is also noted that the 2000/1 Budget proposes a new pooling arrangement to share the increased costs of gap schemes amongst funds.

However there is still a need to place a particular cap on the rate of increase in insurance premiums to discourage funds from engaging in behaviour which might drive up costs.

Measuring inflation

Several submissions drew attention to the need to be more specific about how inflation is to be measured. Steps need to be taken to ensure that the Health Insurance Commission and the Private Health Insurance Administration Council collect the necessary data on:

- the movements in premiums
- the average above schedule fees paid, and
- the size of known gaps

As MBF suggested, the “known gap” should include any additional fees such as booking fees so that it is a true measure of the total amount paid. [5]

The rate of increase in premiums is easier to measure and, because of an Opposition amendment in 1999, is now transparent. The Department of Health is required to publish quarterly figures on movements in premiums.

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[4] Dr Wooding DHAC CA 31

[5] MBF, submission 13, para 13

The Bill and its regulations lack any definition of what is “inflationary”. The Consumers Health Forum has called for the Bill to set out in further detail how the inflationary impact is to be assessed and the extent of inflation that would trigger Ministerial intervention. [6] The benchmark is also required to determine the standard that the scheme must meet in order to gain approval.

Direct comparison to the CPI is not necessarily the most appropriate measure. Other possibilities might be the ABS Index for hospital costs (generally in excess of CPI) and index of salary movements for other professional groups or a figure based on the cost index used for funding the public health system.

The AMA proposes that the benchmark should be that the gap cover schemes should be no more inflationary than products under MPPA’s and PA’s. [7]

The legislation should set a benchmark but the exact index can be left for the government to resolve on technical grounds.

Another unresolved issue is the extent of leniency to be provided in any one year if a fund is forced to push its premiums up by more than the inflationary amount. The Consumer Health Forum proposes that a fund should have a period to rectify problems if in one period the level of inflation is excessive.

The Bill gives the Minister the discretion to review the approval of a particular scheme if it fails to perform but it does not give the Minister an obligation to do so and it sets no benchmark for what would be an unacceptable degree of inflation.

This situation runs the risk of allowing damaging inflation to run for some time unchecked, which would weaken the health system irreversibly. Some funds have already reported pressure for increases in their fund rebate schedules to match the most generous of their competitors. In other words the competition to attract doctors to sign up for schemes is proving inflationary as they will sign up for the best available rates and then demand other funds match this.

The test that needs to be applied to “no gap” schemes is a lot simpler than the tests that must be applied to the more complicated “known gap” schemes.

It is relatively easy to measure the increase in fees and premiums for “no gap” schemes. The focus of negotiation for these schemes rests solely between the fund and the doctor and there is little room for complication.

Under a “known gap” scheme there are three way interests as the fund-member relationship is triggered along with the doctor- patient discussion of fees. For this reason the reporting requirements under “known gap” schemes should be more detailed to ensure that the intent of the Bill is not defeated.

The provision that allows “known gap” schemes to cover defined percentages is too uncertain and fails the criterion that patients are properly informed about costs.

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[6] Consumer Health Forum submission 14, pg 2

[7] AMA Submission 9, pg 6

Publication of the details of schemes

Several witnesses raised the importance of greater transparency in the design of the scheme to ensure that the objectives were achieved.

The ACCC urged health funds to set up their own database of specialist fees for their members to access. It expressed serious concern about a case in Western Australia where a GP wrote to 20 specialists and only one offered details of fees. [8]

Dr Buntine raised his concern that the insurance funds might insist on restrictive clauses which would impact on the clinical independence of doctors and argued for all such agreements to be publicly released or tabled in Parliament. [9] Other witnesses agreed that it was the intention that agreements should be public. The Bill should make this clear.

Revocation of schemes failing the criteria

As MBF [10] has pointed out there is a logical contradiction in the criteria set out in the regulations applying to revocation of failed schemes. The regulations propose that funds be required to show in their application that no member would be worse off if the scheme is later revoked.

However the scheme is designed to deliver benefits for members and if it is stopped they will lose those benefits and have to transfer to other products – where presumably they will no longer have no gap coverage.

The Consumers Health Forum [11] proposed the Bill be amended to provide for annual or biannual review of schemes. The Bill already provides for annual reporting.

The objective could therefore best be achieved by establishing a requirement that a review be undertaken if the annual report reveals that a scheme has failed to meet the criteria applying to the scheme in a significant way

Informed financial consent

The Consumers Health Forum [12] strongly supported the adoption of informed financial consent but was critical of the lack of transparency for consumers. In particular the provision for a known gap to comprise "a specified percentage of the total cost" was seen as too open ended.

In its submission, the AMA states that it strongly advises its members to provide informed financial consent and that other professional organisations such as the Australian Association of Surgeons and the Australian Association of Anaesthetists support this view.[13]

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[8] Professor Fels, ACCC CA 4

[9] Dr Buntine, CA 10

[10] MBF Submission 13

[11] Consumer Health Forum, submission 14, pg 1

[12] Consumer Health Forum, submission 14, pg 2

[13] AMA, submission 9 , pg 6

At the hearing the AMA expressed its strong support for informed financial consent applying to all patients, not just those in gap free schemes.[14]

The Consumer Health Forum [15]saw a need to specify the nature of the advice provided by doctors including :

- the advice to be provided in writing
- for the principal practitioner to inform the consumer of the fees of other practitioners involved in the treatment
- an explanation of the circumstances under which the fee might be varied.

The CHF endorsed the AMA form "Estimate of Fees" as a good model that could be improved on to meet these criteria.

The Private Health Insurance Ombudsman [16] provided the Committee with considerable detail on his work to define "informed financial consent" and a draft set of forms on which consultation was proceeding for the preferred form of notification of patients of the estimate of fees. These highlighted the need for information held by the health funds to be confirmed to ensure the advice from the doctor was correct for the type of cover that the patient has.

MBF[17] stressed the importance of gap schemes encouraging the participation of all the doctors involved in an episode of care.

The Opposition believes the obligation to provide informed financial consent should be entrenched in the legislation in the form of a requirement for medical service providers to give an Estimate of Fees where these will exceed the MBS Schedule fee. This need not be done prescriptively and the best way of moving towards better practice nationally is through Guidelines and education of practitioners. The AMA endorsed an approach of progressively increasing the proportion of doctors providing Estimates of Fees.

In order to maximise participation, providers should be given the option of providing the Estimate of Fees on behalf of other providers they know will be involved or of each provider separately providing informed financial consent to the patient. The long-term goal should be "simplified fee estimates" to match "simplified billing".

Enforceability of Bills

The Australian Health Insurance Association argued forcefully that some constraint was needed to charging of fees above the Schedule fee unless the fee had been clearly and knowingly agreed by the patient in advance. [18] The Association cited a SA Magistrates

[14] Dr Brand, AMA CA 21

[15] Consumer Health Forum, submission 14, pg 3

[16] Private Health Insurance Ombudsman, Submission 7 and other papers submitted

[17] MBF submission 13, para 18 and 19

[18] Australian Health Insurance Association, Submission 6 pg 5

decision in March 1994 concerning a person who was found not to be liable for a fee not disclosed in advance.

There are laws in NSW applying to legal professionals requiring disclosure of fees in advance and limiting the enforceability of bills which had not been made known to the client. The AMA argued that State consumer laws should be relied on when billing disputes arose but this does not address the core of the argument concerning undisclosed bills.

It was generally agreed that such a provision should not apply in the relative minority of cases where it was not practical or appropriate for the patient to receive fee advice prior to treatment.

Holding of patient funds

There was broad support for maximising the use of simplified billing procedures. There was concern that the use of the term should not be seen to limit such services to existing simplified billing agents. The Bill provides for patients to assign their rebates to hospitals, day hospitals, health funds or other prescribed people.

The Australian Doctors Fund[19] argues that if this is to occur then the simplified billing regulatory arrangements should also apply to the funds – most notably in regard to the obligations to hold patient funds in trust and to discharge payments within a maximum period of 90 days.

The Department made a detailed response but failed to establish why health funds should be exempted from these requirements. Indeed it confirmed that should a health fund become insolvent doctors would not be entitled to direct access to any money that was being held by the fund on their behalf.

On balance the provisions applying to the protection of money held following assignment should apply equally to all bodies given this special right. The Bill should be amended to make this clear.

Review of the Legislation

The Australian Health Insurance Association called for a sunset clause to be enacted to ensure that the market behaviour anticipated by the Bill's supporters does not change in a way contrary to the interest of contributors.[20]

Catholic Health Australia proposed that the legislation should be reviewed in 12 months to ensure that funds have achieved an uptake rate of 25% for their no gap products.[21] This seems perhaps too short a period but it is proposed that a clause be added to require an independent review of the legislation after July 2002 to be reported back to the Senate by 31 December 2002.

The Government has set no target for the anticipated penetration of no gap and known gap schemes. Currently about 16% of all claims are made as part of the existing no gap schemes.

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[19] Australian Doctors Fund, Letter to Committee dated 14th April 2000

[20] Australian Health Insurance Association Submission 6, pg 3

[21] Catholic Health Australia, submission 12, pg 8

The Opposition would hope that, if these schemes are successful in the way that their promoters have argued, that over 50% of all medical claims by mid 2002 should be part of these schemes.

Senator Chris Evans
(ALP, Western Australia)

May 2000

APPENDIX 1

SUBMISSIONS AND ADDITIONAL INFORMATION RECEIVED BY THE COMMITTEE

1 Dr Keith Woollard

2 Australian Health Service Alliance (AHSA)

3 Australian Consumers' Association (ACA)

4 Department of Health and Aged Care (DHAC)

Additional information

- Response to Ombudsman dated 14.2.00 and Department Circular dated April 2000 re informed financial consent, provided 3 May 2000
- Response to requested information on billing arrangements, dated 4 May 2000

5 Doctors' Reform Society (DRS)

6 Australian Health Insurance Association Ltd (AHIA)

7 Private Health Insurance Ombudsman (PHIO)

Additional information

- Letter to DHAC dated 10.1.00 re informed financial consent, provided 4 May 2000

8 Australian Healthcare Association (AHA)

9 Australian Medical Association (AMA)

10 Australian Private Hospitals Association (APHA)

11 Mr John A. Buntine

12 Catholic Health Australia (CHA)

13 Medical Benefits Fund of Australia Limited (MBF)

14 Consumers' Health Forum of Australia Inc. (CHF)

15 Australian Doctors' Fund (ADF)

APPENDIX 2

PUBLIC HEARING

A public hearing was held on the Bill on 8 May 2000 in Senate Committee Room 1S2.

Committee Members in attendance

Senator Sue Knowles (Chairman)
Senator Kay Denman
Senator Chris Evans
Senator Brett Mason
Senator Tsebin Tchen

Witnesses

Australian Competition and Consumer Commission

Professor Allan Fels, Chairman
Mr Sitesh Bhojani, Commissioner
Mr Hank Spier, Chief Executive Officer
Ms Isabelle Arnaud, Assistant Director, Compliance Division
Mr Jim O'Brien, Manager, Health Unit

Mr John A Buntine

Mr Peter Woodruff, Treasurer, Royal Australasian College of Surgeons

Australian Medical Association

Dr David Brand, President
Dr Robert Bain, Secretary General
Mr John O'Dea, Director, Medical Practice

Catholic Health Australia

Mr Francis Sullivan, Executive Director
Mr Jeff Simper, Director, Private Health

Consumers' Health Forum of Australia

Mr Matthew Blackmore, Executive Director
Ms Rachel Stephen-Smith, Policy Development Adviser

Department of Health and Aged Care

Dr Robert Wooding, Assistant Secretary, Private Health Industry Branch
Ms Christine Francis, Insurance Policy Section
Ms Jennifer Badham, Director, Health Financing Advisory Group