Senate Community Affairs Committee inquiry into the Private Health Insurance Bill 2006 and related Bills

RESPONSE TO QUESTIONS ON NOTICE TO DEPARTMENT OF HEALTH AND AGEING

Senator Gary Humphries asked:

Will the Department respond to the following recommendations or comments made in submissions to this inquiry as follows:

Australian Private Hospitals Association (APHA) – Sub 11 (pp.4 & 6)

Therefore, APHA contends that any accreditation requirement must apply to all services funded under BHC (including for example, telephone advice lines) in both the public and private sectors.

Response

The Government will introduce safety and quality requirements for privately insured services, to take effect from 1 July 2008, which will apply to providers of services, the facilities in which services are provided and the actual services provided. This requirement will also apply to services currently being covered by private health insurance, such as physiotherapists and dental and optical services. The proposed start date of 1 July 2008 allows enough time for providers to take a considered approach to the level of accreditation required and to get accredited.

In the meantime, insurers are expected to exercise a level of care on behalf of their members as they do now in choosing who will deliver services. For example, all funds currently require accreditation or certification for hospital services and for ancillary services, such as dentists. We are also aware that an existing telephone advice service offered by AHM is accredited under International Standards Organisation Quality Management Systems Requirements 9001.

APHA recommends that the protection of clinical discretion should be a requirement of all agreements between health insurance funds and all service providers, including hospitals.

Australian Medical Association (AMA) – Sub 14 (pp.9-10)

The AMA believes that the guarantee of non-interference in clinical decision making where there is an agreement between a health fund and a medical practitioner is too limited. A broader, more realistic guarantee of no interference in clinical management and clinical decision making extending into the location of care and into the issues around home care and chronic disease management programs is necessary. The existing guarantee is too limited.

Response

The proposed clause 172-5 is based on the current paragraph 73BDAA(1)(a) of the *National Health Act 1953*, although it applies to private health insurers

in their dealings with medical practitioners rather than hospitals dealing with medical practitioners. The Department is unaware of any complaints of insurers attempting to limit the clinical discretion of medical practitioners.

Extending the guarantee to one where there was no interference in clinical management and clinical decision making is not practicable. If this were to occur, insurers might not be able to offer policies which impose limits on benefits for treatment in particular locations, or of a particular type, or in using new experimental procedures/technologies, as they do currently.

The Department considers that unless evidence of interference is available it would be premature to legislate as the AMA is suggesting.

The AMA has established policies requiring a clear separation between the financing of private health services through private health insurance and the provision of that care. These policies reflect the best interests of the patient and the quality of health care. There are fairly obvious conflicts of interest in having private health funds involved in the provision of care. The AMA recommends that the Bill contain provisions which more clearly establish this separation. It is not sufficient to do this via business rules or other subsidiary legislation.

Response

Some private health insurers have operated dental and optometry services for their members for many years, and other have been involved in the ownership of hospital facilities. The Department is unaware of any evidence that these arrangements have in any way reduced access to services or the quality of patient care. In the absence of any evidence of detriment to patients it does not believe it would be appropriate to restrict insurers.

Given the groundbreaking aspects of the Bill and the need to ensure new products do not disrupt existing patterns of specialist and general practice care, the AMA recommends establishment of an industry panel responsible for approval of proposed products in the area of general treatment. The panel to comprise strong medical representation, including the AMA and be formally established under the PHI Bill and the Business Rules.

Response

Private health insurers have, for many years, developed their products (within the confines of the existing legislation) to cover hospital treatment to make private health insurance attractive and responsive to new treatments as they emerge.

The legislation provides health insurers with the flexibility to readily respond to, and fund, changes in clinical practice and the introduction of new technologies as they occur. The development of private health insurance products is commercially sensitive. The formal establishment of an industry panel to approve individual insurer's products would potentially stifle the development and availability of these products and is unprecedented in a commercial market.

The AMA is asking to strongly influence insurer's decision making processes, whilst at the same time asking that insurers not be allowed to interfere with clinical decisions. The Department believes that the right balance has been struck in the proposed legislation between insurers and service providers to ensure that high quality, affordable care is delivered to policy holders.

The AMA has serious concerns that the mandatory nature of the quality provisions in the Bill will encourage overly bureaucratic and costly arrangements which are only marginally related to actual quality services. The AMA recommends greater consideration of the quality provisions of the Bill given that the potential for over regulation and increased costs that are inimical to the broader purpose of the Bill. In particular we recommend the creation of a body reporting directly to the Federal Health Minister with strong professional representation and a focus on the quality aspects of new General Treatment initiatives.

Response

The uniform safety and quality requirements to be introduced from 1 July 2008 will recognise existing accreditation, licensing and registration requirements. The Government will not set any new standards where standards currently exist, and health insurers will not have a role in determining standards.

As these requirements will apply to providers of services, the facilities in which services are provided and the actual services provided, providers of new types of treatments will need to seek accreditation for those services before private health insurance benefits can be paid for them. Accreditation agencies require ongoing reporting about services in order for those services to retain their accreditation. The Government is of the view that this system is the appropriate system under which safety and quality for users of services is assured.

The Department also notes, in this context, the role of the Australian Commission on Safety and Quality in Health Care, which has been funded by the Australian and State and Territory governments to develop a national strategic framework to guide governments' efforts in improving safety and quality across the health system. This includes private health.

The AMA further recommends the consideration of provisions to allow the development of default benefit arrangements in the general treatment area in the event that it may prove necessary to have them.

Response

The default benefit provisions for hospital treatment have been in place for over sixteen years. During this time no need has been identified to extend them to cover non-hospital treatment. Insurers would strongly oppose introduction of default benefit arrangements for general treatment.

The AMA also recommends an amendment to Clause 121-10(3) to make it clear that services which attract a "Medicare benefit" are not covered under general treatment and the business rules cannot provide otherwise.

Response

One of the main policy objectives of the reforms is to allow insurers to cover hospital-substitute treatment. This includes, for example, chemotherapy or dialysis carried out other than in a hospital. Such treatment is covered in the Bill under the definition of general treatment providing it is specified in the Private Health Insurance (Health Insurance Business) Rules. Precluding general treatment from covering such services because they attract a Medicare benefit would effectively prevent the introduction of funding arrangements for hospital-substitute treatment.

The AMA is concerned that in the absence of mechanisms to the contrary, Health Funds will de facto determine the nature of the health services provided in the private health sector by offering no default participating products which will involve traps for providers and consumers alike. The AMA recommends the Government consider provisions to allow the health insurers and the medical profession to engage in discussions, other than at the individual level, to ensure that there are providers willing to offer services consistent with health insurance products to be sold in the market place.

Response

The Department notes that recent amendments to the *Trade Practices Act 1974* will allow collective bargaining between medical practitioners and insurers.

In relation to Chronic Disease Management Plans, there need to be provisions which require the continuing involvement and agreement of the patient's usual treating medical practitioner particularly the patient's General Practitioner and, if relevant, their treating specialist or psychiatrist.

Response

The Private Health Insurance Bill and accompanying rules regulate private health insurance products for the purposes of the payment of private health insurance benefits. They do not, nor is it appropriate for them to, prescribe the way in which health care services are delivered. It would also be inappropriate for legislation to require the involvement of a doctor, particularly if the patient does not want that.

The Bill provides the opportunity for medical practitioners to partner with health insurers to ensure that the best models of care and treatment are covered by private health insurance. The Bill does not restrict in any way patients' ability to continue seeing their usual treating practitioner.

Australian Health Insurance Association (AHIA) – Sub 7 (p.2)

Section 169-15: Notification of CEO Change

This section requires that an insurer must notify DoHA and PHIAC of any change to the name or contact details of its CEO, before the changes take effect. This is inconsistent with the similar requirement under the ASIC regime, as set out in Section 205B of the Corporations Act, for notification of a change within 28 days. We also consider that it is not valid to argue, as have the Department's representatives at the consultation forum on 14 December, that "commonsense" would be applied in enforcing

this provision, as this leaves an unreasonable discretion in the hands of the regulators. The legislation should be reasonable in the first place, rather than relying on the reasonableness of the Department in enforcing it.

Response

The provision as drafted is consistent with the requirement under the *National Health Act 1953* to notify changes of public officer before they take effect. However, the Department accepts that notification of changes to the CEO within 28 days will achieve the objective of maintaining up to date details.

Requirement for current health insurers to register under the new regime

Industry is unclear as to whether or why all existing health insurers are required to re-register under the new legislative regime. AHIA recommends that change be made such that the Bill allows for all ASIC-registered funds to be "grandfathered" into the new regime, rather than place administrative burden on health funds and numerous Department's *[sic]*.

Response

The Department does not believe re-registration will be an onerous requirement, especially as clause 18 of the Transitional and Consequential Amendments Bill allows fifteen months for insurers to register after the Act commences. It will provide an opportunity for insurers to review their practices and procedures to ensure that they comply with the new Act.

Further, any health insurance product approved before 1 April 2007 must be grandfathered into the new regime, rather than inappropriately wasting health fund staff and Department staff valuable time by having to reapply for all fund products that have already been approved by the Minister.

Response

There is no requirement for "reapplication".

Under clause 10 of the Transitional and Consequential Amendments Bill existing products are taken to be complying health insurance products until 1 July 2008 or until a change is made to the premiums, scope of treatment, or benefits for the product. At that stage the insurer will need to ensure that the product complies with the new Act.

Health Insurance Restricted Membership of Australia – Sub 4 (pp5 & 6)

STATUTORY FUNDS

During the consultation period, HIRMAA argued that the proposal that a statutory fund will be required to operate a health insurance fund had not been adequately explained. HIRMAA maintains its position that the DoHA has not provided substantive rationale for introducing the concept of statutory funds other than to contend that such funds have operated successfully in the life insurance industry.
HIRMAA notes concerns expressed at various industry forums that life insurance is characterized by a long claims settlement period requiring security of funding over many years. To the contrary, health insurance is characterized by very short claims settlement period of generally 3 – 4 months and there have been no demonstrated

examples of health insurers abusing the current practices. HIRMAA will continue to work with PHIAC to resolve outstanding issues in a sensible manner.

Response

The *National Health Act 1953* already requires insurers to maintain health benefits funds (paragraph 68(2)(b), sections 73AAC, 73AAD, 82Q), but does not set out a comprehensive framework around these funds.

The Bill clarifies the requirements around health benefits funds. These provisions will:

(a) ensure that the focus of prudential supervision will be on the fund;
(b) make market entry easier (existing ASIC registered corporations will be able to set up a health benefits fund, rather than establish a subsidiary entity to enter the market);
(c) assist market rationalisation (insurers will be able to transfer all or parts of their business contained within discrete funds to other insurers).

PRE EXISTING AILMENTS

The proposal to not allow Pre Existing Ailments (PEA) provisions for Psychiatric, Rehabilitation and Palliative care – two months waiting period only. HIRMAA vigorously contests the proposition that psychiatric, rehabilitation and palliative care fall outside the boundaries relating to PEA. It is our contention that the proposed two months waiting period only applies in the absence of the PEA conditions. Any variation to this condition would expose all funds to widespread exploitation and seriously weaken the integrity of the PEA provisions. Equally it may potentially generate significant increases in contribution rates. At best, funds would be required to provide a buffer within their pricing structure to accommodate members' costs which would inevitably be incurred if the PEA provisions were waived. At worst, it may well result in a dramatically increased claims experience that would in turn create a sharp spike in pricing.

Response

The provisions in the Bill reflect the requirements of the current Act. While it appears that some insurers may have not been complying with the current Act, the Department does not accept that non-compliance with a regulatory requirement is a substantive argument for changing the requirement.

Australian Physiotherapy Association (APA) - Sub 5 (p.3)

The Federal Government should amend Section 172-5 of the Private Health Insurance Bill 2006 to explicitly ensure that the protection of professional freedom to identify and provide appropriate treatment is extended to include physiotherapists. Similarly, the Federal Government should amend Section 72-5 of the Private Health Insurance Bill 2006 to provide physiotherapists parity with doctors.

Response

The proposed clause 172-5 is based on the current paragraph 73BDAA(1)(a) of the *National Health Act 1953*, although it applies to private health insurers in their dealings with medical practitioners rather than hospitals dealing with medical practitioners. The Department is unaware of any complaints of

insurers attempting to limit the clinical discretion of medical practitioners or other service providers.

Extending the guarantee to one where there was no interference in clinical management and clinical decision making is not practicable. If this were to occur, insurers might not be able to offer policies which impose limits on benefits for treatment in particular locations or of a particular type or in using new experimental procedures/technologies, as they do currently.

The Department considers that unless evidence of interference is available it would be premature to legislate as the APA is suggesting.

Proposed clause 72-5 is intended to protect consumers from the impact of agreements between insurers and service providers under which the parties agree to limits on the number of services for which full benefits will be paid, and hence impose co-payments on some patients. The Department considers that patients of physiotherapists should be afforded the same protection.