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Private health insurance reforms – second wave

AMA submission to the Department of Health consultation in relation to options for further reforms to private health insurance.

phiconsultation@health.gov.au

Consultation 4: Applying greater rigour to certification for hospital admission.

The AMA supports a system that ensures a patient's ability to claim and use their health insurance is purely a clinical decision and not one that sees a health insurance call centre operative providing advice on whether a patient requires hospitalisation and can claim their medical treatment under their insurance.

The AMA does not support the establishment of any industry lead and funded mediation panel as we see this as a grave risk to the clinical independence of medical practitioners and the care of patients. The issues that arise from disputes around certification are first and foremost matters for clinical judgement that puts the care of patients first and insurer profits second.

The AMA believes this is an important issue, with these preliminary comments provided on the basis that further consultation will be needed to deliver the intended outcomes. The AMA stands ready to contribute to any further consultation or development work on this issue.

Introduction

The regulation that underpins the interaction between private health insurers, hospitals and patients must promote the effective and efficient supply of health services. Private health insurance has specific features that make the design of efficient regulation especially complex. This is further compounded by the specific historical development and place of private health insurance in the Australian context – as a form of supplementary and complementary insurance to Medicare, with the primary purpose of providing private hospital cover.

There are a range of regulatory requirements specific to private health insurance, which include:

1. Private Health funds are not permitted to insure for out of hospital medical services for which there are Medicare entitlements (e.g. medical services in a primary care setting),

nor are health funds permitted to cover prescription drugs listed on the Pharmaceutical Benefits Scheme;

2. Health insurers seeking to increase premiums are required to seek regulatory approval by making an application to the Minister for Health, who has the right to reject premium increases. The process for each premium round commences in October the previous year with approval and premium changes taking effect in the following April;

3. From July 2015 the responsibility for the prudential supervision of the private health insurance industry was transferred from the Private Health Insurance Advisory Council (PHIAC), a dedicated administrative body reporting directly to the Minister for Health, to the Australian Prudential Regulation Authority (APRA), the prudential regulator of the Australian financial services industry. Through APRA the general principles of solvency, capital adequacy, and governance are applied uniformly to the health insurance sector and with all other financial services;

4. Second tier default benefits, introduced in 1998, is a regulatory requirement whereby eligible hospitals that do not negotiate an agreement with health funds are eligible to default payments equivalent to 85% of the average contracted benefits paid by the health fund to comparable facilities for the same episode of care in that state/territory;

5. The *Private Health Insurance Act 2007* provides legislative authority for the Department of Health and APRA as regulators of private health insurers. This includes providing for the private health insurance ombudsman to report, and make recommendations, about regulatory and industry issues to the Minister or Department and about the practices of particular private health insurers or private health insurance brokers.

The AMA does not believe that the Department of Health is performing as an effective regulator in this area. On the Department of Health's website the page on regulation and compliance only refers to the role of the Private Health Insurance Ombudsman (PHIO):

- *the Private Health Insurance Ombudsman protects the interests of private health insurance consumers*[1].

However, the PHIO is a complaints ombudsman that is limited to the protection of the interests of private health insurance consumers by:

- assisting health fund members to resolve complaints through our independent complaint-handling service
- identifying underlying problems of private health funds or health care providers
- providing advice to government and industry about issues affecting consumers in relation to private health insurance

[1] https://www.health.gov.au/about-us/what-we-do/regulation-and-compliance

- providing advice and recommendations to government and industry about private health insurance, including the performance of the sector and the nature of complaints
- managing PrivateHealth.gov.au, Australia's leading source of independent information about private health insurance for consumers.

Whilst the Department of Health is the appropriate regulator in relation to issues relating to private health insurance, it does not have the resourcing or the independence required to do this job effectively.

Example 1: Regulatory issues with MBS items and Private Health Insurance eligibility

Implementation of the recommendations of the MBS Skin Services review highlights a key regulatory issue that exists. The medical profession worked closely with the Department of Health in 2016 and 2017 on changes to MBS Skin items, and subsequent Private Health Insurance eligibility and banding.

A review of the MBS Skin items was undertaken to streamline the items, encourage appropriate clinical practice, and generate savings to the Government. The MBS Review work was led by one area of the Department that had supported a collaborative approach with the work being led by clinical leaders from each specialty.

However, when the items were allocated to Private Health Insurance 'banding', it was done by the private health insurance area of the Department without clinical involvement. The result was that key procedures, which the MBS items had been designed to cover, were no longer covered by private health insurance benefits. These changes were introduced with only a day or two of notice.

This led to some patients no longer receiving insurance benefits for treatment in a hospital setting. Furthermore, a lack of understanding of how private health insurance benefits were to be applied to the items meant that a patient would be told they were covered for the removal of a skin lesion, only if, after the removal and testing of the sample, it was identified as malignant. Finally, the rushed implementation meant that patients received informed financial consent and were told they were covered under their insurance, only to find out after the fact that they were not covered, due to the change in rules.

Ultimately it took 18 months of work to fix the issue, with the AMA leading work for the Department to define further those conditions, under the broader MBS items in question, should be eligible for private health insurance coverage.

Following 18 months of extensive consultation, at the request of the Department, the relevant Colleges, Societies, Day Hospitals and the AMA produced a list of 'approved reasons' as to why these items should be covered under private health insurance and to assist the Department in directing insurers to pay – as they are required to under relevant legislation. This was achieved via a circular being issued.

This example effectively demonstrates the technical issues that can arise when allocating MBS items to private health insurance eligibility, and the problems that can arise when this work is truncated. But it also highlights the reticence of the Department to assume and prosecute its role as regulator appropriately and quickly, particularly where the issues arise as a result of Departmental decisions.

When the AMA has raised regulatory matters with the Department, there has been in our opinion inadequate response and we have had to work hard to get the Department to carry out their duties (see Example 1 below)[2].

However, even here the issue of resourcing is obvious. This circular providing the clinical guidance still relevant to these items can now only be found on National Library's archived documents website[3].

The AMA believes that the Department of Health is the regulator that should control insurers' behaviours including hospital certification disputes. However, there is scope for the Department to be supported in this role through a clinician led mechanism.

QUESTIONS FOR ALL STAKEHOLDERS: CERTIFICATION FOR HOSPITAL ADMISSION

1. **Should an industry mediation panel be established to resolve hospital certification disputes?**
2. **If an industry mediation panel is established, what process should be undertaken to establish it, including determining membership?**
3. **What parties should be involved in the development of advice on the appropriate criteria for certification?**
4. **Should PSR, or another regulatory body, provide a regulated and enforceable process for reviewing Type C certification?**

The AMA does not support the establishment of an industry lead and funded mediation panel as we see this as a grave risk to the clinical independence of medical practitioners and the care of patients.

The issues that arise from disputes around certification are first and foremost matters for clinical judgement. If a panel were established, it must medical practitioner led. The AMA would support the creation of an independent clinical committee to provide a mechanism to develop policy advice and resolve certification disputes in a timely fashion.

The issue of whether a patient requires hospitalisation should not sit in the purview of a health insurer call centre operative. The crux of these disputes is about in which setting a patient should receive their care. This is a clinical decision and when a treating medical practitioner makes that determination, that should be the end of any argument.

Where additional support is needed then guidelines on specific issues can be developed by those with the appropriate expertise, with the appropriate colleges, association and societies being best placed to provide this advice. Such guidelines would also need periodic review, but the judgement on whether guidelines need review also needs to be based on medical advice, taking into account

[2] https://webarchive.nla.gov.au/awa/20181010234656/https://www.worldaidsday.org.au/internet/main/publishing.nsf/Content/health-phicircular2017-37

[3] https://trove.nla.gov.au/

the ongoing relevance of existing guidelines. Guidelines should be driven by the clinical needs of the patient and must not be influenced by cost or other non-clinical issues.

Once a medical practitioner has made a clinical decision about a patient's treatment, there does remain an issue of enforcement. Protracted disputes and long negotiations are not in anyone's interest.

The AMA supports the Government investigating an appropriate mechanism for this. However, the AMA does not believe that the PSR is the appropriate body for this work.

The PSR was established in July 1994 to protect the integrity of Medicare and the PBS. The agency's role and powers, and the process that it must follow come under the *Health Insurance Act 1973* .

The role of the PSR is to:

> *To protect patients and the community from the risks associated with inappropriate practice and to protect the Commonwealth from having to meet the cost of medical/health services provided as a result of inappropriate practice*[4].

The PSR is responsible for reviewing and examining possible inappropriate practice by practitioners when they provide Medicare services or prescribe Government subsidised medicines under the PBS. The PSR examines suspected cases of inappropriate practice that have been referred by delegates of the Chief Executive Medicare. Medical practitioners already see the PSR as a place where they may subject to punitive actions or even lose their ability to practice. An extension of the PSR role into Type C will be seen by the profession as inappropriate scope creep and potentially a mechanism for punishing doctors.

Additionally, the PSR does not have any regulatory authority to cover private health insurers or hospitals and would require extensive legislative and regulatory changes. It would also require considerable changes to how they work.

The AMA believes that an alternative mechanism should be developed, potentially using the principles developed for the work of the medical indemnity panels that sit under the Australian Financial and Complaints Authority (AFCA).

AFCA uses expert Panels to make Determinations about particularly complex medical indemnity complaints it receives. Panel members are appointed by the AFCA Board based on their objectivity, qualifications, experience and relevant personal qualities. It is mandatory that medical professionals are included in any assessment of medical indemnity issues.

The AMA supports the Government undertaking further work and appropriate consultation with the whole sector on this issue.

[4] https://www.psr.gov.au/

5. Should there be a specified list of 'special circumstances' allowable for Type C certificates?

The AMA does not have detailed knowledge of the clinical issues for each Type C certificate and we defer to the appropriate expert groups to provide this level of understanding.

6. Should hospitals be potentially liable for Type C certificate statements, and if so, in what circumstances?

The AMA is not in a position to comment on this question.

7. What is the likely impact upon premiums of this proposal?

The AMA is not in a position to comment on this question.

8. What is the likely impact on the number of people and/or policies covered of this proposal?

As the full details of the proposal are not available in this consultation document the AMA cannot comment on the likely impact on the number of people and/or policies covered.

9. What are appropriate metrics for measuring the impact of this proposal?

As the full details of the proposal are not available in this consultation document the AMA cannot comment on what the appropriate metrics to measure the impact would be.

10. What is the regulatory burden associated with this proposal?

At the full details of the proposal are not available in this consultation document the AMA cannot comment on the likely regulatory burden.

11. Are there any other reform options that should be considered?

<u>A revised regulatory framework</u>

The AMA believes that as a regulator in this area, the Government does not support or fund the Department appropriately. Additionally, the Department is significantly conflicted by its policy setting and regulatory role and is not best placed to manage this responsibility. The recent example of the implementation of the recommendations of the review of the MBS spinal surgical items highlights a key private health insurance regulatory failing and, the AMA believes, the lack of resources available to the Department in these key areas.

The AMA believes that the creation of an independent body or at least an independent statutory position with adequate resources is critical to better supporting the private health insurance sector. With the pressure on membership and the waves of reform being undertaken by Government, a strong, independent regulator is needed now more than ever.

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