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SUBMISSION

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AMA submission to the Department of Health and Aged Care on the private health reform options consultation paper

By email: private.hospitals@health.gov.au

Introduction

The Australian Medical Association (AMA) is pleased to provide a submission to this consultation, as a follow-up to our confidential submission to the Private Hospital Financial Health Check submitted to the Department of Health and Aged Care (DoHAC) in 2024. As we stated in that submission, comprehensive reform to Australia's private health system is essential to ensuring the ongoing sustainability of the entire system, not just private hospitals.

We were pleased when the health check brought together stakeholders from across the sector to discuss reforms to the system. The AMA's 2022 private health summit and 2023 private health reform workshop demonstrated the willingness of stakeholders from across the sector to work together to achieve reform. As such, we are even more pleased by the continuation of the CEO forum and the reform options presented in this paper.

The viability issues in our private hospitals are a symptom of broader structural issues within the sector which are a result of the lack of genuine reform over the past two decades. While we broadly support the changes proposed in this paper, we would be frustrated and disappointed if it stopped there. The private health system needs reform beyond changes to how insurers pay hospitals for servicers or how contracts are negotiated, it needs reforms that improve the entire system and deliver benefits for all involved — clinicians, consumers and government too.

Reform proposals

2.1 Second-tier default benefits — short-term reform proposal

Proposed changes

The proposed changes are:

1. Update the calculation methodology for second-tier benefits set out in the Private Health Insurance (Benefit Requirement) Rules 2011 by requiring insurers to use

volume-weighting of contract services to determine their second-tier default benefit schedules.

2. Revise the second-tier hospital categorisation and benefit calculation methodologies to increase the second-tier default benefits payable to established non-metropolitan hospitals offering a wide range of services from 85 per cent to 100 per cent of the insurer's contracted rate.

Stated purpose

The consultation paper[i] states that the overall purpose of this reform is to "support private hospital and private health insurer negotiations by improving integrity of second-tier default benefit calculations and increasing the level of support provided by second-tier default benefits for established regional hospitals".

The aim of the first change mentioned is to "address the potential for artificially low second-tier default benefit rates" arising from insurers including in these calculations contracted prices for services that are either not delivered or are delivered at low volumes in certain hospitals.

The aim of the second change appears to be to ensure that established regional hospitals offering a wide range of services, which may face higher per-unit input costs and much lower service volumes than metropolitan hospitals, receive sufficient funding to continue providing a wide range of services to Australians living outside metropolitan areas if they fall out of contract with any specific insurer.

AMA response

The AMA supports the proposed changes.

Second-tier default benefits are an essential safety net for patients using Australia's private health system, in that they ensure consumers have a choice of hospital service provider — including hospitals that do not have a contract with the consumer's private health insurer — and are protected from large out-of-pocket costs.

As a flow-on effect, the existence of default benefit arrangements supports diversity in the private hospital sector and assists in managing the balance of power between hospitals and insurers with very large market shares.

It is important to note only a small percentage of private hospital separations are out of contract, which means default benefits have minimal direct influence on private health insurance (PHI) premiums.

Furthermore, in the current environment where large private health insurers have considerable power in contract negotiations, particularly with smaller private hospitals that are not owned by the larger private hospital chains, second-tier default benefits are an

essential financial "fall-back" protection for such hospitals if they cannot negotiate mutually acceptable contracting arrangements with insurers.

However, the AMA is also aware that in its recent study of private health insurance minimum and second-tier default benefit arrangements commissioned by the department, Ernst and Young found there is "some evidence" that insurers "are able to manipulate second-tier default benefits downwards by including low rates for services in contracts with hospitals that do not provided that service".[ii]

Furthermore, the Ernst and Young report pointed to "possible anti-competitive behaviour in contracting, where insurers restrict payments to doctors to 100% of the MBS fee when the services are performed at a hospital that is not contracted with the insurer". It added that this potentially disincentivises doctors to operate at these hospitals and puts pressure on hospitals to agree on a contract.[iii] The AMA has observed that this does prevent doctors from performing services at second-tier facilities.

For example, Bupa has a clause in its contracts with doctors that refuses to pay doctors their contracted rates for procedures conducted at non-contracted hospitals. This effectively forces hospitals (usually day hospitals) to accept contracts with Bupa, at rates that are lower than second-tier, or doctors will not provide services at these hospitals. The AMA has already raised this issue with the department. The contracted status of the hospital should in no way be linked to the remuneration of the doctors performing services at those facilities.

Given these concerns, the AMA agrees that second-tier default benefit arrangements can be further improved and supports both changes to these arrangements proposed in the consultation paper, with some caveats.

Proposed change 1

As noted in the AMA's 2022 and 2023 submissions on this issue, the AMA supports changing the second-tier benefit calculation formula to require insurers to use volume-weighting to determine their second-tier default benefit schedules. This is so that the rates determined reflect actual claim volumes paid through each contract, provided hospitals in the sample measures are comparable, as recommended to DoHAC by Ernst and Young.[iv]

Provided the volume measure accounts for size and geography, as this proposal appears to do, the AMA believes that a volume measure would be much fairer and recommends that it is implemented on a permanent basis. However, the AMA concurs with the Ernst and Young view[v] that specific allowance should be made for new services where there is little or no volume so as not to inhibit the uptake of new and innovative treatments.

For consumers, this is a "no-brainer" change, designed to close a loophole in the existing formula that otherwise allows insurers to set second default benefits at artificially low rates.

Proposed change 2

In principle, the AMA also supports (with some caveats) the recommendation to increase second-tier benefits for established non-metropolitan hospitals offering a wide range of services to 100 per cent of the insurer's contracted rate. We are aware that in recent years, cost/revenue imbalances and workforce pressures have been particularly acute for many regional and rural hospitals, with the result that many have had to close, or close/reduce access to specific types of services (such as maternity and psychiatry).

To maintain the value of private health insurance for policyholders living in non-metropolitan (MM2 and above) areas, it is essential that established private hospitals that serve these areas by providing a wide range of services are funded sufficiently to continue providing safe, high-quality care.

However, while the consultation paper notes not all private hospitals in MM2 areas and above access second-tier default benefits, it provides no other data by which to assess whether the change to a 100 per cent second-tier default benefit rate for relevant non-metropolitan private hospitals should be temporary or permanent.

Given this, the AMA suggests the change be implemented initially for a three-year period, with a post-implementation review undertaken once the department has two years of data on which to assess the impacts of the change.

Additional arrangements to support these changes

The consultation paper also poses questions about additional arrangements to support the effectiveness of proposed changes, including audits of insurer calculations and publication of second-tier rates.

The AMA is aware that under Schedule 5 of the *relevant Private Health Insurance (Benefit Requirement) Rules 2011*, insurers are already required to have their lists of applicable second-tier default benefits independently audited for compliance in accordance with Australian auditing standards. They must also provide these audit reports, including second-tier default benefit lists, to the Department of Health and Aged Care. In addition, they are required to provide a list of second-tier default benefit rates for any specific hospital to that hospital before those rates commence on 1 September each year.

Despite this, Ernst and Young noted there remains "a lack of confidence in these schedules from stakeholders, as there are several different parties auditing the schedules and a need for greater transparency in the calculation of second-tier default benefits from each insurer". It added that "to further support improvements in transparency and consistency…

consideration could be given to developing specific audit guidelines and a mechanism for enabling the Department direct visibility of underlying calculations". [vi]

There have also been concerns around the audit costs incurred by insurers per annum, adding to the cost of the annual second-tier calculation process and ultimately, to the cost of running a private health insurance business.

Over the medium-to-long-term, the AMA would prefer to see auditing of insurer calculations conducted by a well-resourced and independent Private Health Systems Authority with access to all relevant data to ensure full confidence in the integrity of these calculations and their compliance with any new volume-weighting requirements.

To further support the effectiveness of the proposed changes, the AMA believes it is also essential that private health insurance legislation is amended to disallow insurers from including terms in their contracts with doctors that prevent them from receiving their contracted rate if they conduct procedures in hospitals that are not in contract with the insurer. Without this, the other changes will have no impact.

2.2 Payment terms and administrative costs — short-term reform proposal

Proposed changes

The consultation paper[vii] suggests feedback is requested on "whole of sector approaches" to:

- implementing a moratorium on private hospitals' benefit claims that remain unpaid by private health insurers after a "reasonable payment period (e.g. 45 days) and are not subject to formal contractual dispute proceedings", with the proviso that any such benefits paid by insurers "would remain subject to the usual contractual post payment audit and compliance processes"
- "adopting a consistent approach to the period of time that post payment audit processes, initiated by the insurer can be commenced within, for example 2 years, noting this timeframe aligns with the Medicare Benefits Schedule compliance arrangements"
- "standardising administrative, reporting and compliance contract terms in Hospital Purchaser Provider Agreements that ensure payment integrity but also enable consistent and streamlined claiming and payment of benefits for services delivered by hospitals irrespective of the private health insurer that the patient holds a policy with".

Stated purpose

The stated purpose of these changes is two-fold: firstly, to improve private hospital cash flows; and secondly, to reduce administrative costs across the sector.

AMA response

The AMA supports the proposed changes.

The AMA is aware that in recent times, delayed claim payments by insurers have been a significant concern to private hospitals that has adversely affected their cash-flows. Delays in payment of claims by insurers also adversely affected private health insurance policyholders who need valid claims settled promptly in the face of widespread post-pandemic cost of living increases.

For example, the Private Health Insurance Ombudsman's (PHIO) February 2024 Issues paper Can private health insurers decide that a patient does not need treatment in hospital? provides numerous examples of what it calls "unreasonable" insurer refusal to pay benefits for valid Type C claims, with some insurers leaving claims in limbo for up to two years, and others "indicating that they do not have a cut-off time" for completing or denying a claim.[viii] This is clearly unacceptable.

Currently, there is no mechanism that hospitals or patients can use to resolve delayed payment other than patients seeking the help of the PHIO.

Australia cannot risk a shift towards the managed care environment that has emerged in the United States of America, where it is reported that legitimate claims are routinely denied by private health insurers almost as a default setting, often with serious health-related and financial consequences for patients.[ix]

Accordingly, the AMA fully supports each of these proposals, which provide a reasonable balance between the interests of insurers, their policyholders, and private hospitals. To ensure this has a meaningful immediate impact this policy must apply to all current outstanding payments that are not under dispute.

With respect to the additional issues for stakeholder feedback raised in the consultation paper, firstly, the AMA is opposed to a self-regulatory approach, as it is unlikely to be effective. This is illustrated in the PHIO Issues Paper referred to above, which observes that many insurers appear to have had no compunction about breaking rules clearly set out in both the *Private Health Insurance (Benefits Requirements) Rules 2011* and a later PHI circular issued by the then-Department of Health in 2017.

Instead, the AMA supports regulatory change to legislate the introduction of standardised contractual terms. The AMA would also prefer that over the medium-to-long term, an independent Private Health Systems Authority with sufficient statutory power and expertise was given the role of developing, implementing and monitoring compliance with standardised contractual terms, and resolving disputes.

However, given the urgency of legislating this change, the AMA suggests the department, in consultation with PHIO, takes initial carriage of developing and implementing standardised contractual terms.

With respect to the adjudication of disputes, the AMA would not support this role being given to the Professional Services Review (PSR) agency on anything other than an interim basis, as it lies entirely outside of the proper remit of the PSR.

2.3 Hospital in the home: short-term reform proposal

Proposed changes

The consultation paper[x] suggests that to "improve patient access to established clinically beneficial Hospital in the Home programs and address funding certainty for providers of this care … the sector in collaboration with the department identifies by early 2025 an initial tranche of well-established clinically beneficial Hospital in the Home programs".

Under an amendment to the *Private Health Insurance (Benefit Requirement) Rules,* all insurers will then be required to provide a minimum level of funding for their policyholders to access these mandated programs, subject to:

- the patient holding an appropriate level of cover; and
- the provider of the program meeting appropriate accreditation and service quality standards.

Following the identification and implementation of the first tranches of mandated Hospital in the Home programs that department will engage with the sector on examining processes for the addition of further programs.

AMA position

The AMA supports the proposed changes.

The AMA has been calling for mandated insurer funding of out-of-hospital care for some time, and released its research report Out-of-home models of care in the private health system in October 2023.

Further details of the AMA's position on funding for out-of-hospital care are set out in the AMA position statement Principles for private health insurers to cover out-of-hospital care, and the AMA requests the department reads this statement closely to guide its reform work on this issue.

Firstly, the AMA is concerned about the lack of definition provided in the consultation paper. For example, the term "mandated hospital in the home programs" has caused some confusion within the sector. The AMA took this to mean programs for which insurers are

required under law to provide benefits to hospitals and patients, rather than a mandate on clinicians and hospitals to provide relevant care to all patients with specific medical conditions at home rather than in hospital.

However, the AMA is aware that some other stakeholders interpreted this statement to mean mandated care at home for certain medical conditions. This would of course be an untenable proposition, in terms of clinical judgement, and patient safety, patient choice, and patient rights.

Secondly, the AMA is concerned about the absence of any definition of the term hospital-in-the-home (HITH) care. This is the only type of out-of-home care referred to in the consultation paper, but the consultation paper does not define it.

For example, Victoria, which led the establishment of HITH in 1994, has defined HITH as acute substitution for inpatient care, where, given the intensity of care required by patients selected for these programs, hospitals should be reimbursed at rate equivalent to those paid by insurers for inpatient care. On the other hand, developments in New South Wales have somewhat obscured the distinction between HITH as a hospital service, and lower-intensity out-of-home care (still referred to as HITH) as a community service.

In some cases, the lines between high- and low-intensity hospital substitution care and outpatient care are difficult to distinguish. This is why we have used the term 'out-of-hospital-care' (OOHC) to refer to hospital substitution care in our own publications to date.

Over the longer-term, the AMA would not like to see an expansion of OOHC limited to relatively high intensity HITH where the patient is still considered to be "admitted" to a hospital.

Nevertheless, the AMA recognises urgent reform needs to start somewhere and will be more manageable if implemented in tranches. Starting with high-intensity HITH where the patient is considered admitted given the hospital resources required to care for them is a reasonable starting point.

For the purposes of defining the kinds of benefits insurers will be required to provide, it is critical to establish formal and agreed distinctions between high-resource intensity HITH type care where the patient is still considered to be admitted, relatively low-resource intensity hospital substitution care where the patient is not considered to be admitted, and outpatient care.

For high-intensity HITH provision that requires considerable hospital resources, the AMA suggests that in the short-term the appropriate mechanism for determining what reimbursement private health insurers provide is contract negotiations, supported by the availability of second-tier hospital default benefits as a back-up.

In addition to asking stakeholders to identify an initial tranche of "well-established and clinical beneficial Hospital in the Home programs", the consultation paper seeks feedback on "what priority conditions, if any, should the mandated Hospital in the Home programs focus on and why".

Asking stakeholders to nominate "priority conditions" is the wrong approach. The assessment of whether out-of-home care may be beneficial for a patient must always rest with the treating medical practitioner, and the decision about whether to be treated in hospital or in another setting must always rest with the patient. The whole value proposition of private health insurance rests on patient choice, and this must not be undermined.

The AMA is already aware of many well-run private out-of-hospital care programs. With respect to the consultation paper question on the evidence that should be required to determine that specific hospital-led HITH programs are "well-established" and clinically beneficial before they are funded by insurers, the AMA believes that this is again, the wrong question.

As Ernst and Young[xi] notes in its study of second-tier default benefits, to be eligible to receive second-tier default benefits, hospitals must already meet eligibility requirements, in addition to NSQHS safety and quality care standards and state and territory licensing/registration regimes. They add that most hospital contracts with insurers also include separate safety and quality KPIs and requirements assessed by individual insurers on top of these other requirements, which creates huge administrative inefficiencies for hospitals.

The AMA does not believe private health insurers should be allowed to consider themselves to be the arbiters of quality and safety in healthcare, on top of national and state quality and safety requirements.

2.4 Mental health

Proposed changes

In addition to changes to risk equalisation arrangements for mental health proposed under section 2.6 of the consultation paper and addressed later in this submission, changes proposed by the department in section 2.4[xii]' are as follows:

> "increase the supply of internationally educated psychiatrists able to admit patients to private mental health hospitals by 'amend[ing] the 10-year moratorium requirement under Section 19AB of the *Health Insurance Act 1973*, to support:
>
> - appropriate care to be provided to the patient, including post discharge care; and
> - continued or potentially enhanced provision of acute mental health services by public hospitals, potentially through resource sharing between private and public hospitals."

The consultation paper does not propose a specific amendment to the existing 10-year moratorium requirement, but asks stakeholders to comment on:

- any potential risks/unintended consequences associated with the amendment
- whether it should operate on a time-limited basis, and if so, for how long
- whether it should apply to overseas trained psychiatrists already practicing in Australia, or be limited to cohorts entering Australia following the amendment
- whether it should include provisions requiring that overseas trained psychiatrists dedicate time in both public and private hospital settings, and if so, the proportion of clinical hours that should be performed in private and public hospital roles.

AMA response

The AMA has concerns with the proposed changes.

For many years, the AMA has argued that while Section 19AB has worked to distribute international medical graduates (IMG) to areas of workforce need, it does not meaningfully support retention and instead encourages a transient workforce.[xiii] It is also unacceptably coercive to IMGs. The AMA has advocated for the gradual and careful phasing out of Section 19AB and the implementation of clear and innovative workforce incentives to replace it.

In the absence of effective incentives to work in regional and rural areas, this proposal as it stands risks significant unintended consequences. 19AB already directs overseas-qualified medical graduates towards working in areas of need, and if 19AB is amended for the psychiatrist workforce, it risks completely denuding the most under-served regional and rural communities of a psychiatry workforce, given that private psychiatry services in many city areas are also underserved and would gladly hire them.

The practical implication of this proposal is that overseas trained psychiatrists will have three options for working in Australia:

1. Work entirely in the public hospital system.
2. Work in private practice in a designated area of need.
3. Work without geographical restriction as a psychiatrist across a private facility and a public hospital.

As the third option would allow IMGs access to the MBS while working in a metropolitan setting, we expect this would be the most appealing option.

Even with an increased intake of overseas trained psychiatrists because of the expedited pathway, it is hard to see this proposal not undermining rural psychiatrist recruitment.

In addition, the public hospital component would be challenging, particularly if the department chose to apply it only to new immigrant psychiatrists with no previous time working in Australia, as public hospital patients are often those with the most serious mental health problems. Another key question is how and by whom this requirement would be policed.

Psychiatry was added to the expedited Specialist IMG pathway in December 2024. However, as the AMA has argued in its submission to the Medical Board on the revised standards for specialist registration, it is critical efforts to streamline processes to increase intake of overseas-trained specialists do not come at the expense of Australia's high standards of patient safety and quality care. This requires greater focus on providing holistic educational and transitionary supports to help doctors from different cultures and backgrounds to integrate into the Australian health workforce.

For all these reasons, the AMA cannot support this proposal without further consultation on a proposal with far more details.

2.5 Maternity care

Proposed changes

In addition to risk equalisation changes discussed at 2.6, the consultation paper[xiv] proposes "mak[ing] privately insured maternity care more accessible and affordable, by including maternity cover as a standard inclusion across a greater number of policies, instead of only 'Gold' level policies".

It notes that currently, private hospital insurance for the clinical categories of "pregnancy and birth" and "assisted reproductive services" are only mandated coverage requirements for the gold product tier. Cover for "miscarriage and termination of pregnancy" is mandated for bronze, silver and gold product tiers. If a policy meets the minimum requirements of a tier, but also includes additional coverage, such as "pregnancy and birth" then it can be called a "plus" policy — for example, bronze plus or silver plus.

The government sets the maximum waiting periods that insurers can impose for a policyholder to hospital treatment benefits, which is currently specified as being up to 12 months for pregnancy and birth (obstetrics) for those taking out a new policy or increasing their level of cover.

AMA position

The AMA supports the proposed changes in principle.

The consultation paper asks for stakeholder views on the implications of retaining current arrangements for private health insurance cover of pregnancy and birth services. In short, the

AMA is deeply concerned that without any changes to these arrangements, private hospital maternity services will not exist in Australia by the end of the decade.

The impact of private hospital closures on patients requiring maternity (i.e. pregnancy and birth[xv]) services — particularly those living outside metropolitan centres — has been exacerbated by the fact that numerous private hospitals that otherwise remain open have had to close their maternity services. This is adding significantly to the burden on public hospitals, and potentially putting pregnant women living in regional areas who may have to travel significant distances to give birth at risk.

Further, although waiting periods for maternity services are obviously designed to prevent or reduce "hit-and-run" behaviour on the part of pregnant policyholders, they fail to take account of the fact that many pregnancies are not planned,[xvi] and essentially lock out those who have not had gold health cover with their insurer for 12 months from private maternity services.

Equally important is the high price and relatively low value proposition of gold policy products for many women/couples in their childbearing years. At a time when many younger people are struggling with increased living costs across many areas of basic expenditure such as housing, energy, childcare and groceries, most cannot afford gold tier private health insurance, particularly as many insurers appear to be pricing these products out of the market.[xvii]

In addition, many young Australians are likely to find that maternity services are the only clinical services provided by gold insurance products that are relevant to their short-term needs, so the value proportion of having the highest level of cover does not align with the cost.

Subject to appropriate modelling to ensure any changes made meet the objectives of the system, the AMA supports the following options in principle:

Product design changes

AMA members would welcome maternity services being included in both gold and silver policies. Whatever changes are made, robust economic modelling on the impacts will be required.

However, another option is to move maternity services from gold tier policy products to silver tier products. This may help to reduce the price of gold tier products and improve the value proposition of private health insurance for prospective parents, who would be able to obtain cover for maternity services without needing to pay for cover for services they are unlikely to need.

In the medium-term, the AMA believes there is a strong case for a thorough review of the way the gold/silver/bronze/basic product tier categorisation system is functioning, given the increasingly unaffordable price of gold tier policies, and evidence from DoHAC's own statistics that many Australians have had to downgrade their cover in recent years.

Government funding for maternity into risk equalisation pool

The government could allocate funding to a risk equalisation pool specifically for maternity-related services. To be successful, this would require reclassifying maternity services from gold policies to silver policies. The goal would be to ensure that the cost of private maternity care is distributed fairly among policyholders.

Rebatable fee to upgrade

A one-off cost to upgrade from a silver tier policy to silver plus maternity without a waiting period could be levied by insurers but rebated to those who maintain their silver policy for 10 years. This could be administered in the same manner as the Lifetime Health Cover loading, but in reverse. For example, if you paid $2,000 to upgrade your silver policy to include maternity cover, you could get $200 off your silver policy premium each year for 10 years. That way, you would get a "free upgrade" if you maintain your cover.

There could also be caveats placed on the minimum eligibility for the free upgrade to further deter hit-and-run behaviour. For example, it could be mandated that only those who have held a silver policy for two years could qualify for the free upgrade.

Rebatable fee to upgrade — combine with government funding for maternity into the risk equalisation pool

The "rebatable fee" to upgrade option could potentially be combined with the option of the government putting funding for maternity cover into the risk equalisation pool, with the pool paying the insurer both the one-off upgrade fee and the policy premium discount in subsequent years.

This would leave the insurer no worse off for offering the free upgrade, would leave the individual no worse off if they hold the policy for 10 years. The government would get some cost recovery through people dropping their cover. Importantly, this policy would improve the private health insurance value proposition for younger people while simultaneously upholding the principles of lifetime health cover.

The AMA provides further comment in relation to risk equalisation in the following section.

2.6 Changes to risk equalisation arrangements to support improved access to mental health and maternity care

Proposed changes

The consultation paper[xviii] proposes to "improve access to more affordable private health insurance coverage for mental health and maternity care through amendments to the Risk Equalisation regime" that would "equalise some or all of the benefits insurers pay for mental health maternity care".

Risk equalisation (RE) supports the community rating principle legislated under the *Private Health Insurance Act 2007*, by partially compensating insurers with a riskier demographic profile by re-distributing money from those insurers paying less than average benefits to those paying higher than average benefits.

Current RE regulations include an age-based pool (ABP) which shares a subset of actual claims costs for participants above the age of 55. The proportion of claims pooled increases with age, with more than 80 per cent of costs shared for the oldest members. There is also a high-cost claims pool (HCCP) which shares 82 per cent of costs if someone claims more than $50,000 per year, which is not common.

Private health insurance claims for maternity care delivered in a private hospital (such as for the birth of a baby) and psychiatric care are generally not subject to risk equalisation, unless the claim costs reach $50,000 in a year.

AMA position

The AMA notes that under current RE arrangements, insurers receive less compensation via cross-subsidisation for both pregnancy and mental health claims than they do for other relatively high-cost claim types.[xix]

In principle, the AMA is open to changes to RE arrangements to support improved access to mental health and maternity care, subject to:

- detailed modelling based on current data, to ensure any changes meet the objectives of the health system
- establishment of a regulator with sufficient expertise to take responsibility for ongoing monitoring and adjustment of risk equalisation parameters based on experience data.

This is a very technical area, and the AMA cannot fully support this option without seeing the results of current modelling of the likely consequences both for patients and the whole

private health system. The Finity study was based on unchecked data voluntarily submitted by insurers that is now several years old.

Furthermore, as Finity has itself argued in its final risk equalisation report to the department, a regulator needs to be identified or established to conduct ongoing data collection, analysis and adjustment of RE arrangements and "would require significant lead-time to develop the new capability required" as a whole. [xx]

The AMA is aware DoHAC plans to set up a technical working group early this year to model these changes. However, we doubt a proper review can be undertaken and implemented in the short time frame proposed in this consultation paper.

As discussed in detail in the AMA's 2022 submission on the Finity review of risk equalisation settings, the critical issues that will determine the utility of the recommendations of this technical working group and the AMA response to them will be:

- the modelling expertise represented on the working group
- the definition of the purpose of risk equalisation adopted by the group
- the criteria used by the group to evaluate alternative models and make recommendations
- the nature and form of consultation with the wider private health sector on these recommendations
- how the government plans to ensure any new risk equalisation arrangements implemented are subject to ongoing monitoring and review, rather than ad hoc review by consultants when crises emerge.

With respect to this last point, the AMA advocates for the establishment of an independent, well-resourced Private Health Systems Authority to undertake this ongoing work.

The AMA is aware adjustments to RE are likely to have an impact on the relative pricing of PHI product tiers. Irrespective of any adjustments to RE settings, the AMA argues that so as not to further jeopardise patient access to psychiatric care in private hospitals, it is critical that there is no watering down of the requirement that all insurers must provide at least restricted cover with a two-month waiting period for private hospital psychiatric services in basic, bronze, and silver tier policy products.

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[i] https://consultations.health.gov.au/private-hospitals-branch/private-health-reform-options-dec2024/, pp. 4-5.
[ii] Ernst and Young. 2023. Study of private health insurance minimum and second tier default benefit arrangements. Final report to the Australian Department of Health and Aged Care, p.60.
[iii] Ernst and Young. 2023. Study of private health insurance minimum and second tier default benefit arrangements. Final report to the Australian Department of Health and Aged Care, p.62.
[iv] Ernst and Young. 2023. Study of private health insurance minimum and second tier default benefit arrangements. Final report to the Australian Department of Health and Aged Care, p.65.
[v] Ernst and Young. 2023. Study of private health insurance minimum and second tier default benefit arrangements. Final report to the Australian Department of Health and Aged Care, p.65.
[vi] Ernst and Young. 2023. Study of private health insurance minimum and second tier default benefit arrangements. Final report to the Australian Department of Health and Aged Care, pp.61, 66.
[vii] https://consultations.health.gov.au/private-hospitals-branch/private-health-reform-options-dec2024/, p. 5.
[viii] Private Health Insurance Ombudsman. 2024. Can private health insurers decide that a patient does not need treatment in hospital?, p.8.
[ix] https://www.cbsnews.com/news/health-insurance-humana-united-health-ai-algorithm; https://www.cbsnews.com/news/unitedhealth-lawsuit-ai-deny-claims-medicare-advantage-health-insurance-denials[ix]; https://www.propublica.org/article/cigna-pxdx-medical-health-insurance-rejection-claims
[x] https://consultations.health.gov.au/private-hospitals-branch/private-health-reform-options-dec2024/, pp. 5-6.
[xi] Ernst and Young. 2023. Study of private health insurance minimum and second tier default benefit arrangements. Final report to the Australian Department of Health and Aged Care, p.44.
[xii] https://consultations.health.gov.au/private-hospitals-branch/private-health-reform-options-dec2024/, pp. 6-7.
[xiii] https://www.ama.com.au/articles/international-medical-graduates-2015
[xiv] https://consultations.health.gov.au/private-hospitals-branch/private-health-reform-options-dec2024/, p.7.
[xv] 'Pregnancy and birth services' is the name of the clinical category for private birth services – other services such as IVF and termination of pregnancy sit within other clinical categories set by DoHAC.
[xvi] https://reproductiveandsexualhealth.org.au/handbook/chapter-10/how-common-is-unintended-pregnancy-in-australia/
[xvii] https://www.choice.com.au/about-us/media/media-releases/2024/feb/gold-cover-sneaky-tactics
[xviii] https://consultations.health.gov.au/private-hospitals-branch/private-health-reform-options-dec2024/, p.8.
[xix] Finity Consulting. (2022). Risk equalisation: final report
[xx] Risk equalisation: final report, p. 27